Health Care Transformation Task Force

Partners in Promoting Value

DRIVING COMMERCIAL *VALUE-BASED CARE ADOPTION*

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EXECUTIVE SUMMARY

Employers play a key role in the US health care system, with employer-sponsored insurance (ESI) covering 154 million non-elderly people.[i] Costs are rising rapidly in this segment of the market, as premiums for ESI have increased by approximately 50% over the past decade. Value-based care (VBC) offers a path forward for innovative employers that are seeking to rein in costs while promoting clinical outcomes for their employees.

This report presents a landscape assessment of commercial VBC, including the current state of commercial VBC adoption, barriers to uptake of VBC, and key opportunities and challenges for greater VBC adoption (**Figure ES-1**). The report closes with actionable recommendations for each stakeholder group to drive greater uptake and innovation of VBC in the commercial sector, to improve quality and decrease costs for employers and patients (**Figure ES-2**).

Figure ES-1: Opportunities and Challenges for Greater VBC Adoption

Stakeholder	Opportunities	Challenges
Patients	• Demand for greater affordability • Patient engagement with their own data	• Limited ability to shop for health care
Employers	• Direct contracting • Collective purchasing power • Price transparency • Individual Coverage Health Reimbursement Arrangement	• Limited market concentration • Short time horizon • Opposition to narrow networks • Data limitations • Broker limitations
Payers	• Telehealth • Networking strategies	• Risk adjustment • Benchmark rebasing • Employer contracting • Provider contracting • Claims processing
Providers	• Advanced primary care • Specialty care integration	• Limited risk-readiness for commercial arrangements • Quality measurement

Figure ES-2: Actionable Recommendations to Drive Commercial VBC Adoption

Stakeholder	Reccomendations
Employers	1. Co-develop VBC strategies with providers, payers, and patients 2. Adopt narrow or tiered network plans 3. Create incentives for employees to use value-based providers 4. Demand broker accountability based on value, not volume
Payers	5. Create VBC solutions in collaboration with providers, employers, and patients 6. Implement multi-payer initiatives and streamline model elements 7. Partner with risk-bearing specialty groups 8. Streamline prior authorization policies 9. Share actionable data to support contracting and care decisions 10. Provide tools to help patients identify high-quality providers
Providers	11. Implement risk-based contracts across payers 12. Partner with risk-bearing specialty groups
Patients	13. Where available, use tools to seek care from high-quality providers 14. Where available, select health plans that prioritize high-quality providers

INTRODUCTION

Employers play a key role in the US health care system, with employer-sponsored insurance (ESI) covering 154 million non-elderly people.[ii] Costs are rising rapidly in this segment of the market, as premiums for ESI have increased by approximately 50% over the past decade.[iii] In 2025, the annual cost of health care for a family of four averages $35,119, and a single person averages $7,871.[iv] Additionally, only half of employees at small firms are offered health insurance, as the small group health insurance market continues to decline. Value-based care (VBC) offers a path forward for innovative employers that are seeking to rein in costs while promoting beneficial clinical outcomes for their employees.

Due to rising ESI costs, some employers are seeking alternative arrangements for products historically offered by commercial payers. Both self-insured and fully insured employers face challenges when offering value-based arrangements within traditional ESI offerings – in part because commercial reimbursement is generally a profit center for both payers and providers. Some progressive employers are operating under innovative payment arrangements, but most are limited in size, resources, or bandwidth. However, new price transparency data may incentivize employers to drive VBC as they explore new ways to fulfill their fiduciary duties under the Employee Retirement Income Security Act (ERISA).

This report presents a landscape assessment of commercial VBC, including the current state of VBC adoption and barriers to historical uptake. The report presents key opportunities and challenges in driving commercial VBC adoption among each of the primary stakeholders: patients, employers, payers, and providers. The report closes with actionable recommendations for each group to drive VBC uptake in the commercial market, to increase quality and reduce costs for employers and patients.

DEFINING THE COMMERCIAL MARKET

ESI is the backbone of commercial coverage in the U.S. and is delivered through two primary models: self-insured and fully insured plans. Fully insured plans also include the Health Insurance Marketplace, where individuals can purchase insurance independent of employment. Both self- and fully-insured plans provide health care benefits to employees, but they differ in structure, financial risk, and administrative processes. This section discusses key distinctions by product line, funding mechanisms, rate setting, market segments, and the role of benefit consultants, as summarized in **Figure 1**.

Figure 1: Funding Mechanisms by Product Line

	Self-Insured	Fully Insured
Product Lines	• ESI (under ERISA)	• ESI (purchased from plans) • Health Insurance Exchanges
Funding Mechanisms	• Employer bears risk, hires payer as a Third-Party Administrator	• Employer offers ESI (typically defined benefit) • Individual Coverage Health Reimbursement Arrangement (ICHRA) • Employee self-pay with or without government subsidies
Rate Setting	• Smaller risk pools result in statistical variation, influencing underwriting process.	• Rates filed with states, increasing predictability of benchmarks
Market Segment	• Large group	• Large group, mid-sized, small group
Benefit Consultants	• Guide employer purchasing decisions	• Guide employer purchasing decisions

Self-Insured Employers

Product Lines

Self-insured employers operate ESI under ERISA, which sets standards for the administration of these health plans. Under ERISA, employers and Third-Party Administrators (TPAs) have the legal responsibility to act in the best interest of employees and beneficiaries, ensuring fiduciary responsibility and plan integrity.

Funding Mechanism

Self-insured employers assume full financial responsibility for providing health benefits to their employees. While employers generally outsource administrative tasks such as underwriting, claims management and provider contracting to a TPA, the financial risk remains with the employer. However, the TPA may still establish global risk-based arrangements with providers.

Rate Setting

Because self-insured employers have a smaller risk pool compared to fully insured plans, this results in statistical variation due to small numbers. A high concentration of risk on a smaller group can lead to greater unpredictability in claim costs, which may result in the employer adjusting employee premiums and out-of-pocket costs or narrowing benefits to account for rising health care costs. However, the employer has up-front savings by not paying a risk premium to the payer.

Market Segment

Self-insurance is typically more viable for large employers with the resources to take significant financial risk, as they are responsible for covering the full cost of claims. These large employers often invest in innovative care, particularly those with a concentration of employees in a specific market. Mid-size employers are increasingly becoming self-funded, with assistance from tools like artificial intelligence and access to consortium purchasing power.[v] Smaller or less concentrated employers are less likely to invest in these innovations due to limited resources. In 2024, 63% of covered employees were in a self-insured health plan.[vi]

Benefit Consultants

Both self-insured and fully insured employers use benefit consultants to design and manage health plans. Benefit consultants optimize plan performance, navigate compliance issues, and identify cost-saving opportunities.

Fully Insured Employers

Product Lines

Fully insured plans may be offered through ESI or purchased directly by individuals on the Health Insurance Marketplace. Most employers offer fully insured options as one or more plans from one or more payers selected by the employer. However, some employers offer Individual Coverage Health Reimbursement Arrangements (ICHRAs), which allow individuals to choose a plan from the Health Insurance Marketplace.

Funding Mechanism

Employers who purchase fully insured plans for their employees and dependents pay a fixed premium to a payer for coverage, while the payer assumes financial risk. The payer may pass on some of this risk to providers through global risk-based arrangements. The payer also handles claims and other administrative tasks like managing the provider network. This arrangement is less risky and reduces the administrative burden on the employer, but it generally involves the employer paying a risk premium to the payer to avoid financial uncertainty. Premiums may vary year to year based on the actual cost for the insured group and change in risk profile.

In contrast, ICHRAs are a type of employer-funded health benefit that allows employers to reimburse employees who select an individual plan through the Health Insurance Marketplace. When ICHRAs are offered by employers, both employers and employees have the same tax benefit as other ESI plans. ICHRAs provide greater flexibility for employees to choose a plan that best meets their needs. However, patients may face rising costs as health care costs and inflation rise if the employer's ICHRA contribution, which generally consists of a fixed amount, doesn't keep pace with these costs.

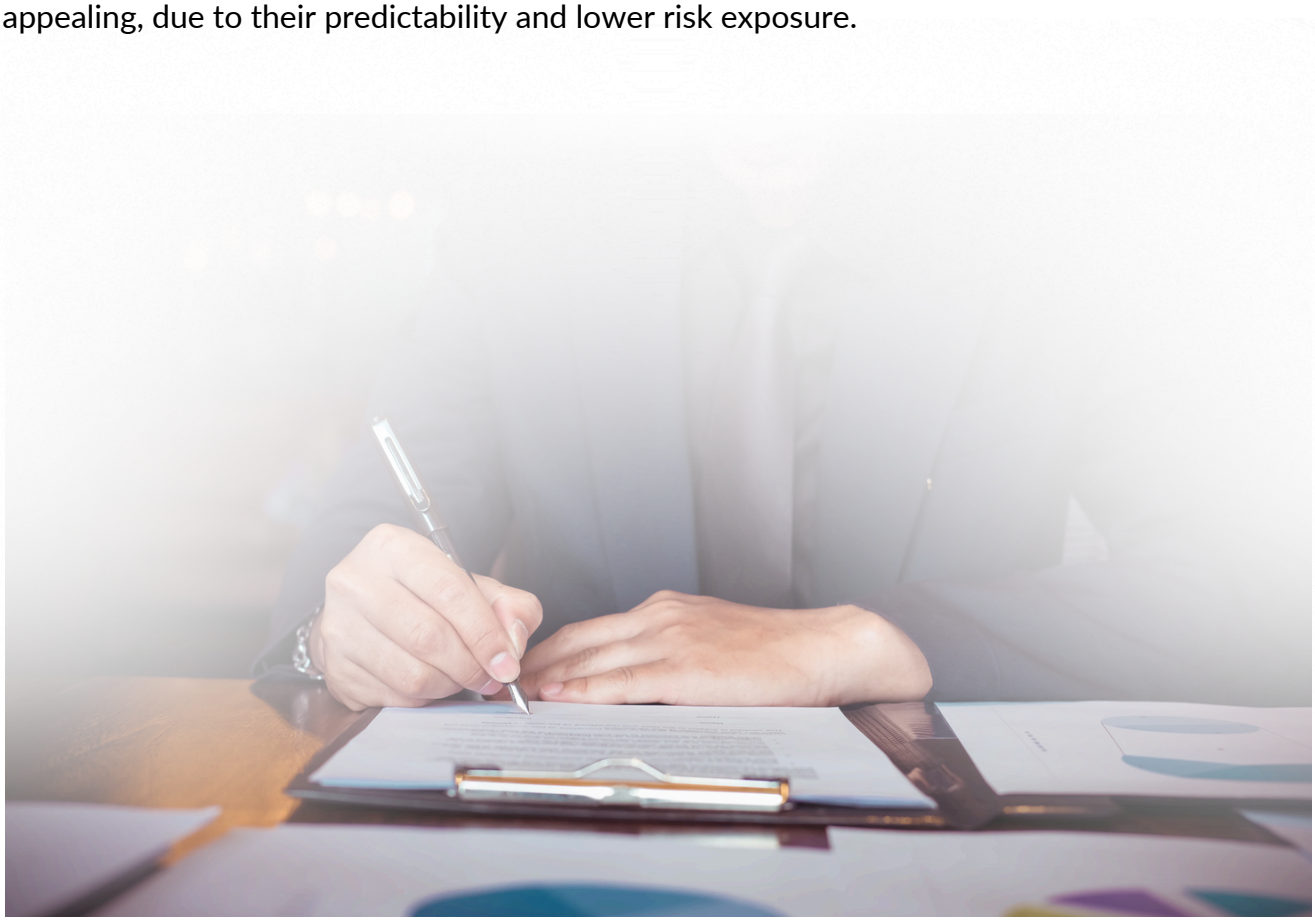
The Health Insurance Marketplace is another key component of the commercial market. Individuals can purchase insurance directly through the marketplace, regardless of employment status. Lower-income individuals shopping for plans through the marketplace may qualify for government subsidies if they are not eligible for ESI that meets certain affordability standards.

