Establishing a Managed Care Strategy

Kelly Mooney, VP of Contracting and Client Service

Mike Scribner, Partner

Strategic Healthcare Partners, LLC – Who We Are and Who We Serve

- Founded by Principals John Crew and Mike Scribner in 2007.
- Over 30 years experience in the field.
- Broad spectrum of healthcare clients including:
  - Rural/Urban/PPS/Critical Access Hospitals/ASCs
  - Over 1,500 physicians/extenders
  - IPAs, CINs, ACOs
- Client services
  - Revenue Cycle Support
  - Managed Care Contracting
  - Decision Support/Financial Analysis

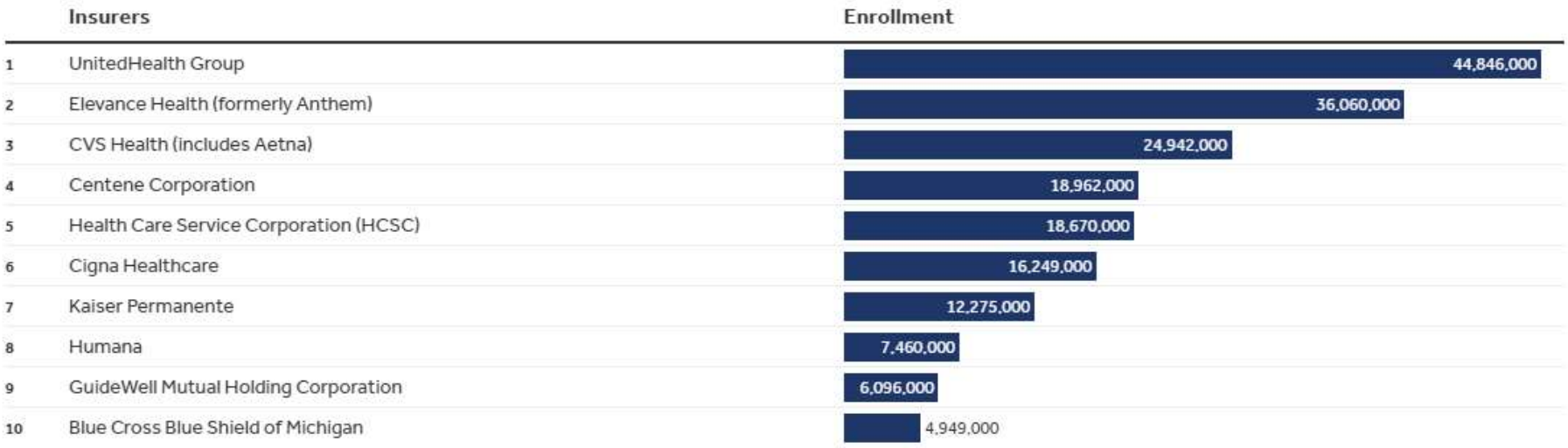
Managed Care Landscape

What is the Current Playing Field?

- Healthcare Market Trends
  - Market Consolidation
  - Impact of the ACA & Big Beautiful Bill
  - Shift from Medicare to Medicare Advantage
- Regulatory Changes
  - No Surprises Act IDR
  - Payer Transparency
- Managed Care Strategy in the New World

Insurer Consolidation Market Trends

Top 10 largest insurers across all insured, by enrollment, 2025



	Insurers	Enrollment
1	UnitedHealth Group	44,846,000
2	Elevance Health (formerly Anthem)	36,060,000
3	CVS Health (includes Aetna)	24,942,000
4	Centene Corporation	18,962,000
5	Health Care Service Corporation (HCSC)	18,670,000
6	Cigna Healthcare	16,249,000
7	Kaiser Permanente	12,275,000
8	Humana	7,460,000
9	GuideWell Mutual Holding Corporation	6,096,000
10	Blue Cross Blue Shield of Michigan	4,949,000

Note: This chart includes enrollment data across the individual market, fully insured and self-funded group plans, Medicaid Managed Care and Fee-for-Service type Medicaid programs, and Medicare Advantage plans. See Methods for additional details. Originally published in Recent trends in commercial health insurance market concentration.

