Plan Management Navigator
Analytics for Health Plan Administration July 2013

Blue Cross Blue Shield Plans' Administrative Costs Were 8.9% of Premiums in 2012

Summary

Blue Cross Blue Shield Plans' administrative expenses declined relative to premiums once again in 2012. Administrative expenses were 8.9% of premiums in 2012 compared with 9.1% of premiums in 2011. They were 9.7% in 2009.

Administrative expenses increased by 5.1% PMPM in 2012. Excluding the effect of changes in product mix, administrative costs increased by 3.8% PMPM. The change in membership was an important factor in this year's *reported* results. Medicare Advantage membership was up strongly, and Medicare Supplemental decreased somewhat, making the cost increases appear higher than they actually were. Since Commercial tilted in direction of ASO / ASC, this effect was muted.

This year's results have three important themes, cost streamlining in Corporate Services, heightened investment in Information Systems and apparent optimism reflected in greater Sales and Marketing expenses.

The median administrative expenses of comprehensive products of Blue Cross Blue Shield Plans (Blue Plans) participating in our performance benchmarking study in 2012 was $29.25 Per Member Per Month (PMPM), but varied greatly by product. In 2012, the FEP product, offered to federal employees, had administrative costs of $18.30 PMPM. Sharing low marketing costs with FEP, POS ASO/ASC had administrative expenses of $19.35 PMPM. Medicare Advantage was the highest administrative cost product, at $78.52 PMPM.

All values exclude investment and non-operating income and expense, income taxes and miscellaneous business taxes. Pharmacy, Mental Health and ICD-10 costs are included in total administrative cost calculations and are allocated to the Account and Membership Administration cluster.

These results are excerpted from the Blue Cross Blue Shield edition of the 2012 *Sherlock Expense Evaluation Report (SEER)*. The results are based on our detailed surveys of 2012 operating parameters of 19 Blue Cross Blue Shield Plans. These plans are disproportionately the larger Blue Cross Blue Shield plans and represent 63% of the revenues, and likely a higher share of members, of single state Blue Cross Blue Shield plans. Plans participating in our benchmarking studies had membership of nearly 1.8 million compared with 1.5 million last year, an increase of approximately 20%.

Administrative Costs and Trends

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. Cost values and rates of change are shown in Figures 1 and 2. For comparison, Appendix A provides values for Plans participating in the 2012 survey, and comprises 2011 data. Of the 19 Plans participating in 2013, 18 participated in 2012. *All rate of change comparisons are based on plans that have participated in both years.*

Figure 1. Benchmark Summary
Blue Cross Blue Shield Costs by Functional Area Cluster, 2012 Data
Per Member Per Month

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales & Marketing	$6.66	$10.26	$7.24	37.7%
Provider & Medical Mgmt.	3.57	5.31	4.12	33.9%
Account & Mem. Admin.	10.87	14.47	13.39	23.8%
Corporate Services	3.61	6.16	4.52	50.9%
Total	$26.10	$35.66	$29.25	25.2%

Sales and Marketing expenses were $7.24 PMPM and grew at an increasing rate, 7.7% in 2012 versus 3.2% growth in 2011. However, after eliminating the effect of product mix changes, Sales and Marketing costs grew less rapidly: PMPM Sales and Marketing costs increased by 6.9% compared with 4.0% in 2011.

The lower constant-mix change, compared with as-reported, in part reflects a shift in mix in favor of Medicare Advantage. Commercial membership was essentially flat for the Blue Plans while the median Medicare growth in continuously participating Plans was 7.0%. (FEP typically also grew, and Medicaid was down though they have more limited marketing expenses.) Commercial products themselves shifted in favor of ASO/ASC.

Sales and Marketing reflected an apparent shift in distribution systems. Broker Commissions per member grew modestly compared with declines in the prior two years on an as-reported basis. On a constant-mix basis, PMPM broker Commissions grew at its slowest pace since at least 2008. Notwithstanding, its substantial size meant that it was the second largest source of increase on an as-reported basis. By contrast, internal Sales grew at its fastest rate since 2005.

