



*Transcript*

# Independent/Provider-Sponsored Administrative Costs: A Review of 2010 Results

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Welcome to our 2011 summary of the benchmarking study of Independent/Provider-Sponsored plans. This is an unusually timely discussion because the health insurance industry is in a period of stress and its managers are focused on reducing the costs under their own roofs.

The impetus to closely look at administrative expenses arises from a weak economy and health care reform. According to the Bureau of Labor Statistics, 13.9 million people are unemployed and 6.2 million have been unemployed for six months or more. This can only affect health plan enrollments: A June 2011 report by the Kaiser Commission on Medicaid and the Uninsured found that 57% of adults who were unemployed and looking for work were uninsured. Negative operating leverage can result if costs are not managed effectively in an environment when revenues are under pressure.

Health care reform leads to additional pressures on health plan administrative expenses. Premium rate increases will be subject to more intense oversight and medical loss ratios (MLRs) will be subject to strict minimums. In short, health care reform limits managerial latitude in many strategic decisions leaving chiefly administrative cost management as the principal avenue of managerial discretion.

However, indiscriminately slashing costs can harm a plan's competitive position. For instance, reducing customer service costs can harm customer satisfaction and hence member retention. Cutting medical management costs may lead to greater health benefit costs. Health plan managers, and I think that is who most of you are, must



balance the need to drive down costs in the light of the long term competitive objectives of your organizations. We hope that this presentation assists you in some way in optimizing those costs.

The theme that the Independent/Provider-Sponsored plans data suggests is that, when compared to last year, plans are adapting to these changes by slowing cost growth. The key notable exceptions to this are in the Sales and Marketing cluster and in the Information Systems and Corporate Executive & Governance functions.

Before I proceed, I do want to thank all of you who are participants in our various benchmarking studies. While participating plans realize a return on their investment in the benchmarking process, it is nevertheless the case that the summary benchmarks that we'll discuss today benefit consumers and the health plan industry as a whole.

This is the second of a series of presentations on health plan performance metrics in 2011. Later this summer we will summarize the TPAs, Medicare and Medicaid plans' results. All these presentations, including this one, will be posted on our web site.

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Today, I would like to provide a little bit of background on Sherlock Company, the levels of costs that the Independent/Provider-Sponsored plans report and the sources of cost increase in 2010. Then I would like to speak to the costs by product reported by these plans. For the sake of brevity, I have included some supporting information only in appendix form.

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Sherlock Company is now completing its 14<sup>th</sup> consecutive annual survey of health plan operations and, at the end of this round, our benchmarks will reflect approximately 510 health plan years of experience. In all of our universes this year, we estimate the plans collectively serve 50.0 million members. Our benchmarks' focus is administrative expenses and related operational drivers, but they also include many metrics of health care utilization.

Sherlock Company benchmarks are in widespread use by health plans, and health plans serving most insured Americans are users of our 2010 metrics. 70% of Blue Cross and



Blue Shield Plans participate in our benchmarking study, and additional ones license it. 55% of all AHIP Board members work for plans that are users of, or participants in, our benchmarks.

Since the benchmarks are designed for plans' internal use, we have designed it to provide a high ratio of insight to effort, though I gratefully acknowledge that the efforts are considerable. Because we have multiple peer groups, and each of them has their strong suits in reporting, our benchmarks benefit from cross-fertilization across these peer groups.

Plans participating in our benchmarking studies agree to complete our survey form in exchange for the resulting report. Costs must be segmented by product as well as by functional area: that segmentation is shown in Appendix C. We also request numerous other metrics such as staffing, compensation and so forth. Our quality assurance procedures are summarized in Appendix D.

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Today I would like to discuss the results for the Independent/Provider-Sponsored plans. These 15 plans are house-hold name companies often associated with prominent hospital systems. At 385,000 members on average, they are substantial organizations, usually with more than 1.4 billion dollars in annual revenues and are in markets "from sea to shining sea." Their market power is often especially strong locally since they have either ownership links with a health system or at least a vestigial relationship with one. This is especially important because they are disproportionately committed to managed care products such as Commercial HMO, Medicaid or Medicare Advantage. These organizations, Provider-Sponsored or not, are usually "household names" in their regional service areas. Two-thirds of these plans have five or more years of experience participating in our benchmarks.

