SAMPLE DELIVERABLE

OneStone Physician Advisory Group

INDEPENDENT · PHYSICIAN-LED · PLAN ADVISORY

STRATEGIC ADVISORY REPORT

Health Plan Strategy & Cost Management Review

An independent, physician-led assessment of plan performance, clinical cost drivers, and prioritized opportunities for the self-funded medical benefit.

PREPARED FOR
Board of Directors & Plan Fiduciaries

PLAN SPONSOR (ILLUSTRATIVE)
Cornerstone Industries Employee Health Plan

REVIEW PERIOD
Plan Year 2025 · Outlook 2026–2027

REPORT DATE
July 20, 2026

ABOUT THIS ENGAGEMENT

Our Role & How to Read This Report

OneStone Physician Advisory Group provides independent, physician-led medical guidance for complex health plan design and cost-management decisions. We are not a broker, a third-party administrator, or a stop-loss carrier, and we do not accept commissions, override compensation, or carrier incentives tied to the recommendations in this report. Our sole obligation is to the plan sponsor and its members. That independence is the reason a practicing-physician lens can be applied to spend that is too often reviewed only through an actuarial or purchasing frame.

This report reviews Plan Year 2025 experience for the self-funded medical and pharmacy benefit and translates it into a prioritized action plan for 2026–2027. Where most vendor reporting stops at *what* was spent, our analysis focuses on *whether the spend reflected clinically appropriate, necessary, and well-coordinated care* — because that is where durable savings and better member outcomes are found together.

WHAT WE REVIEWED

- De-identified medical & pharmacy claims (24 months)
- High-cost claimant detail and case-management notes
- Plan documents, SPD, and current medical policy
- Stop-loss contract terms, lasers, and reimbursements
- Pharmacy benefit (PBM) contract & formulary
- Prior-authorization and utilization-management criteria

OUR CLINICAL LENS

- Medical necessity & evidence-based appropriateness
- Site-of-care and care-setting efficiency
- Specialty & high-cost drug clinical management
- Coordination gaps that drive avoidable cost
- Fiduciary defensibility of coverage decisions
- Member experience and access to the right care

◆ HOW TO USE THIS DOCUMENT

The Executive Summary is written for the full Board. Sections 2–4 provide the supporting analysis and clinical rationale for each finding. Section 5 presents recommendations sequenced by clinical urgency and financial return; Section 6 is a 18-month implementation roadmap. Illustrative figures throughout are representative of a plan of this size and are provided to demonstrate the structure and depth of a OneStone advisory deliverable.

SECTION 1

Executive Summary

The Plan is fundamentally sound but is absorbing cost growth faster than the market and faster than payroll. Net plan spend reached **$38.2M in PY2025, a 9.4% increase** over the prior year — in line with the national medical trend of roughly 9% but concentrated in a small number of clinically manageable areas. Encouragingly, the largest drivers of that increase are ones where physician-led review, better care coordination, and disciplined clinical policy can bend cost without shifting expense to members or reducing benefits.

$38.2M	$564	30%	24.7%
NET PLAN COST, PY2025	TOTAL COST PMPM	CLAIMS FROM MEMBERS OVER $100K	PHARMACY SHARE OF CLAIMS
▲ 9.4% vs. PY2024	▲ 9.4% trend	34 members (<1%)	▲ from 21.8%

What we found

Three findings shape the recommendations that follow. First, **high-cost claimants are driving the trend**: 34 members — fewer than 1% of covered lives — accounted for roughly 30% of gross claims, and several of these cases show opportunities for site-of-care redirection, specialty-drug optimization, and earlier clinical intervention that were not acted upon. Second, **pharmacy — led by GLP-1 and specialty drugs — is the fastest-growing category**, rising to nearly a quarter of claims spend, yet the current clinical guardrails around these agents are thin relative to the dollars at stake. Third, **the plan's utilization-management and medical-necessity framework has not kept pace** with how modern high-cost care is delivered, leaving both savings and fiduciary exposure on the table.

> ◆ PHYSICIAN'S PERSPECTIVE
>
> Nearly every dollar of avoidable cost we identified traces back to a care-delivery decision — where a service was performed, which drug was selected, whether a diagnosis was worked up efficiently — not to the price of an individual claim. That is precisely the layer a purchasing or actuarial review cannot reach, and it is why we believe the opportunity below is both real and durable.

