Plan Management Navigator

Analytics for Health Plan Administration

Healthcare Analysts

Douglas Sherlock, CFA
(215) 628-2289
sherlock@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

John Park
jpark@sherlockco.com

Medicaid Benchmarks: 2013 is the Baseline Year

Total Cost Growth was Effectively 0%, as Core Expenses Increased in Low Single Digits

2013 is the Baseline Year

The 2014 Sherlock Benchmarks reflect the first effects of the Affordable Care Act. While no membership had yet enrolled through expanded eligibility, all plans were aware of the changes effective January 1, 2014. Enrollment, including through exchanges, had begun in October of 2013.

Cost growth was modest and there were actual declines in some key functional areas. As developed later, we think that the modest cost increase, when compared with Blue Cross Blue Shield plans and Independent/Provider–Sponsored plans, stems from the lack of adaptation required of the plans under the Affordable Care Act. Thus plans were able to continue their declining growth in costs since 2011. Only Actuarial was a strong exception to this trend. Cost growth was modest in organizations in states that were expanding or were not expanding their Medicaid programs.

Put a different way, since plans focusing on Medicaid products were not required to undergo the adaptation costs of other plans, they were free to focus on administrative cost management. We expect that this trend towards cost optimization will continue in future years.

Because there was no new enrollment as a result of ACA expansions, the 2013 results will be considered the baseline costs for health insurers in future comparisons. Cost optimization will continue to be a priority.

Total expenses PMPM increased for those selected health plans by 0.2% and declined by 1.4% holding constant the product mix of the plans.

Figure 1. Sherlock Benchmark Summary
Medicaid Plans' Rates of Change for Account and Membership Administration and Subtotal: Core Expenses Constant Mix

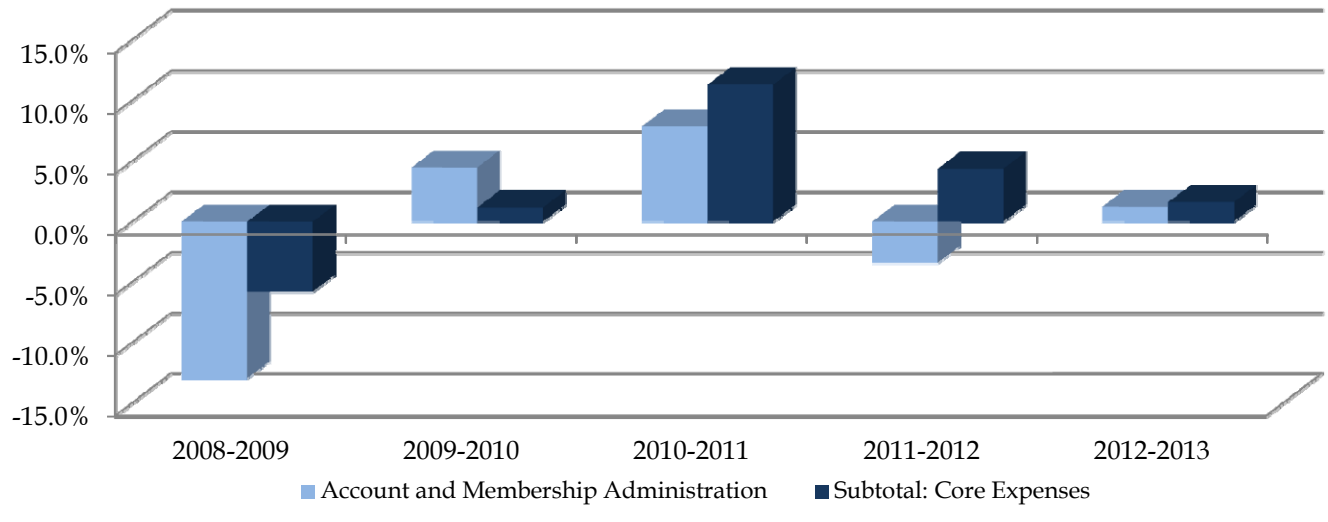

Figure 1 shows the trends in Core and Account and Membership Administration for Medicaid participating plans as reflected in the 2014 Sherlock Benchmarking Study. Rates of growth were 1.6% PMPM for Core expenses (in dark blue). It is lower than the past two years. Account and Membership Administration, at 1.2% increase, was higher than last year's decline but continues a trend of very moderate cost growth.

