



THE HIDDEN TOLL:

How traditional health plan carriers are quietly draining the bottom line



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Introduction

Small and midsize businesses have long been considered the lifeblood of the US economy, employing about 60% of the population.¹ But for many, providing health insurance has been a balancing act – a necessary expense to stay competitive, but an increasingly unsustainable benefit as costs continue to escalate. In 2025, the financial burden of traditional employer-sponsored health plans has gone well beyond the breaking point, and the cost of remaining with the status quo is higher than ever.

It's clear that traditional health plan carriers' cost containment strategies are no longer sustainable. Consider the fact that premiums continue to outpace inflation, with small and midsize businesses facing year-over-year increases of 5 to 9% or more.

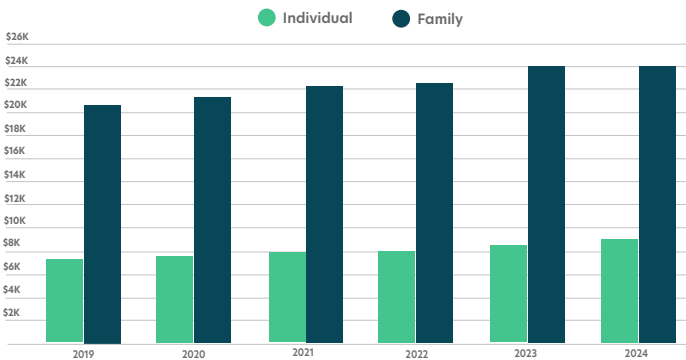
At the same time, more of the costs are shifting to employees, and annual coverage for an average family reached \$25,572 in 2024 – an increase of 7% over the prior year.² The fastest-growing component of health benefit costs? Spending on prescription drugs. In a 2024 Mercer survey, employers reported that drug benefit costs per employee increased by 7.2% compared with 2023.³

**THE INCREASE
IN HEALTHCARE
COSTS IS NOT
A TEMPORARY
SPIKE BUT A NEW
BASELINE.**

But the real cost isn't just in premiums. Real costs are in hidden fees, administrative waste and the lack of transparency, all of which have been built into what is fundamentally a flawed traditional health plan model. Every dollar spent on an opaque, one-size-fits-all plan is a dollar lost to inefficiency and cost savings. But despite the frustration and the real financial evidence that prove traditional plans are no longer viable options for achieving cost savings, employers and brokers seem stuck in the so-called carrier carousel: switching from one major insurer to another in the hope of achieving savings that never seem to materialize.

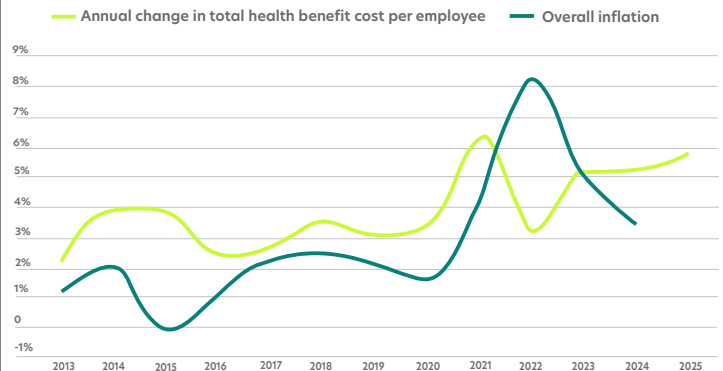
Adding to those downward pressures, workforce challenges are intensifying, especially in industries with blue- and gray-collar workforces – such as healthcare, manufacturing, transportation, automotive retail, construction, non-profit and hospitality. These sectors are struggling to attract and retain skilled workers, remain competitive, and manage productivity losses tied to unmet healthcare needs – or, worse yet, care that employees delay or skip altogether. In today's labor market, many employers are also reluctant to shift more costs to employees, particularly as high-deductible health plans become unaffordable.

