Plan Management Navigator
Analytics for Health Plan Administration March 2014

Decisions of Low Cost Independent/ Provider-Sponsored Plans

Independent / Provider-Sponsored ("IPS") Plans play a central role in local health care markets and health care reform may increase their prominence. They typically enjoy strong brand recognition, often through the association with a health system, hospital or physician group. In their traditional product offerings and through their culture they have tended to focus on managed care.

The following summary is of an analysis that is derived from data collected from the 16 Independent / Provider – Sponsored plans participating in the *Sherlock Expense Evaluation Report* in 2013. We have identified the characteristics of the 25% lowest cost IPS plans and how these four organizations are distinguished from their peers.

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Sherlock Benchmarking Universes

We are now building our 2014 Sherlock Benchmarking universes and are nearing completion on two universes. *Accordingly, as soon as possible, let us know whether participation is of interest since we will begin some of the Sherlock Benchmark surveys in two weeks.* Participation entails efforts on your part but you receive numerous comparative analyses. While licensing, which contains most of the same content as participation, can save your plan time, it costs more and cannot analyze your plan's relative performance.

Blue Cross Blue Shield Plans. Twenty Plans have committed to participate in this year's benchmarking study, or approximately one-half of all primary licensees of the Blue Cross and Blue Shield Association. (Several additional Plans license the materials.) Last week,

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Dashboard Summary

For the trailing three months ended December 31, 2013, the health plans in our *Health Plan Dashboard* reported an increase in health revenues of 8.7%. Revenues for Medicaid grew most rapidly, increasing by 17.2%. Medicare Advantage revenue growth followed at 4.7%, while Indemnity product revenues increased 2.7%. ASO/ASC and Managed Care revenues fell by 6.2% and 4.3%, respectively.

Overall, membership increased 1.1% for all health lines. Enrollment in Managed Care fell 1.1%, while increasing 1.6% for Indemnity. ASO/ASC membership declined 0.4%.

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PULSE Refocused

Plan Management Navigator and its sister publication, *PULSE* are complementary publications. While *Navigator* focuses on operational issues, *PULSE* provides insights on how operational performance translates into valuation and capital costs. If you are not yet a subscriber, let us know and we will be delighted sign you up. Also, if it would be helpful to evaluate *PULSE*, we'll be please to provide you a sample copy.

We've recently re-launched *PULSE,* to focus on and improve its highest value aspects. These include:

- Financial tables with summary valuation metrics and operating measures for all public health plans.
- Analysis of public and private M&A activity in the health plan industry.
- In-depth studies on topics that include: cost management of administrative

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Low Cost IPS Plans: *Continued from Page 1*

Figure 1. Plan Management Navigator
Sources of Total Variances, Mix-Adjusted

	Non-Labor Costs per FTE	Staffing Costs Per FTE	Total Costs Per FTE	FTEs Per 10,000 Members	Costs PMPM
Lowest Four Plans	*$63,717*	*$77,134*	*$140,851*	*11.12*	*$13.05*
Other Plans	$61,412	$85,087	$146,499	18.94	$23.12
Dollar Variance	$2,305	($7,953)	($5,648)	(7.82)	($10.07)
Percent Variance	3.8%	-9.3%	-3.9%	-41.3%	-43.6%
Percent of Total Variance	-2.9%	9.9%	7.0%	93.0%	100.0%
PMPM Dollar Variance	$0.29	($1.00)	($0.71)	($9.36)	($10.07)
Source of As-Reported Data:	*Vol. II.A, Pg312*	*Vol.II.A, Pg. 290*		*Vol.II.A, Pg. 274*	*Vol. I, Pg. 126*

1. The most important factor in overall low costs was a low Staffing Ratio. Staffing Ratios were lower by 41% than their higher cost peers and explained an overwhelming majority of the difference in costs. Moreover, Staffing Ratios were lower than their higher cost peers in every Tactical area[1] by at least 17%.

2. Compensation levels also contributed to the cost advantage of low cost health plans. Their low compensation aligned with the CMS Hospital Wage Index. Most functions were lower, except for Actuarial and Corporate Executive and Governance. It is possible, although this is entirely conjecture, that the high staffing costs for low cost plans in Corporate Executive and Governance stem from performance bonuses.

3. Non-Labor Costs per FTE were high[2], and offset some of the cost advantage for the low cost plans. Finance and Accounting, Information Systems, and Claims were functions that had high Non-Labor Costs per FTE. Most functions, however, were lower for the low cost plans.

4. Information Systems explained more of the superior performance more than any other function. The combination of Claims and Information Systems and claims in low cost plans had costs of 46% lower than that of their higher cost peers. Every tactical function had expenses lower than average, and the ones other than Claims and IS were lower by at least 29%.

5. Scale likely explained some the cost differences since the lower cost plans were, on average, about 26% larger than their higher cost peers.

6. Plans that were low cost in tactical expenses were also lower cost in Strategic[3] expenses. The Sales and Marketing expenses were more than 14% lower. External broker commissions, however, were higher for the low cost plans. The combination of low internal marketing and internal sales, coupled with high commissions suggests that low cost plans favor an external distribution system. Rating and Underwriting costs were also slightly higher.

