Transcript

Medicaid Administrative Costs: A Review of 2013 Results

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<Title Page>

I am Doug Sherlock. Welcome to our summary of the benchmarking study for Medicaid plans. This is the third of a series of presentations summarizing 2013 performance metrics for various peer groups of health plans.

As you know, Medicaid is central to health care reform because of its expansion's overall effect on the proportion of people who uninsured. The ACA reforms "expanded Medicaid to nearly all adults under age 65 with income at or below 138%" of the Federal poverty level, if the states elect to implement this expansion. According to Kaiser Family Foundation, "As of June 2014, 27 states, including DC, were expanding Medicaid, three states were actively debating the issue, and 21 states were not moving forward. Based on the assumption that not all states would adopt the expanded Medicaid in May 2013, the Congressional Budget Office estimated 12 million additional beneficiaries.

Notably, one source of additional enrollment are new streamlined processes that apply in each state. Examples are "no wrong door" programs in the states, making it easier for MCOs to serve the same membership irrespective of whether they are commercial or Medicaid eligible and outreach programs.

This growth may create the impetus for new organizations to participate as Medicaid MCOs. Some of those organizations may come from commercial plans serving the small group market: Medicaid members tend to participate for less than one year and such plans may be their alternative commercial insurance. Conversely, Medicaid plans may

offer commercial products. In any event, regardless of whether the plan currently focuses on Medicaid or commercial business, that both are offered through exchanges should lower barriers to entry of new plans.

Notwithstanding careful expense management is central to success of these organizations. While most Medicaid plans are not subject to minimum federal MLR rules, in eleven states they are. Also, the commercial plans to which Medicaid beneficiaries may migrate are, and existing Medicaid is paid for by states that remain concerned about the costs of the program.

In considering these changes, they appear simpler than in products for commercial members, especially for those that are not in self-insured groups. They don't appear to entail significant changes in benefit design and, if anything, the enrollment processes appear more seamless.

While no membership had yet enrolled through expanded eligibility, all plans were aware of the changes effective January 1, 2014. Enrollment, including through exchanges, had begun in October of 2013. Accordingly, we consider 2013 to be the baseline year.

Total expenses PMPM increased for those selected health plans by 0.2% and declined by 1.4% holding constant the product mix of the plans. Rates of growth were 1.6% PMPM for Core expenses. Account and Membership Administration, at 1.2% increase, was higher than last year's decline but continues a trend of very moderate cost growth.

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I also 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 the reports that are summarized today. This summary discussed today benefits Medicaid 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.

Nine plans participated in this study and, while we believe that the combined Sherlock Benchmark plans serve 9% of all MCO 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 Medicaid is typically the predominant product, it is not the only product offered by our participants.

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 now completing its 17th consecutive annual survey of health plan operations and today's benchmarks are based on the cumulative experience of 657 health plan years. In all of our various universes this year, the 40 health plans serve over 38 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 one consulting firm, "the gold standard" for such metrics. Thus, health plans serving 108 million insured people use our 2014 benchmarks. Users include the overwhelming proportion of Blue Cross Blue Shield plans, the leading provider-sponsored plans and several publicly-traded companies.

Credibility is facilitated through voluntary participation. Respondents have a stake in the data quality and feel it meets the insight-to-effort test.

The results are actionable since the indicators are unambiguous, and linked to actual performance.

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Today, I touched on the changing structure of the Medicaid program, and intend to speak to the long term trends, increases by cluster of expenses, the reasons for the increase and the actual cost values.

For the sake of brevity, I have included some supporting information only in appendix form.

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In our earlier presentations on Blue Cross Blue Shield plans and Independent/Provider-Sponsored plans, we stressed that plans subject to the Affordable Care Act would face both adaptation costs and bulge costs. An example of a bulge cost is the additional staff required to field questions when they are renewed with a product that they did not have in the prior year. An adaptation cost is one that represents a long-term investment to accommodate the new environment. An example of this would be information systems investments for new products.

As we'll discuss later, these costs are more muted than for these plans that serve the commercial market. They weren't nil, but the magnitude was less.

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This slide shows rather modest growth in administrative costs over the past two years. Note that core costs, in dark blue (a term we use for all administrative expenses except for Sales and Marketing) declined from the prior year: 1.6% versus 4.4% in the prior year. It was approximately 10% in the year before that. With that one year's exception, cost trends for these expenses were very moderate.

Account and Membership administrative trend comparisons were less favorable but the end result was even more moderate. This is the light blue bars on the slide. Costs increased by 1.2% compared to a decline of 3.4% in the prior year. In the year before it was 7.9%, but you can see that the trend has been moderate in all of the past five years.

I want to digress to a technical matter here. All year over year comparisons hold constant the plans. In this chart, and some of the others, we go one further which is to hold constant the product mix between the plans. This gives us true apples-to-apples comparisons.

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Let me expand on the previous slide with the current one. Total administrative costs for these plans decreased or were effectively flat in 2013, compared to sizable increases in 2012. There were five continuously participating plans represented here.

