Plan Management Navigator

Analytics for Health Plan Administration

Healthcare Analysts

Douglas B. Sherlock, CFA
sherlock@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

John Park, CFA
jpark@sherlockco.com

Andrew L. Sherlock
asherlock@sherlockco.com

(215) 628-2289

Medicaid Administrative Cost Trends: Core Expenses Rebound From Last Year, increasing by 1.4%

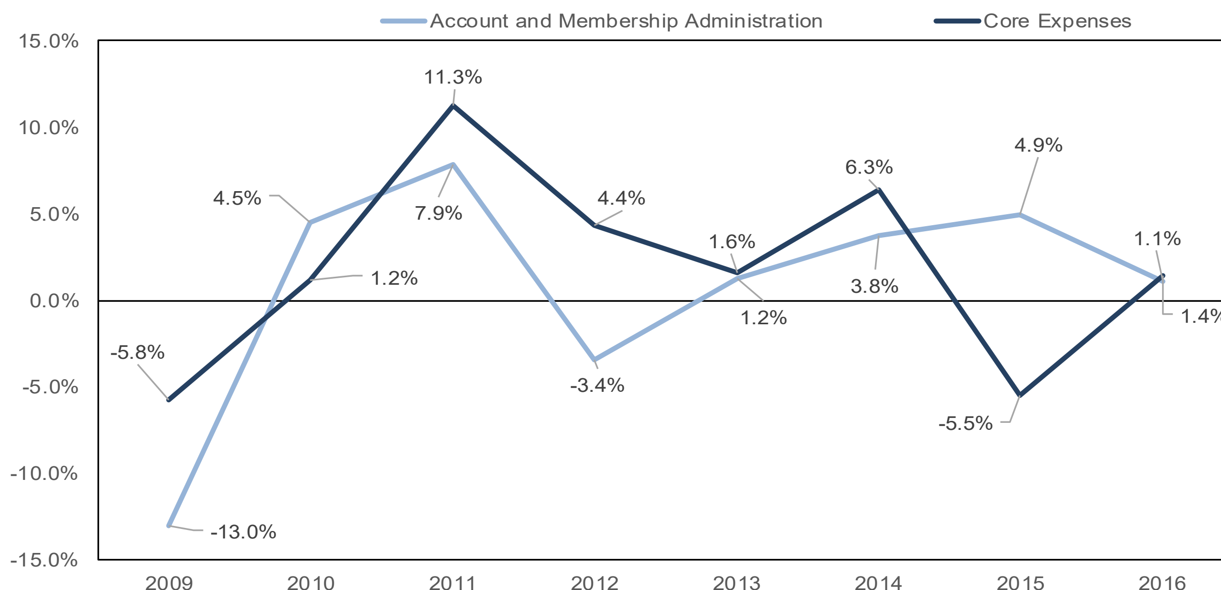
Summary

Total core expenses, PMPM, increased by 1.4% for selected Medicaid health plans, and increased by 1.1% for Account and Membership Administration. This is shown in Figure 1, drawn from the 2017 Sherlock Benchmarking Study. Core Expenses include all of the administrative activities of Medicaid-focused health plans, except those of the Sales and Marketing cluster. State laws governing Sales and Marketing for Medicaid vary so we separate activities like Sales, Marketing, Rating and Underwriting, Advertising and Promotion and Broker Commissions from Core costs to preserve comparability.

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 relative importance of Medicare versus Medicaid in the product portfolios of these health plans.

Background on Medicaid

One of the central purposes of the Affordable Care Act is to reduce the proportion of Americans without health insurance. As shown in Figure 2, based on the US Census Bureau analyses, *Health Insurance Coverage in the United States* (September 2017), the proportion of Americans uninsured declined from 13.3% to 8.8%, 4.6 percentage point decline, between 2013 and 2016. Subject to qualifications noted on the chart, of the 13.7 million newly covered, the 7.4 million additions to Medicaid comprised 53.7%.



