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COST MANAGEMENT WEBINAR SERIES

Breaking the Cost Cycle:

Taking Control of Your Healthcare Cost Strategy

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Agenda

1. Breaking the Cost Cycle
2. Pillar 1: Optimizing High-Cost Therapeutics
3. Pillar 2: Strategic GLP-1 Management
4. Pillar 3: Managing Emerging Catastrophic Risks
5. The Power of Integration
6. The Path Forward

Breaking the Cost Cycle

Why We're Here

The old approach isn't working.

Medical trend:

9% – a 15-year high

Average family premium:

nearly $27,000 – up **26%** in five years

Specialty drugs:

2% of prescriptions,

50% of pharmacy spending

One gene therapy claim:

up to **$4.25M**

The Cycle We're Breaking

The old loop

- Costs rise
- Cut benefits
- Shift costs to employees
- Satisfaction drops
- repeat

The new approach

- Understand your data
- Identify risk early
- Act before costs spike
- Measure
- Stay ahead

Three Pillars of Healthcare Cost Control

1

Optimize High-Cost Treatments & Care

- Specialty drug analytics
- PBM contract optimization
- Site-of-care redirection
- Biosimilar adoption

2

Structure GLP-1 Access & Usage

- Cover for diabetes/CV disease
- Structured weight management programs
- Step therapy + BMI thresholds
- Medical oversight guardrails

3

Manage Emerging Catastrophic Risks

- Gene therapy risk management
- Claims-based risk identification
- Stop-loss & captive solutions
- Outcomes-based coverage models

Each pillar relies on the same foundation – data analytics paired with clinical informatics (clinically-informed analytics)

Pillar 1: Optimizing High-Cost Therapeutics

High-Cost Therapies: Two Levers, One Strategy

Pharmacy

Manage what's dispensed through the pharmacy benefit

- **PBM Contract Optimization**
  Negotiate transparent pricing, rebate pass-through and MAC protections
- **Specialty Drug Management**
  Formulary controls, prior authorization, step therapy to drive appropriate utilization
- **Site-of-Care Redirection**
  Shift infusible drugs from hospital to office/home – same drug, up to 55% savings
- **Biosimilar Adoption**
  Accelerate reference product-to-biosimilar conversion to reduce per-unit cost
- **Rebate Strategy**
  Align formulary design with rebate economics to maximize net cost reduction

Medical

Manage high-cost drugs billed through the medical benefit

- **Site-of-Care Optimization**
  Identify infusions billed at hospital rates; redirect to ambulatory or home settings
- **Clinical Informatics**
  Surface dosing anomalies, over-utilization and payment variances before claims are finalized
- **Gene Therapy Readiness**
  Claims-based risk ID, stop-loss alignment and outcomes-based coverage models for $1M+ exposures
- **Dose Optimization & Audits**
  Validate dosing against clinical guidelines; recover excess payments when standards are exceeded
- **Predictive Risk Stratification**
  Flag high-cost claimants early to enable coordinated care before costs compound

