



NEW INDEPENDENT, PROVIDER-SPONSORED PERFORMANCE BENCHMARKS RELEASED BY SHERLOCK COMPANY

The median costs of independent, Provider-sponsored health plans are \$27.73 Per Member Per Month (PMPM) for all comprehensive products in 2006 or 10.5% of premium equivalents, as reported in Sherlock Company's benchmarks. Provider-sponsored Plans at the 25th percentile reported costs of \$24.38 PMPM (9.3% of premium equivalents), and at the 75th percentile, Provider-sponsored plans reported costs of \$33.55 PMPM (12.6% of premium equivalents). These costs exclude capital costs and taxes.

The prior year's median costs were \$24.67. Differences between the years reflect in part differences in the plans submitting data, and so are not directly comparable. However, the increase in reported costs seemed to be centered on non-commercial lines. Medicaid's reported costs of \$24.47 were 16.9% higher than last years of \$20.93. Medicare Advantage was \$70.90 versus \$61.89 last year, or 12.7% higher. By contrast the PMPM Commercial insured expenses, which in aggregate comprised more than 60% of membership, were higher by 1.1% to \$26.56. Reported PMPM expenses for Commercial ASO were less by 3.7% to \$16.69, from \$17.34 last year.

Health plans are increasingly focused on the aggressive management of their administrative costs, and achieving best practices in operations management. Provider-sponsored plans are, like other plans, motivated by consumer demand and increasingly possess the technological ability to both lower costs and enhance the performance of their operations. This cost-consciousness may be amplified by the tight fiscal constraints of their sponsoring provider systems.

ARE SHERLOCK COMPANY STUDIES USEFUL FOR BENEFITS MANAGERS AND THEIR ADVISORS?

The following is based on notes we prepared for an interview with Robert Whiddon, writer for the weekly e-newsletter Employee Benefit Advisor. The central question was what good advisers should be paying attention to when it comes to managing and selecting carriers for their employer clients, and the usefulness of SEER in such an evaluation.

Price is central to selecting health plans, and our benchmarks are probably not helpful in assessing that. This is because, over the short term, there can be a difference between the premium rates or administrative fees, and the underlying costs to deliver those services. Our focus is on the underlying costs.

But since, over the long term, costs and price have to reconcile, to assure the continuity of your relationship with your carrier it can be very helpful to understand how its costs stack up against other carriers. After all, it is disruptive to ask employees to change health plans.

You can make an analogy between the due diligence involved in the selection of a health insurer or administrator and the sort of financial analysis you'd perform on a vendor with which you're contemplating a long term contract. If you're purchasing a fleet of vehicles, even if the price is attractive, if the vehicles cost more than the price then you might reasonably wonder about whether the vendor will be able to honor its long-term commitments.

Our benchmarks focus on administrative expenses, so our work is potentially valuable for self-insured groups and their advisors, especially if the groups view administrative costs as more subject to reliable control than health care costs. The recent growth in ASO arrangements and even the growth in consumer directed type plans seems to reflect this belief.

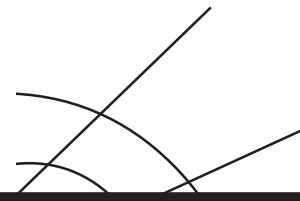
However, our performance benchmarking materials are extremely granular, and it is

Figure 1. Benchmark Summary
Provider-Sponsored Plan Costs by Functional Area Cluster
Per Member Per Month

	25th Pctl	75th Pctl	Median	σ /Mean
Marketing	\$6.43	\$10.24	\$7.93	30.4%
Provider & Medical Management	3.21	5.99	4.74	41.5%
Account & Mem. Administration	6.07	10.43	8.45	30.6%
Corporate Services	4.34	9.63	8.57	47.5%
Total	\$24.38	\$33.55	\$27.73	31.0%

Continued on Page 2

Continued on Page 4



New Benchmarks: *Continued from Page 1*

Background

Independent, provider-sponsored health plans are a central cornerstone of a competitive health plan market-place. Based on information from the Interstudy Competitive Edge, there appear to be approximately 90 such plans. They represent an alternative to national plans, like Aetna or UnitedHealth, or Blue Cross Blue Shield Plans. They frequently possess the now unusual quality of identification with their provider networks making them a modern form of a classic prepaid group practice.

The twelve plans participating in our performance benchmarks are likely an unusually successful sample of provider-sponsored plans. We believe that they are somewhat larger than average for independent plans, and we suspect that they are more profitable than average. They have achieved a degree of strategic separation sufficient to have a robust accounting system and, since “you manage what you measure,” this is indicative to us that they likely manage their operations with greater precision. While most are associated with health systems, some are not, or have only a vestigial relationship.

Sherlock Company is now distributing its performance benchmarks for Provider-Sponsored Plans to this year’s participants, and to Sherlock Company customers who have pre-ordered copies. This is the second release of a series of five universes of benchmarks of performance metrics for health plans, and is the tenth annual performance benchmarks compiled and analyzed by Sherlock Company. Other universes include Medicare Advantage, Medicaid, Blue Cross Blue Shield and Larger Plans.

