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THRIVE Futures Architecture™

Launch Excellence 2035 Winning in an Era of Exponential Change.

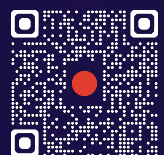
Four futures for the U.S. launch environment, and what they change about turning a medicine into a viable business.

Public U.S. Edition



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Introduction

The pharmaceutical industry is being reshaped at its foundations. Artificial intelligence, genomics, and more precise diagnostics are converging with pressure on affordability, new ways of delivering care, and a changing role for patients. Together, these forces challenge more than how the industry works. They challenge what it can discover, whom it can treat, and how scientific progress becomes clinical and commercial value.

In discovery, AI-assisted screening can search vast libraries of compounds, while generative models can design new molecules for researchers to test.^{3,5,6} AlphaFold and related breakthroughs in predicting protein structures and molecular interactions are expanding the possibilities for understanding and targeting disease.^{1,2} Together, these capabilities could produce a surge in candidates entering development. More candidates will not automatically mean more approved medicines. But they could intensify competition for capital, clinical-trial participants and, ultimately, a differentiated place in treatment.

In parallel, medicine is moving toward greater precision. A familiar diagnosis can conceal different molecular drivers and different responses to treatment. Genomics, biomarkers, and richer patient information are making it possible to match therapies more closely to the biology and circumstances of the people receiving them. The opportunity is not only to develop more medicines, but to intervene more selectively and, where the evidence supports it, earlier. Whether that precision becomes routine or remains concentrated in particular diseases, populations, and care settings is one of the uncertainties ahead.³

The information surrounding treatment is changing, too. In the AMA's 2026 survey, 72 percent of respondents to its practice-use question reported incorporating at least one listed AI use case.⁴ Pew Research Center's June 2026 U.S. survey found that 34 percent of adults reported ever using chatbots for at least one of eight health purposes, and 22 percent for treatment information.²⁵ AI is entering the work of clinicians and the deliberations of patients. How much authority it acquires, and who remains accountable for its influence, are different questions.

Now imagine a launch team that has done its work. The evidence is persuasive. Supply is ready. Clinicians understand the product. Yet a credible competitor arrives sooner than expected. A care program delivers an established treatment so reliably that the new medicine's advantage narrows. A health organization expects payment to depend on results after treatment. Or patients arrive through a service that barely appears in the launch plan. The medicine has not changed. The conditions for its success have.

This exploration follows these forces into four plausible futures for the U.S. pharmaceutical market in 2035. It examines how scientific advances and changing care economics could reshape the biopharma business model, commercial strategy, and the capabilities required for successful launch. Each world combines a lived experience of healthcare with structured analysis of the choices facing the organizations bringing medicines to patients.

These worlds are thinking tools, not predictions. Each describes a dominant pattern; none assumes a uniformly transformed system. Different health plans, specialties, and communities may follow different paths, and international variations are considered in THRIVE's extended analysis. The people and scenes in 2035 are fictional, no probability is assigned to any world, and present-day developments are sourced in the endnotes.

Read with a real medicine, portfolio, or launch plan in mind, but also with a sense of possibility. What new paths to patients could these changes open? Which partnerships could turn scientific promise into better care? What could your organization begin learning, testing, and building today to lead in the markets taking shape? Exploring these futures is an invitation to look beyond today's assumptions, recognize opportunities before they become obvious, and act while there is room to shape them. The ambition reaches beyond preparing for change. It is to help translate the extraordinary possibilities of science into better outcomes for patients and enduring value for the businesses that serve them.

FOCAL QUESTION

What does the U.S. environment for bringing a new medicine to patients look like in 2035, and what does it mean for launch: who finds the patient and how early, who decides, who prescribes, what is paid for, and how fast the market moves. Each world describes a dominant market logic, not a uniformly transformed system; elements may coexist across therapy areas, payer populations, and care settings. International variations are explored in the extended report.

FOR

Leaders who own launches and the functions that support them: commercial, medical, value and access, regulatory, supply, business development, and launch excellence, in global biopharma and in biotechs preparing a first launch. Horizon: 2035, with signals observable between 2026 and 2030.

This edition is written through the lens of launch leaders and the functions that support them. THRIVE's Futures of Biopharma work extends to broader questions of strategy, portfolios, care models, and organizational capability. Request a **THRIVE Futures Briefing** to explore the implications most relevant to your situation. The extended research is shared selectively following the conversation. Contact Eliette Krakora, Founder and CEO of THRIVE Consulting, at launch@thrive-co.com.

The future belongs to those who can hear it coming, prepare for it, and shape what comes next.

EXECUTIVE SUMMARY · 1 OF 3

When the Market Changes as Profoundly as the Medicine

A medicine can succeed scientifically and enter a market whose rules have changed. This exploration asks what happens when advances in discovery and precision medicine meet new decision systems, affordability constraints, competing care models, and more informed patients. Its purpose is not to identify the most likely future. It is to reveal choices that a launch strategy built only around today's market could miss.

The next competitor may arrive sooner.

AI-enabled discovery and a wider pool of credible candidates could compress the interval in which a medicine is meaningfully differentiated. More candidates do not guarantee more approvals; they make the timing and credibility of competition a strategic question.

The alternative may not be a new medicine.

Better delivery of an established treatment, earlier intervention, or a preventive program can change who needs the next therapy. Better care can expand some markets while delaying or reducing demand in others.

The developer may not control the value it creates.

The organization holding the patient relationship can influence which medicine is selected, how care is delivered, and what the business earns. Developers face different choices about remaining suppliers, building partnerships, or taking responsibility for more of the result.

Two Questions Frame the Futures

The decision channel

Does an institutional pathway govern the treatment sequence, or do clinicians and patients retain meaningful discretion among competing recommendations?

The payment currency

Does a material share of payment depend on verified results after treatment, or primarily on units supplied at an agreed net price?

The two questions create four plausible U.S. market environments in 2035. They do not predetermine how far diagnostics, data connectivity, or new care organizations develop. Each world has opportunities and constraints; elements can coexist across therapy areas, plans, and communities.

EXECUTIVE SUMMARY · 2 OF 3

Four Worlds. Four Strategic Choices.

Algorithmic Order

System-governed / Paid for outcomes

Institutional pathways organize care and tie a material share of payment to verified results. Scientific success can bring substantial reach while leaving the developer dependent on the organization that governs treatment.

The Launch Choice. Earn a pathway position and decide how much of the result the company will help deliver.

The Trade-Off. Greater reach and ongoing performance exposure, with only partial control of the care producing the outcome.

The Waiting Room

System-governed / Paid by price and volume

The system identifies more treatable need than existing budgets and capacity can absorb. Companies compete not only to defend a price, but to make useful care affordable at the scale the system can see.

The Launch Choice. Demonstrate where benefit is strongest, then design price, delivery, and reach together.

The Trade-Off. The margin per patient must be considered alongside the number of patients who can actually receive treatment.

Precision Islands

Distributed / Paid for outcomes

Competing networks organize prevention and continuing care around measurable results. Clinicians and patients keep treatment choice; access and participation depend on coverage, resources, and willingness to engage.

The Launch Choice. Build a medicine-plus-care proposition and make evidence, delivery, and performance responsibilities repeatable.

The Trade-Off. Better coordinated care can deepen value, but access is uneven and a first successful partnership may not travel.

Many Doors

Distributed / Paid by price and volume

Care stays predominantly episodic and transactional. Clinicians, patients, payers, and their tools have more information, but continue to make separate judgments that shape treatment.

The Launch Choice. Establish a coherent value proposition across those judgments and connect the handoffs that matter.

The Trade-Off. More sources and routes create opportunity, but visibility, coverage, and advice do not necessarily become treatment.

EXECUTIVE SUMMARY · 3 OF 3

What to Start Now. What to Watch.

Build foundations that are useful across worlds. Test specific options before committing at scale: a pathway arrangement, an affordable-scale proposition, a second network deployment, or an alternative route to care. What becomes contingent is the size, timing, and form of the investment, not whether every capability is useful elsewhere.

