

Plan Management Navigator

Analytics For Health Plan Administration

October 2003

ADMINISTRATIVE EXPENSE BENCHMARKS FOR PROVIDER SPONSORED HEALTH PLANS PUBLISHED BY SHERLOCK COMPANY

Sherlock Company's recently published benchmarks for provider sponsored health plans report median costs of \$18.10 for all commercial insured products and \$16.94 for all products offered. The reporting firms, ten provider sponsored health plans with an average membership of 205,000 members, reported expenses which ranged from \$13.88 for commercial ASO to \$43.62 for Medicare + Choice. Account and membership administration comprised the largest component of health plan administrative expenses. The complete results are published in the *2003 Sherlock Expense Evaluation Report (SEER) Provider Sponsored Edition*.

Expenses were typically lower than in Public Company and Blue Cross Blue Shield universes, notable since they were considerably smaller, a seventh the size of Blue plans and one-eleventh the size of Public firms. The provider-sponsored plans' focus on limited panel products, certain marketing advantages and the possible advantages of vertical integration may contribute to their success. Generalization may not be possible to all provider sponsored plans. These are larger, exhibit profits and may have stronger financial reporting than their peers. Nevertheless, it illustrates that strong performance is possible for such firms. Additional information on these comparisons are available to subscribers in the September, 2003 edition of *PULSE*.

Marketing expenses included Rating and Underwriting, Product Development / Market Research, Sales and Marketing, Commissions and Advertising and Promotion. These expenses represented \$4.24 of the total administrative costs. At the 75th percentile, these costs were \$5.23 but only \$3.56 at the 25th percentile. Commissions paid to brokers comprised \$1.84, the lion's share of these expenses. This was significantly less than the \$2.71 PMPM reported by Blue Cross Blue Shield and publicly traded universes.

Medical & Provider Management was composed of Provider Network Management and Services and Medical Management (including Quality Assurance, Wellness Programs and Grievance / Appeals. These expenses had a median value of \$3.25, higher than other universes, probably stemming from their focus on managed care. At the 75th percentile, these costs were \$3.98, but were as low as \$2.09 at the 25th percentile. Expenses for Medical & Provider Management are highly

sensitive to the mix of products offered: Managed care products such as HMOs tend to require a higher commitment to this function. Insured HMO membership comprised 66.3% of total membership as compared with 41.4% of members served by public companies and 10.1% of those served by Blue Cross Blue Shield Plans.

Account & Membership Administration represented \$5.99 per member per month of administrative expenses in 2002, the largest share of administrative costs. This category of expenses includes many of the core functions such as Enrollment (including Membership and Billing), Customer Services, Information Systems and Claims (including Encounter Capture and Adjudication). Plans reported \$7.83 at the 75th percentile and \$4.62 at the 25th percentile.

Corporate Services represented the final category. It included investments in HIPAA compliance as well as Finance and Accounting, Actuarial, Corporate Services (including Human Resources, Facilities, Legal and Regulatory, Corporate / Executive and Association Dues and Miscellaneous Business Taxes. These expenses collectively represented \$5.13 in administrative expenses. Fewer than 25% exceeded \$6.38 or were less than \$3.72.

Figure 1. Benchmarks for Provider Sponsored Plans' Administrative Expenses: 2003
Cost Per Member Per Month - By Function, Comprehensive Products

	25th Percentile	75th Percentile	Median	σ /Mean
Marketing	\$3.56	\$5.23	\$4.24	36.71%
Medical and Provider Mgmt.	\$2.09	\$3.98	\$3.25	41.90%
Account and Membership Admin.	\$4.62	\$7.83	\$5.99	37.18%
Corporate Services	\$3.72	\$6.38	\$5.13	29.16%
Total Expenses	\$15.25	\$21.23	\$16.94	26.98%

The data included in Figure 1 are summaries of the expense classifications. Plans provided us with information on eighteen major functional areas, detailed in the *SEER* report itself.

