Plan Management Navigator
Analytics for Health Plan Administration September 2013

Administrative Expense Growth for Medicare Plans Accelerate in 2012

Summary

Administrative expenses, per member, grew by 7.3% in 2012 compared with 7.0% in 2011 and an increase of 0.9% in 2010. After adjusting to eliminate the effects of changes in product mix, per member costs increased by 7.4% compared with a growth of 6.7% in 2011, but fell 3.9% in 2010.

The Sales and Marketing cluster of functions were the key source of cost growth posting low double-digit increases in PMPM costs. Corporate Services and Provider and Medical Management clusters experienced modest growth. Comparisons are mix-adjusted.

For the universe of Medicare plans submitting 2012 data, administrative expenses comprised 8.7% of premium equivalents, compared with 8.8% for plans submitting data in 2011. The median administrative expenses of the Medicare Advantage product within this universe was also 8.7% of premiums in 2012.

The administrative expenses of comprehensive products for Medicare plans participating in our performance benchmarking study was $44.57 PMPM, but varied greatly by product. Medicare SNP expenses had a median value of $142.90 PMPM while the commercial ASO costs were $18.05 PMPM. Medicare Advantage administrative expenses were $80.76 PMPM.

In 2012, the commercial ASO administrative expenses were 5.7% of premium equivalents, the lowest ratio for comprehensive products in this universe. Medicare SNP was at 9.1% of premiums and Medicare PFFS was at 11.6% of premiums.

All costs reported in this article *exclude* investment and non-operating income and expense, income taxes and miscellaneous business taxes. Pharmacy, Mental Health, and ICD-10 Information Systems administrative costs are *included* in the

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Benchmarking, Simplified

Sherlock Company is pleased to announce a significant expansion of its services. If requested, Sherlock Company can assume the responsibility to complete the survey materials entailed in participation in the actual study.

Services include:

- Mapping *activities* to the functional areas as preferred by your peer companies through interviews with operational leaders.
- Confirm with the operational leaders their responsibility for costs associated with the mapped activities.
- Recording costs into the Sherlock benchmark spreadsheets.
- Employing cost allocation methodologies normally employed by health plans to allocate costs across products.

The completed survey materials can be incorporated into the benchmarking studies, yielding all of the Sherlock benchmark volumes, all of the summary documents and any desired management presentations.

This approach has many advantages including economy and engagement. It costs less than hiring a full-time employee and training them to participate in the benchmarking study. Despite our uniquely robust data, we are also economical compared with other consultants providing similar services. It also involves operational leaders in the early stages of the process, increasing the likelihood of their acceptance of their conclusions and support for strategies for implementation.

Sherlock Company continues to assure an unbiased analysis because it is provided entirely independent of any solutions provider. Our work has been the starting point for strategies to implement improvements in your operations including those facilitated by other consultants. We enthusiastically support consultants' use of the Sherlock benchmarks on your behalf and we have worked with most of the ones serving health plans.

Let us know if Benchmarking, Simplified would be an attractive solution for your health plan.

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Medicare Expense: *Continued from Page 1*

Figure 1. Medicare Advantage Benchmark Summary
Medicare-Oriented Costs by Functional Area Cluster, 2012 Data
Per Member Per Month

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales and Marketing	$8.40	$23.91	$13.63	59.2%
Provider & Medical Management	7.79	13.66	8.63	64.9%
Account & Mem. Administration	10.98	20.87	17.44	70.5%
Corporate Services	6.72	11.76	7.20	75.2%
Total	$36.55	$68.42	$44.57	62.6%

**Account & Membership Administration Includes Rx, Mental Health, and ICD-10 Information Systems*

Account and Membership Administration cluster. These results are excerpted from the Medicare edition of the 2013 *Sherlock Expense Evaluation Report*, comprising 2012 data.

Background on Medicare

As of December 2012, according to the CMS State/ County Penetration file, Medicare Advantage plans served 13.9 million people of 50.8 million eligibles. Medicare Advantage membership increased by 9.8% in 2012 against a 0.9% increase in eligible people. Penetration increased from 25.8% to 27.3%. According to these reports, as of September 2013, nearly 15 million people are currently enrolled in Medicare Advantage plans, apparently closing on 30% of the eligible population. Interestingly, between December 2011 and December 2012, enrollment in Medicare's Fee for Service increased by 1.6%.*

Taking the longer historical view, and using *Kaiser Family Foundation* calculations, Medicare Advantage participation reached its nadir in 2004, with 12.1% penetration. Since that time Medicare membership has increased by 16.7%, Medicare Advantage membership increased by 147.4% and membership in FFS Medicare declined by 1.3%.

