

Plan Management Navigator

Analytics for Health Plan Administration



Healthcare Analysts

Douglas B. Sherlock, CFA
sherlock@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

John Park, CFA
jpark@sherlockco.com

Andrew L. Sherlock
asherlock@sherlockco.com

(215) 628-2289

Please see page 9 for our invitation to participate in or license the 2021 Sherlock Benchmarks.

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 23rd annual Sherlock Benchmarks and 19th edition of the IPS study. For these purposes, we define “Best-in-Class” plans as those composing the 25th percentile in lowest “Tactical” costs. Others are referred to as “Peer” plans. All results are from the 2020 edition of the Sherlock Benchmarks reflecting year-ended 2019 financials. Corresponding figure numbers, found at the end of the text, are shown in parentheses.

Notwithstanding our referring to low cost plans as Best-in-Class, we recognize that a health plan’s long-term objective is cost levels that are optimal for its strategic objectives. The burden of proof, however, is on high cost functions to demonstrate their value through other objective metrics of superior performance. Put a different way, the focus on low costs is the basis upon which an ROI can be calculated.

The focus of much of this analysis is what we term “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 longer-term objectives such as increasing membership and market share 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 recognize 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 Plans Tactical and Strategic Functional Areas

Tactical

- Account and Membership Administration
 - Enrollment / Membership / Billing
 - Customer Services
 - Claim and Encounter Capture and Adjudication
 - Information Systems Expenses
- Corporate Services Cluster
 - Finance and Accounting
 - Actuarial
 - Corporate Services Function
 - Corporate Executive and Governance
 - Association Dues and License/Filing Fees

Strategic

- Sales and Marketing
 - Rating and Underwriting
 - Marketing
 - Sales
 - External Broker Commissions
 - Advertising and Promotion
- Medical and Provider Management
 - Provider Network Management and Services
 - Medical Management / QA / Wellness

Conclusions

PMPM Tactical expenses were 41% lower for Best-in-Class plans with a mean of \$18.65 compared to \$31.58 for the Peer plans.¹ The low Staffing Ratio was the most important driver in low Tactical costs, contributing 59% of overall low Tactical costs.

Non-Labor Costs per FTE (e.g. those in Information Systems and Facilities) contributed 24% to overall low Tactical costs, while Best-in-Class plans' low Staffing Costs per FTE contributed 17% toward overall low Tactical costs.

It appears that Best-in-Class plans operate in a culture of conservative administrative expenses as every Tactical functional area was lower than the Peer plans.

The largest contributor among functions to superior performance was low costs in Information Systems, which was responsible for 30% of the Tactical difference. The Corporate Services *Function* followed, contributing 17% of the superior performance. Claim and Encounter Capture and Adjudication, Provider Network Management and Services, and Customer Services followed in contribution to low Tactical costs. These three functions composed 31% of the difference between Best-in-Class and Peer plans.

Possible Extraneous Characteristics

We identified five characteristics of the sets of IPS plans that could contribute to cost differences among Best-in-Class vs. Peer plans. These characteristics may or may not affect costs.

Scale. Economies of scale could have played a role. The median membership size for Best-in-Class plans was 900,000 versus 410,000 for the Peers, more than double. Based on preliminary results of Sherlock's Scale Study for IPS plans, approximately 73% of administrative expenses are subject to economies of scale. These subject-to-scale expenses have a BCG slope of 84%.² In other words, if you double the size of a health plan operating at \$54.97 (Total PMPM costs for Peer plans), costs would be expected to fall by about \$4.66 PMPM.

Cost of Living. There was possibly an effect of local costs of living on the comparisons. The mean wage index for Best-in-Class plans was 0.90, compared to the average wage index for Peers of 0.97 and 0.96 for all IPS plans. The median wage index for Best-in-Class was 0.89, while the Peer plans' median wage index was 0.93 and all IPS plans was 0.89. (We employ the Hospital Wage Index used by CMS).

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

² BCG slope is named after the Boston Consulting Group. Please see our *Economies of Scale in Health Insurance* analysis for more information on how scale savings are calculated, published in our *PULSE* newsletter.

