Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

Douglas B. Sherlock, CFA
sherlock@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

John Park, CFA
jpark@sherlockco.com

Andrew L. Sherlock
asherlock@sherlockco.com

(215) 628-2289

Independent/Provider-Sponsored Plans: Optimizing Costs in an Uncertain Environment

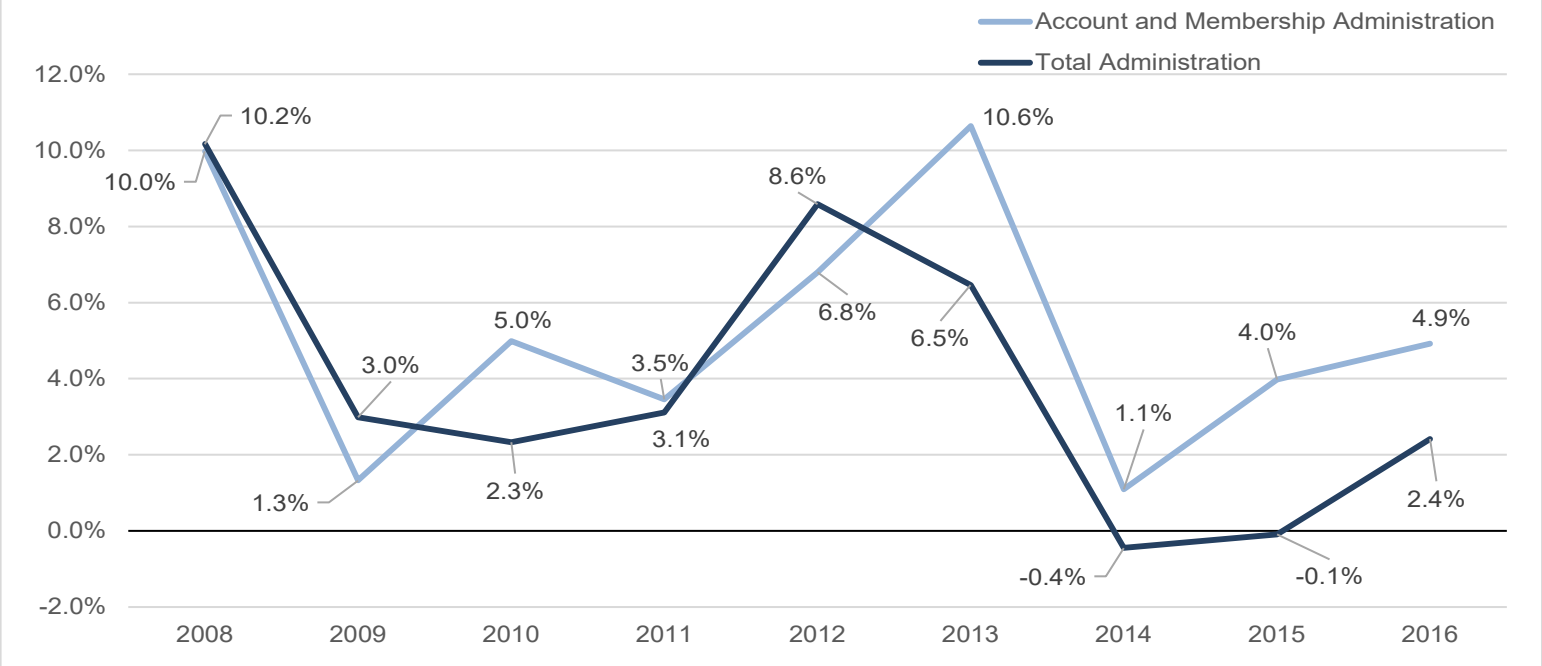
Independent/Provider-Sponsored Health Plans posted administrative expense growth of 2.4% in 2016, the highest rate of growth since 2013 but also in the middle of what has been posted by Independent/Provider-Sponsored plans since 2008. Account and Membership Administration growth, at 4.9%, was also the highest since 2013, also in the middle of the nine-year trend. 2014 was the nadir of growth, reflecting the beginning of the application of the ACA to the commercial market. The record-setting high growth in 2013 stemmed from heavy spending in Information Systems. This is shown as Figure 1.

