Welcome to the 2025 Fall Forum!

Fall Forum Agenda

8:45 AM – Welcome and Introductions

9:00 AM – Employer's Legislative Update

10:00 AM – 340B: What Employers Need to Know

11:00 AM – Unified Care: Strengthening Coordination Across Healthcare

12:00 PM – Networking Lunch

1:00 PM – Employer Strategies to Manage Cell & Gene Therapy

2:00 PM – AI as a Solution for Healthcare Costs

3:00 PM – Wrap-up

Link to presentation slides
will be sent to all attendees following the Forum

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5 recertification credits available for attending today

Activity codes available at registration desk

NORTH CAROLINA BUSINESS COALITION ON HEALTH

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Our Members

Employer Members

All sizes, all industries

(at least 25 employees based in North Carolina)

Affiliate Members

Vetted benefit/HR service providers and consultants

Advisory Council Members

Key Healthcare Stakeholders dedicated to furthering our mission

Our Board of Directors

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ABOUT NCBCH

Formed in 2011 as a coalition of employers using their collective voice
to improve the cost quality and cost of healthcare delivery systems in North Carolina.

Our Mission:

Educate

Empower employers with knowledge and actionable insights
to make informed healthcare decisions.

Advocate

Champion policies and practices that drive higher-quality, more affordable care
for North Carolina employers, employees, as well as all North Carolinians

Innovate

Foster collaboration and explore new solutions that
improve wellbeing and healthcare value statewide.

Our National Presence…

The North Carolina Business Coalition on Health is a member of the National Alliance of Healthcare Purchaser Coalitions, the *only* nonprofit, purchaser-led organization with a *national and regional structure* dedicated to driving health and healthcare value across the country

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

NC Hospital Safety, Quality and Transparency Leader

LEAPFROG

REGIONAL LEADER

SINCE 2019

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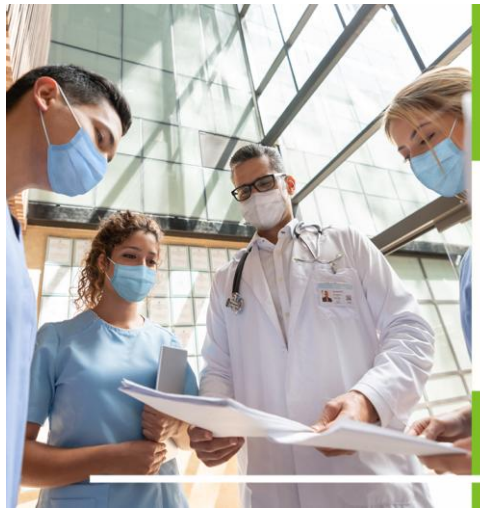
Giant Leaps for Patient Safety



LEAPFROG

HOSPITAL

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A B C D F

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Legislative and Legal Update for Employers

James Olney, J.D.

SVP, Managing Employment Attorney

USI

EMPLOYMENT LAW DEVELOPMENTS 2025 AND BEYOND

September 12, 2025

Presented By:

James Olney, J.D.
SVP | Managing Employment Attorney

Who is Employer Solutions?

- We are a team of employment law attorneys with HR and risk management backgrounds
  - Our primary focus is on the HR and employment law things that make up the people management function within an organization
  - Our advice couples compliance with best practices
- Our flagship service is the Hotline, which provides unlimited phone and email access to the attorneys on the Employer Solutions team for a very low annual fee
- To learn how the Hotline can help you:
  - Scan the QR code
  - Or send an email to employerhotline@usi.com

Agenda

- Legislation
- Executive Orders
- Federal Agency Activity
- Supreme Court Cases
- State Initiatives

Legislation

One Big Beautiful Bill (OBBB)

- Inclusion of employer payments of student loans in the definition of "educational assistance" is made permanent
  - $5,250 is current annual maximum, but inflationary adjustment starts in 2027
- Dependent Care Assistance Program contribution limits increased from $5,000 annually to $7,500 starting in 2026
- Tax deduction for "qualified overtime compensation"
  - Effective starting in the 2025 tax year and expires December 31, 2028
  - Overtime is not paid tax-free; instead, employees can take year-end deduction when they file their taxes
    - Up to $12,500 ($25K for joint filers) can be deducted per year
    - Deduction amount incrementally reduces for every $1,000 of modified adjusted gross income above $150,000 (single) / $300,000 (joint)
    - Deduction can be claimed by "non-itemizers" (i.e., on top of standard deduction)
    - Qualified overtime amounts will have to be separately reported on W-2
  - "Qualified overtime" limited to overtime payments required by the FLSA
    - State law overtime requirements beyond FLSA not covered (e.g., California, etc.)
    - Employer overtime practices such as OT for working on weekends or holidays not covered

One Big Beautiful Bill (OBBB)

- Tax deduction for tip income
  - Effective starting in the 2025 tax year and expires December 31, 2028
  - Employers still withhold taxes on tips and report on W-2, but employees can take year-end deduction when they file their taxes
    - Employers must separately report tip income on W-2 and employee paystubs
    - Deduction can only be claimed on voluntary tips (e.g., not on mandatory service charges)
    - Up to $25,000 can be deducted per year per taxpayer
    - Deduction amount incrementally reduces for every $1,000 of modified adjusted gross income above $150,000 / $300,000
    - Deduction can be claimed by “non-itemizers” (i.e., on top of standard deduction)
  - Deductions for tip income limited to specified occupations (*see next slide*)
  - FICA tip credit expanded to include beauty service businesses to align with food and beverage establishments
    - E.g., barbering, hair care, nail care, esthetics, and spa treatments

Tips tax deduction – initial occupations list

Beverage & Food Service	Entertainment & Events	Hospitality & Guest Services	Home Services	Personal Services	Personal Appearance & Wellness	Recreation & Instruction	Transportation & Delivery
• Bartenders • Wait Staff • Food Servicers, Non-restaurant • Dining Room and Cafeteria Attendants and Bartender Helpers • Chefs and Cooks • Food Preparation Workers • Fast Food and Counter Workers • Dishwashers • Host Staff, Restaurant, Lounge, and Coffee Shop • Bakers	• Gambling Dealers • Gambling Change Persons and Booth Cashiers • Gambling Cage Workers • Gambling and Sports Book Writers and Runners • Dancers • Musicians and Singers • Disc Jockeys, Except Radio • Entertainers and Performers • Digital Content Creators • Ushers, Lobby Attendants, and Ticket Takers • Locker Room, Coatroom, and Dressing Room Attendants	• Baggage Porters and Bellhops • Concierges • Hotel, Motel, and Resort Desk Clerks • Maids and Housekeeping Cleaners	• Home Maintenance and Repair Workers • Home Landscaping and Groundskeeping Workers • Home Electricians • Home Plumbers • Home Heating and Air Conditioning Mechanics and Installers • Home Appliance Installers and Repairers • Home Cleaning Service Workers • Locksmiths • Roadside Assistance Workers	• Personal Care and Service Workers • Private Event Planners • Private Event and Portrait Photographer • Private Event Videographer • Event Officiants • Pet Caretakers • Tutors • Nannies and Babysitters	• Skincare Specialists • Massage Therapists • Barbers, Hairdressers, Hairstylists, and Cosmetologist • Shampooers • Manicurists and Pedicurists • Eyebrow Threading and Waxing Technicians • Makeup Artists • Exercise Trainers and Group Fitness Instructors • Tattoo Artists and Piercers • Tailors • Shoe and Leather Workers and Repairers	• Golf Caddies • Self-Enrichment Teachers • Recreational and Tour Pilots • Tour Guides and Escorts • Travel Guides • Sports and Recreation Instructors	• Parking and Valet Attendants • Taxi and Rideshare Drivers and Chauffeurs • Shuttle Drivers • Goods Delivery People • Personal Vehicle and Equipment Cleaners • Private and Charter Bus Drivers • Water Taxi Operators and Charter Boat Workers • Rickshaw, Pedicab, and Carriage Drivers • Home Movers

Executive Orders

Executive Orders in context

- Executive Orders are not laws
  - Executive Orders have neither written nor repealed any statutes
  - However, Executive Orders can be an indicator of agendas and laws that Congress may seek to pursue (*particularly if one party controls the legislative and executive branches*)
- Executive Orders do not directly regulate private employers
  - Federal workforce can be directly impacted (and has been)
- Executive Orders can direct federal agency agendas and focus
  - Agency interpretation and enforcement (or non-enforcement) of laws and regulations can impact private employers
- State laws and agencies are not impacted by EOs and can be more onerous for employers than federal laws and agency initiatives

Immigration

- "Securing Our Borders" Executive Order focuses on a number of things, including:
  - Detaining "aliens apprehended on suspicion of violating Federal or State law," i.e., undocumented migrants and removing them promptly
  - Pursuing criminal charges against undocumented migrants and "those who facilitate their unlawful presence in the United States," notably ending the practice of "catch-and-release"
  - Enacting federal-state partnerships to enforce these immigration policies
- EO has been accompanied by increased ICE enforcement (*discussed later*)

Gender identity

- "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government"
  - Directs federal agencies to "enforce laws governing sex-based rights, protections, opportunities, and accommodations to protect men and women as biologically distinct sexes."
    - EEOC Acting Chair promptly removed most EEOC guidance on gender identity from website
    - EEOC is making it a priority through compliance, investigations, and litigation to "defend biological and binary definitions of sex and related rights"
    - EEOC "Know Your Rights" poster is being reviewed and will likely remove "sexual orientation" and "gender identity"
  - EO sets up conflict with Supreme Court decision from 2020 (*Bostock v. Clayton County*) that concluded that the protected category of "sex" under Title VII included sexual orientation and gender identity
  - Many state laws explicitly protect sexual orientation and gender identity
    - North Carolina does not have explicit statutory protections

Discrimination claims

- "Restoring Equality of Opportunity and Meritocracy"
  - Directs federal agencies to discontinue enforcement of "disparate impact" discrimination claims
    - A facially neutral policy or practice that happens to disproportionately exclude or target one or more protected categories
  - Agencies will comply…
    - EEOC will still have to accept disparate impact claims
    - EEOC is unlikely to do much by way of investigation
    - EEOC will almost certainly not file new lawsuits involving disparate impact
    - EEOC may drop existing disparate impact litigation
  - …but disparate impact claims are still formally baked into Title VII
    - Employers will still be subject to individual disparate impact lawsuits
    - State agencies are likely to continue enforcement

Affirmative Action

- "Ending Illegal Discrimination and Restoring Merit-Based Opportunity"
  - Revokes EO 11246 (*which was issued in 1965*) requiring affirmative action compliance with respect to race and gender for direct/indirect federal contractors
    - OFCCP ordered to stop all enforcement activity and close any open audits related to EO 11246
  - However, AAP requirements continue to exist under Section 503 of the Rehabilitation Act (*regarding individuals with disabilities*) and VEVRAA (*regarding certain veterans*)
    - Acting DOL Secretary issued an order requiring OFCCP to notify all parties with open reviews or investigations that 11246-related actions are closed, and that "the Section 503 and VEVRAA components of the review or investigation are being held in abeyance pending further guidance"
  - EO doesn't prohibit private employer DEI programs, and, instead, focuses on "illegal" DEI programs, such as explicit hiring/promotion quotas
    - Many common private employer DEI practices most likely don't rise to the level of "illegal"

Agency regulations

- "Regulatory Freeze Pending Review"
  - Suspends any agency rules/regulations that haven't already been published in final form
  - Two pending OSHA rules immediately impacted:
    - "Heat Injury and Illness Prevention in Outdoor and Indoor Work Settings"
    - "Emergency Response Standard"
- "Unleashing Prosperity Through Deregulation"
  - Requires that for each new regulation issued, "at least 10 prior regulations be identified for elimination"

Federal Agency Activity

Equal Employment Opportunity Commission

- Final confirmation of EEOC commissioners still pending, but republicans will eventually have a 2-1 majority
  - Shift focus away from enforcement efforts in connection with historically minority communities (i.e., "group outcomes", particularly in connection with race and gender) to the rights of all individuals
  - Heightened scrutiny of discrimination within DEI programs
    - Giving preferential treatment to any racial or gender group
    - Misapplication of affirmative action
    - Focusing on group metrics
  - National Origin Bias: Ensuring that U.S. workers are protected from "anti-American national origin discrimination"
  - Sex-Based Rights: Defending women's rights to single-sex spaces, such as bathrooms and locker rooms, in the workplace
  - Religious Freedom: Combating religious bias and safeguarding workers' rights to express and practice their beliefs without fear of discrimination
    - Office of Personnel Management memo allows federal employees to persuade coworkers of the correctness of their religious views (i.e., proselytize), if it's not harassing in nature
- EEO-1
  - Option to provide information about non-binary employees eliminated

Equal Employment Opportunity Commission

- EEOC issued two "DEI" related guidances:
  - "What to do if you experience DEI-related discrimination at work"
  - "What you should know about DEI-related discrimination at work"
  - Neither guidance creates a new standard for "illegal DEI", so any DEI practices that would violate Title VII continue to be "illegal"
- All active Charges of Discrimination are being reviewed to ensure that they "comply with applicable executive orders to the fullest extent possible."
- EEOC has recently moved to dismiss lawsuits it has brought on behalf of employees who experienced workplace gender identity discrimination
- Multiple lawsuits challenging EEOC's final PWFA Rule that includes "having or choosing not to have an abortion" in the definition of "pregnancy, childbirth, or related medical conditions" entitled to accommodations
  - EEOC unlikely to enforce the PWFA Rule in connection with employee abortion decisions and the Rule may eventually be rescinded or revised

Department of Justice

- DOJ issued Memorandum: "Ending Illegal DEI and DEIA Discrimination and Preferences"
  - Directs DOJ divisions to create a report with recommendations for "enforcing federal civil-rights laws and taking other appropriate measures to encourage the private sector to end illegal discrimination and preferences, including policies relating to DEI and DEIA"
- DOJ has rescinded 11 different guidance documents regarding how businesses should accommodate or provide access to their goods and services to disabled members of the public

Department of Labor

- DOL issued has paused all enforcement of Biden-era independent contractor status Rules, and issued Agenda to eliminate those Rules without replacing
  - As a result, it's easier to be an independent contactor, but beware of state standards
- New guidance on joint employment expected in December
  - Important for determining who is responsible for labor law compliance
- $15/hour minimum wage for federal contractors rescinded
- Proposal to eliminate the OFCCP and transfer Section 503 enforcement to EEOC and VEVRAA enforcement to Veterans' Employment and Training Service
- Wage and hour initiatives the new administration and/or DOL could pursue:
  - Comp time for private employers?
  - Overtime calculated on a biweekly basis rather than weekly?
  - Federal paid family leave law that preempts state PFL laws?

Immigration and Customs Enforcement

- Increased raids and enforcement
  - Visa sponsorship compliance
  - I-9 compliance
  - Administrative warrants and subpoenas
    - Employers do not need to comply or allow access (*outside of public spaces*)
  - Judicial warrants and subpoenas (*search v. arrest*)
    - Employers generally must comply and allow access
- Potential impacts
  - Worksite disruptions and absences as undocumented workers or those living in mixed-status families may be concerned about coming to work
  - I-9 audits can lead to civil fines up to $2,789 per form and up to $5,579 for knowingly hiring undocumented workers (*for a first offense*)
  - Criminal charges and penalties of up to 10 years and fines of up to $250,000 for harboring undocumented workers
  - Loss of federal contracts
  - Operational disruptions and public relations challenges

Immigration and Customs Enforcement

- Revamping of H-1B program proposed in July
  - Proposal to replace current lottery system for awarding visas with a “weighted selection process”
  - Favors higher wage jobs at well-funded companies (particular tech industry)
  - Education and healthcare positions likely to be deemphasized
- Proposed changes to F-1 student and J-1 exchange work visas
  - Proposal would eliminate any work eligibility beyond completion of academic program and confine such students to a total of 4 years of “lawful status”
    - Currently OPT and STEM-OPT programs allow up to 24 months of work eligibility post-program completion
    - Students will have to file formal OPT extension request in order to be approved for OPT work status
    - Approval process is likely to reduce OPT work opportunities

Occupational Safety & Health Administration

- A Republican Congressman has introduced a bill to repeal the Occupational Safety and Health Act of 1970 entirely and abolish the Occupational Safety and Health Administration (OSHA)
  - Seems unlikely to pass, but agency funding may well be impacted
  - As we've already seen with other agencies, new leadership will likely refocus enforcement agenda and enforcement efforts
- OSHA Walkaround Rule effective 5/31/2024 allowed employees to request that third-parties (such as union officials or attorneys) participate in OSHA workplace inspections
  - Currently subject to legal challenges
  - It seems likely the administration will rescind the Rule

National Labor Relations Board

- NLRB is currently without a quorum, but the administration has nominated two employer-friendly appointees, which will give Republicans majority representation
  - Former General Counsel issued several employee-friendly memoranda regarding common employer practices she claimed impinged on the right to engage in protected concerted activity
    - Restrictions on certain common handbook policy provisions
    - Restrictions on stay-or-pay requirements with employees
    - Restrictions on confidentiality, non-disparagement, and non-compete agreements
  - Former GC's memoranda have been rescinded
- Organizing without an election likely to become more difficult
- Captive audience meeting prohibition likely to be rescinded
  - Several states have enacted similar prohibitions

Federal Trade Commission

- In May of 2024, FTC issued a Non-Compete Clause Rule prohibiting most non-compete agreements nationwide as unfair restrictions on trade
- In August of 2024, as a result of several court actions, a nationwide injunction was issued preventing the FTC from enforcing the Rule
- On September 5, 2025, FTC dropped further appeals of the nationwide injunction
  - An FTC memo from 2/26/2025 announced the creation of a task force examining “deceptive, unfair, and anticompetitive” labor practices, with non-competes being a key focus
- Regardless of the FTC, many states have some form of non-compete prohibitions, and that trend is likely to continue
  - North Carolina does not currently prohibit non-competes, but courts cast a critical eye on such agreements

Supreme Court

Agency deference

- The impacts of the *Loper Bright* decision issued in June 2024 will likely gain steam
  - Decision eliminated the judicial standard of *Chevron* deference in place since 1984
    - *Chevron* basically required courts to give deference to federal agency interpretations of statutes if there is ambiguity in the statutory language
  - *Loper Bright* prohibits courts from automatically deferring to agency interpretation just because statutory language is ambiguous, and requires courts to exercise independent judgement in deciding whether an agency has acted within its statutory authority
  - There already have been and will continue to be a flurry of legal challenges to long-standing regulatory and agency interpretive practices
    - Example: whether the DOL has the authority to establish a salary threshold at all for exemption status
    - Example: whether EEOC overstepped its authority when including accommodations for abortion in its regulations related to the Pregnant Workers Fairness Act
    - Example: OSHA Walkaround Rule giving third-parties right to attend OSHA workplace inspections

Discrimination standard of proof

- *Muldrow* decision issued in April of 2024 lowered the standard of proof necessary to establish "adverse action" in the context of Title VII discrimination cases
  - Plaintiffs no longer required to demonstrate that the harm they suffered was "significant", "serious", "substantial", or any other "heightened bar"
    - Transfer to less desirable schedule or loss of job responsibilities v. reducing pay or terminating employment
  - Plaintiffs should have a greater chance of succeeding in court
- New EEOC positions on sexual orientation and gender identity coupled with lower standard of proof could lead to more court enforcement actions rather than agency managed investigations/mediations
  - EEOC may issue right-to-due letters for pending investigations involving sexual orientation or gender identity

Title VII and FLSA decisions

- "Reverse discrimination" no longer subject to a higher standard of proof than other forms of discrimination claims
  - Employees from "majority backgrounds" (such as White, male, or heterosexual employees) no longer have a higher standard of proof for discrimination claims
- The standard of proof for employers to prove that their employees are exempt under the FLSA has been lowered from "clear and convincing evidence" to a "preponderance of evidence"
  - It is now easier to defend in court an employer's determination that a position is exempt under the FLSA
  - Lower evidentiary standard does not eliminate need to properly assess exemption status for all positions

State Initiatives

Proactive and reactive

- Likely state level trends:
  - Earned paid leave laws (*23 states + D.C.*)
  - Paid Family and/or Medical Leave laws (*14 states + D.C.*)
  - Leaves/protections related to domestic violence, stalking, and sexual assault
  - Pay transparency (*14 states + DC have laws*)
  - Non-compete restrictions
  - Expansive joint employer tests
  - Restrictive independent contractor tests (*including gig/freelance workers*)
  - Captive audience meeting prohibitions
  - Cannabis legalization (*medical and/or recreational*)
  - Consumer protection laws
  - AI restriction laws
  - Reducing restrictions on minors in the workplace

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Thank you!

To learn more about our Hotline:

employerhotline@usi.com

Time for a *Quick Round*

Innovators in Employer Health

Format

Each speaker will have *only* 5 minutes
to convey their innovative product/service

Innovator #1: Mark Burgin

Genomic Life is a genetics-based healthcare navigation company seeking to create a healthier workforce.

GENOMIC LIFE

GENOMIC LIFE

“If you want to stop this cancer in your family…”

For Prevention

Predispositions

- Cancer, Cardiovascular, Metabolic

Medication Responsiveness

- Pharmacogenomics

Family Planning

For those with cancer

Treatment Decisions

- Tumor sequencing, pharmacogenomics

Precision Medicine

- Targeted therapies, clinical trials

Family Follow-up Testing

GENOMIC LIFE

Target high-cost conditions with genetics-based healthcare navigation

Available to all employees and spouses as employee paid or employer funded

1

DNA Screenings

Identify members at risk of cancer, heart conditions, adverse drug reactions, and more.

~1 in 5

members had an increased genetic risk for a medically actionable condition[1]

2

Personalized Guidance

Tailor health actions to enable prevention, screening, and early detection.

70%

of people are behind on at least one cancer screening[2]

3

Cancer Navigation

Support cancer patients and survivors with genetics-optimized care and expert 1-on-1 navigation

16%

reduction in total cost of care for cancer patients utilizing navigation[3]

[1] Data report available upon request [2] Prevent cancer foundation [3] https://ascopubs.org/doi/10.1200/OP.2023.19.11_suppl.557

Privacy & Security

- We do not sell data
- Annual 3rd-party cybersecurity audits

Flexible Plan Designs

- Employee paid
- Opt-in program
- Cancer Solution with employee buy up

Key Outcomes

- Guides high-risk members to prevention
- Gets to the right cancer treatment the first time

340B
What Employers Need to Know

Shawn Gremminger

President & CEO

National Alliance of Healthcare Purchaser Coalitions

340B Drug Pricing Program

Basics, Employer Impact and State & Federal Reform

National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Agenda

- **340B 101:** Origins of the Program and Where We are Today
- **Why it Matters:** 340B's Impact on Employers, Purchasers, and Working Families
- **Deep Dive on the Tarheel State**
- **What Next:** Reform Proposals

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340B 101

Origins of the Program and Where We are Today

340B 101

What is 340B?

Federally run outpatient drug program intended to improve certain qualifying hospital and clinics' access to care for vulnerable patients

Why was it created?

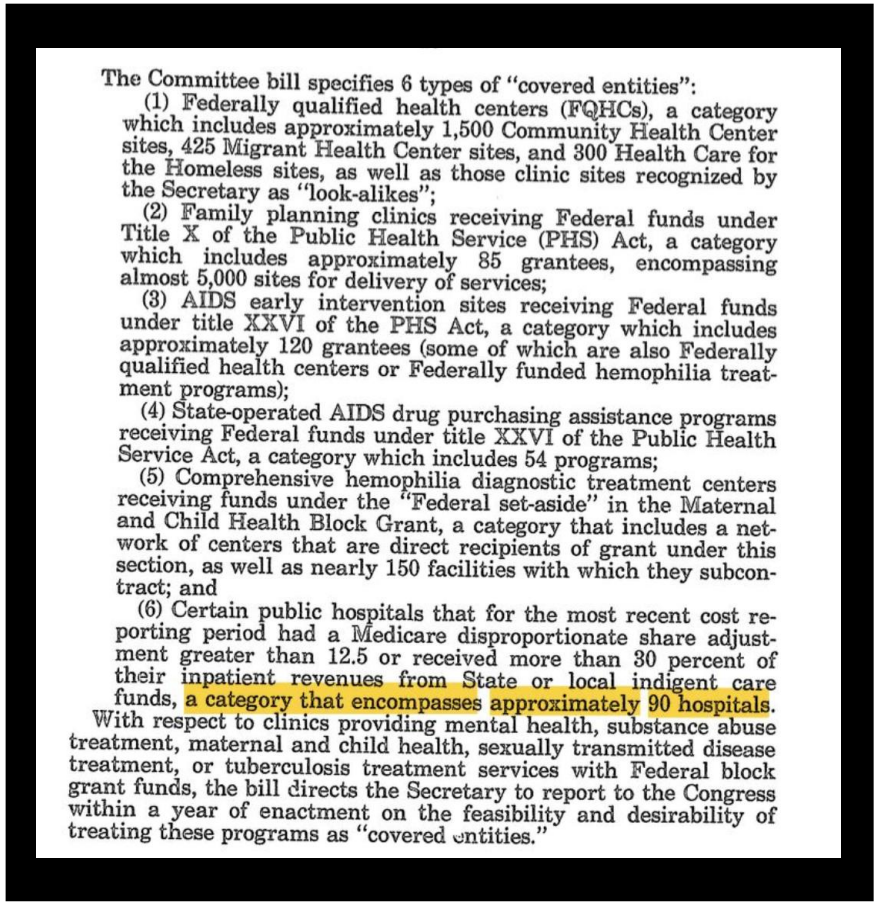
Sought to address unintended consequences of the 1990 Medicaid "best price" drug rebate statute and ensure continued discounts for safety-net providers

How does it work?

Eligible providers ("covered entities" or CEs) purchase outpatient drugs at a discounted "ceiling price," then sell drugs to patients at prevailing rate

How has it changed?

Shifts in the healthcare system and policy changes have expanded the pool of eligible providers, causing exponential growth over the past two decades



The Committee bill specifies 6 types of "covered entities":
(1) Federally qualified health centers (FQHCs), a category which includes approximately 1,500 Community Health Center sites, 425 Migrant Health Center sites, and 300 Health Care for the Homeless sites, as well as those clinic sites recognized by the Secretary as "look-alikes";
(2) Family planning clinics receiving Federal funds under Title X of the Public Health Service (PHS) Act, a category which includes approximately 85 grantees, encompassing almost 5,000 sites for delivery of services;
(3) AIDS early intervention sites receiving Federal funds under title XXVI of the PHS Act, a category which includes approximately 120 grantees (some of which are also Federally qualified health centers or Federally funded hemophilia treatment programs);
(4) State-operated AIDS drug purchasing assistance programs receiving Federal funds under title XXVI of the Public Health Service Act, a category which includes 54 programs;
(5) Comprehensive hemophilia diagnostic treatment centers receiving funds under the "Federal set-aside" in the Maternal and Child Health Block Grant, a category that includes a network of centers that are direct recipients of grant under this section, as well as nearly 150 facilities with which they subcontract; and
(6) Certain public hospitals that for the most recent cost reporting period had a Medicare disproportionate share adjustment greater than 12.5 or received more than 30 percent of their inpatient revenues from State or local indigent care funds, a category that encompasses approximately 90 hospitals.
With respect to clinics providing mental health, substance abuse treatment, maternal and child health, sexually transmitted disease treatment, or tuberculosis treatment services with Federal block grant funds, the bill directs the Secretary to report to the Congress within a year of enactment on the feasibility and desirability of treating these programs as "covered entities."

Committee on Energy and Commerce Report to Accompany H.R. 2890, Sept. 22, 1992

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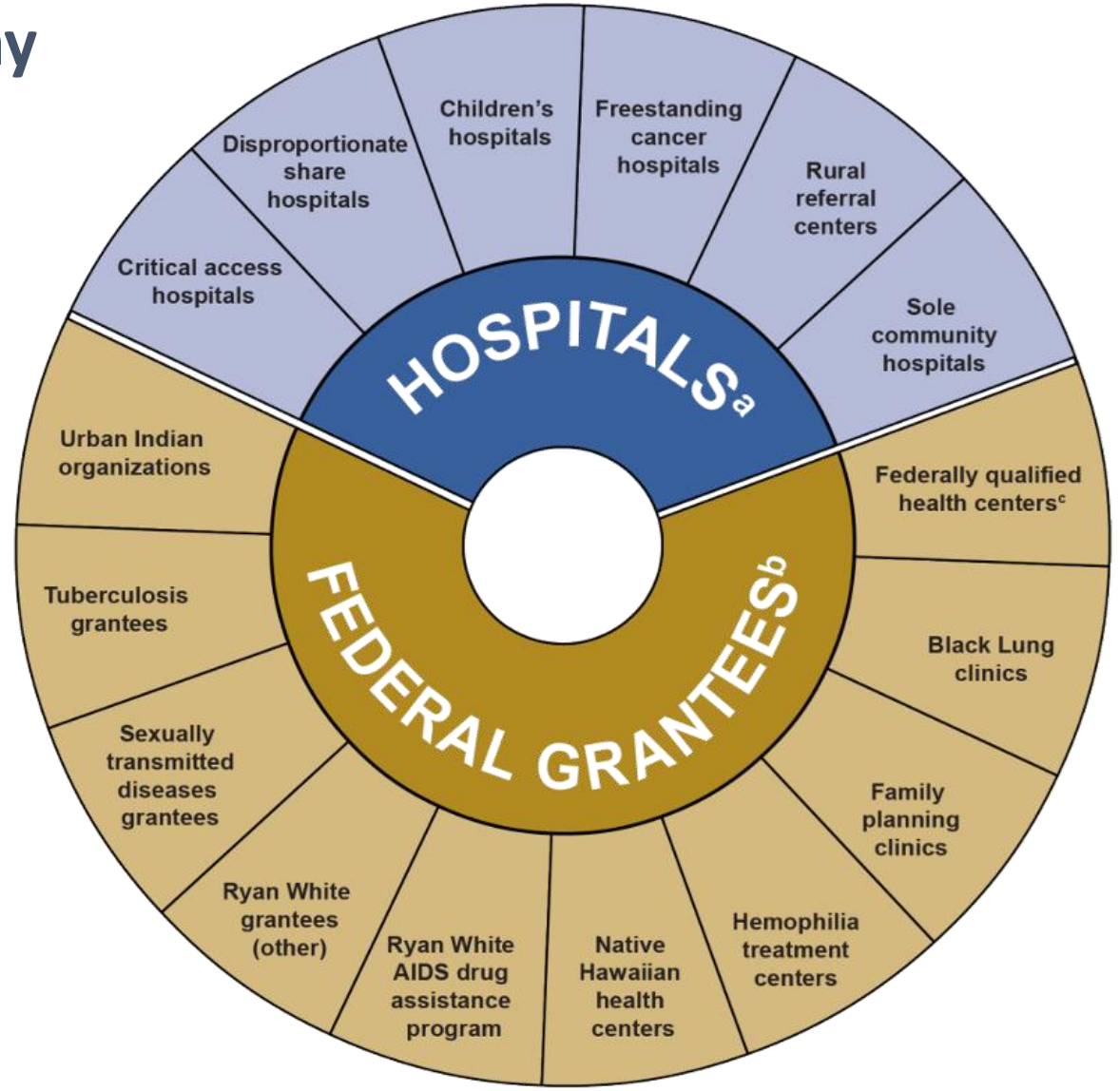
Types of 340B-Eligible Providers Today

340B-eligible providers include certain qualifying hospitals and federal grantees.



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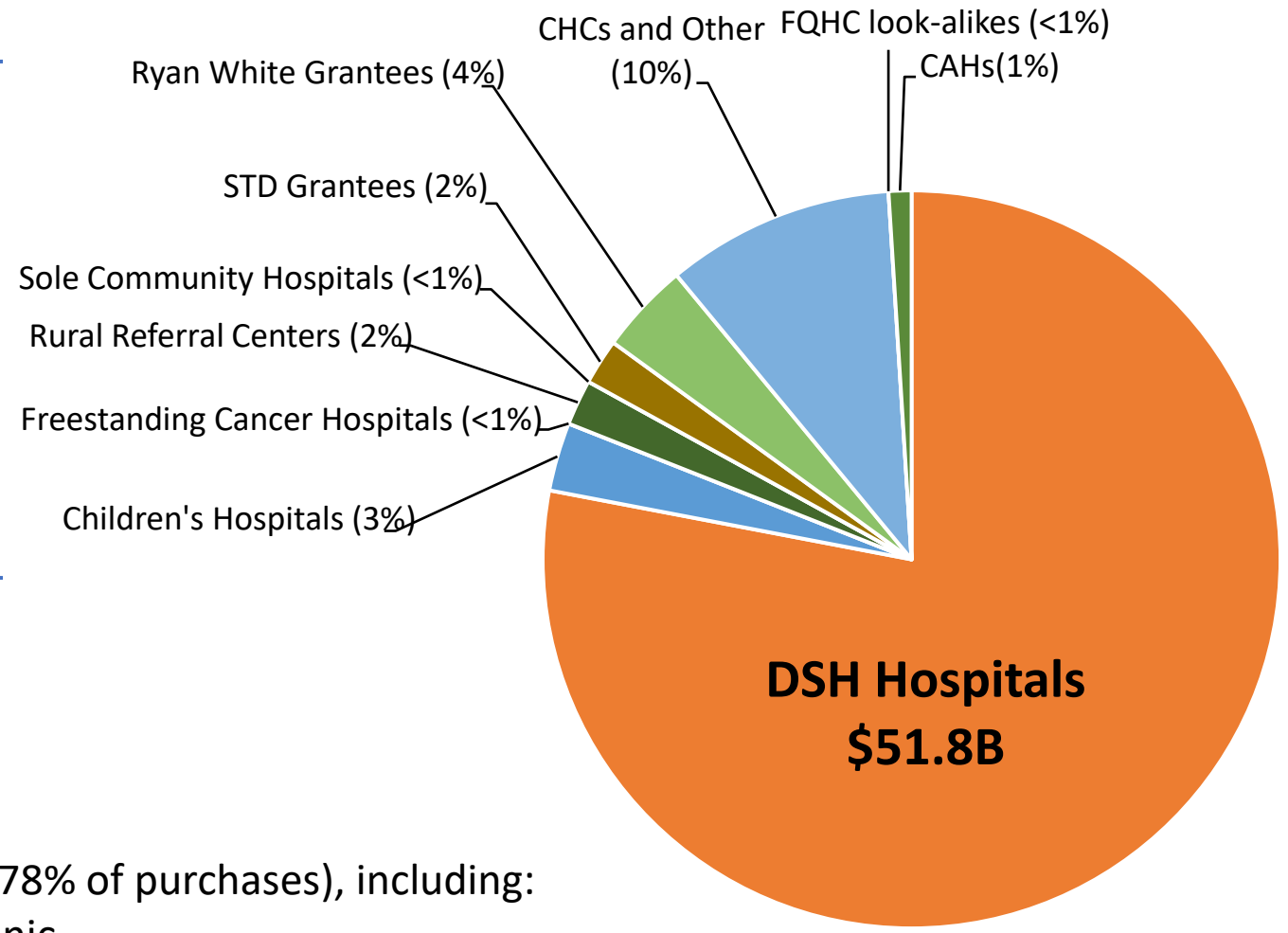
2022 340B Covered Entity Purchases. HRSA

340B Providers in 2023

Out of $66.3B in total 2023 purchases…

$14.5B — **Federal grantees & other hospitals**



FQHC: Federally-Qualified Health Center
CAH: Critical Access Hospital
DSH: Disproportionate Share Hospital

$51.8B

DSH Hospitals (78% of purchases), including:

- Cleveland Clinic
- Duke University
- Cedars-Sinai

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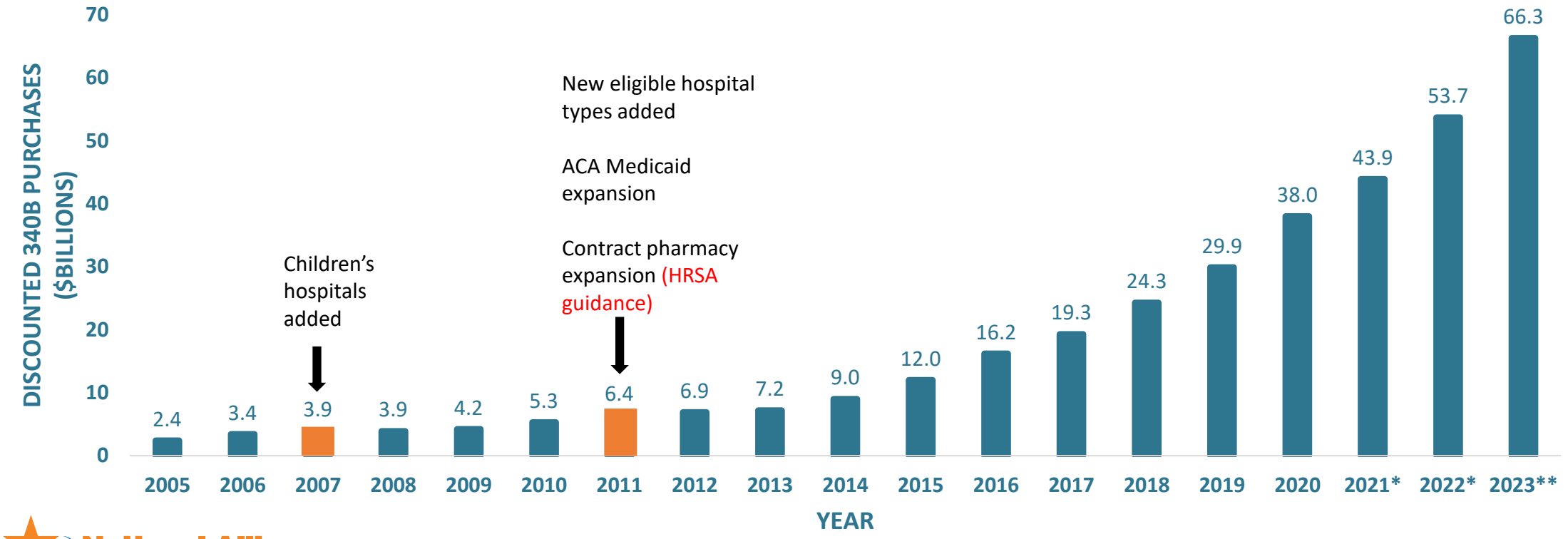
2023 340B Covered Entity Purchases. HRSA

Explosive Program Growth Over Time

340B is now the **second-largest government pharmaceutical program**, based on net drug spending

Figure 4: Total Discounted 340B, 2005-2023



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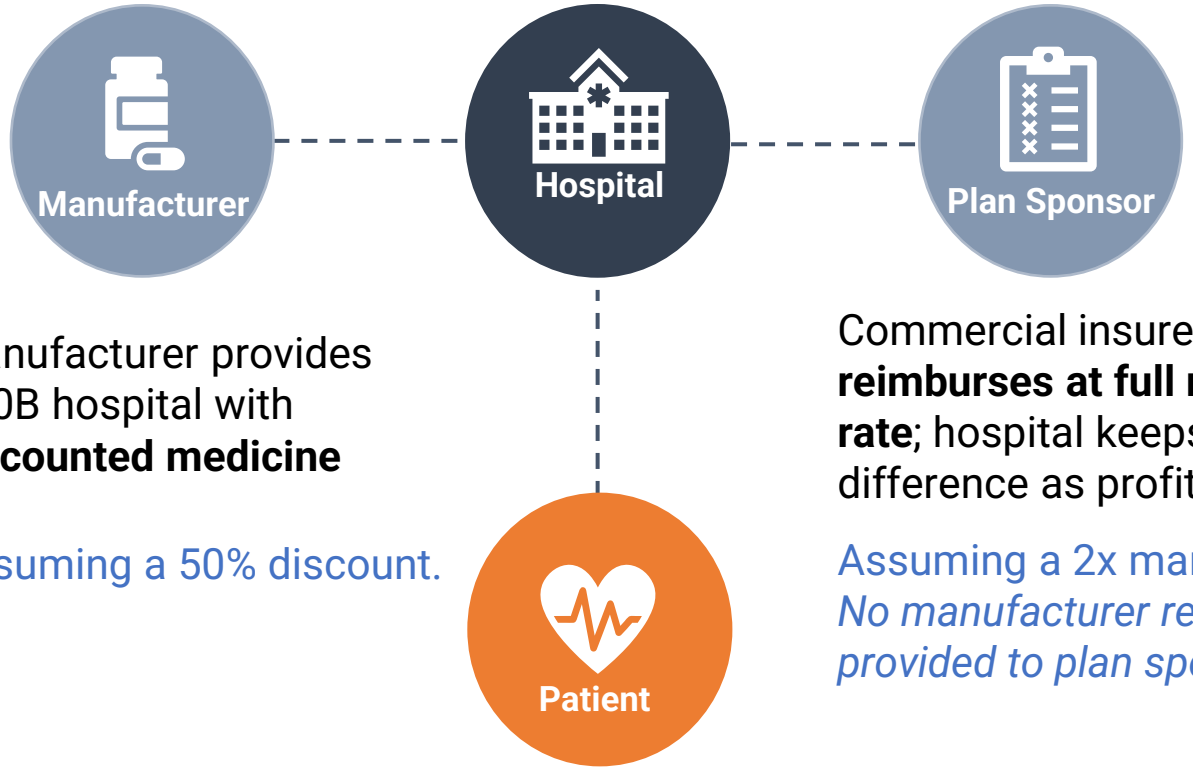
The 340B Drug Pricing Program: Background, Ongoing Challenges and Recent Developments. USC Schaeffer Center for Health Policy and Economics
* The 340B Program Reached $54 Billion in 2022—Up 22% vs. 2021. Drug Channels Institute
** 2023 340B Covered Entity Purchases. HRSA

Buy 340B-Low, Sell Commercial Insurance-High: An Arbitrage Scheme



Manufacturer provides 340B hospital with **discounted medicine**

Assuming a 50% discount.