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Here is a summary of the results for the 2011 benchmarking study, reflecting 2010 calendar year results. (All of the costs are expressed in PMPM values.) Median costs were \$31.99 PMPM. Last year's results, in Appendix A, were \$28.35, with the difference



reflecting actual increases in costs, product mix changes and changes of the participants in the universe.

To analyze the results, we have summarized into clusters the more than 40 functions that the plans report. Appendix C tells what functions go into each cluster reported here. Note that pharmacy and mental health administration is included in the Account and Membership Administration cluster. Also, Miscellaneous Business Taxes are excluded from the Total.

Account and Membership Administration is the dominant cost for health plans at \$11.05 PMPM. This is followed by Sales and Marketing expenses at \$10.09. Provider and Medical Management, at \$5.40, and Corporate Services, at \$4.76, are relatively small clusters of expenses. By the way, the figure numbers refer to our free publication, *Plan Management Navigator*, which is available on our web site, along with this presentation. We distributed this yesterday.

The median costs, expressed PMPM or as a percent of revenues, will be the way that we'll refer to cost metrics. Because medians are the 50<sup>th</sup> percentile value, the clusters won't necessarily sum to the median for total expenses. That is also the case for the 25<sup>th</sup> and 75<sup>th</sup> percentiles.

While I'm discussing calculations, when we make comparisons we try to be as careful as possible make them "apples-to-apples." So, where this slide pertains to all 15 Independent/Provider-Sponsored that participated in the benchmarking study, the slides showing cost *changes* will reflect only those plans that participated in the comparison years. For instance, rates of change for 2010 are for the 12 plans that participated in both 2010 and 2011 surveys.

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This slide shows those rates of change. We see continued moderation in expense growth from prior years, especially in certain clusters of expenses.

On an as-reported basis, IPS plans had per member expense growth that declined from 4.8% in 2009 to 3.9% in 2010. Reweighting the plans' costs to eliminate the effect of changes in their product mix, total expense growth was 2.3%, down from 3.0% in 2009.



Sales and Marketing was one of two clusters that saw growth accelerate. *As-reported*, growth increased from 1.6% to 6.4%. Eliminating the effect of product mix changes, the acceleration was muted, increasing by 4.0% compared with 1.0% in 2009.

Provider and Medical Management costs posted a sharp decline in growth. Growth declined from 9.6% to 1.8% on an as-reported basis and from 9.0% to 0.5% on a constant-mix basis.

Account and Membership Administration was the other cluster, besides Sales and Marketing, to see an increase in cost growth. Growth increased from 2.7% in 2009 to 4.3%, as-reported in 2010, and from 1.3% to 5.0% on a constant-mix basis.

The smallest cluster, Corporate Services, actually declined compared with growth in the prior year. On an as-reported basis, cost growth shifted from an increase of 2.0% in 2009 to decline of 1.0% in 2010. On a constant-mix basis, costs continued their descent from a decline of 4.1% to a decline of 3.9%.

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This slide highlights the functional areas within each cluster that contributed to the changes in costs, on an as-reported basis. Recall that, overall, costs increased by 3.9% PMPM on an as-reported basis. In this slide, the arrows and comments are referring to changes in costs not changes in growth. So an up arrow means that PMPM costs increased in 2010. The column "Greatest Change" refers to the percent change in PMPM costs. The "Highest Weight" column refers to the proportion of the dollar difference in administrative expenses explained by the dollar change in this function.

Growth in all Sales and Marketing functions actually accelerated in 2010. Product Development / Market Research grew the fastest, followed by Broker Commissions. The increase in Broker Commissions was the most important source of functional cost growth, not only in this cluster, but overall as well. Rating and Underwriting and the Sales and Marketing function also experienced increases in PMPM costs.

Provider and Medical Management experienced the sharpest reduction in cost growth. Medical Management grew more rapidly than Provider Management and Services and also comprised the lion's share of the increase in this cluster.



Growth rates increased in 2010 for the cluster of functions that constitute Account and Membership Administration. Information Systems was far and away the most important reason for the increase. Because of its size, Information Systems had the greatest upward effect on costs in this cluster. Enrollment / Membership / Billing grew the second fastest in this cluster, followed by Claim and Encounter Capture and Adjudication. Customer Services costs actually declined.

