SECTION: ABOUT OUR COMPANY

INDUSTRY OVERVIEW

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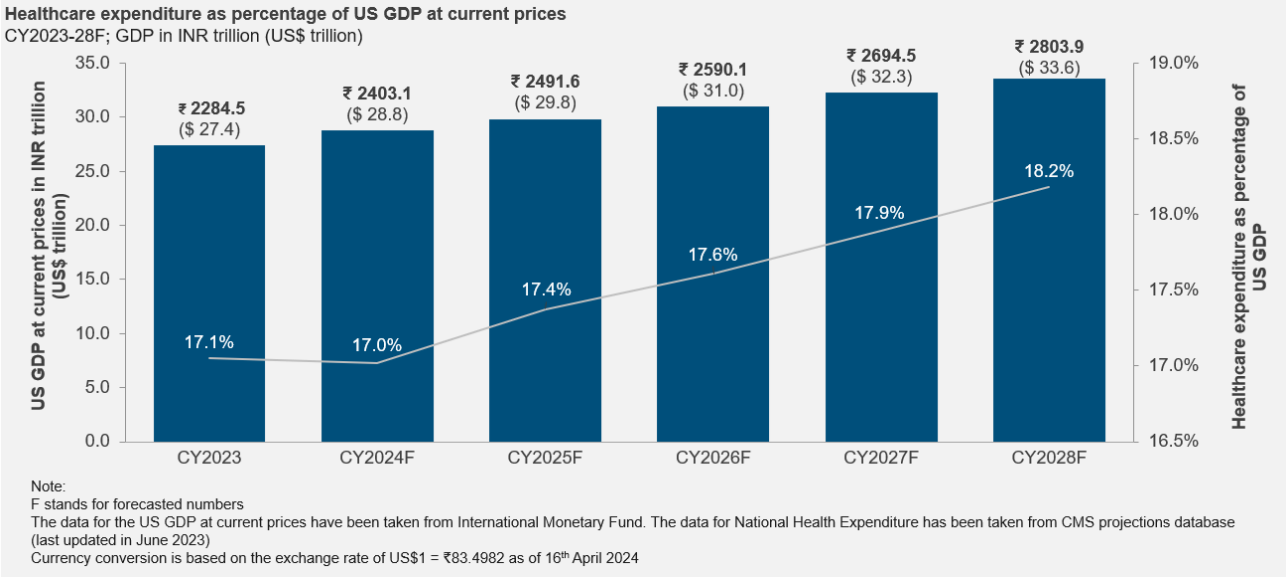
The US economy and the role of healthcare – an overview

According to the International Monetary Fund (IMF)[1,2], the nominal GDP of the United States reached US$ 27.4 trillion (₹ 2,284.5 trillion) in CY 2023 and is projected to steadily grow to US$ 33.6 trillion (₹ 2,803.9 trillion) in CY 2028, at a CAGR of 4.2%.

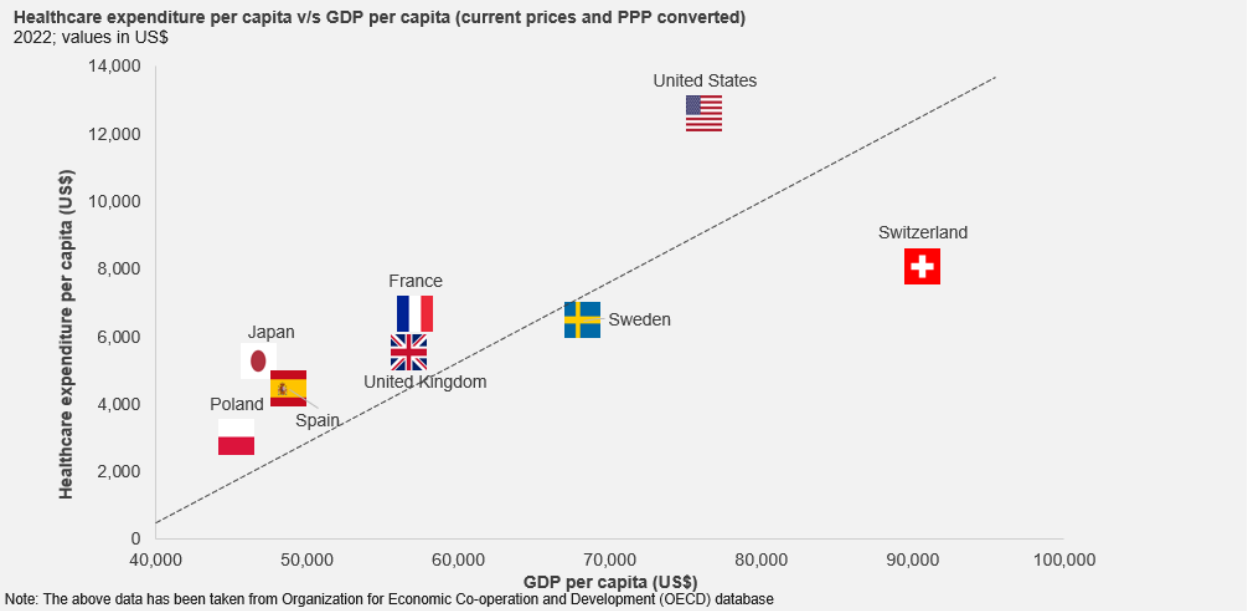
Healthcare is an intricate segment of the US economy accounting for 17.1% of its nominal GDP and amounting to US$ 4.7 trillion (₹ 389.6 trillion) in CY 2023 as per the latest projections by Centers for Medicare & Medicaid Services (CMS)[3]. Furthermore, according to CMS[3], this expenditure is anticipated to grow at a CAGR of 5.5%, reaching US$ 6.1 trillion (₹ 509.8 trillion) by CY 2028.



Note:
F stands for forecasted numbers
The data for the US GDP at current prices have been taken from International Monetary Fund. The data for National Health Expenditure has been taken from CMS projections database (last updated in June 2023)
Currency conversion is based on the exchange rate of US$1 = ₹83.4982 as of 16th April 2024

According to the Organization for Economic Cooperation and Development (OECD)[4], the per capita healthcare expenditure at current prices (Purchasing Power Parity converted) in the US amounted to US$ 12,555.3 (₹ 10,48,345.0) in CY 2022, establishing it as the highest spender on healthcare among leading economies. As per the analysis of OECD data, this expenditure amount is significantly more than Switzerland, the second-highest spender, standing at US$ 8,049.1 (₹ 672,085.4) in CY 2022[4]. Comparatively, the Indian healthcare market is underdeveloped with the latest estimates from World Health Organization (WHO)[5] showing that the health spending per capita is US$ 74.0 (₹ 6,178.9) in 2021.

[1] International Monetary Fund
[2] International Monetary Fund: Terms of use
[3] Centers for Medicare & Medicaid Services
[4] Organization for Economic Cooperation and Development
[5] World Health Organization



Given the substantial difference in healthcare expenditure per capita between the US and other leading economies, the US market is expected to maintain its lead over other nations, with the latest estimates from CMS[3] indicating healthcare expenditure per capita to grow at ~4.8% CAGR from 2023-28.

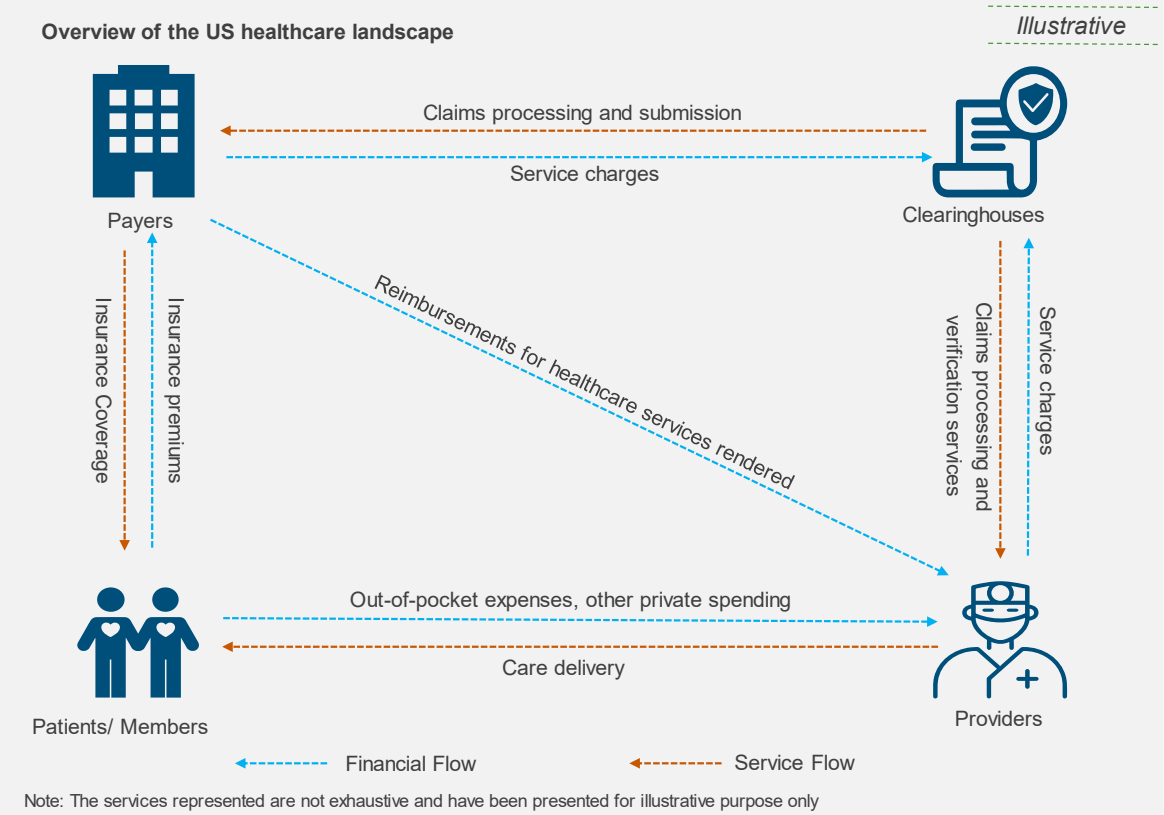
The US healthcare market

Healthcare enterprise segments

The US healthcare market comprises of two primary entities with respect to care financing and care delivery – healthcare payers and healthcare providers:

- **Healthcare payers:** Healthcare payers are entities that pay for or reimburse healthcare services for insured members through health insurance plans
- **Healthcare providers:** Healthcare providers are individuals or healthcare facilities that are licensed to deliver care services or aid in care delivery such as doctors, clinics, hospitals, labs, durable medical equipment providers, etc.

