Plan Management Navigator

Analytics for Health Plan Administration

Healthcare Analysts

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Table of Contents

The Efficacy of Medical Management............................1

The Impact on Customer Services....................................3

Sales and Marketing in Medicare..................................5

Characterics..............................6

Sherlock Benchmarks..............7

See pages 6 and 7 concerning participation opportunities in Medicare and Medicaid universes.

How Medicare and Medicaid Make You Different

In this *Plan Management Navigator*, we explore how Medicare and Medicaid have aspects that affect managerial decisions. These include decisions related to Medical Management, Sales and Marketing, and Account and Membership Administration. When health plans endeavor to manage optimally, it is important to take product mix into account and unique characteristics of products.

The Efficacy of Medical Management

Background

Medical management is amenable to cost-benefit analysis since the intended benefit of investing in medical management is the reduction in health care costs. Too much investment in medical management and health plan resources are squandered, while too little may lead to inflating health care costs. Determining the optimal investment in medical management is further complicated since the payoff can be in the distant future. Molina Healthcare, Inc., a publicly-traded Medicaid-focused health plan, stated in its first quarter earnings that its results were hampered by "*[s]lower than anticipated realization* of the benefits from medical management cost initiatives… [which] have resulted in medical care costs that exceeded our expectations." (Emphasis added.)

Also, minimum MLR regulations may effectively create disincentives to investing in medical management. While quality improvement activities are considered health care costs for MLR purposes, there are other activities that must remain as administrative costs. This may create the disincentive of investing in high ROI medical management initiatives.

Other administrative expenses have tradeoffs as well. Payoffs for additional costs include superior service or growth.

Normal market constraints create the trade-offs noted above. On April 25, 2016, The Centers for Medicare and Medicaid Services (CMS) released the Medicaid and CHIP Managed Care Final Rule. One key rule was the enforcement of minimum MLR regulations on Medicaid plans. Minimum MLR rules have been in effect for commercial products since 2012 and Medicare Advantage plans since 2014. Medicaid plans will be subject to this rule beginning on July 1, 2017.

Analysis

To test the efficacy of medical management in Medicaid we regressed Per Member Per Month (PMPM) medical management costs in Medicaid against the Medicaid Gross Profits PMPM (gross profit in this instance is premium revenue less health care costs). The results of the regression yielded an R^2 of 0.3% and a P-Value of 85.9%, as seen in Figure 1*. The downward slope of the regression line suggests that more spent on Medical Management for Medicaid the lower the gross profit. (One outlier was excluded in this analysis.)

*R^2 calculates the percent of variation around the regression line. If a regression has an R^2 of 100%, then all of the data points lie exactly on the regression line, and that line explains all differences in the dependent (y-axis) variable. The P-Value is an index of confidence for research hypothesis testing. The P-Value is sometimes described as the probability that there is no relationship between the two variables. A lower P-Value suggests a likely association between the two variables.

