Plan Management Navigator
Analytics for Health Plan Administration

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Medicare Advantage Plan Administrative Cost Trends: Declines, Mostly

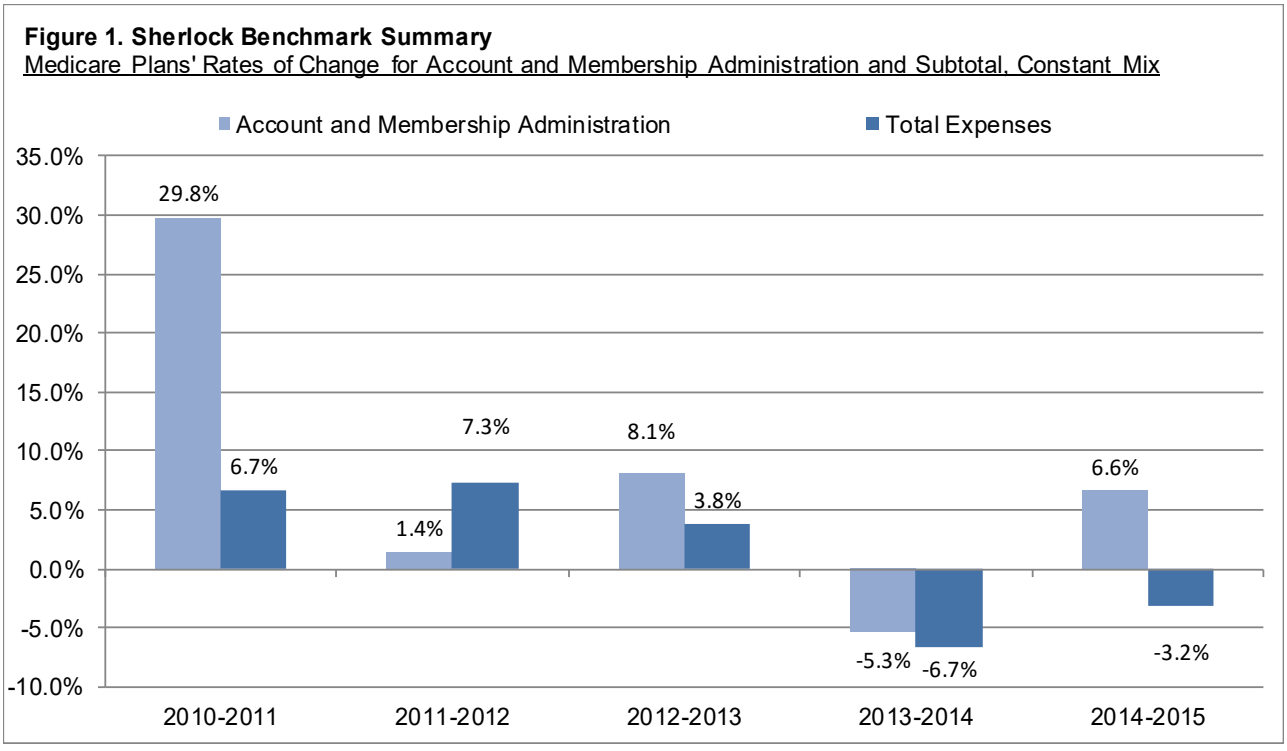
Summary

In 2015, our universe of continuously participating health plans posted higher costs and, in line with national trends, diminished enrollment growth. The higher costs were in Account and Membership Administration, and in Information Systems expenses in particular. Notwithstanding, all other clusters of functions posted reductions in their expenses.

Total expenses, PMPM, decreased by 3.2% for selected Medicare health plans, and increased by 6.6% for Account and Membership Administration. Costs also declined on an as-reported basis. This is shown in Figure 1, drawn from the 2015 Sherlock Benchmarking Study. Rates of growth for Total Expenses were lower than in three of the prior four years, while they were higher in Account and Membership Administration than in all but one of the prior four years.

