Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

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Please see page 7 for our invitation to participate in the 2022 or license the 2021 Sherlock Benchmarks.

Why Commit to Medical Management?

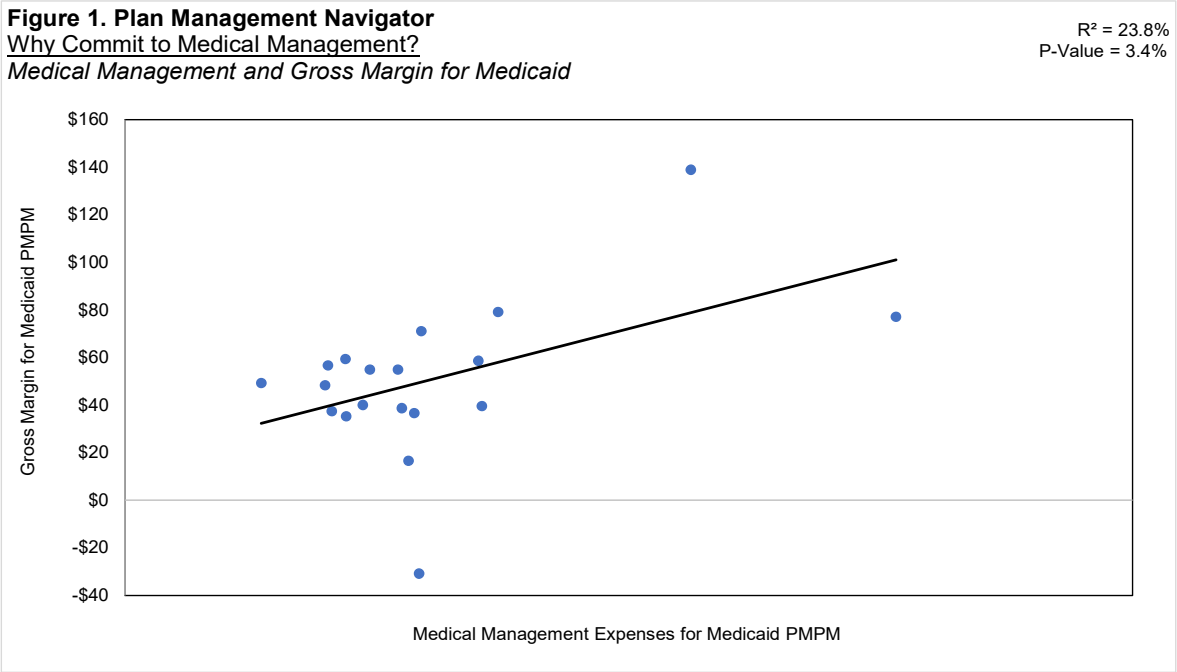
ROI, Medical Management, Age and Utilization in the *Sherlock Benchmarks*

Health plans commit to medical management activities to assure that their members receive optimal care. That is, they spend medical management dollars to make sure that health care expenses are appropriately spent.

At any point in time, it is difficult to measure whether health plans are achieving their goals. For instance, one way of measuring the efficacy of medical management would be if it could be demonstrated that greater per member medical management expenses led to higher gross margins. In fact, during the 2021 benchmarking cycle, the 19 plans that offered Medicaid displayed those results. This was also true for the association between prior year Medicaid medical management and current year gross margins.

Unfortunately for this approach to estimating ROI, the Medicaid product was unique in showing this relationship. Medicare and the commercial products did not show any significant positive relationships between gross margin and medical management. One possible factor contributing to the absence of a calculated ROI in these other product lines is that the universe is composed of "third-party payors." This could mean that a plan's efforts to help providers could bleed over to its competitors that use the same doctors and hospitals. If so, then perhaps the uniquely favorable result in Medicaid results from the often narrow panels of providers available to Medicaid beneficiaries.

Figure 1. Plan Management Navigator
Why Commit to Medical Management?
Medical Management and Gross Margin for Medicaid