The Corporate Services cluster of expenses declined by 1.0%, a reversal from last year. Central to this trend were declines in costs in a group of sub-functions containing Human Resources, Legal, Facilities, Audit, Purchasing, Printing and Mailroom. This is a large functional area and so affects overall trends. Other declining functions include Actuarial and Association Dues and License / Filing Fees. Corporate Executive & Governance had a sharp increase in costs, muting the decline in this cluster. Finance and Accounting costs were the only other function in this cluster to increase, at 0.9%.

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I mentioned that there were significant changes in the product mix of Independent/Provider-Sponsored plans, and this slide details them. Membership grew modestly but especially so in commercial. Within the commercial sector, insured membership increased, while ASO declined slightly. However, membership in Medicaid, Medicare and Medicare Supplemental was up sharply. The relatively fast increase in these government products led to the commercial products having a decline in their share of the overall product mix.

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Changes in product mix have an effect upon the expense mixes of these reporting Independent/Provider-Sponsored because the operational support varies so much between products. This slide reflects the contribution of various functions to cost growth after we hold constant the product mix between the comparison years. Expenses grew by 2.3% PMPM, slower than last year's pace of 3.0%. It is also slower than the 3.9% increase on as-reported basis.

Sales and Marketing costs grew by 4.0% PMPM. This could be due to greater optimism about the economy, a shift in distribution systems or both. Broker Commissions were the single largest source of cost increase for the Sales and Marketing cluster, similar to



the comparisons on as-reported basis. Product Development /Market Research and Rating and Underwriting each had low single digit increases. Advertising and Promotion costs, however, actually declined on a constant-mix basis.

Provider and Medical Management cost growth fell dramatically from last year's rate of 9.0% to 0.5%. There are two functions in this cluster: Medical Management (including precert, disease management, case management, etc.) and Provider Network Management and Services (which fields provider inquiries and negotiates contracts). Both of these functions saw moderate cost increases. Medical Management is the larger functional area and is therefore chiefly responsible for the moderating growth in the costs of this cluster.

Just to anticipate a question, this moderating trend was in no way affected by changes in medical loss ratio definitions under health care reform. Regardless of how health plans report to other audiences, and regardless of how they may actually offset the costs of care, we require that they report Medical Management as administrative expenses for our purposes.

Account and Membership Administration costs were the most important factor of cost increases for Independent/Provider-Sponsored with PMPM growth of 5.0%. Information Systems costs grew fastest in this cluster of functions and had the greatest overall impact on this cluster's cost trend. Customer Services and Claims actually had declines in PMPM costs. It is interesting that IPS emphasis on Information Systems mirrors expectations of information systems investments under health care reform. That Information Systems is going in the opposite direction from Claims and Customer Services suggests the possibility of increased automation of these activities.

Outsourcing decreased slightly for Claims but increased for all other functional areas in this cluster. Overall, outsourcing is relatively unusual among Independent / Provider-Sponsored, equating about 7% of total FTEs, a slight increase from last year.

Corporate Services cost growth declined by 3.9%, compared with an decrease of 4.1% last year. Central to the trend were declines in costs in a group of sub-functions comprised of Human Resources, Legal, Facilities, Audit, Purchasing, Printing and Mailroom. Corporate Executive & Governance costs offset this decline with a sharp increase. Finance and Accounting Costs also increased.



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We are not great fans of expressing administrative expenses as a percent of premium since (a) it isn't actionable, (b) it confounds cost performance with factors of revenue yield, (c) it varies quite a bit by product and (d) if one uses GAAP accounting for the revenue denominator, and that revenue is in part ASO fees, then the actual ratio conflicts with normal intuitions about it.

We cannot solve all of these problems, but we addressed one of them as we prepared this slide. Specifically, we employ premium equivalents for ASO products. Essentially, this means that we incorporate health benefits paid for by the benefit plan sponsor into the ASO top line. Our calculations of premium equivalents are discussed in detail in *Late July's Plan Management Navigator*.