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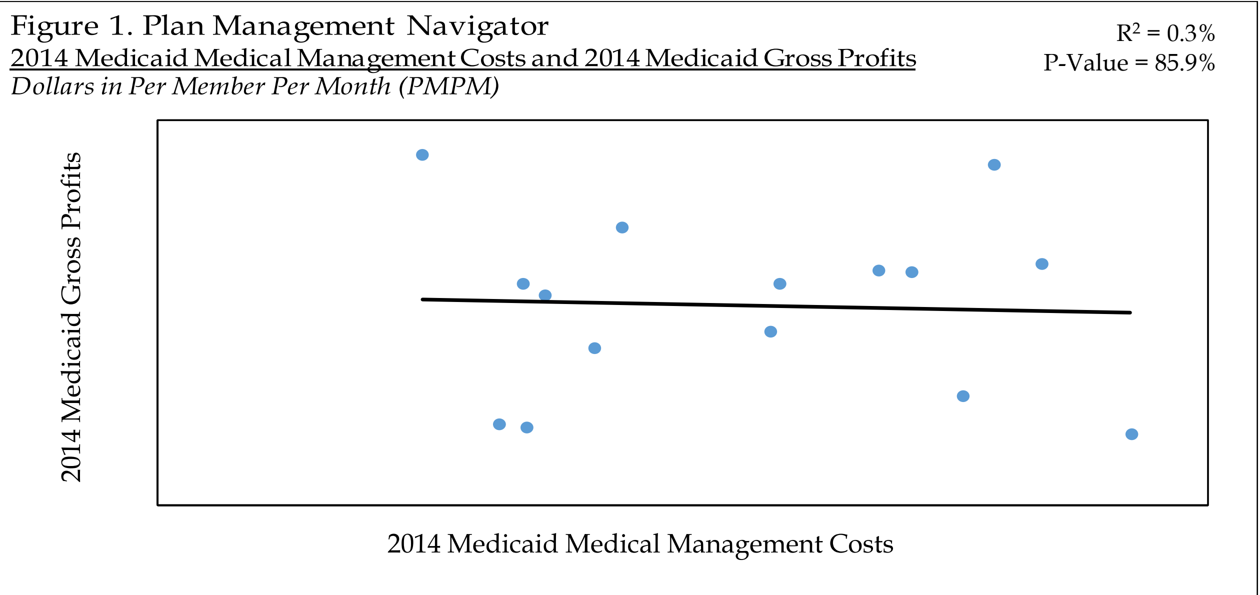
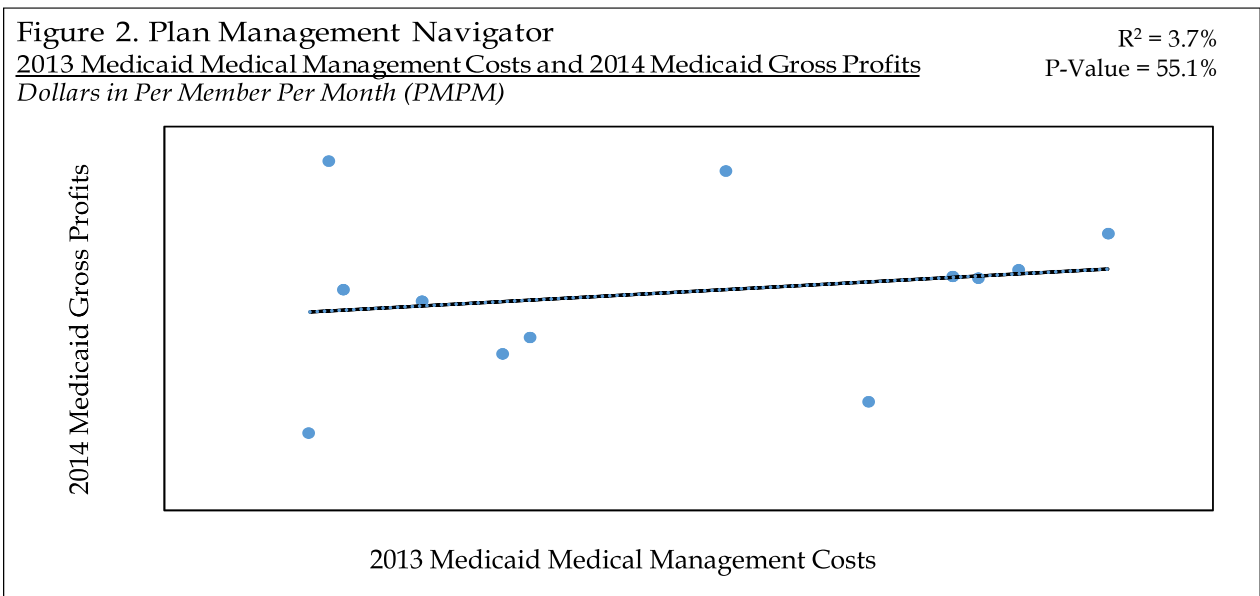
We touched upon one possible explanation of the counter-intuitive results earlier in the Molina comment. The realization of the benefits of the investment in medical management may have not manifested during this measurement period. Therefore, health benefits are higher than anticipated due to the mismatch in timing resulting in downward pressure on gross profits in the current period. We then tested 2014 Medicaid Gross Profits against 2013 Medicaid Medical Management. This upward sloping relationship yielded a R^2 of 3.7% and a P-Value of 55.1% and can be seen in Figure 2. The results of this analysis suggest (weak) support for Molina's statement that sometimes the benefits of Medical Management are delayed. (Only plans in both measurement periods were included in Figure 2 and the same outlier from Figure 1 was also excluded.)





