Plan Management Navigator
Analytics for Health Plan Administration

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Medicare Advantage Plan Administrative Cost Trends: First Overall PMPM Cost Growth Since 2013

Summary

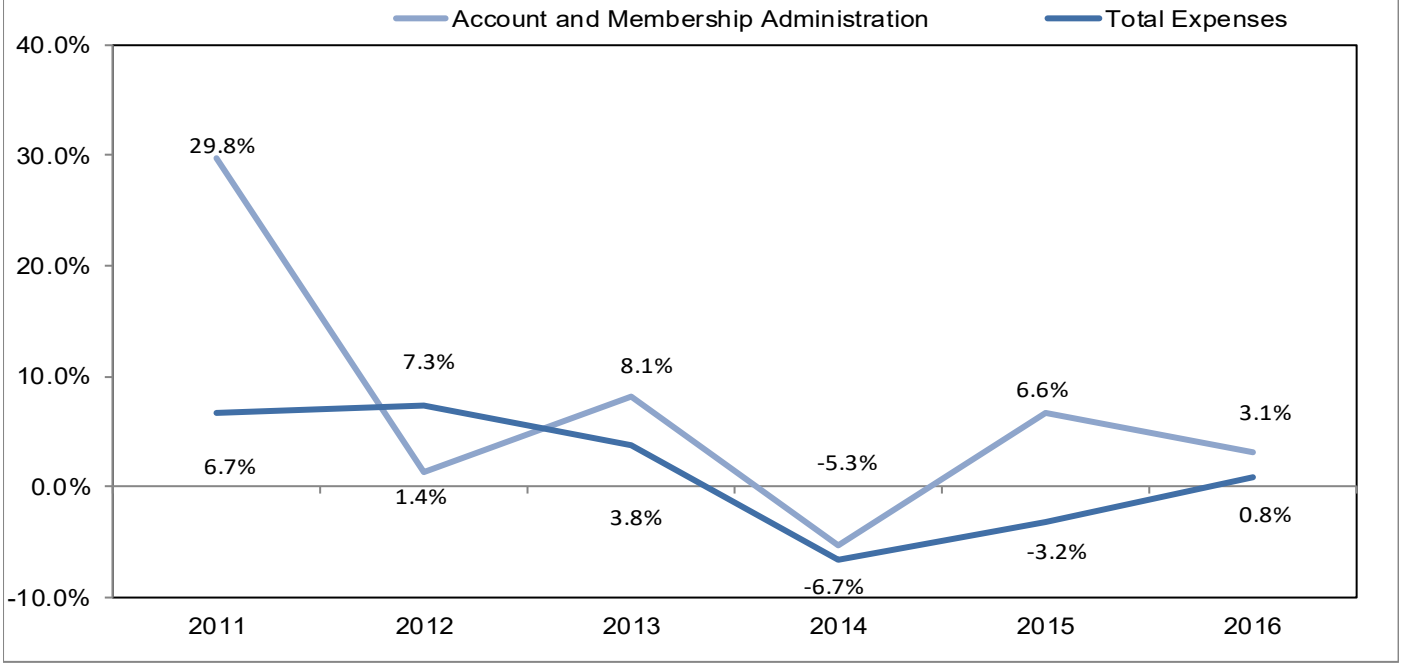
Total expenses, PMPM, increased by 0.8% for selected Medicare health plans, and increased by 3.1% for Account and Membership Administration. On an as-reported basis, costs grew by a slower rate, 0.1%. This is shown in Figure 1, drawn from the 2017 Sherlock Benchmarking Study for Medicare Plans. Rates of growth for Total Expenses have been trending higher since 2014, while Account and Membership growth was the third lowest since 2011.

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.

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.

