Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

Douglas Sherlock, CFA
(215) 628-2289
sherlock@sherlockco.com

John Park, CFA
jpark@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

Please see invitation to participate in the 2016 Sherlock Benchmarking Study on Page 7.

Comparing "Best-in-Class" Blue Cross Blue Shield Plans Against their Peers

In this issue of *Plan Management Navigator*, we provide a summary of our analysis on "Best-in-Class" Plans versus their Peers. Our analysis is based on the 18th annual Blue Cross Blue Shield Sherlock Benchmarks. For these purposes, we define "Best-in-Class" Plans as among the 25th percentile in lowest cost. Others are referred to as "Peer" Plans. All results are from 2014.

We recognize that the long-term preferred objective is cost that are optimal for their strategic objective. But the Best-in-Class focus on low costs places the burden of proof on functions that are relatively high to justify their costs through other objective metrics of superior performance, such as quality membership growth or low health care costs.

The focus of much of this analysis is "Tactical" costs, that is, costs other than Sales and Marketing and Medical Management (which we consider "Strategic" expenses). Those areas have costs most readily associated with strategic objectives such as growing the business and reducing health care costs. The Plans reported costs segmented by product and function, as shown in Figure 1. In making this exclusion, we are recognizing that these strategic expenses have impacts outside of current period administrative costs. We do, however, address these functional areas separately towards the end of this issue.

This analysis highlights the role of careful management in superior health plan operational performance. To perform the analysis, we endeavor to quantify and even eliminate the effect of factors largely beyond management control. We then isolate and measure the specific contributing factors that are more likely to be under the control of the management team.

Figure 1. Best-in-Class Health Plans

Functions in Tactical and Strategic Expenses

Tactical Expenses:

Account and Membership Administration Cluster
- Enrollment / Membership / Billing
- Customer Services
- Claim and Encounter Capture and Adjudication
- Information Systems

Corporate Services Cluster
- Finance and Accounting
- Actuarial
- Corporate Services Function
- Corporate Executive and Governance
- Assocation Dues and License / Filing Fees

Medical and Provider Management Cluster
- Provider Network Management and Services

Strategic Expenses:

Sales and Marketing Cluster
- Rating and Underwriting
- Marketing
- Sales
- Broker Commissions
- Advertising and Promotion

Medical and Provider Management Cluster
- Medical Mgmt. / Q.A. / Wellness

Conclusions

Best-in-Class Plans' Tactical PMPM costs were 32% lower than their Peers. A low Staffing Ratio was the overwhelmingly most important factor in low Tactical Costs, with Best-in-Class Plans holding a 34% advantage and comprising 108% of the difference. Moreover, in every higher level functional area, Best-in-Class Plans operated with lower Staffing Ratios. Staffing Costs per FTE also contributed to low costs, but Non-Labor Costs per FTE were higher for Best-in-Class Plans, by 18%.[1]

It appears that Best-in-Class Plans operate in a culture of conservative administrative expenses since almost every functional area was lower than the Peers. The overwhelming contributor among functions to superior performance was low costs in Information Systems and it was responsible for over half of the difference. The Corporate Services function and Customer Services were also low, so these three functions comprised 78% of the difference between the two sets of Plans.

Select Characteristics of the Two Sets of Plans

Scale. The mean membership size for Best-in-Class Plans was 1.4 million members versus 2.0 million for the Peer plans. The median values for the Best-in-Class and Peer Plans were 1.2 million and 2.3 million, respectively. Size did not determine ranking with plans of all sizes among the lowest half in tactical costs. Three of the four Best-in-Class Plans were smaller than the average and the median of the Peer Plans.

Operating in Low Wage Areas. There was an effect of local costs of living but it was modest. The proportion of the Best-in-Class cost advantage that can be attributed to lower Staffing Costs is approximately 12%. The average wage index for Best-in-Class Plans was about 16% lower than the Peer plans. (We employ the Hospital Wage Index used by CMS). Importantly, Staffing Costs per FTE were lower by approximately 8%, meaning that Staffing Costs per FTE were higher than indicated by the relative wage index.