Source: KFF analysis of Enrollment by Segment Exhibit data from Mark Farrah Associates Health Coverage Portal ™ • Get the data • PNG

Peterson-KFF Health System Tracker

Insurer National Presence – Fully Insured Large Group Market

A small number of insurers have a national presence

Top 10 largest insurers in the fully insured large group market by enrollment, 2023

Fully insured large group market | Fully insured small group market | Individual market

Rank	Insurer	Enrollees	National market share	States where insurer is one of the three largest insurers
1	Kaiser Permanente	7,020,000	18%	7
2	UnitedHealth Group	4,710,000	12%	33
3	Elevance Health (formerly Anthem)	3,406,000	9%	10
4	Health Care Service Corporation (HCSC)	3,119,000	8%	5
5	CVS Health (includes Aetna)	2,345,000	6%	13
6	Cigna Healthcare	1,983,000	5%	16
7	Blue Shield of California	1,135,000	3%	1
8	Blue Cross Blue Shield of Michigan	982,000	3%	2
9	GuideWell Mutual Holding Corporation	912,000	2%	1
10	Highmark	896,000	2%	3

Note: See Methods for details. Originally published in Recent trends in commercial health insurance market concentration.

Source: KFF analysis of HHS MLR Part 1 Exhibit data from Mark Farrah Associates Health Coverage Portal ™ • Get the data • PNG

Peterson-KFF Health System Tracker

Impact of Commercial Consolidation

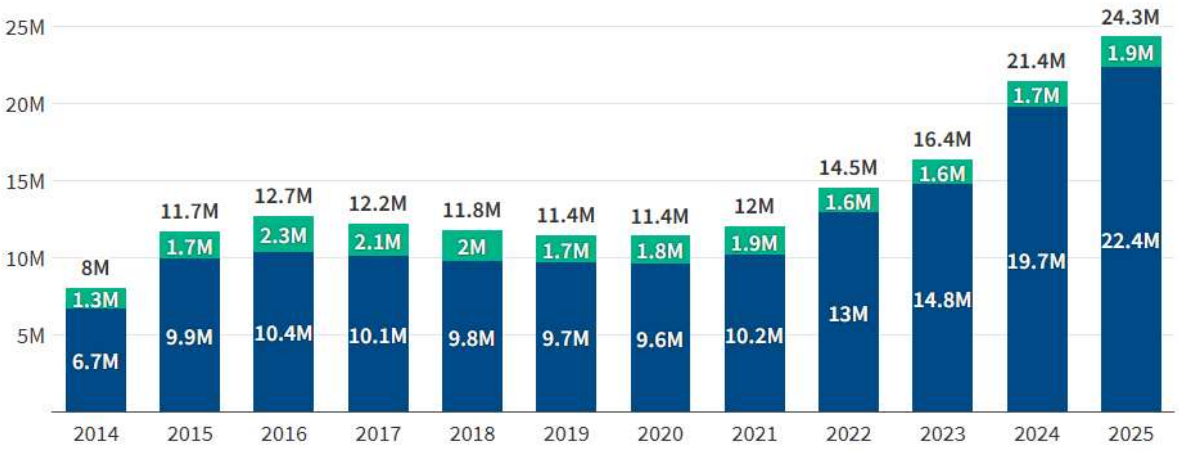
- Over the last ten years – the biggest health plan trend has been continued consolidation/market specialization.
  - In 2022, UnitedHealth Group and Centene were the largest commercial and ACA marketplace private insurers, each with 14 % market share.
  - In 2020, five for-profit insurers—Centene, Elevance, UnitedHealth Group, Molina, and CVS Health—together accounted for 50 percent of national Medicaid managed care enrollment.
  - And in 2022, three payers—UnitedHealth Group, Humana, and CVS/Aetna—captured a significant share of the rapidly growing Medicare Advantage market, which serves millions of older Americans and now accounts for more than half of Medicare enrollment.
- Acquisitions between health plans and providers have also established the health plan as competition to the independent providers in the market
  - i.e. Humana acquisition of Centerwell, Cigna stake in Village MD, etc.
- ***Overall impact of consolidations:***
  - ***Classic impact of a drift toward monopoly level market share in any industry.***
  - ***While initially sold as cost-containment exercises (consolidation of services, etc), Insurers have reaped most of the financial rewards from network consolidations while consumers face increased prices and diminished choices for care, and some providers wind up undercompensated (or at least stagnated rates during times of high inflation).***

Health Exchange Growth through 2025 – 2026 Numbers will Change Significantly

Figure 1

ACA Marketplace Enrollment Hits Another Record High During 2025 Open Enrollment Period

Total ACA Marketplace Plan Selections During Open Enrollment, 2014-2025



Source: KFF analysis of Health Insurance Marketplace Open Enrollment Reports for 2014, 2015, and 2016 and Marketplace Open Enrollment Period Public Use Files • Get the data • Download PNG

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- ***After massive growth past 2 years, lack of subsidies/funding lead millions to be at risk.***

How has the Big Beautiful Bill Impacted ACA Enrollment?

