WHITE PAPER

Healthcare at a Breaking Point:

Restoring Affordability to Employer Health Plans

imagine360

Introduction

Employers stand at a rare moment of leverage in the decades-long struggle to control healthcare costs. After years of cycling through traditional health plan carriers, plan designs, and so-called cost-containment strategies and programs, the impact has been disappointing: costs have continued to rise and affordability has steadily eroded. Today market forces, workforce dynamics and policy shifts are converging to create a strategic inflection point that cannot be ignored.

Understanding this moment begins with separating cost from affordability. Healthcare can be expensive without necessarily being unaffordable—but only if wages, company margins and benefits keep pace. When costs increase faster than revenue or employee earnings, affordability breaks down. Employers become forced to pay more to offer less, and workers get asked to shoulder increasing co-pays, deductibles and premiums. That imbalance has widened into a systemic problem.

> "Premiums and deductibles have risen far faster than wages for decades, meaning more of employee compensation is going to healthcare and less to take-home pay. That makes workers more expensive to employ while leaving them with less financial security."
>
> — **ROSLYN MURRAY**,
> Assistant Professor of Health Services, Policy and Practice, Brown University's School of Public Health

Consider: Over the past 25 years, the gap between the increase in health insurance costs and workers' wages has widened significantly. In fact, the cumulative increase in the cost of employer-provided family health insurance coverage has grown at a rate more than three times that of workers' earnings.[1] Families earning less than $75,000 a year are getting increasingly priced out of adequate coverage,[2] and nearly half of US adults say they could not afford an unexpected $500 medical bill.[3] The current healthcare cost trajectory isn't just unsustainable – it's untenable.

And these rising costs are more than a "benefits problem." They represent a core business and workforce risk. As healthcare costs continue consuming larger shares of operating budgets, employers face pressures to protect profitability while remaining competitive. At the same time, workers are shouldering increasing financial burdens that undermine their well-being, their productivity, and, ultimately, their loyalty. "Employers are struggling to get through the next renewal cycle without alienating their employees," said Imagine360's Bill Demberecky, Chief Financial Officer. "Brokers have to respond to an urgent mandate: help employers pivot from incremental fixes toward models that fundamentally realign cost with value."

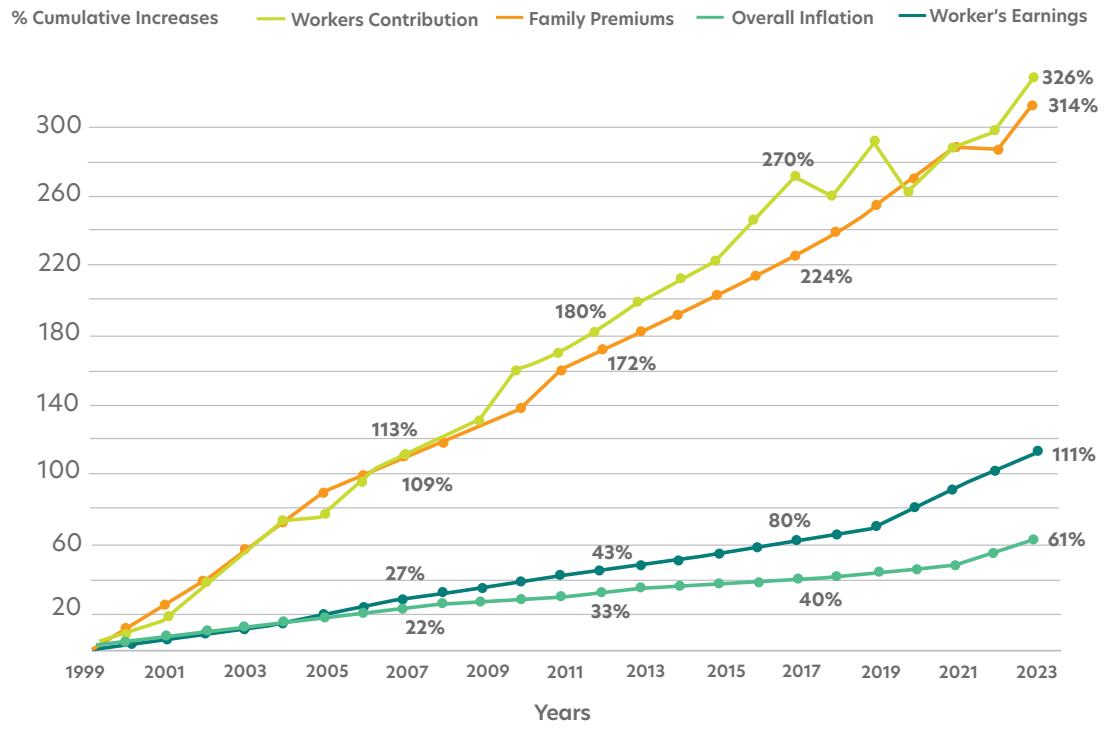
The moment seems right. For years, cost-saving strategies have relied on cost shifting, narrow networks, wellness programs and consumer tools to manage the trajectory of cost increases. Such measures may have slowed growth temporarily, but they've failed to tackle the structural drivers of healthcare inflation. Today the traditional cost-saving levers have become exhausted, and without bold and systemic change, employers will remain trapped in a cycle in which rising costs erode compensation value, diminish employee satisfaction, and weaken long-term competitiveness.