An illustrative representation of these two stakeholders of the US healthcare landscape is as follows:



Within healthcare payers and providers, there exists various categories and sub-categories as elaborated below:

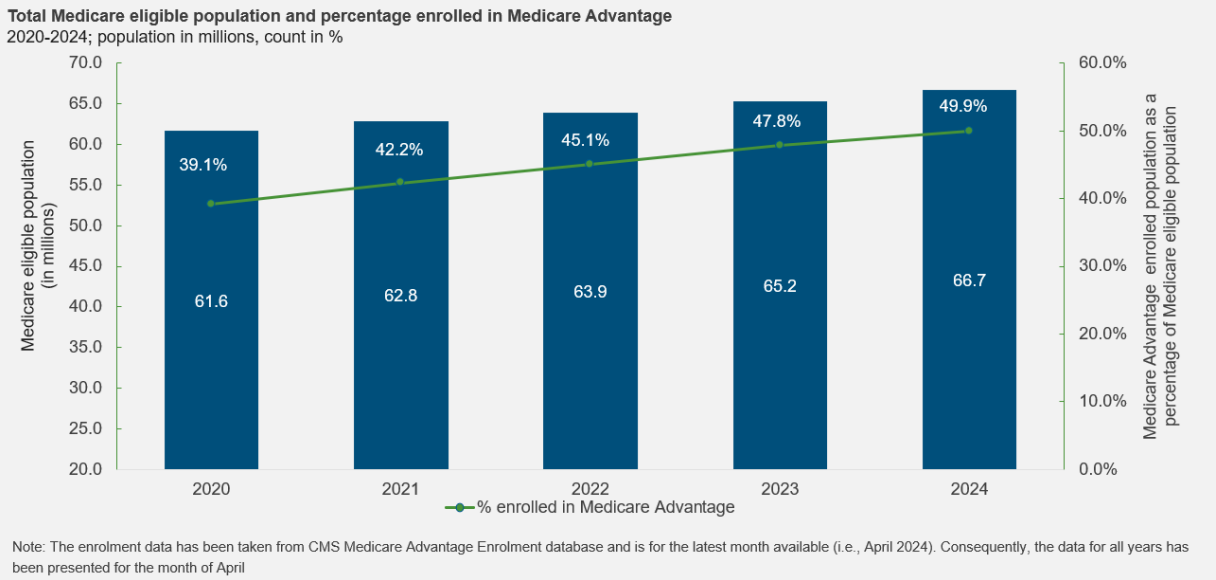
Healthcare payers: Major categories based on the plan type

1. **Government/public plans:** These healthcare plans are funded by federal and state governments. Major sub-categories of these plans include:

- ***Medicaid:*** Medicaid is a collaborative initiative of federal and state governments that provides health coverage to low-income people, families and children, pregnant women etc. These plans are either state-run or administered by private organizations (contracted by states) known as *Managed Care Organizations*, in which case they are called **Managed Medicaid** plans. As of December 2023, Medicaid enrollment stood at over 78 million+ growing at a CAGR of ~2.4% since December 2020, according to CMS[6,7].
- ***Children's Health Insurance Program (CHIP)*:** CHIP is also a collaborative initiative of federal and state governments focusing on children whose household income exceeds Medicaid limits but falls short of other plans. In some states, CHIP covers pregnant women as well. According to CMS[6,7], as of December 2023, national CHIP enrollment was over 7 million+ growing at a CAGR of 2.1% since December 2020.
- ***Medicare*:** It is a federal health insurance program for people aged 65 and older, as well as younger people with certain disabilities. Medicare plans can be administered directly by the federal government (*referred to as Original Medicare*) or offered through private organizations

[6] Centers for Medicare & Medicaid Services
[7] Centers for Medicare & Medicaid Services

that contract with the government, in which case they are called **Medicare Advantage** plans. In addition to the coverage provided by Original Medicare, Medicare Advantage plans may also offer additional benefits for the insured population. According to CMS[8,9], as of April 2024, Medicare enrollment stood at over 66 million, growing at a CAGR of 2.0% since April 2021. Medicare Advantage (MA) enrollment, on the other hand, has been witnessing a consistent uptick at a CAGR of 7.9% over the same period to reach approximately half of the total Medicare enrollment or over 33 million.



Note: The enrolment data has been taken from CMS Medicare Advantage Enrolment database and is for the latest month available (i.e., April 2024). Consequently, the data for all years has been presented for the month of April

- ***Others*:** These include health plans for federal employees, military service members, and veterans through programs such as TRICARE and Veterans Health Administration

2. **Commercial plans:** These healthcare plans are funded and managed by private insurance companies for individuals and families. Some of these health plans are self-funded and are assisted by Third Party Administrators (TPAs) for administrative services. Moreover, several commercial health plans may also include dental and vision benefits. Major sub-categories include:

- ***Employer-sponsored*:** Health insurance plans provided by employers to their employees as part of their employee benefits package. As per the latest reports by Congressional Budget Office (CBO)[10], approximately 161 million people had employment-based coverage in 2023 which is further expected to grow at a CAGR of ~0.3% till 2033.
- ***Health Insurance Exchange (HIX)*:** It is an online marketplace where individuals and small businesses can compare and purchase health insurance plans. According to CMS[11,12], over 21 million consumers have signed up for exchange-based coverage through the marketplaces since the start of the 2024 Marketplace Open Enrollment Period (OEP), indicating a substantial growth at a CAGR of 21.1% from Open Enrolment 2021.
- ***Medicare Supplement*:** Also known as Medigap plans, these are private insurance policies that help cover some of the healthcare costs that Original Medicare does not cover, such as copayments, coinsurance, and deductibles.

[8] Centers for Medicare & Medicaid Services
[9] Centers for Medicare & Medicaid Services
[10] Congressional Budget Office
[11] Centers for Medicare & Medicaid Services
[12] Centers for Medicare & Medicaid Services

Healthcare payers: Major categories based on the carrier type

- **National carriers:** Healthcare payers that offer coverage across most of the states in the US. Examples of national carriers include UnitedHealthcare, Elevance Health, Centene Corporation, CVS Health, Cigna Healthcare, Humana, Health Care Service Corporation, Highmark, and Kaiser Permanente
- **Regional carriers:** These are health insurance plans or companies that operate within a specific region or geographic area. Some examples of such plans are Healthfirst, UPMC Health Plan, L.A. Care Health Plan, CareSource, Medical Mutual of Ohio, Corewell Health West Michigan (Formerly Spectrum Health), Point32Health, and Inland Empire Health Plan. Blue Cross Blue Shield Association (BCBSA)[13] plans are a type of regional carriers that are offered by BCBS association – an association of 33 independent, community-based and locally operated companies (as of June 4, 2024). Some of the examples of BCBSA plans are Horizon Blue Cross Blue Shield of New Jersey, Florida Blue, Independence Blue Cross, CareFirst Blue Cross Blue Shield, Blue Cross Blue Shield of Michigan, Blue Cross and Blue Shield of North Carolina, Blue Cross and Blue Shield of Alabama, and Blue Shield of California

National and regional carriers can offer different types of health plans such as Medicare Advantage and commercial plans.

Healthcare providers: Major categories

- **Hospitals and health systems:** Healthcare organizations operating as independent hospitals or as a network of hospitals, that provide a wide range of medical services, including inpatient (patient staying with the hospital for a treatment) and outpatient care (no stay treatments), emergency services, surgical procedures, and specialized treatments. Hospitals are often bucketed based on different lenses such as the number of beds, Net Patient Revenue earned in a year, etc. According to Organization for Economic Cooperation and Development (OECD)[14], there are more than 6,000 hospitals in the US such as The Johns Hopkins Hospital, Tenet Healthcare, UCSF Health, Cedars-Sinai, Encompass Health, Cleveland Clinic, Northwestern Memorial Hospital, and Universal Health Services.
- **Physician groups and clinics:** These are office-based individual physicians or groups of specialists who collaborate to deliver medical and outpatient care. Cleveland Clinic and IU Health Physicians are some of the examples. According to US Bureau of Labor Statistics[15], as of May 2023, office-based physicians employed 131,460 physicians in the US.
- **Others:** This category includes a range of healthcare providers that provide specialized services such as long-term care facilities, home healthcare agencies, dental clinics, Durable Medical Equipment providers (DMEs), and laboratories. Some examples of this category of healthcare providers are DaVita Kidney Care, Bio-Reference Laboratories, and Laboratory Corporation of America Holdings.

Some of the healthcare providers mentioned above may also come together voluntarily as a group of doctors, hospitals etc., to provide coordinated and high quality care to the patients and prevent unnecessary healthcare utilization. These groups, also called as Accountable Care Organizations

[13] Blue Cross Blue Shield Association
[14] Organization for Economic Cooperation and Development
[15] US Bureau of Labor Statistics

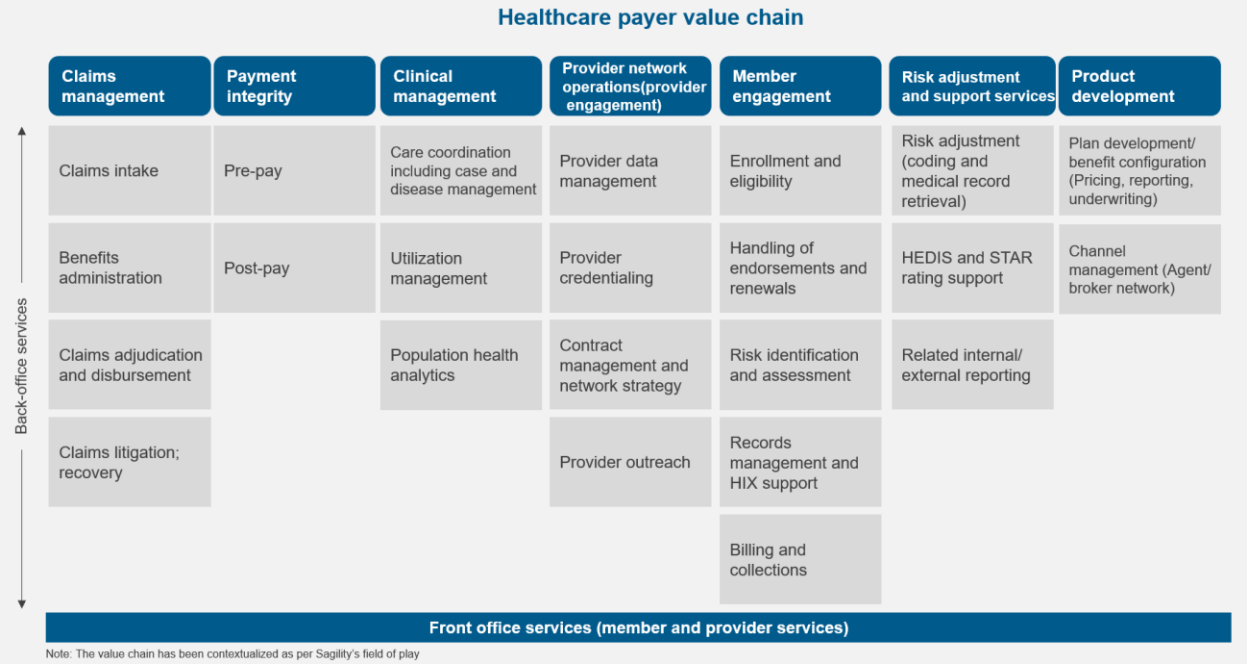
(ACOs), have innovative payment arrangements with healthcare payers that compensates them for the quality of care delivered, instead of the volume of healthcare services provided.

