Transcript

Medicaid Plans Post a Deceleration in Core Expenses

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<Title Page>

I'm Doug Sherlock. Welcome to our summary of the *Sherlock Benchmarks* for Medicaid plans. This is the final presentation in a series that covers the 2020 results of the *Sherlock Benchmarks*. We will be posting the slides and the transcript of this presentation within 24 hours.

To speed through my presentation, the audience will be muted during the presentation itself. I very much welcome your questions at the end of this presentation.

We've posted the three previous presentations on our web site, along with transcripts and MP4s, so I hope you will access them if the Blue Cross Blue Shield, Independent/Provider-Sponsored, and Medicare - Focused health plan information would be helpful.

The 10 Medicaid-focused plans that are chief the subject of this presentation have a combined revenue of $45 billion. On average, 54.5% of the membership is Medicaid HMO and Medicaid CHIP. We believe this universe and the resulting data and analysis to be quite robust.

This year marks the 23rd year of the *Sherlock Benchmarks*, and the 18th for the Medicaid - focused universe. With the closing of our 2020 cycle, our cumulative experience reflects 893 health plan years, and includes Independent / Provider – Sponsored Plans, Blue Cross Blue Shield Plans, Medicaid Plans and Medicare Plans.

<Slide 2>

I'm going to breeze through this slide. It shows the topics that I will address, and lists some of the appendices. The body of the presentation touches on Medicaid as a government health program, discusses trends among continuing plans and the reasons for them, reports cost ratios and provides comparisons with similar Medicaid products offered by our other universes. Eight out of the ten plans that participated in the Medicaid benchmarks were repeat participants.

The appendices contain last year's values and a list of all of the functions in each of the products offered by these health plans. That means that administrative expenses are segmented into more than 700 expense/product cells, each of which are separately analyzed. Also, we touch on our methods of surveying, validation, analysis and reporting.

<Slide 3>

Slide 3 shows the US Census Bureau's analysis on health insurance coverage from 2013 through 2019. The proportion of uninsured Americans dropped from 13.3% in 2013 to 8.0% in 2019, a 5.3 percentage point decline. I have circled those percents in red. Of the 15.7 million newly covered, the 900,000 additions to Medicaid beneficiaries composed about 6% of the newly covered people. These values are circled in blue.

The upshot of this slide is that, since 2013, the number of people without insurance has declined due to the Affordable Care Act, with Medicaid playing an integral part. But this happy outcome is complex. While the 2019 uninsured rate approximated its nadir of 2017, the number of Medicaid members has generally trended lower from its high point in 2015 of 62.4 million, to 55.9 million in 2019. At the same time, Employment-based coverage generally increased in each year since 2013. It plateaued in 2017 and 2018 and accelerated in 2019, for a cumulative increase of 8.6 million people since 2013. Reducing uninsured rates can take many paths.

This benchmarking study captures administrative cost trends for health plans with a high degree of commitment to Medicaid. Ten plans participated in the Medicaid edition of the *Sherlock Benchmarks*. They collectively served 5.5 million members in these products. While Medicaid is typically the predominant product, it is not the only product offered by our participants. On average, Medicaid HMO and Medicaid CHIP comprises 54.5% of plan membership in this universe, with Commercial Insured, Commercial ASO and Medicare among the other products. I imagine in some cases the

same members served by health plan's Medicaid MCO products are otherwise served by their commercial products as employment and family circumstances change.

By virtue of their share, we think that the plans here represent industry trends. The plans that participated in the 2020 *Sherlock Benchmarks*, Medicaid and the other Sherlock universes that we discuss today, serve approximately 13% of all Medicaid members, using the Census Bureau estimates as a denominator. While we aren't able to reconcile Kaiser Family Foundation and Census Medicaid enrollment estimates, if we assume with Kaiser that 69% of Medicaid members are in MCOs, then our samples apparently serve approximately 19.2% of all Medicaid MCO members.

Having said that, I acknowledge that the participants in all our Benchmarking studies are self-selected. That is, on the grounds that "you manage what you measure," the participants may disproportionately reflect those with an interest in optimizing their costs.

<Slide 4>

This slide summarizes long term administrative cost trends for Medicaid - focused plans, which as you can see, has tended to increase since 2012. When I speak of growth in costs in this presentation, including this slide, it will generally be in *per member* terms, for continuously participating plans, after having reweighted the trends to exclude the effects of any changes in product mix.

