Plan Management Navigator
Analytics for Health Plan Administration

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Please see our invitation to participate in the 2021 Sherlock Benchmarks for Medicare and Medicaid Plans on Page 9.

Operational Drivers of Medicare Advantage Costs

Medicare Advantage and Sherlock Company Operational and Cost Metrics

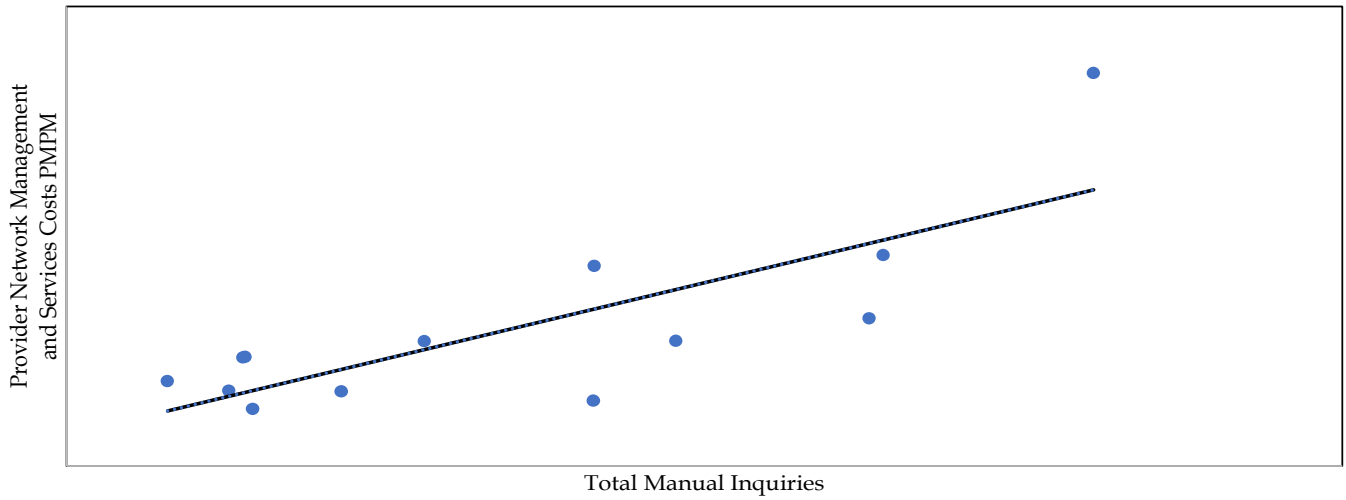
Interest in Medicare Advantage products has increased on several levels. According to the Kaiser Family Foundation, 39% of Medicare eligibles are members of Medicare Advantage plans, up from 31% in 2016. This switch means that 24.1 million Medicare eligible members have opted out of regular Medicare in favor of private insurance. (The most recent Medicare Enrollment Dashboard by CMS shows 27 million of 63 million beneficiaries, or 43% in MA or similar products in January 2021.) KFF reports an enrollment acceleration, from 7.4% in 2018, 7.8% in 2019 to 9.5% in 2020.

In addition, at the other end of the income statement, several Medicare Advantage health plans are going public. These include Clover Health with 58,000 Medicare Advantage members, Alignment Health with 68,000 members and InnovAge with 6,700 PACE members. In addition, there are some new public companies that serve the expense aspects of Medicare Advantage plans, providing both care management and primary care, including Oak Street Health.

Sherlock Company is also interested in the expense aspects of health plans. Our *Benchmarks* provide health plans the information health plans need to manage their operational expenses. That information includes costs per member, staffing ratios, productivity metrics and other norms. In 2020, the various *Sherlock Benchmarks* included 26 plans with Medicare Advantage, collectively serving 2.1 million members, or approximately 20% of those not served by public companies.

Figure 1. Plan Management Navigator
Operational Drivers of Medicare Advantage Costs
The Effect of Total Manual Inquiries on Prov. Net. Mgmt. & Services

R^2 = 62.9%
P-Value = 0.1%
Slope = 1.8



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Sherlock Company's robust data set also allows us to perform analyses that are the subject of this *Plan Management Navigator*. In this *Navigator*, we show relationships evident through a series of regression analyses. The operating metrics that are the independent variables tend to be highly concrete such as claims or inquiries. Only some functions have activities that can be expressed or summarized in this way. All metrics are expressed per Medicare member.