Apart from this, there are also some other enterprises that are crucial in facilitating continuous care, such as Pharmacy Benefit Managers (PBMs), who are administrators of prescription drug programs and serve as intermediaries between health plans, pharmaceutical manufacturers, and pharmacies.

Healthcare operations overview

Healthcare payer operations value chain functions

Healthcare payers engage in a diverse set of activities to ensure operational efficiency and seamless experience for the individuals they cover, referred to as members. These activities can be categorized into seven broad value chain segments across front- and back-office, as shown in the process map below. The process map excludes non-business process operations such as pureplay Information Technology (IT) development and SaaS, IT services, and maintenance.

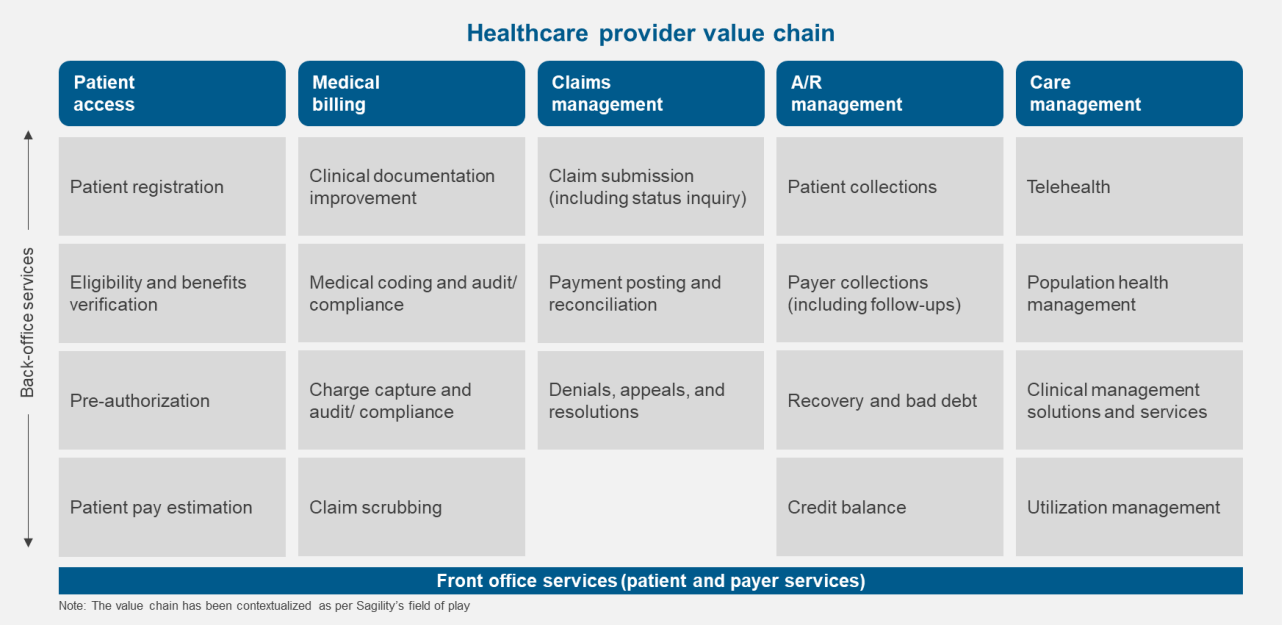


- **Claims management:** This refers to the process of receiving, adjudicating, and paying or denying claims submitted by healthcare providers or members often through technology-enabled tools
- **Payment Integrity:** Payment integrity refers to the process of ensuring accuracy, transparency, and compliance in financial transactions related to healthcare services, claims, and reimbursements. It involves verifying the validity of claims, detecting, and preventing fraud, waste, and abuse, coordinating benefits in case of multiple payers, and optimizing cost management, through analytics and technology solutions
- **Clinical management:** Clinical management is a coordinated approach to healthcare that involves organizing and overseeing member (patient) care. It focuses on optimizing health outcomes, improving quality of care, and controlling costs by ensuring appropriate utilization of services and resources along with leveraging population health insights through technology for effective care management

- **Provider network operations (Provider engagement):** Provider network operations or provider engagement is an intrinsic process that includes credentialing and maintaining an accurate provider directory in a payer's network, as part of regulatory requirements in the US. This segment focuses on maintaining and updating a network of healthcare providers, including hospitals, clinics, and physicians, using integrated technological solution to ensure members have access to quality care
- **Member engagement:** This segment comprises activities that are aimed at supporting member relationships and interactions for smooth navigation of benefits and coverage, often through tech-enabled analytics and platform solutions
- **Risk adjustment and support services:** This segment focuses on activities aimed at securing accurate reimbursements and improving health plan performance metrics through processes such as risk adjustment coding, ratings support, and compliance reporting
- **Product development:** This segment focuses on the design and development of health insurance plans along with the management of agents and broker networks

Healthcare provider operations value chain functions

Apart from core care delivery, healthcare providers undertake a wide range of activities to reduce administrative burden, improve efficiency, and ensure robust patient experience. The processes involved can be categorized into five broad value chain segments across front-office and back-office, as shown in the process map below. The process map excludes non-business process operations such as pureplay IT development and SaaS, IT services, and maintenance.



- **Patient access:** Focuses on ensuring that the patients have timely and efficient access to healthcare services, including appointment scheduling, registration, and insurance verification while leveraging technological solutions such as online portals and scheduling systems to improve efficiency
- **Medical billing:** This segment encompasses activities that are aimed at accurately billing patients or their insurance providers for healthcare services rendered through activities such

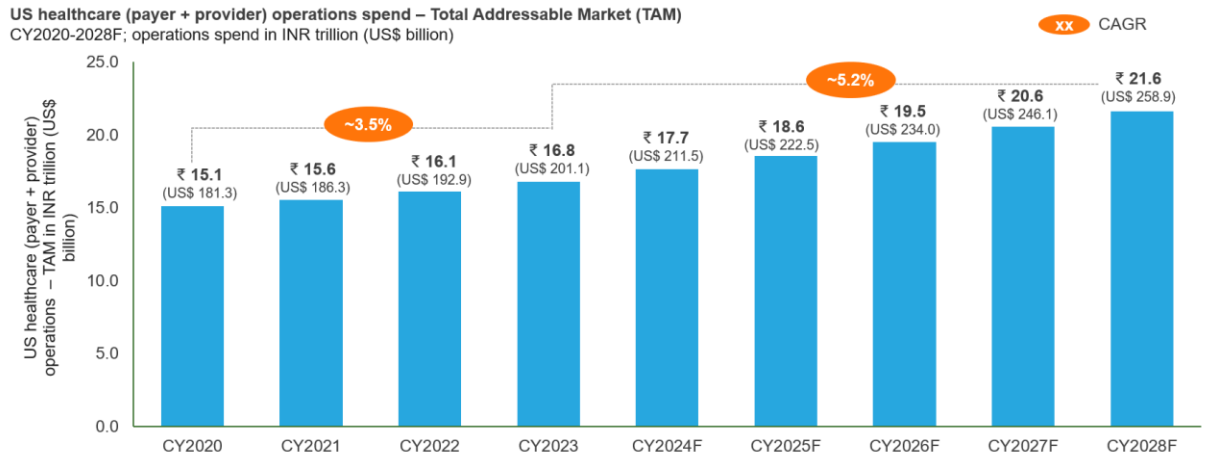
as clinical documentation improvement and medical coding, often utilizing technology solutions such as billing and coding systems to streamline processes and ensure accuracy

- **Claims management:** This segment focuses on getting accurate reimbursements from payers or patients through error-free claim submissions and proficient resolution of denials
- **A/R management:** Responsible for managing and collecting outstanding payments owed to the healthcare providers either by patients or health plans with technology solutions deployed to track and optimize the accounts receivable process
- **Care management:** This segment is focused on the coordination and optimization of healthcare services for patients to ensure comprehensive and effective care

The U.S. healthcare industry is characterized by complex services, stringent compliance requirements, intricate performance measures, and multifaceted payment workflows. These challenges necessitate the involvement of specialized service providers who possess the expertise to navigate and manage these complexities effectively.

US healthcare operations spend

The healthcare operations spend (defined by and limited to the value chain mentioned above) in the US has grown at a CAGR of ~3.5% from CY2020 to CY2023 and was valued at ~US$ 201.1 billion (₹ 16.8 trillion) in 2023. This spend is expected to grow at a CAGR of ~5.2% to reach ~US$ 258.9 billion (₹ 21.6 trillion) in CY 2028F, driven by the rise in aging population, increasing prevalence of chronic diseases, and various governmental initiatives aimed at enhancing healthcare services, among other factors.



