ADDRESSING WASTE IN THE U.S. HEALTHCARE SYSTEM

The Upside of Modern Technology and Aligned Partnerships



How unified electronic infrastructure reduces waste, enhances transparency, improves plan member experience, and future-proofs health benefits programs.

A LETTER FROM OUR CEO

It's Time for Acceptance

I've worked in the pharmaceutical supply chain for more than 20 years, and interest in upgrading the systems we rely on across the continuum of care – and connecting them – has never been higher. It reminds me of the evolution from Material Requirements Planning (MRP) to Enterprise Resource Planning (ERP) in drug manufacturing, only now it's the Core Administrative Processing Platform (CAPS) ushering in a new age of benefit administration infrastructure: the Enterprise Health Platform (EHP).

The reason for the spike in demand is simple. Third-party administrators (TPAs) and plan sponsors have historically relied on traditional vendors with misaligned business models to meet specific claim-processing needs, rather than the more advanced, integrated benefits solutions the market demands. These buyers have realized that an unreasonably large share of overall healthcare spending in our country is wasteful. In my opinion, the level of waste is at least $1 trillion, and an unreasonably large portion of it results from our aging, inflexible infrastructure. The buyer has finally accepted the need to change.

We recognized the issue, too, so we built Judi®, and our mission evolved from focusing on drug pricing and PBM transparency to deploying the electronic infrastructure our nation needs for the healthcare we deserve. With Judi, our proprietary EHP, we can connect health benefit workflows across medical, pharmacy, dental, vision, and ancillary benefits.

The infrastructure written 20 to 30 years ago runs on outdated programming languages and on-premises racks and cabling. These systems were never designed to communicate with one another, let alone with external entities.

If you're responsible for a health benefits program or manage health benefits plans for others and want to take control of and streamline administration, we'd love to introduce you to Judi Health and show you how Judi can alleviate pain points and deliver a material improvement in operating efficiency, plan economics, and overall satisfaction.



AJ Loiacono
Chief Executive Officer
Judi Health

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Healthcare Has a Trillion-Dollar Problem

The only thing more staggering than the amount of money we spend on healthcare in the U.S. is the amount of wasteful spending embedded in the system. In recent years, national healthcare expenditures have skyrocketed to over $5.3 trillion.[1] And if we project forward the most widely cited estimate of wasteful spending, it's not hard to see that we're staring at a $1.5 trillion problem.[2]

Meanwhile, the pressure on the people paying for it keeps building. Consider the following:

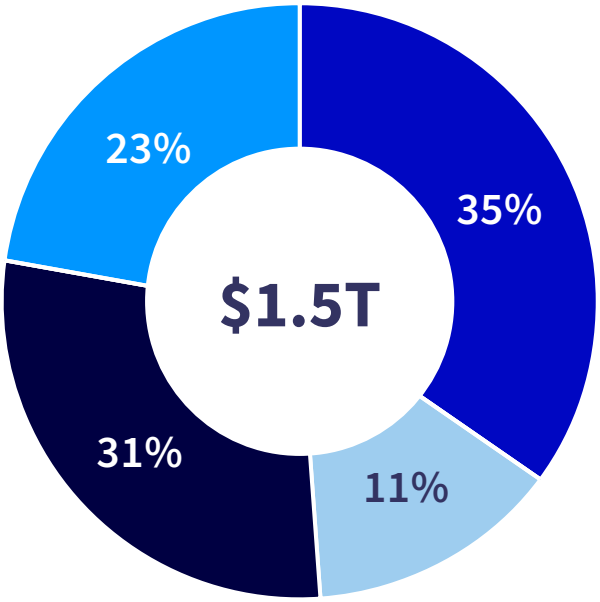
- Entering 2026, employers expected healthcare costs to jump 9% without corresponding gains in outcomes.[3]
- Million-dollar claims are up 61% over the past four years.[4]
- GLP-1s account for 21% of pharmacy benefit spend[5] (the share of U.S. adults taking them for weight loss has nearly quadrupled since 2024).
- 84% of employers say they're very concerned about pharmacy costs, while 75% say they are concerned about the opacity of the supply chain.[6]

> Follow almost any category of waste upstream, and you arrive at the same source: claims infrastructure, written 20 or 30 years ago, split across benefit types that were never designed to talk to each other. Patients navigate a fragmented system where duplicative tests are run because no single source of truth exists."



