Transcript

Blue Cross Blue Shield Administrative Costs: A Review of 2014 Results

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Thanks for attending our presentation of the results of the Sherlock Benchmarking study for the results of the Blue Cross Blue Shield benchmarking study. This is the first of a series of presentations on trends in health plan performance metrics reflecting 2014 results. This conference is timely because of health plans' need to adapt to the more challenging circumstances of the Affordable Care Act.

Last week four national health plans announced that they intended to adapt by merging. Centene's announcement is explicit: "Synergies will come from areas including efficiencies in core G&A …and leveraging capabilities in IT systems and process management." Centene estimates that its synergies will total $150 million annually. If all of this is attributed to operational savings, this could amount to a reduction by 4% of the $3.7 billion annualized administrative costs of the combined health insurers.

While 4% savings is small, a key context is the 2% margin of the combined health plans. If realized, the savings would represent an 18% increase in operating income. Any organization competing with Centene, Health Net, Aetna or Humana, will now need to consider its competitive responses to these actions.

The very modest 1.1% increase in per member administrative expenses, which we will discuss today, indicates that Blue Cross Blue Shield Plans are offering a competitive response to these actions. But taxes are also increasing, which seem to directly add

costs, and from overall cost perspective, increase uncertainty. Miscellaneous business taxes increased sharply, amplifying administrative cost increases to more than 18%.

By way of introduction, I am Doug Sherlock, President of Sherlock Company. We offer what are referred to by leading consultants as "the Gold Standard" for health plan benchmarks. Now in the midst of our 18th consecutive year of benchmarking, we benefit from 700 health plan years of experience, comprised of definitions, systems for compilation and checking as well as processes for reporting and drill-downs. In addition to Blue plans, we also have other universes.

The Blue Cross Blue Shield plans reflected here serve 29 million people with comprehensive insurance, slightly higher than the total last year. The Plans serve 55-60% of the membership of US single state Blue Plans and comprise 47% of US primary licensees. Last year had 17 primary licensees, but lost two because of reorganizations, picked up one more so we have 16 of which 15 are continuing. Many thanks to the Plans that participated in this year's benchmarking study: This web conference is a happy side-effect of your efforts, and benefits the industry as a whole.

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Today, I want to highlight the decline in the rate of administrative cost growth in areas under management control, and the effect of taxes. Then I touch on the groups of functions that led to the cost increase, called clusters, and key functional drivers that contributed to their growth. We then review costs by function and by product. We include some exhibits from last year for reference purposes.

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As we'll develop, the expense growth sharply declined. The decline in growth was deep, wide and no matter how you measure it. This slide shows the overall trend in dark blue and the Account and Membership Administration trend in light blue. These figures eliminate the effect of any changes in participation, and they also eliminate any changes in product mix between these continuing Plans.

Overall costs increased PMPM by 1.1%. That is lower than since prior to 2008. In the most important cluster of functions, Account and Membership Administration, costs increased by 3.0%, down from 8.5% in the prior year. This rate of growth is slower than

the past two years and for the average of the prior six. As we'll discuss later, the Account and Membership Administration trend is in some respects even better than it looks because of the underlying trend in Information Systems costs.

Having said this, it is important to realize that, while the growth rate has diminished, costs are higher than they have ever been before because the modest increases are *on top* of some very high increases in prior years.

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Since we focus on the administrative costs under management control, all of our administrative expense levels and comparisons *exclude* Miscellaneous Business Taxes. This convention includes all of the previous slides and all subsequent ones.

I am making an exception in this one slide. While there was a decline in the rate of cost increase, there was a surge in Miscellaneous Business Taxes that really caught our eye. It is notable because the increase, even outside of managerial control, must be baked into the premium rates.

Those Miscellaneous Business Taxes surged by 369% or by approximately $4.80 to $6.08 PMPM. The context is that, before Miscellaneous Business Taxes, the administrative costs were $33.37 and after they were higher by more than $6.00. So, once the surge in taxes is taken into account, costs increased by 18.4% rather than 1.1%.

