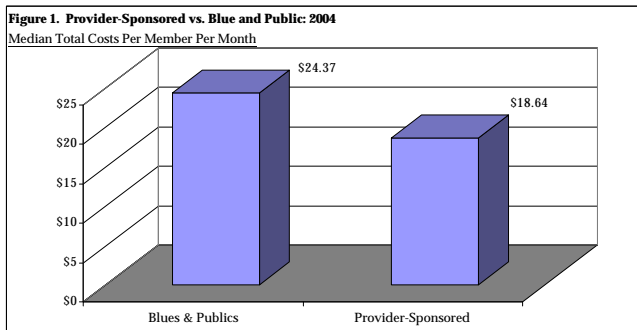


WHY ARE SMALLER PROVIDER-SPONSORED PLANS MORE EFFICIENT THAN BLUES AND PUBLICS?

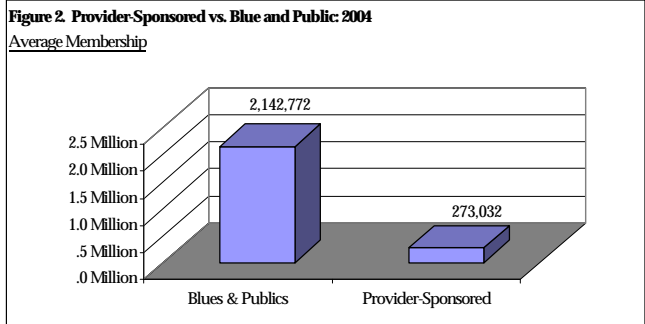
A comparison between the administrative expenses of Provider-Sponsored plans and larger Blue Cross Blue Shield and Public plans indicates that Provider-Sponsored plans tend to run leaner. In this month's *Health Plan Navigator*, we examine these differences and explore how Provider-Sponsored plans achieve cost savings relative to other plans.

As shown in Figure 1, median total administrative costs per member per month (PMPM) for Provider-Sponsored plans was \$18.64, compared with \$24.37 for the combined universe of Blue and Public plans. (All values for the costs in the analyses are medians.) This is surprising since the large plans possess greater ability to exploit scale economies. The average Blue and Public plan is nearly eight times the size of the average Provider-Sponsored plan as illustrated in Figure 2.



Differences in Expenses between Provider-Sponsored and Others

The administrative expenses of Provider-Sponsored plans were generally less than that of their Blue Cross Blue Shield and Public Company

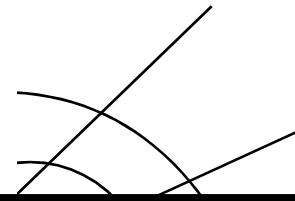


counterparts, among the plans in our sample. The lower costs were evident whether costs were analyzed by product or by major functional area. While we do not show this, when expenses are calculated as a percent of revenues, Provider-Sponsored plans have similar favorable comparisons in each product area.

DIFFERENCES BY PRODUCT

Figure 3 summarizes the PMPM costs of the respective universes in eight product lines. Five of those products were offered by both universes and represented 70.5% of the Blue-Public membership and 98.1% of the Provider-Sponsored membership.

Members of Provider-Sponsored plans were highly likely to be enrolled in products in which the Provider-Sponsored plans had a cost advantage. The products comprised 88.4% of Provider-Sponsored health plan membership and 61.9% of the Blue-Public membership. Provider-Sponsored health plans had lower costs in Commercial HMO Insured at 88.1% of the Blue-Public PMPM costs, the ASO / ASC products at 74.9% of Blue-Public costs and the Medicaid HMO at 82.1% of the Blue-Public costs. It is notable that while Provider-Sponsored plans offer ASO products, they are the self-insured managed care products rather than the open-panel ASO products, reputed to have lower costs.



By contrast, Provider-Sponsored plans operated at higher costs in Commercial POS Insured and in Medicare + Choice, at 106.3% and 106.4%, respectively, of Blue-Public costs. Together, these products comprised only 8.6% of Blue-Public membership and 9.7% of the Provider-Sponsored membership.

In the products for which there was no overlap, the Blue-Public universe's costs for Indemnity and PPO Insured and Medicare Supplemental are slightly higher than average for all the products offered, while the Medicare Cost product offered by the Provider-Sponsored universe are considerably higher than average.

DIFFERENCES BY FUNCTIONAL AREA

While the Provider-Sponsored plans in our universe generally demonstrate their efficiency across products, the functional areas themselves also tend to be relatively lean. Figure 4 segments administrative expenses into functional areas.