The increasing attractiveness of Medicare Advantage to seniors can be understood in the context of how seniors finance their health care. The Medicare program covers much but not all health care costs for seniors. According to a 2009 *Kaiser Family Foundation* analysis only 11% of seniors reported no coverage supplementing their Medicare benefits. The analysis of CMS Medicare Current Beneficiary Survey Cost and Use file by Tricia Neuman et al. indicated that 13% reported use of a Medicare HMO, 15% reported Medicaid, 33% reported some form of employer-sponsored coverage and 26% reported self-purchased Medigap. The amounts are significant in that the mean out-of-pocket expense for Medicare beneficiaries was $4,052 in 2005.

According to Medicare Payment Advisory Commission's March 2013 *Report to the Congress: Medicare Payment Policy*, payments to MA plans exceed FFS spending for each of the various types MA plans. But their *bids* for Medicare covered services are 96% of what Medicare pays, and for MA HMOs, that ratio is 92%. (HMOs comprised two-thirds of all Medicare Advantage beneficiaries as of November 2012.) This suggests that, for the FFS services that Medicare HMOs provide, Medicare HMOs provide it at a cost advantage to the regular Medicare program.

If this apparent cost advantage is accurate, much of the additional Medicare program payments to MA plans went to supplemental services that the beneficiary would otherwise have to pay for through Medicare Supplemental insurance or out-of-pocket. Thus, according to an analysis prepared for the Blue Cross Blue Shield Association by Atherly and Thorpe in 2005, "Beneficiaries with under $20,000 in income are more likely to enroll in Medicare Advantage than to buy Medigap."

While the costs of the Medicare program and its long-term deficits may lead policy-makers to pressure providers of Medicare Advantage services, the nature of the actual beneficiaries creates a commonality of interest : MA is well-regarded by those favoring a consumer choice based competitive solution to managing Medicare costs and quality, and also by those who may be agnostic as to efficacy of competitive markets but are interested in assuring that low income seniors receive the additional benefits at the least possible out-of-pocket costs. For instance, according to the House's Committee on Oversight and Government Reform, the Medicare Advantage Quality Bonus Payment (MA QBP) was intended to "to minimize

the impact of…cuts on seniors enrolled in Medicare Advantage before the (2012) election…."

Figure 2. Medicare Advantage Benchmark Summary
Medicare-Oriented Percent Change in Costs by Functional Area Cluster

	2011 Data		2012 Data	
	Percent Change	Percent Change Mix-Adjusted	Percent Change	Percent Change, Mix-Adjusted
Sales and Marketing	1.2%	-1.1%	10.5%	10.0%
Provider & Medical Management	18.4%	14.7%	1.6%	6.1%
Account & Mem. Administration	31.1%	29.8%	-0.6%	1.4%
Corporate Services	11.4%	8.7%	7.9%	8.0%
Total	7.0%	6.7%	7.3%	7.4%

**Account & Membership Administration Includes Rx, Mental Health, and ICD-10 Information Systems*

Membership Trends and Mix Changes

Of the eleven plans participating in our benchmarking study this year, eight also participated in 2012. These continuing plans grew more rapidly in their Medicare products than the overall Medicare Advantage program. Our plans grew at a median rate of 6.2% (10.2% excluding one outlier), compared with Medicare Advantage growth of 9.8% in 2012.*

Collectively, the Medicare-focused plans served, on average, 1.2 million Medicare beneficiaries during 2012. Our Medicare benchmarks also include, in a separate exhibit, the MA cost attributes of plans offering, but not focused on, MA. These Blue Cross Blue Shield and Independent / Provider-Sponsored plans served 1.1 million and 0.1 million members, respectively. In all, *SEER* reports on a total of 2.4 million Medicare Advantage beneficiaries, or approximately 19% of total Medicare Advantage beneficiaries. This is summarized in Figure 6.

For plans included in the core benchmarks, Medicare products comprised, on average, 57.9% of premiums and fees. Commercial insured comprised 32.2% and Medicaid HMO comprised 7.5% of premiums and fees on average. Stand-Alone part D and ASO fees comprised the rest of the mix.

Administrative Costs and Trends

For convenience of analysis, we group various functional areas into clusters and standardize for size by expressing expenses on a per member per month (PMPM) basis. As we develop later, we also standardize by percent of premiums or equivalents. Values for 2012 and rates of change for these clusters and overall are shown in Figures 1 and 2. Appendix A provides values for all plans participating in the 2012 benchmarking study and reflects 2011 data.

