



Transcript

Medicare Administrative Costs: A Review of 2010 Results

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<Title Page>

I am Doug Sherlock. Welcome to our summary of the benchmarking study for Medicare Plans. This is the fifth in a series of presentations summarizing the health plan performance metrics. Blue Cross Blue Shield financial metrics were summarized in July, Independent / Provider - Sponsored were summarized in August, TPAs were about a month ago, and Medicaid results were summarized about two weeks ago.

Collectively, 60 health benefit organizations participated in our benchmarks this year, compared with 51 two years ago. This probably stems from the fact that increasing numbers of organizations are focused on their operating costs. The weak economic picture pressures enrollment, creating the risk of negative operating leverage. At the same time aspects of health care reform, especially minimum medical loss ratios, make solvency contingent upon administrative cost management. For Medicare plans, the immediate impact of health care reform is payments lower than they would have been but, beginning in 2014, minimum medical loss ratios will occur here as well.

Some of the health plans who are on the call are participants in our benchmarking studies. A byproduct of their participation is the reports that are summarized today. This summary benefits the health plan industry as a whole, and we are grateful for this.

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Today, I would like to touch upon our background, the levels of administrative costs that the Medicare plans incur and the sources of cost decrease in 2010. Then I would

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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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As you may know, we have been performing these benchmarking studies for many years. Sherlock Company is now completing its 14th annual survey of health plan operations and our benchmarks are based on 514 health plan years of experience. In all of our universes this year, the plans serve approximately 50 million members. Our focus is administrative expenses and related operational drivers, but also include metrics of health care utilization.

These benchmarks are widely accepted by health plans and others, and plans serving well over 60% of all insured American are users of our 2011 metrics. 70% of Blues participate, and most plans whose officers serve on the board of AHIP are users or participants. Health plans serving 18% of all Medicare private plan membership are participants in our benchmarks, either through this or other universes. Since our benchmarks are designed for plans' internal use, it benefits from high ratio of insight to effort.

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 the appendix slides. Our quality assurance procedures are also summarized in the appendix.

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The 10 plans that participated in our benchmarking study for Medicare plans serve 2.5 million people under comprehensive health benefit plans, of which 1.0 million are Medicare private health plan beneficiaries. On average, 62% of their revenues are in Medicare Advantage products and three of them also provided stand-alone Medicare Part D. Commercial comprised 29% of their revenues on average and Medicaid provided another 7% of their revenues. The universe was a mix of non-profit and for-profit organizations.

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To begin with, administrative expenses continued their moderating trends in 2010. Looking at the per member per month costs, the increase was 0.9%, compared to a decrease from 4.1% in 2009. The heightened share of Medicare among continuously reporting plans muted that apparent trend though. Once that effect is removed, costs declined by 3.9%, substantially the same as in 2009.

Sales and Marketing was central to this decline, falling by 5.1% as reported and 5.2% on a constant mix basis. These declines were less sharp than last year. Provider and Medical Management costs fell, as did Corporate Services, while Account and Membership Administration increased. The functions that are grouped in each of these clusters are shown in Appendix C, attached to these slides, but I'll touch upon them as we proceed as well. The figure numbers on the slide refer to our free newsletter, *Plan Management Navigator*, which is available on our web site, along with this presentation.

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Here are the per member results for 2010. Median administrative costs for comprehensive products were \$44.73 per member per month and if you refer to Appendix A, you'll see that this can be compared with \$44.71 last year. By the way, the median costs, expressed PMPM or as a percent of premium equivalents, will be the way that we'll refer to cost metrics; we think that medians are often a better measure of central tendency because they mute the effects of outliers. We know that comparing this slide with Appendix A is imperfect since the plans in the annual universes differ.