Background

The Sherlock Benchmarks for Independent/Provider-Sponsored health was created through surveys of 20 health plans, of which 13 are owned outright by hospital systems, and an additional three were formed by or continue to have substantial governance by health care providers. Most of the health plans in this universe are integrated with health care providers.

Vertically integrated health systems combine insurance with health care delivery. In its purest sense, insurance of this kind requires that care be provided by the system's hospitals and physician practices. However, few organizations operate in this way and few people receive their care in this way.

Figure 1. Sherlock Benchmark Summary
Independent / Provider - Sponsored Rates of Change for Account and Membership Administration and Total, Constant Mix



Nevertheless, the link between care and insurance is one that has resonance in consumers' minds. For instance, rhetoric concerning health care reform sometimes conflates health insurance with health care. While the link between population health and insurance is subject to dispute, its appeal reflects consumer recognition that insurance benefit design implicitly assumes a panel of providers, a system of copayments and deductibles and other aspects that may determine one's access to quality health care. In other words, consumers identify their health care with their insurance, both conceptually in the political sphere and concretely as they think about their own insurance coverage.

As noted previously, for most consumers, the link between their insurance with a panel of health care delivery is loose. Consumers have elected to purchase insurance with loose links to providers because they prefer to select from a broad panel at the time care is rendered. This loose relationship between insurance and health care has its drawbacks. Provider information such as prices and health-adjusted success rates, available to consumers at the time of service, is incomplete and often not actionable. By and large, consumers don't examine networks in detail when they purchase health insurance so their impression of network breadth may be incorrect. The effect of the loose relationship between insurance and health care delivery is that consumers possess only weak information necessary to evaluate the price/quality trade-offs of many health insurance choices, especially if consumers think of insurance as a part of the health care production chain.

Years ago, Alain Enthoven advocated vertically integrated health plans to improve the efficiency of consumer choice. Such systems intrinsically highlight the panel far more effectively than a provider directory, potentially allowing the consumer to better evaluate end-to-end quality. The now obsoleted phrase "prepaid group practice" would more precisely describe the parameters of the quality that such systems would offer. (Enthoven complemented this proposal by urging simplicity of benefit design, observing that large copayments and deductibles complicate consumer assessment of price.)

Enthoven's comments were addressed to those focused on health policy, but the consumer appeal of vertical integration is available to both health plans and health systems. In the absence of government policy, vertical integration may have market appeal since the panel that composes the integrated delivery system can differentiate the insurance product to consumers. This could permit products to be sold at a premium or at least mute price declines. The ability of highly regarded local health systems to elicit higher payments from insurers for inclusion in their network is consistent with such differentiation.

In addition, vertical integration may provide the advantage of exploiting operating leverage of providers. While insurance costs are overwhelmingly variable over the intermediate term, they are much more fixed for hospitals. Thus, if insurance can direct patients requiring care to previously empty hospital beds, then the marginal profitability of the integrated service can be higher than insurance alone. The Blue Cross Blue Shield Plan Highmark and UnitedHealth's Optum have integrated backward into health care delivery, while the provider-sponsored plans in the Sherlock Benchmark universe are examples of forward integration. Of course, Accountable Care Organizations, which are encouraged as Medicare policy, can be thought of as precursors to clinical integration. Approximately 6.0 million Medicare members are now served through such ACOs.

The strong marketing and operating cost leverage appeal of vertical integration is a double-edged sword. Success, or the potential for success, on these two attributes may mask run-away health care or administrative costs. So, there are numerous health plans that were owned by health systems that survive only in the nightmares of hospital CFOs. While unwinding the attempt to forward integrate the former hospital company Humana was successful, its experience serves as an important cautionary tale. Though vertical integration has the potential for cost and marketing advantages, they can only be realized if execution is disciplined, including in management of administrative expenses.

