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Ryan S. Daniels, CFA +1 312 364 8418
rdaniels@williamblair.com

Dustin Scaringe +1 617 235 7531
dustinscaringe@williamblair.com

Matthew Mardula +1 312 364 5385
mmardula@williamblair.com

Healthcare Mosaic

Rethinking Employer Health Benefits: Cost Pressures and the Rise of Alternative Healthcare Funding Models



This report is intended for AGraber@willi

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Summary

In our quarterly *Healthcare Mosaic* report, we select a far-reaching topic of interest in the healthcare space and then provide a variety of data points and analyses to offer a more complete picture of what it means for the broader healthcare marketplace—and both public and private investors in the space.

In this edition—now our 41st in the series—we take a deeper dive into the increasing pressures employers are facing from rising healthcare costs. In our view, this is pushing employers to radically rethink health plan designs to offset some of these costs while still providing value-added health and wellness benefits to their employees.

Importantly, we believe this trend has reached a critical inflection point entering 2027, as healthcare costs are accelerating toward their highest levels in several decades and as employers increasingly acknowledge a need to fundamentally redesign their health and wellness benefits.

Accordingly, the purpose of this report is to help investors better understand these trends and the potential market implications of the rise of alternative healthcare funding models over the coming years.

More specific, in this thematic report we analyze:

- How employer health and wellness benefit costs have increased to record levels over the past few years and why 2027 could mark an inflection point in the movement toward alternative healthcare funding models;
- The various solutions that employers are focused on to help control healthcare costs and better engage their workforce;
- How employers balance their health and benefits approaches and what solutions are of highest demand and/or value today;
- The key role solutions like direct primary care (on-site and near-site care), individual coverage health reimbursement arrangements (ICHRAs) and level funding, reference-based pricing, captives, direct contracting/narrow networks, and centers of excellence play in today's marketplace;
- Recent funding, partnership, and M&A activity in the sector; and
- Select companies—in both the public and private markets—that we believe are well positioned to benefit from these trends.

With regard to covered companies that we believe will be most impacted by these trends, our work has relevance to providers that are positioned in the direct-to-employer care delivery market, such as **Hinge Health (HNGE), LifeStance Health (LFST),** and **Teladoc Health (TDOC).**

Moreover, we believe our analysis is relevant for a wide variety of other public and private operators in the healthcare services, benefits technology, and healthcare technology sectors, which we outline in detail throughout this report.

In tandem with this quarter's report, ***we are also hosting a discussion with the CEO of Gravie, Steve Wolin.*** Gravie is a healthcare benefits innovator focused on helping small and mid-size employers manage healthcare costs through alternative health plan solutions and ICHRA offerings. Under its model, Gravie seeks to simplify healthcare benefits while expanding access to more

affordable coverage options for employers and employees. During the conversation, management will discuss the company's operating model, customer value proposition, total addressable market opportunity, and key growth initiatives, among other items.

Please register for this live-only, virtual event, which will take place on October 7, 2026, at noon Central time, via this link.

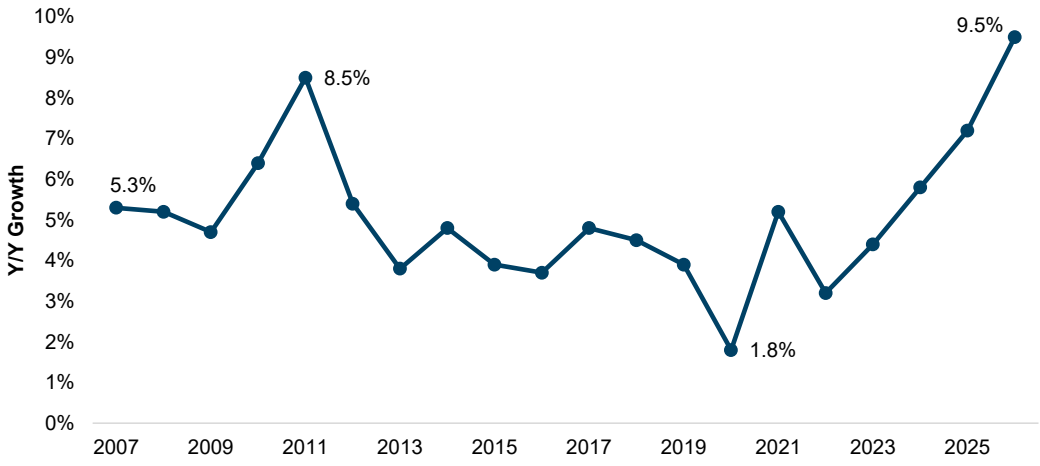
Introduction

In our view, healthcare costs have reached a level that is increasingly difficult for employers to absorb, and, more importantly, a trajectory that many companies now view as unsustainable. Put simply, what was historically treated as a benefits expense is increasingly becoming a material financial and strategic issue for the C-suite, with implications for margins, wage growth, hiring, capital allocation, and overall competitiveness.

For example, Mercer's 2026 CFO survey makes this shift clear: one-third of CFOs rank health benefit costs among their top-three operating expense concerns, up from just 19% in 2024, and nearly three-quarters rank healthcare among their top-five concerns. Similarly, in Business Group on Health's *2027 Employer Healthcare Strategy Survey*, 88% of respondents indicated that senior leaders are "paying more attention to health and well-being initiatives and healthcare costs," with 44% reporting that the CEO is playing a bigger role in benefit decisions.

Unfortunately for these employers, it appears that underlying cost trends provide little reason to expect relief. For example, a recent Aon report *(Healthcare Cost Increases Show No Signs of Slowing: What Employers Can Do)* projects that employer healthcare costs will increase another 9.5% in 2027, marking a second consecutive year at that level and extending one of the most challenging cost environments in decades (exhibit 1).

Exhibit 1
Cost Pressures and the Rise of Alternative HC Funding Models
Year-Over-Year Change in Healthcare Costs for U.S. Employers



Source: Aon Annual Health Value Initiative

Another significance is not simply the magnitude of the increase, but its persistence: employers are facing another year of near-double-digit healthcare inflation after several years of elevated cost growth. As Aon notes, "the current environment represents one of the most challenging cost periods in more than 20 years," with cost increases now being driven by utilization and changes in the type and intensity of care, not simply higher unit prices.

For most organizations, this math is increasingly difficult to reconcile. Mercer found that **most CFOs believe annual healthcare cost increases of more than 6% over the next three years would be unsustainable,** even as that level of growth appears increasingly likely to occur. Mercer also notes that the underlying cost increase for 2026 is about 9%, or roughly 500 to 600 basis points above CPI, which amplifies the overall impact of this cost trend relative to product pricing and overall wage growth.

To this end, only about one in four CFOs reported that their organizations had been able to absorb healthcare cost increases over the prior two years without affecting other areas of the business. And the consequences are increasingly visible outside the HR department: 38% reported an impact on other benefits, 36% on wage growth, and 26% on the prices of their company's products and services. Put simply, **healthcare costs have moved well beyond the benefits realm and are now broadly impacting companies' core operations and strategic planning.**

In our view, this creates a fundamental problem for employers. The traditional playbook—negotiate with carriers and absorb the increases, raise employee contributions, increase deductibles and copays, and repeat the process the following year—is now inadequate. Employers can shift some of the burden, but they cannot sustainably solve a structural high-single-digit cost trend by simply asking employees to pay more. For example, the abovementioned Mercer report found that **CFOs increasingly favor changes to plan design and strategies that address the underlying cost of care rather than simply increasing employee premium contributions.**

As a result, we believe 2027 is emerging as an inflection point in employer healthcare. C-suite leaders are being forced to reassess not just the design of their health plans, but also the fundamental questions of how healthcare should be purchased, financed, and managed. The conversation is also expanding beyond annual renewal negotiations toward network strategy, provider steering, clinical management, pharmacy economics, self-funding, defined-contribution approaches, and a variety of alternative funding models.

Again, Mercer's research underscores this shift: 47% of CFOs expressed strong interest in curated provider strategies such as high-performance networks or variable copay plans, while roughly two-fifths expressed at least some interest in defined-contribution approaches to funding employee health insurance.

Moreover, it appears that the market is already beginning to respond to these demands. For example, another Mercer employer survey found that 31% of large employers currently offer, or plan to offer, at least one nontraditional medical plan, such as a high-performance network or variable copay plan, while another 38% are considering such approaches. At the same time, nearly half of large employers expect to make traditional plan changes that increase employee out-of-pocket costs.

Again, our view is that employer healthcare is moving beyond a period of incremental benefit adjustments and toward a broader reconsideration of the funding and delivery model itself. Put simply: rising costs, greater claims volatility, and widening gaps between healthcare inflation and general inflation are creating the economic catalyst for employers to explore alternatives that can provide greater control, predictability, and value in their health and benefit offerings.

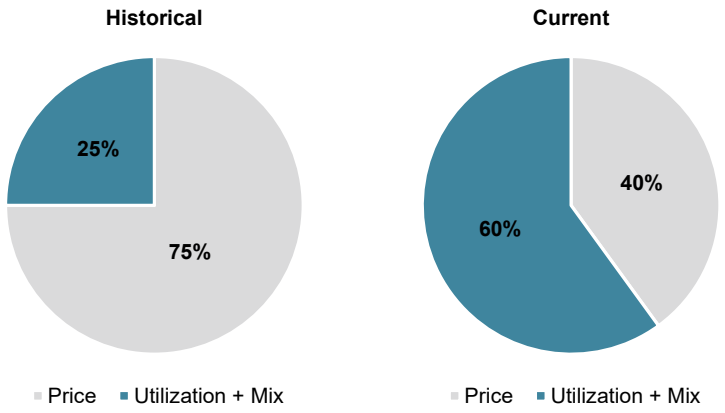
Thus, in our 41st *Healthcare Mosaic* report we examine this transition, analyzing why the traditional employer healthcare model is under increasing pressure, why the current cost trajectory is untenable, and how those pressures are accelerating the adoption of alternative funding models and benefit designs. In short, we believe the next phase of employer healthcare will be defined not simply by who pays for care, but by how employers structure risk, purchase healthcare, and align incentives across employees, providers, payers, and benefits platforms.

What Is Driving Accelerating Healthcare Cost Trends?

Historically, the pricing side of healthcare has been the primary driver of annual cost trend increases in employer healthcare. Aon's analysis has found that price typically accounts for roughly three-fourths of the annual increase in healthcare trend, with utilization playing a comparatively smaller role.

That dynamic has now flipped, however; today, about 60% of healthcare cost trend is explained by changes in care utilization patterns and the mix of services being consumed, rather than simply higher prices for the same care (exhibit 2). This shift has significant implications for employers: if utilization and care mix are increasingly driving cost growth, traditional approaches focused primarily on negotiating lower prices or shifting costs to employees will be insufficient.

Exhibit 2
Cost Pressures and the Rise of Alternative HC Funding Models
HC Cost Trend Drivers: Then vs. Now



Source: Aon Annual Health Value Initiative

It is therefore more critical than ever for employers to consider benefit plan redesigns that directly address utilization, point-of-care consumption, and care-delivery patterns—steering members toward higher-value care, encouraging more appropriate utilization, and creating incentives that can influence where, when, and how healthcare is consumed.

Before assessing how employers are addressing this change, however, we first identify some of the key drivers of this cost trend.

Unit Pricing

Although utilization and changes in the mix of care are now the dominant drivers of healthcare cost trend, pricing remains a meaningful contributor, accounting for roughly 40% of current trend. Several novel factors continue to push the underlying cost of medical services higher:

- ***First, the No Surprises Act's Independent Dispute Resolution (IDR)*** process has resulted in markedly higher reimbursements for many out-of-network services. For example, 45% of employers surveyed for the Business Group on Health 2027 outlook report either already experience or anticipate experiencing high volumes of IDR claims, leading to higher employer costs.

  Similarly, a majority of insurers identified this as a significant cost driver in the first half of 2026; the CEO of UnitedHealth indicated in July that the IDR process alone increased commercial cost trends by 100 basis points in the 2026. Similarly, Elevance Health published a report in June 2026 on the topic (The No Surprises Act: Independent Dispute Resolution for Planned Procedures) showing that IDR awards increased by 43% from 2024 to 2025 alone and that IDR awards to providers for certain planned procedures (e.g., plastic surgery, spine surgery) can be extreme, "averaging more than 50 times benchmarks that reflect in-network commercial rates and Medicare rates."

  Moreover, an August report from researchers at the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy found that total costs associated with the No Surprises Act's dispute resolution process reached $22.4 billion at the end of 2025. Researchers also found that 2.6 million disputes were initiated in 2025, up 77% year-over-year. And it appears that 2026 will be another record year, as 1.75 million disputes have been filed through the first six months of 2026, up an additional 50% from the first half of 2025. In turn, this creates higher underlying medical costs that will ultimately flow through to employers in the form of higher premiums in 2027 and beyond.

- ***Second, ongoing health system consolidation*** is increasing provider market power, enabling health systems to negotiate higher reimbursement rates, especially in the face of reduced government reimbursements and negative patient mix shifts. For example, a nationwide market study released by the KFF Health Costs Initiative in March 2026 exposed a severe lack of hospital competition across U.S. metropolitan areas (MSAs), with just one or two health systems controlling the market for inpatient hospital care in 47% of all U.S. MSAs. Moreover, in 83% of MSAs, one or two health systems command over 75% of the market share, which leads to material unit pricing power.

- ***Third, providers are increasingly using artificial intelligence to optimize billing and augment clinical documentation*** in the revenue cycle management (RCM) process. Ambient listening and AI documentation have become two of the fastest-adopted, most widespread physician-facing technologies in modern healthcare history. And because ambient listening generates highly detailed, optimized clinical charts, it structurally shifts the distribution of billed diagnostic categories toward higher severity scores (known as "up-coding" or "coding optimization").

  For managed care organizations, this results in higher average payout trends per clinical encounter for the same underlying service—effectively creating another form of price inflation that will ultimately be borne by employers. Again, nearly every large insurer has called out this phenomenon as adding to commercial pricing trend in 2026.

- ***Conversely, we believe inflation-driven medical contracting pressures have eased somewhat,*** especially as increases in labor costs for nurses and providers have moderated (and as the need for expensive third-party travel and agency nurse reliance is down to normal baseline

rates). For example, using HCA as a benchmark, labor costs declined to 41% of net operating revenue in second quarter 2026, down from more than 46% just a few years ago. However, the continued rise in the cost of supplies, drugs, and other healthcare services means that the cost per unit of care remains a significant and persistent source of healthcare cost growth that is also adding to unit costs.

Mix and Utilization

Regarding mix and utilization, there are also several factors pushing overall healthcare premiums higher into 2027.

- ***First, and likely top of mind for most employers today, is the impact of GLP-1 drugs.*** Here, the long-term impact of GLP-1 use paints a complicated financial picture for the healthcare industry. Longer term, it appears that GLP-1 drugs can reduce healthcare spending, with the largest reductions driven by a reduction in obesity and related chronic medical costs (cardiovascular disease, sleep interventions, diabetes). In the short term, GLP-1 drugs are creating significant near-term costs for employers.

  For example, 64% of large firms say covering GLP-1s for weight loss has moderately or significantly increased their prescription-drug spending, and 59% of firms with 5,000 or more workers say that the use of these medications for weight loss was higher than expected, according to Peterson-KFF Health System Tracker data.

  As another stark example, Bank of America CEO Brian Moynihan recently said that the company is spending more than $250 million annually on GLP-1s alone, representing 13% of its annual healthcare spending of more than $2 billion. And a July study from International Foundation of Employee Benefit Plans indicated that *in 2026, respondents stated that GLP-1 drugs accounted for 11.4% of annual claims, up from only 6.9% in 2023.* Similarly, another study from Business Group on Health indicated that nearly 8 in 10 employers report that GLP-1s are driving an increase in their company's healthcare costs.

- ***Beyond GLP-1 use, overall growth in specialty medications continues at a midteens rate,*** with drugs for inflammatory conditions (e.g., rheumatoid arthritis, Crohn's disease), oncology, and hemophilia driving a material uptick in spending. This is a key part of the "mix phenomenon," as patients transition from low-cost, traditional small-molecule generics to incredibly expensive biologic and specialty products. This change in clinical choice dramatically spikes the overall cost per treated patient despite relatively low overall utilization.

  More specific, specialty drugs account for only 2% to 3% of total prescription volume but 40% to over 50% of pharmacy dispensing revenue, according to a July 2024 interim staff report from the Federal Trade Commission. Unlike temporary drug treatments, many of the fastest-growing specialty categories require continuous, lifelong maintenance therapy, which should elongate this trend well beyond 2027, in our view.

- ***Third, the sheer frequency and financial severity of high-cost claims have intensified drastically over the last five years,*** despite the historical "Pareto distribution" of healthcare spending, where roughly 5% of members drive 60% of total spend. A claimant who used to cost $150,000 annually five years ago frequently surpasses $500,000 or even $1 million today due to structural shifts in medicine. A May study from SunLife indicated that *$1 million or higher claims increased in frequency by 46% from 2022 to 2026 alone.*

- ***Fourth, an escalation of healthcare cost trends is being driven by both a steady expansion of high-cost legacy conditions, such as cancer and musculoskeletal issues, and a surge in emerging categories, like gastrointestinal disorders.*** For example, GI disorders have been

experiencing a medical spend increase of more than 10% annually, according to data from Aon. Data indicate that gastrointestinal (and also neurological) spend is being fueled by earlier, more frequent diagnoses across wider age groups; for example, a notable rise in diverticulitis cases among individuals in their 20s and 30s, whereas it was uncommon in those under 50 as recently as a decade ago.

- ***Lastly, there has been a large uptick in higher cost of care related to new treatment options.*** For example, advanced imaging (like MRIs, PET, and CT scans) is being ordered at higher frequencies to help in diagnosing neurological and cardiac conditions.