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

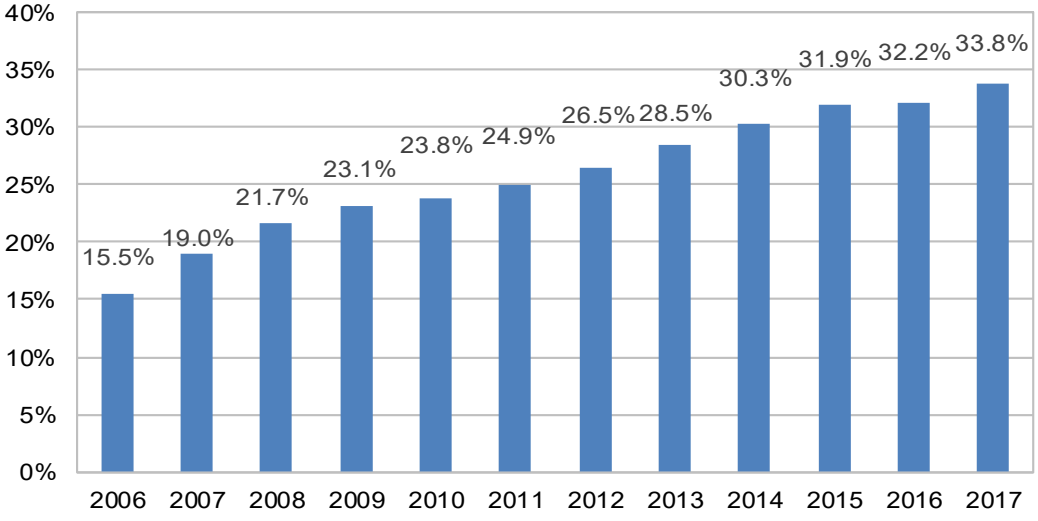


As of March 2017, according to the CMS State/County Penetration file, Medicare Advantage plans served 19.6 million people of the 58.1 million eligible. The proportion of eligible Medicare members selecting Medicare Advantage increased to 33.8% in March of 2017 from 32.2% in 2016. Please see Figure 2. Membership increased by 7.7% from 18.2 million in March of 2016. By contrast, the number of people eligible for Medicare but electing the Fee-For-Service ("FFS") program increased by 0.2% during that period.

Membership growth accelerated notwithstanding that, 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., 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 that Medicare Advantage growth could, by stimulating lower costs for FFS, reduce the ability of MA plans to offer the additional benefits that attract seniors. In other words, growth has overcome a headwind.

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 June 2017, believes that membership in "Group Plan Enrollment" will be 31 million in 2027. 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 33.8% in 2017. In every year since 2005, except for 2016, the net number of people joining MA plans exceeded those joining FFS Medicare. Membership in FFS declined from 2006 through 2009. While there are 15 million more people eligible for Medicare, the number of people served by Medicare FFS is now 800,000 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 2017 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 90% of what Medicare pays, and for MA HMOs, that ratio is 88%. (HMOs comprised 11.7 million or 66.9% of all Medicare Advantage beneficiaries as of November 2016.) *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, but it lacks incentives to coordinate care and is limited in its ability to modify care delivery."

In addition to this evident underlying cost advantage, MA plans enjoy subsidies not available through Medicare Supplement policies. In 2017, MA plans are projected to be paid 106% 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 2017.) 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 the low income beneficiaries noted in the 2011 AHIP study.

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 fourteenth 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. Six of this year's participants participated in the prior year.

The selected plans served 4.0 million members of which 692,000 were Medicare Advantage or Medicare SNP Members. As a percent of revenues, Medicare comprised 47%, on average. In addition, the detailed costs of up to 16 additional plans serving 1.2 million Medicare Advantage members are included in the study. Collectively, Medicare Advantage health plans with detailed cost information included in the Sherlock Benchmarks comprise 1.9 million MA beneficiaries or greater than 10.3% of the total MA membership as of March 2016. For the most part, this *Plan Management Navigator* analysis focuses on the 10 plans in which a plurality of the business stems from MA.

REPORTING CONVENTIONS

We use several conventions intended to make the metrics most useful and intelligible 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.

- For Sherlock Benchmark licensees and participants, note that the values for Account and Membership Administration and Total Administrative costs reported here will 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 variation in employer 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 22 to 24 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 $10.84 and the mean is $11.12, or approximately 13% of administrative costs. Such costs are essentially nil for ASO products. By way of comparison, in 2010, the median Miscellaneous Business Tax for commercial insured products was $2.25 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 $4.39. The Exchange User Fee only applies to Exchange members but the median fee for that population is $12.24.

  On a constant-mix basis, per member Miscellaneous Business Tax costs increased by 9.0% PMPM, compared with an increase of 20.8% in 2015 and down from the surge of 3,224.6% in the year before.

Trends Overall and in Expense Clusters

Figure 3 outlines year-over-year trends on both an as-reported and constant mix basis. For the six continuously participating plans, per member costs on a constant mix basis grew by 0.8% compared with a decline of 3.2% the prior year.

