*Transcript*

# Medicare Administrative Costs: A Review of 2013 Results

October 22, 2014

Douglas B. Sherlock, CFA
sherlock@sherlockco.com
(215) 628-2289

<Title Page>

I am Doug Sherlock. Welcome to our summary of the benchmarking study for Medicare plans. This is the fourth and last a series of presentations summarizing 2013 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 could be helpful. In addition, we published an analysis of the largest of the Blue Cross Blue Shield plans in our universe and, while I did not make a presentation on them, the summary in *Plan Management Navigator* is also on the web site.

<Slide 2>

Total expenses PMPM increased for Medicare plans participating in our study declined by 1.9% and increased by 3.8% holding constant the product mix of the continuously participating plans. Rates of growth were *negative* 5.3% and positive 8.1% for Account and Membership Administration, again with the latter excluding the effect of mix changes. The trends were lower overall but higher for Account and Membership Administration.

This slide shows the rather modest growth in total administrative costs over the past six years. With the exception of a spike in 2011 cost trends (due to both a surge in IS and a reversal of declines in Customer Services and Enrollment ) cost trends were moderate over the past six years. (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.)

Note that total administrative costs, in dark blue declined from the prior year: 3.8% versus 7.4% in the prior year. Account and Membership administrative trend comparisons were less favorable. This is shown as the light blue bars on the slide. Costs increased by 8.1% compared to a increase 1.4 % in the prior year.

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. This gives us true apples-to-apples comparisons.

<Slide 3>

Eleven plans participated in this study and, while the combined Sherlock Benchmark plans serve 15-16% of all Medicare 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 52.2% of revenues or 53.3% if Medicare Part D is included.

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 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 two consulting firms, "the gold standard" for such metrics. Thus, health plans serving 109 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 4>

So far, I touched on the participating plans, Sherlock Company and some trends. We'll go into a little more background, including the quiet reform of the Medicare program, 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.

<Slide 5>

Medicare Advantage is, very quietly, among the most important reform initiatives in health care. At present, nearly 31% of all eligible people are served by Medicare Advantage, or 16.5 million people. The magnitude of this change is very significant. In the first place, consider that in 2005, only 5.6 million people were enrolled in Medicare Advantage, or 12.9% of total beneficiaries. In the second place, net enrollment in Medicare Advantage has exceeded net enrollment in Fee for Service in each year from 2006 through 2014. Remarkably, over that decade, *all* net enrollment in the Medicare program has gone into Medicare Advantage Plans. At the current rates of growth,

Medicare Advantage membership could be in the 35-40% of beneficiaries range in 2017. That this high-utilizing population could migrate to managed care products for the first time could affect overall health care cost trends and stimulate vertical integration by payers and providers.

<Slide 6>

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. Notwithstanding that changing Medicare was not the central purpose of the Affordable Care Act, MA plans will also be subject to medical loss ratio minimums beginning in 2014. Moreover, these plans offer other products that are disrupted by the Affordable Care Act.

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 health plans focused on the commercial market. The effects weren't nil, but the magnitude was less. So, since the MLR rules were still before us, 2013 is the baseline year for health plans offering Medicare.

<Slide 7>

Let me expand on the second slide in the deck with the current one. Recall that total administrative costs for these plans increased moderately in 2013, by 3.8%, compared to larger increases in 2012. By contrast, Account and Membership Administration expenses accelerated, growing by 8.1%, up from 1.4% last year. There were six continuously participating plans reflected here. These changes hold product and universe mix constant. In my view, eliminating the effects of product mix changes provides a more accurate picture of trend.

However, looking at the total per member per month costs, the *reported* decrease of 1.9% was a significant shift from the increase of 7.3% last year.

As you can see, Sales and Marketing costs decreased for our universe of plans that are predominantly focused on Medicare. Notwithstanding, the average membership growth rate for continuously participating plans was robust, as we'll discuss later. The change in Sales and Marketing was key to the change in overall costs.

Of the increases in total costs, Corporate Services grew much more "consistently" at 3.4% as-reported and 2.7% on a constant mix basis. This was sharply lower than the low single- digit values from last year.

Provider & Medical Management was effectively flat. It declined by 1.1% but grew on an as-reported basis, by 0.2%. Both comparisons are lower than in 2012.

Account and Membership Administration was more "volatile" (in the sense of comparisons between the measurements) decreasing by 5.3% as-reported and increasing by 8.1% 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. Last year, this cluster also reported declines on an as reported basis but at a rate less than this year. Growth in this clusters costs was higher this year than last.

<Slide 8>

This slide shows the 1.9% 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.

