Plan Management Navigator
Analytics for Health Plan Administration

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Medicare Plans Administrative Expense Growth Accelerated in 2017

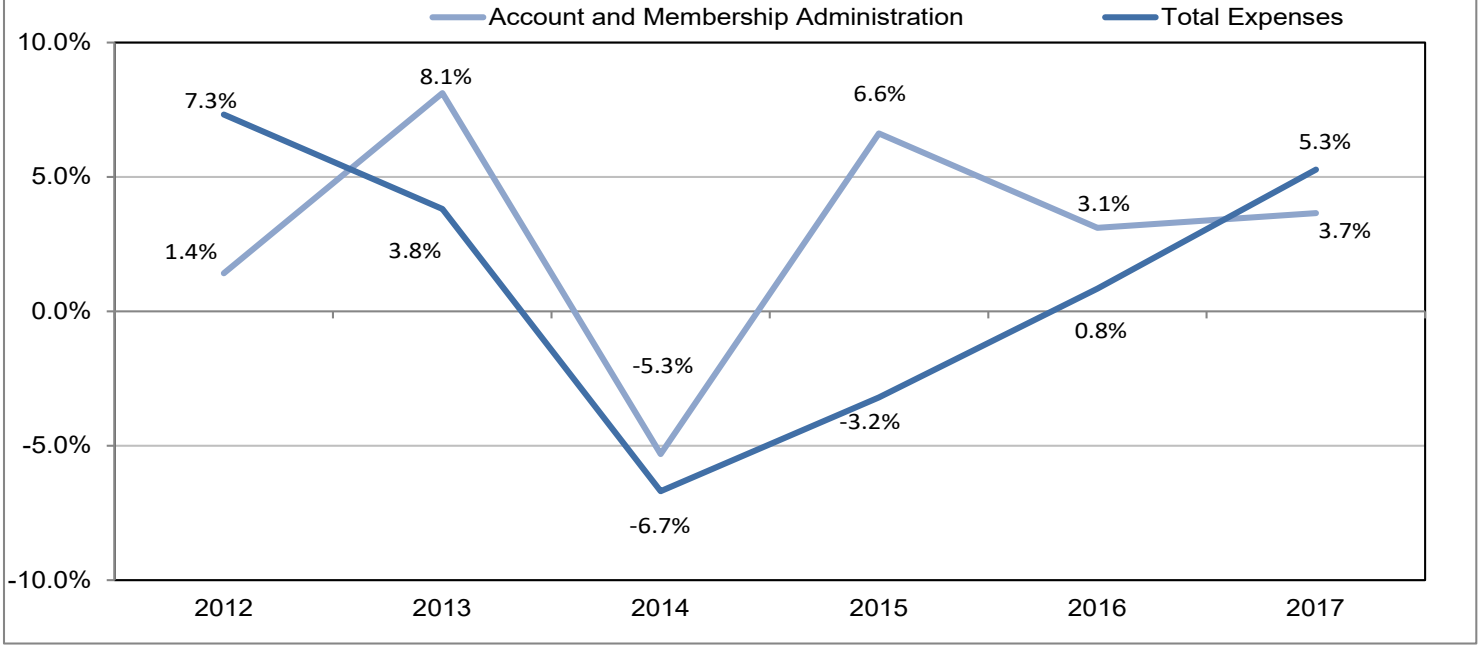
Medicare-focused plans posted a growth of 5.3% in total per member administrative expenses excluding Miscellaneous Business Taxes in 2017, the highest since 2012. Shown in Figure 1, the 2017 trend in Account and Membership Administration continued its growth from a year ago, up by 3.7%, while being the third highest growth since 2012. We have not shown this but, after the effect of Miscellaneous Business Taxes, PMPM total administrative expenses *declined* by 4.6%.

