



A Tragedy of the Commons:

2026 Trends Shaping
the Health Economy

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2026 Trends Shaping the Health Economy

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INTRODUCTION

The U.S. Health Economy Is a Tragedy of the Commons

In *Politics*, Aristotle diagnosed a failure of shared resources, writing that common property "has the least care bestowed upon it" since people think "chiefly of his own, hardly at all of the common interest." Millennia later, Garrett Hardin named that failure the tragedy of the commons. Picture a pasture open to every herder. Each herder, acting rationally in their own interest, adds one more animal to graze until the pasture is depleted. No one intended the outcome, but everyone contributed to it. **The U.S. health economy, which consumes \$1 out of every \$21 of global GDP, is a tragedy of the commons, every stakeholder grazing the metaphorical pasture toward collective ruin.**

The health economy is governed by incentives that reward individual actors for behavior the collective cannot sustain. The insurance risk pool only works if enough healthy people subsidize the sick, yet each individual has a rational incentive to defer enrollment until becoming ill. Every time an antibiotic is prescribed, it increases drug resistance, slowly eroding future effectiveness for everyone. The Emergency Medical Treatment and Active Labor Act guarantees treatment in the emergency department regardless of ability to pay, so the uninsured rationally default to that setting, and the cost is shared across hospitals, payers and taxpayers. Because brokers are paid a commission on premiums, their revenue rises with employer costs, leaving little incentive to negotiate a lower-cost, higher-value plan. The

very nature of fee-for-service reimbursement is a commons: every additional test and procedure generates revenue for whoever delivers it, even as the aggregate effect is a health economy consuming an ever-growing share of GDP, while life expectancy stagnates.

The "herders" in each of these commons are behaving rationally and often according to their fiduciary duties. Providers are paid to treat illness, not to prevent it. Pharmacy benefit managers profit from higher, not lower, list prices. Patients, facing an opaque, fragmented system, default to the path of least resistance regardless of long-term cost. Every stakeholder, operating on the "no margin, no mission" logic of the health economy, is optimizing locally, while the healthcare system

fails as a whole. This is precisely the mechanism Hardin identified: **individually rational choices, driven by incentives that do not account for negative externalities, aggregate into an outcome that no one chose but everyone owns.**

The question for every American is whether the commons that is the U.S. health economy is past the point of recovery. Hardin believed that a commons survives only through enclosure or "mutual coercion, mutually agreed upon." Through whatever mechanism, **the future of the U.S. health economy is dependent on our ability to assign ownership, cost and accountability** throughout the system.

INTRODUCTION

The Healthcare “System” Was Never Designed to Incentivize Health

Implicit in the word “system” is intentional design, with defined boundaries, interdependent components reflecting a shared purpose, feedback loops for iterative improvement and accountability for collective performance. [What America calls its healthcare system is the result of an accumulation of unintended consequences on which everyone depends but for which no one is – or wants to be – accountable.](#)

Consider employer-sponsored insurance (ESI), the conduit through which roughly half of Americans receive healthcare benefits. ESI exists not because employers are best positioned to underwrite health risk – they are not, and most will admit as much – but because the National War Labor Board exempted ESI from the wage freeze imposed by the Stabilization Act of 1942. When Congress codified the tax deduction for ESI in the Internal Revenue Code in 1954, a wartime measure meant to avert labor strikes became the foundation of American health insurance.

This pattern repeats throughout history. In 1965, Medicare and Medicaid were created to guarantee coverage for the populations that ESI could not reach, but the introduction of fee-for-service and “cost-plus” medicine catalyzed spending growth that has consistently outpaced the rest of the economy. The Consolidated Omnibus Budget Reconciliation Act (COBRA)

followed in 1985 to enable workers to maintain coverage after losing a job. However, without any employer subsidy of the premium, COBRA merely created a right to buy insurance that few people who had just lost their income could afford. In 2003, the Part D benefit created by the Medicare Modernization Act introduced outpatient prescription drug coverage for seniors, but it barred Medicare from negotiating drug prices directly and routed the benefit through private pharmacy benefit managers (PBMs), entrenching the rebate-driven pricing opacity that persists today. In 2010, the Affordable Care Act extended coverage to millions and ended exclusions for pre-existing conditions, but it also accelerated hospital and insurer consolidation, trading one set of market distortions for another. Most recently, Federal price transparency mandates were designed to expose healthcare prices to competitive pressure, but the health economy was never designed to compete on value.

What has 80 years of reactive policy produced? A “sick care” system that intervenes after the onset of illness rather than investing in the prevention that would forestall it, and one where rules and prices depend on who is paying. **A system requires a shared purpose, but none exists in the U.S. health economy – no stakeholder, whether provider, payer, life sciences company, employer, broker or PBM, has ever been fully organized around the goal of producing health rather than revenue.**

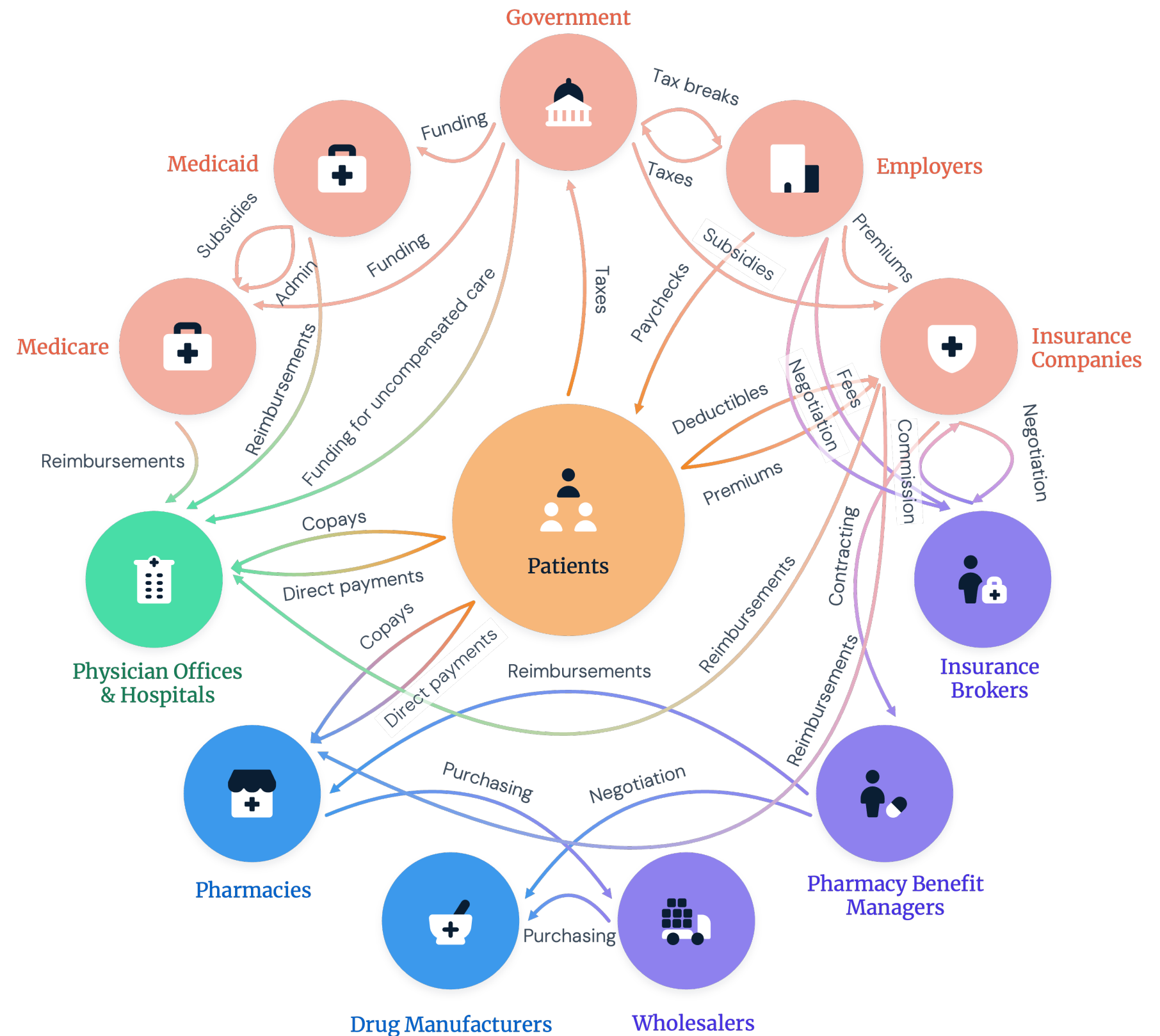
The predictable result is the most expensive healthcare system in the world, one that produces disproportionately little health for what it costs.

INTRODUCTION

The System Is a Function of Its "Design"

The U.S. healthcare system is characterized by a byzantine web of stakeholders that make the system inscrutable to the average American. Moreover, the system lacks a shared purpose – no stakeholder is organized around the goal of producing health.

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

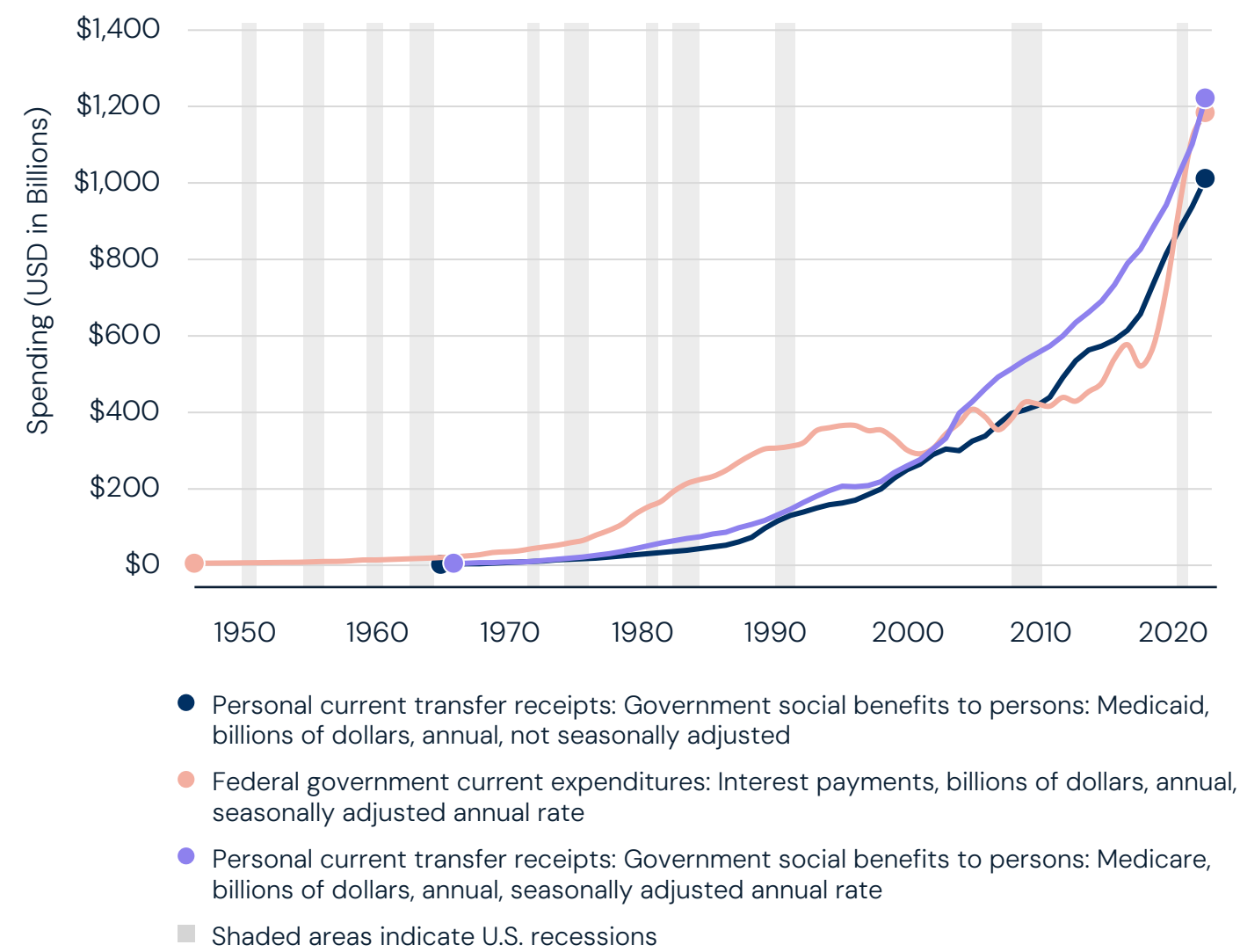


INTRODUCTION

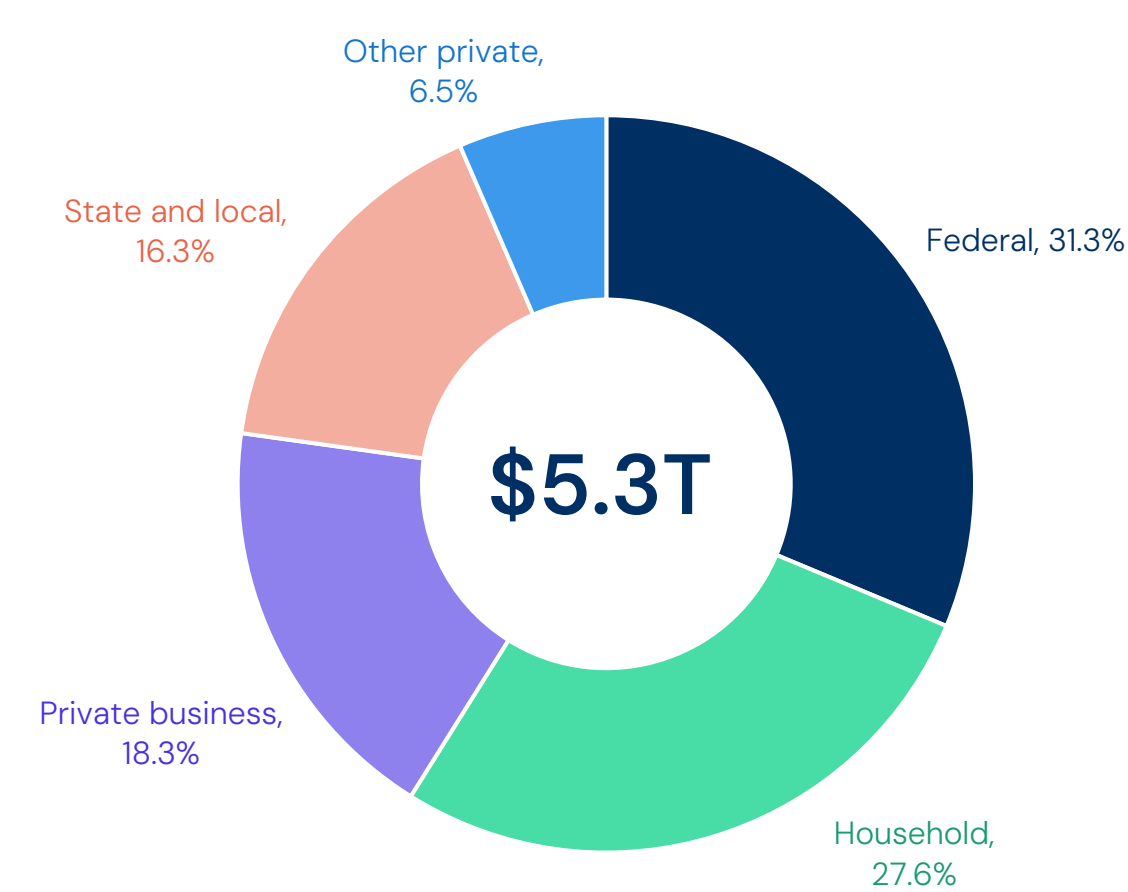
The U.S. Cannot Afford Its Healthcare System

In 2024, U.S. healthcare spending reached \$5.3T, or \$15,474 per capita, representing 18.0% of the nation's GDP. Private businesses and households underwrite a combined 45.9% of NHE. How long can the U.S. allocate more than \$1T each to Medicare, Medicaid and interest on the Federal debt?

U.S. Spending on Medicare, Medicaid and Interest Payments, 1947–2025



U.S. National Health Expenditures, by Sponsor, 2024



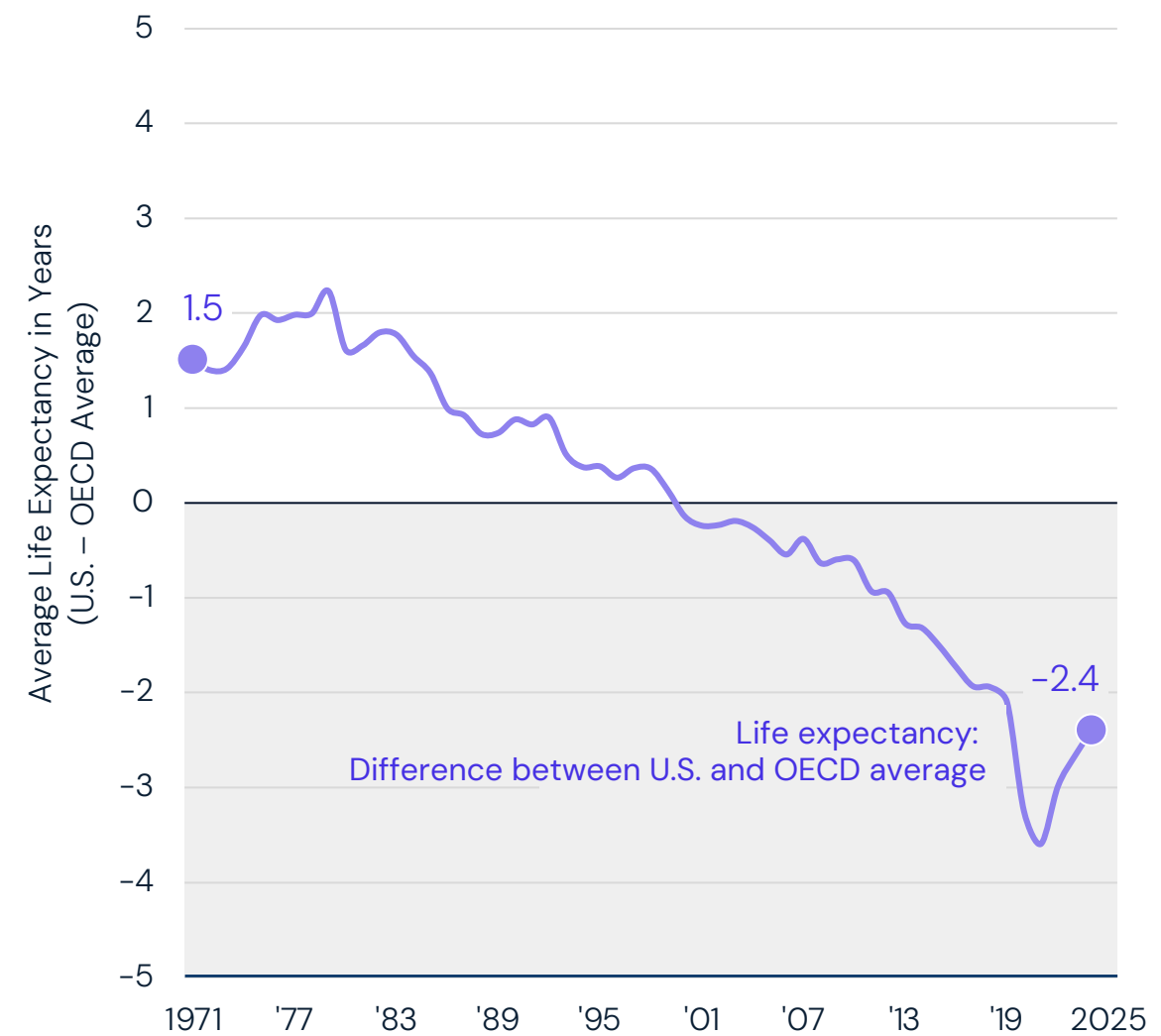
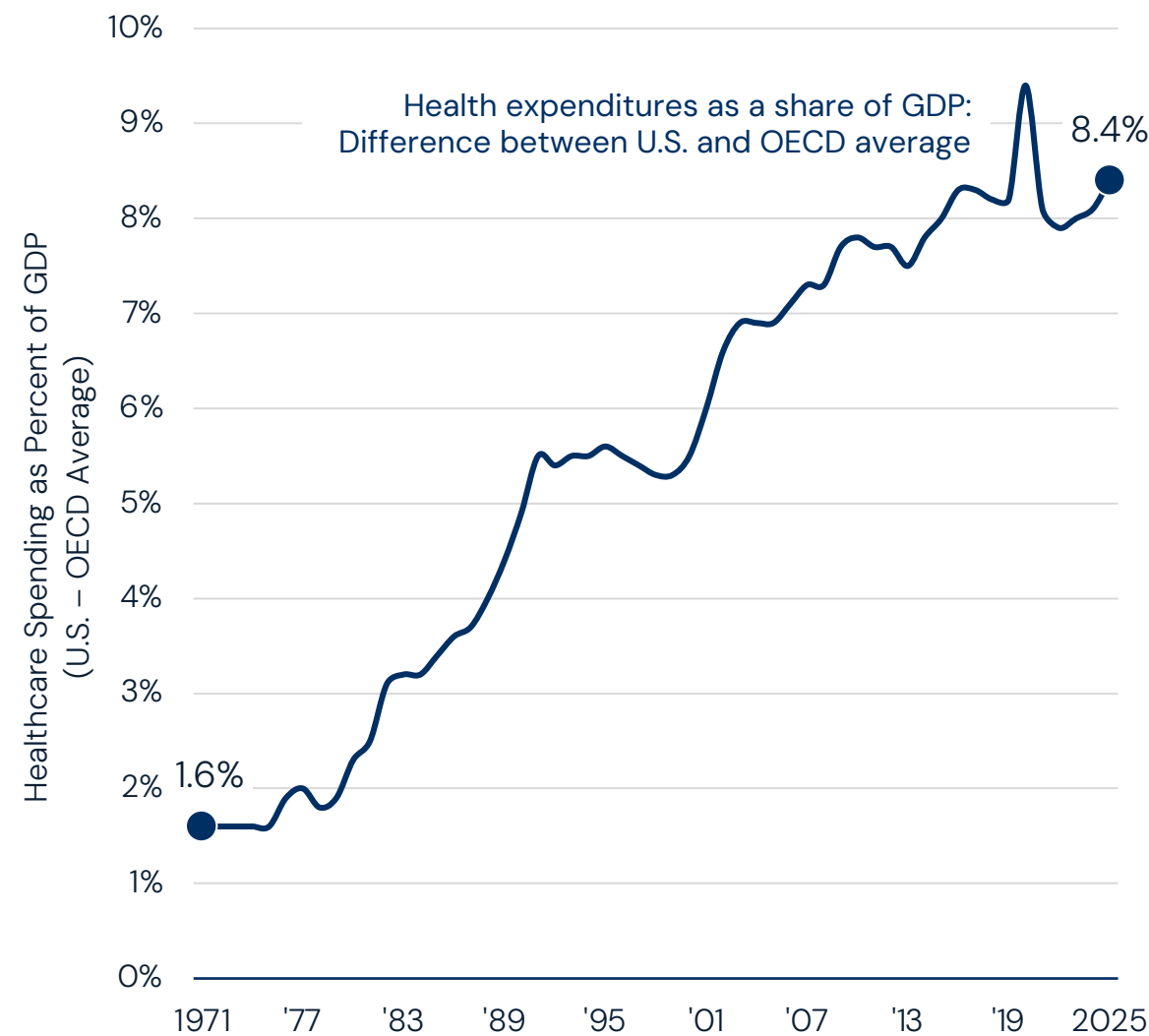
Note: GDP denotes gross domestic product; NHE denotes national health expenditures. Percentages may not add to 100% due to rounding.
Source: U.S. Bureau of Economic Analysis via FRED®; Centers for Medicare & Medicaid Services National Health Expenditures.

INTRODUCTION

The U.S. Healthcare System Delivers Poor Value

In economics, value is a measure of the benefit a good or service provides to an economic agent. In 1972, U.S. health expenditures as a share of GDP were comparable to those of peer countries, and average U.S. life expectancy was 1.5 years longer than the OECD average. However, since the 1990s, the U.S. has spent more than its peers, while life expectancy has fallen below the OECD average – emblematic of poor value.

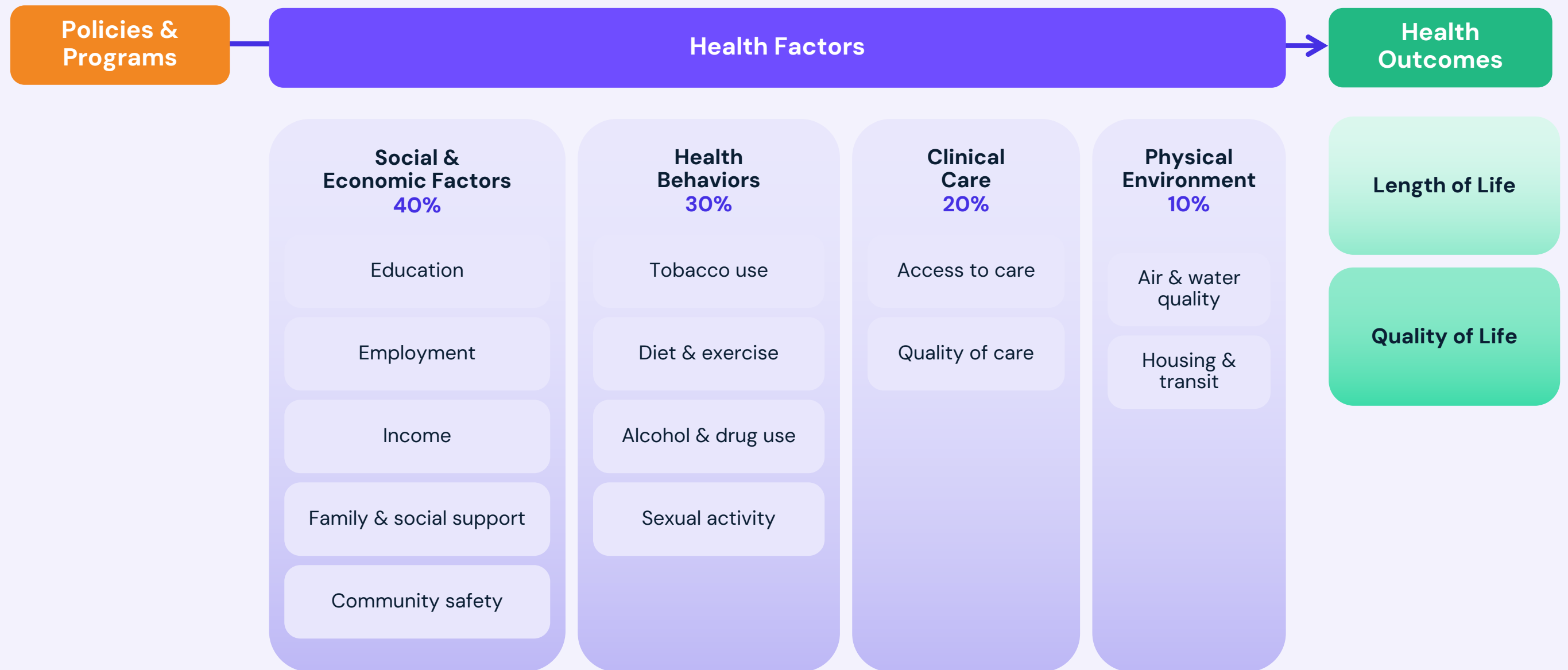
U.S. Health Expenditures and Life Expectancy Relative to the Average of Other OECD Countries, 1971–2025



Note: OECD denotes Organisation for Economic Co-operation and Development; GDP denotes gross domestic product.
Source: Organisation for Economic Co-operation and Development.

Healthcare Is Not the Only Way to Invest in Health

Direct clinical care is only estimated to account for 20% of what determines health outcomes, while the remaining 80% comes from social and economic factors, health behaviors and the physical environment – none of which the health economy is specifically designed to address. The nation's highest return on investment in health may not be a healthcare investment at all.



Source: Hood et al., County Health Rankings: Relationships Between Determinant Factors and Health Outcomes, *American Journal of Preventive Medicine*, 2016.

A Commons in Crisis Reveals the Market Failures That Define the Health Economy

The inputs of the U.S. healthcare system vastly exceed its outputs by any objective measure of the health of the American public. And yet, over the next 10 years, health expenditures are projected to continue to grow faster than the rest of the economy, reaching 20.6% of GDP, or \$25,513 per capita, by 2034. Every dollar spent on healthcare represents a dollar that cannot be spent elsewhere – whether on things that positively impact health, like education or housing, or things that directly impact the financial future of the country, like the national debt. **The current trajectory of the U.S. healthcare system, one which increasingly depletes societal wealth without generating commensurate health gains, is unsustainable for providers, payers, life science companies, employers and patients alike.**

In a functioning market, prices are signals. They tell producers and consumers where to allocate scarce resources, and when circumstances change, prices adjust and behavior follows. The health economy defies this law not because its participants are irrational, but because its prices are opaque, its costs are misallocated and its incentives are misaligned. Beyond the fact that the U.S. health economy is not a free market, it is emblematic of a specific and well-documented market failure: **a commons in which every stakeholder is rational at the margin while the system collectively fails.**

This installment of the Trends Shaping the Health Economy Report examines the U.S. health economy through this lens. Providers are paid to intervene, not prevent. Patients reach for a pill, not a lifestyle change. Payers reduce their own costs by shifting the burden onto patients and

providers. Life science companies price to what rebate structures and patent exclusivity will bear, not to the value delivered. None of these choices are irrational but all of them, in aggregate, deplete the pasture. As it stands, no one is incentivized to improve health. Employers are perhaps best positioned to do so, yet they routinely decline to exert the leverage that comes with their purchasing power.

The Transparency in Coverage initiative and a wave of state and Federal price transparency mandates are, in effect, an attempt at enclosure — assigning ownership, cost and accountability to stakeholders previously insulated from all three. The question for every health economy stakeholder is the same one that commons theory has always posed: **do you govern the resource yourself, or wait for someone else to govern it for you?**

This report does not claim to provide all the answers, but it offers a framework for asking the right questions. Where does your organization escape the cost of its own behavior, and how long will that last? What does your organization look like once the commons on which it has relied is no longer free? Which stakeholder will assign ownership, cost and accountability to the parties that have so far escaped them?

G.K. Chesterton once wrote that "the answer to the question, 'What is wrong?' is, or should be, 'I am wrong.' Until a man can give that answer, his idealism is only a hobby." A Chestertonian mindset about the tragedy of the healthcare commons – a willingness to ask whether the fault lies with your own organization – is the only mindset from which real change is possible.

01

The U.S. Healthcare “System”
Does Not Function as a System

WHAT SYSTEM?

The U.S. has never resolved a series of foundational questions: **what is healthcare, who is entitled to it and who is obligated to pay?** Current policy offers contradictory answers simultaneously. The same clinical encounter can be an earned entitlement, a welfare transfer, a commercially negotiated service or a consumer good, depending on which regulatory or reimbursement framework governs the transaction. Traditional Medicare beneficiaries have different coverage and financial responsibility than Medicare Advantage enrollees, and Medicaid eligibility and coverage are different in all 50 states. Only patients presenting in an emergency department are treated equally in every state, without respect to ability to pay.

Current policy debates are an expression of an unresolved national argument about the nature and boundaries of healthcare itself. Without a shared definition of what healthcare is – **commodity, right, public good or earned benefit** – and without agreement on what basket of services that definition implies, every reform operates on contested premises, and every stakeholder can invoke a legitimate competing framework to resist unfavorable changes. As a result, coherent redesign is not only challenging but, for current stakeholders, economically irrational.

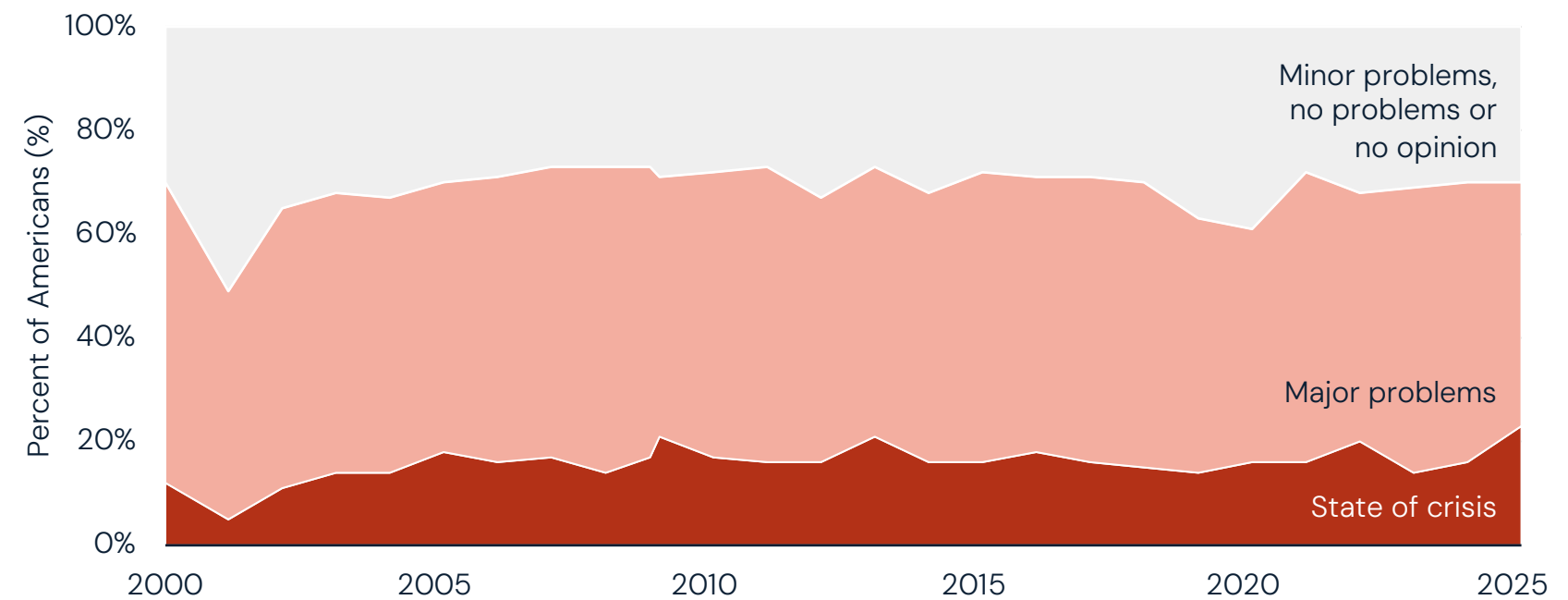
This fundamental disagreement, or rather **lack of agreement**, has been simmering for years, but stakeholders have done little other than increase the American consumer's share of the financial burden. Unsurprisingly, individual Americans do not trust a system that they cannot reasonably and reliably navigate. Health economy stakeholders should expect that the tragedy of the commons will manifest in a "**healthcare election**" on November 7, 2028.

WHAT SYSTEM?

Ubiquitous Concern About the Healthcare System Has Not Translated to a Consensus on Solutions

Since 2000, 69% of Americans, on average, have felt that the healthcare system has major problems or is in a state of crisis. In 2025, the share of Americans who believe the system is in a state of crisis reached a peak of 23%. However, Americans do not agree on a solution. Approximately two-thirds of the population thinks it is the Federal government's responsibility to ensure healthcare coverage, but one-third does not. Moreover, Americans are divided on a public (46%) versus private healthcare system (48%).

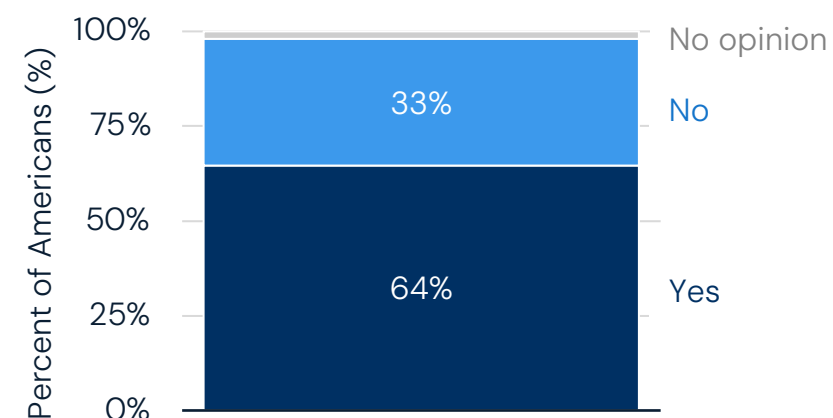
Share of Americans Who Believe the Healthcare System Has Major Problems or Is in Crisis, 2000–2025



Americans' Opinions on Public vs. Private Healthcare, 2025

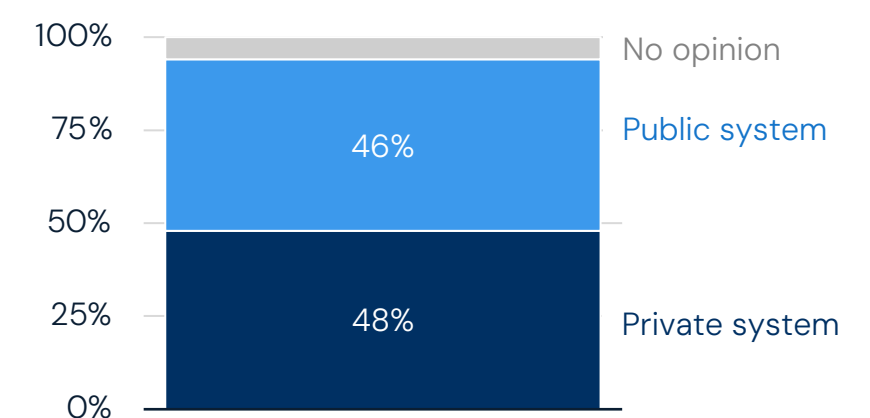
Government Responsibility

Do you think it is the responsibility of the Federal government to make sure all Americans have healthcare coverage?



Type of System

Which of the following approaches for providing healthcare in the United States would you prefer?



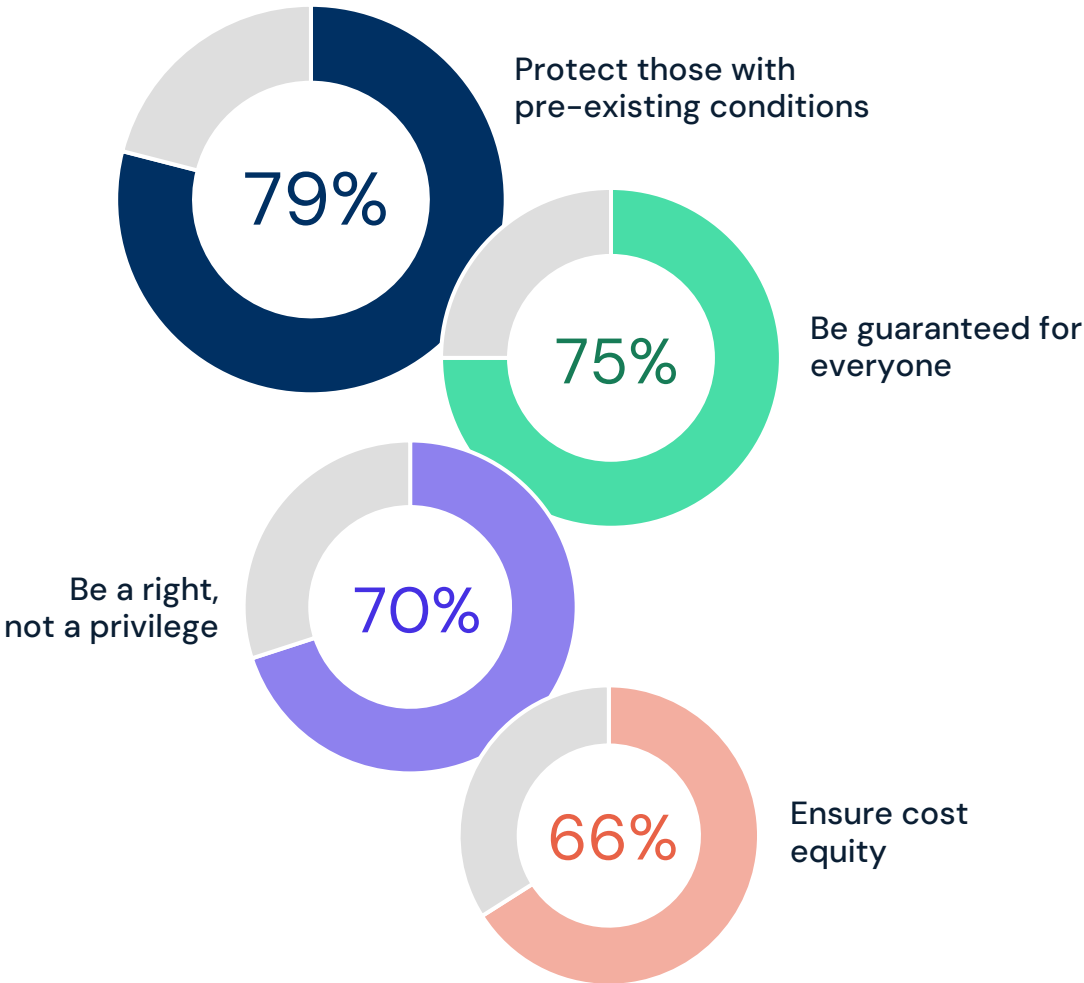
Source: West Health-Gallup Center on Healthcare in America.

WHAT SYSTEM?

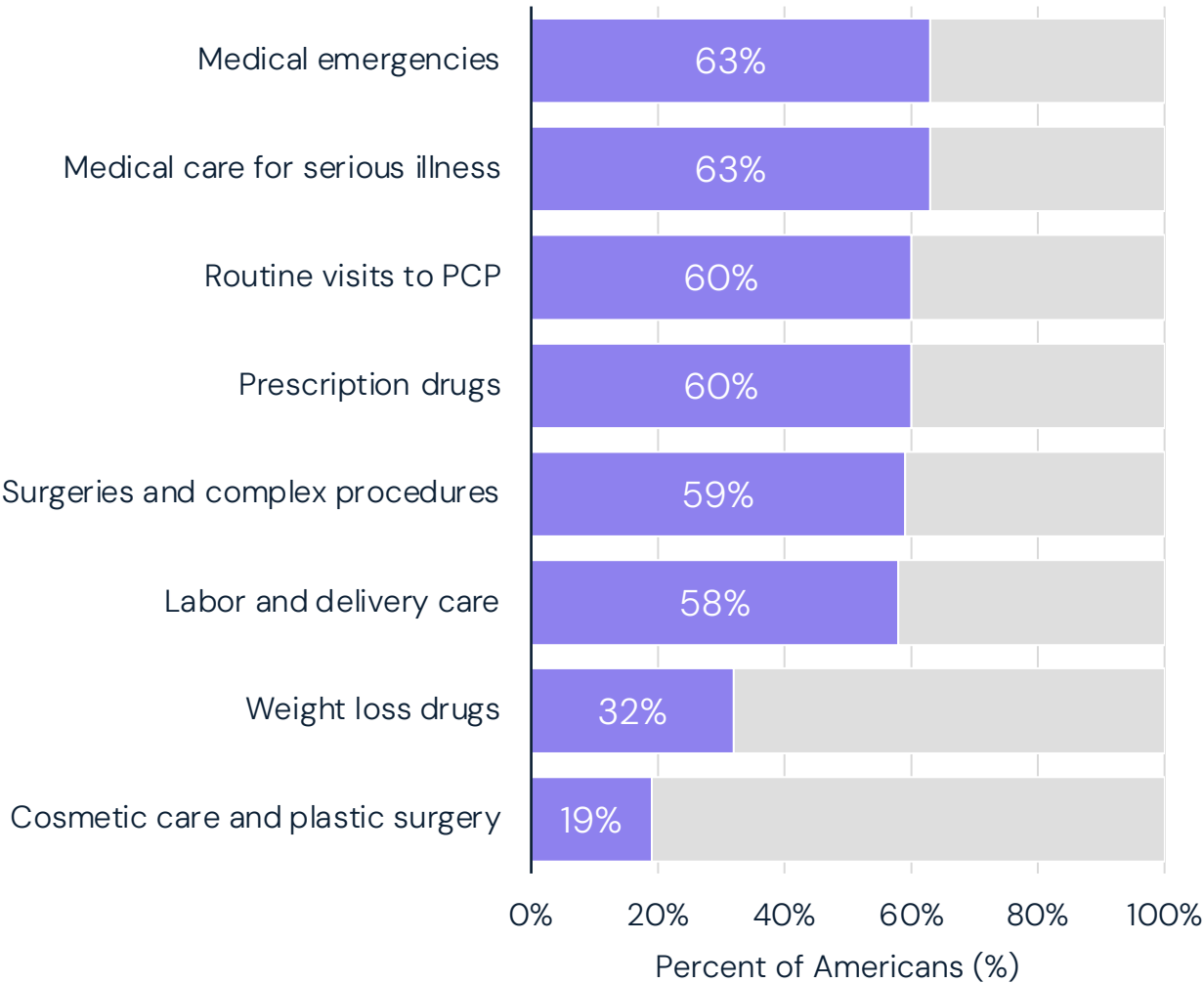
Americans Disagree on What They Want From a Healthcare System

Some general principles about healthcare are widely held: 79% of people believe healthcare should protect people with pre-existing conditions. However, there is a lack of consensus on the specific services that a hypothetical Federal healthcare system should cover. For example, approximately 60% of Americans support coverage of routine visits to PCPs and prescription drugs, but only 32% support coverage of weight loss drugs.

Americans’ Beliefs About What They Want in Healthcare, 2025



Americans’ Support For the Federal Government Covering Medical Services, 2026



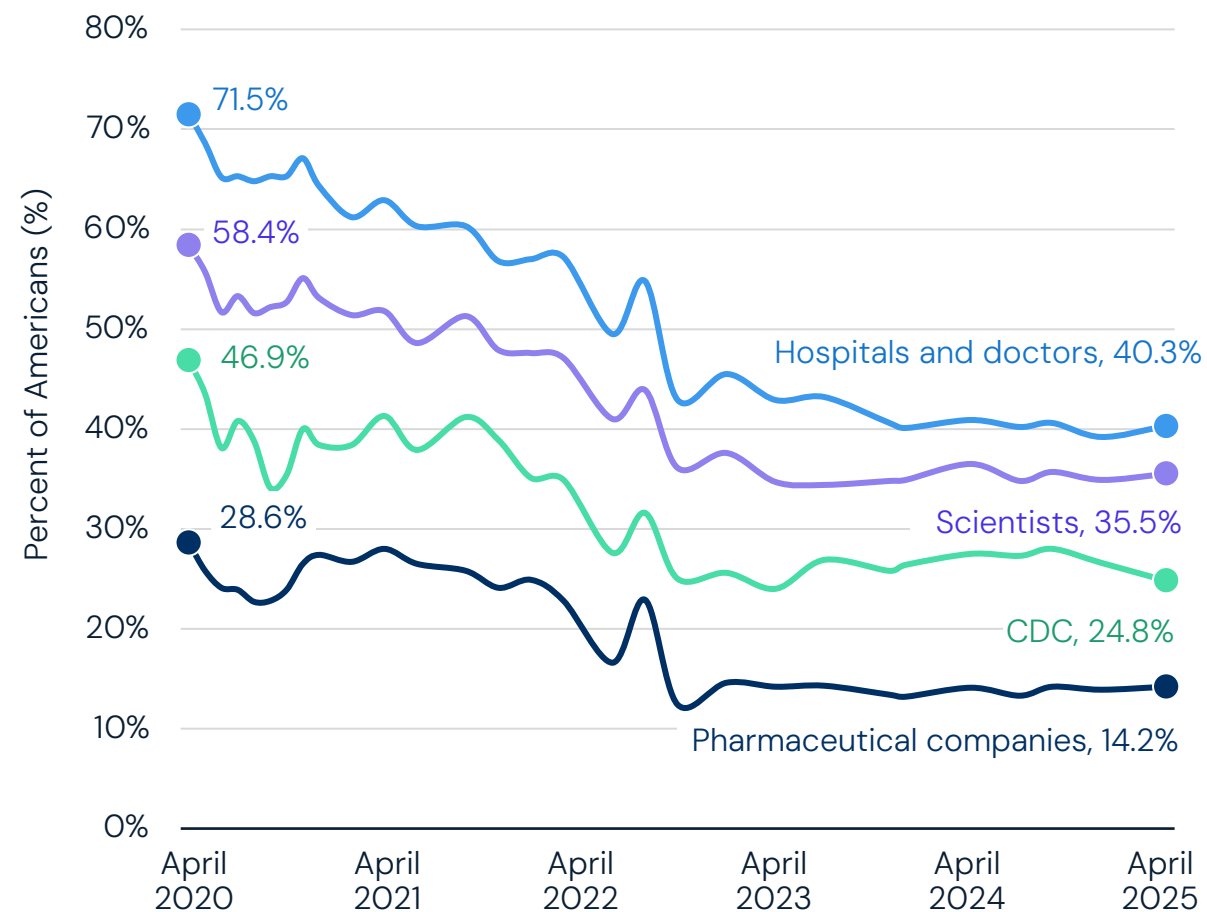
Note: PCP denotes primary care physician. The full items are “There should be guaranteed access to health care for everyone, regardless of ability to pay” and “Health care should ensure equity in billed costs across insurance types.” Medical care for serious illness includes care for conditions like cancer and heart disease.
Source: Searchlight Institute; John Hopkins Institute For Policy Solutions.

WHAT SYSTEM?

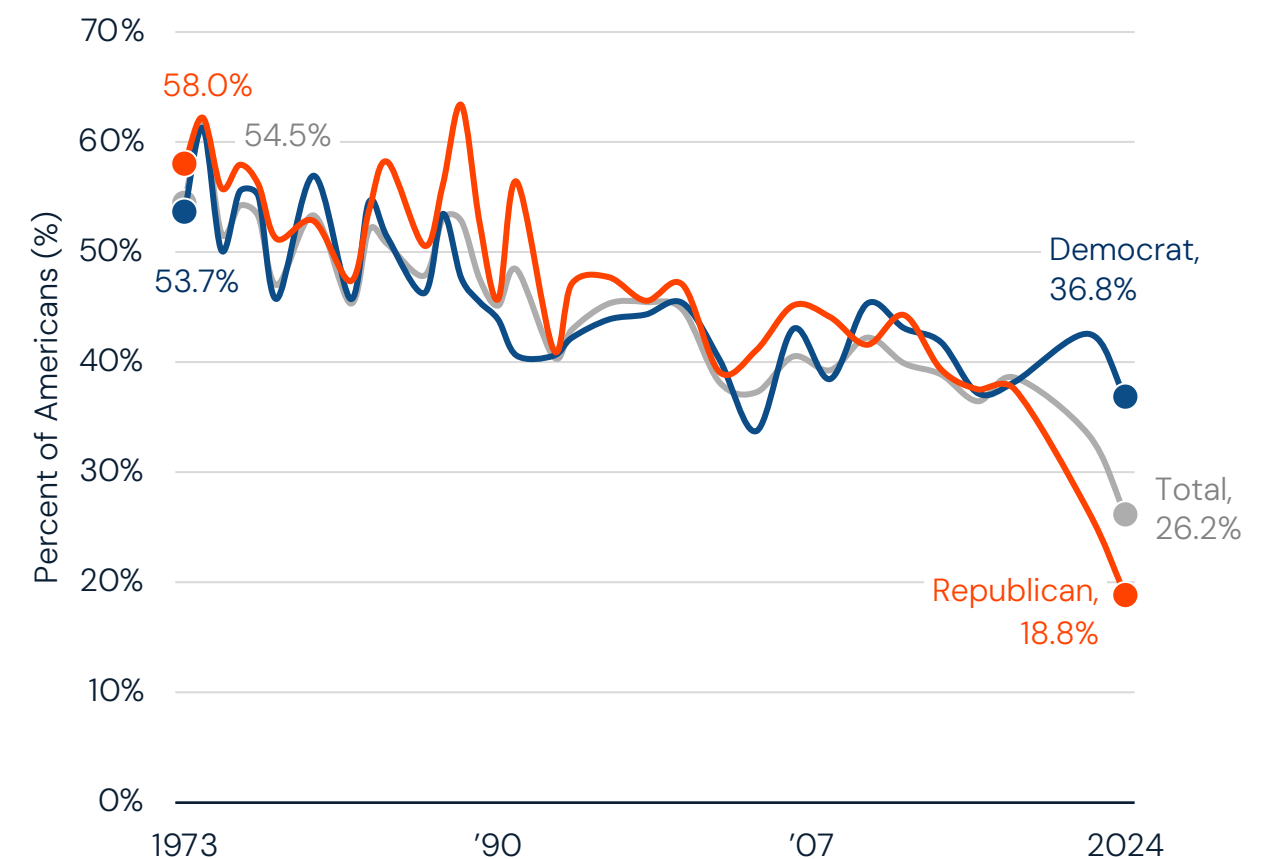
COVID-19 Accelerated Distrust in the Healthcare System

Public opinion toward health institutions has become less favorable over time. In April 2025, 40.3% of Americans had “a lot” of trust in hospitals and doctors, down from 71.5% in April 2020. Trust in pharmaceutical companies is even lower, decreasing from 28.6% in April 2020 to 14.2% in April 2025. While confidence in medical leadership has declined across political parties, this trend has accelerated among Republicans.

Share of Americans Reporting “A Lot” of Trust in Health Institutions, April 2020–April 2025



Share of Americans With “A Great Deal” of Confidence in Medicine’s Leadership, by Political Affiliation, 1973–2024



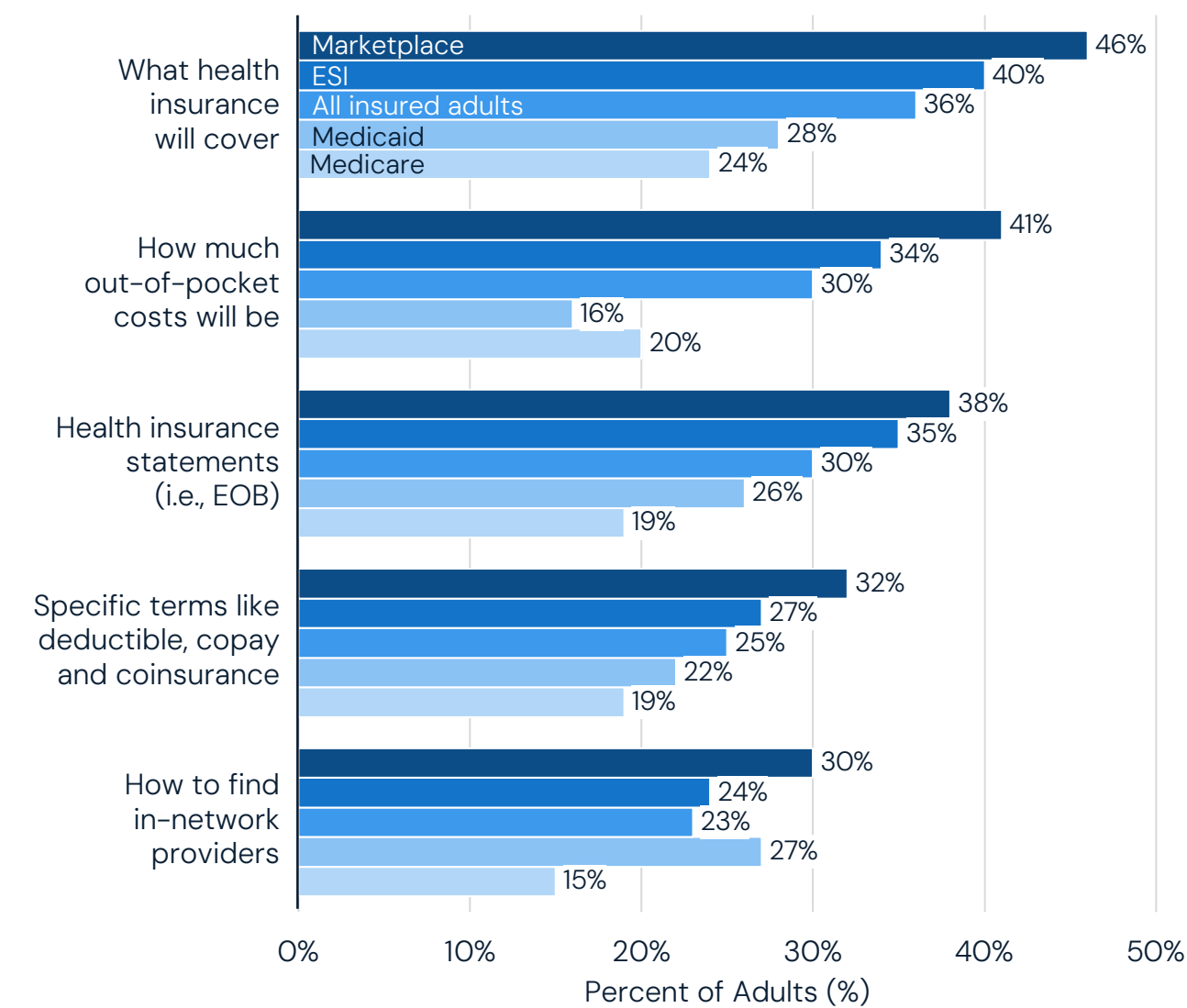
Note: CDC denotes the Centers for Disease Control and Prevention. Scientists includes scientists and researchers. The survey question on trust in health institutions read, “How much do you trust the following people and organizations to do the right thing to best handle the current coronavirus (COVID-19) outbreak?” until August 2022 when it was changed to, “How much do you trust the following people and organizations to do what is right?”
Source: The COVID-19 Consortium for Understanding the Public’s Policy Preferences Across States; NORC at the University of Chicago, General Social Survey 1973–2024.

WHAT SYSTEM?

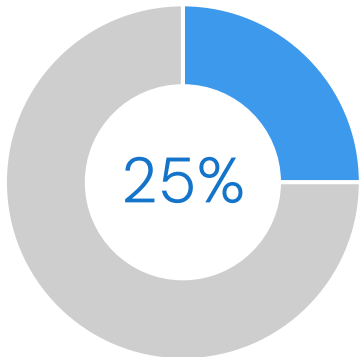
Patients Struggle to Navigate the Healthcare System

A majority of insured Americans (58%) have difficulty understanding at least one aspect of their health insurance (e.g., coverage, out-of-pocket costs, EOB). Meanwhile, 25% of Americans delayed or did not get needed medical care in 2025 because they did not know how to find a provider. Younger adults report the most challenges, with 76% of those ages 18–34 describing healthcare coordination as overwhelming and time-consuming.

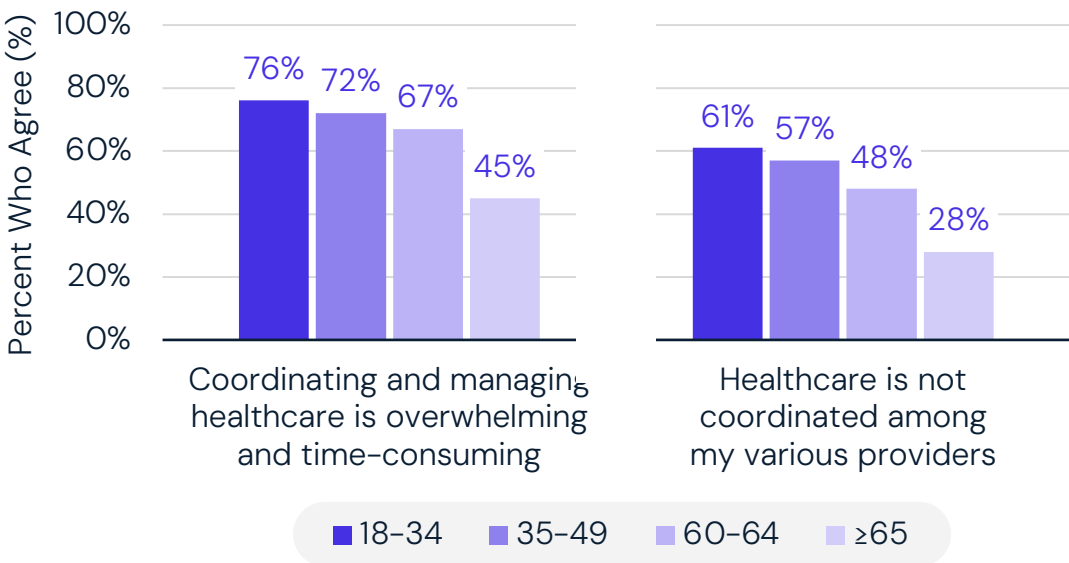
Share of Adults Who Say It Is Difficult to Understand Aspects of Their Current Health Insurance, by Payer, 2023



Share of Adults Who Reported Not Knowing How to Find a Provider Delayed or Prevented Receiving Care in the Last Year, 2025



Share of Adults Who Experienced Healthcare Coordination Challenges, by Age, 2024



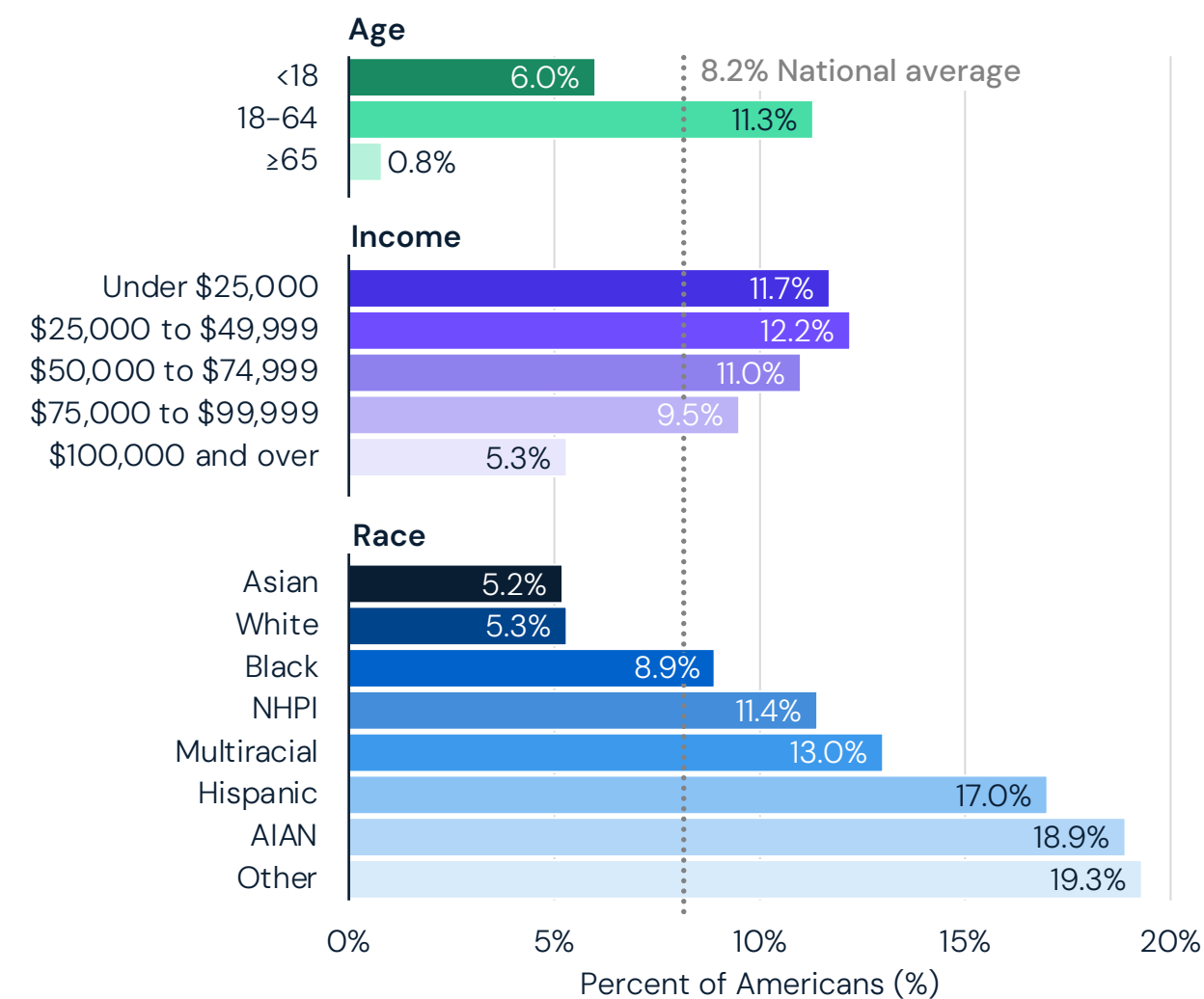
Note: EOB denotes explanation of benefits; ESI denotes employer-sponsored insurance.
Source: American Academy of Physician Associates, The Patient Experience: Perspectives on Today's Healthcare; West Health-Gallup Center for Healthcare in America; KFF, Survey of Consumer Experiences with Health Insurance, 2023.

WHAT SYSTEM?

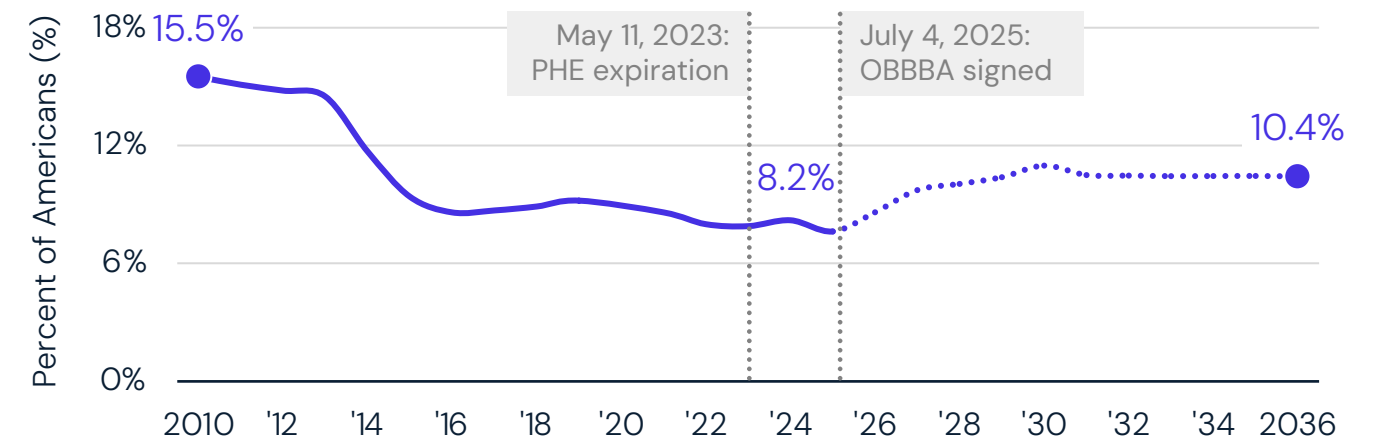
Despite Improvements, 8.2% of Americans Remain Uninsured

Since implementation of the ACA, the share of uninsured Americans has decreased from 15.5% in 2010 to 8.2% in 2024. These improvements are unevenly distributed: 11.3% of adults ages 18–64, 12.2% of those with an annual household income of \$25,000–\$49,999 and 17.0% of Hispanic individuals were uninsured in 2024. In 2024, 30.8% of uninsured Americans delayed or skipped needed care due to cost, compared to 10.0% of Americans overall.

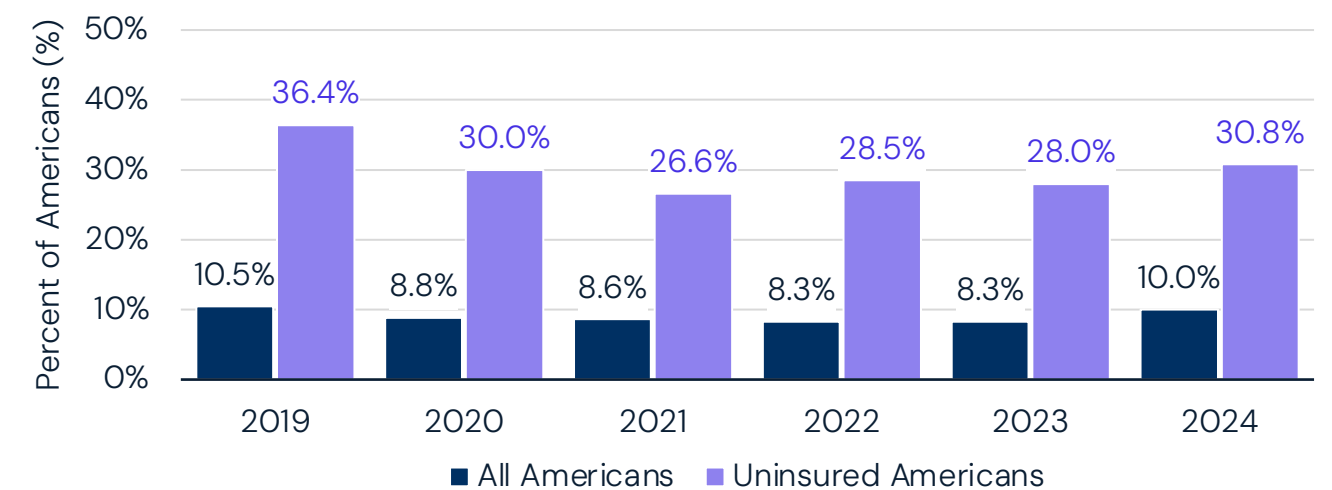
Share of Americans Without Health Insurance, by Age, Income and Race, 2024



Share of Americans Without Health Insurance, 2010–2036



Share of Adults Who Delayed or Did Not Get Care Due to Cost, by Insurance Status, 2004–2024



Note: ACA denotes Affordable Care Act; NHPI denotes Native Hawaiian or other Pacific Islander; AIAN denotes American Indian and Alaska Native; PHE denotes public health emergency; OBBBA denotes One Big Beautiful Bill Act. The OBBBA included expiration of ACA enhanced subsidies and nationwide Medicaid work requirements. Income is household annual income.

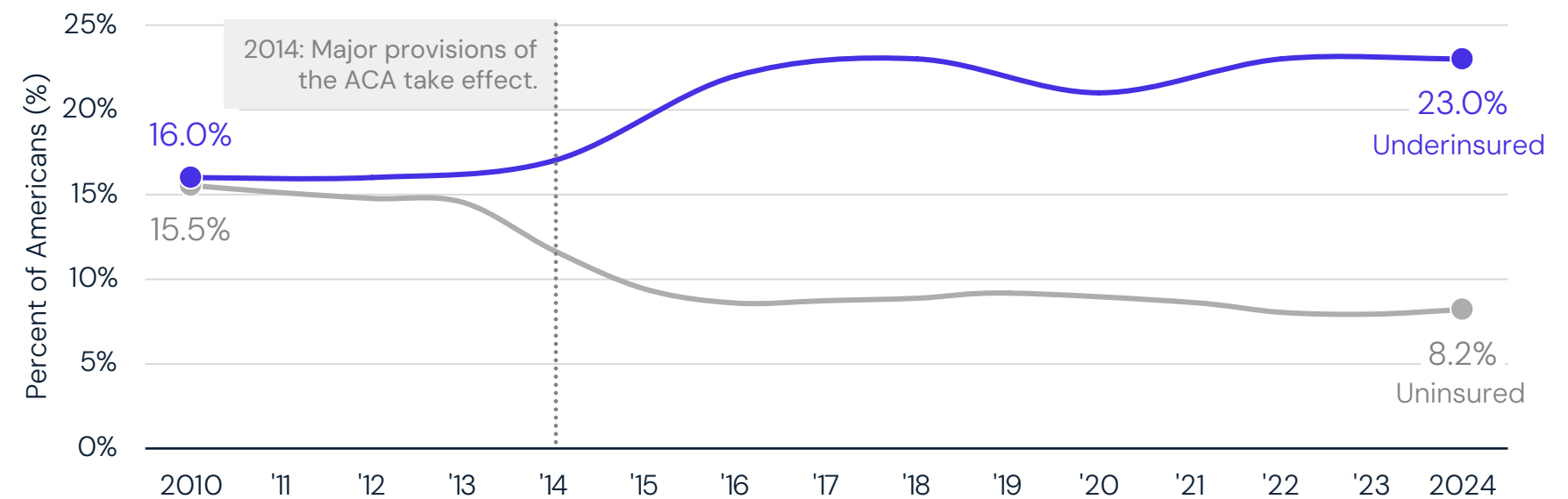
Source: American Community Survey 1-Year Estimates; Congressional Budget Office Baseline Projections; Peterson-KFF Health System Tracker.

WHAT SYSTEM?

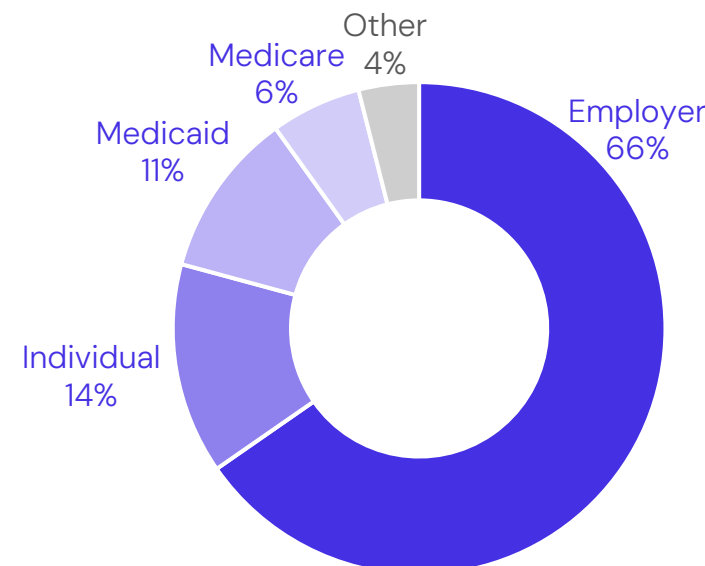
Underinsurance Has Eclipsed Uninsurance as America's Primary Coverage Challenge

Although more people have health insurance following ACA implementation, an increasing share are underinsured, meaning cost sharing is so substantial that it deters care seeking or puts patients at risk of medical debt. Between 2010 and 2024, the share of Americans considered underinsured increased from 16.0% to 23.0%. As of 2024, people with employer-sponsored insurance are over-represented in the underinsured population, accounting for 59% of the insured population but 66% of the underinsured population. While 35% of uninsured individuals have medical debt, this share increases to 44% of underinsured adults.

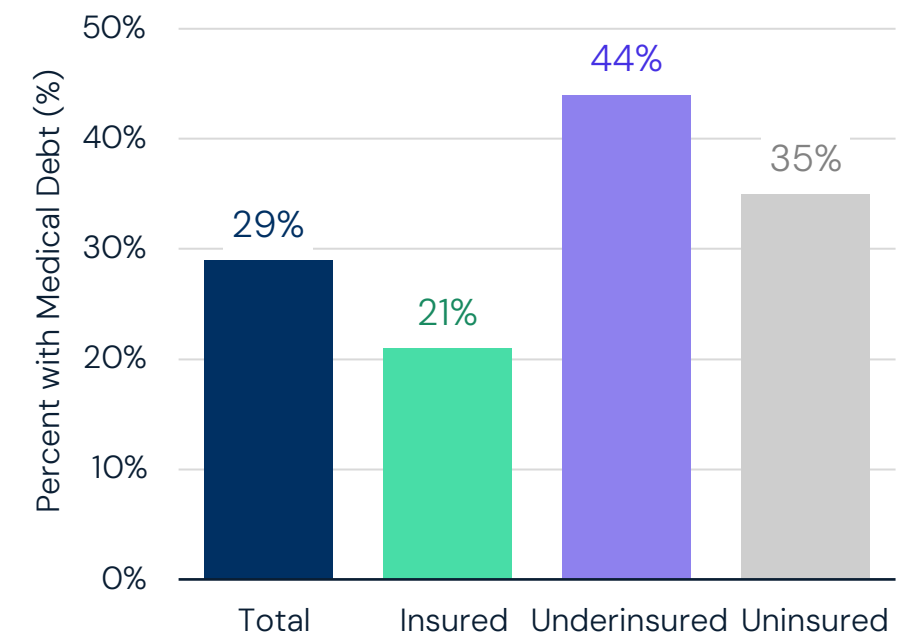
Share of Americans Who Are Uninsured and Underinsured, 2010–2024



Share of Underinsured Working-Age Adults, by Plan Type, 2024



Share of Adults Ages 19–64 With Medical Debt, by Insurance Status, 2024



Note: ACA denotes the Affordable Care Act. Underinsured means being insured all year but experiencing at least one of the following: out-of-pocket costs, excluding premiums, are 10% or more of household income, out-of-pocket costs, excluding premiums, are 5% or more of household income for households under 200% of the poverty line or deductibles are 5% or more of household income. Percentages may not add to 100% due to rounding.

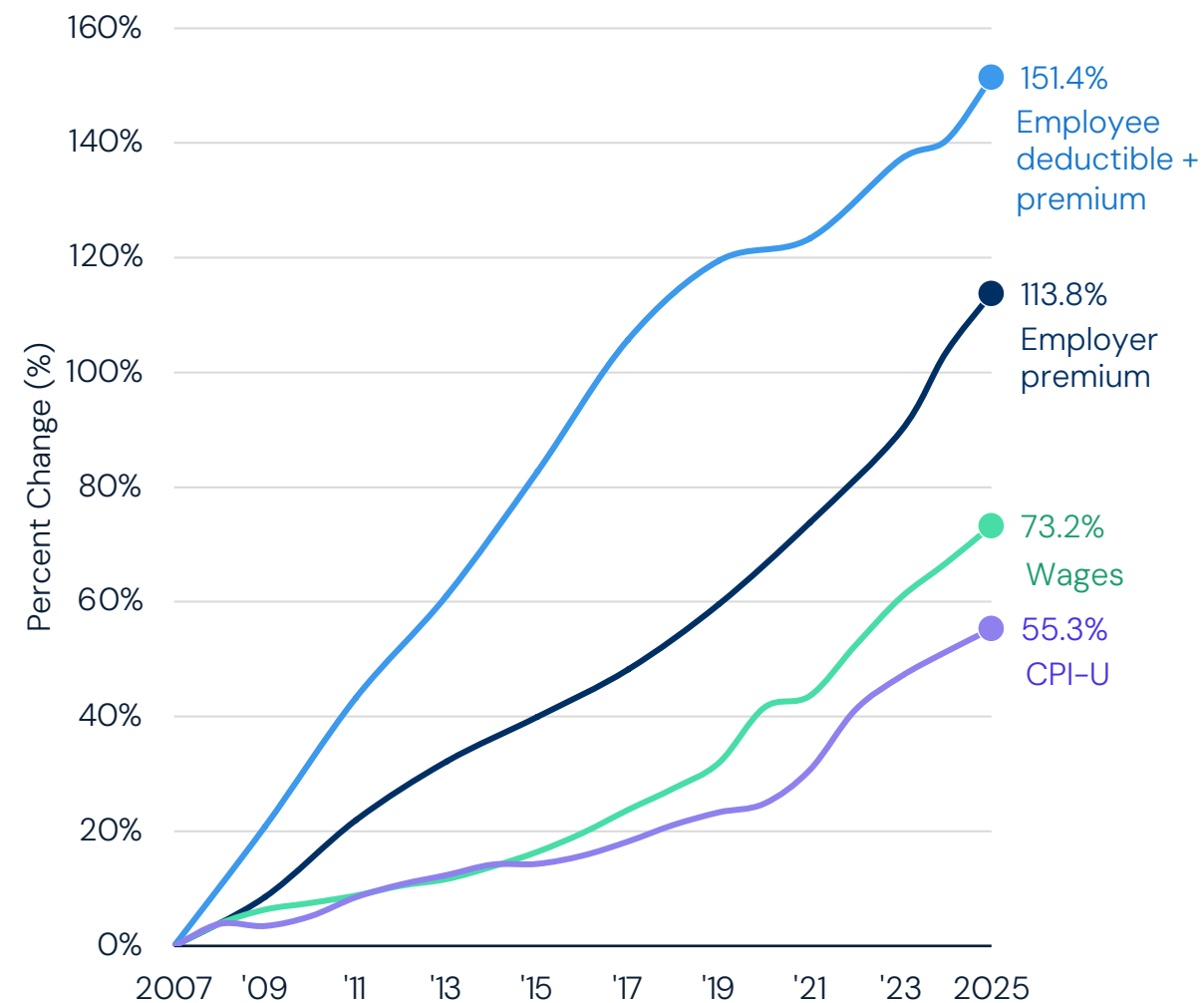
Source: The Commonwealth Fund; American Community Survey 1-Year Estimates.

WHAT SYSTEM?

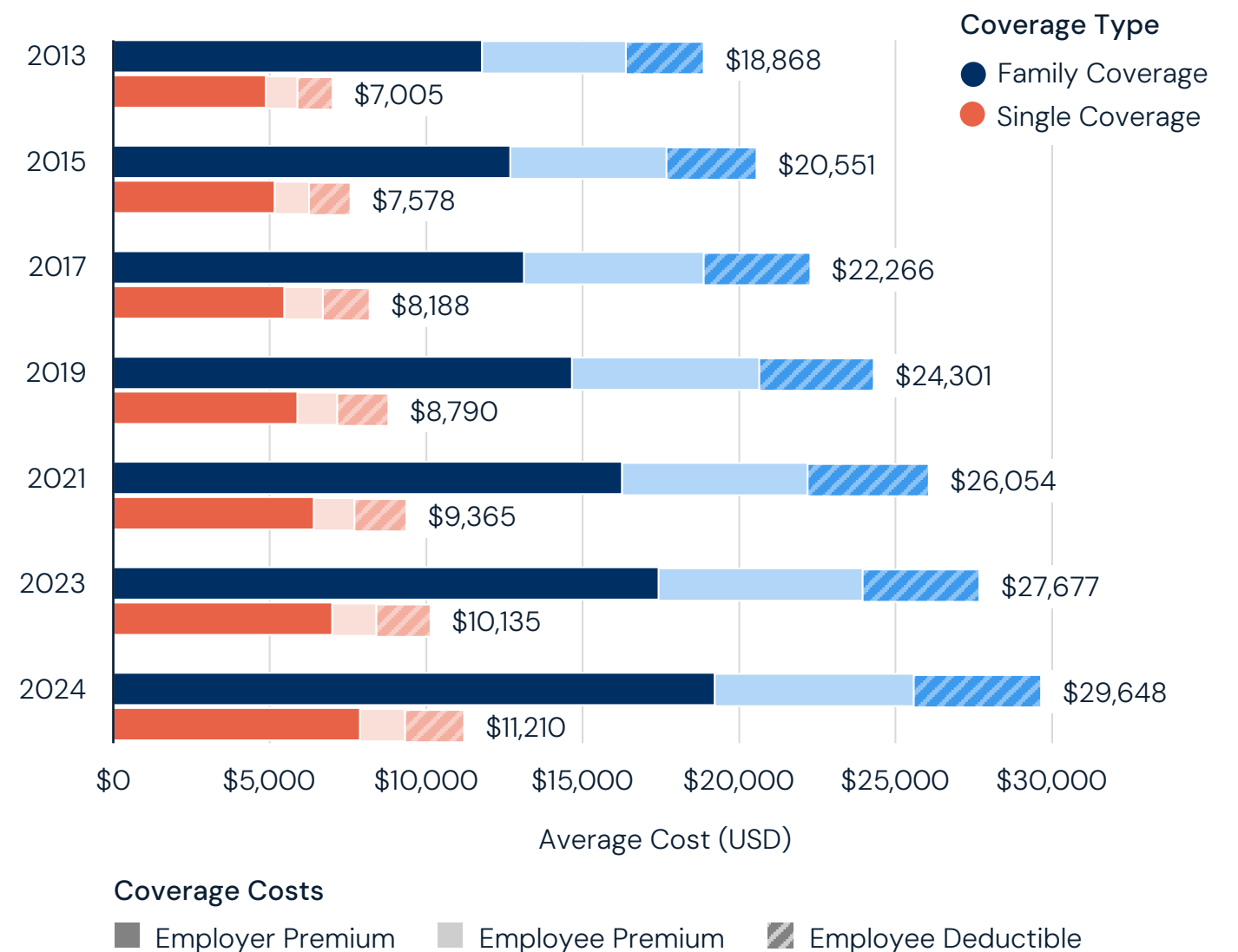
The Cost of Insurance Is Growing Faster Than Wages and Inflation

Employee deductibles and premiums rose 151.4% from 2007 to 2025, outpacing wage growth, inflation and employer premium contributions. On average, employees were expected to cover 29.7% of single coverage insurance costs in 2024, which totals \$3,326 per year.

Cost Growth in Single Coverage Employer-Sponsored Insurance and Wages vs. Inflation, 2007-2025



Average Annual Insurance Costs for Employer-Sponsored Health Plans, by Coverage Type, 2013-2024



Note: CPI-U denotes consumer price index for all urban consumers for all items. Wages are median weekly wages.
Source: U.S. Bureau of Labor Statistics; KFF, Employer Health Benefits Survey, 2025.

WHAT SYSTEM?

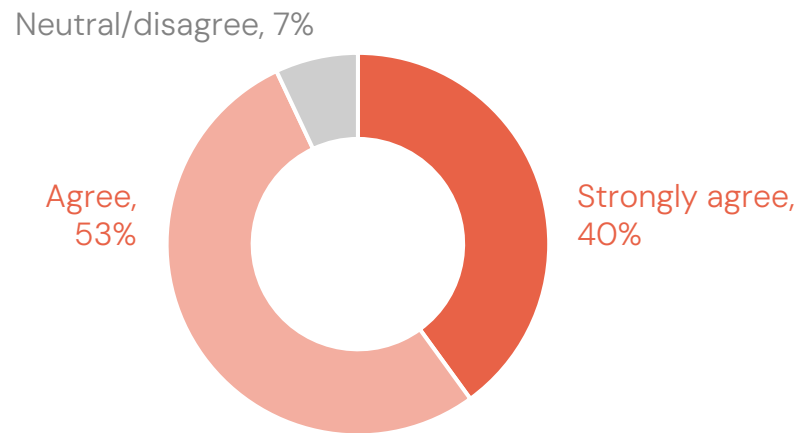
High Deductibles Shift Financial Risk to Patients

HDHP enrollment has increased from 5% of covered workers in 2007 to 33% in 2025. During the same period, the average HDHP deductible increased 49.1% from \$1,750 to \$2,609 and the employee portion of the deductible increased from 59.3% to 70.0%. The OOP maximum for single coverage HSA-qualified HDHPs increased 45.9%, from \$3,090 to \$4,509. Notably, 93% of employers agree that higher costs will result in further cost shifting.

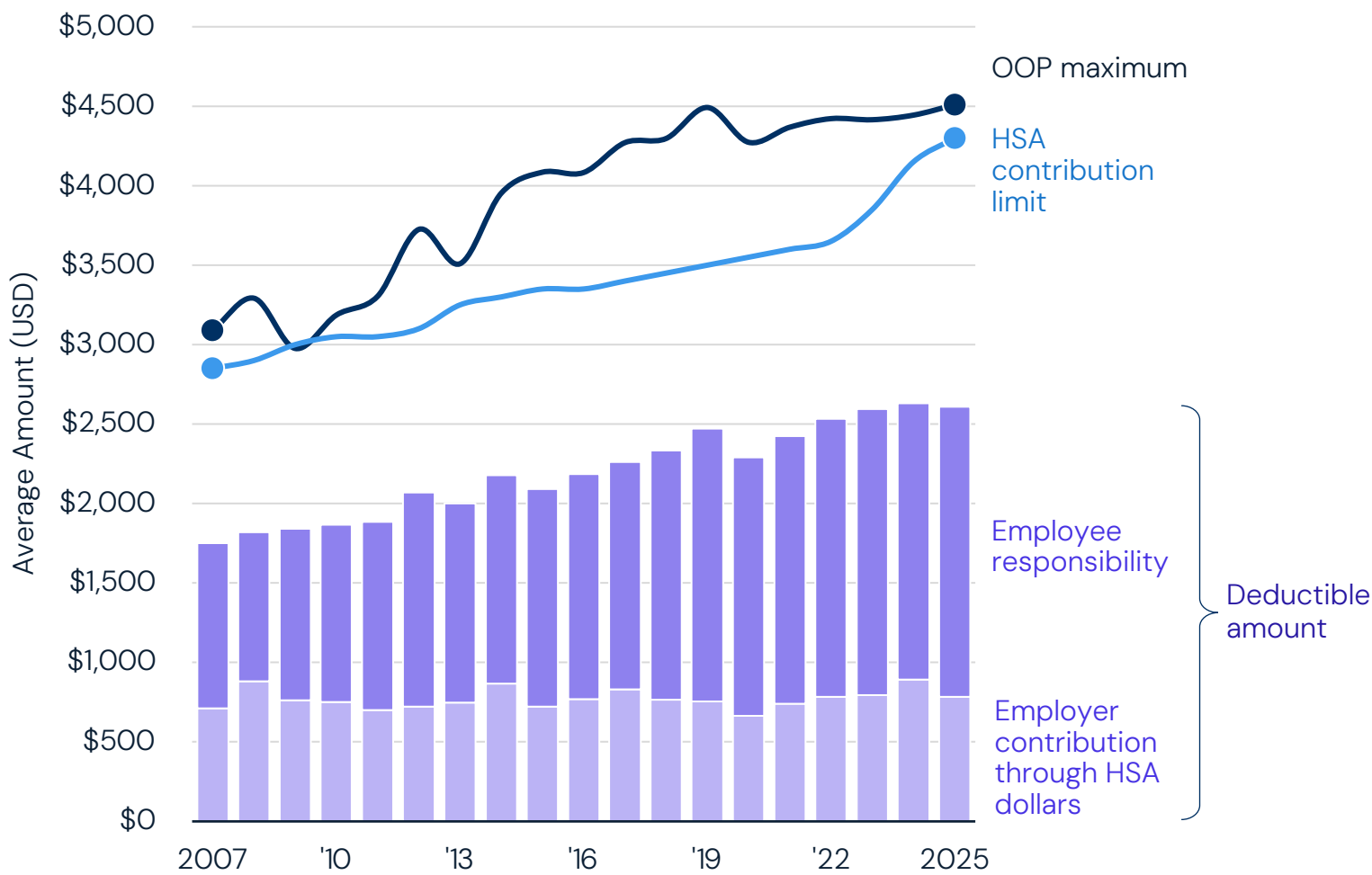
Share of Covered Workers Enrolled in HDHP/SO, 2007–2025



Share of Employers Who Believe Higher Costs Will Result In Further Cost-Shifting, 2026



HSA Contribution Limit, Average OOP Maximum and Average Deductibles for Single-Coverage Workers Enrolled in HDHP/SO, 2007–2025



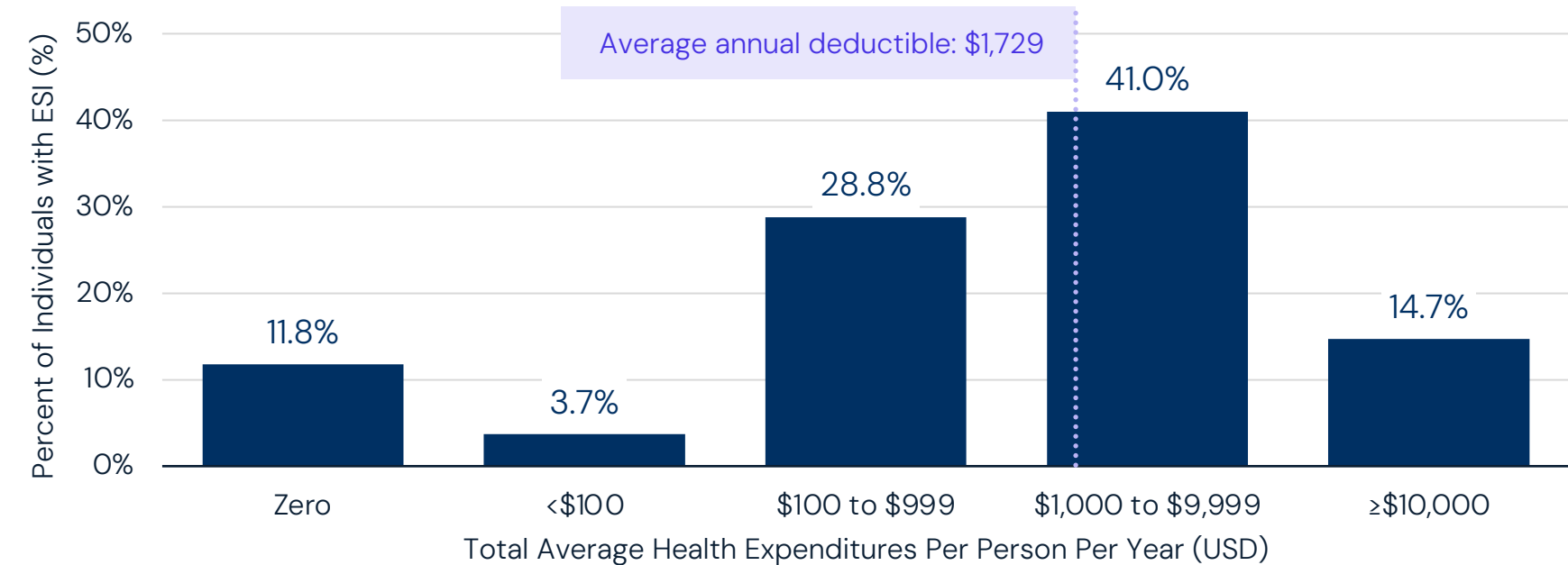
Note: HDHP denotes high-deductible health plan; HDHP/SO denotes high-deductible health plan with a savings option; HSA denotes health savings account; OOP denotes out-of-pocket.
Source: KFF, Employer Health Benefits Survey, 2025; Internal Revenue Service; National Alliance of Healthcare Purchaser Coalitions, Pulse of the Purchaser, 2026.

WHAT SYSTEM?

