2025 strategic outlook: Five key areas to drive health plan success

HealthScape Advisors

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Each year, we delve into the complex landscape in which health plans operate, identifying and distilling the most pressing themes and actions to prioritize. This year, many health plans are taking an especially critical lens to the consumer experience and how well consumers believe their coverage and services are addressing their healthcare needs.

Health plans enter 2025 against the backdrop of vocal consumer scrutiny, potential policy changes stemming from the elections, and the constant forces of innovation and disruption.

Other macro-trends will also materially impact the way our industry serves members. Artificial intelligence (AI) adoption is a particularly important one. While estimates vary widely across sources, AI tools could contribute $5–$10 trillion in productivity gains to our economy by 2030, some of which will come through disruption of health payer assets.

The relentless pursuit of cutting-edge technologies and complex value-based contracts has often overshadowed the importance of operational excellence. As a result, many health plans find themselves grappling with inefficiencies, rising costs, and declining member satisfaction.

As healthcare continues to evolve, we're seeing a cyclical trend in which certain strategies once considered outdated are making a comeback. In 2025, this presents a unique opportunity for health plans to revisit foundational strategies, modernize them for the new age, and leverage the best of both old and new approaches.

In considering the health plan outlook for the new year, we remain focused on helping health plans provide the access, services, affordability, quality of care, and experiences their members are seeking.

This report examines five key areas in which health plans can upgrade strategies to drive long-term success:

1. Redefining the commercial market: Employer-sponsored business is no longer running on autopilot
   Product innovation and an evolving competitive landscape are changing the dynamics of employer-sponsored healthcare. Health plans must explore new operating models to deliver alternative products and compete in a sustainable manner at scale.

2. Headwinds in the Medicare Advantage market have intensified into a "perfect storm"
   The Medicare Advantage (MA) market faces regulatory pressures, slowing growth trends, provider network instability, and rising costs. Consequently, health plans must focus on sustainable profitability and improving retention strategies over pure growth plays.

3. Evolution of the duals landscape necessitates integration across Medicare and Medicaid operating models
   The dual-eligible beneficiary landscape is evolving as new Centers for Medicare & Medicaid Services (CMS) regulations require greater integration between Medicare and Medicaid, urging plans to adopt flexible operating models, strengthen provider partnerships, and address social drivers of health (also known as "social determinants of health" or SDOH.)

4. The future of value-based care: Strategic approaches empower providers and elevate outcomes
   As value-based care (VBC) has fallen short of expectations, health plans struggle to justify investments and demonstrate value. To address this, plans must leverage AI-driven analytics to improve provider enablement and adopt a disciplined approach to VBC program management.

5. Old school payment integrity operational levers need to modernize
   The traditional payment integrity (PI) approach, focused on aggressive cost savings, is unsustainable and strains plan-provider relationships. To modernize PI, health plans must leverage advanced technologies to shift focus to cost avoidance and regain control of core processes.

1. Redefining the commercial market: Employer-sponsored business is no longer running on autopilot

While enrollment growth in employer group plans stagnated over the last 10 years, health plans largely focused on government programs segments (especially Medicare Advantage) as a driver of growth and margin. At the same time, plans' top-line revenue in the commercial segment continued to erode in the ongoing shift to self-funded arrangements. Third-party administrators (TPAs), point solution vendors, and new entrants brought product innovation that disintermediated health plans and further disrupted traditional profit pools.

Given financial headwinds and market activity driven by new products (e.g., ICHRAs, alternative health plans), plans require a strategic refocus on the commercial market. Incremental product, pricing, and capability investments will no longer enable health plans to sustain commercial lines of business—let alone grow in them. As such, health plans can no longer afford to "ignore" the commercial segment. They need to explore key changes to their commercial strategies.

↗ PRODUCT PORTFOLIO EVOLUTION

Employers are seeking more control over costs and options that meet their employees' budget and healthcare needs. Consequently, they are increasingly looking for alternatives to traditional fully insured and self-funded arrangements. A wide range of alternative products and funding arrangements have emerged to meet these needs, including HRA-based solutions (ICHRA, QSEHRA[1]), level-funding, innovative benefits (e.g., zero-dollar deductible and copay plans like Surest and Coupe), risk aggregators (e.g., Professional Employer Organizations (PEOs), Multi-Employer Welfare Arrangements [MEWAs]), and direct contracting arrangements.

