Transcript

Independent / Provider - Sponsored Administrative Cost Growth Moderates in 2018

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<Title Page>

Thank you for participating in this year's review of the Sherlock Benchmarks for Independent / Provider - Sponsored Plans. I am Doug Sherlock, President of Sherlock Company.

Today, I would like to speak about the administrative cost trends of Independent / Provider - Sponsored Plans in 2018. For those of you who participated in the web conference last month for Blue Cross Blue Shield Plans, you will notice some significant differences in trends. Most notably, the growth in administrative expenses declined in 2018 versus 2017 and, with the exception of Medical and Provider Management, all clusters of functions declined.

The most important reason for the *decline* in growth was the decline in growth in the Account and Membership Administration Cluster and in the far sharper decline in small Corporate Services Cluster, especially in the Corporate Executive & Governance function. The single most important function contributing to a decline in growth was the more modest increase in Information Systems. Having said that, the growth in the Corporate Services function was the leading factor in the overall growth.

The 19 Independent / Provider - Sponsored plans that are the subject of this presentation serve 10.2 million people with comprehensive insurance. The average plan participating in the *Sherlock Benchmarks* this year served 534,000 people and the median membership was 470,000. The plans were geographically disbursed, serving 19 states. Of the 16 members of the Alliance of Community Health Plans that are not focused on

public programs or are staff-model plans, ten are participating in this year's Sherlock Benchmarking Study for Independent / Provider – Sponsored health plans.

Of the seven largest members of the Health Plan Alliance that are focused on commercial products, five are participating in this year's Sherlock Benchmarking Study for Independent / Provider – Sponsored health plans. Sherlock Benchmark participating plans represent 47.8% of the total members of this subset of the Health Plan Alliance plans.

All of the results that we will discuss today are the results of surveys. We have made significant efforts to validate plan responses.

The participating plans make significant efforts as well. So, I thank the participating plans, especially our primary contacts within those plans. Since the subject matter of this web conference is free of charge and beneficial to health plans that do not or cannot participate in the study, I hope you share my gratitude. I also thank my talented colleagues for their professionalism and one very visionary Independent / Provider - Sponsored CEO for his being the catalyst for this universe.

I want to offer a framework for today's discussion. Much of the work that we do surrounds the administrative activities of health plans, though we also analyze health care utilization and medical management metrics. We stress administrative expenses since, while health plans may manage the care for many of their members, they provide administrative services in support of all of them.

This year marks the 22nd year of the Sherlock Benchmarks, and the 17th for the IPS universe. Cumulatively, I estimate that by year end our cumulative experience will be more than 855 health plan years, and will include Independent / Provider – Sponsored Plans, Blue Cross Blue Shield Plans, Medicaid Plans and Medicare Plans.

The goal of *Sherlock Benchmarks* is to aid in plans' achievement of optimal costs, that is, to incur only those costs that are necessary to meet plans' strategic objectives. In that way, the Benchmarks establish a norm so that, above those levels, expenses should be justified with an ROI. The measurement of a return on investment is challenging but may ultimately be linked to with more rapid growth or a decline in health benefit trends.

There are at least two other reasons why optimizing administrative expenses is a high priority for health plan managers. First, the surge in expenses of adapting to the Affordable Care Act and onboarding Exchange and Medicaid members have passed. Second, administrative expense visibility has been heightened by the rhetoric of presidential candidates.

<Slide 2>

I'm going to breeze through this slide. It shows the topics that I will address and lists the Appendices. Note that the Appendices contain last year's values. It also lists of all the functions in each of the products offered by these IPS plans. By the way, that means that administrative expenses are segmented into nearly 800 expense/product cells, each of which are separately analyzed. We have also included some Market Segment cost information in the Appendix.

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

<Slide 3>

This slide summarizes long term administrative cost trends for Independent / Provider - Sponsored Plans. The percent changes in costs that you see here, and throughout this presentation, are in *per member* values.