All of the relationships discussed below are solely for Medicare Advantage members. That is, both the costs and the operational metric reflects only Medicare Advantage and no other product. *The dependent variables, in all charts on the on the Y axis are costs expressed per Medicare Advantage member per month*. While plans that participate in the *Sherlock Benchmarks* often have other products, they often report operational metrics and costs by product. So, the regression analyses shown in this report are exclusively related to Medicare Advantage members.

The functions analyzed below are Provider Network Management and Services, Enrollment / Membership / Billing and Claim and Encounter Capture and Adjudication. We also analyzed Customer Services, an important function with concrete operational outputs but no statistically significant relationships were observed.

We think most of the relationships illustrated below make intuitive sense, but their slopes add to the users' quantification of these relationships between operating results and expenses.

In addition, because the relationships shown here tend to validate management and analyst intuitions, the relationships modeled in these analyses validate the *Benchmarks* themselves.

Results of Analyses

Provider Network Management and Services is defined in the *Sherlock Benchmarks Common Guidelines* as, "the sum (a) Provider Relations Services, (b) Provider Contracting, (c) Provider Audit / Billing Validation and (d) Other Provider Network Management and Services." For instance, Provider Contracting entails the recruiting, credentialing and setting up of providers, while Provider Services is the initial point of contact for provider inquiries.

We regressed Total Manual Inquiries against the cost of the entire Provider Network Management and Services function, in Figure 1. The higher the per member manual inquiries for Medicare Advantage members, the higher the PMPM costs.

The *Benchmarks* broadly define Total Manual Inquiries as the sum of Manual Calls, Paper Inquiries and Manual Electronic Inquiries from providers. The actual definition is more detailed, but it counts each inquiry concerning a member as a different inquiry, and excludes the inquiries completed with no human intervention.

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The Provider Relations Services Subfunction is usually 35-40% of Medicare Advantage Provider Network Management and Services expenses analyzed above and represents more than any other subfunction of the function's expenses. The three analyses that follow all show close relationships between communications with providers and Medicare Advantage costs.

Figure 2 shows the relationship between Total Provider Inquiries and the per member costs of this subfunction. Total Provider Inquiries is the Sum of Total Manual Inquiries and Automated Calls. Automated calls are those calls fully handled by automated system, such as IVR or voice response system, and they are finished through this automated system.

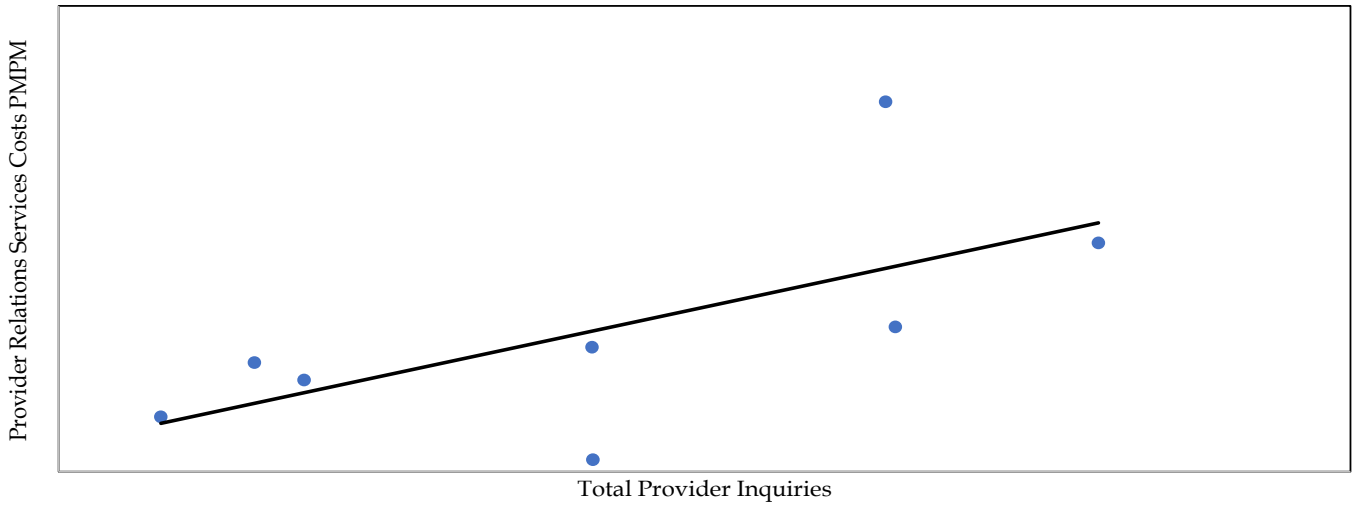
While this subfunction is more integrally linked to the activity, the non-Manual Calls entail little if any effort from this subfunction. This may diminish the significance and explanatory power of that modeled relationship.

