# THE REFERENCE BASED PRICING RECKONING: WHY THE MOST HYPED COST SAVINGS STRATEGY IN EMPLOYE HEALTHCARE IS FALLING APART

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## ABSTRACT

Reference based pricing has emerged as one of the most discussed cost containm strategies in employer healthcare over the past five years, promising employers s of twenty to forty percent on their medical spend by paying hospitals and provid based on a percentage above Medicare rates rather than accepting bloated comm negotiated rates. The pitch is simple and compelling. Medicare pays rational pri that cover actual costs plus reasonable margins. Commercial insurers pay whate hospitals demand because they lack negotiating leverage. If self insured employe simply pay a multiple of Medicare, they can capture the difference and return it employees through lower premiums or higher wages. But after several years of re world implementation across hundreds of employer groups representing million covered lives, the data shows a much more complicated picture. While some employers report impressive savings, others have abandoned the strategy after member and provider backlash. The model works brilliantly in some markets an catastrophically in others. Member satisfaction varies wildly based on implemen details that most vendors gloss over during the sales process. And perhaps most critically, the entire model depends on legal and regulatory assumptions that ma survive the next few years of healthcare policy evolution. This essay examines th

actual performance of reference based pricing across multiple stakeholder grou identifies the specific conditions under which it succeeds or fails, and explores v this once promising innovation may be reaching the limits of its scalability.

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# THE REFERENCE BASED PRICING VALUE PROPOSITION

The economics of reference based pricing sound almost too good to be true, whi should immediately make any sophisticated healthcare investor suspicious. The typical self insured employer pays commercial rates that average somewhere bet two hundred and two hundred fifty percent of Medicare for inpatient care and o hundred fifty to two hundred percent of Medicare for outpatient services. These vary dramatically by market, with some hospitals in concentrated markets commanding three hundred percent of Medicare or higher. Meanwhile, Medicar itself pays rates that the Centers for Medicare and Medicaid Services sets throug incredibly complex formula that attempts to approximate actual cost of care deli plus a small margin. The gap between Medicare and commercial represents pure extraction by providers who have market power.

Reference based pricing vendors come in with a simple pitch. Pay one hundred f percent of Medicare for everything. You immediately save thirty to fifty percent your medical spend. Your members get access to the entire provider network rat than a narrow network. Providers still make money because Medicare rates actu do cover their costs. Everyone wins except the hospitals that were overcharging y The vendor takes a percentage of savings as their fee, so you only pay for perforr Many employers hear this pitch and wonder why they did not do this years ago.

The model has gained significant traction over the past five years. Multiple vend now operate in this space including ELAP Services, SmartHealth, Zelis, and num regional players. Some of the largest third party administrators including Merita and Cigna have launched reference based pricing options for their self insured c Various industry analysts estimate that between two and five million covered liv now operate under some form of reference based pricing arrangement, up from essentially zero a decade ago. Trade publications regularly feature case studies o employers who cut their healthcare spending by millions of dollars through RBF implementation.

But these success stories tend to gloss over some critical implementation details determine whether reference based pricing actually works or becomes a nightma The model depends entirely on execution quality, market conditions, legal strate and member communication. When vendors get these right, the savings are real sustainable. When they get them wrong, employers end up with member revolts, provider lawsuits, and total program failure within eighteen months.

## HOW EMPLOYERS ACTUALLY EXPERIEN RBP IMPLEMENTATION

The employer experience with reference based pricing varies so dramatically tha almost seems like different employers are implementing entirely different strate Some employers report smooth implementations with immediate savings and mi disruption. Others describe implementations as complete disasters that damage employee relations and created enormous administrative burdens. The differenc

comes down to several specific factors that most vendors do not adequately discl during the sales process.

First, market concentration matters enormously. Reference based pricing works in competitive markets where multiple hospital systems compete for patients an single provider has dominant market share. In these markets, when a hospital re payment at one hundred fifty percent of Medicare and threatens to balance bill t member for the difference, the member can credibly threaten to go to a competi hospital next time. The hospital knows this and usually accepts the payment. Th may grumble and send threatening letters, but they ultimately write off the bala because they want to preserve access to that employer's members for future serv

But in concentrated markets where one or two hospital systems control seventy eighty percent of capacity, the dynamics flip completely. The dominant hospital the member has limited alternatives. They can balance bill aggressively and actu collect because members have nowhere else to go for care. The reference based pricing vendor will tell the member to refuse payment and that the vendor will h everything, but the member still gets collection calls and credit score threats. Th employer ends up spending enormous HR time managing member complaints ar ultimately many employers in concentrated markets abandon reference based pr within two years.