Now, however, new price transparency mandates, innovative alternative plan models, and shifting policy dynamics have given employers tools they've never had before. Recent federal rules prohibit gag clauses in provider and carrier agreements, expand employer access to more claims and cost data, and strengthen hospital pricing disclosure requirements — creating unprecedented leverage for plans to understand their healthcare costs and evaluate plan design. Brokers have an opportunity to lead conversations that reframe healthcare savings as a strategic reinvestment in workforce stability and financial security. Choosing to act now enables employers to reclaim leverage, restore affordability, and chart a more sustainable path forward.

Cumulative increases in workers' contributions to healthcare since 1999[4]

PREMIUMS AND DEDUCTIBLES HAVE OUTPACED WORKER WAGES

Figure 1. Cumulative increases (%) in workers' contribution, family premiums, overall inflation, and workers' earnings...



WHEN THE MATH STOPS WORKING

Healthcare is the only major expense with no clear connection between cost and quality—and employers and employees rarely understand what they're paying for. When companies buy raw materials, office space or software licenses, they know the unit price, they understand how quality compares across suppliers and they can negotiate accordingly. But healthcare is different. Prices for the same hospital services vary widely across and within markets and are often unrelated to quality or outcomes.[5]

One of the clearest illustrations of just how disconnected healthcare prices can be from value is in the area of hospital medical procedures. For instance, a knee replacement can cost as little as $12,870 at one hospital and as much as $101,527[6] at another — with no or very little difference in outcomes. That variability creates an affordability crisis employers can't manage the way they do other costs. "Employers can't get a straight answer as to why two facilities charge drastically different prices for the same service or procedure. And without transparent data, they're negotiating costs blindfolded," explained Chris Morocco, Director of Business Development at Imagine360.

UNSUSTAINABLE COST BURDEN

$75k/year

Families earning under this amount are increasingly priced out of adequate coverage.[7]

$220 billion

Medical debt among approximately 20 million adults collectively.[9]

Nearly 50%

of U.S. adults say they could not afford an unexpected $500 medical bill.[8]

Now consider the broader financial toll on employers and their workforces: Take the hypothetical scenario of a midsize employer with 800 employees. Five years ago, the total healthcare spend was $5.5 million; today it's $8 million — a 45% increase.[10] During the same five-year period, however, the employer's revenue grew only 18%. To keep up, the company has had to absorb higher premiums while shifting more costs to employees through higher deductibles and co-pays or reducing benefits. Workers are paying more out of pocket but receiving less value from their benefits, forcing trade-offs between paying medical bills and covering essentials like housing, childcare or even groceries.