Rate Setting

Payers are required to submit their premium rates and other relevant data to state regulatory agencies for review and approval. This process can enhance revenue integrity and ensure fair pricing benchmarks in the ESI market. Additionally, by pooling risk across many policyholders, insurers can better manage high-cost claims.

Market Segment

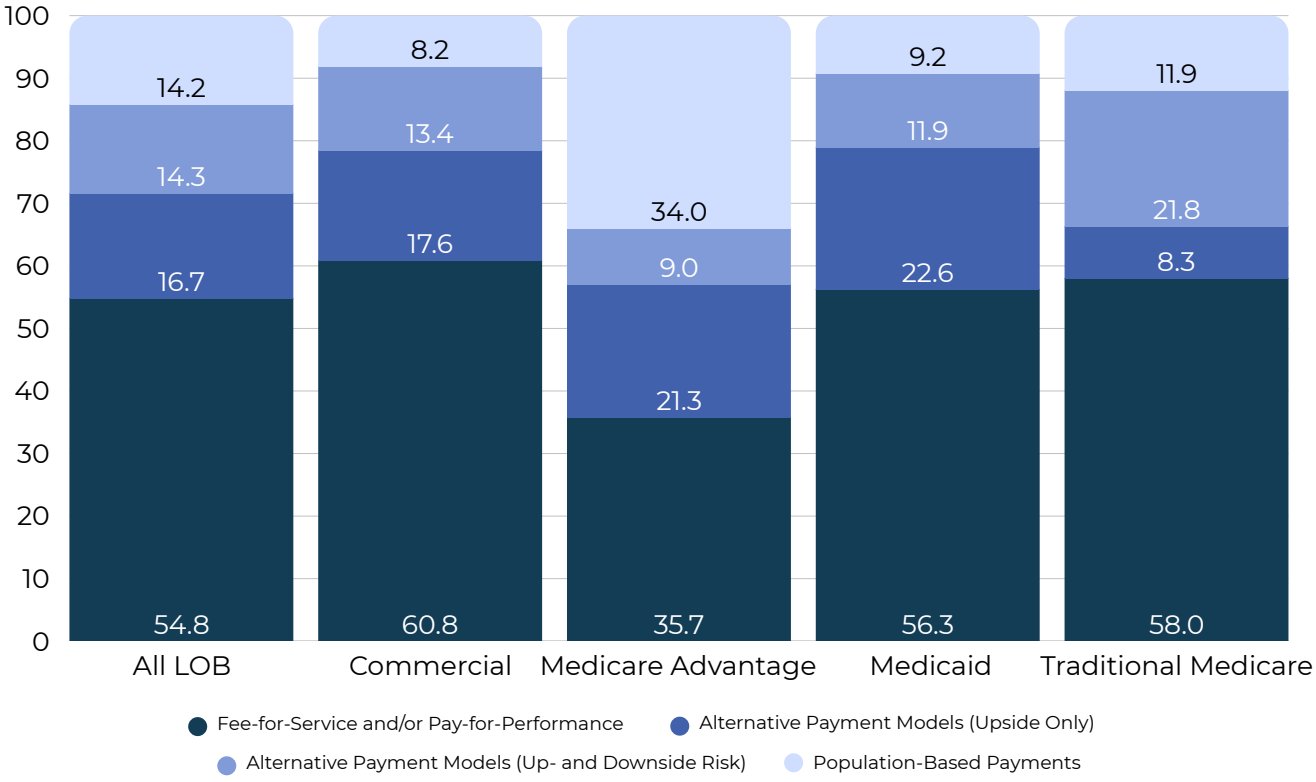
Fully insured arrangements are common among employers of all sizes who prefer to avoid the financial risk of medical claims. Small and mid-sized employers may find this particularly appealing, due to their predictability and lower risk exposure.



CURRENT STATE OF COMMERCIAL VALUE-BASED CARE ADOPTION

Employers are increasingly investing in VBC as they seek to improve health outcomes while controlling rising health care costs. 2023 marked the first year in which commercial VBC adoption for risk-based models exceeded Medicaid. Adoption is increasing year-over-year, with the most growth in population-based models (Figure 2).[vii] This signals a turning point in the commercial market's shift toward adopting alternative payment models.

Figure 2: Proportion of U.S. Health Care Payments in Alternative Payment Models, 2023



Source: HCTTF adaptation of Health Care Payment Learning and Action Network data, 2025.

While these data do not include breakouts by self-insured and fully insured employers, market trends suggest both are contributing to this shift. Large, self-insured employers are leveraging their scale and data access to engage in direct contracting and custom VBC arrangements with health systems and providers.[viii] Meanwhile, fully insured employers are increasing their demand for VBC options from payers as part of their plan offerings.[ix] This shift is also being driven by greater transparency into provider quality and cost data, empowering employers to make more informed decisions about network design and care delivery strategies.

Employer Surveys on VBC Investment

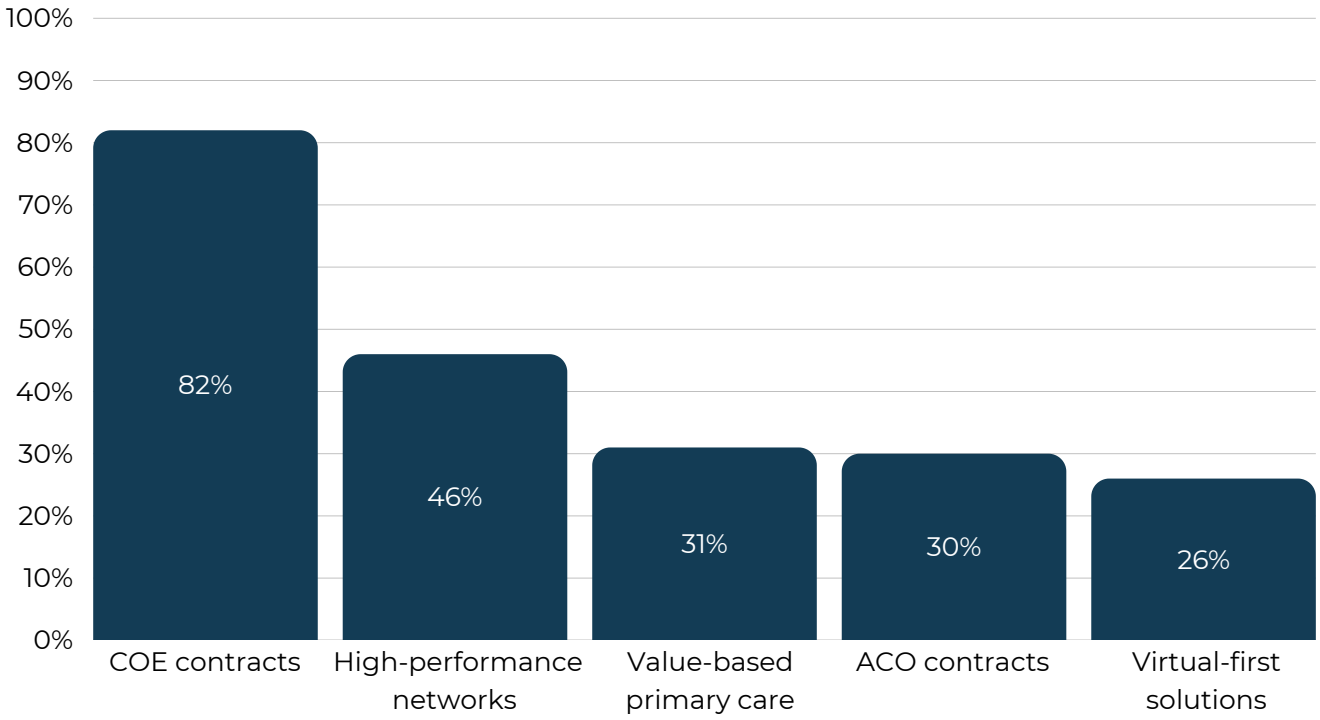
VBC adoption is growing among employers of all sizes, as shown in three recent surveys by the Business Group on Health, the Kaiser Family Foundation (KFF), and the National Alliance for Health Care Purchaser Coalitions (National Alliance). These surveys provide important insights into the VBC arrangements of greatest interest to employers.

Business Group on Health is a community of employers and health industry partners dedicated to driving delivery system transformation while controlling costs. Their 2025 Employer Health Care Strategy Survey explored the strategies employers use to address health care costs.[x] While some of the findings are publicly available, others are proprietary to Business Group on Health members. The survey included 125 extremely large employers covering 17.1 million lives, with 73% of employers having more than 10,000 employees – among the largest employers in the world. Four central themes emerged from these survey findings:

1. **Large employers are actively engaging in VBC.** Over 85% of employers in the Business Group on Health survey were engaged in alternative care delivery, payment and networking arrangements.
2. **Centers of Excellence (COEs) were the most common VBC contracts in place in 2024.** Business Group on Health has publicly shared data on the most common VBC contracts that employers had in place for 2024 (Figure 3).
3. **The COEs were used to engage specialists in VBC.** Figure 4 presents the most common conditions and procedures that employers planned for 2025.
4. **Employers have a hybrid approach for contracting with services and solutions.** Most employers used a hybrid approach to contracting that consisted of contracting independently with providers (carved out approach) and through their health plan (carved-in approach).

