JAIRUS

PLAYBOOK

HEALTHCARE STAKEHOLDERS

Insights into the U.S. healthcare industry and its decision-makers

Updated April 2025

Why it matters

Jairus clients typically have very niche audiences - usually under 10,000 total targets. That means our campaign strategies and outreach methods must be incredibly precise - the approach is very different from B2C.

Understanding clients' call points and the role they play in making a purchasing decision helps us do that. This resource will walk you through some of the key stakeholders in the U.S. healthcare system, and provide insights into their impact on Jairus client success.

Understanding Key Healthcare Stakeholders

Regulators and Policymakers

Agency for Healthcare Research and Quality (AHRQ)

The **AHRQ's** mission is to produce evidence to make healthcare safer, of higher quality, more accessible, equitable, and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used.

Centers for Disease Control and Prevention (CDC)

The **CDC**, part of the Public Health Service, protects the public health of the nation by providing leadership and direction for the prevention and control of diseases and other preventable conditions and responding to public health emergencies.

National Institutes of Health (NIH)

The **NIH,** part of the Public Health Service, supports biomedical and behavioral research within the United States and abroad, conducts research in its own laboratories and clinics, trains promising young researchers, and promotes collecting and sharing medical knowledge.

Office of Inspector General (OIG)

OIG protects the integrity of HHS programs as well as the health and welfare of the program participants.

US Food and Drug Administration (FDA)

The **FDA**, part of the Public Health Service, ensures that food is safe, pure, and wholesome; human and animal drugs, biological products, and medical devices are safe and effective; and electronic products that emit radiation are safe. In addition, FDA oversees regulatory approval of drugs, biologics, diagnostics, and devices in the United States.

Understanding Key Healthcare Stakeholders

Regulators and Policymakers

Center for Drug Evaluation and Research (CDER)

CDER performs an essential public health task by making sure that safe and effective drugs are available to improve the health of people in the United States. As part of the FDA, CDER regulates over-the-counter and prescription drugs, including generic drugs. This covers more than just pharmaceuticals. For example, fluoride toothpaste, antiperspirants, dandruff shampoos, and sunscreens are all considered "drugs."

Center for Devices and Radiological Health (CDRH)

CDRH ensures that patients and providers have timely and continued access to safe, effective, and high-quality medical devices and safe radiation-emitting products. CDRH facilitates medical device innovation by advancing regulatory science, providing industry with predictable, consistent, transparent, and efficient regulatory pathways, and assuring consumer confidence in devices marketed in the United States. The CDRH also oversees the Office of In Vitro Diagnostics and Radiological Health (OIR).

Center for Biologics Evaluation and Research (CBER)

CBER is the center within FDA that regulates biological products for human use under applicable federal laws. CBER protects and advances the public health by ensuring that biological products are safe and effective and available to those who need them. CBER also provides the public with information to promote the safe and appropriate use of biological products.

The US Department of Health and Human Services

HHS is responsible for protecting the health and providing essential human services for all Americans. Several agencies function under HHS, see below. HHS and state-level departments of health are responsible for developing and supervising the implementation of health policies, as well as managing a large part of healthcare expenditure via CMS. However, there is no strict target for federal- or state-wide healthcare expenditure.

Understanding Key Healthcare Stakeholders

Payers

Centers for Medicare & Medicaid Services (CMS)

CMS represents the public health insurance provider for around 30% of Americans and combines the oversight of the Medicare program, the federal portion of the Medicaid program and CHIP, the Health Insurance Marketplace, and related quality assurance activities.

Medicare

Medicare is a single-payer national health insurance program that began in 1966. Funding for this program comes from payroll taxes, premiums and surtaxes from beneficiaries, and general federal revenue.

It primarily provides health insurance to Americans aged 65 and older who have paid into the Social Security system through payroll taxes. (for more information see The Facts on Medicare Spending and Financing under Suggested Reading) Additional health insurance coverage through Medicare is provided to younger people with some disability, patients with amyotrophic lateral sclerosis, or patients with renal failure requiring dialysis or transplant.

Coverage for Medicare is broken down into 4 parts, A through D. Traditional Medicare plans (A, B, and D) do not contain an out-of-pocket spending limit.

Understanding Key Healthcare Stakeholders

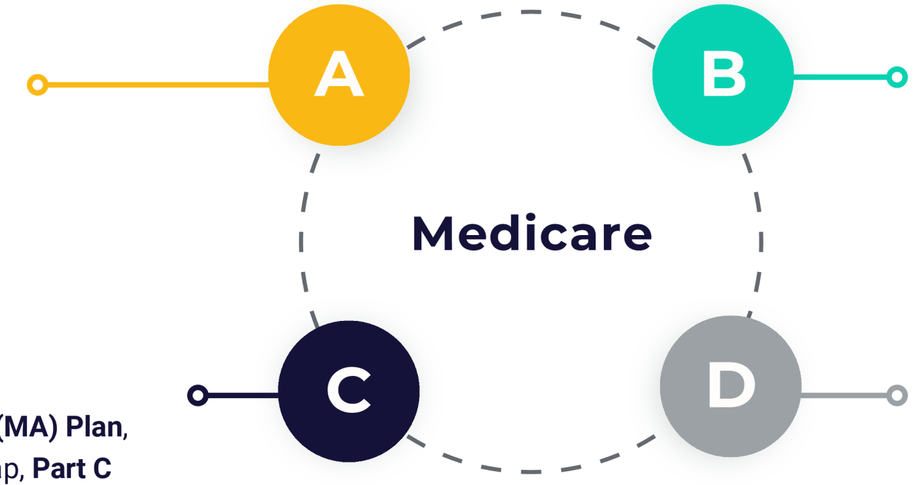
Payers

Plan A

Medicare Part A coverage relates to inpatient hospital costs, skilled nursing, and hospice services.

