Transcript

Medicare Administrative Costs: A Review of 2014 Results

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<Title Page>

I am Doug Sherlock. Welcome to our summary of the benchmarking study for Medicare plans. This is the fourth and last in a series of presentations summarizing 2014 performance metrics for various peer groups of health plans. We've posted all of the others on the web site, along with presentations, so I hope you won't hesitate to access them if the Blue, Independent/Provider-Sponsored or Medicaid information would be helpful.

<Slide 2, Figure 1>

This chart shows the rates of Per Member administrative cost changes. The dark blue is total expenses and the light blue is Account and Membership Administration. Total expenses PMPM decreased for Medicare plans participating in our study and declined by 4.0%. They decreased by 6.7% holding constant the product mix of the continuously participating plans, which we show in the chart. Rates of growth were *negative* 2.4% and *negative* 5.3% for Account and Membership Administration. Again, the latter is shown in the chart and excludes the effect of mix changes. The trends were lower overall but higher for Account and Membership Administration.

The rates of growth for total expenses and for Account and Membership Administration were lower than in any of the previous five years. In addition, over the past six years, this was the only year that had a decline in Account and Membership Administration. (By the way, the figure numbers on this and other slides reference our free newsletter, *Plan Management Navigator*, which is available on our web site.)

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More immediately, rates of change for total administrative costs declined to 6.7% from growth of 3.8% in the prior year. Account and Membership Administration followed a similar trend. Rates of change fell to negative 5.3% compared to an increase of 8.1% in the prior year.

For the first time, plans were subject to certain ACA related taxes. So, if these taxes are included, administrative costs increased by 2.8% PMPM versus a decline of 6.7% before these taxes.

<Slide 3>

Ten plans participated in this study and, while the combined Sherlock Benchmark plans serve approximately 15% of all eligible Medicare Advantage members, we recognize that they are "selected." That is, they may operate at cost levels and trends that reflect that they measure their activities. For instance, on the grounds that "you manage what you measure," these selected plans may disproportionally include those with an interest in optimizing their costs.

While Medicare is typically the predominant product, it is not the only product offered by our participants. On average, Medicare Advantage comprises 41.4% of plans' revenues.

Incidentally, I want to thank the participants in this year's benchmarking study, some of whom are on today's web conference. A by-product of their participation is this summary. It benefits Medicare plans as a whole, and we are grateful for this.

The plans use the benchmarks to learn whether they are world class organizations, to identify those organizations that are best-in-class and to prioritize targets for improvement. These last two are linked because the shortest way to emulate best practice is to achieve improvements in areas that represent the largest differences between you and the best in class. Our benchmarks are also used in many strategic initiatives from budgeting, to evaluation of outsourcing, to evaluating business combinations.

Let me add a word about Sherlock Company. As you may know, we have been performing health plan benchmarking studies for many years. Sherlock Company is

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now completing its 18th consecutive annual survey of health plan operations and today's benchmarks are based on the cumulative experience of nearly 700 health plan years. In all of our various universes this year, the 40 health plans serve approximately 41.5 million members. The Sherlock benchmarks' focus is on administrative expenses and related operational drivers, but they also include metrics of health care utilization.

Sherlock benchmarks are well-accepted, and are, in the words of two consulting firms, "the gold standard" for such metrics. Thus, health plans serving 140 million insured people use our 2014 benchmarks. Users include the overwhelming proportion of Blue Cross Blue Shield plans, the leading provider-sponsored plans and publicly-traded companies. The results are actionable since the indicators are unambiguous, and linked to actual performance.

The Sherlock Benchmarks benefit from our business model. Credibility is facilitated through voluntary participation. Respondents have a stake in the data quality and feel it meets the insight-to-effort test.

Slide 3 shows the topics that this presentation will cover. We'll first touch upon the increase in popularity of Medicare Advantage then we'll cover the decline in administrative expenses among Sherlock Benchmark participants as well as the spike in taxes from ACA regulations. Next we'll examine the rates of decline on an as-reported and constant mix basis and drivers of decline. Lastly, we'll talk about costs by cluster and costs by product on a PMPM and percent of premium basis.