Specialty Drugs by the Numbers

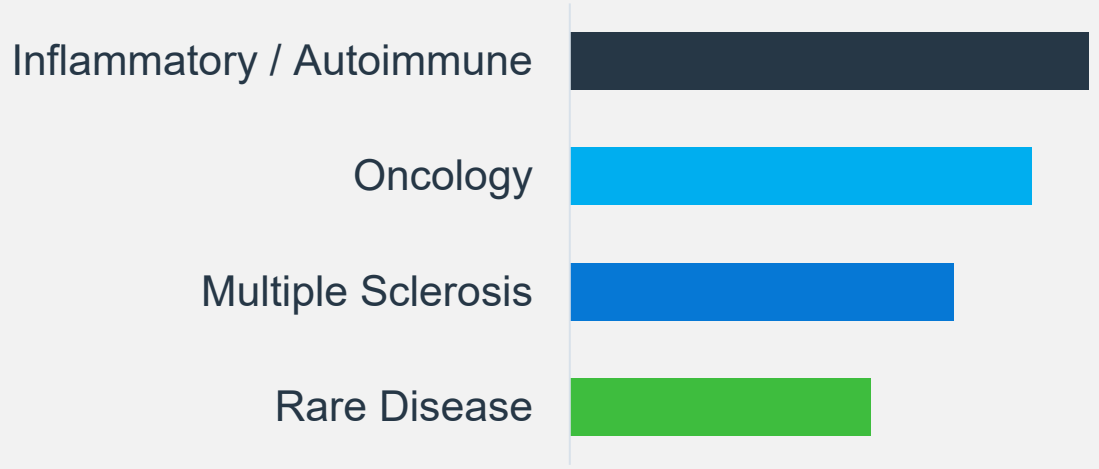
2%
of prescriptions

50%+
of pharmacy spending

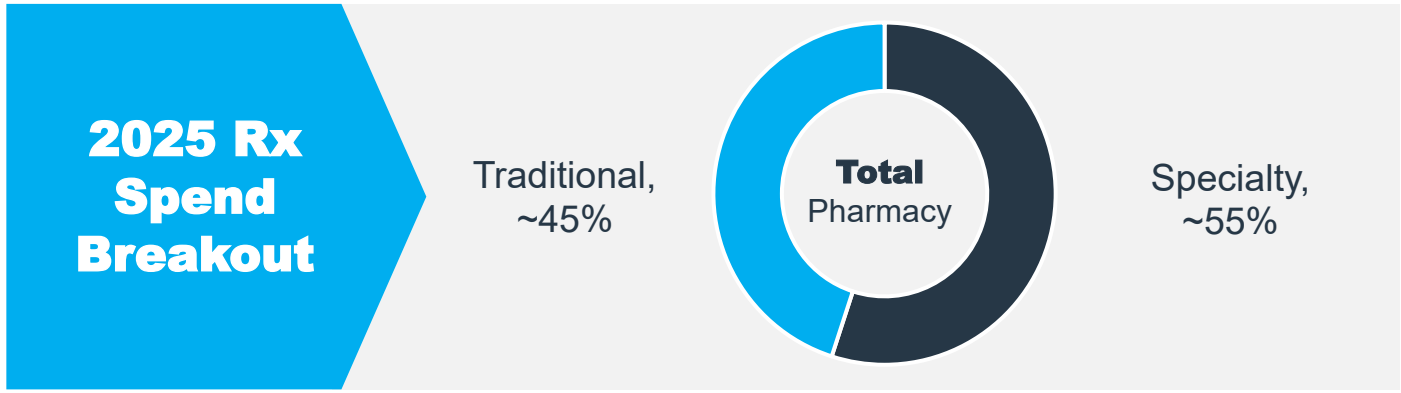
Up to **10%**
of total healthcare spending

Specialty drugs represent the largest – and most addressable – cost category in most employer health plans.

Top Specialty Spend Categories



2025 Rx Spend Breakout



Biosimilar Adoption

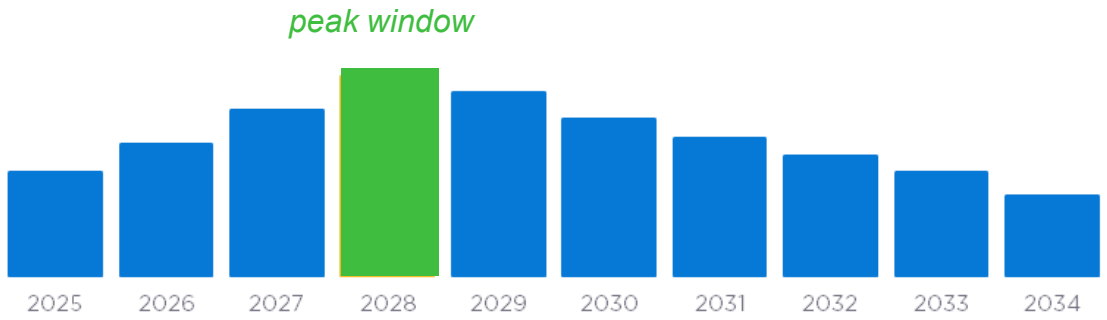
90
FDA-approved biosimilars

$56B
saved since 2015

118
biologics losing patents

30%
average cost reduction

Patent cliff 2025-2034



Up to **$181B** projected savings over 5 years

How employers capture savings:

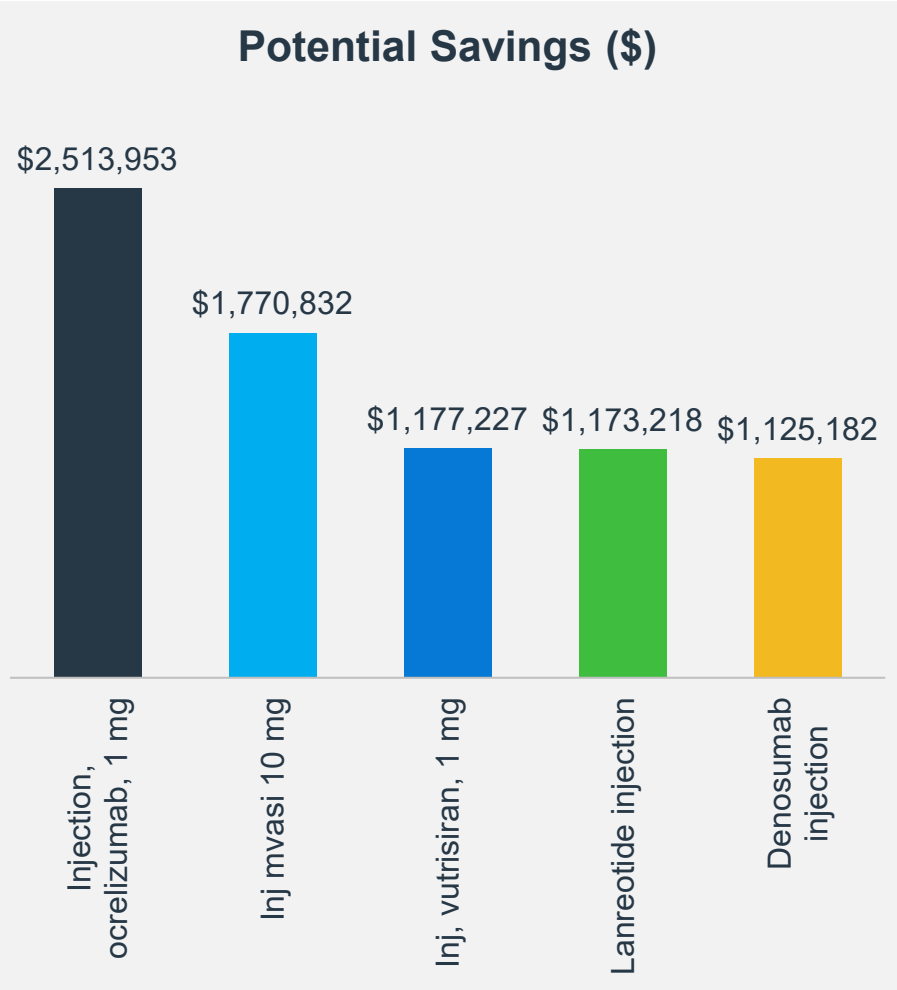
- **Formulary first**
  Tier biosimilars #1. Require prior authorization for branded reference drugs
- **Audit the PBM**
  Rebates may keep branded products preferred – not in your plan's interest
- **Auto-substitution**
  Interchangeable biosimilars can swap at the pharmacy without prescriber sign off
- **Education and convert**
  Clinical outreach removes prescriber hesitation – and accelerates conversion

Same drug. Half the price.

