BOARD MEETING AGENDA
Friday, August 21, 2026 – 10:00 a.m.
2703 NE 14th Street, Ocala, FL 34470

Join Zoom Meeting: https://us02web.zoom.us/launch/jc/85664084625
Conference Line: 1 646 558 8656 Meeting ID: 856 6408 4625

Call to Order		A. Proctor
Roll Call		C. Schnettler
Public Comment		A. Proctor

DISCUSSION ITEMS

Self-Insurance Agency Apex Insurance Advisors Section 1-2	Pages 2 - 51	Brandon Whiteman

PROJECT UPDATES

None

MATTERS FROM THE FLOOR

ADJOURNMENT

OUR VISION STATEMENT

To be known as the number one workforce resource in the state of Florida by providing constructive tools and professional supportive services that are reflected in the quality of our job candidates and meet the needs of the business community.

Request for Information:

Self-Insurance Exploration

Submitted to:

CareerSource Citrus Levy Marion
Attention: Sandra Crawford

2703 NE 14th Street
Ocala, Florida 34470

Submitted by:

Apex Insurance Advisors

1531 SE 36th Avenue
Ocala, Florida 34471

Date:

July 24, 2026

To CareerSource Citrus Levy Marion (CLM),

On behalf of Apex Insurance Advisors, we are pleased to share our expertise and insights as your organization evaluates options for managing employee healthcare costs and explores the potential benefits of a self-insured health plan.

Founded in Ocala, Florida, Apex is an independent employee benefits brokerage serving employers in our local community and beyond throughout Central Florida. We partner with organizations of all sizes to create, implement, and manage benefit programs that address cost control, regulatory compliance requirements, and especially employee experience and management.

The following response reflects our understanding of the scope of information in your request and we certify that the information contained here within is accurate.

We welcome the opportunity to schedule additional meetings to further discuss the information provided. If so desired, an initial presentation to the CLM Board of Directors ("Board") introducing the self-insured group captive concept would require approximately one hour. This allows sufficient time to explain the structure, benefits, and key considerations of a self-insured arrangement, followed by an interactive question-and-answer session. The presentation would also include a representative from the group captive to provide expertise. Although we prefer the opportunity to meet in person, we are fully prepared to deliver the presentation virtually via Zoom if that better suits the Board's schedule or preferences.

Thank you for your time.

Sincerely,

Brandon Whiteman
Founding Partner, Apex Insurance Advisors
Date: 07/24/2026

Tully Gilligan
Founding Partner, Apex Insurance Advisors
Date: 07/24/2026

Firm Overview

Since 2023, Apex Insurance Advisors (“Apex”) has partnered with employer groups of all sizes to tailor benefit programs that support both the employer’s business objectives and the employee’s well-being while taking into consideration cost, participation, and employee experience. Our experience covers a range of medical (including pharmacy discount programs, virtual provider programs, HSA/FSA, wellness programs, etc.), dental, vision, life (group paid and voluntary), short-term and long-term disability, and other ancillary benefits for employers with fully insured, level-funded and self-funded plans.

As an independent brokerage, Apex is not affiliated with any single carrier, allowing us to objectively evaluate the marketplace and recommend solutions that best meet clients’ needs.

By combining practical solutions with hands-on service, Apex helps partners provide a desirable and competitive benefits package while enhancing employee understanding and satisfaction. We operate collaboratively to ensure that questions, challenges, or complex scenarios are handled skillfully and by the team member(s) best suited to the situation. Some members of our team specialize in plan design and tailoring to the group’s needs, while others specialize in employee experience and carrier communication.

Brandon Whiteman, Employee Benefits Consultant and Partner, plays a central role in the strategic and technical execution of client benefit programs. Brandon takes part in carrier negotiations, plan design development, proposal evaluation, and renewal strategy. He works closely with carriers to structure coverage options and pricing, supports clients through complex service issues as needed, and oversees the integration of enrollment and benefits administration technology. He currently holds a Florida 2-15 Life, Health, and Variable Annuities Agent license and a Florida 2-20 Property and Casualty General Lines Agent license.

Tully Gilligan, Employee Benefits Consultant and Partner, serves as a primary front-facing advisor for prospective and existing clients. Tully focuses on building relationships with employers, meeting directly with leadership teams to understand their needs, and presenting benefit strategies and plan alternatives. He guides employers through decision-making by explaining options, funding approaches, and market considerations. While his role emphasizes relationship development, he remains actively involved in client service and ongoing support to ensure alignment between expectations and outcomes. He also currently holds a Florida 2-15 Life, Health, and Variable Annuities Agent license and a Florida 2-20 Property and Casualty General Lines Agent license.

Apex's approach and reputation are built around the following principles:

Strategic Guidance

We work closely with leadership and human resources teams to align their ideal benefit strategy with the best-case scenario for the company. This includes thoughtful plan design to support each employee's needs, funding evaluations from the group, carrier negotiations, and long-term cost management supported by our combined decades of experience and data.

Operational Excellence and Compliance Support

Our team-based service model ensures that clients receive consistent, personalized support with same-day responsiveness throughout the partnership. Apex provides ongoing guidance related to ACA, ERISA, COBRA, HIPAA and other regulatory requirements, helping to mitigate risk while reducing administrative burden on internal teams.

Employee Experience and Engagement

We believe benefits are most valuable when employees clearly understand their options and can make informed decisions. Apex emphasizes clear and timely communication with not only leadership, but also each individual employee supported by straightforward explanations and educational tools to facilitate informed decision-making while minimizing disruption during open enrollment and throughout the year.

Self-Insurance Structure and Requirements

A self-insured health plan allows an employer to assume responsibility for funding employee healthcare claims while partnering with specialized vendors to administer the plan. Unlike a fully insured arrangement, where premiums are paid to an insurance carrier in exchange for assuming all claims risk, a self-insured model offers greater flexibility in plan design, reporting, and long-term cost management. Strategically implementing this type of funding arrangement requires careful planning, experienced vendor partnerships, and ongoing financial and regulatory oversight.

Key Components

Several essential components work together to support the administration and financial stability of a self-insured health plan:

- **Plan Document and Summary Plan Description (SPD):** The governing documents that establish plan eligibility, covered benefits, exclusions, participant rights, and administrative procedures. These documents serve as the foundation for plan administration and compliance.
- **Third-Party Administrator (TPA):** A TPA administers the day-to-day operations of the health plan, including claims processing, customer service, provider network access, eligibility management, and claims reporting.
- **Stop-Loss Insurance:** Stop-loss coverage is a critical risk management tool, particularly for an organization of 55 employees. Specific Stop-Loss protects the plan from unusually high claims incurred by a single participant, while Aggregate Stop-Loss limits the employer's total claims liability during the plan year.
- **Pharmacy Benefit Manager (PBM):** The PBM administers prescription drug benefits, negotiates medication pricing and manufacturer rebates, manages pharmacy networks, and helps control prescription drug costs through clinical and cost-management programs.

Operational Requirements

The successful administration of a self-insured health plan requires ongoing financial management and coordination among all service partners. Considerations include:

- **Monthly Funding:** The nonprofit establishes and maintains a dedicated claims funding account from which the TPA pays eligible healthcare claims and administrative expenses as they are incurred.
- **Claims Adjudication:** The TPA reviews and processes healthcare claims according to the provisions outlined in the Plan Document and Summary Plan Description, ensuring claims are administered accurately and consistently.

- **Vendor Coordination:** Effective communication between the employer, TPA, stop-loss carrier, PBM, and benefits consultant is essential to monitor claims activity, review utilization trends, evaluate financial performance, and identify opportunities for ongoing plan improvements.
- **Reserve Capital:** Maintaining adequate financial reserves is an important consideration for self-insured employers, providing the flexibility to absorb fluctuations in monthly claims experience while supporting long-term financial stability, particularly where claims exceed the expected monthly projection.

Governance Considerations

In addition to financial oversight, self-insured health plans are subject to several important regulatory and fiduciary responsibilities. Employers considering self-insurance should understand these obligations and establish appropriate governance practices.

- **Fiduciary Responsibility:** Under the Employee Retirement Income Security Act (ERISA), nonprofit leaders act as fiduciaries and are responsible for administering the health plan solely in the best interests of plan participants and beneficiaries while ensuring prudent management of plan assets.
- **HIPAA Compliance:** Because employers have direct access to protected health information for plan administration and financial monitoring purposes, there must be appropriate privacy and security safeguards including appointing a designated Privacy/Security Officer, maintain strict Business Associate Agreements (BAAs) with vendors, and implement and enforce privacy policies and procedures.
- **Nondiscrimination Testing:** Self-insured health plans are subject to Internal Revenue Code (IRC) nondiscrimination testing to help ensure plan benefits do not disproportionately favor highly compensated employees.
- **Affordable Care Act (ACA) Compliance:** As an Applicable Large Employer (ALE), the nonprofit must continue to comply with ACA employer mandate requirements by offering affordable, minimum-value health coverage to eligible full-time employees and completing the required annual IRS Form 1095-C/1094-C.