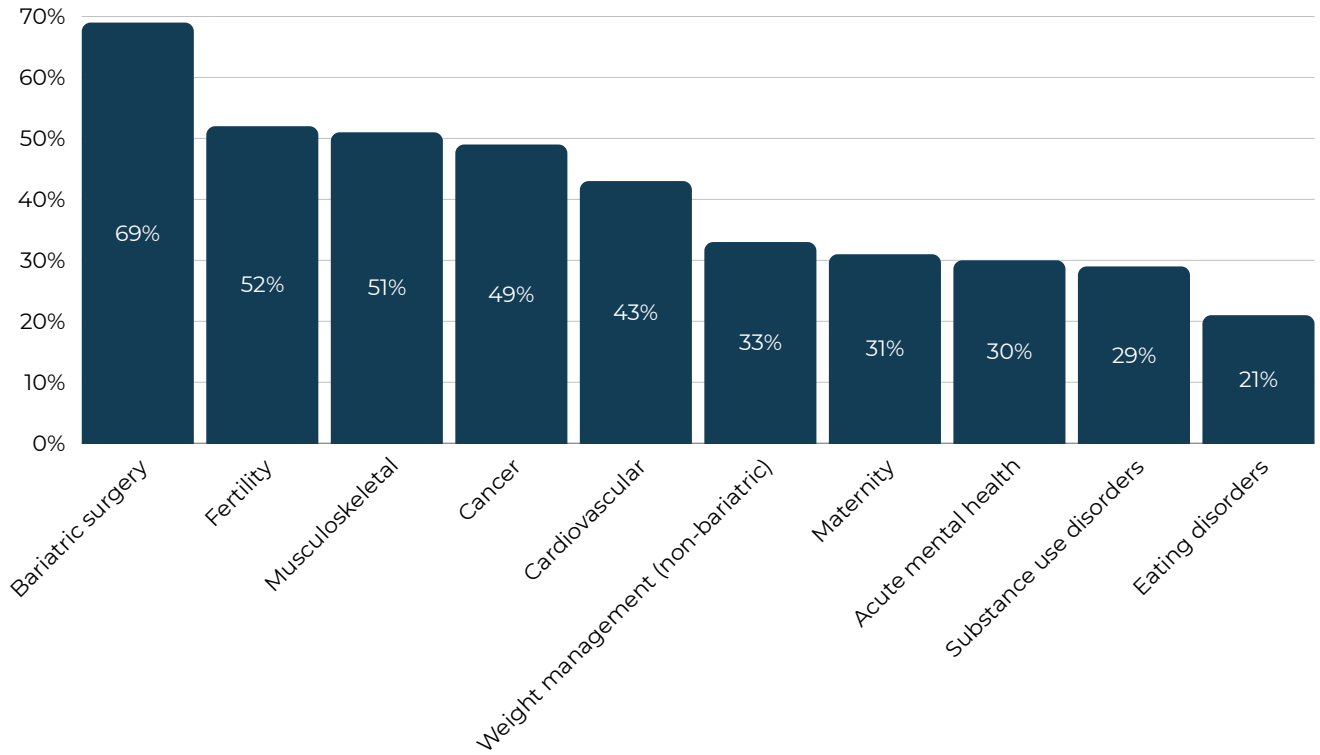
The Business Group on Health data show that employers are adopting solutions based on VBC principles and payment models, particularly in specialty care.

Figure 3: Employer Use of Various Delivery Reforms, 2025



Source: HCTTF adaptation of Business Group on Health data, 2025.

Figure 4: Employer Uptake of Centers of Excellence by Condition, 2025



Source: HCTTF adaptation of Business Group on Health data, 2025.

KFF also conducted an employer health benefits survey, which included smaller firms than the Business Group on Health survey (200 employees and up).[xi] While smaller employers were less likely to be invested in VBC, the KFF survey shared similar key findings as the BGH survey:

1. **COEs were being used among smaller employers.** Among the sampled employers with 200 or more employees, 19% used COEs, with higher adoption among larger firms. 26% of employers reimbursed employee travel expenses to use a COE. Larger firms were more likely to reimburse travel expenses for employees using COEs.
2. **Telehealth was a key strategy for employers.** 87% of employers believed that telehealth would be important in delivering care going forward, and 9% of all firms had added a new telehealth provider to their network in the past year.
3. **Employers included high-performance networks in their benefit design.** 20% of employers included high-performance networks in their benefit design, and 6% offered narrow network plans. In contrast, 54% indicated that they offered at least one plan with a very broad network.

In 2024, the National Alliance also conducted a survey to gauge employer health care trends, including VBC advancement.[xii] The National Alliance is comprised of employer and purchaser members who cover more than 45 million lives. Their most recent survey included 188 employers ranging from 1,000-50,000 employees. Survey findings reveal:

1. Employers who used a value-based formulary rather than rebates had about 3 times lower average spending.
2. Employers with tiered networks were twice as likely to experience lower costs.
3. Employers that engaged in direct contracting with providers were half as likely to experience lower costs.

These surveys signal a turning point in the commercial market's shift toward adopting alternative payment models. Despite using different strategies, small to large employers are increasing their uptake of value-based payment arrangements with continued interest in the coming years.

Barriers to Employer VBC Adoption

Despite recent gains, employer investment in VBC has historically been slow. Employers face several significant barriers to VBC adoption, as outlined in Figure 5.

Figure 5: Barriers to Employer Adoption of VBC

Barriers	Key Takeaways
Health care is not the business of the business	• Employers are generally focused on their core business rather than their role as health insurers. • Most employers rely on expensive benefit consultants and point solutions due to the complexities of the market.
Limited VBC expertise in Human Resources (HR)	• HR is often familiar with fee-for-service (FFS) but may not have experience with the complexities of VBC, which may include a member-based charge. • HR may be reticent to change health benefits to avoid disruption for employees.
Challenging business case	• Employers may mitigate rising health care costs by offsetting with slower salary growth. • There may be limited opportunities for employers to achieve returns on VBC investments, due to employee turnover and a relatively healthier and younger population compared to Medicare.
Less robust self-insured market	• Less market concentration exposes employers to higher financial risk. • This can be offset by pooling with other employers, but this also creates challenges.
Limited VBC standards	• VBC arrangements vary and span from pay-for-performance to total cost of care models. • There are limited guidelines for how to implement and standardize commercial VBC models.

Health Care is Not the Business of the Business

Employers are generally focused on their core business, which is why they hire benefit consultants, brokers, and point solutions to help them navigate the complexities of health insurance, including VBC options. Consultants and brokers sell insurance products and provide strategic guidance to employers as they assess which products best align with their goals and workforce needs. Point solutions are technology-enabled services and clinical offerings, often leveraging virtual care delivery pathways, that seek to improve health care quality and outcomes by addressing gaps in care, such as in chronic disease management, care coordination, and behavioral health. Benefit consultants often help employers integrate these point solutions for an add-on fee into their overall benefits strategy.

While these solutions can help drive employer uptake of VBC, they are costly, making them inaccessible to many small to medium-sized employers. Brokers are often paid between 2% to 8% of the premium paid by plans and employers, and benefit consultants are often paid between 0.5% and 2% of spending on health care services by employers.[xiii] These solutions can also further fragment the current system, making it more challenging for patients to navigate.

Limited VBC Expertise in Human Resources

HR leaders and staff may not have the resources necessary to manage the complexities of VBC and face competing priorities. Most employers are accustomed to evaluating health plans based on FFS rates, where decisions often revolve around unit costs and negotiated discounts. Transitioning to VBC requires a shift to evaluating provider performance, understanding risk-sharing arrangements, and prioritizing outcomes over volume. In addition, many point solutions require a member-based charge, which can be challenging for employers to evaluate, especially if they lack the expertise to measure the return on investment (ROI) or to compare costs across different solutions. Most HR teams do not have the resources needed to navigate this complexity.

Additionally, HR leaders and staff are responsible for employee recruitment and retention. HR may be hesitant to cause disruption to employee benefits that could negatively impact employee access to care and satisfaction. HR must balance the organization's financial and operational goals with the need to maintain a competitive and attractive workplace.

Challenging Business Case

While health care spending generally represents 5-7% of expenses, employers may mitigate rising health care costs by offsetting with slower salary growth.[xiv] Ultimately, employees face the brunt of higher health care spending by experiencing wage stagnation, although this may not be obvious to employees. As health care costs rise, employees also experience higher premiums and out-of-pocket costs,[xv] which increases the financial burden on patients while also potentially contributing to adverse selection for the plans.

Additionally, it may be hard for employers to realize short-term financial benefits from VBC, and they may not benefit from longer-term impacts. Most employees remain with an employer for an average of 3-4 years, which signifies higher plan turnover than Medicare but more stable than Medicaid.[xvi] This turnover makes it challenging for employers to realize savings in longer term outcomes relative to Medicare VBC models. In addition, employees and their dependents are relatively healthy compared to Medicare patients, making it harder to achieve savings than in an older population. Employers may not see an ROI for these programs if they don't positively impact employees until many years down the line.

Less Robust Self-Insured Market

Self-insured employers have fewer covered lives and less market concentration than larger insurers, which increases their exposure to financial risk. Without the ability to spread risk broadly, employers may not feel comfortable entering into downside risk arrangements. While some large employers have invested heavily in innovation, this may not be available to all self-insured employers.[xvii]

To mitigate this risk, some self-insured employers engage in risk-pooling, where multiple employers partner to form larger purchasing groups to share risk and reduce financial exposure. Pooling can also result in cost savings, because larger pools have greater bargaining power. However, pooling also results in aggregated data and outcomes across employers, making it more challenging for employers to set benchmarks and outcomes targeted to their unique population.

Limited VBC Standards

The commercial landscape remains highly heterogenous with no universally accepted standards guiding the structure or implementation of VBC arrangements. Employers engage in a range of payment arrangements, including pay-for-performance, episodes and condition-based incentives, and comprehensive total cost of care models, such as those described in previous HCTTF resources.[xviii] However, the Catalyst for Payment Reform (CPR) recently released national principles for value-based payment programs.[xix] CPR is also developing a recognition program that will validate health plans whose VBC models align with the best practices. Employers can then consider this information when selecting health plan partners.

New Price Transparency Regulations

New price transparency regulations may shift how employers comply with ERISA's fiduciary requirements. Fiduciary responsibilities require that employers must act in the best interest of plan members by assessing plan features upfront, including those related to cost and quality. Until recently, employers had limited information about the costs of services they contracted for.[xx] However, new legal requirements have increased the availability of price data, which may impact how employers comply with their fiduciary duties. In a recent KFF survey, about 63% of employers felt that price transparency would reduce health spending by either "a great deal" (13%) or "somewhat" (50%).[xxi]

There are three new price transparency requirements that impact employers:

1. **Federal price transparency requirements on hospitals and health plans:** Requires hospitals to publicly share standard charges and health plans to share beneficiary deductibles and out-of-pocket limits.[xxii, xxiii]
2. **The Consolidated Appropriations Act (CAA) of 2021's ban on gag clauses:** Allows employers to access their claims and payment rates.[xxiv]
3. **The CAA's service provider compensation disclosure requirement:** Reveals conflicts of interest for brokers, TPAs and Pharmacy Benefit Managers (PBMs).[xxv]

There are currently several lawsuits that contend employers have a fiduciary responsibility for ESI costs.[xxvi] These lawsuits suggest fiduciary failures on behalf of employers led to plan participants paying unnecessarily high health care costs. One lawsuit was recently dismissed because the court found that the plan participant did not incur higher health care costs, despite finding that the employer breached their fiduciary responsibilities.[xxvii] The other lawsuits are in progress, and their outcomes may impact how employers engage with the new price transparency data.