Commercial insurer **reimburses at full negotiated rate**; hospital keeps difference as profit

Assuming a 2x mark up price. *No manufacturer rebate provided to plan sponsor*

340B hospital provides **medicines to 340B "patients,"** including those with commercial insurance.

Discounts not required to be passed to patients; patient may be subject to copay / coinsurance.

Illustrative example assuming $1,000 medicine, $2,000 commercial reimbursement

-$500	Hospital buys medicine at discounted 340B price
+$1,400	Hospital reimbursed at negotiated price by commercial insurer
+$600	Hospital receives 30% coinsurance from patient based on negotiated price

+$1,500 **profit for 340B hospital**

No requirement for hospital to share with patients

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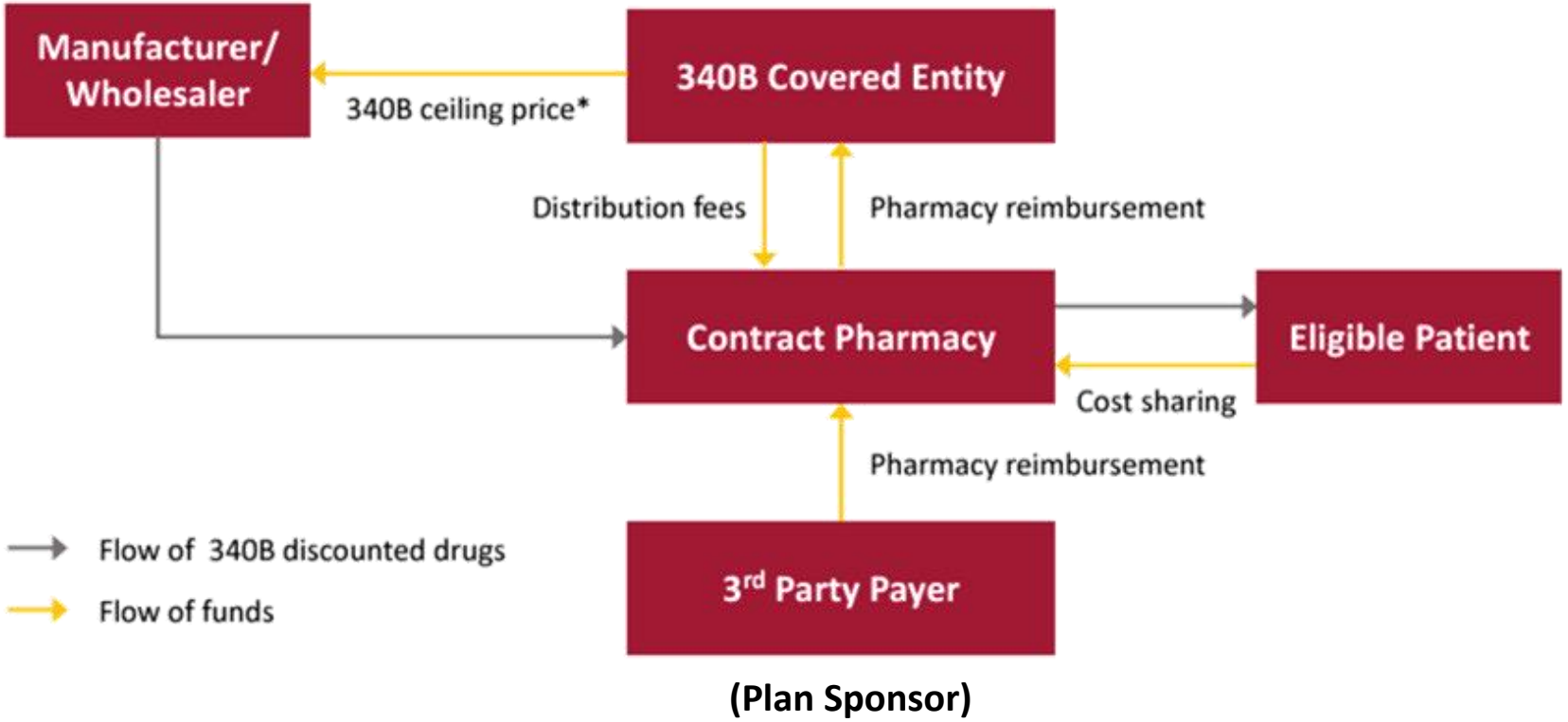
340B Business Model Under Contract Pharmacy

340B hospitals can also contract with external pharmacies, who receive reimbursement fees of **up to 20% of the commercial insurance reimbursement rate** on a given 340B prescription.



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Driving Health, Equity and Value

Federal Oversight of Compliance at 340B Contract Pharmacies Needs Improvement. Government Accountability Office (page 56).
The 340B Drug Pricing Program: Background, Ongoing Challenges and Recent Developments. USC Schaeffer Center for Health Policy and Economics

Why it Matters

340B's Impact on Employers and Working Families

The 340B Program is Broken

- Hospitals arbitrage by **purchasing drugs at steep discounts** and **selling** to patients at prevailing (negotiated) rates
- 340B contributes to rampant horizontal and vertical **consolidation**
- **For-profit pharmacy chains and PBMs** increasingly profit off 340B; program **incentivizes use of higher-priced drugs**
- **Public and private employers are footing the bill** as 340B revenue soars, overall cost of care accelerates, and charity care remains stagnant

GAO **340B Drug Discount Program:** ***Increased Oversight Needed to Ensure Nongovernmental Hospitals Meet Eligibility Requirements***

THE WALL STREET JOURNAL.

Many Hospitals Get Big Drug Discounts. That Doesn't Mean Markdowns for Patients

The New York Times

How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

340B Drives Rampant Horizontal and Vertical Consolidation

The appeal of increased profits from the 340B program is a **factor in health system consolidation** over the past two decades.

340B hospitals can **implement 340B pricing at all participating** outpatient clinics**, including previously independent physician offices** – which would previously be unable to qualify for 340B.

The NEW ENGLAND JOURNAL of MEDICINE

Consequences of the 340B Drug Pricing Program

Authors: Sunita Desai, Ph.D., and J. Michael McWilliams, M.D., Ph.D. Author Info & Affiliations

Published January 24, 2018 | N Engl J Med 2018;378:539-548 | DOI: 10.1056/NEJMsa1706475 | VOL. 378 NO. 6

"The 340B Program has been associated with hospital–physician consolidation in hematology–oncology and with more hospital-based administration of parenteral drugs in hematology–oncology and ophthalmology."

Avalere Health™

Analysis of Hospital Mergers and Acquisitions and 340B Status

Summary

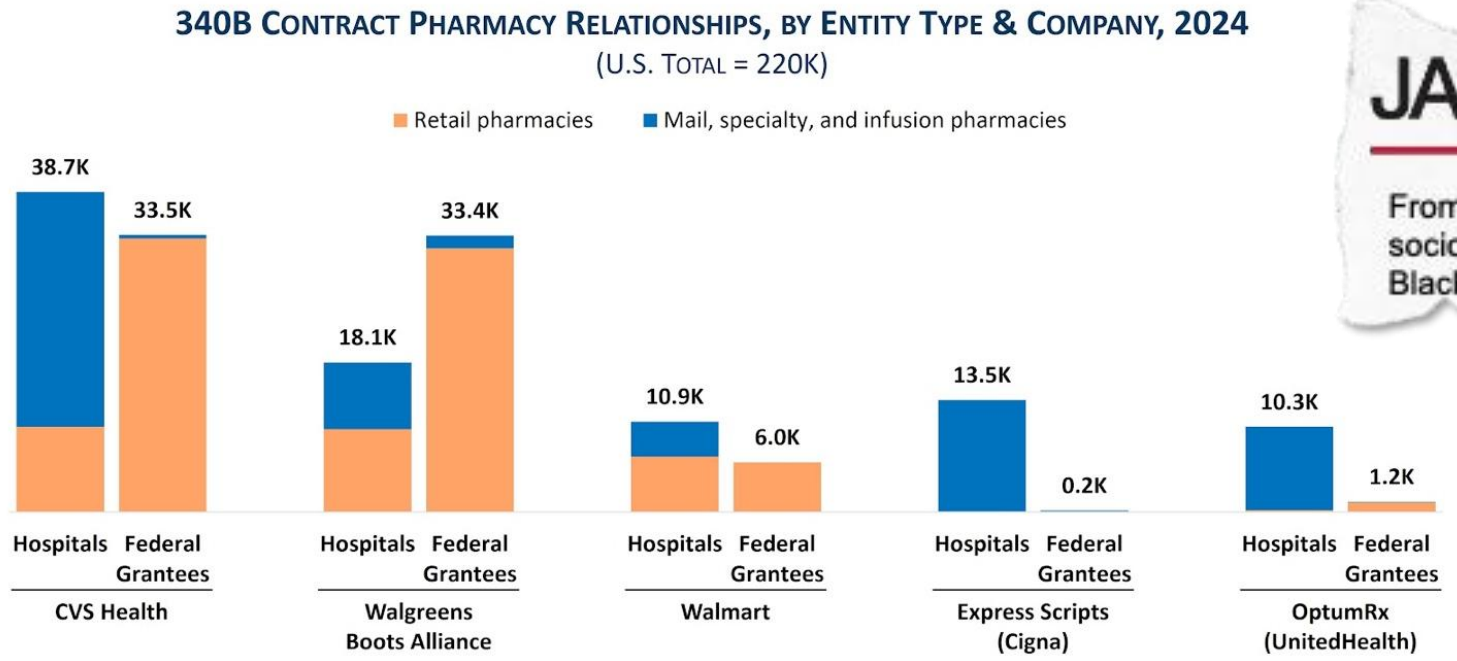
From 2016 to 2024, buyer hospitals undergoing mergers or acquisitions were more likely to be large (500+ beds) and 340B covered entities.

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

Consequences of the 340B Drug Pricing Program. The New England Journal of Medicine

Explosion of Contract Pharmacies

Since 2010, 340B hospitals have been allowed to contract with an unlimited number of external pharmacies. This has led to **explosive growth** in the 340B program by allowing hospitals to drive profits through **pharmacies in well-insured, wealthy neighborhoods**.



JAMA The Journal of the American Medical Association

From 2011 to 2019, the share of 340B retail pharmacies in socioeconomically disadvantaged and primarily non-Hispanic Black and Hispanic/Latino neighborhoods declined.

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Hospitals Are Relying More on PBMs to Manage Manufacturers' 340B Contract Pharmacy Restrictions: DCI's 2024 Market Analysis. Drug Channels Institute

Assessment of US Pharmacies Contracted With Health Care Institutions Under the 340B Drug Pricing Program by Neighborhood Socioeconomic Characteristics, JAMA Health Forum

340B Markups and Effect on Prescribing

- 340B's structure as an arbitrage system **encourages the prescription of higher-priced medicines** to capitalize on the spread.
  - 340B hospitals billed the **North Carolina state employee health plan** an average of **5.4x their 340B acquisition costs for oncology drugs**.
  - Average costs per prescription for commercially insured patients were **150% higher at 340B hospitals** vs. non-340B hospitals.
  - Oncology treatments from newly participating 340B hospitals cost **over $4,000 more** than at non-340B hospitals.
- These incentives in 340B have been found to **limit biosimilar uptake at 340B hospitals.**

HealthAffairs

"Our findings suggest that **the [340B] program inhibited biosimilar uptake**, possibly as a result of financial incentives making reference drugs more profitable than biosimilar medications…340B program eligibility was associated with a **22.9 percentage-point reduction in biosimilar adoption**"

National Alliance of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

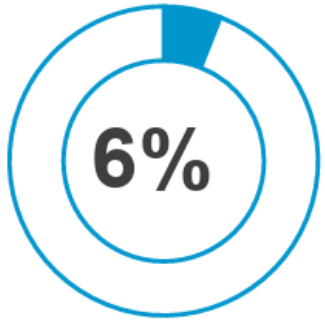
The Role of Financial Incentives in Biosimilar Uptake in Medicare: Evidence From the 340B Program. Health Affairs
Analysis of 2020 Commercial Outpatient Drug Spending at 340B Participating Hospitals. Milliman
Association Between New 340B Program Participation and Commercial Insurance Spending on Outpatient Biologic Oncology Drugs. *JAMA Health Forum*
Examining Hospital Price Transparency, Drug Profits, and the 340B Program 2021. Community Oncology Alliance
Overcharged: State Employees, Cancer Drugs, and the 340B Drug Pricing Program, North Carolina State Health Plan for Teachers and State Employees

Deep Dive on North Carolina

44% Nearly half of North Carolina's 119 hospitals participate in the 340B program, including:

- Carolinas Medical Center ($300 million net income)
- Atrium Health University City (37% positive margin)
- NC Baptist (1% charity care)

1.7x 340B hospitals in the state generate 1.7 times more in profits from the program than they spend on charity care.



North Carolina's 340B hospitals hold 1,716 contracts with 340B pharmacies. Only **6%** of in-state pharmacies are located in areas with below median family incomes.

IQVIA report found that 340B increases healthcare costs by **$97 per beneficiary** due to lost rebates, raising overall healthcare costs by more **than $457 million** per year for North Carolina businesses and families.

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Driving Health, Equity and Value

Bottom Line: Employers and Employees are Paying More Because of 340B

340B's "buy low, sell high" **model directly leads to higher drug costs and overall spending for public and private employers** via:

- Horizontal and vertical consolidation
- Lost rebates on 340B medicines, with profits instead going to chain pharmacies and PBMs
- Distorted prescribing patterns favoring higher-cost drugs

Meanwhile, **patients and communities are largely not benefiting** while healthcare costs rise system-wide.

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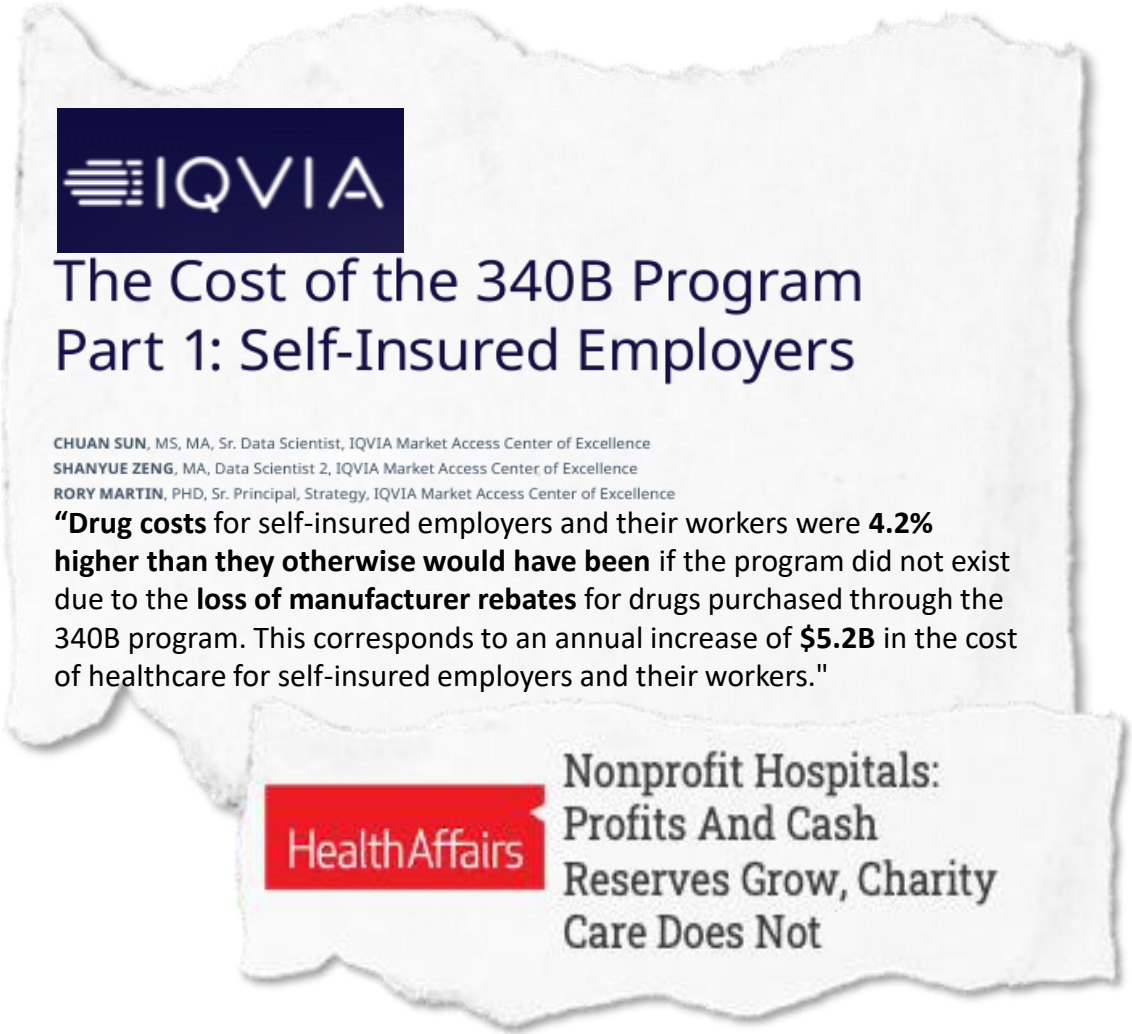


The Cost of the 340B Program Part 1: Self-Insured Employers. IQVIA
Nonprofit Hospitals: Profits and Cash Reserves Grow, Charity Care Does Not. Health Affairs

What's Next

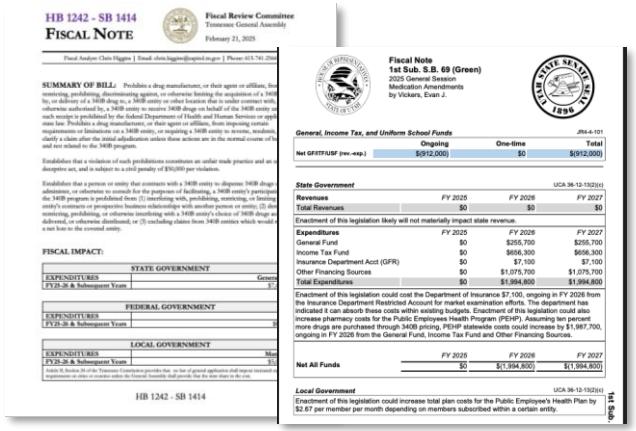
340B Reform Proposals

States Need More Clarity Before Locking In 340B Expansion

Data from various states show **significant budgetary impacts** of locking in contract pharmacy profits and underscore the **importance of transparency** requirements.

Tennessee: Fiscal note found an impact of **$7.5M** (state) and **$5M (**local health plans) over time;

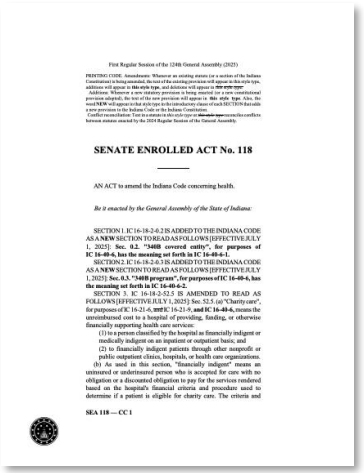
Utah: estimated **$2M a year** in state health plan expenditures


HB 1242 - SB 1414
FISCAL NOTE
Fiscal Review Committee
Tennessee General Assembly
February 21, 2025
SUMMARY OF BILL:
FISCAL IMPACT:
STATE GOVERNMENT
FEDERAL GOVERNMENT
LOCAL GOVERNMENT
HB 1242 - SB 1414
Fiscal Note
1st Sub. S.B. 69 (Green)
2025 General Session
Medication Amendments
by Vickers, Evan J.
General, Income Tax, and Uniform School Funds
State Government
Revenues
Total Revenues
Enactment of this legislation likely will not materially impact state revenue.
Expenditures
General Fund
Income Tax Fund
Insurance Department Acct (GFR)
Other Financing Sources
Total Expenditures
Enactment of this legislation could cost the Department of Insurance $7,100, ongoing in FY 2026 from the Insurance Department Restricted Account for market examination efforts. The department has indicated it can absorb these costs within existing budgets. Enactment of this legislation could also increase pharmacy costs for the Public Employees Health Program (PEHP). Assuming ten percent more drugs are purchased through 340B pricing, PEHP statewide costs could increase by $1,987,700, ongoing in FY 2026 from the General Fund, Income Tax Fund and Other Financing Sources.
Net All Funds
Local Government
Enactment of this legislation could increase total plan costs for the Public Employee's Health Plan by $2.67 per member per month depending on members subscribed within a certain entity.
1st Sub

Minnesota: Report found that **one urban hospital** earned more from 340B **than all rural hospitals and health centers combined**


DEPARTMENT OF HEALTH
340B Covered Entity Report
REPORT TO THE LEGISLATURE
November 25, 2024

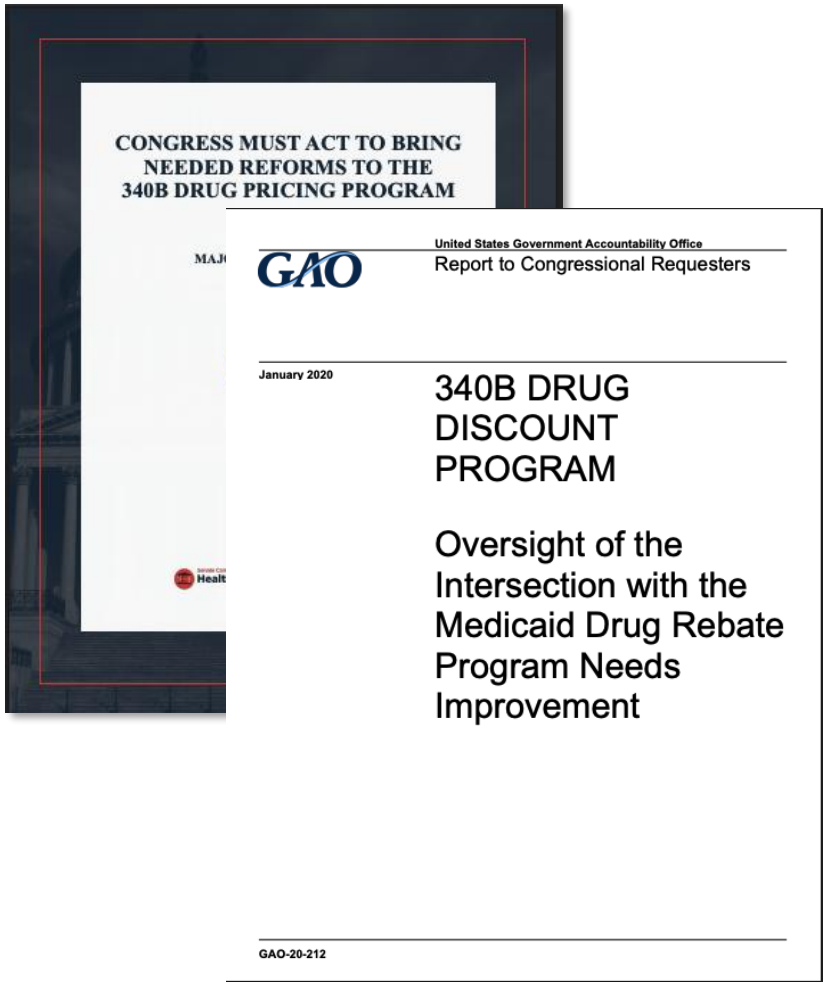
Indiana: **First state** in the country to **require hospitals** to report **how 340B revenue is used**


First Regular Session of the 124th General Assembly (2025)
SENATE ENROLLED ACT No. 118
AN ACT to amend the Indiana Code concerning health.
Be it enacted by the General Assembly of the State of Indiana:
SEA 118 — CC 1

HB1242 - SB 1414 Fiscal Note, TN General Assembly
Fiscal Note, 1st Sub. SB 69, UT State Senate
The Cost of the 340B Program to the States. IQVIA
340B Covered Entity Report, MN Dept of Health
Senate Enrolled Act No. 118, IN General Assembly

State-focused Voice Needed to Inform Federal Efforts

- Federal oversight is minimal and needs improvement
- Congressional action continues to lag behind state policymakers – and fails to consider impact of program on states
- Common-sense reforms at federal level are needed to build on state efforts and:
  - Promote transparency and accountability
  - Rein in costs for public and private health plans, state Medicaid programs
  - Ensure the program is helping the patients it was meant to serve



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Driving Health, Equity and Value

Congress Must Act to Bring Needed Reforms to the 340B Drug Pricing Program. Senate HELP Majority Staff.
Oversight of the Intersection with the Medicaid Drug Rebate Program Needs Improvement. GAO

Thank you!

Time for another *Quick Round*

Innovators in Employer Health

Format

Each speaker will have *only* 5 minutes
to convey their innovative product/service

Innovator #2: Sarah Jarecki

goodpath

WHOLE PERSON CARE FOR CHRONIC CONDITIONS

Weight Management

GLP-1 Care

Diabetes

Mental Health

MSK

Digestive Health

Cancer Quality of Life

Sleep & Insomnia

GLP-1s?

You’ve had to make hard decisions

Covering?

Not covering,
or stopping?

It’s a choice that’s specific
to your company & employees

No matter your GLP-1 decision,

Goodpath delivers results

Cover or not, Goodpath drives better outcomes

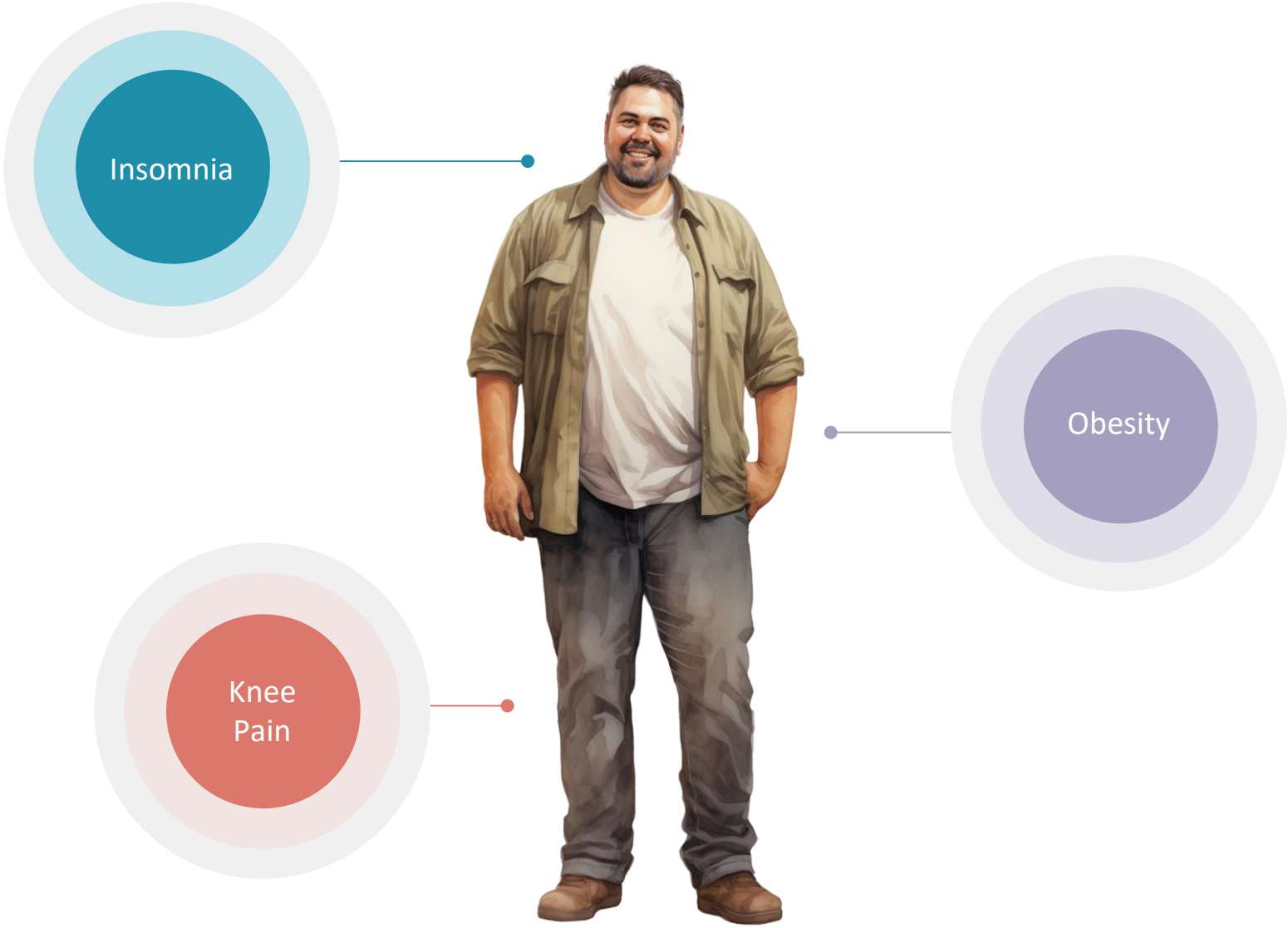
Covering?

- **Maximize your investment in medication with:**
  - **Whole person care**
  - **Lifestyle & behavioral health**
- **Unlimited coaching**
  - **Answer questions about side effects**
  - **Avoid complications like ER visits**

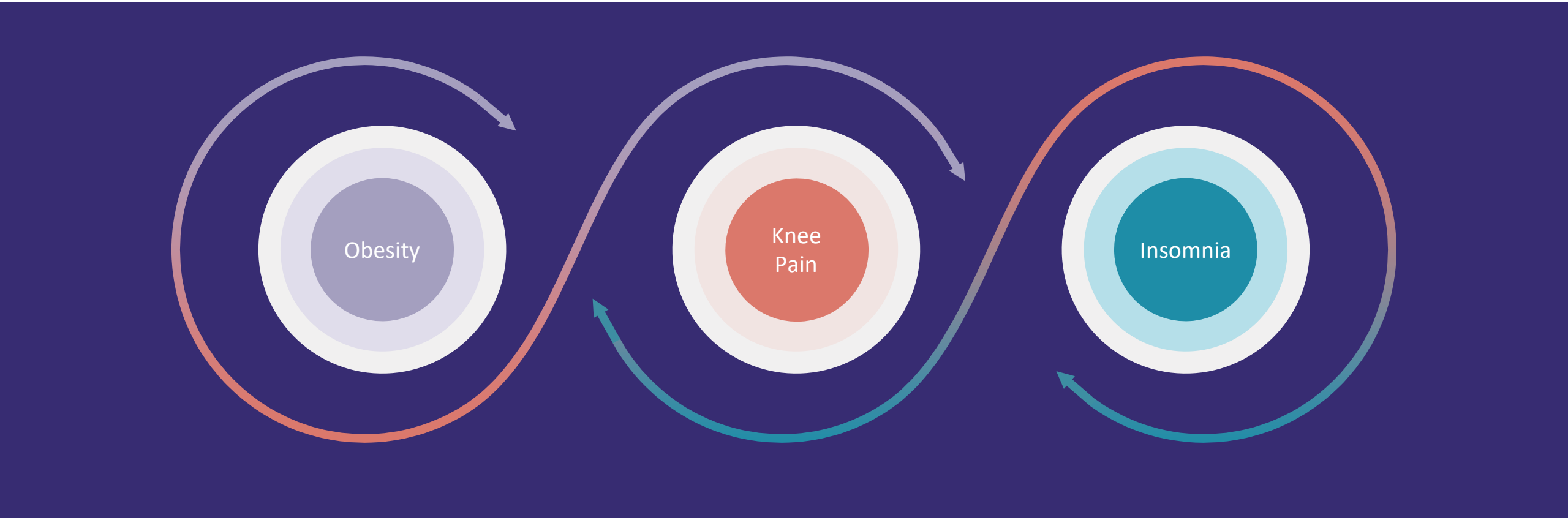
Not covering, or stopping?

- **Self Pay GLP-1 Option:**
  - **Brand Name Zepbound®**
- **Whole Person Care for Weight Health**
- **Unlimited health coaching**
- **Comprehensive care for comorbidities**

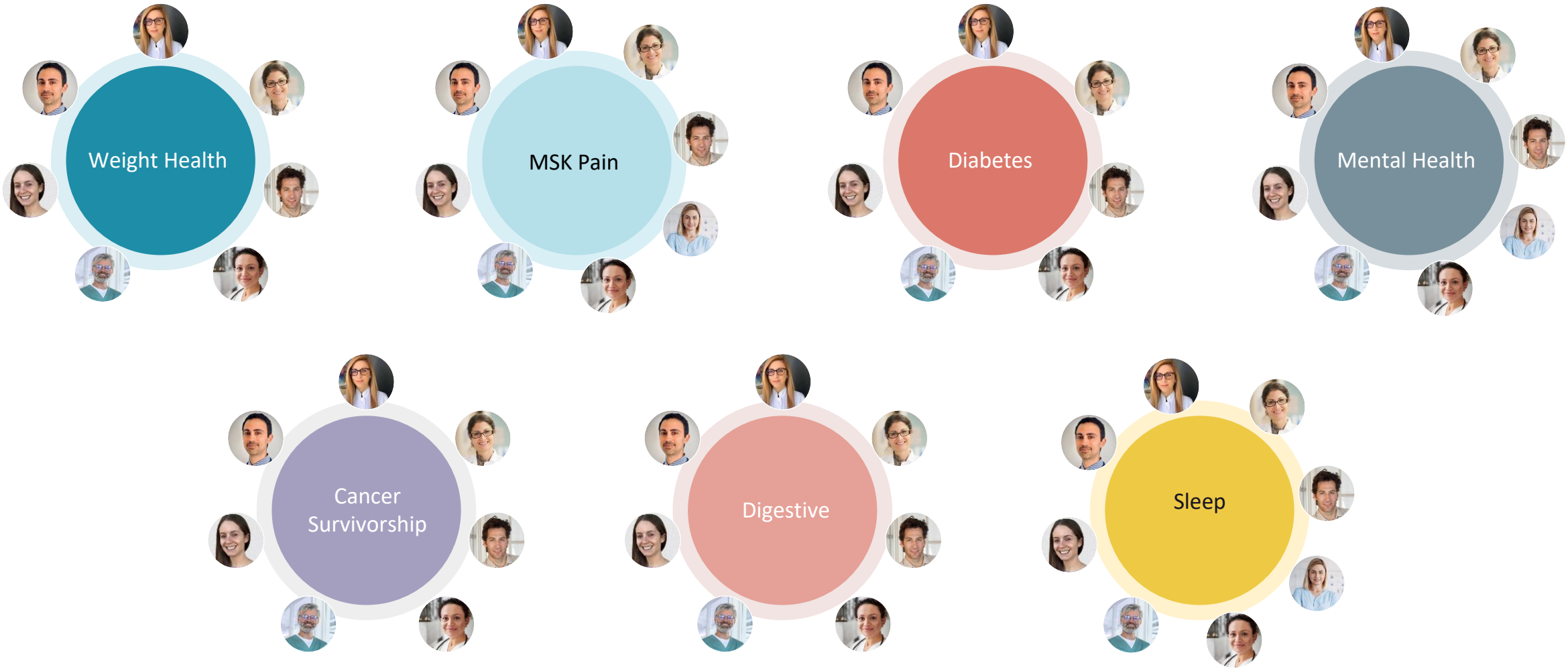
Life Isn’t One Condition at a Time.
Healthcare Shouldn’t Be Either.



Health is Interconnected. Care Should Be Too



Specialized Clinical Teams, Coordinated for Whole-Person Health



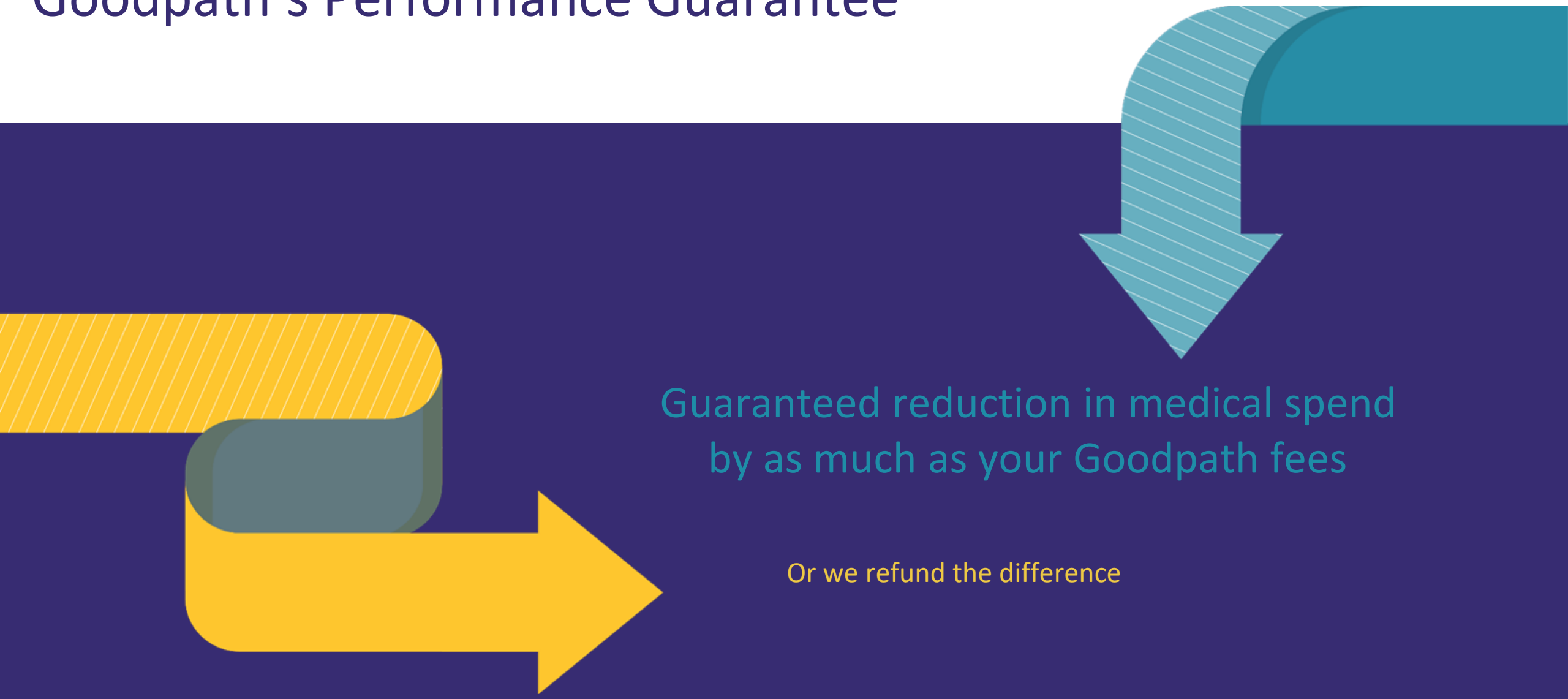
Personalized, Connected Care Delivers Real Results for Members

$2,300

Hard Dollar
Claims Reduction
in Year 1

Obesity	3 Registered Dietician Sessions Specialist Office Visit
Knee Pain	6 Physical Therapy Sessions Urgent Care Visit MRI
Insomnia	Sleep Apnea Screening
Anxiety *3 months later*	Psychiatric diagnostic evaluation 4 psychotherapy session

Goodpath’s Performance Guarantee



Guaranteed reduction in medical spend
by as much as your Goodpath fees

Or we refund the difference

goodpath

WHOLE PERSON CARE FOR CHRONIC CONDITIONS

Weight Management

MSK Pain

Diabetes

Mental Health

Cancer Survivorship

Digestive Health

Sleep

GLP-1 Care

Don’t Cover?

- Self Pay GLP-1 Integration
- Brand Name Zepbound
- Wraparound Coaching & Whole Person Care

Cover?

