Plan Management Navigator
Analytics for Health Plan Administration

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Please see invitation to participate in the 2017 edition of the Sherlock Benchmarks on Page 9.

How do Best-in-Class Blue Cross Blue Shield Plans Achieve It?

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 19th 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 2015. In a few weeks, we will publish a similar analysis of the Independent / Provider – Sponsored plans.

Notwithstanding our referring to low cost plans as Best-in-Class, we recognize that the long-term preferred objective is performance that is optimal costs. But the 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. Put a different way, the focus on low costs is the basis for which an ROI can be calculated.

The focus of much of this analysis is "Tactical" costs, that is, costs other than Sales and Marketing and Medical Management. Those "Strategic" areas have costs most readily associated with strategic objectives such as growing the business and reducing health care costs.

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. In making these exclusions, 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.

Figure 1. Best-in-Class Blue Cross Blue Shield 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 24% lower than their Peers[1]. A low Staffing Ratio was the overwhelmingly most important factor in low Tactical Costs, with Best-in-Class Plans holding a 25% advantage and comprising 106% of the difference. Moreover, in every major functional area, Best-in-Class Plans operated with lower Staffing ratios. Staffing Costs per FTE, lower by 7%, also contributed to low costs, but Non-Labor Costs per FTE were higher for Best-in-Class Plans, by 11%.

It appears that Best-in-Class Plans operate in a culture of conservative administrative expenses since eight of the ten major Tactical functional areas were 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 84% of the difference between the two sets of Plans.

Accounting for Extraneous Factors

To hone to the most manageable factors, we address five factors that are either extraneous to reducing true operational costs or cannot be readily managed over the short or intermediate term.

Scale. Size did not determine ranking with Plans of all sizes in the lowest half in tactical costs. Three of the four Best-in-Class Plans were smaller than the average and the median of Peer plans. The mean membership size for Best-in-Class Plans was 1.4 million members versus 3.0 million for the Peer Plans. The median values for the two sets were 1.1 million and 2.4 million, respectively.

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 Staffing Costs is approximately 13%. The mean wage index was 0.869 among the Best-in-Class Plans and 1.046 among the Peer plans, 16.9% lower (We employ the Hospital Wage Index used by CMS). Importantly, Staffing Costs per FTE were lower by 6.6%, meaning that Staffing Costs per FTE were *higher* than indicated by the relative wage index.

The wage index, as we are referencing it, may exaggerate the actual wage differences experienced by the wage environment 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].When we observe costs that differ between the Best-in-Class and Peer Plans, these are standardized for member months (i.e., PMPM) even if not stated.

Propensity to Outsource. Outsourcing was associated with high costs in the Peer plans. The mean percent of FTEs outsourced was 9% among the Best-in-Class Plans and 13% among the Peer Plans. The median percent of FTEs outsourced was also 9% among the Best-in-Class Plans and 13% among the Peer plans[2].

Information Systems is generally among the functions most often outsourced, at a mean of 19% for all Blue Cross Blue Shield Plans. The mean percent of FTEs outsourced was 14% among the Best-in-Class plans and 21% among the Peer plans. The median percent of Information Systems FTEs outsourced was 16% among the Best-in-Class Plans and 17% among the Peer plans. The Information Systems costs for Best-in-Class Plans cost less than those in Peer plans.

Low Cost Product Mix. By reweighting, as we describe in the section Our Approach, the analysis presented here eliminates 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. Since the Best-in-Class Plans were more focused on ASO products and less focused on Medicare Advantage, reweighting to eliminate the effects of product mix was an important step. The different product mixes can be seen in Figure 2.

Forgoing "Strategic 'Investments.'" A Best-in-Class Plan's declining to spend on Medical Management and the Sales and Marketing functions *could not* contribute to the superior performance measured here since these activities are excluded from the central part of this analysis. In making this exclusion, we are recognizing that these "strategic" expenses have impacts outside of current period administrative costs. We do address these functional areas separately towards the end of this analysis.

