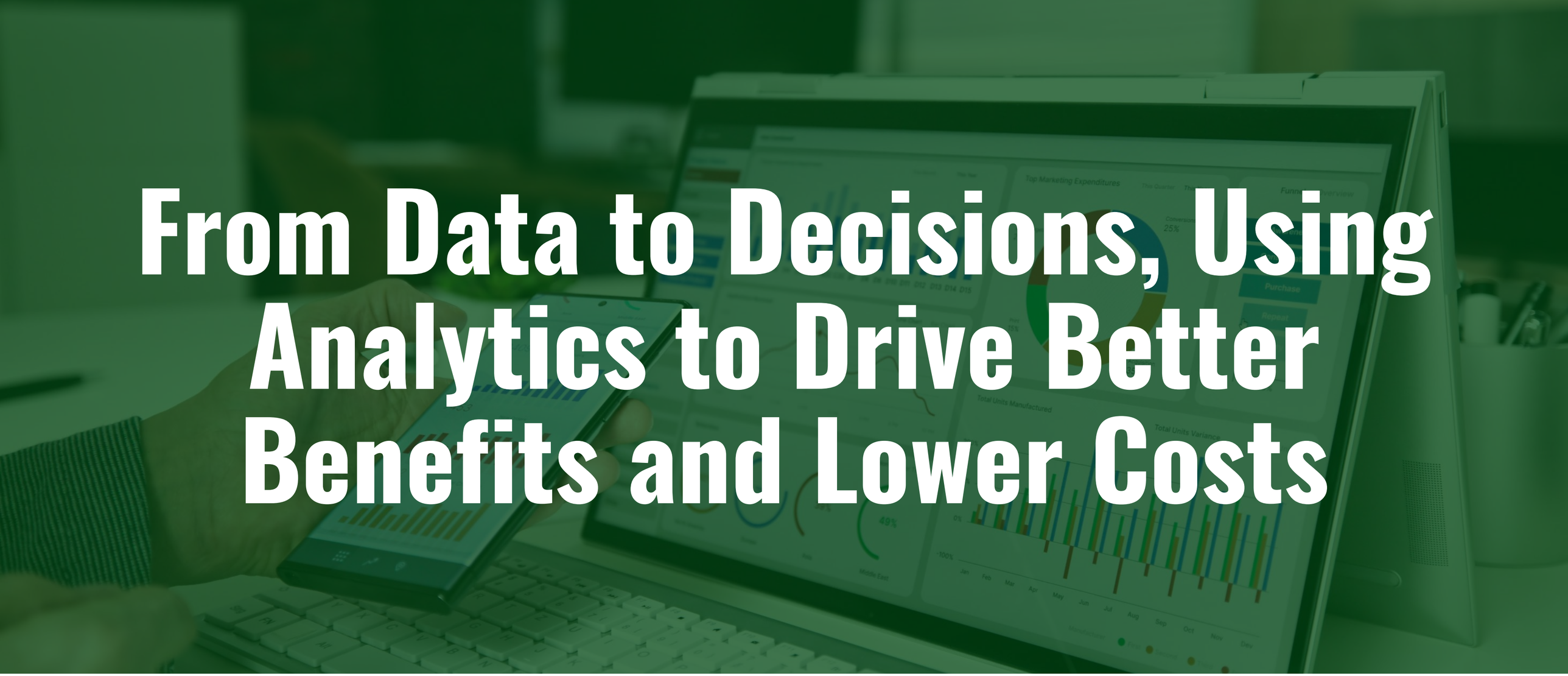


From Data to Decisions, Using Analytics to Drive Better Benefits and Lower Costs

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ROADMAP

TODAY'S DISCUSSION

1) The Real Question

Why confirming bad news at renewal isn't the same as using data to drive decisions.

2) The Data Cadence

How annual, quarterly, and monthly reporting work together to keep a pulse on risk.

3) Reading Cost Drivers

What's driving cost?

4) The Claim Drivers We Pinpoint

Rx, infusion therapy, cancer treatment, MSK, chronic disease, and site of care.

5) Point Solutions That Match

PBM carve-outs, direct contracting, infusion solutions, and chronic disease programs.

6) Matching Driver to Solution

Connecting what the data shows to which lever actually moves it.

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When was the last time your benefits data drove a decision, instead of just confirming the bad news at renewal?

Most plans use data the same way, after the fact.

- Renewal arrives, the increase is explained by “high claims,” and the conversation stops at the trend line.
- The same data set, read differently and reviewed more than once a year, can point to a plan design change, a vendor decision, or a risk you can transfer months before renewal forces the issue.
- Today is about that shift: from data that explains the past to data that shapes the next 12 months.

