



BEST PRACTICES FOR HEALTH PLANS: AN ENTERPRISE VIEW

Best practice is typically considered to be the most efficient way of achieving a desired outcome. The concept is also often criticized for its implication that it is the best for all times and for not specifying what outcomes are most desired. With respect to the first critique, the choice of objectives can vary over time depending on the competitive environment facing the plan. An example of the latter critique is found in customer services: Best practice can involve objectives like minimizing costs or Average Speed of Answer, but there is nothing intrinsic to best practice that would prefer one objective over the other. (We acknowledge that this is an over-simplification – best practice could be a target Average Speed of Answer at the lowest cost, for example, but the complexity in the implied balance can cross functions as well.)

Finally, best practice in its practical application can be siloed to a particular function to the exclu-

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BEST PRACTICE WEB CONFERENCES: CUSTOMER SERVICES AND ITS DRIVERS

Over the next several months, we will be offering web conferences focused on best practices. In these conferences, we will leverage our nearly 400 health plan years of experience to illustrate the relationships that contribute to best practice in the broadest possible sense.

The first web conference will focus on various operational metrics that drive or relate to Customer Services activities and costs. These include activities within Customer Services as well as activities or effects in other functional areas. This conference call will be held on **Wednesday, May 20th at 2:30 pm Eastern Time.**

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LATEST PRIVATE HEALTH PLAN DASHBOARD RESULTS

For the trailing three months ended January 31, 2009, the ten health plans in our *Health Plan Dashboard* reported health revenue growth of 7.7%, with indemnity growth of 18.2%, ASO/ ASC remained stable, while managed care revenue increased by 6.0%. Medicare Advantage grew by 29.0% and Medicaid had revenue growth of 17.6%.

Overall, membership increased by 3.4% in health lines. Membership declined by 2.0% for managed care but increased by 10.7% in the indemnity

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TIMING OF MEDICAID AND MEDICARE BENCHMARKING

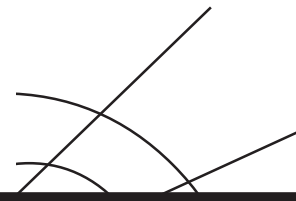
We expect to circulate the benchmarking surveys on or about June 1st, for completion by July 20th. We expect the final reports to be available in early September. At this juncture, seven Medicare and nine Medicaid plans have committed to participate. We will shortly be circulating draft materials to each of the participants.

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TIMING OF BLUE AND IPS BENCHMARKING

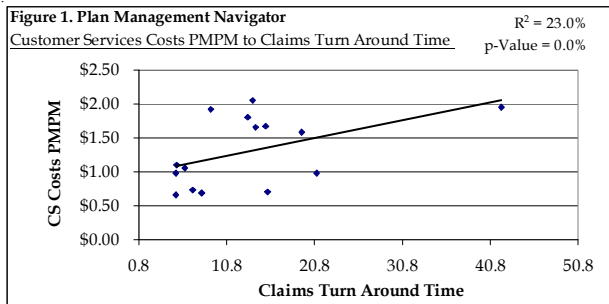
In the past few weeks, we launched our benchmarking studies for two universes. The Blue Cross Blue Shield universe is comprised of 23 plans serving approximately 31 million members and the 16 Independent / Provider-Sponsored Plans (IPS) serve nearly six million members. This follows successful organizational meetings in New Orleans in which the panelists finalized metrics and their definitions. Sherlock Company also presented findings on drivers of customer services

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Enterprise View: *Continued from Page 1*

sion of others, ignoring the practical effects of one function on others. An apparently inefficient claims system may have negative effects on customer services costs as shown in Figure 1.



We believe that the best way of determining best practice in its most practical application is to take a global approach. That is, to start with an overall objective, and using that as a screen, weigh all particular practices in light of how they contribute to the overall objective. It overcomes narrowness of focus by considering the effect on other activities of the firm, and it is sensitive to changes in the plan's competitive environment.

While many other global objectives have appeal, corporate growth strikes us as being an especially promising screen for assessing best practices. If increasing numbers of people find the services of a firm worth buying, then the attractiveness of its services must be increasingly apparent to customers. Of course, this objective is qualified: since no enterprise can long operate with inappropriately low profits, this growth must be profitable growth. Also, such profits must be adequate to replace the capital required to build the product or service that consumers find attractive, including statutory reserves, regardless of whether that capital is financed through debt or equity.

Return on Assets is the metric that uniquely quantifies the link between a firm's experience of top line growth and its having the resources to continue that growth in future periods. In other words, a company earning a Return on Assets of 10% in Year One will, in the absence of dividends or the like, have 10% more assets on which it can base 10% higher revenue in Year Two. If it continues to earn this Return on Assets, it will also be adequately funded to achieve this growth.

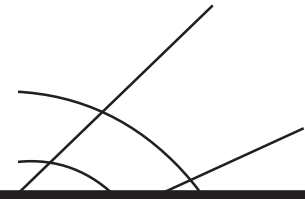
Best practice pervades ratios into which Return on Assets are analyzed. Efficiency requires that assets employed in making the product be minimized for each unit of sales. This is called the Total Asset Turnover. Production costs that are not capitalized should also be minimized, and are measured through the Profit Margin. These metrics themselves are subject to maintaining the attractiveness of the product to a firm's customers in a dynamic environment in which customer preferences change and the market place experiences new entrants. This is shown in Figure 2.

