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Medicare Benchmarks: 2013 is the Baseline Year

Total Cost Growth Sharply Declined, Though Account and Membership Administration Surged

2013 is the Baseline Year

The 2014 Sherlock Benchmarks reflect the first effects of the Affordable Care Act. While the medical loss ratio ceilings were not yet in place, all plans were aware of the changes effective January 1, 2014. Because of this, the 2013 results will be considered the baseline costs for health insurers in future comparisons. Cost optimization will become an increasing priority.

Cost growth was less than last year and there were actual declines in some key functional areas.

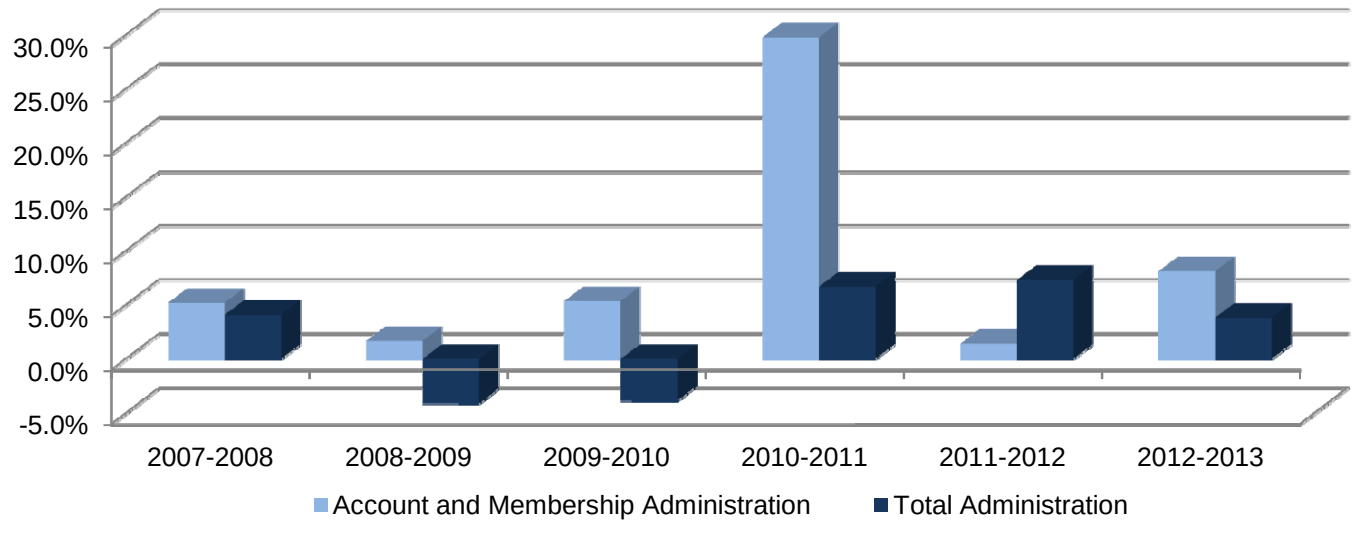
Total expenses PMPM increased by 3.8% for selected Medicare health plans and by 8.1% for Account and Membership Administration. This is shown in Figure 1 as reflected in the 2014 Sherlock Benchmarking Study. Rates of growth for total expenses were lower than the past two years. By contrast, Account and Membership Administration cost growth was higher than that of any year in the past six except the extraordinary 2011 increase.

These comparisons should be understood as "real" increases. That is, they eliminate the effect of changes in the product mix such as the increasing importance of Medicare in the product portfolios of these health plans.

Background on Medicare Advantage

Medicare Advantage (or "MA") replaces regular Medicare for an increasing proportion of beneficiaries.

Figure 1. Sherlock Benchmark Summary
Medicare Plans' Rates of Change for Account and Membership Administration and Total Administration, Constant Mix



Because MA supplies additional benefits above regular Medicare, it combines the supplemental benefits typically purchased with the regular benefits of Medicare.