Background on Medicare Advantage

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

As of March 2018, according to the CMS State/County Penetration file, Medicare Advantage plans served 21.1 million people of the 61.2 million eligible. The proportion of eligible Medicare members selecting Medicare Advantage increased to 34.5% in March of 2018 from 33.8% in 2017. Please see Figure 2. Medicare Advantage membership increased by 7.5% from 19.6 million in March of 2017. By contrast, the number of people eligible for Medicare but eligible beneficiaries electing the Fee-For-Service ("FFS") program increased by 4.3% during that period.

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



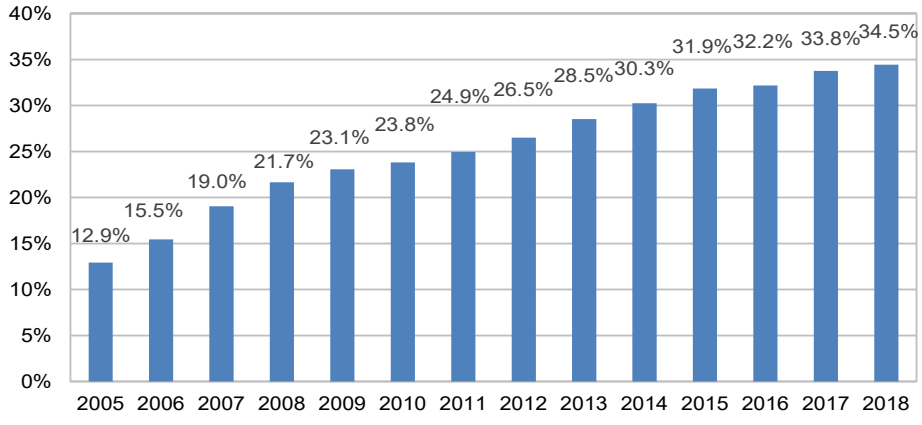
Taking the longer view, MA participation increased from 12.9% of total beneficiaries in 2005 to 34.5% in 2018. In every year since 2007, except for 2016 and 2018, the net number of people joining MA plans exceeded those joining FFS Medicare. While there are 13.4 million more people eligible for Medicare, the number of people served by Medicare FFS is now 2.4 million higher than it was in 2005. In other words, 74% of the additional Medicare beneficiaries since 2005 are in Medicare Advantage, as opposed to 26% in FFS.

Medicare Advantage membership share increased 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 headwinds.

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."

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." In other words, 74% of the additional Medicare beneficiaries since 2005 are in Medicare Advantage, as opposed to 26% in Fee-For-Service.

Figure 2. Sherlock Benchmark Summary
Medicare Advantage Share



Medicare Advantage provides payments for care beyond the scope of regular Medicare. However, this difference is chiefly that Medicare Advantage combines the traditional 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 2018 *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 12.2 million or 58% of all Medicare Advantage beneficiaries.) *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*." (Emphasis added.)

In addition to this apparent underlying cost advantage, MA plans enjoy subsidies not available through Medicare Supplement policies. In 2018, MA plans are projected to be paid 107% of FFS spending, and 106% for the HMO type plans. (These both include quality bonuses which are projected to add on average 4% to the benchmarks in 2018.) 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.

Trends Overall and in Expense Clusters

Figure 3 shows year-over-year trends on both an as-reported and constant mix plans. On an *as-reported* basis, for the seven continuously plans, per member costs grew by 4.5% compared with 0.1% the prior year.

The differences in the rates of growth between the constant-mix (0.8% in 2016 versus 5.3% in 2017) versus as-reported growth were the same (4.4 percentage points). The effect of the mix change is to reduce as-reported cost trends by 0.8 percentage points, implying a shift in favor of products with lower administrative costs, such as commercial products.

The Commercial Insured product membership increased at a median rate of 7.2%, Commercial ASO product was flat at a median of 0.0%. Overall, commercial membership increased by 5.1%. High cost Medicare Advantage grew at a median rate of 6.2%, Medicare SNP grew at a median rate of 7.1%, while low cost Medicaid increased at a median rate of 5.7%. Comprehensive membership in continuous plans grew at a median rate of 7.7%.