These lawsuits also allege breaches in employer's fiduciary duties related to prescription drug benefits and vendor selection process for PBMs.[xxviii] Plaintiffs state that these breaches have led to inflated prescription drug prices that have cost beneficiaries millions of dollars in higher payments for prescription drugs, premiums, and out-of-pocket costs.[xxix] As a result of the lawsuits, a few big employers are already changing their drug plans to better align with their fiduciary responsibilities.[xxx]

These new pressures may encourage employers to explore VBC as a health care cost saving mechanism, with price transparency data serving as a helpful baseline to evaluate potential savings over FFS payment models. However, as VBC becomes more prevalent in the market, price transparency data in its current form – which shows unit-based pricing – may become less relevant. Effective price transparency may look different in a health care system dominated by VBC.

KEY OPPORTUNITIES AND CHALLENGES

Patients, employers, payers, and providers hold different roles in advancing commercial VBC. Each of these stakeholder groups faces distinct opportunities and challenges (**Figure 6**). Understanding these dynamics is important for successful VBC adoption.

Figure 6: Opportunities and Challenges for Greater Commercial VBC Adoption

Stakeholder	Opportunities	Challenges
Patients	• Demand for greater affordability • Patient engagement with their own data	• Limited ability to shop for health care
Employers	• Direct contracting • Collective purchasing power • Price transparency • Individual Coverage Health Reimbursement Arrangement	• Limited market concentration • Short time horizon • Opposition to narrow networks • Data limitations • Broker limitations
Payers	• Telehealth • Networking strategies	• Risk adjustment • Benchmark rebasing • Employer contracting • Provider contracting • Claims processing
Providers	• Advanced primary care • Specialty care integration	• Limited risk-readiness for commercial arrangements • Quality measurement

Patients

Opportunities

Demand for Greater Affordability

Consumers are increasingly calling for greater affordability in the health care system. One poll found that 80% of respondents were dissatisfied with the cost of health care, and listed cost as the most urgent health problem facing the country.[xxxi] In 2024, commercially insured adults were significantly more likely to experience stress due to health care-related financial obligations, compared to those with Medicare or Medicaid.[xxxii]

This stress is explained by the fact that commercially insured patients often face extremely high out-of-pocket costs. In 2023, annual employee premium contributions for ESI single coverage ranged from an average of $4,142 to $8,232, and deductibles ranged from $1,059 to $2,616. Premium contributions and deductibles accounted for over 10% of median household incomes for those with family coverage. These costs don't account for additional out-of-pocket costs such as copayments and coinsurance that remain after deductibles are met.[xxxiii] Consumer demands for affordable care are driving employers to reevaluate traditional FFS models and explore VBC arrangements that focus on improving outcomes, care coordination, and cost containment.

Cost drives most patients' decision-making for their health care choices. If patients are presented with a VBC plan that significantly reduces premiums and deductibles, many will choose it. Incentives such as shared savings when patients select care below a reference price, or exempting high-value providers from deductibles in high-deductible health plans (HDHPs) can prompt meaningful engagement and health care decision making. However, these behaviors will only materialize if patients are presented with clearly designed programs that directly link better care to lower costs.

Patient Engagement with Their Own Data

New interoperability requirements make it easier for consumers to access their own health data and for providers to avoid wasteful, duplicative care and administrative complexity in sharing data. Primarily driven by the 2020 ONC Cures Act Final Rule, interoperability regulations seek to improve patient care and advance health care efficiency.[xxxiv] Health care organizations must develop Application Programming Interfaces (APIs) to comply with these interoperability regulations. APIs are a set of protocols that allow different systems to share data in a standardized way. Organizations can use APIs to connect patient health information from an electronic health record (EHR) to a health app or patient portal. Patients can then access these user-friendly interfaces to view their health data in real time. Greater interoperability also allows providers better access to patient data, which helps them make more informed clinical decisions.

Organizations can use APIs in a variety of ways to improve access to health data. For example, Apple has developed a Health Records API to allow patients access to their medical information, including medications and lab results, through an app on their iPhone.[xxxv] MyChart portals use EHR APIs to present patient health records and allow patients to message their providers. APIs also support remote monitoring by integrating information like vitals gathered through wearables into provider EHRs.[xxxvi] Greater access to health data may provide opportunities for patients to better understand and engage in their health care outcomes, as well as advocating for greater accountability from health care stakeholders to drive improvement.

Challenges

Limited Ability to Shop for Health Care

Despite the high cost of care, patients have limited control over what they spend on the care they choose to obtain. Very few health care services are “shoppable,” as defined by a patient’s ability to make choices about the care they receive in advance, based on cost and quality. Examples of shoppable services include knee and hip replacements and cholesterol tests. However, only about 30-40% of health spending consists of services that can be chosen in advance.[xxxvii] Additionally, cost and quality information is not always available to patients, and lack of competition in the market can limit patient choice.

Price transparency regulations have been largely ineffective at increasing consumer choice. Beginning in 2021, hospitals were required to publicly disclose their prices. However, as of November 2024, only 21% of hospitals were in full compliance with price transparency regulations.[xxxviii] Additionally, pricing and quality information is not always consumer friendly. One study found that while the use of price transparency tools did reduce spending by 14%, only 1% of enrollees used the tool to conduct a price search.[xxxvix] These tools often don't account for individual patients' copayments and deductibles, making them inactionable for patients.[xl] Policymakers have the opportunity to increase patients' access to more accurate and real-time cost estimates.

Engagement with Employers and Payers

Patients are generally not included by employers and payers that are designing and implementing VBC strategies. This creates barriers for patients, as they may not understand why changes are being made or have the chance to influence the design of the plans they are offered. This creates opportunities for employers and payers to better engage patients – both by seeking their input early on when exploring VBC arrangements and by creating feedback loops to receive input as programs are rolled out. Employers can use surveys, listening sessions, focus groups, and/or key informant interviews to understand what matters most to employees and dependents.

Employers

Opportunities

Direct Contracting

Due to recent spikes in health care costs, many employers are exploring alternatives to traditional health plans. Some are turning to direct contracting arrangements with health care providers. Direct contracting refers to arrangements made directly between self-insured employers and providers, effectively bypassing payers. These contracts allow employers to customize care delivery models, establish value-based arrangements, and improve price transparency. According to one survey of primarily self-insured employers, 75% of employers are already engaged in direct contracting, and an additional 41% reported they are likely to consider direct contracting arrangements by 2025.[xli]

Despite the momentum, direct contracting remains largely concentrated among large, self-insured employers. These organizations are better positioned to pursue direct contracting because their employee populations have sufficient volume and geographic concentration to make the effort to set up the arrangement worthwhile for both employers and providers. Employers with a larger employee population have stronger bargaining power, allowing them to negotiate more favorable rates, performance guarantees, and care coordination services. Additionally, large employers are more likely to have the infrastructure – such as benefits teams and data analytics – to manage provider negotiations and performance tracking. In contrast, smaller employers may lack the scale or administrative capacity to justify the investment.

Collective Purchasing Power

Employers provide health care for nearly half of Americans, making them well positioned to increase their purchasing power through collective action to shift market dynamics.[xlii] By pooling their employee populations, employers can create a larger risk pool and gain the leverage needed to negotiate more competitive rates, better coverage options, and higher quality care for their employees. The Catalyst for Payment Reform's blueprint for successful aggregated purchasing presents strategies for employers to create strong partnerships with providers and TPAs, develop a governance structure, and determine which models to consider for different markets.[xliii]

Several purchaser-led initiatives have shown successes, including a Wisconsin-based cooperative called the Alliance.[xliv] The Alliance was formed by seven self-insured employers who wanted increased access to their data, to make better decisions about how to utilize health care. Founding members set up a system to view claims and price them according to contracts negotiated with a provider network. The claims were then sent to TPAs to issue payments. The Alliance uses this greater visibility into their data to steer employees to high-value providers. One employer saved more than $3 million a year by steering employees to high-value musculoskeletal care and imaging. The Alliance also collectively negotiates rates as a percentage of Medicare reimbursement. The Alliance now consists of 300 employers across Wisconsin, ranging from 25 employees to over 5,000 employees.

Individual Coverage Health Reimbursement Arrangements

ICHRAs are employer-funded health plans that offer employees a fixed budget for purchasing a health insurance plan on the open market or through the Health Insurance Marketplaces.[xlv] Employers can either pay the premiums for the individuals under their plan directly, or employees submit their health insurance expenses for reimbursement up to an allocated amount determined by the employer. Since taking effect in 2020, ICHRAs have expanded quickly, growing by 30% from 2023 to 2024. However, the market remains small, covering about 500,000 lives in 2024.[xlvi]

For employers, the primary benefit of ICHRAs are the defined contribution amounts, which offer employers greater predictability in health care spending. This is particularly attractive to employers who face steeply rising health care costs. Additionally, ICHRAs are attractive to employers whose work force has diverse health care needs and preferences, as they allow employees greater flexibility in selecting a plan that best meets their preferences on provider choice, coverage options, and budget.[xlvii]

For employees, ICHRAs may limit affordability for employees over time, if the employer's defined contribution does not keep up with rising health care costs. Additionally, lower-wage employees may have to forgo federal subsidies on the Health Insurance Marketplace once their employer implements an ICHRA. Premiums on the marketplace can be 10-20% higher compared to group plans, adding to employee affordability concerns. In addition, plans purchased on the open market are also ineligible for federal subsidies.[xlviii] However, in some cases ICHRAs may provide continuity of coverage for employees even if their employment changes, because individuals have the option to retain their plan as long as they can afford the premiums.

ICHRAs also present an opportunity to advance VBC by allowing employees the opportunity to select plans on the individual market under larger payers with more resources and flexibility to implement VBC. ICHRAs may facilitate longer-term ROI on VBC because coverage is not tied to employment. Individuals may remain on a plan longer than a typical ESI plan because their coverage isn't automatically terminated resulting from a change in employment status. Additionally, even if an individual switches plans within ICHRA, they remain in the individual risk pool, which provides greater predictability and stability for the health system overall.

Price Transparency

New price transparency regulations can accelerate employers' cost containment efforts. One effort with major employers and health care purchasers found that those who are equipped with pricing data (1) negotiate more competitive health care service rates directly with providers, (2) design higher-value benefit plans and strengthen contractual terms with plans and providers, and (3) commission data-driven studies to reveal health care service price disparities.[xlix] The outcomes of the ongoing lawsuits on employers' fiduciary responsibilities may drive changes in how employers respond to patient calls for greater affordability.

Challenges

Limited Market Concentration

As previously noted, self-insured employers have fewer covered lives and less market concentration than larger insurers. With lower volume, an employer's health care spending only represents a small fraction of a provider's patient population. As a result, most self-insured employers cannot single-handedly drive provider investments in VBC infrastructure and care delivery redesign.

