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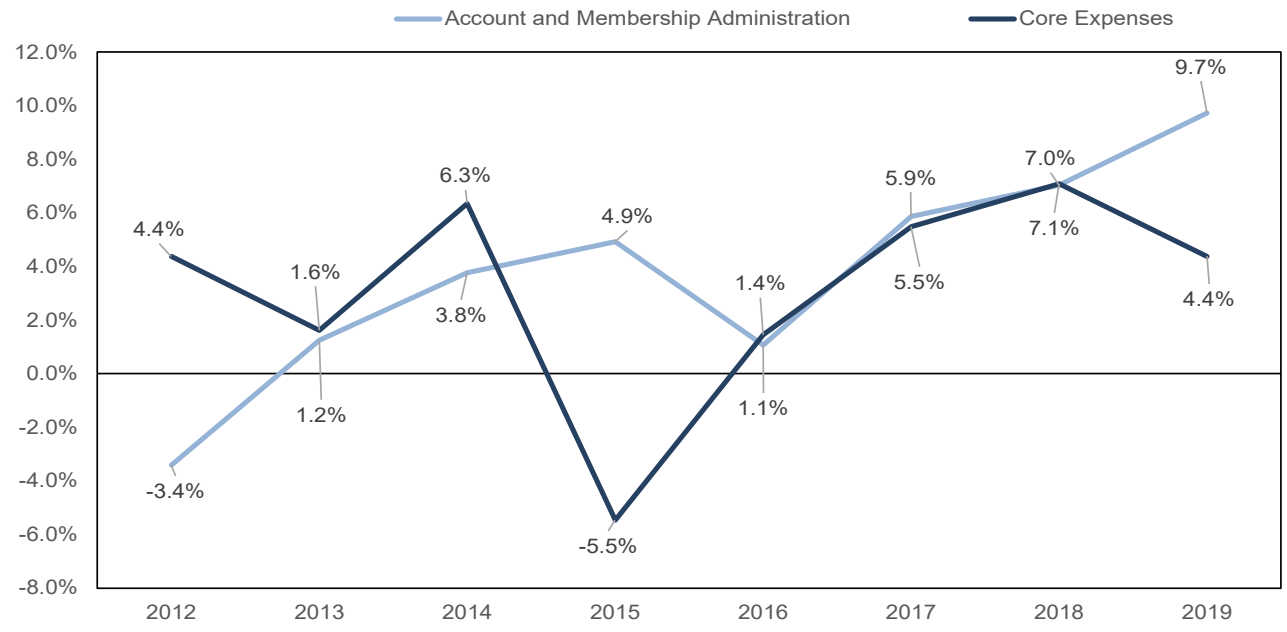
Growth Decelerates in Medicaid Plans' Core Expenses, while Account and Membership Administration Accelerates

Core per member administrative expenses in Medicaid-focused plans grew by 4.4% in 2019, a decline from 2018 and lower than in 2017. By contrast, the largest cluster, Account and Membership Administration, posted its largest growth since 2012, up by 9.7%. Figure 1 displays both trends since 2012. Rates of change hold plans and product mix constant in each year-over-year comparison.

These trends are based on the results of eight continuous plans serving 7.6 million members, of which 5.1 million were Medicaid or CHIP. This report is based on the results of this and new participants, which together served 8.4 million members of which 5.5 million were Medicaid or CHIP.

Core expenses exclude the Sales and Marketing cluster. State laws governing Sales and Marketing for Medicaid vary so we separate from core activities like Sales, Marketing, Rating and Underwriting, Advertising and Promotion and Broker Commissions from Core costs to preserve comparability.

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



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: 2019* (Issued September 2020), the proportion of Americans uninsured dropped from 13.3% in 2013 to 8.0% in 2019, a 5.3 percentage point decline.

Medicaid has historically been integral to this improvement. The peak change in Medicaid coverage was in 2014 with an increase of 6.7 million people. Medicaid membership increased from 55.9 million in 2013, peaking at 62.4 million in 2015. Medicaid participation has declined in each year from 2016 through 2019 to 55.9 million. Subject to qualifications noted on the chart, of the 15.7 million no longer uninsured, the 932,000 additions to Medicaid beneficiaries composed about 5.9% of the newly covered people.

Participation in Medicaid is likely sensitive to the economy. According to the Bureau of Labor Statistics, average annual civilian unemployment fell from 7.4% in 2013 to 3.7% in 2019. Accordingly, employer-based coverage increased by 8.6 million over that 2013-2019 period. In 2019, 4.7 million more people received health coverage through employer sponsored plans compared with 2018.

Direct purchase of health coverage increased by 16.3 million people between 2013 and 2015 to a peak of 52.1 million but has declined since then. This coverage was of 33.2 million people in 2019, a 2.6 million decline from 2013.

