Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

Douglas B. Sherlock, CFA
sherlock@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

John Park, CFA
jpark@sherlockco.com

Andrew L. Sherlock
asherlock@sherlockco.com

(215) 628-2289

Also,

- *Research you may have missed*
- *Medicare and Medicaid Benchmarking Studies*
- *ACO Benchmarking Studies*

Medicaid and the Individual Market

Background

The Affordable Care Act has two aspects that reduce the importance of employer groups in purchasing: the development of subsidized exchanges and the growth in Medicaid. Along with the decline in the number of people who are uninsured, there has been a notable change in the structure of health coverage. According to the Congressional Budget Office, as the number of people in employer sponsored health plans have remained static, Medicaid has grown and the number of people who are classified as Nongroup has declined. Among insured people, those served by the Employer market has declined from 71.8% to 63.3%.

The policy justification of diminishing the role of employer sponsored health insurance is not a new one. In 1980, Alain Enthoven, in his *Health Plan* observed that the employer-based system "works to limit people's choice of health plan and to block competition." He noted that "those without employer-provided health insurance often have great difficulty in getting health insurance." He thought it led to "administrative complexities" through enrollment processes triggered by job changes and changes in life and complexity of product design. He observed that it has "proved to be very difficult to arrange good health insurance coverage for persons in marginal industries or with seasonal, intermittent or otherwise unstable employment." Accordingly, he premised his vision of health care reform on the Federal Employees Health Benefit Plan ("FEHBP"), thereby delegating to individual employees health plan selection through multiple choice and fixed dollar subsidies. The keystone of the FEHBP is the choice afforded to individual employees through what amounts to a market.

Figure 1. Medicaid and the Individual Market
CBO Estimates of Health Insurance Coverage for People Under Age 65[a]
Millions of People

	2013		2016		Percent
	People	Pct Tot.	People	Pct Tot.	Change
Medicaid and CHIP	37	13.6%	68	25.0%	83.8%
Employment-Based	155	57.0%	155	57.0%	0.0%
Nongroup and Other[b]	24	8.8%	22	8.1%	-8.3%
Uninsured	56	20.6%	27	9.9%	-51.8%
Total	272	100.0%	272	100.0%	0.0%
Employer Pct. Insured	*71.8%*		*63.3%*		

[a]2013 estimates were published in February of that year, and 2016 estimates were published in March of that year.

[b]In 2016, Nongroup and Other includes 12 million exchange members, of which 10 million are subsidized. There were no Exchange members in 2013.

The experience of insurers offering to the individual market has been mixed. In June of 2016 *Investors Business Daily* reported that Blue Cross Blue Shield of Minnesota lost $500 million, Health Care Services Corp. lost $1.5 billion, Blue Cross Blue Shield of Tennessee lost $300 million, Highmark Group lost $266 million, Blue Cross Blue Shield of North Carolina lost $280 million and plans in Arizona and Alabama lost $135 million and $185 million, respectively.

Medicaid plans appear to have an easier time with the individual market than do other plans. *The Associated Press* reported in May of 2016 that, "Two companies that report exchange success so far, Molina Healthcare Inc. and Centene Corp., say they have focused on covering low-income customers in markets where they already have an established presence in Medicaid, the state-federal program that covers the poor. Molina sells coverage in nine states and is thinking about adding two for next year."

One reason for this relative success may be that they can serve the same population with similar panels. A patient going to the same panel irrespective of the coverage should benefit from continuity of care, and the plan should benefit from the lower cost of care and administration that would result. Aspects of this continuity include patient care and member navigation of customer service and claims. This is especially effective because rotation on and off Medicaid is common for beneficiaries, and exchange-subsidized individual plans provides coverage when Medicaid products do not.

What the Sherlock Benchmarks Show

Cost of living differences and the Medical Loss Ratio rules may make these advantages hard to quantify for health benefits. But these advantages should also be the case with administrative costs. After all, any lower health care costs would likely result in fewer claims and customer service inquiries along with all supporting functions.

In this analysis, we have used the percent of premiums as the metric for administrative expense levels. While they are less actionable, they offer benefits in this context since they may mute cost of living and product design differences between the plans. Administrative expenses exclude those related to mental health and pharmacy since plans differ in how these benefits are administered. A similar adjustment is made to premiums. Miscellaneous Business Taxes, averaging $13.00 PMPM nearly 25% of administration, are overwhelmingly taxes supporting the Affordable Care Act, and are excluded since management cannot manage these expenses.

