Plan Management Navigator
Analytics for Health Plan Administration

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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 Blue Cross Blue Shield Plans

This is a summary of our analysis of "Best-in-Class" Blue Cross Blue Shield (Blue) Plans compared with their Blue Peers. Our analysis is based on the 2022 edition of the *Sherlock Benchmarks* reflecting year-ended 2021 financials. The *Sherlock Benchmarks* for Blue Cross Blue Shield Plans is this universe's 24th 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 the 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 of 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 =	Costs PMPM
Best-in-Class Plans	*$94,627*	*$125,566*	*$220,193*	*11.35*	*$20.82*
Peer Plans	$81,081	$124,307	$205,388	16.90	$28.93
Dollar Variance	$13,547	$1,258	$14,805	-5.55	-$8.11
Percent Variance	16.7%	1.0%	7.2%	-32.9%	-28.0%
Percent of Total Variance	-19.7%	-1.8%	-21.5%	121.5%	100.0%
PMPM Dollar Variance	$1.59	$0.15	$1.74	-$9.85	-$8.11

**Tactical expenses exclude Misc. Business Taxes, Sales and Marketing cluster and Medical Management expenses.*

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 $8.11 or 28% lower for Best-in-Class Plans with a mean of $20.82 compared to $28.93 for the Peer Plans.[1] The Best-in-Class Staffing Ratio was solely responsible for the lower costs, at 11 FTEs per 10,000 members, compared to Peer Plans at 17. (Figure 1)

Non-Labor Costs (e.g., those found in Information Systems or Facilities) were approximately $95,000 per FTE for Best-in-Class Plans, 17% higher than those of the Peer Plans, which reported $81,000. The Best-in-Class Staffing Costs per FTE were $126,000 versus $124,000 for the Peer Plans, or higher by 1%.

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, almost every functional area was lower than those of the Peer Plans (Figure 2, on the next page). The function contributing most to superior performance was Information Systems' low costs. The exceptions to this were Claim and Encounter Capture and Adjudication and Corporate Executive and Governance, which were high cost.

Low Information Systems cost was responsible for about 68% of the Tactical difference. Corporate Services Function, Customer Services and Enrollment / Membership / Billing followed in their contribution to low Tactical costs. These three functions composed a further 33% of the difference between the two sets of Plans.

Possible Extraneous Characteristics

We considered five characteristics of the sets of Blue Plans that we thought could contribute to cost differences among Best-in-Class and Peer Plans, aside from shear performance. 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, 68% of Blue Cross Blue Shield Plan *Tactical* administrative expenses are subject to scale. Moreover, the slope was gradual: doubling the size of the Plan lead to Tactical costs of 85.9% of the pre-doubling value.

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

Similarly, cost of living did not appear to contribute much to superior performance. The mean wage index for Best-in-Class Plans was lower than Peer Plans by 17%, and the median was lower by 14%. (We employ the Hospital Wage Index used by CMS). Lower cost of living did not affect costs this dramatically: they were lower by only 1% and were responsible for less than 2% of the favorable variance.

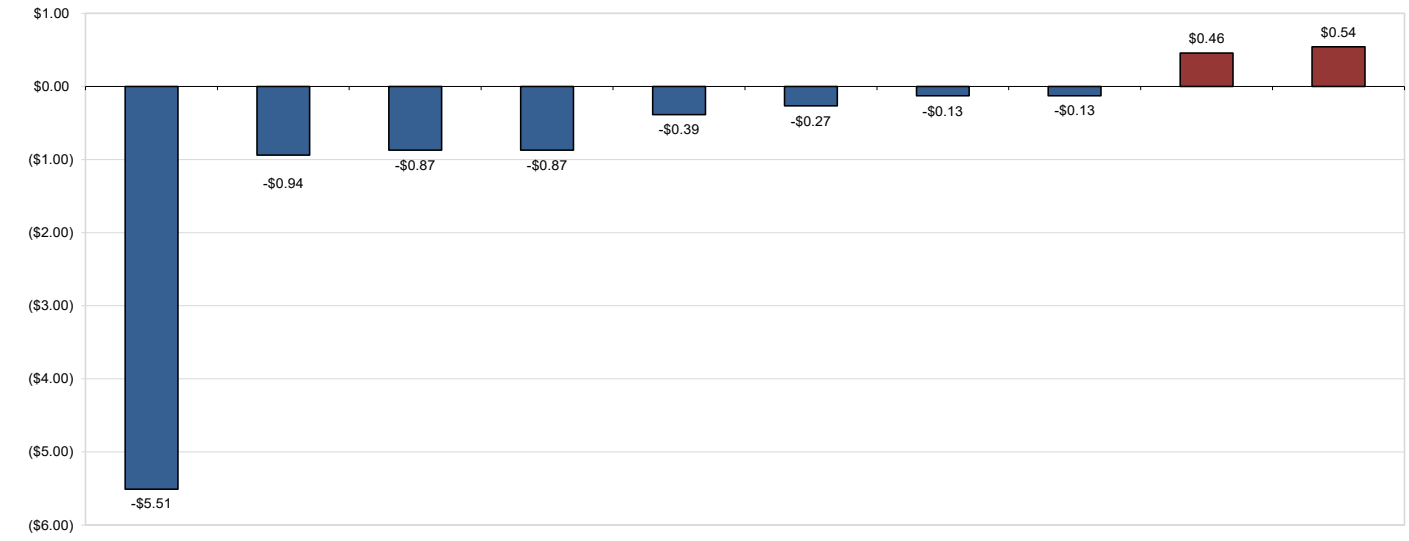
Also, outsourcing was not a contributing effect for favorable comparisons. The median rate of Outsourcing Tactical FTEs was slightly higher for Best-in-Class Plans, by 1.2 percentage points. Best-in-Class Plans were higher in the Corporate Services and Account and Membership Administration clusters, by 2.4 percentage points and 1.0 percentage points, respectively. The Provider Network functional area was higher for Best-in-Class Plans by 2.8 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, found on page 1, 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 later in this analysis.

Figure 2. Best-in-Class Plans Summary

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



Strategic Expenses Were Also Lower

In addition to the Tactical expenses discussed above, 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 the Best-in-Class Plans by 32%. Each Sales and Marketing functional area, except for Rating and Underwriting, had costs that were lower for Best-in-Class Plans.

We cannot rule out that low costs of Sales and Marketing related to membership growth. Comprehensive membership for Best-in-Class Plans *fell* by 0.9%, whereas Peer Plans increased at a median rate of 1.1%. At the product-mix of the Best-in-Class Plans, the Peer Plans posted a median membership increase of 1.6%. Because these expenses can both reflect as well as encourage growth, causality could have gone either way.

Medical Management expenses were 19% lower for Best-in-Class Plans. Best-in-Class Plans had lower gross profit margins at a median of 7% versus 13% for the Peer Plans for *insured* products. (Insured products include Commercial Insured, Medicare Supplement, FEP, Medicare, and Medicaid. Gross profit margins are premiums less health benefits, all divided by premiums). Peer Plans' margins were 14% 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 Blue universe to match the mix of each Plans. Plans were then ranked by the differences between their expenses and the re-weighted Blue universe costs. We selected the lowest cost Blue Cross Blue Shield 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.

Contact

This look at the performance 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 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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