Plan Management Navigator
Analytics for Health Plan Administration

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Please see page 8 for our invitation to participate or license in the Sherlock Benchmarks.

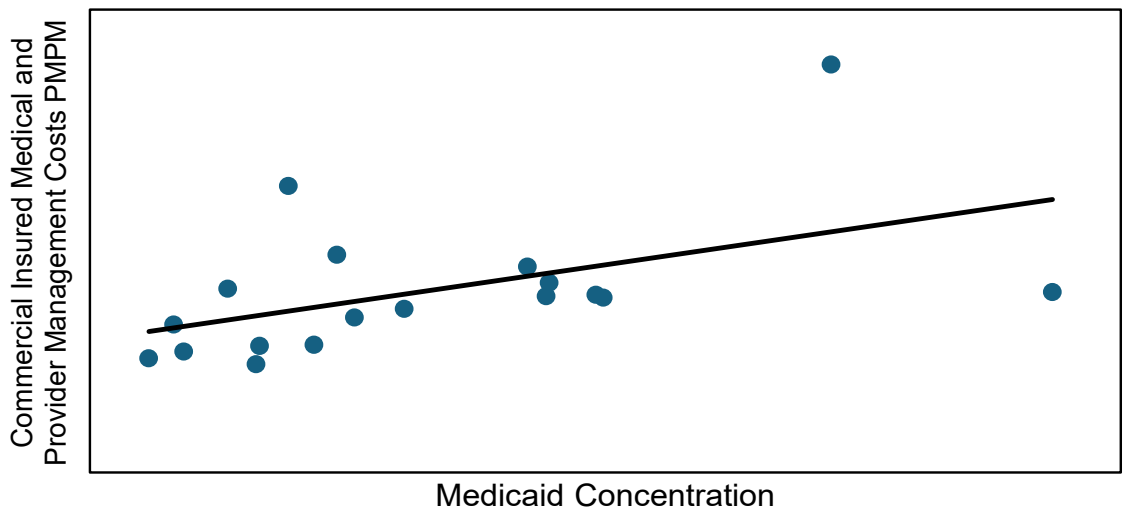
Health Care Management Resource Links Between Medicaid, Commercial Insured and ACA Products

Background

According to a January 24, 2024 paper issued by the White House Council of Economic Advisers, enrollment within the Health Insurance Marketplace reached a record high of 21 million for the 2024 plan year, up from 16 million for the 2023 plan year. One factor in that growth "may be … in part (the) unwinding of the pandemic-era Medicaid continuous coverage rules", that is, the expiration of the suspension of Medicaid redetermination originally instituted during the public health emergency related to Covid-19.

For example, the publicly-traded health plan, Centene, during its fourth quarter earnings call, noted that a portion of its Marketplace growth was attributed to the continuity of coverage for members transitioning from Medicaid. The company stated, "…trend towards the top half of our previously provided guidance range of 200,000 to 300,000 re-determined lives captured by Ambetter (Centene's marketplace health plan). Ultimately, the individual commercial market represents a strategic opportunity for Centene…" As of December 31, 2023, Centene served 3.9 million Commercial Marketplace members and 14.5 million Medicaid members.

Figure 1. Plan Management Navigator
Links Between Medicaid and Commercial Insured
Medicaid Concentration and Com. Insured Med. & Prov. Mgmt.



Introduction

In this *Plan Management Navigator*, we explore possible administrative links in serving Medicaid, Commercial Insured and ACA products. This is notwithstanding that health plans typically serve multiple lines of business, but they are rarely structured to operate along these product lines. In other words, it is typically impractical for plans to operate separate claims, customer services, enrollment functions strictly along product lines.

On the other hand, they do segment administrative costs for the *Sherlock Benchmarks* by product, typically using some form of activity-based costing, such as claims volumes, customer service inquiries and so forth. For that reason, we can know that Provider Network Management and Services is lower for Medicaid than Commercial Insured but Medicaid incurred slightly higher costs for Medical Management. There is evidently a design difference between the products reflected in resource commitments since health care costs are vastly lower for Medicaid than Commercial Insured.