AJ Loiacono
Chief Executive Officer
Judi Health

A Breakdown of Wasteful Healthcare Spending in the U.S.



- **Administrative Complexity**
- **Fraud & Abuse**
- **Operational Opacity**
- **Inefficient Spending on Low-Value Care & Care Coordination**

Sources: Judi Health estimates and Shrank et al., "Waste in the US Health Care System," JAMA (2019); PubMed ID: 31589283.

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Administrative Complexity: Over a Quarter Trillion Dollars of Waste

Administrative complexity alone accounts for at least $266 billion of annual healthcare waste, the single largest category.[7] Medical, pharmacy, dental, vision, and diagnostic claims data have traditionally lived in separate systems, and this disaggregation created gaps where waste proliferates: delays, redundant workflows, provider burden, and layers of operational inefficiency.

On the medical side, a single episode of care can generate claims that pass through an EMR, a billing system, a clearinghouse, a network, and a TPA before anyone knows what's owed. Every additional system is another set of eligibility feeds, another reconciliation, another chance for the data to disagree with itself.

CONTENT SPOTLIGHT:

Building a Single Source of Truth for Medical and Pharmacy Benefits, with Kevin Sundquist & Liya Lomsadze

Click here to listen to Kevin and Liya's full podcast episode

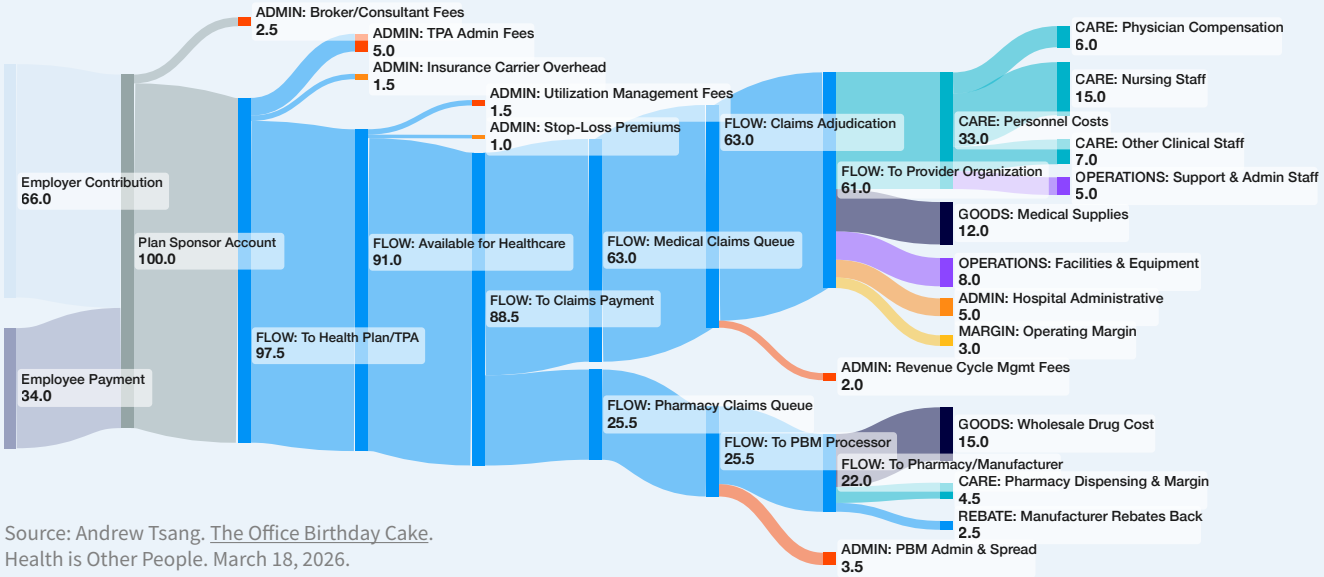
Where Does All the Money Go?

Break the trillion dollars apart and a pattern emerges: the biggest buckets of waste are precisely the ones that fragmented, legacy infrastructure creates, and the ones modern, unified technology is built to eliminate.

The $100 Employer Healthcare Dollar

Where your premium goes, from paycheck to provider.

One thing is clear: accepting the level of inflation everyone is experiencing, and a system that absorbs or redistributes waste rather than eliminating it, is no longer acceptable.



Source: Andrew Tsang. The Office Birthday Cake. Health is Other People. March 18, 2026.