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FRAMEWORK

3 QUESTIONS YOUR DATA SHOULD ANSWER

Every dashboard, chart, and claims report is ultimately in service of three decisions. If a metric doesn't help answer one of these, it's noise.

1) What's Driving Cost?

Look past the increase you get at renewal. What are the categories behind it that are driving that increase? Each has a different cause and possible fix.

2) Where is Risk Concentrated?

A small number of claimants or conditions usually drive a disproportionate share of spend. Knowing where lets you target stop-loss, case management, and plan design precisely.

3) What Will Move the Needle?

Not every lever pays off the same way. Match the fix to the driver, structural changes for fixed cost problems, engagement programs for behavioral ones.

The Pattern We See Most Often: Employers can usually answer Question 1, they know the trend number. Far fewer can answer Question 2 with precision, and almost none connect the answer back to Question 3 before the renewal deadline forces a decision. That gap is where the biggest missed savings live.

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HOW WE KEEP A PULSE ON IT

A CADENCE, NOT A ONCE-A-YEAR EVENT

This is the rhythm we run for every self-funded client — three layers of reporting, each answering a different question at a different frequency.

ANNUAL	QUARTERLY	MONTHLY
Pre-Renewal Deep Dive	**Pulse Reports**	**High-Cost Claimant Reports**
The full trend and cost-driver review — what's driving cost, where risk is concentrated, and what plan design or point solution decisions need to be made before renewal.	A checkpoint between annual meetings: keeping trend, utilization, and emerging risk visible so nothing waits a full year to surface.	Flags any member approaching the specific stop-loss deductible — so case management and risk mitigation start immediately, not at renewal.

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QUESTION 1: WHAT'S DRIVING COST?

THE CLAIM DRIVERS WE PINPOINT

Six categories drive the overwhelming majority of avoidable high-cost claims. We review each one by name at the annual meeting, not folded into a single trend line.

Prescription Drugs

Specialty and high-cost brand Rx, including GLP-1 and rebate-driven trend.

Infusion Therapies

High-cost infused biologics and specialty treatments administered outside the pharmacy benefit.

Cancer Treatments

Oncology cost and site-of-treatment variation, often the single largest individual claim category.

MSK Claims

Musculoskeletal surgery and treatment, highly variable in cost by provider and site of care.

Chronic Disease

Diabetes, cardiac, and other chronic conditions where cost compounds without early intervention.

Site of Care

ER vs. urgent care vs. telemedicine same condition, dramatically different cost by channel.

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DEEP DIVE: PRESCRIPTION DRUGS

RX & SPECIALTY PHARMACY

The First Question to Ask: Is specialty Rx more than 50% of your total pharmacy spend?

Biosimilar Opportunity

Stelara → Yesintek

$26,000
per script
(Stelara)

$410
per script
(Yesintek)

Ask whether your plan or PBM is actively steering to the biosimilar or defaulting to the brand.

The GLP-1 Question

+3.4%

PMPM growth just in GLP-1 weight-loss spend since introduction

Are you covering GLP-1s for weight loss specifically, and is that coverage decision intentional or default?

Levers to Explore

- PBM carve-out or bolt-on option
- 340B pricing access where eligible
- Patient Assistance Programs (PAP)
- Manufacturer Assistance Programs (MAP)
- International Sourcing

Why This Matters: Specialty Rx is where the biggest, fastest-moving dollars live and where the most cost containment infrastructure already exists but goes unused. A single biosimilar conversion or PAP enrollment can offset thousands of dollars per member per year, often without any disruption to the member's care.

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DEEP DIVE: INFUSION THERAPIES

MEDICAL CHANNEL SPECIALTY RX

Drugs like Keytruda and Opdivo are billed under the medical benefit, not pharmacy, which means they're invisible to standard Rx cost containment reporting entirely.

Common High-Cost Infusions

- Keytruda — oncology immunotherapy infusion
- Opdivo — oncology immunotherapy infusion
- Other biologic infusions administered in an outpatient or infusion-suite setting

Questions to Ask Now

- Does your carrier offer a native infusion therapy management option today?
- If not, is a bolt-on infusion therapy partner the right fit for your population?
- Where are infusions being administered? hospital inpatient (highest cost) vs. freestanding infusion suite vs in the home (lower cost, same drug)?

Be Proactive: This is a category where waiting for the annual claims report to flag it is too late. Infusion partner options should be evaluated before a plan has a high-cost infusion claimant, not after. Get ahead of it at the plan design stage.