COPYRIGHT © 2017. ALL RIGHTS RESERVED

The US Census Bureau estimates are directionally supported by Gallup. According to Gallup, the percent of people aged 18 and older who say that they are uninsured fell from 21.2% in the second quarter 2013 to 14.2% in the second quarter of 2017. While “Plan fully paid for by self or family member” comprised the largest increase, of the 3.9 percentage point increase, Medicaid comprised 2.4 percentage points of it.

The number of uninsured, however, increased from 2016 to 2017 by 0.9 percentage points. Much of this was driven by a 1.2 percentage point decline in the number of Plan Fully Paid for by Self or Family Member. According to Gallup, there were a few factors that may have contributed to the increase to the uninsured rate, noting rising insurance premiums from exchanges, coupled with “uncertainty” with ACA. Gallup states that “President Donald Trump's executive order permitting agencies to waive or delay provisions that ‘impose a fiscal burden’ on individuals, as well as the prospect of a new healthcare law may be causing consumers to question whether the penalty for not having insurance will be enforced.”

According to Kaiser Family Foundation (“KFF”) published in the April 2017 *Data Note: Medicaid Managed Care Growth and Implications of the Medicaid Expansion*, 39 states contract with Managed Care Organizations to deliver care to Medicaid beneficiaries. In 28 states “at least 75%” of all Medicaid beneficiaries were enrolled in Managed Care Organizations, while increasing to 90% in 10 of those 28 states. Total enrollment in Medicaid Managed Care Organizations includes 36.1 million beneficiaries.

Figure 2. Sherlock Benchmark Summary

Health Insurance Coverage in the United States

(000's)

	2013		2014		2015		2016		2016 Change	Percent Change	Cml. Change	Percent Change
Any Health Plan	271,606	86.7%	283,200	89.6%	289,903	90.9%	292,320	91.2%	2,417	0.8%	20,714	7.6%
Any Private Plan	201,038	64.1%	208,700	66.0%	214,238	67.2%	216,203	67.5%	1,965	0.9%	15,165	7.5%
Employment-based	174,418	55.7%	175,027	55.4%	177,540	55.7%	178,455	55.7%	915	0.5%	4,037	2.3%
Direct purchase	35,755	11.4%	46,165	14.6%	52,057	16.3%	51,961	16.2%	-96	-0.2%	16,206	45.3%
Any Government Plan	108,287	34.6%	115,470	36.5%	118,395	37.1%	119,361	37.3%	966	0.8%	11,074	10.2%
Medicare	49,020	15.6%	50,546	16.0%	51,875	16.3%	53,372	16.7%	1,497	2.9%	4,352	8.9%
Medicaid	54,919	17.5%	61,650	19.5%	62,384	19.6%	62,303	19.4%	-81	-0.1%	7,384	13.4%
Military health care	14,016	4.5%	14,143	4.5%	14,849	4.7%	14,638	4.6%	-211	-1.4%	622	4.4%
Uninsured	41,795	13.3%	32,968	10.4%	28,966	9.1%	28,052	8.8%	-914	-3.2%	-13,743	-32.9%
Total	313,401		316,168		318,869		320,372		1,503	0.5%	6,971	2.2%

Source: Health Insurance Coverage in the United States, https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf

Note: According to the analysis “Individuals are considered to be uninsured if they do not have health insurance coverage for the entire calendar year” and “The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.”

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Of 51 states, including the District of Columbia, 32 adopted the Medicaid expansion and 19 had not. According to KFF, most of the growth experienced in Medicaid Managed Care Organizations is attributed to expansion states. Of the 39 states that operate Managed Care Organizations, 27 are expansion states, while 12 are non-expansion states. In expansion states that reported both pre and post ACA data, MCO enrollment posted a median increase of 58% to 36.1 million. This compares to non-expansion states median increase of 46% to 10.8 million.

There were 10 organizations participating in this year's benchmarking study, of those, eight also participated last year. One of the new plans operated in an expansion state, while the other did not. Of the eight continuously participating plans, six operated in expansion states.