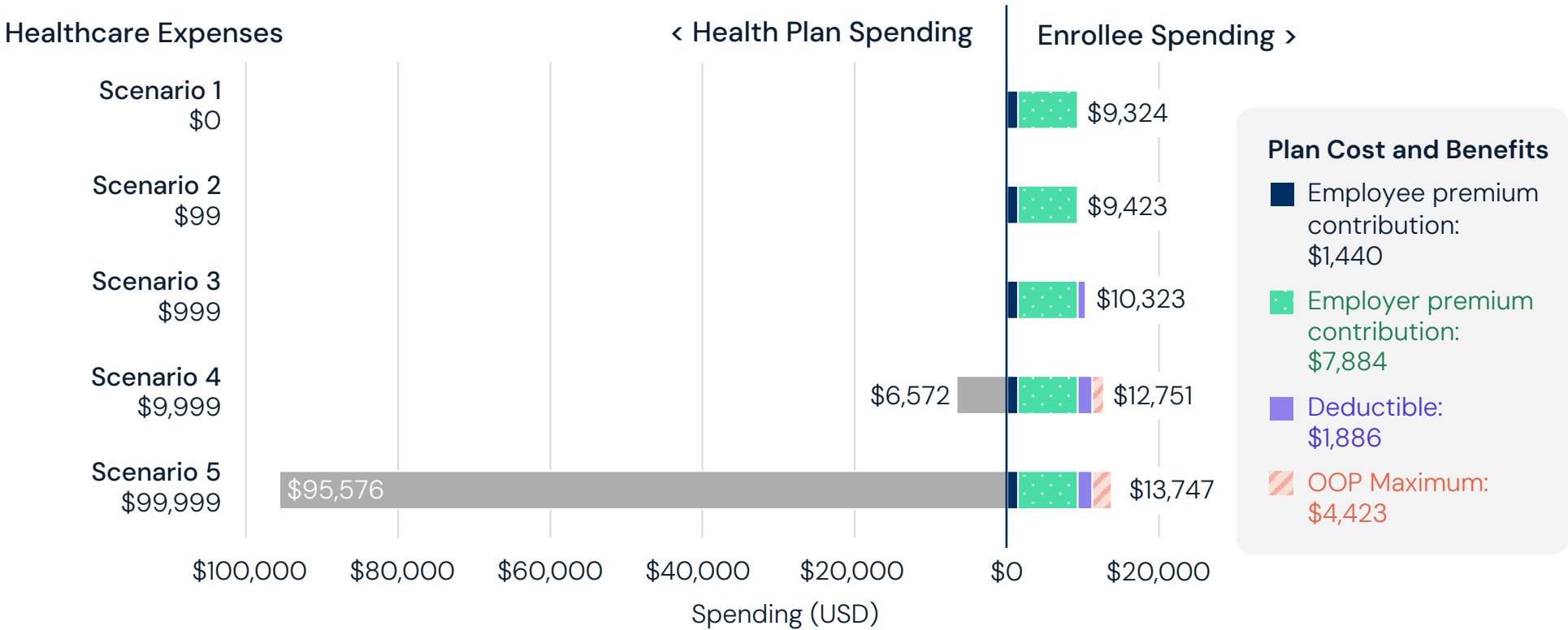
Insurance Functions Only as Catastrophic Coverage for Many Americans

At least 44.3% of employees with employer-sponsored health insurance spent less than the average annual deductible (\$1,729) in 2023. In a scenario where an individual with fully insured employer-sponsored insurance accrues \$9,999 in healthcare expenses, the enrollee and their employer would be responsible for \$12,751 in premiums, deductible and coinsurance, while the health plan would be responsible for \$6,572. In a different scenario with only \$999 in expenses, the employee and employer would spend \$10,323, while the health plan would spend \$0. In an HDHP, patient responsibility would be considerably higher.

Distribution of Total Health Spending Among Individuals with Employer-Sponsored Insurance, 2023



Fully Insured Employer-Sponsored Health Insurance Spending Scenarios



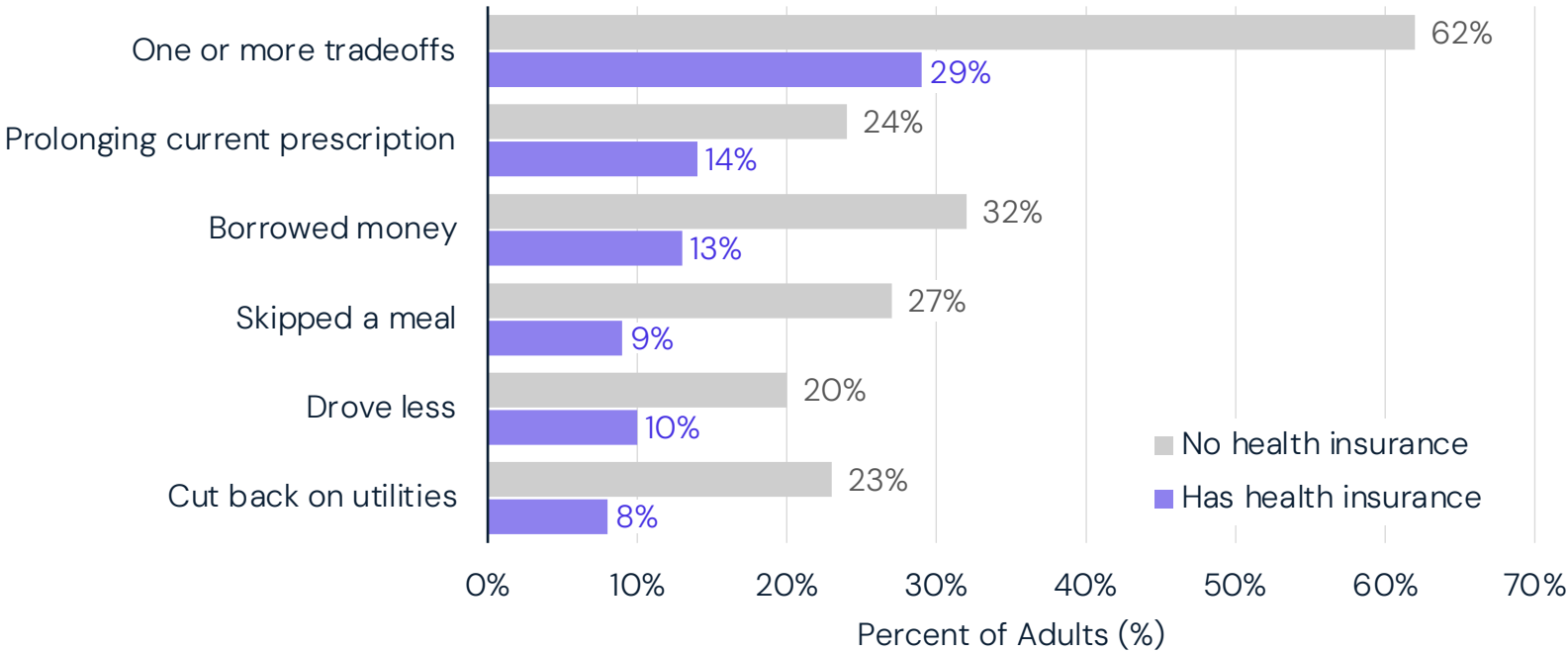
Note: OOP denotes out-of-pocket; HDHP denotes high-deductible health plan; ESI denotes employer-sponsored insurance. Coinsurance of 19% was applied to all scenarios.
Source: Peterson-KFF Health System Tracker; KFF, Employer Health Benefits Survey, 2025.

WHAT SYSTEM?

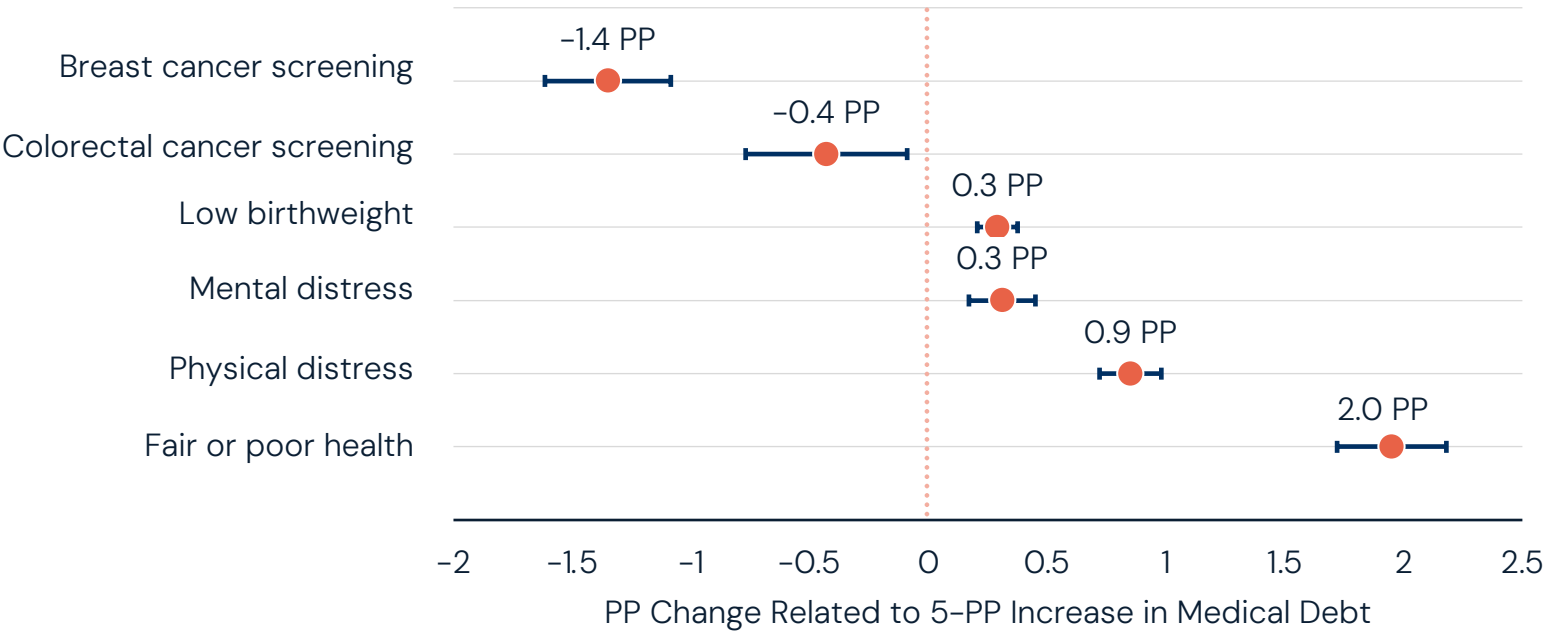
Financial Toxicity Is Associated With Worse Health Outcomes

Financial toxicity refers to the negative physical, psychological, emotional and economic side effects of high medical costs. Over a 12-month period, 62% of uninsured adults made at least one tradeoff to pay for health expenses (e.g., skipping a meal), compared to 29% among insured adults. Between 2017 and 2022, a 5.0 PP increase in a county’s medical debt was associated with a 1.4 PP decrease in its breast cancer screening rate. Similarly, medical debt was associated with increased levels of fair or poor health (2.0 PP) and physical distress (0.9 PP).

Tradeoffs in the Past 12 Months to Pay for Health Expenses, by Insurance Status, 2025



Estimated Effects of County-Level Medical Debt on Health Outcomes Across U.S. Counties, 2017–2022



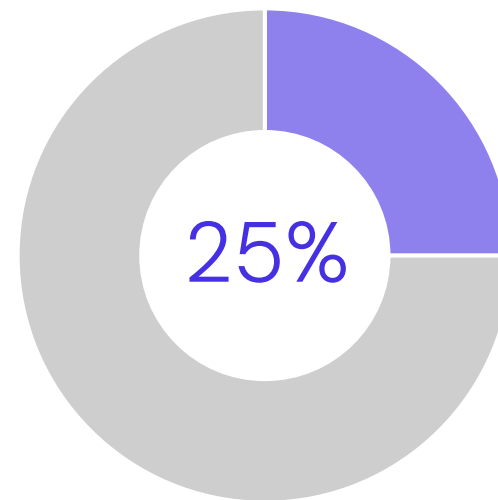
Note: PP denotes percentage point.
Source: West Health–Gallup Center on Healthcare; Chatzipanagiotou et al., Medical Debt in the U.S.: Associations With Cancer Screening, Mortality and Health Status, *Health Affairs*, 2025.

WHAT SYSTEM?

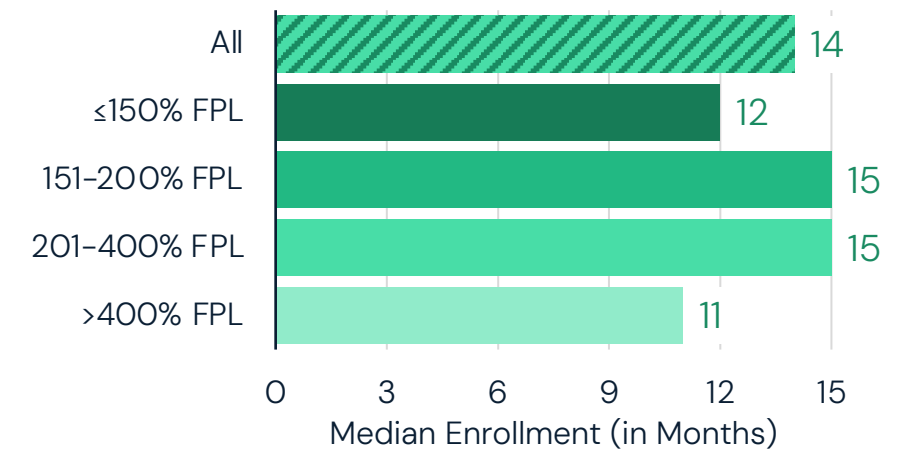
Enrollment Churn Disincentivizes Long-Term Investments in Health

Between 2006 and 2018, 25% of Americans with ESI were continuously enrolled across a five-year period. While Medicare beneficiaries experienced less enrollment churn, 21% of MA beneficiaries switched their coverage source in 2024. Likewise, among Medicaid beneficiaries who were up for renewal, an average of 19.7% were disenrolled from coverage each month between April 2023 and April 2026. In California, median Marketplace enrollment duration was 14 months. From the perspective of insurers, frequent churn lessens incentives to invest in preventive care, chronic disease management and care continuity.

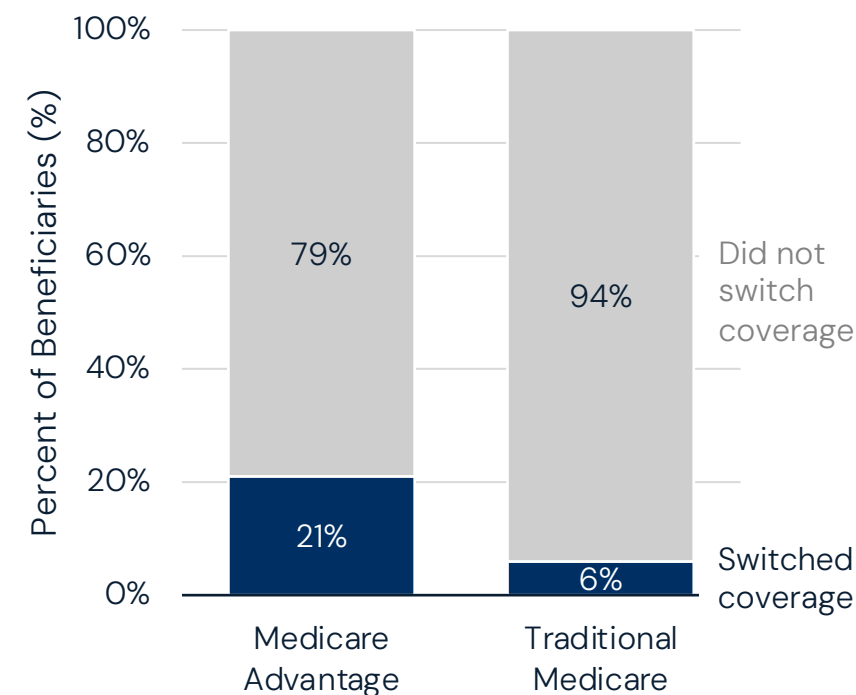
Share of Americans
Continuously Enrolled in ESI for
a Five-Year Period, 2006–2018



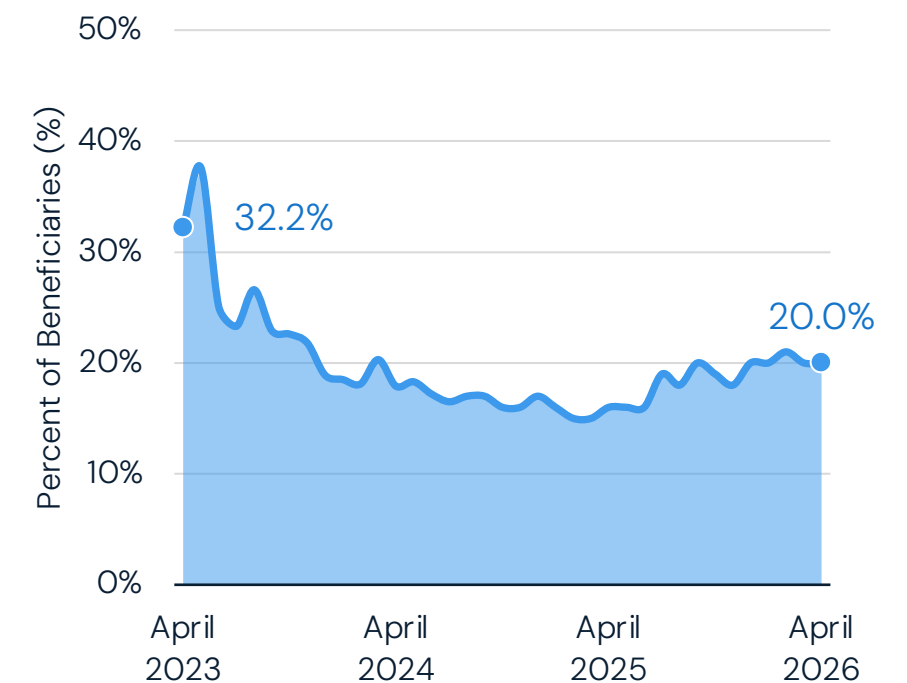
Median Enrollment Length in California
Marketplace Plans, by Demographics,
2012–2021



Medicare Enrollment Plan
Switching, 2024



Monthly Share of Disenrolled Medicaid
Beneficiaries, April 2023–April 2026



Note: FPL denotes federal poverty line; ESI denotes employer-sponsored insurance; MA denotes Medicare Advantage.

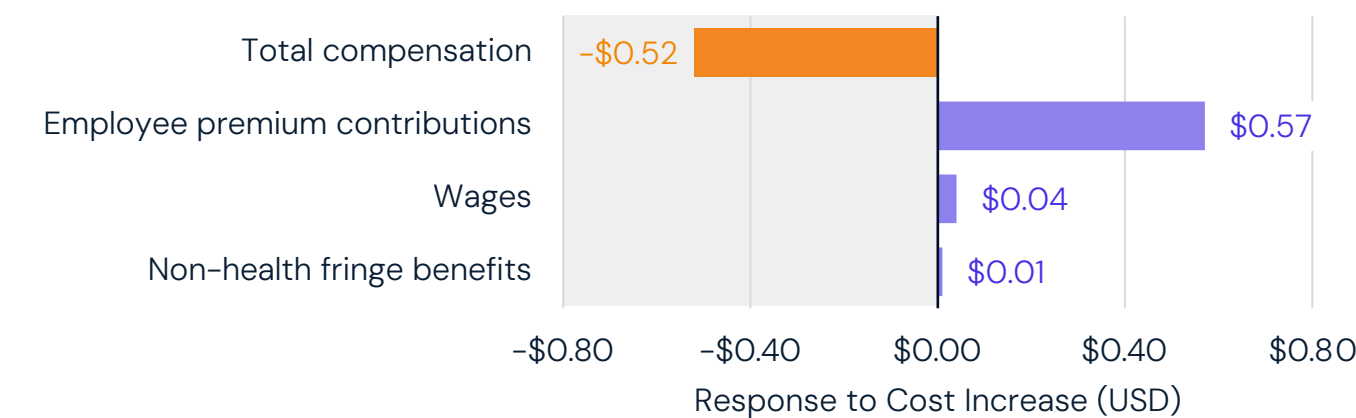
Source: The Commonwealth Fund; Centers for Medicare & Medicaid Services, Medicaid and CHIP Eligibility Operations and Enrollment Snapshot; Fang et al., Trends in Disenrollment and Reenrollment Within U.S. Commercial Health Insurance Plans, 2006–2018, *JAMA Network Open*, 2022; Wolf et al., Assessment of Churn in Coverage Among California's Health Insurance Marketplace Enrollees, *JAMA Health Forum*, 2022.

WHAT SYSTEM?

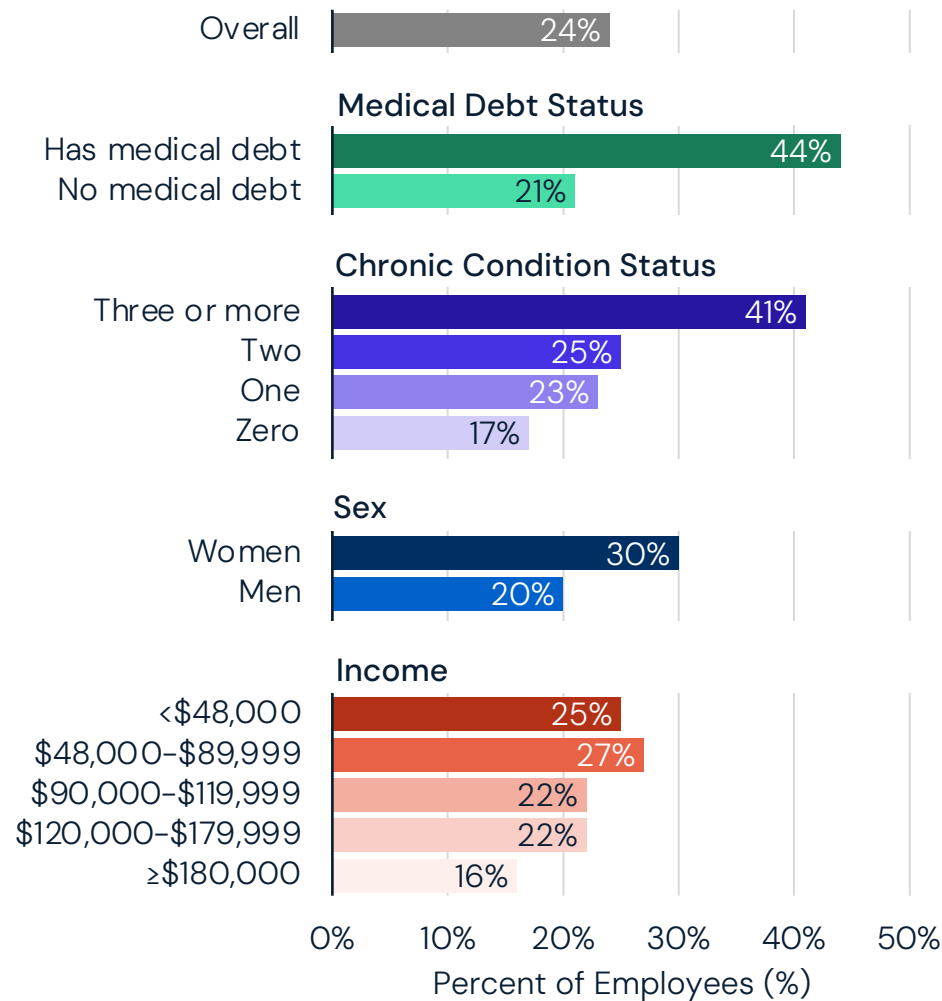
ESI Suppresses Compensation and Job Mobility

For every \$1 increase in health insurance costs, total compensation is expected to decrease by \$0.52, while employee premium contributions increase by \$0.57. Premiums as a percentage of total compensation almost doubled from 1999 to 2025, from 7.2% to 13.2%. In 2025, 24% of employees stayed in an unwanted job to retain their health benefits, i.e., “job lock.” Employees with medical debt or three or more chronic conditions are most likely to experience job lock, at 44% and 41%, respectively.

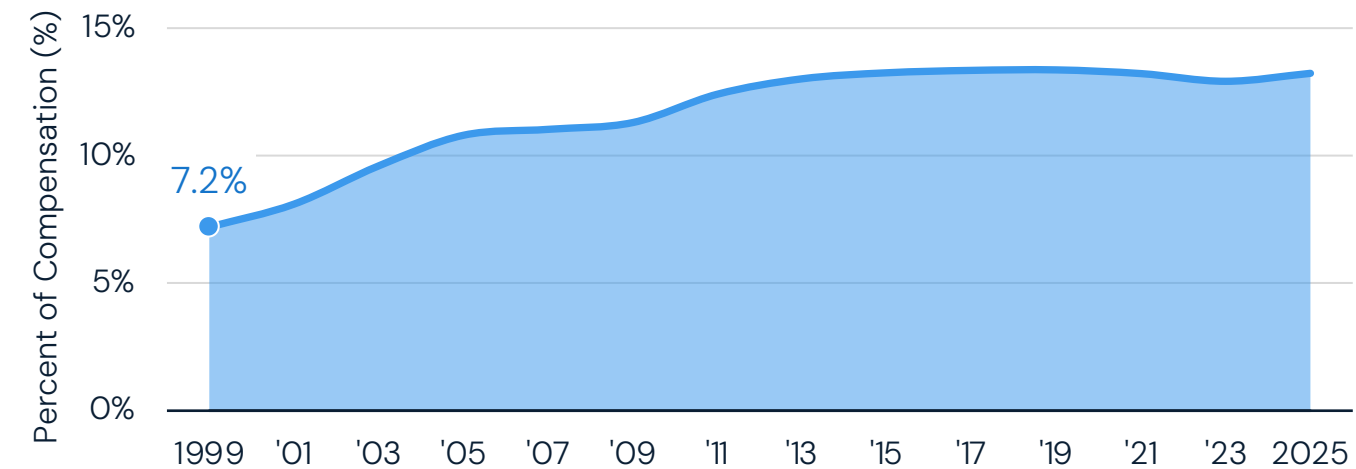
Impact of \$1 Increase in Health Insurance Costs, 2010



Share of Employees Currently Working in an Unwanted Job to Maintain Health Insurance, by Demographics, 2025



Premiums As Share of Compensation, 1999–2025



Note: ESI denotes employer-sponsored insurance. Total compensation is defined as wages plus non-health fringe benefits minus the expected employee premium contribution, adjusted for health insurance uptake. Wages are defined as the hourly cash wage paid to the worker, measured separately from any fringe benefits or premium contribution amounts. Non-health fringe benefits are defined as employer spending on other benefit categories (e.g., paid time off, contributions to retirement funds, life insurance)

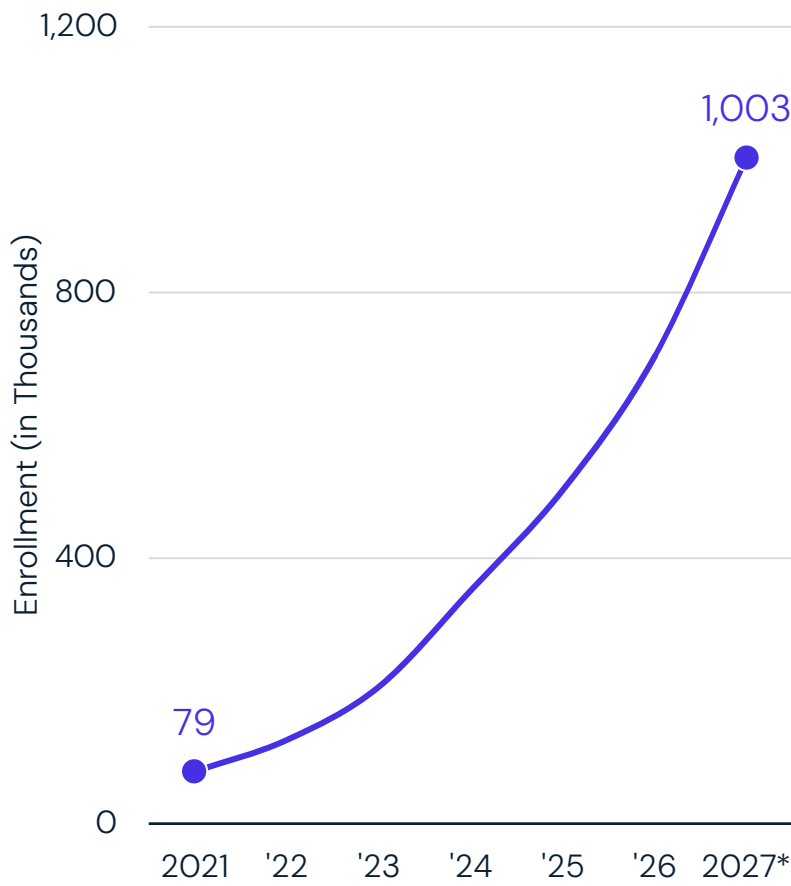
Source: Anand, Health Insurance Costs and Employee Compensation: Evidence From the National Compensation Survey, *Health Economics*, 2016; U.S. Bureau of Labor Statistics; KFF, Employer Health Benefits Survey, 1999–2025; West Health–Gallup Center on Healthcare in America.

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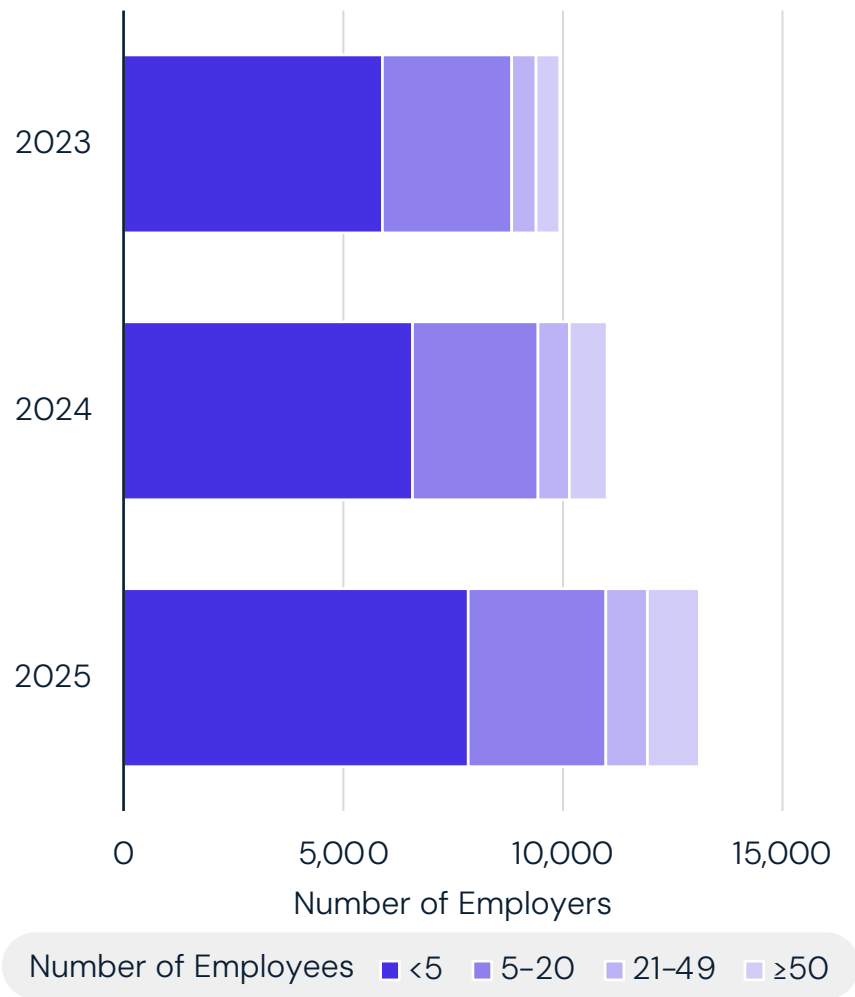
CHOICE Adoption Reflects Employer Frustration Regarding Benefit Administration

Since 2021, the estimated enrollment in CHOICE plans, formerly known as ICHRA, has grown from 80,000 to over 700,000 in 2026 and is projected to exceed 1M by 2027. From 2023 to 2025, the number of employers offering CHOICE plans increased by approximately 30%. In 2025, 18% of small employers not currently offering health benefits reported being likely to adopt CHOICE within the next two years. However, this proportion decreased to 7% across firms that already offer health benefits.

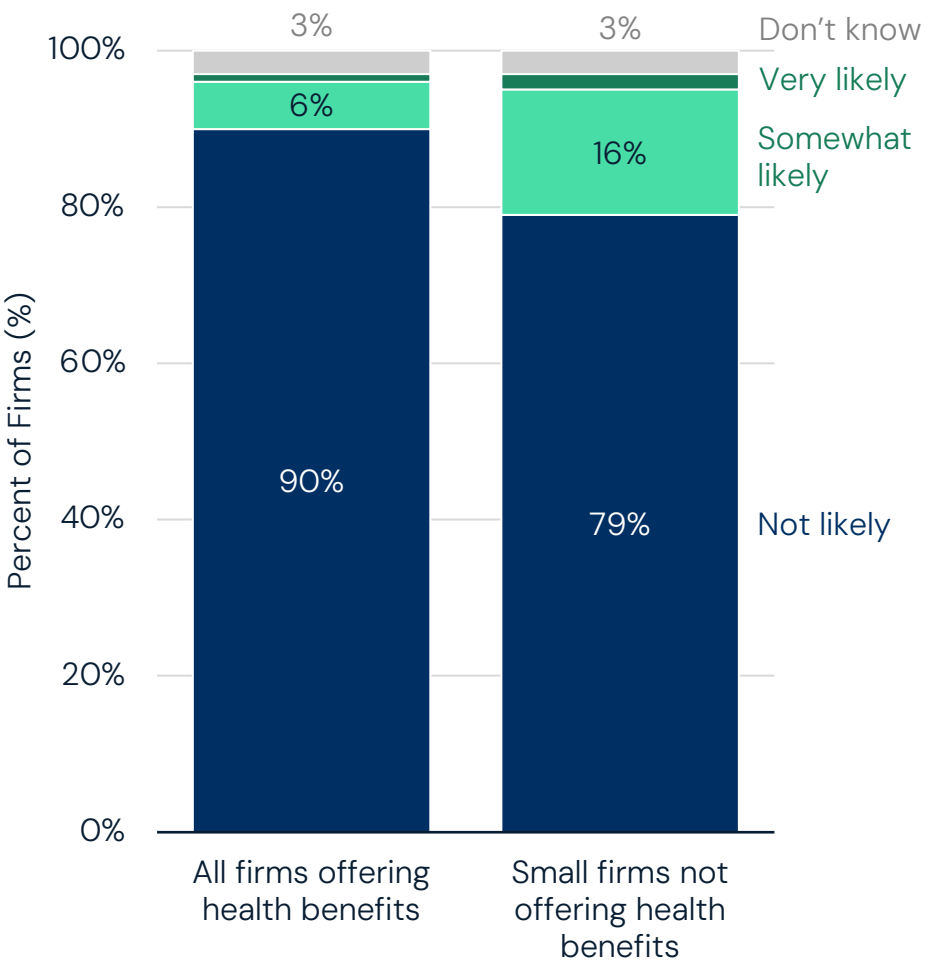
Historic and Projected CHOICE or QSEHRA Enrollment Estimates, 2021-2027



Number of Employers Offering CHOICE or QSEHRA, by Employer Size, 2023-2025



Likelihood of Offering a CHOICE in Next One to Two Years, by Employer Size, 2025



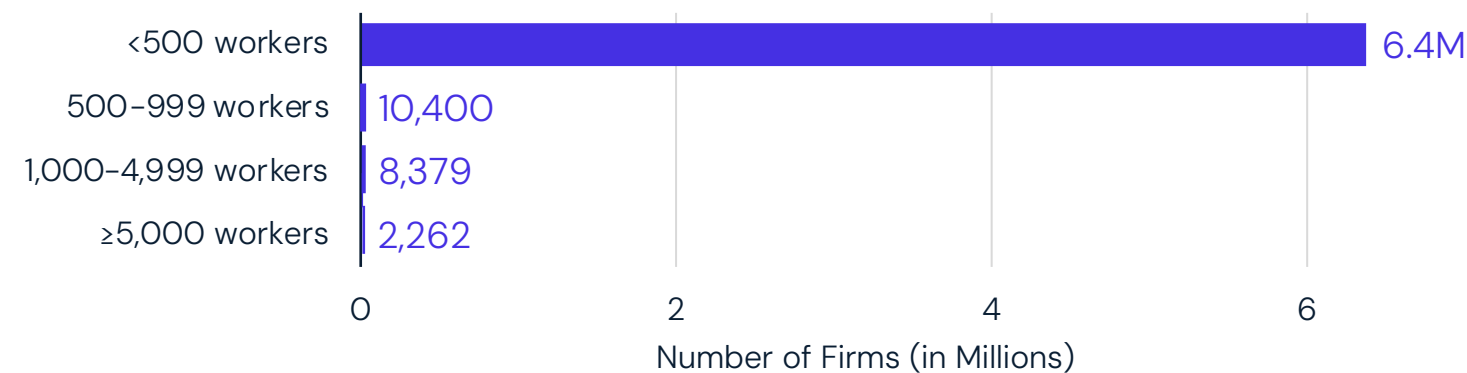
Note: CHOICE denotes custom health option and individual care expense arrangement; ICHRA denotes individual coverage health reimbursement arrangement; QSEHRA denotes qualified small employer health reimbursement arrangement. 2027 data is forecasted. Small firms have 10-199 workers.
Source: HRA Council, Growth Trends for ICHRA and QSHERA, 2024-2025; Remodel Health, 2026 National ICHRA Report, 2026; KFF, Employer Health Benefits Survey, 2025.

WHAT SYSTEM?

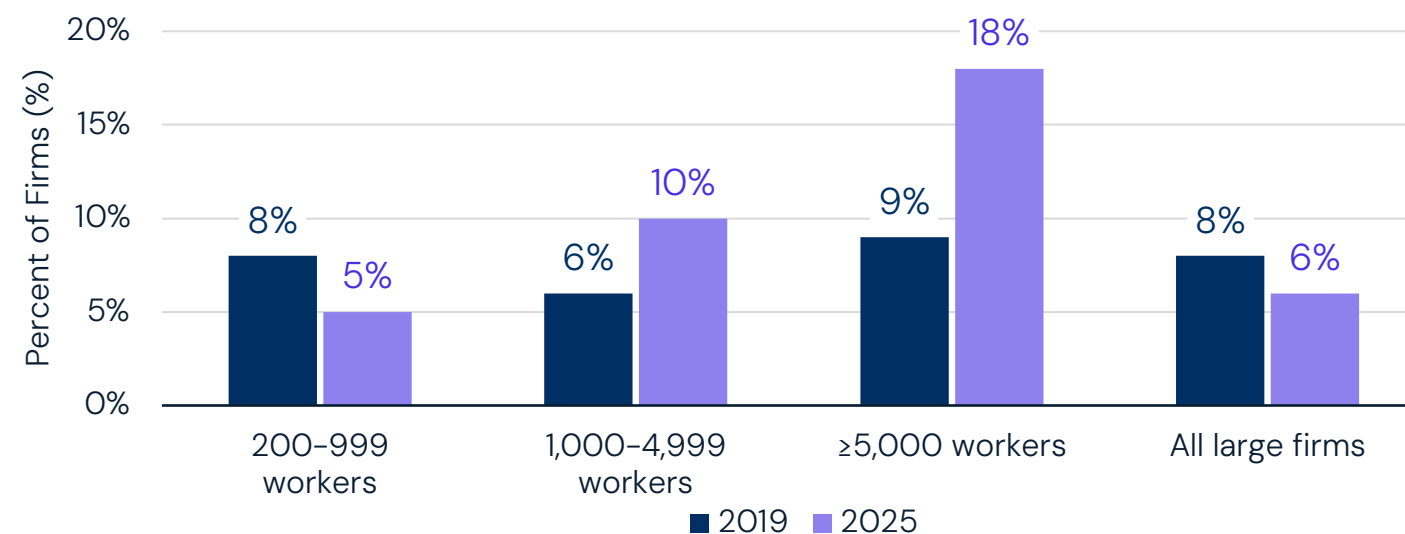
Direct-to-Employer Contracting Is Not Feasible for Most

Between 2019 and 2025, the share of firms with more than 5,000 workers directly contracting with hospitals or health systems increased from 9% to 18%. However, direct-to-employer contracting only works for employers with enough leverage (e.g., a large or geographically concentrated workforce) to negotiate with a provider. Notably, 99.7% of employers in the U.S. have fewer than 500 workers.

Number of Firms in the U.S., by Number of Workers, 2022



Share of Large Firms Offering Health Benefits That Have Any Direct Contracts With Hospitals or Health Systems, by Firm Size, 2019 and 2025



Note: Large firms have 200 or more workers. Direct contract involves employers contracting directly with facilities, independent of the plan's third-party administrator or insurer.

Source: KKF, Employer Health Benefits Survey, 2019–2025; U.S. Census Bureau, County Business Patterns, 2022; publicly available company information; Haitoff et al., Employer–Provider Direct Contracting: Practice and Policy, *HealthAffairs*, 2025.

Examples of Direct to Employer Contracting

Centers of Excellence

Walmart+ uses bundled payments negotiated directly with approximately 18 health systems (e.g., Mayo Clinic, Cleveland Clinic) for complex or high-cost conditions.



Purchaser–Coalition High-Performance Networks

The Alliance is a cooperative of over 500 self-funded employers that negotiates networks and handles health costs for employee benefits.



On-site Clinics

Sargento Foods offers direct care for their manufacturing and corporate workforce via on-site Health and Wellness Centers.

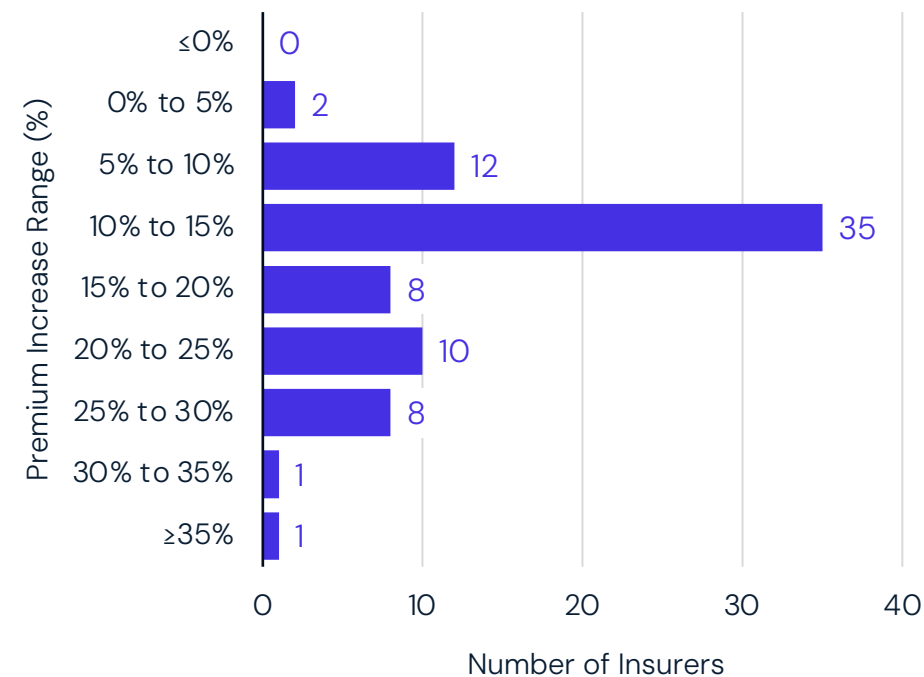


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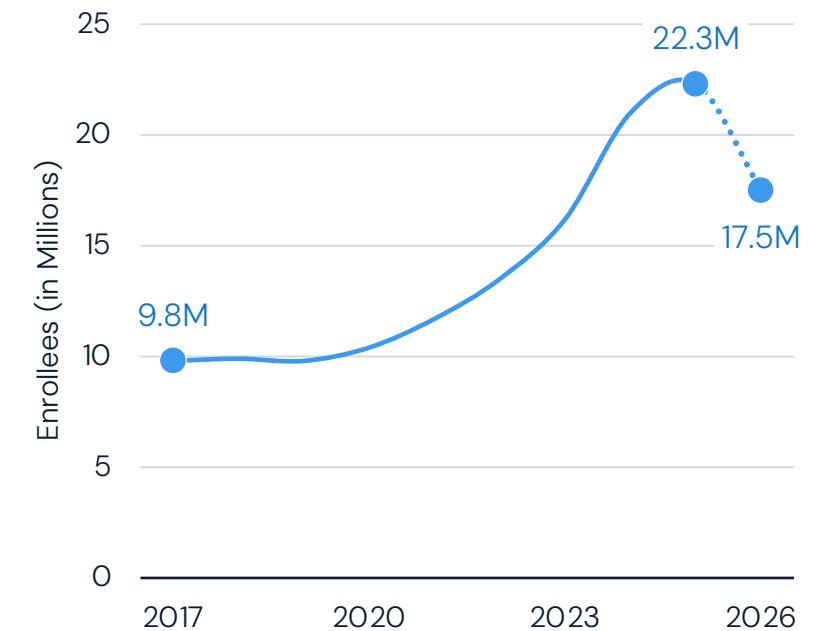
Fewer, Sicker Enrollees Signal a Potential Individual Market “Death Spiral”

Marketplace enrollment is projected to decline to 17.5M in 2026 from a peak of 22.3M in 2025, the first decline since enhanced premium tax credits took effect in 2021. Estimated morbidity within the population could increase by as much as 6.0%. On average, Marketplace insurers are proposing a median premium increase of 14% for 2027, with over 80% of insurers proposing rate increases exceeding 10%. The destabilized market led Cigna to discontinue Marketplace participation for 2027.

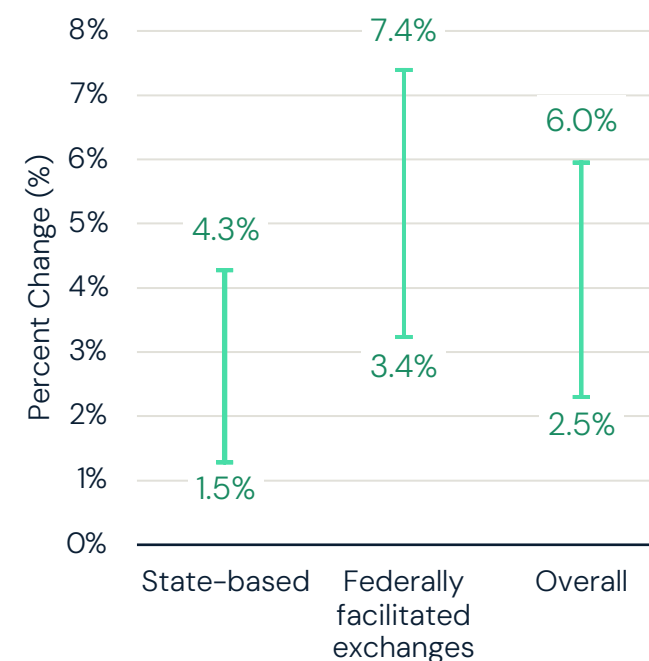
Proposed 2027 Marketplace Median Premium Increases, by Insurer



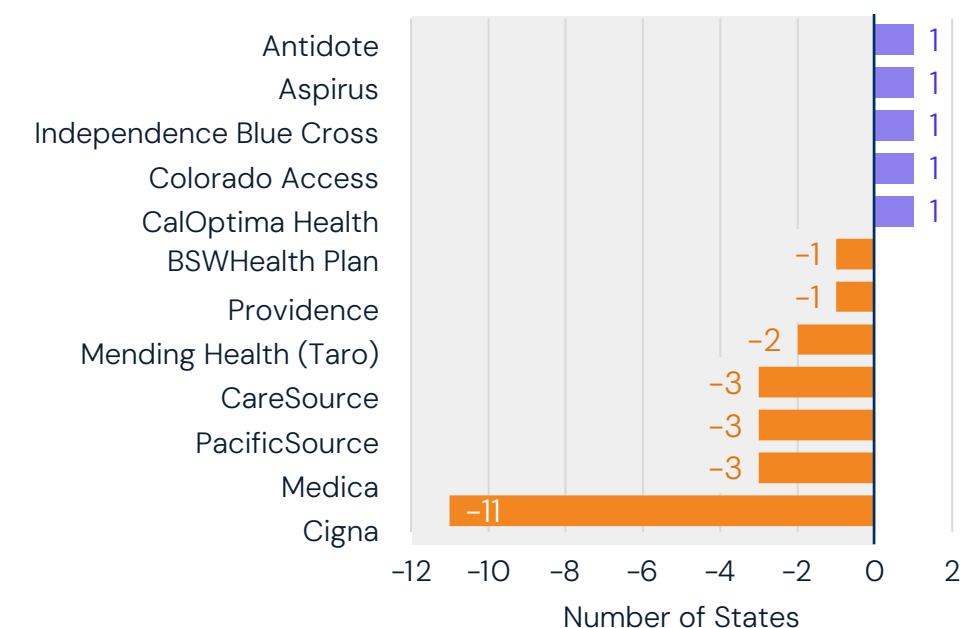
Marketplace Effectuated Enrollment, 2017–2026



Range of Estimated Morbidity Change in State and Federal Marketplaces, 2025 to 2026



Changes in Marketplace Insurer Participation for 2027, by State, by Insurer



Note: ACA denotes Affordable Care Act; BSWHealth Plan denotes Baylor Scott & White Health Plan.

Source: KFF; Wakely Consulting Group, Who Paid, and Who Stayed? Early 2026 Enrollment Trends in the Individual Market, 2026; Centers for Medicare and Medicaid Effectuated Enrollment Reports.

02

Population Unwellness Is
a Collective Failure That
the “System” Is Not
Designed to Address

POPULATION UNWELLNESS

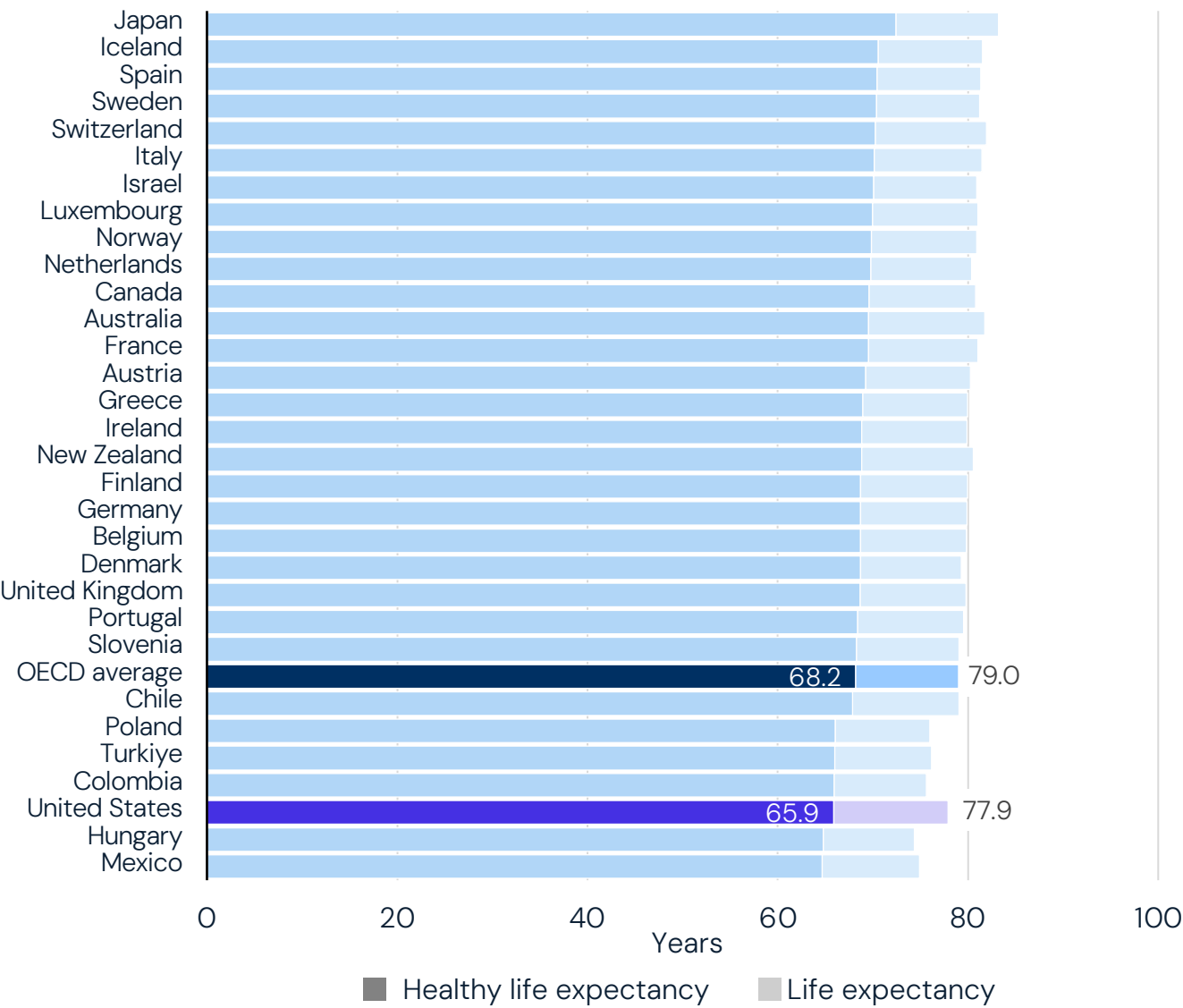
The deteriorating health of the American population is **not entirely a medical system failure** – it is the consequence of lifestyle, demographic and social trends that a sick care system, let alone a well-designed healthcare system, is poorly positioned to reverse. As the tragedy of the commons would predict, the vast majority of the U.S. health economy is oriented toward symptomatic treatment and intervention instead of prevention. **Poor diet, physical inactivity and social isolation** are producing a population that is increasingly unwell, a trend exacerbated by **distrust of the institutions** designed to treat illness. The result is a risk pool that is **deteriorating faster than the system can adapt**. At present, **population health is an unowned externality**. No stakeholder is accountable for it because very little in the health economy measures whether the money spent is making it better or worse. As the American public becomes more aware of how social and structural factors contribute to poor population health, what it expects from the healthcare system will change.

POPULATION UNWELLNESS

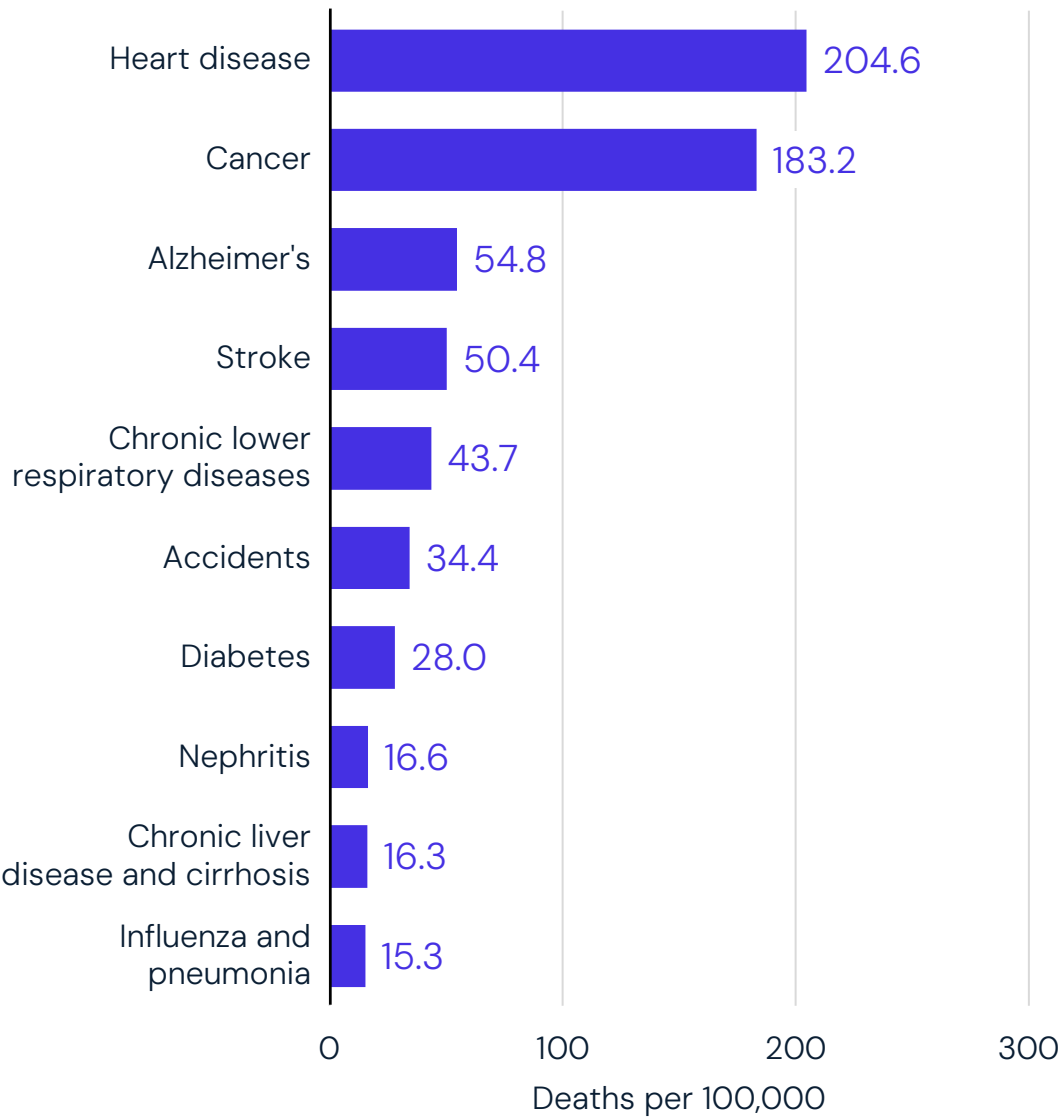
The Typical American Spends 12 Years in Poor Health

Between 2000 and 2021, the U.S. had a lower average healthy life expectancy and total life expectancy than the OECD average. In 2025, heart disease and cancer were the leading causes of death in the U.S., 204.6 and 183.2 deaths per 100,000, respectively.

Average Healthy Life Expectancy and Total Life Expectancy, Among Select OECD Countries, 2000–2021



Mortality Rate per 100,000 Population, Leading Causes of Death, 2025

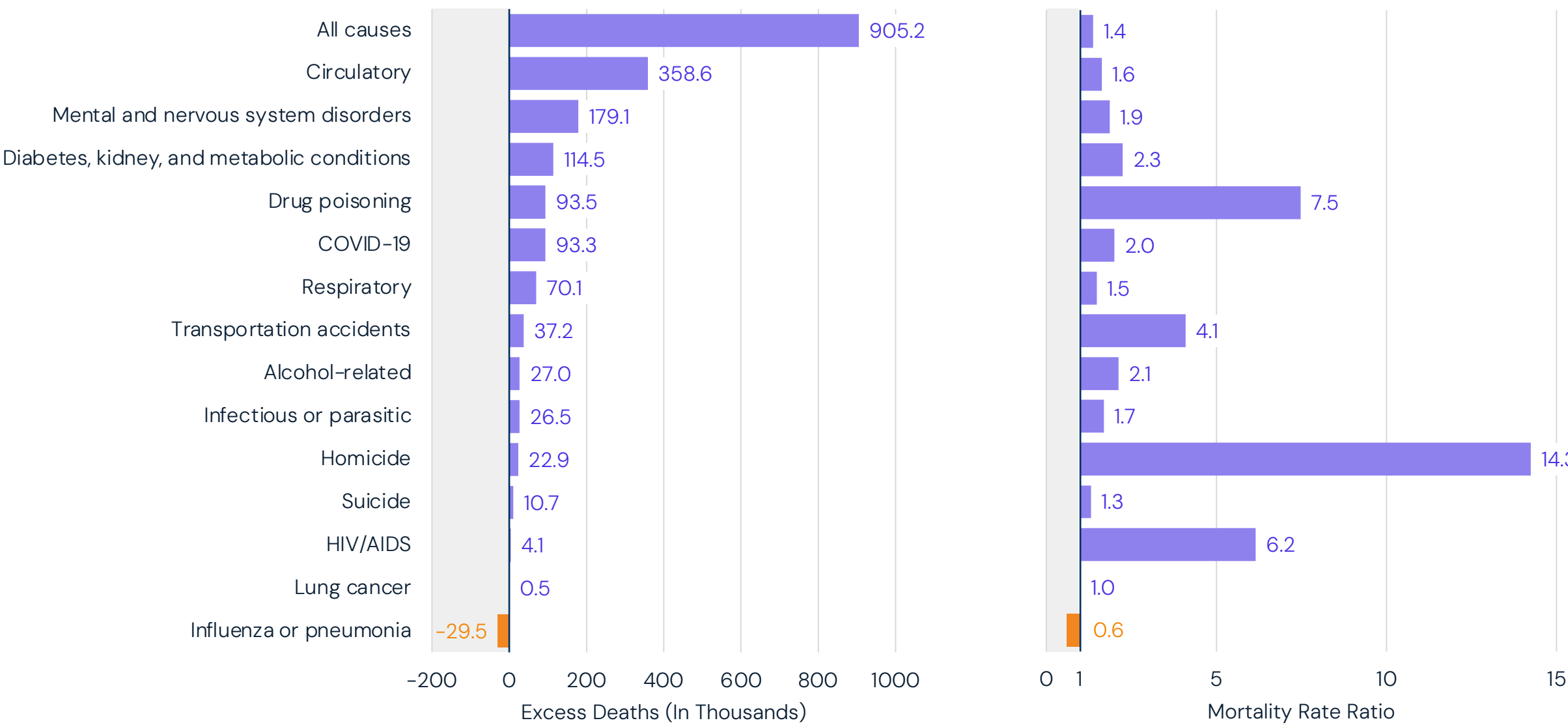


Note: OECD denotes Organisation for Economic Co-operation and Development. 2025 data for leading cause of death and crude mortality rate are provisional.
Source: Centers for Disease Control and Prevention WONDER database; Organisation for Economic Co-operation and Development, Health at a Glance, 2025; World Health Organization.

U.S. Has Excess Mortality Relative to Peer Countries

The U.S. mortality rate is 1.4x higher than the average mortality rate among 17 other high-income countries, resulting in 905,159 excess deaths. Contributing to this, deaths due to homicide (14.3x), drug poisoning (7.5x), HIV/AIDS (6.2x) and transportation accidents (4.1x) are much more common in the U.S. than in peer countries.

U.S. Excess Deaths and Excess Mortality Rate Ratio, U.S. vs. Peer Countries, by Cause of Death, 2022



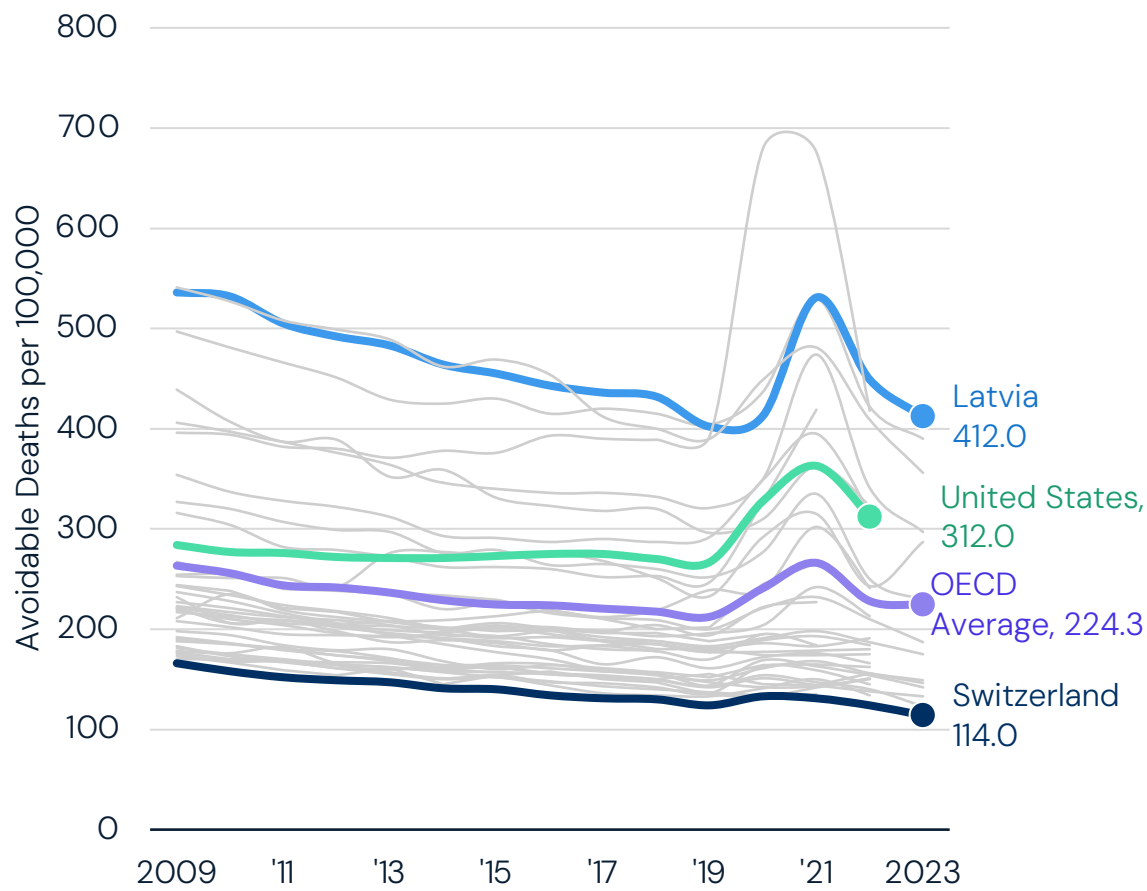
Note: Excess deaths is the difference between observed U.S. deaths and the number of deaths that would have occurred if instead U.S. mortality rates were the population-weighted means of 17 other high-income countries. Mortality rate ratio is the ratio between the age-standardized death rate in the U.S. and the population-weighted mean rate of 17 other high-income countries.
Source: Bor et al., Causes of Excess Deaths in the US Compared With Other High-Income Countries, *JAMA Network Open*, 2026.

POPULATION UNWELLNESS

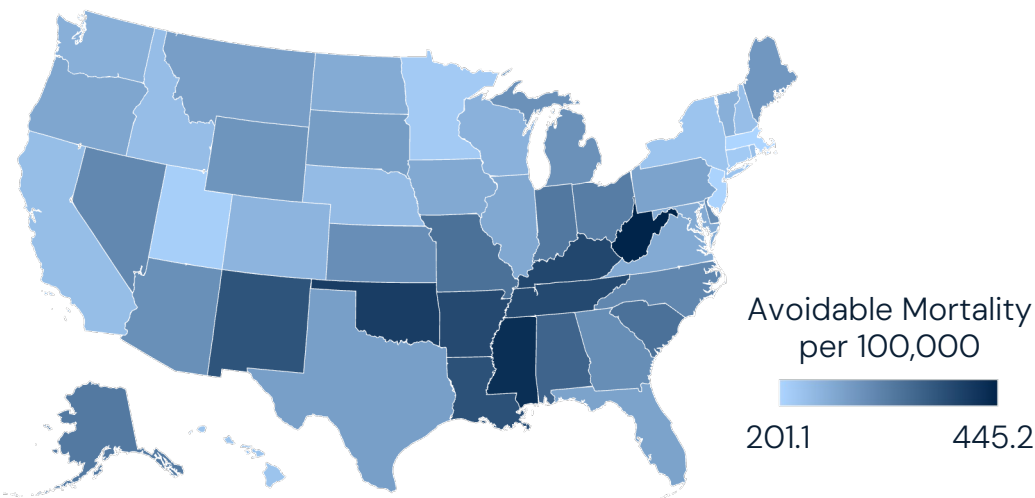
Avoidable Mortality Growth Signals Worsening Health

Avoidable mortality, deaths that could have been prevented through public health efforts and timely and effective healthcare, are high and increasing in the U.S., with a 2022 rate 1.4x above the OECD average. In the U.S., avoidable mortality ranged from 201.1 per 100,000 in Massachusetts to 445.2 in West Virginia in 2023. Every state but New Jersey had higher avoidable mortality in 2023 than in 2018.

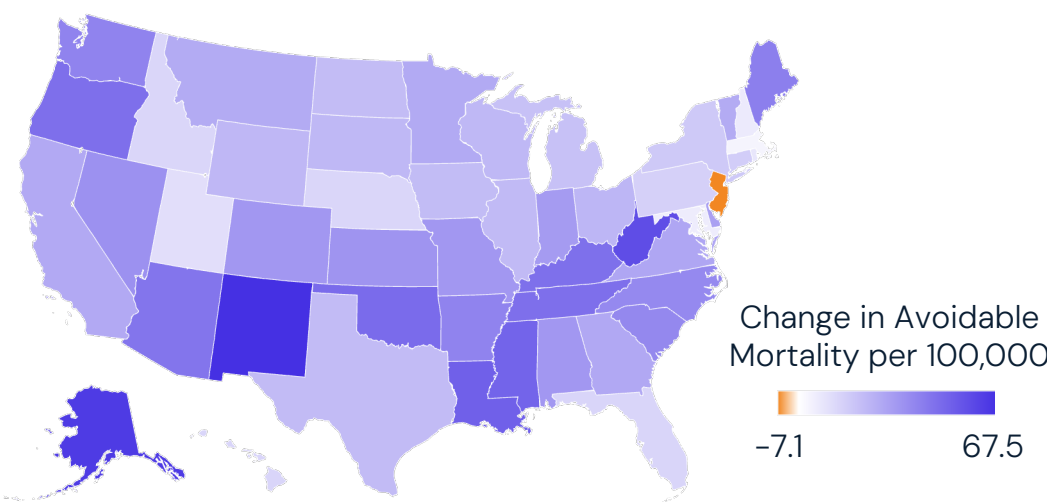
Avoidable Mortality per 100,000 Population in OECD Countries, 2009–2023



Avoidable Mortality Rate, by State, 2022–2023



Difference in Avoidable Mortality Rate, by State, 2018–2019 vs. 2022–2023



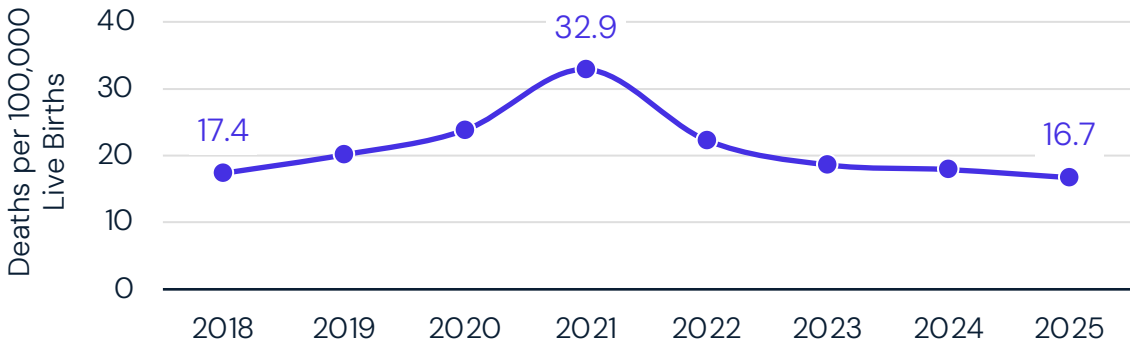
Note: OECD denotes Organisation for Economic Co-operation and Development. Avoidable mortality is deaths in the population younger than 75 years that could have been prevented or avoided through timely and effective healthcare and prevention. Some examples of causes of death that are considered avoidable include measles, tobacco-related lung cancer and sepsis.
Source: The Commonwealth Fund; Organisation for Economic Co-operation and Development.

POPULATION UNWELLNESS

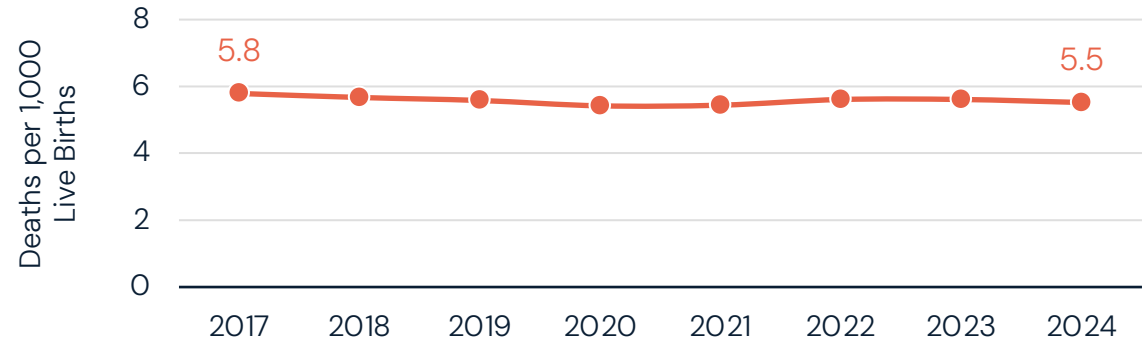
U.S. Maternal and Infant Outcomes Are Worse Than Peer Countries

U.S. maternal (17.9 per 100,000 live births) and infant (5.5 per 1,000 live births) mortality rates exceed peer countries. In 2024, the U.S. maternal mortality rate among Black women was 44.8 compared to 14.2 among White women. In 2024, the mortality rate among Black infants was 11.0 compared to 4.4 among White infants.

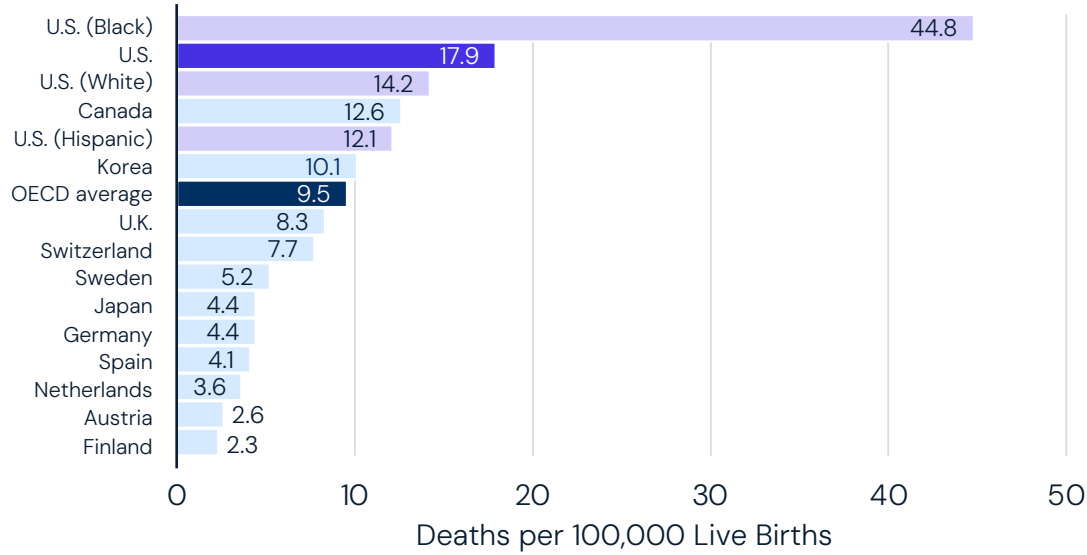
Maternal Mortality Rate in the U.S. per 100,000 Live Births, 2018–2025



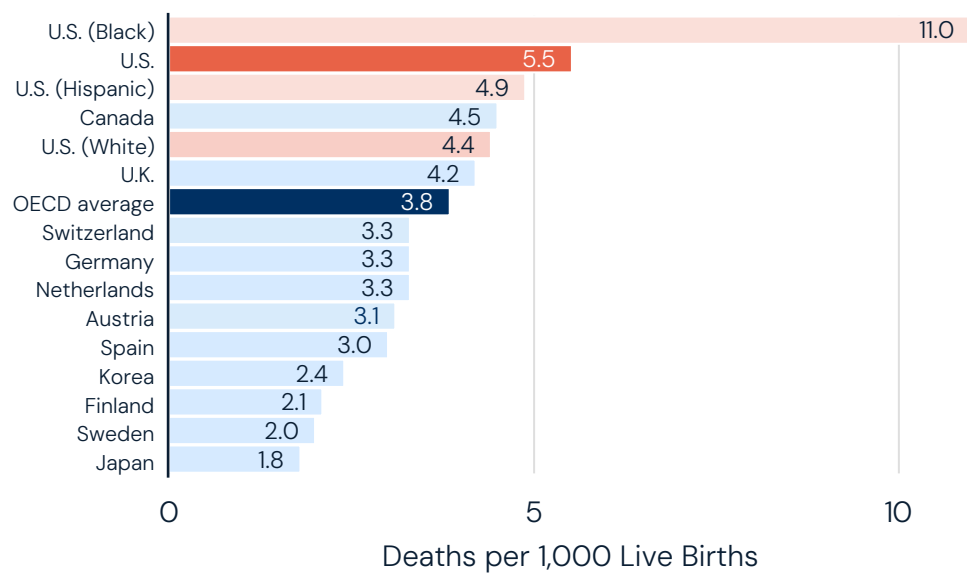
Infant Mortality in the U.S. per 1,000 Live Births, 2017–2024



Maternal Mortality per 100,000 Live Births in Select High-Income Countries, 2024



Infant Mortality per 10,000 Live Births in Select High-Income Countries, 2024

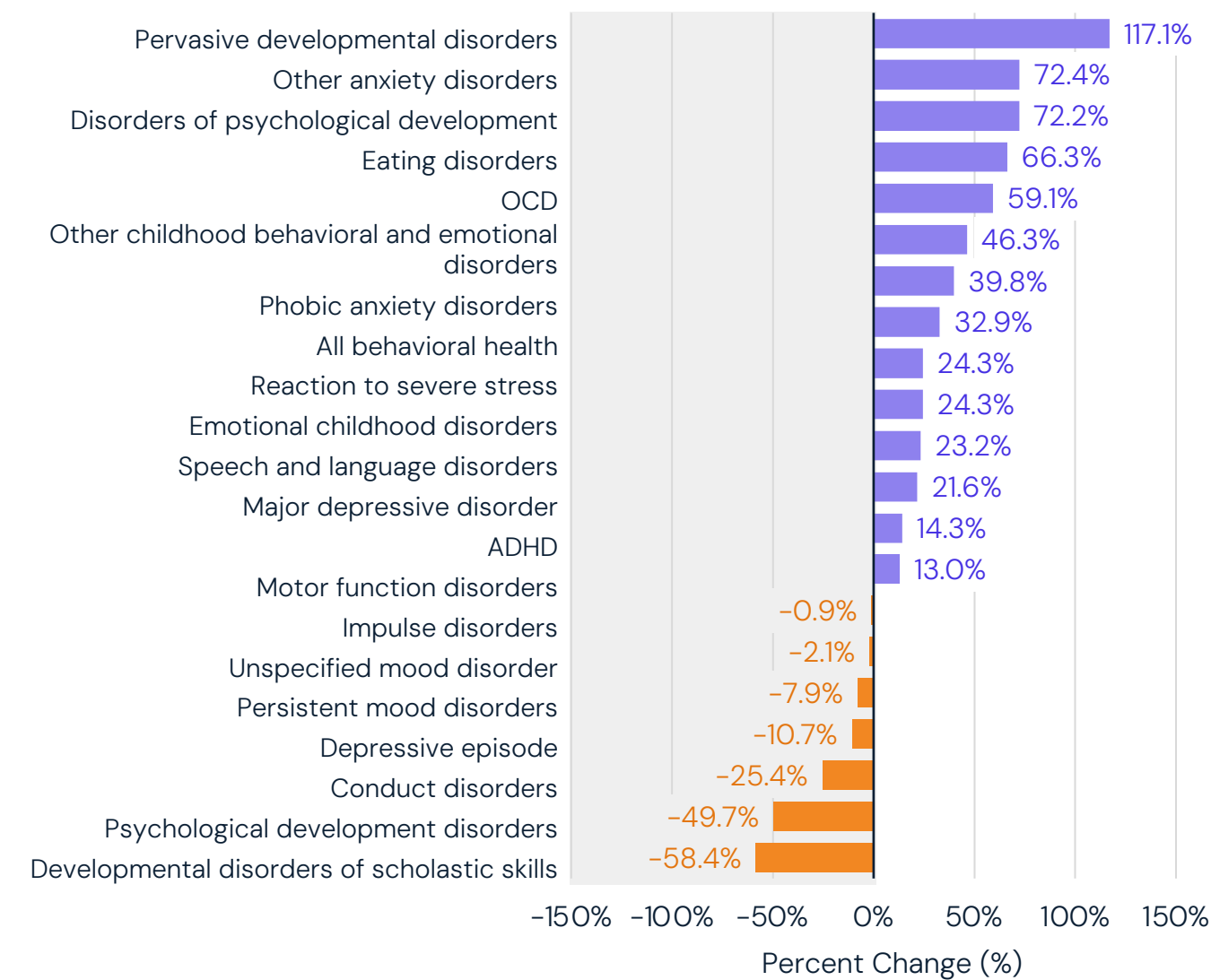


Note: OECD denotes Organisation for Economic Co-operation and Development. The OECD average includes all OECD with available data countries. U.S. maternal mortality data are provisional in 2025.
Source: Organisation for Economic Co-operation and Development; National Center for Health Statistics; Centers for Disease Control and Prevention National Vital Statistics System; Centers for Disease Control and Prevention WONDER database.

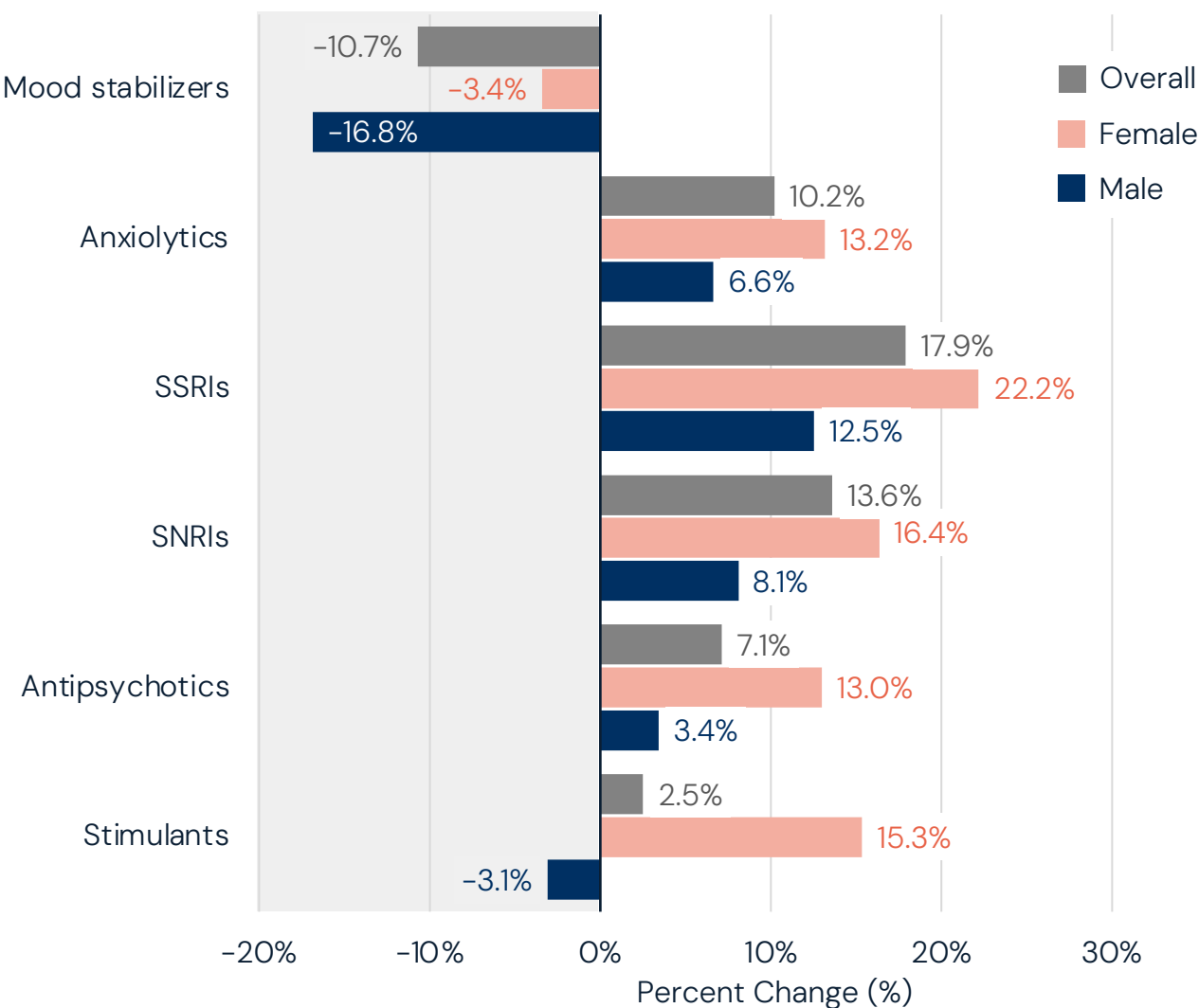
Child and Adolescent Mental Health Is Worsening

Between 2019 and 2025, visit rate for pervasive developmental disorders (e.g., autism, Asperger’s) and other anxiety disorders increased the most. During the same period, the number of pediatric patients receiving a psychiatric medication increased across most drug classes. Prescribing increases were largest among SSRI (17.9%) and SNRI medications (13.6%) and were most pronounced among female patients.

Percent Change in Behavioral Health Visits per 1,000 Among Patients Ages 0–17, by Condition, 2019 to 2025



Percent Change in Patients Ages 0–17 Since 2019, by Drug Class and Sex, 2019 to 2025



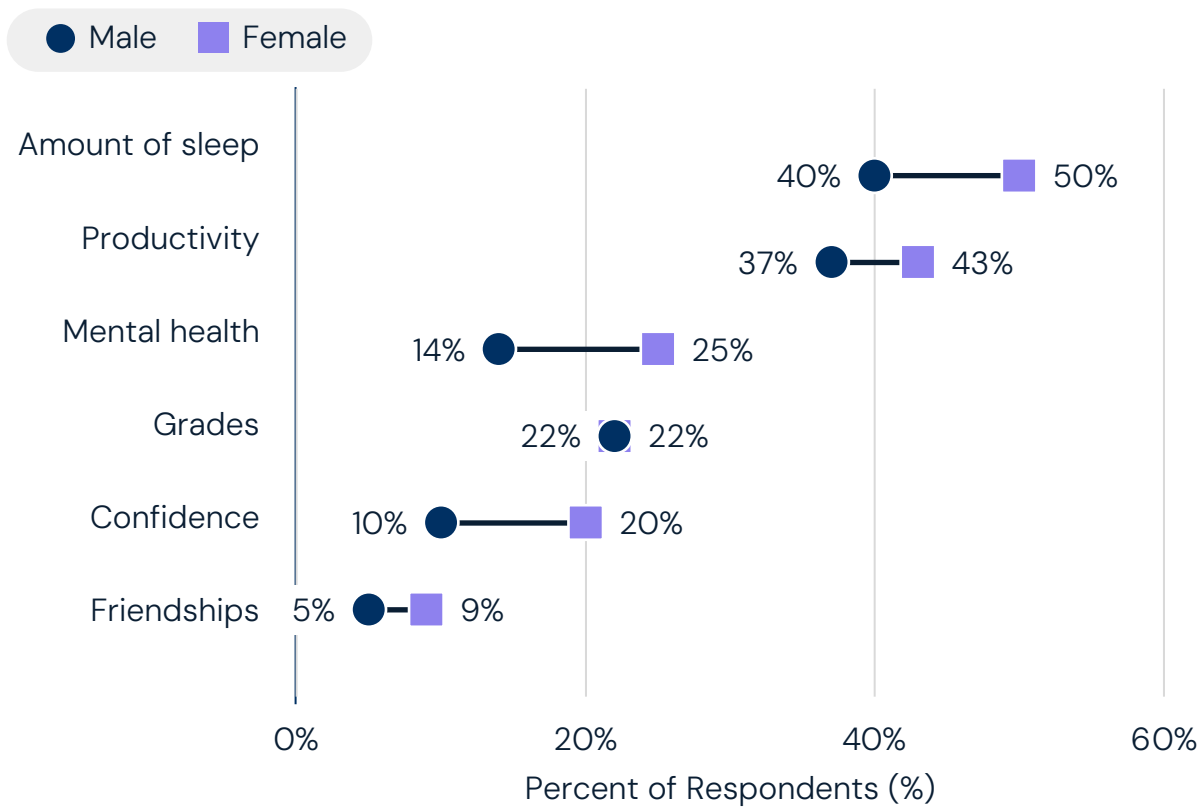
Note: ADHD denotes attention-deficit hyperactivity disorders; OCD denotes obsessive compulsive disorder; SSRI denotes selective serotonin reuptake inhibitor; SNRI denotes serotonin and norepinephrine reuptake inhibitor.
Source: Trilliant Health national all-payer claims database.

POPULATION UNWELLNESS

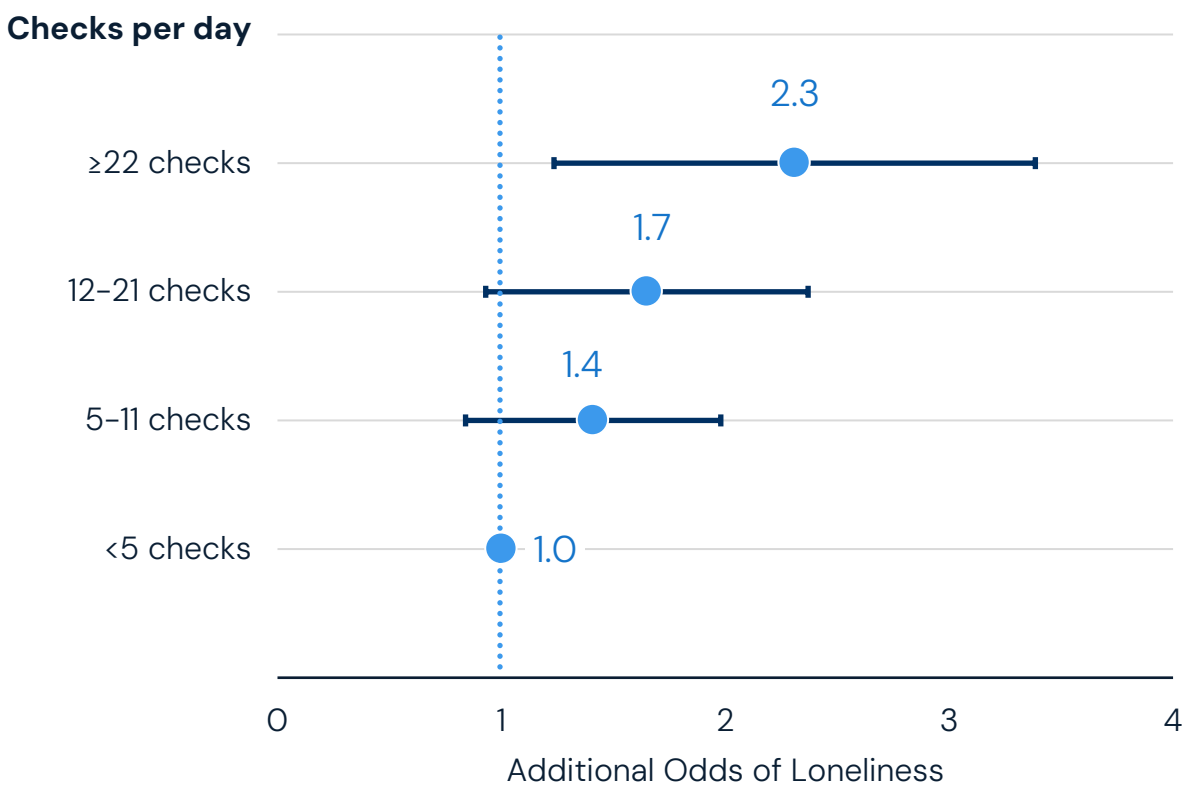
Social Media Has Negative Implications For Mental and Physical Health

Surveyed teens reported that social media negatively impacts their sleep, productivity and mental health status. Among adults ages 30–70, those who check social media 22 or more times per day had 2.3x higher odds of experiencing loneliness than those who check less than five times per day.

Share of Teens Ages 13–17 Who Say Social Media Has Hurt Their Own Well-Being, by Outcome, 2024



Impact of Social Media Habits on Loneliness Among Adults Ages 30–70, 2023

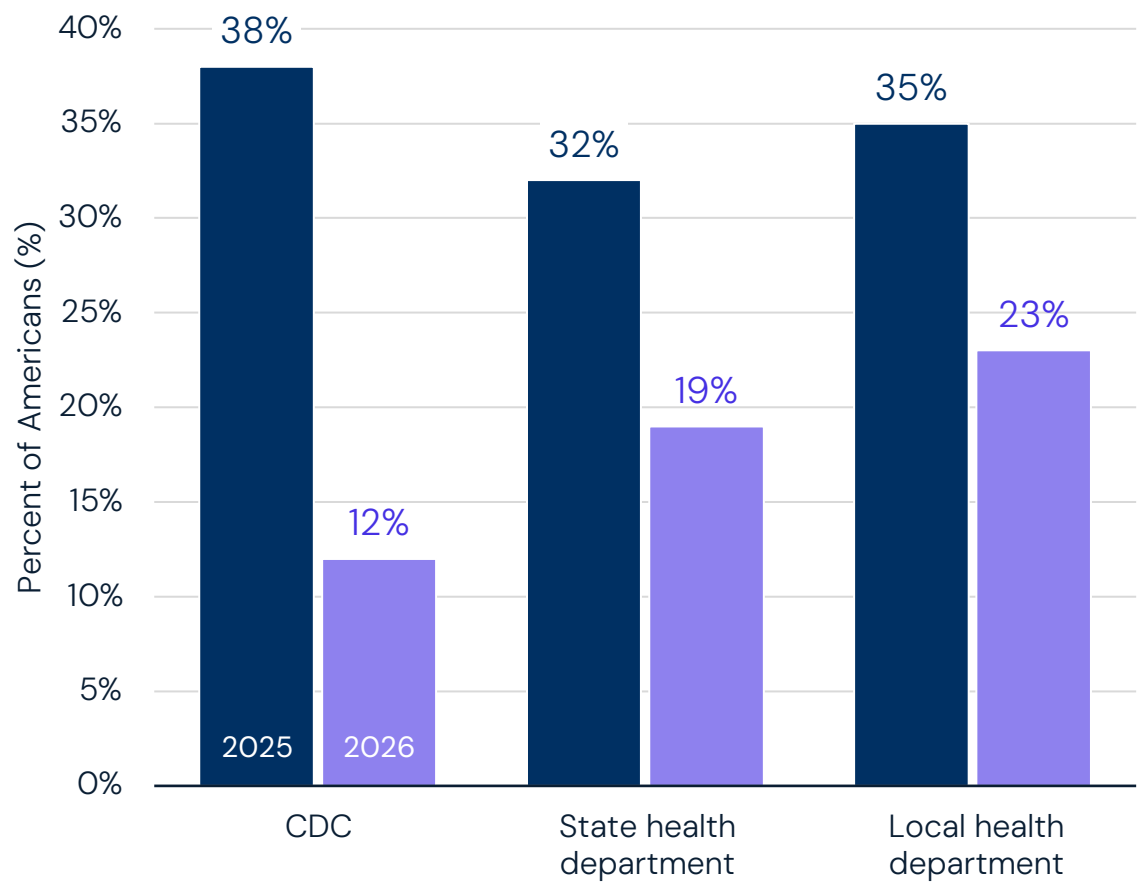


Source: Pew Research Center; Gorman et al., Time and Frequency of Social Media Use and Loneliness Among U.S. Adults, *International Journal of Environmental Research and Public Health*, 2025.

