The Collective

The Oklahoma Business Collective on Health

At the intersection of business and health

***FREE WEBINAR*: The National Alliance Presents**

Why Employers Should Invest in Early Kidney Care

Wednesday, April 30, 2025 | 2:00.-3:00 p.m. CT

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Protecting Your Health Plan
DID YOU KNOW...

Approximately 85% of claims are adjudicated by computer software without any human review? This process is called auto-adjudication. If a human does review the claim, it costs approximately $20 per claim to process it. Obviously, it's cheaper to auto-process.

Most health insurance companies set a dollar threshold of $10,000 - $15,000 per claim. Claims below this threshold are auto-adjudicated.

Often, the software used in claims adjudication is really old, such as COBOL, a software language that was created in 1959.

Claims adjudication software does not catch all doctor and hospital billing duplicates, fraud, waste and abuse. Proper claims oversite still requires a human touch. [*Source: Dr. Eric Bricker, AHealthcareZ]*

2026 Plan Prep

What can employers do to improve plans in 2026? Here's what a national employer survey says: **Acknowledge that you are a fiduciary.** Review your current contracts. Federal law says **ERISA health plan claims data belongs to the employer**. You should secure it at the claims level and be analyzing it. (There are companies whose business it is to house and crunch this detailed data. Find one if you don't have the skillset or a data storage option in-house—it could save you big money). If your 'partners' won't willingly give you full access to all your data—without a fight and repeated letters from your attorneys—you should be wondering why. **Lack of due diligence and prudence can cost your plan a lot and it puts YOU in the fiduciary crosshairs**. In an opaque industry, it's hard to catch everything, but there are things you can do. It's the employer's job to look for best options and document reviews and decisions. Consider these points for inclusion in your plan RFPs and contracts:

- Require access to your data. Nonnegotiable.; *all of your data*, with all detail, and complete and unfiltered access. If this is questioned, if there's an attempted modification, or a huge cost attached, look for a different partner. (HIPAA is not a reason to withhold - data can be de-identified and protected). Loyalty to a partner can't be placed ahead of an obligation for prudent plan decisions. Will it be harder to start with someone new? Yes, but you owe it to your plan and your employees to find the best value.
- Clearly state your expectations. Specify the right to select your own claims auditor, your right of full access to ALL data for auditing and complete claims review

—without limits on timeframe or number of claims. (What does your current contract say about data access and audits?) Any time there's a restriction, recognize it as a "gag clause," which is illegal.

- Maintain the option to carve out your pharmacy. Is your current plan rigid and brand-focused? Does your formulary include generics and biosimilars? Were you promised higher rebates on the brand names? (Think about the data you're given. Do you actually know the price of the drugs in your plan? Do you know what price the rebate is based on? Do you know if you're getting all the rebates you were promised?) Big checks are nice, but a rebate may not really offset the higher price you're paying for the branded drugs.
- Realize that there are conflicting and misdirected incentives in insurance and health services industries. This creates conflicted partners. Protect your plan—make sure all partners are supporting the best interests of your company and your health plan. Trust, but verify. Look at your claims data. (Has your broker signed a conflict-of-interest disclosure?)
- Review the CAA - Liability and fines can be brought to employers who sign contracts that contain gag clauses, don't have documented partner disclosures on direct and indirect compensation, don't protect mental health and substance abuse parity, and those that don't meet/support drug price reporting.

*Do you have questions? Send them to **thecollective@okstate.edu**.*

News You Can Use

What President Trump's Executive Order on Drug Pricing Means for Employers

The President signed an Executive Order on April 15 aimed at lowering prescription drug pricing and increasing PBM transparency. While a significant portion of the Order relates to Medicaid and Medicare drug benefits, there are some things that may impact employer plans:

1. PBM Transparency: within 180 days, the Dept. of Labor must propose regulations to improve fiduciary transparency related to direct and indirect PBM compensation and site-neutral policies.
2. Acceleration of generic and biosimilars entering the market: the order calls for the FDA to create pathways for states to import lower cost drugs.
3. Survey on hospital acquisition costs: a plan for Medicare to capture 340B savings. This may not have a direct impact on employer plans, but it will inform the ongoing 340B debate.