Every single functional cluster decreased in this comparison. Marketing costs decreased from \$16.10 to \$14.63. Provider and Medical Management fell from \$9.23 to \$7.60. Corporate Services decreased from \$11.30 to \$10.25. Account and Membership Administration decreased from \$14.91 to \$12.67. Since this compares plans without adjusting for product mix and with different plan populations, this is only rough-and-ready way.

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Because six of the six plans this year's survey were also in last year's study, it was possible to analyze trends by holding the universe constant. This is a more reliable way of calculating trend in my view.



This slide highlights the functional areas within each cluster that contributed to the changes in as reported costs. We looked at both changes that were extremely dramatic as well as those changes in costs that were responsible for *most* of the change in the cluster of expenses. The later is the percent change weighted by the dollar cost. In most instances, the functions that changed most dramatically also had the greatest impact on overall cost trend in 2010.

Medicare plans reported a 5.1% per member decline in Sales and Marketing Expenses on an as-reported basis. Rating and Underwriting was both the functional area with the largest change and was primarily responsible for the decrease of this functional cluster.

The expense cluster of Provider and Medical Management declined by 1.3% PMPM in 2010. Medical Management / Quality Assurance / Wellness was the function that experienced the largest change over the previous year. It was also the functional area with the greatest influence on the decrease in the cluster's overall costs.

Medicare plans experienced an *increase* of 7.7% in per member Account and Membership Administration cluster expenses. Enrollment / Membership / Billing was the functional area that had the greatest change over the previous year. This double-digit decrease in expenses offset *some* of the cluster's increase in other areas. The area which contributed the greatest dollar amount to the *increase* in costs was seen in the area of Information Systems. This was the most important source of *increase* of all functional areas of Medicare plans.

The functional area cluster of Corporate Services enjoyed a 2.8% decline in PMPM expenses in 2010. In this cluster, the Corporate Executive and Governance function had both the greatest change in expenses over the previous year and the largest impact on the cluster's increase in expenses, in terms of dollars. This function was also the second most important source of functional cost growth, after Information Systems. Notwithstanding this increase Finance and Accounting, Actuarial and Corporate Services all declined, making possible the decline in the cluster's costs.

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Changes in the mix of the products offered by a health plan, or a group of health plans, can have an impact on the apparent trends in costs. The increased emphasis of Medicare on plans that already focus on it is evident in this slide. This helps to explain why the



total PMPM costs increased by 0.9% on an as-reported basis but *decreased* by 3.9% on a constant mix basis.

The membership growth rate was relatively robust in this universe. The typical plan grew by 3.9%. Membership for Medicare Advantage (including PFFS) increased by 10.0%, Medicare SNP grew by 8.8%, while Medicaid increased membership by 19.1% in 2010. Overall, Medicare increased by 9.8%, while Total Commercial decreased by 1.2%.

Note that the mix of membership changed in favor of Medicare Advantage. Medicare Advantage membership increased its share of the mix by 1 percentage point of the mix. Commercial decreased by 1.2 percentage points each. As we develop, this mix shift affects real trends.

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This slide is much like slide 7, highlighting the functional areas within each cluster that contributed to the changes in costs. Again, we looked at both changes that were extremely dramatic as well as those changes in costs that were responsible for *most* of the change in the cluster of expenses. The way that this differs from the earlier slide is that not only did we keep the universes constant but we also kept constant the precise mix of products that these plans offered. Accordingly, this is the most accurate way of measuring administrative costs trends that we are aware of. Total PMPM costs declined by 3.9% in 2010 compared with an increase of 0.9% on an as-reported basis.

As on a constant mix basis, the Corporate Services cluster's costs declined fastest in 2010, 6.7% PMPM. This compared with a decline of 4.1% last year. The functional area of Corporate Services (legal, HR and the like) was overwhelmingly responsible for this. However, Actuarial and Finance and Accounting costs both decreased by double-digits in 2010, which also contributed the decrease in this cluster's costs. Corporate Executive and Governance costs increased however, similar to slide 7.