Figure 2. Best-in-Class Blue Cross Blue Shield Plans
Product Mix Comparisons

	Commercial Insured	Commercial ASO	Commercial Total	Medicare Total	Medicaid Total	Comprehensive Total
Best-in-Class	37%	51%	88%	2%	0%	100%
Peer Plans	42%	39%	81%	4%	4%	100%

*Products not shown are FEP and Medicare Supplement.

[2]Unless otherwise noted, all of the factor ratios referred to in this analysis, i.e., 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 these analyses.

Accounting for Extraneous Factors

Because almost all of the functions in Best-in-Class Plans were lower than their Peers, Best-in-Class Plans appeared to operate in a culture of conservative administrative costs. However, a few of the functions were especially important in the plans' achieving superior performance. We will address them in order of their importance.

The **Account and Membership Administration cluster** of functions comprised 73% of the difference between the Best-in-Class Plans and their Peers. Account and Membership Administration is comprised of the core operating activities of Enrollment/Membership/Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information Systems.

The most important reason why costs in this cluster of functions were lower was Information Systems. Its costs comprised 83% of the low cost variance in this cluster and 60% of low tactical costs. Customer Services contributed 12% to overall low tactical costs, while Enrollment contributed 5%. Conversely, Claim and Encounter Capture and Adjudication contributed -5% to overall low Tactical costs and -7% to low Account and Membership Administration cluster expenses. In addition, the Corporate Services *Function* and Customer Services each contributed 12% to overall low tactical cost variance.

Information Systems. This function's costs were 36% lower in the Best-in-Class Plans. Non-Labor Costs per FTE was 35% lower and contributed the most to low cost variance. Low Staffing Ratio for Best-in-Class Plans was lower by 18%, while Staffing Costs per FTE was 10% lower.

The Information Systems sub-function, Applications Acquisition and Development, contributed the most to low Information Systems, at 77% of the favorable comparison for the function. The Staffing Ratio was the main driver in low Application Acquisition and Development expenses, lower by 71%. Non-Labor Costs per FTE were also lower, while Staffing Costs per FTE was slightly higher.

Corporate Services *Function*. (This word is italicized to distinguish it from the more encompassing cluster of the same name.) This function comprised 12% of the overall low tactical costs variance. Low Corporate Services Function costs were chiefly driven by a low Staffing Ratio with Best-in-Class Plans lower by 10%. Non-Labor Costs per FTE was lower by 14% in favor of the Best-in-Class Plans, while Staffing Costs per FTE was only 0.4% lower.

There were nine sub-functions within this functional area: Human Resources, Legal, Facilities, OPEB (Other Post-Employment Benefits [mainly health benefits to retirees]), Audit, Purchasing, Imaging, Printing and Mailroom and Other. All sub-functions were lower for the Best-in-Class Plans except for OPEB and Imaging.

Paradoxically, this function, along with many of the sub-functions, appear to be subject to economies of scale. Yet the Best-in-Class Plans are typically smaller. Please see the December 2016 Plan Management Navigator *for a complete analysis of economies of scale for health insurance.*

Customer Services. Customer Services also contributed 12% to overall low tactical costs. A low Staffing Ratio contributed 75% to low Customer Services costs and was lower in favor of Best-in-Class Plans by 28%. Best-in-Class Plans also had lower Staffing Costs per FTE and Non-Labor Costs per FTE by 8% and 34%, respectively.

Provider Network Management and Services. Best-in-Class Plans reported lower Provider Network Management and Services expenses by 32%, explainable entirely by a Staffing Ratio that was 37% lower.

All Provider Network Management and Services sub-functions were either lower in favor of Best-in-Class Plans or equal. A low Staffing Ratio was the key to lower costs for all four sub-functions.