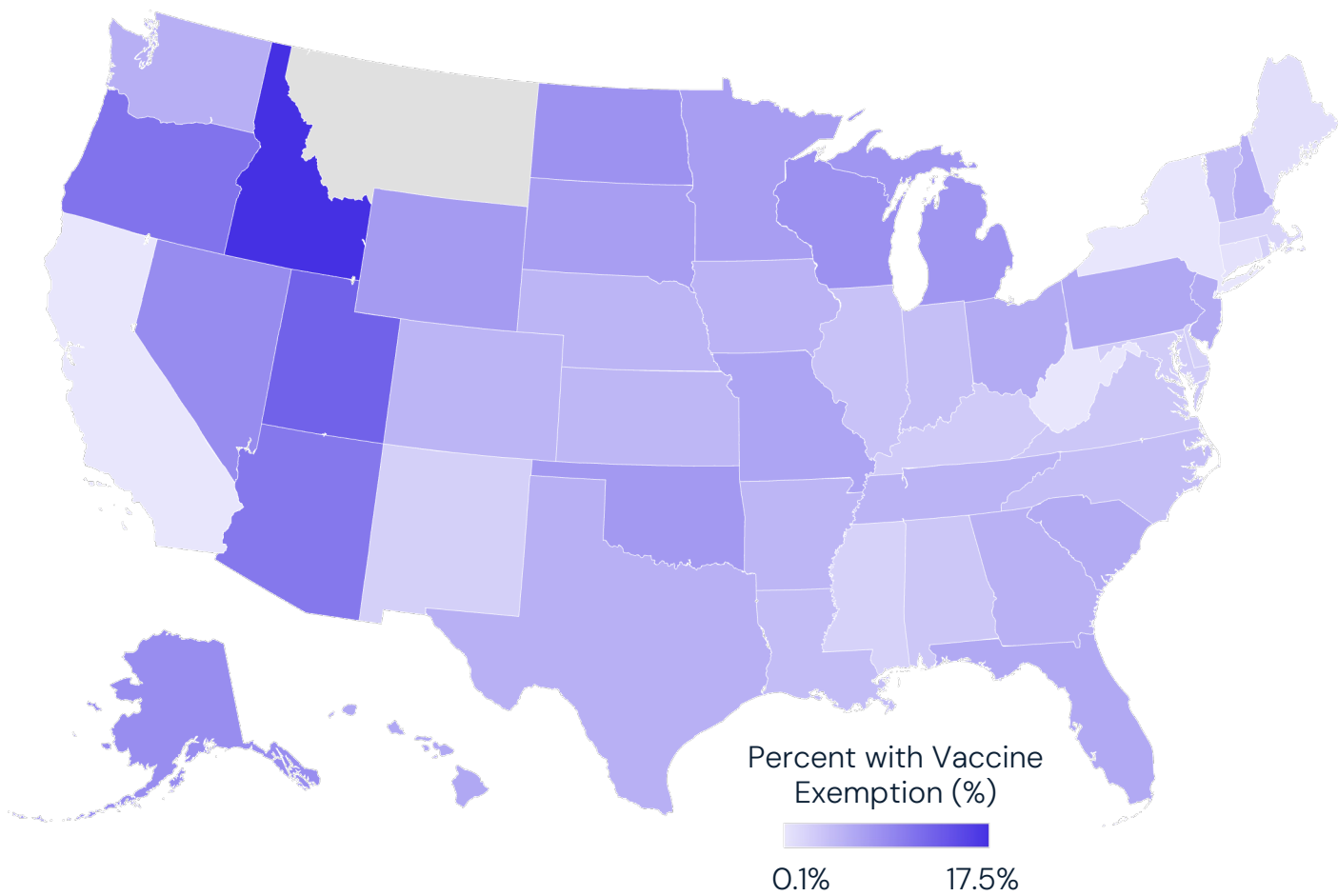
As Trust Erodes, So Does Vaccination Adherence

Trust in public health recommendations declined from 2025 to 2026, especially in CDC recommendations, where it decreased from 38% to 12% of Americans. Relatedly, the median share of kindergartners with a vaccine exemption across states increased from 1.1% in 2010 to 4.8% in 2025. High-exemption clusters, like Idaho at 17.5% of kindergartners, increase the risks of preventable disease outbreaks.

Share of Americans Reporting “A Great Deal” of Trust in Public Health Agency Recommendations, 2025 and 2026



Share of Kindergartners With a Vaccine Exemption, by State, 2025–2026 School Year



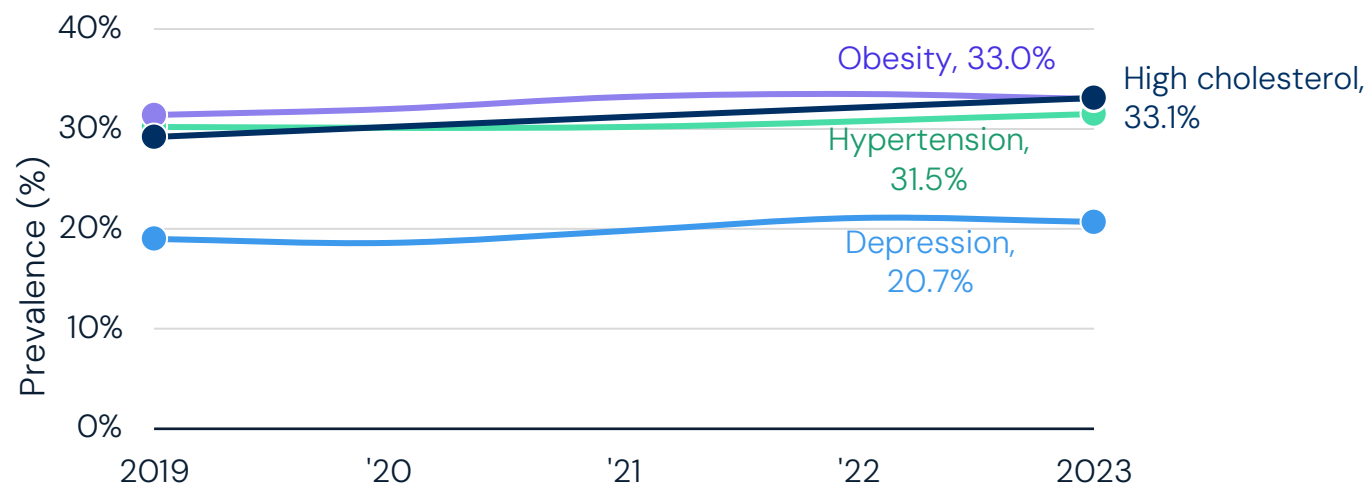
Note: CDC denotes the Centers for Disease Control and Prevention; PP denotes percentage points. Vaccine exemptions include exemptions for medical and non-medical reasons. States in grey do not have available data.
Source: Centers for Disease Control and Prevention; Harvard T.H. Chan School of Public Health, One Year In: Public Views of a Changing Public Health Landscape, 2026.

POPULATION UNWELLNESS

Chronic Disease Is High and Growing Among Young Adults

Chronic condition prevalence is increasing fastest among young adults. From 2019 to 2023, high cholesterol prevalence among adults ages 18–44 increased by 28.1%, compared to 7.7% for adults ages 45–64. Similarly, depression prevalence increased among adults ages 18–44 (16.3%) but remained unchanged in other adult populations. Nationally, multiple chronic condition prevalence is 11.3%, with the highest rates in West Virginia (20.6%), Kentucky (18.0%) and Alabama (15.8%).

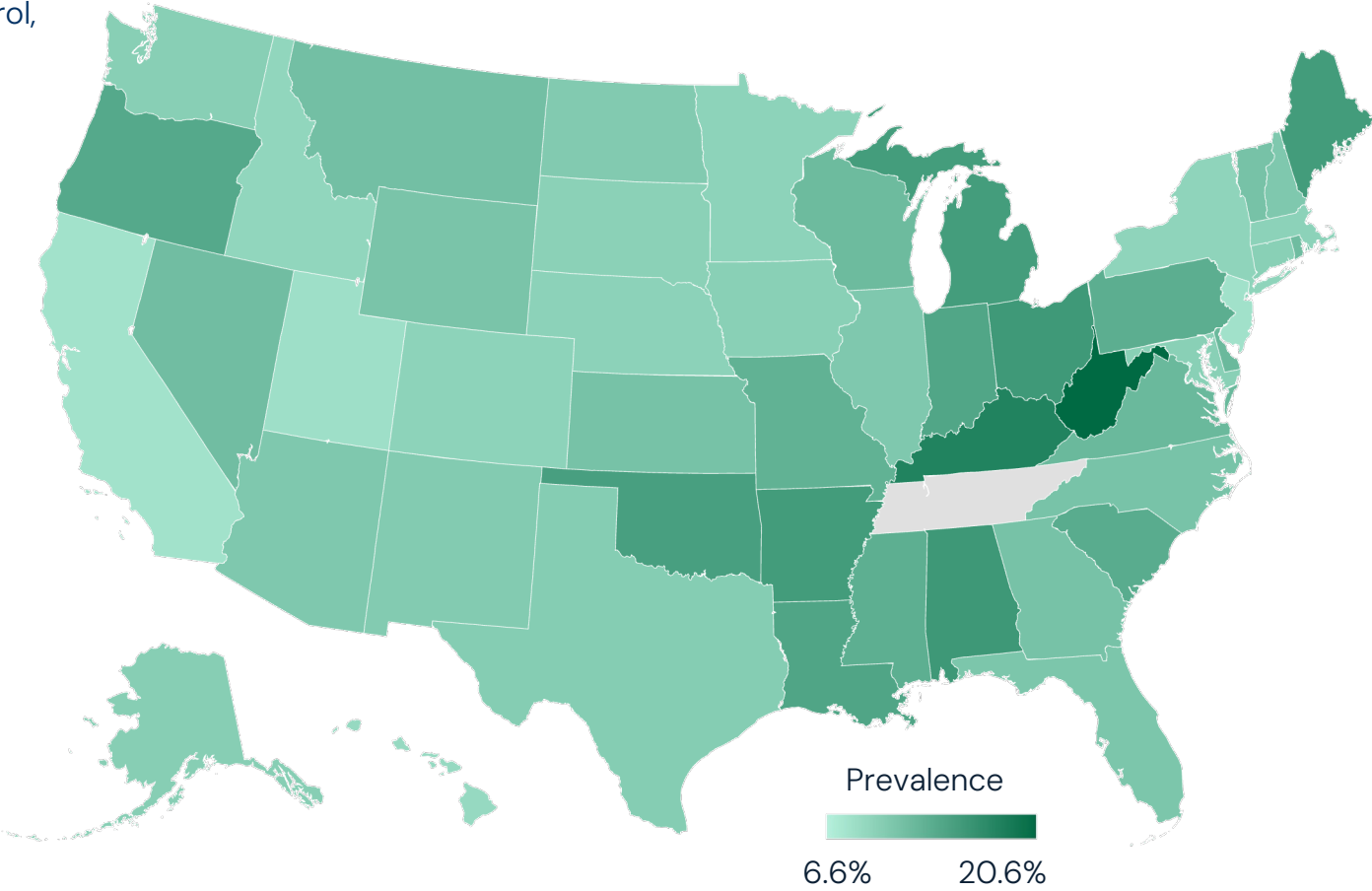
Age-Adjusted Chronic Disease Prevalence Among Adults, 2019–2023



Percent Change in Chronic Disease Prevalence by Age, 2019 to 2023

	18–44	45–64	≥65
Obesity	5.3%	5.4%	3.4%
Depression	16.3%	0.0%	0.0%
High cholesterol	28.1%	7.7%	7.8%
Hypertension	9.2%	3.0%	2.0%

Prevalence of Multiple Chronic Conditions, by State, 2024

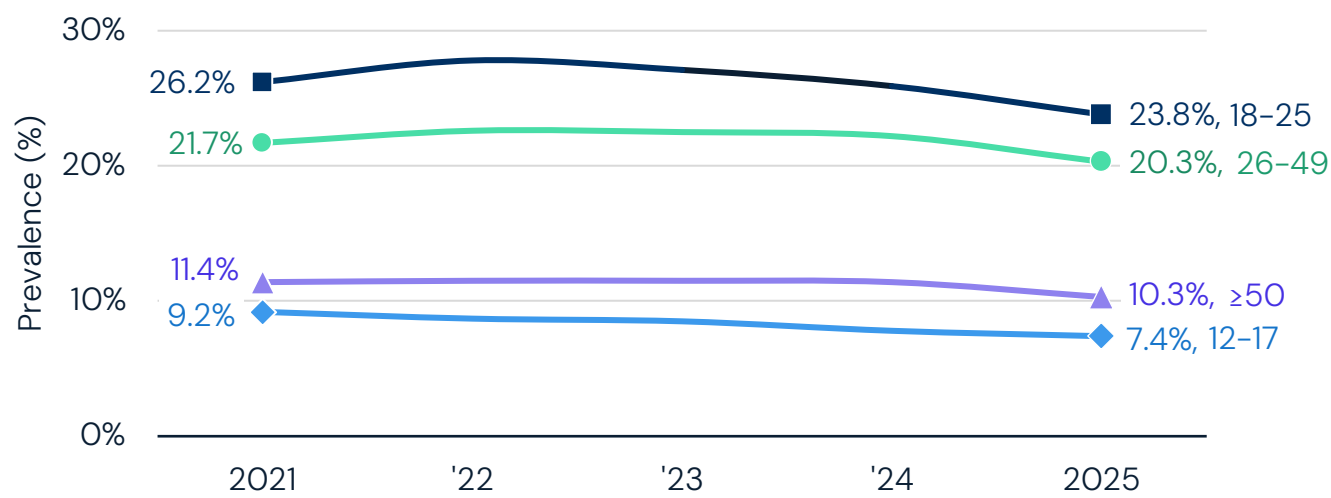


Note: Multiple chronic condition data for Tennessee are not available. Multiple chronic conditions are defined as having three or more of the following: arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease and cardiovascular disease. There are no data observations in 2020 and 2022 for hypertension and high cholesterol.
Source: America’s Health Rankings, Annual Report, 2025; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.

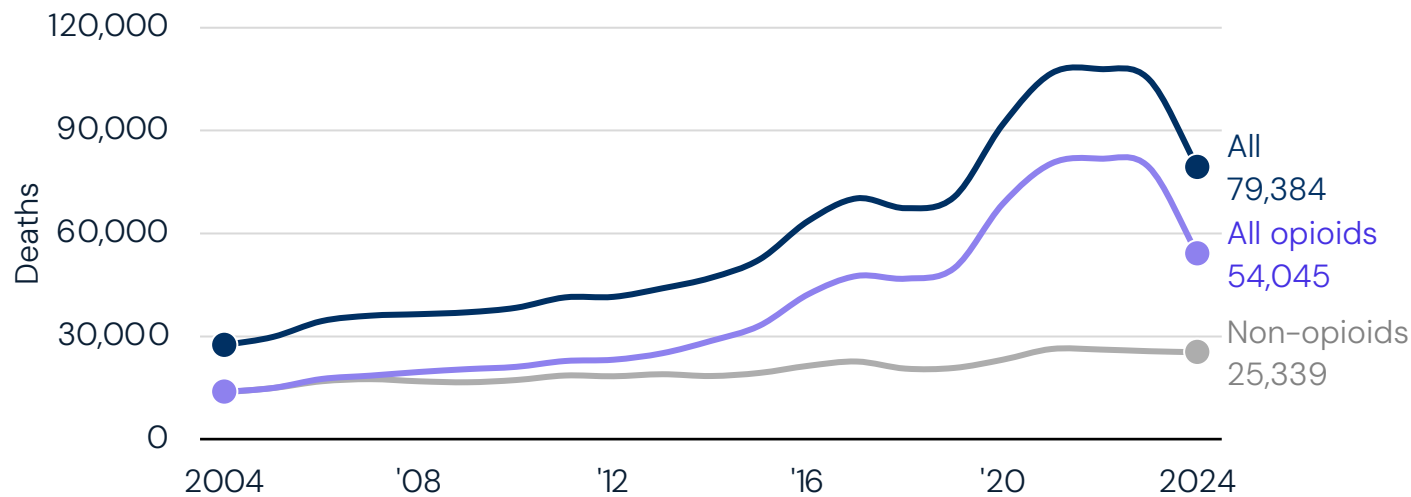
Overdose Deaths Remain Elevated Despite Improvements

In 2025, SUD prevalence was highest among adults ages 18–25 (23.8%). While the number of overdose deaths declined by 24.4% from 2023 to 2024, it remained 189.5% above 2004 levels. In 2025, there were 11 states in which more than 10% of patients with an opioid prescription received hydrocodone or oxycodone prescriptions from three or more distinct providers.

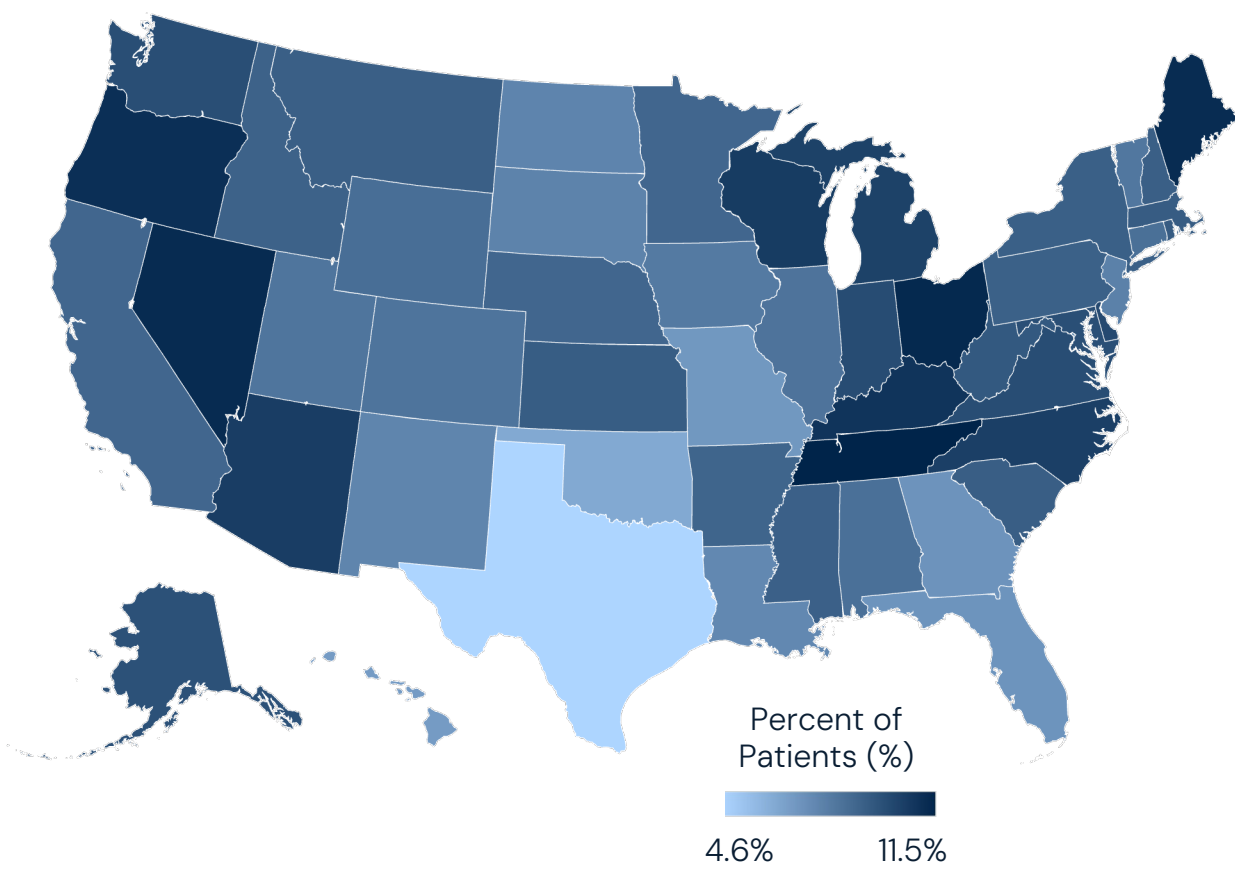
SUD Prevalence, by Age, 2021–2025



Overdose Deaths, 2004–2024



Share of Patients With an Opioid Prescription Receiving Opioids from Three or More Prescribers, by State, 2025



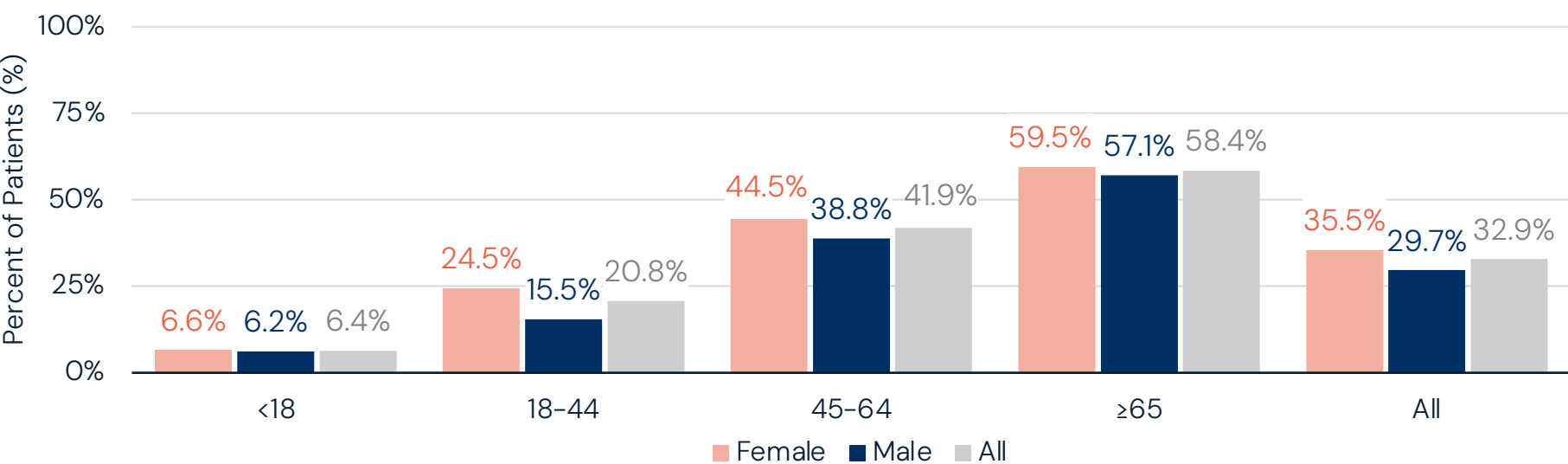
Note: SUD denotes substance use disorder.
Source: Trilliant Health national all-payer claims database and Provider Directory; Substance Use and Mental Health Services Administration, National Survey on Drug Use and Health 2021–2025; Centers for Disease Control and Prevention WONDER database.

POPULATION UNWELLNESS

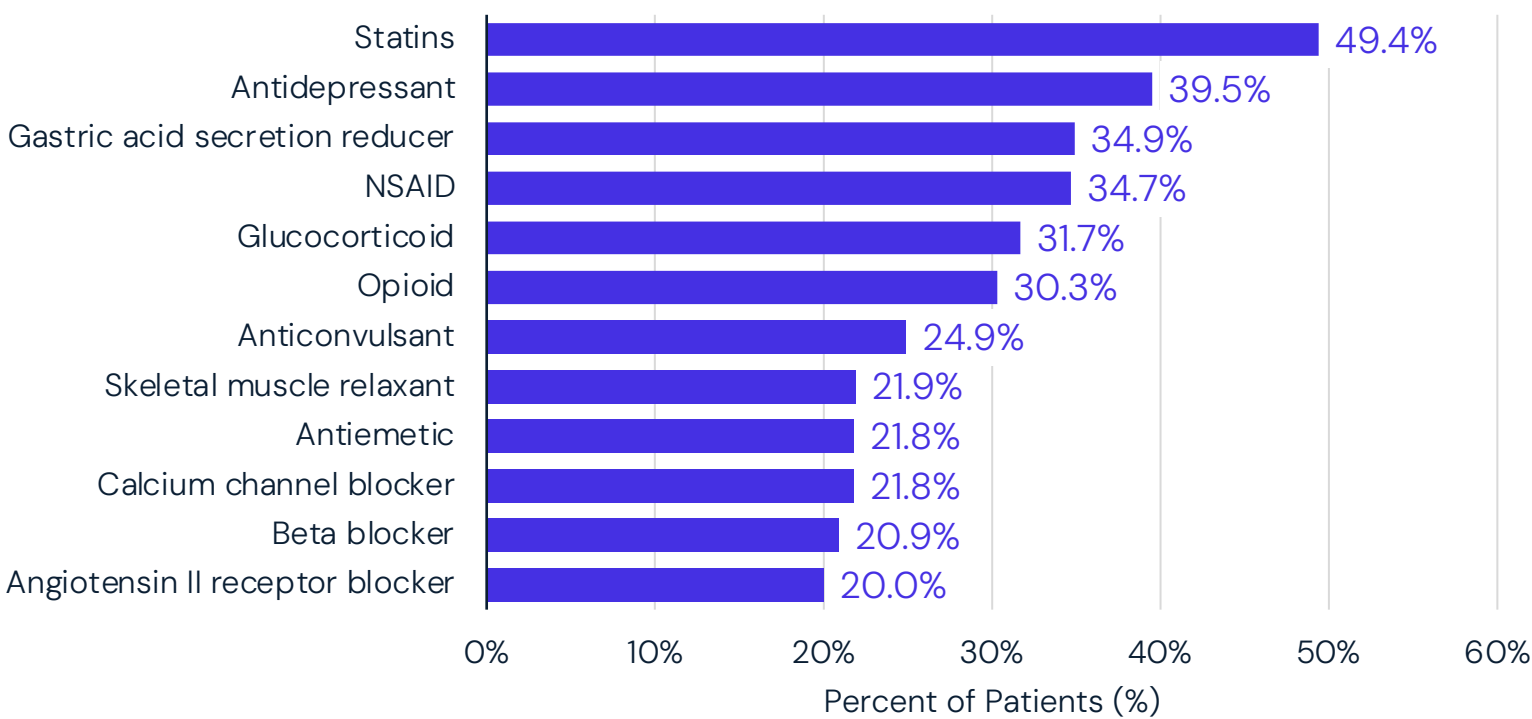
High Polypharmacy Rates Underscore Pharmaceutical Reliance

In 2025, 32.9% of patients prescribed at least one medication were using five or more prescribed medications. Patients ages 65 and older had the highest polypharmacy use (58.4%). Women had higher polypharmacy use compared to men among those ages 18–44 (24.5% vs. 15.5%) and ages 45–64 (44.5% vs. 38.8%). The most common drug classes among individuals with polypharmacy include statins (49.4%), antidepressants (39.5%), gastric acid secretion reducers (34.9%) and NSAIDs (34.7%).

Share of Pharmacy Patients Using Five or More Medications, by Age Group, 2025



Most Common Drug Classes Among Polypharmacy Patients, by Share of Patients, 2025



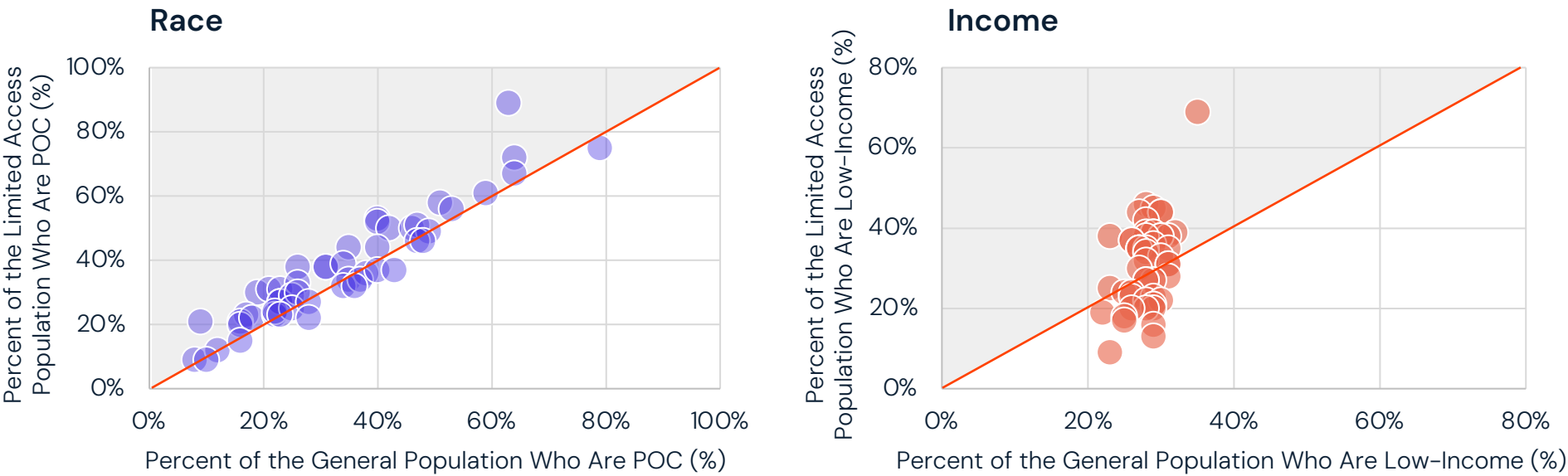
Note: NSAID denotes non-steroidal anti-inflammatory drugs.
Source: Trilliant Health national all-payer claims database.

POPULATION UNWELLNESS

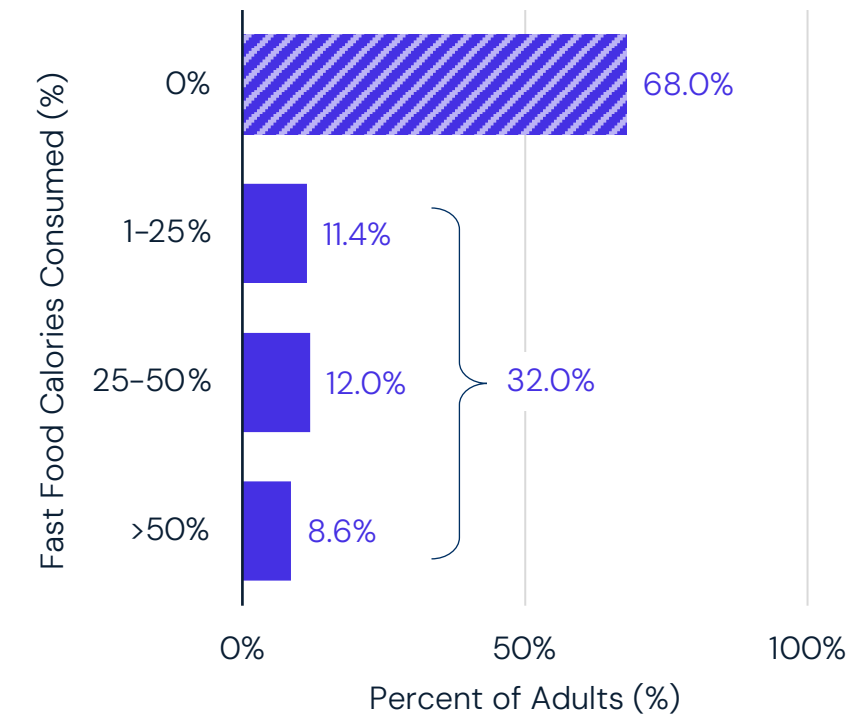
Many Low-Income and Minority Americans Lack Access to Healthy Food Options

Nationally, 8.5% of Americans live in an area with limited access to a grocery store. In most states, POC and low-income residents are disproportionately impacted by limited grocery store access. For example, 38% of Pennsylvania residents with limited access to groceries are POC and 44% are low-income, while 26% of all Pennsylvania residents are POC and 27% are low-income. Consistent with disparities in grocery store access, Black (41.7%), AIAN (40.9%) and Hispanic (35.9%) Americans, along with those earning below \$25,000 (39.2%), have elevated rates of obesity. In addition, nearly one-third of American adults consume fast food each day, with 8.6% deriving more than half of daily calories from fast food.

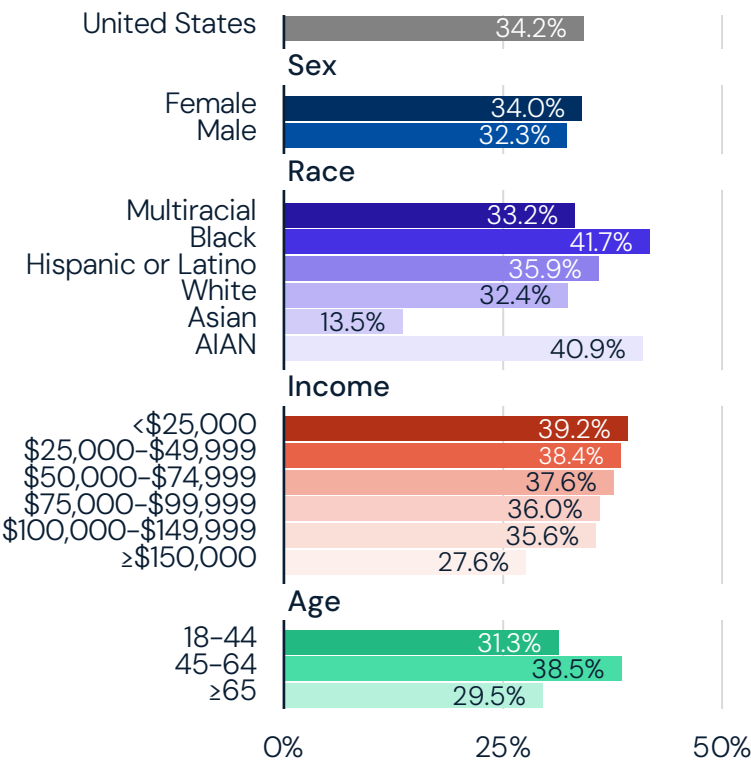
Concentration of Limited Grocery Store Access Across States by Race and Income, 2022



Share of Adults Who Reported Eating Fast Food Daily, by Share of Calories Consumed, 2021-2023



Share of Adults With Obesity, by Demographics 2024



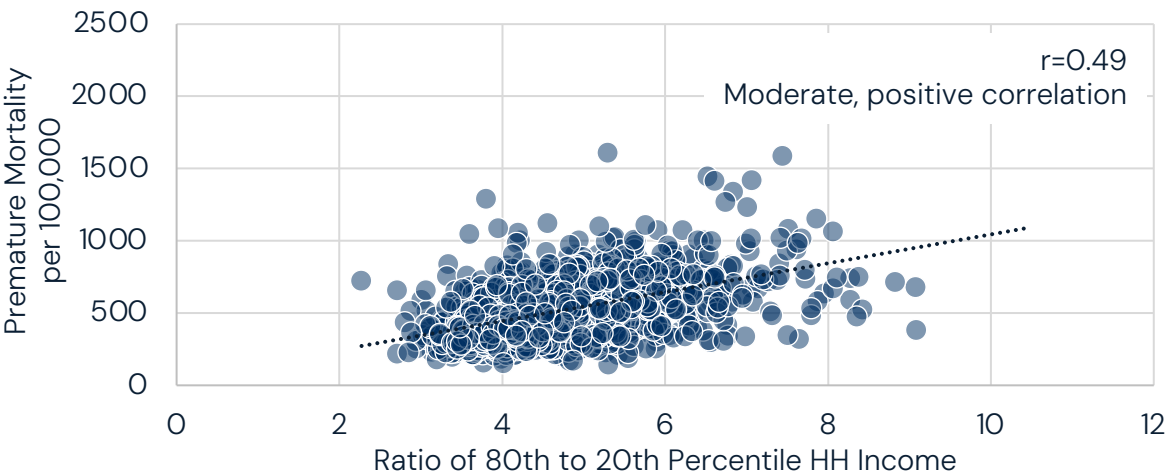
Note: AIAN denotes American Indian and Alaska Native; POC denotes people of color and includes people who are Black, Latino, Asian, Native American or two or more races. Calorie and obesity data includes adults ages 20 and older.
Source: America's Health Rankings; Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System; Reinvestment Fund.

Income Inequality Is Associated With Poor Health

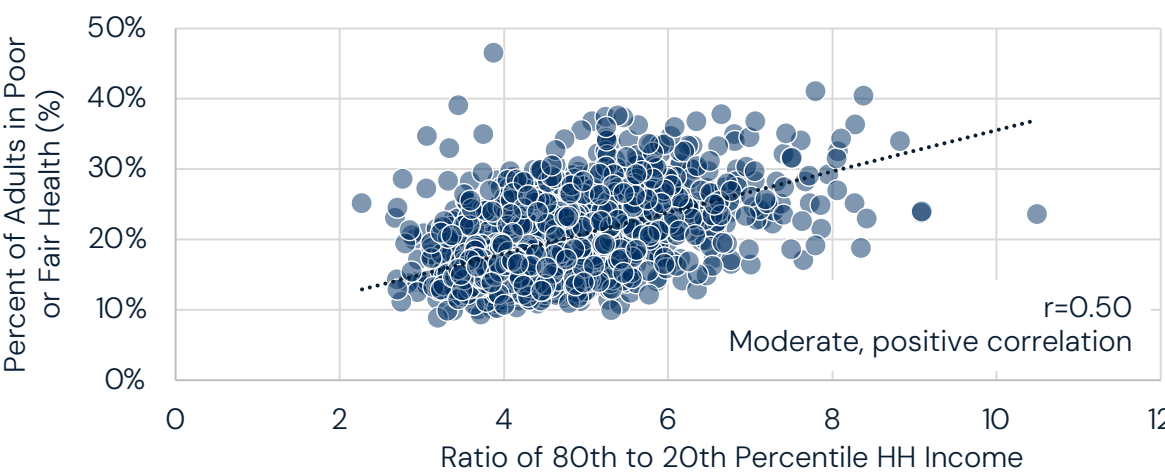
Income inequality is consistently associated with worse health outcomes. The size of the income difference between households has a moderate positive correlation with multiple health outcomes, ranging from $r=0.46$ for low birth rate to $r=0.50$ for poor or fair health status.

County-Level Health Outcomes and Income Inequality

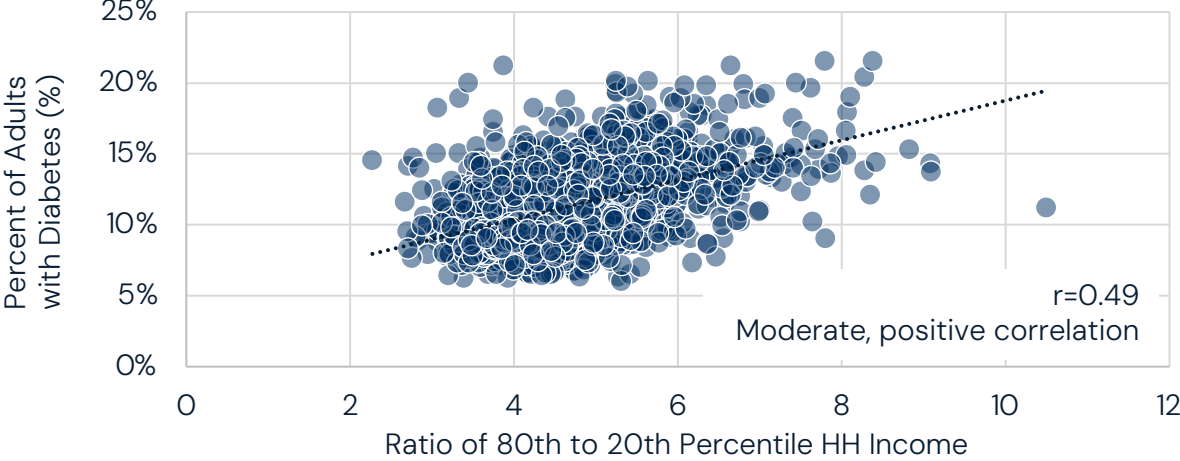
Age-Adjusted Premature Mortality vs. HH Income Inequality



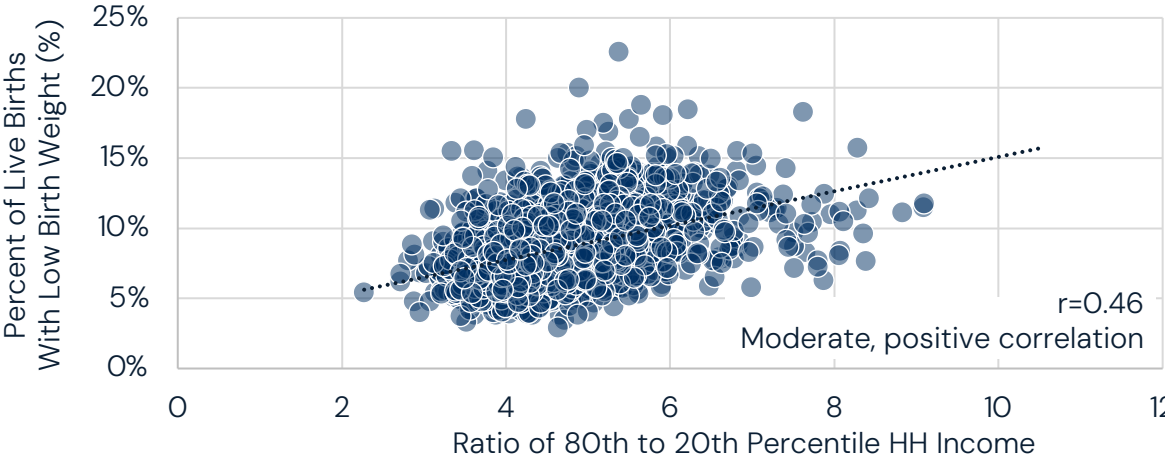
Age-Adjusted Health Status vs. HH Income Inequality



Age-Adjusted Diabetes Prevalence vs. HH Income Inequality



Low Birth Weight vs. HH Income Inequality



← Lower Inequality ————— Higher Inequality →

← Lower Inequality ————— Higher Inequality →

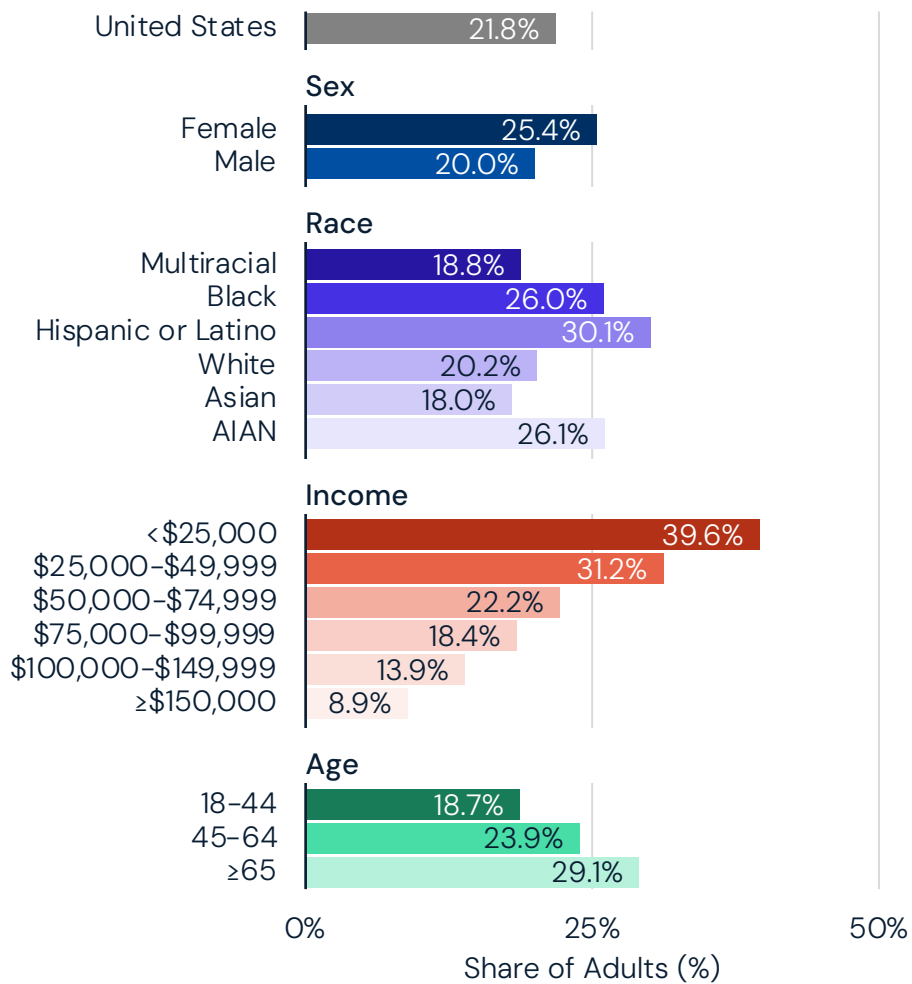
Note: HH denotes household. Premature mortality is defined as the number of deaths among residents younger than 75. Low birth weight is defined as a weight under 2,500 grams. This analysis used the Pearson correlation coefficient (r) to examine the strength of the linear relationship between measures
Source: University of Wisconsin Population Health Institute; County Health Rankings & Roadmaps 2025.

POPULATION UNWELLNESS

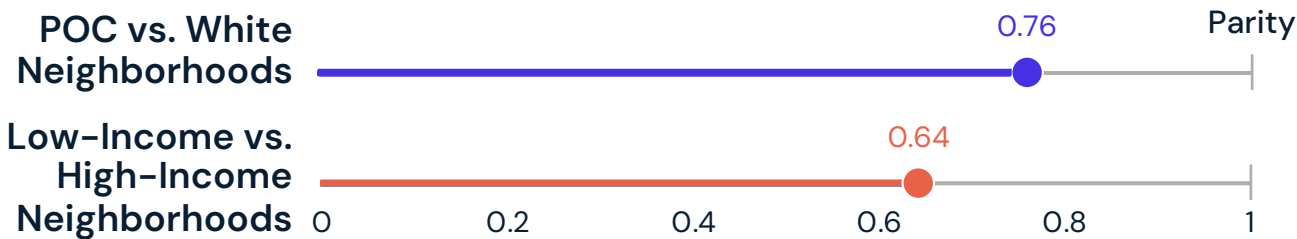
Physical Inactivity Is Common and Increases Risk of Chronic Conditions

In 2024, 21.8% of Americans were physically inactive, meaning they did not do any physical activity or exercise other than their regular job in the past 30 days. Individuals earning below \$25,000 have the most physical inactivity and low-income neighborhoods have less green space than their higher-income counterparts. On average, people who walk 12,000 steps a day are estimated to have a 20% lower risk of falling and a 30% lower risk of cardiovascular disease than those who walk 2,000 steps.

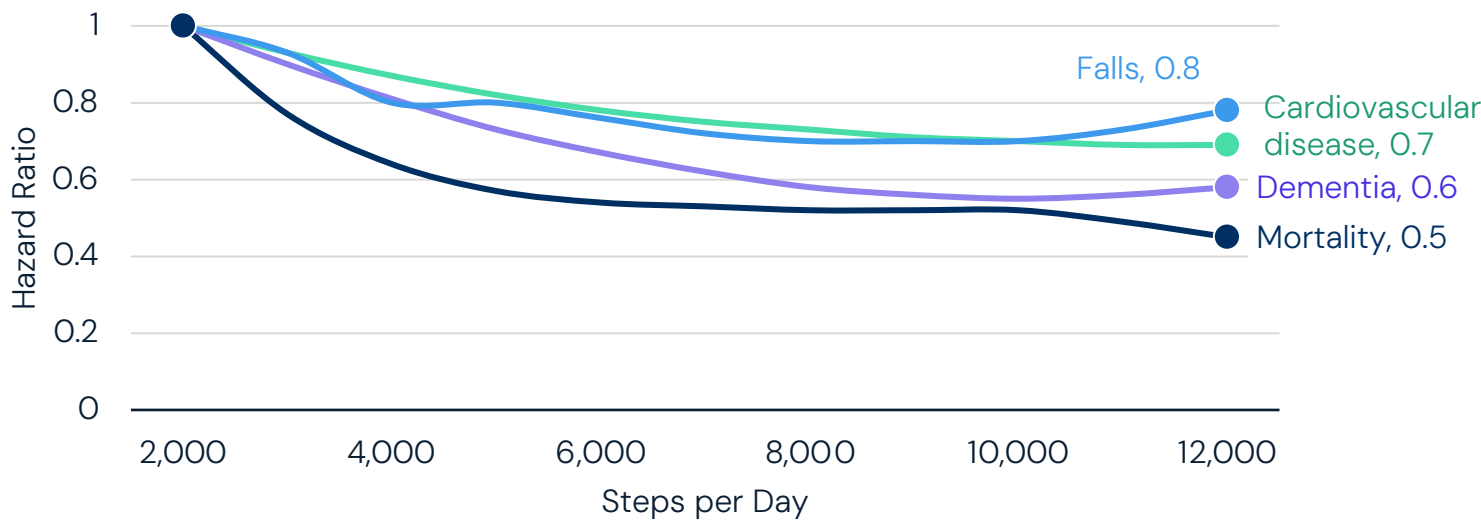
Adult Prevalence of Physical Inactivity, by Demographics, 2024



Ratio of Green Space in Neighborhoods by Demographics, 2026



Hazards of Poor Health Outcomes by Daily Step Count, Compared to 2,000 Steps Per Day



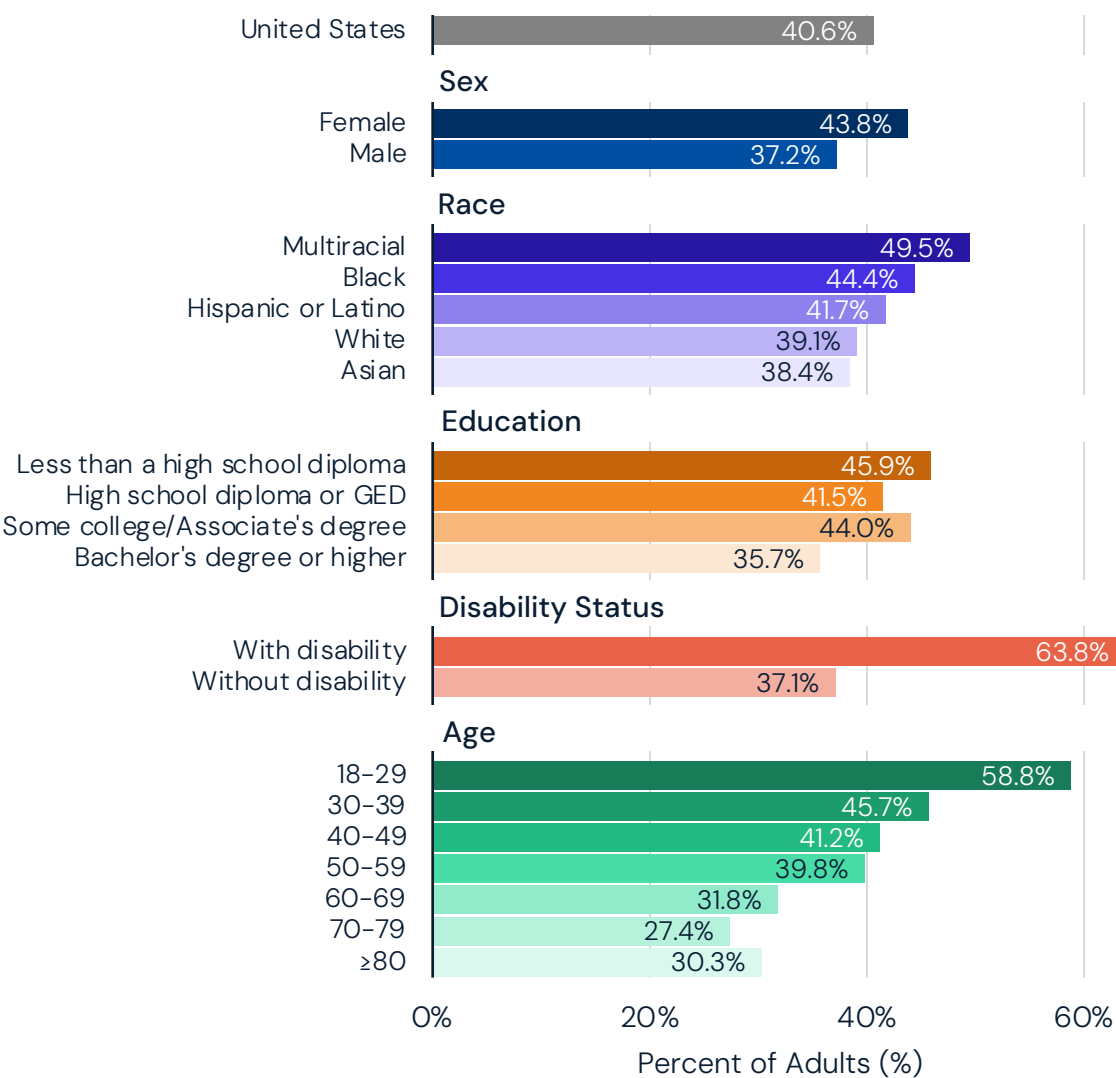
Note: AIAN denotes American Indian and Alaska Native; POC denotes people of color and includes Black, Hispanic, Native American, Asian, Pacific Islander and multiple races. POC neighborhoods are census block groups that are in the top 20% of highest concentration of POC in a city, and White neighborhoods are census block groups that are in the top 20% with regards to concentration of White residents. Low-income neighborhoods are census block groups where the median household income is below 75% of the city’s median income, and high-income neighborhoods are where the median income is above 125% of the city’s median income.
Source: America’s Health Rankings; Smart Growth America; Ding et al., Daily Steps and Health Outcomes in Adults: A Systematic Review and Dose-Response Meta-Analysis, *Lancet Public Health*, 2025.

POPULATION UNWELLNESS

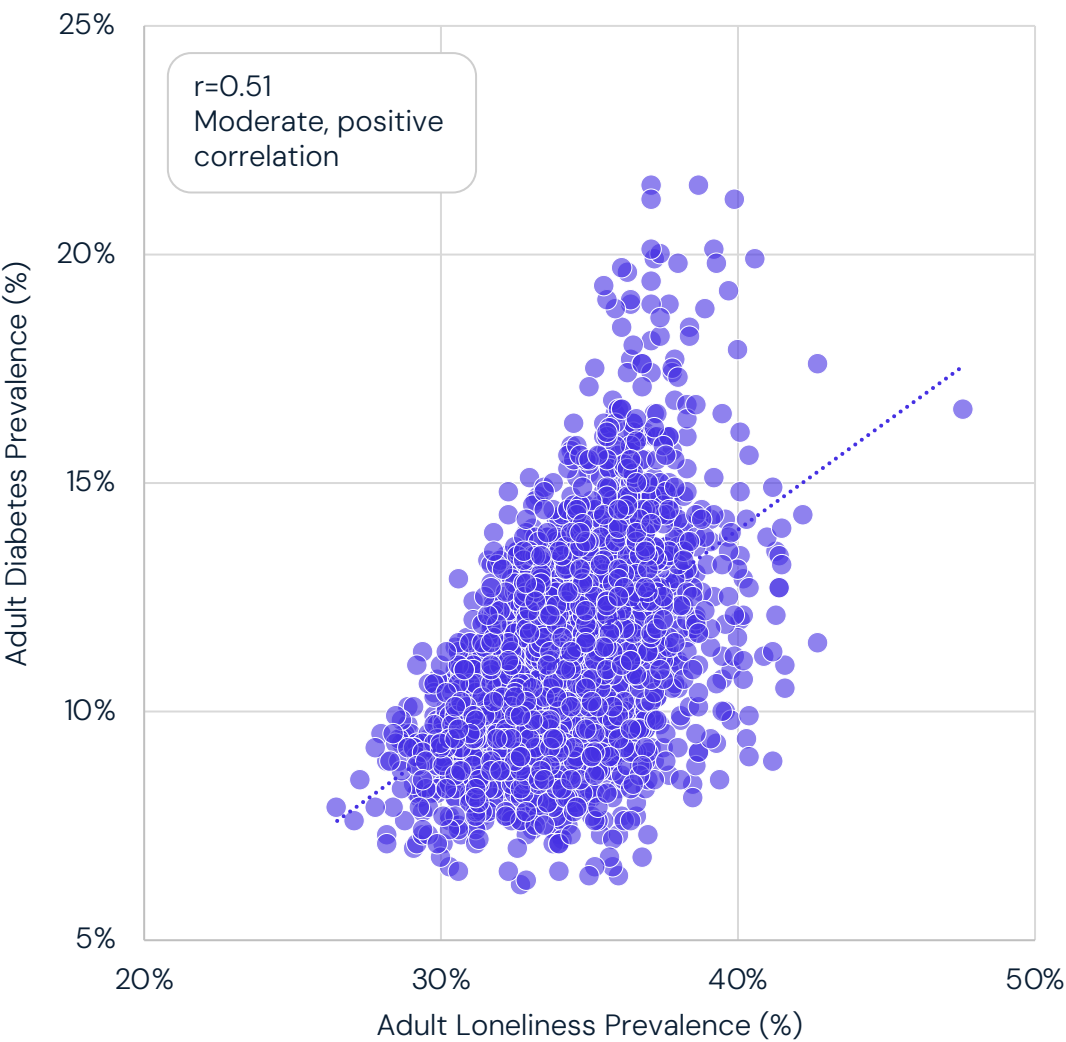
Social Isolation Is a Public Health Crisis

In 2024, 40.6% of American adults reported feelings of loneliness, with rates approaching 50% in states like Alaska and Oregon. Loneliness is especially prevalent among young adults ages 18–29 (58.8%), adults with disabilities (63.8%) and multiracial adults (49.5%). Women report loneliness at higher rates than men, 43.8% vs. 37.2%, respectively. At the county level, loneliness is moderately correlated with diabetes prevalence.

Share of Adults Who Sometimes, Usually or Always Feel Lonely, 2024



Adult Loneliness vs. Adult Diabetes Prevalence, by County, 2024



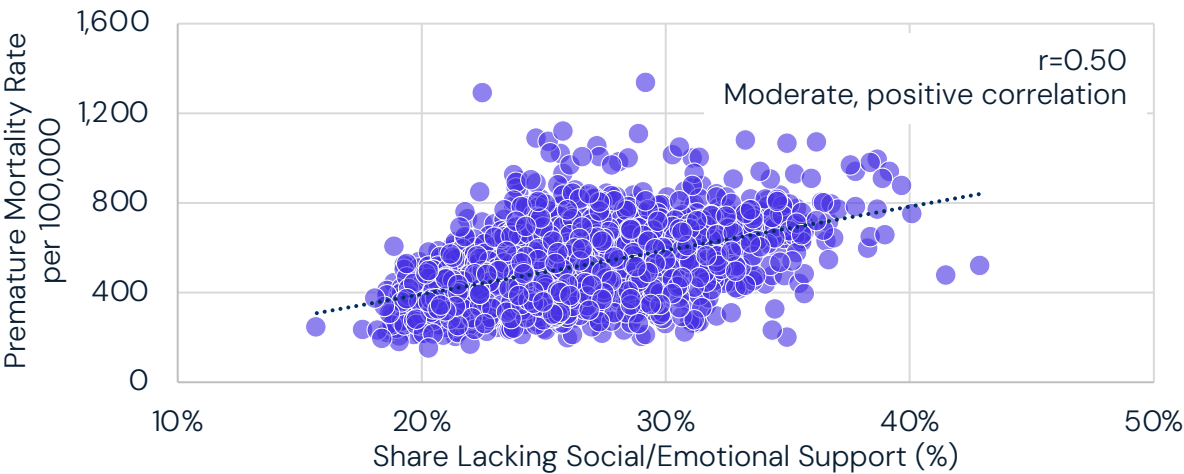
Note: GED denotes general educational development.
Source: Centers for Disease Control and Prevention National Center for Health Statistics; University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2025.

Deaths of Despair Are a Symptom of Social Disintegration That the Healthcare System Cannot Solve

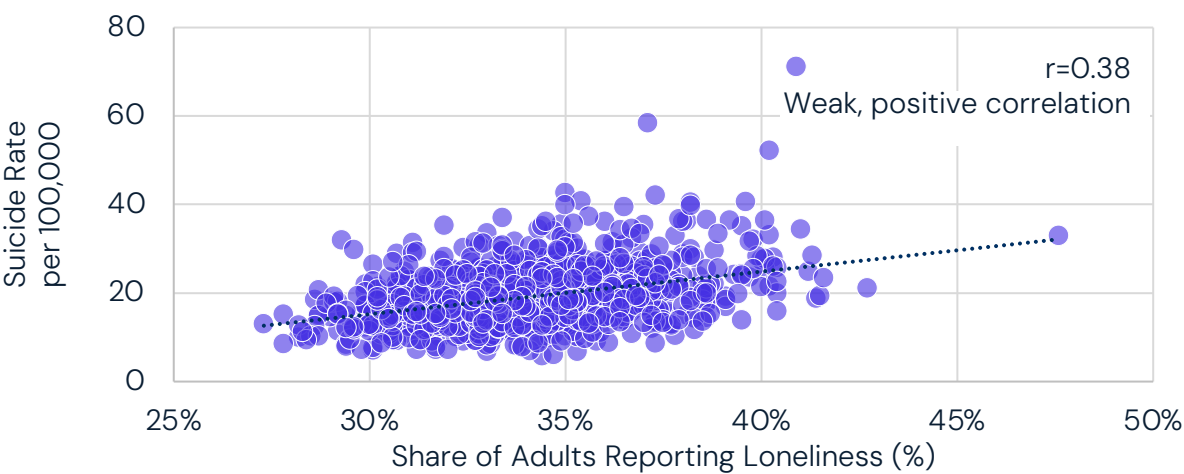
County-level data reveal positive associations between deaths of despair and markers of social disintegration. The strongest relationships are between premature mortality and lack of social/emotional support ($r=0.50$) and excessive drinking and social associations ($r=0.49$), while suicide rates and overdose rates show weaker but directionally consistent associations with adult loneliness and disconnected youth.

County-Level Mortality and Social Support Metrics

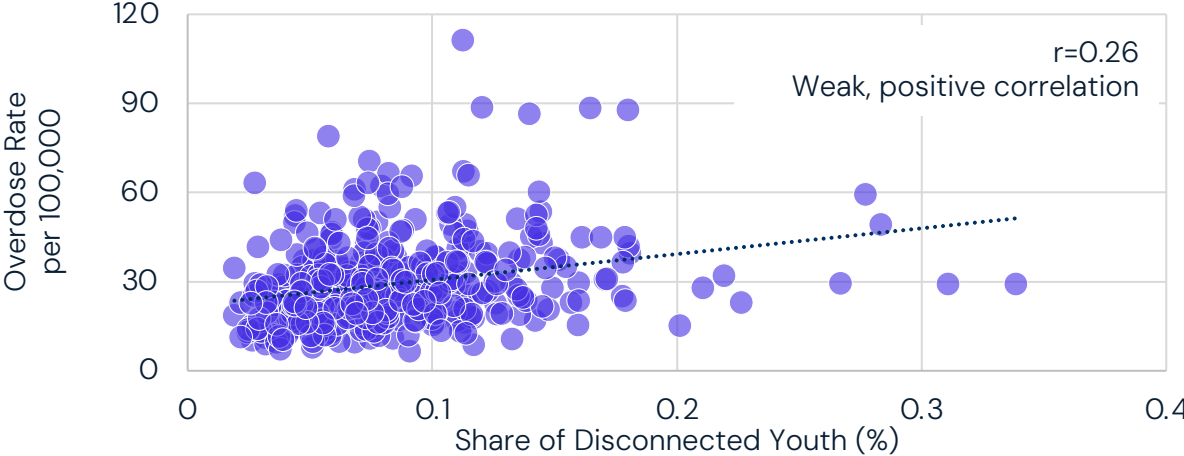
Premature Mortality vs. Lack of Social/Emotional Support



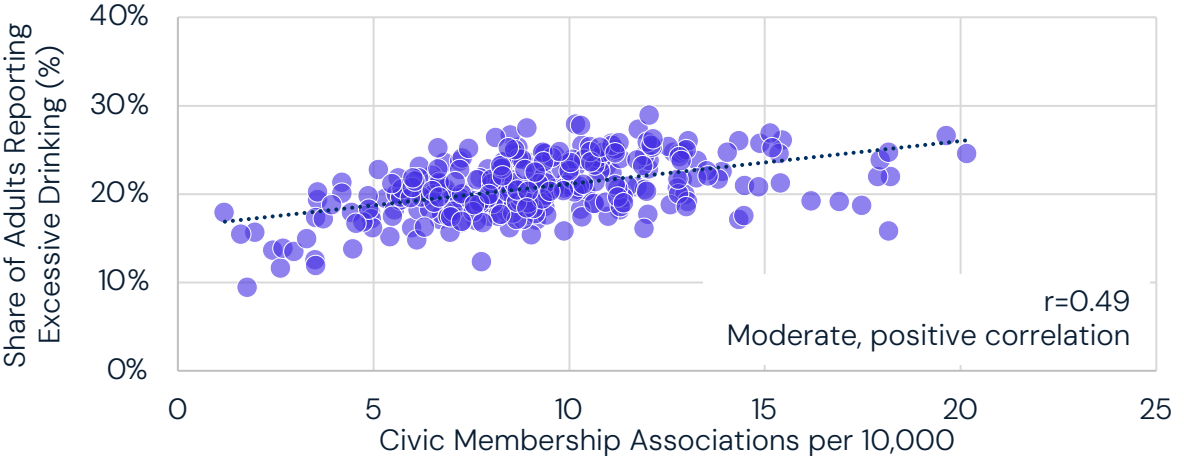
Suicide Rate per 100,000 vs. Adult Loneliness



Overdose Rate per 100,000 vs. Disconnected Youth



Excessive Drinking vs. Social Association Rate per 10,000



Note: Premature mortality is defined as the age-adjusted number of deaths among people ages 0–74 per 100,000 population. Lack of social/emotional support is the share of adults reporting sometimes, rarely or never getting the social and emotional support they need. Adult loneliness is the share of adults reporting that they always, usually or sometimes feel lonely. Disconnected youth is the share of people ages 16–19 who are neither working nor in school. This analysis used the Pearson correlation coefficient (r) to examine the strength of the linear relationship between measures

Source: University of Wisconsin Population Health Institute; County Health Rankings & Roadmaps 2025.

03

The Disconnect Between
Demand and Supply Is a
Market Failure

MARKET FAILURE

The health economy has systematically overbuilt capacity in high-margin specialty and procedural care while **chronically underinvesting in primary care** and behavioral health. The result is a system that delivers an abundance of what is profitable and a scarcity of what is considered essential to health. This mismatch will only intensify as the number of adults 65 and older continues to grow and too few physicians pursue primary care over more lucrative specialties, a financially rational decision.

Utilization has remained relatively flat even as disease burden rises, reflecting **supply that is both constrained and misaligned** with the needs of an increasingly unhealthy population. Simultaneously, those who proactively want to improve or maintain their health find that the current system has little to offer. Polypharmacy, low-value care and unnecessary procedures coexist with unmet need for basic screening and mental health treatment – not because demand is absent but because most reimbursement structures incentivize intervention over prevention, **volume over outcomes** and procedural complexity over cognitive coordination. The system is not undersupplying care. It is all too often **supplying the wrong care, to the wrong patients**, at the wrong stage of disease progression. No single actor is positioned to correct a misallocation that every actor is individually rewarded for deepening.

MARKET FAILURE

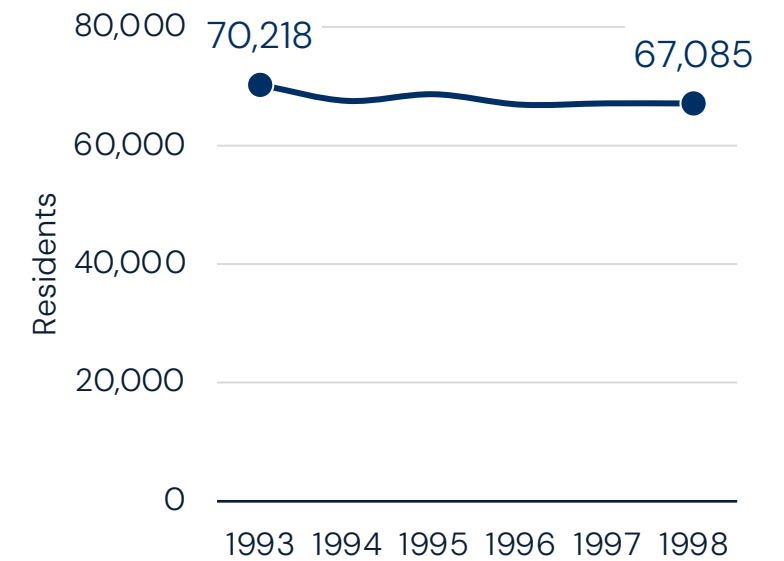
Misguided Policy Decisions Guaranteed an Insufficient Physician Workforce

On the advice of Abraham Flexner, the number of U.S. medical schools halved between 1910 and 1925. Then, from 1980 to 2005, at the behest of what is now HHS, allopathic medical schools voluntarily capped student enrollment and the construction of new medical schools, falling behind population growth. Caps were extended to residency positions when Congress passed the Balanced Budget Act in 1997. Having finally recognized the growing problem of physician shortages in 2005, the AAMC reversed the moratorium on medical school enrollment and expansion. For the first time since 1996, the Consolidated Appropriations Acts of 2021 and 2023 meaningfully expanded Medicare-funded residency positions.

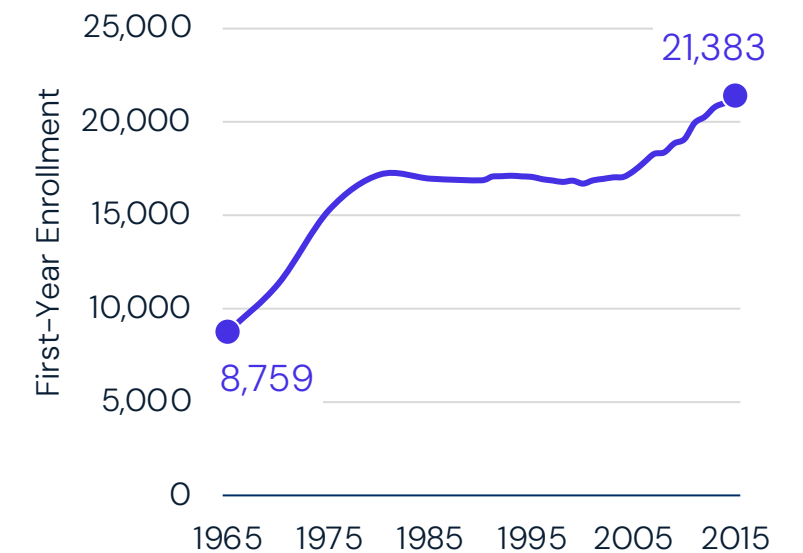
Major Developments in Medical Education

- **1910** Flexner Report is released
Abraham Flexner evaluated the 155 U.S. medical schools and recommended closing most of them.
- **1911–1925** Medical schools close
Following the Flexner Report's advice, 78 of the 155 medical schools closed, including five of the seven predominantly Black institutions.
- **1980** GMENAC predicts physician surplus
The committee recommended a 17% decrease in medical school enrollment, sparking a voluntary moratorium on enrollment.
- **1997** Balanced Budget Act caps resident count
The Act capped all future Medicare funding for medical education to the number of residents that were in training in 1996.
- **2005** AAMC calls for increasing enrollment
The AAMC recommended a 15% increase in medical school enrollment by 2015 in response to physician shortages.
- **2006** AAMC amends recommendation to 30%
The AAMC identified worsening physician shortages and raised their recommendation to a 30% increase in enrollment by 2015.
- **2021** Consolidated Appropriations Act passes
The Act raised the number of residents for which Medicare will provide funding by 1,000 FTE, the first increase since 1996.
- **2023** Consolidated Appropriations Act passes
The Act added another 200 FTE in Medicare resident funding.

Number of Residents, 1993–1998



Medical Student Enrollment, 1965–2015

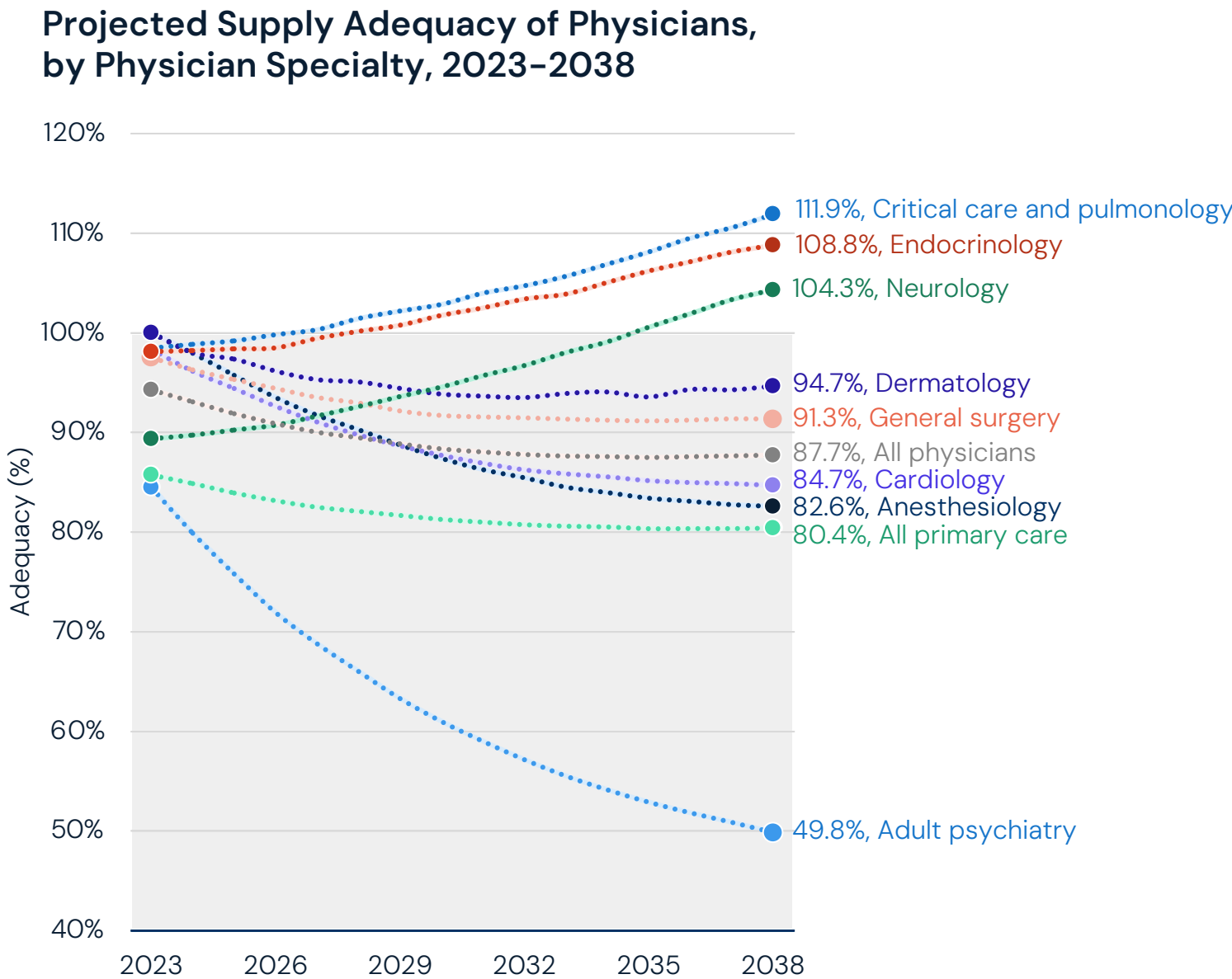


Note: AAMC denotes Association of American Medical Colleges; FTE denotes full-time equivalent; GMENAC denotes Graduate Medical Education National Advisory Committee; HHS denotes the Department of Health and Human Services.
Source: Summary Report of the Graduate Medical National Advisory Committee To the Secretary, Department of Health and Human Services, 1980; Association of American Medical Colleges; Miller et al., Revisiting Black Medical School Extinctions in the Flexner Era, *Journal of the History of Medicine and Allied Sciences*, 2011; Dalen, The Moratorium on US Medical School Enrollment, From 1980 to 2005: What Were We Thinking, *The American Journal of Medicine*, 2008.

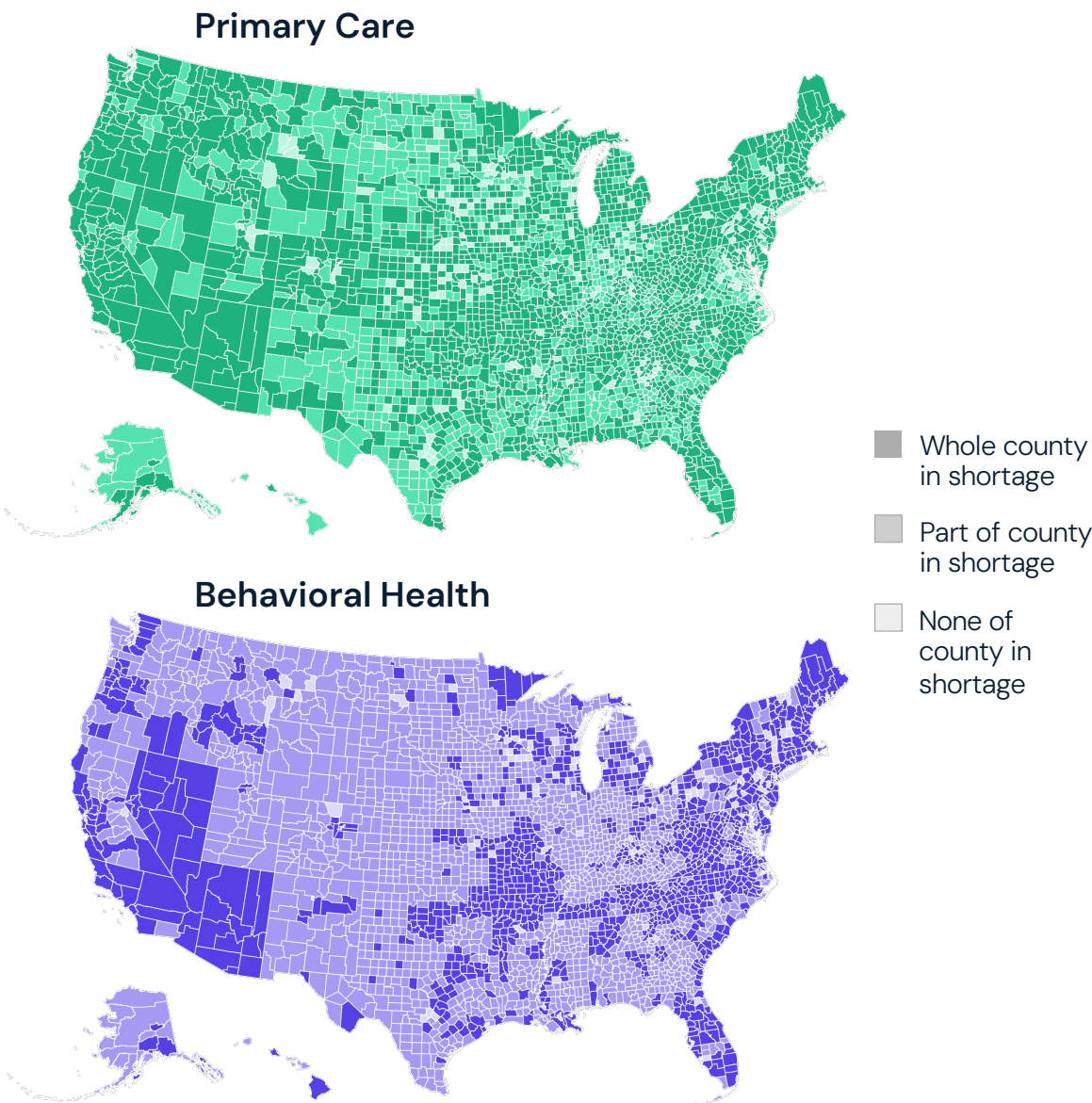
MARKET FAILURE

Behavioral Health and Primary Care Physician Supply Fall Short

By 2038, overall physician supply adequacy is projected to decline to 87.7%. Adult psychiatrists (49.8%) and primary care physicians (80.4%) are projected to be the most undersupplied. In contrast, some specialties are expected to be oversupplied (e.g., neurologists and endocrinologists). In 2025, 89.1% of U.S. counties were partially or entirely in shortage of primary care and behavioral health providers, with 20.1% of counties in complete shortage of both provider types.



Health Professional Shortage Areas, by County, 2025



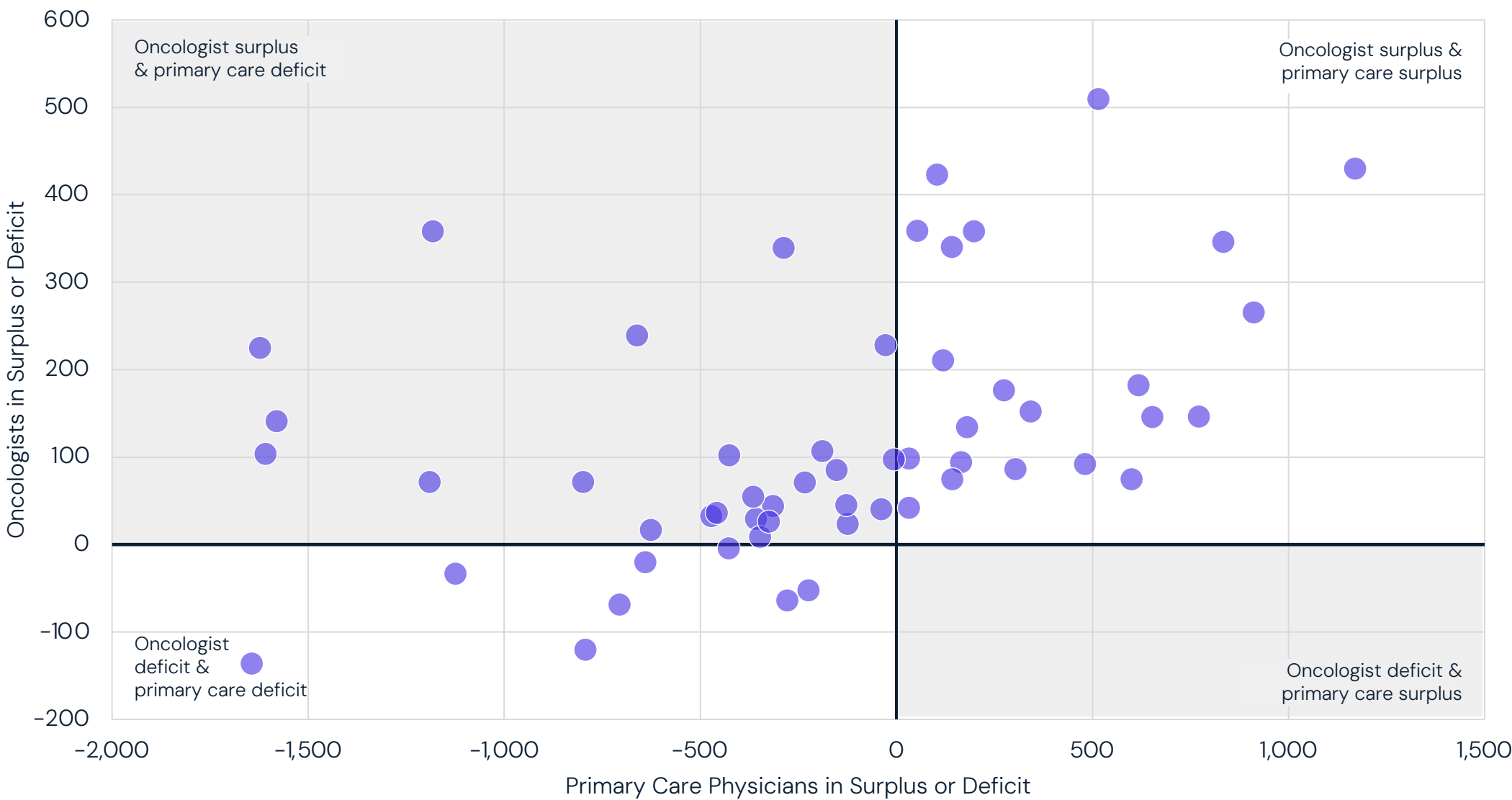
Source: U.S. Health Resources and Services Administration Workforce Projections and Area Health Resource Files.

MARKET FAILURE

Physician Adequacy Is Local

While HRSA projects that the 2038 supply of primary care physicians and oncologists will be 80% and 96% adequate, respectively, there is substantial variation by geography. Among the 55 CBSAs with more than 1M population, nine markets have a deficit of oncologists and PCPs, while 22 markets have a surplus of oncologists and primary care physicians.

Primary Care Physician vs. Oncologist Adequacy, by CBSA, 2024



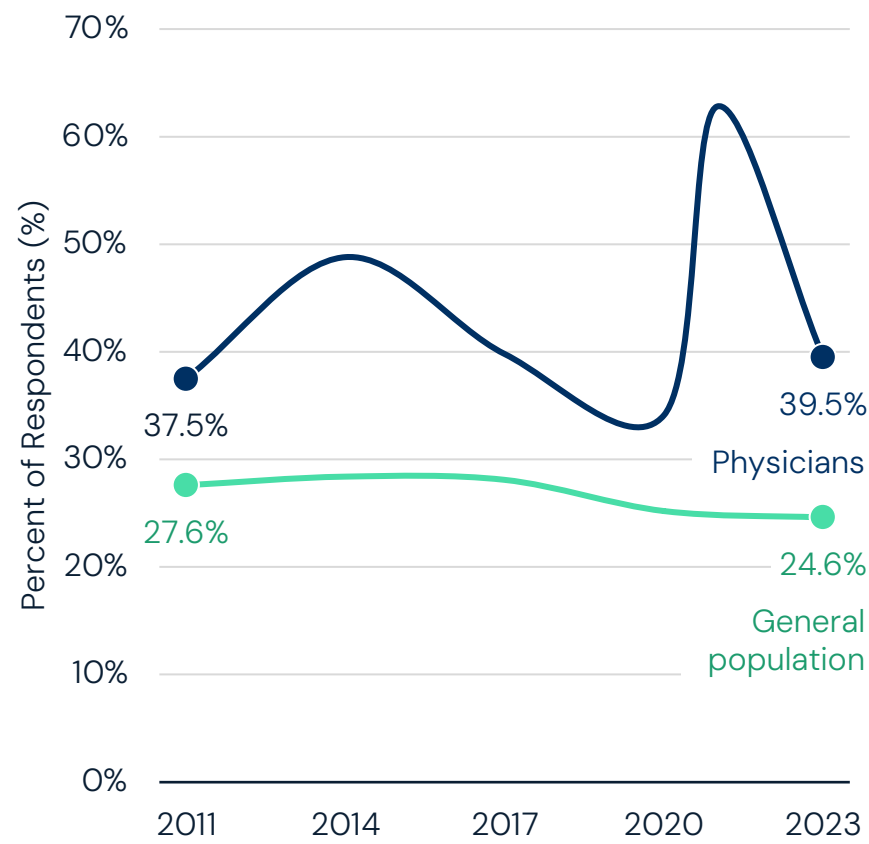
Note: CBSA denotes core-based statistical area; HRSA denotes Health Resources & Services Administration. Analysis is limited to CBSAs over 1M population.
Source: Trilliant Health national all-payer claims database and Provider Directory; U.S. Health Resources and Services Administration Workforce Projections.

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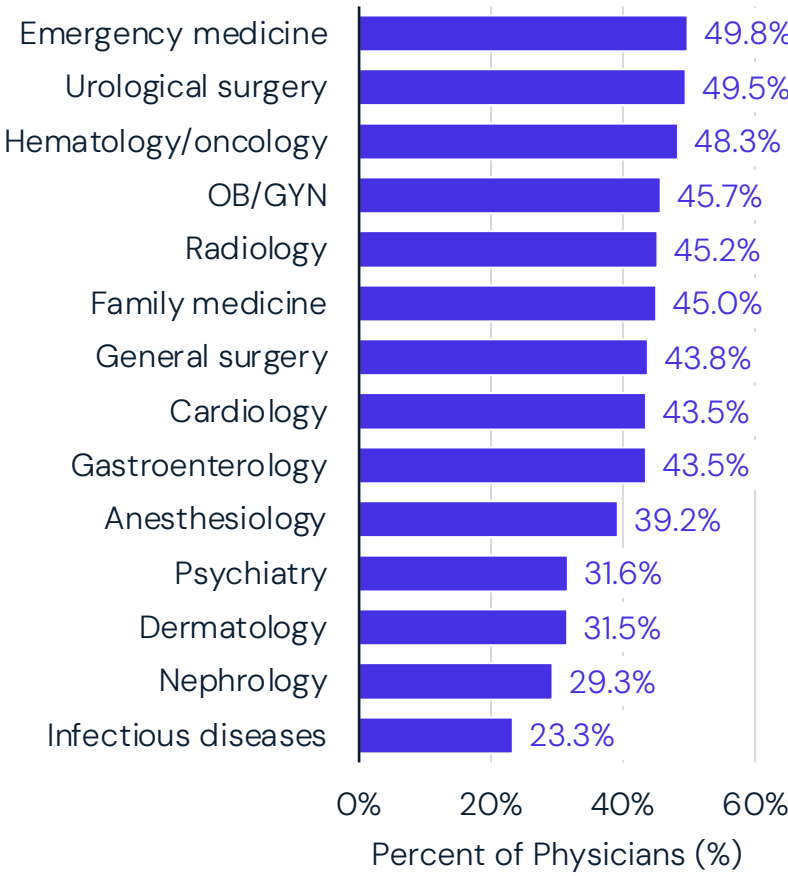
Burnout Threatens to Worsen Physician Shortages

As of 2023, 39.5% of physicians reported burnout, with 82% higher odds than non-physician peers. Burnout varies by specialty, ranging from 49.8% of emergency medicine physicians to 23.3% of infectious disease physicians. Notably, 56% of physicians considered leaving medical practice due to overwork in 2026.

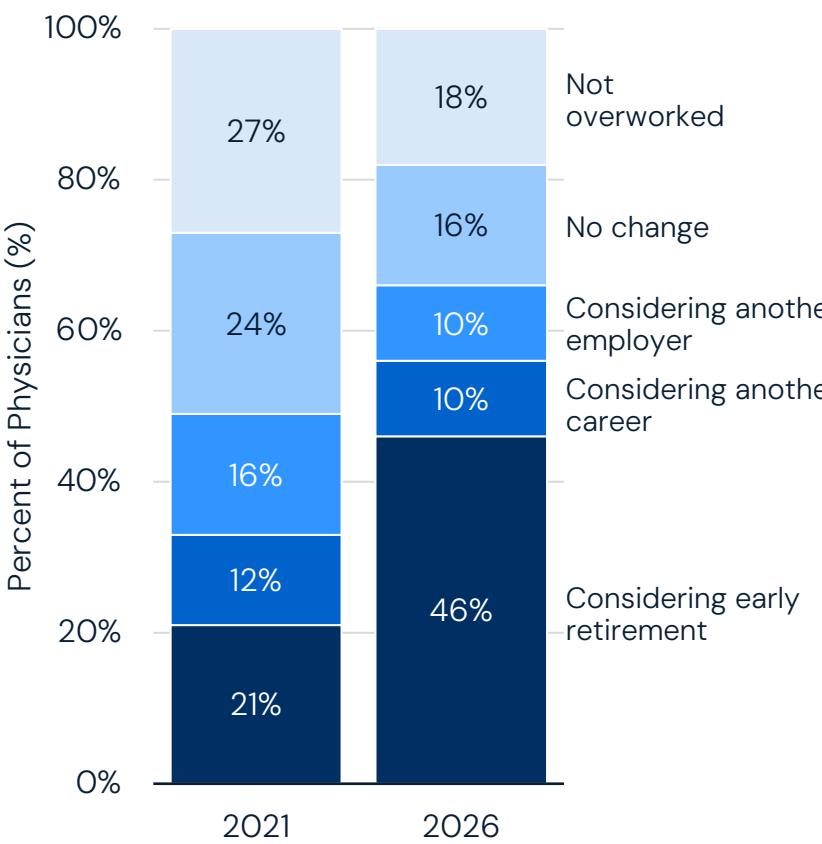
Share of Physicians and the General Population Reporting Burnout, 2011–2023



Share of Physicians With One or More Symptoms of Burnout, by Specialty, 2025



Physicians’ Responses to Overwork, 2021 and 2026



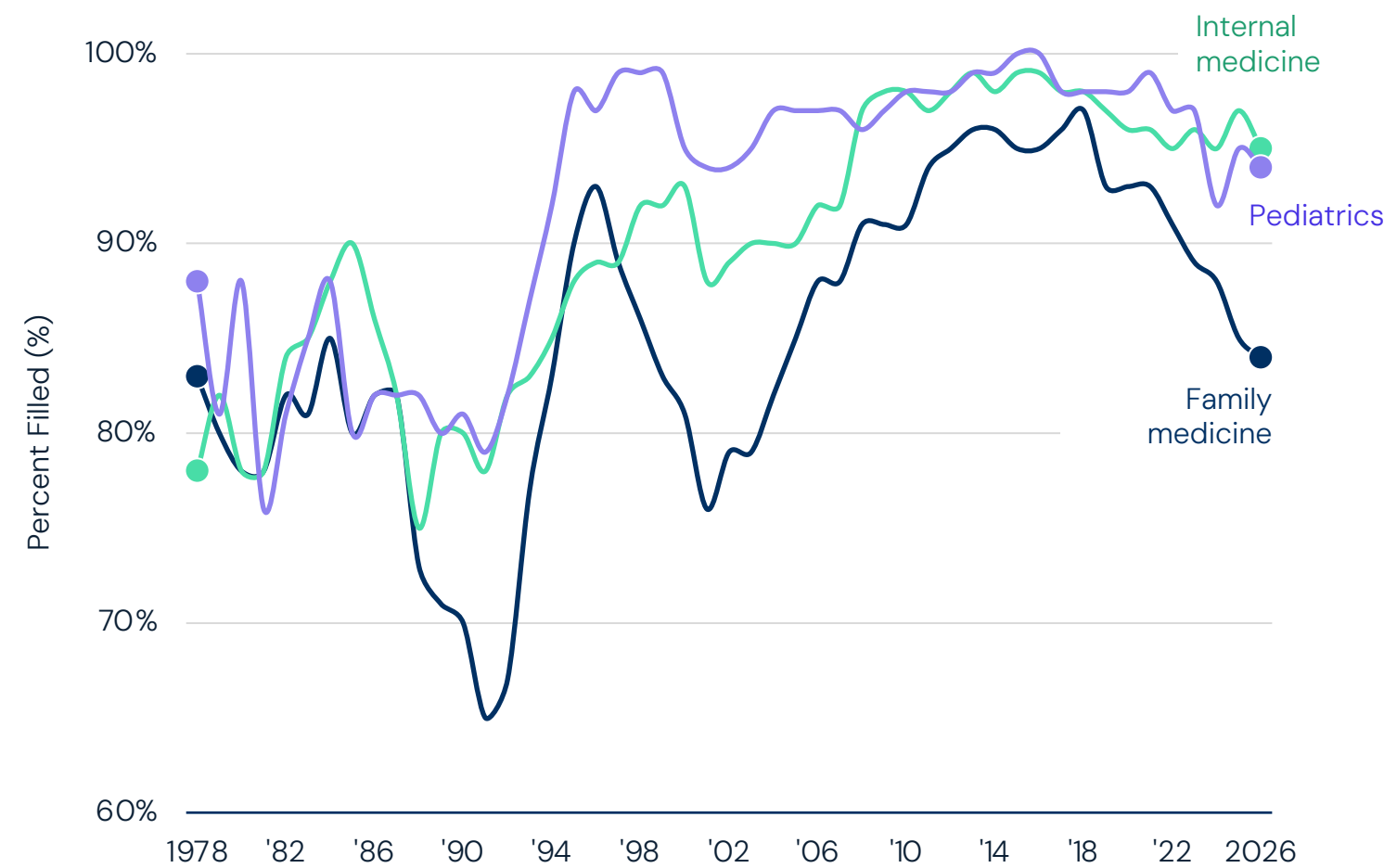
Note: OB/GYN denotes obstetrics and gynecology.
Source: American Medical Association; Doximity, Physician Compensation Report, 2026; Shanafelt et al., Changes in Burnout and Satisfaction With Work–Life Integration in Physicians and the General US Working Population Between 2011 and 2023, *Mayo Clinic Proceedings*, 2025; Shanafelt et al., Changes in Burnout and Satisfaction With Work–Life Integration in Physicians and the General US Working Population Between 2011 and 2020, *Mayo Clinic Proceedings*, 2022; Shanafelt et al., Changes in Burnout and Satisfaction With Work–Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic, *Mayo Clinic Proceedings*, 2022; Shanafelt et al., Changes in Burnout and Satisfaction With Work–Life Balance in Physicians and the General US Working Population Between 2011 and 2017, *Mayo Clinic Proceedings*, 2019; Shanafelt et al., Changes in Burnout and Satisfaction With Work–Life Balance Among US Physicians Relative to the General US Population, *JAMA Internal Medicine*, 2012.