  Moreover, many hospital admissions are now defined by a "high-acuity multiplier," where sicker patients with complex, compounding chronic conditions require intensive, resource-heavy care that exponentially increases daily costs (even among younger, commercially insured populations). For example, based on recent analysis of claims data, nearly 58% of commercially insured patients had at least one chronic condition in 2024, and patients with one chronic condition had nearly twice the average allowed spending of patients with none. Also, these patients or those undergoing complex surgeries often face prolonged, multi-tiered stays that frequently escalate into expensive inpatient care, driving more high-cost claims from single admissions.

Overall, the combination of unit price increases, unfavorable mix shifts, and rising utilization is creating what increasingly appears to be a durable trend of higher healthcare costs. These pressures are in turn driving employer healthcare premiums upward at accelerating rates, placing growing pressure on employers of all sizes and across industries.

As a result, employers are being forced to fundamentally rethink and redesign their health and wellness benefit strategies. Again, we believe the focus is shifting beyond simply managing premium dollars toward improving the value generated by every dollar of benefit spend.

In the pages that follow, we review some of the most promising and fastest-growing strategies that employers are leveraging to better control healthcare spending, improve outcomes, and maximize the value of each benefit dollar.

In our view, these strategies can be bifurcated into two primary areas: 1) benefit plan designs (ICHRAs, level funding, reference-based pricing, etc.) and 2) provider contracting, access management, and care management solutions (centers of excellence, on-site and near-site advanced primary care, narrow networks, navigation and care management solutions, etc.). We begin with a review of key benefit plan designs before turning to provider contracting and care/access management solutions.

Innovative Benefit Plan Designs

According to an August study from the Business Group on Health (again, based on responses from 127 employers covering 11 million lives), employers are actively exploring alternative health plan models. More specific, **26% of respondents indicated that they will offer an alternative health plan in 2027 (18% already had one in 2026 and another 8% are adding in 2027), while another 31% are considering them for 2028 and 2029.** Accordingly, we expect innovative benefit designs to be a key area of growth over the next three years.

Below, we review some of the primary design innovations we believe will continue to gain traction over the coming years.

Level-Funded Plans

Brief Overview
Level-funded health plans offer employers a middle ground between traditional fully insured coverage and self-funding. The employer pays a fixed monthly amount that typically combines estimated medical claims, administrative costs, and stop-loss insurance. This allows employers to gain some of the cost transparency, flexibility, and potential savings of self-funding while limiting their exposure to unexpectedly high claims. Level funding has become particularly popular among small and midsize employers seeking greater control over healthcare costs without assuming the full financial risk of a traditional self-funded plan.

How It Works
Level-funded health plans essentially combine the predictable payment structure of a fully insured plan with the underlying funding mechanics of a self-funded plan. Rather than paying a traditional insurance premium—in which the carrier assumes responsibility for all medical claims—the employer makes a fixed monthly payment to an insurer or third-party administrator. That payment is generally divided into three components: 1) an amount to fund expected employee medical claims; 2) an administrative fee; and 3) the premium for stop-loss insurance.

The claims portion is then used to pay the actual medical expenses of employees and dependents throughout the year. Because the employer is technically funding the claims, it can potentially benefit when actual claims are lower than expected. Depending on the specific contract, any surplus in the claims fund may be returned to the employer at the end of the plan year. Conversely, if claims are higher than anticipated, stop-loss insurance coverage generally protects the employer from potentially large losses. Stop-loss coverage generally includes an individual attachment point, which limits the employer's exposure to an unusually expensive claimant, and may also include an aggregate attachment point that limits total plan liability.

For example, an employer might make a fixed monthly payment of $100,000, with a portion designated for expected claims, a portion for administration, and a portion for stop-loss coverage. If actual claims are lower than projected, the employer may ultimately retain some of the savings, depending on the plan design. If claims are substantially higher, the stop-loss carrier assumes responsibility once the applicable attachment points are reached. Thus, ***the employer receives a relatively predictable monthly expense while retaining some of the economic benefits of self-funding without assuming the full volatility of medical claims.***

In our view, this structure has made level funding particularly attractive to small and midsize employers, which historically have been more likely to purchase fully insured coverage because they lack the scale to comfortably absorb large claims fluctuations. Level funding effectively gives these employers an entry point into the self-funded market while substantially limiting their financial risk.

Another important distinction is that ***level-funded plans are generally structured as self-funded arrangements, rather than traditional fully insured policies.*** This can give employers greater flexibility in plan design and access to claims information, which can be used in tandem with other solutions discussed throughout this report.

Again, employers that use level funding often capture surplus returns, so it creates a direct financial incentive to more actively manage healthcare utilization. Under a traditional fully insured arrangement, an employer generally pays a fixed premium and has limited ability to benefit directly from improvements in claims experience. However, level funding changes this dynamic by allowing the employer to participate more directly in the economics of its healthcare spend while gaining greater visibility into claims and utilization.

In our view, this also creates a stronger incentive to invest in strategies that can actually reduce underlying medical costs. For example, an employer might steer employees toward centers of excellence for complex procedures, high-performing providers, virtual care, chronic-condition management, or more efficient sites of care. If these strategies reduce claims, the employer—not simply the insurance carrier—can potentially capture at least some of the resulting savings.

To this end, research indicates that employers with access to claims information more actively implement a wide range of cost-saving initiatives. For example, a report from the National Alliance of Healthcare Purchaser Coalitions (Pulse of the Purchaser) analyzed 26 cost-reduction strategies, and across all 26, employers with medical claims data were more likely to take action (exhibit 3). In our view, the largest differences appear to be in strategies that require employers to compare prices, assess providers, and implement care management strategies.

Exhibit 3
Cost Pressures and the Rise of Alternative HC Funding Models
Complete Claims Access Linked to Greater Strategy Adoption

Strategy	With complete access	Without
Enhanced screening or early detection	70%	58%
Navigator, advocacy or case management	67%	60%
Stop-loss, captive or financial protection	66%	62%
Disease-specific vendors or programs	65%	51%
Reviewing pharmacy claims billed as medical	63%	46%
Requesting claims data and audits	58%	42%
Steering members to higher-value sites	56%	36%
Centers of excellence or bundled payments (hospital)	55%	39%
Centers of excellence (high-cost claims)	53%	40%
Site-of-care management (infusion, specialty) (high-cost claims)	52%	36%
Expert medical opinion for complex cases	51%	36%
Evaluating networks on price and quality	49%	27%
Coalition or consultant finds high-priced sites	47%	28%
Negotiating or auditing hospital prices	47%	29%
Site-of-care strategies (hospital)	45%	30%
Advanced primary care	45%	22%
Reviewing hospital price transparency data	43%	24%
Tiered networks	42%	28%
Direct contracting (hospitals)	39%	17%

Source: National Alliance of Healthcare Purchaser Coalitions

In this respect, we believe level funding can serve as a stepping stone from simply purchasing health insurance to actively managing healthcare costs though a novel benefits platform; we also believe the adoption of level funding will therefore drive an uptick in other healthcare cost-containment strategies among small employers in the future.

Adoption Trends and Outlook

Level-funded health plans have moved from a relatively niche alternative-funding arrangement to a mainstream option for small and midsize employers over the past decade.

For example, KFF began separately tracking level funding in 2018, when about 6% of covered workers at small firms (3-199 employees) were enrolled in level-funded plans. Adoption increased rapidly, reaching 16% in 2020, and by 2025, 37% of covered workers at firms with 10-199 employees were enrolled in a level-funded plan, according to the most recent KFF data (2025 Employer Health Benefits Survey).

Exhibit 4
Cost Pressures and the Rise of Alternative HC Funding Models
Covered Workers at Small Firms, % Enrolled in a Level-Funded or Self-Funded Plan, 2025

	Among Covered Workers, % in a Self-Funded Plan	Among Covered Workers, % in a Level-Funded Plan	Among Covered Workers, % in a Self-Funded or Level-Funded Plan
Firm Size			
10-49 Workers	18%	35%	44%
50-199 Workers	34%	39%	57%
All Small Firms	**27%**	**37%**	**51%**

Source: KFF Employer Health Benefits Survey, 2025

This represents a substantial structural shift in only seven years, although the relatively flat adoption since 2021 suggests that level funding may now be approaching a mature penetration level among its core small and midsize employer market. Still, the broader movement toward alternative funding is even more pronounced. In 2025, 51% of covered workers at firms with 10-199 employees were enrolled in either a level-funded or self-funded plan (exhibit 5), indicating that roughly half of the small and midsize employer market has moved away from traditional fully insured arrangements.

Exhibit 5
Cost Pressures and the Rise of Alternative HC Funding Models
Covered Workers at Small Firms (10-199 workers),
% Enrolled in a Level-Funded or Self-Funded Plan, 2018-2025

	Among Covered Workers, % in a Level-Funded Plan	Among Covered Workers, % in a Self-Funded or Level-Funded Plan
2018	6%	19%
2019	12%	26%
2020	17%	32%
2021	37%	44%
2022	35%	45%
2023	39%	46%
2024	35%	47%
2025	37%	51%

Source: KFF Employer Health Benefits Survey, 2018-2025

Key Market Participants

While the level-funded market is still dominated by traditional insurers (e.g., UnitedHealthcare, Aetna, Blue Cross Plans), a number of start-ups have been targeting the space of late, many of which we highlight in exhibit 6.

Exhibit 6
Cost Pressures and the Rise of Alternative HC Funding Models
Innovative Benefit Plan Designs Market Map



Source: William Blair Equity Research

Individual Coverage Healthcare Reimbursement Accounts (ICHRAs)

Brief Overview
ICHRAs are an emerging employer-funded healthcare benefit that allows employees to buy their own individual health insurance—using a defined ICHRA allowance provided directly by their employer—rather than enrolling in a traditional employer-sponsored group plan.

Employees generally use their monthly stipend to shop on the health insurance marketplace (HealthCare.gov) or a state insurance exchange (e.g., Get Covered Illinois) and can select an individual ACA plan that best suits their needs (including spending more than their employer-provided stipend, if they desire better coverage and can cover the additional monthly out-of-pocket costs).

How It Works
Instead of buying a group health insurance policy (i.e., negotiating and buying insurance), an employer gives employees a set amount of monthly, tax-free allowances to buy their own insurance (i.e., funding a benefit). Employers can effectively lock in their rate of annual healthcare cost inflation with ICHRAs by simply setting the percentage at which they increase the monthly allowance each year.

Employees then use the allowance to purchase their own individual health insurance plan. Again, employees typically shop on HealthCare.gov or a state exchange for this insurance; however, they can also buy an individual plan directly from an insurer or through a broker. Rather than picking from two to three employer-sponsored group plans (e.g., HMO, PPO, high-deductible plan from the same insurer), ICHRA plans provide access to hundreds of different plan options and members can change their selections every year.

Employers are also actively using technology/benefits administrators that sit between the employer and the individual health insurance market to help reduce friction and enhance the consumer experience. For example, emerging leader Gravie's platform allows users to see individual-market plans available in their geography, with the platform offering access to more than 350 carriers and 8,800 plans nationally. The platform also provides navigation and plan selection services (virtual and human support via the Gravie Care platform) and facilitates payments through a virtual ICHRA funds account for the member.

The federal government created ICHRA through regulations issued by the Departments of the Treasury, Labor, and Health and Human Services in 2019, which became effective January 1, 2020; ICHRAs are thus a fairly new benefit option relative to many other innovations we highlight in this report. In brief, the rules established ICHRA as a new category of health reimbursement arrangements, distinct from traditional group health plans. Most importantly, they defined the legal framework under which employers can use tax-advantaged funds to reimburse employees for premiums on individual health insurance policies.

Adoption Trends and Outlook

Since the introduction of ICHRAs, the individual insurance market has matured enough to support a broader employer population, and many larger insurers have indicated that ICHRAs remain a key long-term growth strategy for their organization.

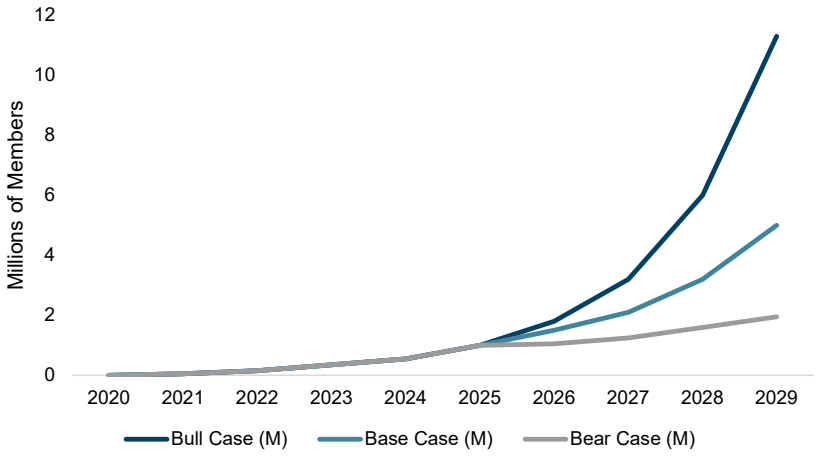
In our view, this also has created an attractive flywheel in the space: rising employer costs increase interest in ICHRAs, leading to greater employer adoption and making the individual market more attractive to insurers, where more participation further improves individual market dynamics (e.g., attracting more technology providers and benefit platforms into the space, stabilizing premiums) and thus makes it easier for employers and employees to adopt the solution.

Early signs of this flywheel appear in data from the HRA Council, which reported that more than 20,000 U.S. businesses offered ICHRA benefits in 2026, covering at least 500,000 employees; this compares with only 13,000 businesses and an estimated 250,000 covered lives in 2025.

The data show particularly strong growth among larger employers. Moreover, the HRA Council noted that ***ICHRA growth held strong even as the ACA marketplace faced stress and lower membership growth due to the expiration of the enhanced premium tax credits and rising monthly premiums in the 2026 plan year.***

When looking at ICHRAs' projected growth, industry analysts project the market could triple again in 2027, while others believe ICHRAs could expand to the low millions of covered lives by 2028. As an example, exhibit 7 from an Oliver Wyman ICHRA Overview report shows base-, bear-, and bull-case scenarios for the potential range of ICHRA adoption and covered lives over the coming years—indicating the market could expand to upward of 12 million lives by 2029.

Exhibit 7
Cost Pressures and the Rise of Alternative HC Funding Models
Potential ICHRA Future Enrollment Sceanarios



Source: Oliver Wyman ICHRA Overview

Given a relatively nascent market today, future projections of ICHRA adoption are quite wide. However, we believe the main catalyst for ICHRA adoption is that traditional employer-sponsored healthcare is becoming increasingly expensive and harder for employers of all sizes to manage and budget for; accordingly, the growth outlook should trend toward the higher end of industry projections over the next several years.

It is important to note that ICHRA adoption was concentrated primarily among smaller employers over the past several years, many of which used the arrangement as an on-ramp to offering health benefits for the first time. For example, the HRA Council's data indicates that in 2025, 83% of employers offering ICHRAs had not previously offered any health coverage, while only 17% had transitioned from traditional group insurance. However, the market is increasingly seeing interest from larger employers as well, which could represent a much more meaningful growth opportunity.

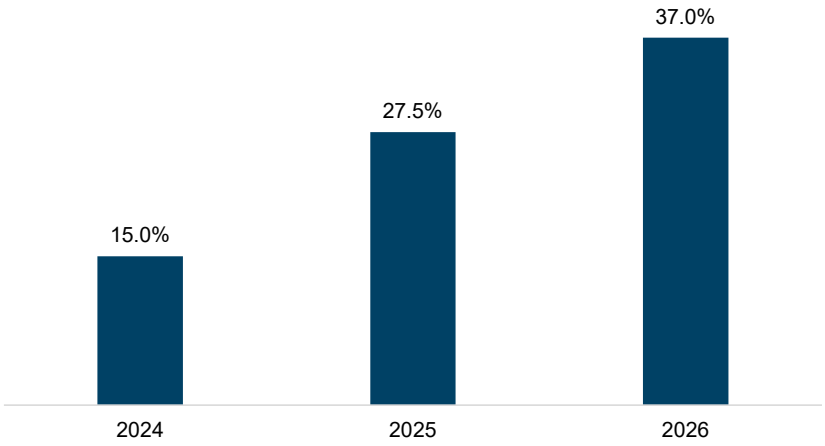
For example, in the latest EBRI-Morgan Health survey of 984 employers, *62% of employers with 100 or more employees said they were likely to adopt an ICHRA within the next two years. Interest was particularly strong among employers with 500-9,999 employees,* where about half reported familiarity with, consideration of, and likelihood of adopting an ICHRA within the next two years. In our view, this is key as larger employers represent a much larger pool of covered lives and therefore could meaningfully accelerate ICHRA market scale as adoption continues.

We believe this distinction suggests that the market is shifting from an on-ramp-to-coverage story to a potential replacement-of-coverage story. Put differently, we believe that if ICHRA adoption were limited primarily to employers that have never offered benefits, the addressable market would remain relatively narrow. However, if larger employers that already offer traditional group plans increasingly begin evaluating ICHRA, the addressable market expands to essentially the entire employer-sponsored insurance ecosystem.

Increasing availability is creating a positive feedback loop. Another key driver of adoption is the growing availability of ICHRA products. We believe ICHRA is benefiting from a classic market feedback loop, where greater employer interest drives demand for brokers, administrators, and technology providers to support ICHRA, which encourages more insurers to participate, and ultimately increases plan availability, making the product more attractive to employers.

The SureCo 2026 State of ICHRA report provides evidence that this ecosystem is becoming established. Based on three consecutive years of survey data from roughly 1,500 HR professionals, employees, and benefits consultants, the report found that *56% of brokers are now actively recommending or implementing ICHRAs, making 2026 the first year a majority of surveyed brokers reported active participation.* More importantly, the percentage of brokers that had moved at least one client to an ICHRA increased from 15% in 2024 to 37% in 2026; we view broker data as particularly important because brokers often serve as gatekeepers in employer healthcare purchasing decisions.

Exhibit 8
Cost Pressures and the Rise of Alternative HC Funding Models
Brokers Who Have Moved at Least One Client



Source: The State of ICHRA 2026

Early adopter results could accelerate broader adoption. The strongest catalyst for the next stage of ICHRA growth may ultimately be the experience of employers that have already made the transition.

