Five Dynamics Impacting Employer Healthcare Affordability

imagine360

Introduction

For years, employers have wrestled with the rising cost of healthcare, searching for ways to balance affordability with employee access to care. Yet the trajectory of healthcare costs remains unsustainable. No single healthcare cost-saving strategy has proven to be a silver bullet for making employer-sponsored healthcare more affordable. During the past several years, employers have experimented with a portfolio of cost-saving approaches — for example, by combining a high-deductible health plan (HDHP) option with robust wellness programs, on-site clinics or centers of excellence (COEs) for high-cost healthcare services and procedures.

Those efforts, while creative and sometimes effective in the short term, have run headlong into new realities. Each strategy has shown areas of notable initial cost savings, improved care and fewer hospital visits, but over time, studies show that cost savings decline, resulting in disappointment that the savings either are not sustainable or require trade-offs. Further, they don't achieve the cost-savings necessary to rein in spending.

Research confirms that bending the curve is no longer enough; employers and brokers must confront the fact that incremental cost-saving strategies can't solve a structural problem with a system that's essentially broken. Sustainable affordability requires rethinking the model entirely, moving beyond short-term fixes and toward alternative health plans like reference-based pricing that reset the baseline of costs, introduce transparency and create sustainable savings that protect both organizations and their employees.

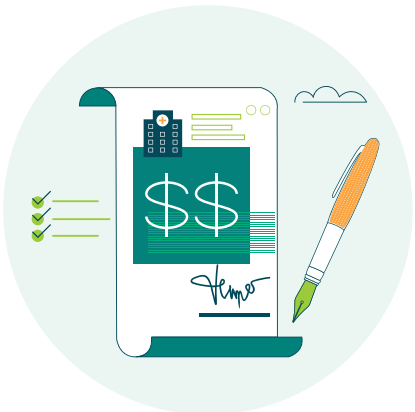
Here are the five emerging trends that are reshaping the healthcare landscape and influencing how employers will make health plan decisions in the coming years.

Prices, not utilization, are driving healthcare costs

Specialty drugs are reshaping the spend curve

Employer cost-saving levers are tapped out

The tight labor market elevates affordability as an enterprise risk



Policy headwinds are creating opportunities for change

TREND 1:

Prices, not utilization, are driving healthcare costs

Since 2010, consumers' use of healthcare services has surged by 47%, contributing to 60% of healthcare spending growth, while underlying prices have grown an additional 31%[1]. In 2023, healthcare utilization saw its biggest spike in more than a decade, rising 4.6%[2], which highlights the significant impact of utilization on cost growth.

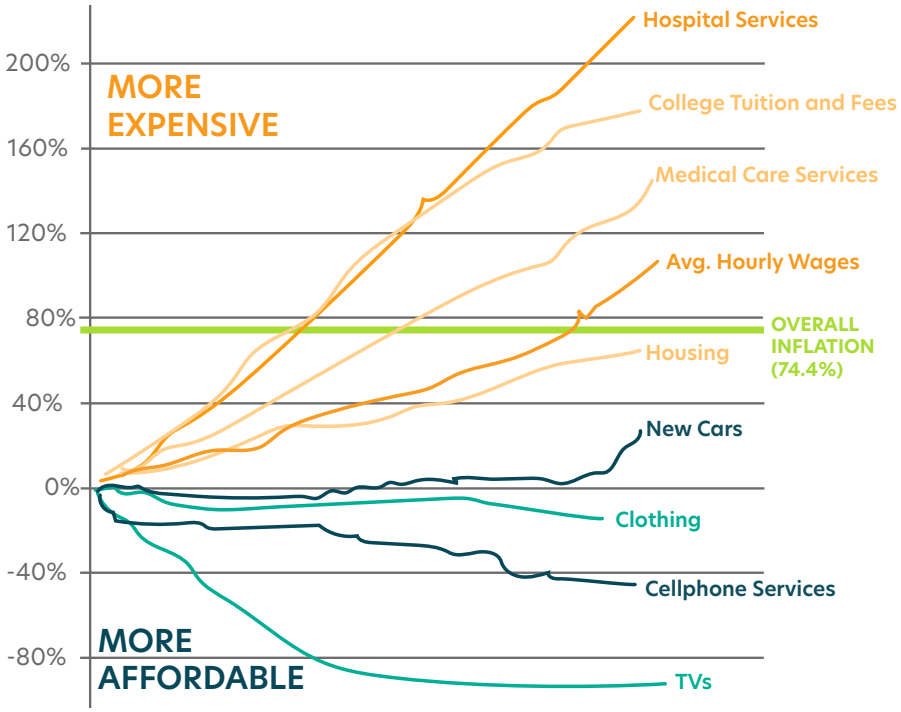
However, when it comes to employer-sponsored healthcare costs, price — not just utilization — is the dominant driver of overall cost growth. Private employer-sponsored plans pay hospitals an average of 254% of Medicare rates for the same inpatient and outpatient services, with some regions pushing that to 300–400%[3]. These inflated prices are not necessarily tied to better quality; rather, they reflect providers' market power in the absence of competitive checks.

