Plan Management Navigator
Analytics for Health Plan Administration

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Right-sizing for Change

Introduction

The Congressional Budget Office recently released its analysis of the Republican plan to repeal and replace the Affordable Care Act ("ACA"). It is not possible for us to reliably predict whether this proposal, the American Health Care Act, will be enacted into law or whether the Affordable Care Act will continue.

Each of these outcomes has important implications for health insurers. If the Affordable Care Act continues, Medicaid growth will largely continue but the individual market will continue its financial difficulties. If the American Health Care Act ("AHCA") is enacted, individual membership and Medicaid MCO membership will decline.

Planning for the alternative scenarios is important because the margins are modest in health insurance, the consequences of expense variances are significant and the timing of any efforts to adapt is accelerated. In this *Plan Management Navigator*, we offer an approach to right-sizing for the effects of both scenarios.

Background on Changes

The changes in the legislative proposal eliminates, reduces or replaces subsidies that have resulted in the 21 million more people being enrolled in health insurance, according to the Congressional Budget Office ("CBO"). Eight million are unsubsidized commercial and 12 million are Medicaid as of January 2017.

Commercial and Medicaid Subsidies

Under the ACA, there are many subsidies and other mechanisms in the commercial market that are intended to provide health insurance to those whose health care needs are greater than average. Of the nine million people enrolled in the commercial marketplaces through the Affordable Care Act, 8 million are subsidized according to the CBO. Employment-based coverage is also higher.

Some differences in ACA from the proposed ACHA are as follows:

1. **Three rating bands from five previously.** This is a subsidy of older people by younger people.
2. **Broad scope of benefits.** This subsidizes people who require such benefits by those who do not. An example of this is sex-specific health care benefits.
3. **Taxes imposed on insurance companies to subsidize insurance purchased in the exchange market places.** These are approximately $14-$15 PMPM. They are invisible to insurance purchasers. The proceeds of the tax subsidize high cost exchange beneficiaries.

4. **Penalties for not purchasing insurance.** The policy significance of this provision is the effect of taxes on those with low care needs since those with high care needs would purchase subsidized insurance anyway. Either this penalty forces healthier individuals to purchase insurance that is above what their expected needs are, or they would pay a tax that could be used to subsidize the care of those whose health care needs are higher.

Under the American Health Care Act, some other subsidies would replace them. There would be a new non-refundable tax credit and those with high health care needs would be excluded from the main insurance pool, and placed in a new subsidized one. Also, those people who drop their insurance coverage would be subject to a 30% surcharge when they reenter the market.

There are also subsidies under the Affordable Care Act for Medicaid market. The expanded Medicaid program, if availed by the states, entailed the Federal Government paying 95% in 2017 (eventually falling to 90% beginning in 2020 and into perpetuity) of the costs of these new beneficiaries.

Under the new proposal, Medicaid would be converted to block grants, and would revert to pre-ACA sharing approaches. Costs per member would also be limited.

CBO ESTIMATE OF EFFECTS OF AHCA

In its analysis, the CBO estimates that in 2018, 14 million fewer people would have insurance under the American Health Care Act. Of these, 5 million would be Medicaid, 6 million would be commercial members in non-group programs, and 2 million would arise from a decline in employment-based coverage. For 2017 and 2018 combined, 17 million fewer people would have coverage, of which 6 million will be Medicaid, 8 million will be non-group, and 3 million will be employment based.

The effect of these changes is shown in Figure 1. Inevitably there is uncertainty in such projections but we consider them a reasonable starting point.

Figure 1. Right-sizing for Change

Analysis of CBO's Table of the Effects of the AHCA in 2017 and 2018

Millions of People by Calendar Year

	2016	Baseline 2017	Chg. in 2017	Chg. in 2018	Chg. Combined in Both Years	2018 after Chg.	Pct. Chg.	Cummul. Pct. Chg.	2018 w/out Reduct.	2018 w/out Reduct. Cummul. Percent Change
Total Population Under Age 65	272	273	1	1	2	274	0.4%	0.7%	274	0.7%
Medicaid	68	67	-1	-5	-6	61	-9.0%	-10.3%	67	-1.5%
Nongroup coverage, including marketplaces	22	24	-2	-6	-8	16	-33.3%	-27.3%	24	9.1%
Employment-based coverage	155	155	-1	-2	-3	152	-1.9%	-1.9%	155	0.0%
Uninsured, CBO Estimate	27	26				41				

Planning Challenge

Significant environmental change is inescapable for 2018 but the form cannot be known. But failure to adapt courts high administrative costs and low or negative margins. Also, similar to the "observer effect" in physics, the presence of uncertainty magnifies the difficulties since the operational managers must address customer, provider and internal concerns, reducing their time for planning. The planning process of every health plan incorporates the insights of these subject matter experts.