Looking at the core per member per month costs (that is, all expenses except Sales and Marketing), the reported increase of 3.2% was a slight increase from 2.7% last year and a sharp deceleration from the prior year's growth trends of 11.3%.

In my view, eliminating the effects of product mix changes provides a more accurate picture of trend. Holding mix constant, core administrative costs increased by 1.6%, down from 4.4% in 2012 and a sharp deceleration from the 11.3% in 2011.

As you can see, Sales and Marketing costs decreased for our universe of plans that are predominantly focused on Medicaid. Notwithstanding, the average membership growth rate for continuously participating plans was 4.9%. While membership in growth in commercial products was 1.7%, Medicare (including Medicare SNP) grew by 17.4%. Medicaid membership increased on average by 16.7%. Note that while we track costs by product, in this slide we are reporting costs for the companies as a whole.

Of the increases in core costs, Provider & Medical Management grew fastest on an as-reported basis, by 2.9%. It increased by 0.2% on a constant mix basis. Account and Membership Administration increased by 2.7% as-reported and 1.2% on a constant mix basis. The latter, again, is the more illuminating value since it eliminates the potentially distorting effects of any product mix differences.

Corporate Services grew much more modestly at 0.0% as-reported and declined 0.6% on a constant mix basis. This was sharply lower than the low-double digit values from last year.

Interestingly, per member Sales and Marketing costs sharply decreased by 1.4% as reported and by 1.0% constant mix. This compares with last year's increases of 12.4% and 17.7%, respectively.

Including Sales and Marketing expenses, on an as-reported basis cost growth was substantially lower than last year from 6.5% to 0.2%. On a constant mix basis, costs trend decelerated more dramatically from 8.3% last year to a decrease of 1.4% this year.

<Slide 7>

This slide highlights the functional areas within each cluster that contributed to the changes in as-reported costs. We looked at both changes that were extremely dramatic as well as those changes in costs that were responsible for *most* of the change in the cluster of expenses. The latter is the amount of change weighted by the dollar cost. In some instances, the functions that changed most dramatically also had the greatest impact on cost trend. The core as-reported change was 3.2%. Total expenses increased by 0.2%.

The fastest growing core cluster was Provider and Medical Management which increased by 2.9%.This cluster of functions is comprised of Medical Management, like precertification and case management, and Provider Network Management and Services, tasked to respond to provider inquiries and to contract with providers. Provider Network Management and Services costs increased by only 0.2% PMPM. Medical Management grew much faster than Provider Network Management and Services. But because Medical Management is so large, its growth was central to overall trend and a high percent of the overall cost increase reported by this peer group on an as-reported basis.

Account and Membership Administration also grew relatively rapidly by 2.7% PMPM. This cluster includes Enrollment/Membership/Billing, Claim and Encounter Capture and Adjudication, Information Systems and Customer Services. Enrollment and Claims declined as Information Systems increased. Customer Services was effectively flat. Information Systems often drives cost trends since it can be a very high percent of total administrative costs.

The Corporate Services cluster includes Finance and Accounting, Actuarial, the Corporate Services function and Corporate Executive and Governance. Corporate Executive and Governance and Finance and Accounting both declined, and the former was especially sharp. This may in part stem from declines in consulting expenses from the prior year. Actuarial expenses, however, grew quickly. This is may be due in

development of new products outside of Medicaid. The Corporate Services function also increased.

We exclude Sales and Marketing costs from core expenses as we previously noted. Plans reported a decrease Sales and Marketing costs in 2013 of 1.4% on an as-reported basis. Functions include Sales, Marketing, Rating and Underwriting, Commissions, Advertising and Promotion and Product Development / Market Research. Sales had a notable decline, and Advertising was also off. Sales is a relatively large function and has a disproportionate effect. While Commissions was up slightly, Rating and Underwriting and Marketing (containing the Product Development subfunction) were both up.

Once again, the sharp decline in Corporate Executive and Governance drove trend on an as-reported basis.

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This slide is much like Slide 7, highlighting the functional areas within each cluster that contributed to the changes in costs. Again, we looked at both changes that were extremely dramatic as well as those changes in costs that were responsible for *most* of the change in the cluster of expenses. It differs because it reweights costs to reflect the current product mix of the participants. Since it in effect backs out the changes in costs that stem from mix differences, I think this is the closest to the true change in costs.

The Core constant-mix change was 1.6%, down from 4.4% in the prior year. The Total change was a decline of 1.4% compared with 8.3% last year.

The biggest change in core costs was in Account and Membership Administration. Costs increased here by 1.2%. While Enrollment and Claims costs declined, the big change was a low single-digit increase in Information Systems costs which was responsible for nearly half of the change in core costs. By contrast, Customer Services was effectively flat. I think we may be seeing the effects of automation here.

Provider and Medical Management costs grew far slower, at 0.2% on a constant mix basis. Provider Network Management and Services costs actually posted a very modest decline while Medical Management had a modest increase.

Corporate Services cluster costs declined by 0.6% compared with an increase of 12.8% PMPM last year and an 11.7% increase the year before. As on an as-reported basis Corporate Executive and Governance was responsible for the trend shift, and the decline was precipitous. Finance and Accounting also declined. However, Actuarial increased sharply and the Corporate Services function grew modestly.