The opportunity

Across seven initiatives, we identified **$2.7M–$3.9M in annualized opportunity (roughly 7%–10% of plan cost)**, achievable over 12–18 months without reducing the value of the benefit to members. The near-term, highest-confidence moves — physician-led high-cost claimant review, a clinical GLP-1 management framework, and specialty-drug site-of-care redirection — represent the majority of that value and can begin within one quarter.

Priority Initiative	Est. Annual Impact	Confidence	Time to Value
Physician-led high-cost claimant & case review	$900K – $1.3M	HIGH	0–6 months
Clinical GLP-1 & anti-obesity management framework	$420K – $620K	HIGH	0–4 months
Total identified opportunity	**$2.7M – $3.9M**	**≈ 7%–10% of net plan cost**	

Priority Initiative	Est. Annual Impact	Confidence	Time to Value
Specialty pharmacy & site-of-care optimization	$500K – $780K	MED–HIGH	3–9 months
Oncology medical-necessity & Centers of Excellence	$300K – $500K	MEDIUM	6–12 months
Musculoskeletal conservative-care pathways	$260K – $410K	MEDIUM	6–12 months
Stop-loss right-sizing informed by clinical risk	$180K – $300K	HIGH	At renewal
Cardiometabolic condition management	$140K – $210K	MEDIUM	9–18 months
Total identified opportunity	**$2.7M – $3.9M**	**≈ 7%–10% of net plan cost**	

Ranges reflect adoption assumptions and clinical case-mix. Estimates are conservative and net of implementation effort; they do not assume benefit reductions or member cost-shifting.

SECTION 2

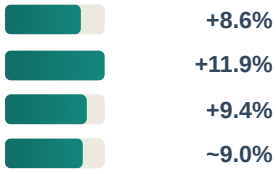
Plan Performance Snapshot

The Plan covers approximately 2,410 employees and 5,640 total lives (a 2.34 dependent ratio), generating 67,680 member months in PY2025. Overall financial performance is stable, but the composition of spend is shifting toward pharmacy and toward a shrinking group of catastrophic claimants — a pattern that rewards clinical management and penalizes a purely defensive, renewal-to-renewal posture.

Financial summary — Plan Year 2025

Component	PMPM	Annual	% of Total
Medical claims (gross paid)	$360	$24,364,800	63.9%
Pharmacy claims (gross paid)	$118	$7,986,240	20.9%
Less: stop-loss reimbursements	($32)	($2,180,000)	(5.7%)
Net paid claims	$446	$30,171,040	79.1%
Administration / TPA (ASO)	$34	$2,301,120	6.0%
Network access fees	$16	$1,082,880	2.8%
Stop-loss premium (spec + agg)	$58	$3,925,440	10.3%
Care management & other vendors	$10	$676,800	1.8%
Total net plan cost	**$564**	**$38,157,280**	**100%**

MEDICAL VS. PHARMACY TREND



WHERE THE PLAN STANDS VS. BENCHMARK

- **On-trend, not ahead of it.** Blended growth tracks the national ~9% medical / 11–12% Rx pattern — meaning current management is holding the line, not gaining ground.
- **Pharmacy is the pressure point,** now 24.7% of claims and growing fastest.
- **Concentration risk is high:** the top ~0.6% of members drove roughly 30% of claims — a small, identifiable, and therefore addressable pool.