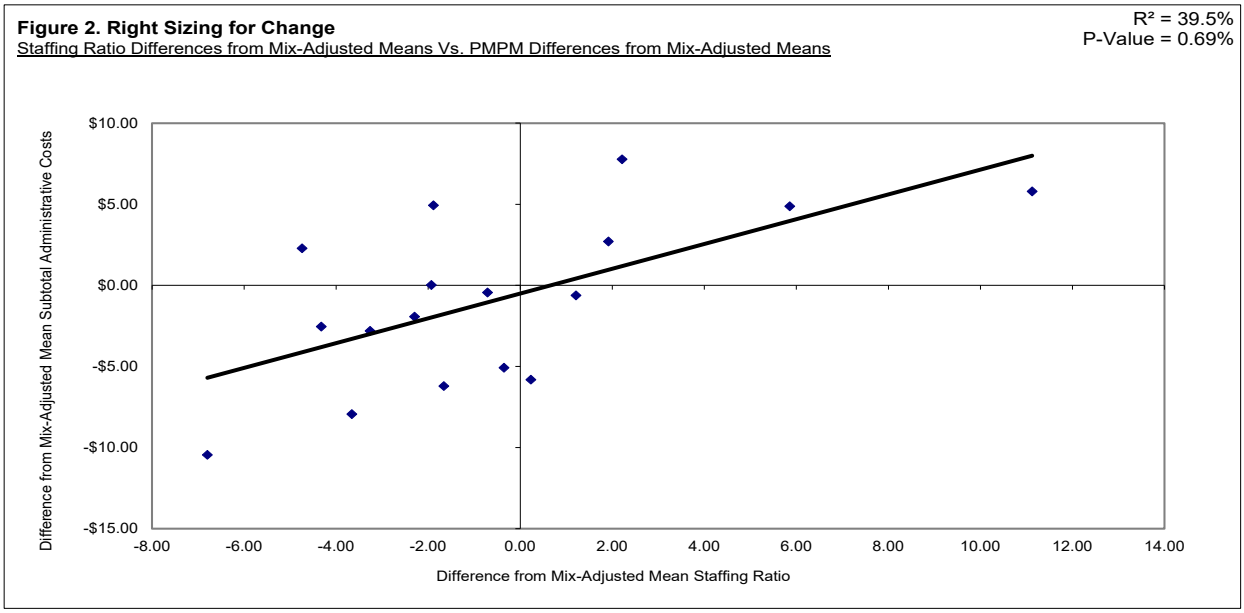
Because of the limited time and the importance of the task, health plans may wish to consider developing cost scenarios at an abstracted level to be refined as the federal policy matters resolve.

As we see it, either the AHCA will either be enacted soon or the ACA will continue. If the American Health Care Act is enacted, the individual market will be smaller in 2018, but more profitable. Under that scenario, Medicaid Managed Care Organizations, the primary way that health plans participate in that market, would have fewer members but would otherwise face few changes. Speaker of the House, Paul Ryan, has said that there are other steps in the efforts to reform the insurance market but we have not taken them into consideration for this analysis.

Medicare is not affected by the American Health Care Act. Medicare membership is expected to increase by 5.9% between 2016 and 2018, according to the Centers for Medicare and Medicaid Services.

If the American Health Care Act does not pass, then the financial losses in the individual product may be less if plans will decide to curtail commitment to that business. This implies a decline in, or low growth in, membership. Medicaid, however, will remain substantially unchanged.

Figure 2. Right Sizing for Change
Staffing Ratio Differences from Mix-Adjusted Means Vs. PMPM Differences from Mix-Adjusted Means



STAFFING AS A KEY COST DRIVER

In planning for each of these outcomes, developing alternative scenarios for staffing can telescope adaptation for costs. Figure 2 shows the strong relationship between staffing ratios and costs. Note that this relationship excludes the effect of product mix differences and the effects of outsourcing. Therefore, in the examples that follow, we directly address the issue of staffing in order to manage costs.