AVERAGE PREMIUM COSTS FOR INDIVIDUALS AND FAMILIES⁵



Source: KFE Employer Health Benefits Survey

CHANGE IN TOTAL HEALTH BENEFITS COMPARED WITH OVERALL INFLATION⁴



Source: Mercer 2024 National Survey of Employer-Sponsored Health Plans

Forward-thinking businesses and brokers are using new, alternative-care models that eliminate hidden costs and facilitate direct contracting that cuts out layers of plan administration, which puts those businesses in direct control of their healthcare spending – without shifting costs or sacrificing quality of care for employees.

There is a growing convergence of other external pressures – economic, financial, social and regulatory – that are pushing employers to reconsider traditional health plan carrier options as they seek to strike a balance between cost management, quality improvement and enhanced employee experience. That perfect storm is marked by the following dynamics:



Employers are now pushed beyond the breaking point as the disconnect between cost and value intensifies. Many employers are being forced to pass costs on to employees, resulting in increased financial strain, higher deductibles and a growing population of functionally uninsured workers. Meanwhile, data shows that high-deductible-health-plan (HDHP) enrollment is declining,⁶ signaling that employers and employees alike are seeking better alternatives.



Overinvestment in point solutions that haven't worked so far to stem costs. Although point solutions may have brought hype, convenience and access, they often operate in silos and fail to contain the underlying cost drivers of healthcare. Simply put, they have failed to impact healthcare costs, have complicated benefits administration and are woefully underutilized. Without integration into a broader model, point solutions may lead to duplicative services, underutilization or fragmented care. More importantly, they rarely shift the core payment structure or incentives in the system, meaning that overall healthcare costs continue to rise despite their adoption.



Employee voice, which is now a catalyst for change. Employees are increasingly voicing dissatisfaction with the rising costs – and limitations – of traditional health plan carriers, which is creating new pressure on employers to explore alternatives. According to the Imagine360 survey, C-Suite and Broker Dynamics 2024, 72% of chief financial officers (CFOs) said their employees are pushing for more-affordable healthcare options, and nearly 60% of human resources (HR) leaders reported that benefits dissatisfaction is directly affecting employee retention.⁷



Deteriorating public trust, which is leading to a lack of system credibility. After perceptions of healthcare have steadily eroded for years, Americans' views of quality and coverage have reached all-time lows. In fact, a 2024 Gallup poll reported that only 28% said coverage is excellent or good – a 24-year low.⁸ The continued downward slide is evidence that the status quo isn't failing only employers. It's failing everyone. Negative public sentiment is rising alongside the calls for greater transparency into costs and practices.



Regulatory tailwinds and fiduciary realities, which are making it easier – and in some cases, more cost-effective – for businesses to move to new health plan models. The regulatory environment is catching up with the need for transformation. Transparency requirements, cost disclosures and fiduciary enforcement actions are all increasing. Under the Employee Retirement Income Security Act of 1974 (ERISA), employers must act in the best financial interests of plan members, making it impossible to meet that obligation without better visibility into plan performance.

Employees push back on traditional healthcare⁹

EMPLOYEES EXPECT MORE FROM THEIR HEALTHCARE

66% 


OF CFOS

reported that employees are pushing back on out-of-pocket costs more than they did a year ago.

IMPLICATION:

There's a growing employee expectation of affordable and predictable healthcare, signaling a shift in tolerance for high deductibles and high copays.

RETENTION CONCERNS ARE TIED TO BENEFITS

52% 

OF CFOS

said employee frustration with health benefits is contributing to retention issues.

IMPLICATION:

Health plan dissatisfaction is no longer a siloed HR concern. It's a business risk that is negatively affecting workforce stability.

EMPLOYEES DEMAND GREATER TRANSPARENCY

48% 

OF CFOS

said their workforces expect more help in navigating the healthcare system.

IMPLICATION:

Not only are employees seeking cost control; they're also demanding employer-sponsored solutions that simplify the healthcare experience.

