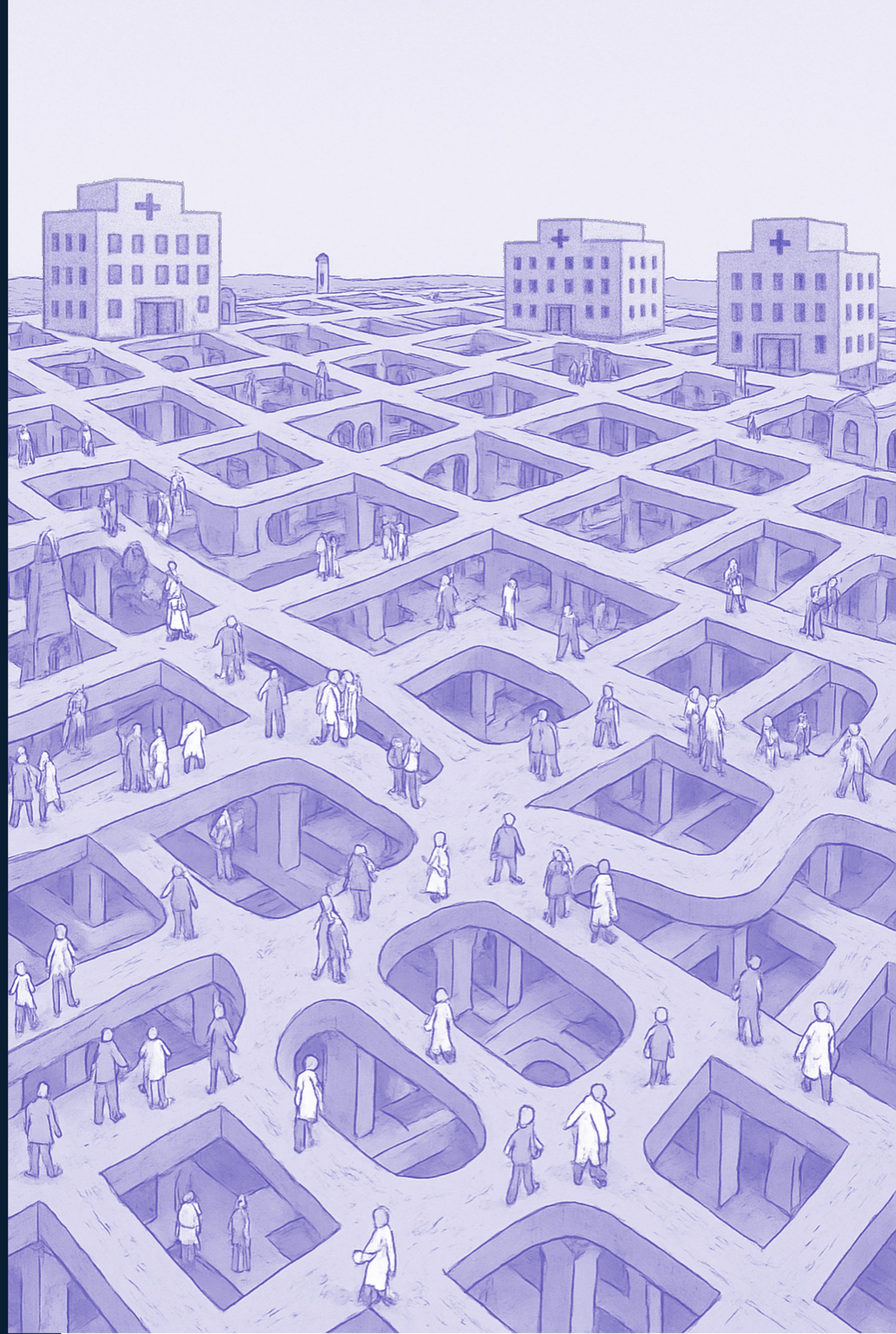
2025
Trends Shaping the Health Economy



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INTRODUCTION

The Laws of Economics Necessitate Change in the Health Economy

The inputs of the U.S. healthcare system vastly exceed its outputs, as measured by the health of the American public. And yet, over the next 10 years, health expenditures are expected to continue to grow faster than the rest of the economy, projected to reach 20.3% of GDP, or $24,200 per person, by 2033. The current trajectory of the U.S. healthcare system, one which increasingly depletes societal wealth without generating commensurate health gains, is unsustainable for patients, payers, employers and providers alike. The fact that the health economy continues to defy the laws of economics confirms that it is not a free market.

This fifth installment of the *Trends Shaping the Health Economy Report* provides insight into six data-driven trends that are either intensifying or emerging. The Transparency in Coverage initiative promulgated by the Centers for Medicare and Medicaid Services makes obvious that the U.S. health economy finds itself at a crossroads; the choice for health economy stakeholders is whether to implement radical and transformational change from the inside or whether to be subjected to such change by external forces, namely Federal and state government. Said differently, the question for health economy stakeholders is this: do you want to make it happen or have it happen to you?

In either scenario, every health economy stakeholder will be required to deliver demonstrable value for money, rather than perpetuating inefficiencies that compound systemic waste. To do so, stakeholders must be willing to reassess the very foundation of the U.S. healthcare system. Rather than thinking about what already exists, the fundamental question is this: what is essential?

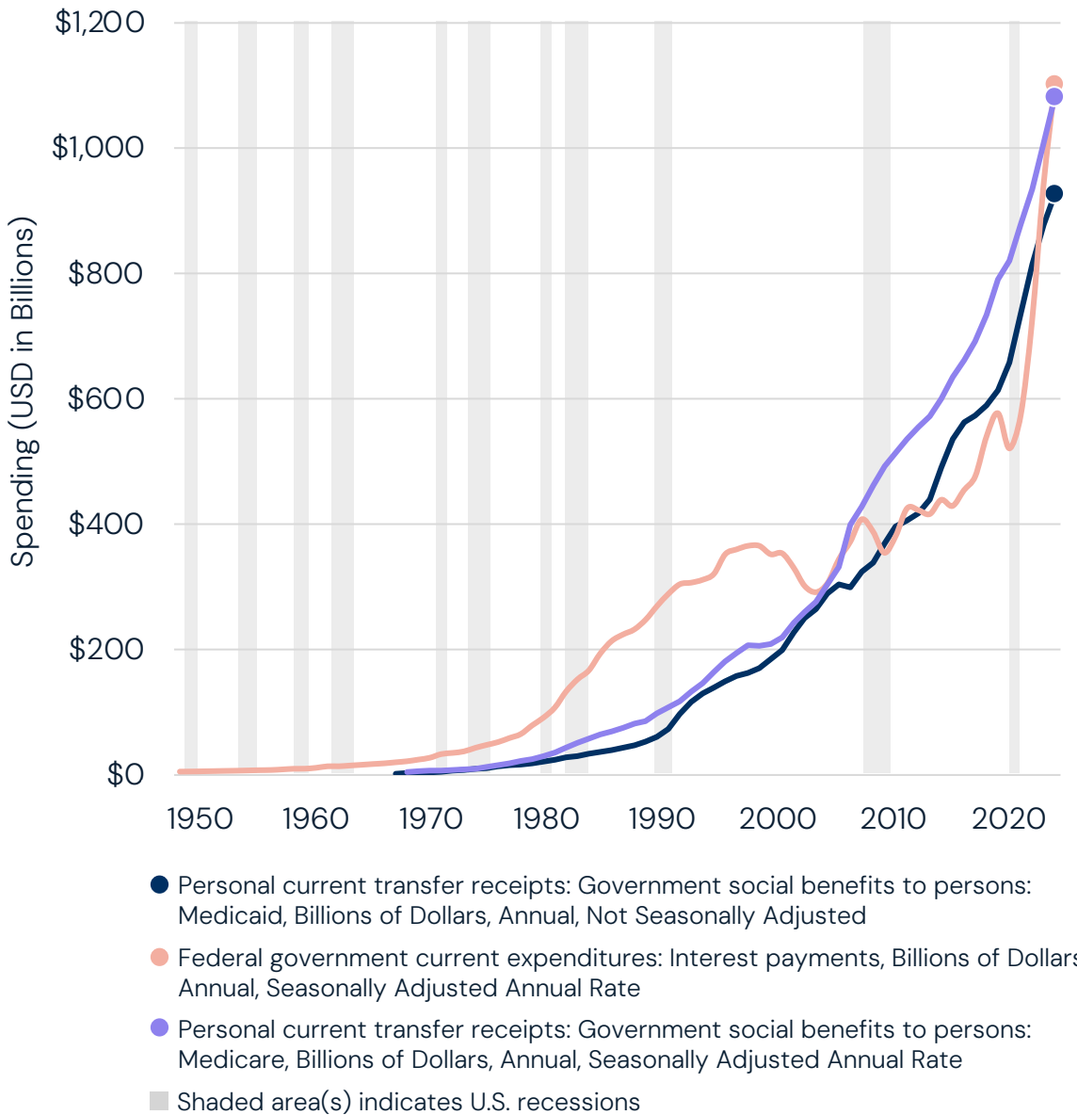
This report does not claim to provide all the answers, but it offers a framework for asking the right questions. What trends have you not considered, and how will they impact the markets that your organization serves? What changes must your organization make to deliver more value for money relative to your current and future competitors? What changes are necessary for your organization to compete effectively in a system that can no longer sustain the status quo?

INTRODUCTION

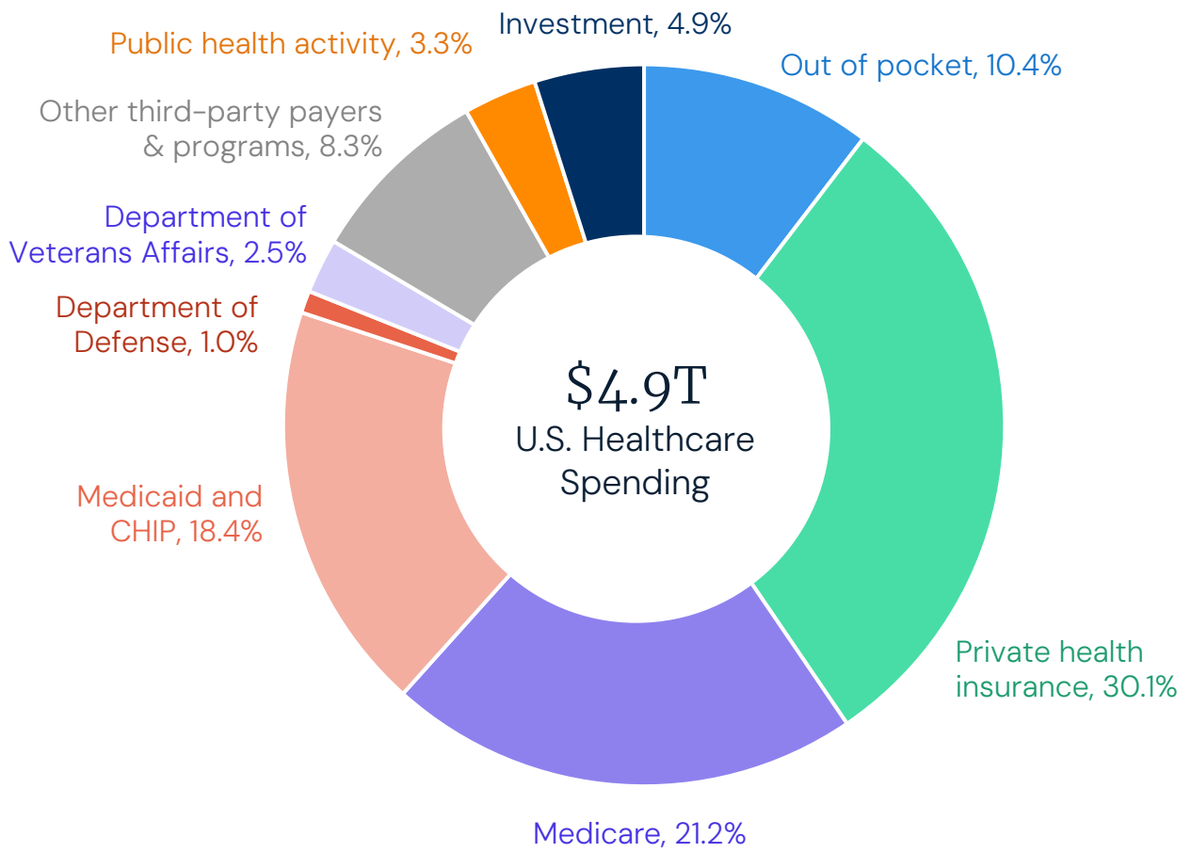
The U.S. Cannot Afford Its Healthcare System

In 2023, U.S. healthcare spending reached $4.9T, or $14,570 per person, representing 17.6% of the nation's GDP. Employers underwrite the largest share of that spending, accounting for nearly $1.4T, or 30.0% of total NHE. How long can the U.S. allocate more than $1T each to Medicare, Medicaid and interest on the Federal debt?

U.S. Spending vs. Federal Spending on Medicare, Medicaid and Interest Payments, 1947-2024



Sources of U.S. National Health Expenditures, 2023

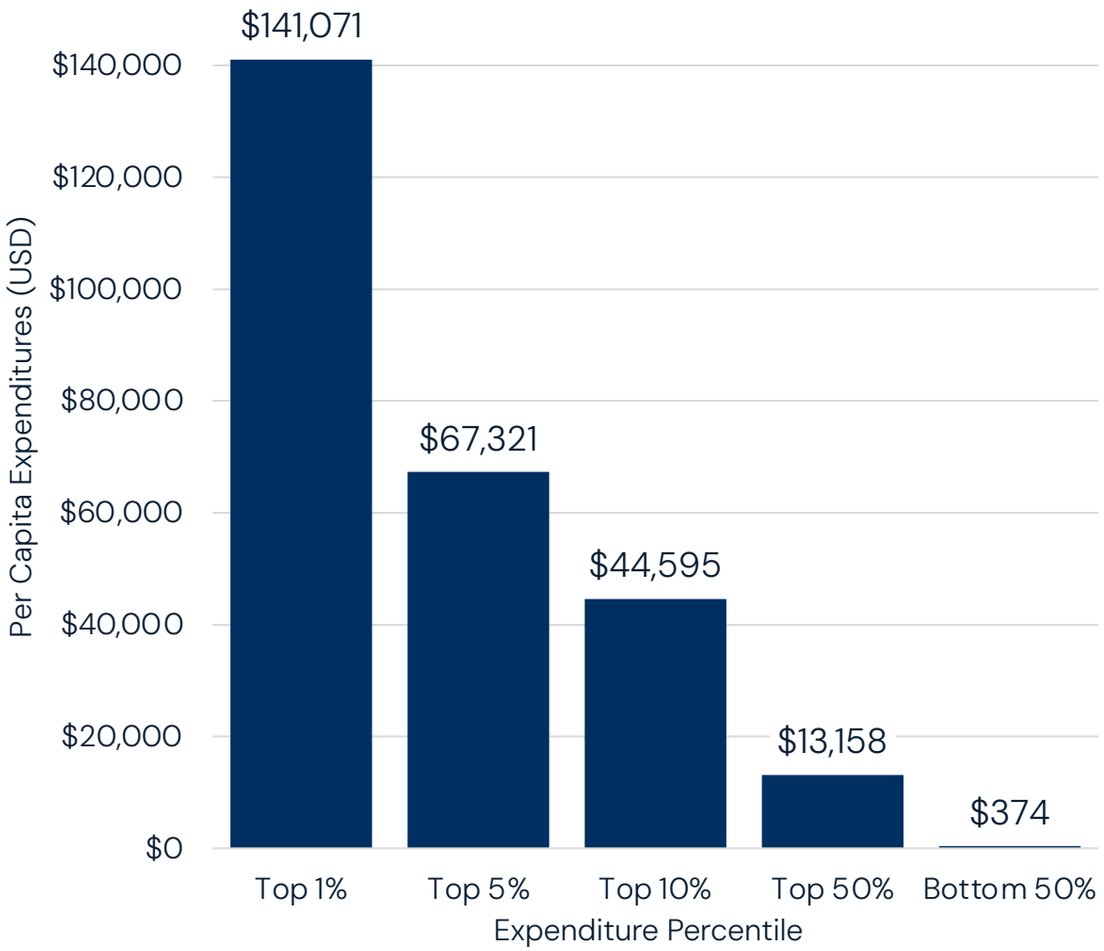


Note: GDP denotes gross domestic product; NHE denotes national health expenditures; CHIP denotes Children's Health Insurance Program. Percentages may not add to 100% due to rounding.
Source: U.S. Bureau of Economic Analysis via FRED®; Centers for Medicare and Medicaid Services National Health Expenditures.

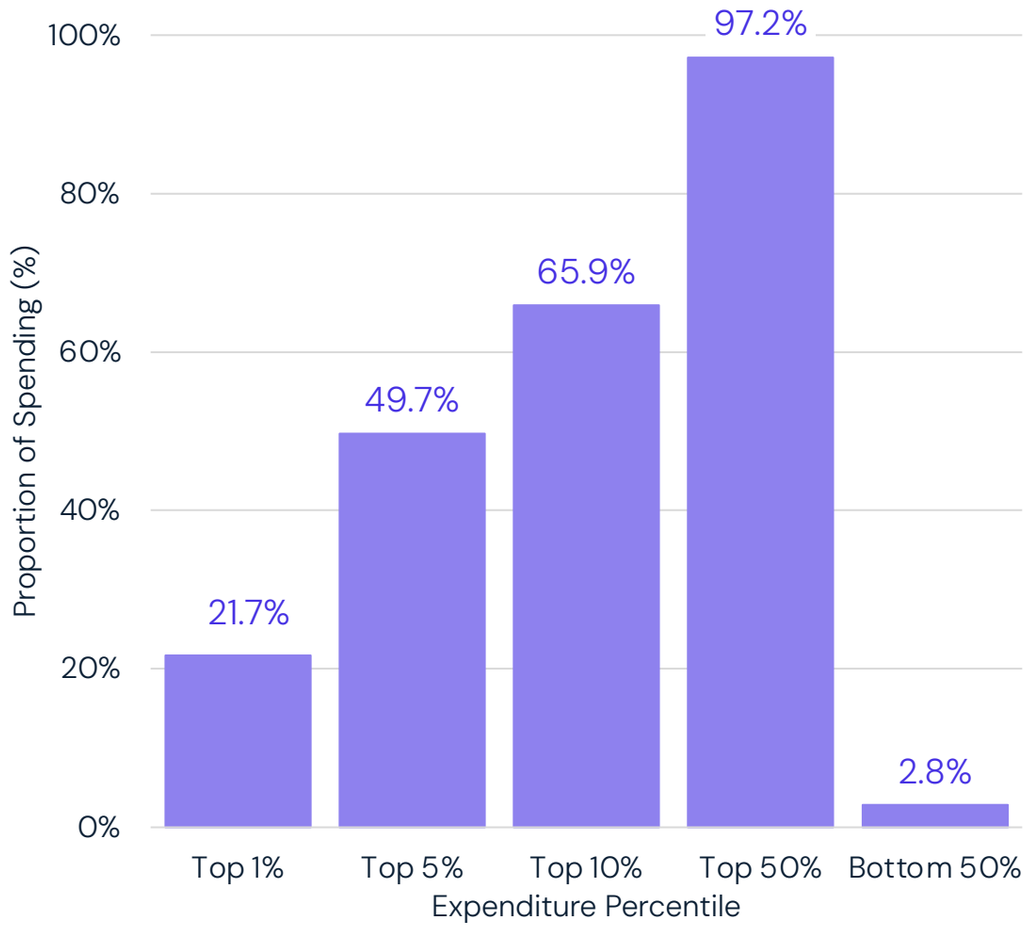
The Most Expensive 10% of Patients Account for Two-Thirds of Spending

U.S. healthcare spending follows the Pareto Principle, also known as the 80/20 rule, in which a small proportion of patients are responsible for the majority of spending. Specifically, the most expensive 5% of the population is responsible for 49.7% of spending, while the least expensive 50% only accounts for 2.8% of spending, or $374 per person.

Average Healthcare Expenditures per Person, by Expenditure Percentile, 2022



Concentration of Spending, by Expenditure Percentile, 2022

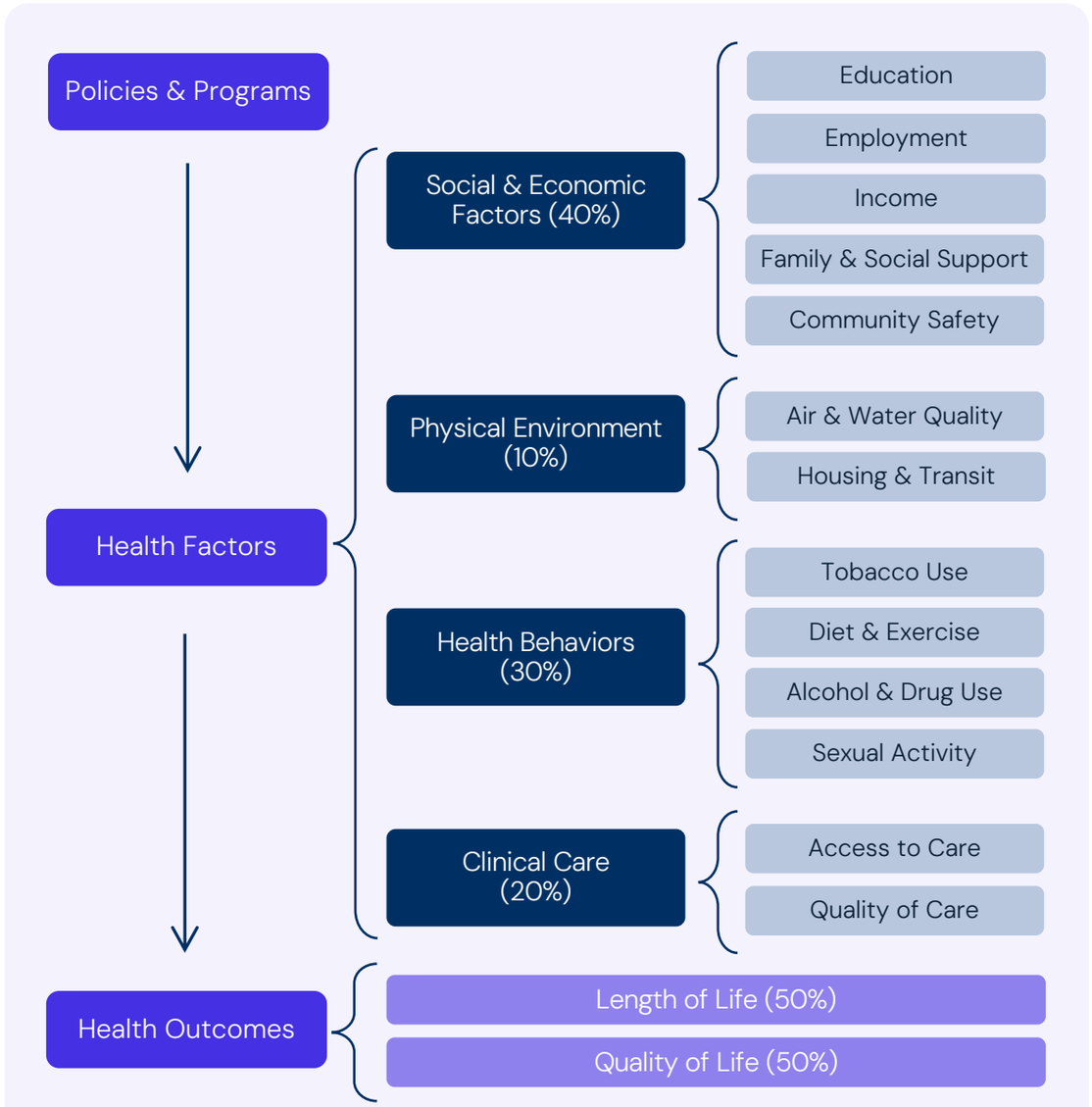


Source: Agency for Healthcare Research and Quality, 2025.

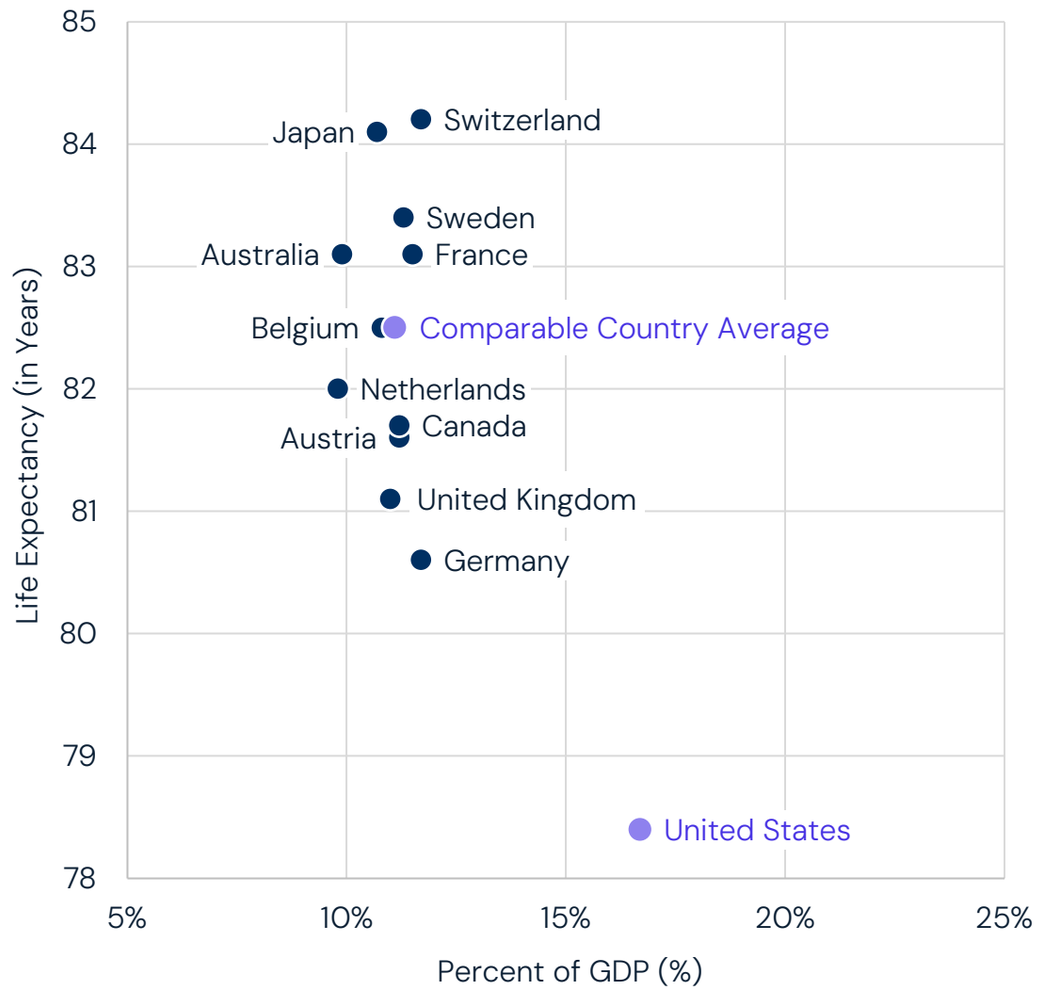
The U.S. Healthcare System Delivers Poor Comparative Value

In economics, value is a measure of the benefit provided by a good or service to an economic agent. By definition, spending more on healthcare with worse results is emblematic of poor value. Based on the comparative value of healthcare systems in peer countries and the comparative effect of medical and non-medical factors on overall health, the reasonable person must question the level of investment in the U.S. healthcare system.

Framework of Determinant Health Factors



Life Expectancy and Healthcare Spending as Proportion of GDP in Select OECD Countries, 2023

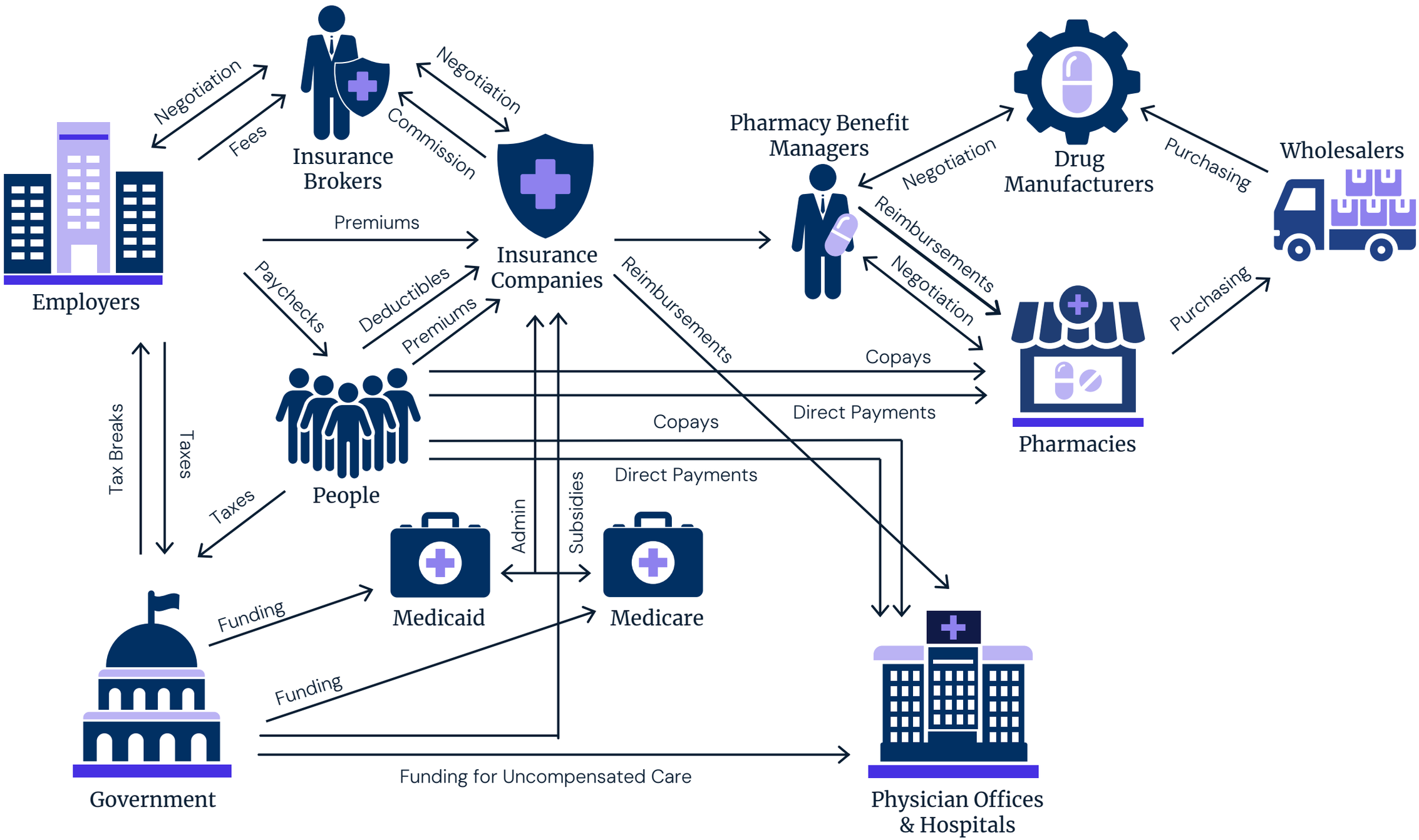


Note: GDP denotes gross domestic product; OECD denotes Organisation for Economic Co-operation and Development.
Source: Hood et al., County Health Rankings: Relationships Between Determinant Factors and Health Outcomes, *American Journal of Preventive Medicine*, 2016; Organisation for Economic Co-operation and Development, 2025.

The Performance of the U.S. Healthcare System Is a Function of Its "Design"

The U.S. healthcare system is peerless in its financial, administrative and regulatory complexity, characterized by a byzantine web of stakeholders that make the system inscrutable to the average American. Although the performance of the U.S. healthcare system has long been suboptimal, current macroeconomic conditions dictate a redesign.

A Visual Guide to the Current U.S. Healthcare System



INTRODUCTION

Demanding Value and Returning to First Principles

The U.S. healthcare system is at a crossroads. National health expenditures have increased from $2.8T in 2012 to $4.9T in 2023 despite relatively little change in demand or utilization. In 2023, healthcare spending accounted for 17.6% of GDP and is expected to reach 20.3% by 2033. Underwritten by the Federal government, state Medicaid programs, employers and the American public, the U.S. health economy is the most expensive healthcare system in the world. **Is the U.S. healthcare system worth what we spend on it? Probably not.**

Average American life expectancy is only negligibly higher than it was in 2000, has declined since 2019 and is almost four years lower than many peer OECD countries. Compared to those same peer nations, the U.S. also has higher rates of chronic disease, infant mortality, maternal mortality and avoidable mortality.

The reputation of the U.S. healthcare system often precedes itself – it is expensive, complex and inefficient. Understanding why begins with the recognition that, regardless of tax status, the "system" is a collection of profit-seeking businesses treating illness – "no margin, no mission" – rather than a thoughtful and comprehensive approach to promoting health. As a result, the U.S. healthcare system ends up providing poor care to many Americans. Additionally, the staggering $4.9T that is invested into the healthcare "system" crowds out other social investment that might contribute to improved wellbeing.

In economics, value is a measure of the benefit provided by a good or service to an economic agent. For consumer goods, value is ultimately subjective but is shaped by price, quality and convenience. In plain terms, the U.S. healthcare system does not provide good value to patients or society. With the national debt exceeding $35T (or 120% of GDP), the U.S. cannot afford to spend 20% of its GDP on a healthcare system that does not provide demonstrable value for money. **How has the U.S. health economy defied the laws of economics for so long?**

Since World War II, the U.S. health economy has not operated as a true market. For decades, the full extent of the pricing problem remained only partially understood because data on negotiated commercial rates were obfuscated by Federal antitrust restrictions and contractual agreements. At the same time, employers – who fund nearly 30% of national health expenditures – have consistently failed to demand value for money, opting to preserve the status quo rather than pursue meaningful changes to benefit design. **The advent of health plan price transparency removes these historical barriers, and in a free market, price transparency always results in prices regressing to the "market mean."**

Health plan price transparency creates new obligations, requiring employers to demand value for money in order to meet their fiduciary duties under ERISA and nearly every state's corporate statutes. Once employers begin to exert this pressure, every other stakeholder in the health economy will lose something – a dynamic that defines a negative-sum game. It is time that health economy stakeholders, like PBMs, begin to lose instead of patients, whom the system is failing.

Transforming the U.S. healthcare system requires a return to first principles. Originally attributed to Aristotle in the 4th century BCE, first principles thinking requires individuals to strip away all "common wisdom" and break things down into their most basic, undeniable truths. Once you reach the fundamental building blocks of a problem, you can reason upward.

What is the core goal of a healthcare system? Does spending more on healthcare mean better health? When is health insurance useful? Do hospitals need to be the central hub of clinical care? Should employers be the main source of healthcare coverage? Should society underwrite the cost of poor health that is attributable to poor lifestyle behaviors or instead promote health and incentivize healthy lifestyles? **Rather than thinking about what already exists, what is essential?**

INTRODUCTION

Analysis of Demand, Supply and Yield Reveals Six Key Trends

This report provides a data-driven analysis of six trends that will define the landscape, and subsequent challenges, that will impact every health economy stakeholder. The original research findings featured in this annual series are gleaned from proprietary Trilliant Health datasets and analytic models that measure various dimensions of demand, supply and yield across the health economy. To study healthcare demand, (i.e., utilization), we leveraged our national all-payer medical and pharmacy claims database. The Trilliant Health Provider Directory was used to study the supply of 5.2M providers, allied health professionals and organizations. The intersection of supply and demand informs expected yield. To measure yield, we leveraged our health plan price transparency dataset, which provides negotiated rate data across large national and small regional health plans. These data components allow for the triangulation of what service was provided, where the service was provided, who provided the service and how much the service cost. In addition to the primary data analyses conducted using Trilliant Health assets, the report includes other publicly available information (e.g., financial statements) and secondary sources (e.g., American Hospital Association, Centers for Disease Control and Prevention).

Demand refers to both the exogenous and endogenous factors that influence consumer preferences for, need for and utilization of healthcare services.

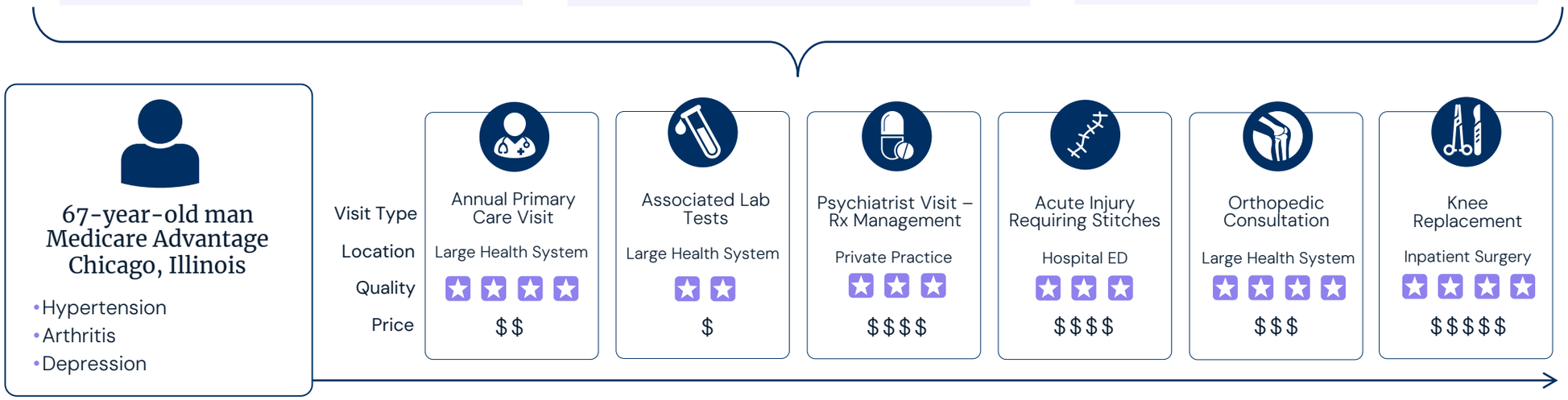
Primary Data Source
National all-payer claims database

Supply refers to the various providers of health services ranging from hospitals and physician practices to retail pharmacies, new entrants and virtual care platforms.

Primary Data Source
Provider Directory

Yield refers to the intersection of demand and supply (i.e., price) and is also influenced by market factors such as policy regulations and reimbursement incentives.

Primary Data Source
Health plan price transparency dataset



2025 Trends Shaping the Health Economy

1 Price Sensitivity and Affordability Concerns Are Reshaping Demand

2 Health Economy Stakeholders Are Slow To Adapt to Changing Demographic and Lifestyle Trends

3 The Healthcare Delivery System Incentivizes Specialty Care Intervention Instead of Primary Care Prevention

4 Fraud, Waste and Abuse Are Pervasive in U.S. Healthcare

5 The Transition to Alternative Care Settings and Therapies Is Accelerating

6 If Industry Cannot Deliver Value For Money and Employers Will Not Demand It, the Government Is Prepared to Force It

CONCLUSION:
The Health Economy Is at a Crossroads: Market Discipline or Structural Reform?

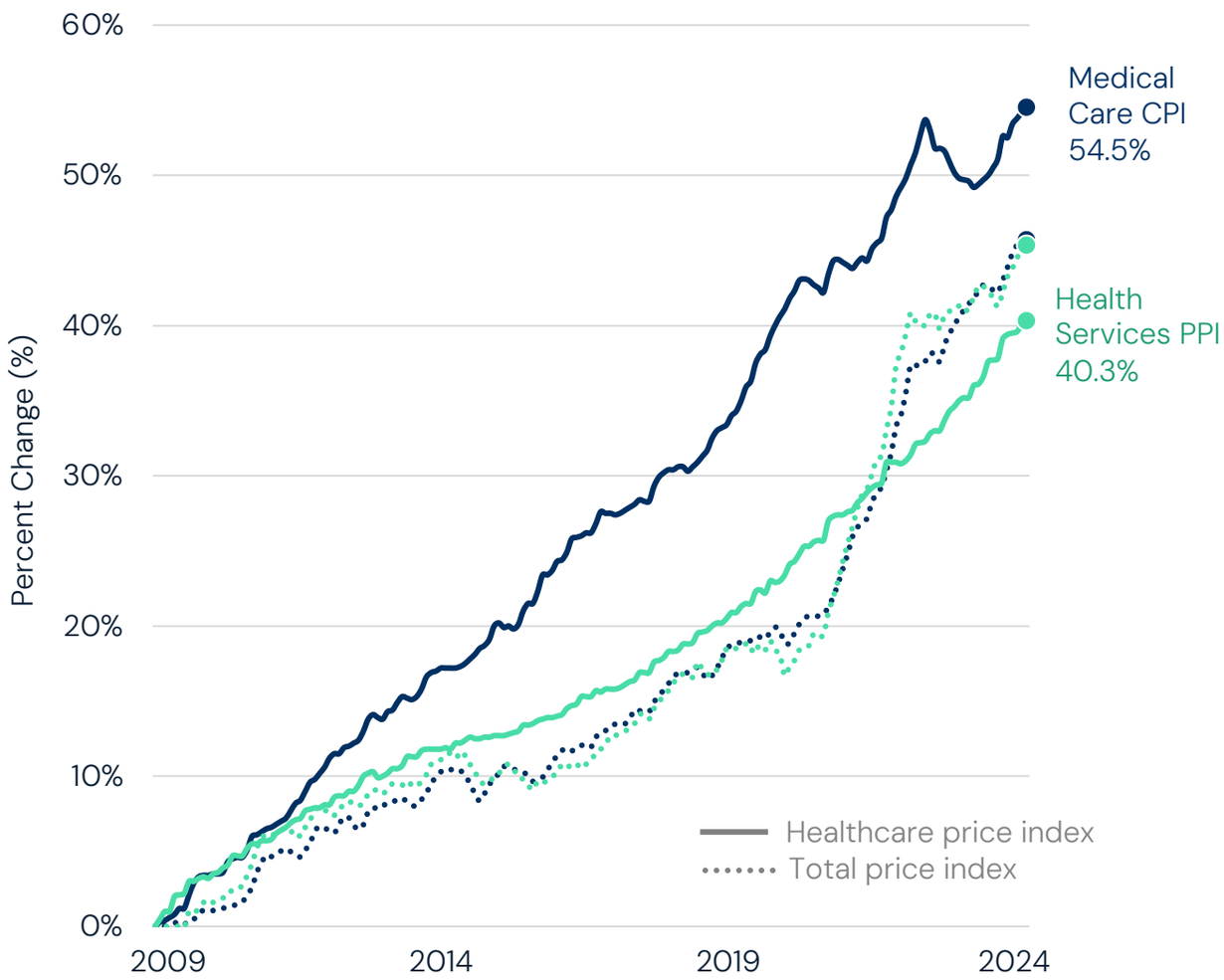
TREND 1

Price Sensitivity and Affordability Concerns Are Reshaping Demand

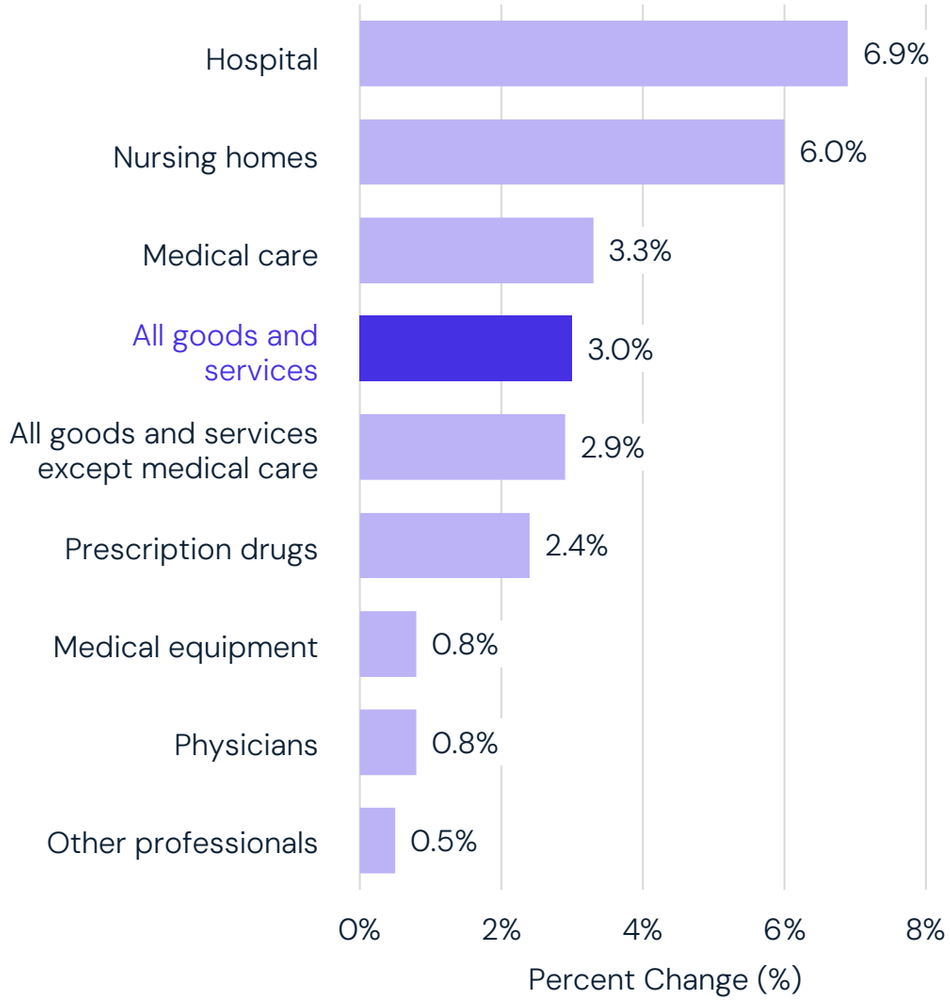
Growth in Medical Prices Continues to Outpace Other Sectors

Since 2009, prices for medical care – including treatment, insurance, equipment and prescription drugs – have risen by 54.5%, compared to a 45.7% increase in overall consumer prices. From 2023 to 2024, hospital services (6.9%), nursing home care (6.0%) and medical care (3.3%) CPI increased faster than all goods and services CPI (3.0%).

Cumulative Percent Change in Select Healthcare and Aggregate Price Indices, June 2009-June 2024



Annual Percent Change in CPI for All Urban Consumers for Medical Care, by Category, 2023-2024

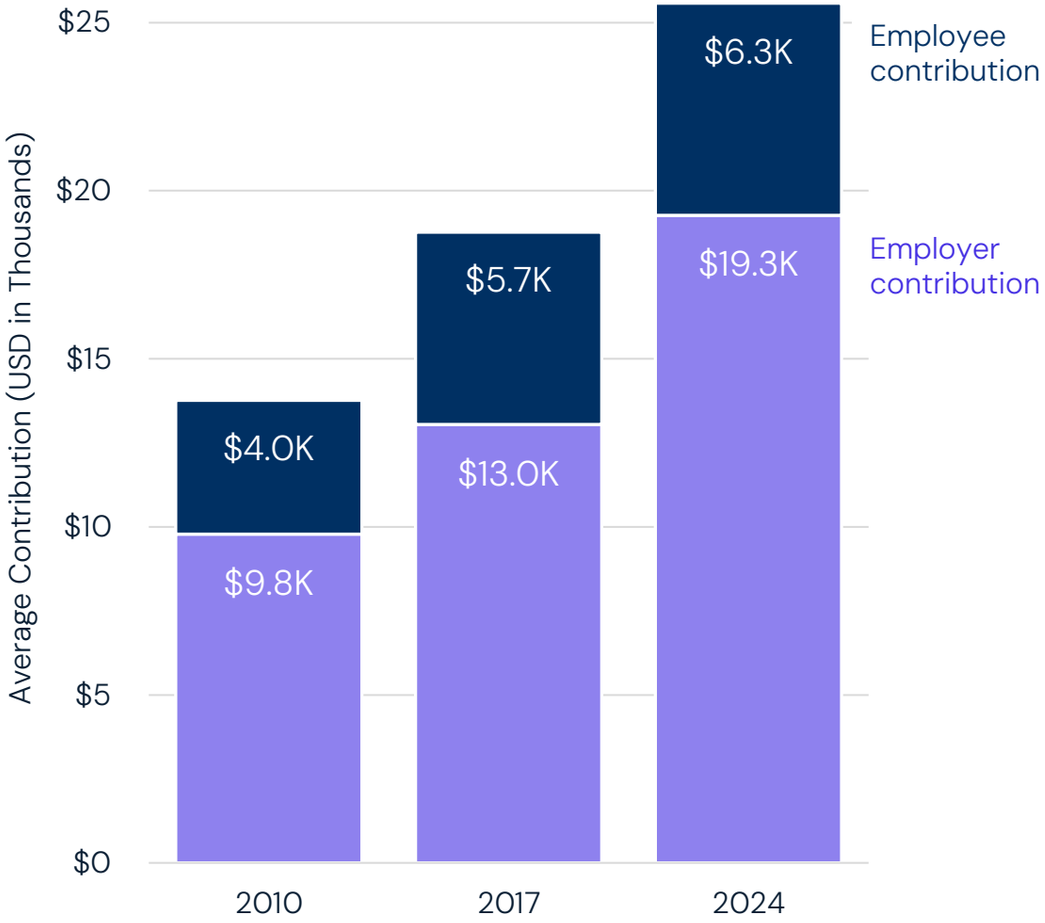


Note: CPI denotes consumer price index; PPI denotes producer price index. CPI and PPI data are not seasonally adjusted.
Source: Bureau of Labor Statistics.

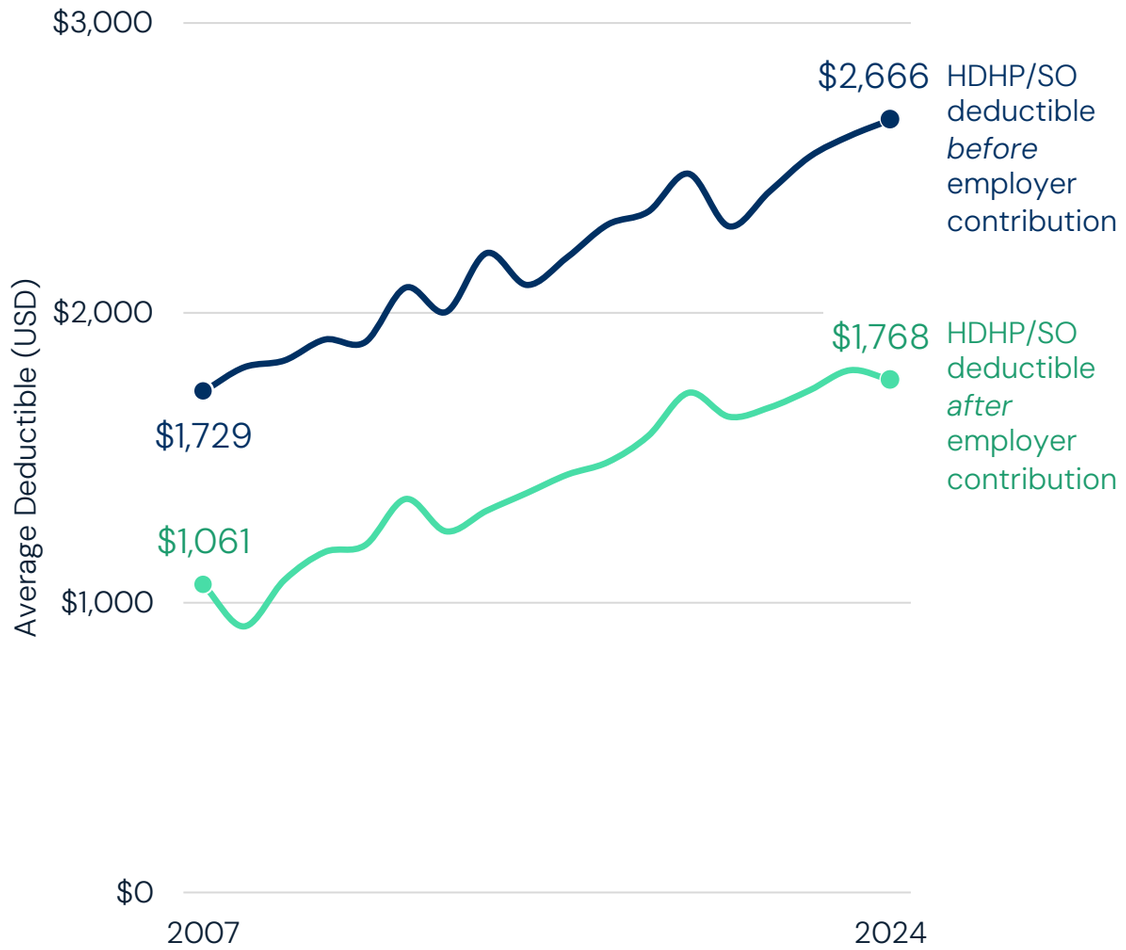
Rising Insurance Costs Impact Employers and Employees

Between 2010 and 2024, average annual premiums increased by 85.7%, with employer and employee contributions increasing by 97.2% and 57.5%, respectively. In 2024, employers were responsible for 75.4% of total premiums. Since 2007, average deductibles before employer contributions for employees with HDHP/SO plans increased by 54.2%.

Average Annual Employee and Employer Premium Contributions for Family Coverage, 2010, 2017 and 2024



Average Deductibles for Workers Enrolled in HDHP/SO, Before and After Employer Contributions, 2007-2024



Note: HDHP/SO denotes high-deductible health plan with a savings option.
Source: KFF Employer Health Benefits 2024 Survey.

ICHRAs Aim to Increase Choice and Lower Employer Costs

ICHRAs are a type of employer-sponsored health benefit plan that allow employers to provide tax-exempt allowances for employees to purchase individual health insurance. As individual and employer health insurance costs continue to grow, ICHRAs provide an alternative approach for employer-sponsored insurance, primarily among small employers. To date, ICHRA adoption remains limited – offered to roughly 200,000 employer-sponsored individuals in 2025 – and their impact on health and spending remains to be seen.

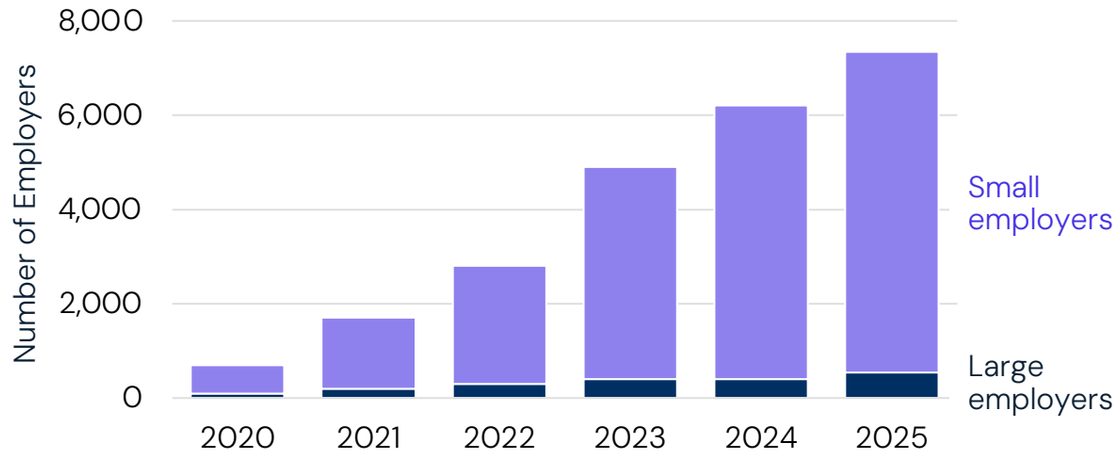
ICHRA vs. Group Health Insurance

	ICHRA	Group Health Insurance
Coverage Payment Arrangement	Employers decide how much money to contribute to employees.	Employers offer a subsidized plan or a selection of subsidized plans to employees.
Coverage Flexibility	Employees choose their health insurance plan based on availability in the individual market.	Employees have a plan or selection of plans to choose from based on what the employer offers.
Coverage Portability	If employees leave the company, they can keep their current plan but pay the premiums in full.	Coverage is terminated when employees leave the company.

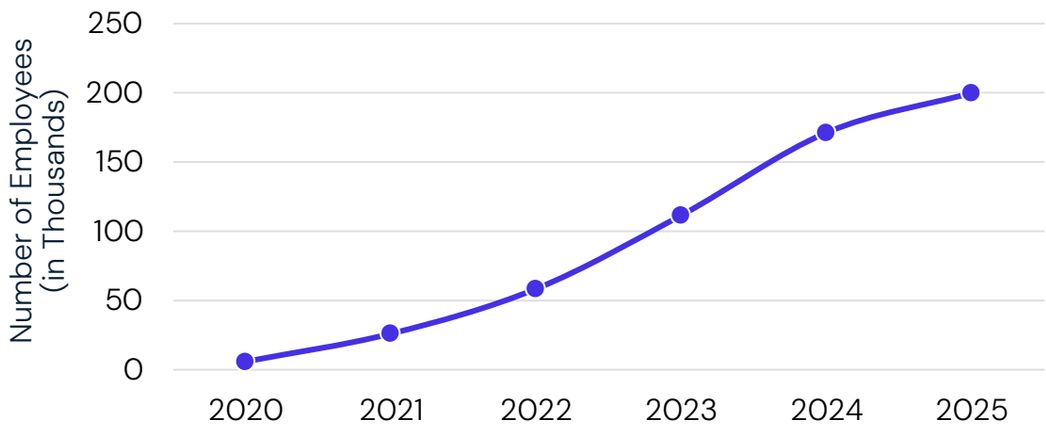
$367.1M

2023-2024 investments in ICHRA platforms

Number of Employers Offering ICHRA, 2020-2025



Number of Employees Offered ICHRA, 2020-2025

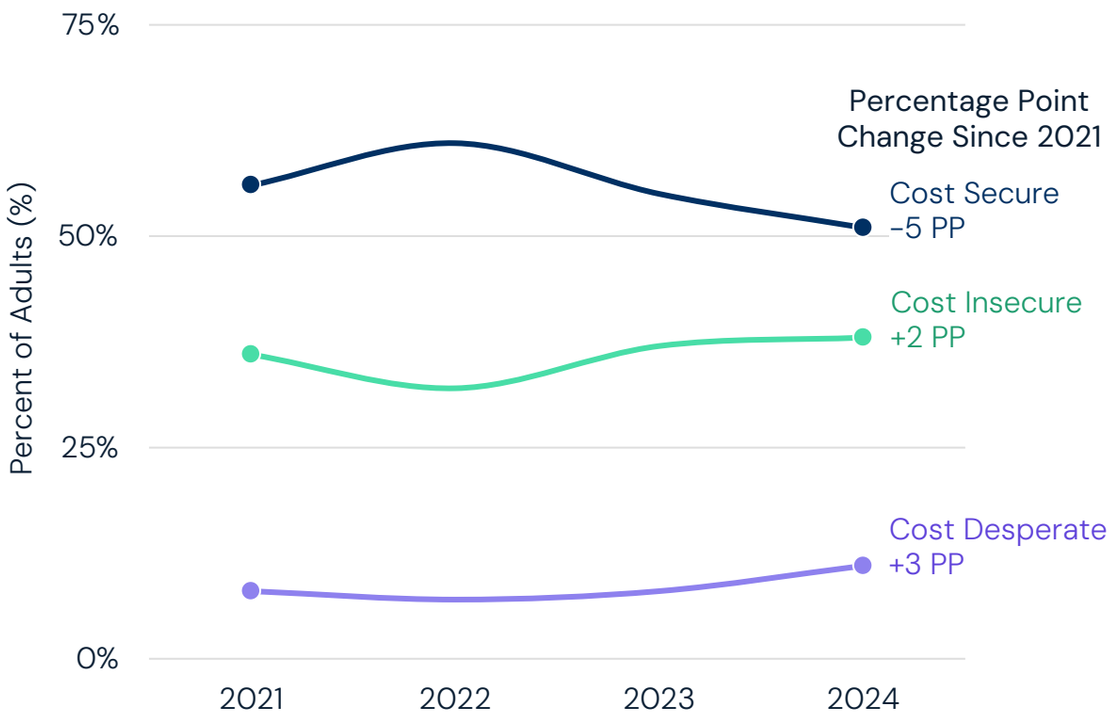


Note: ICHRA denotes individual coverage health reimbursement arrangement. Small employers are defined as having fewer than 50 employees, while large employers have over 50 employees.
Source: HRA Council Growth Trends for ICHRA & QSEHRA 2024-2025 Report.

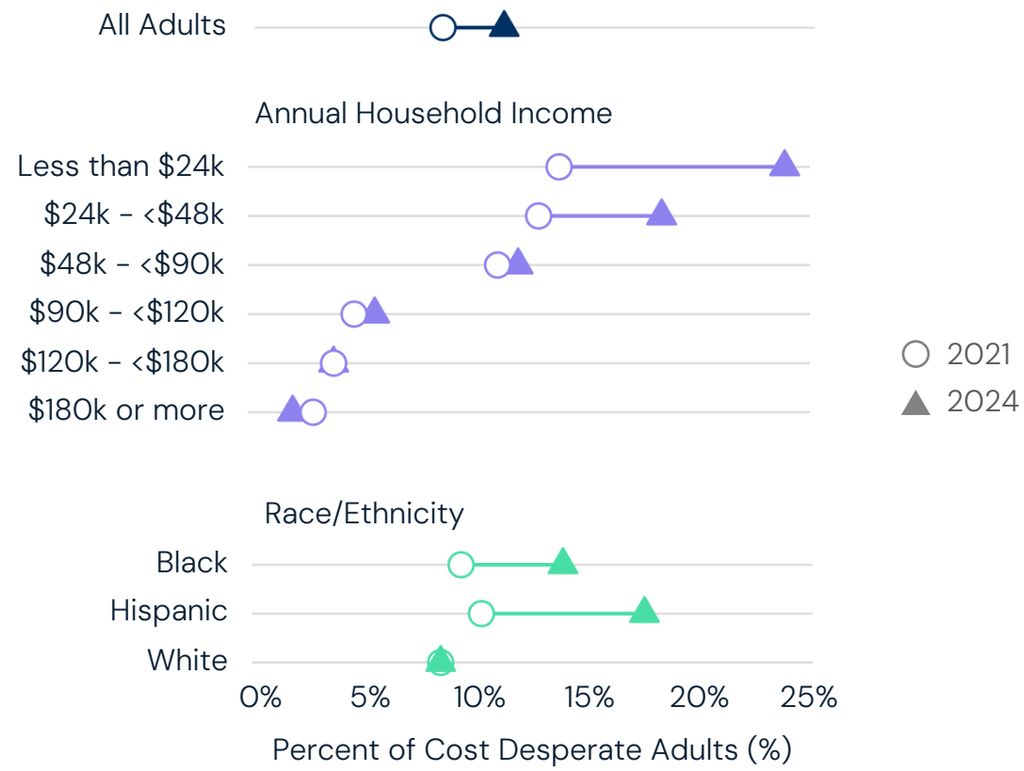
Patients Encounter Declining Affordability and Access

The share of adults reporting the ability to access and pay for healthcare ("cost secure") declined from 56% in 2021 to 51% in 2024. Meanwhile, the share of Americans unable to access and pay for healthcare ("cost desperate") reached a high of 11%. The inability to afford and access healthcare was more pronounced among underserved populations, with the share of cost desperate Hispanic adults increasing by 8 PP and Black adults by 5 PP between 2021 and 2024.

Adults Reporting Ability to Afford and Access Healthcare, by Status, 2021-2024



Share of Adults Categorized as Cost Desperate, by Demographics, 2021 and 2024



Note: PP denotes percentage point. Cost Secure individuals have access to quality, affordable care and can pay for needed care and medicine. Cost Insecure individuals lack access to quality, affordable care or have recently been unable to pay for either needed care or medicine. Cost Desperate individuals lack access to quality, affordable care and have recently been unable to pay for needed care and medicine.
Source: West Gallup Healthcare Indices Survey, 2024.

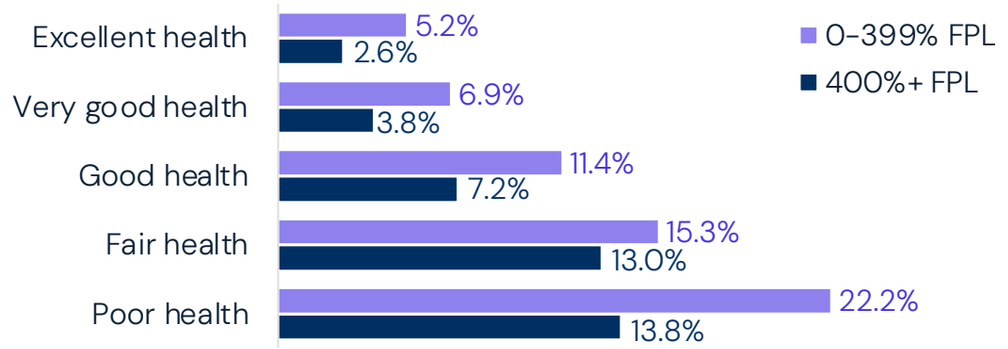
The Financial Burden of Medical Care Is Detrimental to Health Outcomes

Financial toxicity – the negative impact of medical costs on a patient's financial wellbeing – disproportionately impacts patients with serious illnesses, such as heart disease or cancer. In 2021, 15% of American households owed medical debt. One study found that a one percentage point increase in the population with medical debt was associated with 18.3 more physically unhealthy days per 1,000 people. Additionally, higher-income adults in poor health are more likely to report medical debt than lower-income adults in good health.

