

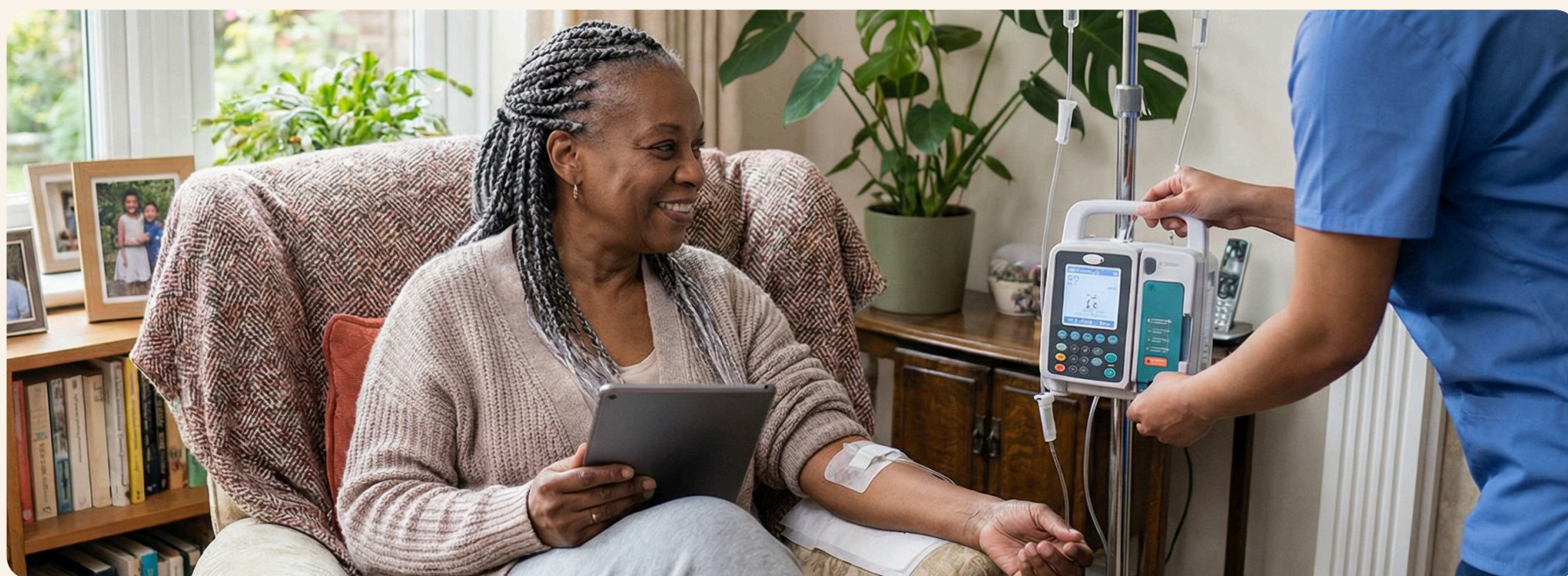


The hidden costs behind specialty medicine spend

Specialty drugs are a significant driver of rising healthcare costs for employers. How well you understand what those costs are will help you set your organization up for success in this fast-evolving category.

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THE REAL COST

How much are specialty medicines costing you?

If you don't know, you're not alone. Just a few employees with high-acuity needs can influence spend in a big way. Take this example:

For two years, Matt made a four-hour round trip to an infusion clinic in New Orleans every six months for his Ocrevus infusion to treat his multiple sclerosis. Each trip cost him a full workday.

When he transitioned to Leap, his first home infusion was scheduled for a Saturday, so he didn't have to miss work again. His plan, his prescriber, and his medication all stayed the same.

What changed for his employer was the claim: Over \$125,000 in claims-validated annual savings to the health plan, due in large part to eliminating drug markups.

If you're a benefits leader, you might be wondering this:

My specialty drug costs are rising every year. *What's going on?*

DID YOU KNOW...

~1-2%

of a self-funded plan's
members are on specialty
infusion therapy, and that
group typically drives 10 to 15%
of total medical spend

THE PAGES AHEAD ANSWER THAT QUESTION →

Get a detailed impact analysis →

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03



THE SCALE OF THE PROBLEM

Healthcare cost trends are *unsustainable*

INDUSTRY INCREASES

9.2%

median increase in healthcare cost trend projected by employers for 2027¹

HOSPITAL PRICING

62%

of employers report that hospital price increases are driving their costs to a great or very great extent²

SPECIALTY INFUSION COSTS

400%+

markups of specialty infusion drug costs by providers³

Top drivers to rising healthcare costs *for employers*

In a recent survey, employers named these as the top threats to their healthcare costs:⁴

77%

Drug prices

75%

High-cost claims

68%

Hospital prices



“Employers have basically become the safety net for a healthcare system that was never designed to handle the complexity patients deal with today.”