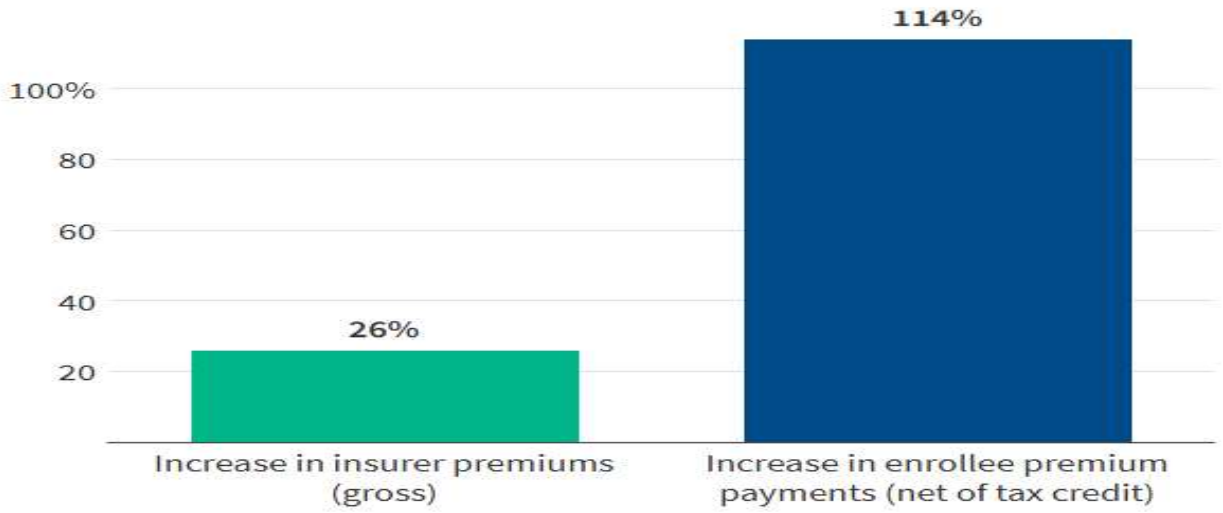
- Eliminates automatic re-enrollment, thus risk of lost coverage simply due to not completing new enrollment.
- Expiration of enhanced ACA premium tax credits; resulting in higher net premiums to enrollees.
- More frequent eligibility verification, which historically results in dropouts even if still eligible.
- Due to projected fallout, plans asked for much higher premium hikes as that typically deteriorates the risk pool (as sicker enrollees have to stay put and healthier enrollees tend to drop coverage).
- Double whammy of higher overall premium/less subsidy.
- Urban Institute estimates a 20% loss of coverage into 2026 (4.8M nationwide).

Exchange Plan Premium Spikes

Figure 1

ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Would See Sharper Increases in What They Pay if Enhanced Tax Credits Expire

