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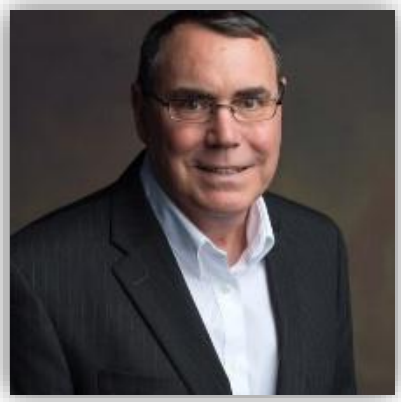
Healthcare Payor Market: Structure, Economics, and Industry Outlook

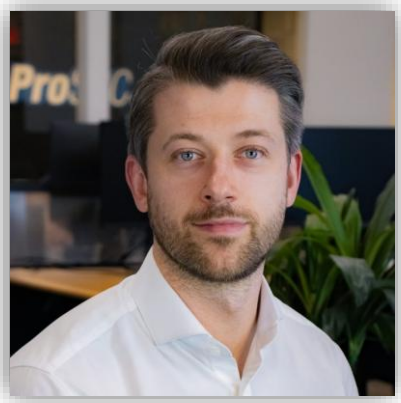
Our Expert:
Gregg Kunemund



- **President – Gregg Kunemund Consulting Group**
- **Chief Operating Officer – Gold Kidney Health Plan (May 2023 – Dec 2024)**
- **Health Plan Chief Executive Officer Medicare & Retirement – United Healthcare (Jan 2010 – Jun 2022)**

Gregg Kunemund has 35+ years of experience in the healthcare payor sector. Gregg managed Medicare and Medicaid for Blue Cross Blue Shield of Florida and was Health Plan Chief Executive Officer (CEO) Medicare & Retirement at United Healthcare from 2010 till 2022. During his tenure at UnitedHealthcare, Gregg oversaw the $4.5 billion government programs business unit, ACO partnerships, Medicare and Medicaid product designs and operations, Medicare Advantage, Group Retiree, Dual Eligible, Chronic, Part D and Medicare Supplement portfolio of products. Gregg is a leading key opinion leader in the healthcare and government programs space as Founder of Gregg Kunemund Consulting.

Our Moderator:
Max Le Sieur



- **President & CEO of TelcoBridges**
- **Founder & Managing Partner at Rosemont Legacy (Aug 2023 – May 2024)**
- **MBA, Harvard Business School - 2022**
- **Investment Banking Associate at BMO Capital Markets (07/2016 – 08/2020)**

Read the Key Takeaways	Review the Transcript	Listen to the Recording

KEY TAKEAWAYS

Medicare and Medicaid Are Large, Growing—but Operationally Challenging

- Medicare is a structurally growing market driven by demographics (11,000 new eligibles per day), while Medicaid growth is tied to state budgets and eligibility cycles.
- Both segments are capital-intensive, highly regulated, and not suitable for inexperienced entrants.
- Reimbursement levels are materially lower than commercial insurance, requiring tight cost discipline.

Medical Costs Dominate the Economics

- Medical Loss Ratios (MLRs) now run ~90%+, up from historical norms.
- Administrative efficiency is critical; best-in-class admin costs are ~8–11%, while smaller plans often exceed this.
- Chronic disease management drives outcomes: ~80% of costs come from ~10% of members.

Post-COVID Dynamics Have Pressured Payer Profitability

- Deferred care during the pandemic led to members returning sicker, with higher chronic disease burden.
- Simultaneously, government funding tightened, creating a "perfect storm" of rising costs and lower margins.
- Industry profitability has deteriorated in 2024–2025, with stabilization expected around 2026.

Stability is a Primary Objective

- Rapid membership growth without operational readiness has proven value-destructive.
- Market exits (rather than expansion) are increasingly common when economics fail.

Preventive Care and Primary Care Are Central to Cost Control

- High-touch, proactive models (annual wellness visits, nurse house calls) materially improve outcomes.

Product Strategy Is Shifting from PPO to HMO Models

- Payers are consolidating product offerings toward HMO-style networks:
- PPOs remain popular with consumers but are harder to manage economically.
- This shift reflects payer economics more than consumer preference.

AI's Biggest Near-Term Impact: Fraud, Waste, and Abuse (FWA)

- FWA is estimated at ~15% of total Medicare spend.
- AI has credible potential to reduce this meaningfully (e.g., to mid-single digits over time).
- AI is no longer a unique competitive advantage—it has become a basic requirement just to stay competitive.

TRANSCRIPT

| Max | Hi, Gregg. My name is Max. And I'll be leading this call on behalf of VISASQ/Coleman Research today. As you know, the purpose of this discussion is to learn about the healthcare payer market in the United States, including key players and trends in the industry. Before we begin, I do want to remind you that we are in no way soliciting any material non-public information or information that is confidential related to any company or organization you are currently or have ever been affiliated with.

| Gregg | Sure.

| Max | If you believe the answer to any question involves non-public information, please just tell me right away and I'll take us in a different direction.

| Gregg | I'll be glad to. Thank you, Max. Nice to meet you.

| Max | Great. So any questions before we jump in?

| Gregg | No, no, I think I'm good.

| Max | Okay. Awesome. So with that being said, Gregg, would you mind providing us just a short overview of your background and experience as it relates to the healthcare payer market?

| Gregg | Yeah. Hey, Max. So I basically have 35, 40 years experience working with payers right out of college. Went to the Blues in New York City and then worked for about two or three different other companies. Most recently, about 14 years as a CEO for UnitedHealthcare. That was in their Medicare and retirement space so it was government programs. I was over five states, about 800,000 members.

| Gregg | That's the market. So basically, Max, I had a lot of people reporting to me, probably well over a thousand, but when people asked what'd you do, I said I was responsible for growth stars and affordability. So I owned the P&L and then I developed products and I got involved with the states as well. I was mainly in the Southeast, so for their Medicaid, their Medicare, and then their dual eligibles. But pretty much operations and finance and executive leadership.

| Max | Perfect. Perfect. So I'd like to start with an overview and context section. And I do want to start from the beginning to help level set everybody's understanding for the rest of the conversation. So can you just very briefly explain the difference between Medicare and Medicaid?

