



At the intersection of business and health

The Collective



Rethinking How Employers Address High-Cost Claims

High-cost claims have emerged as one of the most significant financial threats to employer-sponsored healthcare. Over recent benefit years (2019-2022), nearly nine in 10 employers faced a stop-loss claim, making them a common occurrence. According to a 2023 survey by Willis Towers Watson, 94% of employers expect to face more high-cost claims in the next three years. Nearly 8 in 10 employers consider high-cost claims, drug prices, and hospital prices a significant threat to affordability for employees and their families. The need for comprehensive, sustainable strategies to address high-cost claims has never been more pressing. At the request of coalition members and employers across the country, the National Alliance developed its High-Cost Claims Initiative in 2022. Building on the findings from Phase 1, the National Alliance kicked off Phase 2 in the spring of 2024.

Key Drivers/Findings of High-Cost Claims

- ▶ The top conditions for million-dollar plus claims are cancer, neonatal events, cardiovascular conditions, and sepsis.
- ▶ More than half of employers in this initiative describe \$100,000 (or \$100,000+) as the lower limit for a high-cost claim; some use \$50,000 as a threshold to identify potential high-cost claims early.
- ▶ Employers are seeing a rise in high-cost claims for younger plan members. This is consistent with findings from the pre-survey.
- ▶ Increasing mental health claims often coexist with other chronic conditions.
- ▶ Employers have historically been more reliant on third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to manage high-cost claims. As costs have escalated, employers want to learn how best to hold service providers accountable for better management.
- ▶ As the number of high-cost claims has grown, so has interest in cost-sharing approaches that will keep costs lower for employees and families without compromising care.
- ▶ Data access and utilization, member engagement and adoption of non-traditional payment models are also part of understanding claims for better management.

Key Realizations in Tackling High-Cost Claims

- ▶ You CAN impact high-cost claims.
- ▶ It is NOT a one-size-fits-all problem.
- ▶ You CAN start to move the needle significantly by tackling a handful of individual cases while determining broader strategies.
- ▶ Get your claims data. Analyze it. Trust but verify.

Read the report below for recommendations and action steps.

[National Alliance on High Cost Claims](#)

News You Can Use

Trends in Specialty Drug Benefits Key Findings

Specialty drugs have ushered in remarkable advancements in patient outcomes and quality of life, yet they also introduce significant affordability challenges. Balancing the potential benefits of these groundbreaking treatments with the financial complexities they pose is central to ongoing discussions. The attached report from PSG Consults and Genentech not only addresses long-term considerations for specialty drug benefit design but also contemporary issues such as access to gene therapies, evolution of alternative funding programs, and the unintended consequences of utilization management programs. *Read the full report below.*

From the report:

- **Cost Management is an Essential Goal:** 8 in 10 payers cite managing overall specialty trend/specialty drug costs or managing total cost of care as their top specialty drug management goal.
- **Payers Increasingly Open to Rebate Alternatives:** Payers are most interested in preferring drugs that are a lower price but do not offer a rebate and accepting lower rebate guarantees in exchange for lower cost of drugs at the point of sale.
- **Utilization Management Carveouts Becoming More Common:** 9% of employers and 24% of health plans currently carve out one or more utilization management services.
- **Medical Drug Formularies Widely Adopted:** 72% of plans now utilize a medical drug formulary for managing medications covered under the medical benefit.
- **Payers Express Uncertainty About Cell and Gene Therapy Financial Impact:** Most payers lack confidence in their organization's understanding of the financial impact of cell and gene therapies over the next 2 to 3 years.

[Specialty Drugs Benefits Report](#)

Medical Minute



What's Happening in Pain Treatment Alternatives?
**JOURNAVX - An Oral Non-Opioid Treatment Indicated for
Treatment of Mild-to-Severe Pain in Adults**

On January 30th, in a landmark decision that could reshape the way acute pain is treated in the United States, the FDA approved suzetrigine (brand name, Journavx), a first-in-class non-opioid analgesic that is an alternative to traditional painkillers. Over 80 million people are prescribed medicine to treat acute pain every year in the U.S. - nearly 1 in 3 U.S. adults - and approximately half of these individuals will be treated with an opioid. Developed by Vertex Pharmaceuticals Incorporated, JOURNAVX (suzetrigine) marks the first new class of pain medicine in 20 years.

The painkiller, which has a lofty list price of \$15.50 per pill, blocks pain signals before they reach the brain, unlike opioids that reduce pain by latching receptors to the brain, creating the risk of addiction; this is an opportunity when updating your formulary. Read more about this non-opioid alternative treatment [HERE](#).

June is Men's Health Awareness Month. There is a crisis in men's health. Because of poor health habits, lack of health insurance, failure to seek medical attention, and dangerous occupations, men live sicker and die younger than women. Check out the fact sheet [HERE](#).

June is also Alzheimer's and Brain Awareness Month. Alzheimer's is the most common form of dementia. Over 7 million Americans are impacted. Check out the 2025 Alzheimer's disease facts and figures report [HERE](#).

Advocacy

Tiara Yachts v Blue Cross Blue Shield of Michigan (BCBSM)

On May 21, 2025, the 6th Circuit Court reversed the dismissal of fiduciary breach claims against BCBSM and made clear that the TPAs that control plan assets and profit from their own overpayments are not just 'administrators' - they are fiduciaries - and employers have a shot at holding them accountable under ERISA.

This is a wake-up call and a roadmap to challenge "industry standard" behavior. If your TPA:

- Sets prices, pays claims and restricts your access to data...
- Then offers to recover savings from those same claims and pocket a fee...
- Then tells you it's 'just part of the contract'...

This court decision tells you: That's not a defense. That's a fiduciary breach. 'Contractual duties and ERISA fiduciary status are not mutually exclusive.'

EMPLOYERS: If the courts are willing to entertain the notion that this TPA behavior could be a fiduciary breach, then what are the implications for you if you knowingly permit such behavior to continue? Use this case to demand your data and audit your claims. *[Many thanks to Chris Deacon for breaking this case down in her [Linked-in post](#). Check out her profile. This attorney speaks from experience]. READ MORE ABOUT THE RULING BELOW.*

What's Happening in Oklahoma

[SB889](#) - Requires hospitals to maintain a list of all standard charges for all hospital items and services - with description. There are a number of descriptions and call outs in this bill, but it is a big step to making more prices available to the shopping public. *Bill passed 5/21/25*

Changes to step-therapy policies. [HB1808](#) would require insurers to make certain exceptions to their policies around step-therapy protocols. Step therapy or "fail-first" protocols refer to requirements by insurers that patients must first try and fail certain approved (and often lower-cost) drugs before insurance will pay for other ones. *This bill has gone to the Governor.*

[SB1064](#) Requires step-therapy protocols to be no more restrictive when they are being used to treat a rare disease than for any other condition a drug may be used to treat. *Pending in House Public Safety Committee.*

Prescriptive authority for psychologists. [HB1173](#) would allow psychologists who receive an additional certification the ability to prescribe psychotropic drugs - medications to treat mental health conditions. *Pending.*

[SB787](#) Creates the Oklahoma Health Care Cost Containment and Affordability Act which caps total payments for any health care provider for inpatient or outpatient hospital services at the lesser of 200% of the amount paid by Medicare or the median amount paid by health benefit plans. This measure prohibits a provider from charging or collecting from any patient an amount greater than cost-sharing amounts authorized under the terms of the health benefit plan. Providers must furnish data to the State Health Department to calculate growth rates and monitor compliance. *Pending in the Senate Health and Human Services Committee.*

6th District Court Ruling Tiara Yachts v BCBS of MI



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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