“Given the trajectory of healthcare costs, coupled with the challenging economic climate and continued people challenges, we predict a massive shift away from traditional health plan carriers, and I believe employers are going to lead it. They're ready for change.”

- Chris Schutt

Senior Vice President, Consultant Relationships, Imagine360



The high cost of doing nothing

For decades, traditional health plan carriers have been viewed as the low-risk, “safe” solution. Today the status quo remains one of the most significant financial threats to employer operations and employee well-being. As premiums continue to rise unchecked, revenue growth is flattening, labor markets are tightening, and economic forecasts remain uncertain.

But the true impact is felt most sharply by employees. Many are now considered functionally uninsured, meaning that their coverage is insufficient to offer necessary medical care. According to a survey by the Commonwealth Fund,¹⁰ a staggering, three out of five underinsured adults reported avoiding necessary care due to cost concerns.

The issue is particularly pronounced among blue- and gray-collar workers. A Commonwealth Fund study found that 12% of workers in businesses that had 100 or more employees were considered underinsured.¹¹ Those findings underscore the fact that for many employed individuals, merely having health insurance does not guarantee adequate financial protection or access to necessary healthcare services.

Underinsured employees may lead to unintended consequences for employers. They often skip care or abandon procedures due to high deductibles and out-of-pocket (OOP) costs, which can lead to worsening health conditions and future expenses. Then there are indirect costs such as absenteeism; presenteeism, meaning that the employee is on the job but not functioning at full capacity due to illness, stress or other personal issues; and turnover, all of which may compound employers’ direct financial burdens.

“There are hidden emotional and productivity costs in traditional health plan structures, underscoring the reasons employee experience is becoming a sharper and sharper focus among employers exploring alternative models. HR leaders typically focus on employee well-being. Financial well-being is employee well-being, and if employees don’t have financial health, then they certainly can’t have physical, emotional or mental health.”

- Chris Cigarran
Chief Commercial Officer, Imagine360



3 in 5

underinsured adults report avoiding necessary care due to cost concerns.¹⁰

**100
MILLION**

Americans, the majority of whom are insured through their employers, carry medical debt.¹²

6+
DAYS OF
MISSED WORK
ANNUALLY

occur among employees with unmet medical needs and healthcare-access challenges compared with the rest of the employee population.¹³

Current state - traditional health plan carrier



MEET ELENA, a 39-year-old customer support supervisor and single mom of two*

Elena's employer offers a traditional preferred provider organization (PPO) plan through a major carrier. Elena pays \$300 a month in premiums and has a \$4,000 deductible for family coverage.

Last year, Elena's 9-year-old daughter needed surgery after a bike accident. Even with insurance coverage, Elena was left with \$5,800 in OOP costs. She put \$4,000 of the total on a high-interest credit

card and took out a personal loan for the rest. Today she still carries \$3,200 in medical debt.

Elena now avoids scheduling follow-up appointments and skips her own health exams. She's exhausted, worried about finances and often distracted at work – when she shows up. Elena has already missed several days of work because of her own mental health challenges. She's quietly looking for a new job with better benefits and lower deductibles.

* Scenario is a fictional story for illustrative purposes.

THOUGHT STARTER

How many employees are quietly skipping care because of high deductibles or OOP expenses? What are the downstream effects when employees skip care? How does skipping care affect employers' teams, cultures and businesses? What strategic guidance do employers need as they seek new health benefit options?

The full financial picture: Hidden costs of traditional health plan carriers

Traditional health plan carriers are usually perceived as safe and familiar, but beneath the surface lies a complex ecosystem riddled with cost variances and a lack of transparency. For most financial executives, cost transparency is a given. They know exactly what they're paying for a ream of paper, a server upgrade, or a pallet of 2x4s – down to the cent. Yet when it comes to healthcare, that same level of transparency vanishes. Employers routinely invest millions in healthcare benefits without knowing what they're actually paying for. There's little visibility into the cost of a standard MRI, for example, or the wide variation in pricing for the same procedure across providers, let alone the quality of care that their employees receive. It's a level of financial ambiguity that would be unacceptable in any other part of the business.