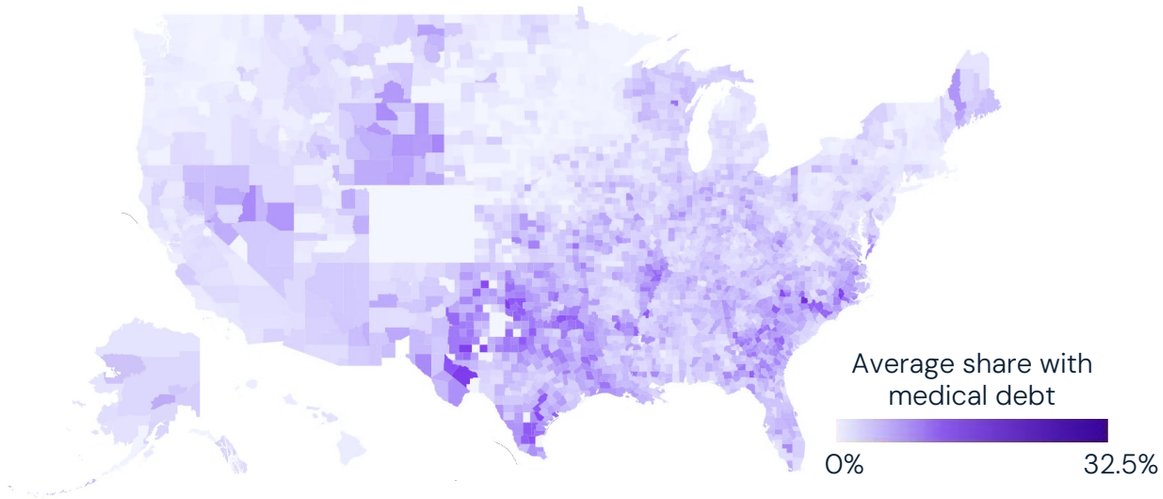
Population Impact of Medical Debt on Health Status and Mortality in the U.S., 2018

	Health Outcome	Change per 1 PP Increase of Population With Medical Debt	Units
Poor health during past 30 days	Poor physical health	18.3	Days per 1,000 people
	Poor mental health	17.9	
	Premature death	1.1	Years lost per 1,000 people
Age-adjusted mortality by cause of death	All cause	7.5	100,000 person years
	Heart disease	1.4	
	Malignant cancers	1.1	
	COPD and other allied conditions	0.7	
	Cerebrovascular diseases	0.4	

Share of Adults With Medical Debt, by Health Status and Income, 2021



Share of Adults With Medical Debt in Collections, by U.S. County, 2023

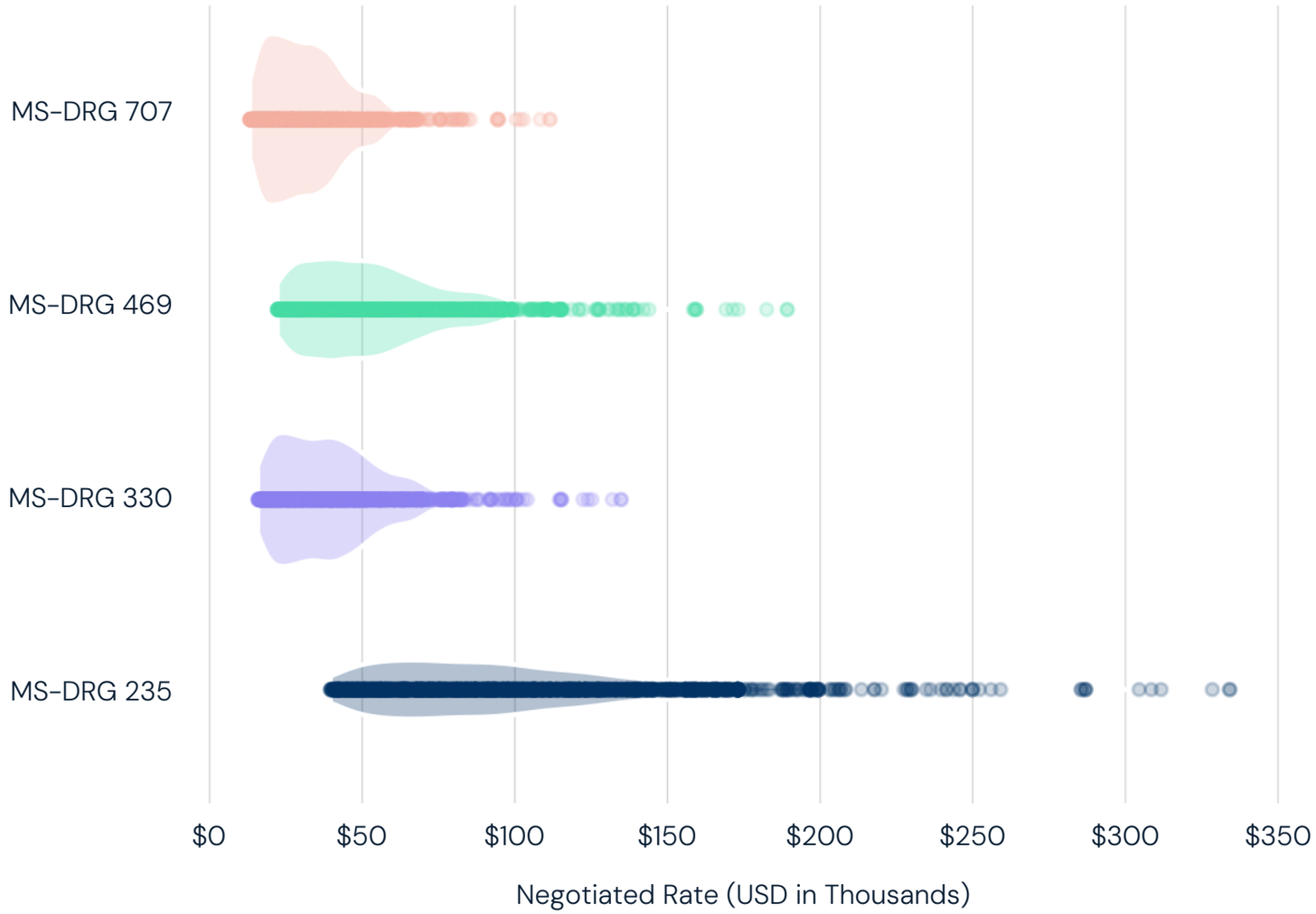


Note: PP denotes percentage point; COPD denotes chronic obstructive pulmonary disease; FPL denotes Federal poverty level. Medical debt information for Colorado is not available due to insufficient sample size. Coefficient is adjusted for county-level percentages of the population who were non-Hispanic, White, below a high school education, uninsured or were unemployed.
Source: Urban Institute, 2024; Han, et al., Associations of Medical Debt With Health Status, Premature Death, and Mortality in the US. *JAMA Network*. 2024; United States Census Bureau Survey of Income and Program Participation (SIPP), 2021; United States Census Bureau Wealth, Asset Ownership, & Debt of Households Detailed Tables: 2021.

Inexplicable Price Variation Contributes to High Costs

Nationally, the commercial negotiated rates for four distinct MS-DRGs vary by a factor of 8.5x, on average. As an example, for coronary bypass without cardiac catheterization with major complication or comorbidity (MS-DRG 235), commercial negotiated rates for UHC range from $39,579 to $334,147.

Commercial Negotiated Rates for Select MS-DRGs at Short-Term Acute Care Hospitals, 2025



Note: UHC denotes UnitedHealthcare. MS-DRG 235 denotes coronary bypass without cardiac catheterization with major complication or comorbidity; MS-DRG 330 denotes major small and large bowel procedures with complication or comorbidity; MS-DRG 469 denotes major hip and knee joint replacement or reattachment of lower extremity with major complication or comorbidity; MS-DRG 707 denotes major male pelvic procedures with complication or comorbidity or major complication or comorbidity. Rates are shown for one national payer, UnitedHealthcare.
Source: Trilliant Health health plan price transparency dataset and Provider Directory.

Even at the Same Facility, the Negotiated Rate Depends on Who Is Paying

Compared to the Medicare base rate of $15,804, the median UHC and Aetna commercial negotiated rates for major small and large bowel procedures with complication or comorbidity (MS-DRG 330) are $38,481 and $36,862, respectively. At Thomas Jefferson University Hospital, Aetna's negotiated rate for MS-DRG 330 is 2x higher than UHC's negotiated rate. However, for CPT 45378, UHC's negotiated rate is 7x higher than Aetna at MedStar Washington Hospital Center.

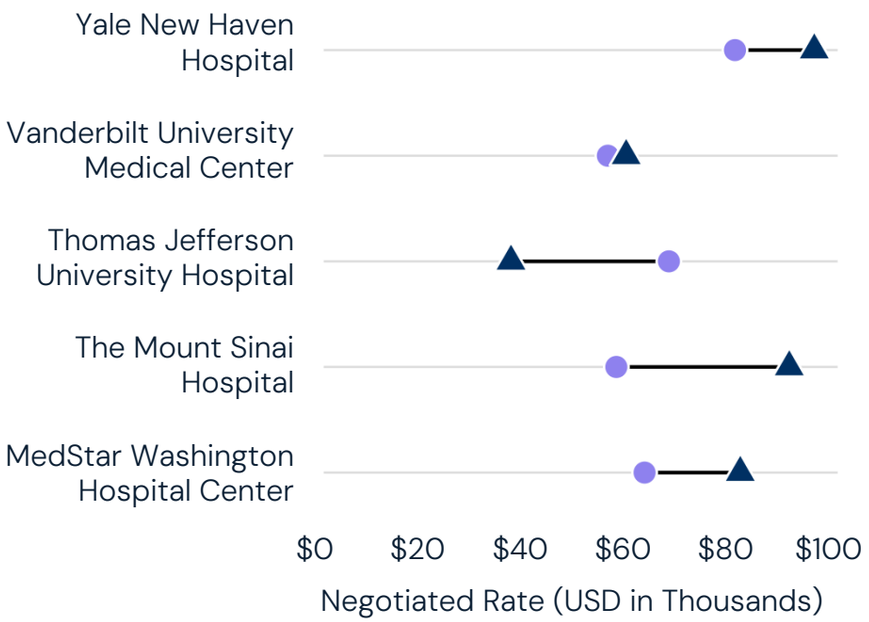
Medicare Base Rate and Median Commercial Rates for MS-DRG 330, 2025

	Commercial	
Medicare	Aetna	UHC
$15,804	$36,862	$38,481

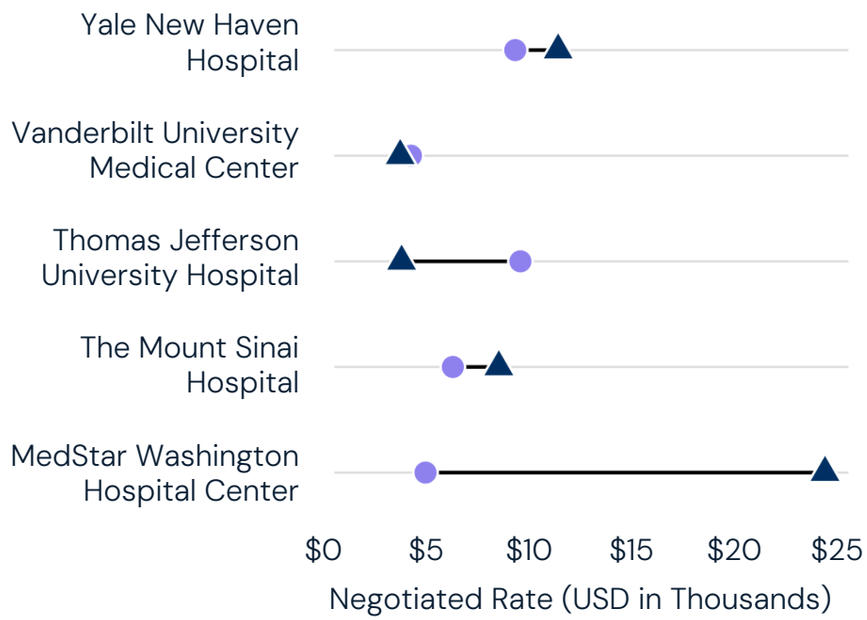
Medicare Hospital Fee Schedule Rate and Median Commercial Rates for CPT 45378, 2025

	Commercial	
Medicare	Aetna	UHC
$1,088	$4,474	$3,256

Commercial Negotiated Rates for MS-DRG 330 at Select Short-Term Acute Care Hospitals, 2025



Commercial Negotiated Rates for CPT 45378 at Select Short-Term Acute Care Hospitals, 2025

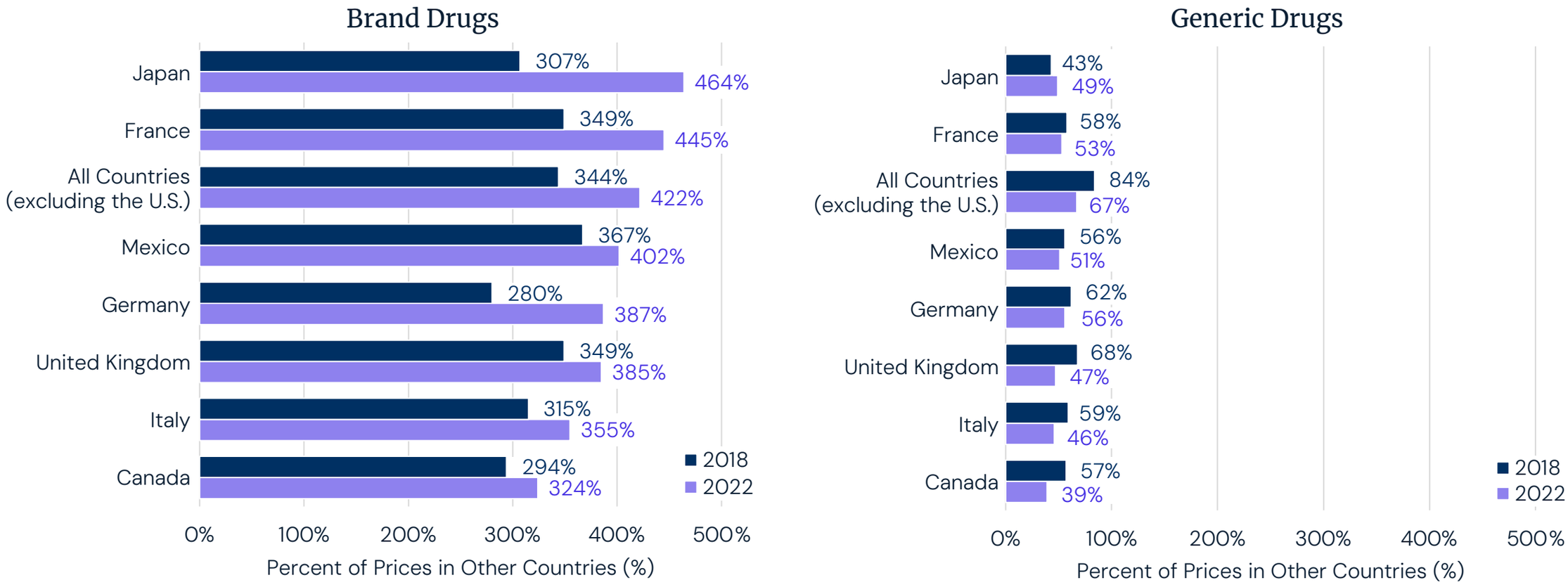


Note: UHC denotes UnitedHealthcare. MS-DRG 330 denotes major small and large bowel procedures with complication or comorbidity; CPT 45378 denotes colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure). Rates are shown for two national payers, UnitedHealthcare and Aetna. National Medicare averages are shown, but base rates vary by hospital, and CMS outpatient fee schedules differ slightly by locality.
Source: Trilliant Health health plan price transparency dataset and Provider Directory.

The U.S. Pays More for Brand Drugs

U.S. brand drug prices were 422% higher than the average of 33 OECD countries in 2022, up from 344% in 2018, although the generic drug price disparity has narrowed since that time. The U.S. accounts for 62.4% of global drug sales, while representing only 23.8% of global prescription volume.

U.S. Manufacturer Gross Drug Prices as a Percent of Prices in Select OECD Countries, 2018 and 2022



Prescription Drug Market Share, by Sales and Volume in the U.S. and Other Countries, 2022

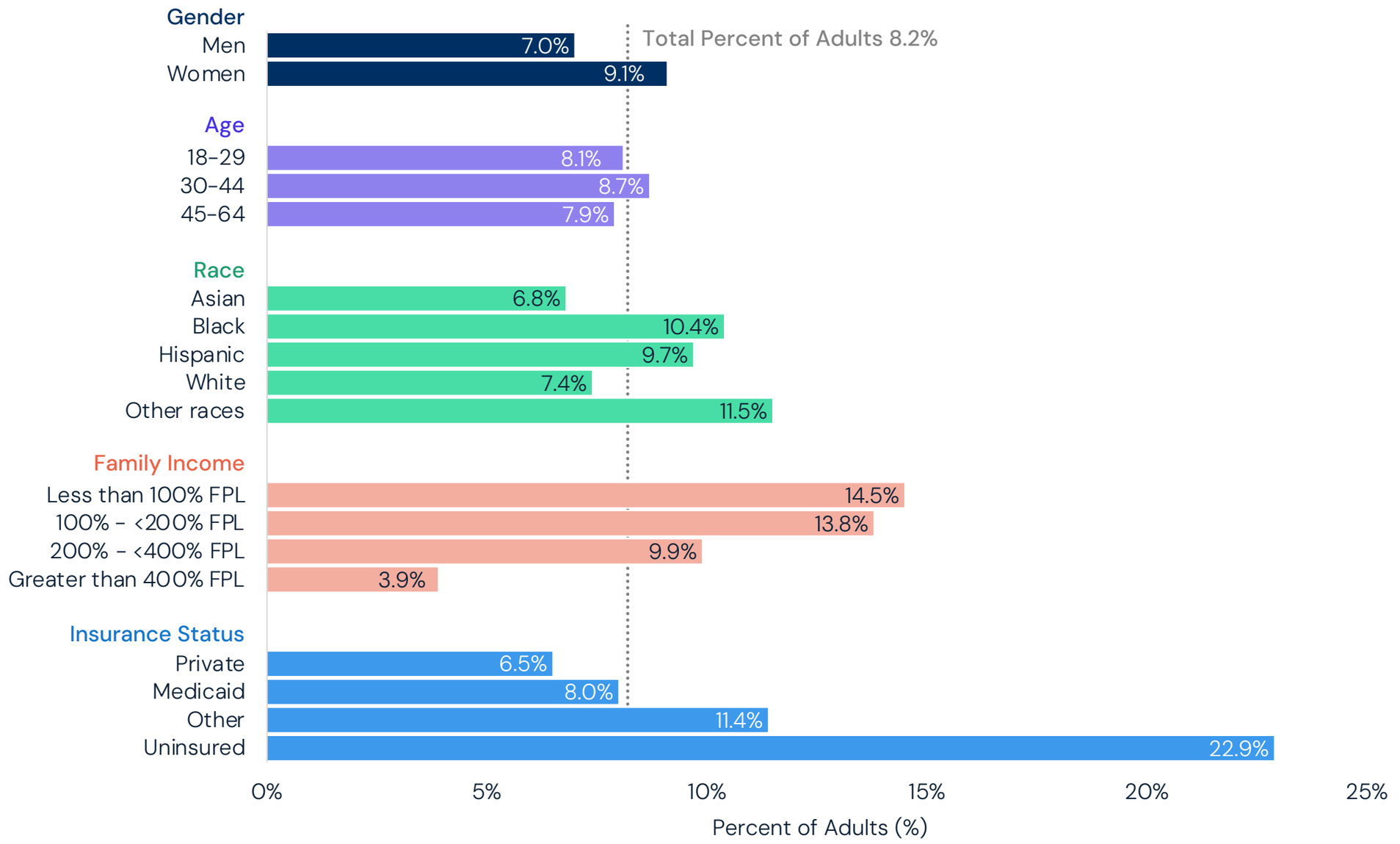
Country	Sales (USD in Billions)	Volume (in Billions)	Share of Sales (%)	Share of Volume (%)
All Countries	**$988.9B**	**1,099.1B**	**100%**	**100%**
All Countries (excluding the U.S.)	$371.7B	837.6B	37.6%	76.2%
United States	$617.2B	261.6B	62.4%	23.8%

Note: OECD denotes Organisation for Economic Co-operation and Development.
Source: RAND Corporation International Prescription Drug Price Comparisons, 2024.

Amid Drug Affordability Concerns, Medication Adherence Suffers

In 2021, 9.2M U.S. adults reported non-adherence with prescription medications due to cost, with more women, minority populations, low-income adults and the uninsured disproportionately affected. Regardless of the cause, the trend of low prescription adherence mirrors the declining health status of Americans.

Percent of Adults Ages 18-64 Who Used a Prescription Medication in the Past Year but Did Not Adhere to the Prescribed Dosage to Save on Costs, 2021



Note: FPL denotes Federal poverty level.
Source: Centers for Disease Control and Prevention NCHS Data Brief.

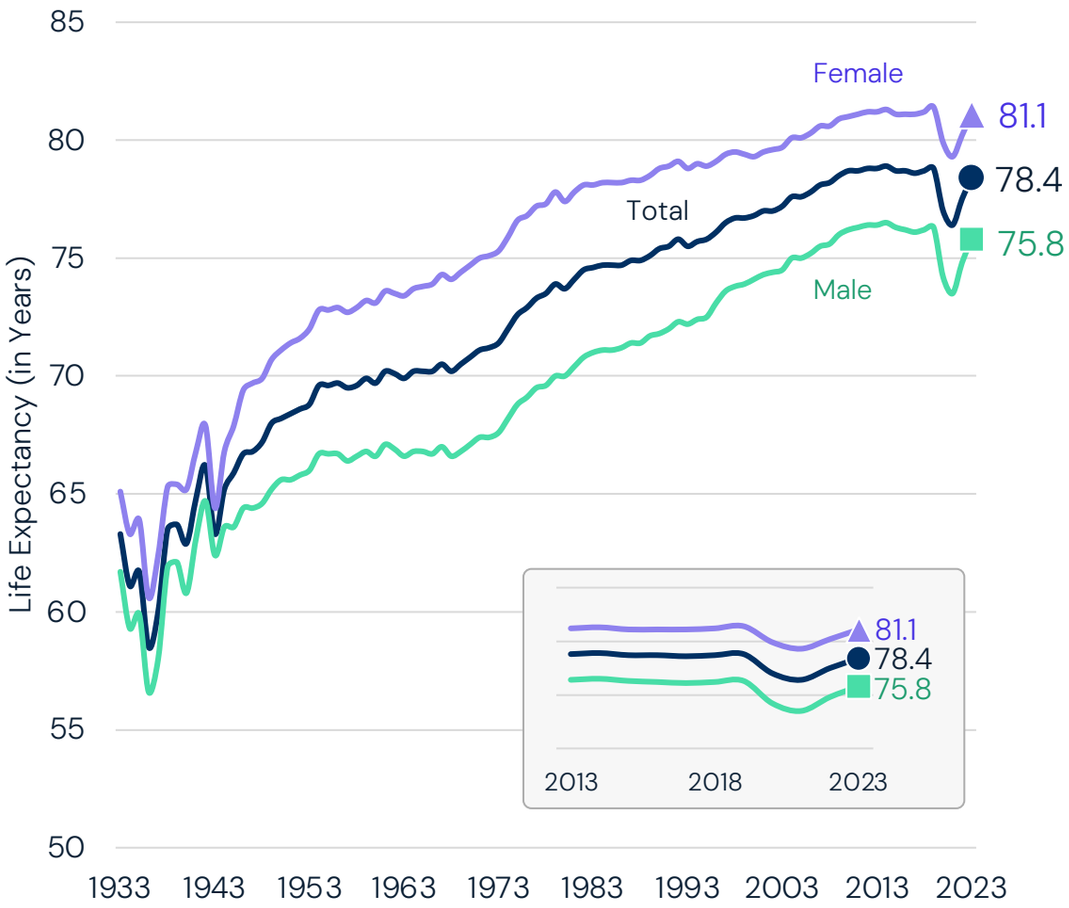
TREND 2

Health Economy Stakeholders Are Slow To Adapt to Changing Demographic and Lifestyle Trends

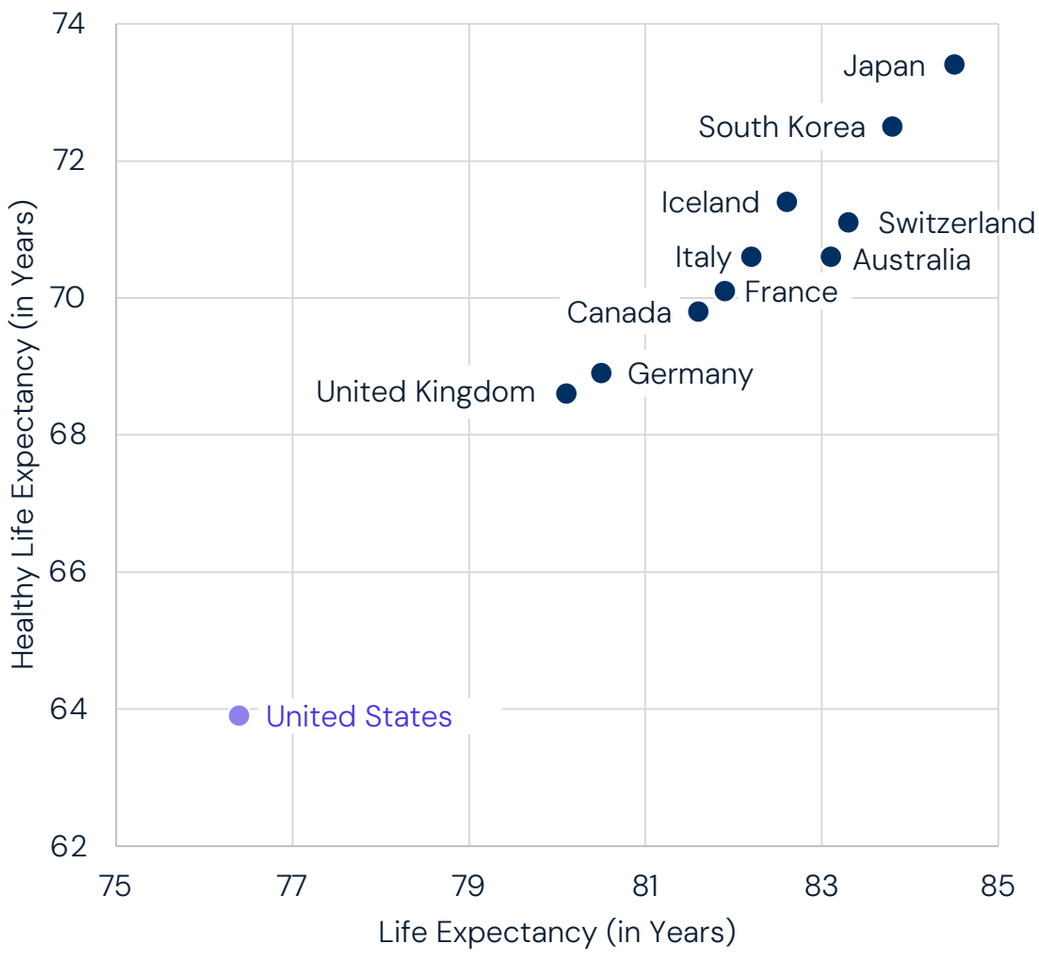
Americans Live Shorter Lives and Spend More Years in Poor Health

After steadily rising for most of the last century, U.S. life expectancy has flatlined over the past decade. In 2021, the average American spent 12.5 years in poor health. In contrast, residents of OECD countries live four to eight years longer and spend more of those years in good health.

U.S. Life Expectancy, by Gender, 1933-2023



Life Expectancy and Unhealthy Life Expectancy in Select OECD Countries, 2021

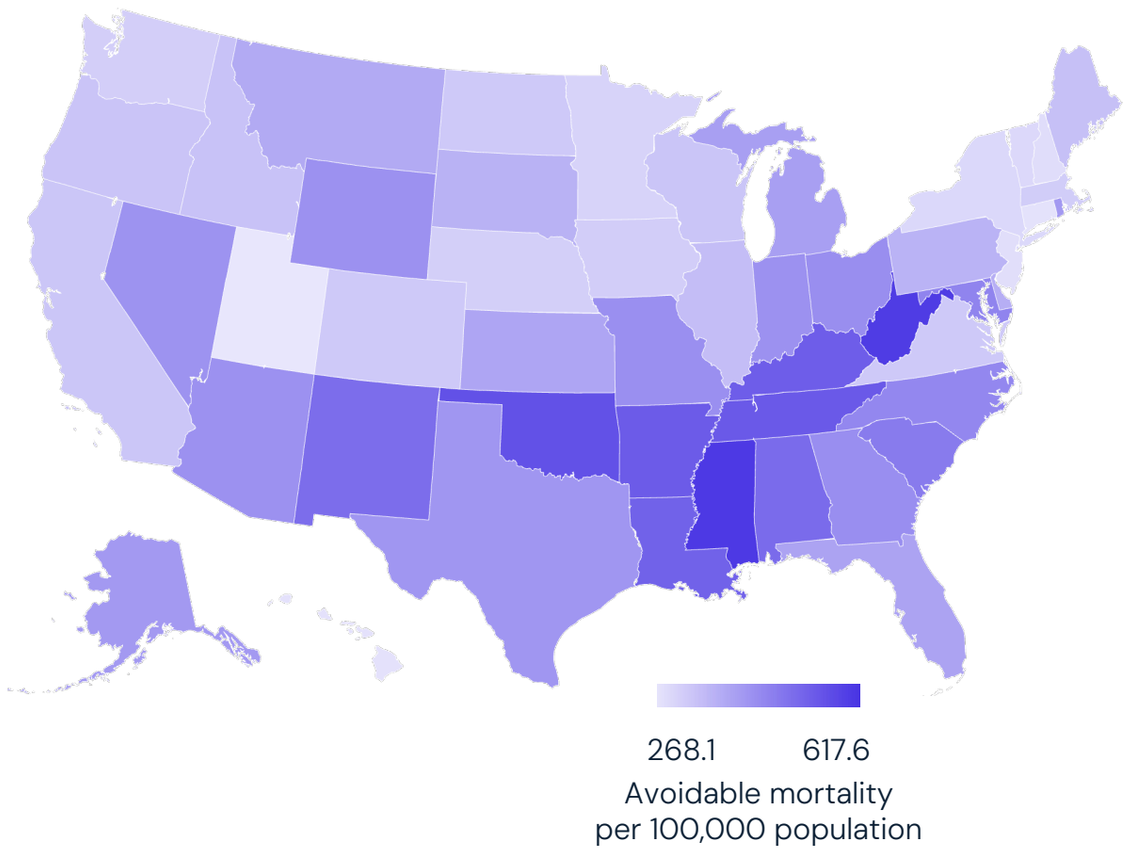


Note: OECD denotes Organisation for Economic Co-operation and Development. Healthy life expectancy is the average number of years that a person can expect to live in "full health" by considering years lived in less than full health due to disease and/or injury.
Source: Centers for Disease Control and Prevention National Center for Health Statistics; World Health Organization.

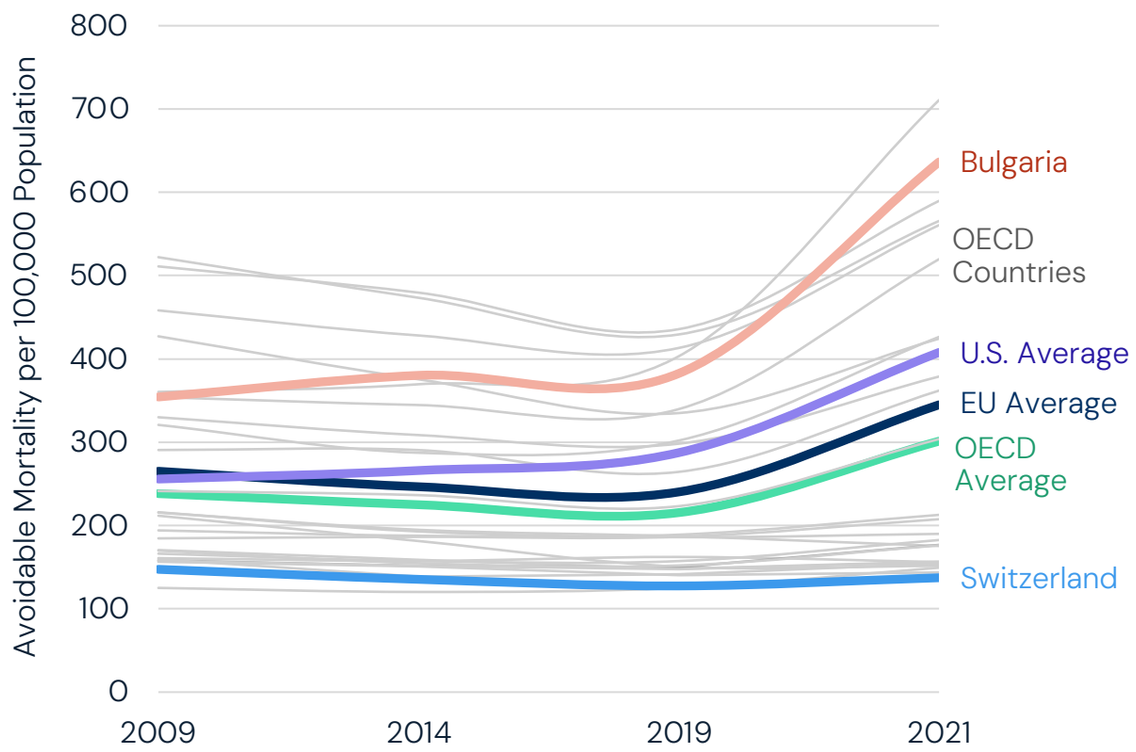
Avoidable Mortality Is Consistently Higher in the U.S. Than in OECD Countries

In 2021, the avoidable mortality rate per 100,000 population was 407.8 in the U.S. and 301.3 in OECD countries. Across states, the avoidable mortality rate ranged from 268.1 in Utah to 617.6 in Mississippi. Since 2009, avoidable mortality has worsened across all U.S. states, with 43 states exceeding the OECD average.

Avoidable Mortality per 100,000 Population, by State, 2021



Avoidable Mortality per 100,000 Population, U.S. Average and OECD Countries, 2009-2021

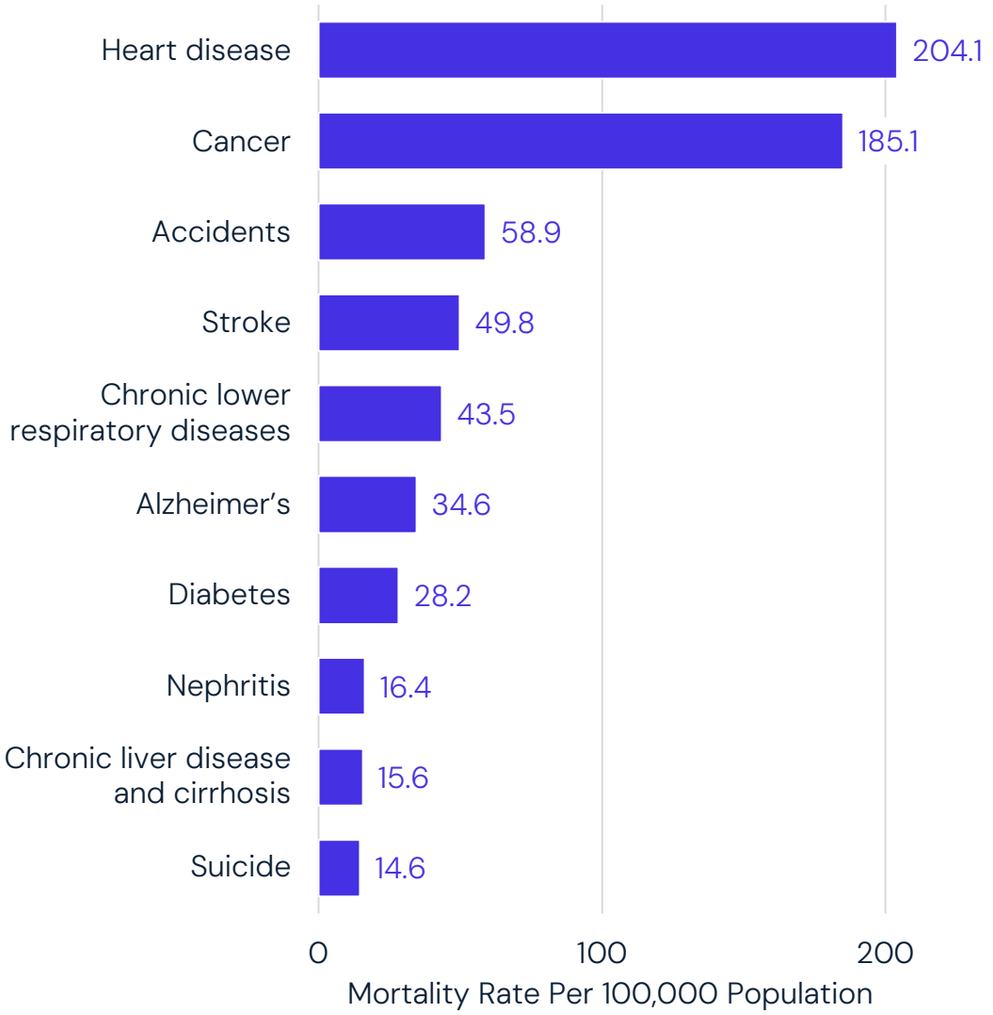


Note: OECD denotes Organisation for Economic Co-operation and Development; EU denotes European Union. Avoidable mortality is a population health measure that tallies the number of deaths each year in the population younger than 75 years that could have been prevented or avoided through timely and effective healthcare and prevention.
Source: Papanicolas et al., Avoidable Mortality Across US States and High-Income Countries, *JAMA Internal Medicine*, 2025.

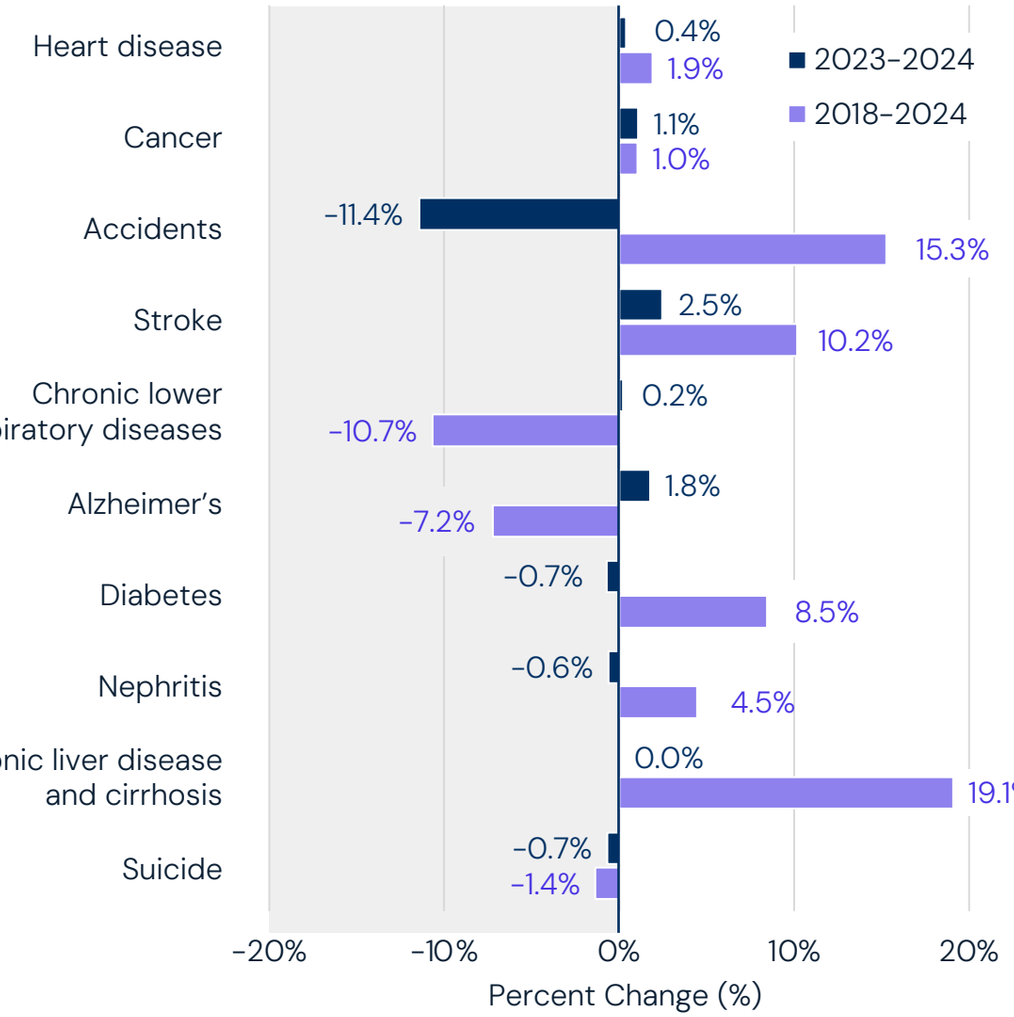
Chronic Disease Burden Continues to Shape U.S. Mortality

Heart disease and cancer are consistently the leading causes of death in the U.S., responsible for 204.1 and 185.1 deaths per 100,000 population, respectively, in 2024. However, since 2018, the mortality rate for other leading causes of death has accelerated, with mortality from chronic liver disease (19.1%), stroke (10.2%) and diabetes (8.5%), outpacing the growth in heart disease (1.9%) and cancer (1.0%).

Mortality Rate per 100,000 Population, Leading Causes of Death, 2024



Percent Change in Mortality Rate per 100,000 Population, Leading Causes of Death, 2018 to 2024 and 2023 to 2024

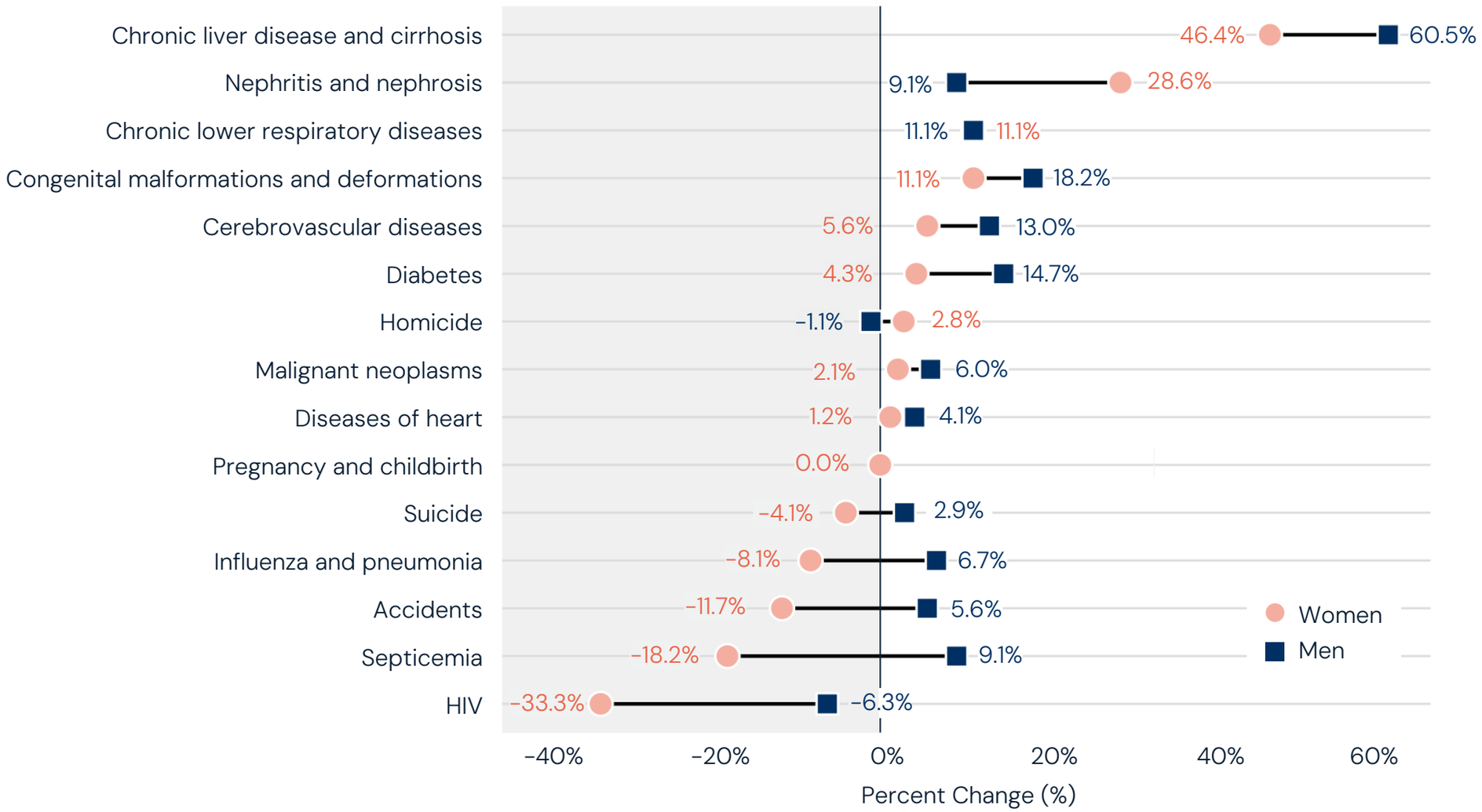


Note: 2024 data for leading cause of death and crude mortality rate are provisional.
Source: Centers for Disease Control and Prevention WONDER database.

Chronic Disease Mortality Is Growing for Young Adults

Between 2018 and 2024, the mortality rate among adults ages 18-44 increased by 6.4%. Among the leading causes of death, the largest increase in mortality rate was observed for chronic liver disease and cirrhosis for both women and men, up 46.4% and 60.5%, respectively.

Percent Change in Mortality Rate per 100,000 Population, Leading Causes of Death, Ages 18-44, by Gender, 2018 to 2024

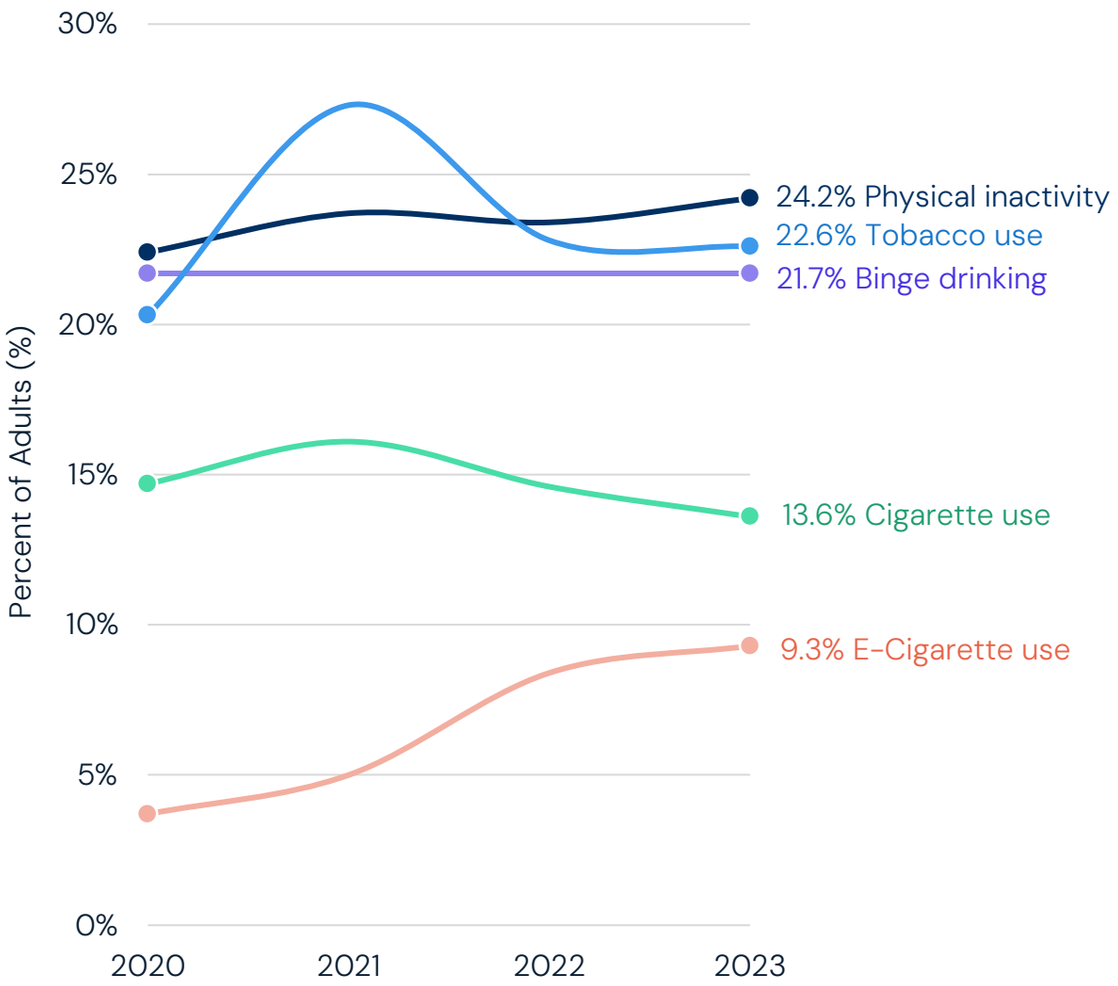


Source: Centers for Disease Control and Prevention WONDER database.

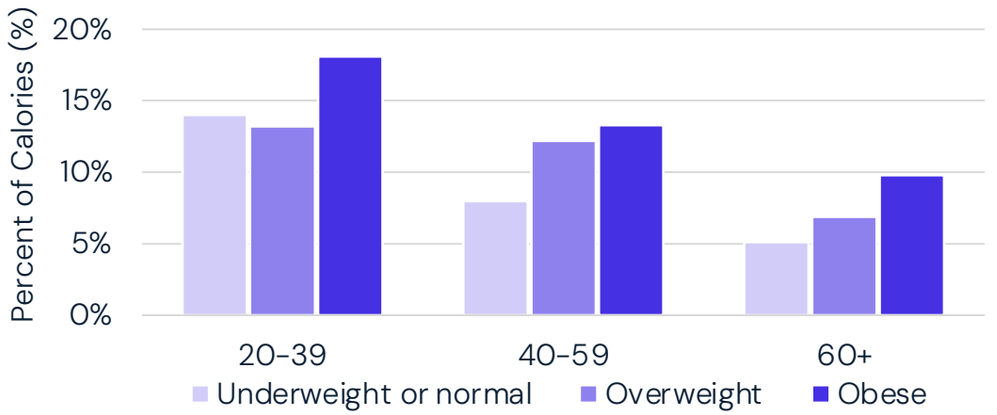
Unhealthy Lifestyle Behaviors Contribute to Declining Health Status

In 2023, 24.2% of U.S. adults reported no physical activity in the past month. In the same period, 21.7% reported binge drinking and 22.6% used tobacco. Between 2021 and 2023, fast food accounted for as much as 18.1% of calories consumed by obese adults ages 20-39. Regardless of age or income level, more than half of calories were derived from ultra-processed foods.

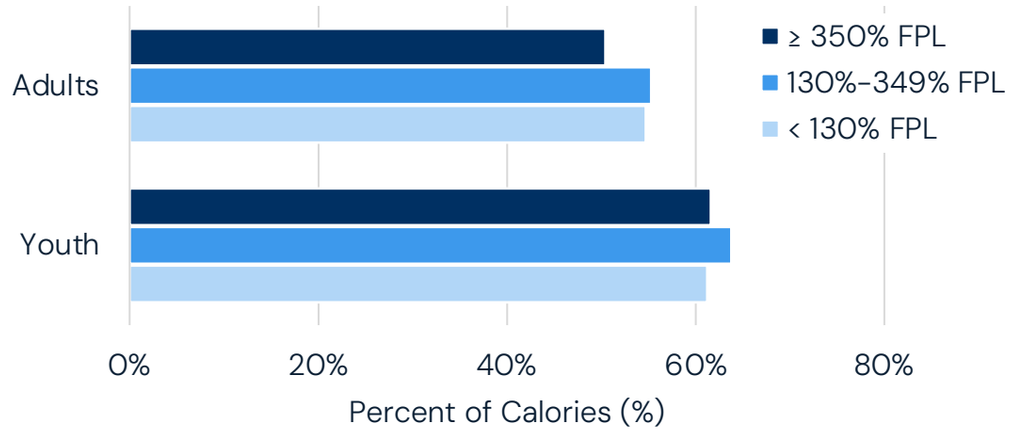
Unhealthy Lifestyle Indicators Among U.S. Adults, 2020-2023



Percent of Calories From Fast Food in the U.S., by Age Group, August 2021-August 2023



Percent of Calories From Ultra-Processed Foods in the U.S., by Income, August 2021-August 2023

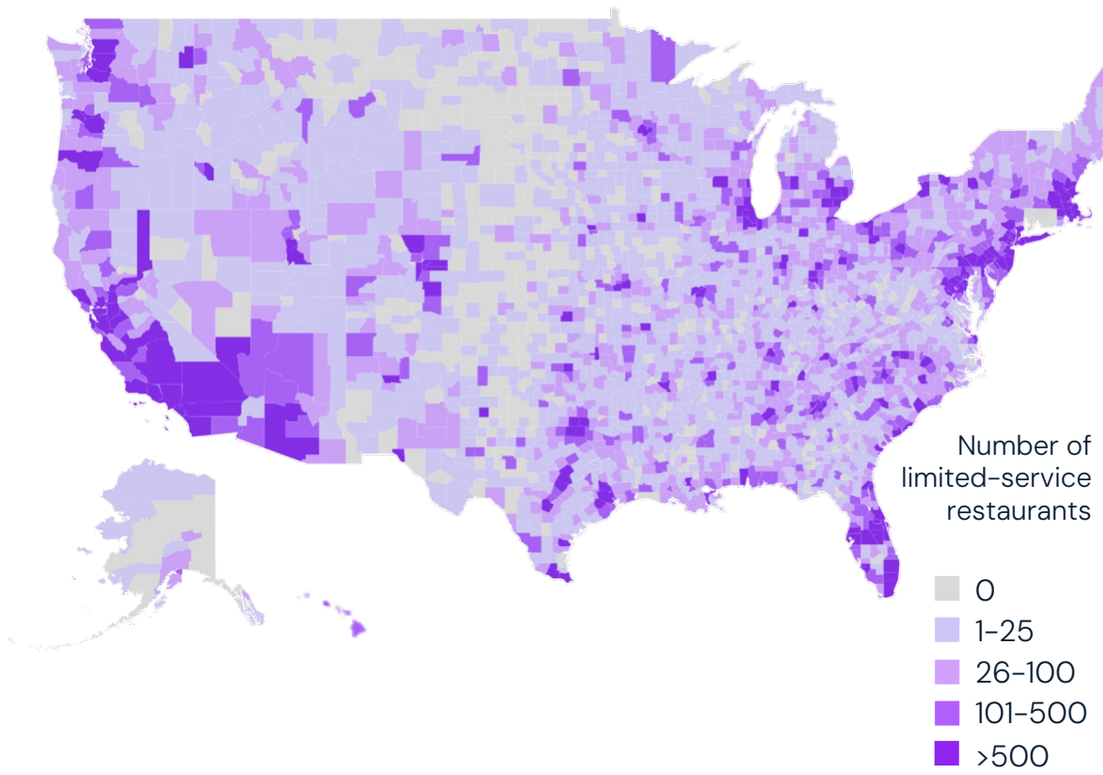


Note: FPL denotes Federal poverty level.
Source: National Survey on Drug Use and Health; National Center for Health Statistics Data Brief No. 533 & No. 536; Behavioral Risk Factor Surveillance System.

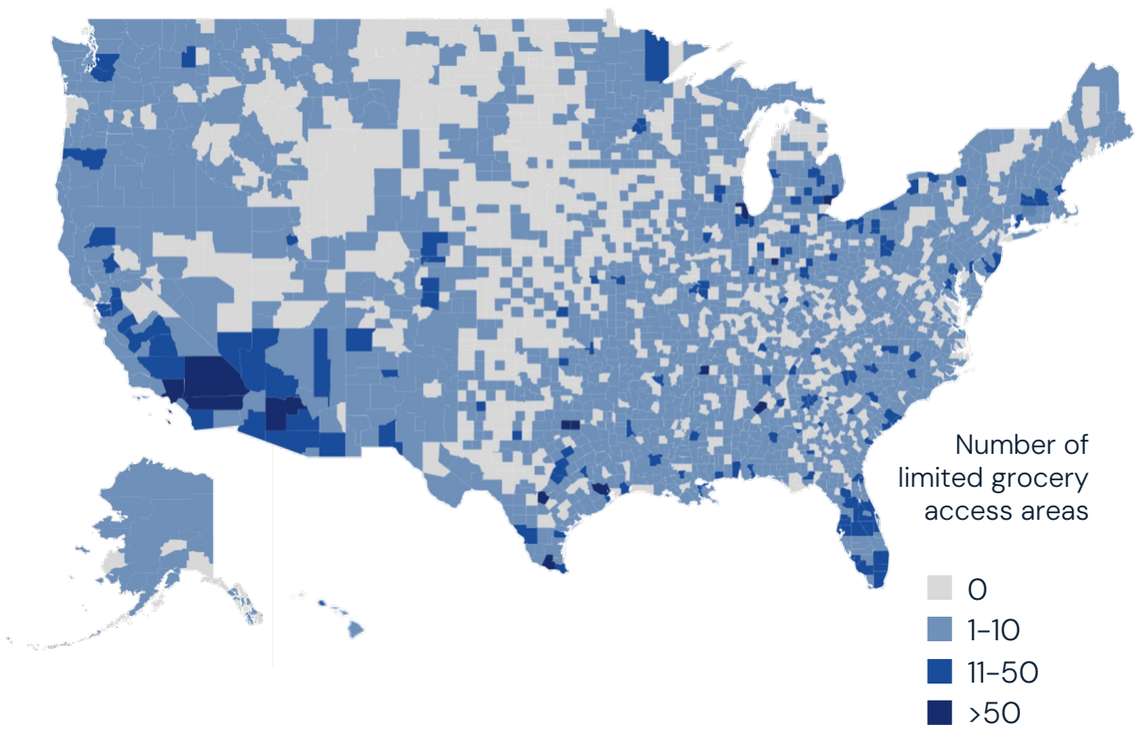
Limited Grocery Access Aligns With Fast Food Concentration

The U.S. has over 9,200 low-income Census tracts that lack access to grocery stores but contain more than 271,000 limited-service restaurants. Over 80% of all limited-service restaurants nationwide are located in the 66.3% of counties with at least one limited grocery access area.

Number of Limited-Service Restaurants, by County, 2023



Number of Limited Grocery Access Areas, by County, 2019

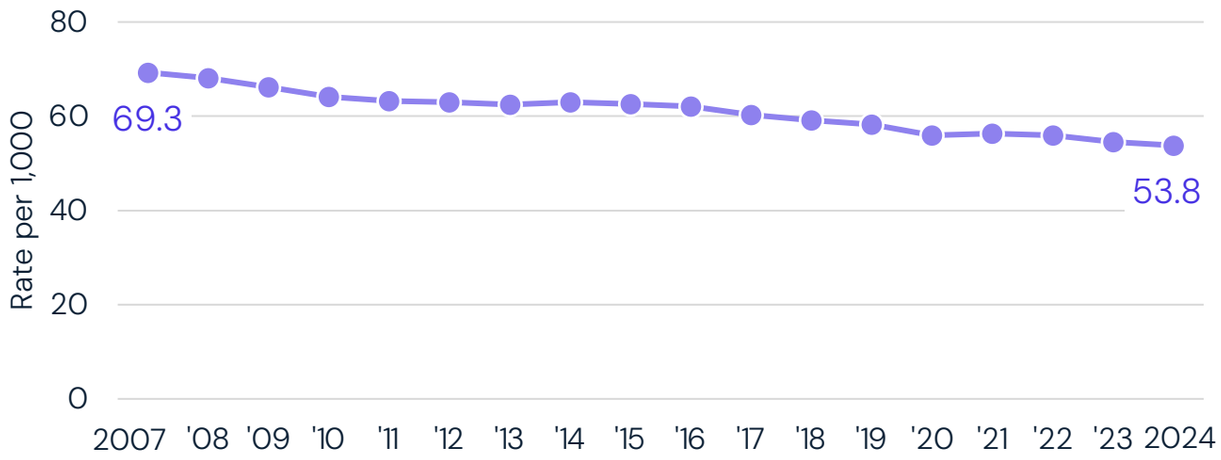


Note: Limited access areas reflect 2019 low-income Census tracts (poverty rate ≥ 20% or median family income ≤ 80% of state or metro median) where at least 500 people or 33% of residents live more than one mile (urban) or 10 miles (rural) from the nearest grocery store. Limited-service restaurants are establishments where customers order and pay before eating, including fast food, pizza delivery, takeout and fast casual.
Source: U.S. Department of Agriculture Food Access Research Atlas; U.S. Census Bureau County Business Patterns.

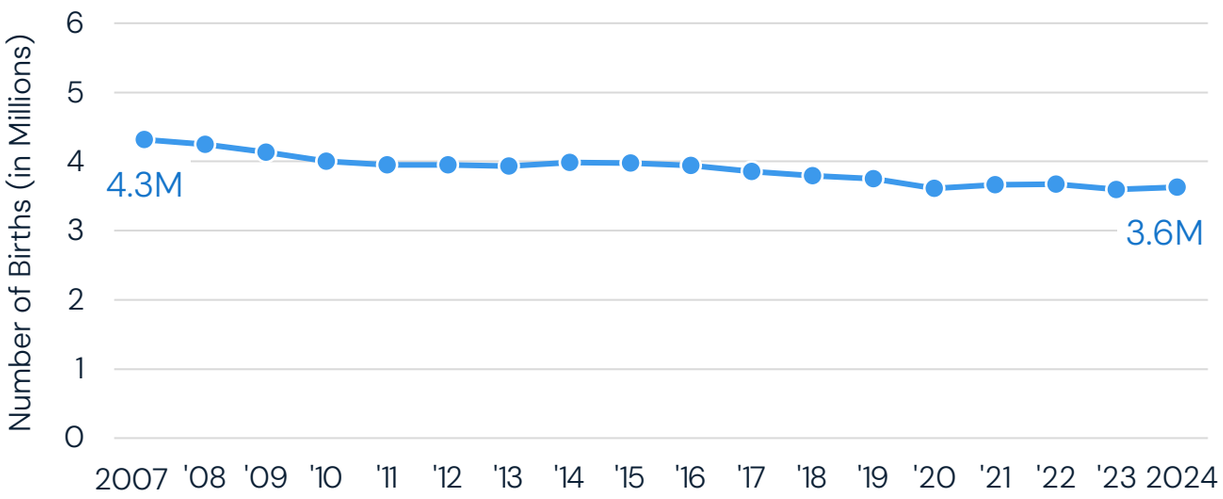
The Number of U.S. Births Fails to Offset Those Aging Into Medicare

By 2030, the Medicare-eligible population is projected to grow by 12.5%, while the population ages 25 and younger is projected to decrease by 2.8%. This widening generational gap reflects a 15.9% decrease in annual births since 2007.