Notes
1. Currency conversion is based on the exchange rate of US$1 = ₹83.4982 as of 16th April 2024
2. TAM is inclusive of vertical (healthcare value chain specific) and CX spending including the spend incurred on pureplay and tech-enabled business operations. Additionally, it excludes spend on pureplay IT/software product and IT services
3. Operations TAM indicates inhouse, captive, and outsourced spending. The growth rate has been estimated on the market size in US$.
4. F stands for forecasted numbers . Forecasts have been made basis historical data analysis and primary interviews with industry connects
5. The above data points and growth figures are approximate numbers that have been rounded off to the closest whole number (or up to one decimal place)
Source:Everest Group (2024)

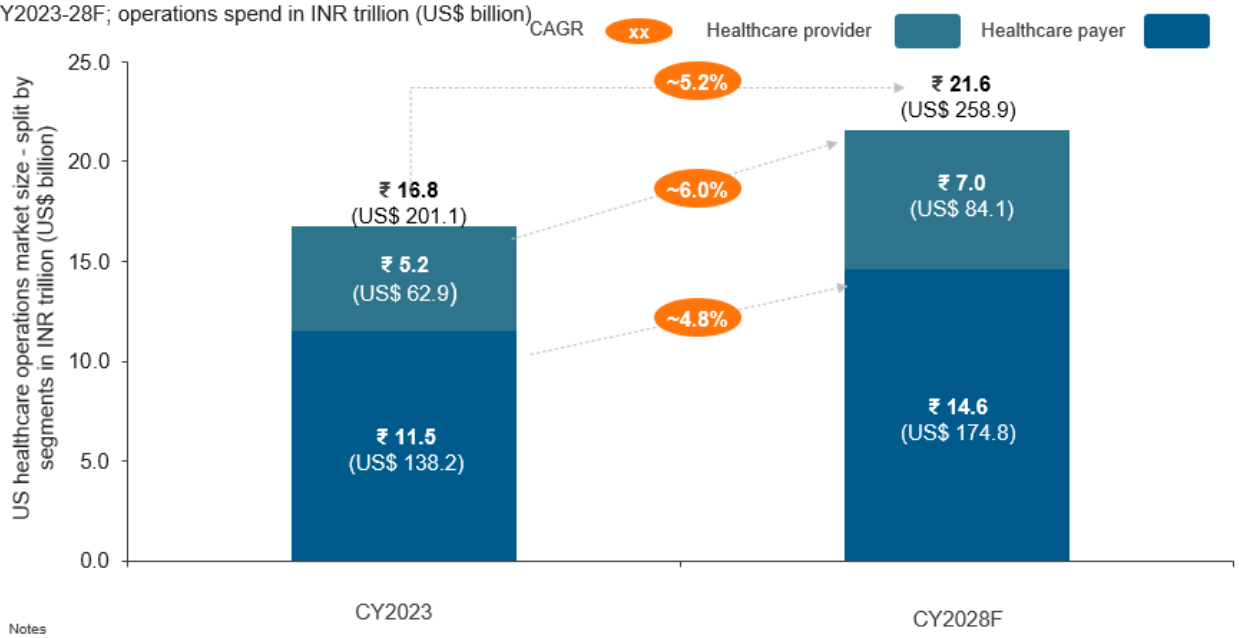
Split of operations spend by healthcare payers and providers

The healthcare payers are estimated to contribute ~68.7% or ~US$138.2 billion (₹ 11.5 trillion) to the overall operations spend of US$ 201.1 billion (₹ 16.8 trillion) in CY 2023. The healthcare

provider market had a comparatively smaller contribution of ~31.3% or US$ 62.9 billion (₹ 5.2 trillion) in CY 2023.

The healthcare payer operations spend is expected to grow at a CAGR of ~4.8% to reach US$174.8 billion (INR 14.6 trillion) in CY 2028. While the insured population has grown at a CAGR of ~1.3% from 2019 to 2022, the growth in the payer operations spending has outpaced this rate. This trend is expected to continue due to factors such as rising consumerism and changing care models, among other factors. On the other hand, the healthcare provider operations market is expected to grow at a CAGR of ~6.0% to reach US$ 84.1 billion (INR 7.0 trillion), driven by factors such as increasing demand for healthcare services and complexities in billing, among other factors.

US healthcare operations spend – Split by market segments
CY2023-28F; operations spend in INR trillion (US$ billion)



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Source:Everest Group (2024)

Tailwinds driving growth in the US healthcare market

The following factors are expected to drive growth in the US healthcare market:

Rise in aging population:

The United States population aged 65 years and older as of July 1 is projected to increase from ~57.8 million in 2022 to ~71.2 million by 2030, growing at a CAGR of ~2.6%. This growth is expected to accelerate the share of 65-and-older population from ~17.3% in 2022 to ~20.6% of the total population in 2030, according to US Census Bureau[16].

As the elderly population grows, the demand for numerous age-related procedures and geriatric care will also increase, given their vulnerability to frequent illnesses. This will lead to a surge in

[16] US Census Bureau

demand for healthcare services, an increase in physician/hospital visits, and greater utilization of resources, thereby, fueling growth in the healthcare industry.

Increasing prevalence of chronic diseases:

The number of people suffering from chronic diseases is rising steadily in the United States. According to Centers for Disease Control and Prevention (CDC)[17], as of 2022, 6 in 10 adults in the US have a chronic condition and 4 in 10 adults have two or more chronic conditions, highlighting the burden of chronic disease in the US.

Chronic diseases such as diabetes, cardiovascular diseases, asthma, cancer, etc. require frequent physician visits, medical care, diagnostic tests, and expensive prescription drugs. As the incidence of chronic diseases rise further, the demand for recurring services such as preventive care, outpatient care, and wellness management will accelerate, resulting in the growth of the healthcare market.

Shift towards value-based care:

Value-based care emphasizes quality, provider performance, and patient outcomes over the traditional fee-based model, thus, prioritizing holistic patient experience and effective results. By 2030, the CMS[18] is targeting to have 100% of traditional Medicare beneficiaries and most of the Medicaid beneficiaries in an accountable care relationship, with advanced primary care serving as key means to attain this objective.

CMS' shift to value-based care and reimbursement will prompt healthcare enterprises to prioritize patient outcomes and deploy preventive strategies, thus, emphasizing outcome-oriented care delivery. This drive necessitates efficient care management operations, enhancing patient satisfaction and healthcare outcomes. As a result, the healthcare payers and providers will need to invest in solutions that lead to actual, long-term impact on improvement in member/patient health, thus, driving growth in the healthcare market.

Increased consumerization in the US healthcare industry:

The growing emphasis on proactive wellness initiatives is encouraging members and patients to seek personalized services to manage their health and treatment decisions. As a result, this has driven the need for transparent processes, elevated customer experience, and nuanced solutions that can attend to patient and member requests 24*7.

Consequentially, healthcare payers and providers are investing in interoperable solutions, tailored care plans, and targeted outreach efforts to ensure comprehensive member experience. As the healthcare consumerization journey evolves further, it is expected to increase the demand for a range of healthcare services including wellness programs, and disease management initiatives, thus, accelerating growth in the US healthcare market.

Shift in care delivery models:

Following the COVID-19 pandemic, the US healthcare industry has seen a surge in the adoption of non-traditional care delivery models like remote patient monitoring, telehealth, and home-based care. According to CMS[19], this trend has been notably reflected in the significant increase in spend by home healthcare agencies that increased 6% in 2022 to reach US$ 132.9 billion (₹ 11.1 trillion),

[17] Centers for Disease Control and Prevention
[18] Center for Medicare and Medicaid Services
[19] Centers for Medicare & Medicaid Services

a notable acceleration from growth of 0.3% in 2021. Furthermore, the expanded coverage of remote monitoring services to additional healthcare providers who can now bill for these services as per Medicare Physician Fee Schedule 2024 has increased accessibility for such types of innovative care options as per CMS[20].

This spurt in the growth of non-traditional care is expected to drive investments from healthcare enterprises into new capabilities around home-based care, telehealth etc., thus, enabling them to diversify their service offerings and cater to evolving patient preferences.

Increasing push by the government to enhance healthcare services:

While the U.S. healthcare expenditure is steadily growing, the US government and CMS has implemented several policy initiatives and guidelines such as CMS Framework for Health Equity and HHS Roadmap for Behavioral Health Integration to improve the healthcare outcomes for the US population.

The primary objective of these programs is to ensure comprehensive and equitable healthcare coverage to the US population irrespective of race, ethnicity, orientation etc., with a keen emphasis on addressing social determinants of health. In fact, as per a proposed rule on health equity, CMS has recommended to incorporate health equity experts on utilization management committees of Medicare Advantage organizations for annual review of their utilization management policies.

These concerted efforts underscore the government's commitment to ensuring robust healthcare services coverage for the populace, thus signaling a conducive environment to the growth of healthcare industry.

Growth in health insurance coverage:

Rising healthcare costs, coupled with the prevalence of chronic diseases, are driving a surge in demand for comprehensive health insurance plans in the US. As a result, individuals and families are increasingly seeking health insurance plans that offer a wider range of benefits, including preventive care, specialist consultations, and coverage for prescriptions. In fact, as per the recent reports from US Department of Health and Human Services[21], the national uninsured rate reached an all-time low of 7.7% among all US residents in Q1 2023.

This highlights the growing awareness among the population about the importance of extensive health coverage, thereby emphasizing the continued expansion of the US healthcare market.

Challenges in the US healthcare market

While the US healthcare market has shown resiliency in overcoming some of the pain points faced by the industry, there is a likelihood of several challenges that may impact the sector. However, the industry is proactively taking steps to mitigate these challenges by engaging external vendors for outsourcing support. Some of the challenges are mentioned below:

Shortage of healthcare talent including physicians and nurses:

[20] Centers for Medicare & Medicaid Services
[21] US Department of Health and Human Services

Labor shortages in the healthcare industry not only affect operational efficiency but also has an impact on patient/member care and experience. According to US Department of Health and Human Services[22,23], the US healthcare industry projects a shortage of 68,020 primary care physicians and 337,970 registered nurses by CY 2036.

This scarcity may likely translate into reduced access to care, longer wait times for patients, and potential dissatisfaction among care-seekers, eventually resulting in deferred treatments and a drop in healthcare revenues. Further, doctors may face increased workloads and burnout, leading to attrition and rise in operational costs for healthcare facilities as they compete to retain talent. As a result, the quality of care, adoption of innovation, and eventually, profitability may get compromised, further impacting the overall growth of the healthcare industry.

Enterprise consolidation and rise in cost of care:
The US healthcare market continues to witness a flurry of consolidations across both – payer as well as provider enterprises. While consolidation does offer opportunities for efficiency, it also brings about significant risks, impacting factors such as competition, access, and pricing. In fact, according to National Association of Insurance Commissioners[24], the net premium per member per month (PMPM) as of December 31 increased by 6.7% in 2022 compared to 2021, rising from US$ 296.0 to US$ 316.0.

As a result, consumer demand for healthcare services and insurance products may get affected, potentially exacerbating health disparities and impacting the growth of the healthcare industry.

Increasing friction between payers and providers impacting member experience and treatment journeys:
The increasing friction between payers and providers poses an emerging challenge that may impact member experience and treatment journeys in healthcare. For example, a review conducted by the Office of Inspector General[25] reveals that Medicaid managed care organizations deny approximately one out of every eight requests for the prior authorization of services, highlighting the gravity of the situation. Factors such as systematic problems with MCO prior authorization processes, limited use of external medical reviews, and administrative problems with MCO prior authorization decisions contribute significantly to these denial rates.