Trends that exclude the impact of product mix changes is a more accurate representation of trends so the discussion that follows is largely based on this. Marketing, Rating and Underwriting, Provider Network Management and Services increased while Association Dues and Sales declined. Outsourcing increased slightly, while Compensation also increased slightly. Staffing Ratios grew.

Account and Membership Administration

This cluster of expenses experienced a PMPM cost increase of 3.7%. Customer Services was the fastest growing function in this cluster, with the Member Services sub-function posting an especially large increase.

The staffing ratio for Customer Services increased significantly, while Compensation per FTE and Outsourced FTEs were slightly higher. However, Non-Labor costs per FTE were lower.

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

	2016 Data		2017 Data	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	6.3%	4.2%	4.1%	5.0%
Medical and Provider Management	-3.4%	-3.1%	4.7%	5.7%
Account & Membership Administration	3.8%	3.1%	6.3%	3.7%
Corporate Services	13.9%	14.6%	4.1%	5.1%
Total Expenses	0.1%	0.8%	4.5%	5.3%

While Customer Services posted the greatest growth in the Account and Membership Administration cluster, the increase in Information Systems had the greatest effect on this cluster because of its size. The Other Application Maintenance sub-function had the fastest growth. Compared with last year, the Information Systems staffing ratio was higher among plans, while outsourced FTEs was slightly up. Conversely, Compensation per FTE and Non-Labor costs per FTE declined from last year.

Sales and Marketing

The Sales and Marketing cluster increased at the fastest rate in the past five years, at 5.0%. For the second year in a row, the fastest growing functional area within this cluster was Marketing. The Other Marketing sub-function was a major driver in high Marketing cost. Examples of activities in the Other Marketing sub-function include strategic planning of a purely marketing nature, retail store marketing, and digital marketing strategy. Plans increased their outsourcing, Compensation, and Staffing Ratio in the Marketing function, while Non-Labor Costs fell.

Rating and Underwriting was the second fastest growing function for this cluster mainly due to Risk-Adjustment expenses. The increase in this sub-function was lower than Marketing. The increase in the Staffing Ratio was the primary reason for the cost increase, while outsourcing and compensation was slightly higher. Non-Labor Costs, however, were lower.

Sales costs were lower despite the higher staffing ratios. Advertising and Promotion expenses decreased entirely on a decline on Non-Labor expenses. Broker Commissions were flat on a constant-mix basis, but only up slightly on an as-reported basis.

Corporate Services

The Corporate Services cluster grew by 5.1%, the second fastest over the past five years. Actuarial was the fastest growing function on a higher staffing ratio, higher compensation, and higher non-labor costs. Outsourcing was also up from 2016. Actuarial expense trends sometimes parallel that of Rating and Underwriting, which was also up in 2017.

The Corporate Executive and Governance function was the cluster's second fastest growing functional area of this cluster on higher average staffing ratios. The most important increase for this cluster was in the Corporate Services *Function*. The sub-functions of Legal, Facilities, and Purchasing drove the increase in the Corporate Services functional area.

Medical and Provider Management

Medical and Provider Management was the fastest growing among clusters, at 5.7%. Within this cluster, Provider Network Management and Services grew the fastest and was the most important source of the cluster's increase. Compensation was higher in every sub-function, as outsourcing also increased. Offsetting this, the function's staffing ratio and non-labor expenses were down from a year ago.

The Medical Management functional area posted its first increase since 2014. Average compensation per FTE was higher. Precertification, Case Management, Disease Management, and Other Medical Management sub-functions grew in 2017.

Miscellaneous Business Taxes. This expense is not part of the expenses that give rise to the 5.3% total increase, but the costs are real and declined by 61% in 2017. According to the IRS, "The Consolidated Appropriations Act of 2016, Title II, § 201, Moratorium on Annual Fee on Health Insurance Providers, suspended collection of the health insurance provider fee *for the 2017 calendar year only*." (Emphasis added.)