- Site of care matters as much as the drug itself:

- Clinical informatics surfaces these opportunities before the expensive claim is ever submitted.

Location Matters



Injectable Drug	Outpatient Hospital		Office Cost per Service ($)	Potential Savings ($)
	Cost per Service ($)	Services		
Injection, ocrelizumab, 1 mg	$56,097	120	$35,147	$2,513,953
Inj mvasi 10 mg	$3,888	752	$1,533	$1,770,832
Inj, vutrisiran, 1 mg	$269,674	8	$122,521	$1,177,227
Lanreotide injection	$18,982	90	$5,947	$1,173,218
Denosumab injection	$4,414	489	$2,113	$1,125,182
Gammagard liquid injection	$6,757	424	$4,238	$1,068,093
Pegloticase injection	$75,870	20	$28,619	$945,036
Injection, vedolizumab	$11,018	223	$6,851	$929,201
Octreotide injection, depot	$10,976	188	$6,073	$921,731
Injection, onabotulinumtoxina	$1,569	1,240	$861	$878,118
All Other Savings Eligible Injectables	—	—	—	$19,507,364
Total				**$32,009,955**

Clinical Case Study

Cost Recovery Infusion Therapy

Executive Summary

The clinical team identified a significant payment anomaly for IV treatment of Crohn's Disease. A clinical review revealed that there was an overpayment due to dosing that exceeded standards of care guidelines, leading to the successful recovery of excess costs.

Key Actions Taken

- Cost variance analysis performed
- Clinical review of dosing protocols
- Requested carrier audit
- Reimbursement claim submitted