As of October 2014, according to the CMS State/County Penetration file, Medicare Advantage plans served 16.5 million people of the 53.7 million eligible. Membership increased by 9.9% from 15.0 million in October of 2013. By contrast, the number of people eligible for Medicare but electing the Fee-For-Service (or "FFS) program increased by less than 100,000 in that period. The proportion of eligible Medicare members selecting Medicare Advantage increased from 28.8% in October of 2013 to 30.7% in 2014. The CBO believes that membership in MA plans will be 21 million in 2017.

Taking the longer historical view, Medicare Advantage participation increased from 12.9% in 2005 to 30.3% in 2014. In every year since that time, the net number of people joining MA plans exceeded those joining FFS Medicare. In fact, because membership in FFS declined from 2006 through 2009, the current participation in Medicare FFS is now lower than it was in 2005.

Medicare Advantage provides payments for care beyond the scope of regular Medicare. The Kaiser Family Foundation ("KFF") believes that 18% of Medicare beneficiaries with traditional Medicare had no supplemental coverage in 2010. So in 2010 approximately 62% of Medicare beneficiaries also had Medicare Supplemental products, 24% had Medicare Advantage and 14% had no supplemental benefits of any kind. According to Medicare Payment Advisory Commission ("MedPAC"), in 2007 31% of beneficiaries had employer-sponsored retiree policies though there has been a long-term trend of decline in employers' offering such programs.

Cost is an issue since, as KFF describes it, "In 2013, half of all people on Medicare had incomes below $23,500 per person." According to an AHIP study published in 2013, "Forty-one (41) percent of Medicare beneficiaries with Medicare Advantage

Figure 2. Medicare Advantage Benchmark Summary
Medicare Advantage Membership Trends
Millions of Members

	March Membership										*October*		*Cumlative*
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2013	2014	2005-2014
Beneficiaries													
Total Medicare	43.3	44.0	44.1	44.8	45.5	46.6	47.7	49.4	51.3	52.8	52.2	53.7	
Medicare Advantage	5.6	6.8	8.4	9.7	10.5	11.1	11.9	13.1	14.6	16.0	15.0	16.5	
Fee for Service	37.7	37.2	35.7	35.1	35.0	35.5	35.8	36.3	36.7	36.8	37.1	37.2	
Change in Beneficiaries													
Total Medicare		0.7	0.1	0.7	0.7	1.1	1.1	1.7	1.9	1.5		1.6	10.4
Medicare Advantage		1.2	1.6	1.3	0.8	0.6	0.8	1.2	1.5	1.4		1.5	10.9
Fee for Service		(0.5)	(1.5)	(0.6)	(0.1)	0.5	0.3	0.5	0.4	0.1		0.1	(0.5)
Pct of Benef. in M.A.	12.9%	15.5%	19.0%	21.7%	23.1%	23.8%	24.9%	26.5%	28.5%	30.3%	28.8%	30.7%	

Source: For periods 2005 - 2012, Kaiser Family Foundation based on its analysies of the CMS State/County Penetration file for March of the reporting year.
For 2013 and 2014, we accessed these files directly.

coverage had incomes of $20,000 or less. By comparison, 37 percent of all Medicare beneficiaries had incomes of $20,000 or less."

Part of Medicare Advantage's appeal comes from its cost efficiency. According to MedPAC's March 2014 Report to the Congress: Medicare Payment Policy, payments to MA plans exceeds FFS spending for each of the various types MA plans.

But their bids for Medicare covered services are 98% of what Medicare pays, and for MA HMOs, that ratio is 95%. (HMOs comprised 9.7 million or 66.9% of all Medicare Advantage beneficiaries as of November 2013.) This suggests that, for the FFS services that Medicare HMOs provide, Medicare HMOs provide it at a cost advantage to the regular Medicare program. That is because, while "traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, but it lacks incentives to coordinate care."

The other part is subsidies. MA plans are paid 106% of FFS spending, and 105% for the HMO type plans. Without the subsidy, presumably, the same members would have purchased supplemental policies or done without, with the latter being especially plausible considering MA members' low incomes. The disproportionate MA participation by low income beneficiaries may also have the effect of muting political pressure to reduce their payments.

