



Transcript

Independent / Provider-Sponsored Administrative Costs: A Review of 2008 Results

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Douglas B. Sherlock, CFA

sherlock@sherlockco.com

(215) 628-2289

<Title Page>

Welcome to our summary of the benchmarking study for Independent / Provider - Sponsored Plans. I believe that most of you are health plan managers. Accordingly, you have responsibility for achieving that optimal mix of costs and benefits that lead to superior long term performance for your customers, your owners and the public at large. We appreciate the complexity of this task.

I want to thank all of you who are participants in our benchmarking studies. While participating plans tend to realize a return on their investment in the benchmarking process, it is nevertheless the case that the summary benchmarks that result benefit other firms as well.

As you may know, we have been performing these benchmarking studies for a number of years. They are widely accepted among health plan managers and other users. 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.

This is the first of a series of presentations on health plan performance metrics. Blue Cross Blue Shield financial metrics will be summarized in two weeks and we expect to host similar web conferences for Medicare and Medicaid plans in September.



<Slide 2>

Today, I would like to touch upon a little bit of background on us, the levels of costs that the Independent / Provider-Sponsored firms report and the sources of cost increase. 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 12th annual survey of health plan operations and our benchmarks reflect 396 health plan years of experience. In all of our universes this year, the plans serve 39 million members. Our focus is administrative expenses and related operational drivers, but also includes metrics of health care utilization.

These benchmarks are in widespread use by health plans, and those serving more than one in every 2.7 insured people used our 2008 metrics. Most Blues and most plans whose officers serve on the board of AHIP are users or participants. Since this is designed for plans' internal use, it has a high ratio of insight to effort. Our benchmarks benefit from cross fertilization across universes.

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The 16 plans that participated in our benchmarking Independent / Provider-Sponsored universe serve 5.7 million members from "sea to shining sea". They are substantial organizations, with more than one billion dollars in annual revenues, on average. 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 HMO, Medicaid or Medicare Advantage.

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Here are the results for 2008. Median costs were \$30.37 and if you refer to Appendix A, you'll see that this compares with \$29.49 last year. By the way, the median costs, expressed PMPM or as a percent of revenues, will be the way that we'll refer to cost metrics. This is an imperfect comparison since the plans in the universe differ.

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Notwithstanding, it is notable that Provider and Medical Management costs were \$5.08 per member per month in 2008, while they were only \$4.39 in 2007. By the way, the figure numbers refer to our free newsletter, *Plan Management Navigator*, which is available on our web site, along with this presentation.

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If you look at the two right columns labeled "2008 Data", you'll see more appropriate comparisons but they tell a similar tale. In this slide, we have made all comparisons reflect the same plans in both years. (We had a net increase of three plans in this universe in the current cycle.) PMPM costs increased by 11.5% for these plans versus an increase of 4.9% in 2007.

But the difference sharply diminishes if you hold constant the product mix. (We do this by weighting the 2007 expenses by the 2008 mix. Remember, plans report to us expenses by functional area and also by product.) Adjusting for this, expense growth is still higher, 6.2% versus 3.1% last year, but much diminished.

Also please note the increase in Provider and Medical Management costs. They were up 22.7% before backing out the effect of product mix differences, and 14.4% adjusted. It is plain that these plans sharply increased their commitments to this cluster of functions, even excluding the effect of the high requirements of Medicare beneficiaries.

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I have been speaking with some certainty that the growth of Medicare has made a difference, and now I would like to try to support this contention. It is difficult to precisely quantify the magnitude of the mix changes but this slide endeavors to do so. For plans that participated in both 2007 and 2008, membership grew by 2.8%, but Medicare membership (including SNP) grew by 15.7%. Thus the share of the plans revenues that were Medicare increased on average by 2.1 percentage points. I believe that, because of the high cost difference between Medicare and commercial products, it had a significant effect on reported cost trends.

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This slide highlights the functional areas within each cluster of functions that contributed to the increase in costs. We looked at both fast growing cost areas as well as costs that were responsible for most of the increase in the cluster of expenses. Marketing costs, which increased by 14.3% in this universe, had very high growth, in most functional areas. The exception to this was Advertising and Promotion whose cost increases were relatively modest. The fastest growing function by far was Rating and Underwriting. Our panel places Medicare HCC activities into this Rating and Underwriting so this was indeed a contributor. But nearly 40% of the increase was in Commissions to external brokers, the largest marketing expense that these plans bear.

Medical and Provider management, at a 22.7% growth, was the fastest growing cluster. While Provider Network Management and Services grew modestly, Medical Management / Quality Assurance / Wellness grew by 28% and was responsible for more than 80% of the total increase for that cluster. This may again reflect the increasing prominence of Medicare in the portfolios of Independent / Provider-Sponsored plans.