Second, the quality of vendor support infrastructure determines whether membe feel protected or abandoned. The best reference based pricing vendors maintain sophisticated member advocacy teams that immediately take over when a provid attempts balance billing. They send legal letters, negotiate directly with provide and shield members from any financial exposure or credit reporting. These vend understand that member experience drives program sustainability. If members f supported and protected, they will tolerate occasional balance billing attempts because they trust the vendor to resolve issues.

But some vendors, particularly smaller regional players, lack the infrastructure t actually protect members at scale. They may have one or two people handling me inquiries for thousands of covered lives. When balance billing occurs, members

generic advice to ignore the bills and wait for the vendor to handle it, but then v go by with no resolution and members panic. Some members just pay the balanc themselves to avoid collections, which completely defeats the purpose of the pro Employers who work with undercapitalized vendors often see terrible member satisfaction scores and high opt out rates.

Third, employer communication strategy before and during implementation mat more than almost anything else. Employers who treat reference based pricing implementation as primarily a communication challenge tend to succeed. They s months before launch educating employees about how the program works, what expect if they receive balance bills, exactly how the vendor will protect them, an the savings benefit everyone through lower premium contributions or higher wa They hold town halls, create detailed FAQs, and establish clear escalation paths member concerns.

Employers who treat implementation as primarily a finance and benefits administration project tend to fail. They announce the change with a brief email provide minimal explanation of how balance billing protection works, and then wonder why members panic when they receive their first unexpected bill. Memb trust evaporates immediately and employees start looking for new jobs at compa with traditional insurance. The program dies within a year regardless of actual financial savings.

Some of the most successful reference based pricing implementations I have see involved employers who actually increased their spending on member communic and support during the first year of the program specifically to ensure smooth adoption. They hired additional HR staff focused exclusively on RBP education, created dedicated hotlines for member questions, and even brought in the vendo account team for monthly employee office hours. These employers saw adoption above ninety percent and member satisfaction scores comparable to traditional networks.

# THE MEMBER EXPERIENCE PROBLEM NOBODY TALKS ABOUT

Member experience under reference based pricing varies from completely seaml absolutely terrible depending on factors that members cannot predict or control variability creates the single biggest long term sustainability challenge for the m Even in successful implementations, probably twenty to thirty percent of membe have at least one negative experience with balance billing or provider access issu For most of these members, the vendor resolves the issue within a few weeks wit lasting financial impact. But the emotional impact of receiving an unexpected fiv thousand dollar bill, even if you intellectually understand the vendor will handle creates lasting anxiety that affects member perception of their benefits.

The member experience problems break into several categories. The most comm involves surprise balance billing after hospital stays. A member goes to the hosp for a planned procedure, understands that their plan pays one hundred fifty perc Medicare, receives the procedure, and then six weeks later gets a bill for fifteen thousand dollars representing the difference between what the hospital charged what the plan paid. The member panics and calls the vendor, who tells them to i the bill and forward it to the advocacy team. The vendor sends letters to the hos explaining the payment methodology and demanding they stop balance billing. T hospital eventually backs down and writes off the balance. Total resolution time usually four to eight weeks.

From a purely rational perspective, this process works fine. The member never actually pays anything beyond their normal cost sharing. Their credit score is ne impacted. The vendor handles all the complexity. But emotionally, receiving that balance bill creates enormous stress even if you trust the process. Many member describe feeling like they are doing something wrong or that they will eventually to pay. Some members have anxiety every time they need medical care because th worry about triggering another balance billing situation. This ambient stress aff their perception of their overall benefits package even if the financial savings are

The second category of member experience problems involves provider access ar willingness to see reference based pricing patients. In theory, members have acc any provider because there is no network restriction. In practice, some providers refuse to see patients they know are covered under reference based pricing plans because they do not want to accept Medicare plus fifty percent for their services is perfectly legal. Providers have no obligation to see patients or accept any parti payment amount from commercial plans. When a member tries to schedule an appointment and the provider office asks about insurance and then says they can accommodate the patient, the member feels rejected and limited even though th theoretically have broader access than a narrow network plan.

The best reference based pricing vendors maintain lists of provider willingness t market and help members find alternatives when they encounter access denials. this still creates friction that members do not experience with traditional netwo With a traditional PPO, members know that if a provider is in network, they wil definitely be able to schedule an appointment. With reference based pricing, me may need to call multiple providers before finding one willing to see them, particularly for specialists. This friction is manageable for motivated members v understand the savings trade off, but it creates real barriers for members with complex medical needs who need consistent access to specialists.

