

SOFTHEON

The Provider-Sponsored Playbook

**Smart Growth Tactics
Without Cutting Corners**



The Pressure is Building

Provider-Sponsored Plans Need a Smarter Operational Strategy

Provider-sponsored health plans (PSHPs), are positioned at the intersection of care and coverage. But in today's environment, that intersection is becoming harder to navigate.

From regulatory shifts to rising operational costs, PSHPs are facing financial pressure from every direction — just as member expectations and digital demands are reaching all-time highs.

Here's what's shaping the moment:

1 ACA Uncertainty Is Back

Uncertainty is already here, but the biggest impact of today's policy and pricing shifts will be felt in 2027. Health plans are heading toward a period of renewed ACA instability that will reshape risk pools, retention, and long-term sustainability.

- ⚠️ Premium pressure continues to build, with early rate indicators pointing to increases that will impact affordability for price-sensitive members and small employers.
- ⚠️ Members are panicking, with more mid-year churn, plan switching, and enrollment gaps that disrupt continuity of care and revenue predictability.
- ⚠️ The expected expiration of enhanced premium tax credits (eAPTCs) means members who previously paid little or nothing for coverage will face higher out-of-pocket premiums. This shift is compounded by CMS ending auto reenrollment for zero-premium plans.

The risk?

Without the right strategy, plans face increased membership churn among lower-income, subsidy-reliant members.



Understanding Market Shifts

2 Medicare Advantage Pressure Is Mounting

Medicare Advantage (MA) enrollment continues to grow, but the operating environment is tightening. Many of the most disruptive impacts of recent policy and reimbursement changes will fully surface in 2027. The risk is not just dissatisfaction. It is long-term disengagement.

- ⚠ Increased medical loss ratio (MLR) scrutiny and reimbursement reductions are compressing margins, particularly for provider-sponsored plans balancing care delivery with plan performance.
- ⚠ Affordability pressures remain the core issue. Policy adjustments have not meaningfully reduced what members feel at the point of care, fueling frustration.
- ⚠ Above all else, member satisfaction is on the decline. According to the [J.D. Power 2025 U.S. Medicare Advantage Study](#), customer satisfaction is down 29 points from a year ago (on a 1,000-point scale).

3 Medicaid Sees More Checks and Less Cushion

The Medicaid landscape is shifting rapidly, with the most significant consequences expected in 2027 as work requirements and eligibility changes take effect. PSHPs are feeling the strain now, even as guidance remains incomplete.

- ⚠ States are increasing eligibility checks and tightening verification timelines, adding operational pressure for plans serving high-need populations.
- ⚠ New work and activity requirements in some states are creating uncertainty for members and plans alike, raising the risk of avoidable disenrollment due to confusion rather than ineligibility.
- ⚠ Funding is under strain as states push value-based models and limit supplemental payments without expanding administrative support.

The risk?

Significant policy changes in the last year have impacted American's trust in MA plans. The primary cause of declining member satisfaction is the 29-point drop in members' trust.

Understanding Market Shifts

4 Medical Costs Hit Rural and Safety-Net Hospitals the Hardest

The cost of delivering care continues to rise, and the impact is not evenly distributed. Rural and safety-net hospitals are shouldering the the greatest strain:

- ⚠️ Ongoing medical inflation
- ⚠️ Shortages in clinical labor
- ⚠️ Disruptions and price hikes across the medical supply chain

For provider-sponsored health plans tied directly to health systems, this creates a double squeeze. The result is a narrowing window to reinvest in growth, innovation, and member experience, even as expectations continue to rise.

5 The Traditional Group Market Faces Funding Issues

The traditional employer-sponsored market is showing signs of fatigue as healthcare costs outpace both wages and general inflation. Employers are struggling to maintain competitive benefits while employees question the value of what they are paying for.