Percent change in gross and net premium payments, 2026

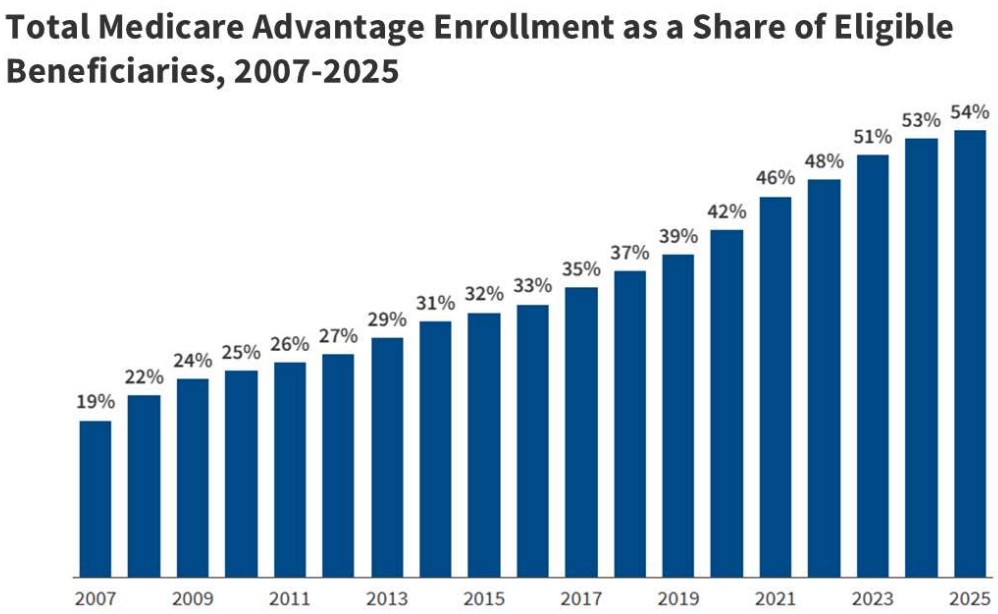


Source: KFF analysis of ACA Marketplace premium data • Get the data • Download PNG KFF

Anticipated Impact of Exchange Plan Changes for 2026

- Individual Market Plans
  - Through 2025, record Setting Exchange Enrollment continued…..but 2026 paints a different picture.
    - ***Loss in coverage expected to move population back to self-pay as they will not qualify for other coverage.***
    - ***Potential for some mitigation if subsidies reaffirmed in subsequent vote, but nothing currently.***
- Re-emergence of traditional commercial carrier impact on individual providers:
  - In states dominated by Anthem (or any single commercial carrier), HIX growth has allowed for a new market to grow from standing start to increase competition in those states.
  - Some states have seen steps toward a reversal of near monopolistic BCBS market share as HIX and MA markets didn't inherit huge pricing advantage maintained by BCBS for commercial market.
- Move back to self-pay/uninsured payor mix spikes
  - ACA created soft landing spot for Medicaid unwinding by inheriting the bulk of disenrollments vs. their transition into self pay but that impact is mitigated for 2026.
- Similar to MA, the myriad of new plans increases billing complexity.
- In many cases, contracts are not specific to individual or HIX market, therefore, providers open to have agreement apply to commercial products in future.
  - ***In several markets, however, Centene has become (and acted like BCBS v 2.0) in the HIX space, so not all roses…***

Medicare Advantage National Trends



- 4% growth ’24 to ’25.
- CMS projecting 2-3% decline for ’26; then 4% growth for next several years beyond.
- Traditional Medicare projected to decline to 40% by 2030; 36% by 2034.

Medicare Advantage National Trends by Carrier

	FY2023 MA Membership	Percentage Growth (FY 2010 vs FY 2023)
Aetna	3.3M	532%
Anthem	4.3M	264%
Humana	5.5M	316%
Cigna	573k	178%
United Healthcare	8.9M	415%
Kaiser Permanente	1.8M	199%
Centene	1.2M	188%

Competitive Impact of Medicare Advantage Growth

- MA Growth Impact on Practices/ASCs has pros and cons -
  - Pro- Implications of more competition
    - One carrier doesn't necessarily dominate MA market like commercial.
    - Has given other carriers glimmer of hope to compete/not leave single carrier dominance in markets.
  - Con- Implications of more MA and more MA options
    - On average, 20-25 higher days in AR for MA plans vs. Traditional Medicare.
    - More administrative burden/clearly excessive medical record requests.
    - Higher pre-auth and claim denial rates.
      - MA plans deny nearly 8% of pre-auths, more than double commercial plans.
      - MA plan initial claim reject rate is over 40%.

Impact of Medicare Advantage Trends

- CBO estimates MA plans pay 3% ***LESS*** than traditional Medicare to providers despite the PMPM for Medicare Advantage being higher…..this trend likely to continue.
- Absent significant provider pushback, the trend to sub-Medicare pricing will continue, starting with smaller independent practices not accessing a larger IPA/CIN mechanism.
- MA growth not going away; it's going to grow, both in plan membership and in number of different carriers/plans involved.
- Inevitably, there will be carrier consolidation (a la commercial market) but a ton of players right now.
- Regulatory support has been garbage; we have to defend ourselves.
  - ***Network adequacy standard enforcement has been nearly non-existent, thus leading to ability for plans to bully providers, thus, leading to larger health system pushback and plan terminations, typically UHC MA.***
- Value based $'s even out the game for primary care but not for specialists/ASCs

Regulatory Changes Impacting Strategy

Independent Dispute Resolution

What is it and why do we care?

IDR- What is it?