But those pressures still remain. Thus MedPAC has "recommended that payments be brought down from previous high levels and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Recent legislation has reduced the inequity between MA and FFS." Also, beginning in 2014, MA plans will be required to meet medical loss ratio (MLR) requirements. "The primary requirement is that the plans must spend at least 85 percent of the premiums they collect (from both the Medicare program and beneficiaries) on medical expenses (as opposed to administrative costs and margins, or profits). If the plans do not meet this requirement, they will be required to refund a portion of the premiums they collected to the Medicare program."

So, What Happened?

The 2014 Sherlock Benchmarks for Medicare Plans (also called the Sherlock Expense Evaluation Report or SEER) reflect continuing efforts to manage administrative expenses combined with increased efforts to adapt to the demands of the market. The increases summarized here reflect PMPM increases and costs stemming from membership whose care and administrative needs changed over the periods. Overall as-reported costs decreased by 1.9% down from an increase of 7.3% last year. Pharmacy, Mental Health and ICD-10 expenses are included as part of the total expenses in this presentation.

For convenience of analysis, we group various functional areas into clusters, and standardize for the size of the health plans by expressing expenses on a per member basis. Clusters are comprised of functions listed, without subcategories, in Appendix C. All rates of change are median values which we view to be more representative of central tendency than means. (The cost of this are some calculation limitations.) All rates of change calculated using plans that have participated during both comparison years. All values exclude investment and non-operating income and expense, income taxes and miscellaneous business taxes.

Account and Membership Administration decreased by 5.3%. Its decline exceeded the 0.6% decline of last year. The only function to increase was Customer Services, consistent with the substantial growth in Medicaid as discussed later. Its increase was in low double digits. All other functions either declined or were flat. Information Systems and Enrollment costs declined sharply in 2013. Claim and Encounter Capture and Adjudication was effectively flat.

Provider and Medical Management cost trends were down slightly. While Medical Management increased at high single digits, Provider Network Management and Services declined by nearly the same amount.

Corporate Services cost growth was 3.4% compared with an increase of 7.9% last year. This area also had a sharp bifurcation in expense trends. While Corporate Executive and Governance declined at a double digit rate, Finance and Accounting increased by nearly the same percent. Actuarial increased at a high single digit rate while the Corporate Services function increased in line with the cluster as a whole.

The decline in Sales and Marketing is largely responsible for the modest growth in total costs. With the exception of broker Commissions, every function declined, PMPM. Rating and Underwriting's decline was in low double digits while Sales and Marketing declined at high single-digit rates. The decline in Advertising and Promotion was at a low single-digit rate. Broker Commissions increased slightly.

Figure 3. Sherlock Benchmark Summary
Medicare Plans' Median Changes in Per Member Per Month Expenses

	2012 Percent Change		2013 Percent Change	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	10.5%	10.0%	-8.9%	-5.9%
Provider & Medical Management	1.6%	6.1%	-1.1%	0.2%
Account & Membership Administration	-0.6%	1.4%	-5.3%	8.1%
Corporate Services	7.9%	8.0%	3.4%	2.7%
Total	7.3%	7.4%	-1.9%	3.8%

Membership growth was quite rapid in continuously participating plans, notwithstanding the sharp decline in Sales and Marketing expenses. The mean membership growth was 15.1%, but was 12.4% for the Medicare Advantage products. Commercial membership was flat and shifted in favor of ASO. Medicaid membership increased at a low double digit rate.

Excluding the Effects of Changes in Mix, What Happened?

On a constant mix basis, total administrative costs increased by 3.8%, a decline from the 7.4% increase last year. We consider the constant mix increase to be the "real" increase in costs. We calculate this as the differences between last year's costs weighted by this year's product mix for continuously participating plans.

While Medicare remained roughly the same proportion of the membership, Medicaid increased at the expense of Commercial. Since the costs in Medicaid are lower, this artificially lowers the reported rate of change in costs. Eliminating that effect means that costs growth is higher.

All cluster growth declined except for Account and Membership administration, which increased sharply by 8.1% compared with an increase of 1.4% in the prior year. Enrollment costs decreased as it has in three of the past four years. Customer Services costs increased in a way consistent with the need to explain plan changes in accordance with the Affordable Care Act. After four previous years of low single digit growth, Claims increased at low double digits in 2013. By contrast, Information Systems costs increased by low single digits compared with four previous years of double-digit increases.

