PLAN GRADER™

The first comprehensive independent plan assessment to measure and improve your health plan strategy

Plan Grader ™ is an independent 360° health plan risk assessment that provides actionable insights to create an effective 3 - 5 year strategy to lower costs and improve benefits.

Plan Grader ™ is built on the Health Rosetta's **eight components** that have been modeled on the successes of hundreds of high-performance plans.

1. Transparent Advisor Relationships
2. High-Performance Plan Design, Docs, and Risk Mgmt.
3. Independent, Active Plan Management
4. Individual Stewardship
5. Value Based Primary Care
6. Transparent Open Networks
7. Major Specialties and Outlier Patients
8. Transparent Pharmacy Benefits

See how your health plan benchmarks to other employers

Why Plan Grader™?

Health plan costs are typically one of an organization's top three expenses. Yet, there haven't been comprehensive third-party assessments to help you understand how your plan is operating, compares to high performance plans, or provides detailed best practices and strategies to improve your plan.

Plan Grader™ provides this objective evaluation that helps you understand where you are today and what to focus on to adopt proven strategies.

Plan Grader™ provides the insight you need to mitigate risk from a 360° perspective, including medical risk, member engagement risk (e.g., proper communications and change management to ensure success), organizational and member financial risk, and legal risk (fiduciary obligations and compliance).

Independent, third-party assessment of your health plan

Build a better strategy one step at a time

See how your plan compares to other employers

Schedule your Plan Grader assessment with your Health Rosetta Advisor

COVERICA
INSURANCE & RISK MANAGEMENT

Mark C. Holland, CES, CHRS
President of Benefits
Direct/Mobile 901-355-3500
Office 469-902-7665

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www.HealthRosetta.org

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PLAN GRADER™
360 Plan Strategy Questions

Plan Sponsor Name:
Date:

Plan Grader Sponsor Profile

1. **Who is deeply involved in your plan's annual review? Please select all that apply.**

- ☐ Human Resources
- ☐ CFO/Finance
- ☐ Employee Representatives
- ☐ CEO/President
- ☐ Other Executive Managers
- ☐ Other (please specify)

2. **Does the Plan Sponsor have a 3-5 year plan strategy?**

- ☐ Yes
- ☐ No
- ☐ Unsure

3. **How Does the Plan Sponsor currently communicate to members?**

- ☐ Benefits satisfaction surveys
- ☐ Meetings with administrator/carrier reps
- ☐ Health fairs
- ☐ Virtual open enrollment meetings
- ☐ In-person open enrollment Meetings
- ☐ HRIS/BenAdmin/Benefits portal
- ☐ Physical handouts
- ☐ Regular employee meetings
- ☐ Regular bulk emails
- ☐ General intranet
- ☐ Employee benefits committee
- ☐ Physical mailings
- ☐ Office hours with HR/benefits teams
- ☐ Onsite materials (e.g., posters in break rooms)
- ☐ Other
- ☐ None

4. **Does the Plan Sponsor have a standing employee benefits committee, focus group, etc.?**

- ☐ Yes, management and non-management
- ☐ Yes, management only
- ☐ No

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5. **How frequently does the Plan Sponsor communicate with employees about benefits?**

- ☐ Weekly
- ☐ Monthly
- ☐ Bi-Monthly
- ☐ Quarterly
- ☐ Varies
- ☐ Unknown

6. **Does the Plan Sponsor warehouse their claims data independently of their plan administrator, advisor, or analytics tool?**
This separate data storage should allow the group to access data without permission from a specific vendor.

- ☐ Yes
- ☐ No
- ☐ Unsured

Plan Grader Plan Infrastructure

1. **How does the plan incentivize members to seek lower cost and/or higher quality care?** Please select all that apply.

- ☐ Reduced/no cost share when independent primary care refers care
- ☐ Waive deductible/co-insurance for specific care
- ☐ Waive deductible/coinsurance at specific providers
- ☐ Time off for screening and preventative care
- ☐ Reduced/no cost share if work with advocate/concierge/navigator
- ☐ Optimizing copays by service type
- ☐ Premium reductions for Wellness program participation
- ☐ Reduced/no cost share for specific medications
- ☐ Other
- ☐ None

2. **How does the plan penalize members for not seeking lower cost and/or higher quality care?** Please select all that apply.

- ☐ Coverage penalties for failing to precertify certain services
- ☐ Coverage penalties for not following care recommendations
- ☐ Coverage penalties for not working with advocate/concierge/navigator
- ☐ Coverage penalties for not seeking referral from primary care provider
- ☐ No coverage for not seeking referral from primary care provider
- ☐ Other
- ☐ None

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3. **What member cost share waivers does the plan leverage?** Please select all that apply.
Cost share waivers can mean any type of preferred benefits tier, specific program, or some other approach where the member's responsibility is meaningfully reduced or removed, such as waiving deductible and coinsurance when members go to certain care providers.

