Why direct-to-employer contracting rarely drives growth

AUTHORS

Shay Pratt
Vice President, Research

Jennifer Leazzo
Senior director, Actuarial Optum Advisory

Allen Zhang
Research analyst

PUBLISHED

August 2026

Employers turn to DTE as providers search for growth

As pressure mounts in the employer-sponsored insurance market, more health systems are exploring direct-to-employer contracting. Employer healthcare costs continue to rise sharply, with projections approaching 9% annual growth,[1] and traditional cost-control levers like higher deductibles, narrow networks, and basic steerage have not delivered sufficient relief. At the same time, the employer-sponsored insurance market is not expanding. For providers, this means growth increasingly depends on capturing share, not organic growth within a relatively flat or even slightly shrinking commercial population.

Employers are responding to these challenges by becoming more active purchasers of care. Direct provider contracts are becoming more popular among large employers seeking more control over cost and quality. Bundled arrangements have also demonstrated meaningful per-episode savings, and advanced primary care models have been shown to reduce total cost of care.

For health systems, these contracts seem to offer an opportunity to become a preferred provider for a defined population, strengthen relationships with employers, and capture a greater share of commercially insured lives. However, this leads to a critical strategic question: **Can DTE contracting actually lead to health system growth?**

The answer, in most cases, is **no**. Although some models can lead to incremental growth if a system increases its share of services from the employed beneficiary pool, the underlying economics of these models are not designed to produce growth for providers.

75%

Of 150 surveyed employers with at least one direct provider contract[2]

DTE reduces demand before providers can capture growth

Across all DTE models, the primary value to employers is fewer unnecessary services, better-managed populations, and more predictable spending. These models are structured to intervene earlier in care pathways, consider conservative treatment options when appropriate, and avoid unnecessary high-cost downstream services.

This leads to a fundamental constraint: any opportunity for providers to grow must occur after demand has already been reduced. DTE does not expand the total volume pool. Instead, it shrinks it, and at best allows providers to compete for a larger share of what remains. This dynamic applies to both primary care and specialty care DTE models.

Primary care models suppress downstream utilization

How primary care models reduce demand

Primary care models (such as advanced primary care, direct primary care, and on-site or near-site clinics) are designed to engage patients earlier and manage them more intensively. These models typically reduce panel sizes, increase time per patient, and improve care coordination and chronic disease management.

The result is a better-managed population with fewer downstream referrals and lower overall utilization.

> Even with strong execution, the incremental gain is small; systems must significantly overperform on share growth to negate the impact of reduced utilization.

Why growth depends on capturing remaining referrals

However, health systems face an immediate tradeoff in primary care models. These models reduce the very downstream utilization health systems rely on for growth, particularly in high-margin service lines like orthopedics, spine, and cardiovascular care. To grow in this model, systems must ensure the remaining necessary referrals stay within their networks.

In practice, attaining this level of capture is extremely difficult to achieve at scale due to patient preferences, existing provider relationships, geographic constraints, and limited control over referral pathways. Health systems also need to partner with employers who are savvy about network design and willing to steer beneficiaries to partnered providers. Even with strong execution, the incremental gain is small; systems must significantly overperform on share growth to negate the impact of reduced utilization.

Specialty care models can shift share with stronger steerage

How specialty care models redirect procedural volume

Specialty care models (primarily bundled payments and centers of excellence) focus on high-cost, high-variation procedures such as joint replacements, cardiac surgery, and spine care. In these arrangements, providers offer discounted, fixed prices for defined episodes of care and take on financial risk for managing those episodes efficiently.

Employers use these models to control costs and standardize care pathways, often steering patients toward designated providers.

Why growth depends on employer benefit design

Unlike primary care models, specialty care models can shift provider share, but only when paired with strong benefit design.

Light-touch approaches to benefit design often include education and navigation, with employers offering information about preferred providers or concierge navigation support without changing what employees pay. These measures are often not strong enough to influence patients' choice of health system and typically produce minimal share movement to partnered health systems.