Risk Mitigation Strategies

Managing financial risk is one of the most important considerations when evaluating a transition to a self-insured health plan. While self-insurance offers greater flexibility and potential long-term cost savings, employers also assume responsibility for funding healthcare claims. A 55-person company is generally too small to self-insure safely on its own due to the volatility of catastrophic claims, so the implementation of a comprehensive risk management strategy is essential to help stabilize an approach that appropriately balances opportunity and risk.

Stop-Loss Protection

Stop-loss insurance serves as the primary financial safeguard against these catastrophic claims. For an employer of a 55-person group, selecting the appropriate stop-loss structure is particularly important to protect the plan from unexpected high-cost claims while maintaining predictable financial performance.

- **Specific Stop-Loss:** Protects the employer against unusually high claims incurred by a single participant or covered dependent. Depending on the financial objectives and risk tolerance, lower specific deductibles – often ranging from $30,000 to $50,000 – may provide greater protection.
- **Aggregate Stop-Loss:** Limits the employer's overall total claims liability for the plan year by reimbursing claims that exceed a predetermined threshold, typically between 120% and 125% of expected annual claims.

Risk-Pooling Arrangements

For smaller employers, participation in a group captive or consortium may provide an effective alternative to operating as a standalone self-insured plan. These arrangements allow multiple employers with similar characteristics to share a portion of their healthcare risk while maintaining many of the advantages associated with self-insurance.

- **Shared Risk Pools:** By distributing catastrophic claim risk among multiple participating employers, group captives can reduce claims volatility and provide greater financial predictability than a standalone.
- **Profit Sharing / Dividends:** Unlike traditionally fully-insured plans, well-performing captive arrangements may allow participating employers to receive distributions or dividends when overall claims experience is more favorable than projected, creating an opportunity to share in the financial success of the program.

Financial Safeguards

Long-term success under a self-insured funding arrangement depends on maintaining appropriate financial protections and implementing proactive cost-management strategies.

- **Terminal Liability Funding:** Establishing adequate reserves to cover claims incurred during the plan year but processed after the plan year has ended helps ensure financial obligations continue to be met without disrupting cash flow.
- **Aggressive Reinsurance Strategy:** In addition to stop-loss coverage, employers may evaluate additional reinsurance options to provide protection against exceptionally large or emerging claim exposures, including high-cost specialty medication and complex medical treatments.
- **Strict Cost Containment Programs:** Partnering with experience TPAs and other specialized vendors can help manage healthcare costs through utilization review, nurse case management, specialty pharmacy programs, reference-based pricing strategies, and other clinical management initiatives designed to improve to outcomes while controlling expenses.
- **Actuarial Funding:** Establishing annual funding levels based on comprehensive actuarial analysis helps ensure the plan is appropriately funded, supports informed financial decision-making, and reduces the likelihood of unexpected funding shortfalls.

Provider Network Continuity

Maintaining continuity of care is a critical consideration when evaluating a transition from a fully insured health plan to a self-insured funding arrangement. Employees value established relationships with their physicians, specialists, hospitals, and other healthcare providers, making provider network disruption an important factor in any evaluation. Apex works closely with employers to identify solutions that preserve provider access while supporting the organization's financial and operational objectives.

As part of the evaluation process, Apex collaborates with CSCLM, the selected group captive (if applicable), and prospective TPAs to compare available provider networks and determine the solution that best meets the needs of the organization and its employees. While the current Blue Cross provider network may remain a viable option, additional broad-network alternatives may also be available through nationally recognized administrators such as UMR (UnitedHealthcare) and Meritain Health (Aetna). All options would feel similar to the current networks that are working for the Region 10 and Region 6 team members.

Third-Party Administrator (TPA) and Pharmacy Benefits Manager (PBM) Functions

A successful self-insured plan relies on experienced service partners to administer benefits, manage costs, and ensure regulatory compliance. Apex works collaboratively with Third-Party Administrators (TPAs), Pharmacy Benefit Managers (PBM), the group captive, stop-loss carriers and other specialized vendors to build a coordinated benefits program.

Third-Party Administrators (TPAs)

The TPA serves as the operational backbone of a self-insured health plan and is responsible for administering the plan on behalf of the employer.

Key responsibilities include:

- **Claims Processing:** Reviewing, adjudicating, and paying eligible medical claims according to the provisions outlined in the Plan Document and Summary Plan Description while maintaining accurate financial reporting.
- **Customer Service:** Serving as the primary point of contact for plan participants by assisting with benefit questions, claims inquiries, ID cards, eligibility, and provider-related concerns.
- **Compliance Support:** Assisting with compliance activities related to ERISA, HIPAA, COBRA, the Affordable Care Act (ACA), and other applicable regulations while maintaining appropriate documentation and audit support.
- **Cost Management:** Coordinating provider networks, administering medical management programs, supporting stop-loss reporting, and implementing strategies such as utilization review, nurse case management, and other clinical initiatives designed to improve outcomes and manage healthcare costs.

Pharmacy Benefit Managers (PBMs)

The PBM administers the prescription drug portion of the health plan and plays a significant role in managing pharmacy costs while maintaining member access to clinically appropriate medications.

Key responsibilities include:

- **Prescription Claims Administration:** Processing retail and mail-order pharmacy claims in real time while ensuring accurate benefit administration.
- **Formulary Management:** Developing and maintaining evidence-based formularies that encourage the use of safe, effective, and cost-efficient medications, including generic and preferred brand alternatives.

- **Cost-Containment and Rebates:** Negotiating pharmacy discounts and manufacturer rebates while implementing clinical programs that help control prescription drug spending without compromising quality of care.

Selection Considerations

Selecting the appropriate TPA and PBM requires careful evaluation of both service capabilities and long-term value. Important considerations include:

- **Pricing Transparency:** Evaluating whether the PBM operates under a fully transparent pricing model, where negotiated rebates and discounts are passed through to the employer or captive, or a spread-pricing model, where the PBM retains a portion of the negotiated savings.
- **Rebate Administration:** Reviewing contract terms to ensure manufacturer rebates are appropriately credited to the health plan or captive, helping reduce overall plan costs.
- **Formulary Flexibility:** Assessing the PB's ability to customize formulary design based on the employer's objectives and employee population while minimizing unnecessary disruption to ongoing treatment.
- **Service and Reporting:** Evaluating customer service performance, clinical management programs, reporting capabilities, and overall partnership to ensure the administrator supports both operational efficiency and a positive member experience.

Data Requirements

To conduct a meaningful and accurate analysis for the CSCLM team, Apex would gather the following to provide the group captive with a complete picture of the organization's current benefits program and healthcare utilization:

- **Employee Census Data** – demographic information such as age, gender, dependent status, employment status, and geographic location.
- **Current Medical Plan Designs** – plan summaries outlining covered benefits, deductibles, copayments, coinsurance, out-of-pocket maximums, and eligibility provisions.
- **Prescription Drug (Rx) Plan Designs** - current pharmacy benefit structure, including copay tiers, formularies, and specialty drug provisions.
- **Current Carrier Invoices** - premium and administrative billing information used to compare current healthcare spending with projected self-funded costs.
- **High-Cost Claimant Information** - de-identified information regarding significant medical claims, when available, to assist in evaluating stop-loss coverage and overall financial risk.
- **Historical Medical and Prescriptions Claim Data** - claims experience, utilization reports, and pharmacy data used to identify trends, forecast future costs, and evaluate opportunities for plan optimization.

Plan Design Options

One of the primary advantages of a self-insured health plan is the flexibility to design a benefits program that reflects the unique needs of the organization and its employees. Rather than selecting from predetermined insurance carrier offerings, employers have greater control over plan provisions, cost-sharing arrangements, and wellness initiatives while maintaining a focus on both employee experience and long-term financial sustainability.

Working collaboratively with CSCLM, Apex Insurance Advisors would evaluate a variety of plan design options, including deductibles, copayments, coinsurance levels, out-of-pocket maximums, prescription drug benefits, and other plan features. Recommendations would be developed based on the organization's financial objectives, workforce needs, historical claims experience, and overall benefits strategy.

Additional plan features may include incentives that encourage employees to utilize high-quality, cost-effective healthcare providers. Depending on the selected vendor partners and provider networks, these incentives could include reduced or waived member cost sharing for services such as MRI imaging, preventive screenings including colonoscopies, outpatient surgical procedures, and other designated healthcare services. These programs are designed to improve access to quality care, encourage informed healthcare decisions, and generate savings for both the employer and plan participants.

Apex Insurance Advisors has experience assisting employers, including nonprofit organizations, in evaluating and developing customized health plan strategies. Our role is to serve as a trusted advisor and strategic intermediary throughout the evaluation, implementation, and ongoing administration of a self-funded benefits program for CSCLM.

Throughout the planning process, Apex coordinates the selection of key service partners, including stop-loss carriers, Third-Party Administrators (TPAs), Pharmacy Benefit Managers (PBMs), and provider networks. Once a self-insured plan is implemented, we continue to provide strategic consulting through renewal negotiations, claims analysis and monitoring, compliance guidance, vendor oversight, and ongoing advocacy on behalf of both the employer and plan participants.