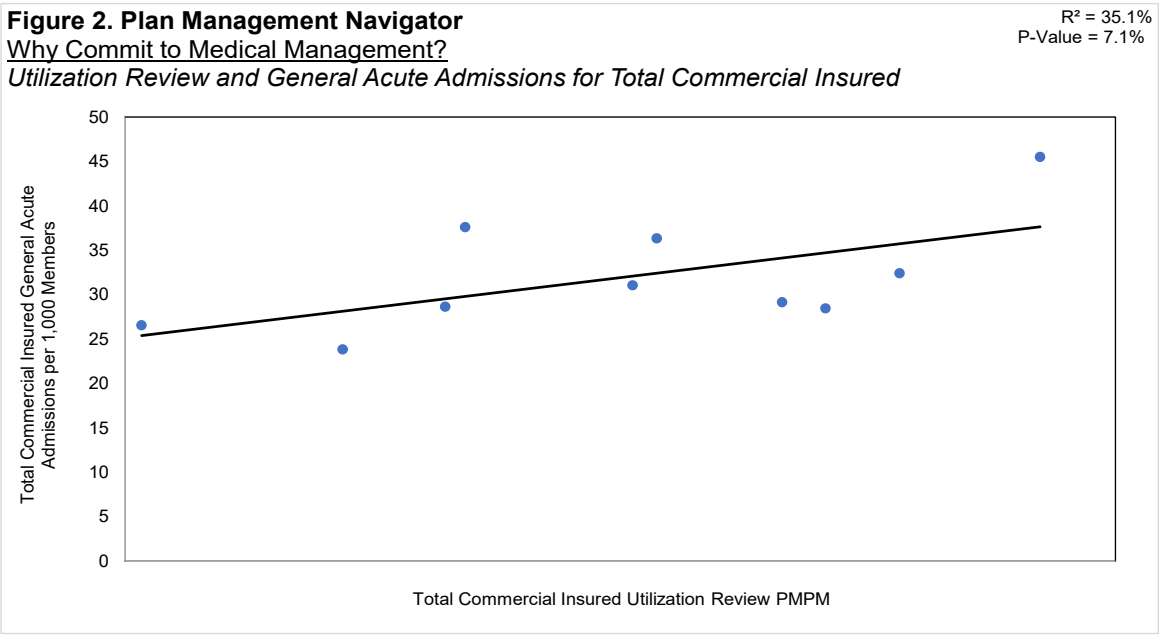
So why make such a commitment if ROI is illusive and hard to measure? We think that these expenditures in medical management may be defensive. That is, they are in reaction to the health care needs of the population they serve. In addition to higher margins, *higher* health care costs are also associated with higher medical management in Medicaid.

Implicit in the design of the *Sherlock Benchmarks* is the recognition that managing costs relates to managing the cost variances actually borne by the plan. For instance, per member Commercial Insured medical management is 1.3 times that of ASO for Blue Plans and 2.3 times for Independent / Provider - Sponsored plans. And, within these products, medical management relates to the needs of the population, both reflecting member age and the actual care that members require.

One way of gauging health care needs is through the utilization of health services. Figure 2 shows a relationship between general acute admissions and utilization review for Total Commercial Insured. A similar pattern for utilization review exists for Commercial HMO insured and Medicare Advantage. While data is far more sparce, there is the suggestion of a similar pattern for Non-Inpatient Specialist Physician Encounters and Case Management.

Another way of measuring those needs is by age of member. After all, older people generally require more health services than younger people. For instance, among our participants, per member Medicare Advantage costs are about 2.4 times that of the commercial HMO product, serving a population that is 1.9 times older.

Figure 2. Plan Management Navigator
Why Commit to Medical Management?
Utilization Review and General Acute Admissions for Total Commercial Insured



That age effect on costs is apparent within products too. For commercial insured, higher health benefit costs are associated with higher age, as shown in Figure 3. So, within a product, if members are older, they may have higher health care needs and health plans respond with greater medical management activities.

Accordingly, as shown in Figure 4, higher medical management expenses are associated with greater age in the commercial members served.

Figure 3. Plan Management Navigator
Why Commit to Medical Management?
Avg Age and Health Benefit Expenses PMPM for Commercial Insured

