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How do Best-in-Class Health Plans Achieve it?

Introduction

The object of benchmarking is to chart a path to performance improvement, a need made more acute by the full implementation of the Affordable Care Act. In this analysis we employ the Sherlock Benchmarks and participant results to identify the characteristics of the Best-in-Class Independent / Provider-Sponsored health plans. For these purposes, we define Best-in-Class as among the 25th percentile in lowest cost. Others are called Peer plans. All data is from 2013.

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.

Summary

Best-in-Class plans operated at PMPM costs of $16.48 compared with $27.47 for their peers, or $10.99 lower. A Staffing Ratio that was 39% lower than their Peers explained 98% of the difference. Non-labor costs were higher than average and lower compensation explained 12% of the difference[1]. The above exclude Sales and Marketing and Medical Management.

Low costs in the Information Systems and Claims areas are responsible for 62% of the difference between the Best-in-Class plans and their Peers. Corporate Services is also low, so these three functions comprise 77% of the difference between the two sets. Almost every functional area was lower for the Best-in-Class Plans. Low staffing ratios are central to this. Thus, for health plans wishing to operate at Best-in-Class levels, focusing on these functional areas and on processes that achieve low staffing are reasonable places to begin.

Account for Extraneous Factors

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

Advantages of Scale. Scale likely played a role but a modest one. We can infer this since the mean membership size for Best-in-Class plans was 512,000 versus 461,000 for the Peer plans. The median values were 493,000 and 346,000 respectively. Size did not determine ranking though since two of the four Best-in-Class plans were significantly smaller than the median size of the Peer plans.

1. All factor ratios, 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.

Operating in Low Wage Areas. There was an effect of local costs of living but it was modest. The mean wage index was 0.902 among the Best-in-Class Plans and 0.994 among the Peer plans, 9.3% lower (We employ the Hospital Wage Index used by CMS). Importantly, Staffing Costs per FTE were lower by 10.9%, meaning that Staffing Costs per FTE were lower than indicated by the relative wage index. In any event, the proportion of the Best-in-Class cost advantage that can be attributed to Staffing costs is only 12%.

The wage index, it should be recognized, may actually distort the actual wage differences experienced by the wage environment actually 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.

Propensity to Outsource. Outsourcing was unlikely to have contributed to low costs in the Best-in-Class plans. The mean percent of FTEs outsourced was 8% among the Best-in-Class plans and 13% among the Peer plans. The median percent of FTEs outsourced was 3% among the Best-in-Class plans and 11% among the Peer plans.

Information Systems was among the functions most often outsourced, at a mean of 15% for all Independent / Provider-Sponsored plans. The mean percent of FTEs outsourced was 7% among the Best-in-Class plans and 18% among the Peer plans. The median percent of FTEs outsourced was 1% among the Best-in-Class plans and 16% among the Peer plans.

Low Cost Product Mix. By reweighting, as we describe in 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 so it is important to make this adjustment to reported costs. The sets of plans were in fact different so that reweighting to eliminate the effects of product mix was an important step.

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 chief part of this analysis. In making this exclusion, we are recognizing that these "strategic" expenses have impacts outside of current period administrative costs. We therefore exclude Medical Management expenses because their effects may produce lower health care costs in the current or future periods. We also exclude Sales and Marketing expenses since they may produce revenue growth, and a significant proportion of that growth occurs in the year following the one in which the expense is incurred. We do, however, address these functional areas separately towards the end of this analysis.

Figure 1. Best-in-Class Health Plans
Product Mix Comparison

	Commercial Insured	Commercial ASO	Commercial Total	Medicare Total	Medicaid Total	Comprehensive Total
Best-in-Class Plans	42%	18%	60%	12%	27%	100%
Peer Plans	55%	20%	75%	12%	10%	100%

Activities That Made a Difference

Because nearly all of the functions in Best-in-Class plans were lower than average, they 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.

First, the Account and Membership Administration cluster of functions comprised 72% of the $10.99 difference between the Best in Class and their peers, or $7.89. This cluster is comprised of Enrollment/Membership/Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information Systems.

The most important reason why costs were lower is Information Systems and Claim and Encounter Capture and Adjudication. Collectively, their costs comprised 62% of overall low cost variance and 86% of the overall low cost variance in Account and Membership Administration. The other two functions in this cluster, Enrollment / Membership / Billing and Customer Services, were also lower.

In addition, the Corporate Services function comprised an additional 15% of the overall low cost variance.

Information Systems. Costs were 46% lower than their Peers and Staffing Ratios were 58% lower. Non-Labor Costs per FTE were much higher.

While Operations and Support, Applications Maintenance and Applications Acquisition and Development contributed similar amounts to the overall low cost variance, Applications Maintenance was most favorable. Application Acquisition and Development was the strongest example of very low Staffing Ratios and very high Non-labor costs per FTE.

Claim and Encounter Capture and Adjudication. This function's costs were also low, primarily due to a low staffing ratio. This is significant in light of the low Information Systems costs since there is always the concern that the same activities in two organizations may be reflected differently, either through reporting error or differing degrees of auto-adjudication. Both sub-functions, Coordination of Benefits and Subrogation, and Other Claim and Encounter Capture and Adjudication, were lower and a low staffing ratio was a central factor.

Enrollment/Membership/Billing and Customer Services. Both functions were low mainly due to low Staffing Ratios.