- Maximize your investment with wraparound coaching & whole person care
- Reduce adverse effects & ER visits

Unified Care:
Strengthening Coordination Across Healthcare

Jillian Kleiner, PT, DPT, ATC

Clinical Solutions Lead

Hinge Health

The Enchanting Journey of Unified Care

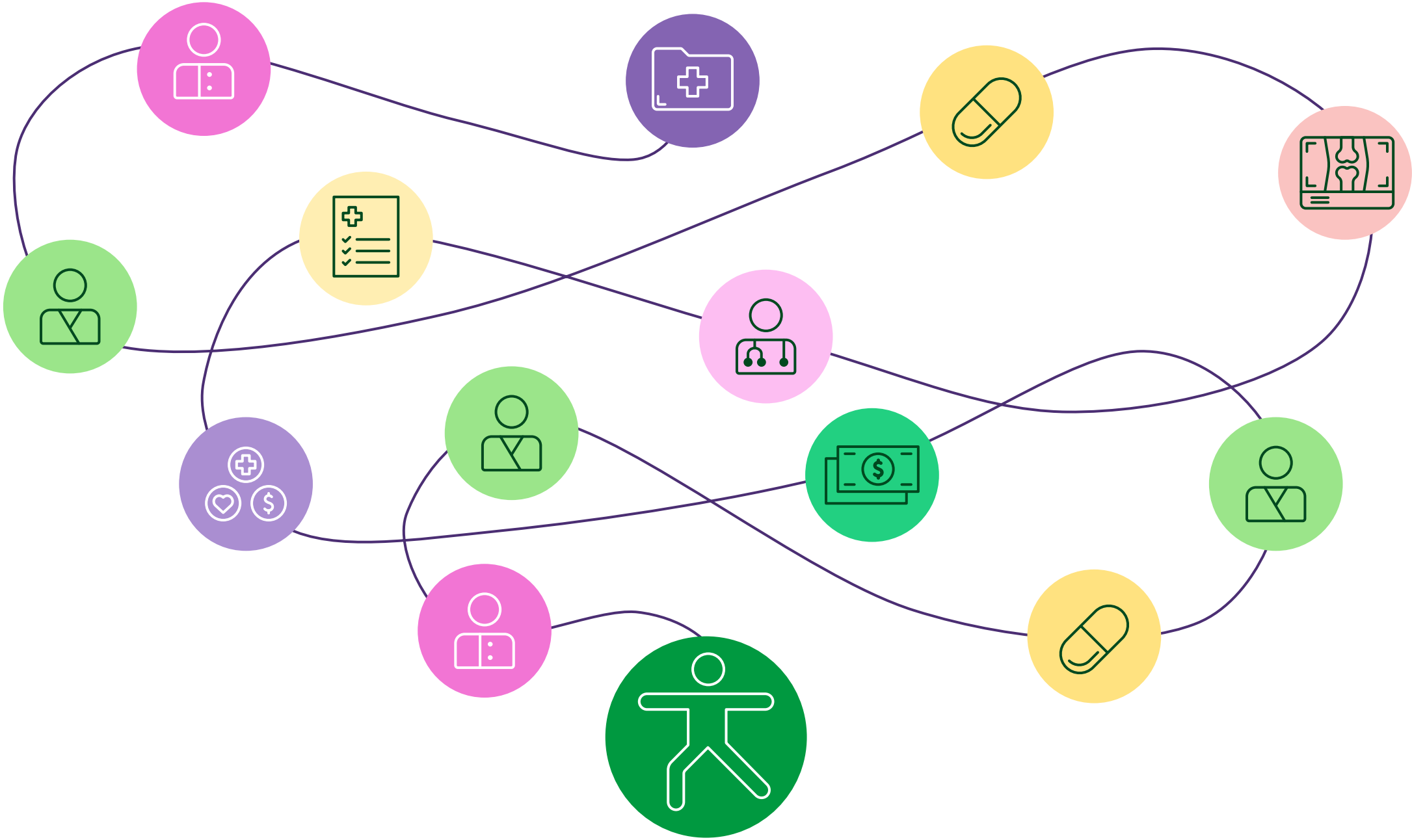
Dr. Jillian Aeder Kleiner, PT, DPT, ATC

Clinical Solutions Lead / Physical Therapist

Experience

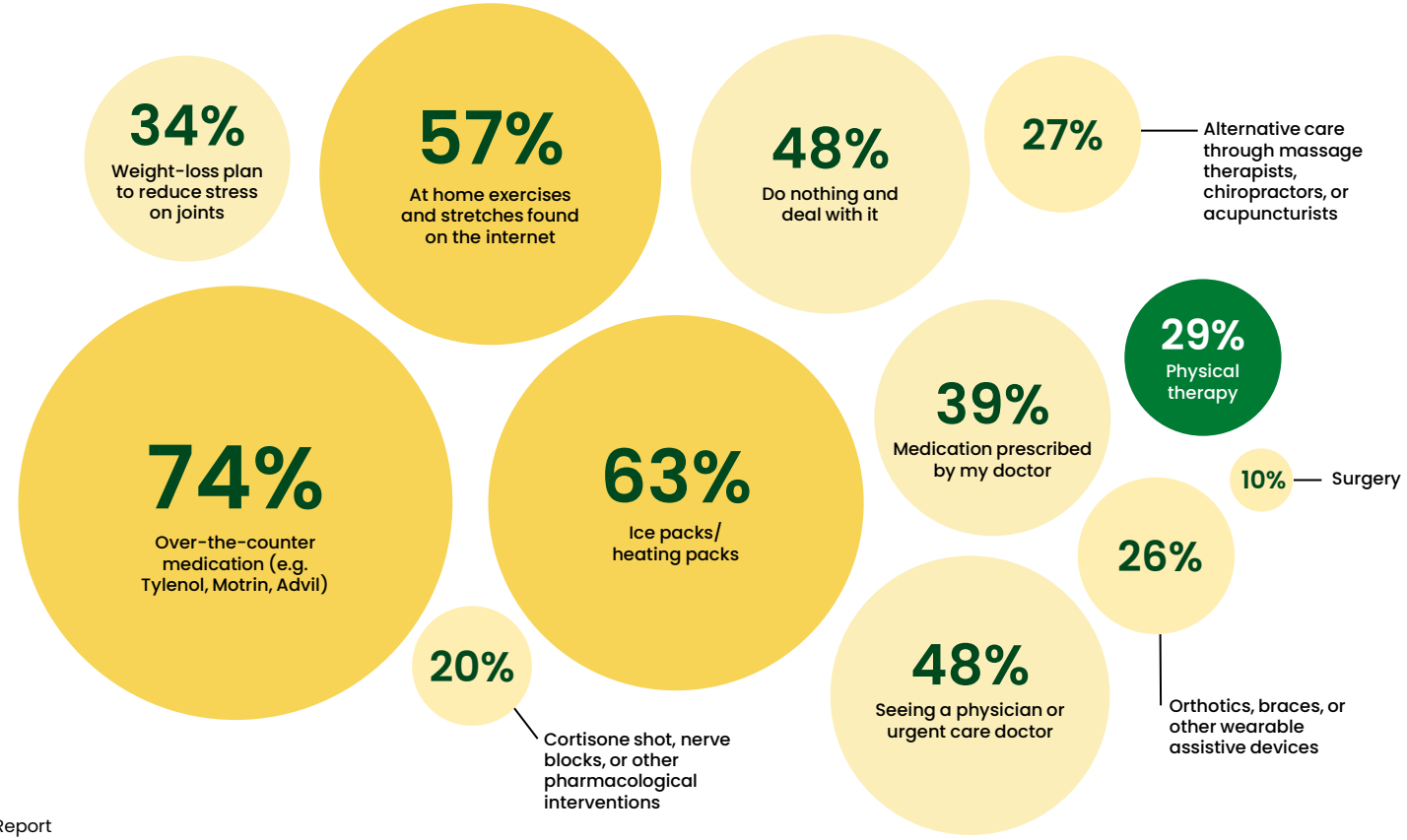
- 10+ years of experience in healthcare
- Worked in a variety of settings
- Specialized in pelvic health, sports medicine, and lifestyle medicine

Traditional care



People aren’t getting the care they need

Pain treatment rankings by usage



Source: 2024 Hinge Health State of MSK Care Report

Pain is a massive cost for employers

$560B–$635B in costs accrued for MSK treatment and lost productivity [1]

People living with MSK pain **missed an average of 10.3 days** in 2021[2]

Sources: 2024 Hinge Health State of MSK Care Report, 1 Gaskin DJ, Richard P. The economic costs of pain in the United States. J Pain. 2012;13(8):715-724. doi:10.1016/j.jpain.2012.03.009, [2] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey, 2020.

Unifying digital and in-person care is in demand

- Meets the complex needs of more people in pain
- Improves outcomes and reduces costs

Simplifying the healthcare journey with unified care: HingeSelect

Unified MSK Care

Comprehensive, end-to-end MSK care

HingeDigital

Digital exercise therapy

Instant access to personalized care

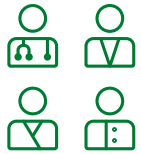
Addresses acute injuries, chronic pain, and pre/post-surgical rehab

HingeSelect

Orthopedic specialist visits

Nationwide access, in as little as 48 hours to specialist via video visit

Provides evaluation, diagnosis, treatment, and in-person referrals

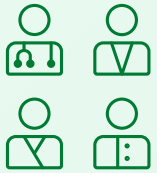


High-performance network

High-quality ortho, PT, and imaging at rates up to **50% below commercial**

Nationwide coverage in 2026

Why providers partner with us



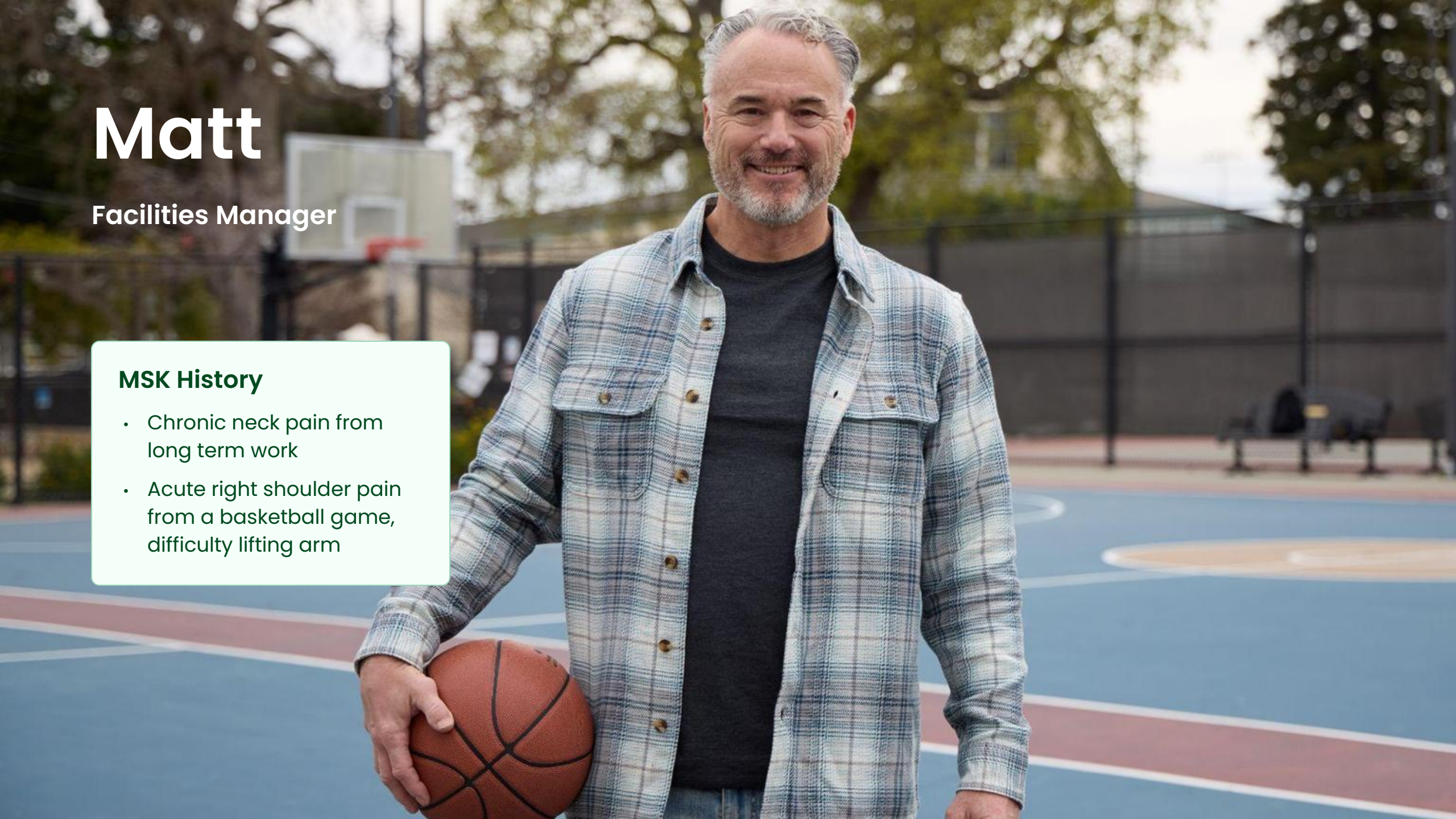
Select local network

Quality referrals

Fast, easy payments

Enhanced satisfaction & differentiation

HingeSelect: Member Journey



Matt

Facilities Manager

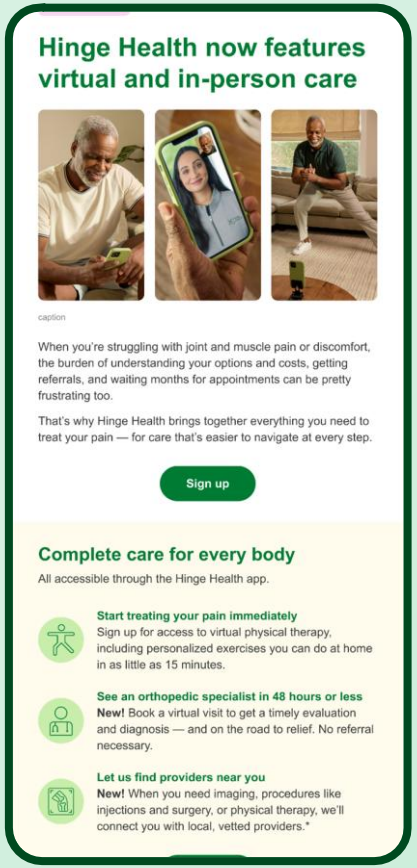
MSK History

- Chronic neck pain from long term work
- Acute right shoulder pain from a basketball game, difficulty lifting arm

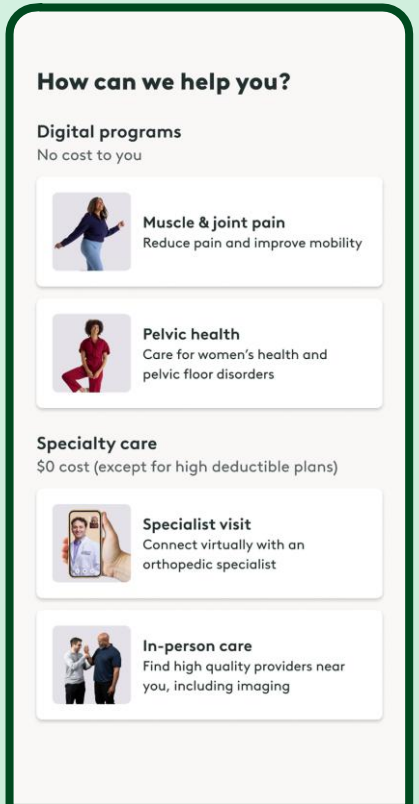
Getting Started

Easily evaluate care options and get started right away

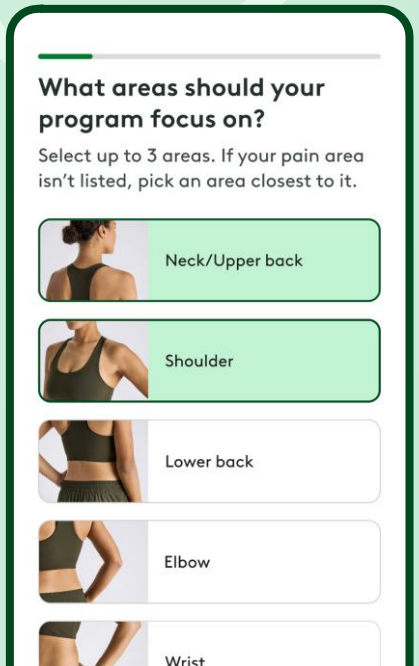
Awareness



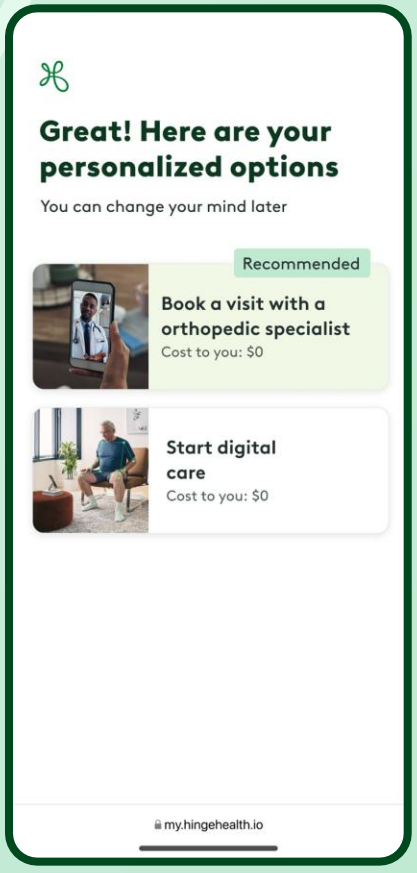
Explore care options



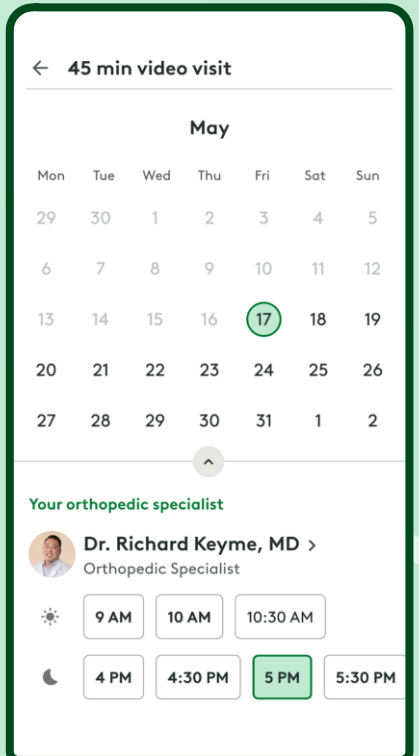
Focus and history

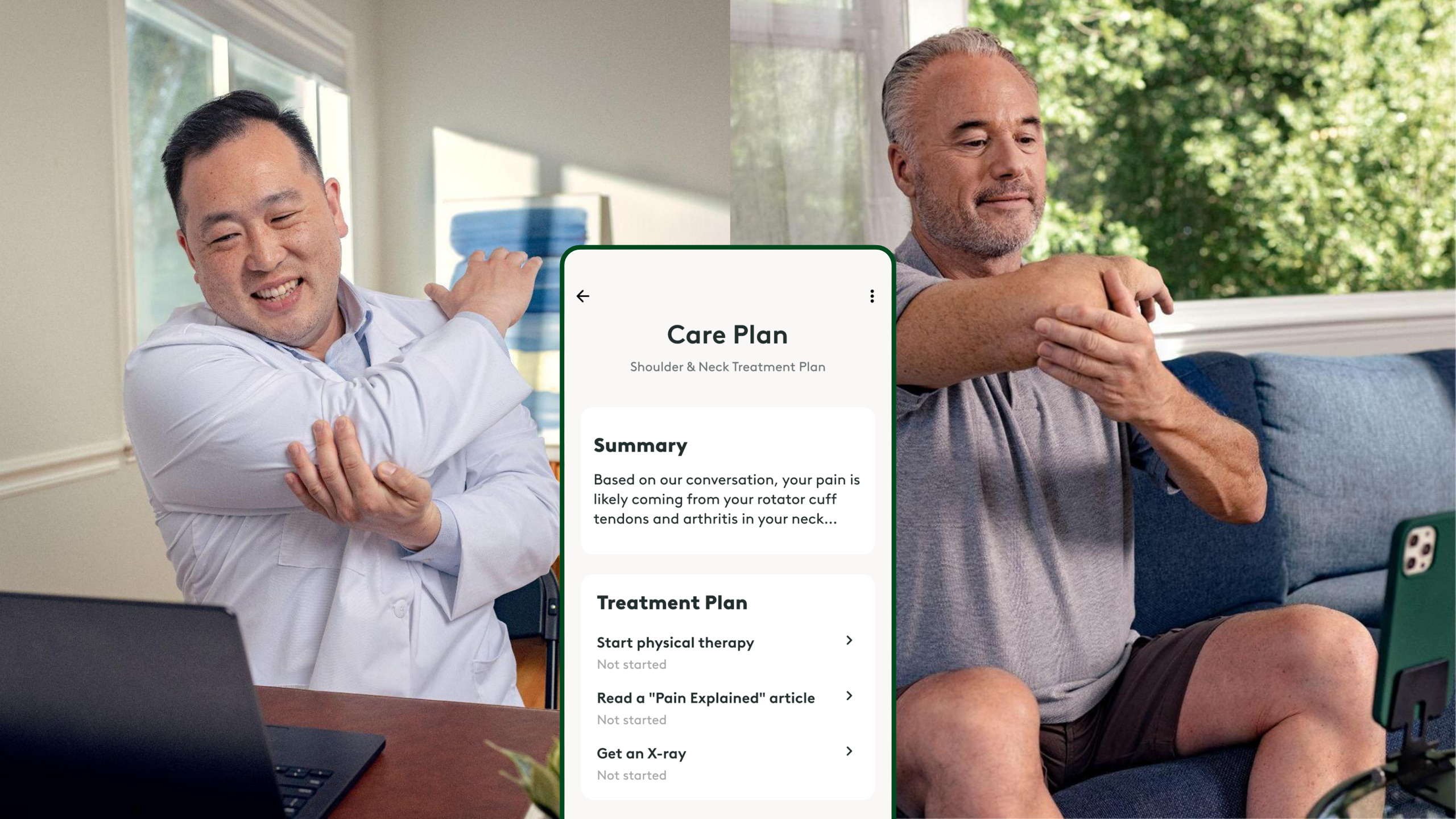


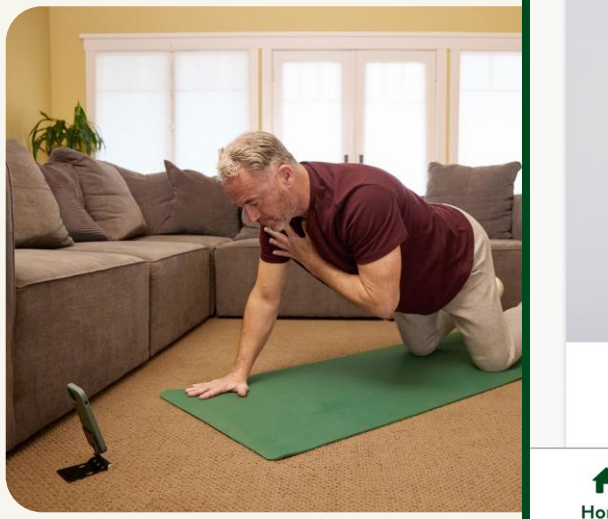
Choose a care path

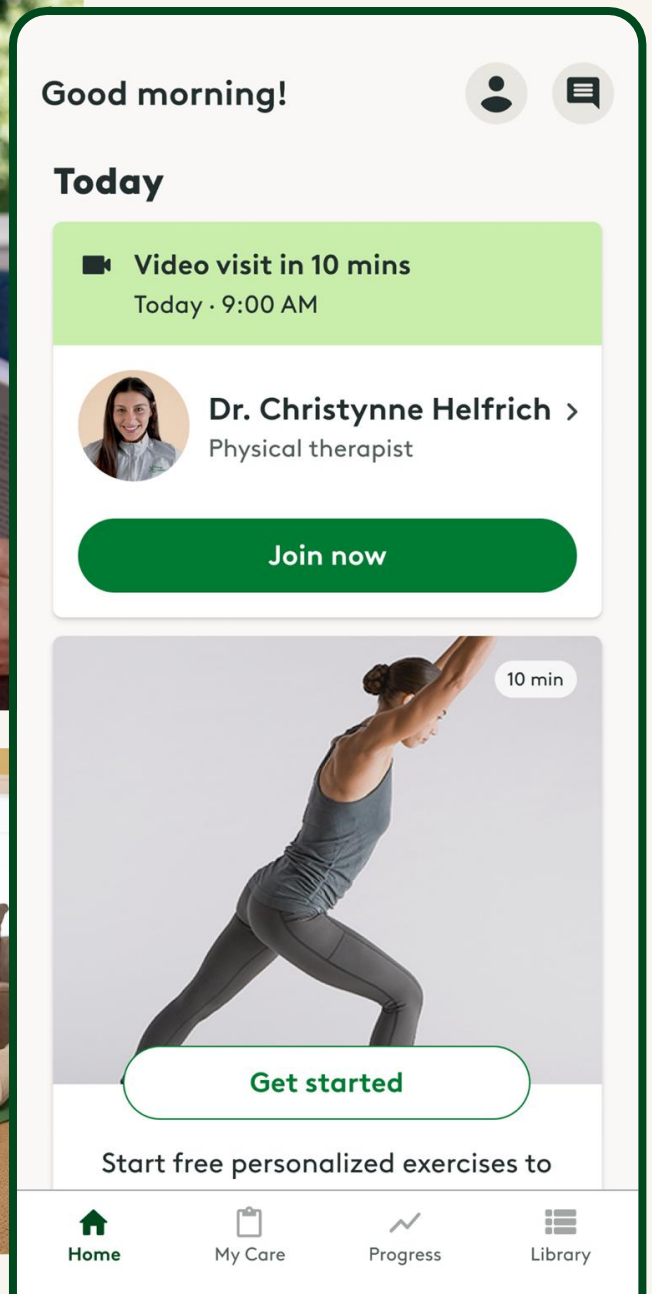


Schedule



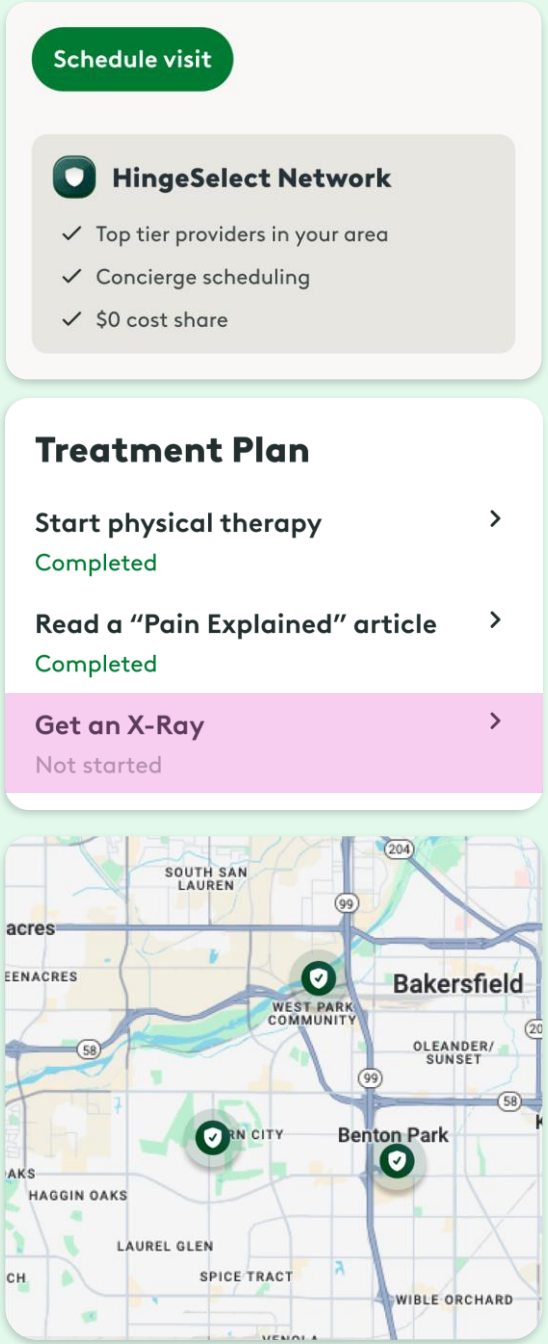

Care Plan
Shoulder & Neck Treatment Plan
Summary
Based on our conversation, your pain is likely coming from your rotator cuff tendons and arthritis in your neck...
Treatment Plan
Start physical therapy
Not started
Read a "Pain Explained" article
Not started
Get an X-ray
Not started

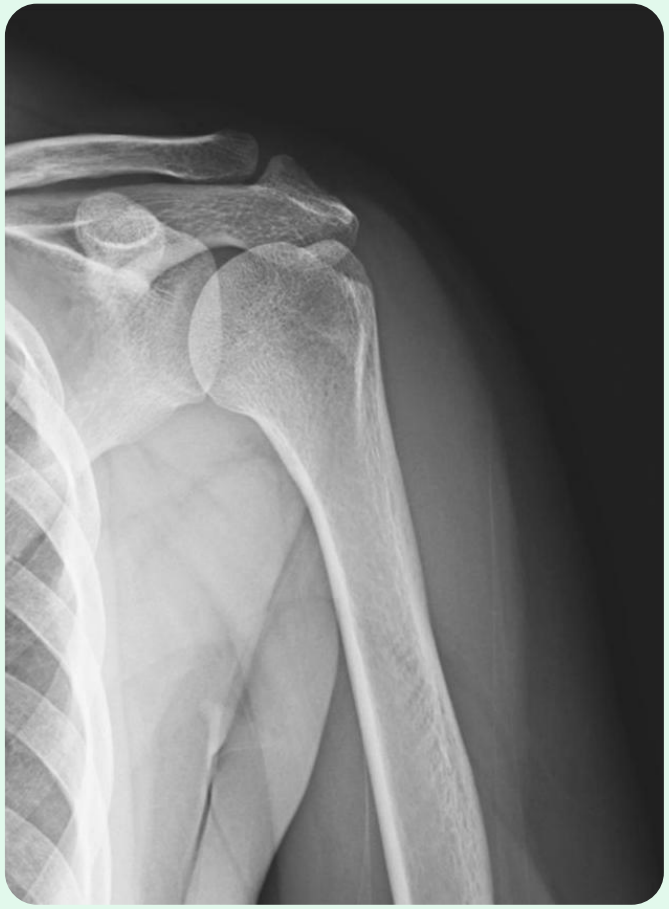




Tailored exercise therapy

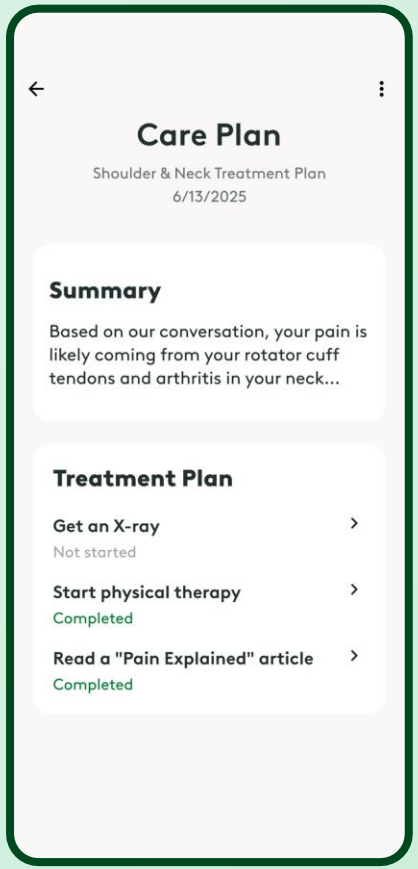
An integrated In-person experience



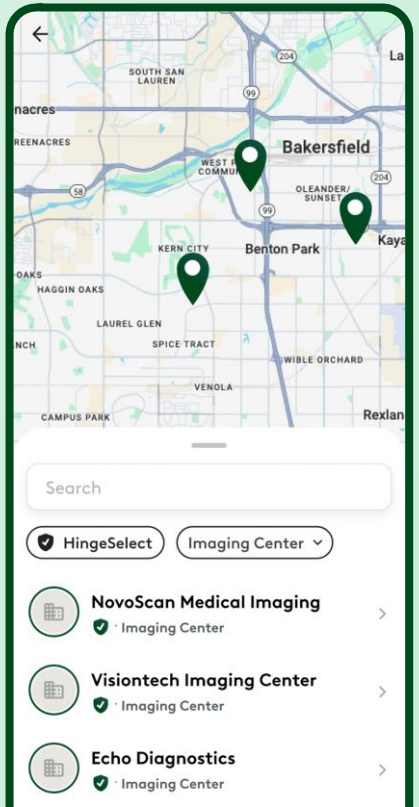


In-person care with the ease of digital

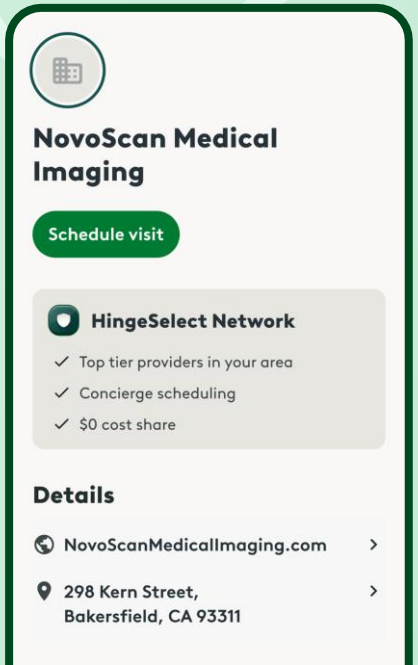
Care plan



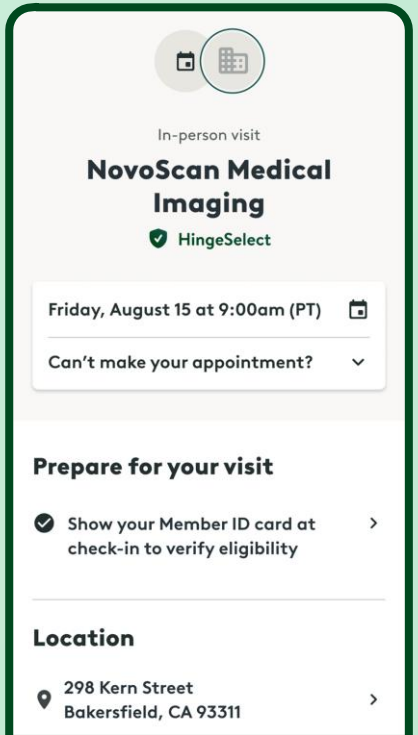
Provider directory



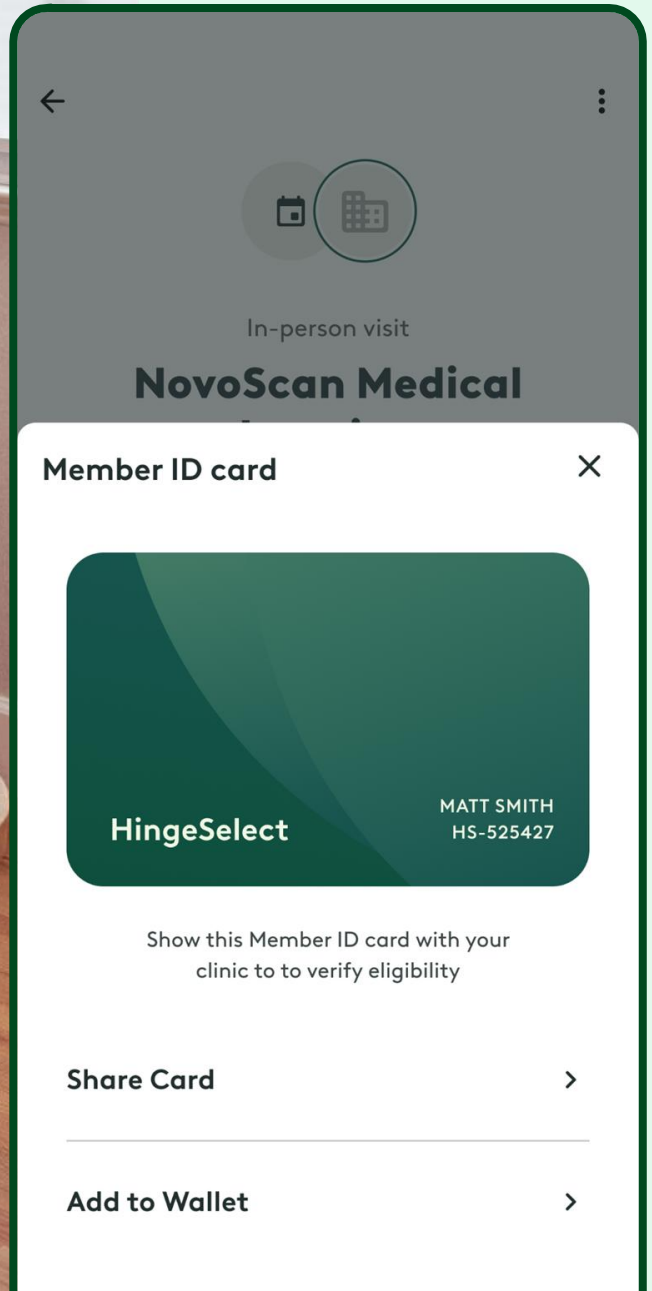
Select a provider



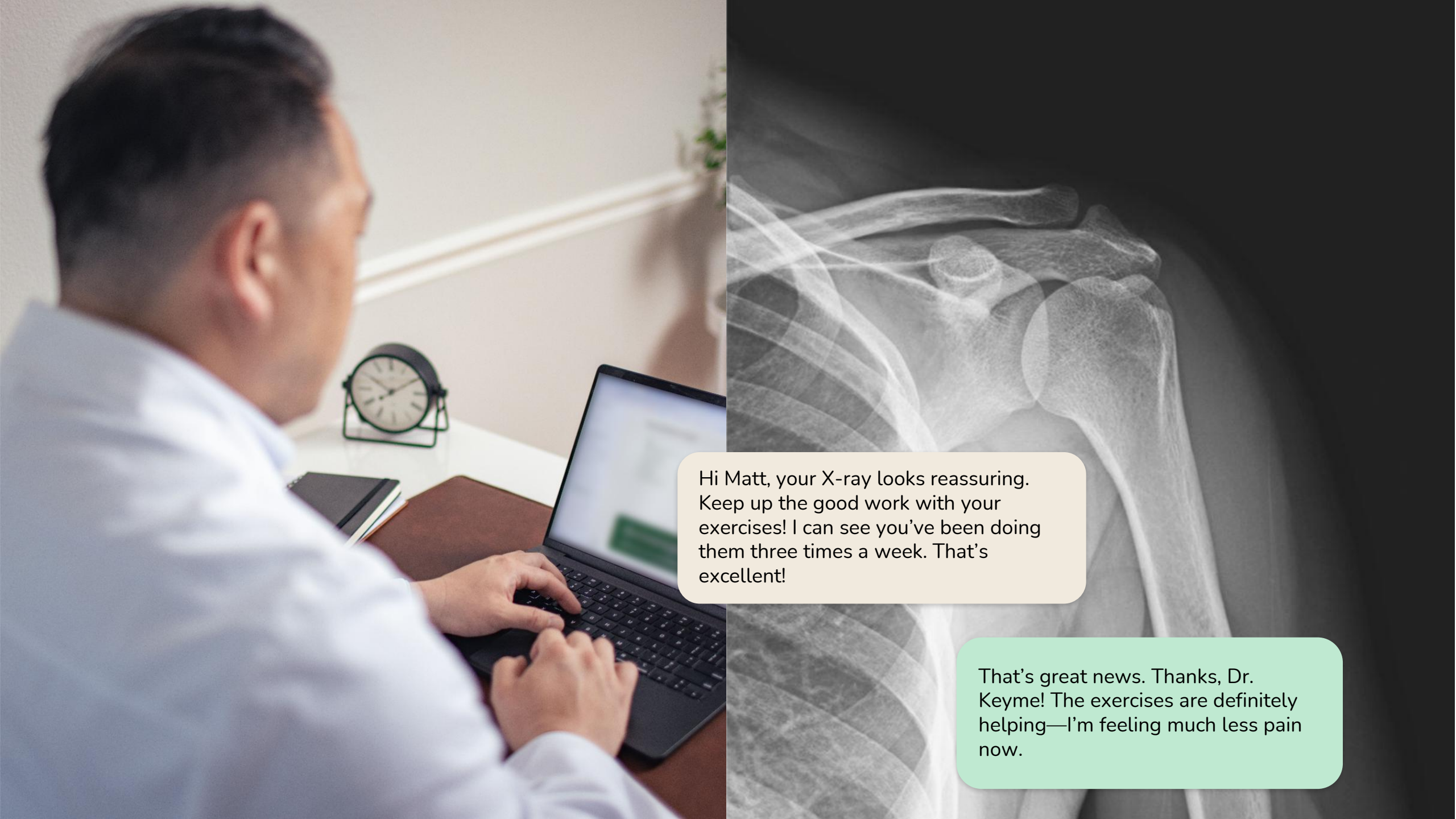
Book visit

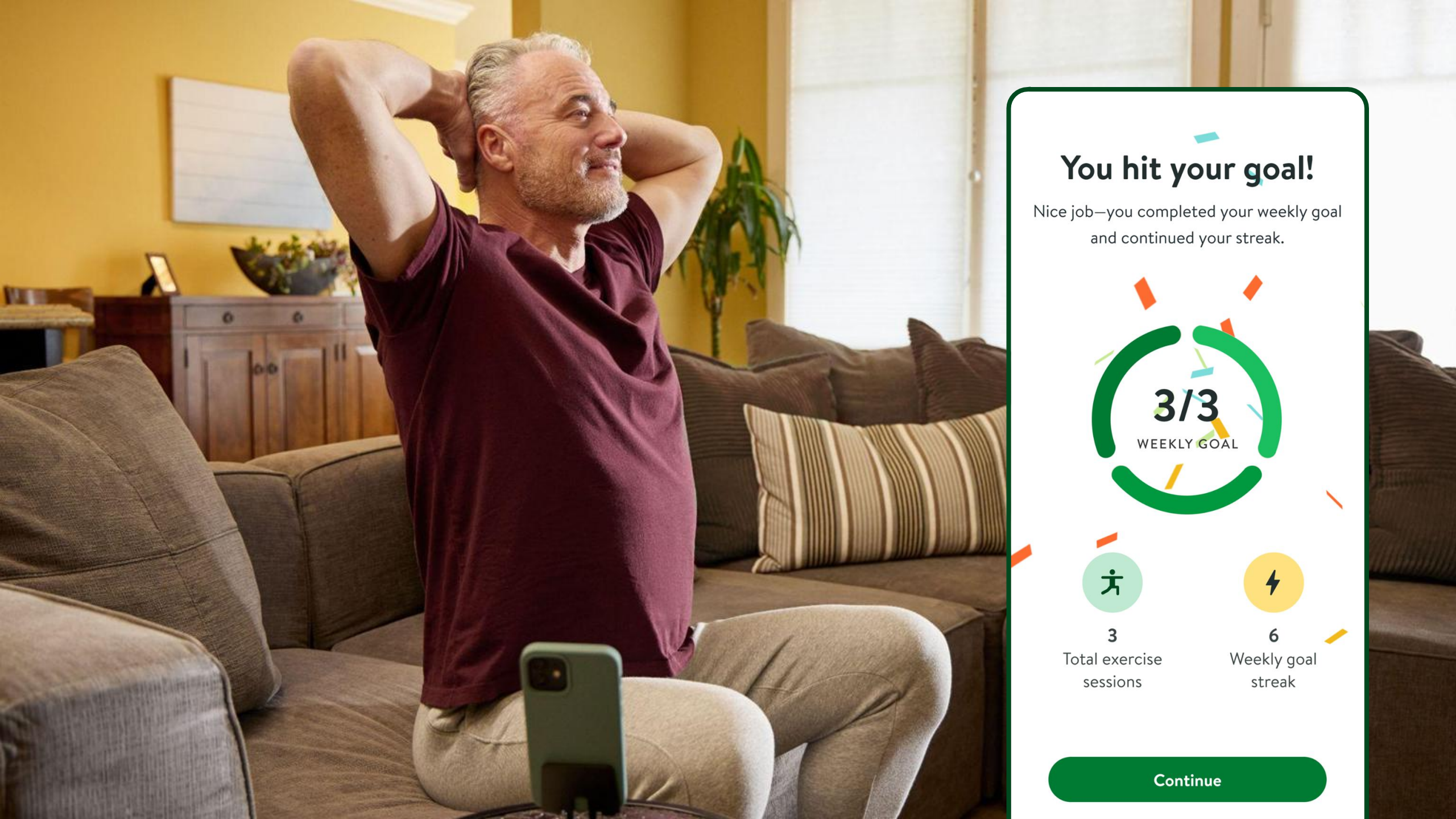


Reminders



Frictionless in-person visit


Hi Matt, your X-ray looks reassuring. Keep up the good work with your exercises! I can see you've been doing them three times a week. That's excellent!
That's great news. Thanks, Dr. Keyme! The exercises are definitely helping—I'm feeling much less pain now.