ACA health care costs are slightly lower than other Commercial Insured but still much higher than Medicaid. Medicaid had lower Provider Network costs than ACA and slightly higher Medical Management costs than ACA. While these administrative costs for Medicaid and ACA were different, their differences were dwarfed by the vastly lower Medicaid health care cost differences.

Put a different way, when measured against the underlying health care costs, Medicaid is managed with greater intensity using Provider Network and Medical Management activities than ACA, which is in turn more aggressively managed than Commercial Insured.

This *Navigator* analysis charts the relationships between various product mixes to determine whether these relationships bleed over into other products. It is based on the 2023 *Sherlock Benchmarks*, which reflects data from year ended 2022. There were 18 plans that served both the Medicaid and Commercial Insured products. Of these, eight of these plans further segmented expenses by function for members on the healthcare exchanges, or Marketplace. We most frequently used "Medicaid Concentration" as the independent variable. Medicaid We define concentration as the proportion of plan members served by Medicaid.

We focused our analyses on the two functions in the Medical and Provider Management cluster. In the process of our analyses, we also analyzed the Account and Membership Administration clusters of expenses though had little success in capturing meaningful relationships. We opted not to test the Sales and Marketing cluster since this area is subject to regulations that vary by state. We also opted not to test the Corporate Services Cluster since economies of scale are sometimes present in this cluster.

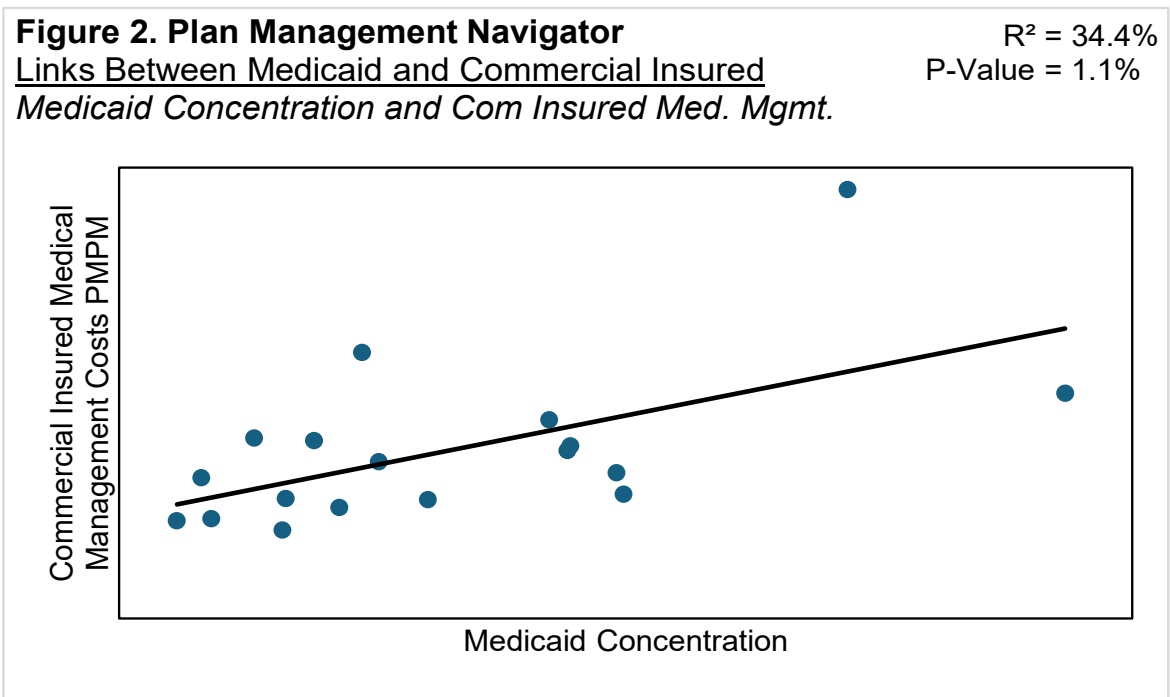
We considered relationships to be significant with P-Values of 10% or less. The R^2 describes the degree to which all the data points are found on the slope. The P-Value is the chance that the relationship described by the regression line could be the result of an unrepresentative sample.

