Transcript

Independent/Provider-Sponsored Health Plan Administrative Costs: A Review of 2013 Results

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Welcome to our annual summary of the results of the Independent/Provider-Sponsored health plan benchmarking study. This is the second of a series of presentations on trends in health plan performance metrics reflecting 2013 results.

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As we'll develop, the expenses surged, and the specific sources of increase are consistent with two likely reasons. First, health plans incurred costs relating to implementation of the Affordable Care Act. For instance, since health plan customers had products that differed from what they had been accustomed to so health plans had costs that temporarily "bulged" to communicate through Customer Services and Advertising and Promotion.

Second, they incurred costs that were, in effect, investments in the newly reformed health care system. The included increases in Product Development (which we group with Marketing), Information Systems, Finance and Accounting and Actuarial. We consider these to be "adaptation" expenses.

However, as I mentioned last year at this time, the secular trend for health plans is for cost optimization. Among pressures, the express intent of the MLR rules is to "create incentives for" health plans "to become more efficient" in the execution of their administrative activities. Plus, self-insurance, also incentivized under ACA, indirectly

creates similar incentives in that segment of the insurance market by heightening the visibility of administrative expenses.

So, because of the (hopefully) unique cost requirements in 2013 and the continuing pressures to reduce costs, we think we may look back on 2013 as an inflection year. In other words, 2013 will be the baseline year for which costs for health plans will be compared in future years.

This presentation concerns Independent/Provider-Sponsored health plan administrative cost trends. Many thanks to the 16 Plans that participated in this year's benchmarking study: This web conference is a happy side-effect of your efforts benefiting the industry as a whole.

A few weeks ago we summarized the Blue Cross Blue Shield plan universe results, and the analysis and presentation material is found on our web site. We'll host similar web conferences for Medicare and Medicaid plans later this summer. All of these presentations will be posted on our web site.

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The Total PMPM cost increase in 2013, shown as the dark blue bar, was the second highest we've recorded in the past five years. At 6.5%, it is lower than last year's growth of 8.6%, but more than double the rate of all other years.

The surge in Account and Membership Administration expenses is even more pronounced. These costs increased by 10.6% compared with 6.8% in the prior year. The growth rate is more than double that of the third highest annual rate of 5% in 2010. As you can see, this cost acceleration is without recent precedent.

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This slide shows the changes for this year and the prior year. As an aside, the rate of growth shown in the previous side corresponds to the fourth and second columns of this table, and like this table, by reweighting, eliminates the effect of any changes in product mix between the comparison periods. Of course, all comparisons in these slides hold the universe itself constant. The cost increases reported by the continuing plans are

in columns one and three, and are "as reported" since the calculations don't adjust for product mix.

The takeaway from this slide is how focused the cost acceleration was. Only two of the eight of the expense cluster values under the 2013 data columns are greater than the corresponding values under the 2012 data columns. I've circled them.

For the next couple of slides, I want to drill into the sources of the increases.

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For those of you who may not be familiar with our benchmarks, costs are segmented in a highly granular way to make them actionable. For Independent/Provider-Sponsored plans, administrative costs are segmented into 50-60 functional areas, summarized as shown in Appendix C into the four expense clusters. (We don't show all the sub-functions there.) That provides us the basis for commenting on trends in a highly granular way. I want to begin by tracing the components of the cost trends, based on the data as the plans reported them to us. To underscore, the trends are as-reported and not adjusted for the product mix changes that occurred.

Overall, they reported administrative expenses that increased by 6.8%, slightly lower than the 7.1% increase in 2012. The fastest increase of all of the functions was Rating and Underwriting, which increased at high double-digit rates. This may be an example of what we earlier called "adaptation" expenses since rating methodologies had to change because of the ACA. This is sort of an investment in the future.

Information Systems growth was the most important increase though. We say that it is more important because, of the total increase in PMPM costs, it was responsible for the single largest share of the difference in dollars. It grew at impressive low double-digit rates but less than three other functions. I earlier characterized this as "investment" though dollars committed to Information Systems are typically expensed.

Provider and Medical Management growth accelerated over the prior year, 7.0% versus 1.9% in the prior year. This was the only cluster to have done so, on an as reported basis. While Provider Network Management and Services grew at the slowest rate in five years, Medical Management accelerated over 2012, and was the second fastest growth over the past five years. Because of its much larger size Medical Management /

Quality Assurance / Wellness function dominated the trend in the cluster, and carries the greatest weight.