As a result, employers are paying significantly more without seeing equivalent improvements in employee health outcomes - a dynamic that underscores the need for transparency initiatives and innovative health plan design to bring cost growth under control.

RISING HOSPITAL PRICES DRIVE SPENDING GROWTH

Price Changes: January 2000 to June 2022

Selected US Consumer Goods and Services, Wages



Source: Bureau of Labor Statistics

"We actually don't see utilization driving the majority of spending increases on the commercial side — it's much more about the prices being charged, especially in hospital settings. Even when utilization stays flat or only goes up slightly, overall spending continues to rise because of the negotiated rates."

— **ROSLYN MURRAY, PhD,** Assistant Professor of Health Services, Policy and Practice, Brown University's School of Public Health

Market consolidation reshapes local market dynamics

Other trends accelerating provider costs? Hospital mergers and acquisitions, which have accelerated in the past decade, fundamentally reshaping local market dynamics. Evidence shows prices can rise 20-40% within two years of a major hospital consolidation[4] with median inpatient prices jumping 32% in highly concentrated hospital markets[5]. Yet, despite higher costs, research finds that patient outcomes generally remain the same - and it's the employer and its employees that bear the brunt through higher premiums and deductibles.

Market consolidation also allows hospital systems to charge more for care that previously would have cost less. This happens when hospitals acquire private physician practices and perform outpatient procedures in those offices, allowing them to charge much higher hospital outpatient facility rates. Site-neutral payment reform aims to ensure health plans and other payers pay the same rate for care - regardless of where it is provided.

"When a hospital system dominates a market, they can set the rates — and employers have very little leverage to push back. We've seen markets where consolidation drives prices significantly higher without any corresponding improvements in quality or outcomes."

— **ROSLYN MURRAY,** Brown University

The consolidation-driven price increases represent only part of the story. Providers are also shifting unreimbursed costs from public programs like Medicare and Medicaid onto commercial payers, pushing private-plan rates two to three times more for identical services.[6] And what's emerging is a system where prices are getting increasingly detached from the actual costs of care delivery. Transparency measures and alternative-plan designs are beginning to expose those discrepancies, giving employers leverage they've never had before. Now employers and brokers must use that leverage — by exerting pressure on providers and exploring alternative-plan options — to rebalance negotiating power.

TREND 2:

Specialty drugs are reshaping the spend curve

Pharmacy benefits have become the new pressure point in employer-sponsored healthcare costs ballooning to 27%[7] of healthcare dollars spent in the past few years. Of those costs, specialty drugs now account for more than 50% of total pharmacy spend while serving less than 2% of members and exerting enormous financial strain on employer-sponsored health plans.[8]

The challenge is only intensifying as the drug pipeline shifts toward ultra-high-cost therapies. The drug pipeline is becoming increasingly weighted toward specialty drugs and cell and gene therapy (C&GT) treatments — some of them can cost upwards of $4 million per patient.[9] For example, Zolgensma, a gene therapy for spinal muscular atrophy, is priced at approximately $2.1 million per treatment.[10] Even though only a handful of employees might ever require such treatment, the financial exposure from a single claim could be devastating. Employers are struggling to manage such costs while maintaining coverage — particularly as more multimillion-dollar claims threaten to hit their plans each year.