The third category involves pharmacy benefits and how they interact with refere based pricing for medical claims. Most reference based pricing programs only co medical claims and still use traditional pharmacy benefit managers for drug cost This creates weird situations where members get great value on hospital stays bu face high costs for specialty medications. Members have trouble understanding v their benefits work so differently for medical versus pharmacy, and some conclu that the program is not really saving them money because their drug costs remai high. Sophisticated vendors now offer integrated medical and pharmacy referenc based pricing, but adoption remains limited because pharmacy rebate economics create different incentives than medical claims.

A small but meaningful percentage of members also report feeling embarrassed stigmatized when explaining their insurance situation to providers. When a prov

asks about insurance and the member has to explain that they have a reference b pricing plan that pays Medicare rates, some providers respond dismissively or su the member has inadequate coverage. This is factually wrong since the member h full coverage with potentially lower cost sharing than traditional insurance, but interaction still feels bad and makes members question their benefits. Some mer start telling providers they are self pay just to avoid the conversation, which defe the purpose of having insurance in the first place.

## PROVIDER RESPONSE AND MARKET POWER DYNAMICS

Provider responses to reference based pricing reveal fundamental dynamics abou market power and negotiating leverage in healthcare. Providers who face actual competition generally accept reference based pricing payments with minimal resistance. Providers with market dominance fight aggressively and often succes force employers to abandon the model. The vendor claims that all providers ever accept the payments ring hollow in markets where one hospital system controls capacity.

In genuinely competitive markets, hospitals that receive one hundred fifty perce Medicare for a service will often grumble but ultimately accept the payment bec they need volume to maintain their cost structure. These hospitals know that if t refuse to see patients from a large employer, those patients will go to competitor the hospital loses both the revenue from that encounter and potential future rev from establishing care relationships. The math works out that taking one hundr fifty percent of Medicare for guaranteed volume makes more sense than holding for two hundred fifty percent of Medicare and risking volume loss.

But hospitals with market power do the math differently. If a hospital controls s percent of beds in a region and the next closest facility is forty miles away, they k that members cannot practically go elsewhere for most care. They can refuse the reference based pricing payment and balance bill aggressively with confidence th many members will eventually pay rather than travel long distances or delay nee

care. These hospitals send bills to collections, report to credit agencies, and file lawsuits against patients. Some even refuse to provide emergency care to known reference based pricing patients beyond federal EMTALA stabilization requiren

The most sophisticated hospital systems have developed specific strategies to undermine reference based pricing. Some immediately send every balance bill to collections rather than negotiating with vendors. This creates maximum stress fo members and maximum administrative burden for employers. The hospital knov that many employers will cave and return to traditional contracting rather than manage thousands of member complaints. Other hospital systems refuse to prov cost estimates or preauthorization for reference based pricing patients, forcing members to proceed with care blind to potential balance bills. This uncertainty drives some members to pay out of pocket at in network facilities rather than ris surprise bills.

Some hospitals have also begun requiring patients to sign agreements acknowlec financial responsibility for any amounts not paid by insurance before providing emergency care. These agreements specifically state that if the patient's insuranc does not pay the hospital's full charges, the patient owes the difference regardles what the insurance considers reasonable. Members who sign these agreements u duress before surgery find themselves legally obligated to pay balance bills that vendors promised to protect them from. The legality of these agreements varies state but they create real exposure that undermines the entire reference based pr model.

Provider organizations have also started lobbying state legislatures to ban or res reference based pricing through various regulatory mechanisms. Some states hav passed balance billing prohibitions that sound like consumer protections but ac prevent reference based pricing from working because they require insurers to p whatever amount is necessary to hold members harmless from balance bills. If members cannot face any balance billing, then hospitals can charge whatever the want and the reference based pricing plan has to pay it. About six states have effectively banned reference based pricing through these types of laws, and more considering similar legislation pushed by hospital associations.

Physician groups generally respond more favorably to reference based pricing th hospitals, probably because physicians have less market power and more compet Most physician practices will accept one hundred fifty percent of Medicare for o visits and procedures without significant resistance. They may request higher payments for particularly complex cases, and good vendors will negotiate case by adjustments when appropriate. But the overall physician response has been muc hostile than the hospital response, which suggests that physicians view Medicar fifty percent as reasonable compensation while hospitals view it as inadequate.