Even fully insured employers face issues related to small volume. While these employers purchase products through payers – which aggregate employee populations to increase volume – the employer itself is dependent upon the plans offered by the payer, which may not include robust VBC options.

Short Time Horizon

Investing in VBC is more likely to result in long-term savings, rather than short-term returns, which may limit employer investment. The focus of VBC on prevention, care coordination, and improving health outcomes reduces the need for costly interventions and hospitalizations over time. However, the average length of time that an employee remains with their employer is 3-4 years.[l] This may deter employers from investing in prevention and wellness programs that promise improved outcomes and costs over longer time frames.

Opposition to Narrow Networks

Many employers oppose narrow networks because it may cause friction with employees, impacting recruitment and retention. However, narrow networks are often a key tool for value-based arrangements, because they can be used to steer employees to select high-performing providers. Narrow networks can only drive value if (1) providers are selected based on their quality performance as well as cost, and (2) there are sufficient high-quality providers available in a given geography, which may be hard to achieve in many rural locations.

In contrast, payers may market broad networks more strongly to employers. Payers generally make higher margins on preferred provider organization (PPO) plans with wide networks, compared to health maintenance organization (HMO) plans with narrower networks. Because of their open network, PPO plans are harder to structure as value-based payment arrangements. Employers struggle to manage risk in PPO plans because the network is not limited to high-value providers.

Data Limitations

Employers often lack the data necessary to advance VBC and slow rising health care costs. When employers aren't equipped with the necessary data, it can limit their ability to influence hospital prices and act in the best interest of employees. Employers have highlighted several data-related areas in need of improvement (**Figure 7**).

Figure 7: Employer Data Limitations

Data Limitations	Key Takeaways
Price transparency	• Price transparency data files are often incomplete and lack standardization and include potential month-over-month variation in data feeds.[li] • Pharmaceutical pricing – one of the principal drivers of rising health care costs, especially for emerging cell and gene therapies – is often missing from price data.[lii] • TPAs maintain proprietary access to key data, limiting employer insights. • Multi-payer claims data often exclude self-insured populations, are expensive, and often lack standardization.[liii]
Interoperability	• Hospital cost and quality measures are not standardized, making it challenging for employers to compare outcomes across providers. • Interoperability and price transparency policies are largely focused on FFS. Clearer policy solutions are needed for increasing VBC uptake.
Benchmarks	• Employers generally lack benchmark data that would provide important insights into opportunities for improvement. • Employers' contracting decisions would benefit from data on how providers perform by region, specialty, and setting.
Data specificity	• The lag between data collection and availability to employers limits their ability to make informed purchasing decisions. • Neither payers nor providers have historically offered employers data that is tailored to their population.

In instances where health data are available to employers, they can be challenging to use. In many markets, data are not being shared with employers. Even when machine-readable files are available, they generally reflect a discount on the chargemaster rate (roughly analogous to a list price) rather than negotiated rates. Because data are not standardized, the information is time-consuming for employers to analyze. Missing information can also limit the usefulness of the data to inform employers' business decisions.[liv]

Broker Limitations

Employers rely on brokers to help them evaluate and select health plans. However, brokers don't always disclose their financial arrangements, such as commissions or bonuses tied to specific payers or plans. These incentives can create a conflict of interest, especially when they are not aligned with the fiduciary responsibilities of the employer, who is obligated to act in the best interest of their employees. Similar claims have been made against TPAs. Several lawsuits raise concerns that TPAs prioritize their own financial interests and obstruct employers' ability to oversee health plan spending and care quality.[lv]

Brokers typically have deep familiarity with traditional FFS models, where plans are evaluated primarily on network discounts and unit costs. As a result, they may lack the necessary expertise to navigate the intricacies of VBC. This knowledge gap can make it difficult for brokers to adequately assess or communicate the advantages or pitfalls of VBC arrangements. Additionally, because each plan structures their contracts differently, there is not a standardized way to communicate about value-based contracts. Each plan may use different metrics, methodologies, and performance benchmarks, making it difficult to compare options. Without a consistent framework to describe these arrangements, employers may struggle to make an informed decision, even with the help of a broker.

Payers

Opportunities

Telehealth

Telehealth can significantly enhance access to care for employees while also driving increased volume to a preferred provider network. By removing barriers to care such as travel time, time off work and caregiving, and transportation costs, telehealth makes it easier for employees to access care. This convenience prompts earlier intervention and greater engagement with care, which can lead to better health outcomes. Steering telehealth visits through a preferred provider or health system ensures that employees receive high-quality care while strengthening partnerships between payers, employers, and providers. Providers benefit from higher patient volume, and employers can leverage this volume to negotiate favorable rates and improve continuity of care across their employees.

Networking Strategies

Many payers are developing innovative benefit design strategies and payment models to address the rising cost of health care.[lvi] These alternative arrangements can drive savings while maintaining or even improving employee access to care. A few notable approaches are highlighted in **Figure 8**.

Figure 8: Payer Strategies for Containing Costs

Payer Strategies	Key Takeaways
Reference pricing	• Reference pricing is a cost containment strategy in which the payer sets a maximum payment limit (the reference price) for specific procedures or services, typically tied to a percentage of Medicare's reimbursement rates. • Providers who charge more than the reference price may leave patients responsible for the difference, incentivizing patients to seek out providers offering more affordable care. In 2021, Oregon's state employee health plan implemented reference pricing and saved more than $112 million.[lvii]
Tiered & narrow networks	• Tiered network plans categorize health care providers into performance-based tiers using criteria such as clinical outcomes, cost, and patient satisfaction. • Plans incentivize employees to choose higher-performing providers by offering reduced copays or deductibles when using providers in the top performing tier. One analysis found that total spending per member per quarter decreased 5% for enrollees in a tiered network.[lviii] • Similarly, narrow network plans limit coverage only to specified providers that can be selected based on cost and quality outcomes.
Multi-payer initiatives	• Multi-payer initiatives involve investment across multiple payers in a single value model with aligned financial incentives and shared quality measures. These initiatives make it easier for providers to deliver high-quality care while lowering administrative costs. • The California Advanced Primary Care Initiative is an example that is described in the Provider quality measurement section below.

Challenges

Risk Adjustment

Benchmarking presents a complex set of challenges for payers offering VBC in the commercial market. Risk adjustment is an essential issue that will determine whether benchmarks – and the financial targets they support – are accurate, fair, and sustainable. In the ESI market, low patient volumes can lead to significant annual cost variation. As a result, accurate risk adjustment becomes critical to ensuring that provider performance is evaluated based on patient acuity, rather than random fluctuations in cost. Inaccurate risk adjustment can skew performance evaluations, making providers appear either more or less efficient and effective than they truly are.

The need for benchmarks to accurately reflect clinical complexity is especially true for specialties that manage a mix of acute episodes and chronic conditions, such as oncology or cardiology, where cost variation can be driven by disease severity as well as the unpredictability of care pathways. To maintain provider credibility, benchmark methodologies must be transparent and reflect this clinical reality. Inaccurate benchmarks undermine provider engagement in value-based initiatives.

Benchmarking is particularly important in market segments like the Health Insurance Marketplace, where risk adjustment functions as a zero-sum game, with one plan's gain representing another's loss. Without careful oversight, the pressure to optimize risk scores may incentivize aggressive or inflated coding practices.

Benchmark Rebasing

Another challenge is the practice of rebasing benchmarks annually, which can undermine the long-term sustainability of VBC models. When providers are successful in reducing costs below the benchmark, their future benchmarks are often reset to reflect that lower spending. While this approach can restrict costs, it can also penalize high-performing providers by making it more difficult to achieve shared savings in subsequent years – essentially penalizing provider for previous improvements. This creates a disincentive for providers to invest in long-term efficiency and care transformation, as the benchmark becomes harder to achieve over time.

Employer Contracting

The lack of uniform start dates on employer benefit cycles also creates a barrier for payers implementing VBC. Unlike Medicare Advantage, which operates on a consistent calendar-year basis, commercial plans begin at various times throughout the year. This fragmentation complicates the administration of VBC contracts, particularly when it comes to tracking performance over time, aligning incentives, and managing quality benchmarks. The misalignment makes it more difficult for payers to apply standardized reporting and performance periods, which increases administrative burden.

Provider Contracting

Payers also face pressure from health systems when structuring VBC models in the commercial market. Commercial reimbursement is a profit center for both payers and providers. When health plans attempt to steer members into more cost-effective models, such as HMOs, they may face resistance from dominant health systems that wield significant market power. This tension can dissuade payers from aggressively pursuing provider accountability through pricing reforms. Instead, some plans may choose to manage costs by curbing enrollee utilization, rather than addressing underlying price growth through direct negotiations or risk-sharing arrangements.[lix] Additionally, as providers and employers increasingly collaborate on value-based payment arrangements, they may explore direct contracting arrangements, therefore bypassing traditional payer involvement. These pain points can hinder VBC adoption and limit payers' ability to drive meaningful change.

Claims Processing

Claims processing presents a significant challenge for payers seeking to implement VBC in the commercial market, because current systems are largely built around FFS models. These systems are designed to handle individual service-level transactions rather than bundled payments based on case rates, conditions, or episodes of care.[lx] As VBC requires more outcome-driven payment structures, the legacy FFS infrastructure lacks the flexibility to efficiently support these models. The complexity is further compounded when it comes to specialty care, where unique clinical pathways and performance metrics may necessitate customized incentive structures. This variability places additional strain on claims systems, making it difficult to automate and scale value-based arrangements across diverse provider networks.

Providers

Opportunities

Advanced Primary Care

Providers have a growing opportunity to lead value-based transformation through advanced primary care models. Advanced primary care increases access to care for patients by allowing for longer, more personalized visits, same-day and next-day appointments, and more expansive clinic hours with virtual options. By focusing on proactive, coordinated care that prioritizes prevention and chronic disease management, advanced primary care can significantly reduce avoidable hospitalizations and emergency department visits – some of the largest cost drivers in commercial populations. This approach not only improves patient outcomes but also positions providers to drive value-based transformation.

Some providers are also offering concierge medicine, in which patients or employers pay a subscription to receive advanced primary care. Providers may offer concierge medicine directly to patients or through an aggregator model. Several vendors have developed national networks of concierge-style primary care practices under aggregated subscription models, funded directly by employers. These models often include care management services that support patients across their health care journey. These models seek to replicate what payers have traditionally done, by aggregating employers on one side and aligning with high performing providers on the other. Depending on their structure, these models may function as technology platforms that enable care navigation and data sharing, or as network-focused models that direct patient volume toward provider organizations engaged in VBC. In either case, by participating in these networks, providers can expand their market share and participate in curated networks that are aligned around shared goals of improving quality and lowering costs. Primary care providers can also impact overall system spending by managing downstream referrals to high quality and cost-effective specialty groups.