Summary of Cost Drivers

The above comments are based on continuously participating plans, and includes the effect of staffing and costs performed on an outsourced basis. Overall, it appears that average staffing is higher than last year among continuing plans. The average staffing ratio for the seven continuing plans was 31 FTEs per 10,000 members, though we estimate that it differs between products and market segments.

Of the 14 functional areas with staff, ten had average ratio increases and four had declines. The largest increases included Corporate Executive and Governance, Rating and Underwriting, and Actuarial.

Compensation increased moderately but varied by function. Provider Network Management and Corporate Services increased notably, while the higher compensation areas of Corporate Executive declined.

Propensity to outsource was slightly higher than last year in total. Nine out of the 14 functional areas with staff increased outsourcing.

Marketing and Information Systems had the largest effect on the increase in total costs. Both functional areas posted higher Staffing Ratios and Outsourcing. Non-Labor Costs per FTE fell for both functions. Compensation for Marketing grew, while falling for Information Systems.

Costs of Medicare-focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 11 participating Medicare-focused plans. In this section we'll touch on comparisons with the results reported last year, notwithstanding certain limitations. The prior year's values are shown in Appendix A.

Bear in mind that this universe of Medicare-focused plans differs from that of last year in product mix and in populations. Since the universes differed by four each year, it is not possible to perfectly compare the performance of plans participating this and last year based on these charts. For the new plans and the ones that participated last year, we can know neither their trends, or their changes in product mix.

The actual total PMPM administrative expenses at $39.80 were 4.5% higher than last year's values, shown in Appendix A. The Corporate Services Cluster was up by 8.7%, while the Account and Membership Administration and Sales and Marketing clusters were higher by 6.8% and 4.1%, respectively. Medical and Provider Management, however, was lower by 1.6%.

Dispersion for Total expenses, measured by the Coefficient of Variation, was very similar year-over-year. Dispersion fell for the Sales and Marketing, Account and Membership Administration, and Corporate Services clusters, but rose for Medical and Provider Management.

Sales and Marketing, the second largest cluster, had median costs of $12.57. Last year's value was lower at $12.07. This function includes Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising. This corresponds with the growth trend shown in Figure 3.

Medical and Provider Management costs per member per month were $7.34, slightly lower than last year's value of $7.46. This group of functions includes Provider Network Management and Services and Medical Management. This contrasts against the increase of continuing plans on a constant mix and as-reported basis.

Figure 4. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2017 Data
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$8.88	$12.57	$14.34	57%
Medical and Provider Management	6.18	7.34	8.20	29%
Account and Membership Administration	14.38	16.81	19.98	35%
Corporate Services	5.70	6.99	8.73	31%
Total Expenses	$37.56	$39.80	$52.80	34%

Account and Membership Administration was the single greatest cluster of expenses at a median value of $16.81, composing over 40% of the total. This cluster's size means that it has a substantial effect on overall trend. This cluster includes the central activities of Information Systems, Enrollment, Claims and Customer Services. Comparing this with last year's median of $15.73, the costs were higher and more clustered.

The Corporate Services cluster costs were higher PMPM than last year at $6.99 versus $6.43. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities like Facilities, HR and Legal. Expenses were more clustered.

Costs of Medicare-focused plans, PMPM by Product

The importance of considering each product's costs is shown in Figure 5. The products vary greatly in their per member costs and, for the products that are responsible for most of their business, the Coefficients of Variation were usually smaller than the 34% for Comprehensive as a whole. For this reason, when we report results to participants, we often reweight product mix to eliminate the effect of any differences between them.

