Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

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Please see page 5 for our invitation to participate in the 2023 or license the 2022 Sherlock Benchmarks.

Best-in-Class Independent / Provider - Sponsored

This is a summary of our analysis of "Best-in-Class" Independent / Provider - Sponsored (IPS) plans compared with their IPS peers. Our analysis is based on the 2022 edition of the *Sherlock Benchmarks* reflecting year-ended 2021 financials. The *Sherlock Benchmarks* for Independent / Provider - Sponsored plans is this universe's 20th annual edition.

For the purpose of this analysis, we define "Best-in-Class" plans as those whose "Tactical" costs are in the lowest 25th percentile. Plans not in the Best-in-Class subset are referred to as "Peer" plans.

Tactical costs are all costs of Comprehensive products other than those in the Sales and Marketing cluster and Medical Management function, which we refer to as "Strategic". The focus of much of this analysis is on relative Tactical costs.

In making Strategic costs less of a focus of this analysis, we are recognizing that they have impacts outside of current period administrative costs. They may have costs most readily associated with longer-term objectives such increasing membership and market share and reducing health care costs.

Also, to perform the analysis, we endeavor to quantify and even eliminate the effect of factors largely beyond management control. For instance, comparisons between sets of health plans are made after reweighting the costs of each activity of each Comprehensive product to eliminate the effects of differences in their respective product mixes. After that reweighting, we then isolate and measure the specific contributing factors to performance that are more likely to be under the control of the management team. We approach costs systematically, in total, by cluster and by function. This approach may enable Peer plans to identify areas where their performance can emulate those of Best-in-Class.

Figure 1. Best-in-Class Plans Summary
*Sources of Tactical Variances, Mix-Adjusted**

	Non-Labor Costs per FTE +	Staffing Costs Per FTE =	Total Costs Per FTE X	FTEs Per 10,000 Members =	Costs PMPM
Best-in-Class Plans	$57,204	$92,366	$149,571	15.16	$18.90
Peer Plans	$60,072	$110,886	$170,957	20.68	$29.46
Dollar Variance	($2,867)	($18,520)	($21,387)	(5.52)	($10.56)
Percent Variance	-4.8%	-16.7%	-12.5%	-26.7%	-35.9%
Percent of Total Variance	4.1%	26.2%	30.2%	69.8%	100.0%
PMPM Dollar Variance	($0.43)	($2.77)	($3.19)	($7.37)	($10.56)

**Tactical expenses exclude Misc. Business Taxes, the Sales and Marketing cluster and Med. Mgmt. expenses.*

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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 corporate objectives. The implication of a broader notion of performance is that high-cost functions might demonstrate the value of their higher costs through other objective metrics of superior performance. Put a different way, the differences between a plan's costs and those of its Best-in-Class peers, if intended to achieve the plan's corporate goals, represents a form of investment upon which an ROI should be expected.

Conclusions

PMPM Tactical expenses were $10.56 PMPM or 36% lower for Best-in-Class plans with a mean of $18.90 compared to $29.46 for the Peer plans.[1] The low Staffing Ratio was the main driver in low Tactical costs with Best-in-Class plans having 15 FTEs per 10,000 members compared to Peer plans at 21 FTEs per 10,000 members. (Figure 1)

Best-in-Class plans' Staffing Costs per FTE was $92,000 and compared to Peer plans' $111,000, lower by 17%. Non-Labor Costs per FTE (e.g., those found in Information Systems or Facilities) were also lower for Best-in-Class plans, by 5%, at $57,000 compared to $60,000 for Peer plans.

It appears that Best-in-Class plans operate in a culture of conservative administrative expenses since every cluster of Tactical expense was lower than its peers. Also, *every* Tactical functional area was lower than the Peer plans. (Figure 2) The function contributing the most to superior performance was Information Systems.

Low Information Systems costs were responsible for about 47% of the Tactical difference. The Corporate Services *Function* and Claims followed, contributing a combined 26% of the low Tactical difference.

Possible Extraneous Characteristics

We considered five characteristics of the sets of IPS plans that could contribute to improved performance in Best-in-Class vs. Peer plans. These included the effects of scale, cost of living, outsourcing, product mix, and strategic investments in Sales and Marketing and Medical Management.