When healthcare becomes unaffordable, people make difficult decisions. Employees may delay or skip preventive care because they can't afford the up-front costs, which leads to higher long-term medical expenses and lost productivity.

In fact, medical debt, or personal debt incurred from unpaid medical bills, is a leading cause of bankruptcy in the United States.[11] Almost one-third of working-age US adults are currently in debt because of medical or dental bills.[12] For employers, that debt creates potentially hidden costs in the forms of increased employee absenteeism, reduced engagement on the job and higher turnover as financially stressed workers seek jobs with better benefits or lower overall cost burdens.

Why can't you get a good deal?

Provider trends

Rising healthcare costs are driven primarily by hospital prices rather than hospital use or utilization, according to Murray, Assistant Professor at Brown University's School of Public Health, which conducts interdisciplinary, evidence-driven studies as part of the university's research program. And although Medicare and Medicaid set rates for healthcare services and procedures based on cost formulas that "account for inflation and increase with inflation," the prices that traditional healthcare plans pay have diverged sharply.

"Employers are increasingly paying more when Medicare and Medicaid keep pace with inflation over time," said Murray, who cited hospital consolidation as one of the biggest drivers of increasing costs. "The literature suggests that after hospitals merge, health services can increase anywhere from 3%-65%, and there's very little evidence of a correlation between higher prices and higher-quality care," she added. Instead, Murray points out, growing market leverage enables hospitals to negotiate higher rates with traditional health plan carriers as the central cause of escalating costs.

Murray also stressed that employers usually lack the data needed to deal with pricing questions. "Employers are typically told by insurers and third-party administrators [TPAs] that they've secured a significant discount from hospital charges, but hospital charges are highly inflated to begin with, and they don't reflect the actual cost of care," she said.

Hospitals and carriers point to restrictive covenants in agreements as a shield to keep them from sharing pricing data with employers, which leaves employers "misled into thinking they're getting a good deal when they're not," Murray said. And even though federal price transparency rules represent an important first step, Murray noted, compliance and usability remain significant obstacles: "Hospitals are required to post prices, but the data are often buried in machine-readable files that are extremely difficult to operationalize." Without better access to accurate pricing information, employers "keep relying on traditional strategies like increases in premiums or reductions in benefits instead of directly targeting high prices."

Pharmacy costs as primary drivers of affordability challenges

Pharmacy costs are the single largest contributors to rising healthcare expenses by consuming an increasing share of employer health budgets. The median percentage of healthcare dollars spent on pharmacy grew to 27% in 2023 — a shift indicating that more than one-quarter of healthcare cost increase is related to pharmacy spend.[13]

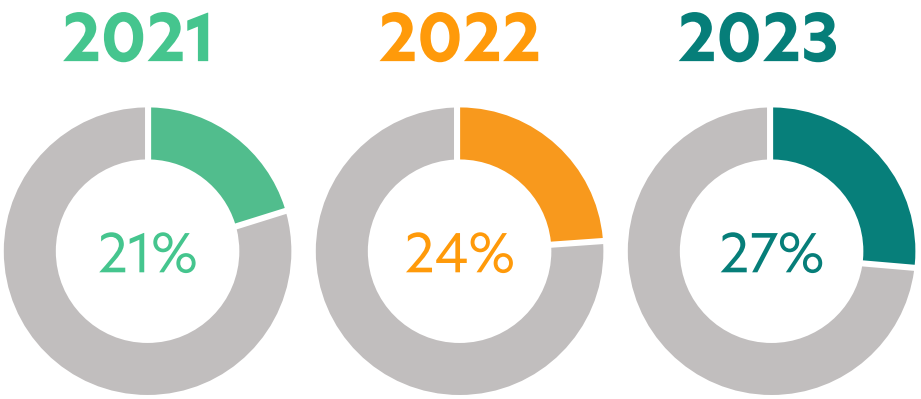


Figure: Business Group on Health's 2025 Employer Health Care Strategy Survey

Employers are responding with concern: According to the Business Group on Health's 2025 Employer Health Care Strategy Survey, 76% are "very concerned" about overall pharmacy costs; 58% worry about the "opaqueness of the pharmacy supply chain"; and 56% worry about the "lack of transparency in contracting and rebates." Martino Luu, Executive Vice President at Imagine360, echoed those challenges by saying, "Pharmacy spend isn't just growing; it's accelerating faster than any other category of health costs, and employers typically lack the visibility needed to understand what's driving it."

