

ARTICLE

Healthcare's financing evolution: Today's novel models are learning labs

| AUG 27, 2026

<https://www.chartis.com/insights/colab/healthcares-financing-evolution-todays-novel-models-are-learning-labs>

This piece is part of a series that explores the future model of care beginning to emerge in the US. We call this model HealthCare360 because it will manage health and care continuously, at scale and lower cost, with the human at the center.

The current financing model for US healthcare relies on a fee-for-service reimbursement model, which ties provider payment primarily to activities rather than longitudinal outcomes.

Because of the myriad reasons for today's financing model, a single paradigm shift will not define the future of US healthcare financing. Nor should leaders view a wholesale replacement of today's financing model as a prerequisite for change. Given the shifting demographics, health systems will need to figure out a way to achieve financial sustainability amid rising utilization and rising costs to deliver care.

Significant early trends toward financing change are already in motion.

Medicare will be similarly burdened and is continuing to experiment with new payment models to reimburse providers for the care they comprehensively deliver to incentivize appropriate reductions in utilization.

Simultaneously, health tech companies are changing how consumers think about their health and who should pay for care for select non-urgent needs, and "buy-up" services are gaining traction with a select population cohort with discretionary income.

Health plans and purchasers are turning to benefit and product design that is more flexible and constructed to guide members to high-value care.

For health systems, the implications for each of these dynamics are distinct—but all point to the importance of figuring out how to engage effectively in a gradually evolving financing environment.

FINANCING DIMENSION:

Consumer access models

WHAT IS CHANGING

Consumers, employers, and health plans are funding direct access to care outside or adjacent to traditional insurance and delivery systems.

ILLUSTRATIVE MODELS

- Direct-to-consumer (DTC) subscriptions
 - Employer- or health-plan-sponsored point solutions
-

FINANCING DIMENSION:

Provider reimbursement models

WHAT IS CHANGING

CMS and other payers are expanding payment models that support proactive, longitudinal, and outcomes-oriented care.

ILLUSTRATIVE MODELS

- Advanced Primary Care Management (APCM)
 - ACCESS Model (Advancing Chronic Care with Effective, Scalable Solutions)
-

FINANCING DIMENSION:

Benefit and product design

WHAT IS CHANGING

Employers and payers are creating products that are more flexible, configurable, and designed to guide members toward high-value care.

ILLUSTRATIVE MODELS

- Variable copay products
 - Individual coverage health reimbursement arrangements (ICHRAs)
-

1. Consumer-centered access models are creating new financing channels outside, or adjacent to, traditional coverage

What is changing: A growing set of consumer-centered “buy-up” clinical services are emerging in select high-demand elective clinical areas, including weight loss, hormonal health, sexual health, fertility and family health, dermatologic health, hair loss, musculoskeletal (MSK) care, and mental health.

Many of these models are selling clinical services directly to consumers through cash-pay options, such as one-time buy-ups and subscription-based models. Others are rooted more in a business-to-business (B2B) model, selling into employers and health plans as sponsored supplemental benefits that sit alongside traditional health insurance coverage.

Examples include:

Hims & Hers. This DTC, subscription-based health platform combines telehealth, prescribing, and pharmacy fulfillment for recurring needs, including sexual health, hair loss, weight loss, and mental health. Customers generally pay out of pocket rather than through insurance for online subscriptions, products, consultations, and prescription refills.

As of March 31, 2026, Hims & Hers had nearly 2.6 million subscribers, up 9% year over year, and an average monthly revenue per subscriber of \$80. Annual revenue in 2026 is expected to reach \$2.8 billion to \$3 billion.¹

Hinge Health. This digital MSK care platform has a consumer-style experience with a B2B sales model. The company offers app-based services, including daily exercise therapy, computer-vision motion tracking, coaching, physical therapy, physician support, pain-relief devices, pelvic health, surgery decision support, and migraine care.

Members access Hinge through an employer, health plan, or other sponsoring organization. Hinge is typically a covered benefit offered alongside traditional insurance rather than an individually purchased product. In 2025, Hinge approached \$590 million in revenue, up 51% year over year. It ended the year with more than 780,000 members (up 47%), from 25 million contracted lives.²

Implications: These clinical service and payment models are setting a new standard for how elective healthcare services could be financed. They also shine light on where consumers are willing to deploy their discretionary income.

We have seen models like this before in the form of concierge medicine. However, these new models are at a much more affordable price point.

While most of these models are not materially disrupting existing business for health systems and health plans, they could represent a revenue or margin diversification opportunity for health systems. They could also represent a partnership path for potential adjacent needs (e.g., therapeutic MSK care provided through a more consumer-centered model, in complement to procedural MSK care).

2. Provider reimbursement models are evolving based on tech-enabled capabilities

What is changing: While various forms of shared risk payment models (e.g., sub-capitation, capitation, bundles) are still in play in select markets and for government payers, many of the commercial segment value-based care models have ended due to challenges with measurement.

