THE REIMBURSEMENT ARCHITECTURE THESIS

Why Employer Health Plan Premiums Are Downstream from Provider Payment Structure

A Strategic Health Benefits Cost Advisory Position Paper

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Executive Summary

Employer health plan costs are usually presented to business owners and financial executives as a premium problem, a renewal problem, a utilization problem, or a trend problem. Those issues are real, but they are not the deepest layer of the system. The deeper layer is the reimbursement architecture underneath the plan: the financial structure that determines what the health plan allows, pays, and ultimately passes through to the employer for medical care.

The central thesis of this paper is straightforward: the primary structural cost driver in an employer health plan is the reimbursement architecture between the insurance carrier, network, and provider system. Premium is downstream from that architecture, combined with utilization, claims experience, underwriting assumptions, stop-loss dynamics, administrative expenses, and carrier margin.

This is not an attack on physicians, hospitals, clinicians, or patient care. Care has value. Physicians and clinicians are essential. The issue is whether the employer's health plan is paying rational, transparent, and economically aligned prices for that care.

The federal government's 2027 Notice of Benefit and Payment Parameters final rule now reinforces the importance of this issue. CMS finalized a pathway for non-network Qualified Health Plans (QHPs), effective for Federally-facilitated Exchanges beginning in Plan Year 2028, while State Exchanges and State-based Exchanges on the Federal platform may allow such plans beginning in Plan Year 2027. These non-network plans are not organized around traditional contracted provider networks. They are organized around benefit amounts, provider acceptance of those benefit amounts as payment in full, public disclosure, methodology, exceptions processes, and provider access standards.[1][2]

Core Thesis

Every employer has a health plan cost structure. The question is whether that structure is still aligned with the economics of the business. The dominant transaction inside that structure is the plan-to-provider reimbursement arrangement. If that arrangement is opaque, inflated, or poorly aligned, the employer's premium will reflect that distortion year after year.

1. The Visible Problem and the Hidden Transaction

Employers see the visible outputs of the health plan system: premium, renewal increases, employee contributions, deductibles, copays, carrier proposals, and broker spreadsheets. Those visible outputs matter, but they are results. They are not the root economic transaction.

The most financially significant transaction inside a health plan is the allowed and paid amount for care. That transaction is shaped by carrier-provider contracts, network access arrangements, reimbursement methodology, facility pricing, professional service allowances, pharmacy reimbursement, and the way those payments are translated into claims experience and future pricing.

In plain terms: the employer is not merely buying insurance. The employer is buying access to a pricing system.

When that pricing system is rational, transparent, and aligned, the plan has a chance to perform economically. When that pricing system is opaque or structurally inflated, the employer can experience recurring premium pressure even when employee behavior, plan design, and broad utilization do not fully explain the increase.

2. Claims Cost Is Not Just Utilization

The traditional employer conversation often focuses on utilization: how often employees use care, how many prescriptions are filled, how many emergency room visits occur, and whether a large claimant distorted the renewal. Utilization is important. But claims cost is not utilization alone.

Claims Cost Formula

Utilization × Unit Cost = Claims Cost

The "unit cost" side of the formula is where reimbursement architecture lives. A claim is not just an event. It is an event multiplied by a price. The same MRI, lab panel, outpatient procedure, infusion, hospital admission, or specialist visit can produce materially different financial outcomes depending on the contracted rate, reference amount, facility setting, claims repricing rule, or reimbursement methodology applied to that service.

When employers are shown only aggregate claims and premium, they may never see whether the underlying unit cost is economically rational. That is the missing layer.

3. Provider Reimbursement as the Dominant Structural Cost Driver

The carrier-to-provider reimbursement structure is the economic center of gravity inside the plan. It determines how much money moves from the plan to the provider system when covered care is used. That payment structure influences claims, claims influence underwriting, underwriting influences renewal, and renewal becomes the employer's premium problem.

This does not mean reimbursement is the only cost driver. Group morbidity, demographics, plan design, large claims, prescription drugs, stop-loss pricing, administrative expenses, risk margin, carrier reserves, and regulatory requirements all matter. But as a structural driver, reimbursement architecture deserves far more scrutiny than most employers are trained to give it.