Interestingly, some of the most expensive providers including academic medical centers often accept reference based pricing payments more readily than mid tie community hospitals. This seems counterintuitive since academic medical cente typically command the highest commercial rates. But these organizations also tr large volumes of Medicare patients and have cost structures that function at Me rates. They may prefer commercial rates but they can survive on Medicare plus f percent. Mid tier hospitals that have built their business models around two hur percent of Medicare margins cannot survive on significantly lower payments and more aggressively.

## THE LEGAL AND REGULATORY TIME BO

The legal and regulatory foundations of reference based pricing rest on several assumptions that may not survive the next few years of policy evolution. The ent model depends on the ability of self insured employers to set their own payment independent of network contracts, the limitation of state insurance regulation o ERISA plans, and the absence of federal balance billing prohibitions for comme insurance. All three of these assumptions face significant threats.

The No Surprises Act that took effect in 2022 created federal balance billing prohibitions for emergency services and certain non emergency services at in ne facilities. The law was primarily intended to protect consumers from surprise bi when they inadvertently receive care from out of network providers at in networ facilities. But the law's independent dispute resolution process for determining

appropriate payment amounts creates a potential model that regulators or legisl could expand to all out of network care. If federal law eventually requires all out network claims to go through an IDR process where arbitrators determine fair payment amounts, reference based pricing becomes much more complicated and potentially more expensive.

Some reference based pricing vendors argue that the No Surprises Act actually h their model by limiting balance billing exposure for members. And in narrow circumstances this is true. Members who receive emergency care or certain surp bills now have federal protections regardless of their insurance type. But the bro trend toward government intervention in payment disputes threatens the fundar premise that employers can unilaterally set payment rates. If every claim become negotiation or arbitration rather than a simple payment at a predetermined percentage of Medicare, the administrative costs and delays undermine the effic that makes reference based pricing attractive.

State legislation poses even more immediate threats. Multiple states have passed are considering comprehensive balance billing prohibitions that apply to all commercial insurance including self insured plans to the extent states can regul them. Texas, California, and New York have all enacted various forms of balance billing limits. These laws typically require insurers to hold members harmless fr balance bills and pay providers adequate amounts to prevent balance billing. Th exact mechanisms vary but the effect is the same. Employers cannot simply pay t chosen percentage of Medicare and force providers to accept it if the provider ca balance bill and the insurer has to hold the member harmless.

Reference based pricing vendors fight these laws in court arguing that ERISA preempts state insurance regulation of self insured plans. Sometimes they win th cases and sometimes they lose depending on how the state law is drafted and wh federal circuit hears the case. But the overall trajectory is toward more state regulation of payment and billing practices, not less. As hospital pricing comes u increasing political scrutiny, state legislators look for ways to protect consumers unexpected bills. Reference based pricing members receiving balance bills look

consumers who need protection, even if those members are theoretically protect vendor advocacy.

The federal government could also act more directly to restrict reference based pricing through modifications to Medicare regulations or ERISA standards. CM authority to prevent providers from accepting payments below Medicare as a condition of Medicare participation. While CMS has historically not exercised tl authority in ways that affect commercial payment rates, the agency could theore require Medicare providers to charge commercial payers at least a certain perce above Medicare to prevent cost shifting. Such a rule would directly impact refer based pricing by setting a floor on commercial rates.

Similarly, the Department of Labor could issue regulations under ERISA that re self insured plans to use reasonable payment methodologies or network adequac standards that effectively prohibit reference based pricing. DOL has generally ta hands off approach to self insured plan design, but as reference based pricing gr and generates more member complaints, regulatory attention increases. A single profile case of a member being harmed by lack of access or balance billing unde reference based pricing plan could trigger federal regulatory action.

The most significant legal risk may come from class action litigation by member claiming that reference based pricing plans breach fiduciary duties under ERISA exposing members to balance billing and limiting practical provider access. Seve such cases are working through federal courts now. If courts determine that pla sponsors have a fiduciary obligation to ensure members have adequate network a and protection from balance bills, reference based pricing in its current form m violate ERISA regardless of financial savings. The savings would be irrelevant if plan design itself is deemed imprudent.

## WHERE RBP ACTUALLY WORKS WELL

Despite all the challenges and risks, reference based pricing does work extremel in specific circumstances. Understanding these circumstances helps identify wh

the model makes sense and where it is likely to fail. The pattern is clear from sev years of implementation data across hundreds of employers.

Reference based pricing works best for large self insured employers with over on thousand covered lives in competitive healthcare markets with at least three competing hospital systems. These employers have enough scale to justify dedica vendor support and sophisticated member communication. Their size also gives some negotiating leverage with providers who cannot easily afford to lose access one thousand potential patients. And the competitive market means providers ca simply refuse care because competitors will take the volume.