Sherlock Company's universe of Independent/Provider-Sponsored health plans has, we believe, a record that suggests the participating plans have been disciplined in their execution of a loose vertical integration strategy. With median revenues of $1.7 billion and a median membership of 385,000, their size relative to their hospital systems makes it impossible to hide execution errors. Indeed, the fact of their survival suggests that operating discipline is a part of the culture.

How We Performed This Analysis

This analysis is based on the twentieth annual edition of our performance benchmarks for health plans. The Sherlock Benchmarks (*Sherlock Expense Evaluation Report* or *SEER*) represent the cumulative experience of approximately 780 health plan years.

Each peer group in the Sherlock Benchmarks was established to be relatively uniform. So within that constraint, it is open to Independent/Provider-Sponsored plans possessing the ability to compile high-quality, segmented financial and operational data. This 15th analysis of IPS plans is based on a peer group of twenty plans who collectively serve 10.0 million people. We believe that participation in this year's study comprises a high proportion of the most successful of such plans.

The geographic reach extended nationwide. The size was evenly distributed in tiers of less than 200,000 members; 200,000 to 600,000 members; and greater than 600,000 members.

Sixteen of this year's participants participated in the prior year. The focus of these plans is Comprehensive, that is, medical and hospital coverage. Within Comprehensive products, 68.5% of members, or 6.8 million, were commercial. Approximately 1.8 million of the commercial members were served under some form of self-insurance arrangement, composing approximately 26.6% of the total commercial members.

Seniors are a key market to this universe of health plans. Medicare Advantage, with over 800,000 members, was offered by 15 plans. It composed 8.1% of the combined comprehensive membership and 21.6% of revenues for Comprehensive products. Medicare SNP offered by four of the plans was responsible for an additional 1.9% of revenues, while Medicare Cost composed an additional 2.6% of revenues. Medicare Part D served an additional 102,000 members. In aggregate, various Medicare products composed 11.6% of total membership and 24.6% of total revenues. Medicare Supplement was responsible for an additional 0.9% of revenues

Service to the poor and disabled is also a commitment of these plans. Medicaid HMO, offered by eleven plans, composed 18.5% of membership and 20.2% of total Comprehensive revenues. Five plans offered CHIP which composed 0.5% of revenues and 0.8% of total comprehensive members.

Reporting Conventions

We use several conventions intended to make the metrics most useful and intelligible for the audience of *Plan Management Navigator*.

- The trends reported in this analysis are median changes, and when we refer to PMPM or percent of premium ratios, these too are medians. This convention reduces the effect of outlying values on overall trends and values. Since each median value is calculated independently, the components cannot be summed. We will nevertheless reference sums of medians to provide a sense of direction.
- References to growth rates hold the universe constant in the comparison years unless otherwise noted. Rates of change that are called "as-reported" are of health plans participating during both comparison years. When we refer to "constant mix" we are calculating rates of change for that same set after reweighting the product mix to eliminate the effect of differences between the years. To be clear, Medicare Advantage, ASO and Medicaid are examples of products.

- Percent of premium ratios are calculated on a premium-equivalent basis. That is, in the case of ASO arrangements, we build to a premium from fees by adding them to the health benefits incurred by the self-insured group. In this way, premium equivalents sum to all of the expenses of health insurance, including profits earned by the health plan, analogous to actual premiums on insured products. While not in accordance with GAAP, this approach achieves comparability of presentation of ASO results with the insured products offered by these plans.

- Expenses exclude capital costs and investment income. Excluded expenses include interest, earnings (including dividends) and similar debt capital costs and other capital formation costs (debt or equity), including transaction costs and interest payments to providers under "prompt pay" laws.