- ☐ Coinsurance amounts
- ☐ Co-pays
- ☐ Premium holidays
- ☐ Premium credits
- ☐ Deductibles
- ☐ Other
- ☐ None

4. **Does the plan include incentives for seeking a second opinion for certain diagnoses or procedures?**

- ☐ Yes, coverage requires getting and following second opinion
- ☐ Yes, coverage requires getting second opinion
- ☐ Yes, financial incentive to obtain and follow
- ☐ Yes, financial incentive to obtain
- ☐ Yes, optional
- ☐ No

5. **Which diagnoses and/or procedures are plan members incentivized to seek a second opinion?**
This could be through plan design, specific vendors, communication, etc.

For example, the group might not have a specific second opinion vendor, but have an onsite clinic where doctors regularly encourage second opinions.

- ☐ MSK/Orthopedic
- ☐ Dialysis
- ☐ Cardiometabolic/Diabetes
- ☐ Mental/Behavioral Health
- ☐ Substance Abuse
- ☐ Tobacco use
- ☐ Specialty drugs
- ☐ Transplant
- ☐ Cancer
- ☐ Elective surgeries/procedures
- ☐ Non-specialty drugs
- ☐ Maternity
- ☐ Other elective hospitalizations
- ☐ Other chronic conditions
- ☐ Other
- ☐ Don't know
- ☐ None of the Above

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6. **What types of digital tools do members have access to?** Please select the most applicable options. For example, if members access a BenAdmin portal, don't select enrollment only tools. Enrollment-only tools are used one time to enroll, but aren't available on an ongoing basis to members

- ☐ Full HRIS/BenAdmin portal
- ☐ Online enrollment-only tool
- ☐ Member concierge/advocate/navigator app or web portal
- ☐ Mobile app for all benefits
- ☐ Medical+Pharmacy mobile app
- ☐ Pharmacy-only mobile app
- ☐ Medical-only mobile app
- ☐ Web portal for all benefits
- ☐ Medical+Pharmacy web portal
- ☐ Pharmacy-only web portal
- ☐ Medical-only web portal
- ☐ None

7. **What types of human support do members have access to?** Please select all that apply.
Note that a specific support source may fulfill multiple roles.
Member Champion's have regular, in-person interactions with members. Often, they are nurses.

- ☐ Health Literacy/Education programs
- ☐ Health coach
- ☐ Member champion at advisor firm
- ☐ Care/clinical concierge/advocate/navigator
- ☐ Benefits concierge/advocate/navigator
- ☐ Plan Sponsor's HR Team
- ☐ Designated member champion at plan sponsor (not just HR team)
- ☐ Advisor firm account team
- ☐ PBM customer service
- ☐ Plan administrator customer service
- ☐ Other
- ☐ None

8. **Did the plan's benefits advisor completely disclose all direct and indirect compensation in a timely manner?**
At minimum, this disclosure should meet the requirements of the new broker compensation transparency rules.

- ☐ Yes
- ☐ No

9. **Which of the plan's solution partners contractually agree to disclose all direct and indirect sources of compensation?** Please select all that apply.

- ☐ TPA
- ☐ Carrier (if Fully-Insured)
- ☐ PBM
- ☐ Underwriter
- ☐ Concierge Service
- ☐ Network/Repricer
- ☐ Medical Add-in Solutions
- ☐ Pharmacy Add-in Solutions
- ☐ All other solutions
- ☐ None of the Above
- ☐ Unknown

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10. **Who reviews the plan's SPD/Plan Documents?** Please select all that apply.
Non-Attorney Consultants include all reviews by subject matter experts who do not legally represent the plan sponsor or advisor firm.

- ☐ Plan Sponsor's ERISA attorney
- ☐ ERISA attorney at the advisor's firm
- ☐ Non-attorney consultant
- ☐ Benefits Advisor
- ☐ No non-TPA review
- ☐ Other
- ☐ Unknown
- ☐ Not Applicable

11. **Who reviews the plan administrator's Administrative Services Agreement (ASA)**? Please select all that apply.
Non-Attorney Consultants include all reviews by subject matter experts who do not legally represent the plan sponsor or advisor firm.