This slide shows administrative expenses as a percent of premium equivalents. At 8.4%, it is above the 8.0% in 2009. Account and Membership administration, at 2.7% of premium equivalents, comprises the single largest portion of administrative expenses, followed very closely by Sales and Marketing at 2.6%. Provider and Medical Management costs and Corporate Services costs were 1.3% and 1.2% of premium equivalents, respectively.

While a precise comparison is impossible since medians don't sum and the universes differ, on a percent basis we can see some rough indications of the source of the increase in percentages. Mix differences make summing these medians especially problematic. Sales & Marketing was the only cluster to have an increase in expenses as a percent of premium equivalents. Provider and Medical Management costs did not change, while both Corporate Services and Account and Membership Administration decreased. Appendix B shows last year's ratios.

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Costs vary quite a bit by product which is why our participants segment costs in this way. After all, it not very informative to know that a health plan focused on commercial ASO products has lower costs than one focused on Medicare Advantage. So this slide endeavors to address a second problem: the fact that ratios differ by product.



As shown in this slide, because of their low marketing costs, Medicaid products are generally the lowest cost comprehensive product offered by Independent/Provider-Sponsored at \$17.11 PMPM. ASO products also have relatively low marketing costs: at costs of approximately \$20, they average about \$15 less PMPM than their insured counterparts. Note that these plans sometimes offer products that are very costly to administer. Medicare SNP has costs of \$128.08 and Medicare Advantage has costs of \$68.81. Other products offered to seniors include Medicare Supplemental at \$25.90 and Medicare Cost at \$29.53. At a PMPM cost for comprehensive products of \$31.99, these plans' relative emphasis on insured managed care products is evident.

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This slide shows the administrative expenses of each product offered by the Independent/Provider-Sponsored universe of plans, expressed as a percent of premium equivalents. Note that the commercial ASO product has the lowest costs measured as a percent of premium, at 5.2%

But also note that, expressed as a percent of premium equivalents, Medicare Advantage is also among the lower cost products, at 7.8% of premiums. Medicare has low administrative costs relative to premium in part because the administrative activities tend to be less relative to any health care episode. Health costs per claim submitted to a plan are about 20% higher for Medicare than for commercial lines. For instance, a hospital stay for a 75 year old is often a more intensive experience than for a 45 year old. Since health care costs are much larger than administrative expenses as a factor of premiums, the administrative expense ratio is lower. Medicare SNP, at 7.7% of premiums, is an even stronger illustration of this phenomenon.

Medicare Supplemental represents the converse case. Not all health care costs are included with Med Sup since it interacts with regular Medicare but many of the administrative activities are. Thus, its administrative expenses are high relative to premium, at 11.5%.

Insured commercial products have far higher administrative expenses relative to premiums than their ASO counterparts. This mainly stems from much smaller Marketing expenses though Medical Management tends to be lower in ASO as well. Note that Medicaid percentages are low, also due to low marketing.



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This is the end of my formal presentation. The headline conclusion is that, for Independent / Provider-Sponsored, administrative expenses are 8.4% of premium, an increase from 8.0% last year. Higher marketing costs overwhelmed the mix effect to increase the percent of premiums committed to administration. The pace of administrative expense growth continues to moderate.

Health care reform and the weak economy have increased the need to optimize health plan administrative costs. It is interesting to us that, at least as far as participating plans go, slow enrollment did not lead to negative operating leverage.

Some of the areas that Independent/Provider-Sponsored had increases were in accordance with what one would expect under health care reform and in a difficult economic environment. Notably, Information Systems, Corporate Executive & Governance, and Finance and Accounting were higher. Product Development /Market Research also had notable growth. Provider and Medical Management growth, however, is sharply down from last year.

Many thanks for your attention to this somewhat dry, but I hope informative presentation. I have attached to the end of this presentation some appendices in support of this presentation. They include 2009's costs, the functions found in the clusters we have been speaking of and some notes on our quality assurance procedures and our business model.

Now I would like to open this for questions.

### *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.

In late summer, we will have similar web conferences on the results of the TPAs and the Medicare and Medicaid plans. We hope that you will consider participating in those web conferences as well. Our previous presentation of Blue Cross and Blue Shield is available online.



I want to close by once again thanking all of you who participated in our various studies for your efforts. Your participation not only enhances your own firm's performance but also raises the bar for all other plans.

This is Douglas Sherlock of Sherlock Company.