- ⚠️ [Large employers project a 9% increase](#) in healthcare spending for 2026 — the steepest in over a decade. Even after benefit design changes, the trend remains high at 7.6%.
- ⚠️ High-cost drugs like GLP-1 weight-loss therapies are driving unsustainable pharmacy budgets.
- ⚠️ [In a Softheon survey](#), 86% of working Americans said they have serious concerns about healthcare affordability, underscoring the growing dissatisfaction with group coverage.

The risk?

Employer-sponsored coverage, once seen as stable, is losing trust. Rising costs without transparency are driving employees to question the value of their plans.



Member Expectations Outpace Internal Capacity

While financial pressures mount behind the scenes, members are judging plans based on something else entirely: the quality of their experience.

Whether it's ACA, MA, or Medicaid, today's members want the same things they get from every other part of their digital lives — speed, simplicity, and clarity.

But for most PSHPs, delivering that level of service is harder than it looks. Why? Because behind the scenes, operations are still heavily manual:

- Staff are processing enrollment files instead of welcoming new members.
- Billing teams are fielding calls about confusing premium notices.
- Outreach is reactive instead of proactive — there's no time to get ahead.

This is the experience gap, and it's growing.

Members expect more, but health plans are often too resource-strapped, too siloed, or too reliant on outdated systems to meet them where they are. The real risk? **Even when care delivery is excellent, the backend experience can still drive disenrollment, churn, and costly member confusion.**

Many provider-sponsored plans are shifting their strategy. They are not just looking to scale. They are looking to simplify. They know the member experience starts long before care is delivered. And they are investing in smarter infrastructure, shared systems, and automation not just to save money, but to serve people better.

WHAT MEMBERS EXPECT:



Easy-to-understand plan information



Real-time billing and payment tools



Guided enrollment without
the paperwork shuffle



Mobile-friendly, proactive
communication

Five Operational Challenges That Hurt Your Members

And what leading PSHPs are doing to fix them.

PSHPs are expected to deliver member-first care **and** run like a lean payer operation while navigating economic uncertainty, rising medical costs, and shifting rules.

These five operational weak spots not only drive-up admin costs — they're directly tied to member experience and retention.



1

Fragmented Data & Disconnected Systems



The Problem

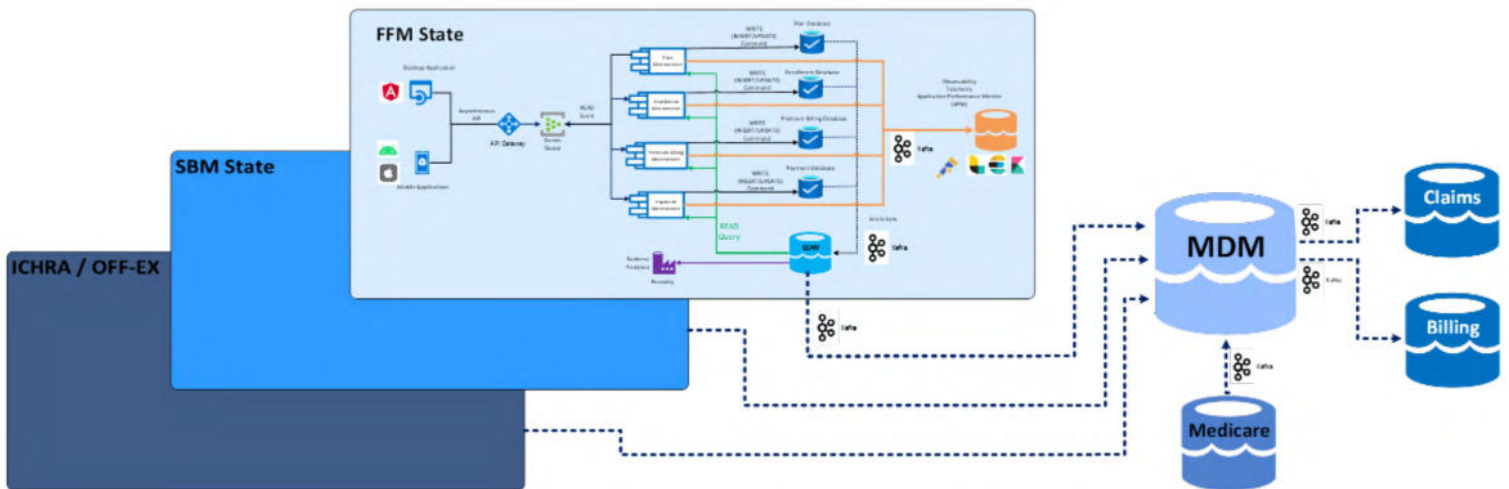
Enrollment lives in one system. Billing in another. Call logs in a spreadsheet. Many PSHPs manage Medicaid, ACA, and MA on completely separate platforms – leading to duplicated roles, redundant processes, and disconnected systems.