Growth in the cluster of Account and Membership Administration was more modest, at 6.0% growth. While most functions grew at a pace that was moderate by 2008 standards, the costs of Claim and Encounter Capture and Adjudication increased by approximately 14% and represented more than 30% of the total increase for the function.

Corporate Services cost growth was also moderate, at only 6.1%. The small Actuarial function was an exception, increasing by more than 10%. While Corporate Executive and Governance is only a small proportion of Corporate Services, it grew slightly faster than the cluster and comprised more than 20% of the increase.

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This slide reflects the contribution of various functions holding constant the product mix. Marketing expenses grew by 6.0%, at a much lower pace than on an as reported basis. Product Development and Market Research grew by nearly 50% PMPM on this basis, though the smallest functional area in the Marketing cluster. By contrast, broker Commissions swamped all other increases in this cluster in its importance.

While the rate of growth at 14.4% in Medical and Provider Management was well below the as-reported rate of 22.7%, it was still quite high. Provider Network Management



and Services costs actually declined on a PMPM basis while spending for Medical Management / Quality Assurance / Wellness grew by nearly 30%. It was, accordingly, solely responsible for the increase in this cluster of expenses. It appears to have reflected an unprecedented commitment to this activity, last approached in 2005.

The expenses committed to Account and Membership Administration increased from 6.0% on an as reported basis to 8.5% on a constant mix basis. Information Systems both increased fastest and was responsible for the greatest share of the increase.

On a mix adjusted basis Corporate Services costs actually declined. However, Actuarial uniquely grew. On a mix adjusted basis it grew by 10-15%, compared with a PMPM decline of 6.8% for the cluster as a whole. All other functional areas declined, and Actuarial is of course a small functional area.

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This slide shows administrative expenses as a percent of premium equivalents. At 8.3%, it is probably lower than consensus estimates for health plan administration. Please note that it excludes taxes imposed by state governments. Our calculations of premium equivalents is discussed in *Plan Management Navigator*.

Perhaps one of the most startling things about the low percent of premium equivalent calculations is how it compares to results reported last year of 9.4%. A precise comparison is impossible since medians don't sum and the universes differ. However, on a percent basis, Marketing and Corporate Services declines, relative to premium equivalents, seem to be central to the ratios being lower.

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The increasing role of Medicare products is probably a factor that explains the low administrative expense ratios and also the change from last year's reported ratios. Note that both Medicare Advantage and Medicare Special Needs Plans have administrative expense ratios that are less than 8%. Since these products typically comprise a quarter of the revenues of these organizations these low values reduce overall ratios. Medicare has low administrative costs relative to premium in part because the administrative activities tend to be less per dollar of health benefits. For instance health costs per claim submitted is higher than for commercial firms.



Another surprising aspect is that even commercial costs seem low. There are likely a variety of reasons for this. Our studies show that scale is a modest factor in health plans, at least among those serving more than 100,000 members. Second, some of these plans are closely linked with a health system, which can lower transactions costs. For instance, we know of one plan in which nearly 100% of its claims are electronically submitted since the plan is linked by hard wires to most of the delivery system. The one exception to this is insured Indemnity and PPO which tends to be a relatively small product for plans in this universe.

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

Note that the Commercial ASO is the lowest cost comprehensive product offered by the Independent / Provider-Sponsored plans, at \$18.35. It costs roughly \$10.00 less to administer than this universe's leading counterpart products serving those under 65, HMO or POS. Most of the difference, by far, is marketing costs, though medical management is often less as well. Broker commissions are much lower in the Commercial ASO segment.

Medicare Advantage administrative costs are typically two and a half times higher than those of their comparable products for those under the age of 65. As I alluded to before, health benefit expenses are nevertheless even higher, at more than 3 times. This difference in relative costs explains why, as a proportion, administrative expenses are less relative to premium than commercial products.

Finally, the Medicare Special Needs products have administrative expenses that are one and a half times that of Medicare Advantage. But these members are very expensive from a benefits perspective and their health costs have a mean value of \$1,200 PMPM, 50% higher than Medicare Advantage. These members require substantially higher medical management efforts and their claims adjudication costs are also higher.

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This is the end of my formal presentation. The main conclusion is that per member administrative expenses grew increased in 2008. But the product mix changes, particularly those in favor of Medicare, affected this. Once product mix is removed as a factor costs increased, albeit at a lower rate.

I have attached to the end of this presentation some appendices in support of this presentation. They include 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 benchmarking study.

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.

Two weeks from today, we will have a similar web conference on the results of the Blue Cross Blue Shield plans. There are 22 participating plans in this universe, comprising most of the primary licensees of the Blue Cross Blue Shield Association. We hope that you will consider participating again in this web conference.

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