These comparisons should be understood as "real" increases. That is, they eliminate the effect of changes in the product mix such as the increasing importance of Medicaid in the product portfolios of these health plans.

Background

According to the Kaiser Family Foundation "Medicaid covered over 66 million Americans – more than 1 in every 5 – at some point during the year." In May 2013, the Congressional Budget Office estimated that Medicaid served, on average, 35 million people in 2013. This estimate includes CHIP, and excludes recipients that are 65 and older. Based on Urban Institute numbers, elderly beneficiaries comprise and additional 3.5 million people for a total of 38.5 million. A subset of Medicaid which chiefly serves the under 65 population, are 1.7 million people who are eligible for both Medicare and Medicaid. According to the Kaiser Family Foundation, dual eligibles account for 82% of total enrollment in SNPs. Accordingly, the turnover every seven months is equal entire Medicaid population.

The ACA reforms "expanded Medicaid to nearly all adults under age 65 with income at or below 138%" of the Federal poverty level, if the states elect to implement this expansion. In addition, all states are required to simplify eligibility and enrollment procedures. According to statereforum.org, examples of this include the use of exchanges or via contractual relationships in MCO contracts. These approaches facilitate, respectively, the transition between Medicaid and private insurance or the transition between products offered by the same health plan. Enrollment is also facilitated through outreach, the use of electronic data rather than paper, real time determinations of eligibility for coverage facilitating what is called a "no wrong door" approach to enrollment.

In considering these changes, they appear simpler than in products for commercial members, especially for those that are not in self-insured groups. They don't appear to entail significant changes in benefit design and, if anything, the enrollment processes appear more seamless.

While originally anticipated to add 16 million to average Medicaid beneficiaries, after the Supreme Court ruled that states retained the right not to participate in the expansion, the Congressional Budget Office revised its estimates to 12 million additional beneficiaries. According to Kaiser Family Foundation, "As of June 2014, 27 states, including DC, were expanding Medicaid, three states were actively debating the issue, and 21 states were not moving forward…"

Kaiser Family Foundation reports that "the Centers for Medicare and Medicaid Services (CMS) shows that as of the end of March 2014, Medicaid and CHIP enrollment had increased by over 4.8 million people since open enrollment began for the new Health Insurance Marketplaces in October 2013."

In our universe of Medicaid Plans, nine participated in 2014. Of these, five were in states implementing expansion, three were not and one was in the process of considering participation.

So, What Happened?

The 2014 Sherlock Benchmarks for Medicaid Plans (also called *Sherlock Expense Evaluation Report* or *SEER*) reflect the bulge and adaptation drivers noted above for the nine selected plans. These increases, summarized here, reflect PMPM increases and costs stemming from membership whose care and administrative needs changed over the periods. Overall as-reported costs increased by 0.2% down from an increase of 6.5% last year. Pharmacy, Mental Health and ICD-10 expenses are included as part of the total expenses in this presentation.

For convenience of analysis, we group various functional areas into clusters, and standardize for the size of the health plans by expressing expenses on a per member basis. Clusters are comprised of functions listed, without subcategories, in Appendix C. We also segregate Sales and Marketing expenses since state laws governing such activities vary. All rate of change are calculated using plans that have participated during both comparison years. All values exclude investment and non-operating income and expense, income taxes and miscellaneous business taxes.

Core costs, that is, excluding Sales and Marketing, increased by 3.2%, modest but slightly higher than growth in 2012. Account and Membership Administration increased by 2.7%. This reversed last year's decline of 4.6% as well as that of the year before.

Figure 2. Sherlock Benchmark Summary
Medicaid Plans' Median Changes in Per Member Per Month Expenses

	2012 Percent Change		2013 Percent Change	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Provider & Medical Management	2.6%	4.9%	2.9%	0.2%
Account & Membership Administration	-4.6%	-3.4%	2.7%	1.2%
Corporate Services	12.1%	12.8%	0.0%	-0.6%
Subtotal: Core Expenses	2.7%	4.4%	3.2%	1.6%
Sales and Marketing	12.4%	17.7%	-1.4%	-1.0%
Total Expenses	6.5%	8.3%	0.2%	-1.4%

Every functional area in this cluster had modest growth or declines whereas last year's Customer Services increase was overwhelmed particularly by the decline in Information Systems. Enrollment has declined in four of the past five years, including this one. The volatile Customer Services function was flat this year. Claims declined for the second year in a row. Information Systems increased modestly after a decline in 2012, following a surge in 2011.