◆ PHYSICIAN'S PERSPECTIVE

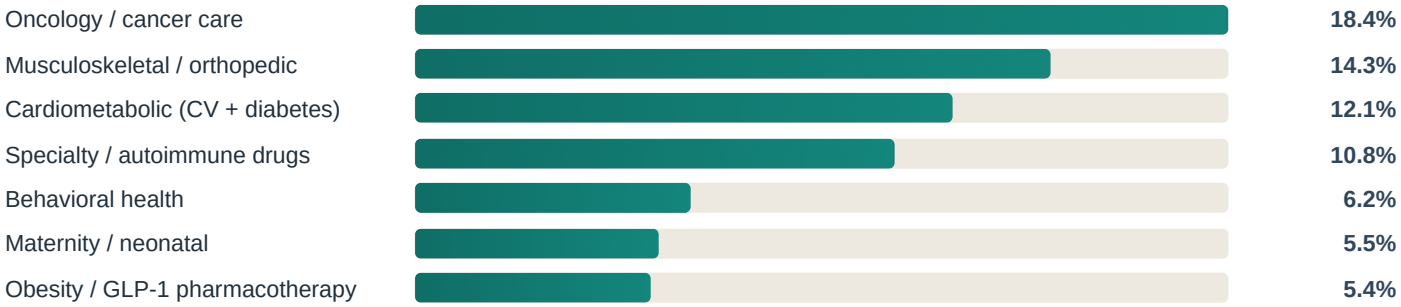
A plan growing "in line with the market" during the highest medical trend in nearly two decades is not a neutral result — it means the plan is inheriting the market's inefficiencies rather than managing around them. The concentration of spend in a small, identifiable group of members is actually good news: it means focused clinical intervention, not broad benefit cuts, is the right lever.

SECTION 3

Clinical Cost-Driver Analysis

We grouped spend by clinical condition and care setting rather than by claim type, so that the Board can see *why* cost is being incurred. The Plan's driver profile closely mirrors national employer experience, where oncology has been the leading cost driver for four consecutive years, followed by musculoskeletal and cardiometabolic disease — with obesity/GLP-1 pharmacotherapy now a rising and distinct category.

Top clinical cost drivers, PY2025 (share of total claims)



Pharmacy & the GLP-1 question

Pharmacy reached $8.0M in PY2025, with specialty drugs and GLP-1 agents accounting for the majority of the growth. Approximately **4.8% of members are now on a GLP-1** (up from 2.1% the prior year), at a gross cost of roughly **$6,500 per patient per year**. GLP-1 agents alone represent an estimated **$1.74M — about 21.8% of pharmacy spend.** National data show that nearly half of members starting a GLP-1 for obesity discontinue within 12 months, which means dollars are frequently spent without the sustained clinical benefit that justifies them.

THE CLINICAL MANAGEMENT GAP

The Plan currently covers GLP-1s for obesity with a BMI trigger but **without** a required comorbidity threshold, documented lifestyle-program participation, or a re-authorization checkpoint tied to demonstrated response and adherence. This is the single largest gap between what the Plan pays for and what the clinical evidence supports paying for.

High-cost claimants & catastrophic risk

Claimant band	# Members	Total Paid	% Gross Claims	Predominant Clinical Driver
> $1,000,000	1	$1,420,000	4.4%	CAR-T / hematologic oncology
$500,000 – $1,000,000	3	$1,980,000	6.1%	Transplant, complex NICU
$250,000 – $500,000	9	$3,060,000	9.5%	Oncology, cardiac, ESRD
$100,000 – $250,000	21	$3,190,000	9.9%	Specialty Rx, orthopedic, sepsis
Members exceeding $100K	**34**	**$9,650,000**	**≈ 30%**	**—**

◆ PHYSICIAN'S PERSPECTIVE

In our clinical review of the 13 claimants above $250K, we identified specific, documentable opportunities in the majority of cases: infusion drugs administered in a hospital outpatient setting at 2–3× the cost of a site-of-care alternative, specialty agents where a biosimilar was clinically appropriate but not used, and at least two oncology cases where a Center of Excellence second review would likely have altered the treatment pathway. These are not hindsight critiques — they are repeatable interventions when a physician reviews high-cost cases in real time.

SECTION 4

Stop-Loss & Risk Structure

The Plan carries specific stop-loss at a **$175,000 deductible** with aggregate coverage at 125% of expected. In PY2025 the Plan recovered $2.18M against $3.93M of premium — a reasonable but not exceptional relationship that warrants active management rather than passive renewal. As catastrophic claims concentrate, stop-loss strategy and clinical management become two halves of the same decision: the better the Plan manages high-cost cases clinically, the more leverage it has at renewal.

Stop-loss element	Current position	OneStone observation
Specific deductible	$175,000	Modeling supports testing $200K–$225K given the Plan's claim frequency; potential premium savings exceed retained risk.
Lasers	2 lasered claimants	Both are clinically stabilizing; a physician-supported renewal narrative can challenge one laser.
Aggregating specific	None	Worth pricing as a middle option between deductible increase and status quo.
Contract basis	Paid 12/12	Confirm run-in/run-out terms align with any TPA change.
Renewal posture	Passive / broker-led	Carriers price uncertainty; clinical documentation on trajectory of large claimants reduces it.