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Opacity, By Design

Legacy infrastructure doesn't just fragment data; it hides it. The opacity runs across every type of benefit, and the "four pillars of insurance" are managed separately, too. On the medical side, plan sponsors rarely see claim-level detail from their ASO carriers, hospital pricing varies wildly for identical services, and employers lack the claims expertise and member-level data to understand their true costs, spot waste, and act as prudent fiduciaries. On the pharmacy side, as PBMs acquired retail and mail-order pharmacies and launched rebate aggregation businesses, vertical integration drove costs up throughout the system while presenting data in aggregated, high-level ways that conceal the full picture. Employers must be able to evaluate their claims and other member-level data to understand their true costs, spot waste, and act as prudent fiduciaries. Shifting to a transparent, fixed payment model for PBMs would reduce annual spending by nearly $100 billion, a 2025 study found.[8]

In 2025, the top six PBMs processed more than 90% of prescriptions in the U.S.[9]

THE FOUR
Pillars of Insurance

Every benefit, whether medical, pharmacy, dental, or vision, rests on the same four pillars of claim administration.

Eligibility
The genesis of all benefits: who is in, who is out, and who their dependents are.

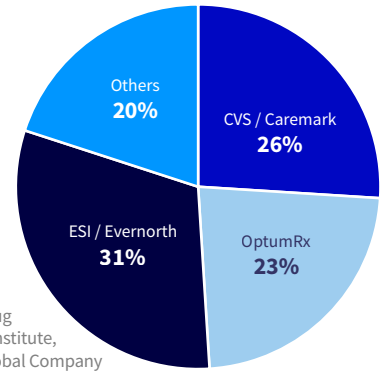
Plan Design
Defines the clinical and financial rule sets, from copays to networks.

Billing
Accounts for the services provided to the plan.

Reimbursement
Pays the networks and partners delivering care.

ON THE PHARMACY SIDE

Legacy Players Consolidated Instead of Innovating



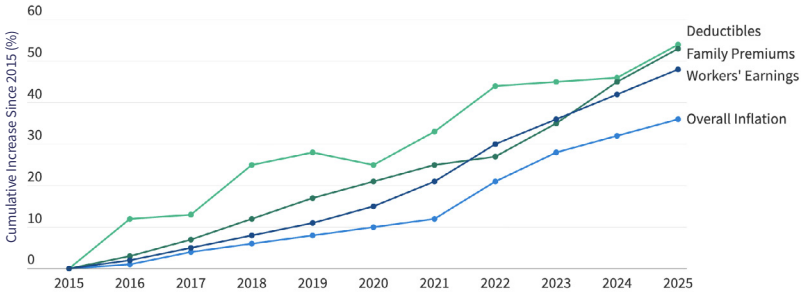
Source: Drug Channels Institute, an HMP Global Company

2025 Market Share

- **30** years
- **40** mergers and acquisitions
- **3** market leaders
- **0** changes to the PBM model

ON THE MEDICAL BENEFITS SIDE

Costs Have Been Pushed to Employers & Plan Members



Source: KFF Employer Health Benefits Survey, 2018-2025; Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2015-2017. Bureau of Labor Statistic, Consumer Price Index, U.S. City Average of Annual Inflation, 2015-2025; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2015-2025

Note: Average general annual deductibles are for single coverage and are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

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The Point Solution Problem

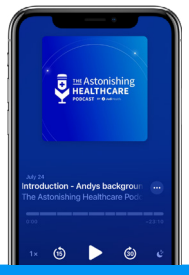
When the core system can't do the job, employers bolt on vendors to compensate, and the patch becomes its own source of waste. A 2026 survey found 42% of benefits leaders manage eight or more digital health vendors, 90% spend more than $1 million annually on them, and the median cost just to manage those vendors runs $580,000 on top of the benefits budget itself.[12]

Many of those solutions are underused or never turned on. For employer-sponsored plans, which account for 154 million people, we estimate there is between $3 and $10 PMPM of wasteful spending in every contract. The costs stack quietly: a few dollars PMPM here, ten or twelve there, plus hidden costs like shared savings arrangements. And each time another party touches a claim, it adds cost, and every workflow that runs twice is, at best, twice as expensive. The problem isn't much different for TPAs.

