

# Plan Management Navigator

## *Analytics for Health Plan Administration*



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## BEST-IN-CLASS BLUE CROSS BLUE SHIELD PLANS

This is our analysis of “Best-in-Class” Blue Cross Blue Shield (Blue) Plans versus their Peers. Our analysis is based on the 22<sup>nd</sup> annual edition of the Blue 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 for 19 Blue Cross Blue Shield Plans.

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.

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### Figure 1. Best-in-Class Blue Cross Blue Shield Health 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

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## Conclusions

PMPM Tactical expenses were 27% lower for Best-in-Class Plans with a mean of \$21.45 compared to \$29.45 for the Peer Plans.<sup>1</sup> Every factor driving PMPM cost variance contributed to the superior performance. The low Staffing Ratio composed 41% of overall low Tactical costs, while low Non-Labor Costs per FTE contributed 52%.

After analyzing functional areas of administrative expenses for numerous years, it appears that Best-in-Class Plans operate in a culture of conservative administrative expenses as every functional area was lower than the Peer Plans.

The overwhelming contributor among functions to superior performance was low costs in Information Systems. This was responsible for about 47% of the Tactical difference.

Other notable low-cost functions include Claims Adjudication, Corporate Executive and Governance and Customer Services. These three functions composed 35% of the difference between the two sets of Plans.

## Possible Extraneous Characteristics

We identified five characteristics of the entire set of Blue Plans that could contribute to cost differences among Best-in-Class vs. Peer Plans.

**Scale.** There was unlikely to be any effect of economies of scale on the performance of Best-in-Class plans. The median membership size for Best-in-Class Plans was 1.8 million versus 1.9 million for the Peer Plans. Based on preliminary results of Sherlock's Scale Study, 43% of administrative expenses are subject to economies of scale. These subject-to-scale expenses have a BCG slope of 85%.<sup>2</sup> In other words, if you double the size of a health plan operating at \$46.57 PMPM (Total costs for Peer Plans), costs would be expected to fall by \$2.94 PMPM.

**Cost of Living.** There was possibly an effect of local cost of living. The mean wage index was 0.845 among the Best-in-Class Plans and 1.028 among the Peer Plans, 18% lower (We employ the Hospital Wage Index used by CMS). The mean wage index for all Plans was 0.980.

If cost of living had a noticeable effect, we would expect to see it in comparisons of compensation levels between the two sets of Plans. Note, however, that Staffing Costs per FTE for the Best-in-Class Plans were only lower by 4%, less than the difference in wage indices. Also, the proportion of the Best-in-Class cost advantage attributed to Staffing Costs per FTE was only 7%. Local costs of living can also be affected through outsourcing and where those service centers are located.

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

<sup>2</sup> 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.

The wage index, it should be recognized, 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 less FTEs than did their Peer plans. The mean percent of FTEs outsourced was 9% among the Best-in-Class Plans and 13% among the Peer Plans. The median percent of FTEs outsourced was 9% among the Best-in-Class Plans and 12% among the Peer Plans.<sup>3</sup>

Information Systems for Best-in-Class Plans cost 31% less than those in Peer Plans and was most important function that contributed to low costs. It is also the function subject to the most outsourcing. An average 18% of IS FTEs for all Blue Cross Blue Shield Plans were outsourced. Best-in-Class Plans outsourced less Information Systems than did the Peer Plans. The mean percent of IS FTEs outsourced was 12% among the Best-in-Class Plans and 19% among the Peer Plans.

**Low Cost Product Mix.** The relative membership composition across products can affect a plan's total costs since some products are more expensive to administer by their nature. The Best-in-Class Plans had more low-cost ASO and Medicaid members, which tended to reduce the average cost of all of their products together. (On the other hand, they also had more high-cost Medicare members than the Peer Plans.) 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.

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

<b>Product</b>	<b>Best-in-Class</b>	<b>Peer Plans</b>	<b>PP Difference</b>
Commercial Insured	29%	38%	-9%
Commercial ASO	51%	44%	7%
Commercial Total	80%	82%	-2%
Medicare Total	6%	2%	3%
Medicaid Total	6%	2%	4%
Medicare Supplement	4%	6%	-1%
FEP	3%	8%	-5%
Comprehensive Total	100%	100%	

<sup>3</sup> 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.

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**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 returns that may not be realized for some time. That said, strategic expenses were in fact lower for Best-In-Class Plans, a result we discuss towards the end of this analysis.

### *Activities that Made a Difference*

Because almost all 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. This conclusion has held true in the past as well as in this current analysis. A few 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 composed 77% of the difference between the Best-in-Class Plans and their Peers. This cluster represented about two-thirds of total Tactical costs. Account and Membership comprises 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 47% of overall low Tactical costs and 62% of the cluster’s low costs. The Claim and Encounter Capture and Adjudication functional area also had lower costs and contributed 17% to overall low Tactical costs and 22% to low Account and Membership Administration cluster. Meanwhile, Customer Services was 26% lower for Best-in-Class Plans, contributing 8% toward overall low Tactical costs; Enrollment/Membership/Billing was lower by 26% and also contributed 5% toward overall low Tactical costs.

**Information Systems.** This function had PMPM costs that were 31% lower for the Best-in-Class Plans, primarily due low Non-Labor Costs per FTE, which were lower by 36%. The Staffing Ratio was 7% lower than the Peer plans and was responsible for 21% of this function’s low PMPM costs.

All Information Systems sub-functions except for Applications Maintenance were lower for Best-in-Class Plans. Operations and Support Services contributed most toward the low Information Systems costs. Best-in-Class Plans were lower in this sub-function by 56%, driven almost entirely by a low Staffing Ratio. Non-Labor Costs per FTE were 1% lower than Peer Plans while Staffing Costs per FTE were 11% higher.

