

MEASUREMENT, MANAGEMENT AND MEDICAL PLANS

While competitive pressures are likely to become more acute for health plan administrative costs, the evolution of the health insurance product will mean that each functional area may be affected differently. While most areas are likely to experience improved performance, medical management and sales cost trends are more dependent on the type and mix of products offered to consumers. Corporate finance opportunities will not, in and of themselves, necessarily make a meaningful contribution to improved performance.

Operations Matters

Main Driver

As a rule, money first enters the health care system in the form of health insurance premiums. Then it is divided into health benefits and health plan administration of a kind that is external to health care delivery. Some activities fall into a “gray area” reflecting the uncertainty about the form of health care preferred by consumers. Despite the separation between the delivery of care as health benefits and health plan administration, health plans continue to serve as a unique gateway to health care and are inextricably linked with the combined health care product.

Today’s most important industry driver is the continuation of the trend towards increased accountability of the industry to consumers. Accountability entails choice based on quality and cost and consumers know viscerally that competition by providers for consumer preferences enhances quality for all users of health care. However, accountability requires that units of delivery be defined and measured so they can be compared. To the degree that units of delivery are left undefined, at least in a way that is intelligible to consumers, consumers will be disappointed in their experiences. The degree of pressure for improved performance of functional areas will depend prima-

rily on the ability of consumers to measure such performance.

Health Benefits

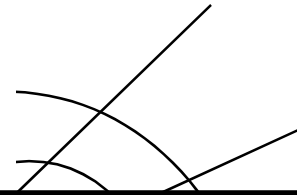
The measurement of health benefits is in great turmoil. While health benefit costs are the vast majority of health care costs, the end of managed care has meant that the industry is now moving away from the annual cost of care model and towards a more granular unit of service model, exemplified by consumer-directed health care. While this probably reflects a reaction to the past commandeering of consumer choice by employers, it has at least temporarily led to less bundled units of delivery. Consumers are poorly equipped to assess quality of unbundled services at present.

Nevertheless, the degree of bundling of individual services that consumers will find convenient is unknown. There will be iterative efforts to define the unit of delivery, measure the quality and costs of how providers deliver it, identify the methodological drawbacks of such measurement, and employ this knowledge to re-define the units of delivery. This process is complicated by technological advancements

In addition, consumers believe that reducing costs may create quality problems offsetting the appeal of savings. For health benefits, consumers believe that suboptimal quality may be catastrophic. For these reasons, competitive pressures will often be deflected from providers.

Health Plan Administration

Often slighted as “overhead,” no similar ambivalence regarding tradeoffs between quality and cost exists for health plan administration. While much smaller than health benefits, administrative costs can be more readily measured and managed by an insurer and are unlikely to result in catastrophic outcomes for the consumer in the event that the management of the costs is too aggressive. So, while the units of health care delivery are still being determined, the reduction



of administrative costs will be subject to aggressive attention in consumer demands for accountability.

Enrollment, customer services, provider relations services and claims will be the focal point of cost management efforts. It is fortuitous that consumer focus on these costs occurs at a time in which Sherlock Company makes it increasingly possible to measure operational and financial performance while implementation steps are increasingly possible thorough connectivity and other technologies. Many vendors, ranging from consultants to software providers seem to be aggressively pursuing the opportunity to assist health plans in this matter.

as disease management, pharmaceutical benefits, mental health and so forth.

Surprisingly, sales and marketing costs also reflect how these unresolved unit-of-delivery issues impact health insurance plan design. The effect is strong if indirect: The more granular the unit of delivery, the more varieties of product design may be available, but the cost of such variety is the need for marketing people to assist consumers in their choices. At \$11.00 PMPM for broker commissions for broker members, flexibility has significant costs, as shown in Figure 1. By contrast, recall that in the 1980's both HMOs and

Figure 1. Measurement, Management and Medical Plans

Cost of Broker Commissions

	Amounts	Pct. Total Admin.	Pct. Broker Admin.
Total Administrative Costs	\$24.95	100.00%	NM
Broker Commissions	<u>3.69</u>	<u>14.80%</u>	NM
Administration Less Broker Commissions	\$21.26	85.20%	64.70%
Broker Commissions for Broker Members	<u>11.61</u>	NM	<u>35.30%</u>
Administrative Costs for Broker Members	<u>\$32.87</u>	NM	<u>100.00%</u>

Source: Sherlock Expense Evaluation Report 2005.