Figure 5. Sherlock Benchmark Summary
Medicare Plans' Costs by Product, 2017 Data
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	$66.13	$81.73	$97.08	25%
Advantage	$66.13	$81.73	$91.52	25%
SNP	$119.83	$126.78	$147.99	22%
Medicare Supplement	$41.06	$54.35	$65.79	36%
Medicaid Total	$21.34	$26.83	$32.77	38%
HMO	$21.34	$27.23	$34.07	39%
CHIP	$19.16	$23.75	$31.29	53%
Commercial Insured Total	$36.23	$47.37	$53.98	32%
HMO	$39.52	$47.89	$58.21	30%
POS	$32.16	$41.45	$42.83	29%
Indemnity & PPO	$35.17	$47.22	$52.02	32%
Commercial ASO	$19.46	$21.81	$24.28	35%
Comprehensive Total	$37.56	$39.80	$52.80	34%

Medicare and Medicaid are government-sponsored products serving seniors and the low-income population. Medicare products are relatively high cost at $81.73 and $126.78 PMPM for Medicare Advantage and Medicare Special Needs Plans respectively. Medicare Advantage average membership mix was 25%, while the average revenue share was 41%. Medicare SNP average membership mix and revenue mix were 1% and 2%, respectively.

Among the comprehensive insured products, Medicaid products fall between commercial insured and commercial ASO. Medicaid HMO, has median PMPM cost of $27.23, while the median PMPM for CHIP is $23.75. Medicaid HMO's average share of members is 15% and its revenue share is 13%. Medicaid CHIP's average member mix and revenue mix was 1%.

Note that Medicare Supplement is a higher than average cost product at $54.35 PMPM. We include this as a comprehensive product in the Sherlock Benchmarks though it pays only when Medicare does not. Seven of the 11 plans offer the product and its mean mix is 1%.

The mean mix of Commercial products was 58% of the membership. Administrative expenses for these costs are both higher and lower than the median comprehensive administrative costs, depending on their financing mechanism, which indirectly bears on the group size. An ASO group possesses the statistical advantages of larger size, which also means that their Sales and Marketing costs are spread through greater numbers of members. The costs of Commercial Insured products are accordingly higher than the median for comprehensive products. The single most important Commercial Insured product is HMO at $47.89. Indemnity and PPO costs $47.22 while POS costs $41.45.

ASO products represented a mean of 26% of comprehensive members. These products' 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 capable of self-insuring. Thus, these products have a median cost of $21.81.

Costs of Medicare-focused plans, Percent of Premiums by Product

Ranking the administrative expenses by the percent of premiums often corresponded with the ranking of the PMPM costs. Ratios are calculated based on premium equivalents for ASO products.

While Medicare Supplement is above average cost when measured PMPM, at 26.7%, its cost ratio was the highest among the comprehensive products. By contrast, it was only a bit more than commercial insured.

Medicare SNP, three times higher PMPM than Commercial HMO Insured, is 9.1%, less than HMO Insured and approaching the average for comprehensive products as a whole. Medicare Advantage costs, while about two times higher than Commercial HMO Insured PMPM, is 8.6% of premiums, slightly lower than Commercial HMO ratio of 10.2%. Both are higher than average for products offered by the Medicare-focused plans, but far less than the doubling of the commercial PMPM values.

The POS and Indemnity & PPO products, with ratios of 6.4% and 9.3% respectively. Medicaid CHIP had lower PMPM cost than average but, at 10.0%, was higher than average. Again, the Commercial Insured HMO product is 10.2%.

Some products had similar ratios across the two calculations. Medicaid was below average in PMPM costs and was, at 7.4%, also below average. Commercial ASO products are 6.2% of premiums. It is also relatively low cost PMPM. The lower Sales and Marketing for self-insured groups is key reason for this difference.

Figure 6. Sherlock Benchmark Summary

Medicare Plans' Costs by Product, 2017 Data

Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	7.8%	8.6%	10.5%	28%
Advantage	7.8%	8.6%	10.3%	28%
SNP	8.8%	9.1%	10.5%	19%
Medicare Supplement	10.9%	26.7%	31.1%	50%
Medicaid Total	7.1%	7.4%	9.6%	28%
HMO	7.1%	7.3%	9.3%	28%
CHIP	8.3%	10.0%	13.4%	48%
Commercial Insured Total	8.5%	9.5%	10.6%	30%
HMO	8.3%	10.2%	11.3%	32%
POS	5.9%	6.4%	7.9%	39%
Indemnity & PPO	7.8%	9.3%	12.9%	50%
Commercial ASO	4.8%	6.2%	7.9%	135%
Comprehensive Total	8.1%	8.5%	9.9%	21%

Costs of Medicare-focused plans, Percent of Premiums by Product

Figure 7 shows the ratios of administrative expenses to premiums or equivalents. Administrative expenses had a median of 8.5% of premiums, unchanged from last year's equivalent value.

