

Redefining the Healthcare Trilemma

A New Operating System for Federal Health



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Learn more about the healthcare trilemma at
www.triafed.com/the-healthcare-trilemma 

Executive Summary



Federal health leaders are constantly balancing the competing pressures of cost, quality and access to care—the healthcare trilemma.

Improvements in one of the three components often result in trade-offs for the other two. That tension isn't new, but contemporary factors make it harder to manage: a shrinking workforce, dynamic policy decisions, increased budget scrutiny, and care delivered across direct, community, and telehealth settings. And a rapidly evolving technology landscape is simultaneously transforming many elements of how Americans seek, provide and receive care.

Federal leaders have a compelling reason to manage the healthcare trilemma effectively: as stewards of taxpayer funds, they want to free up precious resources that can advance the mission. At the scale that federal health agencies operate—where a 1% change can free up billions of dollars in resources—achieving incremental improvement in one component of the trilemma while balancing the other two areas is a meaningful and eventually transformative outcome.

1%

At federal scale, a one-percent change can free up billions of dollars in resources.



COST QUALITY ACCESS

Closing the gaps starts with the operating system

Three gaps characterize the trilemma: cost, quality, and access. Closing these gaps starts with taking a holistic look at the operating system that underpins federal healthcare delivery. When we talk about an agency's operating system, we are referring to all the systems, platforms, policies and workflows that power federal programs.

To effectively manage the trilemma and free up funds, agencies need to assess the elements of their operating system to optimize how programs deliver for Americans. This requires federal leaders and industry partners with the knowledge and experience to determine which parts work well together and which parts are breaking down and require attention.

This e-book introduces a shared vocabulary for a problem you're already navigating and opens the door for a new conversation.



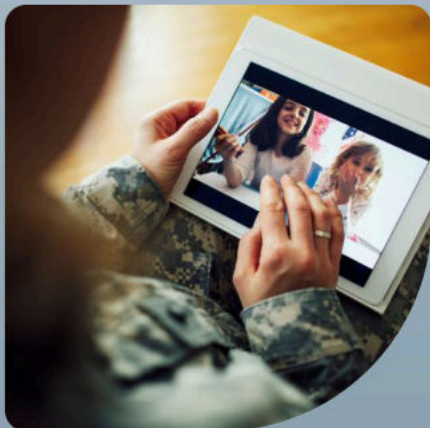
A shared model for a problem federal health leaders are already navigating.



A Medicaid beneficiary opens a letter saying she must re-verify her eligibility in 30 days. One missed form, and her care stops.



A Veteran lies awake at 3 am wondering how soon he can get treated and whether he'll drive 20 minutes or three hours for an appointment.



Overseas, a servicemember waits on a referral for her son that has been held up by an authorization, with her next rotation coming up before it clears.

Beneficiaries like these are what keep us up at night. They are the mission. Their health and happiness are the outcome that we all are working toward.

Their experience depends on decisions by federal health agencies like the Centers for Medicare & Medicaid Services (CMS), Department of Veterans Affairs (VA), and Defense Health Agency (DHA) to effectively balance cost, quality, and access considerations impacting millions of Americans, while simultaneously navigating differing missions, cultures, and policies in each agency.

