SHERLOCK BENCHMARKS

All Universe Edition

SHERLOCK COMPANY

Volume II

Healthcare Utilization Metrics

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All Universes Edition - 2020

Volume II: Healthcare Utilization Metrics

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INTRODUCTION AND BACKGROUND

Background

This is the "Healthcare Utilization Metrics" of Volume II of the *2020 Sherlock Benchmarks – All Universes Edition*. Together, these volumes provide statistics and analysis summarizing the administrative expenses and operational metrics of 36 health plans. These plans consist of Blue Cross Blue Shield Plans, Independent/Provider-Sponsored plans and Medicaid plans. They are intended to facilitate comparisons for users and to assist in the management of health plan administrative expenses. They are useful to operational and financial managers of health plans, consultants and third-party vendors. *Sherlock Benchmarks* should also be valuable to Boards and persons charged with corporate finance responsibilities including strategic planners and investment bankers.

Organization of Sherlock Benchmarks

The *2020 Sherlock Benchmarks* are a carefully compiled and scrubbed summary of the surveyed operational characteristics of leading health plans.

Sherlock Benchmarks assists in performance improvements for health plans by facilitating comparisons between plans and their universe as a whole. It quantifies health plans' relative performance and identifies sources of variance at a highly granular level. *Sherlock Benchmarks* information is unusually comprehensive and a highly valid analytical tool.

The *Sherlock Benchmarks* are produced in two volumes:

Volume I: Financial Metrics includes analyses of administrative expenses through financial ratios such as percent of revenues and per member per month. Data is divided into a total of 14 product lines and 79 functions. Additional descriptions are found below.

Volume II complements Volume I by facilitating in-depth analyses of the financial metrics. It is subdivided into four books: Operational, Staffing and Compensation, Medical Management and Utilization.

Operational metrics translate operating performance into expense performance, so expenses are often analyzed into factors of user demand, employee productivity, unit cost, staffing ratios and cost per employee. For instance, Claim and Encounter Capture and Adjudication is analyzed into claims per member, productivity of claims processors, cost per claim and per-employee costs of claims. In addition, every function is analyzed by factors of staffing ratios, staffing costs per FTE and non-labor costs. Numerous drivers of costs and quality are also provided. In the claims area, for example, these include metrics of electronic submission, auto-adjudication and factors requiring manual intervention.

This document, II – Healthcare Utilization, is divided into nine sections:

TAB 1. INTRODUCTION AND BACKGROUND

This section describes the organization, conventions, applicability and processes of the *Sherlock Benchmarks* studies and this volume in particular. It includes important descriptions and limitations on the data and its presentation in this volume.

TAB 2. SUMMARY ANALYSES

This section provides a brief summary of the results of this survey. Median values for all healthcare costs, per member per month, are reported by product line. In addition, a summary schedule of costs and utilization is provided for each of the product areas. For each product, utilization rates and unit costs are provided for each of thirty-three health care products and services rendered to health plan members.

TAB 3. HEALTHCARE COSTS, PMPM

This section provides analyses of healthcare *costs* for each health service for each product line.

TAB 4. HOSPITAL AND FACILITIES, ACROSS PRODUCTS

This section provides an analysis of *hospital and facilities* costs by type of facility and their utilization rates for each product line. "Facilities" are comprised of Inpatient Hospital (Maternity, Behavioral Health, Rehab, etc.), Outpatient Hospital (ER, Radiology, Ambulatory Encounters, etc.) and Outpatient Surgeries. Data is organized by health service. Costs as a percent of total health benefits is calculated by dividing the costs PMPM for each functional area by each company's health benefit costs PMPM for each product.

TAB 5. PHYSICIAN AND PROFESSIONAL SERVICES, ACROSS PRODUCTS

This section provides an analysis of *physician and professional* costs by type of physician and their utilization rates for each product line. Data is organized by health service. Costs as a percent of total health benefits is calculated by dividing the costs PMPM for each functional area by each company's health benefit costs PMPM for each product.

TAB 6. PRESCRIPTION DRUGS, ACROSS PRODUCTS

This section provides an analysis of *prescription drug* costs by type of prescription drug, unit costs and their utilization rates for each product line. Data is organized by health service. Costs as a percent of total health benefits is calculated by dividing the costs PMPM for each functional area by each company's health benefit costs PMPM for each product.