The most important reason for the decline was the 8.9% decline 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. I'm a little uncomfortable about the interpretation of this slide because of the prior one. Note that on Slide 7, PMPM costs for this cluster increased by 10% in 2012. Well, the big enrollment period is January 1 and the accounting for this business does not permit deferred acquisition costs. So, 2012 costs were incurred to enroll members in 2013. The median increase overall was 9.4% and was 13.4% for Medicare Advantage. It was 15.5% for Medicare SNP.

Setting this complication aside, every functional area in this cluster except for broker Commissions declined. The Rating & Underwriting decline was in double-digits, which

is especially remarkable since this function contains the Hierarchical Condition Category costs. Rating and Underwriting is not the largest function in this cluster but the magnitude of the decline means that, in terms of the dollar contribution to the total, it was the largest factor in the trend of the cluster. Both Sales and Marketing *functions* declined at high single-digit rates and Advertising and Promotion declined at low single digit rates.

Account and Membership Administration is the largest single functional area, and it contains what most people think of when they think of insurance operations. Functions include Enrollment/Membership Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information Systems. Like the Sales and Marketing cluster, this one also declined, by 5.3% on an as-reported basis. Both Information Systems and Enrollment posted sharp declines while Customer Services costs increased sharply. While Enrollment posted the greatest decline, the Information Systems decline was more important because of its overall size. We speculate that the Customer Service increase may have resulted from turmoil in the commercial market associated with the Affordable Care Act.

The two functions in the cluster of Provider and Medical Management trended in opposite direction but by nearly the exact same amount. Both were high single-digit rates of change and the difference between them was one tenth of a percentage point. Even though Medical Management costs are 2-3 times as high as Provider Network costs, since as-reported results do not back out mix differences, the trend was slightly negative. There was a decline in PMPM costs of 1.1% for this function.

The Corporate Services cluster is the smallest. Its cost trend was modest at 3.4%. This cluster contains Finance and Accounting, Actuarial, the Corporate Services *function* and Corporate Executive & Governance. The Corporate Services function is the largest in the cluster and includes sub-functions such as HR, Legal, Facilities, Mailroom and so forth, and it grew at slightly less than the rate for the cluster as a whole. By contrast, Finance and Accounting surged at double-digit rates, by far the fastest increase in the past five years. Conversely, Corporate Executive & Governance declined by a somewhat higher percent. I speculate that this is due to the stage of adaptation to the reforms of the Affordable Care Act – in prior years, much of the efforts were strategic and companywide whereas in the current year Finance and Accounting implemented many of the MLR reporting and other specific adaptations.

<Slide 9>

This slide shows that rates of change in costs after eliminating the effect of product mix changes. Accordingly, we think of these as the "real" changes in costs. As with the previous two slides, this one also excludes the effect of any differences attributable to changes in the universe year over year.

Two slides ago, we showed the sharp difference in trend in Account and Membership Administration with as-reported costs declining and constant mix costs increasing. This central cluster posted a decline only in Enrollment costs whereas on an as reported basis Information Systems costs were lower as well. Customer Services costs increased relatively sharply, possibly stemming from the need to respond to the Affordable Care Act. Surprisingly, there was a sharp increase in Claims. We don't know why this is but let me offer that the claims processing for new products are often handled manually at first and then, once well understood, are converted to an electronic process. The size of the increase also made claims the most important factor in this cluster's trend.

Sales and Marketing costs declined by 5.9% in real terms. Rating and Underwriting declined precipitously and, even though it is small, its substantial decline was the most important factor in the decline. Marketing and Advertizing and Promotion also declined. Sales increased at low single digit rates while Commissions increased at high single digits, the fastest rate of increase in the past five years. Once again, recall that there is something of a mismatch between the costs of Sales and Marketing with the enrollment growth that it helps precipitate.

Provider and Medical Management costs were up only slightly in 2013. The decline in Provider Network Management muted the increase in Medical Management, which nearly always increases.

Overall the Corporate Services cluster costs increased PMPM by 2.7%. With one exception, every function in this cluster increased. That exception was Corporate Executive & Governance which had a very sharp decline in costs. For each of the past four years, this function has had double-digit constant mix increases so, as we discussed earlier, this trend may reflect a rebound from all the corporate-wide adaptation costs relating to the Affordable Care Act. Finance surged at a double-digit rate and Actuarial also increased by high single-digit rates.

<Slide 10>

This slide summarizes the PMPM cost values of the each cluster and the total for the Medicare universe. They total $48.35 PMPM across all products while last year's values totaled $44.57. To report 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 $17.53 PMPM. This is a universe of companies in which Provider and Medical Management is very important, at $7.79 PMPM. The Corporate Services cluster, at $7.95 PMPM, is among the smallest clusters of core expenses and also one with the greatest degree of scalability. Sales and Marketing expenses total $12.63 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 50$^{th}$ percentile value, the clusters won't necessarily sum to the median for total expenses. That is even more the case for the 25$^{th}$ and 75$^{th}$ percentiles.