Rising demand for, for instance, glucagon-like peptide-1 (GLP-1) medications—for diabetes and other cardiovascular conditions—are emerging as major pharmacy cost accelerants. Business Group on Health data show that 79% of employers have seen higher interest in GLP-1 medications among members; 96% already cover GLP-1s for diabetes treatment; and 67% now cover them for off-label uses such as obesity — up from previous years. Luu noted the compounding effect: "These drugs are showing clinical promise, but we're entering uncharted territory on affordability when coverage expands beyond diabetes into obesity and cardiac care."

As pharmacy spend becomes increasingly unsustainable, employers are calling for systemic changes. Luu highlights the pressure points: lack of price transparency, complex rebate structures and rising specialty drug use. He also noted that employers are "starting to push harder for data access, better contracting visibility and more-accountable models from PBMs [pharmacy benefit managers] and TPAs" as ways to regain control over their pharmacy budgets. Moving forward, there needs to be greater alignment to ensure pricing models, contracting practices, and coverage policies evolve to make specialty drugs — and particularly GLP-1 therapies— more financially sustainable.

TRADITIONAL AFFORDABILITY LEVERS HAVE FAILED

For more than a decade, employers have relied on a familiar set of cost-containment tactics to manage healthcare affordability, including high-deductible health plans, wellness programs, steerage strategies and narrow networks. And although those measures can deliver short-term relief, the gains are fleeting. As Matt Monda, Senior Vice President of Employer Risk and Innovation, at Imagine360, explained, "HDHPs [high-deductible health plans] and narrow networks — they're just different ways of shifting costs. They don't solve the root problem. The underlying trend always snaps right back up because within a year or two, total costs rise again."

Despite years of effort at cost containment, healthcare is today no more affordable for employees or their employers than it was 5, 10 or even 15 years ago. "Looking for savings, employers implement particular programs related to muscular or skeletal — programs that focus specifically on certain types of conditions or procedures or maybe centers of excellence (COEs) to find specific providers such as surgery centers — and negotiate direct contracts to try to save money. Unfortunately, though, most such programs promise savings that never materialize," said Imagine360's Morocco.

The frustration comes from knowing that most of the traditional strategies don't fix the underlying problem; they simply redistribute the burden rather than reduce it. And the savings just aren't significant enough because they're typically in the 5-10% range and achieved by tactics like captives, tiered networks or network sculpting.[14] That growing gap between cost savings and affordability is pushing brokers and employers to look beyond incremental levers and toward models that fundamentally realign costs with value.

HDHPS: SHIFTING, NOT SOLVING

HDHPs were widely adopted as levers to control employer spend, but they've proven largely ineffective in containing total cost growth. Employees enrolled in HDHPs are 75% more likely to report cost-related barriers to care compared with employees in traditional plans[15] — meaning that they delay or avoid treatment, which can lead to worse outcomes, higher long-term costs and productivity losses. Employers are increasingly recognizing this trade-off. In response, many organizations that went "full-replacement HDHP" have reversed course by reintroducing lower deductible and out-of-pocket maximum options to prevent employee disengagement and retention risk.

