PLAN SNAPSHOT™

Plan Snapshot helps you quickly gain insight on how to address some of the most critical elements of adopting a high-performance health plan. It is a subset of the Health Rosetta Plan Grader that looks at the 40 most important factors for adopting a high-performance health plan. A Plan Grade helps you build a thorough strategy for improving your health plan by adopting the Health Rosetta framework.

The following pages contain custom recommendations based on your Plan Snapshot responses to help you focus your efforts. This is followed by a more in-depth description of each Health Rosetta component within the overall context of the LOCAL adoption framework that lays out the path to provide better benefits for 20-40% less spend than status quo health plans.

SAMPLE CORP.
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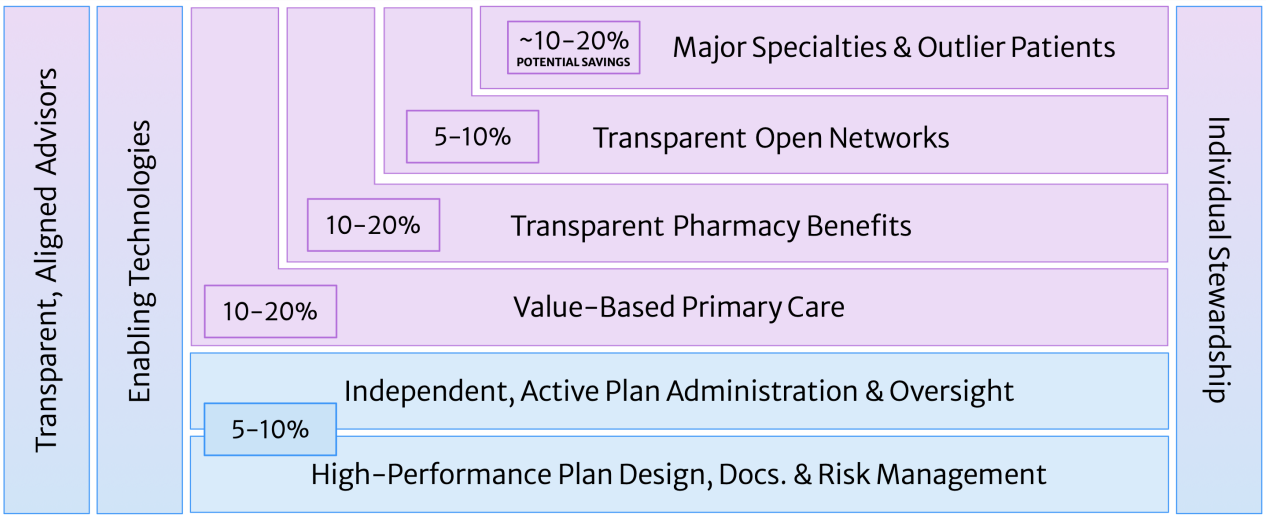
Health Rosetta Components for Building High Performance Health Plans



What is the plan's current funding mechanism?

The truth is that all employers are self-funded. Why do we say that? If you have higher than expected claims in one year, a fully-insured carrier will recapture those losses and more in subsequent years. Even worse, a bad year with a fully-insured carrier resets your baseline, ensuring that every subsequent year will have higher premiums. In other words, you will always lose in the current fully-insured environment and need to do something differently to expect different results. Intelligent self-funding strategies can both effectively manage risk and ensure that one bad year doesn't affect you for the next decade.

YOUR RESPONSE: **Self-funded w/ stop-loss**

KEY ISSUES

Congratulations, you're already tackling some version of self-funding. You now have additional flexibility to optimize your plan and capture cost savings. However, your next renewal should focus on ensuring your current program and vendors are providing you with the flexibility necessary. This may include changing underwriters or stop loss carriers, or ensuring that your contract is giving you the right level of risk mitigation. You may also need to change your plan administrator to effectively tackle this issue since many carrier-administered self-funded programs operate largely unchanged from status quo fully-insured health plans.

What has your average renewal rate increase been for the past 3 years? (aka trend)

While most plans see renewal rates of 5-10% or more every year, this isn't something you need to accept. High performing plans built on the Health Rosetta framework around the country by all sorts of organizations have been able to meaningfully reduce their spend by 20-40%.

YOUR RESPONSE: **7-9%**

KEY ISSUES

Your renewal rates are in the range of typical plans. However, you should demand much better. To start down this path, consider adopting a plan built on the Health Rosetta framework. The next step is to complete a Plan Grade with your Health Rosetta Advisor. This will give you the direction necessary to build an effective strategy for a high performance plan.