As an independent employee benefits brokerage, Apex maintains relationships with multiple insurance carriers, TPAs, provider networks, PBMs, and other industry partners. This independence allows us to evaluate a variety of solutions rather than being limited to a single vendor or platform. By comparing multiple options, we help organizations develop a benefits program that aligns with their financial goals while providing employees with comprehensive coverage and broad access to quality healthcare providers.

For ease of review, sample reference materials have been included as separate email attachments instead of being incorporated into this response. These documents provide additional detail and are intended to supplement the information presented herein.

We have included:

- Sample Quarterly Value Report
- Sample Annual Employer Overview and Playbook
- Sample Annual Report
- Top 5 Questions Overview When Considering Self-Insurance

2025 Playbook

ACME Inc.

Legend Re 1.1

Data Timeframe: 01-01-2024 - 12-31-2024
Claims Paid Through: 12-31-2024

Contents

Introduction

ParetoHealth unlocks two primary advantages for small and mid-sized employers:

1

First, the stability of the captive eliminates volatility to make self-insuring a durable and viable alternative to traditional insurance.

2

Second, our savings engine helps lower healthcare costs for captive Members without compromising access or quality.

Partnering to reduce your healthcare spend - now and into the future.

We believe every company deserves a knowledgeable and collaborative partner in the self-funded healthcare landscape. That's why we provide tools, resources, and personalized data to help you better manage rising costs. By leveraging your data, you can make precise, well-informed decisions to keep your business thriving, employees happy, and your bottom line on-target.

Here you'll find your 2024 data and customized recommendations to guide you in implementing programs and plan adjustments that work for your employees, and their dependents.

We call these recommendations - **Pareto Pathways.**

Pathways serve as structured yet flexible roadmaps that align all stakeholders on measurable goals year over year. As challenges or priorities evolve, each Pathway can be updated per your business needs, and employee needs. Pathways are a reliable source of truth-reflecting current commitments while guiding meaningful actions.

With the right tools, actionable data, and a clear plan - you can take control of healthcare costs and make confident, informed decisions for the future.

2024 Healthcare Industry snapshot: What factors increased costs?

Rising prescription drug costs

Medical inflation

Increased demand for care

Other factors included behavioral health services as mental health awareness and access improved. Also, inpatient and outpatient care continued to climb for elective and chronic needs.

While these trends drive higher healthcare spending, they can also lead to positive effects. Innovative prescription drugs like GLP-1's are effective for obesity management, lowering Type 2 diabetes and the risk of heart disease. Expanded behavioral access is addressing critical mental health needs.[1]

What's new in your 2024 Playbook?

Now that we have an overall industry snapshot, let's see if your healthcare costs trend with the general population.

First, we'll look at your specific data for services during this time frame: **January 2024 - December 2024**

Next, we'll look at your personalized data that includes trends and costs across your company. This helps inform the Pathways we develop to help reduce costs in 2025 and beyond.

Pathways provide tailored insights for cost containment that pertain to your employee/dependent population. This puts you and your consultant in a winning position to develop a customized, multi-year strategy to optimize the health of your population, while managing costs.

[1] *Medical cost trend: Behind the numbers 2025. (2025). PwC. https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html*

PART 1

What are the key components driving costs?

What are the key components driving costs?

Healthcare costs for a population are driven by three key factors:

1 **Who is in the population**

2 **What kind of care they require**

3 **The cost of that care**

This section provides insights into your population and details top cost drivers. This will lay a foundation for the personalized recommendations provided later.

Your time period

All data represented in this section reflect your claims with service dates within the time period indicated above.

If you have less than one year of data, some of these measurements will be adjusted to reflect an annual estimate. This has been done to provide a more accurate reflection of how these costs would play out over a full year with the captive.

Calculations are based on the amount of claims data available. Please note that the net payments reflected in this section exclude any patient out-of-pocket amounts and have not been reduced by any amounts reimbursed through stop-loss. Net pay represents the full payment amount provided through the health plan, minus any out-of-pocket amounts paid by the individual patient.

Finally, these amounts have not been adjusted to reflect claims that have not yet been processed/paid.

Population overview

The demographic composition of a population has a high impact on healthcare cost.

Young adult populations (ages 20-35) tend to have costs that are associated with pregnancies and preventive care.

Middle-aged adult populations (ages 35-50) tend to have costs driven by chronic conditions such as diabetes, heart disease, and back pain.

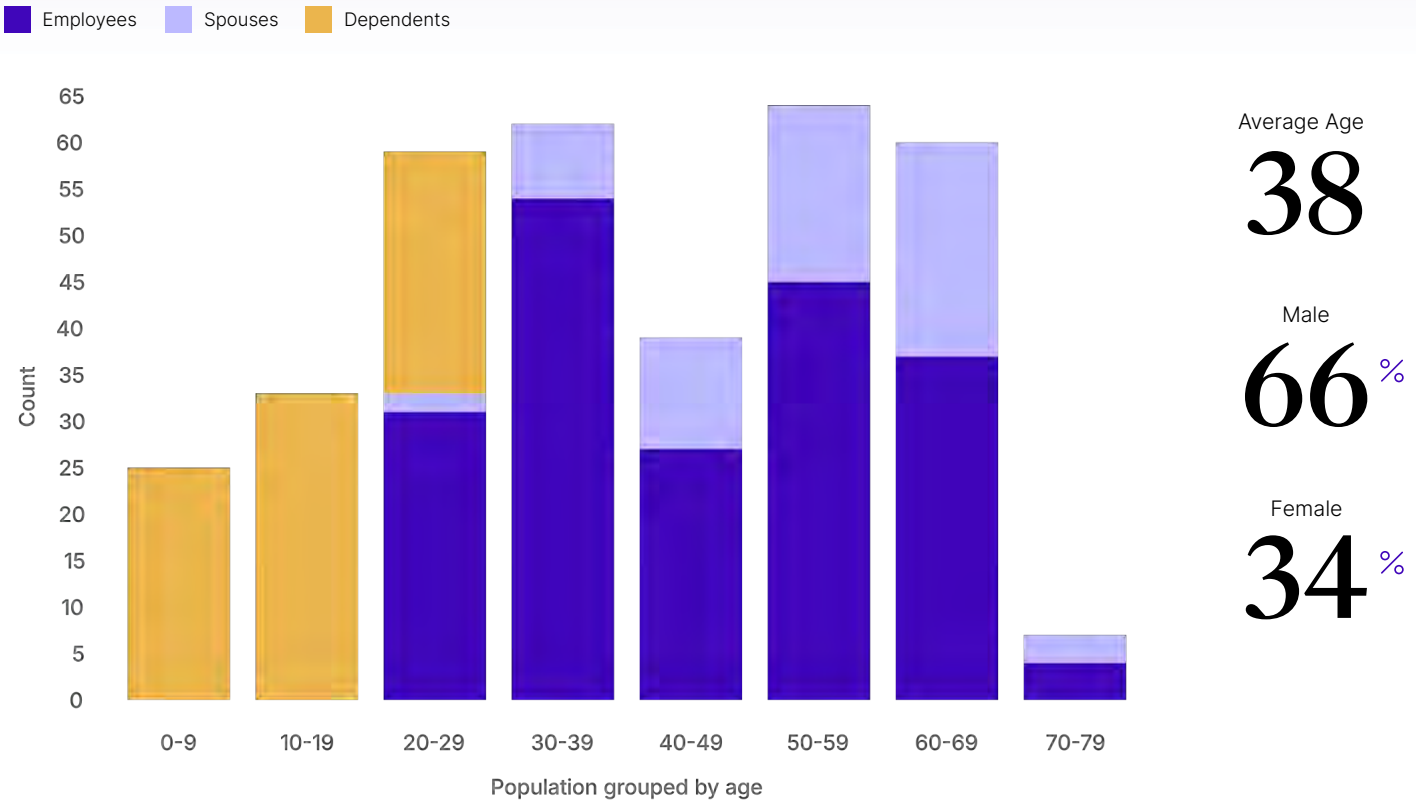
Older adult populations (ages 50-70+) are the costliest due to both increased prevalence of chronic conditions and cancers.

In addition to age, the relationship of each enrollee also can influence healthcare usage. Specifically, spouses tend to be more expensive than employees of the same age and sex.

Below is a graphical representation of your population in 2024 by age, sex, and relationship of each enrollee.

FIGURE 1

Population metrics



Cost drivers

This section explores cost drivers across your population to help uncover the largest opportunities for intervention and savings. First, we examine cost across the highest spend conditions in your population, then we look at conditions at a claimant and frequency level.

A significant benefit to Members is the sharing of responsibility for high-cost patients. The ParetoHealth Risk Shield protects employers from the volatility of large unexpected claims for more predictable year over year costs. **With the strongest stop-loss contract on the market, only ParetoHealth guarantees no new lasers and caps stop-loss increases**, so you can confidently plan for the future.