These conflicts over utilization reviews, reimbursement rates, denials, and billing practices may lead to a subpar patient experience, as patients face delays in accessing care and disruptions in the treatment plans, ultimately resulting in poorer health outcomes. As a result, patients may seek alternative care options or delay treatments, eventually, impacting growth of the healthcare market.

Escalating revenue pressures amid regulatory changes:
As regulatory changes unfold, healthcare enterprises may face escalating financial strains. The conclusion of the Public Health Emergency (PHE) post-COVID-19 lifted off waivers, exacerbating challenges in maintaining financial stability. Further, Medicaid redeterminations are expected to result in loss of coverage for certain ineligible individuals, thus, diminishing access to care.

[22] US Department of Health and Human Services
[23] US Department of Health and Human Services
[24] National Association of Insurance Commissioners
[25] Office of Inspector General

Additionally, the Inflation Reduction Act is expected to alter the financial dynamics, as payers now face increased financial responsibility, rising to 60% in the catastrophic phase for Medicare Part D, according to CMS[26]. This may lead to tighter margins for healthcare enterprises and impact their growth prospects.

Impact of potential slowdown in 2024:
While the concerns around recession in the US diminish on account of improved economic outlook, the impact of a recession on healthcare remains considerable, given its significant contribution to the US GDP. In the wake of the recession, government healthcare spending may face constraints as tax revenues decline, prompting the reallocation of resources. As a result, healthcare being a significant contributor to the US GDP may face budgetary pressure.

Further, healthcare providers may experience reduced demand for non-urgent services due to financial strain on members who lose employment coverage, resulting in deferred treatments and loss of revenue, thus, impacting the growth of healthcare.

Increasing frequency of cybersecurity incidents:
Healthcare organizations are prime targets for cyber-attacks due to the vast amount of sensitive patient data they handle. According to US Department of Health and Human Services[27], over the past five years, there has been a 256% increase in large breaches reported to the Office for Civil Rights (OCR) involving hacking and a 264% increase in ransomware. The recent example of Change Healthcare's cyber outage has cost United Health Group[28], its parent company, nearly US$ 872.0 million.

These incidents can lead to financial losses impacting the already stretched margins, breach in patient confidentiality, and disruption in critical healthcare operations, thus, inviting regulatory scrutiny and impeding the growth of the healthcare ecosystem.

However, the US healthcare industry is already taking steps to mitigate the effects of these challenges by seeking outsourcing support from external vendors. Let us look at some of the major drivers of outsourcing in the US healthcare market below.

Trends driving growth in the US healthcare outsourcing market

Healthcare payers and providers are seeking third-party support to gain capabilities that enable them to deal with the challenges such as evolving regulatory landscape, increasing patient expectations, and burdening clinician pressure, among others. The following trends list down the drivers behind the outsourcing spends of the healthcare payer and provider enterprises:

Continued staffing shortages propelling an increased demand for third-party support

As detailed out in the previous section, the US healthcare industry is likely to face an acute shortage of clinical talent. Healthcare providers, when faced with worsening staffing challenges and an ageing population, face far-reaching consequences that not only strain existing clinical talent but also increases the risk of errors. Moreover, the shortage of resources leads to delays

[26] Centers for Medicare & Medicaid Services
[27] US Department of Health and Human Services
[28] UnitedHealth Group

in reviewing medical records, assessing medical necessity, and undertaking authorization procedures, leading to suboptimal patient experiences, lower Star ratings and potential revenue loss for payers.

As a result, the demand for service providers who can offer skilled talent (e.g., nurses) with domain expertise for services such as clinical management, through a cost-effective delivery model is expected to increase. This will ultimately enable in-house enterprise clinical staff to focus on core care processes, which will positively impact patient care and improve their care journeys.

Regulatory changes accelerating emphasis on better member engagement

Evolving regulatory changes in the healthcare market are compelling enterprises to enhance their capabilities to remain compliant. For instance, with the end of Public Health Emergency (PHE), states have resumed conducting annual Medicaid eligibility reviews, necessitating assistance with processes such as outreach and member engagement and eligibility verification.

Further, despite CMS[29] raising payments for Medicare Advantage Programs by 3.7% in CY 2025, the decrease in effective growth rate along with rising medical inflation could adversely impact the financial health of Medicare Advantage-focused payers. Successfully navigating this complex and evolving regulatory landscape not only requires more resources to focus on administrative processes but also necessitates investments in staff training and technology upgrades, leading to higher operating expenses for healthcare organizations.

As a result, healthcare enterprises are expected to increasingly turn to outsourcing service providers who can handle the entire gamut of administrative processes including eligibility verification, member engagement, clinical documentation, prior authorizations, and claims management while staying abreast of regulatory compliances and mitigating the risk of penalties.

Transition to ICD-11 to elevate the requirement for experienced and certified coders for optimal reimbursements

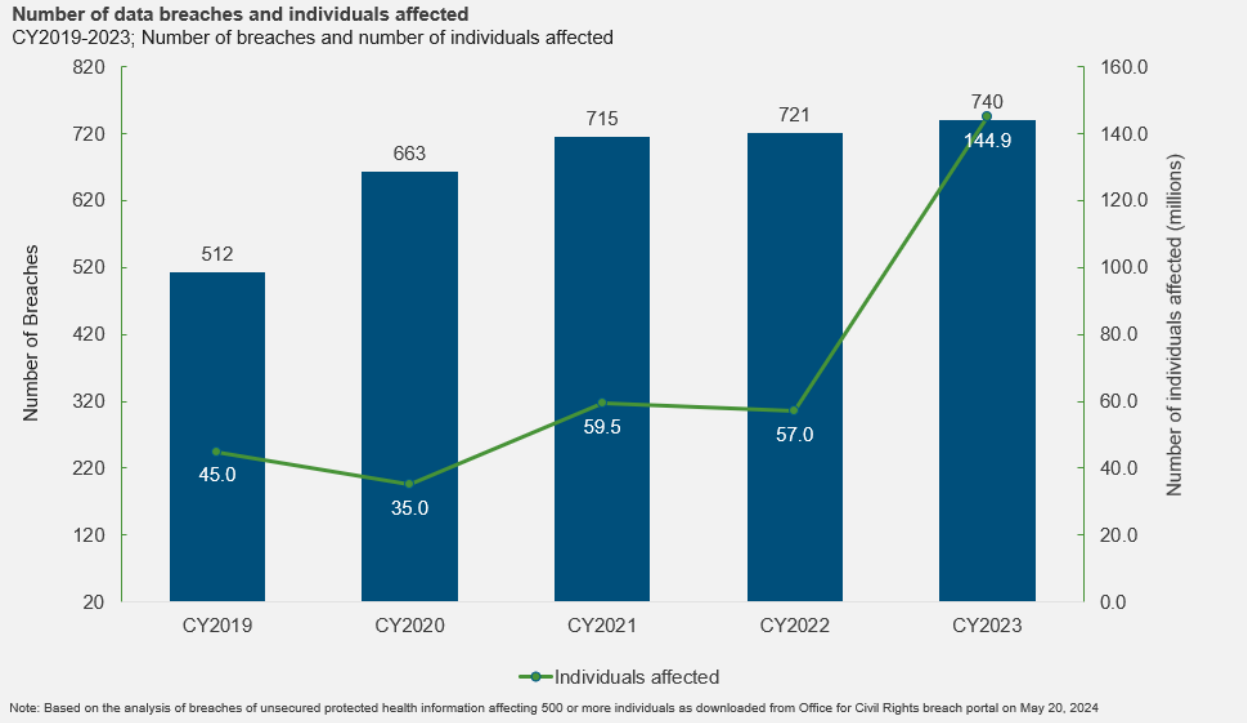
The new coding standard, i.e., ICD–11 coding system has over 55,000 codes to classify diseases, disorders, injuries, and causes of death, compared to the 14,400 in ICD-10, amounting to nearly 4x as many codes as ICD-10, according to Centers for Disease Control and Prevention (CDC)[30]. As countries prepare for this transition, it would bring a plethora of challenges for the healthcare entities in the form of increased administrative work, uptick in the demand of coding talent, higher expenditure on coder training, and need to update technology systems to accommodate the expanded code sets.

The healthcare enterprises that are inadequately prepared for this transition may experience an uptick in rejected claims, decrease in operational efficiency, and consequently, a drop in revenue. This serves as an opportunity for service providers to assist healthcare enterprises by coupling certified coding talent with modular and robust technology to ensure comprehensive delivery of services across coding, billing, claims, and multiple other processes.

Increasing data breaches underscoring the surge in demand for robust data security to ensure compliance and safeguard patient information

[29] Centers for Medicare & Medicaid Services
[30] Centers for Disease Control and Prevention

According to US Department of Health and Human Services[31], there have been over 4,900 healthcare data breaches of 500 or more records that were reported to Office for Civil Rights (OCR) from 2015 to 2024. These breaches have resulted in the exposure or impermissible disclosure of over 520 million healthcare records.



Amidst escalating cybersecurity incidents, the healthcare payers and providers are expected to seek outsourcing partners with robust systems and capabilities to bolster their defenses against evolving cyber threats. As a result, the demand for service providers with future-proof systems that can ensure data security, patient privacy, and compliance with industry regulations such as HITECH and HIPPA is anticipated to increase.

Shift toward proactive healthcare to drive enterprises to develop capabilities in preventive clinical management such as disease management, population health analytics, and remote patient monitoring

The shift toward value-based care, especially for chronic and other diseases that require long term care management, is driving the push for proactive health management that necessitates coordination across different care delivery settings including home-based care. While this shift is driven by the objective of reducing healthcare costs and improving patient outcomes, it also leads to complexities that require capabilities for preventive clinical insights, accurate risk identification, and seamless services without care gaps.

As a result, the demand for service providers who can support healthcare enterprises in areas such as SDoH (data intake and analytics), utilization review, remote patient monitoring, population health management, risk identification and stratification, and other clinical services is expected to increase.

[31] US Department of Health and Human Services

Medical Loss Ratio (MLR) requirements prompting payers to optimize administrative spending

According to CMS[32], the MLR regulations established by Affordable Care Act in the United States require several healthcare payers to spend at least 80% of premium dollars on clinical care and quality improvements, with the remaining portion designated for administrative costs and profits. Furthermore, the payers are required to provide rebate to their customers if they are unable to meet the MLR standards. Given the increasing burden of chronic diseases and higher utilization for several organizations, payers find it difficult to manage administrative expenses, thus, prompting a need for optimization.