This ambiguity is entrenched in our healthcare system and for some the phrase "out of sight, out of mind" applies. But for those employers and brokers looking for answers to year over year cost increases, this lack of consistency in healthcare pricing and unknowns within provider network contracts all works to exacerbate the issue. However, the question remains...is anyone paying attention? Particularly for lower wage employees and lower margin businesses, a fundamentally different approach is needed for premiums and deductibles that are truly affordable and sustainable in the long term.

A different way to price and pay claims

Reference-based pricing uses cost and Medicare data to determine a price for care.

SAMPLE CLAIM

PPOs apply a **standard discount** to this marked-up price. In this case, the discount is **50%**.

PPO plans pay \$2,500

Chargemaster price: \$5,000

This price is not based on the actual cost of providing the service.

RBP rates are based on the actual cost of care or the Medicare rate plus a margin, whichever is higher.

RBP pays \$336

Medicare pays \$280

\$250 actual cost

After all, there are other ways to price and pay claims. Consider the approach taken with reference-based pricing. While traditional carrier PPOs do apply a discount, it is a discount on a price not in relation to the actual cost of providing a service. So while someone may get a discount, say 50%, this is a discount off an artificial price, meaning you still don't actually know what that service truly cost. However, under reference-based pricing, payment is determined by either the actual cost of care or the Medicare rate plus a margin, whichever is higher. This creates a more consistent pricing structure for employers, aligned with how most other businesses price their goods and services. This is also inclusive of a needed profit for organizations involved in delivering care and services which is important to keep all entities strong within the ecosystem.

The future state: Traditional health plan carriers versus alternative plans

Employers facing unsustainable healthcare costs are increasingly exploring alternative health plan options – models that offer flexibility, transparency and cost control. Despite the benefits of those alternatives, however, lingering myths continue to cloud perceptions. Some believe alternative plans are viable only for large corporations or that these health plans would expose companies to too much financial risk.

Others worry about employee dissatisfaction or lack of access to quality care.

But those myths are increasingly at odds with the data and outcomes seen in today's programs, which demonstrate cost savings and continued access to quality doctors and facilities via national provider contracts that don't limit employees to providers in a network but instead offer far more flexibility and choice. For example, Imagine360 sees 15%-30% in savings versus PPO plans with traditional carriers and a net promoter score (NPS) of 78 which is among the best in healthcare.

Navigating alternatives requires first understanding the key building blocks of health plan design – how care is funded, how it's paid for, and how provider access is structured.

FUNDING MODELS

Funding defines who assumes financial risk. Fully insured plans place all risk with the carrier and offer

minimal visibility. In contrast, self-funded and level-funded models allow employers to manage risk more directly – with varying degrees of control and potential for savings.

PRICING AND PAYMENT MODELS

This determines how providers are reimbursed.

Traditional plans rely on opaque network contract rates, which vary wildly by provider and region. In contrast, reference-based pricing (RBP) pegs reimbursement to a fixed percentage above standard rates, including Medicare and federally reported cost.

NETWORK TYPES

Provider access also plays a critical role. From tightly managed HMOs to broad PPOs, employers can choose from a spectrum of networks – or opt out entirely with open-access models that use national contracts, RBP, or a combination of both, to provide flexibility and preserve employee choice.

