Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

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How does Medicaid Affect Commercial Administrative Costs

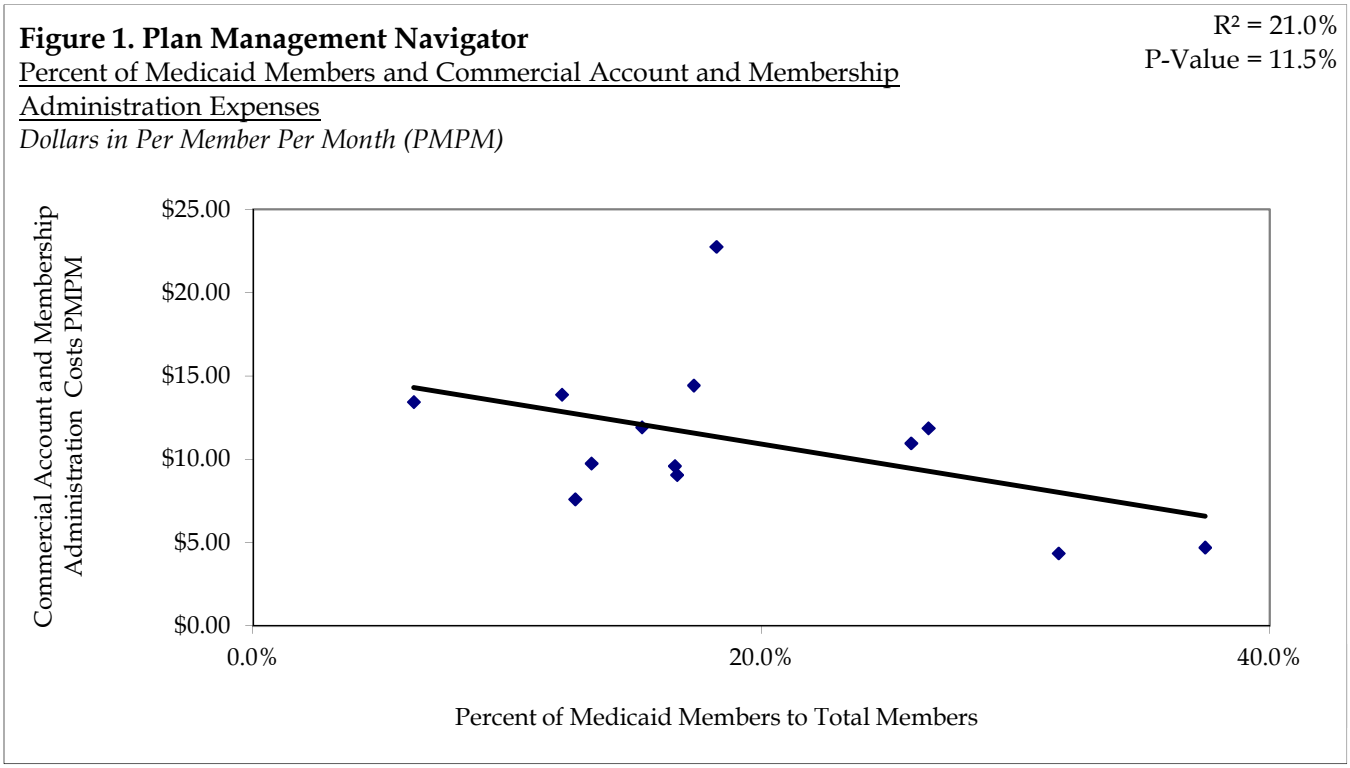
Background: This is the second of a series of Plan Management Navigators *focused on Medicaid and Medicare plans. They expand upon presentations made before Independent Provider-Sponsored and Blue Cross Blue Cross Plans in San Antonio in March in connection with the 18th Annual Sherlock Benchmarking study for health plans. The regression analysis based presentations were intended to draw comments from the participants on the scope of metrics to be included in the Benchmarking Study, and to sharpen the definitions of those metrics.*

A friend of Sherlock Company recently wrote us of his idea about one way of encouraging a culture of conservative administrative costs. Based on his experience with a national diversified health plan and a Blue Cross Blue Shield Plan, he believed that a "larger percentage of Medicaid" was associated with "much lower Account and Membership Administration costs (Enrollment/Membership/Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information Systems)" in the other parts of their business, such as commercial.