- For Sherlock Benchmark licensees and participants, note that the values for Account and Membership Administration and Total Administrative costs reported here will differ from those reported in the Benchmark reports. The values reflected here include administrative expenses associated with pharmacy and mental health, while the Sherlock Benchmarks do not. Because of variation in employer benefit designs and the propensity of the administration of these health services to be outsourced by plans accepting these management responsibilities, the Benchmark Reports carve them out. Pages 22 to 24 in Tab 2 of Volume I of the Sherlock Benchmarks reconcile these two presentations.

- Miscellaneous Business Taxes are a special case of administrative expenses since, short of recapitalization or elimination of commercial insured business, such expenses are impossible to manage. So expense trends, along with the PMPM and percent of premium ratios, are calculated before the effect of Miscellaneous Business Taxes. These taxes are primarily related to the Affordable Care Act. For commercial insured products, the median PMPM value of such taxes is $10.51 and the mean is $10.74, or approximately 20% of administrative costs. Such costs are essentially nil for ASO products. By way of comparison, in 2010, the median Miscellaneous Business Tax for commercial insured products was $1.80 PMPM.

  The ACA fees include the Comparative Effectiveness Research Fee (CERF), Transitional Reinsurance Fee, Risk Adjuster User Fee, Exchange User Fee and Annual Fee on Health Insurers. The Annual Fee on Health Insurers is the largest generally applicable fee since it applies to all insured business and has a median value of $4.55. The Exchange User Fee only applies to Exchange members but the median fee for that population is $17.97.

  On a constant-mix basis, per member Miscellaneous Business Tax costs decreased by 6.4% PMPM, compared with an increase of 14.6% in 2015 and down from the surge of 922.3% in the year before.

Trends Overall and in Expense Clusters

The acceleration in administrative costs was evident in all clusters. Notably, Account and Membership Administration, while tied for the fastest growing function, also had the most modest acceleration.

Figure 2 outlines year-over-year trends on both an as-reported and constant mix basis. While there is broad acceleration of cost trends, they continue to be modest. For the 16 continuously participating plans, per member costs, as-reported, grew by 2.4% compared with a decline of 0.1% the prior year which followed on a decline in the prior year.

Account and Membership Administration also grew from an increase of 4.0% to an increase of 4.9%, the fifth lowest growth in the past nine years. Please see the trends on a constant-mix cost trends, shown in Figure 1.

While Corporate Services increased relatively modestly, at 1.2%, it showed the most rapid acceleration. This was a 9.1 percentage point change from the decline of 8.0% in the prior year. Both Finance and Accounting and Association Dues and License/Filing fees declined at single- digit rates, Actuarial and the Corporate Services grew at mid single-digits. The Corporate Services function, because of its size, was responsible for most of the cluster's change. Corporate Executive increased at low single digit rates.

Medical and Provider Management had the second sharpest acceleration in costs by 8.8 percentage points from -6.1% to 2.6%. Medical Management is the predominant reason for the acceleration since it grew twice as fast as Provider Network Management and Services, plus it is the larger of the two functions. (Because of our definitions and checks, we think we have eliminated any MLR-related reporting bias in this and other clusters of expenses.)

Figure 2. Sherlock Benchmark Summary
Independent / Provider-Sponsored Median Changes in Per Member Per Month Expenses

	2015 Data		2016 Data	
Functional Area	**As-Reported**	**Constant Mix**	**As-Reported**	**Constant Mix**
Sales and Marketing	1.9%	2.5%	5.2%	4.9%
Medical and Provider Management	-7.2%	-6.1%	4.5%	2.6%
Account and Membership Administration	5.3%	4.0%	3.8%	4.9%
Corporate Services	-9.5%	-8.0%	0.7%	1.2%
Total Expenses	-1.5%	-0.1%	3.0%	2.4%

Sales and Marketing grew by 4.9% PMPM, faster than the 2.5% growth in the prior year. Both Sales and External Broker Commissions grew somewhat slower than the cluster. Because of its size, Commissions was the plurality of the growth trend in the cluster. Both Marketing and Advertising and Promotion declined for the third year in a row. Rating and Underwriting grew faster than the cluster, twice as fast as the next fastest growing function. The absence of the sharp declines in Marketing and Sales functions that characterized 2015 results contributed to the acceleration in costs in 2016.