Figure 2. Medicaid and the Individual Market
Administrative Expense Ratios
Commercial Insured

	Blue		IPS		Medicaid		All Plans	
	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Administrative Expense Ratios	12.9%	12.6%	12.9%	13.0%	12.0%	16.8%	12.8%	13.6%
Number of Observations	17	17	15	15	8	8	40	40

The data is for 2015. Each of the 40 plans' data was submitted to us in 2016, and we validated their submissions. The plans are segmented into Blue Cross Blue Shield, Independent / Provider – Sponsored and those focused on Medicaid.

Commercial Insured Administrative Expense Ratios Run High for Medicaid Focused Plans

As a baseline, it is notable that for Medicaid-focused health plans, Commercial Insured members appear to have somewhat higher expenses than Commercial members in other universes. Figure 2, on the previous page, shows that the mean values of Commercial Insured Administrative Expense Ratios run higher than those for the other universes. The average is 16.8% as opposed to approximately 13% for the other two universes. Of course, Medicaid plans are less focused on this product.

But Medicaid Plans' Individual Administrative Costs Run Low

Despite this, Individual Commercial Insured administrative expense ratios are relatively modest for the Medicaid-focused plans at 10% versus 15% and 29% for the Blue and Independent / Provider – Sponsored universes, respectively. This is only suggestive of course – because the Sherlock Benchmarks make optional the population of market segment information, only a subset of plans submitted Individual Commercial cost information. Nevertheless, Medicaid Plans reporting these segment cost ratios say that their costs are low. If generalizable, this is consistent with the idea that low administrative costs may result if continuity is maintained between the people who alternate between Medicaid and other products of health plans. This is shown in Figure 3.

The Greater the Proportion of Individual, the Higher the Commercial Insured Administrative Expense Ratio

To overcome the limitations of segment reporting, we performed a regression analysis to estimate the role of the individual market on overall commercial insured Administrative Expense to Premium ratios. Unlike the detailed administrative cost segmentation that is optional, the health plans reporting in the Sherlock Benchmarks are required to submit the member months of individual members.

Figure 3. Medicaid and the Individual Market
Administrative Expense Ratios
Individual

	Blue		IPS		Medicaid		All Plans	
	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Administrative Expense Ratios	14.9%	15.3%	35.1%	29.2%	10.3%	10.3%	15.1%	17.6%
Number of Observations	9	9	3	3	2	2	14	14

As shown in Figure 4, the greater the proportion of membership that is individual, the higher the administrative costs of Commercial Insured members. The P-Value of 2.1% suggests that this is reliable. Sales and Marketing costs are especially high for this segment. This suggests that to the extent that plans focus on the Individual Market, their costs will be higher.

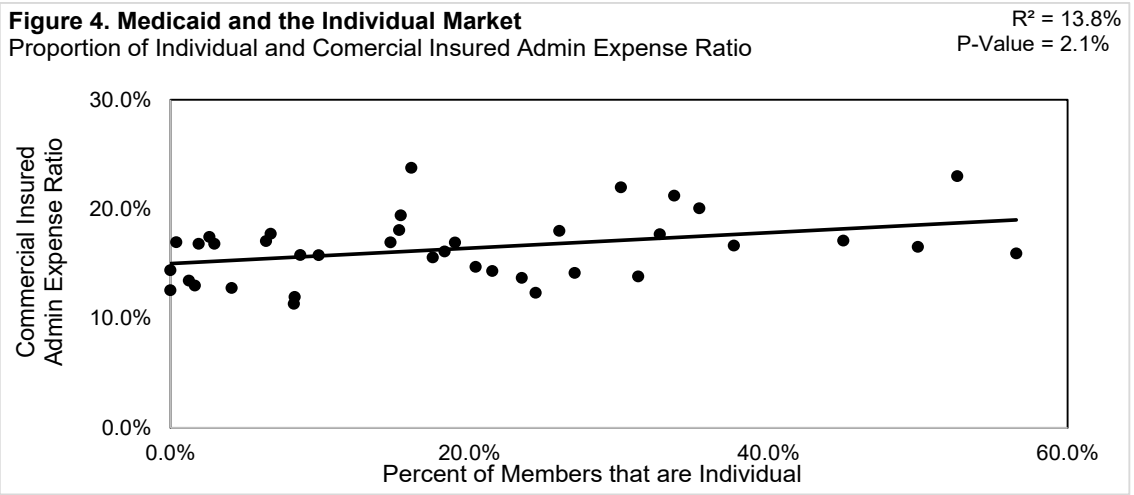
The Greater the Proportion of Medicaid, the Lower the Commercial Insured Administrative Expense Ratio

By contrast, the greater the proportion of overall business committed to Medicaid, the lower the Commercial Administrative Expense to Premium Ratio. It is not a very comprehensive relationship, but at a P-Value of 6.0%, it is a reliable one. This is shown as Figure 5.