"Point solutions and point solution fatigue have been talked about a lot from the member experience and the clinical delivery sides, but there's significant proliferation of point solutions from an infrastructure perspective as well. While they solve single problems, what payers do is bolt on those point solutions. That's how we've ended up with a patchwork of systems. It should all sit on a single code base - there should be a single pane of glass. That's the Judi Cloud business."
- Andy Kageleiry, SVP, Enterprise, Judi Health

CONTENT SPOTLIGHT:
From Legacy Mainframe to Judi Cloud™: Modernizing Claims Adjudication, with Andy Kageleiry

Click here to listen to Andy's full podcast episode



With Judi®, our custom-built enterprise health platform, we can help prevent wasteful spending under the pharmacy and medical benefits by layering a wasteful drug list on top of any of our formularies, for example, or deploying more comprehensive notification and communication strategies involving patients, providers across the continuum of care, and pharmacies to reduce friction and cost."



Sara Izadi, PharmD
Chief Clinical Officer
Judi Health

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The Shortfalls of Legacy Claims Processing Systems

The technology that runs a health plan goes by a name most people have never heard: Core Administrative Processing System, or CAPS. Every health plan or third-party administrator depends on a CAPS, multiple CAPS, or a CAPS with multiple bolt-ons to operate. It processes claims, manages member details, and coordinates the entire financial infrastructure. In other words, if a health plan is a car, the CAPS is its engine.

Since the CAPS touches everything, a failure also touches everything at once: the member experience, the provider network, and the business itself. Errors and delays early in the process cascade across every party in the payer lifecycle. And that's the problem: relying on legacy claims processing systems is a barrier for employers and plans looking to drive better outcomes, lower spend, and future-proof their organizations.

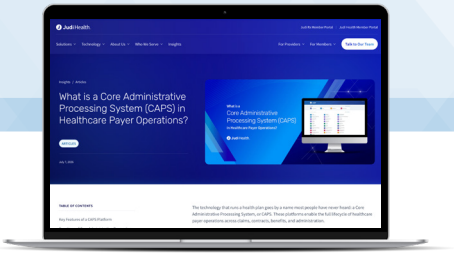
Two Claims, Two Different Centuries

Consider the gap between a pharmacy claim and a medical claim today. A pharmacy claim adjudicates in milliseconds while the member stands at the counter, arguably the most efficient transaction in healthcare. Why? Because there are fewer players involved and less complex contracts. In other words, a pharmacy claim needs to make fewer stops to get to its final destination. A medical claim, however, goes on a very different journey: from the provider's EMR to a billing system, to a clearinghouse, sometimes through a network, and finally to a health plan for processing, often with a human being manually adjudicating it by hand. The member waits weeks to learn what they owe for care they have already received, and the provider waits just as long to learn whether that care will be covered.

Both transactions represent the same thing: one person's health benefit. Yet, they run on entirely separate infrastructure that may have been built in different centuries.

CONTENT SPOTLIGHT:

What is a Core Administrative Processing System (CAPS) in Healthcare Payer Operations?



THE LIFECYCLE OF A CLAIM:

What a Modern CAPS Should Do

Claims entering the Core Processing Platform are in the payer's specific environment. The strategic imperative: deny non-compliant claims fast to prevent wasting processing resources. Each step can result in approval to proceed, flagging for manual review, or immediate denial.

1. **Payer Gateway**
   Serves as a payer's initial entry point, routing claims to divergent internal platforms.
2. **Member ID Verification**
   Confirm eligibility and active coverage at time of service using real-time APIs, enrollment databases, coverage dates. Validate member ID format, coverage active on service date, plan type, COB status.
3. **Provider ID and Contract Verification**
   Validate provider credentials and network status. Check provider NPI validity, active network participation, specialty match, billing privileges. Determines contracted vs. non-contracted reimbursement rates.
4. **Editing & Grouping**
   Apply hundreds of Boolean logic rules and millions of code pairs to detect errors—duplicates, unbundling violations, medical necessity. Group procedures into billing categories using CMS algorithms (APCs, DRGs, APGs).
5. **Pricing**
   Apply negotiated contract rates and calculate payment amount. Use fee schedules, per diem rates, case rates, bundled payments, or reference-based pricing based on contract terms and network status.
6. **Audit**
   Validate claim accuracy through DRG audits, itemized bill review, readmissions audits, high-cost claim review. Prevent overpayment and ensure compliance with contract terms and clinical guidelines.
7. **Benefits Adjudication**
   Determine member cost-sharing responsibility. Calculate deductible application, copays, coinsurance, out-of-pocket accumulation. Apply network discounts and track toward annual maximums.
8. **Payment Processing**
   Issue payment or denial with detailed remittance advice. Options: full approval, partial approval, or denial with specific reason codes. Deliver via direct deposit or clearinghouse transmission.