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IPS Plans: *Continued from Page 2*

7. Medical Management expenses were also lower for low cost plans. Almost all Medical Management sub-functions were lower except for Disease Management. Health Benefit Ratios for the low cost plans, however, ran higher holding the product mix constant.

These conclusions are from the 2013 Sherlock Benchmarks, reflecting 2012 experience. These conclusions also reflect that we have carefully adjusted the results to eliminate the effect of product mix differences.

Additional detail on this is available to licensees and participants of the 2013 IPS benchmarking study. Let us know of your interest and we will email the longer report to you.

[1] Tactical expenses are total expenses excluding Sales and Marketing and Medical Management.

[2] Per FTE Non-Labor can be difficult to interpret in cases in which a function is predominantly non-labor. For instance, the effect of low staffing ratios amplifies differences in non-labor costs.

[3] Strategic expenses are considered Sales and Marketing and Medical Management. Investments in Sales and Marketing are typically realized in subsequent years, while investments in Medical Management can be realized in lower medical expenses.

Dashboard Summary: *Continued from Page 1*

Membership grew in both Medicaid and Medicare by 4.6% and 4.2%, respectively.

Both Managed Care and Medicaid experienced the largest price increases, both at 3.5%. Indemnity followed with a price increase of 1.1%. Medicare Advantage products had a price *decrease* of 2.3%, while ASO/ASC posted a decline of 5.3%.

Health benefit ratios for health lines deteriorated by 2.0 percentage points to 90.0%. Managed Care and Indemnity had the largest increases of 5.4 percentage points and 4.5 percentage points, respectively. The number of scripts per person increased by 0.4 to 9.5 on an annualized basis. E/R visits per thousand members fell 13.4 to an annual rate of 241.8 per thousand, while hospital days also increased by 21.2 days to 335.1 days per thousand.

The administrative expense to premium ratio increased 0.6 percentage points to 11.8%, while the administrative costs per member per month increased 2.3% to $34.76. Claims volumes increased 0.87 to 17.7 per member per year, while inquiries per member grew 0.34 to 1.9 per member per year. Staffing ratios fell 0.32 FTEs per 10,000 members to 21.1.

Health plans in our *Dashboard* universe are comprised of Blue Cross Blue Shield and Independent/Provider-Sponsored Plans. *Participation is frankly thinner than we would like but any participant in any of the benchmarking studies is can do so for free.* Please contact us if you have an interest in participating or receiving the *Dashboard* at 215-628-2289 or sherlock@sherlockco.com

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expenses, economies of scale in health plans, analysis on health plan type, size, and product concentration, and premium rate increases.

Moreover, to enhance usability we are increasing its frequency from monthly to weekly. Financial tables will be sent every week, while in-depth studies will be sent every quarter. Financial analysis and commentary of M&A transactions will be published as they occur. Finally, we are transmitting the documents electronically to enhance its timeliness. The

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Benchmarking Universes: *Continued from Page 1*

the panel met in Houston to discuss and resolve emerging issues in definitions, calculation methodologies and application of the results. We will launch the study in late March, and begin publishing the results in July.

Independent / Provider – Sponsored Plans. This universe so far is comprised of 17 plans, plus two more are evaluating participation. (We also met with this panel in Houston last week.) We believe that, by virtue of their size, their willingness to measure their performance and from what we've learned from participation trends, these organizations tend to be stronger than average compared with their peer group. As a set of plans, they are a minority among the 100 health benefit organizations that either are sponsored by health systems or are regional, independent plans with a managed care focus. These organizations are prominent in their markets and often were originally formed as HMOs. As with the Blue universe, we will launch the study in late March, and begin publishing the results in July.

Third Party Administrators. We are in the process of building a panel for a universe of TPAs. Our approach to recruiting is to begin with large foundational TPAs since this segment is fragmented into relatively small organizations – a TPA with more than $20 million in annual revenues would be in the top 10%. We have the commitments of three such foundational organizations, and several more are considering. TPAs differ from insurers in their remarkably modest cost structure and what they consider to be high flexibility. This study is scheduled to launch in late April and the results will be published in August.

Medicare Universe. The Medicare universe will be launched immediately after the June 2, 2014 bid submission to accommodate the availability of the finance teams normally tasked both the Sherlock survey and the Medicare bid. The results are available to participants and licensees beginning in late September.

Last year, the panel was comprised of 11 plans serving 1.2 million Medicare Advantage members. We also include exhibits from other universes, like Blues and IPS, showing their Medicare cost performance as well. In all, the benchmarks reflect the results of organizations that served approximately 18% of all Medicare Advantage members.

Medicaid Universe. Because Medicaid plans often also participate in Medicare, this universe will also be launched immediately after the June 2, 2014 Medicare bid submission, and again to accommodate time conflicts. Last year, the 11 plans served 1.1 million Medicaid beneficiaries, and 2.3 million when comparable products from other universes are included. The results are available to participants and licensees beginning in late September.

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refocused publication will be provided in PDF format, with the financial tables in easy to use Excel®.

Streamlining *PULSE* is intended to not only be responsive to your needs, but also be more economical. Accordingly, we are sharing these savings with you. The new price is $375; if you have a subscription any amounts in excess of this price will be credited to future periods. Please contact us if you are interested in a subscription. If you would like a sample copy, please let us know and we'll send one immediately.