Medians for Blue Cross Blue Shield Plans.

Complications on the Frontier of Administrative Costs

Some costs are difficult to manage, ultimately stemming from continuing uncertainty about the form in which consumers will ultimately prefer to receive their health care. These costs form a "boarder land" between health care benefits and health plan administration.

Medical management costs incurred by health plans will reflect the experimentation with the definition of units of health care delivery and managing costs within those units. For instance, medical management is more developed in HMO product lines (especially in the prepaid group practice sense) than in indemnity insurance, so that whether it should be considered to be health benefits or administration can arguably depend on the unit of delivery preferred by the consumer. Other "gray area" examples include health benefits outsourced on a capitated basis such

Figure 2. Measurement, Management and Medical Plans

Information Systems and Complexity

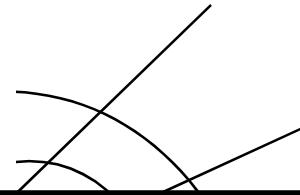
	Blues	P-S
IS Costs per FTE	\$26,992	\$18,238
IS Costs PMPM	\$4.83	\$2.79

Source: Sherlock Expense Evaluation Report 2005

Blues offering "first dollar" coverage rarely needed to reach consumers through insurance brokers.

Finally, the costs of information systems intended to support a wide variety of product designs, benefit parameters (copay options, sublimits, deductibles, coverage options) and health care unit of delivery





choice are apparently very expensive. Figure 2 shows that the provider-sponsored health plans that offer relatively simple product areas tend to have low information systems costs. Blue Cross Blue Shield Plans incur 50% greater information systems costs than do their more narrowly focused provider-sponsored health plan competitors.

There is an interesting paradox between the scope of the products offered and the costs of offering them. If a plan offers many products, the first order effects are likely to be an increase in administrative costs. If the plan is successful in gaining share however it is likely to benefit from economies of scale and, more importantly, bargaining power with providers.

It is worth reemphasizing that these administrative functional areas are dependent upon the unit of delivery of health benefits and the progress that is being made to achieve consumer expectations about it. Because we think that no consensus has arrived or is on the horizon, it may be prudent for firms considering new products to share the development risk for new products with others.

The dominance of health benefits over administration and its close relation to health outcomes will mean that cost pressures on administration are likely to survive any resolution of their respective definitions. To use an analogy from the shipping industry, most consumers would prefer superior reliability of deliveries with mediocre tracking to good tracking system with mediocre delivery reliability.

Corporate Finance Considerations

In the past fifteen years, Blue Cross Blue Shield and other plans have completed many mergers and some have gone public. We generally subscribe to the theory in finance that corporate structure is of limited importance strategically since it can be synthesized through capital markets and other contractual means. While business combinations and conversions make exciting press, it is incorrect to conclude that such activities are always necessary for competitive advantage. The key issue is whether these disruptive and expensive processes add value.

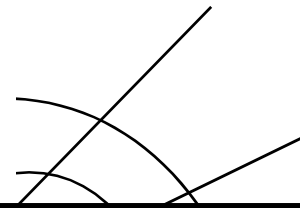
Business Combinations

Administrative economies of scale, geographic diversification, cross marketing of unique products and improved bargaining power vis-à-vis providers are the reasons normally offered by health plans making acquisitions. In today's environment, administrative economies of scale are a core justification, but the benefits are limited and may be synthesized through outsourcing contracts.