Account and Membership Administration decelerated to an increase of 3.1% from an increase of 6.6%, the third lowest since 2011 (please see the trends on a constant-mix cost trends, shown in Figure 1). Enrollment, Membership, and Billing flipped from a single digit increase to a high single-digit pace, while Customer Services accelerated its decline from a low single-digit decline to a low double-digit drop. Claim and Encounter Capture and Adjudication grew at the fastest rate in this cluster, while Information Systems was most responsible for this cluster's growth.

Corporate Services *cluster* growth accelerated sharply from a decline of 11.5% to an increase of 14.6%. Finance and Accounting was the only function to decline in this cluster, while Actuarial, the Corporate Services *Function*, Corporate Executive, and Association Dues and License / Filing Fees each grew by double-digit rates. The Corporate Services function, because of its size, was responsible for most of the cluster's change.

Medical and Provider Management was the only cluster that posted a decline, falling by 3.1% and compares to last year's 9.9% drop. Medical Management, the larger of the two functions in this cluster, slowed its decline from double-digits last year to single-digit this year. Provider Network Management also declined at a single-digit rate. (Because of our definitions and checks, we think we have eliminated any MLR-related reporting bias in this and other expenses.)

Sales and Marketing grew by 4.2% PMPM, up from the 4.0% *decline* in the prior year. The Marketing functional area grew at the fastest rate, but Commissions reflected the plurality of the growth trend in the cluster due to its size. Sales and Advertising and Promotion grew at a single-digit rate, while Rating and Underwriting declined for the fourth year in a row.

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

	2015 Data		2016 Data	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	-1.6%	-4.0%	6.3%	4.2%
Provider & Medical Management	-7.7%	-9.9%	-3.4%	-3.1%
Account & Membership Administration	6.0%	6.6%	3.8%	3.1%
Corporate Services	-10.5%	-11.5%	13.9%	14.6%
Total Expenses	-4.1%	-3.2%	0.1%	0.8%

The Effect of Mix

Note that in Figure 3 the overall rate of change in the constant mix values exceeds that of the as-reported growth. This implies that, while the universe tilted towards lower cost products, 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.

Health plans participating during both 2016 and 2017 posted median membership growth of 7.1%. Membership in lower cost Medicaid increased by 12.7%. Medicare SNP increased by 10.7% as Medicare Advantage membership increased by 1.9%. Commercial Total fell by 1.0%, the more expensive Insured products fell by 2.9%, while the less expensive ASO grew by 0.8%.

The growth patterns in Sales and Marketing likely reflect the increased emphasis on Medicare. Medicare members, as individuals, have higher marketing costs.

As-Reported Increase

Figure 3 also shows the continuous plan trends on an as-reported basis. The rates of change and their importance are faster for Sales and Marketing and Account and Membership Administration. As-reported growth trends were slower for Corporate Services *Cluster*, while the decline was slightly greater in Provider and Medical Management.

Overall Information System was the largest contributor to the Account and Membership Administration cluster's growth because of the function's importance. Broker commissions declined slightly, compared to an increase on a constant mix basis. For the Medical and Provider Management cluster and Corporate Services *Cluster* grew similarly on both an as-reported and constant mix-basis.

Outsourcing appears to be slightly more prevalent this year compared with last year. Functions that showed notable increases in propensity to outsource included Other Claim and Encounter Capture and Adjudication, Actuarial, Human Resources, Purchasing, Risk Management, and Other Corporate Services Function. In total, the median percent of FTEs outsourced was 12.8%. We did not adjust to eliminate differences in universes between this and last survey.

Notwithstanding cost trends, staffing ratios appears to have declined for Medicare Advantage products. Overall, including outsourced FTEs, Medicare Advantage staffing ratios' median value of 48 per 10,000 members compared with 45 last year.

Other Claim and Encounter Capture and Adjudication posted the sharpest decline, while Other Sales experienced the strongest growth. Again, these columns do not adjust for differences in the universes between the two years.

Costs of Medicare-Focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 10 participating plans. Bear in mind that this universe of Medicare-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. All cluster values were lower except Sales and Marketing.

The values appeared to be slightly less dispersed, but that varied by cluster. The Coefficient of Variation was one percentage point lower overall, but sharply lower in Medical and Provider Management, lower in Sales and Marketing and Account and Membership Administration. Corporate Services, however, experience wider dispersion.