<Slide 4>

Medicare Advantage replaces regular Medicare for an increasing proportion of beneficiaries. As of March 2015, about 32% of the 54 million eligible Medicare Beneficiaries, or 17 million, were served under Medicare Advantage. This has steadily increased from March 2005 when 13% of Medicare beneficiaries were served by these plans is up from March 2014 by 1.6 percentage points. As we mentioned in *Navigator*, The CBO projects the number of Medicare Advantage members to increase to 27 million in 2022, or about 40% of all eligible Medicare Beneficiaries.

Medicare Advantage is attractive to beneficiaries because of its superior value proposition. Supplemental benefits are, in MedPAC's view, subsidized by the Medicare

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program. But the MA plans also offer Part A and B benefits at lower cost (again according to MedPAC) allowing them to offer an even better value proposition.

<Slide 5>

As mentioned concerning Slide 2, total administrative expenses decreased by 6.7% in 2014 and compares to the 3.8% increase in 2013. Account and Membership Administration expenses were also lower by 5.3% in 2014 versus an increase of 8.1% in 2013. These comparisons are also reflected on Figure 3 in the columns to the right, which hold constant both the universe and product mix. In my view, eliminating the effects of product mix changes provides a more accurate picture of trend. The curved arrow shows those two columns.

Sales and Marketing expenses fell by 2.4% compared to the 5.9% decline last year. Three of the five functions in this cluster experienced declines. Rating and Underwriting, Advertising and Promotion and broker Commissions all decreased, in declining order of percent decline. By contrast, the Sales function sharply increased and Marketing increased slightly.

For continuously participating plans, Comprehensive Total membership increased by an *average* of 6%. Total Medicaid members surged by 66% on average, while the number of Medicare members grew by 7% on average. Commercial Total grew by less than 1%. Self-funded ASO grew by 18%, while Commercial Insured was flat.

In terms of product mix, Medicaid gained an average of 3 percentage points and Medicare increased by less than 1 percentage point. Commercial Total's share of product mix eroded by over 3 percentage points with Commercial Insured down 3 percentage points and Commercial ASO lower by less than 1 percentage point.

Provider and Medical Management fell from a slight increase of 0.2% in the prior year to a drop of 0.8%. This cluster is comprised of two functional areas, Medical Management / Quality Assurance / Wellness, and Provider Network Management and Services. The Provider Network Management and Services function declined sharply, which was especially remarkable considering that it builds on a notable decline in 2013. Medical Management/Quality Assurance/Wellness increased at its slowest rate since 2010.

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Just to be clear, we *don't* believe that trend was affected by the new MLR rules. Irrespective of whether a medical management activity is included with quality improving activities, we reflect its costs as administrative for the purposes of this analysis.

As previously mentioned, Account and Membership Administration expenses declined this year and was chiefly responsible for the overall drop in PMPM administrative expenses. Information Systems was the sole driver in this cluster's lower costs and was the first drop in at least the last five years. Enrollment, Claims, and Customer Services declined for plans focused on Medicare. Both Total and Account and Membership Administration *includes* Pharmacy, Mental Health, and ICD-10 IS expenses.

Corporate Services expenses fell by 4.7% in 2014 versus the 2.7% increase last year. This was the slowest growth in this cluster since 2010. The Actuarial, Corporate Services *function*, and Finance and Accounting functions led this cluster's expenses to fall. Conversely, Corporate Executive and Governance and Association Dues and License / Filing Fees *increased* at low single digit rates.

<Slide 6>

The previous slide showed both as-reported trends, as well as the constant-mix trends. You may have noticed that the declines were less pronounced in the as-reported column. That is because of the increasing importance of Medicare biased costs higher: Medicare is a high cost product.

This slide shows the 4.0% as-reported decline in per member administrative costs compared with last year. Please note that it excludes any changes that are attributable to changes in the universe, thus only includes the same nine plans that participated in both years.