According to SureCo's 2026 survey, more than 91% of employers that adopted ICHRA said it was the right move for their company, while brokers reported average estimated client savings of about 15.5% after switching to ICHRAs. In addition, 89% of employees reported that their ICHRA coverage was better than their previous group plan.

We believe these results could become particularly important as ICHRAs move toward larger employers. Our view is that this creates an important proof-of-concept effect for the broader market: as more employers can demonstrate measurable savings and positive employee outcomes, ICHRAs become easier for other employers and their benefits advisors to evaluate, particularly during annual renewal periods when ever-rising premiums force employers to reconsider their existing plans.

Payers view ICHRAs as an extension of the individual market opportunity as well. We believe insurers are increasingly interested in ICHRAs because they expand the addressable market for individual coverage products. Historically, individual-market enrollment has largely consisted of consumers purchasing coverage independently through ACA exchanges or directly from insurers. Thus, for payers that have already invested in ACA marketplace infrastructure, provider networks, and pricing capabilities, ICHRAs allow them to leverage existing assets across a broader member base. Rather than building a separate group insurance offering, these insurers can market existing individual products to employer-sponsored populations. In our view, this makes ICHRAs particularly attractive for insurers with established marketplace businesses.

Centene is a prime example of a larger insurer strategically positioning itself to capitalize on new opportunities. Through Ambetter Health Solutions, Centene has created individual-market health plans specifically designed to support employers adopting ICHRAs. The company describes Ambetter Health Solutions as its off-exchange marketplace business, emphasizing predictable employer costs, personalized employee plan selection, and portable individual coverage. The company draws on its local approach from its Medicaid business to guide product development, network design,

and pricing decisions, making its offerings suitable for ICHRA arrangements. Ambetter Health Solutions launched in six states in 2025 and expanded to 13 states in 2026 (Ambetter coverage map), including Arizona, Florida, Kansas, Nebraska, Oklahoma, Tennessee, and Texas.

Centene is already one of the largest individual-market insurers in the country, with about 3.5 million ACA members, giving the company established provider relationships, individual-market pricing capabilities, enrollment infrastructure, and experience managing individual-market risk. ICHRAs therefore give Centene an additional distribution channel for a business it already knows how to operate.

Moreover, company management has clearly stated that it considers ICHRAs a distinct strategic initiative. In January 2025, Centene appointed Alan Silver as the first president of its newly created Ambetter Health Solutions business, a role focused specifically on ICHRAs. In a May 2025 interview with Becker's Payer Issues, Silver explained that Centene wanted someone to lead the strategy because the individual market offers an opportunity to meet employers' evolving needs, describing it as a more direct-to-consumer approach to healthcare.

Silver was even more explicit about the distinction in an October 2025 interview with Fierce Healthcare, explaining that his team operates separately from Centene's broader marketplace organization, mentioning, "This is something different and new, and will require us to think differently than we have in the past." He added that the team's objective is to listen to feedback from employees actively using healthcare, rather than simply designing a product around what an employer traditionally needs. In our view, this distinction is important because it suggests that Centene is not simply adding ICHRAs to its existing employer product portfolio; rather, it is building a dedicated business around the idea that the individual marketplace can become an alternative infrastructure for employer-sponsored coverage. As the company stated in its 2025 annual report, it sees the "opportunity for market disruption of employer-sponsored insurance through ICHRAs."

Centene is also backing the strategy with its own workforce. In 2026, Centene launched an ICHRA for its Indiana-based employees, initially targeting more than 700 workers. The company intentionally selected Indiana as a pilot market, with Silver explaining that approximately 700 employees represented a manageable group for gathering feedback compared with markets where Centene has thousands of employees. Also, Silver said the objective was to use the pilot to gather feedback and learn from the experience before expanding the model.

Perhaps more importantly, Centene's CEO is participating in the ICHRA herself. At HLTH 2025, CEO Sarah London said that she planned to leave the company's group plan and enroll in individual-market coverage in 2026. London said, "I am so bullish on this that I am actually stepping off our group plan and going to join the individual marketplace in 2026 as well, to test and learn this theory, because we think it's a better benefit option for our employees."

We believe this is one of the strongest signals that ICHRAs are moving beyond an emerging benefits concept. It is one thing for a health insurer to sell ICHRAs to small businesses; it is another for a company with more than 60,000 employees to use its own workforce to test the model, and for the CEO to personally participate. In our view, Centene's decision provides an important proof point for the broader employer market. If ICHRAs can work for a large health insurer's own employees, the perceived barrier to adoption among other large employers may begin to fall.

Oscar Health is pursuing a similar opportunity but with a more technology-oriented strategy. At HLTH 2025, Oscar President of Insurance Janet Liang argued that a key barrier to ICHRA adoption is the inertia surrounding the traditional employer-sponsored model. She explained, "I think it's just the inertia from change. It's a big shift for people to think about this, but the country did go through a shift from pensions to defined contribution plans, right? So for me, it's the same idea."

We believe that analogy is particularly relevant. The traditional employer health plan resembles the old defined-benefit pension model. In contrast, an ICHRA resembles a defined-contribution system in which the employer sets its financial commitment, and the employee has greater control over how that contribution is used. This shift also creates new technology and distribution opportunities. As employees assume more responsibility for selecting their own coverage, the enrollment process becomes more important. Rather than simply choosing between two or three employer-sponsored plans, employees may need to compare individual plans.

Oscar Health has thus increasingly built a novel infrastructure around this thesis. In April 2026, the company launched Lucie Health Marketplace, an all-in-one platform that lets consumers and brokers compare individual-market medical plans alongside dental, vision, and other supplemental products. Oscar Health positioned Lucie as a platform for full-time employees, part-time workers, entrepreneurs, and early retirees.

In our view, Lucie is strategically important because it addresses a central challenge created by ICHRAs; as employers become less involved in selecting the insurance product, someone needs to make the individual shopping and enrollment experience simple enough for employees to navigate. We believe this matters because Oscar is trying to participate in more than just the insurance layer of ICHRAs. The company's strategy is increasingly centered on building a consumer marketplace where employees can shop, manage, and compare healthcare products.

Oscar Health has also shown that ICHRAs can be paired with differentiated care delivery. Its partnership with Hy-Vee Health in Iowa combines an employer-funded individual-market plan with concierge primary care. The company described the offer as providing double-digit savings compared with traditional employer group plans.

In our view, this type of product illustrates how ICHRAs could evolve beyond simply changing who pays the premium. Employers can combine an ICHRA financing structure with differentiated networks, direct primary care, and other value-based-care models. This could allow employers to make a predictable contribution while giving employees access to a more customized healthcare experience.

Barriers to Broader Adoption of ICHRAs

Unlike many other innovations discussed in our report, ICHRAs remain in their infancy relative to many other cost-saving solutions in the employer health benefits market. Accordingly, this section also highlights several near-term hurdles ICHRAs face as they seek to expand beyond early adopters and achieve broader market adoption.

We believe the biggest obstacle to broader adoption is the quality and affordability of the individual insurance market. Employees must navigate to find plans that provide adequate provider networks, competitive premiums, reasonable out-of-pocket costs, and a sufficient range of choices. In areas where there are few insurers or limited provider networks, the potential benefits of having a choice can be limited, which could reduce adoption.

The EBRI-Morgan Health survey makes this point particularly clear, as 85% of employers said they would be more likely to adopt an ICHRA if they could guarantee the same provider-network quality and choice as a traditional group plan.

In our view, this factor is crucial to monitor as ICHRAs evolve. If insurance providers respond to increased enrollment by expanding networks, enhancing plan designs, and maintaining competitive pricing, the individual market should effectively support a larger population of employees from larger employers. Conversely, if individual market premiums rise significantly or network quality worsens, employers may hesitate to transition to ICHRAs.

Second, administrative complexity remains a significant barrier to adopting ICHRAs. One challenge is that ICHRAs shift some responsibility from employers to employees. With traditional group health plans, the employer and its broker typically handle plan selection and administration. However, with ICHRAs, employees must understand their allowance, shop for coverage, select a plan, and maintain qualifying coverage.

This shift creates substantial educational and administrative challenges. Employers must comply with ICHRA regulations, properly establish employee classes, provide required notices, and ensure reimbursements are administered correctly. CMS has developed specific tools, such as the ICHRA Employer Lowest Cost Silver Plan Premium Look-Up Table, to help employers determine whether their ICHRA offerings meet affordability requirements. Despite this, ICHRAs' complexity creates challenges, and their adoption may be heavily influenced by administrative burdens.

However, as brokers gain experience, technology platforms become easier to use, and more employers publish successful outcomes, adoption friction should decline.

The final barrier is regulatory and market/premium stability. ICHRAs rely on a functioning individual insurance market, so any changes to premium subsidies, enrollment rules, affordability requirements, or other ACA-related policies can impact their attractiveness. This risk became more evident as the enhanced ACA premium tax credits expired and individual-market premiums rose for the 2026 plan years, driving enrollment declines. While ICHRA adoption continued to grow, the episode shows how ICHRA economics remain tied to broader individual-market policy.

We believe this creates a distinction between ICHRAs' structural advantages and their near-term adoption rate. Structurally, the model addresses a fundamental issue in employer healthcare, with employers seeking predictable costs and employees increasingly desiring choice. However, for ICHRAs to succeed, the individual market must consistently provide affordable, high-quality coverage that continues to attract employers.

Key Market Participants

Exhibit 9
Cost Pressures and the Rise of Alternative HC Funding Models
ICHRA Market Map



Source: William Blair Equity Research

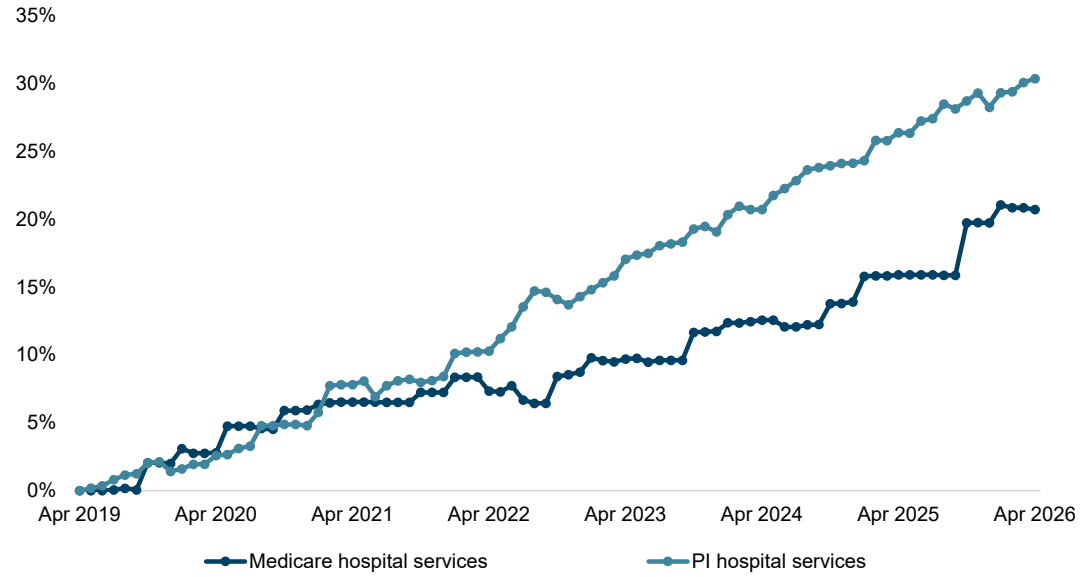
Reference-Based Pricing

Brief Overview
Reference-based pricing (RBP) is a payment strategy whereby an employer-sponsored plan sets a maximum allowable payment for a healthcare service, based on an external benchmark, rather than paying the provider's billed charge or a traditional carrier-negotiated commercial rate. Typically, the pricing benchmark is tied to Medicare reimbursement rates, with many RBP arrangements paying a defined multiple of Medicare, such as 120% to 200%. However, some vendors also incorporate hospital cost reports, market price data, or other reference points.

RBP gives employers a more transparent and auditable pricing framework for facility claims (literal site-of-care bills; the hospital room, equipment, supplies, overhead, etc.), which are often among the largest and most variable components of employer healthcare spending. It also encourages employees to shop for the highest-value site of care, as costs over the reference price may not be funded by the employer (so any overage would be an out-of-pocket cost for the employee).

In our view, RBP has gained momentum over the past several years given the marked increase in healthcare costs, especially at acute-care hospitals. For example, the pricing gap between private insurance payments and Medicare continues to expand; a May 2026 KFF analysis found that private-insurance hospital prices increased 30% from April 2019 to April 2026, compared with a 21% increase in Medicare rates—meaning private hospital prices grew 47% faster than Medicare over that seven-year period (for reasons discussed earlier in this report). Again, we believe this widening spread helps explain renewed employer interest in RBP.

Exhibit 10
Cost Pressures and the Rise of Alternative HC Funding Models
Hospital Services: Medicare vs. Private Insurance



Source: KFF analysis of Bureau of Labor Statistics (BLS) PPI data, 2019-2026

Emerging data also indicate significant savings potential from RBP. A June 2026 Health Affairs Scholar study examined approximately 300,000 lives enrolled in Imagine360's RBP plans. It found hospital payments averaging roughly 140% of Medicare, versus much higher commercial payment levels, and estimated approximately $417 million in savings, or 56.5% versus the counterfactual commercial spend.

Despite this potential, we believe RBP sits at the more aggressive end of the employer cost-containment spectrum, as it directly challenges the commercial provider pricing structure rather than simply optimizing around it. Traditional PPO networks typically produce savings by negotiating discounts off provider charges, but employers still have limited visibility into whether the resulting rate is reasonable relative to an objective benchmark. ***RBP reverses this logic by starting with a publicly available or independently derived reference price and then paying a defined margin above that amount.***

Still, RBP is not simply a lower-cost version of a traditional network product. Because providers generally have not contracted in advance to accept the reference-based rate as payment in full, the model can create balance-billing risk, provider pushback, and member-experience friction if not implemented carefully. As a result, we believe successful RBP programs require a full operating layer around the claims payment methodology, including member education, pre-service navigation, provider outreach, claims repricing, legal and advocacy support, and in some cases direct contracts, centers of excellence relationships, or wrap networks to reduce disruption.

How It Works

At the most basic level, RBP replaces a traditional network rate with a plan-defined payment rule. For example, if Medicare pays $3,000 for a procedure, and the employer RBP plan sets reimbursement at 140% of Medicare, the plan will pay a maximum of $4,200, rather than the hospital's billed charge or a carrier-negotiated commercial rate. If the pricing is above this level, the employee can choose to pay the difference out of pocket or to use navigation tools, centers of excellence (COEs), or alternative care sites (e.g., moving to a less expensive outpatient center) to obtain care. The same pricing logic can be applied across inpatient hospital services, outpatient facility claims, imaging, ambulatory surgery, and selected professional services, although most employers focus first on high-cost facility categories where the gap between commercial and Medicare rates is largest.

Operationally, the plan sponsor typically works with a third-party administrator, repricing vendor, and advocacy partner to adjudicate claims against the selected benchmark. When a claim is received, the vendor compares the billed amount against the reference-based allowed amount, audits the bill for errors or excessive charges, and issues payment based on the plan's stated methodology. If the provider accepts the payment, the claim is resolved. If the provider disputes the amount or balance-bills the member, the advocacy/legal support process is activated to negotiate the bill, defend the plan's payment methodology, and protect the member from inappropriate collection activity. Unlike a PPO contract, the RBP payment rule does not automatically create a contractual provider obligation to accept the allowed amount.

Again, we believe the more mature RBP models increasingly combine open-access reference pricing with targeted direct contracts, narrow networks, COEs, or pre-service steering and navigation assistance. This hybrid approach can reduce the "noise" associated with pure RBP by guiding members to providers that are known to accept the arrangement or have already agreed to defined rates. In our view, this reflects an important evolution: RBP is moving away from a simple repricing tactic and toward a more comprehensive health-plan operating model built around price discipline, navigation, and member support.

Adoption Trends and Outlook

As noted in a WTW analysis of RBP, renewed interest is being driven by escalating cost pressure, price-transparency rules, and a more-mature vendor ecosystem that can support repricing, analytics, advocacy, and provider engagement. RBP has been around for more than a decade, yet adoption remains much smaller than traditional fully insured, self-funded, or even level-funded arrangements. Still, interest appears to be rising of late, as employers become more frustrated with hospital price opacity and sustained high-single-digit healthcare cost trends.

The model has historically been most common among self-funded employers, Taft-Hartley plans, and midmarket groups willing to accept some member disruption in exchange for lower costs. However, the enabling environment has improved meaningfully over the past five years, particularly as price transparency tools have made it easier for employers to compare commercial prices against Medicare-based reference points. This gives employers a more credible foundation for challenging network rates and evaluating whether traditional PPO discounts truly deliver value.

Looking forward, we believe adoption will depend less on whether employers believe RBP can save money and more on whether vendors can make the member experience acceptable. Early RBP models were often criticized for provider disputes, and employee confusion. Newer models attempt to solve these issues through provider pre-engagement, member navigation, direct contracts, data-driven steerage, and stronger advocacy infrastructure. Again, WTW's recent analysis highlights this shift, noting that the vendor ecosystem has matured and that newer RBP approaches increasingly use predictive analytics and provider-navigation tools to send members to providers more likely to accept the reference-based arrangement. In our view, this is critical because employers will not adopt RBP at scale if the savings thesis comes at the expense of employee trust in the health plan.

Over the longer term, we believe RBP is likely to grow as a complementary strategy rather than a full replacement for traditional provider networks. The most durable models may be hybrid designs that use RBP as a pricing floor or backstop while layering in direct contracting, COEs, site-of-care steering, and navigation tools. This would allow employers to attack the most egregious facility pricing and preserve network stability for routine care and high-priority access points. Stated differently, RBP is likely to become part of a broader employer purchasing toolkit alongside ICHRAs, level funding, narrow networks, direct primary care, and COEs, rather than a standalone strategy used by most employers across all services.