Account and Membership Administration, shown on the third row, was up by 7.5%, down slightly from 7.6% last year. All functional areas grew at approximately double-digit rates, except for Enrollment, which expenses declined for the second year in a row. Claims processing cost growth was the fastest. Information Systems costs, because of its size, was the most important increase in the cluster. Customer Services costs grew at a near double-digit rate. We would characterize the surge in Customer Services costs to be an example of "bulge" expenses since we think that this could stem in part from the need to communicate with consumers in this more tumultuous than usual market.

Sales and Marketing grew at a declining rare, 2.8% versus 5.5% last year. But the decline masked that the small Rating and Underwriting area exploded and Marketing costs increased at double-digit rates. In fact, Rating and Underwriting was the fastest growing function. Marketing growth comprised most of the total for this cluster. Sales, Commissions and Advertising and Promotion growth were all in low single digits.

The effects of adaptation are also evident in the Corporate Services cluster of functions. Both Finance and Accounting and Actuarial costs surged at double-digit rates and both increased faster than for any year over the past five. This may stem from the demands to reanalyze the environment in which health plans operate.

Offsetting this was the much larger Corporate Services function, which slightly shrank from 2012. This function is comprised of HR, Legal, Mailroom and so forth. Moreover, Corporate Executive and Governance also declined but at a double-digit rate. This area excludes functional leadership such as the CFO, Chief Medical Officer, Chief Marketing Officer. But it also includes all of the enterprise management consulting activities. It may be that these engagements expired and were replaced by implementation expenses that are reported to us in the functions themselves.

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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. The effect on total expenses was modest 6.5% versus 6.8% as reported, though the composition of the expense growth was quite different.

While membership in commercial products was effectively flat, ASO membership increased by 3.5% while insured was flat to down. The bellwether HMO product posted a decline in membership. As a result, the proportion of commercial membership in continuous plans declined by 4.7 percentage point to 69.8%.

Medicare continued to grow and Medicaid growth was especially strong. Medicare Advantage increased at an average rate of 9.0% and while only a few plans offered Medicare SNP, membership grew by 18.7%. Medicaid growth was the most significant factor in the changing mix of these organizations. Among continuously participating plans, mean membership in this product increased from 12.4% of the total in 2012 to 16.5% in 2013.

Because the resource requirements of each product differs, the expense trends in the clusters also change, once you back out the effects of mix. Perhaps most notably, on a constant mix basis Sales and Marketing costs increased by 4.4% versus 2.8% on an as-reported basis. The effect of Medicaid is evident here since often such products are restricted in their marketing. Thus, elimination of the compressing effect of a higher commitment to Medicaid leads to higher cost trends. This was especially evident in the Advertising and Promotion cost increase, which surged at double-digit rates and was responsible for nearly one-half of the dollar increase in costs of that cluster. Rating and Underwriting and Marketing expenses, in which Product Development is grouped, also increased at approximately double-digit rates. Sales and Commission growth was at low single digits.

The underlying growth in Account and Membership Administration was also more evident when mix change effects are excluded. Growth was 10.6%, as compared with 7.5% incorporating mix changes. It was also much higher than the 6.8% constant mix increase of the prior year. The central reason for this increase was the surge in Information Systems expenses which increased at a low-double digit rate. Because of the size of this function, the growth in its costs not only dwarfed that of every other cost

increase in its function but also exceeded the importance of every other cluster and the next most important three functions.

For many years, Independent/Provider-Sponsored plans had Information Systems costs that were lower than that for Blue Cross Blue Shield Plans. We used to say, somewhat facetiously that when a health system is faced with a choice between spending money on a new health plan information system, which might save it money, or a new MRI, which will make it money, it would always opt for the latter. The relative underinvestment has changed in recent years: the annual rate of Information Systems cost increase has averaged more than five percentage points higher for Independent/Provider-Sponsored health plans. IPS plans now typically spend more for Information Systems than their Blue counterparts.

Claims also grew at low double-digit rates and Customer Service growth was higher than average over the previous four years. Enrollment costs declined.

