trilliant health

THE HEALTH ECONOMY SUMMIT

SEPTEMBER 2023

EXECUTIVE SESSION SUMMARIES

THE Summit

The Health Economy (THE) Summit program has been thoughtfully crafted to foster meaningful discussions and data-driven debate with the goal of challenging the status quo of the health economy.

THE Summit 2023 brought together key executives across the health economy to discuss and debate:

- What the data reveals about the key dynamics shaping healthcare supply, demand and yield; and,
- The implications of emerging trends and necessary strategies from different stakeholder vantage points.

Underlying the discussions was the concept of "first-principles" thinking, which is one of the best ways to reverse-engineer complicated problems and unleash creative possibility. Sometimes called "reasoning from first principles," the idea is to break down complicated problems into basic elements and then reassemble them from the ground up. It's one of the best ways to learn to think for yourself, unlock your creative potential, and move from linear to non-linear results.

This approach was used by the philosopher Aristotle and has more recently been touted by Elon Musk and Charlie Munger. It allows them to cut through the fog of shoddy reasoning and inadequate analogies to see opportunities that others miss. A first principle is a foundational proposition or assumption that stands alone. We cannot deduce first principles from any other proposition or assumption.

For example, Elon Musk's approach to problem-solving is grounded in first principles thinking. He believes that people often rely on past experiences or tradition rather than starting from the fundamental truths of a problem. When Musk wanted to make space travel more affordable, he broke down the cost of rockets to their material constituents and realized that they were only a small fraction of the total expense. He decided to create SpaceX and build rockets from scratch, deviating from the traditional, expensive manufacturing methods.

Applying first principles thinking in healthcare is crucial in order to challenge convention and long-held beliefs of what is possible, encouraging a deeper understanding of problems and innovative solutions by breaking them down to their fundamental elements.

The following executive summary presents the key insights and takeaways from each session across the two-day event, including panelist remarks and participant dialogue, representing diverse perspectives from an array of healthcare stakeholders.

2023 Trends Shaping the Health Economy

Sanjula Jain, Ph.D., Chief Research Officer, Trilliant Health

The health economy creates more data than any other part of the economy, but the industry has been challenged to distill and analyze the data in a way that provides meaningful information for decision makers. In this session, Dr. Sanjula Jain debuted the *2023 Trends Shaping the Health Economy Report*, which features 10 data-driven secular trends shaping the $4.3T health economy. Applying the economic principles of demand, supply and yield, the *Health Economy Trends Report* is the only study that examines data representative of 300M Americans, 2.7M providers and health plan negotiated rates nationally, revealing the emerging and intensifying trends shaping the negative-sum game environment in which all healthcare stakeholders must operate.

KEY TAKEAWAYS

The U.S. health economy continues to defy the laws of economics — demand, supply and yield. Our thesis is that any health economy stakeholder whose business depends on commercially insured patients can no longer afford to overlook these foundational economic principles. Why? Because the healthcare system is what game theorists call a "negative-sum game," whereby the costs invested into the system largely outpace the actual value or benefits received by patients or consumers.

2023 Trends Shaping the Health Economy *cont'd*

Operating in a negative-sum game means that every stakeholder will still lose in comparison to what they currently have or really need. In a health economy defined by reduced yield, the only way to "lose less" is to compete on value. The status quo is unsustainable for the health of Americans, and it is time for all health economy stakeholders to start playing by the immutable rules of a negative-sum game.

Connecting the dots across all 10 of these trends reveals the importance of delivering value for money:

1. The number of commercially insured Americans is declining steadily as declining birth rate fails to offset the aging into Medicare, and migration to sunbelt states will shift healthcare demand.
2. The physical and mental health of Americans has taken a hard turn downward, with higher under-40 mortality, rising cancer mortality and rates of forgone care rising due to cost.
3. Most newly approved drugs target genetic diseases and cancer.
4. Utilization of care in all settings declined except for the emergency department, with the 2021 rebound mostly caused by testing and treatment of COVID-19. The relationship between the number of comorbidities and consumption of healthcare services is not linear.
5. The public's dissatisfaction with healthcare is growing and younger patients are behaving more like consumers in seeking care from retail pharmacies and other non-traditional sources. Virtual care is being offered more widely, but demand is tapering, half of telehealth users have used it just once, and physicians perceive its quality as inferior to in-person care.
6. More consumers are using transactional delivery models such as urgent care and retail. Retailers are using low-acuity primary care as a loss leader.
7. Physician supply is constrained, as "payviders" Optum and Kaiser Permanente employee nearly 10% of U.S. doctors and organizations compete to hire more doctors as supply drops. Nursing supply rebounded in 2022 and the number of allied health providers is increasing to help meet physician shortages. The number of primary care providers would need to increase by 218,000.
8. Some healthcare markets have a price problem, but all have a cost problem, with rates often being lower in monopoly markets. Spending on lobbying is increasing to influence federal policy on M&A. The federal measure of market concentration is limited to inpatient usage, which may not be reflective, and market concentration is not a clear driver of quality or price.
9. Employers are paying more for less as costs rise, with a growing rate of self-insurance. Employer-sponsored insurance leaves employees being financially responsible for 10% and more of their overall incomes.
10. U.S. healthcare spending is unsustainable and value-based payments don't equal value for money. Site-neutral payments could reduce Medicare payments by over $1B for one office procedure alone – lumbar epidurals. Procedures cost multiples when performed in hospitals rather than in an outpatient setting.

According to the laws of economics, when supply exceeds demand or demand is flat or declining relative to supply, price (and therefore yield) goes down. The inverse has been true in healthcare for decades. Analyzing negotiated rates at the market level reveals the true "market price," and providers whose rates or quality are outliers will likely be forced to meet that market price to maintain their market share. The combination of regression to the lower market price with other policy initiatives like site-neutral payments and price caps would further reduce yield.

Hence, health plan price transparency ***should*** catalyze unprecedented and frenzied competition to win the hearts and minds of the consumer and the payer that keeps the current U.S. healthcare system afloat: the employer. If it does, the winners in healthcare's negative sum game will be those who deliver ***value for money***.

Competing in a Negative-Sum Game

Hal Andrews, President and Chief Executive Officer, Trilliant Health
Terry Shaw, President and Chief Executive Officer, AdventHealth
Sara Vaezy, EVP, Chief Strategy and Digital Officer, Providence

Every participant of THE Summit, regardless of stakeholder vantage point or executive role, is navigating the complexities of the hospital business being a negative sum game. The only way to thrive in this situation is to "take something from another party" but even so, the most competitive providers will still experience losses relative to the status quo. Ultimately, every non-hospital or health system stakeholder's business model has some direct or indirect dependency on the traditional provider. Therefore, the question for the collective group becomes "how do we lose less" in a health economy where demand is flat to declining, supply is constrained and yield is random?

KEY TAKEAWAYS

What health economy trend is most concerning and/or important to you as you lead your organization over the next few years? And why? Is this different from what you had been focused on over the past few years?

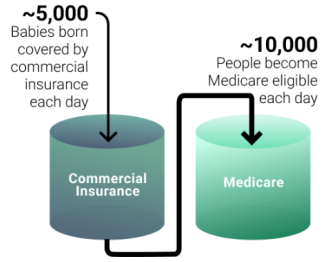
- There's a consensus that healthcare demand is changing and ignoring it or interpreting data differently won't change that reality. The integration of digital healthcare is crucial, but the current fragmented state of telehealth needs improvement.
- Balancing community benefit with limited resources also poses challenges to all health systems, irrespective of geography. To succeed, organizations should prioritize owning a strong provider base and acute facilities while forming strategic partnerships for other services, with an emphasis on streamlined access through a single sign-on in a federated ecosystem.
- In healthcare, assessing market-level demand and reimbursement rates is crucial, particularly for the commercial market, which is declining. While some regions may not immediately experience increasing demand, the ability to capture commercial demand is essential for offsetting community benefit costs.
- Building a robust network of healthcare providers and facilities is essential for maintaining competitiveness. Strategic partnerships, particularly when they allow for a significant ownership stake, can be valuable in areas like surgical units and imaging.
- Winning consumer trust and loyalty is also paramount. Healthcare organizations should focus on capturing the minds and hearts of their target audience. To succeed, it's important to prioritize owning a core network of doctors and a strong acute care footprint while leveraging partnerships for other services.
- Building a provider brand with enough touchpoints across the healthcare system will prevent businesses from becoming delaminated.