Rising specialty costs and GLP-1 pressures

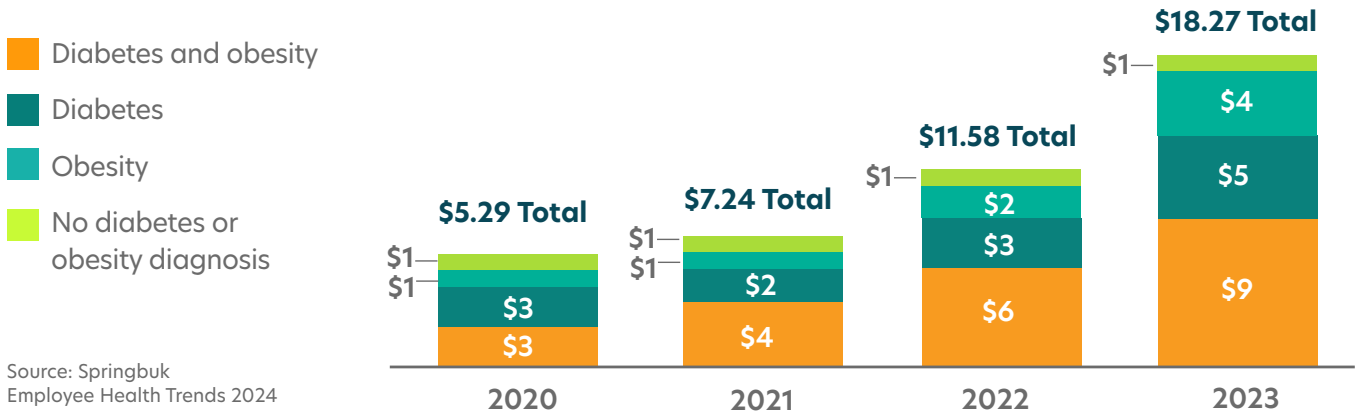
The unprecedented rise in the use of GLP-1 (glucagon-like peptide-1) medications such as Mounjaro, Ozempic and Wegovy have further complicated affordability strategies. Once prescribed primarily for diabetes management, these drugs are now widely sought for weight management, which is resulting in surging utilization.

Employer GLP-1 spending for obesity alone (excluding diabetes) nearly tripled from 2021 to 2023 from 5.9% to 16.5%; and from 2023 to 2024, employer coverage of GLP-1 increased by 8%.[11] Further, three of the top five drugs driving the change in costs per member per month were GLP-1 agonists, a class of medications used primarily to manage type 2 diabetes.[12] And despite the high costs of those medications, demand has continued to increase.

For employers, GLP-1 spending causes a difficult trade-off: although these drugs show strong clinical promise for managing chronic conditions and improving long-term health outcomes, their high costs and rapidly

expanding demand make them increasingly challenging to cover sustainably. Employers are being forced to revisit coverage policies and weigh short-term cost pressures against potential downstream savings from improved metabolic health.

GLP-1 AGONIST PMPM TREND BY CONDITION(S)[1]



Source: Springbuk Employee Health Trends 2024

Pressures are being compounded by an accelerating specialty drug pipeline, which is projected to include dozens of new gene and cell therapies in the coming decade, many of them carrying seven-figure price tags.[13]

Globally, 36 gene therapies have been approved.[14] Since 2019, the US Food and Drug Administration has approved nearly a dozen specialty and C&GT drugs that cost more than $1.5 million per patient.

Among the more recent[15]:

2025

- **$1.75 million** Abeona's Zevaskyn for recessive dystrophic epidermolysis bullosa, 2025
- **$3.20 million** Sarepta's Elevidys for Duchenne muscular dystrophy, 2025
- **$1.65 million** Vertex/CRISPR's Exa-cel for sickle cell disease, 2025

2024

- **$4.25 million** Orchard Therapeutics' Lenmeldy atidarsagene autotemcel for early-onset metachromatic leukodystrophy, 2024

2023

- **$3.10 million** bluebird bio's Lyfgenia for sickle cell disease, 2023
- **$3.20 million** Sarepta Therapeutics' Elevidys for Duchenne muscular dystrophy, 2023
- **$2.20 million** Vertex Pharmaceuticals' Casgevy for sickle cell disease, 2023
- **$3.00 million** bluebird bio's Skysona for cerebral adrenoleukodystrophy, 2022
- **$2.80 million** bluebird bio's Zynteglo for ß-thalassemia, 2022
- **$3.50 million** CSL Behring's Hemgenix for hemophilia B, 2022

"With GLP-1s, we're seeing a huge shift — they were first approved for diabetes, but now everyone wants them for weight loss. The expansion is driving demand in ways we haven't seen before. Employees are even making job and retention decisions based on whether these drugs are covered."