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DEEP DIVE: CANCER TREATMENTS

GET AHEAD OF IT — BEFORE TREATMENT STARTS

Cancer is the driver where timing matters most. Once a member is in active treatment, changing providers or care paths is disruptive and often not realistic to ask of them.

Before Treatment Begins

Full flexibility to steer to a Center of Excellence or direct-contracted oncology provider. Plan design and navigation can influence where and how care happens without disrupting anyone's treatment.

Once Treatment is Underway

Switching providers means disrupting continuity of care during a member's most vulnerable moment. Cost containment options that require a switch are effectively off the table the opportunity has passed.

The Lever: Direct Provider Contracting

Implement direct provider contracting for oncology as a standing part of plan design not a reaction to a specific claimant. That way the steerage option already exists the moment a diagnosis happens, instead of being built after the fact.

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DEEP DIVE: MUSCULOSKELETAL

MSK — ALMOST ALWAYS A TOP 3 SPEND CATEGORY

MSK (musculoskeletal) claims — back, joint, and spine surgery and treatment — land in the top three cost drivers for most self-funded plans. Cost per case varies enormously by provider, which makes this a proactive, not reactive, fix.

Why It's a Top 3 Driver

High procedure volume, wide cost variation by provider and facility, and a strong link to workforce demographics physically demanding jobs and an aging workforce both push MSK spend up.

Questions to Ask

- Is MSK in your top 3 categories this year?
- How much does cost per case vary across your network's providers?
- Are members being steered to high-value providers before surgery is scheduled?

Be Proactive

Work with direct providers to lower this spend before a member is already scheduled for surgery, steerage after the referral is made rarely changes the outcome or the cost.

The Lever: Direct Provider Contracting for MSK

Same principle as oncology, negotiated relationships with high-value MSK providers, built into plan design ahead of time, so the lower-cost path is the default path rather than a special request.

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DEEP DIVE: CHRONIC DISEASE

CHRONIC DISEASE — THE COMPOUNDING DRIVER

Diabetes, cardiac disease, and other chronic conditions don't spike — they compound quietly when care isn't managed. The questions here are less about cost and more about visibility.

4 Questions to Ask About Your Population

- **Compliance:** Are your members with chronic conditions staying in compliance with their care plans?
- **Navigation:** Are you providing care navigator options to help members manage their condition day to day?
- **Source:** Is that navigation support carrier-driven, or something you've layered on intentionally?
- **Awareness:** Are you getting this information in front of members, or does the program exist but go unused?

The Lever: Virtual Chronic Disease Partner Programs & Direct Primary Care (DPC) Partners

A program only pays off if members actually use it. Pair the point solution with a real communication plan open enrollment, paycheck stuffers, direct outreach it can not be just a line item in the benefits guide.

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DEEP DIVE: SITE OF CARE

KNOW WHERE TO GET TREATED

The same condition can cost 30x more depending on where a member is treated. Educating members on this before they need care is one of the highest-leverage, lowest-friction levers available.

Telemedicine	**$10 copay** **$89 avg. cost**	Colds, flu, sinus infections • eye infections • insect bites • low-grade fevers • minor allergic reactions • UTIs
Family Doctor	**$25 copay** **$119 avg. cost**	Non-urgent illness or injury — the default first call when it isn't an emergency
Urgent Care	**$50 copay** **$148 avg. cost**	Earaches, mild dizziness, minor backaches, dehydration — plus ortho UC for sprains, minor fractures, sports injuries
Emergency Room	**$250 copay** **$2,911 avg. cost**	Chest pain, trouble breathing, seizures, heavy bleeding, poisoning — or call 911

Don't delay evaluation for life-threatening injuries or serious illness, go to the nearest ER or call 911.

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QUESTION 2: WHERE RISK CONCENTRATES

HIGH-COST CLAIMANTS AREN'T JUST AN OUTLIER

1-2%

of Members

Typically drive 30-45% of total paid claims.

$100K+

Claimant Threshold

Standard high-cost claimant reporting cutoff

12-24 mo.

Lead Time

Chronic conditions often signal cost before it hits

1.0

Risk Score Baseline

Track prospective score trend, not just this year's paid

What to Look for in the Data:

- Concentration ratio: what % of paid comes from your top 1% and top 5% of members, and how has it moved year over year?
- Diagnosis clustering: are high-cost claims concentrated in a few conditions (renal, cardiac, cancer, GLP-1/diabetes) or broadly spread?
- Chronic condition trend: rising prevalence or cost-per-episode in hypertension, hyperlipidemia, or obesity-related care. These are next year's high-cost claimants.
- Stop-loss fit: does your specific deductible and laser structure actually match where your risk lives?