- ☐ Plan Sponsor's ERISA attorney
- ☐ ERISA attorney at the advisor's firm
- ☐ Non-attorney consultant
- ☐ No independent review
- ☐ Benefits Advisor
- ☐ Other
- ☐ Unknown
- ☐ Not Applicable

12. **Who reviews the plan's PBM contract?** Please select all that apply.
Non-Attorney Consultants include all reviews by subject matter experts who do not legally represent the plan sponsor or advisor firm.

- ☐ Benefits advisor
- ☐ Non-attorney pharmacy consultant
- ☐ ERISA attorney at the advisor's firm
- ☐ Plan Sponsor's attorney
- ☐ Other
- ☐ No third-party review
- ☐ Unknown
- ☐ Not Applicable

13. **Who performs the review to ensure there are not gaps in coverage or conflicts across all of the plan's vendor contracts, policies, and SPD/plan documents?** Please select all that apply.
Non-Attorney Consultants include all reviews by subject matter experts who do not legally represent the plan sponsor or advisor firm.

- ☐ Plan Sponsor's ERISA attorney
- ☐ ERISA attorney at the advisor's firm
- ☐ Non-attorney consultant
- ☐ Benefits Advisor
- ☐ Other
- ☐ No third-party review
- ☐ Unknown
- ☐ Not Applicable

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14. What is the plan's current funding mechanism?

- ☐ Medical Cost Sharing
- ☐ Self-funded w/ stop-loss
- ☐ Self-funded w/ captive
- ☐ Fully-insured
- ☐ Level-funded
- ☐ Self-Funded

15. How is the Plan Sponsor claims budget created?

- ☐ Used premiums provided by the plan administrator
- ☐ Used aggregate claims factors from the stop loss carrier
- ☐ An actuary created aggregate budget liability amounts
- ☐ The sponsor's advisor created aggregate liability budget amounts
- ☐ Other
- ☐ Not Applicable (Group is Fully-Insured)
- ☐ Unknown

16. How did the plan determine its specific stop-loss deductible amount?

- ☐ Formal analysis by the plan's non-actuary advisor
- ☐ Formal analysis by the underwriter
- ☐ Formal analysis by an actuary
- ☐ Carried over prior year's amount
- ☐ General recommendations without formal analysis
- ☐ Not Applicable
- ☐ Other

17. Which of the following is most accurate about the plan's stop loss fees/commissions?

- ☐ Advisor shopped stop loss and can guarantee any fees/commissions (if any) were disclosed
- ☐ Advisor didn't shop the stop loss, but can guarantee any fees/commissions were disclosed
- ☐ Part of advisor's consulting fee is stop loss fees, but was not disclosed
- ☐ A third-party shopped stop los and they charge fees/commissions that were disclosed

18. Does the plan sponsor currently have unrestricted access to full claims data (not just reports)?

- ☐ Yes, medical and pharmacy
- ☐ Yes, medical only
- ☐ Yes, pharmacy only
- ☐ No

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19. What type of data analytics and reports does the plan have access to?

- ☐ Analytics directly purchased by the plan sponsor
- ☐ Analytics provided by the advisor firm
- ☐ Analytics provided by the plan administrator/carrier
- ☐ Only Standard reports from the plan administrator/carrier
- ☐ No access to analytics

20. Does the plan's Third-Party Administrator (TPA) allow the Plan Sponsor to select its stop loss carrier?

- ☐ Yes, for any underwriter
- ☐ Yes, but only to certain underwriters
- ☐ No
- ☐ Unsure
- ☐ Not Applicable

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

- ☐ Yes, for any PBM
- ☐ Yes, but only to certain
- ☐ PBMs
- ☐ No
- ☐ Unsure
- ☐ Not Applicable

22. Is the plan's Third-Party Administrator (TPA) willing to administer direct agreements with care providers?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not Applicable

23. Does the plan's Third-Party Administrator (TPA) regularly provide claim level check registers?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not Applicable

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24. Does the plan's Third-Party Administrator (TPA) let the Plan Sponsor select the dollar amount threshold for auto-adjudicating claims?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Not Applicable

25. Does Plan Sponsor use claims audits and/or payment integrity services to reduce fraudulent claims payment and identity theft risk?

- ☐ Independent vendor provides ongoing, pre-adjudication payment integrity services
- ☐ Plan administrator provides ongoing, pre-adjudication payment integrity services
- ☐ Plan administrator audits single claims or episodes as needed
- ☐ Plan administrator conducts regular claims audits
- ☐ Independent vendor conducts regular claims audits
- ☐ Independent vendor audits single claims or episodes as needed
- ☐ None
- ☐ Unsure
- ☐ Not Applicable

26. What type of plan administrator does the plan use?

- ☐ Independent TPA
- ☐ Carrier Owned TPA
- ☐ Administrative only from carrier
- ☐ Fully-insured carrier
- ☐ Other

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Plan Grader Care Components

1. **What network & physician access strategies does the current plan utilize?**
   Note that a single solution partner may provide more than one of these options.