Key Market Participants
The RBP market includes a mix of dedicated RBP vendors, repricing/payment-integrity platforms, TPAs, benefits consultants, navigation companies, and hybrid health-plan administrators.

Other market participants include TPAs and alternative-plan administrators that embed RBP into broader self-funded or level-funded plan designs; employer-facing navigation platforms that steer members toward fair-price providers; and point solutions focused on claims repricing, bill review, provider negotiation, and member advocacy. We review some of the key RFP providers and enablers in exhibit 11.

Exhibit 11
Cost Pressures and the Rise of Alternative HC Funding Models
Reference Based Pricing (RBP)



Source: William Blair Equity Research

Captive Insurance

Brief Overview
A captive insurance arrangement allows an employer to create or participate in an insurance company that it owns (or controls) to help fund its employees' healthcare costs. Instead of relying entirely on a traditional health insurer, the employer assumes more direct responsibility for its healthcare risk and can potentially retain underwriting profits that would otherwise go to an insurer.

Employers with relatively predictable claims experience often use captives to improve cost control and gain greater transparency into healthcare spending. They can also provide access to alternative risk-sharing arrangements and potentially reduce long-term healthcare costs. Captives are typically paired with stop-loss insurance to protect the employer against unexpectedly high-cost claims.

Overall, the model gives employers more control over healthcare financing while requiring them to take on additional risk and administrative complexity—offering a middle ground between self-insured and fully insured models.

How It Works

A healthcare captive is typically structured as an insurance entity that lets multiple employers pool their healthcare risk rather than each company bearing the full risk on its own. These plans are particularly attractive to smaller and midsize employers, which may lack the scale and/or claims volume to self-insure effectively.

To develop the plan, all employers in the group contribute premiums to the captive, which then uses the pooled funds to pay participating employees' medical claims, while stop-loss or reinsurance products protect the captive and its members from unusually large losses. At the end of the year, if there is a surplus left in the captive (after paying all claims, funding the stop-loss premiums, and accounting for all administrative expenses and reserves) the captive can either build up a surplus for future periods, use the funds to reduce future contributions, or distribute funds back to members.

By combining multiple employers together, a captive plan can create greater scale, diversify risk, and potentially access better pricing, data, and care-management strategies than an individual small employer could on its own. Participating employers generally govern the captive, and an administrator or captive manager handles insurance operations, claims administration, actuarial work, and compliance.

Put simply, by forming a captive, a group of smaller companies can gain many of the benefits of self-insurance while sharing risk across a larger, more diversified pool.

Adoption Trends and Outlook

Over the last several years, captive insurance has gained significant traction among employers. For example, WTW's 2025 Benefit Trends Survey found that more than 40% of employers are using or considering a captive health plan as an alternative financing option. Similarly, a recent AON report found that 31% of respondents in Aon's 2025 Global Benefits Trends Study were considering a captive, up from 26% in 2024.

In the report, Aon also noted that "Companies with a captive are citing better access to claims data, ability to keep benefit costs stable, and better response to medical inflation risk as key drivers to taking this approach." Based on comments from industry participants, we believe captives will be a major growth focus going forward. For example, Nick Hentges, CEO of group captive specialist Captive Resources, stated at a recent industry event that, "There is a tremendous amount of headroom in the employee benefits, medical stop-loss space. And so we've jumped into that in a big way. We are going to continue to try and grow casualty, but medical stop-loss has become a real target for us."

Key Market Participants

The captive market is dominated more by insurance brokers and consultants and traditional P&C and stop-loss insurers, than by healthcare technology and services organizations. However, several pure-play operators (built specifically for health benefits) have grown significantly over the past several years. We list these and several other global captive providers in exhibit 12.

Exhibit 12
Cost Pressures and the Rise of Alternative HC Funding Models
Captive Insurance Enablers

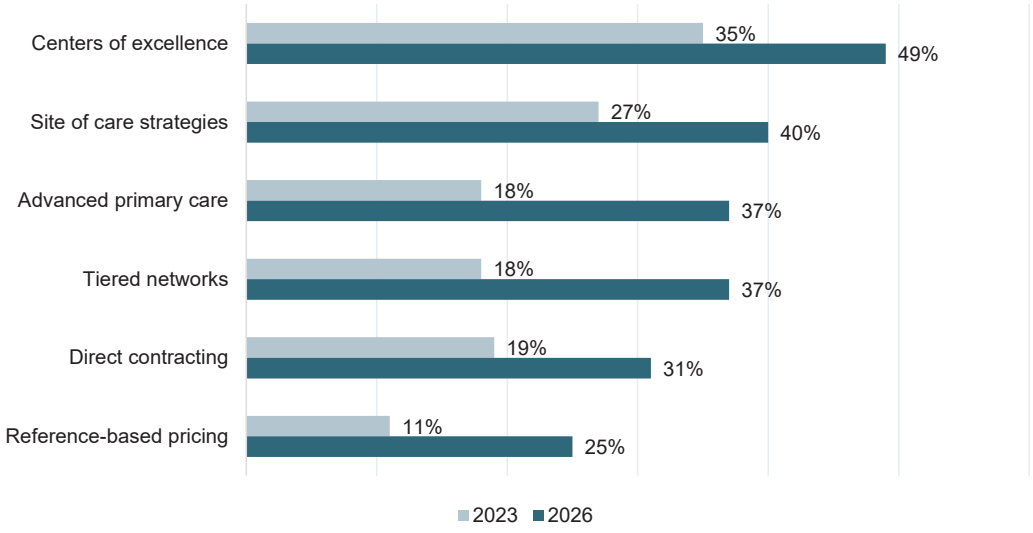
Source: William Blair Equity Research

Provider Contracting, Care Management, and Access Management Solutions

In addition to novel benefit plan designs, we believe employers of all sizes are increasingly turning to novel contracting and access/care management solutions to address rising healthcare costs. Again, we believe many of these initiatives are highly synergistic with benefit plan redesigns, particularly those that provide employers access to more claims data and afford them the opportunity to reduce healthcare spending with a recapture of premium dollars if cost trends are below targets.

As shown in exhibit 13, which is based on data from the *Pulse of the Purchaser* survey discussed earlier in this report, it appears that many of these solutions are already well-established initiatives—having gained significant traction over the past four years alone.

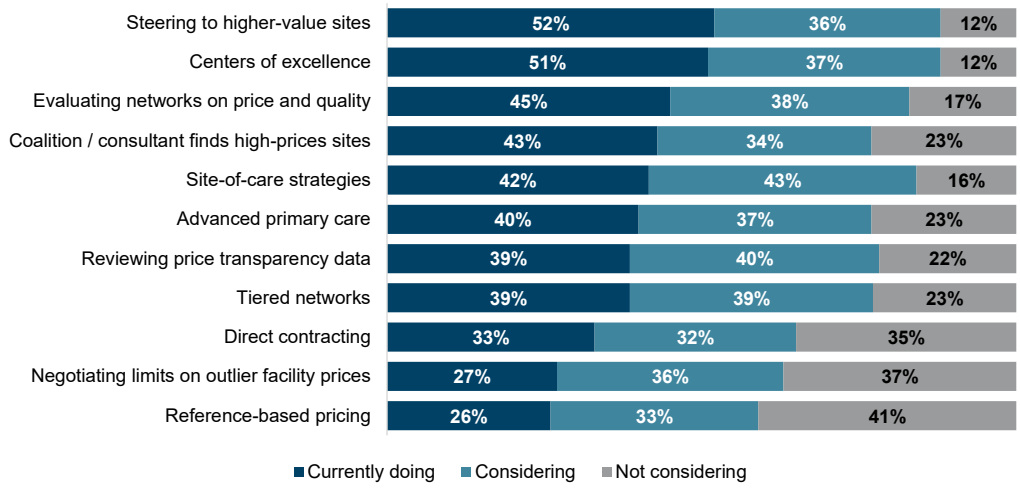
Exhibit 13
Cost Pressures and the Rise of Alternative HC Funding Models
Employer Adoption of Hospital Pricing Strategies, 2023–2026



2023 n=94-96 employers; 2026 n=243-248 employers
Source: National Alliance of Healthcare Purchaser Coalitions

Moreover, an equally large number of organizations appear to be actively considering these (and other) initiatives as well, which we believe presents a robust near-term growth opportunity for leading providers in the various sectors highlighted below.

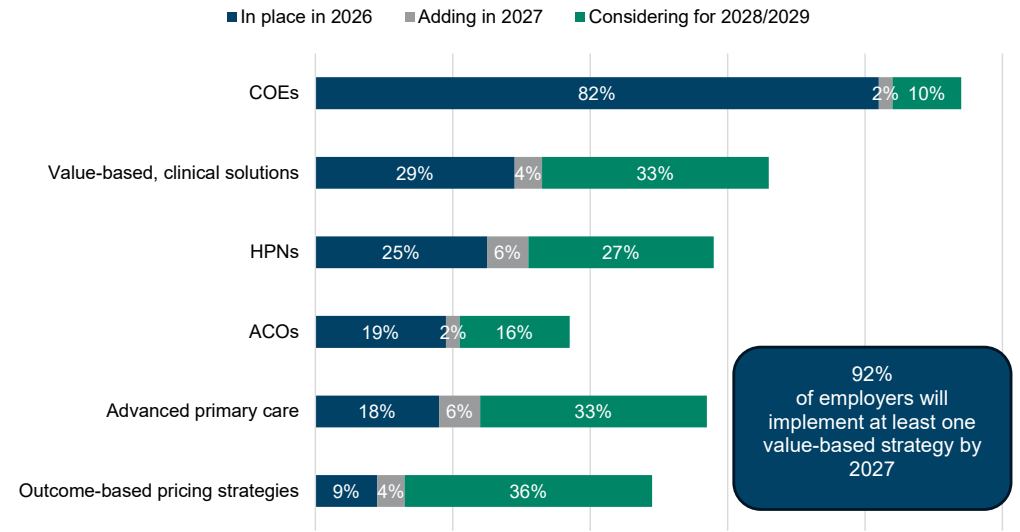
Exhibit 14
Cost Pressures and the Rise of Alternative HC Funding Models
Employer Approaches to Hospital Purchasing



Source: National Alliance of Healthcare Purchaser Coalitions

A similar result can also be seen in the recent Business Group on Health 2027 survey, which indicated that a significant percentage of employers are using value-based models to help improve their cost trends while increasing access to the highest-value care. For example, as seen in exhibit 15, 84% of employers plan to offer at least one COE option in 2027 and some are even considering *requiring* employees to use a COE to receive coverage.

Exhibit 15
Cost Pressures and the Rise of Alternative HC Funding Models
Employer Use of Various Value-based Models, 2026-2029



Source: Business Health Group

Below we review some of the primary access and care management innovations we believe will continue to gain traction over the coming years. Our report excludes patient navigation/advocacy and digital health solutions, as we previously addressed in detail in past reports (Coming Healthcare Cost Tsunami: A Need for Employee Engagement, Cost Containment Solutions).

On-Site and Near-Site Advanced Primary Care

Brief Overview
On-site and near-site care solutions bring convenient, employer-sponsored healthcare services closer to where employees work and live, helping improve access, reduce friction, and lower healthcare costs.

On-site care is delivered directly at an employer's workplace, typically through an employer-sponsored health center or clinic. Services can include primary and behavioral healthcare, urgent care, occupational health, preventive services, labs, care navigation, and chronic condition management. On-site clinics are particularly effective for large employers or concentrated workforces where employee volume can support a dedicated facility and staff.

Near-site care provides similar services at a location close to the workplace or employee population rather than directly on the employer's campus. Near-site centers can serve employees across multiple worksites (or serve multiple employer clients), giving employers access to a broader geographic footprint without the investment required to build and operate an on-site facility.

How It Works
On-site/near-site clinics are primary care facilities that employers pay for directly (typically via PMPM fees for employees and dependents or via a cost-plus model)—and largely operate under an advanced primary care model.

Again, as the employer pays the fee for this service, there are often no actual insurance claims filed; rather, an employee simply can schedule a clinic visit and use the services for free (a very highly valuable benefit that encourages high levels of engagement, greater preventive care, and lower absenteeism).

These clinics can be built and managed by the employer but are typically outsourced to a third-party partner with dedicated solutions (referral management technologies, telehealth, reporting capabilities, navigation services, etc.). In addition, these clinics can be shared among other *nearby* employers and, oftentimes, care can be delivered in a variety of settings—such as virtual-only, hybrid, or in-person.

In addition to enhanced financial benefits, employers appreciate the convenience of these clinics as employees often have better access to healthcare services. We note that on-site and near-site clinics typically enhance the healthcare consumer experience, particularly through increased patient access and lower wait times, longer visits, stronger engagement, and improved patient outcomes. According to a Survey of Worksite Health Centers, more than half (56%) of on-site/near-site clinics report average wait times less than 5 minutes, only 4% report wait times greater than 10 minutes, and nearly all clinics reported that appointments can be scheduled within two days.

Moreover, a core aspect of the value proposition for such clinics is the access to care teams at the facilities. Patients can access integrated care teams including their primary care physician, nurses, physical therapists, and behavioral health providers, and these care teams can provide guidance for care transitions and referrals as well (i.e., helping the patient navigate outside the four walls of the clinic). And the process is simplified for the patient compared with a traditional primary care experience as the employer directly covers most, if not all, of the cost when using a clinic.

Studies also indicate that outcomes are much better and costs are lower at these clinics for workers. A JAMA study looked at more than 23,500 commercially insured employees and dependents of a California-based manufacturing firm to assess the model. A cohort of patients who used either on-site or near-site clinics to receive primary care were matched to a cohort of patients who did not use an on-site or near-site clinic. The study then compared the utilization and cost of worksite clinics to traditional community-based primary care. In short, the key findings were as follows:

1. The worksite cohort was more likely to receive preventive services and chronic disease management.

2. The worksite cohort was less likely to visit the emergency room or be admitted to a hospital.

3. The worksite cohort had lower total healthcare costs.

In greater detail, the study found that members using the on-site/near-site primary care clinics had lower utilization across nearly all service categories—except, importantly, *primary care.* They had 52% fewer emergency department visits, 36% fewer hospitalizations, and 45% fewer specialist visits. Also, members using the subsidized worksite model had 45% lower total adjusted medical and pharmaceutical claims spend on a PMPM basis.

Another systematic review in the *Journal of Occupational and Environmental Medicine* found that 9 of 10 studies demonstrated positive ROI or cost-effectiveness for on-site health centers. Reported annual savings ranged from $35,479 to $2.12 million per health center, with ROI ranging from $1.09 to $15.88 for every $1 invested. The authors noted that larger employers, higher utilization, and longer operating histories tended to produce better results.

Similarly, a 2024 claims-based analysis across 26 employers and 11 industries found that employees/dependents primarily using Premise's on-site or near-site centers had 30% lower total cost of care, or $2,434 per member annually, compared with community-attributed members. It also found 52% fewer inpatient admissions and 17% fewer ER visits.

These models also drive improved workforce productivity and lower absenteeism, while also enhancing employee satisfaction and retention. As a result, we believe that many employers view these clinics not merely as a benefit, but as a core component of their healthcare and human capital strategy.

Adoption Trends and Outlook

On-site and near-site care appears to be a mature but still expanding segment of employer healthcare, with adoption increasingly shifting from traditional workplace clinics toward broader advanced primary-care models.

Based on recent data, more than half of large employers offer an on-site or near-site clinic option, and employers are increasingly expanding existing centers, adding locations, and broadening services rather than simply opening standalone clinics. The 2025 National Association of Worksite Health Centers survey found that *28% of employers planned to add locations in 2026, while 54% planned to expand services or staffing at existing centers.* In our view, the strongest growth opportunity may therefore be in near-site and hybrid models, which allow employers to serve distributed and hybrid workforces without requiring a clinic at every worksite.

Also of note, the market recently has been consolidating around larger national platforms, highlighted by the combination of Marathon Health and Everside (early 2024) and the merger of Premise Health and Crossover Health (completed in early 2026). Publicly traded occupational health services provider Concentra also expanded its footprint in the segment in early 2025 via the

acquisition of Pivot On-site Innovations (more than 240 locations) from Athletico Physical Therapy. Given the scale of these operators, we anticipate additional investments in expanding capabilities and growth models over the next several years.

Moreover, we believe the strategic direction of these clinics is evolving: rather than simply offering an on-site PCP office, employers are increasingly using these centers as an employer-sponsored primary-care front door that can manage chronic conditions, coordinate care, steer employees toward high-value providers and sites of care, and integrate behavioral health and pharmacy services.

As an example, in June 2026, Marathon Health and Lantern announced a partnership to help employers and labor organizations integrate on-site/near-site care with a specialty network of excellence (Marathon clients that do not currently offer Lantern's Specialty Care benefit can purchase it directly through Marathon to ease the contracting process). Data from a pilot program demonstrated the potential of such an initiative, as those in the pilot saw a 37%-100% increase in referrals to Lantern and as referrals from Marathon drove a 47% increase in completed or avoided surgeries.

In our view, **a logical next step for these providers may be deeper integration with managed-care networks, value-based contracts, and alternative health plans.** This could materially expand the addressable market as well, as the clinics would no longer need to be funded entirely through an employer's benefit budget; rather, they could capture medical-cost savings and payer economics as well, thus dramatically expanding the total market opportunity.

Key Market Participants

Exhibit 16
Cost Pressures and the Rise of Alternative HC Funding Models
On-Site and Near-Site Advanced Primary Care



Source: William Blair Equity Research

Centers (Networks) of Excellence (COEs) and Clinically Integrated Navigation

Brief Overview
COEs are employer-sponsored healthcare programs that help navigate employees to a specific network of specialty care providers that have demonstrated superior outcomes, lower complication rates, and more-efficient costs for specific procedures.

COE programs typically focus on high-complexity procedures and conditions such as orthopedic/MSK, cardiac care, oncology, transplants, and fertility care. The objective of COEs is to ensure that employees receive the right care, from the right provider, at the right time, and the program's main goal is to reduce complications and unnecessary costs while providing increased pricing transparency (often times providing fixed pricing for an entire continuum of care) to both employers and patients.