The Provider Relations Services sub-function contributed 65% to the low functional area cost and 5% to overall low tactical costs. It was 44% lower for Best-in-Class Plans. A Staffing Ratio that was 40% lower was the chief driver. Non-Labor Costs per FTE and Staffing Costs per FTE were also lower.

Claim and Encounter Capture and Adjudication. Best-in-Class Plans reported higher expenses than Peer Plans by 7%. Non-Labor Costs per FTE was the only driver for high variance and was higher by 69%. The Staffing Ratio and the Staffing Costs per FTE were lower for Best-in-Class Plans by 18% and 8%, respectively.

Among the Claims sub-functions, BlueCard Home and Custom Par Fees contributed the most to high Claims costs. This sub-function was 78% higher for Best-in-Class Plans, while Medicare Crossover Fees were also higher, by 15%. There are no Staffing Ratios or costs associated with either sub-function. Other Claims and COB and Subrogation were lower for Best-in-Class Plans by 62% and 19%, respectively.

In the Account and Membership Administration cluster as a whole, the Staffing Ratio was lower by 21%, while Staffing Costs per FTE and Non-Labor Costs per FTE were also lower by 8% and 3%, respectively. Similarly, the sum of Information Systems and Claims, closely linked activities, was lower by 23.7%.

Strategic Expenses were Also Lower

Possibly reflecting a culture of conservative administration, Best-in-Class Plans also had lower costs in the Strategic areas of Sales and Marketing and Medical Management. The Strategic Expenses increased the Best-in-Class Plans' cost advantage from 24% lower to 28% lower.

The Sales and Marketing Cluster of expenses was lower for Best-in-Class Plans by 48%. Best-in-Class cost advantage was primarily due to low Non-Labor Costs per FTE, lower by 51%. Staffing Ratio and Staffing Costs per FTE were also lower for Best-in-Class Plans. Best-in-Class Plans' Sales and Marketing outsourced an average of 16% and a median of 18% of FTEs. This compares to Peer Plans outsourcing an average of 11% and a median of 10% of FTEs.

Best-in-Class Plans held a cost advantage in all Sales and Marketing functional areas. Its most important advantage was in external Broker Commissions, at 61% lower for Best-in-Class Plans. In the Sherlock Benchmark classifications, external Broker Commissions are entirely Non-Labor expenses.

Sales functional area costs were also lower, by 23%, for Best-in-Class Plans. Both Staffing Ratio and Non-Labor Costs per FTE contributed similarly to this function's low costs, lower by 11% and 63%, respectively. Staffing Costs per FTE also favored Best-in-Class Plans by 4%.

Marketing expenses were lower by 41%. The sub-function, Other Marketing, comprised the largest source of low Marketing costs with Best-in-Class Plans holding a 47% advantage over Peer Plans. Staffing Ratio was the overwhelming driver in this sub-function's low costs. The Product Development and Market Research sub-function also contributed a significant amount of low costs, which was also due to low Staffing Ratios.

Rating and Underwriting costs were 37% lower for Best-in-Class Plans mainly on a low Staffing Ratio. Non-Labor Costs per FTE and Staffing Costs per FTE were also lower for Best-in-Class Plans. All Rating and Underwriting sub-functions were lower for the Best-in-Class Plans and a low Staffing Ratio was common among the sub-functions.

Advertising and Promotion costs were 25% lower for Best-in-Class Plans mostly due to lower Staffing Ratio. Non-Labor costs were also lower; if the Staffing Ratio was at the norm for the Peer Plans, Non-Labor Costs per FTE would have been lower by 28%. Lower Staffing Costs per FTE also contributed. Both sub-functions, Charitable Contributions and Media and Advertising were lower for Best-in-Class Plans by 68% and 18%, respectively.

Low costs of Sales and Marketing did not impact growth, evidently. Total product membership for the Best-in-Class Plans grew by a median value of 0.5%, compared with a median of decline 0.5% for their Peer plans. At the product-mix of the Best-in-Class Plans, the Peer Plans' membership growth was flat, still less than that of the Best-in-Class Plans.