Competing in a Negative-Sum Game *cont'd*

Who are you most concerned about competing with – Amazon, Walmart or Optum? What are their strengths, weaknesses, opportunities and threats?

- **Optum:** While Optum lacks a core mission, it has a great flywheel and focuses on reinforcing its model to target the profitable parts of the healthcare system and capitalize. They have an agile culture, which facilities fast decision making. Optum is also not intimidated by the regulatory environment, which can't be said of other new entrants to healthcare.
- **Walmart:** Walmart's greatest strengths are trust, price transparency, convenience and customer loyalty, with the greatest opportunity in improving access to primary care in rural America. Walmart would benefit in partnering with health systems to handle downstream needs.
- **Amazon:** Amazon has been successful in treating the first encounter with the patient as the most important touchpoint, which health systems can learn from. Despite this, Amazon needs to better understand the distinctions between patients and consumers. However, Amazon is afraid of the regulatory environment, which is a competitive force for health systems.

Dissecting the strategies of non-traditional or new healthcare entrants like Walmart, Amazon and Optum is crucial for traditional healthcare stakeholders to understand not only the competitive advantages (e.g., expertise in navigating the regulatory environment) they have over traditional players, but what potential learnings (e.g., price transparency, speed to action) could be leveraged in developing winning strategies in a negative sum game.

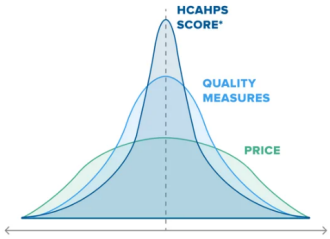


Demand

The commercially insured population is shrinking, as ~10,000 Americans become Medicare-eligible each day, while almost half of the ~10,000 daily births are covered by Medicaid.

Supply

Patients have an increasing number of providers from which to choose, with new entrants offering services to compete with traditional providers at lower prices.



Yield

Negotiated rates have been the most closely guarded trade secret of health insurers -- until now. Health plan price transparency reveals a wide disparity in the rate that payers reimburse different providers for delivering the same service in the same market.

Fireside Chat: Turning Pain into Purpose to Accelerate Therapeutic Access

Devin Carty, Chief Executive Officer, Martin Ventures
Sandra Abrevaya, Co-Founder and Chief Executive Officer, Synapticure; Co-Founder, I AM ALS
Brian Wallach, Co-Founder and Board Co-Chair, Synapticure; Co-Founder, I AM ALS

Meeting in 2008 on Barack Obama's campaign trail, Sandra Abrevaya and Brian Wallach's alliance took on a deeper meaning when Brian received an ALS diagnosis at 37. Refusing to accept the status quo of the U.S. healthcare system, they headed to Washington, D.C. The outlier couple not only lobbied but also played an instrumental role in drafting the 2021 Accelerating Access to ALS Act, channeling $500M towards ALS research. Their advocacy journey led to the establishment of I AM ALS, a patient-led non-profit for families affected by the disease. Taking their mission further, they co-founded Synapticure to redefine ALS patient care through its personalized teleneurology platform. During this Fireside Chat, Sandra and Brian told their inspiring story of resilience and challenging established treatment paradigms.

KEY TAKEAWAYS

- Leveraging their expertise in law, political organizing and advocacy, Sandra and Brian's ability to work alongside policymakers through their efforts to raise awareness and funding for ALS research has garnered hundreds of millions of federal funding for ALS research and expanded earlier patient access to novel and experimental treatments for ALS.
- Alongside their advocacy work with I AM ALS, Sandra and Brian leveraged their own experiences in complex care navigation and prolonged wait times up to 12 months to access neurodegenerative specialists in order to found technology platform, Synapticure. The teleneurology platform provides care navigation and telehealth services for patients with neurodegenerative diseases, cutting wait times to a matter of weeks.
- Sandra and Brian also discussed the outsized role of caretakers for patients with neurodegenerative diseases, emphasizing importance of lending your time to the caretakers in your life.