Costs comparisons shown in Figure 2 are based on the results for plans that participated in both of the comparison years. PMPM and percent values are for all Medicare plans that reported this year. We often employed median values in this analysis so as to minimize the effect of outlier responses.

Sales and Marketing expenses were $13.63 PMPM an increase of 10.5% compared with a 1.2% in 2011. Holding these plans' product mix constant, Sales and Marketing expenses grew by 10.0% PMPM compared with a *decrease* of 1.1% in 2011. At the 25th percentile, Sales and Marketing costs were $8.40 and, at the 75th percentile, were $23.91 PMPM.

Rating and Underwriting grew on an as-reported and constant-mix basis. Notably, the function grew at a double-digit rate on a constant-mix basis. Broker Commissions declined on an as-reported basis, but increased on a constant mix basis. Product Development and Market Research and Advertising and Promotion each grew under both reporting conventions, but both functions grew at a faster rate on a constant-mix basis.

Medical and Provider Management increased at a sharply lower rate, by 1.6% compared with an increase of 18.4% in 2011 and a decrease of 1.3% in 2010. The median PMPM cost for this cluster was $8.63 PMPM. There was similar though less dramatic decline on a constant-mix basis with costs increasing by 6.1% versus an increase of 14.7% in 2011 and an decrease of 5.4% in 2010.

Figure 3. Medicare Advantage Benchmark Summary
Medicare-Oriented Costs by Functional Area Cluster, as a Percent Premiums or Equivalents, 2012 Data
Percent of Premium Equivalents

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales and Marketing	2.5%	3.3%	3.0%	22.7%
Provider & Medical Management	1.7%	1.9%	1.8%	21.5%
Account & Mem. Administration	2.3%	3.7%	3.0%	33.9%
Corporate Services	1.3%	2.4%	1.7%	41.1%
Total	8.2%	10.9%	8.7%	22.5%

**Account & Membership Administration Includes Rx, Mental Health, ICD-10 Information Systems*

On an as-reported basis, Provider Network Management and Services grew modestly but was somewhat less than overall trends on a constant mix basis. The Medical Management / Quality Assurance / Wellness functional areas grew at approximately overall rates of change on both an as-reported and constant mix basis. Medical Management was the most important source of cost increase on an as-reported basis, and the second most important on a constant mix basis.

The costs of Medical and Provider Management at the 25th percentile was $7.79 PMPM and $13.66 PMPM at the 75th percentile.

Account and Membership Administration, including Pharmacy, Mental Health, and ICD-10 Information Systems (IS) expenses, declined by 0.6% on an as-reported basis, and had a median value of $17.44 PMPM. Last year's comparable increase was 31.1%. Mix-adjusted cost growth was also modest, at 1.4%, compared with an increase of 29.8% last year.

In both renderings, Enrollment/Membership/Billing costs were below last year's levels. IS expenses were about average on an as-reported but grew at low double-digit rates on a constant mix basis. IS costs were the most important source of cost increase on a constant-mix basis but were the second most important source of cost increase on an as-reported basis. Customer Services and Claim and Encounter Capture and Adjudication cost growth was modest and grew at a lower rate than last year.

The total cost for this cluster of expenses at the 25th percentile was $10.98 PMPM, while the costs at the 75th percentile were $20.87 PMPM.

Corporate Services costs increased, as-reported, by 7.9% compared with 11.4% increase last year and a decline of 2.8% in 2010. On a constant-mix basis, costs increased by 8.0%, down slightly from an increase of 8.7% in 2011 and a decline of 6.7% in 2010. The costs in this cluster include such support areas as Finance and Accounting, Actuarial, Corporate Services (e.g., Facilities, Legal, Printing and Mailroom and OPEB), Corporate Executive/ Governance and Association Dues and License / Filing Fees.

Actuarial expenses grew at very high rates in 2012 on both an as-reported and constant-mix basis. Corporate Executive / Governance expenses grew at high single-digit rates on an as-reported basis and at low double digit rates on a constant mix basis. It is possible that consulting services were central to these costs trends in 2012.

Miscellaneous Business Taxes were also sharply higher calculated in either way. Association dues and License and Filing fees, and Finance and Accounting costs were lower in either rendering. Corporate Services Costs were lower than average, either as-reported or constant-mix.

Total costs for this cluster was $7.20 PMPM in 2012, while the 25th percentile value was $6.72 PMPM and the value at the 75th percentile was $11.76 PMPM.