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

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



Background on Medicare Advantage

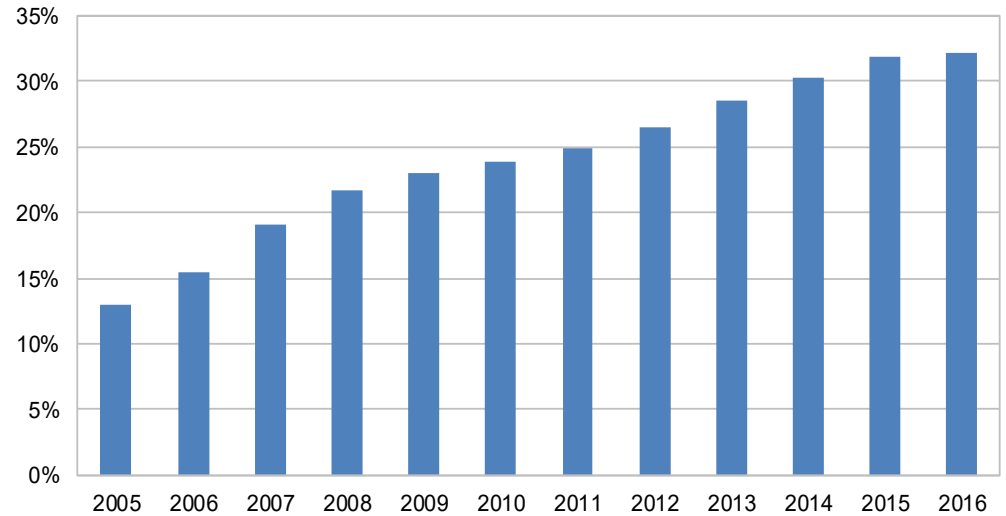
Medicare Advantage ("MA") replaces regular Medicare for an increasing proportion of beneficiaries. MA supplies additional benefits above regular Medicare but, unlike Medicare Supplement policies, they are integrated with the regular benefits of Medicare.

As of March 2016, according to the CMS State/County Penetration file, Medicare Advantage plans served 18.2 million people of the 56.6 million eligible. Membership increased by 5.4% from 17.3 million in March of 2014. By contrast, the number of people eligible for Medicare but electing the Fee-For-Service ("FFS") program increased by 3.8% during that period. The proportion of eligible Medicare members selecting Medicare Advantage increased from 31.9% in March of 2014 to 32.2% in 2015. Please see Figure 2.

This growth is a diminution of recent growth trends. Membership growth declined from 8.3% in the prior year compared with 5.4% this year. According to *Kaiser Family Foundation*, the Affordable Care Act revised its methodology for paying plans and reduced the benchmarks under which health plans are paid during 2010. Moreover, according to a recent article published in *Health Affairs* by Garret Johnson et al suggests that Medicare Advantage growth may be raising the bar for its performance by contributing in moderating FFS Medicare cost trends. The interaction between these two possible dynamics suggests the possibility that Medicare Advantage growth could, by stimulating lower costs for FFS, reduce the ability of such plans to offer the additional benefits that attract seniors.

The *Kaiser Family Foundation* in 2013 noted the possibility of negative effects resulting from the Affordable Care Act, but observed that they had not yet materialized. "When Congress debated the payment reductions in 2010, forecasters and analysts also projected that reductions would drive insurers to raise premiums, cut extra benefits and even pull out of the Medicare Advantage market as they did after the Balanced Budget Act of 1997. Thus far, however, the response by insurers to the ACA cuts has been more muted."

Figure 2. Sherlock Benchmark Summary
Medicare Advantage Share



Notwithstanding, the CBO, as of March 2016, believes that membership in "Group Plan Enrollment" will be 30 million in 2026, or approximately 40.5% of all eligibles. Its classification "Group Plan Enrollment" includes Medicare Advantage plus "cost contracts, and demonstration contracts covering Medicare Parts A and B."

Taking the longer view, MA participation increased from 12.9% of total beneficiaries in 2005 to 32.2% in 2016. In every year since 2005, except for 2016, 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 number of people served by Medicare FFS is only now higher than it was in 2005.