The most important reason for the decline was the 9.7% drop in the Sales and Marketing cluster of expenses. As it is among the largest of the clusters this change has a disproportionate effect on the overall trend. This is the second year in a row that this has been the case, and this trend contrasts with the relatively robust growth in membership.

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Rating and Underwriting expenses dropped by double digits, while External Broker Commissions declined by single digits. Conversely, Marketing, Sales, and Advertising and Promotion grew by single digit rates.

The Provider and Medical Management cluster trends were higher by 1.6% in PMPM costs. Last year's trend was a decrease by 1.1%. Provider Network Management and Services dropped by high single-digits, while Medical Management posted an increase in the low single digits. PMPM dollar cost in Medical Management are 2-3 times greater than Provider Network Management and Services.

The Account and Membership Administration cluster is the largest and contains the central activities of health plan operations. Functions include Enrollment/Membership Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information Systems. Enrollment and Claims each increased by double-digit rates, while Customer Services also grew, but the drop in Information Systems overwhelmed the trend in the cluster. This cluster's PMPM costs fell by 2.4%.

The Corporate Services cluster is the smallest and its cost trended lower by 4.0%. The Actuarial expenses experienced a sharp double-digit decline, while Finance and Accounting decreased at low single-digits. The Corporate Services *function* is the largest in the cluster and includes sub-functions such as HR, Legal, Facilities, Mailroom and so forth. It increased at low single-digits, along with Corporate Executive and Governance and Association Dues and License / Filing Fees.

<Slide 7>

This slide shows that rates of change in costs after eliminating the effect of product mix changes. As with the previous two slides, this one holds the universe of plans constant. Accordingly, we think of these as the "real" changes in costs.

Total expenses fell by 6.7%, which is a greater decrease compared to the as-reported decline of 4.0%. The administrative cost PMPM trends are less after the effect of mix is eliminated because of Medicare *accelerates* overall as-reported trends. Since Medicare has higher per member cost than other products, the faster growth of Medicare amplifies the rate of cost increases. So, when we exclude the effect of the increasing presence of high cost Medicare, the rate of cost growth diminishes.

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The contributions and trends in this slide and the previous slide are similar. However, I've identified differences with gray arrows. First the increase in Sales had the greatest impact on the Sales and Marketing cluster and total costs, while Actuarial replaced the Corporate Services function as the greatest contributor to the trend in the Corporate Services Cluster.

The Sales and Marketing cluster posted a slower decline compared to the as-reported results and from last year. As with the as-reported results, three out of the five functions experienced declines. Rating and Underwriting experienced a double-digit drop, while Commissions and Advertising and Promotion decreased in the single-digits. Sales posted a double-digit increase and had the greatest impact on this cluster's performance. Marketing also increased, in the singled-digits.

Provider and Medical Management was lower than last year after eliminating the effect of mix. While the as-reported trends for this cluster was up, removing the inflating effect of the increase in Medicare illuminates that there was really a decrease in the cost of this cluster. On a constant mix basis, Provider Network costs experienced a larger percent change, sharp enough to overwhelm the increase in Medical Management. The larger PMPM dollar cost of Medical Management mutes the decline in Provider Network.

Account and Membership Administration expenses declined on a constant-mix basis. Declines in IS were key, while the other functions posted increases. Enrollment, Customer Services, and Claims experienced growth. This is the first decline in this cluster in the past five years.

Constant-mix Corporate Services cluster expenses trended lower. The Actuarial function was the main driver in lower expenses and fell by double-digits, while Finance and Accounting and Corporate Services *Function* were down by low single-digits. Corporate Executive and Governance and Association Dues and License / Filing Fees trended slightly higher by low single-digits.

<Slide 8>

Here are the PMPM administrative cost levels for 2014, segmented by clusters of functions. (Again, the figure numbers on the slide reference our free newsletter, *Plan Management Navigator*, which is available on our web site.) The median total

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administrative expenses for comprehensive products were $42.04 PMPM. We highlight the "median" column with an arrow. This is 13.1% lower than last year's reported PMPM costs of $48.35.