You hit your goal!
Nice job—you completed your weekly goal and continued your streak.
3/3
WEEKLY GOAL
3
Total exercise sessions
6
Weekly goal streak
Continue


Hi Matt, it’s been six weeks since our last visit. How have you been feeling? I noticed your pain scores have improved over time.
Hello! Thanks so much for reaching out. My neck and shoulder are feeling much better, and I’m even back to playing basketball with my son.

Elevating the member experience

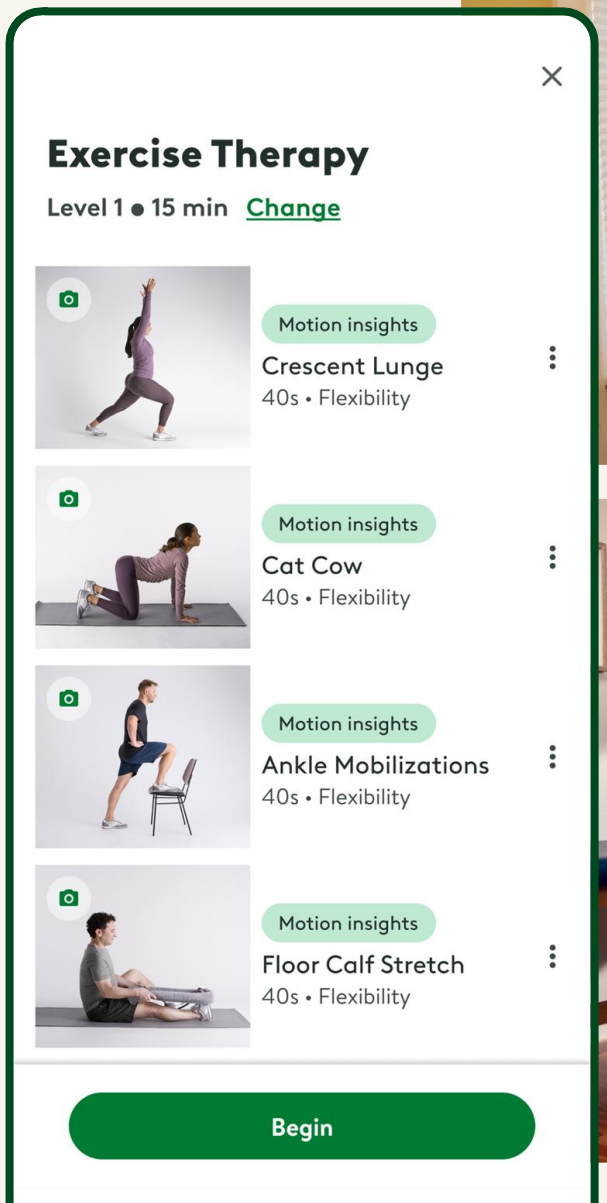
Integrated care delivery

Seamless coordination between digital, virtual, and in-person experience, including:

- Appointments and in-app scheduling
- Streamlined record sharing
- Standardized visit protocols
- Seamless referrals across care settings
- Enhanced care navigation and support

Lower costs for members

$0 out-of-pocket, including HDHP after deductible



Multiple providers,

one coordinated team

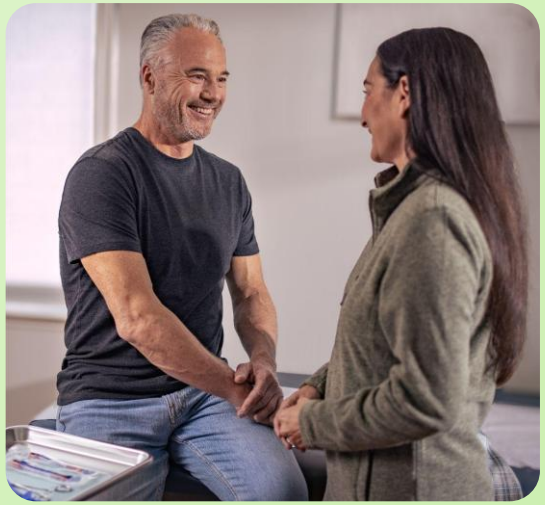
Treatment Plan

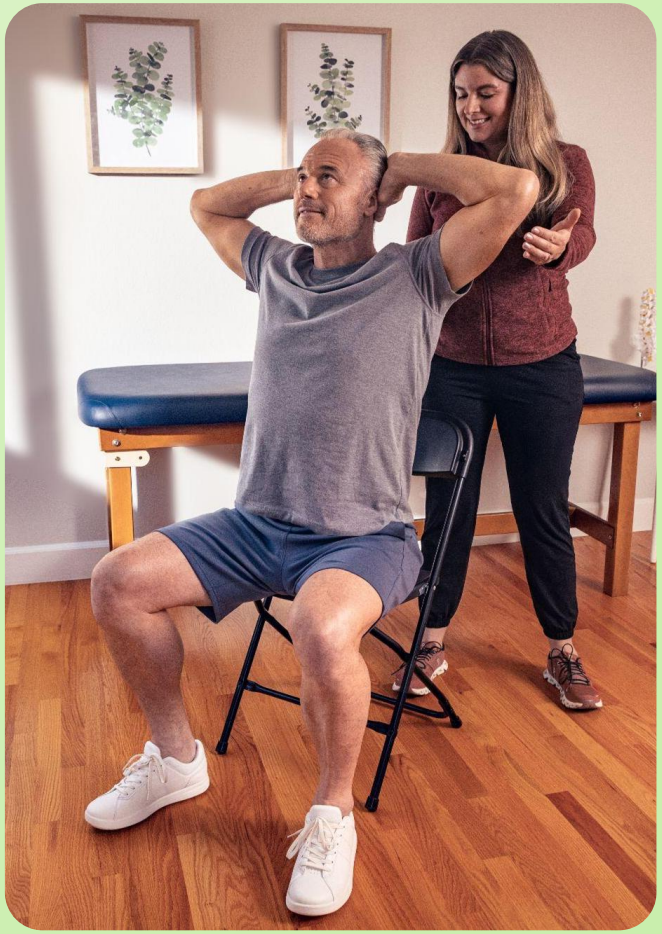
Schedule a steroid injection
Completed

Get an X-ray
Completed

Start physical therapy
Completed

Read a "Pain Explained" article
Completed

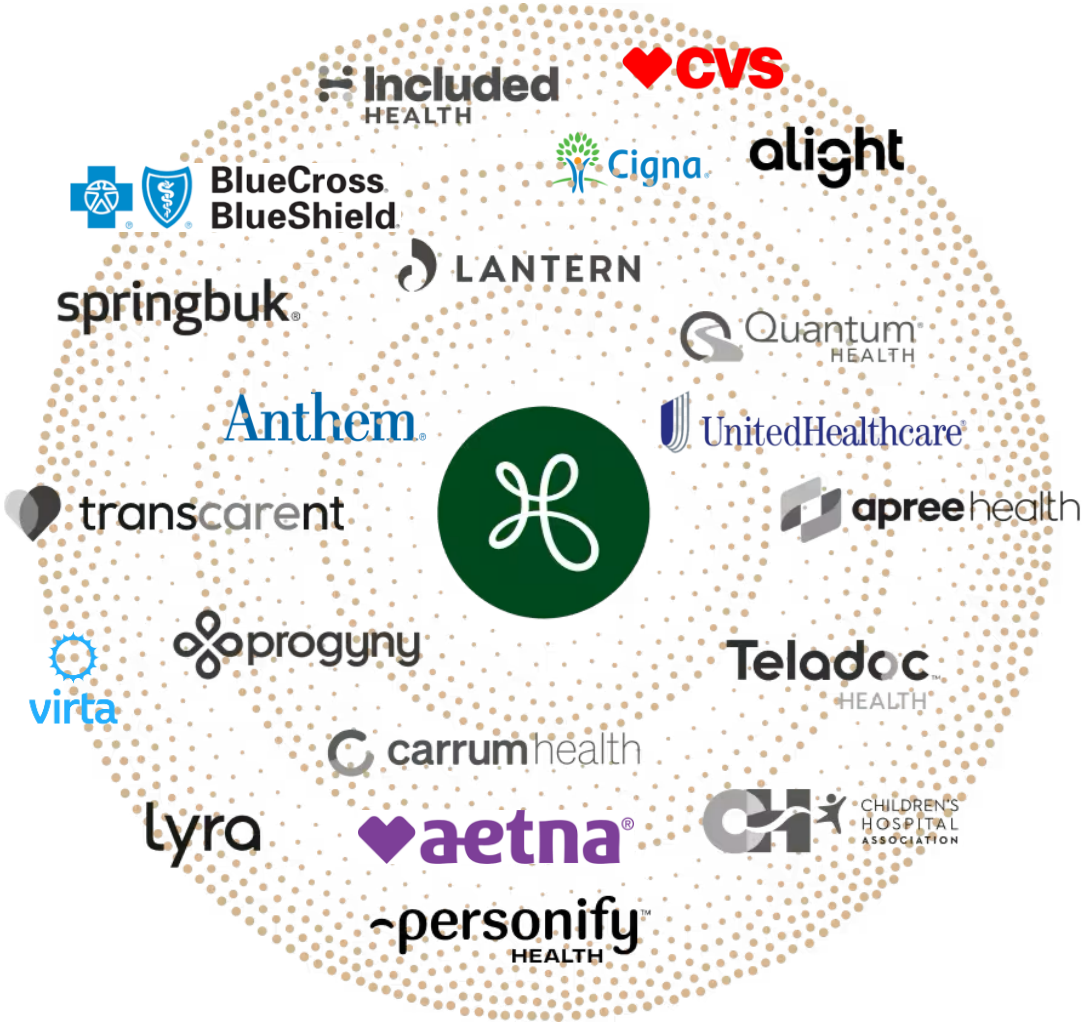




Simplifying the healthcare journey with unified care: Health Plan and Ecosystem Partners

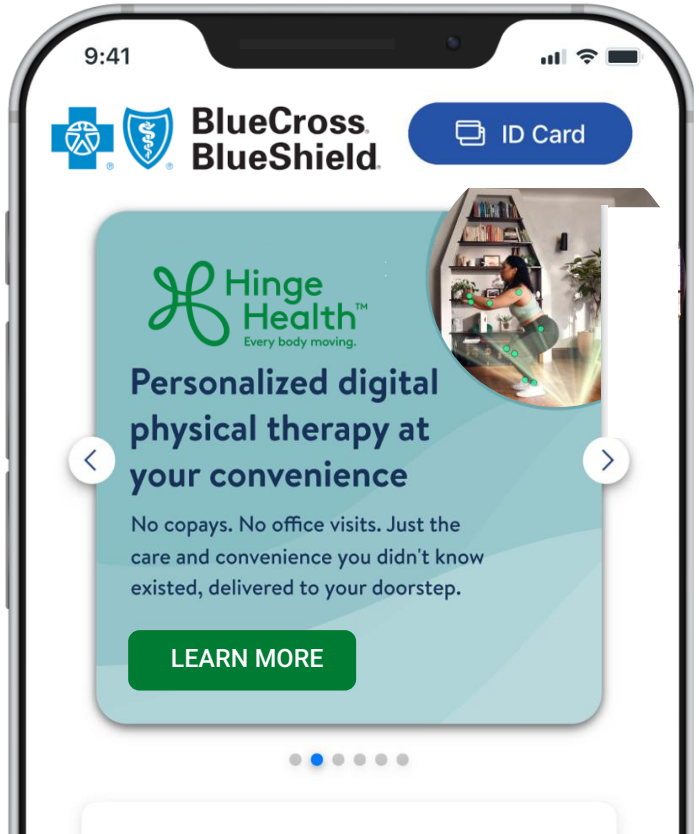
Integrations with Health Plan and Ecosystem Partners

Best support for members by guiding them to the right care at the right time



Hinge Health: Referral process

Hinge Health extends referrals as appropriate to ensure members are aware of all resources within their health plan



Establishing benefits ecosystem database

Each client's database is kept up to date with the current year's benefits and vendor programs available within ecosystem.

Listening for trigger words

Care team is trained to identify opportunities for referrals by listening for "trigger" words.

Coordinating care

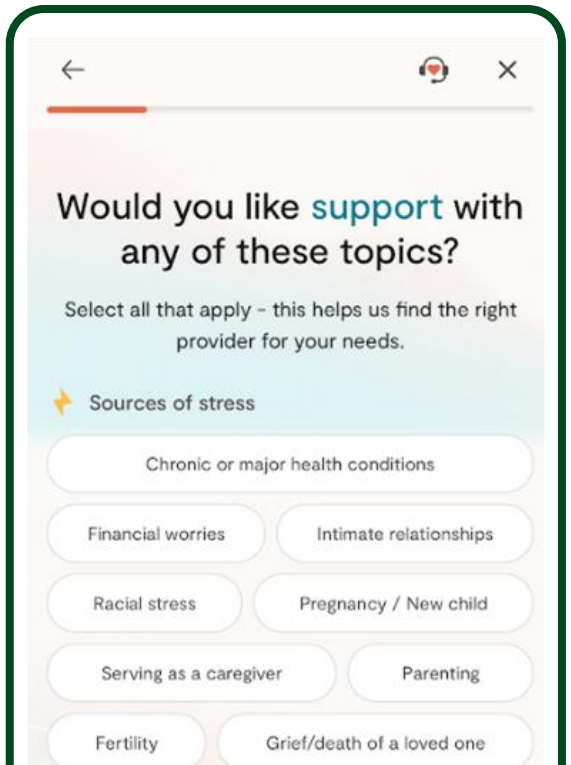
PT's refer members to their health plan care team as needed for care coordination.

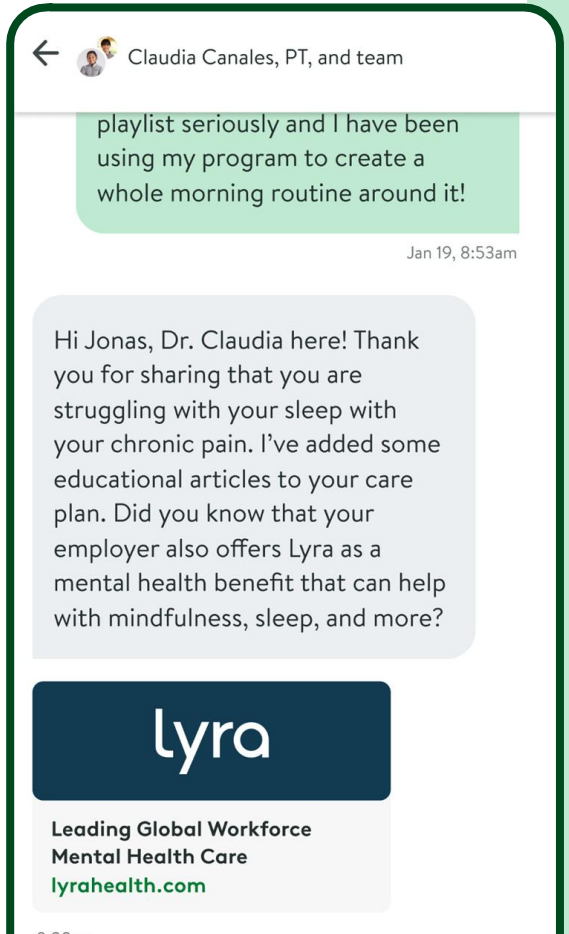
Tracking referral volume

Clinical team documents referral activity so reporting can be shared upon request.

Hinge Health: Delivering additional value

Hinge Health coordinates care as appropriate to ensure members are aware of all resources available to them





Personalized member experience

Members benefit from an integrated care journey that allows them to addresses MSK pain alongside other medical concerns through tailored messaging and resources.

Care team training & bi-directional referrals

Referral system between ecosystem partners and Hinge Health directs members to the appropriate care as needed.

Enhanced outcomes

Leveraging proven clinical quality from both organizations results in improved health outcomes.

Single sign on integration

Through our partnerships, we're streamlining enrollment for all shared clients. Our SSO integration automatically verifies eligibility and pre-fills member details, creating a faster and simpler enrollment experience.

50+ partners for seamless contracting & implementation

151+ members
250+ subscribers
500+ members
1,000+ employees
1,000+ members
1,500+ subscribers
2,000+ members

Health Plans

- Aetna
- Anthem National
- Anthem Local Total Health Connections
- Anthem Local non- Total Health Connections
- Asuris Northwest Health
- Blue Cross and Blue Shield of Alabama
- Blue Cross and Blue Shield of Arizona
- Blue Cross and Blue Shield of Illinois
- Blue Cross and Blue Shield of New Mexico
- Blue Cross and Blue Shield of Oklahoma
- Blue Cross and Blue Shield of Texas
- Blue Cross Blue Shield of Massachusetts
- Blue Cross Blue Shield of Michigan
- Blue Cross Blue Shield of Minnesota
- Blue Cross Blue Shield of Montana
- Blue Cross Blue Shield North Carolina - *Available 1/1/2026*
- Blue Cross of Idaho
- Blue Cross Blue Shield of Rhode Island
- BlueCross BlueShield of Tennessee
- Cigna
- HealthPartners
- Regence BlueCross BlueShield of Utah
- Regence BlueCross BlueShield of Oregon
- Regence BlueShield of Idaho
- Regence BlueShield of Washington
- UnitedHealthcare
- UMR

TPAs

- Assured Benefits Administrators (ABA)
- Brighton
- Collective Health
- HealthComp
- Health Plans, Inc
- Luminare Health
- Meritain Health
- Sunlife
- UMR
- Zenith American Solutions

PBMs

- CVS Health
- ESI
- Optum

Ecosystem

- Transcarent (Accolade)
- Alight
- Apree (Castlight)
- Benify
- Carrum Health
- Lantern
- Personify Health
- Progyny
- Quantum
- Teladoc

Transform the way pain is treated

Improved access

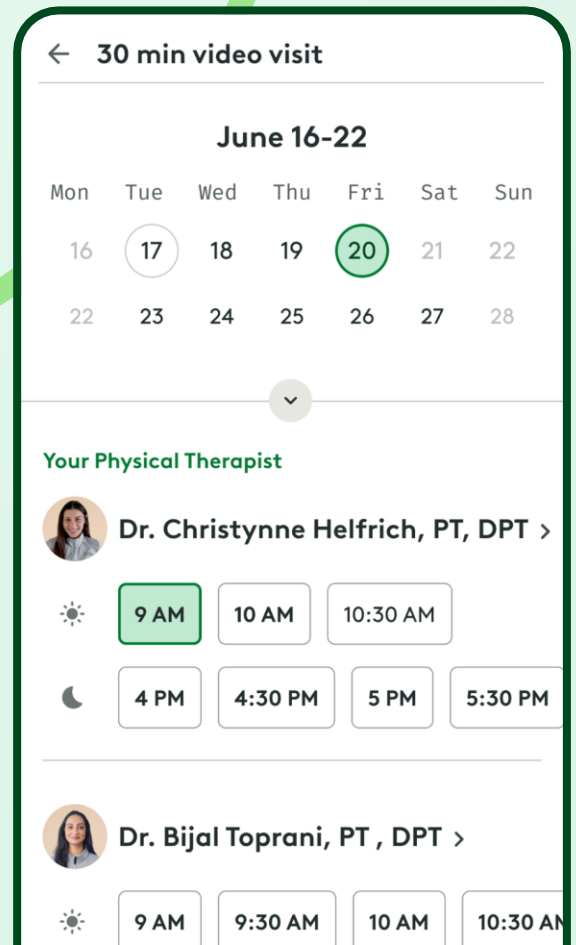
- Same day access
- Choice of device
- Nationwide PT network

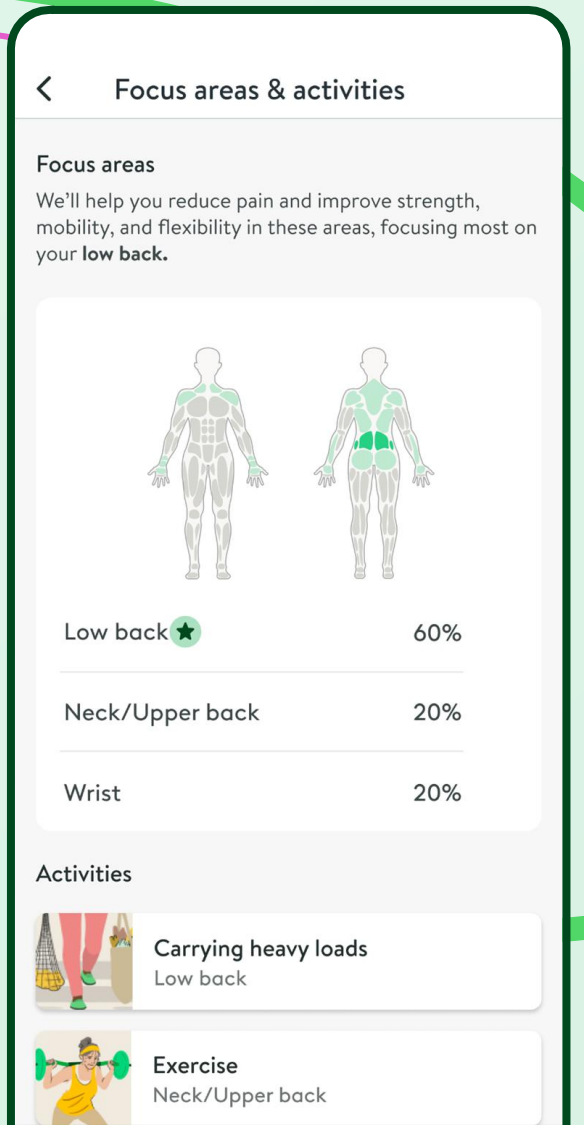
Optimized engagement

- Cohesive experience
- Lifestyle coaching
- TrueMotion personalized guidance

High-quality care

- Embedded women's health
- Enso for drug-free pain management
- Real-time insights empower care teams





Outcomes of unified care

A decade of movement as medicine

1M+
Members treated

59M
Activity sessions

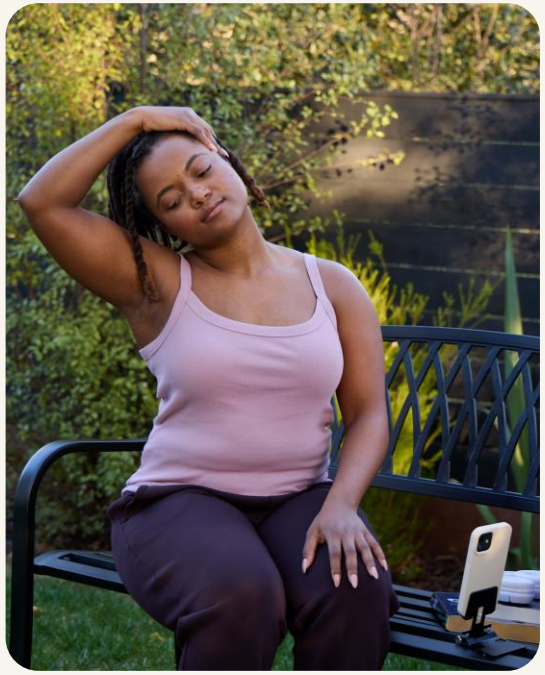
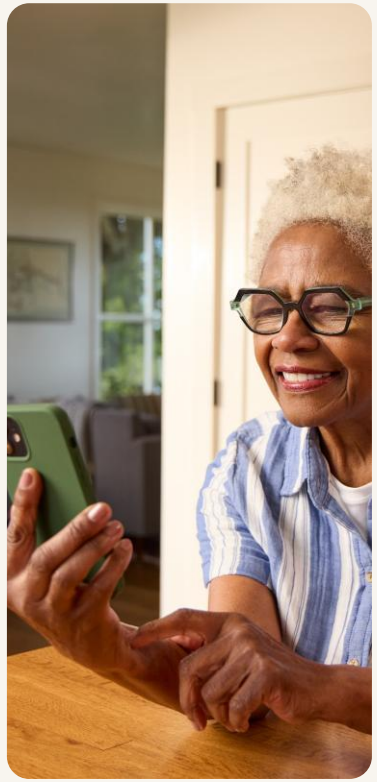
68%
Avg pain reduction per participant after 12 weeks[1]

58%
Avg pain reduction in anxiety, depression after 12 weeks[1]

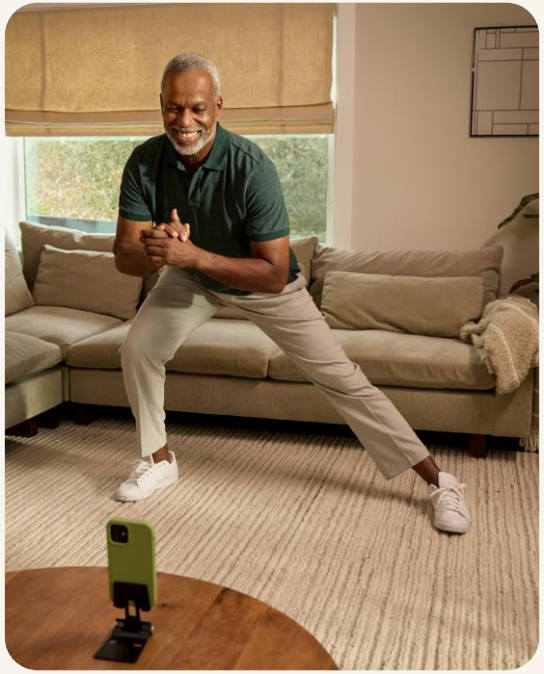
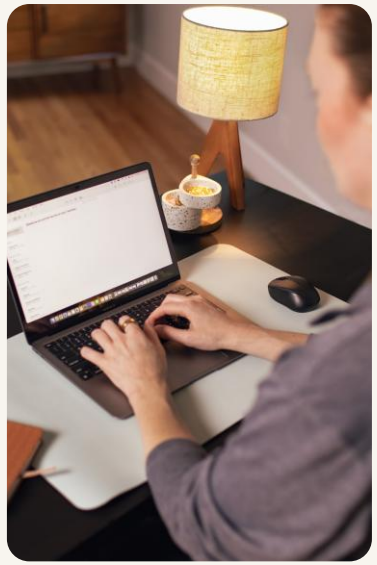
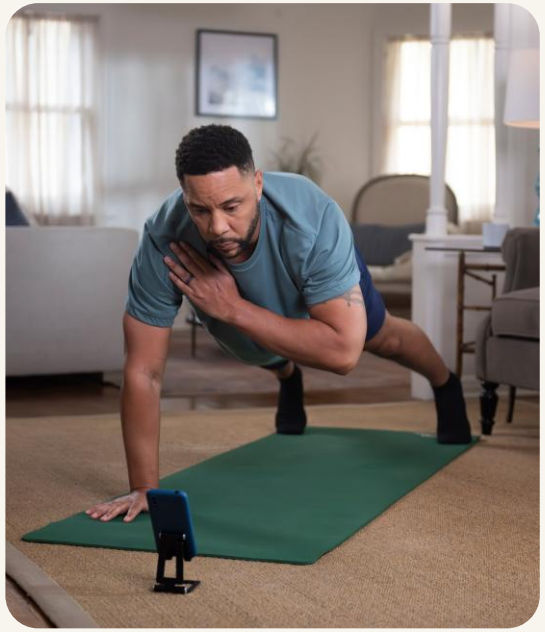
42%
Fewer participants starting opioids[2]

52%
Of musculoskeletal surgeries avoided[3]





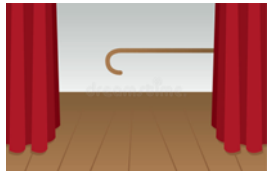
Thank you!

Time for our final 2 *Quick Rounds*

Innovators in Employer Health

Format

Each speaker will have *only* 5 minutes
to convey their innovative product/service



(No stage hook, but microphone cuts off at 5 minutes!)

Innovator #3: Emily Palik

progyny

NCBCH
NC BUSINESS COALITION ON HEALTH

Your **partner** in health for pivotal moments

Emily Palik – VP, Sales

Your employees deserve better than the status quo

1 in 5 couples struggle with infertility, yet many are left out of existing coverage[1]

40%

of U.S. mothers don't attend a postpartum visit with an OB/GYN[2]

57%

of parents reported burnout and mental health concerns[3]

59%

of women missed work due to menopause symptoms, 18% for 8 weeks or more[4]

progyny

Preconception, Fertility & Family Building

Pregnancy & Postpartum

Parent & Child Wellbeing

Menopause & Midlife Care

Your partner in pivotal health moments

Dedicated support to proactively quarterback *every* journey	**Active management** of our entire network for cost and quality
Whole person intervention of risks and needs from day one	**Outcomes-focused** programs for best practice care

1. https://www.cdc.gov/reproductive-health/infertility-faq/index.html#:~:text=Yes.,after%201%20year%20of%20trying | 2. March of Dimes, Your postpartum checkups | March of Dimes | 3. OSU, https://nursing.osu.edu/news/2024/05/08/perfect-parent-study | 4. Menopause Society, https://www.nhmenopausesociety.org/research/impact-of-perimenopause-and-menopause-on-work/

Progyny is the only solution **with dedicated support and an actively managed network** specific to women and family needs

A member experience that is tailored, clinically led, and built to drive results

A proactive, **1:1 Support:** dedicated expert to guide members with high-touch, outbound & inbound care

Expert-Led & Inclusive: PCAs are in-house RNs, social workers, doulas, fertility and menopause experts — matched with each member based on preferences like gender, identity, and language

+80 NPS | **15+** average interactions | **15+** minutes per call

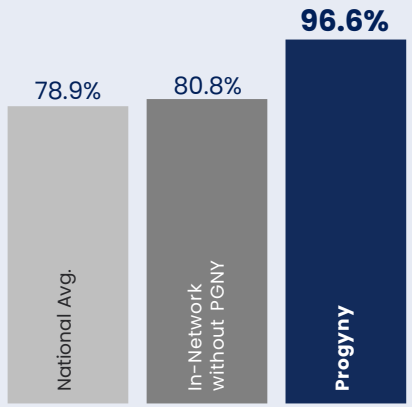
Care delivery from highly qualified, multidisciplinary experts

- Reproductive endocrinologists
- Reproductive urologists
- Embryology labs
- Genetic counselors
- Pelvic floor therapists
- Certified doulas
- Board-certified lactation consultants (IBCLCs)
- Menopause specialists (MDs, nurses, nutritionists)

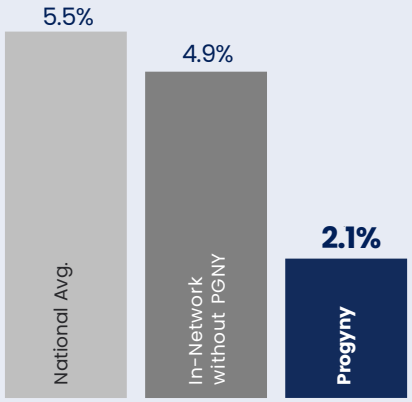
10 years of network leadership | **NCQA** accredited in credentialing | **Virtual & in-person care**

A benefit designed to drive **best individual outcomes**

Single Embryo Transfer Rate



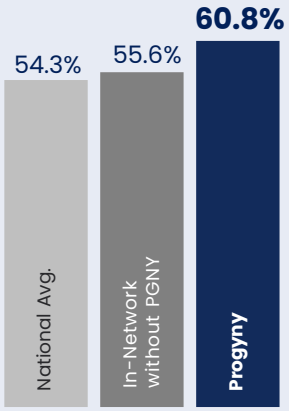
IVF Multiples Rate



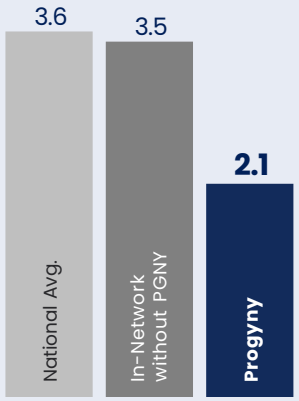
Reduced maternity risk and cost

Our leading SET rate and low multiples rate help clients mitigate high-risk cases, C-sections and NICU admissions – avoiding high-cost claims and complications from the start.

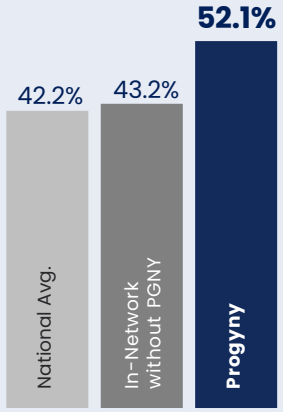
Pregnancy Rate Per IVF Transfer



Retrievals per Live Birth



Live Birth Rate



Faster time to a healthy pregnancy

The Progyny benefit design supports the individual treatment mix that members need, meaning less treatment, medication and cost needed to achieve outcomes – and healthier, satisfied members.

Note: Progyny represents Progyny in-network provider clinic averages for Progyny members based on the 12-month period ended December 31, 2023. For each Progyny outcome presented, the p-value when compared to the national average is <0.0001. | 1. Calculated based on the Society for Assisted Reproductive Technology, or SART, 2021 National Summary Report, finalized in 2024. | 2. Calculated based on CDC, 2022 National Summary and Clinic Data Sets, published in 2024. | progyny.com/milliman-report

Data based on the 12-month period ended December 31, 2023, representing 14,589 transfers.

progyny

Thank you!

Scan the QR Code to go to our website!

Emily Palik

emily.palik@progyny.com | 404.291.2022

progyny

Innovator #4: Ryan Jacobs

Marathon Health

Innovation through Primary Care

North Carolina
Business Group on Health
Fall Forum

September 12th, 2025

What we don’t do today, we pay for tomorrow

Healthcare trend at 7-9%, fueled by a perfect storm of cost drivers

Shortage of primary care doctors in U.S.

CBS News

Population shifts, risk factors may triple U.S. cardio-vascular disease costs by 2050

American Heart Association

Beyond the silo: How engagement fuels healthcare innovation

FierceHealthCare

2024—First year the U.S. expects more than 2M new cases of cancer

American Cancer Society

The real cost of absenteeism — and what you can do about it

Kaiser Permanente

In U.S., inability to pay for care, medicine hits new high

Gallup

Advanced primary care

A radical return to what we know works

Structural change

On hook for health of population

Paid for value vs. fee-for-service

1,000-patient panel (vs. 2,500 with FFS)

New model of care

Proactive, tech-enabled pathway to better, earlier help

Outcomes driven by continuous data and relationships

41% fewer hospitalizations

A healthcare home

Easy destination for up to 90% of health needs

Including value-driven specialty care referral (or avoidance)

9% reduction in specialty claims

Employers, employees and provider's win

More access, more convenience—from a cough to chronic disease management

A personal relationship and less pocketbook pain

The clinician’s original draw to medicine

A healthcare home for up to 90% of one's health needs

1 CHANNEL

HEALTH CENTER ACCESS

- **Network**
- **Hub-and-spoke**
- **Partnership**

ANYTIME ACCESS

- **Virtual care (from client center(s))**
- **CareAnywhere virtual primary care**

2 CORE OFFERING

- **Primary and preventive care**
- **Testing, labs, & immunizations**
- **Condition management**
- **Care navigation and value-driven referrals**
- **Urgent care**
- **General wellness**
- **Incentive management**
- **Mental health support**
- **Rx dispensing, home delivery**
- **Biometric kits, retail pharmacy savings card***

3 INTEGRATED CARE PLUS

- **WorkSafe** Occupational health
- **LiveBetter** Mental health
- **LevelUp** Lifestyle and metabolic health
- **MoveWell** Musculoskeletal health
- **TotalRx** Full pharmacy
- **At-home colorectal cancer screenings**

4 PLATFORM POWER

- Single-instance Athena EMR
- Purpose-built integrated technology suite
- Predictive algorithms for engagement and care
- Omnichannel patient experience
- **After-hours support**

Core and integrated care plus offering availability by vary by channel type
*Services available exclusively through CareAnywhere virtual primary care

Marathon Health by the numbers

2001
began operating

3M+
covered lives

720+
centers

95+
network sites

630+
sponsors

89
member NPS

90%
provider retention

~90,000
screenings for cancer
in the past 12 months alone

5-time
Modern Healthcare
Best Places to Work

6-time
Best in KLAS

“A third of adults suffer multiple chronic conditions. Nearly a quarter had a mental illness in the past year. Almost half worry a health event would mean bankruptcy. We’ve left people to struggle through poor health and a broken system.

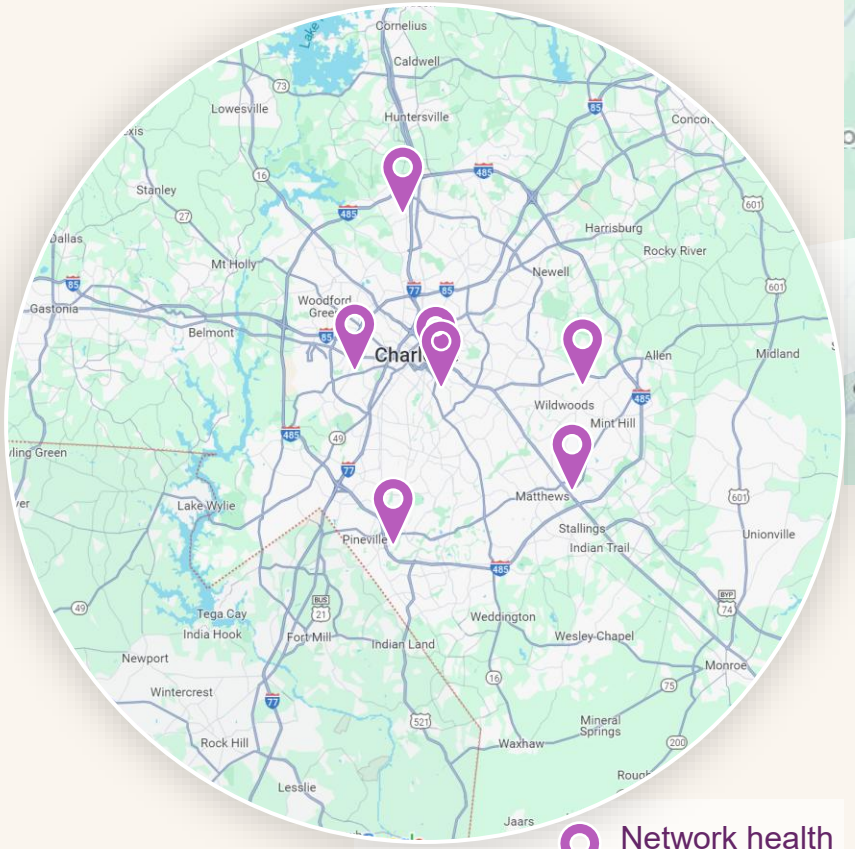
With Marathon, we built a healthcare company where providers can be led by their compassion—free from the confusion and constraints of fee-for-service medicine.

We believe the true enabler of value-based care is carers with the space to act from their values. It’s from this place that patients, providers, and our partners succeed.”