How We Performed This Analysis

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

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

Figure 3. Sherlock Benchmark Summary

Source of Insurance Coverage

	Q2 2013	Q2 2014	Q2 2015	Q2 2016	Q2 2017	2017 Change	Cml. Change
Current or Former Employer	44.4%	43.5%	43.4%	43.5%	43.8%	0.3%	-0.6%
Plan Fully Paid for by Self or Family Member	16.7%	20.7%	20.9%	21.8%	20.6%	-1.2%	3.9%
Medicaid	6.8%	8.4%	9.5%	9.6%	9.2%	-0.4%	2.4%
Medicare	6.4%	6.9%	7.6%	7.4%	7.3%	-0.1%	0.9%
Military / Veterans	4.3%	4.7%	4.9%	4.9%	4.7%	-0.2%	0.4%
A Union	2.8%	2.5%	2.5%	2.5%	2.4%	-0.1%	-0.4%
(Something Else)	3.8%	3.8%	4.1%	4.3%	4.6%	0.3%	0.8%
No Insurance	21.2%	16.2%	13.8%	13.3%	14.2%	0.9%	-7.0%

Source: U.S. Uninsured Rate Rises to 11.7%
http://www.gallup.com/poll/213665/uninsured-rate-rises.aspx

COPYRIGHT © 2017. ALL RIGHTS RESERVED

The selected plans served 8.8 million members of which 4.4 million were Medicaid HMO or Medicaid CHIP members. As a percent of revenues, Medicaid comprised 46%, on average. In addition, the detailed costs of 6 additional plans serving 964,000 Medicaid HMO members are included in the study. Collectively, Medicaid health plans with detailed cost information included in the Sherlock Benchmarks comprise 5.2 million Medicaid beneficiaries. For the most part, this *Plan Management Navigator* analysis focuses on the 10 plans in which a plurality of their business stems from Medicaid.

Reporting Conventions

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

- The trends reported in this analysis are median changes, and when we refer to PMPM or percent of premium ratios, these too are medians. This convention reduces the effect of outlying values on overall trends and values. Since each median value is calculated independently, the components cannot be summed. We will nevertheless reference sums of medians to provide a sense of direction.
- References to growth rates hold the universe constant in the comparison years unless otherwise noted. Rates of change that are called "as-reported" are of health plans participating during both comparison years. When we refer to "constant mix" we are calculating rates of change for that same set after reweighting the product mix to eliminate the effect of differences between the years. To be clear, Medicare Advantage, ASO and Medicaid are examples of products.
- Percent of premium ratios are calculated on a *premium-equivalent* basis. That is, in the case of ASO arrangements, we build to a premium from fees by adding them to the health benefits incurred by the self-insured group. In this way, premium equivalents sum to all of the expenses of health insurance, including profits earned by the health plan, analogous to actual premiums on insured products. While not in accordance with GAAP, this approach achieves comparability of presentation of ASO results with the insured products offered by these plans.
- Expenses exclude capital costs and investment income. Excluded expenses include interest, earnings (including dividends) and similar debt capital costs and other capital formation costs (debt or equity), including transaction costs and interest payments to providers under "prompt pay" laws.

COPYRIGHT © 2017. ALL RIGHTS RESERVED

- For Sherlock Benchmark licensees and participants, note that the values for Account and Membership Administration and Total Administrative costs reported here differ from those reported in the Benchmark reports. The values reflected here include administrative expenses associated with pharmacy and mental health, while the Sherlock Benchmarks do not. Because of variation in employer and other benefit designs and the propensity of the administration of these health services to be outsourced by plans accepting those management responsibilities, the Benchmark Reports carve them out. Pages 24 to 26 in Tab 2 of Volume I of the Sherlock Benchmarks reconcile these two presentations.