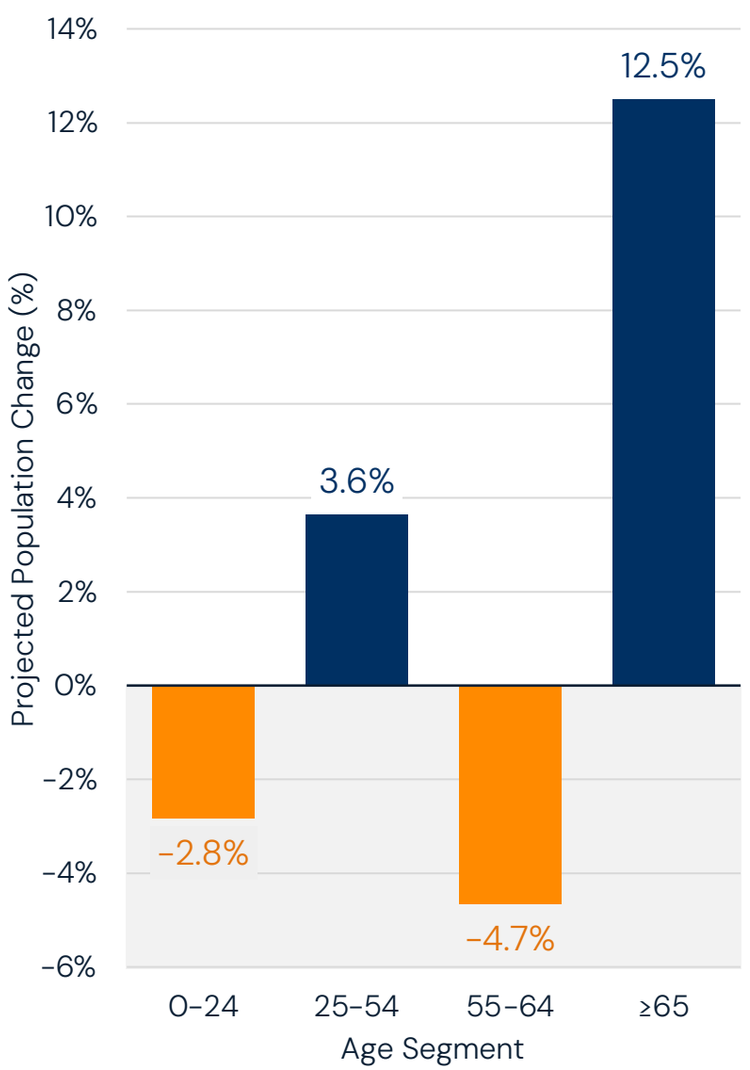
U.S. Fertility Rate per 1,000 Women Ages 15-44, 2007-2024



Number of Births in the U.S., 2007-2024



Projected U.S. Population Change, by Age Segment, 2025-2030

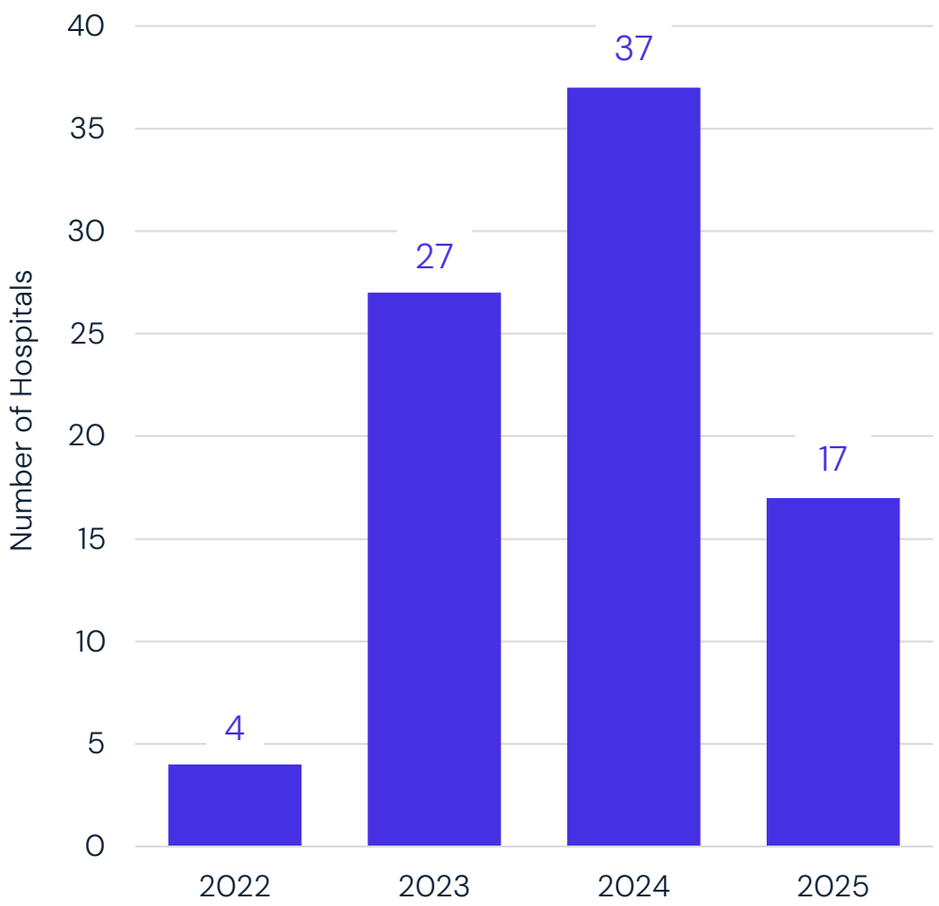


Note: 2024 data for U.S. births and fertility are provisional. General fertility rate refers to the total number of births per 1,000 women ages 15-44.
Source: Centers for Disease Control and Prevention National Center for Health Statistics (NCHS), National Vital Statistics System, WONDER Database; NCHS Data Brief No. 535; Congressional Budget Office, The Demographic Outlook: 2025 to 2055.

L&D Closures Exemplify Tension Between Demand, Access and Specialization

As health systems continue to compete for a shrinking number of births, an increasing number have shuttered their L&D units altogether, with many citing the declining rate of patients. Through the first half of 2025, at least 17 health systems had announced unit closures. This trend is acute in rural areas, where fewer than 42% of rural hospitals still offer L&D services.

Select Labor and Delivery Unit Closures, 2022–2025



Select Health Systems Closing Labor and Delivery Units in 2025

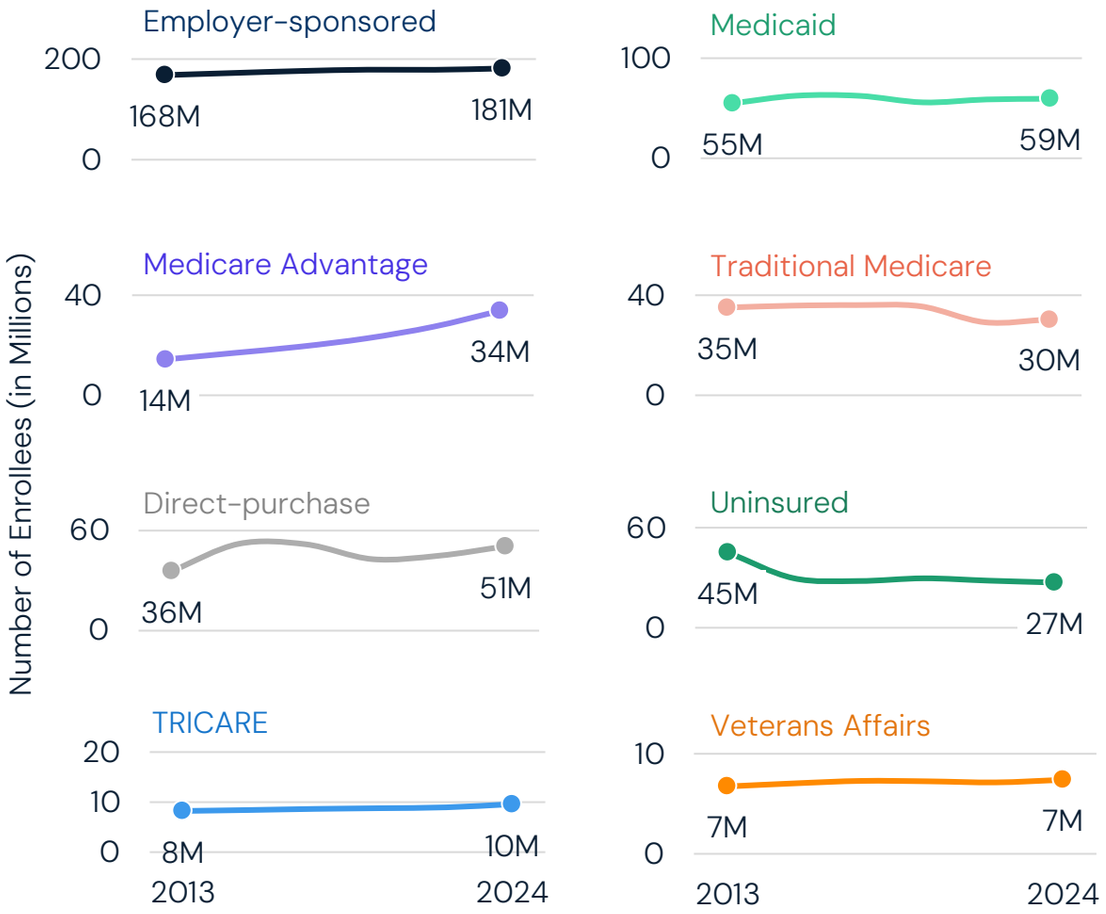
HCA Midwest Health
Memorial Hospital Biloxi
Copley Hospital
Jackson South Medical Center
Providence Seaside Hospital
Providence St. Patrick Hospital
Houlton Regional Hospital
Harrison County Hospital
Mount Desert Island Hospital
Intermountain Health Bloomin' Babies Birth Center
UPMC Cole
CHS
Arkansas Valley Regional Medical Center
Northern Light Inland Hospital
75 Years of Care 1949-2024 Winner Regional Health
Cleveland Clinic Martin Health
ThedaCare Medical Center-Waupaca
MaineHealth Waldo Hospital
Mayo Clinic Fairmont

Note: L&D denotes labor and delivery. 2025 closures are through July.
Source: Becker's Hospital CFO Reports; Center for Healthcare Quality and Payment Reform, Stopping the Loss of Rural Maternity Care, 2025; publicly available news sources.

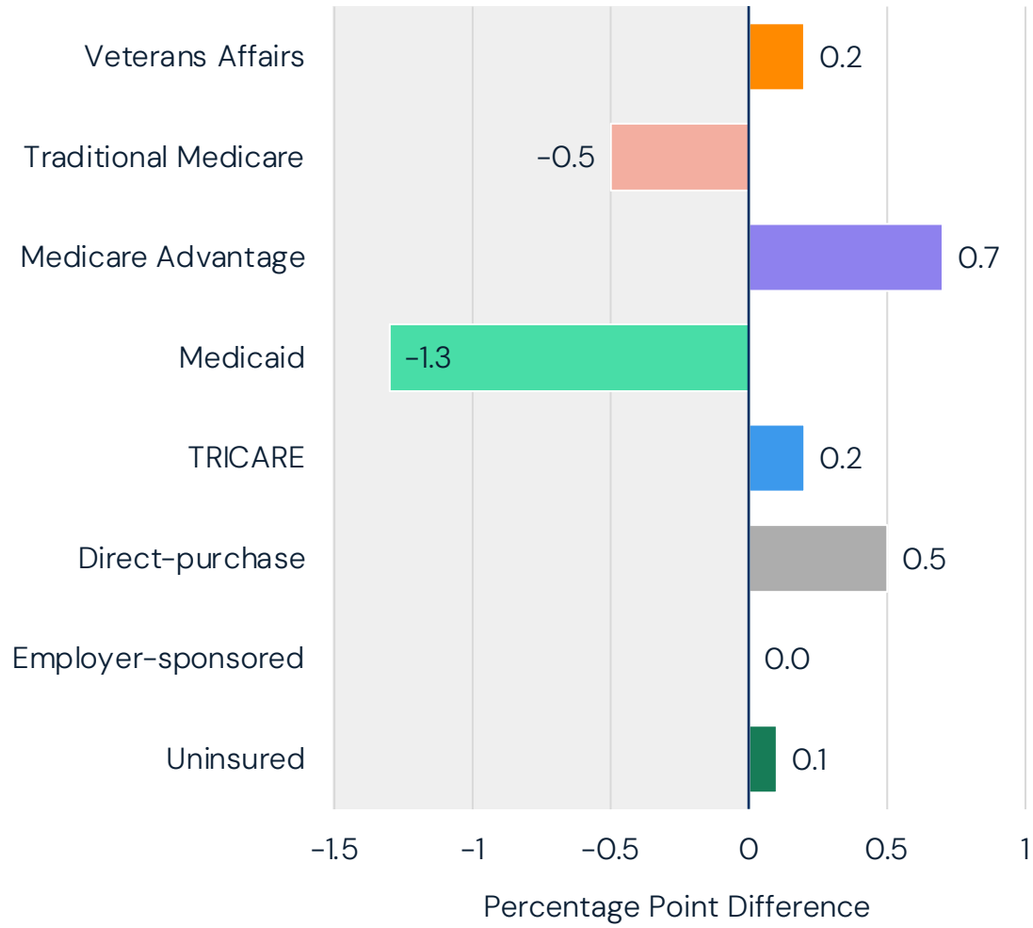
MA Enrollment Accelerates as Employer-Sponsored Insurance Remains Flat

Commercially insured Americans have traditionally accounted for the majority of profitable revenue across the health economy. However, the employer-sponsored share of the population is flat to declining, remaining unchanged from 2023 to 2024. While the number and share of Medicare beneficiaries increases, enrollment is growing disproportionately in Medicare Advantage, which is projected to account for 64% of Medicare beneficiaries by 2034.

Health Insurance Enrollment, by Type, 2013-2024



Change in Health Insurance Enrollment, by Type, 2023-2024

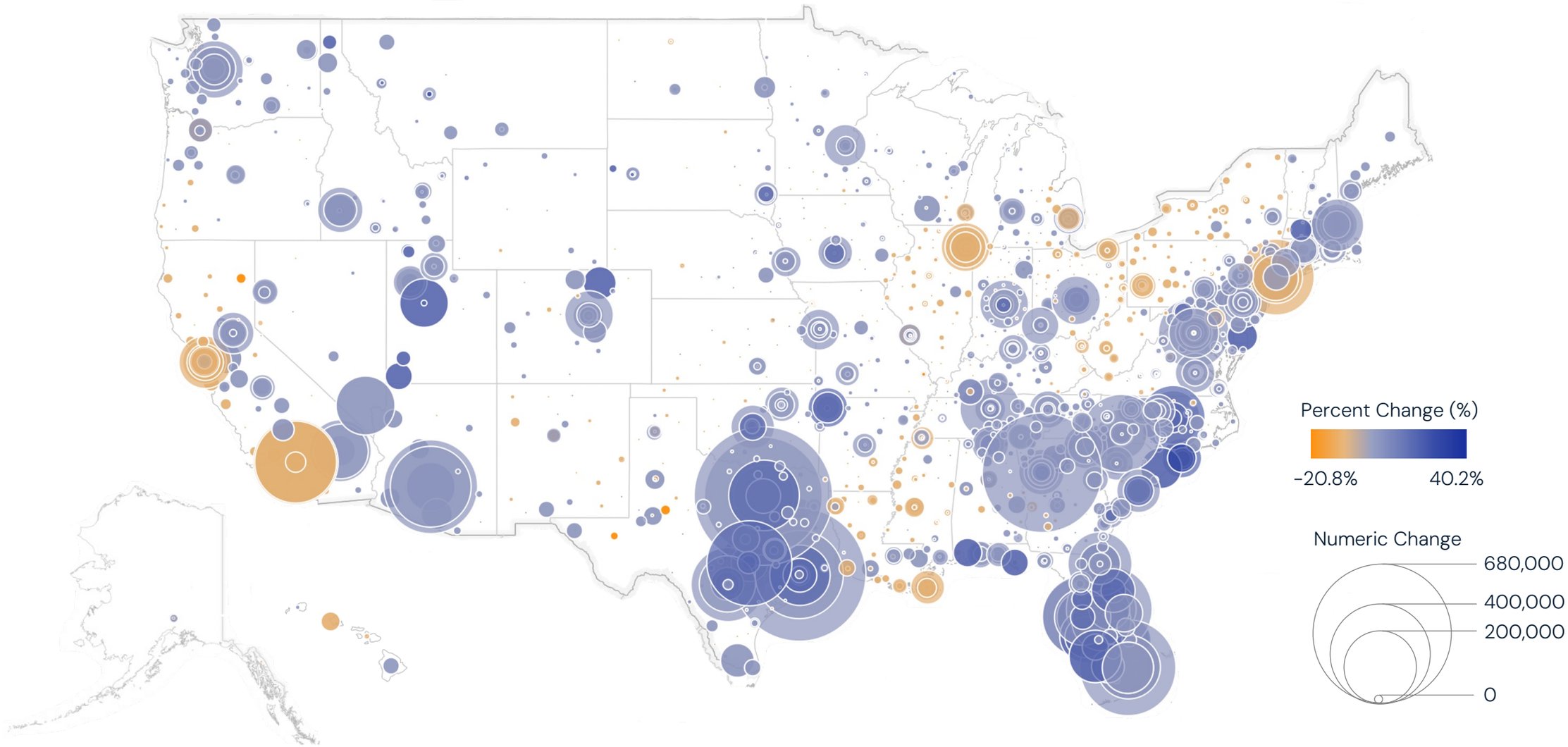


Note: MA denotes Medicare Advantage; PP denotes percentage point. The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.
Source: U.S. Census Bureau; Centers for Medicare and Medicaid Services Medicare Advantage Enrollment Files, 2010-2024; Medicare Enrollment Dashboard 2023-2024.

Recent Population Growth Is Concentrated in the Sunbelt

From 2020 to 2024, the percent increase and numeric population growth was highest in CBSAs concentrated in Texas, Florida and the Southeastern U.S., while CBSAs in California and New York saw the highest numeric population declines.

Percent and Numeric Population Change, by CBSA, 2020-2024

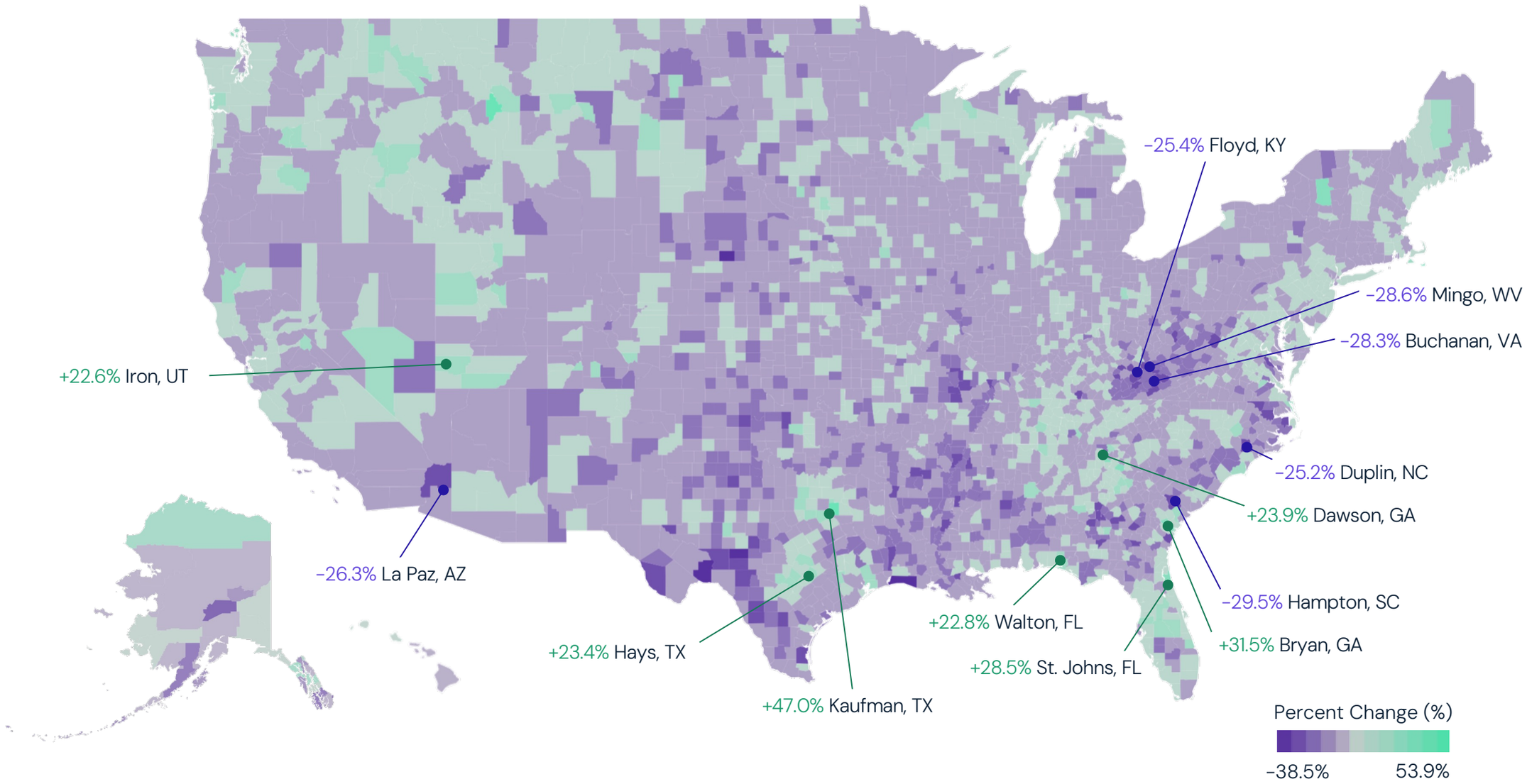


Note: CBSA denotes core-based statistical area. Population growth reflects resident estimates for metropolitan and micropolitan statistical areas. Values represent total change between April 1, 2020–July 1, 2024.
Source: U.S. Census Bureau, Annual Resident Population Estimates for Metropolitan and Micropolitan Statistical Areas, April 1, 2020–July 1, 2024.

Projected Migration Patterns Influence Healthcare Demand...

Through 2029, population growth is projected to concentrate in the South and Mountain West, with sustained growth in Texas, Florida and Utah. The uneven pace of change across markets will inevitably reshape healthcare demand.

Projected Five-Year Population Percent Change, by County, 2025-2029

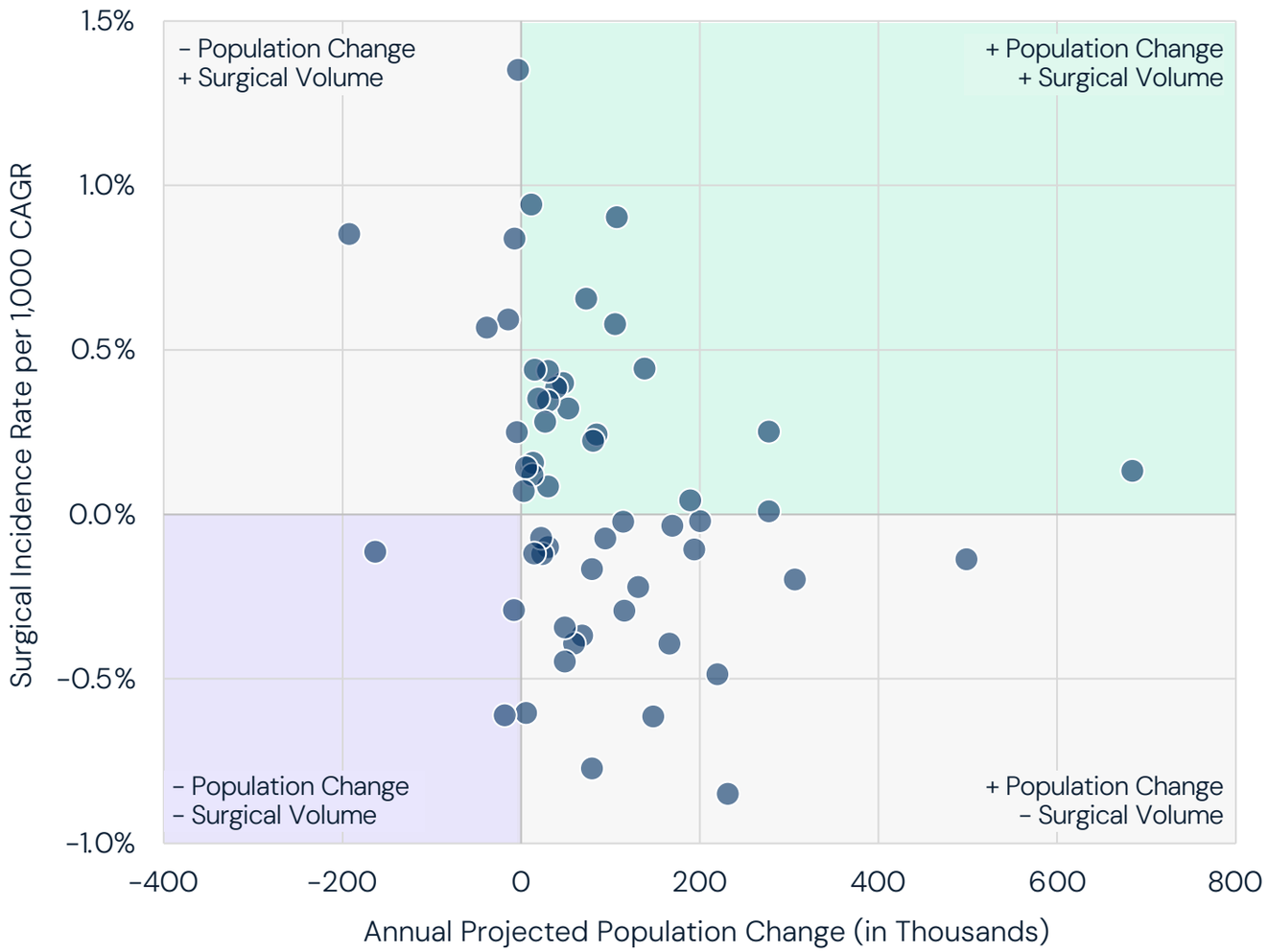


Note: Select counties with populations over 20,000 with high and low projected population growth are highlighted.
Source: Trilliant Health national consumer database.

...But so Do Market-Level Incidence Rates

Patterns in projected surgical incidence rate from 2025 to 2030 vary in their alignment with projected population growth. Orlando, FL is projected to grow in population but decline in surgical demand, while the opposite is expected in Rochester, NY.

Surgical Incidence Rate per 1,000 Population CAGR vs. Annual Projected Population Change in CBSAs With Over 1M Population, 2025-2030



Orlando-Kissimmee-Sanford, FL

2025-2030 Population Change
+231,319

2025-2030 Surgical Incidence Rate CAGR
-0.9%

Rochester, NY

2025-2030 Population Change
-3,662

2025-2030 Surgical Incidence Rate CAGR
+1.4%

Las Vegas-Henderson-North Las Vegas, NV

2025-2030 Population Change
+107,448

2025-2030 Surgical Incidence Rate CAGR
+0.9%

Pittsburgh, PA

2025-2030 Population Change
-18,232

2025-2030 Surgical Incidence Rate CAGR
-0.6%

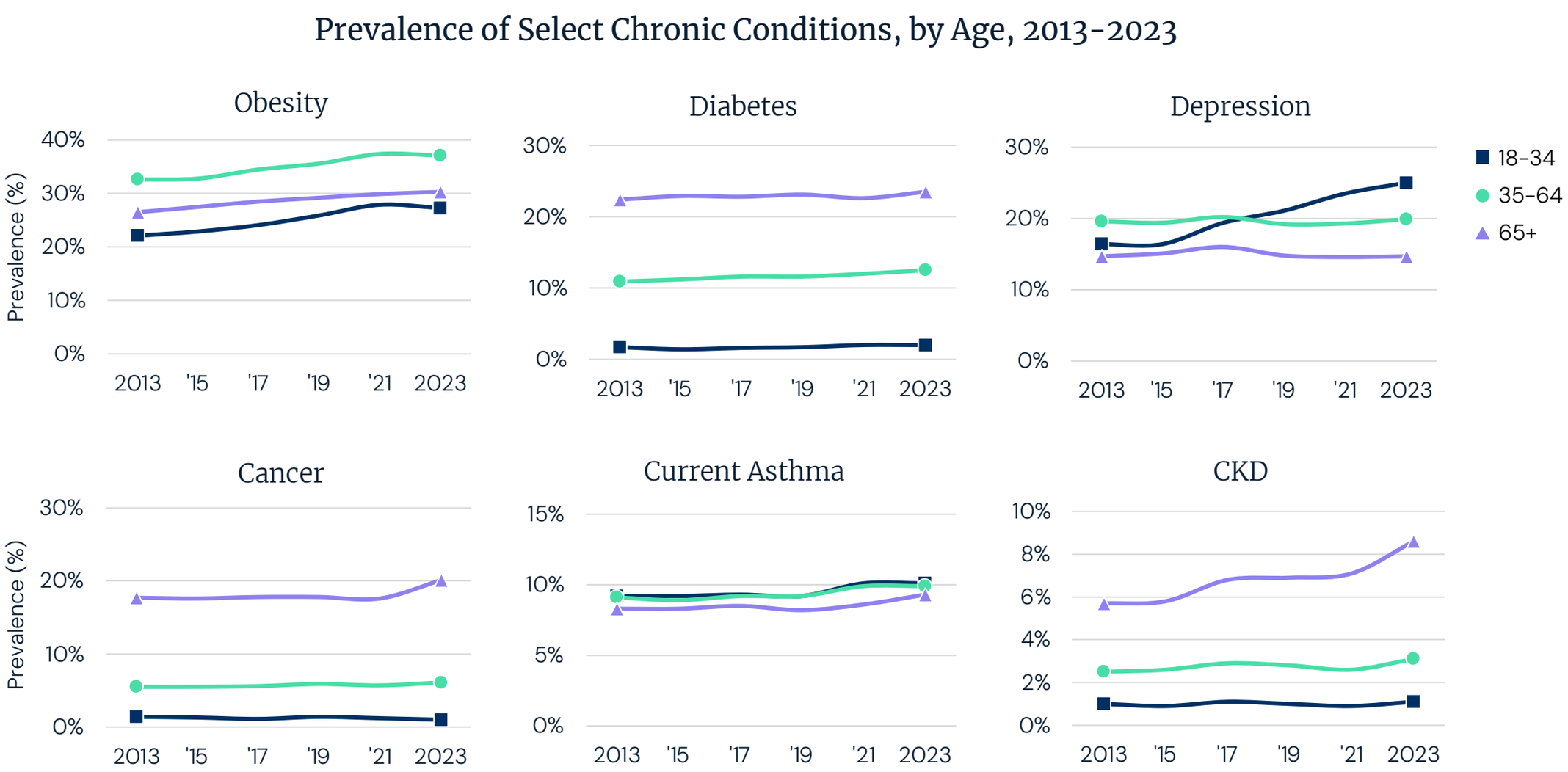
Note: CBSA denotes core-based statistical area; CAGR denotes compound annual growth rate.
Source: Trilliant Health Demand Forecast.

TREND 3

The Healthcare Delivery System Incentivizes Specialty Care Intervention Instead of Primary Care Prevention

The Health Status of Americans Is Deteriorating as Chronic Conditions Rise

Chronic conditions are increasing across age groups, highlighting a decline in health status. Older adults have the highest prevalence of diabetes, cancer and CKD. From 2013 to 2023, obesity and depression rose by 5.2 and 8.6 PP, respectively, among adults ages 18-34. Adults ages 35-64 saw increases in obesity (4.5 PP), diabetes (1.6 PP) and current asthma (0.8 PP).

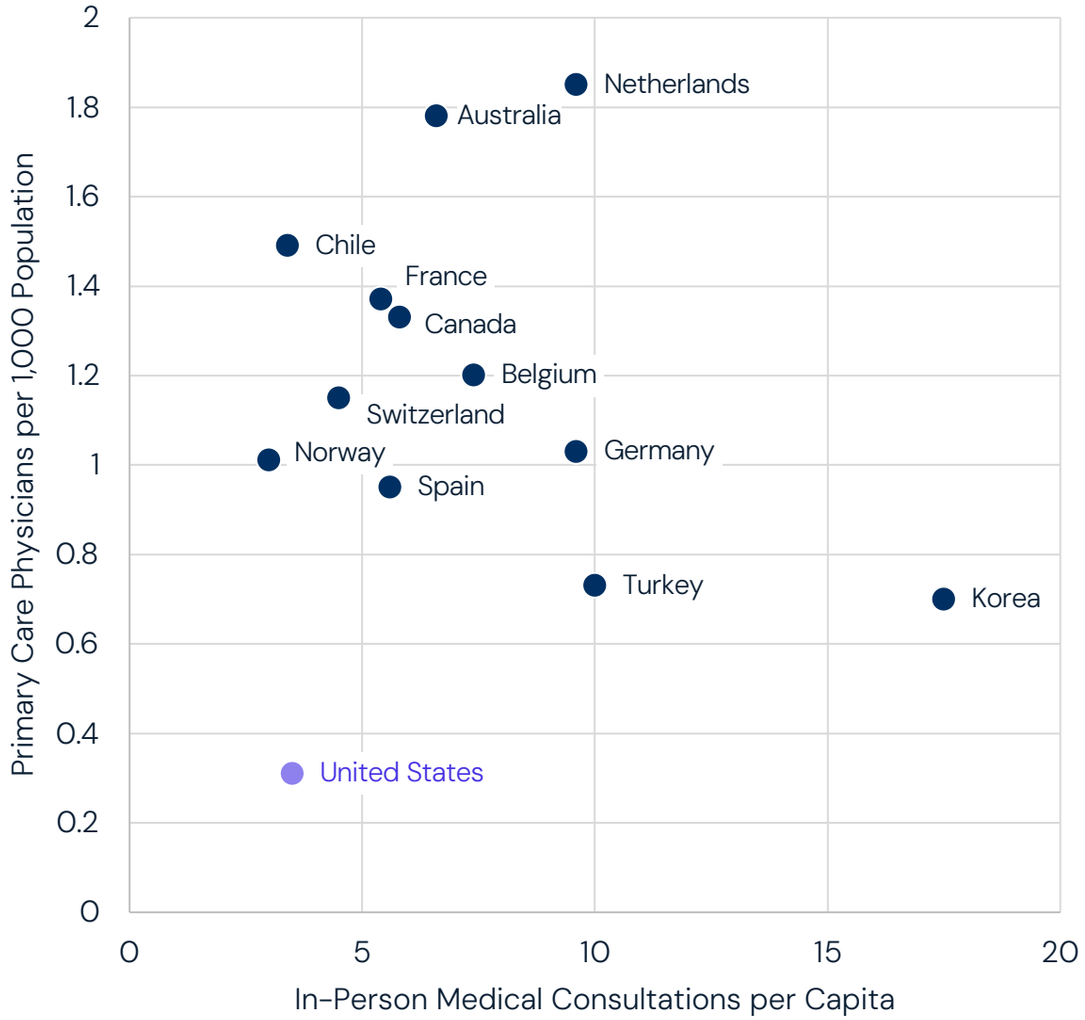


Note: CKD denotes chronic kidney disease; PP denotes percentage point.
Source: Centers for Disease Control and Prevention.

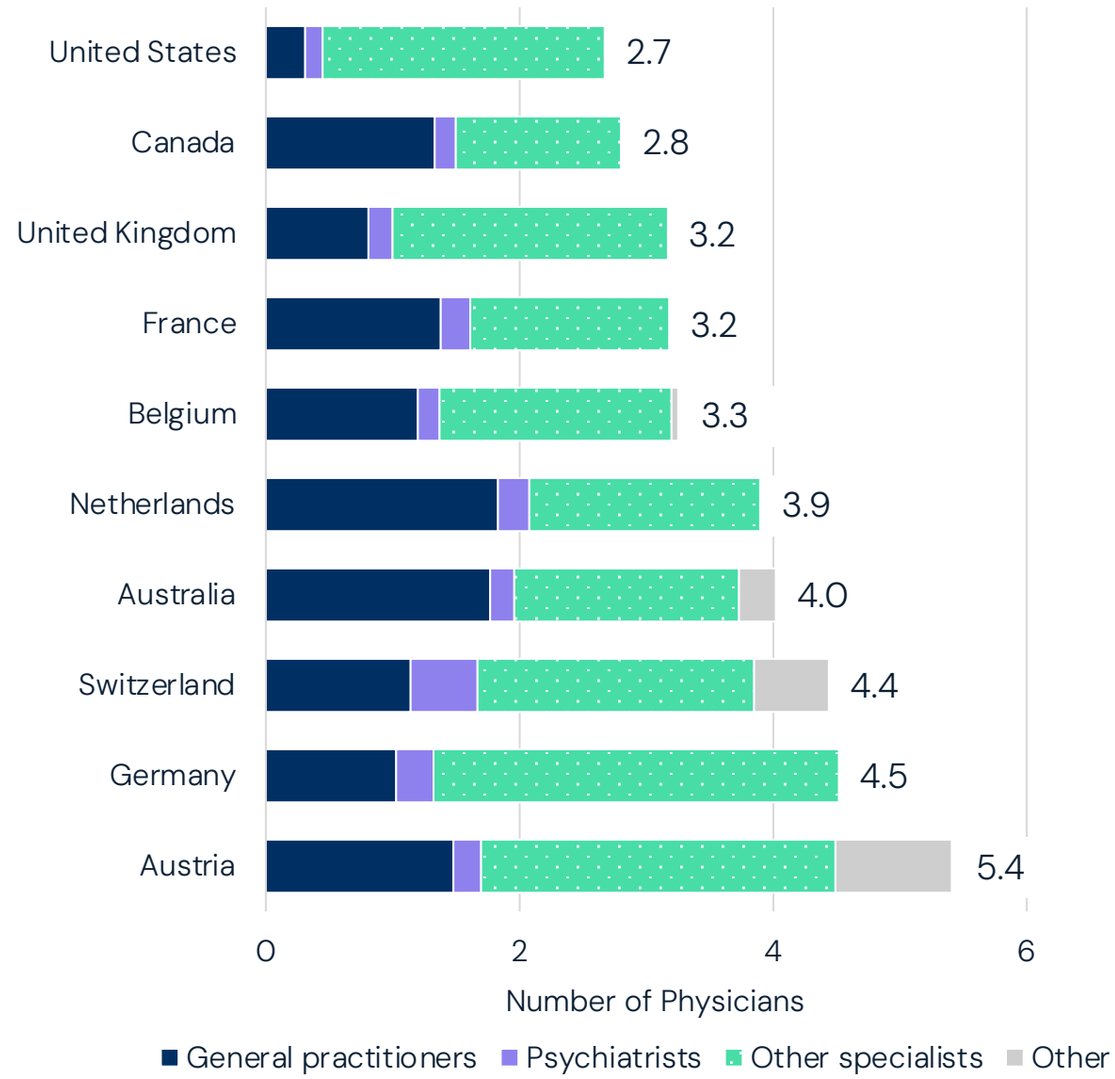
U.S. Primary Care Capacity and Utilization Are Below Peer Nations

In the U.S., patients have access to fewer primary care physicians and utilize primary care less frequently than patients in peer nations. The U.S. has one of the smallest primary care workforces in the OECD, with only 12% of physicians practicing primary care, compared to 25-50% in peer countries.

Primary Care Physicians per 1,000 Population vs. In-Person Consultations per Capita, U.S. and Select OECD Countries, 2022



Physicians per 1,000 Residents, by Specialty, U.S. and Select OECD Countries, 2021

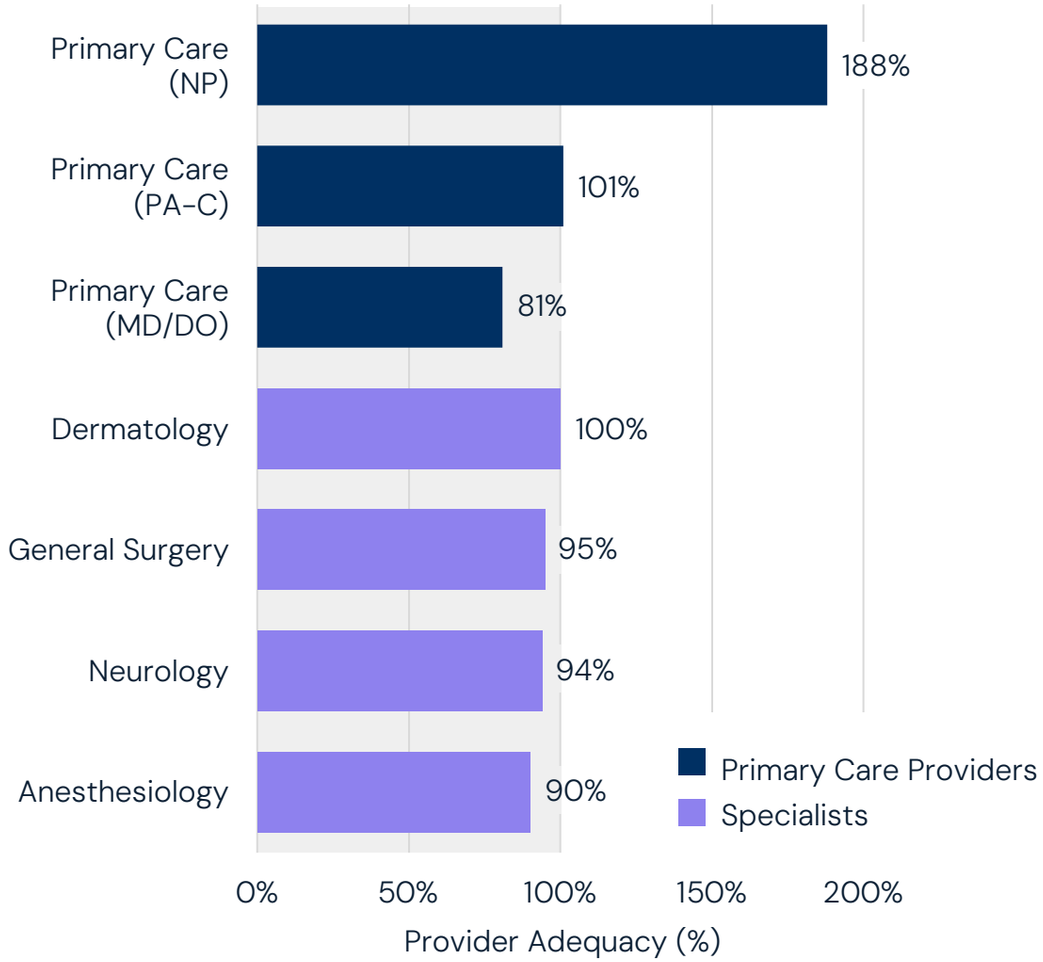


Note: OECD denotes Organisation for Economic Co-Operation and Development.
Source: Organisation for Economic Co-Operation and Development; KFF.

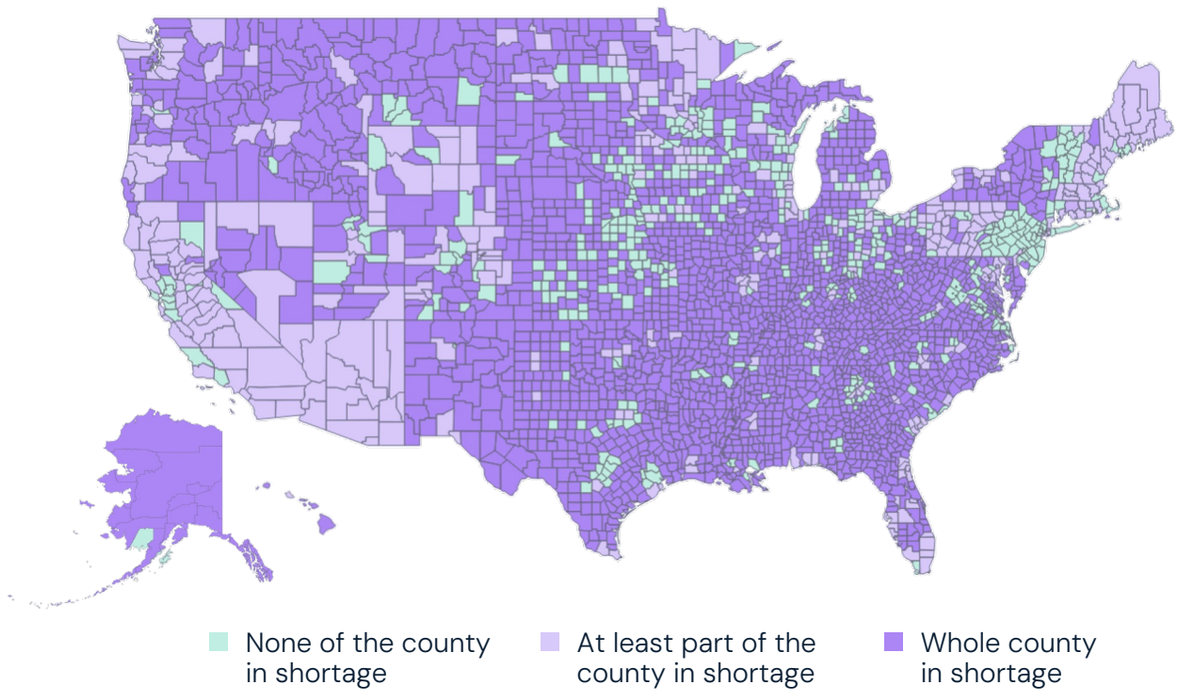
Primary Care Supply Is Insufficient and Uneven

While there is a general physician shortage in the U.S., primary care physicians are most affected, with a projected adequacy of 81% by 2036. Although the allied health workforce has the potential to bolster primary care access, 72.7% of U.S. counties are designated as a primary care professional shortage area.

Projected Supply Adequacy of Primary Care Providers and Select Specialists, 2036



Primary Care Health Professional Shortage Areas, by County, 2025

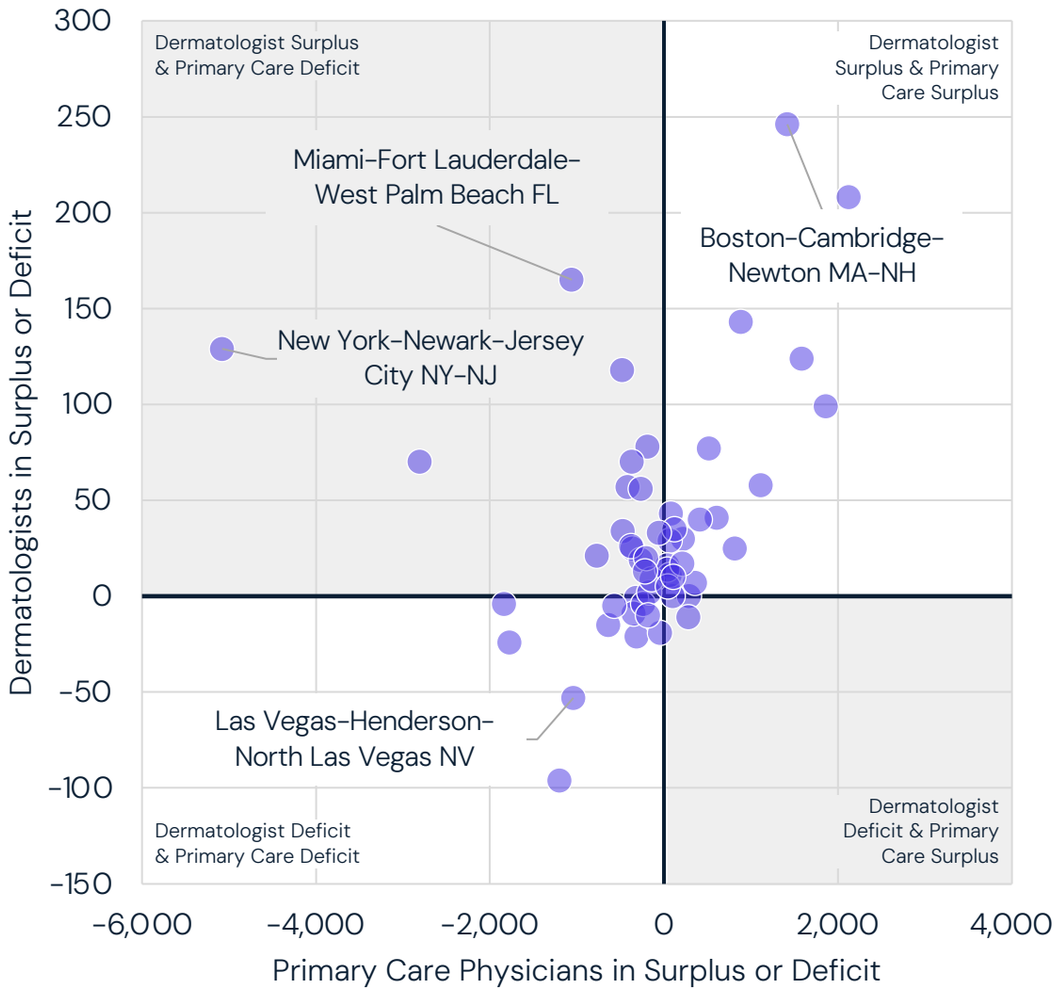


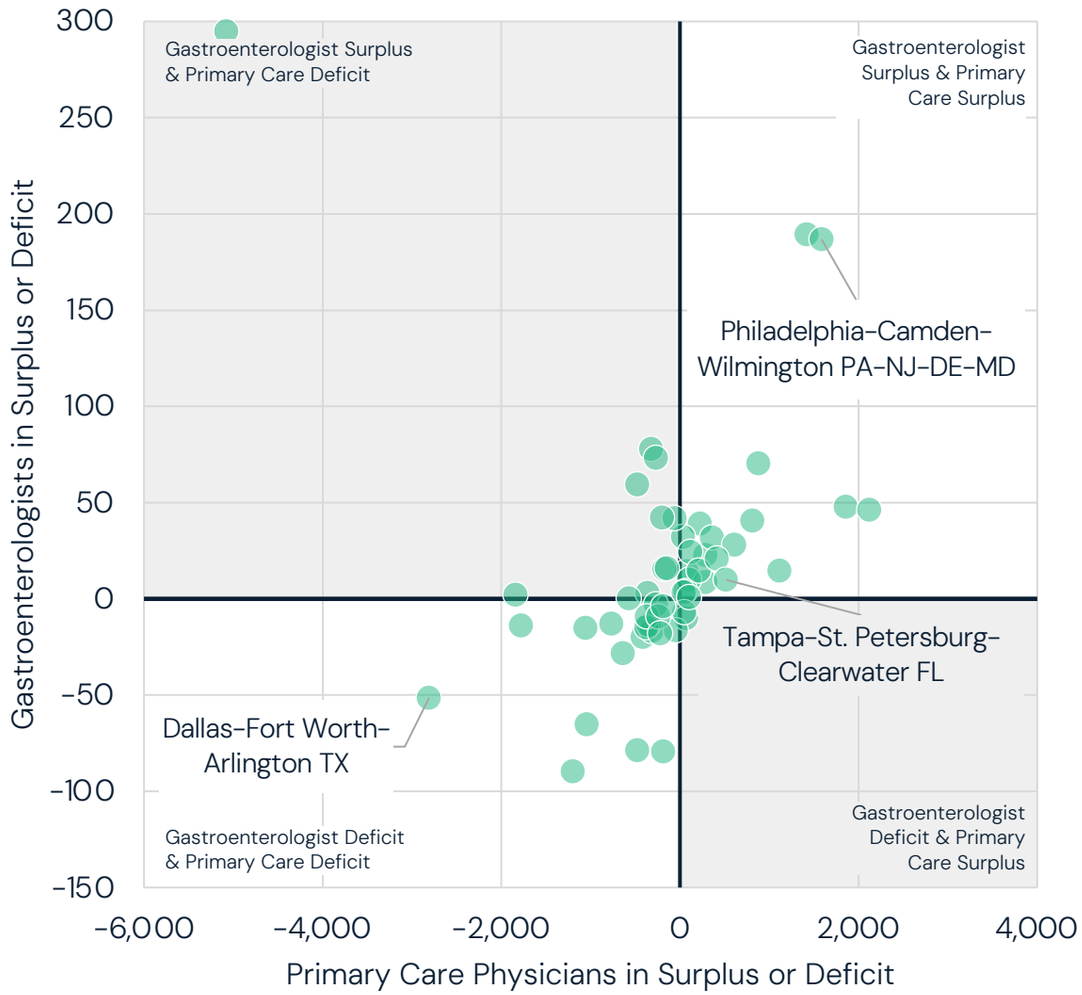
Note: CBSA denotes core-based statistical area. Analysis is limited to CBSAs over 1M population.
Source: Assistant Secretary for Planning and Evaluation; Health Resources and Services Administration.

Specialist Supply Exceeds Primary Care in Several Metropolitan Areas

Across the CBSAs analyzed, primary care physicians consistently had the largest shortages, with many markets facing deficits in the hundreds. In contrast, dermatology and gastroenterology exhibited more localized imbalances. While some CBSAs had notable shortages, others had modest surpluses, with the largest surpluses totaling 246 dermatologists and 295 gastroenterologists.

Supply of Physicians in Surplus or Deficit in Select CBSAs, Primary Care vs. Dermatology and Gastroenterology



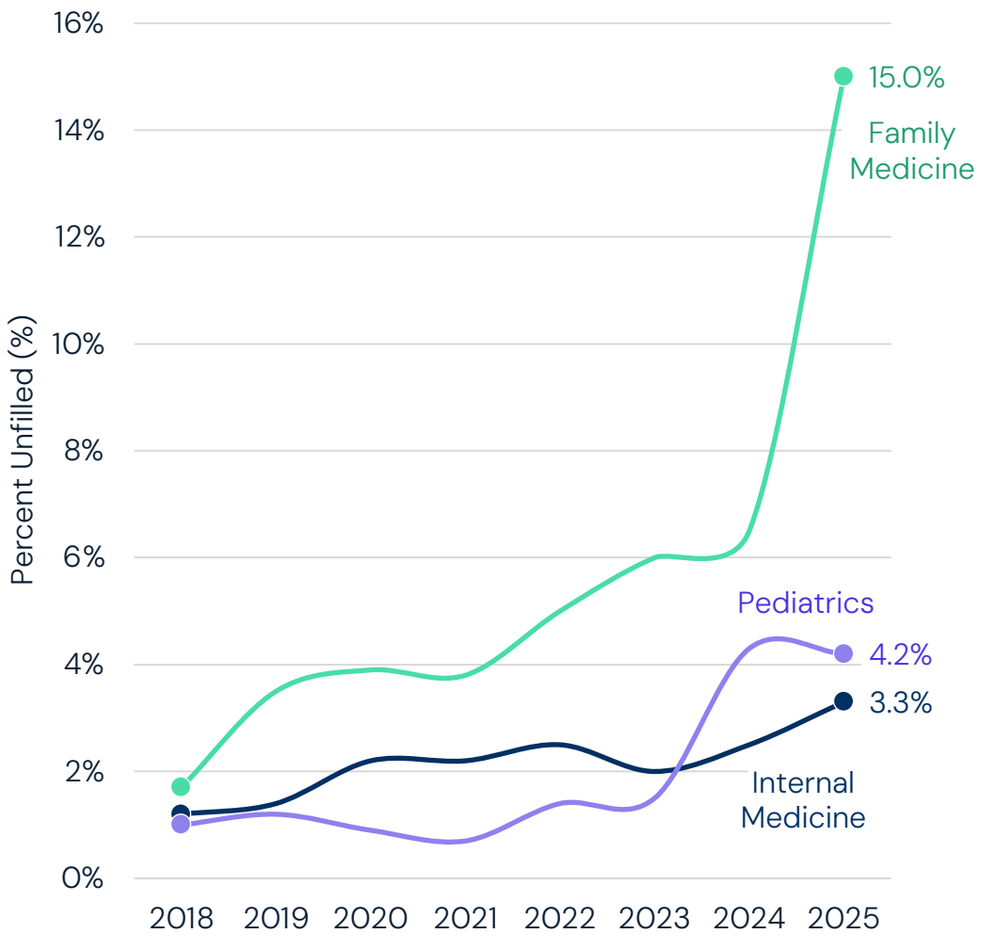


Note: CBSA denotes core-based statistical area; AAMC denotes Association of American Medical Colleges. Analysis is limited to CBSAs over 1M population. Market-level analyses leverage AAMC reported benchmarks for number of people per active physician by specialty. In this analysis, primary care physician includes MD/DO internal medicine, family medicine and pediatrics.
Source: Trilliant Health Provider Directory; Association of American Medical Colleges.

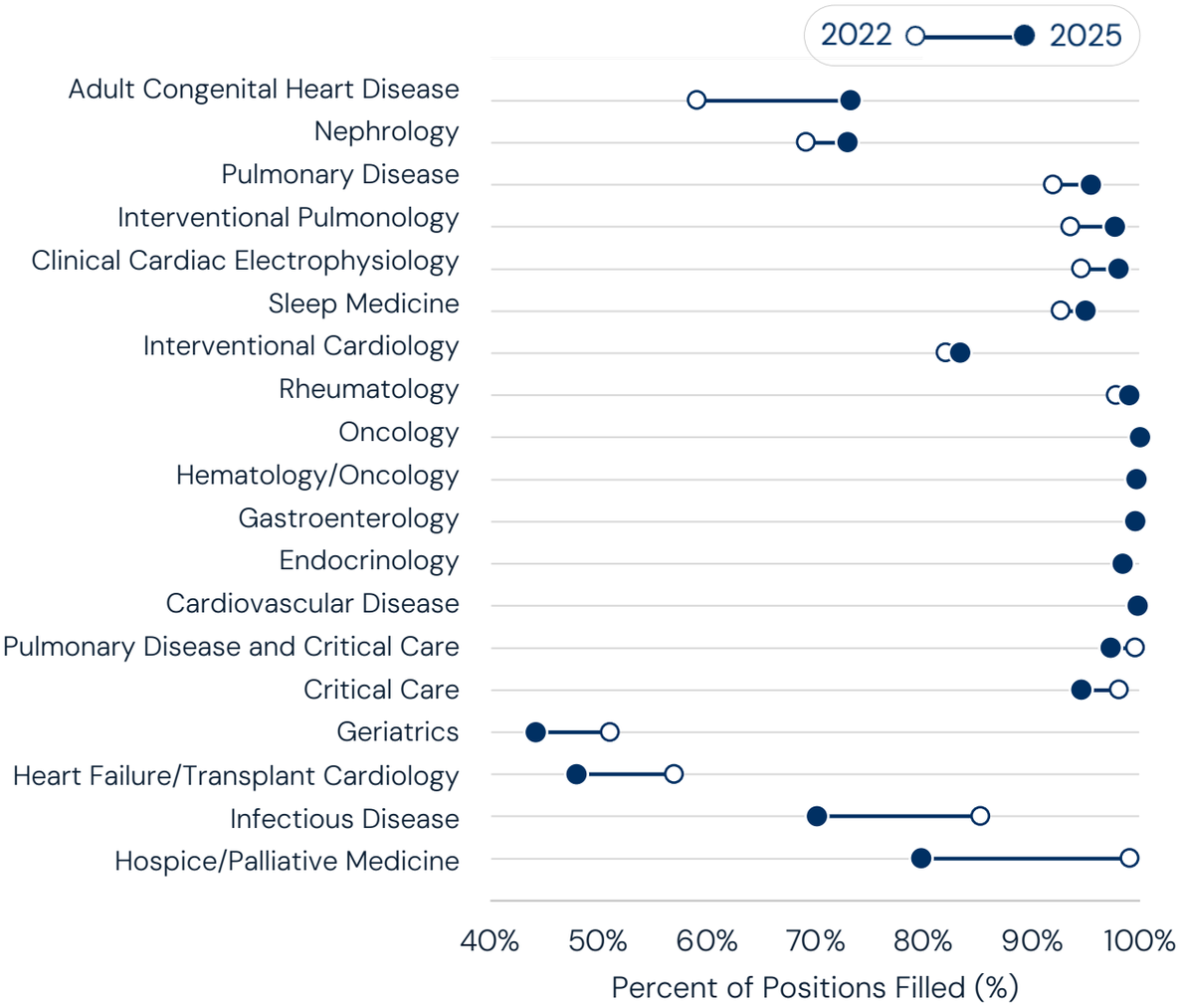
Subspecialization Is Widening the Primary Care Physician Gap

Primary care residencies saw the highest vacancy rates in 2025 – family medicine (15.0%), pediatrics (4.2%) and internal medicine (3.3%), while subspecialty training among internal medicine residents increased from 61.5% in 2018 to 71.8% in 2025.

Percent of Unfilled MD/DO Residency Positions, by Primary Care Specialty, 2018-2025



Percent of Filled Fellowships Following Internal Medicine Residency, 2022 and 2025

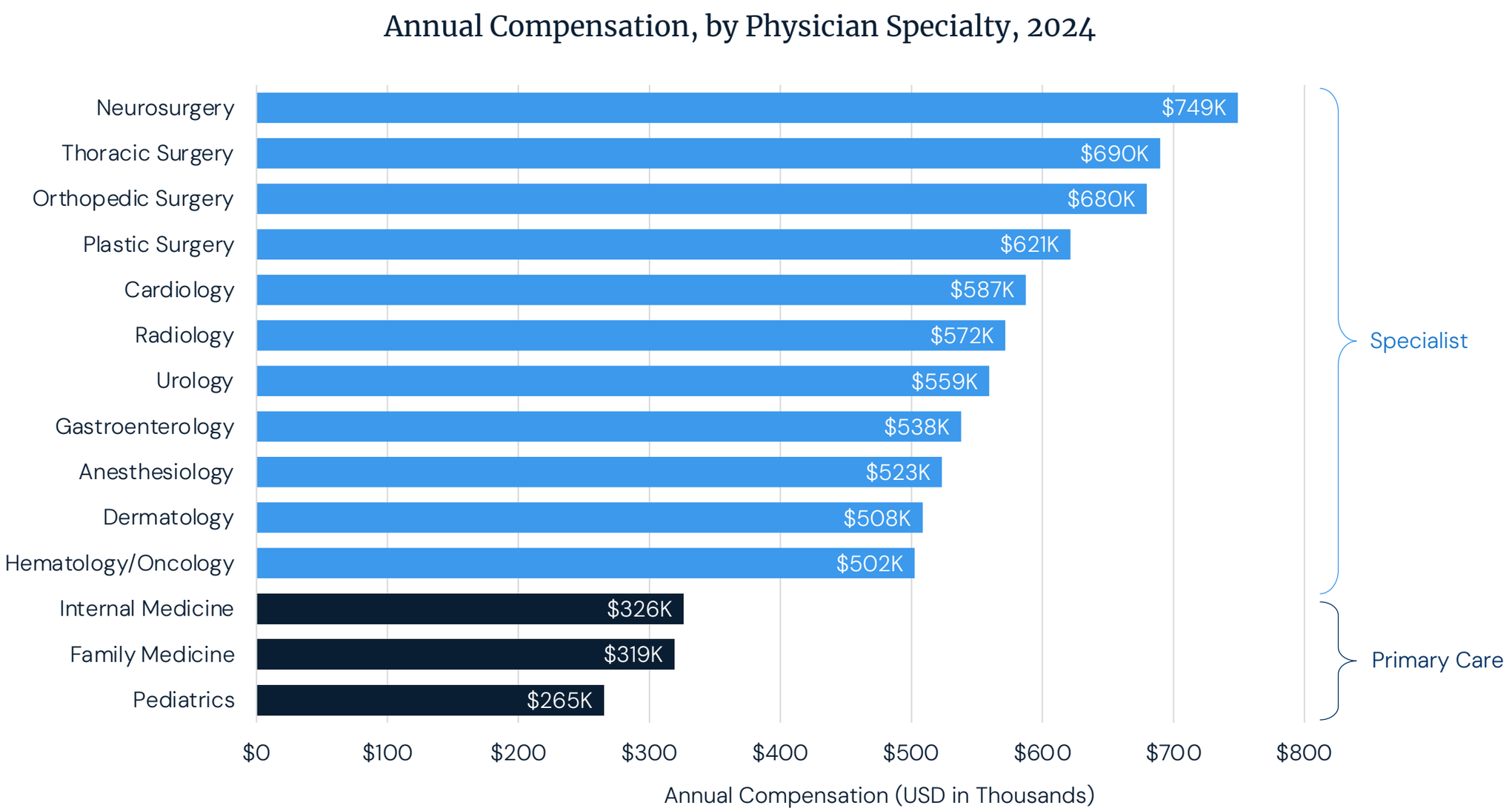


Note: Residency positions are inclusive of PGY-1 and PGY-2 applicants. Specialties with fewer than 70 residency positions available, transitional programs and preliminary programs were excluded.
Source: National Resident Matching Program®. Main Residency Match® Results and Data; Specialties Matching Service® Reports and Data.

TREND 3: NEGLECTING THE FUNDAMENTALS

Pay Disparities Reveal the Perceived Value of Primary Care

Despite its central role in prevention and chronic disease management, primary care compensation remains well below specialty physicians. In 2024, primary care physicians earned an average of $303,435, close to half the average of specialist physicians ($593,697). As new physicians graduate with an average of $194,280 in debt and enter residency earning approximately $60,000, it is unsurprising that many are drawn to higher-paying specialties.



Source: Doximity Physician Compensation Report, 2025.

Most Retailers Have Exited Primary Care in Favor of Specialty Pharmacy

As of 2025, major retailers have either exited or reduced their direct primary care operations. In contrast, each organization has maintained or expanded its presence in specialty pharmacy, where capabilities in distribution and integration with existing care delivery assets have warranted continued investment.

Retailer	Primary Care Entry	Initial Primary Care Strategy	Evolved Primary Care Strategy	Primary Care Status	Specialty Pharmacy Strategy
CVS Health	2014 (MinuteClinic expansion), 2021 (Acquisition of Oak Street Health)	Acquired Oak Street Health for $10.6B to operate value-based senior primary care clinics combined with existing MinuteClinic and Aetna Medicare Advantage.	Slowed expansion of Oak Street clinics; some closures reported; facing profitability and integration challenges.	**Active, but scaling back**	Aggressively expanding specialty pharmacy via Caremark and Cordavis.
Walgreens	2021 (Major investment in VillageMD)	Invested $6B for majority stake in VillageMD to co-locate full-service primary care clinics in stores.	Announced in early 2024 that it would close ~160 VillageMD clinics and sell majority stake amid $5B writedown.	**Exit**	Focused on specialty growth via Shields Health Solutions (acquired 2022).
amazon	2019 (Amazon Care), 2022 (Acquisition of One Medical)	Launched Amazon Care; later acquired One Medical for $3.9B to scale hybrid primary care.	Shut down Amazon Care in 2022. One Medical still operating but experiencing slow growth and unclear integration with Amazon Prime.	**Pivoted**	Entered specialty pharmacy in 2023 via Amazon Pharmacy, now expanding offerings to include specialty medications.
Walmart	2019 (Walmart Health centers)	Built de novo primary care clinics offering low-cost care near stores, targeting self-pay and Medicare Advantage patients.	In 2024, announced exit from 51 health centers and halted further expansion, citing unsustainable costs. Maintains a few clinics in select markets.	**Exit**	Exploring partnerships and payer collaborations in specialty. No standalone specialty pharmacy brand, but strong retail pharmacy infrastructure could support future entry.