Medicare Advantage provides payments for care beyond the scope of regular Medicare. However, this difference is chiefly that Medicare Advantage combines the scope of benefits with supplemental benefits that beneficiaries tend to separately purchase. According to a *Kaiser Family Foundation* analysis of CMS's Medicare Current Beneficiary Survey ("MCBS") for 2011, only 19% of Traditional Medicare beneficiaries had no supplemental coverage. Including the effect of MA, only 14% lacked such coverage.

The increasing proportion of beneficiaries participating in MA may result from the needs of certain seniors coupled with the declining benefits offered by employers. According to a February 2015 AHIP analysis of MCBS, MA members were more likely to have incomes less than $20,000 annually, and more likely to be from a minority population. Moreover, the proportion of large firms that offer retiree health benefits to active workers has declined from 40% in the late 1990s to 25% in 2014.

MA plans apparently enjoy a cost advantage in competing with a package comprised of Traditional Medicare and Medicare Supplement products. According to *MedPAC*'s March 2016 Report to the Congress: Medicare Payment Policy, payments to MA plans exceeds FFS spending for each of the various types of MA plans. But their bids for Medicare covered services are 94% of what Medicare pays, and for MA HMOs, that ratio is 90%. (HMOs comprised 11.0 million or 65.9% of all Medicare Advantage beneficiaries as of November 2015.) *MedPAC* summarizes the sources of the respective cost advantages of the two alternatives as follows: "traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers among those who accept Medicare payment, but it lacks incentives to coordinate care and is limited in its ability to modify care delivery."

Besides the apparent underlying cost advantage, MA plans enjoy subsidies not available through Medicare Supplement policies. In 2016, MA plans are projected to be paid 107% of FFS spending, and 106% for the HMO type plans. (These both include quality bonuses which are projected to add on average 4% to the benchmarks in 2016.) Without the subsidy, (notwithstanding the cost advantage) presumably, some MA members would have to instead purchase supplemental policies or done without the benefits. So the higher payments have the effect of subsidizing supplemental benefits to low income beneficiaries.

As a government sponsored program, MA is subject to political risk. However, there are three factors that may limit this risk. First, MA is disproportionately selected by low income beneficiaries, who are retired for the most part. Second, the margins are low and diminishing. *MedPAC* reports that the industry-wide margin for Part C to be 4.9% in 2012 but 3.7% in 2013. Third, to the degree that pressure comes in the form of the Medical Loss Ratio (MLR) requirements, *MedPAC* estimates the MLR to be 87% compared with a floor of 85%. The plans in the Sherlock study reported median health benefit ratios of 90.6%. In any case *MedPAC*, Medicare's advisory commission, offers that, "The Commission *strongly* supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide." (Italics added.)

Background on the Sherlock Benchmarking Study for Medicare

This analysis is based on the nineteenth annual edition of the Sherlock Benchmarks for health plans. The Sherlock Benchmarks (*Sherlock Expense Evaluation Report* or *SEER*) represent the cumulative experience of approximately 740 health plan years. This is the thirteenth edition of the Medicare study.

Each peer group in the Sherlock Benchmarks is selected to be relatively uniform. Within that constraint, it is open to all Medicare plans possessing the ability to compile high-quality segmented financial and operational data. The peer group universe in this analysis consisted of ten Medicare-focused plans. Seven of this year's participants participated in the prior year.

The selected plans served 3.7 million members of which 673,000 were Medicare Advantage or Medicare SNP Members. As a percent of revenues, Medicare comprised 53%, on average. In addition, the detailed costs of up to 22 additional plans serving 2.0 million are included in the study. Collectively, Medicare Advantage health plans with detailed cost information included in the Sherlock Benchmarks comprise 2.6 million MA beneficiaries or greater than 15.5% of the total MA membership as of March 2015. We believe that this universe is exceptionally robust because it is comprised of health plans serving a high proportion of members in this sector. For the most part, this *Plan Management Navigator* analysis focuses on the 10 plans in which a plurality of the business stems from MA.