Regarding economies of scale, based on the results of Sherlock Company's 2022 Scale Study, 12% of Independent / Provider - Sponsored plan *Tactical* administrative expenses are subject to scale. Moreover, the slope was gradual: doubling the size of the plan lead to Tactical costs of 76.8% of the pre-doubling value. The Best-in-Class plans had a median membership of 977,000 compared with 518,000 for the Peer Plans.

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

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There was possibly an effect of local costs of living on the comparisons. The mean wage index for Best-in-Class plans was 11% lower compared to its Peer plans, while the median was lower by 5%. (We employ the Hospital Wage Index used by CMS).

If lower local cost of living drove the relative staffing costs, we would expect the actual staffing costs per FTE to more or less mirror the local cost of living. Recall that Tactical Staffing Costs per FTE for the Best-in-Class plans was lower by 17%, more than the mean cost of living difference and much more than the median.

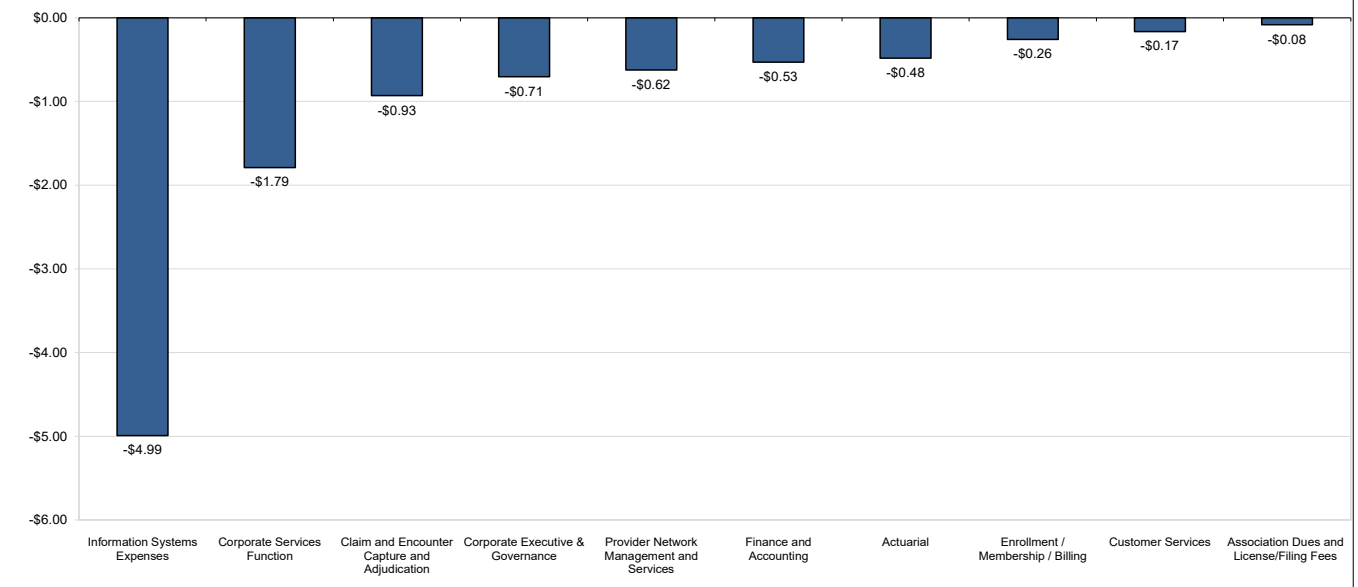
Also, outsourcing was not a contributing effect for favorable comparisons. The median rate of Outsourcing Tactical FTEs was slightly higher for Best-in-Class Plans, by 0.6 percentage points. Best-in-Class plans' medians were higher in the Corporate Services and Account and Membership Administration clusters, by 7.7 percentage points and 5.5 percentage points, respectively. The Provider Network functional area was lower for Best-in-Class plans by 3.0 percentage points.