Manual Calls are the largest subset of Total Manual Inquiries. They are Calls handled by people, usually in a call center.

Manual Calls constitute the lion's share of the activities in this subfunction and this relationship is quite strong. This is shown in Figure 3.

Figure 2. Plan Management Navigator
Operational Drivers of Medicare Advantage Costs
The Effect of Total Provider Inquiries on Provider Relations Services

R^2 = 42.5%
P-Value = 8.0%
Slope = 0.6



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Total Manual Inquiries include not only Manual Calls but Paper Inquiries and Manual Electronic Inquiries. Paper Inquiries are letters through the mailroom and printed faxes. Manual Electronic Inquiries include inquiries via web, mobile, unprinted faxes and emails. In all cases, Total Manual Inquiries are responded to by a human being. Paper Inquiries and Manual Electronic Inquiries are a small part of all Manual Inquiries.

As shown in Figure 4, there was a significant relationship between Medicare Total Manual Inquiries and Medicare Advantage Provider Relations Services Subfunction costs. Possibly it is less strong than for Manual Calls because of noise in reported volumes of Paper and Manual Electronic Inquiries.

Figure 3. Plan Management Navigator
Operational Drivers of Medicare Advantage Costs
The Effect of Manual Calls on Provider Relations Services

R^2 = 82.6%
P-Value = 0.1%
Slope = 0.4

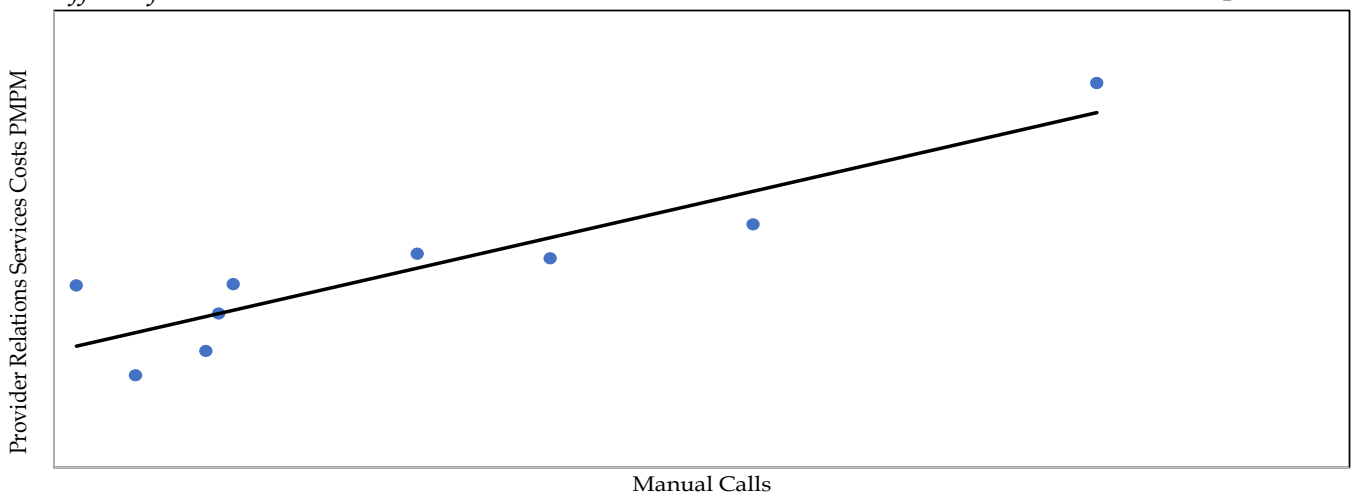
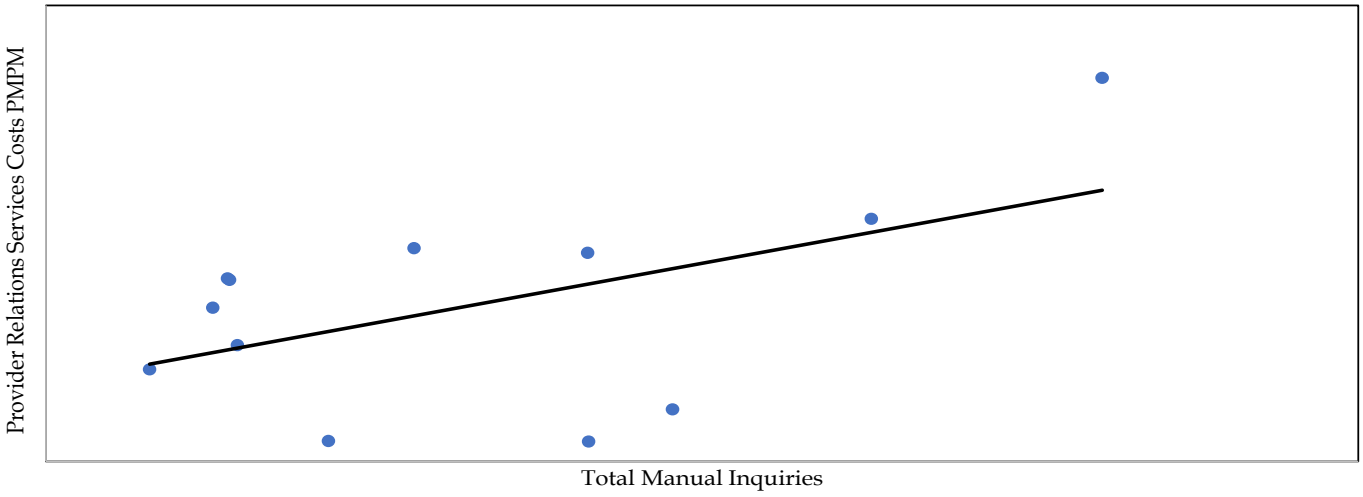