TAB 7. OTHER SERVICES, ACROSS PRODUCTS

This section provides an analysis of *other services* by type of service, unit costs and their utilization rates for each product line. Data is organized by health service. costs as a percent of total health benefits is calculated by dividing the costs PMPM for each functional area by each company's health benefit costs PMPM for each product.

TAB 8. HEALTHCARE BENEFITS, WEIGHTED BY MEMBERSHIP

This section provides an analysis of each of the healthcare metrics noted above for each product line, *weighted by members*. Since plans with large membership are more heavily weighted than those with few members, these metrics are a better representation of *member* utilization experience, as opposed to a plan's performance in managing the utilization.

TAB 9. PARTICIPATION BY MEMBERS AND PLANS

This section provides the participation by plans and the members they serve in each of the healthcare metrics for each product line.

Note on Health Care Expense Data and Calculations

The source of the data included in this analysis is surveys completed by Blue Cross Blue Shield Plans, Independent / Provider-Sponsored plans, Medicaid plan and Medicare plan. Unlike the financial metrics and a limited number of other operational metrics, this section is entirely voluntary. Like the survey itself, it is reasonable to assume that those who submit the data are inclined to use the results of it, helping to promote the quality of the results. However, the results of this survey have substantial limitations and we have introduced some solutions to address them. These matters are discussed below.

Limitations of the Data and Results

We offer below some observations on the data and the results that may be limitations that the reader may wish to consider in his or her use of this material.

1. While 10 of the 36 plans submitted some utilization and cost information, responses varied for each of the health products and services. Responses were typically lower for each of the product areas and the non-commercial lines. Also, every submission was to some degree incomplete.

   This had two implications. We tend to believe that the higher the response rate, the more reliable the resulting metric. Also, the more comprehensive the data provided, the more comfortable we are that information is exhaustive. Tab 9 summarizes the participation both by plans and by the membership served.

2. Data within any given healthcare / product cell may have been incomplete. For instance, many of the Blue Cross Blue Shield Plans' utilization data was distributed on multiple platforms, such as local,

BlueCard, FEP or NASCO. The plans' ability to gather information from these platforms varied, and in some cases, information was not provided for certain platforms. This may lead to distortions, including the potential of mismatch between membership and utilization.

3. Expenses are unlikely to precisely match GAAP, even under circumstances in which the data submission was complete. GAAP health care expenses are based in part upon estimates for claims that have been incurred but not yet reported. By contrast, expenses reported by medical management are actual care provided between January 1, 2018 and December 31, 2018. Thus, the degree of completion and the timing of the care are potentially distorting factors. Another distortion is the effect of COB and other recoveries: Expenses reported here are typically before such recoveries.

4. Our specifications of the data may not have corresponded with the way it is catalogued in particular health plan medical management systems. This could lead to plans omitting from the submission data it actually possesses. For instance, if costs for a service is described by us as having certain UB-92 revenue codes, but they are grouped by the plan using CPT codes, our requested data (notwithstanding written descriptions) may not be readily accessible to our contact in the plan.

5. Another similar problem may have arisen due to services being split or bundled in hard-to-capture ways. Emergency room costs, pathology and injectibles may be particular areas of concern since they may be comprised of both physician and other services.

6. Utilization rates and costs are calculated assuming that all of the associated members in any given product are entitled to these services. Vision and dental riders, available to only a subset of members, which are not broken out from the core medical product, are representative counterexamples that this analysis does not correct for.

7. Capitation can create distortions in unit cost reporting if the utilization rates are unavailable to the plan.

8. While only a minor product for these plans, Medicaid results can be affected by a disproportionate share of SSI – eligible members. We do not adjust for any differences in mix of SSI versus AFDC.

Solutions to These Problems

These limitations are impossible to completely overcome but we took the following steps intended to maximize the usefulness of these metrics to the user, while minimizing the effects of any distortion.

1. Because few reported all health benefits, but many reported some, the calculated value for each service should be evaluated individually.