In the Account and Membership Administration cluster as a whole, Non-Labor expenses per FTE were 9% lower, even as the Staffing Ratio was lower by 38%. So, if the staffing ratio in the Best-in-Class group was the same as the Peers, and if the non-labor costs remained the same, the Non-Labor costs would be lower than average. 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 are responsible for superior performance. Put conversely, productivity is simply higher for the Best-in-Class organizations.

Corporate Services. This function comprised 15% of the overall low cost variance. This function's cost advantage plus those of the Information Systems and Claims variance comprised 77% of the low cost variance of the Best-in-Class plans.

A Staffing Ratio that was 52% less than the Peer plans drove low costs in the Corporate Services function. There were five subcategories within this functional area: Human Resources, Legal, Facilities, Imaging and Other. All were relatively low cost for the Best-in-Class plans. In every subcategory, a low staffing ratio was by far the factor most responsible for the low costs.

Finance and Accounting, the Sole Exception

Of the ten tactical functional areas, the only one that is higher in the Best-in-Class plans is Finance and Accounting. The costs for the sub-category of Credit Card Fees are exactly the same in the Best-in-Class and Peer plans. In the activities of All Other Finance and Accounting, the source of high costs appeared to be Non-Labor expenses per FTE, which were approximately double that of the Peer plans. Since the Staffing Ratio was only low by 20%, even if the Staffing Ratios were identical, the non-labor costs would still be high.

Strategic Expenses were Also Lower

Reflecting the culture of conservative administration, Best-in-Class Plans also have lower costs in the Strategic areas of Sales and Marketing and Medical Management. These costs increase the Best-in-Class advantages by $1.42 PMPM.

Sales and Marketing costs were lower for Best-in-Class plans by $0.76, entirely due to their lower Staffing Ratios. Staffing costs per FTE were higher in this cluster.

All four functions with FTEs, Rating and Underwriting, Marketing, Sales and Advertising and Promotion, had lower staffing ratios. Only in the sub-function of Marketing, Member and Group Communication, the sub-function of Sales, Account Services and the sub-function of Media and Advertising, Advertising and Promotion, did the Best-in-Class have higher staffing ratios. Also, each of these sub-functions had higher compensation levels than the Peer plans. All but Media and Advertising had higher PMPM costs.

Broker Commissions, which we classify as non-labor, were higher in the Best-in-Class plans, by 28%. Similarly, the Best-in-Class plans report that 5.7% of their Sales and Marketing staff is outsourced, compared with 0.8% for the Peer plans.

However, Best-in-Class plans' lower Sales and Marketing costs illustrated a potential trade-off in the rate of membership growth. On one hand, total product membership for the Best-in-Class plans grew by a median value of 1.0%, compared with a median of 0.8% for their Peer plans. More meaningfully, the Peer plans, when weighted at the product-mix of the Best-in-Class plans, posted an increase of 1.5%, growing faster than the Best-in-Class plans.

Best-in-Class plans had lower Medical Management Costs as well, by $0.65. Interestingly, the chief reason is not staffing, which is 24% higher than the Peer plans. It is non-labor costs that are lower, by nearly two-thirds. (Outsourcing was about the same, at 3%.) Staffing was higher in such significant areas as Case Management and Disease Management, but was also higher in Nurse-based Counseling and Health and Wellness. Staffing in Pre-certification, Quality Components, Medical Informatics Utilization Review and Other Medical Management, all of which are relatively small, were low.

Every sub-function had lower non-labor costs except for Disease Management, Utilization Review and Other Medical Management.

It is possible that lower expenses in Medical Management by the Best-in-Class plans resulted lower gross profits, that is, premiums less health benefits. As with Sales and Marketing, it may illustrate a potential trade-off of low costs of administrative expenses on other attributes of health plan performance.

Gross profit margins are higher for the Peer plans. Gross profit margins for Insured products had a median of 11.3% for the Best-in-Class plans and 13.1% for the Peer plans. At the mix of the Best-in-Class plans, the Peer plans had a gross profit margin of 12.2%, still higher but less so.

Gross profits themselves are also higher in the Peer plans. On a PMPM basis, Insured gross profits were $36 PMPM for the Best-in-Class plans and $44 for the Peer plans. At the mix of the low-cost plans, the Peer plans' advantage was greater with gross profits of $49 PMPM.

Similarly, it is notable that the median insured health benefit ratio for the Best-in-Class plans was 88.7%, compared to 86.9% for the Peer plans. At the product mix of the Best-in-Class plans, the Peer plans had a health benefit ratio of 87.8%.

Our Approach

Each of the plans studied in the course of this study 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 Independent/Provider-Sponsored plan universe. To eliminate the potentially distorting effect of mix differences between them, we reweight the costs of the universe to match the mix of each plan. 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 gave 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. 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. 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 2015 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. To date, 23 plans have committed to participate in this year's Independent/Provider-Sponsored Sherlock Benchmarking Study. That is up by 44% from 16 last year. Notably, every plan participating in 2014 is participating again in 2015. Collectively, the so-far committed plans serve 10.5 million people with comprehensive products.

We will distribute the survey forms in March, collect the completed surveys in May and publish beginning in 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 Doug Sherlock at sherlock@sherlockco.com or 215-628-2289 if you are interested. You will be among good company.