The cost differences between this year's and last year's universes stem from three factors: differences between the mix of products that are offered by the two panels, the actual changes in cost trends for the plans and the changes in the underlying costs of the participants between the two years. Most of this year's plans also participated last year. Slide 8 provides insight to both their trends and the effect of their product mix. Since overall expenses grew faster on an as reported basis than they did when one holds the mix constant, the mix in the 2015 survey must have been more expensive than that of the prior year. In other words, the continuously participating plans were more committed to Medicare.

To analyze the results, we have summarized into clusters the more than 50 functions that the plans report. Appendix C tells what functions go into each cluster reported here.

Account and Membership Administration is the dominant source of costs for health plans at $15.60 PMPM. This is a universe of companies in which Provider and Medical Management is very important, at $7.48 PMPM. The Corporate Services cluster, at $7.33 PMPM, is among the smallest clusters of total expenses and also one with the greatest degree of scalability. Sales and Marketing expenses total $11.63 PMPM.

We have been expressing costs as median, either PMPM or as a percent of revenues. Medians minimize the effect of outliers in the way that averages do not. But, because medians are the 50th percentile value, the clusters won't necessarily sum to the median for total expenses. That is even more the case for the 25th and 75th percentiles.

While I'm discussing calculations, let me add that when we make comparisons we try to make them as close to apples-to-apples as possible. So, where this slide pertains to all ten Medicare plans that participated in the current benchmarking study, the slides showing cost *changes* reflected only those plans that participated in both the comparison years. Thus the rates of change for 2014 are for those that participated in both 2014 and 2013 surveys. Rates of change are rates of change in *per member* costs.

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We can't provide much detail during this presentation, but many of you are interested in staffing. After all, staffing costs comprise on average 46% of Medicare plan administrative expenses, though much higher in Customer Services, Provider Network Management and Services and Claims, and far lower in Information Systems. Staffing ratios run at approximately 30 FTEs per 10,000 members, including the effect of outsourced FTEs. We also estimate values for pure Medicare Advantage based on the reasonable assumption that the same mix of resources (labor and non-labor) are used to support all types of members. Staffing ratios for these members are 58 FTEs per 10,000 members, including the effect of outsourced FTEs.

About 16% of such staff in Medicare plans is outsourced, while on average, 23% Information Systems staff is outsourced.

Excluding Pharmacy and Mental Health, median compensation per FTE averages just over $88,000, though certain functions like Corporate Executive and Governance, Actuarial and Marketing are in six figures.

<Slide 9>

This slide shows the administrative expenses of each *product* offered by the Medicare universe of plans. The health care needs of plan members vary quite a bit by product, and the associated administrative expenses do as well.

The administrative costs of Medicare was $83.62 PMPM, while the dominant Medicare Advantage product was $82.42. Medicare SNP (which we believe to be mainly comprised of dual eligibles) cost $127.34 PMPM to administer. Medicare Advantage administrative costs are higher than comparable products for younger people, chiefly because of the high health care needs of seniors. Health care costs normally require supporting claims processing and customer service activities, which are reflected in the administrative expense levels. Similarly, Medicaid members were the lowest cost insured plans, at $27.10 PMPM.

Total costs for *insured* commercial products were higher than those for Medicaid, in part reflecting the marketing costs that such commercial members require. ASO products cost less than either Medicaid HMO or insured commercial, reflecting that ASO products have lower Medical Management costs as well as lower Sales and Marketing costs.

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This slide by the way illustrates why we go to such strenuous efforts to mix adjust; product costs matter.

<Slide 10>

While we prefer the PMPM metric for costs, there are some advantages to a percent of premium standard. It may provide a rough adjustment for cost of living or for the intensity of care required by the specific population served by any given product. Indeed, as an example of their acceptance, the rebate provisions of the ACA are triggered by the MLR, a percent approach to health plan expenses.