Account and Membership Administration was the single greatest cluster of expenses at a median value of $17.16 and comprised about 40% of total expenses. This helps to explain its substantial effect on overall trend. The size of this function includes the central activities of Information Systems, Enrollment, Claims and Customer Services. Comparing this with last year, the costs were slightly lower and less dispersed.

Sales and Marketing, the second largest cluster, had costs with a median value of $12.38. Last year's value was $11.25. This function includes Rating and Underwriting, Sales, Marketing, Broker Commissions and Advertising.

The Corporate Services *Cluster* was lower than last year at $7.46. 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 $7.22 and lower by 15% compared to last year. This group of functions includes Provider Network Management and Services and Medical Management.

Figure 4. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2016 Data
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$10.64	$12.38	$15.68	50%
Medical and Provider Management	6.87	7.22	7.84	18%
Account and Membership Administration	15.18	17.16	20.29	31%
Corporate Services	6.38	7.46	9.01	36%
Total Expenses	$37.14	$42.76	$51.56	28%

Costs of Medicare-Focused Plans, PMPM by Product

The importance of considering both product mix and the product cost values is shown in Figure 5. The products vary greatly in their per member costs. The median mix of commercial products was slightly greater than half of the Comprehensive membership. Administrative expenses for these 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 besides Indemnity and PPO were lower than the median for comprehensive products. The median commercial product's cost is $35.76 PMPM. Commercial Insured HMO totaled $41.20 PMPM. Indemnity and PPO costs $47.99 while POS costs $41.63.

Commitment to ASO products represented 18% 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 $22.53 PMPM, half the cost of similar insured products. (This universe does not distinguish between various forms of Commercial ASO products.)

Note that Medicare Supplement is greater than average cost product at $61.26 PMPM. We include this as a Comprehensive product in the Sherlock Benchmarks though it pays only when Medicare does not.

Figure 5. Sherlock Benchmark Summary
Medicare Plans' Costs by Product, 2016 Data
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	$65.13	$81.11	$85.70	30%
Advantage	$64.95	$77.60	$84.55	30%
SNP	$114.01	$125.17	$131.03	14%
Medicaid Total	$18.50	$23.85	$27.55	27%
HMO	$18.50	$24.23	$28.92	29%
CHIP	$14.85	$17.40	$21.50	36%
Commercial Insured Total	$31.16	$35.76	$40.65	20%
HMO	$37.86	$41.20	$47.61	18%
POS	$38.33	$41.63	$48.28	20%
Indemnity & PPO	$38.63	$47.99	$52.08	28%
Commercial ASO	$19.75	$22.53	$26.20	34%
Medicare Supplement	$45.63	$61.26	$69.68	61%
Comprehensive Total	$37.14	$42.76	$51.56	28%

Medicare and Medicaid are government-sponsored products serving seniors and the poor and disabled. Medicare products are relatively high-cost at $77.60 and $125.17 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. Medicare expenses this year were slightly lower than last year.

Among the comprehensive products, Medicaid products are relatively low cost, at median PMPM values of $24.23 for HMO and $17.40 for CHIP.

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

The ranking of the costs as a percent of premiums varied from those of the PMPM costs, with some important exceptions. While Medicare Supplement was higher than average when measured by PMPM, at 27.7%, its expense ratio was *the* highest among the comprehensive products, which had a median value of 8.6%.

Medicare Advantage costs, while many times higher measured by PMPM, has a median percent of premium ratio of 8.3%. Medicare SNP, at 9.2%, effectively average compared to comprehensive total but about 3 times higher when calculated in PMPM.

Commercial insured products ranged from 9.1% of premiums to 11.1% of premiums and was 10.0% overall higher than average. Costs for these products are lower than average on a PMPM basis.

Figure 6. Sherlock Benchmark Summary
Medicare Plans' Costs by Product, 2016 Data
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	7.6%	8.6%	9.4%	30%
Advantage	7.6%	8.3%	9.5%	31%
SNP	8.8%	9.2%	10.1%	15%
Medicaid Total	7.1%	7.2%	7.5%	17%
HMO	7.1%	7.2%	7.3%	17%
CHIP	7.1%	7.2%	8.8%	24%
Commercial Insured Total	8.8%	10.0%	11.5%	16%
HMO	9.2%	9.8%	10.2%	19%
POS	7.7%	9.1%	10.0%	28%
Indemnity & PPO	8.3%	11.1%	12.2%	34%
Commercial ASO	4.7%	6.6%	7.6%	37%
Medicare Supplement	26.0%	27.7%	29.2%	65%
Comprehensive Total	7.8%	8.6%	9.3%	16%

Most other percent of premiums correspond directionally with the PMPM values. Medicaid HMO was below average in PMPM costs and at 7.2%, was also below average as a percent. Medicaid CHIP, was also below average by PMPM, and was also 7.2% as a percent of premiums. Also, Commercial ASO products were 6.6% of premiums and also had low PMPM costs.