Bargaining power vis-à-vis providers is at best a minor part of the current economics of health plan business combinations since intra-market mergers occur so rarely, especially among Blue Cross Blue Shield Plans. While geographic diversification is appealing among Blue Cross Blue Shield plans, their central position in many states limits extreme competitive pressures from competitor local plans or from customers. The very broad mix of products offered by Blue Plans or other larger health plans limits the ability of any plan to offer something unique to others. On the other hand, for other smaller market share plans, or for those focused on Medicaid with its limited number of customers, diversification can be valuable.

Administrative economies of scale are therefore central. But the real advantages are less than many think. First, they are limited. In the recently announced proposed acquisition of WellChoice by WellPoint, only \$50 million in synergies were identified, representing only 10% of WellChoice's administrative expenses. These synergies also included benefits other than administrative expense savings. From Sherlock Company's studies, only about 17% of health plan administrative expenses are unambiguously scalable. But even those expenses that are scalable typically have a gentle slope: A health plan that doubles in size will have scalable expenses that are 83% of their doubled value. Because health plans are a thin margin business, these small improvements can produce a significant improvement in profits but they represent a probably insignificant degree of additional pricing flexibility. So while a case can be made for public companies to make such transactions because they are accretive to GAAP EPS, the appeal is less powerful from a strategic perspective.





Moreover, we believe that firms can *lose* scalar advantages as they execute other strategic initiatives. For instance, much smaller plans, like provider sponsored plans, have lower costs than Blues. This may be due to extremely competitive internal capital markets but we guess it is mainly due to a more narrow focus, limiting their need for intensive information systems costs, as previously noted.

Health plans, in fact, vary in their performance in the execution of scalable functions. Thus, an alternative solution to a business combination is for underperforming plans to outsource, while superior plans should provide outsourced services. The usefulness of contracts is demonstrated by the fact that sometimes health plans that complete business combinations also outsource their scalable functions. Care should be taken to assure that health plans entering such vendor relationships are not regarded as second-class citizens of the vendor however.

Wall Street likes business combinations because investors commonly value stocks based on price earnings multiples. If an acquisition of a firm is completed at a lower multiple than the suitor's, the suitor will report earnings improvements in future years. However, this purchase of earnings growth is not important to the fundamentals of health plan performance however. We do not argue that business combinations have no value; rather their value should be realistically assessed and considered among the other strategic options available to the firm.

Conversion

Many health plans are non-profit and lack access to external equity capital markets. Such Blue Cross Blue Shield Plans are, ironically, fully taxable placing them in the worst of all possible worlds from the standpoint of building net worth. However, lack of access to the equity markets has not proven to be a decisive competitive disadvantage.

We have no blanket recommendations for such plans considering conversion since each circumstance is different. We think that considerations for conversion of a non-profit health plan are as follows:

- Is it *optimal* to forward the mission of the plan? This depends in part on the plan's current mission and on its history. Put a different way, does the conversion create wealth and a structure that better fulfills the mission than the current structure?
- Is the capital necessary, and are the various equity markets (including being acquired by a for-profit) the best way of gaining it? The cash flow characteristics of its products, the nature of the investment required and the effect on income taxes are among the important considerations.
- Does it improve governance? This relates to the corporate mission, but also relates to creating both accountability and appropriate incentives for managers.
- Does it forward any business combination strategies? A health plan's corporate structure should be considered with its prospective business partners in mind.

While the for-profit stock company organizational form has many advantages including capital flexibility, they have not proven overwhelming, and circumstances vary by plan.

Conclusion

Health plans will continue to respond to increasing consumer demands for accountability. Because of the challenge of measuring health benefits, health plan administration will be an immediate focal point of cost control and other improvements.

Corporate finance activities can support these initiatives but are never a substitute for them. Situations vary for firms contemplating conversion, but certain factors should be considered. While business combinations have their appeal, contracts can often synthesize their advantages.