In 2018, excluding the effect of Miscellaneous Business Taxes, Independent / Provider - Sponsored plans had *real* administrative cost increases of 3.4%, down from 5.5% last year. By "real", I mean the growth in expenses within a constant set of plans, standardized by members. Moreover, this is after having reweighted the 2017 results to exactly match the product mix offered by those plans in 2018. This is shown as the dark blue line. You can see growth was the second fastest since 2014: trend spiked higher in 2017, then continued to grow at a diminished pace in 2018.

As we'll develop later, the actually reported per member administrative trend for the same Plans is 3.7%, down from 5.2% in the previous year. This is a more moderate deceleration in growth from 2017, and the increase is greater than after the effect of mix adjustment.

Since the focus of this discussion is administrative expenses that, once measured, can in fact be managed, we are displaying trends before the effect of the Miscellaneous Business Taxes. These are premium taxes and other similar charges plus all of the ACA related taxes and charges. Excluding the effect of any changes in product mix total administrative expense increased by 14.9% PMPM compared with a decline of 3.8% in the prior year. That increase in excess of the 3.4% shown in this slide is chiefly due to the restoration of the Annual Fee on Health Insurance Providers.

The light blue line is for Account and Membership Administration. You can see that its growth is less than both 2017 and 2016. In 2018, the growth in Account and Membership Administration outstripped the total increase, 4.7% versus 3.4% as it has in every year since 2012. Therefore, growth in functions other than Account and Membership Administration must have grown slower.

This leads me to the key take-aways from this year's results.

- Most clusters of expenses declined in growth.
- However, Medical and Provider accelerated.
- Growth in the Corporate Services function was the single most important reason for administrative expense increase in 2018.
- The shift in favor of products that are higher cost to administer amplified the real growth.

<Slide 4>

I mentioned that the growth in clusters other than Account and Membership Administration must have been slower and this slide details this. The comparisons on the prior slide are detailed in this one, in the second and fourth columns. I have circled in blue the 3.4% and 4.7% increases from Slide 3, and the blue-*filled* arced arrow shows the comparison values from the prior year on a constant mix basis. In other words, the second and fourth columns reflect the thirteen continuous plans, whose cost values have been reweighted to eliminate differences due to product mix.

The first and third columns reflect the as-reported values, that is, before the effect of reweighting to eliminate year-over-year product mix differences. The blue *outlined*

arced arrow shows the comparisons between the same continuous plans without that reweighting.

Among the four clusters of expenses, only Medical and Provider Management has accelerated its rate of growth. Between 2017 and 2018, the cluster increased from 6.1% per member growth to 6.9%.

Account and Membership Administration which, at 4.7%, was greater than the total cost trend but declined from 6.2% last year.

Changes in growth in the clusters of Corporate Services and Sales and Marketing were much more dramatic. Sales and Marketing growth declined from 6.8% in 2017 to 1.8% in 2018. The Corporate Services decline was even greater, from 11.1% to 1.4%.

On an as-reported basis you see a similar though not identical pattern. Overall, growth was slower in 2018 than in 2017. Medical and Provider Management growth was uniquely identical to the prior year's growth, while all others declined. The 4.3% growth in Corporate Services was sharply below the 11.7% increase in 2017, and Account and Membership fell from 9.0% to 5.5%. Reflecting the differences in product mix, Sales and Marketing growth declined only modestly in 2018, quite different from the sharp decline on a mix-adjusted basis.

The higher growth in as-reported costs for Sales and Marketing makes sense when you consider the shift in favor of Medicare Advantage. Medicare products are not only focused on intrinsically expensive seniors but are also 90% individual. This drives costs upward.

Specifically, Medicare Advantage membership increased at a 7.1% median rate as SNP increased at a 5.9% rate, compared with a decline of 0.6% for Commercial membership. Muting this was 0.2% growth in the low cost Medicaid product. Medicaid increased by 0.2%: TANF/SSI decreased by 0.3% while CHIP surged by 7.3%. Also, while Commercial *Insured* membership declined by 1.0%, Commercial *ASO* increased by 1.4%. Self-insured relationships represent less than 40% of commercial members in continuously participating plans.

<Slide 5>

This shows the rates of change and the most important reasons for the changes, after eliminating the effect of product mix differences. In other words, these are the "real" rates of increase. So I will spend a lot of time on this and discuss trends in order of their importance.