Figure 4. Provider-Sponsored vs. Blue and Public: 2004
Cost per Member per Month - by Function, Comprehensive Products

	Blues & Publics	P-S	P-S / Blues Publics
Marketing	\$5.94	\$4.62	77.8%
Medical and Provider Mgmt.	2.88	2.97	103.3%
Account/Membership Admin.	9.59	5.60	58.4%
Corporate Services	5.27	5.50	104.4%
Total Expenses	\$24.37	\$18.64	76.5%

Figures will not sum since they are median values

Marketing Costs. Marketing costs of Provider-Sponsored plans, at \$4.62, were 77.8% of Blue - Public plans, or \$1.32 less. Marketing costs include rating, product development, sales and marketing, commissions and advertising. Interestingly, Provider-Sponsored plans pay only

Figure 3. Provider-Sponsored vs. Blue and Public: 2004
Median Cost Per Member Per Month - By Product Line

	Blues - Public		Provider-Sponsored		P-S v. B-P
	Expense	Pct.	Expense	Pct.	
Comm. HMO, Ins.	\$27.96	17.9%	\$24.64	46.9%	88.1%
Comm. POS, Ins.	\$28.78	5.7%	\$30.60	6.3%	106.3%
Indemn. & PPO, Ins.	\$27.90	23.6%			
ASO / ASC	\$18.93	43.1%	\$14.17	24.8%	74.9%
Medicare + Choice	\$42.74	2.9%	\$45.47	3.4%	106.4%
Medicaid HMO	\$21.38	1.0%	\$17.56	16.7%	82.1%
Medicare Cost			\$39.65	1.9%	
Medicare Supplemental	\$19.87	5.8%			
	\$24.37	100.0%	\$18.64	100.0%	76.5%
<i>Note: Limited Panel Plans *</i>		21.8%		68.9%	
<i>Note: Commonality of Products</i>					
Percent Products in Common		70.5%		98.1%	
Other Products		\$27.90	23.6%	\$39.65	1.9%
		\$19.87	5.8%		
Total			100.0%		100.0%
<i>Note: Percent of Membership in Common Products with Lower Costs</i>					
P-S Lower			61.9%		88.4%
Blue-Public Lower			8.6%		9.7%
			70.5%		98.1%

** Limited Panel Plans are Commercial HMO Insured, M+C, Medicaid HMO and Medicare Cost.*

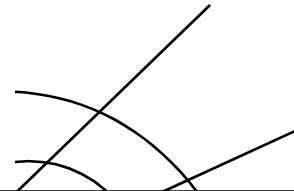
\$1.82 PMPM for commissions as compared with \$3.22 PMPM for the Blues and Publics, more than the total difference in the costs of marketing. We speculate that lower commission payments may stem from the value of the brand: Provider owned plans may find marketing costs less necessary due to the halo of the provider.

Medical and Provider Management.

The higher administrative expenses incurred by Provider-Sponsored plans in medical and provider management, at 103.3% of the median values for Blue-Public firms, probably stems from the concentration of these plans in closely managed products like HMOs. As shown in Figure 3, 68.9% of Provider-Sponsored members were in limited panel

plans as compared with 21.8% of Blue-Public members. It is interesting that those are costs that could be easily subsidized by the provider sponsor itself. That these are in fact higher argues that if such subsidization occurs, it is limited.





Account and Membership Administration.

Administrative costs of Provider-Sponsored plans in the core areas of customer services, claims, information systems, and enrollment functions are 58.4% of those in Blue-Public plans. For instance, the cost of claims processing is, among Provider-Sponsored plans, \$1.77, versus \$2.54 for the Blue-Public universe. This is especially surprising because of the relative expertise of the universe's respective corporate parents.

Corporate Services. Provider-Sponsored plans had Corporate Services expenses that were 104.4% higher than for Blue-Public plans. We think that economies of scale are a plausible explanation of this difference.

So, Why Are These Smaller Plans So Efficient?

There are a number of possible explanations for this apparent greater efficiency. We think that there is merit to two of them and that the truth is probably some combination of these two factors.

One possible factor is that the provider-sponsored plans were subsidized by their sponsoring providers. We think this is unlikely in the major functional areas since there is little incentive from either a tax or organizational perspective for providers to incur expenses in support of health plans which are typically operational stepchildren, especially if the sponsor is a non-profit hospital. Moreover, the functions necessary for providers and those necessary for a health plan are so different that subsidization may be impractical, even if desired.

A second possible explanation is that the Provider-Sponsored plans benefit from their high degree of focus on a limited array of products, HMO and other true managed care. In this way, Provider-Sponsored plans could achieve economies of scale at much lower membership.

