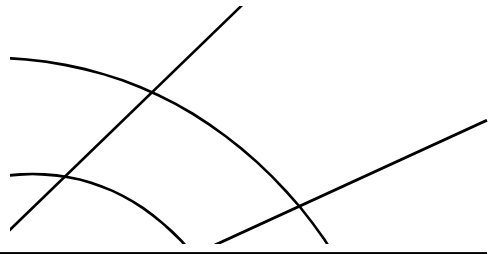


# Plan Management Navigator



Analytics For Health Plan Administration

January 2005

## BENCHMARKING IN 2005

We are in the early stages of our benchmarking for 2005, based on 2004 data. We expect to expand the universes and continue our ongoing efforts to enhance the process and comparability of results. Enhancements include:

- Further development of on-line “forum” to discuss and explain definitions and classifications. Links to website, which includes definitions and descriptions, will be available through links from electronic forms of both survey forms and Guidelines.
- Greater detail in descriptions of activities in functional areas. This complements existing descriptions as well as cost center lists.
- Enhanced operational metrics, especially in medical management and information systems.
- Pop-up definitions, and internal checks have also been added to the survey forms.

The various universes included in the *Sherlock Expense Evaluation Reports* in 2004 comprised 38 plans serving 49 million Americans, excluding those members served by regular Medicare. Universes included **Blue Cross Blue Shield Plans** (most will participate in 2005), **Public Companies**, **Provider-sponsored plans** and **Medicaid-Oriented Plans**. We are also considering adding two additional universes as well. In all cases, the universes are still open so please contact us if you wish to participate.

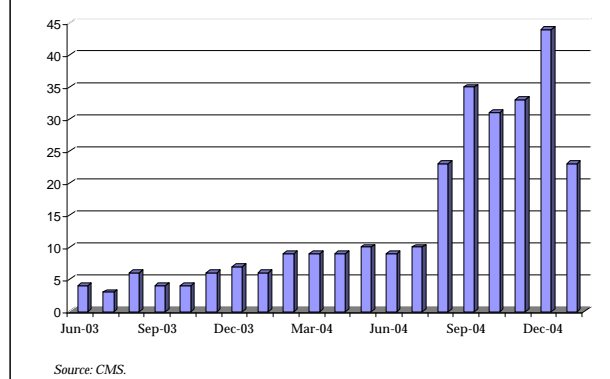
## MEDICARE IS BACK!

Wall Street seems much more enthusiastic about the prospects for health plans since the election. On average, since the beginning of November (President Bush is believed to prefer private sector initiatives in Medicare more than his opponent), health plan stocks appreciated by 27.4% as against a 7.2% gain for the S&P 500. Wall Street seems especially sanguine about the prospects for PacifiCare and Humana, each with a significant commitment to Medicare Advantage, appreciated by 58.7% and 55.0%, respectively, for that time period.

Health plans are themselves more interested in Medicare Advantage than had been the case. Figure 1 illustrates that the number of pending applications has shot up this fall to 44 in December and 23 in January from a more normal level of 8-9 in early 2004. This underscores anecdotal accounts of a surge in applications since the election and that, while most have incremental expansion of existing service areas, some are entirely new operations.

The Medicare Modernization Act expands options for health plans by permitting Medicare Advantage regional plans. The plans are to be structured as Preferred Provider Organizations,

Figure 1. Medicare Advantage Pending Applications



which allow enrollees to go outside the network in exchange for a higher rate of cost-sharing. Such plans would complement those currently available to Medicare beneficiaries.

The regions that PPOs serve can be an entire state or multi-state area. This may especially be attractive to seniors in rural areas since their region may include their areas as well as adjacent urban areas. According to proposed regulations by CMS, about 10 to 50 Medicare Advantage regions will be established.

## How Different is Medicare Advantage?

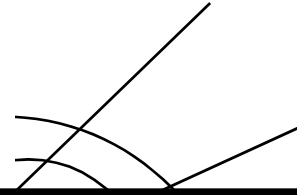
As firms seek to offer Medicare health plans, they must overcome the barrier that this business operates much differently than their existing commercial businesses. Interestingly, it is different in ways that facilitate new entrants.

- The health needs are of course much higher.
- This is a population in which medical management is required. This may represent a significant advantage to local participants that are provider-based.
- The products are sold to individuals, eliminating the advantage of a national marketing presence.
- Because the Medicare Advantage product is sold directly to consumers and these consumers have fixed incomes, a strategy of price leadership may be especially effective.
- Because this population has such high health care needs and somewhat limited mobility, local marketing may be especially appealing.