- Legally mandated arbitration mechanism created by the No Surprises Act to resolve disputes between providers and health plans over payment amounts for certain out of network (OON) services when negotiations fail.
- Patients are not involved in the dispute. A certified independent arbitrator chooses between the payment offered by the provider and the offer from the insurer.
- Arbitrator must consider Qualifying Payment Amount (QPA) among other data points.
  - QPA is the benchmarket insurers are to use to calculate payment for certain OON services.
  - The amount is essentially the insurer's median in-network rate for a specific service in a specific geography.
    I. Plan specific
    II. Service specific (CPT Code specific)
    III. Geography specific
    IV. Based on In-net rates only.
- QPA used set patient cost-share vs. Provider billed charges.

IDR- Who is using it and what is the ROI?

	Approximate % of IDR Claims	Average Award Total	IDR Success Rate	Notes
Emergency Room	45-50%	250%-300% of QPA	85%	Used far more by corporate/Private Equity groups than provider owned groups but changing.
Radiologists	20-25%	400%-500% of QPA	85%	Used far more by corporate/Private Equity groups than provider owned groups but changing.
Surgical/Neurological Specialists (Providers vs. ASC)	10-13%	Median award 1300% QPA		
Anesthesia/Pathology/Other Facility Based Providers	8-10%	Wide variety of results from 3-10x QPA.		

IDR- Results Indexed to National Medicare

Service Type	Count of Records	Count of Records %	Adjudicated Claim % of Global Medicare
Anesthesia	38,540	4.7%	
E&M Services	16,293	2.0%	712%
ER Level 3	38,419	4.7%	1790%
ER Level 4	148,074	18.1%	966%
ER Level 5	100,770	12.3%	877%
ER Critical Care	12,340	1.5%	963%
Medicine Services	85,479	10.4%	2178%
Pathology/Laboratory	64,427	7.9%	83841%
Radiology	236,102	28.9%	379%
Surgery	34,023	4.2%	3300%

IDR- Success Rate by Service Type

Service Type	In Favor of Provider/Facility	In Favor of Plan/Issuer	In Favor of Provider/Facility	In Favor of Plan/Issuer
Anesthesia	33,709	4,831	87.5%	12.5%
DRG	7,250	946	88.5%	11.5%
Drug Code	25,813	3,378	88.4%	11.6%
E&M Services	13,352	2,941	81.9%	18.1%
ER Level 1	162	24	87.1%	12.9%
ER Level 2	786	193	80.3%	19.7%
ER Level 3	32,672	5,747	85.0%	15.0%
ER Level 4	127,079	20,995	85.8%	14.2%
ER Level 5	86,661	14,109	86.0%	14.0%
ER Critical Care	10,846	1,494	87.9%	12.1%
Medicine Services	75,511	9,968	88.3%	11.7%
Misc. Code	4,467	495	90.0%	10.0%
Pathology/Laboratory	56,054	8,373	87.0%	13.0%
Radiology	220,477	15,625	93.4%	6.6%
Surgery	29,553	4,470	86.9%	13.1%
Temp Code	29		100.0%	0.0%
Grand Total	**724,421**	**93,589**	**88.6%**	**11.4%**

Pros/Cons of OON/IDR as Permanent Strategy

- Pros:
  - Strong payment backstop vs. Low reimbursing contracts
    I. Removes OON "Take it or leave it"
    II. Reduces pressure to accept unfavorable renewals/unilateral rate adjustments
  - Increased leverage in payer negotiations
    I. Resets baseline for negotiation via IDR outcomes well above typical offers.
    II. Allows viable alternative to execute termination vs. being stuck in net.
  - Can be applied payer by payer vs. "all or nothing".
    I. Enables payer by payer optimization
    II. Reduces admin burden of being fully OON
- Cons:
  - Regulatory Fragility- Politically controversial vs. guaranteed long term strategy.
  - Administrative Cost/Complexity- Filing fees, Staff/vendor costs/delayed cash flow.
  - Risk of payer retaliation and network narrowing- Potentially steering patients away, pre-auth/UR issues
  - Volume/Access Risk- Referrals/Elective Procedures (where applicable).
  - Reputational/Relationship Risk- Straining facility relationships, risk of facility replacement