WELLNESS PROGRAMS: OVERPROMISED, UNDERPERFORMING

Wellness programs have promised win-win models that would result in healthier employees and lower costs, but rigorous evaluations of their effectiveness in lowering costs and improving health haven't delivered strong results. For example, in a highly cited University of Illinois randomized, controlled trial of more than 4,800 nonfaculty university employees found no significant differences in healthcare spending, clinical outcomes or overall medical use after 24 months among those offered a comprehensive workplace wellness program compared with those who were not.[16]

> "Employers still cling to wellness narratives despite mounting evidence that such narratives limit impact on cost. They think, 'If we just add one more incentive, we'll limit employee behavior,' but the spend doesn't go down, and the renewal rates keep climbing. In practice, wellness rarely moves the needle on total cost and often serves as a distraction from more-long-term solutions."
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> — **CHRIS MOROCCO**, Imagine360

STEERAGE AND COE PROGRAMS: GAINS WITH LIMITS

Provider steerage and COE programs have shown potential for meaningful per-episode savings and improved outcomes when executed well. While these programs may allow enrollees to access more providers who have additional specialized capacities, or achieved outcomes for specific services, enrollees may also face certain limitations. For example, with a limited number of providers, enrollees may have difficulty with timely access to services; and enrollees who prefer providers that do not participate in COE programs may face higher out-of-pocket costs.[17]

Another strategy is the use of captives or use network sculpting, with employers trying to take a more local approach and set up direct contracts with specific providers. "But it's hard to scale those strategies broadly," said Imagine360's Morocco, "and they often overlap with COE models. Some employers also use variable co-pays, encouraging members to choose certain providers by lowering costs of preventive care or offering other incentives."

EMERGING INTERVENTIONS: ENTHUSIASM VERSUS REALITY

The COVID-19 pandemic catalyzed employer plans' rapid adoption of telehealth services. Employers initially viewed emerging solutions like telehealth as transformative cost levers, but real-world results have tempered expectations. In 2021 – at the height of the COVID-19 pandemic – 85% of large employers said virtual care would revolutionize delivery; by 2023, the figure had dropped to 65% with responding citing concerns over fragmentation of care and perceived quality issues as primary reasons.[18]

In fact, industry surveys have found that telehealth services have not replaced high-cost care; telehealth has served only to add another layer of use, particularly among HDHPs. And although telehealth has expanded access to care for many – especially those in rural and remote areas – generally, people didn't stop going to emergency departments or specialists; they just used telehealth on top of what they were already doing.

WHEN THE CURE DOESN'T LAST

	UPSIDE	DOWNSIDES
Narrow networks and tiered provider designs	When combining narrow networks with other steerage tactics such as COE, traditional health plans claim employers can achieve plan savings by 5–15% on high-cost procedures.[19]	Narrow networks often limit provider choice, leading to employee pushback when preferred physicians or hospitals are excluded.[21] Designing effective tiered networks requires robust cost and quality data analytics, which many employers lack the ability to perform internally.[22]
HDHPs	An HDHP's initial savings appear favorable — about 5% lower family premiums, reduced utilization, and a one-time cost drop in upfront savings when adopting the HDHP.[20]	HDHP-only plans are losing their luster by having fallen from 22% in 2018 to 9% in 2022. The reason? Cost barriers. HDHP members were 75% more likely to report cost-related barriers to care. HDHPs typically require consumers to pay first dollar up to a certain amount, providing a disincentive.[23] With about one-third (36%) of adults saying they have skipped or postponed getting health care they needed because of the cost, deferring treatment leads potentially to both higher long-term costs and productivity loss.[24]
Pharmacy cost containment	Employers are applying stricter formulary controls and step therapy protocols to direct members toward lower-cost, clinically equivalent medications. Certain therapies are moving out of acute-care facilities and into lower-cost settings such as home, clinic and physician's office. Carving out preferred infusion networks with TPAs can change the site of care. For GLP-1 utilization management, prior authorization and eligibility criteria are helping manage demand without denying access outright. This targeted approach prevents runaway costs while ensuring high-risk patients maintain coverage.	With rebate-driven contracting models, employers say they're saving money, but rebate-driven contracts actually incentivize higher list prices. The focus on percentage discounts rather than absolute costs creates a cycle of escalating spend. Without full data transparency from PBMs and manufacturers, employers are flying blind, and limited visibility into true costs prevents sustainable, long-term solutions.