While Account and Membership Administration was not the most rapidly growing function, because it represents the single largest cluster, it was the greatest source of increase. Customer Services was by far the fastest growing function in the Account and Membership Administration cluster, which cluster increased by 4.7%. Because of the magnitude of the increase, Customer Services was also the most important source of increase. Staffing ratios sharply increased in this function and compensation increased. Information Systems grew far more slowly but, because of its size, contributed almost as much to the cost increase. Compensation and non-labor costs grew. While Claims increased modestly, Enrollment / Membership / Billing declined.

Growth in the cluster of Medical and Provider Management was the fastest among them, and was the second most important contributor to growth. The patterns of growth varied greatly in both components, Medical Management / Quality Assurance / Wellness and Provider Network Management and Services. However, the growth in Provider Network Management and Services was greater and, despite its smaller size, contributed more than Medical Management to the growth in this cluster. It appears that outsourcing increased for this function.

The Sales and Marketing cluster increased by 1.8%, sharply lower than last year. Rating and Underwriting and Broker Commissions declined, the latter for the second year in a row. The decline in Commissions was the single most important change. Growth in the Marketing and Sales functions together outweighed the Commission decline. For Marketing, non-labor costs surged as staffing ratios decreased. For Sales, compensation and non-labor increased. Advertising and Promotion also increased though modestly.

The cluster of Corporate Services costs increased by 1.4%, a sharp decline from the 11.1% pace in 2017. The most important source of growth was the Corporate Services function, by far the largest function in this cluster. The Corporate Services function includes such activities as HR, Legal, Audit, Purchasing, Printing and Mailroom and the like. Growth in Compensation and in Non-Labor expenses appeared to be the drivers. Non-labor cost growth was especially notable in the Legal subfunctions of Government Affairs and All Other Legal.

Actuarial was the second fastest growing function in this cluster but, because of its small size, was only a very modest source of growth. Increases in Staffing Ratios, Compensation and Non-Labor expenses all contributed, while outsourcing declined. For the third year in a row, Actuarial has grown faster than the rest of expenses.

Finance and Accounting also grew, but modestly. Interestingly, that modest growth was also the fastest in five years. It also is small and so contributed little to growth. While Staffing Ratios appeared to decline, compensation grew rapidly.

The Corporate Executive and Governance function declined and had the second greatest effect on the Corporate Services cluster. While the Staffing Ratio and Non-Labor costs increased, compensation declined. It is this decline that explains a paradox: while the Account and Membership Administration cluster was the central driver of growth, so was the Corporate Services function because Corporate Executive offset it within their cluster.

<Slide 6>

This slide shows the *reported* rates of change, that is, the values with no adjustments for changes in product mix. These trends, again, are based on the plans that participated in both 2018 and 2019. Because there is often a correspondence between the relative rates of growth and their importance between the constant mix and as-reported renderings, I focus on functions and clusters where they differ.

Like constant mix, growth was slower in 2018 on an as-reported basis, 3.7% compared with 5.2% in 2017. Compared with the mix-adjusted growth trends, the cost growth was more rapid, reflecting the increasing importance of Medicare.

In the Sales and Marking cluster, on an as-reported basis, Sales supplanted Marketing as the fastest growing function, perhaps stemming from the prominence of direct sales to the Medicare segment. The modest increase in Rating and Underwriting, compared with a decline on a constant mix basis, may also reflect the Risk Adjustment requirements of Medicare Advantage. Advertising and Promotion was similarly far more rapid.

Medical and Provider Management cost trends were similar on an as-reported basis as on a constant mix basis. The heavy care management requirements of seniors may be reflected by the prominence of Medical Management / Quality Assurance / Wellness as the driver of expenses in this cluster. Compensation and non-labor surged as staffing ratios declined.

In Account and Membership Administration, the high dollar weighting of Information Systems displaced the faster rising costs for Customer Services as the key contributor to this cluster's growth.