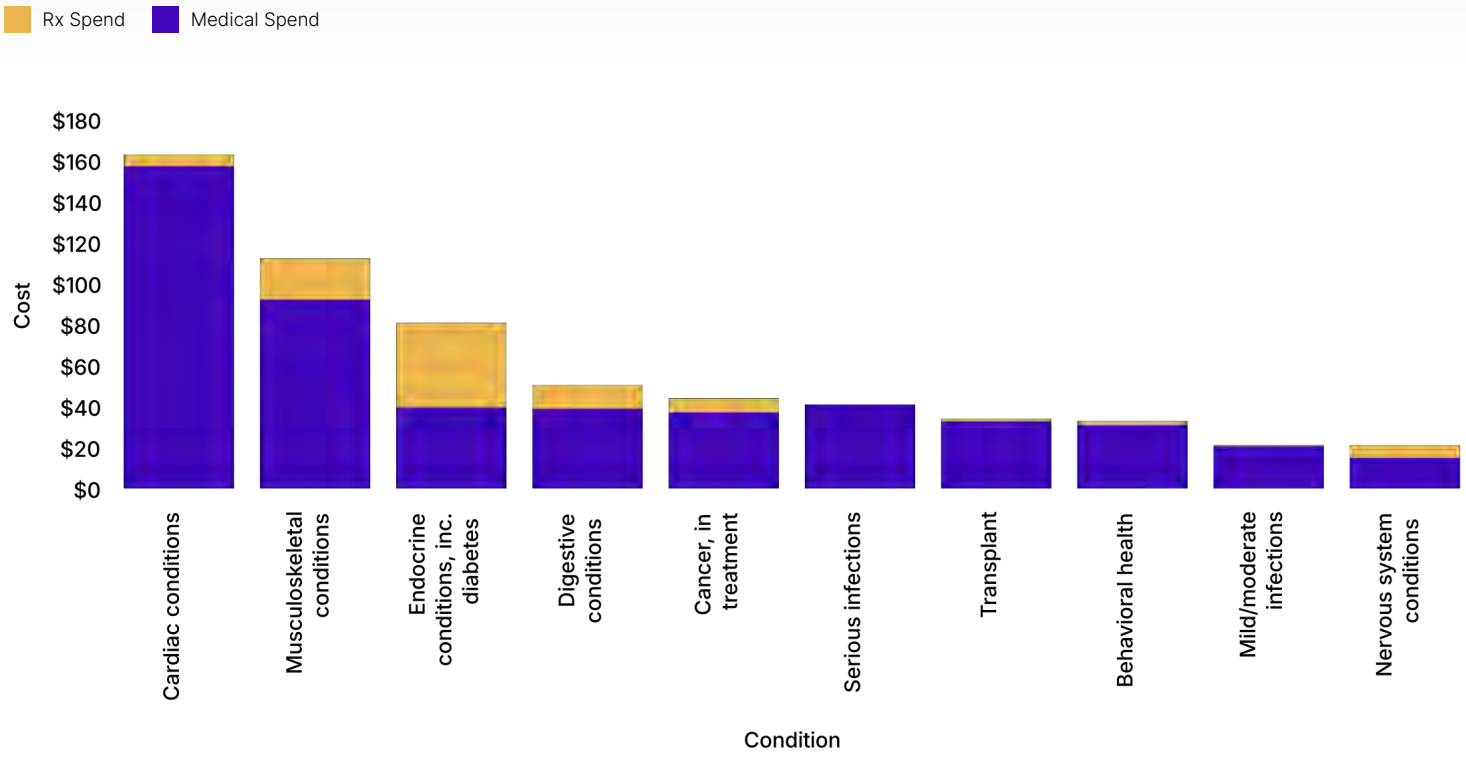
Cost by top conditions

To identify the medical conditions driving your costs, we grouped medical diagnosis codes into broader categories and included related pharmacy costs [Appendix Table X provides a further definition of each group, including examples of common and costly diagnoses].

The graph below illustrates the top 10 condition groups by cost across your population in 2024. This includes both medical and drug plan payments related to the condition.

FIGURE 2

Top 10 condition groups by net pay PMPM



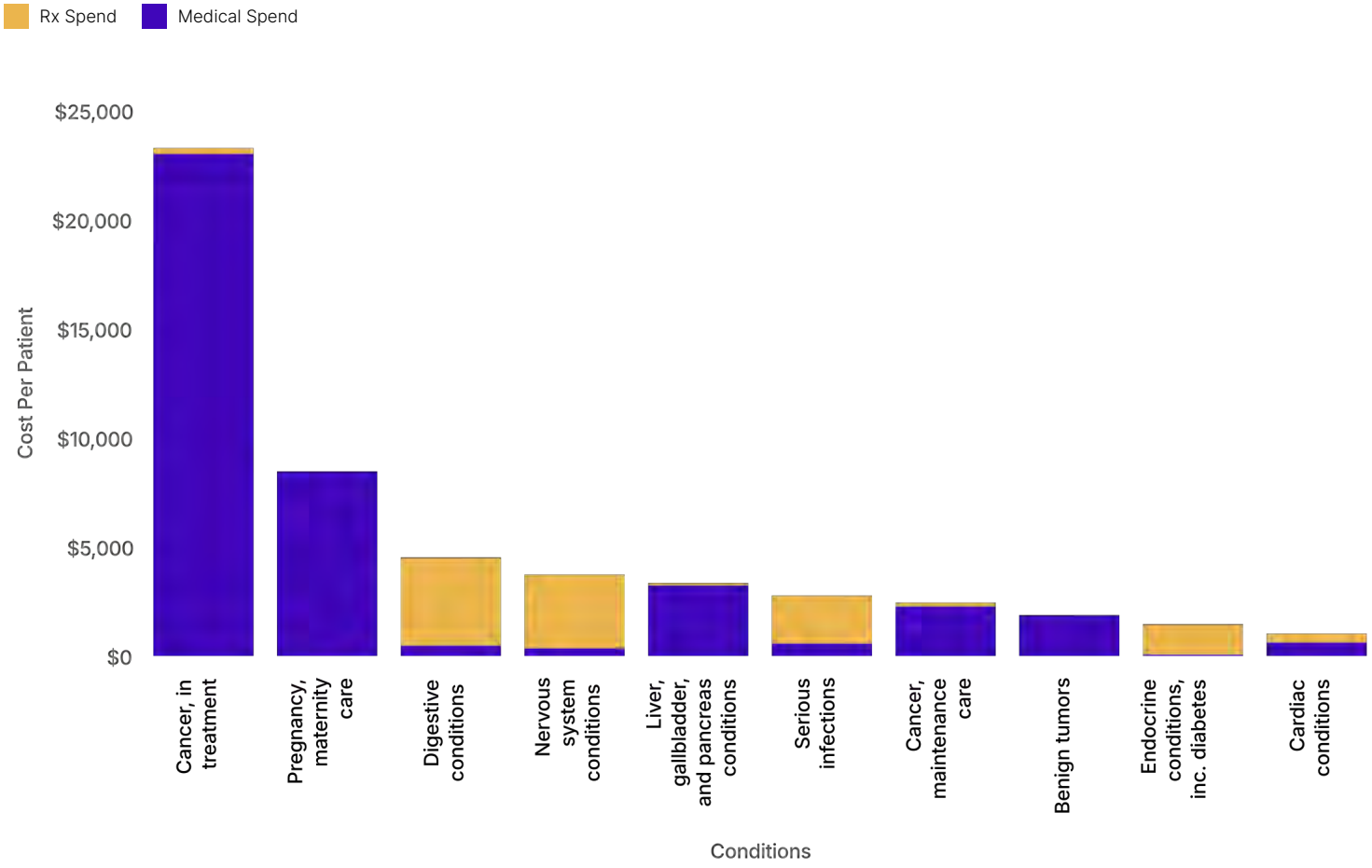
**See Appendix for detailed definitions.*

To better understand how specific conditions impact your cost, we broke this down a bit further. Let's take a look at the conditions that are the most expensive per claimant.

These are conditions that may be impacting a small subset of your population; however, the care and prescription costs associated with these conditions represent a larger percentage of spend. For that reason, this list of conditions may differ from the list above.

