Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

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

John J. Park
jpark@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

How do Best-in-Class Blue Cross Blue Shield 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 Blue Cross Blue Shield 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 $15.27 compared with $20.82 for their peers, or $5.54 lower. A Staffing Ratio that was 30% lower than their Peers explained 117% of the difference. Non-labor costs were higher than average and lower compensation explained 12% of the difference.

Low costs in the Information Systems function was responsible for 52% of the difference. The Provider Network Management and Services and Corporate Services function were also low, so these three functions comprise 74% of the difference between the two sets. Every functional area was lower for the Best-in-Class Plans.

Low staffing ratios were prominent, even dominant, contributors in each case. Thus, for health plans wishing to operate at Best-in-Class levels, focusing on these functional areas and achieving processes that achieve low staffing ratios 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 some role. We can infer this since the mean membership size for Best-in-Class Plans was 2.0 million members versus 1.4 million for the Peer Plans. The median values were 1.6 million and 620,000 respectively. Size did not *determine* ranking though since our seventh smallest Plan ranked the lowest in tactical costs. Two of the five Best-in-Class Plans were significantly smaller than the median size of the Peer Plans.

Operating in Low Wage Areas. There was an effect of local costs of living but it was modest. The mean wage index was 0.872 among the Best-in-Class Plans and 0.962 among the Peer Plans, 9.4% lower (We employ the Hospital Wage Index used by CMS). Importantly, Staffing Costs per FTE were lower by 6.7%, meaning that Staffing Costs per FTE were higher than indicated by the relative wage index. In any event, 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 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 9% among the Best-in-Class Plans and 18% among the Peer Plans. The median percent of FTEs outsourced was 8% among the Best-in-Class Plans and 13% among the Peer Plans.

Information Systems was among the functions most often outsourced, at a mean of 31% for all Blue Cross Blue Shield Plans. The mean percent of FTEs outsourced was 19% among the Best-in-Class Plans and 35% among the Peer Plans. The median percent of Information Systems FTEs outsourced was 21% among the Best-in-Class Plans and 38% among the Peer Plans.

Low Cost Product Mix. By reweighting, as we describe in the last section in this analysis titled: *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.

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.

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 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 68% of the $5.54 difference between the Best-in-Class and their peers, or $3.78. Account and Membership Administration includes 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 52% of the low cost variance in this cluster. Both Enrollment / Membership / Billing and Customer Services were lower and comprised an additional 14% of the lower costs of the Best-in-Class Plans. Claim and Encounter Capture and Adjudication was also lower and contributed 3% to the overall low cost variance.

In addition, the Provider Network Management and Services and the Corporate Services functions comprised an additional 22% of the overall low cost variance.

Information Systems. Costs in this function were 37% lower in the Best-in-Class Plans. Non-Labor Costs per FTE were 42% lower and comprised most of the low cost variance. Staffing Ratios were 19% lower and comprised most of the remaining difference. Staffing Costs per FTE were also slightly lower.

Applications Acquisition and Development contributed 72% to the low cost variance in Information Systems. All its drivers were lower but the staffing ratio, lower by 66%, was responsible for 70% of the low cost variance in that sub-function. The sub-function Operations and Support was also lower, by 29%, and the low Staffing Ratio was responsible for all and more of the difference.

Enrollment/Membership/Billing and Customer Services. Both functions were low mainly due to low Staffing Ratios. In both functions, Staffing Costs per FTE were lower by double-digit percents.

Claim and Encounter Capture and Adjudication. This function's costs were also low, but by only 4%. However, the 38% low staffing ratio was almost completely offset by higher Non-Labor costs per FTE. Low Staffing Ratios were generally found in the sub-functions as well.

In the Account and Membership Administration cluster as a whole, Non-Labor expenses per FTE was only 10% higher, but the Staffing Ratio was lower by 30%. 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 and low Non-Labor costs 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.