- Rob LaHayne, Chief Commercial Officer, Leap



WHY EMPLOYERS STAY STUCK

It's not 1 problem. *There are 3.*

Nearly 1 in 2 benefits leaders rank the high cost of specialty drugs as a top healthcare cost concern.⁵

Three forces are compounding the challenge for employers:

- ! Partial fixes that manage the drug markup instead of removing it.
- ! A billing model that lacks transparency.
- ! A market that keeps shifting underneath any strategy built for today's conditions.

Let's define each of these forces.

01

Site-of-care economics

Where an infusion happens changes what it costs, but moving the location has never removed the markup, only relocated it.

02

The claim itself

A bundled J-code or Q-code claim that combines the drug cost, the markup, and the coordination fee into one line an employer can't take apart.

03

The market underneath both

Hospital consolidation, access restrictions, and an ever-growing volume of specialty drugs, all shifting the ground before any fixed strategy can catch up.

Let's dive deeper into each of these, then show what changes when all three are addressed. →

Site of care alone won't solve for rising costs

Site-of-care programs are a common response to rising infusion costs. Business leaders sometimes think, because hospital costs can run high, that moving treatment from an outpatient department to an infusion center should shrink the markup.

And it does. But this is still a marked-up drug that's driving up employer spend unnecessarily.

Site-of-care programs manage where the markup happens. But they don't eliminate the markup itself. Employers are still susceptible to rising costs.



“When the cost is ‘lower than a hospital,’ that’s clearing a pretty low bar. But it’s not a strategy that removes drug markups.

- John Reade, SVP Growth Strategy and Operations, Leap

Hospitals vs Site of Care



42%

decline in outpatient costs among patients at alternative sites-of-care rather than an HOPD

Changing site of care might reduce costs, but it doesn't eliminate the entire markup.

Sources: Healthcare, Journal of Managed Care + Specialty Pharmacy (JMCP)

You don't know what you're buying

A member on Remicade for rheumatoid arthritis needs an infusion every six to eight weeks. Her employer sees one number on the claim for roughly \$6,000 per encounter. Was that \$6,000 the price of the drug, and/or the provider's markup, and/or something else? You can never be quite sure.

The encounter is bundled into one line item. For a lot of providers, this is the business model. It's by design. Hospitals and provider clinics buy the drug at acquisition cost, mark it up by as much as 400%, and submit a single claim under a J-code or Q-code (which are the billing codes payers use for drugs administered in a clinical setting).



What's hiding inside that bundled number?



340B pricing gaps between what a hospital paid for a drug and what it billed.



Claim complexity, like incorrect unit counts or duplicate claim lines that even a clinical review can't always untangle.



Percentage-of-charge contracts, which pay a provider more for marking up a drug.



Drug package sizes and dosing that can leave waste baked into the unit cost.

A benefits leader can't audit a number without the details.



FORCE 03

The market is moving faster than your strategy

Underneath all of this is a specialty medicine market that's evolving faster than most employers' strategies.

Hospital systems have been increasingly acquiring independent physician practices for close to two decades, and infusion-heavy specialties like oncology and rheumatology have been common targets.

Once an independent practice is folded into a hospital system, you'll often see the same clinicians, in the same building, seeing the same patients, are reclassified as a hospital outpatient department. That reclassification alone can trigger payment increases of 100% to 200% for the same care.⁶

At the same time, the volume of specialty drugs keeps growing. Fewer than 30 specialty drugs were on the market in 1995. Today, there are hundreds of specialty drugs, with thousands more in the FDA pipeline.

A pricing strategy that only works under today's site-of-care map, network structure, or drug list is building on ground that's shifting.

There's a clear need to modernize.

GROWING SHARE

59%

of physician practices are owned by hospitals and corporate entities, which is up from 39% just four years ago⁷

UNNECESSARY COSTS

Up to 200%

payment increases for the same care due to hospital outpatient department (HOPD) reclassification

What a transparent claim *actually looks like*

It can feel like rising healthcare costs are the new norm. After all, employers are projected to face near-double-digit percentage increases in healthcare costs for a fourth consecutive year.⁸ But the drivers behind these healthcare cost increases are too often unclear.

What employers need to truly understand this challenge is transparency within their specialty medicine claims. When an employer has a transparent infusion claim, they should see a clear breakdown of the claim into three visible lines:



The drug at its true acquisition cost.



Care coordination as a flat fee.



Clinical administration on its own line.

That's the standard that employers and their consultants should hold any specialty medicine program to. A repair bill separates parts from labor. An itemized infusion claim should separate the drug from the markup.