FIGURE 3

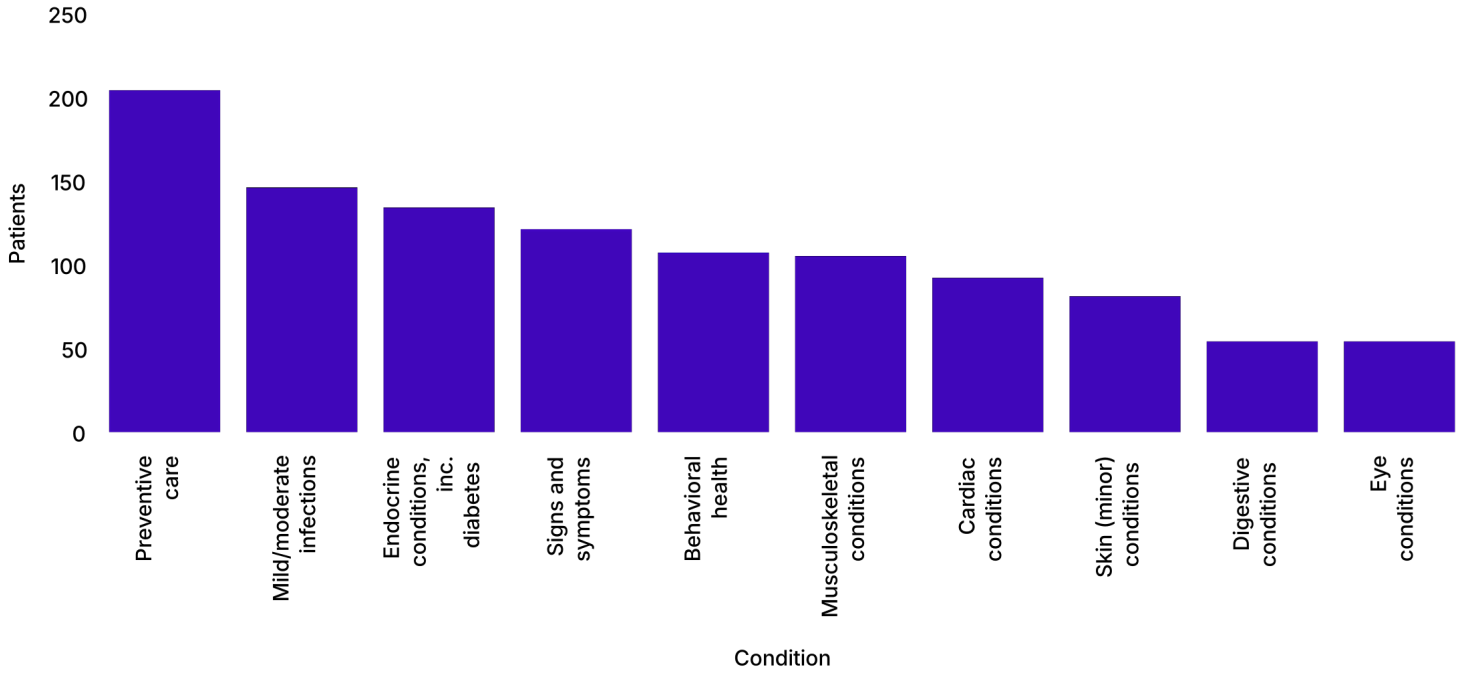
High cost conditions per patient



To round out the picture, we've also broken down conditions with the highest frequency. These conditions are sometimes lower in cost per patient, but high in volume.

FIGURE 4

High volume conditions



Cost by site of care

Another factor that often influences the cost of healthcare is the site of care in which the service takes place. Here we see a breakdown of the 4 most common sites of care.

Inpatient care

Inpatient care is generally reserved for critical situations, major invasive procedures, and newborn deliveries.

Emergency Department care (ED)

Emergency Department care is used to treat conditions which are urgent in nature but do not require hospitalization.

Outpatient care

Outpatient care represents a wide range of treatments, ranging from routine physician visits to surgeries performed in an outpatient setting.

Other sites of service

Other sites of service grouped into “All Other” represents a combination of care delivered in settings such as homes, urgent care settings, clinics, and via telehealth.

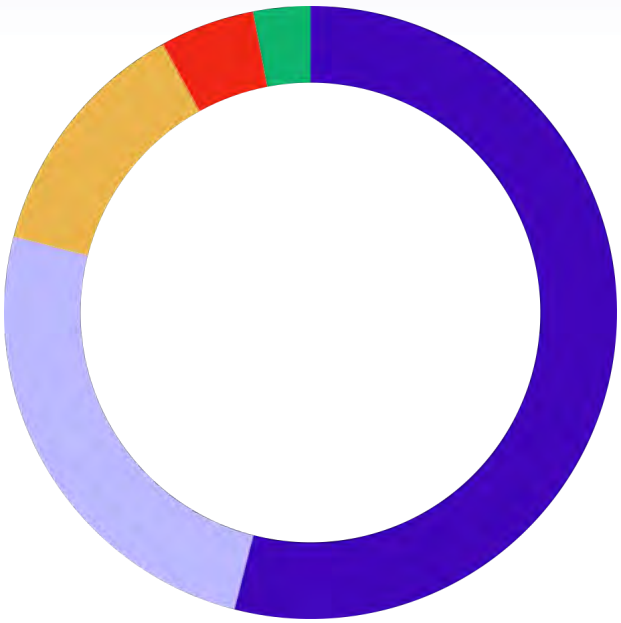
This chart below shows your distribution of spending across these settings in 2024.

Inpatient Care is the costliest, but less frequent and required by fewer employees.

Outpatient Care, such as doctor visits, represent the vast majority of needs and services delivered, but at a lower cost.

FIGURE 5

Spend by site of service



Total Spend

$3,369,761

- Outpatient (54%)
- Inpatient (25%)
- Rx (13%)
- Other (5%)
- Emergency Department (3%)

PART 2

Your personalized recommendations

A deeper dive into your costs

In the following sections, we provide you with more detailed analyses about various aspects of your population, their healthcare usage, and associated costs. For each analysis, we highlight specific actions you can take to impact those costs.

Talk to your ParetoHealth Account Manager to form Pathways that work for you now, and into the future.

Who is on your health plan?

Typically, participants in an employer's health plan include several groups:

- **Active employees**
- **Spouses and dependents**
- **Employees no longer with the business who are now on COBRA**
- **Retirees**

Often, these groups have very different healthcare needs and spending. In this section, we provide insights into the spending for key parts of your population that may be eligible for coverage off your health plan.

Medicare

Overview

When people turn 65 years of age, they qualify for medical coverage through Medicare.[1] If they or their spouses are still working and have access to employer-sponsored insurance, they do not have to transition to Medicare immediately. Not surprisingly, older populations often have higher medical needs and associated costs.

Your opportunity

11
Enrollee(s)

You had 11 enrollee(s) who were 63 or 64 (nearing the age of Medicare eligibility) at the end of your Time Period.

13
Enrollee(s)

You had 13 enrollee(s) who were already eligible for Medicare (age 65 +) at the end of your Time Period.

$377,765
Annual savings

If all enrollee(s) eligible (or soon to be eligible) for Medicare were moved off your plan as soon as they turn 65, you would save around $377,765 annually (based on captive-wide over-65 average cost).

3%
Enrollee(s)

Across ParetoHealth, about 3% of enrollee(s) are over the age of 65.

9%
Healthcare costs

These enrollee(s) account for nearly 9% of ParetoHealth healthcare costs.

Your recommendation

Drive more utilization of SmartConnect

There's significant opportunity in your population to reduce costs by helping eligible enrollees move to Medicare.

We're thrilled that you have already adopted SmartConnect powered by SmartMatch, a program ParetoHealth offers to all Members at no cost, that helps your plan participants learn about, evaluate and choose the best Medicare coverage that fits their unique needs.

SmartConnect can be even more effective if your plan participants are familiar with the program and recognize the name when they receive outreach. ParetoHealth has developed a suite of materials you can use to drive more awareness among your employee population, which should help SmartConnect become more effective over time. Please contact your ParetoHealth Account Manager to access these materials.

Reminder: In addition to helping you mitigate costs, having SmartConnect in place gives you credit towards your annual Member Cost Containment Index score, which positively influences your stop loss premium renewal rates.

SmartConnect Impact

Across ParetoHealth in 2024, a total of 501 individuals engaged with the SmartConnect service, with 245 successfully transitioning from their health plan to Medicare - a 49% conversion rate demonstrating the program's effectiveness in helping individuals make informed coverage decisions.

By engaging with SmartConnect, Members who converted to Medicare generated an estimated $3.9M in employer savings, based on the captive's average cost for individuals over age 65.

Your SmartConnect value

4

Enrollee(s)

You had 4 enrollee(s) that engaged with SmartConnect during the Time Period.

1

Enrollee(s)

1 enrollee(s) converted from your plan to Medicare through their engagement with SmartConnect.

25%

Conversion rate

This represents a 25% conversion rate.

$15,740

Annual savings

Engagement with SmartConnect resulted in a total estimated savings* of $15,740 annually.

**Estimated savings based on captive average cost for individuals over the age of 65.*

[1] Who's eligible for Medicare? HHS.gov. (2022, December 7). https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html

COBRA

Overview

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows qualified workers, and their families who lose their health benefits, the right to choose to continue group health benefits for limited periods of time under certain circumstances (e.g., job loss, reduction in the hours worked, divorce, death).[1]

COBRA is designed to cover people with a gap in employment, but it's expensive.

People with greater healthcare needs are more likely to pay out of pocket for COBRA and less likely to accept any gap in coverage.

Those who have fewer healthcare needs are more likely to pay out of pocket, buy a cheaper plan with less coverage, or go without insurance until they start with a new employer.

A recent Kaiser Family Foundation Study found that COBRA enrollees tend to be older, more likely to have multiple chronic conditions, and more than twice as likely to report poor health status - resulting in annual healthcare spending that is nearly twice that of other enrollees on the health plan ($11,695 vs $6,144).[2]

Your opportunity

47%

Turnover rate

The job turnover rate in the US as of 2021 was 47%.[3] While turnover rates vary by industry and from company to company, it is likely you will experience some turnover and should therefore consider a solution to mitigate COBRA costs.