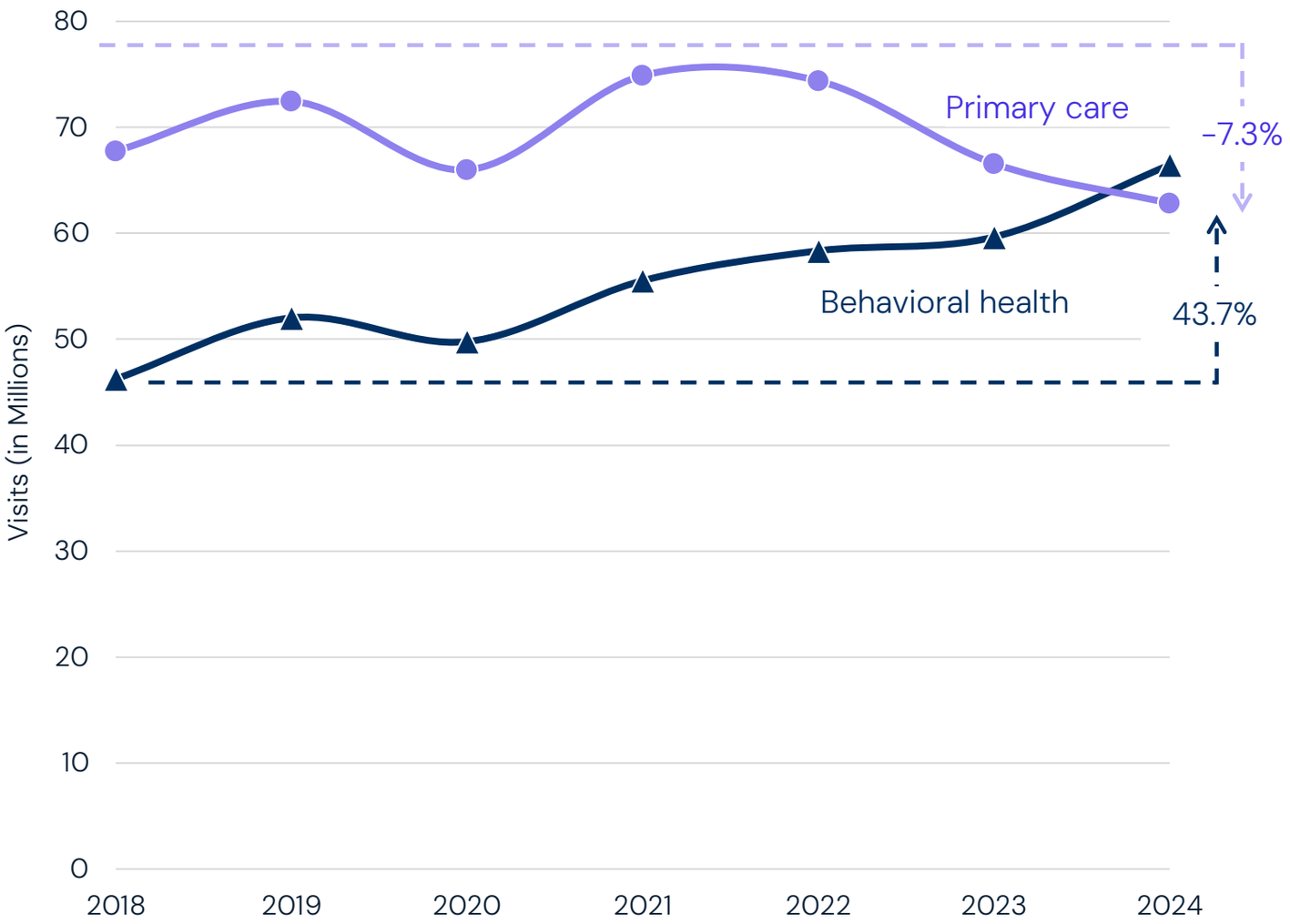
> *"The decision to close all 51 health centers across five states and shut down the virtual care offering was not easy. While we will no longer operate health centers, we will take what we learned as we provide trusted health and wellness services across the country through our nearly 4,600 Pharmacies…Over the past few years, the importance of Pharmacies has continued to grow, and we have expanded the clinical capabilities of the services we provide. We continue to offer immunizations and have grown to provide Testing and Treatment services, access to specialty pharmacy medication and care, as well as other essential services such as medication therapy management and a variety of health screenings."* – Walmart press release

Source: Publicly available company information.

Behavioral Health Utilization Outpaced Primary Care in 2024

Amid the backdrop of inadequate and declining primary care physician supply, from 2018 to 2024, primary care volume declined by 7.3%, while behavioral health volume increased by 43.7%. Between 2023 and 2024, utilization of behavioral health was up by 11.4%, and primary care was down by 5.6%.

Primary Care and Behavioral Health Visits, 2018-2024



Primary Care Percent Change	
2018 to 2024	**-7.3%**
2018 to 2019	6.9%
2019 to 2020	-8.9%
2020 to 2021	13.5%
2021 to 2022	-0.7%
2022 to 2023	-10.5%
2023 to 2024	-5.6%

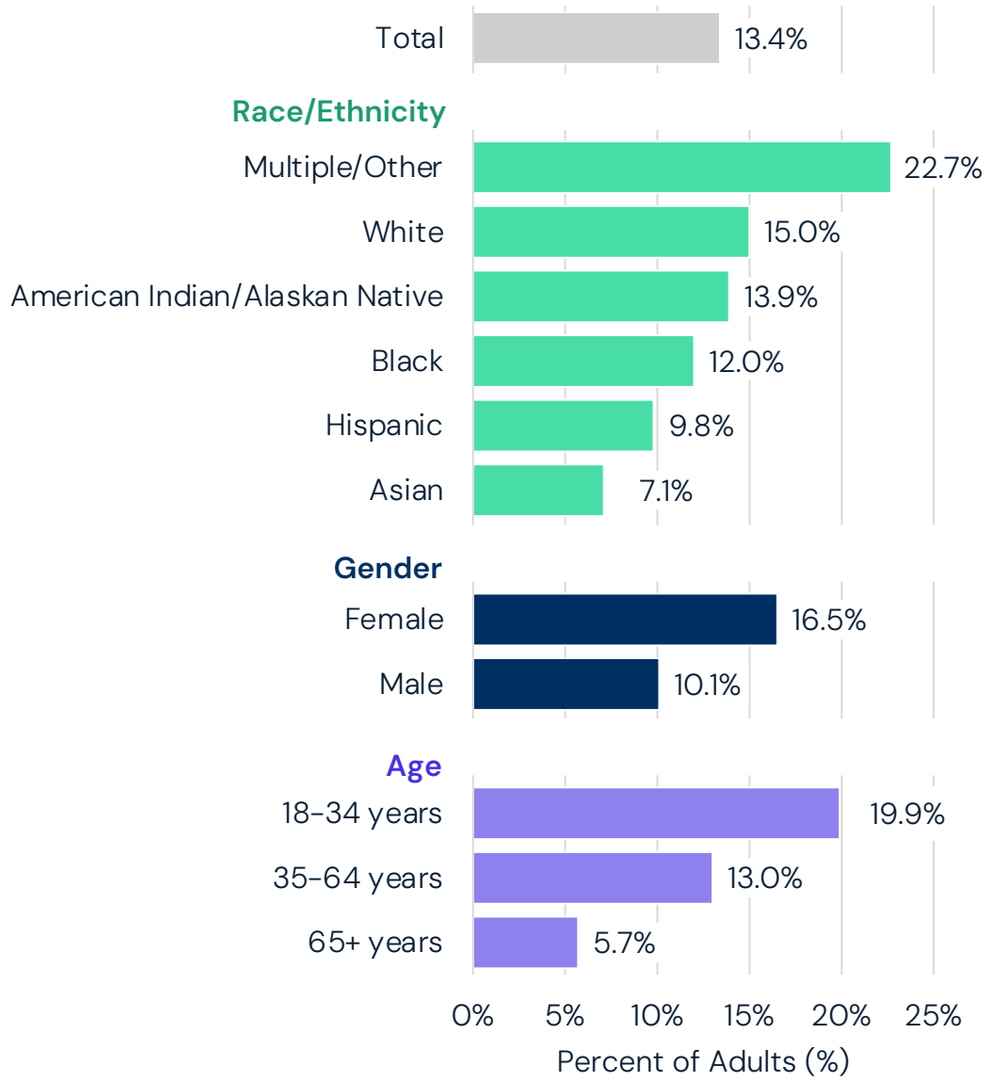
Behavioral Health Percent Change	
2018 to 2024	**43.7%**
2018 to 2019	12.5%
2019 to 2020	-4.3%
2020 to 2021	11.6%
2021 to 2022	5.1%
2022 to 2023	2.2%
2023 to 2024	11.4%

Note: Analysis is limited to commercially insured patients. In this analysis, primary care includes MD/DO internal medicine, family medicine and pediatrics.
Source: Trilliant Health national all-payer claims database.

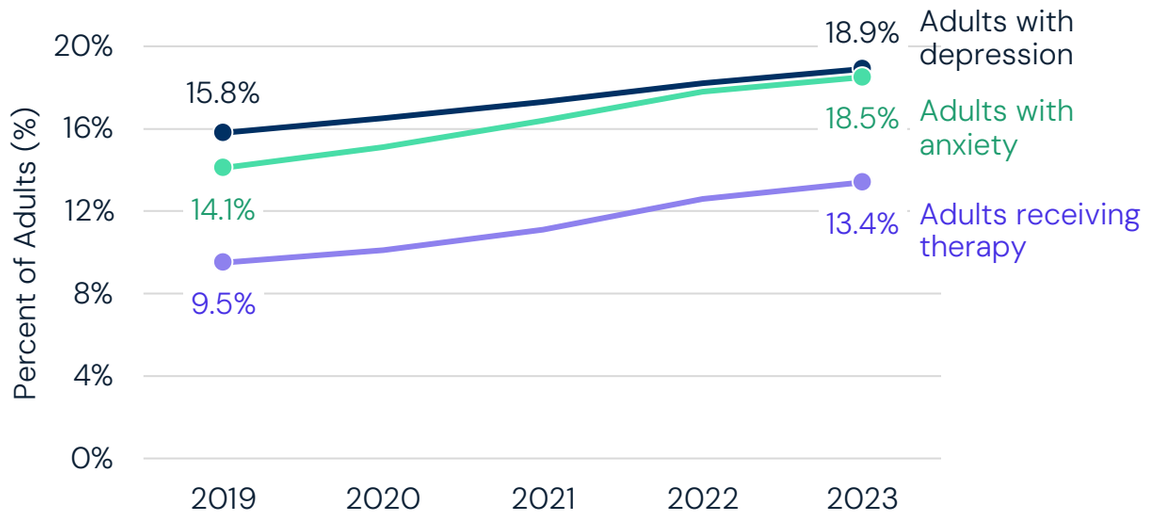
Behavioral Health Demand Is Rising, but Access Remains a Challenge

Nearly one in five U.S. adults report anxiety or depression, but only 13.4% receive therapy, up from 9.5% in 2019. Reported barriers to behavioral health care include high costs (80%), lack of insurance coverage (74%) and inadequate provider supply (63%). The USPSTF recommends depression screening for adolescents ages 12-18 using the same standardized questions as adults, while anxiety screenings begin as early as age eight with tools simplified for children.

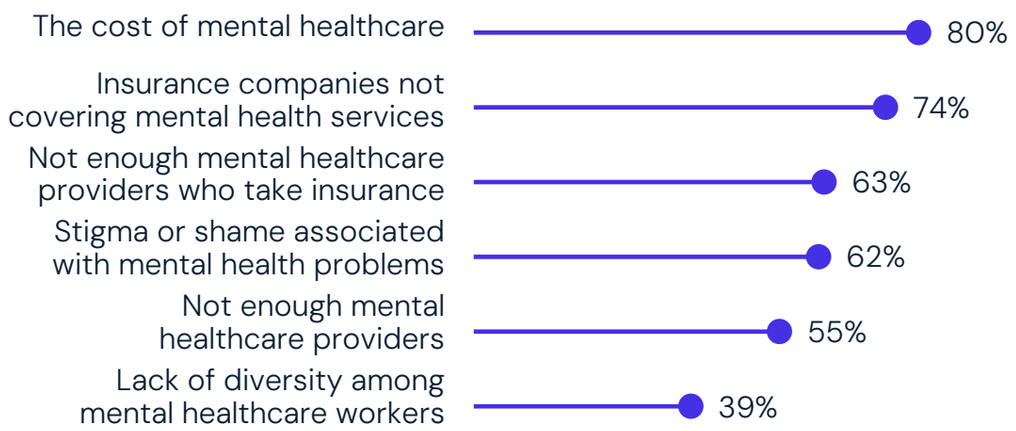
Share of U.S. Adults Receiving Therapy, 2023



Share of U.S. Adults With Mental Health Conditions or Receiving Therapy, 2019-2023



Reported Barriers to Accessing Mental Health Services, 2022

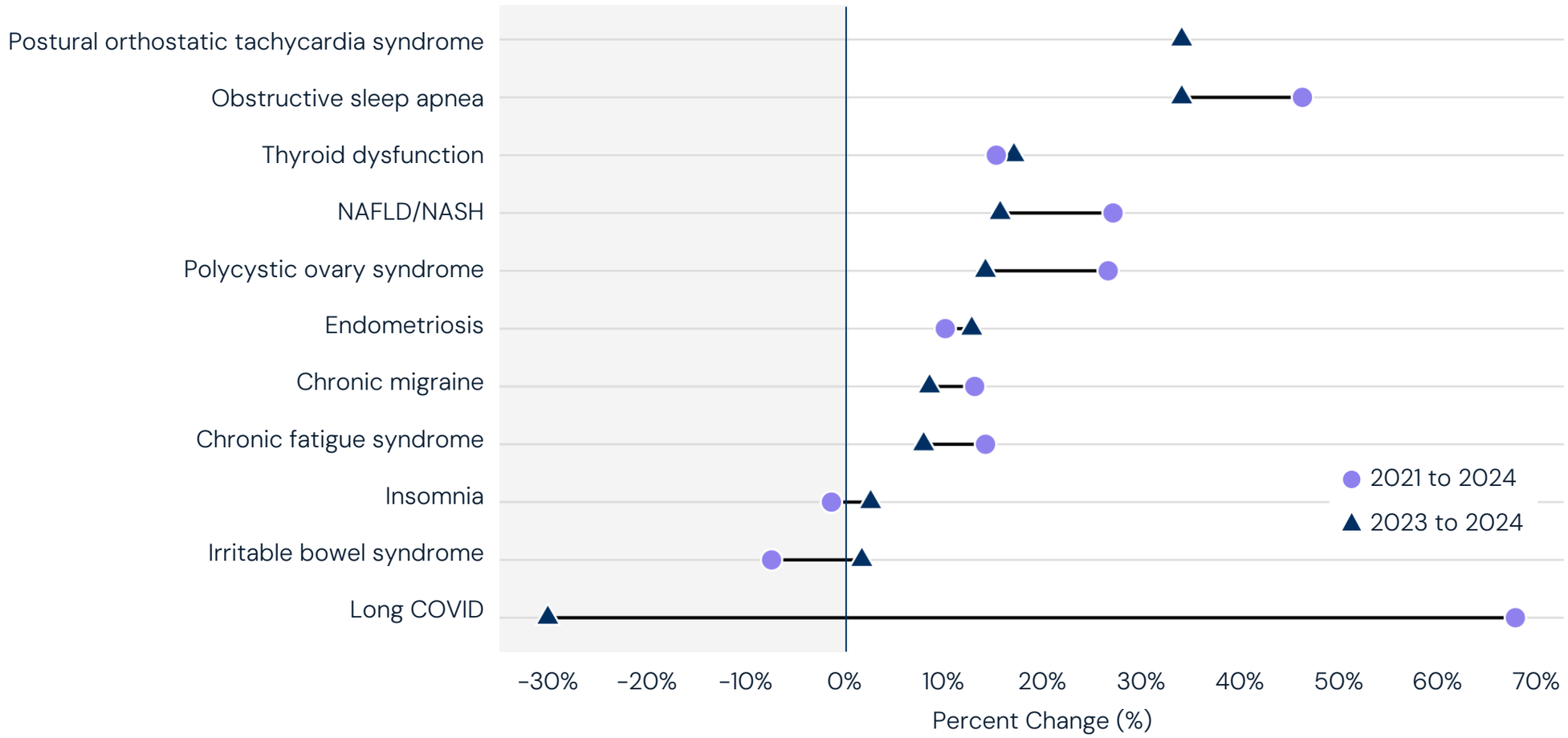


Note: USPSTF denotes U.S. Preventive Services Task Force.
Source: Centers for Disease Control and Prevention, Mental Health Conditions & Care, 2025; KFF/CNN Mental Health in America, 2022; U.S. Government of Accountability Office, 2024; U.S. Preventive Services Task Force.

Emerging Chronic Conditions Signal a General Sense of Unwellness

Between 2021 and 2024, most emerging chronic conditions increased in prevalence, with the largest relative growth observed in long COVID (68.0%), obstructive sleep apnea (46.3%) and NAFLD/NASH (27.0%). In 2023, a formal ICD-10 diagnosis was established for POTS, which resulted in a 34.0% increase from 2023 to 2024. These trends suggest shifting clinical attention and diagnostic activity toward certain metabolic, respiratory and post-viral conditions.

Percent Change in Select Emerging Chronic Conditions, 2021 to 2024 and 2023 to 2024

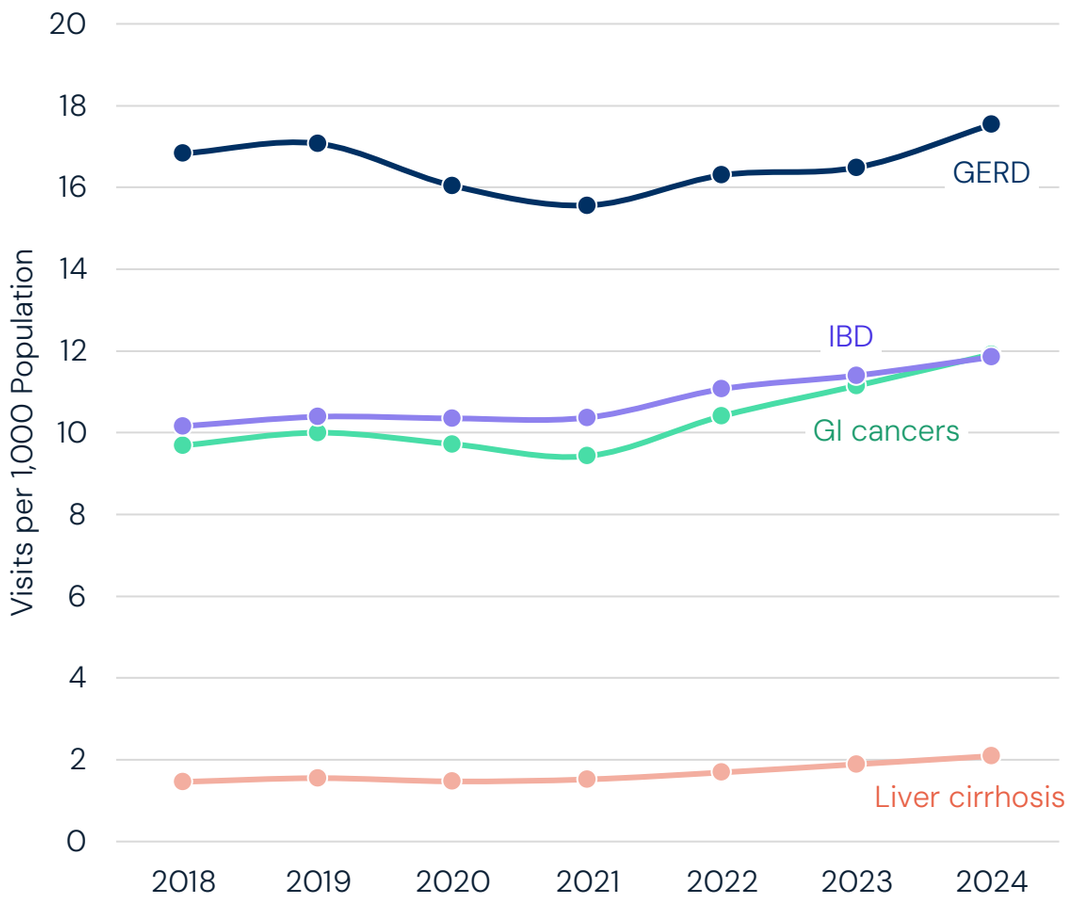


Note: NASH denotes nonalcoholic steatohepatitis; NAFLD denotes nonalcoholic fatty liver disease; POTS denotes postural orthostatic tachycardia syndrome. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

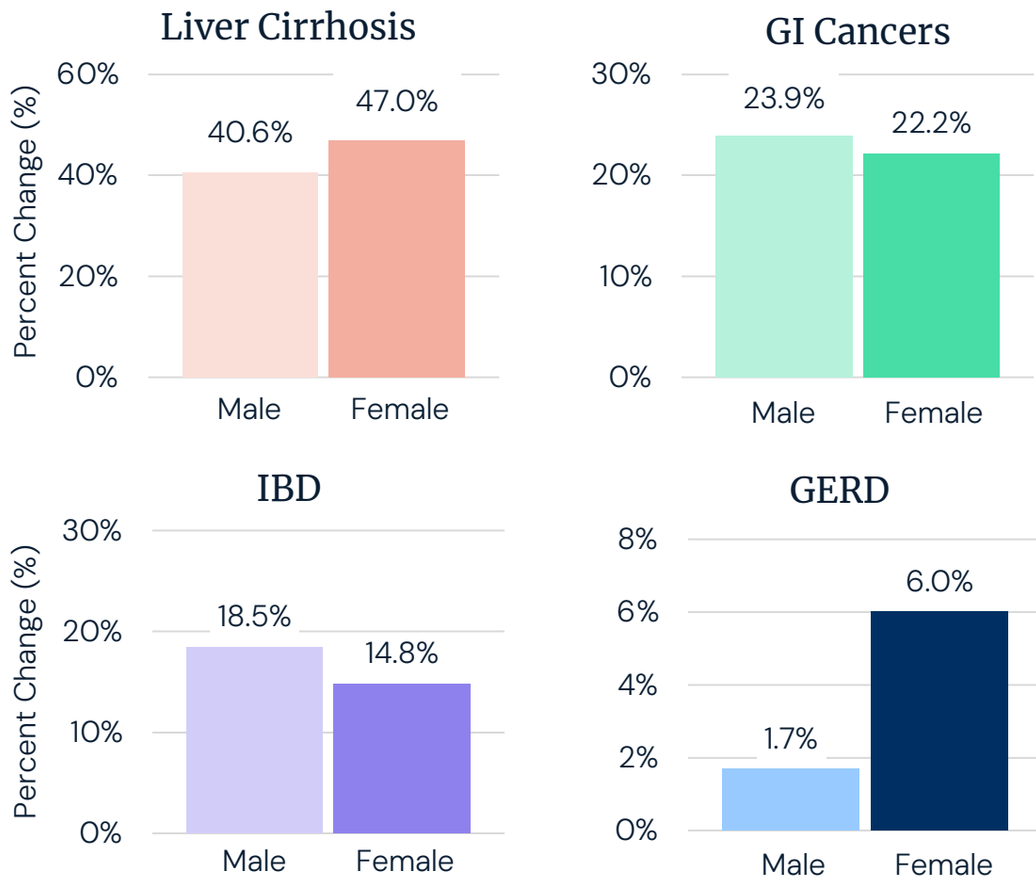
Common GI Conditions Are Growing in Prevalence

In 2024, rates for four common GI conditions were higher for both men and women than in 2018. Liver cirrhosis and GI cancers showed the largest percent increases over the period, up 40.6% and 23.9% among men and 47.0% and 22.2% among women, respectively.

Select GI Conditions per 1,000 Population, 2018-2024



Percent Change in Select GI Conditions per 1,000 Population, by Gender, 2018 to 2024

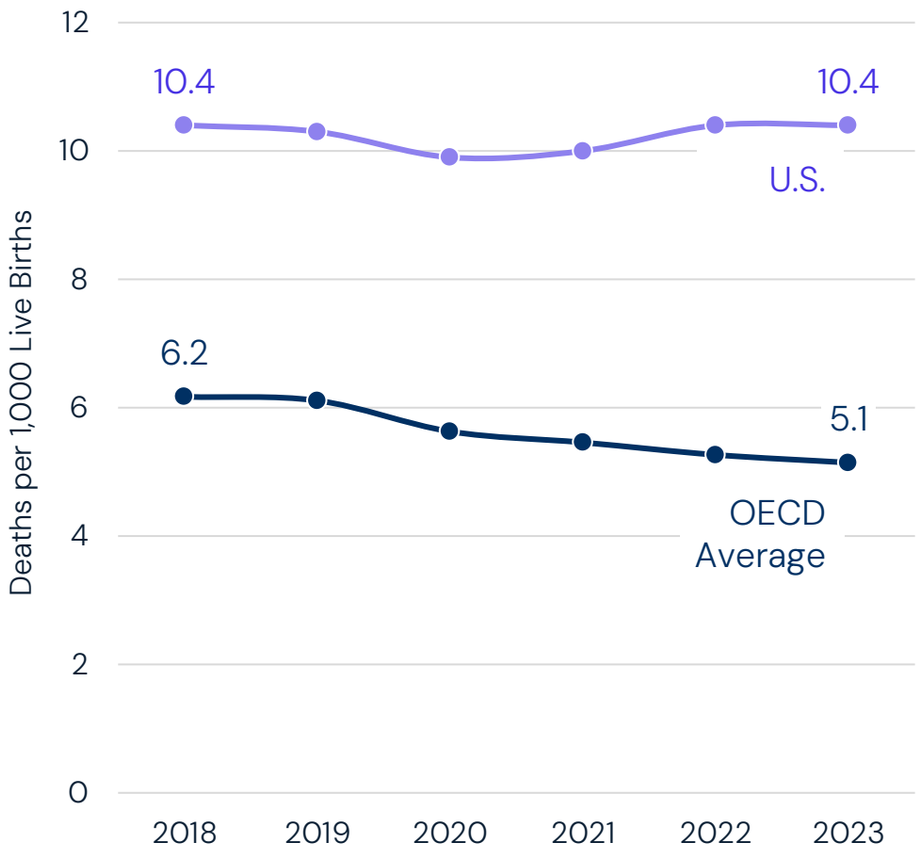


Note: GI denotes gastrointestinal; GERD denotes gastroesophageal reflux disease; IBD denotes inflammatory bowel disease. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

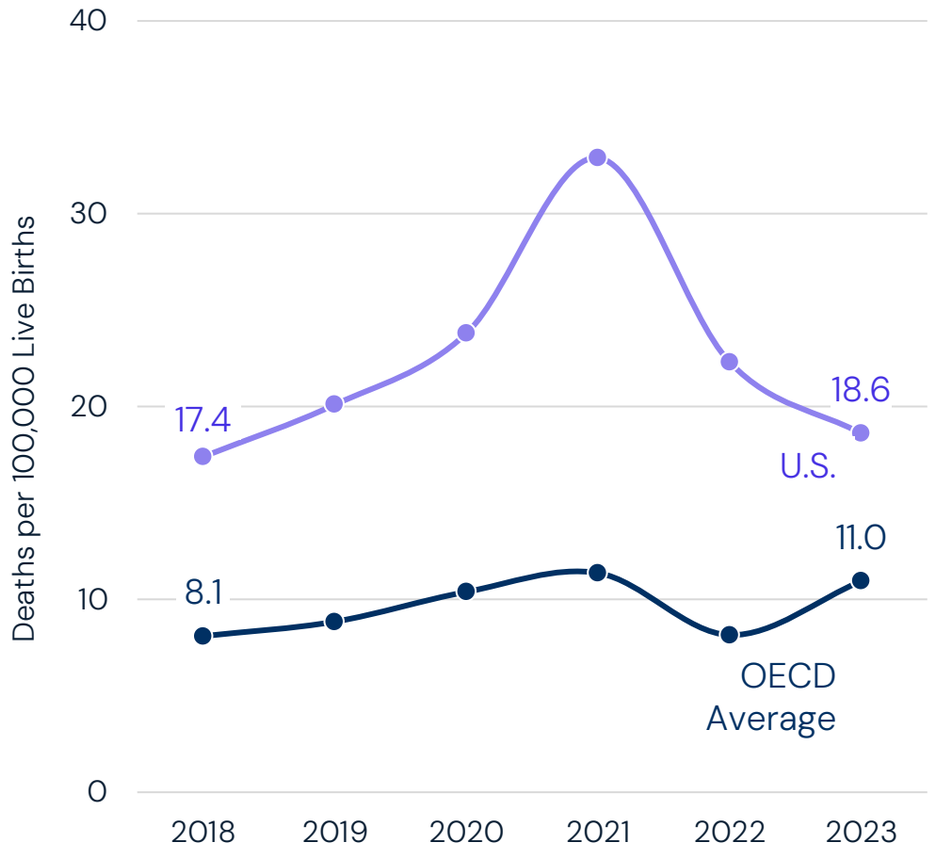
U.S. Infant and Maternal Mortality Rates Are Well Above Peer Countries

The U.S. infant mortality rate is persistently higher than the OECD average, which has declined by 17.7% since 2018. The U.S. maternal mortality rate per 100,000 live births, which is nearly 2x the OECD average, increased from 17.4 per 100,000 in 2018 to 18.6 per 100,000 in 2023.

Infant Mortality Rate per 1,000 Live Births, U.S. and OECD Average, 2018-2023



Maternal Mortality Rate per 100,000 Live Births, U.S. and OECD Average, 2018-2023

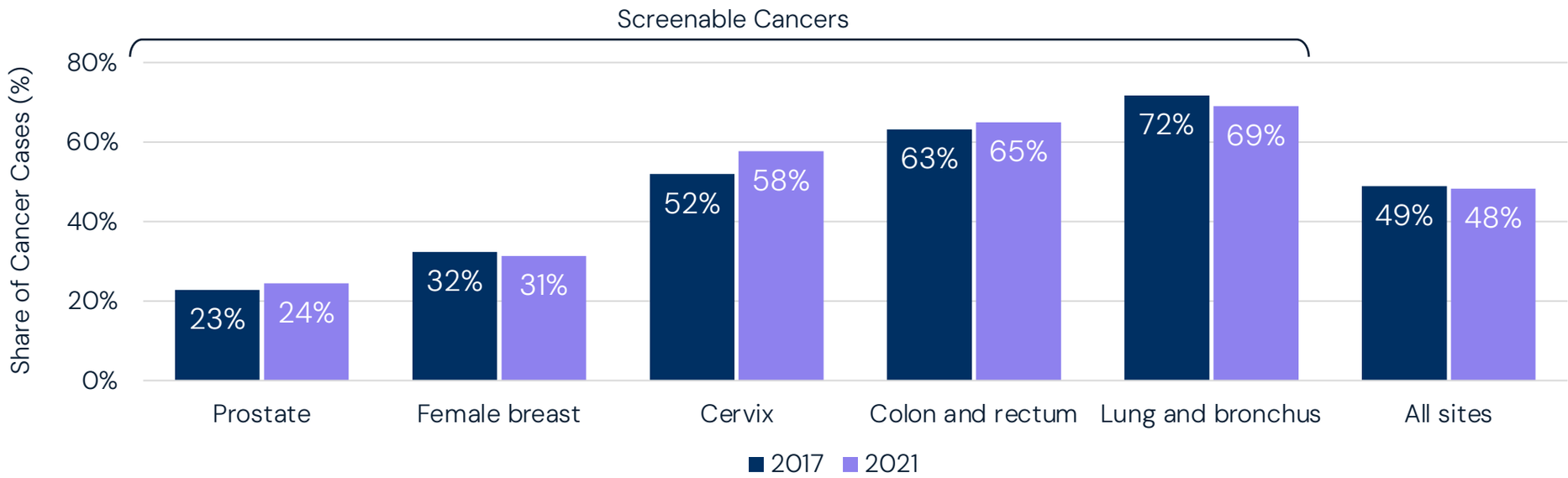


Note: OECD denotes Organisation for Economic Co-Operation and Development. OECD average excludes U.S. from calculation.
Source: Organisation for Economic Co-Operation and Development.

Nearly Half of All Cancer Diagnoses Occur at a Late Stage

Despite the clear correlation between early diagnosis and survival, nearly half of all cancer cases are diagnosed at a late stage, which remained relatively unchanged from 2017 to 2021. Even among screenable cancers, the share of cancer cases diagnosed at a late stage ranges from 24% for prostate cancer to 69% for lung cancer.

Share of Cancer Cases Diagnosed at a Late Stage, by Cancer Type, 2017 and 2021



Five-Year Cancer Survival Rates			
Cancer Type	Localized	Regional	Distant
Prostate	>99%	>99%	37%
Breast	>99%	87%	32%
Cervix	91%	62%	19%
Colon and rectum	91%	74%	16%
Non-small cell lung cancer	67%	40%	12%
Small cell lung cancer	34%	20%	4%

Note: Late-stage is defined as cases diagnosed at regional or distant stage. Cancer stages are defined by localized (cancer has not spread outside site), regional (cancer has spread to nearby structures or lymph nodes) and distant (cancer has spread to distant organs or parts of body).
Source: Sherman et al., Annual Report to the Nation on the Status of Cancer, featuring state-level statistics after the onset of the COVID-19 pandemic, *Cancer*, 2025; American Cancer Society.

Novel Drug Approvals Target Chronic and Rare Diseases

Since Q4 2024, 42 novel medications have received FDA approval, with one-third targeting cancers. Significant portions of recent approvals also include cell and gene therapies, as well as treatments for chronic conditions such as ulcerative colitis, non-alcoholic steatohepatitis and chronic kidney disease.

FDA Novel Drug Approvals, Q4 2024-Q3 2025

Q4 2024	itovebi™ inavolisib 3mg•9mg tablets; VYLOY® zolbetuximab-clzb for injection 100mg vial; RevuForj™ (revumenib) tablets 25 mg • 110 mg • 160 mg; Attruby™ (acoramidis) 356 mg tablet;  ; UNLOXCYT™ (cosibelimab-ipdl) Injection; NDC 83076-1100-6 Ensacove™ (ensartinib) capsules; alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor) 10 mg/50 mg/125 mg tablets 4 mg/20 mg/50 mg tablets; HYMPAVZI™ marstacimab-hncq injection | 150 mg/mL; Orlynvah™ (sulopenem etzadroxil and probenecid); ZIIHERA® (zanidatamab-hrii) 50mg/ml Injection for IV; Rapiblyk (landiolol) for injection 280 mg/vial; Bizengri® zenocutuzumab-zbco 20 mg/mL Injection for IV Use; Crenessity™ (crinecerfont); Tryngolza™ (olezarsen) 80 mg injection; Alhemo® concizumab-mtci injection | 60 mg | 150 mg | 300 mg pens
Q1 2025	DATROWAY® datopotamab deruxtecan-dlnk 20 mg/mL INJECTION FOR INTRAVENOUS USE; GRAFAPEX® (treosulfan) for Injection; JOURNAVX™ (suzetrigine) 50mg tablet; GOMEKLI™ (mirdametinib) 1 mg tablets for oral suspension 1 mg and 2 mg capsules; RomVimza™ (vimseltinib) 30mg capsules; NOW APPROVED BLUJEPA™ (gepotidacin) 750 mg tablets; Qfitlia™ (fitusiran) injection 50 mg/0.5 mL
Q2 2025	VANRAFIA™ (atrasentan) tablets 0.75 mg;  ; imaavy™ (nipocalimab-aahu); AVMAPKI™ FAKZYNJA™ CO-PACK (avutometinib capsules; defactinib tablets) 0.8 mg; 200 mg; Emrelis™ (telisotuzumab vedotin-tllv) injection for intravenous use 20 mg | 100 mg; TRYPTYR® (acoltremon ophthalmic solution) 0.003%; ENFLONSIA™ (clesrovimab-cfor) 105 mg injection; IBTROZI™ taletrectinib 200mg capsules; ANDEMBRY® garadacimab-gxii
Q3 2025	ZEGFROVY®; LYNOZYFIC™ (linvoseltamab-gcpt) Injection 5mg | 200mg; Ekterly® (sebetralstat) tablets 300 mg; Anzupgo; Sephience™ sepiapterin; VIZZ (aceclidine ophthalmic solution) 1.44%; HERNEXEOS™ zongertinib tablets | 60 mg; Brinsupri™ (brensocatib); DAWNZERA™ (donidalorsen) 80 mg/0.8 mL injection; WAYRILZ™ (rilzabrutinib) 400 mg tablets

Therapeutic Areas of Approved Drugs

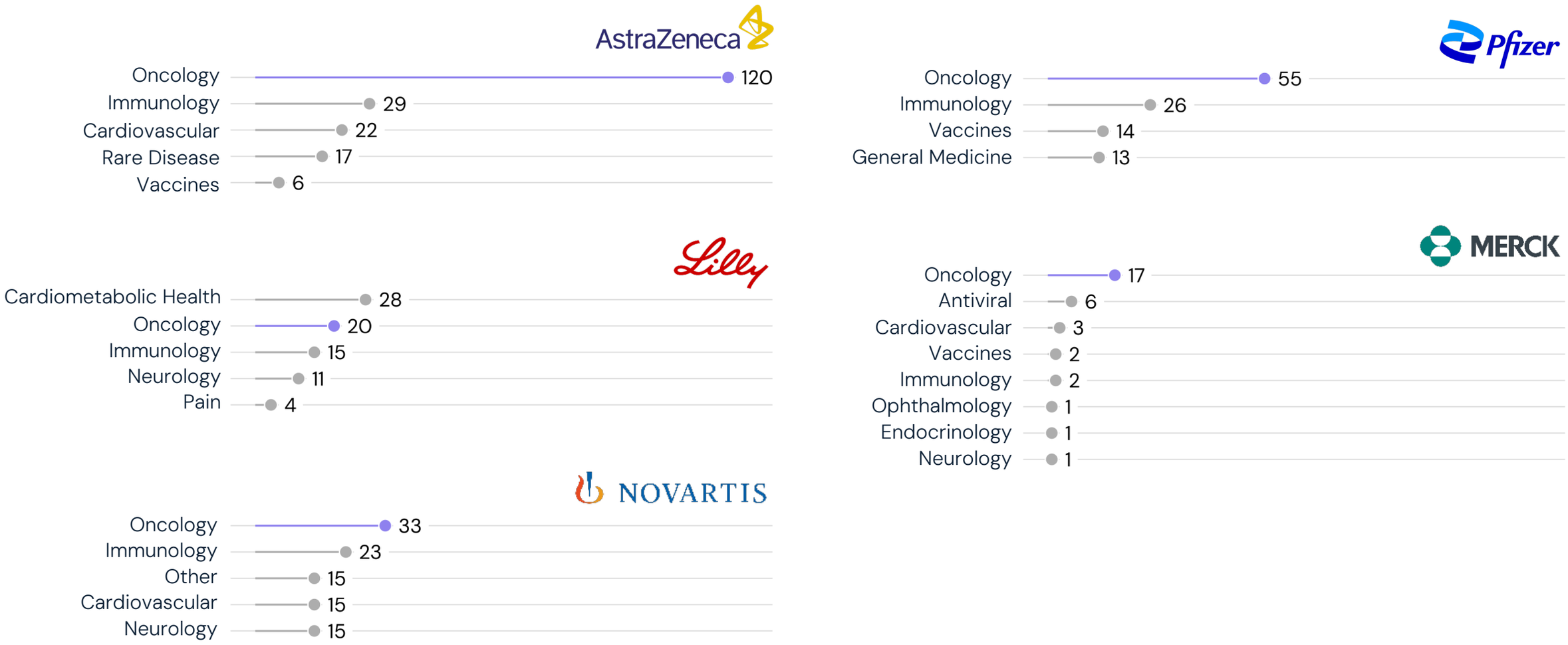
Genetic	Oncology	Chronic	Infectious Disease	Other
8	17	6	3	8

Note: FDA denotes U.S. Food and Drug Administration. "Novel" drugs are new drugs that have not been previously approved or marketed in the U.S.
Source: U.S. Food and Drug Administration Novel Drug Approvals for 2024 and 2025.

Oncology Dominates Drug Manufacturer Pipelines

Oncology treatments account for over half of the clinical development pipelines of AstraZeneca (61.9%), Merck (51.5%) and Pfizer (50.9%). AstraZeneca has significantly expanded its overall pipeline since last year, resulting in a larger number of oncology drugs in development than either Pfizer or Merck. Eli Lilly's cardiometabolic pipeline, which includes GLP-1 therapies, now exceeds its oncology pipeline.

Clinical Development Pipelines of Major Biopharmaceutical Manufacturers, as of Q3 2025

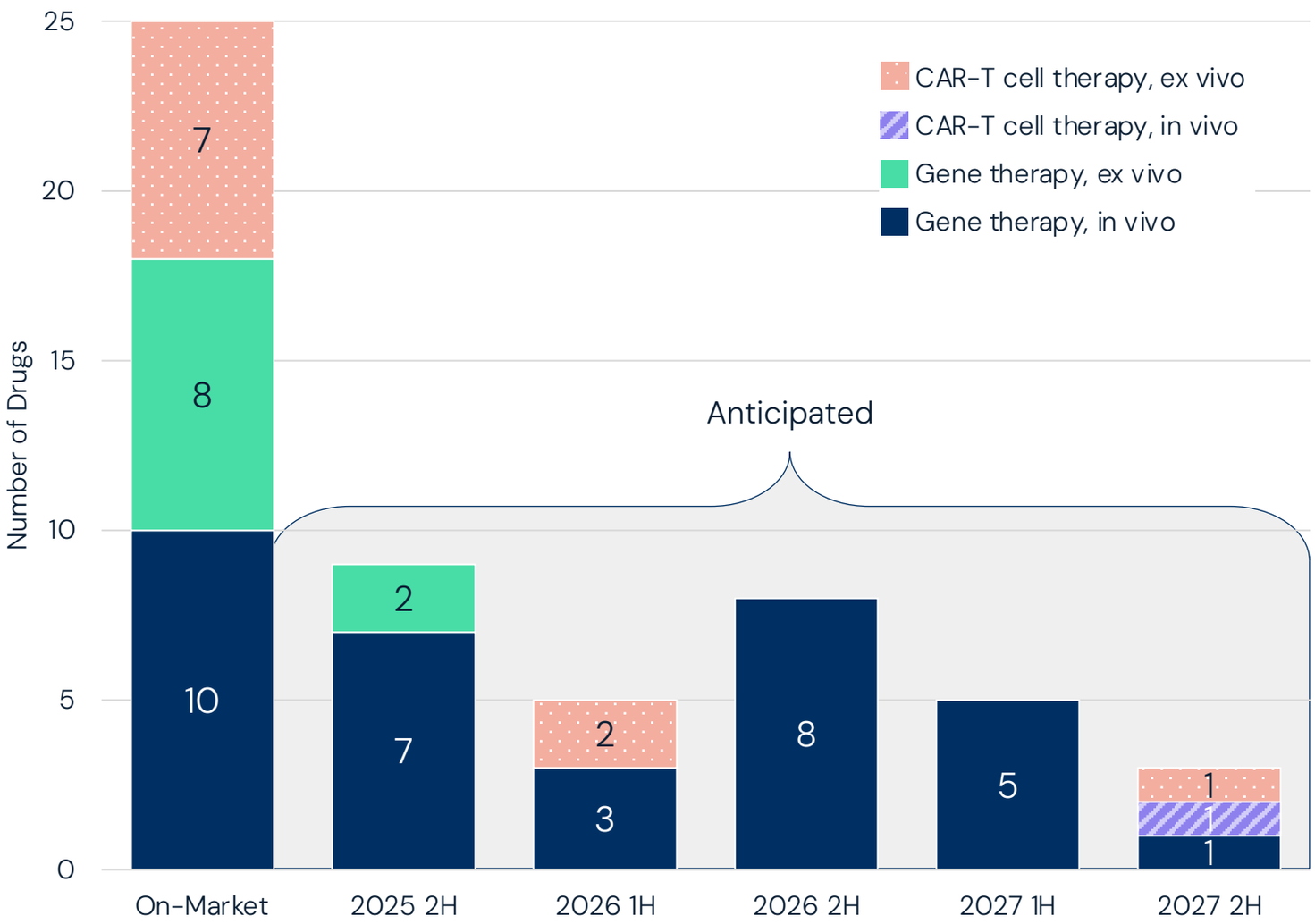


Note: GLP-1 denotes glucagon-like peptide-1. Some products and projects in these pipelines are new molecular entities, while others are indications and different formulations for marketed products.
Source: Company clinical development pipelines.

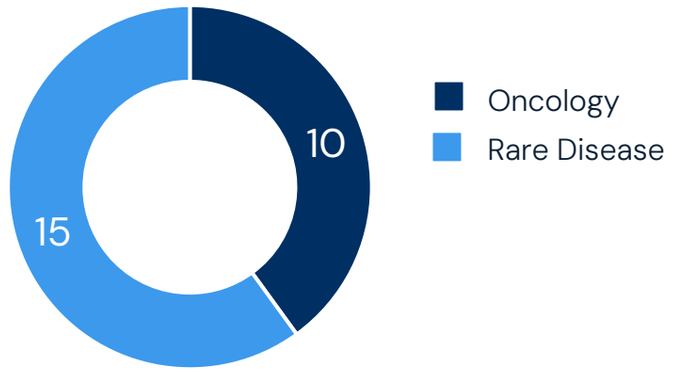
High-Cost and Complex CGTs Primarily Target Rare Disease

Of the 25 on-market gene and CAR-T therapies, 75% treat rare diseases, defined as conditions affecting fewer than 200,000 patients. This trend is expected to continue, with 70% of anticipated therapies also targeting rare disease.

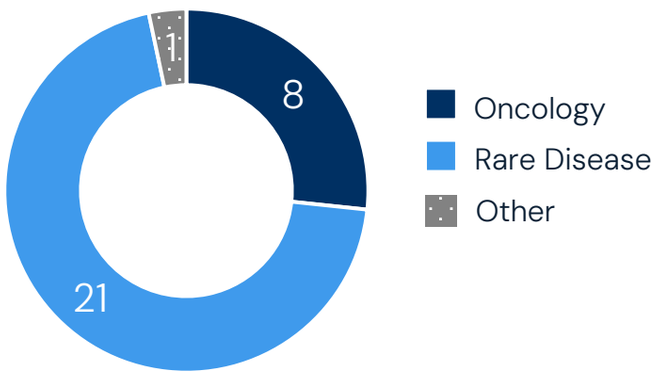
Gene and CAR-T Cell Therapies Already on Market or With Projected Launch Years Between 2025 and 2027



On-Market Therapies, by Indication



Anticipated Therapies, by Indication

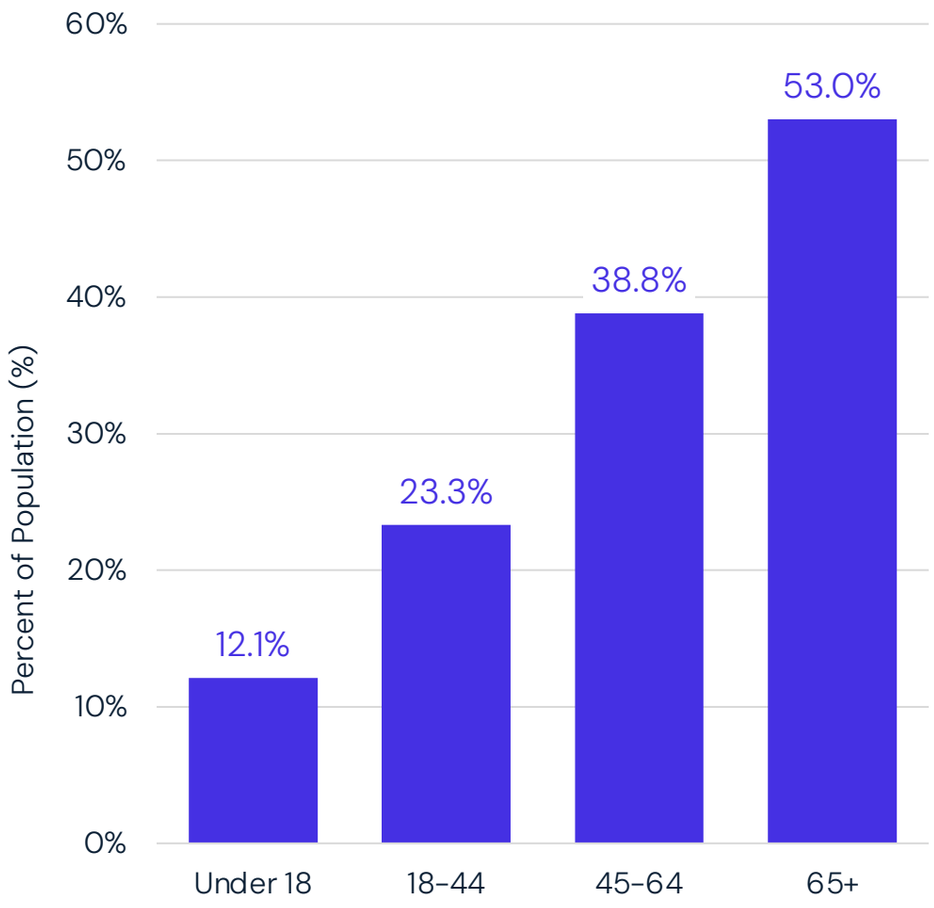


Note: CGT denotes cell and gene therapy; CAR-T denotes chimeric antigen receptor. Rare disease drugs are for diseases with less than 200,000 potential U.S. patients.
Source: CVS, Gene Therapy Report, Q1 2025–Q4 2027; U.S. Food and Drug Administration "Approved Cellular and Gene Therapy Products."

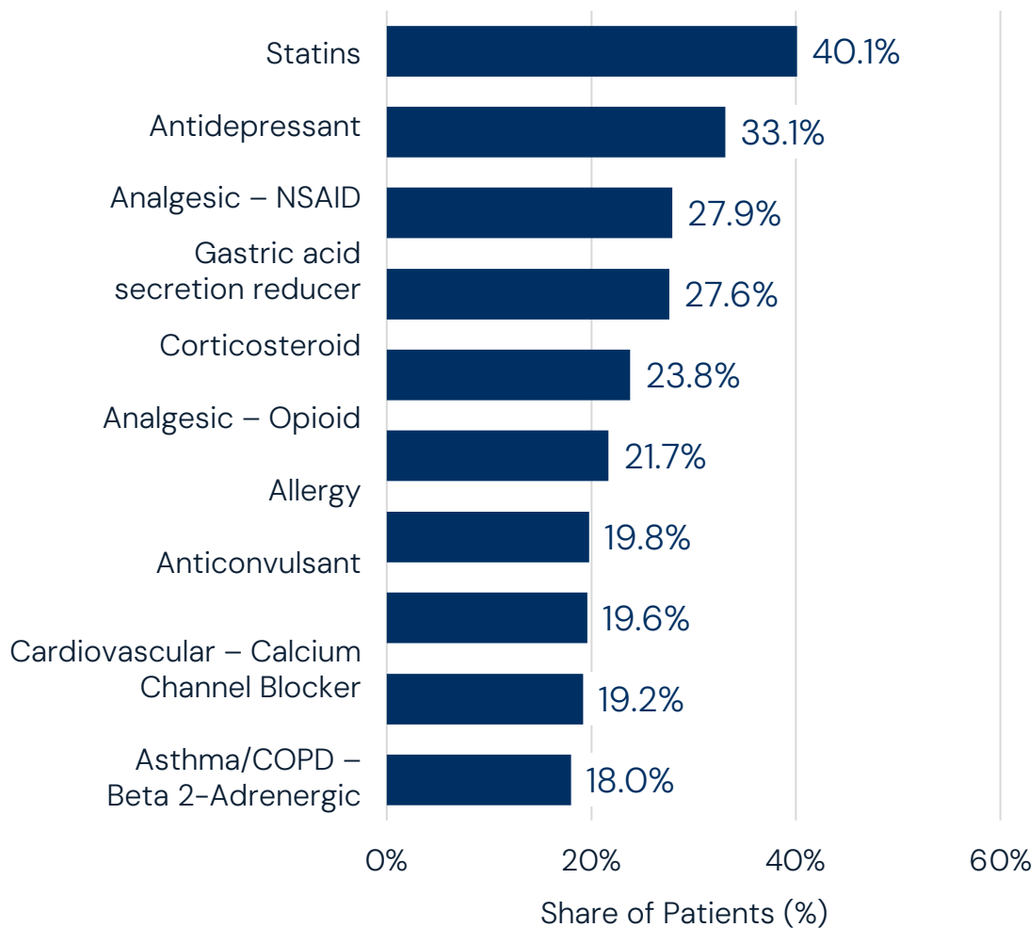
High Polypharmacy Rates Underscore Pharmaceutical Reliance

Polypharmacy, the regular use of five or more medications, is associated with a 16% higher risk of hospitalization and a 25% higher mortality risk. In 2024, 53.0% of adults ages 65 years and older were prescribed five or more medications, followed by 38.8% of adults ages 45-64. The most common drug classes among individuals with polypharmacy include statins (40.1%), antidepressants (33.1%) and NSAIDs (27.9%).

Percent of U.S. Population Using Five or More Medications, by Age Group, 2024



Most Common Drug Classes Among Polypharmacy Patients, by Share of Patients, 2023



Note: NSAID denotes non-steroidal anti-inflammatory drugs; COPD denotes chronic obstructive pulmonary disorder.
Source: Trilliant Health national all-payer claims database; Chang et al., Polypharmacy, Hospitalization, and Mortality Risk: A Nationwide Cohort Study, *Nature Scientific Reports*, 2020.

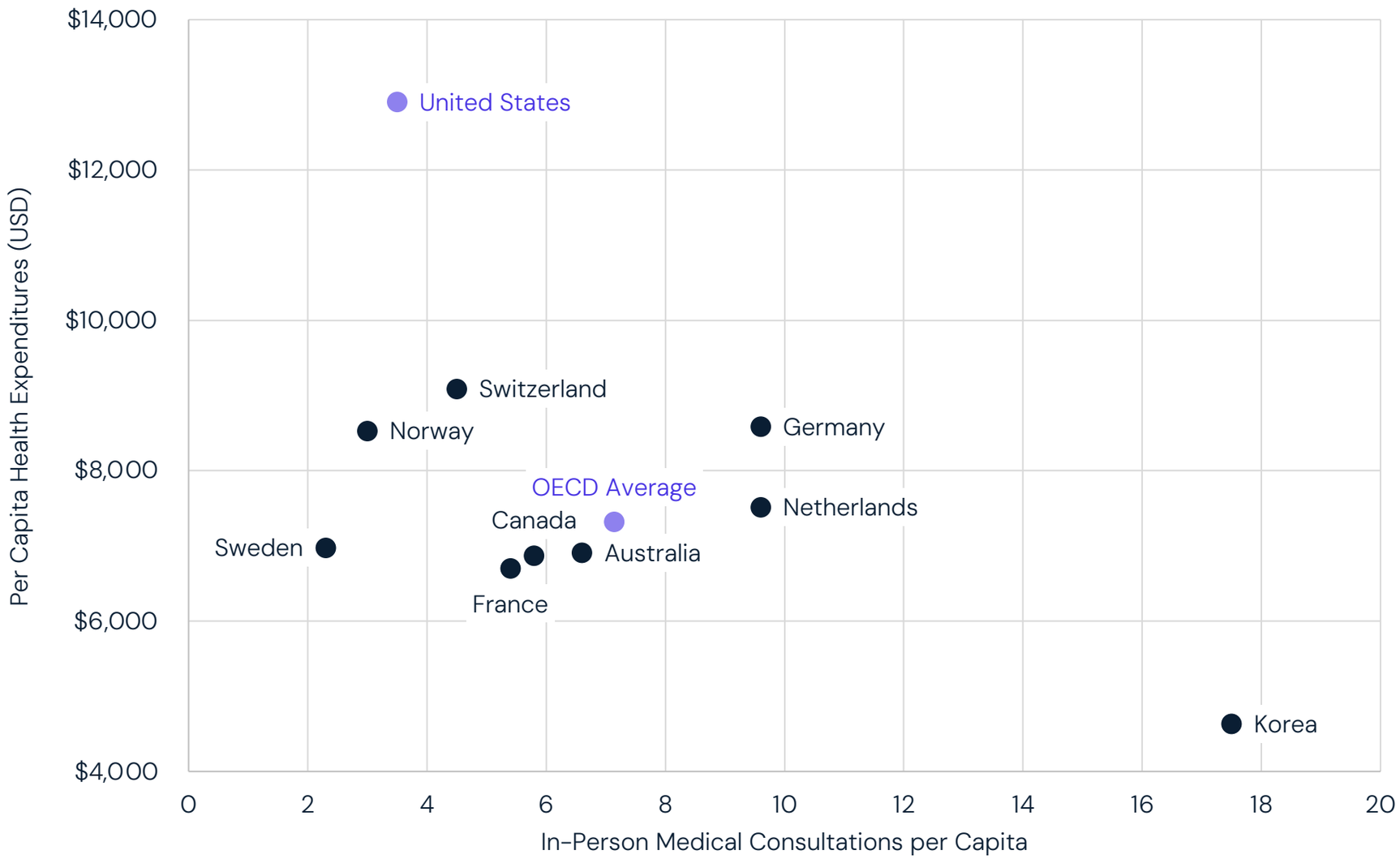
TREND 4

Fraud, Waste and Abuse Are Pervasive in U.S. Healthcare

The U.S. Uses Less Healthcare But Spends More Money Than Peer Countries

Despite spending $12,902 per person on healthcare in 2022 – 1.8x more than the OECD average of $7,314 – the number of physician consultations per person in the U.S. was 3.6 less than the OECD average of 7.1.

Physician Consultations vs. Per Capita Health Spending, U.S. and Select OECD Countries, 2022

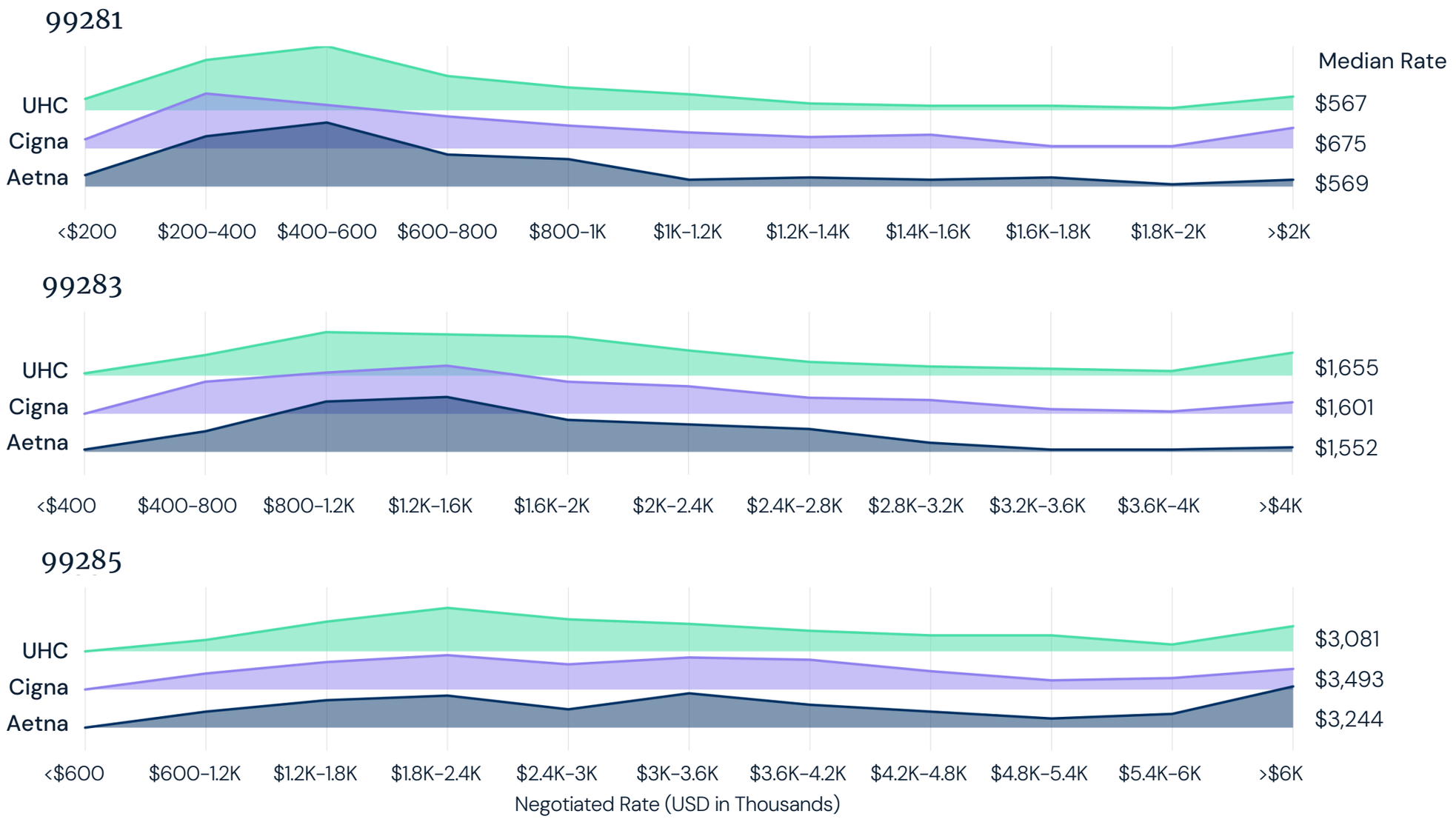


Note: OECD denotes Organisation for Economic Co-Operation and Development. OECD Average excludes U.S.
Source: Organisation for Economic Co-Operation and Development.

Within and Across Payers, Negotiated Rates Have Inexplicable Variation

Across emergency department CPT codes, negotiated rates ranged by more than 10x for each payer. For CPT 99281, Cigna had the highest median negotiated rate, $675. However, for CPT 99283, UHC had the highest median negotiated rate, $1,655, and Cigna had the highest negotiated rate for CPT 99285, $3,493.

Commercial Negotiated Rates for CPTs 99281, 99283 and 99285 for Select Payers, 2025

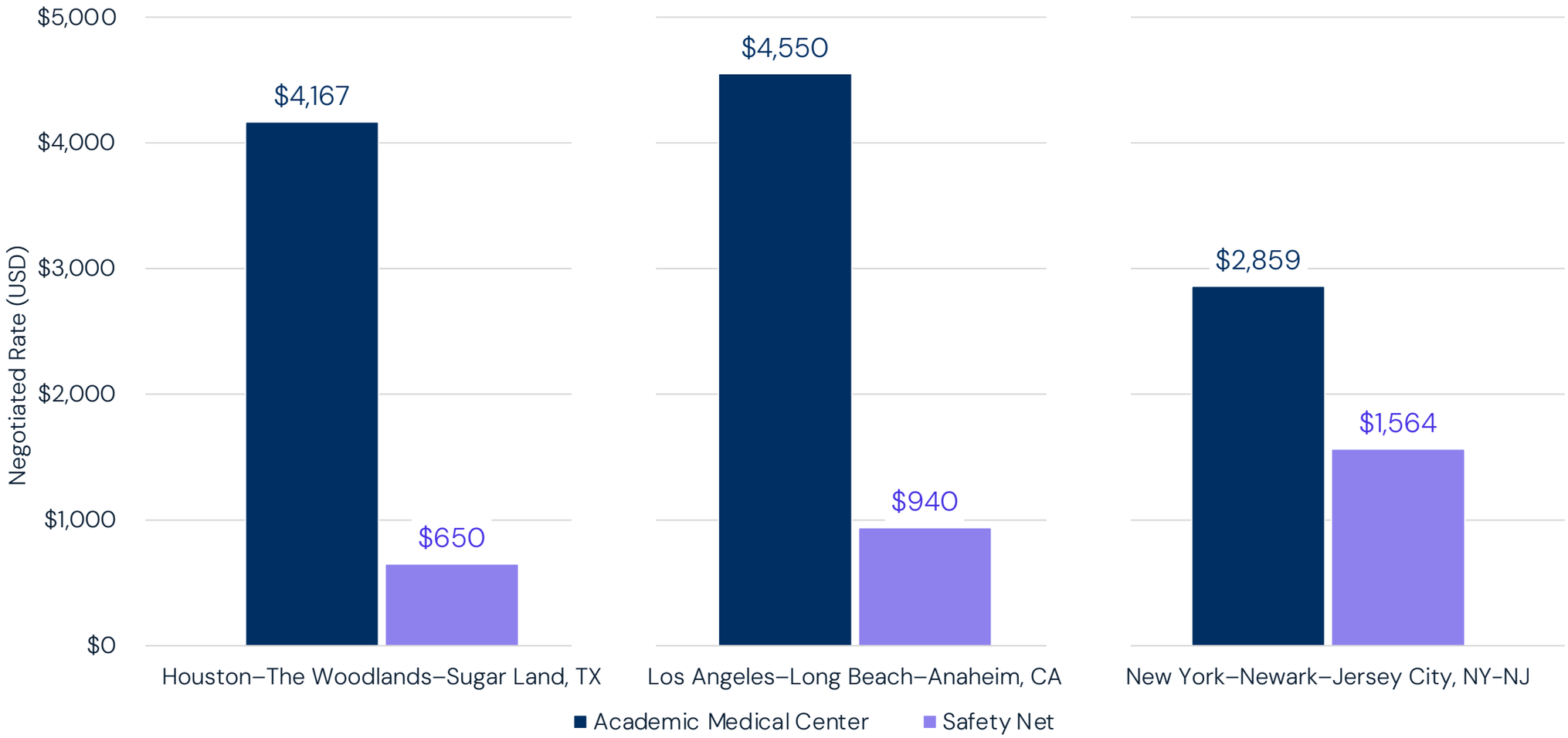


Note: UHC denotes UnitedHealthcare. CPT 99281 denotes emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional; CPT 99283 denotes emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making; CPT 99285 denotes emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. Institutional rates are represented.
Source: Trilliant Health health plan price transparency dataset and Provider Directory.

