Microdosing

When Health Plan Disputes Become the New Normal

Rising clashes between hospitals and insurers are exposing outdated fee-for-service infrastructure

Paul Schrimpf, Christine Arbesman

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It's becoming a familiar headline. A major hospital system like Scripps Health or Hartford HealthCare announces it's ending its contract with an insurer. Or a payer like Anthem or Cigna warns members that a local hospital will soon be out of network. What used to be rare has become routine. Contract disputes between providers and insurers are now a defining feature of today's healthcare landscape.

In late 2024, there were 133 major disputes across the U.S., the highest ever recorded. While the number eased somewhat in early 2025, the disputes that continued tended to be larger, more public, and more disruptive. At stake are not just dollars, but patient access, continuity of care, and trust. Behind it all lies a system straining under outdated tools, rigid contracts, and competing pressures.
The way forward points to smarter, more flexible partnerships powered by modern technology; but getting there won't be easy.

The Cost Battle at the Center

At the heart of these disputes is a financial tug of war. Health systems argue they need higher payments to cover rising labor, supply, and technology costs. Insurers push back, warning that big rate hikes will make premiums unaffordable for employers and families. In states like California, New York, Connecticut, and North Carolina, these battles have played out in recent months. Often, tens of thousands of patients are caught in the middle.

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Marie DeFreitas of HealthLeaders pointed out: "Seventy percent. That's how much payer-provider disputes have surged in just the last two years. Contract terminations, lawsuits, and drawn-out reimbursement battles have become the new normal, and hospitals are bleeding cash as a result."

Outdated Systems Built Around Fee for Service Make It Worse

Beyond dollars and cents, these disputes reveal deeper structural problems. The systems most hospitals and insurers rely on today were designed for a fee-for-service world. Their core functions are built around claims processing and reimbursement for individual services, not for managing outcomes or total cost of care.

Traditional EMRs are a major part of the problem. They document care but were never designed to support bundled payments, shared savings, or patient-reported outcomes. They struggle with the operational and financial complexity of value-based care (VBC). When a contract falls apart, these systems make it harder to

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adapt. Insurers can't easily reconfigure networks. Providers can't adjust billing or care coordination quickly. The result: patients left confused and frustrated.

What's needed are systems that support seamless data exchange, hybrid payment models, and fast operational pivots when circumstances change. As David Blumenthal, of the Commonwealth Fund, cautions us on the reality of the current state of VBC, "The major purpose of value-based care is to increase value, not create simplicity."

Value-Based Care Is Finally Seeing Meaningful Traction

After years of talk and pilot projects, value-based care is finally gaining real traction. As Sanjay Doddaman of UpStream Health reminds us, "The first decade in value-based care was really focused on risk adjustment without too much … true health outcomes improvement." Providers and regional health plans are finally putting their money where their mouth is. They're signing real contracts that tie payment to outcomes, not just volume.

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We're seeing local systems and plans, like Memorial Hermann or Blue Shield of California, make value-based models a core strategic bet rather than a side project. Hospitals and insurers are designing agreements to reduce emergency visits, prevent readmissions, and better manage chronic conditions. These are no longer small experiments. They are becoming central to how care is paid for and delivered.

But making value-based care work requires more than commitment. It takes technology that delivers real-time data, supports bundled payments, tracks performance, and manages shared savings arrangements. Traditional systems weren't built for this. They can't handle the layers of operational and financial complexity that come with value-based care.

As Faris Ghawi noted, value-based care is a massive opportunity, but one loaded with complexity: "It's basically combining all the complexities of insurance with all of the complexities of being a provider, with all the complexities of being a technology company, and all the complexities of being a FinTech company. You miss one of those and you're toast."

Flexibility Is the Bridge Between Fee for Service and Value Based Care
Healthcare organizations face a simple truth: without flexibility, they'll remain stuck in transactional disputes that harm patients and strain relationships. Bridging the gap between fee for service and value-based care means building systems that support both models, sometimes side by side.

That means moving beyond slow, complex claims cycles and manual reconciliations. It means weaving patient engagement into the care model. Proactive outreach, care navigation, and real-time feedback need to align with financial incentives. Flexible technology makes that possible. Without it, providers and payers stay locked in rate battles instead of working together to lower costs and improve care.

Provider-Sponsored and Regional Health Plans Are Poised for Growth
The next wave of innovation in healthcare won't just come from national insurers like UnitedHealthcare or Aetna. It will come from provider-sponsored and regional health plans. These organizations — think of systems like Geisinger or Intermountain — are creating insurance products that are better aligned with their care models. They're offering local employers and communities alternatives that blend insurance and care in smarter ways.

To succeed, these plans need flexible infrastructure. They need systems that let them launch new products quickly, manage value-based contracts, and deliver strong member experiences without building everything from scratch. Modular platforms can enable them to scale operations while staying focused on their local communities. As employers and Medicare Advantage buyers demand more customized options, these regional plans will be ready if they have the right tools behind them.

The Industry Has Already Begun to Respond and Adapt
Change is already happening. Investors are backing companies that build the infrastructure to help payers and providers work together. Health systems are experimenting with risk-sharing arrangements and provider-sponsored plans. As one American Hospital Association report put it, "Provider-sponsored health plans offer a good way for hospitals and health systems to take on risk as they move toward value-based care."

Physicians and care teams are also calling for better technology. "The transition to value-based care represents a fundamental shift. Updated EHR and revenue cycle technologies to meet the evolving demands are leading to positive patient outcomes," said Doug Brown, President of Black Book.

These shifts show the path forward. The organizations that embrace flexible, modular systems will be the ones best positioned to thrive.

Smarter partnerships, supported by modern technology, won't eliminate every dispute. But they can limit the fallout and refocus the industry on what matters most: delivering better care at sustainable cost.

Acknowledgements and Citations

This report draws insights and direct quotes from:

- Marie DeFreitas, Editor, HealthLeaders — "AI, Lawsuits, and Power Plays. Why the Payer-Provider War Just Got More Dangerous for Healthcare CFOs."
- Faris Ghawi, CEO, Vytalize Health — Interview with HC Innovation Group on the complexity of value-based care.
- Doug Brown, President, Black Book — Quoted in Medical Economics on EHR and RCM technology.
- David Blumenthal, M.D., Former President, The Commonwealth Fund — Quoted on the primary purpose of value-based care.
- Sanjay Doddamani, M.D., CEO, UpStream Health — Quoted on the first decade of value-based care and risk adjustment.
- American Hospital Association Trustees Report — "Provider-sponsored health plans offer a good way for hospitals and health systems to take on risk as they move toward value-based care."