The model also works well for employers with relatively young and healthy populations who use healthcare services infrequently. These members have fewe encounters with the healthcare system and therefore fewer opportunities for bal billing conflicts. When they do need care, it is usually straightforward and predi rather than complex cases requiring multiple specialists and facility types. The member experience remains positive because the overwhelming majority of mem never face a balance billing situation.

Employers who invest heavily in member education and support infrastructure s much better outcomes than employers who treat reference based pricing as a set and forget it cost saving measure. The successful employers create detailed communication campaigns explaining how the model works, what members shou expect, and exactly how to escalate concerns. They train HR staff to handle refer based pricing questions and empower them to intervene quickly when member i arise. They track member satisfaction metrics constantly and adjust the program based on feedback.

Geographic location also matters enormously. Reference based pricing works mu better in the Sun Belt and Western states than in the Northeast or Midwest. Thi reflects differences in hospital market concentration, state regulatory environme and provider business models. Florida, Texas, Arizona, and California have num competitive markets where reference based pricing thrives. Massachusetts, New

Pennsylvania, and Illinois have more concentrated markets and more restrictive regulations where the model struggles.

The model also works well for specific types of healthcare spending including outpatient surgery, diagnostic imaging, and physical therapy. These services hav commercial payment rates relative to Medicare, significant provider competitio most markets, and straightforward balance billing resolution because the dollar amounts are usually manageable. Employers can implement reference based pric just for these categories while maintaining traditional networks for inpatient ca complex specialty services. This hybrid approach captures savings where the mo works well while avoiding the risks where it performs poorly.

Some vendors now offer reference based pricing as an opt in program where me can choose traditional network coverage or reference based pricing with enhanc benefits. Members who choose reference based pricing get lower deductibles, lo out of pocket maximums, or higher HSA contributions in exchange for accepting model. This approach dramatically improves member satisfaction because only members who understand and accept the trade offs participate. It also creates selection effects where the members most likely to have smooth experiences cho the program while members with complex medical needs or strong provider preferences stay in traditional networks.

## THE FUTURE OF COST CONTAINMENT

Reference based pricing represents one of the more creative attempts to address underlying problem of excessive commercial payment rates in American healthc The model has demonstrated that significant savings are possible when employe willing to challenge provider pricing power directly rather than accepting netwo negotiated rates. But the model also reveals the limits of employer driven cost containment in a system where providers have enormous market power and poli influence.

The future probably involves some combination of reference based pricing for s services in competitive markets, continued traditional networks for complex car

concentrated markets, and increasing government regulation of payment rates a
all payer types. Employers who want to control costs cannot rely on any single st
but need sophisticated benefits designs that use different approaches for differe
types of care.

The most interesting development may be the emergence of direct contracting
between large employers and specific providers at negotiated rates above Medica
but below traditional commercial rates. Rather than using reference based prici
with universal percentage of Medicare payments and balance billing risk, emplo
negotiate specific rates with key providers that both sides agree to in advance. T
provides cost savings similar to reference based pricing with member experience
similar to traditional networks. The challenge is that direct contracting requires
significant employer resources to negotiate and administer compared to the sim
of paying percentage of Medicare for everything.

Some sophisticated employers are now using reference based pricing as a negoti
tool rather than a permanent payment model. They implement reference based p
to demonstrate they are willing to walk away from unreasonable network rates, u
the resulting leverage to negotiate better contracts with must have providers, an
return to a traditional network with much lower rates. This approach captures t
cost savings without the long term member experience and regulatory risks.

For investors evaluating companies in this space, the key questions are about
scalability and regulatory risk. Can reference based pricing vendors build sustai
businesses as state and federal regulations increasingly restrict balance billing?
providers develop strategies to undermine the model at scale? Can vendors main
quality member support as they grow to millions of covered lives? The most
successful vendors will probably be those who evolve from pure reference based
pricing into broader cost containment platforms that use reference based pricin
selectively as one tool among many.

The underlying problem that reference based pricing attempts to solve, which is
excessive commercial payment rates driven by provider market power, remains
unsolved. Until the country addresses hospital consolidation and the resulting p

power, employers will continue searching for ways to avoid paying two hundred percent of Medicare or higher for routine care. Reference based pricing is unlik be the ultimate solution, but the innovation and market pressure it creates may eventually force more fundamental reforms in how we pay for healthcare.

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