Misaligned Incentives Compound the Problem

There's a structural conflict hiding inside most legacy claims administration platforms, especially on the pharmacy side: the company that owns the system is usually also its biggest user. The owner's book of business comes first for enhancements, roadmap items, January 1 installations, and sometimes support, which means everyone else waits in line. Worse, many plans are buying their claims processing, network access, and administrative services from a direct competitor, so every dollar they spend strengthens the company they compete against. The same dynamic plays out on the medical side, where the largest carriers own the platforms their ASO clients depend on.

Legacy architecture then compounds the conflict. Because these systems are table-based, with decades of process modifiers and hard coding to wrestle with, everything takes longer and requires more overhead to test and manage. A benefit change request should not take 30+ days, but the delay has a simple cause: with only a handful of legacy vendors, contracts grew complex and configurations grew brittle, and when a small error in any one table can impact the entire adjudication process, every change must be tested against everything. So while wait times are a serious friction point, they also aren't a surprise given the structural problems baked into existing processes.

The primary CAPS used by TPAs across the U.S. today are all decades old.

Name	Date Created	Architecture
TriZetto (Facets/QNXT, RIMS/QicLink)	1990s/ Early 2000s	Client-server, on-premise or hosted.
NASCO (NPS)	1980s	Mainframe (IBM), hosted
Conduent (Health Solutions Plus)	1990s	Client-server, on-premise, or hosted
ElDorado (HEALTHpac)	1980s	Legacy midrange, on-premise

KEY QUESTIONS TO ASK TO
Find an Aligned Partner

Most health plans and TPAs switch their CAPS once, maybe twice – ever. This makes this evaluation matter more than almost any other technology decision they will make:

Configurability

Can plan administrators build and modify benefit designs, network tiers, and contract terms without deep technical expertise or a vendor ticket queue? If something routine takes six weeks, that friction compounds every time the business needs to move.

Integration Capability

Does the CAPS exchange data cleanly and in real time with the rest of the technology stack, or does it need custom-built bridges to connect with standard industry tools?

Scalability

Will the CAPS perform as well at 200,000 members as it does at 50,000? Growing organizations cannot afford a platform that becomes the ceiling on what they can offer.

Data Visibility

Can administrators, employer clients, and clinical teams get accurate, timely information without manual exports? A system that can't produce basic reporting on demand is not serving the organization at the level modern healthcare demands.

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From Confusion to Acceptance: The Market Has Turned



Age of Indifference

Sticking to the status quo

Judi® Launch

Skepticism, even outright dismissal

Age of Confusion

Mounting scrutiny; the status quo unravels

Age of Acceptance

Incumbents adopt the challenger's playbook

When Judi launched in 2021, the idea of building a modern health benefits platform was met with skepticism, even outright dismissal. We had been in an "age of indifference" for decades. By 2022, the Age of Confusion had taken hold: healthcare companies faced mounting scrutiny, employers frustrated by rising costs started questioning the savings they were promised, and actuaries pointed out the glaring disconnect between positive trend reports and unsustainable savings claims. The status quo was unraveling.

Now the industry has entered the Age of Acceptance. Incumbents, once dismissive, are mimicking the very model the challengers pioneered, promising transparency, alternative pricing, and flexibility, while pharma pushes back with direct purchasing models. When an incumbent starts to adopt a challenger's playbook, the industry has turned a corner.

Judi represents a new standard, and the lessons learned in pharmacy, along with the power of integrating AI into a modern platform, are now being brought to medical, vision, and dental benefits administration.

AI-based tools could reduce healthcare costs by $200 billion to $360 billion annually.[13]

"This is not disruption. This is just a better product. This is better for our patients. This is better for our service models. This is better for our budgeting."



AJ Loiacono
Chief Executive Officer, **Judi Health**

CONTENT SPOTLIGHT:
Astonishing Healthcare, Episode 100

Click here to listen to AJ's full podcast episode

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Meet Judi®: The First Unified Claims Processing™ Platform

Judi is the first Unified Claims Processing platform and infrastructure deployed in the U.S. Through our unified health benefits administration solution, Judi Care™, self-funded employers, health plans, TPAs, labor groups, and health systems can combine medical, pharmacy, vision, and dental claims administration on a single, cloud-native system to improve the patient experience and reduce costs through seamless patient and plan management. In other words, Judi is the modern CAPS the previous section's evaluation questions describe, built for the modern era rather than three decades ago. And through our Judi Cloud™ model, TPAs and health plans can license the Judi platform for their pharmacy or CAPS needs.