Academic Medical Centers Negotiate Higher Rates Than Safety-Net Hospitals

Commercial negotiated rates for CPT 99283 are substantially higher at academic medical centers compared to safety-net hospitals located in the same CBSA. Specifically, academic medical center rates are 6.4x higher in Houston, 4.8x higher in Los Angeles and 1.8x higher in New York City.

Commercial Negotiated Rates for CPT 99283 at Academic Medical Centers and Safety-Net Hospitals in Select CBSAs, 2025



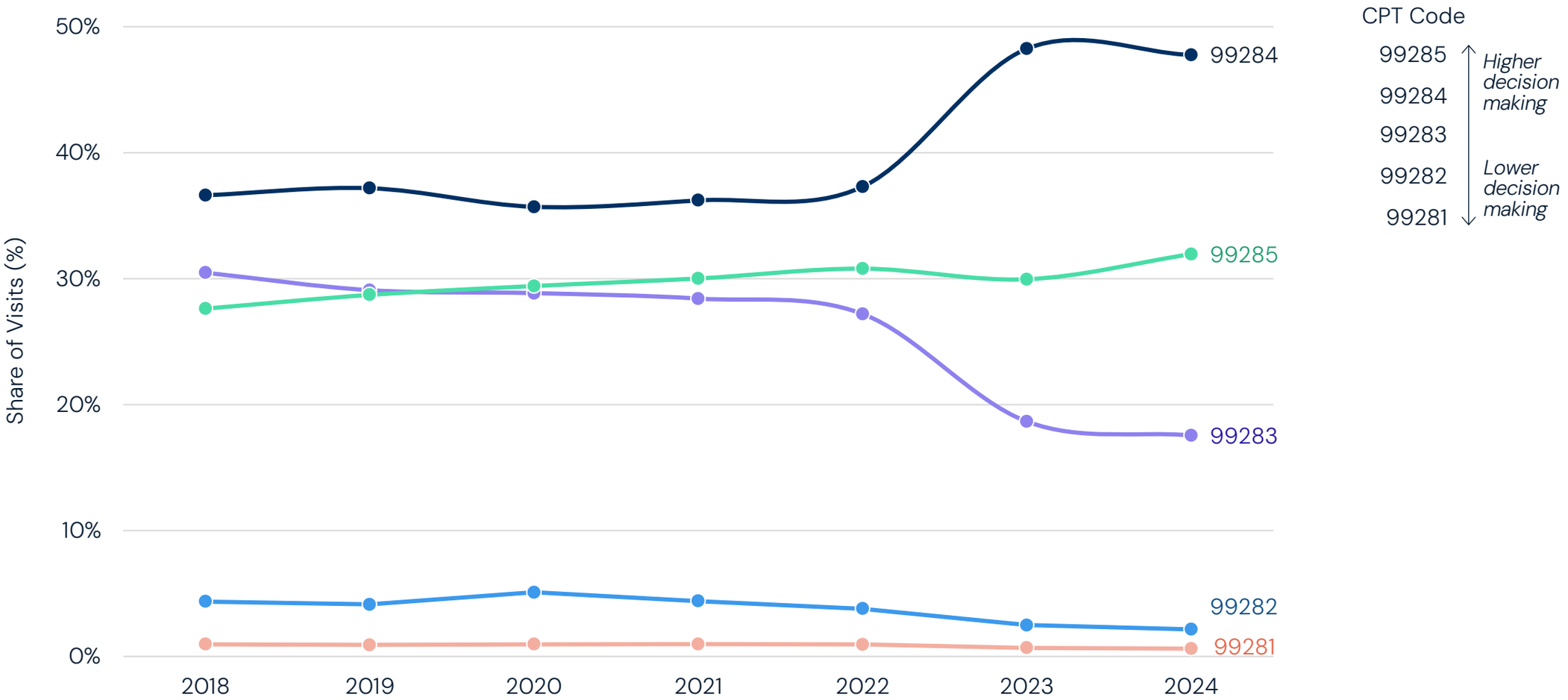
Note: CBSA denotes core-based statistical area; CPT 99283 denotes emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. Rates are shown for one national payer, UnitedHealthcare. Institutional rates are represented.
Source: Trilliant Health health plan price transparency dataset and Provider Directory.

TREND 4: FRAUD, WASTE AND ABUSE

Upcoding in Emergency Departments Results in Higher Spending

From 2018 to 2024, the share of emergency department visits coded at higher complexity levels (CPTs 99284-99285) increased from 36.6% to 47.8% and 27.6% to 31.9%, respectively. Median commercial rates range from $2,561 for CPT 99283 to $3,317 for CPT 99285.

Share of Emergency Department Visits, by CPT Code, 2018-2024

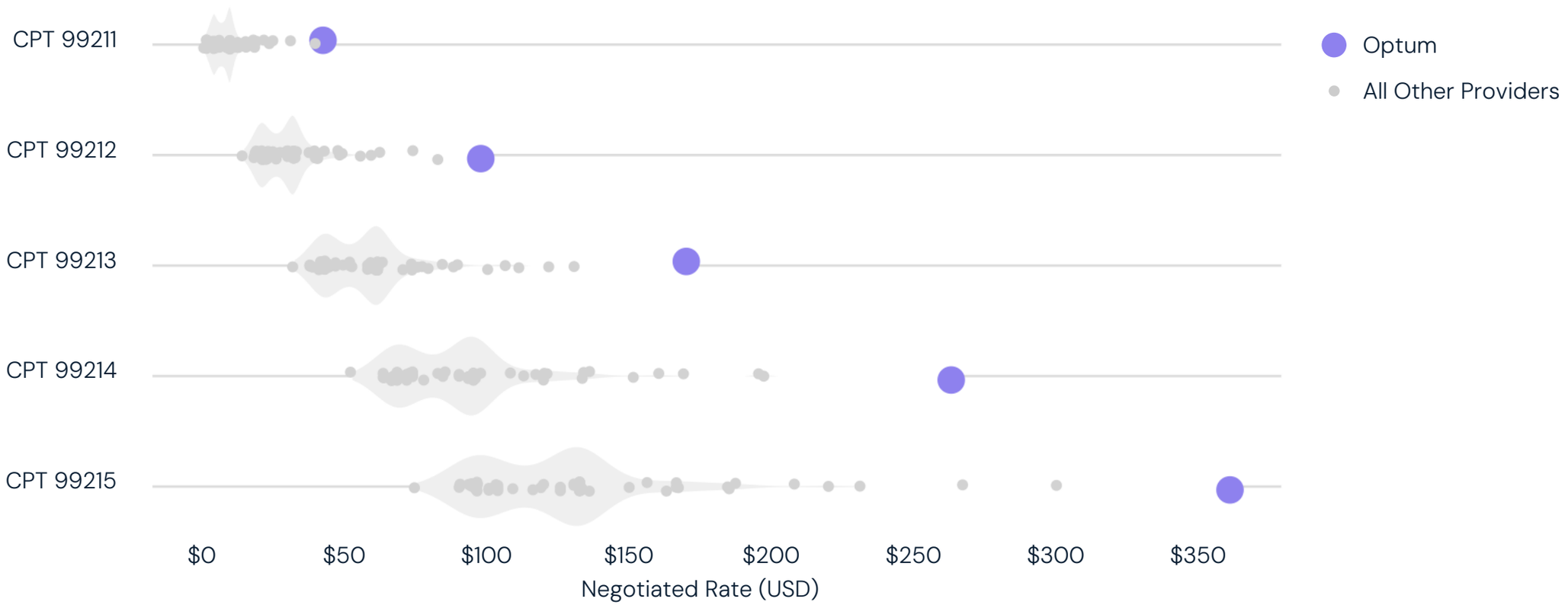


Note: Analysis is limited to commercially insured patients. CPT codes 99281-99285 denote levels of emergency department evaluation and management (E&M) services, with 99281 representing straightforward/low-complexity medical decision making and 99285 representing high-complexity medical decision making.
Source: Trilliant Health national all-payer claims database and health plan price transparency dataset.

UHC Frequently Pays Itself More Than Everyone Else

Kelsey Seybold Clinic receives UHC reimbursement rates that are consistently higher across E&M CPT codes (99211-99215) compared to other providers in the Houston CBSA. The difference ranges from approximately 5% higher at the lowest complexity code (99211) to nearly 70% higher at the highest complexity code (99215) relative to the average market rates.

Commercial Negotiated Rates for CPTs 99211-99215 in Houston-The Woodlands-Sugar Land, TX, 2025

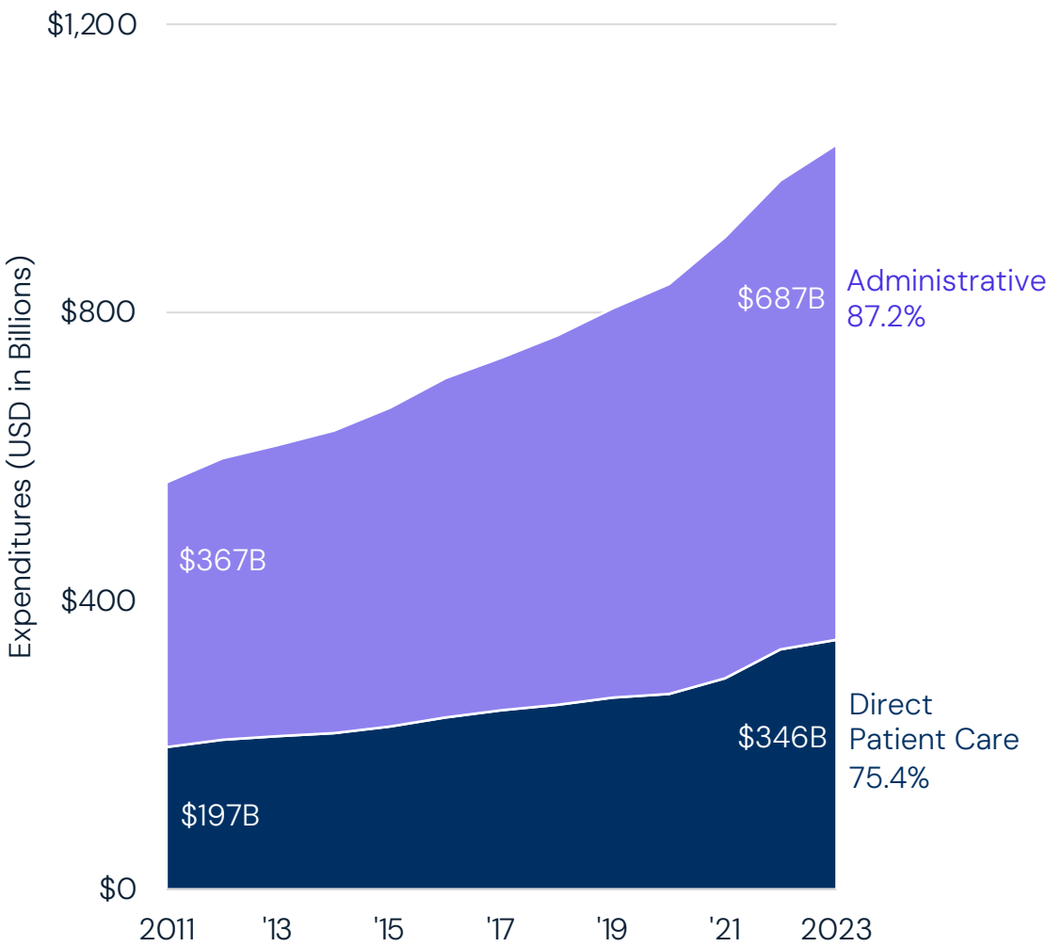


Note: CBSA denotes core-based statistical area; UHC denotes UnitedHealthcare.; CPT codes 99211–99215 denote outpatient evaluation and management (E&M) office visits, with increasing levels of complexity and intensity from 99211 (minimal service) to 99215 (comprehensive, high-complexity visit). Rates are shown for one national payer, UnitedHealthcare. Kelsey Seybold Clinic is owned by Optum.
Source: Trilliant Health health plan price transparency dataset.

Hospitals Spend More on Healthcare Administration Than Direct Patient Care

From 2011 to 2023, both administrative and direct patient care expenditures increased in absolute terms, reaching $687B and $346B, respectively, but administrative costs have grown at a faster pace (87.2%). Generally, these spending allocations are strongly correlated, the ratio of which can be used as a measure of hospital efficiency.

Administrative and Direct Patient Care Expenditures at U.S. Hospitals, 2011-2023



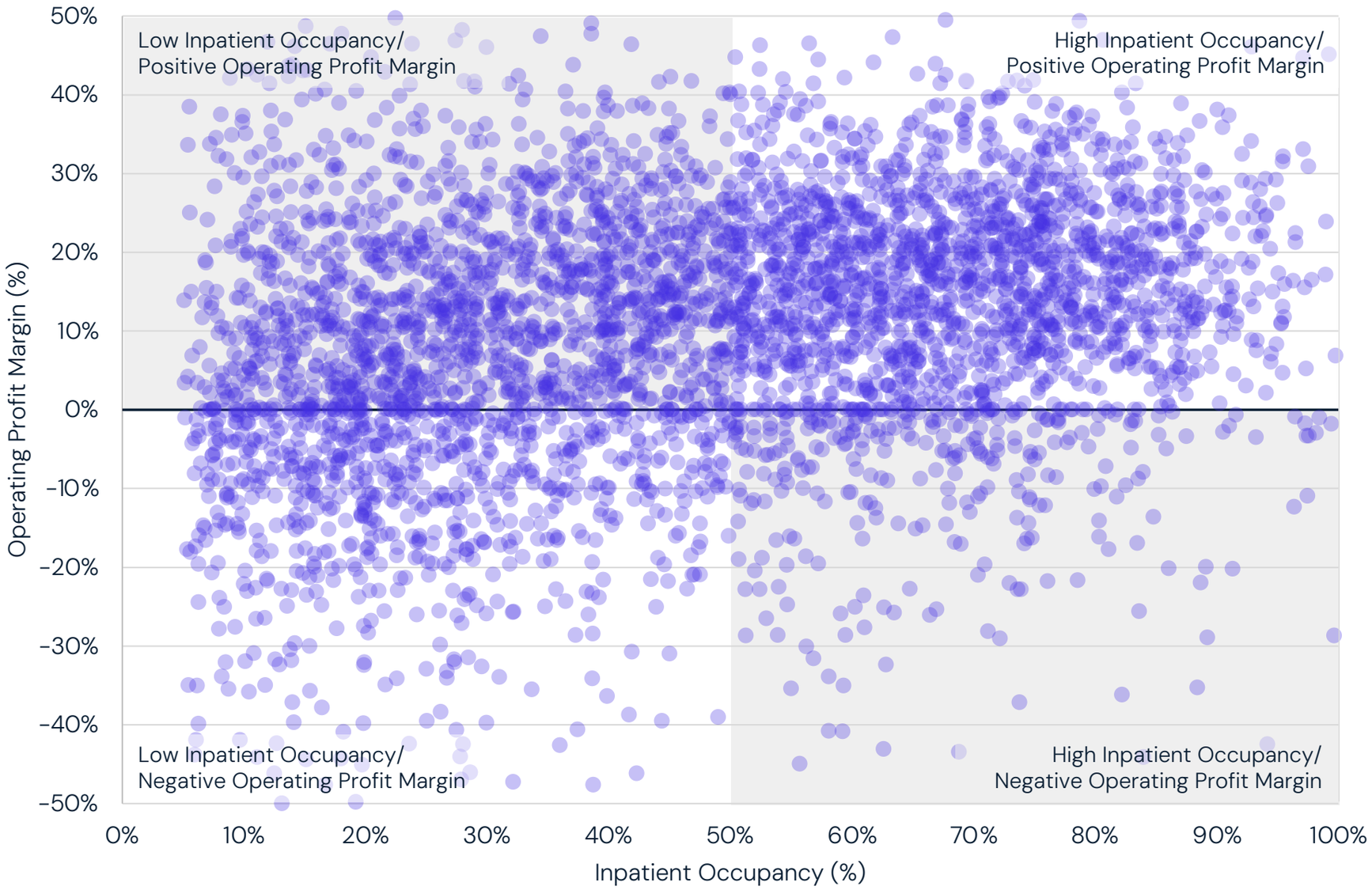
Administrative Expenditures vs. Direct Patient Care Expenditures, by Hospital, 2023

Note: Median hospital-level costs were extrapolated to 6,764 U.S. hospitals. Hospitals above the 90th percentile in direct patient care or administrative costs were excluded for readability. The ratio of direct patient care expenditures to administrative expenditures was calculated and points were marked greater than the median (0.53) or below or equal to it. Limited to short-term acute care hospitals.
Source: National Academy for State Health Policy Hospital Cost Tool; Centers for Medicare and Medicaid Services Healthcare Cost Report Information System (HCRIS); Agency for Healthcare Research and Quality Compendium of U.S. Health Systems.

Occupancy Rates and Profit Margin Are Not Correlated

The inpatient occupancy of a hospital and its operating profit margin reveal a weak correlation (r=0.27). A signal of market inefficiency, 1,547 hospitals had occupancy rates below 50% with a positive operating margin, while 340 hospitals had occupancy rates above 50% with a negative operating margin.

Inpatient Occupancy vs. Operating Profit Margin at U.S. Short-Term Acute Care Hospitals, 2023

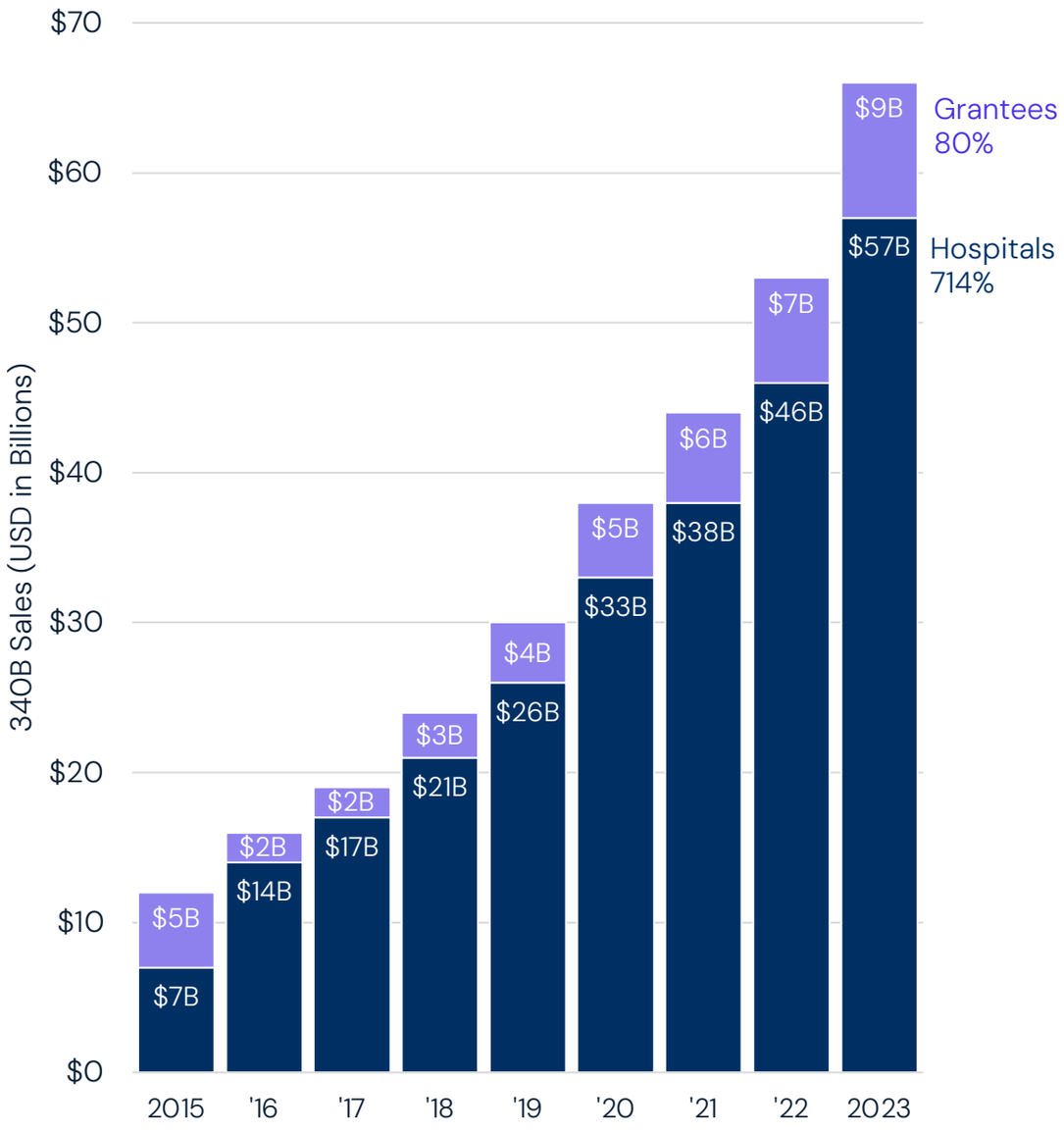


Source: Centers for Medicare and Medicaid Services Healthcare Provider Cost Reporting Information System (HCRIS).

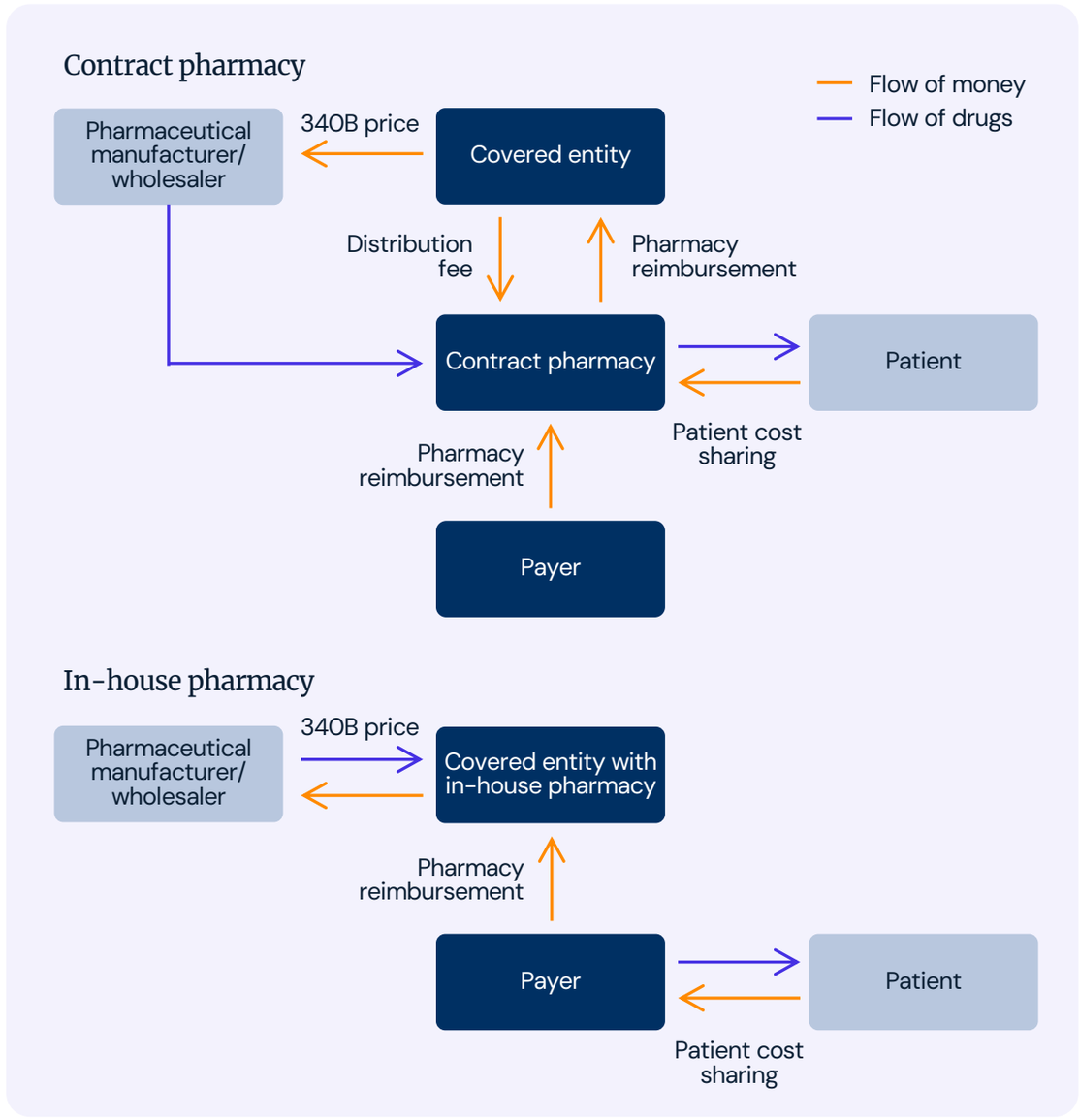
Hospitals Disproportionately Benefit from 340B Drug Discounts

340B sales at hospitals increased by 714% from 2015 to 2023 and accounted for 86.4% of sales, while grantee spending increased by 80%. Intended to ensure low-income patients could afford the costs of medications, 340B participation has expanded to over 2,700 hospitals.

340B Drug Sales, Hospitals and Grantees, 2015-2023



Flow of Money and Drugs in the 340B Drug Pricing Program

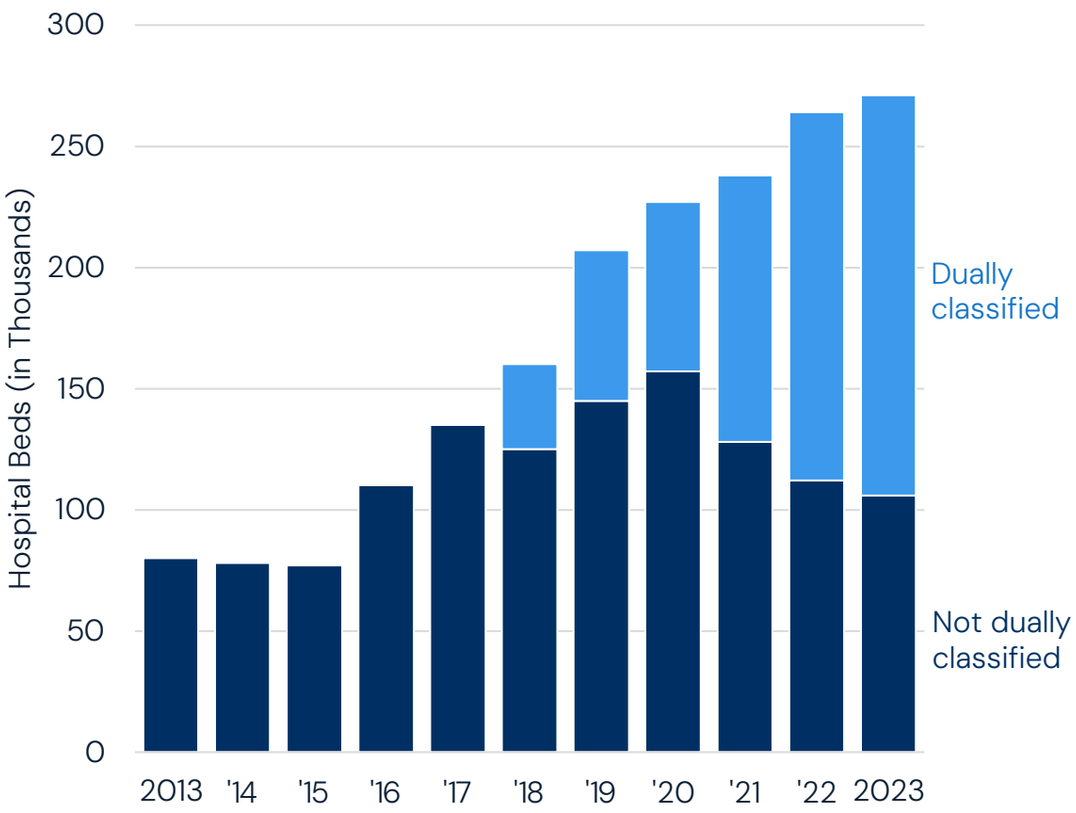


Note: 340B grantees include sites such as federally qualified health centers and Ryan White clinics.
Source: Health Resources and Services Administration 340B Covered Entity Report.

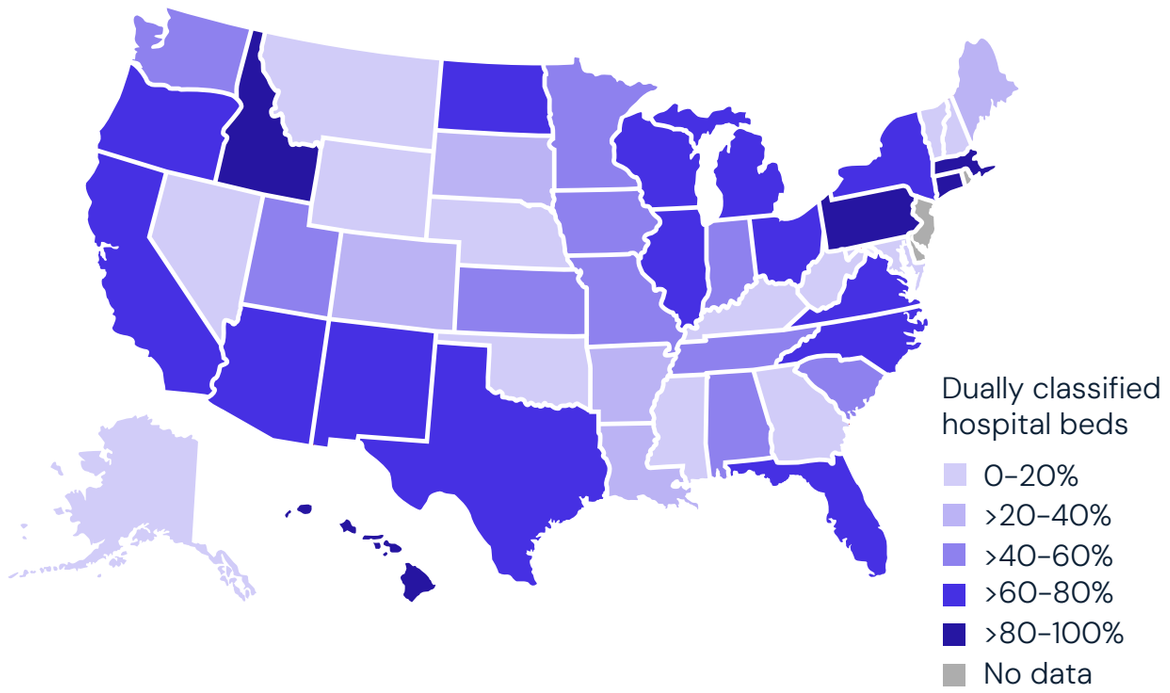
More Urban Hospitals Are Claiming Rural Status

The share of hospital beds classified as “administratively rural” grew from 13% to 45% between 2013 and 2023, driven by the dual classification of many urban hospitals. This expansion allows large metropolitan facilities to access rural-focused subsidies and programs like 340B under lower thresholds than those applied to urban hospitals.

Administratively Rural Hospital Beds, by Dual-Classification Status, 2013-2023



Proportion of Dually Classified Hospital Beds Among All Administratively Rural Hospital Beds, by State, 2023

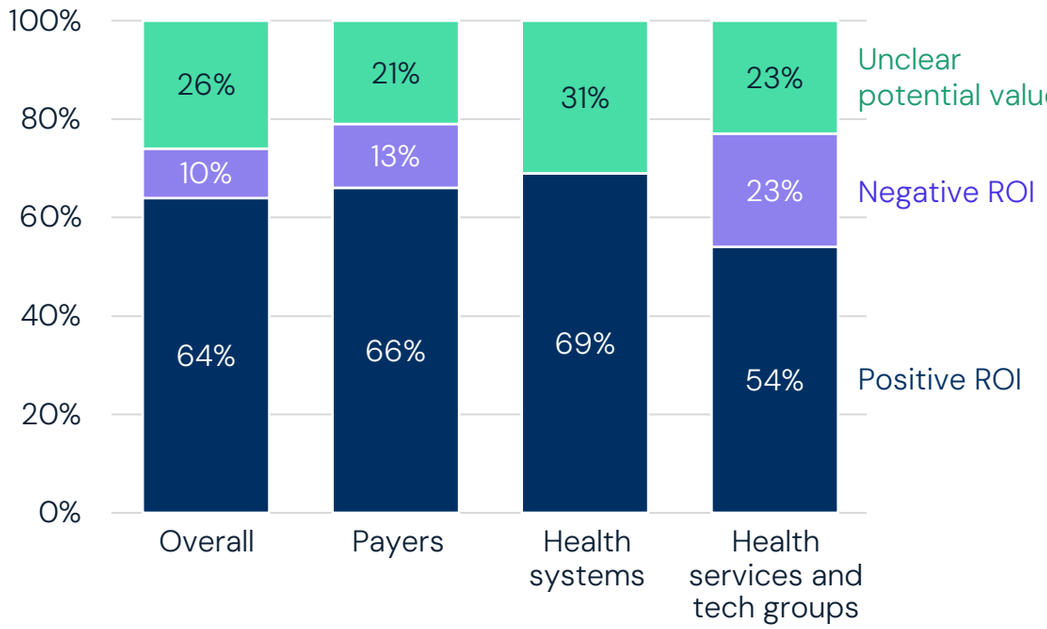


Source: Yang et al., Sharp Rise In Urban Hospitals With Rural Status In Medicare, 2017–23, *Health Affairs*, 2025.

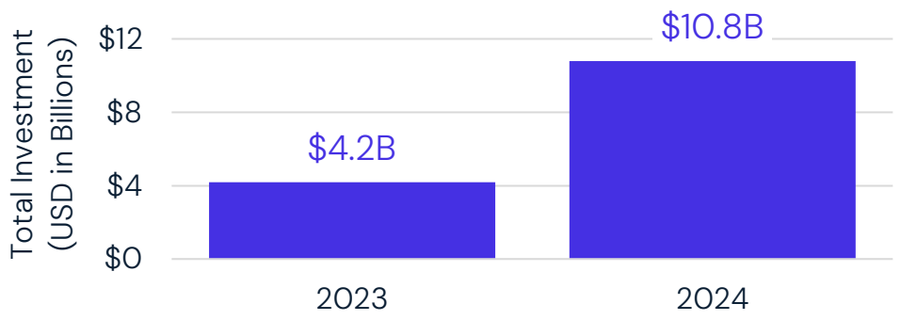
AI Solutions Require Rigorous Evaluation of Return on Investment

Global investment in healthcare AI more than doubled from $4.2B in 2023 to $10.8B in 2024. Across stakeholders, 36% report unclear or negative ROI from generative AI use cases, emphasizing the importance of rapid experimentation.

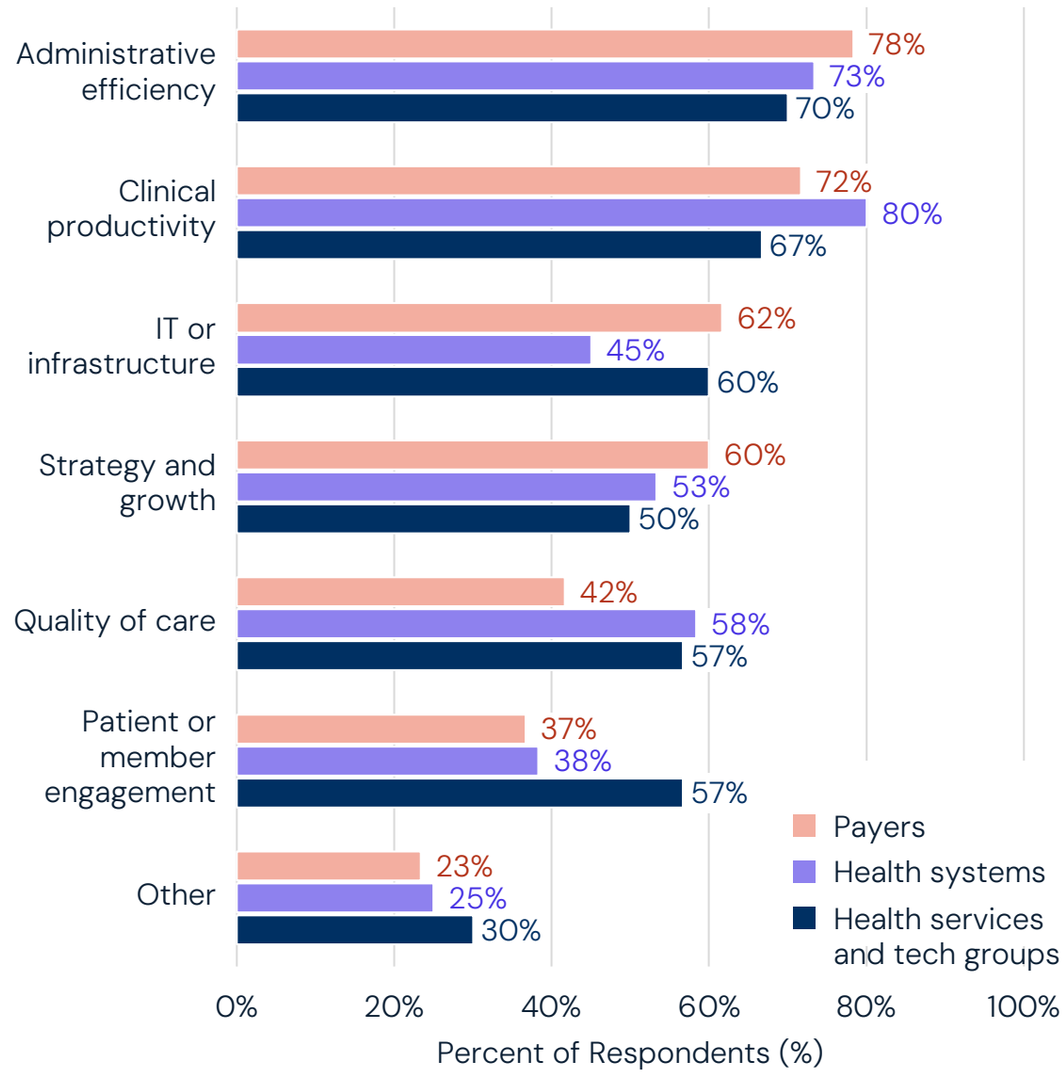
Reported ROI From Implemented Generative AI Use Cases, by Organization Type, 2024



Global Private Investment in AI in Medical and Healthcare, 2023-2024



Perceived High-Value Use Cases for Generative AI, by Organization Type, 2024

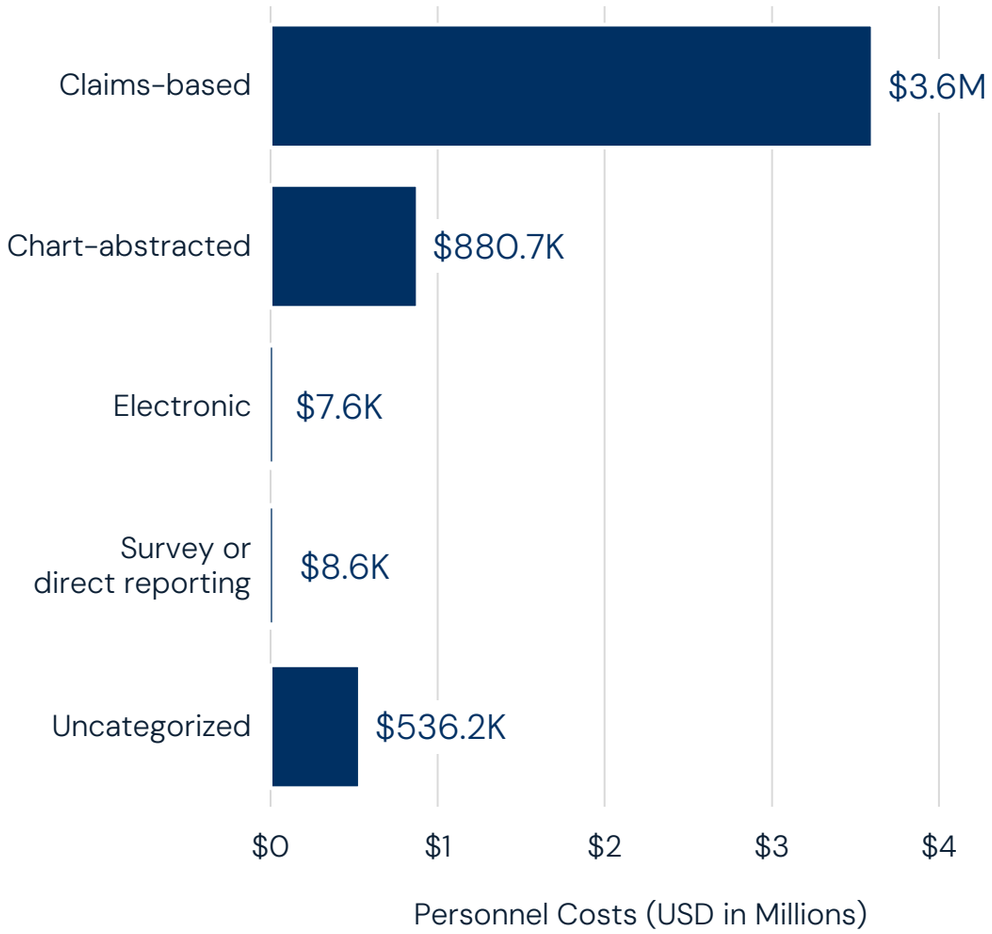


Note: ROI denotes return on investment.
Source: Stanford Artificial Intelligence Index Report 2025; McKinsey & Company, Generative AI in Healthcare: Current trends and Future Outlook, 2024; Becker's Health IT.

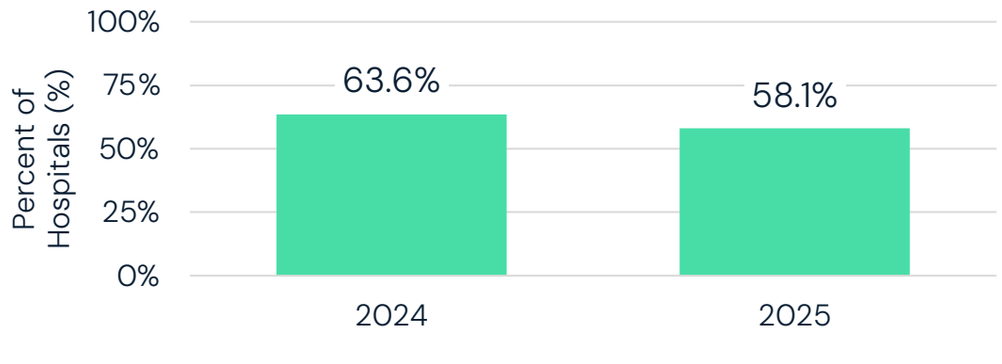
Quality Reporting Is Expensive, With Low Return on Investment...

CMS requires hospitals to report data on various quality metrics, with one academic medical center spending over $5.5M to track 162 measures annually. The number of hospitals penalized for high readmissions under the HRRP has remained relatively stable over the past decade, while quality reporting compliance has decreased.

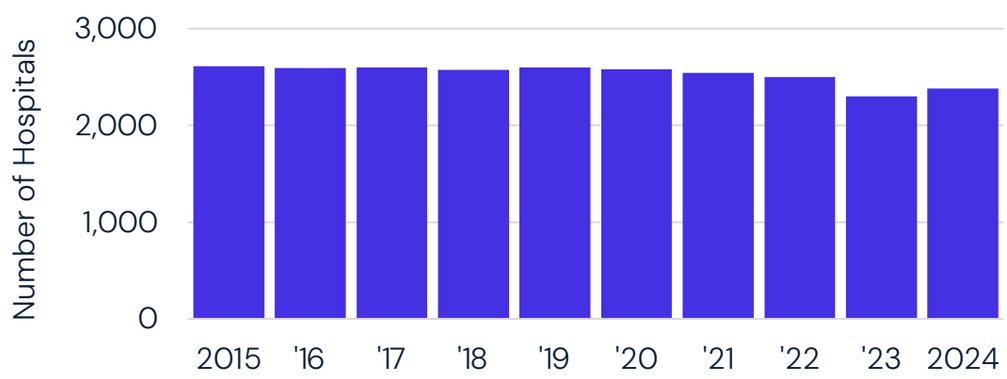
Personnel Cost of Quality Data Reporting by a Large Academic Medical Center, 2018



Percent of Hospitals Reporting 30-Day Heart Failure Mortality Rates, 2024-2025



Hospitals Penalized by CMS for High Hospitals Readmissions, 2015-2024

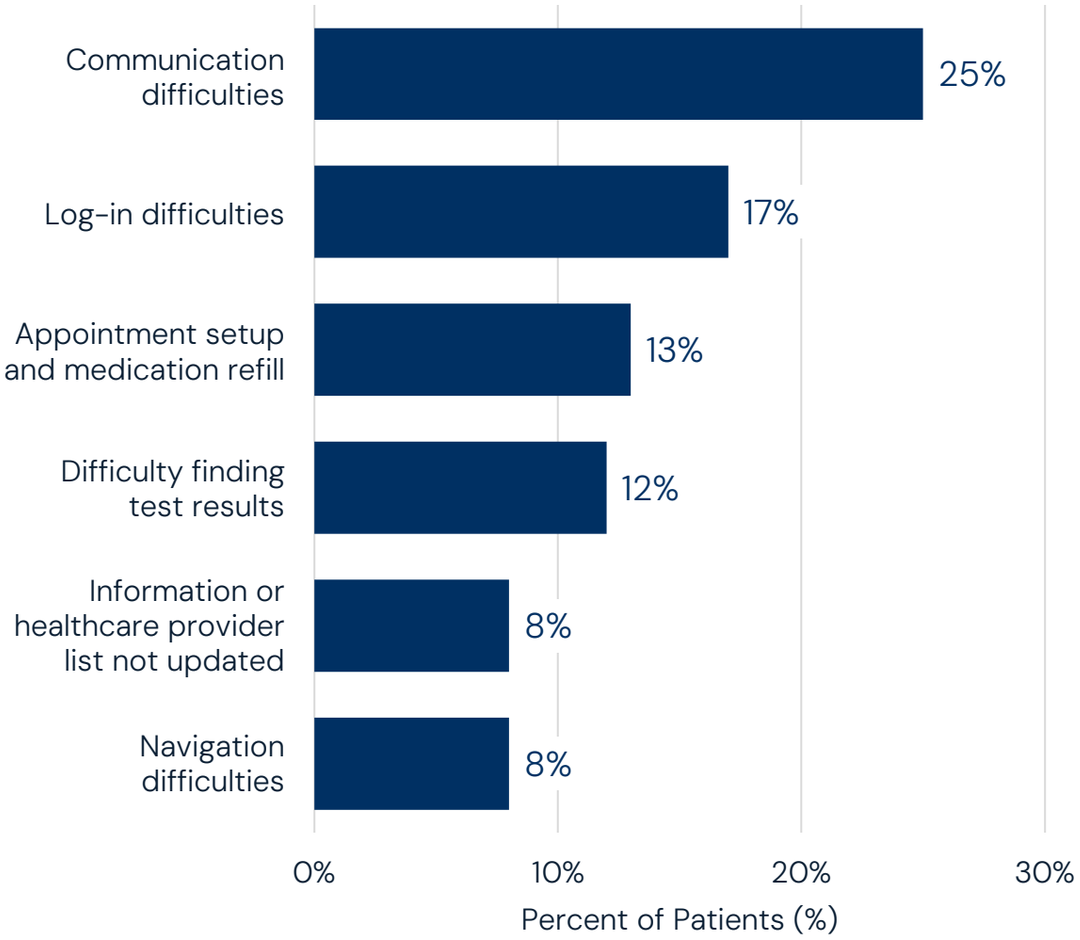


Note: CMS denotes Centers for Medicare and Medicaid Services; HRRP denotes Hospital Readmissions Reduction Program.
Source: Saraswathula et al., The Volume and Cost of Quality Metric Reporting, *JAMA Network Open*, 2023; Centers for Medicare and Medicaid Services Quality Net.

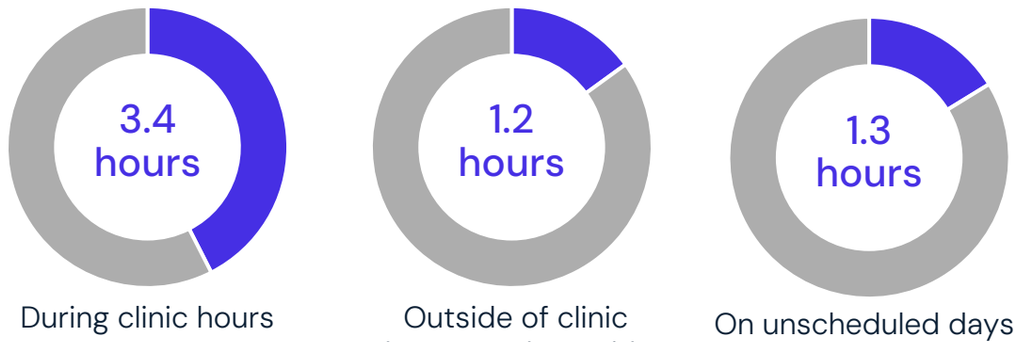
...And EHRs Are Even More Expensive, With Low Return on Investment

The EHR market is highly concentrated, with Epic having 42.3% market share in 2024, up from 31.0% in 2021. Several challenges to EHR adoption and meaningful use persist, including high costs, limited patient uptake and lack of interoperability. While intended to improve efficiency, most physicians disagree that the EHR improves their workflow.

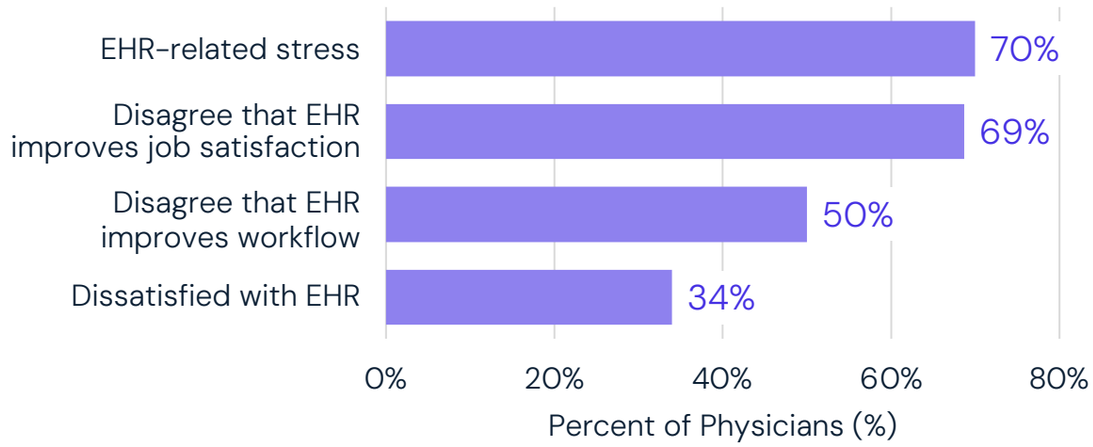
Percent of Adults Reporting Difficulties With EHR Patient Portals, 2020



Physician Time Spent in EHRs, 2021-2022



Physician Views on EHRs, 2021

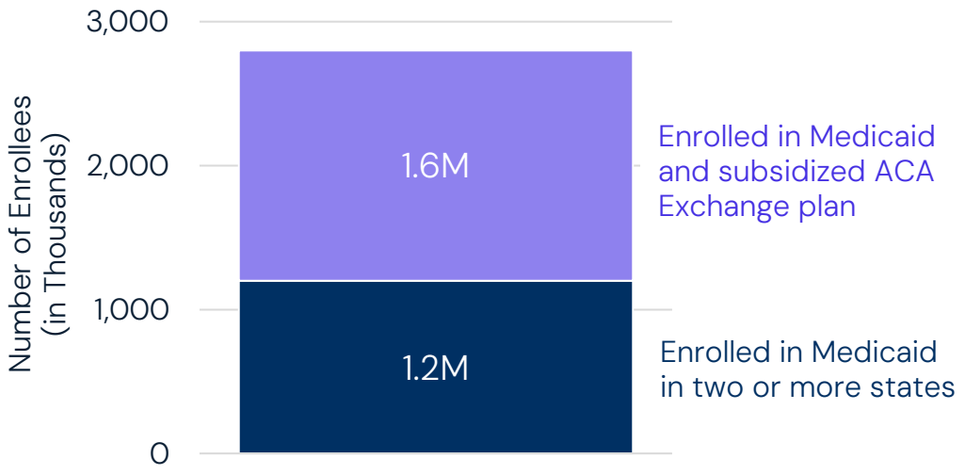


Note: EHR denotes electronic health record. Clinic hours are defined as patient-scheduled hours.
Source: Becker's Health IT; Son et al., Adult Patients' Experiences of Using a Patient Portal With a Focus on Perceived Benefits and Difficulties, and Perceptions on Privacy and Security: Qualitative Descriptive Study, *JMIR Human Factors*, 2023; Budd et al., Burnout Related to Electronic Health Record Use in Primary Care, *Journal of Primary Care & Community Health*, 2023; Holmgren et al., National Comparison of Ambulatory Physician Electronic Health Record Use Across Specialties, *Journal of General Internal Medicine*, 2024.

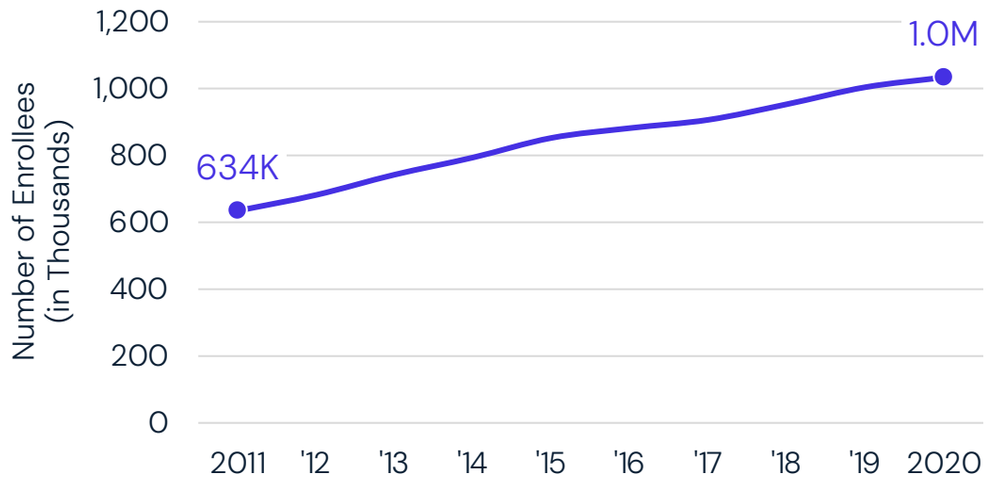
Duplicate Insurance Coverage Drives Billions in Excess Spending

In 2024, 2.8M people were enrolled in more than one Medicaid and/or ACA exchange plan, resulting in at least $4.3B in duplicate payments. In the same year, nearly 8M ACA exchange enrollees (37%) did not have a medical claim. Relatedly, dual enrollment between VHA and MA coverage increased by 62.9% from 2011 to 2020. For dual enrollees, MA plans still receive full capitated payments, which corresponds to duplicate Federal payment for the care of the same beneficiaries.

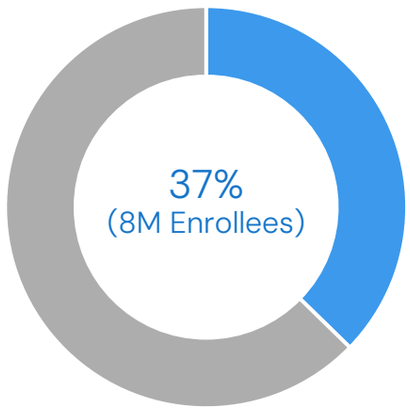
Number of Medicaid and/or ACA Exchange Dual Enrollees, 2024



Number of VHA/MA Dual Enrollees, 2011-2020



Share of ACA Exchange Enrollees Without a Medical Claim, 2024



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Research Letter

Spending by the Veterans Health Administration for Medicare Advantage Dual Enrollees, 2011-2020

David J. Meyers, PhD[1,2]; Aaron L. Schwartz, MD, PhD[3,4]; Lan Jiang, MS[1] ; et al

Taxpayers Spent Billions Covering the Same Medicaid Patients Twice

When recipients signed up in two states at once, insurers often got paid by both; 'it definitely is wasteful'

Note: ACA denotes Affordable Care Act; MA denotes Medicare Advantage; VHA denotes Veterans Health Administration.
Source: The Centers for Medicare and Medicaid Services; U.S. Department of Veterans Affairs Health Systems Research; Becker's Payer Issues; Meyers et al., Spending by the Veterans Health Administration for Medicare Advantage Dual Enrollees, 2011-2020, *JAMA*, 2024; Marketplace Open Enrollment Period Public Use Files.

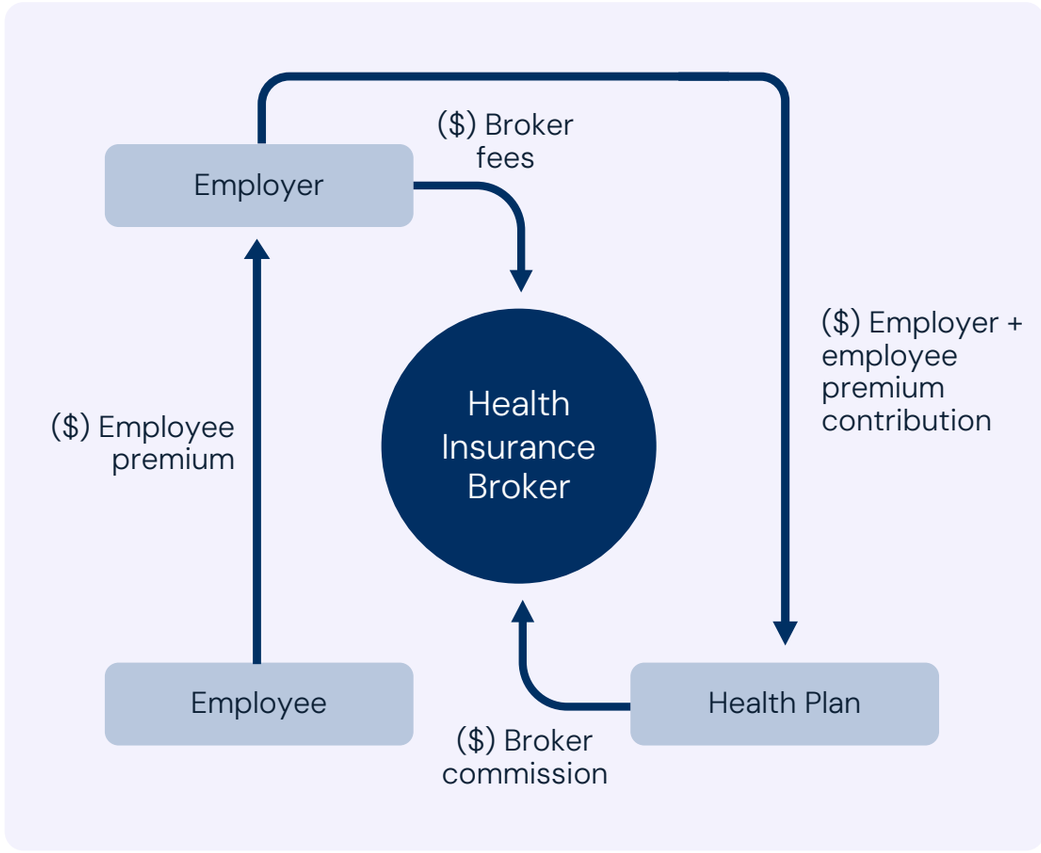
Healthcare Middlemen Are Wasteful and Inefficient

Healthcare middlemen, such as health insurance brokers, exist to facilitate negotiations but frequently add complexity, while receiving opaque financial remuneration. For example, brokers could receive $10.9M in commissions from a self-insured employer with 50,000 employees in the Pacific region.

Commissions per Enrollee and Commission-to-Premium Ratios Across U.S. Census Divisions, 2017

U.S. Census Division	Unadjusted median commission per enrollee	RPP adjusted median commission per enrollee	Median commission-to-premium ratio
New England	$161	$152	2.8%
Middle Atlantic	$205	$187	3.9%
East North Central	$146	$157	3.8%
West North Central	$125	$136	3.5%
South Atlantic	$145	$149	4.5%
East South Central	$157	$178	5.0%
West South Central	$164	$174	4.9%
Mountain	$146	$149	4.3%
Pacific	$218	$194	4.7%

Health Insurance Broker Overview

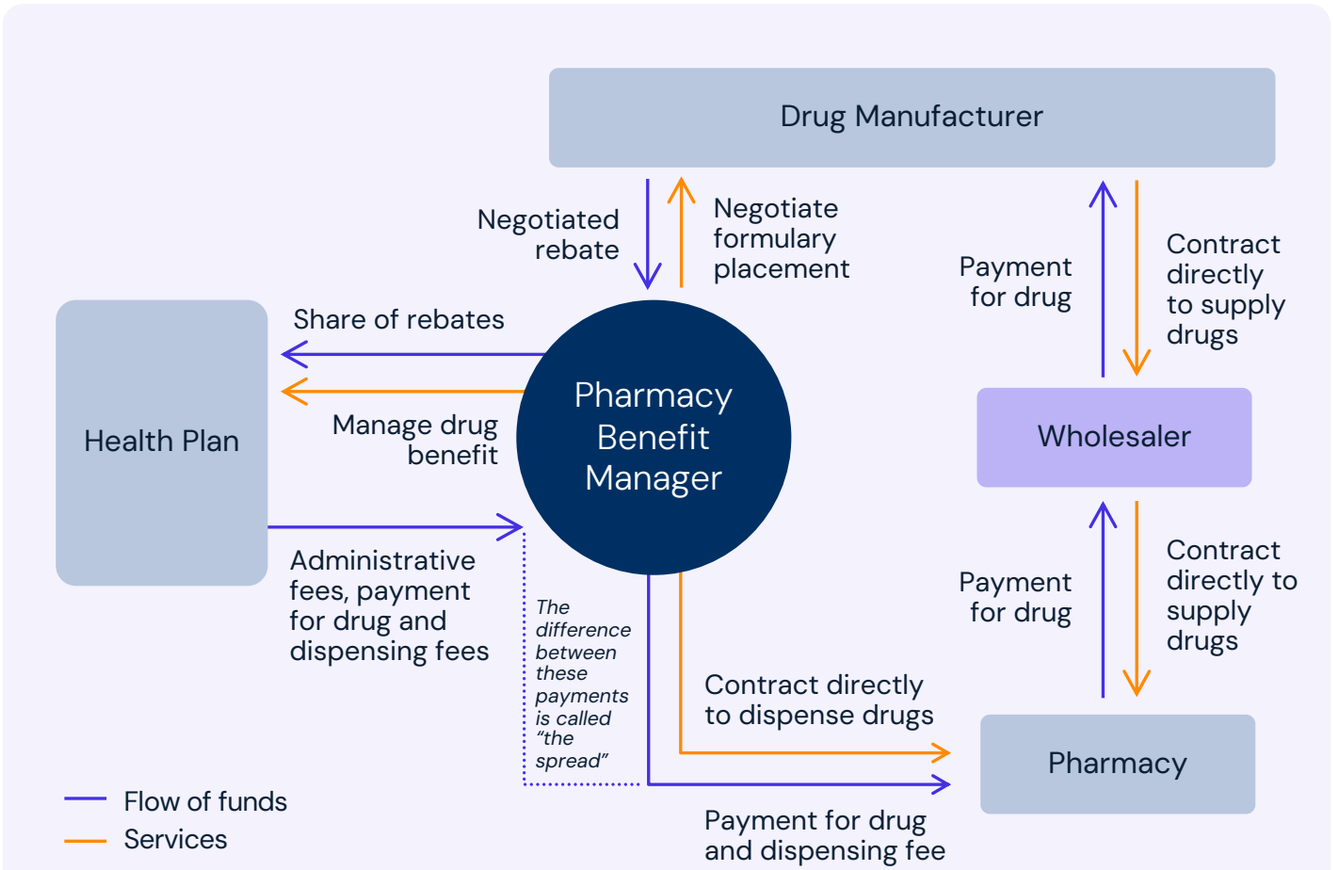


Source: Bai et al., The Commissions Paid to Brokers for Fully Insured Health Insurance Plans, *Medical Care Research and Review*, 2020.