Figure 4. Plan Management Navigator
Operational Drivers of Medicare Advantage
The Effect of Total Manual Inquiries on Provider Relations Services

R^2 = 27.6%
P-Value = 8.0%
Slope = 0.3



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Enrollment / Membership / Billing consists of Enrollment and Membership, and Billing. Enrollment is the processing of installation, recording and maintenance of the relationship between the plan and its members. Membership is the recording of and changes in demographic information and the development of member materials. Billing is the process of calculation, documentation and the submission to customers of invoices. Among plans that report, Billing composes about 30% of this but many of the plans do not segment this function into these two subcategories. But, considering that Medicare Advantage, the focus of this analysis, is primarily offered to individuals, Enrollment and Membership may well track with Billing.

In health insurance, many activities have been automated. In the *Sherlock Benchmarks*, when those activities are automated, their costs are included in the Information Systems functional area, so the functional area itself (e.g., provider service, member services, claims, etc.) is primarily an area of manual activities.

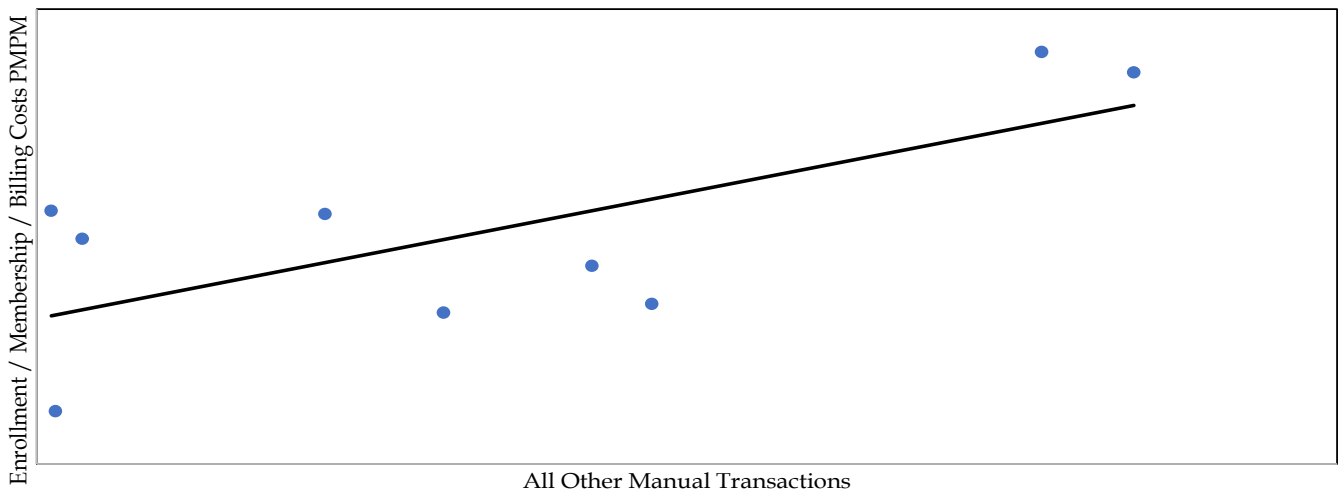
The activity analogous to Provider Service inquiries are Enrollment Transactions, both member and group. They include the total number of member enrollments, dis-enrollments, utilization transfers, as well as group installation, group benefit changes. Since Medicare Advantage is primarily an individual product, the Member Transactions represent the key activities, as opposed to Group Transactions.