Let me close this part of my presentation with a few summary observations. All my trend comments are based on continuously participating plans and includes the effect of staffing and costs performed on an outsourced basis. Overall, it appears that staffing ratios are lower than last year among continuing plans. Participating Independent / Provider - Sponsored Plans have, we estimate, approximately 25 FTEs per 10,000 commercial insured members, a decline of approximately 3-4% from the prior year. (This estimate is based on actual values, adjusted to the product by assuming the same mix of labor and non labor in each product.)

Of the 14 functional areas with staff, 11 had median ratio decreases. *Key* areas of staffing declines included Corporate Services, Medical Management and Claims. Customer Services increased. Compensation was typically higher: eleven of the 14 primary functional areas with staff had compensation increases. The declining functions were Provider Network Management and Services, Enrollment / Membership / Billing and, very sharply, Corporate Executive & Governance.

Overall, outsourcing was higher than last year. Six of the 14 functions increased in outsourcing notably the staffing-intensive areas of Claims, Customer Services and Provider Network.

<Slide 7>

Up until now, I have focused solely on the administrative expenses that managers can control. For instance, we have excluded from the discussion capital costs such as interest and dividends because they are the result of financing decisions made at the board level or at least beyond the purview of the operating managers. (For those with an interest in investment theory, this cost segmentation also comports with the

observation that financial leverage is independent of operating performance and works the same way whether the firm or the investor employs the debt.)

For that same management control reason, we have excluded Miscellaneous Business Taxes from this analysis. These taxes, which are primarily associated with the Affordable Care Act, layer in additional costs. Unless the plan restructures to consolidate government business in one non-profit, these taxes are unaffected by management, especially operational management. From an operating perspective, perhaps the central attribute of such taxes is to amplify the need to manage administrative costs.

This Miscellaneous Business Tax expense is not part of the expenses that give rise to the 3.4% total increase after mix adjustment, but those costs surged with the expiration of the Moratorium on Annual Fee on Health Insurance Providers. The whole Miscellaneous Business Tax expense more than doubled to a median of $10.87 for commercial insured products, representing about 18% of all administrative costs. So, if we were to have included that expense in trend, total costs would have increased by 14.9%.

<Slide 8>

To this point, we have focused on rates of change rather than the underlying values of the components of administrative costs. They were based on a constant set of plans over each two-year comparison period.

The next few slides speak to the values of these activities for the entire set of plans: six plans joined this universe and seven plans withdrew. Because of the difference between the two sets of plans, changes between the values is a poor gauge of trend. The median PMPM value of $41.28, 7.6% greater than the median value of $38.35 last year. The prior year values are shown in Appendix A of this slide deck and are also excerpted on this page.

There is little correspondence with the overall administrative cost trends on Slide 4 and increases that resulted in the values shown here. The closest comparison, the decline in Sales and Marketing to $9.45 from $10.22, corresponds with the sharp decline in growth holding the universe constant.

Corporate Services of $7.54 is much higher than $6.75 reported last year. The increase in Account and Membership Administration to $17.72 PMPM was 15.7% greater than the $15.32 of 2017. Medical and Provider Management was 8.0% higher, at $7.35 versus $6.80 last year.

Interestingly, the cluster values in 2018 are more "clustered" than in 2017. The differences between 25th and 75th percentile values are smaller overall, and in the largest functions of Account and Membership Administration and Sales and Marketing. Similarly, the coefficients of variation were smaller in total and in Account and Membership Administration.

<Slide 9>

I have emphasized the effect of product mix changes on trend and this slide shows what I mean. There are very significant cost differences between the various products.

The highest cost Comprehensive products are the various Medicare Advantage products. Regular Medicare Advantage at $90.71 is 85% higher than Commercial Insured HMO at $48.97. The rapid growth in Medicare Advantage combined with the decline in the various Commercial Insured Products is a central reason why the constant mix calculated growth is less than the as reported growth. Membership in Medicare SNP also increased rapidly and its costs were $155.56 PMPM, three times the cost of Commercial Insured.

The other insured commercial products, POS and Indemnity and PPO, were $49.63 and $54.16, respectively.