- 01 Rehearse, Monitor, and Adapt.** Test assumptions repeatedly and connect signals to an accountable response.
- 02 Build Evidence That Earns Trust.** Answer meaningful clinical and value questions, and remain explicit about uncertainty.
- 03 Build Answer Engine Optimization (AEO) and Decision-System Readiness.** Learn on marketed products, then carry accurate evidence and monitoring into launch.
- 04 Design Access for Affordable Scale.** Test price, delivery requirements, and reachable treatment together.
- 05 Build With Patients, Not Only for Them.** Let experience, burden, and access barriers shape the proposition.
- 06 Choose Ecosystem Roles and Partners.** Clarify what the company will provide and who is responsible for the rest.
- 07 Rehearse Delivery and Accountability.** Test capacity and handoffs, assign decision rights, and reuse the learning.

Watch Combinations, Not Isolated Headlines

World	A Consequential Combination
Algorithmic Order	Pathways gain practical authority and payment is genuinely reconciled against later results.
The Waiting Room	Identification expands, fixed-price terms persist, and affordable propositions win funded use.
Precision Islands	Networks organize prevention and continuing care; performance agreements replicate while treatment choice remains personal.
Many Doors	Care stays episodic and payment unit-linked while several separate advice and access decisions materially affect treatment.

SECTION 1

The Forces Every Future Contains

These forces are already in motion. Every world explores their influence; their pace, reach, and commercial consequences depend on how science, institutions, and markets develop. The middle column distinguishes the evidence already visible from the implications THRIVE explores in the final column.

Driving Force	What We Can Already See	Implication for Launch
AI compresses target identification and candidate design	Rentosertib reported randomized phase 2a results in 2025; its sponsor announced first-patient dosing in a phase 3 trial in China in September 2026. A 2026 ASCO analysis identified 117 AI-enabled assets from 63 companies that had entered trials through July 1, 2025. AlphaFold provides more than 200 million predicted protein structures. ^{6,7,8,1}	Could increase the flow of candidates; validation, evidence, delivery, and payment still determine clinical and commercial progress.
Modality proliferation: cell and gene therapies, RNA medicines, protein degraders, multispecific antibodies	FDA-authorized products already include cellular and gene therapies and bispecific antibodies. These are examples of the broader range of modalities in the pipeline, not evidence that every new approach will reach scale. ^{9,10}	Extends the druggable universe and brings new manufacturing, delivery, pricing, and evidence problems with it
Real-world, wearable, and patient-generated data move toward decision-grade evidence	FDA has final RWE guidance. FDA and EMA issued AI principles in 2026; CMS uses outcomes-based agreements for cell and gene therapies. None makes all real-world data sufficient for approval or payment. ^{36,11,12}	The basis for performance-linked payment exists in principle; whether it can be adjudicated at scale is open
Medicare price negotiation, expanding by cycle and reaching physician-administered drugs	The first negotiated Medicare prices took effect in January 2026. The third cycle includes Part B medicines. Separately, the White House reported 26 manufacturer pricing agreements by August 31, 2026; participating products can reach patients through TrumpRx. ^{13,14}	Changes pricing exposure and route economics; effects depend on the product, eligibility, and agreement.
Continuous monitoring and computational diagnostics find disease before symptoms	FDA-cleared cmAngio software detects and localizes breast arterial calcification on screening mammograms. This is an example of extracting additional information from routine imaging, not proof that every finding changes treatment or improves outcomes. ¹⁵	Can move investigation earlier and change the population considered for treatment, where confirmation and useful intervention follow.

Driving Force	What We Can Already See	Implication for Launch
AI enters the treatment decision, on both sides of the desk	In the AMA survey, 72 percent reported at least one listed AI use case in their practice. Utah announced a regulated pilot for AI prescription renewals. OpenAI reports more than 300 million people globally bring health-related questions to ChatGPT each week. ^{4,16,17}	Changes who is identified, when, by whom, and with what advice in hand
Care moves out of the hospital, into organizations that combine coverage and delivery	CMS estimates 14.3 million Medicare beneficiaries in accountable-care arrangements. Kaiser Permanente and Risant Health report nearly 13.1 million members combined. Included Health announced an agreement to acquire Firefly Health; Amazon reports launching Health AI on its U.S. app and website. ^{18,19,20,21}	Changes where the patient is reached and who sits between the developer and the prescriber
More credible competitors arrive sooner, including candidates originating in China	Reuters, citing PharmCube, reported \$137.7 billion of Greater China licensing-out deal value in 2025. Headline deal values include potential milestones; they do not establish how many assets will succeed or their eventual treatment costs. ²²	Could shorten meaningful differentiation as alternatives mature; launch teams must test the timing and credibility of those alternatives.
Patients arrive informed, and with a preferred treatment	KFF reports 32 percent of U.S. adults used AI chatbots for health information in the past year. EY reports 55 percent have requested, or would consider requesting, a test, treatment, or prescription based on AI information. ZS reports increased named-therapy requests among 68 percent of surveyed providers across the U.S., Germany, and China. ^{5,23,24}	More informed patients gain influence as LLMs reshape how treatment information is found and interpreted. AEO becomes a launch-readiness priority.
Fiscal stress on payers and employers, and an aging population ³⁷	Kaiser Permanente and Risant Health report a combined 1.1 percent operating margin in 2025. Included Health describes substantial cost pressure on the employers it serves. These examples illustrate pressure; they are not an industry-wide estimate. ^{19,20}	Scrutiny of value claims intensifies; the total cost of care becomes the frame in which a medicine is judged

Across these forces, the commercial issue is not only the speed of first approval. Reliable, reimbursed use also depends on evidence, delivery design, and negotiation. Data and delivery capability can become competitive assets held by organizations that developers neither own nor control. The frame in which a medicine is judged can extend from the product to the total cost and result of care, so that a better-delivered existing treatment, a preventive program, or a cheaper alternative becomes a serious competitor.

Recent U.S. surveys show substantial use, but use is not the same as validated benefit. KFF's 2026 poll found that 19 percent of adults used AI to understand or compare physical-health treatment options in the past year; 77 percent were concerned about medical-data privacy, even though 13 percent had uploaded personal medical information.⁵ These self-reported measures do not establish improved clinical decisions or outcomes.

SECTION 2

What Is Open: Ten Uncertainties

Ten uncertainties shape the U.S. environment for launch in 2035. They were consolidated from the wider set surfaced in the research and assessed for their impact on launch and how open they remain. The qualitative ratings are starting points for debate, not numerical probabilities or forecasts.

Uncertainty	The Two Poles	Impact on Launch	How Open in 2026
1. The decision channel	An institutional pathway sets the presumptive treatment sequence and departing from it requires justification, or clinicians and patients keep discretion among competing tools	Very high	Balanced
2. The payment currency	A material share of what is paid depends on performance verified after treatment, or payment follows units at an agreed net price	Very high	Balanced
3. Registry and real-world evidence	Accepted by FDA and payers as primary evidence for approval and payment, or case by case	High	Leaning toward acceptance
4. The reach of price negotiation	Medicare negotiation expands and spills into commercial pricing, or stays narrow, cycle by cycle	High	Balanced
5. Integrated care organizations	Consequential holders of the patient relationship in selected populations by 2035, or a margin around conventional insurance and practice	High	Balanced
6. One-time therapies at scale	Capacity and treatment sites built ahead of demand, or delivery confined to a few centers	High	Decided largely by the payment path and delivery economics

Uncertainty	The Two Poles	Impact on Launch	How Open in 2026
7. The AI-regulation climate	Stays open to clinical and payer AI, or closes under state law, professional resistance, and public concern	High	Balanced: Washington enacted a law requiring licensed review of relevant coverage denials; a federal executive order directs challenges to certain state AI laws. ^{26,27}
8. AI discovery translation	Computationally designed candidates convert to approved medicines at a rate that changes the pipeline, or at the historical rate	Medium to high	Balanced
9. Who holds the data	A connected spine, national or platform-level, that a pathway can run on, or fragmented holders with access negotiated case by case	Very high	Balanced: CMS reports more than 700 organizations pledged to its Health Tech Ecosystem. Commitments do not establish seamless operational exchange. ²⁸
10. Precision beyond oncology	Broad, into primary care, or confined to specialist centers	Medium to high	Balanced

Two uncertainties frame the four worlds: who governs treatment decisions, and what payment depends on. Both have high implications for launch and materially different plausible outcomes. The other eight remain part of the analysis, specifying additional conditions within each world rather than following automatically from the two axes.

