Plan Management Navigator

Analytics for Health Plan Administration

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Please see our invitation to participate in the 2019 Sherlock Benchmarking Study on Page 10.

Best-in-Class Blue Cross Blue Shield Plans

Yesterday, March 12, 2019, the Wall Street Journal *reported that Cambia Health Solutions and Blue Cross and Blue Shield of North Carolina "will merge their managements in a combined structure that will retain the Cambia name." This does not appear to be a business combination, "neither company will formally acquire the other", rather the "affiliation was structured to give them flexibility, with continued local presence" and "the ability to combine resources to invest in technology and other initiatives." We consider this Navigator to be especially timely in light of this news.*

This is our analysis of "Best-in-Class" Blue Cross Blue Shield (Blue) Plans versus their Peers. Our analysis is based on the 20th annual edition of the Blue 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 2017.

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 the Medical Management function. Those "Strategic" areas have costs most readily associated with strategic objectives such as growing the business and reducing health care costs.

Figure 1. Best-in-Class Blue Cross Blue Shield Health Plans
Functions in Tactical and Strategic Expenses

Tactical Expenses:

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

Medical and Provider Management Cluster
- Provider Network Management and Services

Strategic Expenses:

Sales and Marketing Cluster
- Rating and Underwriting
- Marketing
- Sales
- Broker Commissions
- Advertising and Promotion

Medical and Provider Management Cluster
- Medical Mgmt. / Q.A. / Wellness

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.

Conclusions

PMPM Tactical expenses were 28% lower for Best-in-Class Plans with a median of $17.35 compared to $24.08 for the Peer Plans.[1] Every factor driving PMPM costs contributed to the superior performance. Lower FTEs per 10,000 members contributed the most to low Tactical costs for Best-in-class Plans composing 45% of the difference.

Non-Labor Costs per FTE composed 36% of low Tactical variance with Best-in-Class Plans. The Best-in-Class Staffing Costs per FTE were lower at $93,000 versus $103,000 for peer Plans and 19% of total variance.

It appears that Best-in-Class Plans operate in a culture of conservative administrative expenses since nearly every functional area was lower than the Peer Plans.

The overwhelming contributor among functions to superior performance was low costs in Information Systems and it was responsible for over half of difference. The other notable low cost function includes the Corporate Services Function. These two functions composed 85% of the difference between the two sets of Plans.
Costs are standardized for member months (i.e. PMPM) even if not stated.

Accounting for Extraneous Factors

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

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

Scale. Scale *could* have played a role since Best-in-Class Plans membership is twice as large as Peer Plans. But as we demonstrated in our earlier *Navigator* analysis on economies of scale, only 37% of administrative expenses are subject to economies of scale. These subject-to-scale expenses have a BCG slope of 86.3%. In other words, if you double the size of a health plan operating at $40.00, costs would be expected to fall by $2.02.

Cost of Living. There was likely an effect of local costs of living, but it was modest. The mean wage index was 1.015 among the Best-in-Class Plans and 1.019 among the Peer Plans, 0.4% lower (We employ the Hospital Wage Index used by CMS). Meanwhile, mean wage index for all Plans was 1.018. Importantly, Staffing Costs per FTE for the Best-in-Class Plans were lower by 6.3%, meaning that Staffing Costs per FTE were *higher* than indicated by the relative wage index.

The wage index, it should be recognized, may 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. Also, outsourcing can affect these comparisons as discussed below.

Propensity to Outsource. The mean percent of FTEs outsourced was 10% among the Best-in-Class Plans and 14% among the Peer Plans. The median percent of FTEs outsourced was 11% among the Best-in-Class Plans and 11% among the Peer plans.[2]

Information Systems is, among the functions, most often outsourced for all Blue Cross Blue Shield Plans. The mean percent of FTEs outsourced was 9% among the Best-in-Class Plans and 22% among the Peer Plans. The median percent of Information Systems FTEs outsourced was also 6% among the Best-in-Class Plans and 15% among the Peer Plans. The Information Systems costs for Best-in-Class Plans cost less than those in Peer Plans.

Low Cost Product Mix. Mix can make a difference since product costs can differ. The Best-in-Class Plans had more low cost ASO and Medicaid 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.