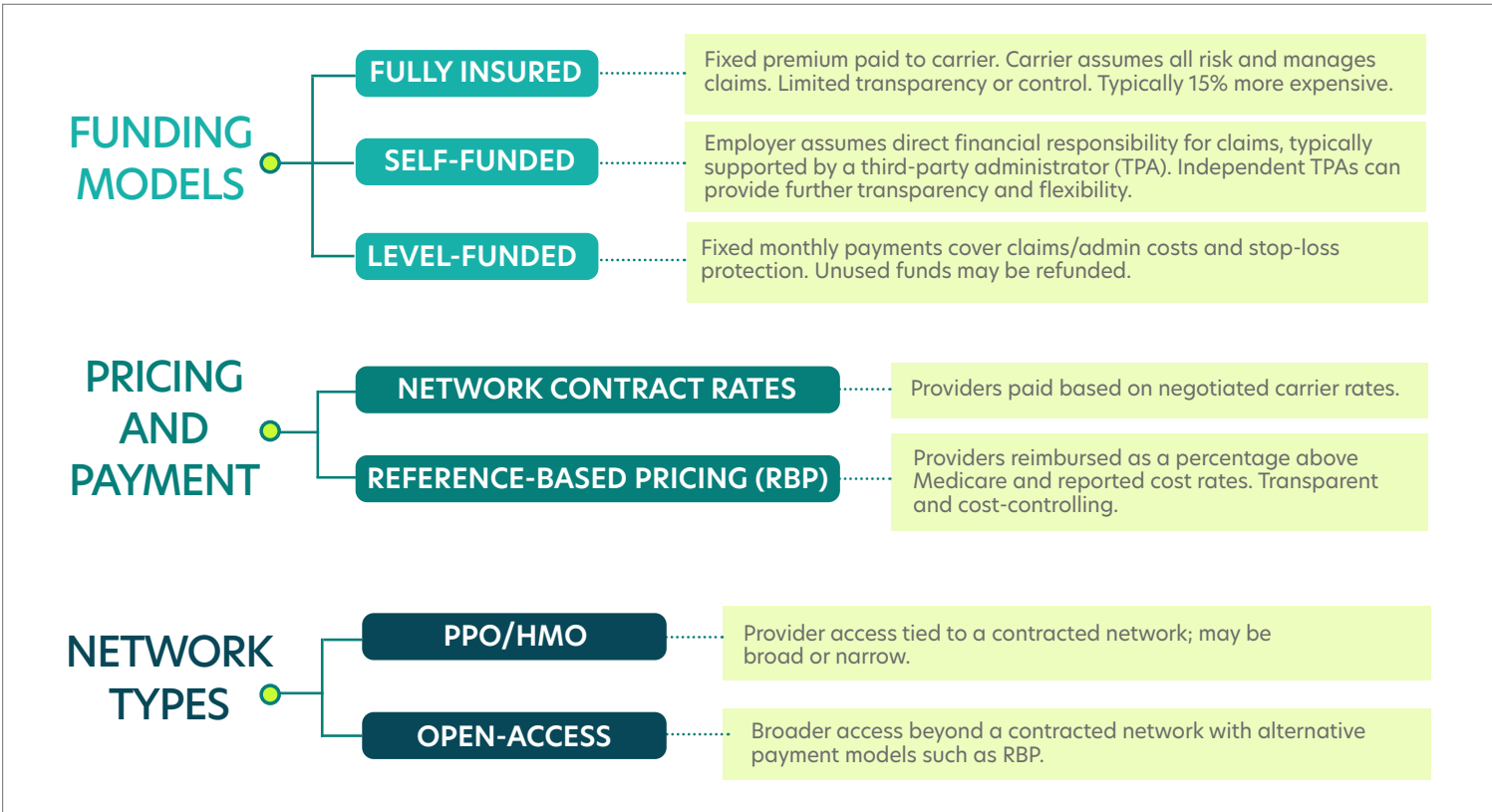
Together, these elements allow employers to follow a more progressive path toward high-performance plan design. For example, consider how an RBP model transforms the healthcare cost structure: payments grounded in transparent, consistent pricing; access to quality care without narrow networks; and the opportunity to eliminate carrier overhead.

“There may be a level of disbelief among employers, and they can't accept that the system could be this wasteful – that costs could be as outrageous as they are. We often hear there's no way they could be charged 500% of what it costs for care, but the fact is, that's exactly what's happening.”