SECTION 3

Two Questions, Four Futures

Scenario planning is not about predicting the future. Its purpose is to build the capacity to navigate deep uncertainty by constructing valid alternative models of it: to expand the future rather than narrow it, to reveal the hidden assumptions a linear plan rests on, to increase strategic degrees of freedom, and to build resilience by remembering the future before it arrives.

The worlds diverge on two questions. One concerns authority. The other concerns money. Neither tells us how advanced every technology becomes; how far diagnostics, connected information, and new care models reach is specified inside each world, and it does not follow automatically from who makes the decision or what is paid for.

THE DECISION CHANNEL

System-governed

Institutional pathways establish the presumptive treatment sequence. Clinicians can depart from it, and must justify the exception.

Distributed

Clinicians and patients keep meaningful discretion among competing recommendations. An adviser can rank the options without owning the decision.

THE PAYMENT CURRENCY

Paid for Outcomes

A material share of what is paid depends on results verified after treatment. Payments can be earned, withheld, adjusted, or returned.

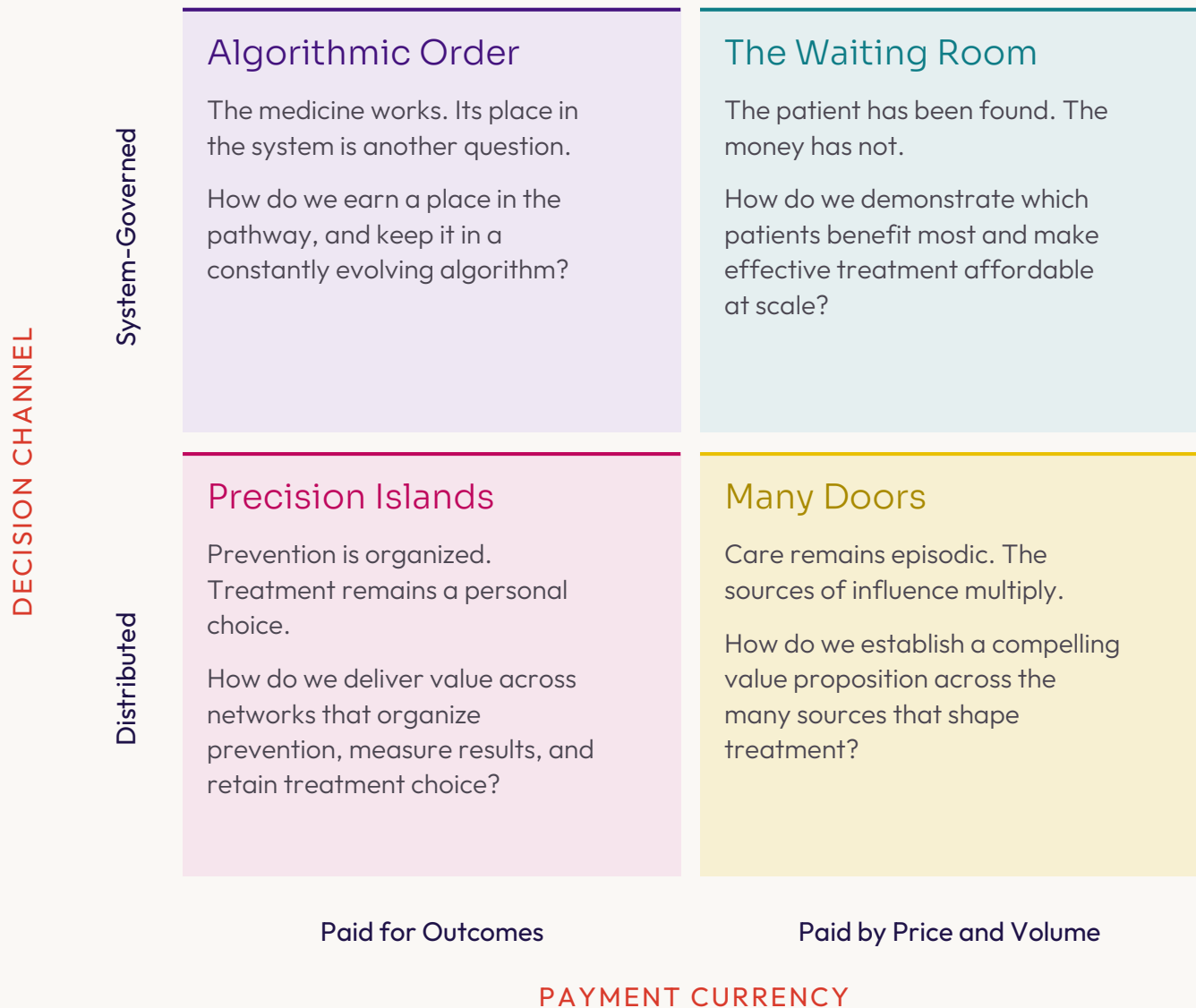
Paid by Price and Volume

Payment depends primarily on units supplied at an agreed net price. Outcomes still matter to demand and to future negotiations; they do not routinely determine payment for the patients already treated.

The distinctions matter. An insurer can benefit from better prevention while still buying medicines at fixed prices. An installment schedule need not depend on treatment success. And a competitive market can contain several organizations that each tightly govern clinical choices: a network that mandates its own algorithmic sequence is a system-governed pocket.