Once again, plans reported sharp decreases in Sales and Marketing costs in 2013 of 1.0% compared with an increase of 17.7% on a constant mix basis last year. Every function declined, except for Marketing. Those declining functions included Rating and Underwriting, Sales, Commissions and Advertising and Promotion. Marketing cost growth was nearly as sharp as the decline in Sales, and Product Development / Market Research may have been responsible.

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Here are the PMPM administrative cost levels for 2013, segmented by clusters of functions. (By the way, the figure numbers on the slide reference our free newsletter, *Plan Management Navigator*, which is available on our web site.) Median *core* administrative costs for comprehensive products were $24.48 per member per month. If you refer to Appendix A, you'll see that this PMPM cost is higher than the $23.90 reported last year. This is an imperfect comparison since the plans in the annual universes differ. The difference reflects actual changes in costs, product mix changes and changes in plan participation.

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 $14.61. This is a universe of companies in which Provider and Medical Management is very important at $7.24 PMPM. The Corporate Services cluster, at $5.05 PMPM, is the smallest cluster of core expenses and also one with the greatest degree of scalabilty.

Again, we exclude Sales and Marketing expenses from core costs, but they total $8.80. By the way, have a look at the Sales and Marketing cluster of functions' standard deviation divided by the mean. We use this calculation to express standard deviation,

which would be expressed in dollars, in percent form. This ratio is also called the coefficient of variation. The coefficient of variation is much greater that of the other clusters. That reflects why we exclude these from the core expenses: costs vary from state to state since the laws governing marketing also vary from state to state.

The median costs, expressed PMPM or as a percent of revenues, will be the way that we have been referring to cost metrics. 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 nine Medicaid 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 2013 are for those that participated in both 2013 and 2012 surveys. Rates of change are rates of change in *per member* costs.

We can't provide much publicly available detail on this, but many of you are interested in staffing. After all, staffing costs comprise on average 59% of core administrative expenses, though much higher in Customer Services, Provider Network Management and Services and Claims, and far lower in Information Systems. Core staffing ratios run at approximately 20 FTEs per 10,000 members, and when you look at inferred values for pure Medicaid, the staffing ratios are the same. About 21% of such staff is outsourced, but Disease Management, Nurse-based Counseling, COB and Subrogation and Actuarial all had more than 20% of their staff outsourced, on average. Information Systems was 22% outsourced.

Excluding Pharmacy and Mental Health, median core compensation per FTE averages just over $81,000, though certain functions like Quality Components, Other Medical Management, Total Information Systems, Finance, Actuarial, Legal and Corporate Executive are in six figures.

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This slide shows the administrative expenses of each *product* offered by the Medicaid universe of plans. The health care needs of plan members vary quite a bit by product,

and the associated administrative expenses do as well. I want to key on a few comparisons by way of illustration.

The administrative costs of Medicaid HMO were $32.31 PMPM, while Medicaid Child Buy-in was $23.29 PMPM. The Commercial ASO had the lowest per member administrative expenses. The median costs for this product is $18.63 PMPM. Medicare SNP was the highest cost product at $141.62 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.

Medicare Advantage administrative costs are higher than comparable products for younger people, partly because of the high health care needs of seniors. Health care costs normally entail claims processing and customer service activities, which are reflected in the administrative expense levels. The effects of health care needs are especially evident when comparing the Medicare SNP product, at $141.62 PMPM, versus Medicare Advantage, at $91.37 PMPM.

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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 a 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 percents 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. Thus the percent of revenues tends to be less for these high health care cost product lines. Medicare Advantage costs were 10.0% while Medicare SNP was among the lowest cost at 8.7%.

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. Child Buy-In is relatively high cost at 10.9% for much the same reason that Medicare tends to be low. The lowest cost product, measured as a percent, is ASO at 5.9%.

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This slide shows that *core* administrative expenses as a percent of premium equivalents were 6.8%. Including Sales and Marketing costs, administrative expenses equaled 10.5% of premium equivalents. Please note that it excluded taxes imposed by state governments as well as capital costs.

Note that the percent of premium equivalent of 6.8% is 30 basis points higher than last year's value of 6.5%, as shown in Appendix B. A precisely comparable comparison is impossible since medians don't sum and the universes differ. Both Corporate Services and Account and Membership Administration increased relative to last year's ratios.

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This is the end of my formal presentation. Administrative cost growth for continuously participating plans was very modest this year, reflecting the relatively modest bulge and adaptation costs. Medicaid plans are not as exposed to this.

Cost growth was moderate both on an as-reported and constant mix basis. Remarkably, the Corporate Services cluster of expenses declined. This was mainly powered by a sharp decline in Corporate Executive and Governance. Actuarial climbed, however. Sales and Marketing costs tended to decline for these plans.

Account and Membership cost growth was modest and focused on Information Systems. Other functional trends in this cluster were flat to down.

Sales and Marketing costs declined in 2013. All functions in this cluster declined except for Marketing.

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.

Now I would like to open this for questions about the results of the Medicaid 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.