Some health plans have already successfully introduced alternative products, often through partnership or acquisition. Their peers need to act quickly to defend market share in their own markets. While launching new products can be appealing, the degree and breadth of change in the commercial market requires health plans to fundamentally revisit their product strategy and weigh the impacts of additional risk pool shifts, new product margin profiles, new competitive dynamics, and expanded member choice (e.g., ICHRAs).

1. ICHRA = Individual Coverage Health Reimbursement Arrangement
   QSEHRA = Qualified Employer Health Reimbursement Arrangements

STRATEGIES FOR PRODUCT GROWTH

ICHRAs, for example, are one of the fastest growing alternative products in the commercial landscape, achieving a 139% CAGR in enrollment from 2020 to 2024. Plans have recognized the potential of ICHRAs and are forming partnerships with ICHRA administrators to tap into this growing market. For example, Centene has partnered with Take Command, and Blue Cross and Blue Shield of Nebraska has partnered with Bavvy.

In these cases, the ICHRA administrator provides a technology platform that enables plan shopping, selection, and back-end funding capabilities while the health plan provides access to their customer base and brand. While these partnerships offer opportunities for growth, the long-term sustainability of such arrangements remains uncertain. For health plans, bringing alternative products to market may require building in-house capabilities, partnering with specialized providers, or acquiring existing solutions.

OPERATING MODEL MODERNIZATION

As increased product innovation and access to self-funded products continues to take hold in down-market segments (i.e., small and medium employers), health plans need a commercial operating model that supports innovation, flexibility, and customization at scale. Some health plans have an opportunity to combat rising administrative costs by moving away from legacy administrative services only (ASO) models tied to high-cost fully insured platforms that are burdened by legacy tech debt.

Instead, they can shift to lean, agile TPA platforms that allow for product/benefit customization at scale. Large national health plans, such as United (UMR) and Aetna (Meritain), and select Blue Cross Blue Shield plans have invested in such TPA models. They have earned market success by coupling scalable and flexible operating models with a robust network and competitive rates.

OPTIMIZING VENDOR INTEGRATIONS

A component of the future-state commercial operating model is determining how to sustainably manage a growing portfolio of buy-up solutions for self-funded products. Vendor options and associated integration points have proliferated as employers experiment with new point solutions that address high healthcare costs and evolving employee needs.

These vendor solutions can target chronic conditions, manage weight and nutrition, and allow fast and easy access to virtual care. But an unwieldy vendor portfolio can lead to added operating costs, gaps in member/employee experience, and barriers to achieving the desired outcomes. Health plans and TPAs that optimize and balance vendor solutions can become a “one-stop shop” by convening vendors and offering combined billing and cross-vendor reporting to preserve revenue opportunities from buy-up solutions.

What should health plans do?

Diversify products and adapt operating models to preserve competitive positioning

Health plans need to prioritize revamping their commercial strategies now to avoid significant losses in their commercial books of business. Diversifying their product portfolio can preserve market share and keep the business in house, even if the margin profile looks significantly different from historical commercial business.

To successfully navigate the continued growth of ICHRAs and other alternative products, health plans need to identify a build-buy-partner strategy to deliver new capabilities quickly while also cementing their role and value in the market. This could include getting comfortable with cannibalizing their current book of business with new or alternative products.

As part of this strategy, health plans need to determine an efficient operating model for delivering alternative products and servicing the self-funded segment to preserve remaining margin. They also need to establish a vendor management strategy that advises employers on the right suite of point solutions that is seamless and low cost (via standardized data sets, APIs, etc.) for all stakeholders.

2. Headwinds in the Medicare Advantage market have intensified into a "perfect storm"

The MA market is facing significant headwinds as it navigates a series of regulatory and competitive challenges that threaten profitability and membership stability. These market forces are starting to look like a perfect storm.

↗ REGULATORY PRESSURES

New and evolving regulations, including the Inflation Reduction Act and risk model changes, are tightening Medicare Advantage organization (MAO) revenue streams. Meanwhile, declining star ratings are further challenging financial performance. These pressures may subside under a second Trump Administration, which has signaled a relaxed regulatory environment and intentions to further privatize Medicare coverage. Across various lines of business, MA is likely to be one of the biggest winners from upcoming federal regulatory changes.