— **MARTINO LUU**, Executive Vice President, Imagine360Rx

PBM spread pricing and federal scrutiny

Traditional pharmacy benefit manager (PBM) models, which are built on rebates and spread pricing, have obscured employers' true costs of drugs. "Spread pricing occurs when PBMs charge more for a prescription drug than the amount they reimburse the pharmacy and then keep the difference as profit," explained Imagine360's Luu. "This practice distorts true drug costs for employers and limits pricing transparency, making it harder to manage pharmacy spend effectively."

Spread pricing

A pricing model where a company charges customers more for a product or service than it costs to obtain it. In the context of pharmacy benefits, PBMs charge health plans or employers a higher price for medications than what they pay pharmacies. The difference between these two amounts is called the "spread."

Rebates

The same concept as spread pricing, rebates involve giving employers a smaller rebate than what they receive from pharmaceutical manufacturers.

Transparency means having clear and accessible information on the amount the PBM paid to a pharmacy for each drug, how much the PBM received in revenue for each prescription and the cost of each component of any fees. Lack of such clarity can mislead employers to believe they are receiving better deals than they are, ultimately challenging PBMs' transparency claims.

Further muddying the waters are rebates, which are often positioned as savings and yet serve only to incentivize higher list prices rather than lower overall spend, said Luu. Federal scrutiny is intensifying, however, via Federal Trade Commission investigations of rebate practices and policymakers pushing for reforms that require pass-through pricing and greater transparency in PBM contracts.

Viewing drug spend holistically

Another friction point is siloed decision-making between pharmacy and medical benefits, which continues to drive unnecessary costs.[16] Prescription drug costs flow through two distinct systems: everyday medications go through the pharmacy benefit and are managed by a PBM. High-cost specialty drugs, infusions and C&GTs are billed under the medical benefit, where costs are based on a single treatment and can often be much higher per claim.

In a theoretical scenario, Imagine360's Luu described a situation in which denial of a $50,000 specialty drug could potentially trigger downstream medical costs exceeding $200,000 due to avoidable hospitalizations. "Fragmentation between medical and pharmacy analytics undermines negotiation leverage, leaving employers unable to fully capture total cost drivers across the continuum of care," he said.

The solution, according to Luu, is integrated analytics — the merging of claims and pharmacy data into a unified view that strengthens both plan sustainability and outcomes. The unified view enables employers and brokers to model total cost of care, identify cost-shifting dynamics and negotiate from stronger positions. Luu said: "When you finally see medical and pharmacy together, the story changes. What looks expensive on the front end often saves money overall."

TREND 3:

Employer cost-saving levers are tapped out

For more than a decade, employers have relied on familiar tactics to manage rising healthcare costs: HDHPs, wellness programs, steerage strategies, narrow networks and COEs. Those measures promised relief, but the gains have been incremental, inconsistent and unsustainable, according to most research. In fact, most of the traditional cost-containment levers deliver only 5–15% savings[17] at best — and those gains are typically short-lived. With mixed results, employers are retooling these types of programs, with fewer providing HDHP-only plans, and narrow networks and COEs used only selectively and in targeted conditions.

The evidence

Consider: Studies consistently find that while programs such HDHPs can reduce upfront premiums, they can also create unintended barriers to care. For example, employees enrolled in HDHPs are 75% more likely to report cost-related barriers to care compared with employees in traditional plans,[18] leading many to delay — or avoid — necessary treatment, which in turn drives worse health outcomes, higher downstream costs and reduced productivity. In response, employers are increasingly reversing full-replacement HDHP strategies, with the number of HDHP enrollees continuing to fall.[19]

Other levers have similarly underperformed. Wellness programs, once touted as win-wins for costs and health, have shown little measurable impact on overall health outcomes. A widely cited University of Illinois randomized controlled trial involving more than 4,800 employees found no significant differences in spending, clinical outcomes or overall utilization after 24 months among those offered a comprehensive workplace wellness program versus those not offered one.[20] Steerage and COE programs, meanwhile, can deliver meaningful per-episode savings when executed well, but they come with trade-offs: limited provider choice, access challenges and employee resistance.