In any event, comparability is improved if one is careful to keep denominators consistent. I mention this as a calculation note since we use premium equivalents as the denominator for ASO relationships for consistency with insured products.

Using percent of premiums, the cost metric ranking can be much different than the PMPM ranking. Medicare Advantage products, ranked highest PMPM, ranked below average when calculated as a percent of premium. While Sales and Marketing costs distort this a bit, the underlying reason for the lower costs of Medicare Advantage measured as a percent of premium is that these populations incur higher medical costs for their associated administrative support. Health care costs *per claim submitted* tend to be 20% higher for Medicare than for equivalent commercial members. Similarly, the health care need that prompts a customer service inquiry will tend to have a higher dollar value. Medicare Advantage costs were 9.2% of premiums while Medicare SNP was 7.7%.

Recall that Medicaid products were relatively low cost on a PMPM basis. Expressed as a percent of revenues, Medicaid HMO, at 8.6%, is lower than average for the products served by this universe. Again, advertising is limited for this product. CHIP is relatively high cost at 14.2% for much the same reason that Medicare tends to be low. The lowest cost product, measured as a percent, is ASO at 5.7%.

<Slide 11>

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This slide shows administrative expenses as a percent of premium equivalents were 8.9%. It excluded taxes imposed by state governments and the ACA taxes as well as capital costs.

The percent of premium equivalent of 8.9% is 130 basis points lower than last year's value of 10.3%, as shown in Appendix B. A precisely comparable comparison is impossible since medians don't sum and the universes differ. Both Sales and Marketing and Medical and Provider Management were lower relative to last year's ratios.

<Slide 12>

As you know, health plans participating in our benchmarking studies segment their costs by product. So it is possible for us to compare the same products across universes. When I compare Medicare products offered by this universe to that of Blue Cross Blue Shield Plans, you can see similar PMPMs, with only a $2.36 PMPM difference in median values and 0.3 percentage points difference, measured in percent of premiums. The IPS plans were much higher both in PMPM and in percent of premium. This likely has to do with the very small share that in the IPS's product portfolio. Start-up business lines are normally expensive.

A close analysis of the Blue Cross Blue Shield universe indicates that the chief difference is that the Medicare-focused plans have much higher Corporate Services expenses. These expenses are more likely to be scalable and the Medicare-focused plans are smaller. This Blue advantage is partially offset by higher Sales and Marketing Costs. Medical and Provider Management also tends to be higher among the IPS Plans. Interestingly, the Account and Membership Administration area is typically lower for the Medicare-focused plans.

The 25th Percentile plans in the Medicare universe were lower than the 25th percentile values in the other universes. This is true when expressed PMPM or as a percent of premiums. This suggests the possibility of specialization being a virtue.

<Slide 13>

This is the end of my formal presentation.

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On a constant mix basis, administrative costs for continuously participating plans declined. Rating and Underwriting, Provider Network Management, Information Systems, and Actuarial were central to the cost declines.

There was a sharp increase in Miscellaneous Business Taxes. These are of course not under the control of management but the effect of their increase was significant.

Provider and Medical Management was slightly lower as Provider Network fell, but Medical Management was higher. Account and Membership Administration costs declined solely on a drop in IS expenses, while Enrollment, Customer Services, and Claims increased. The Corporate Services cluster also fell mainly on lower Actuarial expenses with Finance and Accounting and Corporate Services Function contributing.

I have attached to the end of this presentation some appendices. They include last year's costs and a list of the functions included in each cluster of expenses.

I want to close with the common sense observation that low costs are not the same as optimal costs. But the benchmark of low costs shifts the burden of proof to functional areas with high costs to demonstrate an ROI on those higher costs.

Now I would like to open this for questions about the results of the Medicare benchmarking study.

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If there are no further questions, I want to again thank you for your participation in this web conference. More in depth and actionable information is available in the benchmarking study itself, which anyone can license. Please contact me directly if you are considering licensing these materials.

I want to close by thanking once again all of you who participated in this study for your efforts. They not only enhance your own firm's performance but also raise the bar for all other plans.

Thank you.

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