The most important question is not simply whether employees used care. It is what the plan paid when care was used.

4. Network Discounts Can Conceal the Real Price

Traditional network plans are often sold around the promise of discounts. But a discount is only meaningful if the starting price is economically meaningful. A large discount from an inflated billed charge does not automatically mean the employer received a rational price.

This is where the employer's visibility often breaks down. The employer may see the premium, the renewal, and the carrier's "discount" narrative, but not the actual reimbursement logic driving the allowed amount. The question is not whether a network exists. The question is whether the network produces rational pricing relative to reasonable benchmarks and the economics of the business funding the plan.

The employer should be able to ask:

- Are we paying reasonable prices for the care being delivered?
- Are allowed amounts benchmarked in any meaningful way?
- Is the plan relying on inflated billed-charge discounts rather than rational reimbursement?
- Are facility charges and site-of-care economics driving avoidable cost?
- Is the renewal being explained as trend when the deeper issue is structural pricing?

5. The Provider-Sensitive Position

This thesis must be stated carefully because reimbursement critique can be misunderstood as an attack on providers. That is not the position.

Provider-Sensitive Positioning

I am not anti-provider. Physicians and clinicians are essential. The problem is that employers are often asked to fund a pricing system they are not allowed to fully see. My work is focused on helping employers understand whether the reimbursement structure behind their health plan is transparent, rational, and economically aligned.

Care Has Value

We are not questioning whether care has value. We are questioning whether the employer's health plan is paying rational prices for that care.

The critique is not clinical. It is economic. It is not aimed at the medical necessity of care or the skill of clinicians. It is aimed at the financial architecture through which care is priced, reimbursed, and passed through to the employer.

A rational reimbursement structure protects employers, employees, and long-term access to care. When employer costs rise beyond what the business can absorb, employers shift cost to employees, reduce benefits, narrow options, delay hiring, suppress wages, or exit coverage altogether. None of those outcomes is pro-patient or pro-provider.

6. Strategic Health Benefits Cost Advisory

Strategic Health Benefits Cost Advisory is the discipline of evaluating whether an employer's health plan cost structure is economically aligned with the business funding it. It is not ordinary renewal shopping. It is a structural review of the plan's economics.

The advisory lens asks whether premium is being driven by actual risk or by a misaligned structure. The work includes analyzing claims experience, renewal logic, funding arrangement, underwriting assumptions, plan design, carrier behavior, provider reimbursement architecture, pharmacy cost, stop-loss exposure, contribution strategy, and the plan's relationship to revenue, margin, and business economics.

The practical output is a clearer answer to this question:

Advisory Question

Is the health plan merely expensive, or is it structurally misaligned with the economics of the business?

7. SOBA: The Diagnostic Application

The Second Opinion Benefits Analysis (SOBA) is the diagnostic application of this thesis. It is designed to give the employer an executive-level explanation of the current health plan structure, the drivers of cost, and the potential pathways for correction.

A proper SOBA should not merely quote alternative carrier rates. It should explain why the existing cost structure is producing its current result and whether the employer has better options. It should examine the plan as an economic system.

A reimbursement architecture review should become a visible section of the SOBA. Its purpose is to determine whether the employer's plan is paying structurally inflated unit costs for care through the existing carrier network, reimbursement model, or funding arrangement.

Key SOBA review questions include:

- Is the current plan's cost structure still aligned with revenue growth, margin, and pricing power?
- Are renewal increases being driven by actual claims risk, structural cost, or both?
- Are large claims and stop-loss factors being interpreted accurately?
- Is provider reimbursement transparent enough to evaluate?
- Could an alternative funding or reimbursement strategy reduce structural cost while preserving access to care?
- Does the current plan protect employees from excessive out-of-pocket exposure while maintaining employer affordability?

8. The Federal Signal: CMS and Non-Network QHPs

The federal government's 2027 ACA/QHP rulemaking is significant because it formally recognizes an alternative to traditional contracted-network plan architecture inside the Exchange framework.