Plans participating in this year's benchmarking study had slightly fewer staff than last year, after adjusting for Medicare, in both the Sales and the Marketing functions. Compensation levels in this year's peer group was higher than last year. As previously noted, the typical Blue Cross Blue Shield participating plan was 20% larger in 2013 and accordingly more focused on high cost urban areas.

Rating and Underwriting was the fastest growing function on both an as-reported basis and on a constant-mix basis. The Sales and Marketing function was the second and third fastest growing functions on these bases. Advertising and promotion also grew rapidly. Adjusting for mix, per member Advertising and Promotion grew at its fastest rate since 2008.

The 75th percentile value for this cluster was $10.26 and the 25th percentile value was $6.66 PMPM.

The economy continues to be fragile and that continues to affect membership trends. Year-over-year, for the 18 continuous Plans, the median decrease in comprehensive product membership was 0.4% and membership grew by 0.2%, on average. Total commercial membership grew on average by 0.6% but had a median decline of 0.7%. Commercial insured membership declined at a median rate of 0.2% as ASO/ASC declined by 0.1%. By contrast, FEP membership grew a median rate of 1.0%.

Of the thirteen continuous Plans offering Medicare Advantage, this product's median membership growth was 7.0.%. Medicare Supplemental declined at a median rate of 1.2%. While some of the Medicare Supplemental decline may have been due to switching, the increase in Medicare Advantage exceeded the decline in Medicare Supplemental overall, and net accretion occurred in eight of the 13 plans.

Membership in Medicaid products offered by participating Blue Cross Blue Shield plans declined at a median rate of 3.1%. Of the five continuously participating plans, three posted membership declines.

Figure 2. Benchmark Summary
Blue Cross Blue Shield Percent Change in Costs by Functional Area Cluster

	2011 Data		2012 Data	
	As Reported	Constant Mix	As Reported	Constant Mix
Sales & Marketing	3.2%	4.0%	7.7%	6.9%
Provider & Medical Mgmt.	7.3%	4.9%	4.2%	3.5%
Account & Mem. Admin.	2.3%	0.5%	5.0%	5.3%
Corporate Services	5.9%	5.1%	-2.7%	-2.6%
Total	4.1%	4.2%	5.1%	3.8%

Provider and Medical Management, in contrast with Sales and Marketing, posted a decline in growth, by 4.2% (compared with 7.3% last year) to $4.12 PMPM. On a constant-mix basis, per member cost growth was also lower, 3.5% versus 4.9%.

Medical Management is the larger of two functions in this cluster. Its growth rate declined on an as-reported basis but remained steady on a constant-mix basis. Adjusting for the important growth in Medicare Advantage, staffing ratios, including outsourced staff, tended to increase.
Precertification and Health and Wellness were especially notable in their staffing increase.

Provider Network Management and Services increased more rapidly than did Medical Management on a constant-mix or as-reported basis. Staffing ratios were higher especially in Provider Relations Services and Provider Contracting.

The costs of Provider and Medical Management at the 25th percentile was $3.57 PMPM and was $5.31 PMPM at the 75th percentile.

Account and Membership Administration costs increased to $13.39 PMPM, up 5.0% from last year. At the 25th percentile the cost of Account and Membership Administration was $10.87 PMPM, while the costs at the 75th percentile was $14.47 PMPM. In 2011, the rate of growth, on an as-reported basis, was 2.3% so cost growth accelerated in 2012. On a constant-mix basis, cost growth accelerated faster, to an average increase of 5.3% as against an increase 0.5% in 2011.

Note that this cluster includes Information Systems' ICD-10 implementation expenses. This expense sharply increased this year. Without this increase, we estimate that Account and Membership Administration would have increased by 4.5% as-reported and 4.8% on a constant-mix basis.

