Plan Management Navigator
Analytics for Health Plan Administration
Early April 2010

Timing of 2010 Benchmarking Studies

This year we have 25 Plans serving 33.6 million members in our 2010 Blue Cross and Blue Shield universe, an increase of three Plans. For the Independent/Provider-Sponsored plan universe, we have 16 plans serving 6.3 million members. We just recently distributed the survey materials for these universes and will publish their final benchmarking studies, beginning in early July. Panels for the Medicare and Medicaid-Oriented universes are currently being developed. A universe of Third-Party Administrators is new this year, but early indications are that it will be a strong panel. Let us know if you would like to learn more about participation in or licensing any of these benchmarking studies.

Medicare, Medicaid, Health Care Reform and Administrative Expenses

Viable health plans are profitable health plans. To maintain those profits, health plans serving Medicare and Medicaid will need to contend with compressed revenue yields and a concentrated provider market. They will also face minimum health benefit ratios as a result of the new health care reform law, leaving administrative expense management as the focal point of assuring sustainability. Sherlock Company looks at administrative expenses using both financial and operating ratios to understand the relationships between various metrics.

Figure 1. Plan Management Navigator
Timing of 2010 Benchmarking Studies

	2010		Change			
	Members Served	*Plans Included*	*Members Served*	*Plans Included*	*Survey Distribution*	*Benchmark Publication*
Independent/Provider-Sponsored	6.3 million	16	9.6%	0.0%	Mar-10	Jul-10
Blue Cross and Blue Shield	33.6 million	25	7.6%	13.6%	Mar-10	Jul-10
Medicare-Oriented		*Building the Universe*			Jun-10	Aug-10
Medicaid-Oriented		*Building the Universe*			Jun-10	Aug-10
TPA		*Building the Universe*			Jun-10	Aug-10

General Note Regarding Navigator

Health care reform's most immediate and direct impact will be on government programs such as Medicare and Medicaid. Both will face pressures on top lines, which will require more aggressive management of administrative expenses of health plans serving those markets. Because of this, we are focusing the next several issues of *Plan Management Navigator* on operational issues affecting health plans doing business with public benefit programs.

Pressures and the Need for Administrative Cost Management

Pressures on health plans serving Medicare and Medicaid are quite different but require similar responses. In the case of Medicare Advantage (MA), payment cuts will be directly imposed on plans offering such products. The size of the cuts will vary by product offered. Thus, a PFFS product, believed by MedPAC to be offered at a 13% premium to the same payments offered to regular Medicare beneficiaries, would face an 11.5% reduction in payments, while an HMO, believed to be offered at an 8% premium, would face a 7.4% reduction in payments. (This assumes that increases and decreases in the payment rate due to geography would average out.)

(These premiums do not take into account that the payments cover services for beneficiaries in excess of those provided to regular Medicare. When comparing the cost of comparable services delivered to MA and regular Medicare

Continued on Page 2

beneficiaries, MA HMOs actually cost 3% less. Because these plans cost less than Medicare plus Medicare Supplemental policies, members of Medicare Advantage plans are often low income people.)

The source of Medicaid pressures are harder to quantify but more centrally related to the underlying premise of the health care reform. Fully one-half of all newly insured members under health care reform result from the expansion of Medicaid. Although federal financing rates will cover all of the increased costs in 2014 to 2016, these rates fall to 90% in 2020. This will leave the remaining amount to be paid for by state governments, which are constrained by their own weak financial conditions. At this moment, according to the Center on Budget and Policy Priories, 41 states are operating with deficits and their collective budget deficit is $38 billion. Accordingly, states will ultimately endeavor to minimize their payments to health plans.

Facing top line pressures, Medicare and Medicaid health plans will endeavor to manage their costs even more aggressively. Health care utilization review procedures and more volume-based negotiations will result from this. In the case of Medicare, we would expect Medicare Advantage plans to be increasingly focused on HMO products with limited panels. One could even envision a sort of exchange in which PFFS plans swap membership to achieve a critical mass in geographic areas to make them capable of negotiating contracts with providers. However, since hospitals, along with their associated providers, are relatively concentrated, even health plans with limited panels have severe limitations on their abilities to achieve discounts in exchange for their business.

Because of the revenue and health benefit constraints, the management of administrative expenses is likely to be the cornerstone of any strategy of plans to preserve health plans' viability and competitive position. In effect, managing the costs under Medicare and Medicaid plans' own roofs is the only strategy available.

Oddly, administrative expense management is an area that has not historically been central to the focus of health plans and is often an underdeveloped skill set. This is possibly due to administrative expenses being so much smaller than health care costs: A 2% reduction in health benefit costs leads to margin improvement of 1.7 percentage points for a company operating at an 86% health benefit ratio. But a 2% reduction in administrative expenses leads to only to a 0.2 percentage point margin improvement. This may also be due to interactions between administrative costs and health benefit costs. For instance, one health plan manager used to boast that his administrative expenses ran high since he wanted each claim to have the most thorough possible review. Finally, many senior health plan managers entered the business in the late 1970s and 1980s when the name "prepaid group practice" was still occasionally employed to describe what we now call health plans: administrative cost management is almost culturally foreign. This may be particularly the case for health plans serving Medicare and Medicaid populations, who often have both complex health needs and the ability to close their panels.

Types of Administrative Cost Drivers

The series of articles that follow will focus on administrative cost drivers for Medicare and Medicaid plans. They will identify relationships that drive such costs and the resources used and the activities associated with various administrative functions.

Simple algebra is helpful in analyzing the resources committed to each functional area. At Sherlock Company, we think of per member per month (PMPM) costs as the product of total costs per FTE and the staffing ratio (FTEs per 10,000 members). Often, we divide total costs per FTE into compensation and non-labor components. Together, the costs of any functional area can be analyzed based on the contributions of compensation costs per FTE, non-labor costs per FTE and the staffing ratio.

The available insights get even more fruitful if a concrete metric of output is associated with the functional area. For instance, the claims function executes adjudicated claims and customer service completes member inquiries. With such output metrics, the analysis can then include a metric of primary demand (units per member), and a metric of productivity (units per FTE) plus a metric of unit cost (cost per unit.)

Additional insights are available by analyzing the relationships between costs and operational metrics. Sherlock Company does not provide process engineering services but our extensive databases provide the means to analyze the relationships between various operating measures and costs. For instance, the proportion of claims that are adjudicated electronically may affect the underlying costs of the claims area. These relationships do not identify the precise causality but may provide further hints to strategies for operational improvements.

Conclusion

The sorts of relationships identified above cannot provide a how-to to managers, any more than a medical diagnostic test provides a how-to to physicians treating a patient. But the metrics both hone the search for the cause of expense variances, and suggest some operational levers for enhancing their performance. The search for operational improvement seems especially timely in the current environment after health care reform.