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Please see page 5 for our invitation to participate in the 2022 or license the 2021 Sherlock Benchmarks.

Best-in-Class Independent / Provider-Sponsored Plans

This is our analysis of "Best-in-Class" Independent / Provider – Sponsored (IPS) plans versus their Peers. Our analysis is based on the 2021 annual edition of the *Sherlock Benchmarks* reflecting year-ended 2020 financials. This is the 24th annual edition of the Sherlock Benchmarks and 19th edition of the IPS benchmarking study.

For these purposes, we define "Best-in-Class" plans as those whose "Tactical" costs are in the lowest 25th percentile. Others are referred to as "Peer" plans.

Notwithstanding our referring to low-cost Plans as Best-in-Class, we recognize that a health plan's long-term objective is cost levels that are *optimal* for its strategic objectives. The burden of proof, however, is on high-cost functions to demonstrate their value through other objective metrics of superior performance. Put a different way, the identification of low cost performance norms by one's peers is the basis upon which an ROI can be calculated.

The focus of much of this analysis is what we term "Tactical" costs, that is, costs other than the Sales and Marketing cluster and Medical Management function. Those "Strategic" areas have costs most readily associated with longer-term objectives such increasing membership and market share and reducing health care costs.

This analysis highlights the role of careful management in superior health plan operational performance. To perform the analysis, we endeavor to quantify and even eliminate the effect of factors largely beyond management control. We then isolate and measure the specific contributing factors that are more likely to be under the control of the management team. In making these exclusions, we are recognizing that these strategic expenses have impacts outside of current period administrative costs. We do, however, address these functional areas separately towards the end of this report.

Figure 1. Best-in-Class Independent / Provider-Sponsored Plans
*Sources of Tactical Variances, Mix-Adjusted**

	Non-Labor Costs per FTE	+	Staffing Costs Per FTE	=	Total Costs Per FTE	x	FTEs Per 10,000 Members	=	Costs PMPM
Best-in-Class Plans	*$71,430*		*$91,834*		*$163,264*		*14.24*		*$19.37*
Peer Plans	$66,297		$93,843		$160,140		22.18		$29.60
Dollar Variance	$5,133		($2,008)		$3,124		(7.94)		($10.23)
Percent Variance	7.7%		-2.1%		2.0%		-35.8%		-34.6%
Percent of Total Variance	-7.6%		3.0%		-4.6%		104.6%		100.0%
PMPM Dollar Variance	$0.78		($0.30)		$0.47		($10.70)		($10.23)

**Tactical expenses exclude Miscellaneous Business Taxes, the Sales and Marketing cluster and Medical Management expenses.*

Conclusions

PMPM Tactical expenses were 35% lower for Best-in-Class plans with a mean of $19.37 compared to $29.60 for the Peer plans.[1] The low Staffing Ratio was the overwhelming driver in low Tactical costs with Best-in-Class plans having 14 FTEs per 10,000 members compared to Peer plans at 22 FTEs per 10,000 members (Figure 1). The Staffing Ratio contributed 105% to overall low Tactical costs.

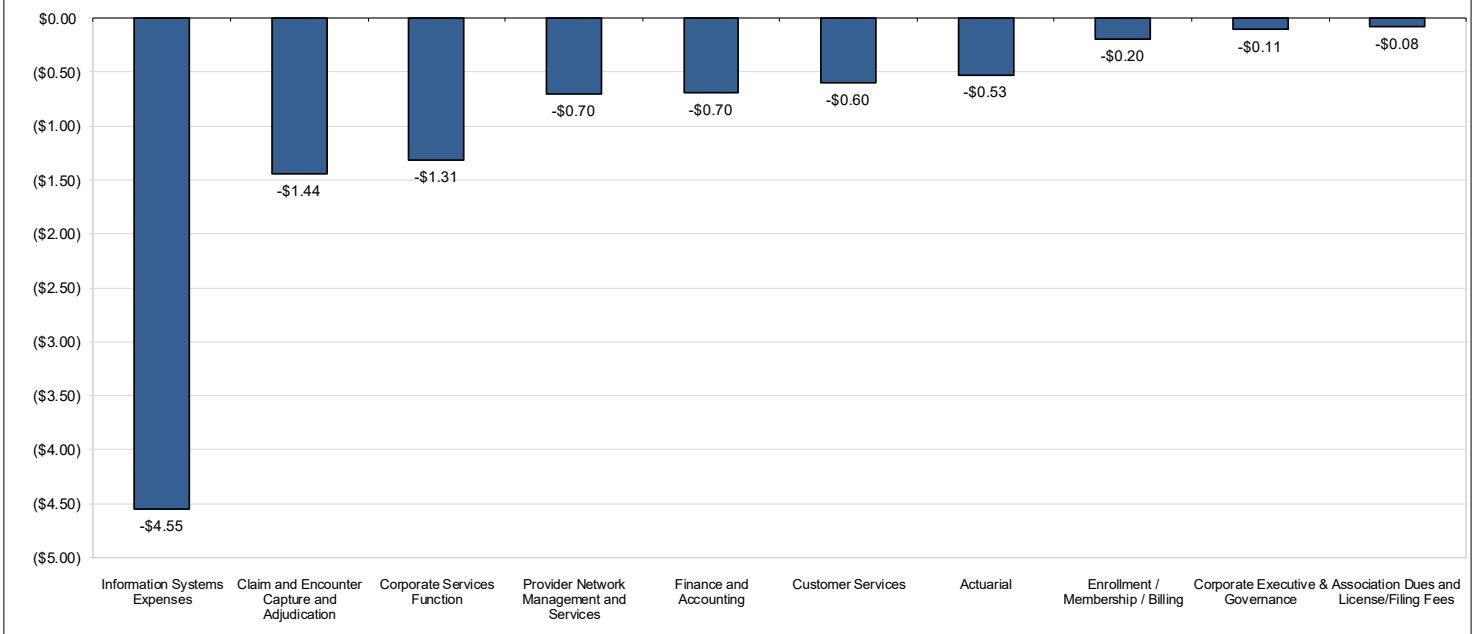
Best-in-Class plans' Staffing Costs per FTE was $92,000 and compared to Peer plans' $94,000. Staffing Costs per FTE contributed 3% toward overall low Tactical costs. Non-Labor Costs per FTE (e.g., those found in Information Systems and Facilities) were *higher* for Best-in-Class plans at $71,000 compared to $66,000 for Peer plans. This offset overall low Tactical costs by 8%.