◆ PHYSICIAN'S PERSPECTIVE

Stop-loss carriers laser and load premium when they cannot predict where a large claimant is headed. A credible physician assessment of a claimant's clinical trajectory — whether a course of therapy is ending, whether a condition is stabilizing — is often the difference between a punitive renewal and a fair one. This is advocacy the Plan currently is not bringing to the table.

SECTION 5

Strategic Recommendations

Each recommendation below pairs a clinical rationale with an estimated financial impact and the specific actions required. They are sequenced so that the highest-confidence, fastest-return initiatives begin first and help fund the rest.

1 Physician-Led High-Cost Claimant & Case Review

$900K – $1.3M

Stand up a standing clinical review, led by a OneStone physician, for every member crossing $75K in annualized spend — focused on site-of-care, drug selection, care coordination, and Center-of-Excellence eligibility while care is still in progress.

CLINICAL RATIONALE
Real-time review changes trajectories; retrospective review cannot.

KEY ACTIONS
Trigger list, physician case rounds, TPA data feed, intervention log.

OWNER
OneStone medical lead + TPA case management.

CONFIDENCE
HIGH · Time to value 0–6 mo.

2 Clinical GLP-1 & Anti-Obesity Management Framework

$420K – $620K

Retain coverage but add evidence-based guardrails: comorbidity threshold in addition to BMI, required lifestyle/nutrition program participation, and a response-and-adherence re-authorization at 4 and 9 months to stop paying for therapy members have abandoned.

CLINICAL RATIONALE
~48% discontinue within a year; pay for demonstrated benefit, not starts.

KEY ACTIONS
Update PA criteria, member communication, PBM configuration.

OWNER
OneStone + PBM clinical account team.

CONFIDENCE
HIGH · Time to value 0–4 mo.

3 Specialty Pharmacy & Site-of-Care Optimization

$500K – $780K

Redirect clinically appropriate infusions from hospital outpatient to home or free-standing settings, and implement a biosimilar-preferred pathway with physician review of exceptions. Add a specialty prior-authorization tier for agents above $15K/course.

CLINICAL RATIONALE
Same drug, same outcome, materially lower cost and often better member experience.

KEY ACTIONS
Site-of-care policy, biosimilar formulary edits, exception review.

OWNER
OneStone + PBM + TPA.

CONFIDENCE
MED–HIGH · Time to value 3–9 mo.

4 Oncology Medical-Necessity & Centers of Excellence

$300K – $500K

Introduce an expert-second-opinion and Center-of-Excellence pathway for new complex cancer diagnoses, with physician review of treatment plans against national guidelines before high-cost therapy begins.

CLINICAL RATIONALE
Guideline-concordant care improves outcomes and avoids low-value, high-cost regimens.

KEY ACTIONS
COE contracts, referral triggers, member navigation support.

OWNER
OneStone medical lead.

CONFIDENCE
MEDIUM · Time to value 6–12 mo.

5 Musculoskeletal Conservative-Care Pathways

$260K – $410K

Require documented conservative care and a surgical second opinion before elective spine and major joint procedures, paired with a physical-therapy-first benefit design and site-of-care steerage for imaging and surgery.

CLINICAL RATIONALE
A meaningful share of elective ortho is avoidable or premature; PT-first improves function.

KEY ACTIONS
Pathway criteria, second-opinion vendor, benefit-design nudge.

OWNER
OneStone + TPA UM.

CONFIDENCE
MEDIUM · Time to value 6–12 mo.

6 Stop-Loss Right-Sizing Informed by Clinical Risk

$180K – $300K

Enter renewal with a physician-authored assessment of each large claimant's trajectory, test a higher specific deductible against modeled retained risk, and actively contest lasers where the clinical course supports it.

CLINICAL RATIONALE
Priced uncertainty is expensive; clinical clarity is leverage.

KEY ACTIONS
Claimant trajectory memos, deductible modeling, market RFP.

OWNER
OneStone + broker of record.

CONFIDENCE
HIGH · Time to value at renewal.

7 Cardiometabolic Condition Management

$140K – $210K

Target the diabetes/hypertension/hyperlipidemia population with medication-adherence support and primary-care coordination to reduce downstream cardiac and renal events — the long-tail complement to the GLP-1 framework.

