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Please see invitation to participate in the 2018 Sherlock Benchmarking Study on Page 9.

Best-in-Class Independent / Provider-Sponsored Plans

This is our analysis of "Best-in-Class" Independent / Provider – Sponsored (IPS) plans versus their Peers. Our analysis is based on the 20th annual Sherlock Benchmarks and 15th edition of the IPS study. 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 2016.

Notwithstanding our referring to low cost plans as Best-in-Class, we recognize that the maximizing long-term objective are costs that are optimal for its strategic objectives. 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 the Sales and Marketing cluster and Medical Management function. 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 Independent / Provider-Sponsored Health Plans
Functions in Tactical and Strategic Expenses

Tactical Expenses:
Provider Network Management and Services

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

Strategic Expenses:
Sales and Marketing Cluster
- Rating and Underwriting
- Marketing
- Sales
- Broker Commissions
- Advertising and Promotion

Medical Management / Quality Assurance / Wellness

Conclusions

Median PMPM Tactical expenses were 45% lower for Best-in-Class plans compared to the Peer plans[1]. A low Staffing Ratio was the main driver in low Tactical costs for Best-in-Class plans, an advantage of 40% and comprising 87% of the difference. Every functional area for Best-in-Class plans operated at a lower Staffing Ratio.

Staffing Costs per FTE were 19% lower in favor of Best-in-Class plans and contributed 20% to low Tactical costs. Conversely, Non-Labor Costs per FTE were *higher* for Best-in-Class plans, a difference of 9% comprising negative 7% of low tactical expenses.

It appears that Best-in-Class plans operate in a culture of conservative administrative expenses since all Tactical functional areas were lower than the Peer plans. The overwhelming contributor among functions to superior performance was low costs in Information Systems and it was responsible for 30% of the difference. Other notable low cost functions include the Corporate Services function and Claims functions. These three functions composed 65% of the difference between the two sets of plans.

Accounting for Extraneous Factors

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

Scale. If scale played a role, it was modest. The mean membership size for Best-in-Class plans was 607,000 versus 462,000 for the Peer plans, about 24% smaller. The median values for the two sets were 731,000 and 361,000, respectively. The standard deviations of the two sets are about 448,000 for the peer plans and about 443,000 for the Best-in-Class plans, together showing overlap between the sets.

Cost of Living. There was likely an effect of local costs of living but it was modest. The mean wage index was 0.920 among the Best-in-Class plans and 0.985 among the Peer plans, 7% lower (We employ the Hospital Wage Index used by CMS). Meanwhile, mean wage index for all plans was 0.969. Importantly, Staffing Costs per FTE for the Best-in-Class plans were lower by 19%, 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 attributed to Staffing Costs per FTE is 20%.

[1] Costs are standardized for member months (i.e., PMPM) even if not stated.

The wage index, it should be recognized, may actually exaggerate 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 associated with higher costs in the Peer plans. The mean percent of FTEs outsourced was 13% among the Best-in-Class plans and 18% among the Peer plans. The median percent of FTEs outsourced was 10% among the Best-in-Class plans and 18% among the Peer plans[2].

Information Systems is generally among the functions most often outsourced, at a mean of 25% for all Independent / Provider-Sponsored plans. The mean percent of FTEs outsourced was 22% among the Best-in-Class plans and 28% among the Peer plans. The median percent of Information Systems FTEs outsourced was 19% among the Best-in-Class plans and 26% among the Peer plans. The Information Systems costs for Best-in-Class plans was the most important factor in their lower costs.

Low-Cost Product Mix. Mix can make a difference since product costs can differ. The Best-in-Class plans had more low cost Medicaid, but fewer low cost ASO members. However, by reweighting to equalize the mixes, as we describe in the section Our Approach, the analysis presented here eliminates the effect of any product mix differences between the sets of plans. The different product mixes can be seen below. These are mean values.

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 "investments" are excluded from the central part of this analysis. In making this exclusion, we are recognizing that these "strategic" expenses generate benefits in future periods. We do address these activities separately towards the end of this analysis.

Figure 2. Best-in-Class Independent / Provider-Sponsored Health Plans
Product Mix Comparisons*

	Commercial Insured	Commercial ASO	Commercial Total	Medicare Supplemental	Medicare Total	Medicaid Total	Comprehensive Total
Best-in-Class	47%	21%	69%	3%	11%	18%	100%
Peer Plans	49%	24%	73%	3%	11%	13%	100%

[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.