$5,450

Average Monthly Cost

+568%

Variance

$30,977

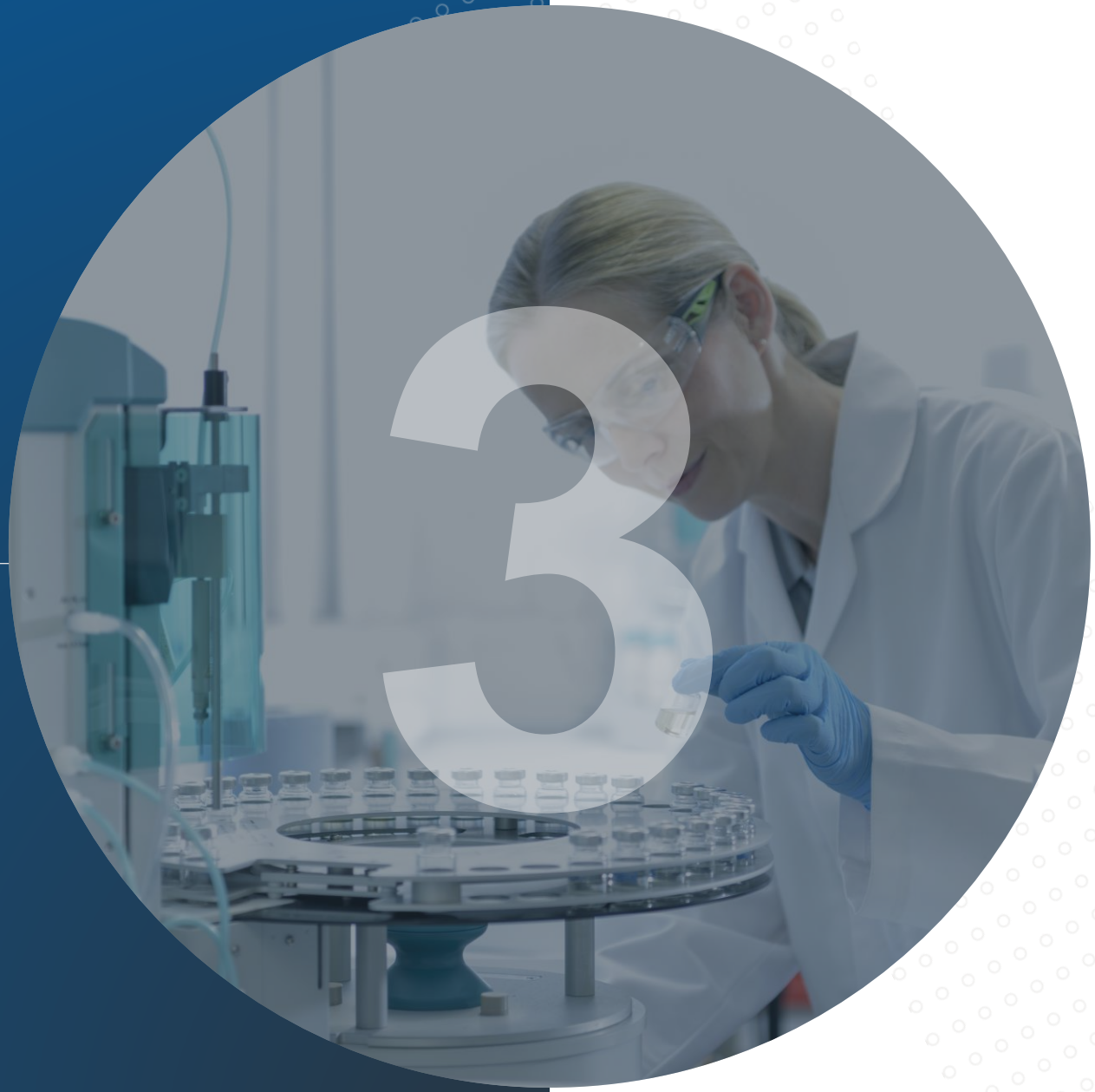
Payment Anomaly

Clinical Risk Review Facilitated

$27,247

Total Financial Recovery

Pillar 2: Strategic GLP-1 Management



GLP-1 Market Overview & Outlook

57M+
Eligible U.S. Population

$77B
Projected Market Value by 2030

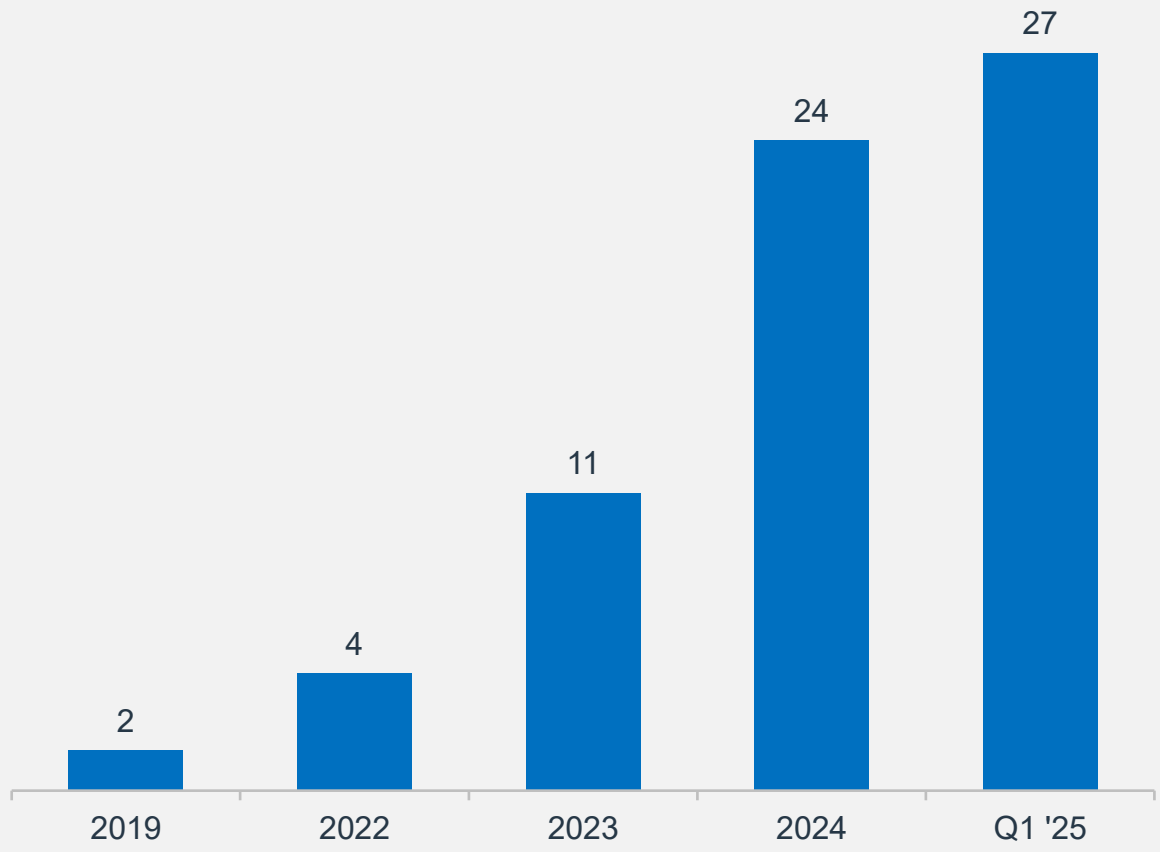
21%
Share of Total Pharmacy Spend

7.8%
Projected Healthcare Cost Increase

GLP-1s for weight management driving premium increases of **5-14%** annually

Blanket coverage and blanket exclusions both carry risk

Per-Member-Per-Month (PMPM) Cost Trajectory



GLP-1 Coverage: differentiate by indication

Always cover

- **Diabetes management**
- **Cardiovascular disease**
- **Cardiometabolic conditions**

Covering GLP-1s for diabetes and cardiovascular conditions is clinically essential and widely expected by employees