This cluster of functions includes Enrollment, Claims, Customer Service and Information Systems. Claims declined on an as-reported basis and constant-mix basis. In four of the past five years, costs have increased by less than 1% on an as-reported basis. On a constant-mix basis, costs have never been more than flat except one during the past five years.

By contrast, Information Systems had robust growth. On an as-reported basis, it was the third fastest growing function and comprised nearly one half of the total PMPM increase. On a constant-mix basis, it was also third fastest but was responsible for *most* of the increase in costs. Since IS costs comprise more than half of all Account and Membership Administration, fast growth in this function affects the entire cluster.

Enrollment costs grew at their fastest pace since at least 2008 on an as-reported basis and since 2009 on a constant-mix basis. Customer services costs increased at their fastest rate since at least 2008 on a constant-mix basis, though down from 2011 on an as-reported basis.

Including the effect of higher mix of Medicare members, staffing ratios in Information Systems were higher, especially in Information Systems Application and Maintenance and Information Systems Applications Acquisition and Development. The staffing ratios for Claims were down, while Enrollment and Customer Services were unchanged. Compensation levels were higher, except for Claims.

Outsourcing, measured by estimated FTEs, increased for most plans in most Account and Membership Administrative functions. Overall, outsourcing is relatively unusual among Blue Cross Blue Shield Plans, equating to 16-17% of total staffing levels, higher than last year. ICD-10 was sharply higher in its outsourced staffing, and most FTEs in this area are outsourced. Medical Management also has outsourcing, especially notable in

Nurse-based Counseling and Health and Wellness.

Corporate Services costs decreased by 2.7% on an as-reported basis and 2.6% on a constant-mix basis. These growth rates were sharply lower than last year when per member costs in this cluster increased by 5.9% on an as-reported basis and 5.1% on a constant-mix basis.

Notably, Finance and Accounting and Corporate Executive and Governance declined on both an as-reported and constant-mix basis. Except for Association Dues and Miscellaneous Business Taxes, all of the functions in this cluster grew at a slower pace than last year.

Corporate Executive & Governance compensation levels were lower, while Finance and Accounting, and Actuarial, were higher. HR, Legal and Audit compensation levels were all higher in 2012.

Total costs for this cluster was $4.52 PMPM in 2012, while the 25th percentile value was $3.61 PMPM and the value at the 75th percentile was $6.16 PMPM.

In short, administrative expenses appeared to reflect plan assumptions about an economic recovery along with a commitment to invest in cost savings through automation of administrative expenses. Paradoxically, considering their significance in adapting to change, areas such as Finance and Accounting and Corporate Executive and Governance costs were lower in 2012. Overall, staffing ratios were slightly lower, taking into account the increasing importance of Medicare Advantage and the increasing importance of outsourcing.

Calculation of Constant-Mix Rates of Expense Growth

To make the most useful comparisons of administrative expenses, it is helpful to eliminate the effects of product mix differences. This improves comparability both between organizations with different product mixes and between periods.

Accordingly, in comparing expenses between periods, we hold constant the product mix between the two years. This is especially important since Medicare Advantage and ASO/ASC products have increased in the product portfolios of Blue Cross Blue Shield Plans. Medicare Advantage consumes far more resources per member than comparable products for people under 65 years of age, and marketing costs are sharply lower for ASO/ASC products versus their insured counterparts.

To calculate cost trends while excluding mix changes, we take advantage of the fact that Blue Cross Blue Shield Plans report to us by product. We can then reweight their prior year expenses to match the product mix in the current period. We then calculate the rates of change in costs based on these reweighted estimates. The adjustment to eliminate the effect of product mix changes is laborious, so we do not do this for subfunctions.