**Claim and Encounter Capture and Adjudication.** This function was the second most important driver in low Tactical costs, contributing 17%. Claims administrative costs were lower for Best-in-Class Plans by 31%. The Staffing Ratio was 23% lower and contributed the most toward this function’s overall low PMPM costs. Non-Labor Costs per FTE were 16% lower than Peer Plans, while Staffing Costs per FTE were 3% lower.

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The most significant driver in low Claims was the Other Claims sub-function. Note, Other Claims represents the majority of costs in this functional area with activities primarily focused on the manual processes involved in claims adjudication. Best-in-Class Plans were lower by 37%, driven by Non-Labor Costs per FTE that were lower by 51%, while Staffing Costs per FTE were lower by 10%.

**Corporate Executive and Governance.** Best-in-Class Plans had expenses in this function that were lower by 50% and contributed 10% to overall low Tactical costs. A Staffing Ratio that was lower by 56% for Best-in-Class Plans was the main driver in this function's low cost. Non-Labor Costs per FTE were lower by 11%, while Staffing Costs per FTE were higher by 34%.

**Customer Services.** This function was the fourth most important driver in low Tactical costs, contributing 8%. Customer Services PMPM costs were lower for Best-in-Class Plans by 26%. Their Staffing Ratio was lower by 16%, contributing 59% toward this function's low PMPM costs. This was followed by Staffing Costs per FTE, lower by 12%, and Non-Labor Costs per FTE, lower by 4%.

### *Strategic Expenses were Also Lower*

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 21%. The key driver in the cluster's low costs was Non-Labor Costs per FTE, lower by 23%. Staffing Costs per FTE were lower by 8%, while the Staffing Ratio was lower by 3%.

Best-in-Class Plans outsourced their Sales and Marketing FTEs at a rate greater than that of their Peer Plans. A median of 16% of Best-in-Class Sales and Marketing FTEs were outsourced, compared with 7% for the Peer Plans. On average, of 12% were outsourced for Best-in-Class Plans versus 8% for Peer Plans.

All Sales and Marketing functional areas were lower for Best-in-Class Plans. Marketing expenses were lower for Best-in-Class Plans by 45% and contributed 30% to low Sales and Marketing cluster PMPM costs. A Staffing Ratio that was lower by 32% for Best-in-Class Plans was central, while Non-Labor Costs per FTE and Staffing Costs per FTE were lower by 26% and 14%, respectively.

The largest sub-function contributor to low Marketing expenses was Other Marketing, which was lower by 57%. This sub-function includes strategic marketing planning and product leadership. The low costs of this sub-function were driven by both low Non-Labor Costs per FTE and a low Staffing Ratio. Product Development was also low cost mainly due to a low staffing ratio.

External Broker Commissions were 4% lower for Best-in-Class Plans and contributed 9% toward low Sales and Marketing cluster costs. External Broker Commissions are included within Non-Labor expenses. There are no Staffing Costs in this function.

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Advertising and Promotion costs were lower by 54% and contributed the most to lower costs in the Sales and Marketing cluster. This was primarily due to a low Staffing Ratio. Media and Advertising costs were lower by 51% and composed most of the low Advertising and Promotion costs. Charitable Contributions costs were lower by 71%.

The Sales functional area was 33% lower for Best-in-Class Plans. Low Non-Labor Costs per FTE contributed 36% of this function's low costs, while low Staffing Costs per FTE contributed 44%. The Staffing Ratio was lower by 8%. The Other Sales sub-function was key to low Sales costs, with Best-in-Class Plans lower by 46%, due to both low Non-Labor Costs per FTE and low Staffing Costs per FTE.

Rating and Underwriting for Best-in-Class Plans was lower by 5%. Both the Risk Adjustment and Other Rating and Underwriting subfunctions contributed to the low costs. Employer Group Reporting was higher for the Best-in-Class plans by 52%.

We cannot rule out that low costs of Sales and Marketing impacted membership growth. Comprehensive membership for Best-in-Class Plans fell by 1.0%, whereas Peer Plans increased at a median rate of 0.9%. At the product-mix of the Best-in-Class Plans, the Peer Plans posted a median membership increase of 0.1%.

Medical Management expenses were 26% lower for Best-in-Class Plans. A low Staffing Ratio contributed the most toward this function's low PMPM costs, at 15% lower. All subfunctions of Medical Management were lower for Best-in-Class Plans, except that Disease Management was equal to the Peer Plans. Precertification was the most important source of low Medical Management expenses, which was lower by 48%.

Best-in-Class Plans outsourced fewer Medical Management FTEs than did the Peer Plans, with a median of 11% and an average of 9%, while Peer Plans outsourced a median and average of 15% of their Medical Management FTEs.

Best-in-Class Plans had slightly less gross profit margins at a median of 15% versus 16% for their 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 15% when reweighted at the mix of Best-in-Class Plans.

Gross profits Per Member Per Month for insured products were lower for the Best-in-Class Plans. On a PMPM basis, insured gross profits were \$63 PMPM for the Best-in-Class Plans and \$71 for the Peer Plans. At the mix of the lower-cost Plans, the Peer Plans' PMPM gross profits did not change, at \$71 PMPM. (Gross profits are premiums less health benefits.)

The median insured health benefit ratio for the Best-in-Class Plans was 84%, compared to 83% for the Peer Plans. At the product mix of the Best-in-Class Plans, the Peer Plans had a median health benefit ratio of 85%.

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## *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 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 Blue Cross Blue Shield 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. 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 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.

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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 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](mailto: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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