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

	2014 Data		2015 Data	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	-9.7%	-2.4%	-1.6%	-4.0%
Provider & Medical Management	1.6%	-0.8%	-7.7%	-9.9%
Account & Membership Administration	-2.4%	-5.3%	6.0%	6.6%
Corporate Services	-4.0%	-4.7%	-10.5%	-11.5%
Total Expenses	-4.0%	-6.7%	-4.1%	-3.2%

Trends in Expense Clusters

After eliminating the effect of product mix changes, the 2015 per member administrative costs declined by 3.2%. As reported costs declined by 4.1% PMPM.

The mix changed to diminish the role of the expensive-to-administer Medicare Plans. The median membership growth for the continuously participating plans was 8.1%. While Total Medicare increased at a median rate of 9.5%, Medicaid membership increased at a median rate of 23.3%. The sharper decline in costs on an as reported basis than on a constant mix basis stems from this mix shift in favor of relatively low cost Medicaid products. The effect of the mix change is to reduce cost trends by 0.9 percentage points.

Setting aside Account and Membership Administration, note that all clusters declined, both on an as reported basis and on a constant mix basis. Moreover, the rate of decline accelerated in each of the clusters with the exception of Sales and Marketing on an as reported basis, which declined less slowly.

Account and Membership Administration increased on both an as reported and constant mix basis, compared to declines in both last year. Information Systems was overwhelmingly responsible for this acceleration on both an as reported and constant mix basis. It increased at mid and high single digit rates, respectively. Claims administration was flat or down. The percent of claims that are suspended is not yet available but would bear on both of these metrics.

Enrollment, while a small function, grew at a mid-single digit rate in both comparisons. Individual membership did not appear to increase for this universe. Customer Services costs declined on both a constant mix and on an as reported basis at a low single digit rate.

Staffing ratios, including outsourced staffing, appeared to decline. The proportion of Account and Membership Administration FTEs that were outsourced also appears to have declined.

Unlike the approach we use in the Benchmarks themselves, we include administrative costs of Pharmacy, Mental Health and ICD-10 Information Systems in Account and Membership Administration for the purposes of reporting in the *Plan Management Navigator*. These expenses surged by high teens and low 20 percents, as reported and constant mix.

Corporate Services costs declined sharply, especially in Finance and Accounting and Corporate Executive and Governance. The Corporate Services function, which includes HR, Legal, Facilities and so forth, also declined. However, Actuarial expenses increased PMPM by greater than 25% in both calculations and was higher by far of any year over the past five.

Sales and Marketing expenses decreased compared with prior year's results. This was the third year in a row of cost declines in this function, on both an as reported and constant mix basis. Nevertheless growth occured in Medicare and Medicaid, as noted above. Commercial Insured products increased at a rate of 4.8% and Commercial ASO increased at a medial rate of 3.4%.

Sales expenses were sharply lower, as was Advertising and Promotion. Broker Commissions declined on an as reported basis, but were higher on a constant mix basis. Marketing expenses were higher. Product Development is a part of Marketing. Remarkably, Rating and Underwriting costs were much lower, even as Actuarial expenses were higher.

Medical and Provider Management costs were lower, both on an as reported and on a constant mix basis. Both Medical Management and Provider Network Management and Service were lower on an as reported basis, but Provider Network was higher on a constant mix basis. We have thought for a number of years that one effect of the MLR rules was to reduce the return on investment in medical management and this trend is consistent with that expected trend.

Staffing ratios appeared to have declined for this universe. For Medicare Advantage product offered by this universe, we estimate that their staffing ratios were a median were 52.3 FTEs per 10,000 members.

While an actual administrative expense, we have not included the effect of Miscellaneous Business Taxes in these trends. The median PMPM cost of this in 2015 is $5.28 compared with $4.56 in 2014 and $0.13 in 2013. These taxes grew at a median rate of approximately 5.8% on an as reported basis and by 20.8% on a constant mix basis in 2015. It now comprises approximately 10% of total administrative costs.

