Plan Management Navigator
Analytics for Health Plan Administration Late January 2012

Decisions of Low Cost Blue Cross and Blue Shield Plans in 2010

Blue Cross Blue Shield plans operating with low costs make expense decisions that differ from their peers that operate at higher costs. This analysis summarizes the hallmarks of those decisions. The most important reason for their superior performance stems from staffing ratios that are remarkably low. Low costs in Account and Membership Administration was a central factor in this, and low Information Systems was the largest contributor to low costs.

This analysis is derived from data collected from the 27 Blue Cross Blue Shield Plans participating in *Sherlock Expense Evaluation Report* in 2011. These plans comprise 71% of plans based in the contiguous United States.

Background and Methodology

For this analysis, the term "low cost" refers to the performance of health plans for the functional areas which make up approximately 75% of total administrative costs. These costs exclude the functional area of Medical Management and the cluster of Sales and Marketing. The purpose of excluding Medical Management is that, when effective, it drives down health benefit costs. Health benefits are identifiably discrete from administration and medical management may have benefits spanning years. Similarly, effective Sales and Marketing expenses often affect growth in subsequent years. This analysis focuses on the remaining expenses that have an immediate impact on the operations of a health plan. Their effect is largely confined to current period activities and each function's performance principally affecting only those other remaining activities.

We call these remaining expenses "tactical" for the purposes of this analysis. We acknowledge that,

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Dashboard Summary

For the trailing three months ended November 30, 2011, the thirteen health plans in our *Health Plan Dashboard* reported an increase in health revenues of 5.4%. Revenues for Medicare Advantage grew most rapidly, increasing by 9.8%. Product revenues for ASO/ASC followed with growth of 7.8%, while the product revenues for Indemnity grew by 4.9%. Conversely, product revenues for Medicaid and Managed Care fell 1.6% and 2.2%, respectively.

Overall, membership increased 3.1% for health lines. Membership declined by 1.9% in Managed Care and 1.8% in Indemnity. ASO/ASC experienced the largest membership growth at 8.2%. This was followed by membership growth of 5.6% in

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New *SEER* Universes Being Formed

The challenging operating environment for health plans has convinced many managers that effective management of operating costs is central to their plans' long-term success. The weak economy is placing great pressure on commercial enrollment, creating the risk that administrative expenses could be a source of negative operating leverage.

Health plans face the additional challenge of health care reform. Under the Patient Protection and Affordable Care Act (PPACA), the administrative expenses of health plans serving the commercial market are subject to the indirect limitations of the minimum medical loss ratios. Moreover, health care reform also facilitates the use of health insurance "exchanges." In theory, prices will be subject to greater scrutiny by health plan customers. For plans offering Medicare Advantage,

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for Information Systems in particular, this segmentation is subject to criticism. We also recognize that the architecture of expenses is established over multiple years. These tactical expenses are incurred, however, in ways that largely reflect, in that period, those management decisions affecting a health plan's business processes.

To identify the decisions that lead to low costs, we divided the universe of Blue Cross and Blue Shield Plans into a low cost group, comprised of approximately 25% of the universe, and all other Plans in that universe. Seven of the 27 Plans were selected for the low cost group. The low cost group was determined based on relative performance, after our comparisons eliminated the effect of product mix differences. We did not adjust for any cost of living differences since health insurance operating functions are not geographically confined.

We use a number of terms as synonyms for "low cost" including superior performance, favorable variance and so forth. This should not be construed as meaning that low costs are necessarily optimal. However, we do not have any certainty that low costs in these tactical areas lead to suboptimal performance in other aspects of their operations.

Overall Cost Savings

Overall, low cost Blue Cross Blue Shield Plans had tactical administrative expenses that were $5.63 PMPM, or 29%, lower than their higher cost counterparts. In the low cost Plans, the staffing ratio was significantly lower than the high cost Plans and accounted for three quarters of the cost savings. Staffing costs per FTE were also lower by approximately 10% and were the next most important factor. Non-labor costs (supplies, depreciation and other operating expenses) were also lower for the low cost plans.