The darker of the two lines represents *Core* expenses, which are total expenses less Sales and Marketing. We exclude Sales and Marketing expenses from Core expenses since rules for Medicaid marketing vary from state to state with some being highly constrained. Core expenses have generally increased since 2015 but decelerated in 2019.

The lighter line is the annual rates of increase in Account and Membership Administration, which accelerated to growth of 9.7% in 2019, its highest level in the past eight years. This expense cluster is Enrollment, Customer Services, Claims and Information Systems. This cluster is of particular interest since it composes the direct administrative activities of health plans: enrolling members, fielding calls and processing claims, whether manual or automated through information systems. It also includes administrative costs of behavioral health and pharmacy benefits. In addition to composing some central activities of health plans, this cluster's activities tend not to be

quite as subject to economies of scale as finance and accounting or corporate executive and governance.

In the slides that follow, we'll discuss the trends in all four clusters, and touch on the trends of the individual functions. As we will develop, most functions increased and the most important sources of growth were Information Systems, Medical Management and Provider Network Management and Services.

We will also drill into the expense drivers. By that I mean non-labor expenses, staffing costs and staffing ratios. For instance, inferred Medicaid Core Staffing Ratios were higher. We'll also touch on outsourcing, which was lower.

<Slide 5>

This slide is a summary of the cost trends for continuously participating plans in 2019. These columns are organized by year, 2018 and 2019, showing each cluster's growth.

On the previous slide, we showed increases in per member Core Administrative Expenses, of 4.4%, and in per member Account and Membership Administration, of 9.7% for 2019. They are shown on the fourth column, labeled "Constant-mix", "2019 Increase", and I have circled them in blue. The fourth and second columns reflect cost trends among *continuously participating* plans, *backing out the effect* of product mix and changes in those plans between the two years. I consider this the real increase. The dark blue arced arrow is to draw your attention to the comparison with prior year's values.

The two columns that are labeled "as-reported" reflect per member trends in continuous plans. The as-reported columns are linked by an unfilled arced arrow.

Growth rates are faster in the as-reported comparison in 2019 relative to the constant mix growth rates. This faster growth suggests shift in favor of more expensive products, like Medicare Advantage, and that is what happened. For continuously participating plans, membership in high cost Medicare Advantage increased at a median rate of 5.5% as Medicare SNP grew by 8.6%, while Medicare Supplement fell by 5.7%. Commercial Insured declined by 10.2% while Commercial ASO increased by 0.9%. Low cost Medicaid HMO fell by 0.8% and lower cost Medicaid CHIP increased by 4.6%.

Except for Corporate Services, every cluster experienced accelerating per member cost growth regardless of whether they are as-reported or constant-mix. On a constant-mix basis, Account and Membership Administration was the fastest growing at 9.7%. Medical and Provider Management increased by 7.1%, while Corporate Services cluster fell by 2.3%. While not included in Core expenses, Sales and Marketing posted a 5.6% increase.

The as-reported rates of change were parallel to those on a constant mix basis. Account and Membership administration had the sharpest growth and greatest acceleration, followed by Medical and Provider Management. Corporate Services declined. Sales and Marketing accelerated faster as well. Again, the shift in mix towards more expensive products made as-reported growth rates faster than when mix is held constant.

<Slide 6>

Slide 6 shows the rates of change and the most important reasons for the changes, after eliminating the effect of product mix differences. Again, 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.

Costs in Core expenses increased by 4.4% PMPM. The Account and Membership cluster was the fastest growing cluster and posted its fastest growth rate compared to the past eight years at 9.7%. By the way, this includes the effect of Behavioral Health and Pharmacy administration, which also increased in 2019. Information Systems was the cluster's fastest growing functional area and the most important source of growth for this cluster and in total. Customer Services also increased, up by high single digits. Conversely, Enrollment and Claims fell by single digits.

This cluster's median compensation and inferred Medicaid staffing ratio were higher than last year. Conversely, propensity to outsource, and non-labor costs per FTE were lower.

This is a good time to underscore a Sherlock Benchmark reporting convention. Outsourcing is common among health plans, including those focused on Medicaid. The median outsourced *core* FTEs is 10.0%, but range from a low of 0.0% to a high of 45.3%. To avoid distortion of staffing ratio, we consider it helpful to add outsourced FTEs to

internal FTEs for its calculation. Similarly, we adjust staffing costs per FTE and Non-labor costs per FTE for any outsourced activities.