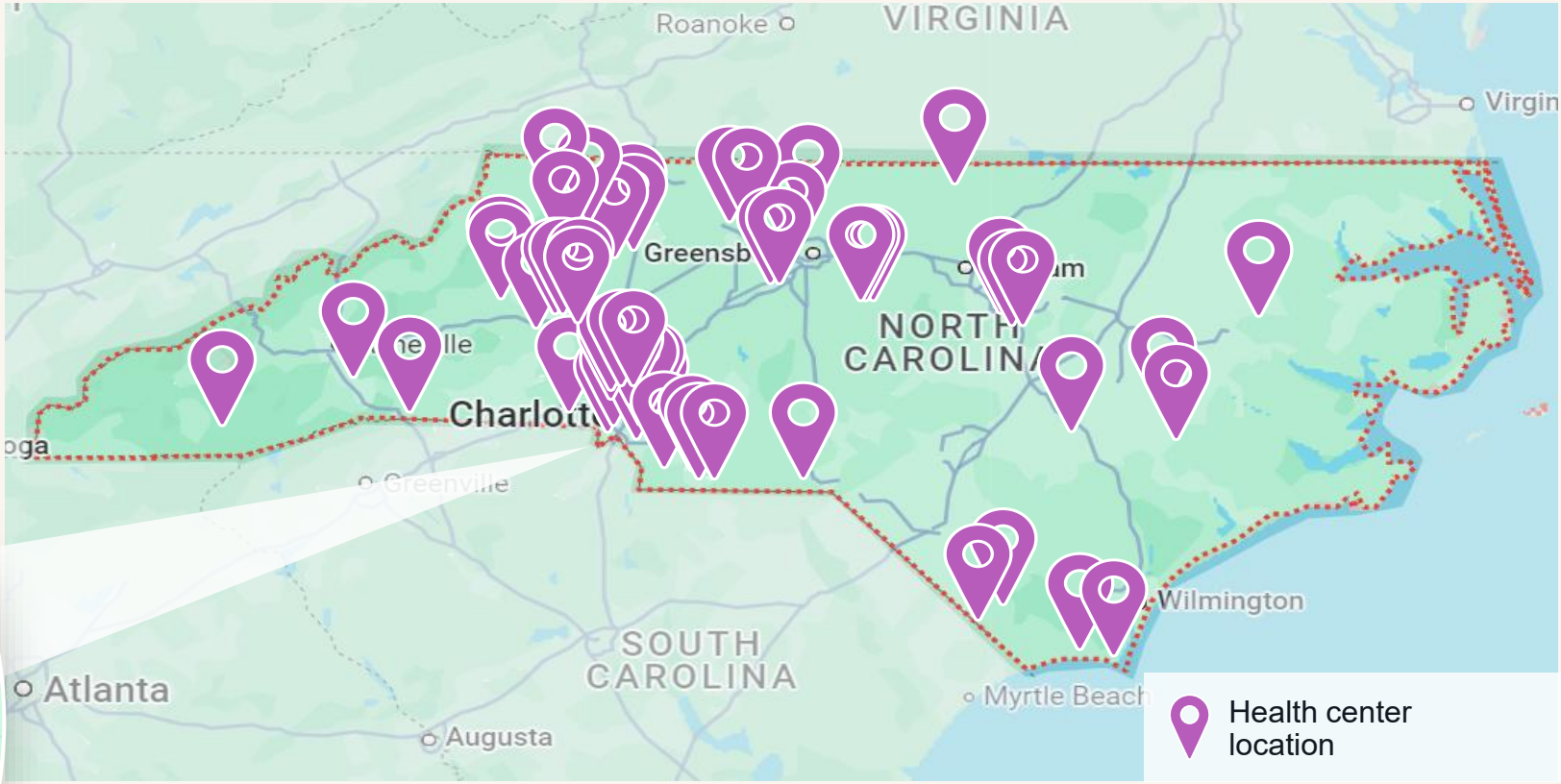
— Jeff Wells, CEO and founder, internal medicine physician, former state Medicaid director

Book-of-business as of May 2025

Marathon Health – Making an impact in NC



Network health center location



Health center location

Marathon Health – Making an impact in NC

Increased access and engagement

patient satisfaction [36]

1.2
days average wait for primary care [37]
(vs. 41 days average in Charlotte [38])

18.3
days for mental health appointments [39]
(vs. 6 weeks nationally [40])

74%
engagement among employees

82.6%
among those with chronic conditions [41]

Improved outcomes and quality of life

of engaged, at-risk members lowered their health risk [42]

47%
improved diabetes control (A1C) [43]

57%
reduced systolic blood pressure [44]

80%
improved triglyceride level [45]

THANK YOU

Employer Strategies to Manage Cell & Gene Therapy

Panel Session:

Drew Wilkins, Partner, Deloitte

Paula Stop, Director of Total Rewards, The Fresh Market

Todd Bixby, RPh, Johnson & Johnson

Employer Strategies to Manage Cell & Gene Therapy

September 12, 2025

Johnson&Johnson

Learning Objectives

- Learn about the crucial role employers can play in making CGTs more accessible and potential benefits of CGT coverage.
- Navigate the patient journey pre- and post-CGT treatment.
- Gain firsthand CGT insights from Johnson & Johnson and their partner.
- Begin navigating the complexities of the CGT landscape for your organization.
- Start formulating your organization's strategic CGT approach.

Overview of Genomic Testing & Precision Medicine

Todd Bixby RPh, MBA

Group Director

US Medical Affairs Oncology

Johnson & Johnson

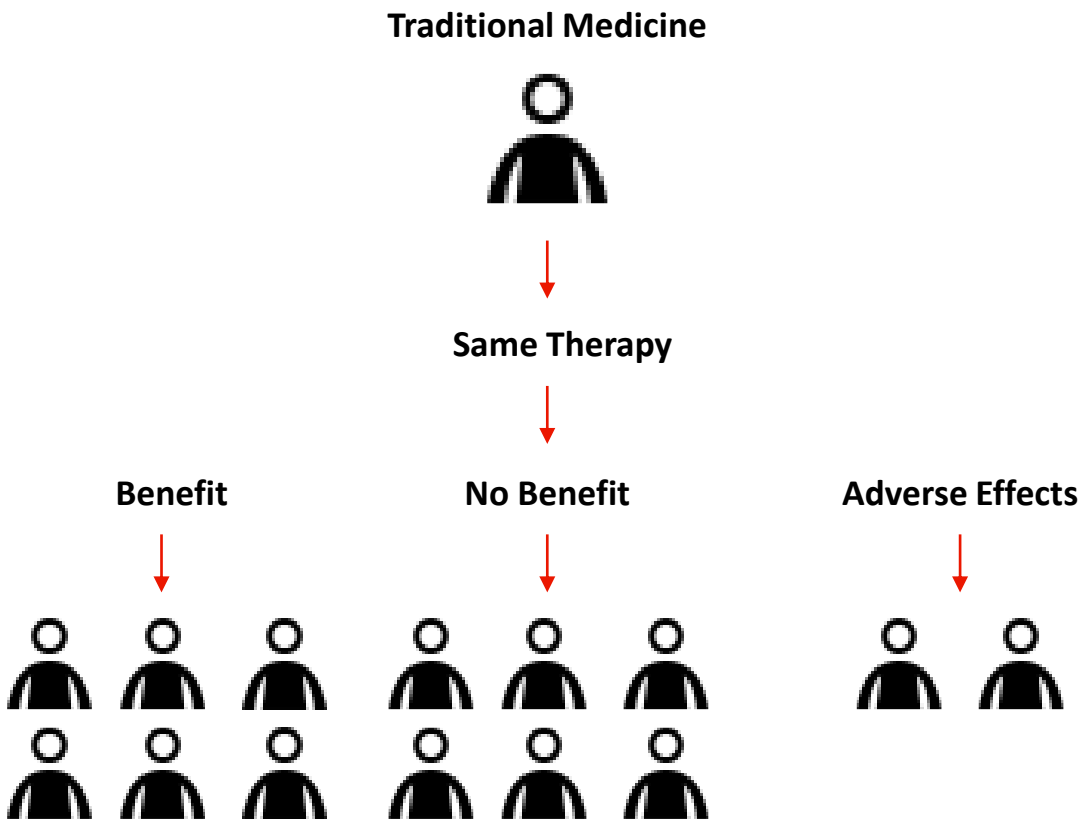
Johnson&Johnson

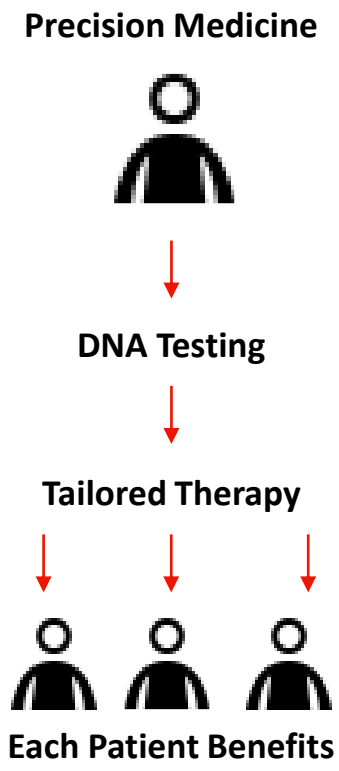
Key learning objectives

- Precision medicine uses genetic and genomic information to tailor treatment to the individual
- Many treatments rely on genetic/genomic testing for optimal medication dose or patient population selection to avoid adverse events and improve the likelihood of treatment success
- Cell therapies and gene therapies are not the same thing—but share a complexity of manufacturing and patient access
- Cell and gene therapies are the epitome of precision medicine
- Success stories of precision medicine continue to grow, in cancer and non-cancer conditions
- Rare (genetic) disorders are now treatable and potentially curable

Precision medicine confirms patient eligibility

Traditional vs. “Precision” Medicine?

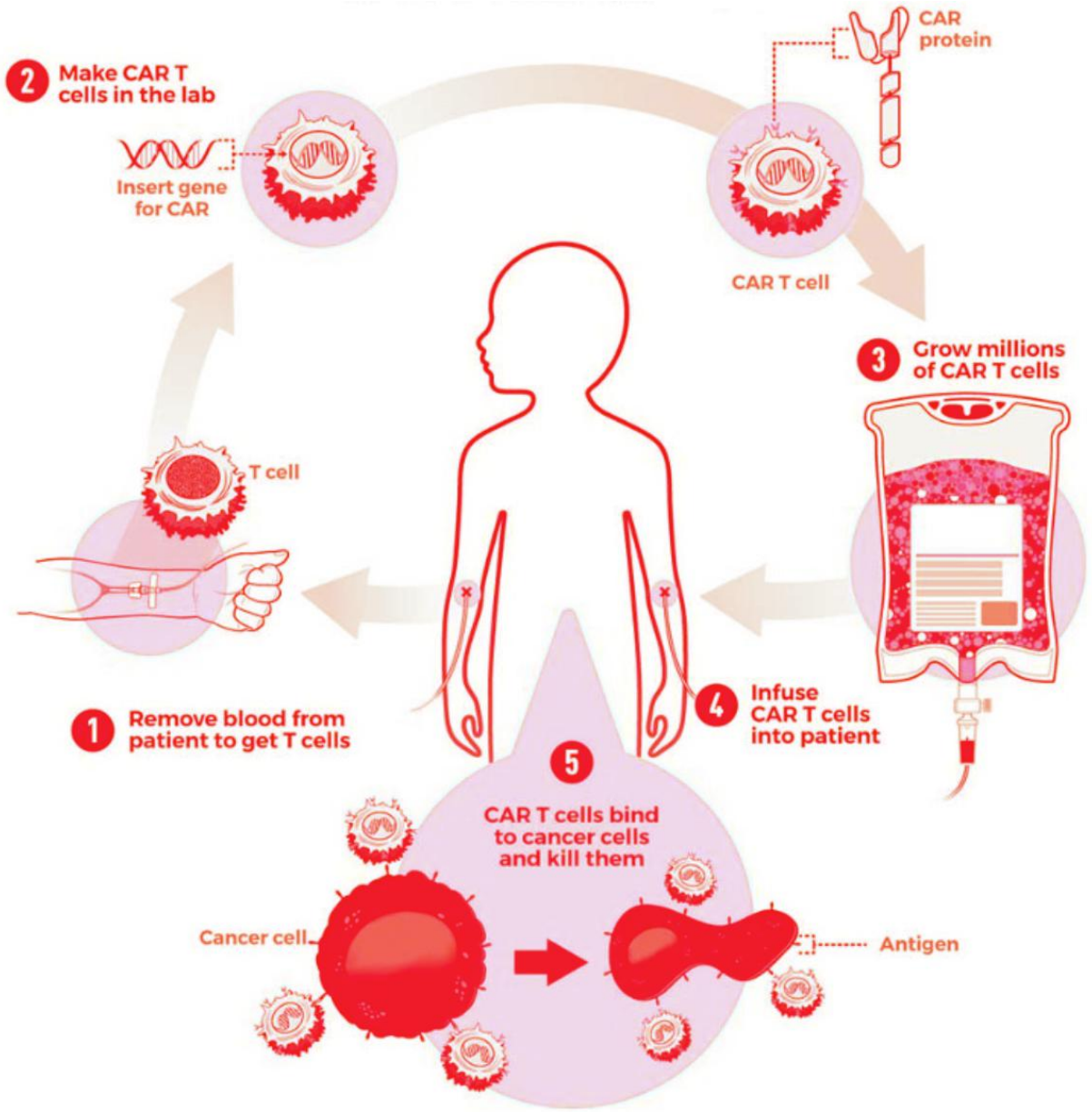




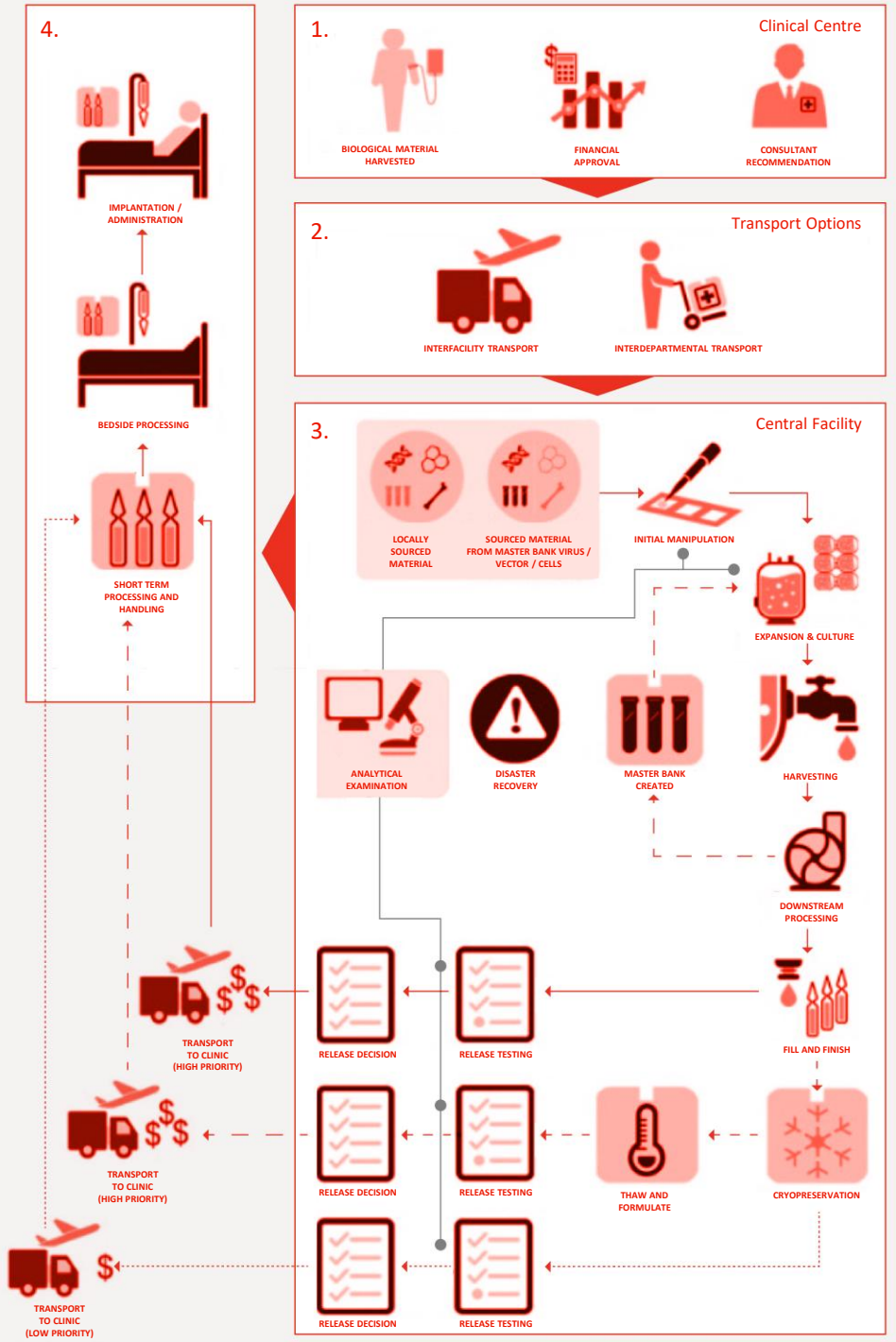
How do we know if the patient sitting in the exam room will benefit from a treatment?

CAR-T therapies are customized to each patient

Chimeric Antigen Receptor (CAR) T cell therapy[1]



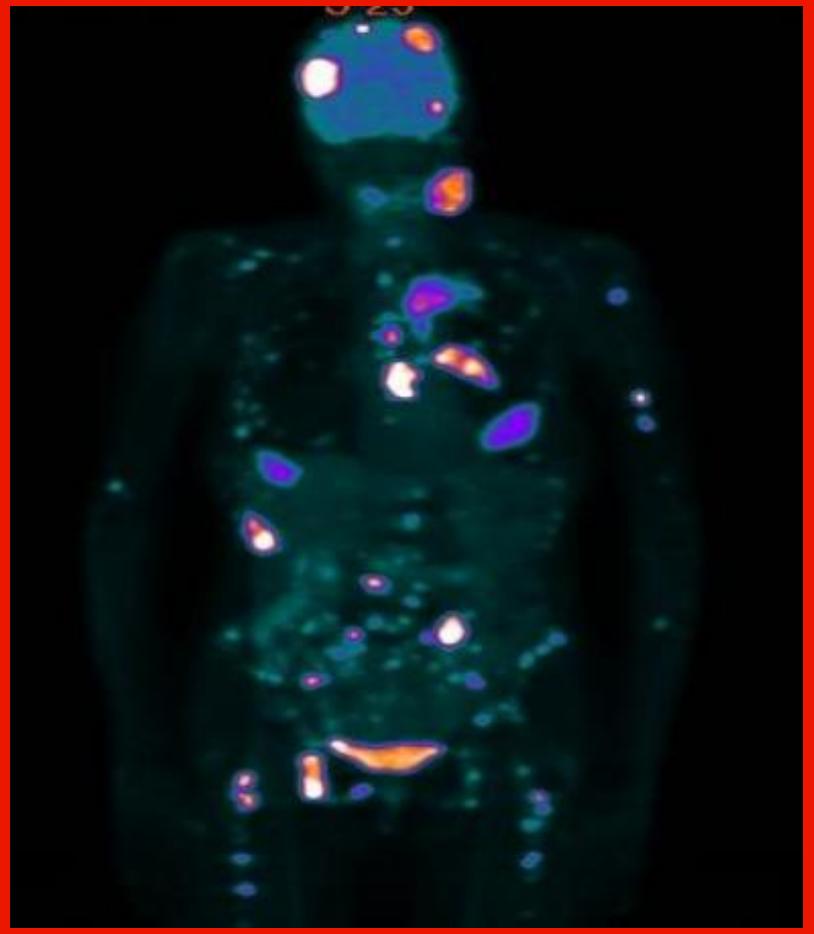
Manufacturing contributes to cell & gene therapy complexity



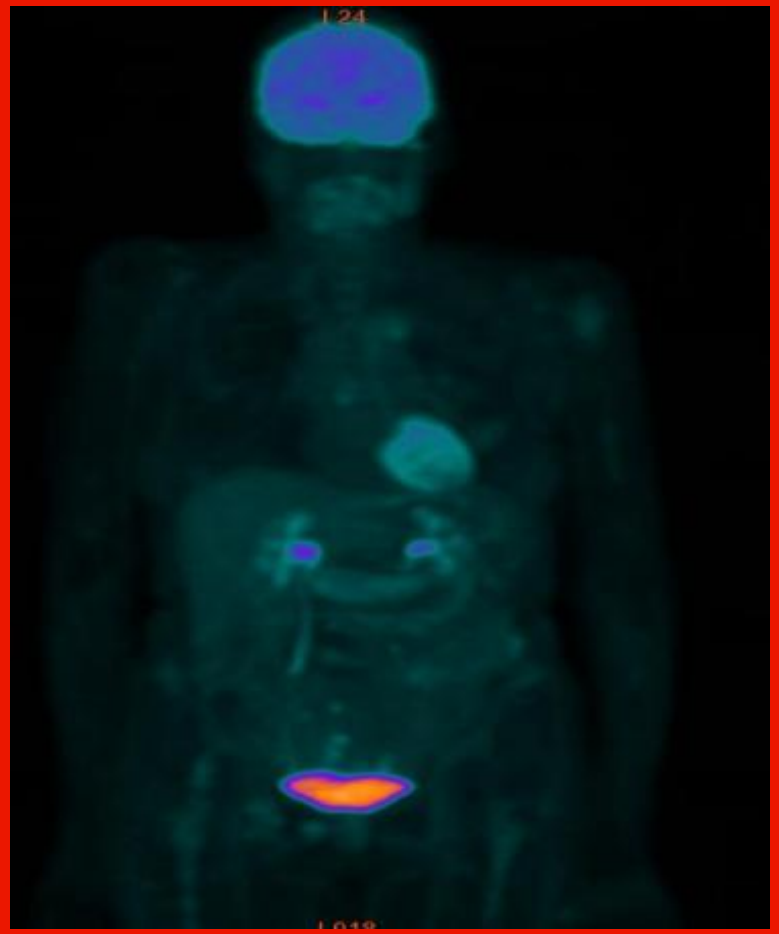
J&J

Image reference: Harrison RP, Ruck S, Rafiq QA, Medcalf N. Decentralised manufacturing of cell and gene therapy products: Learning from other healthcare sectors. Biotechnol Adv. 2018 Mar-Apr;36(2):345-357. doi: 10.1016/j.biotechadv.2017.12.013. Epub 2017 Dec 24. PMID: 29278756.

CAR-Ts are fighting previously unbeatable cancers



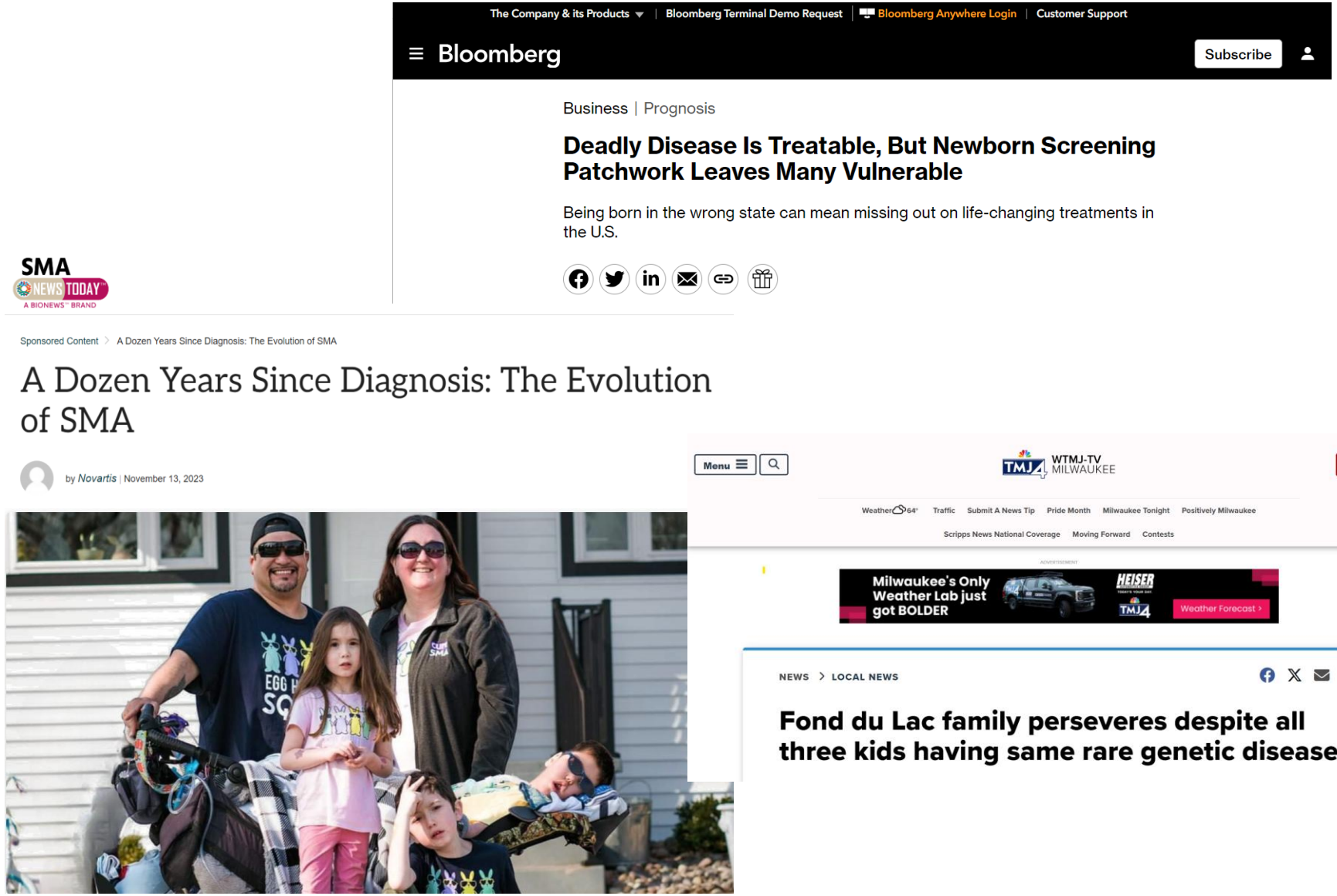
Pre CAR-T Therapy



Post CAR-T Therapy

Gene therapies bring hope to patients and families

- Spinal Muscular Atrophy (SMA)[1]
- Duchenne Muscular Dystrophy
- Sickle Cell Disease
- Retinal Dystrophy
- Hemophilia
- ... And more



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Deadly Disease Is Treatable, But Newborn Screening Patchwork Leaves Many Vulnerable

Being born in the wrong state can mean missing out on life-changing treatments in the U.S.

SMA NEWS TODAY A BIONEWS BRAND

Sponsored Content > A Dozen Years Since Diagnosis: The Evolution of SMA

A Dozen Years Since Diagnosis: The Evolution of SMA

by Novartis | November 13, 2023

Menu

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NEWS > LOCAL NEWS

Fond du Lac family perseveres despite all three kids having same rare genetic disease

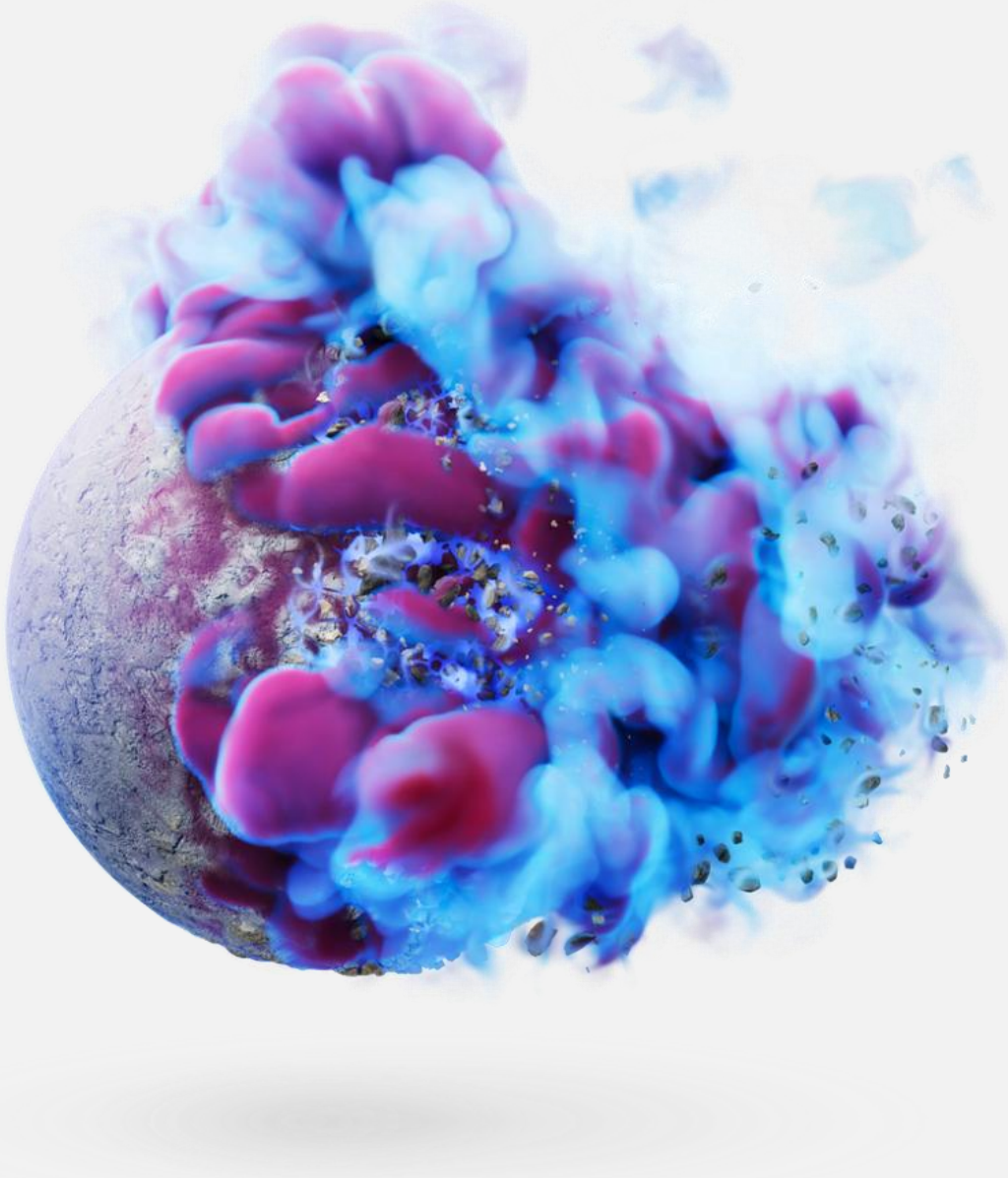
1. https://www.bloomberg.com/news/articles/2019-07-17/newborn-screening-for-rare-disease-can-be-a-life-or-death-lottery?embedded-checkout=true; https://smanewstoday.com/sponsored-content/a-dozen-years-since-diagnosis-the-evolution-of-sma/#:~:text=Amelia%2C%20the%20youngest%20Medina%2C%20was,treated%20at%20eleven%20days%20old; https://www.tmj4.com/news/local-news/fond-du-lac-family-perseveres-despite-all-three-kids-having-same-rare-genetic-disease

Take-away points

- Precision medicine uses genetic and genomic information to tailor treatment to the individual
- Many treatments rely on genetic/genomic testing for optimal medication dose or selection of patient population to avoid adverse events and improve the likelihood of treatment success
- Cell therapies and gene therapies are not the same thing—but share a complexity of manufacturing and patient access
- Cell and gene therapies are the epitome of precision medicine
- Success stories of precision medicine continue to grow, in cancer and non-cancer conditions
- Rare (genetic) disorders are now treatable and potentially curable

Transformative Therapies Require Innovative Payment Models

2025



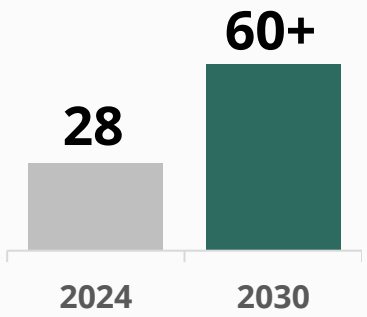
Deloitte.

While many employers have not had CGT claims, the number of patients on CGTs is expected to grow significantly – increasing the likelihood of expensive 'lightning strike' claims and increased cost of care

More CGTs in the Market

Anticipated 30+ new launches by 2030 across Oncology, Blood & other diseases[1,2]

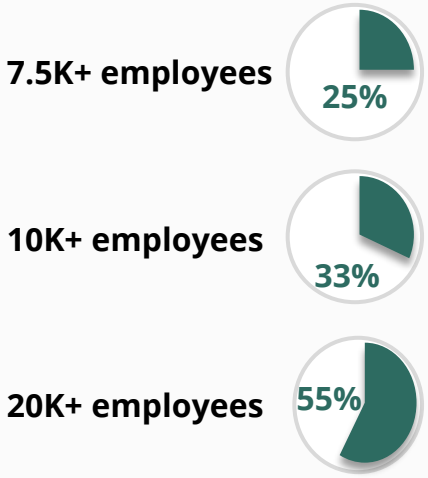
Covering 100k-300k+ US Patients by 2030



More Anticipated Claims

Higher % probability to receive at least 1 gene therapy claim by 2029 for employers[3]

% likelihood for employers with…



Costlier Coverage & Claims

We anticipate an increase in stop-loss premiums to maintain the existing limit range of $800K-$2M for recurring therapy claims

> Soon stop-loss providers will **have to carve out gene therapy coverage** or **raise premiums** very high. -- *VP & Chief Analytics Officer at a Transportation Manufacturer*

1) FDA. Approved Cell & Gene Therapies . Accessed August 28, 2024. 2) CVS Health. Gene Therapy Report Q1 2024-Q4 2026. 2024. 3) Brown & Brown. 2023 Employee Benefits Market Trends. 2023. 4) Science Translational Medicine. 2024 5) Gallagher Research & Insights. 2024 Cell & Gene Therapy Employer Research.

As more CGTs come to market, available solutions in the market will fall short in enabling adequate CGT access and affordability – exposing >100M employees to risk

The market was **not built for one-time, high-cost curative therapies.**

The price tag for a CGT treatment is significantly higher than traditional, typically chronic treatments that "amortize" the cost of care over months or years.

Recent Examples:

While multiple programs / services have been developed, they are **unlikely to be sustainable**

Existing Risk Pool Carve-Outs	Reinsurance	Stop Loss Coverage	Patient Assistance Programs

Common models - these leave critical financing gaps…

1. Existing Risk Pool Carve Outs are **expensive, limited** in coverage, and limited to own members
2. Reinsurance and stop loss coverage are **expensive (and increasing)**
3. Stop loss **deductibles are high** limiting utilization ($800K - $2M)
4. PAPs are typically **only available to patients who qualify** based on income thresholds

1) Deloitte. Innovative CGT Financing Models. 2024.

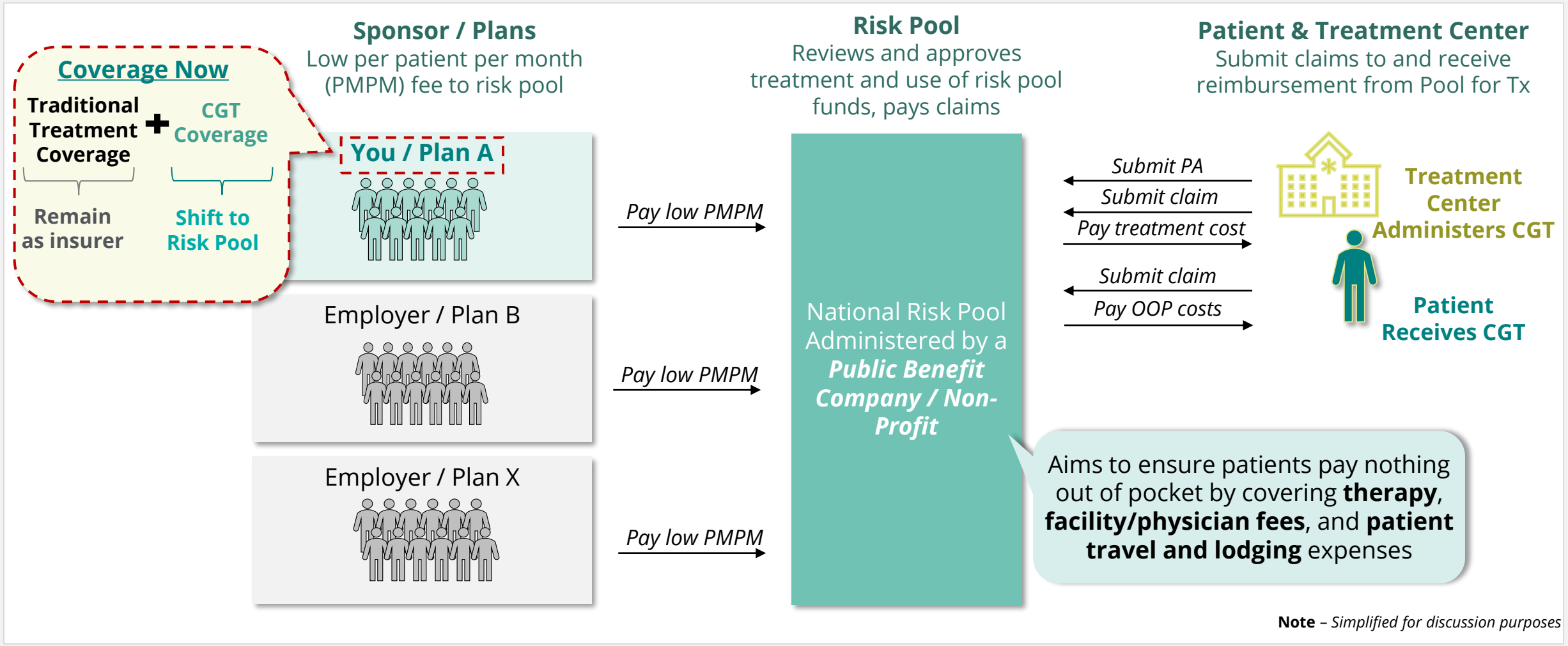
Deloitte.

We explored three innovative models – supplementing existing offerings and creating new offerings – that we believe could fundamentally change the way CGTs are financed

	1	2	3
Model	**Supplemental Risk Pool**	**New Insurance Product**	**Therapeutic Health Credit**
Description	Sponsors contribute funds to a **nationally available risk pool** which is used to cover the cost of CGT treatments for patients	Generate new financing opportunities through **new insurance policies or offering riders** on existing insurance plans	Develop **financial instruments for CGTs which can be traded** in the market
Value prop	Create a larger risk pool to distribute risk (and costs)	New insurance offering to protect against high costs	Introduce new players to share in risk and repayment

1) Deloitte. Innovative CGT Financing Models. 2024.

A novel supplemental risk pool spreads risk across multiple employers – insulating against sizable cost increases and lightning strike claims



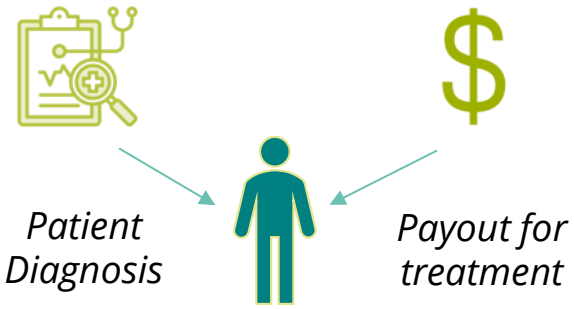
Note – *Simplified for discussion purposes*

Who benefits? The sponsor

Deloitte.

New insurance product models could include: accelerated benefits products, supplemental insurance products, and an extended/optional warranty model

Accelerated Benefit Product



Patient receives a **premature payout from their insurer upon CGT diagnosis** to cover the cost of treatment

Supplemental Insurance Product

- A **rider on a policy**, available at an additional premium
- **Covers patient OOP costs as well as indirect costs** of receiving treatment (e.g., loss of income)

Extended/Optional Warranty

Purchased at the time of care (point of differentiation from today's warranty models)

Ensures repayment or a cash outlay to the patient **in the event the therapy does not work** as intended

*While likely not enough to cover the full cost of treatment, this would **provide an added benefit to patients** as they undergo therapy and need additional financing support*

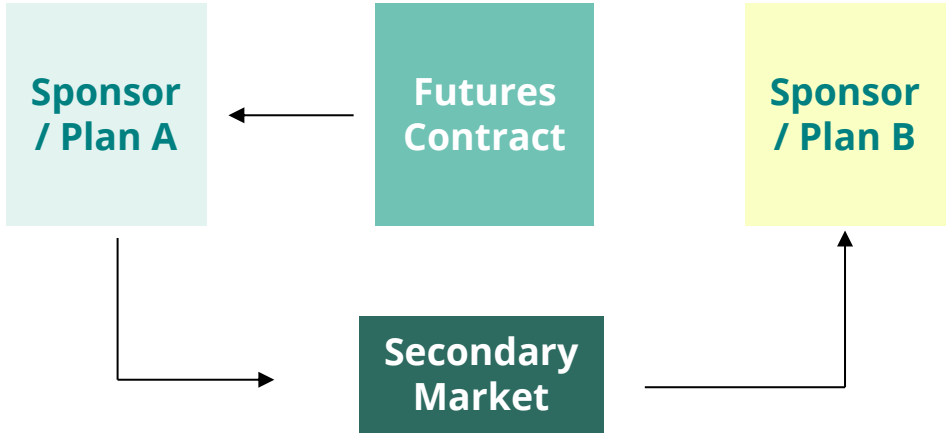
Who benefits? The patient / member

Deloitte.