More aggressive strategies — such as reduced cost sharing (lower copays or deductibles for using preferred providers), paid travel, or even exclusive networks that limit coverage to a single provider for a given procedure — can drive more substantial shifts. In the most stringent models, employers may steer a majority of procedures to designated providers through near mandatory incentives. That said, many employers stop short of aggressive network design out of concern that limiting patient choice will be perceived as disruptive to employee preference.

Why financial benefits are limited

However, even when provider share increases, several forces limit the return. These models often lead to reduced demand due to improved triage and increased use of nonsurgical or conservative care pathways. Providers must also accept price concessions through bundled discounts, reducing revenue per case. Additionally, there are meaningful costs associated with building and maintaining these programs.

Although providers may be able to capture a larger share of a smaller or lower-priced pool, this often leads to break-even economics at best. Both primary care and specialty care models can shift where care is delivered, but they do not meaningfully increase how much care is delivered.

Primary care vs. specialty care models

Model	Employer value	Provider growth logic	Why benefits are limited
Primary care	Earlier management, managed downstream utilization	Retain necessary referrals in network	Suppresses the downstream volume providers rely on
Specialty care	Predictable cost, procedural utilization scrutiny	Shift more procedures to preferred provider	Requires strong steerage and lower per-case pricing

Not every market can support DTE at scale

Even beyond model economics, the feasibility of DTE is highly dependent on local market conditions. Successful programs require a sufficient number of large, self-insured employers, enough covered lives to justify program investment, and employers with the sophistication and willingness to implement more complex benefit designs.

Many markets lack this combination, making it difficult to scale beyond one or two anchor employers. Markets dominated by a single large employer pose concentration risk, while more fragmented markets often lack the employer density needed to generate meaningful volume. Geographic dispersion can also further limit the effectiveness of care steerage.

As a result, even when a DTE model succeeds with one employer, scaling it to a level that produces meaningful financial impact is not guaranteed. In many markets, the ceiling for DTE is determined more by employer composition and willingness than by provider capability.

What determines a market's DTE ceiling?

Question	Low ceiling	Medium ceiling	High ceiling
How many large employers are present?	1–2	3–7	10+
How many covered lives are available?	<10K	10K–25K	>25K
How concentrated is the workforce?	Dispersed	Mixed	Highly concentrated
How sophisticated are employers?	Traditional benefits	Some steerage	Aggressive benefit design
How dependent would the model be on a single employer?	Very dependent	Moderately dependent	Diversified

Treat DTE as a strategic capability, not a growth engine

DTE contracting is becoming necessary to operate effectively in many markets, particularly among large employers seeking to control healthcare costs. In one recent survey of 150 employers, 75% reported having at least one direct provider contract in place.[2] In addition, bundled payment arrangements have been associated with roughly 10.7% price savings per episode across several surgical procedures.[3]

The organizations that succeed will be those that align their goals accordingly — treating DTE as a defensive, cost-aligned capability, not a growth engine.

For health systems, DTE's primary value is strategic rather than financial. Although it is not a reliable path to increase total volume or drive significant commercial growth, it can help systems:

- Advance value-based care and population health goals by building capabilities in care management, navigation, risk-based contracting, and performance reporting.
- Defend market share by strengthening relationships with large employers and reducing leakage from commercially insured lives.
- Demonstrate affordability to purchasers by offering more predictable pricing, clearer quality expectations, and measurable cost accountability.

The organizations that succeed will be those that align their goals accordingly — treating DTE as a defensive, cost-aligned capability, not a growth engine.

Want to see if DTE contracting is right for you?

Optum consulting experts can help you figure out if DTE is appropriate for your health system and assist with setting it up.

Contact us at: **advisory.com/optum-support**

Endnotes

1. What employers want from direct provider health plan contracts. Brighton Health Plan Solutions. Accessed April 17, 2026.
2. Casolo E. The forces driving 2026 health insurance price hike forecasts. *Becker's Payer Issues*. September 11, 2025.
3. Whaley C, et al. An Employer-Provider Direct Payment Program is Associated with Lower Episode Costs. *HealthAffairs*. March 1, 2021.

Advisory Board

655 New York Avenue NW, Washington DC 20001 | **advisory.com**