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 Plans Post Fastest Growth in Core Expenses Since 2014

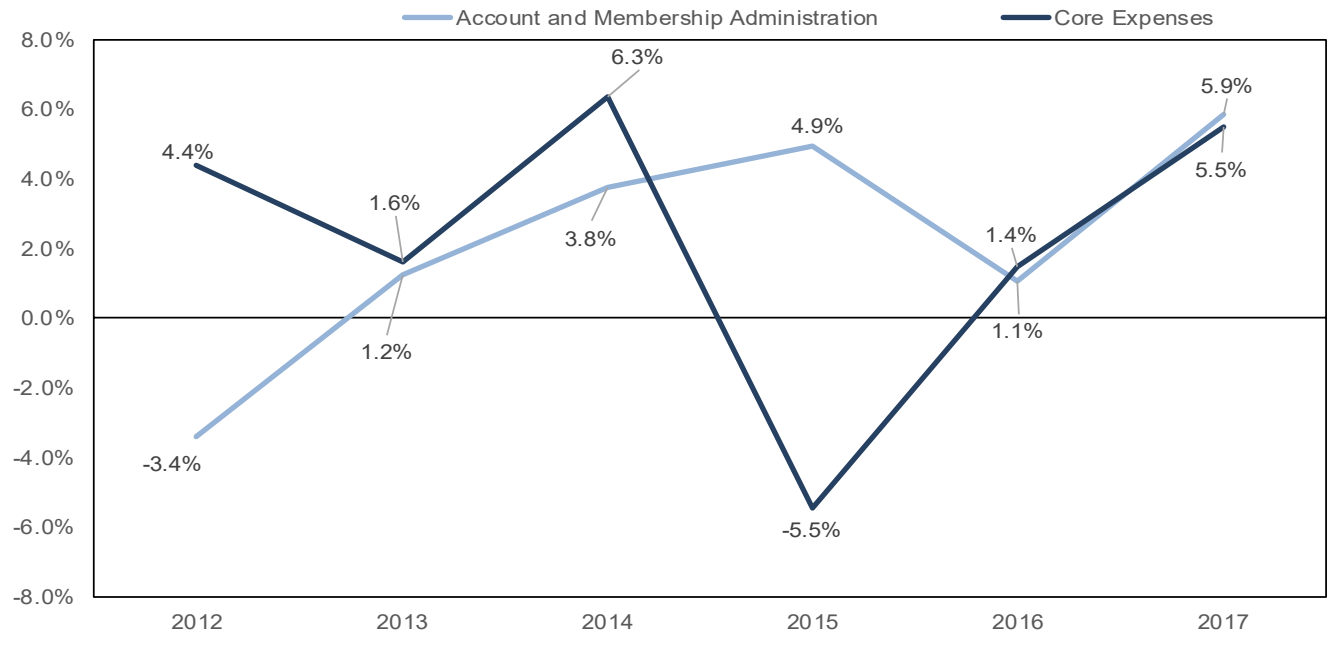
Core per member administrative expenses in Medicaid-focused plans grew by 5.5% in 2017. Account and Membership Administration also accelerated from last year, up by 5.9%. Figure 1 displays both trends since 2012. The above trends exclude the effect of Miscellaneous Business Taxes; PMPM total administrative expenses declined by 3.5% if they are included. The above trends exclude the effect of Miscellaneous Business Taxes; PMPM total administrative expenses *declined* by 3.5% if they are included.

Core expenses exclude 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.

Background on Medicaid

One of the central purposes of the Affordable Care Act was to reduce the proportion of Americans without health insurance. As shown in Figure 2, based on US Census Bureau analyses, *Health Insurance Coverage in the United States* (September 2018), the proportion of Americans uninsured dropped from 13.3% in 2013 to 8.8% in 2017, a 4.6 percentage point decline. Subject to qualifications noted on the chart, of the 13.3 million newly covered, the 7.6 million additions to Medicaid beneficiaries composed about 57% of the newly covered people.