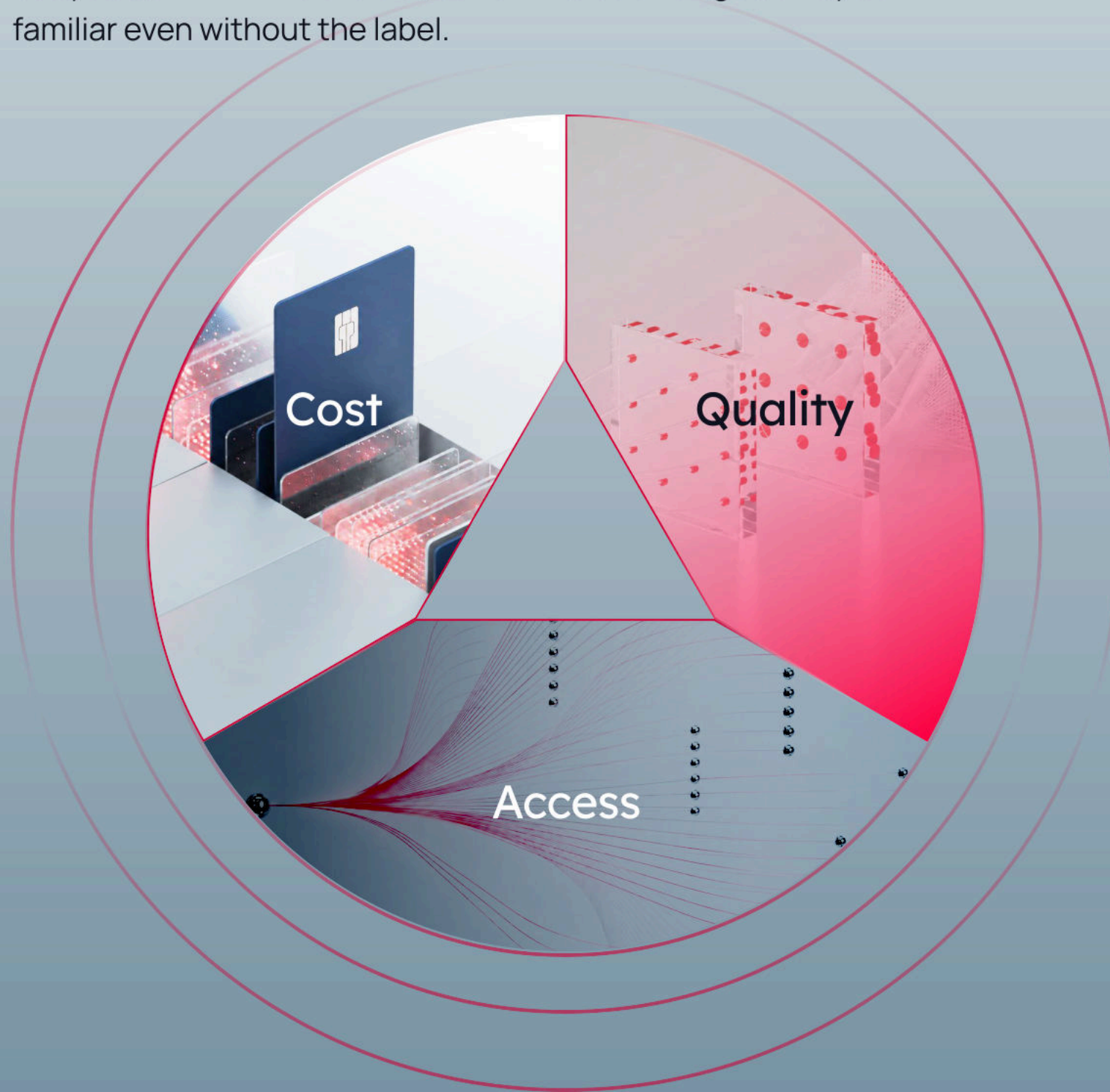
That trade-off has a name: the healthcare trilemma. It plays out differently at each federal health agency. But it's the same underlying tension, managed at enormous scale, with real people affected by every decision.

The best of intentions means little if decisions are not made with an understanding of the full operating system behind health care delivery.

The Trilemma, Defined



The healthcare trilemma, also known as the iron triangle of healthcare, is the persistent tension between controlling cost, improving quality, and expanding access to care. Improve one, and conventional wisdom says you must compromise one or more of the others. You can't optimize all three components at the same time, but you can minimize the tradeoffs. This balancing act may be familiar even without the label.



“You can expand access, but that often increases cost. You can reduce cost, but that may impact quality or limit access. And improving quality typically requires more coordination, more data, and more investment.”



Tim Borchert

CEO, Tria Federal

Why it matters more now than a decade ago

The tension isn't new; the environment is. Several pressures are converging at once:

Workforce compression

Fewer people doing more, with less room for manual workarounds.