↗ GROWTH HEADWINDS

Slowing growth in the MA market (5.4% in 2024 vs. 9.4% the year prior) and intensifying competition are straining MAOs' growth efforts. As MA penetration continues to increase (as a % of Medicare eligibles), the rate of MA growth is likely to continue slowing down. Health plans will increase focus on lifetime value creation for each member. Additionally, waning member loyalty, exacerbated by market exits and weakening benefits, is driving increased shopping and switching behavior. Nearly 2 million (10%) individual MA enrollees were impacted by plan terminations or service area reductions for plan year 2025.

↗ PROVIDER TENSION AND NETWORK INSTABILITY

Increasing utilization and medical costs are outpacing CMS rate increases, tightening margins for MAOs. In response, MAOs are implementing cost management efforts that often cause provider abrasion. Additionally, growing disputes over contract negotiations are leading to network disruptions and potentially threatening members' access to care and satisfaction.

↗ SHIFT FROM GROWTH TO PROFITABILITY

As a result of these trends, national and local health plans are shifting their focus from growth to profitability. Major players (e.g., UnitedHealthcare, Humana, Aetna) signaled their intent to exit certain markets or adjust benefit designs and products to improve financial performance. Additionally, some nationals are eliminating broker commissions on select MA plans for 2025 to tamp down growth and reduce costs. The heightened regulatory and competitive environment is also leading many smaller, local MA plans to exit the market entirely (e.g., BCBSKC, Premera, Care 'n Care). These health plan reactions to prioritize sustainability fuel greater market disruption.

What should health plans do?

MAOs must manage disruption and position for sustainability

Short term: Mitigate disruption and strengthen financial performance
To address immediate challenges, MAOs should prioritize member retention and performance turnaround. Health plans can mitigate member disruption post-annual enrollment period (AEP) through targeted interventions based on data-driven insights into member behavior and competitor moves. By analyzing historical data on risk scores and encounters/utilization, MAOs can identify high-risk members and implement strategies to stabilize their member base.

Additionally, with star ratings directly impacting financial performance, MAOs should prioritize measures that align their current performance with high potential for improvement. By leveraging analytic tools like HealthScape's proprietary MA Stars Tool, MAOs can identify opportunities that can help drive sustained improvements.

MAOs can further mitigate financial pressures by identifying short-term cost-saving opportunities, such as streamlining processes, improving payment accuracy, and renegotiating provider contracts.

Long term: Drive growth through diversification and strengthen provider relations
Despite the aforementioned headwinds, the size and momentum of the MA market presents meaningful opportunity for plans in the long term. To position themselves for long-term success, MAOs should consider diversifying their product offerings into growth markets like Special Needs Plans (SNPs), Employer Group Waiver Plans (EGWPs), and veteran-focused plans that can offer less crowded competitive environments and provide sustainable growth potential. A data-driven approach to product rationalization and expansion can help MAOs capitalize on local market factors and mitigate competitive pressures.

Finally, in light of increasing payer-provider tension, fostering collaborative partnerships with providers is crucial. Creating incentive-aligned contracts can help MAOs avoid disruptive terminations and preserve network stability, ultimately benefiting members and enhancing overall plan performance.

While clearer skies may be on the horizon for MAOs, the MA market is facing an unprecedented array of challenges that require both strategic foresight and tactical agility. MAOs that effectively navigate regulatory changes, member loyalty concerns, rising costs, and provider relationships will be better positioned to weather these headwinds. By focusing on both immediate and long-term strategies, MAOs mitigate current disruptions and establish a foundation for sustainable success in a complex and evolving market.

3. Evolution of the duals landscape necessitates integration across Medicare and Medicaid operating models

The landscape for dually eligible beneficiaries is transforming. CMS's 2025 Calendar Year Final Rule outlined significant changes for Dual SNPs (D-SNPs), including the requirement for D-SNPS to affiliate with Medicaid managed care organizations (MCOs). This mandate aims to strengthen alignment between Medicare and Medicaid, improving transitions of care, medication reconciliation, and provider communication.

As states progress toward the 2027 and 2030 deadlines, D-SNPs will need to strategically adapt their operations to align product portfolio planning. This also includes partnering with providers, coordinating high-quality care, and emphasizing SDOH.

PRODUCT PORTFOLIO ALIGNMENT

Foundational to expansion in the dual-eligible market is a well-defined growth strategy across all government lines of business (in addition to ACA). By analyzing market trends and regulatory changes, plans can identify opportunities and develop effective market entry strategies. Sophisticated plans are proactively planning 5 or more years ahead to align with Medicaid procurement schedules and capitalize on potential growth opportunities.