IDR- Strategic Implications

- Thus far, for many provider types, IDR isn't that big a deal (at least just yet).
- For applicable provider types (ER, Facility based providers, surgery/neurosurgery), however:
  - Certain providers can reliably monetize OON care without balance billing patients.
  - IDR can be a De Factor "Backstop" for contracting as a potential backdoor rate setting mechanism.
  - At a minimum, can reset historical average reimbursement by building up enough successful IDR history to support higher requested rates.
  - Allows greater willingness to walk away from unfavorable contracts/increased tolerance for OON exposure where patient volumes are stable (or not controlled by the practice).
  - Larger groups/more efficient/cost effective batching is resulting in resurgence of consolidation of hospital based specialties.
- For Facilities:
  - Long drift of provider based specialties toward in network participation is reversing in an ever increasing way.
  - On one hand, higher IDR results with OON providers might lower or eliminate subsidies (ER/Rad/Anesthesia especially).
  - On the other, more OON facility based providers means potential pushback from payers and patients.
    I. Payers- Facility payment reductions for OON facility based providers services.
    II. Patients- OON patient liability with facility based providers must be handled appropriately to avoid volume loss/community reputational damage.

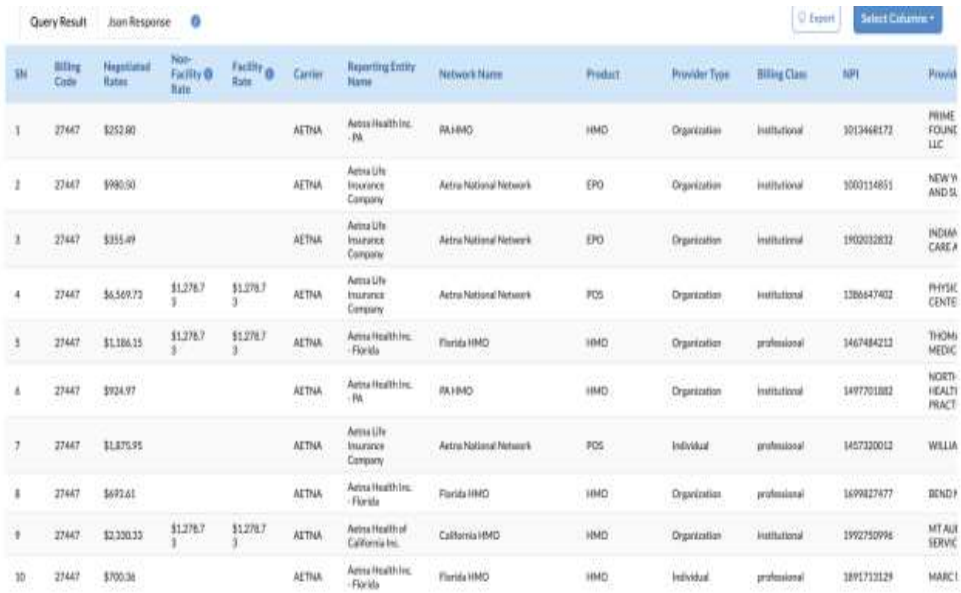
Payer Transparency

Payer Pricing Transparency

- Potential game changer for market knowledge.
- Critical component of negotiation/market analysis/vetting new market payers in the new world.
- Publicly available data now that avoids having to obtain anecdotal information/info providers aren't supposed to have.
- Data based on payer submissions/postings, therefore, would seem to be quite useful to leverage in payer discussions.

Payer/Pricing Transparency

SN	Billing Code	Description	Negotiated Rate			
			Median	25th Percentile	75th Percentile	Billing NPI Count
1	470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	$21,064.55	$1,413.26	$34,144.24	3,847
2	99213	OFFICE O/P EST LOW 20-29 MIN	$76.00	$58.59	$98.94	137,444
3	99201	Office/Outpatient Visit, New	$49.00	$39.00	$54.00	78
4	0250	Pharmacy	$21.00	$6.00	$53.00	312
5	J3490	Drugs Unclassified Injection	$0.00	$0.00	$0.00	4,807
6	E1399	Durable Medical Equipment Mi	$0.00	$0.00	$297.00	114



Hospital vs. ASC Reimbursement (NY, CA, and ME)

Hospital vs. ASC Reimbursement for Select Surgical Codes
All BUCA Payers/All Providers in CA/NY/ME