Recall that Tactical Staffing Costs per FTE for the Best-in-Class plans was lower by 14%, well more than the cost of living difference. Moreover, the proportion of the Best-in-Class cost advantage attributed to Staffing Costs per FTE was 17%. The main driver of lower costs, however, was a low Staffing Ratio, followed by low Non-Labor Costs per FTE.

In our view, the wage index may exaggerate 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. Also, outsourcing can affect these comparisons as discussed below.

Propensity to Outsource. Best-in-Class plans tended to outsource slightly less than the Peer plans. The mean percent of FTEs outsourced was 12% for Best-in-Class versus 14% for Peer plans. The median percent was 9% for Best-in-Class versus 13% for Peer plans.³

One of the functions that is most often outsourced, Information Systems, was outsourced by all IPS plans at a mean rate of 22%. Outsourcing of this function was slightly higher for Best-in-Class Plans. Among Best-in-Class plans, IS was outsourced at a mean rate of 25% and a median rate of 12%. In comparison, Peer plans outsourced an average of 21% of IS FTEs and a median of 10%.

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

Product	Best-in-Class	Peer Plans	Pct. Pt. Difference
Commercial Insured	49%	37%	12%
Commercial ASO	19%	36%	-17%
Commercial Total	68%	73%	-5%
Medicare Total	12%	7%	5%
Medicaid Total	19%	18%	2%
Medicare Supplement	1%	2%	-1%
Comprehensive Total	100%	100%	

³ 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.

Low-Cost Product Mix. Mix can make a difference in cost comparisons, since individual product costs can have significantly different average costs. The Best-in-Class plans had more commercial insured members, fewer low-cost ASO members and more high-cost Medicare members. On an as-reported basis, such plans would be expected to have higher costs. However, the analysis presented here eliminates the effect of any product mix differences between the sets of plans. As we describe in the section Our Approach, we do this by reweighting to equalize the product mixes. The mean values of the different product mixes are shown below.

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 forward-looking “investments” are excluded from the central part of this analysis. In making this exclusion, we are recognizing that these “strategic” expenses are intended to generate benefits in future periods. We do address these activities along with their benefits towards the end of this analysis. It also happens that these expenses mostly run lower for the Best-in-Class plans.

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 was the greatest contributor to low cost performance. The relative costs in this function comprised 56% of the difference between the Best-in-Class plans and their Peers. Account and Membership Administration comprises the central health plan activities of Enrollment/Membership/Billing, Claim and Encounter Capture and Adjudication, Customer Services and Information Systems.

In the Account and Membership Administration cluster, the Staffing Ratio was the most important driver, which was lower by 19% and contributed 43% toward this cluster’s low PMPM costs. Staffing Costs per FTE were lower by 23% and contributed 33% to the cluster’s low variance, while Non-Labor Costs per FTE were 26% lower.

The most important reason why this cluster was lower was Information Systems. Its cost advantage comprised 54% of the low-cost variance in this cluster and 30% of low Tactical costs.

Information Systems. This function’s costs were 35% lower for the Best-in-Class plans contributing 30% to overall low Tactical costs. Non-Labor Costs per FTE was the primary driver for this function’s low cost, which was lower by 27%. Staffing Costs per FTE was lower by 20%, while the Staffing Ratio was lower by 15%.

All Information Systems subfunctions were lower than the Peer plans. The IS sub-function Operations and Support Services contributed the most to overall low IS expenses, at 35% of Information System's variance. Best-in-Class plans' costs were 33% lower, mainly due to a Staffing Ratio that was 58% lower. Staffing Costs per FTE were lower by 27%, while Non-Labor Costs per FTE were more than double those of the Peer plans.

Claim and Encounter Capture and Adjudication. Best-in-Class plans' Claims costs were 52% lower and contributed 15% to overall low Tactical costs. The Staffing Ratio was 42% lower for Best-in-Class plans, while Staffing Costs per FTE were lower by 29%. Non-Labor Costs per FTE were higher for Best-in-Class plans by 26%.

Subfunctions of this function include COB and Subrogation, which was 10% higher for Best-in-Class plans, and Other Claims, which was 57% lower for Best-in-Class plans. Other Claims costs were lower mainly due to a Staffing Ratio that was 50% lower. Staffing Costs per FTE was lower by 27%, while Non-Labor per FTE was higher by 34%. Note, Other Claims represents the majority of costs in this functional area with activities primarily focused on the manual processes involved in claims adjudication.