SECTION 4

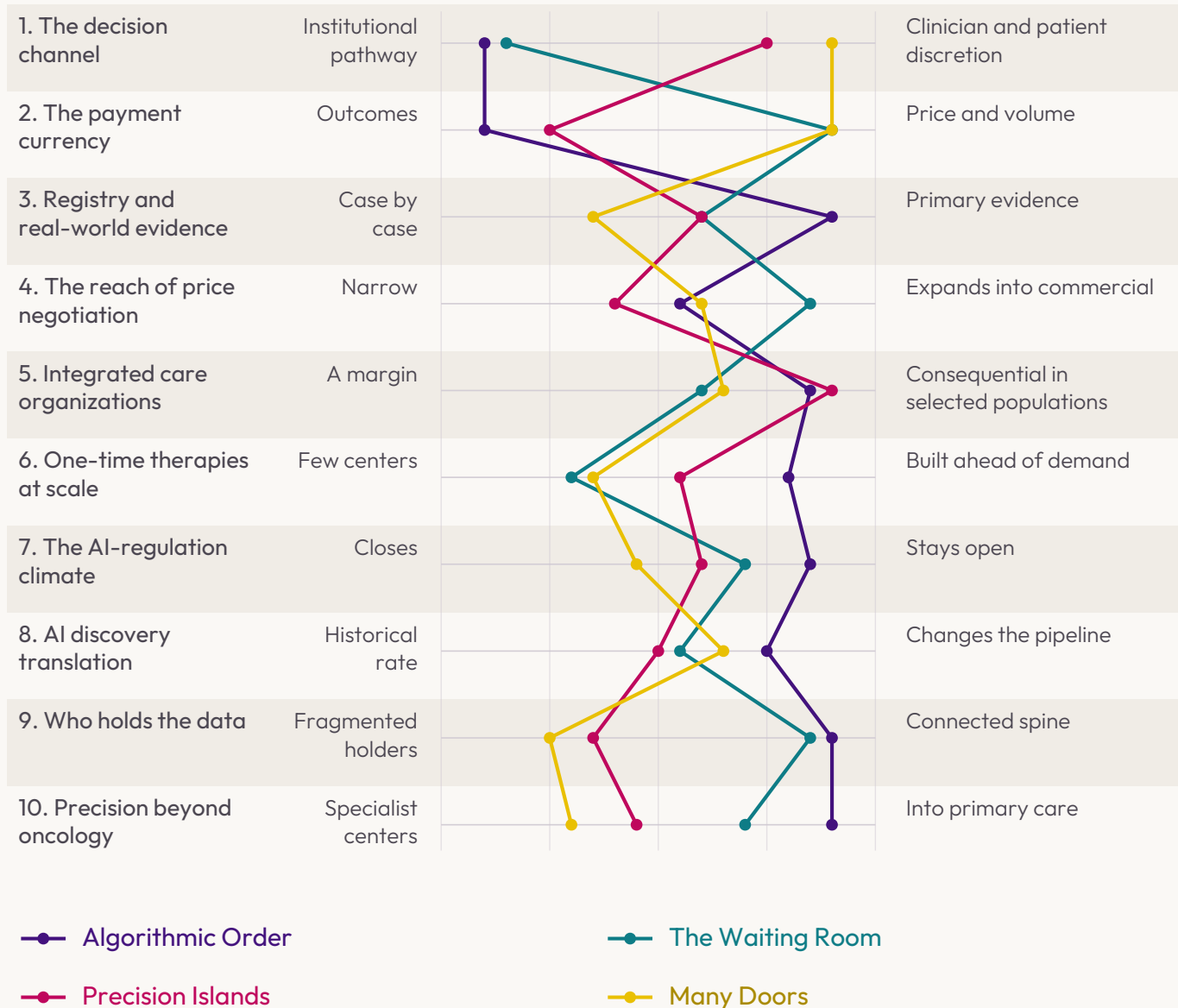
Four Worlds



The worlds combine different decision and payment arrangements. Their care patterns are explicit scenario assumptions, not automatic consequences of the axes. Precision Islands emphasizes competing networks accountable for prevention and results over time. Many Doors emphasizes episodic, transactional care with distributed sources of information and influence. The chart that follows retains the ten-uncertainty profiles; it is an interpretive map, not a probability estimate.

Four Worlds Across Ten Uncertainties

Where the paths share a position, the worlds agree. Where they part, the uncertainty separates them. Positions are schematic, not measured scores.



Rows 1 and 2 were chosen as the scenario axes. The other eight positions are analytical judgments about where each world's logic would push the uncertainty, placed relative to the other worlds; they are not measurements, and they are meant to be argued with. Theoretically, the future could unfold in many combinations of those ten uncertainties.

Algorithmic Order

The medicine works. Its place in the system is another question.

THE SYSTEM GOVERNS THE DECISION × PAID FOR OUTCOMES



By 2035, much of U.S. care is organized through institutional pathways that connect diagnosis, treatment, and follow-up. Organizations combining coverage and delivery use connected records, home monitoring, and more precise diagnostics to identify need earlier. Clinicians remain responsible for patients, but following the pathway is the default; a departure requires a documented reason.

A material share of payment depends on results verified after treatment. The same infrastructure supports ongoing comparison between a new medicine, a competing product, and better delivery of an established treatment. A therapy can reach a substantial population quickly, yet its position and commercial terms remain open to reassessment.

For patients, the promise is coordinated care and less of the journey to assemble themselves. The trade-off is a shorter list of institutionally preferred choices. For biopharma, scientific success does not ensure commercial leadership. Developers must choose whether to remain specialist suppliers, take responsibility for part of the care around a medicine, or help build the care business itself.

How do we earn a place in the pathway, and keep it in a constantly evolving algorithm?

A MOMENT IN 2035 She is looked after. She has little say.

Three weeks ago, she felt perfectly well. Now, after an alert, confirmatory tests, and a specialist appointment arranged by her care organization, she is due to start cancer treatment on Monday. Nothing has been left for her to organize. But she has read about another medicine that would mean fewer visits, and she brings the article to her oncologist. “The pathway doesn’t support that option for your profile,” he explains. “We can request an exception, but I don’t see the evidence that would get it approved.” He shows her why the recommended treatment ranks first. She understands the reasoning. She had thought her preference would count for more. As she leaves, Monday’s appointment appears on her phone, followed by transport, monitoring, and follow-up. She accepts the schedule. The article remains open.

Who Owns the Result?

The clinical team is encouraged by follow-up. Finance is less certain how much revenue the company will keep. The care organization asks why outcomes differ between sites. The contract connects those questions: it defines the population, the result, how it is measured, and what changes the payment.

Settlement follows the endpoint. Some measures allow frequent reconciliation; durable remission needs years of observation. Hospitalizations avoided require an agreed comparison, not merely an admission count. Provisional payments can bridge the intervals. Data show what happened, but do not settle which party caused it.

The developer controls its medicine, not every appointment, support service, or treatment site. A specialist-supplier model can work well where the contribution is distinctive. It becomes exposed when an alternative delivers a similar result on better terms. Partnerships may protect that contribution, but require capital, capabilities, and a willingness to carry more risk.

The Position Must Be Earned Again

The launch begins with a choice about responsibility. Evidence must support the pathway's clinical comparison and the performance agreement. Diagnostics, supply, support, and follow-up must make the promised result deliverable. An earned position opens a route to patients; it does not create capacity or guarantee sustained use.

Medical and evidence teams maintain the scientific case. Access and finance assess the money at risk. Supply and delivery partners establish what can be provided. The launch lead brings the decisions together; Launch Excellence makes dependencies visible and carries learning across assets.

Engaging the pathway means understanding its evidence standards, governance, and reassessment process. Monitor whether current evidence is accurately represented and whether patients actually receive the expected care. Reassess placement and terms as endpoints mature, delivery changes, or a new competitor changes the comparison.

Greater reach can come with performance exposure and less control over the patient relationship.

Who Gains

Organizations coordinating care; developers with distinctive, measurable benefit or reliable delivery advantages.

Who Is Exposed

Interchangeable suppliers; products whose benefit cannot be demonstrated under the relevant terms; commercial models unable to engage pathway governance.

Question	In This World
Who finds the patient, and how early	The pathway, in primary care and at home, often before symptoms; the clinician confirms
Who decides which treatment	The pathway sets the sequence; the clinician confirms or documents an exception
Who prescribes	The clinician, inside the pathway; departures are reviewed
What is paid for	A material share depends on verified post-treatment results; settlement timing follows the endpoint.
Discovery to patient	Earlier investigation can reveal patients sooner; access still requires evidence, an earned position, and delivery capacity.
How fast the market moves	Use can expand quickly once capacity is ready; positions change as evidence and alternatives develop.

EARLY INDICATORS

Illustrative future headlines. These events are scenario fiction.

Early Drift, 2026 to 2030

- 2027: CMS makes registry enrollment a condition of coverage for two oncology indications under performance terms
- 2029: An integrated care organization publishes the first pathway ranking with settlement terms attached, by indication

Taking Shape, 2031 to 2035

- 2032: Two-thirds of covered lives in the ten largest U.S. metros are managed under a certified pathway, HHS survey finds
- 2034: Most new specialty launches enter under performance-linked terms in at least one large network

TRIGGER COMBINATION

Pathways gain practical authority, and a material share of revenue is reconciled against later results. Revisit how much to invest in pathway integration, evidence operations, and responsibility for care.

SIGNALS ALREADY OBSERVED

Sourced developments, not evidence that this world must arrive.

- CMS reports participation by 33 states, the District of Columbia, and Puerto Rico in its Cell and Gene Therapy Access Model, using outcomes-based agreements for sickle cell therapies.¹²
- WISeR uses technology with licensed clinical review for selected prior-authorization decisions in six states. Separately, 84 percent of respondents to the 2025 NAIC health-insurer survey reported AI or machine-learning use in some capacity.^{30,31}
- FDA published a generative-AI medical-device discussion paper in August 2026. It requests feedback on regulatory considerations; it is not a binding rule.³²

The Waiting Room

The patient has been found. The money has not.

THE SYSTEM GOVERNS THE DECISION × PAID BY PRICE AND VOLUME



The system can identify treatable need earlier and more precisely. Institutional pathways combine clinical evidence with coverage rules to establish the expected treatment sequence. Clinicians can see who could benefit, which treatment is recommended, and which option the patient's plan will fund.

Payment remains predominantly tied to units at negotiated prices. Outcomes may be measured well without determining payment after treatment. Budgets and delivery capacity do not expand as quickly as the population now identified. Risk tiers, exceptions, and restrictions make the gap between clinical need and funded care visible.

The commercial opportunity is not only to defend a premium in a smaller population. Companies compete to make worthwhile treatment affordable for more people, through better patient selection, credible lower-cost alternatives, simpler administration, or better use of existing care. Employer programs and other routes help some patients obtain treatment sooner, but can widen differences in access. The strongest proposition shows where benefit is greatest and what it takes to deliver it at a sustainable scale.

How do we demonstrate which patients benefit most and make effective treatment affordable at scale?

A MOMENT IN 2035 Knowing earlier does not mean receiving the recommended treatment earlier.