Figure 1. Sherlock Benchmark Summary
Medicaid Plans Rates of Change for Account and Membership Administration and Core, Constant Mix



While the classifications and definitions differ, 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 20.8% in the fourth quarter of 2013 to 14.8% in the fourth quarter of 2017, a 6.0 percentage point decline. While the Group responding "Plan fully paid for by self or family member" comprised the largest increase at 2.7 percentage points, Medicaid came in second with a 1.9 percentage point increase.

The proportion of uninsured, however, increased year-over-year from fourth quarter of 2016 to 2017 by 1.7 percentage points. Gallup noted "[s]ome insurance companies stopped offering insurance through the exchanges, and the resulting lack of competition drove up the cost of plans for consumers. This may have caused some Americans, especially those who failed to qualify for federal subsidies, to forgo insurance." The company also added "media coverage of the policies to repeal and replace the healthcare law may have caused some consumers to question whether the government would enforce the penalty for not having insurance. Congressional Republicans made several attempts to repeal or replace the healthcare law during 2017, ultimately passing a tax bill in December that repealed the individual mandate [effective 2019]."

Figure 2. Sherlock Benchmark Summary
Health Insurance Coverage in the United States: Census Bureau
(000's)

	2013		2014		2015		2016		2017		2017 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%	294,613	91.2%	2,293	0.8%	23,007	8.5%
Any Private Plan	201,038	64.1%	208,700	66.0%	214,238	67.2%	216,203	67.5%	217,007	67.2%	804	0.4%	15,969	7.9%
Employment-based	174,418	55.7%	175,027	55.4%	177,540	55.7%	178,455	55.7%	181,036	56.0%	2,581	1.4%	6,618	3.8%
Direct purchase	35,755	11.4%	46,165	14.6%	52,057	16.3%	51,961	16.2%	51,821	16.0%	-140	-0.3%	16,066	44.9%
Any Government Plan	108,287	34.6%	115,470	36.5%	118,395	37.1%	119,361	37.3%	121,965	37.7%	2,604	2.2%	13,678	12.6%
Medicare	49,020	15.6%	50,546	16.0%	51,875	16.3%	53,372	16.7%	55,623	17.2%	2,251	4.2%	6,603	13.5%
Medicaid	54,919	17.5%	61,650	19.5%	62,384	19.6%	62,303	19.4%	62,492	19.3%	189	0.3%	7,573	13.8%
Military health care	14,016	4.5%	14,143	4.5%	14,849	4.7%	14,638	4.6%	15,532	4.8%	894	6.1%	1,516	10.8%
Uninsured	41,795	13.3%	32,968	10.4%	28,966	9.1%	28,052	8.8%	28,543	8.8%	491	1.8%	-13,252	-31.7%
Total	313,401		316,168		318,869		320,372		323,156		2,784	0.9%	9,755	3.1%

Source: Health Insurance Coverage in the United States: 2017, https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

Note: According to the analysis "Individuals are considered to be uninsured if they did not have health insurance coverage at any point during the 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."

Figure 3. Sherlock Benchmark Summary
Source of Insurance Coverage: Gallup

	Q2 2013	Q4 2013	Q2 2016	Q4 2016	Q2 2017	Q4 2017	2017 Change	Cml. Change
Current or Former Employer	44.4%	44.2%	43.5%	44.3%	43.8%	43.7%	-0.6%	-0.5%
Plan Fully Paid for by Self or Family Member	16.7%	17.6%	21.8%	21.3%	20.6%	20.3%	-1.0%	2.7%
Medicaid	6.8%	6.9%	9.6%	8.8%	9.2%	8.8%	0.0%	1.9%
Medicare	6.4%	6.1%	7.4%	7.6%	7.3%	7.5%	-0.1%	1.4%
Military / Veterans	4.3%	4.6%	4.9%	4.7%	4.7%	4.3%	-0.4%	-0.3%
A Union	2.8%	2.5%	2.5%	2.7%	2.4%	2.9%	0.2%	0.4%
(Something Else)	3.8%	3.5%	4.3%	4.6%	4.6%	4.5%	-0.1%	1.0%
No Insurance	21.2%	20.8%	13.3%	13.1%	14.2%	14.8%	1.7%	-6.0%

Source: U.S. Uninsured Rate Steady at 12.2% in Fourth Quarter of 2017
https://news.gallup.com/poll/225383/uninsured-rate-steady-fourth-quarter-2017.aspx

Trends Overall and in Expense Clusters

Figure 4 shows year-over-year trends on both an *as-reported* and constant-mix plans. On an *as-reported* basis, for the eight *continuously participating* plans, per member *core* costs grew by 7.1% compared with 3.9% the prior year.