Medicaid Concentration and Commercial Insured Costs in the Medical and Provider Management Cluster

Figure 1, shown on Page 1, shows the results of Medicaid Concentration and Commercial Insured PMPM costs in Medical and Provider Management cluster. (This cluster is comprised of the functional areas of Provider Network Management and Medical Management / Quality Assurance / Wellness.) The analysis resulted in a P-Value of 3.6% and R^2 of 24.7%. The positive correlation implies that the higher the focus on Medicaid, the higher the plan's Commercial Insured Medical and Provider Management expenses PMPM. As noted previously, every dollar of Medicaid health care costs is typically more subject to systems of cost management, and this appears to bleed into the Commercial Insured products of highly Medicaid focused plans.

We then tested Medicaid Concentration against the Commercial Insured expenses in each of the Provider Network Management and the Medical Management functions. Medicaid Concentration and Provider Network Management failed to yield a significant correlation with a P-Value of 84.5% and R^2 of 0.25%. However, Medicaid Concentration and Medical Management PMPM expenses yielded a P-Value of 1.1% and R^2 of 34.4%, shown in Figure 2.

Figure 2. Plan Management Navigator
Links Between Medicaid and Commercial Insured
Medicaid Concentration and Com Insured Med. Mgmt.



The positive relationship between the variables suggests that the higher proportion in Medicaid leads to higher costs in Medical Management Commercial Insured PMPM Costs. What we draw from this is that the effect of Medicaid Concentration on the cluster is primarily, though not exclusively, the result of the Medical Management function.

Medicaid Concentration and Commercial Insured Staffing Ratios in Medical and Provider Management

We also analyzed the proportion of members in Medicaid against inferred staffing ratios for Commercial Insured. (Staffing Ratios are inferred by dividing Commercial Insured costs by total costs per FTE.) For most health plan activities, staffing ratios are closely related to per member costs.

The analysis in Figure 3 shows that the greater the proportion of Medicaid members, the higher the staffing ratios for the Medical and Provider Management cluster in Commercial Insured. The resulting correlation had a P-Value of 1.8% and a R^2 of 34.0%. This is similar to the analysis shown in Figure 1, earlier.

Within the cluster's functional areas, Medicaid Concentration displayed a significant and positive link. In Figure 4, on the next page, we show that the higher the focus on Medicaid, the higher the staffing ratios within Provider Network Management function for Commercial Insured. The R^2 was 64.9% and the P-Value was 0.02%. Note that there was no similar positive association between focus on Medicaid and the costs for Commercial Insured Provider Network Management and Services.

Figure 3. Plan Management Navigator R^2 = 34.0%
Links Between Medicaid and Commercial Insured P-Value = 1.8%
Medicaid Concentration and Com Insured Med. & Prov. Staffing Ratio