At a 4.9% increase, Account and Membership Administration was tied with Sales and Marketing for its rate of growth, though its acceleration was the smallest; last year's increase was the fastest at 4.0%. Enrollment, Membership and Billing declined in 2016 as it has in four of the past five years. Claim and Encounter Capture and Adjudication was the most responsible for the increase in expenses at a mid single-digit pace. Customer Services also increased at approximately the same rate. Customer Service is less volatile here than for Blue plans, possibly due to less exposure to the Exchange business: Individuals are 11.4% of IPS commercial insured membership compared with 28.6% of Blue membership. Information Systems grew by less than 1%. In most years, this function has been increasing at or near double digits. The continued growth in Account and Membership Administration suggests an increased across-the-board commitment to these activities.

The Effect of Mix

Note that in Figure 2 the overall rate of change in the as-reported values exceeds that of the constant mix values. This implies that the universe tilted towards higher cost products: the constant mix comparisons back that effect out. Trends excluding the effects of changes in product mix is a more accurate representation of true trends in our view.

Health plans participating during both 2016 and 2017 posted median membership growth of 3.7%. Membership in lower cost Medicaid increased at exactly that rate. Medicare SNP increased by 10.3% as Medicare Advantage increased by 2.2%. While commercial total increased by 2.2%, the more expensive Insured products increased by 0.3% while the less expensive ASO increased by 3.1%.

The growth patterns in Sales and Marketing and in Medical and Provider Management likely reflect the increased emphasis on Medicare. Medicare members, as individuals, have higher marketing costs. They also have greater health needs, necessitating greater medical management.

AS-REPORTED INCREASE

Figure 2 also shows the continuous plan trends on an as-reported basis. The rates of change and their importance are faster than that of the constant mix, except for Account and Membership Administration, which grew slower but was more of a factor in the overall trend. While the overall Information System trend remained modest, it was faster than on a constant mix basis. It was the largest contributor to the cluster's growth because of the function's importance. Finance and Accounting increased, compared to a decline on a constant mix basis. Medical and Provider Management grew more rapidly and contributed more to overall trend than on a constant mix basis. In that cluster, Provider Network Management and Services increased slightly more rapidly than Medical Management.

OUTSOURCING AND STAFFING

Outsourcing appears to be more prevalent this year compared with last year. Functions that showed notable increases in propensity to outsource included Other Claim and Encounter Capture and Adjudication, Information Systems Applications Maintenance, Security Administration and Enforcement, Actuarial, Facilities, All Other Legal, Purchasing and Risk Management. On the other hand, Nurse Information Line was brought in-house. In total, the median percent of FTEs outsourced was 15.8%. We did not adjust to eliminate differences in universes between this and last survey.

Notwithstanding cost trends, staffing ratios appears to have declined for commercial insured products. Overall, including outsourced FTEs, they have a median value of 25 compared with 28 last year. Information Systems declined especially greatly while Rating and Underwriting grew sharply. The former possibly reflects growth while the latter is a result of the need to serve risk-adjustment methodologies. Again, we did not adjust for differences in the universes between the two years.

Figure 3. Sherlock Benchmark Summary
Independent / Provider-Sponsored Costs by Functional Area Cluster, 2016 Data
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$8.66	$10.49	$12.85	31%
Medical and Provider Management	5.32	6.82	7.54	29%
Account and Membership Administration	12.75	17.16	20.29	36%
Corporate Services	4.80	6.17	7.93	38%
Total Expenses	$34.97	$38.23	$47.32	26%

Costs of Independent/Provider-Sponsored Plans, by Cluster, PMPM

Figure 3 shows the values of administrative expenses for all 20 participating plans. Bear in mind that this universe of IPS plans is different from that of last year in product mix and in populations. In this section, we'll touch on comparisons with the results reported last year, notwithstanding this limitation. The prior year's values are shown in Appendix A.