When examining the specific activities that were the sources of savings, the cluster of functional areas called Account and Membership Administration explained 59%. The actual expenses that make up this cluster were also responsible for the majority of reported overall tactical costs of health plans. In this cluster of functions, a low staffing ratio explained 89% of the superior cost performance. Both non-labor costs and per FTE staffing costs were also lower.

The functional area responsible for the vast majority of the superior performance of the Account and Membership Administration cluster was Information Systems. This function was also the most important reason for lower tactical costs. Low non-labor costs was the most important contributor to low IS costs, but a low staffing ratio and Staffing costs per FTE were also important. In 2010, Information Systems for low cost Plans were less likely to be outsourced than the high cost Plans.

Enrollment and Customer Services functions also had low costs. Enrollment costs were lower by 38% and Customer Services costs were lower by 23%. Both functions had lower staffing ratios and lower staffing costs per FTE. Interestingly, both also had *higher* non-labor costs compared to their higher cost peers.

Unique among the functions, Claim and Encounter Capture and Adjudication costs were actually higher. Even still, the staffing ratio was far lower than the higher cost plans. Both non-labor and staffing costs per FTE were higher, however. Because so much of Information Systems is in support of Claims, it is notable that the sum of these two functions is 25% lower than that their peers.

The cluster of Corporate Services comprised 36% of the low cost plans' tactical expenses. The functions in this cluster include Finance and Accounting, Actuarial, Corporate Services function and Corporate Executive and Governance. For this cluster, a low staffing ratio was responsible for most of the

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favorable comparison. Staffing costs were also low, while non-labor costs were high.

Many of the scalable functions are found in the Corporate Services cluster. The median size of the low cost Plans was 1.8 million members, compared with 650,000 members among their higher cost peers. Economies of scale may play a role here.

The Corporate Services *function* is comprised of the subfunctions Human Resources, Legal and Facilities, among others. This function was responsible for 19% of the favorable comparisons in tactical expenses as a whole and 53% of the favorable comparisons in the cluster. Like the cluster of the same name, a low staffing ratio was responsible for most of the favorable comparison. Staffing costs were also low and non-labor costs were high.

The functional area of Provider Network Management and Services contributed only 5% to the overall tactical favorable comparison. Again, the vast majority of this cost savings came from a low staffing ratio. Non-labor costs per FTE were slightly lower, as were staffing costs per FTE.

The Choices Low Cost Plans Make in Tactical Expenses

Low cost Plans make decisions that differ from their higher cost peers. Hallmarks of these decisions include levels and distributions of expenses between functions, the levels and distribution of staff between functions, the levels of compensation and its distribution between functions and the distribution between functions and levels of non-labor expenses.

Cost Variances. Among the low cost Plans, Finance and Accounting represented the greatest percent favorable variance enjoyed by the low cost Plans, followed by Corporate Executive and Governance. One significant finding was that the low cost Plans did not spend more on one function and reduce costs in others. Rather, they maintained low costs in all functions but Claims, but some functions were lower than others.

Components of Cost Variance. The leading sources of the overall favorable variance were the functional areas of Information Systems and Corporate Services. This was followed by the functional areas of Corporate Executive and Governance and Enrollment.

Staffing Ratio Variances. Low staffing ratios were primarily responsible for the difference between the low cost and other Plans. In terms of functional areas, Corporate Executive and Governance for low costs Plans had the greatest variance from their high cost peers, followed by Finance and Accounting.

Components of Staffing Ratio Variances. As noted earlier, the staffing ratios of low cost Plans were significantly lower than those for their high cost peers. The most important source of this difference was in the functional area of Claim and Encounter Capture and Adjudication followed by Enrollment / Membership / Billing.

Staffing Cost Variance. Staffing costs also contributed to the favorable performance of low cost health plans. Information Systems and Actuarial costs were especially low. Staffing costs were slightly higher, however, in Claims.