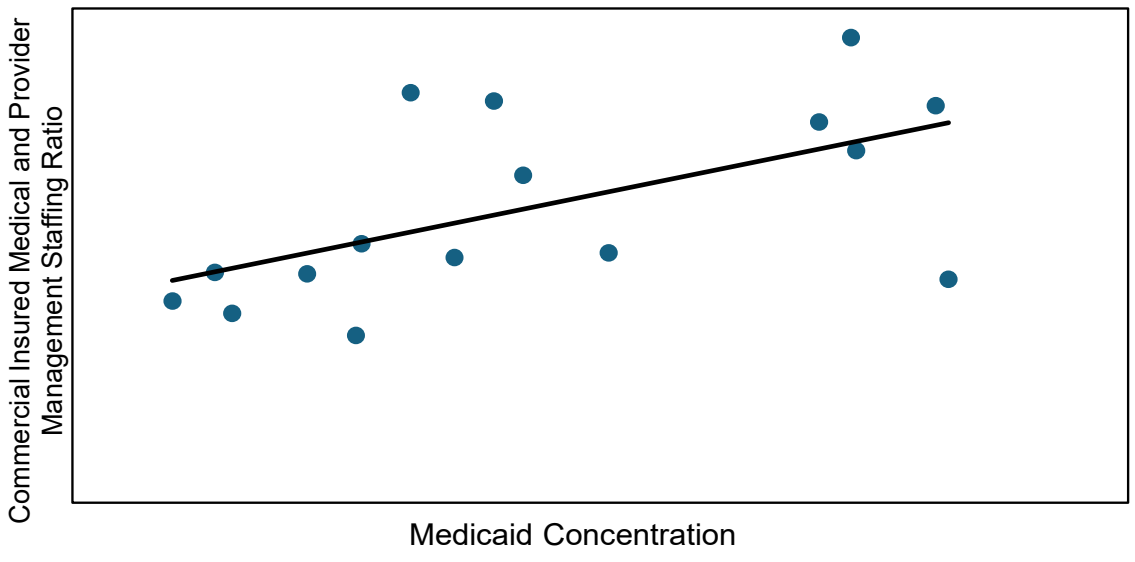
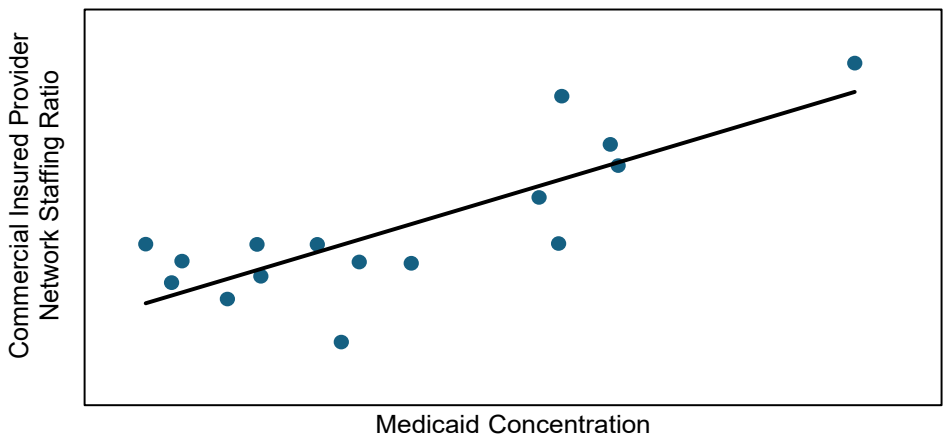


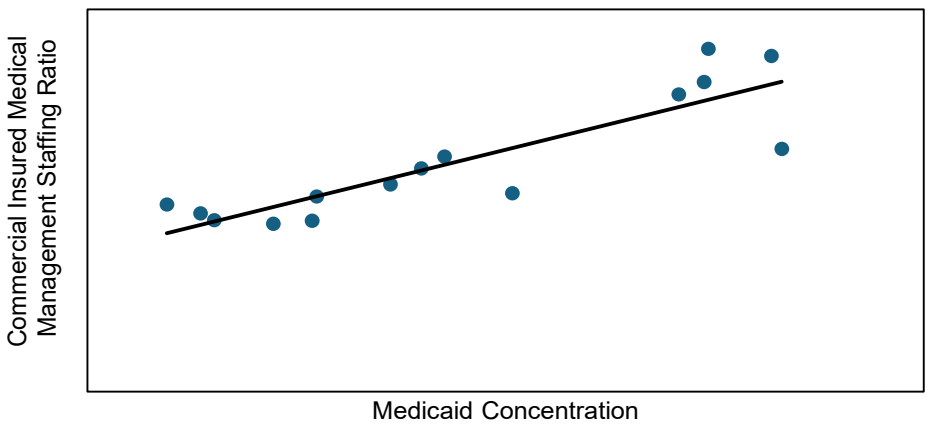
Figure 4. Plan Management Navigator R^2 = 64.9%
Links Between Medicaid and Commercial Insured P-Value = 0.02%
Medicaid Concentration and Com Insured Prov. Net. Staffing Ratio



The nature of the R^2 being less than 100% admits of other factors that could affect the relationship. Among these that could be found in Provider Network Management and Services expenses in the cases in which vertical integration sharply reduces non-labor costs or the development of new geographic markets sharply increases non-labor costs.

While not shown, we also examined the Provider and Medical Management sub-functions. Within Provider Network, Provider Relations and Provider Contracting sub-functions exhibited significant correlations with Medicaid Concentration. Both analyses resulted in positive relationships with an R^2 of 24.3% and a P-Value of 5.2% for Provider Relations and an R^2 of 22.7% and a P-Value of 6.2% for Provider Contracting.