Medicaid vs. Medicare – What are the Differences?

| Gregg | Yeah, thanks, Max. That's a tough question briefly. I'll do my best. Medicare is a program for basically seniors. Here in the United States, employees that are working and their employers, they contribute a little bit to their Medicare system. Once they turn 65, if you're no longer working, or you could even do it if you're employed, but basically Medicare is for 65 plus. About 94% of the 68 million people enrolled in Medicare are over 65. There's no dependents. It has four parts, A, B, D, and C, and I could explain them later if you want, but it's more like hospital, inpatient, outpatient, drugs, and then the Medicare Advantage plans, which are also Part C. So it's great. I love that product, especially here with the boomers aging in one every 10 seconds or 11,000 a day. So it is a growth market now. Plans are challenging a little we'll get into.

TRANSCRIPT

| Gregg | Medicaid really is ... It's partially funded by our federal government here in the states, but it's run by each state. So for example, when I had five states, I used to have to work with every Department of Insurance to offer plans to replace traditional Medicaid, but it could be the CHIP program for kids. It's lower income. And then there's certain thresholds where you're at with your income and your income, 100% of poverty level, 200%. And that could help determine your benefits. And they could change as people change. But in order to enroll in Medicaid, you have to meet the income requirements and that's forms that you would have to complete. Do you own a car, a house, et cetera. When Medicare, it's almost formal once you ... A couple of months before your 65th birthday, you could start to enroll.

| Max | Got it. Perfect. Thank you. That was great. And we use this term payer. Can you explain what the payer business model is? How do they generate revenue and what are their expenses?

| Gregg | Yeah. Well, the payer model I recommend ... And I've done them both, you kind of segment Medicaid and Medicare. You can call it government program. So when you want to build a product, work with a product team, claims and customer service, you can consolidate those. But from a payer space, you have a dedicated team that would work with the federal government on Medicare and dual eligibles and then with the local states. So I would just say it's best to do that segmented. It's not for the faint of heart. We get paid. Plans get paid. For Medicare, almost 100%. Some plans have Medicare Advantage plans have a slight premium, maybe $50, $25. But for the most part, it's all paid, and that's based on risk score and star, age, where you live.

| Gregg | And Medicaid get funded to the states, and then the states would approve you to have a plan. So that's one of the challenges. At least with the federal government, you deal with CMS here in the United States, but for Medicaid, you're going to deal with Alabama, Arkansas, Georgia. And they may set up different benefits, different eligibility requirements, and you had to go through those hurdles.

| Max | Got it. And so you've touched on it a little bit, but can you elaborate on the advantages and disadvantages of working with each of Medicare and Medicaid?

| Gregg | Yeah. I would say the disadvantage is just you're dealing with the government. So there's some red tape, there's changes, there's new administrations, and then that's challenging. You have to have a core set of benefits. And Max, they never consider me as a friend, but you got to have great relationships either with the federal government, CMS, or the states. So that's one of the key things there. Again, I told you how we're paid already. And then the advantages are, if you look at Medicare, who doesn't want to be in a business when you could charge your Medicare eligible zero premium. They paid into their Part A and their B. And then Medicaid. So Medicare is growing. Medicaid is growing. It's challenges there. It's just an awesome space. I would say for Medicaid, the level of reimbursement is a lot less than Medicare, and Medicare is a lot less than commercial insurance here in the states. So one of the advantages is you can grow it, you can cater your plans, you meet the state or the federal government requirements, you set up your business model, your operations, your clinical team, and it's a business that's certainly growing. So there's opportunity for pretty much growth, but it's not for the faint of heart. Your clinical costs are high, the changes like in Medicaid eligibility and so on.

| Max | Got it. And just to be clear, for the Medicare and Medicaid businesses, if we think of those differently for payers as distinct, is the largest expense in both basically paying for folks'-

| Gregg | Yeah, your medical costs.

| Max | Medical costs. Okay.

Medical Costs & Medical Loss Ratios (MLRs)

| Gregg | Your medical costs, at least 85%. Now they're running close to 90, so MLRs are 90 and higher. Administrative cost, best in class is eight to 11, but the smaller plans, it's a lot higher. But yeah.

| Max | What MLR? What's MLR, Gregg?

| Gregg | Medical loss ratio. Some people call it benefit cost ratio, BCR. So your clinical cost could be your prescription drugs. There's a lot of new on the market now. Some of the obesity that came out, you're inpatient, you're outpatient. But for both segments, chronic illness is prevalent. And that's really what good plans could do a better job managing or outsourcing that.

| Max | And can you give us a sense of scale? So how big is Medicaid for a typical payer? What percentage of their overall business? And then same question for Medicare.

| Gregg | Yeah. So for Medicaid, it depends. There is some dedicated health plans just for Medicaid, but for the most part, it's fairly small. It could be segmented by state. So if someone offers commercial insurance to ACA here, the Affordable Care Act a Medicare plan or a Medicaid plan, it's probably less than 10%, even though there's more people enrolled in Medicaid, but not everyone wants to get involved with it because fee schedule's building a network. And then Medicare would be a little bit higher. But again, the big plans, like say UHC, Aetna, Elevance here in the States, Medicare is probably like 20% of their revenue and 20% of their membership. But we scaled that back the last year or two. I don't know if you read about it, but MLRs are high and we could talk more about some of the trend there. But there's smaller Medicare plans that just do Medicare and there's smaller plans that may just do Medicaid. But the typical plan, if you're an investor, usually both of them combined are going to be 20 to 30%.

| Max | Of a payer's revenue?

| Gregg | Yeah.

| Max | Got it. Super helpful. And then dual mix, can you just briefly explain what that means?

| Gregg | Yeah. So the way I interpret that is in Medicare and Medicaid there's people who are Medicare eligible. They have their red, white and blue card, they have their AB and so on, but they also qualify for Medicaid on income. So if you're a full dual, that's what we call a DSNP member, a dual special needs plan. You can create a separate product for those members if they're full dual.