Expressing Costs as a Percent of Premium Equivalents

Notwithstanding its important drawbacks, health plans and others often express administrative costs as a percent of premiums. Indeed, the MLR rules under PPACA indirectly employ indirectly this percent as a driver for rebates paid to commercial customers.

As shown in Figure 3, administrative expenses were 8.7% of premium equivalents for comprehensive products sold by Medicare plans. The 25th percentile value was 8.2% and the value at the 75th percentile was 10.9%. Comparing these results to those in Appendix B, administrative expenses were 17 basis points lower as a percent of premium equivalents.

Sales and Marketing costs comprised 3.0% of premium equivalents, with the 25th percentile value at 2.5% and the value at the 75th percentile at 3.3%. The comparable median percent in 2011 was 2.5% or 50 basis points higher.

The value at the 25th percentile for Provider and Medical Management was 1.7% of premium equivalents, while 1.9% of premium equivalents represented the 75th percentile. The median value, at 1.8%, was effectively identical to last year.

The cost of Account and Membership Administration was 3.0% of premium equivalents, an increase of 23 basis points from last year's reported median of 2.8%. The value at the 25th percentile was 2.3% of premium equivalents and 3.7% of premium equivalents at the 75th percentile.

The median proportion of premium equivalents due to Corporate Services was 1.7%, 29 basis points higher than last year's value of 1.4%. Twenty-five percent of plans had values below

Calculation of Premium Equivalents

Administrative services relationships comprise a relatively small part of the business mix of Medicare Advantage plans. On average, they comprise 20.5% of members and their median mix was only 21.2%. Nevertheless, to the extent such relationships exist, they play havoc with the intuition that administrative costs, when expressed as a percent, are a proportion of the premium dollar. That is because, under ASO relationships, employers are only billed for the administrative services that they provide rather than for the cost of care, which is borne by the self-insured groups.

Our solution to this is to express expenses as a percent of premium equivalents. Since each of the plans submits the health care expenses for the self-insured groups (which they know since they process their self-insured claims), by adding this amount to the administrative service fees actually billed, we are able to estimate the premium equivalents of the ASO arrangements.

Note that, as with premiums, fees charged to ASO clients reflect a profit assumption. Therefore, to estimate premium equivalents it is appropriate to add the fees, rather than the administrative expenses, to the reported health benefits to directly compare costs with the insured business.

Calculation of Constant-Mix Rates of Expense Growth

To make the most useful comparisons of administrative expenses between years, it is illuminating to eliminate the effects of product mix differences. This is beneficial both between organizations with different product mixes and also between periods. Accordingly, in comparing expenses between periods, we hold constant the product mix between the two years.

To do this, since Medicare plans report to us by product, we reweight their expenses so that the product mix applied in the prior year is the same as in the current one. We then recalculate the constant-mix rates of change based on these reweighted values.

1.3% of premium equivalents and twenty-five percent of plans had values above 2.4% of premium equivalents in 2012.

Because medians are the 50th percentile value they won't sum. It should be noted that each metric is separately calculated so different plans may be reflected in each column. It is notable that each of the coefficient of variation narrowed when you compare Figures 1 and 3 to their respective appendices.

Administrative Expenses by Product

All participants in our benchmarking studies segment their costs by product as well as by over forty functional areas. Overall, the resources required to serve customers of these products differ quite sharply between them. Our participants normally have strong cost allocation methodologies to facilitate this, including sometimes quite robust activity-based costing systems, so that costs are not normally allocated by member.

For example, suppose commercial HMO members have, on average, 40% of the number of annual claims as members in Medicare Advantage products. Commercial products' per member claims adjudication expenses will be correspondingly lower as well. Similarly, ASO products have lower overall costs than their insured counterparts since ASO arrangements are normally provided only to larger groups that tend to require fewer marketing resources per group.

These differences are manifest in their overall cost differences. The most expensive product offered by Medicare plans is their Medicare SNP product at $142.90 PMPM. PFFS followed at $106.76 though only one company submitted cost information on this product. Medicare Advantage cost $80.76. The least expensive comprehensive product offered by these health plans was the ASO product at $18.05 PMPM. The stand-alone Medicare Part D cost $22.97 PMPM to administer. This is shown in Figure 4.