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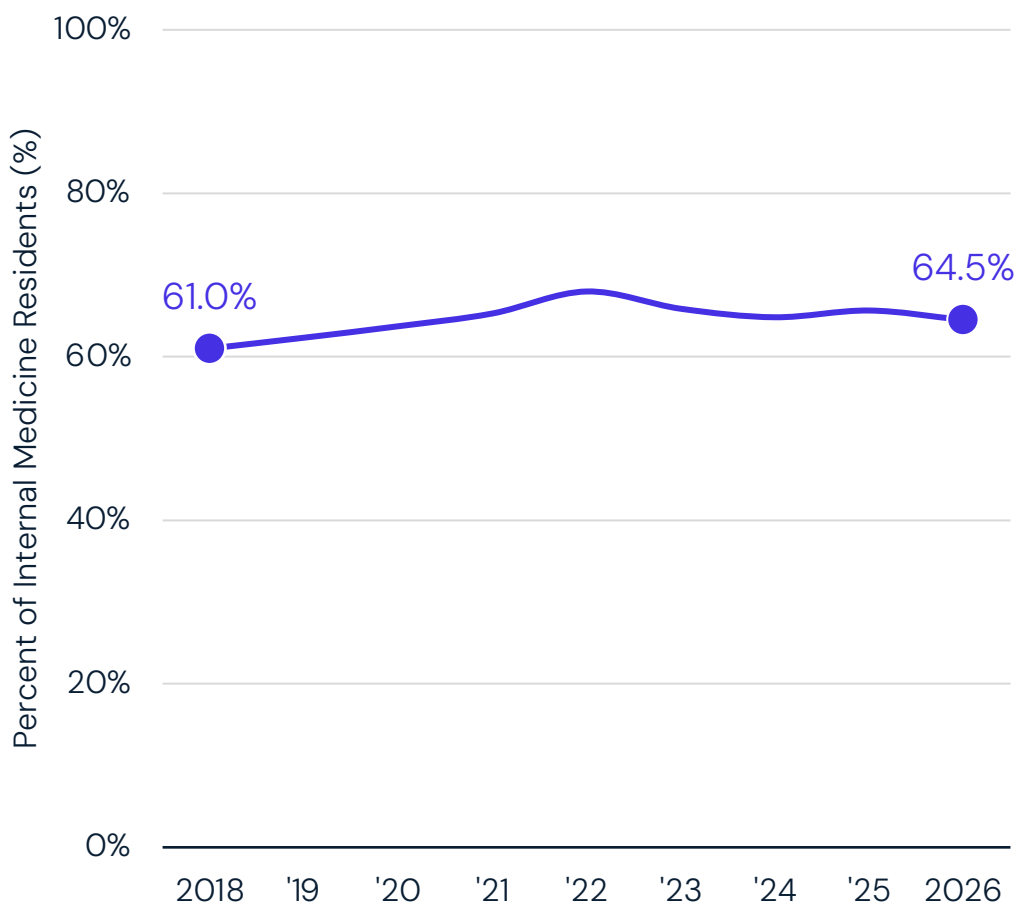
Unfilled Primary Care Residencies Exacerbate Shortages

Primary care residency fill rates recovered from their early 1990s trough and have held near or above 90% since the mid-2010s, though family medicine declined to 84% in 2026. Even so, over 60% of internal medicine residents have elected to subspecialize through fellowship programs every year since 2018 (e.g., cardiology, gastroenterology).

Primary Care Residency Fill Rates, 1978–2026



Share of Internal Medicine Residents Subspecializing in Fellowships, 2018–2026



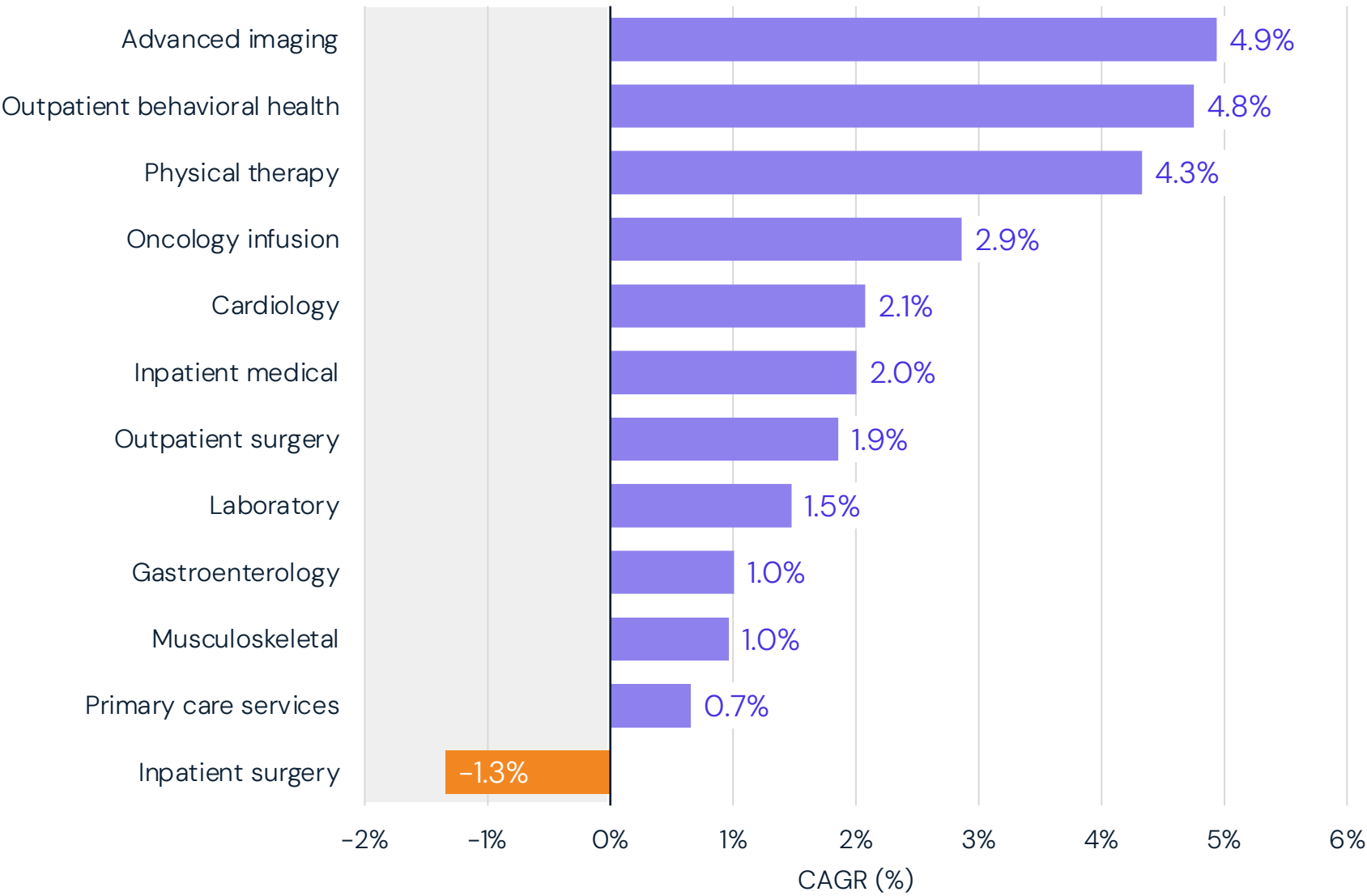
Note: Fellowships include cardiovascular disease, critical care medicine, endocrinology, diabetes and metabolism, gastroenterology, geriatric medicine, hematology and oncology, hospice and palliative medicine, infectious disease, nephrology, pulmonary disease, pulmonary disease and critical care medicine, rheumatology and sleep medicine.
Source: National Residency Match Program® Specialties Matching Service® Reports and Data (1978–2026).

MARKET FAILURE

Specialty Care Growth Outpaces Primary Care

Utilization patterns across clinical service lines shifted meaningfully between 2019 and 2025. Advanced imaging visits per 1,000 increased fastest at a 4.9% CAGR, followed by outpatient behavioral health (4.8%) and physical therapy (4.3%). Primary care visits per 1,000 increased slowest at a 0.7% CAGR. The inpatient surgery rate declined during the time period.

Visits per 1,000 for Select Clinical Areas, CAGR 2019 to 2025



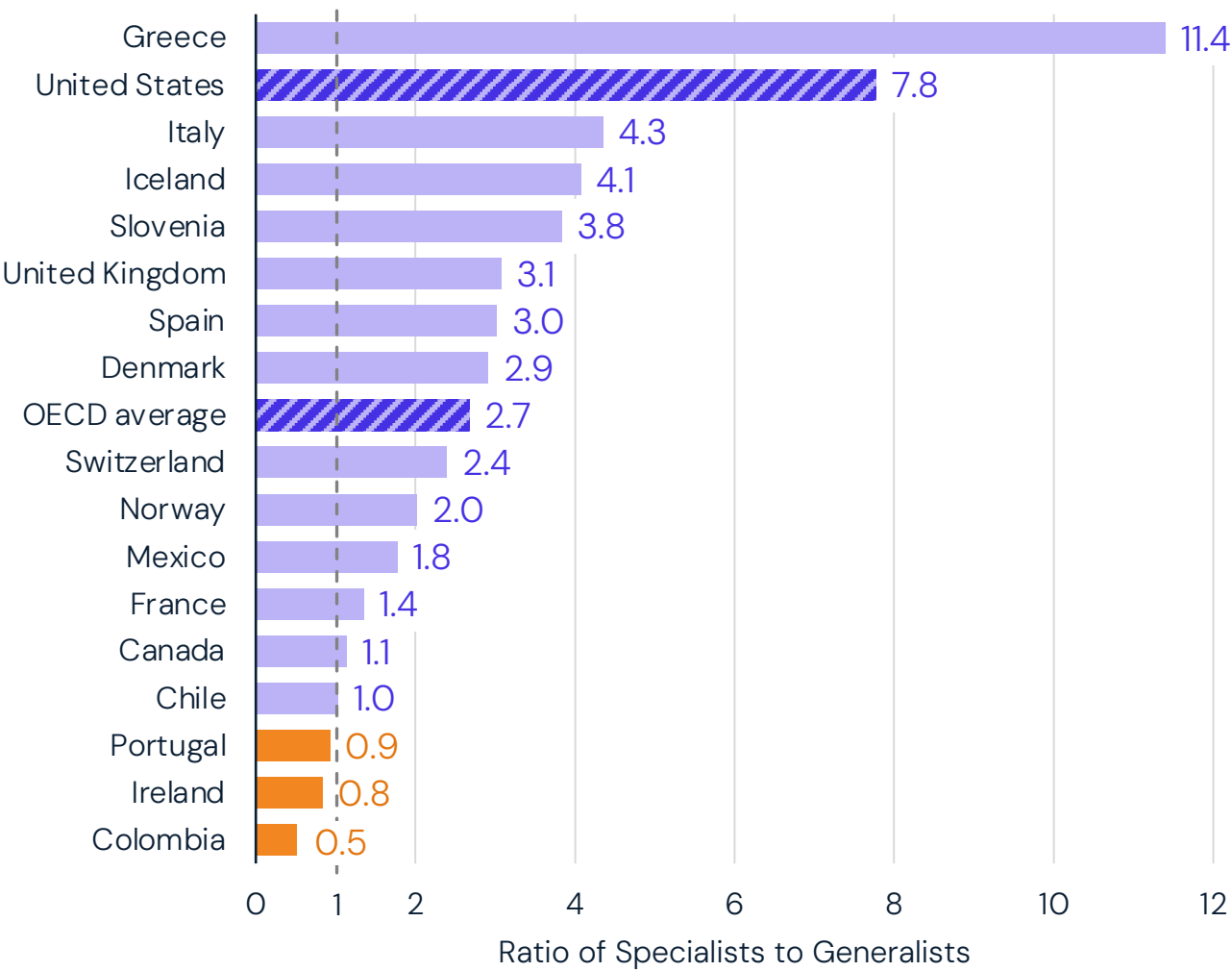
Note: CAGR denotes compound annual growth rate.
Source: Trilliant Health national all-payer claims database.

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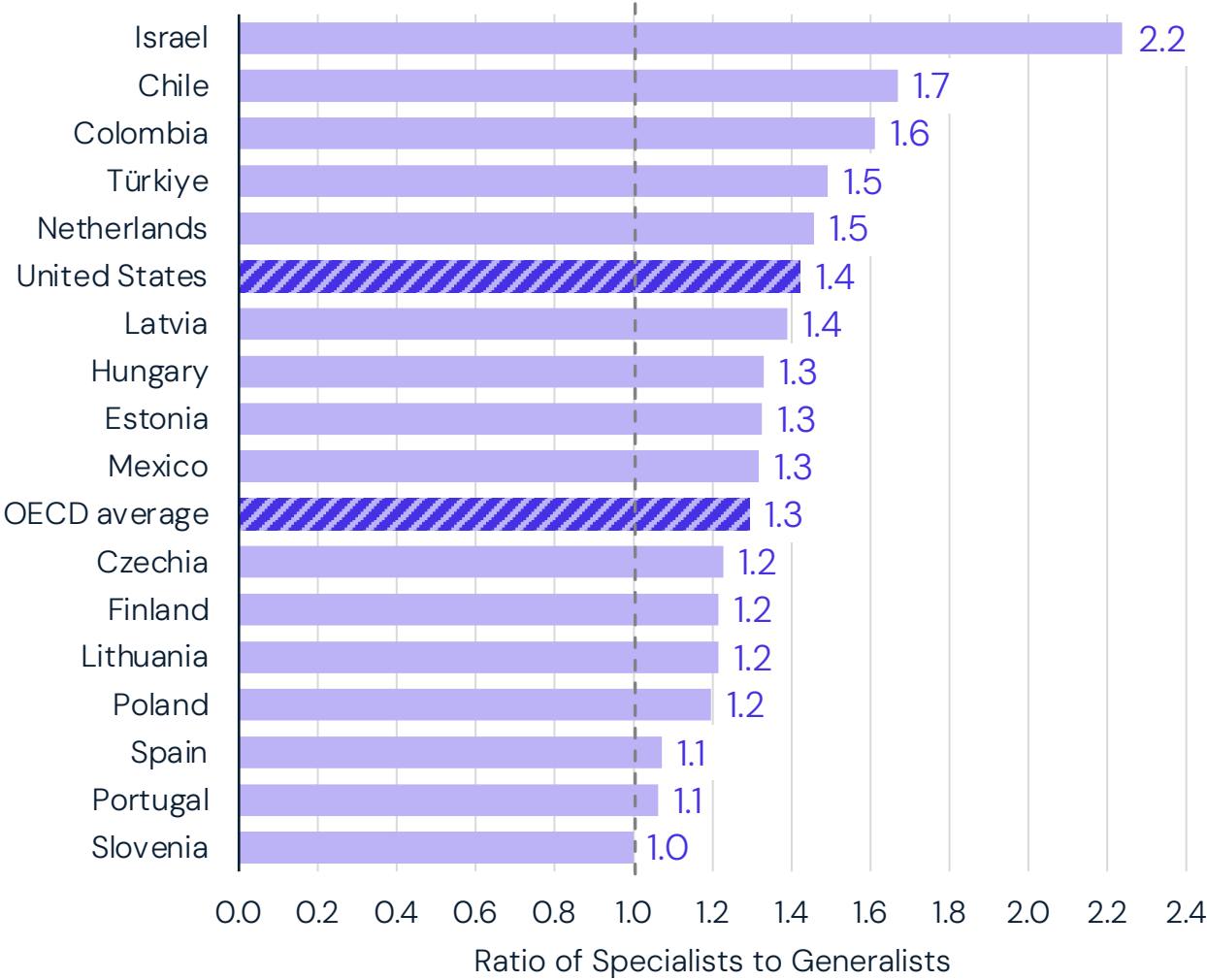
The U.S. Invests in Specialty Care at the Expense of Primary Care

There are 7.8x more specialists than generalists in the U.S., the second highest ratio in the OECD behind Greece. On average, specialist physicians in the U.S. earn 42% more than generalists, a gap that slightly exceeds the OECD average.

Ratio of Specialists to Generalists in Select OECD Countries, 2023



Ratio of Specialist Income to Generalist Income in Select OECD Countries, 2023



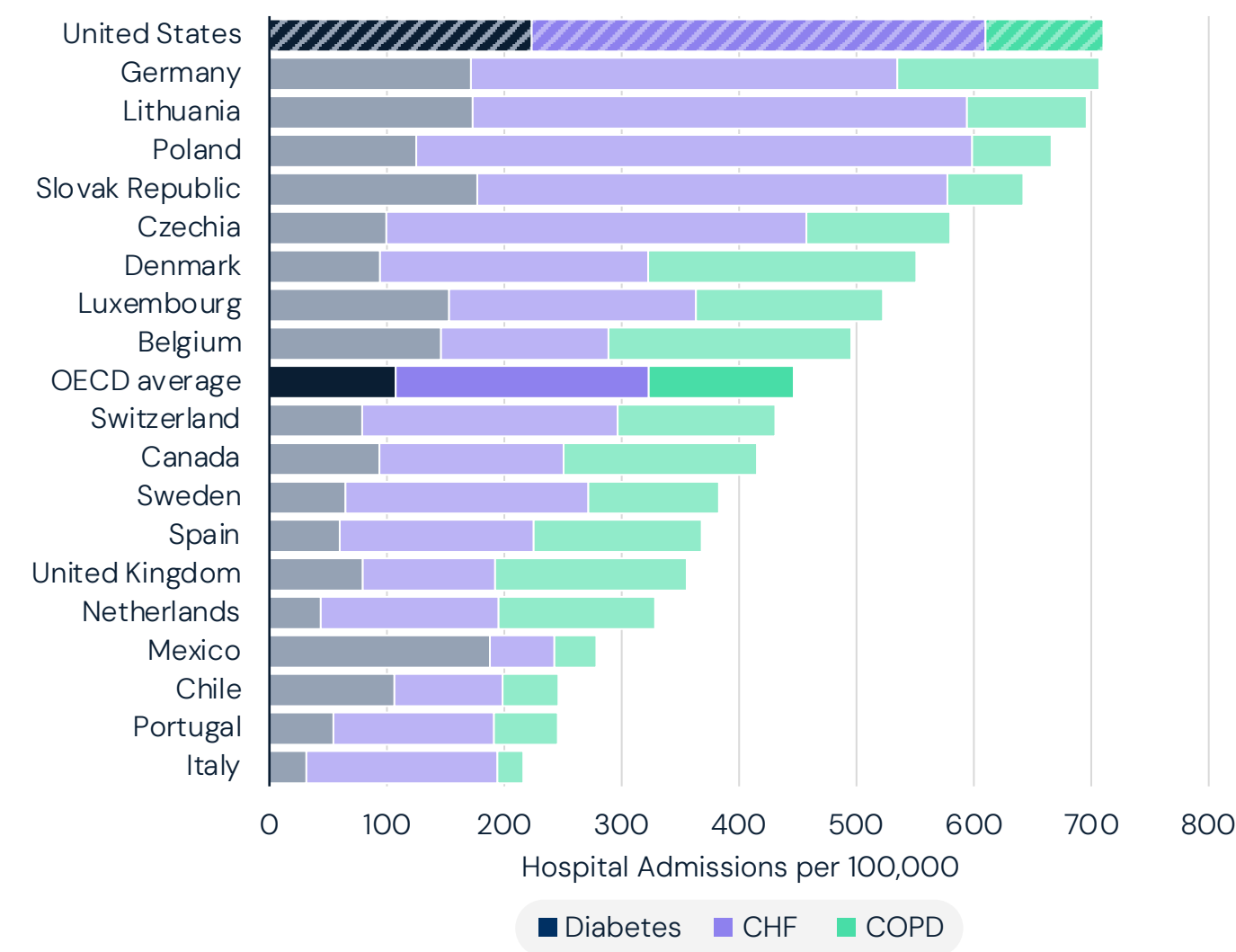
Note: OECD stands for Organisation for Economic Co-operation and Development. The OECD defines generalists as physicians “responsible for ongoing care to individuals and families.” Sweden, the U.S. and Lithuania may use slightly different definitions of generalist and specialist than the other countries. OECD averages are based on all available data, even if not all countries are shown.
Source: Organisation for Economic Co-operation and Development.

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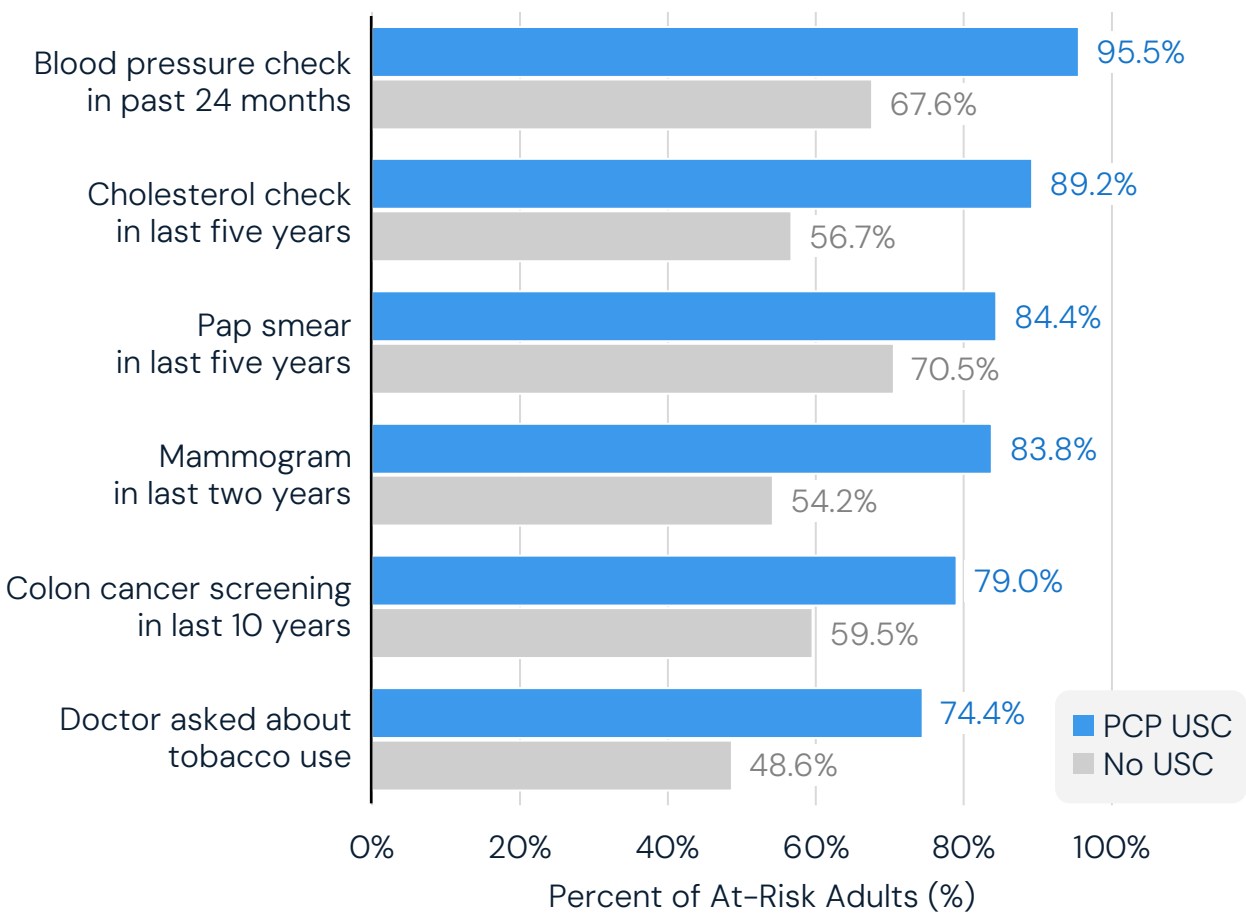
Underinvestment in Primary Care Has Avoidable Consequences

With its chronic underinvestment in primary care, the U.S. has fallen behind its peers. The U.S. had the highest rate of avoidable hospital admissions of any OECD country in 2022, at 710.3 per 100,000. Establishing care with a PCP is associated with higher screening rates, with 83.8% of patients with an established PCP receiving a mammogram in the last two years, compared to 54.2% of those without an established PCP.

Avoidable Hospital Admissions per 100,000 Population, by Cause and Country, 2022



Share of At-Risk Adults Who Reported Receiving Screening for Cardiovascular Risk Factors or Cancer, by Usual Source of Care Status, 2016–2022



Note: OECD denotes for Organisation for Economic Co-operation and Development; COPD denotes chronic obstructive pulmonary disease; CHF denotes congestive heart failure; PCP denotes primary care physician; USC denotes usual source of care. Avoidable hospital admissions are admissions to a hospital where the primary diagnosis is a chronic condition that could have been avoided through better management in primary care. Admission rates are per 100,000 Americans ages 15 and older, and they are age- and sex-standardized. Avoidable hospital admission data for Germany and the United Kingdom are from 2021. OECD averages are based on all available data.

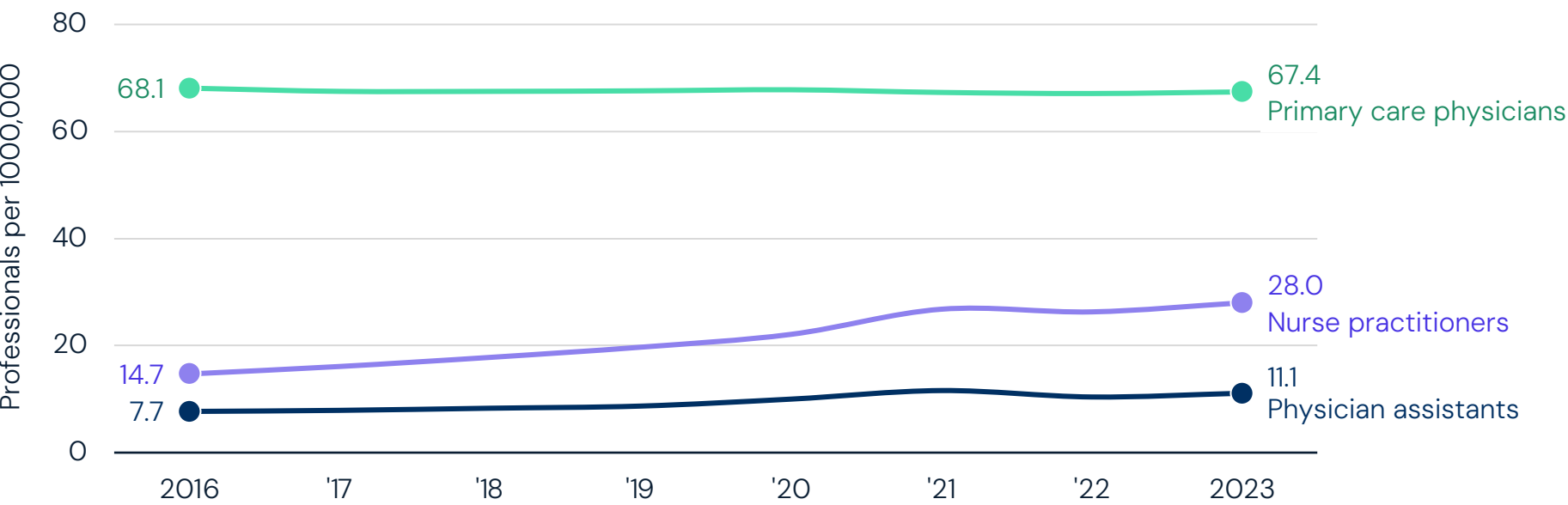
Source: Organisation for Economic Co-operation and Development; Millbank Memorial Fund.

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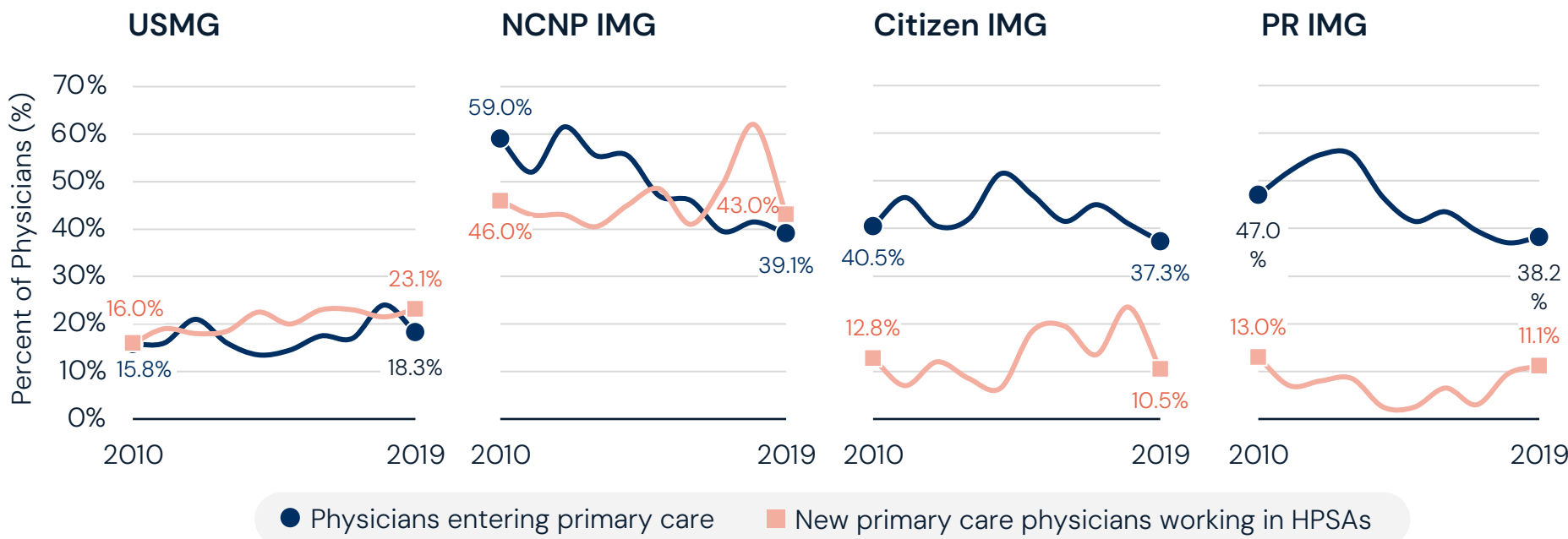
Allied Health
Providers Partially
Offset Shortages;
H-1B Visa Costs
Will Deter
International
Graduate Supply

The primary care workforce has grown very slowly over time, supplemented by growth in allied health professionals practicing primary care. In contrast, the number of primary care physicians per 100,000 has decreased slightly from 68.1 in 2016 to 67.4 in 2023. In 2024, 39.1% of noncitizen non-permanent international medicine graduates (NCNP IMGs) entered primary care, compared to 23.1% of U.S. medical graduates (USMGs). Of these new primary care NCNP IMGs, 43.0% work in HPSAs, which is 24.7 PP more than USMGs. One reason for these differences is that the Conrad 30 program requires NCNP IMGs to work in underserved areas for H-1B visa eligibility. Of hospitals participating in the H-1B visa program, 64% plan to pause, defer or limit H-1B recruitment of IMGs because of a newly instated \$100,000 H-1B fee.

Primary Care Supply Per 100,000 Population, by Provider Type, 2016–2023



Share of Physicians Entering Primary Care and New Primary Care Physicians Working in HPSAs, by Medical Graduate Status, 2010–2019



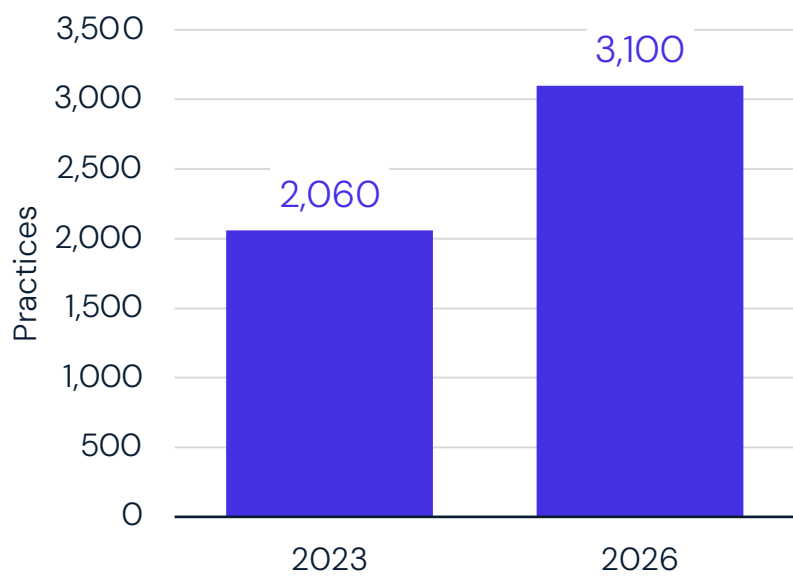
Note: NCNP IMG denotes noncitizen non-permanent resident international medical graduate; USMG denotes U.S. medical graduate; PR IMG denotes permanent resident international medical graduate; HPSA denotes Health Professional Shortage Area. Allied health professionals include nurse practitioners and physician assistants.
Source: Millbank Memorial Fund; American Hospital Association; Ramesh et al, Effects of Citizenship Status on International Medical Graduate Specialty Choice and Practice Location, *Journal of General Internal Medicine*, 2025.

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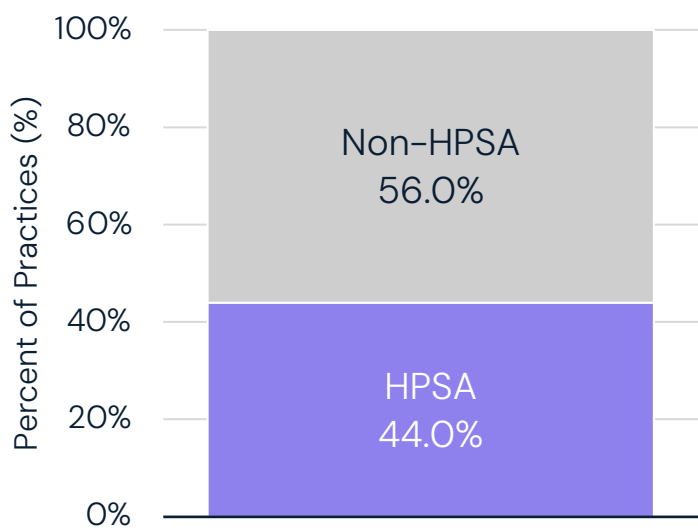
Direct Primary Care Is a Niche Model That Signals Failings of the Current System

The number of active DPC practices and patients pursuing DPC have increased in recent years, reaching approximately 0.5% of Americans in 2025. As of 2023, 44% of DPC practices were located in HPSAs. Notably, 60% of DPC membership costs were covered by employers in 2025, an increase of 42 PP from 2017. Will DPC continue to complement employer-sponsored insurance or become a substitute, with patients dropping insurance coverage to enroll in DPC and assume the risk of catastrophic care?

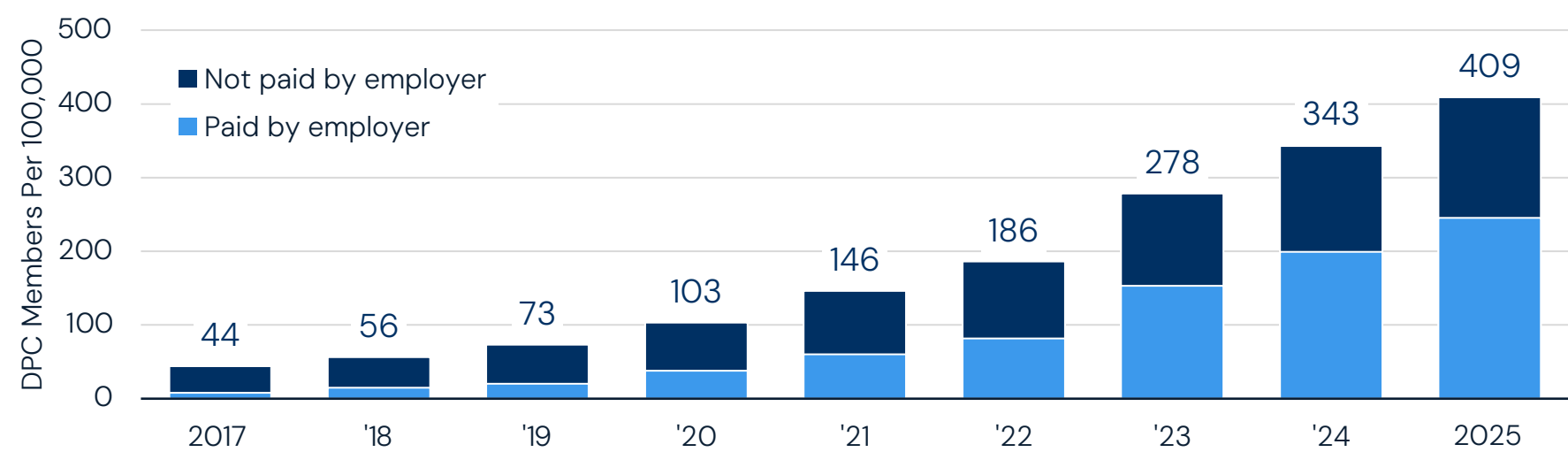
Number of Active U.S. DPC Practices, 2023 and 2026



Share of DPC Practices Located in HPSAs, 2023



Number of DPC Members Per 100,000 Population, by Employer Coverage, 2017–2025



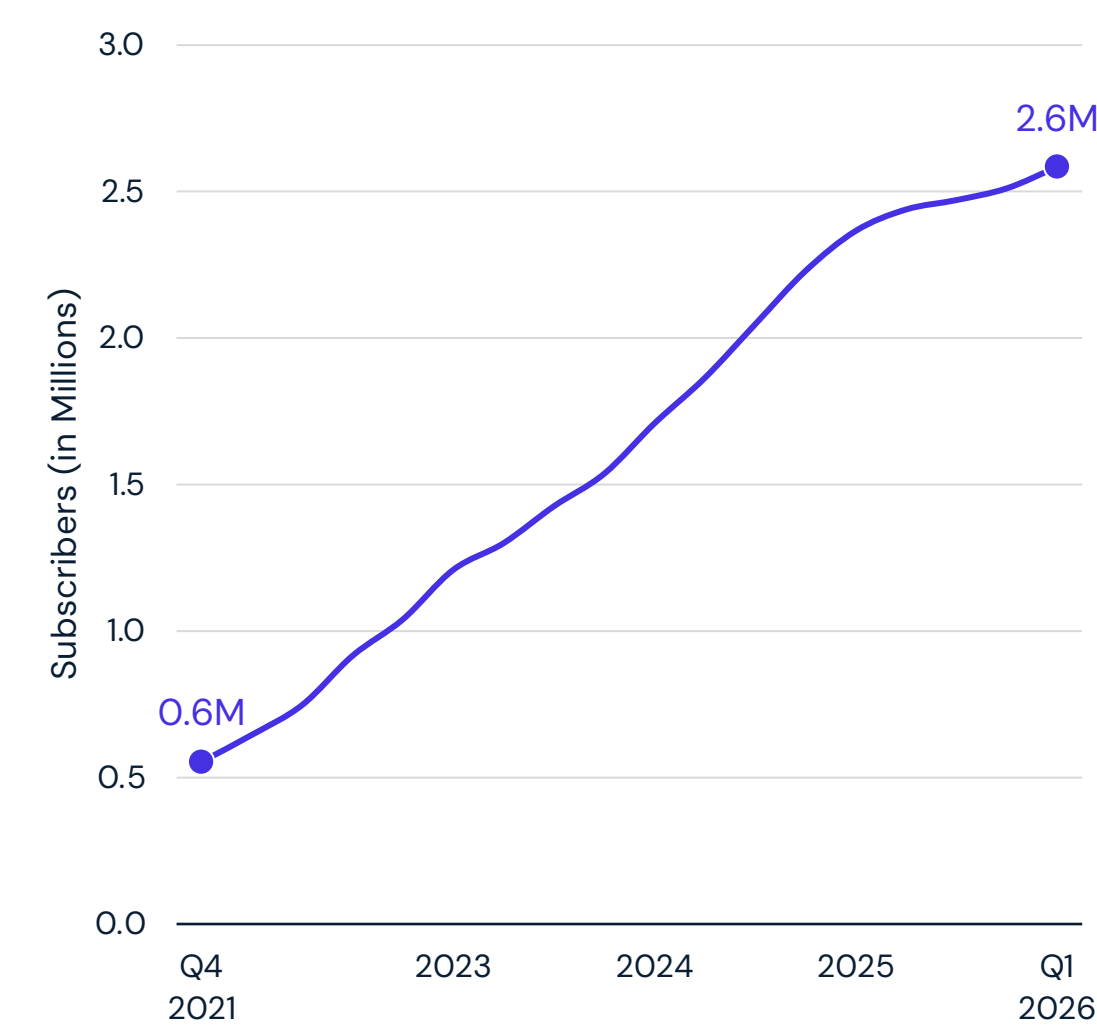
Note: DPC denotes direct primary care; PP denotes percentage point; HPSA denotes Health Professional Shortage Area. DPC members are those on Hint Health's database with an active membership at some point during the census year.
Source: Hint Health, Trends in DPC, 2026; Goldstein et al., Are Direct Primary Care Practices Located in Health Professional Shortage Areas?, *Annals of Family Medicine*, 2024.

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Dissatisfaction Is Fueling a Subscription Care Boom

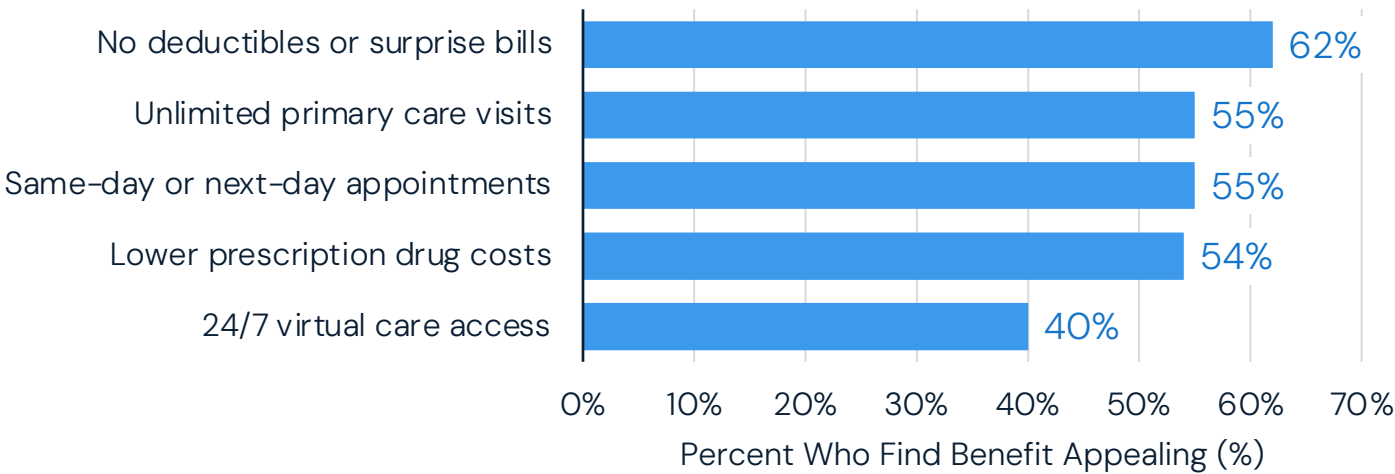
Interest in subscription-based healthcare has grown in recent years, driven by perceived convenience and price transparency. For example, the number of Hims & Hers subscribers, a company that focuses on DTC wellness offerings, has increased 366.4% since 2021. While 62% of consumers reported the benefit of no surprise bills, 56% were hesitant regarding price, and 37% cite the continued necessity of traditional insurance in addition to subscriptions.

Hims & Hers Subscribers, Q4 2021–Q1 2026

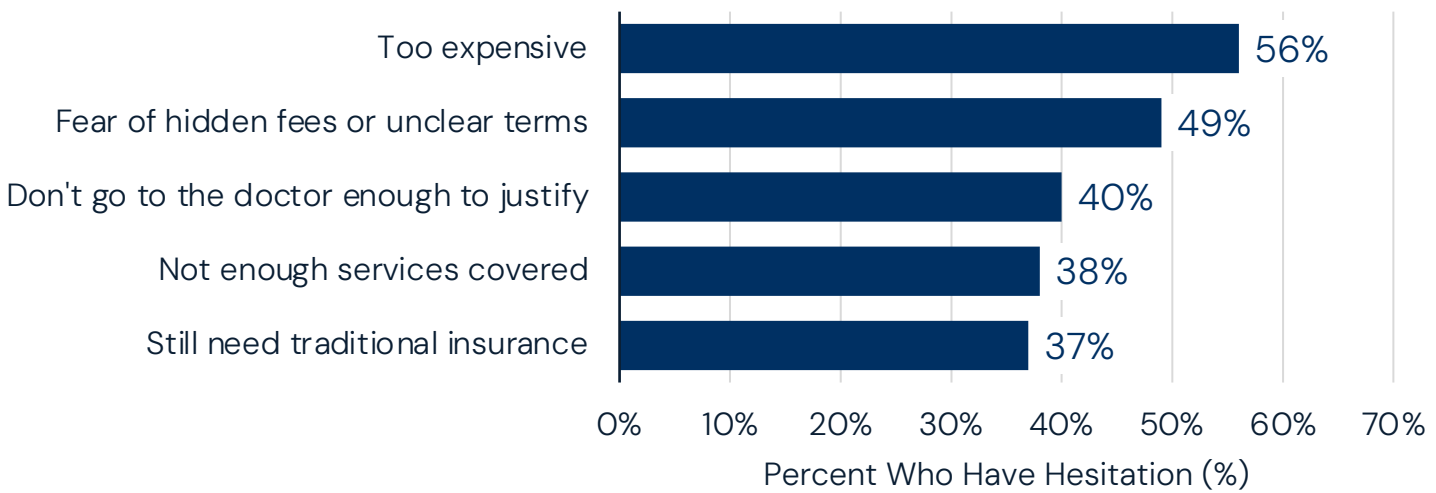


Note: DTC denotes direct to consumer.
Source: Company press releases; Tebra.

Top Perceived Benefits of Healthcare Subscriptions, 2025



Top Hesitations About Healthcare Subscriptions, 2025

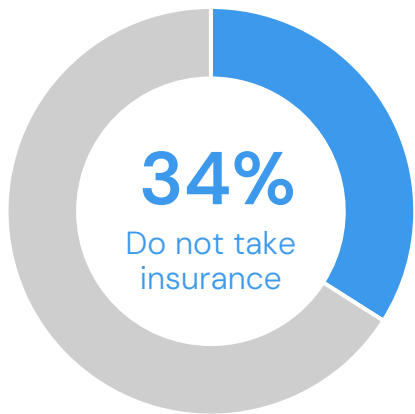


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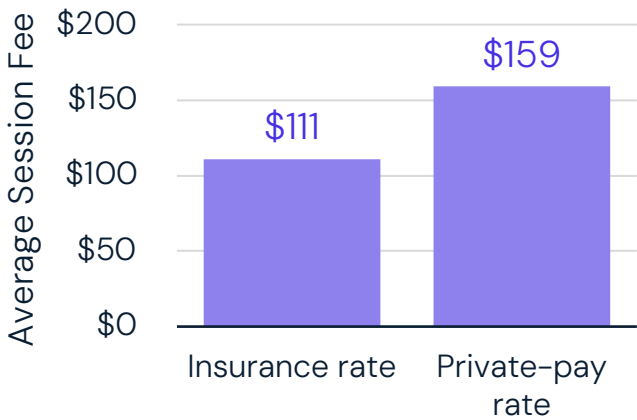
Behavioral Health Point Solutions Do Not Resolve Mental Health Access Issues

DTC online therapy care models vary significantly, with some limited to talk therapy and others offering psychiatric care and medication prescribing. Most online platforms accept insurance, but 34% of psychologists do not, making it harder for patients to find in-network care. Patients are 10.6x more likely to see a psychologist out-of-network compared to medical or surgical physicians and 8.9x more likely to see an out-of-network psychiatrist. Private-pay rates for individual therapy sessions average \$159 per session, compared to average insurance reimbursement rates of \$111.

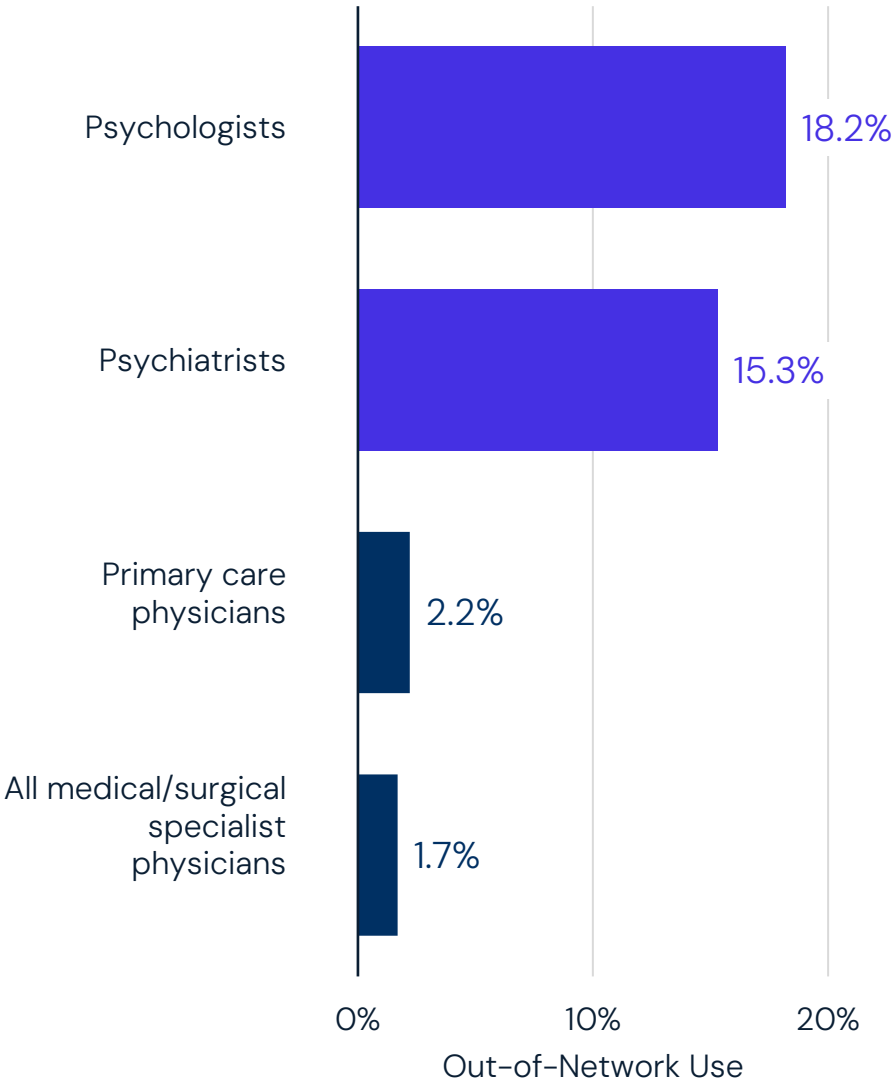
Psychologist Participation in Insurance, 2024



Average Session Fee, by Payment Type, 2024



Share of Out-of-Network Use, by Provider Type, 2021



Select Direct to Consumer Behavioral Health Platforms





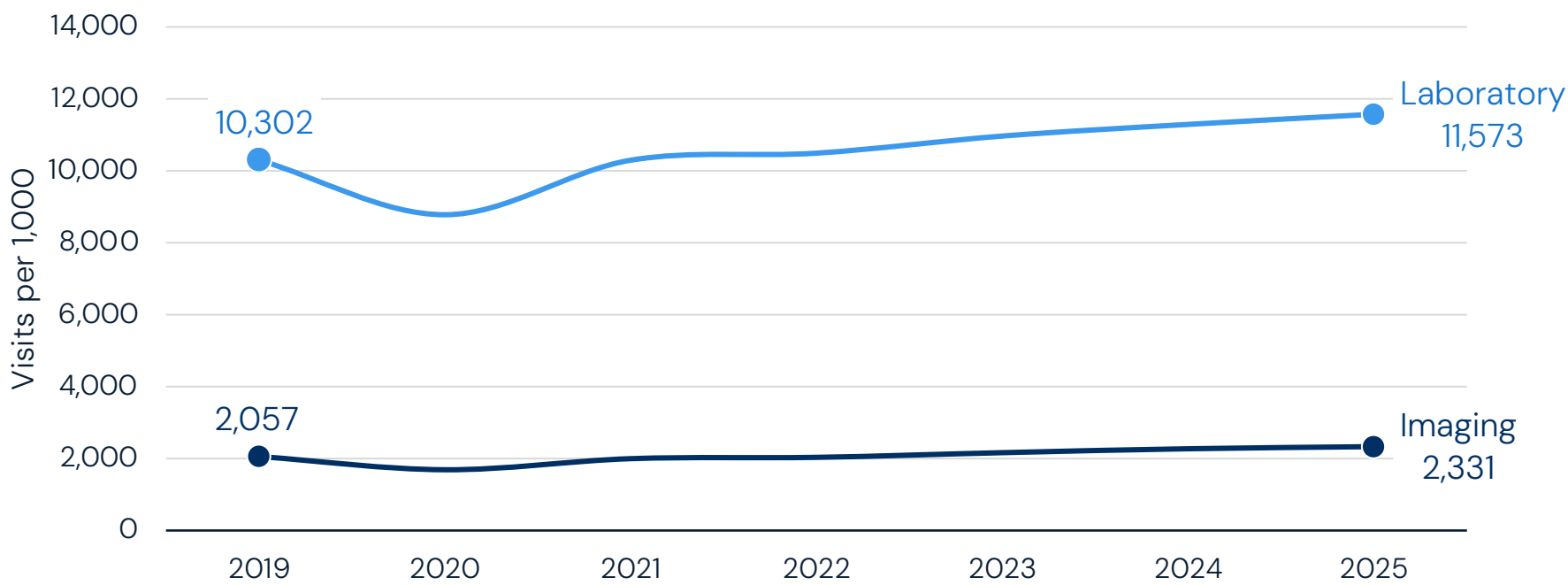
Note: DTC denotes direct to consumer. In March 2026, Universal Health Services announced its acquisition of Talkspace.
Source: Publicly available company information; American Psychological Association; RTI International; Heard, The 2025 Financial State of Private Practice Report, 2025.

MARKET FAILURE

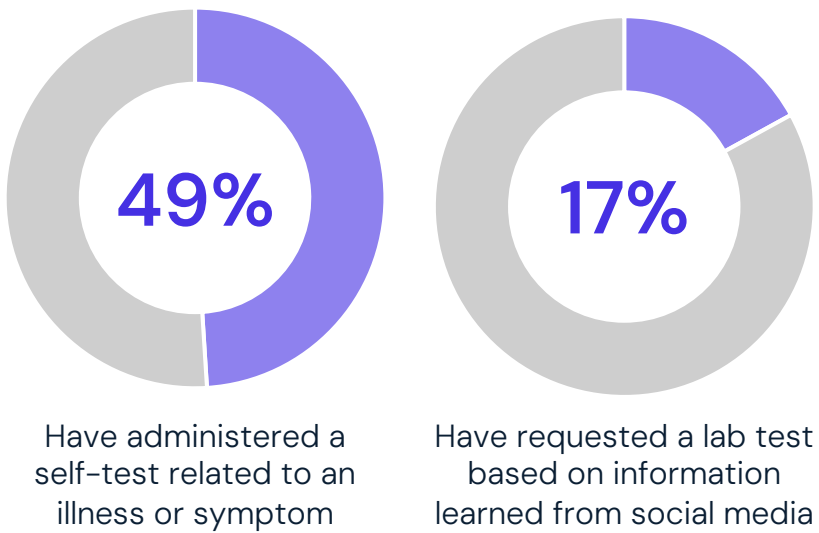
Consumer Demand for “Health” Drives Patients Toward Non-Traditional Suppliers

Visits with laboratory procedures increased from 10,302 to 11,573 per 1,000 population from 2019 to 2025, and visits with imaging increased from 2,057 to 2,331. In 2026, 49% of patients report having administered a self-test for an illness or symptom, and 17% report having requested a lab test based on information learned from social media. Given this interest, non-traditional suppliers including telehealth platforms and retail laboratories are expanding DTC testing.

Rate of Visits With Laboratory or Imaging per 1,000 Population, 2019–2025



Share of Patients Reporting Lab Testing, 2026



Telehealth company launches direct-to-consumer imaging order service

Hims & Hers Introduces Labs, a Holistic, In-Depth Testing Experience That Puts Customers in Control of Their Health and Wellness Journeys

Labcorp’s consumer genetic testing reflects rising demand for self-ordered care

The Rise of the Self-Serve Blood Test

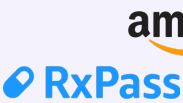
Note: DTC denotes direct to consumer.
Source: Trilliant Health national all-payer claims database; publicly available news releases; Siemens Healthineers, Insights and Trends from a National Survey: Patient Testing in America, 2026.

MARKET FAILURE

DTC Prescribers Increase Access and Fragmentation

DTC prescribing-focused new entrants offer expanded choices for consumers but pose other care coordination challenges. These stakeholders influence the prescription drug patient journey, potentially disrupting traditional patient-provider relationships and increasing care fragmentation and duplication.

DTC Prescribing-Focused New Entrants

											
Price Point	\$5/month Requires an Amazon Prime membership	\$29/direct message care \$49/video care visit Formerly Amazon Clinic	Starts at \$74/month + cost of prescription	\$59/consultation \$69/month for medication management	\$10-20/month for membership \$19-\$49/consultation + prescription cost	\$60/month for medication management \$365/month for medication management and therapy	\$69-\$1,799/month	\$35/month	\$199-\$299 for consultation + \$149 for subsequent visit or \$299 per month + prescription cost	\$89/visit	\$33-73/visit
Included Services	50+ low-cost generic drugs	Sexual health, dermatological treatments, other low-acuity services	GLP-1s	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	GLP-1s and other weight management, dermatology, antibiotics, mental health	Antibiotics, women's health, allergies, GLP-1s, heart health, sexual health, dermatology
Mail-Order Required?	Yes	No	Yes	Yes	No	Yes	Yes	No	Yes	No	No
Prescribing or Dispensing?	Dispensing	Prescribing	In-house prescribing and dispensing	In-house prescribing and dispensing	Prescribing	In-house prescribing and dispensing	In-house prescribing and dispensing	Dispensing	In-house prescribing and dispensing	Dispensing	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	No	No

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

04

Value Is Not Incentivized;
Therefore, It Is Not
Measured or Managed

INCONSISTENT VALUE

The population is growing sicker, despite record levels of health spending. That disconnect exists because the health economy has never clearly defined, and therefore has never properly incentivized, the concept of **value for money**.

On average, there is **no observable correlation between cost and quality** for most common hospital procedures – higher negotiated rates do not predict better outcomes. This is both a quality problem and a pricing problem. More than 25 years after To Err is Human¹, just 27% of active CMS quality measures are tied to outcomes. At the same time, price is determined by geographic accident, negotiating leverage, broker relationships and institutional inertia rather than clinical performance. Every stakeholder that benefits from the current pricing environment – insurers who earn higher premium revenue as costs rise, providers whose rates are uncorrelated with quality, intermediaries who profit from complexity – has a **structural incentive to resist the value framework** that the system nominally claims to pursue. Price transparency has made value for money calculable for the first time, but whether any stakeholder with sufficient scale will choose to demand or opt to deliver it is an open question.

Across every domain, the system generates enormous quantities of activity without a coherent framework for determining whether that activity produces proportionate – or any measurable – health benefit. Low-value care persists not because clinicians are indifferent but because the system does not penalize it and patients ask for “more.” High-cost pharmaceuticals displace surgical procedures without comparative cost-effectiveness data or, in some cases, any efficacy data at all. Polypharmacy accumulates without deprescribing protocols. Coding intensity rises without audit mechanisms to confirm equivalent clinical intensity. The absence of value measurement is not an oversight, but rather a structural feature of a fee-for-service system that **monetizes volume rather than outcomes**.

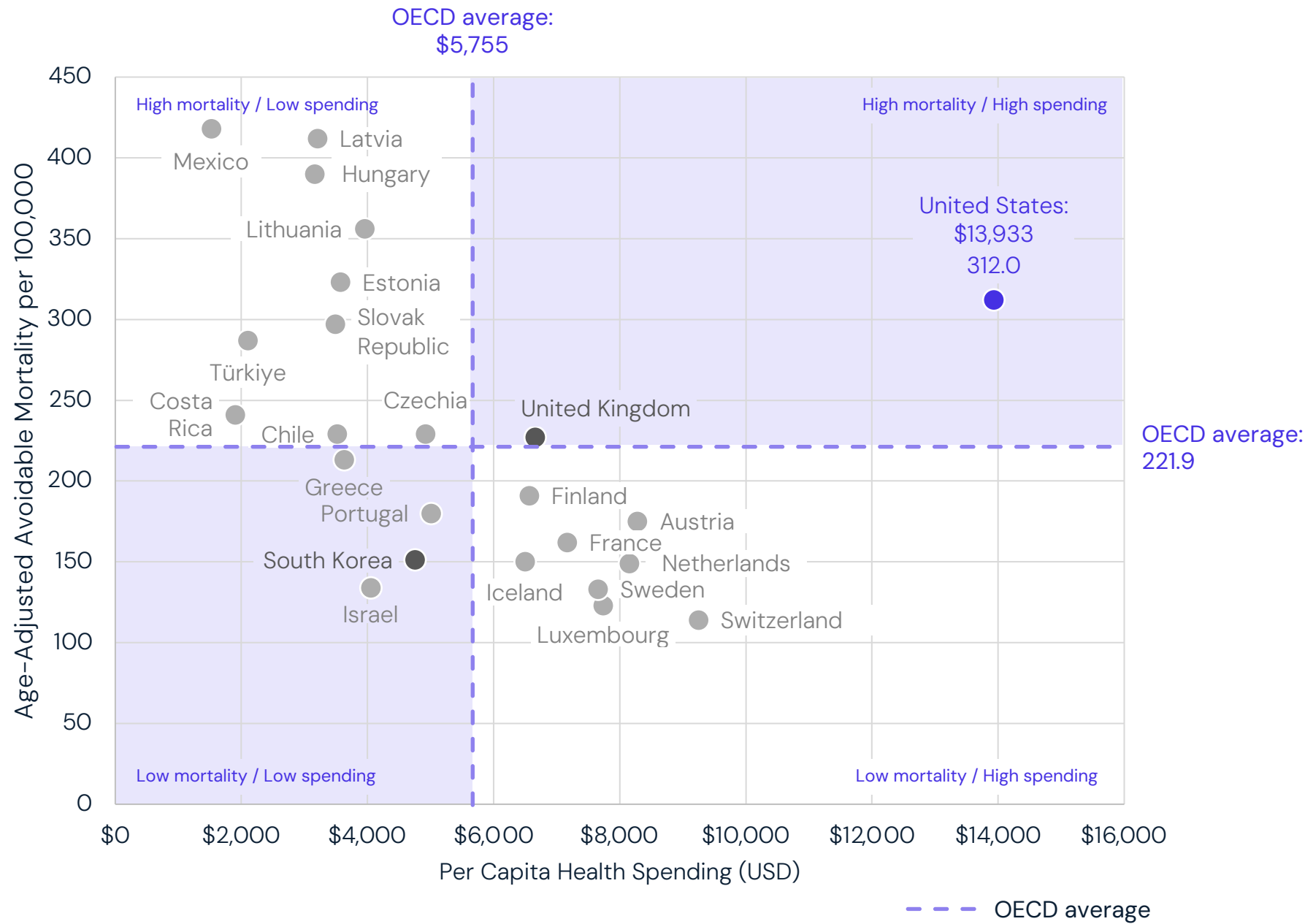
¹To Err Is Human: Building a Safer Health System is a 1999 report published by the Institute of Medicine (now the National Academy of Medicine) that brought national attention to the epidemic of preventable medical errors in American hospitals.

INCONSISTENT VALUE

Despite High Spending, the U.S. Has Above-Average Avoidable Mortality

The U.S. spent approximately \$13,933 per capita on healthcare in 2023, the most of any OECD country, yet its avoidable mortality rate of 312.0 deaths per 100,000 exceeded the OECD average (221.9 per 100,000). The U.K. serves as a useful counterexample, spending less than half as much per capita (\$6,665), while achieving a lower avoidable mortality rate (227.0 per 100,000). Likewise, South Korea spends one-third (\$4,757) as much on healthcare with 2x lower avoidable mortality (151.0 per 100,000) compared to the U.S.

Per Capita Health Spending vs. Age-Adjusted Avoidable Mortality per 100,000, Select OECD Countries, 2023



Note: OECD denotes Organisation for Economic Co-operation and Development. Avoidable mortality is deaths in the population younger than 75 years that could have been prevented or avoided through timely and effective healthcare and prevention. Data for the United States, Ireland, France, Canada, Denmark, Iceland, Finland, Portugal, Italy, South Korea, Israel, Poland, Estonia, Chile, Greece, Costa Rica and Mexico are from 2022. OECD averages include data from all OECD countries.

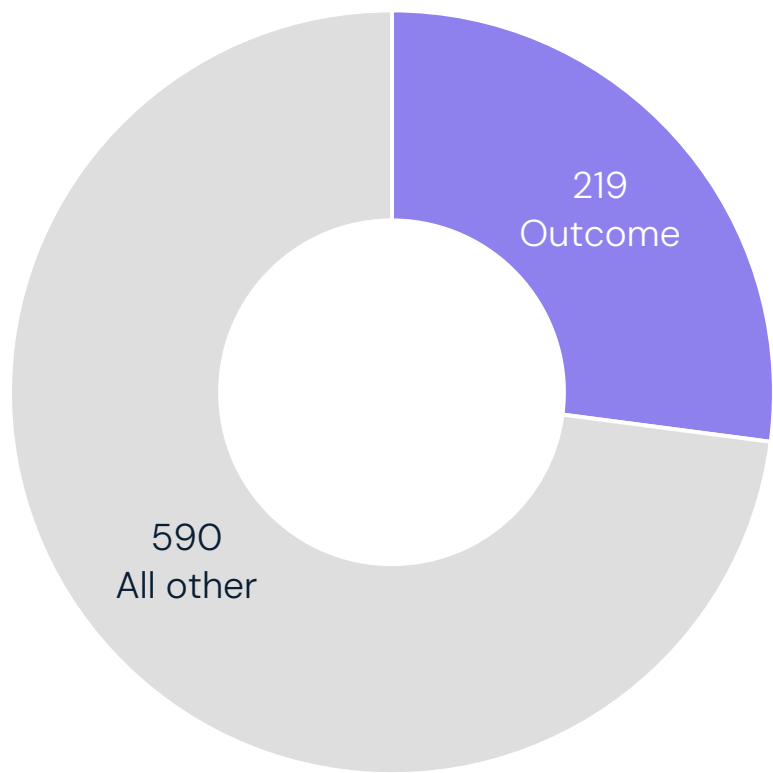
Source: Organisation for Economic Co-operation and Development.

INCONSISTENT VALUE

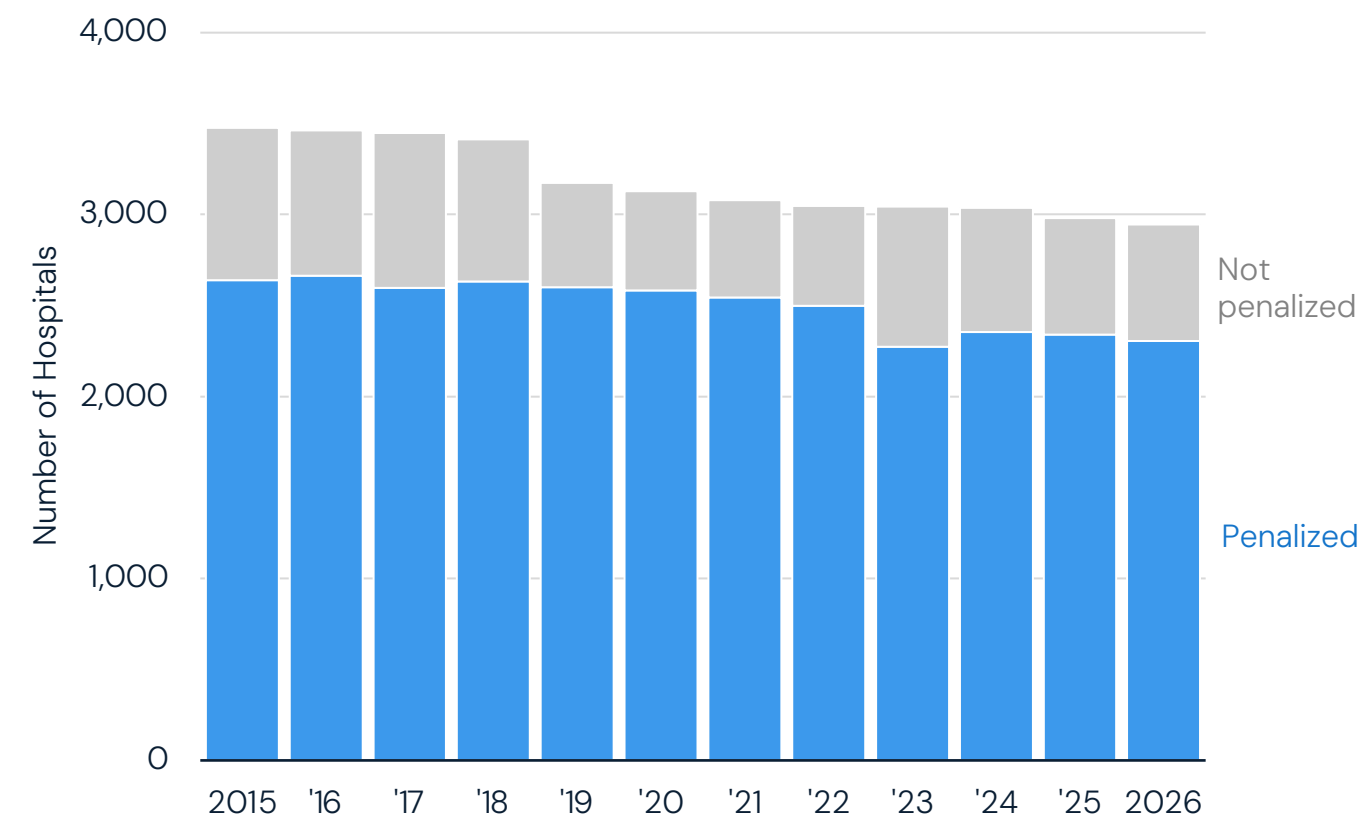
Quality Reporting Prioritizes Process Over Outcomes

CMS uses over 800 active quality measures, with just 27% directly tied to outcomes. The majority of measures address structure, process or patient experience (e.g., HCAHPS). The share of hospitals penalized for high readmissions has remained relatively unchanged for a decade, likely reflecting that the revenue from poor quality exceeds the penalties for rendering it.

Active CMS Quality Measures, by Type, 2026



Hospitals Penalized by CMS for High Hospitals Readmissions, FY 2015–2026



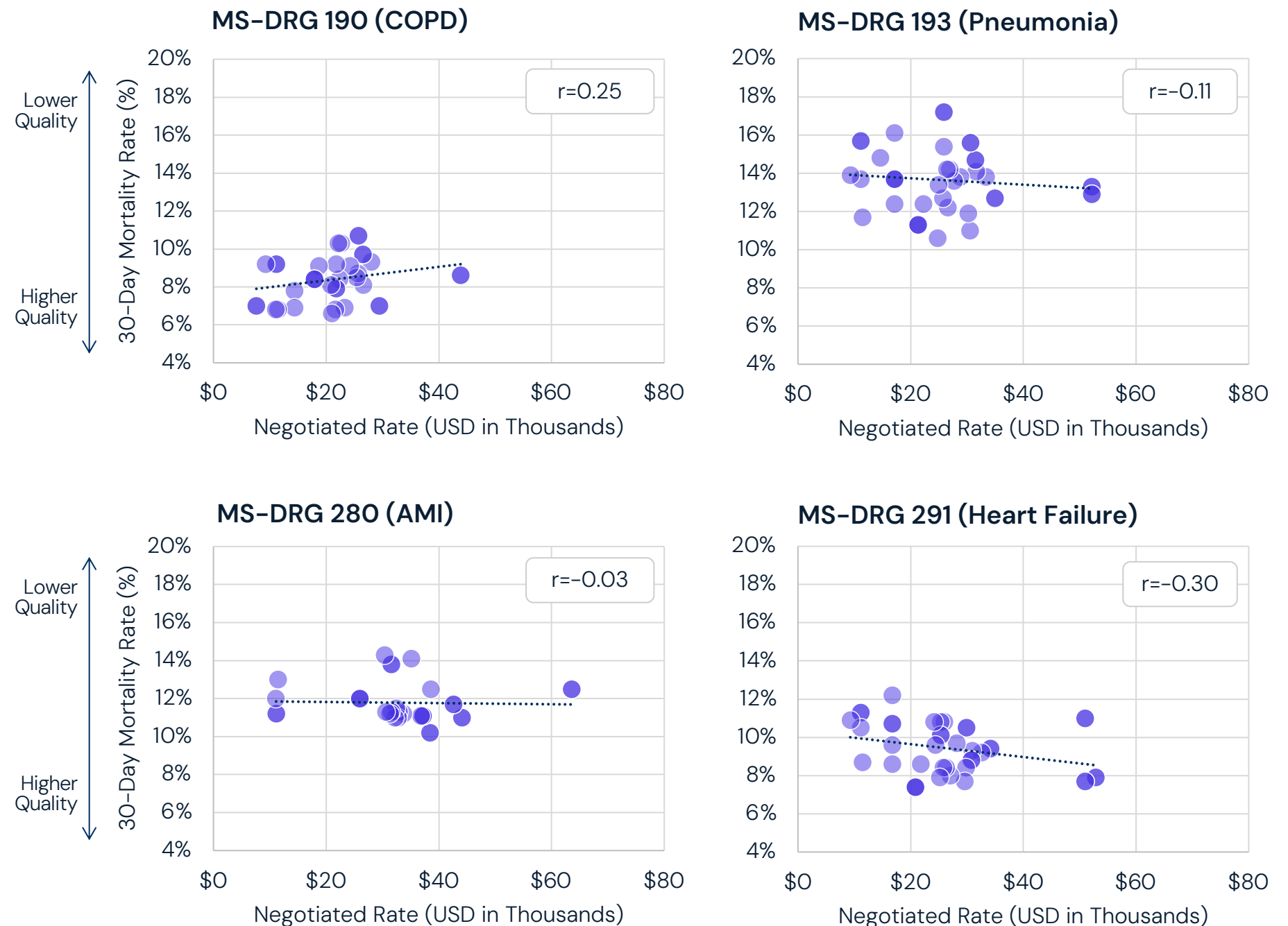
Note: FY denotes fiscal year; HCAHPS denotes Hospital Consumer Assessment of Healthcare Providers and Systems; CMS denotes Centers for Medicare & Medicaid Services. "All other" quality measures include structure, process, patient experience and efficiency.
Source: Centers for Medicare & Medicaid Services QualityNet and Hospital Readmissions Reduction Program.

INCONSISTENT VALUE

Price and Quality for Common Services Are Not Correlated

While the median negotiated rate for MS-DRG 280 (heart attack) in Los Angeles is \$32,858, the hospital receiving the highest rate (\$63,622) also has the fifth highest mortality rate of the hospitals analyzed. For these four common medical MS-DRGs, the correlation coefficient between negotiated rate and mortality rate ranges from $r=-0.30$ (heart failure) to $r=0.25$ (COPD). If higher price and better quality were perfectly correlated, the correlation coefficient would be $r=-1$.

Commercial Negotiated Rate vs. 30-Day Condition-Specific Mortality Rate, Short-Term Acute Care Hospitals in Los Angeles-Long Beach-Anaheim CA, 2026



Note: AMI denotes acute myocardial infarction; COPD denotes chronic obstructive pulmonary disease. Analysis was conducted using negotiated rates for UnitedHealthcare. Correlation is a measure of the relationship, or lack thereof, between two things. This analysis used the Pearson correlation coefficient (r) to examine the strength of the linear relationship between measures of hospital quality and hospital negotiated rate.

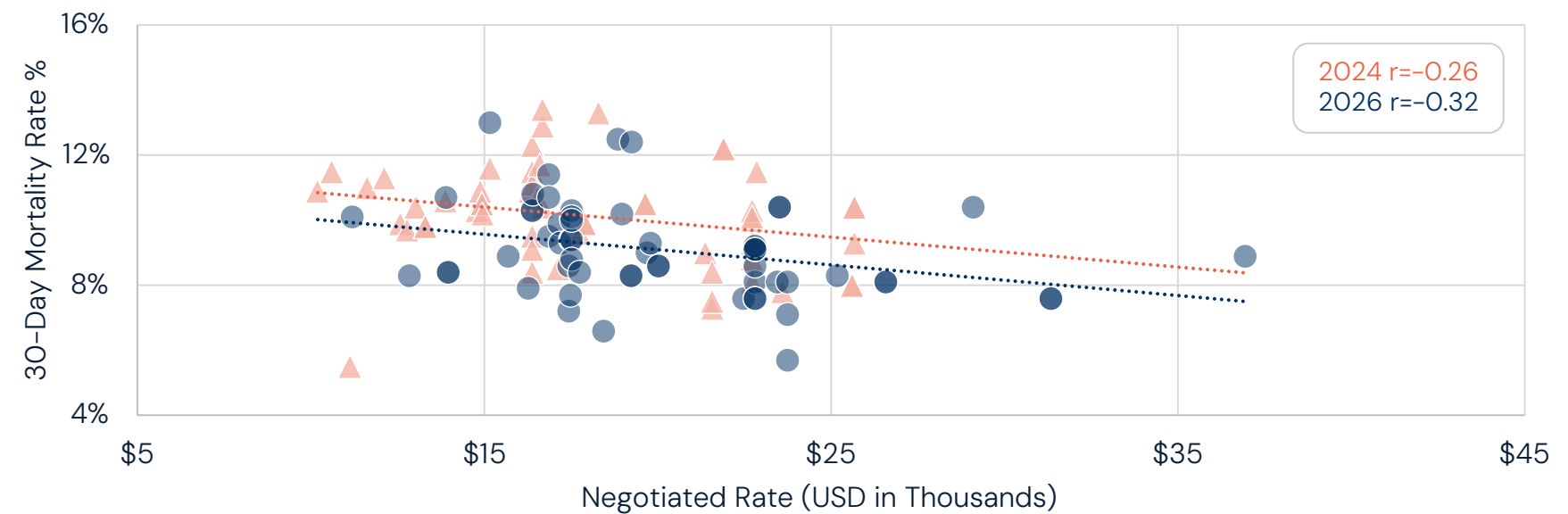
Source: Trilliant Health national all-payer claims database, Provider Directory and health plan price transparency dataset; Centers for Medicare & Medicaid Services Hospital Readmissions Reduction Program.

INCONSISTENT VALUE

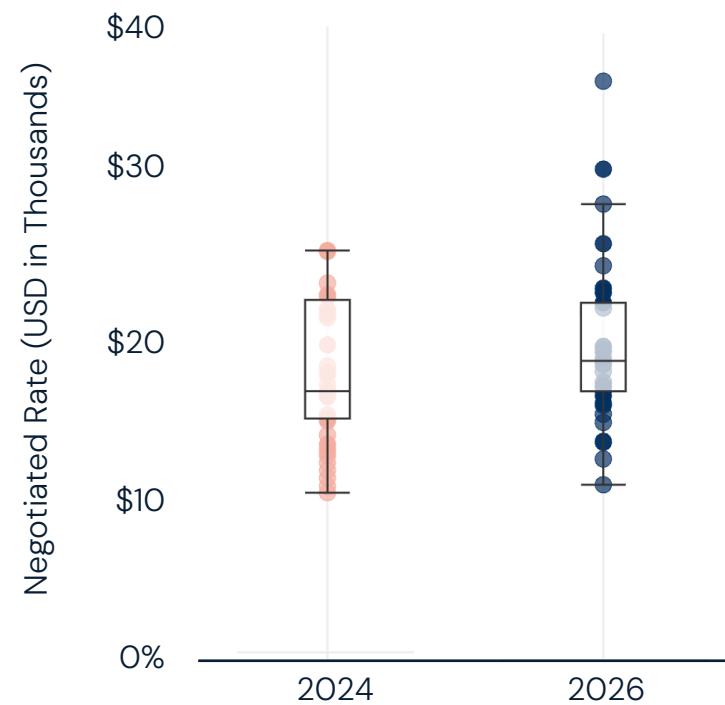
Price Transparency Data Enables But Does Not Ensure Value for Money

While negotiated rates and quality are generally not correlated, the availability of health plan price transparency data has the potential to motivate value-based competition. For example, between 2024 and 2026, the correlation between 30-day heart failure mortality and negotiated rate improved in the Chicago CBSA, decreasing from $r=-0.26$ to $r=-0.32$ (i.e., lower rate, higher quality). While the median mortality rate improved from 10.3% in 2024 to 8.9% in 2026, the median negotiated rate increased from \$16,689 to \$19,105. The range of negotiated rates widened from 2.5x to 3.3x, while the mortality rate range narrowed slightly from 2.4x to 2.3x, indicating that prices diverged even as quality converged.

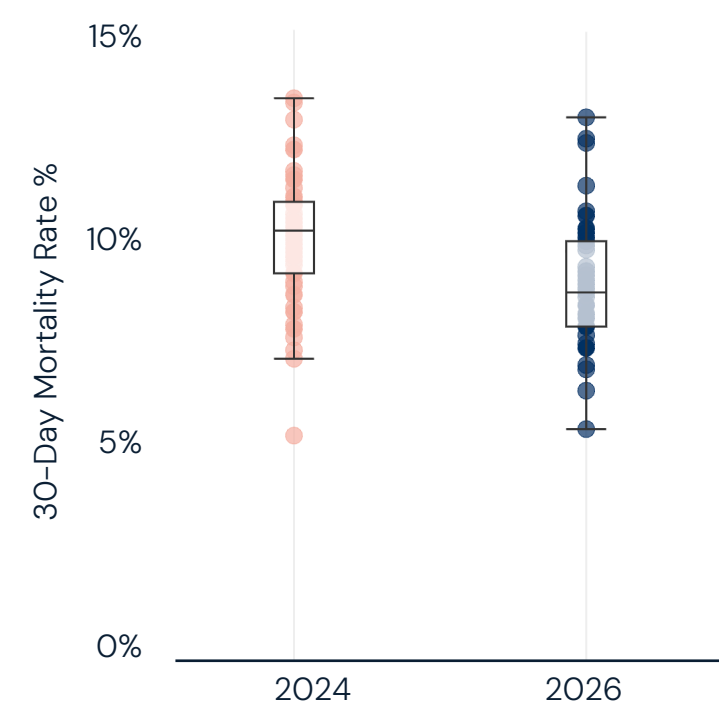
Commercial Negotiated Rate vs. 30-Day Mortality Rate, MS-DRG 291 (Heart Failure), Short-Term Acute Care Hospitals in Chicago-Naperville-Elgin IL-IN, 2024 vs. 2026



Negotiated Rate



30-Day Mortality



Note: CBSA denotes core-based statistical area. Analysis was conducted using negotiated rates for UnitedHealthcare. Correlation is a measure of the relationship, or lack thereof, between two things. This analysis used the Pearson correlation coefficient (r) to examine the strength of the linear relationship between measures of hospital quality and hospital negotiated rate.

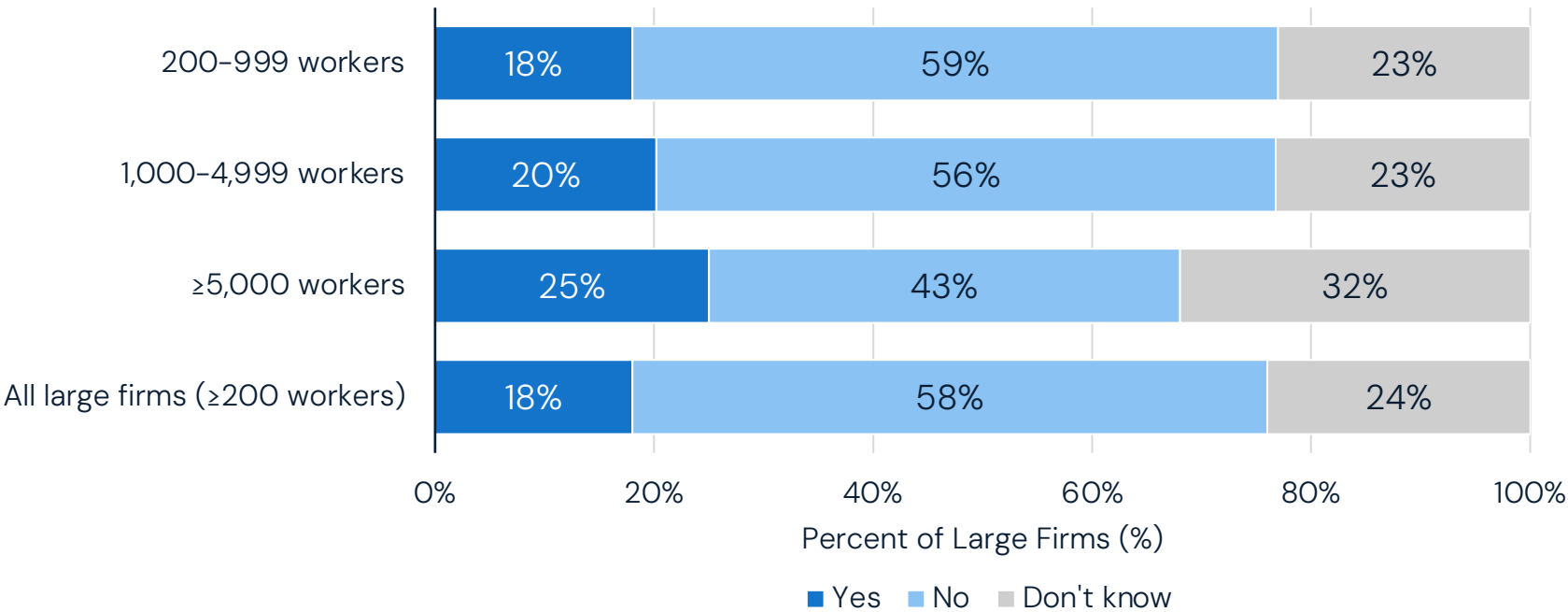
Source: Trilliant Health national all-payer claims database, Provider Directory and health plan price transparency dataset; Centers for Medicare & Medicaid Services Hospital Readmissions Reduction Program.

INCONSISTENT VALUE

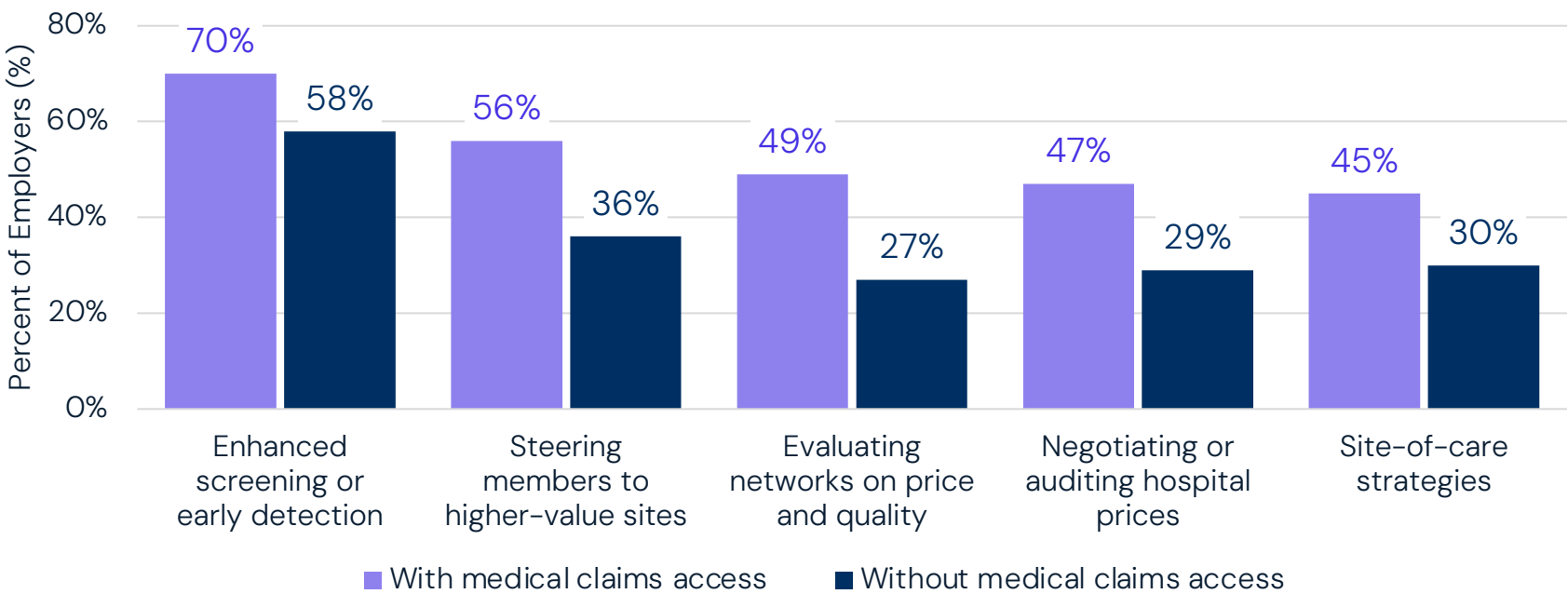
Data Availability Has Not Translated to Data-Driven Benefit Design

Price transparency gives employers, the largest single purchasers of commercial insurance, the ability to design high-value health benefits for employees. However, as of 2025, only 18% of large firms have conducted or received an analysis using price transparency data, with utilization increasing with employer size. Employer access to medical claims data can also help to improve health benefit design. For example, 49% of employers that have access to medical claims data are evaluating networks on price and quality, while only 27% of employers without access are pursuing this strategy.

Share of Large Firms That Have Conducted or Received an Analysis Using Price Transparency Data, by Firm Size, 2025



Employers Using Select Data-Driven Strategies, by Medical Claims Access, 2026



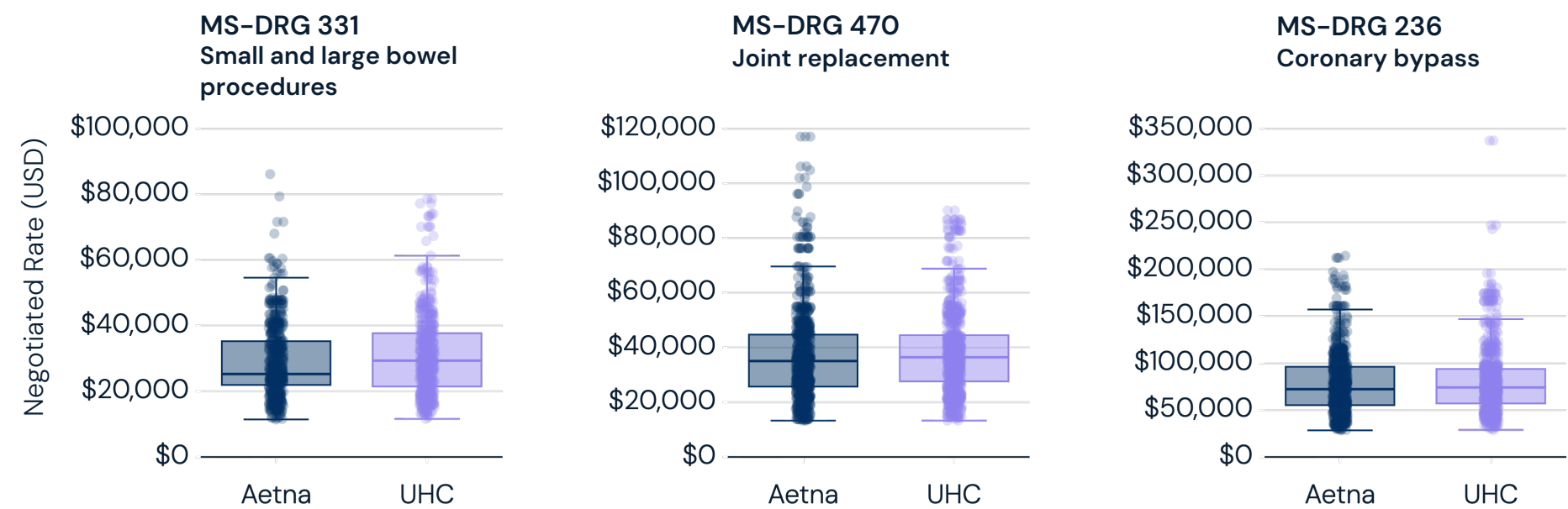
Note: Large firms include 200 or more workers. An analysis may include details on the prices that hospitals and providers charge to various plans and payers. Federal policy requires that health plans make available the price of services at different providers as well as cost-sharing estimates for enrollees, in real-time.
Source: KFF, Employer Health Benefits Survey, 2025; National Health Alliance, Pulse of the Purchaser, 2026.