| Gregg | So basically what happens is Medicare is primary and then Medicaid is secondary, but plans like me would usually get in a capitated agreement, meaning we filed a bid and RFP, we got accepted and we agreed to charge certain amounts to the states. So dual eligible is someone that has Medicare and Medicaid, a long story short.

| Max | Perfect. And what are MA stars?

| Gregg | Those are Medicare Advantage Stars. Really key in the Medicare space. CMS, the Centers for Medicare, Medicaid Services, they bonus plans based on outcomes. It could be quality outcomes, customer service, enrollment, disenrollment, and it could be up to 4%. So say a typical Medicare Advantage plan, the average PMPM is anywhere from 1,200 to 4,000. If you hit four stars or higher, you could earn an additional three to almost 4% additional revenue. So it bumps up your revenue to cover some of your costs. And it's also a good metric for letting CMS know and potential members know that they're in a plan that has good quality. If your three and a half plan is a little bit of part de rebate, and really under that, there's nothing. So most plans ... I know I always wanted to be 85% of my members in a four plus star plan. And it's easier said than done because the rule changed, but that's with the stars. And when you go to our website or medicare.gov website, it will have the stars feature. Are they two stars, three, four, or five?

| Max | Got it.

| Gregg | So it's a scale of one to five.

| Max | Got it. And just what's PMPM for the audience?

| Gregg | Per member per month.

| Max | Got it. Perfect. Thank you for that. So I think we've gotten some of the key terms out of the way. And then another level setting topic is, can you just describe the landscape? So when we talk about payers, who are we talking about?

| Gregg | Well, it would be any large health insurance or a small insurance that is certified by the states or the federal government. So it's UnitedHealthcare, Aetna, CVS, Cigna. Gosh, there's about 30 different ones, but those are some of the big ones, Devoted Health are some of the smaller ones that are coming into the market. So there's probably 30 to 40 different competitors. And depending on what state you're in, if they offer both Medicare and Medicaid or some just Medicare, and there could be parts of the state, neither can go there because you can't build a network, for example.

| Max | Got it. Super helpful. Now, trends in the industry, Gregg, what would you say are the top line trends in the payer landscape today? And then we'll double click on a few of them later on in the conversation.

Post-COVID Dynamics & Payer Profitability

| Gregg | Sure. Yeah. I'd say the trends haven't been good from ... I always say post-pandemic, people came back sicker because they didn't go in and get their wellness features or other things like their colonoscopies. So MLRs are up. Administrative costs are up. Payers are paying more to health systems to get in the network. So that's increasing administrative, of course.

| Gregg | So it was like a perfect storm post COVID. But long story short, it's challenging. Some are ahead of others. Some quarter earlier, like United was a little bit late where I came from, but if they listen to earnings calls, they're right-sizing that business now. So what we have to do is really focus back to what we do here in the States is keeping people healthy, getting their preventive services and managing their care. So value-based contracting helps in others. But long story short, it's challenging right now. I see a better 2026 and that's starting to stabilize. I think by Q2 or '26, we'll see more definitive who's a winner, who's still challenged with it.

| Max | Super helpful. And so just to be clear, your perspective is that MLRs are higher as a result of the post COVID ironing out of folks' health?

| Gregg | Well, that and from the government programs, the funding was cut a little bit. States are running out of money. The federal government, there was a new administration. So trend normally goes up, your medical trend, 3% a year. But yeah, people after ... Well, you'd think during the pandemic, unfortunately, people were sick and in hospitals. But all the electives were canceled. So no one got knees and hips and shoulders. No one was going to their primary care doctor. And then when things start to open up, the people who weren't getting tested their cholesterol and blood pressure and some of those other services, it just seemed ... The delayed surgery is you expected a year max, but I saw that a little bit after and just people came back a little bit sicker. So the chronic illnesses came to light. And then a little bit cuts in funding, both from states and the federal government, that made it challenging.

| Max | Got it. That's helpful. And so before we move on to speaking about individual payers more in detail, can you just describe what you think are the key operational benchmarks in the industry? If you had to compare the operations of different payers, what are the two, three, four things? I have a couple of my notes here, like error rates or appeals, auto adjudication, satisfaction rates. Are those relevant? What would yours be in terms of operational metrics?

| Gregg | Well, the first thing I look at is how you built your team up and your costs. What's your administrative cost? Could you outsource? Could you not outsource? But stars is key. You mentioned auto adjudication rates, that helps have less people that manually process claims. That should be 95% plus. Appeals and grievances are low. The clinical ones, they get a lot of noise because unfortunately a baby may get denied something. It was experimental or just not covered. But you want to have best in class customer service, which is a high net promoter score, and then your stars should reflect that low voluntary terms and consistency and benefits. But for appeals and grievances, low. Most are upheld anyway. Less than 30, 40% are overturned, which means the member or the physician went to the appeals and it was overturned upon review either by the plan, by a different medical director or another entity, either the state or the federal government that has hired that.

Key Players – Stabilizing Costs & Growth

| Max | Got it. Okay. That's helpful. Yeah. Moving on to the next section now, Gregg. So just key players more broadly. I guess for someone who hasn't been in this space in a long time, the assumption is maybe that payers would all have similar business models, but maybe that's not true. So what payers would you say have the best operating or best operations and best business model right now and why?

| Gregg | Yeah. Well, I'll start with ... I work for United, right? I told you in United Optum. I just think that Optum is a game changer here in the United States and it helps on the backend of operations and claims and AI and auto adjudication.

| Max | What is Optum, Gregg, just for the audio?