Constant mix changes in Medical and Provider Management were effectively flat, PMPM. While Provider Network Management and Services declined, Medical Management/Quality Assurance/Wellness increased. Both functions increased in 2012 and in 2011. Medical Management increased very sharply.

Sales and Marketing expenses were lower by 5.9%. On a constant mix basis three of the five functions in this cluster declined. Both Sales and broker Commissions increased whereas Rating and Underwriting, Marketing and Advertising and Promotion increased. Marketing contains the subcategory of Product Development and Market Research.

Corporate Services costs increased by 2.7%, compared with 2012's increase of 8.0%. While Finance and Accounting increased at low double-digit rates, Corporate Executive and Governance decreased even more rapidly. Actuarial expenses also increased at high single-digit rates. The Corporate services function increased below the trend for the cluster.

Administrative Expenses for Medicare Plans were $48.35 PMPM

The costs to administer all comprehensive products for Medicare Plans were $48.35 PMPM. This should be interpreted as a weighted average value. With a different universe and a different product mix, last year's reported costs were $44.57 PMPM. The costs are shown in Figure 4 with last year's costs shown in Appendix A.

The cost differences between this year's and last year's universes stems from three factors: differences in universes, the overall cost trends and differences in product mix in the plans. Account and Membership administrative costs is the largest cluster of functional areas, comprising Enrollment, Claims, Customer Services and Information Systems. Costs of this cluster, at $17.53 PMPM, were $0.09 higher than last year.

The change in mix in favor of Medicaid from Commercial had the most important overall effect, and it reduced costs. As previously, noted the pure administrative cost trend was 8.1%. The underlying higher costs of this universe compared with last year's also contributed to a cost increase.

Per member per month Sales and Marketing Costs, at $12.63, was 7.4% lower than last year, or by $1.00. The dominant factor was a decline in trend, comprising nearly 80% of the total difference. The change in mix in favor of Medicaid from Commercial was also an important factor. This is the second most important cluster of functions and includes Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Provider and Medical Management costs of $7.79 PMPM were $0.84 lower than last year's values. Thus cluster contains the functions of Provider Network Management and Services and Medical Management. This cluster is the smallest. While the trend levels were positive, this year's universe had less of a commitment to the cluster, and the mix required less of this cluster's activities.

Figure 4. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2013 Data
Per Member Per Month

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Sales and Marketing	$10.87	$13.66	$12.63	42%
Provider & Medical Management	6.73	9.21	7.79	94%
Account & Membership Administration	13.53	22.71	17.53	42%
Corporate Services	6.75	9.64	7.95	57%
Total	$37.71	$62.16	$48.35	46%

Corporate Services includes Finance and Accounting, Actuarial, Corporate Executive and Governance as well as the sub functions such as HR, Legal, Facilities, Mailroom and similar activities. The PMPM costs of $7.95 was $0.75 higher than last year. This was chiefly due to universe differences, combined with the pure administrative cost trends for this cluster of functions.

Last year's cluster values are shown in Appendix A.

Administrative Costs in Each Product Maintained Their Relative Relationships

The Medicare plans that participated in the Sherlock Benchmarks offered products in 2013 that maintained their historic directional cost relationships with one another. Medicare Advantage cost 65% more than the per member costs of the closest commercial equivalent, Commercial HMO Insured. Costs of the products were $79.25 PMPM and $46.19 PMPM, respectively.

Commercial ASO was approximately one-half the cost of Commercial HMO product at $21.67 PMPM. The cost of Medicare SNP was $139.35 PMPM, an amount that is 76% higher than Medicare Advantage. Medicare SNP beneficiaries are often dual eligible (with Medicaid) and are sicker than most Medicare beneficiaries.

Medicaid was the lowest cost insured product for the population less than 65, at $21.67 PMPM.

The administrative expenses of both Medicare Advantage and Medicare SNP were both somewhat less than reported in 2013.

