



Best-in-Class Analytics and Reporting

Customized reports to better manage health benefit costs

HealthNow
Administrative Services



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At HealthNow Administrative Services (HNAS), our Analytics Team has over 100 years of collective experience in the health care industry. That means you're working with a partner who understands your needs and has the ability to help control your plan costs through intelligent analysis of claims data and trends.

Our consultative approach helps you interpret and use your plan information to make smart, data-driven decisions. We don't just send reports. We sit down with you to discuss plan utilization, look at trends, and leverage that data to mitigate risk and lower your costs.



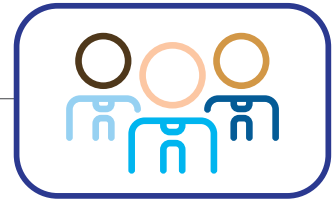
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*Director, Employer Group Reporting and Analytics
HealthNow Administrative Services*

Start with an Experienced Team

The HNAS team is deeply committed to helping you manage your plan dollars. We import Johns Hopkins clinical modeling into our system to create monthly reports, with risk scores for disease states that are managed by our disease management team. This helps us identify potential high claims and monitor member risk.

HNAS takes a holistic view of each client relationship, looking at the total health of individual members and monitoring the client's financial and clinical risk. Working with disease management and case management teams, we apply knowledge from the data to provide better health outcomes and ultimately save you money.





Creating cost savings and efficiencies

The challenge: A key broker partner paid an outside consultant for reports and analyses, but the practice was very costly and the spreadsheets were quickly outdated and of little real value.

HNAS goals:

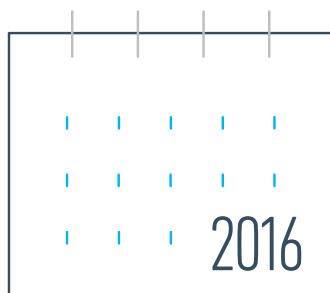
- Eliminate the broker's added expense
- Improve turnaround time
- Ensure accuracy and on-time delivery

Solution: The HNAS Analytics Team used the broker's proprietary workbook template to create monthly report packages, research reports, and more, which undergo a quality review process with a 99% accuracy rate — all delivered on time.

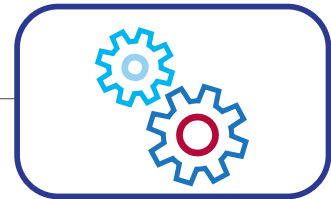
Results: The broker realized significant time and money savings and, with HNAS, now generates custom reports for clients an average of 10 to 15 business days faster.

Meeting the needs of our brokers coast-to-coast

During the first three quarters of 2016, the following was generated for the broker:



Advanced Analytics



The HNAS Analytics Team uses enhanced system capabilities to accurately gather, organize, and analyze spend. We can fully customize a reporting package that meets your unique needs at no additional cost. *Here's what sets HNAS apart:*

- Daily integration of paid, in-process, and prescription drug claims into our data warehouse and analytics engine.
- Monthly capture of fixed costs, such as administration, PPO access, and other fees.
- Reporting details about total plan costs, rather than just claim expenditures.
- Comparing data to national benchmark resources to identify trends and population management.
- Use of predictive clinical modeling to project future costs.
- Flexible data analysis, report configuration, and ad hoc report creation to provide the most relevant information for you.
- Monthly reporting to stop-loss carriers to identify potential risks.
- Ability to work within brokers' proprietary spreadsheets to populate content and generate reports at no cost.

Fully customized reporting packages



Monthly reporting

- Normative comparison summary
- Monthly cost summary
- Plan experience summary
- Top-10 payee analyses
- Top-10 diagnosis analyses
- Shock claim summary
- Ad hoc reports as requested

Quarterly reporting

- Normative comparison summary
- Claim analysis overview
- Quarterly cost summary
- Prescription utilization summary
- Plan experience summary
- Shock claim summary
- Payee analysis
- Diagnosis analysis
- Key utilization indicators
- Medical benefits distribution by category
- Preventable conditions summary
- Ad hoc reports as requested

Plan Performance: Normative Comparison Summary



Provided monthly and quarterly, the normative comparison summary shows all the components that make up an employer's plan spend, including:

- Claim payment costs by benefit category (medical, dental, prescription drug, vision)
- Claim payment costs by treatment category (inpatient, outpatient, professional)
- Fixed costs, such as administration fees, PPO access fees, prescription drug administration fees, broker commissions, HIPAA, COBRA, ID cards, or other miscellaneous fees

This summary also shows the number of health plan enrollment contracts (employees) and health plan members (employees plus all covered dependents), as well as the average age of employees and members.

Predictive data

This is used to estimate the claim costs for a specified period of time going forward and includes a predicted cost indicator based on the Johns Hopkins Adjusted Clinical Grouping (ACG) information and an assigned predicted resource index.

Statistics and benchmarks

- **Care episode statistics** for inpatient, outpatient, and emergency care.
- **Utilization statistics**, benchmarked against the Kaiser Family Foundation annual report and for inpatient and outpatient, professional services, and prescription drugs.
- **In-network statistics** reflect the number of services and plan payment amount paid for in-network utilization.

Network data

The per-network savings shows how the PPO discount arrangements are performing. Claims are further designated as inpatient or outpatient facilities, or professional services, reflected as a percentage of services provided and plan payment amount.