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Another possible benefit to medical management is superior quality ratings, such as Medicare Star. In prior years, our analyses have found that there is a positive correlation between the two variables suggesting that higher medical management spending may lead to higher Medicare Star ratings.

The results of the regression analysis found in Figure 1 is comprised entirely from the 2015 edition of the *Sherlock Benchmarks,* reflecting fiscal year 2014 financials. 2013 Medicaid Medical Management expenses are from the 2014 cycle of the *Sherlock Benchmarks*.

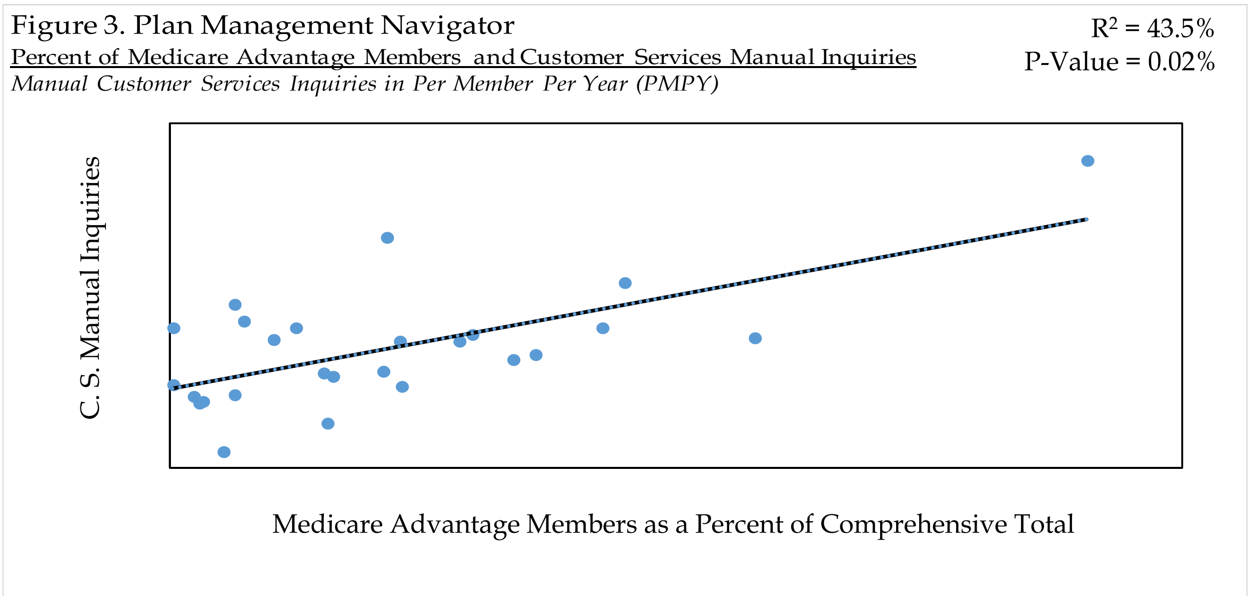
The Impact of Medicaid and Medicare on Customer Services

BACKGROUND

The Customer Services area can illustrate that low costs are not the same as optimal costs. An example we've cited is when one health plan was reluctant to participate in the *Sherlock Benchmarks* claiming to be operating leanly, especially in the Customer Services area. The health plan eventually elected to participate and, in fact, that its customer services expenses were low. It also discovered, however, that its customer satisfaction metrics were also low. This may have adversely impacted its other operational performance measures including its member retention rate and modest membership growth. We've also noticed that generally seniors will be heavy users of Customer Services relative to other populations.

ANALYSIS

In Figure 3, we analyze how the percent of Medicare Advantage members impacts workload in the Customer Services area, represented by the number of Customer Services Total Inquiries Per Member Per Year (PMPY). We found that there was a strong relationship with an R^2 of 43.5% and a P-Value of 0.02%. The upward slope of the linear regression can be interpreted as the greater amount of Medicare Advantage members leads to more Manual Customer Services Inquiries PMPY. Other measures that reinforce seniors are heavier users of Customer Services relative to Commercial members include higher customer services handle times, appeal rates, and the number of claims inquiries. Medicare Advantage members are also less likely to utilize automated call systems.