To be clear about the economics of this, the difference is not explainable by a reduction in broker commissions due to participation on exchanges. This reduction didn't occur. It is not overcome by anticipated recoveries under reinsurance, and I think consensus is that it is highly unlikely to be overcome by recoveries through risk corridors.

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The balance of this presentation is focused on the true operating expense trends. The key thing is that trends declined: They declined in total, they declined in all of the clusters and they declined no matter how you measure it.

Before I begin, please note that all of the comparisons *hold constant* the universes. In other words, while there were 16 primary licensees participating in 2015, the two 2014

columns show only the fifteen continuously participating ones. The "As Reported" column means just that, for those Plans. There is *no* distortion in trend from the addition or removal of a Plan from the universe.

The Constant Mix columns take this one step further by *reweighting* each Plan's results in the prior year to their current year's product mix. Since the mix is held constant, there is no effect on trend stemming from a change in the mix products offered by the Plans. I'm going to emphasize the Constant Mix format in this presentation since it reflects the actual, real changes in cost trends as far as it is possible to do so.

As you can see, PMPM cost growth increased by 1.1%, sharply down from 6.2% last year. Corporate Services costs actually *declined* by 1.4% compared with an increase of 4.5% PMPM in the prior year. But, if you review, each of the clusters of functions declined in growth, including Sales and Marketing, Medical and Provider Management and Account and Membership Administration. I'll define these clusters as we proceed but they are also found in Appendix C of the slide deck.

The Sales and Marketing cluster's costs increased at a median rate 2.0% versus 8.9% last year. When you look at the underlying functions, the median rates of increase for every function in this cluster (Rating and Underwriting, Marketing, External Broker Commissions, Advertising and Promotion) declined.

Both Marketing and Advertising and Promotion declined from double-digit growth to one percent or less. Trends in Advertising and Promotion were the lowest since at least 2009. Marketing expense growth was also the lowest in the past five years. Rating and Underwriting cost growth declined, and the number of employees in this function declined precipitously. I was surprised to see that Broker Commissions grew in line with historic trends. I had thought that perhaps the Exchanges would have muted growth but that was not the case. Sales growth declined on a constant mix basis but the shifting mix accelerated costs of this function on an as-reported basis.

Speaking of mix shift, you can see its general effects on the higher rate of growth as reported versus mix adjusted. It costs more to market to Medicare members so the increase as-reported costs were more rapid. For instance total costs increased by 3.5% versus 1.1% on a constant mix basis.

While membership increased at a median rate of 4.2%, Medicare Advantage grew by approximately 20% and Stand-Alone Part D grew by approximately 4%. Medicare Supplemental also grew. By contrast Commercial grew by only an average rate of 2.8%. While Commercial ASO/ASC increased by 7.2%, Commercial Insured grew by 2.4%.

You can see that Medical and Provider Management trend also declined to 1.6% from 4.5% in the prior year, in this instance to the lowest level since at least 2010. Both components of this function, Medical Management and Provider Network Management and Services, declined in growth. The latter was especially dramatic, falling from 6.4% to 3.7% and staffing ratios also declined for this function.

The larger Medical Management function also had declining growth. Medical Management cost growth was its lowest since at least before 2010. The Disease Management sub-function costs actually *declined*, year over year. As might be expected from the shift in favor of Medicare Advantage, health plan administrative costs for this *function* (not cluster) actually accelerated on an as-reported basis.

Account and Membership Administration growth declined from last year's levels and, at 1.6%, posted the lowest rate of growth since 2011. This seems to have mainly been powered by a decline in Information Systems growth, from the mid double-digit rate to very low single digits. By contrast, all of the other functions, Enrollment / Membership / Billing, Customer Services and Claims accelerated. As-reported results had a similar pattern.

Other than Information Systems, Claims had the slowest pace for the cluster, continuing a trend for moderate growth. This likely continues a trend towards automation: While PMPM costs for Claims function costs are less than 1% higher since 2009, they are 32% higher for Information Systems. Bouncing back from the heavy development in prior years, the Application Acquisition and Development sub-function costs actually *declined* sharply. Enrollment / Membership / Billing is at its highest rate of growth since at least 2010. More remarkably, Customer Services had a double-digit increase for the second year in a row after three years of low single-digit growth.