- Miscellaneous Business Taxes are a special case of administrative expenses since, short of recapitalization or elimination of commercial insured business, such expenses are impossible to manage. So expense trends, along with the PMPM and percent of premium ratios, are calculated *before* the effect of Miscellaneous Business Taxes. These taxes are primarily related to the Affordable Care Act. For commercial insured products, the median PMPM value of such taxes is $9.82 and the mean is $10.66, or approximately 16% of administrative costs. Such costs are essentially nil for ASO products. By way of comparison, in the 2011 benchmarks, the median Miscellaneous Business Tax for commercial insured products was $1.20 PMPM.

  The ACA fees include the Comparative Effectiveness Research Fee (CERF), Transitional Reinsurance Fee, Risk Adjuster User Fee, Exchange User Fee and Annual Fee on Health Insurers. The Annual Fee on Health Insurers is the largest generally applicable fee since it applies to all insured business and has a median value of $3.82. The Exchange User Fee only applies to Exchange members but the median fee for that population is $10.17.

  On a constant-mix basis, per member Miscellaneous Business Tax costs decreased by 1.8% PMPM, compared with an increase of 33.6% in 2015 and an increase of 617.7% in the year before.

Trends Overall and in Expense Clusters

Figure 4 outlines year-over-year trends on both an as-reported and constant mix basis. For the eight continuously participating plans, per member *Core* costs on a constant mix basis grew by 1.4% compared with a decline of 5.5% in the prior year. On an as-reported basis, core administrative costs grew by 3.9% versus a decline by 10.3% in the prior year.

Account and Membership Administration's growth slowed from an increase of 4.9% from last year to 1.1%. (Please see the trends on a constant-mix cost trends, shown in Figure 1). Enrollment / Membership / Billing's decline decelerated from a high single digit pace to low single digit, while Customer Services accelerated its decline from low single digit decline to a low double-digit decrease. Claim and Encounter Capture and Adjudication flipped from a drop last year to a mid-single digit increase. The growth in Information Systems slowed from a low double digit increase to a low single digit growth.

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Corporate Services cluster reversed from a high single digit decline last year to a 2.1% increase. Corporate Executive and Governance and the Corporate Services function decelerated their declines, while the small Actuarial function drop accelerated. Finance and Accounting flipped from a low double digit drop to a low single digit gain, while Association Dues and License / Filing Fees flipped from a slight growth to a decrease.

Medical and Provider Management was the only cluster to post a decline for Medicaid plans, falling by 2.1% compared to last year's 4.5% decrease. Medical Management, the larger of the two functions in this cluster, flipped from a mid-single digit drop to a mid-single digit growth. Provider Network Management and Services fell from a mid-single digit gain to zero growth. (Because of our definitions and checks, we think we have eliminated any MLR-related reporting bias in this and other expenses.)

As noted previously, Sales and Marketing is not included as a Core expense. Nevertheless, this cluster is central to the Commercial and Medicare products that are offered by these Medicaid-focused plans. Sales and Marketing expenses grew by 0.9% from a decrease of 5.3% last year. The Sales function and Marketing function each flipped from declines last year to increases this year. Rating and Underwriting fell by low single digits compared to the low double digit increase last year. Advertising and Promotion slowed its decline from a high single digit drop to a low single digit decrease. External Broker Commissions grew at a similar single digit rate as the prior year.

THE EFFECT OF MIX

Note that in Figure 4 the overall rate of change in the constant mix values lags that of the as-reported growth. This implies that the universe product-mix shifted towards higher cost products in 2016. The constant mix comparisons back that effect out. Trends excluding the effects of changes in product mix is a more accurate representation of true trends in our view.

Figure 4. Sherlock Benchmark Summary

Medicaid Plans' Median Changes in Per Member Per Month Expenses

	2015 Data		2016 Data	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	-2.8%	-4.5%	2.5%	-2.1%
Account and Membership Administration	6.0%	4.9%	1.0%	1.1%
Corporate Services	-9.4%	-9.2%	4.8%	2.1%
Subtotal: Core Expenses	-10.3%	-5.5%	3.9%	1.4%
Sales and Marketing	-6.2%	-5.3%	-0.3%	0.9%
Total Expenses	-4.1%	-5.8%	4.0%	2.7%

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Health plans participating during both 2016 and 2017 posted median membership growth of 10.5%. Membership in lower cost Medicaid also increased by 10.5%. Medicare SNP increased by 19.9% as Medicare Advantage membership increased by 0.4%. Commercial Total grew by 5.6%, the more expensive Insured products increased by 12.6%, while the less expensive ASO grew by 0.8%.

