Transcript

Independent/Provider-Sponsored Administrative Cost Trends A Review of 2015 Results – Cost Optimization Continues

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<Title Page>

Thank you for participating in this year's review of the Sherlock Benchmarks for Independent / Provider - Sponsored Plans.

I want to begin with an anecdote. I do offer it with some peril since some of you heard it during my last presentation on results of the Blue Cross Blue Shield plans. Prior to the passage of the Affordable Care Act, I was invited to a meeting of congressional staffers for a conversation concerning administrative costs under the proposed law. At that point the, MLR rules were considered integral to the vision but details about calculations had not yet been worked out. The MLR rules require that revenues that are in excess of levels yielding a Medical Loss Ratio of 80 or 85% must be shared with the customer. In the emphatic view of one of the staffers, the denominator of the calculation should be premiums, *plus fees under ASO arrangements*. Setting aside that this would have triggered a wave of corporate restructurings, the staffer's comment highlights the focus on administrative costs that has since animated the law and regulations on health plans.

The 21 Independent / Provider - Sponsored plans reflected here serve 10.8 million people with comprehensive insurance, higher than last year. Eleven of those plans are owned by health systems. Eight more have a vestigial relationship with providers, and were in some cases founded by providers. The remaining two are independent plans.

For the most part, they come from a managed care background and, more than Blues, they are focused on managed care products such as those serving Medicaid and Medicare populations.

We think that the level of participation in this universe is quite high. Of the 13 members of the Alliance of Community Health Plans that are not focused on public programs or are staff-model plans, 11 are participating in this year's Sherlock Benchmarks. Most of the largest members of the Health Plan Alliance that are not focused on public programs are participating in this year's Study.

By way of introduction, I am Doug Sherlock, President of Sherlock Company. We offer what at least three leading consultants call "the Gold Standard" for health plan benchmarks. Now in our 19th consecutive year of benchmarking health plans, we benefit from more than 740 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 Independent / Provider – Sponsored plans, we also have other universes of Blue plans, Medicaid Plans and Medicare plans. We also offer a subset of the Blue Cross Blue Shield Plans which we call the Larger Plans edition. We spoke on the Blue Plans two weeks ago.

Before I begin though, I want to offer our thanks to the plans that participated in this year's benchmarking study and in particular our primary contacts. While plans benefit from their participation, the rest of the industry does too via publicly available information such as this conference. You participants are not only setting a course for everyone, you are providing something of a roadmap as well.

<Slide 2>

I'm going to breeze through this slide. It shows the topics that I will address, and lists the appendices. Note that the appendices contain last year's value and a list of all of the functions in each of the products offered by these Independent / Provider - Sponsored plans. There are eleven products and without duplicating major functions or clusters, 50 different subfunctions. That means that administrative expenses are segmented into over 500 expense/product cells, each of which are separately analyzed. We will only summarize broad trends in this presentation.

I will be posting the slides and the transcript of this within the next 24 hours. I very much welcome your questions at the end of this presentation and the audience will be muted during the presentation itself.

<Slide 3>

For the second year in a row, the median administrative costs for Independent / Provider – Sponsored plans declined: 0.1% per member versus 0.4% last year. Over the past eight years declines were without precedent until last year's survey. Now it is back to back declines. This is shown in the dark blue bar.

The light blue bar is the cluster of Account and Membership Administration expenses. Recall that these are the core expenses of Enrollment, Claims, Customer Services and Information Systems. Here the trends are moderate though less dramatic. Costs increased by 4.0% compared with an average increase since 2007 of 5.3%. Last year's increase was 1.1%

We have made these calculations as carefully as possible – in all comparisons, we have reweighted the product mix of the Independent / Provider – Sponsored Plans to eliminate the effect of product mix differences between the two years. Also, every comparison uses only health plans that participated in both comparison years. In short, we think that cost trends reflect, in part, the incentives that health plans now face for cost optimization.