How It Works

COE program operators begin by identifying individual providers (and/or facilities) that deliver superior outcomes at a lower total cost of care--using clinical, cost, and patient satisfaction data to identify meaningful differences in quality, outcomes, and efficiency for a given procedure type and/or disease state. This data generally spans across multiple conditions and geographic locations, so that an entire network of curated providers is developed. The COE program contracts with these providers, often obtaining fixed (and/or discounted) pricing for an entire continuum of care, in return for inclusion in the network.

Employers then partner with specialized COE program operators based on their individual workforce needs (e.g., high MSK cost trends, elevated oncology costs) and geographic coverage—generally signing an agreement directly with a COE program operator to obtain specialty care and navigation solutions.

When employees need a procedure, they are then encouraged, and in some cases even required, to obtain care through a designated COE provider. For example, an employee who needs a knee replacement may be able to receive care from a local in-network hospital or travel to a designated COE that has demonstrated better surgical outcomes and lower total episode costs. In many programs, the employee may have little or no out-of-pocket cost if the COE is used, and patients typically receive assistance coordinating the entire episode of care though digital and in-person care navigation services as well.

Of note, data indicate that major cost savings can be achieved via the use of COEs. For example, a RAND Corporation study examined three major surgical procedures and found that using a COE with a bundled payment program significantly reduced surgery costs—by more than $16,000 per procedure—which represented an average decrease of more than 45%.

Similarly, data from Quantum Health (exhibit 17) demonstrate the value created as employers shift patients from low- to high-performing providers. Again, we believe these cost and quality savings are driving material adoption of COE solutions in the current environment.

Exhibit 17
Cost Pressures and the Rise of Alternative HC Funding Models
Unmanaged Variation Is Driving Medical Trends

	Cost of Low-Performing Providers	Cost of High-Performing Providers	Cost Savings
Obstetrics	$2,246	$956	$1,290
Ortho-Joint	$7,182	$435	$6,747
Spine	$12,154	$1,287	$10,867

Source: Quantum Health

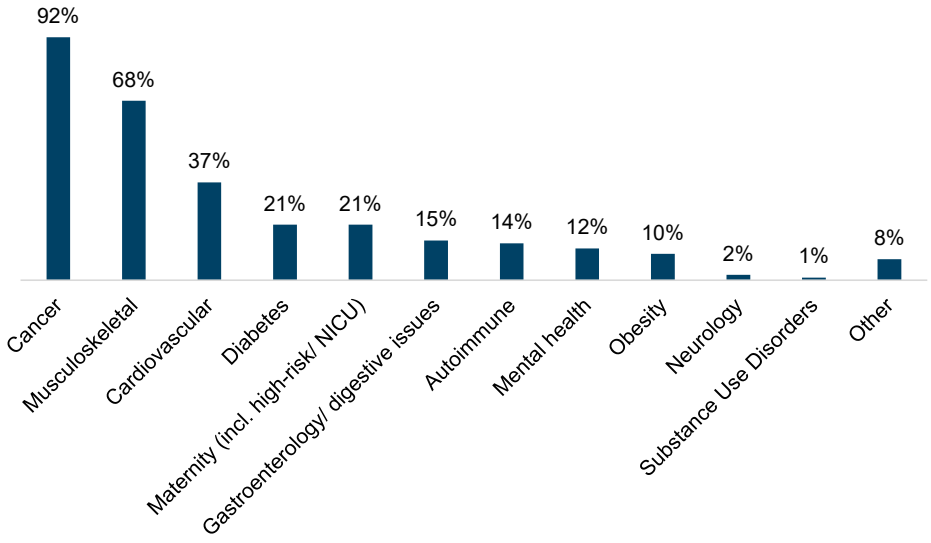
Adoption Trends and Outlook

According to Business Group on Health's 2027 Employer Healthcare Strategy Survey, 84% of employers plan to offer at least one type of COE in 2027, and employers increasingly view high-performance specialty networks as an important tool needed in their health plans. In fact, the report notes that many employers are considering requiring employees to use a COE in order to receive coverage for certain procedures/conditions.

This trend is also evident in the expansion of COEs across high-cost and complex conditions. For example, the Business Group on Health's 2026 Employer Healthcare Strategy Survey, indicated that, "about half of employers will offer a cancer COE in 2026, and another 23% are considering doing so by 2028."

Here, we believe the continued expansion of COEs into areas such as oncology illustrates how employers are increasingly using targeted provider networks to address several of the most significant sources of healthcare spend. For example, we believe the top conditions driving employer healthcare costs (as shown in exhibit 18) have all become focal areas for COE provider networks.

Exhibit 18
Cost Pressures and the Rise of Alternative HC Funding Models
Top Conditions Driving Healthcare Costs, 2026



Source: 2027 Employer Healthcare Strategy Survey

Another key trend is that **COE programs are being integrated into broader care navigation platforms and digital health offerings.** One example of this shift is how Quantum Health offers multiple COE platforms in its navigation model to guide members to trusted specialty care providers. These COE solutions for Quantum Health members include both Carrum Health and Lantern, where members can access high-quality care from a variety of local and national providers in these networks. Of note, Quantum Health describes the COE programs in its broader navigation model as bringing "people, data and decisions together in one place."

Another example of the evolution of COEs is the August 2026 announcement by Included Health that it would embed Carrum Health's COE platform directly into its navigation platform and novel insurance offering. In discussing the deal, Included Health Chief Health Officer Dr. Ami Parekh stated that, "by working with Carrum Health and bringing their value-based specialty care into our alternative plan offering, we can help members reach high-quality care sooner, with clear guidance and clear costs." Of note, the collaboration between the two companies will target treatments that see high variability, such as surgeries, cancer care, and substance-use disorder treatment. Included Health will first identify complex specialty care needs through its platform and refer patients to Carrum Health; after treatment, Carrum Health will then transition members back to Included Health for ongoing support.

Also, in August of this year, Transcarent launched a bundled payment model for advanced cancer therapies, a first of its kind for the company. This payment model will connect Transcarent members to leading oncology providers across various settings.

Hinge Health recently added HingeSelect to its core digital MSK offering, giving users access to a curated network of more than 4,100 provider locations across all 50 states. With HingeSelect, the company now offers an integrated care team that can help manage an entire MSK care journey: digital or in-person physical therapy, specialist evaluations, surgery, and post-surgical recovery. Of note, network users typically capture 30% to 50% savings versus commercial rates, and early data indicates a 20% reduction in total MSK spend, as well as a 60% reduction in imaging and surgery utilization, compared with commercial benchmarks.

We also believe COEs are evolving from travel-dependent programs into locally accessible networks of excellence. More specific, COE programs originally focused on directing members to a limited number of *nationally recognized* providers, which often required significant travel for care and limited the procedure base to only the most expensive cases (where the cost savings would more than offset travel and boarding expenses).

Moreover, despite the potential for better outcomes, patients' unwillingness to travel made the original model less impactful, as overall utilization remained quite low. For example, data from Lantern indicate a roughly eightfold difference in utilization when care is offered locally versus when it requires a flight, and about a fivefold difference when patients have to drive more than two hours to another major metro area to obtain care.

As a result, we believe leading COE programs have expanded beyond the traditional model by building broader groups of high-performing providers across local markets. Here, Lantern's CEO John Zutter describes Lantern's approach as a "network of excellence model": instead of having the most famous doctors at the most well-known academic medical centers, the company identifies high-quality specialty care physicians and facilities closer to patients' homes. And as travel costs and scheduling no longer become friction points, a flywheel effect takes place where utilization increases and the value of the network continues to improve over time (more outcomes data to identify the top providers, more providers included, an expansion in covered procedure types even into lower-cost cases, more patients serviced, more employer interest, etc.).

Again, data indicate that these networks can have a material impact on cost trends. For example, Lantern published a study showing how the site of care dramatically impacts outcomes and costs: when including physicians at a local level that are experienced Lantern providers, data shows:

- 75% lower readmission rates;
- Ten times lower revision rates for total joint replacements; and
- Six times lower infection rates than hospital outpatient surgeries.

Again, we believe these data points will increasingly encourage adoption of the COE model in the coming years.

Key Market Participants

Exhibit 19
Cost Pressures and the Rise of Alternative HC Funding Models
Centers (Networks) of Excellence (COEs) and Clinically Integrated Navigation



Source: William Blair Equity Research

Direct Contracting and Tiered Networks

We also see employers increasingly exploring direct contracting and tiered/high-performance networks as additional tools to address rising healthcare costs. In our view, these represent more nuanced, targeted approaches than the broader macro trends discussed above, and are likely to be deployed selectively based on an employer's local market, workforce, and provider dynamics.

We also view both more as adjuncts to COEs, which we believe offer a more value-added and scalable solution given their ability to steer members toward high-quality providers while addressing specific high-cost episodes of care. The COE market also benefits from a more established ecosystem of scaled operators and dedicated platforms, whereas direct contracting and high-performance networks require much greater local-market customization and direct employer involvement (often limiting the solutions to only the largest employers in a market).

Nevertheless, we briefly recap both solutions below given their relevance in the broader employer cost-containment marketplace.

Brief Overview and How They Work
Direct contracting generally means an employer contracts directly with a healthcare provider or provider organization to obtain care—often with negotiated pricing and/or a defined payment arrangement—rather than relying entirely on a traditional insurance carrier or broad provider network. In our view, the solution is mainly relevant to large self-insured employers, because they bear the actual cost of the claims and therefore have a stronger incentive (and the scale of employed lives and dependents) to directly negotiate with providers. Some of country's largest employers (Boeing, Walmart, Lowe's, and General Electric) have been early adopters of the solution.

A ***tiered network*** differs as it puts healthcare providers into different levels based on some combination of price, quality, and outcomes. Employees pay different amounts (either different percent copayments or overall out-of-pocket expenses) depending on which tier they use.

For example, an employer might structure a plan so that a knee replacement at a preferred orthopedic group practicing in an outpatient surgery center costs the employee $1,000, while using a less efficient acute-care-based provider costs $3,000. The employee is still afforded the choice of which provider to use but would be required to cover the additional cost above the preferred rate (in this case $2,000 of out-of-pocket spend) if the less efficient provider/site of care is selected.

Adoption Trends and Outlook
Tiered and high-performance networks have achieved adoption among larger employers, although they remain far from universal.

KFF data indicate that 15% of employers with 50 or more employees offered a tiered or high-performance network in 2025, while this increased to about 25% among employers with 1,000 to 5,000 or more employees.

Mercer has a somewhat broader definition, which suggests adoption is higher. Mercer's Survey on Health and Benefit Strategies for 2026 found that 35% of large employers now offer at least one plan that directs employees to "smaller networks of higher-performing providers." This includes variable copay plans, in which copayments for the same healthcare service vary by individual provider and are disclosed to members up front.

A second Mercer report from June 2026 further indicated that 31% of large employers currently offer, or plan to offer, at least one nontraditional medical plan in 2027, such as a high-performance network or variable copay plan. Another 38% are considering one of these approaches for the future.

Key Market Participants
Most large insurers offer high-performance networks to employers; however, there are also several private players in the space, including those we highlight below.

As it relates to direct contracting, we believe the majority of large employers develop these contracts in house (e.g., Walmart uses its internal people services team to perform direct outreach, on-site health-system visits, and deep historical claims data audits), but employers also rely on third-party administers (TPAs) to help operationalize and manage the contracts.

Exhibit 20
Cost Pressures and the Rise of Alternative HC Funding Models
Direct Contracting and Tiered Networks



Source: William Blair Equity Research

Recent Funding, M&A, and Partnership Activity Also Indicate Broad Interest in the Sector

2025 Funding and M&A Activity

- ***Remodel Health*** *– $100 million financing from Oak HC/FT and Hercules Capital at the end of 2024 (which we still include in our recap given the size of the transaction).* The investment was aimed at accelerating Remodel Health's expansion in the ICHRA market, including continued investment in its technology platform, broker distribution, and ability to help employers transition from traditional group health plans to individual-market coverage.

- ***Thatch*** – *$40 million series B:* Thatch raised $40 million in April 2025 in a series B led by Index Ventures, with participation from existing investors including Andreessen Horowitz and General Catalyst and strategic participation from ADP Ventures. The company provides technology for ICHRAs and personalized employer health benefits. The round brought total funding to roughly $85 million.

- ***Imagine360*** – *acquisition:* Acquired HealthFirst, Ardent Health's third-party administrator, in a transaction completed December 31, 2024, and announced January 15, 2025. Imagine360 also acquired related entities Medical Management Solutions and Risk Funding Alternatives; financial terms were not disclosed.

- ***Arlo Health*** – *$4 million seed:* Arlo Health raised $4 million in seed funding on March 25, 2025, led by Upfront Ventures, with participation from 8VC and General Catalyst. Arlo is particularly relevant to level-funding work because it is a level-funded health-plan platform focused on small and midsize employers. The company said it had already written mid-eight figures of premium in its first year and was using the capital to expand engineering, sales, and operations.

- ***Advanced Medical Pricing Solutions (AMPS)*** – *debt financing:* In April 2025, Crestline Investors provided AMPS with a senior secured term loan to support growth, expansion of its healthcare cost-containment offerings, and rollout of new software products. The financing amount was not disclosed; AMPS is backed by Cimarron Healthcare Capital.

- ***Vitable Health*** – *acquisition:* In May 2025, Vitable Health acquired Liferaft's HRA platform to add ICHRA administration and technology to its direct primary care and employee benefits platform. The combination gives Vitable an integrated offering that pairs ICHRA-funded individual insurance with primary care, mental health, prescriptions, and other benefits, primarily targeting small and midsize employers that struggle to afford traditional group coverage. Liferaft brought HRA technology, claims infrastructure, broker relationships, and experience serving hundreds of employers; Vitable said the acquisition accelerated its ICHRA go-to-market by at least six months and expanded its broker and employer distribution.

- ***Beyond Health*** – *consolidation:* In May 2025, Beyond Risk Management consolidated three of its employee-health businesses—Beyond Health, SL Management Partners (SLMP), and BeyondRe Stop Loss Insurance Services—under the unified Beyond Health brand. Beyond Health operates an employee health benefits group captive within HatterasRe, while SLMP provides medical stop-loss underwriting and claims solutions, and BeyondRe specializes in underwriting captive stop-loss programs. The transaction was positioned as a strategic consolidation, bringing captive and traditional stop-loss capabilities onto a single platform to improve underwriting scale, systems integration, claims expertise, and broker/client service. In our view, the move was significant as it illustrates the broader trend toward vertically integrated health-benefit funding platforms that combine captives, stop-loss, underwriting and cost-management capabilities, particularly for midmarket employers.

- ***Zelis*** – *acquisition:* Acquired the assets of Medxoom from Allied Benefit Systems in June 2025. Medxoom provides a mobile member-experience platform, and Zelis is integrating it with its pricing, provider, quality, and cost data to expand price transparency and member engagement capabilities.

- ***Angle Health*** – *$134 million series B:* Angle Health raised $134 million in December 2025, in a round consisting of both equity and debt. The financing brought Angle's total funding to nearly $200 million. Angle is one of the most important companies for our analysis as it combines level-funded/alternative funding, insurance risk, technology, and care-management capabilities in a full-stack platform for SMB employers.

- ***XO Health*** – *$52.2 million:* XO Health raised about $52.2 million in September 2025. The company is building a value-based health-plan platform for self-insured employers, with technology, provider contracting, claims, and care-management capabilities. XO had previously announced institutional backing from Thurston Group and Sea Court Capital, but the $52.2 million 2025 financing is the important new-money event. Of note, we would classify this as a more of a value-based care/network solutions financing event.

- ***Capital Rx and Judi Health*** – *$400 million financing:* Capital Rx announced a $400 million financing in September 2025, including a $252 million series F, plus additional investment in the company's securities. The round was led by Wellington Management and General Catalyst, with participation from Generation Investment Management, Goldman Sachs Alternatives, 9Yards, B Capital, Edison Partners, Prime Health Investments, Transformation Capital, and others. Capital Rx subsequently rebranded as Judi Health in 2026. This is broader than PBM now: the company is positioning Judi as an enterprise health-benefits administration platform spanning pharmacy, medical claims, care, and benefits technology.

- ***Gravie*** – *roughly $144 million financing:* Gravie raised about $144 million in 2025, adding substantial capital to a platform that combines ICHRAs, level-funded insurance, and benefits administration. Gravie is particularly notable, in our opinion, as it sits directly at the intersection of two of the fastest-growing alternative-funding models.

- ***Benefitbay*** – *$5 million financing:* Benefitbay raised about $5 million in 2025 to expand its ICHRA platform. The company focuses on helping employers move toward defined-contribution health benefits while providing technology for employees to select individual coverage.

- ***The Difference Card*** – *PE acquisition:* Stone Point Capital acquired The Difference Card from Northlane Capital Partners in 2025. Financial terms were not disclosed. The transaction is relevant to level funding and alternative plan design because The Difference Card provides employer health-plan products designed to give employers more control over healthcare spending.

- ***HealthEZ*** – *roughly $360 million strategic exit:* Horizon Blue Cross Blue Shield of New Jersey acquired HealthEZ from private-equity owner Abry Partners for about $360 million in 2025. HealthEZ provides infrastructure for TPAs and self-funded plans, making the deal particularly relevant to the level-funded/self-funded market. In our view, this deal represents a good example of a PE-backed benefits platform ultimately being acquired by a health-plan strategic.

- ***OneDigital*** – *$7 billion valuation:* Stone Point Capital and CPP Investments made a major investment in OneDigital in 2025 at a valuation reportedly exceeding $7 billion. While OneDigital is much broader than level funding, the transaction is important because it gives institutional investors exposure to one of the largest employer-benefits distribution platforms, including self-funded and alternative-funding products.