The reality is clear: employers have exhausted the traditional cost-containment playbook. Incremental measures have failed to keep pace with rising costs, leaving brokers and employers searching for structural solutions that realign spend with value. Models like reference-based pricing, level-funded plans and pass-through PBMs represent a move away from cost shifting and instead toward fundamental plan redesign, giving organizations new ways to regain control, protect affordability and preserve workforce health.

HDHPs Enrollees in a high-deductible health plan are 75% more likely than low-deductible enrollees to experience a cost-related barrier to care.[21]

Wellness Despite some success stories, study results suggest that workplace wellness plans can affect health behaviors but have no significant effects on health outcomes.[22]

COE When coverage is limited to COE providers, employees may have difficulty with timely access or may face higher cost-sharing if they choose an out-of-network provider due to personal preference.[23]

HDHPs and narrow networks - they're just different ways of shifting costs. They don't solve the root problem. Costs are still increasing. In a year or two the plan will absorb those increases again unless they shift more cost to their employees. Or until they start actually addressing the cost of health care.

— **MATT MONDA**, Senior Vice President, Employer Risk and Innovation, Imagine360

TREND 4:

The tight labor market elevates affordability as an enterprise risk

US midsize employers continue to operate in an exceptionally tight labor market. The competition for talent remains intense, reshaping employer priorities around benefits and workforce investment. In fact, according to the August 2025 National Federation of Independent Business Small Business Optimism Index, 32% of business owners reported unfilled job openings — a level not seen since 2020.[24] This ongoing scarcity of talent has made healthcare affordability a clear enterprise risk in that rising costs not only strain budgets; they also directly influence recruitment, retention and workforce stability.

In fact, healthcare affordability has become a critical differentiator for employers competing for talent. According to Imagine360's Chris Morocco, director of business development, "Some employers are using free healthcare or benefits as a competitive advantage in hiring, which changes the conversation with candidates." In a market in which skilled labor remains scarce, organizations with unaffordable or restrictive plans risk losing candidates before an offer is ever made.

But the enterprise risk extends beyond recruitment. Rising premiums, higher deductibles and limited coverage often push employees to delay or forgo needed care. "Too often, HR teams equate richer benefits with better value. The real value comes from making healthcare affordable. When employees can't afford to use their plan, they're effectively uninsured — delaying care, which ends up costing the plan more in the long run," Morocco said.

According to the Commonwealth Fund Biennial Health Insurance Survey of 2024, 66% of working-age adults who are underinsured (i.e., insured all year but facing high out-of-pocket costs relative to income) are covered through employer-sponsored plans.[25] That fact indicates that although individuals may technically have insurance, many face financial barriers serious enough to render the coverage ineffective. The downstream impact translates directly into higher disability claims, avoidable emergency care and measurable productivity loss.

AMERICANS ARE MAKING EMPLOYMENT DECISIONS BASED ON HEALTHCARE COVERAGE[26]

67%

of survey respondents say health benefits play a significant role in searching for or deciding whether to stay in their current job.

28%

of respondents would leave their employer — even if it meant accepting a pay reduction — for better healthcare benefits.

Retention challenges compound the risk. As Imagine360's Morocco put it, "Employers underestimate how much benefits influence turnover. Cost shifting and placing more of the burden on their employees is no longer an option. When healthcare becomes unaffordable, people leave for competitors that offer better coverage." In a constrained labor market, replacing skilled employees carries both direct costs — from recruiting and onboarding to lost institutional knowledge — and indirect costs because open roles affect team performance and customer experience.

Taken together, rising healthcare costs now sit at the intersection of workforce strategy, financial risk and business performance. Employers that treat healthcare affordability as an enterprise risk — rather than a benefits problem — are better positioned to stabilize their workforces, protect margins and compete for talent in an environment in which every hiring decision matters.

TREND 5:

Policy headwinds are creating opportunities for change

Policy reform is by no means a silver bullet for healthcare affordability, but the momentum is shifting the power balance decisively toward employers. One critical development is the gag clause prohibition part of the Consolidated Appropriations Act (CAA) of 2021, which now prohibits contracts that restrict employers from accessing cost data, quality data or claims data. Annual attestations of compliance, called Gag Clause Prohibition Compliance Attestations (GCPCAs), have been required since December 31, 2023, with penalties possible for noncompliance.