Provider and Medical Management cost trends were slightly higher than last year, at 2.9% versus 2.6% in the prior year. This acceleration stemmed from growth greater than the overall trend for Medical Management. By contrast, there was nearly no growth in Provider Network Management and Services.

Corporate Services costs were flat at a 0.0% growth. Corporate Executive and Governance, which posted a double-digit decline in costs, was responsible for most of the change. The Finance and Accounting function also declined. However, Actuarial grew at double-digit rates and the Corporate Services function also increased.

Sales and Marketing, as noted above, is excluded from Core Costs. It decreased by 1.4% compared with a surge of 12.4% the prior year. This was largely due to declines in Sales and Advertising, the second and fourth largest functions respectively. Sales declined at a double digit pace. However, Rating and Underwriting and Marketing grew at single-digit rates. Commission growth was extremely low.

Most plans grew and, while some of the plans had sharp increases, the mean growth rate for continuously participating plans was 4.9%. While membership in commercial products was 1.7%, Medicare (including Medicare SNP) grew by 17.4%. Medicaid membership increased on average by 16.7%.

Excluding the Effects of Changes in Mix, What Happened?

On a constant mix basis, total administrative costs declined by 1.4%, a precipitous fall from the 8.3% increase last year. We consider the constant mix increase to be the "real" increase in costs. (We calculate this as the differences between last year's costs weighted by this year's product mix for continuously participating plans.) All cluster growth declined except for Account and Membership administration, which increased slightly compared with a decline in the prior year.

As previously noted, the selected plans enjoyed membership growth particularly in Medicaid. The membership share in Medicaid plans increased by 3.2 percentage points as Commercial and Medicare were essentially flat. Medicare SNP grew nearly as fast as Medicaid though it remains relatively small.

The resource differences of this shift have the effect of changing trends. While Sales and Marketing expense are lower by 1.4% as reported, they are only down by 1.0% once mix is eliminated since Medicaid Sales and Marketing requirements tend to be much less.

On a constant mix basis every function in this cluster declined, except for Marketing. Marketing contains the subcategory of Product Development and Market Research. The Sales decline was especially sharp.

Constant mix changes in Medical and Provider Management were effectively flat, PMPM. While Provider Network Management and Services declined slightly, Medical Management/Quality Assurance/Wellness increased slightly. Both functions increased in both 2012 and 2011.

Growth in Account and Membership Administration was only 1.2% PMPM on a constant mix basis, but it was above the decline of 3.4% last year. Enrollment declined, as it has in four of the past five years. Customer Services was flat, well below both 2012 and 2011. Claims declined slightly and Information Systems increased slightly.

Corporate Services Costs declined by 0.6%, compared with 2012's increase of 12.8%, and the only such decrease in the past five years. This was due primarily to a sharp decline in Corporate Executive and Governance. We speculate that this may be in part due to a rebounding off of many years of very high growth in this function, perhaps relating to consulting expenses. Finance and Accounting was also down compared to a surge last year. Actuarial growth was in double-digits, a rate similar to 2012. The very large Corporate Services function grew above the five year trend and also well above the cluster, indirectly indicative of the magnitude of declines in the other functions.

Administrative Expenses for Medicaid Plans were $33.57 PMPM

The costs to administer comprehensive products for Medicaid Plans were $33.57 PMPM. With a different universe and a different product mix, last year's reported costs of $29.50 PMPM. While this year's mix was more focused on Medicaid and less on Medicare, plan's reporting in this year's cycle had much higher costs in nearly every product than last year's panel. Last year's values are shown in Appendix A.