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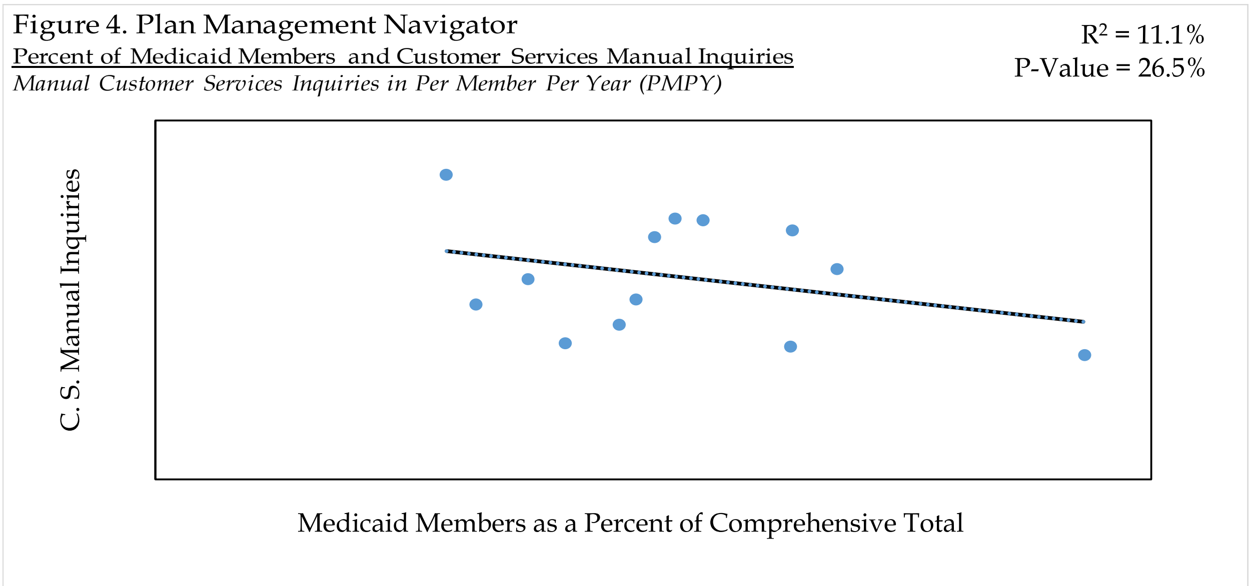
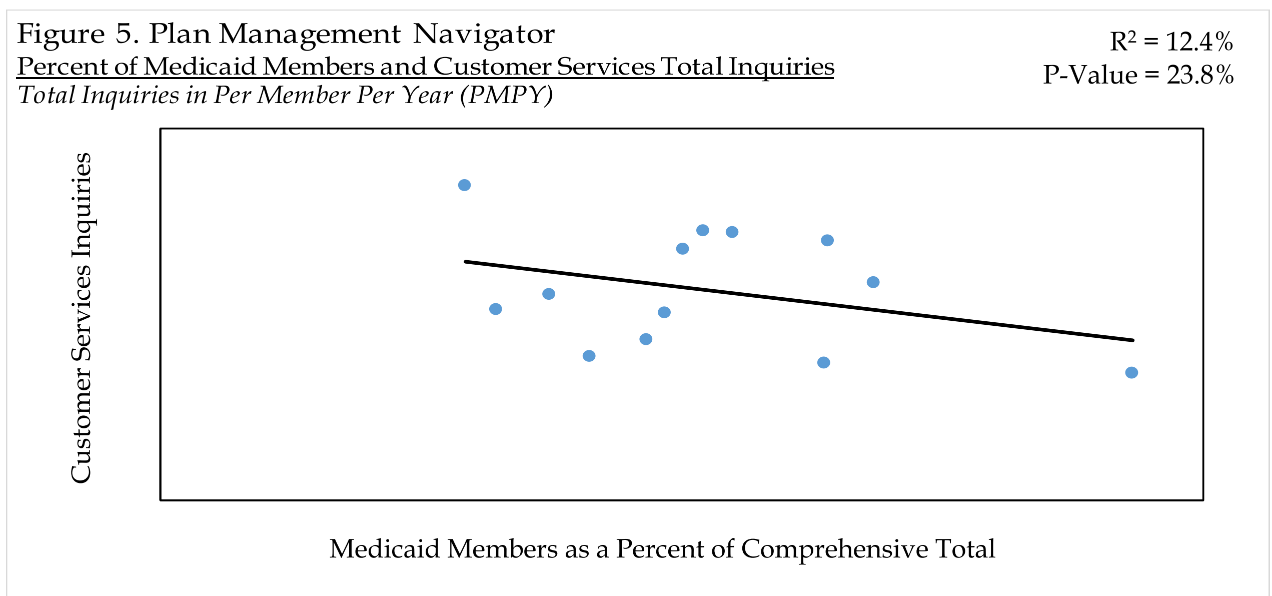
We performed the same analysis on the proportion of Medicaid members and Manual Customer Services Inquiries PMPY. Shown in Figure 4, our analysis resulted in a negative sloping regression line with a R^2 of 11.1% and a P-Value of 26.5%. The downward slope indicates that the higher the proportion of Medicaid members the lower the number of Manual Customer Services Inquiries. We also looked at the proportion of Medicaid members to Total Customer Services Inquiries PMPY. This yielded similar results with a negative slope and a R^2 of 12.4% and a P-Value of 23.8%. (Manual Inquiries includes Manual Calls, Paper / Written Inquiries, and Manual Electronic. In comparison, Total Inquiries will also include Automated Calls and Automated Electronic Inquiries. There were also two outliers excluded from Figures 4 and 5.)