Why It Hurts

Members experience long onboarding delays, inaccurate communications, and different treatment depending on their plan type. Internal teams spend more time cleaning up than serving.

The Fix

The first step is to unify data across every coverage type. For many PSHPs, that doesn't mean ripping out every existing system. It means building a Master Data Management (MDM) layer that acts as the single source of truth. This MDM foundation can sync enrollment, billing, claims, and communications data so every team member sees the same, accurate information in real time.



* Modeled from Softheon' MDM workflow. Assumes that On-Exchange enrollment is the core business unit

Once MDM is in place, application programming interface (API) and targeted integrations can pull in data from your electronic medical records (EMRs), claims processing, and member portals, creating an operational backbone that works across Medicaid, ACA, and Medicare Advantage lines of business. The result is fewer manual reconciliations, cleaner handoffs, and the ability to automate processes without worrying about conflicting data.

With this approach, PSHPs can introduce personalized communications, coordinated billing, and faster onboarding – all without the “which system has the right info?” guessing game. For members, it means one experience from the moment they enroll, regardless of their coverage type.

2

Rising Cost of Administrative Labor



The Problem

Manual tasks, like matching eligibility, reconciling payments, and preparing CMS reports, are eating up hours. Burnout is high, and the pipeline for trained operations staff is shrinking.

Why It Hurts

Every error or delay increases member frustration. Teams work reactively instead of strategically, and innovation stalls.



The Fix

The way forward isn't simply to hire more people — it's to protect and elevate the talent you already have by eliminating repetitive, rules-based work. The most effective PSHPs start with a simple question: which manual processes happen most often and cause the most pain when they fail? These are your prime automation targets.

For example, incoming 834 eligibility files can be automatically validated for common errors, with exceptions routed directly to the right team. Subsidy changes can trigger real-time alerts so members don't get an unexpected bill. Payment reconciliation can run nightly without manual spreadsheet work. By systematically removing these low-value tasks, staff get time back for high-touch work like resolving complex member issues or designing better onboarding processes.

This shift not only lowers operational costs but also makes the member experience measurably better. Instead of waiting on hold for a fix, members get faster resolutions, fewer mistakes, and more personal attention from staff who aren't buried in administrative backlog.

3

Premium Billing Confusion & Payment Complexity



The Problem

Unclear invoices, misapplied subsidies, and missing payments are among the top reasons members leave. Confusion around first payments, especially in ACA and Individual Coverage Health Reimbursement Arrangements (ICHRA), leads to avoidable terminations.

Why It Hurts

When members can't understand their bill or pay in their preferred way, they delay payment or drop coverage entirely.



The Fix

Billing should be one of the clearest, most transparent touchpoints in the member journey. But for many PSHPs, it's a source of churn. The fix starts with a centralized billing platform that consolidates invoicing into a single, consistent format. This platform should automatically account for subsidies, employer contributions, and provider-sponsored payment programs so members see exactly what they owe and why.