INCONSISTENT VALUE

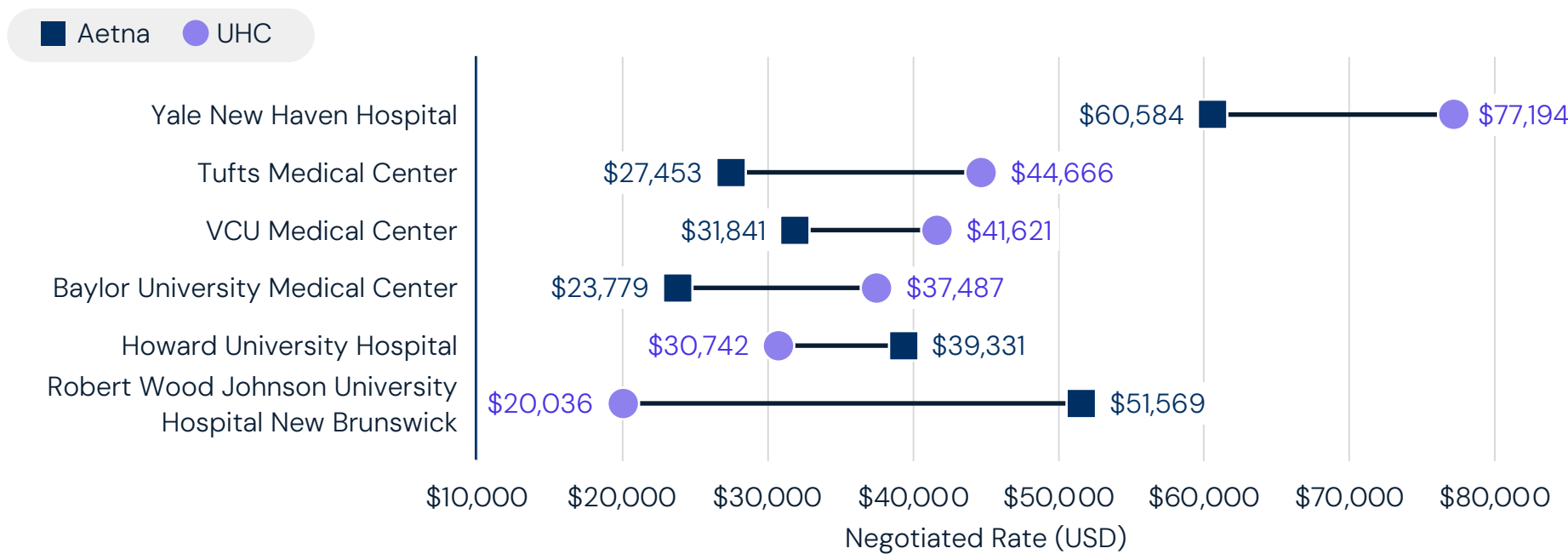
Negotiated Rates Vary Not Only Nationally but Within the Same Facility

Commercial negotiated rates vary by both geography and payer. Nationally, Aetna negotiated rates for MS-DRG 470 range from \$13,290 to \$117,081, a factor of 8.8x. Nationally, the median UHC commercial negotiated rate for MS-DRG 331 is \$4,064 higher than the median Aetna rate, \$29,336 and \$25,272, respectively. Even within a single hospital, negotiated rates can vary substantially by payer. At Tufts Medical Center, the UHC negotiated rate for MS-DRG 331 is 2.6x higher than the Aetna negotiated rate. At Robert Wood Johnson University Hospital New Brunswick, the Aetna rate is 2.6x higher than the UHC rate.

Commercial Negotiated Rates for Select MS-DRGs at Short-Term Acute Care Hospitals, by Payer, 2026



Commercial Negotiated Rates for MS-DRG 331 at Select Short-Term Acute Care Hospitals, by Payer, 2026



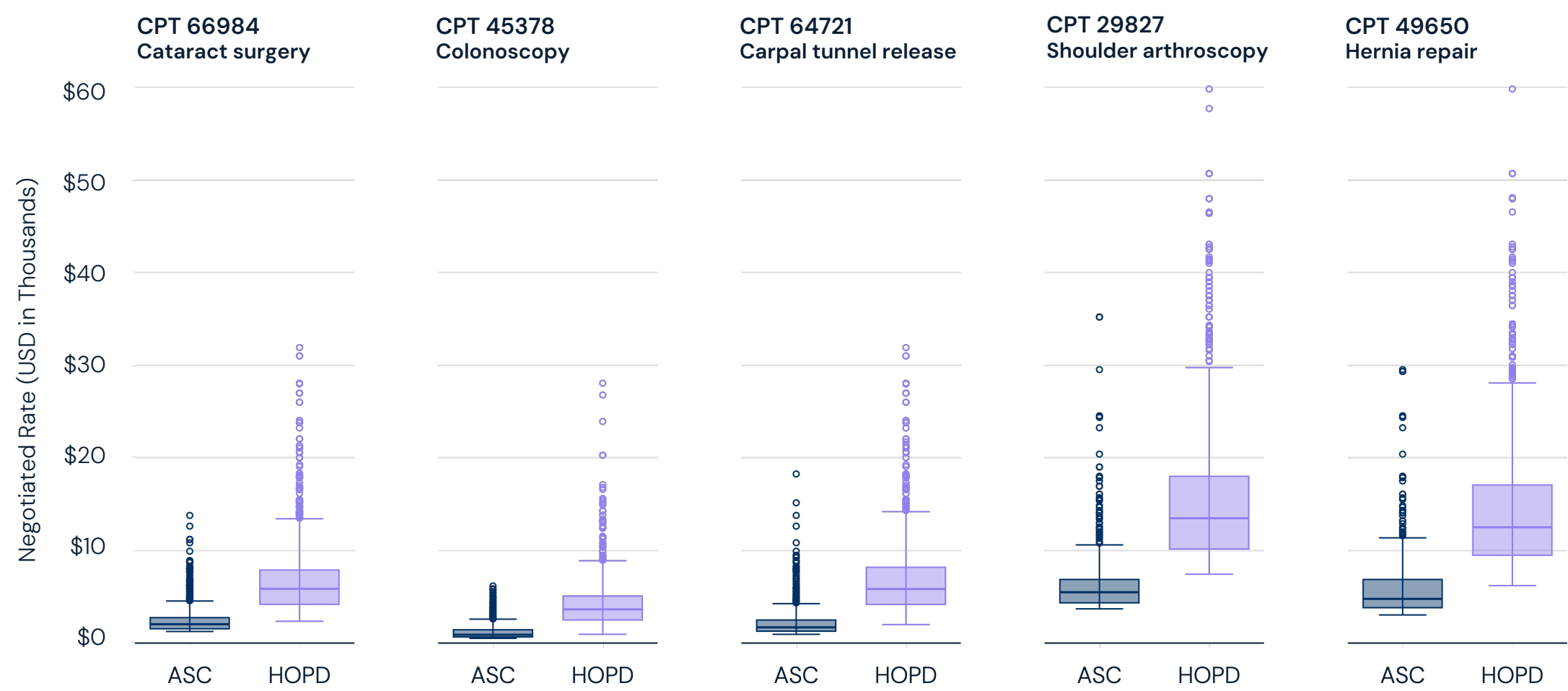
Note: UHC denotes UnitedHealthcare. MS-DRG 331 denotes major small and large bowel procedures without CC/MCC; MS-DRG 470 denotes major hip and knee joint replacement or reattachment of lower extremity without MCC; MS-DRG 236 denotes coronary bypass without cardiac catheterization without MCC.
Source: Trilliant Health health plan price transparency dataset and Provider Directory.

INCONSISTENT VALUE

Negotiated Rates Are Higher and More Variable at HOPDs Than ASCs

Negotiated rates for the same procedure are higher at HOPDs than ASCs. Nationally, the median UHC HOPD negotiated rate for CPT 29827 (shoulder arthroscopy) is \$13,477, while the median ASC rate is \$5,492. Negotiated rates are also more variable at HOPDs. UHC HOPD commercial negotiated rates for CPT 29827 range from \$7,437 to \$59,816, compared to \$3,697 to \$35,196 at ASCs.

UHC Commercial Negotiated Rates for Select CPTs at ASCs and HOPD, 2026



Note: ASC denotes ambulatory surgery center; HOPD denotes hospital outpatient department. CPT 66984 denotes routine cataract surgery; extracapsular cataract removal with insertion of an intraocular lens prosthesis; CPT 45378 denotes diagnostic flexible colonoscopy; examination extending to the cecum, with or without specimen collection by brushing or washing; CPT 64721 denotes carpal tunnel release; CPT 29827 denotes surgical shoulder arthroscopy with rotator cuff repair; CPT 49650 denotes laparoscopic repair of an initial (first-time) inguinal hernia. Analysis was conducted using negotiated rates for UnitedHealthcare.

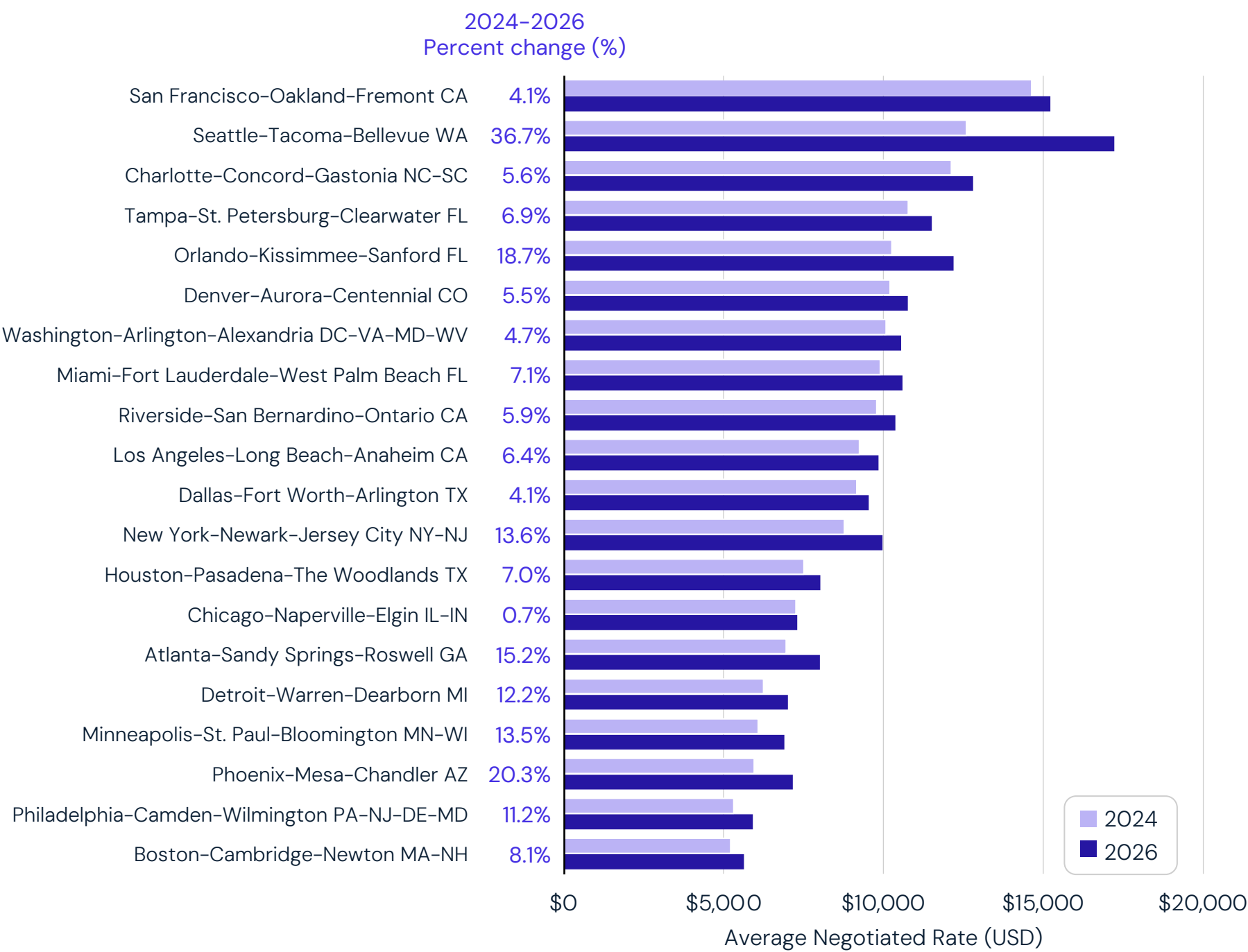
Source: Trilliant Health health plan price transparency dataset and Provider Directory.

INCONSISTENT VALUE

Negotiated Rates Are Variably Increasing Across Major Markets

From 2024 to 2026, market-level rate changes for a basket of six CPT codes ranged from 0.7% in Chicago–Naperville–Elgin, IL–IN to 36.7% in Seattle–Tacoma–Bellevue, WA. The largest absolute average increase occurred in Seattle–Tacoma–Bellevue, WA, up \$4,368 from 2024 to 2025. During this period, the percent change in negotiated rates in 12 of these 20 markets exceeded the corresponding change in CPI-U (6.6%). As of 2026, the average UHC rate for this basket of services ranged from \$5,643 in Boston–Cambridge–Newton MA–NH to \$17,216 in Seattle–Tacoma–Bellevue WA, a difference of \$11,573.

Average UHC Commercial Negotiated Rates for Select CPT Codes, by CBSA, 2024 and 2026



Note: CBSA denotes core-based statistical area; CPT 27447 denotes arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty); CPT 43235 denotes esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (diagnostic upper gastrointestinal endoscopy); CPT 45378 denotes colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing when performed (diagnostic colonoscopy); CPT 49650 denotes laparoscopy, surgical; repair initial inguinal hernia (laparoscopic initial inguinal hernia repair); CPT 64721 denotes neuroplasty and/or transposition; median nerve at carpal tunnel (open carpal tunnel release); CPT 66984 denotes extracapsular cataract removal with insertion of intraocular lens prosthesis, single-stage procedure, manual or mechanical technique (cataract removal with intraocular lens insertion).

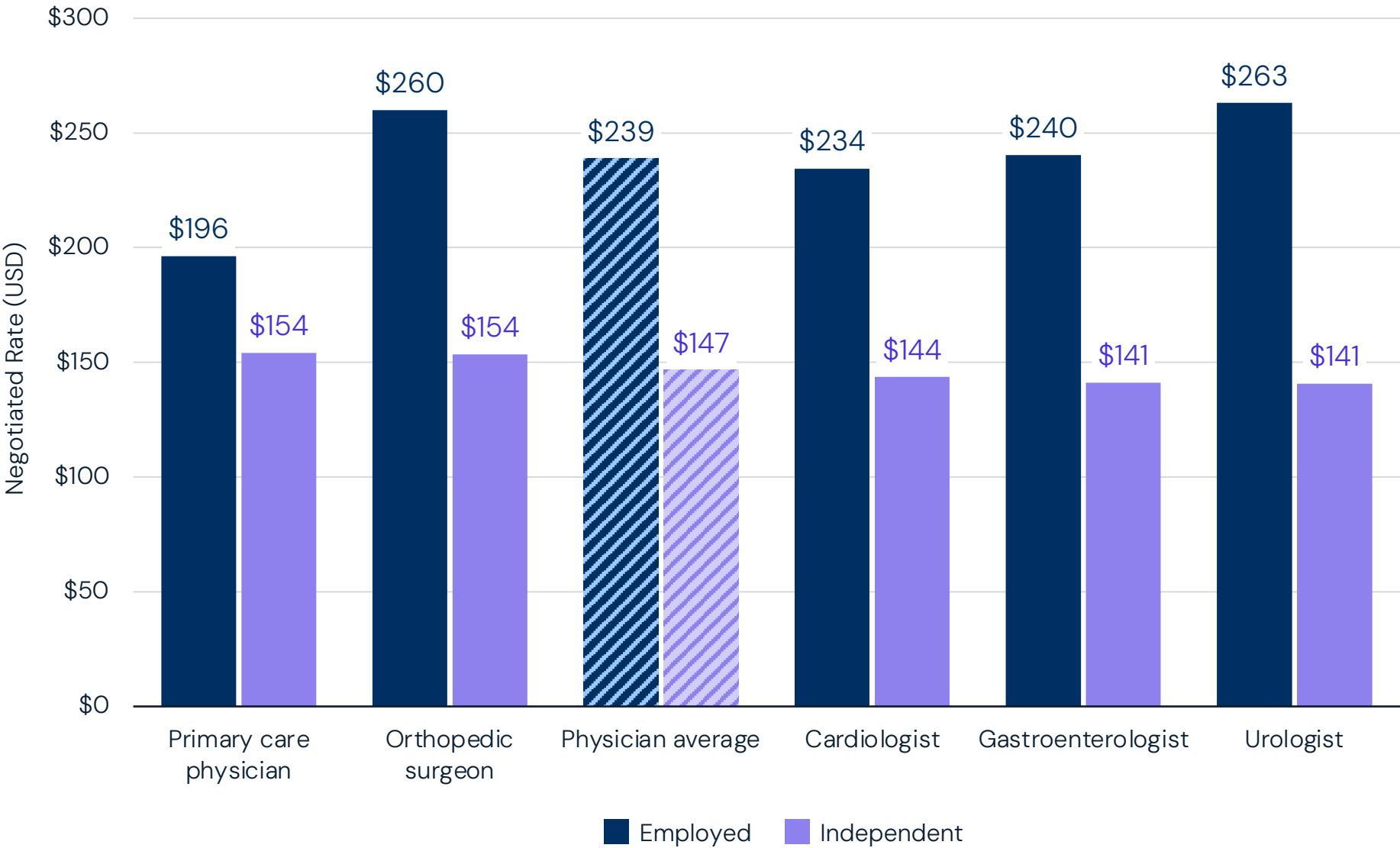
Source: Trilliant Health health plan price transparency dataset.

INCONSISTENT VALUE

Hospital-Employed Physician Rates Exceed Those of Independent Physicians

Across all studied specialties, hospital-employed physicians in Chicago receive higher commercial reimbursement than their non-hospital employed peers. On average, the blended E/M negotiated rate for hospital-employed physicians was \$239, compared with \$147 for independent physicians, a difference of \$92. The difference in commercial reimbursement varies by specialty type, ranging from \$42 in primary care (\$196 compared with \$154) to \$122 in urology (\$263 compared with \$141).

Blended Commercial Average E/M Negotiated Professional Rates in Chicago, Independent and Employed Physicians, 2026



Note: E/M denotes evaluation and management. The blended rate includes new and established E/M CPT codes: 99202–99215. Analysis was conducted using negotiated rates for multiple payers.
Source: Trilliant Health Provider Directory and health plan price transparency.

INCONSISTENT VALUE

The FDA Approved 85% of Drugs Not Recommended By NICE

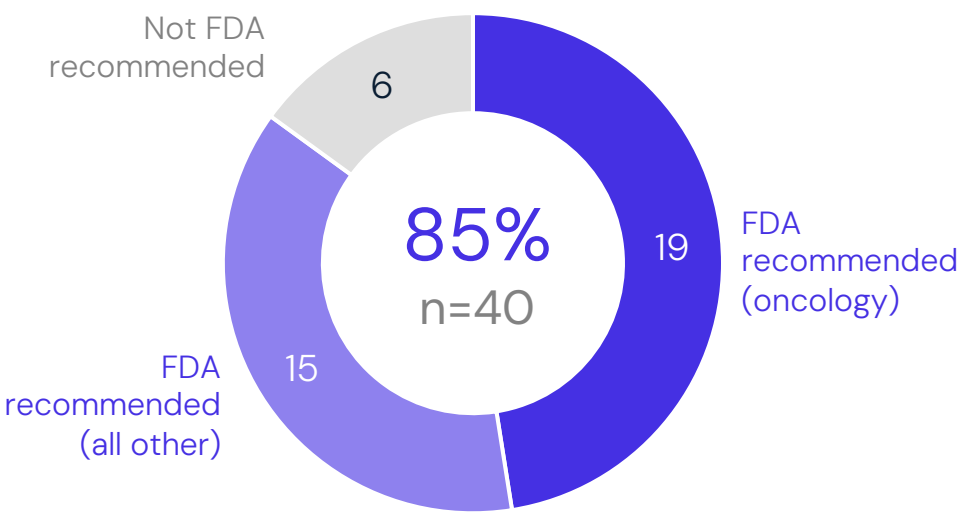
Of the drugs NICE has designated as “not recommended” since 2020, 85% have been approved by the FDA, most of which are indicated for oncology. The median cost of drugs “not recommended” by NICE but approved by the FDA between 2017 and 2020 was \$155,281 per patient per year.

What is NICE?

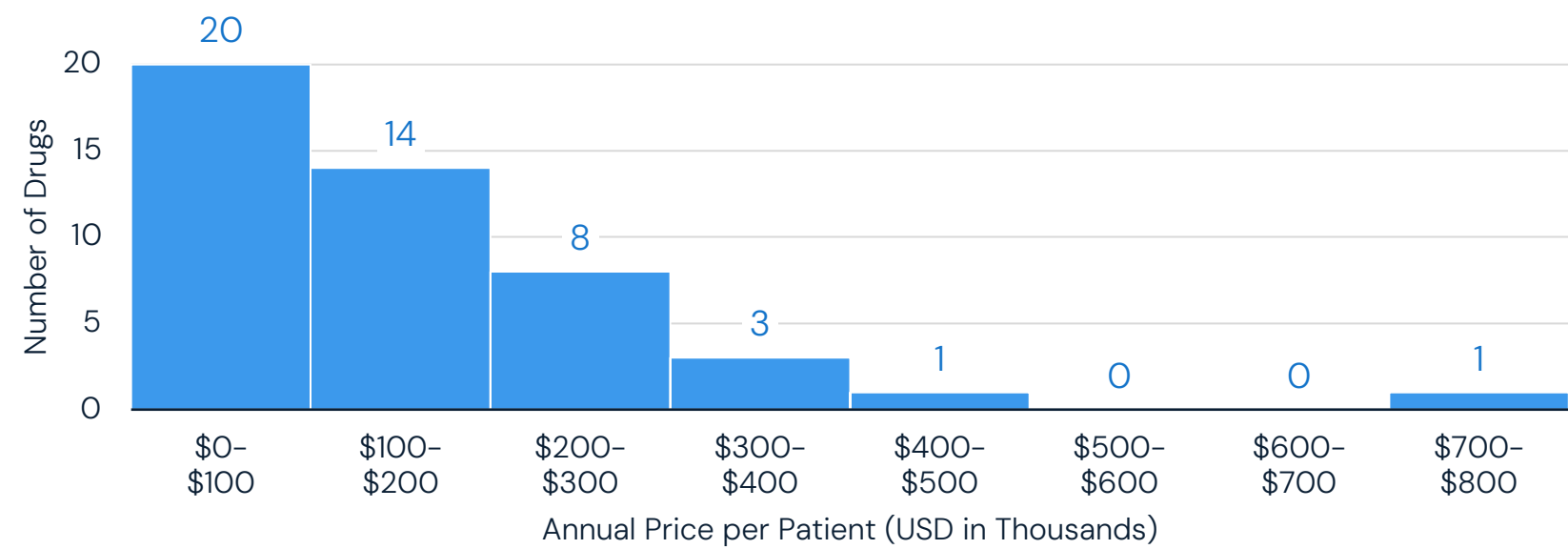
The National Institute for Health and Care Excellence (NICE) is a U.K. public body that creates clinical guidelines based on evaluations of new drugs, treatments and medical technologies. Treatments receive a designation as “not recommended” if they are not cost-effective enough for routine funding.

NICE’s cost-effectiveness threshold is £25,000-£35,000 per QALY gained.

Share of Drugs “Not Recommended” by NICE Approved by the FDA, by Indication, 2020–2026



Price of FDA-Approved Drugs “Not Recommended” By NICE, 2017–2020



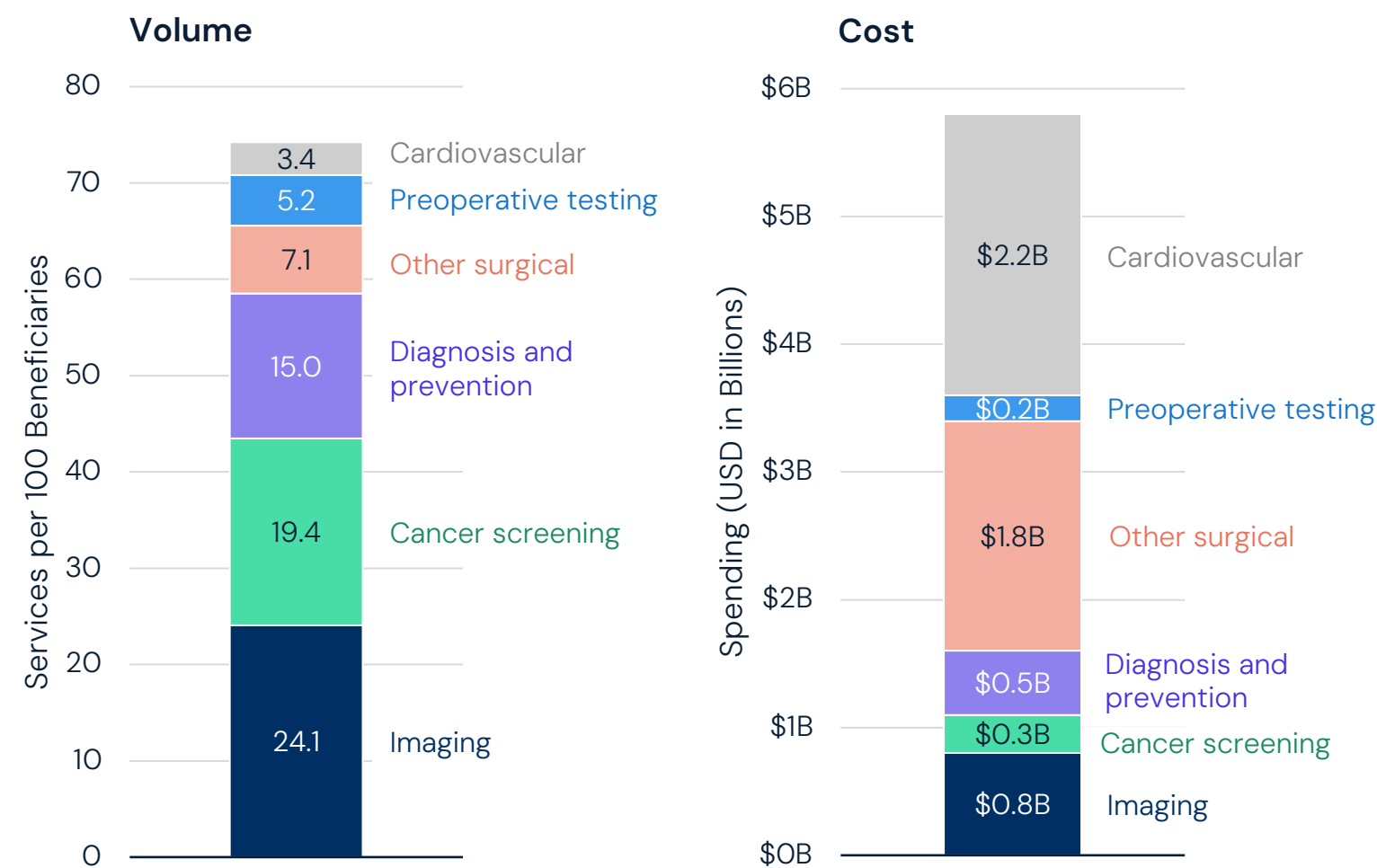
Note: FDA denotes U.S. Food and Drug Administration; NICE denotes National Institute for Health and Care Excellence; QALY denotes quality-adjusted life year.
Source: National Institute for Health and Care Excellence; Pham et al., Assessment of FDA-Approved Drugs Not Recommended for Use or Reimbursement in Other Countries, 2017–2020, *JAMA Internal Medicine*, 2023.

INCONSISTENT VALUE

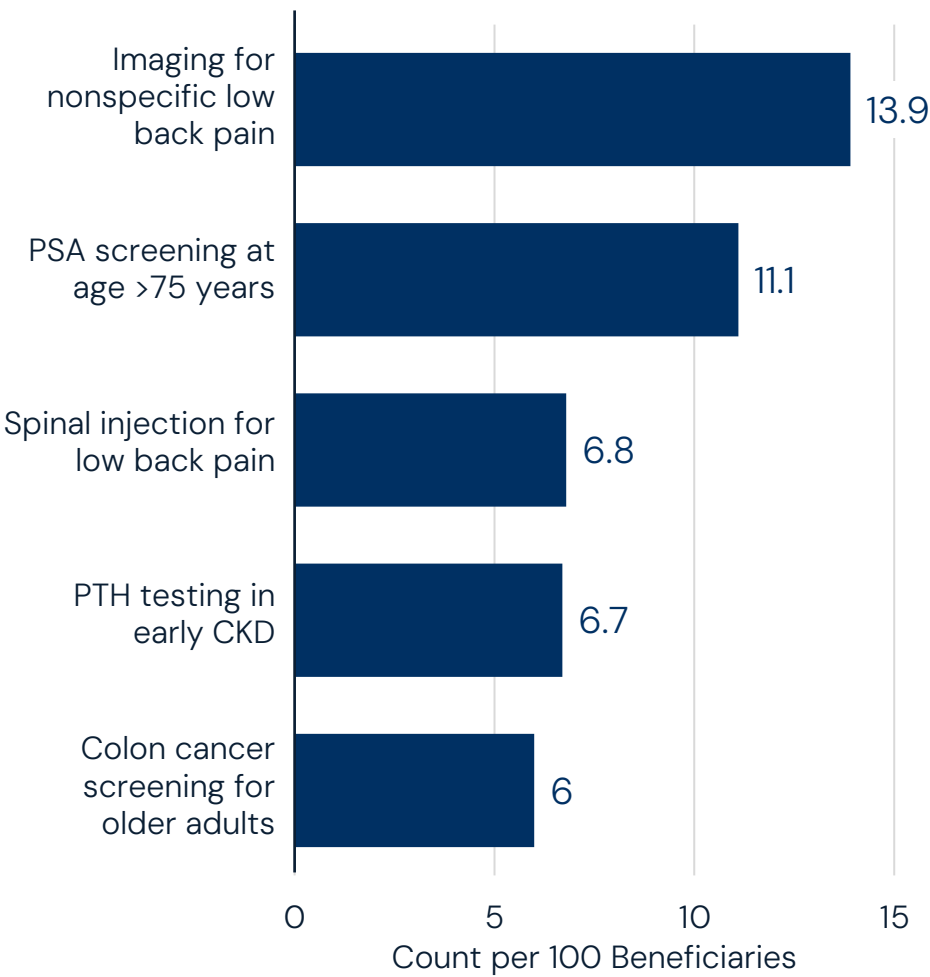
Low-Value Care Is Common and Costly

In 2023, there were 74.2 low-value services per 100 Traditional Medicare beneficiaries, equivalent to \$5.8B in wasteful spending. While imaging is the most common type of low-value care, cardiovascular testing and procedures generate the most wasteful spending.

Volume and Spending of Low-Value Care in Traditional Medicare, 2023



Most Common Low-Value Procedures in Traditional Medicare, 2023



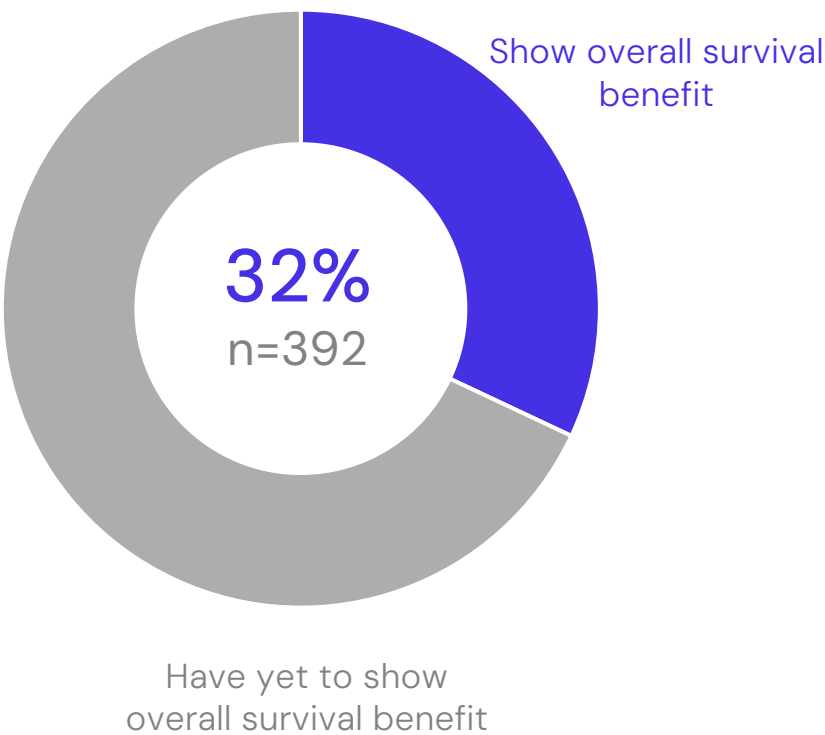
Note: PSA denotes prostate-specific antigen; PTH denotes parathyroid hormone; CKD denotes chronic kidney disease. Cardiovascular includes testing and procedures.
Source: Medicare Payment Advisory Commission July 2026 Data Book.

INCONSISTENT VALUE

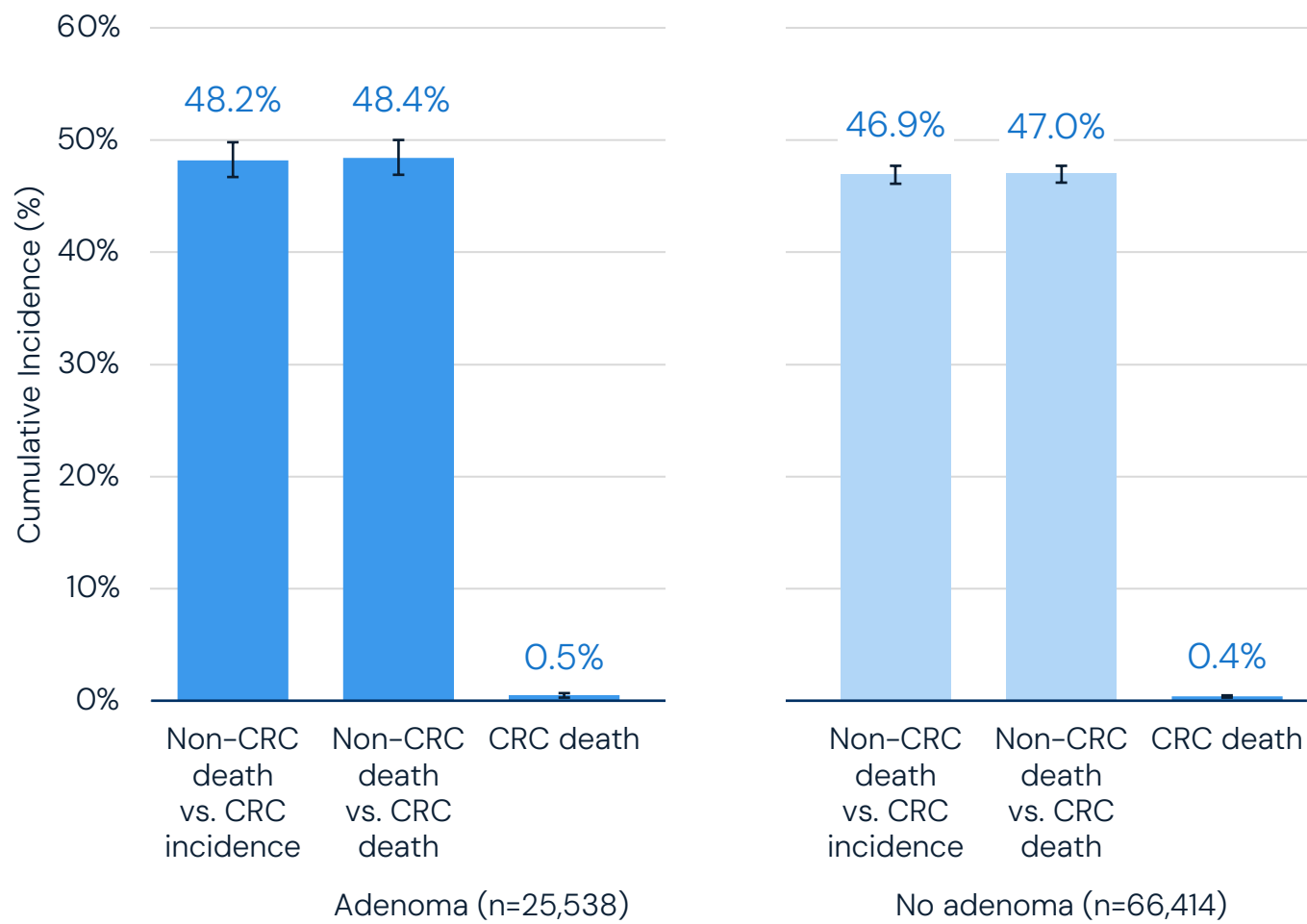
Mortality is the Ultimate Outcome Measure

Mortality is the most conservative measure of effectiveness, though it is underprioritized in U.S. regulatory frameworks. For example, across 392 drugs approved for oncology, only 32% had an overall survival benefit. Mortality reductions are even more challenging to achieve in asymptomatic screening, given the much larger risk of dying from something else. Among Veterans with an adenoma, they were 96x more likely to die from something other than colorectal cancer.

Share of FDA-Approved Oncology Drugs, by Overall Survival Benefit Status, 2006-2023



10-Year Secondary Colorectal Cancer Outcomes Among Veterans With and Without Adenoma on Screening Colonoscopy



Note: CRC denotes colorectal cancer.
Source: Elbaz et al., An Empirical Analysis of Overall Survival in Drug Approvals by the US FDA (2006-2023), *Cancer Medicine*, 2024; Gupta et al., Colorectal Cancer and Mortality Risk Among Older Adults With vs Without Adenoma on Prior Colonoscopy, *JAMA*, 2026.

INCONSISTENT VALUE

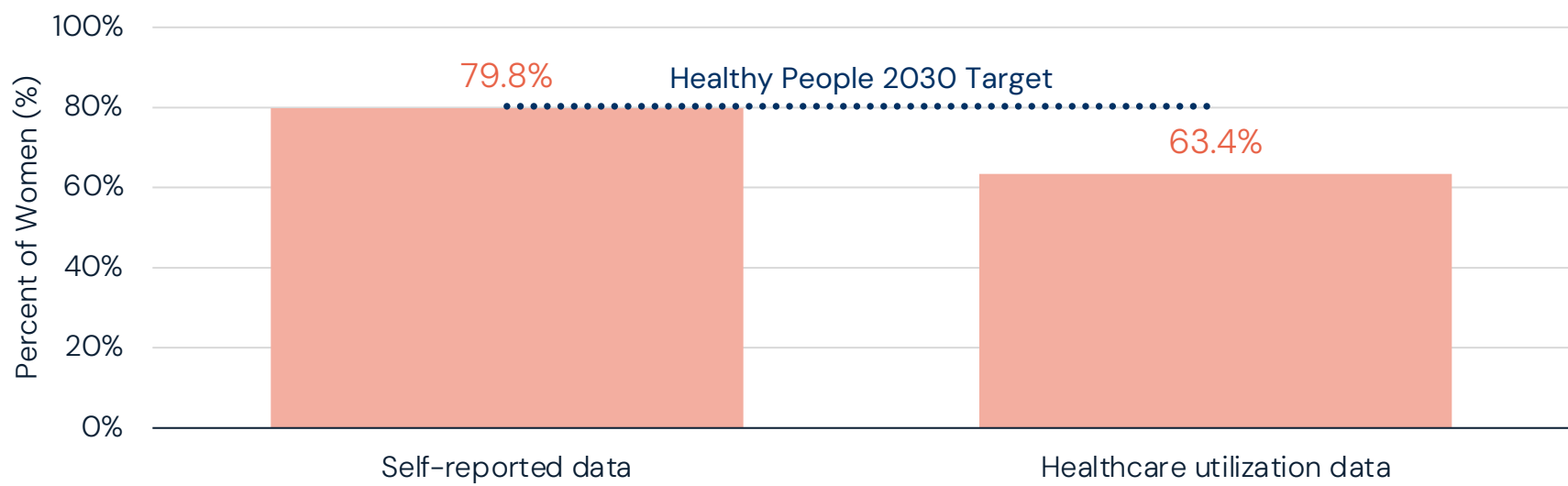
Amid Variable Recommendations, Utilization Data Finds Breast Cancer Screening Is Lower Than Reported

Across organizations, breast cancer screening recommendations vary by age and frequency. Among the most conservative recommendations, CTFPHC cites limited absolute benefit for more aggressive screening. Self-reported breast screening compliance was 79.8% in 2023, nearing the Healthy People 2030 target of 80.3%. However, analysis of national all-payer healthcare claims data reveals that 63.4% of eligible women had received a mammogram between 2021 and 2023. The difference in these screening rates likely reflects some amount of bias (e.g., recall, social desirability) in self-reported survey data. While limitations of claims data (e.g., self-pay encounter) could lead to an underestimate, both the survey- and claims-based screening rates reflect some amount of persistent underuse.

Current Breast Cancer Screening Recommendations, by Organization

Organization	Age	Frequency
USPSTF	40–74	Biannual
American Cancer Society	40–44, optional; 45, no fixed cutoff, individualized based on health status	Annual through 54; may switch to biannual over 55
American College of Obstetricians and Gynecologists	40–75, individualized beyond	Annual
American College of Radiologists/Society of Breast Imaging/NCCN/ASBrS	40, no fixed cutoff, individualized based on health status	Annual
World Health Organization	50–69	Biannual
Canadian Task Force on Preventive Health Care	50–74	Biannual

Share of Eligible Women Receiving Breast Cancer Screening, by Data Source, 2023



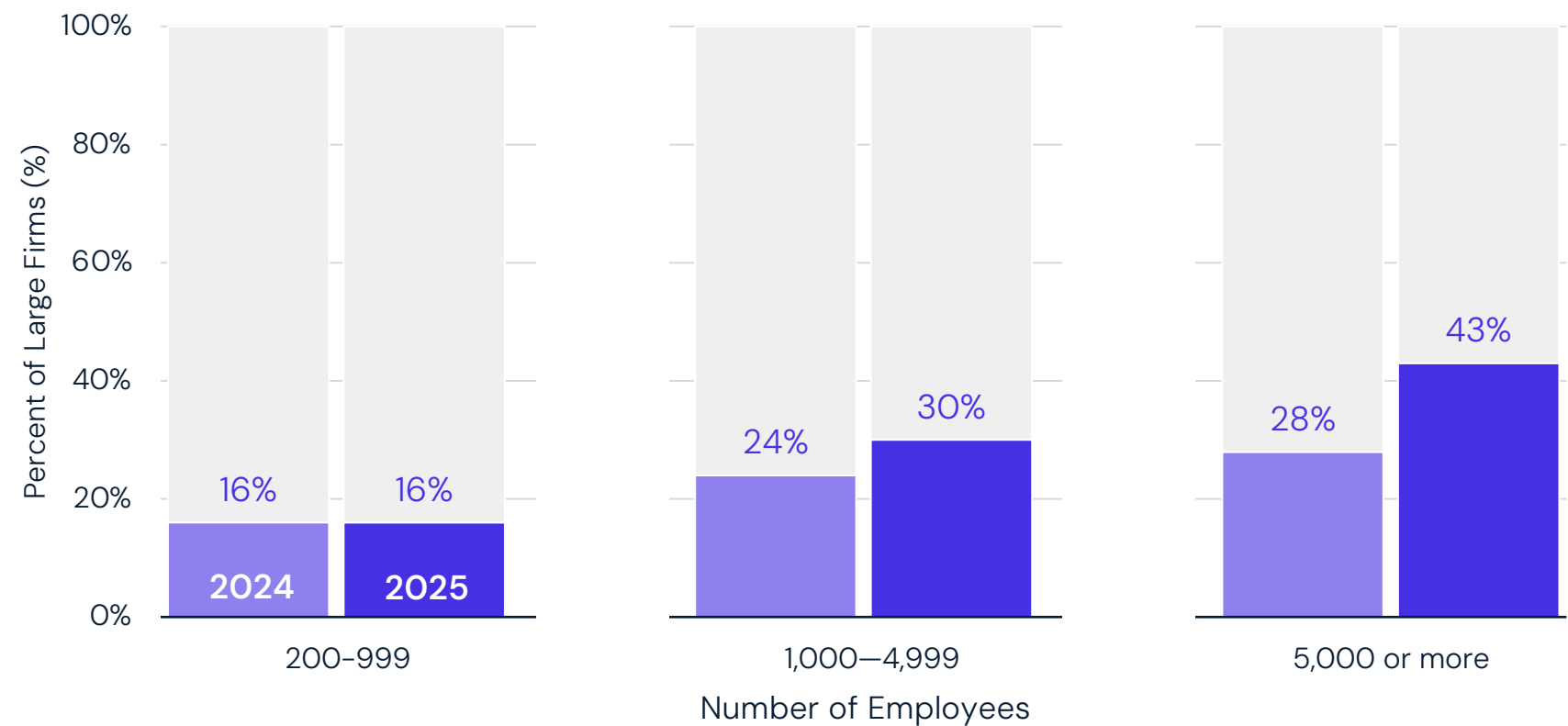
Note: CTFPHC denotes Canadian Task Force on Preventive Health Care; NCCN denotes National Comprehensive Cancer Network; ASBrS denotes American Society of Breast Surgeons. Analyses are limited screening eligible women.
Source: Trilliant Health national all-payer claims database; Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2023.

INCONSISTENT VALUE

Payers Are Divided on GLP-1 Coverage for Weight Loss

Although obesity is a common risk factor for diabetes, coverage for weight loss remains limited. In general, smaller firms are less likely to have GLP-1 coverage. Between 2024 and 2025, the share of employers providing coverage of GLP-1s for weight loss increased from 28% to 43% for firms with 5,000 or more employees and from 24% to 30% for firms with 1,000 to 4,999 employees.

Share of Large Firms With GLP-1 Coverage Indicated For Weight Loss, 2024 and 2025



GLP-1 Coverage, by Indication and Payer, 2026

	ESI	Medicare	Medicaid	VA	TRICARE
Diabetes	Yes	Yes	Yes	Yes	Yes
Weight loss	Variable	Temporary Bridge program (Exp. 12/31/2027)	Only in 12 states	Yes, for premium plans	No

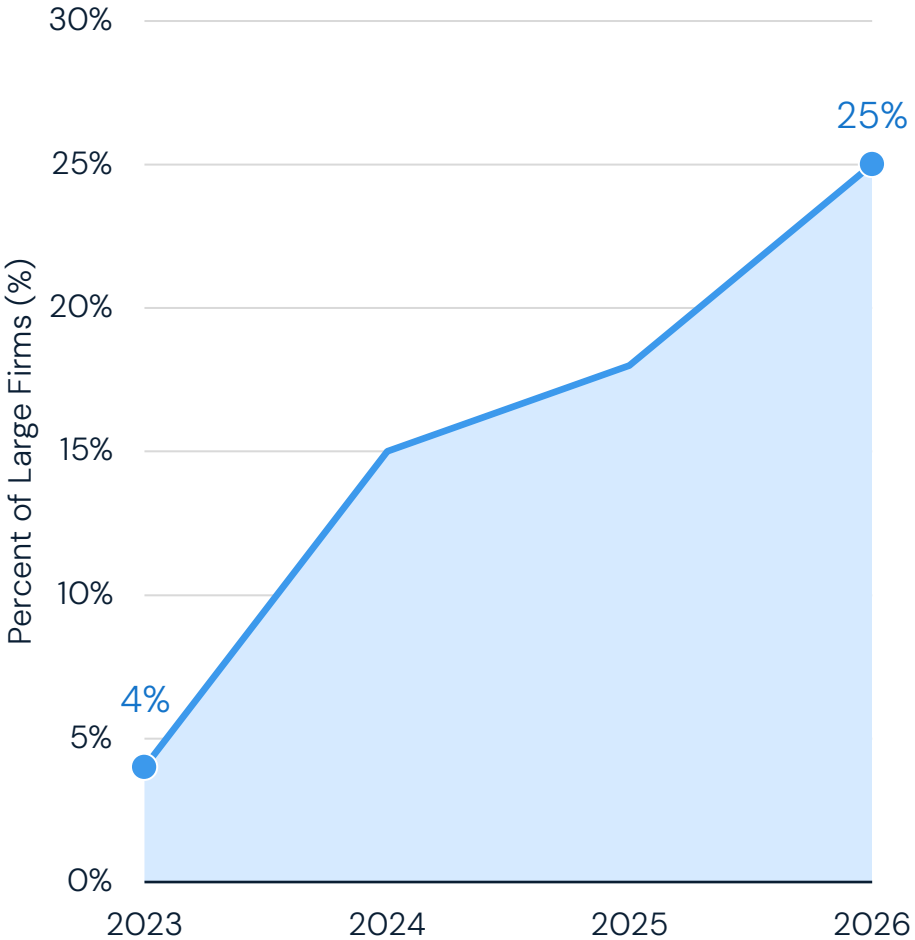
Note: VA denotes Veterans Affairs; GLP-1 denotes glucagon-like peptide-1; ESI denotes employer-sponsored insurance. Share of firms with GLP-1 coverage describes firms' largest plan.
Source: KFF, Employer Health Benefits Survey 2024, 2025.

INCONSISTENT VALUE

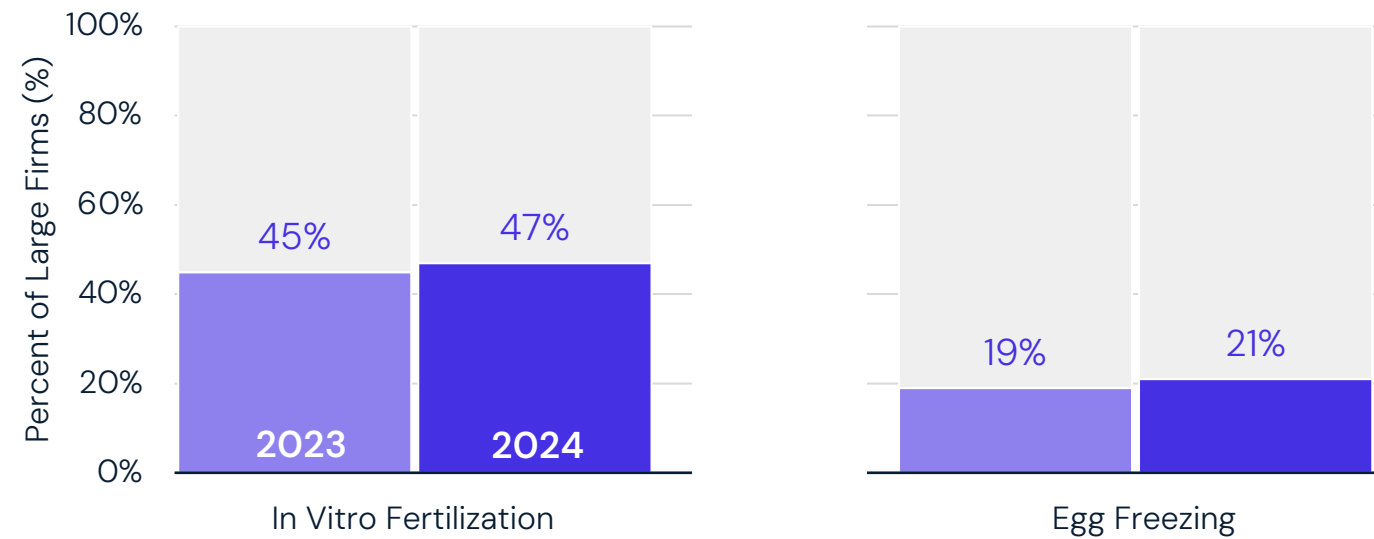
Coverage of Reproductive Care Is Limited and Inconsistent

Coverage for IVF and egg freezing is variable in ESI and extremely limited through public payers. Among large firms, less than half (47%) covered IVF, and only 21% covered egg freezing in 2024. While the share of large firms covering menopausal care increased by 21 PP between 2023 and 2026, just 25% offer coverage in 2026.

Share of Large Firms That Currently Provide or Plan to Provide Menopausal Care, 2023–2026



Share of Large Firms With Fertility Care Coverage, 2023 and 2024



Fertility Coverage, by Payer, 2026

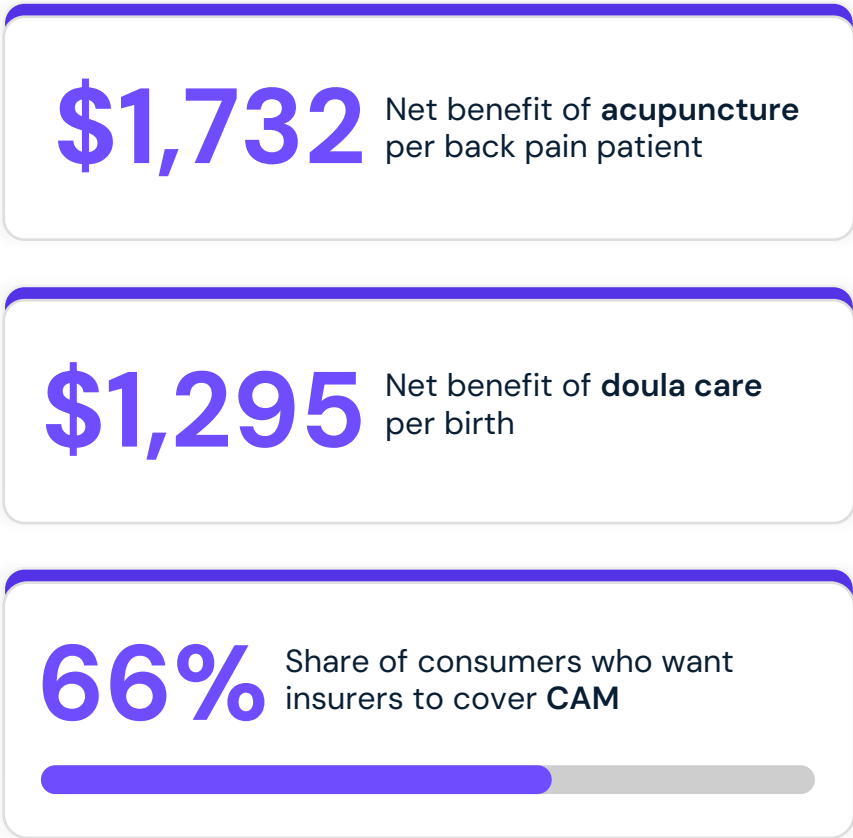
	ESI	Medicaid	VA	TRICARE
IVF	Variable	Only in UT, due to genetic conditions	Only due to a service-related injury	Only due to a service-related injury
Egg freezing	Variable	Only in five states, due to iatrogenic infertility	Only due to a service-related injury	DHA 3-year pilot for eligible active-duty personnel

Note: VA denotes Veterans Affairs; PP denotes percentage points; IVF denotes in vitro fertilization; ESI denotes employer-sponsored insurance; DHA denotes Defense Health Agency. Iatrogenic means infertility due to a medical cause like cancer treatment. Large firms are those with 500 or more employees. Personnel eligible for the DHA pilot are those deployed to dangerous countries and those who will be separated from their partner for at least six months.
Source: KFF; Mercer 2024 National Survey of Employer-Sponsored Health Plans; Mercer Survey on Health & Benefit Strategies Reports, 2023–2025.

INCONSISTENT VALUE

Alternative Medicine Coverage Varies Despite Evidence

Despite evidence of cost-effectiveness and strong demand, coverage for complementary and alternative medicine (CAM) is highly variable across payers and services. For example, most payers cover chiropractic care, but few cover massage therapy. Similarly, TRICARE covers birth doulas, but the VA does not.



Complementary and Alternative Medicine Coverage, by Payer, 2026

	Description	ESI	Medicare	Medicaid	VA	TRICARE
Acupuncture	Needle-based stimulation to relieve pain or treat illness	59% of employers in 2026	Yes, for chronic low back pain	Yes, in 6 states	Yes	No
Chiropractic care	Manual spinal and joint adjustment to relieve pain and improve function	Yes, a large majority of plans	Yes	Yes, in 43 states	Yes	Only for service members at designated locations
Massage therapy	Manipulation of soft tissue to relieve tension and pain	Very few plans	Yes, in some MA plans for pain	Some managed care plans	Only at 18 sites	Yes, if performed by a PT or OT
Birth doula care	Non-clinical labor and childbirth support	12% of employers in 2026	n/a	Yes, in 10 states	No	Yes

Note: MA denotes Medicare Advantage; CAM denotes complementary and alternative medicine; PT denotes physical therapist; OT denotes occupational therapist; ESI denotes employer-sponsored insurance; VA denotes Veterans Affairs. Net monetary benefit is the difference of the cost of an intervention and its health benefits expressed in dollars. The acupuncture net monetary benefit was calculated by multiplying the added quality adjusted life-years (QALYs) from the acupuncture treatment relative to a control by the approximate value of each QALY in dollars and then subtracting the treatment cost. The doula net monetary benefit was calculated by multiplying the reduction in preterm birth rates in patients with doulas by the cost to Medicaid of preterm births relative to full-term births and then subtracting the cost of doula care.

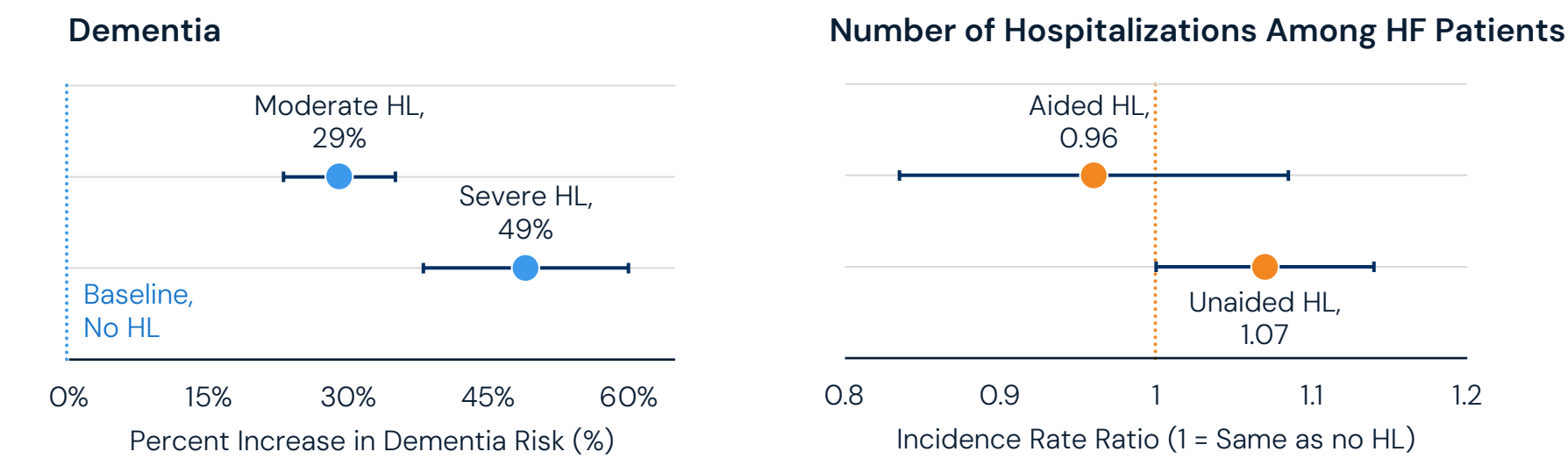
Source: ValuePenguin; Mercer; Society for Human Resource Management; Ijaz et al., Governing Therapeutic Pluralism: An Environmental Scan of the Statutory Regulation and Government Reimbursement of Traditional and Complementary Medicine Practitioners in the United States, *PLOS Global Public Health*, 2023; Skonnord et al., Cost-Effectiveness Analysis of Acupuncture Compared with Usual Care for Acute Non-specific Low Back Pain: Secondary Analysis of a Randomised Controlled Trial, *Acupuncture in Medicine*, 2022; Malak, Leveling the Start: Cost-Effectiveness of Community-Based Doula Care Among Medicaid Births, *BMC Public Health*, 2026.

INCONSISTENT VALUE

Gaps in Hearing Coverage Have Major Consequences for Health Outcomes

One in eight Americans over age 12 have hearing loss, and 55% of Americans ages 75 and older have disabling hearing loss. Compared to individuals with normal hearing, those with severe hearing loss have a 49% higher risk of dementia, on average. Among heart failure patients, unaided hearing loss is associated with a 7% increase in the rate of hospitalizations. Despite this, over half of Americans who needed hearing aids went without them in 2024, with 56% citing high OOP costs and 29% citing inadequate coverage. Coverage of hearing care is inconsistent across payers, and only the VA offers hearing aids without cost sharing.

Estimated Effects of Hearing Loss on Health Outcomes From Meta-Analyses



Hearing Coverage, by Payer, 2026

	ESI	Traditional Medicare	Medicare Advantage	Medicaid	VA
Coverage	Varies, 4.6% of adults live in a state with a hearing aid coverage mandate	Hearing aids and routine hearing exams are not covered	95% of beneficiaries are in plans offering hearing benefits	Coverage for hearing aids for adults in 32 states	Hearing aids and care are fully covered
Costs	Cost-sharing prohibited in just one state	Responsible for full cost	Usually subject to cost-sharing	Cost-sharing prohibited in 10 states	Free aside from travel costs

Note: HF denotes heart failure; OOP denotes out-of-pocket; VA denotes Veterans Affairs; HL denotes hearing loss; ESI denotes employer-sponsored insurance. **Source:** Centers for Medicare & Medicaid Services; KFF; National Institute on Deafness and Other Communication Disorders; Swamy et al., Bridging the Hearing Divide: Policy Solutions for Aging Americans, *American Journal of Public Health*, 2025; Arnold et al., Number of States Providing Medicaid Hearing Aid Coverage For Adults Increased, Variability Was Substantive, 2017–23, *Health Affairs*, 2025; Morales et al., State Mandates for Hearing Aid Coverage: An Opportunity for Improving Access to Hearing Health, *American Journal of Public Health*, 2024; Windmill, Financial Influences Linked to Hearing Aid Purchases, *Seminars in Hearing*, 2025; West et al., The Impact of Hearing Loss on Hospitalizations Among US Adults with Heart Failure, *Journal of General Internal Medicine*, 2026; Nguyen et al., Hearing Loss and Risk of Dementia: A Burden of Proof Study, *Alzheimer’s & Dementia*, 2025.

INCONSISTENT VALUE

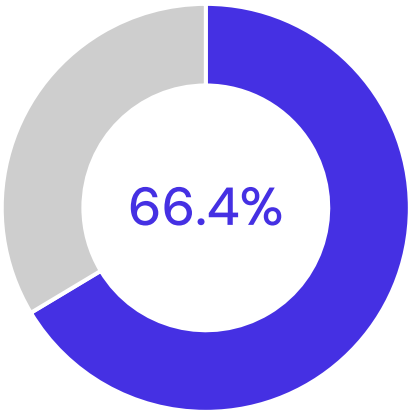
Oral Health Impacts Overall Health, Yet It Is Not a "Medical" Benefit

Poor oral health is linked to a range of physical conditions including diabetes, heart disease, respiratory disease, cancer and Alzheimer’s disease – yet dental coverage is separate from medical coverage. In 2025, 66.4% of adults received a dental exam within the past 12 months. Along with the potential to exacerbate comorbidities, lack of preventive dental care has implications for total cost of care. Patients with diabetes and CAD who adhered to recommended preventive dental care saved an estimated \$866–\$1,718 on annual healthcare spending.

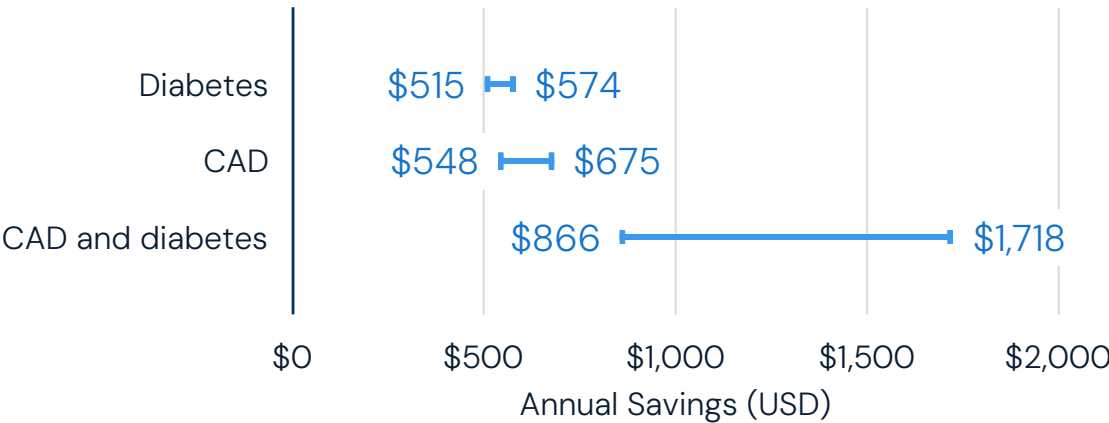
Relationship Between Oral Health and Other Health Outcomes

Comorbidities	Relationship
Diabetes	Gum disease has a bidirectional relationship with diabetes. Gum disease triggers a systemic inflammation response throughout the body, impairing its ability to process insulin. A high-glucose diet can lead to harmful bacteria and plaque growth.
Heart disease	Gum disease triggers chronic systemic inflammation that contributes to atherosclerosis – the narrowing or hardening of arteries.
Alzheimer’s disease	Gum-related bacteria and toxic enzymes can travel to the brain and contribute to Alzheimer’s.
Rheumatoid arthritis	Gum disease triggers an immune response that worsens joint inflammation and flare-ups.
Respiratory disease	Inhaled harmful oral bacteria from saliva and plaque can colonize in the lungs, leading to pneumonia or bronchitis.
Cancer	Individuals with gum disease have a higher likelihood of developing kidney, pancreatic and blood cancers, though the mechanism is uncertain.

Share of Adults With a Dental Exam or Cleaning In the Past 12 Months, 2025



Estimated Annual Savings Due to Preventive Dental Care Among Cardiometabolic Patients, 2022



Note: CAD denotes coronary artery disease.
Source: Centers for Disease Control and Prevention National Center for Health Statistics; Harvard School of Dental Medicine; Murphy et al., Association Between Preventive Dental Care and Healthcare Cost for Enrollees With Diabetes or Coronary Artery Disease: 5-Year Experience, *Compendium of Continuing Education in Dentistry*, 2022; Wall Street Journal.

INCONSISTENT VALUE

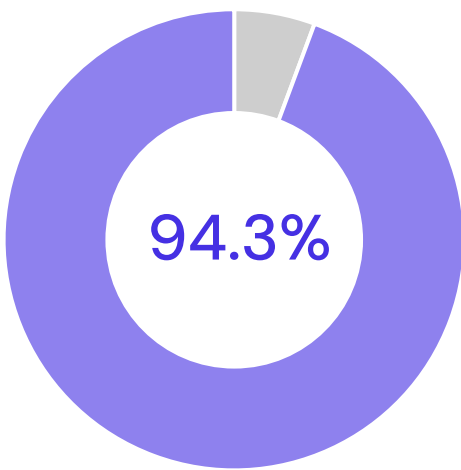
Self-Directed Testing Increases Utilization Without Commensurate Benefit

Numerous companies offer DTC testing that is not well supported by current evidence. Low-value testing and imaging can lead to unnecessary downstream utilization and worry. For example, 94.3% of patients that received a whole-body MRI had at least one abnormal finding, 91.0% of which were found to be benign upon follow-up. Notably, 13% of patients reported they would not trust their physician’s guidance if they advised against a patient-requested test, likely leading to more self-ordered testing.

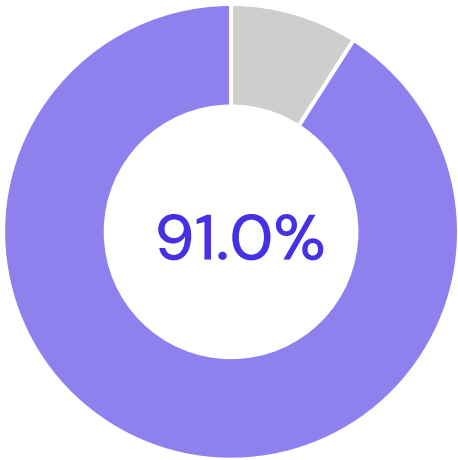
DTC Imaging and Laboratory Testing, by Type and OOP Costs

Service	Companies	OOP Price
Whole-body MRI	 	\$1,350–\$4,499/scan
Multi-cancer early detection blood test	 	\$949/test
Comprehensive lab panel subscription		\$365–\$499/year
Consumer-ordered lab tests	 	\$29–\$239/test

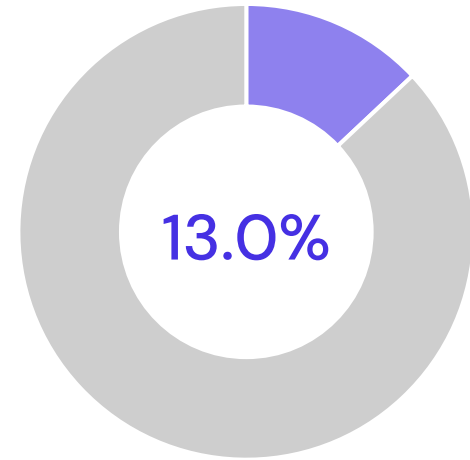
Share of Whole-Body MRI Patients With at Least One Abnormal Finding



Share of Whole-Body MRI Abnormal Findings That Were Benign



Share of Patients Who Would Not Trust Their Physician If They Advised Against a Requested Test



Note: DTC denotes direct-to-consumer; OOP denotes out-of-pocket; MRI denotes magnetic resonance imaging.
Source: Published prices from Prenuvo, Ezra, GRAIL Galleri, Function Health, Labcorp OnDemand and QuestDirect; American College of Radiology screening guidance; Fonseca et al., "Whole-body MRI for opportunistic cancer detection in asymptomatic individuals," *European Radiology*, 2025; Zugni et al., Whole-Body Magnetic Resonance Imaging for Cancer Screening in Asymptomatic Subjects of the General Population: Review and Recommendations, *Cancer Imaging*, 2020; Siemens Healthineers, Insights and Trends from a National Survey: Patient Testing in America, 2026.

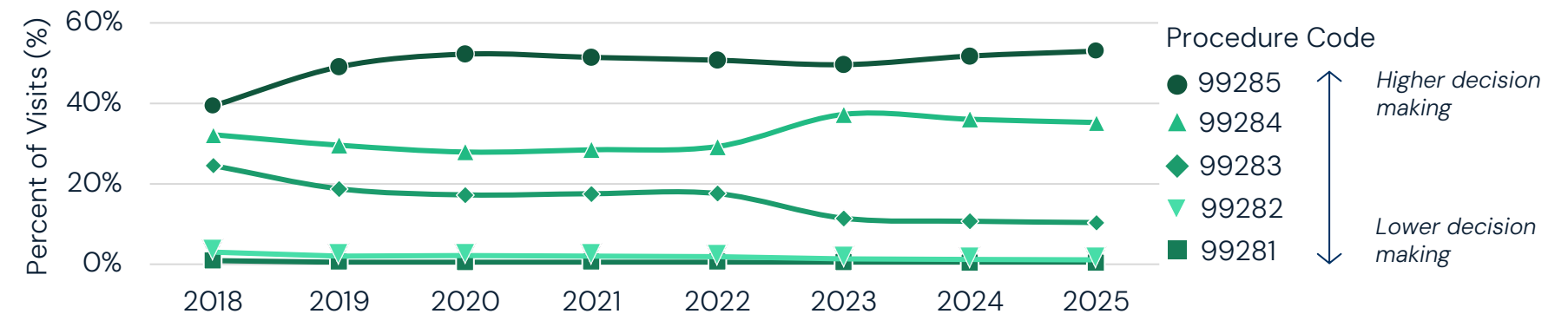
INCONSISTENT VALUE

Higher-Intensity Coding May Not Accurately Reflect Higher Clinical Intensity

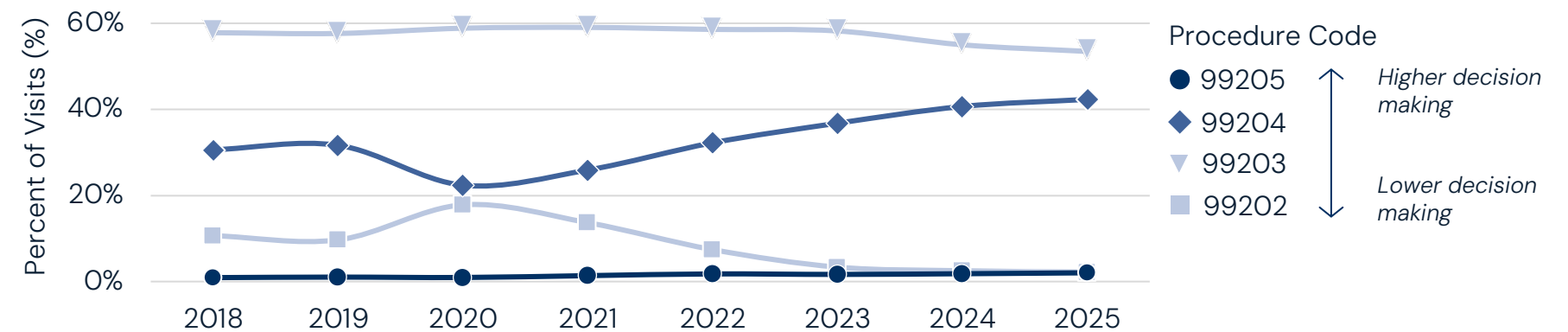
From 2018 to 2025, there was a steady shift toward higher-acuity procedure codes across care settings. Notably, the share of emergency department visits coded at CPT 99284 (i.e., higher complexity) grew from 29.3% in 2022 to 35.2% in 2025, while the share of visits billed at CPT 99283 decreased by 7.2 PP. In the urgent care setting, use of higher-acuity codes such as CPT 99204 increased from 22.4% in 2020 to 42.3% in 2025, while lower-acuity codes like CPT 99202 saw a decline from 17.8% to just 2.2%. The physician office setting also reflects this trend, with code 99214 rising from 41.0% in 2018 to 52.5% in 2025. Given high-acuity codes receive higher reimbursement, billing of a more intense CPT without a commensurate change in clinical complexity is indicative of worsening value.

Share of Outpatient E/M Visits, by CPT Code and Setting, 2018–2025

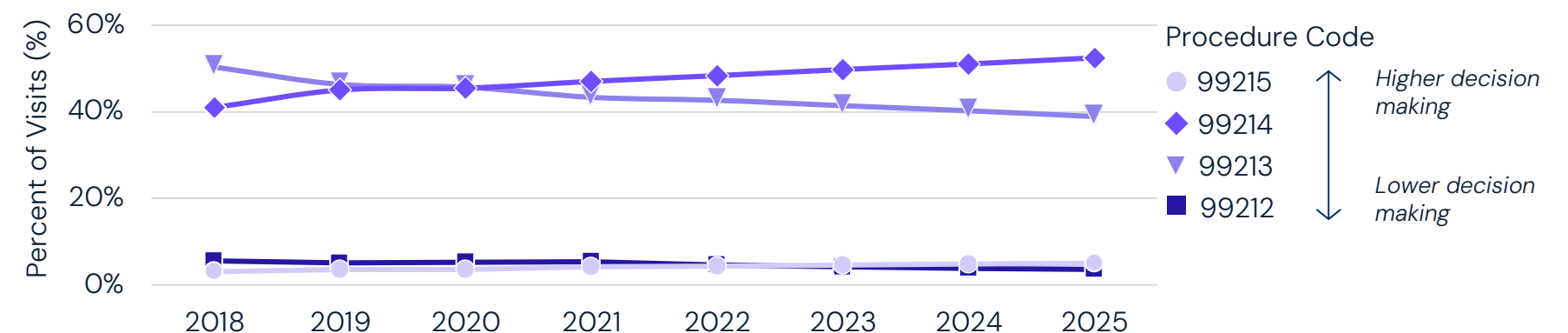
Emergency Department



Urgent Care



Physician Office



Note: E/M denotes evaluation and management. CPT codes 99281 through 99285 are emergency department E/M codes, and since January 1 2023 they have been selected on medical decision making (MDM) complexity rather than time, ranging from 99281 which may not require the presence of a physician or other qualified health professional, to 99282 for straightforward MDM, 99283 for low MDM, 99284 for moderate MDM and 99285 for high MDM. CPT codes 99212 through 99215 are established patient office or other outpatient E/M codes selected on MDM or total time, where 99212 reflects straightforward MDM, 99213 reflects low MDM and 99215 reflects high MDM. CPT codes 99202 through 99205 are new patient office or other outpatient E/M codes selected on the same basis, where 99202 reflects straightforward MDM, 99203 reflects low MDM, 99204 reflects moderate MDM and 99205 reflects high MDM.

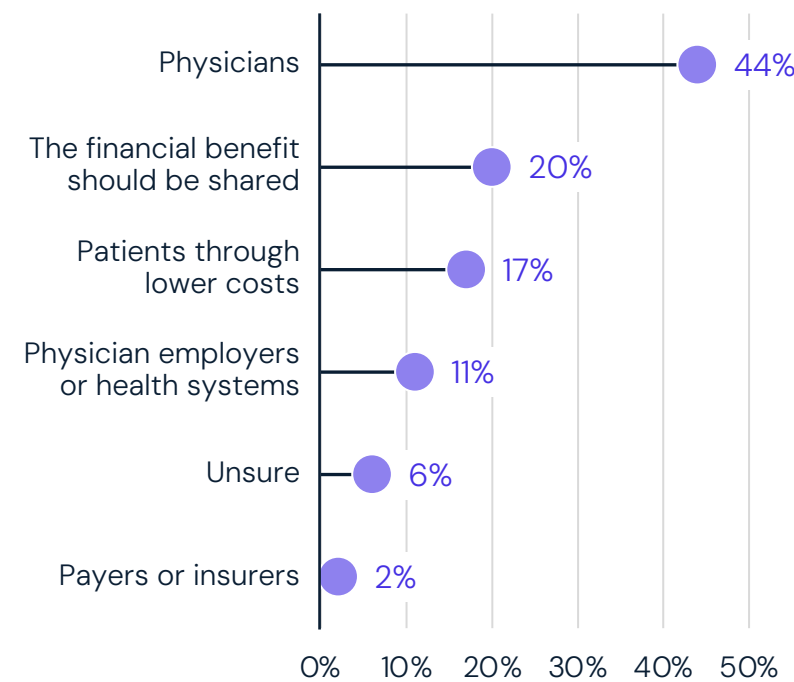
Source: Trilliant Health national all-payer claims database.

INCONSISTENT VALUE

AI Will Automate Dysfunction Unless the Goal Becomes Value Generation Over Value Extraction

The disconnect between adoption and measurable impact of AI was raised by Centene CEO Sarah London, warning of “a risk of spending a lot of money on AI and getting no return for it.” To improve value, the healthcare system will need to agree on what AI should optimize for. For example, 44% of physicians believe they should financially benefit from AI efficiency gains, while only 20% believe the financial benefit should be shared. Similarly, the majority of RCM leaders are prioritizing AI strategies that target claims denials, prior authorization and coding.

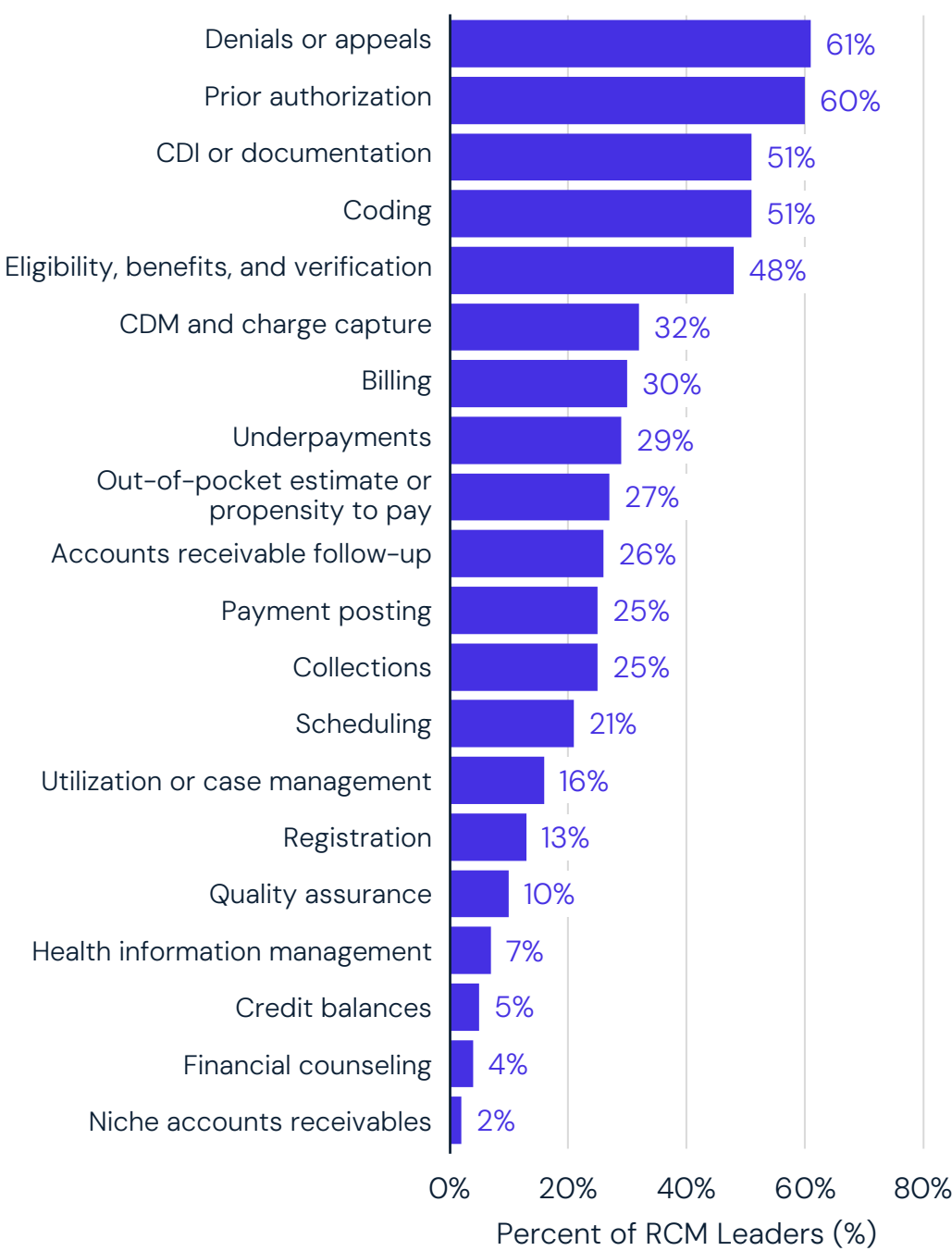
Physician Views on Who Should Financially Benefit from AI Efficiency Gains, 2025



I think it's easy to get on an earnings call and say, "We're doing AI everywhere, and we've got all these great partnerships. "Our view is that there is also a risk of spending a lot of money on AI and getting no return for it. That's not something that we can afford to do as a Medicaid first company, in a margin compressed environment.

-Sarah London, Centene CEO

Functions That RCM Leaders Are Prioritizing to Implement AI, 2025



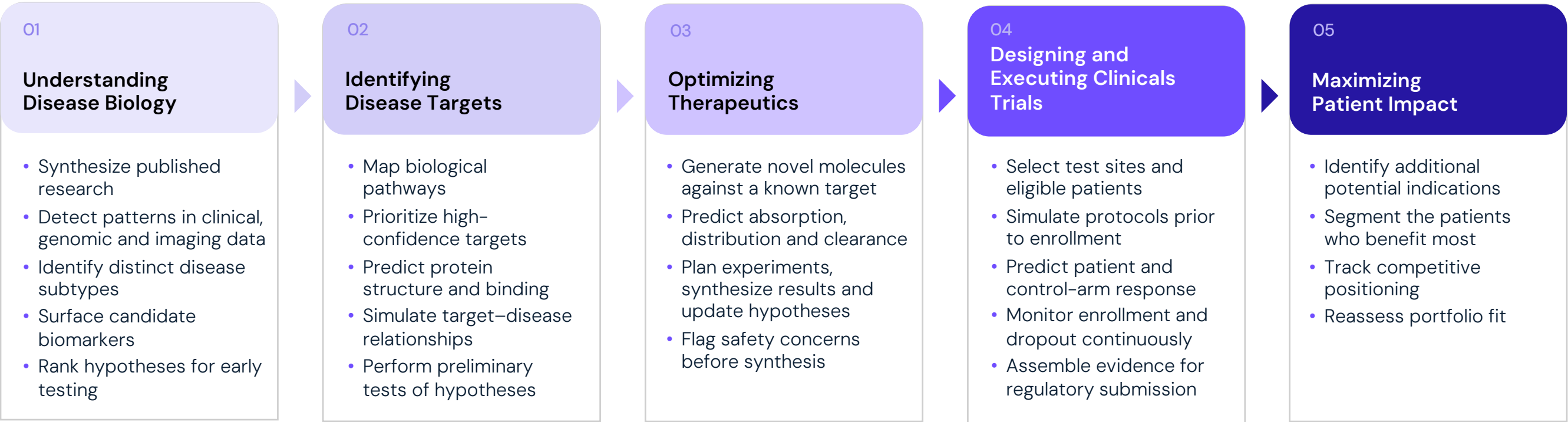
Note: AI denotes artificial intelligence; CDI denotes clinical documentation improvement; RCM denotes revenue cycle management.
Source: Doximity, Physician Compensation Survey, 2026; McKinsey; Centene earnings call transcripts.

INCONSISTENT VALUE

AI-Accelerated Drug Discovery Does Not Guarantee Lower Prices

Agentic AI can accelerate drug discovery by an estimated 18 weeks, saving up to \$21M through integration in each stage of the development pipeline. In response, investment by major drug manufacturers and in AI-first companies has skyrocketed. Even if drug developers can reduce their costs, they have no clear incentive to lower list prices.

Role of AI in Drug Discovery, By Stage



Leading AI-First Drug Discovery Companies

	FUNDING	PIPELINE ASSETS BY STAGE					THERAPEUTIC FOCUS	
 Recursion.	\$452M	2	3	1	1		Oncology and rare disease	
 Insilico Medicine	\$510M	12			3	2	1	Oncology and chronic disease

Preclinical Phase I Phase I/II Phase II Phase III

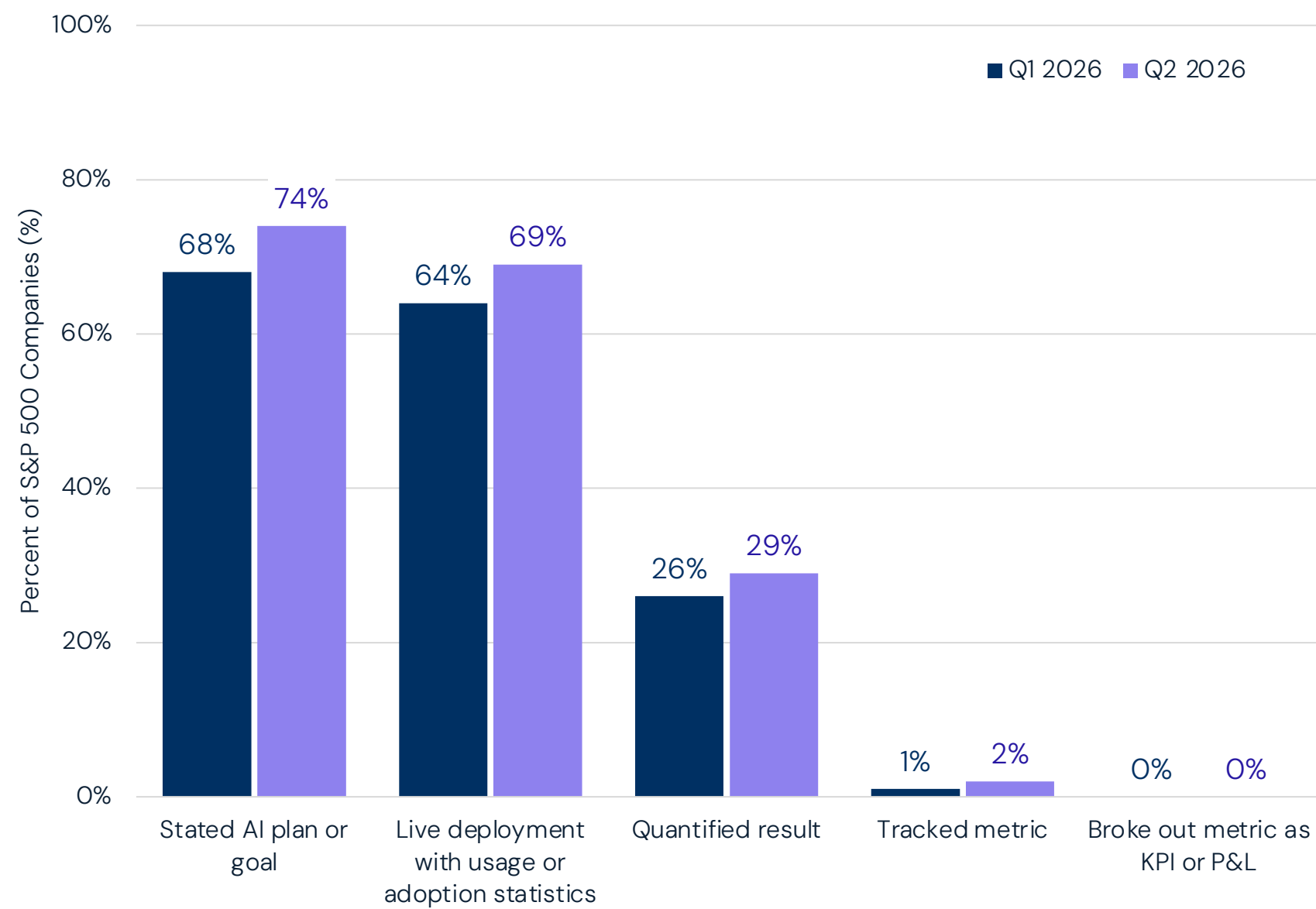
Note: AI denotes artificial intelligence. Number of drugs in discovery pipelines excludes those out-licensed. Chronic disease includes fibrosis/pulmonary, immunology/inflammatory, metabolic/obesity, central nervous system and pain.
Source: Company websites; Tracxn; McKinsey & Company; Medable.

INCONSISTENT VALUE

Major Corporations Are Not Monitoring the Value Derived from AI

In Q2 2026, 69% of S&P 500 companies reported live deployment of AI strategies, up from 64% in Q1 2026. However, only 29% quantified the relative ROI of that deployment and just 2% reported a metric tracked over time. Notably, none have formally tracked the value stemming from AI strategies as a single KPI or P&L line.

Share of S&P 500 Companies Disclosing AI Adoption, by Level of Specificity, Q1 and Q2 2026



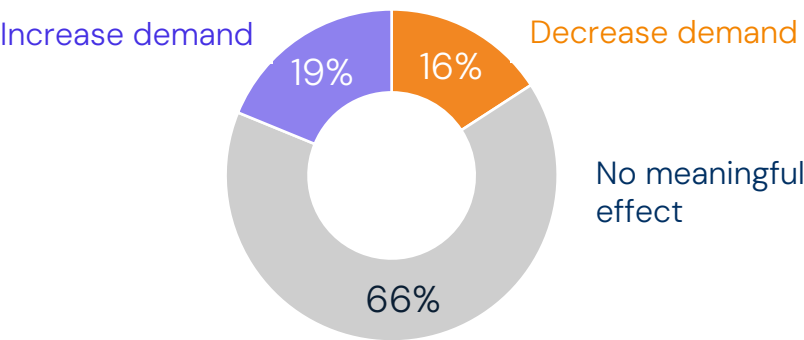
Note: AI denotes artificial intelligence; KPI denotes key performance indicator; P&L denotes profit and loss.
Source: Apollo.

INCONSISTENT VALUE

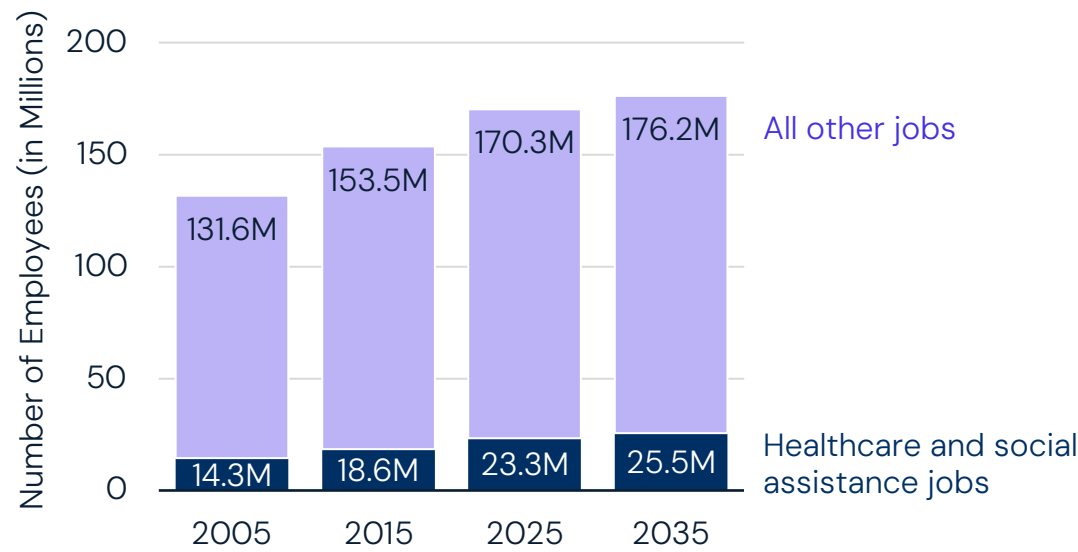
AI Will Reduce Spending When It Reduces Headcounts

Between 2025 and 2035, 37% of all new jobs are projected to be healthcare jobs. Notably, 85% of physicians think AI will increase (19%) or have no effect on (66%) the physician workforce. To this point, while 81% of physicians under age 30 used AI weekly, only 25% reported AI is reducing their workload.