<Slide 4>

The far right column of Figure 2 on Slide 4 shows 0.1% per member total administrative cost decrease and the 4.0% Account and Membership Administration increase mentioned above. The arced arrows are to draw your attention to the comparison with prior year's values.

These comparisons, in the second and fourth columns, show the difference in trends in greater detail. You can see that Account and Membership accelerated from 1.1% last year to 4.0% this year. On an as reported basis the trend reversed from a decline of 0.6% to an increase of 5.3%. Sales and Marketing, while also reversing from a 3.4%decline in 2014 to an increase of 2.5%, remained relatively moderate.

Both Medical and Provider Management and Corporate Services clusters of expenses declined sharply, by 6.1% and 8.0% respectively on a constant mix and as reported basis. These compared with the increases during 2014 that were even more pronounced on an as reported basis.

Note how the as-reported costs decreased more rapidly than the constant mix costs. This stems from the more rapid increase in low cost to administer products.

Put a different way, The effect of mix changes had the effect of causing cost growth to apparently be less. The effect of the customers embracing lower cost to administer products is a reduction of 1.4 percentage points. The average mix of Commercial insured dropped by 1.8 percentage points to 49.7%. Medicaid increased by 1.4 percentage points to 14.5%. Medicare Supplemental and Medicare Advantage each increased by 0.2 percentage points to 2.3% and 9.9%, respectively.

Just a word about the growth in this universe. The median rate of membership growth was 3.9%. Commercial Insured declined by 6.1% and ASO increased by 3.6%. Medicare Advantage and SNP increased by 8.7% and 6.9% respectively, as Medicare cost increased by 6.8%. While CHIP declined by 1.7%, Medicaid HMO increased by 20.5%. These numbers, differ slightly from the values published in *Navigator* but the general conclusions remain valid.

A median of 73.1% of the continuous universe was enrolled in Managed Care as compared with 63.6% of last year's universe. They appeared, through the application of the Herfindahl-Hirschman Index, to be slightly more focused in their product offerings. Including the *entire* universe, individual membership increased from 11.6% of commercial insured, on average to 14.1% of commercial insured.

<Slide 5>

The administrative expense cluster growth was driven by the speed of their increase and the size of the function making that increase. We've captured these factors in the "Greatest Change" meaning speed, column and in the "Highest Weight", meaning the dollar value of the increase. (As the product of speed and weight, perhaps we should call this momentum?) Size, of course, is measured in dollars of costs. This slide pertains to as reported results.

The largest single factor in the Sales and Marketing cluster of expenses was the surge in Rating and Underwriting. This function matches premium rates with population health characteristics. Accordingly, the growth of HCC (or Risk Adjustment Expenses) in Medicare, Medicaid and, in all likelihood, individual products has been the fastest growing and the greatest single change in this cluster. It was also the fastest growing of all functions of entailed in operating a IPS plan.

However, every other function in Sales and Marketing declined or was effectively flat. Marketing decreased at near double-digit rates, while Sales and Broker Commissions declined. Advertising was flat. Overall, Sales and Marketing increased by 1.9% PMPM.

The growth in Account and Membership administration was the fastest among the clusters at 5.3% PMPM. Information Systems growth was at near double-digit rates and, as is sometimes the concurrent case, Claim and Encounter Capture and Adjudication was down. So Information Systems was both the fastest growing and, because it is also the largest function in the cluster, the most important source of cost growth. Reflecting the continued turmoil among consumers, Customer Services costs grew at mid-single digit rates. Enrollment cost growth was nearly as rapid as Customer Services, and may in part be due to the changing mix of the business.

The Medical and Provider Management cluster declined very sharply, by 7.2%. Provider Network Management and Services increased at mid-single digit rates. But Medical Management declined more rapidly and, since it is much larger than Provider Network Management and Services, its impact on trend was greater, leading to an overall decline in growth. Medical Management both changed fastest and had the greatest impact overall trend.