Your recommendation

Drive utilization of eHealth

There's an opportunity to reduce your costs by helping those who are making a transition out of the organization.

ParetoHealth offers an alternative to COBRA - eHealth. This solution helps your employees make smart decisions about their coverage after terminating their employment. eHealth is a platform that connects individuals with top insurance carriers, offering an easy way to compare and enroll in individual plans online or with an agent.

eHealth provides lower out of pocket costs with robust coverage.

eHealth is free to all Members. All you need to do is share a link with your employees and remind them to use it when making that important coverage decision. ParetoHealth has materials you can use to drive more awareness among your employee population and maximize the value you get out of eHealth.

Please contact your ParetoHealth Account Manager to access these materials.

Reminder: In addition to helping you mitigate costs, having eHealth in place gives you credit towards your annual Member Cost Containment Index score - which positively influences your stop loss premium renewal rates.

eHealth impact

Across ParetoHealth, over 300 individuals have opted to use the eHealth platform since 2018 to purchase individual marketplace plans, choosing this alternative over the employer-sponsored COBRA plan.

In 2024, 43 COBRA-eligible and/or active participants purchased a marketplace plan through the ParetoHealth eHealth platform.

[1] *U.S. Department of Labor. (2019). COBRA brief.* https://www.dol.gov/general/topic/health-plans/cobra
[2] *Pollitz, K., Rae, M., Cox, C., Kamal, R., Fehr, R., & Young, G. (2020, May 28). Key Issues Related to COBRA Subsidies. Kaiser Family Foundation.* https://www.kff.org/private-insurance/issue-brief/key-issues-related-to-cobra-subsidies/
[3] *Heinz, K. (2023, April 17). 38 Employee Turnover Statistics to Know | Built In.* https://builtin.com/recruiting/employee-turnover-statistics

What are your most common and costly health conditions?

For the past several years, the costliest conditions for ParetoHealth overall have been cancer, endocrine disorders (including diabetes and obesity), musculoskeletal conditions, cardiovascular disease, behavioral health (like depression), gastrointestinal conditions, nervous system conditions (like multiple sclerosis), and pregnancy.

These conditions vary enormously in terms of their prevalence and cost per patient. For example, diabetes is very common (6% of the population) but relatively lower cost per patient ($5.5K per patient) while cancer is rarer (0.6% of the population) but much costlier per patient (approximately $81K per patient). Also, these conditions vary in terms of what drives their costs: For endocrine disorders, 70% of the costs are for medications whereas for maternity, 99% are for medical care such as physician visits, hospital costs, and procedures.

This suggests that cost containment strategies must be customized for each condition.

In this section, we provide insights into the most common and costly conditions affecting your population and suggest ways to help direct enrollees to high quality, cost-effective care.

Cancer

Overview

The cancer landscape has evolved significantly over the last 20 years, with an increase in both survivorship and prevalence. Employers across the US recognize that cancer is a leading driver of healthcare costs and see first-hand the effects of cancer on employee's ability to work, quality of life, and mental health.[1] As a result, they have focused on improving access to high quality care, through cancer case management programs, employee support groups (ESGs), robust paid leave policies for patients and caregivers, and more. These interventions have been demonstrated to increase both quality and length of life for cancer patients - and are increasingly important as the complexity of cancer management demands ever greater specialization among oncologists.

In 2024, ParetoHealth Members with cancer cost approximately $50 PMPM.

Breast cancer is overwhelmingly the most common cancer for Members but among the lower cost cancers to treat (about $50K per patient). Many women with early-stage breast cancers have excellent treatment options which vary enormously in cost. In contrast, multiple myeloma is rare but the most expensive cancer among adults (over $200K per patient).

Finally, while it is fortunately very rare for children to have cancer, these are among the costliest of all patients across ParetoHealth (over $250K per patient). Members have several options for how to help their enrollees access high value cancer care.

Your opportunity

6

Enrollee(s)

You had 6 enrollee(s) with Cancer diagnoses in active treatment during your Time Period.

0.6%

of enrollees

Across ParetoHealth, 0.6% of individuals have cancer being actively treated and the average cost across all types is $76.5K per patient per year (cost varies significantly based on the type of cancer).

Estimates of the percentage of cancer patients who are initially misdiagnosed range from 10% to 28%.[2]

Your recommendation HIGH PRIORITY

Drive more utilization of CancerCare

You can prioritize your employee experience, while driving down costs. You have already adopted CancerCare, a program ParetoHealth offers to all Members, which guides your plan participants throughout the experience of a cancer diagnosis - coordinating second opinions, ensuring treatment is in accordance with guidelines, and helping the patient and their families navigate all aspects of care during an emotional time.

But there is still opportunity for CancerCare to have a greater impact on your population. CancerCare is most effective when plan participants are familiar with the program and therefore recognize the name when they receive outreach, or contact CancerCare themselves. ParetoHealth has developed a suite of materials you can use to drive more awareness among your employee population, which should help CancerCare become more effective over time.

Please contact your ParetoHealth Account Manager to access these materials.

Reminder: In addition to helping you mitigate costs, having CancerCare in place gives you credit towards your annual Member Cost Containment Index score, which positively influences your stop loss premium renewal rates.

CancerCare impact

In 2024, CancerCare supported 785 active patients across the Pareto captive, with 88% classified as medium- or high-risk based on their diagnoses.

Delivered an estimated $12,046,501 in total savings captive-wide, demonstrating its ability to optimize costs while ensuring high-quality, personalized care.

CancerCare generates savings through a variety of strategies, with the most impactful areas highlighted below:

Type of savings	Average savings per case
Avoided unnecessary treatment	**$90,421**
Optimization of management	**$52,779**
Steerage to lower cost alternative	**$31,570**
Steerage to evidence-based care	**$25,000***
Complication avoidance	**$16,045**

**This category is based on an estimate of what would have occurred without CancerCare intervention.*

Chronic Kidney Disease

Overview

In the US, 36 million adults have chronic kidney disease (CKD) - that is one in every seven adults.

CKD is most often caused by poorly controlled diabetes and hypertension. Because it is typically asymptomatic, nine in every ten adults with CKD do not know they have it and often don't find out until it is very advanced.[1]

Unfortunately for many patients, CKD leads to kidney failure (end stage renal disease, or ESRD), which requires either dialysis or transplantation.

Across the ParetoHealth population, less than 1% of adults are diagnosed with CKD, but an additional 6-7% are at risk for CKD based on their age, gender, and comorbidities. In some groups, the "at risk" percentage is above 25%. Because the decline into ESRD can be delayed by careful control of comorbidities and the high cost of ESRD (average the monthly cost for dialysis is nearly $15K),[2] it is important for these people to get appropriate care early.

Your opportunity

4
Enrollee(s)

You had 4 enrollee(s) with Chronic Kidney Disease (CKD) diagnoses (at any stage) during your Time Period.

$41,691
Average annualized cost

The average annualized cost for a patient with Chronic Kidney Disease at any stage across ParetoHealth is $41,691, but costs rise as the disease progresses.

$173K
Average annualized cost

The average annualized cost for a patient with End Stage Renal Disease (ESRD) is over $173K.

Your recommendation

Adopt Renalogic

There's significant opportunity within your population to better manage costs related to Chronic Kidney Disease (CKD).

We have a solution for you: ParetoHealth offers a program called Renalogic (at best-in-class rates) to all Members.

Renalogic offers a variety of products:

- Dialysis at lower costs in a savings-based pricing structure.
- Access that ensures appropriate and cost-effective care management of patients with CKD at any stage and aims to slow or even prevent disease progression.

Contact your ParetoHealth Account Manager to get the process started.

Reminder: In addition to helping you mitigate costs, implementing Renalogic can give you credit towards your annual Member Cost Containment Index score, which positively influences your stop loss premium renewal rates.

Renalogic impact

Renalogic achievements:

- **50-75% savings off contracted dialysis rates**, translating to **$75,000-$125,000 in savings per dialysis patient annually**.
- Renalogic 's programs have delivered up to a **91% reduction in emergency department (ED) visits** and an **89% reduction in hospital admissions** for participating Members.
- Renalogic achieves a **98% success rate in preventing end-stage renal disease**, delivering an average savings of **$207 PMPM**.

[1] *CDC. (2024b, May 6). Chronic Kidney Disease in the United States, 2023. https://www.cdc.gov/kidney-disease/php/data-research/?CDC_AAref_Val=https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html*

[2] *League, R. J., Eliason, P., McDevitt, R. C., Roberts, J. W., & Wong, H. (2022). Assessment of Spending for Patients Initiating Dialysis Care. JAMA Network Open, 5(10), e2239131. https://doi.org/10.1001/jamanetworkopen.2022.39131*

What are effective ways to keep your population healthy?