Also, when I refer to inferred Medicaid staffing ratios, I am referring to a calculation to allow comparability between plans and years irrespective of mix. The underlying assumption in ascribing staffing to a product is that the same mix of labor and non-labor is employed in each product.

The cluster of Medical and Provider Management grew at the second fastest rate, at 7.1%. The Provider Network Management and Services was the fastest growing, but the Medical Management functional area was the most important source of growth in this cluster. All Provider Network sub-functions increased, and the Medical Management sub-functions that posted increases were Nurse Information Line, Health and Wellness, Quality Components, Medical Informatics and Other Medical Management.

The Medical and Provider Management cluster's combined staffing costs per FTE and inferred Medicaid Staffing Ratio increased, while non-labor costs per FTE and outsourcing were lower.

The Corporate Services cluster was the only *cluster* to post a decline, dropping by 2.3%. The decline was driven entirely due to the Corporate Services *function*. The Corporate Services sub-functions that fell included Outside Litigation, Purchasing, Imaging, Printing and Mailroom, Risk Management, and Other Corporate Services function.

Median propensity to outsource, Non-Labor costs, and staffing ratios for the Corporate Services *cluster* decreased, while compensation was higher. All factors driving Corporate Services *function* were lower, including Staffing Ratios, Staffing Costs per FTE, Non- labor Costs per FTE and Outsourcing. The fastest rate of change in this cluster was the increase in Actuarial.

As noted previously, the Sales and Marketing cluster is not included in Core expenses. Nevertheless, this cluster is central to the Commercial and Medicare products offered by Medicaid-focused plans. Also, Risk Adjustment (including for Medicaid) is classified as a sub-function of Rating and Underwriting, included with this cluster.

The Sales and Marketing cluster increased by 5.6% on a constant-mix basis. Marketing was the cluster's fastest growing function, but Commissions was the most important

source of growth. Median Sales and Marketing compensation, outsourcing, and inferred staffing ratios increased, while non-labor costs per FTE was lower.

Total expenses, including Sales and Marketing, grew by 5.5% on a constant-mix basis. Information Systems dominated growth.

<Slide 7>

This slide explains the *reported* rates of change, that is, the values with no adjustments for the greater proportion of more costly to administer products. Like in the prior slide, these trends are based on continuous plans.

For the most part, the greatest changes and highest weights functional areas were the same regardless of constant-mix or as-reported basis. In the Corporate Services *cluster*, the Corporate Services *function* had the fastest rate of change on an as-reported basis, compared with Actuarial on a constant-mix basis. While not a core function, Rating and Underwriting posted the fastest growth in the Sales and Marketing cluster on an as-reported basis. This displaced Marketing, which was the fastest Sales and Marketing functional area on a constant-mix basis.

Let me close this part of our presentation with a few summary observations. All my trend comments are based on continuously participating plans.

Overall, the median core Medicaid staffing ratio was higher for continuously participating plans at 23 FTEs per 10,000 Medicaid members. Of the 14 functional areas with staff, eight had staffing ratio increases and six had declines.

The median core compensation per FTE was about $102,000, which increased by 6% from last year, but varied by function. Customer Services posted the largest increase within *core* functions, while Marketing was the largest increase in total functions. Of the 14 functions with staff, 10 experienced increases from a year ago.

Propensity to outsource was lower than last year in total. Of the 14 functional areas with staff, four increased outsourcing, while two functions were flat from last year, and eight were lower.

<Slide 8>

To this point, we have focused on rates of change rather than the underlying values of the components of administrative costs. The next few slides speak to the values of these activities, though it is necessarily a summary.

Let me offer a word about this universe of plans. For all ten of them, Medicaid HMO and Medicaid CHIP together composed an average of 55% of membership and 44% of revenues for comprehensive products. The median Medicaid membership was 40%, and its revenue proportion was 35%. In comparison, Commercial products represented a median of 50% of membership and 29% of revenues. Combined Medicare Advantage and SNP represents a median of 10% and 23% of members and revenues, respectively.

Bear in mind that this universe of Medicaid-focused plans differs from that of last year in product mix and in populations. There were 12 plans that participated in *last year's* study, four plans dropped out of the universe from a year ago and there were two additions. Therefore, it is not possible to perfectly compare the performance of plans participating in this and last year based on this slide.

For all 10 participating plans in this year's study, the median core PMPM value of $34.00, was 2% higher than last year's median of $33.48. The prior year values are shown in Appendix A to this presentation and are also excerpted on this page.