The twelve Plans included in this study serve 3.5 million people under comprehensive health benefit plans. Approximately 734,000 of the commercial members were served under some form of self-insurance arrangements, comprising approximately 21% of the total commercial members. In addition to these ASO members, commercial members were segmented into three types of insured health coverage products. In addition, these plans also provided products including Medicare Advantage, Medicare SNP products, Medicare Part D, Medicare Cost, Medicaid HMO and Medicare Supplement.

Of the respondents participating in this year’s Provider-Sponsored study, two-thirds participated with us last year, and 50% of this year’s participants have three or more years of experience participating in SEER. This “practice effect” along with the extensive documentation, and data review helps to assure the reliability of our metrics.

The financial metrics summarized here are complemented by extensive operational metrics in companion volumes, facilitating more in-depth analyses. Typically, expenses are deconstructed into factors of user demand, employee productivity, unit cost, staffing ratios and cost per employee. For instance, Customer Service reports “manual” inquiries per member, productivity of customer service representatives, cost per inquiry and per-employee costs of customer service. Numerous drivers of costs and quality are also provided. In the customer area, for example, these include average speed of answer and abandonment rate, and inquiry resolution time.

Expenses by Functional Area Cluster

In the Provider-Sponsored edition of *Sherlock Expense Evaluation Report*, administrative expenses for each product are segmented into nearly forty different functional areas. For the purpose of the *Plan Management Navigator*, we have summarized these functional areas into “clusters” of Marketing, Medical and Provider Management, Account and Membership Administration and Corporate Services.

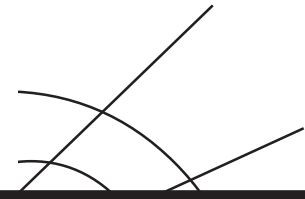
Marketing expenses represented \$7.93 PMPM (2.7% of premium equivalents) of the total administrative costs. At the 75th percentile, these costs were \$10.24 PMPM but only \$6.43 PMPM at the 25th percentile. Commissions paid to brokers comprised \$3.12 PMPM, the lion’s share of these expenses. This is notable since historically only 25% of members are served through insurance brokers. Other expenses in this cluster include Rating and Underwriting, Product Development / Market Research, Sales and Marketing and Advertising and Promotion.

Medical & Provider Management is the cluster of Provider Network Management and Services and Medical Management. Provider contracting, provider service, case and disease management and precertification are among the activities provided by functions in this cluster. These expenses had a median value of \$4.74 PMPM (1.8% of premium equivalents). At the 75th percentile, these

Figure 2. Benchmark Summary
Provider-Sponsored Plan Costs by Functional Area Cluster
Percent of Premium Equivalents

	25th Pctl	75th Pctl	Median	σ /Mean
Marketing	2.6%	3.6%	2.7%	32.5%
Provider & Medical Management	1.2%	2.0%	1.8%	32.4%
Account & Mem. Administration	2.7%	3.7%	3.2%	27.1%
Corporate Services	1.8%	3.4%	2.9%	40.8%
Total	9.3%	12.6%	10.5%	23.7%

Continued on Page 3



New Benchmarks: *Continued from Page 2*

costs were \$5.99 PMPM, but were as low as \$3.21 PMPM at the 25th percentile.

Expenses for Medical & Provider Management are highly sensitive to the mix of products offered: Managed care products are emphasized by these plans, and they tend to require a higher commitment to this function. The high commitment to medical management is a distinguishing quality of this universe.

Account & Membership Administration represented \$8.45 per member per month of administrative expenses (3.2% of premium equivalents) in 2006, the largest share of administrative costs. This cluster of expenses includes many of health plans' core functions such as Enrollment (including Membership and Billing), Customer Services, Information Systems and Claims (including Encounter Capture and Adjudication). Plans reported \$10.43 at the 75th percentile and \$6.07 at the 25th percentile.

Corporate Services represented the final cluster of expenses. It included expenditures for 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 \$8.57 PMPM (2.9% of premium equivalents) in administrative expenses. Fewer than 25% exceeded \$9.63 PMPM or were less than \$4.34 PMPM. These expenses are more susceptible to economies of scale than other groups of functional expenses, based on Sherlock Company's economies of scale studies.

Expenses by Product

The products varied in their costs because they have different functional requirements. For instance, HMO products of all kinds tend to have a much greater commitment to medical management, and the various ASO products operate with lower marketing and medical management costs than their insured counterparts.

Among the products offered by Provider-Sponsored plans, Medicare Advantage had among the highest costs at \$70.90 PMPM. As might be expected, the Medicare Special Needs Plans had a median PMPM cost of \$83.17. The stand-alone

Medicare Part D product had administrative costs with a median value of \$9.88, the lowest cost plan.