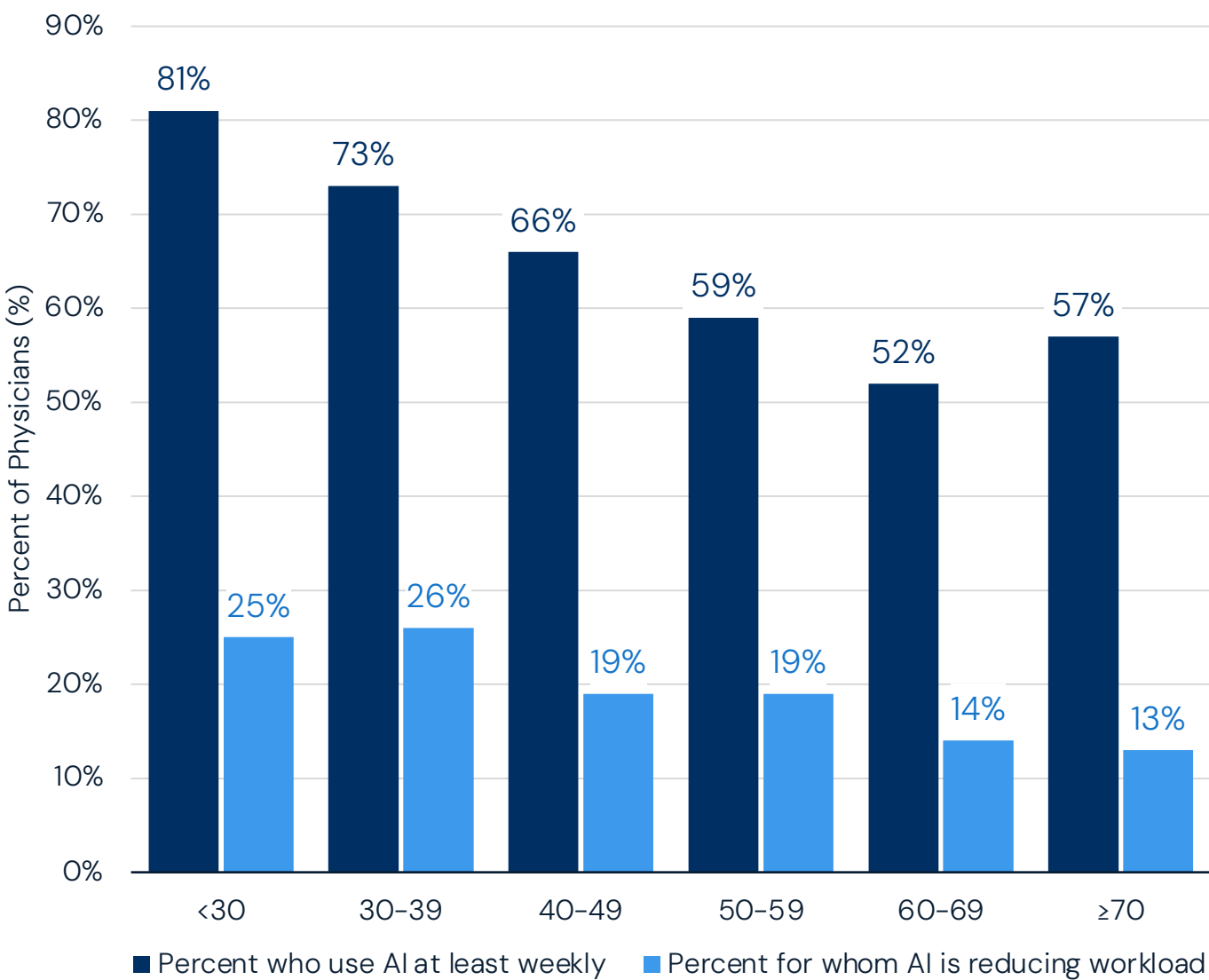
Perceived Near-Term Impact of AI on Physician Demand Within Respondents' Specialty, 2025



Estimated Number of Jobs, by Industry, 2005–2035



Weekly AI Use and Perceived Workload Reduction Among Physicians, by Age, 2025



Note: AI denotes artificial intelligence. Percentages may not add to 100% due to rounding.
Source: Doximity; Peterson-KFF Health System Tracker; U.S. Bureau of Labor Statistics.

05

Misaligned Incentives
Manifest in Systemic Fraud,
Waste and Abuse

FRAUD, WASTE, ABUSE

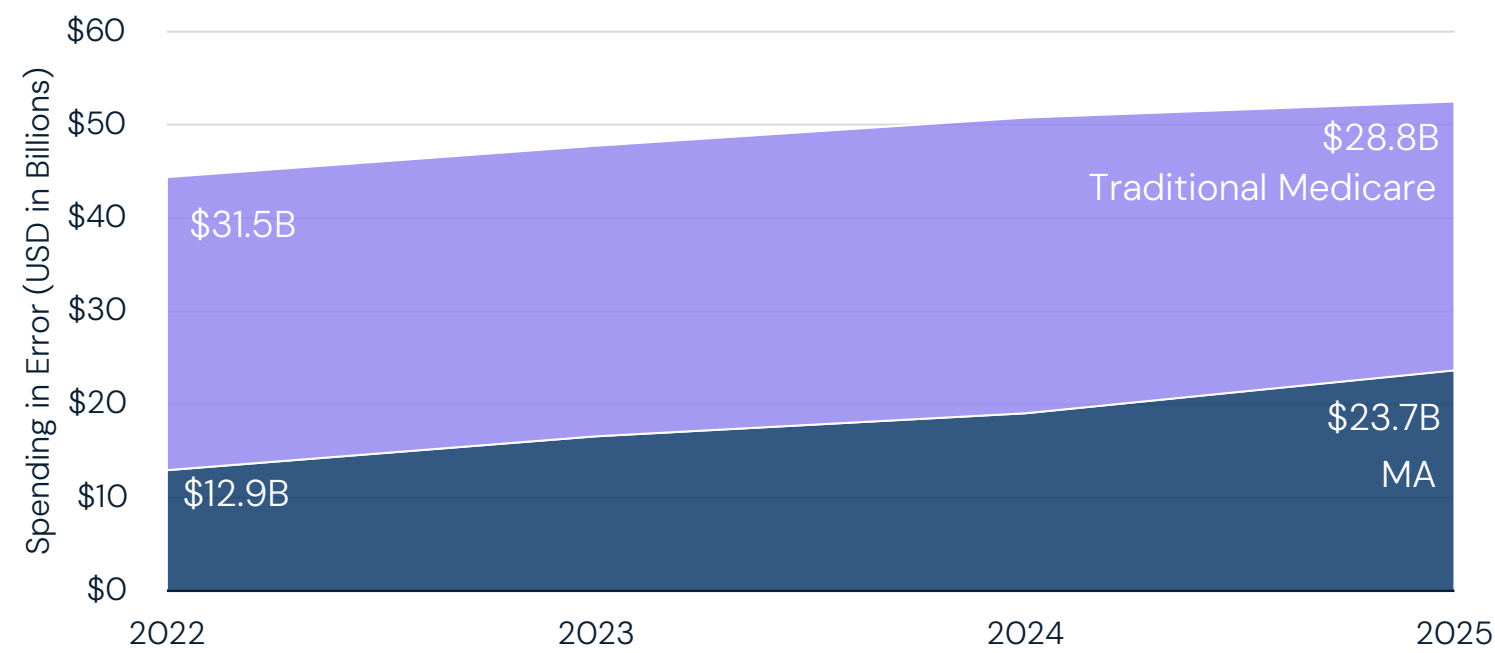
Fraud, waste and abuse are inevitable in the current U.S. healthcare system. Medicaid financing mechanisms, such as provider taxes that inflate state spending to capture incremental FMAP funding, reward creative accounting. Site-of-service payment differentials **unintentionally incentivize** hospital ownership over independent practice. Medical loss ratio requirements, intended to limit how much premium health insurers keep for overhead and profit, instead reward them for increasing claim volumes and tunneling profits to their own vertically integrated affiliates. Certificate of need laws, intended to prevent oversupply and duplicative infrastructure, instead protect incumbent hospitals and **negatively impact quality and access**. Fee-for-service reimbursement rewards volume over outcomes – unnecessary imaging, duplicative testing and low-value procedures persist because the incentive structure makes ordering them economically rational for providers, and because patients are left to use **"more" as a proxy for better** care. Each policy designed to constrain the system creates a workaround that is **individually rational and collectively destructive**, the very definition of a tragedy of a commons. Because no single actor bears the full cost of the distortion, none has sufficient incentive to correct it.

FRAUD, WASTE, ABUSE

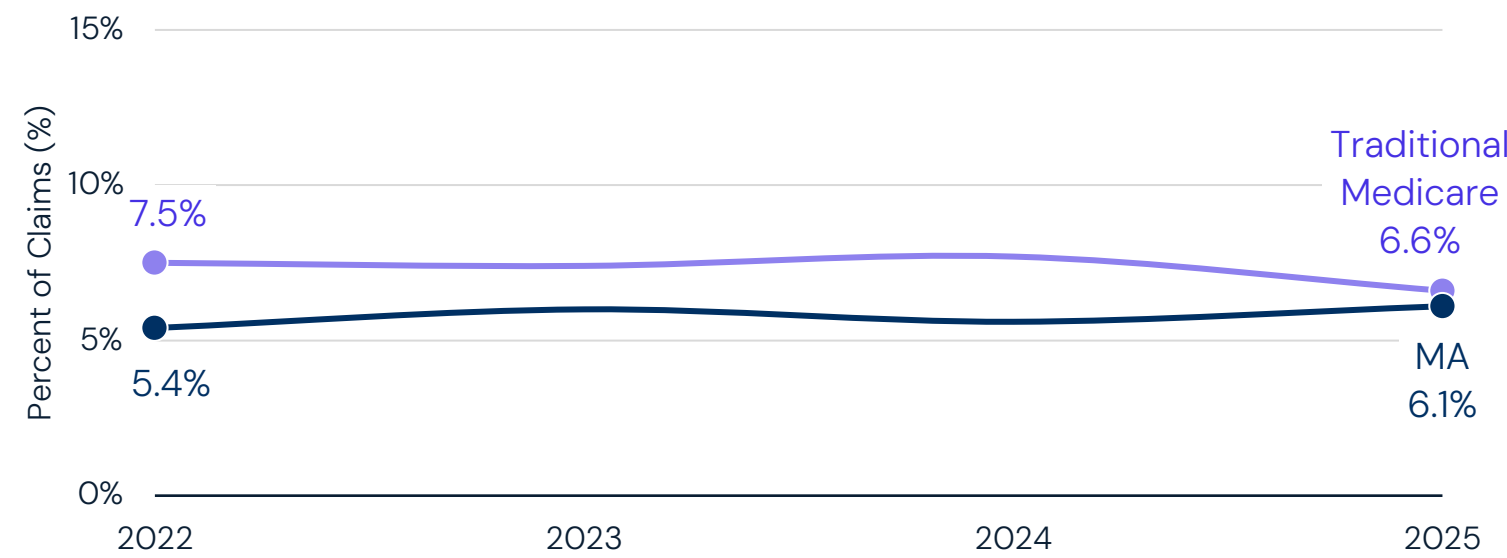
Medicare Claim Overpayment Generates \$50B in Wasteful Spending

The surplus costs of improper Medicare payments increased from \$44.4B in 2022 to \$52.5B in 2025. Due in part to enrollment shifts, MA accounts for a growing share of this spending, reaching 45.1% of improper payment cost in 2025. Since 2022, the error rate of Traditional Medicare payments has exceeded that of MA. However, the error rate is converging between the two coverage sources at 6.6% and 6.1% in 2025, respectively. Between 2007 and 2036, MA overpayments are projected to represent \$1.3T in wasteful spending.

Surplus Cost of Improper Medicare Payments, FY 2022–2025



Error Rate of Medicare Payments, FY 2022–2025



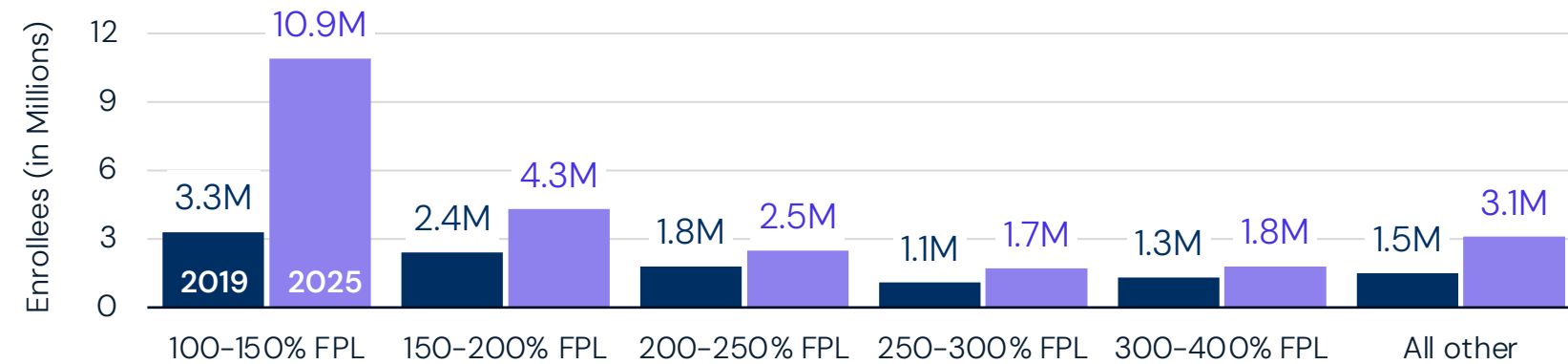
Note: MA denotes Medicare Advantage; FY denotes fiscal year.
Source: Centers for Medicare & Medicaid Services Improper Payments Measurement Program; Committee for a Responsible Federal Budget.

FRAUD, WASTE, ABUSE

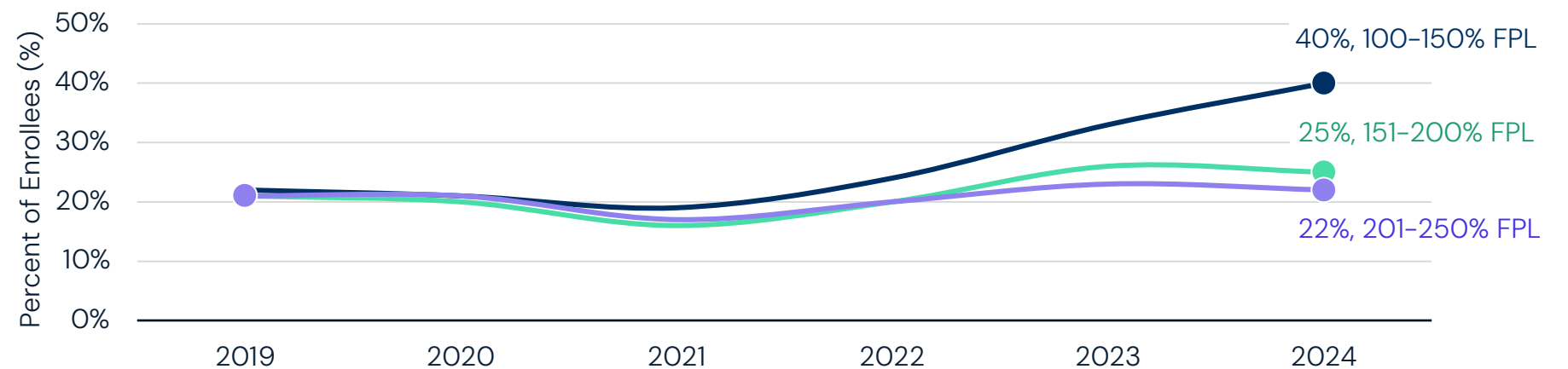
Improper Exchange Enrollment Is a Growing Source of Wasteful Spending

Exchange enrollment in the 100–150% FPL group – the income bracket that qualified for zero-premium plans under the American Rescue Plan Act’s 2021 subsidy – increased from 3.3M in 2019 to 10.9M in 2025, outpacing other income brackets. In this same group, 40% of enrollees had zero claims in 2024. This suggests that a large portion of enrollment growth was driven by fully subsidized plans that went unused. In tandem, improper and phantom enrollments reached 5.6M, or 25.3% of total enrollment, before decreasing to 2.6M (13.5%) in 2026 as verification efforts increased (e.g., income verification, elimination of the monthly special enrollment period for people at or below 150% FPL, removal of the automatic 60-day extension).

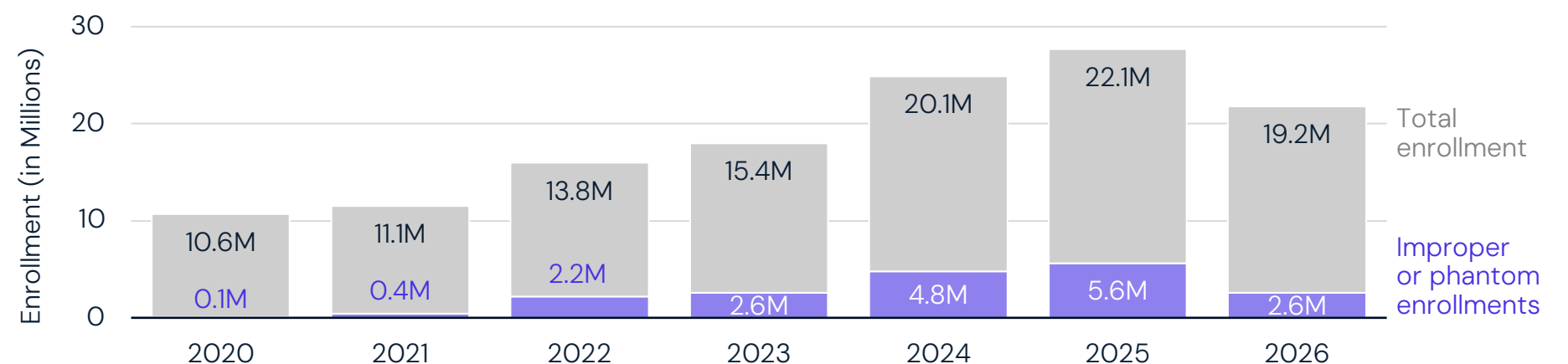
Exchange Enrollment, by FPL, 2019 and 2025



Share of Exchange Enrollees Without Healthcare Claims, by FPL, 2019–2024



Total Enrollment and Improper/Phantom Enrollments in Exchange Plans, 2020–2026



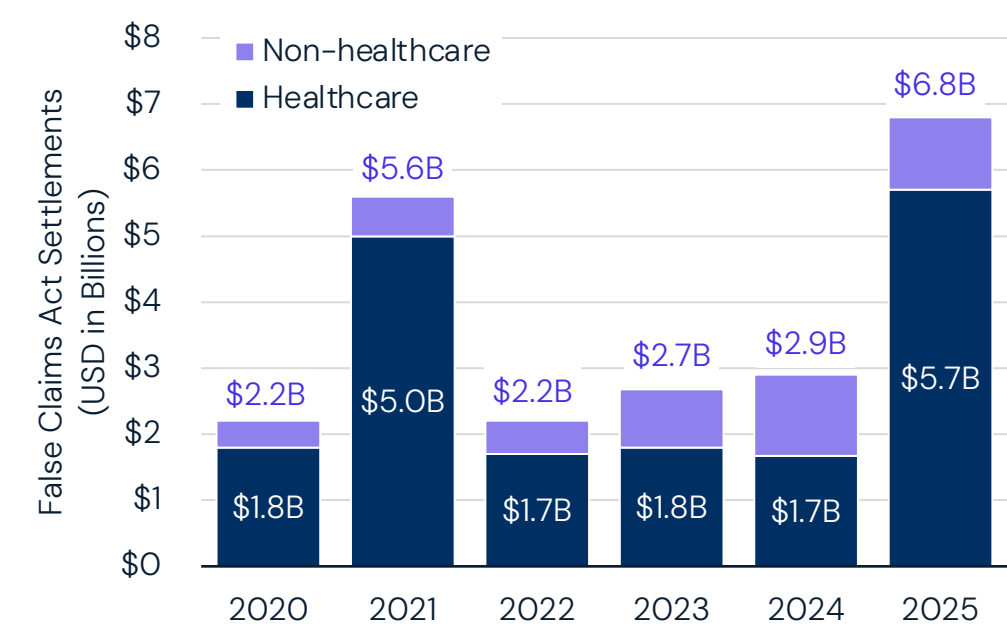
Note: FPL denotes federal poverty level.

Source: Department of Health and Human Services Assistant Secretary for Planning and Evaluation, ACA Exchange Enrollment, 2026.

MA Upcoding Fraud Leads to Major Settlements

False Claims Act settlements totaled \$6.8B in 2025, with 83.8% associated with healthcare cases. MA risk-adjustment fraud has driven some of the largest recent settlements, including a \$541.5M settlement with the Villages Health (now Humana/Centerwell) for retroactively adding ICD-10 codes months after patient visits. At the Villages Health, the share of ICD-10 codes unsupported by clinical evidence increased from 28.6% in 2020 to 50.7% in 2024.

False Claims Act Settlements, Healthcare and Non-Healthcare Cases, 2020-2025



PRESS RELEASE
The Villages Health System LLC Agrees to \$541.5M Settlement to Resolve False Claims Act Allegations

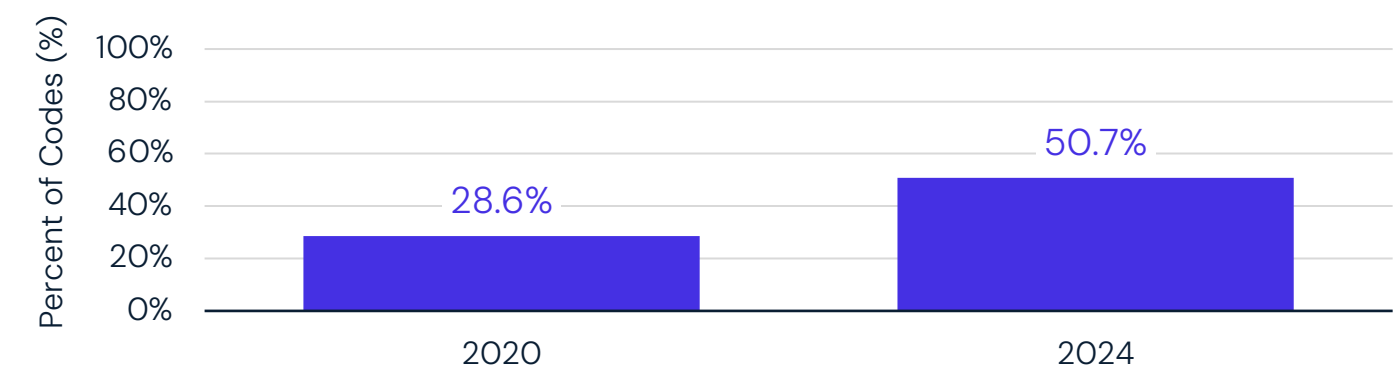
Aetna Agrees to Pay \$117.7 Million to Resolve Allegations that it Violated the False Claims Act by Submitting or Failing to Correct Inaccurate Diagnoses for Medicare Advantage Enrollees

Kaiser Permanente Affiliates Pay \$556M to Resolve False Claims Act Allegations

Overview of Select MA Fraud Settlements

Company	Settlement	Period	Mechanism
Kaiser Permanente	\$556.0M	2009-2018	Retroactive chart "addenda" adding diagnosis codes months to a year after visits
The Villages Health (now Humana/Centerwell)	\$541.5M	2020-2024	Retroactive chart "amendments" and "sprints" adding diagnosis codes months to a year after visits
Aetna	\$117.7M	2015 and 2018-2023	Used chart reviews to add diagnoses that increased payment but ignored the same reviews when they showed overpayments it should have refunded

Share of ICD-10 Codes Unsupported by Clinical Evidence at The Villages Health, 2020 and 2024

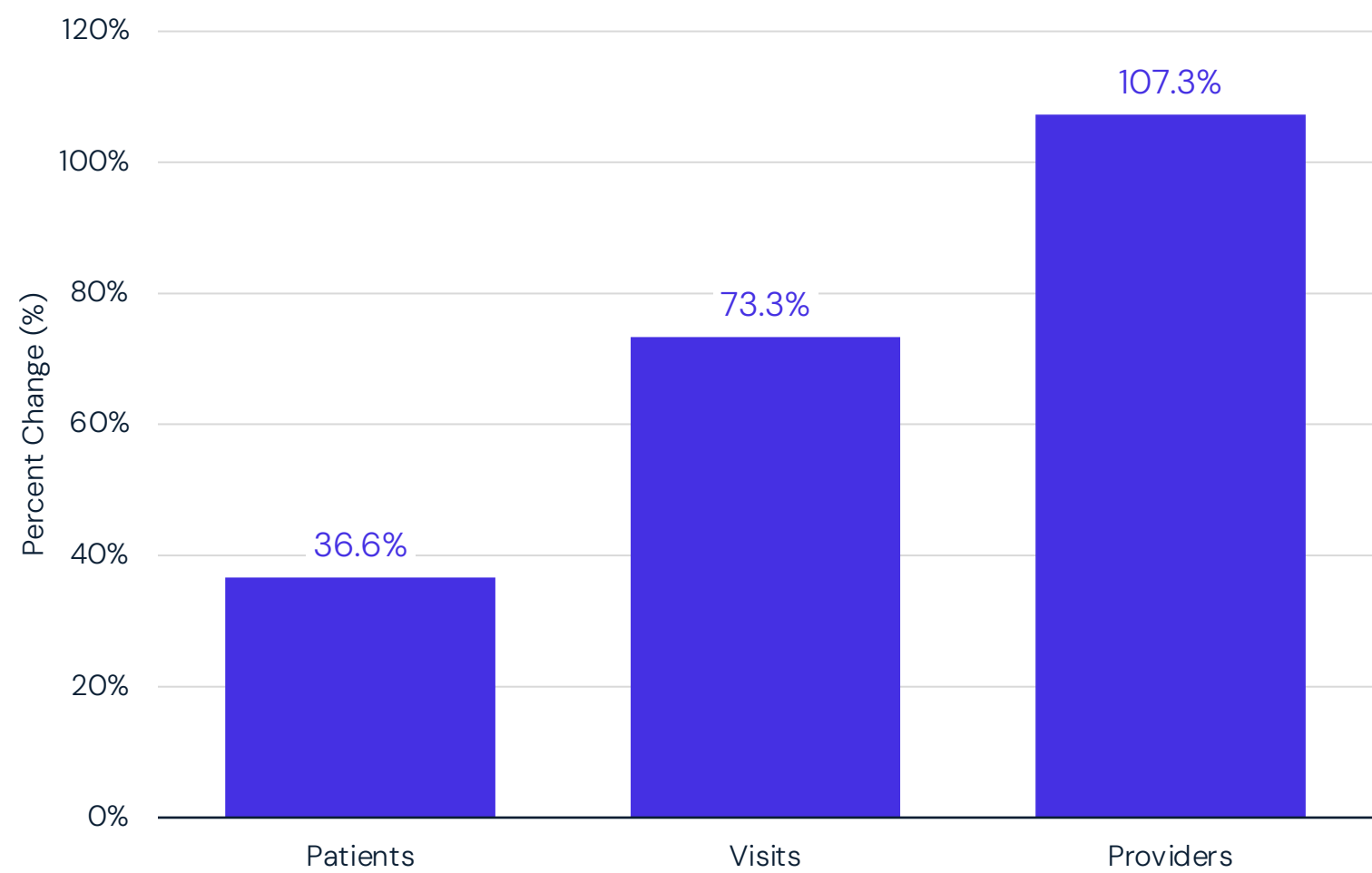


Note: MA denotes Medicare Advantage. Risk-adjustment fraud occurs when Medicare Advantage plans submit inaccurate data to CMS that their members are sicker than they truly are, resulting in a higher payout.
Source: Department of Justice; Becker's Payer Issues; Healthcare Dive.

The Number of ABA Providers Doubled In Three Years

Medicaid expanded ABA therapy coverage following 2014 Federal guidance from CMS, with all 50 states offering coverage by 2022. Between 2022 and 2025, distinct patients increased 36.6% and visit volume increased 73.3%. In the same period, the number of distinct providers delivering ABA services increased by 107.3%. In some states, ABA providers have been the subject of Medicaid fraud investigations.

Percent Change in Number of ABA Distinct Patients, Visits and Providers, 2022 to 2025



Note: ABA denotes applied behavioral analysis; CMS denotes Centers for Medicare & Medicaid Services.
Source: Trilliant Health national all-payer claims database; publicly available news sources.

THE WALL STREET JOURNAL.

The Boom in Autism Therapy Is Medicaid’s Fastest-Growing Jackpot



**United States Attorney’s Office
District of Minnesota**

PRESS RELEASE

First Defendant Charged in Autism Fraud Scheme

STAT+ | POLITICS

Federal Medicaid audit finds massive overpayment for autism therapy in Colorado

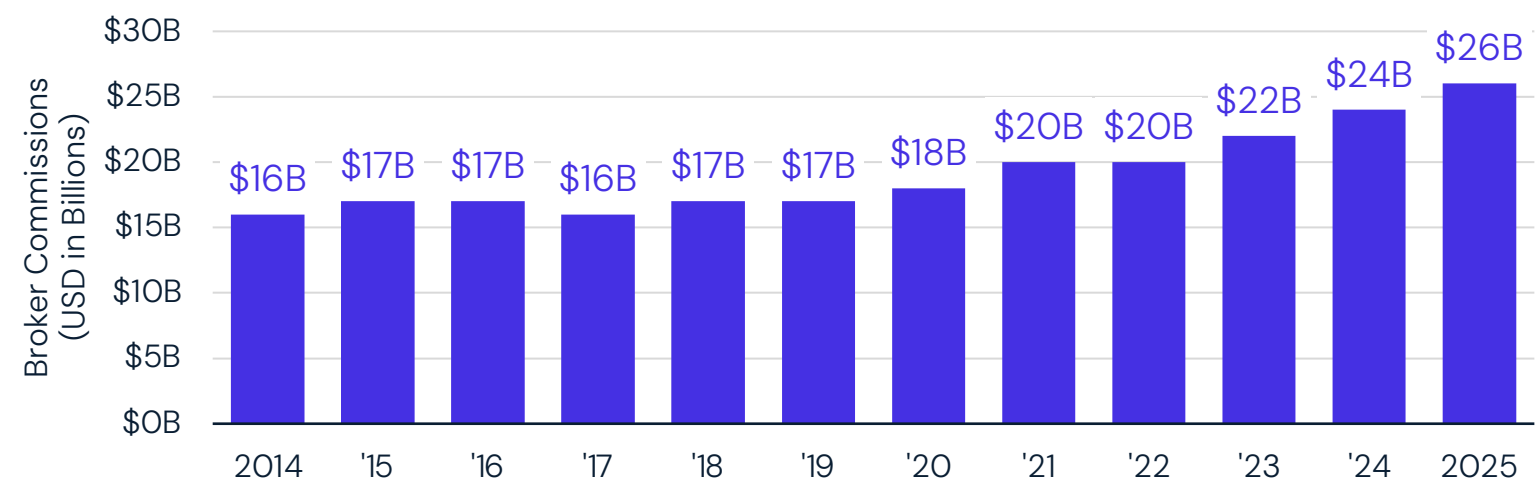
The HHS OIG uncovered \$285.2 million in improper and potentially improper payments

FRAUD, WASTE, ABUSE

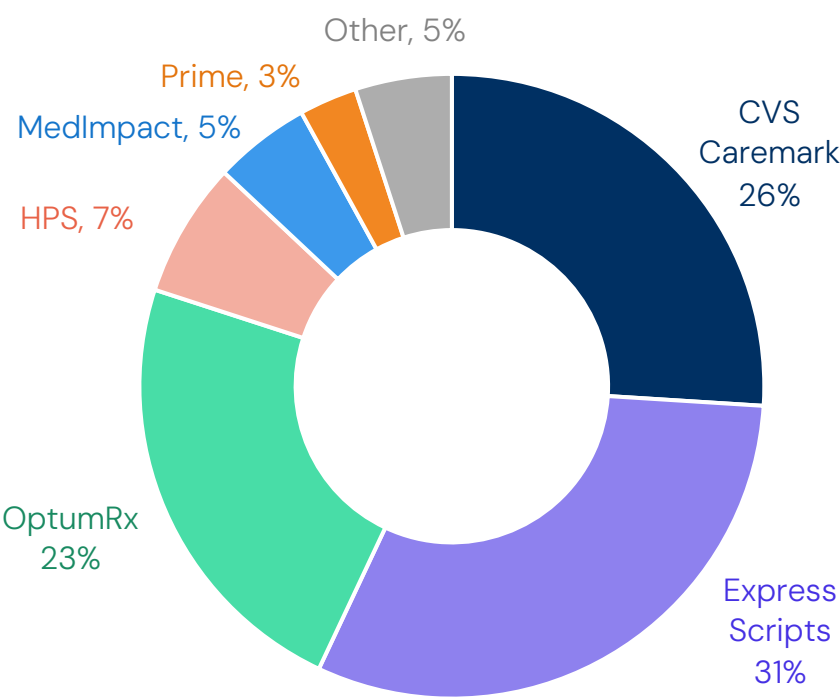
Middlemen in Healthcare Add Cost and Complexity, Not Efficiency

Healthcare middlemen continue to grow revenue, rather than streamline the healthcare system as initially intended. Total annual broker commissions increased from \$16B in 2014 to \$26B in 2025, and TPA revenue is projected to grow from \$106.6B to \$156.2B by 2035. Similarly, PBM revenue is projected to grow from \$609.1B in 2025 to \$991.9B in 2034. Notably, 80% of PBM market share is concentrated among the “Big Three” (i.e., CVS Caremark, Express Scripts and OptumRx).

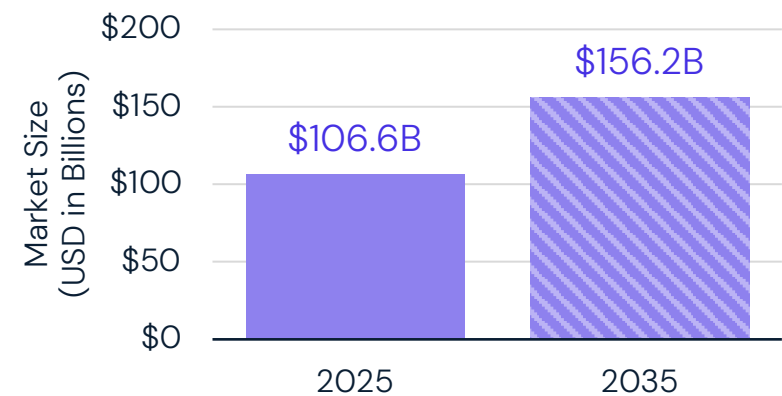
Total Annual Commissions Paid to Brokers by Insurance Companies, 2014–2025



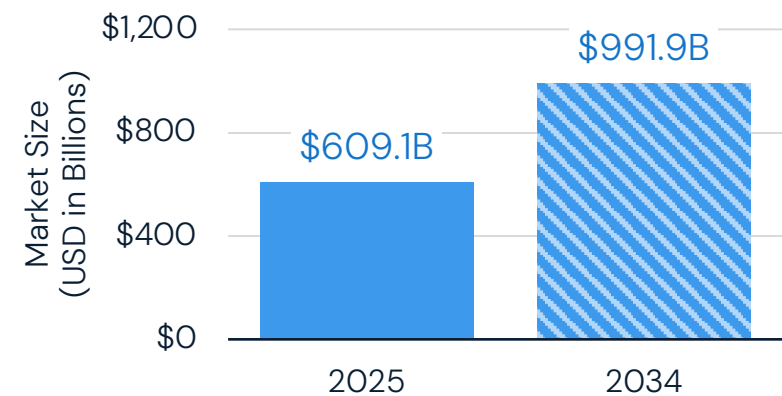
Share of Total Equivalent Prescription Claims Managed, by PBM, 2025



U.S. Health Insurance TPA Revenue, 2025 and 2035



Global PBM Revenue, 2025 and 2034



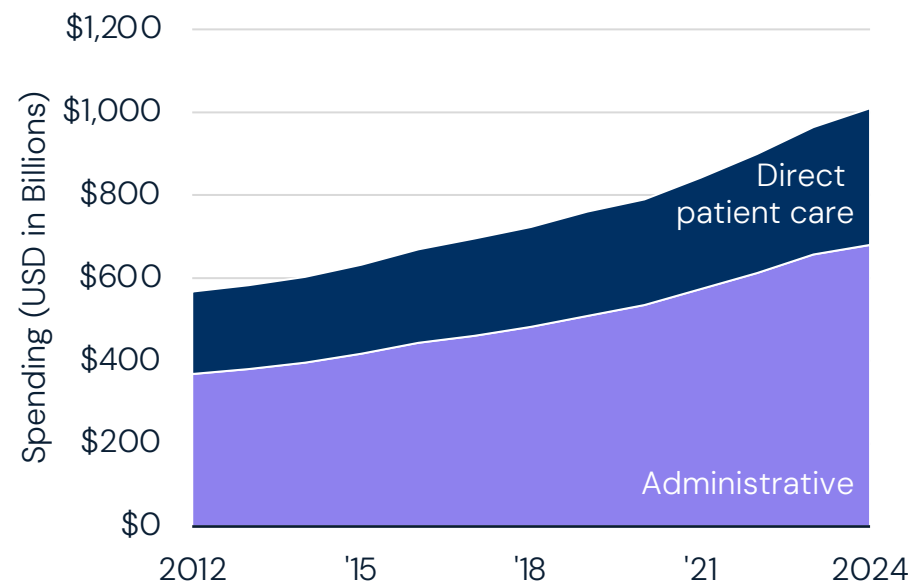
Note: TPA denotes third party administrator; PBM denotes pharmacy benefit manager; HPS denotes Humana Pharmacy Services. Figures represent broker fees and direct sales costs per member per month (PMPM), combining commissions paid to independent brokers/agents with salaries and benefits for insurers’ in-house direct sales staff.
Source: KFF; DrugChannels; U.S. Senate Joint Economic Committee; Next Move Strategy Consulting; Fortune Business Insights.

FRAUD, WASTE, ABUSE

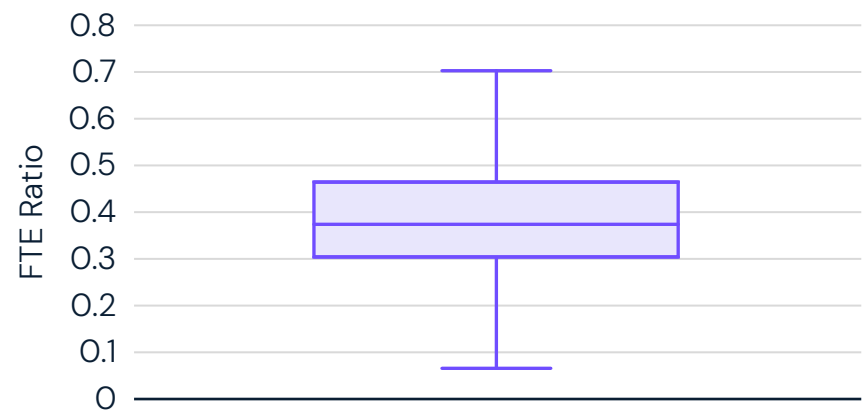
U.S. Spending on Health Administration Exceeds Peers'

In 2024, administrative health expenditures represented 7.4% of total U.S. health expenditures, more than twice the OECD average of 3.5%. U.S. hospitals also spent twice as much on administration (\$679.4B) than direct patient care (\$330.3B). The median ratio of administrative to direct patient care FTE in U.S. hospitals was 0.4, meaning there were four administrative FTE for every 10 patient care FTE.

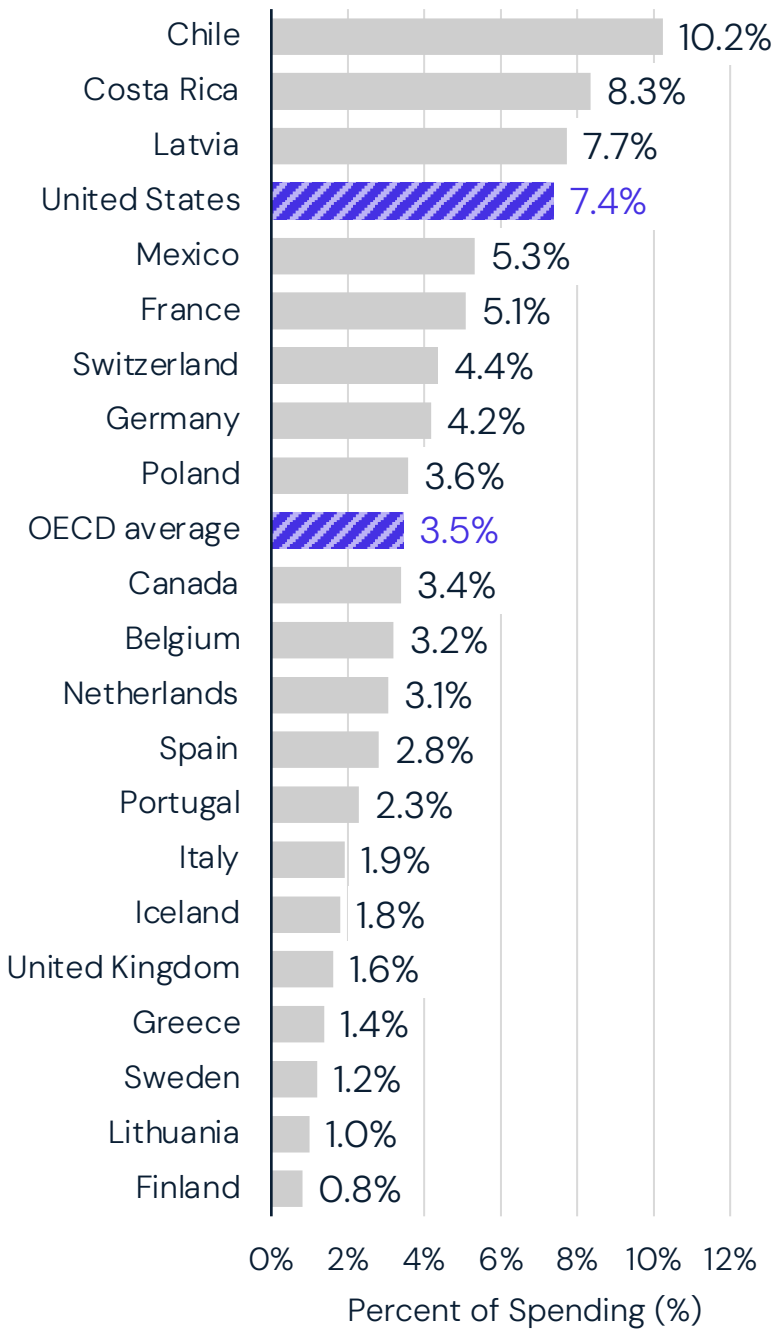
Expenditures at U.S. Hospitals, by Type, 2011-2024



Administrative vs. Patient Care FTE Ratio at U.S. Hospitals, 2024



Share of Health Expenditures Spent on Administration in Select OECD Countries, 2024



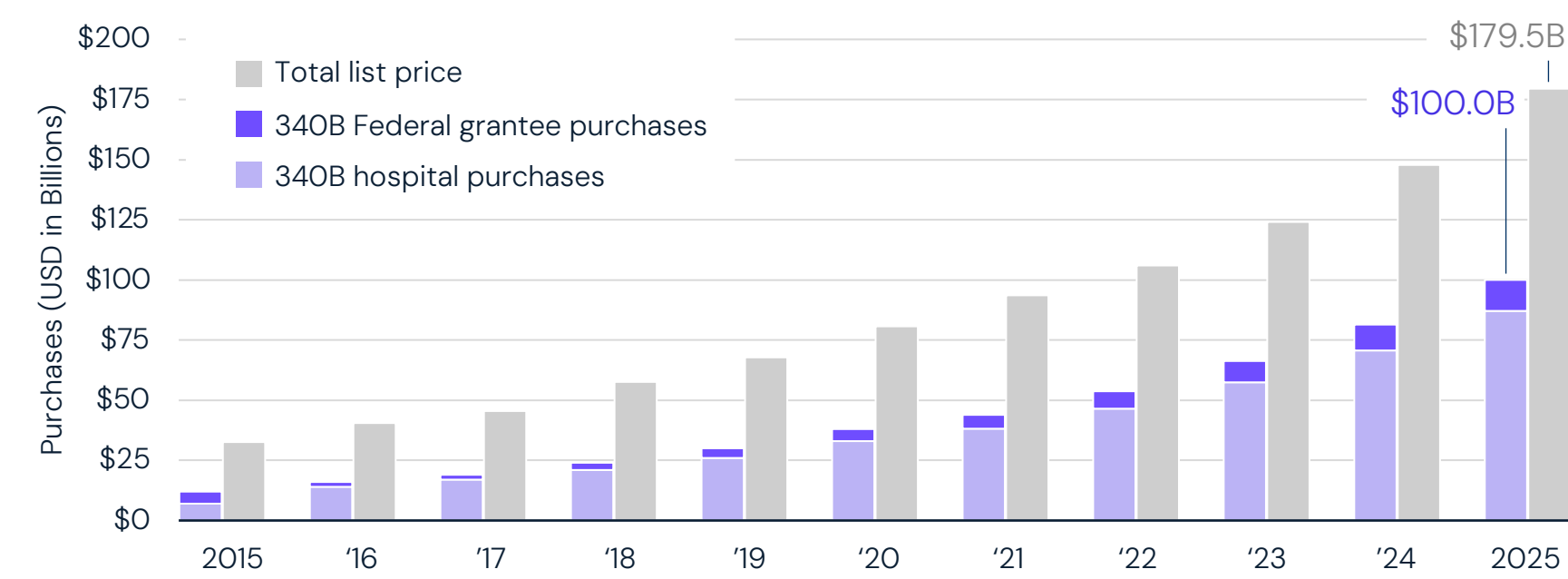
Note: OECD denotes Organisation for Economic Co-operation and Development; FTE denotes full time equivalent. The OECD average is computed from all available countries' data, not just those shown.
Source: Organisation for Economic Co-operation and Development; National Academy for State Health Policy Hospital Cost Tool.

FRAUD, WASTE, ABUSE

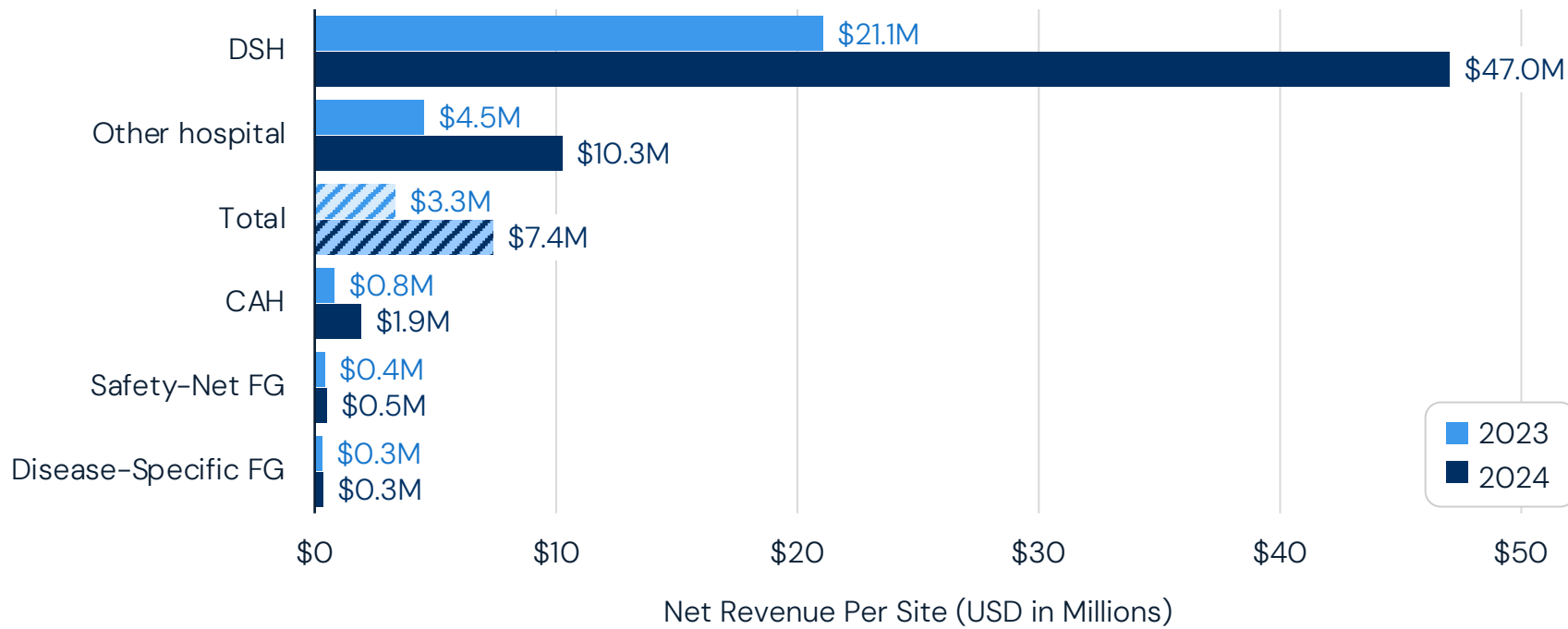
As 340B Spending Multiplies, Revenue Accrues to Hospitals

The 340B Drug Pricing Program enables covered entities to purchase outpatient prescription drugs at discounted prices. In 2025, 340B participants purchased \$100.0B of discounted drugs, which otherwise would have cost \$179.5B. Notably, hospitals were responsible for 87.1% of drug spending but only account for approximately 60% of covered entities. Hospitals also generated more revenue from the program than Federal grantees, with DSHs in Minnesota netting an average of \$47.0M per hospital in 2024, compared to an average of \$0.5M at safety-net Federal grantees.

Drug Purchase Amounts at 340B Discounted Prices vs. List Prices, 2015–2025



Average Net 340B Revenue Among Minnesota Facilities, by Entity Type, 2023 and 2024

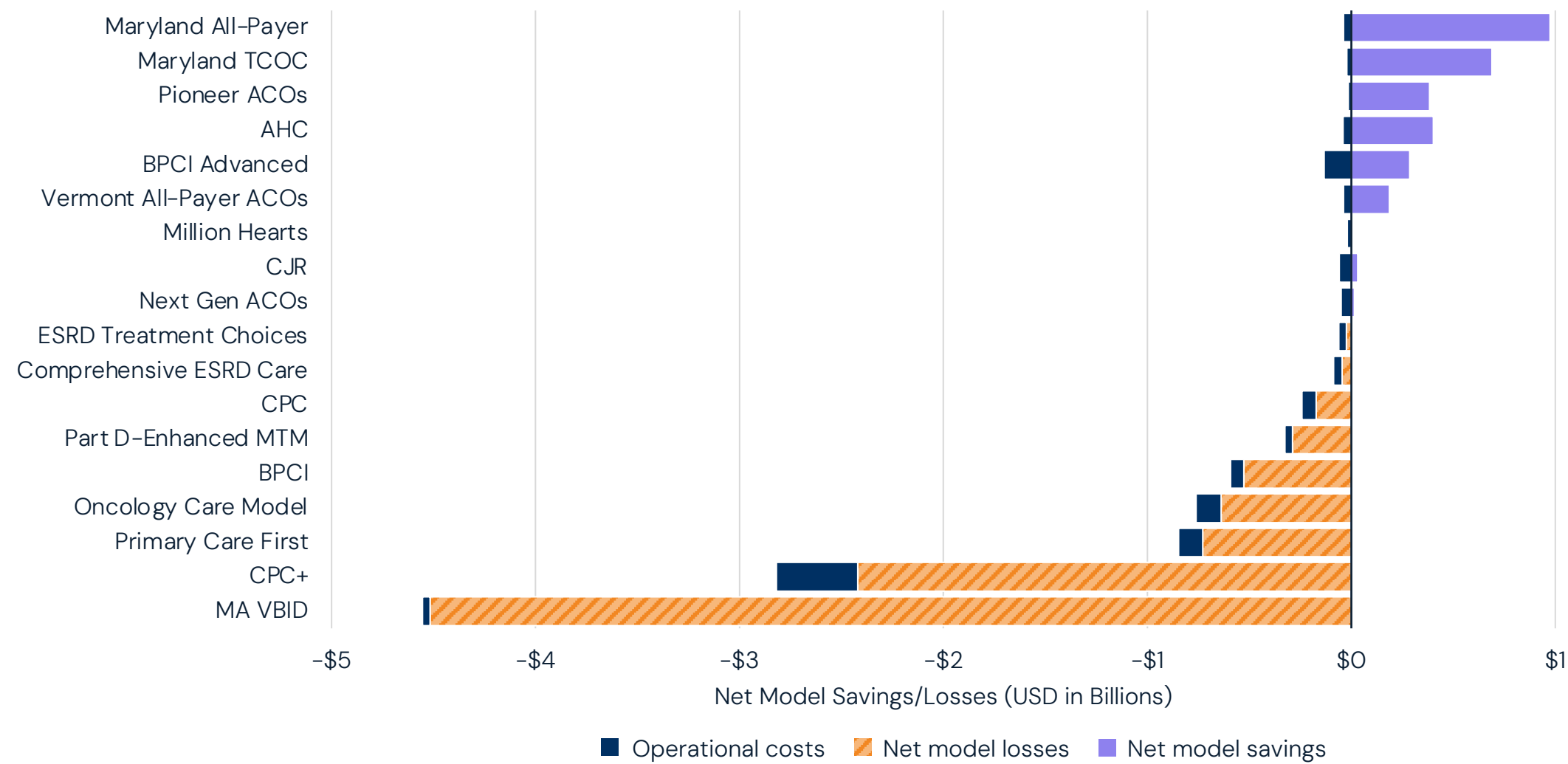


Note: DSH denotes Disproportionate Share Hospital; CAH denotes Critical Access Hospital; FG denotes Federal grantee.
Source: Drug Channels; Minnesota Department of Health.

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 net losses from APMs launched between 2012 and 2025.

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

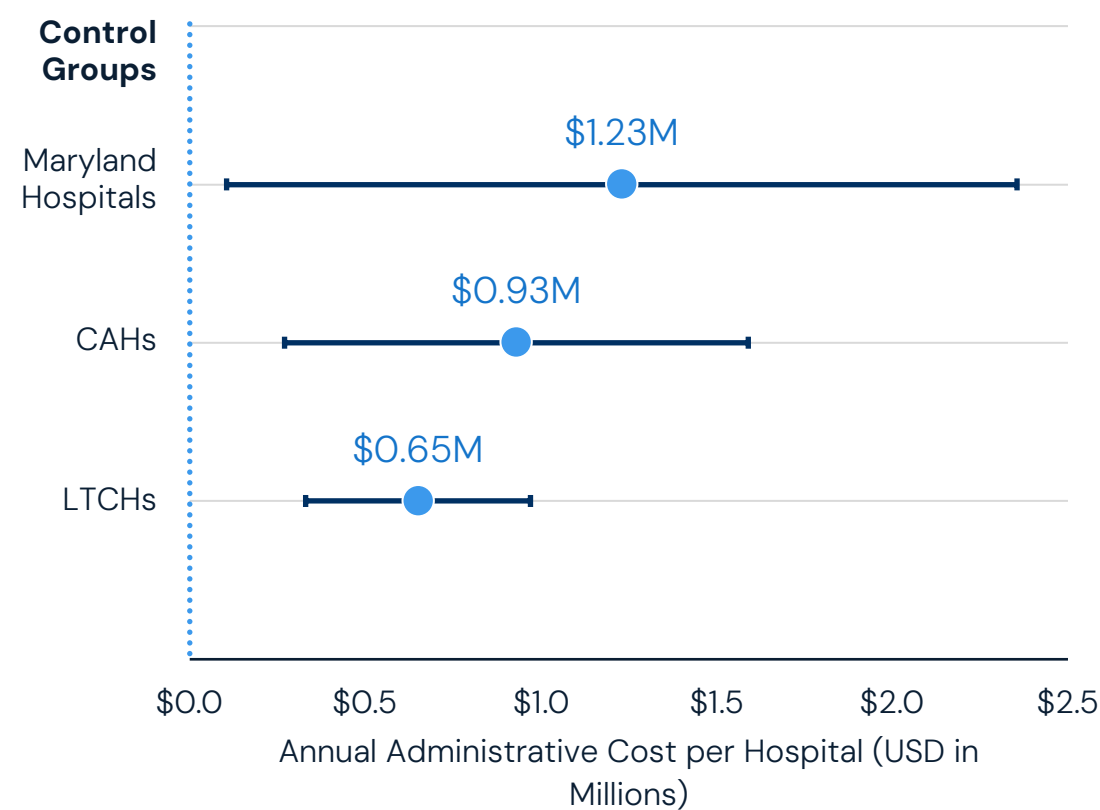


Note: APM denotes alternative payment model; CMMI denotes Centers for Medicare & Medicaid Innovation; TCOC denotes total cost of care; ACO denotes accountable care organization; AHC denotes accountable health communities; BPCI denotes bundled payments for care improvement; CJR denotes comprehensive care 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 & Medicaid Services; Avalere Health, Analysis of CMMI Model Costs, Quality Performance, and Transparency.

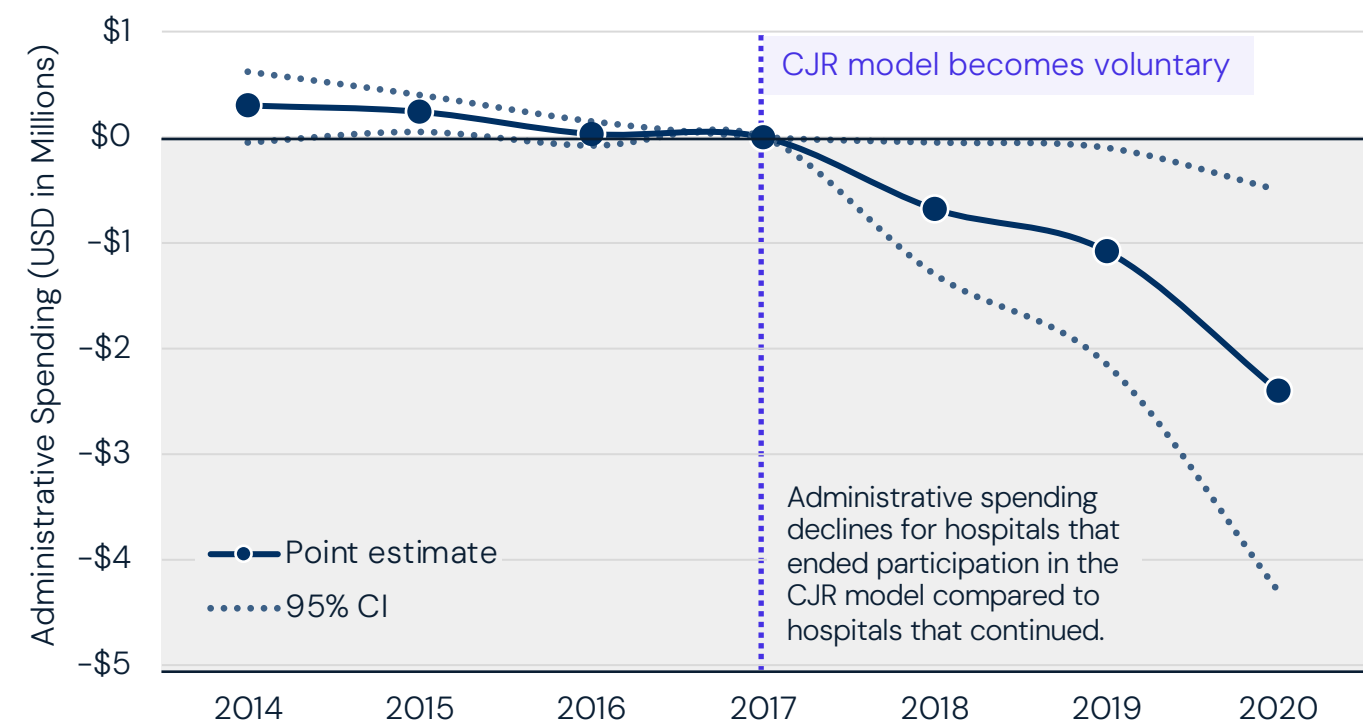
Mandatory VBC Programs Added \$3B in Administrative Costs

Participation in mandatory VBC programs was associated with \$3B in additional annual administrative spending between FY 2008 and FY 2017. Across control types, hospitals participating in mandatory programs (i.e., HVBP, HRRP, HACRP) had \$0.94M more annual administrative spending on average than control hospitals. After the CJR model became voluntary in 2017, hospitals that ended CJR participation had \$0.85M lower administrative costs than those that continued participating.

Effect of Mandatory Universal VBC Models on Administrative Spending in Participating Hospitals Compared to Control Hospitals, FY 2008–2017



Difference in Administrative Spending Between Hospitals That Ended vs. Continued CJR Model Participation, 2014–2020



Note: FY denotes fiscal year; VBC denotes value-based care; CJR denotes Comprehensive Joint Replacement Model; CAH denotes critical access hospital; LTCH denotes long-term acute care hospital; HVBP denotes Hospital Value-Based Purchasing; HRRP denotes Hospital Readmissions Reduction Program; HACRP denotes Hospital-Acquired Condition Reduction Program; CI denotes confidence interval. Mandatory universal VBC programs include the HVBP, HRRP, HACRP. Mandatory VBC programs include all of the universal programs as well as the CJR model.

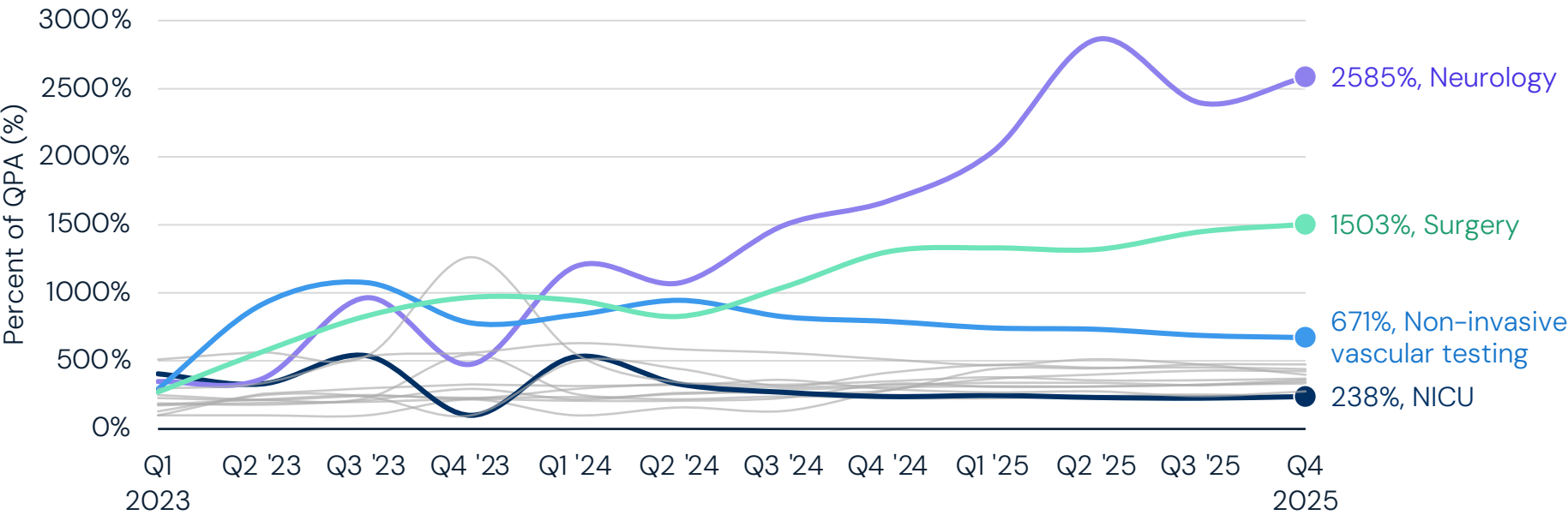
Source: Zhou et al, Mandatory Value-Based Payment Programs and Hospital Administrative Costs, *JAMA Health Forum*, 2026.

FRAUD, WASTE, ABUSE

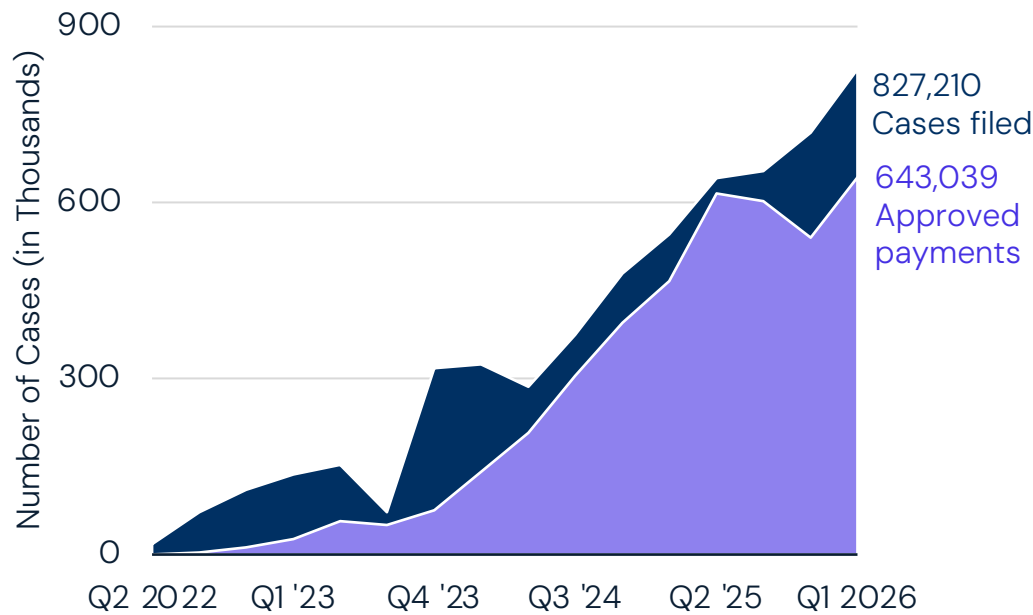
The No Surprises Act Is Big Business for Providers and Middlemen

Despite its goal of protecting patients from unexpected medical bill, the No Surprises Act has become a growing source of revenue for some providers. Claims resolved through independent dispute resolution (IDR) often award providers twice as much as the qualifying payment amount (QPA), with specialties like neurology receiving an average IDR reimbursement that is 2,585% of the QPA. Some companies have built entire business models around helping providers maximize these payouts. For example, HaloMD alone accounted for 22% of all IDR filings in 2025.

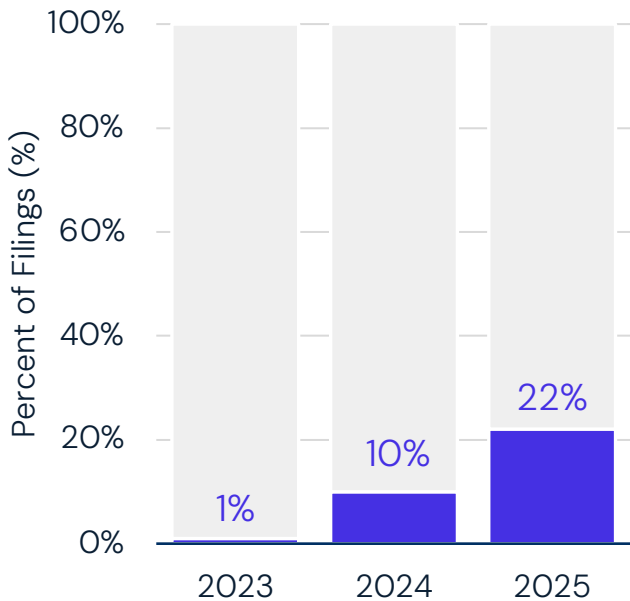
Median Prevailing IDR Offer Relative to QPA, by Specialty, Q1 2023–Q4 2025



Number of Filed and Approved IDR Cases, Q2 2022–Q1 2026



Share of All IDR Filings by HaloMD, 2023–2025



Note: IDR denotes independent dispute resolution; QPA denotes qualifying payment amount; NICU denotes inpatient neonatal intensive care services and pediatric and neonatal. IDR is the process of settling payment disputes between providers and insurers for out-of-network reimbursement. QPA is the median contracted rate for a medical service in a specified geographic region. Neurology includes neurology and neuromuscular procedures. HaloMD share for 2024 and 2025 is from Q2.

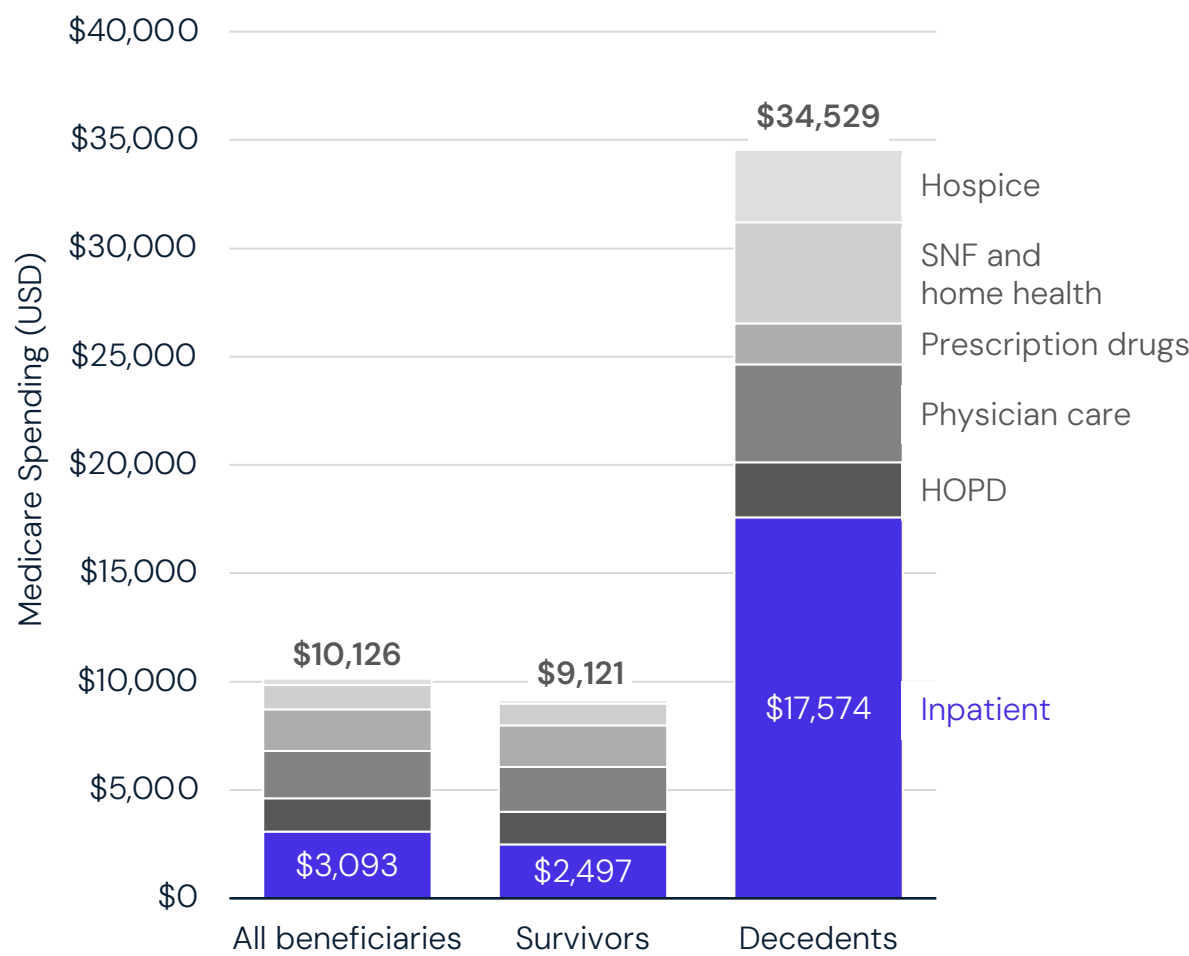
Source: Centers for Medicaid & Medicare Services; Georgetown University Center on Health Insurance Reforms; Hoadley et al., The Substantial Costs Of The No Surprises Act Arbitration Process, *Health Affairs*, 2025; Hoadley et al., The No Surprises Act ADR Process: An Early Look At 2025 Data, *Health Affairs*, 2026.

FRAUD, WASTE, ABUSE

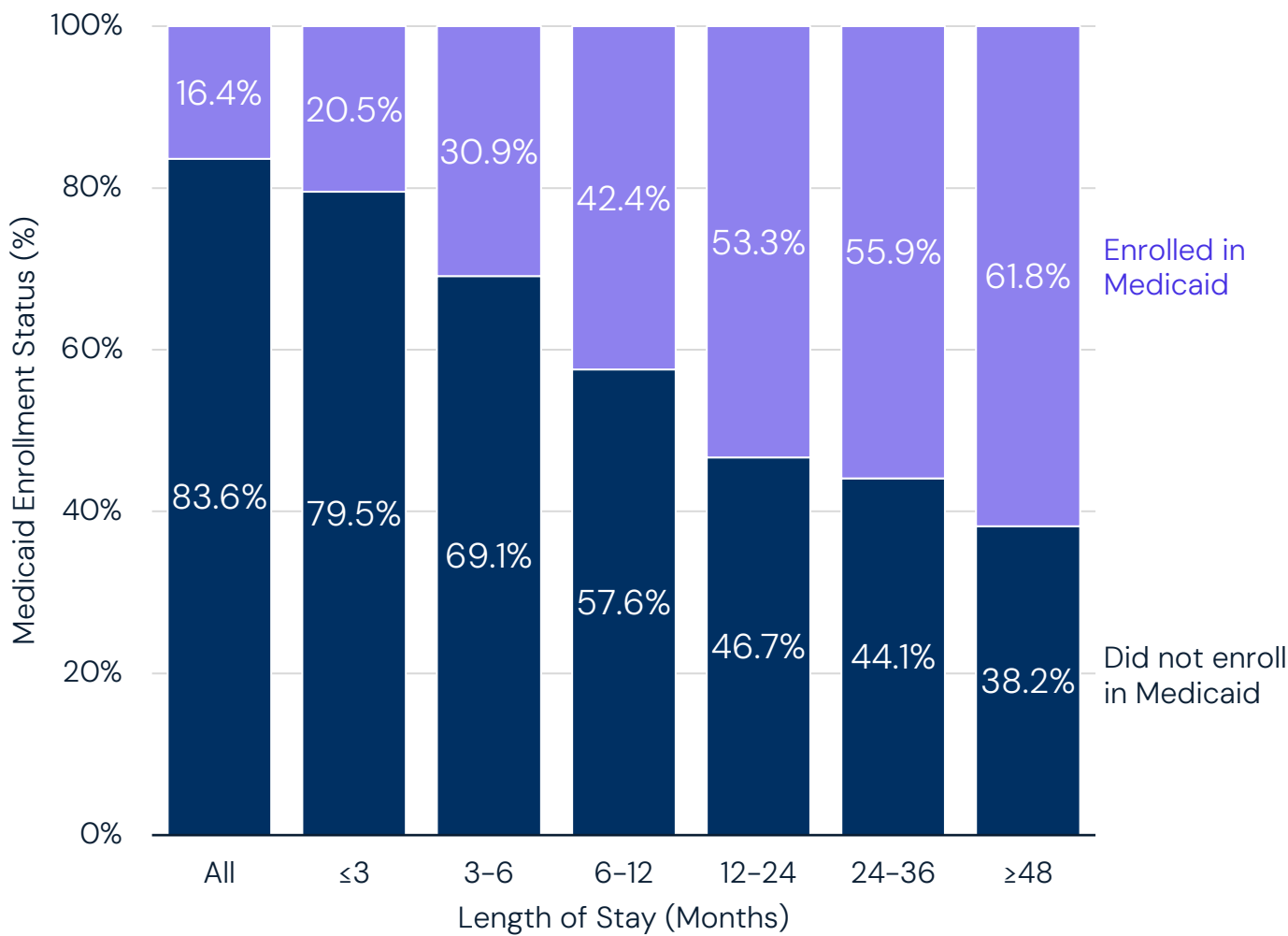
Patients Are Incentivized to Spend Down Assets to Access Long-Term Care

Medicare spending in the last year of life averaged \$34,529 per beneficiary in 2014, more than 3x the average per capita cost. Most of this spending (50.5%) is for inpatient care. Given these costs, many Medicare beneficiaries exhaust their assets to qualify for Medicaid, which covers expenses that would otherwise be paid out of pocket. Among nursing home residents who initially paid out of pocket, 61.8% had spent down into Medicaid after four years.

Average Medicare Spending per Beneficiary, by Survival Status and Service Category, 2014



Spend-Down Rate Among Nursing Home Residents Not Initially Enrolled in Medicaid, by Length of Stay, 2018–2022



Note: HOPD denotes hospital outpatient department; SNF denotes skilled nursing facility. Sample sizes among those initially non-Medicaid enrolled are N=126,626 (All), N=48,613 (3 months), N=37,380 (6 months), N=27,775 (1 year), N=16,687 (2 years), N=9,849 (3 years) and N=4,644 (4 or more years). These denominators shrink at each time point because the sample is restricted to residents who were alive and still in the nursing home at that point. As a result, the time-point estimates are not directly comparable to one another or to the "All" estimate, since each reflects a different (and progressively smaller) subset of the original cohort.

Source: KFF; Aboulafia, G. et al., Asset Spend-Down and Medicaid Enrollment in Nursing Homes. *JAMA Network Open*. 2025.

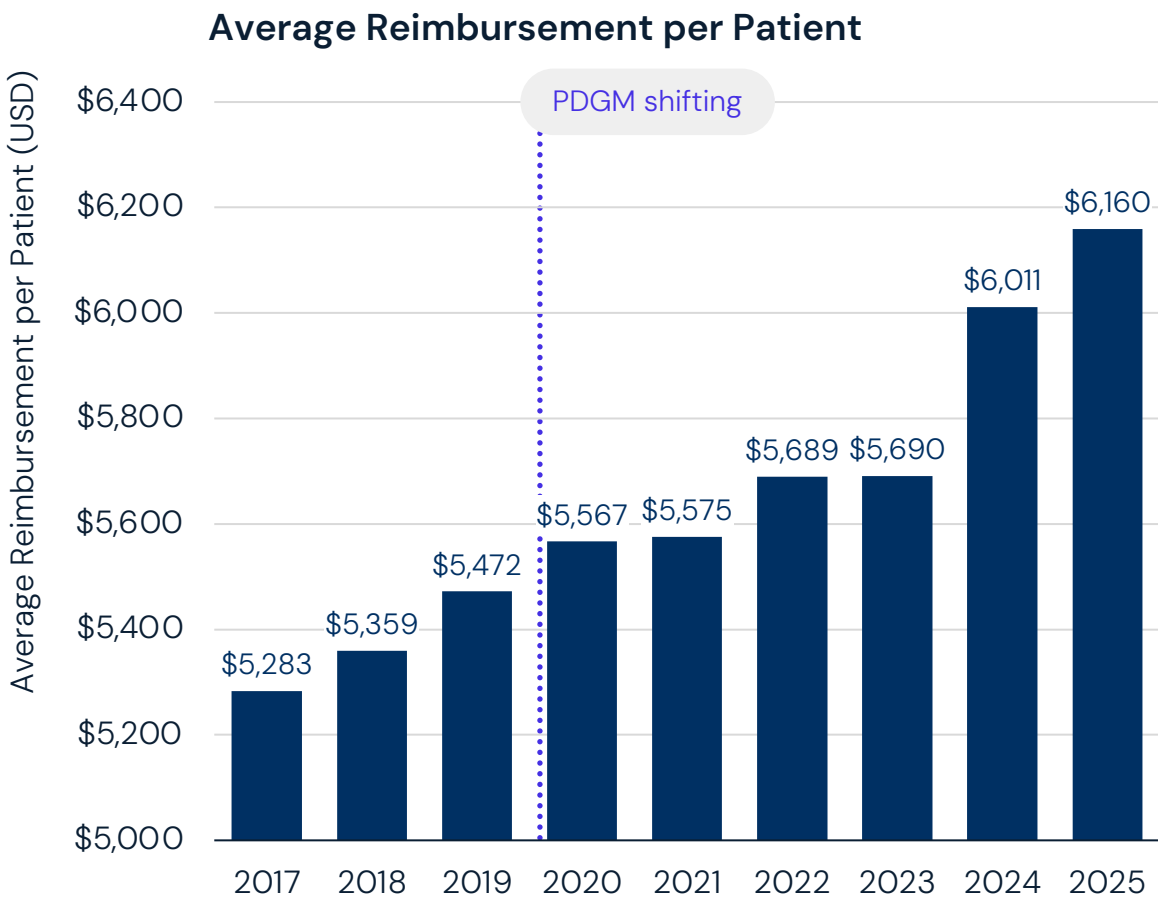
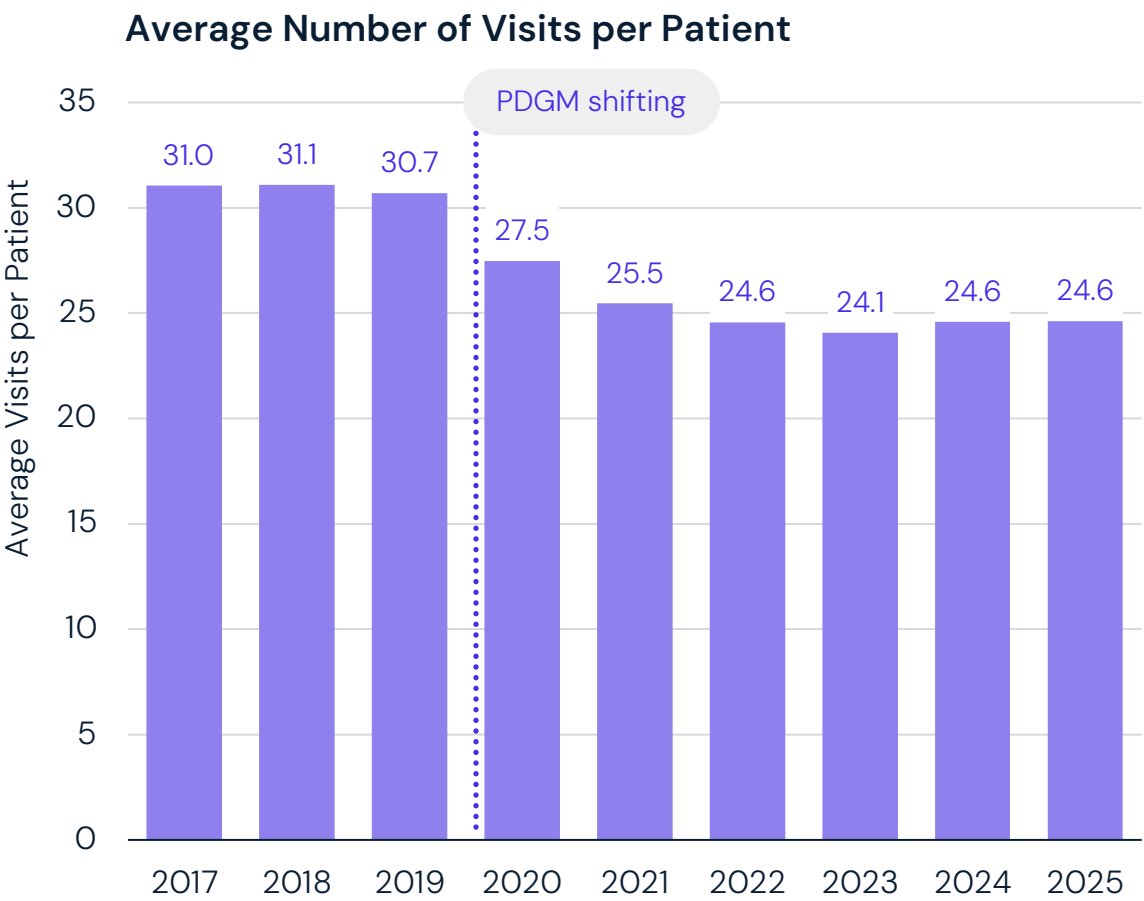
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Home Health Acuity Increased After Payment Incentives Changed

Between 2017 and 2025, Medicare home health visits per patient decreased 20.7%, while average reimbursement per patient increased 16.6%. These trends align with a change in corresponding Medicare payment structure, from visit-based to diagnosis-coded case-mix payments, which creates an incentive to inflate OASIS function-status scores rather than grow revenue through additional visits.

Average Medicare Home Health Reimbursement and Visits per Patient, 2017-2025

January 1, 2020: CMS implements PDGM shifting from 60-day utilization-based payments to 30-day acuity-based payments



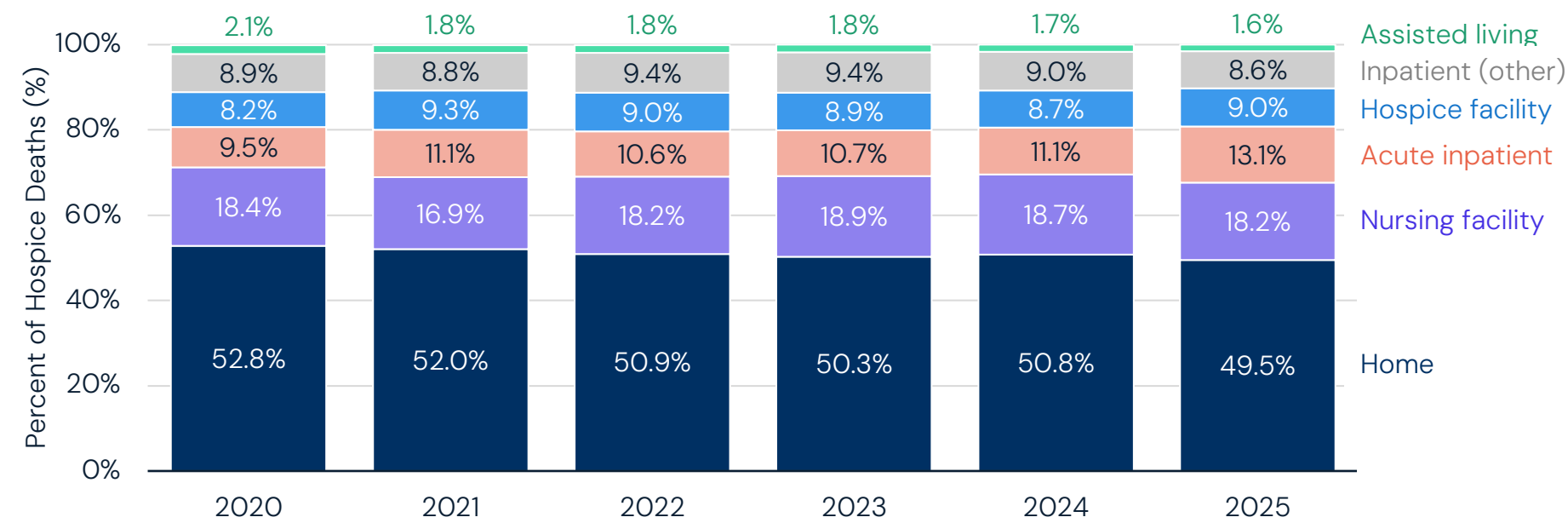
Note: PDGM denotes Patient-Driven Groupings Mode; OASIS denotes Outcome and Assessment Information Set.
Source: Centers for Medicare & Medicaid Services.

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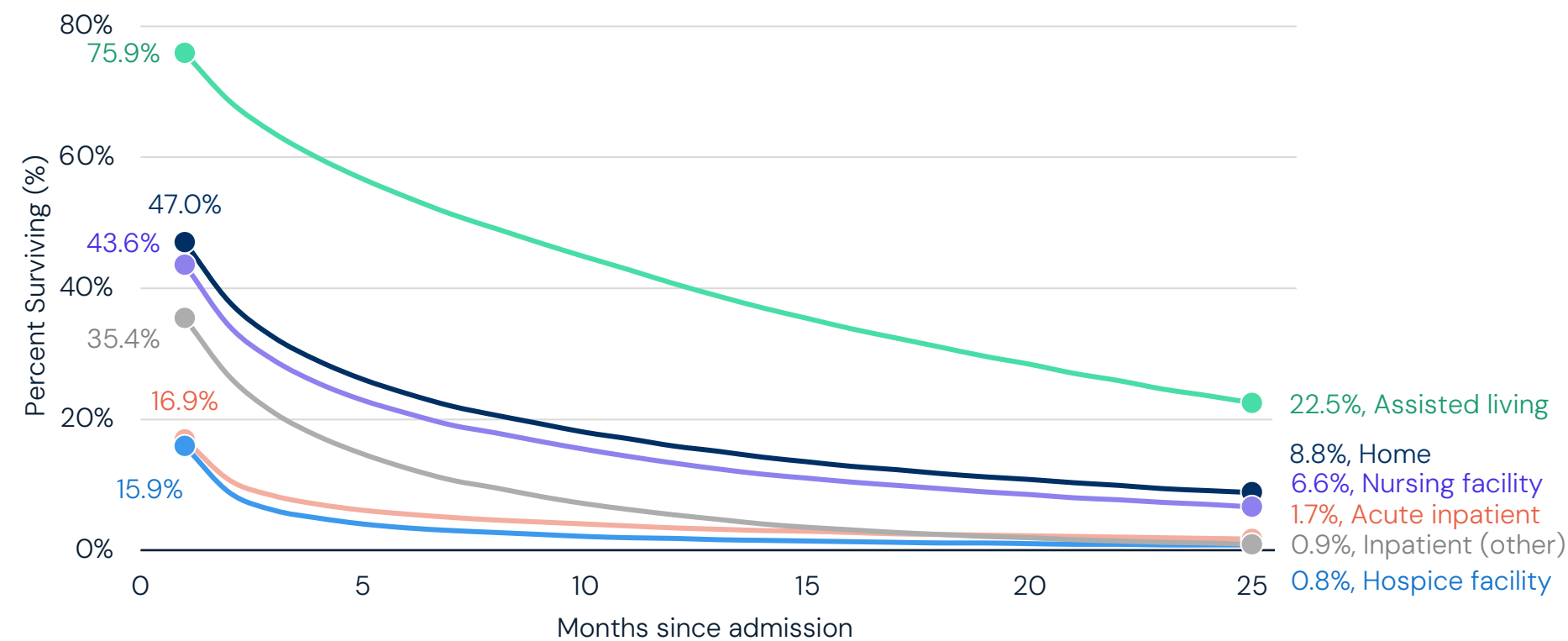
Medicare Payment Incentives Lead to More Facility-Based Deaths

Despite patient preferences, a decreasing share of hospice patients are dying at home, down from 52.8% in 2020 to 49.5% in 2025. Meanwhile, the proportion of inpatient hospice deaths has increased by 3.3 PP, from 18.4% to 21.7%. Notably, hospice patient survival varies widely by care setting, with implications for guideline-concordant hospice use.

Share of Hospice Deaths, by Setting, 2020–2025



Survival After Hospice Admission, by Initial Setting, 2020–2023



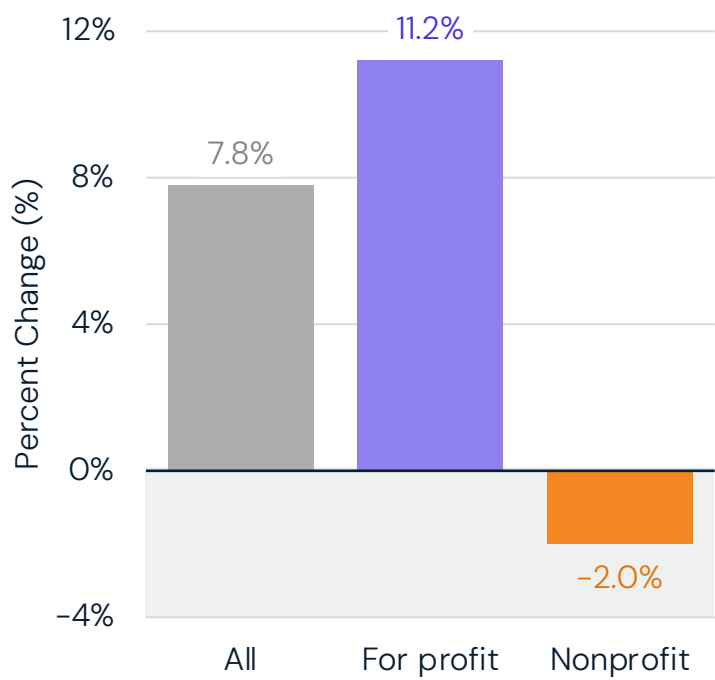
Note: PP denotes percentage point. Percentages may not add to 100% due to rounding.
Source: Trilliant Health national all-payer claims database and Provider Directory; Pinto et al., Patient and Family Preferences About Place of End-of-Life Care and Death: An Umbrella Review, *Journal of Pain and Symptom Management*, 2024.

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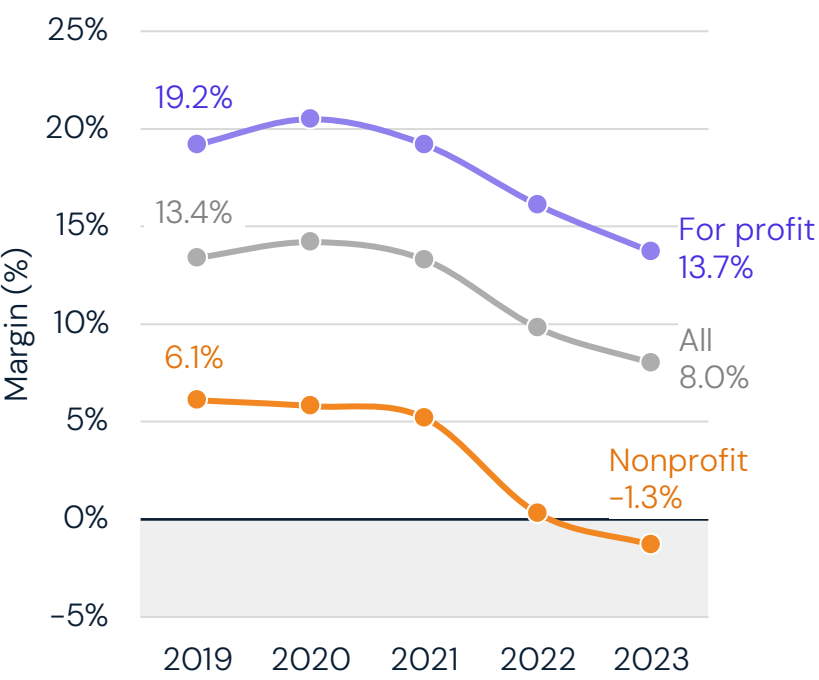
For-Profit Hospice Ownership Is Associated With Longer Stays and Higher Margins

From 2019 to 2024, the number of Medicare-participating hospices increased 7.8%. The number of for-profit hospices increased 11.2%, while nonprofit hospices decreased 2.0%. In 2024, length of stay at for-profit hospices averaged 120 days, compared to 71 days at nonprofit hospices. For-profit hospices have the highest Medicare margins, 13.7% in 2023 compared to 8.0% among all hospices and -1.3% among nonprofit hospices.