– Chris Cigarran,
Chief Commercial Officer,
Imagine360

THOUGHT STARTER

Most employers wouldn't tolerate mystery pricing in any other area of their business. So why accept it in healthcare? Start investigating: What does a procedure actually cost across your provider network? Where are the biggest pricing gaps hiding? Are your contracts built on real, auditable numbers—or vague discounts on inflated charges? Ask who sets the prices, who profits from the opacity, and why are you left in the dark. If you can't see the inputs, you can't manage the outcomes.



Employers' CFOs are taking note of today's mature and proven alternative models. According to the Imagine360 C-Suite and Broker Dynamics 2024 survey,¹⁴ 85% of finance executives said their brokers should bring them more nontraditional solutions; 78% said their current health plans aren't delivering enough value. The appetite for change is growing, and the path to transitioning is based on an organization's mindset and operational and cultural characteristics.

Future state: Alternative health plan

A new outcome for Elena and her family

Let's revisit our earlier scenario and now consider how Elena's experience may change under a modern self-funded plan. In our current-state scenario, Elena delayed seeking care for her daughter's condition due to high OOP costs, which then led to emergency surgery and \$7,000 in lingering medical debt.

Under a self-funded model with reference-based pricing and navigation support, healthcare for Elena's daughter could have been guided proactively. Her OOP costs may have been capped at a reasonable level, and her daughter's complications identified and treated earlier — potentially avoiding surgery altogether. With improved access to affordable diagnostic services, such as a CT scan priced at just \$150 under an RBP model compared with \$1,528 under a traditional PPO¹⁵, care may have been delivered sooner — and at a fraction of the cost.

From the employer's standpoint, this approach translates into potential cost savings, more stable financial projections, and increased employee satisfaction. Instead of having to absorb inflated PPO charges or cover costly emergency procedures, the employer could pay closer to the actual cost of care — usually 70% or more below traditional network rates. That not only potentially lowers overall spend but also improves plan sustainability and forecasting. By minimizing employee financial strain, the employer may also benefit from greater employee productivity and retention because workers like Elena are able to remain focused and engaged at work rather than feel overwhelmed by unaffordable medical bills.



Characteristics of future-focused organizations

Organizations ready to transition away from traditional healthcare carriers are not defined solely by employee population type, profit margins or size. What truly differentiates them is their orientation toward innovation, transparency and their change management capabilities. They are often led by finance or HR executives no longer willing to accept rising costs and diminishing returns as inevitable. Instead, these leaders are becoming increasingly frustrated by opaque pricing structures, hidden markups and limited control under traditional health plan carriers.

Organizations ready for change are data driven and want greater visibility into their health plan spending. They value having control over plan design, cost containment and vendor relationships. Many have experienced years of double-digit premium increases with no correlating improvement in care quality or employee satisfaction. They're looking not only for cost savings but also for alignment between dollars spent and outcomes achieved.

Culturally, change-ready organizations embrace change and have leadership teams that understand healthcare as a strategic business issue, not just a benefits line item. They may already be taking steps toward health innovation in other areas and are now ready to go further. They may have tried and failed to introduce cost savings through point solutions such as wellness programs. And they find they're out of options.

“Employers don't need to have it all figured out right from the start. They simply **NEED** to be willing to ask **MORE** questions about the alternatives to traditional plans that may change the current results. That should be enough to get them started on the path to a new type of health plan.”

- Chris Schutt, Imagine360

At the same time, these employers are rethinking the employee experience. They acknowledge that rising deductibles, complex billing systems and limited provider access are not just financial issues. They are issues that erode employee trust, reduce care-seeking behavior and lead to worse outcomes. Employees don't want a maze; they want a guide. Change-ready companies are actively seeking solutions that help employees navigate care, avoid unnecessary costs and feel supported – not abandoned – when they seek care. Change-ready companies see the employee healthcare experience as a lever for engagement, retention and productivity – and they recognize that traditional health plans are falling short.