The Manual set of these transactions is again the main activity of the Enrollment / Membership / Billing functional area. Some of these are Electronic transactions that are kicked out of the automated system because they require manual intervention. The independent variable, All Other Manual, is solely manually processed paper or telephonic transactions and may be the cleanest for our purposes.

Figure 5 shows that the higher the Medicare Advantage All Other Manual transactions, the greater the Medicare Advantage Costs PMPM.

Figure 5. Plan Management Navigator
Operational Drivers of Medicare Advantage
The Effect of All Other Man. Transactions on Enroll. / Member. / Billing

R^2 = 48.6%
P-Value = 3.7%
Slope = 2.3



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Claim and Encounter Capture and Adjudication costs in this functional area are primarily those associated with the manual processing of claims as opposed to being autoadjudicated. These are referred to as Suspended Claims.

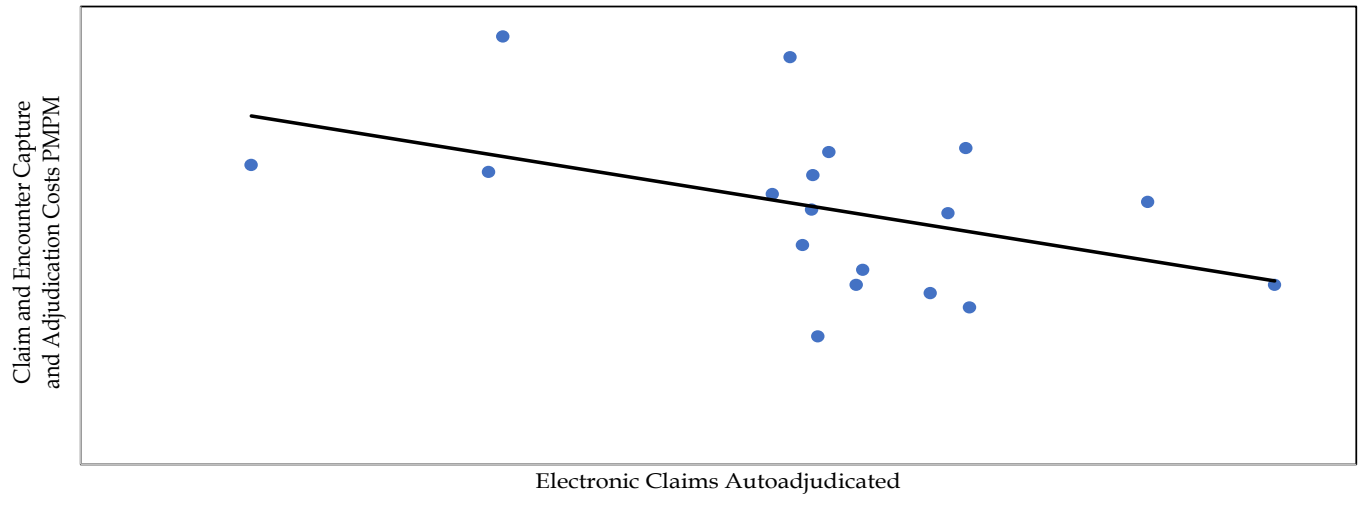
The relationship between costs and manually processed claims is complex in that that both overall volume (irrespective of the adjudication process) and automation can affect the volume of manual claims. Since the claims processing activity analyzed here is solely of Medicare Advantage members, the higher health care and claims requirements of seniors have been mitigated to a degree.