Percent Change in Number of Medicare-Participating Hospices, by Ownership Type, 2019-2024



Hospice Medicare Margins, by Ownership Type, 2019-2023



Hospice Length of Stay Among Decedents, in Days, by Ownership Type, 2024

	Average LOS	10 th percentile	50 th percentile	90 th percentile
For profit	120	3	25	359
Nonprofit	71	2	13	195

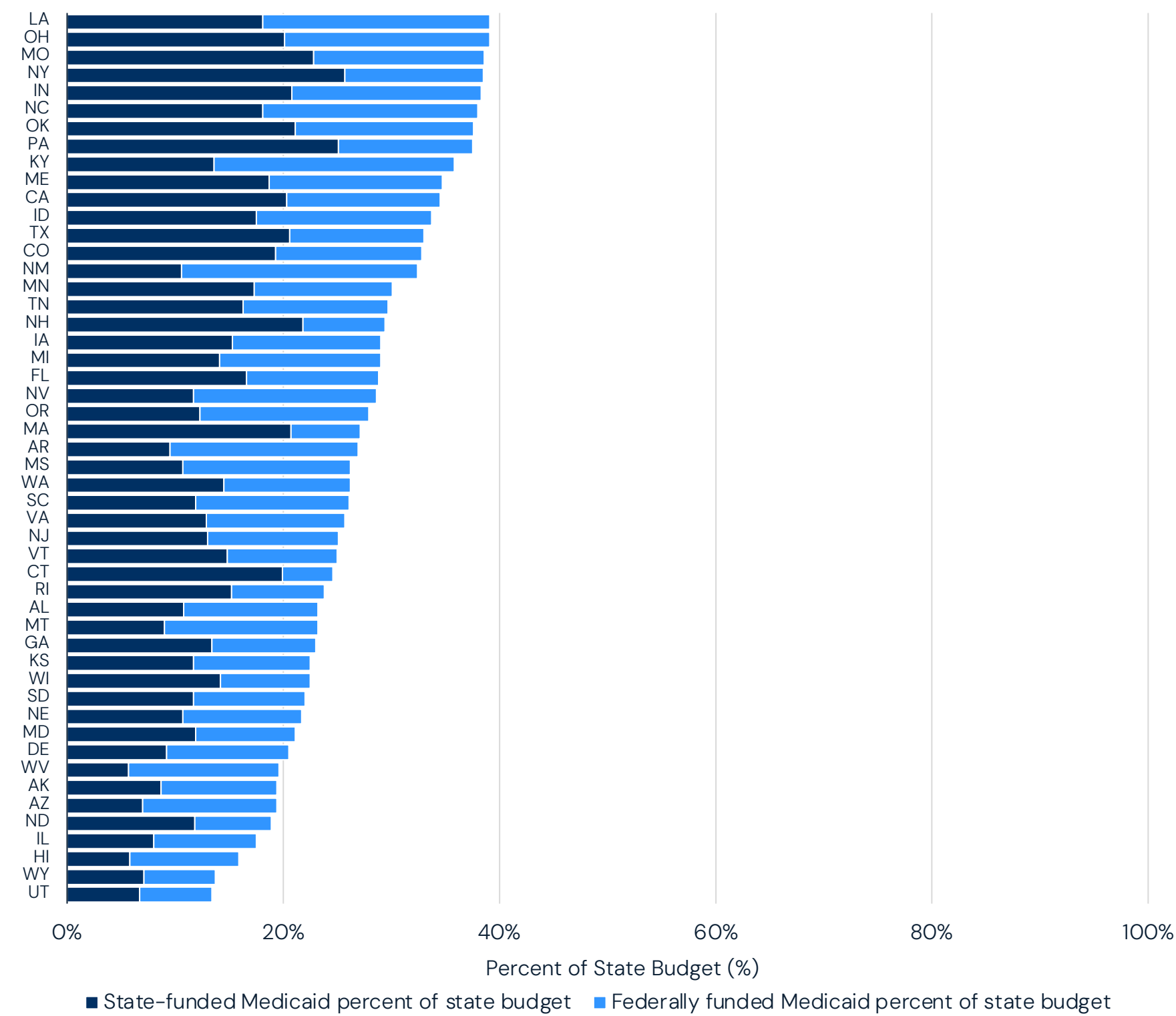
Source: Medicare Payment Advisory Commission July 2026 Data Book.

FRAUD, WASTE, ABUSE

Disproportionate Medicaid Share of State Budgets Raises Oversight Concerns

Combined state and Federal spending on Medicaid accounts for an average of 27.4% total state budgets, ranging from 13.4% in Utah to 39.1% in Louisiana and Ohio. The state-funded Medicaid share of total state budgets also varies, from 5.8% in Hawaii to 25.7% in New York, reflecting different levels of financial exposure.

Medicaid Spending as a Share of the Total State Budget, by Funding Source, by State FY 2024



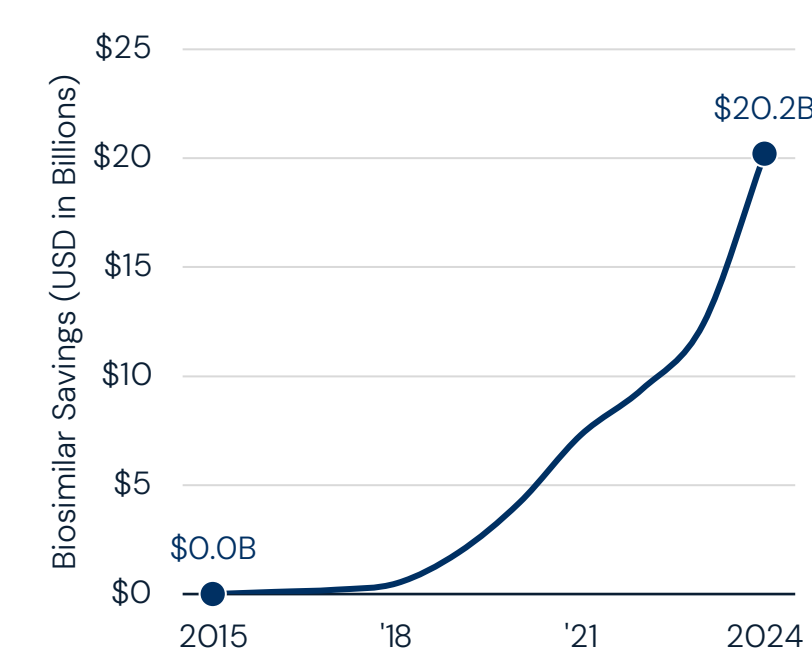
Source: National Association of State Budget Officers, Expenditure Report, 2025.

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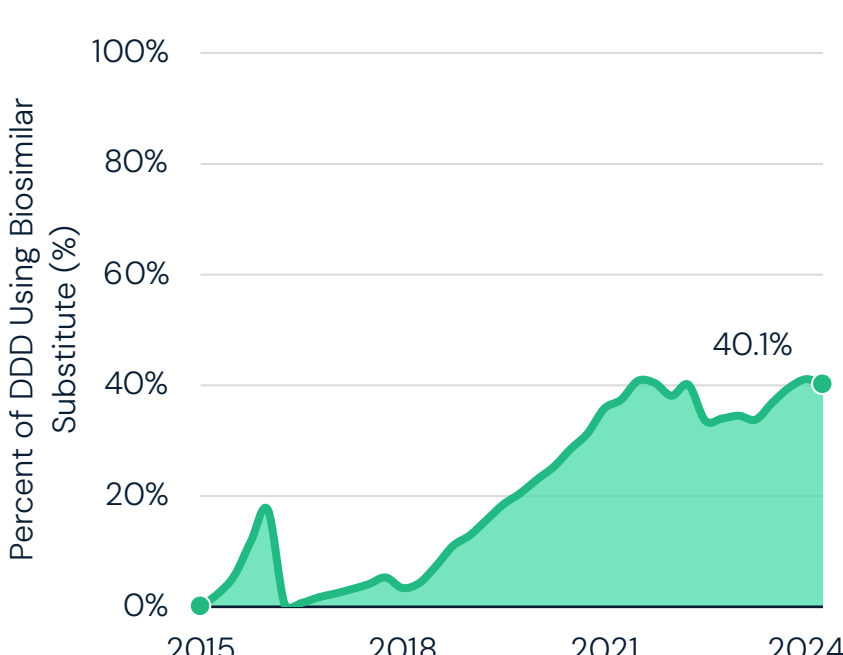
Biosimilars Save Billions, But Patent Litigation Slows Adoption

With biosimilar prices averaging only 30.4% of reference biologic prices, biosimilars are well positioned to cut healthcare costs but remain underutilized. To this point, biosimilars reduced spending by \$20.2B in 2024, even though the corresponding biosimilar efficiency rate was only 40.1% of DDD. Efficiency is partly shaped by the high rate of patent litigation affecting biosimilars in the U.S., with 73% facing litigation in 2021. In turn, patent litigation frequently leads to launch delays, which average 34.0 months in the U.S., compared to 7.4 months in Canada and 4.7 months in the U.K. Of the 118 biologics losing exclusivity in the next decade, only 10% currently have biosimilars in the development pipeline.

Annual Savings From Biosimilars, 2015–2024

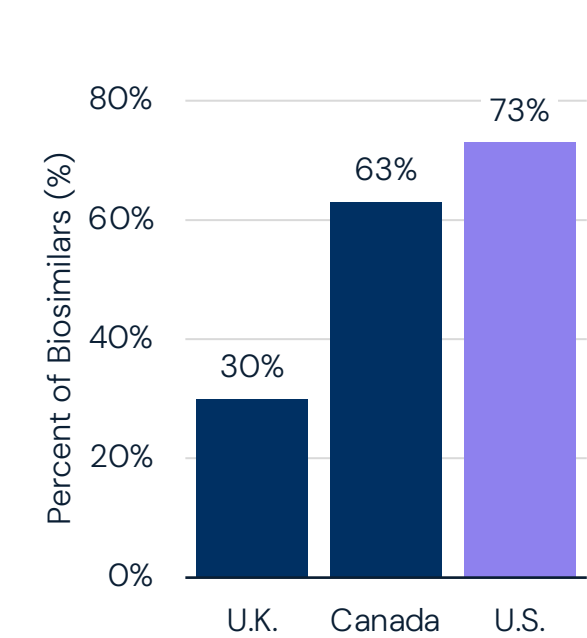


Biosimilar Efficiency Rate, 2015–2024

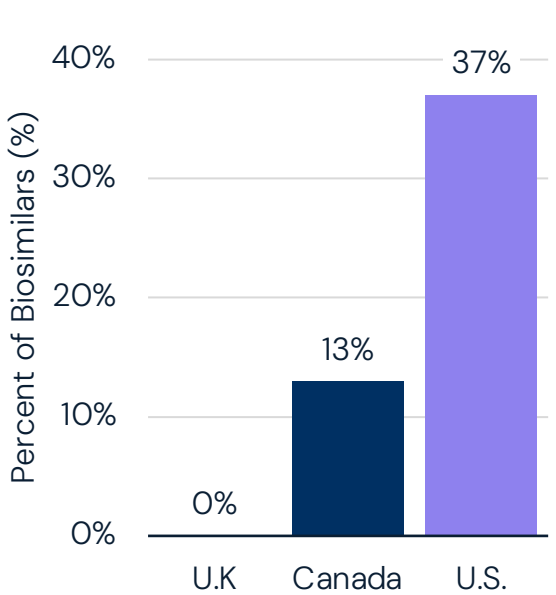


Biosimilar Litigation in the U.S. vs. Canada and the U.K., 2021

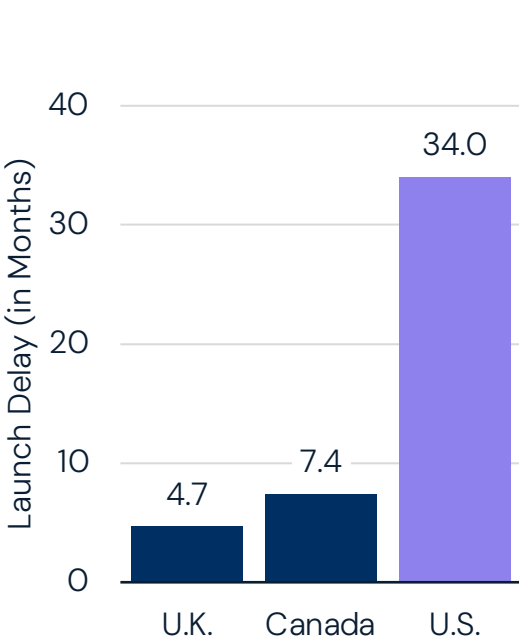
Share Facing Patent Litigation



Share With Pre-Litigation Settlement



Average Launch Delay



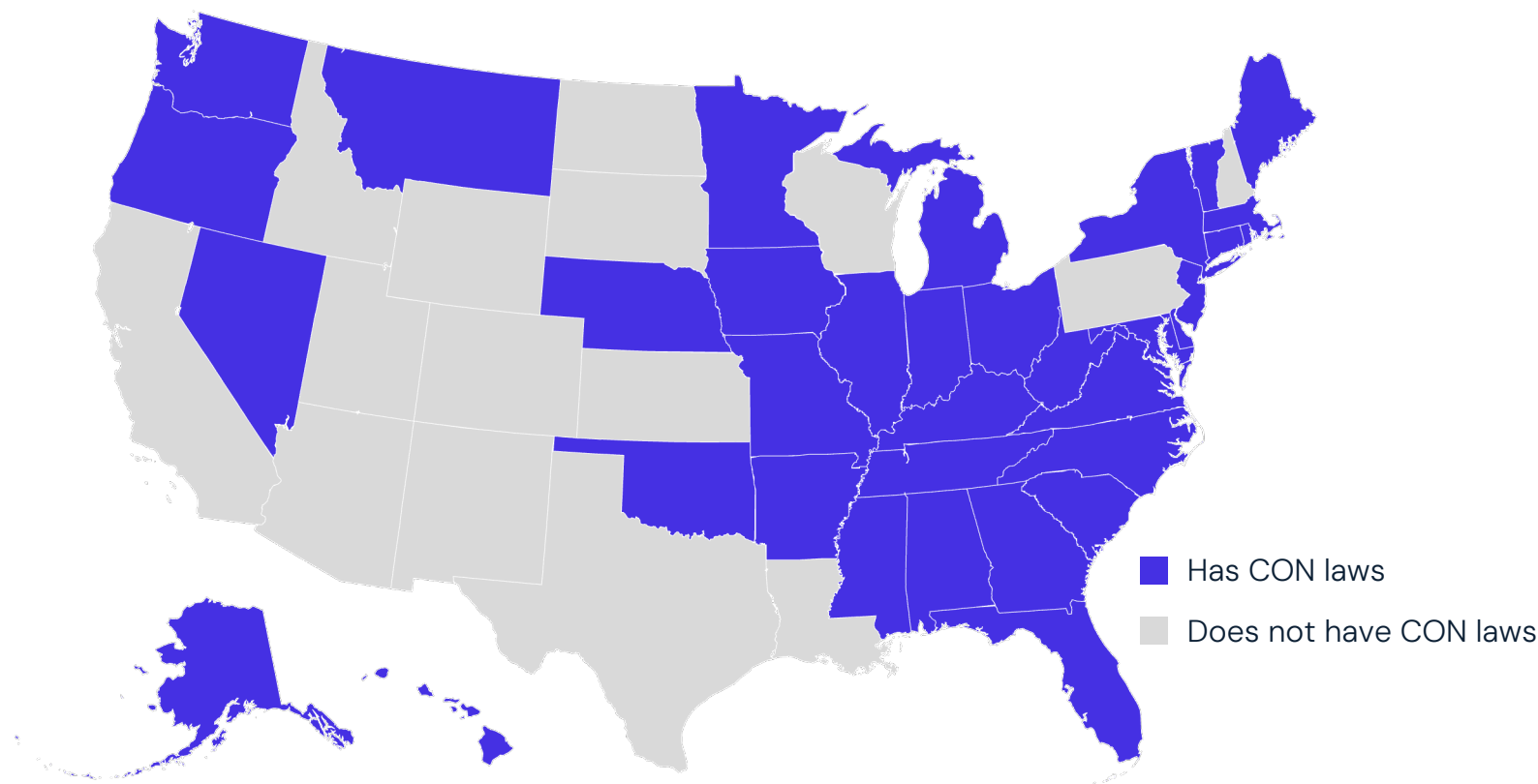
Note: DDD denotes defined daily doses.
Source: Samsung Bioepis; Association for Accessible Medicines; Goode et al., Biological Patent Thickets and Delayed Access to Biosimilars, An American Problem, *Journal of Law and the Biosciences*, 2022.

FRAUD, WASTE, ABUSE

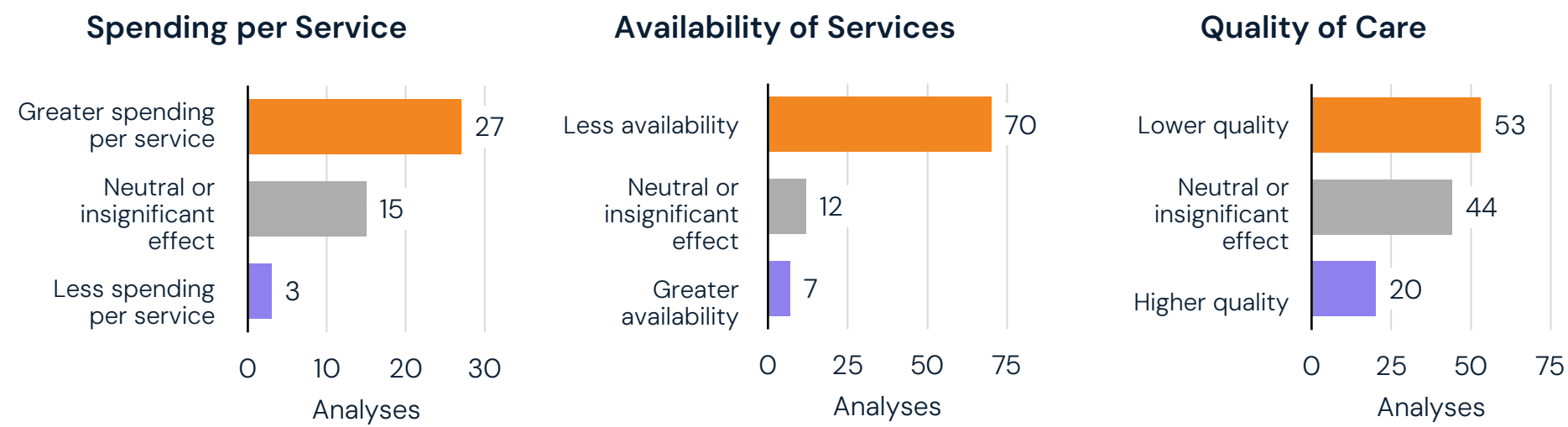
Certificate of Need Laws Hinder Access and Quality

CON laws require providers to obtain state approval before opening facilities (e.g., nursing homes, ASCs, new hospitals) or expanding services (e.g., cardiac catheterization, radiation therapy, rehabilitation). While intended to curb unnecessary healthcare spending, CON laws often limit market entry, reduce competition and increase administrative burden. Across studies, 27 analyses found CON laws are associated with greater spending per service, 70 found reduced service availability and 53 found lower quality.

Presence of CON Laws, by State, 2026



Analyses Assessing the Effects of CON Laws



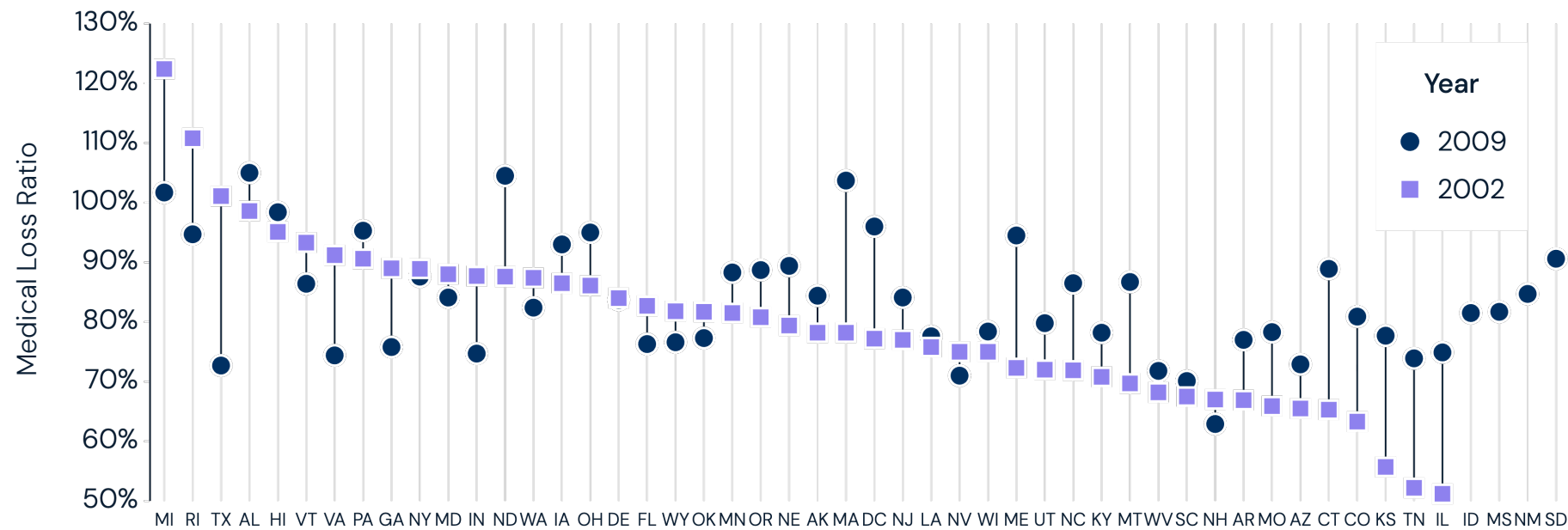
Note: ASC denotes ambulatory surgery centers; CON denotes certificate of need. Tennessee has legislatively repealed CON requirements, but this will not go into effect until 2030. CON requirements for South Carolina hospitals will end on January 1, 2027.
Source: National Academy for State Health Policy; Mitchell, Certificate-of-Need Laws in Healthcare: A Comprehensive Review of the Literature, *Southern Economic Journal*, 2024.

FRAUD, WASTE, ABUSE

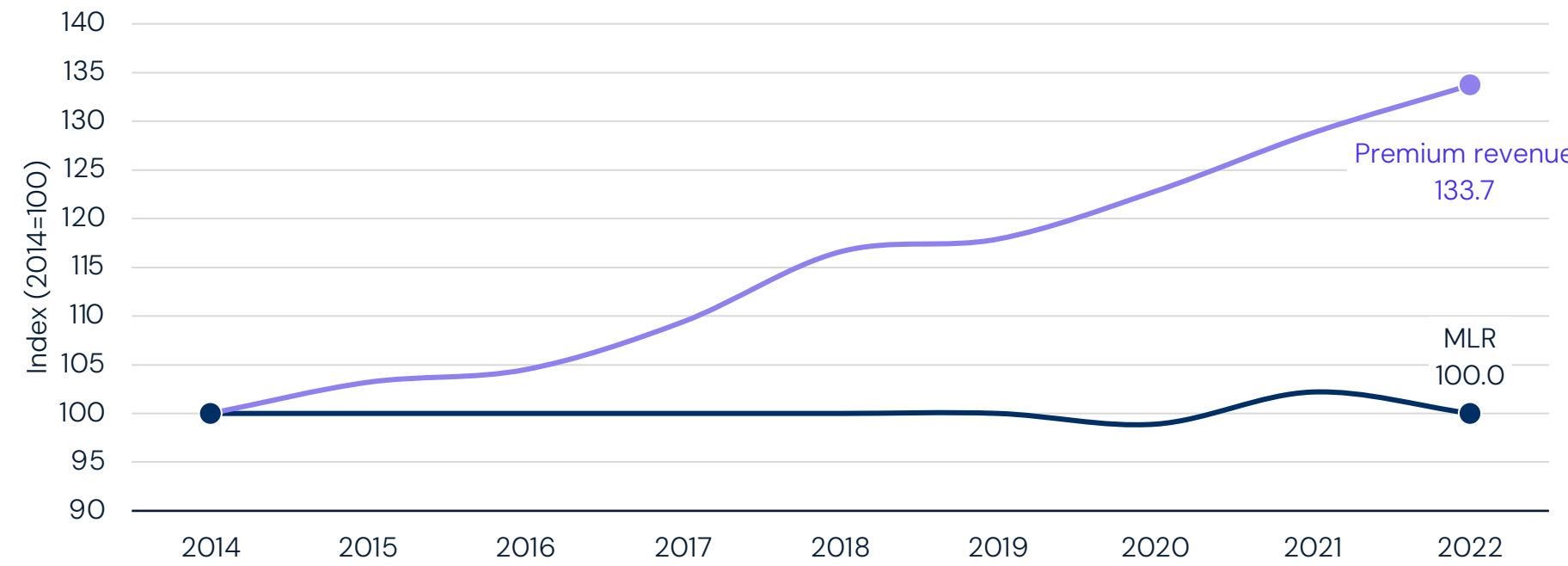
Because of ACA
MLR Mandate,
Payers Prioritize
Premium Revenue
Over Cost Control

Before the ACA, enrollment-weighted average MLRs ranged widely across states and time, from 51% to above 120%. The ACA mandated an MLR floor (i.e., the share of premium revenue that must be spent on medical claims and quality improvement), with a floor of 80% in the individual and small group markets and 85% in the large group market. After the ACA, the average MLR has remained flat through 2022 while premium revenue per member increased 33.7%. Essentially capping insurer profit margins at 15–20%, the ACA MLR mandate means profits from ACA products can grow only if revenue does. As such, health insurers have responded to the 80–85% MLR floor by continuously increasing premiums.

Pre-ACA Enrollment-Weighted Average MLR, by State, 2002 and 2009



MLR and Premium Revenue Per Member, Indexed to 2014, 2014–2022

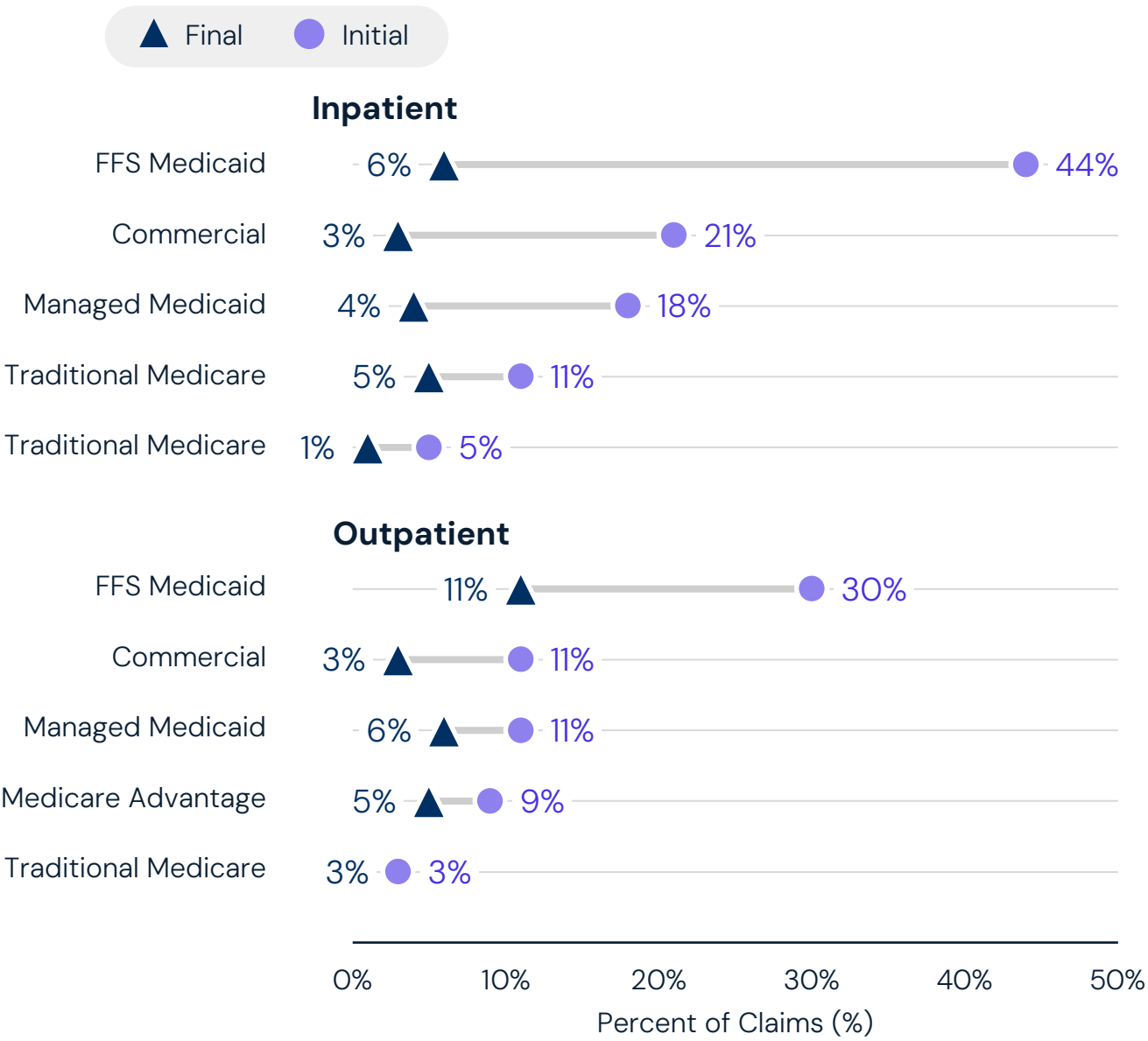


Note: ACA denotes Affordable Care Act; MLR denotes medical loss ratio. Underlying values are median per member per month figures from the CMS Center for Consumer Information and Insurance Oversight Medical Loss Ratio Public Use File, large group market 2014 to 2022. Median MLR and median premium revenue are each indexed to 2014 equal to 100. MLR is a ratio shown as an index rather than a dollar amount. 2002 data are not available for Idaho, Mississippi, New Mexico and South Dakota.
Source: Abraham et al., Regulating the medical loss ratio: implications for the individual market, *American Journal of Managed Care*, 2011; Chen, Grabowski and Trish, Medical Loss Ratio's Role in the Large Group Insurer Market, *American Journal of Managed Care*, 2025.

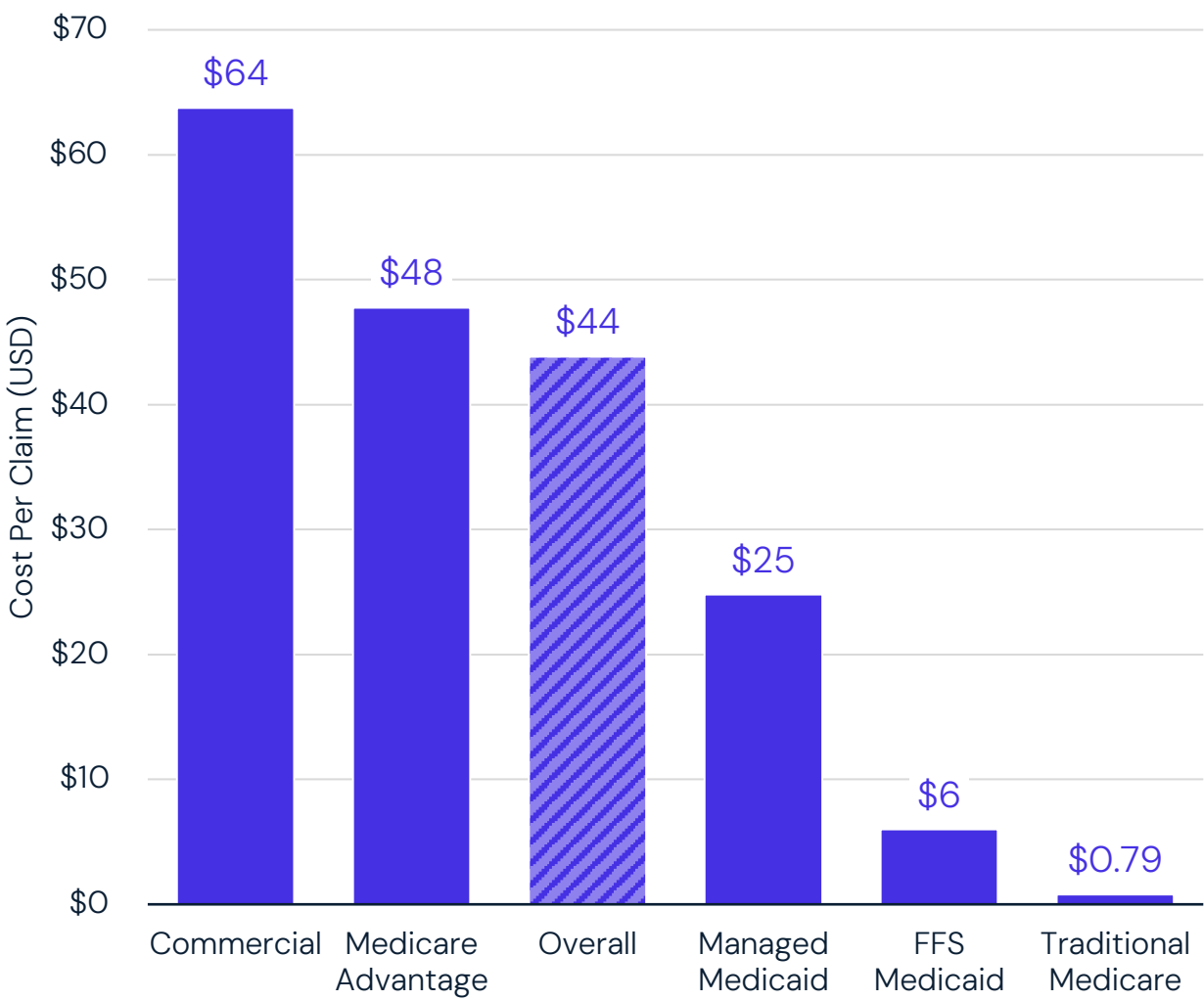
Claim Denials Waste Billions

Although commercial payers initially denied 21% of inpatient claims in 2025, only 3% of claims remained denied after final review. These overturned claims generate significant administrative cost. For example, pursuit of denials cost \$0.79 per claim in Traditional Medicare but \$48 per claim in MA and \$64 per claim in commercial plans.

Claim Denial Rates, by Setting and Payer, 2025



Average Administrative Cost of Providers' Pursuit of Denials Per Claim, 2023



Note: MA denotes Medicaid Advantage; FY denotes fiscal year; FFS denotes fee-for-service.
Source: Kodiak, State of the Healthcare Revenue Cycle, 2026; Premier Inc.

06

Stakeholders Fail to
Understand the Health
Economy Is a Negative-Sum
Game at Their Peril

NEGATIVE-SUM GAME

For decades, the financial model of U.S. healthcare has operated on a simple premise: more procedures, more patients, more revenue. That historical model is at odds with the realities of supply, demand and yield. **Revenue growth is a function of price** – not volume – and is concealing margin erosion for most stakeholders. The combination of flat surgical volumes, pharmaceutical substitutes for procedures, the continued migration of care to lower-cost settings, a contracting commercially insured population and sub-inflationary Medicare rate increases are signals of a **collapsing market**.

Providers, payers and life sciences companies have not voluntarily aligned price with value. As a result, Federal and state governments, which finance roughly half of U.S. healthcare spending, are positioned to impose **blunt unit-price constraints** onto providers and manufacturers, with direct implications for revenue. The numerous policy initiatives focused on spending suggest that the U.S. health economy will incur a period of structural inversion in which capital-intensive assets – beds, operating rooms, inpatient infrastructure – will become liabilities faster than new revenue streams can replace them.

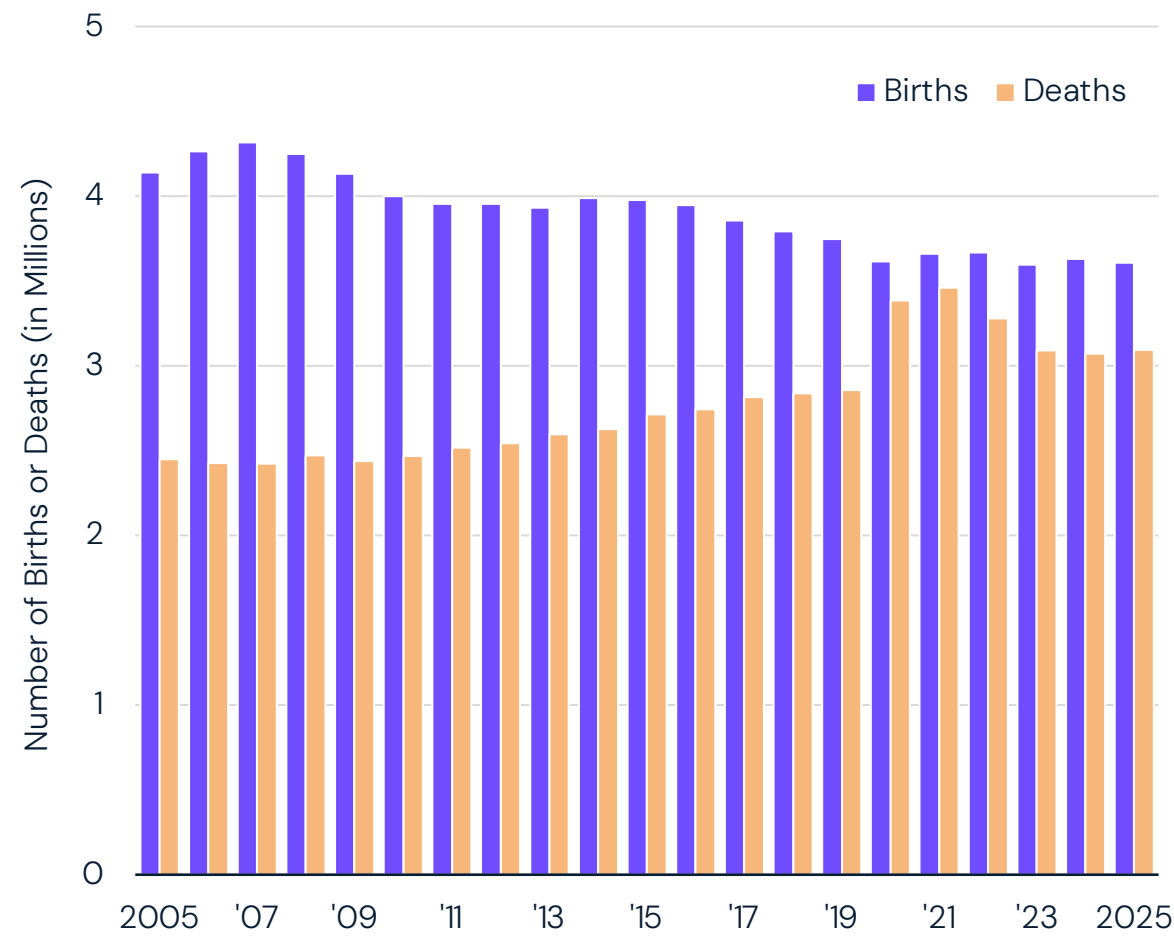
The U.S. healthcare system is not a growing market in the traditional sense. Instead, **every gain in market share for one stakeholder comes at the expense of another**, the enduring state of a negative-sum game, where **winning is characterized by losing less** than the competition. In a negative-sum game, the winners are those who recognize the nature of the competition earliest and adapt.

NEGATIVE-SUM GAME

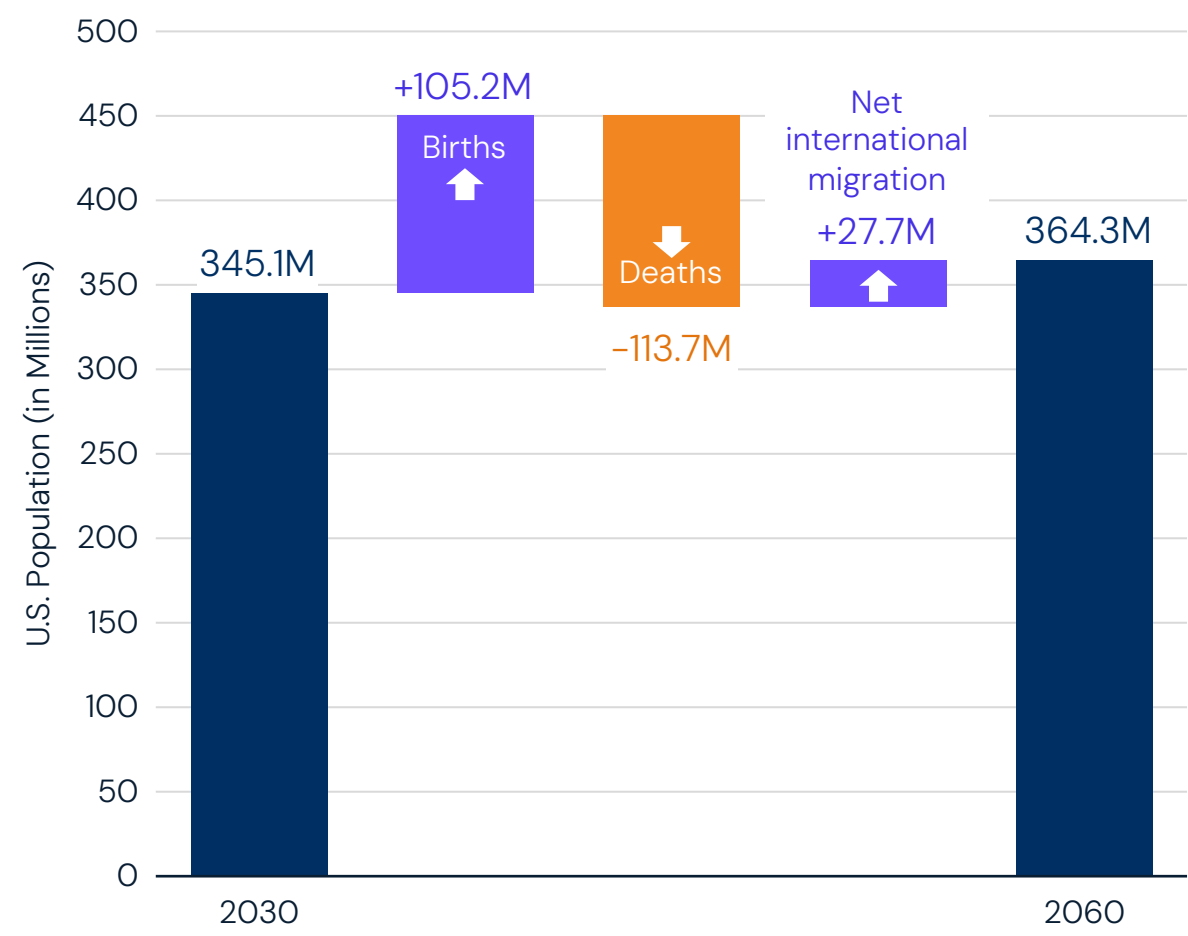
U.S. Deaths Are Projected to Surpass Births by 2060

Over the last two decades, the difference between the number of births and deaths has narrowed. In 2025, there were 3.6M births and 3.1M deaths, compared to 4.1M births and 2.4M deaths in 2005. Between 2030 and 2060, deaths are projected to exceed births, but the overall population is expected to increase by 19.2M as a result of immigration.

U.S. Births and Deaths, 2005–2025



Projected U.S. Population, Births, Deaths and Net International Migration, 2030 to 2060



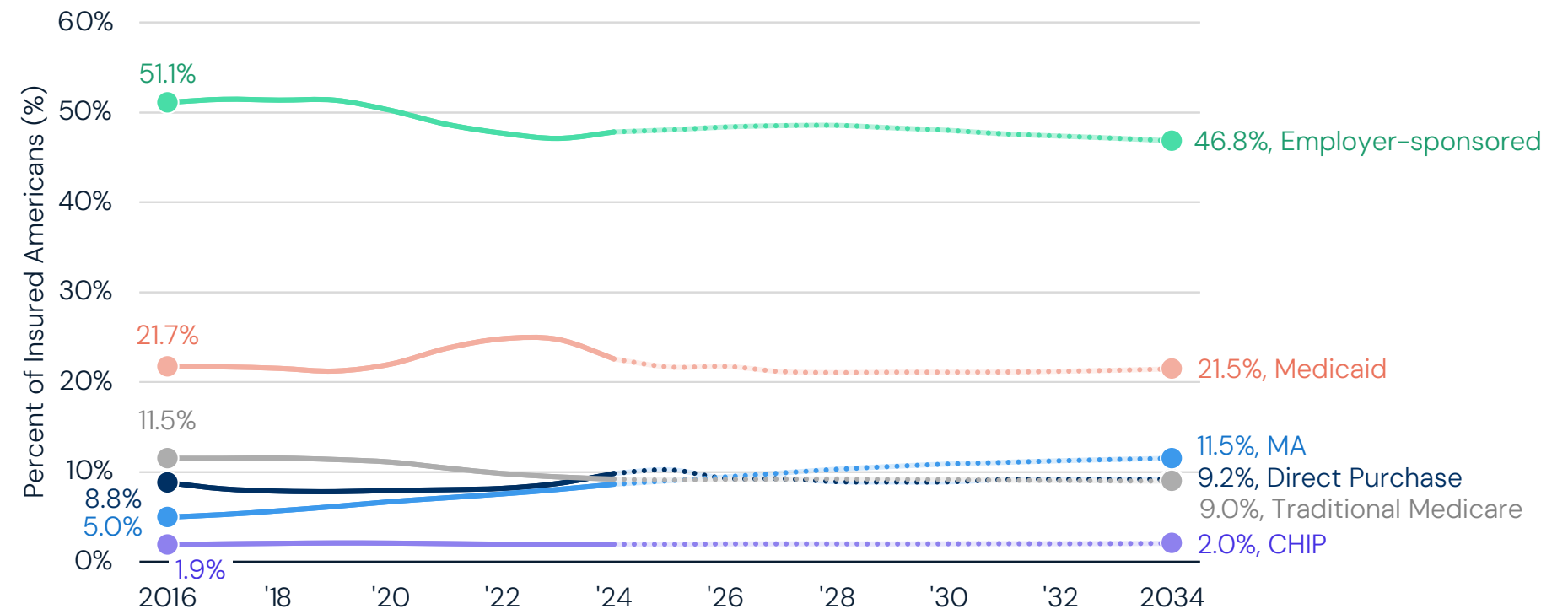
Note: 2025 data are provisional.
Source: Centers for Disease Control and Prevention, WONDER database and National Center for Health Statistics.

NEGATIVE-SUM GAME

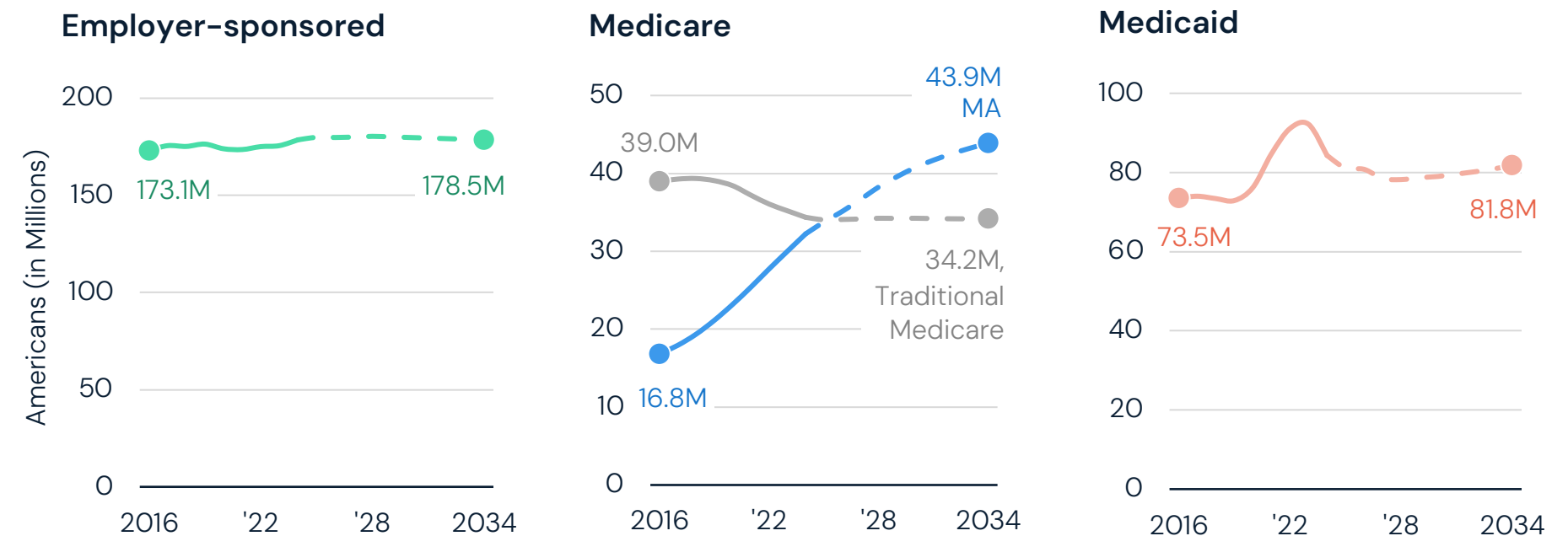
The Commercially Insured Share of the Population is Declining

While the number of Americans covered by employer-sponsored health insurance is expected to increase from 2016 to 2034, the share of insured Americans with an employer-sponsored plan is projected to decline from 51.1% to 46.8%. Meanwhile, the proportion of Americans enrolled in MA is projected to increase to 11.5% in 2034, while the share of Traditional Medicare enrollees is projected to decline to 9.0%. The declining share of employer-sponsored lives has revenue implications for almost every provider, payer and life sciences company.

Share of Insured Population, by Payer, 2016–2034



Size of Insured Population, by Payer, 2016–2034



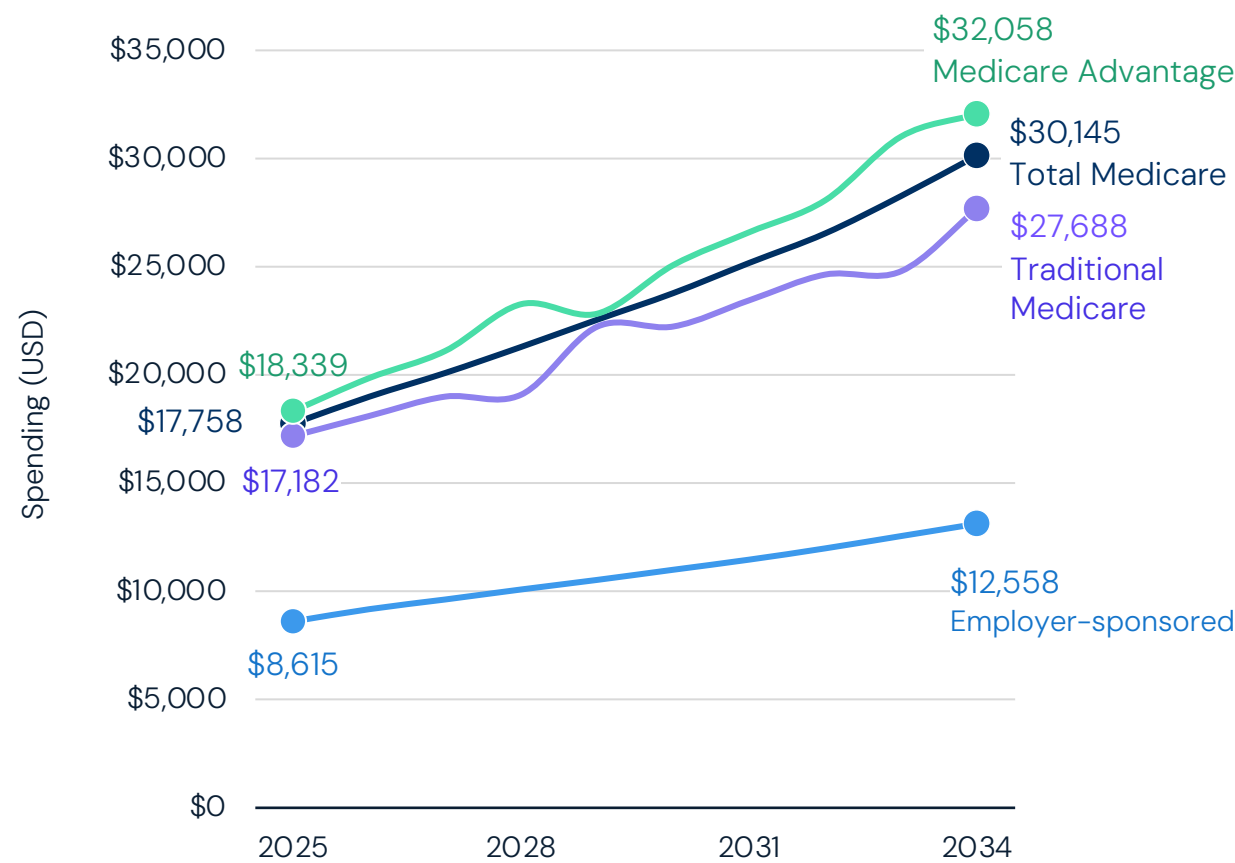
Note: MA denotes Medicare Advantage; CHIP denotes Children's Health Insurance Program. Percentages may not add to 100% due to rounding.
Source: Centers for Medicare & Medicaid Services National Health Expenditures; Congressional Budget Office Baseline Projections.

NEGATIVE-SUM GAME

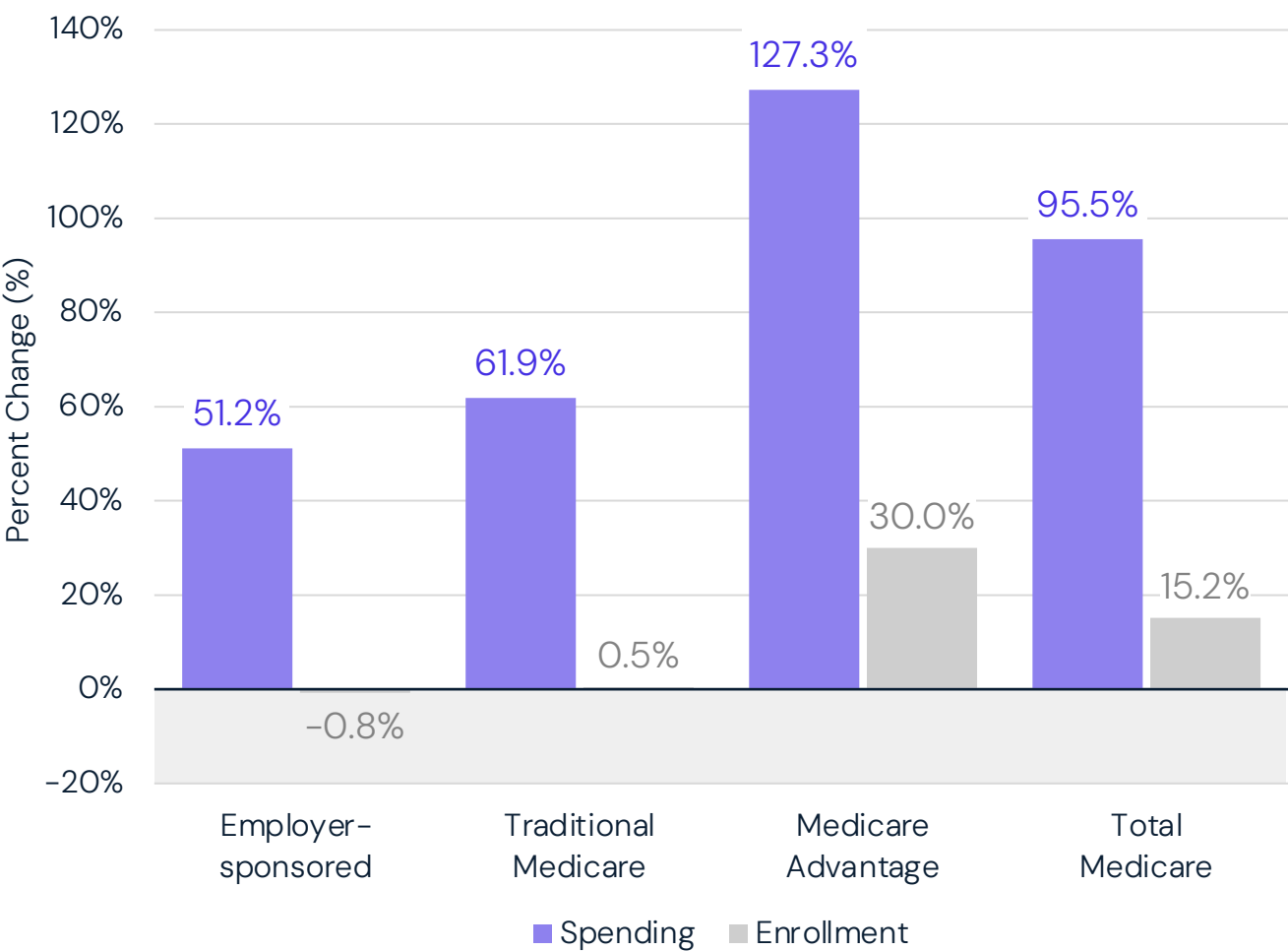
The Aging Population Will Increase Already High Spending

As of 2025, adults ages 65 and older represented 18.9% of the U.S. population, up from 8.8% in 1960. From 2025 to 2034, Medicare spending is projected to double from \$1.2T to \$2.4T 6.3x faster than enrollment. This gap between spending and enrollment projections is consistent across all payer types. Per capita spending is projected to increase the most among MA beneficiaries (74.8%), compared to per capita employer-sponsored insurance spending (52.4%).

Projected Per-Capita Spending on Medicare and Employer-Sponsored Insurance, 2025-2034



Percent Change in Medicare and Employer-Sponsored Insurance Spending and Enrollment, 2025 to 2034



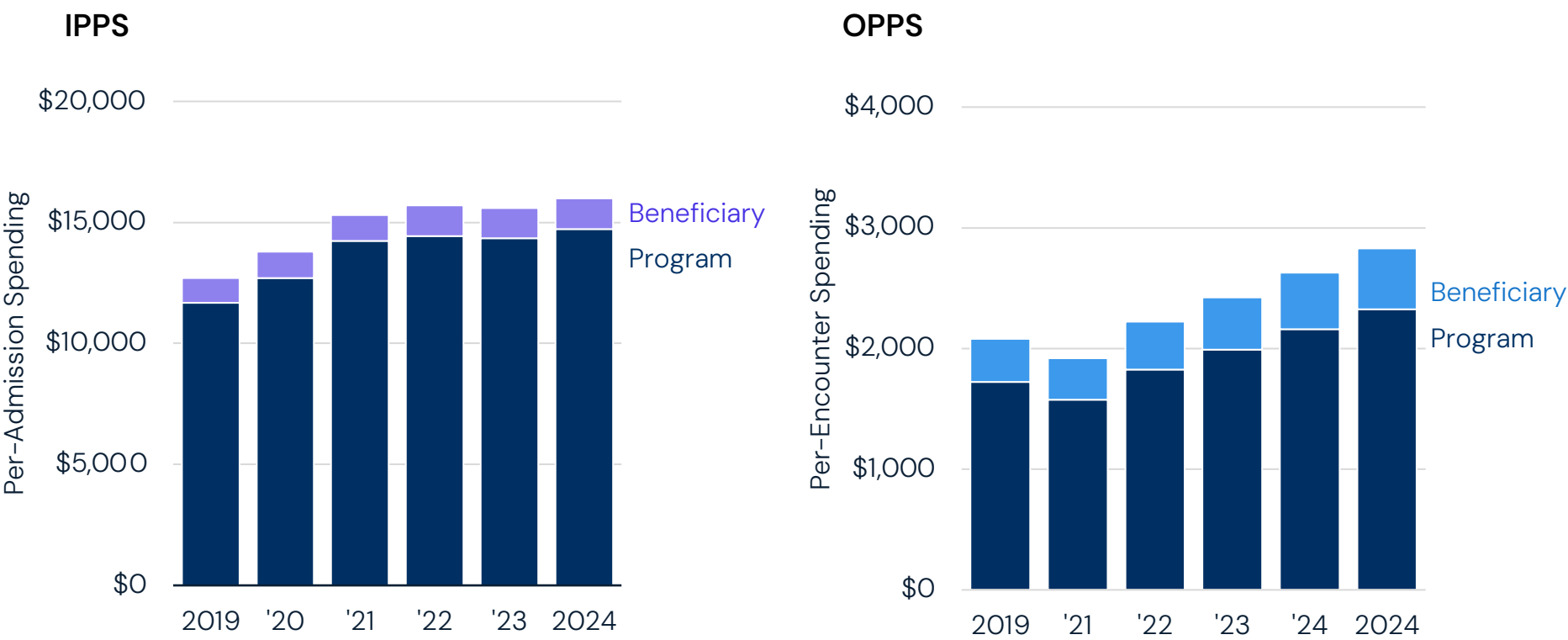
Note: MA denotes Medicare Advantage.
Source: Centers for Medicare & Medicaid Services National Health Expenditures; Congressional Budget Office Projections; KFF.

NEGATIVE-SUM GAME

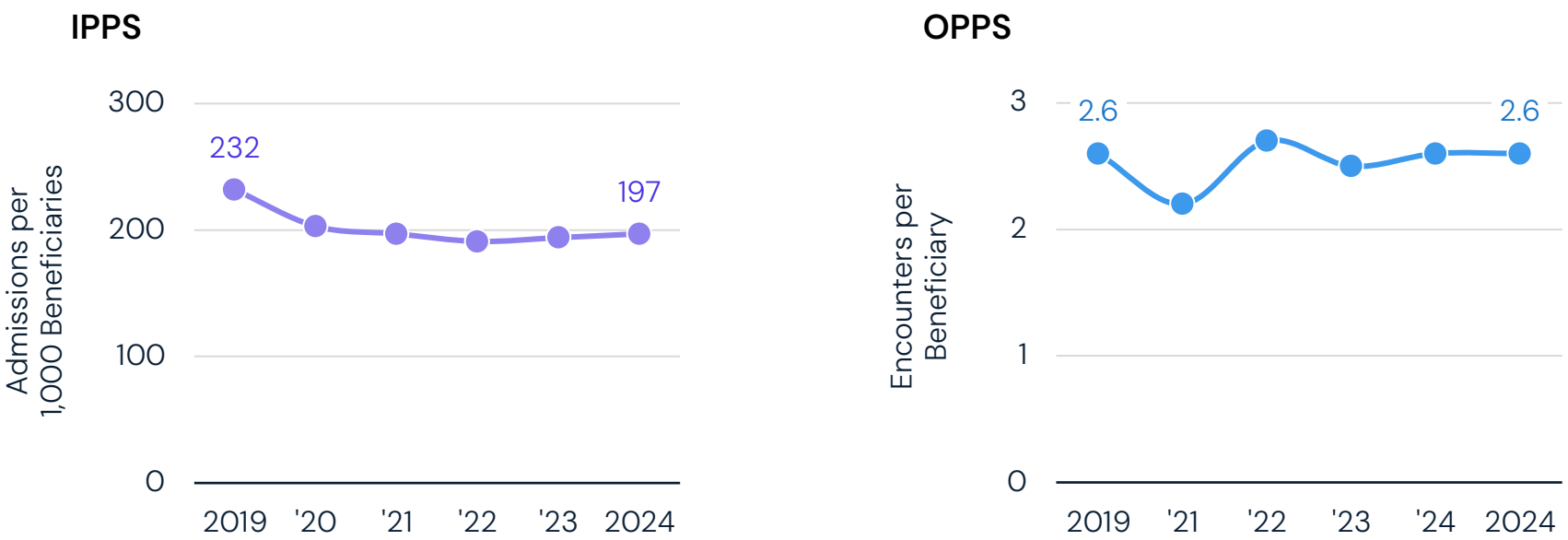
Demand Has Stagnated While Spending Increases for the Most Expensive Patient Population

The average cost of an inpatient Medicare hospital admission is growing even as the number of admissions per beneficiary declines. IPPS payments per admission averaged \$16,000 in FY 2024, up 20.6% from \$12,700 in 2019, even as IPPS admissions per 1,000 Traditional Medicare beneficiaries declined by 15.1%, from 232 to 197, over the same period. Similarly, OPPS payments per Part B beneficiary increased 33.3% from \$2,100 to \$2,800 between 2019 and 2024, while OPPS encounters remained mostly flat at 2.6 visits per beneficiary.

IPPS and OPPS Spending per Traditional Medicare Encounter, FY 2019–2024



IPPS and OPPS Encounters, FY 2019–2024



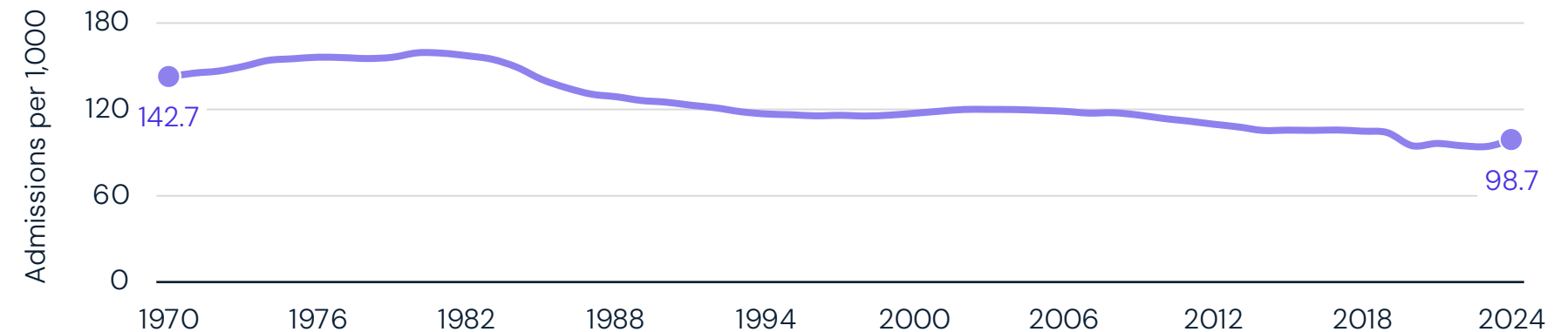
Note: IPPS denotes Inpatient Prospective Payment System; OPPS denotes Outpatient Prospective Payment System; FY denotes fiscal year.
Source: Medicare Payment Advisory Commission July 2026 Data Book.

NEGATIVE-SUM GAME

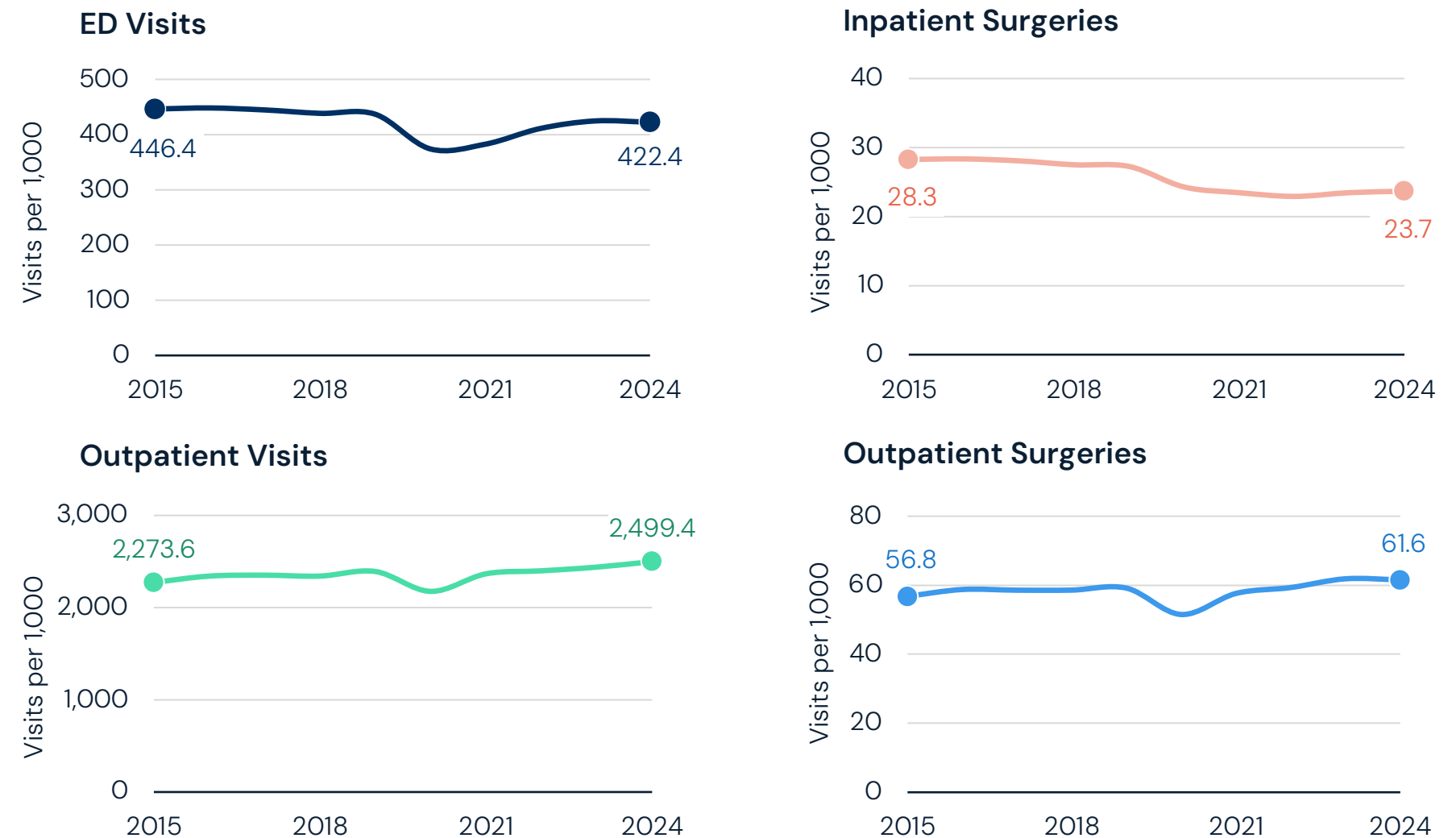
Inpatient Utilization Is Declining While Overall Hospital-Based Utilization Is Flat

Between 1970 and 2024, inpatient admissions decreased 30.8% from 142.7 admissions per 1,000 population to 98.7. More recently, the inpatient admission rate declined 6.5% from 2015 to 2024, while ED visits declined 5.4%. During the same period, the number of inpatient surgeries per 1,000 declined 16.3% from 28.3 to 23.7, as outpatient surgeries increased 8.4% from 56.8 to 61.6 per 1,000, meaning that total surgeries per 1,000 were effectively flat over the past decade. Only outpatient visits have increased on a per 1,000 basis, from 2,273.6 to 2,499.4 per 1,000.

Inpatient Admissions per 1,000 Population, 1970–2024



Visits per 1,000 Population, by Setting, 2015–2024



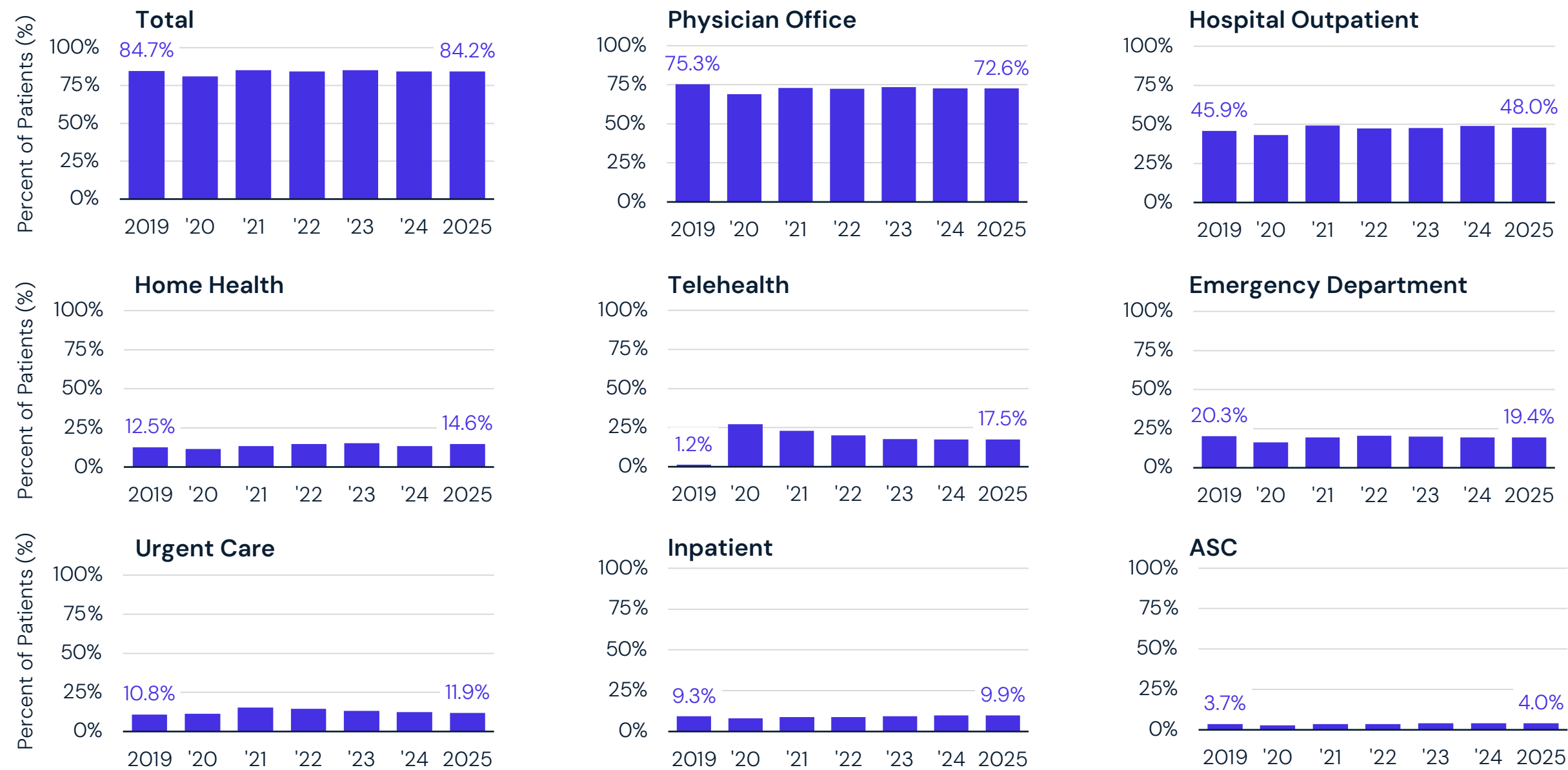
Note: ED denotes emergency department. Analysis reflects nonfederal short-term general hospitals and other special hospitals.
Source: American Hospital Association, Hospital Statistics, 2021 and 2026.

NEGATIVE-SUM GAME

The Share of Patients Using Healthcare Is Flat

The share of continuously enrolled patients with at least one visit at any care setting has remained relatively steady, nominally decreasing from 84.7% in 2019 to 84.2% 2025. However, there was variation by setting. The share of insured patients using physician offices (75.3% to 72.6%) and the ED (20.3% to 19.4%) declined, while a growing share used HOPDs (45.6% to 48.0%), home health (12.5% to 14.6%) and urgent care (10.8% to 11.9%) at least once.

Share of Patients Using Healthcare, by Care Settings, 2019–2025



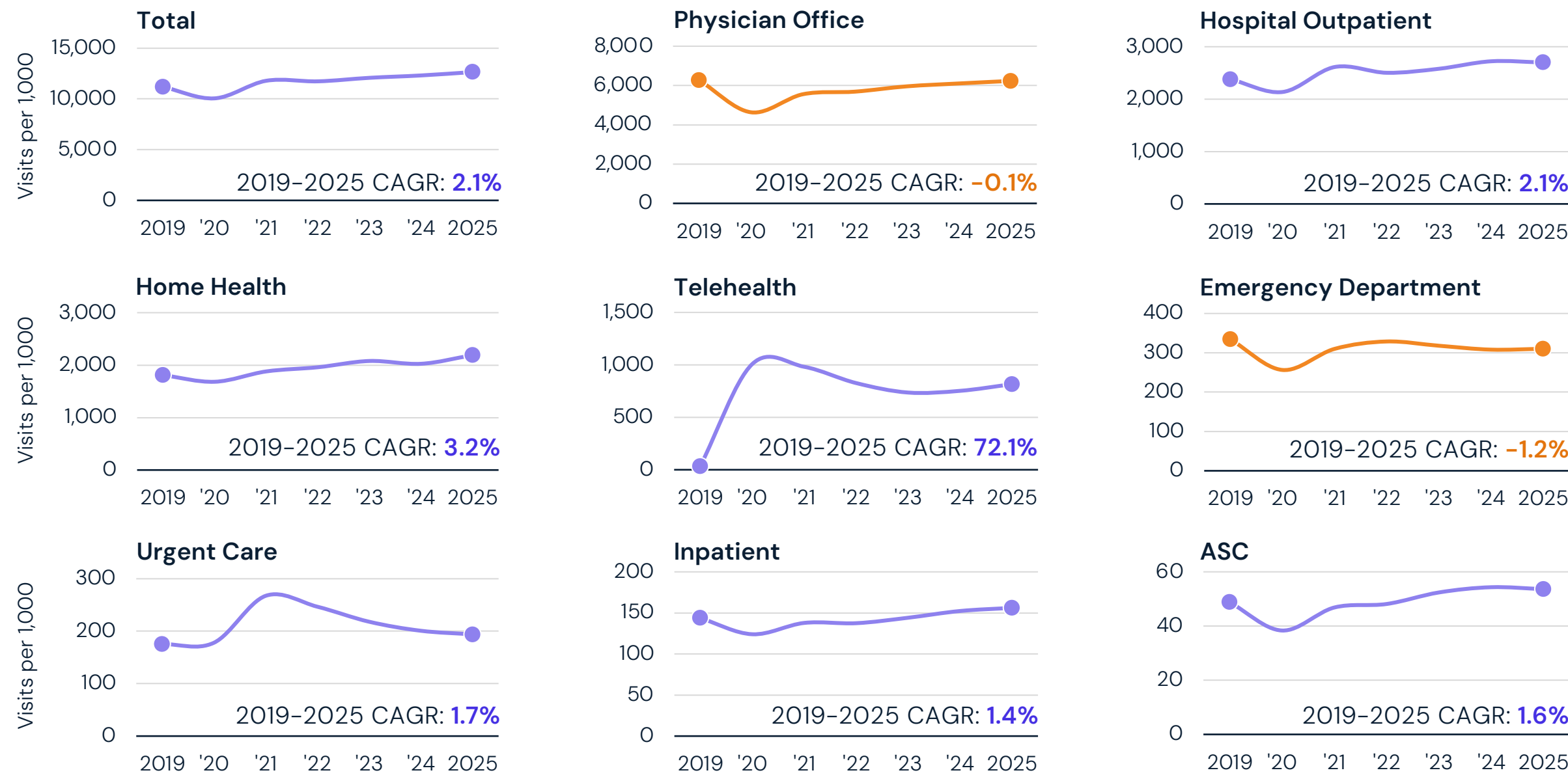
Note: ASC denotes ambulatory surgery center; HOPD denotes hospital outpatient department; ED denotes emergency department.
Source: Trilliant Health national all-payer claims database.

NEGATIVE-SUM GAME

Utilization Is Relatively Flat Across Care Settings

Among continuously enrolled patients, healthcare utilization across care settings was relatively flat between 2019 and 2025, with a CAGR of 2.1%. The five-year CAGR in visit rates ranges from -1.2% for emergency department to 3.2% for home health, excluding the 72.1% CAGR observed for telehealth following the COVID-19 pandemic.

Visits per 1,000 Population, by Care Setting, 2019-2025



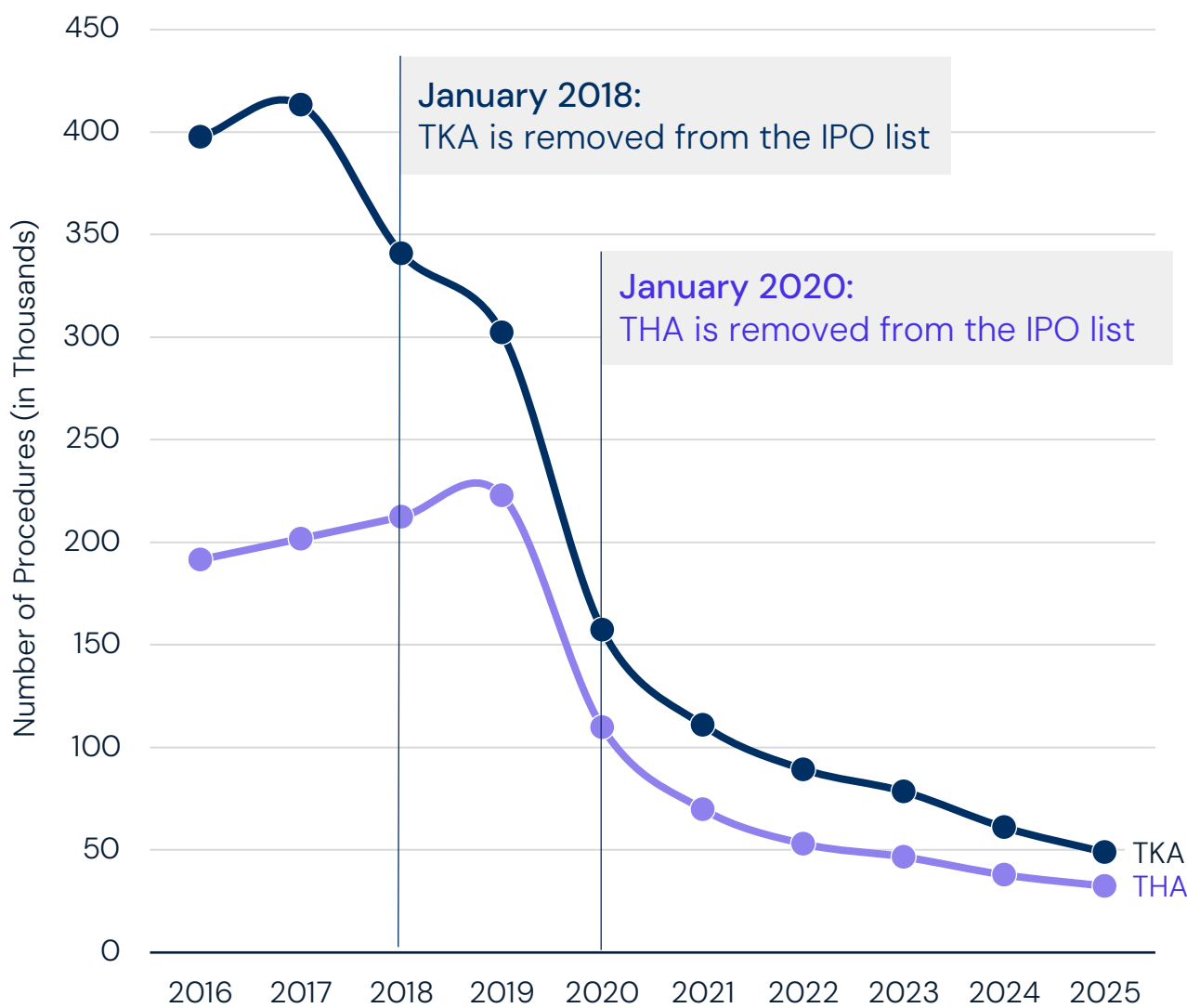
Note: ASC denotes ambulatory surgery center; CAGR denotes compound annual growth rate.
Source: Trilliant Health national all-payer claims database.

NEGATIVE-SUM GAME

Procedures Eliminated From IPO List Will Likely Mirror Joint Replacement Trends

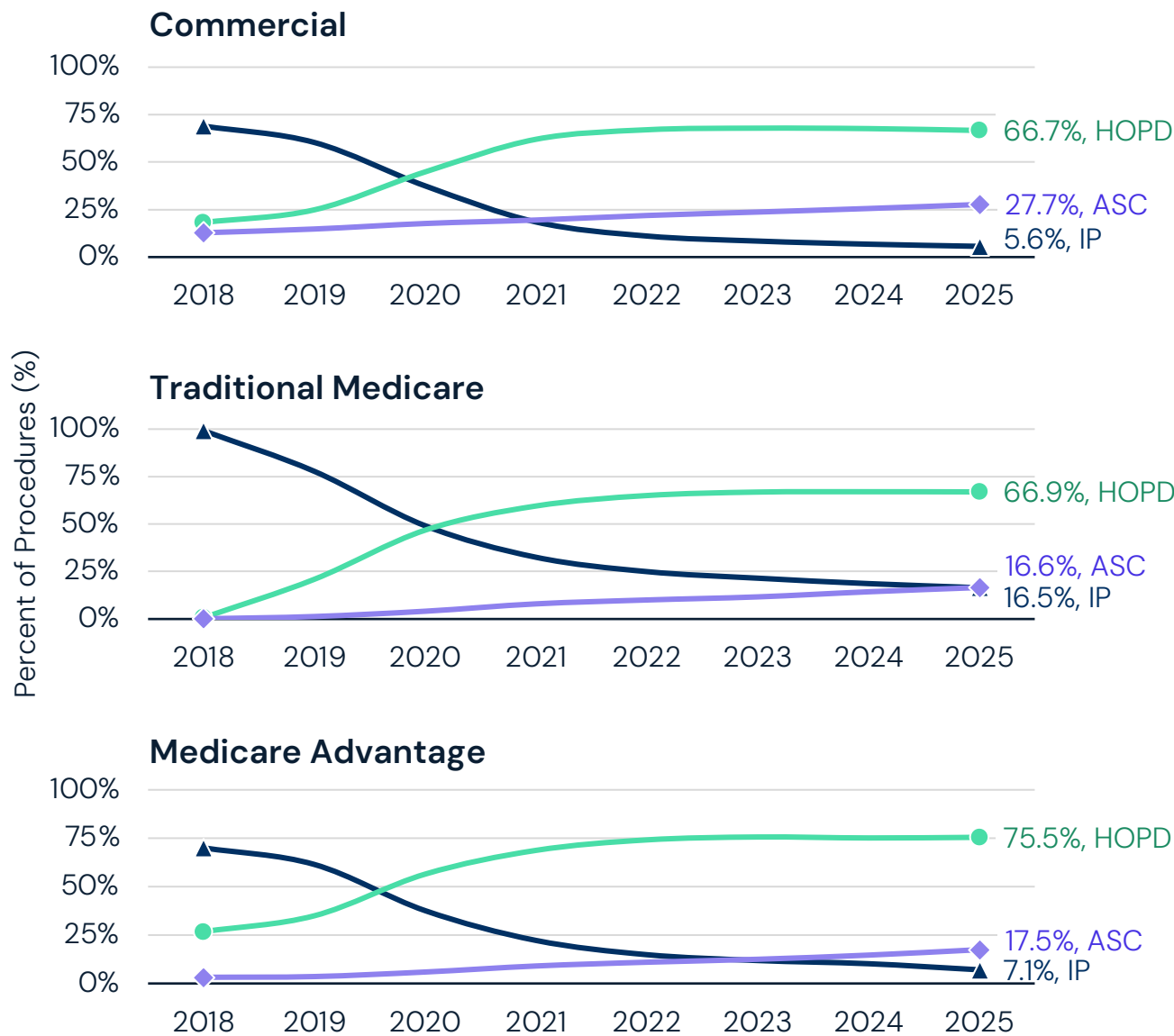
After TKAs were removed from the IPO list at the beginning of 2018, inpatient TKA volume declined by 17.5% from 2017 to 2018. As of 2025, 66.9% of Traditional Medicare LEJRs are delivered in HOPDs and 16.6% in ASCs. The three-year phaseout of the IPO list, which began in January 2026, will have implications for over 1,700 procedures.

Inpatient Traditional Medicare Total Knee Arthroplasty and Total Hip Arthroplasty, 2016–2025



Note: IPO denotes Inpatient Only list; TKA denotes total knee arthroplasty; THA denotes total hip arthroplasty; CMS denotes Centers for Medicare & Medicaid Services; HOPD denotes hospital outpatient department; ASC denotes ambulatory surgery center; IP denotes inpatient; LEJR denotes lower-extremity joint replacement. Percentages may not add to 100% due to rounding.
Source: Trilliant Health national all-payer claims database.

Share of LEJR, by Setting, by Payer, 2018–2025

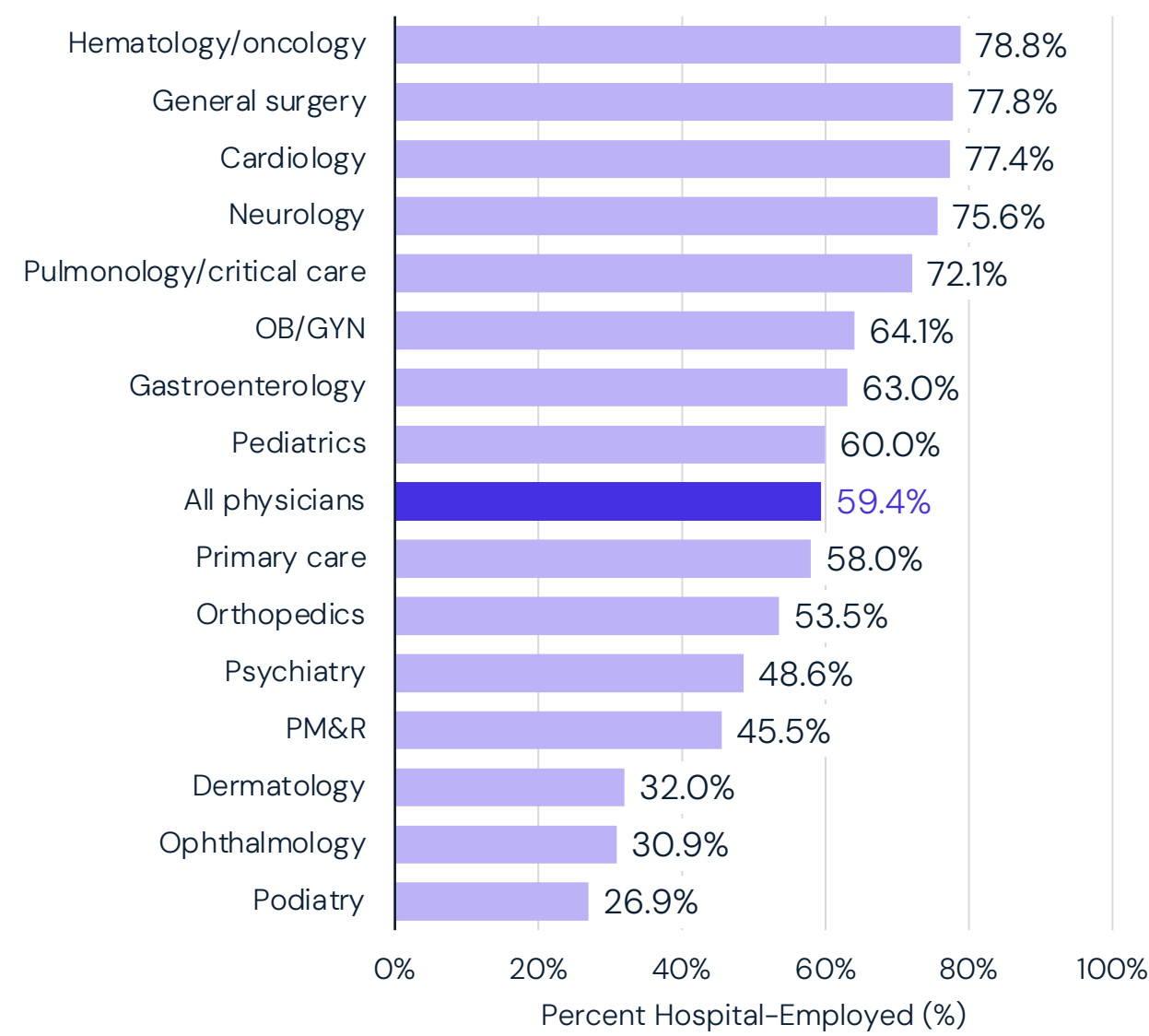


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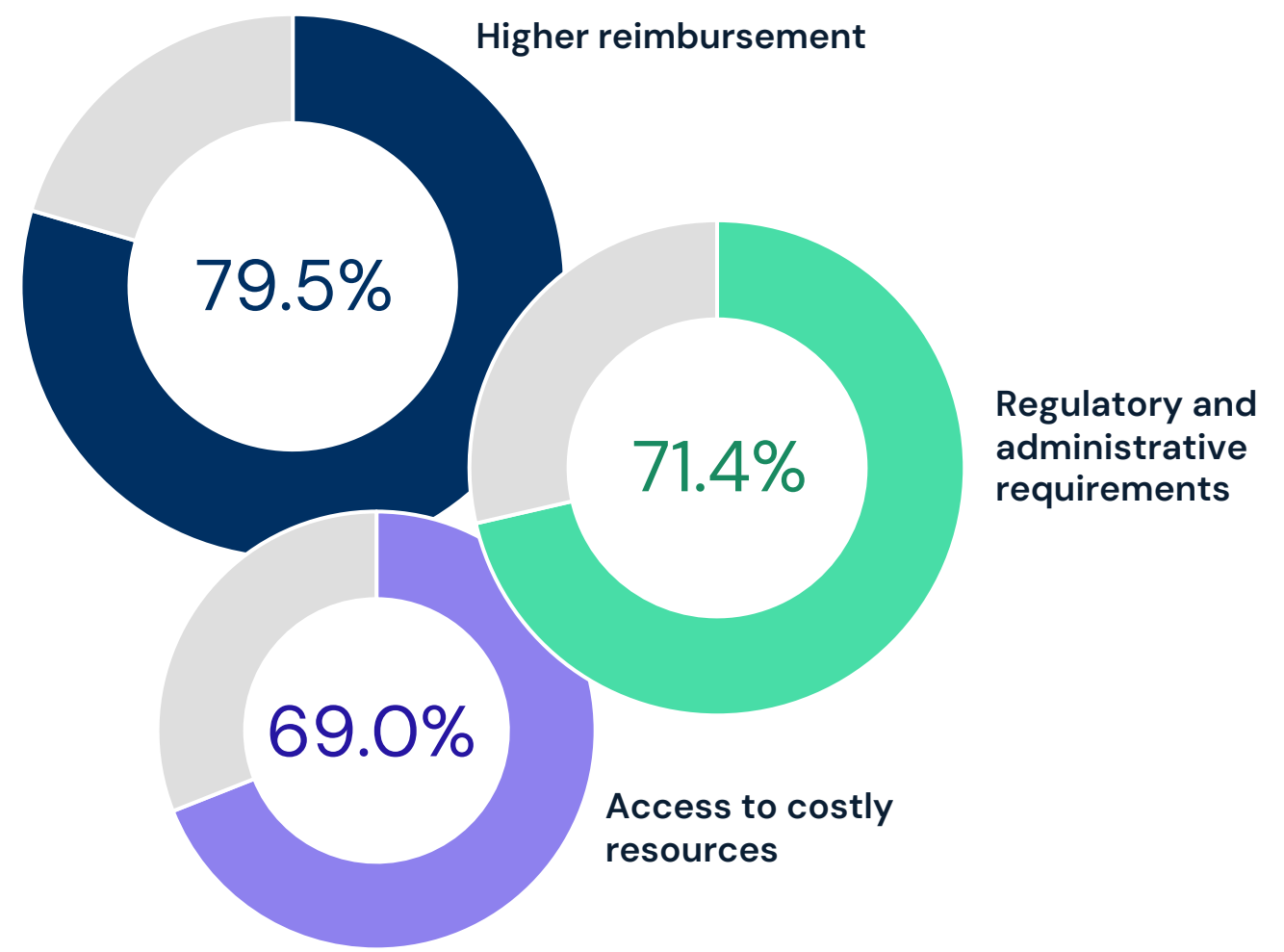
Nearly 60% of Physicians Are Employed by Hospitals

Nationally, 59.4% of physicians are employed by hospitals. Specifically, hematology and oncology physicians have the highest share of hospital-employed physicians (78.8%), followed by general surgery (77.8%) and cardiologists (77.4%). In contrast, only 26.9% of podiatrists are hospital-employed, followed by ophthalmologists (30.9%) and dermatologists (32.0%). Among physicians who sold their practice, 79.5% cited higher reimbursement as an important reason for selling to a hospital.