Does the Plan Sponsor have a 2-3 year plan strategy?

Organizations have long-term plans for all critical functions (e.g., sales, HR, finance, etc.), yet often only plan on 12-month cycles for health plans. The most successful organizations have 2-3 year health plan strategies to help ensure long term cost containment and improve employee retention. Many of the most successful organizations we've seen retain employees for 5-10 years.

YOUR RESPONSE: **Yes**

KEY ISSUES

Congratulations for having a 2-3 year health plan strategy. The next step is to regularly review and work with your advisors to ensure that strategy is comprehensive.

Does the Plan Sponsor currently have unrestricted access to full claims data (not just reports)?

Put simply, if you don't have unrestricted access to full claims data, you can't effectively manage your plan. An experienced benefits advisor can almost always help you get full access to claims data from existing vendors or help you select new ones. The more difficult your claims administrator makes it, the more you can guarantee bad things are happening in your plan. Note that if you're fully-insured, you'll need to change your funding structure to access this data.

YOUR RESPONSE: **Yes, medical and pharmacy**

KEY ISSUES

Congratulations, you've secured access to your plan's critical claims data. We recommend reviewing the data you receive to ensure that you have all fields necessary to perform any data analyses. A good advisor will be able to support you on this.

How does the plan incentivize members to seek lower-cost and/or higher-quality care?

Traditional plan design changes are frequently insufficient incentives. High-performing plans create more compelling incentives and innovative plan design features to simplify making care decisions that lower costs and/or improve quality. Fortunately, higher quality care is usually lower cost care too, the opposite of what we experience in the rest of life.

YOUR RESPONSE: **None; Other; Reduced/no cost share for specific medications; Reduced/no cost share if work with advocate/concierge/navigator**

KEY ISSUES

Congratulations, you're already employing more advanced incentives that are typically more effective. You might want to review during your next renewal, but your strategy may be working as intended and any improvements will come from member education.

ADDITIONAL RECOMMENDATIONS

By not differentiating between high-value and low-value medications, your health plan plays into the hands of one of the most sophisticated industries that knows how to maximize profits at your expense.

What types of human support do members have access to through the plan?

As much as we may like digital self-service tools, when healthcare is complex or expensive, it also gets scary. Human support from trusted resources is critical. The highest-performing plans ensure that members have a single point person to go to for support. Ideally, this person (e.g., member champion, nurse navigator, primary care doctor, etc.) has built trust with the member before a complex need arises.

YOUR RESPONSE: **Advisor firm account team; Benefits concierge/advocate/navigator; Health Literacy/Education programs; PBM customer service; Plan administrator customer service**

KEY ISSUES

Having some form of human support for members goes a long way in making sure members are getting the care they need. Whichever form you choose, make sure it's consistent, easy to follow, and effective.

ADDITIONAL RECOMMENDATIONS

Congratulations on having a type of benefits concierge/advocate/navigator/champion to support members through a wide range of issues. Some are more focused on clinical issues while others are more focused on care and benefits logistics/education support. We recommend working with your advisor during your next renewal to ensure your solutions address all of these issues. Frequently, advanced primary care is part of the most effective strategies.

Did the plan's benefits advisor, completely disclose all direct and indirect compensation in a timely manner?

Trust is built on transparency and openness. The benefits industry is rife with conflicts of interest and hidden compensation that undermines this trust. The latest regulations requiring consultants and brokers to disclose direct and indirect compensation will help make it easy for you to surface these conflicts. Frequently, we view that the best advisors are undercompensated, while everyone else is over-compensated in ways they're not telling you about.

YOUR RESPONSE: **Yes**

KEY ISSUES

By requesting disclosure of all compensation sources, you've already created the foundation for a trusted relationship with your advisor and are further ahead than most plans. The latest regulations are increasing the breadth and depth of disclosures. Be sure you receive these before making critical decisions. Additionally, request disclosure on compensation for voluntary and non-health benefits as well to get a full picture.

What type of plan administrator does the plan use?

Once you have the right advisor, the next most important decision is most likely to be selecting the right plan administrator. Your plan administrator is a critical partner to building a high-performance plan. The right administrator will give you the necessary flexibility and experience to create the best health plan to

improve care and lower costs, letting you attract and retain a great workforce.

YOUR RESPONSE: **Carrier-owned TPA**

KEY ISSUES

There is a lot of variability in the flexibility that Carrier-owned TPAs allow. We've seen some very progressive, high-performing plans leverage a carrier-owned TPA to adopt their goals, but frequently they limit the flexibility you need to improve care and lower costs, won't agree to critical contractual or data requirements, or lack capabilities and/or experience in certain strategies.