Therapeutic health credit drives access to therapies using financial instruments that exist today – allowing for the diversification of the risk associated with "lightening strike" nature of CGT claims

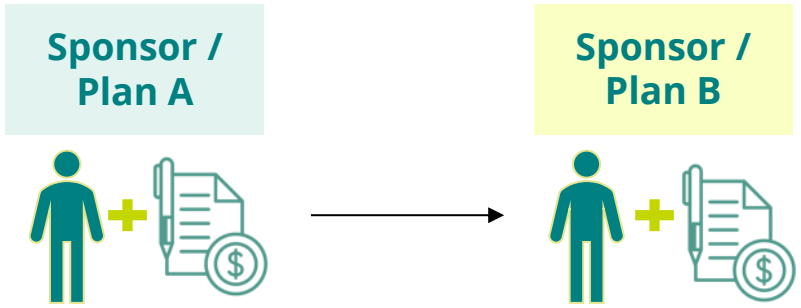
Futures Contracts Approach

1. **Health plan sponsor acquires futures contract** to cover the cost of an unexpected claim



2. If the claim does not materialize, **a secondary market would allow the sponsor to sell the contract to another sponsor** who has an immediate need for a treatment

Loan Contracts Approach



A low-interest loan could make a CGT more like the traditional chronic care model familiar to health plan sponsors.

These loans with repayment terms could become "pre-existing conditions**"**, allowing the **asset to transfer with employees if they leave the company**.

Who benefits? The sponsor (likely larger companies)

Deloitte.

What should you do TODAY to prepare for potential CGT claims?

1. **Develop your strategy**
2. **Check your policies**
3. **Talk about emerging models**

Questions? Let's connect.
Drew Wilkins
Managing Director, Deloitte Consulting
drwilkins@deloitte.com

Who is The Fresh Market?

The Fresh Market is a specialty grocery store founded in 1982

Provides a unique grocery shopping experience with warm and inviting atmosphere, classical music, soft lighting, delightful aromas and superior customer service

Full Time Team Members: 5,700

179 stores in 22 states

Corporate Office: Greensboro, NC

Gene Therapy Journey

Initial launch for first therapies wanted to cover did not have a strategy

Medical RFP in 2023 for 2024 added Embarc program with Cigna

- Covers cost of the drug
- Plan covers other expenses including inpatient stay

Fall of 2024 became aware of a possible patient for Sickle Cell

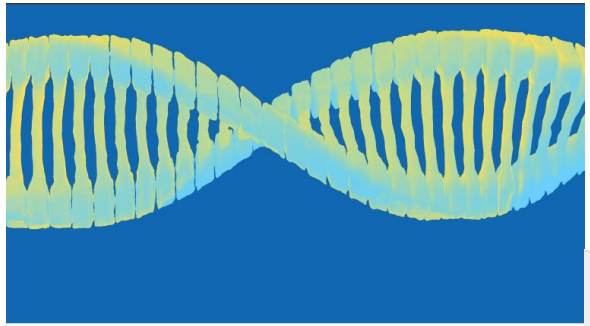
- Update in 2025 proceeding with Casgevy treatment
- Moderate expenses to this point for inpatient stays for stem cell collection
- Still in process of preparing treatment

www.ThisIsCGT.com

Data rates may apply.

Employer CGT Educational Resources

- The next innovation in disease treatment
- Navigating the financial landscape
- Understanding the benefits and challenges
- Incorporating CTGs into your health plan
- A health benefit design checklist



For self-funded employers

Key Considerations for Cell and Gene Therapy Coverage

A Health Benefits Design Checklist

This comprehensive checklist of considerations is designed to provide organizations with information on health benefits design, especially as it pertains to the coverage and management of CGTs. This may be used in conjunction with discussions with a plan carrier, PBM, consultants, or brokers.

CGT=cell and gene therapy; PBM=pharmacy benefit manager.

Conversation starters

Asking plan carriers, PBMs, consultants, or brokers the following questions can help ensure appropriate CGT coverage:

1. **What is the likelihood that our organization will see a claim for a CGT, based on our employee population and current market availability?**
2. **How are CGTs covered under our COC?**
   a. Does our COC include all CGTs, or only select therapies?
   b. Are they covered under the pharmacy benefit or the medical benefit?
   c. What CGT-related cost limits and requirements for out-of-pocket expenses are specified within our current policy?
3. **Is there a prior authorization process for CGTs within our current policy?**
   a. What are the criteria, and who will support claim review and approval decisions?
4. **How does our plan cover CGTs in the case of referrals into COEs?**
5. **Does our plan cover relevant genetic testing?**
6. **How are we currently protecting our risk in the event of a CGT claim?**
   a. With these solutions, how much would we pay for each CGT claim, and how can we enhance our options to better protect against financial exposure?
7. **How does our stop-loss insurance cover CGT claims?**
   a. Does it include all CGTs or only select therapies?
   b. Are there CGT-specific riders or policies?
   c. Are there specific limitations, exclusions, lasers, or adjusted cost sharing we should be aware of?
8. **Are we eligible to enroll in other programmatic offerings from national plan carriers or third parties?**
   a. What services do they provide, and what are the associated costs and benefits?

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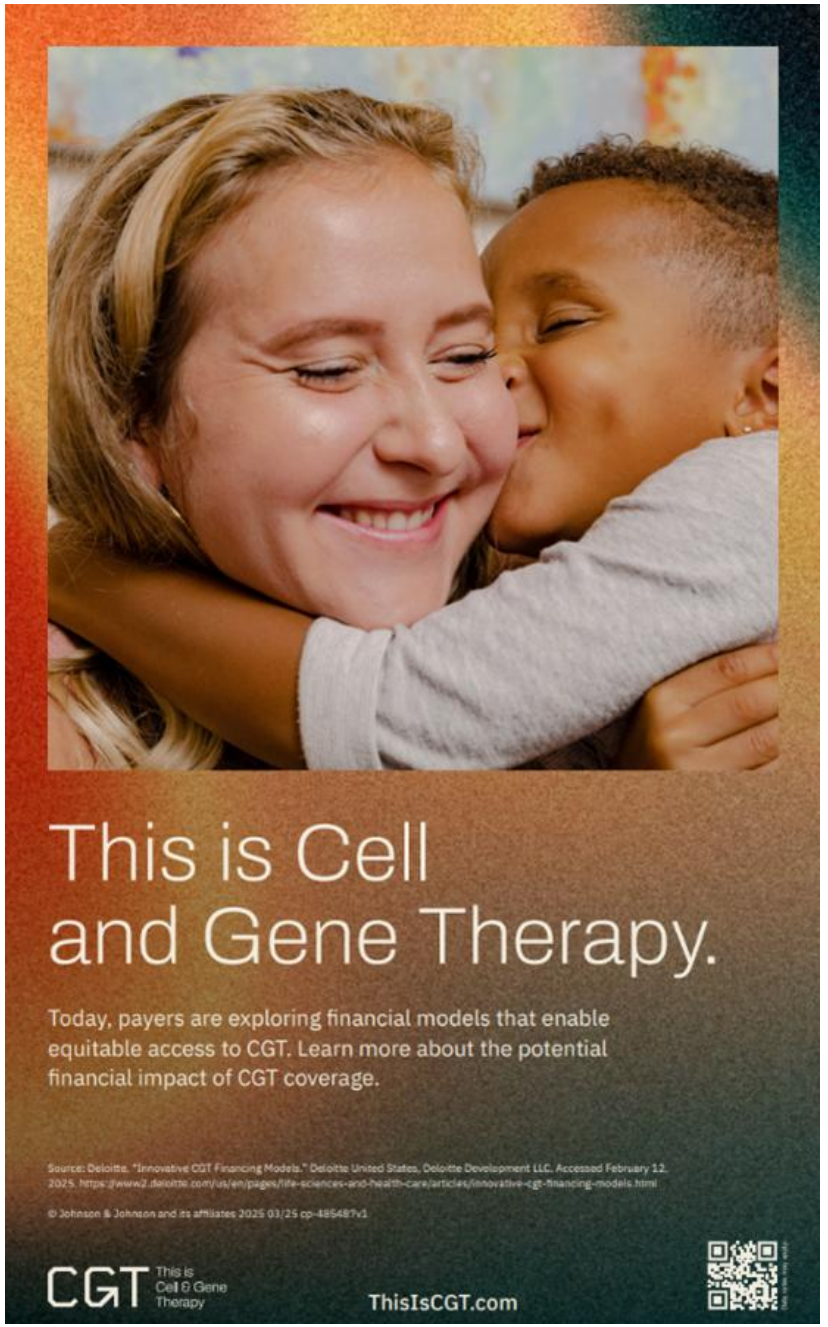
Questions and Answers



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Thank you

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Todd Bixby RPh, MBA

Group Director

US Medical Affairs Oncology

Johnson & Johnson

Todd Bixby is a Group Director for the US Medical Affairs CAR-T Team at Johnson & Johnson, leading the evidence generation strategy for CARVYKTI.

Todd is a registered pharmacist whose clinical experience includes 10-years of in-patient and outpatient oncology pharmacy practice in Pennsylvania.

For the past 27 years Todd worked in the pharmaceutical industry in clinical research, professional education, marketing, and medical affairs, and has authored several peer reviewed articles on topics ranging from the implications of biosimilars in the US market to the perceptions of patients receiving administration of outpatient CAR-T.

Todd earned his pharmacy degree from the Philadelphia College of Pharmacy and Science and Master of Business Administration from Pennsylvania State University.

Johnson&Johnson

Drew Wilkins
Managing Director,
Deloitte Consulting LLP

Drew Wilkins is a Managing Director in Deloitte Consulting LLP's commercial strategy practice.

He has more than 20 years of consulting experience and focuses on commercial strategy and innovative business models for biopharmaceutical and medtech clients.

He helps clients solve the strategic challenges associated with growth, innovation and ecosystem disruption. This includes a focus on innovative access models and health equity for commercial life sciences organizations.

Drew also leads Deloitte's efforts related to innovative financing models for advanced and emerging therapies, including cell and gene therapies. His recent work includes designing a novel supplemental risk pool to spread the cost of gene therapies across multiple payers.

Drew earned his BS from Vanderbilt University and his MBA from the Tuck School of Business at Dartmouth College. He lives in Annapolis, Maryland with his school-aged children.

Paula Legendre Stop
Director of Total Rewards
The Fresh Market, Inc.

As the Director of Total Rewards for The Fresh Market, Inc. Paula Legendre Stop is responsible for the company benefit and compensation programs.

Paula received her Professional of Human Resources (PHR) designation in 2005. In 2016, Paula earned her CEBS (Certified Employee Benefits Specialist) designation and in 2019 and 2020 earned the Fellowship designation. She serves as the board chair for the North Carolina Business Coalition on Health (NCBCH) and also serves on the governing council for the International Society of Certified Employee Benefit Specialists (ISCEBS).

She has a B.A. degree in French and International Business from the University of Tennessee and an M.B.A from the University of North Carolina at Greensboro.

Healthcare's Risk to Our Country, Our Companies and Our Jobs: AI as a Solution

Chris Chan

Chief Value Officer

finHealth

finHealth

Healthcare's Risk to Our Country, Our Companies and Our Jobs: AI as a Solution

September 2025

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Chief Value Officer
cchan@finhealth.com

CHRIS CHAN
CHIEF VALUE OFFICER
@FINHEALTH

RECOVERING CONSULTANT

wtw Mercer

Healthcare's Risk to Our Country, Our Companies and Our Jobs

It is your duty to your employer and your country to do something about it.

ChatGPT

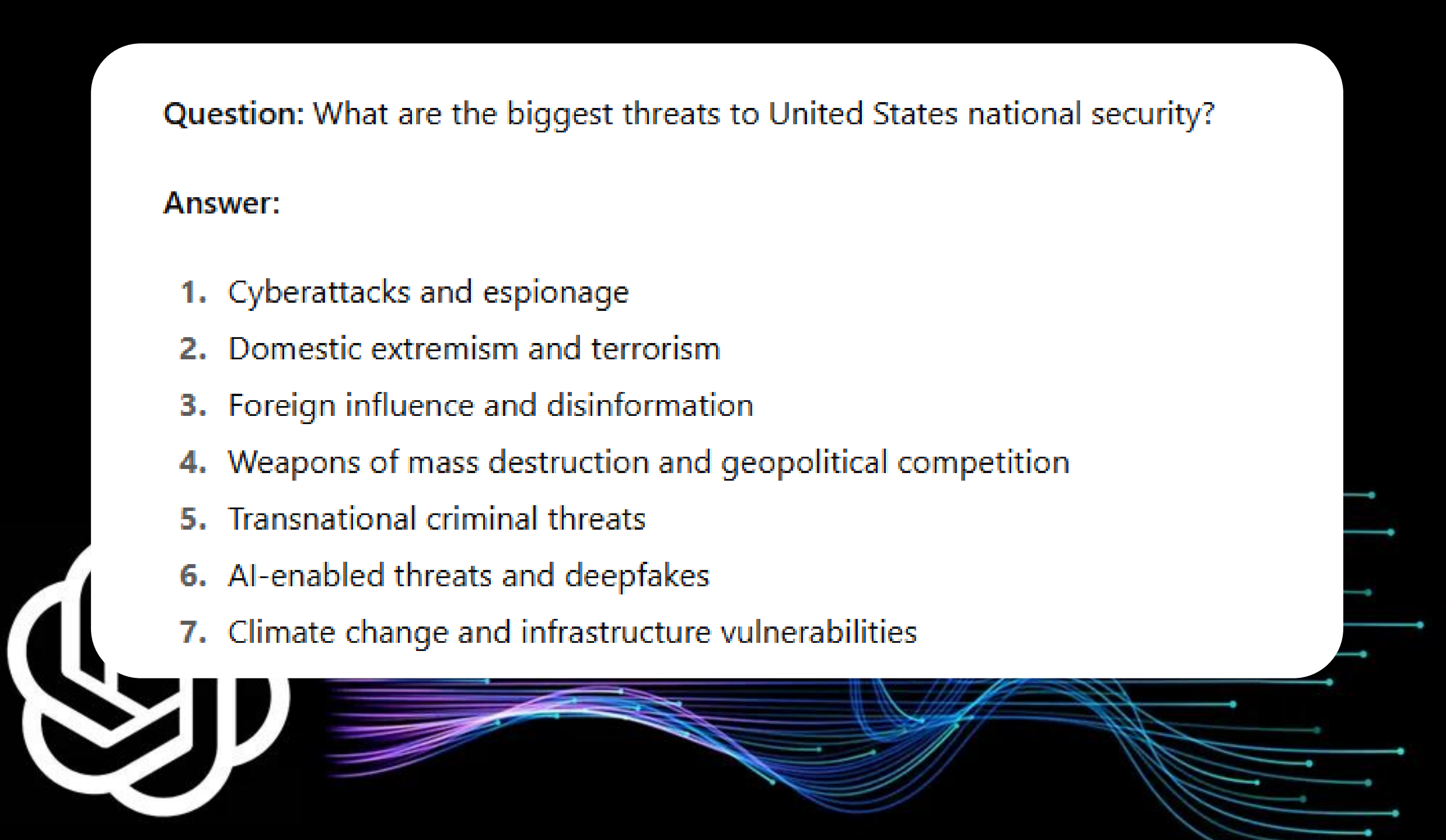
A. Macro Level
US Threats

Macro Threat #1: Domestic Disinformation and Deepfakes

Question: What are the biggest threats to United States national security?

Answer:

1. Cyberattacks and espionage
2. Domestic extremism and terrorism
3. Foreign influence and disinformation
4. Weapons of mass destruction and geopolitical competition
5. Transnational criminal threats
6. AI-enabled threats and deepfakes
7. Climate change and infrastructure vulnerabilities



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7. Climate change and infrastructure vulnerabilities

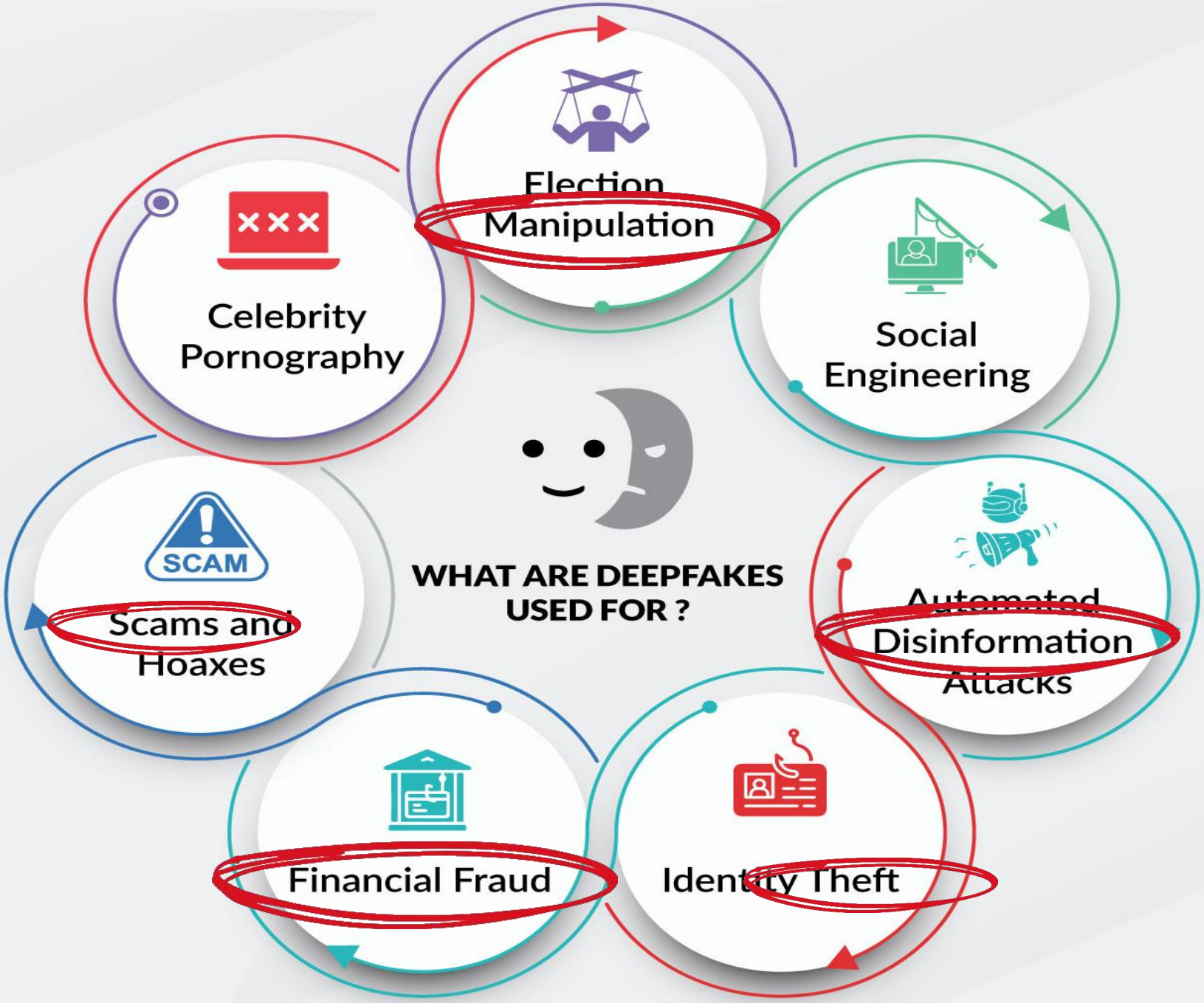

Original: Fallon
Swapped
Target: Oliver

Finance worker pays out $25 million after video call with deepfake ‘chief financial officer’

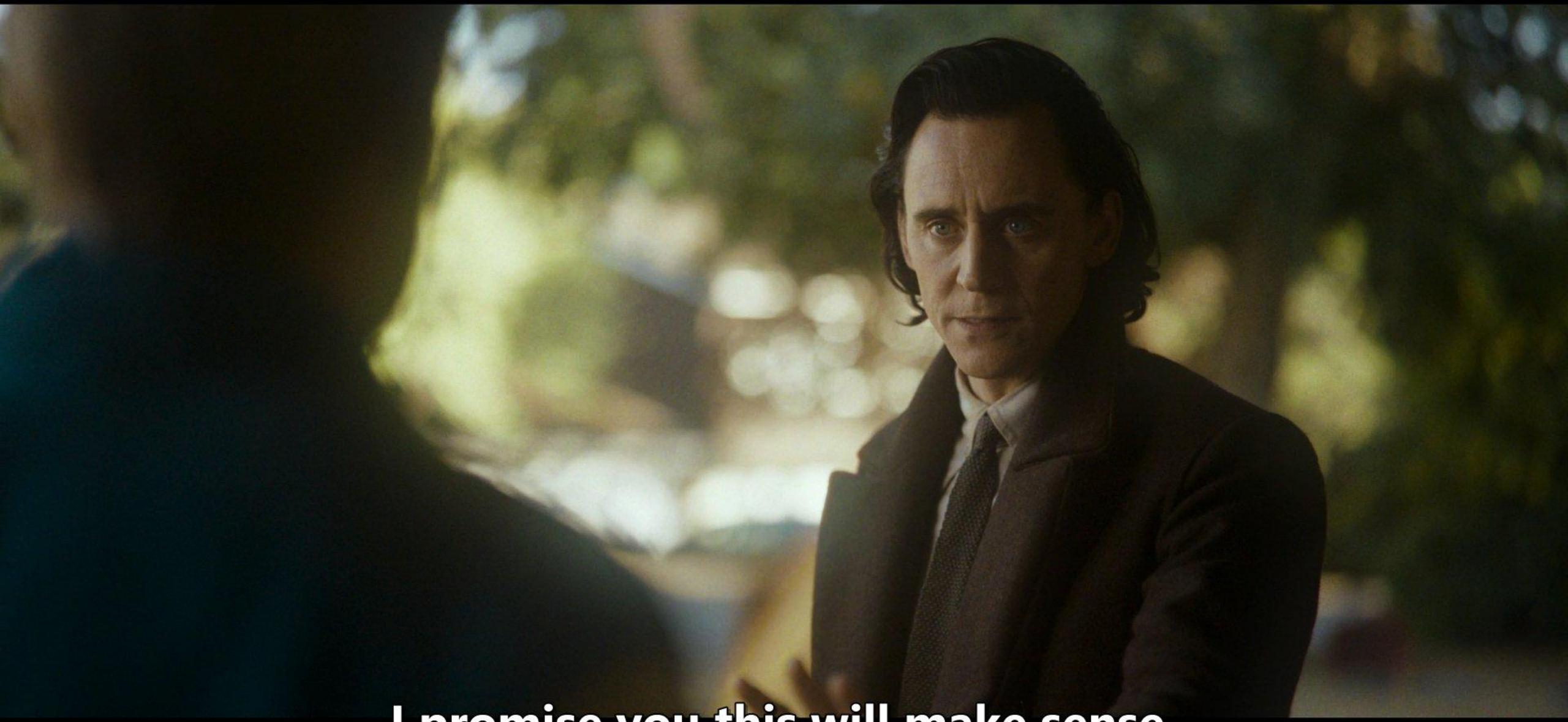
By Heather Chen and Kathleen Magramo, CNN

2 minute read · Published 2:31 AM EST, Sun February 4, 2024


Election Manipulation
Social Engineering
Automated Disinformation Attacks
Identity Theft
Financial Fraud
Scams and Hoaxes
Celebrity Pornography
SCAM
WHAT ARE DEEPFAKES USED FOR ?


Election Manipulation
Social Engineering
Automated Disinformation Attacks
Identity Theft
Financial Fraud
Scams and Hoaxes
Celebrity Pornography
SCAM
WHAT ARE DEEPFAKES USED FOR ?

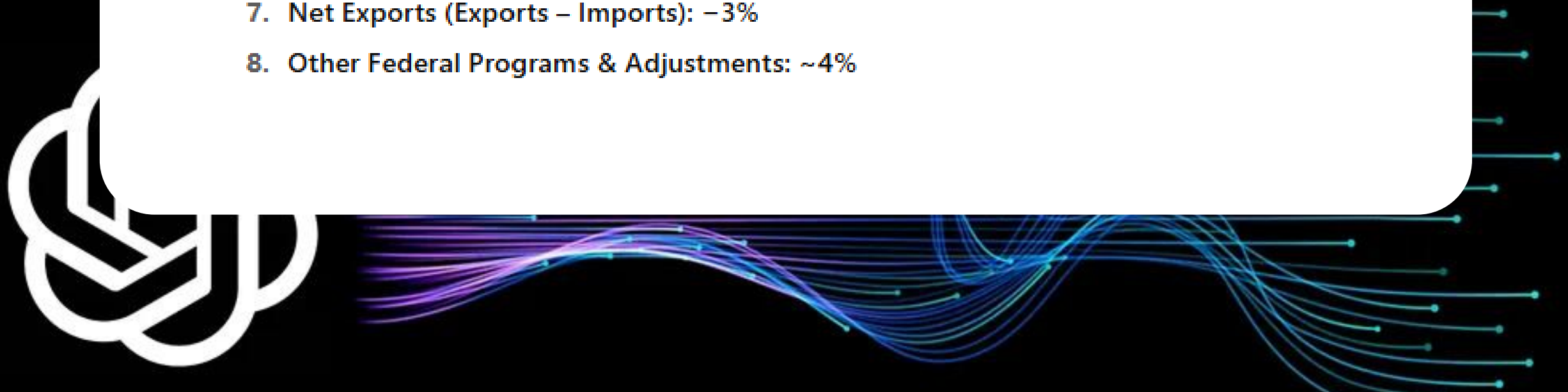
Key Takeaway:
DEEPFAKES are a Threat to Our Country


I promise you this will make sense.

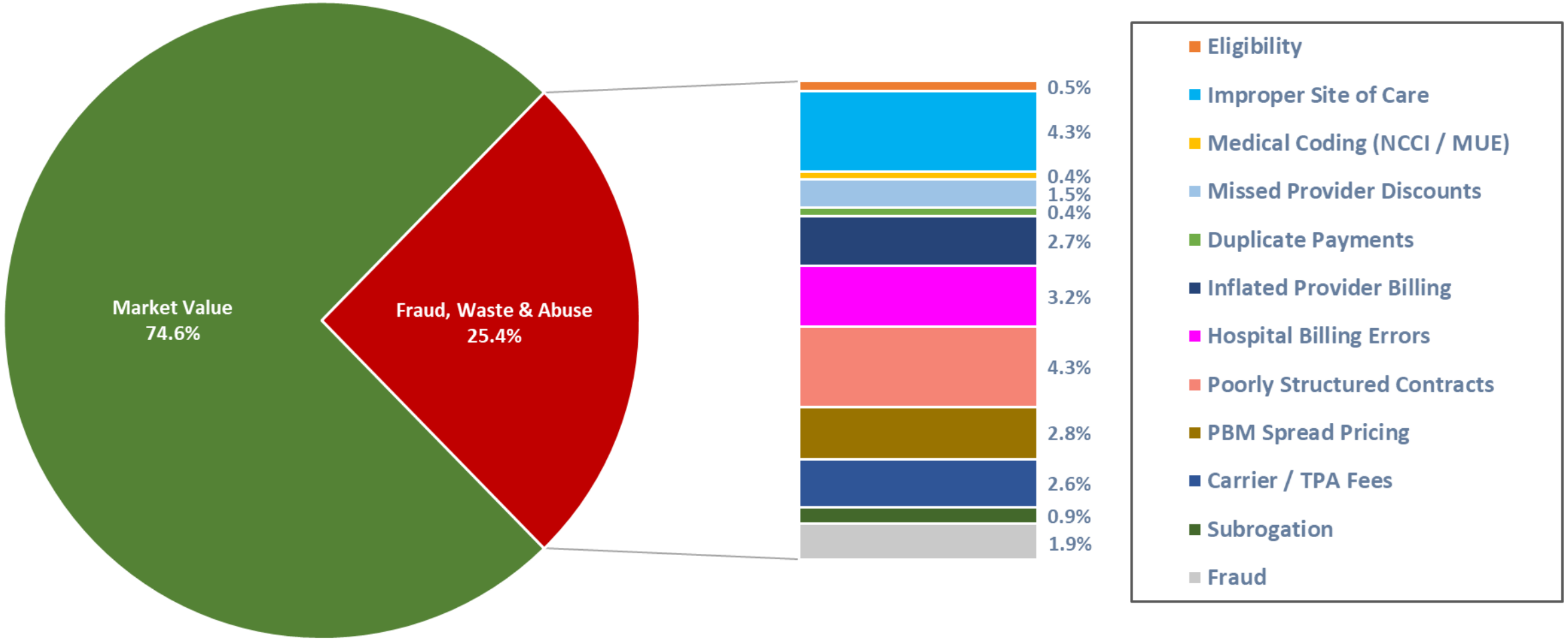
Macro Threat #2: Healthcare Drags Down Our Economy

Question: What are the top U.S. GDP categories by percentage?

1. Personal Consumption (non-healthcare): 51%
2. Healthcare Spending (all sources: government, private insurance, out-of-pocket): 18%
3. Private Investment (business capital & residential): 18%
4. State & Local Government Spending (non-healthcare): 6%
5. Federal Defense Spending: 3.4%
6. Federal Non-Defense Spending (non-healthcare): 3.0%
7. Net Exports (Exports – Imports): −3%
8. Other Federal Programs & Adjustments: ~4%



25%-30% of Healthcare spending is Waste



Imagine having 4%-6% to spend elsewhere

Question: What are the top U.S. GDP categories by percentage?

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8. Other Federal Programs & Adjustments: ~4%

US Has World's Most Expensive Healthcare

Source: OECD (2023), Health spending (indicator)
Note: Healthcare Spending in US dollar/Capita

INTERNATIONAL BUSINESS TIMES

The Best Healthcare in the World:

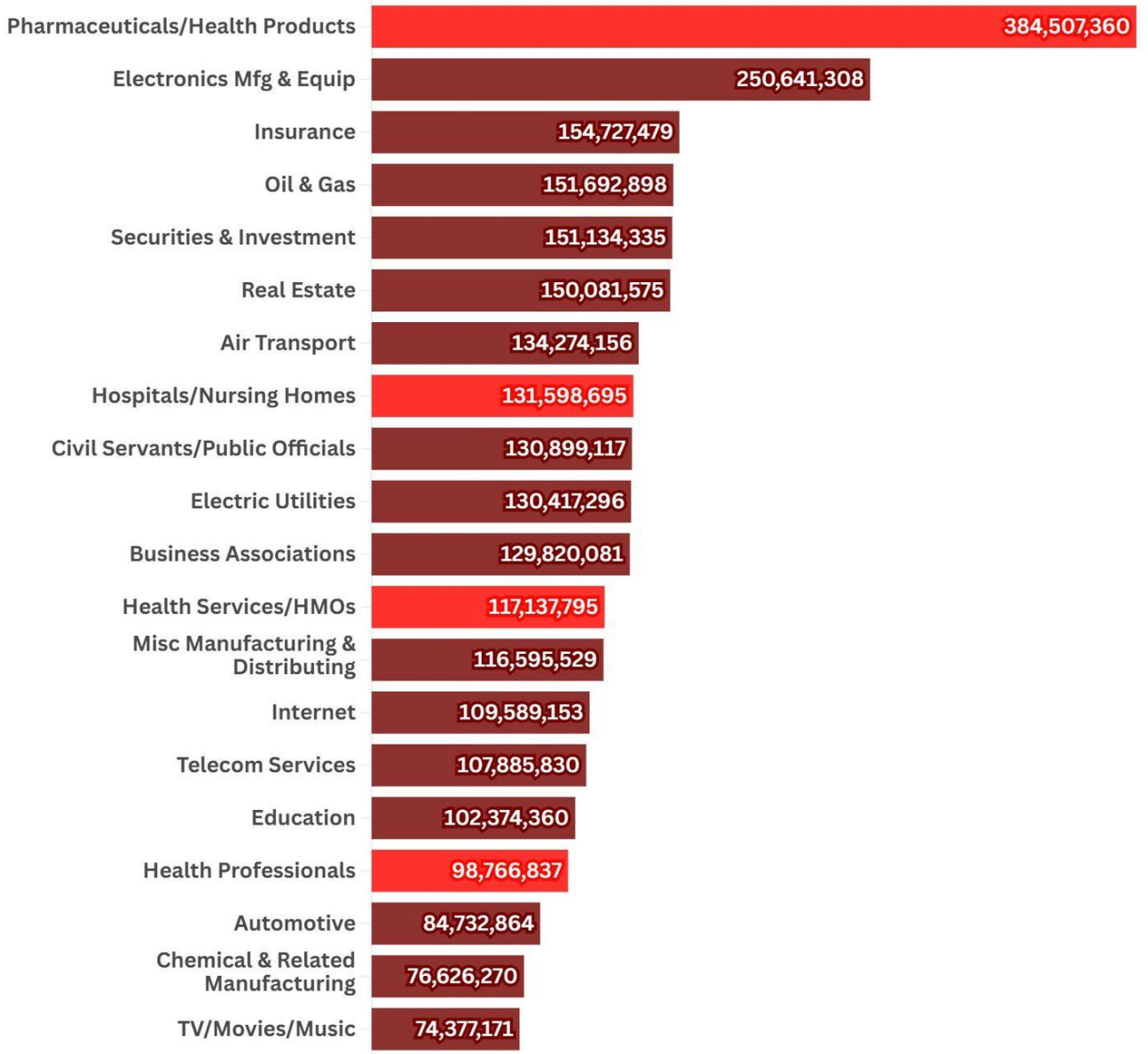
Country Rankings

	AUS	CAN	FRA	GER	NETH	NZ	SWE	SWIZ	UK	US
OVERALL RANKING	1	7	5	9	2	4	6	8	3	10
Access to Care	9	7	6	3	1	5	4	8	2	10
Care Process	5	4	7	9	3	1	10	6	8	2
Administrative Efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	—	4	5	9
Health Outcomes	1	4	5	9	7	3	6	2	8	10

TOTAL SPENDING ON LOBBYING

THE INSIDER

TOP 20 INDUSTRIES IN US, 2024, $



Source: OpenSecrets

Key Takeaway:
We Spend The Most on Healthcare,
Receive the Least

B. Micro Level Employer Threats

Employer Threat #1: Healthcare

Question: What are the biggest threats to U.S. employers?

Answer:

1. Ransomware and cyberattacks
2. Supply chain disruptions and tariff-related instability
3. Immigration enforcement and I-9/audits burden
4. Executive security risks and workplace violence
5. Regulatory compliance complexity (labor, AI, data privacy, classification)
6. Talent shortages, retention struggles, and "quiet quitting"
7. Burnout, disengagement, and low employee well-being
8. AI-related job insecurity, bias, and surveillance concerns
9. Cultural polarization and DEI backlash
10. Return-to-office (RTO) tensions, ghost jobs, and distrust of HR


99% of all problems can be solved by money – and for the other 1% there's alcohol.
Quentin R. Bufogle
quotefancy

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9. Cultural polarization and DEI backlash
10. Return-to-office (RTO) tensions, ghost jobs, and distrust of HR

Question: What are the top people costs that U.S. employers spend money on?

Answer:

1. Total cash compensation (wages, salaries, bonuses, incentives, and commissions)
2. Health insurance premiums
3. Retirement plan contributions
4. Payroll taxes
5. Paid time off (PTO)
6. Training and development
7. Workers' compensation insurance
8. Overtime pay
9. Other fringe benefits

"General Motors is a health and benefits company with an auto company attached."

- Warren Buffett

Starbucks spends more on healthcare than coffee beans.

Question: What are the top things that U.S. employers waste money on?

Answer:

1. Inefficient healthcare spending (low-quality care, unnecessary services, inflated prices)
2. Administrative inefficiencies and redundant processes
3. Small unmanaged expenses (gift cards, meals, perks)
4. Excessive stock buybacks over workforce investment
5. Corporate retreats and low-ROI perks
6. Overuse of consultants and overengineered processes
7. Idle assets, unsold inventory, and abandoned projects

Ron Leopold, MD, MBA, MPH • 1st

High-Cost Medical & Rx Claims Consulting for Employers / Brokers

3d • Edited •

www.ronleopold.com

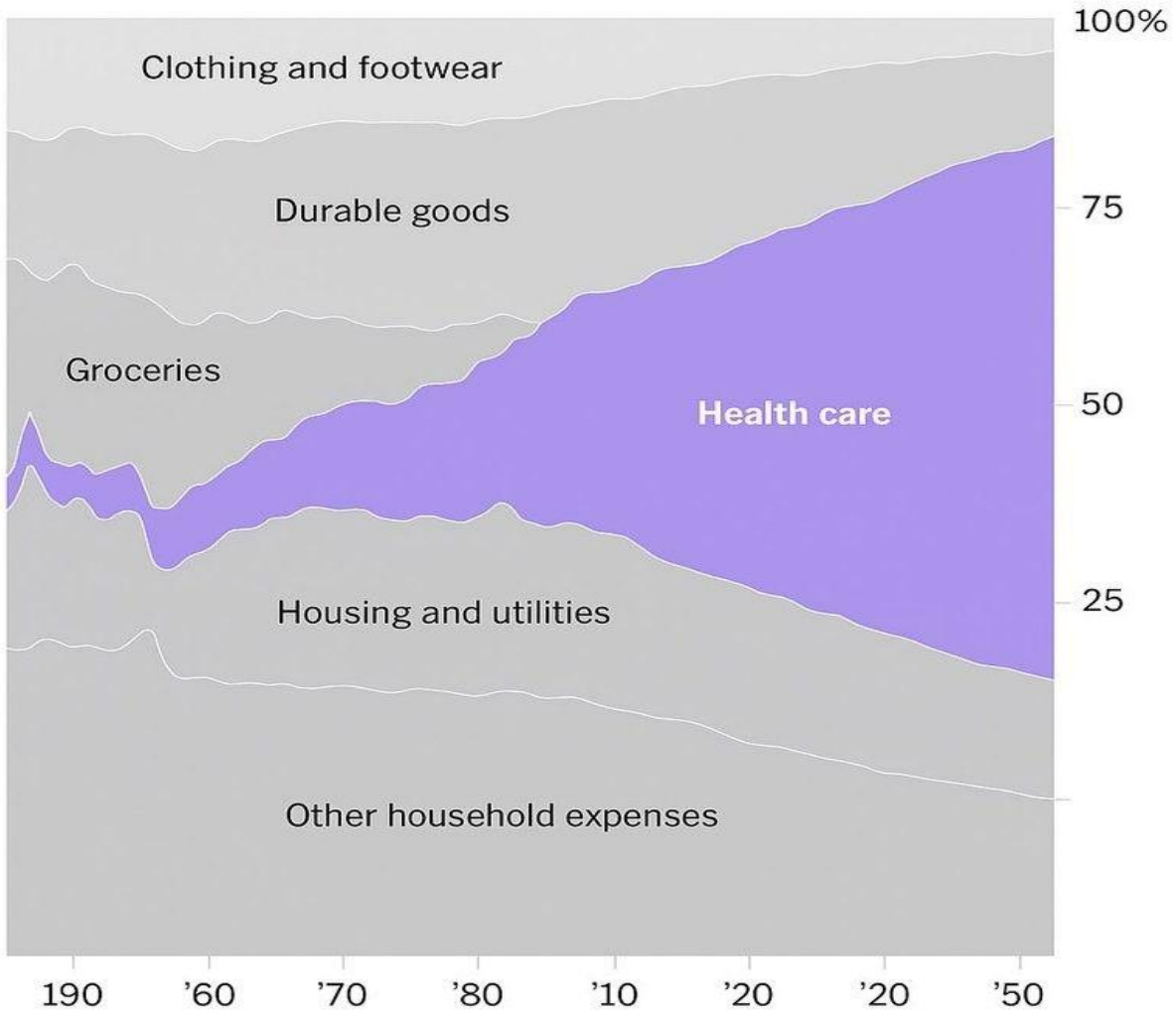
Strategies for High Cost Claims are varied and require an appreciation of employer benefits, culture, carriers, point solutions, industry and plan member demographics. Are you on track?
(Image from Union Healthcare Insight).

Employers expect medical spending to accelerate in 2025

	Business Group on Health	AON	Mercer	pwc	wtw
Typical trend (post-ACA)	5 – 7%				
2024 cost trend	7.2%	8.0%	N/A	7.5%	6.9%
2025 projected cost trend	7.8%	9.0%	7.0%	8.0%	7.7%
Notable cost drivers	• Pharmacy costs (esp. GLP-1s) • Cardiovascular disease	• Cardiovascular disease • Cancer	• Medical inflation (i.e. price) • Drugs (GLP-1s + specialty)	• Hospital prices • Drugs (GLP-1s + specialty) • Behavioral health	• Medical inflation • Drugs • Cancer • Behavioral health

Americans now spend more on health care than groceries or housing

Share of U.S. household expenditures. 1929–2024



Source: New York Times analysis of Bureau of Economic Analysis data

• Note: The health care category includes spending on health insurance and other modutical and other medical products.

• By The New York Times

The Impact is Professional and Personal

Key Takeaway:
HEALTHCARE is a Drain on Employer and Personal Budgets

Employer Threat #2: Litigation Risk

Employers Suing Health Plans

Ford

Union of Bricklayers and Allied International Craftworkers

Sheet Metal Workers Local 40 Org. 1923

Healthcare • Pension • Annuity • Legal Services
Benefits for Laborers

Massachusetts Laborers' Benefit Funds

Kraft Heinz

The School District of Osceola County, FL

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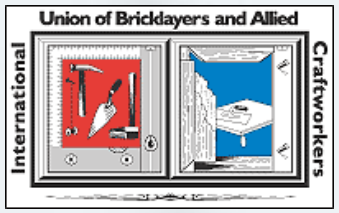
Employers Suing Health Plans



MASSACHUSETTS
LABORERS' BENEFIT
FUNDS

The School District of Osceola County, FL

Employees Being Solicited to Sue Their Employers

The likelihood that U.S. employers will be sued by employees for breach of healthcare fiduciary duties is **growing**. Here's why:

1. **Increasing scrutiny:** Regulators and plaintiff lawyers are paying more attention to health plan fiduciary compliance, especially as healthcare costs keep rising sharply.
2. **Rising number of lawsuits:** There has been a noticeable increase in class-action lawsuits alleging breaches of fiduciary duty related to healthcare plans over the past 3-5 years.
3. **Targeted mostly at large and mid-sized employers:** Employers with complex, self-funded health plans and large numbers of participants face higher risk because there's more at stake and more opportunity for alleged mismanagement.
4. **Preventive compliance can reduce risk:** Employers who actively monitor their plans, conduct regular audits, negotiate fees, and maintain transparent communications greatly reduce their chances of litigation.