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Sales and Marketing in Medicare Plans

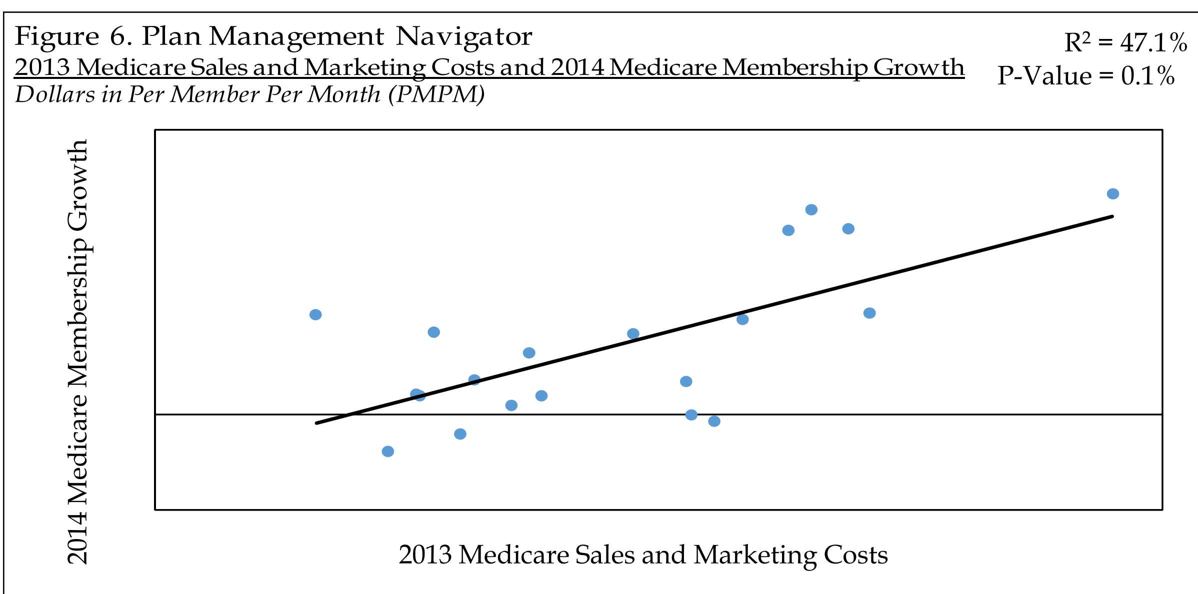
BACKGROUND

From April 2015 to April 2016, Medicare Advantage enrollment increased by 5% to 17.2 million, while the *Kaiser Family Foundation* found that 31% of all Medicare eligible beneficiaries are served by a private health plan (includes MSA, Medicare Cost, SNP, and demonstration plans). The CBO projects that the number of Medicare beneficiaries are anticipated to grow from 55 million in 2015 to 75 million in 2026. Potential membership growth can be the impetus for health plans to invest in Medicare-focused Sales and Marketing. Similarly to Medical Management, the benefits of Sales and Marketing investments may be realized in a future period.