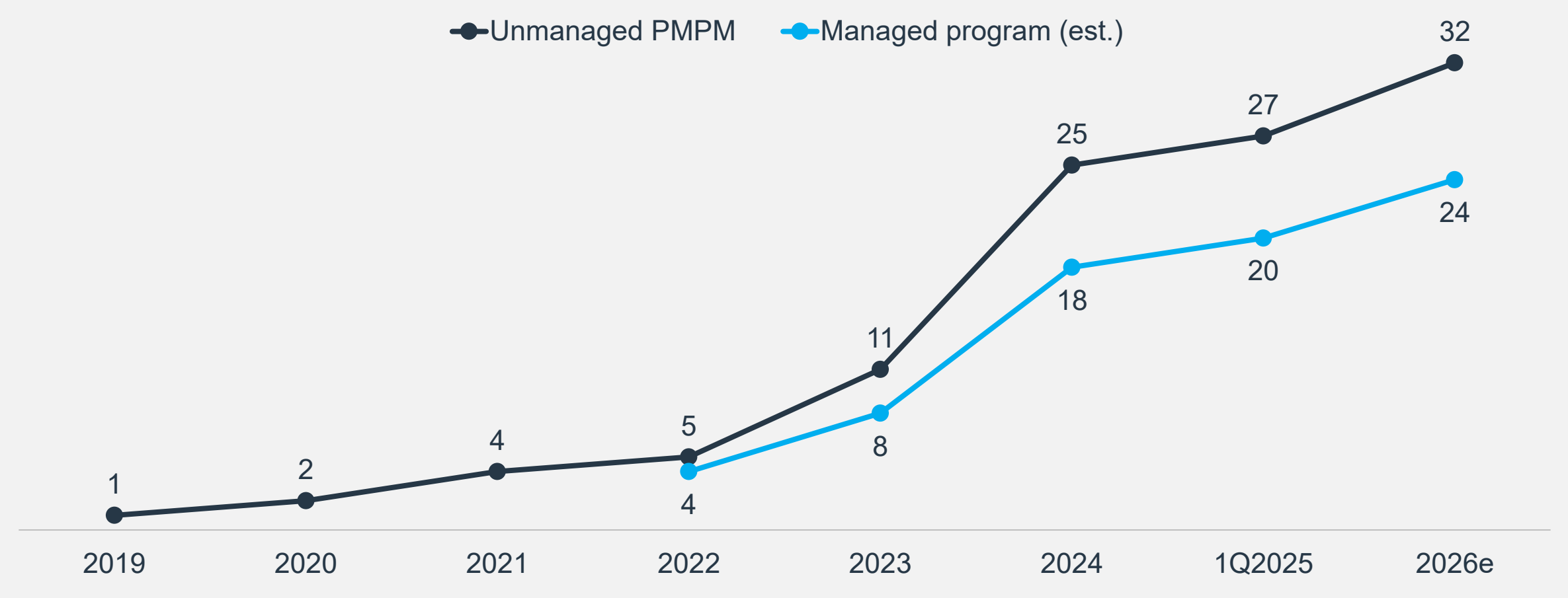
Structure for obesity / weight management

Required guardrails

- Step therapy requirements
- BMI thresholds with comorbidities
- Lifestyle program participation
- 6-month progress reviews
- Nutrition coaching + adherence monitoring

Without guardrails:
muscle loss, bone density reduction, weight regain > new costs that offset pharmacy savings

PMPM Trajectory: unmanaged vs. managed GLP-1



Unmanaged: WTW/Rx Collaborative Q1 2025 ($27.23); AssuredPartners 2024 ($24.59); 2026e directional. Managed: CVS 26% reduction applied to unmanaged baseline; corroborated by Navitus 7% drug trend vs. 12.8% industry.

Pharmacy Case Study

Self-Funded Employer in Public Sector · $35M Estimated Annual Pharmacy Spend

28%
Net PMPM Reduction

+$47.45
Rebate Improvement PMPM

$61.18
Net PMPM Savings

PMPM COST COMPARISON

Metric	Carved In	Carved Out	Change
Plan Cost PMPM	$305.77	$292.04	−$13.73
Rebate PMPM	$91.08	$138.53	+$47.45
Net PMPM	**$214.69**	**$153.51**	**−$61.18**

THE CHALLENGE

- Pharmacy embedded with health carrier — no cost visibility
- Rebate yield significantly below market benchmarks
- Carrier-controlled formulary with limited flexibility
- Limited cost containment recommendations

THE SOLUTION

- Contract improvement- carved out pharmacy to large independent PBO, negotiated 100% rebate pass-through
- Monthly reporting with itemized visibility of spend: ingredient cost, dispensing fees, and rebates
- Dedicated account team overseeing pharmacy performance
- Formulary management with clinical optimization and biosimilar-first strategies reduced gross plan cost by $13.73 PMPM.

Achieved a 28% net PMPM reduction through rebate transparency, improved contracting, formulary redesign, and a dedicated pharmacy account team.

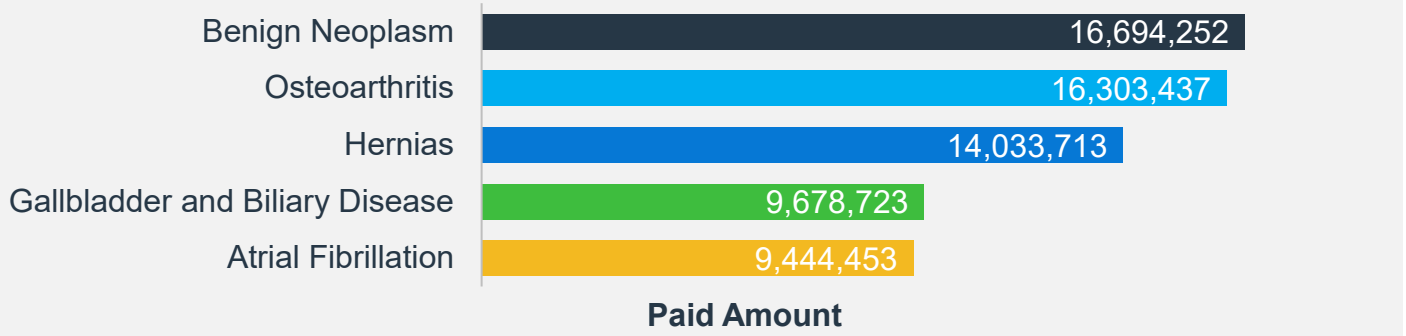
Pillar 3: Managing Emerging Catastrophic Risks