How We Monitor It:

This is exactly what our monthly high-cost claimant report tracks, flagging any member approaching the specific stop-loss deductible so case management and risk mitigation start immediately, not at renewal.

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QUESTION 3: WHAT WILL MOVE THE NEEDLE

THE COST CONTAINMENT LEVER MAP

Not every lever pays off the same way — or the same amount. Separating lever type from how dependent it is on employee engagement keeps the savings story honest.

Structural / Contractual	Behavioral / Engagement-Dependent	Risk Financing / Transfer
Locked in once implemented, no member action required.	*Savings scale with adoption, the gap between "bought" and "realized" lives here.*	*Doesn't reduce claim cost, reallocates volatility.*
PBM carve-out • International sourcing bolt-on • Direct provider contracting (DPC, MSK & specialty conditions)	Infusion therapy solutions • Virtual chronic disease partner programs • Site-of-care steerage • Direct Primary Care	Stop-loss structure • Lasering • Captives • Level-funding

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FROM FRAMEWORK TO ACTION

THE POINT SOLUTIONS WE DEPLOY

Once we know the driver, we bring in the specific solution built for it — not a generic point-solution stack.

Pharmacy Carve-Out / Sourcing

PBM carve-out or a bolt-on international sourcing option to manage specialty and high-cost brand drug spend directly.

Direct Provider Contracting

Negotiated contracts for specialty conditions, MSK and DPC physicians; steering to quality providers at a controlled cost.

Infusion Therapy Solutions

Site-of-care and sourcing programs purpose-built for high-cost infused biologics and specialty treatments.

Virtual Chronic Disease Programs

Partner programs for diabetes, cardiac, and other chronic conditions; engagement dependent, high long-term payoff.

Risk Mitigation Techniques

Stop-loss structuring, lasering review, and funding strategy to make sure risk transfer matches where risk actually lives.

PUTTING IT TOGETHER

MATCH THE DRIVER TO THE POINT SOLUTION

If the driver is…	We bring in..
Specialty / high-cost prescription drugs	PBM carve-out or international sourcing bolt-on
High-cost infusion therapies	Infusion therapy sourcing and site-of-care solutions
Cancer treatment and other high-cost conditions	Direct provider contracting for high-cost conditions
MSK claims	Direct provider contracting for MSK
Chronic disease (diabetes, cardiac, etc.)	Virtual chronic disease partner programs & DPC
Site-of-care misuse (ER vs. urgent care vs. telemedicine)	Steerage and member education built into plan design
Concentration in a small number of claimants	Risk mitigation — stop-loss structure and lasering review

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COMMON BLIND SPOTS

WHERE EMPLOYERS OVERLOOK THE SIGNAL

1) Participation-weighted savings, sold as guaranteed

A vendor's modeled savings assumed 60% engagement. Actual enrollment came in at 20%. The gap between “we bought it” and “we realized it” is the single most common source of renewal surprise.

2) Enrollment mix shift hiding in the trend number

Headcount growth, dependent mix changes, or an aging population can look like “cost trend” on a summary slide when it's really a membership story and it calls for a different response.

3) Dependent eligibility never re-verified

Ineligible dependents are one of the few cost drivers with no clinical or engagement dependency. An audit is close to pure savings, yet it's rarely on the annual review calendar. Can you over other solutions?

The Common Thread:

- None of these require new data, they require reviewing the data you already have on a different cadence and asking a different question of it.
- A single annual claims report, read once at renewal, will not surface a mix shift, a participation gap, or an eligibility issue in time to act on it.
- A quarterly review of the same source data, built around the three questions from earlier, usually will.

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BOTTOM LINE

TURNING DATA INTO THE NEXT DECISION...

The right analytics partner pinpoints what's really driving your cost and that's what leads to the right decision on a solution.

STEP 1
Identify Cost Drivers
Pinpoint what's driving your claims spend

STEP 2
Find Valued Point Solution Partners
Match each driver to a partner that proves its value

The Three Tests for Every Point Solution

A solution only makes our list if it clears all three.

Lowers Overall Net Cost

Savings show up in your claims data net of every dollar the program costs the plan.

Shared Savings Only

No upfront fee, no PMPM, no per-participant charge. They only win if you win.

Better for Employees

A better experience and better benefits for your employees and their families.

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Top Marketing Expenditures
This Quarter
This Year
Conversions
25%
Acquisition
35%
Funnel
Overview
Awareness
Consideration
Purchase
Repeat
43.5%
Total Units Manufactured
Total Units Variance
200%
100%
0%
-100%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
7453
532
49%
Middle East

Questions?

DO YOU SEE THESE PATTERNS IN YOUR DATA?

Any questions, don’t hesitate to reach out!



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