Provider Network Management and Services. This function had lower costs overwhelmingly due to a 52% lower staffing ratio. Also, all sub-functions had lower staffing ratios. The Provider Relations Services sub-function was responsible for 70% of the low cost variance for the function. The staffing ratio for this sub-function was 59% lower. Staffing costs per FTE generally ran higher, notably in Provider Audit / Billing Validation.

Corporate Services. This function comprised 10% of the low cost variance. This function's cost advantage plus those of the Information Systems and Provider Network Management and Services variance comprised 74% of the low cost variance of the Best-in-Class Plans.

A Staffing Ratio that was 17% less than the Peer Plans drove low costs in the Corporate Services function. There were nine sub-functions within this functional area: Human Resources, Legal, Facilities, OPEB, Audit, Purchasing, Imaging, Printing and Mailroom and Other. Except for OPEB, and Other Corporate Services, all were low cost for the Best-in-Class Plans. In most sub-functions, the Plans had low staffing ratios and in each of those cases, a low staffing ratio contributed at least 72% of the low cost comparison.

Strategic Expenses were Also Lower

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 by $2.89 PMPM.

Sales and Marketing costs were lower for Best-in-Class Plans by $2.37 PMPM, 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 were lower except for Rating and Underwriting, which costs were higher by $0.10 PMPM. Higher Staffing and Non-Labor Costs PMPM are central to this superior performance.

We classify broker Commissions are entirely Non-Labor. They were $1.35 lower PMPM. Interestingly, and by contrast, 12.3% of Best-in-Class Sales and Marketing FTEs were outsourced compared to 10.2% of the Peer Plans.

Sales costs were also lower, by $0.71 chiefly due to a Staffing Ratio that was lower by 82%.

Marketing Costs were also lower, by $0.28. The chief source of this was Product Development and Market Research, at $0.23 lower, chiefly due to a low Staffing Ratio. This was the driver of the cost advantages of the other Marketing sub-functions that were lower as well.

However, Best-in-Class Plans' lower Sales and Marketing costs illustrated a potential trade-off in the rate of membership growth. Total product membership for the Best-in-Class Plans grew by a median value of 1.9%, compared with a median of 2.1% 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 2.8%, an even more dramatic differential.

Best-in-Class Plans had lower Medical Management Costs as well, by $0.52. The chief reason is staffing ratio, which was 25% lower than the Peer Plans. (Both sets had just over 10% of their FTEs outsourced in this function.) Staffing was lower in every sub-function except Utilization Review.

While compensation was approximately the same, it was higher in every sub-function except for Quality Components, Medical Informatics and Utilization Review.

Non-Labor costs were higher in all sub-functions except for Nurse-based Counseling and Utilization Review.

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 in the Peer Plans. Gross profit margins for Insured products had a median of 7.5% for the Best-in-Class Plans and 12.3% for the Peer Plans. At the mix of the Best-in-Class Plans, the Peer Plans had a gross profit margin of 12.8%.

Gross profits themselves are also higher in the Peer Plans. On a PMPM basis, Insured gross profits were $20 PMPM for the Best-in-Class Plans and $45 for the Peer Plans. At the mix of the low-cost plans, the Peer Plans' advantage was similar with gross profits of $44 PMPM.

Similarly, it is notable that the median insured health benefit ratio for the Best-in-Class Plans was 92.5%, compared to 87.7% for the Peer Plans. At the product mix of the Best-in-Class Plans, the Peer Plans had a median health benefit ratio of 87.2%.

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 Blue Cross Blue Shield universe. To eliminate the potentially distorting effect of mix differences on the cost comparisons, we reweighted 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. Five 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, 94% of the continuing Blue Cross Blue Shield primary licensees that participated in last year's study have committed to do so again in 2015. The number of committed primary licensees is exactly the same, with the addition of one Plan. Collectively, the so-far committed Plans serve over 28 million people with comprehensive products.

In the Independent/Provider-Sponsored Universe, 100% of last year's plans are participating in 2015, plus we have added seven more. Collectively, the 23 Independent/Provider-Sponsored plans serve more than 10 million people with comprehensive health coverage.

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.