While this executive order provides insights into the administration's intentions, it will take further administrative action to take make any of this happen.

Payouts Over Patients?

A study of publicly traded healthcare companies is uncovering just how much shareholder payouts, such as stock buybacks and dividends, have skyrocketed over the last two decades. These stock buybacks that the companies receive, in turn, increase the value of their remaining shares, leading to more investors expecting more returns. Excessive profits given to shareholders is money not returned or retained to improve actual care. (A large contributor to high healthcare costs?)

Researchers suggest that policymakers encourage healthcare dollars to be reinvested into patient care and limit share buybacks, but this rarely seems to be the case. (Your plan dollars may be going into these big companies...what are the financial priorities of the healthcare sector?)

These findings highlight a massive, continuous issue with the modern

healthcare system. The employer voice needs to be heard and inserted into policy discussions. Otherwise, it continues, status quo. *[See HealthLeaders and Yale below for more on the study].*

Trump's April 15 Executive Order

HealthLeaders CFO Report

Yale School of Medicine Report

Medical Minute

Cardiovascular Disease, Diabetes and Obesity in Women

A systematic review of 49 studies found that compared to men with diabetes, women with the same condition had 57% additional risk for coronary heart disease.

Research shows that women are seven times more likely than men to be misdiagnosed—and then discharged—while in the midst of a heart attack.

Obesity is the most significant risk factor for the development of diabetes in women. In the U.S., 30% of women 18-44 are considered obese. Roughly 15 million are living with diabetes, mostly Type 2.

Many thanks to our sister coalition, the Northeast Business Group on Health, who put together a guide for employers around Cardiovascular Disease, Diabetes and Obesity in Women. [click below].

Employer Guide: Cardiovascular Disease, Diabetes, and Obesity in Women

Work@Health

Employer Training

June 26-24, 2025

Rogers County Health Department, Claremore

If you want to start or enhance employee wellness at your worksite, join this free two-day training for employers. The Work@Health program is an initiative of the CDC to promote wellness through employer education, training and technical assistance. This includes why wellness programs make good business sense, creating a wellness environment, assessing workforce needs, and monitoring to improve your wellness

program.

E-mail Karin Leimbach at KarinL@health.ok.gov to learn more and register today!

Advocacy

Federal

Transparency Price Bill 2.0: This bill aims to codify hospital price transparency rules, requires hospitals and health plans to post rates, increases employer access to health data, and proposes civil monetary penalties for non-compliance. (Likely to be re-introduced by Senators Marshall and Hickenlooper).

Oklahoma

HB1512 This bill **grants the Insurance Commissioner certain authority over Patient Protection and Affordable Care Act waivers.** It passed Senate Appropriations 24-2.

HB1811 – This bill **modifies the timeframe for treatment of chronic conditions and validity period for prior authorization of inpatient and non-inpatient care from 72 to 24 hours.** Prior Auth to remain valid for 6 months. It passed the Senate Business and Insurance Committee 9-0.

HB2048 – This bill **creates the 340B Nondiscrimination Act which prohibits health insurers and pharmacy benefits managers from reimbursing 340B entities for certain drugs at reduced rates or engaging in other discriminatory actions**. It passed the Senate Appropriations Committee 22-1.

HB2298 – This bill **grants independent prescriptive authority to Advanced Practicing Nurses who meet certain requirements.** It passed the Senate Health and Human Services Committee 8-4.

SB515 – This bill **allows people to pay out of pocket for health care services and requires their carrier to count the amount spent towards their deductible.** It passed the House Commerce and Economic Development Oversight Committee 16-0.

If you have questions or concerns, contact your House and/or Senate representatives.

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