The Collective

The Oklahoma Business Collective on Health

At the intersection of business and health

Happy Holidays!
Wishing you a happy and safe holiday season.

Please add your voice and support The Collective in 2025.

Trump Healthcare 2.0: The Laundry List of Disruption Targets

The incoming Trump administration is committed to cutting government waste and reducing regulation. That pledge puts the U.S. healthcare industry in the crosshairs for budget cuts and heightened attention. It's also a high-profile industry that's ripe for disruption.

Healthcare is the economy's biggest private-sector employer (18.3 million) and accounts for 17.3% of the GDP and 28% of total federal spending. Since 2008, annual increases for prescription drugs, hospitals and physician services have increased faster than the "All Items" index widening every year (See chart in the attachment). From 2012 to 2022, the average annual growth rate was 4.2% for physician services, 4.4% for hospital care, 4.7% for prescription drugs and 5.0% for insurers who experienced the highest volatility of the four.

Looking ahead, per the Congressional Budget Office, spending for healthcare is forecasted to increase 5.6% per year for the next decade to 19.7% of the GDP —well above GDP growth (4.3%). Assuming continued aging, medical inflation (drugs, technologies and facilities), and labor costs, the health industry's dominance will be increasingly problematic to the rest of the economy. It underlies the Trump Healthcare team's belief that incremental changes to the health system are a waste of time and money. Click below to read the rest of this article. *Source: The Keckley Report*

Article: Laundry List of Disruption Targets

News You Can Use

Why Are Drug Prices So High?

The authority to negotiate drug prices was established in 2022 by the Inflation Reduction Act (IRA) as a policy response to the pharmaceutical industry (hereafter 'industry') having set prices that made the United States by far an outlier among wealthy countries in drug spending per capita.

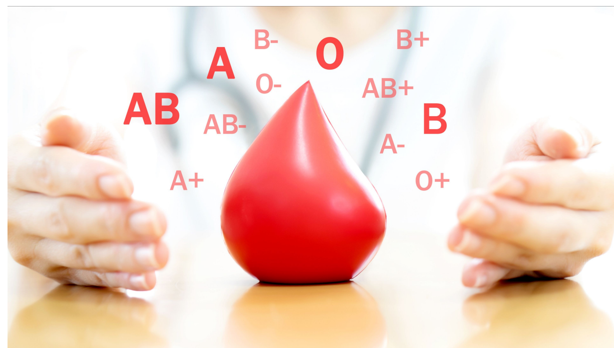
The Industry has offered three broad justifications for high prices: that they are required to recoup the costs of research and development (R&D); that hikes in prices reflect incremental clinical (and occasionally nonclinical) benefits; and that prices would not be so high if middlemen, such as pharmaceutical benefit managers (PBMs), passed on rebates made to payers to consumers. A growing body of evidence, some of which is summarized in the attached article, contradicts these assertions.

What's missing from the public policy debate about drug prices is an understanding of how pharmaceutical R&D — including the establishment and transfer of intellectual property rights — and the drug market have changed over the past 45 years. These changes, driven principally by a handful of laws described in the article, have brought new research organizations and investors into the R&D process, increased the industry's pricing power and its willingness to use it, and diminished private purchasers' negotiating power. Understanding this 'new' R&D ecosystem is important. Policy is being written on 'what we know,' and stopped by those 'who don't want us to know.' What DO we really know? *Read more - click below.*

Why this matters: Commercial insurers are contributing a disproportionate share of revenue into the health 'system.' Drug spend is huge — it's important to understand the pharmaceutical industry behind all the rhetoric. It will help you as you make plan decisions. *Source: Health Affairs Forefront. Read the full article below.*

Article: Real Reasons Why Drug Prices Are So High

Medical Minute



January is National Blood Donor Month

January is designated as National Blood Donor Month in the United States. Holiday celebrations, inclement weather, and cold and flu season during the winter months are often a time of reduced donations and an increased risk for blood shortages. National Blood Donor Month celebrates blood donors during this critical time and reminds people of the importance of donating blood.

How is donated blood used? There are different kinds of blood donation:

Plasma: Used to treat patients with liver failure, serious burns, and bad infections, and to protect people with brain and nerve diseases.
Whole blood: Used to treat patients with life-threatening injuries or for people undergoing surgery. Whole blood can be transfused in its original form or separated into its components for use by multiple people.
Blood transfusions: A common procedure in hospitals, blood transfusions are used to treat patients who have lost blood due to injury or surgery, or who have blood disorders.
Red blood cells: Used to treat people with blood disorders like sickle cell disease or anemia, or to increase red blood cell counts in premature babies.
Platelets: Used to treat cancer, and to help with blood clotting in patients recovering from a severe hemorrhage, or having open-heart surgery or an organ transplant.

Donated blood is shipped to hospitals 24/7, and hospitals work with blood donation organizations to ensure that blood is used appropriately. You can help save lives: use the links below to organize a work-site blood drive.

Giving = Living

OBI - Host a Blood Drive

Red Cross - Host a Blood Drive

Advocating For Employers

Spread Pricing: It's real
Hello, Plan Fiduciary...are you out there?

Spread pricing is the difference between what an employer plan pays and the amount providers actually receive for their services. The guys in the middle may be keeping big chunks of your money — and many of your contracts allow it to happen. Check out this clause from a real carrier contract:

"Claim administrator's compensation for its services under the agreement shall include the difference between the net claim payments reimbursed to the claim administrator by the employer and the net amounts paid to providers by the claim administrator."

If language like this is in your contract, you've just agreed to allow spread pricing. You'll never know how many dollars are actually passed through to providers or kept by the middleman. *(A real example*: This employer pays $4 million. The provider was paid—drumroll, please—$876,000. Where did that other $3.2 million go? (admin fees and the 'difference'). Scrub those contracts — look for these weasel word clauses!

Transparency alone is not sufficient to transform healthcare, but it's definitely a start. Bottom line: plan sponsors need enough access to billing data and hospital prices to calculate how much the middle folks are taking in spread.

For more on the magnitude of spread pricing goings-on, read Chris Deacon's take on the recent Owens & Minor lawsuit (filed a few weeks ago). This lawsuit alleges egregious misconduct by Anthem BCBS, including actively frustrating

attempts by the plan sponsor to analyze claims data, leading to substantial losses for the self-funded healthcare plan. This is a case study in how hard some of these middlemen/carrier entities are working to obscure and hide what they are doing. Note that this employer documented everything in their attempts to obtain and use their own data. A word to the wise. *Source: Relentless Health Value - Stacey Richter, episode 457.*

Don't forget your year-end CAA attestation. It's the employer's fiduciary responsibility to make sure this happens, and it's the employer who will be called out if a partner lets something slip while filing for you.

Watch: Humorous Take on Health Plans

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