Plan Management
Navigator

Analytics For Health Plan Administration April 2005

2005 Benchmarking Cycle Underway

We have recently begun the 2005 cycle of *SEER* benchmarks. At this juncture we enjoy the participation of most of the Blue Cross Blue Shield Plans (a three plan increase) and a 38% increase in the number of Provider-sponsored plans, to 18. A third universe comprised of the largest Blue plans and public companies is also underway. For those universes, we have distributed survey materials and we are currently answering clarifying questions on our online forum.

While we have recently distributed draft survey materials on the Medicaid universe, we are still accepting participants. Cost pressures, as outlined in our recent speech before the National Managed Health Care Congress, have stimulated increasing interest among these plans. **Please let us know if your plan would like to participate. Also, if you are interested in a .pdf of our Power Point® presentation, let us know.**

SEER reports in the 2005 cycle should become available beginning in July of 2005.

From Descriptive to Prescriptive: Benchmarks as a Catalyst for Change

Ellen Gaucher and Richard Covey, in *Breakthrough Performance* note that the purpose of benchmarking is, "to improve processes and outcomes." It helps plans, "recognize the need to change, determine the priorities for change, and develop a model for change." Gaucher and Covey (Gaucher is Group Vice President of Operations / Quality and Customer Satisfaction of WellMark, a Blue Cross Blue Shield Plan serving Iowa and South Dakota) notes that Benchmarking "serves as an impetus and method for incremental improvement… (and) can also stimulate innovation and creativity."

Benchmarks are often opaque in their implications however. For instance, a plan noting that its customer service costs are high might ask:

1. How do those who are best in class actually achieve it? Is it through automation? Low prevailing wage costs? A culture of excellence?

2. Do low costs in one area affect overall firm performance? Do low costs in customer service imply low costs over all, or is there an offset somewhere else? More strategically, are customer satisfaction and retention affected by the means by which low customer service costs are achieved?

3. Are other functional areas so integrated with the area of study that the production chain must be considered as a whole? Is the performance of the claims function so linked to the customer service function that they must be considered together?

The answers to these questions both illuminate the meaning of the benchmarks and can also provide strategic direction to the health plan. Drill-down analyses of various kinds, such as the identification of factors or the analysis of drivers are means of getting at these questions.

Logical Links

One way of looking at desirable outcomes is to deconstruct costs into logically linked factors. So customer service costs can be algebraically parsed into *factors* of primary demand, staffing ratios, productivity and unit costs.

This approach serves to quickly and accurately identify major sources of variance. The explanatory power of these factors has important limitations, however. The factors are, as implied by near tautological character of the algebra, precise but simplified. For instance, we may identify high demand (customer service calls per member per year) as a factor contributing to high PMPM customer service costs but it does not answer why use is high. A little more analysis of a similar nature may reveal more detail; since we capture inquiries by product, a high proportion of Medicare members may lead to those higher inquiries. In other words, that higher total inquiries per member may be expressed algebraically as the effect of the weight of the high-use Medicare population.

Supporting Drivers

But there are other plausible *drivers* of demand of a population for customer service that are more challenging to describe. For instance, a less developed customer service web portal or an inaccuracy-prone claims system may each increase customer service inquiries. But these are hard to describe in that while there may not be a one-to-one relationship between these possible drivers and member inquiries, there may be a tendency.

Moreover no matter how apparently linked certain factors are to an outcome, in reality, each suggestive relationship is the product of the combination of these factors, as well as the specific circumstances of the plan. Perhaps a health plan with high customer service inquiries has both a high mix of Medicare as well as apparently low employee productivity. Or perhaps there are other hard-to-isolate interactions with other departments. Since determining the relative contribution of these factors would remain a problem, looking at plausible drivers can be helpful.

Some Interesting Examples

In using benchmarks to take an unprejudiced look at these relationships, we have been able to identify a number of interesting examples of relationships that may assist health plans' strategic initiatives.

one dollar increase in the customer service cost per inquiry results an approximate $0.04 increase in per member per month customer service costs. This relationship is quite strong with a p-Value of 4.9%.

The number of FTEs per 10,000 members seems to be a factor positively associated with customer service costs per member

Figure 1. Best Practices
Regression Results (All Plans)

Output	Input	Slope	R^2	p-Value
Enrollment Costs PMPM	FTEs per 10,000 Members	0.401	43.2%	0.42%
Enrollment FTEs per 10,000 Members	% Electronic Enrollment Transaction	(1.356)	76.8%	0.96%
Customer Service Costs PMPM	FTEs per 10,000 Members	0.414	54.4%	0.62%
	Customer Service Cost per Man. Inq.	0.037	30.8%	4.90%
Customer Service Manual Inquiries PM	Claims Overall Accuracy %	(35.971)	34.1%	9.85%
Customer Service FTEs per 10,000 Member	Customer Services FTE Turnover	3.252	24.7%	14.36%

Enrollment

Staffing (the number of FTEs per 10,000 members) is intuitively a factor that should determine per member per month enrollment costs. As expected, we found that the relationship between "FTEs per 10,000 Members" and "Enrollment Costs PMPM" had a positive slope of 0.401.

This slope indicates that there will be a $0.04 cent increase in enrollment costs pmpm for each additional FTE per 10,000 members. With a p-Value of 0.42%, there is greater than a 99% chance that there is a relationship between these two variables.

The proportion of enrollment transactions performed electronically seems to drive a health plan's FTEs per 10,000 members. We expected electronic enrollment transactions to positively drive the staffing ratio because greater electronic transactions should decrease the need to have staff to execute these transactions.

The slope of -1.356 between "% Electronic Enrollment Transactions" and "FTEs per 10,000 Members" indicates that the number of enrollment FTEs per 10,000 members declines by 0.1356 as the percentage of enrollment transactions that are submitted electronically increases by ten percent. Here, the p-Value is 0.96%, so there is greater than a 99% probability that this relationship does, in fact, exist.

Customer Service

The per unit cost of customer service inquiries appears to be a contributing factor to customer service costs per member per month. With a slope of 0.037 between "Customer Service Cost per Manual Inquiry" and "Customer Service Costs PMPM," a per month, as we surmised it might. The p-Value of 0.62% shows the relationship most likely exists. With a slope of 0.414, there would be a $0.041 increase in customer service costs PMPM for each additional tenth of an FTE per 10,000 members.

Experience seems to matter in customer service. With a p-Value of 14.36%, we found that for a ten percent increase in "Customer Service FTE Turnover," "Customer Service FTEs per 10,000 Members" grows by 0.325, a slope of 3.252.

Customer service costs also have some interesting interactions with other departments. For instance it appears that the lower the proportion of claims that are processed accurately, the higher the number of customer service manual inquiries per member. For example, if a provider submits a claim and is not paid for service, it would invoice the member. Then, the member would then contact the health plan. With a slope of -35.971 and p-Value of 9.85% (less than 10% chance that there is no relationship), the slope suggests that if claims accuracy rises by ten percent, member inquiries tend to fall by 0.360.

Background

In our analyses above, we have tended to take a fresh look at these relationships. To avoid any bias in these analyses, we have not ruled in or out any relationships that may stem from any potentially faulty preconceptions.

The source of these analyses are the financial and operating data collected for the *2004 Sherlock Expense Evaluation Report (SEER)*, Blue Cross Blue Shield Edition. We underscore that these analyses, and others that we have made, should be subject to the mediating judgment of managers who are the users of this analysis.