| Gregg | Optum Health, it has different segments. It's like a clinical piece. It supports claims. They own a bunch of practices for value-based contracting. They bought Change Health for EMR, electronic medical records. So they are just like the engine that drives a health plan and Optum is able to do that. So most people are using Optum. And if you look at UHC, it's probably the biggest ... The highest percentage of growth in their revenue is from Optum. Other people are using them. Physicians, doctors, other health plans as well. And they also have, I saw somewhere like a PBM that's a pharmacy benefit manager. They could manage prescription costs, negotiate rates and work with pharmacies. So it's really, really key to support a health plan. And then they do some clinical things as well. They have a nurse program, a house call program where they send nurses to patients' homes focusing on wellness. So I think that model has worked and a lot of people are copying it because it's so expensive now to build it Max internally. So you got to find the right partners that could help you manage your administration costs, increase your patient satisfaction, physician satisfaction. And also about 80% of medical costs comes from 10% of your population. Those are the sicker of the sick. So who can manage those or how do you prevent someone who has kidney disease from hitting a stage five and going on to a dialysis? And that's some of the things that Optum is able to do, but they also support customer service claims and clinical pieces as well.

| Max | Any other business outside of Optum that you're impressed by?

| Gregg | Well, I always was impressed with Humana and their stars, and they went down the last few years. They built a great model. Elevance has built a great model. Devoted Health. The ones who could do a service model, which is a personal service specialist, seem to do the best, which is high touch making outbound calls instead of waiting for inbound calls. But if you want to look at Medicare, Medicaid, look at the quality, that's a first start, but then also the patient and physician satisfaction scores. And then I would just say stability in the market. Are they growing? Are they not growing?

| Max | Got it. Got it. Got it. I'd like to ask you to put together two ideas that you've mentioned so far. So you mentioned that there's growth in the Medicare business, which is positive for a lot of these payers, but you've also mentioned that payers are challenged these days with higher administrative costs and higher health payment costs. Can you help me reconcile those two things that are seemingly contradictory?

| Gregg | Yeah. Well, they weren't years ago, but the last two to three or four years ... Growth I don't think is really ... Plans are focusing on growth right now. What they want to do is get their business model down, manage their members that they have, stop them from leaving, getting their stars, getting the quality and controlling medical costs. So growth right now, I wouldn't say that that's a deciding factor to how well a plan is doing. I really think stability in the market, so that's some of the biggest changes. Do you have a second part of that question?

| Max | No. No. That's okay. That's really helpful. That's really helpful. I want to move on now to discuss investment opportunities in this space more generally. So you mentioned there's about 30 or so plans approved by the federal government.

| Max | Can you formalize your description of barriers to entry for this market? It does seem like it would be a difficult market to compete in or to attempt to participate in if you're starting from scratch, but maybe that's wrong. So can you describe a little bit what are the barriers to entry and ... Yeah.

| Gregg | Yeah. Well, you have to build a segment and a business model to manage both Medicare and Medicaid. So before you do anything, you've got to say, "All right. What's my infrastructure today?" For example, you can't manage people like who are employers here in the United States. We call them commercial members. Medicare, Medicaid is completely different. So you have to build that business model. You're going to service them a little bit different. You may enroll through agents instead of having your own employees, and then you're going to have to work with the federal government to say, okay, I want to file for this. I have to meet a certain network, so you got to build out the right network, you have to get approved, you have to get the right physicians. So the members are happy with the people that are in the network. And then you have to file usually on an annual basis, your bids to Medicare and the states could have one, two, or three years. So you have to have people connected to those others.

The other thing I would say is that it's not for the faint of heart. You're probably going to lose some money early on and to get that infrastructure, you have to figure out what's the right infrastructure. And if I was doing it, I would say, all right, I wouldn't build it from scratch. I would be okay to enter a market and build my infrastructure to file a bid, get approved, and have my network and service. But there's other companies that could outsource, that could do your PBM, your pharmacy management, that could pay your claims, handle your service and help you with your clinical programs. But you got to-

| Max | Okay.

| Gregg | Yeah.

| Max | That's interesting. That's interesting. Is that a trend that you're seeing a lot of payers pursue? You'd say that's a key decision for payers is what they choose to do in house versus what they choose to outsource?

| Gregg | Yeah. There's a lot of head scratching, a lot in executive rooms, well, you don't want to outsource this or have good employees, but your administrative costs are really key, Max. And so you have to be lean and mean, but meet the government requirements, more especially your membership. So if there's people who could do it cheaper and better because they have the data and the software just to build systems and EMR connectivity, it's millions and millions of dollars, but there's a company that already has done that. So you could use their software, their services, and maybe their support system to help with that, but it's not for a faint of heart. Medical costs are high, like I said.

| Max | And just going back to the barriers to answer your question, I guess, are they different? Can you choose to just operate in the commercial segment, in which case are the barriers to entry lower and different there than if you choose to also participate in Medicare and Medicaid, in which case you have this whole government approval and government system set up? Can you describe how different those are and if that's possible to just operate in commercial?

| Gregg | Yeah. Commercial is completely different. You need the state approvals to enter the state and have the adequate network, but you can have local salespeople in your plan working with employer groups, whether 50 plus employees, the big and large.

| Gregg | And then the employer picks up a good percentage of the premium. So you work with the employer on the benefit design, the eligibility requirements, and there's usually requests for proposals, bids that you have to go out to get those. But it's not as regulatory as state and federal programs, but I think that's the easiest one to get out there. You can build a network fairly easy. The patients are usually younger and healthier, so your clinical model doesn't have to be as strong. But if you look at the Affordable Care Act here, Medicare, Medicaid, you have a lot of red tape, you have to file and get approved for that. So the ACA, like you talked about growth, the Affordable Care Act, people can grow tremendously, but also those costs, people are exiting because they can't manage the care with the premiums that they're collecting and with the subsidies they receive. So government is completely different and I would recommend ... You may have a business lead, one over Medicare, Medicaid, and then one over commercial. Someone could build a network for any product. In fact, you could share a network for the most part.

| Max | Got it. That's helpful. Are there more competitors on the commercial side? You said the commercial side was 70% of a payers to business typically, right?

| Gregg | Could be, yep. Yeah.

| Max | So the commercial market is bigger than Medicare and Medicaid?

