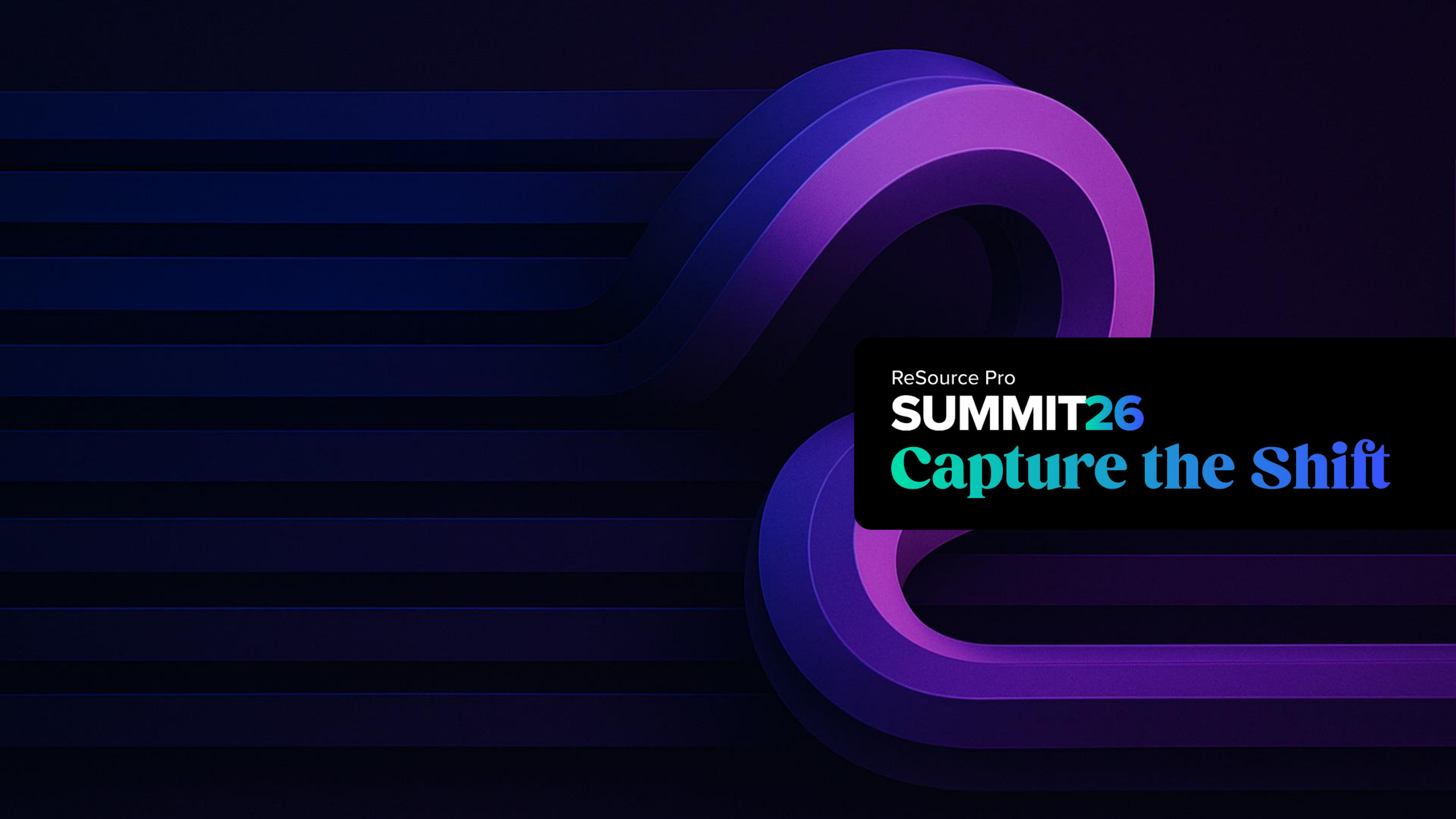


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**Capture the Shift**



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# Why, what & how to benchmark effectively