2. Since each health care / product cell had its own limitations, the potential for outliers is great. We believe that medians are less subject to such distortion. *Note that if a plan provided what we considered outlying information, we eliminated the data from the report.*

3. Since few reported information for all expenses, totals were not possible to capture for most of the health plans. Therefore, where totals are presented, they represent health benefits costs including pharmacy and mental health from the Finance survey form submitted by those participants. Accordingly, in those instances where we present costs of particular health benefits as a percent of total health benefits, we used each company's health benefit costs PMPM for each product as the denominator and the individual expense of the plan as the numerator.

4. Tab 9 in Volume II - Healthcare Utilization is the participation by the number of members that corresponds to the various metrics and the number of plans that responded to each metric, both by product. This expands upon our practice of reporting the number of respondents for each metric. We intend that this information help users to assess the reliability of the resulting metrics.

Conventions Used in this Report

In the *Sherlock Benchmarks,* we analyzed costs and operations for the health plans as a whole, by functional area and also by product. We have employed a number of reporting conventions, which we discuss below.

1. The terms "high" and "low" mean the average of the *two* highest and *two* lowest values, respectively. The standard deviation is the measure of dispersion. To facilitate comparability of standard deviations, we have expressed standard deviation as a percent of the mean, commonly termed the coefficient of variation.

2. Statistical results are un-weighted. That is, each metric reflects equally the experience of each health plan that reports a functional area for a product, without regard to the plan's size.

3. Statistical measures for each functional area are calculated independently. Accordingly, the statistical analysis of total expenses is not the sum of the statistical analysis of each component cost.

4. Results were carefully validated to identify, and correct if possible, reporting errors.

5. Within each firm, ratios based on the total scope of products (for instance in the Total and Comprehensive values) are intrinsically weighted by the relative importance of each product to that firm. For instance, a firm with a heavy commitment to Indemnity & PPO ASO will reflect that product's weighting and its company-wide costs will be lower as a result.

We offer a few additional comments regarding Volume II – Healthcare Utilization.

1. The information we received is through our contact, typically someone in the finance area, rather than directly from the operational department themselves.

2. The response rate was considerably lower in operational metrics as compared with financial metrics. Operational metrics are largely voluntary to help assure quality of responses.

3. The components may not sum to totals, for example in the case of product line breakouts. That is because response rates varied in each of the component parts and in totals.

4. Additional discussion about *Sherlock Benchmarks* survey procedures, data analysis and presentation is found under Tab 1 of Volume I – Financial Metrics.

5. A complete description of the characteristics of the participating plans is found in Tab 10 of Volume I – Financial Metrics.

Questions and Comments

We invite questions and comments on the *Sherlock Benchmarks.*

Douglas B. Sherlock, CFA
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In addition, please know that we support your use of the *Sherlock Benchmarks*. We hope that you will not hesitate to contact us if you have any questions concerning classifications, calculation methodologies and the application of the *Sherlock Benchmarks* to improve the performance of your health plan.

Tab 2

Summary Analyses

This section provides summary analyses of the median healthcare metrics for each product line.

Tab 3

Healthcare Costs, PMPM

This section provides an analysis of the healthcare costs composition of each product line. Data is presented on a per member per month basis. It includes a statistical analysis of expenses.

Tab 4

Hospital and Facilities

This section provides an analysis of facilities costs and utilization across product lines. Data is organized by functional area.

Hospital and Facilities (continued)

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Tab 5

Physician and Professional Services

This section provides an analysis of physician costs and utilization across product lines. Data is organized by functional area.

Physician and Professional Services (continued)

Tab 6

Prescription Drugs

This section provides an analysis of prescription drug costs and utilization across product lines. Data is organized by functional area.

Tab 7

Other Services

This section provides an analysis of various other health products and services costs and utilization across product lines. Data is organized by functional area.

Other Services (continued)

Tab 8

Healthcare Costs, Weighted by Plan Membership

This section provides summary analyses of the healthcare metrics for each product line weighted by membership.

Tab 9

Participation by Members and Plans

This section provides the participation by plans and their members for each healthcare metrics in each product line. Number of Members Measured for Metric means the membership associated with each plan providing a metric for that product. Number of Plans Measured for Metric is the number of plans providing a metric for that product.

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