Offsetting the impact of senior product growth was growth in Commercial ASO: at $21.73, it was 44% of Commercial Insured Products. The overwhelming reason for the difference stems from Sales and Marketing cost differences. What this means is that, when there is a shift in favor of these products, reported cost trends decline. In fact, membership did grow, muting the effect of the shift in favor of Medicare.

This universe has a relatively heavy exposure to Medicaid. For HMO and CHIP, PMPM costs are $28.41 and $25.01, respectively, and half the cost of commercial insured products. These products grew faster than other products and, like the growth in ASO, muted the reported increase in expenses.

Medicare Supplement at $41.09, was almost identical to the total, $41.28. It is a very small product that declined in membership.

<Slide 10>

This is similar to the previous slide, only expressed in percents. The median administrative expense relative to premiums was 8.6% similar to the value for last year of 8.5%. (By the way, we are using premium equivalents here.) In many respects, the relationships between the costs of various products measured in percents parallel those measured in PMPM values. The ASO products have a very low median value of 5.9%, substantially lower than the ratios for insured products that range from 9.4% for HMO to 11.7% for Indemnity and PPO.

Medicaid percents, like for PMPM, run low. For the HMO and CHIP, the percents are similar to Commercial products. Their Sales and Marketing costs are modest.

It is in products for seniors that larger differences appear. While SNP and MA run very high PMPM, they are 11.0 and 9.2% respectively, substantially identical to commercial products.

Senior products covering only part of the scope of benefits are still higher cost as a percent but moderate cost PMPM. So, Medicare Supplement, moderate cost PMPM is at 19.0% the high cost product here. Likewise, while Medicare Cost is the lowest cost senior quasi-MA product, measured as a percent at 13.1%, is the high cost Medicare product.

<Slide 11>

This slide shows the administrative expenses by cluster of functions expressed as a percent. Overall, costs were at 8.6% of premium equivalents, roughly the same as the 8.5% last year. There was change among the clusters in their contribution though.

Most importantly, Account and Membership Administration increased by 0.5 percentage points to 3.8% of premium. This was largely offset by the 0.4 percentage point declined in Sales and Marketing, to 2.1%.

Medical and Provider Management nudged up by 0.1 percentage points to 1.6% of premium and Corporate Services percents remained the same at 1.5%

These ratios cluster more than are found in the PMPM values on Slide 8. I suspect that this is because local cost of living and product mix differences differences are not as much reflected in percents as they are in PMPMs. For instance, the coefficient of variation of 16% compares with 27% on Slide 8.

<Slide 12>

I want to touch on the role of vertical integration. The idea for this came from one of the participants at our kick-off meeting in March and I'm grateful to her.

The nineteen health plans that participate in the benchmarking study are characterized by their local focus, generally have a commitment to managed care products, such as commercial HMO, and all provide (or arrange for) substantially all administrative costs of health coverage. But these plans may also be segmented in that they are about evenly divided between those that are owned by health systems and those that are not.

We made a quick comparison between the ten health system owned plans and the nine unaffiliated plans, integrated and non-integrated respectively. We divided them into two sets, calculated average values, then weighted those values by the subset average product mixes and then by those of their counterparts. The relative values are shown in Slide 12. We looked at total costs, information systems and all costs other than information systems.

Overall, the as-reported costs in health system owned plans were lower than their independent peers. This is true whether regardless of whether the cost values were weighted by the product mix of integrated plans, at 85.1%, or the product mix of the non-integrated, at 88.6%. The differences were especially great for the Information Systems functional area where integrated plan costs were 63% of non-integrated plans.

This difference may overstate the differences because the cost of living averages about 16% higher for non-integrated than for integrated plans. Adjusting costs to exclude cost of living largely eliminated differences between integrated and non-integrated plans in Comprehensive and Other Functions. But significant differences remain in favor of

integrated plans in Information Systems. Excluding the cost of living effects, Information Systems in integrated systems are 73% of non-integrated.

Interestingly, the growth in costs ran higher for the non-integrated plans. Excluding the effects of changes in product mix, total costs increased by 5.8% PMPM for non-integrated plans and by 2.5% for integrated plans. For Information Systems, costs increased by 4.6% PMPM for non-integrated plans and by 1.0% for integrated plans.