He offered two reasons why this may be the case. (We slightly edited his comments.)

1. "Medicaid is a highly regulated program where major shifts in benefit design and administrative requirements occur infrequently, and where cost is a major driver of program design and management. Benefit design and administrative requirement changes are often coordinated between the managed care plans and the state, such that the burden of resources and cost is spread over a mutually agreed upon time frame to avoid spikes in cost which the plans are reluctant to absorb. They often lag behind the commercial and Medicare Advantage sectors in making such 'investments.' They are also very price-sensitive to vendor proposals as well."

Figure 1. Plan Management Navigator
Percent of Medicaid Members and Commercial Account and Membership Administration Expenses
Dollars in Per Member Per Month (PMPM)



2. "Many Independent/Provider-Sponsored plans are organized around either a class of providers referred to in the PPACA as 'essential community providers', e.g., non-profits such as federally-qualified community health centers, or from provider groups formed at the urging of or in response to health plan contracting or hospital system initiatives. These latter entities run with very low overhead. Many of their more advanced capabilities were not funded from internal capital, but instead from endowments, grants, health plan/hospital system infrastructure subsidies and other externally provided sources. This mindset also influences how they approach health plan capital investments, from a conservative funding perspective. Their emphasis is not on what the health plan needs, but what their providers are looking for. Truly a classic privately held small-business management model, not what is usually seen from traditional health insurers."

While his is a plausible hypothesis, we can't be certain without testing it. After all, some health plans operate their Medicaid operations using an entirely different platform so that conservative administrative practices in Medicaid would not necessarily translate into conservative administrative practice in commercial lines. Also, plans selling Medicaid may even outsource their Medicaid administration to dedicated specialty TPAs. Additionally, some of the plans are not provider-sponsored so the effect of any capital constraints on organizations that are not sponsored by providers would be indirect.

So we tested his hypothesis by regressing the percent of total members that were Medicaid against the PMPM costs of Account and Membership Administration in the health plans' dominant commercial segment. The organizations included were the 13 health plans that offered both Medicaid and commercial products that participated in the 2014 Benchmarking Study. The slope implies a decline in PMPM costs of $0.25 for every 1.0 percentage point of Medicaid membership relative to total membership. The P-Value of 11.5% is suggestive that it is unlikely that there is no relationship between commitment to Medicaid and commercial costs. The R^2 means that the regression line explains 21% of the differences between the points.

Based on this, we think that our friend may likely be onto something. Additional information about this insightful consultant is available upon request.

Sherlock Benchmarks. The Sherlock Benchmarks are considered the "gold standard" for management of health plan administrative expenses. Health plans serving more than 109 million people are users of the 2014 editions. Most Blue Cross Blue Shield Plans use the benchmarking studies and nearly one-half participate. The 23 participating plans in the Independent /Provider-Sponsored universe serve approximately 10 million members. We circulated the Blue and IPS surveys to their respective universes in late March.

Medicare and Medicaid surveys will begin later. Because of the time required by finance and accounting personnel to prepare Medicare Advantage bids, we will distribute our Medicaid and Medicare benchmarking surveys in early June. **We are actively recruiting participants for these universes.** All functional area costs are segmented by product so it is noteworthy that the 16 so-far committed plans offering Medicaid recruited in other universes serve approximately 1.9 million Medicaid members. The Medicaid results for many of these plans will be included in the 2015 Sherlock Benchmarks.

Please contact Douglas B. Sherlock, CFA if you are interested in considering participation. He can be reached at sherlock@sherlockco.com.