As mentioned before, since the degree of automation can affect where claims processing activities are reflected, it is notable that both Information Systems and Claims functions are lower for the Best-in-Class plans.

Customer Services. This function contributed 8% toward overall low Tactical costs and was 36% lower for Best-in-Class plans. Staffing Costs per FTE that were 24% lower for Best-in-Class plans was the main driver, closely followed by the Staffing Ratio, which was 20% lower. Non-Labor Costs per FTE were 42% higher for Best-in-Class plans.

Enrollment / Membership / Billing contributed 4% to overall low Tactical costs. Low staffing ratio was the chief cause of favorable variance in this function.

The **Corporate Services cluster** of functions comprised 36% of the difference between the Best-in-Class plans and their Peers. Costs were 49% lower than the Peer plans, due almost entirely to a low Staffing Ratio. All functions in this cluster were lower than the Peer plans.

Corporate Services Function. (This word is italicized to distinguish it from the more encompassing cluster of the same name.) Best-in-Class plans reported expenses that were 44% lower than Peer plans, composed 17% of overall low Tactical costs and 48% of low Corporate Services Cluster costs. This function's low costs were overwhelmingly driven by a Staffing Ratio that was 59% lower for Best-in-Class plans. Staffing Costs per FTE were lower by 6% for Best-in-Class plans, while Non-Labor Costs per FTE were higher by 66%.

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 in favor of Best-in-Class plans except Printing and Mailroom.

Corporate Executive and Governance and **Finance and Accounting** each contributed over 6% toward overall low cost. Finance and Accounting had a staffing ratio that was less than half that of the Peer plans. Corporate Executive and Governance had low costs due to both a low Staffing Ratio and low Staffing Costs per FTE.

Actuarial contributed 5% to overall low Tactical costs. Low staffing ratio was the chief cause of favorable variance in this function.

Provider Network Management and Services. This function's costs for the Best-in-Class plans were 35% lower than those in the Peer plans, contributing 9% toward overall low Tactical expense. Low Staffing Costs per FTE contributed the most toward this function's low costs, followed by a low staffing ratio. Non-Labor Costs per FTE were also low. All subfunctions, Provider Relations Services, Provider Contracting and Other Provider Network Management and Services, were lower than the Peer plans.

Strategic Expenses were Also Lower

Best-in-Class plans also had lower costs in the Strategic areas of Sales and Marketing cluster and the Medical Management function.

The **Sales and Marketing cluster** of expenses was lower by 11% for Best-in-Class plans. This cluster's low costs were mainly because of its Staffing Ratio, which was low by 27%. Staffing Costs per FTE were lower by 15%, while Non-Labor Costs per FTE were higher by 40%.

Best-in-Class plans' outsourced Sales and Marketing FTEs at a higher rate than the Peer plans. An average of 13% and a median of 15% of Best-in-Class plans' FTEs were outsourced. This compares to Peer plans outsourcing an average of 7% and a median of 3% of its Sales and Marketing FTEs.

Sales, which can be considered a complementary distribution system to brokers, was the most important driver of low costs for the Sales and Marketing cluster. It was lower by 52% in favor of Best-in-Class plans. The Staffing Ratio was 43% lower, while Staffing Costs per FTE were lower by 28%. Non-Labor Costs per FTE were higher by 35%. The largest driver of low Sales expenses was the Other Sales (Including Internal Commissions) sub-function. Best-in-Class plans were lower by 45%, explainable mainly by a 50% lower Staffing Ratio.

External Broker Commissions, on the other hand, were 8% higher for the Best-in-Class Plans. There is no staff associated with this function.

Marketing expenses were lower by 14% for Best-in-Class plans. Staffing Costs per FTE were lower by 17%, while Non-Labor Costs per FTE were lower by 21%. The Staffing Ratio, however, was 7% higher for Best-in-Class plans. Most of this was due to low Product Development and Market Research costs, with Staffing Costs per FTE as the most important driver, followed by a low Staffing Ratio.

Advertising and Promotion expenses were higher by 21%. Its Staffing Ratio represented the sole reason for higher costs, at over double that of the Peer plans. Non-Labor Costs per FTE were lower by 51%, and Staffing Costs per FTE were lower by 23%. Note that both this and Commissions are high, corresponding with the high Non-Labor Costs per FTE for the Sales and Marketing Cluster.