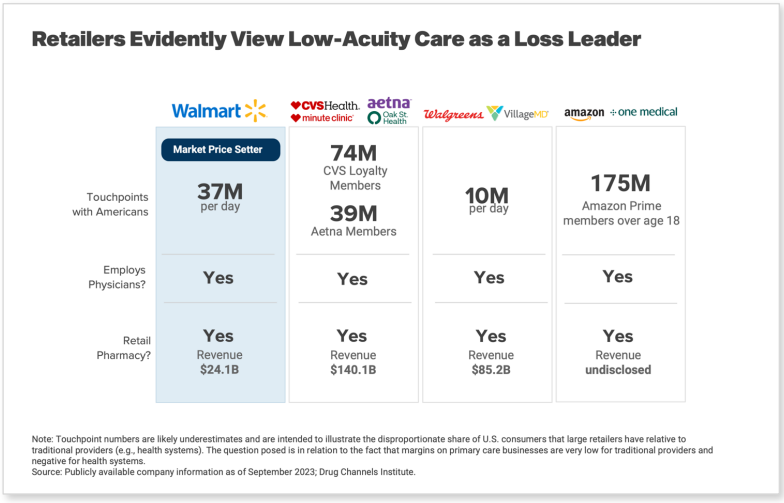
Building Flywheels for Healthcare

Sara Vaezy, EVP, Chief Strategy and Digital Officer, Providence
Aaron Martin, VP of Healthcare, Amazon

Loyalty is essential for increasing share of care, lowering churn, increasing system capacity and reducing costs to re-acquire consumers – all strategic priorities for any organization. As more industries have vertically integrated, loyalty programs have taken various shapes and sizes but are all predicated on the same concept – the flywheel effect. In business terms, a flywheel is the mechanism that drives consumers to a platform and keeps them coming back for more. While a flywheel is hard to start, once it has started moving, it is difficult to stop. Successful flywheel strategies range from companies like Starbucks whose consumers often buy drinks several times a week, to Amazon Prime members spending on average $800 more per year than nonmembers, to avid skiers who plan their entire winter around a trip to a flagship Vail-owned mountain. How can we take this concept and apply it to healthcare?

KEY TAKEAWAYS

- Successful flywheels include Amazon, which focuses on speed, selection and lower prices, and Starbucks, which focuses on building daily habits, building a financial "bank" through loyalty programs and prioritizing personalization. These concepts can be applied to healthcare, though they would materialize differently.
- Building flywheels in healthcare can be challenging. Healthcare is not traditionally consumer-centric has historically been a business-to-business (B2B) industry, with consumers often feeling incidental between providers and payers. Improving the customer experience in healthcare is essential to building a flywheel. Root problems, such as payment processing and financing, have remained unsolved in healthcare. These problems hinder the creation of consumer-centric flywheels. Healthcare's risk tolerance and mechanisms for decision making differ from tech industries (e.g., Amazon's efficient data-driven six pager meeting structure), leading to slower innovation and adoption. Payment mechanisms need to evolve to support consumer-centric healthcare, such as models with $0 deductibles and copay-only structures. A shift in healthcare culture towards data-driven decision-making and streamlined processes is necessary.
- Healthcare can benefit from digital transformation, as demonstrated during the COVID-19 pandemic when telehealth was rapidly deployed by health systems without substantial errors and quality concerns, but the solutions deployed were ultimately substandard. Instead, there was a missed opportunity in treating telehealth like shift towards "digital transactions" in banking, which can be harnessed to create more efficient and consumer-centric processes.



- Healthcare organizations can collaborate with third-party providers to offer a broader range of services. This approach aligns with the marketplace model, where buyers and sellers of healthcare services are better matched. Partnerships and marketplace models, like Amazon's approach, can help navigate this complexity.
- Applying the flywheel concept to healthcare involves focusing on fundamental principles, personalizing patient experiences, simplifying decisions and overcoming the unique challenges of the healthcare industry. This approach, combined with partnerships and a commitment to data-driven decision-making, can drive loyalty and improve patient outcomes in healthcare.