When further tests confirm the risk first flagged on her mammogram, she tells her daughter they have caught it in time. At the appointment, her doctor shows her a treatment intended to reduce that risk. Then he opens the coverage screen: she meets the clinical criteria, but not the plan's funded threshold. "So you think I should have it?" she asks. He does. He starts an available alternative and files an exception request. Six weeks later, the refusal arrives while she is making dinner. Her sister, insured through a different employer, has already started the recommended medicine. The alternative is helping, and she is relieved to have treatment. She puts the two messages side by side: the care system's recommendation and the insurer's refusal. Both carry her name.

The Competitor With a Different Price of Admission

Inside the developer of the preferred therapy, one team proposes a familiar defense: focus on the patients for whom the strongest price can be justified. Another asks what happens if a competitor makes useful treatment affordable for the much larger population the system has identified.

The alternative need not be better on every measure. It must offer a credible balance of benefit, safety, delivery, and total cost. Administration, monitoring, and support can change the number of people a budget will reach. A reliable program using an established medicine can also change the case for escalation.

Organizations that combine coverage and care judge those wider costs. They can be demanding purchasers and useful partners. Not every developer should discount: a substantial incremental benefit may sustain a premium. Equally, a small population provides no immunity from difficult funding choices.

Make the Value Proposition Deliverable

The team needs more than one price and one account of value. It must show which patients benefit most, what care is required, and how price, service intensity, and channel affect reach and contribution. These choices should shape evidence and delivery while the plan can still change.

Prepare an affordable-scale case alongside the premium case. Test whether a simpler delivery model or different terms actually fund more treatment. Preparing an option is not a commitment to launch it. Medical and evidence teams establish the benefit; Access, Finance, Supply, and partners test what can be funded and delivered.

Launch Excellence brings those dependencies into the same review. The pathway must be able to interpret the clinical and budget evidence, and the funded tier must convert into treated patients. A threshold agreement is a gate, not the result. The plan still has to work after the next competitor responds.

Protect the value of substantial benefit without overlooking the larger market a more affordable proposition could serve.

Who Gains

Developers with credible affordable-scale propositions; care organizations that make identified need treatable; therapies with clearly demonstrated incremental benefit.

Who Is Exposed

Premium propositions without sufficient differentiation; diagnostic models that depend on unfunded follow-up; plans built only to protect price.

Question	In This World
Who finds the patient, and how early	The pathway, in primary care and at home, early; eligibility is set by funded tiers inside the same pathway
Who decides which treatment	The pathway ranks by cost-effectiveness at the negotiated price; the clinician confirms within the funded tier
Who prescribes	The clinician, inside the pathway, with prior authorization automated against the budget
What is paid for	Units at negotiated net prices, under population-level budgets; outcomes shape future negotiations, not payment for this year's patients
Discovery to patient	Shorter to approval; longer to funded access; a waiting list is normal
How fast the market moves	Fast to identify, slow to fund; the affordable alternative moves fastest

EARLY INDICATORS

Illustrative future headlines. These events are scenario fiction.

Early Drift, 2026 to 2030

- 2028: A national payer imposes a population-level budget cap on an AI-identified early-stage cancer indication
- 2029: A lower-cost entrant displaces the first-line position in a diagnostically expanded cardiovascular indication within a year

Taking Shape, 2031 to 2035

- 2031: Investors price a premium for affordable-scale pipelines and a discount for premium assets in expanded populations
- 2033: Patient groups in three states bring a coordinated legal challenge over eligible-but-unfunded status

TRIGGER COMBINATION

Pathways identify and control access for larger populations; fixed-price terms persist; lower-total-cost propositions win funded use. Revisit the balance between premium positioning, affordable reach, and the delivery model.

SIGNALS ALREADY OBSERVED

Sourced developments, not evidence that this world must arrive.

- The first ten negotiated Medicare prices took effect in 2026; fifteen more follow in 2027. The third cycle includes Part B medicines. These are product-specific negotiation measures.¹³
- Washington enacted licensed-review requirements for relevant prior-authorization denials. The December 2025 federal executive order separately directs challenges to certain state AI laws; it does not automatically preempt all state regulation.^{26,27}
- FDA-cleared cmAngio detects and localizes breast arterial calcification on screening mammograms. The clearance illustrates additional information from routine imaging, not a proven increase in treatment eligibility or improved outcomes.¹⁵

Precision Islands

Prevention is organized. Treatment remains a personal choice.

CLINICIANS AND PATIENTS KEEP THE DECISION × PAID FOR OUTCOMES



Competing care networks organize prevention, treatment, and follow-up around results over time. Employer-linked plans, regional insurer-provider partnerships, specialist networks, and new entrants connect information and services for their members. Clinicians and patients retain meaningful choice among treatments and competing advisers. Integration does not require obedience to one institutional ranking.

Networks benefit when better care improves outcomes and avoids unnecessary expenditure. They also use performance-linked agreements for medicines where results can be measured reliably. Earlier intervention, ongoing monitoring, and support become part of the proposition. A therapy competes on its contribution to that proposition, not just its clinical profile in isolation.

The best experience is not equally available to everyone. Coverage, affordability, geography, and practical support affect access; willingness to participate, share relevant information, and engage in prevention affects use. Highly engaged patients can still lack access, while well-covered patients may decline intrusive monitoring. For pharma, the opportunity is to build partnerships that deliver meaningful results and can be repeated beyond the first successful network.

How do we deliver value across networks that organize prevention, measure results, and retain treatment choice?

A MOMENT IN 2035 Care follows her life, but membership determines who gets that support.

The nurse calls while she is walking her dog. Her home readings have changed, and the team wants to understand why before the next scheduled visit. She admits she has stopped taking the afternoon dose on days she cares for her father. Nobody lectures her. At a video appointment, she and her physician compare two covered options, including the one her personal adviser suggested. They choose a plan she believes she can sustain; the network arranges follow-up and checks back the next week. For once, she does not have to start the story again with each person she speaks to. Her brother asks how he can get the same support. He is just as willing to participate, but neither of the plans available through his employer includes the network.

The Second Network Is the Harder Sale

The first partnership works. Patients receive the medicine, follow-up is reliable, and the agreed results justify payment. The second network asks who will supply monitoring. It has fewer staff, different devices, and a different patient population. The company has shown that its proposition works. It has not yet shown that it travels.

A material share of revenue depends on performance in defined populations. Agreements can be operated on network data without a shared national infrastructure, but evidence does not become cheap merely because a contract exists. Each deployment brings work on definitions, responsibilities, and continuity.

Prevention creates an additional competitive test. Better use of an established therapy or an earlier intervention can change demand for a new medicine. Other programs identify previously untreated patients or improve adherence. The direction depends on the condition and the care delivered, not on a general assumption that prevention reduces pharmaceutical use.

Build the Partnership to Travel

The market map shows partner populations and delivery capabilities as well as accounts and territories. Membership is not the medicine's reachable market. The team needs to know who is eligible, funded, willing and able to participate, and supported by sufficient treatment capacity.

Work with the first partners early enough to shape evidence and delivery. Define what must remain consistent: clinical claims, safety requirements, performance measures, and minimum support. Let the rest adapt where the evidence and economics allow it. Patient and clinician input should help determine which burdens are reasonable.

Test the second deployment before scaling. Track the cost and quality of replication, not only contracts. The launch team agrees evidence, financial exposure, and delivery responsibilities; Launch Excellence carries the standards and learning across assets.

Coordinated care can deepen value while uneven access, participation, and bespoke arrangements limit its reach.

Who Gains

Networks that deliver prevention and continuing care; developers with repeatable evidence and delivery propositions; patients able and willing to participate.

Who Is Exposed

One-off partnership models that cannot travel; patients excluded by coverage or practical barriers; products whose results depend on unsupported local conditions.

Question	In This World
Who finds the patient, and how early	Networks investigate earlier among participating members; access and engagement vary within and outside them.
Who decides which treatment	Clinician and patient choose among recommendations; network coordination does not dictate one sequence.
Who prescribes	The clinician, directly; developers reach clinicians through medical and evidence teams and through the network
What is paid for	Performance verified on the network's data, contract by contract; units at net price where no contract exists
Discovery to patient	Variable: fast inside a contracted network, slow outside
How fast the market moves	Network by network; a launch is a sequence, and replication sets the pace

EARLY INDICATORS

Illustrative future headlines. These events are scenario fiction.