The Affordable Care Act's effects can perhaps be seen Enrollment and Customer Services trends. The rapid Enrollment growth which may have been associated with membership churn and the effect of the new Exchanges. Customer Service cost growth was also the highest since at least 2010. One of our participants calls this surge an

example of "bulge" costs: since nearly all commercial members had new products, customer inquiries may have required higher levels of staffing.

I want to digress to flesh out staffing factors which are key drivers of these costs. To maintain an apples to apples comparison, I want to focus the staffing ratios of the commercial insured business. (My earlier comments about staffing are also focused on the commercial insured lines.) This of course was the set of products most dramatically impacted by ACA in 2014. Staffing ratios, with the effect of outsourcing, appeared to have been effectively flat at about 23-24 FTEs per ten thousand for these products. While one would normally expect Staffing ratios to grow modestly for the Information Systems functional area, they actually increased. The reason may have been a 5.7 percentage point decline in the median proportion of IS FTEs that were outsourced, to 26.2%. (Approximately 13% of all Blue FTEs are outsourced.)

I noted that Plans may have observed what they call "surge" costs. In Customer Services staffing ratios, they appeared especially important, climbing by over 17% to more than 2.5 FTEs per ten thousand. In other words, the declines in the staffing of Rating and Underwriting, Provider Network Management and Services and other areas were offset by the surge in this function.

The median compensation for the Blue plans in this study was $97,000. It was $87,000 in the Account and Membership Administration cluster of expenses.

The costs in the cluster of Corporate Services *declined* by 1.4%, driven in large part by the 1.8% decline in the Corporate Services function. The rate of growth in Finance and Accounting declined though staffing ratios increased. Actuarial growth sharply decelerated from 2013 levels while staffing was flat. It is possible that in 2013 there were consulting engagements that did not recur during 2014.

Legal expenses decelerated: Compliance costs grew modestly, from a surge in 2013, though Government Affairs accelerated.

Last year we had thought perhaps that, in 2013, the high cost increases would make that year both an inflection year and the baseline year for which costs for health plans will be compared in future years. This appears to have been the case.

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This slide shows reiterates some of the comments I've made earlier. As you know, to make the results actionable, for Blue Cross Blue Shield Plans, administrative costs are segmented into nearly 60 functional areas, summarized as shown in Appendix C into the four expense clusters.

I want to begin by tracing the components of the cost trends, based on the data as the Plans reported them to us. Here we are emphasizing rates of growth and, by weighting growth by the dollar value of the costs, their importance to overall trend.

Overall, they reported administrative expenses that increased by 3.5%, below the 7.3% reported in the prior year, and the 5.1% increase in 2012. The fastest increase of all of the functions was in Customer Services, at low double-digit rates and this function was also the most important source of increase, comprising about 20%.

Overall however, Account and Membership Administration, shown on the third row, was up by only 1.7%. While Enrollment grew in mid-single digits, Information Systems costs and Claims grew at low single digits.

Sales and Marketing was the fastest growing cluster, at 7.2% but is down from 8.1% in the prior year. The Sales function grew fastest, but the increase in the huge broker Commission function was dominated the increase after weighting by its contribution. Advertising and Promotion and Marketing costs both *declined*. Rating and Underwriting grew but at considerably slower rates than in prior years.

Medical and Provider Management decelerated over the prior years, 3.0%, versus 5.7% last year and 4.2% in the year before. Medical Management grew faster than Provider Network Management and Services and, since it comprises most of this cluster, was also the most important cause of the cluster's increase.

The decline in the Corporate Services cluster of functions by 0.7% versus an increase of 4.2% last year was mainly due to a decrease in the Corporate Services function. Per member Actuarial costs also declined. Corporate Executive costs increased at a higher than average rate.

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This slide reflects what I would call "real" increases in expenses. In other words, it eliminates any effects of changes in product mixes between the Plans being compared over the two year period. Recall that the continuously participating Plans grew, emphasized Medicare more and, within the Commercial market, emphasized ASO/ASC products more. There was a mix effect, as you could see earlier – this shows a total increase of 1.1% compared with a 3.5% increase without holding the mix constant. This rate of 1.1% rate of increase is sharply lower than the 6.2% increase for last year and again the slowest growth since at least 2008.