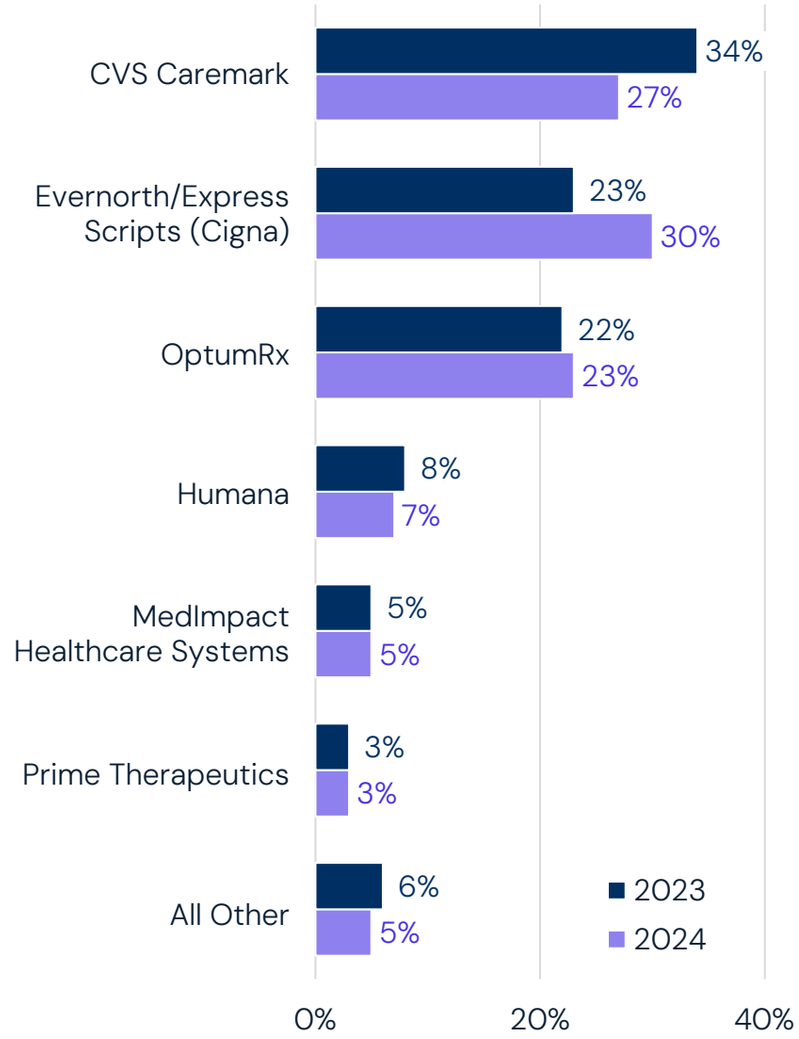
PBMs Add Complexity to the Drug Distribution and Pricing Process

PBMs negotiate rebates and discounts from manufacturers, design drug formularies and oversee pharmacy networks and claims processing on behalf of payers. The three largest PBMs, which fill nearly 80% of prescriptions, are vertically integrated with insurers and pharmacies. While theoretically positioned to help control drug spending, undisclosed financial incentives have the opposite effect. For consumers, actual savings are unpredictable, variable and situational.

PBM Overview



PBM Market Share, by Total Prescription Claims Managed, 2023 and 2024

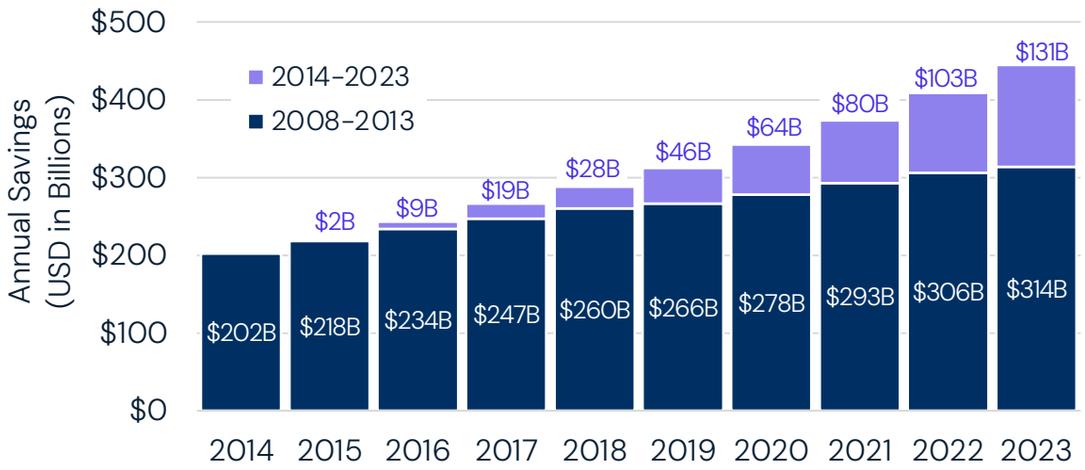


Note: PBM denotes pharmacy benefit manager.
Source: Commonwealth Fund; Federal Trade Commission Interim Staff Report, 2024.

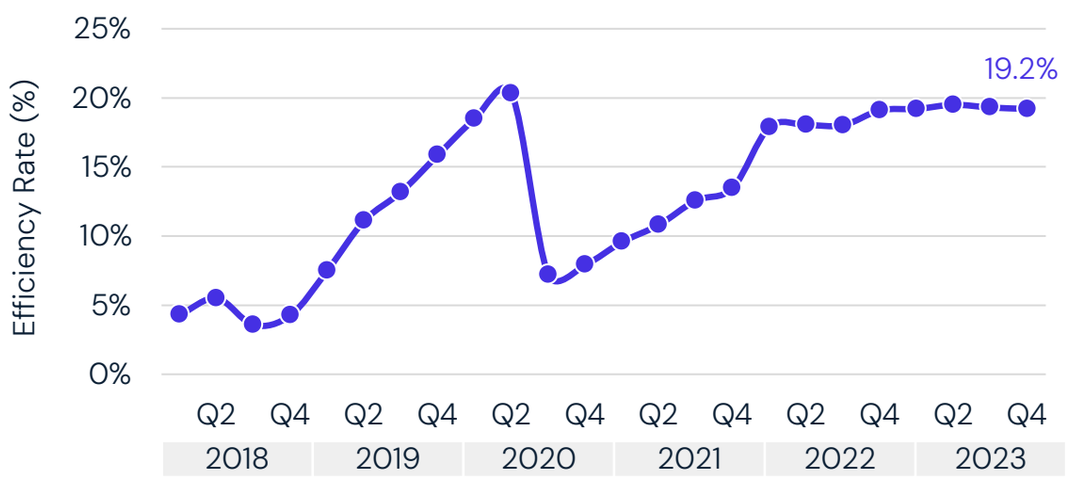
Misaligned Incentives Continue to Hinder Biosimilar and Generic Savings

Between 2014 and 2023, generics and biosimilars generated $3.1T in savings. Despite these savings, biosimilars are dispensed just 19.2% of the time when available. Across leading biologics, ASP fell by 1% to 95% after the launch of a biosimilar, though market share ranged from 27% to 88% as of Q3 2024.

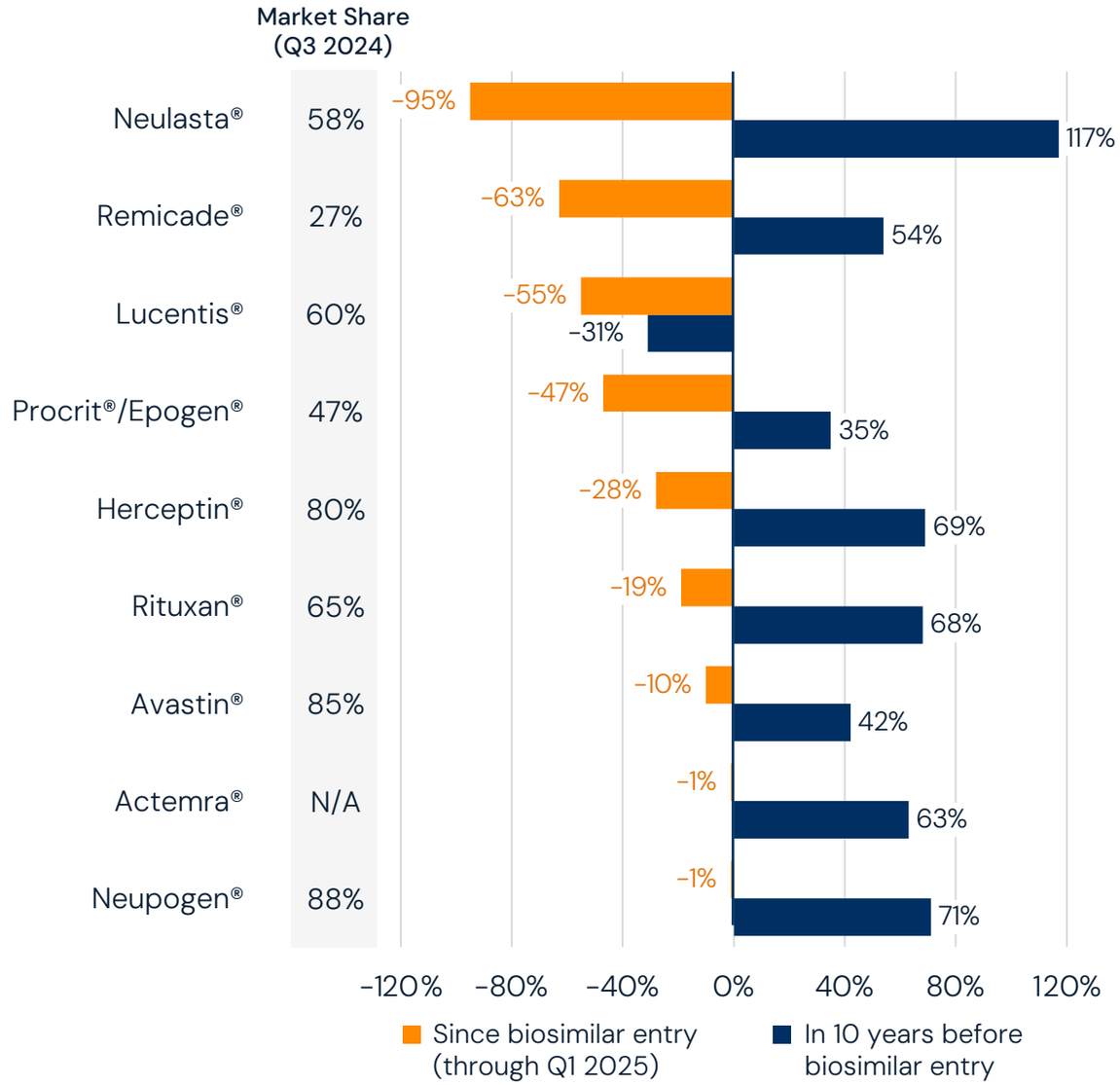
Annual Savings From Generics and Biosimilars, by Launch Year, 2014-2023



Biosimilar Efficiency Rate, Q1 2018-Q4 2023



Percent Change in Originator Biologic's ASP Before and After Biosimilar Entry, 2025



Note: ASP denotes average sales price. Market share reflects biosimilar volume as a percent of total product volume by molecule, as of Q3 2024. Includes biosimilars launched through 2023. Biosimilar efficiency rate is a metric used to gauge the uptake or dispensing rate of biosimilar medicines once they are available on the market.
Source: Medicare Payment Advisory Commission; The Association for Accessible Medicines U.S. Generics and Biosimilar Medicines September 2024 Savings Report.

Over 75% of FDA-Approved Drugs Are Not Recommended by NICE

Despite costing 56.1% less in the U.K. than the U.S., NICE has determined that many FDA-approved drugs do not meet the necessary clinical and cost-effectiveness thresholds required for coverage by the NHS.

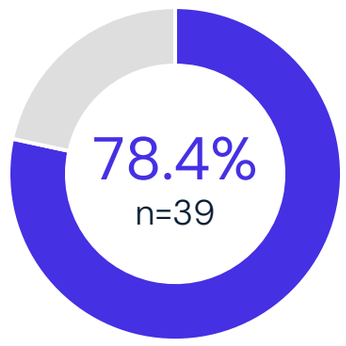
NICE Overview

What is NICE?

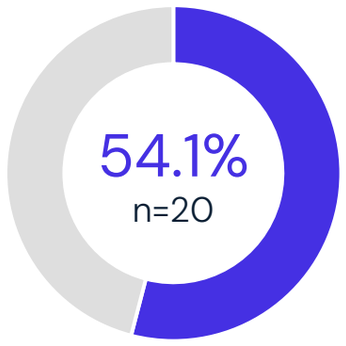
The National Institute for Health and Care Excellence (NICE) provides clinical guidelines, technology appraisals and quality standards on treatment and care for providers, social workers, patients and caregivers in the U.K. NICE guidelines are intended to improve patient outcomes, in line with the **best available evidence of clinical and cost-effectiveness**.

Experts have estimated that NICE's maximum cost-effectiveness threshold is **£20,000–30,000/QALY.**

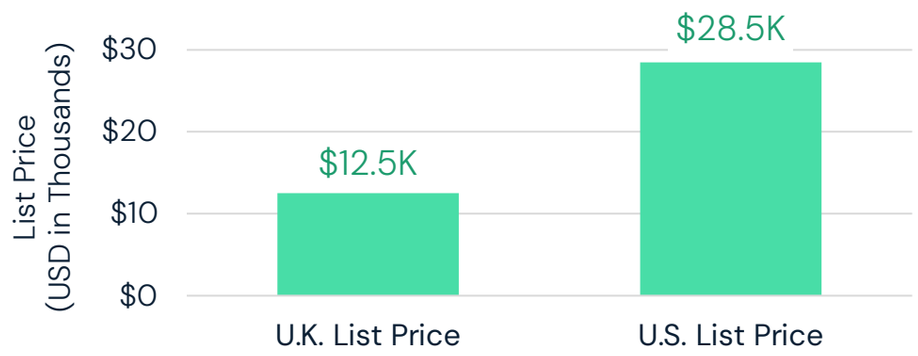
Percent of Drugs Approved by FDA Since 2020 **Not Recommended** by NICE



Percent of Drugs Indicated for Oncology **Not Recommended** by NICE



U.K. and U.S. Average List Prices for Drugs **Not Recommended** by NICE



Note: NICE denotes the National Institute for Health and Care Excellence; QALY denotes quality-adjusted life-year; NHS denotes National Health Service. U.K. average list price conversion from GBP to USD reflects May 2025 conversion rates. The NHS is England's national health service.
Source: NICE Guidelines Development Manual and Technology Appraisal Recommendations Data; Sun et al., Cost-Effectiveness Thresholds or Decision-Making Threshold: A Novel Perspective, *BioMed Central*, 2024; Drugs.com Price Guide; U.S. Food & Drug Administration; publicly available manufacturer press releases.

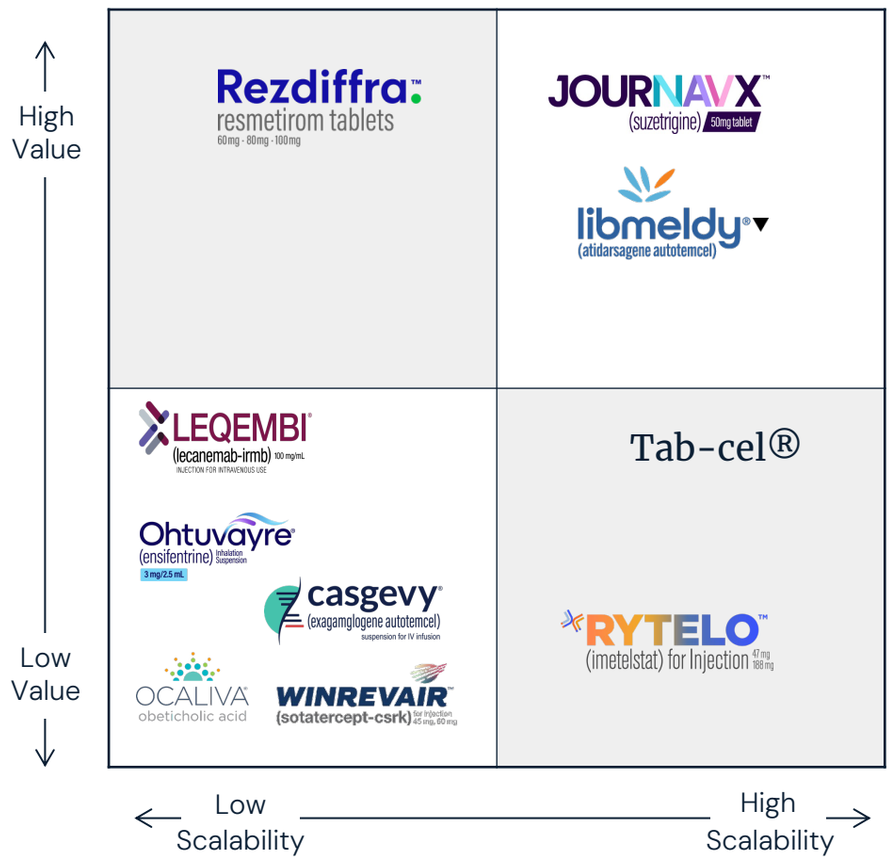
Value for Money Remains Elusive for Many Specialty Therapies

Specialty drugs consistently launch above their health benefit price benchmarks, the range ICER deems cost-effective. Cost per QALY is also typically above these thresholds, ranging from $127K (Libmeldy®) to $2.3M (Winrevair®). Few remain affordable beyond 20% uptake – while Rezdiffra® demonstrates value within benchmark, it impacts budgets at just 6.5% uptake, and Tab-cel® and Rytelo® scale to nearly all patients but exceed $150K per QALY.

Acquisition Costs, Value Benchmarks and Price Differentials for Select Specialty Therapies Analyzed for Cost-Effectiveness, 2023-2025

Drug	Indication	Wholesale Acquisition Cost	Health Benefit Price Benchmark	Cost per QALY ($)
Journavx®	Acute pain	$232.50/week	Cost-saving	Less costly, more effective
Tab-cel®	EBV+ PTLD	N/A	$143,900 – $273,700	$184,000
Winrevair®	PAH	$400,000	$17,900 – $35,400	$2.38M
Casgevy®	Sickle cell disease	$2.2M/year	$1.35M – $2.05M	$193,000
Rezdiffra®	NASH	$47,400/year	$39,600 – $50,100	Less costly, more effective
Ocaliva®	NASH	$85,111/year	$32,600 – $40,400	$568,000
Leqembi®	Alzheimer's	$26,500/year	$8,900 – $21,500	$277,000
Ohtuvayre®	COPD	$35,898/year	$7,500 – $12,700	$248,000
Rytelo®	MDS anemia	$365,197/year	$94,800 – $113,000	$1.3M
Libmeldy®	MLD	$4.25M	$2.3M – $3.9M	$127,000

Specialty Therapies Mapped by Price per QALY Gained and Percent of Patients Treated Before ICER Budget Impact Threshold



Note: ICER denotes Institute for Clinical and Economic Review; QALY denotes quality-adjusted life year; EVB+PTLD denotes Epstein-Barr virus–positive post-transplant lymphoproliferative disorder; PAH denotes pulmonary arterial hypertension; COPD denotes chronic obstructive pulmonary disease; NASH denotes nonalcoholic steatohepatitis; MDS anemia denotes myelodysplastic syndromes–related anemia; MLD denotes metachromatic leukodystrophy. Tab-cel® are FDA designated novel therapies, pending approval. Chart quadrants are categorical, not to scale. Scalability defined by percent of eligible patients treatable before breaching ICER's $735M per year threshold: low (0.5–15.5%), high (82.3–100%). Value categorized by cost per QALY: high value (<$150K), low value (>$150K).
Source: Institute for Clinical and Economic Review.

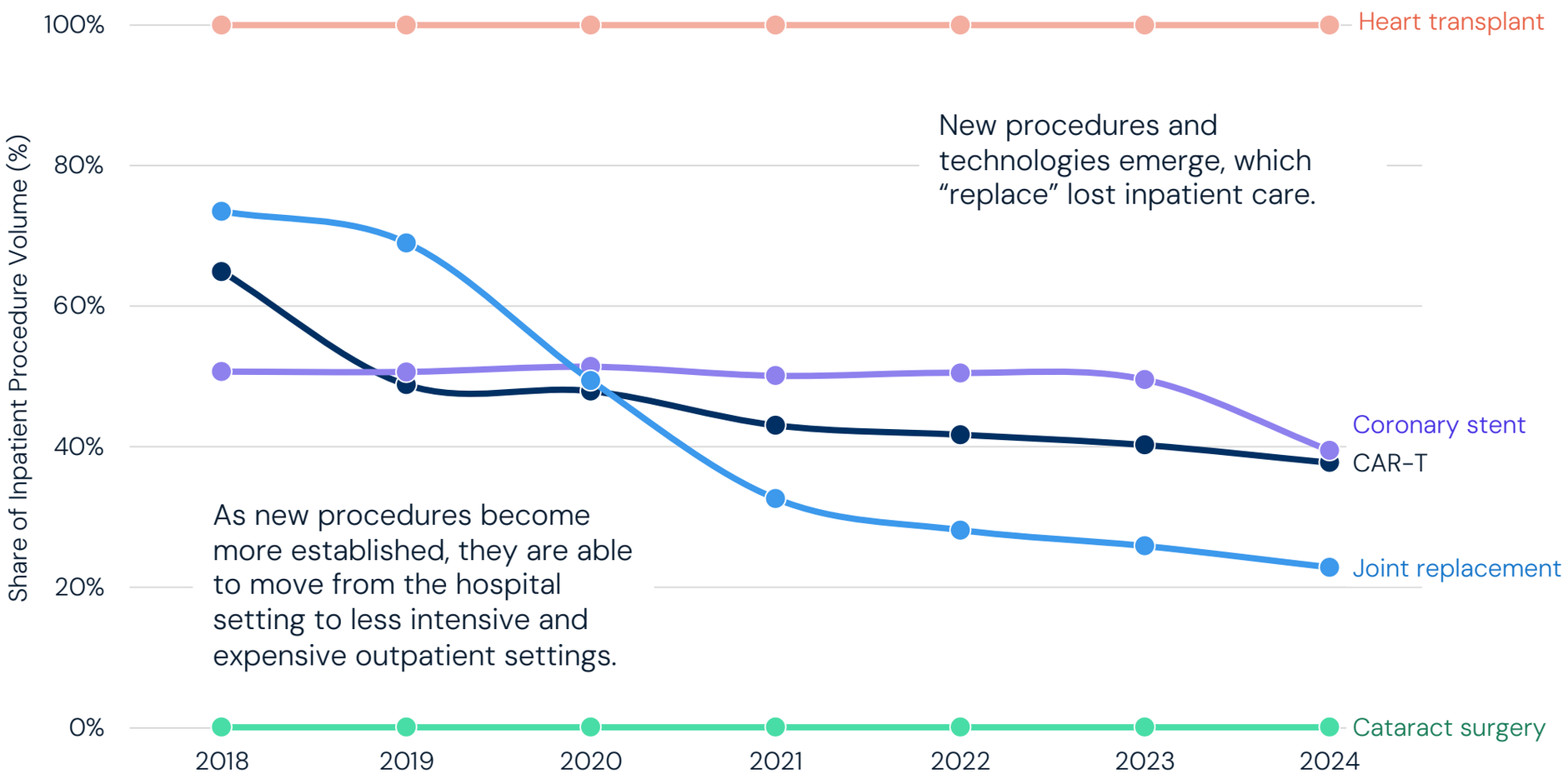
TREND 5

The Transition to Alternative Care Settings and Therapies Is Accelerating

The Cycle of Innovation Influences Rate of Care Migration Outside the Hospital

New treatment paradigms are frequently introduced in the hospital setting, then migrate to less intensive and expensive outpatient settings over time. Historically, novel complex therapies (e.g., CAR-T) replace the lost inpatient care and start a new cycle of innovation.

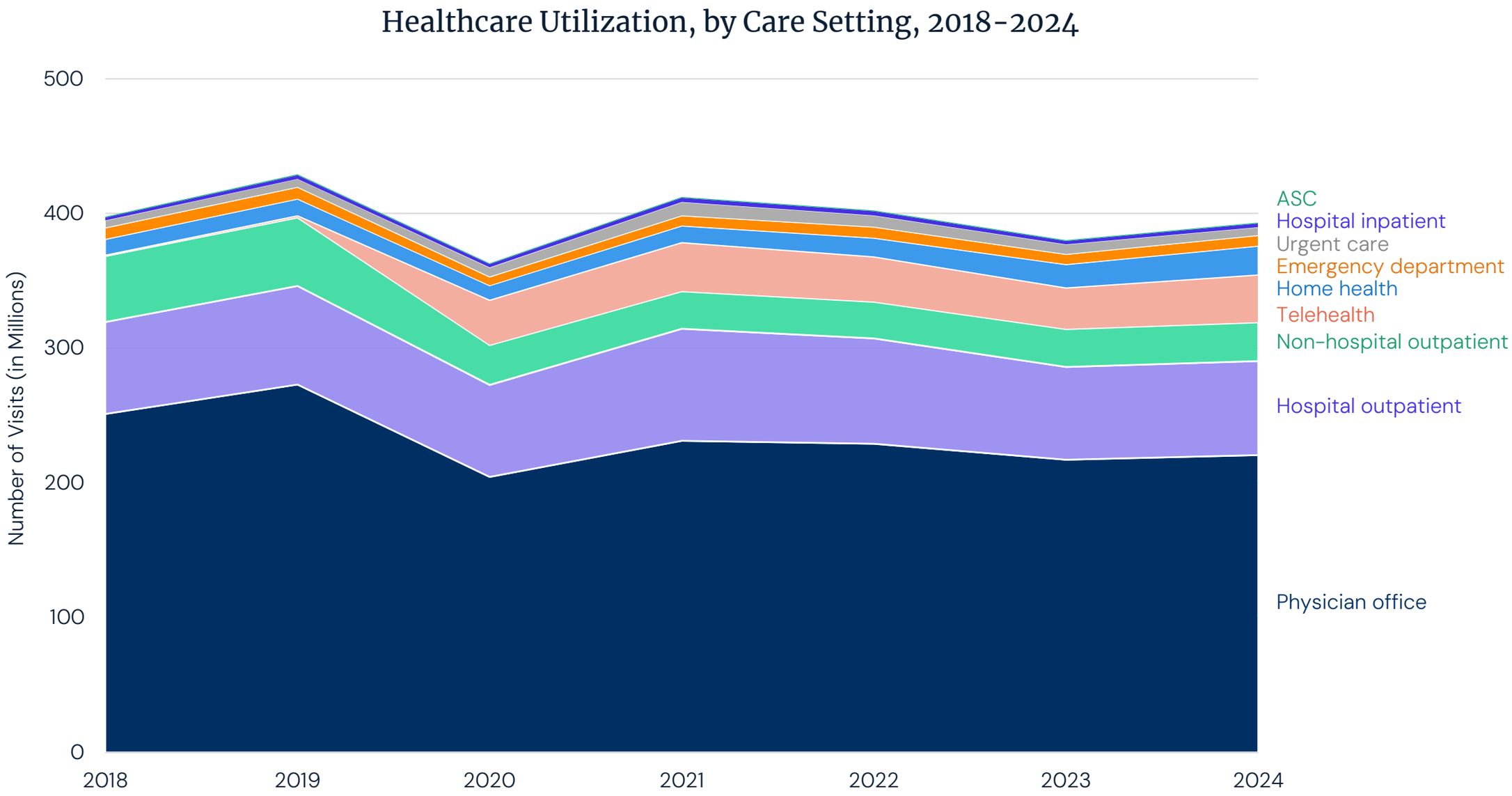
Cycle of Care Delivery Shifting From Hospital to Non-Hospital Settings, 2018-2024



Note: CAR-T denotes chimeric antigen receptor.
Source: Trilliant Health national all-payer claims database.

Utilization Is Slightly Up From 2023 but Remains Below Pre-Pandemic Levels

Healthcare utilization grew by 3.6% from 2023 to 2024, though overall volume in 2024 remained 8.0% below 2019 and 0.8% below 2018. Emergency department utilization followed a similar pattern, rising 5.1% year-over-year but falling 6.8% short of 2018 levels. In contrast, urgent care utilization declined 12.9% from 2023 to 2024 yet remained 13.5% higher than in 2018.

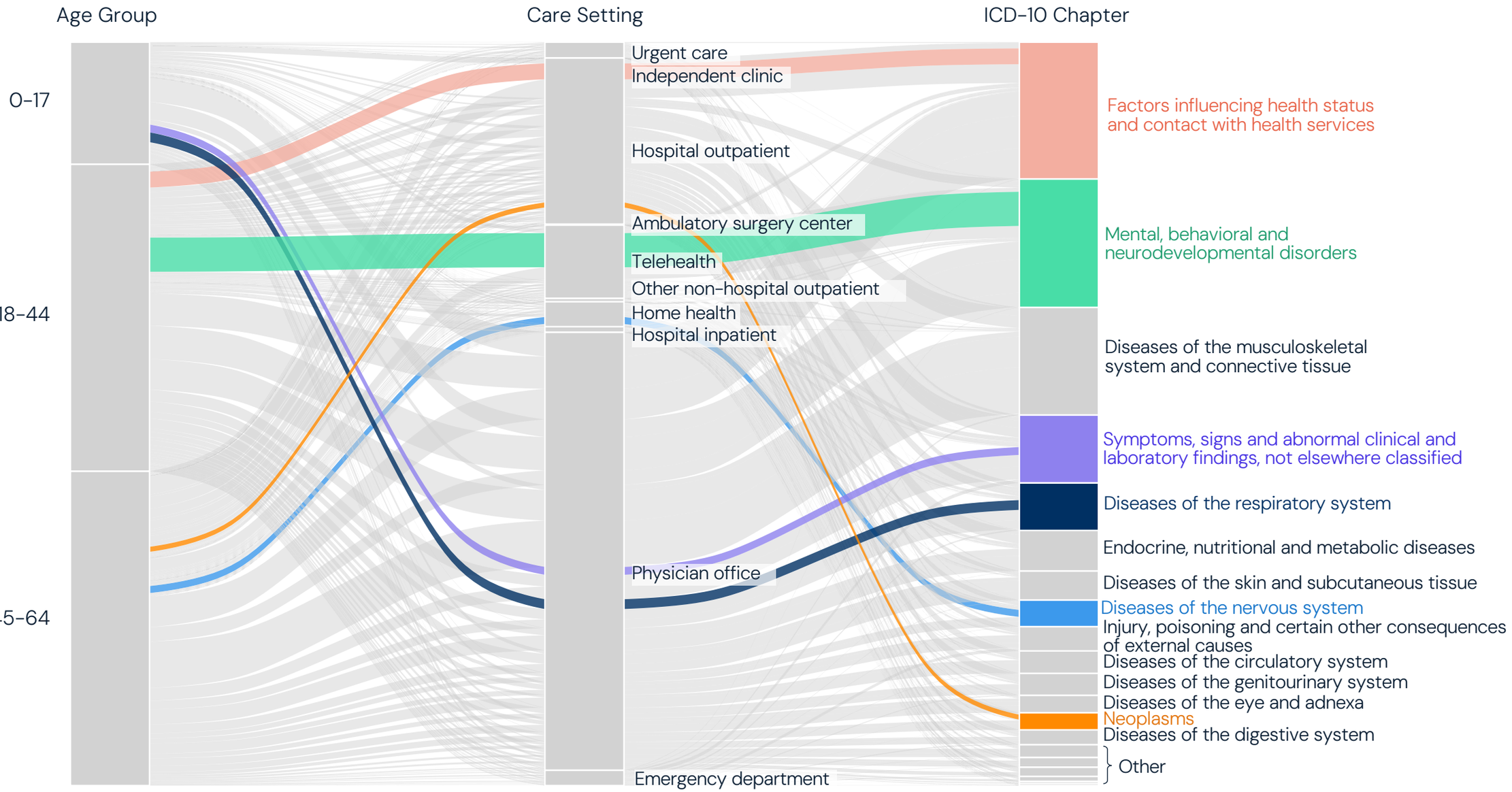


Note: Analysis is limited to commercially insured patients. ASC denotes ambulatory surgery center.
Source: Trilliant Health national all-payer claims database.

Site of Care Utilization Differs by Age Group and Clinical Need

While care utilization varies by setting, different trends are observed across age groups and visit reasons (i.e., diagnosis). For example, among adults ages 18-44, 74.7% of telehealth utilization was for behavioral health reasons.

Healthcare Utilization, by Age Group, Care Setting and ICD-10 Chapter, 2024

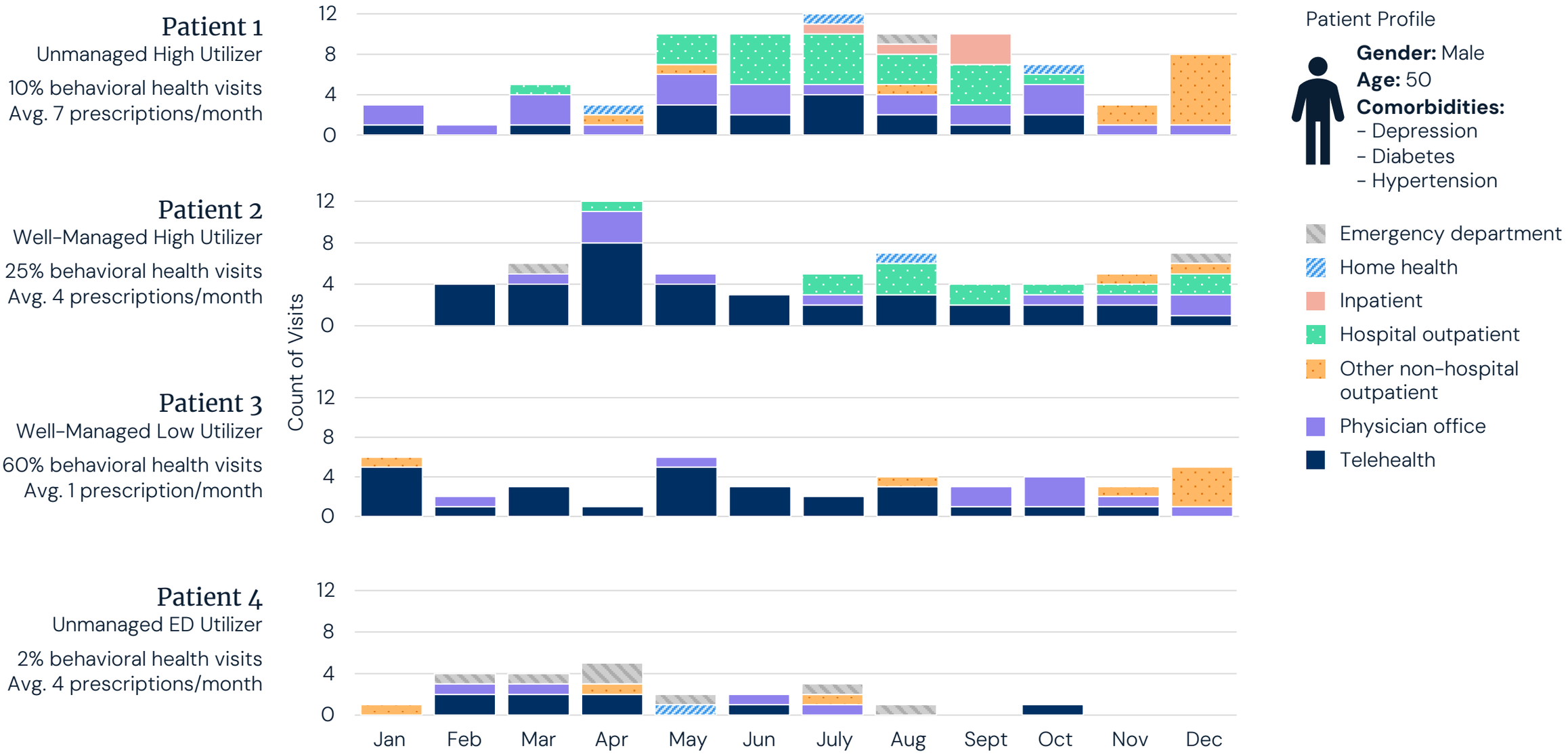


Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

Patient Journey Varies for Clinically Similar Patients

Although clinically similar, these four patients have disparate care utilization patterns. Patients with higher behavioral health utilization (Patients 2 and 3) show more coordinated, outpatient-focused care, while those with minimal behavioral health care (Patients 1 and 4) rely more on emergency and acute settings.

Healthcare Utilization for Four Clinically Similar Patients, by Setting and Month, 2024



Note: ED denotes emergency department. Analysis is limited to commercially insured patients. Examples are illustrative but represent data from actual deidentified patients.
Source: Trilliant Health national all-payer claims database.

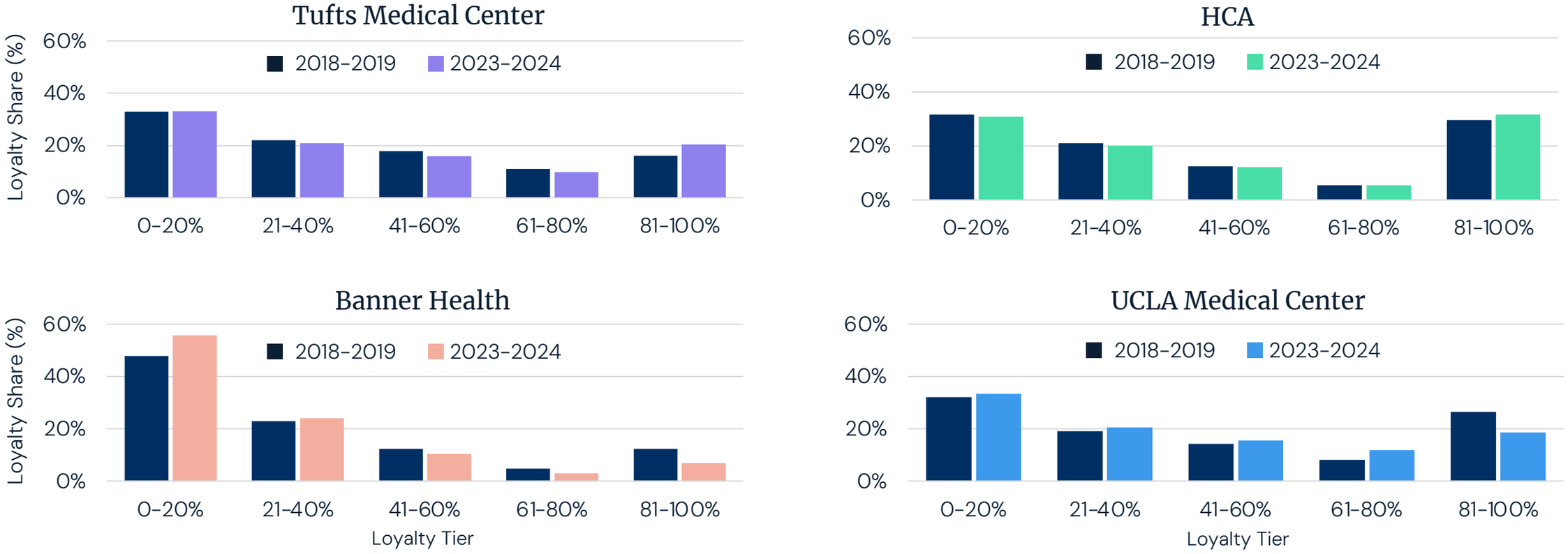
Most Patients Are Not Loyal to a Single Health System

Among four health systems in geographically diverse markets, market share in 2023-2024 ranged from 12.1% at UCLA to 32.3% at HCA in Dallas. HCA had the largest share of loyal patients, with 31.6% using the system for at least 81% of all hospital care. UCLA saw the largest decline in highly loyal patients, decreasing from 26.4% in 2018-2019 to 18.6% in 2023-2024.

Market Share of Select Health Systems, Hospital Care, 2018-2019 and 2023-2024

Time Period	Tufts Medical Center (Boston, MA)	HCA (Dallas, TX)	Banner Health (Phoenix, AZ)	UCLA Medical Center (Los Angeles, CA)
2018-2019	9.3%	31.2%	31.3%	12.4%
2023-2024	12.6%	32.3%	30.2%	12.1%

Patient Loyalty for Select Health Systems, Hospital Care, 2018-2019 and 2023-2024

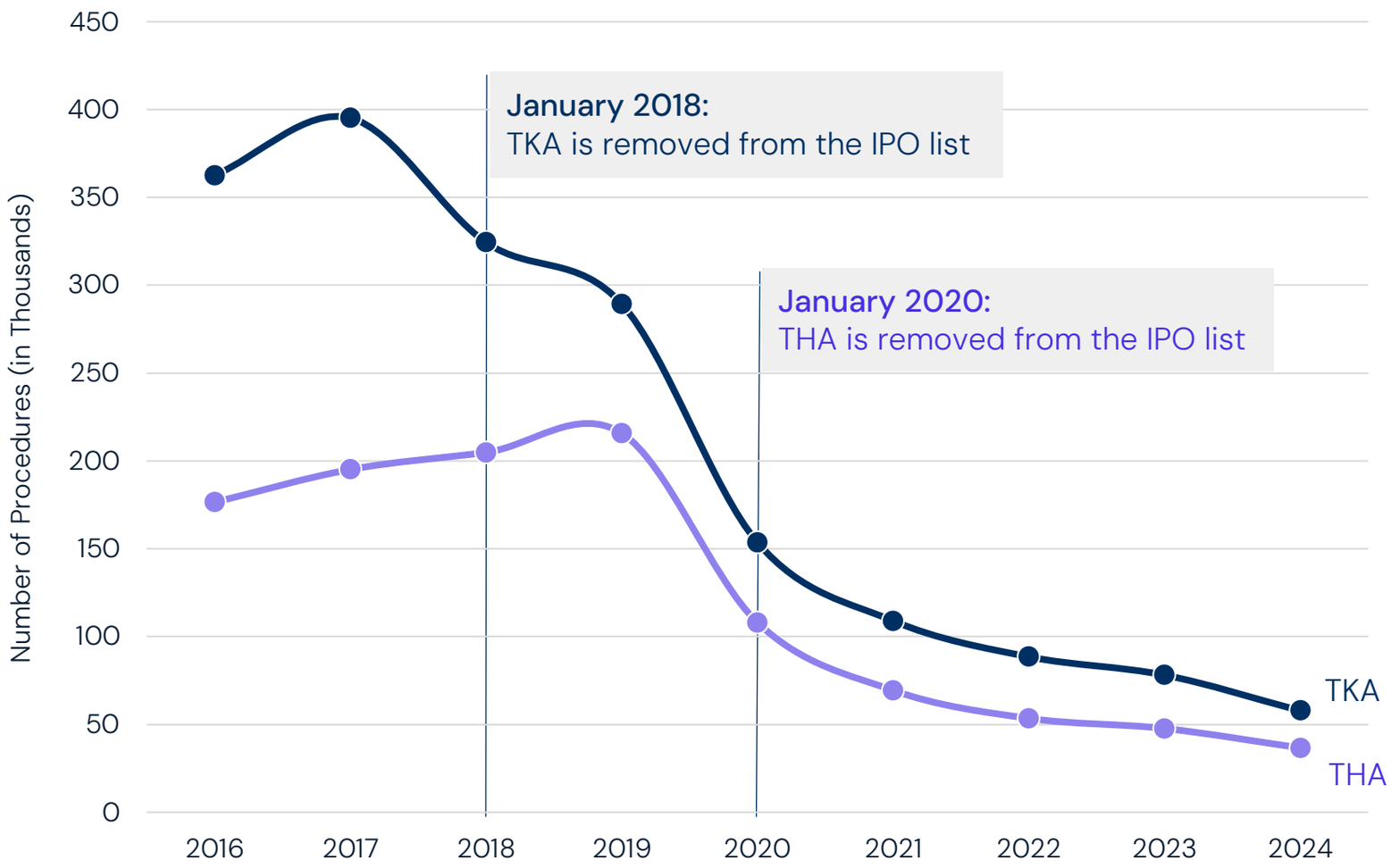


Note: Analysis is limited to commercially insured patients. Loyalty Share represents the share of a patient's hospital-based care rendered at the health system.
Source: Trilliant Health national all-payer claims database and Provider Directory.

Inpatient Surgical Volume Is Threatened by the Proposed IPO List Removal

In July 2025, CMS proposed to eliminate the Medicare IPO list over the next three years, beginning with 285 mostly musculoskeletal procedures. After TKAs were removed from the IPO list in 2018, inpatient volume declined by 17.9% from 2017 to 2018, with 2024 inpatient TKA volume 85.4% below 2017. Similarly, inpatient volume for THA declined by 35.8% in the year following its removal, with 2024 inpatient THA volume 66.1% below 2019.

Inpatient Medicare Total Knee Arthroplasty and Total Hip Arthroplasty, 2016-2024

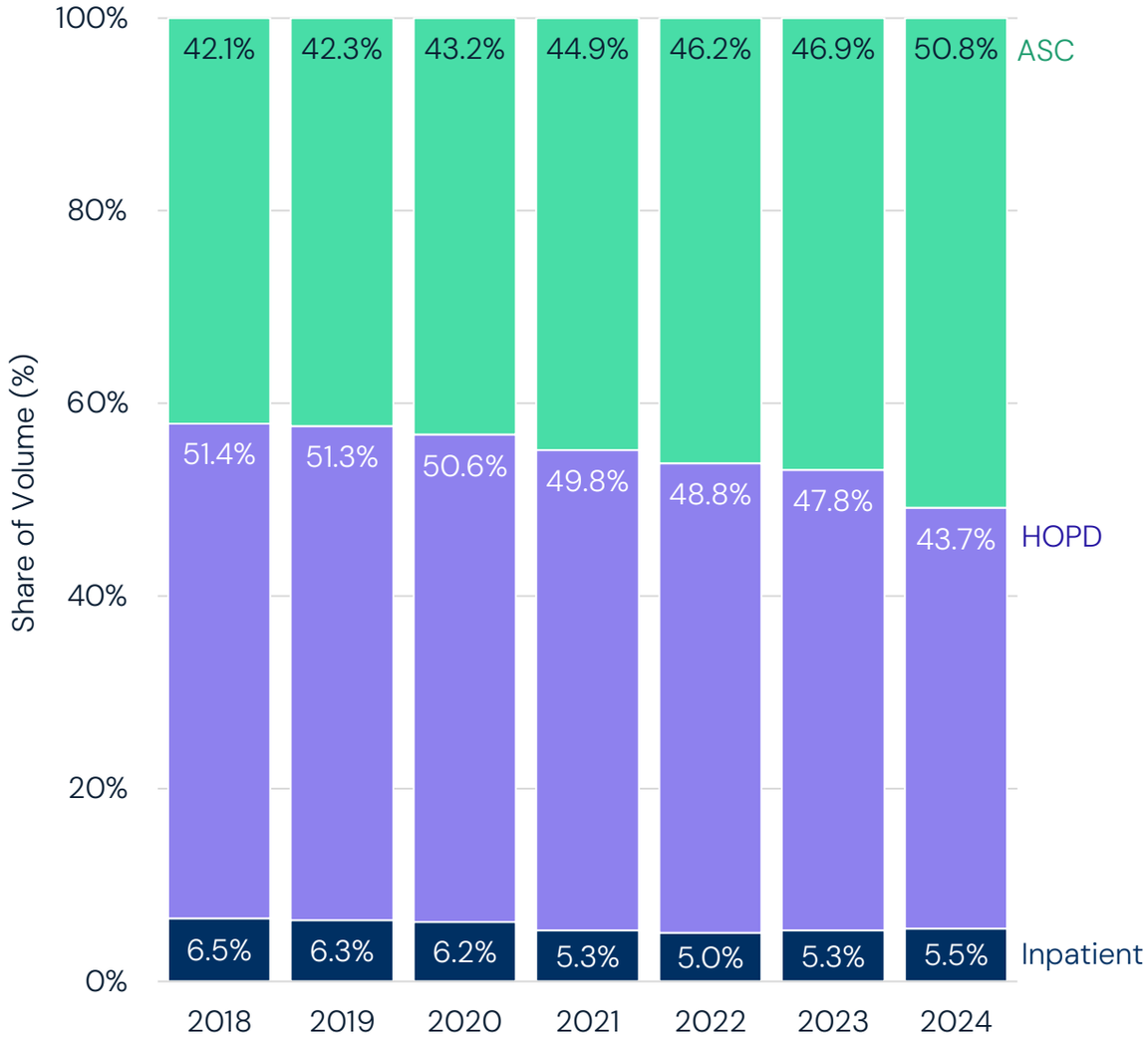


Note: IPO denotes Inpatient Only list; TKA denotes total knee arthroplasty; THA denotes total hip arthroplasty; CMS denotes Centers for Medicare and Medicaid Services. Analysis is limited to Medicare patients.
Source: Trilliant Health national all-payer claims database.

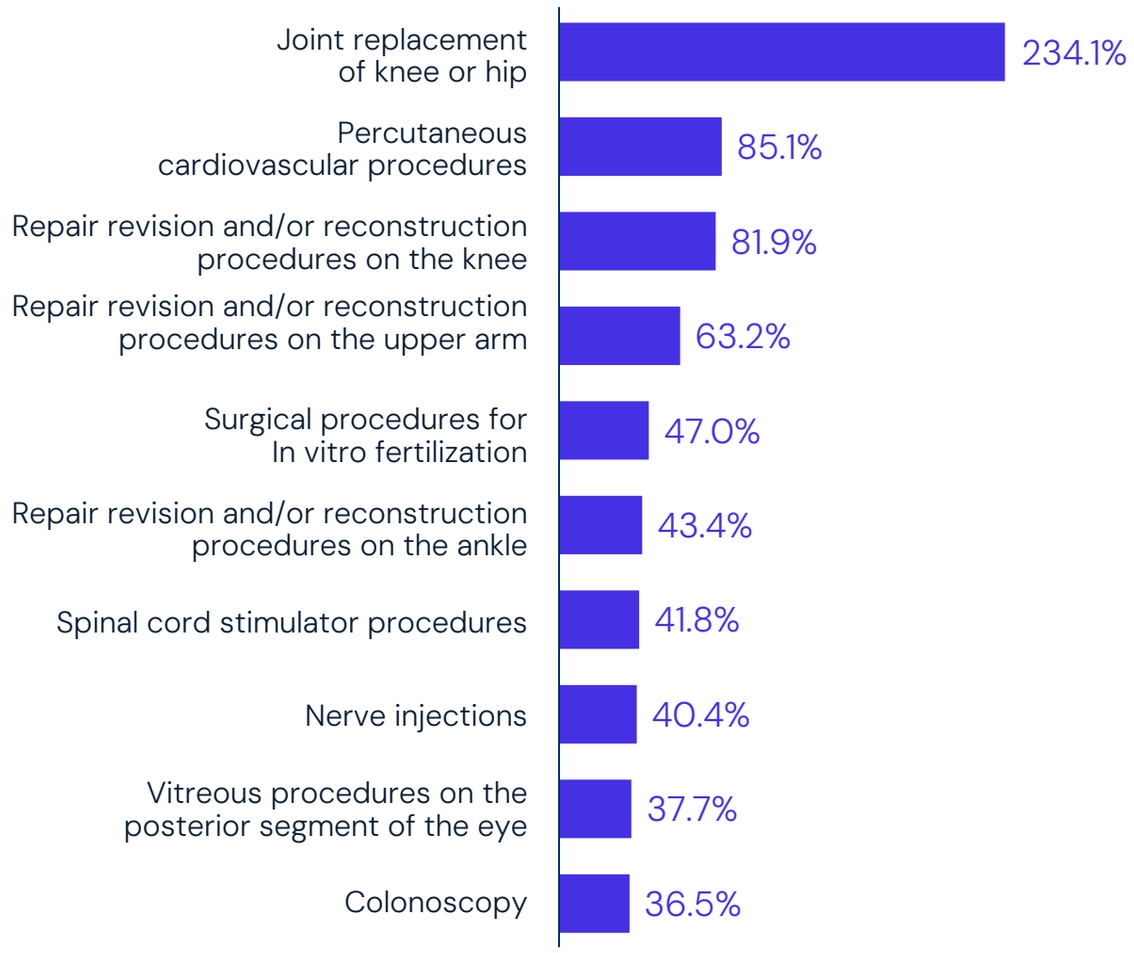
Surgical Care Continues To Migrate to ASCs

The share of ASC-eligible surgeries performed at ASCs increased by 8.7 PP from 2018 to 2024, accounting for 50.8% of surgeries in 2024. In contrast, the share of surgeries delivered in inpatient and HOPD settings has steadily declined. From 2018 to 2024, ASC-based hip and knee replacements increased most, up 234.1%.

Share of ASC-Eligible Surgeries, by Setting, 2018-2024



Percent Change in High-Growth ASC-Eligible Surgeries at ASCs, 2018 to 2024

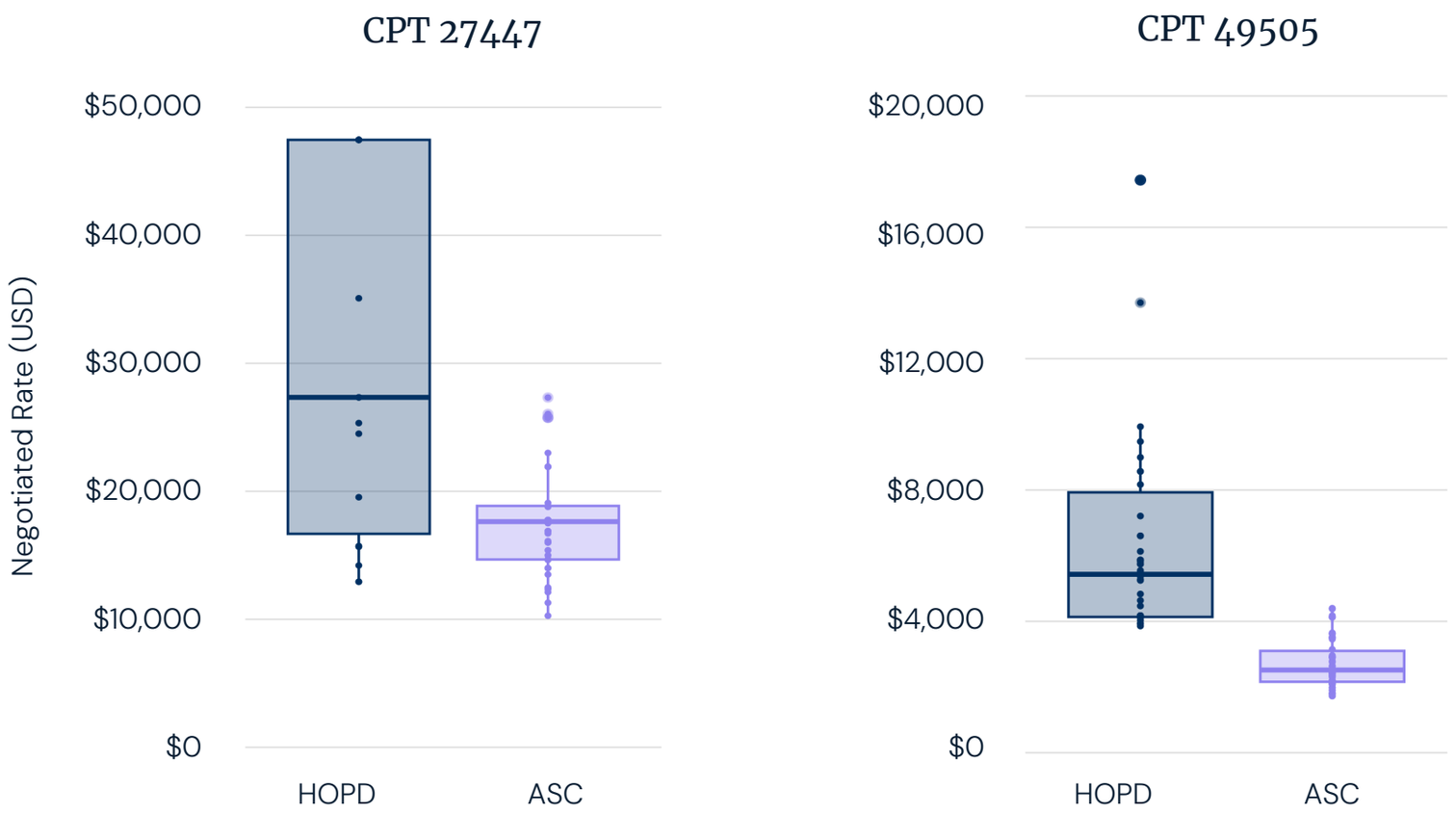


Note: ASC denotes ambulatory surgery center, HOPD denotes hospital outpatient department; PP denotes percentage point. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

Negotiated Rates Are Higher and More Variable at HOPDs Than ASCs

Negotiated rates are generally higher at HOPDs than ASCs. In Chicago, commercial negotiated rates for CPT 27447 range from $12,933 to $47,462 at HOPDs with a median of $27,340, compared to $10,275 to $27,326 at ASCs with a median of $17,631. For CPT 49505, HOPD rates range from $3,857 to $17,439 with a median of $5,433, while ASC rates range from $1,726 to $4,400 with a median of $2,518.

Commercial Negotiated Rates for CPTs 27447 and 49505 at ASCs and HOPDs in Chicago-Naperville-Elgin, IL-IN-WI, 2025



Note: ASC denotes ambulatory surgery center; HOPD denotes hospital outpatient department. CPT 27447 denotes arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty); CPT 49505 denotes repair initial inguinal hernia, age 5 years or older; reducible. Commercial negotiated rates are reflected for a single national payer – UnitedHealthcare.
Source: Trilliant Health health plan price transparency dataset and Provider Directory.

Outpatient Migration Will Shift Revenue to ASCs and Reduce Spending

In July 2025, CMS proposed to eliminate the Medicare IPO list. Lumbar spinal fusion (CPT 22558) is among the proposed procedures that would also be moved to the ASC CPL. When 100% of Medicare lumbar spinal fusions are inpatient, spending total $1.1B. However, if 50% of lumbar spinal fusions were performed in HOPDs and 50% in ASCs, expenditures would total $760.2M, a net reduction of $359.8M.

Potential Scenarios for Medicare Inpatient vs. Outpatient Lumbar Spinal Fusion Utilization and Associated Spending

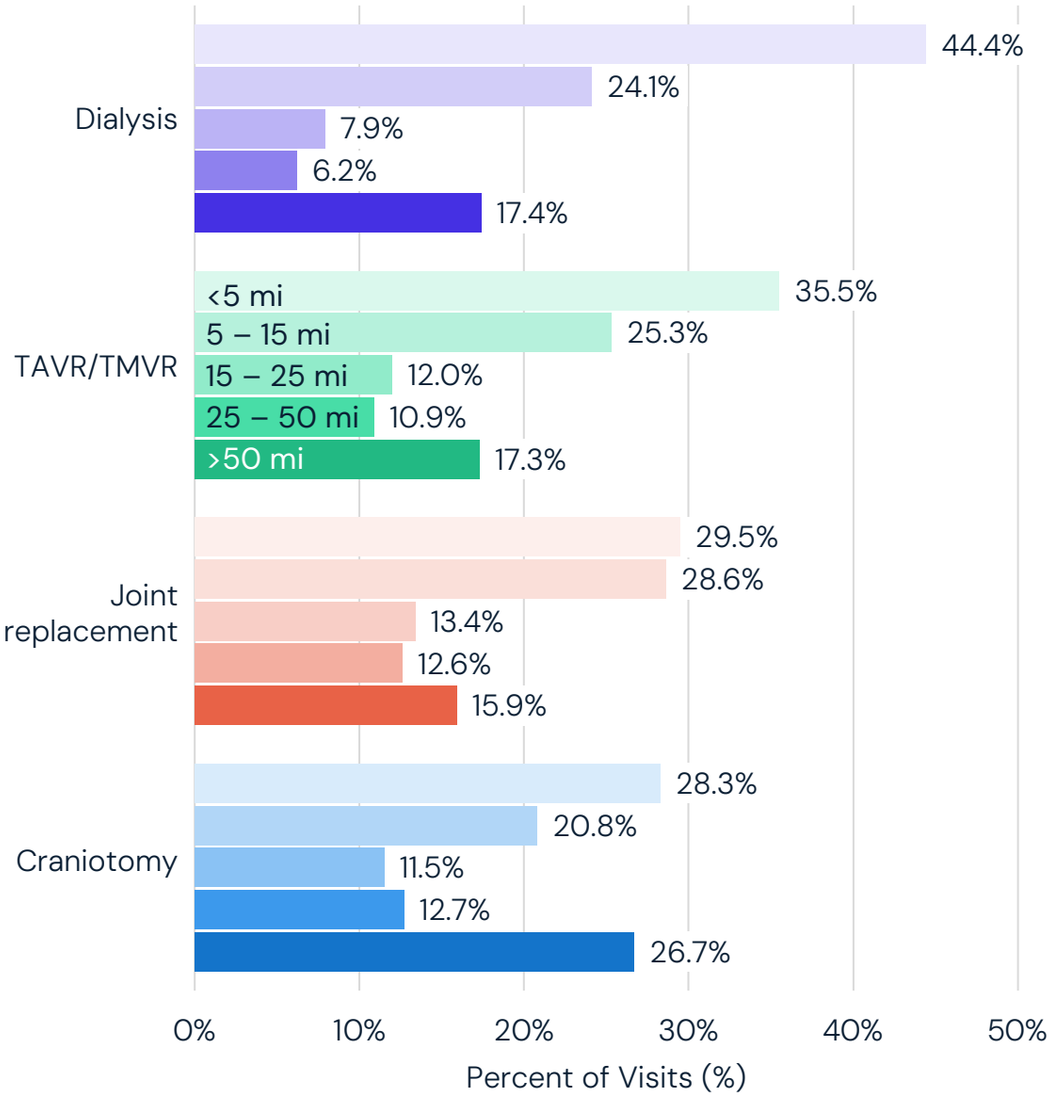
Scenario	Description	Volume x Payment	Spending (USD)
Scenario 1	• 100% Inpatient	• 40,000 Lumbar spinal fusion x $28,000	**$1.1B**
Scenario 2	• 50% Inpatient • 50% HOPD	• 20,000 Lumbar spinal fusion x $28,000 • 20,000 Lumbar spinal fusion x $21,538	**$990.8M**
Scenario 3	• 40% Inpatient • 30% HOPD • 30% ASC	• 16,000 Lumbar spinal fusion x $28,000 • 12,000 Lumbar spinal fusion x $21,538 • 12,000 Lumbar spinal fusion x $16,470	**$904.1M**
Scenario 4	• 5% Inpatient • 55% HOPD • 40% ASC	• 2,000 Lumbar spinal fusion x $28,000 • 22,000 Lumbar spinal fusion x $21,538 • 16,000 Lumbar spinal fusion x $16,470	**$793.4M**
Scenario 5	• 50% HOPD • 50% ASC	• 20,000 Lumbar spinal fusion x $21,538 • 20,000 Lumbar spinal fusion x $16,470	**$760.2M**

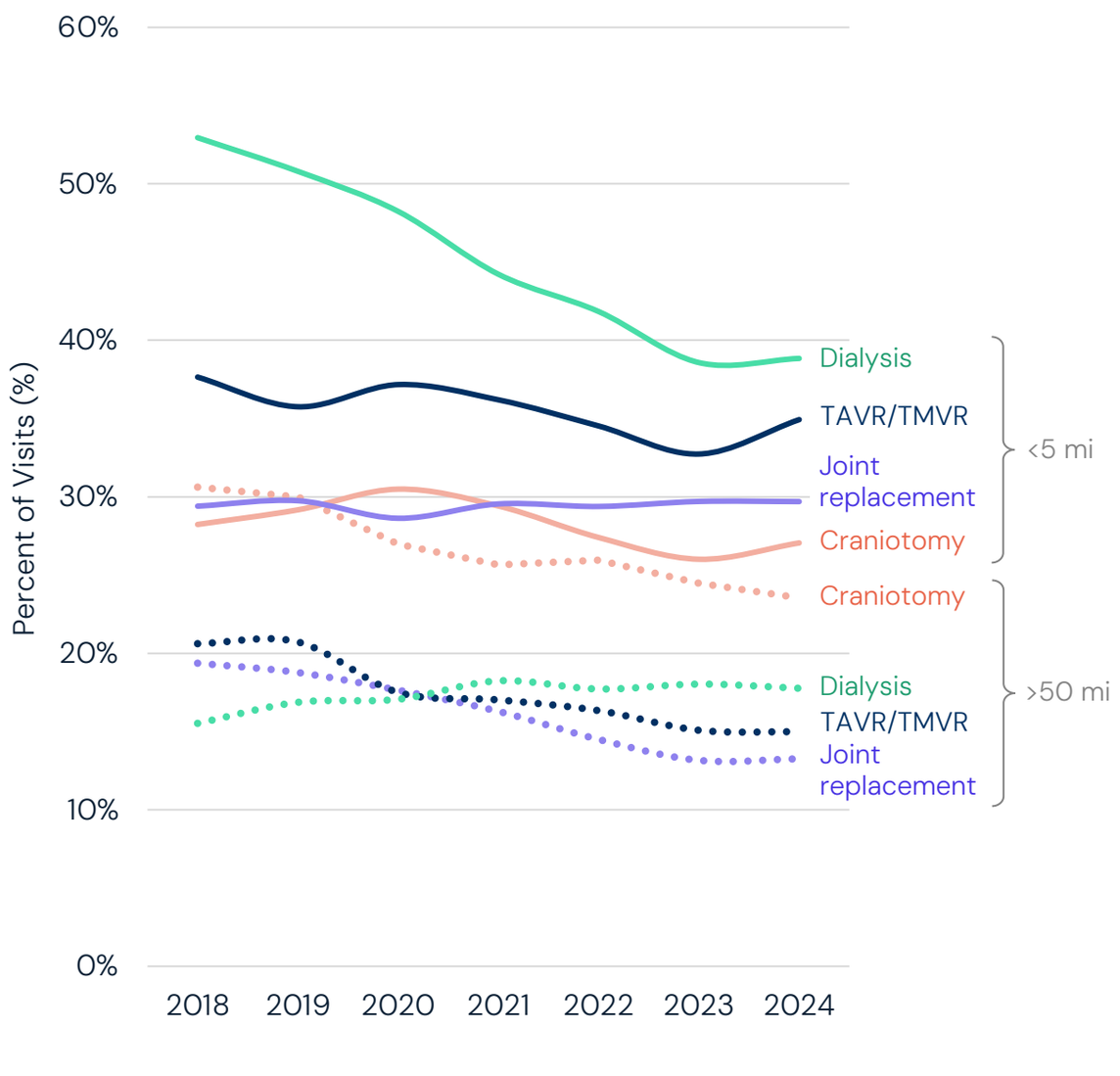
Note: ASC denotes ambulatory surgery center; CMS denotes Centers for Medicare and Medicaid Services; CPL denotes Covered Procedures List; HOPD denotes hospital outpatient department; IPO denotes Inpatient Only list. CPT 22558 denotes arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar. Because CPT 22558 is currently designated as an inpatient-only procedure, no outpatient Medicare rates exist. To approximate outpatient payment levels, ratios of inpatient-to-HOPD-to-ASC rates from other comparable procedures were applied.
Source: Centers for Medicare and Medicaid Services Inpatient and Outpatient Prospective Payment Systems.