Plan C

Also known as a **Medicare Advantage (MA) Plan**, Medicare Supplement Plans, or Medigap, **Part C** coverage is an alternative to traditional Medicare that allows patients to choose private plans with at least the same benefits of Parts A and B, and often D (as a Medicare Advantage Prescription Drug [MAPD] plan). These plans provide an annual out-of-pocket spending limit, which traditional Parts A and B plans do not contain.



Plan B

Medicare Part B coverage relates to outpatient physician services. Durable medical equipment (DME), such as diabetic testing supplies, is covered under these plans. Some drugs also may be covered under Medicare Part B and are usually treatments that require the intervention of a physician to administer, such as chemotherapy, immunosuppressant drugs, and dialysis drugs.

Plan D

Medicare Part D coverage relates to prescription drug coverage. This coverage has a standard benefit design for all patients. See Figure 5 below for a breakdown of costs for Medicare Part D plans in 2019. [21]

Understanding Key Healthcare Stakeholders

Payers

Managed Care Organizations (MCOs)

MCOs operationalize health insurance for their enrollees by providing a complete healthcare delivery system consisting of affiliated and/or owned hospitals, physicians, and other providers that provide a wide range of coordinated health services. These health organizations contract with insurers, or self-insured employers, to deliver healthcare.

Preferred Provider Organizations (PPO)

These health plans have a preferred network of providers but will still cover out-of-network care. Patients can see specialists without a referral from a primary care physician visit. Because these plans are less restrictive, patients tend to have higher monthly premiums and cost-sharing. These plans have lost some popularity due to efforts to control costs. Premiums and deductibles are often higher when compared to HMOs.

Health Maintenance Organizations (HMOs)

In this healthcare plan model, patients tend to have lower monthly premiums and “in-network” restrictions on primary care physicians. Sometimes, patients are required to select a single primary care physician for treatment. Specialists require referrals from the primary care provider and out-of-network services are not covered. Premiums and deductibles are often lower when compared to preferred provider organizations.

Tiered-Network Plans (TNP)

Tiered networks can be considered a hybrid plan that combines the physician networks of an HMO and the expanded network options of a PPO. With a tiered network, members pay lower out-of-pocket costs when they visit a preferred tier provider. Patients can visit nonpreferred physicians for healthcare but will pay more out of pocket. Even if a patient visits a nonpreferred physician, the incurred out-of-pocket costs go towards the out-of-pocket limits established by the ACA.

Understanding Key Healthcare Stakeholders

Others Involved in the US Healthcare System

Pharmacy and Therapeutics Committee (P&T):

Develops and manages the formulary systems used in many different settings, ie, hospitals, long-term care facilities, Medicare, Medicaid, insurance companies, and managed care organizations. It acts as the liaison between pharmacy and medical staff in terms of coverage decisions for therapies that are effective, safe, and cost-effective for their particular facility or insurance plans.

Value Analysis Committee:

Similar to a P&T Committee, these groups focus on the management of medical diagnostics and devices in a health system. Additionally, these groups also assess the value of certain clinical services to ensure the cost-effective provision of care. In a hospital, new products (such as medical devices) are reviewed by a VAC before physicians within the hospital can begin using the product on patients.

Understanding Key Healthcare Stakeholders

Others Involved in the US Healthcare System

Integrated Delivery Networks (IDN):

DNs utilize vertical integration of healthcare to deliver the full range of healthcare services to its patients. The major distinction of an IDN is that the healthcare providers covered by the health plan are also employees of the health plan, rather than contracted physician networks. When patients receive care in the outpatient, specialist, and inpatient settings, they will utilize services owned and provided by the health plan executor. Kaiser Permanente, on the West Coast of the United States, is a good example of this type of healthcare delivery system.[24]

Pharmacy Benefit Managers (PBM):

PBMs design, implement, and manage pharmacy benefits and coverage. Health plans and self-insured employers often partner up with PBMs and let the latter manage pharmacy-related insurance responsibilities.

Self-Insured Employers:

In addition to the private health plan organizations listed above, many employers will choose to **self-insure** and fund their own healthcare plans for their employees. In this scenario, employers will contract with healthcare providers to administer their health plans but have full control of coverage options and total responsibility for costs. These self-insured employers are able to offer health plans tailored to their insured population and can serve as a cost-containment method. There is the risk, however, of high-cost individuals driving up overall costs to the employer, who maintains full responsibility for payment.