Costs of Medicare Plans, by PMPM Cluster

Figure 4 shows the values of administrative expenses for all 10 participating plans. The values in this figure do not correspond with those in Figure 3 because it includes all of the Medicare Plans rather than only the ones participating in both comparison years. 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.

Figure 4. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2015 Data
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$9.11	$11.25	$12.15	54%
Medical and Provider Management	7.24	8.52	9.99	63%
Account and Membership Administration	14.78	17.44	19.53	33%
Corporate Services	6.33	7.97	9.42	27%
Total Expenses	$39.50	$44.72	$57.95	29%

The actual total PMPM administrative expenses at $44.72 were 6.4% higher than last year's values of $42.04. But as previously mentioned, this in part includes the effect of an industry product mix shift in favor of Medicaid products. This is consistent with the possibility that this year's universe has higher underlying costs than last years, though the performance of plans that did not participate cannot be known.

Total costs are more clustered, and this is also the case in Corporate Services and Account and Membership Administration. Sales and Marketing and Provider and Medical Management are more dispersed, however. The average product mix is more concentrated.

Because of product and universe mix differences, strict comparisons between the values of last year's comparisons are not possible. Also, since each median value is calculated separately (and they are median values after all), the cluster values will not sum to the total.

Medical and Provider Management showed the greatest change with PMPM costs of $8.52, 14.0% higher than last year's values. Account and Membership Administration was the single greatest cluster of expenses at a median value of $17.44 and comprised nearly 40% of the total. It also increased the second fastest at 11.8% in large part due to Information Systems costs as previously discussed. The fast growth and high weighting helps to explain this cluster's overall effect on trend, overcoming declines in other clusters. This function includes the central activities of Information Systems, Enrollment, Claims and Customer Services.

Sales and Marketing costs were lower than last year, PMPM, by 3.3% to $11.25. Corporate Services Costs were higher, PMPM. This year's value was $7.97, up by 8.7%.

Costs of Medicare Plans, PMPM by Product

The importance of considering the product values is shown in Figure 5, on Page 8. The products vary greatly in their costs so it is important to take product mix into consideration when comparing the results of the health plans.

Medicare Advantage comprised on average, 28.1% of membership in the Medicare universe, and its costs, at $81.21 PMPM were the second highest. Medicare SNP is the highest cost product at $142.91 – it comprises 0.5% of comprehensive membership. (Measured by revenues, the mean mixes are 51.2% and 1.7%, respectively.)

Medicaid products are relatively low cost, at median PMPM values of $27.62 and $21.37 for HMO and CHIP respectively. Their average membership share is 14.2% and 0.6%, respectively.

Commercial insured products are slightly higher than the median total values for the products. The single most important product is ASO at $20.88. The most important commercial insured product is HMO with a median cost of $55.72. POS and Indemnity and PPO cost $43.58 and $46.19, respectively.

Costs of Medicare Plans, Percent of Premiums by Product

The median cost of Medicare Plans was 8.6% of premiums or equivalents. This is seen on Figure 6, page 9. Rankings of the percents of premiums or equivalents are much closer and in a different order than the PMPMs. While PMPMs have up to a seven fold difference, Medicare Supplement, at 15.4% is less than three times higher than the administration of the ASO product.

Medicare SNP and Medicare Advantage are higher than average at 10.8% of premiums and 9.8%, respectively. Medicare Supplement, at 15.4%, is because the nature of the product is that health benefit costs are intrinsically low relative to administrative requirements because the Medicare program is primary.

Medicaid HMO was quite low at 7.5% of premiums. Medicaid CHIP expense ratio is higher than average at 9.6% of premiums. CHIP serves a population that tends to be low cost per service provided, since there are many children served by this product.

Commercial insured products range from 9.9% or premiums to 12.1% of premiums, above average. By contrast, commercial ASO is 5.3% of premium equivalents.