Figure 5. Sherlock Benchmark Summary
Medicare Plans' Costs by Product, 2013 Data
Per Member Per Month

Product	25th Percentile	75th Percentile	Median	Coefficient of Variation
Medicare Total	$71.52	$114.03	$79.65	29%
Advantage	$71.21	$112.92	$79.25	30%
SNP	$131.60	$144.80	$139.35	12%
Medicaid Total	$22.44	$42.87	$31.96	46%
Commercial Insured Total	$33.55	$51.04	$41.89	28%
HMO	$38.49	$52.89	$46.19	26%
POS	$33.80	$50.12	$43.69	31%
Indemnity & PPO	$35.64	$47.64	$42.91	25%
Commercial ASO	$18.84	$23.74	$21.67	23%
Comprehensive Total	$37.71	$62.16	$48.35	46%
Medicare Part D	$13.00	$39.25	$26.61	66%

Administrative Expense for Medicare plans was 10.3% of Premiums

Overall the administrative expenses increased by 1.6 percentage points as a percent of premiums and equivalents to 10.3%, compared with 8.7% last year. Despite this, Medicare Advantage costs declined as a percent of premiums. Medicare Advantage was 8.5% of premiums compared with 8.7% last year. Medicare SNP, however, increased to 9.7% compared with 9.1% last year. We no longer track the diminishing PFFS product, but overall the Medicare comprehensive products had median administrative costs of 8.5% down from 8.7% last year.

All of the commercial insured ratios improved versus last year but their mix of products was more expensive. HMO was 10.3% and POS and Indemnity and PPO were 9.4% and 12.7%, respectively. However, Commercial ASO increased by 0.2 percentage points to 5.9% of premium equivalents.

Medicaid was the exception to this overall improving trend. Its costs increased by 1.2 percentage points to 9.5% of premiums.

The Medicare products are distinguished by their high costs PMPM and low costs when measured as a percent of premiums. Approximately one-half of the differences in percent are attributable to Sales and Marketing expenses. They are twice as high per member but 1.5 percentage points lower than commercial insured products.

Figure 6. Medicare Advantage Benchmark Summary
Medicare Plans' Costs by Product, 2013 Data
Percent of Premium Equivalents

Product	25th Percentile	75th Percentile	Median	Coefficient of Variation
Medicare Total	7.9%	11.6%	8.5%	22%
Advantage	7.9%	11.7%	8.5%	27%
SNP	9.4%	10.1%	9.7%	10%
Medicaid Total	8.8%	10.3%	9.5%	22%
Commercial Insured Total	9.6%	12.6%	12.1%	19%
HMO	9.1%	10.9%	10.3%	24%
POS	8.7%	13.2%	9.4%	30%
Indemnity & PPO	11.7%	14.3%	12.7%	21%
Commercial ASO	5.4%	6.6%	5.9%	24%
Comprehensive Total	8.3%	11.6%	10.3%	19%
Medicare Part D	6.5%	15.4%	11.0%	54%

The Composition of Expenses also Shifted

As previously noted, administrative expenses increased 1.6 percentage points relative to premiums to 10.3% (last year's results are in Appendix B). Please note that all of the percents are in premium equivalents to place ASO products on the same revenue basis as insured products.

Both Sales and Marketing and Provider and Medical Management were lower than last year's results by 0.2 percentage points and 0.1 percentage points, respectively. Sales and Marketing and Provider and Medical Management comprised 2.8% and 1.7% of premium equivalents.

Conversely, Account and Membership Administration and Corporate Services both increased. Account and Membership Administration increased by 0.4 percentage points to 3.4% and Corporate Services increased by 0.5 percentage points to 2.2%.

There is a loose correspondence between the growth in expenses and the change in costs as a percent of premiums. The clusters in which the percents declined had constant mix declines or were effectively flat, while those clusters that grow in percents are the ones that that showed constant mix increases.

Comparisons Across Universes

Health plans in other Sherlock Company benchmark universes also offer Medicare products. In this section we compare the results of the Medicare products offered Blue Cross Blue Shield plans to that of the plans in our Medicare Advantage universe. Together, these two universes serve 2.31 million Medicare Advantage members, more than 15% of all Medicare Advantage members late in 2013.

The PMPM costs comparisons are remarkably similar, with Blue Cross Blue Shield plans being only $0.03 higher than their peers. Notably, however, Blue Account and Membership Administration is 5.1% higher than their Medicare focused peers, while spending less on Corporate Services. (The latter may stem from scale advantages.) They spend the same on Sales and Marketing and Provider and Medical Management.