Patient Travel Depends on Procedure Complexity and Access to Care

For ongoing chronic condition management, 44.4% of dialysis care occurs within five miles of a patient's home, compared to 28.3% for craniotomy, 29.5% for joint replacement and 35.5% for TAVR/TMVR. From 2018 to 2024, the proportion of surgeries performed more than 50 miles from a patient's home declined by 6.3 PP, compared to a 2.2 PP increase in dialysis. The increased travel for dialysis care could be explained by facility closures, while reduced travel for surgical care could be an indicator of broader accessibility.

Distribution of Select Procedures, by Distance Traveled, 2018-2024



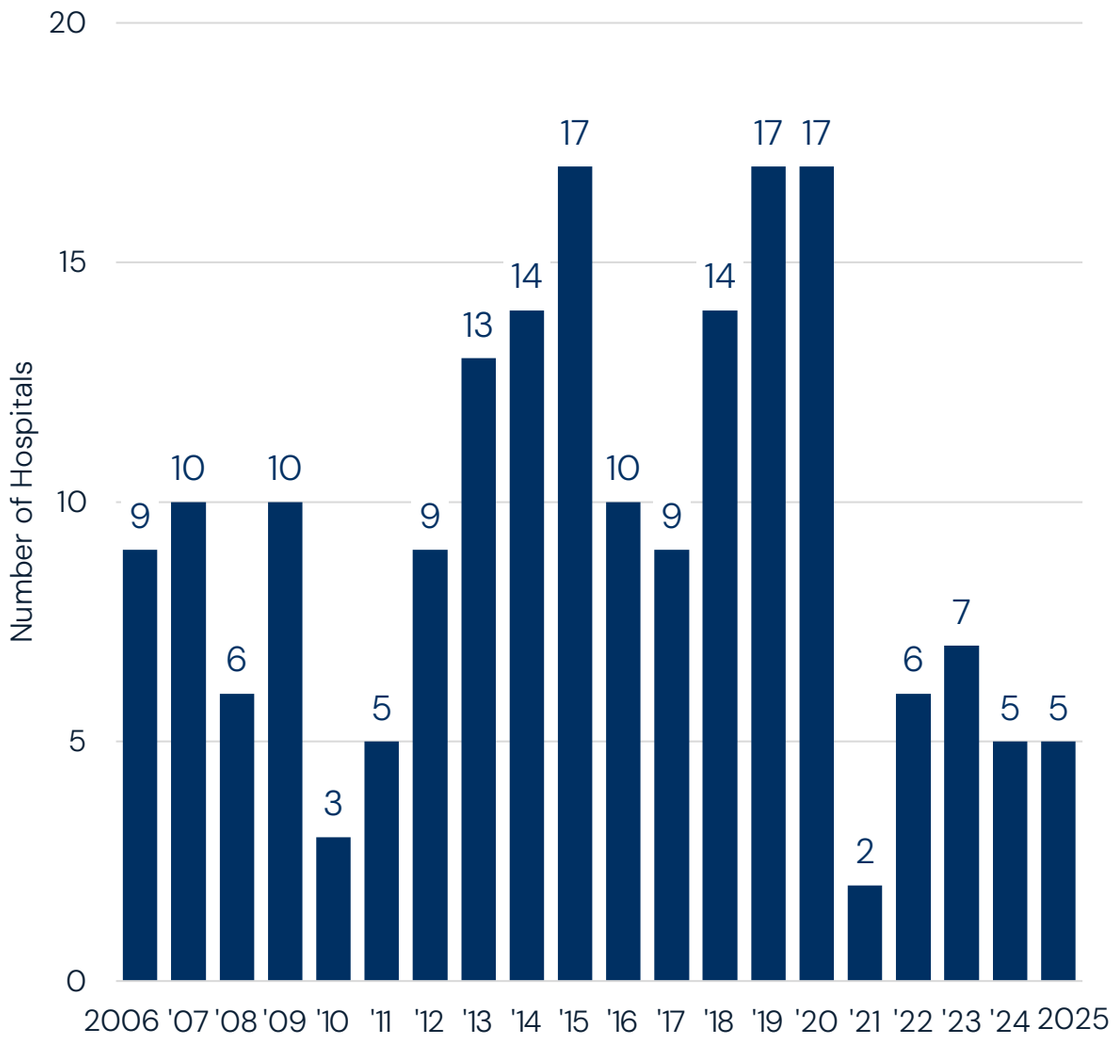


Note: TAVR/TMVR denotes transcatheter aortic valve replacement/transcatheter mitral valve replacement; PP denotes percentage point. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

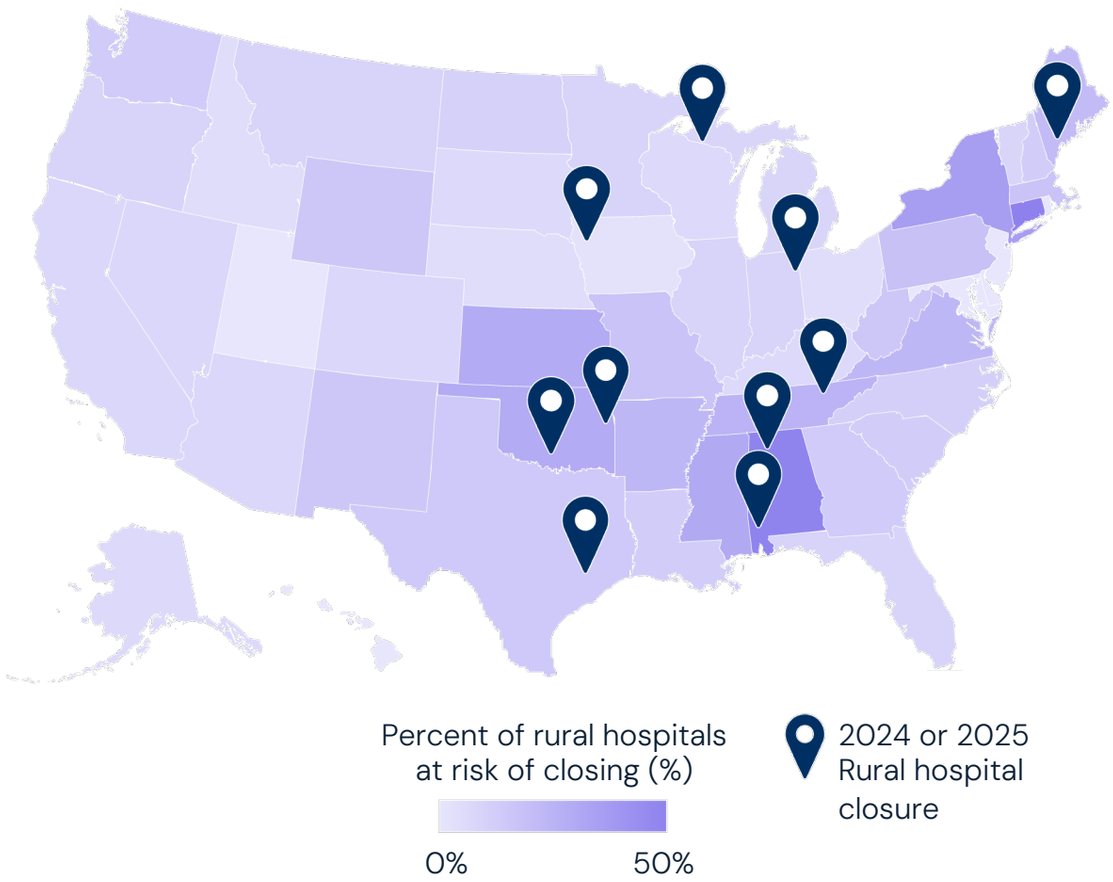
Rural Care Access Is Shrinking as Hospitals Close and Cut Inpatient Services

Since 2015, 109 rural hospitals have closed, and since 2023, 40 more have shifted to emergency-only care. Currently, 314 rural hospitals remain at immediate risk of closure, while another 760 are financially vulnerable. Despite low demand and limited reimbursement, many remain open as the sole care provider and as a critical anchor to the local economy.

Rural Hospital Closures, 2006-2025



Percent of Rural Hospitals at Immediate Risk of Closing, by State, as of June 2025

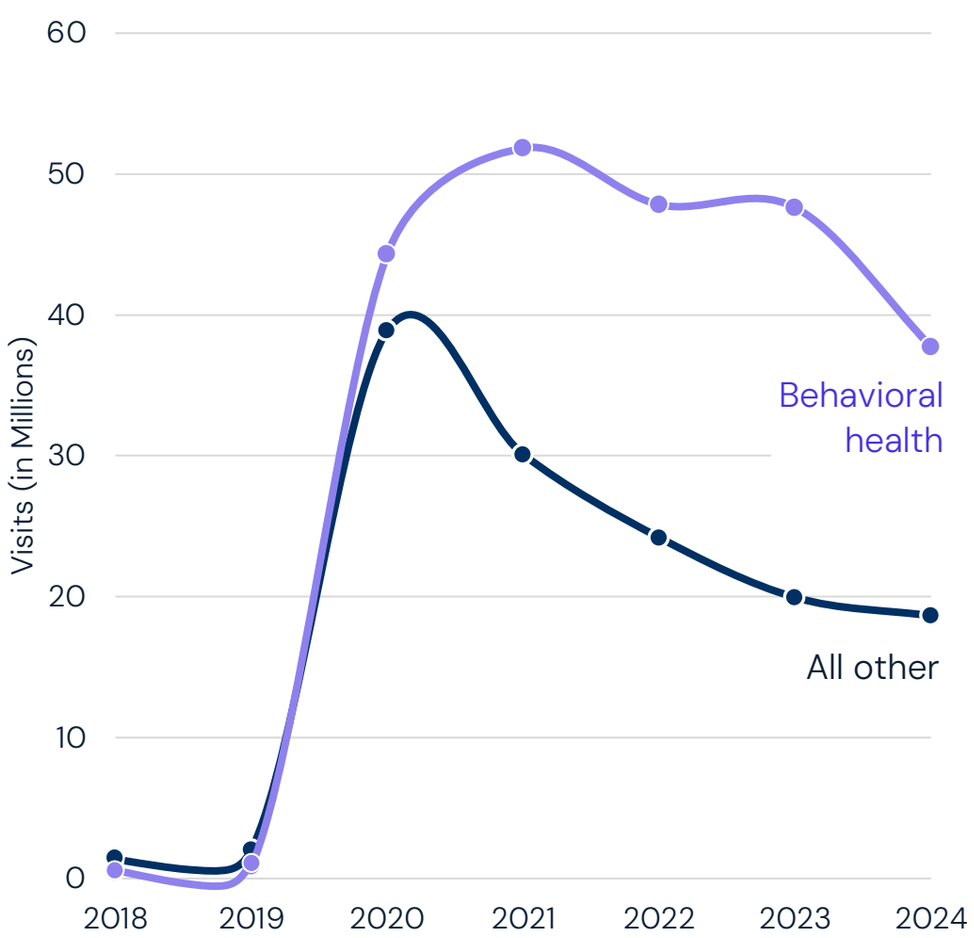


Source: The Cecil G. Sheps Center for Health Services Research; Becker's Hospital CFO Reports; Center for Healthcare Quality and Payment Reform.

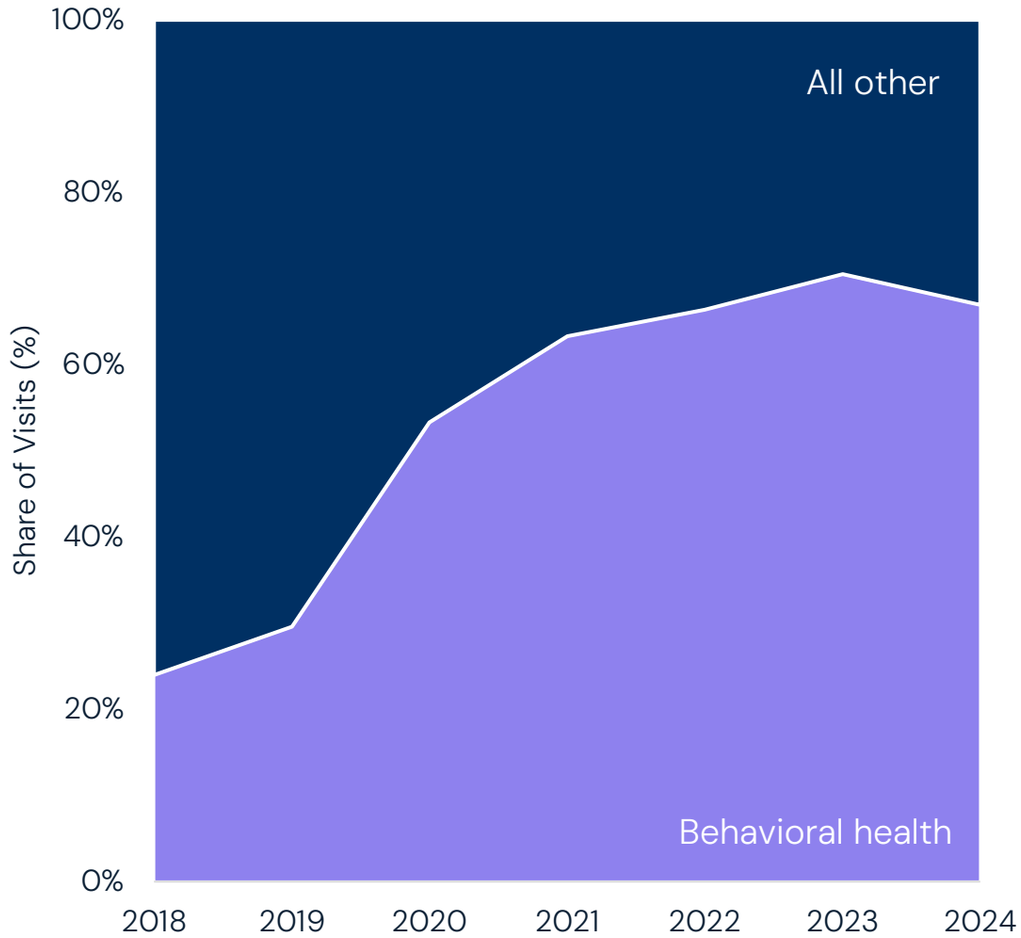
Telehealth Utilization Continues To Decline

Since 2020, telehealth volume has declined by 32.2%, down 52.0% for non-behavioral virtual care. Telehealth for the treatment and management of behavioral health conditions has emerged as a viable substitute for in-person care but declined from 70.5% of all telehealth volume in 2023 to 66.9% in 2024.

Telehealth Visits, Behavioral Health and All Other, 2018-2024



Share of Telehealth Utilization, Behavioral Health and All Other, 2018-2024



Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

Most Patients Receive In-Person Care Exclusively

Across age groups, most patients consistently pursue in-person only healthcare. While hybrid care peaked amid the COVID-19 pandemic, it has declined but stabilized at over 25% for patients ages 18-44 and is lowest among children. Across adult age groups, women are more likely to pursue hybrid care than men.

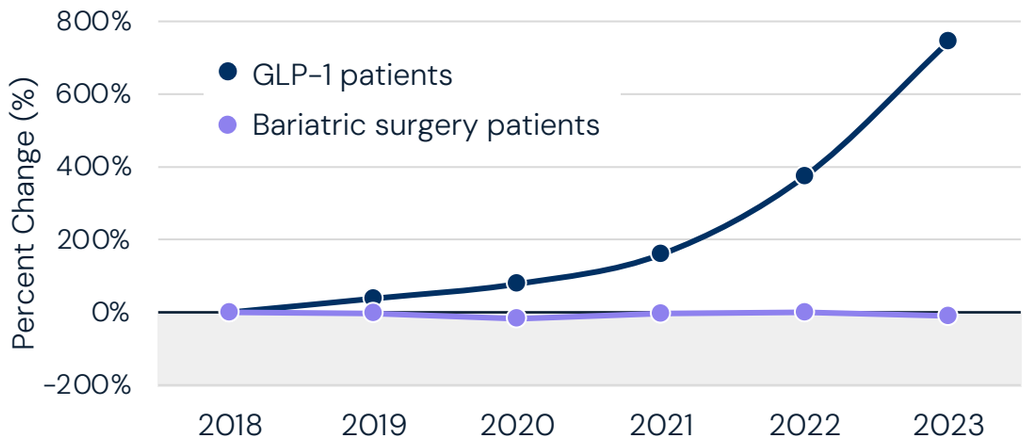
Share of In-Person Only, Hybrid and Telehealth Only Patients, by Age and Gender, 2018, 2020, 2022 and 2024

Note: Hybrid care includes both in-person care and telehealth. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

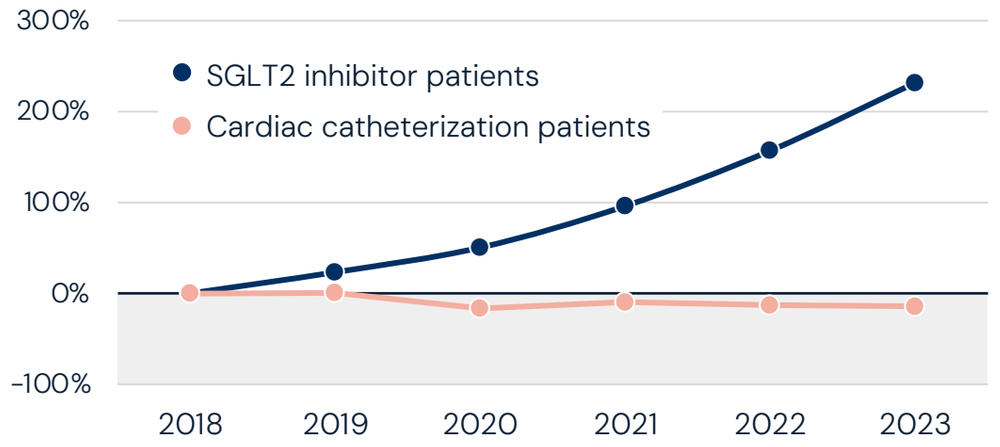
Surgical Procedures May Be Imperiled by Novel Drugs

As new therapies enter the market, the prevailing procedure-based approach to care will change. Between 2018 and 2023, GLP-1 patients increased by 744.6%, while bariatric surgery volume was flat to declining. During the same period, SGLT2 inhibitor patients grew by 231.7% as cardiac catheterization volume declined by 14.4%. However, in both clinical use cases, a small patient cohort was prescribed medications both before and after surgery, calling into question the extent to which these medications serve as replacements versus supplements to surgery.

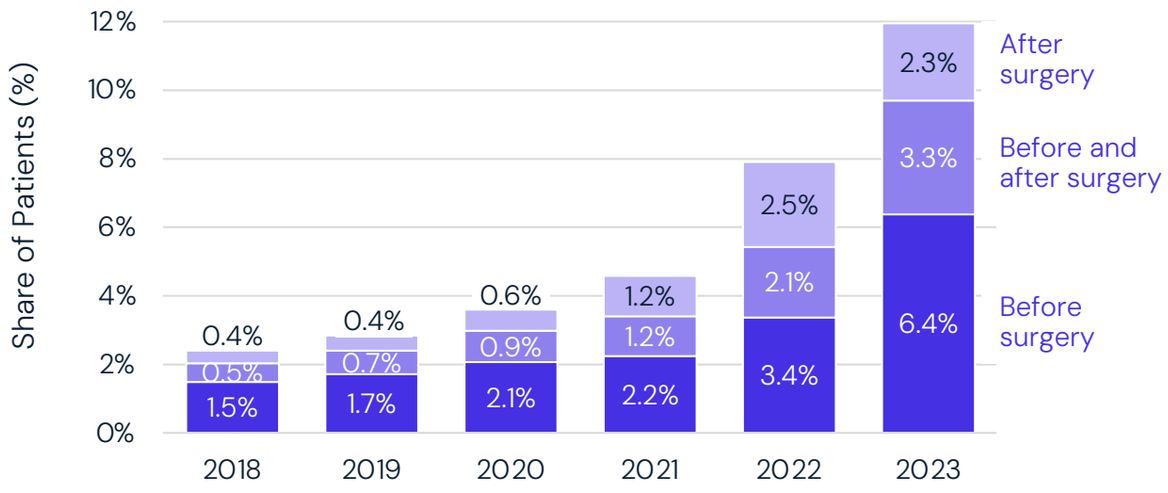
Percent Change in **GLP-1** and **Bariatric Surgery** Patient Volume, Compared to 2018, 2018-2023



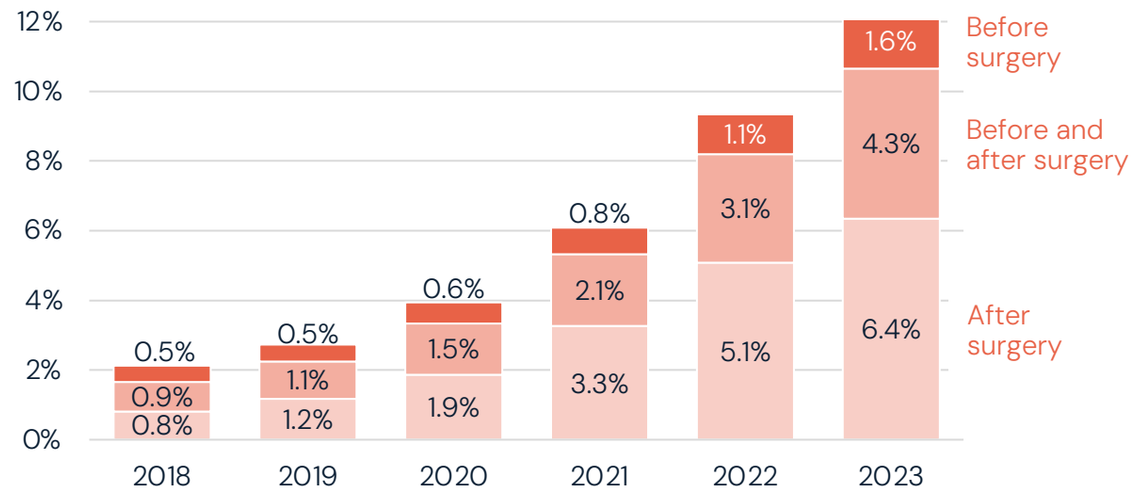
Percent Change in **SGLT2 Inhibitor** and **Cardiac Catheterization** Patient Volume, Compared to 2018, 2018-2023



Percent of **Bariatric Surgery** Patients With a **GLP-1** Prescription Before or After Surgery, 2018-2023



Percent of **Cardiac Catheterization** Patients With a **SGLT2 Inhibitor** Prescription Before or After Surgery, 2018-2023



Note: SGLT2 inhibitor denotes sodium-glucose cotransporter 2; GLP-1 denotes glucagon-like peptide 1. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DTC Prescribers Are Influencing the Patient Journey More Often

DTC prescribing-focused new entrants offer expanded choices for consumers. With vertical integration, these stakeholders will influence more of the prescription drug patient journey, disrupting traditional patient-provider relationships, potentially increasing care fragmentation and duplication.

DTC Prescribing-Focused New Entrants

	amazon RxPass clinic	WeightWatchers	NURX.	GoodRx Care	Cerebral	hims & hers	NovoCare	Lilly Direct
Price Point	**$5**/month	**$9**/month for membership **$199** for non-Prime members for membership annually **$29-$49**/ visit without membership	Starts at **$84**/month + cost of prescription	**$30-$80**/ consultation **$6-$48+**/ month for medication management	**$10-20**/ month for membership **$19-$49**/ consultation + prescription cost	**$60**/month for just RX **$365**/month for RX and therapy	**$69-$1,799**/ month	**$35**/month	**$199-$299** for consultation + **$149** for subsequent visit or **$299** per month + prescription cost
Included Drugs	50+ low-cost generics	Sexual health, dermatological treatments, other low-acuity services	GLP-1s only	GLP-1s, sexual health, dermatological treatments, behavioral health	Short-term refills, diabetes, dermatological treatments, sexual health, general health	ADHD, anxiety, bipolar disorder and depression treatments	GLP-1s, behavioral health, dermatological treatments	GLP-1s and diabetes	GLP-1s, diabetes, memory and thinking, migraine, sleep apnea
Mail-Order Required?	**Yes**	**No**	**Yes**	**Yes**	**No**	**Yes**	**Yes**	**No**	**Yes**
Prescribing or Dispensing?	Dispensing only	Prescribing only	In-house prescribing and dispensing	In-house prescribing and dispensing	Prescribing only	In-house prescribing and dispensing	In-house prescribing and dispensing	Dispensing only	In-house prescribing and dispensing
Subscription/ Membership Required?	**Yes**	Available but not required	**Yes**	**No**	Available but not required	**Yes**	Required for subscription medications	**No**	**No**

Note: GLP-1 denotes glucagon-like peptide 1; ADHD denotes attention deficit hyperactivity disorder; DTC denotes direct-to-consumer.
Source: Publicly available company information.

Established Companies and New Entrants Are Betting on DTC Diagnostics

The DTC diagnostics market is expected to grow, with a projected value of $6.8B by 2032. Since 2022, Labcorp has expanded from its traditional focus on physician-ordered lab testing to offering over 60 diagnostic tests through its DTC business unit, Labcorp OnDemand.

DTC Diagnostic Test Categories

Annual Wellness
- Men's health tests
- Women's health tests
- Cancer screening
- Urine analysis

Nutrition
- Vitamin deficiency tests
- Celiac disease test
- Anemia test

Fertility and Sexual Health
- Pregnancy testing
- STI testing
- Paternity testing

Heart Health
- Diabetes risk tests
- General heart health tests

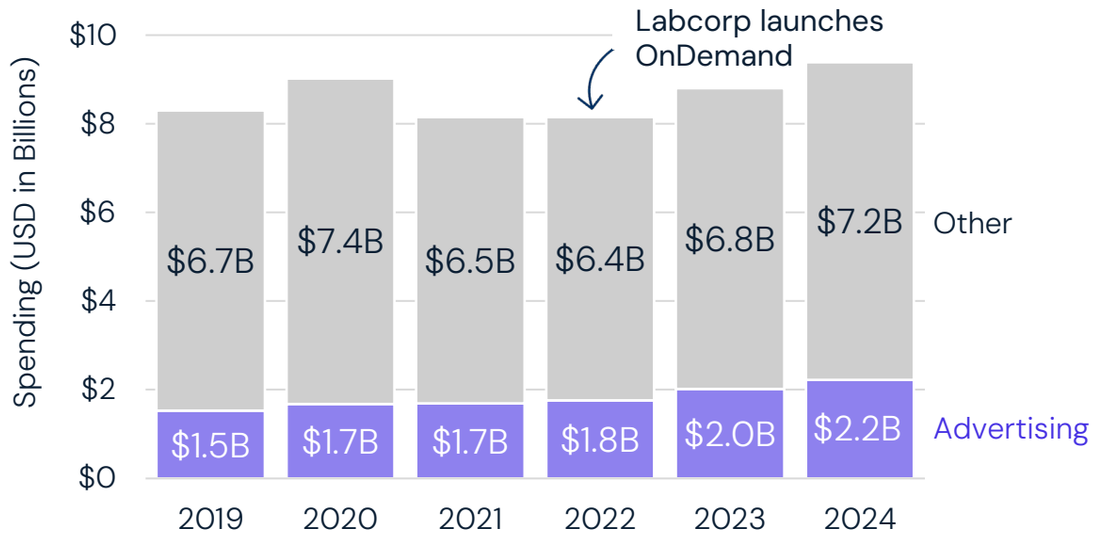
General Health
- Weight loss
- Drug testing
- Blood type testing
- Diabetes management and risk

Immunity/Infectious Disease
- COVID-19, tuberculosis, MMR, measles and chickenpox immunity tests
- PCR testing

Hormones
- Thyroid, testosterone and progesterone tests
- Menopause test

Allergy
- Dog and cat allergy tests
- Food allergy tests

Labcorp Advertising Expense as Share of Total Cost of Revenue, 2019-2024



TECH

Function Health buys Ezra, launches full-body scan for a third of the price

PUBLISHED MON, MAY 5 2025-12:00 PM EDT

Celebrity-Backed Startup Function Health Seeks $2 Billion Valuation

Co-founded by author and RFK Jr. ally Dr. Mark Hyman, Function sells a $499 package of lab tests for longevity.

HEALTH • HEALTH CARE

What Getting 105 Blood Tests From a Health Startup Taught Me

Note: DTC denotes direct-to-consumer; STI denotes sexually transmitted infection; PCR denotes polymerase chain reaction; MMR denotes measles, mumps and rubella.
Source: Publicly available company information; Labcorp Annual Income Statements, 2019, 2020, 2021, 2022, 2023 and 2024.

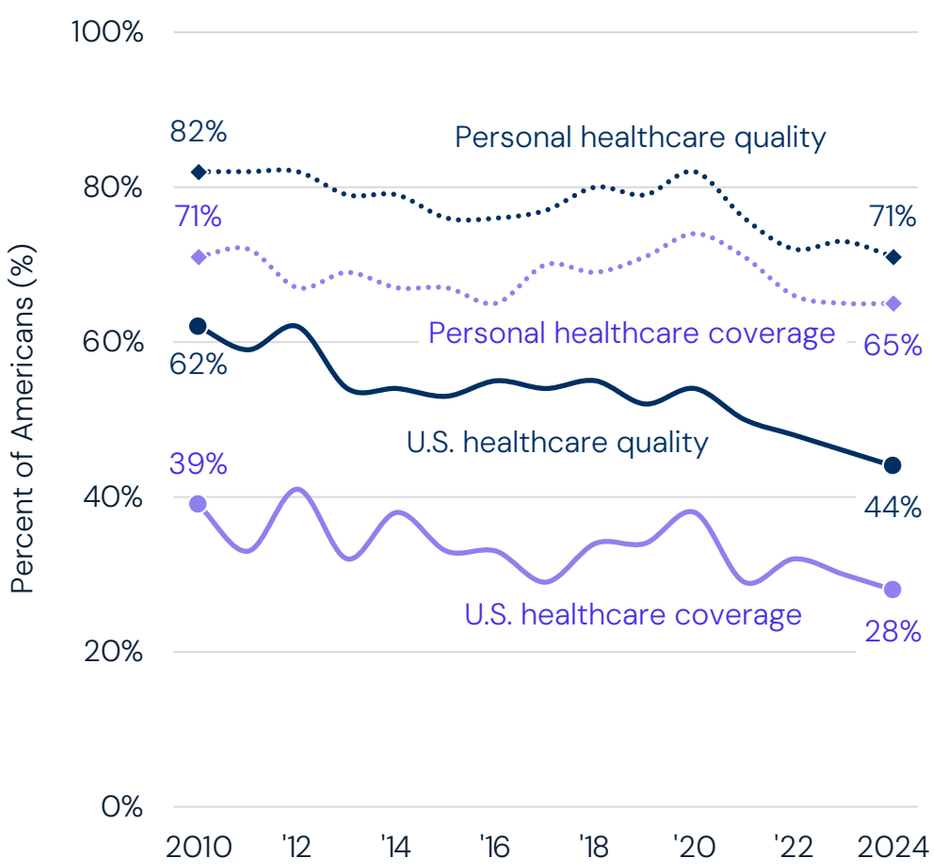
TREND 6

If Industry Cannot Deliver Value For Money and Employers Will Not Demand It, the Government Is Prepared to Force It

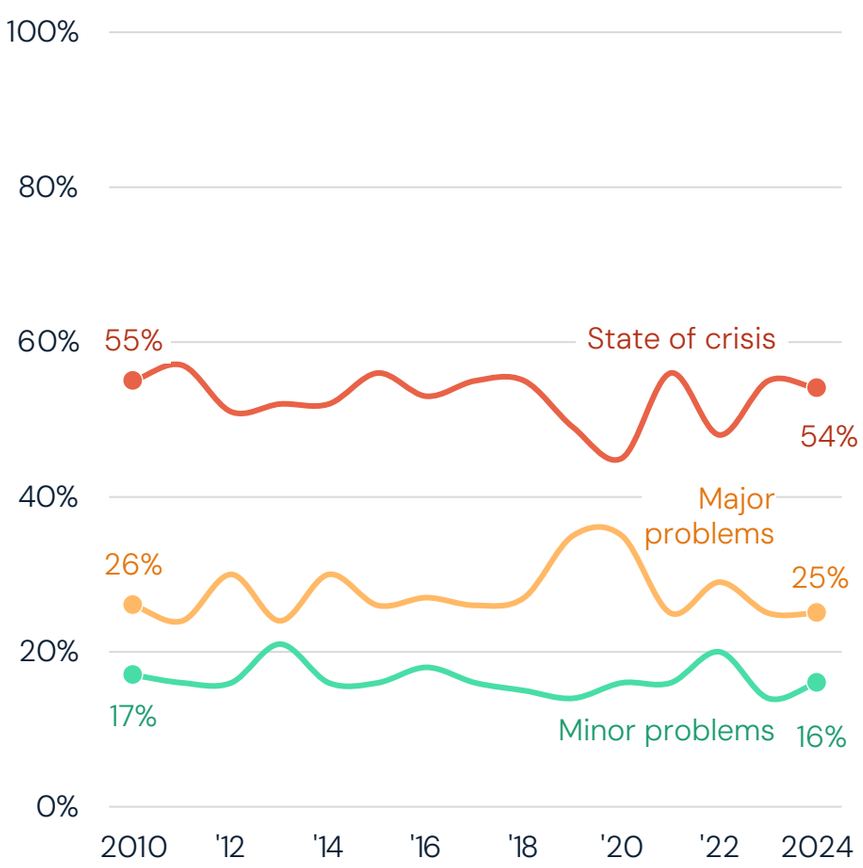
Dissatisfaction With the U.S. Healthcare System Persists

Americans express discontent with the U.S. healthcare system, despite rating their personal healthcare quality higher. In 2024, 65% of Americans characterized their own healthcare coverage as "good or excellent," while just 28% view system-wide coverage in the same way. At the same time, 54% reported that the system is in a state of crisis.

Share of Americans Reporting Good/Excellent Healthcare Quality and Coverage, 2010-2024



Americans Overall Views of the Condition of the U.S. Healthcare System, 2010-2024

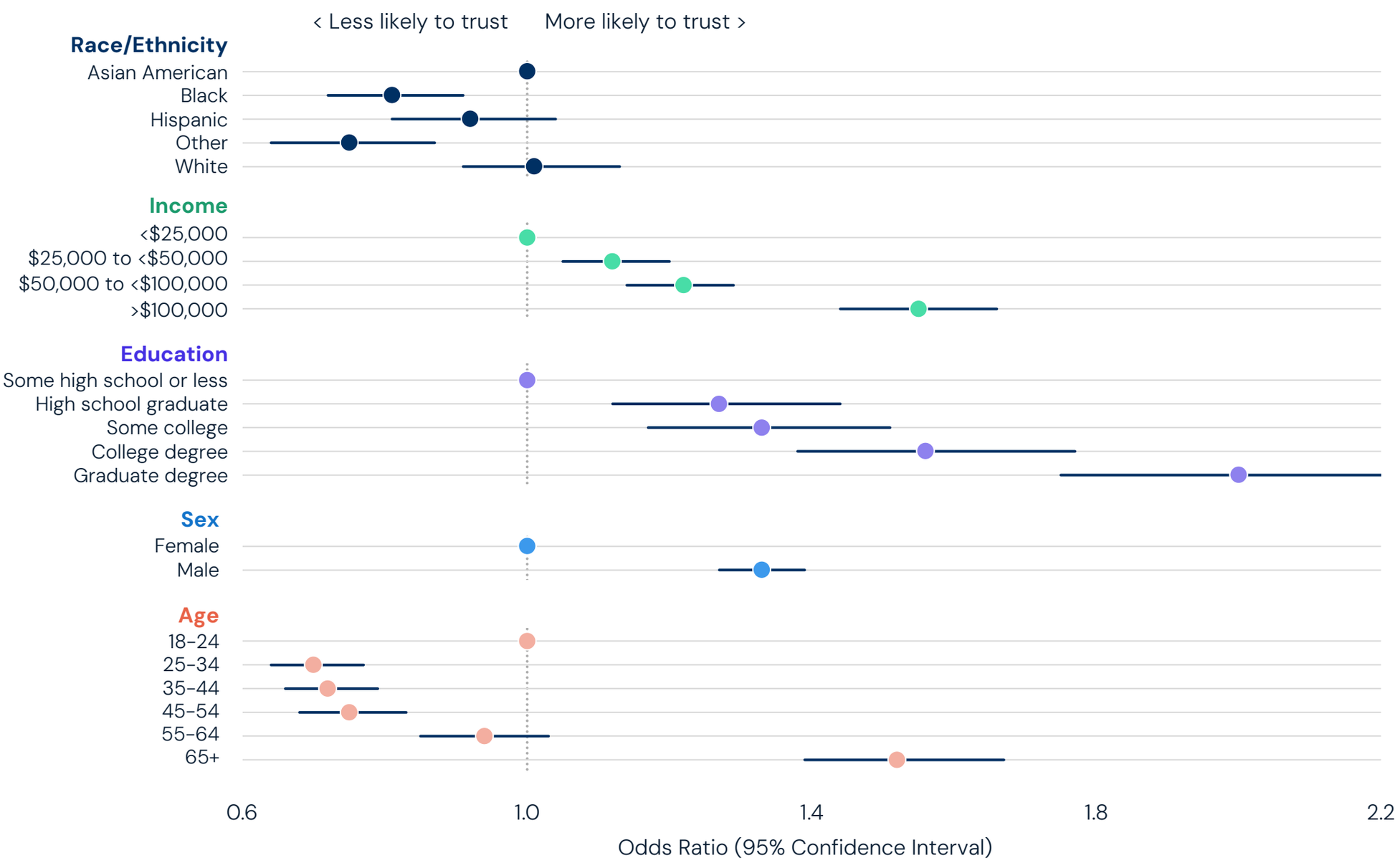


Note: Respondents who said the healthcare system does not have any problems or who had no opinion are not shown.
Source: Gallup, View of U.S. Healthcare Quality Declines to 24-Year Low, 2024.

Patient Demographics Influence Level of Trust in Physicians and Hospitals

White adults, those with incomes over $100,000, men, those with college or graduate degrees and those over age 65 were more likely to trust physicians and hospitals compared to other sociodemographic groups.

Association Between Individual Sociodemographic Features and Trust in Physicians and Hospitals, 2023

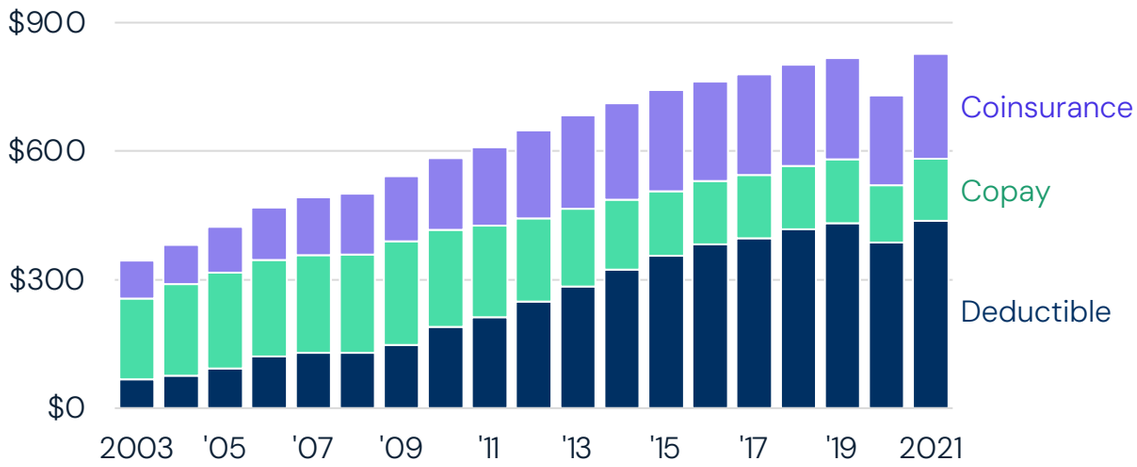


Note: The odds ratio compares the odds of one segment of a sociodemographic group having a different level of trust in physicians and hospitals compared to a baseline (i.e., patient segment with an odds ratio equal to 1.0). Segments with lower odds ratios (i.e., below 1.0) were less likely to trust physicians and hospitals. Sociodemographic group segments with higher odds ratios (i.e., above 1.0) were more likely to trust physicians and hospitals.
Source: Perlis et al., Trust in Physicians and Hospitals During the COVID-19 Pandemic in a 50-State Survey of US Adults, *JAMA Network Open*, 2024.

Employer Strategies to Contain Healthcare Costs Are Ineffective

Employer strategies to control healthcare costs have focused on increasing patient cost sharing via coinsurance, copays and deductibles. Not only has increased cost-sharing failed to meaningfully reduce overall healthcare spending, but it is associated with reductions in use of both low-value and high-value care. Despite this knowledge, employers remain focused on increasing premium contributions, moving to HDHPs and implementing wellness programs.

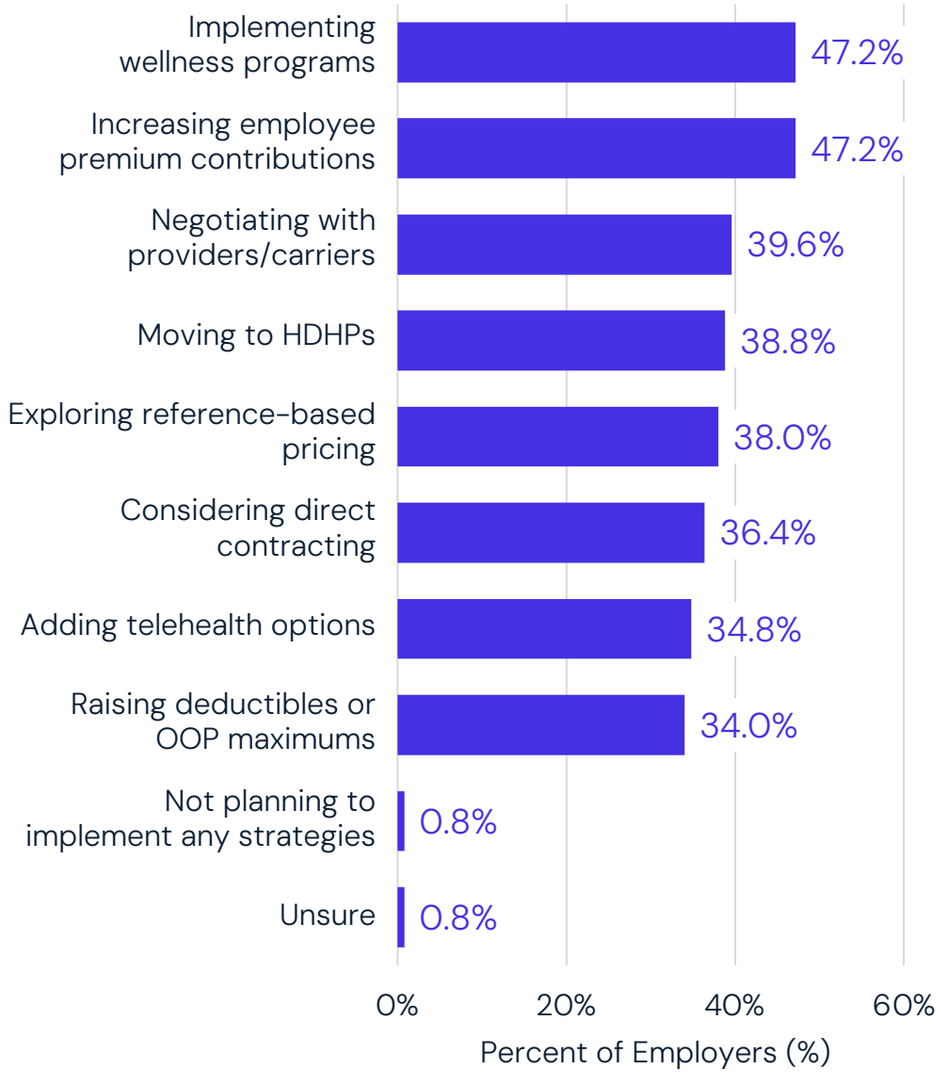
Average OOP Spending for People with Large Employer Coverage, by Type of Cost Sharing, 2003-2021



Predicted Percent of Patients with an Episode of Care in One Year, by Medical Effectiveness and Plan Type

	Adults		Children	
Medical Effectiveness	Free Care	Cost Sharing	Free Care	Cost Sharing
Quite effective	23%	18%	22%	18%
Less effective	30%	19%	13%	10%
Rarely effective	11%	7%	5%	3%

Reported Employer Healthcare Cost Containment Strategies, 2025

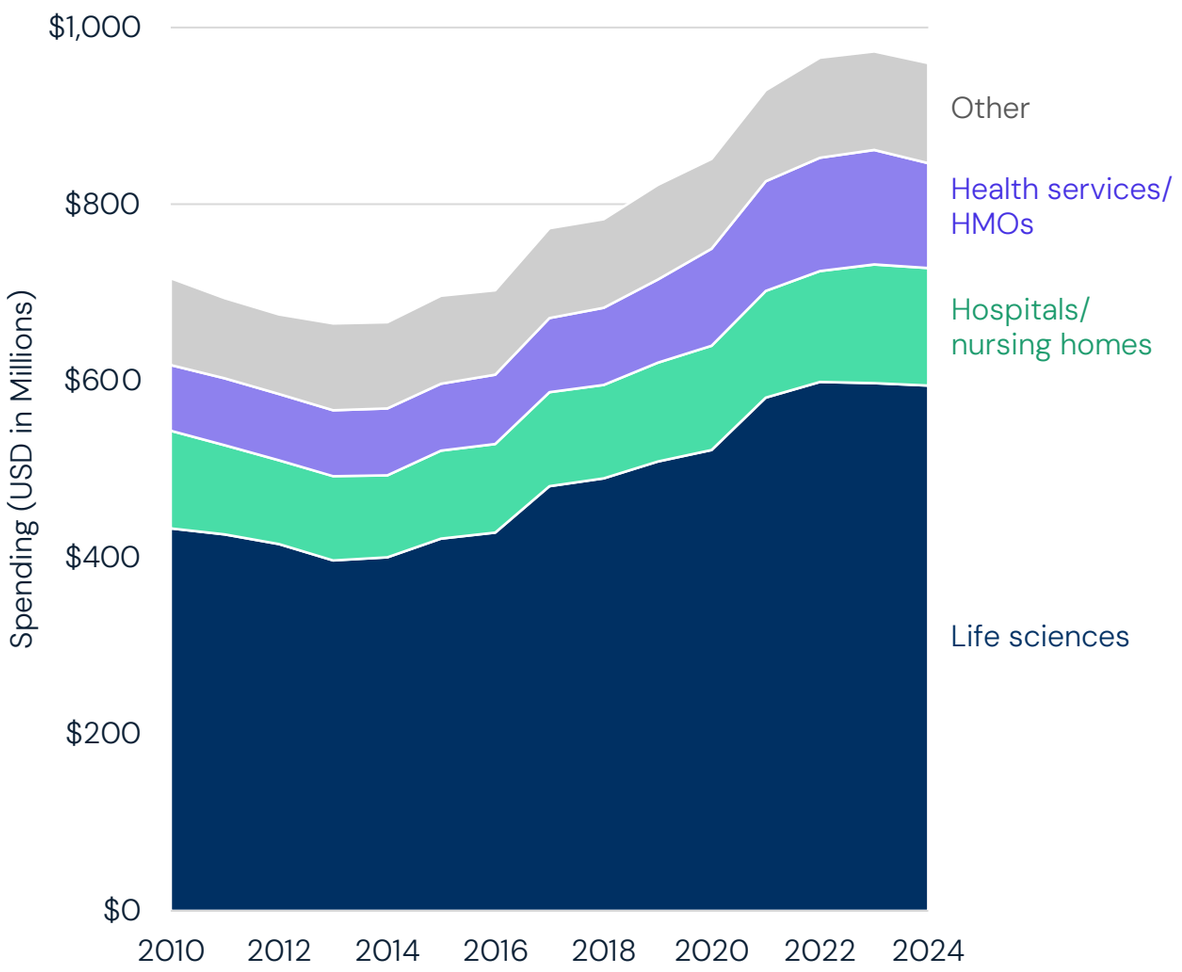


Note: HDHP denotes high-deductible health plan; OOP denotes out-of-pocket spending.
Source: Peterson-KFF Health System Tracker; Lohr et al., Use of Medical Care in the RAND Health Insurance Experiment, Medical Care, 1986; *Rezilient*, 2025.

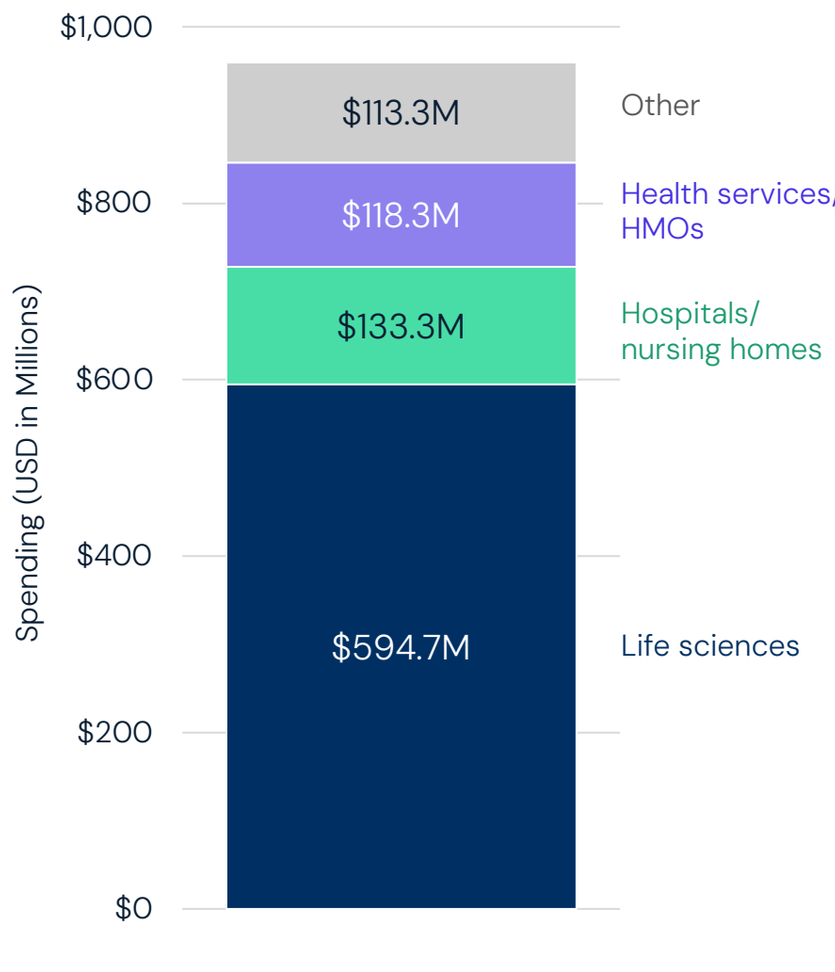
Outsized Healthcare Lobbying Spending Reinforces the "Status Quo"

From 2010 to 2024, lobbying spending by health economy stakeholders grew by 34.0%, from $716.0M to $959.5M. Life sciences consistently represents the largest proportion of healthcare lobbying each year, accounting for 62.0% of spending in 2024.

Healthcare Lobbying Spending, by Stakeholder, 2010-2024



Healthcare Lobbying Spending, by Stakeholder, 2024



Note: HMO denotes health maintenance organization. Life sciences was calculated by summing lobbying spending from medical supplies, pharmaceutical manufacturing and pharmaceuticals/health products; Other was calculated by summing lobbying spending from chiropractors, dentists, health professionals, nurses and nutritional and dietary supplements.
Source: The Senate Office of Public Records Lobbying Disclosure Act Reports.

High and Increasing Drug Prices Are Unsustainable

The 10 most expensive specialty drugs range from $1.1M to $4.3M for either a single dose or annual treatment, depending on the drug. Drug prices often continue to increase in the years following launch. For example, Enbrel® and Stelara® saw WAC increases of 254% and 179% since drug launch.

Most Expensive Specialty Drugs, 2024

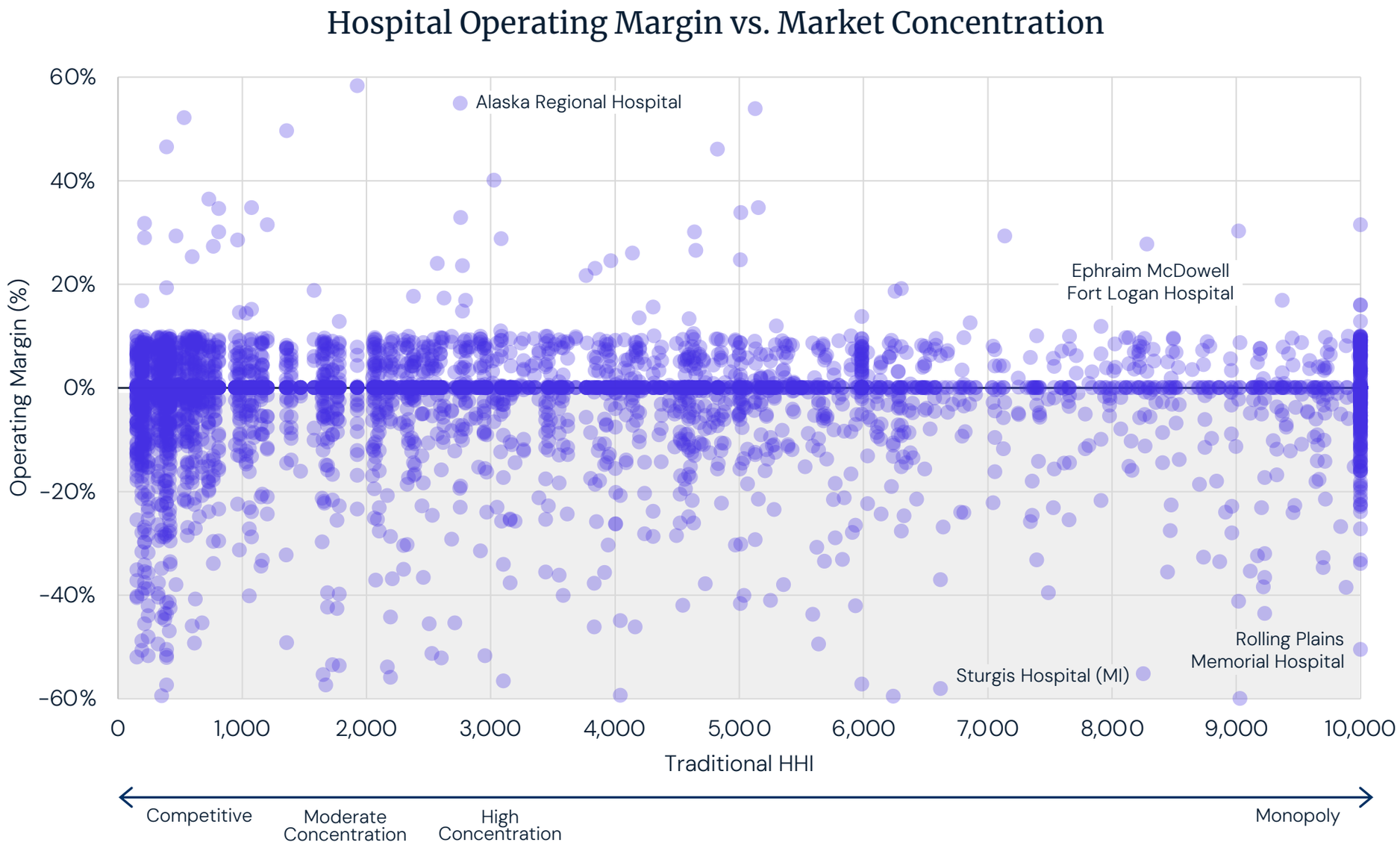
Drug Spending and Price Increases Since Launch for Select Medicare Part D Drugs, 2019-2024

	Medicare Spending 2023 (USD in Billions)	Growth in Medicare Spending (2019-2023)	WAC Increase Since Launch (%)
Enbrel®	$2.9B	45%	254%
Stelara®	$3.0B	275%	179%
Xarelto®	$6.2B	55%	125%
Eliquis®	$18.3B	150%	118%
Imbruvica®	$2.4B	-3%	105%
Januvia®	$4.1B	16%	102%
Jardiance®	$8.8B	511%	85%
Entresto®	$3.4B	323%	76%
Farxiga®	$4.3B	755%	69%
Rybelsus®	$1.7B	2,168%	25%
Ozempic®	$9.2B	1,564%	14%

Note: ASP denotes average sales price; CPI-U denotes Consumer Price Index for All Urban Consumers; WAC denotes wholesale acquisition cost. List price changes for select drugs reflect cumulative WAC increases from FDA approval through 2024.
Source: Initiative for Medicines, Access & Knowledge (I-MAK) The Drug Patent Book, 2023; Drugs.com.

Even in Monopoly Markets, Hospitals Generate Negative Operating Margins

Within the 336 CBSAs that are "controlled by a single firm," the average operating margin is -1.7%. Overall, 1,547 hospitals have a negative operating margin.

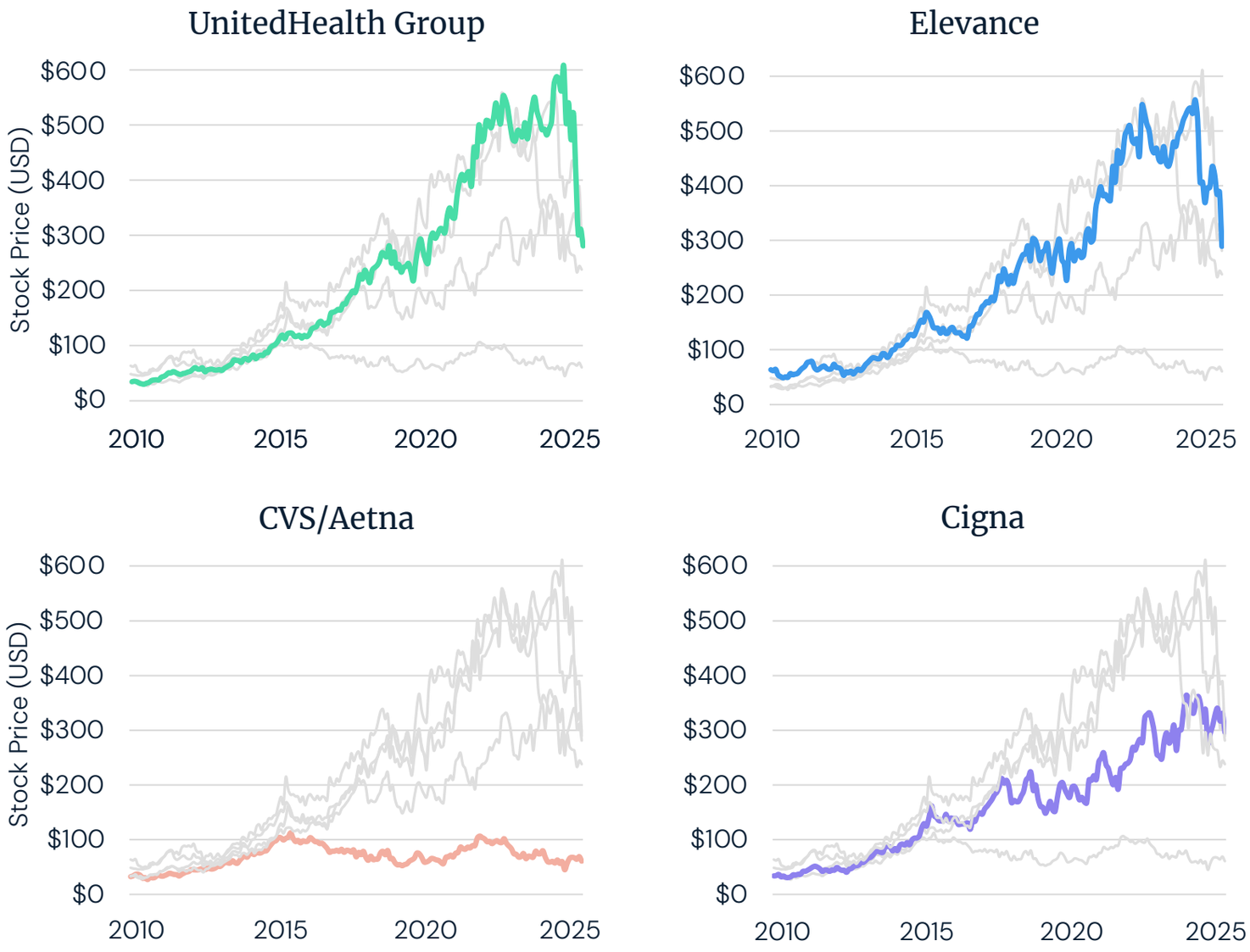


Note: CBSA denotes core-based statistical area; HHI denotes Herfindahl-Hirschman Index. Comparison of the operating margin of 4,560 short-term acute care hospitals with their HHI score. A HHI below 1,500 indicates a competitive market; between 1,500 and 2,500 indicates a moderately concentrated market, whereas a value greater than 2,500 indicates a highly concentrated market.
Source: Centers for Medicare and Medicaid Services Healthcare Cost Report Information System (HCRIS); Trilliant Health's national all-payer claims database.

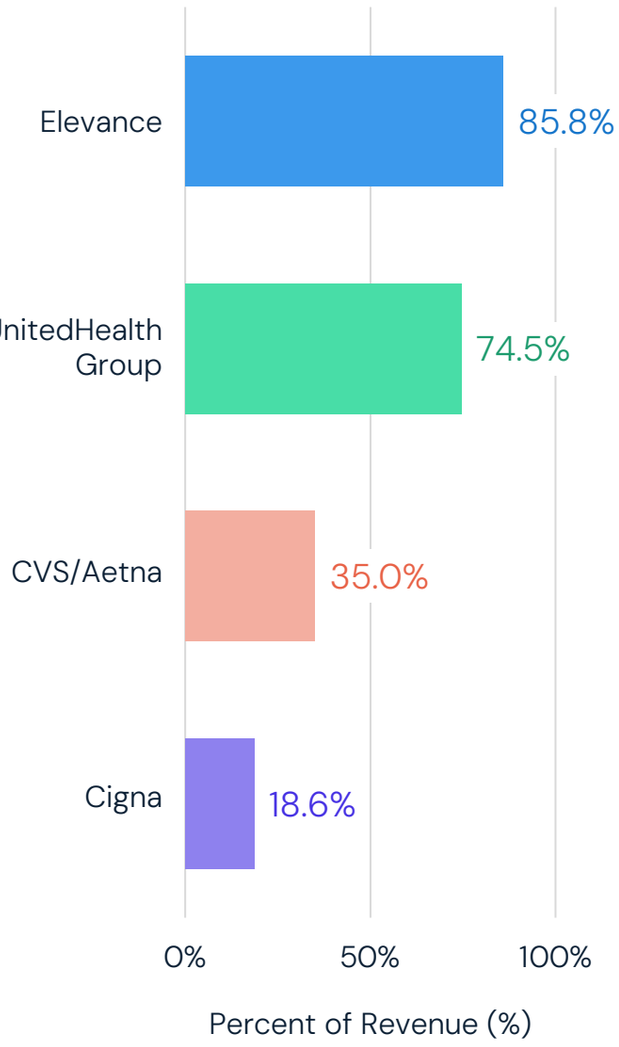
Employers and Patients Pay the Price When Insurance Companies Falter

Until the end of 2024, the stock performance of major health insurance companies had consistently grown since 2010. While most have attributed their declining financial performance to higher-than-anticipated care utilization, a closer examination of revenue sources reveals more nuanced dynamics. As publicly traded insurance companies respond to market pressures, patients and employers will bear the brunt of the consequences through higher premiums and utilization management.