As Benjamin Franklin said, “An ounce of prevention is worth a pound of cure.”[1]

Each year, the US Preventive Services Task Force provides a report to Congress outlining evidence-based recommendations for preventing illness. Their recommendations, which serve as the foundation of guidelines for Primary Care providers among others, cover a wide range of topics including screening and early detection of cancers, management of key preventable risk factors like elevated blood pressure, tobacco use, and obesity, prevention of infection diseases with immunizations, and interventions to prevent accidents and injuries like firearm safety, use of seat belts, and poison prevention.

In this section, we provide insights into effective interventions most relevant to preventing illness in your population.

[1] *Spee, R. F., Kemps, H. M., & Vromen, T. (2023). “An ounce of prevention is worth a pound of cure.” Netherlands Heart Journal, 32.* https://doi.org/10.1007/s12471-023-01839-3

Weight Management

Overview

In the US, it is estimated that 40% of adults are classified as obese.[1] It's important to note that the obesity rates presented in this playbook are based on medical claims. Studies show that obesity reported through medical claims can under-represent the true rate of obesity in a population by up to 60% This means that a claims-reported obesity rate as low as 16% could still correspond to a true obesity rate of 40%.[2]

Notably, the prevalence of severe obesity increased from 8% in 2020 to 10% in 2023.

Obesity increases the risk of serious health conditions including heart disease, stroke, type 2 diabetes, some cancers, digestive disorders, sleep apnea, osteoarthritis, and fatty liver disease.[3] Obesity can also take a toll on mental health, increasing rates of depression and anxiety.[4]

Captive enrollees follow these national trends. For example, among ParetoHealth Members:

- **51% of adults between 36 and 64 years** who have gallstones are overweight or obese
- **50%** of those with obstructive sleep apnea are overweight or obese
- **42%** of those with diabetes are overweight or obese

Given the prevalence of obesity and the expense of obesity-associated conditions, people who are overweight or obese have higher annual healthcare costs than non-obese people. This rings true within ParetoHealth data where we see similar higher costs among obese vs. non-obese patients, especially when we evaluate the costs of specific conditions.

Among ParetoHealth Members in 2024, non-obese patients who were diagnosed with gallstones had an average annual cost of $8k compared to $11k for gallstone patients who were also diagnosed as overweight or obese. Similarly, patients who were pregnant had an average annual cost of $8k, while those diagnosed as overweight or obese saw their average cost rise to $12k.

Fortunately, obesity medications and lifestyle changes can result in long-lasting weight loss for many.

While GLP-1s such as Wegovy and Zepbound have gained popularity for weight loss, there are numerous other medications (such as Contrave) that can be nearly as effective and are often well tolerated.

Employers interested in providing weight management for their population should consider reputable organizations, with excellent clinical oversight, that offer a range of medications including GLP-1s and low-cost generics, in concert with a robust lifestyle management program.

Your opportunity

22 %

of enrollee(s)

22% of your enrolled population was diagnosed as obese or overweight during your Time Period.

2.3x

Across the captive, the average cost for adults diagnosed as obese or overweight in 2024 was 2.3x those without this diagnosis.

% of patients on GLP-1s for weight loss captive wide	Average annualized Rx costs per patient
2%	$11,398

While GLP-1s can be very effective for weight loss, they are also costly, and it's important that there be proper oversight and support around their usage.

Brand Name Medication[5] (Generic name)	Estimated weight loss	Monthly list price
Saxenda (liraglutide)	6 to 8%	$1,349
Zepbound (tirzepatide)	15 to 21%	$1,067
Wegovy (semaglutide)	8 to 15%	$935 to $1,349
Contrave (naltrexone/buproprion)	6-7%	$562
Qsymia (phentermine/tomiramate)	8-10%	$270
Zenical (orlistat)	6-11%	$18

Your recommendation

Adopt Found

There's an opportunity within your population to better manage obesity and weight. ParetoHealth offers a program called Found (at best-in-class rates) to all Members.

Found offers a comprehensive obesity management solution designed to help enrollees achieve sustainable weight loss while reducing long-term healthcare costs.

Contact your ParetoHealth Account Manager to get the process started.

Reminder: In addition to helping you mitigate costs, having Found in place gives you credit towards your annual Member Cost Containment Index score, which positively influences your stop loss premium renewal rates.

Found Impact

Found delivers personalized, clinically backed solutions that empower enrollees to achieve sustainable weight loss. Through tailored care, participents experience an **average annual weight loss of 12%** of their total body weight.

Notably, **90% of those achieving a 15% or greater weight reduction** did so without the need for GLP-1 medications, underscoring Found's commitment to safe, effective, and accessible weight management.[6]

[1] *CDC. (2024). Obesity and Severe Obesity Prevalence in Adults: United States, August 2021–August 2023. https://www.cdc.gov/nchs/products/databriefs/db508.htm*
[2] *Suissa, K., Schneeweiss, S., Lin, K. J., Brill, G., Kim, S. C., & Patorno, E. (2021). Validation of obesity-related diagnosis codes in claims data. Diabetes, Obesity and Metabolism, 23(12), 2623–2631. https://doi.org/10.1111/dom.14512*
[3] *Mayo Clinic. (2023, July 22). Obesity. https://www.mayoclinic.org/diseases-conditions/obesity/symptoms-causes/syc-20375742*
[4] *Marks, J. (2022, June 23). How Obesity and Mental Health Are Connected. https://psychcentral.com/anxiety/being-overweight-tied-to-anxiety-depression*
[5] *Healthline. (2022, September 22). GLP-1 Agonists for Weight Loss: An Evidence-Based Review. https://www.healthline.com/health/weight-loss/glp1-for-weight-loss*
[6] *Clark, J. M., Smith, B. J., Juusola, J. L., & Kumar, R. B. (2025). Long-Term Weight Loss Outcomes in a Virtual Weight Care Clinic Prescribing a Broad Range of Medications Alongside Behavior Change. Obesity Science & Practice, 11(1). https://doi.org/10.1002/osp4.70036*

What care and costs are avoidable?

In the US, 20-30% of healthcare costs ($760B and $1.8T) are considered unnecessary because they are for services that are either unnecessary or, worse, harmful.[1]

Examples of this wasted spending include:

- **Unnecessary services** - when intensive services are offered despite the availability of appropriate lower cost services or when test results are not shared across providers and diagnostic tests are repeated.
- **Expensive settings** - when services such as an imaging tests are conducted in a hospital as opposed to a lower cost free-standing imaging center.
- **Treating conditions that will self-resolve** - such as giving ineffective antibiotics to someone with a viral upper respiratory infection.
- **Excessive administrative costs / fraud and abuse** - such as billing for services that were not actually delivered, improper billing practices, and misrepresenting the frequency or duration of services provided.[1]

In this section, we focus on examples of care in your population that could be directed to alternative, high quality, lower cost settings.

[1] *Speer, M., McCullough, J. M., Fielding, J. E., Faustino, E., & Teutsch, S. M. (2020). Excess Medical Care Spending: The Categories, Magnitude, and Opportunity Costs of Wasteful Spending in the United States. American Journal of Public Health, 110(12), 1743–1748. https://doi.org/10.2105/ajph.2020.305865*

Outpatient procedures

Overview

Many elective (i.e., scheduled) outpatient procedures can be safely performed outside the hospital setting for significantly lower cost.

Today, more and more care is delivered outside traditional hospitals in sites that include physician offices, patient homes, and ambulatory centers that specialize in imaging, endoscopy, surgery, and cardiac testing.

Cost for procedures conducted outside the hospital can be 40% less expensive.[1] In addition, patients like the convenience, lower cost, and quality of service they receive outside the hospital as evidenced by non-hospital care settings, consistently receiving higher patient satisfaction scores than hospitals.[2]

Example procedures that can be performed outside the hospital include imaging tests (MRIs and CT scans), diagnostic tests (echocardiograms and cardiac stress tests), and low-acuity procedures (colonoscopies, breast biopsies, and arthroscopies).

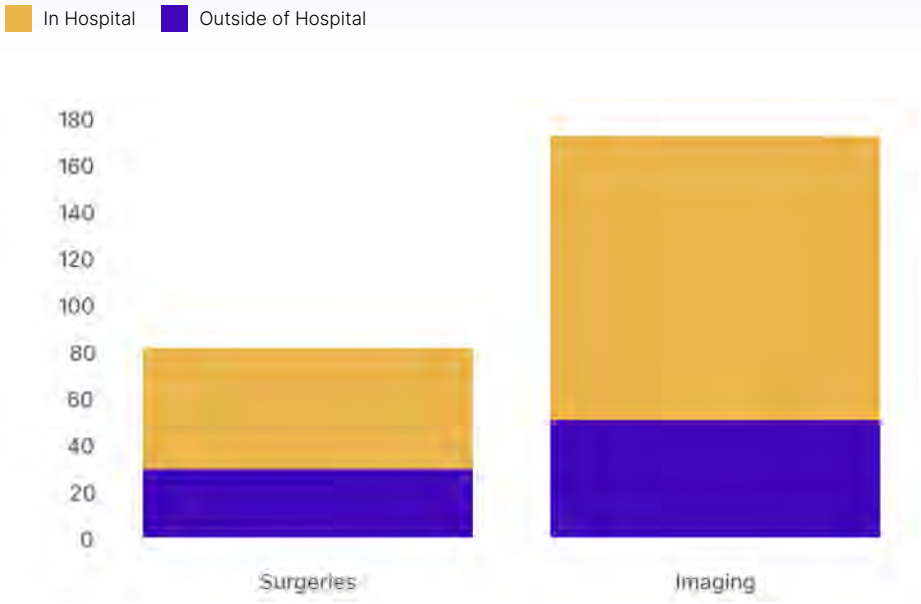
For diagnostic imaging procedures, a study found that in 2019 the average price of one performed in a hospital outpatient department was 165% more than the price of the same procedure performed in a stand-alone imaging center or physician's office.[3]

Guiding your employees to outpatient procedures can greatly reduce your costs, and result in equally beneficial care for your employees.