Figure 3. Benchmark Summary
Blue Cross Blue Shield Costs by Functional Area Cluster, 2012 Data
Percent of Premium Equivalents

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales & Marketing	1.8%	3.0%	2.2%	39.2%
Provider & Medical Mgmt.	1.0%	1.4%	1.3%	32.9%
Account & Mem. Admin.	3.5%	4.4%	4.0%	19.6%
Corporate Services	1.2%	2.0%	1.4%	42.7%
Total	8.0%	10.6%	8.9%	20.8%

Calculation of Premium Equivalents

Administrative services relationships, comprising 59% of all Blue Cross Blue Shield Commercial members, play havoc with the intuition that administrative costs are a proportion of the premium dollar. That is because, under ASO/ASC relationships, benefit plan sponsors are only billed for the administrative services that health plans provide rather than for the cost of care, which is borne by the self-insured groups. In other words, if administrative costs are expressed as a percent of ASO/ASC fee revenues, the ratio may approach 100% because the denominator is a small fraction of the premium dollar. This is a source of confusion that became increasingly visible during health care reform debates.

Our solution to easing interpretation of this ratio is to express expenses as a percent of *premium equivalents*. To do so, we estimate what the premiums would have been if the groups has been insured. This calculation is the sum of the administrative service fees actually billed, plus the health care expenses for the self-insured groups, which the Plans know since they process their groups' self-insured claims.

Note that, as with premiums, fees charged to ASO/ASC clients reflect a profit assumption. Since revenues less expenses equal profits, to estimate premium equivalents it is appropriate to add the fees rather than the administrative expenses to directly compare costs with the insured business.

Costs as a Percent of Premium Equivalents

Notwithstanding its important drawbacks, health plans and others often express administrative costs as a percent of premiums. That insights are thought to be available through the use of this metric is an underlying premise of the medical loss ratio provisions of the Patient Protection and Affordable Care Act.

As shown in Figure 3, administrative expenses were 8.9% of premium equivalents for comprehensive products sold by Blue Cross Blue Shield Plans. The 25th percentile value was 8.0% and the value at the 75th percentile was 10.6%.

Comparing these results to those in Appendix B, 2011 administrative expenses were two-tenths of a percentage point lower relative to premium equivalents. This appears to be entirely attributable to the decline in Corporate Services percents.

Sales and Marketing costs comprised 2.2% of premium equivalents, with the 25th percentile value at 1.8% and the value at the 75th percentile was 3.0%. The comparable median percent in 2011 was 2.1% and the increase was 17 basis points in 2012.

The value at the 25th percentile for Provider and Medical Management was 1.0% of premium, while 1.4% of premium equivalents represented the 75th percentile. The median value, at 1.3%, was 20 basis points higher than last year.

The costs of Account and Membership Administration was 4.0% of premium equivalents, slightly higher than last year. (Both 2012 and 2011 values for this cluster report the direct costs of Pharmacy, Mental Health and Information Systems expenses associated with ICD-10 implementation.) The value at the 25th percentile was 3.5% of premium equivalents and 4.4% of premium equivalents at the 75th percentile.

The median proportion of premium equivalents due to Corporate Services was 1.4%, 18 basis points lower than last year's value. Twenty-five percent of Plans had values

below 1.2% of premium equivalents or above 2.0% of premium equivalents in 2012.

Comparisons between years of ostensibly similar results can be misleading since the product mixes are much different. Notwithstanding that costs are lower than last year's results, the mix change has the effect of increasing costs. Put a different way, had this year's Plans operated at last year's mix then the 2012 costs would have been even lower. The most important difference is that Medicare Advantage is more important and Medicare Supplemental is less so. This upward bias is muted by the fact that there is also a greater commitment to ASO/ASC products which tend to have lower administrative expenses.