This is also consistent with the theory of the simplicity of the service to members of alternative products, Medicaid and Commercial, sold by the same plan to the same member. It is also consistent with another theory that participation in state Medicaid programs has the effect of creating a culture of conservative administration.

Unfortunately, there is the conflating reality that, among Sherlock Benchmark participating plans, organizations that have a heavy focus on Medicaid also have a modest focus on the Individual market. Since we know that Individuals have high costs, the low percent of commercial that is comprised of individual could be an element of this relationship.

Figure 4. Medicaid and the Individual Market
Proportion of Individual and Comercial Insured Admin Expense Ratio



The Greater the Proportion of Medicaid, the Lower the Individual Commercial Insured Administrative Expense Ratio

Figure 6 eliminates this commercial mix distortion, focusing solely on the individual commercial market segment. As the proportion of the total business that is Medicaid increases, the administrative costs decline as a percent of revenues. The P-Value of the relationship is 8.0%, a value considered reliable.

Conclusion

The beginning of this article noted that organizations have had different experiences in the individual markets since the Affordable Care Act was implemented. Molina and Centene are notable exceptions to widespread difficulties and both are focused on Medicaid. An analysis of the costs of the individual market among participants in the Sherlock Benchmarks suggests the possibility that Medicaid and the Individual segment are complimentary insofar in administrative costs.

Figure 5. Medicaid and the Individual Market
Percent Members in Medicaid and Commercial Insured Admin Ratio

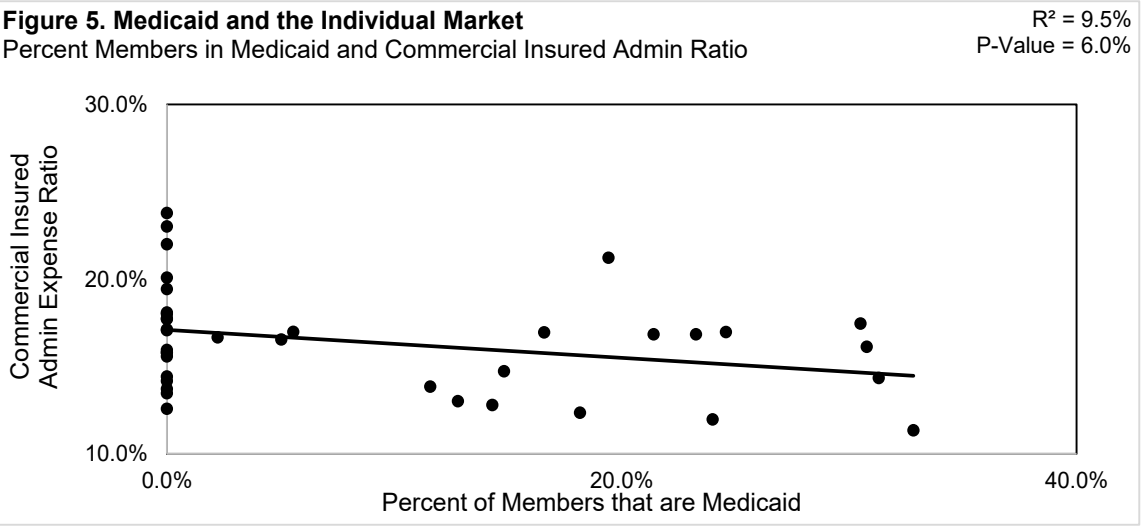
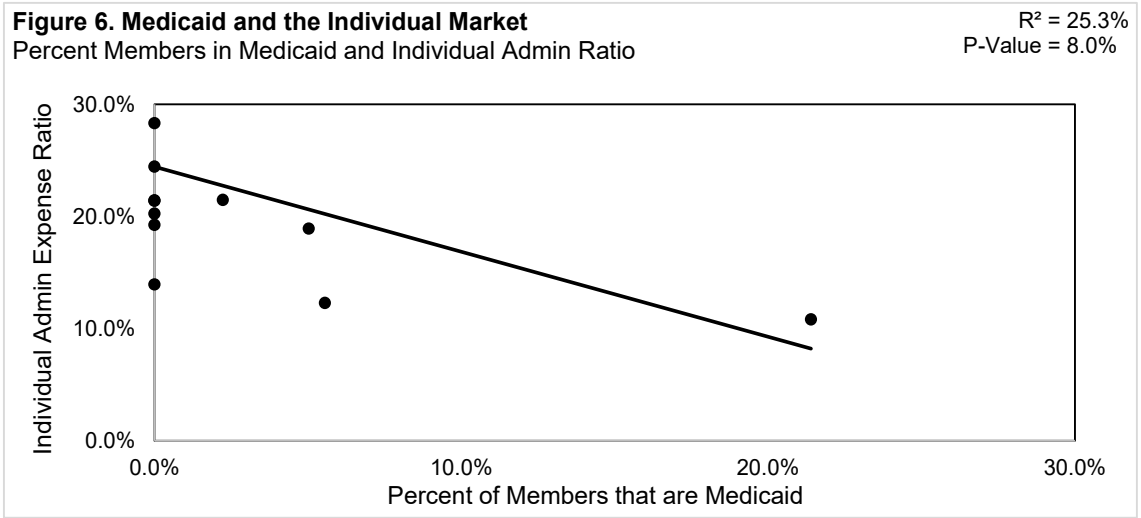