GAINING LEVERAGE: EMPOWERING EMPLOYERS AND BROKERS TO DRIVE CHANGE

With new transparency mandates, PBM and drug cost reforms, and innovative and transparent cost-control strategies emerging, brokers and employers now have an opportunity to reset the affordability equation and regain control.

For many employers, moving to a self-funded model is the first step toward regaining control over healthcare costs. Unlike fully insured arrangements, self-funding offers access to claims data and the flexibility to hand-pick partners—such as an independent third-party administrator (TPA)—who can help reduce administrative burden, administer a customized plan design, and provide the financial transparency needed to evaluate costs effectively. This approach empowers employers to break free from traditional carrier-driven pricing models and implement smarter benefit strategies that align spend with value while supporting both financial and workforce priorities.

With that foundation in place, RBP sits at the center of this shift. By tying payments to rational, external benchmarks, RBP offers an inherently transparent pricing model. Employers, employees, and providers can understand how claims are paid, and why. When paired with other transparent plan models, RBP positions employers to reclaim leverage, reduce wasteful spending, and reinvest savings into better benefits, workforce health, and long-term business stability. Unlike traditional health plan structures, alternative models such as RBP give self-funded employers levers they've never had before – opening up new ways to directly influence costs rather than simply reacting to annual renewal increases.

MOMENT OF LEVERAGE

Traditional cost-saving levers like HDHPs, wellness programs and narrow networks are tapped out, yet employer healthcare spend continues climbing. To make a real impact, brokers must guide employers beyond incremental fixes and toward structural plan redesign. Models like reference-based pricing (RBP) reset the underlying cost dynamics and realign spend with value.

"I often use a puzzle analogy: An employer must break the puzzle apart and rebuild it (pharmacy, medical, stop loss) to access a transparent solution. Under traditional or legacy carrier health insurance contracts, there are limited audit provisions and an employer cannot see why a claim was paid the way it was. Recently, we've seen large carriers tell groups they cannot access their own data unless the groups sign restrictive documents stating the employer won't use the data for competitive marketing reasons."

—**ERIN DUFFY**, Director of Business Development, Imagine360

How RBP works

Unlike traditional PPO pricing that anchors reimbursement to inflated chargemaster, or hospital list price, rates – on average approximately 254% of what Medicare would pay[25] – RBP ties payments to rational, external benchmarks, such as profit above the hospital's Medicare reimbursement rate or a profit above the hospital's costs.[26] Employers can significantly reduce spending if they negotiate RBP access. Third-party experiences confirm 20-30% savings with RBP-enabled plans compared with traditional health plan models.[27] Through Imagine360's RBP solution, for example, employers may potentially realize up to 20% savings alongside transparent PBM models.[28]

What makes RBP more affordable

TRANSPARENT, KNOWN PRICING

Plans that utilize RBP set payments based on fixed, predictable rates, replacing inflated, negotiated hospital charges with cost-based benchmarks.

LOWERING UNIT COSTS BY BENCHMARKING TO MEDICARE

Studies shows that plans accessing contracts based on a hospital's charges pay approximately 254%+ of Medicare reimbursement rates[25], while RBP plan designs average payments closer to 140–160% above Medicare reimbursement rates[29], cutting costs without sacrificing provider margins.

TARGETING HIGH-DOLLAR CLAIMS

Most employer healthcare costs result from a small percentage of high-dollar claims. RBP reduces the per-claim cost of such services by anchoring claims to a Medicare-based reference price and creating significant aggregate savings without changing the broader benefit design.

CHANGES CONVERSATIONS WITH HOSPITALS AND PROVIDERS

Reimbursing using an RBP plan design ensures that hospitals are making a profit for the services they provide to a member, and it allows plans to know that they are getting value for the services they are paying for.

REVEALING VARIABILITY

Access to RBP data enables employers to identify and challenge massive pricing variations for the same services or procedures across regions and facilities.