| Gregg | Yeah, you could have 50, 60, 100 million commercial lives built on what you offer. And then Medicare only has 68 million enrolled. We know it's growing. And you have to do that by state and build a plan.

| Max | Got it. Are there big-

| Gregg | So you have to be very careful.

| Max | Sorry. Sorry, I didn't mean to interrupt.

| Gregg | No. I just said you have to be very careful in government business where you enter. What's the model and can you manage it and grow it?

| Max | Are there big payers that are commercial only?

| Gregg | I think Cigna now got rid of their government business and they sold it to another unit, but I don't think any of the other big ones ... I think they depend on commercial membership for margins.

| Max | One of the things I haven't heard you say with regards to barrier standard is the benefits of scale. It seems based on what you're describing, there's a lot of advantages to being big enough that the unit economics on an individual claim or what have you are lower than someone who's who does not have that scale. And so how do you think about that? Do you think scale is important in this space?

| Gregg | Yeah. In the long term it is. I mean, everyone has to start out. So you start at one, you work your way to 10, but the larger your membership, you could ... Excuse me. Spread out your costs a little bit more.

| Max | Okay. There's this concept of prior auth that is emerging in this space as we understand it. And so can you explain what that is and why AI is being touted as a game changer for prior auth and claims processing generally?

| Gregg | Well, prior auth can help manage your clinical costs. You're going to look at inpatient, outpatient, some of the expensive services, part D expensive drugs. You would have a medical director, a nurse, and other things involved in medical records. Gosh. Excuse me. AI can streamline that. It could almost do auto. Getting the records sent into a computer, you may not even need a nurse or a doctor to look at it. So we'll say the diagnosis is this, the treatment is that, they're going in network, that's approved. So it's just less hands and that's going to help automate it. But prior authorization really helps you get a control to expect a potential big claim or medical expense and you want to be aware of it. So this way you could follow the outcome. The discharge, say of a hospital. It's a big one or a new drug that hit the market.

| Max | But sorry, what is prior authorization exactly? What does it mean?

| Gregg | It means getting approval prior to the service being rendered. So the physician will call the health plan and say, "All right, I need this special MRI and it needs an authorization." And the health plan will say, "Well, what's the member's name and number and this? And what's the diagnosis and what do you want to do?" And then AI would say, all right, the check marks, there's a couple companies out there that will say, all right, yeah, that's medically necessary, that's experimental, or maybe an x-ray could do instead of an MRI. So it's kind of pre-treatment.

| Max | Got it. Got it. That's helpful. And so on this theme of applying artificial intelligence or machine learning or whatever you want to call it, technology to automating the checklists and the process, what in your opinion is credibly achievable in the next 24 months? How much of it is hope and farther away than folks think? How much of it is actionable that you've seen work? Give us your perspective.

| Gregg | Okay. I just want to make sure I got your question.

| Max | What is credibly achievable in terms of operational improvements as a result of automation and AI?

| Gregg | Yeah. I would just say best-in-class operation effectiveness is paying claims timely, automation, approving services that are medically necessary. Don't put the member and a physician through hurdles. It's a step here, step there. So that's one of the biggest things that I would look at and what patients and physicians would look at. What's the health plan built? What's their model? Could it be a simple thing they fill out online that gets automatically approved or do you have to go through a little bit more? Does the member have to call customer service, et cetera?

| Max | Got it. What's an operational metric that you would look at? Does that come into MLR and then you would be able to observe operational improvements in the MLR or is there some other KPI?

| Gregg | Well, there's a lot of KPIs. It could be service and how you're doing there. The first thing, the metric to me is the quality, what's your bed days, emits per 1000? How does that all look?

| Max | Got it.

| Gregg | What's your benefits? The stability of the plans. What you don't want is a heavy growth that we've seen and then a detraction of members. So a KPI would be your voluntary terms. How many people come in and are they leaving to go to another plan? And if the reason is why.

| Gregg | The other one would be the stars feature you mentioned, Max. That's also key because it shows the federal government, the state, Medicaid and the members and agents and brokers that sell your plans, that if you're a four-star plan, you're doing the right thing for the patient.

| Max | Got it. Super helpful. Okay. So we've talked a little bit about automation. We've talked about the KPIs just now. And then earlier we spoke about this outsourcing and in house decision faced by a lot of big payers. What in your view are the three most effective cost management levers for payers generally?

Cost Control - Preventative & Primary Care

| Gregg | Yeah. Well, one is that house call program that I spoke to. Having members access a nurse or even go to the patient's home, I think that could help you with your coding and your stars, but also monitoring outcomes in patients. So really in Medicare don't have a preexisting condition. So if they come on sick and you see a claims come in or extended emergency room visits, those type of things, a nurse could go out there or we could send a home physician. So that's one of the biggest things. The other one is, I did mention emergency rooms, but you want to keep patients out of the ER, so that goes back to your preventative. So focusing on an annual care visit. Every year a patient goes in, it's free, they see their physician, do all the blood pressure and blood work and things like that. And if you can get 90, 95% of your members in for an annual care visit, that's going to also help know your members better, but also potentially track some different things.
And then there's a lot of new drugs on the market, so you have to be careful those. Those are approved and what's medically necessary, what isn't. Those have really gone up the last few years.

| Max | That's interesting. So you're saying effectively preventative processes seem to, in your opinion, correlate to improved operational outcomes because hopefully you are aware of things and can manage them before they get bad and therefore expensive.

| Gregg | Yeah. And even when they get sick like post-pandemic, I talked about the chronic illnesses were up and diabetes was up and chronic kidney disease and heart failure. There's things that you could prevent if they did go to their doctor or if you catch them early enough like a male prostate exam. If you didn't go for three years and then you went back now post-pandemic ... I think one out of every 10 men here in the States could be diagnosed with prostate cancer. Well, then it's too late. Not that it could have been prevented, but that's just an example. But diabetes and chronic kidney disease are the others, depending on what stage they're at, there's different levels. And if people are aware they have chronic kidney disease, the doctors could work with them to eat better, take whatever prescriptions.