While I'm digressing on 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 eleven 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.

Once again, the PMPM costs this year are higher than last year's reported costs. There are three factors affecting how the PMPM values for each cluster differ from those of last year shown in Appendix A: product mix, the underlying trend in administrative expense cost growth and the change in the universe. Their effects can be isolated from each other and we do so. For Sales and Marketing, the decline in costs was primarily due to the trend among the continuously reporting plans. Universe differences explained most of the differences in Provider and Medical Management and, to a lesser extent, Corporate Services. Account and Membership Administration trends were complex: while the trend in costs raised them, and the current universe had higher costs than last year's, the effect of mix largely canceled out these effects. The cautionary message here is that a simple year over year comparison of the PMPM values, or

assuming the same mix of costs between products, will produce incorrect answers for your plan.

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 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 34 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 56 FTEs per 10,000 members, including the effect of outsourced FTEs.

About 19% of such staff in Medicare plans is outsourced, but Claims, Rating and Underwriting and Advertising and Promotion all had more than 20% of their staff outsourced, on average. Information Systems was 18% outsourced.

Excluding Pharmacy and Mental Health, median compensation per FTE averages just over $83,000, though certain functions like Corporate Executive and Governance, Actuarial and Marketing are in six figures.

<Slide 11>

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 $79.65 PMPM, while the dominant Medicare Advantage product was $79.25. Medicare SNP (which we believe to be mainly dual eligibles) cost $139.35 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 entail claims processing and customer service activities, which are reflected in the administrative expense levels. Similarly, Medicaid members were the lowest cost insured plans, at $31.96 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.

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

<Slide 12>

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. The chief reason for this is that Sales and Marketing costs are a lower percent of the premium dollar for Medicare products. To a lesser extent, Corporate Services costs are also lower as a percent. All clusters and functions are of course higher but, because of the higher health needs of seniors, the denominator is greater as well. Medicare Advantage costs were 8.5% of premiums while Medicare SNP was 9.7%.

Recall that Medicaid products were relatively low cost on a PMPM basis. Expressed as a percent of revenues, Medicaid HMO, at 9.5%, is also lower than average for the products served by this universe.

Commercial Insured products had a median administrative expense to premium ratio of 12.1%. But the values varied by product with POS relatively low and Indemnity and PPO relatively high. The lowest cost product, measured as a percent, is ASO at 5.9%.

<Slide 13>

This slide shows administrative expenses as a percent of premium equivalents were 10.3%. Please note that it excluded taxes imposed by state governments as well as capital costs.

The percent of premium equivalent of 10.3% is 160 basis points higher than last year's value of 8.7%, as shown in Appendix B. But Medicare Advantage alone was 8.5% as you recall from the previous slide compared with 8.7% last year.

A precisely comparable comparison is impossible since medians don't sum and the universes differ. However, corresponding to the constant mix administrative cost trends both Account & Membership Administration and Corporate Services are higher percents than last year and Sales and Marketing and Provider & Medical Management are lower than last year.

<Slide 14>

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 a remarkable correspondence of PMPMs, with only a $0.03 PMPM difference in median values.

However, this mutes some significant differences. First, *mean* values are $2.25 lower PMPM for the Medicare plans. More importantly, the composition of expenses are different. While Medicare plans tend to have lower Account and Membership Administration costs, they have higher Sales and Marketing, Provider and Medical Management and Corporate Services costs.

Note also that, on a percent of premium basis, the administrative costs of Blue Cross Blue Shield plans are a higher percent than are the Medicare plans.

I do not interpret this as saying the Medicare plans operate in a superior fashion. I am however a believer in the virtues of experience and focus in all things. Blue Cross Blue Shield commitment in this area has extremely rapid and broad based.

<Slide 15>

This is the end of my formal presentation.

Medicare is, very quietly, reforming to increasingly emphasize Medicare Advantage over FFS. This will have important implications for the health system as a whole because of the substantial health needs of seniors.

Administrative cost growth for continuously participating plans was modest this year. Overall because of the focus on Medicare, there were relatively modest bulge and adaptation costs, though the surge in claims costs may have been an exception.

Cost growth was moderate both on an as-reported and constant mix basis. Sales and Marketing costs declined notwithstanding that membership sharply increased for these plans.

Provider and Medical Management was effectively flat as Provider Network declined but Medical Management increased. Account and Membership cost growth provided a dramatic illustration of the importance of product mix. Costs were down on an as-reported basis and up on a constant mix basis. Enrollment was down but IS and Customer Service was up, and Claims was up dramatically.

The Corporate Services cluster of expenses grew moderately. While Finance in particular and also Actuarial grew, there was also a sharp decline in Corporate Executive and Governance.

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 Medicare benchmarking study.

● ● ●

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.