Early Drift, 2026 to 2030

- 2027: First performance contract signed between an employer-sponsored care plan and a developer on the plan's own outcome data
- 2029: A quarter of new performance contracts replicate a template first executed in another network, industry survey finds

Taking Shape, 2031 to 2035

- 2031: A prevention-led network and two developers publish outcome-adjusted results for a joint cardiovascular program
- 2033: Investors value developers on contracted covered lives and replication rate; the metric enters earnings calls

TRIGGER COMBINATION

Networks sustain performance agreements and replicate them while clinicians and patients keep discretion. Revisit which partners to prioritize, and how much of the support offering to build for reuse.

SIGNALS ALREADY OBSERVED

Sourced developments, not evidence that this world must arrive.

- CMS estimates 14.3 million Medicare beneficiaries in accountable-care arrangements as of January 2026, compared with 13.7 million a year earlier.¹⁸
- Included Health announced an agreement in July 2026 to acquire Firefly Health. Firefly membership exceeds 20,000 according to the company, which also reports lower total care costs in its self-insured book; those cost results are not independently validated here.²⁰
- OpenAI announced a U.S. rollout connecting supported medical records, Apple Health, One Medical, and Function Health with user permission. Access to records outside the originating institution is not the same as portable insurance coverage.¹⁷

Many Doors

Care remains episodic. The sources of influence multiply.

CLINICIANS AND PATIENTS KEEP THE DECISION × PAID BY PRICE AND VOLUME



Care remains predominantly episodic and transactional. Patients, clinicians, and payers have more information, but no organization routinely assembles it into continuous care for most people. A clinical visit, a coverage decision, a diagnostic test, and a prescription may still be handled separately. Medicines are paid for mainly through units at agreed net or cash prices.

Technology advances around those arrangements. Personal AI advisers, clinical tools, virtual services, employer programs, and membership offerings create more sources of advice and more routes to treatment. Some coordinate care well; most do not reorganize the wider system. Clinicians and patients keep the treatment decision while weighing recommendations that reflect different information and priorities.

For pharma, the challenge is to establish a coherent value proposition across these distributed judgments. A medicine must make clinical sense to the prescriber, practical sense to the patient, and economic sense to the payer, while being represented credibly in the tools each uses. Competition can enter through a new product, better delivery of an existing treatment, or a service that changes how patients consider their options.

How do we establish a compelling value proposition across the many sources that shape treatment?

A MOMENT IN 2035 She has more information and more options. Connecting them is still her job.

By Thursday, she has three recommendations and no prescription. Her physician favors one medicine, her insurer prefers another, and her personal adviser has found a newer option with a dosing schedule that fits her working day. The membership service reviewing her wearable data has useful observations, but they are not in her physician's record. She uploads the summary, requests another conversation, and compares the costs. Her doctor agrees the newer option is appropriate. A manufacturer's cash channel makes it affordable, and the prescription is routed there. By Friday, the medicine is on its way. She is pleased with the result and surprised by how much of her week it has taken. Before closing her laptop, she adds a reminder to tell the membership service that her treatment has changed.

The Value Proposition Has Many Audiences

The familiar commercial model persists, but a single message does not travel unchanged through every decision. The clinician examines comparative benefit and safety. The patient weighs burden, convenience, and trust. The payer examines affordability and alternatives. Their advisers and tools may draw on different evidence and arrive at different recommendations.

A coherent proposition is not a different truth for each audience. It is the same credible clinical case, expressed with the evidence and context needed for each decision. Companies must understand where the information diverges, where a handoff fails, and who can address it.

More credible products can shorten the window of differentiation. Better delivery of an established medicine can also change demand. Integrated care challengers exist, but remain pockets rather than the dominant arrangement. Prevention and monitoring occur without routinely linking a material share of pharmaceutical revenue to verified results after treatment. Episodic care is a condition of this world, not an inevitable consequence of unit pricing.

Connect the Decisions That Lead to Treatment

The team maps how people recognize need, seek advice, obtain a prescription, secure funding, and start treatment. It tests the proposition with clinicians, patients, payers, and relevant services. The task is not to be present at every door; it is to understand which combinations matter for this medicine.

AEO and decision-tool monitoring start with accurate, current evidence and representative questions. Test what different systems say, whose needs are being missed, and whether the answer helps the next step in care. Visibility is not the same as adoption, and adoption is not the same as sustained benefit.

Test whether selected channels reach additional patients or shift existing demand. A one-time therapy still requires a qualified center, funding, and follow-up. Launch Excellence links the reviews so strength in one part does not conceal a failed handoff elsewhere.

More ways to reach a patient, but more separate judgments to satisfy and more opportunities for the journey to break.

Who Gains

Developers that establish credible value across clinical, patient, and payer decisions; services that remove meaningful treatment barriers.

Who Is Exposed

One-message strategies; plans that mistake coverage or AI visibility for demand; channels that add cost without improving treatment access.

Question	In This World
Who finds the patient, and how early	Clinicians, patient advisers, and care services identify need at different times; follow-up is not routinely connected.
Who decides which treatment	Clinician and patient, informed by several sources; payers and services make separate access and delivery decisions.
Who prescribes	The clinician, reached by field, digital, and peer channels, and by the patient who arrives with a request
What is paid for	Units at negotiated, referenced, or cash prices; outcomes shape demand and future negotiations
Discovery to patient	Faster to approval; access depends on the route the patient takes
How fast the market moves	New information and competitors move quickly; adoption depends on several separate decisions and handoffs.

EARLY INDICATORS

Illustrative future headlines. These events are scenario fiction.

Early Drift, 2026 to 2030

- 2028: Fewer than 10 percent of performance-based pilot contracts renewed or scaled, CMS and major commercial payers report
- 2029: A chronic medicine gains substantial uptake through a combination of clinical advice, employer services, and a manufacturer channel

Taking Shape, 2031 to 2035

- 2031: Membership-based care services cover a tenth of commercially insured adults in the largest metros
- 2033: A lower-cost entrant gains share by aligning clinical evidence, patient convenience, and payer terms across separate care channels

TRIGGER COMBINATION

Care remains largely episodic and payment unit-linked, while multiple advice and access routes materially shape treatment. Revisit which decisions and handoffs the value proposition must support, and which routes merit investment.

SIGNALS ALREADY OBSERVED

Sourced developments, not evidence that this world must arrive.

- The White House reported 26 manufacturer pricing agreements by August 31, 2026. It describes TrumpRx as a route to discounts on participating medicines; terms are product-specific.¹⁴
- Amazon reports launching Health AI on its U.S. app and website, with permission-based appointment and prescription-related actions. EY reports 55 percent of U.S. respondents have requested, or would consider requesting, a test, treatment, or prescription based on AI information.^{21,23}
- IQVIA states that 80 percent of launches continue along their early trajectory and describes post-pandemic trajectories as weaker on average. This is its published analysis, not a measure of the causal effect of alternative routes.³³

SECTION 5

Two Medicines, Four Launch Environments

Meridian: A Recurring Medicine

Meridian is an invented once-monthly subcutaneous therapy that slows early-onset heart failure in adults with a specified molecular signature. The eligible group sits within a larger cardiovascular population. Its clinical profile is held constant across all four worlds.

World	Decisive Launch Choice	Main Commercial Vulnerability
Algorithmic Order	Secure a pathway position with a credible performance and delivery proposition. Decide which monitoring and support responsibilities the company can reliably undertake.	The product earns use but not the expected revenue if the measured benefit, delivery performance, or agreed attribution does not support settlement.
The Waiting Room	Compare the premium case with a lower-price or simpler-delivery proposition that funds treatment for more eligible patients.	Preserving margin in a narrow funded tier loses the larger opportunity to a credible alternative; discounting without incremental funded reach also destroys value.
Precision Islands	Partner with a prevention-led network, define the contribution of medicine and support, then test replication in a second population.	Results depend on local delivery and participant engagement; an effective first program cannot simply be transferred to a different network.
Many Doors	Support clinical, patient, and payer value judgments with one coherent evidence base, then test the handoffs and routes that convert decisions into treatment.	The value proposition satisfies one audience but not another, or channel growth shifts existing patients without improving reach or contribution.