| Max | No. That's super helpful. Are those things widespread now then, Gregg? And or is it pretty new that the group of payers have realized that preventative has such a positive outcome on operations?

| Gregg | Well, if it wasn't, it is now. Because when your medical costs went up. So everyone always focused on wellness features, especially when CMS came out with stars, maybe 10 years ago, I'm not sure, but it was also good. Employers wanted it because their costs were low. The government programs, we wanted it, even for the kids, to go in and get their vaccination shots. So everyone is all over that now. And sometimes it's outsourced. Like that nurse on call, there's a few companies that have their own nurses. Optum has one as well, and most people are using those.

| Gregg | And if you're smaller, you're just delegate it. You find someone like Optum or another company that could do those services for you. But I would say everyone is a hundred percent in on those and it's better for the patient, better for the family, better for the employers and the members.

| Max | Okay. That's helpful. And before moving on to investment risks, I want to ask one more question. On this outsource versus keep in house decision, what is the framework you use or you would suggest folks use to decide what should be kept in house and what should be delegated?

| Gregg | Right. Yeah. It's usually just what's the cost of it. For example, if you start in operation efficiencies, call centers pretty much could be outsourced. Instead of building it in house, you got to pay the employee, you have to train the employee, you have to pay their 401k and their benefits. So most of your enrollment, claims, customer service, eligibility. There's so many companies that are available there. Some here in the States, some is outsourced overseas. But when I looked as a P&L owner, my actuaries and underwriters, what's my PMPM running, my per member per month for how many members I have? What's the KPIs for the competitors out there because they're all filed with the states. So you want to stay at least in the middle, but try to be on the lower end. And if you're a small plan with 5,000 members, you have to cover 24 hours during enrollments. You just have to hire staff to do all that, but you don't have the revenue that's coming in. So that's really where I would start most of my efficiencies there. And then it did go to as nurse calls, PBMs, Optum doing EMR services. There's some things you want to keep in house. You probably build your own network with your network team.

| Gregg | And then for commercial sales, you want your own sales team very involved with the employers and the people that serves that. But Medicare, for example, and Medicaid and ACA even, it's all agent-driven. So they're not really employees. They're just contracted for you, they're certified by you, and then you pay them a commission every time they sell. So you don't have that overhead.

| Max | Got it. Got it. That's great. Okay, Gregg, moving on to our last section, which is investment risks. What would you say is the underappreciated risk for payers going into 2026?

| Gregg | Yeah. I think as I did say, 2026 is the bubble year. I think right now the risks are less than it was in '24 and '25 because the trends, people are now all over them. The market has seen that. So the underappreciated risk is now if I stabilize it, which people are doing, small and big, what's my risk for growing too much? So instead of growing 15, 20%, you want stagnant stability growth, but you don't want to go from a 100,000 members to 400,000 members in one year. So you have to look what's the competition offering? And you could do that for a certain extent. Sometimes agents help, but benefits are posted out there. So the risk really is who's getting it right. If it's in the government programs like Medicare, the risk score is going up, that's revenue, like they're coded based on their chronic condition. Are there stars up? And if they're not four stars, do they have a plan to get the four stars? Because that 4% revenue could be a ton of money. And the other one would be just stability in the market. Do you want to grow? Do you want to expand? You want to exit? And UHC is a good example. They did a lot of market exits. And usually when you leave a market, Medicare may not let you in for two or three years. So you really-

| Max | Can you elaborate on that? Why did they exit markets? What's the-

Product Strategy – HMOs & PPOs

| Gregg | It's really that they were losing money. There could be other things politically correct, but their MLRs were too high and they couldn't build the right network or have the right clinical model to service that need. So what we've seen is ... I don't know, Max, but Alex may know. In Medicare and Medicaid, they're kind of doing away with PPO plans, open access where you can go in and out of network. In fact, when I was at UHC, we said we had a national network and you can use in network or out of-network, and you would just pay the Medicare or the Medicaid fee schedule. Well, now everyone is starting to go back to HMOs. And HMO is a health maintenance organization, more focused on primary services. You talked about prior authorization, I don't think things in an HMO business are going to need a referral to see a specialist like they were here in the States 15, 20 years ago. Your doctor had to write a script and you had to do all that. You want to give open access.
But the HMO model, almost not as much like Kaiser, which is the staff model like doctors under the roof, but that is happening, but not as much. But most people are now going back, really focusing on the role of a primary care and making sure the members see them and then have a big enough network that when the member does need to see a specialist, that they can do that.

| Max | Got it. So the HMO model is to refocus on the primary care and making sure people are going to see their doctor because it speaks to the preventative aspect we talked about and it allows you to be aware of stuff earlier. Is that right?

| Gregg | Yeah. Also allow you ... The HMO, you're restricted to the network. So the PPO, you can go to a doctor who is not contracted with a health plan. So you don't know that much about them. They have their license and everything, but they have their Medicare and Medicaid, but they may not submit claims timely. They may not be coding for the risk adjustment correctly. So it's basically, everyone wants the PCPs engaged, PPO, HMO, but the HMO really in this model, they get reports. They know who their members are. If a member's going out of network in a PPO, you can't really track them as much. So in the HMO model, it's the network. Network primaries working with network specialists, working with network hospitals, and then also working with the health plan.

| Max | And just to be clear, all payers offer both HMO or PPO, or are there some that are one or the other? When you say people are focusing on HMO, does that mean they're just ... What does that mean exactly for a payer?

| Gregg | Well, you had different products for HMO, PPO, right?

| Max | Got it.

| Gregg | I don't know of an exclusive HMO ... Well, Kaiser would be one, but a larger health plan usually had different product offerings. HMO, PPO. We have some called POS here, point of service. But I think what you've seen is a consolidation of PPO plans and sometimes exiting and then offering just the HMO plans there.

| Max | I see. I see. It's like a product strategy decision for the payer.

| Gregg | Yes. It's a product strategy decision 100%.

| Max | Got it. Got it. Super helpful. Super helpful. And is that consistent with what consumers want because then they ultimately have a choice?

| Gregg | No.