From there, a digital-first approach can drive both cost savings and member satisfaction. Immediate "PayNow" options following enrollment reduce the risk of missed first payments. Flexible methods (recurring ACH, credit/debit, and mobile wallets) meet members where they are. And a member portal with downloadable invoices, payment history, and status tracking cuts down on "did you get my payment?" calls.

When billing is transparent, accurate, and easy to act on, members are far less likely to lapse coverage. For the PSHP, that means lower churn, fewer reinstatement headaches, and a smoother revenue cycle.

4

Misaligned Member Communications



The Problem

Generic letters and long wait times don't build loyalty. Members expect proactive, relevant communication delivered in their language, on their device, when they need it.

Why It Hurts

When people feel ignored or confused, they disengage. They miss renewal deadlines, let coverage lapse, or call in angry.

The Fix

Fixing communication starts with knowing your audience – and that means segmenting by plan type, preferred language, and behavior history. Instead of mass mailers, members should receive personalized reminders via text or email for enrollment and renewal deadlines. Digital welcome kits sent within hours of enrollment set expectations early, and confirmation emails for key actions (like payment received or ID card shipped) help members feel informed.

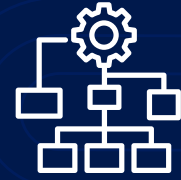
With CMS granting more flexibility on 2026 notices, PSHPs can now tailor messaging around premium changes due to eAPTC expiration. Help members understand what's happening before the bill arrives. Integrating SMS opt-in and self-service status tools also reduces call center load, freeing up agents for complex issues.

Meeting members in their preferred channels isn't just convenient; it builds trust, reduces friction, and encourages long-term retention.



5

Operational Inflexibility That Stalls Growth



The Problem

PSHPs know they need to grow, but legacy systems make it hard. ICHRA, provider-sponsored billing, and geographic expansion all require agility that inflexible infrastructure can't support.

Why It Hurts

If your operations can't adapt quickly, you risk missing high-value opportunities, becoming overdependent on shrinking markets, and leaving your plan exposed to shifts you can't control.

The Fix

Growth today isn't about casting the widest net — it's about entering new markets strategically with the right operational foundation. PSHPs pursuing innovative strategies like ICHRA or provider-sponsored payments need systems that can quickly adapt to different funding models, regulatory requirements, and member expectations without standing up entirely separate teams.



"There's a need for growth whether that be in the traditional geographic sense or expansions into new markets. Jumps into Medicare and ICHRA could be ways to navigate this new environment and political landscape."

— Lindsey Miller,
Director of Health Plan Programs, Softheon



The most successful organizations start by consolidating their tech stack so that new lines of business can be layered on without duplicating core processes. A shared enrollment, billing, and communications infrastructure — ideally built on the same MDM foundation from Challenge #1 — allows new offerings to launch with consistent member experiences from day one.

This kind of flexibility not only accelerates time-to-market but also ensures that expansion doesn't compromise service quality. Whether a member is switching from Medicaid to ACA or enrolling in a new ICHRA-friendly plan, they get the same seamless experience. And the PSHP grows without losing operational efficiency.

Growth Through Innovation

Findings from Spring Street Exchange's 2025 Strategy in Action Report

51% are actively pursuing new and innovative revenue opportunities beyond traditional offerings

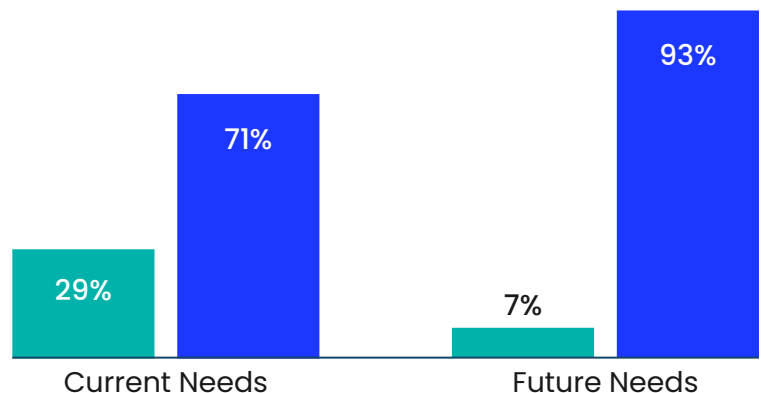
"Fifty-one percent reporting revenue streams outside of their usual bundle is a dramatic change. Historically, most healthcare organizations have stayed within their standard operating lanes. This growing interest in exploring new sources of revenue — and in thinking differently about how to connect the pieces — is a sign of optimism and resilience in the industry."