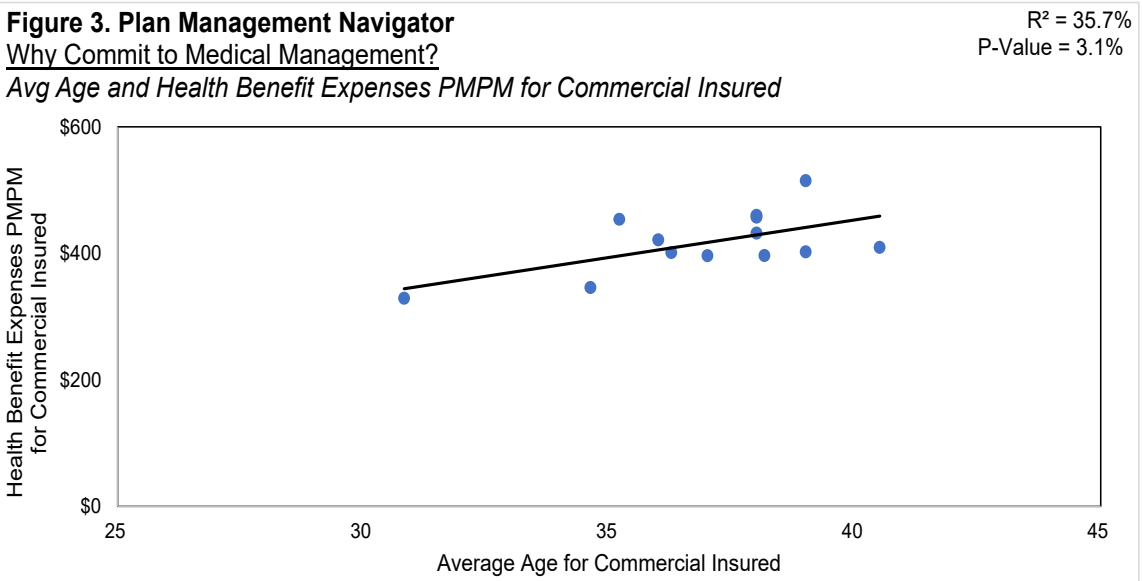
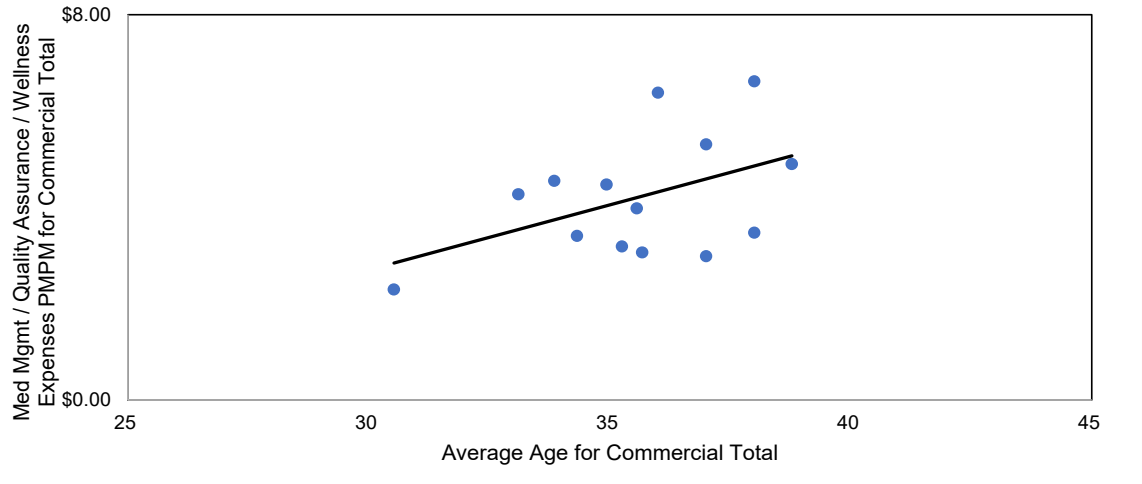


Figure 4. Plan Management Navigator
Why Commit to Medical Management?
Avg. Age and Med Mgmt/QA/Wellness Expenses PMPM for Commercial Total