High-Cost Claimants Aren’t Random

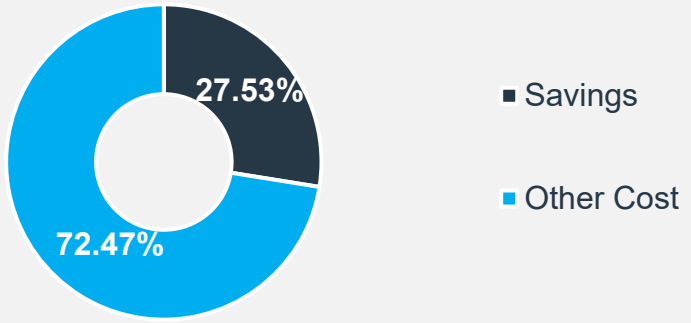
- A small number of members accounts for an outsized share of spend – and with the right data, you can see them coming.
  - 41 members > $4.8M in costs > 21% of total plan spend
  - Predictive analytics + targeted coordination + site-of-care optimization
  - Result: 18% cost reduction | $864K in annual savings

Site of Care Opportunities

Top Surgery Diagnoses by Potential POS Switch Savings



Potential Savings as a % of Total MRI & CT Cost



Diagnosis Grouper	Outpatient Hospital Cost / Surgery ($)	ASC Cost / Surgery ($)	Outpatient Hospital Surgeries	Potential Savings ($)
Benign Neoplasm	$12,614.42	$4,931.84	2,173	$16,694,252
Osteoarthritis	$24,716.64	$17,976.90	2,419	$16,303,437
Hernias	$14,139.03	$6,540.92	1,847	$14,033,713
Gallbladder and Biliary Disease	$14,187.57	$7,318.35	1,409	$9,678,723
Atrial Fibrillation	$38,219.51	$20,858.38	544	$9,444,453
Ear Nose and Throat Disorders	$9,080.28	$4,688.86	2,141	$9,402,031
Spondylosis/Stenosis	$10,210.73	$4,414.85	1,600	$9,273,407
Dislocations and Sprains - Lower Extremities	$14,303.17	$7,023.88	1,087	$7,912,581
Urinary Calculus	$12,152.83	$5,209.48	1,085	$7,533,532
Female Genital Disorders	$11,814.06	$4,906.29	1,059	$7,315,334
All Other	--	--	37,907	$162,854,956
Total	--	--	**53,271**	**$270,446,419**

Metric	MRI ($)	CT ($)
Hospital Average Paid	$1,401	$1,291
Office Average Paid	$548	$541
Potential Savings Per Service	$853	$750
Savings Eligible Services	$26,705	$28,342
Potential Savings	$22,777,598	$21,254,852
Total Potential Savings		**$44,032,450**

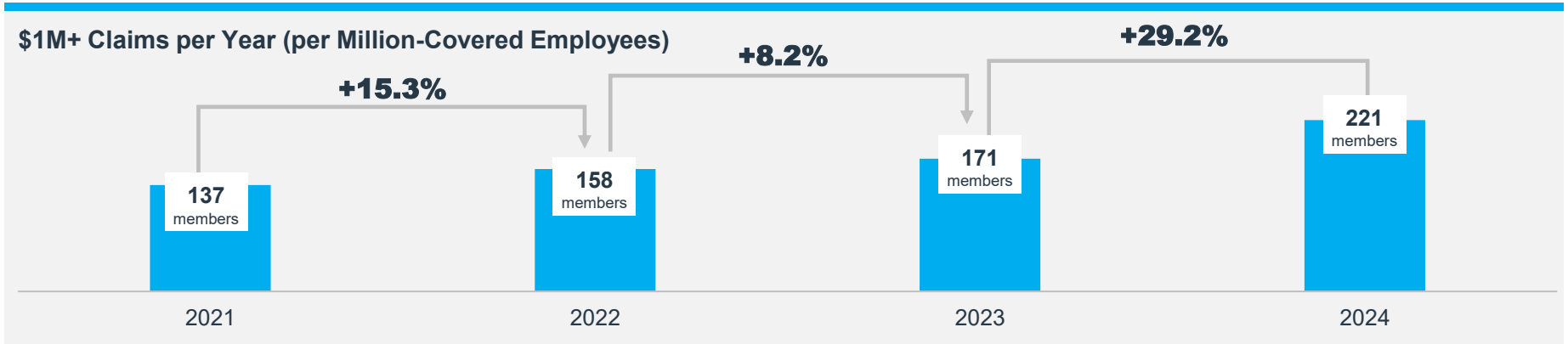
High-Cost Claimants Clinical Oversight

- High-cost claimants drive a disproportionate share of costs. With healthcare trend this will continue to rise without intervention.
- Our clinical leverages the data to review HCC claimants — enabling clinical education, projected risk quantification, and targeted opportunities where appropriate. Where they are not, projected risk informs budgeting and stop-loss strategy.
  - Where high-cost members are identified, our clinical team collaborates with multi specialty practices to evaluate drug-specific opportunities, site-of-care, programs evaluation, and more.

The impact of million-dollar claims

Million-dollar+ claims-per-million-covered employees increased nearly 30% after climbing at a steady pace the prior three years.

This rise in million-dollar claims is due in part to cost rising across all aspects of healthcare, medical advancements and the return to utilization levels beyond pre-pandemic levels.