In early 2025, the US Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury issued further guidance clarifying that even downstream agreements — agreements carriers or third-party administrators (TPAs) have with other entities — cannot block employers from accessing data.[27] Enforcement can include requiring plans to report obstructions during attestation filings.

The department's policy shift reflects a renewed commitment to pricing transparency in healthcare. Employers now have legal authority to demand visibility into true costs — whether from providers, PBMs or TPAs.

Beyond gag clause reform, policy is enabling deeper transparency across the healthcare system. A 2025 executive order reinforces the executive branch and agency's commitment to transparency and desire to enforce regulations against providers that do not comply. With those changes, employers can use standardized pricing data as benchmarks to renegotiate contracts and evaluate provider networks. At the federal level, enforcement clarity creates a meaningful shift in that noncompliance could now result in penalties and public scrutiny.

> "We're finally seeing some movement from a policy perspective, especially around price transparency and pharmacy benefit manager reforms. These changes are starting to give employers access to data they've never had before, which opens the door for more informed negotiations and alternative plan designs."
>
> — **ROSLYN MURRAY**, Brown University

Meanwhile, federal PBM reform continues to gather force. The proposed PBM Reform Act (H. R. 4317) includes measures to ban spread pricing in Medicaid and requires transparent fee structures, creating a policy backdrop for private health plans that favors cost accountability over rebate-driven incentives and sets the stage for broader employer leverage in controlling pharmacy spend.

POLICY TIMELINE[28]

2023 — Gag clause attestation begins

CAA of 2021 requires employers to attest that their contracts do not include gag clauses restricting access to cost, quality or claims data.

First annual GCPCA is due December 31, 2023.

Employers gain legal authority to request full pricing data from TPAs, carriers and PBMs.

2024 — Federal PBM reform accelerates

24 states pass legislation targeting PBMs and addressing rebate pass-throughs, spread pricing and licensing requirements.

H.R. 4317 advances, requiring transparent fee structures.

Early employer sentiment shifts, and brokers begin renegotiating PBM contracts with a focus on cost accountability.

2025 — Hospital data transparency mandates expand

January 2025: DOL, HHS and Treasury issue clarifying rules confirming that gag clause bans extend to downstream agreements such as vendor-to-vendor contracts.

February 2025: Proposed executive order on hospital pricing transparency mandates publishing real, up-front prices — not estimates — backed by new civil penalties for noncompliance.

Federal enforcement ramps up; employers now have verified benchmarks to compare negotiated hospital rates against Medicare and market averages.

Where employers and brokers win together

The trends shaping employer-sponsored healthcare — from price transparency mandates and PBM reforms to rising specialty drug costs and new plan models — are fundamentally reshaping the benefits landscape. Although cost pressures remain significant, the shifts generate new affordability opportunities for employers and brokers to rethink benefits strategy, challenge outdated models and adopt alternative health plan solutions that align costs with value. For organizations willing to act, now is the moment to use data transparency, innovation and market change to adopt alternative health plans that work better for both the organizations and their people.

Resetting the baseline

As employers search for sustainable affordability strategies, RBP has emerged as one of the most powerful tools for resetting the cost baseline. By tying provider payments to a multiple of Medicare rates, RBP introduces immediate transparency and reduces price variation. As price pressures intensify, the adoption of RBP positions organizations to take back control, negotiate from strength and realign healthcare spending with actual value delivered.

For employers, the path forward starts with transparency and choice. Gaining access to claims data, pharmacy spend and provider pricing is the foundation for better decision-making. With that insight, organizations can evaluate alternative-plan designs to develop sustainable benefits strategies that support workforce health, protect financial stability and enhance competitiveness in a tight labor market.

Brokers' roles are evolving from plan managers to strategic advisers. Employers increasingly expect brokers to bring market intelligence, actionable benchmarking and negotiation strategies to the table. And brokers that lead with insights can position themselves as trusted partners in the delivery of solutions that improve affordability and strengthen employee value.

The next era of healthcare affordability offers an inflection point: employers and brokers that act early and embrace transparency can shift from reacting to rising costs and toward building benefit strategies that balance business health, workforce stability and long-term sustainability.

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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 18 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, brokers and consultants 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 or subscribe for more content like this.

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