Figure 5. Plan Management Navigator R^2 = 76.7%
Links Between Medicaid and Commercial Insured P-Value = 0.002%
Medicaid Concentration and Com Insured Med. Mgmt. Staffing Ratio



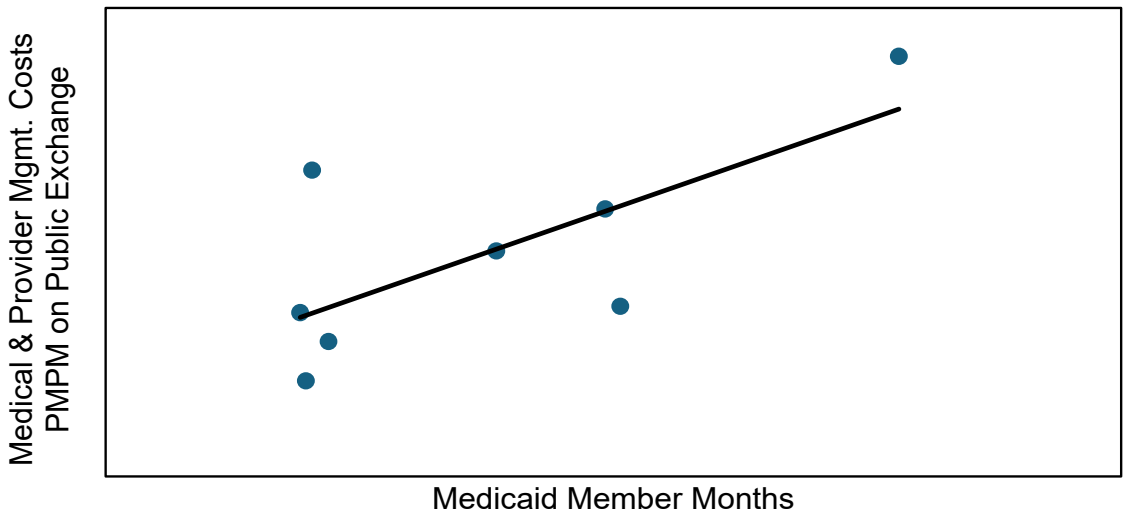
The analysis of the relationship between Medicaid concentration and the staffing ratio for the function of Medical Management for Commercial Insured had a P-Value of 0.002% and R^2 of 76.7%, shown in Figure 5 on the previous page. The positive slope suggests that the greater the proportion in Medicaid, the higher the staffing ratios for Commercial Insured Medical Management. This is a similar but stronger relationship than was shown in Figure 2 – we have found that many analyses of staffing ratios are stronger than similar ones for PMPM costs. Our studies of economies of scale often show this.

Medical Management sub-functions that were significantly related to Medicaid Concentration included Disease Management (P-Value = 3.8% and R^2 = 27.2%), Nurse Information Line (P-Value = 5.8% and R^2 = 34.4%) and Medical Informatics (P-Value = 3.3% and R^2 = 32.7%). We do not show these but the positive slope in all three cases indicate that the higher the proportion of a plan's members that are in Medicaid, the higher the Commercial Insured staffing ratio will be for Disease Management, Nurse Information Line, and Medical Informatics.

Medicaid Membership Volume and ACA Under 65 Exchange Costs

As noted earlier, a sub-set of the plans that served both the Medicaid and Commercial Insured products also provided additional details of their Exchange or Marketplace product expenses. Those reporting plans are apparently not all *Sherlock Benchmark* participants that offer them. For instance, nearly all Blue Plans offer to the Individual Market, which composes a median of 23% and a mean of 27% of their Commercial Insured Membership. Approximately 70% of those individual members are using an ACA product.

Figure 6. Plan Management Navigator
Links Between Medicaid and Commercial Insured
Medicaid Members and Med & Prov. Mgmt Costs on Exchange



Although Medicaid Concentration did not show a significant association with Medical and Provider Management for the exchange product, there was a notable correlation with Medicaid *member months*. This resulted in a similar relationship shown with Commercial Insured with a P-Value of 4.9% and R^2 of 50.3%, shown in Figure 6 on the previous page. The positive slope suggests that the higher the Medicaid member months, the higher the Medical and Provider Management costs for the exchange product. With only eight data points, and no adjustments for the size of the membership in the two products, this conclusion should be viewed with caution. But it raises the question of whether the sheer size of the Medicaid commitment affects management views of the business model of their ACA product.