Figure 4. Medicare Advantage Benchmark Summary
Medicare-Oriented Costs by Product, 2012 Data
Per Member Per Month

	25th PCTL	75th PCTL	Median	σ/ Mean
HMO	$41.64	$53.03	$45.32	18.9%
POS	37.75	41.85	38.06	32.2%
Indemnity & PPO	39.69	51.91	45.61	17.2%
Total Comm. Ins.	$38.58	$50.58	$44.85	20.4%
ASO	17.40	25.16	18.05	40.1%
Total Commercial	$26.86	$40.61	$35.26	24.2%
Medicare Advantage	75.09	98.38	80.76	34.2%
Medicare Advantage PFFS	106.76	106.76	106.76	NM
Medicare SNP	131.41	195.60	142.90	40.2%
Medicare Total	$75.09	$104.55	$84.93	29.7%
Medicaid	17.52	29.41	25.80	40.1%
Comprehensive Total	$36.55	$68.42	$44.57	62.6%
Medicare Part D	$14.55	$24.87	$22.97	59.0%

Figure 5. Medicare Advantage Benchmark Summary
Medicare-Oriented Costs by Product, 2012 Data
Percent of Premium Equivalents

	25th PCTL	75th PCTL	Median	σ/ Mean
HMO	10.5%	11.5%	10.9%	14.5%
POS	8.5%	10.4%	9.6%	19.8%
Indemnity & PPO	10.2%	15.1%	13.2%	25.5%
Total Comm. Ins.	10.2%	13.3%	11.9%	20.6%
ASO	4.6%	6.8%	5.7%	39.6%
Total Commercial	7.5%	11.6%	9.0%	23.8%
Medicare Advantage	7.5%	10.5%	8.7%	30.7%
Medicare Advantage PFFS	11.6%	11.6%	11.6%	NM
Medicare SNP	9.0%	10.6%	9.1%	17.9%
Medicare Total	7.5%	10.7%	8.7%	26.9%
Medicaid	8.0%	9.6%	8.3%	13.8%
Comprehensive Total	8.2%	10.9%	8.7%	22.5%
Medicare Part D	7.0%	15.9%	10.3%	76.5%

As shown in Figure 5, the ranking of administrative expenses by product is different on a percent of premium basis. The ASO product remained among the lowest cost on a percent basis, at 5.7% of premium equivalents, but it was followed by Medicaid and Medicare Advantage at 8.3% and 8.7%, respectively. The high cost products, calculated based on a percent of premium equivalents, were Indemnity and PPO Insured at 13.2% and Medicare Advantage PFFS at 11.6%.

Figure 6. Medicare Advantage Benchmark Summary
Medicare-Oriented Characteristics by Universe, 2012 Data

	Medicare	Independent / Provider-Sponsored	BCBS	Combined Universes
Administrative Expenses PMPM				
25th PCTL	$75.09	$55.62	$74.38	$74.16
Median	80.76	63.54	78.52	79.38
75th PCTL	$98.38	$71.46	$104.81	$99.99
σ/ Mean	34.2%	35.2%	22.2%	29.2%
Administrative Expenses as a Percent of Premiums				
25th PCTL	7.5%	6.8%	8.2%	7.3%
Median	8.7%	7.2%	9.6%	9.1%
75th PCTL	10.5%	7.6%	11.5%	10.6%
σ/ Mean	30.7%	15.8%	28.8%	29.8%
Plans Offering Medicare Advantage	11	3	14	35
Medicare Members (Millions)	1.20	0.12	1.11	2.44
Medicare Revenues ($ Billions)	$14.4	$1.5	$11.9	$27.8
Comprehensive Total Revenues ($ Billions)	$25.8	$8.2	$116.7	$150.8

It is helpful, when thinking about the differences in cost rankings to bear in mind the nature of the health care needs of seniors. For instance, the cost of a hospital visit is normally much higher for a senior than for a younger person. But both hospital admissions trigger claims submissions. Since the cost of care is fully reflected in the premium denominator, Medicare Advantage administrative costs are smaller relative to premiums.

Comparisons Across Universes

Health plans in other Sherlock Company benchmark universes also offer Medicare products. In fact, the combined Medicare membership in the Independent/Provider-Sponsored and Blue Cross Blue Shield universes exceeds that of the Medicare universe itself. Together, the three universes are comprised of health plans serving 19% of all of the Medicare Advantage beneficiaries.

Figure 6 compares the results for the Medicare Advantage products of the three universes. The Medicare focused universe has the highest PMPM costs, followed by Blue Cross Blue Shield (Blue) Plans and Independent/Provider-Sponsored (IPS) plans. However when administrative expenses are expressed as a percent of premium, Blue Cross Blue Shield Plans have the highest ratios, followed by the Medicare plans with the Independent/ Provider-Sponsored plans as the lowest.