Value Competition for Employer Networks

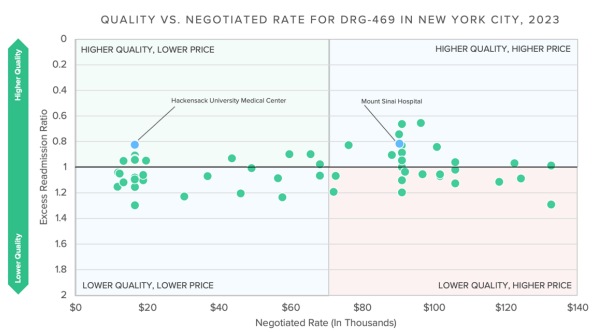
Hal Andrews, President and Chief Executive Officer, Trilliant Health
Stu Clark, Chief Financial Officer, Premise Health
Jodi Hubler, Gratum Ventures
Jason Ross, EVP Medical Groups, Privia Health

The startling spread in pricing for healthcare services begs for explanation. As a result, health plan price transparency should inaugurate an era of unprecedented and frenzied competition to win the hearts and minds of the payer that keeps the current U.S. healthcare system afloat: the employer. Producing value for money for employers requires value-based competition by providers across every service line, meaning that open networks and any willing provider statutes are essential. To what extent can employers bend the cost curve merely by steering "away" from a handful of providers who are outliers on price or quality for a particular service line?

KEY TAKEAWAYS

- Healthcare costs are increasingly becoming an earnings per share (EPS) issue. Healthcare is the most expensive thing for most organizations and are at higher risk of missing EPS because of their company's health plan. However, there are disincentives from health plans to control costs. There is misalignment in the $2T employer healthcare industry because consultancies are telling employers to not be proactive.
- When engaging large employers around value-based care, most don't have the skillset to be successful with network development. Fostering engagement requires having local primary care provider (PCP) who actually have the time and willingness to understand value-based care and making it clear how patients benefit. When healthcare needs arise, the PCP needs to coordinate care in a hyper local way. Scaling this model across multiple geographies is incredibly challenging, however.
- There is a dearth of PCPs, which are the gatekeepers to the healthcare system if applied correctly. However, Optum owns 70K doctors and health systems acquired provider practices. If the health system oversees primary care practices for your employees, their incentives ultimately are "heads in beds" and high-cost diagnostics. In that system, there are no incentives for the PCPs to "own" the patient and help them through the system. Employers need to create access, remove financial barriers and have PCPs ensure that patients are effectively referred to specialty care.
- Applying first principles, if we deconstructed health insurance from scratch, what would it look like? A health plan with a $0 deductible and a copay structure that breaks things down intuitively by a condition, characterized by transparent prices based on quality of providers and services. This plan structure allows for free market principles by paying more for the higher efficacy provider, but the option to go to the other lower efficacy provider at a different price.

Price and Quality Are Not Correlated in Highly Competitive Markets Like New York...



Note: Analysis was conducted using negotiated rates for a single national payer — UnitedHealthcare. MS-DRG 469 indicates Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity.
Source: Trilliant Health's national all-payer claims database; Provider Directory; Health Plan Price Transparency dataset; Hospital Readmissions Reduction Program data.

- No single health system can be good at everything. To solve the cost problem, health systems need to figure out which services they are best at. Service line market share would change drastically, but market-level volume would remain constant.

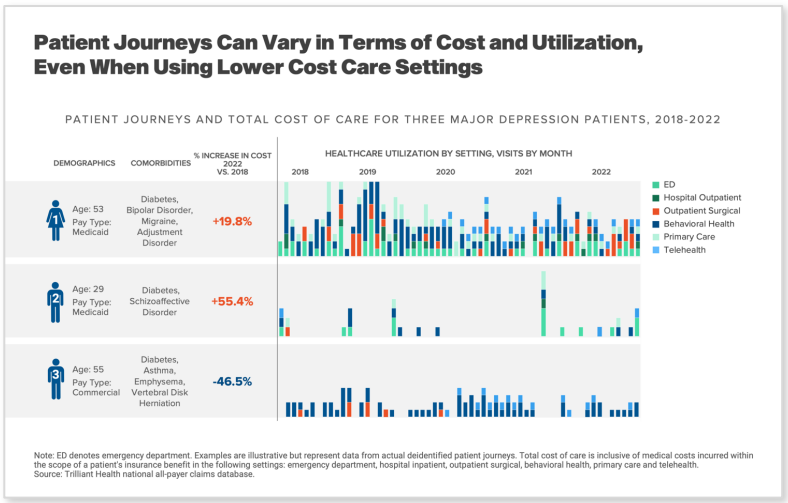
Balancing Consumer Preferences and the "Ideal" Patient Pathway