Modeling the Two Scenarios

The two charts that follow model the changes to a health plan serving 500,000 members (6.0 million member months). Each scenario considers three effects. First, since each product has a different profile of administrative resource use, the staffing model takes into account changes in its product mix. Also, since under each scenario the number of members served would be affected, the overall membership is taken into account. Finally, since economies of scale are evident (though relatively modest) we have taken its effects into account as well.

The baseline product mix is loosely based on the mix in the U.S. Population served by some form of private or government coverage. The rates of change in membership are based on the CBO's analysis summarized in Figure 1, except that we have used the Medicare growth rate developed by CMS.

Figure 3. Right-sizing for Change
Impact of Growth, Mix and Economies of Scale on Staffing
Scenario 1: Changes if AHCA is Enacted

	Individual	Other Commercial	Medicaid	Medicare	Total
Current Member Months	438,393	3,088,675	1,355,032	1,117,901	6,000,000
Percent of Members in Each Product	7.3%	51.5%	22.6%	18.6%	100.0%
Plan Staffing Ratios	21.81	15.43	16.35	40.69	20.81
Weight	1.59	7.94	3.69	7.58	
Total FTEs					1,040
2018 Percent Change	-27.3%	-1.9%	-10.3%	5.9%	-4.2%
2018 Member Months	318,831	3,028,894	1,215,543	1,183,660	5,746,928
Percent of Members in Each Product	5.5%	52.7%	21.2%	20.6%	100.0%
Weight	1.21	8.13	3.46	8.38	21.18
Total FTEs – 2018, before the effect of Economies of Scale.					1,014
Percent Change in Staff					-2.5%
Percent of FTEs subject to Economies of Scale					36.2%
Marginal Scale Effect					73.7%
Total FTEs after the effect of Economies of Scale.					1,019

*Staffing ratio is estimated based on Total Costs per FTE of $235,000, loosely based on Sherlock Benchmarks for Blue Cross Blue Shield Plans, published in 2016.

*Product Growth is based on CBO baseline estimates in March 2016 and of the AHCA completed in March 2017, and CMS National Health Account estimates published in February 2017.

The staffing ratios for each product are estimated based on Blue Cross Blue Shield PMPM costs values from the Sherlock Benchmarks, published in the *Plan Management Navigator* of June 2016. Most organizations do not operate with separate staffs for each product – a claims processor might follow a commercial claim with a Medicare claim. Accordingly, we estimate staffing assuming that the same mix of labor and non-labor occurs without respect to product. In other words, we assume that the same total cost per FTE is found in each product. To get the staffing ratio, we divide the PMPM costs by a total cost per FTE assumption of $235,000. This value is for illustrative purposes only.

MODELING SCENARIO 1 - AHCA IS ENACTED

This scenario models a *reduction* in the members served by 4.2%. The change in product mix assumes the enactment of the American Health Care Act summarized in Figure 1, and growth in Medicare in accordance with CMS estimates. However, since the mix of members increases in favor of Medicare, the overall impact on staffing is more modest at a 2.5% decline.

Countervailing this decline is the effect of economies of scale. As mentioned in various editions of *PULSE*, 36.2% of staffing is subject to economies of scale. A doubling of the size in the enterprise would lead to staffing of 83.1% of the predoubling value in the functions subject to economies of scale. In this case, the *marginal* scale effect of a 2.5% reduction in staff equates to 73.7% of the baseline value. So, since the plan is moving up the scale slope, after the effect of the economies of scale, the company's staffing goes to 1,019 FTEs, or a decline from the original by only 22 FTEs or by 2.1%.

Figure 4. Right-sizing for Change

Impact of Growth, Mix and Economies of Scale on Staffing

Scenario 2: Changes if AHCA is Not Enacted

	Individual	Other Commercial	Medicaid	Medicare	Total
Current Member Months	438,393	3,088,675	1,355,032	1,117,901	6,000,000
Percent of Members in Each Product	7.3%	51.5%	22.6%	18.6%	100.0%
Plan Staffing Ratios	21.81	15.43	16.35	40.69	20.81
Weight	1.59	7.94	3.69	7.58	
Total FTEs					1,040
2018 Percent Change	0.0%	0.0%	-1.5%	5.9%	0.8%
2018 Member Months	438,393	3,088,675	1,335,105	1,183,660	6,045,832
Percent of Members in Each Product	7.3%	51.1%	22.1%	19.6%	100.0%
Weight	1.58	7.88	3.61	7.97	21.04
Total FTEs – 2018, before the effect of Economies of Scale.					1,060
Percent Change in Staff					1.9%
Percent of FTEs subject to Economies of Scale					36.2%
Marginal Scale Effect					73.2%
Total FTEs after the effect of Economies of Scale.					1,059

