Reshaping Employer Health Care With Reference-Based Pricing

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Reference-based pricing (RBP) can safeguard health plan participants from excessive medical charges while also saving money for health plan sponsors. The authors outline a three-phase approach for implementing RBP.

Rising health care costs continue to burden plan sponsors and participants alike. Traditional preferred provider organization (PPO) networks—typically offering access to the greatest possible number of providers—often contribute to escalating expenses. The goal is typically to offer a network as broad as possible so that participants can access their desired provider. As a result, negotiated fees with PPOs typically range from 170% to 375% of Medicare rates for the same treatment, at the same facility, from the same providers.[1]

Reference-based pricing (RBP) offers a potential alternative for self-funded plans that may safeguard participants from excessive charges by aligning medical pricing with benchmarks created by the federal government. When RBP is implemented strategically and targets the maximum allowable charge at 125-140% of the Medicare allowable amount, providers typically receive full reimbursement of the cost to provide services. Further, RBP may ease compliance with federal regulations, such as the No Surprises Act (NSA),[2] and may help prevent overpayments and provide a sustainable model for employer-sponsored health benefits.

This article will discuss how RBP may help plan sponsors and participants reduce health care costs and describes a three-phase approach for implementation.

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The Challenges of Traditional PPO Networks

Employer-sponsored health plans continue to be the primary source of health care coverage for more than 160 million people in the United States.[3] However, these plans are increasingly burdened by systemic cost shifting, leading to rising expenses for both plan sponsors and participants, including the following.

- **Rising premiums:** Employer-sponsored health plan costs have steadily risen, with employers projecting a 5.8% increase in 2025, (after plans have increased deductibles and other point-of-purchase cost sharing),[4] marking the third consecutive year of growth above 5%.
- **Higher deductibles:** Between 2013 and 2024, the share of covered workers enrolled in single coverage with deductibles exceeding $2,000 increased from 10% to 32%.[5] Over the same period, the average deductible for single coverage rose from $1,135 to $1,787—an increase of 57%. Looking further back, the average deductible has increased 206% from 2006, when it was $584.[6]
- **High provider payments:** Employers frequently pay 170-365% of Medicare rates for identical services provided at the same facilities by the same health care professionals.[7] The difference is even higher when compared with Medicaid.[8]

At the same time, enrollment in taxpayer-funded, fixed-price health care programs like Medicare and Medicaid has expanded, reducing the uninsured population while shifting more costs onto employer-sponsored plans. In the absence of a proactive cost-control strategy, employer-sponsored plans are likely to continue to face premium hikes, larger deductibles and wage stagnation as escalating health care costs consume an ever larger share of employees' total rewards.

RBP may provide a transparent, cost-efficient alternative with the potential to curb excessive spending while protecting the workforce and the employers' bottom line and not reducing quality.

Addressing Cost Inefficiencies and Protecting Employees

One of the most significant advantages of RBP is its ability to establish transparent, predictable and fair pricing for medical services. Unlike traditional PPO networks, where negotiated rates often come with hidden markups, RBP uses a clear, defensible benchmark to determine reimbursement rates.

By anchoring payments to Medicare rates, plan sponsors can substantially reduce expenses paid by the plan and participants, often achieving savings of 15% to 40% compared with traditional, network-based plans. The figure summarizes 326 high-cost claims, each exceeding $50,000, providing an estimate of the savings from applying RBP.

As the figure shows, the gross charge for these 326 claims was $35.5 million, where an estimated $21.2 million of that charge was found to be ineligible under the terms of the various plans. Instead of using a network of providers where the allowable charge averages 254% of Medicare,[9] the plans set the maximum allowable charge at an average of 140% of Medicare. The difference is the estimated maximum savings from deploying RBP, with the estimated split between the plan and participants as highlighted above. (Note: The savings for both the plan and participants will be less for less expensive services or if stop-loss insurance applies.)