What to ask when evaluating specialty medicine billing

- ❓ Can you see the drug's actual acquisition cost, separate from what's billed?
- ❓ Is care coordination priced as its own line, or folded into the drug cost?
- ❓ Is clinical administration billed separately from the drug and the coordination fee?
- ❓ Would this claim survive being broken into parts and reviewed line by line?

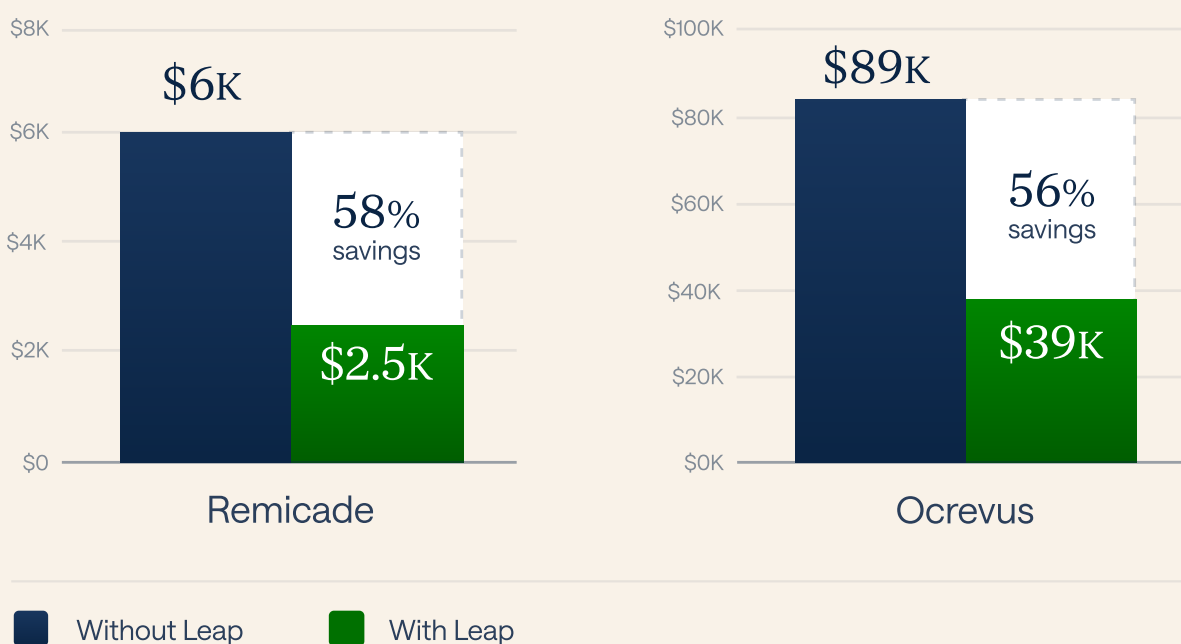


A REAL-WORLD EXAMPLE

You have the data. Here's what to do with it.

Applied to the Remicade example from a few pages back, when restructured into three lines, the same \$6,000 encounter (based on third-party market benchmarks) becomes about \$2,500 with Leap, a 58% reduction. A comparable Ocrevus encounter drops from roughly \$89,000 to \$39,000, a 56% reduction, with no change to the drug, the prescriber, or the member's plan.

- That's not a smaller markup with better paperwork.
- It's the markup removed at the source, and it holds up across Leap's full book of claims, not just one drug.
- And you're receiving transparency regarding the specifics with what you're being charged.



3 simple steps

to give you the confidence you need with any solution you're evaluating:

01

Share your claims data with the vendor, at no cost and no commitment.

02

The vendor runs a claims-based repricing analysis against your own specialty infusion spend.

03

You review a validated savings number with the vendor that you can bring straight to your executive leadership team.

That standard is what Leap runs on. It's what happens when your own claims get run through the same three-line standard.



HOW LEAP CAN HELP

The time is now to modernize your approach

Hospital consolidation won't slow down. The volume of specialty drugs available to your employees will keep growing. But neither is a reason to wait for the market to settle, because it won't. In fact, it's a reason to modernize your approach now, because all signs point to this challenge continuing to grow.

A program built around today's site-of-care map or today's network structure is not enough. What employers need is the truth about where their healthcare spend is going, no matter what changes around it.

For decades, employers asked one company to build the network, negotiate prices, administer claims, manage utilization, and increasingly deliver pharmacy and specialty services. That model is unbundling, category by category. Specialty medicine is one of the categories being rebuilt.

Margins are thin for many employers, so those that stand out in your space will be the ones that get the most value from their benefits instead of those that cut their benefits in order to maintain the status quo in an unsustainable cost environment.

“The system to deliver to patients is broken. We're rebuilding it.”

- HANI ELIAS, CEO, LEAP



Get a transparent view of how much you could save with Leap.

[Request an impact analysis →](#)

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