The effect of Medicaid growth also effected Provider and Medical Management. Growth on a constant mix basis was only 3.3% compared with 7.0%, as reported. Moreover, this 3.3% growth is also a decline from the 5.1% pace of last year. But, whereas the growth of Medicaid compressed reported Sales and Marketing growth, it amplified reported Provider and Medical Management growth. Median Medical Management expenses for Medicaid HMO members are approximately 25% higher than for Commercial Insured products. As we've written in other Plan Management Navigators, we can better quantify the ROI on medical management for Medicaid than for other products.

Eliminating the effect of mix, growth in Provider Network Management and Services and Medical Management were both lower than in the prior year. Medical Management growth was more than twice as fast and was responsible for more than 6 times the dollar increase of Provider Network Management and Services.

The effect of the mix change was least pronounced in the trend for Corporate Services. The as-reported change was a decline of 0.3% while the constant mix change was an increase of 0.6%. Both were sharp declines from the near double-digit increases last year. The most notable changes were surges in Finance and Accounting and declines in Corporate Executive and Governance. Their rates of change were approximately the same, high double-digits. But while Corporate Executive sharply declined, Finance and

Accounting increased by the same amount. Actuarial increased at near double digit rates. The very large Corporate Services function increased very modestly.

Let me touch on staffing since, as a people business, it can be the driver of cost changes in health plans. The dominant products for this universe remain commercial insured products. If I simply compare the inferable staffing ratios for commercial insured products for all reporting Plans, including the staff that the Plans believe to be outsourced, there is an indication of slightly *lower* levels of staffing to 26.2 FTEs per 10,000 members versus 27.5 last year. While Customer Services remained approximately the same, both Medical Management and Sales staffing were lower.

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The costs to administer comprehensive products for Independent/Provider-Sponsored Plans was $38.59, 0.4% higher than last year's reported costs of $38.42. Last year's values are shown in Appendix A. The numbers are not perfectly comparable; while both universes contain 16 plans, four of the Plans turned over, so that 75% of the plans were the same as last year.

Because of some comparability exists, some of the earlier comments are paralleled when the comparing the values over the two years. Most notably, Account and Membership costs were much higher, corresponding with the high rate of increase in constant mix changes. Corporate Services, which had effectively no increase in cost PMPM, was substantially the same as last year's values for that cluster. The clusters of Provider and Medical Management and Sales and Marketing both grew relatively modestly in 2013 on a constant mix basis, and their values for 2013 are lower than reported last year.

Unlike the Blue Cross Blue Shield plans, the Independent / Provider – Sponsored plan universe had slightly greater dispersion in cost values in 2013. So, while the Coefficient of Variation was 25.7% in 2012, it was 27.7% in 2013. Sales and Marketing and Account and Membership Administration expanded, though Provider and Medical Management contracted.

Similarly, the differences between the 75th percentile and the 25th percentile values also increased slightly. The difference in these percentiles for Total costs increased by $1.00. Sales and Marketing increased by $0.57 and Corporate Services increased by $0.67. By

contrast, the Account and Membership Administration difference in percentiles declined by $0.78 and those of Provider and Medical Management diminished by $1.20.

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This slide shows the costs for each of the products offered by the 16 participating plans. The Independent/Provider-Sponsored plans that participated in the Sherlock Benchmarking study offered products in 2013 maintained their historic directional cost relationships with one another. Insured products were more expensive to administer than ASO products, Medicaid cost less than commercial insured products and Medicare cost twice the per member costs of the closest commercial equivalent, Commercial HMO Insured. By far the most expensive product was Medicare SNP which was nearly double the cost of the Medicare Advantage product.

But if you compare this slide with the equivalent slides for last year (they are available on our website), you'll notice some differences. I've circled some products that cost less in this year's universe compared with that of last year's. Note that they are all insured products.

However, differences narrowed between ASO and Insured Commercial products. The average cost of insured products in 2013 was $20.03 higher than ASO, compared with $25.10 in 2012. The ratio of ASO to the costs of the average insured product was 56%, up from 41% last year. This compression was largely due to the median cost of the ASO product increasing by nearly 20% between the two measurement years.

