Plan Management Navigator
*Analytics for Health Plan Administration*

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*Please see invitation to participate in the 2018 Sherlock Benchmarking Study on Page 9.*

## 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 19th 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 2016.

Notwithstanding our referring to low cost plans as Best-in-Class, we recognize that the long-term objective are costs that are optimal for its goals, such as growth, earnings, competitive position, etc. 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 Medical Management function. Those "Strategic" areas have costs most readily associated with long-term objectives such as growing the business and reducing health care costs. 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.

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.

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

**Tactical Expenses:**
Provider Network Management and Services

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

**Strategic Expenses:**
Sales and Marketing Cluster
- Rating and Underwriting
- Marketing
- Sales
- Broker Commissions
- Advertising and Promotion

Medical Management / Quality Assurance / Wellness

## *Conclusions*

PMPM Tactical expenses were 18% lower for Best-in-Class Plans. Every factor driving PMPM costs contributed to the superior performance. Lower Staffing Costs per FTE contributed the most to low Tactical costs for Best-in-class Plans, at about $90,000 versus $104,000 composing, 41% of the difference.[1]

Non-Labor Costs per FTE composed 36% of low Tactical variance with Best-in-Class Plans at $73,000 compared to Peer Plans of $86,000. The Best-in-Class Staffing Ratio was 13 FTEs per 10,000 members versus 14 for Peer Plans, composing 23% of the low Tactical costs.

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. Other notable low cost functions include the Customer Services and Corporate Services Function. These three functions composed 82% of the difference between the two sets of plans.

## *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.

**Scale**. If economies of scale played a role, it was modest. The mean membership size for Best-in-Class Plans was 1.3 million versus 3.3 million for the Peer Plans, about 60% *smaller*. The median values for the two sets were 1.2 million and 3.3 million, respectively. The standard deviations of the two sets are about 4.2 million for the Peer Plans and about 1.0 million for the Best-in-Class Plans, together showing overlap between the sets.

**Cost of Living**. There was likely an effect of local costs of living, but it was modest. The mean wage index was 0.915 among the Best-in-Class Plans and 1.060 among the Peer Plans, 14% lower (We employ the Hospital Wage Index used by CMS). Meanwhile, mean wage index for all plans was 1.019. Importantly, Staffing Costs per FTE for the Best-in-Class Plans were also lower by 14%. In any event, the proportion of the Best-in-Class cost advantage attributed to Staffing Costs per FTE is 41%.

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

The wage index, it should be recognized, may actually 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 12% among the Peer Plans. The median percent of FTEs outsourced was 11% among the Best-in-Class Plans and 9% among the Peer plans.[2]

Information Systems is, among the functions, most often outsourced, at a mean of 16% for *all* Blue Cross Blue Shield Plans. The mean percent of FTEs outsourced was 13% among the Best-in-Class Plans and 18% among the Peer Plans. The median percent of Information Systems FTEs outsourced was also 13% among the Best-in-Class Plans and 11% among the Peer Plans. The Information Systems costs for Best-in-Class Plans are less than those in Peer Plans. All outsourced FTEs, Staffing and Non-Labor Costs are included in these analyses as though they are provided internally.

**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.

**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.

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

| | Commercial Insured | Commercial ASO | Commercial Total | FEP | Medicare Supplemental | Medicare Total | Medicaid Total | Comprehensive Total |
|---|---|---|---|---|---|---|---|---|
| Best-in-Class | 35% | 48% | 83% | 5% | 5% | 2% | 5% | 100% |
| Peer Plans | 43% | 40% | 83% | 6% | 6% | 3% | 2% | 100% |

[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.

## *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 82% 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 56% of overall low Tactical costs and 69% of the cluster's low costs. The Claim and Encounter Capture and Adjudication functional area contributed 2% to overall low costs and 3% to the low cluster's costs. Since the degree of automation can cause distortions where certain activities are reflected, it is interesting to see that both IS and Claims are lower. The sum of IS and Claims were lower for Best-in-Class Plans by 19%. Meanwhile, Customer Services were 33% lower for Best-in-Class Plans contributing 16% to low Tactical costs and Enrollment/Membership/Billing was lower by 26% and comprised 7% of low Tactical costs.

**Information Systems.** This function's costs were 27% lower for the Best-in-Class Plans primarily due to Non-Labor Costs per FTE being lower by 33%. Staffing Costs per FTE were lower in favor for the Best-in-Class Plans by 17%, while the Staffing Ratio was lower by 3%.

The Information Systems sub-function, Applications Acquisition and Development, contributed the most to overall low Information Systems expenses. Best-in-Class Plans were lower by 61%. Non-Labor Costs per FTE was the main driver for this sub-function, lower by 65%. The Staffing Ratio was lower for Best-in-Class Plans by 40% and Staffing Costs per FTE were lower by 8%.

**Customer Services.** This functional area was responsible for 16% overall low Tactical costs with Best-in-Class Plans lower by 33%. Non-Labor Costs per FTE was lower in favor of Best-in-Class Plans by 61% and drove 25% of low Customer Services costs. The Staffing Ratio and Staffing Costs per FTE for Best-in-Class Plans were lower by 20% and 8%, respectively.