AS-REPORTED INCREASE

Figure 4 also shows the continuous plan trends on an as-reported basis. The rates of growth were generally faster compared to the constant-mix basis. As-reported growth trends were faster for Corporate Services *cluster* and Medical and Provider Management. Conversely, Account and Membership Administration was slightly slower, while the rate of change for Sales and Marketing declined on an as-reported basis.

The Corporate Services cluster increased by 4.8% compared to the decline of 9.4% last year. Finance and Accounting grew the fastest in this cluster after posting double digit declines last year. The Medical and Provider Management cluster increased by 2.5% up from last year's decrease of 2.8% with Medical Management posting growth compared to a drop in the prior year. The Account and Membership Administration cluster increased 1.0% versus a 6.0% growth last year. Customer Services experienced a decline from an increase last year, while Information Systems slowed its increase compared to last year.

Outsourcing appears to be slightly more prevalent this year compared with last year. Functions that showed notable increases in propensity to outsource included Marketing, Precertification, Quality Components, Printed Materials, Operations and Support Services, Applications Maintenance, All Other Legal, and Imaging. In total, the median percent of FTEs outsourced was 16.0%. Regarding outsourcing, there are differences in universes between this and the last survey.

Notwithstanding cost trends, staffing ratios appears to have increased for Medicaid HMO products. Overall, including outsourced FTEs, Medicaid HMO staffing ratios' median value of 21 per 10,000 compared with 18 last year. Again, these staffing ratio comparisons do not adjust for differences in the universes between the two years.

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Costs of Medicaid-Focused Plans, by Cluster, PMPM

Figure 5 shows the values of administrative expenses for all 10 participating plans. Bear in mind that this universe of Medicaid-focused plans is different from that of last year in product mix and in populations. In this section, we'll touch on comparisons with the results reported last year, notwithstanding this limitation. The prior year's values are shown in Appendix A.

The values were similarly dispersed when compared to last year for Core clusters. The Coefficient of Variation was 0.1 percentage points higher for Core expenses. Corporate Services cluster was 2.9 percentage points lower, but Medical and Provider Management was 2.9 percentage points higher and Account and Membership Administration was 1.4 percentage points higher.

Including the Sales and Marketing cluster, total expenses became less dispersed with the Coefficient of Variation falling by 4.7 percentage points and the Sales and Marketing cluster experiencing a drop of 8.8 percentage points.

Account and Membership Administration is the largest cluster of expenses at a median value of $15.30 versus $13.74 last year and comprised approximately 37% of total administrative expenses. This cluster includes the central activities of Information Systems, Enrollment, Claims, and Customer Services.

The Corporate Services *cluster* expenses were $6.17, higher than last year's value of $5.70. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities like Facilities, HR and Legal.

Medical and Provider Management costs per member per month were $7.32 and higher by 1.8% compared to last year. This group of functions includes Provider Network Management and Services and Medical Management.

Sales and Marketing costs were $7.65. Last year's value was $8.56. This function includes Rating and Underwriting, Sales, Marketing, Broker Commissions and Advertising. Total expenses including Sales and Marketing costs were $36.26, 2.1% higher than last year.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2016 Data
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$6.04	$7.32	$7.92	25%
Account and Membership Administration	11.60	15.30	17.53	32%
Corporate Services	5.56	6.17	6.41	17%
Subtotal: Core Expenses	$23.50	$29.56	$31.32	21%
Sales and Marketing	$6.26	$7.65	$10.59	43%
Total Expenses	$34.32	$36.26	$38.30	19%

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Costs of Medicaid-Focused Plans, PMPM by Product

The importance of considering both product mix and the product cost values is shown in Figure 6. The products vary greatly in their per member costs.