Figure 2. Plan Management Navigator
Return on Assets Ratio

Return on Assets	=	Total Asset Turnover	x	Profit Margin
$\frac{\text{Net Income}}{\text{Total Assets}}$		$= \frac{\text{Revenue}}{\text{Total Assets}}$		$\times \frac{\text{Net Income}}{\text{Revenues}}$

For completeness, we would add that the mix of debt and equity sources to fund assets used in production is also a matter of best practice, though this is not the focus of this article. The greater the amount of debt, including short-term debt like IBNR, the higher the Return on Equity, but also the higher the risk that equity will be wiped out. Best practice, in the case of an optimal capital structure, relates to the achievement of an optimal mix of debt and equity based on the volatility of profits in the health insurance business.

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Thus, for a given portfolio of products, subject to their intrinsic volatility, the best practice or optimal capital structure is entirely separable from operational best practice. More practically, this means that firms emphasizing ASO products may well have a different optimal capital structure than those offering insured products. Figure 3 illustrates the extension of Return on Assets to include the capital structure of the enterprise.

cost) as possible. Indeed, such reduction in claims staff achieves best practice by not only improving Profit Margins but also by enhancing Total Asset Turnover. This could occur since, with the reduction of staff, the plan is also able to reduce its investments in computers, phones and equipment required by those eliminated claims people.

However, the problem with the functional approach to best practice is that simply reducing the costs in one functional area may actually prove harmful to the company as a whole. If claims are

Figure 3. Plan Management Navigator

Return on Equity Ratio

Return on Equity	=	Total Leverage Ratio	x	Return on Assets
$\frac{\text{Net Income}}{\text{Shareholder's Equity}}$	=	$\frac{\text{Total Debt}}{\text{Shareholder's Equity}}$	x	$\frac{\text{Net Income}}{\text{Total Assets}}$

processed slower or with greater errors, the decline in the number of claims people may be offset by an increase in the number of customer service reps that are

The operational (non-financial) drivers that management controls, then, are those of relating to capital deployment and those involving efficiency of costs relative to revenues. Summarized as Return on Assets, this objective is also global; that is, any improvement in any given functional areas will likely affect other ones and it is important to assure that the effect is not a net negative for the firm as a whole.

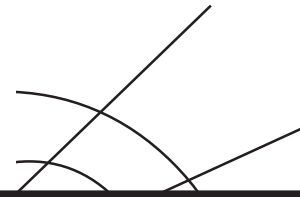
therefore required. More customer service inquiries may come in, and if met with busy lines, declines in customer satisfaction and membership may ensue. Thus, in our simplified model, best practice within a functional area can be quite different from that of the company as a whole.

Suppose a health plan seeks acceleration in its growth. To do so it must make the appropriate investments to achieve it. For instance, to properly serve additional members, it must employ more customer service people who will require desks, phones, desktop computers and so forth.

Accordingly, we think it is best to consider best practice to be a concept ideally understood in the context of the firm as a whole. Improvements in any functional area should be weighed against the effects throughout the organization, and should be done explicitly.

Excluding any external capital sources, this investment is likely to require funding through improvements in profit margin or turnovers or both. Let us suppose that to fund such improvements the number of claims processors is reduced. Suppose also that this could be achieved in a focused way by meeting the best practice of operating the claims shop as efficiently (at as low

The notion of best practice is often applied with respect to specific functional areas. But functions are not independent entities, and they interact with one another. The weakness of a narrow focus is that it neglects consideration of its effect on other functional areas. As discussed above, a promising metric of the enterprise as a whole is Return on Assets. As a criterion though which any intended improvement is deemed best practice, it forces a consideration of all of the functional areas employed by a firm in service to its customers. ♣



Web Conferences: *Continued from Page 1*

The cost will be \$225. *Participation is free of charge to health plans participating in our 2009 benchmarking studies.*

If you are interested in participating, please e-mail Erin Sawchuk at erinsawchuk@sherlockco.com or call at 215-628-2289. ♣

Dashboard Results: *Continued from Page 1*

business. Membership in Medicare Advantage products soared by 16.9%.

Managed care and indemnity had price increases of 6.9% and 2.0%, respectively, while indemnity posted a 0.1% decrease. Medicare Advantage posted an increase of 9.5% as Medicaid premiums increased by 7.6%.

Health benefits ratios overall grew by 2.7 percentage points, but decreased by 4.1 percentage points (as a percent of premium equivalents) for Medicare Advantage line and grew by 6.5 percentage points for indemnity. The number of scripts per person remained at 10.3 on an annualized basis. E/R visits per thousand members decreased by 5.7 to an annual rate of 276.6 per thousand and hospital days increased by 10.0 days to 317.3 days per thousand. All products except Medicare Advantage experienced declines in hospital utilization.

The administrative expense to premium ratio decreased 0.6 percentage points to 8.2%. Claims volumes increased by 0.32 to 14.1 per member per year while inquiries per member fell 0.02 to 1.7 per member per year. Staffing ratios increased by 0.63 FTEs to 18.7.

Health plans in our *Dashboard* universe are comprised of a mix of Blue Cross Blue Shield and Independent/Provider-Sponsored Plans. Please let us know if additional information would be of interest to you and your organization. ♣

Medicaid/Medicare: *Continued from Page 1*

The timing is intended to provide the greatest flexibility to those plans having to submit bids for Medicare Advantage. On March 30th, CMS announced that bids would be due on June 1st. While this is obviously a concern for plans serving Medicare Advantage members, it has also been an issue for Medicaid plans. Medicaid plans often serve the frail elderly through Special Needs Plans that are also required to submit bids.

Because of the heavy use of financial personnel in completing the bids, this is important to our scheduling of the survey for these universes. We organize our survey so that it avoids conflicts with the other activities of participants and our survey contacts. ♣

Blues/IPS: *Continued from Page 1*

and information systems, and panelists participated in implementation discussions.

The survey materials are due back to us beginning May 18th. After compilation, scrubbing and management reviews, the benchmarks will be published beginning in July. ♣