PROVIDER PARTNERSHIP AND CARE COORDINATION FOCUS

Building strong provider relationships is crucial for D-SNP success, particularly given the impact to providers, especially those delivering Long-Term Services and Supports (LTSS) and Home- and Community- Based Services (HCBS). An integrated provider relations and support model can serve as a "one-stop shop" for provider needs, facilitating collaboration, and easing the transition to increased adoption of shared payment models.

Additionally, a member-centered approach with personalized care plans and multidisciplinary care teams can enhance care coordination and improve outcomes. High-intensity care coordination is a requirement for soon-to-be sunset Medicare Medicaid Program (MMP) plans. Sharing best practices from Medicaid will ensure commensurate support across both lines of business.

EMPHASIS ON SDOH

State Medicaid agencies are increasingly prioritizing SDOH and health-related social needs (HRSN) such as housing, food, security, and transportation due to the higher prevalence of these challenges among the dual-eligible population. By incorporating these concepts into state Medicaid contracts and CMS Medicare requirements, states and CMS aim to address the root causes of health disparities and improve the overall health outcomes for dually eligible beneficiaries.

What should health plans do?

Prioritize operating model flexibility and scalability to support duals growth and sustainability

As market opportunity grows and integration requirements increase, plans need to carefully plan and execute an integrated operating model for D-SNP products across both local and centralized markets. This approach will be essential to efficiently manage the complexities of the dual-eligible population, and to capitalize on market opportunities.

- This begins with defining target markets and establishing a compelling value proposition. This will position plans for success in acquiring and retaining D-SNP members. Effective distribution channel management across Medicare and Medicaid lines of business will ensure member "stickiness" and help plans capitalize on the broader enrollment opportunities from these regulatory changes.

- Integrating HRSN into care management, quality, and broader plan operations can significantly improve health outcomes for dually eligible beneficiaries and support sales channel optimization through stars and risk adjustment. Plans that invest in programs that address SDOH and incorporate quality as an underpinning to how the organization operates more broadly will be best positioned for success.

- Leveraging shared services across contact centers, enrollment, and claims can significantly reduce costs and improve efficiency. Health plans must pair tightly coordinated (and integrated) teams with a robust platform strategy to create a seamless member experience. This level of integration will also ensure complete, accurate payment processing across both lines of business. By consolidating member information, claims data, and clinical records, these platforms can facilitate care management and streamline billing processes. Additionally, analyzing Medicaid and Medicare datasets can provide valuable insights into the unique needs of dually eligible beneficiaries.

- Finally, strict adherence to the complex array of Medicaid and Medicare regulations is non-negotiable to ensure successful launch and maintenance of D-SNPs, both today and in the future. Plans without core Medicaid and Medicare discipline run the risk of jeopardizing contracts. That may be through penalties or competitive state Medicaid procurements that long-term enrollment is contingent upon. Risk management strategies to identify vulnerabilities and effective mitigation will strengthen the broader organization while protecting both revenue streams.

4. The future of value-based care: Strategic approaches empower providers and elevate outcome

VBC is at a crossroads: The promise of achieving the original Triple Aim has often fallen short of expectations, and health plans are challenged to justify resource use to their leadership and self-insured clients. This inability to demonstrate the desired quality and cost outcomes has lingered despite significant investments, leading to a pressing need for a modernized approach. The solution requires both looking forward to leveraging new AI and predictive analytics as a part of provider enablement strategies as well as taking a back-to-basics approach for unified VBC program management.

RELIANCE ON FINANCIAL MODELS INSTEAD OF PROVIDER SUPPORT

Over the years, health plans' primary method to achieve greater VBC success has been increasingly complex reimbursement models that have intricate attribution, utilization, and quality measures and risk pools. As a result, providers struggle to meet multiple, often-conflicting value-based measures. They must comb through endless rows of claims data that reflect historical utilization patterns, while simultaneously attempting to improve future care delivery to earn VBC rewards.

To further compound the situation, many plans adapt VBC programs into a PPO environment in which PCP assignment or selection does not exist. Plans determine patient attribution through a complex process that essentially evaluates providers based on the patients that end up at their doorstep. Those patients may have bounced between specialists, often circumventing their PCP, while their health plan's VBC models put increasing accountability on that same PCP for expensive care that they had no opportunity to direct. Within this complex system, it is no wonder that many providers have simply conceded to delivering on the lowest common denominator across health plans, giving up on proactively managing their attributed risk pool.