However, agentic AI is now making more timely, integrated data processing available. This could enable financially pressured health plans to resurrect such shared risk models, making targeted refinements informed by past limitations.

In the meantime, CMS is testing and implementing a broad portfolio of reimbursement changes that reflect its continued attention on outcomes and affordability. CMS continues to push in the direction of shared risk payment models through new versions of its accountable care organization (ACO) models (ACO REACH and ACO LEAD); bundled payments for select procedures (TEAM); and primary care models (Primary Care FLEX).

On the more innovative side, CMS is signaling that it values technology-driven clinical innovations through its APCM services and ACCESS Model, which emphasize 24/7 access and technology-supported chronic care management, respectively.

As we have seen in the past, commercial payers often follow in CMS's footsteps. While we have not yet seen commercial plans offer similar payment models, they may soon follow. Several large payers have pledged to stand up ACCESS-like models by 2028.³

Examples include:

APCM services. APCM creates a monthly payment pathway for primary care practices that meet advanced care management requirements. These include **24/7 access**, comprehensive care planning, care transition support, medication management, enhanced communication, population-level management, and performance reporting.

APCM is not a Center for Medicare and Medicaid Innovation (CMMI) demonstration. Rather, it is embedded into the Medicare Physician Fee Schedule and introduces a mechanism to reimburse care delivered between visits, rather than relying solely on encounter-based payment. It also materially simplifies care management reimbursement by structuring billing around a per-patient, per-month model rather than the legacy time-based care management codes.

ACCESS Model. Launched in July 2026, ACCESS tests outcome-aligned payments for **technology-supported management** of common chronic conditions across cardio-kidney-metabolic (CKM), behavioral health, and MSK tracks.

Rather than paying for volume of activity, the model is designed to reimburse participating organizations based on measurable patient outcomes such as blood pressure control, HbA1c reduction, and pain and function improvement. Primary care and referring clinicians will also be eligible to receive co-management payments for documented coordination with ACCESS organizations.

CMS provisionally approved more than 150 organizations for ACCESS. Many of these organizations represent technology-enabled care models that have not historically served Medicare—underscoring the program’s role both as a payment test and a pathway for new entrants into Traditional Medicare.⁴

ACCESS is also notable because CMS has explicitly linked the model to prompt private payers to follow suit, suggesting a broader push toward common payment approaches for technology-enabled chronic care.

Implications: CMS’s new payment mechanisms—while not paying a large amount relative to broader reimbursement—offer opportunities to enable care model innovation. They provide some means to support continuity and coordination of care, patient engagement between episodes, and requisite infrastructure and capabilities.

As health systems innovate new technology-driven models of care, they also should consider how to partner with payers and employers on funding. Ultimately, these investments will drive lower total cost of care, which benefits both health plans and employers.

3. Benefit and product design are becoming more flexible, personalized, and value-directed

What is changing: A third financing shift is occurring inside the benefit product itself. Newer benefit designs are using consumer-oriented navigation, price transparency, provider performance data, and more tailored cost-sharing structures to shape how individuals select coverage and access care.

Rather than applying a one-size-fits-all benefit design across a broad employee cohort, these products aim to give individuals clearer choices, more actionable guidance, and financial incentives that reflect the relative value, cost, and appropriateness of different options.

We expect new products in this category to grow as consumers and employers seek to control costs while accounting for growing consumer expectations for individualized choice. According to a recent survey of employers with 500 or more employees, more than one-third planned to offer high-performing networks, alternative health plans, or network optimization models in 2026. Nearly another third were considering offering these models in the near future.⁵

Examples include:

Variable copay products. In place of the blunt instruments of deductibles and coinsurance, employers are using variable copay products to drive consumers toward optimal (most cost-effective, high-quality) choices. In these products, copays vary by provider, site of care, treatment option, and/or expected value.

These models depend on an infrastructure layer that lets consumers search for care and see current out-of-pocket costs, so they can make informed choices for their priorities and needs.

It is too early to determine how effective these more tailored products will be in driving higher-value care, but interest seems to be growing. In 2025, 7% of large employers offered a variable copay plan, and roughly 30% of workers opted in.⁶ For 2026 and 2027, 20% of large employers were considering offering variable copay plans. UnitedHealthcare's variable copay product, Surest, is its fastest growing commercial product. Half of the health plan's largest clients have opted into the plan.⁷

Defined contribution through ICHRAs

In an individual coverage health reimbursement arrangement (ICHRA), employers provide a fixed monthly allowance that employees use to purchase their own insurance through the individual market, rather than providing traditional group coverage to employees.⁸

Employees may make their selection through established channels, such as the ACA Marketplace or an insurance broker, or through newer digital platforms designed to support both employers and consumers with navigation.

While employer-sponsored defined benefit group insurance remains the dominant model, uptake has grown rapidly since ICHRAs were first introduced in 2020.⁹ Most growth to date has been driven by employers that previously did not offer insurance, but early signals indicate that a broader set of employers may explore ICHRAs as a mechanism to mitigate unpredictable and increasing costs and/or manage needs associated with an increasingly complex workforce.