Account and Membership Administration increased by 4% to a median of $18.01. This cluster is about 42% of the total costs to deliver coverage products to this universe. It is the central elements of Enrollment, Customer Services, Claims and Information Systems.

The Corporate Services Cluster posted a median PMPM cost of $6.69 and was lower by 11% from last year. Medical and Provider Management cluster's costs was $8.99 and was 1% less than the prior year. Sales and Marketing 4% lower, with a median PMPM cost of $8.48, while total expenses were at a median of $42.42, higher by 2%.

Dispersion for Core Expenses, measured by the coefficient of variation, was tighter than last year, falling by 3 percentage points. Dispersion also tightened for Account and Membership and Corporate Services cluster decreasing by 3 percentage points and 4 percentage points, respectively. Dispersion for Medical and Provider Management widened, increasing by 2 percentage points. Dispersion in Sales and Marketing

increased by 9 percentage points, while falling by 2 percentage points for Total Expenses.

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As we discuss in previous slides, we believe that analyses that reduce or eliminate the effect of product mix is a better way of understanding trends. This slide illustrates why. Note that this slide *includes* Sales and Marketing except for the measures noted at the bottom.

Medicaid products are relatively low at for Medicaid HMO at $28.93 PMPM and Medicaid CHIP at $25.14 PMPM. By contrast, Medicare products are relatively high cost at $102.09 and $228.89 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. So a shift in favor of Medicare would artificially increase the trends in costs, as we saw in 2019.

Medicare Supplement is a product sold to seniors in lieu of Medicare Advantage. It is a lower than average cost product at $36.10 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Four of the 10 plans offer this low-cost product.

The Commercial Insured HMO, POS, and Indemnity median costs were $51.35, $49.92, and $52.56, respectively. These are roughly one-half the per member cost of Medicare Advantage.

Self-insured Commercial ASO products are about half the cost of the insured Commercial products. An ASO group possesses the statistical advantages of larger size, which allows the sponsor to self-insure. It also means that their Sales and Marketing costs are spread through a greater number of members, driving down per member Sales and Marketing and Enrollment costs. The Median Commercial ASO product was $20.75.

There is a note at the bottom that relates Medicaid products to some of the earlier slides on trends in aggregate and by cluster of functions. Per Member Per Month *Core* Medicaid expenses were $25.80 PMPM. Medicaid HMO and Medicaid CHIP were $26.08 and $21.02, respectively. Note the very modest differences between the median total costs at the top of the figure and the Core expenses expressed in the note at the bottom. These Sales and Marketing costs for Medicaid are typically modest, but we do

include Rating and Underwriting, including Risk Adjustment, within this cluster. You can get a rough sense of Medicaid Sales and Marketing by subtracting the values in the note from the values in the body of the chart.

<Slide 10>

This is similar to the previous slide, only expressed in percent of premium equivalents. By premium equivalent I mean, for a denominator, we have added medical expenses to the fees on self-insured relationships.

The median administrative expense relative to premiums was 8.5%, higher than last year's value of 8.3%. In many cases, the relationships between the costs of various products measured in percents parallel those measured in PMPM values.

Medicaid HMO was lower than comprehensive total on both a PMPM and percent of premium basis at 7.3%. Much smaller Medicaid CHIP was lower than comprehensive total on a PMPM basis but, at 10.9%, is higher than comprehensive on a percent of premium basis. Overall, Medicaid was low using either metric.

Medicare SNP, the highest cost product on a PMPM basis was tied for second highest on a percent of premium basis at 11.7%. Meanwhile, Medicare Advantage expenses, while about two times greater than Commercial HMO Insured products on a PMPM basis, is higher but much less so on a percent of premium basis, at 10.4%.

While Medicare Supplement is below comprehensive total when measured on a PMPM basis, at 13.0%, its cost ratio was the highest among the comprehensive products.

On a percent of premium basis, administrative expenses for Commercial Insured POS, HMO and Indemnity were 7.9%, 9.6%, and 11.7%, respectively. These products are higher than average for this universe. In general, commercial insured products are higher than average both on a percent and on a per member basis.

Commercial ASO products are 5.4% on a premium equivalent basis. It is also relatively low cost when measured on a PMPM basis. The lower Sales and Marketing for self-insured groups is key reason for this difference.

Core expenses as a percent of premium for Medicaid Total was 6.7%, while Medicaid HMO was also 6.7%, and Medicaid CHIP was 9.5%. The differences between total and core are minor since Sales and Marketing costs are modest for this group of products.