Figure 7. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2013 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Sales and Marketing	2.6%	3.0%	2.8%	14%
Provider & Medical Management	1.5%	2.0%	1.7%	46%
Account & Membership Administration	3.1%	4.3%	3.4%	34%
Corporate Services	1.7%	2.8%	2.2%	52%
Total	8.3%	11.6%	10.3%	19%

However, the median percents of premium are much higher for Blue Cross Blue Shield plans, at 10.5% versus 8.5%. This seems to result from the revenues PMPM being 10-20% higher for the organizations focused on Medicare Advantage.

Both organizations have similar health benefit ratios of approximately 90%. Operating margins are similar in both sets of organizations.

About the Sherlock Benchmarks and the Medicare Universe

These results are excerpted from the Medicare edition of the 2014 Sherlock Expense Evaluation Report. The results are based on our detailed surveys of 2013 operating parameters of 11 Medicare Plans. Accordingly 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.

Including all of our benchmarks, those published in 2014 will comprise the experience of approximately 660 health plan years. We also have universes of Blue Cross Blue Shield Plans, Larger health plans, Medicaid plans and Independent/Provider-Sponsored plans. Earlier this month, we published results on the Medicaid plans and a few months ago on the Blue Cross Blue Shield Plans and Independent/Provider-Sponsored plans.

Medicare health plans are especially interesting in today's environment because they are a source of growth for health plans and are marketing primarily to individuals rather than through an employer sponsor .

The Medicare universe consists of 11 plans serving a total of 1.3 million Medicare Advantage plus 35,000 Medicare SNP members. These two products comprise an average of 52% of their annual revenues. In addition, more than 100,000 additional members are served through a stand-alone Medicare Part D.

Figure 8. Medicare Advantage Benchmark Summary
Medicare-Oriented Characteristics by Universe, 2013 Data

	Medicare	BCBS	Combined
Per Member Per Month			
25th Percentile	$71.21	$73.68	$71.14
Median	$79.25	$79.28	$79.27
75th Percentile	$112.92	$107.23	$113.47
Coefficient of Variation	30%	26%	27%
Percent of Premiums and Equivalents			
25th Percentile	7.9%	8.0%	7.9%
Median	8.5%	10.5%	9.5%
75th Percentile	11.7%	13.1%	12.7%
Coefficient of Variation	27%	33%	30%
Plans Offering Medicare Advantage	11	11	22
Medicare Members (Millions)	1.30	1.01	2.31
Medicare Revenues (Billions)	$13.56	$10.71	$24.28
Comprehensive Total Revenues (Billions	$28.04	$95.27	$123.31

Appendix A. Medicare Advantage Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2012 Data
Per Member Per Month

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Sales and Marketing	$11.57	$23.91	$13.63	59%
Provider & Medical Management	7.79	13.66	8.63	65%
Account & Membership Administration	10.98	20.87	17.44	70%
Corporate Services	6.72	11.76	7.20	75%
Total	$36.55	$68.42	$44.57	63%

Appendix B. Medicare Advantage Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2012 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	75th Percentile	Median	Coefficient of Variation
Sales and Marketing	2.5%	3.3%	3.0%	23%
Provider & Medical Management	1.7%	1.9%	1.8%	22%
Account & Membership Administration	2.3%	3.7%	3.0%	34%
Corporate Services	1.3%	2.4%	1.7%	41%
Total	8.2%	10.9%	8.7%	22%

Appendix C. Sherlock Benchmark Summary
Functions Included in Each Administrative Expense Cluster

Sales & Marketing
- Rating and Underwriting
- Marketing
- Sales
- Commissions (external)
- Advertising and Promotion

Provider & Medical Management
- Provider Network Management and Services
- Medical Management / Quality Assurance / Wellness

Account & Membership Administration
- Enrollment / Membership / Billing
- Customer Services
- Claim and Encounter Capture and Adjudication
- Total Information System Expenditures (as expensed)

Corporate Services
- Finance and Accounting
- Actuarial
- Corporate Services Function
- Corporate Executive and Governance
- Association Dues and License/Filing Fees

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