[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.

Figure 2. Best-in-Class Blue Cross Blue Shield Health Plans
Product Mix Comparisons

	Commercial Insured	Commercial ASO	Commercial Total	Medicare Total	Medicaid Total	Comprehensive Total
Best-in-Class	28%	54%	81%	2%	6%	100%
Peer Plans	45%	38%	82%	4%	1%	100%

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 central part of this analysis. In making this exclusion, we are recognizing that these "strategic" expenses have impacts outside of current period administrative costs. We do address these functional areas separately towards the end of this analysis.

Activities that Made a Difference

Because almost all of the 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 55% of the difference between the Best-in-Class Plans and their Peers. Account and Membership is comprised of the central health plan activities of Enrollment / Membership / Billing, Claim and Encounter Capture and Adjudication, Customer Services, and Information Systems.

The overwhelming driver in low costs for this cluster was Information Systems, comprising 57% of overall low Tactical costs and 105% of the cluster's low costs. Enrollment/Membership/Billing was lower by 31% and comprised 5% of low Tactical costs. Meanwhile, Customer Services contributed only minor cost savings for Best-in-Class Plans. Claim and Encounter Capture and Adjudication was *higher* for the Best-in-Class Plans by a 16%. This negatively impacted the Best-in-Class Plans by 8%. Non-Labor Costs per FTE were higher by 46%.

Information Systems. This function's costs were 40% lower for the Best-in-Class Plans primarily due to the Staffing Ratio at 30% below Peer Plans. Non-Labor Costs per FTE were lower by 29%. Staffing Costs per FTE were slightly higher than Peer Plans.

The Information Systems sub-function, Applications Maintenance contributed the most to the overall low Information Systems expenses. Best-in-Class Plans were lower by 61%. The Staffing Ratio was 54% lower than the median for Peer Plans. Staffing Costs Per FTE were lower by 13%.

Applications Acquisition and Development, contributed to overall low Information Systems expenses. Best-in-Class Plans were lower by 66%. The Staffing Ratio was 68% lower than Peer Plans. Staffing Costs per FTE were lower by 19%. This functional area contributed 26% to lower Tactical costs for the Information Systems Function.

Corporate Services *Function.* (This word is italicized to distinguish it from the more encompassing cluster of the same name.) Best-in-Class Plans posted expenses that were lower by 43% and drove overall low Tactical expenses by 27%. Staffing Ratio was the chief driver of costs, at 32% lower. Non-Labor Costs per FTE were 24% lower for Best-in-Class Plans.

There were ten sub-functions within this functional area: Human Resources, Legal, Facilities, OPEB, Audit, Purchasing, Imaging, Printing and Mailroom, Risk Management and Other Corporate Services. The Best-in-Class Plans reported lower costs than the Peer Plans in the Human Resources, Legal, Facilities, OPEB, Audit, Purchasing, Printing and Mailroom, and Other Corporate Services.

Corporate Executive and Governance. Best-in-Class Plans were less than Peer Plans by 20%. The Staffing Ratio was the primary driver for this functional area. The Staffing Ratio for Best-in-Class Plans was 20% lower compared to Peer Plans. Non-Labor Costs per FTE were lower by 4.6% for Best-in-Class Plans.

Corporate Executive and Governance is limited to executives who are not directly tied to a function or department, as well as Board of Directors costs. This functional area also includes functions that support Corporate Executive & Governance such as strategic planning and business analysis.

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 were lower for the Best-in-Class Plans by 18%. Low Non-Labor Costs per FTE and the Staffing Ratio were central to Best-in-Class Plans' advantage. The Staffing Ratio was lower by 15% and Non-Labor Costs were lower by 6%.

Best-in-Class Plans outsourced an average of 14% and a median of 16% of its Sales and Marketing FTEs. This compares to Peer Plans outsourcing an average of 10% and a median of 10% of Sales and Marketing FTEs.

Best-in-Class Plans reported lower expenses in Sales and Marketing functional area. External Broker Commissions were 5% lower for Best-in-Class Plans. Note, *Sherlock Benchmark* includes external Broker Commissions within Non-Labor expenses.