Conditions with the Highest Number of Million-Dollar Claims by Year

Rank	2021	2022	2023	2024
1	Leukemia, Lymphoma, Multiple Myeloma	Malignant Neoplasm	Malignant Neoplasm	Malignant Neoplasm
2	Malignant Neoplasm	Leukemia, Lymphoma, Multiple Myeloma	Newborn/Infant Care	Leukemia, Lymphoma, Multiple Myeloma
3	Newborn/Infant Care	Tied: Newborn/Infant Care and Cardiovascular	Cardiovascular	Newborn/Infant Care
4	Tied: COVID-19 and Congenital Anomaly	Sepsis	Sepsis	Cardiovascular
5	Cardiovascular	COVID-19	Leukemia, Lymphoma, Multiple Myeloma	Congenital Anomaly

Source: 2025 Sun Life High-Cost claims and injectable drug trends report; HUB International 2026 Cost Management Report (hubinternational.com)

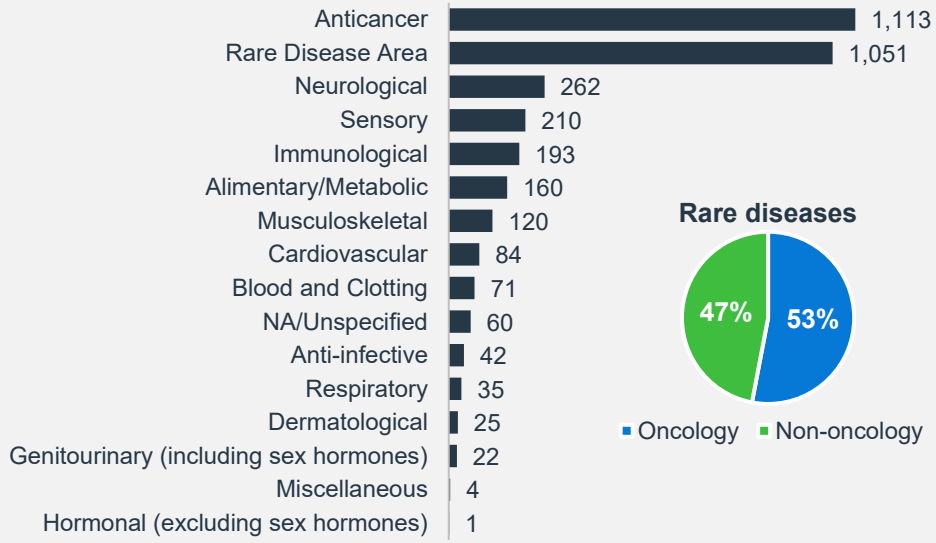
Gene Therapy: No Longer Theoretical

- 36 approved gene therapies globally
- 140+ therapies expected by 2030
- 5+ additional FDA approvals expected in 2025 (ARM, ASGCT) pipeline accelerating across rare disease states, oncology, and chronic conditions
- Gene therapy average cost range: $1.5M–$4M per treatment (ETS, 2025); $850K–$900K (Luxturna)
- $913K - $4.25M per treatment
- Diabetes, Parkinson’s, Alzheimer’s therapies coming within 3-5 years
- Market: $9.1B by 2034
- One claim can reshape a plan year

The Gene Therapy Pipeline

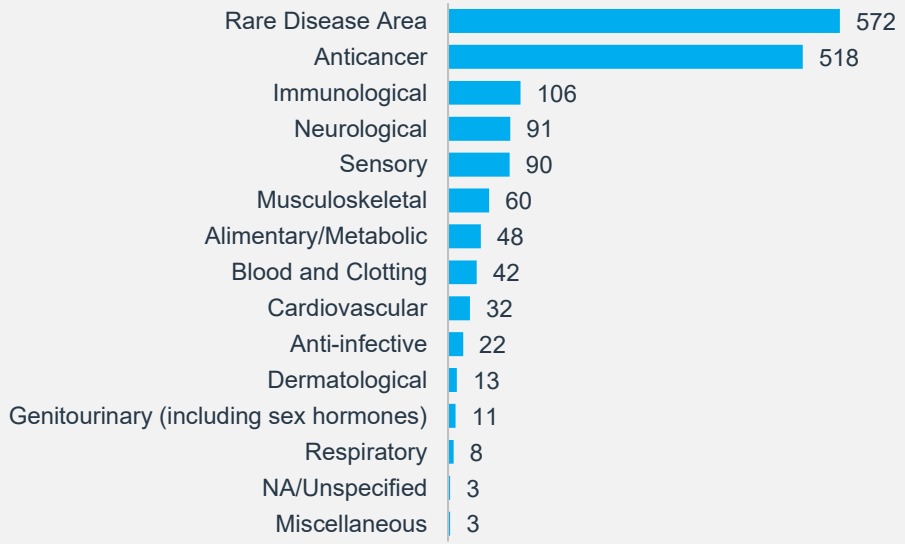
- Rare diseases and oncology remained the top areas of gene therapy development in both the overall pipeline (preclinical to pre-registration) and in the clinic (Phase I to pre-registration).
- Development for rare diseases is no longer split equally between oncology and non-oncology rare diseases, with oncology representing three percentage points higher than the previous quarter.

Number of therapies from preclinical through pre-registration



Note: Figures based on indications in pipeline development only for each therapy

Number of therapies in the clinic (excludes preclinical development)



Source: Pharmaprojects | Citeline, April 2026

From Risk to Readiness

- Gene therapy is difficult to determine if and when a claim will hit or exactly what it will cost. This is determined by individual factors, contracts, and funding mechanisms.
- What clinical can do is identify members who *may* be candidates, educate about the condition and pipeline, and identify any program or steerage opportunities where they exist.
- Projected risk still informs budgeting and stop-loss planning:

Claims analysis to identify genetic condition markers, HLA testing signals, and other individual factors

Leveraging data insights to generate population-specific risk assessments and therapy eligibility reviews

Evaluate gene therapy riders, carve-outs and outcomes-based models

Sources: HUB International 2026 Cost Management Report (hubinternational.com) | EBRI Issue Brief No. 651, Feb 2026 (ebri.org) | Aegis Risk Stop Loss Premium Survey 2025 (aegisrisk.com)

The Power of Integration

Why These Strategies Work Better Together

Each pillar delivers value independently.