<Slide 11>

This slide shows the administrative expenses by cluster of functions, expressed in percent. As in the previous slide, core costs were a median of 6.6% of premium equivalents, approximately flat from last year. Account and Membership Administration was 0.5 percentage points higher than last year at 3.6%, loosely corresponding with its rapid PMPM growth. Medical and Provider Management was higher by 0.03 percentage points to 1.8%. The Corporate Services cluster was lower by 0.3 percentage points to 1.3%. This loosely corresponds with the decline in PMPM costs in 2019.

Sales and Marketing was slightly lower by 0.1 percentage points to 1.8%.

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The health plans participating in our benchmarking studies segment their costs by product. So, we can compare the same products *across* universes. Medicaid-focused plans generally have costs that are lower than their peers for Medicaid HMO.

The percent of premium metric could possible have the advantage of capturing member acuity so low costs using this metric might best indicate the advantages of focus. Medicaid HMO Core expenses for Blue Cross Blue Shield Plans were 8.2% of premiums, were 1.5 percentage points higher than Medicaid plans.

Medicaid HMO Core Independent / Provider – Sponsored plans were higher by 1.3 percentage points at a median of 8.0%. (The differences are due to rounding.) For *Total* Expenses, Blue Plans' percent of premiums at 8.6% was higher by 1.3 percentage points. On a percent of premium basis, IPS plans were 1.5 percentage points higher at 8.6%.

The PMPM differences largely corroborated this. Compared with the Medicaid universe, Medicaid HMO Core expenses for Blue Cross Blue Shield Plans were $39.89 PMPM, or $13.80 greater than Medicaid-focused plans. Blue Cross Blue Shield Plans had *total* median expenses of $43.04 PMPM, and was $14.10 higher than Medicaid plans.

For *Total* Expenses, Independent / Provider – Sponsored plans posted a median of $29.09 PMPM, higher by $0.15. The one exception to this is that *core* Independent / Provider – Sponsored plans were lower by $0.11 PMPM versus the Medicaid-focused plans, with a median of $25.97.

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Let me close by summarizing. The core cost trends grew by 4.4% (constant-mix) or 5.4% (as-reported), Account and Membership continued its acceleration in cost growth from last year and was the fastest growing cluster. The only core cluster to post a decline was Corporate Services. Sales and Marketing, while not a core cluster, accelerated posting increase of 5.6% on a constant-mix basis.

Information Systems was the most rapidly growing core functional area and the most important source of growth. Provider Network Management and the Actuarial functions also grew rapidly. Within the Sales and Marketing cluster, Marketing was the fastest growing, while Broker Commissions was largest growth driver.

The median core Medicaid staffing ratio was higher for continuously participating plans, at 23 FTEs per 10,000 Medicaid members. Of the 14 functional areas with staff, eight had staffing ratio increases and six had declines.

Median core compensation per FTE increased but varied by function. Including the functions within the Sales and Marketing cluster, 10 of the 14 functions with staff experienced increases from a year ago. Customer Services posted the largest increase within core functions, while Marketing was the largest increase in total functions. The median core compensation was $102,000 per FTE and compensation for all functions was $105,000 per FTE.

Propensity to outsource was lower than last year in total. 4 out of the 14 functional areas with staff increased outsourcing, while two functions were flat from last year, and eight were lower.

In closing, this presentation, (transcript and slides) will be posted on our web site in the next few hours. In addition to these slides, we will include last year's values and some descriptive materials.

You will also find the presentations on Blue Cross Blue Shield, Independent / Provider – Sponsored, and Medicare-focused trends. Please contact me for information on licensing these universes. Additional information, including tables of contents on the benchmarks themselves are found on the website. Reach out if you have any questions.

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

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Questions and Answers

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Thank you again for your participation in this web conference.

I want to close by hoping that none of you and yours were directly affected by the coronavirus but, if you were, I hope that you or they made a speedy and complete recovery.

Once again, I want to thank everyone involved in the 18th annual edition of the Medicaid benchmarks for their insights and hard work. Participation pays off in lower costs for the plans, but we hope that the results benefits the industry as a whole.

I especially thank my outstanding team at Sherlock Company for making this possible.

Finally, I would like to remember Randy Edwards, former CFO of Blue Cross Blue Shield of Georgia. Randy was the catalyst for the Sherlock Benchmarks, and passed away in June. Let light perpetual shine upon him.

This is Douglas Sherlock of Sherlock Company.