Budget scrutiny

Every dollar is under more sustained examination.

Fragmented delivery

Beneficiaries increasingly move across direct care, community networks, and telehealth.

The disruption of data and AI

New tools that can close gaps faster than ever, but only if they're pointed at the right problem by people who understand the entire system.

Federal health at a national scale

Federal health accounts for the largest portion of government spending: more than 30% of the total FY 2026 budget, greater than combined spending on Social Security and defense.

\$1.118T

Annual Medicare spending, covering 66.6M Americans

\$949.2B

Total Medicaid spending, covering 1 in 4 Americans

\$165B

VA's FY2026 budget request for health care, serving 9.2M+ enrolled Veterans

\$64B

Military Health System's FY2026 budget request, covering 9.4M beneficiaries

KEY TAKEAWAY

At this scale, the trilemma is a challenge that impacts millions of people and hundreds of billions of dollars.

Compounded Gains Are the Real Opportunity

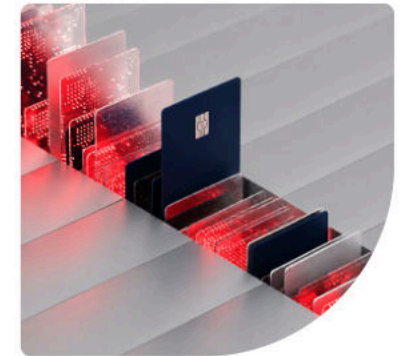


In federal health, a one-percent margin of improvement in one dimension of the trilemma can represent billions of dollars of healthcare resources—a significant outcome.

The aim is to close one or more of the following gaps:

Cost

A cost gap is spending that outpaces the value it delivers; this includes waste, an unsustainable financial burden, or dollars that never support the intended beneficiary.



Quality

A quality gap is care that's inconsistent, fragmented, or falls short of the standard a beneficiary was promised.



Access

An access gap is care that exists on paper but isn't reachable in the time, distance, or availability a beneficiary needs.





Where good intentions go wrong

A procurement team writes a contract. A tech team releases a system upgrade. A policy office issues a regulatory interpretation. Each action can be well-executed and well-intentioned yet still fail to move the needle when made in isolation from everything it touches. Here are examples of routine actions that can detract from the mission:

Restrict prior authorizations to limit spending

Adding authorization requirements to prevent unnecessary utilization can delay or interrupt care that's genuinely needed. Beneficiaries pushed into emergency settings—or who abandon treatment entirely—generate costs that routinely exceed what the tighter controls were meant to save.

Build a national program for average conditions

A bundled-payment model built for consistent national execution runs headlong into the reality that getting medical care in rural areas looks nothing like accessing the same care in a dense urban area.

Consolidate facilities to reduce overhead

Closing outlying clinics reduces costs on paper. But beneficiaries who can't make the longer drive stop seeking care. Delayed care leads to worsened conditions and higher emergency utilization—costs that frequently exceed the savings that prompted consolidation.

“We are not saying that something's fundamentally broken. We are saying that we understand there are opportunities to improve experiences across cost, quality, and access to care; that's where we operate, and that's where we thrive.”



Tim Borchert
CEO, Tria Federal



How to achieve compounded gains

Each failure on the previous page follows the same pattern: a decision made with visibility into one dimension, blind to what it costs the other two. On the other hand, when a decision is made with full system visibility, the fix often moves more than one dimension at the same time.

Prior Authorizations, Redesigned

Consider the prior authorization challenge, taken in the other direction. Rather than adding authorization layers to limit utilization and hoping care continuity holds, you redesign authorization criteria with visibility into where delays are occurring and what's driving them.

Streamlining criteria for high-evidence treatments eliminates unnecessary friction without opening the door to inappropriate utilization. Care that reaches patients on schedule is an access outcome. A decrease in abandoned treatment is a quality outcome. And a decline in administrative overhead is a cost outcome. One decision, made with system visibility, could impact all three dimensions.