Together, the impact compounds.

The pillars don’t just add up – they multiply. Each one makes the next one work harder.

The Power of an Integrated Solution

Baseline assessments build the foundational data that informs every downstream decision

Clinical informatics and predictive analytics convert that data into targeted action

Those insights drive specialty drug and gene therapy strategies like biosimilar adoption, dose optimization, contract transparency and rebate alignment that systematically eliminate waste

The same analytics reveal optimal financing structures, from reference-based pricing and spousal incentive health reimbursement arrangements (SIHRAs) to centers of excellence and gene therapy carve-outs

Your Path Forward

Where to Start

- Start where the pressure is the greatest.

- Every starting point builds toward the next.

Assess Your PBM Contract

What a contract review typically uncovers:

Hidden fees, spread pricing and administrative costs buried in contract language

Termination penalties

Rebate terms behind the market

Formulary gaps creating unnecessary cost exposure

MAC list opacity with no challenge rights

Specialty drug definition creep inflating plan spend

Audit clause limitations restricting independent review

Your 12-Month Roadmap

Month 1: Know Your Baseline

Claims analysis > Contract Review > Gene therapy exposure assessment

Months 2-3: Build Your Strategy

Prioritize interventions > Model ROI > Engage clinical support

Months 4-12: Execute and Measure

Launch > Communicate > Track and adjust

Q&A

Upcoming Events

hubinternational.com/events/

WEBINAR – Employee Benefits

What the One Big Beautiful Bill Means for Your 2027 Benefits Strategy

Wednesday, July 15 | 12 PM CT

WEBINAR – Employee Benefits

From Projections to Planning:

Making the Most of HUB's Benefits Cost Trends Report

Wednesday, July 22 | 12 PM CT

WEBINAR – Employee Benefits

Beyond Fully Insured:

Alternative Benefits Funding Strategies for Small- and Mid-Sized Employers

Wednesday, July 29 | 12 PM CT

Thank you

For more information visit **www.hubinternational.com**

Appendix

Glossary of Terms

- **Biosimilar** — A medication that is highly similar to an already-approved biologic drug. Biosimilars offer a lower-cost alternative and are increasingly used to reduce specialty drug spending.
- **Captive Solution** — An alternative insurance arrangement in which employers pool risk through a shared entity to gain greater control over claims funding, stop-loss coverage and long-term cost management.
- **Clinical Informatics** — The practice of examining healthcare data through a clinical lens to identify opportunities to improve patient outcomes and reduce costs. Used in this context to flag high-cost risk, guide site-of-care decisions and support care coordination.
- **Formulary** — A list of prescription drugs covered by a health plan, used to manage which medications are available to members and at what cost.
- **Gene Therapy** — A treatment that modifies or replaces genetic material to address the root cause of a disease. Approved therapies currently range from $913,000 to $4.25 million per treatment.
- **GLP-1 (Glucagon-Like Peptide-1 Receptor Agonist)** — A class of medications originally developed to treat Type 2 diabetes, now widely used for weight management. Examples include Ozempic® and Wegovy®. A significant and growing driver of pharmacy costs in employer-sponsored plans.
- **HLA Testing (Human Leukocyte Antigen)** — A genetic test used to identify members who may be candidates for certain gene therapies, enabling proactive risk assessment before claims materialize.
- **Medical Trend** — The rate at which healthcare costs increase year over year, driven by factors including utilization, unit cost increases, new treatments and population health changes.
- **PBM (Pharmacy Benefit Manager)** — A third-party administrator that manages prescription drug benefits on behalf of health insurers and employers, including formulary design, drug pricing, rebate negotiations and pharmacy network management.
- **Predictive Analytics** — The use of data, statistical algorithms and machine learning to identify the likelihood of future outcomes. In benefits management, used to identify high-cost claimants before conditions become severe.
- **Reference-Based Pricing** — A cost-containment strategy that sets a maximum reimbursement limit for specific medical services, typically based on a percentage of Medicare rates, rather than negotiated network rates.
- **SIHRA (Spousal Incentive Health Reimbursement Arrangement)** — An employer-funded benefit strategy that incentivizes employees to move eligible spouses onto their own employer's health plan, reducing the number of dependents on the primary plan and lowering overall plan costs.
- **Site-of-Care Optimization** — The practice of redirecting medical treatments — particularly infusion therapies — from high-cost hospital settings to lower-cost, equivalent-quality alternatives such as physician offices or ambulatory care centers.
- **Specialty Drugs** — High-cost medications used to treat complex, chronic or rare conditions, including biologics, oncology treatments and gene therapies. Though representing just 2% of all prescriptions, they account for approximately 50% of pharmacy spending.
- **Spread Pricing** — A practice in which a PBM charges an employer more for a prescription drug than it pays the pharmacy, keeping the difference as profit. Often buried in contract language and a key target of PBM contract reviews.
- **Step Therapy** — A coverage approach that requires members to try lower-cost treatment options before a plan will cover a more expensive medication, commonly applied to GLP-1 coverage for weight management.
- **Stop-Loss Insurance** — A form of reinsurance that protects self-funded employers from catastrophic or unpredictable claims by reimbursing costs above a predetermined threshold.