Figure 6 shows the tradeoff between the costs of Claim and Encounter Capture and Adjudication and the volume of Electronic Claims that are Autoadjudicated. The higher the per member claims that are autoadjudicated, the the lower the PMPM costs for this functional area. Typically, over 80% of Medicare Advantage claims are autoadjudicated.

Again, claims that are manually processed are referred to as suspended claims. Suspended claims can arise regardless of whether they are submitted electronically or in paper form. Paper claims are often scanned to enable autoadjudication.

Figure 6. Plan Management Navigator
Operational Drivers of Medicare Advantage
The Effect of Electronic Claims Autoadjudicated on Claims

R^2 = 21.1%
P-Value = 5.5%
Slope = -0.1



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In Figure 7, we show that Total Suspended Medicare Advantage Claims per Member is a strong determinant of costs in this function, irrespective of how the claims are submitted.

This relationship between Medicare Advantage cost and the mode of submission of the suspended claim is illustrated in Figures 8 and 9. Figure 8 shows, if claims are submitted in paper form, the higher the number that are suspended, that is, Paper Claims Suspended, the higher the costs. Figure 9 shows a similar result for claims that are submitted in electronic form, Electronic Claims Suspended.

Figure 7. Plan Management Navigator
Operational Drivers of Medicare Advantage
The Effect of Total Claims Suspended on Claims

R^2 = 54.3%
P-Value = 0.1%
Slope = 0.3

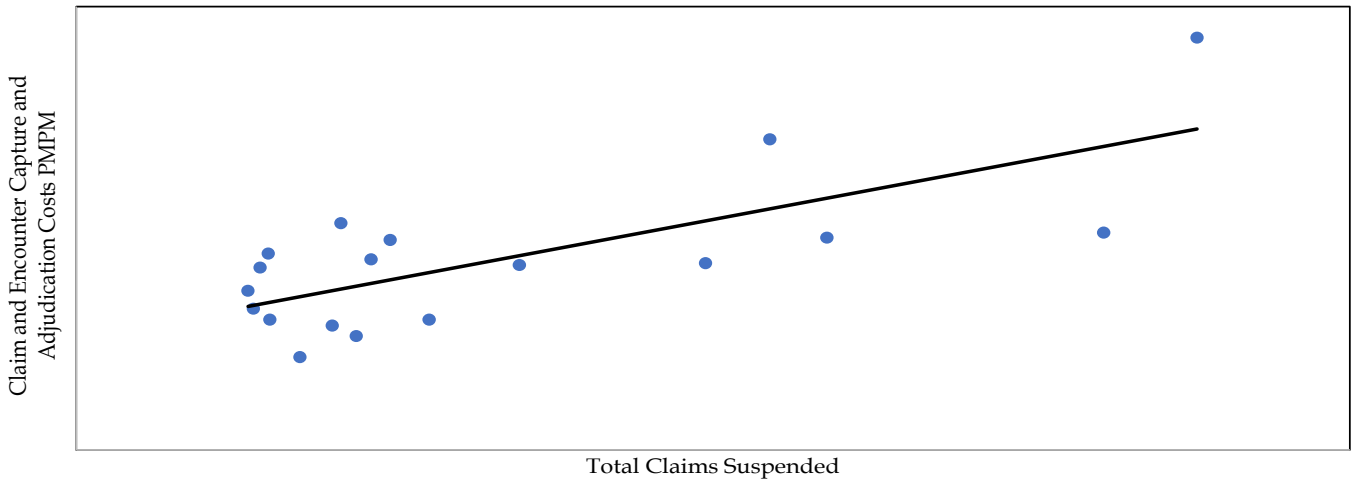
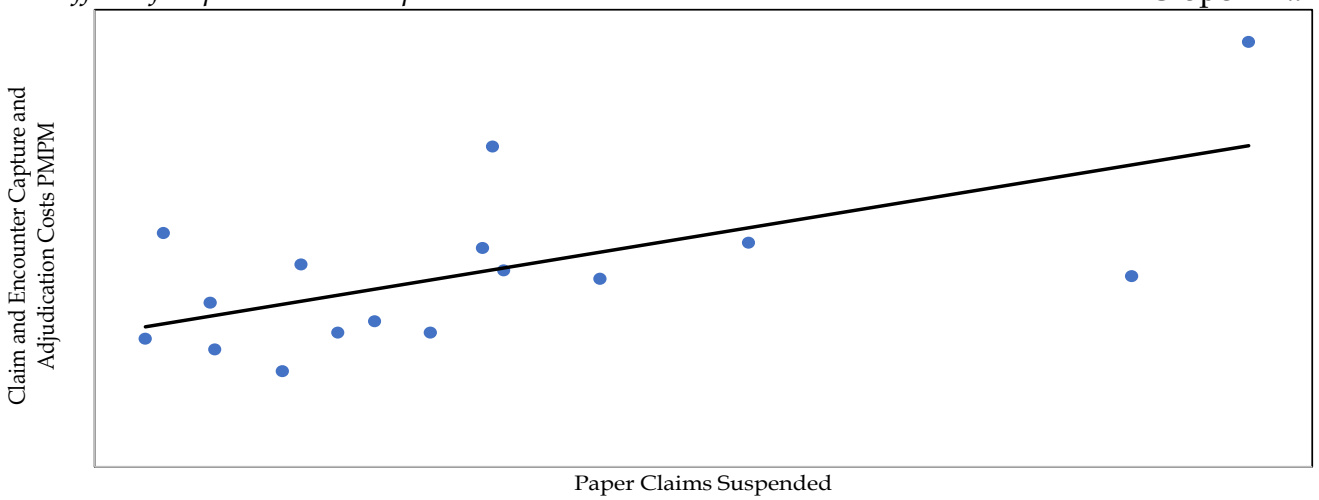