Does the plan's Third-Party Administrator (TPA) allow the Plan Sponsor to select its Pharmacy Benefits Manager (PBM)?

A common attribute of good plan administrators is that they'll let you select the right PBM, so long as you give them enough time to appropriately integrate with a PBM they haven't worked with before.

YOUR RESPONSE: **Yes, but only to certain PBMs**

KEY ISSUES

Whether you can't choose your own PBM, aren't sure, or you can only select certain approved ones, your flexibility to select the best options for your group is limited. You should dive into this issue with your advisor at your next renewal. If you're fully-insured, consider some form of self-funding at your next renewal.

ADDITIONAL RECOMMENDATIONS

Note that there are reasonable reasons a plan administrator might not want to integrate with new PBM's they haven't worked with before. Be sure to understand why they only want to work with certain PBMs. Specifically ask if they receive compensation from their partnered PBMs.

Which major specialty area(s) does the plan have specific

strategies and programs for?

In a given year, as few as 6% of members can account for 80% of your total plan spend. This spend typically falls into major specialties where getting individuals to the best care possible is paramount. In some cases, the unit cost of care may even be more expensive. Tackling these major specialties is typically a combination of plan design, second opinions, access to center of excellence, focused vendor selection (sometimes), and effective care navigation.

YOUR RESPONSE: **MSK/Orthopedic; Mental/Behavioral health; Non-specialty drugs; Specialty drugs**

KEY ISSUES

There are a wide range of specialty areas that require specific strategies to tackle. Because of the breadth of this, we recommend working with your advisor to create, review, and/or improve your strategy to address these specialties. We've found that frequently the most effective place to start is cancer, orthopedics, maternity, transplants, specialty drugs, and mental health because they can have the most immediate improvements in both cost and quality, as well as being high cost and utilization specialties in nearly every plan.

Remember, building a strategy for each specialty doesn't mean having a separate vendor for each specialty. Frequently, advanced primary care can tackle at least some elements of an effective strategy for every specialty, so that may be a great place to start.

ADDITIONAL RECOMMENDATIONS

Dialysis and End Stage Renal Disease should be high on your list of specialties to tackle because there are a number of options available to effectively tackle these high-cost conditions.

Transplants are a must-tackle specialty because of the risk they post to your plan's viability. They aren't common, but they have enormous costs and there are many mature options in the market to tackle the cost and quality of them.

Research shows that more than 25% of all cancer cases are either misdiagnosed or have an inappropriate treatment plan, making it one of the most important specialties to address.

What types of add-in pharmacy programs and strategies does the plan leverage?

Leaving no stone unturned is a good drug procurement rule of thumb. Targeted add-in pharmacy

programs can provide strong financial returns without major changes to the plan. These are often where many plans start their journey. However, some strategies have complex nuances (such as compliance issues) to navigate, so selecting the right options requires working with the right advisors.

YOUR RESPONSE: **Co-pay assistance; International sourcing; Manufacturer assistance programs; Specialty drug carve outs**

KEY ISSUES

Congratulations, looks like you've adopted at least some add-in strategies provided by your PBM or a third party vendor. However, we recommend reviewing claims data to ensure you're tackling as many issues as possible with your current strategy. Also, note that some of the strategies here have complex compliance issues that need to be effectively discussed and addressed with your advisor independently of what vendors try to sell you.

ADDITIONAL RECOMMENDATIONS

Manufacturer Assistance and International Drug Sourcing programs are two examples of strategies with complex compliance and tax issues that should be effectively addressed.

What Value Based Primary Care strategies does the plan employ?

There is no single "right" model for improving primary care. Consider your population's geographic distribution, tech savviness, and the number of workers in a given location to identify the best options for your organization. Be sure to have an advisor who is well-versed in the trade-offs of the various options.

YOUR RESPONSE: **None**

KEY ISSUES

Without effective primary care, your members become their own de facto primary care provider, forcing them to make complex decisions they generally lack the skills to do, particularly when dealing with complex medical conditions and procedures. 70% of people with medical bill driven bankruptcies had "insurance" and preventing this starts with primary care. We recommend working with your advisor to select the right strategy for your plan. We've observed that nearly any employer can adopt direct primary care, onsite/nearsite clinics, and/or advanced virtual primary care.

ADDITIONAL RECOMMENDATIONS

Be sure you do your due diligence on virtual primary care organizations.

Some simple telehealth companies have done little more than rebrand themselves as virtual primary care. In contrast, the best virtual primary care models have rethought care delivery and accompanying risk management from the ground up. The best produce outcomes that are comparable to other Advanced Primary Care providers.