Figure 3. Sherlock Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2013 Data
Per Member Per Month

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Provider & Medical Management	$5.53	$8.44	$7.24	31%
Account & Membership Administration	9.46	16.51	14.61	40%
Corporate Services	4.25	6.66	5.05	38%
Subtotal: Core Expenses	$20.71	$28.10	$24.48	32%
Sales and Marketing	5.79	12.22	8.80	54%
Total Expenses	$24.53	$41.27	$33.57	28%

Notwithstanding the differences, some of the earlier comments still apply. By far, the largest increase was in Account and Membership Administration was much higher than last year, and it increased to $14.61 PMPM. On a constant mix basis, it was the fastest growing cluster of functions.

Sales and Marketing costs, at $8.80 PMPM was lower than 2012 and was one of two clusters that posted a decline in median costs between the periods. The Corporate Services cluster of functions, at $5.05 PMPM, was a modest increase over last year's results, corresponding with the zero to slight decline trend on a constant mix basis.

Provider and Medical Management was the other cluster whose costs were lower than reported last year, at $7.24 PMPM, but trends for continuous plans were positive. The increasing importance of Medicaid may have led to this result.

Administrative Costs in Each Product Maintained Their Relative Relationships

The Medicaid plans that participated in the Sherlock Benchmarking study offered products in 2013 that maintained their historic directional cost relationships with one another. Medicaid HMO costs, at $32.31 PMPM, were 5% less than commercial insured products, and Child Buy-In costs, at $23.29 PMPM, were 28% less than Medicaid HMO.

Figure 4. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2013 Data
Per Member Per Month

Product	25th Percentile	75th Percentile	Median	Coefficient of Variation
Medicaid Total	$22.24	$33.59	$31.96	29%
HMO	$22.24	$33.59	$32.31	28%
Child Buy-In	$17.79	$56.32	$23.29	100%
Medicare				
Advantage	$70.78	$152.34	$91.37	73%
SNP	$102.26	$147.98	$141.62	41%
Commercial Insured Total	$31.17	$40.18	$33.88	21%
HMO	$32.35	$38.52	$33.57	19%
POS	$24.51	$34.18	$28.51	26%
Indemnity & PPO	$28.67	$49.83	$47.08	30%
Commercial ASO	$18.27	$21.78	$18.63	18%
Comprehensive Total	**$24.53**	**$41.27**	**$33.57**	**28%**

Since dual eligibles account for 82% of total enrollment in Medicare SNPs, this product could arguably be grouped with Medicaid rather than Medicare. The administrative expenses for this product, at $141.62 PMPM were 55% higher than Medicare Advantage. Medicare Advantage cost nearly three times the per member costs of the closest commercial equivalent, Commercial HMO Insured.

Commercial ASO products cost least to administer. At $18.63 PMPM, it was 45% lower than the insured commercial products.

Administrative Expense for Medicaid plans was 10.5% of Premiums

Overall the administrative expenses increased by 2.3 percentage points as a percent of premiums and equivalents to 10.5%, compared with 8.2% last year. While every product except for Indemnity & PPO had an increase in administrative expenses relative to premiums, the increase in Medicaid HMO was only 0.5 percentage points to 8.6% of premiums. As noted previously, costs increased for the current universe compared with last year's in most products.

Child Buy-In was higher than average at 10.9% of premiums, which contrasts with it being the second lowest cost product when measured on a PMPM basis.

The low cost product was commercial ASO with an administrative expense ratio of 5.9%, which was 31% below the commercial insured equivalents. Indemnity & PPO Insured was the high cost product at 14.3%. HMO and POS are 9.6% and 9.1% of premiums respectively.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2013 Data
Percent of Premium Equivalents

Product	25th Percentile	75th Percentile	Median	Coefficient of Variation
Medicaid Total	7.1%	9.5%	8.6%	24%
HMO	7.0%	9.4%	8.6%	24%
Child Buy-In	9.1%	13.0%	10.9%	35%
Medicare				
Advantage	7.7%	19.9%	10.0%	96%
SNP	6.2%	9.9%	8.7%	49%
Commercial Insured Total	7.1%	9.5%	8.6%	24%
HMO	9.0%	10.7%	9.6%	13%
POS	8.1%	9.9%	9.1%	29%
Indemnity & PPO	13.8%	15.9%	14.3%	24%
Commercial ASO	5.5%	6.6%	5.9%	19%
Comprehensive Total	8.8%	11.0%	10.5%	20%

The Medicare products are distinguished by their high costs PMPM and low costs when measured as a percent of premiums. Medicare Advantage, at 10.0%, is lower than average but the second highest PMPM. Medicare SNP is the third lowest cost product, at 8.7% but was by far the highest cost product on a PMPM basis.