It appears that Best-in-Class plans operate in a culture of conservative administrative expenses as *every* Tactical functional area was lower than the Peer plans. The largest contributor among functions to superior performance was low costs in Information Systems.

Low Information Systems cost was responsible for about 44% of the Tactical difference. Claims and the Corporate Services *Function* followed, contributing 14% and 13%, respectively, to low Tactical costs. These three functions composed 71% of the difference between Best-in-Class and Peer plans.

Figure 2. Best-in-Class Independent / Provider - Sponsored Plans

Functional Area Components of Low Cost Variances From Mean, PMPM, Mix-Adjusted



[1] Costs are standardized for member months (i.e., PMPM) even if not stated.

Possible Extraneous Characteristics

We considered five extraneous characteristics that may have contributed to improved performance in the Best-in-Class plans. These included the effects of scale, cost of living, outsourcing, product mix, and strategic investments in Sales and Marketing and Medical Management. We tentatively estimate that Scale may have contributed 24% of the difference. The entire difference in wages contributed only 3% of the cost advantage. Outsourcing was effectively the same in both sets. Product mix was adjusted for to eliminate its effect. The Strategic investments were excluded from the central part of this analysis.

Strategic Expenses were Also Lower

Best-in-Class Plans also had lower costs in the Strategic areas of the Sales and Marketing cluster and the Medical Management function.

The Sales and Marketing Cluster of expenses was lower for the Best-in-Class Plans by 15%.

Sales, which can be considered a complementary distribution system to brokers, was the most important driver of low costs for the Sales and Marketing cluster and contributed 61%. External Broker Commissions, on the other hand, were 7% *higher* for the Best-in-Class plans.

The low costs of Sales and Marketing did not impact growth. Comprehensive membership for the Best-in-Class plans increased by a median rate of 2%, compared with a median *decline* of 2% for Peer plans. At the product-mix of the Best-in-Class plans, the Peer plans' median membership also declined by 2%.

Best-in-Class plans had lower Medical Management costs by 35%, with all components contributing to low costs.

Median gross profit margin for *insured* products was 14% for both Best-in-Class and Peer plans. (Insured products include Commercial Insured, Medicare Supplement, Medicare and Medicaid). At the mix of Best-in-Class plans, however, Peer plans were lower at 13%. (Gross profit margins are premiums less health benefits divided by premiums.)

Our Approach

Each of the plans included in this analysis differs in many key characteristics. So, to compare them, we employed a composite approach to summarize the characteristics of the low cost, Best-in-Class plans and the Peer plans to which they are compared.

We identified the Best-in-Class plans by comparing each plan's costs to its universe. We selected the plans that constituted lowest cost 25% of the total IPS universe. To make this selection, and to eliminate the potentially distorting effect of mix differences on the cost comparisons, we reweighted the costs of the universe to match the mix of each plan.

Staffing Ratios for each function were estimated to eliminate the effect of product mix differences and to overcome the fact that health plans generally do not segment their staff by product. This entails estimating the staffing ratios for each product offered by each plan.

Contact

This look at the characteristics of Best-in-Class Plans has the virtue of being mutually exclusive and collectively exhaustive. Because we have polled the plans, the data is controlled for quality and comparability. While the results are relatively objective and strongly emphasize the quantitative, the process is complex. We hope that you feel free to address any questions to:

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Invitation to Participate in the 2022 Sherlock Benchmarking Study

The highly valid, well-populated *Sherlock Benchmarks* provide an unbiased ranking and helps prioritize cost management activities to have the greatest impact on improving your health plan's overall operating performance.

The 2022 study will be the 25th consecutive year, reflecting a cumulative experience of 929 health plan years. Since June 2018, health plans serving 173 million insured Americans use the *Sherlock Benchmarks*, including most Blue Cross Blue Shield Plans, public companies and the largest Independent/Provider-Sponsored health plans.

For the most recent cycle of the *Sherlock Benchmarks*, of the 33 U.S.-based Blue Cross Blue Shield primary licensees, fourteen serving approximately 41.5 million people, participate in this year's Sherlock Benchmarking Study for Blue Cross Blue Shield Plans. Of the 15 members of the Alliance of Community Health Plans that are not focused on public programs or are staff-model plans, seven are participating in this year's Sherlock Benchmarking Study for Independent / Provider –Sponsored health plans. Most of the members of the Health Plan Alliance with greater than 300,000 members are participating in this year's *Sherlock Benchmarks*.

The *Sherlock Benchmarks* have been called the "Gold Standard" by leading health care consultants. Report publication begins in late June but varies by universe. Participation entails efforts on your part since useful outputs require relatively granular inputs. However, the cost is relatively modest.

The *Sherlock Benchmarks* are also available to license. Please reach out to Douglas Sherlock at sherlock@sherlockco.com or 215-628-2289 if you are interested in either participation or licensing. You will be among good company.

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