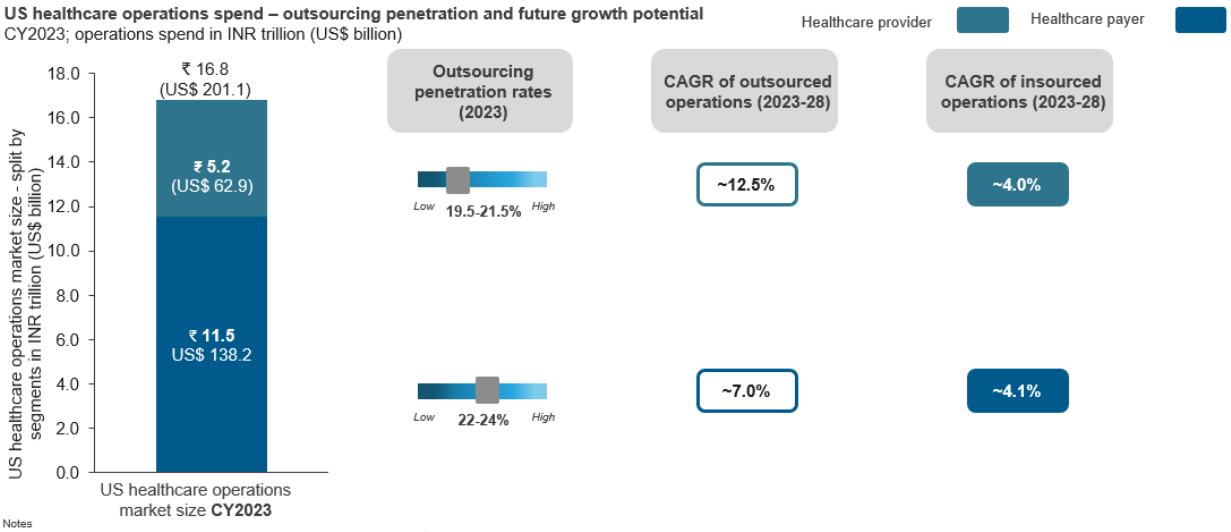
This is expected to compel payers to resort to outsourcing non-core functions such as member engagement, claims processing etc. to streamline operations and reduce administrative overheads, while enabling them to maintain MLR standards and ensure compliance.

Healthcare operations outsourcing market

Healthcare operations outsourcing penetration by market segments

In CY 2023, the aggregate outsourcing penetration rate in the US healthcare operations market stood at 21.5-23.5 %, resulting in a total outsourced operations spend of ~US$ 45.0 billion (~₹ 3.8 trillion). The healthcare payer market had a relatively higher outsourcing penetration at 22.0-24.0%, while the healthcare provider market had a relatively lower outsourcing penetration at 19.5-21.5%.

Further, the growth in the outsourced operations market is expected to outpace the growth in the insourced market. While the overall healthcare outsourced operations market is expected to grow at a CAGR of ~8.7%, the payer outsourced market is forecasted to grow at a CAGR of ~7.0% from CY 2023-28. The provider operations outsourced market, on the other hand, is expected to grow at a CAGR of ~12.5%.



[32] Centers for Medicare & Medicaid Services

US healthcare outsourcing supplier landscape

Categorization of service provider landscape and details of services provided:

There are 4 broad categories of service providers within the healthcare industry –

- **Healthcare specialists:** These firms focus exclusively on the healthcare market. Healthcare specialists leverage their deep domain and process expertise to offer robust offerings across multiple value chain segments to clients. CorroHealth, Sagility, Shearwater Health, and Omega Healthcare are some examples of healthcare specialists having capabilities in both healthcare payer and provider markets. While some firms such as Omega Healthcare has a stronger presence in the provider (RCM) space, players such as Sagility uniquely stand out as a tech-enabled healthcare services firm with integrated offerings in payer and provider markets

- **Broad-based IT and business services firms:** These companies typically offer a blend of IT services (e.g., software development and implementation, IT maintenance support) and business services across various industries, including healthcare. In the healthcare sector, they may provide services to payers, providers, or both, such as claims operations, revenue cycle management (RCM) operations, provider network operations (provider engagement) services, and other vertical-specific processes. Accenture, Cognizant, and EXL are some examples of broad-based IT and business services firms. While this category of firms also provides industry-agnostic services such as human resources, finance, and accounting services, etc., some of them do not have an integrated offering for healthcare

- **Product-focused companies:** Companies that specialize in providing products or solutions for the healthcare industry, such as electronic health records (EHR) systems, health information systems, analytics solutions, etc. Their business model often incorporates a license-based engagement as well as partnerships with service providers for bundled offerings. Optum, Cotiviti, FinThrive, and Epic Systems are some examples of product-focused companies

- **Broad-based CX firms with presence in the healthcare market among other verticals:** In healthcare, these companies prioritize enhancing the experience and satisfaction of members/patients by offering front-end services such as member support, inquiries, issues, etc. through traditional contact centers as well as digital channels. These firms typically have limited capabilities on the back-office operations such as utilization management, claims management amongst others which limits their ability to provide integrated end-to-end healthcare offerings. ResultsCX is an example of a broad-based CX firm with a presence in the healthcare market

The typical value propositions and focus areas of the 4 broad categories of service providers are given below:

Typical operating models and value propositions

	Healthcare specialists	Broad-based IT and business services firms	Product-focused companies	Broad-based CX providers with healthcare presence
Key focus areas	Specialized healthcare offerings and domain expertise for payers, providers, or both	Broad-based operations; technology/IT offerings and improvement of domain expertise	Product-centric offerings for integrated insights, analytics, and information retrieval	Focus on process expertise and outcomes to streamline CX operations
Value proposition	• Healthcare domain specialization • Strong market access • Scalable operations • Pivot toward technology-enabled solutions	• Broad-based portfolio • Cost optimization through offshoring • Services augmented by technology offerings • Consulting-led transformation	• Integration capabilities with existing solutions; strong partnership play • Cloud/on-premise offerings • Unified data source for predictive insights	• Focus on omnichannel CX • Multi-linguistic support; rapid scalability • Global delivery footprint

Digital adoption in healthcare

While the service provider landscape is extensive, differentiation requires strategic investments in digital solutions. However, the adoption of these technologies in healthcare depends on various factors driving the pace of digital adoption.

Factors that will determine the pace of digital adoption in healthcare:

There are multiple factors that will determine the pace of digital adoption in healthcare services. Some of the notable factors are described below:

1. **Timeframe associated to achieve interoperability across multiple platforms and systems:** Interoperability in healthcare enables different systems to access, integrate, and use data seamlessly, improving care coordination and reducing redundant processes. Multiple regulatory provisions such as CMS Interoperability and Prior Authorization rule and Health Information Technology for Economic and Clinical Health (HITECH) Act promote interoperability by focusing on adoption of electronic data exchange through APIs and incentivizing adoption of EHRs respectively.

   However, achieving full interoperability still presents multiple technical and non-technical challenges, such as standardizing diverse systems, replacement cost concerns, and privacy issues. Overcoming these requires collaboration among stakeholders to establish shared standards, data exchange protocols, and supportive policies, thus, necessitating the need to develop modular and flexible solutions capable of integrating with diverse set of existing systems.

2. **Wider acceptance of proactive and digital patient care initiatives:** The healthcare landscape is rapidly embracing proactive patient care initiatives, fueled by the recognized advantages of prevention and early intervention, alongside increased regulatory backing for preventive care and remote monitoring policies. However, the adoption of digital care initiatives is contingent upon organizational readiness to support modern infrastructure and compliance with regulatory standards. As a result, healthcare enterprises will require real-time analytics and automation capabilities that can ensure seamless care delivery

and improved outcomes by identifying potential health risks, predicting disease progression, and ensuring right intervention.

3. **Pace of modernization of legacy EHR/EMR systems:** Many healthcare providers are grappling with outdated technology infrastructure, which consists of fragmented modules and databases that are ill-equipped to handle the vast data volumes generated from modern digital solutions. Furthermore, transitioning from legacy systems to new-age systems demands substantial investments in financial resources and technical expertise. As this transition progresses, the adoption of digital solutions is expected to accelerate, resulting in improved data accessibility, enhanced member experience, and robust predictive capabilities such as fraud detection, thus enhancing operations across multiple processes.

4. **Training and enablement of digital healthcare workforce:** The adoption of digital solutions in healthcare necessitates comprehensive training and the acceptance of a digitally proficient healthcare workforce among patients and members. This entails providing targeted education programs to equip staff with the necessary skills to effectively utilize new technologies. As enterprises increase investment in developing and providing such training programs, the impact on optimizing operations, enhancing decision-making processes, and improving service delivery shall be realized.

Generative AI and its value promise for healthcare

Generative AI refers to the application of artificial intelligence techniques that can generate new content in the form of text, images, videos, audio, and more. This technology is built on underlying models that are trained on large, extensive datasets. Some of the prominent GenAI models in the market include OpenAI's GPT, Google's Gemini, and Meta's LLaMA.

GenAI has the potential to improve organizational productivity by streamlining a variety of tasks, thereby increasing efficiency, optimizing processes, and enhancing the overall patient/member experience. While it has numerous applications in healthcare, most can be grouped into the following categories:

Support	Generate	Stimulate
Compilation and summarisation • Integrate information from various sources for a coherent view and gather robust insights such as population health • Analyse medical charts to create concise summaries for quicker evaluation	**Content generation** • Create customized reports, e.g., pattern identification for claims fraud detection • Generate personalized member communication material	**Advanced search** • Efficient and quick extraction of pertinent information from extensive clinical, claims, and medical databases
Translation • Assist in translating various types of content for patient and member education in local languages	**Medical coding** • Streamline medical coding tasks by analysing clinical notes and generating appropriate medical codes	**Analytics** • Analyse vast clinical datasets to discern trends, patterns • Support healthcare organizations with decision making

While GenAI shows promise in simplifying tasks with low-to-moderate complexity, the solutions still require human-in-the-loop engagements in the healthcare industry due to the degree of risk involved and regulatory concerns. Human intervention ensures that AI-generated outputs are reliable and error-free, particularly in critical decision-making processes. Moreover, the dynamic nature of healthcare demands adaptability and contextual understanding, areas wherein human expertise complements AI capabilities.