Sanjula Jain, Ph.D., Chief Research Officer, Trilliant Health
Saranya Loehrer, M.D., MPH, Chief Health Equity Officer, Teladoc Health
Todd Latz, CEO, GoHealth Urgent Care
James Allen, VP, Test-to-Treat & Strategic Partnerships, Antivirals and Diagnostics, Pfizer

The healthcare consumer has more care options today than ever before, many of which are also lower cost. The tradeoff, however, is that as new models of care and new players enter the health economy, healthcare is becoming more disintermediated. The focus of consumer interactions will be increasingly transactional and disconnected from the broader healthcare delivery system. For example, while retail players meet a healthcare consumer's need for convenient care for low-acuity conditions (e.g., sinusitis), the lack of relationship between the consumer and retail provider makes it even more challenging for the individual to navigate the system for the broader set of medical services they should receive. How can omni-channel strategies balance consumer preferences while appropriately navigating them to the right care setting at the right time?

KEY TAKEAWAYS

- There is a distinction between who has access to telehealth services and who actually utilizes those services. For example, 50% of demand for Teladoc's chronic condition service comes from patients in underserved areas. Understanding differences in utilization by consumer segment and clinical application is essential for improving healthcare delivery.
- Prior to the pandemic, virtual care was available across multiple markets, but adoption was only driven by being able to get reimbursement for virtual care.
- Consumer behaviors have evolved over the years, with initial enthusiasm for digital healthcare followed by a preference for in-person care when given the option. This suggests a need to refine the virtual care experience. There is motivation to seek rapid care, but there is a substantial drop off-rate for virtual care, which shows access is not translating to adoption.
- In the urgent care setting, virtual care has served as a successful triage model, with onsite medical assistants and offsite physicians.
- There are challenges in sustaining primary care. Patients increasingly choose providers that offer both in-person and virtual services, even if they never utilize virtual care. However, the increase in provider options, including retail and telehealth, can contribute to care fragmentation and confusion for consumers. Clear communication and intelligent triage systems are essential to guide patients to the appropriate care pathways.
- Telehealth offerings provided by payers may face challenges in consumer adoption, possibly due to pricing perceptions (e.g., how is the quality of a $29 telehealth visit perceived?). Loyalty and first-encounter interactions are crucial for successful adoption, and partnerships with established telehealth providers – especially if Amazon and Walmart are ultimately successful – can be effective.



Investing in "Behavioral Health 3.0" to Deliver Whole-Person Care

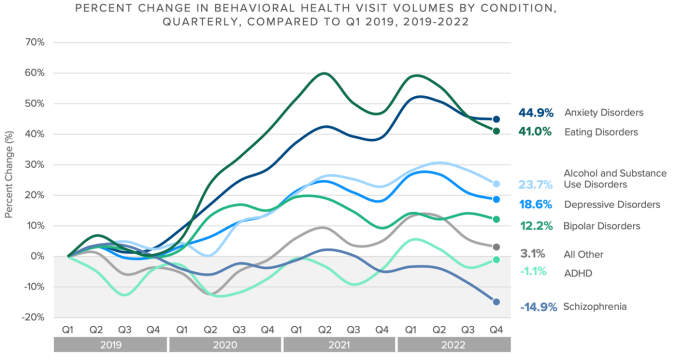
Sanjula Jain, Ph.D., Chief Research Officer, Trilliant Health
Imad Ahmed, SVP, Product Management for the Behavioral Health Division, Universal Health Services

While the magnitude of the behavioral health crisis is well documented, less is known about the solutions needed to meet the growing demand for behavioral health care. Today, most care delivery models have been focused on partial integration (2.0), but in preparation for the future, stakeholders should adopt the 3.0 model for behavioral health care that considers the needs of the whole person. What factors must be considered in building an integrated, personalized, and value-focused ecosystem that leverages technology and analytics and allows individuals to move seamlessly across the behavioral health and medical care continuum? How do you reconcile the return on investment in a payment model that does not incentivize the 3.0 model?