Other Analyses

We performed numerous other regression analyses to see if we could identify expenses in other products that appear to relate to Medicaid focus. They yielded no significant relationships.

We examined the Account and Membership cluster of expenses, as well as Total expenses for Commercial Insured. (Account and Membership is comprised of the activities central to health plan operations such as Claims, Customer Services, IS, and Enrollment.) Neither of these yielded significant correlations with Medicaid Concentration with Account and Membership with a P-Value of 27.9% and R^2 of 7.3% and Total expenses with a P-Value of 87.6% and R^2 of 0.2%.

We also conducted additional analyses between Medicaid Concentration and ACA health insurance exchange PMPM expenses in the Account and Membership Administration cluster, Medical and Provider Management cluster, as well as other metrics such as operating margins, health benefits and premiums. However, there were no significant correlations between these variables either.

Conclusion

It appears that there are links between health plans' focus on Medicaid and their resource commitments in health care management in Commercial Insured and possibly ACA Products. Both costs and staffing ratios reflect this. The direction of the causality is not known but the implications are interesting either way. For instance, these modeled relationships could occur among organizations with a prior commitment to Medicaid, with the attendant commitment to intensively managing care, who decide to serve Commercial Insured and ACA members who alternate between the two benefit plan sponsors. Or perhaps organizations disposed to care management in Commercial Insured and ACA products are drawn to serve the Medicaid market where this need is especially acute.

This analysis is based on the 2023 Benchmarks, which are of data from years ended 2022. Medicaid redeterminations resumed in May 2023 so the relationships here may have strengthened, weakened, or changed altogether. In considering these relationships, we focused on the significant correlations found within the Medical and Provider Management cluster of expenses. For the most part, its activities are often aligned with longer-term goals, such as healthcare cost reduction. As a result, investments made in this area may not yield immediate returns and may be realized over subsequent years.

Invitation to Participate in the 2024 Sherlock Benchmarking Study

The highly valid, well-populated *Sherlock Benchmarks* provide participating health plans with an unbiased ranking and, within those plans, helps prioritize cost management activities to have the greatest impact on improving each health plan's overall operating performance.

The surveys for the Independent / Provider – Sponsored ("IPS") universes were launched in recent weeks and the surveys are due back by Mid-May. The IPS universe is comprised of 12 plans. *If your plan has an interest in participating in this universe, please reach out immediately so we can execute a mutual confidentiality agreement.*

The **Medicare** and **Medicaid** universes will be launched on June 4th, immediately after the Medicare bids are due. Please reach out to us if your health plan has an interest in participating in these universes.

The Blue Cross Blue Shield survey forms are due back by April 26th with 14 Plans participating. Drafts are tentatively available in late May with final Reports beginning in Early June. *Please let us know if you're interested in licensing*.

The 2024 study will be the 27th consecutive year, reflecting a cumulative experience of more than 1,000 health plan years. Health plans serving more than 200 million Americans are either licensees or participants in the *Sherlock Benchmarks* from June 2021. Plans using the Benchmarks include most Blue Cross Blue Shield plans, large public companies, Independent / Provider-Sponsored health plans, Medicare plans and Medicaid plans, as well as their consultants.

For those unable to participate, licensing is available. Please see the following link www.sherlockco.com/sherlock-benchmarks for additional information on the *Sherlock Benchmarks*. The Report Tables of Contents shown on that page mirror the Reports received by participants. The difference is that each participant edition is tailored to that participating health plan.

The *Sherlock Benchmarks* have been called the "Gold Standard" by leading health care consultants. Report publication begins in late June but varies by universe. Participation entails efforts on the part of the plans since actionable outputs require relatively granular inputs. However, the cost is relatively modest.

Please reach out to Douglas Sherlock at sherlock@sherlockco.com or 215-628-2289 if you are interested in either participation or licensing.

You will be among good company.

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