Using the cost data from the plans, we are unable to determine why the health systems owned plans have lower information systems costs. They seem to have similar product concentrations, similar focus of ASO and their scale is also similar. One possibility is that Information Systems of provider-sponsored plans are not fully reflected in their costs. For instance, these costs could subsidized by the health system parent, though this seems counter productive as management policy.

Another possibility stems from relative ease of communication between two affiliated organizations: as one plan told us, "our claims submission system is a cable under the street between the clinics and the health plan." Somewhat refuting this is that provider owned does not necessarily mean a perfect overlap between insurance and care. When we polled a few of them last summer we found that only one had health plan members in the neighborhood of 30% of patient census in facilities or census.

A third possibility is that the ability to support more complex benefit designs may be desired to differentiate non-integrated plans in the absence of a "halo" of association with a provider. We don't know the answers to this but are continuing to study the issue.

<Slide 13>

The Plans that participated in this year's study had costs that were $41.28 PMPM versus $38.38 last year. In this presentation, I've emphasized growth holding the universe constant but changes in participation plus changes in product mix also made a difference.

The overall cost trends increased by 3.7%, lower than last year's increase of 5.2%. Once we back out the effect of product mix differences that favored higher cost products such as Medicare Advantage, the trend was 3.4%, down from 5.5% in the prior year.

While growth in most clusters of expenses diminished, Medical and Provider Management accelerated. This was driven by Provider Network Management and Services. Two additional important factors were growth in Customer Services and Corporate Services.

Health plans participating in this year's study were about evenly divided between those that are independent versus those that are provider-sponsored. We endeavored to adjust for product mix and cost of living differences. Information Systems costs tended to run lower in vertically integrated organizations however we are unclear why that is the case.

The restoration of the Health Insurance Tax has caused Miscellaneous Business Taxes to increase from 11% to 20% of commercial insured product costs. We haven't included the effect of this in any of our trend analyses since they are impractical to manage. Needless to say, cost growth would have been much higher had we included the effect of this.

This presentation, (transcript and slides) will be posted on our web site, hopefully later today. In addition to these slides, we include last year's values, some descriptive materials and, perhaps most interesting, a slide analyzing costs by segment. By segment, I mean ACA and non-ACA individual and small, medium and large groups. There is also a description of our benchmarking process.

Later this summer, we will host similar web conferences for Medicare and Medicaid plans. Additional information, including tables of contents on the benchmarks themselves are found on the website. Call me if we can elaborate.

Thank you for your attention to our presentation. Now I would like to open this for questions.

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Q. Why do you think that customer services costs increased so sharply?

A. We are not certain from a strategic perspective. It may have been a commitment to develop a "high touch" organization, presumably benefiting retention and growth, but that is not available through our survey.

But we do know that the staffing ratios and compensation, which drive PMPM cost trends, are both notably higher.

Q. Why do you think that broker commissions declined?

A. We haven't looked at commissions product by product and so cannot tell you for certain. But it is notable that it has declined both after eliminating the effect of mix differences and with those mix differences included. So it may be both the effect of an emphasis on products that favor internal distribution systems, like ASO and Medicare, as well as declines in commissions even within products that are more frequently sold through brokers.

Q. Where is utilization management found in this analysis?

A. It is found in the Medical and Provider Management cluster, in the Medical Management/Quality Assurance/Wellness function. Depending on which activity you are referring to, it will be found in any of the nine sub-functions shown on slide 20.

Q. How is telehealth handled?

A. Here is our guidance on this:

> Physician services delivered telephonically. This is care provided to the members by physicians who are licensed in the state of the service area of the plan and these physicians can prescribe medicines. Both "visit" charge and the access fee should be charged to health care. Administrative costs related to managing the relationship should be in 6 (b) Provider Contracting.

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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 early September, 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.

I want to once again thank the participants for the hard work that has gone into the 17th annual edition of the IPS benchmarks. Participation pays off in lower costs. But the "by-product" is something that benefits the industry as a whole. Thank you!

This is Douglas Sherlock of Sherlock Company.