The functional cluster of Sales and Marketing decreased by 5.2%. Rating and Underwriting was the function most important to the decrease in expenses overall. It also declined precipitously. Advertising and Promotion also decreased greatly on a mix-adjusted basis and contributed the second most to the overall decrease in this cluster. Product Development / Market Research also declined at double-digit rates.



Provider and Medical Management costs decreased by 5.4%. Both of the underlying functions also declined as well holding constant the change in product mix. The decline in Provider Network Management and Services, in terms of dollar value, was double that of Medical Management. It also declined four times faster.

Account and Membership Administration was unique among the clusters in that it grew, by 5.4% on a constant mix basis. Interestingly, this function shows evidence of automation in that IS PMPM costs increased at double digit rates. By contrast, Enrollment declined at double digit rates as Customer Services also declined. Claims increased by less than 1%. The declines in functions served by IS provide even more indications of automation. Over time, perhaps overall Account and Membership Administration costs will fall. Of course, IS was the dominant source of increase in this clusters' costs.

Overall costs declined. While Rating and Underwriting is normally a relatively small part of costs in most health plans, because it includes Hierarchical Condition Categories (HCC) activities, is much larger in Medicare plans. It fell sharply. By the way, IS increased by nearly one-half the dollars that Rating and Underwriting declined.

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This slide shows administrative expenses as a percent of premium equivalents of 8.1%. Our calculations of premium equivalents is discussed in the November edition of *Plan Management Navigator*.

Note that the percent of premium equivalent of 8.1% is 90 basis points lower than last year's value of 9.0%, as shown in Appendix B. A precise comparison is impossible since medians don't sum and the universes differ somewhat. However, directionally, a comparison may be helpful. Sales and Marketing and Corporate Services each decreased by 40 basis points. Provider and Medical Management and Account and Membership Administration declined 10 basis points each.

I should add that administrative expenses for the Medicare Advantage product remained at 8.1% in both years. So, this percentage point improvement may reflect, in part, the increasing share of Medicare products in this universe.

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This slide shows the administrative expenses of each product offered by the Medicare universe of plans. The health care needs of plan members vary quite a bit by product as do the associated administrative expenses. I want to key on a few comparisons by way of illustration.

The ASO products had the lowest per member administrative expenses. It runs approximately \$20.62 PMPM. Marketing costs are the overwhelming reason why ASO costs less than insured products. Lower broker commissions are central to this.

Medicare Advantage administrative costs run about two and a half times as high as comparable products for younger people because of the high health care needs of seniors.

The most expensive product offered by Medicare plans is their Medicare SNP product at \$162.65 PMPM, followed by Medicare Advantage and PFFS, which had similar operating costs. But on a percent of premium basis, the ranking of administrative expenses by product is different as shown on the next slide.

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Percent rankings are different than PMPMs. While the lowest cost product remains the ASO, at 6.1%, order changes sharply for the Medicare products. Medicare SNP, the highest cost product, falls on this basis below two of the commercial insured products. Medicare PFFS and Medicare Advantage each fall below all of the commercial insured products.

The underlying reason for the difference between the percent and the PMPM rankings of Medicare versus commercial members is that seniors incur higher medical costs for their associated administrative support. For instance, health care costs per claim submitted tends to be 20% higher. Similarly, the health care need that prompts a customer service inquiry will tend to have a higher dollar value. Thus the percent of revenues tends to be less as well.

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In this slide, we compare the costs of Medicare Advantage products offered Medicare plans with similar products offered by health plans in other universes. On a PMPM basis, you can see that they fall between that of the Independent / Provider – Sponsored Plans and the Blue Cross Blue Shield Plans.

The reasons for this are specific to the functions. Medicare-focused plans have higher Sales and Marketing costs than do IPS plans and much higher than Blue plans. Both internal Sales and Rating and Underwriting are higher for the Medicare Plans.