The more rapid increase (5.5% in 2017 versus 1.4% in 2016) in the constant-mix growth compared to (7.1% in 2017 versus 3.9% in 2016) on an as-reported basis implies a net shift in favor of higher administrative cost products.

High cost Medicare Advantage grew at a 1.9% median rate, while Medicare Advantage SNP, largely dual-eligibles, increased by 38%, and Medicare Cost fell by 5.7%. The Commercial Insured product membership increased at a median rate of 7.8%, Commercial ASO product grew at a median rate of 13.5%. Overall, commercial membership grew by 5.7%. Low cost Medicaid HMO decreased by a median of 3.6%, while Medicaid CHIP grew at a median of 23.0%.

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 these trends. Actuarial, Corporate Services Function, Corporate Executive and Governance, and Provider Network Management and Services were functions with notable increases, while Enrollment / Membership / Billing was the only core function to decline. Staffing Ratios and Outsourcing increased, while compensation fell.

CORPORATE SERVICES CLUSTER

The Corporate Services cluster posted the most rapid PMPM increase, growing by 12.0%, and the fastest over the past five years. Actuarial was the fastest growing function sharply higher non-labor costs. In this function, compensation and outsourcing were higher, while the average staffing ratio was up slightly.

Figure 4. Sherlock Benchmark Summary
Medicaid Plans' Median Changes in Per Member Per Month Expenses

	2016 Data		2017 Data	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	2.5%	-2.1%	6.8%	5.7%
Account and Membership Administration	1.0%	1.1%	8.6%	5.9%
Corporate Services	4.8%	2.1%	11.8%	12.0%
Subtotal: Core Expenses	3.9%	1.4%	7.1%	5.5%
Sales and Marketing	-0.3%	0.9%	5.0%	5.2%
Total Expenses	4.0%	2.7%	5.1%	4.8%

The Corporate Services *functional area* (within the Corporate Services Cluster) represented the most important source of growth. Most sub-functions within this area grew except for Imaging and Printing and Mailroom. This functional area's staffing ratio coupled with compensation led to the increase. Non-Labor costs per FTE and outsourcing were higher, on average.

Account and Membership Administration

The Account and Membership Administration cluster of expenses posted a PMPM increase of 5.9%. Customer Services grew at the fastest pace among functions in this cluster, with the Member Services sub-function responsible for the entire increase in this function. The staffing ratio for Customer Services increased significantly, while compensation also grew. Average non-labor costs were down, and outsourcing was up slightly.

The functional area with the greatest effect on the Account and Membership Administration cluster was Information Systems, due to its size. The Security Administration and Enforcement sub-function grew at the fastest rate, closely followed by Applications Maintenance and Applications Acquisition and Development. The sub-function of Operations and Support Services, however, fell.

For the continuously participating plans, the average staffing ratio and staffing costs per FTE were higher for Information Systems. Non-Labor Costs per FTE and Outsourcing were lower.

Medical and Provider Management

PMPM expenses in the Medical and Provider Management cluster grew by 5.7%. Provider Network Management and Services grew at the fastest rate, but the larger Medical Management / Quality Assurance / Wellness function was the most important source of growth because of its higher cost values.

The staffing ratio and non-labor costs for Provider Network Management and Services were higher than the previous year. Combined staffing costs were lower, while average outsourcing by the plans was higher.

Staffing Ratios were also a major driver for increased Medical Management functional area expenses. Non-Labor costs per FTE were lower, as the average proportion of FTEs outsourced was slightly higher. Compensation was marginally lower.

The Medical Management sub-functions that posted cost increases included Precertification, Case Management, Disease Management, Health and Wellness, Utilization Review, and Other Medical Management.