While Medicare Cost is becoming rarer, its median costs were \$41.27. The Medicare Supplemental product cost \$40.46. Medicaid offering typically cost \$24.47 PMPM to administer.

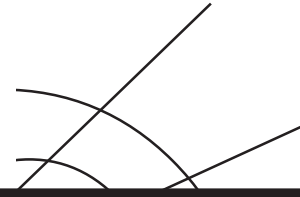
Continued on Page 4

Figure 3. Benchmark Summary

Provider-Sponsored Plan Costs by Product

Per Member Per Month

	25th Pctl	75th Pctl	Median	σ /Mean
HMO	\$22.57	\$33.65	\$27.52	36.3%
POS	\$24.75	\$30.39	\$28.40	28.5%
Indemnity & PPO	\$23.98	\$36.03	\$29.23	33.8%
Total Comm. Ins.	\$22.25	\$31.82	\$26.56	31.8%
ASO	\$13.94	\$18.88	\$16.69	30.4%
Total Commercial	\$20.69	\$27.85	\$23.84	31.4%
Medicare Supplemental	\$38.06	\$49.13	\$40.46	36.2%
Medicare Advantage	\$62.39	\$83.62	\$70.90	31.0%
Medicare SNP	\$76.55	\$89.79	\$83.17	22.5%
Medicare Cost	\$33.30	\$44.73	\$41.27	33.8%
Medicare Total	\$47.70	\$73.67	\$57.00	41.4%
Medicaid	\$21.58	\$24.56	\$24.47	18.2%
Comprehensive Total	\$24.38	\$33.55	\$27.73	31.0%
Medicare Part D	\$6.19	\$9.97	\$9.88	57.7%



New Benchmarks: *Continued from Page 3*

Percent of Premiums or Equivalents by Product

Expressing administration as a percent of premium is controversial since both the numerator and the denominator can be subject to factors other than efficiency. Business mix, differences between the relative cost of health care and the relative cost of administrative services can limit the usefulness of such calculations. However, such ratios are a common and intuitively appealing shorthand. In making this presentation, for similar reasons, we have expressed administrative expenses as premium equivalents. That is, for the ASO/ASC arrangements, we employed as a denominator the sum of the ASO/ASC fees and the medical costs associated with this product.

Expressed as a percent of premiums or equivalents, administration also varied by product. Excluding the effect of services that are commonly capitated or outsourced, such as behavioral health and prescription drugs, Medicare Advantage SNP had the lowest costs, at 6.9% of premiums, with the high among Comprehensive products of 25.0% for Medicare Supplemental. Medicare Advantage administration was 9.3% of premiums.

Among the commercial products, Indemnity & PPO had the highest costs at 14.4% of premiums, followed by HMO at 13.3% of premiums and POS at 11.7% of premiums. Again, the ASO/ASC products comprised a lower percent of premium equivalents than their insured counterparts, at 7.5% of premium equivalents.

Further information concerning the results of our benchmarking studies is available from Sherlock Company. Other summaries will be published in coming editions of *Plan Management Navigator*.

Benefits Managers: *Continued from Page 1*

not obvious to us that for the vast number of employers this level of depth is all that useful. My guess is you'd need thousands of employees and dependents simply for the data to be economically beneficial. Moreover, at this level of granularity, the health benefit plan sponsor would have to be willing to purchase or provide aspects of plan administration "a la carte" in order for our information to be actionable. On the other hand, we have some useful free stuff on our web site, in back copies of *Plan Management Navigator* so perhaps this alone could be useful.

Even with useful benchmarking information, a plan sponsor would still have the challenge of accessing comparative information from the perspective carrier. To some degree a health benefit plan can encourage their cooperation. For regulated entities, one can begin with the statutory blanks if no other information is available. These financial statements have numerous well known limitations, but this is at least a starting point. Non-regulated vendors could presumably be persuaded to comply if customers view such submissions as a baseline requirement.

Figure 4. Benchmark Summary
Provider-Sponsored Plan Costs by Product
Percent of Premium Equivalents

	25th Pctl	75th Pctl	Median	σ /Mean
HMO	10.7%	13.9%	13.3%	31.0%
POS	10.3%	13.7%	11.7%	25.4%
Indemnity & PPO	10.6%	18.3%	14.4%	37.9%
Total Comm. Ins.	10.0%	13.9%	11.8%	28.8%
ASO	7.1%	8.8%	7.5%	112.3%
Total Commercial	9.7%	12.2%	10.8%	25.1%
Medicare Supplemental	21.1%	28.8%	25.0%	31.6%
Medicare Advantage	8.2%	11.4%	9.3%	31.6%
Medicare SNP	5.3%	8.4%	6.9%	65.0%
Medicare Cost	7.5%	11.0%	8.2%	28.0%
Medicare Total	7.4%	10.6%	9.2%	28.4%
Medicaid	9.3%	12.8%	10.2%	30.1%
Comprehensive Total	9.3%	12.6%	10.5%	23.7%
Medicare Part D	3.0%	8.2%	5.1%	90.3%