takeaways

- When using reference-based pricing (RBP), employer-sponsored health plans typically pay a percentage of Medicare reimbursement rates. This is different from preferred provider organization (PPO) plans that attempt to negotiate rates with providers and direct plan participants to networks.
- The challenges of traditional PPOs include rising premiums and deductibles, while payment to providers are often 170-375% of Medicare rates.
- When implemented strategically, RBP may ease compliance with federal regulations, such as the No Surprises Act (NSA); prevent overpayments; lower the cost for both the plan sponsor and participants; and provide a sustainable model for employer-sponsored health benefits.
- Employers may want to consider a phased approach when implementing RBP. They can start by introducing RBP for out-of-network claims, then expand to certain in-network claims and, finally, transition to a model that applies RBP across all or almost all services to eliminate network-based pricing.
- Challenges of RBP include providers that reject RBP rates and issue balance bills and potentially file lawsuits against participants.

FIGURE

Illustration of Potential Savings From Reference-Based Pricing (RBP) on High-Cost Claims With Initial Billed Charges of More Than $50,000

			Estimated/Assumed					
Number of Claims	Range	Billed Amount	Ineligible or Avoided Expenses	Network @254% of Medicare*	Allowed @140% of Medicare**	Charges Avoided Due to RBP	Plan Paid	Participant Paid
2	$500,000+	$1,405,727	$682,419 48.5%	$645,811	$355,959 25.3%	$367,349	$355,186 99.8%	$772 0.2%
121	$100,000-$499,999	$19,770,412	$12,732,077 64.4%	$6,284,228	$3,463,748 17.5%	$3,574,587	$3,323,689 96.0%	$140,058 4.0%
203	$50,000-$99,999	$14,310,459	$7,778,505 54.4%	$5,832,102	$3,214,544 22.5%	$3,317,410	$2,848,987 88.6%	$365,557 11.4%
326		**$35,486,597**	**$21,193,000 59.7%**	**$12,762,140 40.3%**	**$7,034,251 49.2%**	**$7,295,347 50.8%**	**$6,527,862**	**$506,388**
			Estimated Maximum Savings Due to RBP				**$6,736,754**	**$522,593**

*Per *Hospital Price Transparency Study 5.0.* RAND.
**Typical RBP Structure (125-150% of Medicare)
Source: aequum, LLC. Billed amounts, allowed amounts and benefits paid from aequum, LLC records. Estimates of ineligible or avoided expenses, comparable network fees and charges avoided due to RBP based on authors' calculations. Totals may not add up due to rounding.

Participants could benefit from lower out-of-pocket costs and lower contributions as coverage remains affordable. Beyond cost control, RBP also may protect participants from overpayment and surprise medical bills. When coupled with strong participant advocacy programs that provide negotiation support and legal defense when disputes arise, RBP can safeguard participants from excessive provider fees and balance billing.

RBP may also minimize the cost of complying with NSA, a law that took effect in 2022 to protect health plan participants from certain surprise medical bills. Because RBP plans have limited networks or no networks, NSA doesn't apply in the same way it would for a traditional network PPO plan design. A full discussion of NSA compliance is beyond the scope of this article.

RBP Challenges

RBP is not without its challenges, and a recent survey from the International Foundation of Employee Benefit Plans found that only 5.3% of organizations used RBP as a cost-management technique in 2024.[10]

Because RBP plans operate outside traditional networks, participants may encounter providers who reject RBP rates and issue balance bills for the remaining charges. In rare cases, this can escalate into legal action against the patient, unless strong advocacy support is provided. Where these disputes are allowed to cause confusion and stress for participants, RBP can be a "noisy" solution.

For this reason, successful RBP models depend on proactive communication, clear plan design, and robust advocacy and dispute resolution services that shield plan members from these risks and help them navigate care confidently.

Best Practices for Plans Transitioning From PPOs to RBP: Three-Phase Approach

Successfully shifting from a traditional PPO structure to an RBP model requires a well-planned transition that allows plan sponsors to assess cost savings, refine implementation strategies and build participant confidence in the new system. By gradually integrating RBP, plans can ensure a smooth shift while avoiding participant confusion or resistance.

Plans transitioning to RBP may prefer a phased approach that optimizes chances for success. This strategy begins with introducing RBP for out-of-network claims where NSA does not apply, then extends the use of RBP to all providers other than those delivering primary care and later expands to a pure RBP model that eliminates reliance on network contracts altogether.

