Plan Management Navigator
Analytics for Health Plan Administration April 2013

Could 72,000 Health Plan Employees Lose their Jobs Under Health Care Reform?

Health care reform is intended to "create incentives" to lower administrative expenses. But what does that mean for health plan employment? One-half of health plan administrative expenses are staffing costs so any cost reduction will inevitably involve personnel. In this month's *Navigator*, we apply a simple model to estimate the effect. We estimate that after considering the effect of new enrollment in Medicaid and Exchanges, combined with improved efficiency, health plan staff may decline by 21% or by 72,000 FTEs.

Sherlock Company has the most robust data set of administrative expenses of health plans. Collectively, our survey-populated benchmarks for 2011 comprise the results of 62 health benefit organizations serving nearly 50 million people, or approximately 23% of all privately insured Americans. (We are now collecting 2012 information.) In this edition of *Plan Management Navigator*, we employed analyses of this data set to estimate the total employment in the health insurance industry and how it may be affected by combined factors of increased membership in health plans and the impetus towards lower administrative costs. It builds on the analysis in the *Plan Management Navigator* of December 2012, the Decisions of Low Cost Blue Cross Blue Shield Plans in 2011.

We employed results from our Blue Cross Blue Shield universe since we viewed it most representative of the industry as a whole and because of the relative uniformity of their product mix. The Blue participants comprised 65% of all U.S. Primary Licensees in 2012. By contrast, for instance, our universe of Independent/Provider-Sponsored Plans has a much more diverse product mix and is a smaller share of the total number of similar organizations. Staffing ratios include outsourced staffing. The mean proportion of staff that was outsourced was 12% in 2011.

Figure 1 shows Kaiser Family Foundation estimates of the number and distribution of privately insured U.S residents and our estimates of the health plan employees who provide the administrative support in core functions. (By "core," we refer to all administrative activities except medical management and marketing. These excluded activities can be largely independent of the ongoing functions of health plans.)

Kaiser estimates that approximately 211 million people have private health insurance, including approximately 56% of all Medicaid members. To estimate the health plan staff necessary to support this membership, we converted all private insurance members into commercial equivalents. To estimate the staffing required to serve Medicare and Medicaid

members, we applied conversion factors of 3.07 for Medicare members and 0.78 for Medicaid members. These factors were based on the relative core costs of commercial, Medicare and Medicaid products for Blue Cross Blue Shield from the 2012 edition of the *Sherlock Expense Evaluation Report*. So, expressed as commercial member equivalents, the 211 members served by private insurers equate to 232 million commercial equivalents.

We applied the staffing ratios, calculated from Blue Cross Blue Shield plan values, of 15.01 per 10,000 members to the 232 million commercial equivalents. The weighting between low cost and high cost plans reflects slight economies of scale: the low cost 25% of plans served 28% of the members. This is also reflected in Figure 3. We estimate that there are approximately 348,000 people employed in core insurance functions for privately insured people. This is consistent with the February 2013 Bureau of Labor Statistics estimate of 466,400 for Direct Health and Medical Insurance Carriers since 76.5% of total Blue Cross Blue Shield employees are in core functions.

In Figure 2, we show the effect of health care reform on the Kaiser estimates of insured people and its immediate effects on health plan employment. The changes in coverage are based on Congressional Budget Office estimates developed shortly after last summer's Supreme Court decision. We assumed that the same proportion of Medicaid beneficiaries would be served by MCOs as exists now, approximately 56%, and we ascribed all of the new Exchange members to the Other category, which we assumed to be equivalent to Commercial. Medicare is assumed unaffected by health care reform. Thus, the effect of health care reform is to increase the number of the

Figure 1. Plan Management Navigator
Estimate of Privately Insured U.S. Residents and Health Plan Employees in Core Functions
Members in Millions

	Un-Insured	Emp-loyer	Indiv-dual	Medicaid [a]	Other	Non-Elderly	Medicare [b]	Total U.S. Residents
Members and Uninsured:								
Total [c]	48	149	15	47	8	266	50	316
Privately Insured [d]		149	15	26	8	198	13	211
Commercial Equivalents [e]		149	15	20	8	192	40	232
Staffing Ratio of Core Functions [f]								15.01
Estimated Core Employment by Health Insurers								348,325

[a] *Kaiser Family Foundation. The Uninsured: A Primer - Supplemental Data Tables, October 2012 is source of total beneficiaries. Excludes those also served under Medicare.*
[b] *Kaiser Family Foundation. Medicare Advantage Fact Sheet, November 2012.*
[c] *Kaiser Family Foundation. The Uninsured: A Primer Supplemental, Data Tables, October 2012.*
[d] *Kaiser Family Foundation is source of Medicaid MCO membership: Executive Summary of A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50 State Survey.*
[e] *Sherlock Company commercial membership equivalency sssumptions based on core expenses from 2012 SEER for Blue Cross Blue Shield Plans. Medicare is 3.07 times Commercial and Medicaid is 0.78 times Commercial.*
[f] *Sherlock Company estimate based on our December 2012 analysis.*