CPT Code	Average of OPPS	Avg ASC Rate	Avg Hosp Rate	ASC/ OPPS	Hosp/OPPS	ASC % of Hospital
29824	3,036	4,270	10,900	141%	359%	***39%***
29848	839	3,227	9,088	384%	1083%	***36%***
29881	3,036	3,460	8,661	114%	285%	***40%***
30140	1,350	2,358	8,023	175%	594%	***29%***
30520	3,034	2,784	9,154	92%	302%	***30%***
42820	5,798	3,033	9,523	52%	164%	***32%***
42826	1,262	2,602	8,496	206%	673%	***31%***
42830	1,396	2,567	7,847	184%	562%	***33%***
52000	571	1,193	3,940	209%	690%	***30%***
52310	1,920	1,943	5,559	101%	289%	***35%***
55250	1,917	2,038	5,666	106%	296%	***36%***
55700	1,751	1,725	5,949	98%	340%	***29%***
64483	835	1,052	4,197	126%	503%	***25%***
64493	797	1,057	4,218	133%	529%	***25%***
64635	1,670	1,639	7,029	98%	421%	***23%***
69436	1,342	1,729	6,216	129%	463%	***28%***
76872	91	120	852	132%	937%	***14%***
	Straight Line Average % of Medicare			***146%***	***499%***	***29%***
	% of Hospital to ASC Reimbursement %				***342%***	

Payer/Pricing Transparency Case Study- UHC/Atlanta Market

	Payor Transparency Reported Rates	Percent of Medicare ATL NF	CHOA rates as a % of GIK rates	Payor Transparency Reported Rates	Percent of Medicare ATL NF
43235	1,251	435%	278%	450	156%
43239	1,666	443%	179%	931	248%
43762	1,011	449%	275%	368	163%
45380	1,901	439%	183%	1,040	240%
99203	354	316%	306%	116	103%
99204	541	322%	304%	178	106%
99205	683	309%	304%	225	102%
99213	246	270%	199%	124	136%
99214	357	278%	288%	124	96%
99215	480	265%	306%	157	87%
99222	455	350%	295%	154	118%
99223	667	388%	242%	276	160%
99232	238	304%	199%	120	153%
99233	344	292%	216%	159	135%
99239	353	310%	291%	121	106%
99243	408	362%	260%	157	139%
99244	611	380%	246%	249	155%
99254	560	407%	222%	252	183%

What we've learned so far……

- Tie negotiation asks to specific/relevant local market targets (key competitors, where business would go if not in network, etc.). Payers want to find any way to kill credibility of data/dismiss impact.
- Make analysis and presentation clean and organized.
- Benchmark to specific codes or service lines vs. overall aggregate averages that can be easily dismissed by the payer.
- Consider specific calculation of provider utilization vs. alternative provider setting (i.e. ASC vs. Hospital for example) to show accurate payer cost increases.
- If good provider rates, be proactive. Prep your trend analysis vs. market ahead of time and be prepared to defend with total costs vs. unit costs, etc.

Payer Transparency Pitfalls/Barriers

- The data is complex and technically difficult to use, thus running the risk of inaccurate comparisons/poor credibility.
- Utilizing max per code or another method that, while technically supported by transparency data, results in overall non-starter proposals.
- General payer pushback regarding market comparisons, non-reprentative comparison points, dismissing comparison by provider type (Hospital vs. ASC vs. Independent Practice vs. Imaging Centers, etc.).
- Contract complexity makes comparison standardization tricky. Need to be able to apply common index of rates to final reimbursement.

So What?

Traditional Specialty Practice/ASC Managed Care "Strategy"

Summary Strategy:

- *MD side- Be in everything/match your referral sources;*
- *ASC side default to out of network, then evaluate as reimbursement goes south, no out of net benefit plans become prevalent, and pre-auth gets tougher to obtain on OON basis.*

Where did this leave us?

- Often antagonistic payor relationships.
- Only conversation was ever about money or administrative pain to get paid.
- Basically asking “Mother may I?” when time to fix issues/address rates.
- Managing patient burdens to continue providing care.

Strategy Development in the “New, New World”

Monitoring Payer Performance

- Clean Claim Pass Rate by Payer
- Denial Rates / Zero Pay by Payer by Code
- Days in AR by Payer
- Rates vs. Market by Payer by service
- Underpayment by Payer
- Assessing Administrative Burden by Payer
  - MA Plans vs Traditional Medicare
  - Pre-auth Burden
  - Appeal Overturn Rate

Understand Payer Goals

- Understanding carrier goals around other product lines and your issues with those products plays in to practice/ASC response.
- Real Examples:
  - ASC with exceptional % of charge Anthem commercial agreement (35% of payer mix vs. 2% Anthem MA product. Little motivation to fight MA issues.
  - Practice/ASC with many Humana/UHC MA issues receives Medicaid managed care proposal. Response- No consideration of Medicaid until MA record requests/claim issues are resolved.

