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Analysis from Sherlock Benchmarks: The Account and Membership Administration Cluster

In our most recent *PULSE* insert, we analyzed the effects of certain plan characteristics and its impact on the Account and Membership Administration cluster, or the core operating areas of 35 health plans, of Blue Cross Blue Shield ("BCBS") and Independent/Provider-Sponsored ("IPS") plans. Approximately 42% of all administrative expenses and 7% of the health insurance dollar are represented by this cluster. Functions in this cluster include Enrollment / Membership / Billing, Customer Services, Claims, and Information Systems.

The results indicate that plan size does not offer a cost advantage for larger firms over their smaller peers. Additionally, it appeared that plan type did not affect administrative costs, while product fragmentation also did not lead to higher costs. We did, however, find evidence that larger firms do have lower staffing ratios than their smaller peers. We emphasize that this did not lead to lower costs. Thus, the underlying costs of the functions cannot be said to be a barrier to entry to new health plans.

Similar to our analysis of overall health plan costs, we achieved comparability between all of the BCBS Plans and IPS plans by reweighting universe product mixes so that they match each plan's. Then, cost values were analyzed as differences from the mix-adjusted universe values. Our measurement of economies of scale used two different methodologies. Our first approach was by regression analysis, while the second approach ranked the plans by cost differences from the reweighted mean. The regression approach did not yield a correlation between lower costs and size. Health plans of all sizes were scattered throughout the ranking approach. We performed the regressions for each of the four functional areas as well, and economies of scale were not evident there.

We also analyzed the ranking to determine if plan type (i.e., IPS vs. Blue) led to superior cost performance in Account and Membership Administration expenses. While the lowest cost five plans were from the IPS universe, the three highest cost firms were also IPS plans. In addition, there were 17 plans that were lower than the reweighted mean with 9 IPS plans and 8 Blue Plans. We also found that dispersion may have affected the ranking with Blue Plans more closely clustered compared to IPS plans.

Using the two ranking and regression approaches, we analyzed plan staffing ratios. While size does not appear to determine cost advantages, large firms may in fact operate differently than their smaller peers. Under both approaches, larger firms tend to have lower staffing ratios compared to smaller firms.

Lastly, we looked at product focus, using the Herfindahl-Hirschman Index, in the Account and Membership Administration cluster. We did not find that increased product focus, or plans with fewer products, led to lower costs.

In summary, cost advantages in the Account and Membership Administration cluster do not exist due to scale or product focus. Larger plans operate differently with lower staffing ratios compared to their smaller peers, but this also does not lead to cost advantages. Therefore, since cost advantages are only achieved through excellence of execution, administrative scale is *not* a barrier to entry to new health plans. *The source of the data used in this study are editions of the 2014 Sherlock Expense Evaluation Reports, which are available for license.*

SHERLOCK BENCHMARKS

Sherlock Benchmarks comprised of Blue Cross Blue Shield, Independent / Provider – Sponsored, Medicaid and Medicare plan data are available for license. We also offer a subset of the largest of the Blue Cross Blue Shield plans called the Larger Plan edition. Please contact us if you wish to license them the Sherlock Benchmarks.

The benchmarks help you discover how you are managing administrative costs, in an environment that increasingly rewards its excellence. They also help you to prioritize any operational cost variances as well as staffing, compensation and productivity differences. Accordingly, they are often referred to as the "gold standard" of health insurance operational benchmarks. Health plans serving 109 million people served with comprehensive health insurance products are users of the Sherlock Benchmarks. Please contact 215-628-2289 or sherlock@sherlockco.com if we can send you additional information on the Sherlock Benchmarks. A brochure is attached to this email.

HAVE YOU CONSIDERED PARTICIPATING IN THE SHERLOCK BENCHMARKS?

In 2013, the Affordable Care Act required health plans to make investments, thereby making it the baseline year. Now that ACA is largely implemented, 2014 is Year 1. So, with the adaptation and "bulge" expenses past, and with the finance department less occupied in support of these investments, perhaps it is timely for your plan to consider participation in the Sherlock Benchmarking study in 2015.

We are now building our 18th consecutive annual panels for Blue Cross Blue Shield Plans and Independent / Provider - Sponsored Plans. We also welcome plans to the Medicaid and Medicare universes, though their survey process will begin a little later in the year. Draft survey materials for the Blue Cross Blue Shield and Independent / Provider - Sponsored universes will be distributed in late January. The survey forms will be finalized and distributed in March. The completed survey will be due back to us in mid-May and reports will be distributed beginning in the first week in July.

We hope you can join other Sherlock Benchmark users in participating in the "gold standard" effort to begin the process of optimizing administrative costs. Additional information and a mutual confidentiality agreement are available upon request.