Activities that Made a Difference

Because all tactical 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 58% of the difference between the Best-in-Class plans and their Peers. Account and Membership Administration is comprised of the central health plan 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 slightly more than half of the low-cost variance in this cluster and 30% of low tactical costs. Claim and Encounter Capture and Adjudication contributed 15% to overall low tactical costs and 25% of the cluster's low costs. Since the degree of automation can cause where certain activities are reflected, it is interesting to see that both IS and Claims are lower. The sum of Information Systems and Claims, was lower for the Best-in-Class plans by 45%. Customer Services and Enrollment contributed 7% and 6%, respectively, to overall low tactical costs.

In the Account and Membership Administration cluster as a whole, the Staffing Ratio was the most important driver, responsible for three quarters of the variance, and was lower by 34%. Non-Labor Costs per FTE and Staffing Costs per FTE were lower than the peer plans by 15% and 11%, respectively.

Information Systems. This function's costs were 38% lower for the Best-in-Class plans with the Staffing Ratio being the sole factor for this function's low cost, lower by 38%. Non-Labor Costs per FTE were higher by 0.7% and Staffing Costs per FTE were greater by 0.6%.

The sub-function, Applications Acquisition and Development, contributed the most to overall low Information Systems expenses. Best-in-Class plans were 55% lower in this sub-function's costs with a low Staffing Ratio a chief driver. The Staffing Ratio was 54% lower in favor of the Best-in-Class plans, while Staffing Costs per FTE was lower by 15%. Non-Labor Costs per FTE, however, was higher by 8%.

Corporate Services *Function*. Best-in-Class plans posted 51% lower expenses compared to Peer plans and composed 20% of overall low tactical costs. This function's low costs were chiefly due to a low Staffing Ratio at 52% lower in favor of Best-in-Class plans. Staffing Costs per FTE and Non-Labor Costs per FTE, however, were higher for Best-in-Class plans by 4% and 1%, respectively.

There were nine sub-functions within this functional area: Human Resources, Legal, Facilities, Audit, Purchasing, Imaging, Printing and Mailroom, Risk Management and Other. All sub-functions were lower for the Best-in-Class plans except for Audit and Printing and Mailroom.

Claim and Encounter Capture and Adjudication. Best-in-Class plans reported expenses that were lower than Peer plans by 53% and contributed 15% to overall low tactical expenses. All factors were lower for Best-in-Class plans with a 43% lower Staffing Ratio the central driver. Non-Labor Costs per FTE was 32% lower than Peer plans, while Staffing Costs per FTE was 11% lower.

Provider Network Management and Services. This function contributed 10% to overall low tactical costs and were lower for Best-in-Class plans by 46%. Low Staffing Ratio was the overwhelming driver for this function and was lower by 44% in favor of Best-in-Class plans. Staffing Costs per FTE was 19% lower for Best-in-Class plans. Conversely, Best-in-Class Non-Labor Costs per FTE were double that of Peer plans.

All Provider Network Management and Services sub-functions were lower in favor of Best-in-Class plans. A low Staffing Ratio was found for each of the three sub-functions.

Of the sub-functions, Provider Contracting contributed the most to overall low tactical costs, at 4%. PMPM expenses were 46% lower for Best-in-Class plans with a Staffing Ratio lower by 73% the sole driver. Non-Labor Costs per FTE were higher for Best-in-Class plans by over 8 times. Staffing Costs per FTE were higher for Best-in-Class plans by 6%.

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 the Sales and Marketing cluster and the Medical Management function.

The Sales and Marketing Cluster of expenses was lower for Best-in-Class plans by 19%. Best-in-Class cost advantage was primarily due to a low Staffing Ratio, which was lower by 43%. Staffing Costs per FTE were 10% lower, but Non-Labor Costs per FTE were significantly higher by 65% for Best-in-Class plans.

Best-in-Class plans' Sales and Marketing outsourced an average of 7% and a median of 10% of its FTEs. This compares to Peer plans who also outsourced an average of 5% and a median of 8% of FTEs.

Best-in-Class plans held a cost advantage in the majority of functions in the Sales and Marketing cluster. Its most important advantage was in Marketing, which was 55% lower than the Peer plans. The Staffing Ratio was 61% lower for this function, while Staffing Costs per FTE were 6% lower. Non-Labor Costs per FTE were 39% higher than the Peer plans.