Health plans like Centene, Anthem, and other Blues plans are establishing ICHRA business units, positioning for this small but potentially important channel. ICHRAs could become even more relevant if employer cost pressure pushes more companies toward defined-contribution health benefits.

Implications: We expect these novel models to serve as learning labs for plans and purchasers. They can test and refine product levers and navigation infrastructure to more effectively engage consumers to consider value in their healthcare decision-making.

As product and benefit design further activates consumerism, attracting and retaining consumers will increasingly depend on health systems' points of differentiation across dimensions such as quality, cost, experience, and convenience.

Proactively position to capture value

Health systems cannot fully control financing dynamics or the pace of payment reform. However, they can proactively identify and pursue financing opportunities that align with strategic priorities and operational realities.

To succeed, health systems will need to manage through a mixed-payment environment while positioning themselves to capture value from longitudinal, lower-utilization care going into the future.

Sources

¹ "Hims & Hers Health, Inc. Reports First Quarter 2026 Financial Results," Hims & Hers Investor Relations, May 5, 2026, <https://investors.hims.com/news>.

² "Hinge Health Reports Fourth Quarter and Full Year 2025 Financial Results," Hinge Health Investor Relations, February 10, 2026, <https://ir.hingehealth.com/news/news-details/2026/Hinge-Health-reports-fourth-quarter-and-full-year-2025-financial-results/default.aspx>.

³ Centers for Medicare & Medicaid Services, "Major Health Plans Join ACCESS Payer Pledge," CMS Innovation Center, 2025, <https://www.cms.gov/priorities/innovation/innovation-insight-major-health-plans-join-access-payer-pledge>.

⁴ Centers for Medicare & Medicaid Services, "ACCESS Model Accepted Applicants," CMS Innovation Center, 2026, <https://www.cms.gov/priorities/innovation/access-model-accepted-applicants>.

⁵ "Employers Are Shifting Healthcare Costs to Employees While Expanding Choice and Navigation Support," Mercer, 2025, <https://www.mercer.com/en-us/about/newsroom/employers-are-shifting-healthcare-costs-to-employees/>.

⁶ "Survey on Health and Benefit Strategies for 2026," Mercer, 2025, https://www.mercer.com/assets/us/en_us/shared-assets/local/attachments/pdf-2025-us-survey-on-health-and-benefit-strategies-for-2026.pdf.

⁷ Michael McAuliff, "Aetna, UnitedHealthcare Invest in Variable Copay Plans," Modern Healthcare, 2025, <https://www.modernhealthcare.com/insurance/mh-aetna-unitedhealthcare-variable-copay-plans/>.

Michael McAuliff, "Variable Copay Health Plans Gain Employer Interest as Costs Rise," Modern Healthcare, 2025, <https://www.modernhealthcare.com/insurance/mh-variable-copay-health-plans-employer-costs/>.

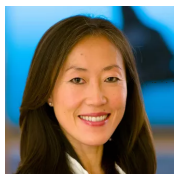
⁸ ICHRAs are available to employers with more than 50 employees, while Qualified Small Employer HRAs (QSEHRAs) are available to smaller employers with fewer than 50 employees. In practice, QSEHRAs operate very similarly to ICHRAs, with some specific differences—most notably that they are subject to an annual IRS limit.

⁹ “HRA Council Growth Trends for ICHRA & QSEHRA, Vol. 4: 2025 Data Report,” HRA Council, June 2025, <https://www.hracouncil.org/report>.

Explore more forces at play and implications for health systems in The CoLab

[Read more](#)

LEARN MORE ABOUT THE AUTHORS



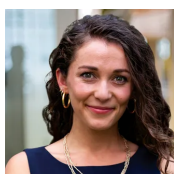
Cindy Lee

Managing Partner and Chief Strategy Officer



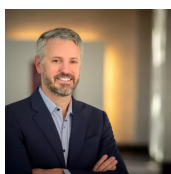
Anneliese Gerland

Partner and Senior Vice President of Strategy



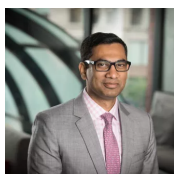
Rachel Prensky-Pomeranz

Director of Strategy



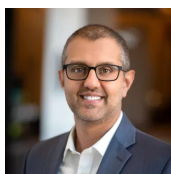
Dan Delaney

Managing Partner, HealthScape Advisors



Akshay Jindal

Senior Partner, HealthScape Advisors



Tej Shah

Managing Partner and National Payer Market Leader, HealthScape Advisors

[Learn more about the HealthCare360 advisory team](#)

Our services

STRATEGIC TRANSFORMATION

PERFORMANCE TRANSFORMATION

DIGITAL & TECHNOLOGY TRANSFORMATION

CHARTIS CENTERS FOR AI & STRATEGIC INTELLIGENCE

PAYER TRANSFORMATION

STRATEGIC COMMUNICATIONS & CHANGE MANAGEMENT