Since the universes differed, it is not possible to reliably compare the performance of plans participating this and last year. We can know neither the trends, nor the changes in product mix of the plans that did not participate. The actual total PMPM administrative expenses at $38.23 were 6.9% lower than last year's values, shown in Appendix A. All cluster values were lower, with Corporate Services being especially lower.

The values appeared to be slightly more dispersed, but that varied by cluster. The Coefficient of Variation was 2 percentage points higher overall, higher in Account and Membership Administration and Corporate Services, lower in Sales and Marketing and much lower in Medical and Provider Management.

Account and Membership Administration was the single greatest cluster of expenses at a median value of $17.16 and comprised nearly one-half of the total. This helps to explain its substantial effect on overall trend. The size of this function includes the central activities of Information Systems, Enrollment, Claims and Customer Services. Comparing this with last year, the costs were lower and more dispersed.

Sales and Marketing, the second largest cluster, had costs with a median value of $10.49. Last year's value was $10.83 so the lower costs is the opposite of the growth trend that shown in Figure 2. This function includes Rating and Underwriting, Sales, Marketing, Broker Commissions and Advertising.

Corporate Services costs were also lower than last year at $6.17. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities like Facilities, HR and Legal.

Medical and Provider Management costs per member per month were $6.82 and slightly lower than last year. This group of functions includes Provider Network Management and Services and Medical Management. The costs in this group of expenses increased, but the values became more clustered.

Costs of Independent/Provider-Sponsored Plans, PMPM by Product

The importance of considering the product cost values is shown in Figure 4. The products vary greatly in their per member costs.

The median mix of commercial products was 71% of the Comprehensive membership. Administrative expenses for these costs are both higher and lower than the median Comprehensive administrative costs, depending on the financing mechanism. (Financing is also a rough proxy for group size since only large groups can self-insure.) Commercial insured products are higher than the median for comprehensive products. The median commercial product's cost is $45.52 PMPM. The single most important product is Commercial Insured HMO at $43.85 PMPM. Indemnity and PPO costs $49.03 while POS costs $47.97.

As a sector, Independent/Provider-Sponsored plans have less of a commitment to ASO products than Blue Cross Blue Shield Plans, at a median of 20.1% versus a median of 44.3% of comprehensive members, respectively. Their costs are lower than for comparable insured products largely due to the modest per member Sales and Marketing expenses required for large groups that are eligible to use these products. Those costs are $21.62 PMPM, half the cost of similar insured products. (This universe does not distinguish between various forms of Commercial ASO products.)

Figure 4. Sherlock Benchmark Summary
Independent / Provider-Sponsored Costs by Product, 2016 Data
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Commercial Insured				
HMO	$38.62	$43.85	$49.73	17%
POS	$38.58	$47.97	$49.94	50%
Indemnity & PPO	$39.69	$49.03	$54.63	29%
Total	$38.51	$45.52	$50.38	21%
Commercial ASO	$18.52	$21.62	$27.34	49%
Medicare				
Advantage	$73.68	$81.14	$119.63	51%
SNP	$119.59	$131.03	$137.77	13%
Cost	$57.29	$59.12	$60.95	9%
Medicaid				
HMO	$18.23	$24.23	$31.80	46%
CHIP	$17.40	$25.60	$39.37	52%
Medicare Supplement	$32.74	$45.14	$58.91	62%
Comprehensive Total	**$34.97**	**$38.23**	**$47.32**	**26%**
Stand-Alone Medicare Part D	$13.06	$15.96	$34.50	88%

Note that Medicare Supplement is a slightly greater than average cost product at $45.14 PMPM. We include this as a Comprehensive product in the Sherlock Benchmarks though it pays only when Medicare does not.