That's what compounded means in this context: not three separate workstreams running in parallel, but a single well-designed intervention creating positive movement across cost, quality, and access simultaneously.

There's a second dimension to compounding: gains build on each other over time. A beneficiary who stays enrolled builds a care history. A care history enables better-targeted interventions. Better-targeted interventions reduce avoidable utilization. Each improvement creates the conditions for the next one.

At the scale of federal health programs, where a one-percent shift touches millions of people and hundreds of billions of dollars, that dynamic accumulates into something meaningful. Sustainable improvement requires seeing the operating system as a whole. This takes expertise, experience, and deep knowledge of the mission, policy and agency.



KEY TAKEAWAY

A fix built with system visibility does more than hold; it creates the conditions for the next improvement. That's the compounded gains opportunity: not a single breakthrough, but a sequence of interconnected gains that build on each other at a scale where a percentage point matters.

Past efforts to reduce trilemma trade-offs haven't failed from lack of investment or good intent. They've failed because neither the agency nor its industry partners had a shared, comprehensive picture of the operating system they were changing.

Complexity is the real challenge. The more moving parts a system has—agencies, contractors, legacy platforms, statutory requirements, beneficiary populations—the higher the odds that a well-intentioned fix creates a problem elsewhere.

For two decades, across multiple administrations and shifting priorities, Tria Federal has been an embedded partner helping agencies navigate these changes. Every mission needs partners who understand the ecosystem well enough to operate within it, but can also dissect the system and rebuild it in better shape than they found it.

Failing to properly diagnose the system before intervening can come with a variety of consequences:



A budget spent that doesn't get re-appropriated.



A problem that becomes more entrenched and more expensive to unwind the longer it runs.



Timelines that stretch past the administration or leadership that started them.



Eroded trust with the oversight bodies that agencies answer to every time a promised fix falls short.

KEY TAKEAWAY

Most failures in federal health reform trace back to an inaccurate diagnosis, not a lack of effort. The cost of a flawed diagnosis is: wasted budget, entrenched problems, and eroded oversight trust.

A New Operating System for Federal Health



When we talk about an agency's operating system, we are referring to everything required to power federal programs—and how they work together. It is the underlying layer that manages a system's resources and delivers a working experience to users. It's a way of seeing the whole picture at once, instead of managing each contract or workflow in isolation.

To more effectively manage the trilemma and free up precious resources, agencies need to holistically assess their operating system to optimize how programs are delivered.

The trilemma model should answer:

- What are we optimizing?
- What constraints do we face?
- How do we make trade-offs?



Seven connected components

Historically, the government and its industry partners have managed the operating system in isolation. At Tria, we visualize seven components within an integrated system, acknowledging up front the complex connections and dependencies at play.

Beneficiary

Knowing who someone is and what they're entitled to receive is the entry point into everything; nothing downstream works if this isn't right. It is also where the process concludes and begins anew, as the beneficiary is the reason for and the focus of the operating system.

Policy

Coordinating the rules, laws, and regulations imposed on an agency—and how that agency understands and implements them—across agencies and programs so they don't work against the beneficiary they're meant to serve.

Resources

Turning policy into a workflow. Ensuring an agency has the workforce, facilities, provider networks, technology, funding and supply capacity to execute the planned workflow.

Workflow

Organizing how the workforce—and increasingly the technology supporting it—delivers services in support of the mission.

Measurement

Developing appropriate metrics and data collection methods to track outcomes, efficiencies and effectiveness. The process of measurement converts the operating system from concept into reality.

Accountability

Deciding who has the power to make critical course corrections when delays or problems arise matters because inaction shows up later as cost, quality, or access consequences.

Outcome

Answering the question, “what did you do for the patient today?”



A policy change moves through the whole system

Consider how a single policy change moves through the whole system. For example, when the COMPACT Act removed a cost barrier for Veterans facing a behavioral health crisis, it changed more than a policy. It changed:

Workflow

Processing new copay waivers at the point of care



Accountability

Ensuring waivers were provided in real time, not weeks later



Outcome

A Veteran receives care in the moment of need, without waiting on a bill



This is what "operating system" thinking means in practice—a disciplined method for tracing a decision all the way through to see who it reaches, and what it costs them if a connection gets missed.