Figure 4. Benchmark Summary
Blue Cross Blue Shield Costs by Product, 2012 Data
Per Member Per Month

	25th PCTL	75th PCTL	Median	σ/ Mean
Commercial HMO				
Insured	$36.68	$45.97	$39.82	22.9%
ASO / ASC	$22.65	$31.11	$27.56	24.4%
Commercial POS				
Insured	$30.47	$37.04	$33.68	40.9%
ASO / ASC	$16.39	$27.70	$19.35	34.5%
Indemnity & PPO				
Insured	$29.61	$44.62	$39.95	29.5%
ASO / ASC	$18.43	$27.63	$24.27	29.2%
FEP	$14.28	$23.07	$18.30	32.2%
Medicare Advantage	$74.38	$100.72	$78.52	23.2%
Medicaid	$21.32	$23.39	$22.83	14.2%
Medicare Supplemental	$23.65	$36.94	$26.82	42.0%
Comprehensive Total	$26.10	$35.66	$29.25	25.2%
Stand Alone Dental	$1.56	$4.02	$3.19	97.9%
Medicare Part D	$11.52	$23.11	$16.49	43.5%

Administrative Expenses by Product

All health plans that participate in our benchmarking studies segment their costs by product as well as by over forty functional areas. Our participants employ activity-based cost allocations and sometimes full-blown activity-based cost accounting systems to make these allocations. For example, members in Medicare Advantage products submit far more claims than commercial members so total claims processing costs may be allocated by claims as opposed to members. Similarly, since Sales and Marketing costs can be identified by customer and the product that they elect, distribution system costs are directly allocated.

These differences are manifest in their overall cost differences. The most expensive product offered by Blue Cross Blue Shield Plans is their Medicare Advantage product, at $78.52 PMPM, followed by Commercial Indemnity & PPO Insured at $39.95 and Commercial HMO Insured products at $39.82 PMPM. Excluding FEP, the least expensive comprehensive product was Commercial POS ASO/ASC at $19.35 PMPM. The FEP product cost $18.30 PMPM to administer. Some of the activities to administer FEP are performed by the Blue Cross Blue Shield Association, which holds the prime contract for this product.

As shown in Figure 5, on a percent of premium equivalent basis, the product ranking of administrative expenses is different. The lowest median percent of premium equivalents was commercial POS ASO/ASC at 6.1%, followed by ASO / ASC forms of Indemnity & PPO and HMO, at 7.3% and 9.1%, respectively. (FEP, a unique product as discussed previously, was 5.1%.) The highest cost product, measured by the percent of premiums attributable to administration, was Medicare Supplemental at 14.5%. Medicare Advantage, the high cost plan on a PMPM basis, is 9.6% as a percent of premiums.

Figure 5. Benchmark Summary
Blue Cross Blue Shield Costs by Product, 2012 Data
Percent of Premium Equivalents

	25th PCTL	75th PCTL	Median	σ/ Mean
Commercial HMO				
Insured	9.4%	11.7%	10.9%	25.0%
ASO / ASC	6.5%	9.7%	9.1%	21.6%
Commercial POS				
Insured	8.4%	12.1%	9.3%	33.6%
ASO / ASC	5.8%	7.9%	6.1%	44.2%
Indemnity & PPO				
Insured	9.8%	13.9%	12.7%	27.8%
ASO / ASC	6.3%	9.2%	7.3%	32.0%
FEP	4.0%	5.4%	5.1%	26.0%
Medicare Advantage	8.2%	11.5%	9.6%	28.8%
Medicaid	8.9%	9.6%	9.1%	36.9%
Medicare Supplemental	12.9%	20.2%	14.5%	37.9%
Comprehensive Total	8.0%	10.6%	8.9%	20.8%
Stand Alone Dental	8.6%	21.0%	16.4%	56.8%
Medicare Part D	10.1%	14.6%	13.0%	42.2%

The while the effect of the mix change increases as-reported cost trends, the same effect decreases *the percent of premium results. Medicare Advantage and ASO/ASC products all have low administrative expense to premium ratios and these are more prominent. Medicare Supplemental is less prominent this year and that fact helps to reduce the administrative expense ratio.*

Background on Sherlock Benchmarks

The universe in this analysis consisted of nineteen Blue Cross Blue Shield Plans, which collectively serve 34.1 million members. These Plans are also nineteen primary licensees of the Blue name and mark, and collectively comprise 63% of the revenues of all single-state Plans. Eighteen of this year's participants participated in the previous year and 89% of this year's participants have six or more years of experience participating in *SEER*. Fifty-eight percent of the participants have 11 or more years of participation in our benchmarks.