Medicare and Medicaid are government-sponsored products serving seniors and the poor and disabled. Medicare products are relatively high-cost at $81.14 and $131.03 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. The median cost of Medicare Cost is $59.12. Health plans are responsible for only some health services required by seniors, so administrative costs are less for this product. Medicare expenses this year are nearly identical to last year, except that the Medicare Cost product is higher. Many plans have shifted their emphasis from Medicare Cost to Medicare Advantage, possibly giving rise to negative operating leverage for this product.

Among the comprehensive products, Medicaid products are relatively low cost, at median PMPM values of $24.23 for HMO and $25.60 for CHIP. The specialty product of Stand-Alone Medicare Part D was a very low-cost product at $15.96 PMPM.

Figure 5. Sherlock Benchmark Summary

Independent / Provider-Sponsored Costs by Product, 2016 Data

Percent of Premium and/or Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Commercial Insured				
HMO	9.4%	10.0%	10.9%	14%
POS	7.8%	9.6%	10.9%	38%
Indemnity & PPO	9.5%	11.4%	12.9%	25%
Total	9.5%	10.5%	11.2%	14%
Commercial ASO	4.6%	5.7%	7.6%	40%
Medicare				
Advantage	7.9%	9.6%	12.9%	67%
SNP	7.4%	8.8%	9.7%	31%
Cost	13.5%	13.9%	14.3%	8%
Medicaid				
HMO	6.5%	7.2%	10.1%	29%
CHIP	7.2%	10.5%	14.5%	40%
Medicare Supplement	16.6%	22.4%	27.3%	64%
Comprehensive Total	**7.9%**	**8.7%**	**9.8%**	**21%**
Stand-Alone Medicare Part D	11.0%	14.8%	17.3%	46%

Costs of Independent/Provider-Sponsored Plans, PMPM by Product

The ranking of the costs as a percent of premiums corresponds with those of the PMPM costs with some important exceptions. While Medicare Supplement was approximately average when measured by PMPM, at 22.4%, its expense ratio was the highest among the comprehensive products, which had a median value of 8.7%.

The specialty product, Stand-Alone Medicare Part D, was a relatively high-cost product at a median value of 14.8%. This was an extremely low-cost product on a PMPM basis.

Medicare Advantage costs, while many times higher measured by PMPM, has a median percent of premium ratio of 9.6%. Medicare SNP, at 8.8%, effectively average compared to comprehensive total but 3.4 times higher when calculated in PMPM. Medicare Cost was low by PMPM but was high measured as a percent of premium at 13.9%.

Again, most other percent of premiums correspond directionally with the PMPM values. Medicaid was below average in PMPM costs and at 7.2%, was also below average as a percent. CHIP, while below average by PMPM, at 10.5% was higher than average.

Commercial ASO products was 5.7% of premiums. Commercial insured products ranged from 9.6% of premiums to 11.4% of premiums and was 10.5% overall.

Costs of Independent/Provider-Sponsored Plans, Clusters as Percent of Premiums

Figure 6 shows the ratios of administrative expenses to premiums or equivalents. Administrative expenses were 8.7% of premiums while last year's equivalent value was 8.9%.

Corporate Services and Medical and Provider Management was unchanged, both at 1.5% of revenues. Sales and Marketing was up by 0.1 percentage points to 2.3% of revenues. Account and Membership Administration declined by 0.3 percentage points to 3.5% of revenues.

Figure 6. Sherlock Benchmark Summary
Independent / Provider-Sponsored Costs by Functional Area Cluster, 2016 Data
Percent of Premium and/or Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	1.9%	2.3%	3.0%	31%
Medical and Provider Management	1.1%	1.5%	1.6%	26%
Account and Membership Administration	2.9%	3.5%	4.3%	31%
Corporate Services	1.1%	1.5%	1.6%	29%
Total Expenses	7.9%	8.7%	9.8%	21%

Note on the Sherlock Benchmarks

These results are excerpted from the Independent/Provider-Sponsored Edition of the 2017 *Sherlock Benchmarks*. The results are based on our detailed surveys of 2016 operating parameters of 20 Independent/Provider-Sponsored plans serving 10.0 million members. Much more information is available by licensing the Sherlock Benchmarks.