The shift presents both a challenge and an opportunity for both employers and brokers. For employers, there is an opportunity to lead the conversation...to push the change agenda. For brokers, if they continue to focus on traditional plans, they risk being seen as out of touch. But brokers that guide employers through more-innovative, employee-centric models can position themselves as strategic partners.

THOUGHT STARTER

Trying to understand and compare healthcare costs by region and figure out why there is so much variation? You can refer to the RAND Corporation's Hospital Price Transparency Study,¹⁶ which examined claims data provided by self-insured employers, state-based all-payer claims databases and health plans and then compared the prices with those paid by Medicare. Access the report to compare prices between hospitals and determine whether the prices paid are appropriate.

A progressive path to a sustainable future state

Transitioning to an alternative health model is not an all-or-nothing proposition. There is a spectrum of change, but the key is to start building momentum by making changes that break inertia and help begin realizing savings and cost control. The path to change depends on a number of factors, but whether an organization begins small or rapidly advances toward total replacement, the key is to take action that aligns with the organization's size, employee population, goals, and risk tolerance.



LEAVE THE CARRIER ADMINISTRATION, BUT KEEP THE PLAN'S NETWORK ACCESS

A pivotal move occurs when an employer retains its carrier's network but replaces the carrier's administrative services with a third-party administrator. This unlocks plan design flexibility, enables better claims oversight and offers control over vendor contracts.



OFFER A DUAL OPTION

As confidence grows, an employer might implement a dual-option strategy at open enrollment that enables employees to choose between a traditional BUCA plan and a more-cost-effective alternative. The offer of choice empowers early adopters, demonstrates value and builds trust across the organization.



GO FULL REPLACEMENT WITH ONE PLAN FOR ALL EMPLOYEES

This approach involves a complete transition to a self-funded alternative, often anchored in RBP. Under this model, the employer fully owns the plan design, pays providers directly based on a defined reimbursement schedule and delivers proactive employee support through navigation and billing protection.

“Cost control doesn't require sacrificing quality or shifting cost to employees - it requires changing the model. If your broker won't support transparency or blocks new ideas, walk away. Whether it's full claims access or vendor independence, true control means eliminating layers that increase complexity.”

- Barbara Barrett
Assistant Vice President of HR, Langdale Industries



Conclusion: Strategic implications of inaction

Remaining with a traditional health plan carrier isn't just costly; it can put a business at competitive and financial disadvantages. Companies that fail to rethink their approaches are losing out on cost savings, employee retention and the ability to instead reinvest in growth and their employees. Brokers that don't stay current with alternative health plan options risk losing credibility and relevance as employers seek more-cost-effective, transparent and employee-friendly solutions.

Employers that are ready to break away from traditional models are those that have both the strategic urgency and the operational willingness to try something different. They're asking not, "Can we afford to change?" but, rather, "Can we afford not to?" For brokers, that means proactively educating themselves on emerging health plan models, building partnerships with alternative solution providers, and coming to the table with innovative strategies that align cost control with better employee experience.

“In the end, brokers and employers must do something to reinforce their roles in driving lasting change. The type of alternative health plan or solution they decide on matters less; they need only to have a viable choice beyond the status quo. The ways employers buy health plans – and the ways benefits consultants advise them – is changing rapidly. And that's a net positive for businesses and hardworking families already stretched thin.”

– Chris Cigarran,
Imagine360



About Imagine360

Imagine360 is a leading healthcare solutions provider that helps self-funded employers take control of their healthcare costs while delivering better experiences for members. With more than 15 years of expertise in RBP and health plan administration, Imagine360 develops fully integrated solutions that combine deep industry knowledge, data-driven strategies and concierge-level support for employers.

The company partners with employers and brokers to design and manage customized health plans that lower costs, increase transparency and improve outcomes – without compromising quality or access. Backed by dedicated advocacy, legal protection and proven results, Imagine360 is reimagining what smarter healthcare can look like for organizations and their employees.

Learn more at [Imagine360.com](https://www.imagine360.com) or [subscribe](#) for more content like this.

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