The Composition of Expenses also Shifted

As previously noted, administrative expenses increased 2.3 percentage points relative to premiums to 10.5%. (Last year's results are in Appendix B.)

Incidentally, health benefit ratios tended to be higher in this year's universe. Medicaid's health benefit ratio was substantially the same, but its operating margin was lower.

Both Corporate Services and Account and Membership Administration were significantly higher, to 2.2% of premiums and 3.9% of premiums respectively. The amounts by which Corporate Services and Account and Membership Administration were higher were 0.9 percentage points and 0.8 percentage points, respectively. This year's universe had higher commitment to Sales and Marketing by 0.2 percentage points to 2.8%. Provider and Medical Management was lower by 0.1 percentage points to 1.8%.

The lack of correspondence between rates of growth and differences in percents of premiums committed to administration is explained by changes in mix and participating plans.

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2013 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Provider & Medical Management	1.5%	2.5%	1.8%	37%
Account & Membership Administration	3.4%	4.8%	3.9%	40%
Corporate Services	2.0%	2.8%	2.2%	22%
Subtotal: Core Expenses	5.2%	9.0%	6.8%	32%
Sales and Marketing	2.4%	3.1%	2.8%	46%
Total Expenses	8.8%	11.0%	10.5%	20%

About the Sherlock Benchmarks and the Medicaid Universe

These results are excerpted from the Medicaid edition of the 2014 *Sherlock Expense Evaluation Report*. The results are based on our detailed surveys of 2013 operating parameters of 9 Medicaid Plans. Accordingly much more information is available by licensing the Sherlock Benchmarks. We hope you will not hesitate to contact us (sherlock@sherlockco.com) if you are interested in licensing these materials or if we can answer any further questions.

Including all of our benchmarks, those published in 2014 will comprise the experience of approximately 660 health plan years. We also have universes of Blue Cross Blue Shield Plans, Larger health plans, Medicare Advantage plans and Independent/Provider-Sponsored plans. Earlier this month, we published results on the Blue Cross Blue Shield Plans and Independent/Provider-Sponsored plans and we will be reporting on the results of the Medicare universe in the next few weeks.

Medicaid health plans are especially interesting in today's environment because of initiatives through health care reform to encourage their growth as a vehicle to reduce the proportion of people without health insurance.

The Medicaid universe consists of 9 plans with a total average membership of 3.87 million members. The mean membership mix in Medicaid HMO or Child Buy-In is 39.7%. An additional 46,000 members participate in Medicare SNP and are likely to be dual eligibles.

Appendix A. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2012 Data
Per Member Per Month

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Provider & Medical Management	$4.67	$7.77	$7.44	32%
Account & Membership Administration	9.26	13.56	11.10	31%
Corporate Services	4.37	6.03	4.83	35%
Subtotal: Core Expenses	$20.89	$27.79	$23.90	24%
Sales and Marketing	4.14	12.51	10.30	59%
Total Expenses	$27.49	$38.42	$29.50	28%

Appendix B. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2012 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Provider & Medical Management	1.6%	2.0%	1.9%	18%
Account & Membership Administration	2.6%	4.2%	3.0%	35%
Corporate Services	1.2%	1.6%	1.3%	33%
Subtotal: Core Expenses	5.3%	7.5%	6.5%	24%
Sales and Marketing	1.5%	3.1%	2.6%	54%
Total Expenses	7.4%	10.6%	8.2%	21%

Appendix C. Sherlock Benchmark Summary
Functions Included in Each Administrative Expense Cluster

Sales & Marketing
- Rating and Underwriting
- Marketing
- Sales
- Commissions (external)
- Advertising and Promotion

Provider & Medical Management
- Provider Network Management and Services
- Medical Management / Quality Assurance / Wellness

Account & Membership Administration
- Enrollment / Membership / Billing
- Customer Services
- Claim and Encounter Capture and Adjudication
- Total Information System Expenditures (as expensed)

Corporate Services
- Finance and Accounting
- Actuarial
- Corporate Services Function
- Corporate Executive and Governance
- Association Dues and License/Filing Fees