KEY TAKEAWAYS

- Intake processes are at the core of the behavioral health business, and their effectiveness is crucial. While there is no one-size-fits-all approach to accessing behavioral health services, various entry points should be considered. Developing a fully integrated medical-behavioral care model is essential to capitalize on all entry points to the healthcare system. Viewing behavioral health conditions as chronic rather than episodic helps in providing continuous and effective care.
- The 3.0 model for behavioral healthcare builds on the historic developments in treatment, starting in the pre-2000s when behavioral healthcare was not integrated at all. Moving into the 2.0 model, integrated care became more common, especially in terms of treating substance use disorders and medication management for behavioral health conditions. However, the 3.0 model is an integrated, personalized and value-focused ecosystem of behavioral health and wellness leveraging technology and analytics, allowing individuals to move seamlessly across the care continuum.
- Despite the advancements made over the past decade, there are still concerns about system readiness when it comes to novel treatments and therapeutics for serious mental illness and substance use disorders.
- Often when it comes to behavioral health, money is often "left on the table," underscoring the importance of better managing and leveraging the local, state and federal funding that is provided for treatment of behavioral health patients.
- Opportunities exist to optimize reimbursement strategies in behavioral health by managing patients across various care settings, from inpatient to outpatient, virtually and at home. Funding for behavioral health is coming from various sources, including federal programs and private equity targeting commercial behavioral health patients.
- Payers allocate a relatively small portion of their budget (around 3%) to behavioral health, and this allocation is not growing significantly. Payers should consider covering behavioral health comprehensively and holistically, recognizing its impact on overall medical care.

Behavioral Health Demand Varies by Condition, With Most Trending Upwards



Source: Trilliant Health national all-payer claims database.

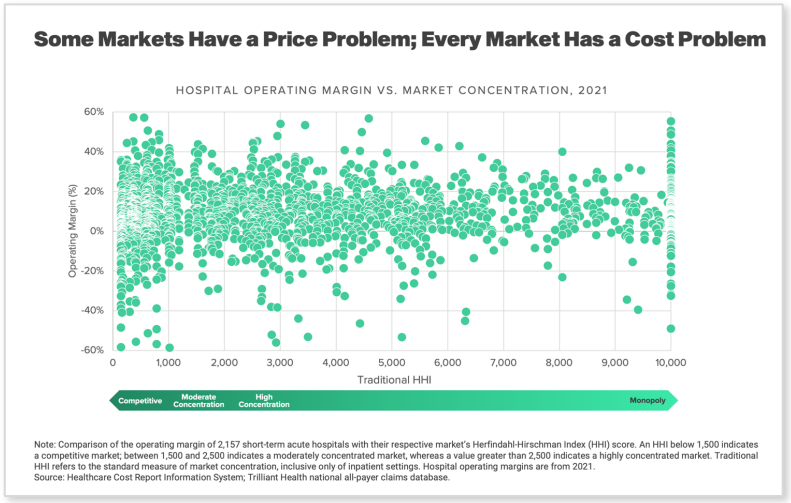
Implications of Near-Term Policy Changes for Innovation and Clinical Strategies

Hal Andrews, President and Chief Executive Officer, Trilliant Health
Nathan Bays, Healthcare M&A, Citi
Julie Barnes, Founder & Principal, Maverick Health Policy

Healthcare is political and understanding the "push and pull" dynamics exerted by Federal and other policy initiatives is paramount. From changes to prior authorization to data standards to payment rate updates and regulation of consolidation, there is a distinction between the “theory” and the “reality” of what these various proposed or implemented rules suggest for the health economy. What are the near and long-term implications of the latest discussions in Washington on the clinical and innovation strategies and implementation tactics for every stakeholder?