This is not a legacy system with a new interface, or new systems bolted onto the back of cardboard infrastructure. Judi Health is the only company in the industry that built its own tech stack from the ground up and operates as the benefit administrator on it, processing both commercial and government claims (medical and pharmacy alike). The lessons learned processing pharmacy claims at scale, where accuracy is demanded in milliseconds at the point of sale, are what made it possible to stand up medical claims processing in a single year when others have spent far longer and far more without success. And the platform is built to a security standard rare in this industry: SOC 1, SOC 2, and HITRUST certified, operating under FISMA and FedRAMP® standards.

> We believe that Judi Health is building the foundational infrastructure for a more transparent U.S. healthcare system. For as long as health benefits remain obscured by misaligned incentives and legacy technology, patients will continue to suffer, whether at pharmacy counters or hospital beds. Today, as Judi Health expands from pharmacy into unified claims and full benefit administration, we see it reaching a critical inflection point — and we are pleased to partner with them at this moment of acceleration."



Jonah Surkes
Generation Investment Management



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What Running Modern Benefits Plans on Judi® Looks Like

What is it like to run modern health benefits plans without the patchwork of disconnected systems, manual workarounds, and blind spots that drain your operations team's time? Judi answers that question by bringing every benefits workflow onto a single modular, configurable platform.

Capability	What Your Team Can Do	Why It Matters
Unified claims	See the full story of any claim on one page, with medical, pharmacy, vision, and dental information shown side by side, with network information, overrides, dates of service, status, provider, and remark codes. Check plan maximums like acupuncture, chiropractic, and physical therapy, including visits used and remaining.	One source of truth replaces fragmented, dual-system processing, so your team stops chasing records across separate platforms.
Members & Member Dashboard	Pull up a member in seconds, accumulators, claim counts, nearby pharmacies, and a full chronological history spanning pharmacy claims, medical claims, prior authorizations, and eligibility. Update eligibility in real time and reconcile against the next file when a partner's data lags.	Pended or rejected claims are handled instantly, and member and provider questions are answered on the first call.
Plan build & test adjudication	Configure plans down to variable cost share by visit, cycle, or place of service. Set custom rule sets that flag claims by modifier, DRG, allowed amount, a specific NPI, or a TIN you've had issues with. Work in draft benefits and test every change against real plan logic before it goes live.	Costly errors get caught before launch, and retroactive changes reprocess automatically, sparing your team from manually reworking hundreds of thousands of claims.
Prior Authorization	Ingest hundreds of files daily, so authorization data populates member profiles automatically. Match incoming claims against existing authorizations, pend rather than deny while a PA is outstanding, and let AI organize documentation and analyze submissions against client-specific clinical criteria. Import PAs from an incumbent PBM during implementation.	Faster clinical reviews, continuity of care through a transition, and no denied EOBs that get reversed days later.

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Capability	What Your Team Can Do	Why It Matters
Codes & Networks	Manage CPT, ICD, HCPCS, modifiers, remark codes, and custom codes from one place, with direct CMS integration flagging new and retired codes the moment they arrive. Support as many network tiers as you need, with cost sharing, service carve-outs, and prompt-pay and timely-filing rules set by tier.	Accurate adjudication starts with accurate codes, and network precision doesn't break the plan.
Payments & Invoicing	Process payments natively and watch each claim's payment status alongside the full claim data, with direct banking integration recognizing funding in real time. Create consolidated invoices that break down PEPM, print costs, claims editing, and network performance.	A critical advantage for stop-loss and pre-funding workflows, plus the line-item transparency that the traditional CAPS vendors, PBMs, and BUCAs don't always deliver.
Data Exchange & Reporting	Connect partners and point solutions via API or SFTP across industry-standard formats. Monitor every feed from one dashboard that flags issues early. Build and run reports in real time from thousands of attributes or schedule them to run on their own.	Judi is your plan's plumbing and brain: you stay vendor-agnostic and keep your choice of networks, telehealth, and point solutions.
Documents & Case Management	Access letters, EOBs, and EOPs pulled back into the member's record, request digital or print ID cards from the dashboard, and route operational work through a purpose-built case management module in the same platform as claims, eligibility, and payments.	Correspondence stays connected to the relevant claim and member, and your team stops toggling between tools.
Real-Time Oversight & Member Experience	Understand what's happening with your plan in 30 seconds via Judi Live: claims coming in across the country, call center wait times, the PA queue, and turnaround times. Give members one front door through the member portal, with fully translated Spanish-language member and enrollment portals.	Total plan visibility for you, one front door for members, and CMS translation requirements met out of the box.