Approximately 16.4 million of the commercial members were served under some form of self-insurance arrangement, comprising approximately 58.5% of their total commercial members. Medicare Advantage, offered by 14 Plans, comprised 3.3% of their total comprehensive membership. In seven of the Plans, Medicare Advantage comprised 19% or more their total revenues, and in 12 cases, their Medicare Advantage revenues exceeded their historically important Medicare Supplemental revenues. Combining all of this universe's revenues, those from Medicare Advantage are nearly four times that of Medicare Supplemental.

Rates of change in costs are calculated for Plans that participated in both of the comparison years. By contrast, PMPM values are actual for *all* Plans in the universe. We often employed median values throughout this analysis as the measure of central tendency because this calculation minimizes the effects of any outlier responses.

Including all of our benchmarks, those published in 2013 will comprise the experience of approximately 620 health plan years. We also have universes of Independent / Provider-Sponsored Plans, Larger Health Plans, Medicare Advantage Plans and Medicaid Plans. Later this month, we will publish results on the Independent / Provider-Sponsored Plans and we will be reporting on the results of other universes in the months that follow.

Why Administrative Costs Matter Now

Optimizing administrative costs is central to health plan industry strategies.

- The intention of the MLR rules is to "create incentives for" health plans "to become more efficient" in the execution of their administrative activities.
- The economy remains fragile, creating price pressures and employer interest in self insurance.
- Weak state budgets pressure Medicaid programs, while rate review pressures commercial products.
- The need for earnings has increased to invest in exchange-based and Medicaid products under the ACA. Since savings from medical costs may be limited, only administrative efficiencies remain.

Appendix A. Benchmark Summary
Blue Cross Blue Shield Costs by Functional Area Cluster, 2011 Data
Per Member Per Month

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales & Marketing	$4.69	$9.38	$7.34	42.0%
Provider & Medical Mgmt.	2.91	4.52	3.65	33.0%
Account & Mem. Admin.	10.27	14.32	12.60	22.7%
Corporate Services	4.10	6.34	4.82	33.2%
Total	$23.87	$33.99	$29.87	22.9%

Appendix B. Benchmark Summary
Blue Cross Blue Shield Costs by Functional Area Cluster, 2011 Data
Percent of Premium Equivalents

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales & Marketing	1.4%	2.8%	2.1%	44.3%
Provider & Medical Mgmt.	0.9%	1.4%	1.1%	29.7%
Account & Mem. Admin.	3.3%	4.3%	3.9%	21.1%
Corporate Services	1.2%	2.0%	1.6%	27.4%
Total	7.3%	9.7%	9.1%	21.0%

For these reasons, health plans serving most Americans are users of Sherlock Benchmarks.

Health plans use the Sherlock Benchmarks to:

- Assess whether their plan is operating at optimal cost levels.
- Improve operating cost structure by identifying highest ROI opportunities for performance improvements.
- Estimate the contribution to corporate objectives of functions that are high quality, but also high cost.
- Evaluate outsourcing of selected health plan operations, and the value-added of management consultants.
- Develop a realistic and cost-effective budget.
- Execute business combinations including due diligence, estimation of the effect of synergies and development of a plan for successful integration.
- Learn what attributes are associated with superior performance.

Additional information can be found at http://www.sherlockco.com/seer.shtml. Alternately, we hope you will not hesitate to contact us if you are interested in licensing these materials or if we can answer any further questions.