The Corporate Services cluster showed the most significant decline in growth at 9.5% per member. Both Finance and Accounting and Association Dues and License / Filing Fees posted low double-digit declines. Actuarial and Corporate Services also declined at mid-single digit rates. However, the Corporate Executive and Governance area increased at low single digit rates, the only function to have grown. Its staffing ratios did not increase.

<Slide 6>

Slide 6 shows the rates of change and the most important reasons for the changes for the group, after eliminating the effect of product mix differences. Again, this reflects a reweight of the prior year so that the product mix is the same in both years. Overall, of course, the cost decreases are less since the effect of the move to less expensive to administer products has been eliminated.

Slide 6 shows many of the same trends as are evident in Slide 5. However, I would like to highlight a few differences.

Note that, in the Sales and Marketing cluster, broker Commissions are now the most important source of increase. Put a different way, the lack of an increase in broker Commissions on an as reported basis was largely due to the shift away from products that brokers sell, such as Medicaid and ASO products. At 2.5% per member, cost growth in this function is faster than the 1.9% as reported values.

Interesting, for Medical and Provider Management, the same patterns were evident on the constant mix as the as reported analysis. Provider Network Management and Services grew more slowly and Medical Management declined more slowly but Medical Management trends were dominant.

Information Systems is an even more important factor in Account and Membership administration growth, and grows faster. The decline in Claims was even more rapid without the effect of product mix differences. Likewise the growth in Customer Services is faster as well. The growth in Enrollment was more modest.

The decline in the Corporate Services cluster masks some differences between the constant mix and the as reported trends. On a constant mix basis Corporate Executive declines rather than grows. Accordingly, every function in this cluster declined. Actuarial declines far more sharply. Finance and Accounting, the Corporate Services function and Association Dues and License / Filing Fees were about the same in their rate of cost decline.

The effect of the changes in mental health costs, pharmaceutical costs and ICD-10 accelerated the decline in expenses on a constant mix and an as reported basis.

The constant mix increase in Information Systems exceeded the change for expenses as a whole, and the increase in Information Systems dominated the increase on an as-

reported basis. It is almost as though the plans are taking a portfolio approach to their expenses – reducing Medical Management and most of the Sales and Marketing activities and Actuarial and investing in Customer Services, Provider Network, Rating and Underwriting and Information Systems.

<Slide 7>

Up until now, I have focused solely on the administrative expenses that managers can control. For instance, I have excluded from the discussion capital costs such as interest and dividends because they are the result of financing decisions made at the board level.

For the same reason, we have excluded Miscellaneous Business Taxes. These taxes, which are primarily associated with the Affordable Care Act, layer in additional costs. With the exception of corporate restructuring to consolidate government business in one non-profit, these taxes are unaffected by management, especially operational management. From an operating perspective, perhaps the central attribute of such taxes is to magnify the need to manage administrative costs.

On a constant-mix basis, per member Miscellaneous Business Tax costs increased by 14.6%, down from the surge of 922.3% last year. These taxes grew at approximately 4-5% annually prior to the ACA implementation.

These taxes, largely the result of ACA, comprise approximately 15% of total administration. Such costs are essentially nil for ASO products and range from $11.00 to $12.00 for commercial insured products. The median PMPM cost of this in 2015 is $6.62, compared with $0.61 in 2013.

<Slide 8>

A very rough gauge of trend is difference in the raw numbers between last year's values and this year's. The median PMPM value of $41.04, 2.6% less than the median value of $42.14 last year. The "real" decline was 0.1% however and the change in the product mix caused the reported growth to be muted by 1.4 percentage points. We don't know what the plans that didn't participate actually did but it seems to me that costs in this year's universe operated at 1.2% lower costs than last year's universe.

The prior year values are shown in Appendix A. Because of mix and universe differences, and because of the nature of medians, there is little relationship between the differences between the actual rates of change on Slide 4 and the differences between this and last year's total results. The cluster that really corresponds well is Account and Membership Administration. It grew fastest holding the universe constant and its per member costs were 11% higher than last year, to $17.80 PMPM. Also, Corporate Services which had lower values and also reported declines. It had a PMPM cost of $6.58.