Stock Price of Select Health Insurance Companies, 2010-Q3 2025



Revenue Attributed to Health Insurance, 2024

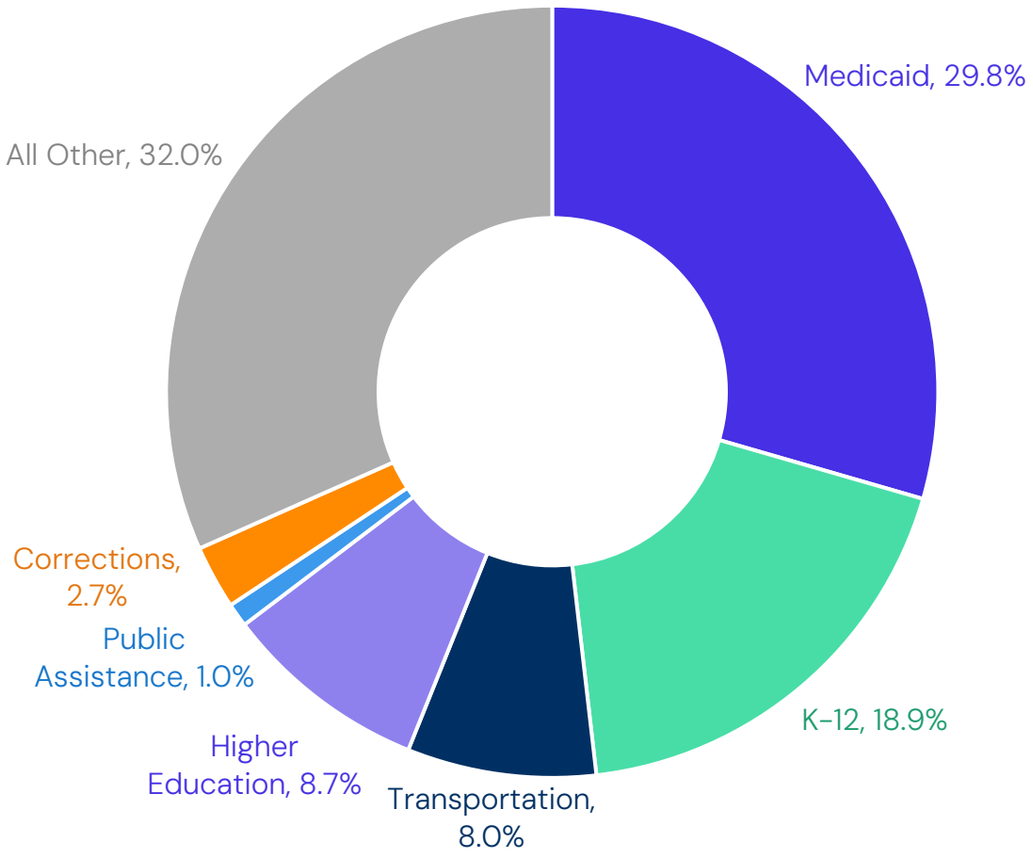


Source: Nasdaq; company 10-K forms.

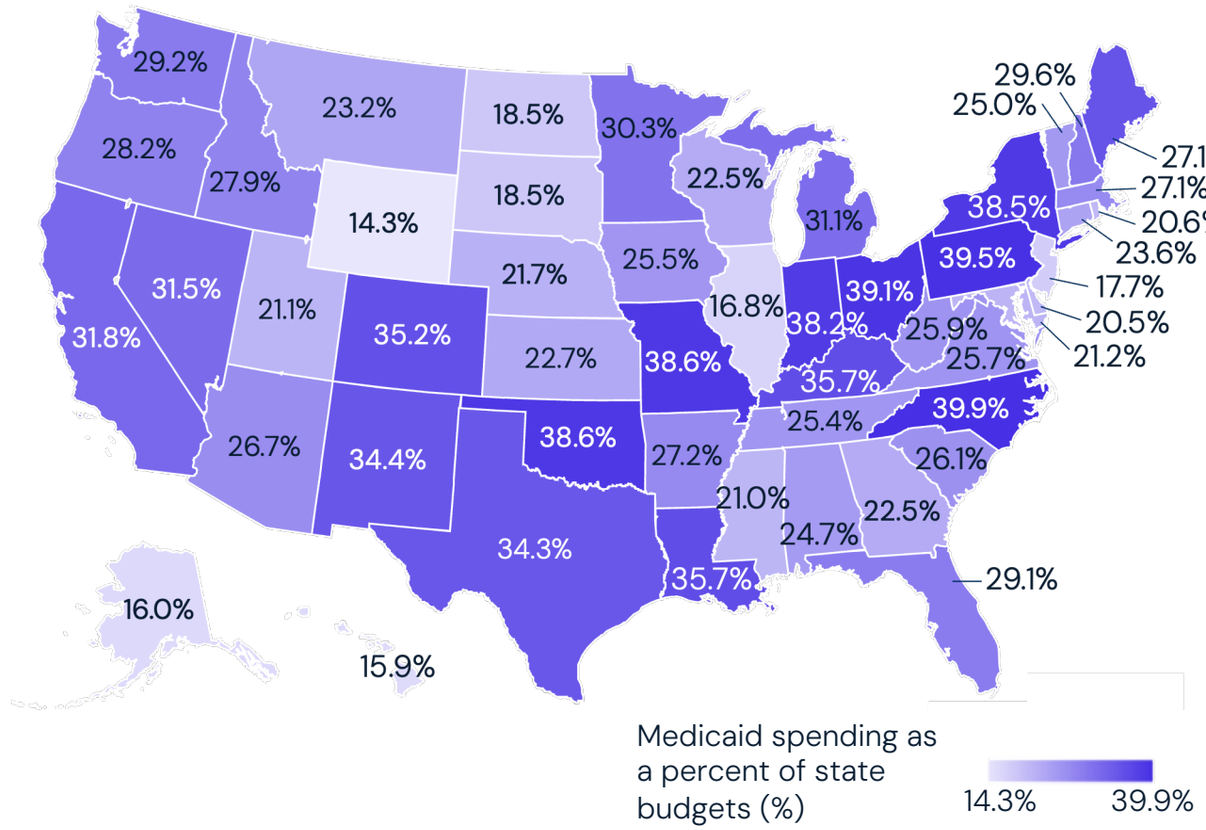
Medicaid Accounts for a Disproportionate Share of State Budgets

On average, nearly 30% of state budgets are allocated to Medicaid financing, with 18 states spending over 30% of state budgets on the program in FY 2024.

Average State Budget Allocations, FY 2024



Medicaid Spending as a Percent of State Budgets, FY 2024

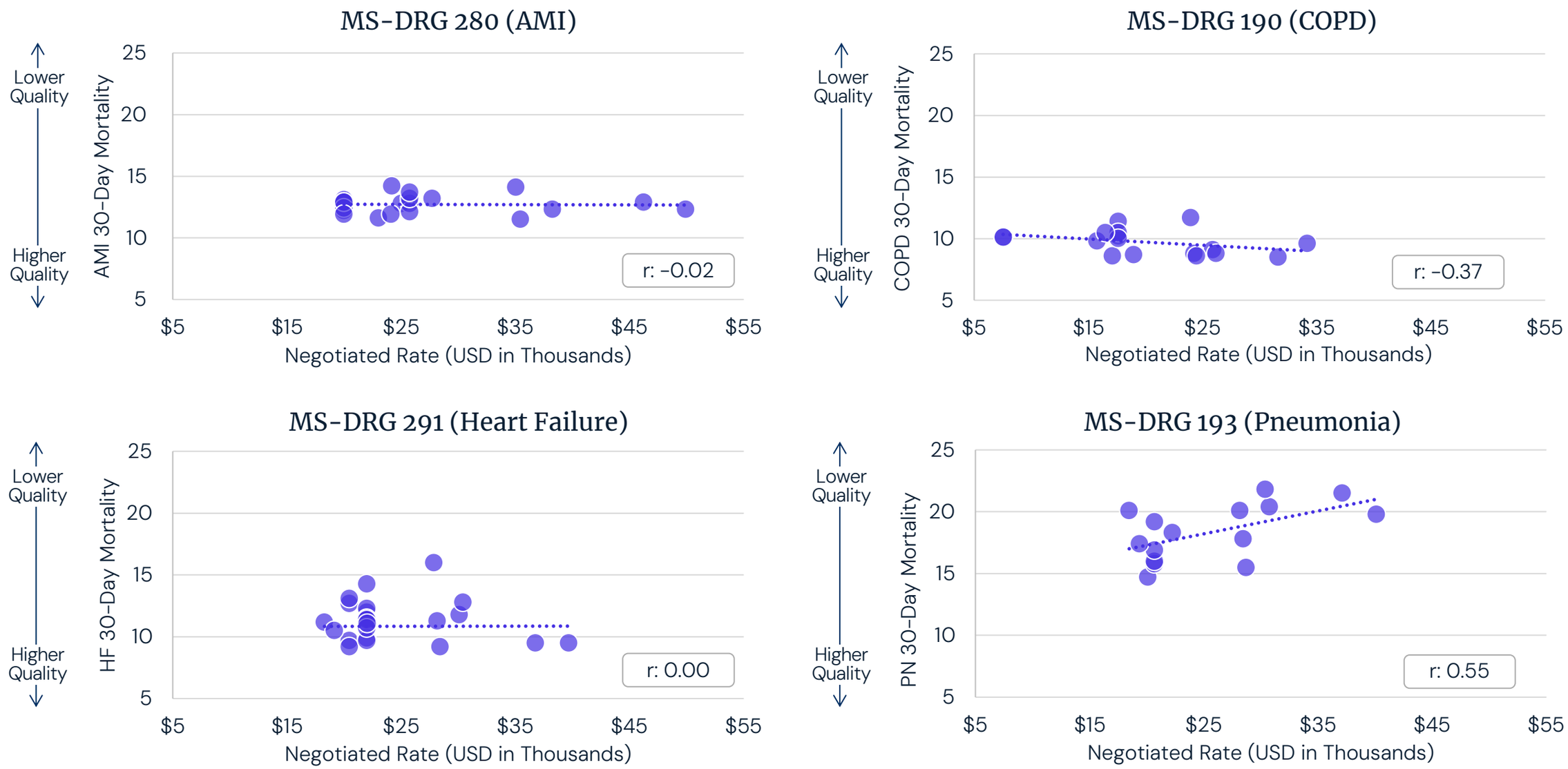


Note: FY denotes fiscal year. Percentages may not add to 100% due to rounding.
Source: National Association for State Budget Officers.

Price and Quality for Common Services Are Not Correlated

While the median negotiated rate for MS-DRG 193 in Miami is $22,255, the provider receiving the highest rate has the sixth-highest mortality rate out of the 15 hospitals. Additionally, for these four common MS-DRGs, the correlation coefficient ranges from -0.37 (COPD) to 0.55 (pneumonia), reflective of a lack of a consistent correlation between price and quality.

Negotiated Hospital Rate vs. 30-Day Mortality in Miami-Fort Lauderdale-West Palm Beach, FL, 2025



Note: AMI denotes acute myocardial infarction; COPD denotes chronic obstructive pulmonary disease; HF denotes heart failure; PN denotes pneumonia. Analysis was conducted using negotiated rates for a single national payer — UnitedHealthcare. Correlation is a measure of the relationship, or lack thereof, between two things. Our analysis used the Pearson correlation coefficient (r) to examine the strength of the linear relationship between measures of hospital quality and hospital negotiated rate.
Source: Trilliant Health national all-payer claims database, Provider Directory and health plan price transparency dataset; CMS Hospital Readmissions Reduction Program.

Most Government Interventions Have Not Contained Healthcare Spending

Since the 1980s, policymakers have pursued policies to improve affordability, quality and consumer choice. However, national health expenditures have increased from $2.8T in 2012 to $4.9T in 2023 and are expected to reach $8.6T, or 20.3% of GDP, by 2033.

Federal Efforts to Lower Healthcare Costs, 1981-2025

Administrative Price Controls

1981 >	1982 >	1983 >	1984 >	1989 >	1992 >	1996 >
Medicaid capitation rules set actuarial standards	Tax Equity and Fiscal Responsibility Act establishes Medicare capitation	CMS adopts DRGs with prospective payment anchored by base rate	Fully operational DRG-based payments across Medicare inpatient hospitals	Omnibus Budget Reconciliation Act authorizes Medicare physician fee reform	CMS adopts RBRVS to determine Medicare physician payment rates	DOJ releases guidance on exchanges of price and cost information for providers

Market-Based Cost Management

1997 >	2003 >	2005 >	2006 >	2008 >
Balanced Budget Act launches Medicare+Choice, precursor to Medicare Advantage (MA)	Medicare Modernization Act creates prescription drug benefit (Medicare Part D) and MA	HSA/HDHP expansion shifts patients to consumer-directed plans	Part D fully implemented	CMS revises MA benchmarks and begins payment realignment through MIPPA

Value-Based Care Models

2010 >	2011 >	2012 >	2013 >	2015 >	2018 >
Affordable Care Act establishes CMMI, MSSP and prospective rate review process for insurers	CMMI launches Pioneer ACO Model	CMMI launches first value-based payment models	Bundled payments for care improvement (BPCI) Model begins	MACRA ends sustainable growth rate and launches QPP; Physician Value-Based Modifier	Bundled payments for care improvement

Price Transparency

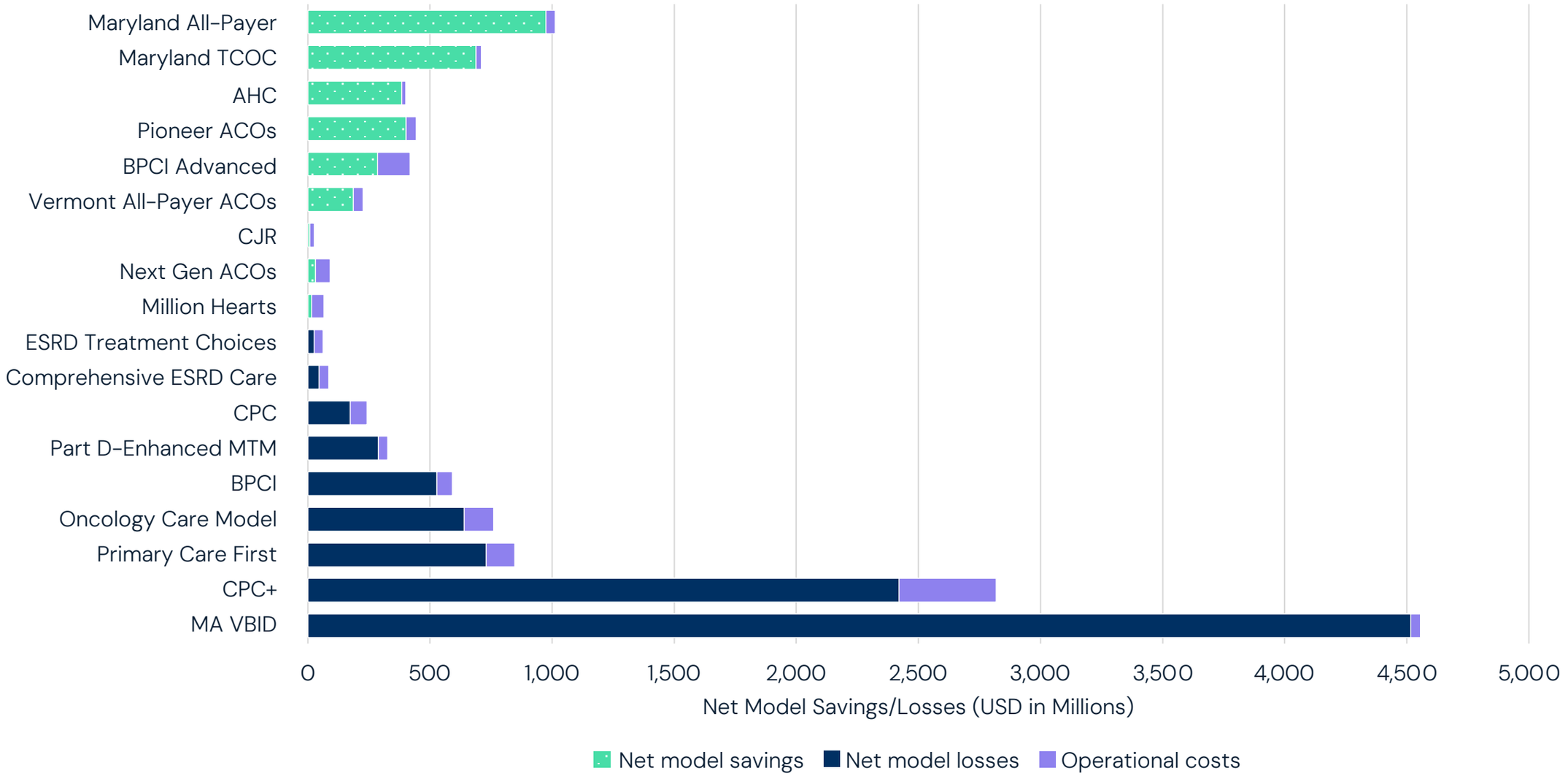
2019 >	2020 >	2021 >	2022 >	2023 >	2025
White House launches price transparency plan; MIPS and APMs begin affecting clinician payments under QPP	CMS finalizes Transparency in Coverage rule requiring insurers to disclose pricing info and offer cost-comparison tools	Hospital Price Transparency takes effect	IRA caps insulin, sets cost-sharing limits, and authorizes Medicare drug negotiation; payer price transparency takes effect	DOJ repeals 1996 safe harbor for healthcare pricing	One Big Beautiful Bill Act signed

Note: CMS denotes Centers for Medicare and Medicaid Services; DRG denotes diagnosis related group; DOJ denotes Department of Justice; CMMI denotes Center for Medicare and Medicaid Innovation; MA denotes Medicare Advantage; GDP denotes gross domestic product; RBRVS denotes resource-based relative value scale; HSA denotes health savings account; HDHP denotes high-deductible health plan; MIPPA denotes Medicare Improvement for Patients and Providers Act; MSSP denotes Medicare Shared Savings Program; ACO denotes Accountable Care Organization; MACRA denotes the Medicare Access and CHIP Reauthorization Act of 2015; IRA denotes the Inflation Reduction Act of 2022; APM denotes an Alternative Payment Model; QPP denotes the Quality Payment Program.
Source: Centers for Medicare and Medicaid Services.

APMs Are Expensive and Tend To Generate Net Losses

In contrast to fee-for-service reimbursement, APMs are intended to reward quality and value rather than volume of services. Despite the intended goals, CMMI has generated an estimated $5.4B in losses from APMs launched between 2012 and 2025.

Net Savings, Losses and Operational Costs of CMMI Models, 2012-2025

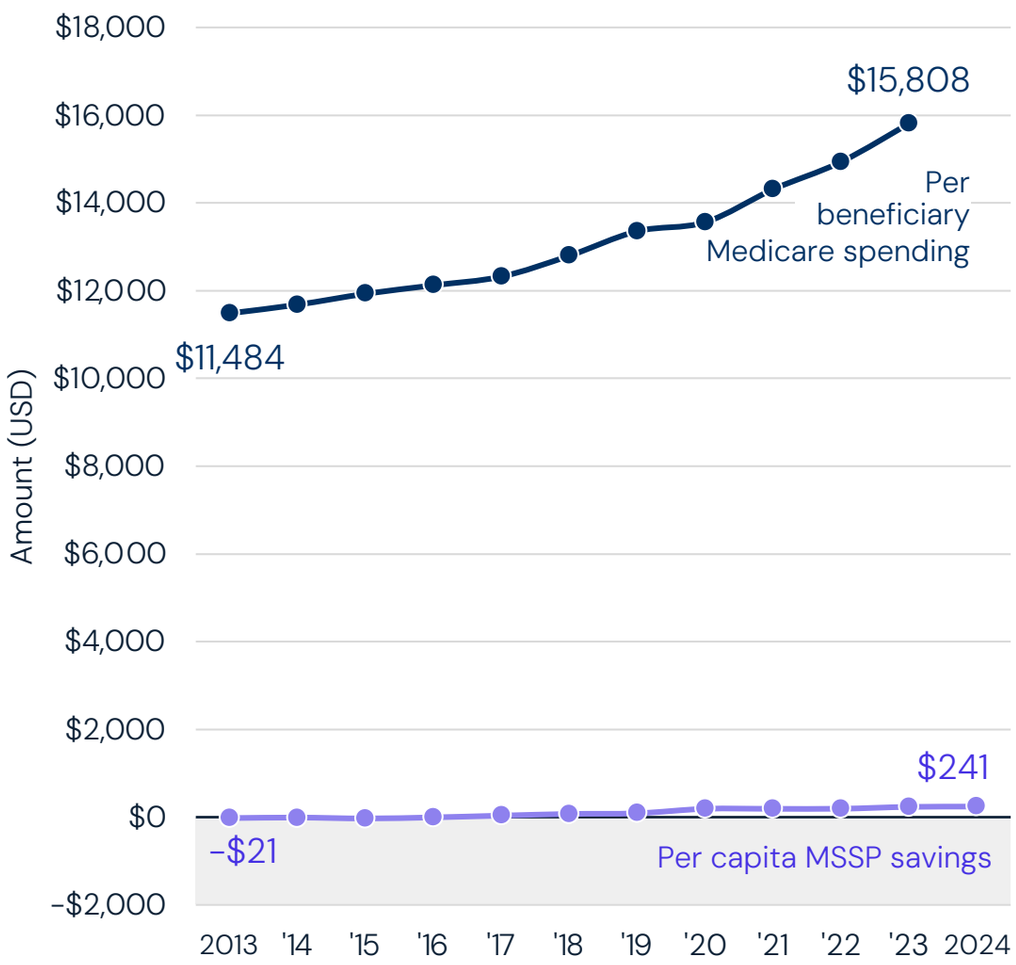


Note: CMMI denotes Center for Medicare and Medicaid Innovation; TCOC denotes total cost of care; ACO denotes accountable care organization; AHC denotes accountable health communities; BPCI denotes bundled payments for care improvement; CJR denotes comprehensive care for joint replacement; ESRD denotes end stage renal disease; CPC denotes comprehensive primary care; MTM denotes medication therapy management; MA VBID denotes Medicare Advantage value-based insurance design.
Source: Centers for Medicare and Medicaid Services; Avalere Health, Analysis of CMMI Model Costs, Quality Performance, and Transparency.

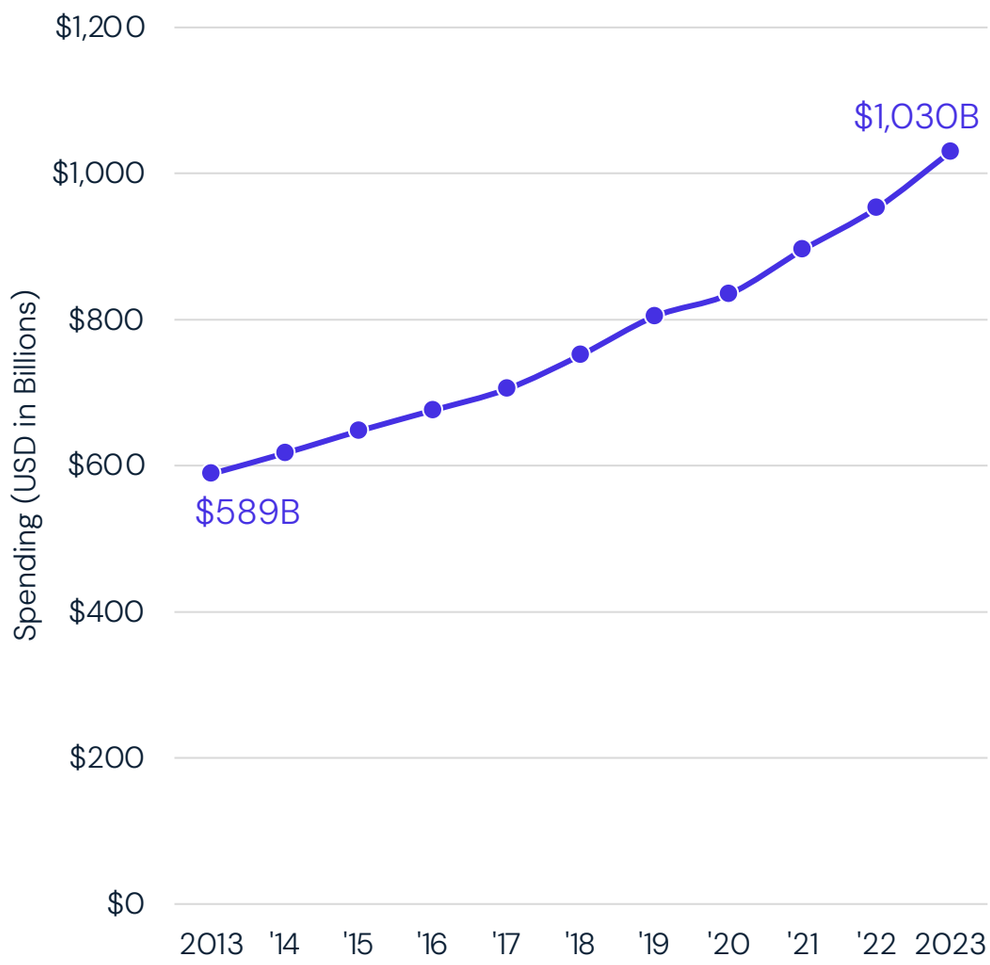
MSSP Savings Are Totally Eclipsed by Total Medicare Spending

In 2024, ACOs in the Medicare Shared Savings Program (MSSP) generated $2.4B in Medicare savings, equivalent to $241 per capita. Yet with per-enrollee Medicare spending at $15,808 in 2023 and total Medicare spending exceeding $1T, those savings amount to less than 1% of overall program costs.

MSSP Net Program Savings Per Capita and Medicare Spending Per Beneficiary, 2013-2024



Medicare Spending, 2013-2023



Note: MSSP denotes Medicare Shared Savings Program; ACO denotes accountable care organization.
Source: Centers for Medicare and Medicaid Services National Health Expenditures; Morken et al., Medicare Accountable Care Organizations In 2023: Large Savings With Increasing Value-Based Programmatic Competition, *Health Affairs*, 2025.

CBO Believes That Healthcare Prices Respond Most to Price Controls

While transparency and competition are already core themes of previous reform efforts, government-mandated caps on commercial prices would fundamentally reshape stakeholder economics, particularly for employer-sponsored health plans, which cover more than 60% of Americans under age 65. If rates in all private plans are capped at 200% of Medicare, the average hospital price paid by private plans would decrease by 7.6%.

CBO Policy Approaches To Reduce What Commercial Insurers Pay for Healthcare Services

		Change In Average Hospital Price Paid By Private Plans (%)	Change In Hospital Spending (USD in Billions)	Change In National Health Spending (%)
Price Transparency – Very Small Price Reductions				
34% Shoppable Services	Patient-Driven	-1.7%	-$8.7B	-0.2%
43% Shoppable Services		-1.4%	-$11.1B	-0.3%
75th Percentile Price	Employer-Driven	-2.2%	-$13.2B	-0.4%
Median Price		-4.7%	-$26.6B	-0.7%
Increased Competition – Small Price Reductions				
Small Price Response	HHI decreases to 1,500	-1.6%	-$9.9B	-0.3%
Medium Price Response		-3.1%	-$19.7B	-0.5%
Large Price Response		-11.2%	-$68.9B	-1.9%
Capped Rates In All Private Plans – Moderate				
100%	Percent of Medicare Rates (%)	-43.2%	-$246.4B	-6.8%
125%		-30.8%	-$178.5B	-4.9%
150%		-20.5%	-$119.1B	-3.3%
175%		-12.7%	-$72.8B	-2.0%
200%		-7.6%	-$42.7B	-1.2%

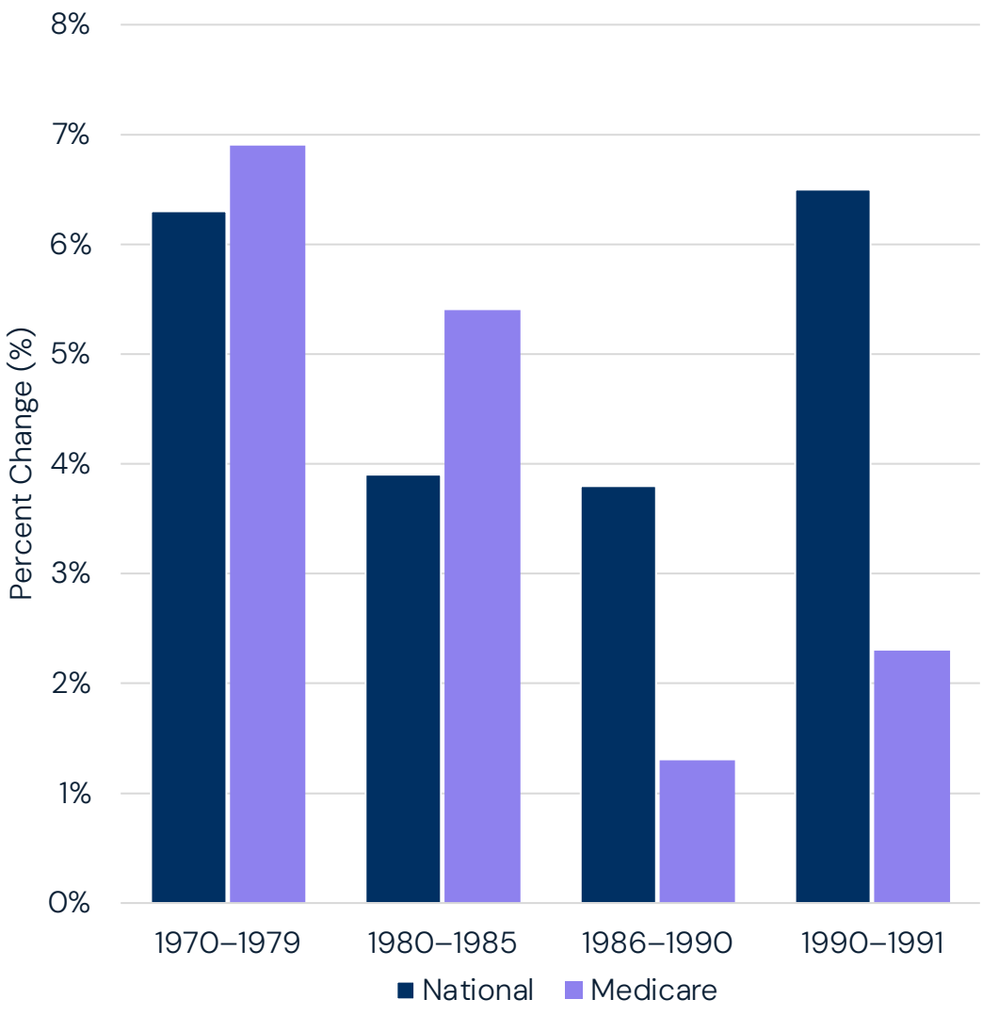
CBO estimates that if rates in all private plans are capped at 200% of Medicare, the average hospital price paid by private plans would decrease by 7.6%, equivalent to $42.7B. If prices are capped to 150%, this would reduce hospital spending by $199.1B or 3.3% of total national health spending.

Note: CBO denotes Congressional Budget Office.
Source: Congressional Budget Office, Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services, 2022.

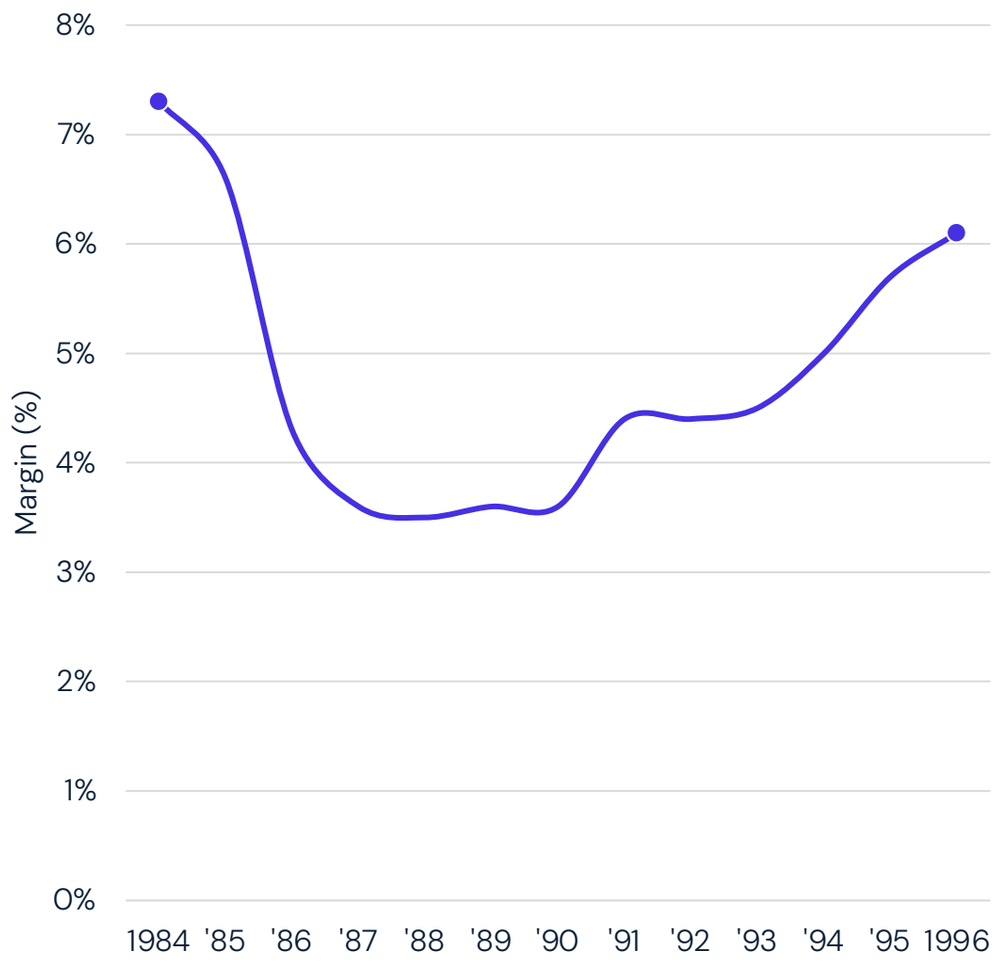
In 1983, the Introduction of DRGs Slowed Spending Growth

The introduction of Medicare's prospective payment system using Diagnosis-Related Groups (DRGs) in 1983 fundamentally changed hospital reimbursement, shifting payments from a cost-based approach to a fixed, episode-based model. Following the policy's implementation, the rate of Medicare hospital spending growth slowed relative to national per capita spending and hospital margins declined.

Annual Percent Change in National and Medicare Hospital Per Capita Spending, 1970-1991



Hospital Margins, 1984-1996

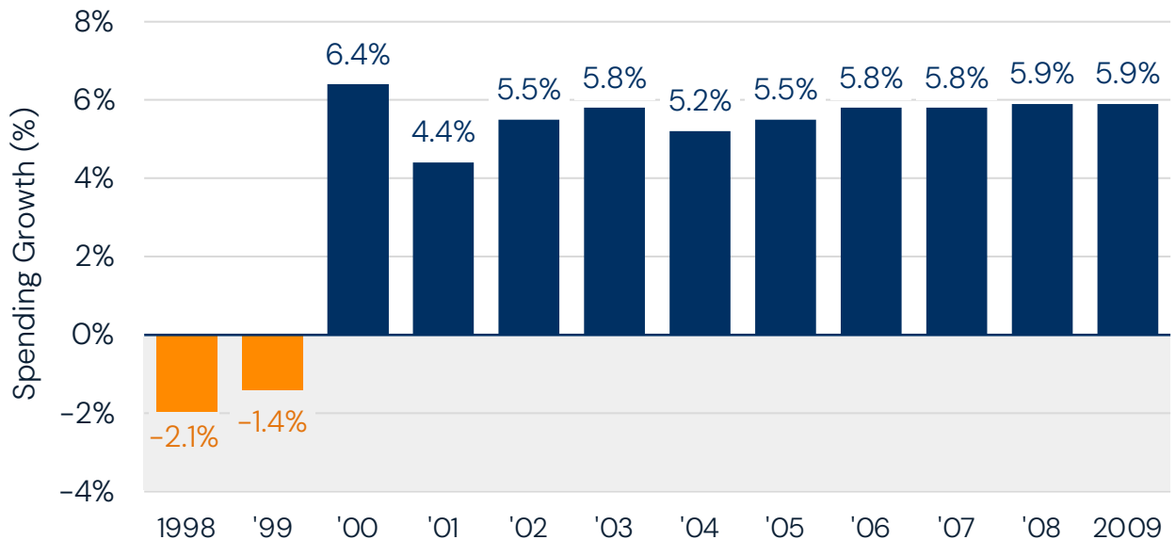


Note: DRG denotes diagnosis-related groups.
Source: Centers for Medicare and Medicaid Services; Prospective Payment Assessment Commission, 1992; Gold et al., Effects of selected cost-containment efforts: 1971-1993, *Health Care Finance Review*, 1993.

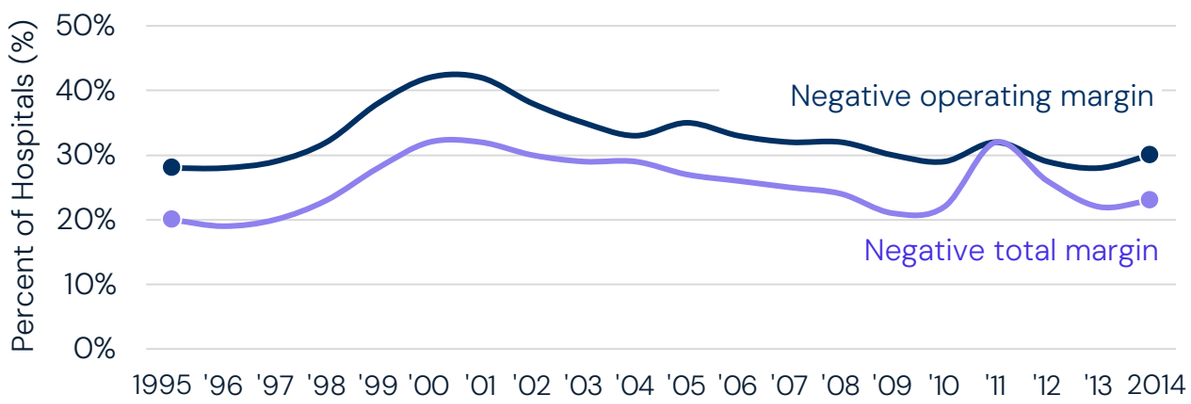
In 1997, the BBA Strained Hospital Financial Performance

The Balanced Budget Act of 1997 substantially reduced Medicare payment rates for hospitals and other providers and slowed the growth of future increases, resulting in an uptick in the number of hospitals with a negative operating margin. Even so, since the BBA's passage, hospital spending has increased 4x from $363B in 1997 to $1,520B in 2023.

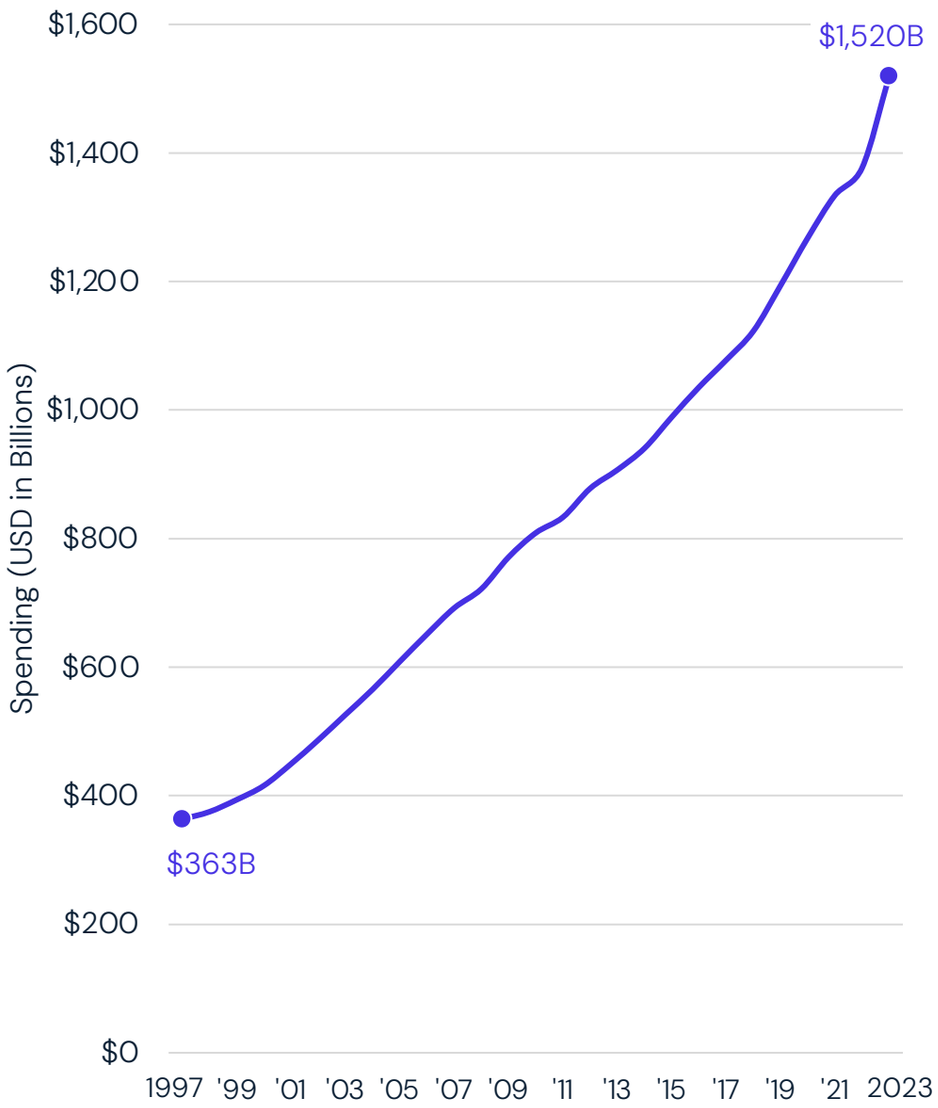
Annual Traditional Medicare Spending Growth Rate, 1998-2009



Hospitals with Negative Total and Operating Margins, 1995-2014



Hospital Spending, 1997-2023



Note: BBA denotes the Balanced Budget Act of 1997.
Source: Centers for Medicare and Medicaid Services National Health Expenditures; American Hospital Association.

In 2026, the Mandatory TEAM Model Will Expand Upon DRGs

The Transforming Episode Accountability Model (TEAM) is a mandatory, episode-based APM developed by CMMI, which is projected to save Medicare $481M between 2026 and 2030. Unlike CMMI's experimentation with voluntary VBC models that have failed to generate material savings, TEAM is a mandatory model that applies a bundled payment like a DRG, but over a longer period of time.

CBSAs Required to Participate in TEAM, 2026

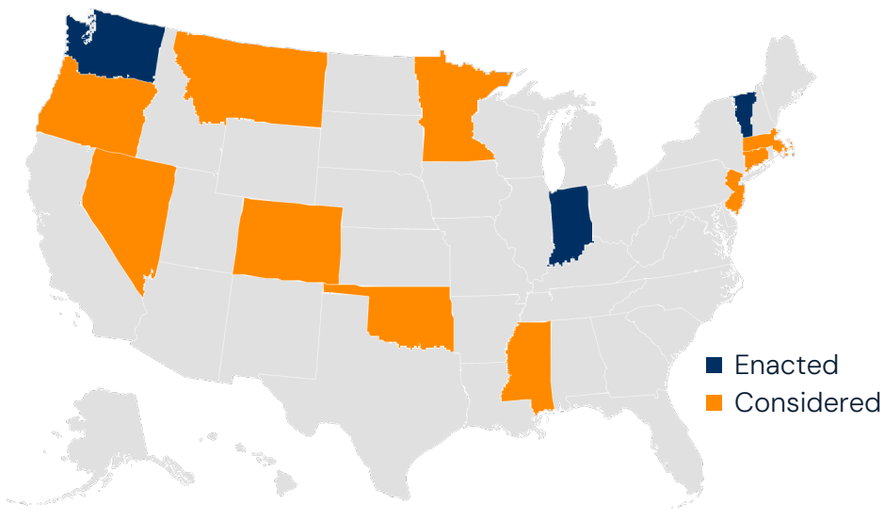
MS-DRGs Subject to TEAM
Lower extremity joint replacement (MS-DRGs 469, 470, 521, 522)
Hip and femur fracture surgeries (MS-DRGs 480-482)
Coronary artery bypass graft (CABG) (MS-DRGs 231-236)
Major bowel procedures (MS-DRGs 329-331)
Spinal fusion (MS-DRGs 402, 426-430, 447-448, 450-451, 471-473)

Note: CBSA denotes core-based statistical area; APM denotes an Alternative Payment Model; CMMI denotes the Center for Medicare and Medicaid Innovation; VBC denotes Value-Based Care; TEAM denotes Transforming Episode Accountability Model.
Source: Centers for Medicare and Medicaid Services.

States Are a Harbinger of Federal Price Control Legislation

In 2025, 13 states considered legislation that would establish reference-based pricing requirements, with Indiana, Washington and Vermont enacting laws as of September 2025. After considering similar legislation in 2023, the Indiana General Assembly enacted HB 1004 in May 2025, which establishes a study of commercial hospital prices to inform future inpatient and outpatient hospital price caps for nonprofit hospitals.

States Considering Reference-Based Pricing Legislation, 2025



State	Summary of Enacted Reference-Based Pricing Provisions
Indiana	Requires nonprofit health systems to submit financial disclosures and audited statements, requires the state to study commercial hospital prices, which will inform a price cap for nonprofit hospitals.
Vermont	Implements hospital reference-based pricing by setting prices as a percentage of Medicare.
Washington	Sets a Medicare-based reimbursement limits for in- and out-of-network hospital services, with reporting, premium adjustments and impact studies.

Timeline of Price Cap Proposals in Indiana

2023: Early iterations of HB 1004 (2023) included penalties for nonprofit hospitals that priced services above 260% of Medicare, but as the bill moved through the Senate, lawmakers replaced the 260% concept with a benchmarking study to calculate nonprofit hospital system prices as a percentage of Medicare and required a compilation of Medicaid reimbursement data.

2024: Policy advocates urged the General Assembly to lower the 285% benchmark to 260% and add penalties, but that was not enacted.

2025: HB 1004 (2025) requires nonprofit health systems to submit financial disclosures and audited statements and requires the state to study commercial hospital prices. Study results will inform a price cap that nonprofit must comply with following the conclusion of the study. Earlier versions of the bill would have capped commercial hospital prices at 200% of the Medicare reimbursement rate.

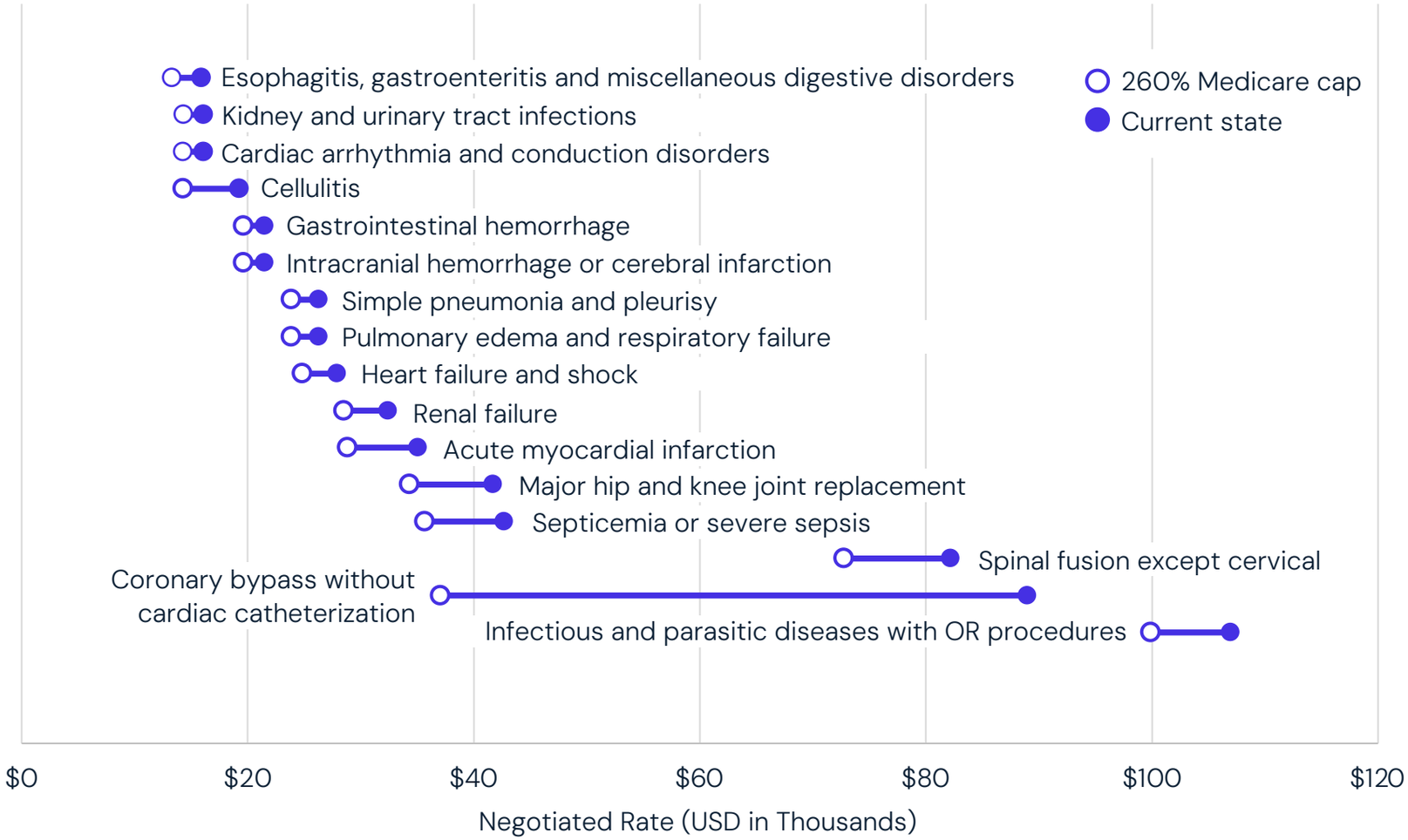
2025: Indiana's FSSA proposed a revised Direct Provider Payment plan linking Medicaid reimbursement rates to a hospital's average commercial rate.

Note: FSSA denotes Family and Social Services Administration.
Source: National Academy for State Health Policy; Indiana General Assembly.

Price Caps Are Imminent Unless the System Starts Delivering Value for Money

In 2025, the Indiana General Assembly passed a law that will implement commercial hospital price caps based on a study of hospital prices in the state, which will take effect no later than July 2029. In a scenario where the threshold is set at 260% of Medicare reimbursement, using coronary bypass with cardiac catheterization procedures as an example, reimbursement would decline by $51,900 per case, equivalent to $25.9M in lost revenue for a health system performing 500 procedures.

Actual and 260% Medicare Capped Rates for Select MS-DRGs at an Indiana Hospital



Coronary Bypass With Cardiac Catheterization Procedures

Current State Scenario
Procedure Volume: 500

Negotiated Rate: $88,999

Total Reimbursement: $44.5M

260% Medicare Cap Scenario
Procedure Volume: 500

Negotiated Rate: $37,044

Total Reimbursement: $18.5M

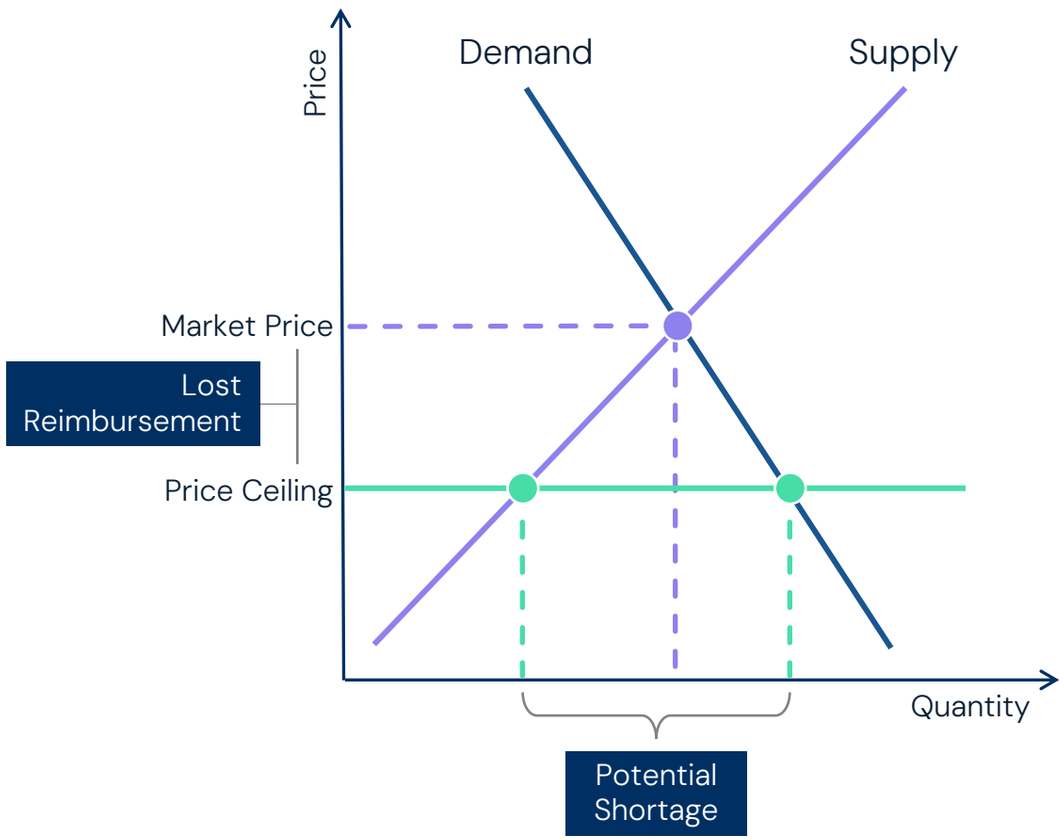
Reduced Payment
-$25.9M

Note: Analysis was conducted using negotiated rates for a single payer – Anthem.
Source: Trilliant Health's national all-payer claims database; Provider Directory; health plan price transparency dataset.

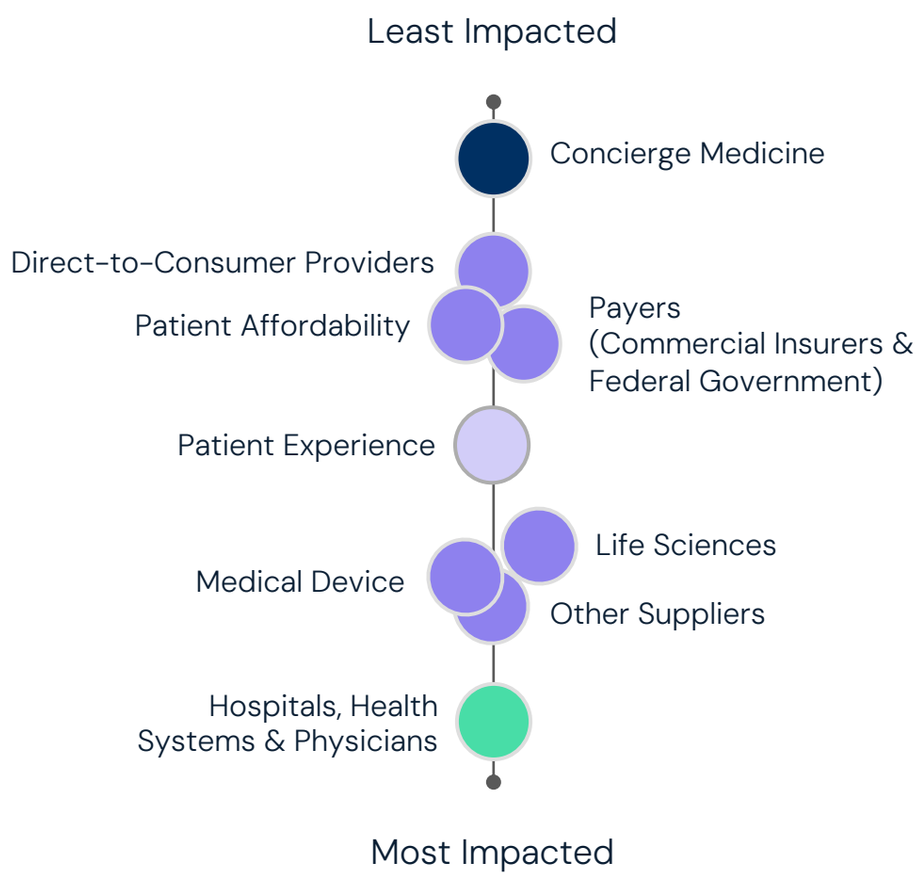
How Might Price Controls Impact Health Economy Stakeholders?

A government may impose a price ceiling when it believes a good is essential for survival and that market prices are prohibitively high. In healthcare – a market that is far from perfect – such a ceiling would lower reimbursements for providers, which in turn would ultimately impact payers and life science companies, as well as stakeholders who are middlemen. All stakeholders need to anticipate and plan for the consequences of reduced revenue.

Yield Implications of Capped Commercial Prices



Impact of Reduced Yield, by Stakeholder



CONCLUSION

The Health Economy Is at a Crossroads: Market Discipline or Structural Reform?

CONCLUSION

The Ongoing Healthcare "Doom Loop"

The U.S. healthcare system is caught in a doom loop of self-reinforcing dynamics that drives costs upward, health outcomes downward and makes reform increasingly difficult.

Healthcare spending continues to outpace inflation and wage growth even as employers, government and households face growing financial strain. Instead of innovation or transformation, payers respond with ever-increasing premiums and deductibles, while providers seek higher commercial rates to offset reimbursement pressures from government payers and patients delay or avoid care due to affordability concerns.

Having avoided preventive and primary care, patients often need more expensive and specialized care, creating enduring compensation gaps between specialists and primary care, which is perpetually underfunded and underutilized. Meanwhile, closed-loop EHR systems prevent meaningful use, reinforcing inefficiency and waste, and reform efforts stall or result in incremental fixes that add further complexity. Each stakeholder defends its revenue model, also known as maintaining the status quo.

The result: costs continue to rise, access worsens, health outcomes stagnate and resources are allocated inefficiently. Together, this exemplifies a negative-sum game in which all participants expend more and collectively gain less.

The trajectory of healthcare reform hinges on whether change is pursued proactively from within the system or imposed externally through government intervention.

U.S. Healthcare System Doom Loop

CONCLUSION

Breaking the U.S. Healthcare Doom Loop Requires First Principles Thinking

Improving the U.S. healthcare system requires someone to break the doom loop, and the key question is who will be the first to break the chain. The risk to every health economy stakeholder is that change will be imposed from the outside, primarily by Federal and state government. History suggests that government has only one effective tool in its healthcare reform toolbox: price controls, whether in the form of rate setting, bundled pricing or price caps.

Proactive reform requires stakeholders – providers, payers and life sciences companies – to embrace **market discipline** by competing transparently on price, quality and access, either because they recognize the merit of the strategy or because employers finally demand it. Said differently, health economy stakeholders must reorient their business models to deliver value for money. Waste is the most obvious obstacle to value for money in healthcare. Any activity in any enterprise that is not necessary creates waste, and this report demonstrates only a portion of the fraud, waste and abuse in the U.S. healthcare system.

The universal solution to waste is first principles thinking. In healthcare, first principles thinking requires stripping away all "common wisdom" and deconstructing the U.S. healthcare system to its atomic truths. **The question about everything in healthcare is this: Is it necessary?** At its core, the healthcare system is intended to connect patients with providers for medical care. What does that mean for everyone else – employers, private and public payers, life sciences, health IT vendors, PBMs, group purchasing organizations, lobbyists, consultancies and advisory firms?

Which stakeholders currently provide value to the system by delivering essential services or goods?

In a functioning market, patients would be able to compare providers on measurable outcomes and costs, thereby rewarding efficiency and innovation while pressuring high-cost, low-value participants to adapt or exit. In a free market, the healthcare system would be characterized by the "focused factories" about which Regina Herlizinger wrote 30 years ago, with hospitals focused on two or three service lines and life sciences companies focused on one or two disease states and claims adjudication performed completely electronically using a framework like SWIFT banking. Such dynamics could improve affordability and accountability without the need for heavy-handed regulation. However, as Upton Sinclair noted, "it is difficult to get a man to understand something when his salary depends on his not understanding it."

Because stakeholders have failed to initiate meaningful change in the past 30 years, unconstrained costs and persistent inequities have catalyzed mounting political pressure for more sweeping, government-directed **structural reform**, which may be less responsive to local variation and less efficient in its design. The critical question, then, is whether the health economy will undertake reforms that align incentives with value for money, or whether inaction will invite externally imposed solutions that redefine the system on less favorable terms. **Do you want to make change happen, or do you want change to happen to you?**

METHODOLOGY

METHODOLOGY

Analytic Approach

A variety of data sources were leveraged as part of this research, with most insights gleaned from Trilliant Health's proprietary datasets with visibility into patients, providers and negotiated rates across the country. Trilliant Health's national all-payer claims database combines commercial, Medicare Advantage, Traditional Medicare and Medicaid claims, providing a nationally representative sample on a deidentified basis. Claims-based data analyses use data through Q4 2024. Trilliant Health's Provider Directory enables a direct view into providers and their practice patterns, accounting for 5.2M providers, allied health professionals and organizations. The Trilliant Health health plan price transparency dataset is comprised of health plan machine-readable files that have been parsed and cleaned. Trilliant Health leverages its Provider Directory and claims data against the health plan price transparency dataset to reveal the negotiated reimbursement rate between any commercial health plan and any provider for any service rendered at any location.

Additional data were obtained from a variety of publicly available sources (and are noted in respective source notes), including individual health system, health plan and company financial statements, U.S. Census Bureau, KFF, the Congressional Budget Office, American Hospital Association, American Medical Association, Centers for Disease Control and Prevention, Healthcare Cost Report Information System and the Bureau of Labor Statistics.

This research does not include data from self-pay encounters or encounters provided at no cost through commercial insurers that do not generate a claim.

Most data are presented with a national view, while some were exclusively focused on counties or the largest markets – defined as the core-based statistical areas (CBSAs) – to illustrate local variation. Most analyses in the *2025 Trends Shaping the Health Economy Report* are limited to the commercially insured population, which generates most of the health economy's revenue.

Study Data

Data Source	Feature	Category	Description
Trilliant Health National All-Payer Claims Database	Utilization	**Inpatient**	Visits associated with medical and surgical care delivered inpatient on the campus of a hospital.
		Outpatient	Visits associated with medical and surgical care delivered in the outpatient setting, separating care delivered on the campus of a hospital and in non-hospital settings.
		Primary Care	Visits with physicians characterized as general practice, family, internal, geriatric, adolescent and pediatric medicine, excluding hospitalists.
		Behavioral Health	Visits categorized into the Major Diagnostic Categories 19 (Mental Diseases and Disorders) and 20 (Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders).
		Urgent Care	Visits delivered at medical facilities where the site of service was identified as urgent care.
		Telehealth	Synchronous audio-video, audio-only, chat-based, asynchronous chat-based and store-and-forward encounters, delivered off the campus of a hospital.
		Home Health	Visits delivered at a patient's home with the place of service categorized as home health.
	Competition	**Herfindahl-Hirschman Index (HHI)**	The Federal government utilizes the HHI as the standard measure of market concentration. HHI is calculated by squaring the market share of each firm competing in a market and then summing the resulting numbers. It approaches zero when a market is occupied by several firms of relatively equal size and reaches its maximum value (10,000) when a market is controlled by a single firm (i.e., monopoly). HHI increases both as the number of firms in the market decreases and as the disparity in size between those firms increases.
	Pharmacy	**Utilization**	Prescription utilization measures the count of pharmacy patients using corresponding pharmacy claims data, which can be crosswalked back to the medical claims on a deidentified basis. Specific medications are identified using a combination of name, NDC code and GPI category.
Trilliant Health Health Plan Price Transparency Dataset	**Negotiated Rates**		Minimum, median, average or maximum in-network commercial negotiated rates for UnitedHealthcare, Cigna and Aetna. Whether the negotiated rates are for professional or institutional services is specified on individual analyses. The MS-DRG or CPT code is specified on individual analyses.

Acknowledgements

Trilliant Health's "noble purpose" recognizes that every American is impacted by the health economy, and we are committed to making it exponentially better.

The fifth annual installment of the *Trends Shaping the Health Economy Report* is a collaborative effort across Trilliant Health.

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