Medicare and Medicaid are government-sponsored products serving seniors and the poor and disabled. Among the comprehensive products, Medicaid products are relatively low cost, at median PMPM values of $26.57 for HMO and $26.65 for CHIP. Medicare products are relatively high-cost at $85.68 and $140.41 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. We believe that approximately 80% of Medicare SNP are people who are eligible for both Medicare and Medicaid. Medicare Cost expenses were $62.78 PMPM. Medicare expenses this year were higher than last year.

Administrative expenses for Commercial costs are both higher and lower than the median Comprehensive administrative costs, depending on the financing mechanism. (Financing is also a rough proxy for group size since only large groups can self-insure.) Commercial insured products were greater than the median for comprehensive products. The median for commercial insured products was $41.75 PMPM. Commercial Insured HMO totaled $43.85 PMPM, Indemnity and PPO costs were $42.89, and POS costs were $47.97.

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2016 Data
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$22.43	$25.70	$33.71	40%
HMO	$22.31	$26.57	$34.27	41%
CHIP	$19.45	$26.65	$36.45	46%
Medicare	$81.14	$86.86	$125.00	68%
Advantage	$77.55	$85.68	$112.20	25%
SNP	$136.89	$140.41	$208.58	49%
Cost	$62.78	$62.78	$62.78	NM
Commercial Insured Total	$27.79	$41.75	$48.02	26%
HMO	$34.08	$43.85	$48.83	24%
POS	$44.16	$47.97	$48.46	61%
Indemnity & PPO	$30.87	$42.89	$52.21	37%
Commercial ASO	$21.43	$22.08	$24.81	15%
Medicare Supplement	$29.56	$33.89	$42.28	40%
Comprehensive Total	$34.32	$36.26	$38.30	19%

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Commitment to ASO products represented 12% of comprehensive members. Their costs are lower than for comparable insured products largely due to the modest per member Sales and Marketing expenses required for large groups that are eligible to use these products. Total ASO costs are $22.08 PMPM, half the cost of similar insured products. (This universe does not distinguish between various forms of Commercial ASO products.)

Medicare Supplement is lower than average cost product at $33.89 PMPM. We include this as a Comprehensive product in the Sherlock Benchmarks though it pays only when Medicare does not.

Costs of Medicaid-Focused Plans, Percent of Premiums by Product

The ranking of the costs as a percent of premiums was similar to those of the PMPM costs, with some important exceptions. While Medicare Supplement was lower than average when measured by PMPM, at 15.9%, its expense ratio was *the* highest among the comprehensive products, which had a median value of 8.4%. Also, CHIP expenses were relatively low PMPM, but as a percent of premiums, at 12.5%, were relatively high. Most other percent of premiums correspond directionally with the PMPM values.

Medicare Advantage costs, while many times higher measured by PMPM, has a median percent of premium ratio of 9.6%. Medicare SNP, at 11.1%, slightly higher than average compared to comprehensive total but almost 4 times higher when calculated in PMPM. Medicare Cost expenses were 14.6% of premiums.

Figure 7. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2016 Data
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	6.7%	7.5%	8.5%	28%
HMO	6.7%	7.5%	8.1%	27%
CHIP	8.0%	12.5%	14.5%	36%
Medicare	8.8%	11.0%	13.0%	32%
Advantage	8.3%	9.6%	11.7%	22%
SNP	8.3%	11.1%	18.5%	51%
Cost	14.6%	14.6%	14.6%	NM
Commercial Insured Total	9.0%	9.7%	10.7%	13%
HMO	9.3%	9.4%	9.8%	19%
POS	8.6%	10.6%	11.2%	45%
Indemnity & PPO	8.7%	10.0%	11.3%	22%
Commercial ASO	4.9%	5.9%	7.2%	27%
Medicare Supplement	9.5%	15.9%	16.1%	50%
Comprehensive Total	7.8%	8.4%	9.5%	15%

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Commercial insured products ranged from 9.4% of premiums to 10.6% of premiums. HMO expenses were 9.4%, Indemnity expenses were 10.0%, and POS expenses were 10.6%. On a PMPM basis, these costs were slightly higher than average. Also, Commercial ASO products were 5.6% of premiums and had low PMPM costs.