While Medical and Provider was 9.4% higher than last year's values, to $7.09, it actually posted declines among continuously participating plans. Similarly, Sales and Marketing posted costs that were 5.8% lower than last year's universe's values, to $10.83, the continuing plans actually reported modest growth.

<Slide 9>

I have been emphasizing the effect of product mix changes on trend and this slide shows what I mean. Note that the ASO/ASC products have costs that are about half of that of the insured commercial products. The overwhelming reason for the differences stem from Sales and Marketing cost differences.

Median ASO PMPM costs are $24.14. The HMO product was the high cost commercial insured product at $47.64 PMPM. The median PMPM cost for this cornerstone product was $44.93 last year. It comprised 25.3% of comprehensive membership compared with 27.2% last year. The Commercial Insured POS product was $43.20 and the median PMPM cost of Indemnity and PPO Insured was $47.05.

Besides the increased ASO product focus, this universe increased its commitment to Medicaid. The median administrative cost of this product offered by this universe was $29.59 PMPM.

The highest cost of IPS comprehensive products is Medicare SNP which costs $132.88 PMPM to administer. This is followed by Medicare Advantage at $81.21. Medicare Advantage increased as noted earlier.

Medicare Cost was, by contrast, relatively low cost to administer at $36.71 PMPM. Medicare Supplemental was $42.55 PMPM.

<Slide 10>

The median administrative expense relative to premiums was 8.9% while the equivalent value for last year was 9.2%. (By the way, we are using premium equivalents here.) There were a number of factors that contributed to this decline.

Many of the products posted declines in their ratios. Notably, Indemnity and PPO insured declined from 13.2% last year to 10.8% this year and ASO declined from 6.2% last year to 5.8% this year.

Also Medicaid both decreased its ratios, from 8.6% to 7.5%, and increased its proportion of the total mix among all surveyed plans by 0.3 percentage points. This shows this year's percents. Please look at last Late July's *Navigator* for last year's ratios. Of course, the universe was different as well.

In many respects, the relationships between the costs of various products measured in percents parallel those measured in PMPM values. The ASO product is low at 5.8% while the insured products are higher and range from 9.2% to 10.8% for POS and Indemnity and PPO, respectively.

There are some paradoxes. Medicare Advantage has a lower ratio than the equivalent insured commercial products, and Medicare SNP is equal to the highest cost commercial insured product. The high health care requirements of seniors entail higher administrative costs.

Medicaid HMO is relatively low cost at 7.5% of premiums, corresponding with the low PMPM values. Note that the high cost of Medicare Supplemental at 17.6% is also among the lowest values measured on a PMPM basis. Medicare Cost is also high at 14.1% but low cost PMPM. I suspect that this has to do with some of the benefits being received by seniors are not the responsibility of the plans to manage, but it remains their responsibility to conduct certain administrative activities associated with those benefits.

<Slide 11>

This slide shows the administrative expenses by cluster of functions. As in the previous page overall costs were at 8.9% of premium equivalents, lower than the 9.2% last year.

The median values for the clusters of Sales and Marketing and Corporate Services declined. Mix differences likely explained the former while the decline in the actual amounts actually spent on Corporate Services explained the latter. The 0.1 percentage point increase in Account and Membership Administration corresponds with the increase in those costs shown in Figure 2, but the sharp decrease in Medical and Provider Management costs was not reflected in the decline in percent values. As noted earlier, these differences won't track with the values shown in Slide 4 because the universe and mix has changed. The 2014 values shown in Appendix B.

<Slide 12>

The overall costs declined in 2015. This is true whether you look at the actual reported values, the differences using the same universe in both years or if you look at the same universe and eliminate the effect of changes in business mix between the two years.

The 2015 decline was especially notable because, once you eliminate differences between the years, the decline was the second one in a row.

Once you eliminate the effects of product mix and universe changes, the decline was less pronounced than last year, 0.1%.