Sales and Marketing

While Sales and Marketing is not included in *Core* expenses, it is still central to Commercial and Medicare products offered by these Medicaid-focused plans. The Sales and Marketing cluster grew by 5.2%, the fastest rate in the past five years. Rating and Underwriting represented the fastest growing functional area and most important source of growth within the Sales and Marketing cluster. Notably, Rating and Underwriting and Actuarial trends often parallel one another: that relationship was evident in this instance as Actuarial was the fastest growing function in the Corporate Services cluster.

The Risk Adjustment sub-function was the major driver in higher Rating and Underwriting expenses. Plans sharply increased their staffing in this sub-function. Compensation was also slightly higher. Non-Labor Costs and outsourcing were lower.

Miscellaneous Business Taxes. This expense is not part of the expenses that give rise to the 5.5% core increase or 4.8% total increase, but the costs are real and declined by 62% 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, the average staffing ratio is higher than last year among continuously participating plans. The average staffing ratio for the eight plans was 26 FTEs per 10,000 members, though we estimate that it differs between products and market segments. Recall that membership growth emphasized high cost products.

Of the 14 functional areas with staff, ten had average ratio increases and four had declines. The largest rate of growth is found in Rating and Underwriting, and Corporate Executive and Governance followed.

Compensation increased slightly and varied by function. Corporate Executive posted the largest increase, while the Corporate Services functional area followed (This function includes HR, Legal, Facilities, and similar activities, segmented into sub-functions). In total, eight of the 14 functions with staff experienced increases from a year ago.

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

Actuarial costs posted the fastest rate of growth of the core functions followed by the Corporate Services function. The Corporate Services Functional Area and Information Systems were the most important sources of cost growth.

Costs of Medicaid-focused Plans, by Cluster, PMPM

Figure 5 shows the values of administrative expenses for all 12 participating Medicaid-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 Medicaid-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 only participated last year, we can know neither their trends, or their changes in product mix.

Account and Membership Administration is the largest cluster of expenses and is comprised of activities central to health plan operations, increased by 6.9% to a median of $16.35 PMPM. This compares to the as-reported and constant-mix increase of 8.6% and 5.9%, respectively, seen in Figure 4. This cluster's size means that it has a substantial effect on overall trend. This cluster includes the Information Systems, Enrollment, Claims and Customer Services.

Medical and Provider Management costs per member per month were $7.13 PMPM, 2.6% lower than last year's value of $7.32. This is slower than the as-reported increase for the continuously participating plans of 6.8% and 5.9% on a constant-mix basis. This group of functions includes Provider Network Management and Services and Medical Management.

The Corporate Services cluster costs were higher PMPM than last year at $6.75 versus $6.17, an increase of 9.4%. The as-reported increase for plans participating in both years is 11.8% and, on a constant-mix basis, is 12.0%. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities like Facilities, HR and Legal.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2017 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$6.27	$7.13	$8.00	22%
Account and Membership Administration	10.82	16.35	17.01	31%
Corporate Services	5.41	6.75	7.47	25%
Subtotal: Core Expenses	$27.46	$28.82	$31.22	21%
Sales and Marketing	$7.12	$7.69	$10.65	45%
Total Expenses	$32.57	$38.35	$39.71	19%

Core administrative expenses were $28.82 PMPM, 2.5% lower than last year shown in Appendix A. For plans participating in both years, as-reported growth in Core expenses was 7.1% and was 5.5% on a constant-mix basis.

Total Expenses grew by 5.8% to $38.35 PMPM (as-reported was 5.1% and constant-mix was 4.8%). The Sales and Marketing cluster grew by 0.5% to a median of $7.69 PMPM (as-reported was 5.0% and constant-mix was 5.2%). Sales and Marketing functional areas include Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Dispersion in Core Expenses, measured by the Coefficient of Variation, tightened compared to last year. Dispersion fell for both Medical and Provider Management and Account and Membership Administration clusters. Dispersion in the Corporate Services cluster, however, increased from last year. Dispersion in Total Expenses and the Sales and Marketing cluster increased.

Costs of Medicaid-focused plans, PMPM by Product

The importance of considering each product's costs when analyzing costs and trends is shown in Figure 6. 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 varied compared to the 19% for Comprehensive Total 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. Note that Figure 6 displays total expenses by product, which include Sales and Marketing, except for the note at the bottom of the Figure.