CLINICAL RATIONALE
Controlled cardiometabolic disease prevents the six-figure events downstream.

KEY ACTIONS
Registry, adherence outreach, PCP coordination.

OWNER
OneStone + care-management vendor.

CONFIDENCE
MEDIUM · Time to value 9–18 mo.

SECTION 6

Implementation Roadmap

The sequence below front-loads the highest-confidence initiatives so early savings help fund later work, and aligns structural changes (stop-loss, specialty policy) with the renewal calendar.

MONTHS 0–3

Foundation

- Stand up physician-led high-cost claimant review and data feed with the TPA.
- Finalize and file updated GLP-1 clinical criteria with the PBM; launch member communication.
- Complete clinical review of all active claimants above $250K.

MONTHS 3–9

Build

- Deploy specialty site-of-care and biosimilar-preferred pathways.
- Contract Centers of Excellence for oncology, transplant, and complex surgery.
- Prepare physician-authored stop-loss renewal package ahead of marketing.

MONTHS 9–18

Optimize

- Launch musculoskeletal conservative-care pathways and second-opinion benefit.
- Activate cardiometabolic condition-management program.
- Establish quarterly clinical/financial dashboard and Board reporting cadence.

◆ GOVERNANCE NOTE

We recommend a standing quarterly review with the Board's benefits committee, at which OneStone reports realized savings against this plan and refreshes the claimant-risk picture. Clinical cost management is not a one-time project; it is an operating discipline.

SECTION 7

Projected Financial Impact

$2.7–3.9M	$1.3–1.9M	~7:1	0
ANNUALIZED OPPORTUNITY	ACHIEVABLE IN YEAR 1	EST. RETURN ON ADVISORY FEE	BENEFIT REDUCTIONS REQUIRED
7%–10% of plan cost	**near-term initiatives**	**conservative case**	**no member cost-shift**

Initiative	Year 1	Run-Rate (Yr 2+)	Basis
High-cost claimant & case review	$550K	$900K–$1.3M	Site-of-care, drug selection, coordination
GLP-1 / anti-obesity framework	$420K	$420K–$620K	Adherence gating, discontinuation savings
Specialty pharmacy & site-of-care	$300K	$500K–$780K	Setting redirection, biosimilars
Oncology COE & medical necessity	$120K	$300K–$500K	Guideline concordance, second opinion
Musculoskeletal pathways	$90K	$260K–$410K	Conservative-care-first, surgical review
Stop-loss right-sizing	$180K	$180K–$300K	Deductible & laser optimization
Cardiometabolic management	$40K	$140K–$210K	Event avoidance (lagged)
Total	**≈ $1.7M**	**$2.7M – $3.9M**	**Illustrative, conservative**

Projections are illustrative and depend on adoption, clinical case-mix, and vendor cooperation. They are intended to demonstrate the structure and rigor of a OneStone impact model, not to serve as a guarantee of savings.

Recommended next step

With the Board's direction, OneStone will convert this assessment into a signed 90-day work plan beginning with the high-cost claimant review and GLP-1 framework — the two initiatives that deliver the fastest, highest-confidence return — and will report realized impact at the next quarterly meeting.

APPENDIX

Methodology, Benchmarks & Important Notices

METHODOLOGY

Findings are based on physician review of 24 months of de-identified medical and pharmacy claims, high-cost claimant detail, plan and stop-loss documents, and utilization-management criteria. Cost-driver categorization groups claims by clinical condition and site of care. Savings estimates apply conservative adoption and case-mix assumptions and are presented as ranges. All member-level clinical review is conducted by licensed physicians under appropriate privacy safeguards.

BENCHMARK SOURCES

Market context in this report draws on published 2025–2026 employer health benchmarks, including the Business Group on Health 2026 Employer Health Care Strategy Survey (9.0% projected trend; cancer as the leading cost driver for a fourth consecutive year; ~24% pharmacy share), the Segal 2026 Health Plan Cost Trend Survey (median 9% medical, double-digit Rx trend), PwC Health Research Institute Medical Cost Trend (9% group-market trend; GLP-1 and behavioral-health drivers), and published GLP-1 utilization and discontinuation data. National figures are used for context; all plan-specific figures in this sample are illustrative.

INDEPENDENCE STATEMENT

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