Our values were adjusted so that product mix did not impact comparisons: product mix was adjusted to eliminate its effect. We describe this method earlier in the fifth paragraph of this *Navigator*.

Finally, the strategic investments (Sales and Marketing and Medical Management) could not have affected comparisons because they were excluded from the central part of this analysis. We do touch upon this next.

Figure 2. Best-in-Class Plans Summary

Functional Area Components of Low Cost Variances From Mean, PMPM, Mix-Adjusted



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Strategic Expenses Were Also Lower

Best-in-Class plans had mixed cost comparisons in the Strategic areas of Sales and Marketing cluster and the Medical Management function. While they were lower in the Medical Management, they had slightly higher Sales and Marketing costs.

The Sales and Marketing cluster of expenses was higher by 3% for Best-in-Class plans. The functional areas of Marketing, External Broker Commissions, and Advertising and Promotion were higher for Best-in-Class Plans.

We cannot rule out that higher costs of Sales and Marketing related to membership growth. Comprehensive membership for the Best-in-Class plans increased by a median rate of 3%, compared with a median *decline* of 0.8% for Peer plans. At the product-mix of the Best-in-Class plans, the Peer plans' median membership grew by 2.4%.

Best-in-Class plans had lower Medical Management costs, by 25%. Median gross profit margin for *insured* products was 11% for both Best-in-Class and Peer plans. (Insured products include Commercial Insured, Medicare Supplement, Medicare, and Medicaid. Gross profit margins are premiums less health benefits, all divided by premiums). Peer plans' margins were lower at 10% when reweighted at the mix of Best-in-Class plans.

Our Approach

Each of the plans included in the dataset that used this analysis differs in many key characteristics. So, to compare Best-in-Class plans to Peer plans, we employed a composite approach to summarize the characteristics of each subset. Granular costs are reported by product by the plans, and the costs in the two sets were weighted to have a common product mix.

We identified the Best-in-Class plans by comparing each plan's costs to its universe. To do so, and to eliminate the potentially distorting effect of product mix differences on the cost comparisons, we reweighted the costs of the IPS universe to match the mix of each plans. Plans were then ranked by the differences between their expenses and the re-weighted IPS universe costs. We selected the lowest cost IPS plans as the 25% with the most favorable cost comparisons.

The Staffing Ratios for each plan were provided by the plans, but also included outsourced FTEs inferred from payments to outsourcers. Staffing ratios for each product of each plan was inferred from their PMPM costs and from their total costs per FTE. The subset staffing ratios were drawn from the Best-in-Class and Peer plans respectively, and each subset reflects the same reweighting of plan values, using the same process as costs as described in the previous paragraph.

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Contact

This look at the characteristics of Best-in-Class plans has the virtue of being mutually exclusive and collectively exhaustive. Because we have polled the plans to develop this analysis, the data controlled for quality and comparability. While the results are relatively objective and strongly emphasize the quantitative, the process is complex. We hope that you feel free to address any questions to:

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Invitation to Participate in the 2023 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 2023 study will be the 26th consecutive year, reflecting a cumulative experience of 966 health plan years. Since June of 2019, health plans serving at least 210 million people have licensed the *Sherlock Benchmarks* including most Blue Cross Blue Shield plans, public companies and the largest Independent/Provider-Sponsored health plans.

For the most recent cycle of the *Sherlock Benchmarks*, of the 33 U.S.-based Blue Cross Blue Shield primary licensees, sixteen serving approximately 49.1 million people, participated in the *Sherlock Benchmarks* for Blue Cross Blue Shield Plans. For Independent / Provider – Sponsored Plans, fifteen plans serving 10.6 million people participated in the most recent cycle. Of the 15 members of the Alliance of Community Health Plans that are not focused on public programs or are staff-model plans, six participated in this year's Sherlock Benchmarking Study for Independent / Provider – Sponsored health plans. Four of the 10 largest commercial-focused Health Plan Alliance members participated in the prior year's *Sherlock Benchmarks*.

The *Sherlock Benchmarks* have been called the "Gold Standard" by leading health care consultants. Report publication begins in late June but varies by universe. Participation entails efforts on the part of the plans since actionable 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.*

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