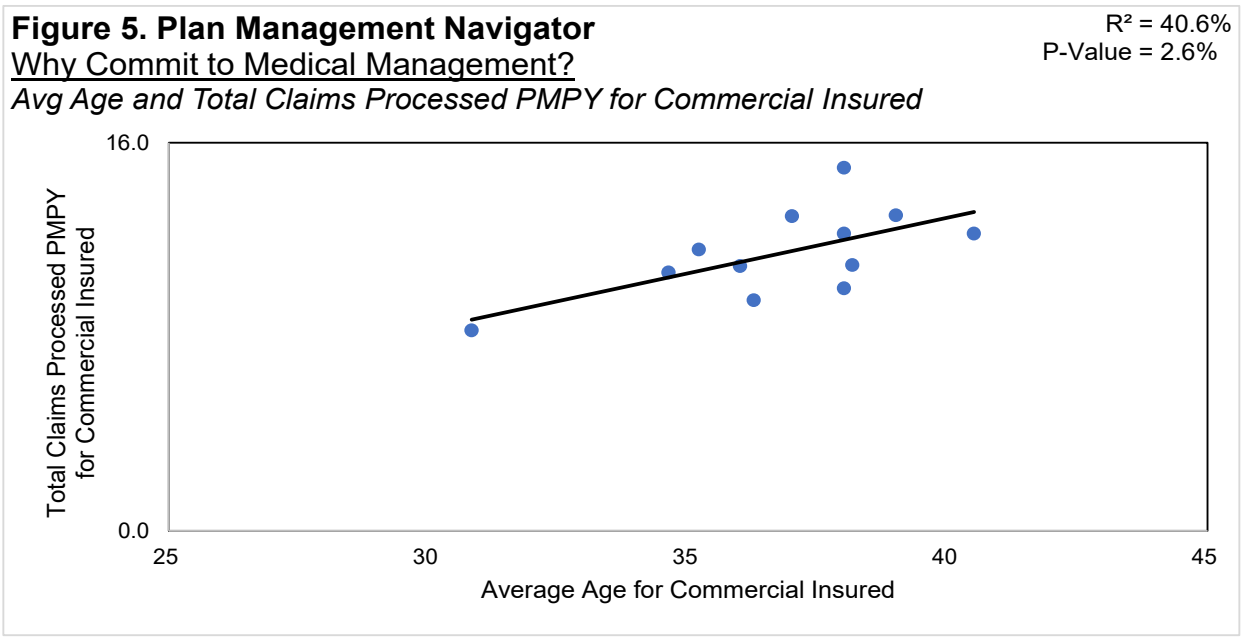
The overall theme of this analysis relates to medical management and calculating an ROI. As shown above, measuring this is not a straightforward exercise in that the medical management commitments may be defensive. That is, to forgo medical management for an insured population without consideration of population health care requirements risks incurring disproportionately high costs for that population in an already thin margin business.

But, as we looked at the effect of health care needs on health care costs and medical management, we discovered that they also affected other functions. After all, health care delivery is part of an entire production chain beginning with the consumer and his or her selection of the selection of care bundled as health insurance.

More concretely, a health care need, such as a hospital stay, is memorialized in the claims system; thus, in the *Sherlock Benchmarks*, the claims function is referred to as "claim and encounter capture and adjudication," sufficiently broad to include activities that reflect health needs but may be actually paid for though capitated, risk-bearing providers.

This "production chain" charactor is reflected in administrative activities other than medical management activities. Total claims processed per member per year are sensitive to the age of the population served. For instance, among IPS plans, claims processed per member for Medicare Advantage is more than 2.5 times higher than that of commercial HMO. Considering the disproportionate impact of seniors on total health plan administration, it is not surprising that age is associated with higher claims volumes in health plans.

Figure 5. Plan Management Navigator
Why Commit to Medical Management?
Avg Age and Total Claims Processed PMPY for Commercial Insured

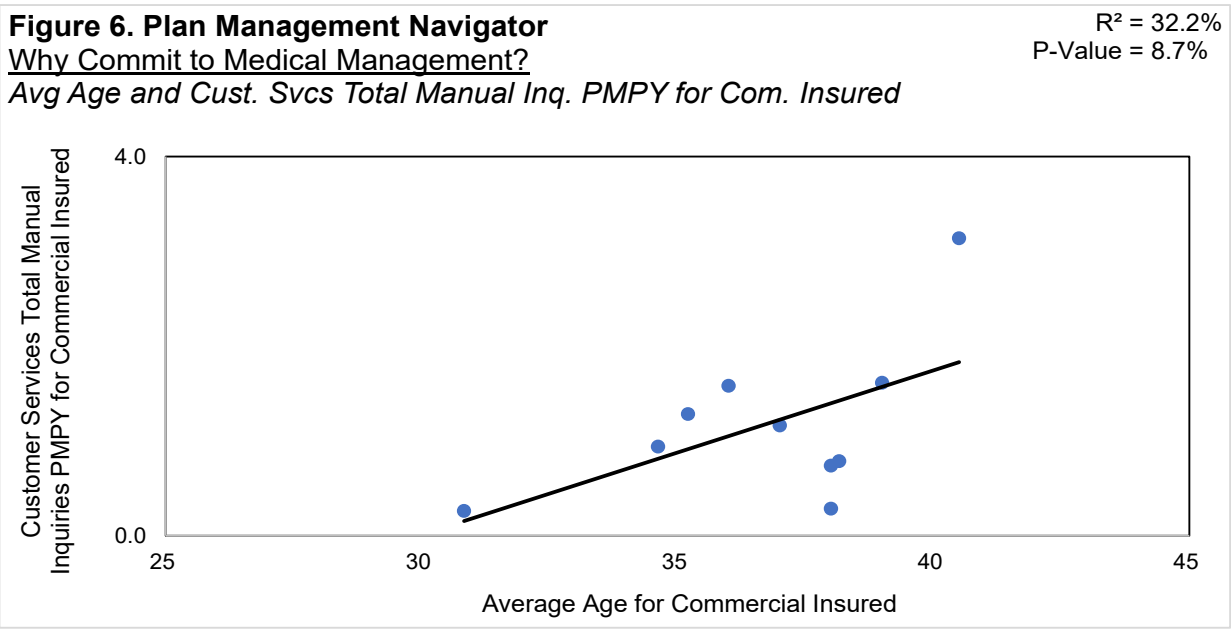


This age effect is also true *within* the underlying products. For commercial insured products, claims processed per member per year is associated with the age of the membership, as shown in Figure 5.