Specialty Care Integration

Specialty care also represents a significant opportunity for providers to drive VBC adoption, particularly through models like COEs. COEs concentrate patient volume within a select group of high-performing specialty groups, which often include both physicians and multi-disciplinary care teams (e.g., physical therapists, dieticians, and behavioral health clinicians). These specialty groups benefit from the increase in volume, while employers and payers benefit from lower negotiated rates and better clinical outcomes. COEs often focus on either condition-based care such as comprehensive management of knee pain or episodic care like high-quality knee replacements. By centralizing care delivery and aligning incentives around outcomes and cost, COEs allow employers and payers to manage specialty expenditures more effectively while ensuring patients receive consistent evidence-based treatment. According to a recent Business Group on Health survey, COEs remain the most common value-based arrangement that employers invest in, highlighting their appeal as a scalable and impactful strategy.[lxi]

Beyond COEs, some specialty groups are beginning to assume financial risk for specific conditions or episodes of care. For example, organizations like Oshi Health assume financial accountability for all gastrointestinal-related spending. In 4 months, 92% of Oshi patients received symptom control, resulting in $10,202 total cost of care savings over a six-month period. Several other companies are optimizing specialty expenditure through VBC models in the Nephrology space, such as Strive Health, whose kidney care model has decreased hospitalizations by 49% and reduced readmissions by 29%, resulting in 20% savings in the total cost of care.[lxii]

While specialty VBC companies are on the rise, they face several operational hurdles, including the complexities related to coding, billing, and contracting with payers and employers under case rate arrangements.[lxiii] Additionally, many specialty-focused models are geared toward condition-based care rather than episodic interventions, and their scalability will depend on how quickly payers and self-insured employers are willing to invest in new models that hinge on prevention. Despite these challenges, specialty integration is a critical element in reducing the total cost of care and improving patient outcomes. The Task Force's specialty landscape paper provides a more in-depth assessment of the current specialty landscape and presents several industry examples.[lxiv]

Challenges

Limited Risk-Readiness for Commercial Arrangements

Not all providers are ready to take on commercial risk arrangements, even those with experience with Medicare and Medicare Advantage. Commercial contracts often involve different risk structures, performance metrics, and financial terms than Medicare, requiring different competencies in areas like contract negotiation, actuarial analysis, and patient engagement. Without the appropriate infrastructure, it may be challenging for providers to scale their VBC strategies to meet the demands of commercial payers and employer-sponsored plans. Additionally, because providers make greater margins on commercial fee-for-service rates, which help them to offset the cost of Medicaid and Medicare, they may be reticent to enter into VBC contracts.

There are several aspects of commercial arrangements that make them challenging to implement (**Figure 9**).

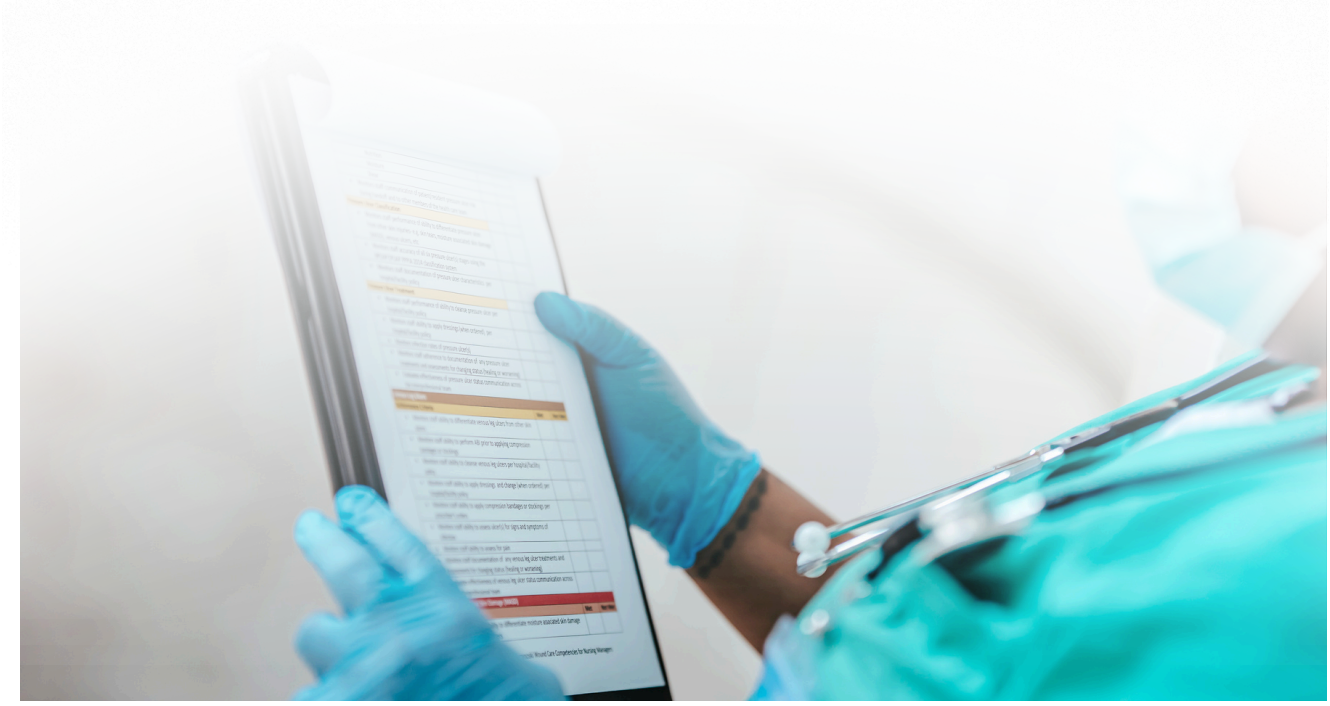
Figure 9: Provider Challenges to Implementing Commercial VBC Arrangements

Challenges	Key Takeaways
Smaller population size	Commercial VBC contracts often cover smaller cohorts than Traditional Medicare models, making providers less likely to invest in clinical care infrastructure tailored to the commercial population.
Higher member churn	Employees stay with their employer for 3-4 years on average.[lxiv] As a result, providers face bigger challenges in impacting long-term health outcomes and recoup investments in care delivery transformation. Providers' risk pools can change dramatically throughout the year as people switch employers.
Fewer opportunities for savings per enrollee	Because commercial enrollees tend to be healthier and have fewer chronic conditions than the Medicare population, it is harder for providers to achieve short-term savings. While short-term savings may still be possible, it's often targeted to specific sub populations and care patterns.
Lack of standardization across commercial plans	Wide variability in benefit design, quality metrics, and attribution methods creates challenges, especially to benchmarking. This is especially true when "buying down" premiums can lead to low benchmarks, or when there is no comparable benchmark population to fairly assess performance. In addition, the variation in quality measures between payers adds extensive reporting burden for providers.
Limited experience managing drug costs	Drug spending is a growing portion of total cost of care in the commercial sector, especially for emerging cell and gene therapies. Employers may want providers to take on risk for drug costs, but many providers aren't prepared to manage pharmacy benefits
Aggregated risk across lines of business	Managing risk across multiple payer types requires balancing different contract terms, performance metrics, and financial incentives, and can be challenging.
Revenue dependence on FFS rates	Higher commercial FFS rates are often used by providers to subsidize other lines of business. Taking on downside risk in the commercial space increases financial risk.

Quality Measurement

The lack of standardized quality measures across health plans is a major barrier for commercial payer adoption of VBC. Each payer defines and tracks quality in its own way, resulting in a highly fragmented system that places a disproportionate administrative burden on providers. This variation and the sheer volume of quality measures providers report on drives up reporting requirements and necessitates extensive education and onboarding efforts, particularly for practices working with multiple payers. The high administrative burden also diverts providers' time and resources away from direct patient care. Misaligned quality measures limit efforts to drive better outcomes and reduce costs.

Most states don't have mature multi-payer efforts, although there are some notable exceptions. For example, the California Advanced Primary Care Initiative is an effort led by Aetna, Blue Shield of California, and Health Net. The payers have invested in a single primary care model with aligned financial incentives and shared quality measures.[lxvi] The model combines capitation and fee-for-service with additional payments for population health management, which support services such as care coordination and analytics. There is a 15% performance incentive tied to includes eleven quality measures.[lxvii] Ultimately, the initiative seeks to bring together providers, health plans, and purchasers to drive high quality value-based primary care.



CALL TO ACTION

Patients, employers, payers, and providers can take collective action to advance commercial VBC to improve health outcomes and drive down costs. Shifting from FFS to VBC can benefit all stakeholders – employers can ensure healthier workforces, providers are supported in delivering high-quality care, payers can better manage costs, and patients receive more affordable, higher quality, and better coordinated care. This section offers actionable recommendations for stakeholders to drive commercial VBC adoption.

Figure 10: Actionable Recommendations to Drive Commercial VBC Adoption

Stakeholder	Reccomendations
Employers	1. Co-develop VBC strategies with providers, payers, and patients 2. Adopt narrow or tiered network plans 3. Create incentives for employees to use value-based providers 4. Demand broker accountability based on value, not volume
Payers	5. Create VBC solutions in collaboration with providers, employers, and patients 6. Implement multi-payer initiatives and streamline model elements 7. Partner with risk-bearing specialty groups 8. Streamline prior authorization policies 9. Share actionable data to support contracting and care decisions 10. Provide tools to help patients identify high-quality providers
Providers	11. Implement risk-based contracts across payers 12. Partner with risk-bearing specialty groups
Patients	13. Where available, use tools to seek care from high-quality providers 14. Where available, select health plans that prioritize high-quality providers

Employers

1. **Co-develop VBC strategies with providers, payers, and patients:** Employers should partner with providers, payers, and patients (employees and dependents) to develop VBC strategies that align the interests of all stakeholders. These stakeholders should openly discuss their goals for implementing VBC strategies, including aligning models with patient priorities, and consider challenges that may arise. Stakeholders should work together to develop financial models that are transparent to all parties. Fully insured employers should consider opportunities to increase purchasing power by joining VBC plans that include other employers. Self-insured employers should consider aligning their metrics with existing VBC arrangements. The largest self-insured employers can consider sophisticated options like direct contracting with providers.

2. **Adopt narrow or tiered network plans:** Employers should adopt networks that guide employees toward high-performing providers through narrow and tiered network plans (where allowed by law). To successfully implement these plans, employers must also invest in employee education and communication strategies to convey their alignment with patient priorities, including improved health outcomes and lower out-of-pocket costs.

3. **Create incentives for employees to use value-based providers:** Employers can influence employee decision making by creating meaningful incentives that steer employees toward value-based providers. Examples of incentives include lower premiums for value-based care plans, reduced cost-sharing for employees who see preferred providers, or coverage for travel expenses for employees using a COE. Employers can also collaborate with payers to embed these incentives into plan design.

4. **Demand broker accountability based on value, not volume:** Employers must shift how they evaluate and engage with benefit consultants and brokers by demanding transparent assessments based on total cost of care, quality outcomes, and provider performance. Holding brokers accountable to these standards fosters a more transparent, performance-driven market.