Annual Managed Care Strategy

- Develop your annual plan:
  - Consider all major plans/all major product lines.
  - Special consideration and vetting for new carriers and new product lines of existing carriers.
  - Understand shifts in payer market share by product line.
  - Specifically lay out current rates vs. market via payer transparency.

- Some considerations:
  - Remember- Old agreement does not equal bad agreement; but old fixed rates (even with a small escalator) usually means below market rates.
  - Know who is trying to put something new in the market. Determine whether they need you and impact on any leverage you might have.
  - Managed care strategy needs to jive with overall growth/physician recruitment/local employer outreach strategy. Consider all when laying out strategy.
  - Think long term vs. short term…if cash flow allows.

Summary Managed Care Action Plan Review

Sample Practice

FFS/Value Based Programs

Network	Product	Accessed	Current Discount %	Current % of Medicare	Claim Filing Limit	Appeal Filing Limit	Payer Retro Audit	Anniversary Date	Term Renewal	Term Notice	Suggested 2020 Fee for Service Action Plan
Medicaid CMO Plans											
Amerigroup	Medicaid	Direct	64.3%	80.5%	12 Months	12 Months	12 Months	9/2/2017	1 Year	120 Days	No action necessary.
Caresource	Medicaid	SGPA	62.8%	83.9%	12 Months	12 Months	12 Months	n/a	n/a	90 Days	No action necessary.
PeachState	Medicaid	SGPA	60.5%	88.8%	180 Days	13 Months	12 Months	n/a	n/a	90 Days	Participate in incentive program when/if available.
Wellcare	Medicaid	SGPA	60.3%	89.4%	180 Days	180 Days	Not Specified	n/a	n/a	90 Days	No action necessary.
Health Exchange Plans											
Caresource	Exchange	SGPA	Go Live 1/1/20		12 Months	12 Months	12 Months	n/a	n/a	90 Days	No action necessary.
Ambetter	Exchange	SGPA	Not Listed		180 Days	90 Days	12 Months	n/a	n/a	90 Days	Participate in incentive program when/if available.
BCBS Pathways	Exchange	Direct	Not Listed		90Days	90 Days	Not Specified	3/23/2018	1 Year	180 Days	Consider termination if BCBS movement not obtained.
Commercial Plans											
Aetna/Coventry	Commercial	SGPA	45.7%	122.3%	120 Days	180 Days	Not Specified	n/a	n/a	90 Days	Participate in incentive program when/if available.
BCBS	Commercial	Direct	49.8%	113.0%	90 Days	90 Days	Not Specified	3/23/2018	1 Year	180 Days	No action necessary.
Cigna	Commercial	Direct	43.6%	127.0%	180 Days	180 Days	24 Months	n/a	n/a	6 Months	No action necessary.
Humana	Commercial	SGPA	43.0%	128.4%	90 Days	12 Months	18 Months	n/a	n/a	90 Days	No action necessary.
UHC	Commercial	Direct	42.3%	129.9%	90 Days	12 Months	12 Months	1/7/2010	3 Years	120 Days	No action necessary.
Local Network	Commercial	Direct	47.3%	180.3%	180 Days	180 Days	12 Months	Evergreen	1 Year	90 Days	No action necessary.
Medicare Advantage Plans											
Aetna/Coventry	Medicare	SGPA	49.0%	114.7%	120 Days	180 Days	12 Months	n/a	n/a	90 Days	No action necessary.
Clover	Medicare	SGPA	Immaterial until 2020.		180 Days	90 Days	12 Months	n/a	n/a	90 Days	No action necessary.
Humana	Medicare	SGPA	49.9%	113.0%	90 Days	12 Months	18 Months	n/a	n/a	90 Days	No action necessary.
UHC	Medicare	Direct	50.5%	111.0%	90 Days	12 Months	12 Months	1/7/2010	3 Years	120 Days	No action necessary.
Wellcare	Medicare	SGPA	51.5%	109.7%	180 Days	180 Days	Not Specified	n/a	n/a	90 Days	No action necessary.

Wrap Up & Questions

Follow Up:
kmooney@shpllc.com

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