Sales and Marketing was similar to last year at 2.7% of premium. Account and Membership Administration increased by 0.1 percentage points to 3.4% of premium. Corporate Services also was down by 0.2 percentage points, to 1.5% of premiums. Medical and Provider Management was unchanged, remaining at 1.5% of premium.

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 43%, with 26% and 52% 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 33,000 members in the Medicare universe and 288,000 members in all universes.

Since the data definitions are the same, it is possible to directly compare our Medicare Advantage universe with Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans. Together, these three universes serve 2.0 million Medicare Advantage members, or about 10% of all Medicare Advantage members, as of March 2018.

Figure 7. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2017 Data
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.0%	2.7%	3.2%	37%
Medical and Provider Management	1.3%	1.5%	1.7%	27%
Account and Membership Administration	3.2%	3.4%	3.9%	28%
Corporate Services	1.3%	1.5%	1.6%	21%
Total Expenses	8.1%	8.5%	9.9%	21%

Shown in Figure 8, compared with the Medicare plans, Blue Cross Blue Shield Plans cost $15.90 more than the Medicare Plans and, measured as a percent of premiums, were 2.7 percentage points more. The IPS plans were higher both in PMPM, by $34.27, and as percent of premium, by 6.0 percentage points. Both scale and focus may affect the relative performance of these health plan sets.

How We Performed This Analysis

This analysis is based on the fifteenth annual edition of our performance benchmarks for Medicare-focused health plans. The Sherlock Benchmarks (*Sherlock Expense Evaluation Report* or *SEER*) represent the cumulative experience of 818 health plan years.

Each peer group in the Sherlock Benchmarks is established to be relatively uniform. So, within that constraint, it is open to all Medicare-focused plans possessing the ability to compile high-quality, segmented financial and operational data. This 15th analysis of Medicare plans is based on a peer group of eleven plans who collectively serve 5.1 million people. Seven of this year's participants participated in the prior year.

The average plan participating in the Medicare Sherlock Benchmarks this year served 462,000 people and the median membership was 371,000 million. The geographic reach extended from coast to coast.

Figure 8. Sherlock Benchmark Summary

Medicare Advantage Product Characteristics by Universe, 2017 Data

	Medicare Plans	IPS Plans	BCBS Plans	Combined Plans
Total Costs				
Per Member Per Month				
25th Percentile	$66.13	$110.30	$90.35	$79.19
Median	81.73	116.01	97.63	96.85
75th Percentile	91.52	128.71	116.88	116.01
Coefficient of Variation	25%	21%	23%	27%
Percent of Premiums and Equivalents				
25th Percentile	7.8%	13.0%	10.0%	8.8%
Median	8.6%	14.6%	11.3%	11.3%
75th Percentile	10.3%	15.9%	14.6%	14.2%
Coefficient of Variation	28%	17%	27%	29%
Plans offering Medicare	11	6	10	27
Medicare Advantage Members (millions)	0.74	0.22	1.09	2.05
Comprehensive Total Members (millions)	5.08	5.99	37.09	48.15

Medicare Advantage (including SNP) were 772,000 members. It composed 15% of the combined comprehensive membership and 34% of revenues for comprehensive products. The average Medicare revenue and membership proportion was 43% and 25%, respectively. Medicaid products, including CHIP, comprised 16% of membership 14% of revenues, offered by 7 plans.

Fifty eight percent of membership was commercial, or 3.1 million. Approximately 1.2 million of the commercial members were served under some form of self-insurance arrangement, comprising approximately 24% of the total commercial members.