Payers

5. **Create VBC solutions in collaboration with employers, providers, and patients:** Payers can co-develop value-based solutions in collaboration with employers, providers, and patients. Stakeholders can collaborate on elements such as plan design, high performance networks, and innovative value-based payment arrangements. Engaging patients will ensure that models align with patient priorities from the outset. By pooling multiple employers in a defined geography, payers can create larger risk pools that enhance purchasing power when negotiating with providers. Payers must also partner with primary care physicians to communicate the ROI to both employers and patients to drive engagement. Additionally, payers should ensure that benchmarks are actuarily sound and should align start dates to make the reconciliation process more efficient.

6. **Implement multi-payer initiatives and streamline model elements:** Payers should collaborate with other payers and implement multi-payer initiatives to advance model efficiencies in benefit design, quality metrics, and attribution methods. Payers should also standardize measure definition and data governance to ensure scalability of technology investments. While most states do not have existing multi-payer initiatives, many continue to pursue this goal and payers should engage in this work.

7. **Partner with risk-bearing specialty groups:** Payers should actively engage specialists who are willing to accept financial risk for delivering high-quality, evidence-based care. Payers can support these providers by including them in networks and by collaboratively developing payment mechanisms for case rates and/or condition-based payments. In addition, by incorporating telehealth-first providers in network, payers can further increase access to care for patients. Payers should also invest in clear attribution models, especially as VBC expands to specialists.

8. **Streamline prior authorization policies:** Payers can reduce administrative burden for providers by streamlining or waiving prior authorization requirements, especially for providers in higher risk arrangements. By streamlining prior authorization policies for providers in VBC arrangements, payers can use this as an incentive to encourage providers to join commercial VBC models, expanding access to VBC for employers. The Task Force's prior authorization principles call for prior authorization policies to be collaborative, safe, transparent, patient-centered, and expedient.[lxviii]

9. **Share actionable data to support contracting and care decisions:** Payers should routinely share comprehensive data on the total cost of care – including medical and pharmaceutical spend – as well as metrics on quality measures, clinical outcomes, and patient experience and outcomes. By sharing this information, payers can empower employers and providers to make informed decisions when designing and negotiating contracts.

10. **Provide tools to help patients identify high-quality providers:** Payers should offer patient-facing tools that rate providers on clinical quality, patient experience, and cost efficiency. Payers should also offer navigators to help patients select providers who are aligned with VBC principles to improve their care experience, particularly for elective procedures.

Providers

11. **Implement risk-based contracts across payers:** Providers should increase their engagement in VBC models, including those with financial risk, to align their practice's incentives around improving quality across all patient populations. To succeed in these arrangements, providers must either build or buy the infrastructure necessary to track, document, and report on key performance indicators including clinical outcomes, cost and utilization metrics, and patient experience.

12. **Partner with risk-bearing specialty groups:** Providers in risk-bearing arrangements should partner with high-quality specialist groups that are also willing to bear risk for delivering high-quality outcomes. These partnerships enable more coordinated, patient-centered care, especially for patients with complex needs. In cases where risk-bearing specialists are not available for a given specialty or market, providers can instead focus on referring patients to high-quality specialists and referral pathways. When selecting specialty partners, providers should assess not only clinical quality and outcomes but also a provider's readiness to participate in case rates, condition-based payments, and/or bundled payment arrangements. The Task Force's specialty integration paper can help providers explore considerations for taking on risk based on specialty and payment arrangements.[lxix]

Patients

We recognize that the availability of tools to advance patient choice are limited and imperfect. In instances where they are available, patients should use them to make informed decisions about their health plan and providers.

13. **Where available, use tools to seek care from high-quality providers:** Some health plans, employers, and third-party platforms offer tools that rate providers on clinical quality, patient experience, and cost efficiency. If these resources are available, patients should use these sources to select providers who are aligned with VBC principles to improve their care experience, particularly for elective procedures.

14. **Where available, select health plans that prioritize high-quality providers:** There are many barriers to patient choice of health insurance plans, since this assumes that patients have multiple plans to choose from, have information on provider availability and quality, and can afford the available options. However, to the extent that patients can make an informed choice, they should prioritize plans that include high-quality providers – such as practices offering advanced primary care or ACO networks – in selecting their ESI plans or purchasing plans on the Health Insurance Marketplace. For most patients, out-of-pocket costs remain a top concern, and high-value networks may allow patients to optimize both cost and quality. Narrow network and tiered plans often include providers who deliver effective, patient-centered care. These plans may also include lower costs for patients, both in terms of premiums and other out-of-pocket costs like deductibles, co-pays, and co-insurance. The plans may also emphasize prevention, care coordination, and better health outcomes, which can also reduce avoidable medical expenses in the long run.

LOOKING FORWARD

As health care costs continue to climb and patients demand more affordable high-quality care, employers are increasingly motivated to pursue alternative payment models and drive care delivery transformation. However, meaningful progress requires coordinated action across the entire health care ecosystem – including patients, employers, payers, and providers. The insights in this report are intended to help organizations better understand the barriers, opportunities, and actionable steps to accelerate the shift toward a more efficient and person-centered health care system. We call on all stakeholders to drive VBC adoption in the commercial market to increase access to high-quality, affordable health care.

Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.

ACKNOWLEDGEMENTS

HCTTF wishes to acknowledge and thank the following strike group participants for their significant contributions to this resource.

Sean Cavanaugh
Aledade

Daniel Green
Blue Cross Blue Shield of Massachusetts

Jason Hover
Blue Cross Blue Shield of Michigan

Ryan Mahoney
Blue Cross Blue Shield of North Carolina

Chip Howard
Cambia Health Solutions

Heather Laffin
Elevance

Rich Lipeles
Heritage Provider Network

Andy Marino
Honest Medical Group

Rakshay Jain
Innovaccer

Andrea Seykora
Kaiser Permanente

Nathan Paulsen
Oshi Health

Bryan Smith
Premier, Inc.

Sam Holliday
Oshi Health

Kara Hawkin
Sentara Health

Jessica Gubing
UAW Retiree Medical Benefits Trust

Heather Schultz
Washington State Healthcare Authority

REFERENCES

i. Kaiser Family Foundation (2024). 2024 Employer Health Benefits Survey. https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/ (accessed 3/28/25).
ii. Kaiser Family Foundation (2024). 2024 Employer Health Benefits Survey. https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/ (accessed 3/28/25).
iii. RAND (2024). Prices Paid to Hospitals by Private Health Plans. https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html (accessed 3/28/25)
iv. Milliman (2025). 2025 Milliman Medical Index. https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/2025-Milliman-Medical-Index.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top (accessed 6/4/25).
v. Virtue Alliance (2024). Why Mid-Size Employers are Moving to Self-Funding in 2024. https://virtuealliance.com/insights/why-mid-size-employers-are-moving-to-self-funding-in-2024/?utm_source=Linkedin%20VH&utm_medium=Social%20Media&utm_campaign=Why%20Mid%20Size%20Employers%20are%20Moving%20to%20Self%20Funding%20in%202024&utm_term&utm_content=Newsletter (accessed 6/5/25).
vi. Kaiser Family Foundation (2024). Employer Health Benefits Annual Survey. https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf (accessed 4/21/25).
vii. Health Care Payment Learning & Action Network (2024). 2024 Measurement Effort. https://hcp-lan.org/wp-content/uploads/2024/11/2024-APM-Infographic.pdf (accessed 4/21/25).
viii. Brighton Health Plan Solutions (2024). What Employers want from Direct Provider Health Plan Contracts. https://brightonhps.com/wp-content/uploads/2024/08/What-Employers-Want-from-Direct-Provider-Health-Plan-Contracts.pdf (accessed 4/30/25)
ix. Milken Institute (2024). Reimagining the Future of Employer-Sponsored Health Care to Drive Value: Survey Insights. https://milkeninstitute.org/content-hub/research-and-reports/reports/reimagining-future-employer-sponsored-health-care-drive-value-survey-insights (accessed 4/30/25).
x. Business Group on Health (2025). Value-Based Purchasing Employer Guide: Executive Summary. https://www.businessgrouphealth.org/Resources/Value-based-Purchasing-Employer-Guide-Executive-Summary (accessed 4/11/25).
xi. Kaiser Family Foundation (2024). 2024 Employer Health Benefits Survey. https://www.kff.org/report-section/ehbs-2024-section-13-employer-practices-provider-networks-coverage-for-glp-1s-abortion-and-family-building-benefits/(accessed 4/11/25).
xii. National Alliance of Healthcare Purchaser Coalitions (2024). National Alliance Survey Reveals Employers Using Innovative Payment Approaches Experienced Lower Healthcare Costs. Gerhardt, G. and Burton, R. (2022). Integrating Episode-Based Payment with Population-Based Payment. Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2021/10/APMs-episodes-MedPAC-March-2022.pdf (accessed 9/17/24). (accessed 4/11/25).
xiii. Health Affairs (2025). Implications of the Health Care System's Design for Administrative Costs. https://www.healthaffairs.org/content/forefront/implications-health-care-system-s-design-administrative-costs (accessed 4/10/25).
xiv. Union Healthcare Insight (2025). Employer Healthcare Spending in 2025: Why it's Likely to Accelerate https://www.unionhealthcareinsight.com/post/why-employer-healthcare-spending-in-2025-is-expected-to-accelerate (accessed 5/2/25).
xv. Milliman (2025). 2025 Milliman Medical Index. https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2025-Articles/2025-Milliman-Medical-Index.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top (accessed 6/4/25).

xvi. Bureau of Labor Statistics (2024). https://www.bls.gov/news.release/pdf/tenure.pdf Employee Tenure in 2024. (accessed 5/2/25).

xvii. Business Group on Health (2024). Employers Driving Change Now and Into the Future. https://www.businessgrouphealth.org/en/Resources/Employers-Driving-Change-Now-and-Into-Future (accessed 6/4/25).

xviii. Health Care Transformation Task Force (2024). The Next Frontier: Specialty Integration in Value-Based Care. https://hcttf.org/the-next-frontier-specialty-integration-in-value-based-care/ (accessed 6/4/25).

xix. Catalyst for Payment Reform (2025). First-Ever National Principles for Value-Based Payment. https://www.catalyze.org/first-ever-national-principles-for-value-based-payment/ (accessed 6/4/25).

xx. Health Affairs (2023). ERISA Fiduciary Duties: An Old Dog with New Tricks? https://www.healthaffairs.org/content/forefront/erisa-fiduciary-duties-old-dog-new-tricks (accessed 4/21/25).

xxi. Kaiser Family Foundation (2024). 2024 Employer Health Benefits Survey. https://www.kff.org/report-section/ehbs-2024-section-13-employer-practices-provider-networks-coverage-for-glp-1s-abortion-and-family-building-benefits/ (accessed 4/30/25).

xxii. Federal Register (2025). Hospital Price Transparency. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-E/part-180#180.40 (accessed 4/21/25).

xxiii. Federal Register (2025). Transparency in Coverage – Definitions. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-147/section-147.210 (accessed 4/21/25).