Figure 8. Plan Management Navigator
Operational Drivers of Medicare Advantage
The Effect of Paper Claims Suspended on Claims

R^2 = 41.0%
P-Value = 0.8%
Slope = 2.9



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While, regardless of how they are submitted, most claims are autoadjudicated, Medicare Advantage claims submitted in paper form are much less likely to be autoadjudicated than claims submitted in electronic form.

Paper Claims Processed Per Member are intrinsically more expensive to process. This is shown in Figure 10 where the higher the number of Paper Claims, the higher the costs of the Claim and Encounter Capture and Adjudication Function. Higher costs of paper claims may result from the higher propensity for paper claims to be suspended. It is also possible that some pre-processing costs are found here as well, though paper claim imaging costs are found in the Imaging subfunction of Corporate Services.

Figure 9. Plan Management Navigator
Operational Drivers of Medicare Advantage
The Effect of Electronic Claims Suspended on Claims

R^2 = 54.6%
P-Value = 0.1%
Slope = 0.4

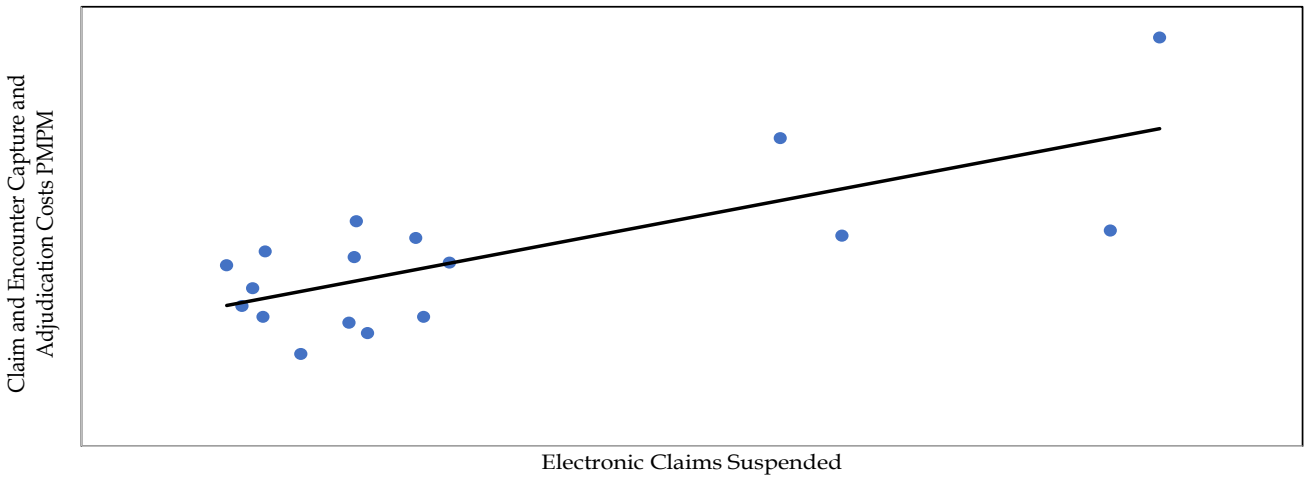
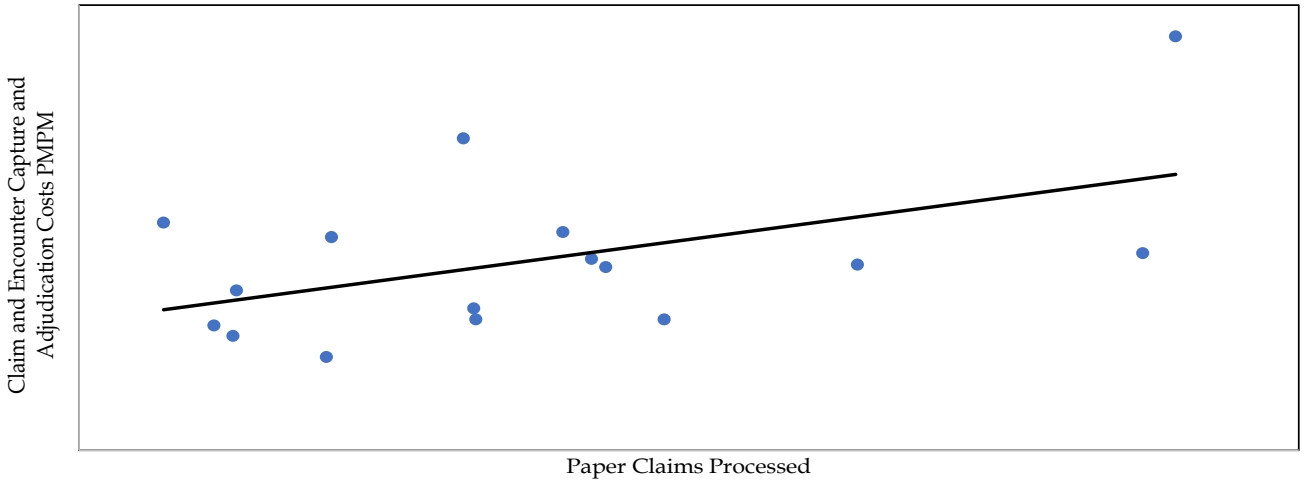


Figure 10. Plan Management Navigator
Operational Drivers of Medicare Advantage
The Effect of Paper Claims Processed on Claims

R^2 = 26.2%
P-Value = 4.3%
Slope = 1.3



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How We Performed these Analyses

The *Sherlock Benchmarks* for 2020 are the basis of this analysis. To facilitate comparability between each plan in populating the surveys, we supply extensive documentation, numerous checks throughout the process and collaborate with each participant to identify and amend incorrect submissions. We reviewed the each of the plans results to validate their accuracy including an analysis of each product/expense cell and with a comparison to audited financials. Also, since participation is voluntary, the participants' intended application of the results is their stake the quality of their submissions.