Accordingly, the costs differ, both in their absolute values and distribution. Medicare Advantage administrative expenses are 7.41% of premiums versus 15.23% (median values) for commercial HMOs. (Source: *Sherlock Expense Evaluation Report 2004 Blue Cross Blue Shield Edition*.)



# Navigator



**Figure 2. Medicare Advantage**  
Median Administrative Costs, PMPM

High Level Area	Medicare Advantage	Commercial HMO	Difference
Marketing	\$5.41	\$8.90	-39.2%
Medical & Provider Mgt.	\$14.22	\$3.76	278.2%
Account & Membership Admin.	\$18.26	\$7.60	140.3%
Corporate Services	\$13.64	\$6.73	102.7%
Total Expenses	\$49.87	\$27.96	78.4%

Source: *Sherlock Expense Evaluation Report 2004 Medicare-Oriented Edition.*

greater for Medicare Advantage compared with other products offered. Staffing, at 4.48 FTEs per 10,000 members is not surprisingly 140% higher to serve them. This leads to a cost difference PMPM of 105%, or \$2.69 for the Medicare Advantage product and \$1.31 for other products.

This sort of difference is also pronounced in such areas as claims and customer services. Customer service calls tend to be higher, the number of claims tends to be higher and while no available unit volume is meaningful, medical management costs tend to be higher as well.

As shown in Figure 2, median marketing costs for Medicare Advantage plans are \$5.41 per member per month, 39% lower than the commercial HMO product at \$8.90, mainly due to lower commissions. However, Account and Membership Administration was \$18.26 pmpm, 140% higher than for commercial HMO. Medical and Provider Management for Medicare Advantage had the largest difference, costing \$14.22 pmpm, 278% higher than \$3.76 from commercial HMO.

These differences represent a significant challenge to those plans intending to offer Medicare products in that the costs and staff required to support such products are so different. If the costs of providing services to this population are not properly anticipated it could spell the difference between success and failure.

## Medicare Advantage Operates Differently

For example, one of the components of Medical and Provider Management is Provider Network Management and Service Costs. For Medicare Advantage plans, these costs are \$2.69, or 105% higher than the cost to serve other products. The drill-down analysis in Figure 3 (some of the following are inferred), isolates the components of the costs of this functional area to identify the drivers of the cost differences. (Please note that because Figure 3 represents medians, the values will not precisely multiply across.)

The differences are evident in each aspect of this functional area. Providers serving Medicare beneficiaries seem to call their health plans more: The number of Provider Management Manual Inquiries per Member, at 2.70 per year, are 170%

## A Possible Business Model

We mentioned previously that local plans may find this to be an attractive opportunity. However, local providers, frequently the sponsors of local plans, may nevertheless be reluctant to get involved. It seems to us that, for the most skittish, an acceptable business model would insulate the provider from a portion of insurance risk and would not require the development of specialized knowledge. The model would capitalize on the brand recognition of the provider. It would also be designed to permit transparency and periodic evaluation by the provider board that sponsors it. We would imagine that forms of management contracts would be an attractive way for these plans to be formed.

## Source of the Data Used in this Analysis

The source of the data used in this universe is the *Sherlock Expense Evaluation Report 2004 Medicare-Oriented Plans* edition. The peer group universe consisted of five selected Medicare-Oriented plans. The mix of peer group included plans from the Blue Cross Blue Shield, Publicly-traded, Medicaid-Oriented, and Provider-Sponsored universes. We estimate that these plans comprise approximately 17% of all Medicare Advantage members. Overall, 20% of the combined membership was enrolled in a Medicare Advantage product. The plans' commitment to Medicare Advantage ranged from 7% to 22% as measured in members. Overall, 45% percent of total revenues came from Medicare Advantage premiums and the percent of revenues from Medicare Advantage ranged from 23% to 49%.

**Figure 3. Medicare Advantage**  
Median Provider Network Management Costs

	Manual Inquiries/Member	Members/FTE	Manual Inquiries/FTE/Year	Cost per Manual Inquiry	Provider Mgt. Costs/FTE	FTEs per 10,000 Members	Provider Mgt. Costs PMPM
Med. Advantage*	2.70	1,983.96	4,545.18	\$14.07	\$81,152	4.48	\$2.69
All	1.00	5,361.43	5,171.57	\$14.07	\$81,152	1.87	\$1.31

\*Medicare Advantage values are estimated in general using the relative costs of this to all other product costs.  
Source: *Sherlock Expense Evaluation Report 2004 Medicare-Oriented Edition.*