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Licensing the Infrastructure of the Future, Today

For TPAs and health plans, the platform question isn't only whose system to buy services on. It's whether you can run your own business on modern infrastructure. Judi Cloud enables you to license the Judi platform itself. Your clients, your configurations, running on the same unified claims engine, real-time dashboards, and automation described above. Instead of stitching together a legacy CAPS and a stack of bolt-ons, your operation gets one modern system, without building it yourself, and without buying core services from a competitor.

Proof, Not Promises

Judi Health's implementation team, leveraging Judi-based workflows, has a 100% implementation success rate across all clients to date. A multipronged approach supports an on-time, high-quality implementation in 12 months or less while taking members' needs into consideration to minimize disruption. For Commercial, Exchange, Medicare, and Medicaid implementations, specialists oversee every aspect of the process, from plan inception and build through testing, go-live, and beyond!

Batch testing remains a true differentiator. Judi is designed to fully test an entire client benefit in under 15 minutes, and unlike legacy platforms that require a separate test environment, all testing occurs in production. Batches are fully customizable to a client's intent: member demographics and stacked claim history can simulate scenarios as if the member had been going to the pharmacy or provider all along, which is most useful for step therapy, accumulators, and continuation of therapy. Clients can run their own batch testing, and output summaries explain the rationale for why a claim adjudicated the way it did in plain language.

CONTENT SPOTLIGHT:

To learn more about our implementation process, check out our podcast episode with:



Tracey Rollins, CPM
Sr. Director, Client Implementations



Kristen Morgan
Director, Health Plan Implementations

Beyond the Status Quo

Healthcare is at an inflection point. With utilization, medical cost trend, and pharmacy costs on the rise, the current health benefits administration infrastructure is not sufficient to support high-quality care at a lower cost. Judi offers a modern alternative.

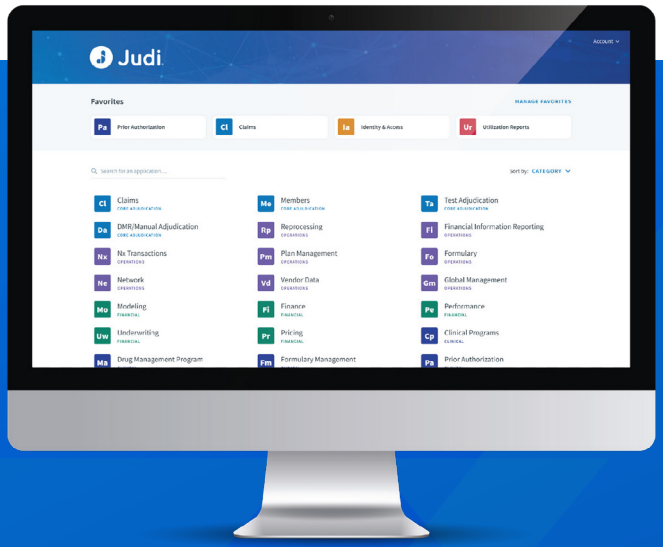
Unified claims processing fills a critical void in the market, simultaneously transforming the industry as it exists and laying the foundation for a new standard of care. It provides a transparent, holistic view of every member, drives better outcomes, reduces wasteful spending, and creates a stronger, more sustainable healthcare system for all.

Most health plans live with their CAPS instead of questioning it, because switching can often feel riskier than staying put. That logic stops making sense when staying costs more than moving.

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See For Yourself What Judi® Can Do

If you're responsible for a health benefits program, you can find ease at your fingertips and peace of mind with a true partner. Reach out to see how Judi Health can help make your life easier and provide you and your members with a superior benefits experience.



Want to Learn More?

Contact the Judi Health team today to learn about our transparent, financially aligned approach to pharmacy and health benefits administration.

Contact Us Today

Follow Us on LinkedIn & Subscribe to Our Newsletter.

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