Claims processing is a definitional activity of health plans. For instance, other names for health plans are "third party payors" and "fiscal intermediaries." But other purely operational activities can stem from this role. Claims can give rise to member inquiries – approximately 13% of Independent / Provider Sponsored plan calls are reported to us to be claims-related. Continuing with the production chain model of health plan operations, it is unsurprising that customer services inquiries also are associated with age. Figure 6 shows that the volume of inquiries is age related for the commercial insured market segment.

This relationship between health care needs and various health plan administrative activities extends to other activities in the insurance portion of the health care production chain. And, in fact, administrative costs are age-sensitive in the plans' total comprehensive products.

Figure 6. Plan Management Navigator
Why Commit to Medical Management?
Avg Age and Cust. Svcs Total Manual Inq. PMPY for Com. Insured



Conclusion

Calculating ROI on medical management is not straightforward and the most direct way of calculating it yields results that are visible only in Medicaid. It may be that the narrower provider panels of such products reduce the effect of spill-overs to competitors. Instead, health plans might be committing to medical management as a strategy to ameliorate cost variances where it identifies high health care needs measured by utilization or by age of member.

Not only does medical management reflect these health care needs but also so do other aspects of the health insurance portion of the health care production chain.

Note on Process

A lesser-known aspect of the *Sherlock Benchmarks* are metrics that bear on health care costs, such as utilization, and the relationship between them and factors that may contribute to them. These factors include the age of the population served and medical management activities that may optimize costs, irrespective of age.

In the *Sherlock Benchmarks*, age and health care utilization information are relatively thinly populated. So qualified, our analysis of the limited information suggests that health plans tend to increase medical management costs when their members are older, and when they experience high utilization in certain products.

MEMBER AGE

The *Sherlock Benchmarks* collect member age information on a voluntary basis, that is, it is not required for full participation in the *Sherlock Benchmarks*. This is limited to age by product segmented into brackets. The limited data stems from the difficulty we face in validating these self-reported values. By contrast, we can check financial metrics such as cost and staffing information against a combination of audit information and very granular statistical analysis. Instead, validation recognizes that participants' own effort versus insight calculations encourage reporting only if they are confident in the reliability of their own data.

In the *Sherlock Benchmarks*, the compilation of member age is found in the Membership and Billing subfunction. Twelve Independent / Provider – Sponsored plans completed this but only three Blue Cross Blue Shield Plans did. In general, the reporting Blue Plans have younger participants than do the reporting IPS plans.

HEALTHCARE UTLIIZATION

Like member age, utilization metrics are voluntary, and they are so for the same reason. Only ten of the 36 total participants submitted any usable health care utilization information.

Sherlock Benchmarks: Participation and Licensing

This *Plan Management Navigator* analysis relies on the results of the 2021 *Sherlock Benchmarks*, our 24th annual study.

In this analysis, all data is for the 2020 calendar year and has been carefully validated both by us and by the plans themselves. Collectively, the 32 plans served 51 million Americans. The range of membership was from 329,000 to over 5 million among Blue Plans and about 52,000 to 1.6 million among IPS plans. In addition to the Blue Cross Blue Shield and Independent / Provider – Sponsored universes, we also have universes of Medicare, Medicaid, and Larger plans.

Your health plan is invited to participate in the 2022 cycle based on 2021 results. While the surveys will be distributed beginning in March, twenty-eight plans in the above universes have already signed agreements to participate in the 2022 cycle. So far, we are expecting 16-18 Blue Cross Blue Shield participants and 16-18 IPS participants.

-For those that cannot participate, licensing is available. Please see the following link https://sherlockco.com/sherlock-benchmarks for additional information on the *Sherlock Benchmarks*. The Reports shown on that page are also the Reports received by the participants.

Contact

Please do not hesitate to contact us with questions concerning this analysis or the *Sherlock Benchmarks* on which it is based, or your interest in licensing the 2021 edition or participating in the 2022 *Sherlock Benchmarks*. We can be reached at sherlock@sherlockco.com or (215) 628-2289.

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