In summary:

If an employer sponsors a self-funded health plan and doesn't manage it carefully, the risk of a breach-of-fiduciary-duty lawsuit is **moderate to high** over time.

Question: Can HR representatives be named in lawsuits alleging breach of healthcare fiduciary duties?

Answer:

Yes, HR representatives **can be named in these lawsuits**, but usually as part of a group of plan fiduciaries rather than as sole defendants.

- Under ERISA, fiduciaries include anyone with discretionary authority or control over the health plan's management or assets, which can include HR staff involved in plan decisions.
- If HR representatives influence vendor selection, plan design, or benefit administration, they may be considered fiduciaries and potentially liable.
- Lawsuits often name the plan, the employer, and fiduciary individuals collectively, including HR, benefits managers, and executives.
- Courts typically focus on those with actual control, so not all HR staff are automatically at risk.
- To reduce risk, HR professionals should understand their fiduciary roles, follow prudent processes, and carefully document decisions.

Key Takeaway:

HEALTHCARE Litigation is a Risk Both Professionally and Personally

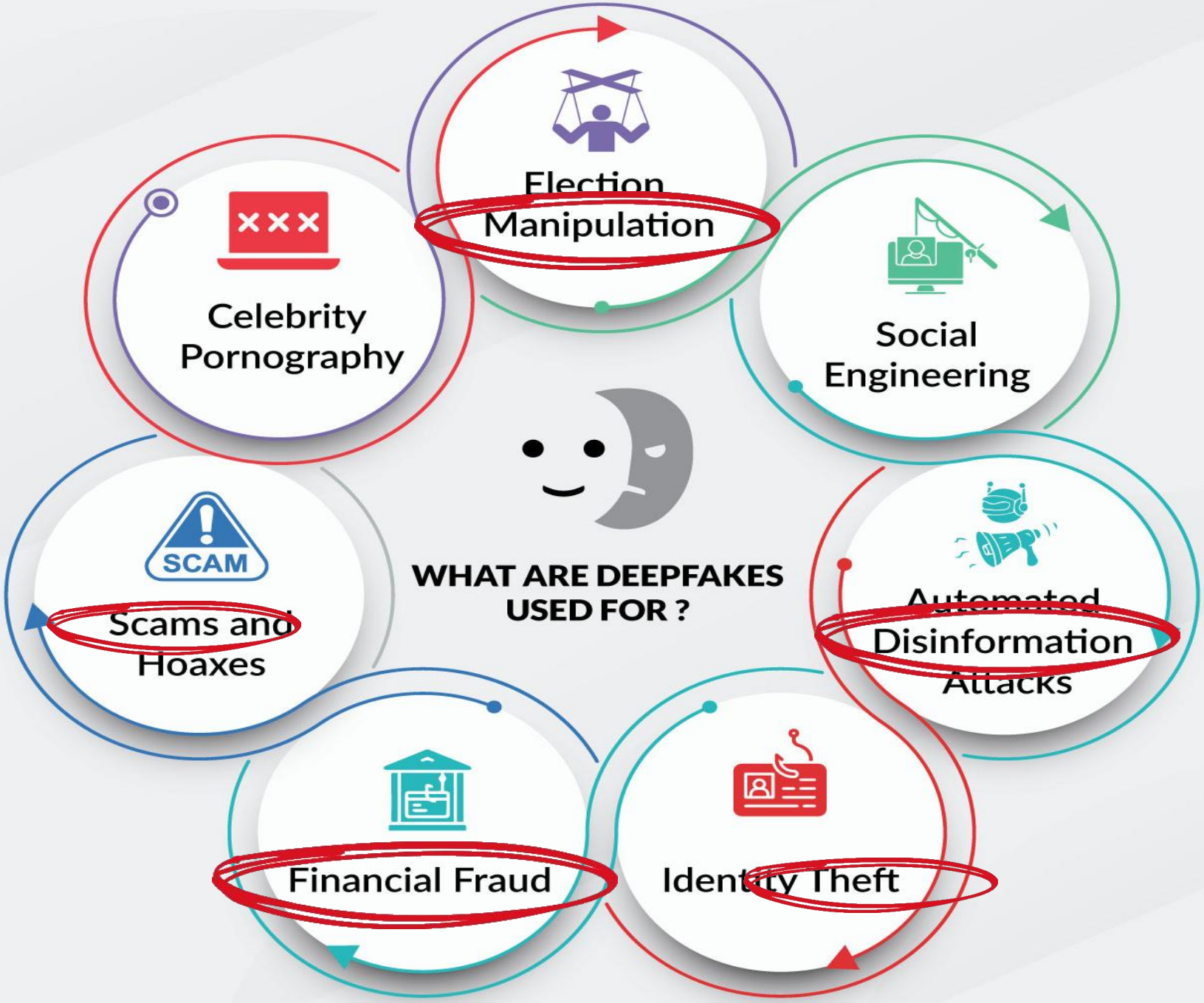
Takeaways so far:

1. Deepfakes are a threat to our country
2. We spend the most on Healthcare, receive the least
3. Healthcare is a drain on employer budgets
4. Healthcare Litigation is a Professional and Personal Risk

Blending Everything Together

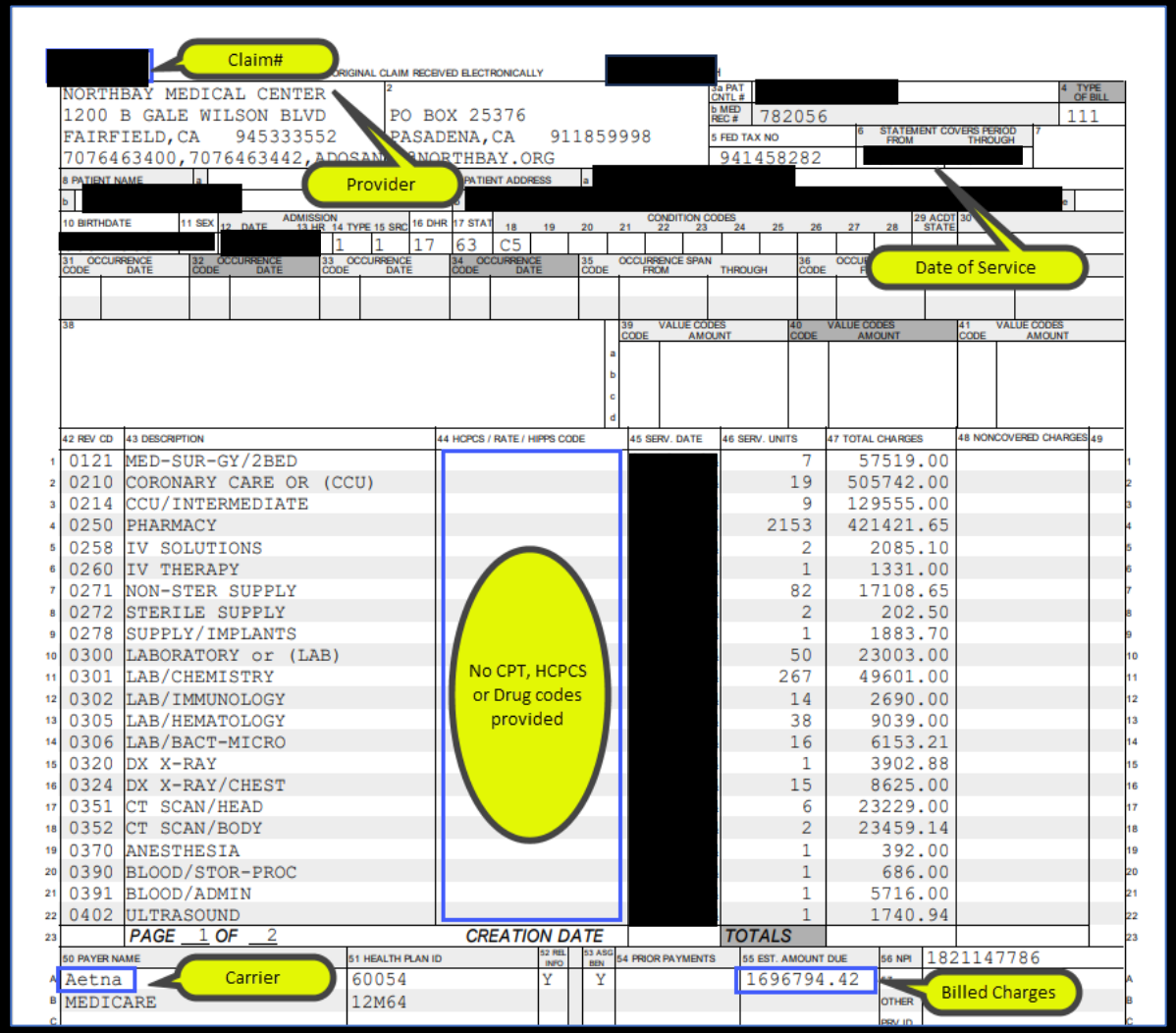
HEALTHCARE DEEPFAKES

ARE A THREAT TO OUR COUNTRY, OUR COMPANIES AND OUR JOBS


Election Manipulation
Social Engineering
Automated Disinformation Attacks
Identity Theft
Financial Fraud
Scams and Hoaxes
Celebrity Pornography
SCAM
WHAT ARE DEEPFAKES USED FOR ?

So…WHAT DOES A HEALTHCARE DEEPFAKE LOOK LIKE?

Prepayment Example: UB-04



NORTHBAY MEDICAL CENTER
1200 B GALE WILSON BLVD
FAIRFIELD,CA 945333552
7076463400,7076463442,ADOSAM@NORTHBAY.ORG

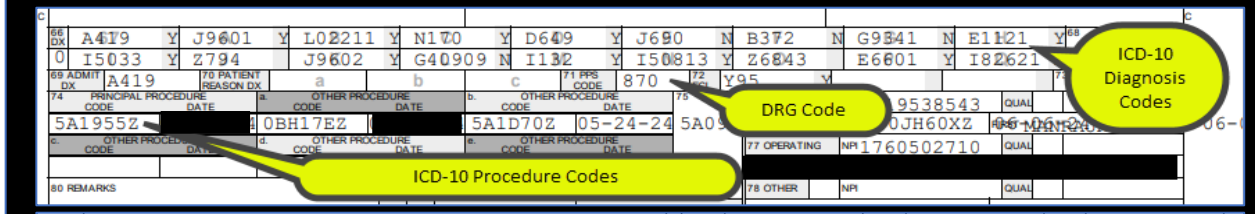
PO BOX 25376
PASADENA,CA 911859998

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES
0121	MED-SUR-GY/2BED			7	57519.00	
0210	CORONARY CARE OR (CCU)			19	505742.00	
0214	CCU/INTERMEDIATE			9	129555.00	
0250	PHARMACY			2153	421421.65	
0258	IV SOLUTIONS			2	2085.10	
0260	IV THERAPY			1	1331.00	
0271	NON-STER SUPPLY			82	17108.65	
0272	STERILE SUPPLY			2	202.50	
0278	SUPPLY/IMPLANTS			1	1883.70	
0300	LABORATORY or (LAB)			50	23003.00	
0301	LAB/CHEMISTRY			267	49601.00	
0302	LAB/IMMUNOLOGY			14	2690.00	
0305	LAB/HEMATOLOGY			38	9039.00	
0306	LAB/BACT-MICRO			16	6153.21	
0320	DX X-RAY			1	3902.88	
0324	DX X-RAY/CHEST			15	8625.00	
0351	CT SCAN/HEAD			6	23229.00	
0352	CT SCAN/BODY			2	23459.14	
0370	ANESTHESIA			1	392.00	
0390	BLOOD/STOR-PROC			1	686.00	
0391	BLOOD/ADMIN			1	5716.00	
0402	ULTRASOUND			1	1740.94	
	PAGE 1 OF 2	CREATION DATE		TOTALS		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
Aetna	60054	Y	Y		1696794.42	1821147786
MEDICARE	12M64					

Key Takeaways

- UB-04 Form is forwarded by the carrier.
- The form is used by finHealth to perform an initial valuation of the claim.
- The form give us important fields such as the DRG, diagnosis, and procedure codes; as well as dates of service and a high-level summary of the charges.



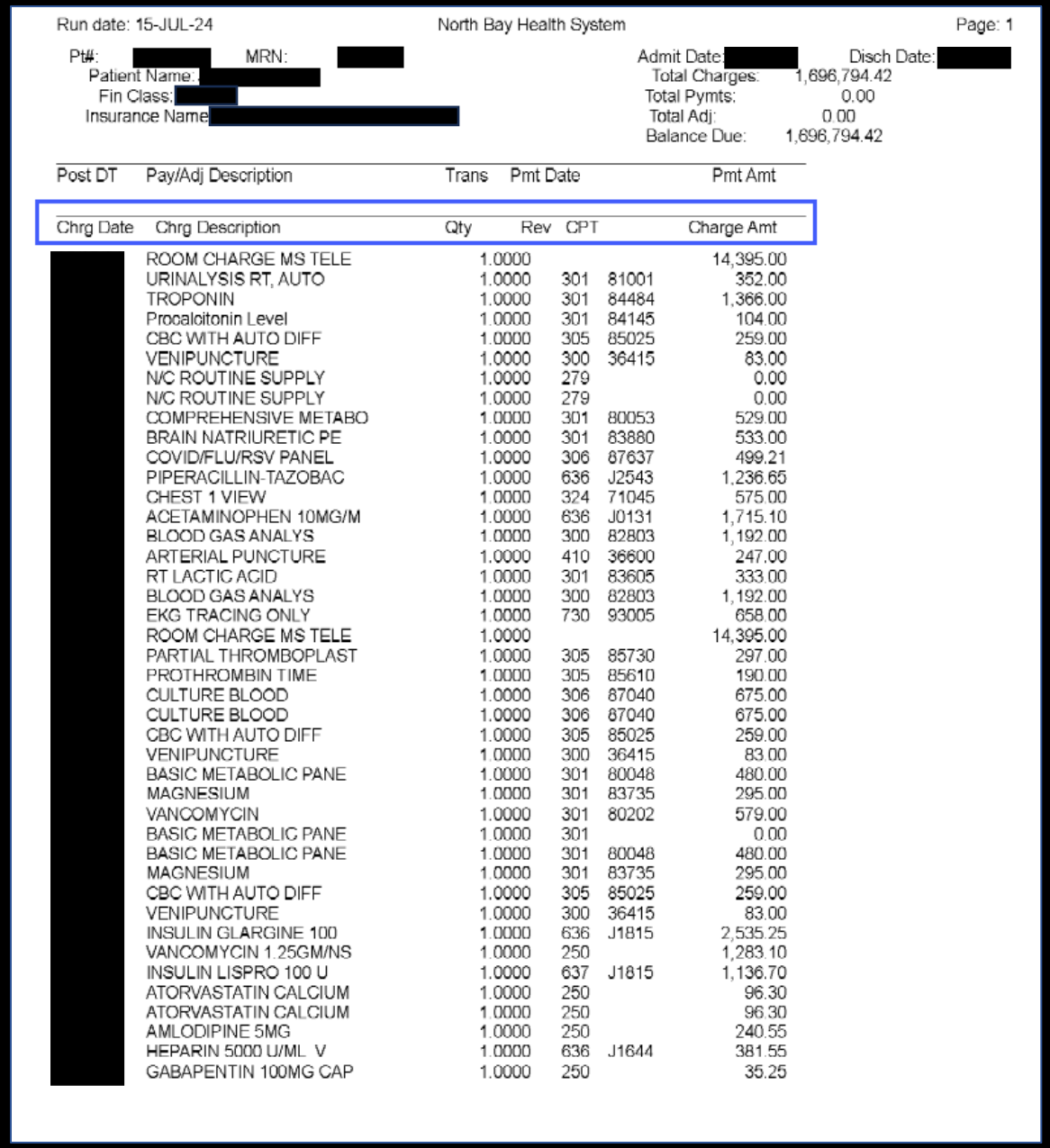
42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NONCOVERED CHARGES
0410	RESPIRATORY SVC			42	196695.00	
0420	PHYSICAL THERAP			7	1099.00	
0424	PHYS THERP/EVAL			1	206.00	
0430	OCCUPATION THER			1	157.00	
0434	OCCUP THERP/EVAL			1	68.00	
0440	SPEECH PATHOL			5	2125.00	
0444	SPEECH PATH/EVAL			1	471.00	
0450	EMERG ROOM			3	25604.00	
0460	PULMONARY FUNC			137	25545.00	
0480	CARDIOLOGY			1	20652.00	
0611	MRI-BRAIN			2	12400.00	
0635	DRUG/EPO>10,000 UNITS			500	25809.50	
0636	DRUGS/DETAIL CODE			440	29455.15	
0730	EKG/ECG			1	658.00	
0740	EEG			6	31161.00	
0801	DIALY/INPT			10	26130.00	
0921	PERI VASCUL LAB			2	3473.00	
0000						
	REPRICED BY: AETNA CHOICE POS II TO:				1136852.28	

Allowed Amount (33% discount off of billed charges.

Prepayment Example: Itemized Bill

Key Takeaways

- Based on an unfavorable initial valuation, finHealth asks the carrier to send an itemized bill (IB).
- The IB details by day all the charges for services.
- It includes a description, revenue code, HCPCS / CPT / Drug code and the billed charges from the hospital.
- The IB is uploaded into finHealth's application and reprices the bill compared to what is paid to peer hospitals for the same services.
- The example provided is 1 of 39 pages.



Run date: 15-JUL-24 North Bay Health System Page: 1

Pt#: [redacted] MRN: [redacted]
Patient Name: [redacted]
Fin Class: [redacted]
Insurance Name: [redacted]

Admit Date: [redacted] Disch Date: [redacted]
Total Charges: 1,696,794.42
Total Pymts: 0.00
Total Adj: 0.00
Balance Due: 1,696,794.42

Post DT	Pay/Adj Description	Trans	Pmt Date	Pmt Amt

Chrg Date	Chrg Description	Qty	Rev	CPT	Charge Amt
[redacted]	ROOM CHARGE MS TELE	1.0000			14,395.00
	URINALYSIS RT, AUTO	1.0000	301	81001	352.00
	TROPONIN	1.0000	301	84484	1,366.00
	Procalcitonin Level	1.0000	301	84145	104.00
	CBC WITH AUTO DIFF	1.0000	305	85025	259.00
	VENIPUNCTURE	1.0000	300	36415	83.00
	N/C ROUTINE SUPPLY	1.0000	279		0.00
	N/C ROUTINE SUPPLY	1.0000	279		0.00
	COMPREHENSIVE METABO	1.0000	301	80053	529.00
	BRAIN NATRIURETIC PE	1.0000	301	83880	533.00
	COVID/FLU/RSV PANEL	1.0000	306	87637	499.21
	PIPERACILLIN-TAZOBAC	1.0000	636	J2543	1,236.65
	CHEST 1 VIEW	1.0000	324	71045	575.00
	ACETAMINOPHEN 10MG/M	1.0000	636	J0131	1,715.10
	BLOOD GAS ANALYS	1.0000	300	82803	1,192.00
	ARTERIAL PUNCTURE	1.0000	410	36600	247.00
	RT LACTIC ACID	1.0000	301	83605	333.00
	BLOOD GAS ANALYS	1.0000	300	82803	1,192.00
	EKG TRACING ONLY	1.0000	730	93005	658.00
	ROOM CHARGE MS TELE	1.0000			14,395.00
	PARTIAL THROMBOPLAST	1.0000	305	85730	297.00
	PROTHROMBIN TIME	1.0000	305	85610	190.00
	CULTURE BLOOD	1.0000	306	87040	675.00
	CULTURE BLOOD	1.0000	306	87040	675.00
	CBC WITH AUTO DIFF	1.0000	305	85025	259.00
	VENIPUNCTURE	1.0000	300	36415	83.00
	BASIC METABOLIC PANE	1.0000	301	80048	480.00
	MAGNESIUM	1.0000	301	83735	295.00
	VANCOMYCIN	1.0000	301	80202	579.00
	BASIC METABOLIC PANE	1.0000	301		0.00
	BASIC METABOLIC PANE	1.0000	301	80048	480.00
	MAGNESIUM	1.0000	301	83735	295.00
	CBC WITH AUTO DIFF	1.0000	305	85025	259.00
	VENIPUNCTURE	1.0000	300	36415	83.00
	INSULIN GLARGINE 100	1.0000	636	J1815	2,535.25
	VANCOMYCIN 1.25GM/NS	1.0000	250		1,283.10
	INSULIN LISPRO 100 U	1.0000	637	J1815	1,136.70
	ATORVASTATIN CALCIUM	1.0000	250		96.30
	ATORVASTATIN CALCIUM	1.0000	250		96.30
	AMLODIPINE 5MG	1.0000	250		240.55
	HEPARIN 5000 U/ML V	1.0000	636	J1644	381.55
	GABAPENTIN 100MG CAP	1.0000	250		35.25

Prepayment Example: Error Identification

description	code|1	code|1|type	code|2	setting	billing_class	standard_charge|gross	standard_charge|discounted_cash	standard_charge|min	standard_charge|max	standard_charge|[redacted]|negotiated_dollar	standard_charge|[redacted]|negotiated_percentage	standard_charge|[redacted]|negotiated_algorithm	standard_charge|[redacted]|methodology
GAS NITRIC OXIDE HOURLY	41810912	CDM	419	inpatient	facility	$5,544.00	$5,544.00	$2,494.80	$5,544.00				
GAS NITRIC OXIDE HOURLY	41810912	CDM	419	outpatient	facility	$5,544.00	$5,544.00	$233.00	$5,544.00	$233.00			per diem

To the best of its knowledge and belief, the hospital has included all applicable standard charge information in accordance with the requirements of 45 CFR 180.50, and the information encoded is true, accurate, and complete as of the date indicated.

JPPT The Journal of Pediatric Pharmacology and Therapeutics

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▸ J Pediatr Pharmacol Ther. 2024 Oct 14;29(5):525–529. doi: 10.5863/1551-6776-29.5.525

While the use of iNO in the preterm population remains a subject of debate, its use in this population has exponentially increased over time.[11,12] Some studies demonstrate promise in the preterm population, including a potential reduction in chronic lung disease.[13,14] - Although the current incidence of iNO use in the preterm population is unknown, past literature has indicated that up to 26.2% of infants less than 34 weeks' gestation, admitted to the NICU in the United States, are treated with iNO[15] and that treatment varies with gestational age (13.9% of neonates at 23 to 24 weeks' gestation versus 0.6% of 33 weeks' gestation).[12] What remains a constant, however, is that iNO is one of the most expensive therapies in the NICU. While costs vary by contract, the cost per hour nationwide in recent years was $140 per hour.[16] Based on this and with its increased use in the NICU, judicious weaning is needed.[16]

Key Takeaways:

- Hospital billed "Gas Nitric Oxide Hourly" at a rate of $4,950 per hour.
  - According to The Journal of Pediatric Pharmacology and Therapeutics (JPPT), the cost per hour nationwide in recent years for Inhaled Nitric Oxide is $140/hour (35X).
  - This hospital's published chargemaster rate per hour for outpatient is $233 for "Gas Nitric Oxide Hourly" (21X).

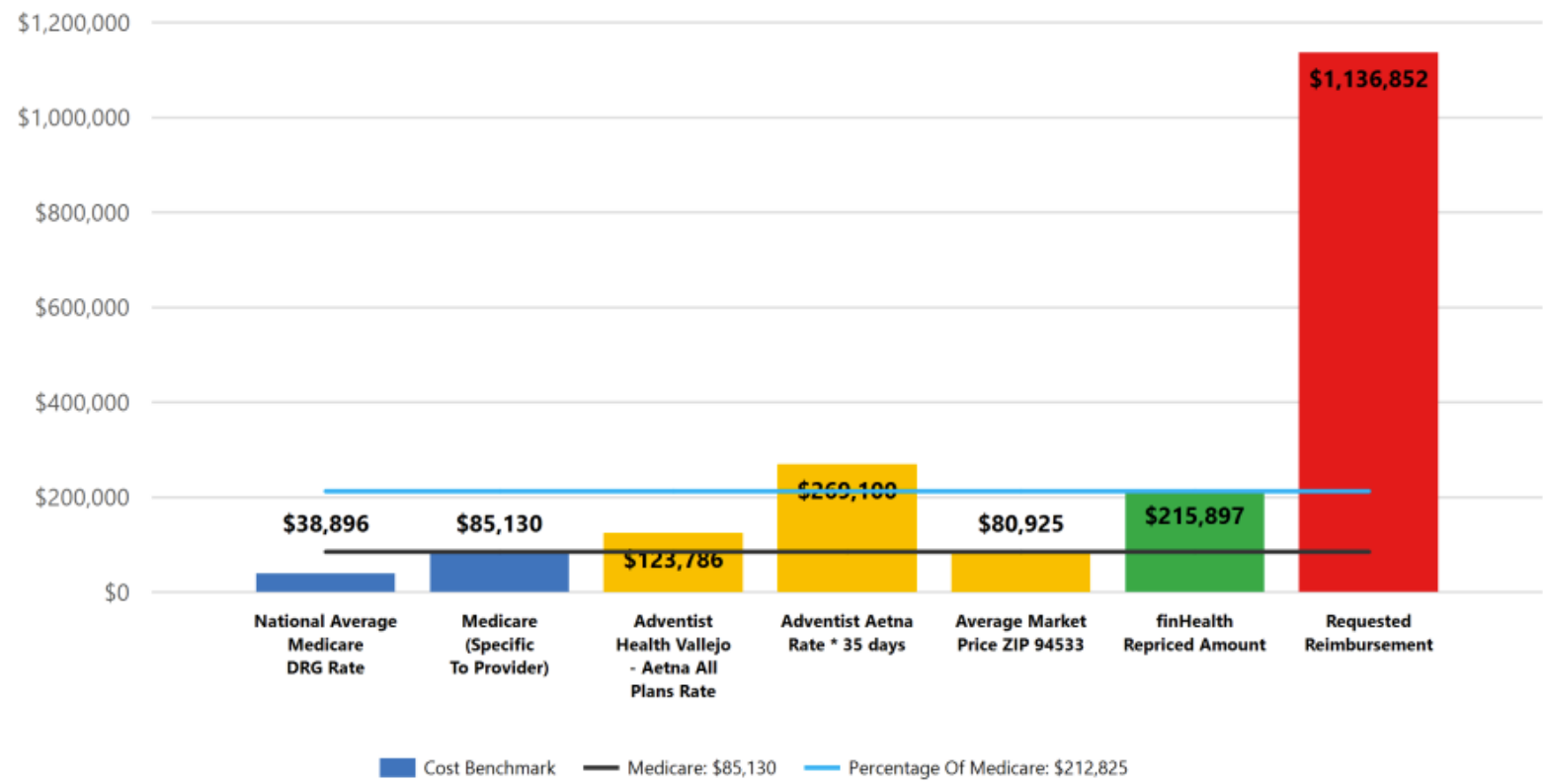
Prepayment Example: Fair Payment

Key Takeaways

- This graph compares the price being requested to industry benchmarks including:
  - Medicare
  - Provider's chargemaster
  - Average market price in Fairfield, CA, ZIP 94533
  - Peer hospitals (finHealth repriced amount)
- Northbay excessively charged for the majority of services.
- Even if we extrapolate the Carrier chargemaster rate to 35 days, this claim was overpaid by $868K.
- finHealth would have recommended a "Fair Pay" of $216K not to exceed $269K.

Claim #: [redacted]

Billed Charges: $1,696,794.00 | **Allowed Amount:** $1,136,852.00 | **Medicare:** $85,130.32 | **%age of Medicare:** 1,335%



This is a 68-year-old female with Septicemia or Severe Sepsis with MV > 96 Hours (DRG Code 870). The AMLOS for DRG 870 is 16.1; this was a 35-day stay. Northbay Medical Center does not publish DRG chargemaster rates. Adventist Health Vallejo's, a nearby hospital, published Aetna rate is $123,786. Adventist Health Vallejo's maximum published charge for DRG 870 is $144,584, while their Cash Price is $75,392. The Average Market Price in Fairfield, CA (ZIP 94533) is $80,925. We recommend a single case rate "Fair Price" of $212,826, not to exceed $269,100 (Adventist Aetna rate * 35 days).

Prepayment Example: Fair Payment

Key Takeaways

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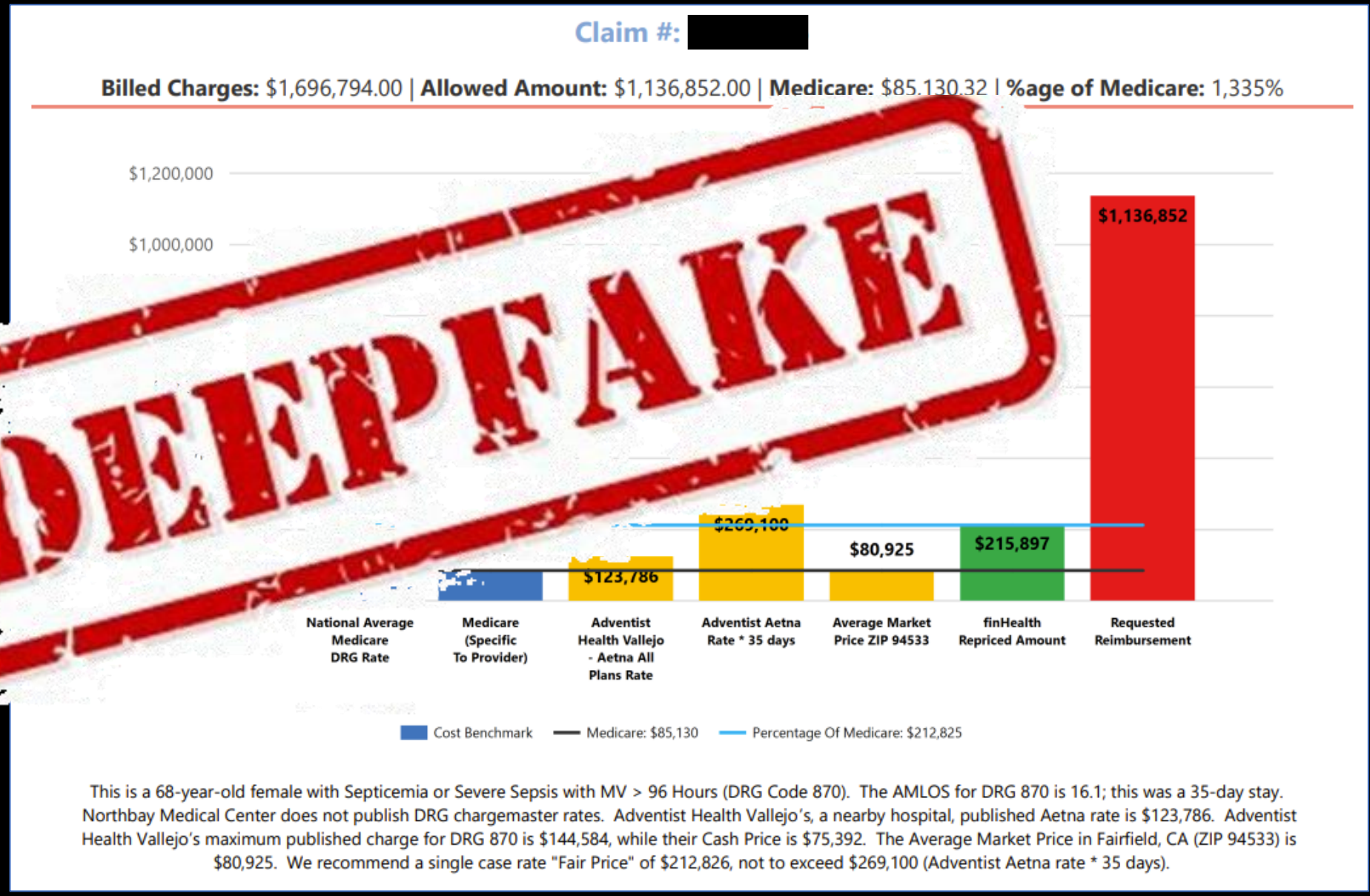

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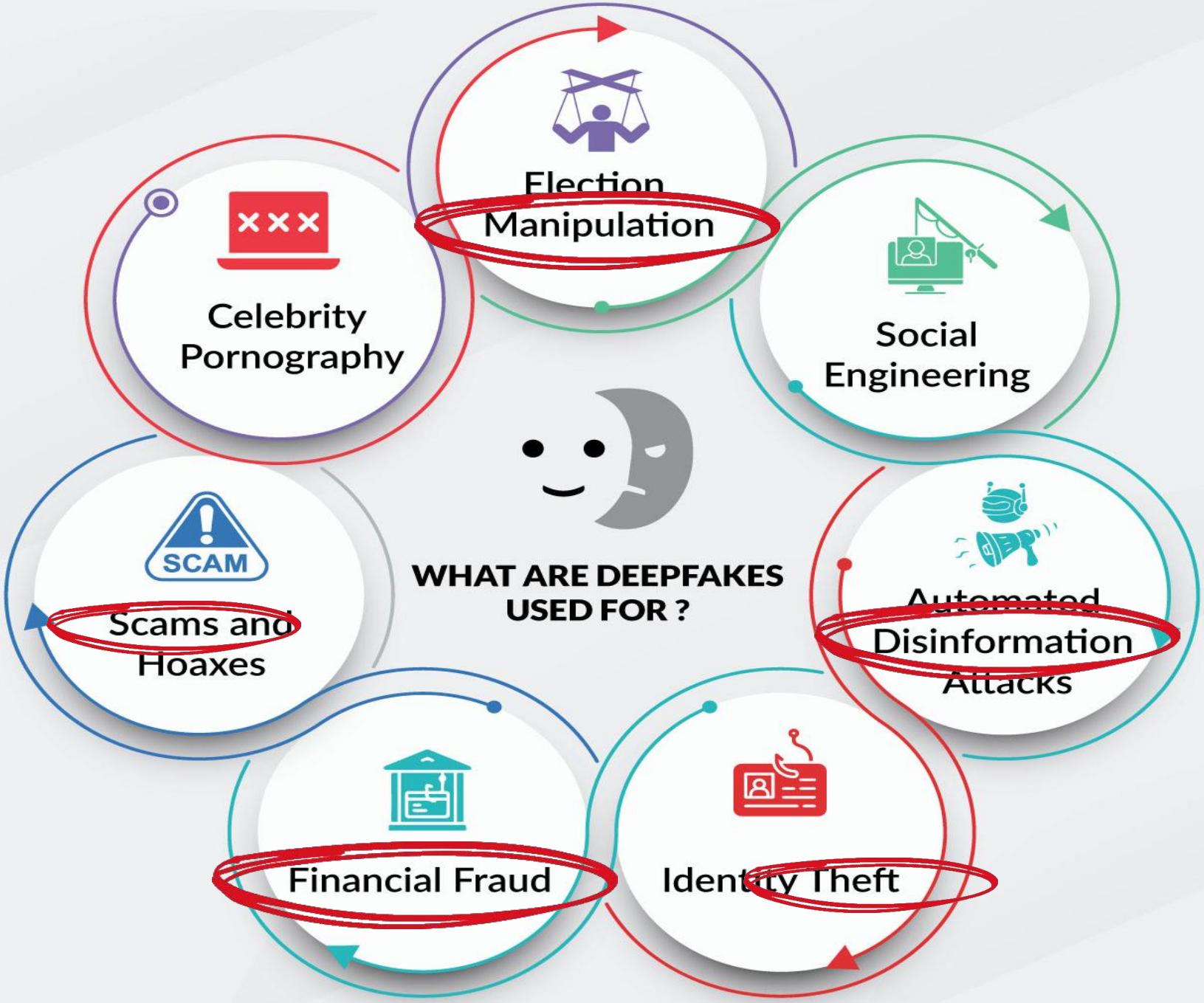
Election Manipulation
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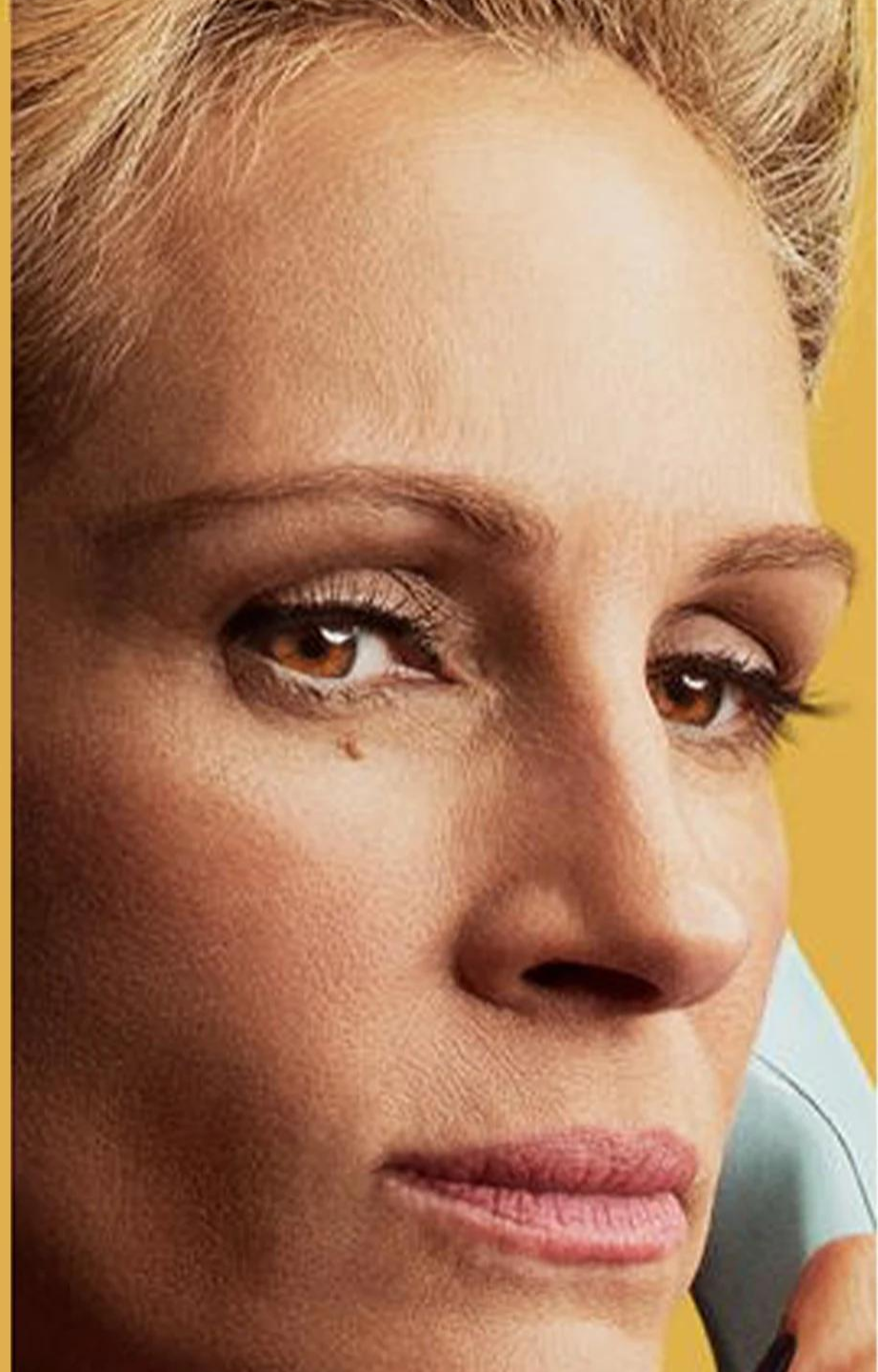
SCAM
WHAT ARE DEEPFAKES USED FOR ?

WE ARE BEING

GASLIT



Actual Carrier Responses:

"Why are you charging $228K above the highest published chargemaster rate?"

finHealth

"We do not follow chargemaster rates."

insurance

Actual Carrier Responses:

"Why was this claim paid at 273% more than your network's published chargemaster rate?"

finHealth

"Our agreements include provisions that may result in exceeding billed charges."

insurance

Actual Carrier Responses:

"Why was this claim paid at 1,331% of Medicare (+$525K)?"

finHealth

"We do not determine fair prices."

insurance

EXAMPLES TO WORK ON

Example #1: Repeated Carrier Processing Error - $500,000 Savings

DEEPFAKE

[redacted]

Claim #: [redacted]

Consolidated Claim View

Encounter #: 8916860470020230409

Billed Charges: $1,108,293.77 | **HWI:** 80.3 % | **Medicare Rate:** $40,486 | **%age of Medicare:** 1,744.0 %

Allowed Amount: $706,097.74

Member #: [redacted]

Bill Type: F-1 - F-1 (Facility)

Source: [redacted]

Group: [redacted]

ICD Codes: I25.5 - Ischemic cardiomyopathy
A41.81 - Sepsis due to Enterococcus
Z51.5 - Encounter for palliative care
Z23 - Encounter for immunization

DRG: 270 - Other Major Cardiovascular Procedures With M...

DRG Weight: 5.1100 **Length Of Stay:** AMLOS - 9.5 | GMLOS - 6.6

[redacted]

Admission Type: 2 - Urge...