Best-in-Class Plans had higher Medical Management Costs, by 5%, with high Non-Labor Costs per FTE as the central driver. Staffing Ratios were also higher for the Best-in-Class Plans by 4%. Staffing Costs per FTE were lower by 3%. (Best-in-Class Plans outsourced an average of 10% and a median of 8% of their Medical Management FTEs compared to Peer Plans at an average of 14% and 11% median.)

Despite higher Medical Management expenses, Best-in-Class Plans experienced lower gross profit margins at a median of 12% versus 13% for Peer Plans for *insured products*. (Insured products include Commercial Insured, FEP, Medicare Advantage, and Medicaid HMO). Peer Plans had even higher margins when reweighted at the mix of Best-in-Class Plans, at 17%. (Gross Profits are premiums less health benefits.)

Gross profits for *insured products* themselves were also higher in the Peer plans. On a PMPM basis, *insured* gross profits were $36 PMPM for the Best-in-Class Plans and $59 for the Peer plans. At the mix of the lower-cost plans, the Peer plans' PMPM gross profits were $58.

Similarly, it is notable that the median *insured* health benefit ratio for the Best-in-Class Plans was 88%, compared to 87% for the Peer Plans. At the product mix of the Best-in-Class Plans, the Peer plans had a median health benefit ratio of 86%.

There may be a unifying theme in these results though we do not further explore it in this report. That is, the Best-in-Class plans may have achieved their growth not through aggressive Sales and Marketing efforts but through low prices. They enabled this strategy by keeping Tactical and Sales and Marketing administrative costs low and investing in Medical Management. Any low health care costs that resulted from success in medical management were perhaps invested in low prices, attractive to the customers of these Best-in-Class Plans.

Our Approach

Each of the Plans studied during this study differs in many key characteristics. So, to compare them we employed a composite approach to summarize the characteristics of the low cost, Best-in-Class Plans and Peer Plans to which they are compared. We summarize the steps below.

1. We identify the Best-in-Class Plans by comparing each Plan's costs to its universe. We selected the lowest cost plans that comprise 25% of the total Blue Cross Blue Shield universe. To do so, and to eliminate the potentially distorting effect of product mix differences on the cost comparisons, we reweight the costs of the universe to match the mix of each plan. Thus, the lowest cost plans were those with the smallest differences from Plan-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 employed in establishing the factors underlying the differences between 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 identically calculated 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 as weights for both sets of Plans.

4. Staffing Ratios for each function were estimated so as to eliminate the effect of product mix differences and to overcome the fact that health plans generally don't segment their staff by product. To make this estimate, we first calculate 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 to adjust for the fact that the Staffing Ratios are presented in 10,000 members rather than per member.

5. The percent of total variance by the Best-in-Class Plans is calculated through a series of simulations and interpolations. Since costs Per Member Per Month is the product of Total Costs per FTE and the Staffing Ratio, each factor is held constant to assess the dollar impact of its opposite. The two resulting values are interpolated. The same procedure is employed on the per FTE Costs of Staffing and Non-Labor, given the calculation of the contribution of Total Costs per FTE.

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Would Your Health Plan Like to Participate in the 2017 Sherlock Benchmarking Study?

The highly valid, well-populated Sherlock Benchmarks provide an unbiased ranking and helps prioritize cost management activities to have the greatest impact on improving your health plan's overall operating performance. The combination of the current environment of the Affordable Care Act along with the distinct possibility of changes in law and regulation may make participation by your health plan an appropriate and necessary response to the strong incentives to cost efficiency.

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 the Selected Characteristics chart for what last year's participation looked like.

While the calendar varies by universe, broadly speaking we will meet to finalize the content of the survey in late February, distribute the survey forms in March, collect the completed surveys in May and publish beginning in late June or early July. Participation entails notable efforts on your part since useful outputs require relatively granular inputs. However, 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.

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