Failure rarely lives inside any single one of these components. It shows up at the seams between them; for example, a policy written without accounting for workflow capacity or an outcome nobody defined clearly enough to hold anyone accountable. Seeing the whole system is what makes those seams visible before they become failures.

Expertise vs. Capability



Expertise

What Tria has learned from 20+ years embedded in federal health missions, helping customers manage the trade-offs between cost, quality, and access to care.



Capability

The constantly evolving methods we use to translate our expertise into action. Today that includes software and digital platforms, operational optimization, and data, analytics, and applied AI.

KEY TAKEAWAY

This way of organizing expertise ensures changes are made with full knowledge of their impact across the system. Every federal health decision creates consequences across cost, quality, and access. The operating system concept makes those trade-offs visible and establishes accountability for managing them.

“We’re passionate about helping federal health agencies navigate the healthcare trilemma because we’ve seen it, we’ve done it, and we care about the ultimate beneficiary. Whatever the trilemma looks like inside a particular agency, we bring the expertise needed to shift that frontier.”



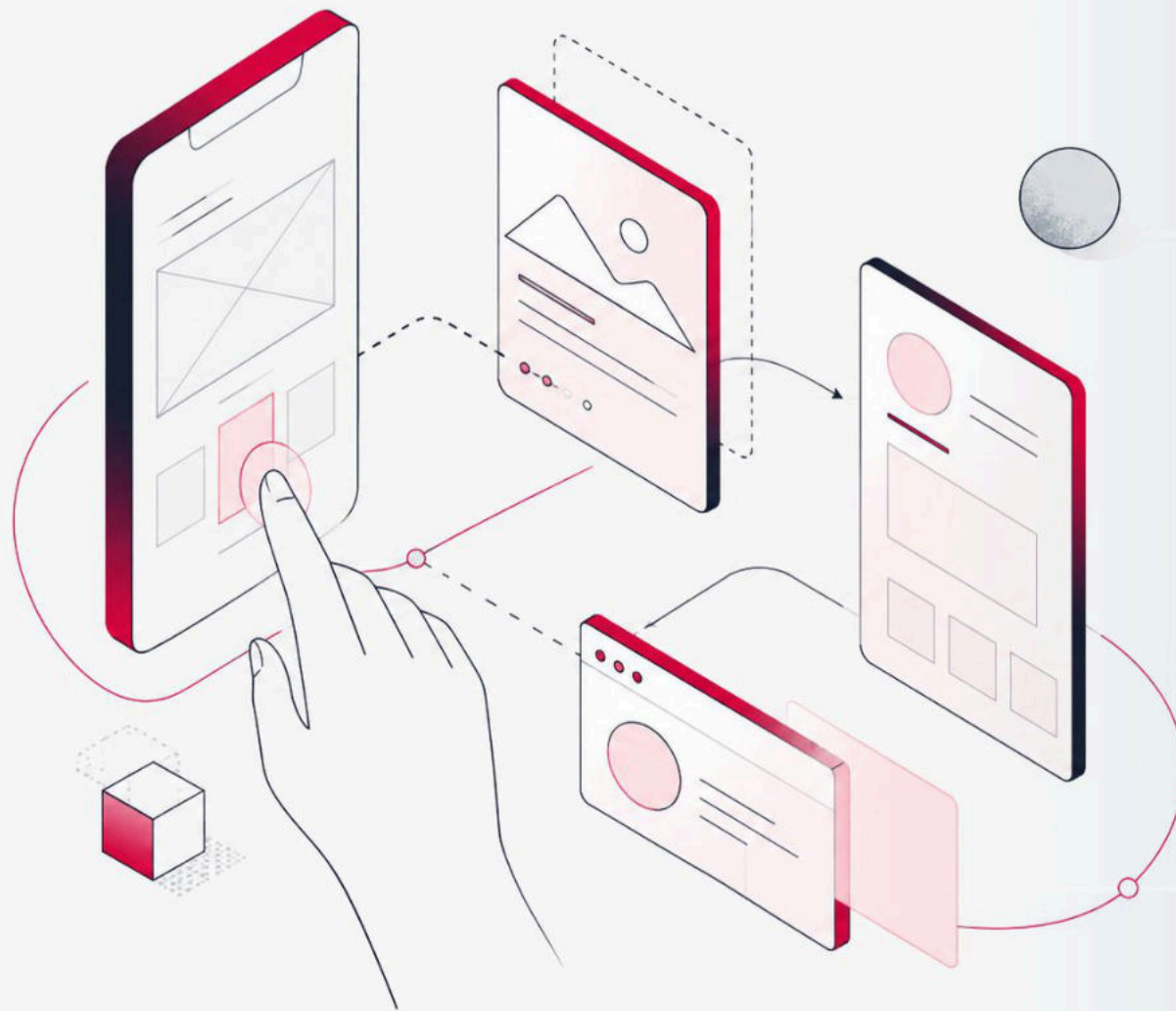
Diana Ceban

Chief Growth Officer, Tria Federal

Where Technology Fits—and Where It Doesn't



Emerging technologies are not a guest star in this operating system; they are a critical factor for transforming organizations and minimizing the trade-offs tied to the healthcare trilemma.



Consider an enrollment process that requires someone to enter the same information three times, across three disconnected systems. Redesigning that into one unified flow doesn't just make it faster; it also improves accuracy and lowers cost, without adding headcount.

At a more advanced level, federal health agencies are experiencing a period of technological disruption. The arrival of generative AI and powerful language models, when combined with the implementation of new health IT systems and solutions, creates a challenging environment in which to operate. This disruption is forcing agencies to rethink legacy systems, workforce models, and program integrity controls all at once, raising the stakes for getting AI adoption right in environments where failure is not an option.

What technology can do

Cost, quality, and access all move together. That's the pattern behind every example below.

01

AI-assisted Medicare counseling