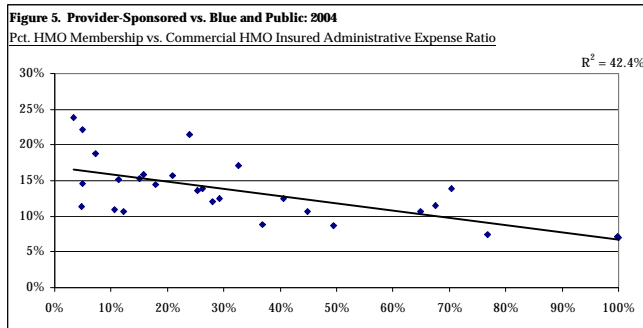
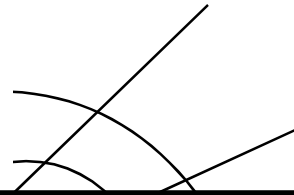
By contrast, a plan selling a highly diverse mix may incur more claim adjudication and information systems costs for the additional complexity of supporting all its products.

Because the most important product of the Provider-Sponsored plans is the Commercial Insured HMO (and its costs are normal to high among insured products), we used the percent in Insured Commercial HMO as a measure of focus. We regressed this measure of focus against the administrative expense to premium ratio and, in accordance with this hypothesis, concentration in the HMO product is associated with lower costs as a percent of revenues. This is shown in Figure 5.

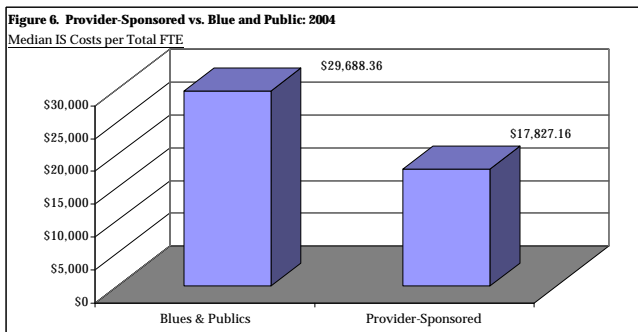
To estimate this relationship, we combined all of the firms in the Blue, Public and Provider-Sponsored universes participating in the *Sherlock Expense Evaluation Report (SEER)*, thirty four plans, into one universe. We excluded the six plans that did not offer an HMO product. The regression testing the focus metric against the HMO administrative expense *ratio* had an R^2 of 42.4%. We performed a similar analysis of the PMPM administrative expense, and calculated an R^2 of 25.1%.

There are several important limitations to these results. First is the fact that when we tested other products, or total administrative costs, against other measures of focus the regressions were less strong. (It should be noted that no product dominates health plan product portfolios like Insured Commercial HMOs dominate those of the Provider-Sponsored plans. Please see Figure 3.) Another limitation is that the unique predominance of the Insured Commercial HMO product in Provider-Sponsored plans means that the association between low costs and dominance of HMOs may simply reflect that the low cost Provider-Sponsored plans happen to focus on HMOs.





A final possible explanation is that the Provider-Sponsored plans operate as bootstrap enterprises, in an environment in which there is intense competition for capital for investment in infrastructure. For instance, many of these plans are owned by hospital systems, which must weigh investment in Health Plan information systems versus investment in revenue-producing hospital capacity.



Because of the nature of investment in information systems, which are frequently either expensed or amortized rapidly, we think that expenses may be a fairly good proxy for investment in information systems. As shown in Figure 6, the information systems costs of approximately \$18,000 per employee per year in Provider-Sponsored plans are only 60.0% of that of Blue-Public firms.

Firms Used in Analysis

The data used in this analysis comes from the *Sherlock Expense Evaluation Reports*, for Blue Cross Blue Shield Plans, for Public Companies and for Provider-Sponsored Plans. In aggregate, the 34 firms included in this study comprise 43.4 million commercial members. In addition, these firms serve 5.1 million members in Medicare + Choice, Medicare Cost, Medicare Supplemental or Medicaid HMO coverage. In all, this analysis is based on results from 48.5 million members or 20.5% of all insured people, including those served under Medicare.

Our Blue universe is comprised of 18 Plans serving 27.9 million Americans. This represents 43.9% of the total plans and 31.4% of the membership. The 41 independent Blue Cross Blue Shield Plans covered, as of December 31, 2003, approximately 88.8 million Americans in all fifty states, Washington D.C. and Puerto Rico.

There were three plans in our Public Company universe, serving 8.5 million insured members, or approximately 30.3% of the insured membership and 30.0% of the plans themselves. Including ASO/ASC membership, the Public plans in our universe serve 17.1 million members. There were 10 publicly traded non-Blue plans focused on commercial members with approximately 28.0 million insured members as of December 31, 2003.

Our universe of Provider-Sponsored Plans consists of thirteen plans which serve 3.5 million Americans.

The *SEER* studies include thousands of analyses of up to ten product areas and nearly fifty functional areas. The *SEER* report is comprised of two volumes, one of financial metrics and another of operational metrics. In addition to the universes noted above, a Medicaid study is pending.