Medicare and Medicaid are government-sponsored products serving seniors and the low-income population. The median for Medicaid products fall between commercial insured and self-funded commercial ASO. Median costs for Medicaid was $26.93 PMPM, Medicaid HMO was $27.13, and Medicaid CHIP was $26.24 PMPM. Medicaid HMO's average share of members is 43% and its revenue share is 40%. Medicaid CHIP's average member mix and revenue mix was 1%.

Medicare products are relatively high cost at $96.85 PMPM for Medicare Advantage, $215.95 PMPM for Medicare Special Needs Plans, and $57.71 PMPM for Medicare Cost. Average membership mix for Medicare Advantage was 7%, Medicare SNP was 1%, and Medicare Cost was 3%. Average revenue mix for Medicare Advantage was 15%, Medicare Advantage SNP and Medicare Cost were each 3%.

Note that Medicare Supplement is a higher than average cost product at $55.52 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Half of the plans in the Medicaid universe offer the product and its mean mix is 1%.

The mean mix of Commercial products was 46% of the membership and Commercial ASO was 15%. Commercial administrative expenses are both higher and lower than the median comprehensive total, which depends on their financing mechanism and indirectly bears on group size. As 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 $42.21 PMPM. Indemnity and PPO costs $51.61 PMPM while POS costs $41.45 PMPM.

ASO products represented a mean of 15% 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 $20.98 PMPM.

Per Member Per Month *Core* Medicaid expenses were $25.48. Medicaid HMO and Medicaid CHIP were $25.69 and $20.18, respectively.

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2017 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$24.88	$26.93	$33.31	49%
HMO	$24.88	$27.13	$33.63	50%
CHIP	$21.25	$26.24	$46.43	62%
Medicare	$79.75	$100.34	$120.79	135%
Advantage	$83.23	$96.85	$109.43	25%
SNP	$174.72	$215.95	$281.81	93%
Cost	$57.70	$57.71	$57.72	0%
Medicare Supplement	$37.46	$55.52	$72.88	44%
Commercial Insured Total	$35.48	$38.85	$47.53	22%
HMO	$36.96	$42.21	$48.63	18%
POS	$32.16	$41.45	$43.37	32%
Indemnity & PPO	$34.78	$51.61	$56.02	34%
Commercial ASO	$18.62	$20.98	$21.87	17%
Comprehensive Total	$32.57	$38.35	$39.71	19%
Note: Core Expenses of Medicaid				
Medicaid Total	$23.06	$25.48	$30.02	44%
HMO	$23.06	$25.69	$30.32	44%
CHIP	$19.53	$20.18	$44.59	59%

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

Ranking the administrative expenses by the percent of premiums is generally similar to the ranking of the PMPM costs with the exception of the Medicare products. The percent of premium ratios used here are calculated based on premium equivalents for Commercial ASO products. This is not GAAP, of course, but enhances comparability between the products.

Medicaid HMO was lower than average on both a PMPM and percent of premium basis at 7.1%. Medicaid CHIP was lower than average on a PMPM basis but, at 11.3%, is higher than average on a percent of premium basis. The note at the foot of the figure shows that Core Medicaid administrative expenses are 6.2% of premiums, with HMO at 6.2% and CHIP at 8.7%.

Medicare SNP, vastly higher on a PMPM basis than Commercial HMO Insured, is 11.4%, only 1.4 percentage points higher than Commercial HMO. Medicare Advantage expenses, while about two times greater than Commercial HMO Insured products on a PMPM basis, is almost equal on a percent of premium basis at 10.1%. Medicare Cost was the highest among Medicare products on a percent of premium basis at 13.4%.

While Medicare Supplement is above average cost when measured PMPM, at 22.3%, its cost ratio was the highest among the comprehensive products.