FRAGMENTED OPERATING MODEL

On the other hand, plans are challenged to demonstrate efficiencies and outcomes resulting from VBC programs. And they are increasingly sitting across the table from their ASO clients who ask where the return is for their incentive dollars. To guarantee results, health plans often roll out more programs, investing heavily in costly operational improvements to administer the complex incentive payments and reallocating resources to conduct manual activities since VBC processes are not easily automated.

But while they continue to unknowingly increase the cost of operations, they are often missing a program management framework that evaluates the benefits of the program against those investments. One reason is that this spending has been made incrementally and as VBC evolved over time, market acceptance grew. Even today, the types of programs continue to change, and program ownership often shifts from quality to network to product teams, resulting in fragmentation and lack of an enterprise-wide VBC owner.

Even when centrally designed, historic focus has been on model design and deployment without additional consideration for the ongoing operational/administrative efforts and their impact on long-term savings. This necessitates a critical review of the existing VBC program management model, including its guardrails and processes for design, management, and evaluation.

What should health plans do?

Leverage analytics to improve provider enablement and strengthen discipline in operations of VBC models

Enabling providers through analytics and reporting that tracks patient outcomes and supports informed decision-making is central to the success of VBC programs. Plans need to find ways to support high-performing providers in value-based arrangements by proactively identifying and managing patients in their risk pool earlier in their disease progression before complex treatment or surgery—instead of relying on outdated, static reports and claims data to identify past actions.

As AI begins to permeate all areas of medical care, health plans can use it as a critical enabler for their providers to transition from reactive to proactive population health management. AI-driven predictive analytics can anticipate future health issues, enabling early intervention and treatment of chronic diseases. Plans can proactively identify opportunities for efficiency as well as quality improvements for at-risk patients. In turn, they can empower providers to target cost-effective interventions and prioritize outreach.

Ultimately, by improving VBC provider enablement with predictive tools and AI, plans will ensure providers have the tools that they need to succeed, focusing critical resources on the right patients, improving outcomes, and earning greater value-based incentives.

Health plans must adopt a disciplined approach to VBC program management, aligning goals with enterprise-wide growth and implementing rigorous performance management. Goal setting is the foundation. Strategically aligning VBC initiatives with the health plan's overall goals leads to greater internal stakeholder support, engagement, and resource sharing. A unified "North Star" is crucial for stakeholder alignment. Otherwise, single departmental goals and objectives will consume resources and attention, resulting in sub-optimal management and operational processes.

Treating VBC as its own "product line" with a profit and loss (P&L) statement is critical for highlighting the economic benefits and informing strategic decisions, ensuring that VBC delivers both financial and health-related returns. This rigorous approach enables evaluation of both individual models and the overall portfolio. Evaluating broadly (across the portfolio) and deeply (within a given program) will help plans identify efficiencies and prioritize high-impact models (i.e., "doing the right things" versus doing everything). While establishing this internal operational discipline takes time, health plans can enhance their VBC programs with renewed stakeholder input, optimize resource allocation toward successful programs and providers, and ultimately demonstrate greater return on investments.

5. Old school payment integrity operational levers need to modernize

Chasing affordability is nothing new for health plans, which have historically seen PI levers as a reliable path to short-term, substantive cost savings, driving the PI industry toward a staggering $9 billion and 7% growth rate annually. The industry, however, needs a reset in how it approaches PI. It needs less focus on aggressive, rapidly realized savings and greater emphasis on transparency and preserving the "integrity" in payment integrity.

Payer PI approaches—traditionally post-payment—often rely on manual review and complex rules that can delay care and provider payment. Providers many times leave deserved payment on the table because they don't understand the rules of the game. They then offset these losses by building their own measures to optimize revenues. Vendors, serving both sides, drive a wedge between plans and providers and create an arms race of bolted-on revenue cycle and waste-detection solutions.

In summary, the PI industry has reached a point of fatigue, with staggering costs and time-consuming processes that disrupt plan-provider relationships. Rather than promoting affordability, they detract from it and, even most concerningly, from patient care.

↗ PI REFRESH

Plans can benefit from a fundamental strategic reset regarding the goals of PI, establishing aggressive targets toward streamlined provider payment processes and strategic vendor partnerships. Such a highly functioning PI model requires shifting focus toward cost avoidance through upfront and ongoing transparency with providers. It also requires ensuring claims are as "clean" as possible as early as possible, while using vendors judiciously to improve efficiency and workflow.