Share of Hospital-Employed Physicians, by Specialty, 2026



Top Three Reasons for Selling a Physician Practice to a Hospital, by Share Rating Each Reason Important or Very Important, 2022



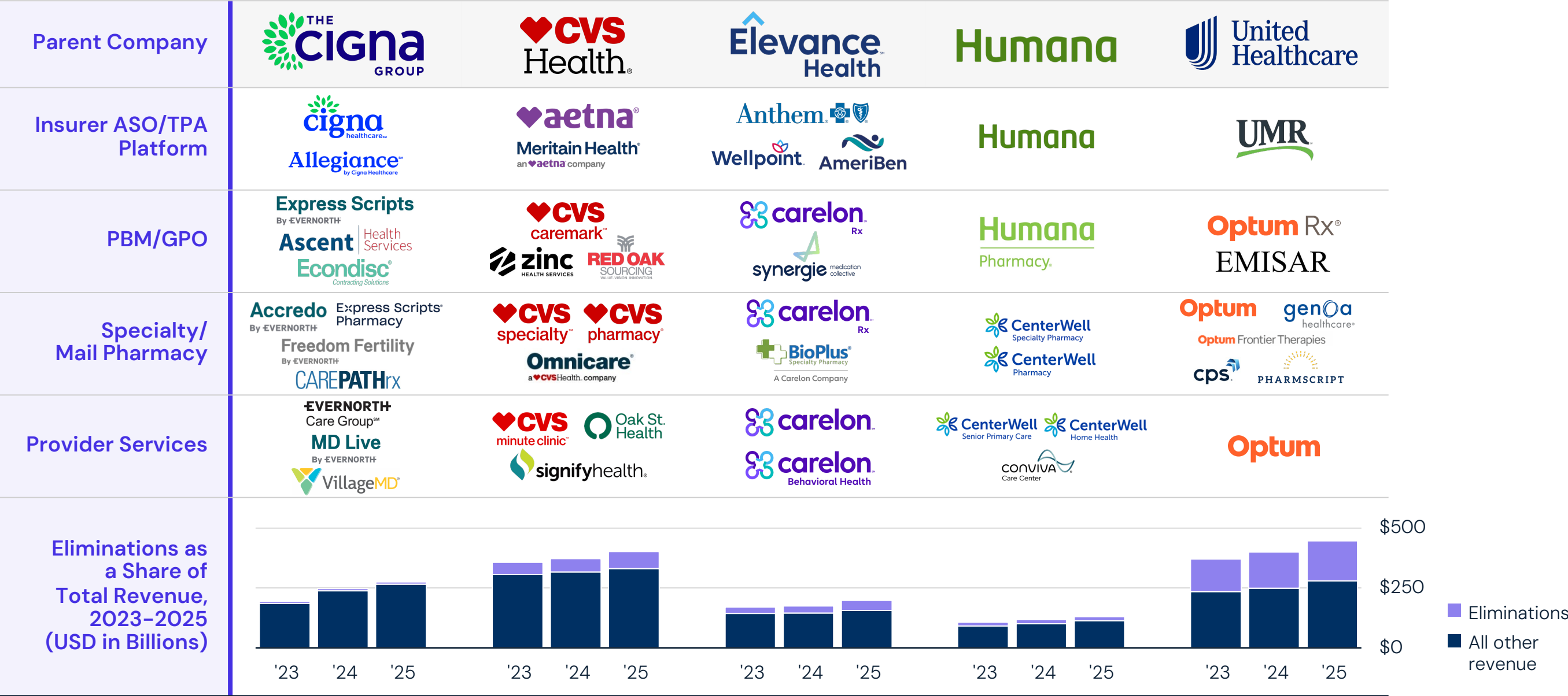
Note: PM&R denotes physical medical and rehabilitation; OB/GYN denotes obstetrics and gynecology. The top 15 specialties with the greatest number of total providers were included in the bar chart.
Source: Trilliant Health Provider Directory; American Medical Association, Physician Practice Benchmark Survey, 2022.

NEGATIVE-SUM GAME

Payers and Providers Are Increasingly Consolidating

Vertical integration in the health insurance sector manifests in ownership of PBM and provider networks, allowing profit maximization in non-regulated affiliates through intercompany transfer pricing (i.e., eliminations). In 2025, eliminations as a share of revenue ranged from 3.0% at Cigna to 37.5% at UnitedHealth Group. These intercompany transactions, particularly health insurers “selling” the product of one subsidiary to another subsidiary, represent an increasing percentage of revenue in vertically integrated healthcare enterprises.

Vertical Payer-Provider Relationships, by Parent Company



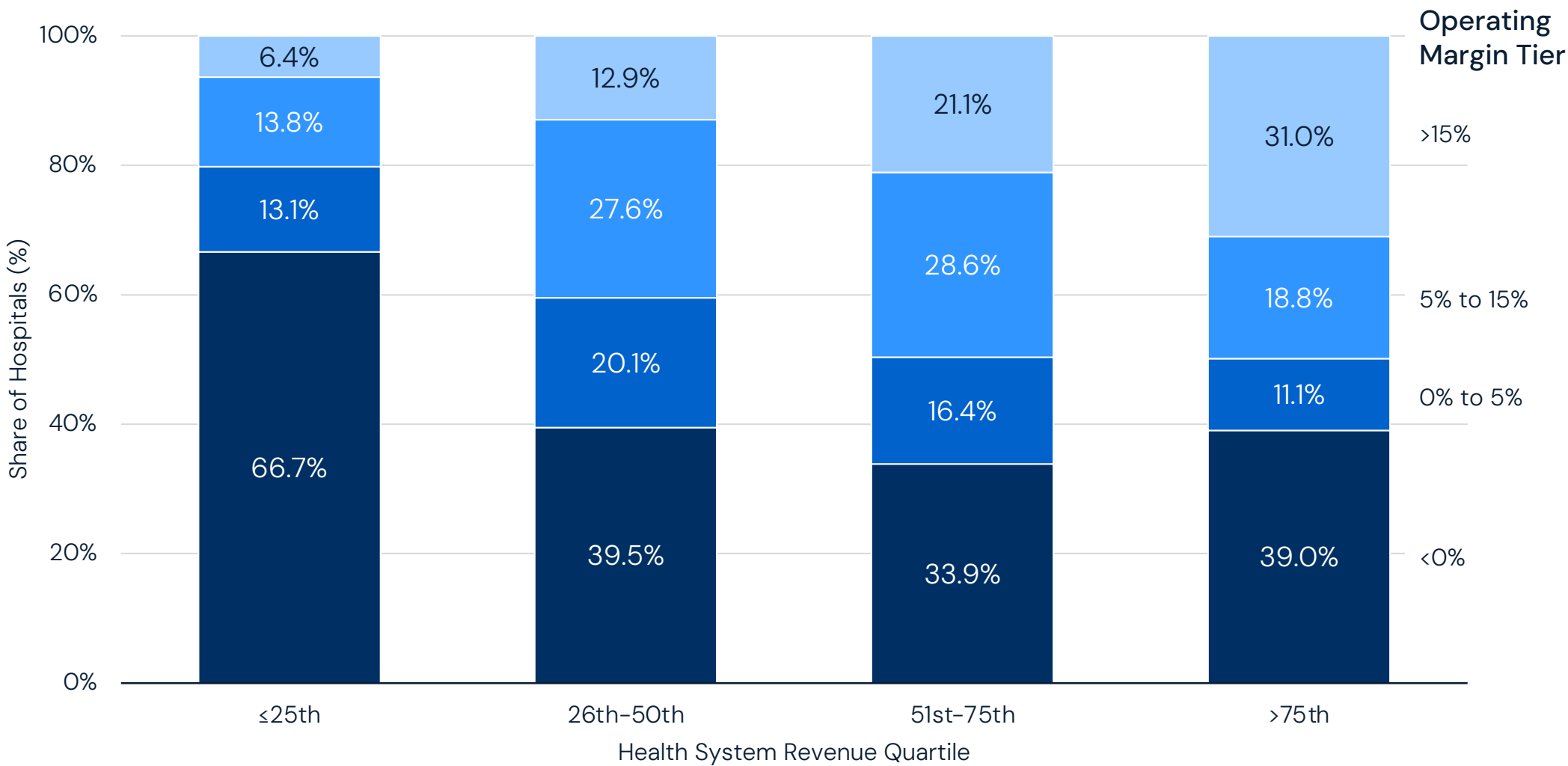
Note: ASO denotes administrative services only; TPA denotes third-party administrator; UHG denotes UnitedHealth Group; PBM denotes pharmacy benefit manager; GPO denotes group purchasing organization.
Source: United States Government Accountability Office; Drug Channels; Publicly available 10-K filings, FY2023-FY2025.

NEGATIVE-SUM GAME

Smaller Hospitals Bear the Brunt of Losses

Hospitals in the lowest-revenue health systems reported negative operating margins at 1.7x the rate of those in the highest-revenue systems, 66.7% compared with 39.0% in 2024. Among the highest-revenue hospitals, 60.9% reported a positive operating margin, with 49.8% exceeding a 5% margin. As higher-margin services (e.g., surgery, imaging) increasingly shift to non-hospital settings, smaller and independent hospitals have the least capacity to absorb the financial strain associated with this shift.

Distribution of Hospitals by Operating Margin and Revenue Quartile, 2024



Note: The analysis reflects an analysis of 1,182 hospitals. Revenue quartiles are based on health system net patient revenue for hospitals affiliated with a health system. For independent hospitals or those not matched to a health system, individual hospital net patient revenue was used in place of system-level revenue. The 25th percentile of health system revenue is \$946.9M, the 50th percentile is \$4.4B and the 75th percentile is \$15.5B. Percentages may not add to 100% due to rounding.

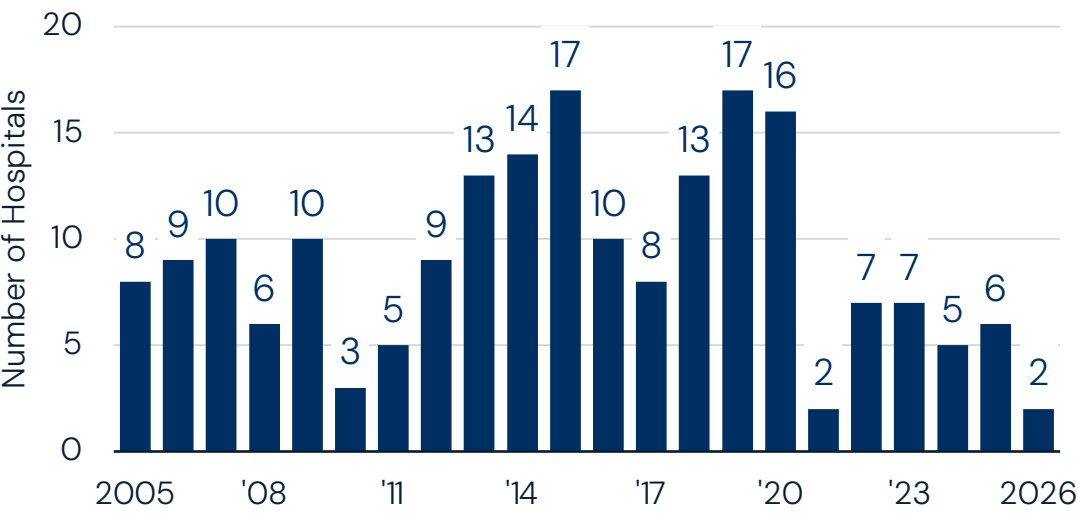
Source: Centers for Medicare & Medicaid Services Healthcare Cost Report Information System; National Academy for State Health Policy Hospital Cost Tool; Agency for Healthcare Research and Quality Compendium of U.S. Health Systems.

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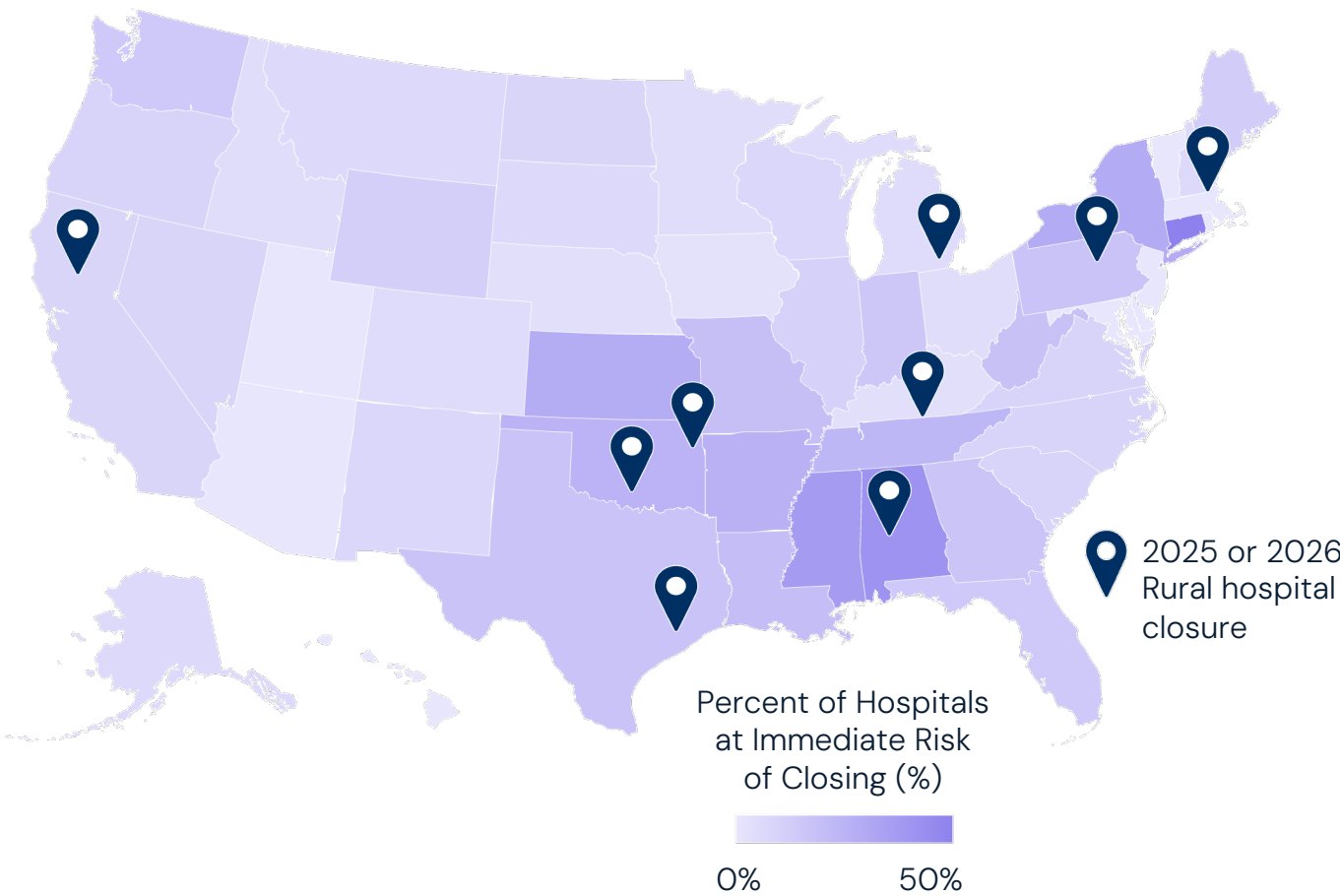
Rural Hospital Closures Further Reduce Access and Increase Mortality

Since 2005, 143 rural hospitals have closed. In 2026, nearly 300 are at immediate risk of closure and more than 700 are financially vulnerable to closure. At-risk hospitals are disproportionately concentrated in the South. Hospital closures compound existing access gaps and are associated with a 76% increase in ED transport times.

Rural Hospital Closures, 2006–2026



Percent of Rural Hospitals at Immediate Risk of Closing, by State, as of July 2026



Impact of Rural Hospital Closures

76%

Increase in ED transport times

8.7%

Increase in mortality for time-sensitive conditions

-14%

Change in healthcare jobs available in rural county

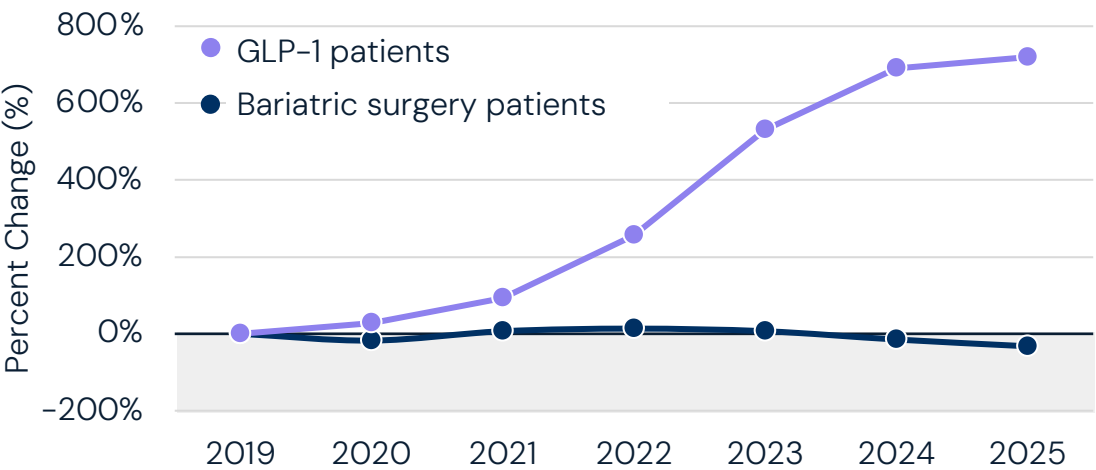
Note: ED denotes emergency department. Hospital closures are as of October 2026.
Source: The Cecil G. Sheps Center for Health Services Research; Center for Healthcare Quality and Payment Reform; Gujral, K. and Basu, A., Impact of Rural and Urban Hospital Closures on Inpatient Mortality, NBER Working Paper No. 26182, 2019 (revised 2020); University of Kentucky’s Institutional Repository; American Hospital Association; Chatterjee et al, Changes in Economic Outcomes Before and After Rural Hospital Closures in the United States: A Difference-in-Differences Study, *Health Services Research*, 2022..

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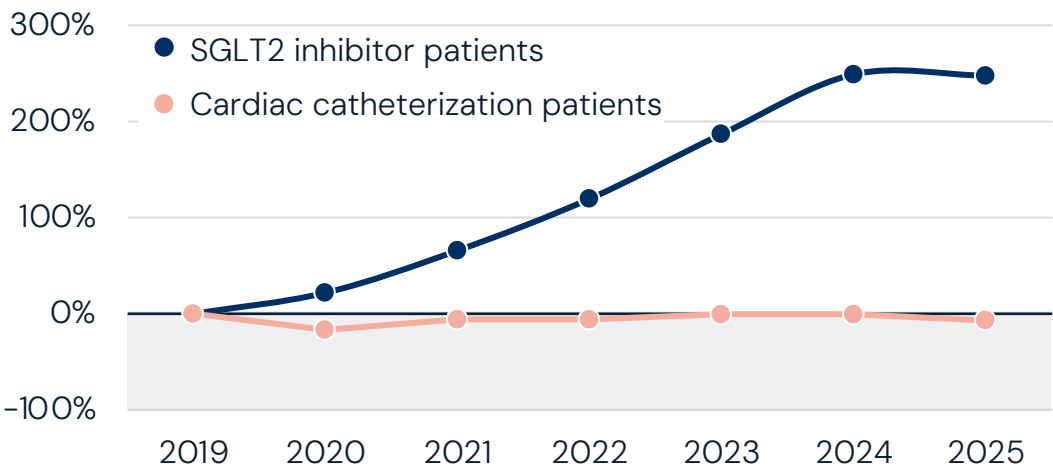
Novel Drugs Are Poised to Replace Surgical Volume

As new therapies enter the market, the prevailing procedure-based approach to care will change. Between 2019 and 2025, GLP-1 patients increased by 719.7%, while bariatric surgery patients declined by 32.4%. During the same period, SGLT2 inhibitor patients grew by 247.7% as cardiac catheterization volume declined by 7.1%. However, 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.

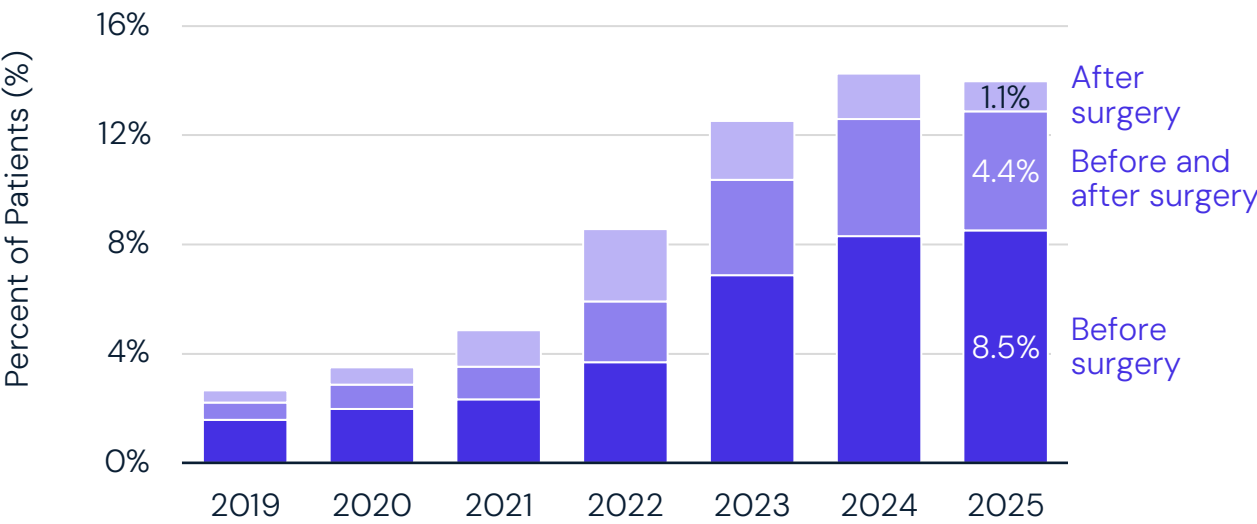
Percent Change in GLP-1 and Bariatric Surgery Patient Volume, Compared to 2019, 2019-2025



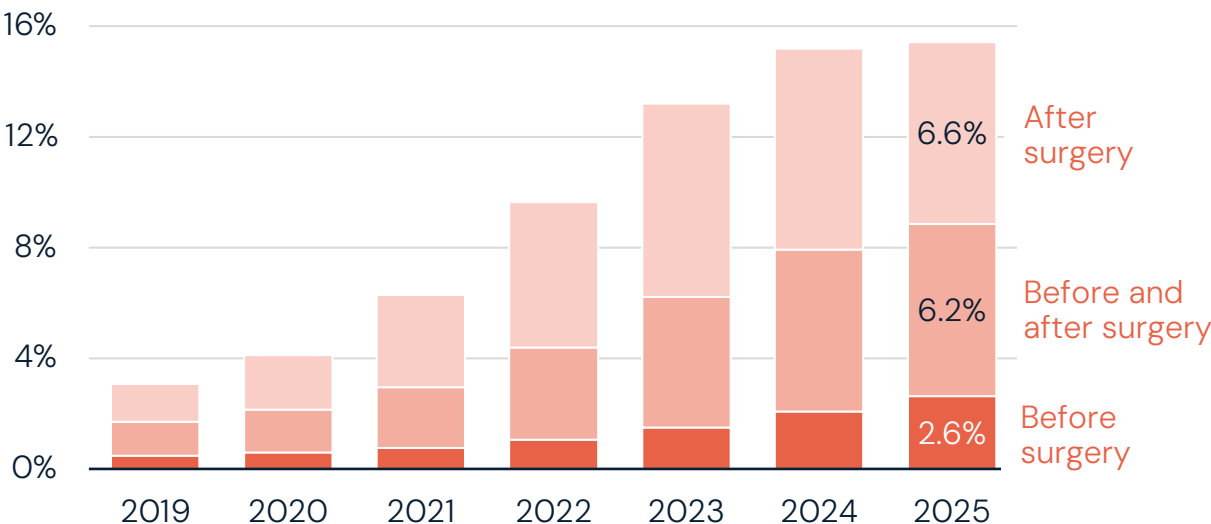
Percent Change in SGLT2 Inhibitor and Cardiac Catheterization Patient Volume, Compared to 2019, 2019-2025



Share of Bariatric Surgery Patients With a GLP-1 Prescription Before or After Surgery, 2019-2025



Share of Cardiac Catheterization Patients With a SGLT2 Inhibitor Prescription Before or After Surgery, 2019-2025



Note: SGLT2 inhibitor denotes sodium-glucose cotransporter 2; GLP-1 denotes glucagon-like peptide-1.
Source: Trilliant Health national all-payer claims database,

NEGATIVE-SUM GAME

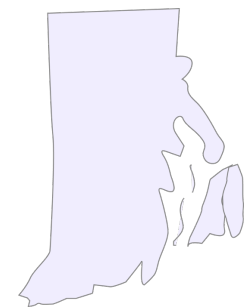
Cost Containment Addresses Symptoms, Not Underlying Incentives

Price caps and rate setting compress unit prices, but the extent to which they address FFS volume incentives varies. Rhode Island constrains price growth, Oregon indexes to a Medicare benchmark and Vermont and Indiana will cap commercial rates, each regulating the price of individual services at hospitals.

State and Federal Approaches to Healthcare Cost Containment

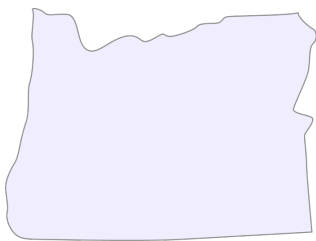
Less Regulatory Involvement

More Regulatory Involvement



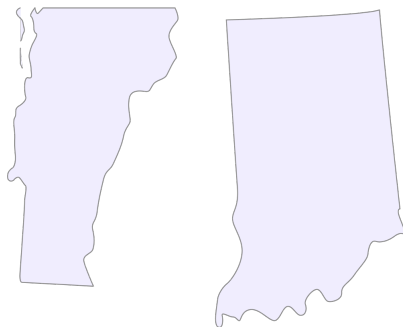
Price Growth Caps constrain the overall rate at which hospital prices can increase

Since 2010, **Rhode Island** has capped the amount by which insurers can annually increase reimbursement rates for hospital services to the inflation rate, defined as CPI-U + 1%.



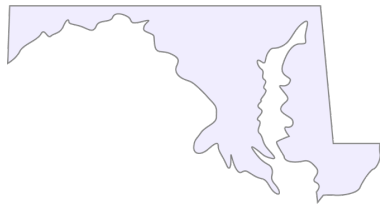
Reference Pricing sets reimbursement rates tied to a specified benchmark

In 2017, **Oregon** began capping state employee health plan payment for all hospital services at 200% of Medicare for in-network hospitals and 185% of Medicare for out-of-network hospitals.



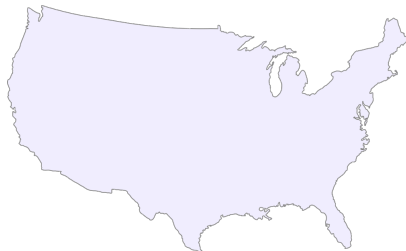
Price Caps impose an upper limit on how much providers charge

In 2025, **Vermont** and **Indiana** passed legislation to set a ceiling on hospital prices across all commercial payers by capping the amounts that hospitals can charge.



Global Budgets set annual revenues at hospitals regardless of services rendered

Maryland has an independent commission that caps each hospital's total annual revenue through a global budget rather than a price per service.



Rate Setting mandates payment amounts

CMS sets **national** reimbursement rates for Traditional Medicare payment systems, and **states** set fee schedules for Medicaid.

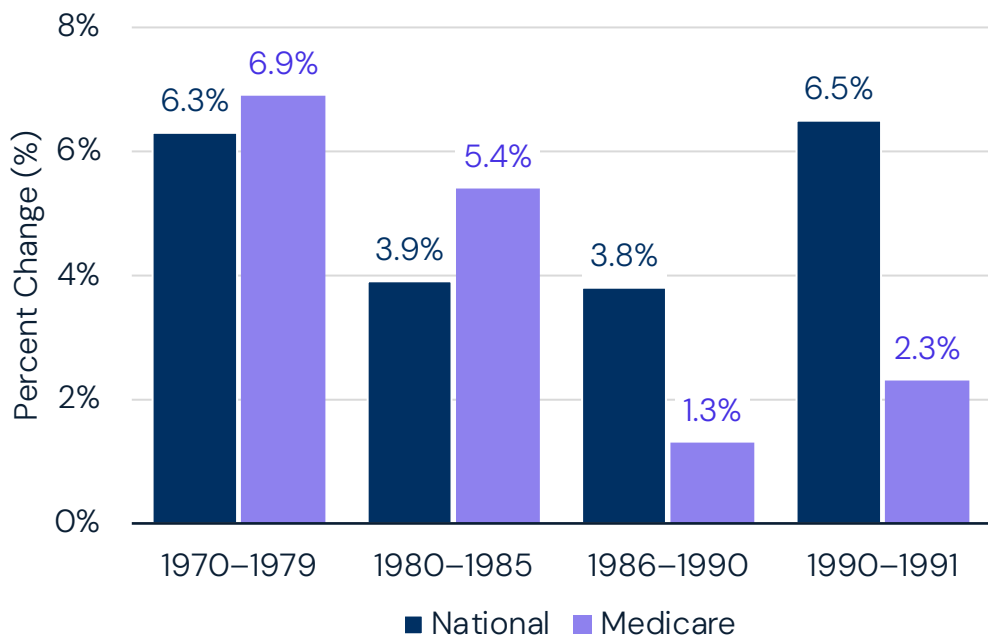
Note: CPI-U denotes national urban consumer price index; FFS denotes fee for service; CMS denotes Centers for Medicare & Medicaid Services.
Source: Georgetown University Center on Health Insurance Reform.

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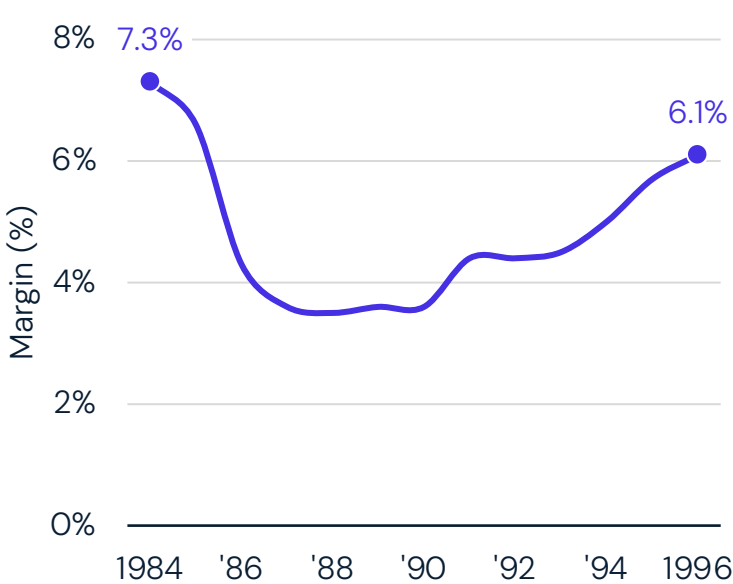
DRG Implementation Fundamentally Changed U.S. Healthcare Reimbursement

In 1983, Medicare hospital reimbursement transitioned from FFS to fixed prospective payment with the introduction of Diagnosis-Related Groups (DRGs). With DRGs, the only way for hospitals to generate positive margins is to deliver care during an inpatient stay at a cost lower than the applicable DRG payment amount. Immediately following this change, average hospital margins declined from 7.3% in 1984 to a low of 3.5% in 1988, followed by a period of moderate recovery. Notably, average length of stay declined by 3.4 days across five common conditions, ranging from a decrease of 5.6 days for hip fracture to a decrease of 1.7 days for pneumonia.

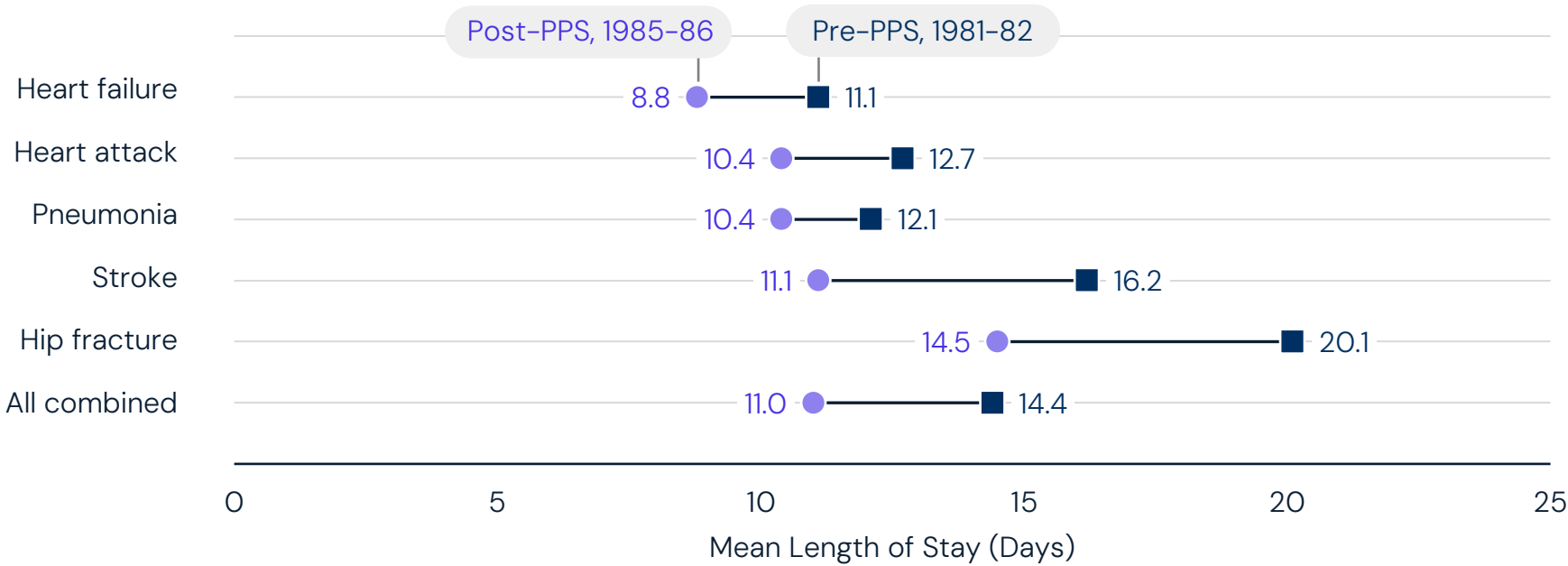
Annual Percent Change in National and Medicare Hospital Per Capita Spending, 1970–1991



Average Hospital Margins, 1984–1996



Average Length of Stay, Before and After DRG-PPS, by Condition



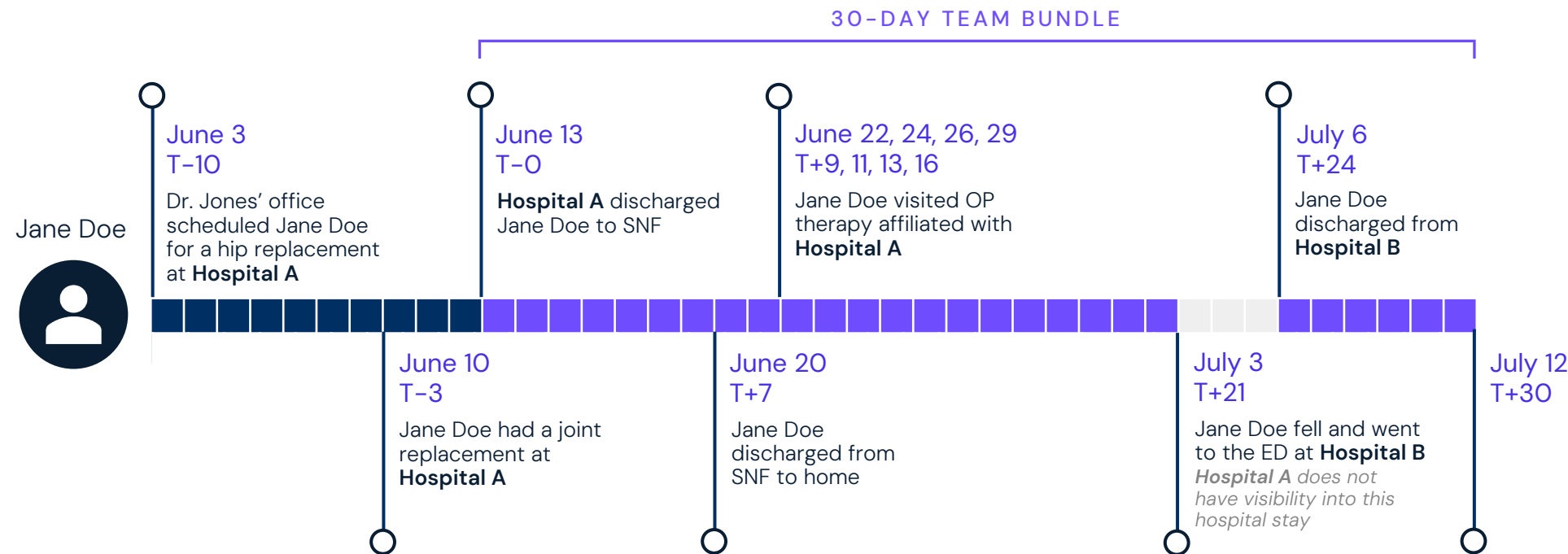
Note: PPS denotes prospective payment system; FFS denotes fee-for-service.
Source: Centers for Medicare & Medicaid Services; Prospective Payment Assessment Commission, 1992; Gold et al., Effects of selected cost-containment efforts: 1971–1993, *Health Care Finance Review*, 1993; RAND.

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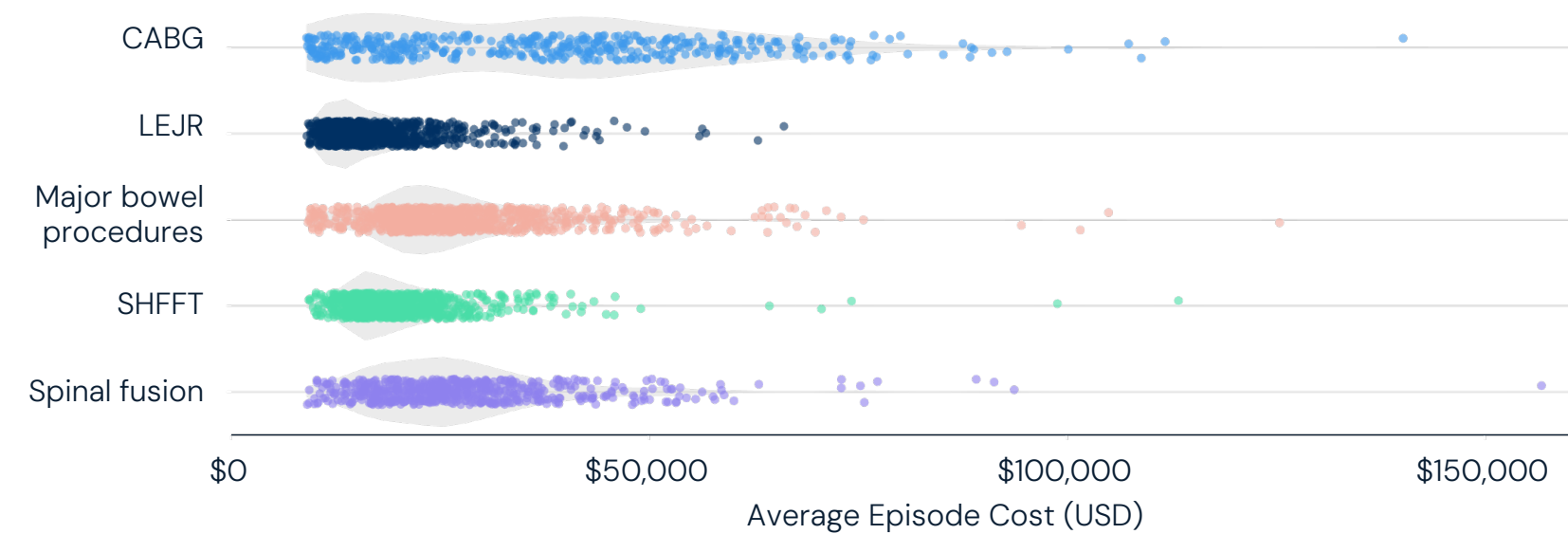
TEAM Imposes 30-Day Bundled Price Caps on the Most Profitable Surgeries At Over 700 Hospitals

TEAM is a mandatory, episode-based APM developed by CMMI to improve care coordination and cost efficiency for Traditional Medicare beneficiaries undergoing surgical procedures in one of five high-revenue categories. In essence, TEAM “expands” the DRG payment for procedures in these five categories across a 30-day period, regardless of where that care happens. Implemented across 186 CBSAs, TEAM covers roughly 25% of Medicare beneficiaries. Across TEAM hospitals, average 30-day episode costs were highest for CABG, averaging \$36,453 and ranging 15.4x.

TEAM Patient Journey Scenario



Average Episode Cost of Eligible Surgeries Performed at Mandatory TEAM Hospitals, 2024



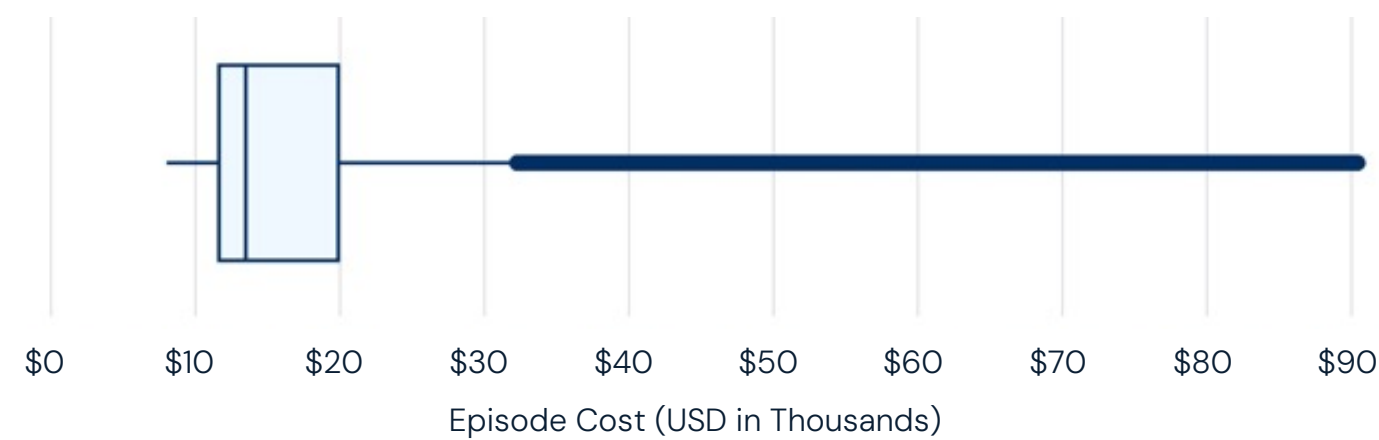
Note: TEAM denotes Transforming Episode Accountability Model; APM denotes alternative payment model; CMMI denotes Centers for Medicare and Medicaid Innovation; OP denotes outpatient; ED denotes emergency department; CABG denotes coronary artery bypass graft; LEJR denotes lower-extremity joint replacement; SHFFT denotes surgical hip and femur fracture treatment; SNF denotes skilled nursing facility; CBSA denotes core-based statistical area. Analysis is limited to episodes with a minimum cost of \$8,000, reflecting the Medicare outpatient facility fee floor for lower-extremity joint replacement procedures, and episode costs are winsorized at the 99th percentile to mitigate the influence of extreme high-cost outliers. T- indicates days from hospital discharge date.
Source: Centers for Medicare & Medicaid Services Limited Data Set (LDS) files.

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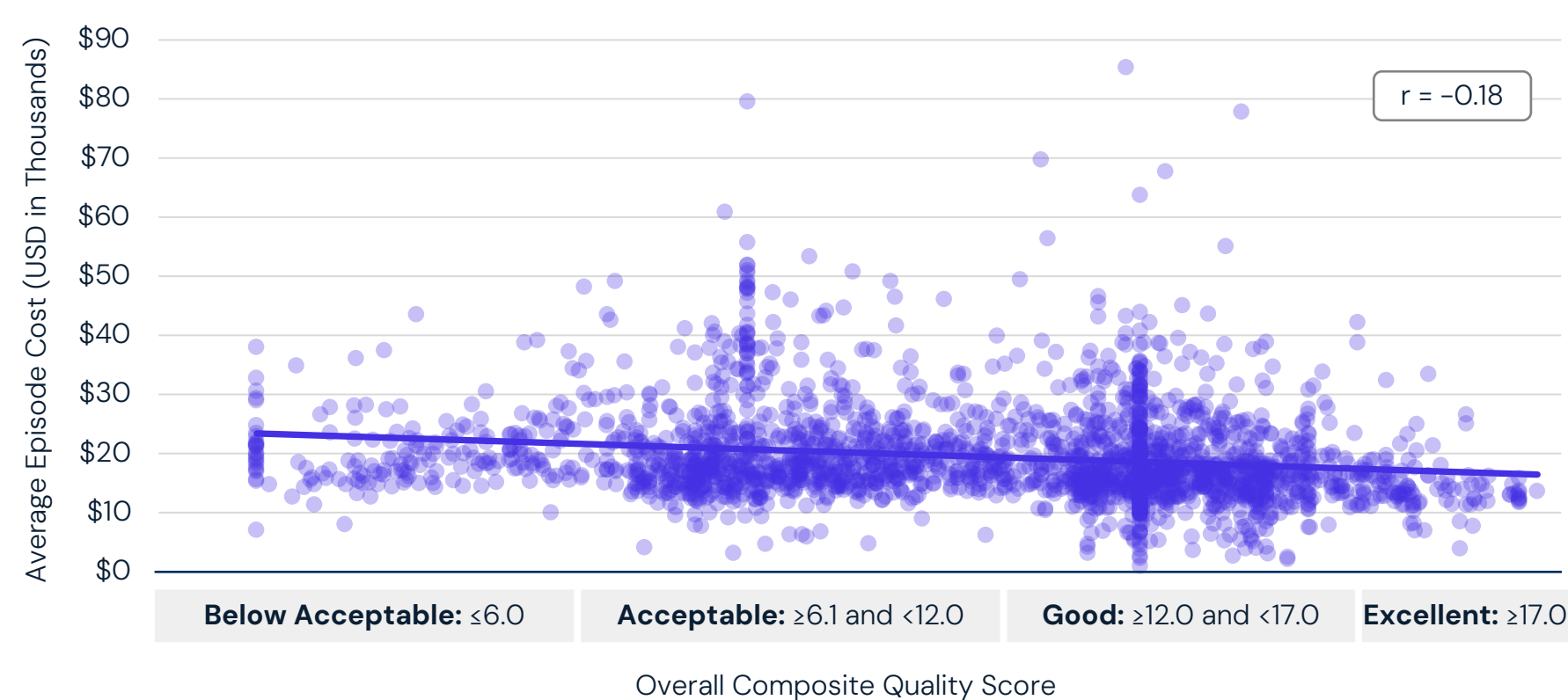
CJR-X Extends Price Caps for LEJR to 90 Days at Remaining Hospitals

The CJR-X model, beginning January 1, 2028, will require every short-term acute care hospital not already participating in TEAM (except hospitals in Maryland) to assume financial accountability for the total 90-day cost of LEJR episodes for Traditional Medicare beneficiaries. In 2024, 90-day LEJR episode costs at CJR-X hospitals averaged \$19,179. Notably, there is an extremely weak correlation ($r=-0.18$) between average episode cost and hospital CQS.

90-Day LEJR Episode Costs at CJR-X Hospitals, 2024



Average 90-Day LEJR Episode Cost vs. CQS at CJR-X Hospitals, 2024



Note: TEAM denotes Transforming Episode Accountability Model; CJR-X denotes Comprehensive Care for Joint Replacement Expanded; CQS denotes Composite Quality Score; LEJR denotes lower-extremity joint replacement. Analysis is limited to episodes with a minimum cost of \$8,000, reflecting the Medicare outpatient facility fee floor for lower extremity joint replacement procedures, and episode costs are winsorized at the 99th percentile to mitigate the influence of extreme high-cost outliers. This analysis used the Pearson correlation coefficient (r) to examine the strength of the linear relationship between measures of episode cost and CQS.

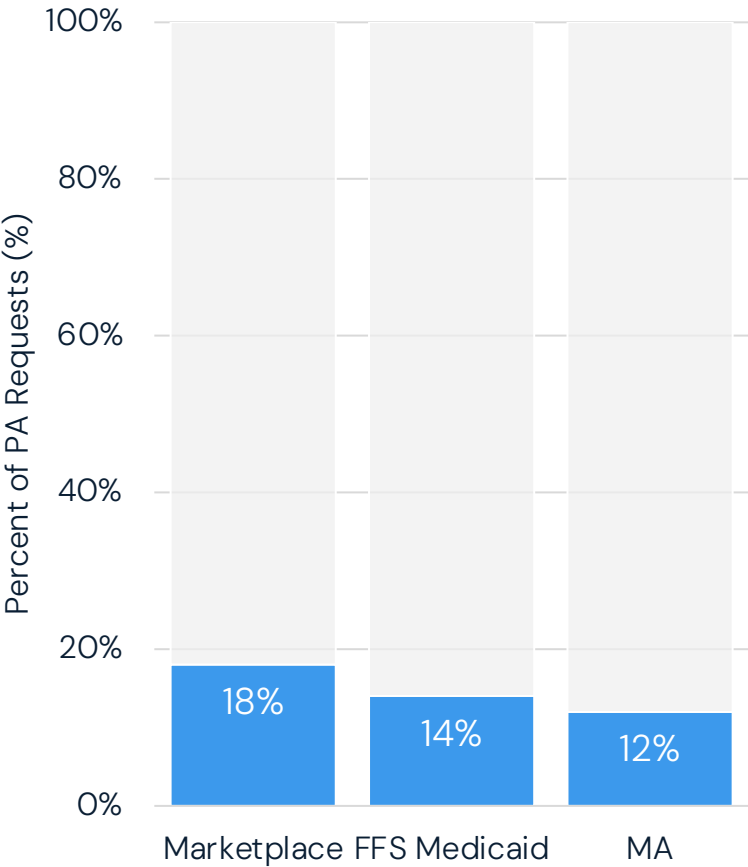
Source: Centers for Medicare & Medicaid Services Limited Data Set (LDS) files.

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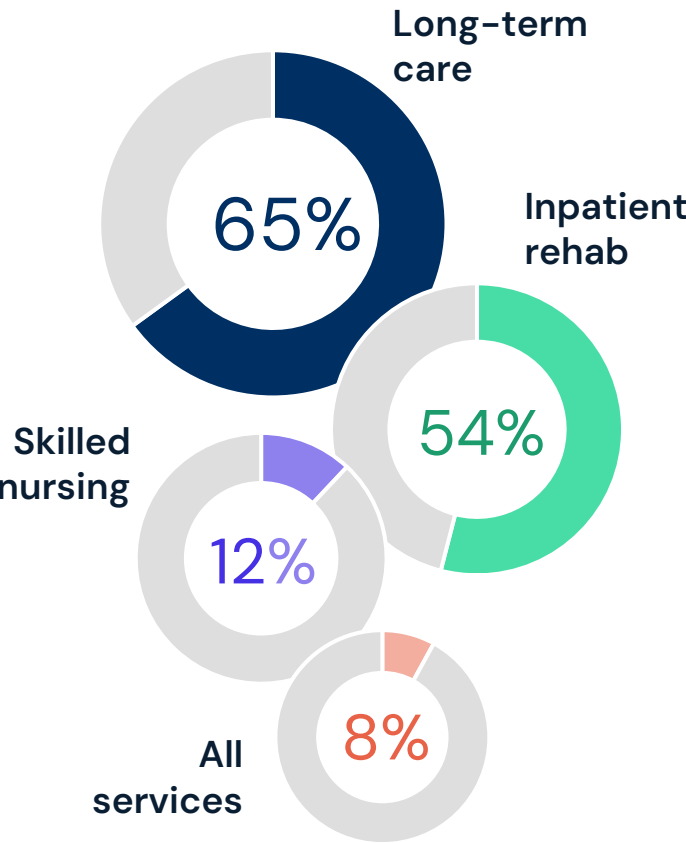
Prior Authorization Prioritizes Short-Term Savings Over System Efficacy

Of prior authorization requests, 18% of ACA marketplace, 14% of FFS Medicaid and 12% of MA requests were denied in 2025. Overall, 8% of all services in MA required prior authorization in 2024, but that share rose to 65% for long-term care services. Most physicians report that prior authorization increases utilization by requiring ineffective initial treatment (75%) and additional office visits (73%).

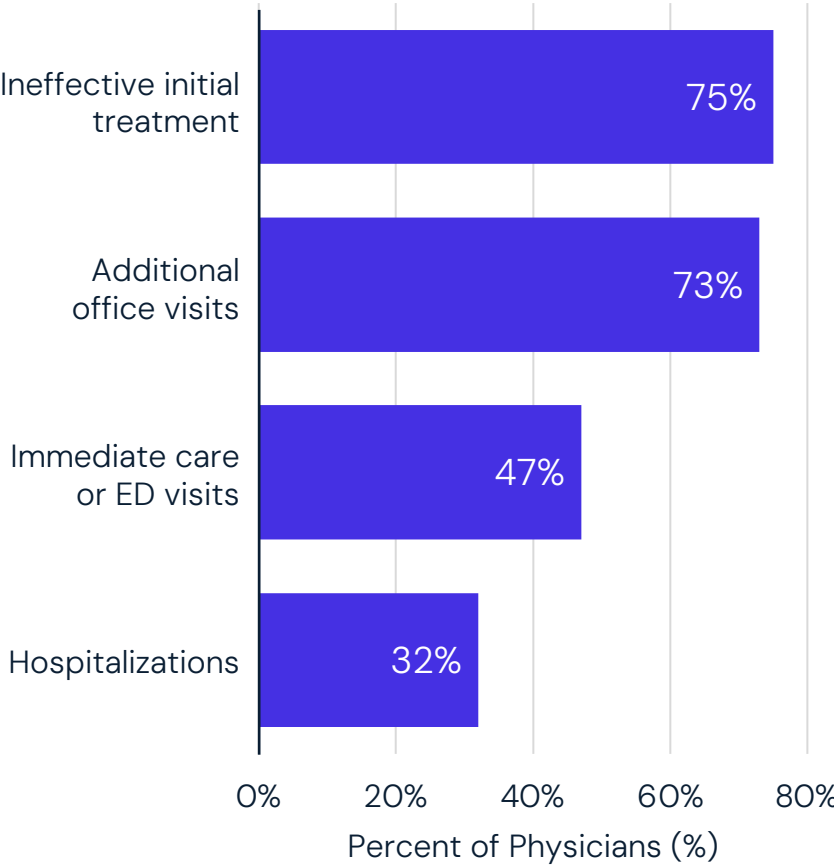
Share of PA Requests Denied, by Payer, 2025



Share of MA Services Requiring Prior Authorization, 2024



Share of Physicians Reporting PA-Driven Utilization Increases, 2025



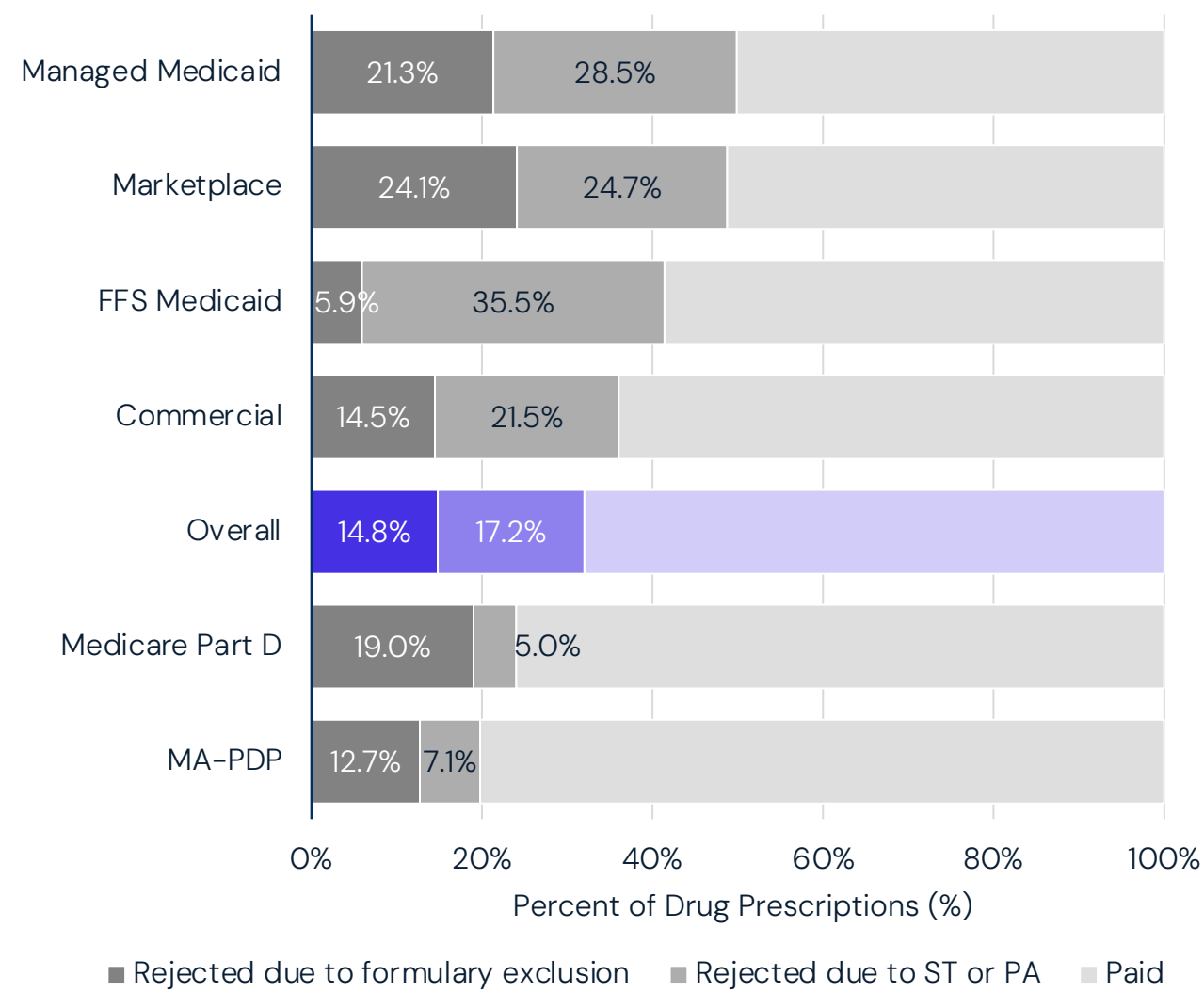
Note: PA denotes prior authorization; MA denotes Medicaid Advantage; FFS denotes fee-for-service; ED denotes emergency department; ACA denotes Affordable Care Act.
Source: KFF; American Medical Association Prior Authorization Physician Survey.

NEGATIVE-SUM GAME

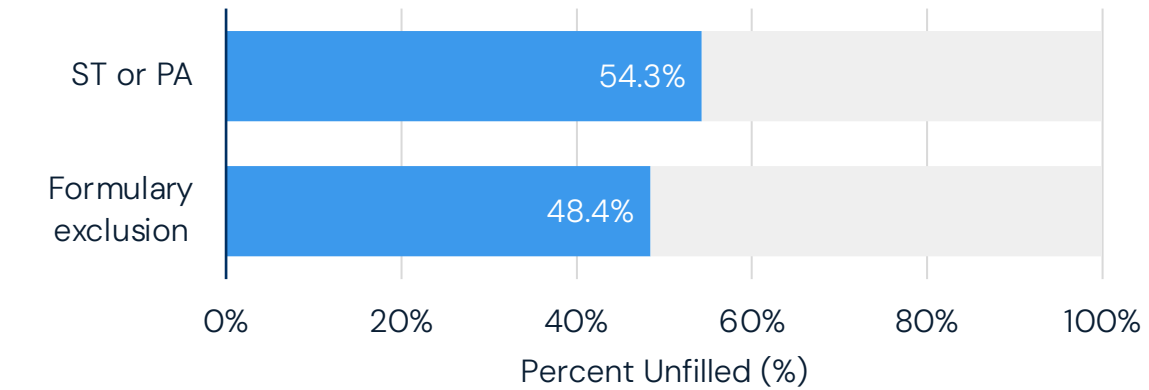
Utilization Management Creates Therapeutic Gaps and Delays

Utilization management, consisting of step therapy, prior authorization and formulary exclusion, is applied to 32.0% of all drug prescriptions and almost half of prescriptions on managed Medicaid (49.8%) and Marketplace plans (48.8%). Utilization management has consequences for patients. About half of prescriptions subject to utilization management went unfilled, and even those that were eventually filled were delayed an average of 10.8 to 13.3 days.

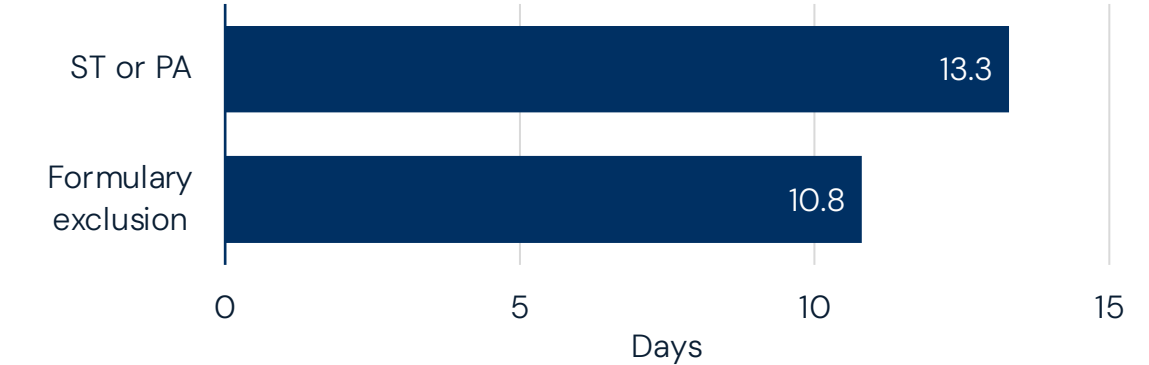
Prescription Drug Payment Decisions by Payer, 2018–2024



Share of Prescription Drugs Subject to Utilization Management That Went Unfilled, 2018–2024



Average Fill Delay for Prescription Drugs Subject to Utilization Management, 2018–2024



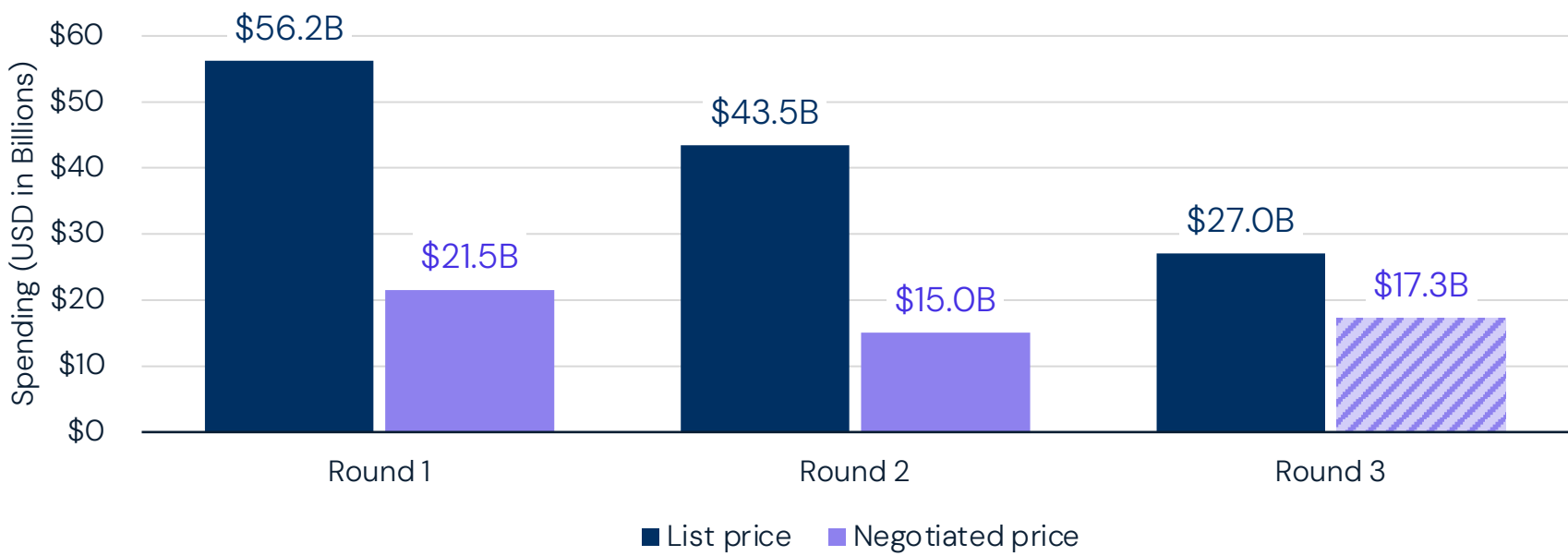
Note: ST denotes step therapy; PA denotes prior authorization; FFS denotes fee-for-service; MA denotes Medicare Advantage; MA-PDP denotes Medicare Advantage Prescription Drug Plan.
Source: Levy et al., Formulary-Related Insurance Denials of Single-Source Branded Drugs in the United States, JAMA, 2026.

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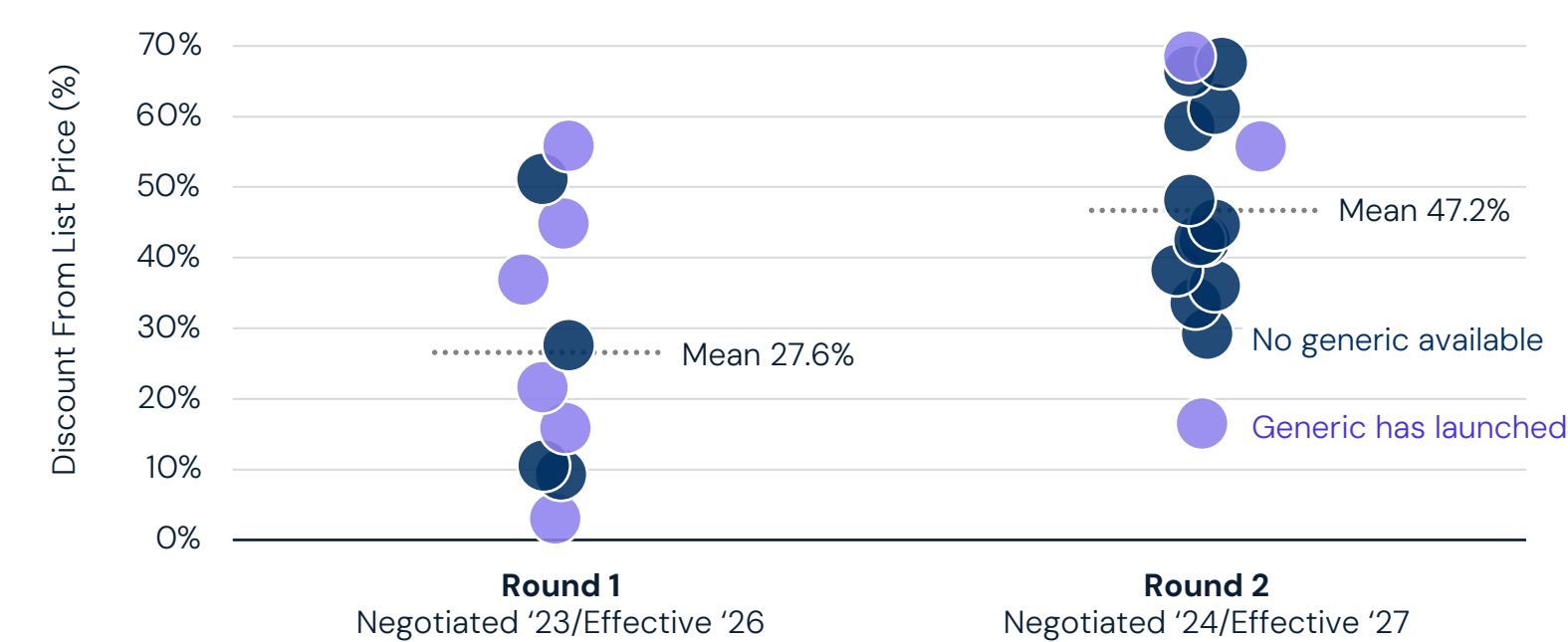
IRA Drug Negotiations Have Saved an Estimated \$63.1B

The Inflation Reduction Act amended existing law that previously barred the HHS Secretary from negotiating drug prices with manufacturers. Since enactment, CMS has released three rounds of drug price negotiations, taking effect between 2026 and 2028. Medicare spending on drugs included in the first round of negotiations totaled \$56.2B in 2023. Under the negotiated prices, spending would have been \$21.5B. With negotiated prices in place for drugs in the first two rounds, Medicare is projected to save \$63.1B in drug spending over 10 years. Notably, generics were launched for six of the 10 drugs included in the first round and three of the 14 drugs included in the second round.

IRA Negotiated Drug List Prices vs. Negotiated Prices, by Round



IRA Negotiated Drug Discounts From Estimated Net Cost Pre-IRA, by Round



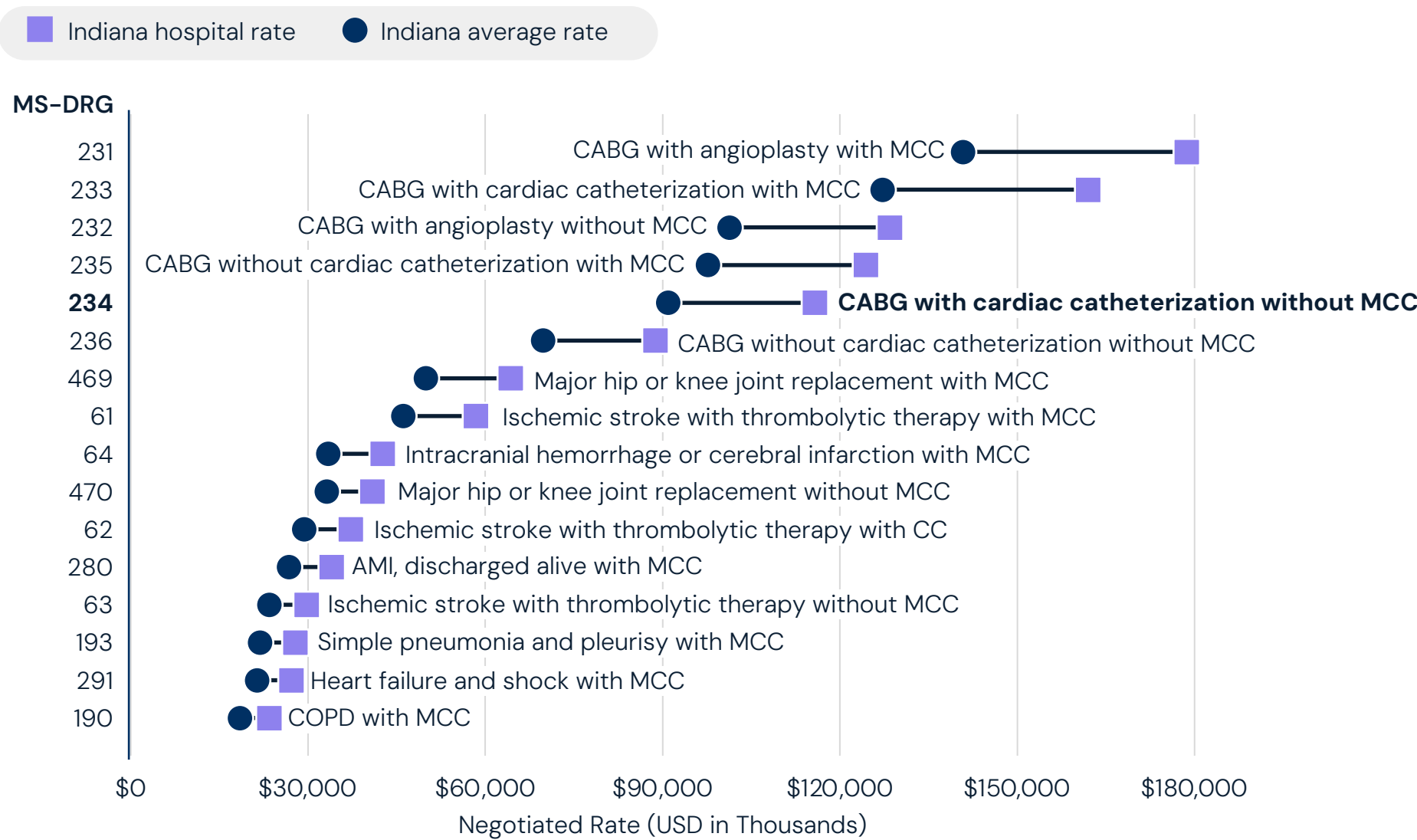
Note: IRA denotes Inflation Reduction Act. Round 1 list prices are from 2023, round 2 list prices are from 2024. Round 3 negotiated prices have not yet been finalized; prices are expected by November 2026. Projected spending reflects an estimate derived by applying a 36% net savings rate – the midpoint of the 22%–44% range observed across Rounds 1 and 2 of IRA negotiations – to Round 3 baseline expenditures. Estimate sourced from American Action Forum (February 2026). Actual savings will vary.
Source: Centers for Medicare & Medicaid Services; American Action Forum; The Brookings Institution.

NEGATIVE-SUM GAME

Price Caps Carry Substantial Revenue Implications

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 the state-level average, using coronary bypass with cardiac catheterization procedures as an example, reimbursement would decline by \$24,835 per case at a select Indiana hospital, equivalent to \$5.0M in reduced revenue for a hospital performing 200 procedures annually.

Actual and Capped State Average Rates for Select MS-DRGs at a Select Indiana Hospital, 2026



Coronary Bypass with Cardiac Catheterization (MS-DRG 234)

Approximate hospital-level procedure volume: **200**

Hospital-level average negotiated rate: **\$115,754**

Indiana average negotiated rate: **\$90,919**

Current reimbursement amount: **\$23.2M**

Reimbursement under state average: **\$18.2M**

Reduced reimbursement
-\$5.0M

Note: CABG denotes coronary artery bypass graft; MCC denotes major complication or comorbidity; CC denotes complication or comorbidity; AMI denotes acute myocardial infarction; COPD denotes chronic obstructive pulmonary disease. Analysis was conducted using negotiated rates for UnitedHealthcare.

Source: Trilliant Health Provider Directory and health plan price transparency dataset.

Conclusion

2026 Trends Shaping the Health Economy

01

WHAT SYSTEM?

The U.S. Healthcare "System" Does Not Function as a System

02

POPULATION UNWELLNESS

Population Unwellness Is a Collective Failure That the "System" Is Not Designed to Address

03

MARKET FAILURE

The Disconnect Between Demand and Supply Is a Market Failure

04

INCONSISTENT VALUE

Value Is Not Incentivized; Therefore, It Is Not Measured or Managed

05

FRAUD, WASTE, ABUSE

Misaligned Incentives Manifest in Systemic Fraud, Waste and Abuse

06

NEGATIVE-SUM GAME

Stakeholders Fail to Understand the Health Economy Is a Negative-Sum Game at Their Peril

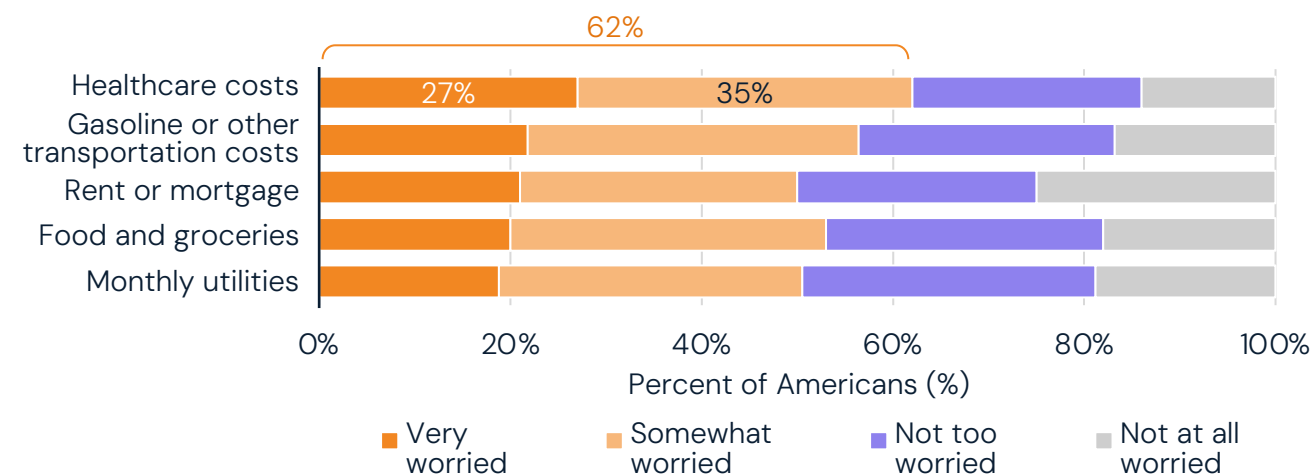
CONCLUSION

Key Stakeholders Are Ready for Change

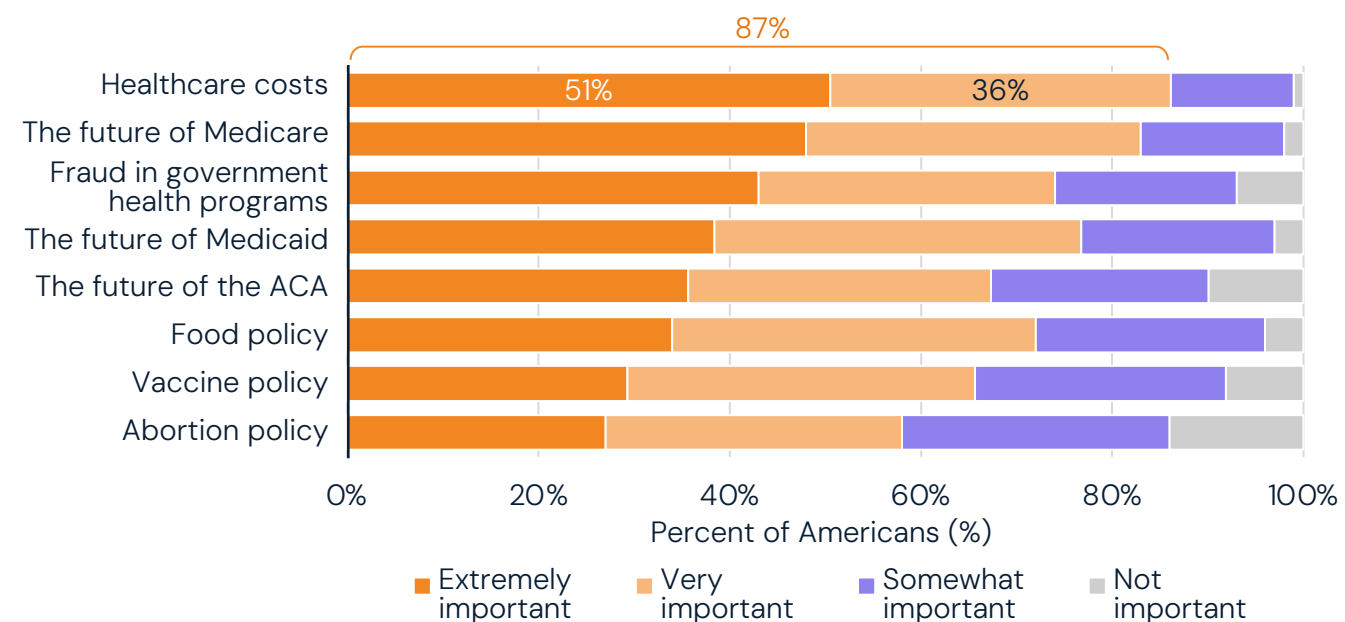
While they might not know it by name, the electorate understands the tragedy of the commons and is ready for change. As the 2026 midterm elections approach, healthcare costs are the public's top economic worry, ahead of gasoline, groceries and housing costs, and fraud in government health programs is a top concern. Likewise, employers see growing value in policy reform. Between 2023 and 2026, the share saying that hospital rate regulation would be very or somewhat helpful grew from 65.5% to 82.6%.

American Sentiments

How worried, if at all, are you about being able to afford each of the following for you and your family?

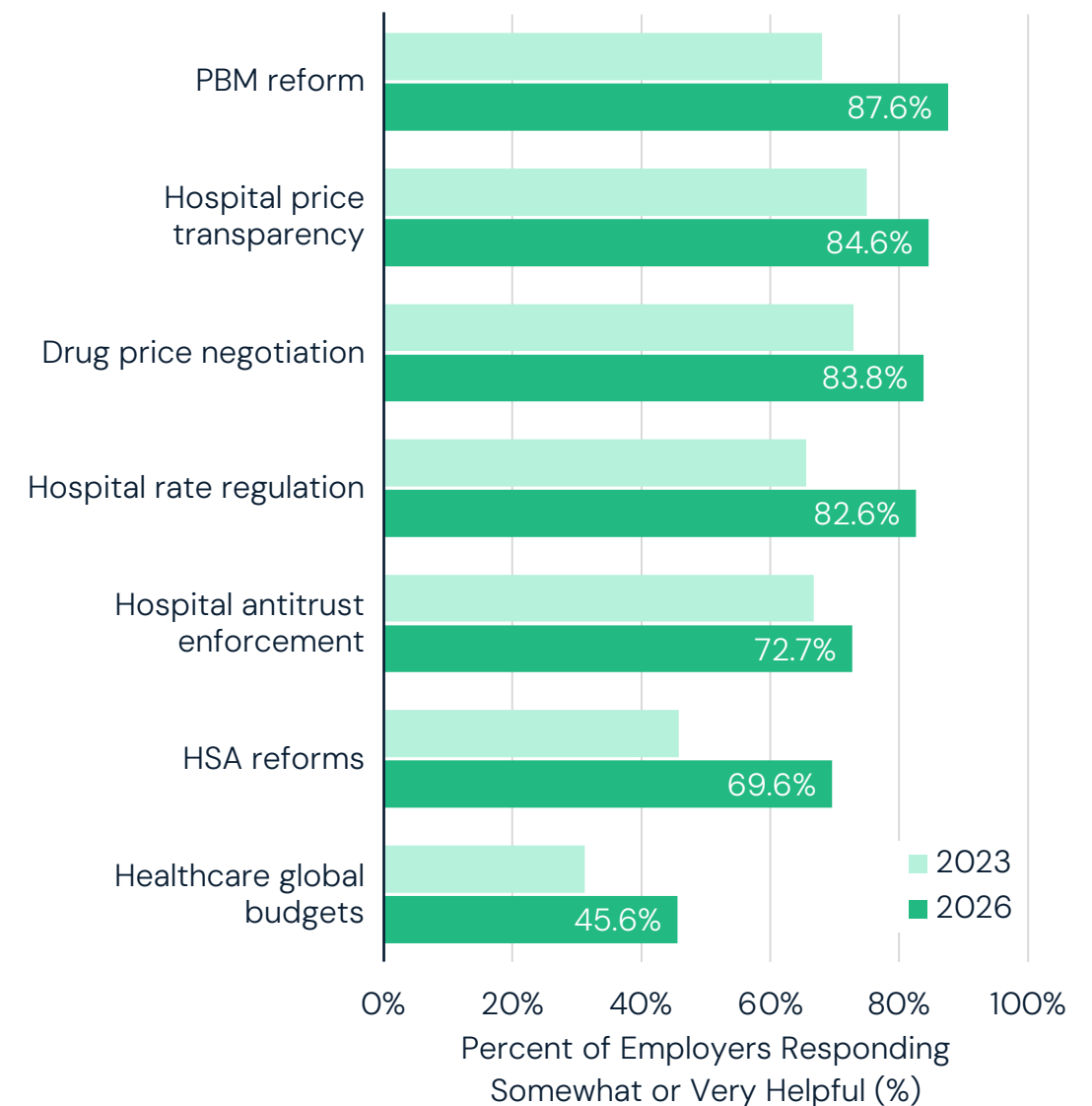


How important, if at all, do you think it is for candidates in the 2026 midterm elections to talk about each of the following?



Employer Sentiments

How helpful will these policy reforms be?



CONCLUSION

Bringing Value to the U.S. Health Economy Requires Enclosing the Commons

The U.S. health economy is a textbook case of a tragedy of the commons: every stakeholder's individually rational response deepens a collective failure. As a result, costs continue to rise, access worsens, health outcomes stagnate and resources are allocated inefficiently.

Because of the scope of the health economy's tragedy of the commons, reform is inevitable. **The question is whether change is pursued proactively from within the system or imposed externally through government intervention.**

Who will assign ownership, cost and accountability to the parties that have so far escaped them, and which stakeholders will be impacted the most?

This report highlights six trends that reveal the nature of the tragedy: 1) an accidental history that produced a system no one designed and increasingly few can afford; 2) a population whose health is declining faster than a sick care system built to intervene, not prevent, can respond; 3) a marketplace that has never defined, and therefore does not measure, whether what it delivers is comparatively – or at all – valuable; 4) an incentive structure so misaligned that fraud, waste and abuse have become structural rather than exceptional; 5) a supply of care built around what is profitable rather than what is needed,

leaving primary and preventive care chronically scarce; and 6) and a reckoning now arriving from outside the system, as cost controls collide with a health economy that is no longer organically growing.

Hardin considered **two paths out of the tragedy** he described. One was **enclosure**: converting an open-access resource, one anyone can use and no one is individually responsible for maintaining, into a bounded resource with a specific, accountable owner who bears the full cost and captures the full benefit of their own decisions. Applied to grazing land, enclosure meant fencing the commons and assigning each parcel to a herder, who could no longer profit from overgrazing a pasture that was now their own. The other was what Hardin called "**mutual coercion, mutually agreed upon,**" rules imposed and enforced from outside, typically by government, whether or not any individual user agrees to them. The choice is stark: **choose to enclose yourself or be enclosed by government regulation.**

To begin building fences in the health economy, two things are required, one is a question of values and the other is a question of data.

First, **stakeholders must agree on a shared goal.** The tragedy of the commons is rooted in the reality that Americans have never reached a consensus: **what is the U.S. healthcare system intended to deliver, to whom and at whose expense?**

Second, enclosure requires accountable owners. However, owners cannot be held accountable for costs that cannot be identified, and for most of the U.S. health economy's history, its costs were hidden by design and in accordance with antitrust laws. Price transparency has, for the first time, made it possible to calculate the cost of healthcare goods and services across markets, providers and clinical alternatives. With this information, **stakeholders across the health economy can build fences that create accountability for delivering value for money.**

CONCLUSION

Enclosure Should Be a Choice, Not an Accident

Enclosure from within depends on a precondition that has not yet been resolved: a shared understanding of what the health economy is intended to deliver, to whom and at whose expense.

The rest of the world provides ample evidence of how a value-informed enclosure manifests. The most comparable example is England's National Health Service, for which value for money is a stated, if undelivered, goal.

What should a healthcare system maximize, and which medical services and which stakeholders contribute to that goal? There is also a matter of responsibility. Who is obligated to finance that care? The individual, the employer or the government? And in turn, what is the purpose of health insurance itself? A risk pool for catastrophic, unpredictable events, as in every other insurance market, or a prepaid reimbursement mechanism for predictable, near-certain encounters and preventive care?

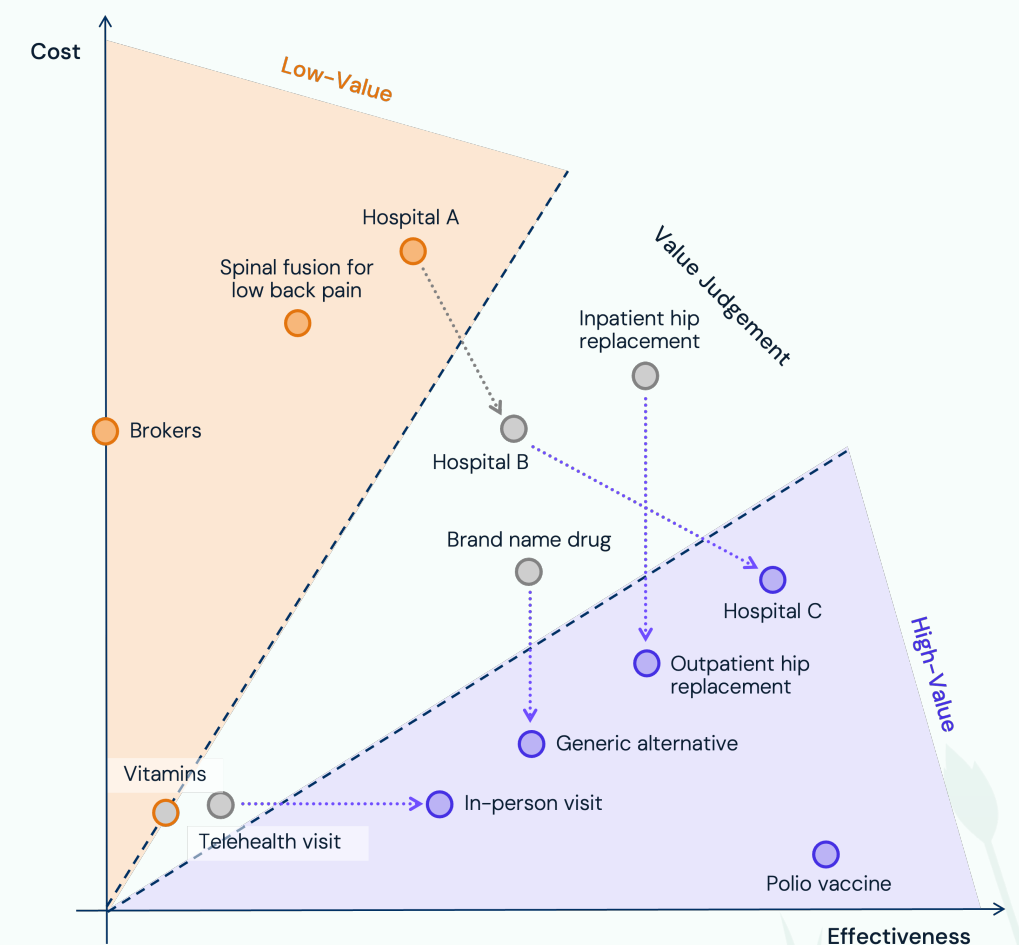
This report does not explicitly answer these questions, but it insists they be answered purposefully, and soon. As a starting point, this report asserts that value exists at the

intersection of cost and quality. **However, because value exists on a continuum, determining where high-value care begins and ends is something that the U.S. health economy will need to decide.** Enclosing the health economy according to a shared value framework provides an opportunity to deliberately choose what to prioritize, how to assign accountability and which stakeholders should bear the cost.

Importantly, this report reveals that Federal and state governments have already imposed several partial enclosures tied to cost: bundled payment models like TEAM and CJR-X enclose an episode of care, state-level price caps enclose a market and Medicare's drug price negotiation under the Inflation Reduction Act encloses manufacturer pricing power.

Unless we, as a society, begin to deliberately enclose the U.S. healthcare commons with a focus on value, the government will continue to fence it in for us with a focus on cost.

A Visual Guide to Assigning Value in Healthcare



Methodology & Acknowledgements

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 2025. 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.

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



67-year-old Man
Medicare Advantage
Chicago, Illinois



Annual Primary Care Visit
Large Health System
★★★
\$\$



Associated Lab Tests
Large Health System
★★
\$



Psychiatrist Visit – Rx Management
Private Practice
★★
\$\$\$\$



Acute Injury Requiring Stitches
Hospital ED
★★★
\$\$\$\$



Orthopedic Consultation
Large Health System
★★★
\$\$\$



Knee Replacement
Inpatient Surgery
★★★★
\$\$\$\$\$

★= Quality Rating \$= Relative Price

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

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