Your opportunity

FIGURE 6

2024 site of service for surgeries & imaging



63% of your outpatient surgeries and 71% of your imaging procedures happened in a hospital setting during your Time Period.

Here are the national average costs of a few common gastrointestinal procedures in Ambulatory Surgery Centers v. Hospital settings.[4]

Gastrointestinal procedures	Ambulatory surgery centers	Hospital setting
Small intestinal endoscopy	**$850**	**$1,760**
Colonoscopy with biopsy	**$728**	**$1,240**

Last year your population also had 30 outpatient surgery procedures and 51 outpatient imaging procedures that were candidates for lower, bundled rates through KISx (see next page).

Your recommendation

Educate on lower-cost hospital alternatives

You have a significant volume of procedures taking place in hospital settings that may be more affordable at an alternative site of care. Many of these procedures may be able to take place at ambulatory surgery centers, freestanding imaging centers, or some doctors' offices - which would likely result in significantly lower cost.

Drive utilization of KISx

A good number of these procedures may be provided through KISx, which would result in even greater savings.

Employers who face a high volume of hospital-based procedures when there are alternatives, should ensure that their plan design is optimized to financially incentivize enrollees to look for lower cost sites of care, and educate their employees about those alternatives. ParetoHealth has developed materials to help you accomplish this.

You have already adopted KISx, a program ParetoHealth offers to all Members at no cost, that offers bundled, lower cost prices for very common outpatient imaging and surgical procedures.

Your data suggests there is even more opportunity for KISx to have a greater impact on your population. Promoting awareness of KISx allows it to be more useful by encouraging a larger segment of your population to engage when appropriate. ParetoHealth has developed a suite of materials you can utilize to drive more awareness among your employee population, which should help KISx become more effective at reducing your costs over time.

Please contact your ParetoHealth Account Manager to access these materials.

Reminder: In addition to helping you mitigate costs, having KISx in place gives you credit towards your annual Member Cost Containment Index score, which positively influences your stop loss premium renewal rates.

KISx impact

In 2024, 3621 plan participants utilized the KISx benefit to schedule 5208 total procedures.
By utilizing the KISx benefit, the program drives savings to both the patient and the plan.

Here's a breakdown of the savings* achieved across ParetoHealth through the KISx program:

Procedure Type	Number of 2024 Procedures	Average Plan Savings Range*
MRI Scans	**2129**	**$352 - $1,503**
CT Scans	**854**	**$552 - $1,110**
Endoscopic Procedures	**783**	**$2,285 - $2,827**
Orthopedic Surgeries	**252**	**$7,230 - $15,860**
All Other	**1190**	**Varies by Procedure**

**This is the average plan savings range per procedure. Savings can vary based on several different factors such as network discount, geography, facility, etc.*

[1] *Nelson, R., Whitcomb, J., McDonald, A., & Manning, L. (2023). How and where to capitalize on the ongoing shift of care outside of hospital settings Healthcare procedures on the move.* https://kpmg.com/kpmg-us/content/dam/kpmg/pdf/2023/healthcare-procedures-on-the-move.pdf
[2] *The Leapfrog Group. (2022, April 6). Leapfrog Group Series "Patient Experience During the Pandemic" Indicates More Favorable Experiences for Outpatient Surgery at ASCs Than Hospital Outpatient Departments.* https://www.leapfroggroup.org/news-events/leapfrog-group-series-%E2%80%98patient-experience-during-pandemic%E2%80%99-indicates-more-favorable
[3] *Group, U. (2024, February 15). New Research Reveals Savings Opportunities for Diagnostic Imaging.* https://www.unitedhealthgroup.com/newsroom/research-reports/posts/new-research-reveals-savings-opportunities-for-diagnostic-imaging-471266.html
[4] *Newitt, P. (2022, March 30). ASC vs. HOPD costs for 5 most common gastroenterology procedures.* https://www.beckersasc.com/gastroenterology-and-endoscopy/asc-vs-hopd-costs-for-5-most-common-gastroenterology-procedures.html

What are your most common and costly prescription medications?

Prescription drug costs are increasing more quickly than medical claims spending.[1]

Among ParetoHealth Members, prescription drug spend was approximately $112 PMPM and accounted for 22% of total healthcare spending in 2024.

Prescription drugs are generally classified as generic, brand name, or specialty medications.*

Generic vs. Name-brand

Nationally, generic medications represent nearly 90% of prescriptions but only 15% of spending.

Specialty name-brand drugs account for only 1-2% of prescriptions but 30-40% of spending.

For the past decade, specialty name-brand drugs like Humira (used for autoimmune conditions like psoriasis) were the costliest drugs. But in 2023, Ozempic used for diabetes and related GLP-1s, took the lead.

Out of the top ten costliest drugs across ParetoHealth, half are for diabetes and heart disease, underscoring the importance of these conditions as cost drivers for the captive.

In this section, we provide recommendations on how to create a cost-savings strategy to benefit your employees, and your bottom-line.

** For the purposes of this discussion, we are only considering medications covered by the pharmacy benefit. Specialty drugs that are administered via infusion or injection and are paid for under the medical benefit are not included.*

Your opportunity

8 %

of total claims costs

8% of your total claims costs last year came from pharmacy claims.

$163

PMPM drug costs

Your drug costs PMPM last year were $163.

90% of your drug spend last year came from brand drugs, and 2% came from specialty drugs.

- More than 131M people, or approximately 66% of American adults, take at least one prescription medication.[2]
- Almost half (48%) of the cost of prescription drugs is paid out-of-pocket. Concerns about cost lead some consumers to take less than the prescribed medication.[2]

Your recommendation

Adopt PRxC

Pharmacy spend is a big contributor to your annual healthcare costs and is growing rapidly each year (at around double the rate of medical care spend). ParetoHealth offers a comprehensive solution to help you manage your Pharmacy costs - the ParetoHealth Rx Consortium: PRxC.

ParetoHealth leverages our captive scale, data, and clinical expertise - along with an external pharmacy consultant - to secure top Pharmacy Benefit Manager (PBM) contracts with audited guarantees for our Members.

Regular market checks and requests for proposals optimize terms annually, while formulary reviews and new drug workflows ensure cost-effective plan designs. Our in-house pharmacists oversee prior authorizations and large claims to maintain cost control and compliance. PRxC is your best solution for managing pharmacy expenses!

To learn more about joining PRxC, contact your ParetoHealth Account Manager.

Reminder: In addition to helping you mitigate costs, implementing PRxC can give you credit towards your annual Member Cost Containment Index score, which positively influences your stop loss premium renewal rates.

PRxC impact

Thanks to our focus on brand-to-generic strategy and effective formulary management, PRxC Members consistently fill generics over brand-name medications at industry-leading rates, with 87% of prescriptions filled as generics.

This approach drives significant cost savings for employers and enrollees while maintaining high-quality care.

Common examples where there are significant savings opportunities by driving utilization of generic vs brand drugs are:

Brand name	Generic name	Total savings
Xyrem	**Sodium Oxybate**	**$77,589**
Avonex	**Teriflunomid**	**$86,296**
Xeloda	**Capecitabine**	**$36,576**
Epclusa	**Sofsbuvir/Velpatasvir**	**$51,772**

ParetoHealth's Custom Drug Exclusion List and New-to-Market Drug Program proactively addresses high-cost drug spending while ensuring access to clinically effective treatments. Developed through a close partnership between our clinical pharmacy team and pharmacy consultants, the program is updated quarterly to ensure timely adjustments.

By evaluating the clinical value and cost-effectiveness of medications, we exclude unnecessary high-cost drugs and assess new market entrants for inclusion based on their value to Members. This strategic approach drives significant cost savings, with employers seeing an average reduction of $6-10 PMPM in drug spend.

In 2024, PRxC's clinical prior authorization review program delivered an average of $72,690 where a change was made. Since the program's launch in 2018, this program has saved the captive over $11,873,632 total that otherwise would have hit the employer plans. In addition to prior authorization reviews, our clinical pharmacists review for opportunities for additional savings through alternative sourcing options or programs.

When these recommendations were followed, Members saved on average an additional $15,492.

In 2024, ParetoHealth leveraged the size and scale of PRxC to negotiate enhanced contract terms and performance guarantees, projected to deliver an additional 7-15% in savings for PRxC Members starting in 2025 and beyond, creating significant additional value compared to previous years.