Low costs of Sales and Marketing did not impact growth, evidently. Comprehensive membership for the Best-in-Class plans increased by a median rate of 7%, compared with a median *decline* of 1% for Peer plans. At the product-mix of the Best-in-Class plans, the Peer plans' median membership declined by 2%.

Best-in-Class plans had lower Medical Management costs by 45%, based almost entirely on a Staffing Ratio that was lower by 45%. Non-Labor Costs per FTE were 16% higher, while Staffing Costs per FTE were 4% lower.

All nine sub-functions were lower cost than the Peer plans, with Case Management contributing more than any other toward the function's low cost. Best-in-Class plans outsourced an average of 5% and a median of 6% of their Medical Management FTEs, compared to Peer plans at an average of 16% and a median of 10%.

Peer plans experienced a slightly lower gross profit margin at a median of 8% versus 12% for Best-in-Class plans for *insured products*, despite spending more on Medical Management. (Insured products include Commercial Insured, Medicare Supplement, Medicare and Medicaid). At the mix of Best-in-Class plans, margins for Peer plans were 7%. (Gross profit margins are premiums less health benefits divided by premiums.)

Gross PMPM profits for *insured products*, before mix adjustment, were lower in the Peer plans. On a PMPM basis, *insured* gross profits were \$56 PMPM for the Best-in-Class plans and \$42 for the Peer plans. At the mix of the Best Practice plans, the Peer plans' PMPM gross profits were \$41 PMPM. (Gross profits are premiums less health benefits.)

Similarly, the median *insured* health benefit ratio for the Best-in-Class plans was 88%, compared to 92% for the Peer plans. At the product mix of the Best-in-Class plans, the Peer plans had a median health benefit ratio of 93%.

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 on the next page.

1. We identified 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 IPS plans universe. To do so, and 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 were those with the smallest differences from plan-reweighted universe values. Three of the plans 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 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 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 estimate Peer plans' staffing ratios adjusting for Best-in-Class product mixes, we took advantage of the fact that, algebraically, a plan's PMPM cost is the product of its Total Costs per FTE and its Staffing Ratio. Since we know each plan's PMPM for each product, and we assume Total Costs per FTE is the same for each product, we can infer staffing ratios for each product.

In the area of Finance and Accounting, for example, suppose a plan has costs of \$0.75 PMPM for Medicare and its Total Costs per FTE in this function were \$150,000. The Medicare Staffing Ratio is then estimated as $(\$0.75 / \$150,000) \times 120,000$, or 0.60. (The division is multiplied by 12 to take into account the member month conversion and by 10,000 to put the ratio on a 10,000 member basis.) We can then apply the same methodology for cost mix-adjustments to these staffing ratios to calculate mix-adjusted staffing ratios for the Peer plans.

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.

INVITATION TO PARTICIPATE IN THE 2021 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 Affordable Care Act and the effects of COVID-19 may make participation by your health plan an appropriate and necessary response to the strong incentives to cost efficiency.

With cumulative participation of 893 health plan years, health plans serving almost 180 million insured Americans are licensed users of the *Sherlock Benchmarks*. Of the 34 U.S.-based Blue Cross Blue Shield primary licensees, 19 Plans serving approximately 50 million people participated in the 2020 edition of the *Sherlock Benchmarks* for Blue Cross Blue Shield Plans.

The *Sherlock Benchmarks* have been called the "Gold Standard" by leading health care consultants. Besides **Blue Cross Blue Shield** Plans, our universes include **Independent/Provider-Sponsored** health plans, **Medicare** and **Medicaid** plans.

Report publication begins in late June but varies by universe. Participation entails efforts on your part since useful outputs require relatively granular inputs. However, the cost is relatively modest.

The *Sherlock Benchmarks* are also available to license. Please reach out to Douglas Sherlock at sherlock@sherlockco.com or 215-628-2289 if you are interested in either participation or licensing. *You will be among good company.*

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:

Douglas B. Sherlock, CFA
President
Sherlock Company

(215) 628-2289
sherlock@sherlockco.com
www.sherlockco.com

1180 Welsh Road
Suite 110
North Wales, PA 19454

This Page Intentionally Left Blank