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

Figure 7 shows the ratios of administrative expenses to premiums or equivalents. Administrative expenses were 8.6% of premiums while last year's equivalent value was also approximately 8.6%. Corporate Services and Medical and Provider Management were slightly lower by 0.7 percentage points to 1.5% and lower by 0.2 percentage points to 1.4%, respectively. Account and Membership Administration was down by 0.1 percentage point to 3.3%, while Sales and Marketing was up by 0.3 percentage points to 2.6% of revenues.

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 for the Medicare-focused plans was 40%, with 32% and 54% at the 25th and 75th percentile values, respectively.

Not included in the comparisons in Figure 8 are members served through SNP products, Medicare Advantage products served by Medicaid Plans, and Medicare Cost contracts. These products serve 30,000 members in the universe and 299,000 members in all universes. Collectively, the Sherlock Benchmarks include the results of 1.9 million people or 10.3% of all Medicare Advantage members in March 2016. Including these other products and other universes, Sherlock Benchmarks reflect the performance of 2.2 million people or 11.8% of all MA members in March 2016.

Figure 7. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2016 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.0%	2.6%	3.3%	32%
Medical and Provider Management	1.2%	1.4%	1.5%	15%
Account and Membership Administration	2.8%	3.3%	3.5%	29%
Corporate Services	1.3%	1.5%	1.6%	25%
Total Expenses	7.8%	8.6%	9.3%	16%

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 1.9 million Medicare Advantage members.

Shown in Figure 8, compared with the Medicare plans, Blue Cross Blue Shield Plans cost $16.09 more than the Medicare Plans and, measured as a percent of premiums, were 3.0 percentage points less. The IPS plans were higher 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 generally had higher Sales and Marketing, Medical and Provider Management, and Account and Membership Administration Medicare expenses compared to Independent/Provider-Sponsored plans. Medicare Advantage expenses for Corporate Services *cluster*, however, were higher for the IPS plans. Medicare-focused plans generally held a cost advantage over both universes for all clusters. Again, there is a great deal of variation between the plans.

The Medicare plans had somewhat lower health benefit ratios with a median of 88% versus 105% for Independent / Provider – Sponsored plans and 89% for Blue Cross Blue Shield Plans.

Details on costs of MA products sold by other universes are included with the Sherlock Benchmarks for Medicare plans.

Figure 8. Sherlock Benchmark Summary

Medicare Advantage Product Characteristics by Universe, 2016 Data

	Medicare Plans	IPS Plans	BCBS Plans	Combined Plans
Total Costs				
Per Member Per Month				
25th Percentile	$64.95	$85.78	$73.51	$73.54
Median	77.60	119.63	93.69	83.41
75th Percentile	84.55	128.67	114.20	115.05
Coefficient of Variation	30%	52%	27%	43%
Percent of Premiums and Equivalents				
25th Percentile	7.6%	11.3%	8.7%	8.3%
Median	8.3%	12.6%	11.4%	9.9%
75th Percentile	9.5%	15.2%	16.7%	14.4%
Coefficient of Variation	31%	70%	35%	55%
Plans offering Medicare	10	6	10	26
Medicare Advantage Members (millions)	0.66	0.21	1.00	1.87
Comprehensive Total Members (millions)	4.03	5.99	38.27	48.29

Note on the Sherlock Benchmarks

These results are excerpted from the Medicare Edition of the 2017 *Sherlock Benchmarks*. The results are based on our detailed surveys of 2016 operating parameters of 10 Medicare-focused plans serving 4.0 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 Medicare-focused universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Larger Health Plans, Independent/Provider-Sponsored Plans and Medicaid Plans. We reported on the Blue Cross Blue Shield Plans, Independent/Provider-Sponsored Plans, and Larger Plans earlier in the summer. We will be reporting on the results of the Medicaid universe in the next few weeks.

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*.

Appendix A. 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%

Appendix B. 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%

Appendix C. Sherlock Benchmark Summary

Major Functions Included in Each Administrative Expense Cluster

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

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

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

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