Place of Service	Encounter Begin Date	Encounter End Date	Length of Stay	Hospital Admission	Hospital Discharge	Discharge Status	Latest Dates Submitted	Latest Dates Payment	Days To Pay
21 - Inpatient Hospital	[redacted]					06 - Discharged/transferr...	07/11/23	09/01/23	110

Provider #: [redacted]

NPI#:

CMS ID(CCN#):

Pricing Method: N/A **Pay Type:** P - Payment Made to ...

Median Treatment $/Day for Inpatient Hospital: $40,869

Encounter Treatment $/Day: $9,673

Medicare Rating: ★★★

Taxonomy: General Acute Care Hospita...

2022 Rand Study
281.0% of Medicare
3,242 Services

ICD Procedures: 5A02210 - Assistance with Cardiac Output using Balloon Pump, Continuous
5A02210 - Assistance with Cardiac Output using Balloon Pump, Continuous
5A02210 - Assistance with Cardiac Output using Balloon Pump, Continuous
BB4BZZZ - Ultrasonography of Pleura

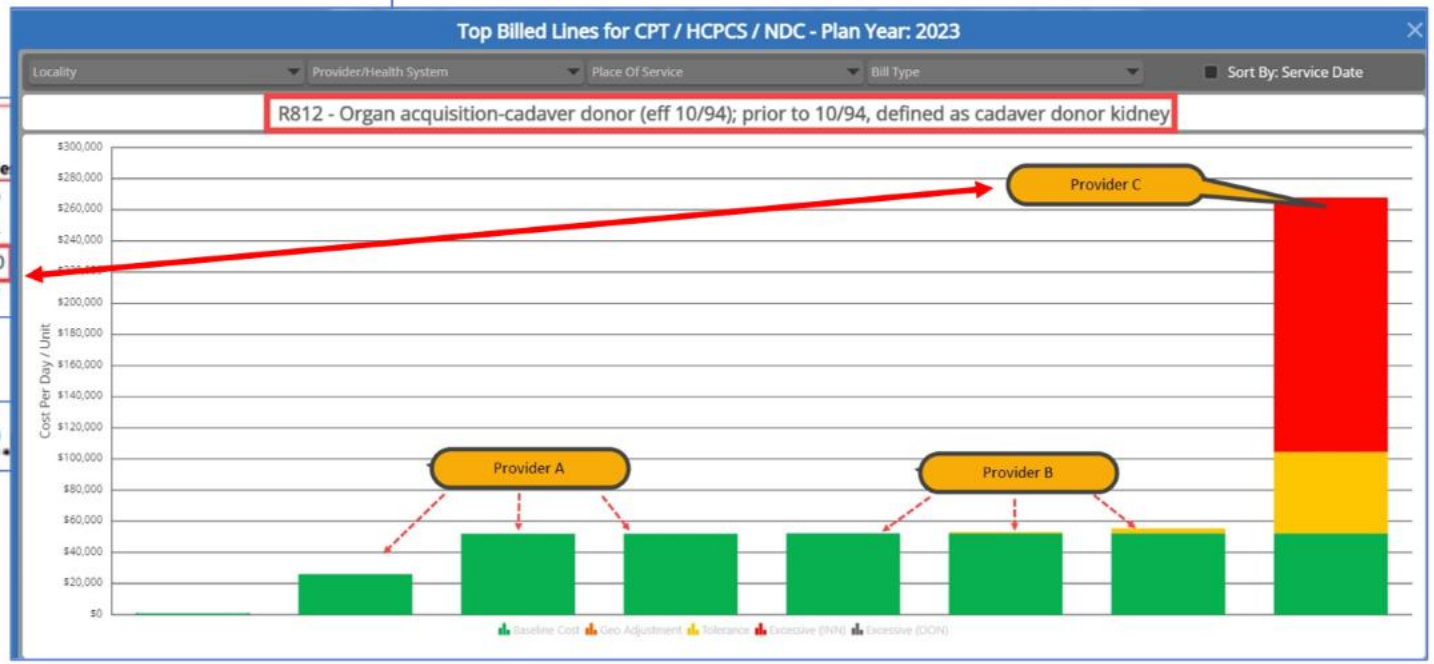
Claim Nbr (Line #)	Dates Begin	Dates End	Medical Code	Days Or Units	Allowed Amount	Billed Charge
20232232900100 (10)	06/05/23	06/21/23	R201 - Intensive care-surgical	8	$44,566.10	$44,566.10
20232232900100 (20)	06/05/23	06/21/23	R206 - Intensive care-post ICU; redefined as	8	$19,579.84	$19,579.84
20232232900100 (30)	06/05/23	06/21/23	R812 - Organ acquisition-cadaver donor (eff	1	$267,952.80	$267,952.80
20232232900100 (40)	06/05/23	06/21/23	R360 - Operating room services-general	1	$60,334.17	$60,334.17

Payment Date: 10/13/2023 **($500,112.07)** **($500,112.**

Key Takeaways

- 16-day Inpatient claim for a heart transplant
- Provider "C" overcharged for a cadaver organ acquisition compared to peer hospitals in Michigan
- Questioning the price of the organ led to an error in the way carrier processed Long Term Acute Care (LTAC) claims

Overpaid Amount – Plan credited $500,112



Example #2: Durable Medical Equipment Provider Error
$68,000 Savings

DEEPFAKE

[redacted]

Claim #: [redacted] Consolidated Claim View

Encounter #: 6558CCE434668A1E70220220415

Billed Charges: $187.61 | **HWI:** 0.0 % | **Medicare Rate:** $0 | **%age of Medicare:** 0.0 %

Allowed Amount: $187.61

Member #: [redacted]

ICD Codes: Z39.1 - Encounter for care and examination of lactati...
Z34.82 - Encounter for supervision of other normal pr...
Z34.83 - Encounter for supervision of other normal pr...

[redacted]

Bill Type: OME - OME (Facility)

Admission Type: N/A - N/...

Source: [redacted]

Group: [redacted]

DRG: #Error

DRG Weight: **Length Of Stay:** AMLOS - | GMLOS -

Place of Service	Encounter Begin Date	Encounter End Date	Length of Stay	Hospital Admission	Hospital Discharge	Discharge Status	Latest Dates Submitted	Latest Dates Payment	Days To Pay
12 - Home	04/15/22	04/18/22	3			N/A - N/A	04/27/22	08/03/22	32

Provider #: [redacted]

NPI#:

CMS ID(CCN#):

Median Treatment $/Day for Home: $125

Encounter Treatment $/Day: $63

Medicare Rating:

In-Network

Pricing Method: N/A **Pay Type:** PROVIDER - Payment M...

Taxonomy: Durable Medical Equipment ...

Claim Nbr (Line #)	Dates Begin	Dates End	Medical Code	Days Or Units	Allowed Amount	Billed Charges	Member Paid	COB Amount	Company Paid
04202022E001449-00 (1)	04/15/22	04/18/22	E0603 - Breast pump, electric (ac and/or dc), any	181	$33,957.41	$33,957.41	$0.00	$0.00	$33,957.41
			Modifier 1: NU - New Equipment (DME)						
			Payment Date: 5/24/2022		**$33,957.41**	**$33,957.41**	**$0.00**	**$0.00**	**$33,957.41**
04202022E001449-01 (1)	04/15/22	04/18/22	E0603 - Breast pump, electric (ac and/or dc), any	(181)	($33,957.41)	($33,957.41)	$0.00	$0.00	($33,957.41)
			Modifier 1: NU - New Equipment (DME)						
04272022E022224-02 (1)	04/15/22	04/15/22	E0603 - Breast pump, electric (ac and/or dc), any	1	$187.61	$187.61	$0.00	$0.00	$187.61
			Modifier 1: NU - New Equipment (DME)						
			Payment Date: 8/3/2022		**($33,769.80)**	**($33,769.80)**	**$0.00**	**$0.00**	**($33,769.80)**

Key Takeaways

- Provider billed 2 claims in error for rental of a breast pump
- Billed $187.61 for 181 units vs. 1 actual unit

Overpaid Amount – $67,540 ($33,770 X 2 claims)

finHealth

Example #3: Air Ambulance Overage - $80K Savings

Billed Charges: $130,060.00 | **HWI:** 66.3 % | **Medicare Rate:** $0 | **%age of Medicare:** 0.0 %

Allowed Amount: $104,504.00

Member #

Dependent / N/A

Shasta Lake, CA

Bill Type: P - Professional (Professional)

Source: HCSC

Group: 000152000 - 000152000

ICD Codes: E80.6 - Other disorders of bilirubin metabolism

Admission Type: N/A - N/...

DRG: N/A - Not Available

DRG Weight:

Length Of Stay: AMLOS - | GMLOS -

Place of Service	Service Begin Date	Service End Date	Length of Stay	Hospital Admission	Hospital Discharge	Discharge Status	Latest Dates Submitted	Latest Dates Payment	Days To Pay
41 - Ambulance Land	08/22/22	08/22/22	0			N/A - N/A	10/31/22	10/10/23	429

Provider #: N1154774073 Calstar Air Medical Services

NPI#: 1154774073 1800 Air Medical Dr

CMS ID(CCN#): West Plains, MO 65775

Pricing Method: N/A **Pay Type:** N/A - N/A

Median Treatment $/Day for Ambulance Land: $1,078

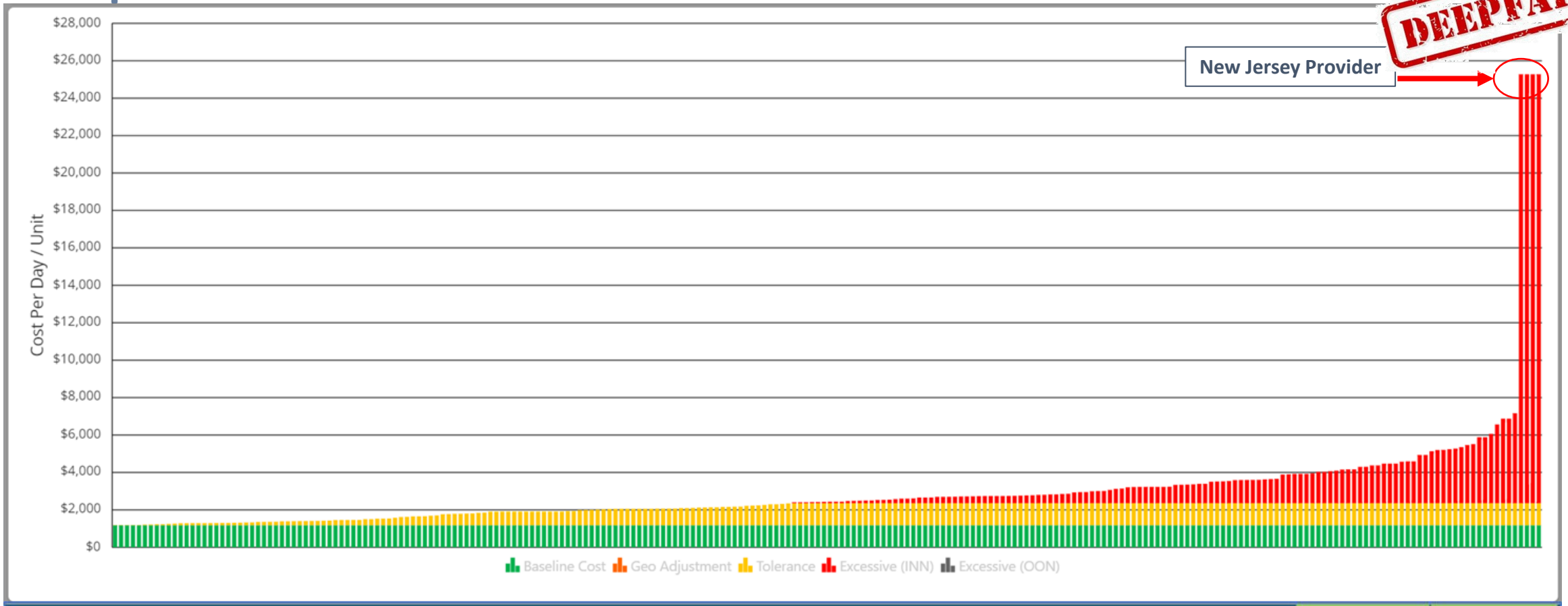
Encounter Treatment $/Day: $104,504

Medicare Rating:

Taxonomy: Ambulance

Claim Nbr (Line #)	Dates Begin	Dates End	Medical Code	Days Or Units	Allowed Amount	Billed Charges	Member Paid	COB Amount	Company Paid
Example 5	08/22/22	08/22/22	A0431 - Ambulance service, conventional air Modifier 1: HH - Hospital to Hospital	1	$0.00	$63,272.00	$0.00	$0.00	$0.00
Example 5	08/22/22	08/22/22	A0436 - Rotary wing air mileage, per statute mile Modifier 1: HH - Hospital to Hospital	118	$0.00	$66,788.00	$0.00	$0.00	$0.00
Example 5	08/22/22	08/22/22	A0431 - Ambulance service, conventional air Modifier 1: HH - Hospital to Hospital	(1)	$0.00	($63,272.00)	$0.00	$0.00	$0.00
Example 5	08/22/22	08/22/22	A0431 - Ambulance service, conventional air Modifier 1: HH - Hospital to Hospital	1	$31,026.70	$63,272.00	$0.00	$0.00	$31,026.70
Example 5	08/22/22	08/22/22	A0436 - Rotary wing air mileage, per statute mile Modifier 1: HH - Hospital to Hospital	(118)	$0.00	($66,788.00)	$0.00	$0.00	$0.00

Example #4: 74177 - CT scan of abdomen and pelvis with contrast

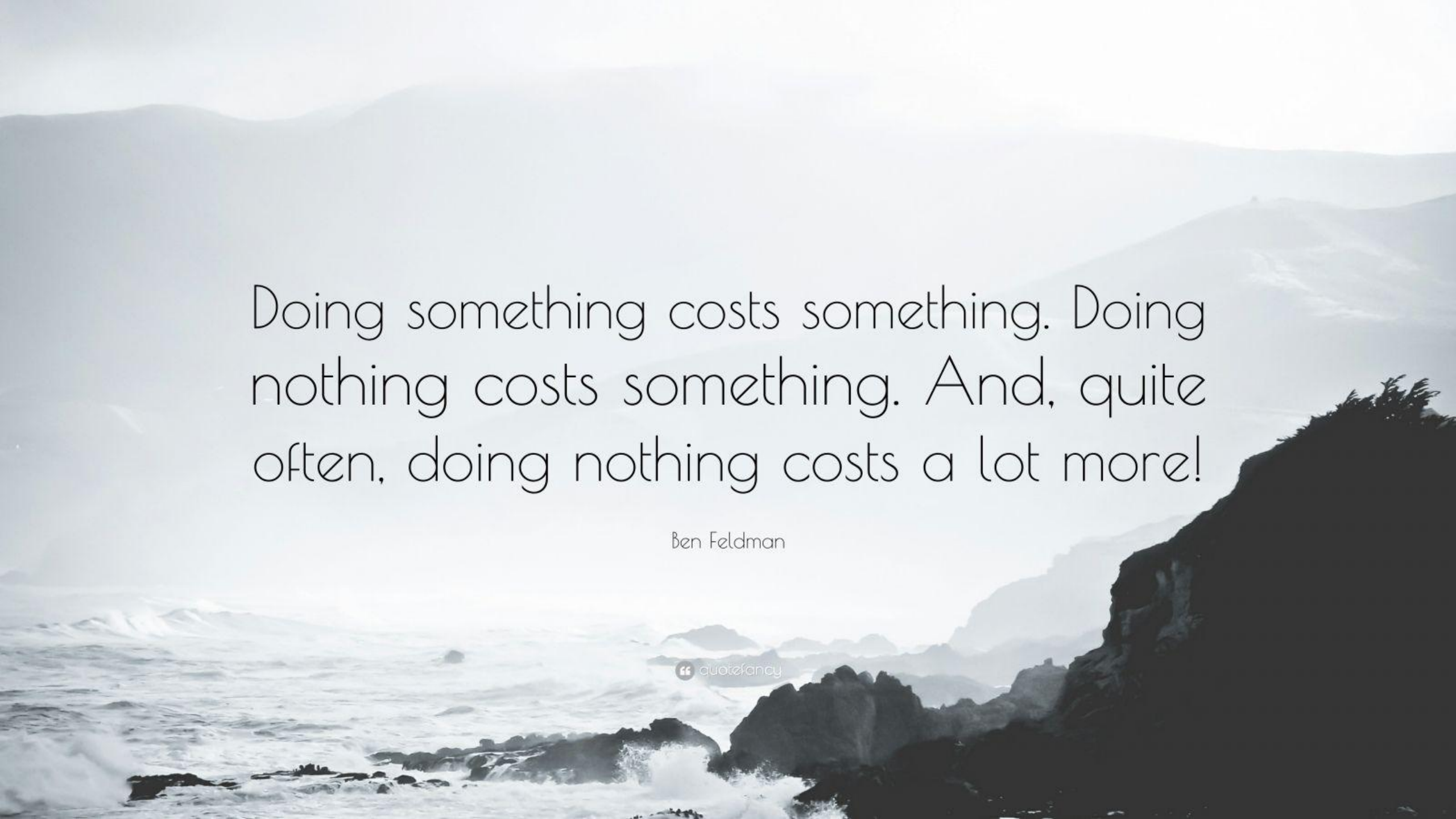


Place of Service	Payment Date	Medical Code	Allowed Amount	Member Paid	Median Cost	Variance vs. Median	Provider Chargemaster Rate	Cost Variance vs. Chargemaster
ER Hospital	4/12/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$153	$810	$24,466	$899	$24,377
ER Hospital	8/30/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$0	$810	$24,466	$899	$24,377
Outpatient	8/18/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$0	$810	$24,466	$899	$24,377
Outpatient	11/8/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$0	$810	$24,466	$899	$24,377

Benefits Team: Ask your Finance / Procurement / Legal / Accounts Payable:

Would you automatically pay any other bill over $50,000 without reviewing it?

Why do we allow it with our Healthcare plans?


Doing something costs something. Doing nothing costs something. And, quite often, doing nothing costs a lot more!
Ben Feldman
quotefancy

Question: *What will happen in the U.S. if healthcare costs don't stop increasing at an 8%–10% rate?*

---

1. Households

Insurance premiums and deductibles will rise faster than wages, leaving families with less disposable income. Underinsurance and medical debt will become more common, leading many to skip necessary care.

2. Employers

Benefit costs will climb, leading to higher employee cost-sharing or dropped coverage. Rising costs will make U.S. companies less competitive globally and may encourage automation or outsourcing to reduce headcount.

3. Insurers & Providers

Smaller insurers could exit the market as risk pools worsen, and providers may consolidate to gain negotiating leverage, further driving prices up. Hospitals will focus on high-margin procedures over preventive care, worsening long-term outcomes.

4. Government Budgets

Medicare and Medicaid will become harder to sustain, forcing tax hikes, benefit cuts, or rationing. Federal debt will rise faster, and state budgets will be squeezed, crowding out spending on education, infrastructure, and public safety.

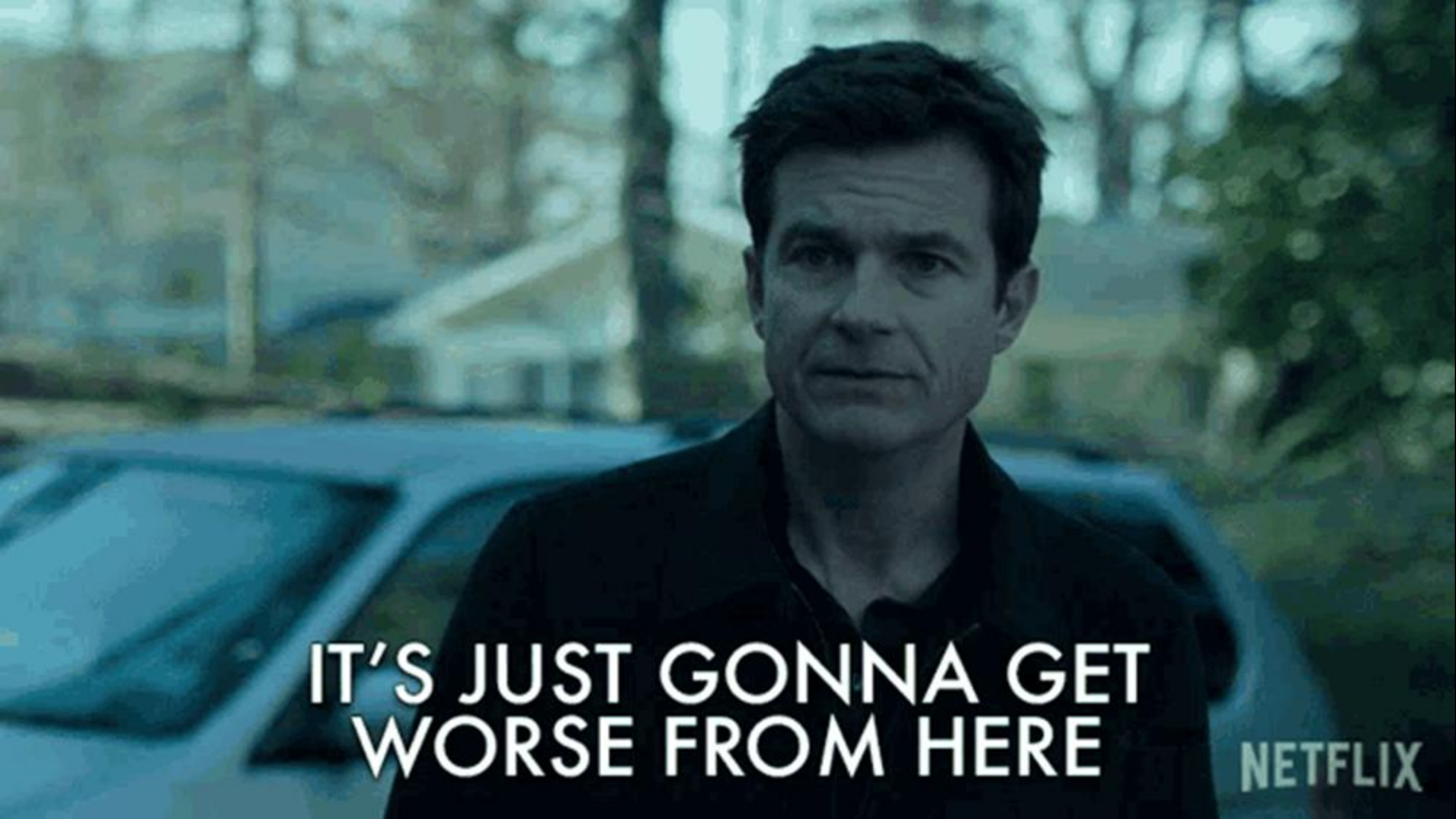
5. Broader Economy

Healthcare's share of GDP could exceed 25% within 10–15 years, slowing economic growth. Rising costs will fuel inflation, and inequality will widen as wealthier households maintain access while others see declining coverage and health outcomes.

If the government cuts spending on Medicare and Medicaid, employer health plans will feel it in several ways:

- **Higher provider prices for private plans**
  Lower public program payments often lead hospitals and doctors to charge more to employer plans to make up the gap.
- **More people turning to employer coverage**
  Those losing Medicare or Medicaid may join an employer plan, sometimes bringing higher health costs into the risk pool.
- **Potential new taxes or mandates**
  To fill funding gaps, the government could raise payroll taxes or shift more coverage responsibilities to employers.
- **More retiree health costs for some companies**
  Employers with retiree plans may have to pay more if Medicare covers less.
- **Stronger cost-control measures**
  Employers may respond by narrowing networks, increasing deductibles, or adding onsite/near-site care to manage spending.

Bottom line: Cuts to Medicare and Medicaid often raise costs for employer plans and push companies to make bigger changes to benefits.


IT'S JUST GONNA GET
WORSE FROM HERE
NETFLIX

Contract Recommendations

- ***Fiduciary*** – **<Client>** expects **<Carrier>** to serve as a "functional fiduciary" in safeguarding health plan assets and always act in the best interests of the members and the self-funded health plan.
- ***Data Ownership*** - claims data is owned by **<Client>;** it will be made available on a weekly basis & include "open" claims already adjudicated and authorized for payment.
- ***Internal Controls*** - **<Client>** has the right to implement prepayment verification to safeguard health plan assets & validate healthcare value.
- ***Advance Notification for High-Dollar Claims*** - <Carrier> should immediately notify employer on all high dollar claims submitted (currently defined as $100,000) and provide one week advance warning PRIOR to payment release to the provider.
    - If **<Carrier>** (or one of their affiliates) inadvertently releases payment, **<Client>** is legally responsible up to what would be considered a "reasonable" amount for that encounter (i.e., <= 250% of Medicare).
    - **<Client>** reserves the right to direct contract with providers and/or negotiate "single case rate" agreements with providers in the event of a disputed claim, particularly if paying the claim conflicts with their fiduciary duties to the health plan.
- ***Post-Payment Review*** - **<Client>** may perform post-payment review of claims & present exceptions to **<Carrier>** on a monthly cycle. **<Carrier>** will research & provide resolution within two weeks of submission.
    - If determined to have been paid in error (as defined by **<Client>** not **<Carrier>), <Carrier>** will reimburse the health plan within two weeks. It will be **<Carrier's>** responsibility to reclaim those monies back from the provider versus awaiting reimbursement prior to refunding to the plan.
    - If **<Carrier>** does not meet these service levels, **<Client>** (or their business associate) reserves the right to contact the provider directly.
- ***No Surprises Act*** - **<Carrier>** has clearly defined and monitored guidelines relative to the processing of claims that are governed by the ***No Surprises Act***. This includes timely payment to the provider (within 30 days), the calculation and use of a ***Qualified Payment Amount (QPA)*** and procedures to fulfill the dispute resolution process on the employer's behalf.
- ***Carve-Out*** - **<Client>** has the right to "carve out" selected reimbursement types from the plan without penalty (member advocacy, fertility, ESRD, advanced primary care, etc.).
    - **<Carrier>** will make best efforts to integrate with these offerings without financial penalty.
- ***Compensation*** -**<Client>** requires **<Carrier>** to report all fees & compensation received from the health plan to be fully disclosed on no less than a monthly basis.
    - This includes embedded fees such as third-party audit reviews, clinical claim reviews, etc.. Additionally, any compensation paid by **<Carrier>** on behalf of the **<Client>** health plan to brokers, consultants, affiliates, technology vendors, etc. must also be reported monthly as it impacts the independence of the chosen contractors.
- ***Fees "At Risk"*** - We suggest that a significant portion of administrative fees (i.e., 20%) be "at risk" and tied to performance.
    - While we have tried to document the "hard measures" of performance for **<Carrier>** as a service provider, the intangible aspect of cooperation has been the key differentiator between successful and unsuccessful relationships with carriers / TPAs / PBMs. The agreement should have sufficient "teeth" to adversely impact **<Carrier>** for less than stellar performance.

QR Code Download for Contract Recommendations and this Presentation

To Recap Our Story Arc:

- Macro level threats (the U.S.)
- Micro level threats (the employer)
  - Healthcare deepfakes are a threat to our national security, our budgets and our jobs
  - We are being gaslit
- Specific Healthcare examples
- What you can do about it today

Steps to Take Immediately:

For the next claim over $50K:

- Pend the claim; don’t immediately pay
- Ask for the itemized bill.
- Ask for a full reconciliation of carrier payment integrity results and shared savings fees.
- Find the outliers.
- Question the inconsistencies.
- Refuse to Pay. It’s your ERISA obligation. It’s your patriotic obligation.

finHealth

Thank you!

Chris Chan
Chief Value Officer
cchan@finhealth.com

Example #1

DEEPFAKE

[redacted]

Claim #: [redacted]

Consolidated Claim View

Encounter #: 8916860470020230409

Billed Charges: $1,108,293.77 | **HWI:** 80.3 % | **Medicare Rate:** $40,486 | **%age of Medicare:** 1,744.0 %

Allowed Amount: $706,097.74

Member #: [redacted]

Bill Type: F-1 - F-1 (Facility)

Source: [redacted]

Group:

ICD Codes: I25.5 - Ischemic cardiomyopathy
A41.81 - Sepsis due to Enterococcus
Z51.5 - Encounter for palliative care
Z23 - Encounter for immunization

DRG: 270 - Other Major Cardiovascular Procedures With M...

DRG Weight: 5.1100 **Length Of Stay:** AMLOS - 9.5 | GMLOS - 6.6

[redacted]

Admission Type: 2 - Urge...

Place of Service	Encounter Begin Date	Encounter End Date	Length of Stay	Hospital Admission	Hospital Discharge	Discharge Status	Latest Dates Submitted	Latest Dates Payment	Days To Pay
21 - Inpatient Hospital	[redacted]					06 - Discharged/transferr...	07/11/23	09/01/23	110

Provider #: [redacted]

NPI#:

CMS ID(CCN#):

Pricing Method: N/A **Pay Type:** P - Payment Made to ...

Median Treatment $/Day for Inpatient Hospital: $40,869

Encounter Treatment $/Day: $9,673

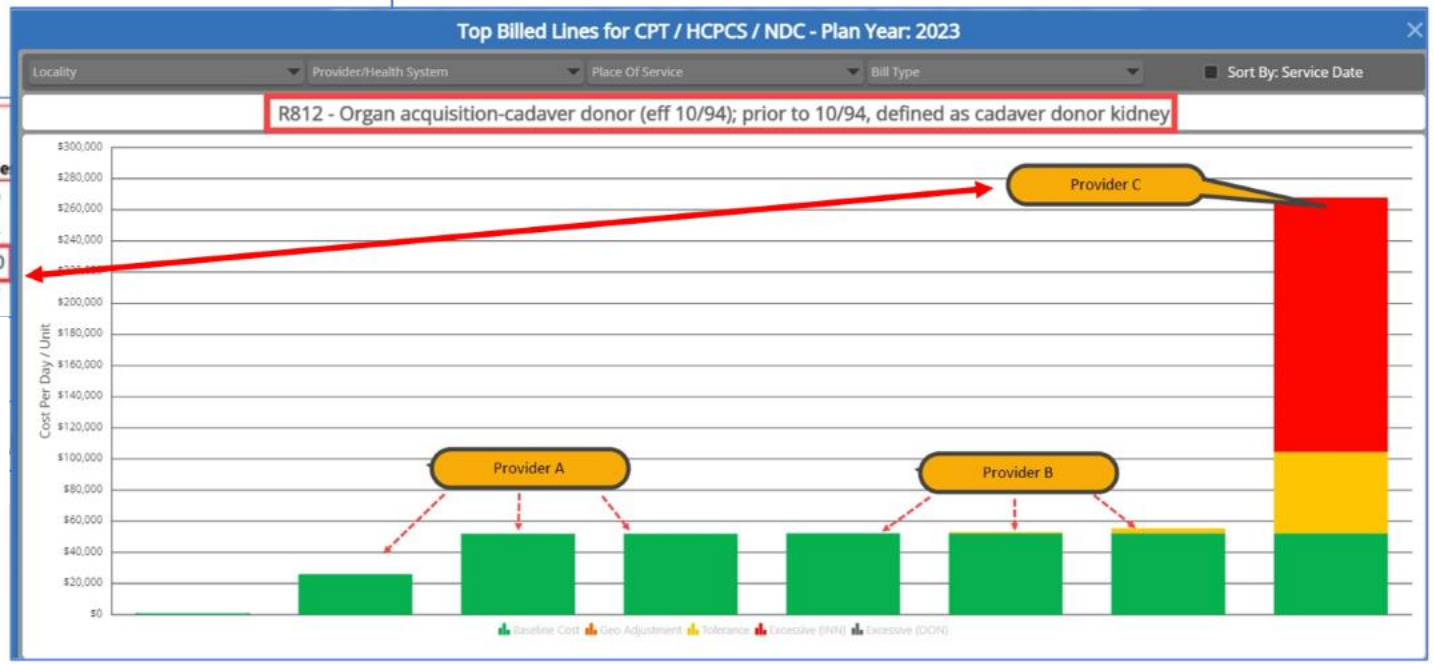
Medicare Rating:

Taxonomy: General Acute Care Hospita...

2022 Rand Study
281.0% of Medicare
3,242 Services

ICD Procedures: 5A02210 - Assistance with Cardiac Output using Balloon Pump, Continuous
5A02210 - Assistance with Cardiac Output using Balloon Pump, Continuous
5A02210 - Assistance with Cardiac Output using Balloon Pump, Continuous
BB4BZZZ - Ultrasonography of Pleura

Claim Nbr (Line #)	Dates Begin	Dates End	Medical Code	Days Or Units	Allowed Amount	Billed Charge
20232232900100 (10)	06/05/23	06/21/23	R201 - Intensive care-surgical	8	$44,566.10	$44,566.10
20232232900100 (20)	06/05/23	06/21/23	R206 - Intensive care-post ICU; redefined as	8	$19,579.84	$19,579.84
20232232900100 (30)	06/05/23	06/21/23	R812 - Organ acquisition-cadaver donor (eff	1	$267,952.80	$267,952.80
20232232900100 (40)	06/05/23	06/21/23	R360 - Operating room services-general	1	$60,334.17	$60,334.17



Key Takeaways

- 16-day Inpatient claim for a heart transplant
- Provider "C" overcharged for a cadaver organ acquisition compared to peer hospitals in Michigan

Example #2: Paying for 1 Breast Pump

DEEPFAKE

[redacted]

Claim #: [redacted]

Consolidated Claim View

Encounter #: 6558CCE434668A1E70220220415

Billed Charges: $187.61 | **HWI:** 0.0 % | **Medicare Rate:** $0 | **%age of Medicare:** 0.0 %

Allowed Amount: $187.61

Member #: [redacted]

ICD Codes: Z39.1 - Encounter for care and examination of lactati...
Z34.82 - Encounter for supervision of other normal pr...
Z34.83 - Encounter for supervision of other normal pr...

[redacted] [redacted]

Bill Type: OME - OME (Facility)

Admission Type: N/A - N/...

Source: [redacted]

DRG: #Error

Group:

DRG Weight:

Length Of Stay: AMLOS - | GMLOS -

	Encounter			Hospital			Dates		
Place of Service	Begin Date	End Date	Length of Stay	Admission	Discharge	Discharge Status	Submitted	Payment	Days To Pay
12 - Home	04/15/22	04/18/22	3			N/A - N/A	04/27	08/03/22	32

Provider #: [redacted]

NPI#:

CMS ID(CCN#):

Median Treatment $/Day for Home: $125

Encounter Treatment $/Day: $63

Medicare Rating:

In-Network

Pricing Method: N/A

Pay Type: PROVIDER - Payment M...

Taxonomy: Durable Medical Equipment ...

Claim Nbr (Line #)	Dates Begin	Dates End	Medical Code	Days Or Units	Allowed Amount	Billed Charges	Member Paid	COB Amount	Company Paid
04202022E001449-00 (1)	04/15/22	04/18/22	E0603 - Breast pump, electric (ac and/or dc), any	181	$33,957.41	$33,957.41	$0.00	$0.00	$33,957.41
			Modifier 1: NU - New Equipment (DME)						
			Payment Date: 5/24/2022		**$33,957.41**	**$33,957.41**	**$0.00**	**$0.00**	**$33,957.41**

finHealth

Example #3: Air Ambulance

DEEPFAKE

Billed Charges: $130,060.00 | **HWI:** 66.3 % | **Medicare Rate:** $0 | **%age of Medicare:** 0.0 %

Allowed Amount: $104,504.00

Member #

Dependent / N/A

Shasta Lake, CA

Bill Type: P - Professional (Professional)

Source: HCSC

Group: 000152000 - 000152000

ICD Codes: E80.6 - Other disorders of bilirubin metabolism

DRG: N/A - Not Available

DRG Weight:

Length Of Stay: AMLOS - | GMLOS -

Age

Admission Type: N/A - N/...

Place of Service	Service Begin Date	Service End Date	Length of Stay	Hospital Admission	Hospital Discharge	Discharge Status	Latest Dates Submitted	Latest Dates Payment	Days To Pay
41 - Ambulance Land	08/22/22	08/22/22	0			N/A - N/A	10/31/22	10/10/23	429

Provider #: N1154774073 Calstar Air Medical Services

NPI#: 1154774073 1800 Air Medical Dr

CMS ID(CCN#): West Plains, MO 65775

Pricing Method: N/A **Pay Type:** N/A - N/A

Out-Of-Network

Median Treatment $/Day for Ambulance Land: $1,078

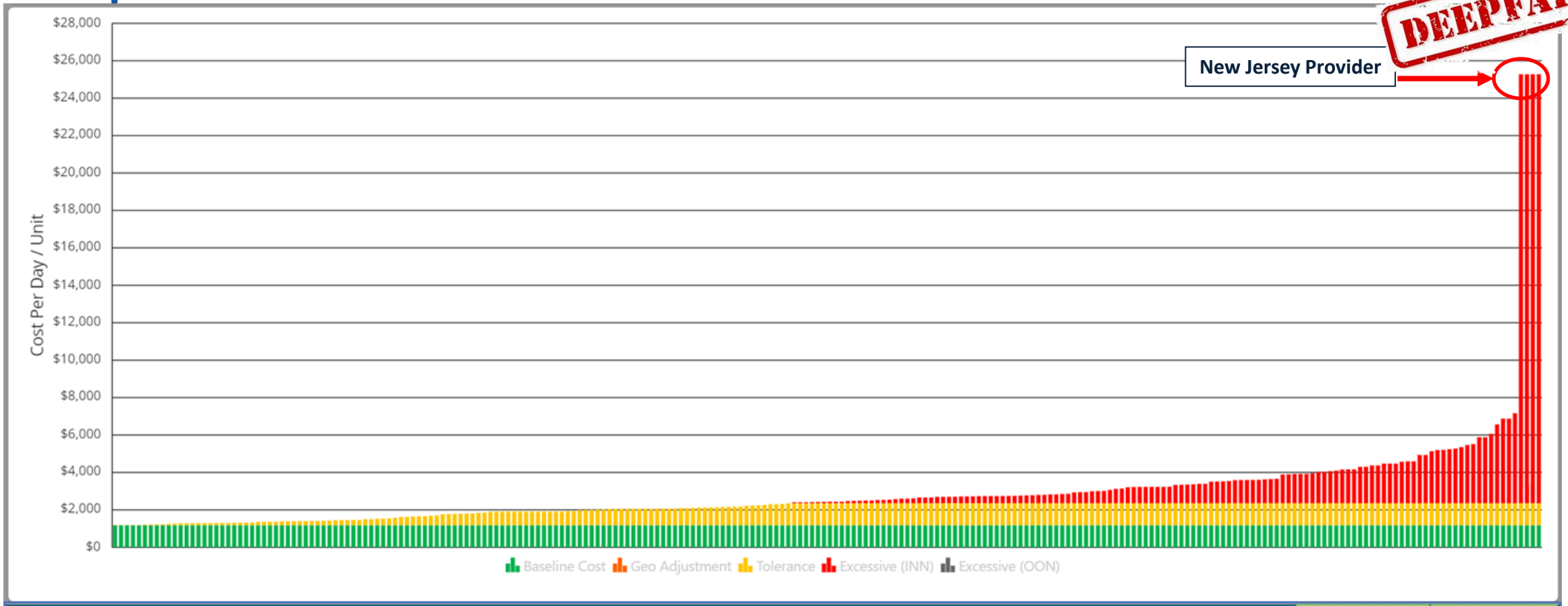
Encounter Treatment $/Day: $104,504

Medicare Rating:

Taxonomy: Ambulance

Claim Nbr (Line #)	Dates Begin	Dates End	Medical Code	Days Or Units	Allowed Amount	Billed Charges	Member Paid	COB Amount	Company Paid
Example 5	08/22/22	08/22/22	A0431 - Ambulance service, conventional air Modifier 1: HH - Hospital to Hospital	1	$0.00	$63,272.00	$0.00	$0.00	$0.00
Example 5	08/22/22	08/22/22	A0436 - Rotary wing air mileage, per statute mile Modifier 1: HH - Hospital to Hospital	118	$0.00	$66,788.00	$0.00	$0.00	$0.00
Example 5	08/22/22	08/22/22	A0431 - Ambulance service, conventional air Modifier 1: HH - Hospital to Hospital	(1)	$0.00	($63,272.00)	$0.00	$0.00	$0.00
Example 5	08/22/22	08/22/22	A0431 - Ambulance service, conventional air Modifier 1: HH - Hospital to Hospital	1	$31,026.70	$63,272.00	$0.00	$0.00	$31,026.70
Example 5	08/22/22	08/22/22	A0436 - Rotary wing air mileage, per statute mile Modifier 1: HH - Hospital to Hospital	(118)	$0.00	($66,788.00)	$0.00	$0.00	$0.00

Example #4: 74177 - CT scan of abdomen and pelvis with contrast



Place of Service	Payment Date	Medical Code	Allowed Amount	Member Paid	Median Cost	Variance vs. Median	Provider Chargemaster Rate	Cost Variance vs. Chargemaster
ER Hospital	4/12/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$153	$810	$24,466	$899	$24,377
ER Hospital	8/30/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$0	$810	$24,466	$899	$24,377
Outpatient	8/18/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$0	$810	$24,466	$899	$24,377
Outpatient	11/8/23	74177 - CT scan of abdomen and pelvis with contrast - Facility	$25,276	$0	$810	$24,466	$899	$24,377

SAVE THE DATE!

2026 Spring Forum

April 30 – May 1

Greensboro-High Point Marriott Airport

2026 Culture of Wellbeing Award

Applications open next week

Complete online

Deadline 1/31/2025

Winners will be announced at the 2026 Spring Forum

Thank you for attending the NCBCH Fall Forum!