One possible reason for the differences is the health condition of the members in each plan. The Medicare Advantage plans have the highest premiums PMPM, followed by the Independent/ Provider-Sponsored plans and the Blue Cross Blue Cross Blue Shield Plans.

The Medicare Advantage products offered by the three universes operate somewhat differently, as discussed below.

Sales and Marketing: Medicare-focused plans have much higher Sales and Marketing costs than Blue plans and IPS plans. Rating and Underwriting (which contains the HCC costs) is highest for the Medicare-focused plans, distantly followed by the IPS and Blue plans. Advertising costs are also higher in Medicare than for the other universes. The Internal Sales and Marketing function (as opposed to cluster) is lower for Blue plans and the IPS plans. By contrast, Blue and IPS plans rely more heavily on external brokers, reflected by higher Commissions than Medicare-focused plans.

Provider and Medical Management: Medicare plans have considerably higher costs in this cluster than their Blue or IPS peers. Medical

Management costs are the dominant costs in this function and they are much higher for the Medicare universe, followed by IPS and Blues, in that order. Medicare plans, when compared to Blues, emphasized Disease Management, Quality Components and Utilization Review. The Medicare universe's Provider Network Management and Services costs were slightly higher than in the other two universes.

Account and Membership Administration: Blues had the highest costs in this expense cluster by a wide margin over the Medicare plans. In order of importance, Blue plans had higher costs than their Medicare peers due to Claims, Customer Services, Enrollment and Information Systems.

Appendix A. Medicare Advantage Benchmark Summary
Medicare-Oriented Costs by Functional Area Cluster, 2011 Data
Per Member Per Month

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales and Marketing	$8.37	$22.89	$15.18	47.9%
Provider & Medical Management	7.22	13.72	7.91	100.4%
Account & Mem. Administration	11.17	24.83	15.39	71.2%
Corporate Services	5.35	18.00	8.52	85.4%
Total	$37.74	$77.04	$45.68	67.4%

**Account & Membership Administration Includes Rx, Mental Health, ICD-10 Information Systems*

Appendix B. Medicare Advantage Benchmark Summary
Medicare-Oriented Costs by Functional Area Cluster,
as a Percent Premiums or Equivalents, 2011 Data
Percent of Premium Equivalents

	25th PCTL	75th PCTL	Median	σ/ Mean
Sales and Marketing	2.2%	3.2%	2.5%	23.7%
Provider & Medical Management	1.4%	2.0%	1.8%	53.8%
Account & Mem. Administration	2.5%	3.4%	2.8%	38.0%
Corporate Services	1.0%	2.6%	1.4%	53.3%
Total	7.6%	10.6%	8.8%	29.6%

**Account & Membership Administration Includes Rx, Mental Health, ICD-10 Information Systems*

IPS plans had lower costs than Medicare plans for this cluster. But the resource mix was different. IPS plans had lower Information Systems costs but all other functions were lower than their Medicare counterparts, but their Enrollment costs were higher. Medicare-focused plans' Claims and Customer Services costs were also higher.

Corporate Services: Medicare-focused plans' Medicare Corporate Services costs were much higher than those of IPS plans and Blue plans. Every function was higher in this cluster than for Blue plans and the IPS plans. The Medicare plans' Corporate Services *functional* costs and Corporate Executive/Governance costs were especially high compared with the other universes.

Background on SEER

Forty-two health benefit organizations participated in this year's studies, and they collectively serve 43 million beneficiaries of comprehensive health programs. These participants are segmented into peer groups of Independent /Provider-Sponsored Plans, Larger Health Plans, Third Party Administrators, Blue Cross Blue Shield Plans, Medicaid Plans and Medicare Plans.

Now completing our sixteenth year benchmarking health benefit organizations, the 2013 benchmarks (containing 2012 data) comprise the cumulative experience of approximately 620 health plan years. Summary results of the various universes may be found on our web site www.sherlockco.com.

The *Sherlock Expense Evaluation Report* is a compilation of the results of surveys completed by each participant, who receives a copy of the report in exchange for its participation and other consideration. The benefit of the report to participants is its application for internal cost management; this voluntary participation promotes the accuracy of participant reporting. Sherlock Company reinforces accuracy through a series of checks and analyses intended to identify responses that are not in accordance with *SEER* definitions.

* Aggregate Medicare Figures on pages 2 and 3 have been corrected, and Sherlock participating trend comments on page 3 has been extended.