Introducing AI to the State Health Insurance Assistance Program (SHIP) offers beneficiaries and volunteer counselors real-time, contextual answers instead of requiring years of training to reach that level of knowledge. This lowers the cost of delivering counseling, improves the consistency and accuracy of the answers provided to beneficiaries, and increases support capacity.

03

Automation and administrative relief

Prior authorization delays can turn into delayed or abandoned treatment. Automating that process speeds care and frees clinical staff to spend time on patient care instead of paperwork. The same principles scale elsewhere: robotic process automation at VA's Financial Services Center saved more than 14,800 work hours. A separate effort cut processing time from hours or even days to minutes, allowing staff to work through a half-million backlog of Veteran records requests.

02

Telehealth

Proven at scale during the COVID-19 pandemic, telehealth eliminates the travel burden for rural and Veteran populations, in particular. This means expanded access without new facilities, at a fraction of in-person cost. Similarly, remote patient monitoring improves care quality and access and cuts down on emergency or follow-up visits.

04

Broader data visibility

Access to clear, actionable data in real-time dashboards drives improved decision-making at lower operating cost than manually entering and tracking data in spreadsheets.

What technology can't do alone

Technology simply accelerates a process; it doesn't consider whether the process is good or bad.

Automating an inefficient process just makes the inefficiency faster and harder to unwind. Knowing what to automate requires a human who understands the domain, ecosystem and stakeholders—and who can use technology to build a better process.

AI comes with incredible promise and risk, which is best addressed by not treating it as an isolated technology implementation issue but as a fundamental disruptor to the entire operating system.

KEY TAKEAWAY

Technology can positively impact multiple components of the trilemma, but only when it's directed by people who understand the domain first. Automation without that understanding just makes an existing problem move faster.

“An ungoverned agent puts decisions around cost, quality, and access in the hands of a system nobody can fully explain, audit, or defend under machine-speed attack. A governed agent does the opposite: it gives program owners a defensible, traceable basis for the decisions that determine whether a beneficiary gets timely access to care, whether a payment is accurate, and whether a program can withstand scrutiny.”