| Max | No.

| Gregg | It's not consistent, in my opinion. It depends on your network or your area. I live in Florida, you're in Miami-Dade, you're going to go to a nice model like a Kaiser clinical model and they're HMO and they're fine. It's very close-knit. But for the most part, employers really have PPO because their employees are like, "Max, we're all over the place.“

| Max | All over the place. Yeah.

| Gregg | Okay. But those employees, when they retire are used to having ... "I want to see my doctor," or, "I want to go to Johns Hopkins Hospital for my once a year checkup." I had cancer 10 years ago, but if they're not in the HMO network, you can't do that. So I would say if the patients are happy with the network that's in network, happy with their doctors, it's probably no big deal. But if those ... And usually only 10 to 15% of the people even in the PPO model will go out of network, but like I said, the plans couldn't track when they did that, maybe didn't know about admissions, et cetera. I think most people prefer, especially the boomers, the PPO, but they're going to get acclimated or already are. And if they're not, they're going to go back to their regular fee for service, Medicare. So those are decisions plans made. I'm going to lose some enrollment, but I think this model is better.

| Max | Got it. So product strategy. No, that's interesting. That's really helpful. And I have a question here on data breaches, which maybe for an outsider who's not familiar with the space, that would be a risk or something that payers would be sensitive to. But maybe that's a wrong assumption. How do payers think about data breaches or the security standard is always so good that they're super rare and it's ... How do you guys think about it?

| Gregg | They are at risk and it's happened to everyone. Unfortunately now with computers and phones, people could access patient details, not only charts, but your numbers, your phone numbers, use your cards. And there's a lot of abuse and sometimes even fraud in healthcare, especially in government programs.
So AI is key. It's a big investment. If you're small enough, you're going to outsource it. Look at UHC two years ago, they had this huge hit and I thought that would be impossible. I know everything that they had, the data centers, but it's just there's devious people out there. So AI is huge and you can get fined, you can get shut down, you've got to notice your members, the impacted, just like if it's a bank. So maybe a good investment is looking at the companies that could do that a little bit better, but it's definitely a concern.

| Max | I see. Okay. That's helpful. Are there certain payer names that are better at security than others or not so much? That's the wrong-

| Gregg | I don't know, Max. I don't know the just of it. I mean, Anthem Elevance was hit, United was hit, I think Humana was hit. So it's like, what is the scale? But I couldn't say if someone does it better, what system do they use and who do they go through? But I would just say it is a big part of operation costs and protecting health insurance information.

| Max | Got it. Perfect. Super helpful. And so we talked a little bit about AI in the context of automating claims. You just talked about AI in the context of helping prevent fraud. So where do you think artificial intelligence stands to have the biggest impact within the payer industry?

AI's Impact on Fraud, Waste, and Abuse (FWA)

| Gregg | I'd say definitely fraud. And we talked about that a little bit. And then it could be not only fraud Max, it could be fraud, waste and abuse. AI could help. If someone had an MRI a month ago and then another specialist wants an MRI of the same thing, AI could show that, right?

| Max | Yeah.

| Gregg | Would be waste in the system. So that's one of the biggest things that I have seen.

| Max | Got it.

| Gregg | And then operation cost efficiencies has really been key, but we're seeing it in clinical. When the hospitals, electronic medical records, physicians and the health plan, as long as it's secure or sharing that with the primary care, they're all on the same page and AI can do that for you. So instead of a PCP writing a prescription for this, the specialist writing one for that ... Because sometimes when my parents were alive, they didn't even know what their prescriptions were for, and the primary wasn't involved. So I really think that's the beauty of AI. They say it could cut reduction in workforce because they're able to do things. But healthcare is very fickle.

| Gregg | It's very much for yourself. You have to be careful on who could do what and the data breaches that you talked about. But it's definitely the future in healthcare. But I really think if you look at fraud, waste and abuse, is that test necessary? Was it done fraudulently? Someone got your Medicare card and you're ordering all these things and then trying to sell ... Supply companies here in the United States always seems like every month another one as there's some fraud and they're getting arrested for over billing Medicare, Medicaid, and AI should stop that. So let's hope, but that's the just.
I think we're in its infancy in the healthcare for a good reason, as long as, again, you keep your data secure and the doctors. Like I say, if you can connect everyone ... We used to look at AI charts when I was at UHC and say, "Who's connected here? Who's going there? Who's doing what?" And one medical director could be able to manage or quarterback that with all the AI instead of doing one medical director per state or per market.

| Max | Yeah. Gregg, can you help us understand the quantum of what you're referring to? So let's use this terminology of fraud, waste and abuse. You think if the technology delivers on its promise, call it, which I know is vague, but let's just use that term. Is that a 5% decrease in costs, 10%? I guess what is the fraud waste abuse bucket and how small could it get in your view if the technology works the way it's supposed to?

| Gregg | Yeah. If you look in traditional Medicare, fraud, waste and abuse was estimated 15%, in that range.

| Max | The total cost of Medicare?

| Gregg | Right.

| Max | Wow.

| Gregg | And Medicaid for that matter. So if you could take it from 15% to 6% in three years, just think of those savings and go from six to three. There's always going to be some fraud or waste or abuse. People, they're smart. The people where they do it overseas, they can get access and look at the algorithms and change it. But I think it's already shown. It just hasn't been maybe quick enough, but it's definitely starting to show. And the reason MLRs were higher just real quick is that people overestimated benefits to grow or to keep their members or their employers. And then when the MLRs went up, they were losing money, but this AI could help with that, not only administration costs, but looking at the fraud, waste and abuse.

| Max | I see. I see. Because it is possible ... Again, back to the product strategy point, which you've made clear is really important. It is possible to get the product wrong in terms of what is covered versus how much it costs, and then you end up on the wrong side of operations.

| Gregg | Yeah. It's a spreadsheet, Max. You bring all people in. I used to bring actuaries, underwriters, my field agents, my service, my stars team. And the first thing you'll look at as your competitors. Do I have the right product in the right market? Can I sell it? Can I grow it profitably? In profit, it's usually two or three or 4% of premiums, but when you have a $4 trillion revenue from the government, 4% of that, you're going to help meet the margins of the company.