Figure 7. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2017 Results
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	6.4%	7.1%	9.2%	34%
HMO	6.4%	7.1%	9.0%	33%
CHIP	8.7%	11.3%	19.8%	46%
Medicare	9.5%	10.9%	12.5%	58%
Advantage	8.6%	10.1%	11.4%	29%
SNP	9.5%	11.4%	14.7%	69%
Cost	13.3%	13.4%	13.6%	4%
Medicare Supplement	12.3%	22.3%	30.9%	49%
Commercial Insured Total	9.0%	9.7%	10.9%	23%
HMO	9.2%	10.0%	10.9%	24%
POS	4.4%	6.4%	9.7%	49%
Indemnity & PPO	8.4%	10.3%	10.9%	25%
Commercial ASO	4.7%	5.3%	6.6%	25%
Comprehensive Total	7.6%	8.4%	9.2%	15%
Note: Core Expenses of Medicaid				
Medicaid Total	5.8%	6.2%	8.5%	34%
HMO	5.8%	6.2%	8.5%	33%
CHIP	8.0%	8.7%	14.5%	34%

Administrative expenses on a percent of premium basis for Commercial HMO, POS and Indemnity, and POS were 10.0%, 10.3%, and 6.4%, respectively.

Commercial ASO products are 5.3% on a premium equivalent basis. It is also relatively low cost when measured on a PMPM basis. The lower Sales and Marketing for self-insured groups is key reason for this.

Costs of Medicaid-focused plans, Expense Clusters as Percent of Premium

Figure 8 shows the ratios of administrative expenses to premiums or equivalents. Core administrative expenses were 0.2 percentage points lower than last year's at a median of 6.6%. Medical and Provider Management and Corporate Services were flat at 1.6% and 1.5%, respectively. Account and Membership Administration fell by 0.2 percentage points to 3.5%.

Total expenses, including Sales and Marketing, had a median percent of premium of 8.4%, 0.1 percentage point higher than the prior year. Sales and Marketing increased by 0.1 percentage point to a median of 2.0%.

Comparisons Across Universes

Health plans in other Sherlock Benchmark universes also offer Medicaid products. In this section, we compare the results of Medicaid HMO offered by Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans to those 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 44%, while the 25th and 75th percentiles were 25% and 58%, respectively.

Figure 8. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2017 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.4%	1.6%	1.7%	27%
Account and Membership Administration	2.5%	3.5%	4.1%	27%
Corporate Services	1.3%	1.5%	1.7%	21%
Subtotal: Core Expenses	5.9%	6.6%	7.4%	18%
Sales and Marketing	1.6%	2.0%	2.5%	42%
Total Expenses	7.6%	8.4%	9.2%	15%

Since all *Sherlock Benchmarks* data definitions are the same, it is possible to directly compare Medicaid MCO products offered by our Medicaid universe with similar products offered by the Blue Cross Blue Shield and Independent / Provider – Sponsored universes. Together, these three universes serve 5.0 million Medicaid HMO members.

Medicaid plans appear to have costs in the middle of the sets when measured by PMPM, but somewhat low measured as a percent of revenues. Shown in Figure 9, compared with the Medicaid universe, Medicaid HMO Core expenses for Blue Cross Blue Shield Plans were $28.35 PMPM more than Medicaid-focused plans, while 7 percentage points higher on a percent of premium basis. Independent / Provider – Sponsored plans were *lower* by $7.19 PMPM versus the Medicaid-focused plans. On a percent of premiums basis, however, Independent / Provider – Sponsored plans were higher by 0.6 percentage points.

Total expenses, including Sales and Marketing, produced similar results to differences in Core Expenses. Blue Cross Blue Shield Plans were $29.87 PMPM higher than Medicaid plans and higher by 5 percentage points on a percent of premiums basis. Independent / Provider – Sponsored plans were $7.11 PMPM lower and 0.1 percentage points higher than Medicaid-focused plans.