KEY TAKEAWAYS

- Healthcare's importance in Congress and across election cycles as a key issue fluctuates over time. At the time of the session, the potential looming government shutdown – which was temporarily averted – raised concerns about who will bear the financial burden to avert the shutdown and where healthcare would fit into those negotiations. The budget negotiations reflect an overarching power struggle, impacting funding for critical health issues like COVID-19, HIV and opioids. However, Democrats and Republicans are aligning on market intervention, including rate setting.
- Regulatory capture and legal challenges are prevalent in healthcare, with increasing costs of compliance and legal involvement. There are so many different federal agencies who are pitching in to ongoing regulatory capture. For example, the FTC chairperson is nothing short of a legal reformer, with DOJ/FTC pulling down their guidance on consolidation. Agencies are actively fighting with one another (e.g., CMS wants people to form ACOs meanwhile people are worried about getting in trouble for consolidation). We need competition law in this country, but we need to figure out where the “bumpers” start and end. Having a prescriptive line around competition will always be a challenge.
- In terms of industry-level lobbying power, pharma and device companies are most sophisticated and well-funded, while providers excel at short-term battles but lack a clear long-term vision. Payers seem to hold an advantage in healthcare, with government interest in ensuring their stability.



Emerging Patient Needs and the Future of Oncology Specialty Care

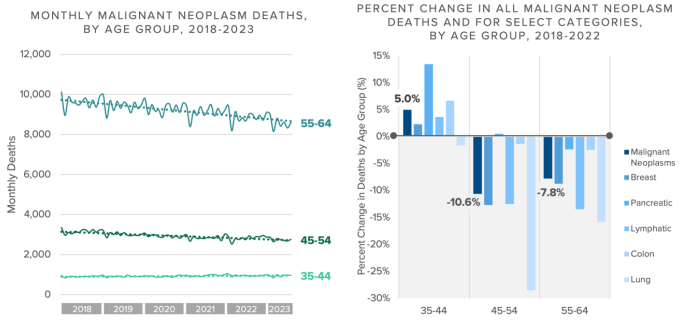
Devin Carty, Chief Executive Officer, Martin Ventures
Diane Hammon, VP, Chief Strategy Officer, Moffitt Cancer Center

While cancer incidence is on the rise, the impact of other factors such as new therapeutics and treatment paradigms could result in differences between future surgical and medical oncology demand. Emerging data trends suggest that the oncology care delivery and competitive landscape over the next decade will look very different from the previous ten years. For example, cancer mortality is increasing for Americans ages 35-44 and decreasing for older age groups in tandem with the fact that current cancer screening practices are not necessarily concordant with evidence-based guidelines. How should various stakeholders adapt their oncology strategies to cater to evolving patient needs? What are the distinctions in the strategic considerations between payers, providers, digital health solutions and life sciences?

KEY TAKEAWAYS

- There is growing potential of immunotherapy and gene therapy in oncology, with expectations of their expansion into various disease sites beyond myeloma, including ovarian and bladder cancers. National Cancer Institutes are often at capacity and expect to continue to be at capacity for the next ten years. At the same time, there are growing ambulatory and at-home opportunities to limit patient travel when possible.
- Conversations about value-based care (VBC) in oncology began in the early 2010s, but there is a disconnect with payers, who lack the requisite analytics to support VBC arrangements. From a payer strategy standpoint, there is a need to ensure proper reimbursement for CAR-T therapies, as there is a misconception that these therapies generate substantial revenue.
- The development and introduction of VBC payment structures were early/premature in some cases, with many payers and providers lacking full preparedness, resulting in financial losses rather than expected savings.
- Cancer increases in younger populations is due to increasing incidence, rather than earlier or better testing.
- The data shows an increase in colorectal cancer deaths and blood cancer diagnoses among younger populations, highlighting the shift away from primarily serving patients aged 65 and older. Although there is an established program for rare cancers in adolescents, youth, and adults, there is a growing need to develop services and care delivery for individuals aged 30-44.
- The high cost of oncology care primarily stems from drug expenses, emphasizing the importance of early cancer detection through screening to reduce overall costs and improve patient outcomes. While preventive cancer screening recommendations remain broad, the return to normal screening pathways has been challenging.

Cancer Mortality Increasing for Americans Ages 35-44, While Decreasing for Older Age Groups



Source: Centers for Disease Control and Prevention WONDER database.

- There is an ongoing debate in the oncology space regarding the role of AI, with significant investments in machine learning and natural language processing (e.g., developing original oncology-oriented AI capabilities instead of relying on external tools like ChatGPT).
- Investment in research remains a priority, with funding allocated based on research needs, and economic considerations are integrated into payer strategy decisions.