The process for selection regression analyses was ultimately subjective, but drawn from relationships that had p-values of less than 10%. We also excluded relationships that were apparently strong but were thinly populated.

The subjective element was our method of testing the relationships by removing individual company values that appeared to determine the relationship. If, once these values were excluded, the relationship remained strong, it was included in this report.

INVITATION TO PARTICIPATE IN THE SHERLOCK BENCHMARKS FOR MEDICARE AND MEDICAID PLANS

We are in the midst of the 24th annual health plan performance benchmarking study and beginning our preparations for Medicare and Medicaid Plans.

The past year's adaption to COVID-19 has been challenging for health plans. The unemployment rates remain high and, in addition to overall membership declines, Medicare and Medicaid are increasing their share of the industry product mix.

In this uncertain environment, the most manageable activities are those under the direct control of health plan leaders. For most health plans, these activities are administrative, that is, fielding calls from providers and customers, processing claims and enrollment, conducting medical management and risk management in an efficient and effective way, plus assuring that the information system infrastructure is optimal. Put a different way, optimizing administrative expenses advantageous under any scenario.

We encourage you to consider participation in these universes if a plurality of your membership is Medicare Advantage or Medicaid. You'll be among good company.

If you would like to discuss the process, commitments and outputs, we hope that you will not hesitate to reach out to us at:

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