Reporting Conventions

We employ a number of conventions to make the metrics most beneficial 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.
- References to growth rates hold the universe constant in the comparison years unless otherwise noted. Rates of change identified as "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 each plan's values to eliminate the effect of product mix differences between the years.
- 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 has two advantages: comparability of ASO ratios with those of insured products offered by these plans, and an intuitive appeal to most readers.
- Expenses exclude capital costs and investment income. Specifically excluded expenses include interest 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.

- Participants in and licensees of the *Sherlock Benchmarks* will note that the values for Account and Membership Administration and Total Administrative costs reported here will differ from those reported in the Benchmarks. The values reflected in *Navigator* 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 these management responsibilities, the Benchmark reports carve them out. Pages 22 - 24 in Tab 2 of Volume I of the 2018 *Sherlock Benchmarks* reconciles these two presentations.

- Medicare Part D is not discussed here since only one plan offered it. Interestingly, while 71% of Blue Plans offered Medicare Part D, only 20% of Independent / Provider – Sponsored plans offered this product.

- Miscellaneous Business Taxes are a special case among 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 generally 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 $5.78 and the mean is $6.09, or approximately 11%. (As noted earlier, this is sharply lower than in the prior year.) 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 Comparative Effectiveness Research Fees (CERF), Transitional Reinsurance Fee, Risk Adjuster User Fee, Exchange User Fee and Annual Fee on Health Insurers. The Annual Fee on Health Insurers was formerly the largest generally applicable fee since it applied to all insured business and had a median value of $4.39 in 2016. The Risk Adjuster Fee and the CERF had a median value of $0.17 PMPM and $0.20, respectively. The Exchange User Fee only applies to Exchange members but the median fee for that population is $17.37 PMPM.

  On a constant-mix basis, per member Miscellaneous Business Tax costs decreased by 61.4% PMPM, compared with an increase of 9.0% in 2016, a major shift from the surge of 3,224% in 2014.

Note on the Sherlock Benchmarks

These results are excerpted from the Medicare-focused edition of the 2018 *Sherlock Benchmarks*. The results are based on our detailed surveys of 2017 operating parameters of 11 Medicare plans. Accordingly, much more information is available by licensing the Sherlock Benchmarks.

Information about the Benchmarks are found here: https://sherlockco.com/sherlock-benchmarks/. Tables of Contents, report formats, citations, quality assurance and other information can be found here. In addition, we have an application that allows you to try out the Benchmarks for no charge.

If you are interested in licensing the *Sherlock Benchmarks* or if we can answer any further questions about them or you have questions about this *Plan Management Navigator*, we hope you will not hesitate to contact us (sherlock@sherlockco.com).

Health plan managers endeavor to achieve optimal costs. If that is achieved, favorable health care trends amplify operating profits and mute operating losses. Managing what you measure facilitates your achievement of that goal. In a competitive environment, measurement implies comparison with the leaders of your industry.

The Sherlock Benchmarks reflect 818 health plan years of experience over 21 consecutive years. Thus, planning, budgeting and cost benefit analyses are credibly informed by the Sherlock Benchmarks.

In addition to the Medicare-focused plan universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Independent / Provider – Sponsored Plans, Larger Health Plans, and Medicaid Plans. We reported on the Blue Cross Blue Shield Plans and Independent / Provider – Sponsored Plans a few weeks ago and we will be reporting on the results of the Medicaid plans in the next few weeks.

Appendix A. 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	$12.07	$15.69	57%
Medical and Provider Management	6.99	7.46	8.00	19%
Account and Membership Administration	14.39	15.73	19.21	38%
Corporate Services	5.70	6.43	8.09	33%
Total Expenses	$36.56	$38.10	$53.10	34%

Appendix B. 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	2.1%	2.7%	3.3%	34%
Medical and Provider Management	1.3%	1.5%	1.5%	14%
Account and Membership Administration	2.8%	3.3%	3.4%	33%
Corporate Services	1.2%	1.3%	1.5%	20%
Total Expenses	7.7%	8.5%	9.1%	17%

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
    - (2) Government Affairs
    - (3) Outside Litigation
    - (4) 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

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