Sales expenses were lower by 43%. The Staffing Ratio was the central driver in this function's low costs, lower by 43%. Staffing Costs per FTE were 14% lower, while Non-Labor Costs per FTE were greater by 129%.

By contrast, External Broker Commissions were 7% higher for the Best-in-Class plans. In the Sherlock Benchmark classifications, external Broker Commissions are entirely Non-Labor expenses.

Rating and Underwriting costs were 38% lower for Best-in-Class plans explainable entirely by a low Staffing Ratio. Staffing Costs were also low, but Non-Labor Costs per FTE were 94% higher for Best-in-Class plans.

Advertising and Promotion costs were slightly higher by 1% for Best-in-Class plans mostly on higher Staffing Ratio, while Staffing Costs per FTE were also higher.

Low costs of Sales and Marketing did not impact growth, evidently. Comprehensive membership for the Best-in-Class plans grew by a median value of 11%, compared with a median decline of 1% for Peer plans. At the product-mix of the Best-in-Class plans, the Peer plans posted a median membership decline of 3%.

Best-in-Class plans had lower Medical Management costs by 25%, with a low Staffing Ratio as the primary driver. Staffing Costs per FTE, as well as Non-Labor Costs per FTE, were also low. All sub-functions except for Disease Management and Nurse Information Line were lower cost than the Peer plans. (Best-in-Class plans outsourced an average of 16% and a median of 5% of their Medical Management FTEs compared to Peer plans at an average of 9% and a median of 3%.)

Suggestive of the possibility of an ROI on Medical Management, Peer plans experienced *higher* gross profit margins at a median of 10% versus 9% for Best-in-Class plans for *insured products*. (Insured products include Commercial Insured, Medicare Supplement, Medicare and Medicaid). Peer plans had even higher margins when reweighted at the mix of Best-in-Class plans, at 11%. (Gross profit margins are premiums less health benefits divided by premiums.)

Gross profits for *insured products* themselves were also higher in the Peer plans. On a PMPM basis, *insured* gross profits were $42 PMPM for the Best-in-Class plans and $46 for the Peer plans. At the mix of the lower-cost plans, the Peer plans' PMPM gross profits were $52. (Gross profits are premiums less health benefits.)

Similarly, it is notable that the median *insured* health benefit ratio for the Best-in-Class plans was 91%, compared to 90% for the Peer plans. At the product mix of the Best-in-Class plans, the Peer plans had a median health benefit ratio of 89%.

Our Approach

Each of the plans included in this analysis 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 constitute 25% of the total Independent / Provider-Sponsored 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. Five of the plans, or 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 compose 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 weights were then summed to arrive at a total for each function. The sum of the function costs yielded a total cost value. 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 do not 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.

Contact

This look at the characteristics of Best-in-Class plans has the virtue of being systematic and controlled for data quality and comparability. While the results are relatively objective and strongly emphasize the quantitative, the process is complex. We hope that you will feel free to address any questions to:

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INVITATION TO PARTICIPATE IN THE 2018 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.

With cumulative participation of 780 health plan years, health plans serving more than 75% of all insured Americans are licensed users of the Sherlock Benchmarks since June 2015. The Sherlock Benchmarks have been called the "Gold Standard" by Deloitte Consulting, Navigant Consulting and Gorman Health Group among others.

Approximately 40 health plans serving approximately 50 million people with health insurance are participants in the 2017 Sherlock Benchmarking study. Of the 34 U.S.-based Blue Cross Blue Shield primary licensees, fourteen serving 38.3 million people, participated in that year's Sherlock Benchmarking Study for Blue Cross Blue Shield Plans. 55% of Blue members not served by public Blue Cross Blue Shield Plans are in Plans included in this Study.

Our universe of Independent / Provider – Sponsored Health Plans was composed of 20 plans serving approximately 10 million people. Of the 14 members of the Alliance of Community Health Plans that are not focused on public programs or are staff-model plans, 7 are participating in this year's Sherlock Benchmarking Study for Independent / Provider – Sponsored health plans. Most of the largest members of the Health Plan Alliance that are not focused on public programs participated in last year's Sherlock Benchmarking Study for Independent / Provider – Sponsored health plans.

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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