Figure 2. Plan Management Navigator
Effect of Growth in Coverage Health Plan Membership and Employment
Members in Millions

	Un-Insured	Emp-loyer	Indiv-dual	Medicaid [a]	Other	Non-Elderly	Medicare [b]	Total U.S. Residents
July 2012 CBO Estimate of Change [g]	-14	-1	-1	7	9	0	0	
Members and Uninsured:								
Total [c]	34	148	14	54	17	266	50	316
Privately Insured [d]		148	14	30	17	208	13	222
Commercial Equivalents [e]		148	14	23	17	202	40	242
Staffing Ratio of Core Functions [f]								15.01
Estimated Core Employment by Health Insurers								363,390

[a] *Kaiser Family Foundation. The Uninsured: A Primer - Supplemental Data Tables, October 2012 is source of total beneficiaries. Excludes those also served under Medicare.*
[b] *Kaiser Family Foundation. Medicare Advantage Fact Sheet, November 2012.*
[c] *Kaiser Family Foundation. The Uninsured: A Primer Supplemental, Data Tables, October 2012.*
[d] *Kaiser Family Foundation is source of Medicaid MCO membership: Executive Summary of A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50 State Survey.*
[e] *Sherlock Company commercial membership equivalency sssumptions based on core expenses from 2012 SEER for Blue Cross Blue Shield Plans. Medicare is 3.07 times Commercial and Medicaid is 0.78 times Commercial.*
[f] *Sherlock Company estimate based on our December 2012 analysis.*
[g] *CBO. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision, July 2012.*

privately insured from 211 million to 222 million, and commercial equivalent members from 232 million to 242 million. If the same staffing ratio applied to this population as applies to the Figure 1 estimate, then the staffing would increase by 15,000 to 363,000 FTEs. (This excludes temporary employees necessary for the initial transition period. For instance, we have anecdotal reports that additional customer service representatives may be necessary to explain benefit changes under health care reform.)

But there is also a second effect of health care reform: that all health benefit organizations may ultimately operate at costs that approach those of the low cost organizations. Lower administrative costs is the specific intent of the new MLR minimum levels, and a potential consequence of the exchanges.

Of the difference between high and low cost Blue Cross Blue Shield plans, 94% is explained by lower staffing levels. As described in the December 2012 *Plan Management Navigator*, low cost Blue Cross Blue Shield Plans achieve their low costs in part by organizing their processes so that their staffing ratios are 11.41 FTEs for every 10,000 members. This is 5.00 fewer staff than their higher cost peers, which operate at 16.41 FTEs for every 10,000 members. (We hold business mix constant between these two sets of plans.)

If the higher cost organizations are successful at matching the lower cost plan staffing ratios, the combined effects of the heightened enrollment and greater efficiency will be a decline of nearly 72,000 employees, or 21%, to 276,000. This calculation assumes that 28% of privately insured people are served by low cost plans. Calculations are shown in Figure 3.

We would expect that the reduction in staffing would be on functions as outlined in the December 2012 *Navigator*. That is to say, the most important source of the decline in staffing will be Claim and Encounter Capture and Adjudication followed by Information Systems and Customer Services. That edition of *Navigator* is available upon request and it is also found on our web site.

This estimate is of course qualified by the assumptions that we have outlined earlier. In addition, we have also assumed that Blue Cross Blue Shield Plans, especially our sample of them, operate in ways that are similar to their peers. This is intuitive since all health plans compete in the same markets for health insurance and administrative talent and operate in a similar technical environment. While we earlier stated that economies of scale are not a major factor in administrative costs, there is an impact: the lowest cost 25% of the plans served 28% of the membership. Finally, as we've "pressure-tested" the model in other ways, there is 5-10% "play" in the aggregate staffing estimates.

Having acknowledged this, there are reasons why this decline in employment may be an underestimate. First, we have found that the lowest cost plans improved their relative performance in the most recent year. Moreover, while the businesses are not perfectly comparable, and the universe is not nearly as representative, in last year's TPA benchmarking study we found that the median staffing ratio was 12.77 FTEs per 10,000 commercial equivalent member.

If your health benefit organization has an interest in participating in the Sherlock Benchmarks, we invite you to contact us. We have already distributed surveys for the Blue Cross Blue Shield and the Independent/Provider-Sponsored panels, and other surveys will begin shortly. Please contact us at 215-628-2289 or sherlock@sherlockco.com.

Figure 3. Plan Management Navigator
Effect of Growth in Coverage on Health Plan Membership and Employment
Members in Millions

		After New Enrollment		After New Enroll. & Efficiency	
	Private Insured Comm. Equiv.	FTEs per 10k Member	Indicated FTEs	FTEs per 10k Members	Indicated FTEs
Low Cost Health Plans	68	11.41	77,346	11.41	77,346
High Cost Health Plans	174	16.41	286,044	11.41	198,889
Total	242	15.01	363,390	11.41	276,235
Difference from Original Employment Estimate					*72,090*
Percent Difference from Original Employment Estimate					*20.7%*