In such a perfect state, traditional savings from claims denials simply do not occur, allowing the system to focus on true aberrancies and "bad apple" providers. PI teams ultimately should aspire to zero medical cost savings, with a tremendous mitigation in SG&A.

What should health plans do?

"Moving left" and "moving in" through the adoption of progressive technologies

While the PI industry has historically seen only marginal improvements in efficiencies and costs through small changes in technology and processes, AI and machine learning are poised to transform long-standing operating models. Plans need to focus on "moving left" (moving PI interventions as far upstream in the adjudication process as possible) and "moving in" (taking back control of solutions that have traditionally been outsourced to vendors). Up until the past decade, PI focused on post-payment savings through recoupments associated with fraud, waste, and abuse. Increasing sophistication through technological advancements has shifted plan focus toward pre-payment processes, thereby seeking to reduce administrative waste and mitigate provider abrasion. In fact, some estimate that pre-pay PI functions are outgrowing post-pay three-fold.

"Moving left," particularly focusing on moving post-pay to pre-pay, has been a PI theme for years. Now, plans must test just how far left the PI process can go—potentially as far as the providers' practice management systems. With the adoption of more advanced technologies such as generative AI, plans are now further empowered to take an even more proactive approach to PI. These technologies can anticipate millions of claim edits (traditionally requiring Boolean logic and reference tables) prior to claim submission. Even traditional COB routines can be replaced with newer technologies that can achieve significant cost savings by adjusting member eligibility files at the source with real-time primacy determinations that correct eligibility issues at the initial look-up stage.

However, this does not imply that plans should abandon their downstream PI tools entirely. Plans will always need a safety net to address outlier cases. Regardless, pushing the boundaries of "moving left" can create a colossal change in SG&A for both plans and providers and relieve a tremendous burden on the system.

Plans that systematically "move in" their PI tools and processes and regain control are increasingly favorably positioned. In doing so, plans should continually evaluate the effectiveness and efficiency of their PI vendor "stack." Plans have historically been reluctant to bring these processes in house because of the heavy staffing needs and the subject matter expertise required to make determinations. But AI solutions can optimize claim "pick rates" and increase the probability of choosing the right claims for review.

The technology can zero in on the exact connection point amongst an articulated policy, the presenting claim(s), and the medical record, without any human intervention. And it can queue up the trifecta into an efficient workflow for a human eye to double-check. "Moving in" can mean avoiding steep vendor contingencies—currently averaging about 15%—and prioritizing investment of advanced tools while protecting provider relationships. With cloud technology, health plans can achieve all this through an API call that can potentially be inserted in 90 days' time. *(continued)*

The implications of “moving left” and “moving in” are substantive to both plans and providers. Both are poised to finally adopt technology that can materially change the decades-long status quo of “savings” and “revenue optimization” made through attempts to compensate for each other’s overreaching PI processes. In the process, they can dramatically lower the floor on operating costs. In an industry that traditionally moves at a glacial pace, these new technologies could create a firestorm. Plans and providers need to pay attention to this movement to stay competitive.

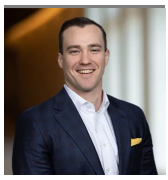
HealthScape can help

We believe 2025 will be a year of strategic transformation for health plans. As the industry navigates a complex landscape of evolving consumer expectations and accountability, regulatory changes, and technological advancements, health plans must adopt a proactive approach to address these challenges and capitalize on emerging opportunities. By redefining the commercial market, navigating the complexities of MA, embracing the evolving duals landscape, modernizing value-based care, and streamlining payment integrity operations, health plans can position themselves for long-term success.

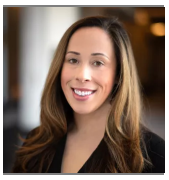
We bring a unique approach to help plans navigate this complex landscape and develop actionable strategies to drive sustainable growth and improve outcomes.

We are committed to further exploring the topics discussed in this paper and will be releasing more detailed content in extended versions.

Authors



Nate Akers
Senior Partner
nakers@healthscape.com



Jackie Allard
Partner
jallard@healthscape.com

Jeannie Hubbell
Partner
jhubbell@healthscape.com

Lynn Garbee
Partner
lgarbee@healthscape.com

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Contributors

Jacqueline Vitta, Associate Partner
jvitta@healthscape.com

Neil Precilio, Associate Partner
nprecilio@healthscape.com

Kirsten Bickford, Associate Partner
kbickford@healthscape.com

Ashley Conroy, Consultant
aconroy@healthscape.com

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