Medicaid HMO was below average in PMPM costs and, at 7.5%, was also below average as a percent of premiums.

Costs of Medicaid-Focused Plans, Clusters as a Percent of Premiums

Figure 8 shows the ratios of administrative expenses to premiums or equivalents. Account and Membership Administration expenses were 3.7% of premiums, down by 0.1 percentage point last year. Medical and Provider Management was lower by 0.1 percentage point from last year to 1.6%, while the Corporate Services Cluster was 1.5%, down by 0.4 percentage points. Core expenses were 6.8% of premiums, which is up by 0.2 percentage points. Sales and Marketing costs were 1.9% of premiums, relatively flat from last year. Total expenses including Sales and Marketing comprised 8.4% of premiums, lower by 0.2 percentage points.

Comparisons Across Universes

Health plans in other Sherlock Benchmark universes also offer Medicaid HMO products. In this section, we compare the results of the Medicaid HMO products offered by Blue Cross Blue Shield Plans and Independent/Provider-Sponsored plans to those of organizations focused on Medicaid. We define "focused" to be those plans that have a disproportionate commitment to the Medicaid product. The mean percent of revenues from Medicaid products for the Medicaid-focused plans was 46%, with 32% and 55% at the 25th and 75th percentile values, respectively.

Since the data definitions are the same, it is possible to directly compare our Medicaid universe with Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans. Together, these three universes serve 5.2 million Medicaid HMO members.

Figure 8. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2016 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.5%	1.6%	1.7%	27%
Account and Membership Administration	3.1%	3.7%	4.1%	30%
Corporate Services	1.3%	1.5%	1.6%	23%
Subtotal: Core Expenses	5.9%	6.8%	7.9%	22%
Sales and Marketing	1.5%	1.9%	2.2%	34%
Total Expenses	7.8%	8.4%	9.5%	14.9%

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Shown in Figure 9, compared with the Medicaid plans, Medicaid HMO Core expenses for Blue Cross Blue Shield Plans cost $25.97 more than Medicaid plans, while 7 percentage points greater on a percent of premiums basis. IPS plans were lower by $6.93 compared to Medicaid plans, but higher by 1.4 percentage points on a percent of premium basis.

Expenses including Sales and Marketing were similar to Core expense comparisons. Blue Cross Blue Shield Plans were $25.57 PMPM higher than Medicaid plans and 7 percentage points on a percent of premiums basis. IPS plans were $8.35 PMPM lower, while higher by 1 percentage points on a percent of premiums basis.

There is variation between the plans but IPS plans tend to have lower Medical and Provider Management in the Medicaid HMO product compared to Medicaid-focused plans. Blue Cross Blue Shield Plans tend to have higher expenses in Account and Membership Administration expenses relative to Medicaid-focused plans.

The Medicaid plans' health benefit ratio was 92.9%, lower than Blue Cross Blue Shield Plans at 95.1%, but higher compared to the 81.3% for IPS plans.

Figure 9. Sherlock Benchmark Summary

Medicaid HMO Product Characteristics by Universe, 2016 Data

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$20.30	$16.85	$43.21	$17.69
Median	23.99	17.06	49.96	23.38
75th Percentile	30.27	18.83	56.71	32.13
Coefficient of Variation	38%	18%	38%	48%
Percent of Premiums and Equivalents				
25th Percentile	6.1%	6.5%	10.9%	6.1%
Median	6.6%	8.0%	13.5%	7.1%
75th Percentile	7.4%	9.6%	16.1%	9.2%
Coefficient of Variation	26%	26%	54%	42%
Total Costs				
Per Member Per Month				
25th Percentile	$22.31	$17.89	$45.47	$19.12
Median	26.57	18.23	52.14	24.55
75th Percentile	34.27	20.10	58.82	35.72
Coefficient of Variation	41%	17%	36%	48%
Percent of Premiums and Equivalents				
25th Percentile	6.7%	7.0%	11.5%	7.0%
Median	7.5%	8.5%	14.1%	7.7%
75th Percentile	8.1%	10.2%	16.6%	10.0%
Coefficient of Variation	27%	25%	52%	39%
Plans Offering Medicaid	10	4	2	16
Medicaid HMO Members (millions)	4.26	0.31	0.65	5.22
Comprehensive Total Members (millions)	8.80	2.10	16.17	27.07