Emerging use cases of generative AI in the healthcare industry

Numerous use cases for GenAI are emerging across healthcare payers and providers in areas such that are aimed at enhancing patient care and improving operational efficiency. While majority of the use cases are still in pilot/testing stage, examples of the notable ones are as follows:

Market segment	Use case (non-exhaustive)	Business problem	Outcomes of GenAI-enabled solutions
Payer	Member support	High call volumes and complex inquiries may lead to delay in resolutions, impacting, member experience and ratings	• Generate personalized responses based on user interactions • Assist customer services agents with after call work and sentiment analysis • Reduces average handling time by call route optimization and real-time assistance
	Enhanced claims management	High claim volumes straining operational capacity may result in incorrect adjudications and higher denial rates	• Intelligent document processing for mailroom operations • Claims denials prediction, appeals and grievances response
Provider	Improved clinical documentation and coding	Time-consuming documentation detracts providers from patient care	• Detects discrepancies and simplifies clinical documentation • Increases coder accuracy by assigning appropriate codes and streamline coding audits
	Enhanced patient engagement	Complex registration, delays in appointment, and lack of information about the services, costs, etc. impact patient experience	• Assists agents in handling patient inquiries such as scheduling requests, provider matching, and billing inquiries

While these use cases do provide an opportunity to enhance existing processes, their impact will be subject to the factors driving digital adoption in healthcare such as interoperability and modernization of legacy systems, among others. Furthermore, careful considerations will have to be given to several challenges and risks associated with Gen AI to ensure its safe and effective implementation.

Risks and challenges in the adoption of Generative AI

The integration of GenAI into healthcare comes with several challenges and risks. The healthcare industry lacks a centralized data pool as healthcare enterprises often use multiple IT systems that are fragmented and disparate. AI algorithms on the other hand, require a robust data set for training and validation. As a result, the lack of a comprehensive data repository, limited interoperability, biases in training data, and unclear data origin can raise questions about the accuracy of the outputs. In addition, AI hallucinations, which are erroneous outcomes resulting from inadequate training data or biases, may have further consequences. Lastly, regulatory, and ethical concerns surrounding patient privacy, data ownership, and accountability needs to be alleviated as several government agencies plan to regulate AI usage within defined frameworks (e.g., the U.S. government's Blueprint for an AI Bill of Rights, and the UK government's Artificial Intelligence (Regulation) Bill).

The risk mitigation strategies for GenAI adoption includes rigorous testing, human-AI collaboration, and expert oversight. While some healthcare organizations may choose to build out their own GenAI capabilities, the majority will likely need to engage in collaborative partnerships with service providers who have robust domain and process expertise across payer and provider operations. As a result, the capabilities of these providers complemented with GenAI solutions can be instrumental in achieving the right outcomes for the healthcare ecosystem.

Generative AI-focused value proposition of prominent players across the service provider landscape

The following table highlights broad GenAI-value proposition and the focus areas for each of the player categories in the healthcare service provider landscape:

	Healthcare specialists	Broad-based IT and business services firms	Product-focused companies	Broad-based CX providers with healthcare presence
Key focus areas	Complement deep domain capabilities with digital solutions infused with AI/GenAI-enabled offerings	Development of proprietary Gen AI portfolio of solutions and establishing partnerships to offer end-to-end services	Incorporating Gen AI into their suite of applications for one or multiple use cases	Improve customer experience journeys through GenAI enabled operational optimization
Value proposition	• AI services and solutions suite tailormade for healthcare domain • Domain data trained models • Healthcare transformation with demonstrable proof points across front, and back-office	• Industry-agnostic AI solutions infused in verticalized offerings • Skill development & training and change management	• Integration of GenAI in product applications and workflows • Healthcare specific use cases • Robust security and compliance measures	• GenAI-enabled omnichannel CX • Quicker resolution of queries through GenAI-led multi-linguistic support

Overview on Sagility

Sagility is one of the largest tech-enabled healthcare services firms (by revenue) with a cumulative operations revenue of ~₹ 47.5 billion in FY2024 and growing at a YoY growth rate of ~12.7 % with services spanning across healthcare payer and provider markets.

For healthcare payers, Sagility provides a comprehensive set of services across the payer value chain such as claims management, payment integrity, clinical management, provider network operations (provider engagement), and front-office services, among others, thus, helping optimize operational spending and improve care quality for health plans. As an end-to-end RCM provider, Sagility integrates patient access, A/R management, and clinical services with licensed professionals to streamline administrative processes and ensure efficient billing and revenue cycle management. As of January 2024, Sagility has clients across payers and providers that includes five of the top 10 largest healthcare payers by enrollment in the US, one of the largest US-based hospital networks by revenue, and three of the top 6 PBMs by claims volume, among other enterprise segments such as Blues, DMEs and labs.

Sagility's portfolio is characterized by a suite of cloud-based Business Process-as-a-Service (BPaaS) solutions that bundle operations and technology along with several healthcare process-specific solutions. Its offerings include solutions such as Aging in Place solution to personalize

interactions through self-service portals, and data-hub-based provider solution for outreach and credentialing, among others. Sagility's tech-enabled healthcare services focus across end-to-end front and back-office healthcare services sets it apart among business services firms, technology transformation firms, and back-office service providers.

BirchAI's acquisition to augment its AI-driven capabilities

In March 2024, Sagility acquired BirchAI, a company specializing in cloud based GenAI technology, powered by natural language processing (NLP). BirchAI offers AI-driven real-time customer support solutions for healthcare transactions. Its advanced speech-to-text model, tuned for domain-specific conversations, automates key tasks such as call classification, and summarization, and identifies customer trends in real-time to improve agent performance. Its acquisition is expected to enhance Sagility's AI Center of Excellence for client transformation through dedicated AI operations, governance, and solutions support, thus, improving capabilities in other operations such as fraud, waste & abuse identification, clinical reviews & decision support, among other things. This is expected to help Sagility swiftly identify opportunities across the gamut of healthcare payer and provider clients, allowing it to engage with them more meaningfully and create value.

Devlin Consulting's acquisition to enhance payment integrity (PI) capabilities

In April 2023, Sagility acquired Devlin Consulting, Inc. (DCI), a technology services company providing payment integrity services, thus, strengthening its precision payment integrity solutions for health plans. This integration of DCI's technology with Sagility's existing services allows the firm to offer cohesive PI solutions including pre-pay cost avoidance and post-pay recoveries and improve client access across national and regional plans, thus unlocking additional opportunities.

Sagility's competitive positioning

The comparative assessment of Sagility has been conducted through two approaches:

Everest Group's PEAK Matrix® Assessment

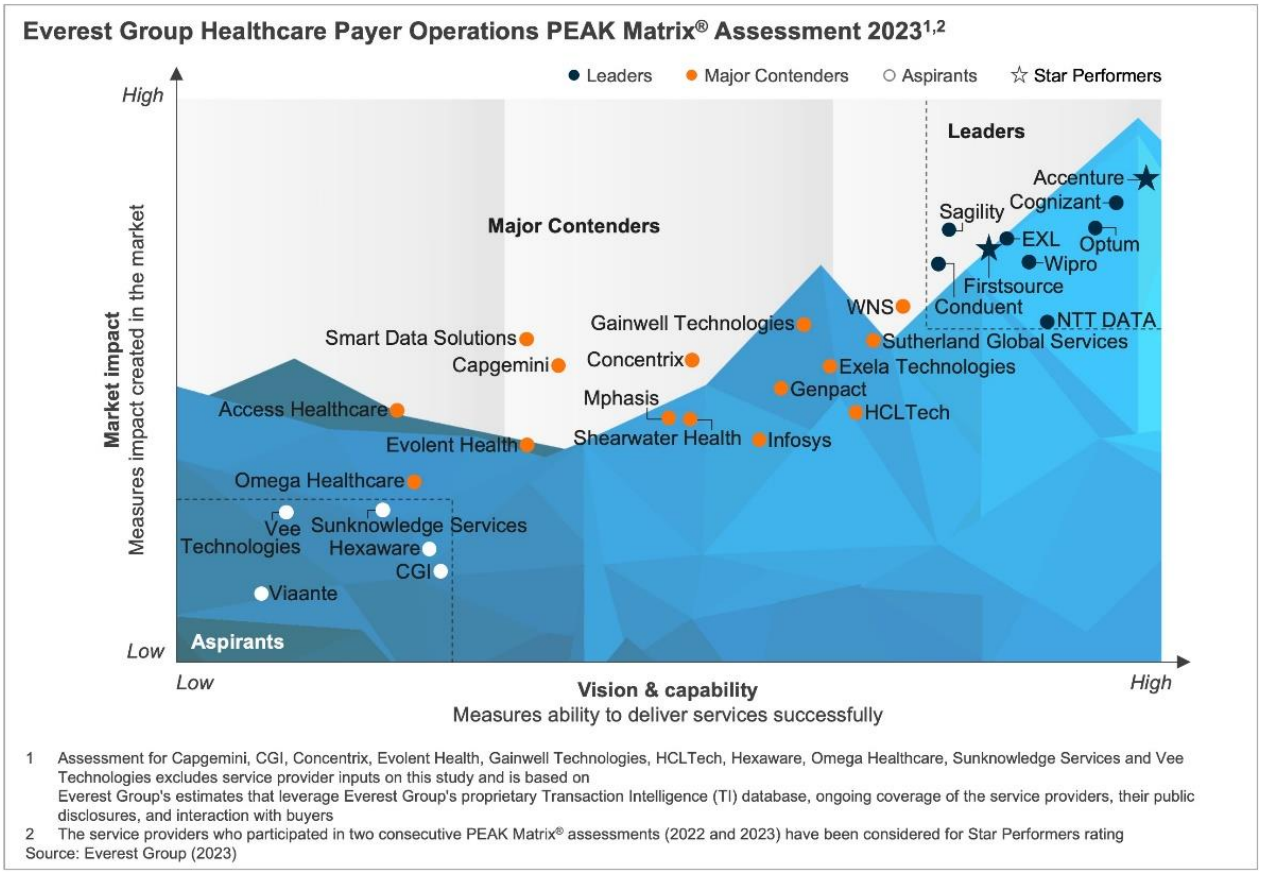
The PEAK Matrix is a proprietary framework for assessing the relative market success and overall capability of technology and technology-enabled service providers based on performance, experiences, ability, and knowledge. Each provider is comparatively assessed on two dimensions: market success and delivery capabilities. Market success is measured by revenue, number of clients, and year-over-year growth. Delivery capability is measured by scale of operations, scope, technology and innovation, delivery footprint, and buyer satisfaction. The PEAK Matrix assessment process also includes provider customer reference interviews – a critical step that some other research firms exclude.

Everest Group's Healthcare Payer Operations PEAK Matrix® Assessment 2023 and Sagility's positioning

Everest Group's Healthcare Payer Operations PEAK Matrix® Assessment 2023 was an assessment featuring 29 leading healthcare payer service providers and presented a relative evaluation of their strengths and limitations. The PEAK Matrix® assessment is based on

information collected from primary research, including interactions with participating firms and client reference checks, and targeted secondary research.