The wage index, it should be recognized, may actually exaggerate the actual differences facing the health plans. The wage index is applied based on the city where the plan is headquartered. Presumably, the higher the wage levels in the headquarters' cities, the more advantageous remote service centers can be.

[1]All of the factor ratios used in the analyses that follow this section, e.g., Staffing Ratios, Staffing Costs per FTE and Non-Labor Costs per FTE, are adjusted to treat outsourced activities as in-sourced. In other words, outsourced staffing is included in the Staffing Ratios reported in those analyses.

Propensity to Outsource. Outsourcing was associated with high costs in the Peer Plans. On average, Best-in-Class Plans outsourced about 8% of their FTEs compared to an average of 17% among their Peers.

Low Cost Product Mix. By reweighting, as we describe in the Our Approach section at the end of this issue, our analysis eliminated the effect of any product mix differences between the groups of plans. A plan focused on ASO products will have lower per member costs than one focused on Medicare Advantage irrespective of its efficiency so it is important to make this adjustment to reported costs. The product mixes of the plans were in fact different so that reweighting to eliminate the effects of product mix was an important step. The different product mixes can be seen in Figure 2.

Activities that Made a Difference

The Account and Membership Administration Cluster, which includes functions central to health plan operations, contributed 68% to the Best-in-Class Plans' low costs. The PMPM expenses for this cluster were 32% lower for Best-in-Class Plans. The functions in this cluster includes Enrollment/Membership/Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information Systems.

Information Systems was the main driver of low costs in the Account and Membership Administration cluster. Information Systems comprised 79% of the low cost variance in this cluster and 54% of low overall Tactical costs. Customer Services contributed 17% to the cluster's low cost and 11% to low Tactical costs, while Enrollment comprised 9% and 6% to low cluster and Tactical costs, respectively. Claim and Encounter Capture and Adjudication was the only functional area that Best-in-Class Plans was higher than their Peers by 6%. Claims offset the Account and Membership Administration cluster's low costs by 4% and contributed -3% to overall low Tactical costs.

Information Systems. Costs in this function were 44% lower in the Best-in-Class Plans. The Staffing Ratio was 29% lower and comprised most of the low cost variance. Non-Labor Costs per FTE were 40% lower, while Staffing Costs per FTE were 5% lower.

Figure 2. Best-in-Class Health Plans

Product Mix Comparisons

	Commercial Insured	Commercial ASO	Commercial Total	Medicare Total	Comprehensive Total
Best-in-Class	35%	53%	89%	2%	100%
Peer Plans	45%	37%	82%	3%	100%

*Products not shown are FEP, Medicaid, and Medicare Supplemental.

Information Systems sub-function, Applications Acquisition and Development contributed 67% to the low cost variance in Information Systems. Staffing Ratio, lower by 71%, was responsible for 73% of the low cost variance in this sub-function. The sub-function Operations and Support was also lower, by 43%, and the low Staffing Ratio was primarily responsible for the difference, while Staffing Costs per FTE also contributed. Best-in-Class Plans reported higher Applications Maintenance and Security Administration and Enforcement expenses.

Corporate Services Function. This function contributed the second most to overall low Tactical costs and contributed 13%. Non-Labor Costs per FTE was 27% lower for the Best-in-Class Plans and was the key driver in low costs in the Corporate Services function.

There are nine sub-functions within this functional area: Human Resources, Legal, Facilities, OPEB, Audit, Purchasing, Imaging, Printing and Mailroom and Other. Except for OPEB and Imaging, all sub-functions were lower for the Best-in-Class Plans. In most sub-functions, the Best-in-Class Plans had either lower Staffing Costs per FTE or lower Staffing Ratios or both.

Customer Services. This function was low primarily due to a low Staffing Ratio and contributed 11% to overall low Tactical costs. Staffing Costs per FTE and Non-Labor Costs per FTE were also lower for Best-in-Class Plans.