- ***Concentra and Pivot On-site Innovations*** – *$55 million acquisition:* Concentra (covered by analyst Jared Haase) acquired Pivot On-site Innovations for about $55 million in 2025. Pivot operates employer on-site health clinics, making the deal a direct example of strategic consolidation in on-site employer care.

- ***Agile Occupational Medicine and Akeso*** – *PE-backed merger:* Angeles Equity Partners and Kain Capital combined their respective occupational-health businesses, Agile Occupational Medicine and Akeso Occupational Health, in 2025. The combined platform expanded its employer-focused clinical footprint and represents the continued PE consolidation of occupational and employer-direct care.

- ***Transcarent and Accolade*** *– $621 million acquisition:* Transcarent acquired Accolade for about $621 million in 2025. The combination brought together navigation, virtual care, specialty care, and employer health-plan services and significantly expanded Transcarent's employer and health-plan footprint. It is one of the clearest examples of direct contracting, navigation, and specialty-care capabilities being consolidated into a single employer-health platform.

2026 Funding and M&A Activity

- ***Gravie*** *– General Atlantic growth investment:* General Atlantic made another investment in Gravie in 2026. The amount was not publicly disclosed, but the transaction brought Gravie's cumulative capital raised to roughly $460 million.

- ***Benefitbay*** *– $18 million series A:* Benefitbay raised about $18 million in a 2026 series A led by Ten Coves Capital. The financing followed its 2025 capital raise and gives the company additional resources to scale its ICHRA technology and employer distribution platform.

- ***Thatch and Venteur*** *– acquisition:* Thatch acquired Venteur's business in 2026, with terms undisclosed. In our view, this transaction is significant because it represents one of the first signs of consolidation among ICHRA technology platforms rather than simply another startup raising venture capital.

- ***Included Health*** *– acquisition:* In July 2026, Included Health announced an agreement to acquire Firefly Health, a clinically integrated health-plan and advanced primary-care company. The deal combines Included Health's virtual care/navigation platform with Firefly's primary-care-led health plan, nationwide in-person/in-home network, and alternative benefit design.

- ***Lantern*** *– $30 million strategic investment:* Lantern, formerly Employer Direct Healthcare, raised $30 million from Morgan Health and Echo Health Ventures in 2026. Lantern operates a specialty-care platform that connects employers with high-quality providers for surgery, cancer care, and other complex services (e.g., networks of excellence). In our view, the investment is particularly significant because Morgan Health represents a major employer-health strategic investor rather than traditional venture capital.

- ***Premise Health and Crossover Health*** *– merger:* Premise Health and Crossover Health announced a merger in 2026, creating a combined employer-focused primary-care platform with roughly 900 clinics serving more than 400 organizations. The transaction brings together Premise's large on-site/near-site infrastructure with Crossover's technology-enabled advanced primary-care model.

- ***Difference Card and HealthCorum*** *– acquisition:* The Difference Card acquired HealthCorum in 2026. HealthCorum provides healthcare analytics, provider-quality intelligence, and technology designed to help employers identify higher-value providers. The acquisition is particularly interesting because it adds a data and provider-steering layer to an alternative-funding platform.

Expanding the Value Proposition Through Partnerships

Another clear trend that is emerging across the employer healthcare market is that companies are increasingly expanding their value proposition through strategic partnerships rather than trying to build every capability internally.

In our view, as employers face sustained healthcare cost increases and greater pressure to demonstrate measurable savings, *standalone point solutions are becoming less attractive.* Employers increasingly want more comprehensive solutions that address multiple parts of the healthcare

journey, while reducing the burden of managing a collection of disconnected vendors. This is driving a wave of partnerships that connect previously separate capabilities—including alternative funding, primary care, navigation, provider steering, direct contracting, COEs, specialty care, and site-of-care optimization. Carrum, Lantern, and XO Health, for example, are broadening their offerings by connecting with complementary platforms, providers, and distribution partners.

In our view, **the frequency of these partnerships reflects a fundamental shift in what employers are looking for: employers increasingly want an integrated model that can identify a need, direct the member to the right provider, manage the economics of care, and ultimately improve outcomes.** For the companies themselves, partnerships provide a relatively capital-efficient way to expand their addressable market and increase the value of their existing platforms.

In our view, the result is an emerging employer healthcare ecosystem where companies are assembling more comprehensive solutions by connecting complementary capabilities rather than building everything internally—creating greater value for employers while making their individual platforms more strategically important. We review several of the more noteworthy partnerships from the past two years in the pages below.

- ***XO Health and Gravie:*** In April 2025, XO Health partnered with Gravie to bring XO's value-based provider network into Gravie's employer health-plan offering in Minnesota. The partnership is notable because Gravie is an ICHRA and level-funding platform, while XO is a value-based, self-funded health-plan platform. Together they connect alternative plan design with value-based provider contracting and faster provider payment.

- ***XO Health and National Cancer Treatment Alliance:*** In April 2025, XO Health partnered with the National Cancer Treatment Alliance to give XO's self-insured employer clients access to NCTA's national network of independent community oncology practices. The arrangement creates a direct-contracting pathway between an employer health-plan platform and community oncology providers, allowing employers to access specialty care outside traditional hospital-system contracting.

- ***XO Health and PayMedix:*** In February 2025, XO Health partnered with PayMedix to provide XO members with interest-free healthcare financing and simplified payment processing. The relationship adds a consumer-payment component to XO's broader self-funded and value-based health-plan platform.

- ***Carrum Health and Teladoc Health:*** In March 2025, Teladoc selected Carrum as a COE partner for its Connected Care program. Teladoc's employer clients can access Carrum's specialty network, with Teladoc clinicians referring eligible members into Carrum. The relationship connects virtual-care and primary-care touchpoints with specialty referrals and COE care.

- ***Carrum Health and AssuredPartners:*** In April 2025, AssuredPartners partnered with Carrum to make Carrum's COE network available to its self-insured employer clients. The arrangement provides a distribution channel through a major benefits broker and expands access to Carrum's surgery, cancer, and substance-use treatment programs.

- ***Claritev and Lantern:*** In May 2025, Claritev entered a strategic partnership with Lantern to integrate Claritev's cost-containment capabilities with Lantern's specialty-care platform, with the goal of improving surgical cost transparency, care quality, and savings.

- ***Carrum Health and Sidecar Health:*** In September 2025, Sidecar Health partnered with Carrum to incorporate Carrum's bundled specialty-care network into Sidecar's consumer-driven health-plan platform. The combination brings together Sidecar's transparent plan design with Carrum's bundled pricing and specialty-provider network.

- ***Carrum Health and Lyra Health:*** In January 2026, Carrum and Lyra created an integrated specialty-care and mental-health solution. Carrum provides surgery, cancer, and substance-use-disorder care, while Lyra provides behavioral health. The partnership is designed to address members with complex conditions where physical and behavioral health needs overlap.

- ***Carrum Health and Virta Health:*** In March 2026, Carrum and Virta launched an integrated metabolic and surgical-care pathway combining Virta's nutrition coaching, virtual care, and medication management with Carrum's surgical network. The model creates a continuum from chronic metabolic disease management and medical weight loss through potential bariatric surgery.

- ***Imagine360 and Health Rosetta:*** In July 2026, Imagine360 and Health Rosetta launched Choice360, an integrated health-plan offering combining Imagine360's alternative health-plan/RBP model with Health Rosetta's employer and advisor ecosystem. The offering went through Health Rosetta's Embedded Solutions evaluation process and is being positioned as a standardized alternative for employers facing high healthcare costs.

- ***Carrum Health and Included Health:*** In August 2026, Included Health selected Carrum as its preferred COE partner and embedded Carrum's specialty network into Included Health's Alternative Health Plan. Included Health can identify members needing specialty care and route them to Carrum, with members transitioning back to Included Health for continuing care after treatment. This represents a combination of alternative health-plan design, navigation, primary care, and specialty/COE care.

- ***Lantern and Infusion for Health:*** In 2025, Lantern partnered with Infusion for Health to expand access to infusion therapy in lower-cost, nonhospital settings. The relationship allows employers to steer appropriate infusion treatment toward alternative sites of care while reducing costs associated with hospital-based infusion.

- ***Lantern and Quantum Health:*** In February 2026, Quantum Health partnered with Lantern to make Lantern's specialty-care network available to self-insured employers using Quantum's navigation platform. Quantum effectively becomes a navigation and distribution layer between employers and Lantern's specialty-care network.

- ***Lantern and Marathon Health:*** In June 2026, Marathon Health and Lantern launched an integrated primary- and specialty-care model. Marathon's advanced primary-care physicians can identify patients who need specialty treatment and refer them directly into Lantern's network, initially with a focus on orthopedic care. The model creates a continuum from on-site/near-site primary care to specialty navigation, high-value specialists, and direct-contracting/COE care.

- ***Lantern and AccessHope:*** In February 2026, Lantern expanded its cancer-care offering through a partnership with AccessHope, providing members with access to expert cancer reviews, NCI-designated cancer-center expertise, clinical trials, and oncology navigation.

- ***Lantern and Pelago:*** In 2025, Lantern partnered with Pelago to incorporate substance-use-disorder treatment into its specialty-care platform, expanding Lantern beyond surgery and other traditional specialty categories.

- ***Marathon Health and Medbridge:*** From 2025-2026, Marathon partnered with Medbridge to integrate virtual musculoskeletal care into Marathon's primary-care and MoveWell MSK programs. The relationship allows Marathon to extend its physical therapy and MSK capabilities through a technology-enabled model.

- ***Marathon Health and Garner Health:*** Marathon's relationship with Garner is strategically relevant to its provider-referral model, using provider-quality and cost data to improve specialist referrals. However, the core Marathon–Garner relationship predates 2025 and therefore should not be treated as a new 2025-2026 partnership.

- ***Angle Health and PerfectQuote:*** In August 2025, Angle partnered with PerfectQuote to provide firm, underwritten level-funded quotes through PerfectQuote's digital RFP platform. The partnership is significant because it digitizes the broker quoting and distribution process for Angle's level-funded plans and allows brokers to receive pricing much more quickly.

- ***Angle Health and Leap Health:*** In January 2026, Angle partnered with Leap Health to provide its SMB employer population with lower-cost infusion options, including home infusion where clinically appropriate. The relationship combines level-funded insurance with specialty-care management and site-of-care optimization.

- ***Sana Benefits and PerfectQuote:*** In March 2026, Sana partnered with PerfectQuote to distribute Sana's level-funded medical plans through PerfectQuote's benefits-quoting and RFP platform. The partnership expands Sana's broker distribution and makes its level-funded products accessible through a digital quoting workflow.

- ***Crumdale Specialty and HPS/PayMedix:*** In November 2025, Crumdale partnered with HPS/PayMedix to expand its level-funded and self-funded offerings in Wisconsin. HPS provides a regional provider network covering hospitals, physicians, and clinics. The arrangement illustrates how emerging level-funded platforms can assemble regional network infrastructure through external partners rather than building networks themselves.

- ***Judi Health and EmblemHealth and Amazon Pharmacy:*** In 2025, EmblemHealth worked with Judi Health and Amazon Pharmacy to create a pharmacy model combining Judi's technology and claims infrastructure with Amazon Pharmacy's consumer experience and home delivery. The relationship illustrates Judi's evolution from a standalone PBM into a broader health-benefits administration platform.

- ***Judi Health and CLEAR:*** In 2026, Judi partnered with CLEAR as a preferred identity-verification partner, integrating CLEAR's identity technology into Judi's health-benefits platform. This is more infrastructure-focused than care-delivery focused, but it reflects Judi's broader effort to create an end-to-end benefits administration platform.

- ***Arlo Health and Nationwide:*** Arlo's relationship with Nationwide is strategically important because Nationwide provides medical stop-loss capacity while Arlo operates as an MGU for its small-business health-plan offering. However, the relationship was announced in 2024 and therefore falls outside a strict 2025-2026 partnership analysis.

Conclusion

As discussed throughout this report, rising health costs are driving employers to seek novel benefit designs and provider contracting solutions that will have myriad implications for patients, payers, and providers over the coming years.

Equally important, an entire ecosystem of service and platform providers will be required to enable this evolution to progress in a safe, frictionless, and cost-effective manner—in our view, creating a multibillion-dollar addressable market for innovative providers that offer scaled solutions to address the opportunity.

While the list in the next section is in no way a full review of all these leaders, we attempt to provide brief insights on several of the current category leaders in each specific area related to our theme.

Company Profiles

We see a number of high-growth public and private entities in the space that are set to benefit from the developments discussed in this report, including the operators we profile in detail listed on the following pages.

Innovative Benefit Plan Designs

Angle Health Headquarters: San Francisco, CA https://www.anglehealth.com	Angle Health is an AI-enabled health insurance company delivering tech-enabled, level-funded group health plans for employers. Its platform integrates with more than 100 payroll, HRIS, and benefits administration systems, and members receive support from a dedicated care team to help them understand benefits, navigate coverage, and access care.
Arlo Health Headquarters: New York, NY https://www.joinarlo.com	Arlo is a level-funded health plan built for small and midsize businesses with 5 to 250 employees seeking transparent, prevention-first coverage without the traditional price tag. Its plans feature upfront pricing, $0 primary-care copays, and data-driven underwriting designed to keep year-over-year premium increases in check.
Crumdale Specialty Headquarters: Paoli, PA https://crumdalespecialty.com	Crumdale Specialty is a diversified insurance firm that unifies risk, administration, pharmacy, and care management into one connected self-funded healthcare model. Its integrated approach, spanning captive solutions, TPA services, medical stop-loss, and pharmacy benefit management, helps employers and brokers lower costs and improve outcomes.
Decent Headquarters: Austin, TX https://www.decent.com	Decent helps small businesses make health insurance more affordable by eliminating unnecessary costs and rebuilding coverage around Direct Primary Care. By reducing administrative overhead, broker fees, and other waste that drives up premiums without improving care, Decent delivers a simpler, more-transparent health plan designed to put more of every premium dollar toward better health outcomes.
The Difference Card Headquarters: Greenwich, CT https://www.differencecard.com	The Difference Card is a medical expense reimbursement plan (MERP) administrator that works alongside an employer's existing health plan to reduce healthcare costs by 5% to 20% without reducing employee benefits. With 25 years of experience and more than $2.13 billion in delivered savings, the company uses plan design and data-driven strategies to identify opportunities to lower costs while maintaining the quality and accessibility of care for employees.
Gravie Headquarters: Minneapolis, MN https://www.gravie.com	Gravie is one of the fastest-growing health benefits companies, serving small and midsize employers with its flagship Comfort plan. This level-funded plan covers most common healthcare services at zero cost to members. Gravie also offers an industry-leading ICHRA solution that gives employers predictable costs and employees more choice.
Judi Health (Formerly Capital Rx) Headquarters: New York, NY https://www.judi.health	Judi Health is an enterprise health technology company and benefits administrator delivering pharmacy, medical, and platform-licensing solutions through Judi Rx, which was formerly Capital Rx, Judi Care, and Judi Cloud. Its Judi platform unifies pharmacy, medical, dental, and vision claims processing, replacing fragmented, opaque benefit systems with transparent, aligned administration.
Sana benefits Headquarters: Austin, TX https://www.sanabenefits.com	Sana Benefits provides small and midsize businesses with flexible, level-funded health plans built around Sana Care, a virtual-first primary care and care navigation service. Members get unlimited messaging with a dedicated care team, transparent pricing, and access to a nationwide network of more than 1.2 million providers.
Sidecar Health Headquarters: El Segundo, CA https://www.sidecarhealth.com	Sidecar Health is an ACA-compliant health insurance company that pays members a fixed benefit amount based on the typical local cost of care, letting them see any provider with no networks, referrals, or prior authorizations. Members who choose care below the benefit amount keep half the savings, an approach the company says lowers employer costs and out-of-pocket spending while giving members full price transparency.
Surest Headquarters: Minnetonka, MN https://www.surest.com Ticker: UnitedHealth Group (UNH)	Surest, a UnitedHealthcare health plan, is a copay-only, ACA-compliant medical plan that eliminates deductibles and coinsurance. Its app shows members upfront pricing and quality ratings before they seek care, helping them choose cost-efficient, high-value providers within the UnitedHealthcare network.

Tres Health Headquarters: Boca Raton, FL https://www.tres.health/	Tres Health provides a comprehensive suite of alternative medical insurance solutions for employers, from small businesses to large groups. Its offerings span ACA-compliant minimum essential coverage (MEC) preventive health plans, minimum value plan (MVP) health plans that help employers avoid ACA penalties, and gap insurance to help employees cover out-of-pocket deductibles and coinsurance.
XO Health Headquarters: Alpharetta, GA https://xohealth.com	XO Health is a value-based health plan and technology platform offering fully integrated medical and pharmacy benefits with a built-in savings guarantee for employers. Its platform aligns plan administrators, providers, and members around measurable health outcomes rather than volume-based fee-for-service care.