By and large the same observations that applied to the as-reported values also apply to the constant mix comparisons as well. In fact, there is only one major change between the two charts: Note that the fastest growing area in Medical and Provider Management is now Provider Network Management and Services, rather than Medical Management.

Just to reiterate, the cost trends tended to be more modest through, after adjusting to eliminate mix effects. The growth in the senior products likely dampened the constant mix change in Medical Management versus the as reported presentation. It appears that administrative expense associated with pharmacy, mental health and ICD-10 likely accelerated the costs of the Account and Membership Administration area.

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The median costs to administer comprehensive products for Blue Cross Blue Shield Plans was $33.37, which I have highlighted with a gray arrow. It is 9.3% higher than last year's reported costs of $30.53, shown in Appendix A. The product mix weighting may explain much of the difference: if you employ the 2014 product mix to weights the 2013 product cost values, the $30.53 shown in Appendix A becomes $33.39, substantially identical to this year's values. This is oversimplified of course. The numbers remain not perfectly comparable because the Plans differed, as noted earlier.

Because of the high comparability, some of the earlier comments are paralleled when the comparing the respective universe values over the two years. Thus, Sales and Marketing costs at $8.20 was only a little above last year's costs of $8.09, corresponding with the slow growth on a constant mix basis. The lower cost of Medical and Provider Management, at $3.93 versus $4.05 echoes the 1.6% increase on a constant mix basis.

Account and Membership Administration is fastest growing, both comparing the raw values, $14.74 and their constant-mix changes. The trend is less clear with the Corporate Services Cluster.

A notable change between the two years is the decreased clustering of values. The total coefficient of variation is 28%, up from 24% last year and 25% in the year before. This is especially the case in the Sales and Marketing cluster where it increased from 36% to 46%. Similar results are evident when you compare the spread between the 25th and 75th percentiles year over year. While we have stressed the mix change overall each Plan changed on its own. So one possible reason for this is the increasing differences in the product mixes of the participating Plans. For instance, the coefficients of variation of the share of membership that was Commercial increased from 6.7% to 7.5%.

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This slide shows the costs for each of the products offered by the participating Plans. In general, the relationships are fairly similar to the patterns we've seen before in prior years, and across universes. In short, insured products cost much more than administer than their ASO/ASC counterparts. Medicare Advantage costs at $80.06 much more to administer than do the equivalent commercial products, say Commercial HMO Insured at $44.39 for example.

But if you compare this slide with the equivalent slides for last year (they are available on our website), you'll notice a sharp change in the differences between the costs of Insured versus ASO/ASC products. While last year, the difference averaged $18.37, this year they averaged $21.07. There's always been a difference and for the most part, those differences come from lower Sales and Marketing expenses for ASO/ASC. Notably, the individual business segment (another cut of the data in the Blue benchmarking study), which is always insured, comprised a median of 7.8% of the membership in the 2014 study and 12.7% in the current one.

It happens that several Plans report to us individual product costs. The administrative costs in this year's universe are higher by 8.1% to $50.74. Moreover, for the first time we began to collect the individual products segmented by type. The ACA compliant products are reported far more expensive than Grandfathered programs, approaching Medicare Advantage level PMPMs.

We suggested last year that, if employers capable of self-insurance increasingly elect to do so, the cost differences between insured and self-insured will increase further. We cannot rule out this factor based on this year's results.

Before I leave this slide I want you to know that this content is available as an application on our website. Go to our website, look for "Benchmark Calculator" and populate it with your membership. You can, if you wish, also supply your administrative expenses. The application will tell you how your plan's costs compare to this peer group after adjusting for the mix differences that are so important. It works even if you only know your total administrative costs and you don't segment your administrative activities by product.