Top-five diagnosis groups

These provide an overview of the disease states presented in the claims for the reporting period selected, which either ensures your plan is performing as expected or identifies if adjustments are needed in population management, case management, or benefit levels to compensate for plan variances, abuse, or misuse.

Key Monthly Reports to Help Manage Your Spend



Tracking claims and trends: monthly cost summary

The monthly cost summary provides an overview of the claim dollars spent by category (e.g., medical, dental, prescription) and covered employees and members. By following the monthly costs it's easier to identify trends in spending. If reporting is required based on your stop-loss contract period and terms, the monthly cost summary can be filtered to show claims incurred and paid during a particular reporting period.

Planning for annual expected claim costs

Tracking monthly claims expenditures provides helpful insight into funding patterns when planning for annual expected claim costs.

For instance, the “employee responsibility” category provides information on out-of-pocket expenses your employees are spending on a monthly basis for deductible, coinsurance, and copayments.

Monthly total cost spend: plan experience summary

The plan experience summary shows your monthly total cost spend. This report provides fixed and variable costs on one report and includes a monthly breakout of:

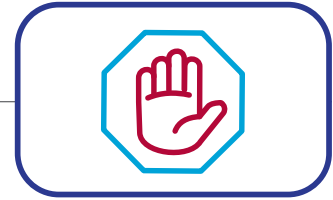
- Total charges
- Discount amount
- Employee responsibility
- Exclusions
- Other insurance payments

The plan payment is reflected as a percentage of the total charge amount, and any stop-loss reimbursements for the specified reporting period.

The total cost summary section includes the plan payment, other expenses—such as stop-loss premium administration fees or other fees—and total plan cost. The report also reflects the total cost per employee and total cost per member for each month.



Managing Stop Loss Coverage: Shock Claim Reports



Shock claim summary

The shock claim summary, provided monthly, tells how many members are experiencing claim costs above your plan's threshold. These claims are known as shock claims and can be eligible for reimbursement from the stop-loss carrier.

Shock claim example

A member with a diagnosis of cancer is receiving chemotherapy treatments and has incurred significant claims.

- Member claims incurred: \$75,000
- Stop-loss deductible: \$150,000

This member has the potential to surpass the stop-loss deductible and is considered a potential high or “shock” claimant. Eligible claim payments could be reimbursed by the stop-loss carrier if the member goes above the specific stop-loss deductible.

Shock claim detail

The shock claim detail provides in-depth information regarding the shock claimants and their claim utilization. In addition to claim costs, every diagnosis code and correlating diagnosis description is included. This information provides insight into the treatment and claim experience of the individual who is considered a shock claimant.

When filing claims with the stop-loss carrier on the client's behalf, the shock claim detail report is provided as documentation of the service dates.

Monitoring claims

The summary and detail include the number of members who have had claims paid above the threshold and the three most expensive primary diagnosis codes paid for those.

Payee and Diagnosis Analysis



Payee analysis

The payee analysis provides insight into the providers paid by the plan.

The payee analysis indicates who the top payees are (which may be different from the actual top providers), providing valuable insight into decisions about PPOs.

Diagnosis analysis

The diagnosis analysis shows the top diagnosis codes by number of services, indicating the most common conditions diagnosed for members who are receiving treatment. Diagnosis code analysis can provide early identification of conditions that could become significant from a cost perspective, helping you plan for additional claim expenses in advance.



Plan Trending: Key Utilization Indicators



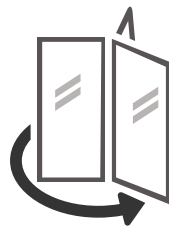
This report provides detailed period-over-period information that helps identify plan trends.

For plan trending, it's important to note the dollars being spent in the inpatient and outpatient facility and professional services categories. The percentage difference between the reporting periods provides an indication of plan utilization in each of these key areas.

The plan payments are also reflected as a per-enrollment contract and per-member amount. This is significant in determining the overall utilization ratio and the percentage difference between employee and dependent costs.



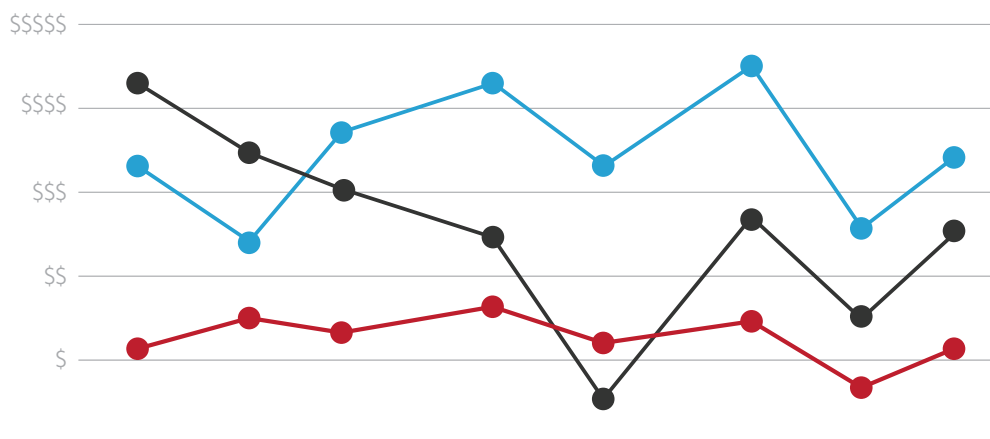
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