ICHRAs

Ambient Headquarters: Alpharetta, GA https://www.ambienttpa.com Ticker: Priority (PRTH)	Ambient, a division of Priority, is a payments-as-a-service platform that helps TPAs, brokers, and employers administer ICHRA plans. Its technology automates premium funding and payments, generates ERISA-compliant plan documents, and handles benefit elections and reconciliation for individual coverage health reimbursement arrangements.
BenefitBay Headquarters: Kansas City, MO https://www.benefitbay.com	BenefitBay is an end-to-end ICHRA administration platform that helps agents, employers, and employees model, deploy, and manage individual coverage health reimbursement arrangements. The platform simplifies plan modeling, compliance, and enrollment while giving employees visibility into government subsidy dollars and personalized plan choice.
Centene Headquarters: Saint Louis, MO https://www.centene.com Ticker: CNC	Centene is the largest Medicaid managed care organization and the longest-running carrier on the Health Insurance Marketplace, serving Medicaid, Medicare, and ACA members nationwide. Through its Ambetter Health subsidiary, Centene is expanding into ICHRA-eligible plans as more employers shift toward individual coverage models.
Gravie Headquarters: Minneapolis, MN https://www.gravie.com	Gravie is one of the fastest-growing health benefits companies, serving small and midsize employers with its flagship Comfort plan. This level-funded plan covers most common healthcare services at zero cost to members. Gravie also offers an industry-leading ICHRA solution that gives employers predictable costs and employees more choice.
Healthos Headquarters: Alpharetta, GA https://www.heathos.com/	Healthos is a healthcare insurance services ecosystem that helps insurance agencies and carriers streamline distribution, administration, and member experiences. The company brings together FirstEnroll, a third-party administrator focused on enrollment and billing; AdminOne, a claims administration platform; and Sonic Marketing, a national marketing organization that facilitates direct carrier contracts and expands insurance distribution. Healthos primarily operates in the individual health insurance market, providing agencies and agents with access to a broad range of insurance products.
HealthShrepa Headquarters: San Francisco, CA https://www.healthsherpa.com	HealthSherpa is the nation's largest private ACA enrollment platform and has powered more than 20 million marketplace enrollments since 2014. Its suite of ICHRA APIs serves as a connectivity layer linking carriers and ICHRA platforms, enabling scalable quoting, enrollment, and policy-status tracking across the ICHRA ecosystem.
Nexben Headquarters: Irvine, CA https://www.nexben.com	Nexben offers full-service ICHRA administration, giving benefit consultants and employers modern tools to manage health benefit payments and plan design. The company is trusted by more than 500 benefit consultants and provides access to more than 180 health insurers nationwide.
OneBridge Benefits Headquarters: Buffalo, NY https://onebridgebenefits.com	OneBridge Benefits is the nation's largest funded HRA administrator, offering its YourWay suite of ICHRA, HRA, HSA, and FSA accounts. Employers provide tax-free contributions, while employees shop for and purchase individual coverage tailored to their needs through OneBridge's white-glove enrollment support.

Oscar Health Headquarters: New York, NY https://www.hioscar.com Ticker: OSCR	Oscar Health is a healthcare technology company built on a full-stack platform with a relentless focus on member experience. In addition to its individual and family insurance plans, Oscar offers ICHRA solutions and Oscar technology services that help employers provide flexible, defined-contribution health benefits.
Remodel Health Headquarters: Indianapolis, IN https://remodelhealth.com	Remodel Health is the nation's largest ICHRA administrator by revenue and team size, serving thousands of employers and brokers nationwide. Its ClearChoice and ICHRA platforms combine structured transition management, licensed benefits advisors, and automated premium payments to make ICHRA benefits simple to offer at any scale.
Savii Headquarters: Savannah, GA https://savii.ai	Savii is a modern ICHRA benefits platform that lets employers define contribution amounts by employee class while employees shop a curated marketplace of individual health plans. Savii manages enrollment communication, compliance, and reporting so employers can offer flexible, predictable health benefits with less administrative burden.
StretchDollar Headquarters: San Francisco, CA https://www.stretchdollar.com	StretchDollar is an ICHRA platform purpose-built for small businesses and their brokers, enabling employers to set up custom health benefits in as little as 10 minutes. Employees choose ACA-compliant individual plans that fit their needs and receive automated, tax-free premium reimbursement every month.
Take Command Health Headquarters: Richardson, TX https://www.takecommandhealth.com	Take Command Health is the first-to-market leader and a top ICHRA and QSEHRA administration platform, trusted by more than 8,000 organizations nationwide. The company handles plan design, enrollment, employee communications, and compliance so employers can offer personalized health benefits without managing a traditional group plan.
Thatch Headquarters: San Francisco, CA https://thatch.com	Thatch is an ICHRA-powered health benefits platform that lets employers set a healthcare budget while employees choose their own health, dental, and vision insurance. Employers can use unused funds through a Thatch debit card for additional healthcare costs, and an AI-powered assistant, Ask Thatch, provides 24/7 support for compliance and spending questions.
Venteur (A part of Thatch) Headquarters: San Francisco, CA https://www.thatch.com/venteur	Venteur was an AI-driven ICHRA administration platform that helped employers set defined contributions while employees shopped for personalized individual health coverage. In April 2026, Thatch acquired Venteur, transitioning its ICHRA programs and members to the Thatch platform. The acquisition expanded Thatch's capabilities in the ICHRA market while combining Venteur's technology and employer relationships with Thatch's broader benefits infrastructure.
Vitable Health Headquarters: Philadelphia, PA https://www.vitablehealth.com	Vitable Health is a health benefits platform built for hourly and everyday workers, pairing virtual primary care with ICHRA and other benefit solutions. Its offerings deliver affordable, no-copay healthcare access for employers such as home care agencies and franchises that have traditionally struggled to offer competitive benefits.
Zizzl Health Headquarters: Milwaukee, WI https://zizzlhealth.com	Zizzl Health is a broker-first ICHRA administrator that designs, implements, and manages individual coverage health reimbursement arrangement programs for employers. The company helps replace volatile group renewals with predictable employer contributions and personalized plan choice, while keeping brokers at the center of the client relationship.
Zorro Headquarters: New York, NY https://www.myzorro.co	Zorro is an AI-powered ICHRA platform that combines automated plan design, decision support, and administration to give employers fixed monthly contributions and cost predictability. Employees get a modern shopping experience with personalized, ACA-qualified coverage options tailored to their needs.

Reference-Based Pricing (RBP)

6 Degrees Health Headquarters: Portland, OR https://www.6degreeshealth.com	6 Degrees Health combines a concierge service model with its MediVI analytics platform to deliver reference-based pricing solutions that lower healthcare costs by 20% to 40% compared to traditional PPO plans. Its offerings include claims repricing, payment integrity, member advocacy, and legal support for balance-billing disputes.
Advanced Medical Pricing Solutions (AMPS) Headquarters: Phoenix, AZ https://www.amps.com	AMPS is a healthcare technology company delivering claim repricing, payment integrity, and pharmacy benefit management through its PriceDynamix, ClaimInsight, and Drexi business units. AMPS serves self-funded employers, TPAs, and health plans seeking to reduce costs through reference-based pricing and transparent PBM services.
Allied Headquarters: Chicago, IL https://alliedbenefit.com	Allied is a healthcare solutions partner that helps employers manage and optimize self-funded health plans. The company provides a broad range of services spanning claims administration, medical management, utilization review, pharmacy and provider solutions, and healthcare cost containment. By combining technology and data-driven insights with hands-on member advocacy, Allied helps employers gain greater visibility and control over their healthcare spend.
Claritev (Formerly MultiPlan) Headquarters: McLean, VA https://www.claritev.com	Claritev, formerly known as MultiPlan, is a healthcare technology and data company that has spent more than 45 years bringing transparency to healthcare costs, pricing, and payments. Its network and analytics solutions connect more than 700 payers and 1.4 million providers to help control costs and reduce or eliminate balance bills for patients.
HealthEZ Headquarters: Bloomington, MN https://healthez.com	HealthEZ is a third-party administrator that simplifies self-funded health benefits for employers, combining custom plan design with reference-based pricing models to deliver savings of up to 25% versus fully insured plans. Its EZ Pay and EZrx tools give members simplified bill payment and transparent pharmacy benefit management.
Health Rosetta Ecosystem Headquarters: Seattle, WA https://healthrosetta.org	Health Rosetta is an ecosystem that accelerates adoption of practical, non-partisan fixes to the U.S. healthcare system, helping public and private employers and unions reduce health benefits spending by at least 20%. The organization vets a network of trusted advisors, vendors, and reference-based pricing solutions that make up its high-performance benefits plans.
Imagine360 Headquarters: Wayne, PA https://www.imagine360.com	Imagine360, which ELAP Services is a part of, is a leading alternative health plan for self-funded employers, combining reference-based pricing, direct contracting, and a fully transparent pharmacy benefit with independent validation showing 15% to 30% cost savings versus traditional commercial plans. Its integrated model gives employers greater control and visibility into healthcare spending while helping members access high-quality care.
OneDigital Headquarters: Atlanta, GA https://www.onedigital.com	OneDigital is a national insurance company that partners with more than 100,000 employers to design benefits, insurance, and workforce strategies that control costs and improve outcomes. Its offerings include alternative funding strategies and an ICHRA framework that provides compliance, messaging, and enrollment support for employers moving to individual coverage models.
Valenz Health Headquarters: Wayne, PA https://www.valenzhealth.com/	Valenz Health, provides an online healthcare shopping solution that helps employers cut costs by guiding employees to high-quality, cost-effective facilities and physicians. Its fair price transparency tools give members cost estimates before scheduling care, driving movement to high-value providers.
Vistara (A part of Claritev) Headquarters: McLean, VA https://www.claritev.com/	Vistara, a part of Claritev, delivers value-driven health plan services that give employers a reference-based pricing alternative tightly integrated with the PHCS Network. HST processes hundreds of thousands of claims annually, generating roughly $1 billion in medical cost reduction for its clients. Its approach combines transparent pricing, network access, and claims advocacy to help employers reduce healthcare costs.

Zelis Headquarters: Boston, MA https://www.zelis.com	Zelis is a healthcare payments and network technology company that modernizes the financial experience for more than 770 payers nationwide, including health plans, regional insurers, TPAs, and self-insured employers. Its platform spans network solutions, claims optimization, and payment integrity to simplify the healthcare financial experience. By connecting these capabilities across the healthcare ecosystem, Zelis helps payers and employers gain greater cost control while improving the experience for providers and members.

Captive Insurance Enablers

Artex Risk Solutions Headquarters: Rolling Meadows, IL https://www.artexrisk.com	Artex Risk Solutions, a Gallagher company, is one of the world's largest insurance and captive managers, operating with more than 500 professionals across 15 international offices. Artex serves more than 2,000 clients through more than 1,000 captives, cells, and specialty programs, offering single-parent, group, cell, and employee benefit captive structures alongside program and facility management and insurance-linked securities administration.
Benecon Headquarters: Lititz, PA https://benecon.com/	Benecon provides self-funded medical benefit programs and health plan solutions for public and private sector employers. The company pioneered self-funded consortiums and cooperatives and today manages multiple self-funded programs serving employers across the United States. Its VERIS Benefits Consortium gives employers greater transparency, control, and long-term stability in health benefits financing, allowing groups to retain unused claims dollars while protecting pooled stop-loss purchasing.
Beyond Health Partners Headquarters: Beverly, MA https://www.beyondhealthpartners.com	Beyond Health Partners, a part of the Beyond Risk family of companies, delivers integrated health benefits funding programs that combine stop-loss expertise, captive strategy, and cost containment into one coordinated platform for employers. Its Choice Captive and Turnkey Captive models are built for groups with 50 to 3,000 employees seeking multiyear stability, deeper visibility into claims data, and predictable renewals in place of the traditional fully insured cycle.
Captive Resources Headquarters: Itasca, IL https://www.captiveresources.com	Captive Resources is the leading consultant to member-owned group captives, with four decades of experience helping midmarket companies become owners of their own insurance company rather than buyers of insurance policies. The firm currently advises more than 55 medical stop-loss group captives comprising over 7,800 members and $5.8 billion in annual premiums, supporting every aspect of the captives it advises, including claims advocacy, risk management, regulatory compliance, and investment services.
ClearPoint Health Headquarters: Columbia, SC https://getclearpoint.com/	ClearPoint Health is an employee benefits and medical stop-loss captive platform that helps small and midsize employers move away from traditional fully insured arrangements. Its platform is designed primarily for employers with about 10 to 1,500 employees and offers multiple funding structures. ClearPoint also provides integrated data and performance management through its ClearChoice Health Plans framework, emphasizing proactive clinical intervention and employee engagement.
Hylant Headquarters: Toledo, OH https://hylant.com	Hylant is a full-service insurance brokerage offering business insurance, employee benefits, and risk management consulting, along with a dedicated global captive solutions practice. Its captive team works with clients throughout the full captive lifecycle, from evaluating whether a captive makes sense to forming, managing, and optimizing the structure over time. Hylant also helps employers with risk strategy, assessing coverage options, and managing costs as their needs change.

ParetoHealth Headquarters: Philadelphia, PA https://paretohealth.com	ParetoHealth is the largest and fastest-growing health benefits captive community in the country, combining more than 4,000 small and midsize employers representing over 1.3 million covered lives and $8.4 billion in healthcare spent under management. Its Risk Shield offers one of the strongest stop-loss protections on the market with no new lasers for the lifetime of membership. At the same time, its Savings Engine combines medical and pharmacy cost-management solutions to deliver compounding, multiyear savings versus staying fully insured.
Roundstone Headquarters: Rocky River, OH https://roundstoneinsurance.com	Roundstone pioneered the first self-funded medical group captive in 2005 and now works with more than 1,000 employers. As a family-owned company, Roundstone takes an employer-first approach to captive insurance. The company says employers see total annual costs that are 25% lower than the industry average, renewal increases that are about one-third of the industry average, and $60 million returned to employers over the past five years. Roundstone also guarantees that employers moving from fully insured plans will save money over five years, or the company will make up the difference.
Spring Consulting Group Headquarters: Boston, MA https://www.springgroup.com	Spring Consulting Group, an Alera Group Company, is a multidisciplinary employee benefits and risk management consultancy providing strategic and actuarial services across employee benefits and alternative risk financing and captives. Spring supports organizations through the full captive lifecycle with feasibility studies, program modeling, implementation, and ongoing administration and actuarial support across single-parent, group, risk retention group, and segregated cell captive structures in all domiciles.

On-Site and Near-Site Advanced Primary Care

Apree Health Headquarters: Sandy UT https://apreehealth.com/	Apree Health is the parent company of Castlight Health, a healthcare navigation and benefits-transparency platform, and Vera Whole Health, an advanced primary care provider, offering an integrated model that combines clinical navigation with on-site primary care for employers. The company reports that 60% of its population is engaged in navigation and advocacy programs, with an average $34 monthly cost reduction for members using its Care Guides.
Archer Health Headquarters: Carlsbad, CA https://archerhealth.com	Archer Health delivers real, in-person on-site and near-site primary care clinics for self-funded employers with 100 to 1,000 employees, a segment the company says legacy on-site clinic vendors have historically overlooked. Its model bundles primary and acute care, on-site pharmacy dispensing, and virtual access through the Archer app for one predictable monthly cost.
CareATC Headquarters: Tulsa, OK https://www.careatc.com/	CareATC provides on-site and near-site primary care clinics for self-funded employers, combining in-person care with virtual health services. Its model focuses on improving access to primary care, managing chronic conditions, and reducing avoidable healthcare costs by bringing care directly to employees and their families. CareATC also provides health coaching, behavioral health, and pharmacy services as part of its employer-focused platform.
Concentra Headquarters: Addison, TX https://www.concentra.com/ Ticker: CON	Concentra is one of the largest providers of occupational health, urgent care, and workforce-focused clinical services in the United States. The company's services center on workforce health and accessibility, delivering occupational medicine and consumer-directed urgent care for non-work-related injuries and illnesses, along with customized employer health programs and telemedicine embedded in on-site clinics.

Crossover Health (A part of Premise Health) Headquarters: San Clemente, CA https://crossoverhealth.com	Crossover Health is a national medical group delivering on-site, near-site, and virtual care for large employers, combining primary care, mental health, physical medicine, and care navigation on one proprietary care platform. In March 2026, Crossover merged with Premise Health, creating a combined advanced primary care organization that will serve members through a national footprint and integrated care delivery model, combining Crossover's technology-enabled approach with Premise Health's broad on-site and near-site clinic network.
EHE Health Headquarters: New York, NY https://ehe.health/	EHE Health is a preventive care company offering comprehensive, doctor-led executive physicals that analyze more than 130 biomarkers, compared with the 20 to 30 markers typical of standard annual physicals. The company operates the largest dedicated preventive-care network in the U.S., with 7 company-owned clinics and more than 200 partner locations across 41 states, pairing exams with year-round health coaching for employer clients.
Frontier Direct Care Headquarters: Harlingen, TX https://frontierdirect.com/	Frontier Direct Care is a direct primary care company serving level-funded and self-funded employers, building and staffing near-site clinics at no upfront cost. Its bundled model spans primary care clinics, specialist referral coordination, and $0 generic prescriptions with home delivery, and the company puts 100% of its fees at risk against employers' total healthcare spend.
LifeStance Health Headquarters: Scottsdale, AZ https://lifestance.com Ticker: LFST	LifeStance Health is one of the nation's largest outpatient behavioral health providers, offering therapy, psychiatry, and specialty treatments such as TMS through both in-person and telehealth visits. LifeStance Health operates in more than 550 locations across 33 states and reports that telehealth accounts for over 70% of its appointments.
Marathon Health Headquarters: Indianapolis, IN https://marathon.health/	Marathon Health operates a network of employer-sponsored health centers that deliver advanced primary care, mental health services, and care navigation for employee populations. The company's model focuses on longitudinal, relationship-based care, where providers manage patients over time rather than through episodic visits, leading to better chronic disease outcomes and lower total cost of care.
Medcor Headquarters: McHenry, IL https://medcor.com/	Medcor is an occupational health provider focused on helping employers improve workforce health, safety, and regulatory compliance. The company delivers care through on-site, near-site, and mobile clinics, as well as workers' compensation support. Its model combines evidence-based clinical care with proprietary technology to help employees receive the right care while reducing unnecessary offsite visits, claims, and costs.
Next Level Medical Headquarters: Houston, TX https://www.nextlevelurgentcare.com/	Next Level Medical is a healthcare organization focused on making high-quality, affordable care more accessible to individuals, families, and employers. The company operates a growing network of urgent care and primary care clinics across Texas, complemented by virtual care and employer-sponsored healthcare solutions. Through its Next Level PRIME platform, the company provides employers with integrated primary care, urgent care, and other health services.
One to One Health Headquarters: Chattanooga, TN https://onetoonehealth.com/	One to One Health is a physician-led, employer-sponsored primary care provider focused on delivering relationship-based healthcare on a scale. The company combines convenient on-site and near-site primary care clinics with TextCare. This on-demand virtual concierge care platform provides members with direct access to dedicated care teams by text, phone, and video. Its clinics offer comprehensive primary care, urgent care, and other services. At the same time, TextCare expands access to care and helps members build an ongoing relationship with the same clinical team, rather than relying on one-off telehealth encounters.
OnMed Headquarters: Tampa, FL https://www.onmed.com/	OnMed develops and operates technology-enabled CareStations that deliver on-demand healthcare services in retail settings. Its platform integrates telehealth, diagnostic tools, and real-time clinician access to provide convenient, immediate care outside traditional clinical environments, reducing reliance on higher-cost settings such as emergency departments and hospitals.