Figure 5. Sherlock Benchmark Summary
Medicare Plans' Costs by Product, 2015 Data
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	$81.10	$84.71	$91.05	22%
Advantage	$74.32	$81.21	$89.72	24%
SNP	$132.90	$142.91	$231.79	77%
Medicaid Total	$22.67	$26.60	$29.89	32%
HMO	$22.74	$27.62	$29.89	32%
CHIP	$18.06	$21.37	$30.76	52%
Commercial Insured Total	$40.64	$50.99	$59.21	35%
HMO	$40.38	$55.72	$67.94	31%
POS	$37.08	$43.58	$49.29	19%
Indemnity & PPO	$37.70	$46.19	$52.61	58%
Commercial ASO	$19.96	$20.88	$26.17	59%
Medicare Supplement	$26.51	$39.93	$53.94	45%
Comprehensive Total	$39.50	$44.72	$57.95	29%

Costs of Medicare Plans, by Percents, by Cluster

Figure 7, on page 10, shows the ratios of administrative expenses to premiums. In the case of ASO products, we have added health benefit expenses to fees for this product's denominator. While this is not GAAP, this approach makes these ratios comparable across all the products. Administrative expenses were 8.6% of premiums and last year's equivalent values were 8.9%.

Every cluster of functions declined compared with last year. Corporate Services' declined was 0.3 percentage points to 2.2%. This was followed by a decline of 0.2 percentage point decline in Sales and Marketing also to 2.2%. Medical and Provider Management and Account and Membership Administration each declined by 0.1 percentage point to 1.6% and 3.4%, respectively.

Figure 6. Sherlock Benchmark Summary

Medicare Plans' Costs by Product, 2014 Data

Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	8.5%	9.8%	10.7%	23%
Advantage	8.3%	9.8%	10.7%	24%
SNP	10.2%	10.8%	13.2%	36%
Medicaid Total	7.0%	7.5%	9.8%	19%
HMO	6.9%	7.5%	9.5%	19%
CHIP	9.4%	9.6%	16.0%	54%
Commercial Insured Total	9.5%	12.0%	12.5%	37%
HMO	10.2%	12.1%	14.8%	36%
POS	7.5%	9.9%	12.6%	32%
Indemnity & PPO	8.5%	10.1%	11.1%	74%
Commercial ASO	4.4%	5.3%	6.0%	63%
Medicare Supplement	11.0%	15.4%	24.2%	55%
Comprehensive Total	7.8%	8.6%	10.5%	19%

Comparisons Across Universes

Health plans in other Sherlock Benchmark universes also offer Medicare products. In this section, we compare the results of the Medicare Advantage products offered by Blue Cross Blue Shield Plans and Independent/Provider-Sponsored plans to those of organizations focused on Medicare. We define "focused" to be those plans that have a disproportionate commitment to the Medicare product. The mean percent of revenues from Medicare products was 51%, with 39% and 57% at the 25th and 75th percentile values, respectively.

Not included in these comparisons are members served through SNP products, Medicare Advantage products served by Medicaid Plans and Medicare Cost contracts offered by other universes. Collectively, the Sherlock Benchmarks include the results of 2.6 million people or 15.5% of all Medicare Advantage members in March 2015.

Since the data definitions are the same, it is possible to directly compare our Medicare Advantage universe with Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans. Together, these three universes serve 2.21 million Medicare Advantage members.

Seen in Figure 8 on page 11, compared with the Medicare plans, Blue Cross Blue Shield Plans cost $2.85 more than the Medicare Plans and, measured as a percent of premiums, were 0.70 percentage points less. The IPS plans were lower both in PMPM and as percent of premium. Both scale and focus may affect the relative performance of these health plan sets.

There is variation between the plans but Blue Cross Blue Shield Plans tend to have lower Provider and Medical Management and Corporate Services than the Medicare products of the Medicare plans. They also have higher Account and Membership Administration and Sales and Marketing expenses, leading to overall higher costs. Likewise, the most important source of cost advantage of the Independent / Provider – Sponsored Plans in the Medicare product is in Provider and Medical Management and Corporate Services. Again, there is a great deal of variation between the plans.

The Medicare plans had somewhat lower health benefit ratios with a median of 90% versus 91% for Independent / Provider – Sponsored plans and 93% for Blue Cross Blue Shield Plans.