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As you can see, this slide is similar to the previous, except that we've expressed administration relative to premiums or equivalents. Once again, I have circled the declining values. In some respects, the relative values are similar: ASO percent is considerably lower than their insured counterparts. And the differences are similar as well. The median PMPM costs of ASO is 56% of the central insured HMO product costs, and the similar ratio for percents of premium is 57%.

But the ratios do differ in the products for seniors. Medicare Supplemental, at $37.59 PMPM, is a lower-than-average cost product. But at 20.9% 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.

Medicare Advantage cost ratios are exactly reversed. On a PMPM basis, they are the among highest cost product, at $75.40 but lower than all of the commercial insured products when expressed as a percent of premium, 8.5%. The same is true for Medicare SNP which costs are $139.35 and also has 9.2% of revenues in administrative expenses. The health benefit per claim is considerably higher for MA and Medicare SNP members, giving rise to the low percent.

Note that the overall costs are 9.7%. This is higher than the 8.7% reported last year. Of the total difference, we estimate that 0.7 percentage points related to changes in business mix. Much of the shift was in favor of high administrative expense ratio products. There was a nearly 7 percentage point increase in the proportion that is Indemnity and PPO to 23.0%. Medicare Supplemental increased by 2.4 percentage points to 2.8%, and Child Buy-in, a product we did not capture last year, and comprised 0.4% of members.

All of these products had higher than average administrative expense ratios. The Indemnity and PPO administrative expense ratio was 13.8% Medicare Supplemental was 20.9%, Child Buy-in had administrative expenses of 16.2% of premiums.

Please do note that the rates of change reflect a constant universe but this table is a one-year snapshot. While 75% of the plans in this year's universe participated in the prior year, there was some turnover. The equivalent tables for last year are found on our website at the link for *Navigator* late July 2013.

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Once again, administrative costs for Independent/Provider-Sponsored plans were 9.7% of premiums. The comparable values for the prior year are shown in Appendix B. Plans' sharp increase in the percent of premiums devoted to Sales and Marketing was most

responsible for this. Provider and Medical Management and Account and Membership Administration also increased. Corporate Services barely increased in percent, corresponding to the fact that its growth was very modest.

As noted earlier, of the 1 percentage point increase in administrative expense ratios, 0.7 percentage points are due to a shift in business mix.

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The most recent year saw administrative costs that, in their rate of growth, was higher than in recent years. In fact, Account and Membership Administration growth was more than 55% higher than last year.

Information Systems was, far and away, the most important factor in overall cost growth. But it was followed in its contributions in such key areas as Medical Management, Advertising and Promotion and Claims. Many analytical areas also increased especially Finance and Accounting, Rating and Underwriting and Actuarial.

Customer Services also increased at higher than normal rates. By contrast, Corporate Executive and Governance declined.

The increase in the administrative expense to premium ratio is largely due to a mix shift in favor of some of the higher ratio products.

The cost increases seem to us to reflect "bulge" costs, for example, communication through Advertising and Promotion and adaptation costs, for example, Information Systems. From a measurement perspective, 2013 was notable because every health plan was exposed to these kinds of costs and, it is to be hoped, these were largely one-time events. That would make 2013 important as the baseline year for future health plan administration cost comparisons. Going forward, cost optimization is a central priority for health plans.

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

personally but my colleagues say that that is because I am the one whose actual analytical work would be least missed.

There are 16 Independent/Provider-Sponsored health plans that participated in this year's benchmarking study, and I believe many of you are on the call today. So let me take this opportunity to thank you all for the hard work that goes into this edition of the IPS 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!

Finally, before we go into questions, let me "plug" a free application of these benchmarks on our calculator. It is found on our website. The application allows you to compare your, or your client's if you're a consultant, health plan results to the Sherlock Benchmarks. This works regardless of your mix of comprehensive health benefits products. Plus, it works even if you only know your total administrative costs and you don't segment your administrative activities by product. We expect to update the IPS values shortly.

You might recall that two weeks ago we provided a small demonstration of this. If it would be helpful to do so once more, I'd be happy to do so. Send me an email of your interest and we'll host another web conference to do so.

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 2012's costs and the functions found in the clusters we have been speaking.

Additional information 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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Questions and Answers

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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 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. For those of you who missed the Blue Cross Blue Shield presentation, we've posted the *Navigator*, the slides, a transcript and an audio.

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.