| Max | Yeah. Yeah. For sure. No, okay, that makes a lot of sense. Okay. And then on this AI implementation, I really like this fraud, waste and abuse concept you've introduced. Do you think it's going to be an industry-wide thing and best practices will propagate and it's just about the whole market's going to get better at it? Or do you think there's alpha in some teams, some payers becoming really good at implementing it versus others that are slow and therefore will introduce this difference in operational levels?

| Gregg | Yeah. I think there was alpha two, three years ago, not anymore. Everyone's aware of it, and that's where Optum is growing so much using their platforms and systems and Change Healthcare, but there's others out there as well. Everyone is concerned with fraud, waste and abuse because it takes away not only profits, but it just deletes government programs and the money that are going into them that we want them to be around 20, 30 years from now. And it's usually seamless to the patient. That's the thing. Some, you have a fraudulent provider. For whatever reason they say a patient came in and they just build it and that's going to happen. But the fraud, waste and abuse to AI is going to be huge and stop duplication of services and give better outcomes and just look at the overall circle in one's health that it's being touched on. So it's the most exciting thing in healthcare because physicians, they get help from that. Hospitals ... Helps stop hospitals from readmissions because they could look at the data or it shows if they're ready for discharge or not. Duplication of tests and services is also big. That's why most like I'm pumped up about that.

| Max | Oh, that's great. That's great. I'm glad you brought that up. Super interesting. Gregg, last question. Is there something we haven't touched on today that you think is important with regards to thinking through or learning about the payer market in the US?

| Gregg | Well, you did a really good job. Questions were thorough. I would just say right now ... I said it a few times. It's like we're in a bubble and who's going to survive? Because we want the small ones to get big and the big ones stay competitive because competition is good for everyone. But I think what you're going to see is more consolidation just because it's so, like we talked about, to build that right model and track everything. Will we be a single payer? I'm not really sure where the United States is going, but I do feel that the questions you asked are key for the healthcare system here and states, and it's key to all of us is you want people to live a longer and healthier life. So you don't want a health plan just be a claims payer. You don't want them to be like a robot or a widget. You want them to be actively involved. And that means getting involved with patient caregivers, family members, physicians, hospitals. It's like a big circle that really needs to be-

| Max | Sorry, Gregg, you said something interesting. You said, will the US be a single payer? Is that a prospect according to you, you think? You think consolidation reaches a point where ... Elaborate on what that thought was.

| Gregg | I think that's a 10-year view on my part because we're getting to a point where things are so expensive. Premiums are going up, costs are going up. Hospitals want to ... I'm blaming hospitals, but they have to pay their staff too, so they want to get paid more and so the physicians. So I just think the Affordable Care Act right here in the States now, the subsidies are under or they're going to extend them, and that could be the start. I don't think United States is built for a single payer. I don't know if we'll ever get there, but we'll get closer to it. So it could be three or four major carriers instead of 30 because I don't know, Max, how the smallest ones can survive even if they do everything right

| Gregg | Just the administration of that. And again, Medicare, you file bids at 85% of your expected benefit costs, at least 15% for administration costs. And if you want to take out your two or 3% margins for a for-profit company, you have to get them in the ... Like I said, under 11% to me was always best in class, and it's harder for these smaller plans to do that.

Sometimes a small plan that has a niche in a market, East Tennessee, I had a state there and they had a good health system where they just managed it well and they did everything, but it wasn't on a scale across the country, so you could see pivots and markets here. Like I said, we're in a bubble, 26, I think things will stabilize then. We'll start to see '27, '28, and then if premiums cannot continue to go up as much as they have been, but healthcare costs are going up, new things, people are living longer. And if you look at Medicare itself, it's almost like a single payer. You had fee-for-service, Medicare, both Max and I think Katie's on, and you probably weren't, you're not in the States, but the employer's paying into that for their employees.

The employee is paying into it. And then you get this benefit once you're Medicare eligible, like turning 65 is the biggest one, but it could be due to disability. So Part C plans, Medicare here in the States was supposed to filter out instead of having just one single payer for Medicare, which is fee-for-service, where the costs were higher 20% of costs and you had deductibles, Medicare Advantage plans were managing it, getting costs and being able to do it profitably. But that profit has gone away the last few years. So '26 and '27, Max should tell us if the plans could get to a 3% margin, three or four. But now they're at negative one, negative two or maybe one. And I don't know if that's scale. So that's why I think '26 ... I think by Q2 '26, we'll get a good idea. And then '27, it could go back to where it was, where health plans can grow and make money at it. But we don't have the money. The states are running out of money to afford Medicaid. So big decisions are going to happen.

| Max | And who would you say are the consolidate tours if you had to play that out? And would you say that this prospect of consolidation is top of mind for those execs? You would say they're actively looking at, "Hey, there's a small provider in this state that's doing a really good job, but it's going to be hard for them to scale, so why don't we go in and acquire them?“

| Gregg | Yeah. I think acquisitions is always on the back of everyone's mind. It was on my mind as a CEO, but I think right now growth isn't the key. So it's once they could look at, did they have the right business model, which we've talked in length about. If they get that and they're able to manage care and their bed days go down and their MLRs drop, they're going to go all in and the little ones probably will be acquired. Who could be a national payer? UAC Optum just because of Optum, but maybe it's Optum. Elevance is another big one. Aetna Health has done good, CVS. The Blues, Local Blues plans do fairly well. There's one here in Florida. But it'd be two, three, or four. But let me put this out there. I don't think the American people want a single payer.

| Max | Got it. Fair enough.

| Gregg | Even though Medicare is a single payer, but they have their choice to go to a Part C plan.

| Max | Yeah. Well, Gregg, listen, thank you so much for your time. I think that's a great way to end the conversation. This has been super insightful.

| Gregg | Great.

| Max | We're really thankful to have gotten a little bit of your time. Okay. Thank you for sharing it with us.