CUTTING CATASTROPHIC COSTS

RBP targets primarily high-cost-facility claims — the ones most likely to hit stop-loss. When RBP lowers the total cost of a million-dollar claimant, the stop-loss carrier saves the difference and it may pass it back to the plan. For employers, stop-loss can represent a significant percentage of total health plan spend, depending on deductible. Over the period of 2015-2022 there was a staggering 144% rise in $1 million claimants.[30]

THE POWER OF RBP

RBP restructures the ways claims get priced by benchmarking payments to external reference rates — usually, Medicare plus a margin. The method creates transparency and fairness.

Medicare provides a useful price benchmark because it is the largest purchaser of healthcare services in the world and in many ways defines and enforces the technical standards adhered to claims processing and payment in the US health care system.

"RBP flips the script on negotiated rates. But there is sometimes pushback. Providers often argue that Medicare and Medicaid pay too little to cover their costs. TPAs also claim that RBP will trigger cost shifting. 'We'll have to charge more elsewhere,' they say. It's interesting that those arguments persist, because the evidence doesn't support them. But without access to their own data, employers aren't empowered and end up relying on what others tell them."

—**ROSLYN MURRAY**, Brown University

Leveraging PBMs and level-funded plans

Complementing RBP are pass-through PBM contracts, level-funded plans and employer coalitions. Transparent, pass-through PBMs eliminate spread pricing and align performance with net cost reduction. Meanwhile, level-funded plans offer health cost predictability — with embedded stop-loss protection and the potential for year-end surplus refunds, which is especially beneficial for employers with good claims experience.

In fact, level-funded models are becoming increasingly popular; Kaiser found that in 2024, 42% of small firms reported had adopted level-funded plans compared with just 7% in 2019.[31] Collectively, employers are also exploring coalitions by banding together to increase purchasing power and pressure providers for fairer pricing — especially in local markets suffering from high hospital consolidation.

"Stop loss premiums have increased more in recent years because several major carriers took significant losses and are right-sizing their books. Loss drivers include a surge in very high-cost cancer claims and the growing prevalence of million-dollar premature baby cases, exacerbated by limited competition among children's hospitals. Many cost-saving measures merely chip at the margins, but RBP is the lever that materially affects stop loss costs by reducing the biggest facility claims that drive carrier pricing."

—**MATT MONDA**, Imagine360

How Hendry Marine reinvested healthcare savings into its workforce

After realizing healthcare cost savings with RBP, Hendry Marine Industries, located within Port Tampa Bay, Florida, decided to bring healthcare to its employees by means of a mobile walk-in clinic that is literally on-site at the shipyard. Since the January 2022 opening of the clinic, the types of services offered have been expanded to include full blood draws, wellness exams, sick visits, flu shots, return-to-school and sports physicals, and zero-cost prescriptions delivered on-site.

Many employees now use the clinic as their primary care physician's office. One employee who visited the clinic was surprised to learn that his blood sugar was astronomically high. He then enrolled in Imagine360's diabetic care program and with the help of his doctor and a care team that checks in with him regularly, is on his way to better health.

Conclusion

Employers have never had more leverage — or more at stake. Rising health costs are no longer slow bleeds; they are direct threats to workforce stability, business margins and long-term business competitiveness. At the same time, policy shifts — from hospital price transparency mandates to PBM reforms — have cracked open data that was once hidden. Employers can now see what they're paying, can benchmark against rational rates and can negotiate from positions of strength.

But this moment is about more than managing costs — it is about creating health plans that work better for the people who rely on them. Traditional approaches have left many employees with rising deductibles, unpredictable bills, and limited access to care. When coverage becomes unaffordable or unusable employees delay necessary care, stress increases, and business performance suffers.

Transparent models like RBP give organizations a chance to change that dynamic. By replacing traditional health plan coverage with alternative models, employers can make healthcare costs more predictable, simplify decision-making, and preserve access to quality care for the workforce.

The opportunity is clear, and so is the urgency: organizations that act now can redefine healthcare affordability in ways that improve business health, protect employee well-being, and create a more sustainable path forward.

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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