Expenses varied significantly between products. The most expensive product to administer, by far, was Medicare + Choice, which had a median cost of \$43.62. The least expensive was ASO, which had expenses of \$13.88. Among insured products, the lowest cost plan to administer was Medicaid HMO, at \$15.03. The next lowest comprehensive product to manage was Commercial HMO at a median cost of \$17.05. The focus on these products and their success in managing their costs contributed to low overall costs.

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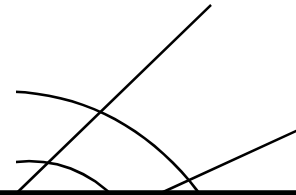


Figure 2. Benchmarks for Provider Sponsored Plans' Administrative Expenses: 2003
Cost Per Member Per Month - By Product Line

	25th Percentile	75th Percentile	Median	σ /Mean
Commercial				
HMO	\$14.88	\$23.65	\$17.09	27.97%
POS	\$23.08	\$27.50	\$26.95	24.69%
ASO	\$11.38	\$17.28	\$13.88	31.54%
Public Sector				
Medicare + Choice	\$30.09	\$50.33	\$43.62	33.13%
Medicaid HMO	\$14.23	\$17.69	\$15.03	22.19%

Health plan administrative expenses varied by product when measured as a percent of revenues as well. Despite its high per member costs, Medicare + Choice is the lowest cost to administer, at 7.59% of revenues: Medicare beneficiaries have higher underlying health costs, leading to higher claim processing and customer service calls. Among commercial insured plans, the POS was the highest cost to administer, at 14.44%, compared to 9.09% for Commercial HMO. Medicaid HMO had administrative expenses of 7.65%.

Figure 3. Benchmarks for Provider Sponsored Plans' Administrative Expenses: 2003
Costs as a Percent of Revenue - By Product Line

	25th Percentile	75th Percentile	Median	σ /Mean
Commercial				
HMO	8.15%	12.43%	9.09%	28.66%
POS	12.48%	14.76%	14.44%	29.30%
ASO	73.96%	88.77%	83.08%	53.61%
Public Sector				
Medicare + Choice	4.79%	8.55%	7.59%	37.02%
Medicaid HMO	6.73%	9.20%	7.65%	18.92%

Provider sponsored health plans generally operated profitably in their insurance products provided on an ASO basis.

BACKGROUND ON THE PROVIDER SPONSORED PLANS AND SEER

According to the InterStudy *Competitive Edge*, there are 81 provider sponsored plans with approximately 7.2 million members. The ten plans in our universe serve 2.1 million members, or approximately 29% of the membership and 12.3% of the plans themselves. Because of confidentiality agreements we are not able to disclose the identities of the participants.

Information contained in *SEER* is from extensive surveys of the participants, who report to us administrative costs as well as

certain operational metrics. This is the sixth year that we have been performing benchmarking studies, although this is only the first for provider-sponsored plans. We are now completing one for Medicaid oriented health plans.

The surveyed items, the survey instrument, the definitions and the process are developed through the active participation of the surveyed plans. *SEER* data

is provided by the companies who receive copies of the report in return for participation.

Volume I of *SEER* for Provider Sponsored plans contains approximately 1,500 analyses of six principle product areas and eighteen functional areas. All information is as of December 31, 2002. Separate analyses include outsourced functions such as mental health, pharmacy and COB / Subrogation. Products offered by the plans include HMO,

Point-of-Service, ASO products, Medicare HMO and Medicaid HMO.

OTHER PENDING OR PLANNED SEER REPORTS

To date we have distributed to participants five *SEER* volumes, including financial metrics (Volume I) for Public, Blue and Provider Sponsored universes, as well as operating metrics (Volume II) for Blue and Provider-sponsored universe. Summaries

for the Volumes I are above and in *Navigator* in July and August 2003. A description of Volume II is found in the September edition.

Medicaid Oriented Health Plans. We are gathering data from eight firms who are oriented to the Medicaid market. Five of them are entirely focused on this market segment and the other three have over 30% of their membership in this segment. We expect to complete this in late November or early December.

Function Specific Analyses. We are considering offering a low cost set of products intended to meet the needs of health plans who are focused on selected functional areas. Specialized reports may be Marketing, Medical and Provider Management or Claims and Information Systems, among others. Please call for additional information.