Figure 9. Sherlock Benchmark Summary
Medicaid HMO Product Characteristics by Universe, 2017 Results

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$23.06	$17.70	$47.20	$19.82
Median	25.69	18.50	54.04	25.44
75th Percentile	30.32	19.31	60.88	31.37
Coefficient of Variation	44%	6%	36%	51%
Percent of Premiums and Equivalents				
25th Percentile	5.8%	6.4%	10.7%	6.0%
Median	6.2%	6.7%	12.7%	6.6%
75th Percentile	8.5%	7.9%	14.7%	10.0%
Coefficient of Variation	33%	29%	45%	39%
Total Costs				
Per Member Per Month				
25th Percentile	$24.88	$19.53	$50.11	$22.00
Median	27.13	20.02	57.00	26.52
75th Percentile	33.63	20.78	63.89	36.92
Coefficient of Variation	50%	8%	34%	53%
Percent of Premiums and Equivalents				
25th Percentile	6.4%	6.6%	10.8%	6.6%
Median	7.1%	7.2%	12.3%	7.2%
75th Percentile	9.0%	9.0%	13.8%	10.5%
Coefficient of Variation	33%	34%	35%	35%
Plans Offering Medicaid	12	4	2	18
Medicaid HMO Members (millions)	3.96	0.31	0.68	4.95
Comprehensive Total Members (millions)	9.12	2.46	16.50	28.07

There is variation between the plans, but Independent / Provider – Sponsored plans tend to have lower Corporate Services and Medical and Provider Management expenses in the Medicaid HMO product versus the Medicaid universe. Blue Cross Blue Shield Plans had notably higher Medical Management and Account and Membership Administration expenses compared to the Medicaid Universe.

We don't know the reason for the low percent of premium administration and the high PMPM administration costs displayed in the Medicaid universe. One possibility is that the Medicaid focused plans serve members requiring a higher degree of administrative support: their more intense care needs may be associated with greater Medical Management and Claims costs.

How We Performed This Analysis

This analysis is based on the sixteenth annual edition of our performance benchmarks for Medicaid-focused health plans. The *Sherlock Benchmarks* (*Sherlock Expense Evaluation Report* or *SEER*) represent the cumulative experience of more than 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 Medicaid-focused plans possessing the ability to compile high-quality, segmented financial and operational data. This 16th analysis of Medicaid plans is based on a peer group of twelve plans who collectively serve 9.1 million people in comprehensive products. Eight of this year's participants participated in the prior year.

The average plan participating in the Medicaid *Sherlock Benchmarks* this year served 760,000 people under comprehensive products and the median membership was 578,000. The geographic reach extended from coast to coast.

Medicaid HMO and CHIP combined were 4.1 million members and composed 44% of the combined comprehensive membership and 44% of revenues for comprehensive products. The median Medicaid revenue and membership proportion was 44% and 35%, respectively.

All twelve plans served at least one type of Medicare product, either Medicare Advantage, Medicare SNP, or Medicare Cost. The median Medicare revenue and membership proportion was 23% and 11%, respectively. There were about 851,000 Medicare members served by these plans.

Forty-six percent, or 4.2 million, of all comprehensive members were served under a commercial product. Approximately 1.1 million were served under some form of self-insurance arrangement, comprising a little over a quarter 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 24 - 26 in Tab 2 of Volume I of the 2018 *Sherlock Benchmarks* reconciles these two presentations.

- Medicare Part D is not discussed here since only two provided cost segmentation.

- 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 $4.36 and the mean is $5.07, or approximately 11% of total administrative costs. (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 $1.20 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 $3.82 in 2016. The Risk Adjuster Fee and the CERF each had a median value of $0.20 PMPM. The Exchange User Fee only applies to Exchange members but the median fee for that population is $16.32 PMPM.

  On a constant-mix basis, per member Miscellaneous Business Tax costs decreased by 61.7% PMPM, compared with an decrease of 1.8% in 2016, a major shift from the surge of 617.7% in 2014.

Note on the Sherlock Benchmarks

These results are excerpted from the Medicaid-focused edition of the 2018 *Sherlock Benchmarks*. The results are based on our detailed surveys of 2017 operating parameters of 12 Medicaid 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 over 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 Medicaid-focused plan universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Independent / Provider – Sponsored Plans, Larger Health Plans, and Medicare Plans. We reported on the Blue Cross Blue Shield Plans, Independent / Provider – Sponsored Plans, and Medicare plans a few weeks ago and we will be holding a conference call on the results of within this Medicaid-focused report in the next week or so.

Appendix A. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2016 Results
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%

Appendix B. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2016 Results
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%

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

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
    - (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

This Page Intentionally Left Blank