CMS's 2027 Payment Notice final rule states that QHP certification of non-network plans is part of the final rule package.[1] CMS further explains that, beginning in Plan Year 2028 for Federally-facilitated Exchanges, issuers offering non-network plans may receive certification as QHPs by demonstrating a sufficient choice of providers consistent with sections 1311(c)(1)(B) and (C) of the ACA.[1]

CMS describes non-network plans as different from network-based plans because they do not rely on a contracted set of providers with directly negotiated payment rates, and do not condition or differentiate benefits based on whether the issuer has a network participation agreement with a provider. Instead, the plans set specific benefit amounts for covered services and communicate those amounts to enrollees.[1][3]

The final rule document states that a plan may determine the benefit amount using "an established methodology such as a percentage of a publicly available benchmark, a reference-based pricing structure, or another reimbursement standard," including Medicare or private payer rates.[3] That language is important. CMS is not merely allowing a different network label. It is acknowledging reimbursement methodology as a plan-design architecture.

CMS also finalized new 45 CFR § 156.236, which requires a non-network QHP to ensure access to providers that accept the plan's benefit amount as payment in full, including essential community providers and providers specializing in mental health and substance use disorder services, so services are accessible without unreasonable delay.[4]

9. What CMS Finalized Under 45 CFR § 156.236

The final regulatory text requires non-network plans applying for QHP certification through a Federally-facilitated Exchange, for plan years beginning on or after January 1, 2028, to submit information showing access to providers that accept the benefit amount as payment in full. The required information includes:

- the assessed percentage of providers in the plan's service area accepting the benefit amount as payment in full;
- ECP acceptance metrics and category-per-county requirements;
- outreach strategy to available providers;
- strategy for publicly making benefit amounts available and updating changes;
- methodology for determining benefit amounts;

- consumer-friendly information regarding balance billing scenarios and expected out-of-pocket costs;
- an exceptions process for enrollees who cannot find providers willing to accept the benefit amount as payment in full; and
- customer service, provider directory, and real-time cost-estimate assistance resources.[4]

This is not the same as saying every non-network QHP will pay 100% of Medicare. CMS does not appear to mandate a single Medicare reimbursement formula. Instead, it requires a disclosed methodology, public benefit amounts, access sufficiency, provider acceptance, consumer protection processes, and exceptions mechanisms.

The likely architecture is therefore not one flat national reimbursement formula. It is more likely to develop as a defined-benefit-amount framework, potentially using Medicare multiples, public benchmarks, private payer references, negotiated provider acceptance, service-specific schedules, or hybrid methodologies depending on issuer, service category, state rules, and market conditions.

10. Timing: The 2027-2028 Window

The timing matters. The final CMS document explains that HHS is delaying implementation for Federally-facilitated Exchanges to Plan Year 2028, while State Exchanges and State-based Exchanges on the Federal platform retain discretion to allow non-network plans for plan years beginning on or after January 1, 2027, if such plans are allowed through the Exchange.[2]

That means the policy window is best described as 2027-2028: 2027 for states positioned to act through State Exchanges or State-based Exchanges on the Federal platform, and 2028 for Federally-facilitated Exchanges.

This makes the issue early, not speculative. The policy framework exists, the federal signal is clear, and the operational details will continue developing through issuer guidance, state decisions, certification processes, and market adoption.

11. Why This Supports the Reimbursement Architecture Thesis

The CMS non-network QHP policy supports the core thesis in four ways.

1. It confirms that traditional contracted-provider networks are not the only possible architecture for certified health plan access.
2. It places provider payment methodology, benefit amounts, and provider acceptance at the center of plan certification for non-network plans.
3. It requires public visibility into benefit amounts and methodology, which directly addresses the opacity problem employers face in traditional plans.
4. It recognizes that consumer protection must be built around whether providers accept the plan's payment amount as payment in full, not merely whether the plan lists a provider network.

For employer health benefits strategy, the implication is direct: reimbursement architecture is not an administrative detail. It is plan economics. It determines whether the plan's cost structure is rational, transparent, and aligned with the employer's financial reality.

12. Policy Position

Policy Position

Strategic Health Benefits Cost Advisory is not an attack on physicians, hospitals, or patient care. It is a challenge to opaque reimbursement architecture. Employers deserve to know whether the health plan cost structure they are funding is reasonable, transparent, and aligned with the economics of their business.