The Sales functional area was 31% lower for Best-in-Class Plans with the Staffing Ratio the key driver. The Staffing Ratio was 33% lower for Best-in-Class Plans than for Peer Plans. Non-Labor Costs per FTE were slightly higher and Staffing Costs per FTE were slightly lower. All of the sub-functions of the Sales function were lower for Best-in-Class Plans. These subfunctions are Account Services, Internal Sales Commissions and Other Sales. In particular, the Account Services sub-function was lower by 43% compared to the Peer Plans.

Expenses in Rating and Underwriting for Best-in-Class Plans were lower by 34% mainly on a low Staffing Ratio. The Staffing Ratio for Rating and Underwriting was lower by 34%. Non-Labor Costs per FTE were also lower by 25%. Staffing Costs per FTE were higher by 10%. The Risk Adjustment sub-function contributed the most to low Rating and Underwriting costs. Best-in-Class Plans reported 63% lower expenses in this sub-function almost entirely due to low Staffing Ratio. The Staffing Ratio was 66% lower.

Best-in-Class Marketing expenses were lower by 19% mainly due to a lower Staffing Ratio. The largest contributor, the Member and Group Communication sub-function, was lower by 27% chiefly on a lower Staffing Ratio.

Advertising and Promotion costs were lower by 43% primarily as a result of a low Staffing Ratio. While Charitable Contribution sub-function was low by 57%, the Media and Advertising sub-function drove low Advertising and Promotion costs. The sub-function was lower for Best-in-Class Plans by 38%.

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 1.1%, compared with a median decline of 0.25% for Peer Plans. At the product mix of the Best-in-Class Plans, the Peer Plans had a median membership growth of 0.26%.

Medical Management expenses were 6% lower for Best-in-Class Plans. Non-Labor Costs per FTE were 22% lower in favor of Best-in-Class Plans and were the central driver for low Medical Management costs. Of the nine sub-functions, Pre-Certification and Disease Management were stand outs for lower costs of Best-in-Class Plans. Pre-Certification was 58% lower than Peer Plans, primarily because of a 45% lower Staffing Ratio. Non-Labor Costs per FTE and Staffing Costs per FTE were also lower by 73% and 13% respectively. Disease Management's primary driver was lower Non-Labor Costs per FTE. Non-Labor Costs per FTE were lower by 70%.

Suggestive of the possibility of an ROI on Medical Management, Peer Plans experienced *higher* gross profit margins at a median of 19% versus 15% for Best-in-Class Plans for *insured products.* (Insured products include Commercial Insured, Medicare Supplement, FEP, Medicare, and Medicaid). Peer Plans' margins were also 19% when reweighted at the mix of Best-in-Class Plans. (Gross profit margins are premiums less health benefits divided by premiums.)

Gross profits for *insured products* were lower for the Best-In-Class Plans. On a PMPM basis, *insured* gross profits were $53 PMPM for the Best-in-Class Plans and $78 for the Peer Plans. However, at the mix of the lower-cost Plans, the Peer Plans' PMPM gross profits were *higher* at $75.

The median *insured* health benefit ratio for the Best-in-Class Plans was 84%, compared to 80% for the Peer Plans. At the product mix of the Best-in-Class Plans, the Peer Plans had a median health benefit ratio of 81%. The evidence is not decisive on a return on Medical Management.

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 Blue Cross Blue Shield universe. To do so, and to eliminate the potentially distorting effect of 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. 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 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 2019 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 818 health plan years, health plans serving more than 72% of all insured Americans are licensed users of the Sherlock Benchmarks since June 2016. 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.

The Sherlock Benchmarks have been called the "Gold Standard" by leading health care consultants. Approximately 40 health plans serving approximately 50 million people with health insurance are participants have already committed to participate in the 2019 Sherlock Benchmarking study. Besides Blue Cross Blue Shield Plans, our universes include Independent / Provider – Sponsored Health Plans with 23 plans serving approximately 11 million people, plus Medicare and Medicaid plans which are still under development.

While the survey forms for the Blue Universe went out last Friday, there is still time to participate in this, as well as all other universes. Report publication begins in late June but varies by universe. 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.