xxiv. CMS. Gag Clause Prohibition Compliance Attestation. CMS. Gag Clause Prohibition Compliance Attestation. csca (accessed 4/21/25) (accessed 4/21/25).

xxv. U.S. Department of Labor (2021). Field Assistance Bulletin No. 2021-03. https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2021-03 (accessed 4/21/25).

xxvi. Modern Healthcare. (2024). New Pricing Data Fuel Employer Lawsuits Against Aetna. https://www.modernhealthcare.com/legal/price-transparency-aetna-lawsuit-health-plan-costs (accessed 4/30/25).

xxvii. Employers Health Co. (2025). Johnson & Johnson Lawsuit – An Update for Employers. https://www.employershealthco.com/resource-center/articles/johnson-and-johnson-lawsuit-an-update-for-employers/ (accessed 4/30/25).

xxviii. KFF Health News (2024). How a Duty to Spend Wisely on Worker Benefits Could Loosen PBMs' Grip on Drug Prices. https://kffhealthnews.org/news/article/pbms-pharmacy-benefit-managers-erisa-lawsuit-mark-cuban-cost-plus/ (accessed 4/21/25)

xxix. PLANSPONSOR (2025). JPMorgan Sued Over Cost of Generic Drugs in Health Plan. https://www.plansponsor.com/jpmorgan-sued-over-cost-of-generic-drugs-in-health-plan/ (accessed 4/21/25).

xxx. KFF Health News (2024). How a Duty to Spend Wisely on Worker Benefits Could Loosen PBMs' Grip on Drug Prices. https://kffhealthnews.org/news/article/pbms-pharmacy-benefit-managers-erisa-lawsuit-mark-cuban-cost-plus/ (accessed 4/21/25).

xxxi. Gallup (2024). View of U.S. Healthcare Quality Declines to 24-Year Low. https://news.gallup.com/poll/654044/view-healthcare-quality-declines-year-low.aspx (accessed 4/8/25).

xxxii. PAN Foundation (2025). Insured Adults want Policy Action in 2025 on Healthcare Coverage and Costs Amid Rising Financial Stress, New Polling Finds. https://www.panfoundation.org/insured-adults-want-policy-action-in-2025-on-healthcare-coverage-and-costs-amid-rising-financial-stress-new-polling-finds/ (accessed 4/8/25).

xxxiii. Commonwealth Fund (2025). How Affordable is Job-Based Health Coverage for Workers? https://www.commonwealthfund.org/blog/2025/how-affordable-job-based-health-coverage-workers?utm_source=Linkedin&utm_medium=social&utm_campaign=Achieving+Universal+Coverage (accessed 4/8/25).

xxxiv. Federal Register (2020). 21st Century Cures Act. https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification (accessed 4/21/25).

xxxv. Apple (2018). Apple Opens Health Records API to Developers. https://www.apple.com/newsroom/2018/06/apple-opens-health-records-api-to-developers/ (accessed 5/2/25)

xxxvi. Marketing Scoop (2024). Healthcare APIs in 2025: Top 7 Use Cases & Case Studies. https://www.marketingscoop.com/ai/healthcare-api/ (accessed 4/30/25).

xxxvii. Kaiser Family Foundation (2021). Price Transparency and Variation in U.S. Health Services. https://www.healthsystemtracker.org/brief/price-transparency-and-variation-in-u-s-health-services/#Average%20allowed%20charges%20for%20office-based%20lower%20back%20MRIs%20in%20large%20employer%20plans,%20by%20MSA,%202018 (accessed 4/10/25).

xxxviii. Patient Rights Advocate (2024). The Seventh Semi-Annual Hospital Price Transparency Compliance Report. https://www.patientrightsadvocate.org/seventh-semi-annual-hospital-price-transparency-report-november-2024 (accessed 4/10/25).

xxxix. Health Affairs (2017. Offering a Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1636 (accessed 4/10/25).

xl. AMA Journal of Ethics (2020). What Should "Shopping" Look Like in Actual Practice? https://journalofethics.ama-assn.org/article/what-should-shopping-look-actual-practice/2022-11 (accessed 4/10/25).

xli. Brighton Health Plan Solutions (2024). What Employers want from Direct Provider Health Plan Contracts. https://brightonhps.com/wp-content/uploads/2024/08/What-Employers-Want-from-Direct-Provider-Health-Plan-Contracts.pdf (accessed 4/14/25).

xlii. Health Affairs (2024). Empowering Employer Purchasers: Recommendations to Support Market Transparency and Health System Performance. https://www.healthaffairs.org/content/forefront/empowering-employer-purchasers-recommendations-support-market-transparency-and-health (accessed 4/14/25).

xliii. Catalyst for Payment Reform (2021). Aggregated Purchasing of Health Care Services: Lessons Learned and Blueprints for Success. https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2021/05/Full-Report-Aggregated-Purchasing_Published_May-2021-fljkrq.pdf (accessed 4/11/25).

xliv. The Commonwealth Fund (2022). Tackling High Health Care Prices: A Look at Four Purchaser-Led Efforts. https://www.commonwealthfund.org/publications/2022/apr/tackling-high-health-care-prices-look-four-purchaser-led-efforts (accessed 4/11/25).

xlv. Cass, L. (2024) A New Horizon in Health Care: How ICHRAs Could Transform American Health Insurance. https://laurencecass.substack.com/p/a-new-horizon-in-health-care-how (accessed 4/30/25).

xlvi. Redesign Health (2025). ICHRA Reality Check: Exploring the Good, the Bad, and the Road to Scale. https://www.redesignhealth.com/insights/ichra-reality-check-exploring-the-good-the-bad-and-the-road-to-scale (accessed 4/11/25).

xlvii. Laurence Cass (2022). A New Horizon in Health Care: How ICHRAs Could Transform American Health Insurance. https://laurencecass.substack.com/p/a-new-horizon-in-health-care-how (accessed 4/11/25).

xlviii. HealthCare.gov. Private Plans outside the Marketplace Outside Open Enrollment. https://www.healthcare.gov/private-plan-exceptions-outside-open-enrollment/ (accessed 5/2/25).

xlix. Health Affairs (2024). Empowering Employer Purchasers: Recommendations to Support Market Transparency and Health System Performance. https://www.healthaffairs.org/content/forefront/empowering-employer-purchasers-recommendations-support-market-transparency-and-health (accessed 4/8/25).

l. Bureau of Labor Statistics (2024). https://www.bls.gov/news.release/pdf/tenure.pdf Employee Tenure in 2024. (accessed 5/2/25).
li. Patient Rights Advocate (2024). The Seventh Semi-Annual Hospital Price Transparency Compliance Report. https://www.patientrightsadvocate.org/seventh-semi-annual-hospital-price-transparency-report-november-2024 (accessed 4/10/25).
lii. Journal of Managed Care + Specialty Pharmacy (2025). Limited Utility of Price Transparency Data for Drugs. https://www.jmcp.org/doi/10.18553/jmcp.2025.31.4.338 (accessed 4/30/25).
liii. Health Affairs (2024). Empowering Employer Purchasers: Recommendations to Support Market Transparency and Health System Performance. https://www.healthaffairs.org/content/forefront/empowering-employer-purchasers-recommendations-support-market-transparency-and-health (accessed 4/30/25).
liv. Health Affairs (2024). Empowering Employer Purchasers: Recommendations to Support Market Transparency and Health System Performance. https://www.healthaffairs.org/content/forefront/empowering-employer-purchasers-recommendations-support-market-transparency-and-health (accessed 4/14/25).
lv. Health Affairs (2025). Third-Party Administrators – the Middlemen of Self-Funded Health Insurance. https://www.healthaffairs.org/content/forefront/third-party-administrators-middlemen-self-funded-health-insurance (accessed 5/21/25).
lvi. Health Affairs (2024). In an Era of Premium and Provider Price Increases, State Employee Health Plans Target Key Cost Drivers. https://www.healthaffairs.org/content/forefront/era-premium-and-provider-price-increases-state-employee-health-plans-target-key-cost (accessed 4/14/25).
lvii. Health Affairs (2024). In an Era of Premium and Provider Price Increases, State Employee Health Plans Target Key Cost Drivers. https://www.healthaffairs.org/content/forefront/era-premium-and-provider-price-increases-state-employee-health-plans-target-key-cost (accessed 4/14/25).
lviii. Commonwealth Fund (2017). Enrollment in a Health Plan with a Tiered Provider Network Decreased Medical Spending by 5 Percent. https://www.commonwealthfund.org/publications/journal-article/2017/may/enrollment-health-plan-tiered-provider-network-decreased (accessed 4/30/25).
lix. Health Affairs (2024). In an Era of Premium and Provider Price Increases, State Employee Health Plans Target Key Cost Drivers. https://www.healthaffairs.org/content/forefront/era-premium-and-provider-price-increases-state-employee-health-plans-target-key-cost (accessed 4/14/25).
lx. Harry M, Berk J, Fendrick AM (2025). Episode-Based Cost Sharing. VBID Health. https://vbidhealth.com/wp-content/uploads/2025/06/Episode-Based-Cost-Sharing.pdf (accessed 6/11/25).
lxi. Business Group on Health (2025). Value-Based Purchasing Employer Guide: Executive Summary. https://www.businessgrouphealth.org/Resources/Value-based-Purchasing-Employer-Guide-Executive-Summary (accessed 4/11/25).
lxii. Health Care Transformation Task Force (2024). The Next Frontier: Specialty Integration in Value-Based Care https://hcttf.org/the-next-frontier-specialty-integration-in-value-based-care/ (accessed 4/16/25).
lxiii. Harry M, Berk J, Fendrick AM (2025). Episode-Based Cost Sharing. VBID Health. https://vbidhealth.com/wp-content/uploads/2025/06/Episode-Based-Cost-Sharing.pdf (accessed 6/11/25).
lxiv. Health Care Transformation Task Force (2024). The Next Frontier: Specialty Integration in Value-Based Care https://hcttf.org/the-next-frontier-specialty-integration-in-value-based-care/ (accessed 4/16/25).
lxv. Bureau of Labor Statistics (2024). https://www.bls.gov/news.release/pdf/tenure.pdf Employee Tenure in 2024. (accessed 5/2/25).
lxvi. California Quality Collaborative. California Advanced Primary Care Initiative. https://www.calquality.org/initiative/ca-advanced-primary-care-initiative/ (accessed 4/16/25).
lxvii. Purchaser Business Group on Health (2025). Common Value-Based Payment Model Guide for Primary Care Physicians & Payers. https://www.calquality.org/wp-content/uploads/2024/11/CQC_CAPCI_Guide_November_2024.pdf (accessed 4/16/25).

lxviii. Health Care Transformation Task Force (2023). Principles for Prior Authorization Policies in Value-Based Care Arrangements. https://hcttf.org/prior-authorization-principles/ (accessed 4/18/25).
lxix. Health Care Transformation Task Force (2024). The Next Frontier: Specialty Integration in Value-Based Care. https://hcttf.org/the-next-frontier-specialty-integration-in-value-based-care/ (accessed 4/18/25).