ANALYSIS

In Figure 6, we regress 2013 Medicare Sales and Marketing PMPM expenses (excluding Rating and Underwriting, which is HCC cost-related) against Medicare Membership growth during 2014. Much of the Sales and Marketing takes place in the Fall and enrollment is realized in the following year. The analysis resulted in a positive sloping regression line with a R^2 of 47.1% and P-Value of 0.1%. This relationship suggests that health plans with higher spending in Sales and Marketing for Medicare Advantage in the prior year posted greater membership growth in Medicare Advantage. (Twenty plans that offered Medicare Advantage and participated in both years of the *Sherlock Benchmarks* were included in this figure. One outlier was excluded.)

No meaningful results were found in a similar analysis of Medicaid plans. Rules limiting Sales and Marketing activities and which vary from state to state may affect this analysis.



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Characteristics of Medicaid and Medicare Plans

As previously noted, it is important to take product mix into account when analyzing health plans. There are many attributes that make Medicare and Medicaid plans different.

In Figure 7, as an example, we display revenue yields and staffing ratios by product. Average premiums for Medicare Advantage are more than double Commercial Insured at $852.57 PMPM versus $375.63 PMPM. Servicing Medicare Advantage members, however, requires additional staff compared to Commercial Insured. The average staffing ratio (or FTEs per 10,000 members) for Medicare Advantage plans 54, while Commercial Insured staffing ratio was 28. Average Medicaid premiums PMPM were $334.11, or 11% less than Commercial Insured and its staffing ratio of 19 is 34% lower. The relationships between the products not only varies greatly, but each functional area varies by cost and staffing ratio.

In the past we found that health plans serving Medicaid members tend to operate in a "culture of conservative administrative costs." We've found that generally the larger the percent of Medicaid members to Comprehensive total members the lower the Account and Membership Administration cluster of expenses. (This cluster comprises the central health plan activities of Enrollment / Membership / Billing, Claim and Encounter Capture and Adjudication, Customer Services, and Information Systems.)

Participation in the Sherlock Benchmarks

We are currently enrolling health plans for our Medicare and Medicaid universes. The survey forms will be distributed the *day after* the Medicare Advantage bids, which are due on June 6th. Participation consists of supplying enrollment, premiums, and expenses by product and by functional area. Staffing levels, staffing costs, and outsourced costs are segmented by functional area. Your plan will also need to supply a few select operational metrics. There is a fee, and we sign mutual confidentiality agreements.

Figure 7. Plan Management Navigator
Premiums and Staffing Ratios by Product
Premiums in PMPM

Product	Premiums	Staffing Ratio*
Commercial Insured	$375.63	28
Medicare Advantage	$852.57	54
Medicaid HMO	$334.11	19

*Staffing Ratios are Full-Time Equivalent FTEs, including outsourced Staff, expressed per 10,000 Members

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The *Sherlock Benchmarks* are considered the "gold standard" for management of health plan administrative expenses. These are some of the reasons why:

- Sherlock Company is currently in the middle of its 19th consecutive year for its *Sherlock Benchmarks*.
- So far, participants in the various Sherlock Benchmarking universes include 41 health plans serving more than 55 million members in comprehensive products.
- Of the U.S.-based Blue Cross Blue Shield primary licensees, over one-half are participating in this year's Benchmarking study.
- Of the 13 members of the Alliance of Community Health Plans that are not focused on Medicaid or Medicare or are staff-model plans, 11 are participating in the Independent / Provider – Sponsored (IPS) universe.
- Most of the largest members of the Health Plan Alliance that are not focused on public programs are also participating in this year's IPS study.
- Health plans serving at least one-half of all insured Americans are licensed users of the Sherlock Benchmarks since January 1, 2015.

For additional information please contact Douglas Sherlock, CFA. He can be reached at sherlock@sherlockco.com or 215-628-2289.

Please note that the surveys will be distributed immediately after the June 6th Medicare bids. Participation requires significant efforts so, if participation is of interest, we invite your inquiries as soon as convenient.

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