— Nancy Wise, Spring Street Exchange

But Organizations Aren't Ready

While interest is high, many organizations lack the operational flexibility, integrated systems, and market readiness to successfully execute on these new growth opportunities.

Innovation Capacity: Now vs. the Future





The 5 Things PSHPs Should Be Doing Now to Get Ahead for 2027

What	How	Common Pitfalls to Avoid
1 Use AI to streamline work, not replace people	<ul style="list-style-type: none">• Apply AI-powered automation to repetitive, rules-based tasks like eligibility checks, notices, and payment validation.• Start with self-service member populations where risk is lowest.• Use clear guardrails, human oversight, and transparency before extending AI to higher-need members.	<ul style="list-style-type: none">• Treating AI as a staffing shortcut.• Applying AI broadly without an adoption strategy.• Using automation in overlooked and underserved populations before trust, governance, and oversight are in place.
2 Consolidate your technology stack	<ul style="list-style-type: none">• Reduce redundant systems across Medicaid, ACA, Medicare Advantage, and employer-funded lines.• Invest in shared enrollment, billing, and communications infrastructure to lower operating costs as financial pressure on health systems increases.	<ul style="list-style-type: none">• Keeping siloed systems because they already exist.• Adding new tools on top of broken foundations.• Underestimating the cost of fragmentation as margins tighten.
3 Lead with member experience innovation	<ul style="list-style-type: none">• Design experiences around how members actually engage, not how plans are organized.• Personalize communication, simplify billing, and ensure consistency across coverage types so transitions feel seamless to members.	<ul style="list-style-type: none">• Assuming experience improvements require flashy tools.• Treating digital as optional.• Ignoring how confusion and friction directly drive churn and distrust.
4 Explore new ways to keep members covered	<ul style="list-style-type: none">• Expand beyond traditional group and Marketplace-only strategies.• Support models like ICHRA that give members continuity when employers change benefits or funding models.	<ul style="list-style-type: none">• Waiting for demand to force change.• Treating ICHRA as a niche offering instead of a retention strategy.• Launching new models without operational readiness.
5 Start connecting with members today	<ul style="list-style-type: none">• Segment members by coverage type, language, risk, and behavior.• Begin proactive education now around affordability changes, renewal expectations, and coverage options so members are not surprised later.• Expand in trusted communication channels to meet members where they are.	<ul style="list-style-type: none">• Waiting until Open Enrollment or policy deadlines. Relying on one-time mailers.• Assuming members understand changes without ongoing, clear communication.

About Softheon

Provider-sponsored health plans do not need another point solution. They need a partner who understands the complexity of operating across markets and the responsibility that comes with serving diverse member populations.

For more than 25 years, Softheon has partnered with provider-sponsored and mission-driven health plans to modernize how members shop for coverage, enroll, pay for their premiums, and stay connected throughout their coverage journey. Our platform is built to support every line of business you serve, including the ACA Marketplace, ICHRA-funded coverage, Medicare Advantage, Small Group, Dental, and Vision.

By unifying shopping, enrollment, billing, and member management on a single platform, Softheon helps plans reduce operational friction while delivering one consistent experience to members. As the market continues to evolve, plans need infrastructure that can adapt without disruption. Softheon provides the stability, flexibility, and scale to grow responsibly, retain members through uncertainty, and serve communities better.

One platform for health plans. One experience for members.

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