At each step in the process, the plan sponsor should clearly communicate the potential cost savings that RBP achieves for participants.

Phase 1: Introducing RBP for Out-of-Network Claims

The first step of a phased approach to implementing RBP is to apply it exclusively to non-network claims, keeping the existing PPO framework intact.

To execute this phase effectively, plans may want to consider partnering with a claims administrator (TPA) with experience in RBP administration to provide pricing information as well as advocacy support for participants. A strong patient advocacy program helps to navigate billing disputes and to negotiate with providers. During this stage, it is crucial to track cost reductions and establish baseline comparisons to quantify RBP's financial impact.

Plan sponsors should clearly communicate to participants that out-of-network pricing will now be based on a transparent, market-driven benchmark and confirm how the new benchmarks will reduce participant costs.

Phase 2: Expanding RBP and Communicating Savings

Following the successful introduction of RBP for out-of-network claims, the next step is to expand its application to certain in-network services while reinforcing its value to participants. Plans can begin by applying RBP to specific high-cost services, such as imaging, outpatient procedures and elective surgeries, while retaining PPO contracts for primary care and routine visits.

Plans can use real-world examples and case studies to illustrate how RBP has successfully lowered medical costs for participants. Educating participants on how to navigate the RBP plan can empower them to make cost-effective health care choices without compromising quality of care. In addition, it is crucial to reinforce the availability of patient advocacy resources, ensuring that participants have the support they need to resolve billing concerns and avoid excessive charges.

In this phase, the plan sponsor should also reevaluate in-network vs. out-of-network cost sharing given the curtailment of network providers. For example, plans may want to eliminate separate deductibles and out-of-pocket expense maximums for out-of-network providers.

Phase 3: Transitioning to a Pure RBP Model

The final step in the transition is to fully replace PPO network agreements with a pure RBP model. At this stage, RBP would apply across all services, and network-based pricing structures are eliminated entirely.

How RBP Works in Practice for Participants

Unlike traditional preferred provider organization (PPO) networks that come with a preapproved list of in-network providers, referenced-based pricing (RBP) plans typically do not rely on fixed networks. Instead, participants can seek care from any provider, with reimbursement rates based on a predetermined benchmark, usually a percentage of Medicare pricing.

Participants are not expected to shop for care entirely on their own. Most RBP administrators, which may be the claims administrator or third-party administrator (TPA), offer access to tools and support services that help participants identify providers likely to accept RBP terms or providers who have a history of cooperating with RBP plans. Some plans choose to create informal lists of preferred providers based on prior positive experiences or negotiated arrangements.

Patient advocacy services are also central to making RBP a success. These services often include previsit provider outreach, price confirmation and assistance with billing negotiations. If a provider disputes the RBP reimbursement, the advocacy team steps in to resolve issues, minimizing employee involvement and preventing surprise bills. In many cases, participants are also encouraged to contact advocacy teams before seeking nonemergency care to receive guidance on how best to proceed.

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To support this transition, provider negotiation strategies should be strengthened to mediate billing disputes and ensure that participants are not exposed to balance billing risks. In addition, plan designs should be adjusted to ensure that cost-sharing mechanisms (such as contributions, deductibles and out-of-pocket maximums) clearly confirm the participant savings from RBP. Plan sponsors should clearly communicate the financial advantages of transitioning to a pure RBP model, emphasizing lower premiums and reduced out-of-pocket costs. To encourage cost-effective choices, offering incentives for using RBP-preferred providers can further reinforce the benefits of the model.

In addition, ongoing support through patient advocacy and education programs is essential to ensure that participants feel informed, supported and confident in managing their health care coverage.

The Future of Employer-Sponsored Health Care With RBP

By anchoring allowable expenses to market-based benchmarks, RBP may represent a solution that can control cost while ensuring high-quality coverage for plan participants.

With rising health care costs, evolving regulations and ever-increasing financial pressures on both plan sponsors and participants, plan sponsors may find that RBP provides them with a cost-efficient, compliant and sustainable health care model for the future.

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Endnotes

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