The drivers for the declines were a number of activities in the Corporate Services cluster, and declines in Medical and Provider Management, especially declines in Medical Management expenses. Notably, there was an increase in Account and Membership Administration, especially Information Systems. It is as though, through the constraint of low overall cost trends, plans funded the cost commitments of Information Systems with declines in Medical Management.

I had mentioned that the MLR rules and competition has led to a focus on administrative expense optimization. Miscellaneous Business Taxes, which are overwhelmingly associated with the Affordable Care Act, are an additional impetus since they now comprise 15% of total administrative costs.

Many thanks for your attention to this dry, but I hope informative, presentation on a matter of critical importance to your organization. Again, this presentation, (transcript and slides) will be posted 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. Additional information, including tables of contents on the benchmarks themselves are found on the website. Call me if we can elaborate.

In a few weeks, we will summarize the results from the Medicare and Medicaid plan universe. In that vein, I want to share with you our progress. In about two weeks, we'll receive the results. For the next month following, we'll validate the data, and then publish in very early September. We'll have a web conference at that time on each of these universes.

For those of you who subscribe to the IPS or Blue benchmarks and are looking forward to the operational metrics (e.g., productivity and quality metrics for the functions), we expect to circulate a final draft to the participants this week so it should be available shortly.

Now I would like to open this for questions.

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Questions and Answers

Q. Do you publish staffing ratios?

A. Yes. For commercial insured products, the staffing ratio declined from 28 to 27 per ten thousand members. For Blues, they declined from 24 to 22. Actually, we publish the staffing ratios for all functions. The staffing ratio includes imputed staff through outsourced relationships to preserve an apples to apples comparison. The differences between the two universes stem from staffing appears to stem from differences in corporate culture in which Blue Plans emphasize Information Systems.

Q. What's driving the decrease in medical management?

A. There is a cultural difference between Blue and IPS plans. I mentioned that Blue emphasize Information Systems. But IPS plans emphasize Medical Management. Current trends suggest a convergence. In addition, the effect of the MLR ratio rules is to reduce the ROI on medical management.

Q. How were expenses related to risk accuracy accounted for in this analysis? Were only expenses classified as administration included or were some expenses classified as medical expense included as well?

A. Risk Adjustment expenses were classified as Rating and Underwriting, irrespective of how they were reflected in the internal financials of the participants.

Having said that, we have been concerned that, since the same chart review used to assess risk *could* also be used to develop treatment plans for patients that require it (and this activity is categorized as Medical Management in the Sherlock Benchmarks) there could be the potential inconsistencies in how they are reported. However, at this point, we don't actually see chart reviews for Risk Adjustment actually being used for treatment plans. So we have actually not faced this reporting problem yet.

Q. What is the average membership size of the plans used to determine PMPM numbers?

A. Our 21 plans serve 10.8 million members. So, on average, they serve 516,000 members. The median members served is 349,000.

Note that this apparently means that we have a high share of these organizations.

Q. Any insight on what is driving the increase in IT spending?

A. Applications Acquisition and Development, followed by Applications Maintenance. There is a subfunction of Applications Maintenance called Benefit Configuration which, while small, grew very rapidly in 2015. We don't have any qualitative insights for you.

Q. Do you look at staffing ratios by provider? In other words, do you capture such ratios as Providers per Provider Contracting FTE?

We do and while we often see strong productivity relationships, we remain attentive to the potential for technical problems in counting. For instance, a solo practitioner who also works part time at a group practice could conceivably create some problems if it is not well understood that they are two separate providers. Since we do define providers

as possessing a National Provider Identification and it actually does take work to contract with providers irrespective of size, we have a degree in confidence in the ratios.

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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.

We hosted a similar web conference on the results of the Blue Cross Blue Shield plans two weeks ago. 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.

Let me thank you all for the hard work that goes into the 15th annual edition of the Independent / Provider - Sponsored benchmarks. We know, because we measure this, that participation pays off in lower costs. But the "by-product" is something that benefits the industry as a whole. Thank you!

This is Douglas Sherlock of Sherlock Company.