*Staffing ratio is estimated based on Total Costs per FTE of $235,000, loosely based on Sherlock Benchmarks for Blue Cross Blue Shield Plans, published in 2016.

*Product Growth is based on CBO baseline estimates in March 2016 and of the AHCA completed in March 2017, and CMS National Health Account estimates published in February 2017. However, we have assumed that individual members remain constant, other commercial declines are reversed and Medicaid grows in accordance with CBO projections before the effects of AHCA.

MODELING SCENARIO 2 – AHCA IS NOT ENACTED

This scenario models *growth* in the members served by 0.8%. The change in product mix assumes that the American Health Care Act is not enacted into law. In this scenario, Medicare growth is assumed as CMS projects and no growth is projected for Individual or Other Commercial. The CBO had, in March of 2016, projected a modest decline in Medicaid membership and we have incorporated that into this scenario. As with Scenario 1, since the mix of members increases in favor of Medicare, the overall impact on staffing is amplified for a 1.9% increase.

In this case, the *marginal* scale effect of a 1.9% increase in staff equates to 73.2% of the baseline value. So, since the plan is moving down the scale slope, after the effect of the economies of scale, the company's staffing goes to 1,059 FTEs, or an increase from the baseline staff only 19 FTEs or by 1.8%.

Final Notes

Health plans' budgeting for 2018 will, for many plans, take place during the summer of 2017. Coincidentally, this is taking place as significant health policy changes are being debated. Federal policy will lead to changes in the health insurance environment from either the current path of the Affordable Care Act or through its replacement by the American Health Care Act.

So, while change is inevitable in 2018, it is not possible know with any confidence the final outcome of federal policy. On the other hand, planning now is important since change will occur, and adaptation will take many months to implement. The margins are low in this business so the cost of not planning ahead could be very high indeed.

The solution to this conflict between the uncertainty of change and the need to plan for change is to focus on right-sizing the staffing. The staffing ratio approach to modeling may be helpful as the default alternative, or it can be also thought of as a reality check against projections developed by function leaders.

In the previous examples, we have used a highly-simplified approach. Each function has different cost characteristics. For instance, the scale slopes, cost per FTE, and the staffing ratios differ from function to function and by product to product.

We hope that you will not hesitate to reach out to us if you have any questions on this, or if Sherlock Company can help you formulate your plan.

Appendix: Key Provisions of the American Health Care Act, as Modeled by the CBO

- Eliminating penalties associated with the requirements that most people obtain health insurance coverage and that large employers offer their employees coverage that meets specified standards.
- Reducing the federal matching rate for adults made eligible for Medicaid by the ACA to equal the rate for other enrollees in the state, beginning in 2020.
- Capping the growth in per-enrollee payments for most Medicaid beneficiaries to no more than the medical care component of the consumer price index starting in 2020.
- Repealing current-law subsidies for health insurance coverage obtained through the nongroup market—which include refundable tax credits for premium assistance and subsidies to reduce cost-sharing payments—as well as the Basic Health Program, beginning in 2020.
- Creating a new refundable tax credit for health insurance coverage purchased through the nongroup market beginning in 2020.
- Appropriating funding for grants to states through the Patient and State Stability Fund beginning in 2018.
- Relaxing the current - law requirement that prevents insurers from charging older beneficiaries (64 years old or younger) premiums that are more than three times larger than the premiums charged to younger people in the nongroup and small-group markets. Unless a state sets a different limit, the legislation would allow insurers to charge older beneficiaries five times more than younger ones, beginning in 2018.
- Removing the requirement, beginning in 2020, that insurers who offer plans in the nongroup and small-group markets generally must offer plans that cover at least 60 percent of the cost of covered benefits.
- Requiring insurers to apply a 30 percent surcharge on premiums for people who enroll in insurance in the nongroup or small-group markets if they have been uninsured for more than 63 days within the past year.

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