**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 12% and drove overall low Tactical expenses by 10%. Non-Labor Costs per FTE, at 22% lower, was the chief driver in low costs. Staffing Ratio, however, was higher for Best-in-Class Plans by 12%.

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

**Corporate Executive and Governance.** Conversely, this functional area offset overall low Tactical costs by 8% with Best-in-Class Plans greater than Peer Plans by 41%. All factors for Best-in-Class Plans were higher with Non-Labor Costs per FTE chiefly responsible for high costs, greater by 58%. Staffing Ratio was higher for Best-in-Class Plans by 13%, while Staffing Costs per FTE were greater by 10%.

*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 33%. Low Non-Labor Costs per FTE were central to Best-in-Class Plans' advantage, lower by 37%. Staffing Costs per FTE and the Staffing Ratio were also lower by 19% and 2%, respectively.

Best-in-Class Plans outsourced an average of 16% and a median of 20% of its Sales and Marketing FTEs. This compares to Peer Plans outsourcing an average of 9% and a median of 5% of Sales and Marketing FTEs.

Best-in-Class Plans reported lower expenses in every Sales and Marketing functional area. External Broker Commissions were 43% lower for Best-in-Class Plans. Note, the Sherlock Benchmarks includes external Broker Commissions within Non-Labor expenses.

The Sales functional area was 16% lower for Best-in-Class Plans with Staffing Costs per FTE the key driver. Non-Labor Costs per FTE were also lower, but the Staffing Ratio was higher for the Best-in-Class Plans by 9%. The Other Sales sub-function was central to low Sales costs with Best-in-Class Plans lower by 19%. Low Staffing Costs per FTE was the primary driver. Examples of Other Sales activities include the administration of broker commissions, product sales, sales management, and generating referrals.

Expenses in Rating and Underwriting for Best-in-Class Plans were lower by 31% mainly on low Non-Labor Costs per FTE. The Risk Adjustment sub-function contributed the most to low Rating and Underwriting costs. Best-in-Class Plans reported 43% lower expenses in this sub-function almost entirely due to low Non-Labor Costs per FTE. Staffing Costs per FTE and Staffing Ratio were almost the same between the two sets of Plans.

Best-in-Class Marketing expenses were lower by 21% mainly due to a lower Staffing Ratio. The largest contributor, the Member and Group Communication sub-function, was lower by 45% chiefly on lower Non-Labor Costs per FTE.

Advertising and Promotion costs were lower by 17% primarily as a result of low Staffing Costs per FTE. (Figure 54) While Media and Advertising was low by 4%, the Charitable Contribution sub-function drove low Advertising and Promotion costs. The sub-function was lower for Best-in-Class Plans by 81%. Similarly to broker commissions, this sub-function is entirely non-labor.

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%, compared with a median decline of 1% for Peer Plans. At the product-mix of the Best-in-Class Plans, the Peer Plans posted a median membership increase of 1%, the same as Best-in-Class Plans.

Medical Management expenses were 5% lower for Best-in-Class Plans. Staffing Costs per FTE were 17% lower in favor of Best-in-Class Plans and was the central driver for low Medical Management costs. Of the nine sub-functions, only Case Management, Quality Components, and Utilization Review were lower for Best-in-Class Plans. Best-in-Class Plans outsourced an average of 13% and a median of 10% of their Medical Management FTEs. Peer Plans outsourced an average of 13% and a median of 11%.

Suggestive of the possibility of an ROI on Medical Management, Peer Plans experienced *higher* gross profit margins at a median of 14% versus 12% for Best-in-Class Plans for *insured products*. (Insured products include Commercial Insured, Medicare Supplement, FEP, Medicare, and Medicaid). Peer Plans' margins were also 14% 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 Peer Plans. On a PMPM basis, *insured gross profits* were $55 PMPM for the Best-in-Class Plans and $53 for the Peer Plans. However, at the mix of the lower-cost Plans, the Peer Plans' PMPM gross profits were *higher* at $57. (Gross profits are premiums less health benefits.)

The median *insured* health benefit ratio for the Best-in-Class Plans was 85%, compared to 87% for the Peer Plans. At the product mix of the Best-in-Class Plans, the Peer Plans had a median health benefit ratio of 86%. 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 2018 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 780 health plan years, health plans serving more than 75% of all insured Americans are licensed users of the Sherlock Benchmarks since June 2015. The Sherlock Benchmarks have been called the "Gold Standard" by Deloitte Consulting, Navigant Consulting and Gorman Health Group among others.

Approximately 40 health plans serving approximately 50 million people with health insurance are participants in the 2017 Sherlock Benchmarking study. 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.

Our universe of Independent / Provider – Sponsored Health Plans was composed of 20 plans serving approximately 10 million people. Of the 14 members of the Alliance of Community Health Plans that are not focused on public programs or are staff-model plans, 7 are participating in this year's Sherlock Benchmarking Study for Independent / Provider – Sponsored health plans. Most of the largest members of the Health Plan Alliance that are not focused on public programs participated in last year's Sherlock Benchmarking Study for Independent / Provider – Sponsored health plans.

While the calendar varies by universe, broadly speaking we will meet to finalize the content of the survey in late February, distribute the survey forms in March, collect the completed surveys in May and publish beginning in late June or early July. 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.*

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