## Why now?

The stakes are higher than ever

- Healthcare = top-3 operating expense
- Cost volatility is compounding annually
- CFOs demand predictability, not surprises
- Stop-loss & specialty exposure accelerating



## What to measure

Benchmarking that actually means something

- Risk-adjusted cost vs. true peer cohorts
- Unit cost vs. utilization vs. mix shift
- High-cost claimant tail-risk exposure
- Clinical quality & future cost trajectory



## How to act

From insight to funded decision

- Separate inherited risk from controllable cost
- Diagnose root cause before choosing fix
- Connect analytics to funding & vendor strategy
- Build a predictive, not just historical, picture

These three questions shape **The Four Types of Benchmarking** — the framework that turns data into decisions.

# Rising healthcare costs: what's driving the market

**9–10%+**



Annual employer healthcare  
spending growth

2× higher than historical levels

**4% vs 10%**



What employers budget  
vs. actual trend

A dangerous gap that must be closed

Specialty  
pharmacy

50%+ of Rx spend

Chronic  
conditions

Rising post-pandemic

Delayed care  
rebound

Pent-up utilization

Provider  
consolidation

Reduced competition

Medical  
inflation

Outpacing general CPI

# The top 3 drivers of rising healthcare costs

01

## High-cost claimants & specialty drugs

The 5/50 Rule

**\$1M+**

Large claims growing in frequency & severity

**\$2M+**

Gene & cell therapies per patient

**50%**

Specialty Rx spend from only ~2% of members

02

## Chronic condition burden

Post-Pandemic Acceleration

Diabetes, hypertension, obesity, and behavioral health conditions are all rising post-pandemic — creating sustained, compounding cost pressure that isn't episodic, it's structural.

03

## Medical inflation & provider consolidation

A Market in Tension

Medical trend continues to outpace general inflation. Hospital consolidation is reducing competition — driving up costs and creating tension between carriers and health systems that ripples across the entire employer ecosystem.

Claim patterns are driving market trends — understanding the why is the foundation of smarter benchmarking.

The problem might not be your costs.  
It's how you're measuring them.



If your benchmark says you're 3% below average — does that mean you're performing well, or just underinvesting in your people?



### **Benchmarks Without Risk Adjustment**

High-risk employers look inefficient. Low-risk employers look like heroes. Neither is true.



### **Averages That Hide the Real Story**

Aggregate PEPM masks whether your cost problem is unit price, utilization, or mix shift.



### **Benchmarking Cost Without Predicting It**

A 12-month snapshot tells you where you've been — not where you're headed or what to do next.

# A complete benchmarking framework

1

## Demographic

Workforce composition

- Age / gender mix
- Salary bands & geography
- Industry risk characteristics
- Family status

What you inherit

2

## Plan design

Benefit richness

- Deductibles & OOP maximums
- Copay vs coinsurance
- Actuarial value / richness index
- HSA adoption

What you design

3

## Healthcare cost

Risk-adjusted performance

- PEPM total cost
- Medical vs pharmacy split
- Unit cost vs utilization
- High-cost claimant frequency

★ Primary focus

4

## Clinical

Quality & care management

- Preventive care compliance
- Chronic condition rates
- ER avoidable utilization
- Specialty drug adherence

Future trajectory

# What Healthcare Cost Benchmarking Should Actually Measure



## Risk-Normalized Total Cost

Benchmark what you control, not what you inherit.

- Age / gender mix
- Chronic condition prevalence
- High-cost claimant probability
- Geography



## Cost Decomposition Analytics

### Unit Cost

Provider rates | Network pricing | Allowed amounts

### Utilization

Admissions/1K | ER visits | Imaging | Rx scripts

### Mix Shift

Site-of-care | Specialty drugs | Outpatient surgical



## High-Cost Claimant Analytics

Employers chronically underestimate tail risk.

Top 1% of spend

\$250K+ claimants

GLP-1/Specialty exposure

Stop-Loss trigger probability

# Advanced cost benchmarking analytics

## Trend Benchmarking

Benchmark what you control, not what you inherit.