The exhibit below depicts the latest edition of Everest Group's Healthcare Payer Operations PEAK Matrix® Assessment conducted in 2023. For more details on the Payer Operations PEAK Matrix Assessment, please click here.



1 Assessment for Capgemini, CGI, Concentrix, Evolent Health, Gainwell Technologies, HCLTech, Hexaware, Omega Healthcare, Sunknowledge Services and Vee Technologies excludes service provider inputs on this study and is based on Everest Group's estimates that leverage Everest Group's proprietary Transaction Intelligence (TI) database, ongoing coverage of the service providers, their public disclosures, and interaction with buyers

2 The service providers who participated in two consecutive PEAK Matrix® assessments (2022 and 2023) have been considered for Star Performers rating

Source: Everest Group (2023)

Scope of the assessment:

The scope of the assessment covered the entire healthcare payer operations value chain, including product development, member engagement, provider network operations (provider engagement), clinical management, claims management, and risk and compliance. The ecosystem of players included in this assessment comprised of healthcare specialists such as Shearwater Health, Omega Healthcare among others from product-focused firms and broad-based IT and business services firms.

Sagility's positioning:

Everest Group's Healthcare Payer Operations PEAK Matrix® Assessment 2023 identified Sagility as a "Leader". The 2023 assessment identified the following strengths of Sagility:

- Investments in custom-built offerings strengthened Sagility's technology portfolio, further focus on BPaaS-led deals has fueled its growth

- Launch of a new delivery center in offshore region increased its offshore presence which was complimented by its balanced presence of resources in onshore and nearshore locations
- While it exhibited a strong claims portfolio, Sagiltiy also invested in ramping up its payment integrity and Fraud, Waste and Abuse (FWA) capabilities through advancements in predictive analytics. It further invested in growing areas such as remote patient monitoring, telehealth, and population data analytics
- Referenced buyers highlighted Sagility's relationship management, implementation management, and flexibility to scale as strengths

Everest Group's Revenue Cycle Management Operations PEAK Matrix® Assessment 2023 and Sagility's positioning

Everest Group's Revenue Cycle Management (RCM) Operations PEAK Matrix® Assessment 2023 was an assessment featuring 31 leading revenue cycle operations providers and presented a relative evaluation of their strengths and limitations. This assessment deep dived into the RCM operations market, which is the other segment of the healthcare market (healthcare provider). For more details on the latest edition of the Revenue Cycle Management Operations PEAK Matrix® Assessment, please click here.

Scope of the assessment:

The scope of the assessment covered the RCM operations value chain segments including patient access, medical billing, claims management, and A/R management. The ecosystem of players included in this assessment comprised of product-focused firms, broad-based IT and business services firms, and healthcare/RCM specialists.

Sagility's positioning:

This assessment identified Sagility as a "Major Contender". The 2023 assessment identified the following strengths of Sagility:

- Sagility developed a strong foothold in the growing DMEs and labs segment and expanded focus on domain expertise and coverage across different processes of the RCM value chain in 2022
- Clients highlighted proactive account management and swift leadership style as strengths for the firm

Everest Group's Clinical and Care Management (CCM) Operations PEAK Matrix® Assessment 2023 and Sagility's positioning

Everest Group's Clinical and Care Management Operations – Services PEAK Matrix® Assessment 2023 was an assessment featuring 15 leading clinical and care management operations providers and presented a relative evaluation of their strengths and limitations. This assessment deep dived into the clinical and care management value chain segment in contrast to the above two assessments which are more broad-based in nature. For more details on the latest edition of the CCM Operations PEAK Matrix® Assessment, please click here

Scope of the assessment:

The scope of the assessment covered the CCM operations value chain including population data management and analytics, utilization management, care coordination, and quality improvement

services. The ecosystem included in this assessment comprised of broad-based IT and business services firms, product-focused companies, and healthcare/clinical specialists.

Sagility's positioning:

This assessment identified Sagility as a "Major Contender" and identified several key strengths as highlighted below:

- Sagility developed comprehensive and scalable solutions targeted for whole-person care by utilizing data from multiple data sources to deliver improved member experience and clinical outcomes. Additionally, it leverages BPaaS for utilization management which further strengthened its capabilities
- Sagility's balanced spread of clinical FTEs across onshore, offshore, and nearshore locations, growth strategy for the CCM market through the productization of clinical programs, and focus on virtual health enables it to meet the increasing demand from enterprises
- Sagility has a broad presence within the payer market as it caters to a wide variety of buyer types, ranging from employer plans to Medicare and Medicaid, highlighting its ability to cater to different payer enterprises with varied requirements
- Clients highlighted its skilled talent pool, especially on domain knowledge, responsive account management, willingness to partner, and flexibility to accommodate requirements

Evaluation of breadth and depth of Sagility's portfolio

While there are many service providers offering services across payer and provider landscape, there are fewer specialists that are only focused on healthcare. As of May 2024, in a comparative evaluation conducted by Everest Group, 9 other companies are identified alongside Sagility, that provide healthcare solutions to enterprises. This comparative peer set serves to facilitate a comprehensive assessment of Sagility's capabilities across the supplier landscape.

Service provider classification - depth and breadth		Healthcare specialists				Broad-based IT and BPOs			Product-focused companies		Broad-based CX firms with healthcare presence
Service provider/ functions		Sagility	Shearwater Health	Omega Healthcare	CorroHealth	Cognizant	EXL	Accenture	Cotiviti	FinThrive	ResultsCX
Healthcare payer	Value chain functions - Claims management - Payment Integrity - Clinical management - Provider network operations (provider engagement) - Member engagement - Risk adjustment and support services - Product development	High coverage	Medium coverage	Medium coverage	Limited to no coverage	High coverage	High coverage	High coverage	Medium coverage	Limited to no coverage	Medium coverage
	Position on Everest Group's Healthcare Payer Operations PEAK Matrix® Assessment 2023	Leader	Major Contender	Major Contender	Not profiled	Leader	Leader	Leader	Not profiled	Not profiled	Not profiled
Healthcare provider	Value chain functions - Patient access - Medical billing - Claims management - A/R management - Care management	High coverage	Medium coverage	High coverage	Medium coverage	High coverage	Limited to no coverage	Limited to no coverage	Limited to no coverage	High coverage	Limited to no coverage
	Position on Everest Group's Revenue Cycle Management Operations PEAK Matrix® Assessment 2023	Major Contender	Major Contender	Leader	Major Contender	Leader	Not profiled	Not profiled	Not profiled	Not profiled	Not profiled
Percentage exposure to healthcare and life sciences as a proportion of total revenue (2023)		100.0%	Not available	Not available	Not available	29.3%	Not available	12.0%	Not available	Not available	Not available

Source: Companies websites, case studies, and other public source

Notes:

a. *Coverage is estimated based on the weighted average of presence across total number of functions and sub-functions based on the in-scope value chain*
b. *The percentage exposure to healthcare and life sciences as a proportion of total revenue comprises the entire set of healthcare and life sciences revenue, including business process services, software products, and IT services*
c. *The values for percentage exposure to healthcare and life sciences as a proportion of total revenue have been derived from the service providers' annual financial report. Cognizant reports healthcare and life sciences under the Health Sciences segment. Accenture reports healthcare under the Health and Public Services segment and life sciences under the Products segment. The reporting period for Accenture is from July 2022 to August 2023, and for Cognizant, it is from January 2023 to December 2023*
d. *Shearwater Health, Omega Healthcare, CorroHealth, Cotiviti, FinThrive, and ResultsCX are unlisted companies, therefore their percentage exposure to healthcare and life sciences is not publicly available. While EXL does have a healthcare reporting segment, some portion of its analytics segment also include healthcare services, which has exposure to other industry verticals. Given that, its overall exposure to health and life sciences vertical is not available in the public report, it has not been mentioned.*

Summary findings of the comparative analysis

Based on the analysis above, Sagility is one of the leading tech-enabled healthcare specialists with comprehensive coverage across healthcare payer and provider markets. Everest Group's Healthcare Payer Operations PEAK Matrix® Assessment 2023 has identified Sagility as a "Leader" underscoring superior performance on market impact and vision and capability. Additionally, Sagility is one of the largest tech-enabled healthcare services firm (by revenue) and has achieved a YoY growth rate of ~12.7% in FY2023-24, outpacing healthcare revenue growth of several publicly listed firms such as Accenture and Cognizant[33]**.** Given Sagility's healthcare-only focus across the payer and provider markets, there are no listed service providers in India or abroad that cater to US healthcare enterprises (as defined in the report) and are its immediate comparables in size and business model (which is categorized as a pureplay healthcare specialist). However, there is a recently listed company in India called Indegene, which, like Sagility is a specialist, but focuses on the life sciences market (i.e., pharmaceuticals and medical devices).

Threats and challenges to Sagility

Although Sagility stands out as one of the leading tech-enabled healthcare services firms, there are several threats and challenges to its business on account of evolving market, possibility of new market entrants, and shifting enterprise considerations, among others. Some of the major threats and challenges (not exhaustive) are mentioned below:

1. **Decline in the growth of the US healthcare industry**: Given Sagility's exclusive focus on the US healthcare market, issues impacting the growth of the US healthcare industry such as potential reduction in government spending during recession and decrease in the demand of non-urgent services may impact Sagility's business

2. **Potential hesitancy for enterprises to outsource**: Although the industry is increasingly shifting towards an outsourcing model, data privacy concerns, compliance challenges, shift in enterprise strategy to shift to an in-house model, or future regulations preventing outsourcing, may increase reluctance among healthcare enterprises toward outsourcing. As a result, this may become a threat to Sagility's growth prospects

3. **Talent retention and up-skilling challenges:** As the US healthcare industry continues to face talent shortage, higher attrition rates, inability to up-skill, and inefficient resource utilization may impact Sagility's business. Consequentially, the competition to attract talent within the industry, along with the expenses of hiring and training, may jeopardize Sagility's future profitability and obstruct business growth

4. **Wave of technology disruption impacting efficiencies**: The technological advancements in various healthcare processes may significantly enhance efficiencies, thus, disrupting existing productivity. As a result, inability to deliver robust technological solutions that provides enhanced throughput and integrates seamlessly with client systems may impact Sagility's business

[33] Note: Revenue growth for the publicly listed firms is calculated as highlighted in their annual reports and may include revenues from providers, payers, and life sciences segments as well as revenues from software and IT services

5. **Potential competition amidst the impending possibility of new market entrants**: The potential entry of new entrants with disruptive business models and differentiated solutions that can cater to the evolving client needs may increase further competition in the healthcare market, hence, posing a threat to Sagility's business. While there are currently no new entrants with significant play in the healthcare outsourced market, inability to keep up with future investments of disruptive players may impact Sagility's growth.