With respect to Provider and Medical Management, the Medicare plans have considerably higher costs in this cluster than their Blue or IPS peers. Medical Management costs are the dominant costs in this function and they are much higher for the Medicare universe.

Comparisons of Account and Membership Administration between the universes were more complex. Blue plans tended to have higher costs than the Medicare plans mainly due to IS but also due to Claims and Enrollment. But Independent / Provider – Sponsored plans had lower costs than the Blues or Medicare plans because of low IS and Customer Services.

Medicare focused plans and Blue plans had similar expense levels in the Corporate Services cluster, while IPS plans were significantly lower. Medicare plans had particularly high costs in Finance and Accounting and Corporate Executive and Governance areas possibly due to the need to adapt to provisions of the PPACA.

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This is the end of my formal presentation. Just to reiterate, PMPM administration increased by 0.9% versus a decrease of 4.1% in 2009. Since the product mix changed, PMPM costs declined by 3.9% similar to the 4.1% decline last year. Marketing costs were central to the decline, especially Rating and Underwriting costs. This masks a increases in Information Systems and Corporate Executive and Governance expenses.

I have attached to the end of this presentation some appendices in support of this presentation. They include our publication schedule for our benchmarks, last year's costs, how we segment products, the functions found in the clusters we have been speaking of and some notes on our quality assurance and business model.



Now I would like to open this for questions about the results of the Medicare benchmarking study.

Questions and Answers

1. What happened to staffing ratios in 2010?

Overall staffing ratios declined from 42.16 FTEs per 10k members in 2009 to 34.54 in 2010. That's an 18% decline of nearly 8 FTEs per thousand.

All of the clusters declined, actually. Account and Membership Administration declined by close to 2 FTEs, possibly stemming from that automation we spoke of. Provider and Medical Management staffing ratios declined second highest.

2. The decline in Rating and Underwriting appeared counterintuitive. Could you explain?

We don't know why this is but the function remains nevertheless very large. It is important to remember that Rating and Underwriting includes HCC activities. Reasonable people may differ but it is notable that this is where the panel likes to see it. Their justification is based on the notion that Rating and Underwriting should be responsible for matching payment to risk regardless of the product.

3. Where are ACO expenses found? That Provider Network Management and Services declined is surprising in light of this. Was IS impacted?

We don't know the degree to which our plans incurred ACO expenses, if at all. It was the intention of the panel that all general consulting, certainly including the exploratory studies of ACO feasibility, would be found in Corporate Executive and Governance. That function increased. I am under the impression that ACOs were not embraced in 2010 so perhaps the provider contracting activities of Provider Network Management and Services never occurred.

All of the ACO development, except those of a strategic nature, are borne by the affected functions. So, you are correct, IS and Provider Contracting would be directly affected.



2. Were there any changes in productivity in 2010?

- Enrollment transactions per FTE sharply increased.
- Customer Services Manual Inquiries per FTE also surged by 18%.
- Provider Services Manual Inquiries per FTE increased.
- Claims processed per FTE very sharply.

3. Were there any notable trends in plan's tendency to outsource?

For all functional areas, the typical plan increased the proportion of outsourced FTEs from 14% to 24%. My supposition was that this was may have been IS. In fact it did increase by 7 percentage points to 26%. By more dramatic leaps were found in (in declining order) Facilities, Provider Relations, HR, and Marketing.



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.

This was the last of our benchmarking web conferences. For the balance of the year, we'll be focusing on the development of next year's panel. I think it is generally acknowledged that health plans, especially firms focused on Medicare Advantage, have to focus on managing administrative costs. Let us know if you think that your plan may find this of interest.

In that vein, we'll be publishing in *Navigator* summaries of the choices that health plans make in their commitments to various functions to achieve low costs. We look forward to your comments on this.

I want to close by thanking once again all of you who participated in this study for your efforts. Your efforts not only enhance your own firm's performance but also raise the bar for all other plans.

Thank you.