Figure 7. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2015 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	1.9%	2.2%	2.5%	27%
Medical and Provider Management	1.4%	1.6%	1.8%	62%
Account and Membership Administration	3.0%	3.4%	3.6%	27%
Corporate Services	1.7%	2.2%	2.9%	45%
Total Expenses	7.8%	8.6%	10.5%	19%

Note on the Sherlock Benchmarks

These results are excerpted from the Medicare edition of the 2016 *Sherlock Expense Evaluation Report*. The results are based on our detailed surveys of 2015 operating parameters of 10 Medicare Advantage plans. In addition, the results of health coverage products sold to seniors by Medicaid, Blue Cross Blue Shield and Independent / Provider – Sponsored plans are also included. Accordingly, much more information is available by licensing the Sherlock Benchmarks.

Including all of Sherlock Benchmarks, those published in 2016 will be the culmination of the experience of approximately 740 health plan years. We also have universes of Blue Cross Blue Shield Plans, Larger Health Plans, Independent / Provider-Sponsored Plans and Medicaid Plans.

Sherlock Benchmarks are often referred to as the gold standard for operational and financial metrics for health plans. Health plans serving most insured Americans are users of 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 *Navigator*.

Figure 8. Sherlock Benchmark Summary

Medicare Advantage Product Characteristics by Universe, 2015 Data

	Medicare Plans	IPS Plans	BCBS Plans	Combined Plans
Total Costs				
Per Member Per Month				
25th Percentile	$74.32	$75.08	$74.66	$74.32
Median	81.21	80.51	84.06	81.21
75th Percentile	89.72	96.75	101.75	101.18
Coefficient of Variation	24%	36%	22%	26%
Percent of Premiums and Equivalents				
25th Percentile	8.3%	8.1%	8.2%	8.1%
Median	9.8%	9.2%	9.1%	9.3%
75th Percentile	10.7%	11.4%	13.0%	11.8%
Coefficient of Variation	24%	43%	32%	33%
Plans offering Medicare	10	8	12	30
Medicare Advantage Members (millions)	0.64	0.46	1.11	2.21
Comprehensive Total Members (millions)	3.72	7.30	44.96	47.12

Appendix A. Sherlock Benchmark Summary

Medicare Plans' Costs by Functional Area Cluster, 2014 Data

Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$10.06	$11.63	$11.90	28%
Medical and Provider Management	5.21	7.48	9.15	23%
Account and Membership Administration	13.51	15.60	18.33	45%
Corporate Services	6.63	7.33	8.95	67%
Total Expenses	$34.49	$42.04	$45.71	34%

Appendix B. Sherlock Benchmark Summary

Medicare Plans' Costs by Functional Area Cluster, 2014 Data

Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.3%	2.4%	19.6%	20%
Medical and Provider Management	1.4%	1.7%	1.9%	18%
Account and Membership Administration	3.1%	3.5%	4.1%	38%
Corporate Services	2.2%	2.5%	3.0%	49%
Total Expenses	8.5%	8.9%	11.3%	23%

Appendix C. Sherlock Benchmark Summary

Major Functions Included in Each Administrative Expense Cluster

Sales & Marketing

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

Provider & Medical Management

6. Provider Network Management and Services
   - (a) Provider Relations Services
   - (b) Provider Contracting
   - (d) Other Provider Network Management and Services
7. 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

Account & Membership Administration

8. Enrollment / Membership / Billing
   - (a) Enrollment and Membership
   - (b) Billing
9. Customer Services
   - (a) Member Services
   - (b) Printed Materials and Other
10. Claim and Encounter Capture and Adjudication
    - (a) Coordination of Benefits (COB) and Subrogation
    - (e) Other Claim and Encounter Capture and Adjudication
11. 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

Corporate Services

12. Finance and Accounting
    - (a) Credit Card Fees
    - (b) All Other Finance and Accounting
13. Actuarial
14. 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
15. Corporate Executive and Governance
16. Association Dues and License/Filing Fees

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