Provider Network Management and Services. This function had 49% lower costs overwhelmingly due to a Staffing Ratio that was 38% lower.

All of the Provider Network Management and Services sub-functions were lower for the Best-in-Class Plans and had lower Staffing Ratios, Non-Labor Costs per FTE and Staffing Costs per FTE. The Provider Relations Services sub-function was responsible for 51% of the low cost variance for the function. Non-Labor Costs per FTE for this sub-function was 51% lower. Other sub-functions include Provider Contracting, Provider Audit / Billing Validation, and Other Provider Network Management and Services.

Claim and Encounter Capture and Adjudication. This was the only function that Best-in-Class Plans reported having higher expenses compared to the Peer plans, by 6%. Non-Labor Costs per FTE was the sole driver in higher costs, comprising 124%. Staffing Ratio and Staffing Costs per FTE were lower. BlueCard Home and Custom Par Fees were 77% higher for Best-in-Class Plans and Medicare Crossover fees were slightly higher. Note that no Staffing Ratios or Staffing Costs are associated with either function. Conversely, Other Claims was 19% lower for the Best-in-Class Plans and COB and Subrogation was 67% lower.

In the Account and Membership Administration cluster as a whole, Non-Labor expenses per FTE was 18% higher, but the Staffing Ratio was lower by 33%. So, if the Staffing Ratio in the Best-in-Class group was the same as the Peers, and if the Staffing Costs per FTE remained the same, the Non-Labor Costs per FTE would be approximately one-third of that of the Peer plans. That means that the low Staffing Ratios are not likely to be artifacts of flawed reporting stemming from outsourcing or classification. The low Staffing Ratio suggests that it is superior processes that are responsible for superior performance. Put conversely, productivity is simply higher for the Best-in-Class organizations.

Strategic Expenses

Reflecting the culture of conservative administration, Best-in-Class Plans also had lower costs in the Strategic areas of Sales and Marketing and Medical Management. These lower costs increased the Best-in-Class advantage to 36%.

Sales and Marketing Cluster costs were lower for Best-in-Class Plans by 51%, primarily due to its lower Non-Labor Costs per FTE. Staffing Costs per FTE and Staffing Ratios were also lower in this cluster.

All functions for this cluster were lower with Broker Commissions especially lower for Best-in-Class Plans, by 63%. Broker Commissions are entirely Non-Labor. 12% of Best-in-Class Plans' Sales and Marketing FTEs were outsourced compared to 11% of the Peer Plans.

The Sales functional area displayed PMPM costs that were lower by 36%, chiefly due to a Staffing Ratio that was lower by 20%. Non-Labor Costs per FTE and Staffing Costs per FTE were also lower for the Best-in-Class Plans.

Marketing costs were also lower, by 43%, for Best-in-Class Plans. The most important source of this cost advantage was Product Development and Market Research, chiefly due to a low Staffing Ratio. Note that a lower Staffing Ratio was the central driver in cost advantages for the Best-in-Class Plans in the other Marketing sub-functions as well. The other Marketing sub-functions are Member and Group Communication and Other Marketing.

Advertising and Promotion costs were 21% lower for Best-in-Class Plans mostly due to lower Non-Labor Costs per FTE. The sub-functions, Media and Advertising and Charitable Contributions were both lower for the Best-in-Class Plans by 14% and 56%, respectively.

Low cost did not impact growth, evidentially. Total product membership for the Best-in-Class Plans grew by a median value of 7%, compared with a median of 5% for their Peer Plans. Reweighting the Peer Plan membership mix to equal that of the Best-in-Class Plans, the Peer Plans' members grew by 3%.

Medical Management costs were also lower for Best-in-Class Plans, by 15%. The primary reason was the Staffing Ratio, which was 15% lower than the Peer Plans. (Best-in-Class Plans outsourced 10% of their FTEs, while Peer Plans outsourced 14%.)