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This slide is similar to the previous, except that we've expressed administration relative to premium equivalents. (This includes the non-GAAP treatment of the ASO/ASC products to include health benefits in revenues. This is necessary for comparability with insured products.) In some respects, the relative values of the products are similar: ASO/ASC percents are considerably lower than their insured counterparts. And the differences are similar as well. For the central Indemnity & PPO product, median PMPM costs of ASO are 54% of the insured costs, and the similar ratio for percents of premium equivalents is 55%.

But they do differ in the products for seniors. Medicare Supplemental, at $31.38 PMPM, is a relatively low cost product. But at 16.7% of premiums, it is among the highest cost products when calculated in this way. This stems from the fact that many administrative activities for this population are incurred for events in which Medicare Supplemental is the secondary payer.

But Medicare Advantage cost ratios are exactly reversed. On a PMPM basis, they are the highest cost product but lower than all of the commercial insured products when expressed as a percent of premium. The health benefit per claim is considerably higher for MA members, giving rise to the low percent.

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Note that the overall costs are 9.0%, slightly higher than the 8.7% last year, shown in Appendix B. As with Slide 8, part of this is an artifact of the changing mix. If we reweight last year's product cost values by this year's membership mix, then you'd get a 2013 administrative expense to premium equivalent ratio of greater than 9%. In other words, the ratios actually improved somewhat. The equivalent tables for last year are found on our website at the link for *Navigator* July 2014.

Again, administrative costs for Blue Cross Blue Shield Plans were 9.0% of premiums. Paralleling the modest growth in each of the functional area clusters shown in Slide 5, the proportion of premium equivalents declines or is a negligible difference in all cases.

Now is a pretty good time to remind everyone that since medians are the 50th percentile values, you can't add them. It is even more the case with the 25th and 75th percentile values since they are calculated by function, not Plan. We employ the medians since they are, in our view, more representative of the typical plan.

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Administrative costs in 2014 grew at a far lower rate than in 2013. In fact, the decline in trend was overall, across all clusters and irrespective of whether you employ as reported or mix adjusted values.

The Affordable Care Act includes important new taxes to the cost mix that add $6.00 to total administrative expenses. On a base cost level of $33.00, it must ultimately be baked into the premium rates. Administrative expense growth was quite high after the effect of the new taxes.

The growth in Customer Services and its staffing was the key driver of the cost growth, notable because it repeated last year's growth. Information Systems cost growth was very modest after high growth in previous years.

Membership growth was strong among the plans. While commercial products grew, especially those in the ASO/ASC area, Medicare Advantage was especially strong.

The recent announcements of potential mergers by some of the largest national health plans suggest that some of the plans are adapting to the Affordable Care Act by endeavoring to increase their scale. While economies of scale exist for health plans, they are limited in breadth and in amplitude. So we believe that these potential business combinations are best understood as emblematic of the "incentives for efficiency" imbedded in the ACA as a requirement for success. After all, it is not uncommon for smaller plans to outperform larger ones in cost management, and there many examples of recent new entrants.

Many thanks for your attention to this dry, but I hope informative, presentation on a matter of critical importance to your organization. I have attached to the end of this presentation some appendices in support of this presentation. They include 2013's costs and the functions found in the clusters we have been speaking.

Today we've gone through a lot of numbers and if you're like me, this is very hard to digest at one sitting. So this presentation, (transcript and slides) will become available on our web site in the next few hours. Please feel free to call us at any time. Those of you who have called in the past know I normally pick up our telephone personally but if I am not there, my colleagues Chris, Erin and John will be able to help.

Finally, there are 16 Blue Cross Blue Shield primary licensees that participated in this year's benchmarking study, and the overwhelming proportion of them have at least one representative on this call today. Let me thank you all for the hard work that goes into the 17th annual edition of the Blue benchmarks. We know, because we measure this, that participation pays off in lower costs. But the "bi-product" is something that benefits the industry as a whole. Thank you!

A few weeks from now we will summarize the Independent / Provider-Sponsored plan universe results, and we expect to host similar web conferences for Medicare and Medicaid plans later this summer. All of these presentations, including this one, will be posted on our web site. Additional information, including tables of contents on the benchmarks themselves are found on the website. Call me if we can elaborate.