- Multi-year rolling trend comparison
- Pharmacy trend isolation
- Condition-specific trend (diabetes, oncology)
- Specialty drug inflation vs peer exposure

## Volatility Benchmarking

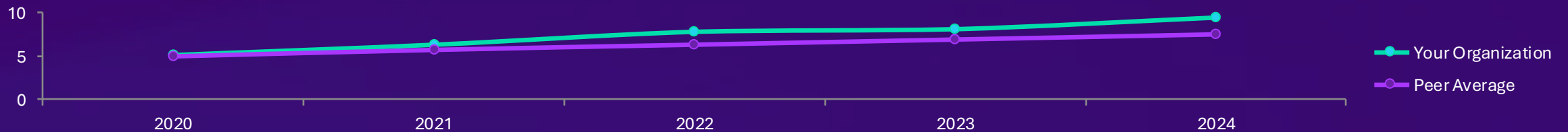
Measure stability and reserve adequacy

- Year-over-Year Variance
- Std. Deviation of Monthly Claims
- Stop-Loss Efficiency
- Reserve Adequacy Relativity

If trend exceeds peers — isolate utilization, price, or clinical management.

Unlock the power of your data to drive impactful decision-making and transform your benefits strategy.

PMPM Cost Trend: Your Organization vs. Peer Average (%)



# Data analytics | the 4-step framework

Unlock the power of your data to drive impactful decision-making and transform your benefits strategy.

1

## Descriptive Analysis

- PEPM trends over time
- Claims by category
- Top diagnoses & procedures
- Member utilization patterns

What is the historical data telling me?

2

## Diagnostic Analysis

- Cost decomposition (unit vs. util)
- Risk-adjusted peer comparison
- High-cost claimant drivers
- Site-of-care analysis

Why am I seeing a specific claim pattern?

3

## Predictive Analysis

- Multi-year trend modeling
- Stop-loss trigger probability
- Specialty drug pipeline exposure
- Chronic condition trajectory

Will a pattern continue in the future?

4

## Prescriptive Analysis

- Funding strategy optimization
- Network & vendor interventions
- Pharmacy benefit redesign
- Care management programs

What can we do now to mitigate the impact?

# Turning analytics into decisions



## Funding Decisions

- Fully insured vs self-funded
- Stop-loss attachment levels
- Risk corridor calibration
- Reserve adequacy



## Vendor & Network Strategy

- Network discount relativity
- Allowed amount per procedure
- Site-of-care differential
- Steerage program design



## Pharmacy Strategy

- Specialty penetration
- GLP-1 exposure
- Biosimilar adoption rates
- Rebates as % of gross cost

# The future of healthcare cost benchmarking

## Static 12-Month Reports Are Already Obsolete

The pace of change in specialty drugs, site-of-care shifts, and high-cost claims demands a real-time approach.

- Real-Time Dashboards**  
Continuous vs. point-in-time monitoring
- Predictive Large Claim Alerts**  
Flag high-cost trajectories before they materialize
- Micro-Cohort Benchmarking**  
GLP-1 users, oncology — not just all-member averages
- Site-of-Care Arbitrage**  
Quantify savings from shifting care settings

AI-Driven Anomaly Detection

## Emerging Capabilities



### Real-Time Dashboards

Replace static reports with always-current cost intelligence.



### Predictive Alerts

AI-flagged high-cost claim trajectories weeks in advance.



### Micro-Cohort Analytics

Benchmark GLP-1, rare disease cohorts, specialty Rx separately.



### AI Anomaly Detection

Surface billing anomalies, fraud patterns, and clinical outliers.

# Three takeaways

1

## Demographic & Plan Design Benchmarking

Explain inherited cost — separating what you're born with from what you built.

Explain inherited cost

2

## Healthcare Cost Benchmarking

Explains performance — your risk-adjusted efficiency relative to true peers.

Explain performance

3

## Clinical Benchmarking

Predicts sustainability — quality of care management driving tomorrow's cost.

Predict sustainability

Isolate what you inherit. Measure what you control. Predict what comes next.



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