We hope you will not hesitate to contact us (sherlock@sherlockco.com) if you are interested in licensing these materials or if we can answer any further questions about them or this *Plan Management Navigator*. In an environment of uncertainty, cost optimization is a no-regret move. Benchmarking can contribute to this aspect of performance improvement.

Including all of Sherlock Benchmarks, those published in 2017 will reflect the experience of approximately 780 health plan years. In addition to the Independent/Provider-Sponsored universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Larger Health Plans, Medicare Advantage Plans and Medicaid Plans. We reported on the Blue Cross Blue Shield Plans last month and we will be reporting on the results of the other universes in the months that follow.

Appendix A. Sherlock Benchmark Summary
Independent / Provider-Sponsored Costs by Functional Area Cluster, 2015 Data
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$8.54	$10.83	$12.38	36%
Medical and Provider Management	5.51	7.09	7.68	63%
Account and Membership Administration	14.77	17.80	20.00	27%
Corporate Services	5.13	6.58	8.38	32%
Total Expenses	$37.05	$41.04	$50.31	24%

Appendix B. Sherlock Benchmark Summary
Independent / Provider-Sponsored Costs by Functional Area Cluster, 2015 Data
Percent of Premium and/or Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.0%	2.3%	3.0%	34%
Medical and Provider Management	1.3%	1.5%	1.7%	52%
Account and Membership Administration	3.3%	3.8%	4.8%	24%
Corporate Services	1.2%	1.4%	1.8%	26%
Total Expenses	8.6%	8.9%	10.5%	17%

Appendix C. Sherlock Benchmark Summary

Major Functions Included in Each Administrative Expense Cluster

Sales & Marketing

- Rating and Underwriting
  - (b) Risk Adjustment
  - (c) All Other Rating and Underwriting
- Marketing
  - (a) Product Development and Market Research
  - (b) Member and Group Communication
  - (c) Other Marketing
- Sales
  - (a) Account Services
  - (b) Internal Sales Commissions
  - (c) Other Sales
- External Broker Commissions
- Advertising and Promotion
  - (a) Media and Advertising
  - (b) Charitable Contributions

Account & Membership Administration

- Enrollment / Membership / Billing
  - (a) Enrollment and Membership
  - (b) Billing
- Customer Services
  - (a) Member Services
  - (b) Printed Materials and Other
- Claim and Encounter Capture and Adjudication
  - (a) Coordination of Benefits (COB) and Subrogation
  - (e) Other Claim and Encounter Capture and Adjudication
- Information Systems Expenses
  - (a) Operations and Support Services
  - (b) Applications Maintenance
    - (1) Benefit Configuration
    - (2) All Other Applications Maintenance
  - (c) Applications Acquisition and Development
  - (d) Security Administration and Enforcement

Provider & Medical Management

- Provider Network Management and Services
  - (a) Provider Relations Services
  - (b) Provider Contracting
  - (d) Other Provider Network Management and Services
- Medical Management / Quality Assurance / Wellness
  - (a) Precertification
  - (b) Case Management
  - (c) Disease Management
  - (d) Nurse Information Line
  - (e) Health and Wellness
  - (f) Quality Components
  - (g) Medical Informatics
  - (h) Utilization Review
  - (i) Other Medical Management

Corporate Services

- Finance and Accounting
  - (a) Credit Card Fees
  - (b) All Other Finance and Accounting
- Actuarial
- Corporate Services Function
  - (a) Human Resources
  - (b) Legal
    - (1) Compliance
    - (3) All Other Legal
  - (c) Facilities
  - (e) Audit
  - (f) Purchasing
  - (g) Imaging
  - (h) Printing and Mailroom
  - (i) Risk Management
  - (j) Other Corporate Services Function
- Corporate Executive and Governance
- Association Dues and License/Filing Fees