Employers should not be forced to fund a pricing system they cannot understand. They should be able to evaluate whether the cost of care is being translated into premium through a rational structure or through an opaque system that rewards inertia, complexity, and hidden pricing.

This is the advisory opportunity. The employer does not need another spreadsheet showing a slightly different premium. The employer needs a structural diagnosis.

Conclusion

The employer health plan market is moving toward a more explicit confrontation with reimbursement architecture. The old surface-level conversation - "What is the renewal?" - is no longer enough. The better question is: "What pricing structure created the renewal?"

The Reimbursement Architecture Thesis is that employer premium is downstream from the reimbursement model. Utilization matters. Claims matter. Risk matters. But the price paid for care is the structural transaction that shapes the claim and ultimately shapes the renewal.

CMS's 2027-2028 non-network QHP framework strengthens this thesis. The federal government is now formally creating a pathway for plans that are not built around traditional carrier-provider network contracts, but around defined benefit amounts, provider acceptance as payment in full, public methodology, access standards, and consumer protection requirements.

That is not a minor technical change. It is a federal acknowledgment that reimbursement architecture itself is a plan-design variable.

For Strategic Health Benefits Cost Advisory, the conclusion is clear: the future employer health plan conversation will increasingly move from premium comparison to cost-structure diagnosis. The advisor who can explain reimbursement architecture, provider access, funding strategy, claims risk, and business alignment will operate at a higher level than the broker who merely shops the renewal.

Source Notes and Regulatory Receipts

The following source notes are included to support the federal/CMS statements in this paper. The final rule PDF was, at the time accessed, an HHS-approved document submitted for Office of the Federal Register review; the document itself states that the Federal Register version will be the official HHS-approved document after publication.[5]

[1] CMS Fact Sheet: HHS Notice of Benefit and Payment Parameters for 2027 Final Rule. CMS states that the final rule includes QHP certification of non-network plans; that for PY 2028 CMS is finalizing a pathway for non-network plans to receive QHP certification through the FFE; that these plans do not rely on contracted provider sets with directly negotiated rates; and that they set specific benefit amounts, require provider acceptance as payment in full, and aim to reduce costs through price transparency and reduced traditional network-management overhead. Source link

[2] CMS-9883-F Final Rule PDF: Implementation Timing and State Flexibility. CMS explains that it finalized the policy with a modification delaying FFE implementation to PY 2028, while State Exchanges and SBE-FPs may allow non-network plans for plan years beginning on or after January 1, 2027, if such plans are allowed through the Exchange. Source link

[3] CMS-9883-F Final Rule PDF: Description of Non-Network Plans and Benefit Amount Methodology. CMS describes non-network health plans as plans that do not rely on contracted providers with negotiated payment rates; instead they set specific benefit amounts and communicate those amounts to enrollees. CMS states the plan may determine benefit amounts using a publicly available benchmark, reference-based pricing structure, or another reimbursement standard, including Medicare or private payer rates. Source link

[4] CMS-9883-F Final Rule PDF: Regulatory Text Adding 45 CFR § 156.236. The final regulatory text adds § 156.236, "Provider access and essential community providers standards for non-network plans," requiring access to providers accepting the non-network plan's benefit amount as payment in full and listing information required for QHP certification through an FFE beginning with plan years on or after January 1, 2028. Source link

[5] CMS-9883-F Final Rule PDF: Office of the Federal Register Notice. The PDF states that it is an HHS-approved document submitted to the Office of the Federal Register (OFR) for publication and that the document published in the Federal Register is the official HHS-approved document. Source link

[6] Federal Register Proposed Rule: 91 Fed. Reg. 6292, CMS-9883-P. The proposed rule, published at 91 FR 6292 on February 11, 2026, proposed adding § 156.236 to allow plans that do not use a network to receive QHP certification by demonstrating sufficient choice of providers that accept the plan's benefit amount as payment in full, including access to essential community providers. This is the Federal Register source trail for the proposal that preceded the final CMS-9883-F rule. Source link

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