



At the intersection of business and health

The Collective



Why is it So Hard to Cut Healthcare Costs?

When stakeholders benefit from the status quo, they resist change.

Everyone claims to support making healthcare cheaper and more efficient. But when concrete steps are taken to do exactly that – even when proposed changes are supported by evidence – those changes are often met with outrage. That outrage rarely stems from legitimate concern about patient harm. More often, it comes from those within health delivery: payers, brokers, pharmacy benefits managers, etc., trying to protect a lucrative revenue stream. Add to that a third-party payment system that shields patients from the true cost of care, and you've got a perfect recipe for ever-rising healthcare spending, where just changing the site of care can have an enormous impact on costs.

So why the outrage? The problem lies in how American healthcare is paid for. Because patients rarely bear the full cost of the services they consume, they're naturally less sensitive to price. This makes them vulnerable to emotional appeals that equate higher cost with better care. In many cases, they don't even realize there's a price difference – let alone that the more convenient option may also be far more affordable. (For the record: there is no proven relationship between cost and quality in healthcare).

This disconnect also enables entrenched interests to resist change. Physician groups, hospitals, and drug infusion centers often profit handsomely from administering these medications in-office. When insurers or employers attempt to reduce costs by shifting care to the home, they're not just changing care delivery, they're cutting off a revenue stream. It's no surprise that such efforts are met with resistance, often cloaked in the language of patient advocacy.

Does anyone make money when people are healthy? No – unless you're the employer. So, what is the incentive for the industry to change the healthcare status quo? Employers insure the majority of the working-age population and these commercial plans contribute a disproportionate share of revenue to providers. Employers – you have a choice. Continue to battle the rising costs of your health plan or stand up to combine voices, and demand change.



News You Can Use

How Employers Can Fight the Price Crisis

The U.S. healthcare price 'crisis' is hitting employees, employers, and public purchasers hard. With over 60% of Americans covered by employer-sponsored health insurance in 2024, plan sponsors should look hard at adding policy advocacy to their cost-control toolkit.

A recent article from the *American Journal of Managed Care* (below) looks at how employers can learn from those who have engaged in the policy fight. The work in Texas (by the employer coalitions in Houston and Dallas), and the Employers Forum of Indiana mentioned in the article, are sister coalitions to The Collective. We all have ties to The ERISA Industry Committee through our National Alliance partnerships).

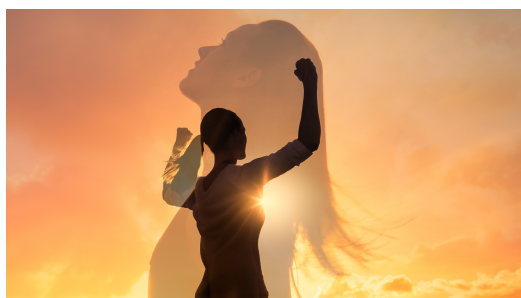
Key Takeaways:

- Employer plan sponsors are significantly impacted because they bear the burden of rising healthcare costs. This diverts resources from business investment.
- Plan sponsors have a fiduciary obligation to act in the best interest of their members.
- **Market-based solutions are becoming less effective due to healthcare system consolidation. Policy change is the most effective long-term solution, even though it can be challenging.**
- **Business coalitions offer expertise, enabling employer plan sponsors to participate in policy change without leading efforts.**
- Plan sponsors should establish a public policy strategy and review it annually in conjunction with their purchasing strategy.

Leverage a membership with The Collective to stay current and bring your voice to policy advocacy. Email thecollective@okstate.edu for more information.

Add Policy Advocacy To Your Toolkit

Medical Minute



Virtual Solutions for Depression & Anxiety

Peterson Health Technology Institute (PHTI)

Despite growing rates of depression and anxiety, many people with symptoms do not receive effective treatment. Provider shortages, out-of-pocket costs, limited insurance networks, social stigma, and poor follow-up leave many patients with limited or no access to care. *Virtual solutions* for depression and anxiety aim to improve patients' symptoms and expand access to timely care.

This report evaluates 15 solutions that offer digital programs, including on-demand digital content libraries and activities. Some solutions also provide more comprehensive platforms that integrate care from clinical providers. The solutions reviewed in this report can be grouped into three broad categories, based on both the primary purchaser and the components of the solution offerings.

Summary of Findings (based on PHTI's review of the clinical evidence): Virtual solutions that include digital content improve symptoms of depression and anxiety, particularly for people who are not otherwise receiving mental health therapy. These solutions have the potential to improve access to care and health outcomes. Users who experience improvements in depression and anxiety symptoms also reduce their overall healthcare spending.

Virtual Solutions for Depression & Anxiety

Advocacy

Mining for Drug Transparency

The largest business relationships controlling or influencing drug prices secured their position through vertical integration. **Vertical integration** is a business strategy where a company takes ownership of its suppliers, distributors, or retail locations to gain greater control over its supply chain. These companies argue that they create opportunities to lower healthcare costs, however, these strategies also create the potential for anti-competitive behavior that raises prices and profits.

Vertical integration provides insurers with greater control over downstream pharmacy and provider assets. This enables more effective implementation of formulary and site-of-care strategies. There is limited data documenting any cost savings. The Federal Trade Commission (FTC) investigated the three largest PBMs and revealed differences between reimbursement to PBM-affiliated pharmacies compared with unaffiliated pharmacies. The FTC found that [affiliated pharmacies were almost always reimbursed at higher rates than unaffiliated ones—with disparities especially pronounced in commercial plans versus Medicare Part D](#). **Specialty generic drugs with the most significant markups were primarily dispensed by PBM-affiliated pharmacies.**

What's the message to employers?

Healthcare and Pharmacy relationships are fraught with misaligned incentives and opaque revenue streams. Be aware that [three companies](#) control the lion's share of:

- Health insurance (as payers)
- Pharmacy Benefit Managers (PBMs)
- Retail, mail-order, and specialty pharmacies
- Healthcare delivery systems (clinics, urgent care, home health)

- Increasingly – even drug manufacturing (biosimilars, generics)

These vertically integrated giants *profit from every step* in the healthcare supply chain. This means they:

- **Set the price** (as insurers/PBMs);
- **Control access** (via networks and prior authorization);
- **Fill the prescription** (at their own pharmacies); and
- **Keep the rebate/markup** (instead of passing savings to employers or patients).

The Impact: Employers think they're paying "net" prices – but these conglomerates are double-dipping across business units. [Just so you know...drug pricing and discounts are whatever they say they are and will vary to suit current strategies].

There's a great matrix included in the article which outlines who owns or is affiliated with the top seven drug price influencers. *How many are you partnered with?*

Vertical Integration of Pharma



Our mailing address is:

The Oklahoma Business Collective on Health
c/o OSU Center for Health Systems Innovation
1111 W 17th Street
Tulsa, OK 74104

Website: drivinghealthvalue.org

thecollective@okstate.edu

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