WHAT THIS CASE TESTS

The recurring-treatment case tests whether earlier identification becomes sustained use, and whether a new route expands the market or redistributes it.

Keep the Medicine Constant. Change the Market.

Tessera: A One-Time Specialist Therapy

Tessera is an invented one-time cell therapy for severe, treatment-refractory lupus, intended to produce durable remission. Durability remains uncertain. Specialist delivery and follow-up are necessary in every world; a new commercial arrangement does not remove those requirements.

World	Decisive Launch Choice	Main Commercial Vulnerability
Algorithmic Order	Align pathway placement, qualified delivery capacity, long-term observation, and performance-linked payment terms.	The company carries durability or delivery exposure that it cannot adequately price or control. An initial agreement does not create a treatment slot.
The Waiting Room	Build a funded, capacity-matched launch with a credible total cost of treatment and a workable route through access requirements.	Clinically eligible patients exceed the funded or deliverable population. Strong evidence does not by itself resolve the initial budget requirement.
Precision Islands	Partner with networks and specialist centers able to sustain follow-up and operate the performance agreement; make responsibilities portable where feasible.	Small, bespoke populations, different evidence systems, and continuity problems make long-term verification and replication costly.
Many Doors	Align specialist referral, patient understanding, payer funding, and center capacity across otherwise separate decisions.	Interest and clinical eligibility grow, but separate funding and delivery decisions fail to create an executable treatment plan.

WHAT THIS CASE TESTS

The one-time-treatment case tests a different constraint: finding the patient is not the same as assembling the funding, capacity, and follow-up needed to deliver durable benefit.

SECTION 6

What to Do Next

A scenario exercise becomes useful when it leads to action. The starting point is a clearer account of what the existing plan depends on.

The Critical Gate to Viable Adoption Changes.

What the worlds change is where the launch's commercial logic is tested most sharply: an earned position with performance terms, a workable threshold and price agreement, a repeatable network arrangement, or route-specific coverage and adoption. None of these gates guarantees delivered treatment or sustainable economics. The dangerous assumption is that the route from evidence to adoption to revenue that carried the last medicine will carry the next one.

The Reachable Population Is Not the Eligible Population.

In Algorithmic Order the gap is small; in The Waiting Room it is set by the funded tier; in Precision Islands by which networks have contracted; in Many Doors by the routes the plan built. A forecast built on epidemiology overstates reach in every world but the first.

Decision-System Readiness Is a Shared Foundation.

Institutional pathways, network tools, and personal advisers place different demands on a medicine's evidence. LLMs can help patients find and interpret public research without visiting the original source or belonging to its intended audience. That can strengthen their role in treatment decisions while making accurate interpretation more important. The audience for scientific information is no longer limited to the audience it was written for. AEO is therefore a launch-readiness imperative: make credible evidence discoverable and monitor whether AI-mediated explanations preserve its context, risks, uncertainty, and approval status. Relationships and monitoring should match each system's role.^{25,34}

The Launch Stays Cross-functional, and the Launch Lead Owns It.

Evidence and contract governance; patient selection and affordable-scale design; prevention partnerships and replication; value across distributed decisions. Which functions carry the decisive work changes, but the launch remains cross-functional.

Seven No-Regret Moves

Certain actions can create value no matter how the future takes shape or which combination of worlds materializes. These are recurring disciplines, not a prescribed execution order. They can run in parallel; the scale and form of investment should remain proportionate to the asset and the evidence.

No-Regret Move	Accountability	Practical Starting Point
1. Rehearse, Monitor, and Adapt	Launch Excellence and Insights, with launch leads	Test current launch plans against all four worlds and the alternatives each medicine must beat. Maintain a shared view of signals, patient experience, uptake, and safety; assign thresholds and owners for revisiting assumptions. Repeat the exercise when evidence or the market changes.
2. Build Evidence That Earns Trust	Medical, Clinical, and HEOR, with Access	Design clinical and real-world evidence around consequential treatment questions, relevant subgroups, and practical outcomes. Make limitations explicit and evidence comparable and reusable. Bring clinicians into the scientific dialogue early; update the case when experience challenges it.
3. Build AEO and Decision-System Readiness	Digital and Commercial, with Medical, Regulatory, and Legal; Launch Excellence connects the learning	Start answer engine optimization (AEO) with one or two on-market products. Audit the clinical and patient questions that shape treatment preferences; improve permitted public information's clarity, accessibility, and currency. Check how LLMs represent evidence, risks, limitations, and approval status. Carry the learning into launch preparation. For development programs, maintain accurate trial records and nonpromotional scientific disclosures through Medical, Regulatory, and Legal review. Test whether AI summaries preserve investigational status and evidence limits. Keep scientific exchange distinct from product promotion; discoverability does not create a preapproval-promotion exemption. Treat formal pathway engagement separately.^{34,38}
4. Design Access for Affordable Scale	Launch lead, Access, HEOR, and Finance	Model price, delivery intensity, and service requirements together. Test which patients benefit most and what terms make treatment reachable. Prepare an affordable-scale alternative where relevant without committing to a discount or assuming that volume guarantees value.

No-Regret Move	Accountability	Practical Starting Point
5. Build With Patients, Not Only for Them	Patient Engagement and Medical, with the launch team	Bring patients and caregivers into evidence priorities, care design, and support decisions. Test treatment and monitoring burdens, privacy preferences, and access barriers. Use their experience to improve the proposition, rather than treating engagement only as a route to uptake.
6. Choose Ecosystem Roles and Partners	Commercial leadership and launch leads, with Access and Legal	Decide where the company will supply a medicine, partner in delivery, or provide part of the ongoing service. Select partners accordingly. Agree who supplies diagnostics, care, data, and verification, with explicit responsibilities and continuity arrangements.
7. Rehearse Delivery and Accountability	Launch lead and Operations; Launch Excellence coordinates	Bring evidence, access, supply, patient support, and partner readiness into one review. Test demand shifts, capacity limits, and failed handoffs before scale-up. Assign decision rights and escalation owners, and reuse what is learned in later launches.

What This Asks of Launch Excellence.

Launch Excellence provides a shared way to expose assumptions, test readiness, and learn across launches. It ensures that evidence, engagement, access, and delivery fit together without taking over every specialty. The accountable launch lead runs the launch; senior leaders choose the commitments and provide the decision rights to act.

For the First-time Launcher.

A first-time biotech may have no separate Launch Excellence function. The same work still needs named owners, a shared view of the evidence and delivery requirements, and a practical way to resolve cross-functional dependencies before they become launch barriers.

SECTION 7

Test Cheaply, Commit Deliberately

Some capabilities help in several worlds. What becomes contingent is their scale, organizational form, and timing. A small experiment can reveal whether a larger commitment is justified without requiring the company to declare that one future has won. Preparing an option is different from paying to build the whole future around it.

Keep the medicine constant. Change the market. Then ask which part of the business case no longer holds.

World	Option-Building Experiment	Larger Commitment Most Justified Under This Market Logic	Exposure Created by the Commitment
Algorithmic Order	Test one pathway-integration and performance-settlement arrangement with one operator, on the operator's own data; learn what the outcome exposure means	Contract and evidence operations as a standing competency, with responsibility for part of the care that produces the outcome	Interchangeable inside the pathway, or a capability built for a world that stayed a pilot
The Waiting Room	Test reach, not only willingness to discount: one affordable-scale proposition with one regional payer or integrated organization	A second price tier and delivery model for the full risk population; supply that flexes under caps; managed access built as infrastructure	Margin given away for reach that a cap then limits anyway
Precision Islands	Test the second deployment early: one performance contract written as a template from the start, with a replication plan	A partnership organization: network steering seats, program enablement, a contract team, and a delivery package the company supplies	Replication that does not travel; a package built for a network that switches partners
Many Doors	Test whether one coherent value proposition works across clinical, patient, and payer decisions in a selected care route.	A cross-channel evidence and engagement model, with route-specific delivery and measurement of incremental treatment.	Duplicated engagement, conflicting representations, or channel shifts without sufficient additional treatment or return.