LOCAL FRAMEWORK SUMMARY

The Health Rosetta framework is modeled on the successes of hundreds of high-performance plans. Your Plan Snapshot™ gets you started on the path to repeat what they've done. The LOCAL adoption framework simplifies this path.

L - Learn how to be liberated from the status quo

O - Optimize health plan infrastructure (e.g., risk mgmt., plan design, plan admin, plan docs/contract, data analyses, compliance)

C - Carve out Pharmacy Benefit Manager (PBM)

A - Add Value Based Primary Care (e.g., DPC and near site clinics)

L - Leave behind value-extracting PPO networks (e.g., direct contracting, bundles, cash pay, RBP)

Using the LOCAL process to adopt the Health Rosetta framework can help you provide better benefits for 20-40% less spend than status quo health plans. Four of the LOCAL steps are either positive to members or completely invisible to members, reducing fears of requiring major change. It also helps you offer benefits that attract and retain your workforce by freeing up resources to support your bottom line, people, and community.

Learn how to be liberated from the status quo

Transparent Advisor Relationships

Identify an advisor with aligned and transparent incentives that develops a 3-5 year strategy with you that is tailored to your specific objectives and constraints.

- Knows, manages, and discloses all advisor and vendor compensation sources and conflicts of interest
- Provides cost containment and risk mitigation strategies
- Doesn't just shop carrier-controlled plans with "shock" renewal rates that perpetuate rapidly rising costs

Optimize health plan infrastructure

(e.g., risk mgmt., plan design, plan admin, plan docs & contracts, data analyses, compliance)

High-Performance Plan Design, Docs, and Risk Mgmt.

The contracts and plan documents are reviewed by a qualified third-party to ensure your plan is fully compliant and optimized to provide the best benefits at the lowest cost.

- Fully-compliant ERISA plans that protect your plan from abuse
- Aligned plan and vendor documents that create 360 degree risk mitigation
- Stop-loss and underwriting best practices to ensure plan assets are protected
- Smart plan design that incentivizes members to make smart healthcare decisions and reduces their costs, the key to a better member experience

Independent, Active Plan Management

All plan vendors have aligned incentives to lower health plan costs and improve quality, and you have the tools to oversee the plan and your vendors.

- Plan vendors with aligned incentives
- Third-party administration proactively manages claims and payments, leverages risk mitigation strategies, and pulls together the pieces of your plan
- Data access and analyses that empower you to oversee, audit, intervene, and improve your plan

Individual Stewardship

Members have resources to help navigate healthcare's complexity and cost, supporting care journeys and benefit needs.

- Plan members have access to people and tools that help navigate benefits & care
- Quality and cost resources to help seek care at high value providers
- Information is clear and accessible, and plan members know where to get help

Carve out Pharmacy Benefit Manager (PBM)

Transparent Pharmacy Benefits

Transparency and control over PBM services and drug costs.

- All pharmacy costs and expenses are known and contractually agreed to with the ability to audit
- Ensure clinical decisions are based solely on efficacy and actual drug costs
- Aligned incentives that work on behalf of the member and plan's best interests

Add Value Based Primary Care (e.g., DPC and near site clinics)

Value Based Primary Care

Primary care with aligned incentive to achieve the Quadruple Aim (improve the care team experience, which naturally leads to an improved patient experience, in turn, leading to improved health outcomes and lower plan costs).

- 24/7 access to primary care team
- Member access to same or next day appointments
- A clinical team that proactively manages the health of the member population

Leave behind value-extracting PPO networks

(e.g., direct contracting, bundles, cash pay, RBP)

Transparent Open Networks

Access to care providers at fair, transparent prices to employer and members with high-quality care and reporting.

- Providers can set transparent prices agreed to by the plan
- Plan design that incentivizes members to go to preferred providers at no cost to them
- No surprise bills for employers or members

Major Specialties and Outlier Patients

Access to evidence-based and disease-specific care navigation, pathways, and treatment protocols.

- Second opinions and centers of excellence at no charge for employees
- Lower complication rates & avoidance of unnecessary procedures
- Highly coordinated care with defined handoffs between care providers

ABOUT HEALTH ROSETTA

The Health Rosetta accelerates adoption of simple, practical, non-partisan fixes to our healthcare system. It leverages bright spots in employer-sponsored healthcare where employers across the country are delivering exceptional healthcare outcomes and benefits at 20-40% of the cost. Health Rosetta blueprint is made up of 8 components that when adopted can deliver exceptional benefits at a 30% cost savings to the employer.