Components of per Employee Staffing Cost Variance. Of the total staffing costs' favorable variance, Information Systems comprised the majority of it followed by Customer Services and Enrollment / Membership / Billing. Claims staffing costs were higher, on the other hand, slightly offsetting the favorable variance.

Non-Labor Cost Variance. While non-labor costs contributed to low tactical costs, most functions had higher non-labor costs. The unfavorable variance for Actuarial and Claim and Encounter

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Capture and Adjudication was especially high. By contrast, Information Systems costs were quite low.

Components of Non-Labor Cost Variance. The functional area of Information Systems was the greatest, nearly sole, contributor to the overall favorable variance of non-labor costs. Claims was responsible for the most significant offsetting unfavorable comparison.

Strategic Expenditures of Low Cost Plans

As noted above, certain expenses, especially Sales and Marketing and Medical Management, have returns that may be realized over a longer period of time. In addition, Medical Management expenses may yield lower health care costs. For this analysis, we call these "strategic" activities. Therefore, we have considered these expenses separately and, in this analysis, assumed that health plans with low costs in the tactical functions are also likely to make insightful decisions regarding strategic functions as well. Interestingly, like the tactical expenses, the strategic expenses are also lower overall.

For the low cost Blue Cross Blue Shield Plans, the Sales and Marketing functional area cluster had expenses lower than the other Plans, but the mix drivers of these costs were different. As with the tactical expenses, the favorable variance was primarily due to a low staffing ratio. But, while staffing cost was low, non-labor costs was high. Non-labor costs for this cluster include broker Commissions and much of Advertising.

The most important source of lower costs was in external broker Commissions. No staffing was associated with this activity and all costs were considered non-labor for our purposes.

Advertising and Promotion cost was also low, due to a low staffing ratio and staffing costs per FTE. Non-labor costs, however, were 69% higher than the high cost Plans.

Internal Sales costs were also low, the next most important contributor after Commissions to this cluster's favorable comparison. While the staffing ratio was lower than average, both per FTE staffing costs and non-labor costs were high.

Both low cost and higher cost Plans' membership declined in 2010. Low cost Plans declined at a faster rate than their higher cost peers, though this difference diminishes when the product mixes are matched.

The firms with the lowest costs in the tactical areas also had low costs in Medical Management. Staffing ratios were low and are the overwhelming driver of the total favorable variance in costs. Both non-labor costs and staffing costs were higher than the high cost Plans.

The median health benefit ratio for the low cost Plans was higher than that of the Plans with higher administrative costs. This was also true when adjusting for the mix of products offered by the low cost Blue Plans, though the difference diminished considerably.

Conclusion

This analysis identifies the hallmarks of the choices that low cost Blue Cross Blue Shield Plans make. It is free of product mix bias, and the data has been thoroughly scrubbed.

A few conclusions may be drawn. While the expense savings were concentrated in Information Systems, Corporate Services and Corporate Executive and Governance, they were found in all tactical functions excepting Claims. This is suggestive of an overall management commitment and a culture of conservative spending throughout the organization.

Also, low costs was mostly the result of lower staffing ratios. Compensation per employee and

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non-labor costs was also lower but their effects are relatively modest. This mix of drivers was suggestive of thoughtful attention to the processes of executing health plan transactions.

It is possible that low administrative costs came at a cost. Health Benefit Ratios and membership growth comparisons were unfavorable for the low cost plans. Economies of scale may have benefited the low cost plans, which typically had greater numbers of members.

Low cost Blue Cross Blue Shield Plans were less likely to outsource for Information Systems but slightly more likely for Claim Encounter Capture and Adjudication. High non-labor expenses in Advertising and Promotion were an important component of low cost Plans' Sales and Marketing costs, *offsetting* some of the overall lower costs.