Watch for Consequences, Not Headlines

World	The Combination to Watch	What Would Weaken the Case	Decision to Revisit
Algorithmic Order	Pathways gain practical authority, and a material share of revenue is reconciled against later results	A major data breach or serious AI failure causes patients, clinicians, or regulators to retreat from pathway authority; or performance terms expose little revenue.	How much to invest in pathway integration, evidence operations, and responsibility for care
The Waiting Room	Pathways identify and control access for larger populations; fixed-price terms persist; lower-total-cost propositions win funded use	Capacity and affordable treatment that absorb the identified need	The balance between premium positioning, affordable reach, and the delivery model
Precision Islands	Networks strengthen prevention and continuing care; performance agreements replicate while clinicians and patients keep discretion.	Partnerships cannot repeat their results, exclude too many patients, or harden into mandatory treatment pathways.	Which partners to prioritize, and how much of the support offering to build for reuse
Many Doors	Care stays largely episodic; several advice, funding, and delivery decisions shape treatment; payment remains predominantly unit-linked.	Care becomes predominantly longitudinal and coordinated, with substantial performance-linked pharmaceutical payment.	Which value judgments and handoffs to support, and which channels create genuinely additional treated patients.

A signal earns its place on the dashboard when it could change a launch decision. Track the developments that support a world and those that would weaken it; a single contract announcement, application launch, or denied claim rarely distinguishes one future from another. Set decision thresholds for the asset rather than borrowing a national percentage: a route that matters to a cardiovascular launch may be irrelevant to a specialist cell therapy, and a performance agreement matters when enough revenue is exposed to change the business case.

SECTION 8

10 Questions Worth Exploring

- 1 Of the four worlds, which one does your organization expect?
- 2 Which world has your organization prepared for?
- 3 Which of our next five launches has a commercial logic that survives in only one of the four worlds, and do we know which one?
- 4 For each of them, what is the alternative the medicine must beat in each world: a competing product, a better-delivered existing treatment, or a prevention program? Does the plan name it?
- 5 Where is the critical gate to viable adoption in each plan, who is accountable for it, and what must happen after it?
- 6 What is the reachable population for each launch in each world, and does the forecast carry that line?
- 7 What do the clinical tools and the personal advisers say about our medicine today, and who in the organization knows?
- 8 For every large-population asset, do we hold an affordable-scale proposition alongside the premium case, and who would execute it?
- 9 Which integrated care organizations sit in the footprint of our next launches, and are we their supplier, their partner, or their competitor for the patient relationship?
- 10 What would the launch organization need to stop doing by 2028 to free the capacity these moves require, and who has the authority to make that decision?

EXPLORE WHAT THIS MEANS FOR YOU

Request a **THRIVE Futures Briefing** to explore what these futures mean for your situation, from a specific launch to broader portfolio and organizational questions. The extended research is shared selectively following the conversation. Contact launch@thrive-co.com.

About This Report

The Method.

THRIVE Futures Architecture™ is THRIVE's scenario planning method for decisions under deep uncertainty. It moves from what is given (the driving forces) to what is open (the critical uncertainties, assessed and consolidated), to the uncertainties selected as axes, to the worlds those axes define, and then to the response for a specific decision-maker. The worlds are built so that a strategy or plan can be tested against each of them; the value lies in what holds across all four and in what only one or select worlds demand.

Development Notes.²⁹

Launch Excellence 2035: Winning in an Era of Exponential Change was developed by Eliette Krakora, THRIVE Consulting, in September 2026. The worlds build on THRIVE's December 2025 first scenario set on the same subject augmented by structured research of secondary sources and insights from expert talks. Present-day claims retained in this edition are supported by the sources listed below; company reports and survey populations are identified where relevant. Generative AI tools (Claude, Perplexity, ChatGPT) and THRIVE's proprietary scenario engine, the THRIVE Futures Architect™, supported research, exploration, drafting, and editing. The author directed the scenario design and selected, revised, and validated the final scenario logic, conclusions, and recommendations. The author remains responsible for the content.

What Is Imagined, and What Is Observed.

The scenarios are structured thought experiments to support strategic planning and leadership dialogue. They are not predictions, and no probability is assigned to any of them. Future people, scenes, dialogue, company decisions, and dated future headlines are fictional. Meridian and Tessera are invented comparison assets. Named institutions in future scenes do not imply claims about their current strategy or performance. Present-day developments are distinct, sourced observations; company-reported figures and expert statements are identified as such

Scenario Use & Disclaimer:

These scenarios are structured thought experiments developed to support strategic planning and leadership dialogue. They are not predictions, forecasts, or representations of what will occur, and no probability is assigned to any scenario. Actual developments may differ materially from those described. Future people, scenes, dialogue, events, company decisions, and dated future headlines are fictional; present-day observations are separately identified and sourced. This material is provided for informational and discussion purposes only and does not constitute investment, legal, medical, regulatory, financial, or other professional advice. No representation or warranty, express or implied, is made as to the accuracy or completeness of any future-oriented assumption or outcome. Readers remain responsible for their own decisions and should not rely on these materials as a substitute for independent judgment or professional advice.

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Endnotes

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26 Washington Legislature. SB 5395, chapter 157, Laws of 2026. Signed March 23; announcement March 25. Stated effective date June 11, 2026. Addresses licensed review of relevant prior-authorization denials for covered plans. [Bill History ↗](#) | [Announcement ↗](#)

27 White House. Executive Order 14365, Ensuring a National Policy Framework for Artificial Intelligence, December 11, 2025. Directs specified challenges, reviews, and legislative recommendations; does not itself nullify every state AI law. [Source ↗](#)

28 CMS. First wave of Health Tech Ecosystem tools, April 9, 2026. Organizational pledges and initial tools do not establish universal operational interoperability. [Source ↗](#)

29 THRIVE Consulting. December 2025 scenarios and PHLEX London workshop, including the 10 Critical Success Factors and no-regret discussion. Presented at the Pharmaceutical Launch Excellence Summit, London, December 1, 2025.

30 CMS. WISer model, 2026–2031. Original Medicare model in six states for selected services. Uses technology with clinical review; non-payment recommendations require licensed clinical review. It is not unrestricted automated denial or all-service prior authorization. [Source ↗](#)

31 NAIC. Health AI/ML Survey Report, May 2025, pp. 8 and 10. N=93 companies. Call issued October 31, 2024; responses due January 22, 2025. Eighty-four percent reported AI/ML use in some capacity. Not a 2026 measurement or an autonomous-decision rate. [Survey ↗](#) | [Announcement ↗](#)

32 FDA. Considerations for the Regulation of Generative AI-Enabled Medical Devices, discussion paper and request for feedback, August 18, 2026. This is a discussion paper, not binding guidance. [Source ↗](#)

33 IQVIA. Launch Strategy and Management. Company-published observation that 80 percent of launches continue as they start in the first six months, with commentary on post-pandemic trajectories. The public page does not fully specify the underlying sample or method. [Source ↗](#)

34 Google Search Central. AI Features and Your Website. Standard search fundamentals remain relevant; no special AI markup or guaranteed inclusion is offered. This supports the accessibility component of AEO, not any claim about pharmaceutical clinical ranking. Reviewed September 27, 2026. [Source ↗](#)

35 Stokes JM, et al. A Deep Learning Approach to Antibiotic Discovery. *Cell*. 2020;180(4):688–702.e13. doi:10.1016/j.cell.2020.01.021. Direct experimental evidence of AI-assisted screening; a foundational mechanism example, not a 2026 adoption estimate. [Research Record ↗](#)

36 FDA. Considerations for the Use of Real-World Data and Real-World Evidence To Support Regulatory Decision-Making for Drug and Biological Products. Final guidance, August 2023. Does not imply blanket acceptance of wearable or patient-generated data for approval. [Final Guidance ↗](#)

37 U.S. Census Bureau. Older Adults Outnumber Children in 11 States and Nearly Half of U.S. Counties. June 26, 2025. Official age estimates support the aging-population framing; not evidence of a particular pharmaceutical demand forecast. [Population Estimates ↗](#)

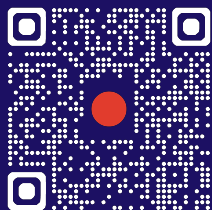
38 21 CFR 312.7(a). Promotion of investigational drugs. Restricts preapproval promotion while preserving full scientific exchange, including dissemination in scientific or lay media. This is not an AEO-specific exemption. Reviewed September 28, 2026. [Regulation ↗](#)

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