Murali Mallina

Chief Technology Officer, Tria Federal

One Size Does Not Fit All Agencies



The trilemma is universal. How it shows up and how it is addressed are not.



CMS

Operates systems that cover eligibility, payment integrity, and performance accountability for Medicare, Medicaid, and CMS Innovation Center programs—encompassing extraordinary scale and visibility, but without delivering care directly. That responsibility sits with the networks and providers that CMS oversees, which means CMS's version of the trilemma plays out almost entirely in administration: getting eligibility, payment, and performance data right at a scale of tens of millions of beneficiaries, without directly touching clinical decisions.



The same trilemma, different missions



VA

Operates as both a direct care provider and a network administrator, running its own medical centers while managing a large, growing Community Care network. That dual role requires balancing the trilemma internally and externally. It also means holding VA to a different standard than a commercial plan: Veterans have earned care through service, and direct care tends to be more comprehensive than the narrower scope of community care. Getting that balance right, at scale, is a distinct operational challenge.



DHA

Delivers direct care and also has a critical mandate to maintain warfighting readiness. Field hospitals, combat medical response, standing up care in hours rather than weeks—these are all expected elements that live alongside routine beneficiary care for service members and their families. That mission adds a dimension that doesn't map onto VA or CMS.

Together, these agencies comprise a substantial share of American healthcare itself, along with organizations such as the Indian Health Service. Federal programs touch many Americans' healthcare experiences at some point in their lives, whether or not they think of it as "federal health".



Expertise moves between systems

These systems do not operate in isolation. Lessons from CMS' work on system administration—how to structure claims, onboarding, and payment integrity at scale—inform how VA's care delivery system gets built. The reverse is just as true: what's learned running VA's direct and Community Care network operations feeds back into how CMS-side programs get designed. The systems are different, but the expertise moves between them.

There is no one-size-fits-all fix to the healthcare trilemma, because there is no one-size-fits-all system. CMS's administrator-only structure, VA's dual role, and DHA's readiness mission are genuinely different operating systems, even though all three face the same trilemma. Treating them as interchangeable produces the familiar pattern of missed targets and overspent budgets.

KEY TAKEAWAY

While navigating the healthcare trilemma, agencies learn lessons, gain expertise and develop capabilities that can be shared with other agencies, but a fix built for one rarely transfers cleanly to another.



Let's Talk About Your Trilemma



Think back to the three people who opened this conversation: the Medicaid beneficiary waiting on a re-verification letter, the Veteran lying awake at 3 am, the servicemember whose child's referral clock is running out.

Their outcomes aren't determined by any single decision. They're determined by whether the whole system behind those decisions is functioning cohesively. That's what a better-functioning operating system means in practice. Not perfection. Not wholesale change. A system where the gap between what's promised and what's delivered gets smaller.

Every agency's version of that operating system is different, even if they are built upon the same fundamental truths about providing healthcare in the United States. And within each agency, every program office is navigating its own mix of pressures today.



Three things worth carrying forward:

01

The trilemma in your program is real and specific. Name where your pressure sits—cost, quality, or access—and ask whether you can see the effects of your current approach on the other two components.

02

A marginal, connected improvement is a realistic goal. You don't need a sweeping transformation to move the needle; you need system visibility and expertise to act on it. Do this repeatedly, and the collective impact will still prove change.

03

The right partner has been inside your system long enough to know what they're fixing. That's the standard worth holding.

This matter is an urgent one: the health of beneficiaries, Veterans and servicemembers is at stake. The mission is on the line.



Contact us today and tell us about your version of the trilemma.

Agencies need industry partners like Tria who are embedded with the major federal health systems and are adept at navigating both obvious and nuanced differences. Schedule a conversation with Tria's federal health team to discuss where your cost, quality, and access pressures sit today, and what a better-functioning system could look like.

Start the Conversation



Prefer email? Reach us directly at trilemma@triafed.com 