Figure 6. Medicaid and the Individual Market
Percent Members in Medicaid and Individual Admin Ratio



SHERLOCK COMPANY RESEARCH YOU MAY HAVE MISSED

Right-Sizing for Change	How to plan staffing to take into changes in product mix and scale that may result from changes in the Affordable Care Act	Late March 2017
Resolving the Paradox of Scale Among Blue Cross Blue Shield Plans	Why aren't Economies of Scale more evident, notwithstanding that the large plans have lower staffing ratios?	March 2017
How do Best-In-Class Independent / Provider – Sponsored Health Plans Achieve it.	Identifies cost drivers and individual function performance characteristic of low cost independent and provider sponsored health plans	February 2017
How do Best-In-Class Blue Cross Blue Shield Plans Achieve it.	Identifies cost drivers and individual function performance characteristic of low cost independent and provider sponsored health plans	January 2017
Economies of Scale In Health Insurance	We quantify the Economies of Scale in the universes of Blue Cross Blue Shield Plans and Independent / Provider – Sponsored Plans	December 2016
Apples to Apples, or How We Eliminate Mix Distortions	How to exclude cost differences stemming solely from differences in products offered.	November 2016
Administrative Staffing Subject to Economies of Scale	Function by Function analysis of effect of scale on health staffing ratios. Both Blue and IPS. Product mix differences are eliminated.	February 2017. This is far more detailed than a similar treatment in Plan Management Navigator. *Available in PULSE by subscription only.*
Economies of Scale in Health Insurance	Function by Function analysis of Economies of Scale. Both Blue and IPS. Product mix differences are eliminated.	December 2016. This is far more detailed than a similar treatment in Plan Management Navigator. *Available in PULSE by subscription only.*

Upcoming Benchmarking Studies Medicaid, Medicare and Accountable Care Organizations

Medicare and Medicaid Plan Benchmarking

We are now building our panels for the 2017 Medicaid and Medicare Benchmarking studies, and would welcome your participation.

Health plans participate in the Sherlock Benchmarks to determine whether their administrative expenses are in line with other similar organizations and, if they are not, to identify which functional areas are chiefly responsible for any variances. The focus on administrative expenses, as exemplified by the MLR rules under the Affordable Care Act, make the identification of cost variances especially timely.

In addition, the Sherlock Benchmarks can be helpful in adapting your staffing and cost structures for changes in membership and product offerings.

We will launch the 2017 Benchmarking Studies for Medicaid and Medicare plans in a few months. Nearly forty health plans serving approximately 50 million people in various universes have already signed such agreements to participate in 2017. We will send you a mutual Confidentiality Agreement if that is of interest.

We expect to launch the survey in early June to avoid conflicts with the Medicare bid submissions, due on June 5th. (Serving Dual-Eligibles gives rise to a requirement to participate in the bid process.) By mid-September, we expect that you will have the financial metrics, staffing ratios and the CFO Letter summary, with operational metrics to follow.

Accountable Care Organization Benchmarking

A key cost management element of the Affordable Care Act is Accountable Care Organizations. In April of 2016 David Muhlestein and Mark McClellan published estimates that 28.3 million people are covered by an accountable care arrangement. They are covered through Medicaid, Medicare and Commercial insurance.

Measurement of the activities of ACOs is central to their future and this benchmarking study is intended to help address it. The goal is to provide feedback to ACOs so that they can better manage their activities. This feedback must be specific to be actionable. For instance, Muhlestein and McClellan observe "to effectively manage a population, a successful ACO must first understand their population, which requires developing and using health information technology (IT) in new ways. Selecting, implementing, and maintaining connected electronic data to support population health platforms remains a challenge, with both providers and the vendors creating new products and refining data-sharing and analytic technologies."

So it is our goal to help the ACOs quantify the underlying activities that enable ACOs to optimally manage the activities that enable their success.

We are now at the trial stage of our efforts and are working with two large ACOs to establish a comprehensive scope of metrics, data definitions. With an eye towards achieving an optimal balance between insight and efforts. Based on this, we intend to launch in June and publish in September or October.

If I can answer any questions, I trust that you won't hesitate to reach out to me. We hope that we will be working together on this important project.