Now I would like to open this for questions.

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Q. Does some of the decline in Medical Management costs stem from their classification as health benefits?

A. In the Sherlock Benchmarks, all medical management costs are included in administrative expenses *even if they are classified as Quality Improvement Activities for Medical Loss Ratio calculations*. The concept is that we are trying to capture all the costs under the health plan's roof.

Q. Is it possible that you are counting only the tax increases but not the revenues they gain from the reinsurance and the risk corridor?

A. We *are* solely focused on the administrative expenses which is where the tax increases are reflected. Payments to be received under these programs are carried as receivables until paid. After health benefits and administrative expenses, I believe this is intended to be economically neutral and it may bear out this way. We may learn more about this in August.

But there is reason to be skeptical at this point. For the continuously participating Plans, health benefit ratios improved by a little more than 1 percentage point, equating to about $4-4.50 PMPM for commercial insured members. Again, this is after booking the reinsurance receivables. But the typical increase in Miscellaneous Business Taxes for them was approximately $9.00 PMPM. Moreover, six of the continuous plans paid the higher taxes and reported *worsening* health benefit ratios.

Second, there is a difference in the credit associated with the receivable and the normal relationship with a customer. The money owed to the plans will be due from an agency of a government. The relative bargaining power between the plans and the payer is much different.

This asymmetry between what is paid and what is owed may be acute for risk corridor payments. S&P's analysis, published in May, stated that "the aggregate risk-corridor payables recorded by U.S. insurers for 2014 are less than 10% of the aggregate risk-corridor receivables booked by insurers for the same year."

Q. How do you know the staffing ratio for the Commercial Insured business? Do the Plans actually operate in this way?

A. No, they really don't operate that way. Instead, what we do is make an estimate based on the assumption that for every service that a health plan member needs, an identical mix of staffing and non-staffing costs are required. So, if we know what the *total* costs per FTE are and the PMPM product costs, we can divide to infer the staffing. While there remains the art of each plan's product cost allocations, we carefully check the reasonableness of each product's total costs and those of each function in those products.

Q. You had mentioned the increasing automation of the claims area. How do you treat the claims services that are provided automatically?

A. We effectively confine our claims area solely to manually adjudicated claims. Since the work to autoadjudicate is actually performed in IS, we keep those expenses there. This is of course cleaner since it doesn't mandate estimations. However, about one-third of the plans submit a separate schedule that estimates the cost on an end to end basis.

Q. Do you know whether Blues Plans are outsourcing a greater portion of their back office functions, and if this is a driver of the lower OPEX trends in 2014?

A. I don't have a broad answer available. But I can say that there was 5.7 percentage point decline in the median proportion of IS FTEs that were outsourced, to 26.2%. Because of the way that we calculate this, you should understand this ratio as a proxy for the costs. It is possible that this decline is related to the actual decline in per member Application Acquisition and Development between 2013 and 2014. Overall, approximately 13% of all Blue FTEs are outsourced.

Q. Is part of the reduction of outsourcing by Blues due to the acquisition of entities like TPAs, who previously did some of that work?

A. I have not asked that question, nor have I heard any anecdotes about that possibility. If I had to guess, I would doubt it. After all, TPAs tend to be very small relative to Blue Cross Blue Shield plans so if they did so, it would, be unlikely to make much of a difference. Moreover, in our experience, there are some big cultural differences between the Blues and TPAs that could constrain the use of this approach.

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I want to again thank you for your participation in this web conference. More in depth and actionable information is available in the Sherlock Benchmarks themselves, which anyone can license. Please contact me directly if you are considering licensing these materials.

In late July, in two weeks actually, we will have a similar web conference on the results of the Independent/Provider-Sponsored plans. In late summer, we will have similar web conferences on the results of the Medicare and Medicaid plans. We hope that you will consider participating in those web conferences as well.

Again, thank you who participate in our various benchmarking studies. While participating plans realize a return on their investment in the benchmarking process, it is nevertheless the case that the summary benchmarks that we discussed today benefit consumers and the health plan industry as a whole.

This is Douglas Sherlock of Sherlock Company.