OnSite Health Headquarters: Granger, IN https://on-sitehealthcorp.com	OnSite Health provides employers nationwide with comprehensive on-site safety, occupational health, and primary care services. Founded as one of the country's earliest companies dedicated to on-site occupational health, the company delivers customized workplace health programs tailored to each employer's and workforce's specific needs. By bringing care directly to the workplace, OnSite Health helps employers reduce employee downtime and improve workplace safety.
PeopleOne Health Headquarters: Orlando, FL https://peopleonehealth.com/	PeopleOne Health is a value-based primary care company operating employer-funded health centers that deliver primary care, diagnostics, imaging, mental health, nutrition, physical therapy, and pharmacy services. The company reports up to 30% healthcare cost savings for employers.
Premise Health Headquarters: Brentwood, TN https://www.premisehealth.com/	Premise Health, which Crossover Health recently merged into, is one of the largest providers of employer-sponsored healthcare, offering on-site, near-site, and digital health services to large organizations. Its platform delivers a full spectrum of care and emphasizes data-driven population health management, using predictive analytics to identify risks and optimize care pathways while focusing on prevention and chronic condition management.
Proactive MD Headquarters: Simpsonville, SC https://proactive-md.com	Proactive MD partners with employers to provide broad-scope advanced primary care that makes quality healthcare more convenient, from on-site health center implementation to ongoing price negotiations with network providers. The company also offers Proactive Rx, a pharmacy program that lowers costs and optimizes medication management for employer-sponsored health plans.
Radish Health Headquarters: New York, NY https://radish.health	Radish Health pairs employees with a dedicated physician-led care team that serves as their first call for both medical care and help navigating the healthcare system, whether virtually, in person, or through an on-site nurse. The model aims to lower costs by improving the member experience, speeding access to care, and improving health outcomes.

Centers (Networks) of Excellence (COEs) and Clinically Integrated Navigation

Accolade Headquarters: Seattle, WA https://www.accolade.com	Accolade is a personalized healthcare navigation and advocacy company that pairs members with a care team of nurses and clinicians to help them access benefits and find high-quality providers to help manage their care. Its Accolade Care and 2nd.MD offerings add virtual primary and mental healthcare and expert medical second opinions, giving employers a single trusted point of contact for their workforce's healthcare needs.
Carrum Health Headquarters: San Francisco, CA https://carrumhealth.com/	Carrum Health is a value-based centers of excellence network that negotiates directly with top-quality healthcare providers to give employers and their populations nationwide access to the best specialty care. Its network now covers 90% of Americans within 50 miles of a Carrum COE, saving employers up to 45% per procedure while eliminating medical bills for patients.
Covera Health Headquarters: New York, NY https://www.coverahealth.com/	Covera Health is a healthcare technology company that improves the quality, consistency, and efficiency of medical care through AI-powered clinical intelligence. The company works with employers, health plans, and healthcare providers to identify high-quality providers and deliver actionable insights throughout the patient journey, with an initial focus on radiology and diagnostic imaging. Its platform uses clinically validated data and analytics to help patients receive more accurate diagnoses and appropriate care while reducing unnecessary utilization and costs.

First Stop Health Headquarters: Chicago, IL https://www.firststophealth.com/	First Stop Health is a virtual healthcare company that provides employers and their employees with affordable and whole-person care through digital channels. Its platform offers virtual urgent care, primary care, mental health, and other services designed to support employees throughout their healthcare journey. First Stop Health emphasizes a high-engagement, patient-centered experience, giving members access to licensed providers through its app, website, or phone with little or no cost to employees and their dependents.
Hinge Health Headquarters: San Francisco, CA https://www.hingehealth.com Ticker: HNGE	Hinge Health provides a digital platform for musculoskeletal care, offering virtual physical therapy and personalized exercise programs. Its technology helps users manage pain and improve mobility at home by combining coaching, wearable sensors, and educational content. By delivering care remotely and focusing on early intervention and sustained engagement, Hinge Health aims to improve outcomes and reduce reliance on costly in-person care.
Included Health Headquarters: San Francisco, CA https://includedhealth.com	Included Health is a personalized, all-in-one healthcare company combining virtual and in-person primary, specialty, and mental health care with expert navigation and billing advocacy. Formed through the 2021 merger of Grand Rounds Health and Doctor On Demand, the company is trusted by a third of Fortune 100 companies. It reports an average savings of $4,642 per member engaged with its primary care and behavioral health services.
Lantern Headquarters: Dallas, TX https://lanterncare.com/	Lantern connects members with specialty care for complex, high-cost conditions such as surgery, cancer, and infusion therapy, which make up roughly half of healthcare spending. Its curated Network of Excellence delivers a complication rate of less than 1%, compared with the 8 to 15% national average, saving employers an average of $20 PEPM while improving outcomes.
Leap Health Headquarters: New York, NY https://www.leaphealth.com	Leap Health is a transparent specialty infusion benefit platform that helps employers reduce specialty drug costs by up to 60% by coordinating members' infusion therapy at home or at a nearby care site. Each member is paired with a dedicated care guide, who manages scheduling, pharmacy, and insurance details alongside the patient's prescribing physician.
Quantum Health Headquarters: Dublin, OH https://quantum-health.com/	Quantum Health is a healthcare navigation and care coordination company that partners with employers to guide members through the healthcare system. Its proprietary Real-Time Intercept platform combines data analytics, clinical expertise, and personalized engagement to influence care decisions at the point of need and steer patients toward appropriate, high-value sites of care.
OneImaging Headquarters: Miami, FL https://www.oneimaging.com/	OneImaging is a healthcare technology and imaging services company that makes diagnostic imaging more affordable, accessible, and transparent for patients and employers. The company connects members with a nationwide network of accredited imaging centers, helping patients find convenient locations, schedule appointments, understand costs upfront, and receive hands-on support throughout the process.
Oshi Health Headquarters: New York, NY https://oshihealth.com/	Oshi Health is a virtual gastrointestinal healthcare company that transforms how digestive health conditions are diagnosed and treated through personalized, multidisciplinary care. The company provides patients with access to gastroenterology providers, registered dietitians, gut-brain specialists, and other care team members through a coordinated virtual care model.
Redirect Health Headquarters: Phoenix, AZ https://www.redirecthealth.com/	Redirect Health offers an insurance-optional healthcare membership model for businesses, individuals, and families, built around a single membership that bundles healthcare access, prescriptions, and advocacy. Members get online primary care and prescriptions, plus a care team that helps them decide whether and when to use insurance, guiding them to the lowest-cost path for any given need. The company also negotiates directly with providers on members' behalf, redirecting more than $250 million in medical-bill savings back to members to date.

Regenexx Headquarters: Des Moines, IA https://regenexxcorporate.com	Regenexx was an early pioneer in using stem cells derived from bone marrow concentrate to treat orthopedic injuries and degenerative conditions. Through its corporate program, more than 2,000 employer groups have added the Regenexx benefit to their self-funded health plans, providing employees with access to non-surgical orthopedic treatment options. The company reports that its approach can help avoid up to 70% of elective orthopedic surgeries, offering employers a potential pathway to lower musculoskeletal care costs.
Sword Health Headquarters: New York, NY https://swordhealth.com	Sword Health combines human clinicians with AI to deliver whole-person AI care across musculoskeletal pain, women's health, cardiometabolic health, and mental health. Its platform uses AI-powered clinical technology, personalized treatment plans, and ongoing support from licensed clinicians to deliver accessible care for each member. Across its book of business, Sword delivers an average three-to-one client gross ROI and $3,177 in annual member savings on MSK and related chronic conditions, with 55% of members remaining surgery-free.
TailorCare Headquarters: Nashville, TN https://www.tailorcare.com	TailorCare is a risk-based care navigation company that takes a personal, data-driven approach to improving outcomes for joint, back, and muscle conditions. Its clinical navigators are licensed physical therapists who combine a patient's clinical assessment, health history, and goals with predictive data to help patients choose and navigate the most effective treatment pathway.
Teladoc Health Headquarters: New York, NY https://www.teladochealth.com Ticker: TDOC	Teladoc Health is the largest and longest-running telemedicine company in the United States, connecting patients and providers for 24/7 care, primary care, mental health, and chronic condition management across more than 175 countries. The company brings together brands including BetterHelp, Livongo, and Catapult Health to deliver virtual care at scale for employers and health plans.
Transcarent Headquarters: San Francisco, CA https://transcarent.com/	Transcarent is a consumer-directed healthcare platform designed to simplify access to care through bundled pricing and curated provider networks. The company offers a comprehensive suite of services delivered through a digital front door, supported by AI and care advocates, that guides members to high-value providers and settings.
Vori Health Headquarters: Nashville, TN https://www.vorihealth.com	Vori Health is a physician-led, nationwide specialty medical practice treating back, neck, and joint pain through an integrated team of physicians, physical therapists, dietitians, and health coaches. Board-certified physicians guide diagnosis, risk stratification, and treatment planning from day one to help patients avoid unnecessary, hard-to-reverse care pathways.
Zero Health Headquarters: Tulsa, OK https://zero.health	Zero Health has created a bundled-payment centers of excellence marketplace that lets self-funded employers offer members $0 out-of-pocket care, with no copays, deductibles, or coinsurance for labs, imaging, orthopedic surgery, physical therapy, and other high-cost services. The platform connects members with vetted providers through pre-negotiated, bundled prices. Employers pay only a transparent transaction fee, while members receive a simplified care experience with fewer financial barriers to accessing high-quality providers. Zero Health reports average savings of about 44% versus typical allowed amounts.

Direct Contracting and Tiered Networks

Health 2 Business (H2B) Headquarters: Boise, ID https://health2business.com	Health2Business (H2B) establishes and administers direct contracts between employers and healthcare providers, allowing employers to bypass traditional insurance intermediaries and negotiate healthcare costs directly. Through these arrangements, H2B helps employers secure transparent, pre-negotiated pricing and establish clearer terms around quality, access, and member experience. Employers using the H2B model report an average of 24% first-year premium savings and a 90% reduction in employee out-of-pocket costs, showing the potential for direct contracting to lower employer costs while making care more affordable for employees.
HealthCorum (A part of The Difference Card) Headquarters: Boston, MA https://healthcorum.com/	HealthCorum is a health data analytics company that generates objective provider quality scores across more than 1.5 million providers nationwide, spanning more than 90 subspecialties, to identify providers who deliver high-value care. Health plans, self-funded employers, and ACOs use HealthCorum's insights to strengthen network development and drive high-value referrals. In August 2026, The Difference Card acquired HealthCorum, bringing its provider analytics fully in-house to power The Difference Card's new Provider Lookup Manager Tool (PLUM) and AI Navigator, a conversational search experience.
Nomi Health Headquarters: Orem, UT https://www.nomihealth.com	Nomi Health rebuilds healthcare through a direct contracting model that removes intermediaries between employers and providers, powering more than 2,500 self-funded employers nationwide. Its Direct Network eliminates member out-of-pocket costs, pays providers within 48 hours, and reduces overall healthcare costs by up to 30% through transparent, direct pricing.

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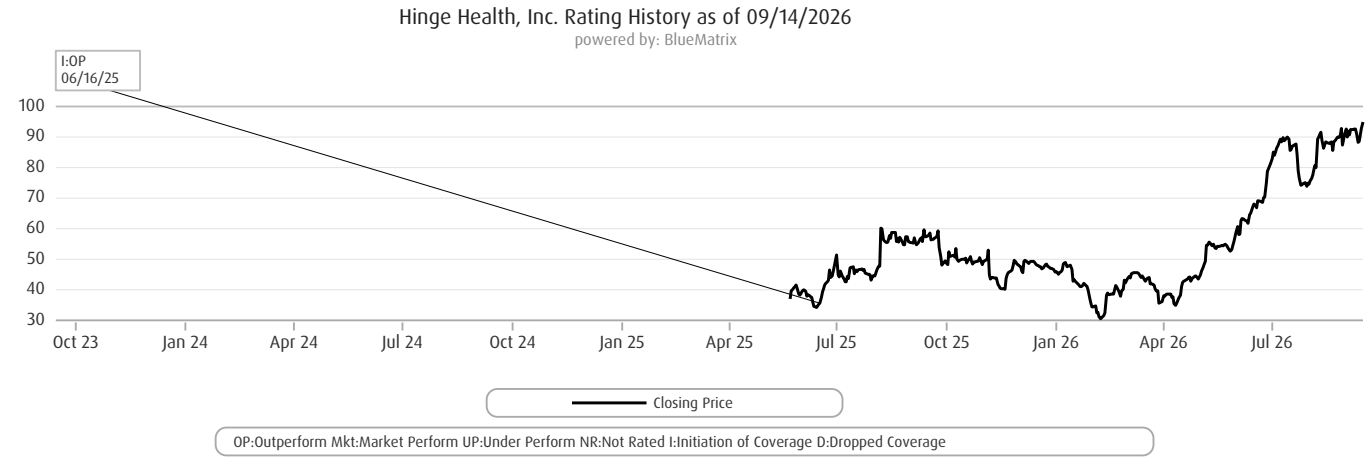
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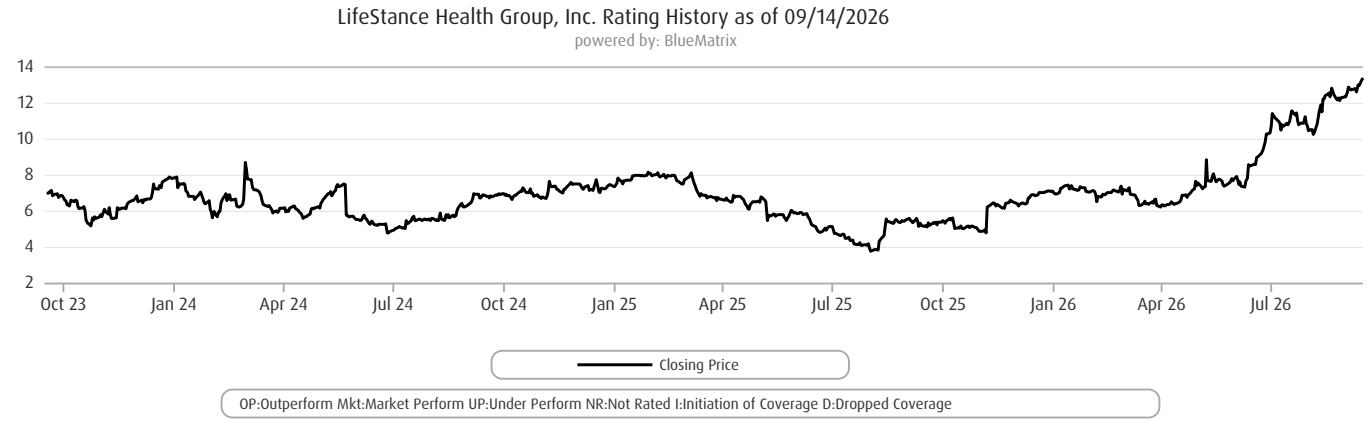
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DOW JONES: 52093.10
S&P 500: 7585.73
NASDAQ: 25981.60



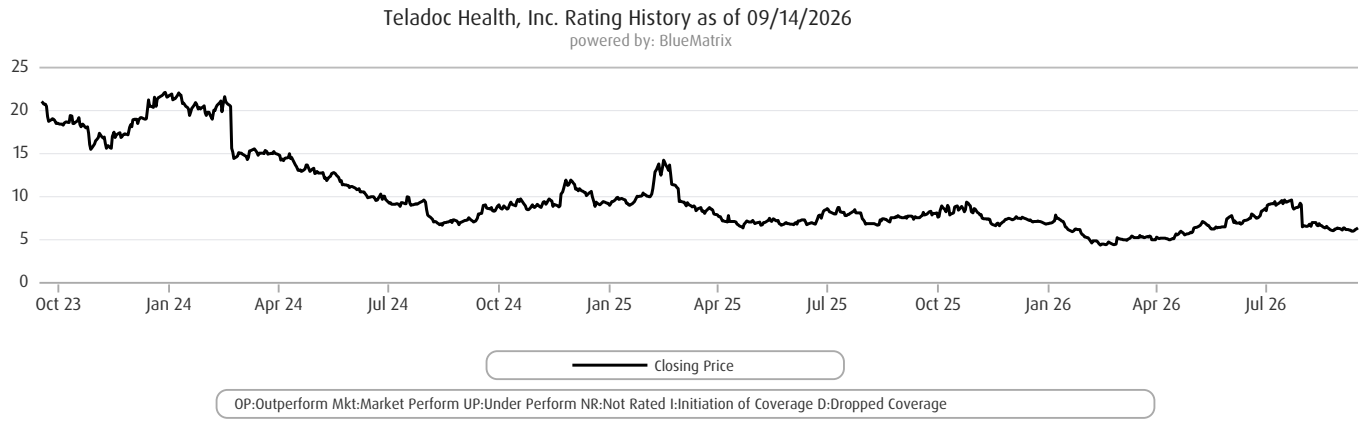
Source: FactSet & William Blair

Current Rating for HNGE: Outperform



Source: FactSet & William Blair

Current Rating for LFST: Outperform



Source: FactSet & William Blair

Current Rating for TDOC: Market Perform

Additional information is available upon request.

Current Rating Distribution (as of September 16, 2026):

Coverage Universe	Percent	Inv. Banking Relationships *	Percent
Outperform (Buy)	72	Outperform (Buy)	15
Market Perform (Hold)	28	Market Perform (Hold)	4
Underperform (Sell)	1	Underperform (Sell)	0

*Percentage of companies in each rating category that are investment banking clients, defined as companies for which William Blair has received compensation for investment banking services within the past 12 months.

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