It is possible that lower expenses in Medical Management by the Best-in-Class Plans resulted in lower gross profits, that is, premiums less health benefits. Gross profit margins are higher in the Peer Plans. Gross profit margins for Insured products had a median of 14% for the Best-in-Class Plans and 16% for the Peer plans. At the mix of the Best-in-Class Plans, the Peer Plans had a gross profit margin of 18% for Insured Products.

Gross profits themselves were also higher in the Peer Plans. On a PMPM basis, Insured gross profits were $43 PMPM for the Best-in-Class Plans and $59 for the Peer Plans. At the mix of the low-cost plans, the Peer Plans' advantage grew slightly larger, increasing to $60 PMPM.

Similarly, it is notable that the median insured health benefit ratio for the Best-in-Class Plans was 86%, compared to 84% for the Peer Plans. At the product mix of the Best-in-Class Plans, the Peer Plans held a similar median health benefit ratio of 84%.

Our Approach

Each of the plans studied in the course of this analysis differs from its Peers in many key characteristics. So to compare them we employed a composite approach to summarize the characteristics of the low cost, Best-in-Class health plans. We summarize the steps below.

1. We identify the Best-in-Class Plans by comparing each Plan's costs to its universe. We then selected the lowest cost plans that comprise 25% of the total Blue Cross Blue Shield universe. To eliminate the potentially distorting effect of mix differences on the cost comparisons, we reweigh the costs of the universe to match the mix of each plan. Thus, the lowest cost Plans are those with the smallest differences from reweighted universe values. Four of the plans, 25%, were called "Best-in-Class" and the others were called "Peers."

2. Best-in-Class and Peer Plans were compared as composites of the Plans that comprise them. That is, the central tendencies of the two sets of Plans were compared with each other. The median cost drivers of Staffing Costs per FTE and Non-Labor Costs per FTE for each cluster, function and sub-function of the two sets were directly employed in each of the composites.

3. The Costs per Member per Month used in each of the composites employed the mean values for each function and product for its respective composite set of Plans. To develop the total function values for each composite, we multiplied the mean product mix for the Best-in-Class Plans times each of the mean cost values for each function. These weightings were then summed to arrive at a total for each function. The sum of the function costs yielded a total Tactical cost value. The Tactical costs plus the Strategic costs equaled the total costs. To assure comparability between the Best-in-Class and Peer Plans, we employed the product mix for the Best-in-Class Plans for both sets of plans.

4. The Plans supplied detailed staffing information to us. We used this information to estimate Staffing Ratios for each function to eliminate the effect of product mix differences. We first calculated Total Costs per FTE as the sum of the median per FTE Staffing and Non-Labor Costs. Then we divided the PMPM costs for each function by the Total Costs per FTE. This value is then multiplied by 120,000 to convert annual values to monthly ones, and adjust for the fact that the Staffing Ratios are presented in 10,000 members rather than per member.

Would Your Health Plan Like to Participate in the 2016 Sherlock Benchmarking Study?

Our highly valid, well-populated Benchmarks provide an unbiased ranking and helps prioritize activities that will have the greatest impact on improving your health plan's overall operating performance. Now that most provisions, including the MLR limitations, of the Affordable Care Act have been implemented, participation by your health plan may be an appropriate and necessary response to the strong incentives to cost efficiency.

We believe that many of your peers have concluded that participation is timely. The overwhelming proportion of health plans participating last year are participating this year, and we have added several plans. Please link to www.sherlockco.com/seer/peers.shtml for what last year's participation looked like.

We will meet to finalize the content of the survey in February, distribute the survey forms in March, collect the completed surveys in May and publish beginning in late June or early July. Participation entails efforts on your part since useful outputs require relatively granular inputs. The cost is relatively modest.

Please reach out to Douglas Sherlock at sherlock@sherlockco.com or 215-628-2289 if you are interested. You will be among good company.

This Page Intentionally Left Blank