This analysis is not intended as an operational blueprint. It contains no recommendations on what information system to buy, what proportion of claims should be autoadjudicated or the appropriate mix of manual versus automated customer service inquiries to shoot for.

The premises of this and our other Sherlock benchmarking efforts from which this analysis is drawn is that the heads of the various functional areas of the health plans are experts on how to improve their operations and are committed to doing so. We also recognize that aggressive cost management requires that managers make difficult decisions. In other words, our benchmarks are intended to serve as catalysts to the actions that managers may already see as necessary on an intuitive level and also provide a broad-brush description of what those operational targets must look like. Those managers are likely experts in executing the goals implied in this analysis.

Additional information is available to users of the Blue Cross and Blue Shield edition of the Sherlock Expense Evaluation Report.

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Medicare Advantage. Medicaid membership grew by 2.2%.

The Indemnity and Managed Care products reflected the largest price increases at 3.3% and 3.1%, respectively. ASO/ASC experienced price increases of 2.3% with Medicare Advantage at 1.7%. The Medicaid product had a price *decrease* of 3.6%.

Health benefit ratios for health lines decreased by 0.5 percentage points to 88.0%. The Medicaid product had the largest increase at 4.2 percentage points. The number of scripts per person declined by 0.1 to 10.1 on an annualized basis. E/R visits per thousand members fell 1.3 to an annual rate of 242.4 per thousand, while hospital days fell 8.8 days to 330.1 days per thousand.

The administrative expense to premium ratio fell 0.4 percentage points to 9.7%, while the administrative costs per member per month increased 6.8% to $27.47. Claims volumes decreased 0.13 to 15.4 per member per year, while inquiries per member declined 0.04 to 1.4 per member per year. Staffing ratios fell 0.07 FTEs per 10,000 members to 19.7.

Health plans in our *Dashboard* universe are comprised of Blue Cross Blue Shield and Independent/Provider-Sponsored Plans. Please contact us if you have an interest in participating or receiving the *Dashboards* at 215-628-2289 or sherlock@sherlockco.com.

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administrative costs will be subject to pressures of their own. This product will ultimately be subject to MLR minimums, but rate increases will be especially meager in the intermediate term. For plans offering Medicaid, weak state budgets will place continuing pressure on their Medicaid operations.

Benchmarking helps firms determine whether they are operating at best practice for costs and, if not, what functional areas provide the highest return on management's efforts in improvement. If improving your plan's performance is on your company's agenda for 2012, we invite you to consider participation in Sherlock Company's benchmarking surveys.

We have a very strong network of Plans. Sixty health benefit organizations serving nearly than 50 million insured Americans participated in our benchmarking studies in 2011. Our universes consist of Blue Cross Blue Shield Plans, Independent/Provider–Sponsored Plans, Medicare Plans, Medicaid Plans and Third Party Administrators.

We have unparalleled experience. Now initiating our fifteenth survey, we will have approximately 575 health benefit years of experience by the end of this cycle. Our data definitions, metrics, "scrubbing" procedures and analysis methods are well-developed. Our experience means our benchmarks achieve a high degree of insight for your efforts.

Our benchmarks are generally accepted. Including licensees, health plans serving more than 140 million Americans are current users of our benchmarks. They are also relied upon for advocacy and health policy purposes.

We are structurally sound. Reliability is enhanced by voluntary participation, freedom from conflicts of interest and incentives against the "tragedy of the commons."

If your organizations would like to consider participation, we invite you to give us a call at 215-628-2289 or email us at sherlock@sherlockco.com. Key dates are shown below.

Figure 1. Plan Management Navigator
New SEER Universes Being Formed

Universe	Draft Circulation	Survey Circulation	Survey Return	Estimated Publication Initiated
Blue Cross Blue Shield	Late January	Late March	Late May	July
Independent / Provider - Sponsored	Late January	Late March	Late May	July
TPAs	February	April	June	August
Medicare	Early April	Early June	Late August	September
Medicaid	Early April	Early June	Late August	September