   - ☐ Traditional full PPO or similar network
   - ☐ Tiered full preferred network
   - ☐ Narrow network
   - ☐ Direct provider contracting
   - ☐ Traditional physician only network
   - ☐ Value-based primary care network
   - ☐ Reference-based pricing for facilities
   - ☐ Reference-based pricing for non-facility services
   - ☐ ACO
   - ☐ Reference-based pricing for out-of-network claims
   - ☐ Wrap network
   - ☐ Bundled care arrangements
   - ☐ Network carve-outs
   - ☐ Other physician access arrangements
   - ☐ None

2. **How are primary care physicians paid by the plan for standard primary care services?**
   Additional incentives is a general category for compensation in addition to a fee-for-service reimbursement, such as gainshares or higher reimbursement rates for meeting certain population health metrics.

   - ☐ Fee-for-Service w/ additional incentives
   - ☐ Fee-for-Service
   - ☐ Subscription or Capitation
   - ☐ Other
   - ☐ Not Applicable
   - ☐ What value-based primary care strategies does the plan employ?
   - ☐ Virtual primary care (not just telehealth)
   - ☐ Direct agreements w/ Independent primary care practices
   - ☐ Onsite clinic
   - ☐ Nearsite clinic
   - ☐ Direct Primary Care
   - ☐ Other
   - ☐ None

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3. **What value-based primary care strategies does the plan employ?**

- ☐ Virtual primary care (not just telehealth)
- ☐ Direct agreements w/ Independent primary care practices
- ☐ Onsite clinic
- ☐ Nearsite clinic
- ☐ Direct Primary Care
- ☐ Other
- ☐ None

4. **Which major specialty area(s) does the plan have specific strategies and programs for?**
Note that these may be through plan design, specific vendors, defined strategies, or other specific mechanisms (not just access through a network).

This question does not imply that plans should have separate vendors for each of these areas. This question intends to identify how the plan tackles types of care with known cost and/or quality challenges.

- ☐ ER visits
- ☐ Transplant
- ☐ Other elective hospitalizations
- ☐ Other disease-specific conditions
- ☐ Tobacco use
- ☐ Substance abuse
- ☐ Mental/Behavioral health
- ☐ Specialty drugs
- ☐ Dialysis
- ☐ Cancer
- ☐ MSK/Orthopedic
- ☐ Maternity
- ☐ Non-specialty drugs
- ☐ Elective surgeries/procedures
- ☐ Cardiometabolic/Diabetes
- ☐ Other
- ☐ None
- ☐ Don't Know

5. **What other strategies does the plan leverage to help members access lower cost and higher quality care for complex care episodes?**

- ☐ Plan design/coverage/financial incentives
- ☐ Care advocate/concierge/navigator
- ☐ Tobacco Cessation
- ☐ Health Advocacy
- ☐ Cancer Management
- ☐ Maternity Management
- ☐ Disease Management
- ☐ Biometric Screening
- ☐ Health Risk Assessment
- ☐ Large Case Management
- ☐ Centers of Excellence
- ☐ Other
- ☐ Non

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6. What elements are included in the pharmacy benefit plan?

- ☐ Custom formulary
- ☐ Contractual language that plan owns Rx data
- ☐ Strict concurrent drug utilization reviews
- ☐ Comprehensive access to claims data
- ☐ Quantity limits to proactively ensure proper utilization
- ☐ Ability to audit all pharmacy network, manufacturer, and/or rebate aggregator contracts
- ☐ Customizable prior authorization protocols
- ☐ Step therapy/starter dose programs to ensure appropriate opioid dispensing
- ☐ Other
- ☐ None

7. What contractual guarantees does the plan's PBM contract have?

- ☐ Pass-through of all rebates without holdbacks or limitations
- ☐ Guaranteed PEPM spend
- ☐ Minimum Per-drug rebates
- ☐ Per-drug or per-script AWP guarantee management (not aggregate)
- ☐ Usage of lowest available AWP (where applicable)
- ☐ Guaranteed per-unit or MAC pricing on generics
- ☐ Other
- ☐ Unsure
- ☐ None

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

- ☐ Dispensing through Advanced Primary Care clinic
- ☐ Co-pay assistance
- ☐ International sourcing
- ☐ Manufacturer assistance programs
- ☐ Specialty drug carve outs
- ☐ Steerage to therapeutic equivalents

Your Score by Health Rosetta Component