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Note on the Sherlock Benchmarks

These results are excerpted from the Medicaid Edition of the 2017 *Sherlock Benchmarks*. The results are based on our detailed surveys of 2016 operating parameters of 10 Medicaid-focused plans serving 8.8 million members. Much more information is available by licensing the *Sherlock Benchmarks*.

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

Including all of Sherlock Benchmarks, those published in 2017 will reflect the experience of approximately 780 health plan years. In addition to the Medicaid-focused universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Larger Health Plans, Independent/Provider-Sponsored Plans and Medicare Plans. We reported on the Blue Cross Blue Shield Plans, Independent/Provider-Sponsored Plans, Larger Plans, and Medicare Plans earlier this year.

Appendix A. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2015 Data
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$6.24	$7.19	$8.64	22%
Account and Membership Administration	12.36	13.74	16.48	30%
Corporate Services	5.23	5.70	6.73	20%
Subtotal: Core Expenses	$24.02	$29.06	$30.37	21%
Sales and Marketing	$4.48	$8.56	$10.56	52%
Total Expenses	$32.34	$35.50	$40.31	24%

Appendix B. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2015 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.4%	1.7%	2.0%	28%
Account and Membership Administration	2.9%	3.8%	3.9%	25%
Corporate Services	1.7%	1.9%	2.1%	16%
Subtotal: Core Expenses	6.2%	6.6%	7.4%	18%
Sales and Marketing	1.2%	1.9%	2.3%	43%
Total Expenses	7.8%	8.6%	8.7%	13.0%

COPYRIGHT © 2017. ALL RIGHTS RESERVED

Appendix C. Sherlock Benchmark Summary

Functions Included in Each Administrative Expense Cluster

Core Functions:

Provider & Medical Management

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

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

Account & Membership Administration

Enrollment / Membership / Billing
- (a) Enrollment and Membership
- (b) Billing

Customer Services
- (a) Member Services
- (b) Printed Materials and Other

Claim and Encounter Capture and Adjudication
- (a) Coordination of Benefits (COB) and Subrogation
- (e) Other Claim and Encounter Capture and Adjudication

Information Systems Expenses
- (a) Operations and Support Services
- (b) Applications Maintenance
  - (1) Benefit Configuration
  - (2) All Other Applications Maintenance
- (c) Applications Acquisition and Development
- (d) Security Administration and Enforcement

Corporate Services

Finance and Accounting
- (a) Credit Card Fees
- (b) All Other Finance and Accounting

Actuarial

Corporate Services Function
- (a) Human Resources
- (b) Legal
  - (1) Compliance
  - (3) All Other Legal
- (c) Facilities
- (e) Audit
- (f) Purchasing
- (g) Imaging
- (h) Printing and Mailroom
- (i) Risk Management
- (j) Other Corporate Services Function

Corporate Executive and Governance

Association Dues and License/Filing Fees

Non-Core Functions:

Sales & Marketing

Rating and Underwriting
- (b) Risk Adjustment
- (c) All Other Rating and Underwriting

Marketing
- (a) Product Development and Market Research
- (b) Member and Group Communication
- (c) Other Marketing

Sales
- (a) Account Services
- (b) Internal Sales Commissions
- (c) Other Sales

External Broker Commissions

Advertising and Promotion
- (a) Media and Advertising
- (b) Charitable Contributions

COPYRIGHT © 2017. ALL RIGHTS RESERVED.