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

	2013		2014		2015		2016		2017		2018		2019		2019 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%	296,890	92.1%	296,206	91.5%	298,438	92.0%	2,232	0.8%	26,832	9.9%
Any Private Plan	201,038	64.1%	208,700	66.0%	214,238	67.2%	216,203	67.5%	218,209	67.7%	217,780	67.3%	220,848	68.0%	3,068	1.4%	19,810	9.9%
Employment-based	174,418	55.7%	175,027	55.4%	177,540	55.7%	178,455	55.7%	178,751	55.4%	178,350	55.1%	183,005	56.4%	4,655	2.6%	8,587	4.9%
Direct purchase	35,755	11.4%	46,165	14.6%	52,057	16.3%	51,961	16.2%	35,499	11.0%	34,846	10.8%	33,170	10.2%	-1,676	-4.8%	-2,585	-7.2%
Any Government Plan	108,287	34.6%	115,470	36.5%	118,395	37.1%	119,361	37.3%	112,151	34.8%	111,330	34.4%	110,687	34.1%	-643	-0.6%	2,400	2.2%
Medicare	49,020	15.6%	50,546	16.0%	51,875	16.3%	53,372	16.7%	56,170	17.4%	57,720	17.8%	58,779	18.1%	1,059	1.8%	9,759	19.9%
Medicaid	54,919	17.5%	61,650	19.5%	62,384	19.6%	62,303	19.4%	59,814	18.5%	57,819	17.9%	55,851	17.2%	-1,968	-3.4%	932	1.7%
Military health care	14,016	4.5%	14,143	4.5%	14,849	4.7%	14,638	4.6%	11,436	3.5%	11,754	3.6%	11,755	3.6%	1	0.0%	-2,261	-16.1%
Uninsured	41,795	13.3%	32,968	10.4%	28,966	9.1%	28,052	8.8%	25,600	7.9%	27,462	8.5%	26,111	8.0%	-1,351	-4.9%	-15,684	-37.5%
Total	313,401		316,168		318,869		320,372		322,490		323,668		324,549		881	0.3%	11,148	3.6%

Source: Health Insurance Coverage in the United States: 2019, https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf

Note: According to the Census Bureau 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."

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 eight *continuously participating* plans, per member core costs grew by 5.4% lower than the prior year's 7.1% increase.

The two columns that are labeled "as-reported" reflect per member trends in continuous plans. Implicit in this calculation is that a shift in favor of higher administrative cost products, such as Medicare Advantage and Medicare SNP, would lead to the appearance of accelerated growth, while a shift in favor of less expensive products would lead to deceleration. In 2019, cost trends did reflect a shift in favor of higher cost products, shown in higher cost growth on an as-reported basis 5.4% versus the constant-mix basis of 4.4%.

Comprehensive Total Membership for the eight continuously participating plans decreased by an average of 2.6%. Low cost Medicaid HMO increased by an average of 1.2%, while CHIP, at even lower cost, increased by an average of 5.0%. High cost Medicare Advantage increased by 4.3% and Medicare SNP grew by 11.0%. Five out of eight of the continuously participating plans served the Medicare Advantage and Medicare SNP populations. Commercial Total fell by an average of 9.5% with Commercial Insured down by an average of 13.0% and ASO down by 1.5%.

Trends Holding Product Mix Constant

Trends that eliminate the impact of product mix changes is a more accurate representation of trends so the discussion that follows is largely based on this. To make this calculation, we reweight the plans' product mix of the prior year to match that of the current year. Only those plans that report in both periods are compared.

Provider Network Management, Information Systems, and Actuarial were functions with especially rapid increases. Median non-labor costs per FTE, and the propensity to outsource were lower, while compensation per FTE and Medicaid staffing ratios were higher. (These metrics are calculated after converting outsourced staff, compensation and non-labor costs to internal equivalents. Staffing ratios are expressed holding product-mix constant.)

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

	2018 Increase		2019 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	6.8%	6.9%	8.5%	7.1%
Account and Membership Administration	7.0%	7.0%	10.1%	9.7%
Corporate Services	10.9%	10.1%	-0.4%	-2.3%
Subtotal: Core Expenses	7.1%	7.1%	5.4%	4.4%
Sales and Marketing	5.2%	1.8%	6.0%	5.6%
Total Expenses	7.0%	6.2%	5.8%	5.5%

(Throughout this discussion, we will refer to Medicaid staffing ratios. They are inferred based on the assumption that the labor/non-labor resource mix is the same for each product. This convention also assures comparability in staffing ratios between years.)

Account and Membership Administration

The Account and Membership Administration cluster of expenses posted a PMPM increase of 9.7%, on a constant-mix basis. Information Systems was, by far, the fastest growing function for this cluster and in total. This function's outsourcing was lower than last year. Conversely, compensation and non-labor costs per FTE, and inferred Medicaid staffing ratio for this function increased.

Customer Services also grew, at high single digits. The Customer Services functional area experienced higher compensation, non-labor costs, propensity to outsource, and inferred Medicaid staffing ratios. Enrollment / Membership / Billing and Claims both declined at a single digit rate.

Medical and Provider Management

Holding constant the product mix, PMPM expenses in the Medical and Provider Management cluster grew by 7.1%.

Both Provider Network Management and Services and Medical Management increased with Provider Network growing at a faster rate.

All Provider Network Management and Services sub-functions posted cost increases from the prior year. Staffing Costs per FTE and the inferred Staffing Ratios were higher than last year. Non-Labor Costs per FTE, however, was lower. The propensity to outsource was flat.

Medical Management / Quality Assurance / Wellness sub-functions that increased from the prior year include Nurse Information Line, Quality Components, Medical Informatics, and Other Medical Management. This function's compensation per FTE and inferred Medicaid Staffing Ratio grew, while Non-Labor Costs per FTE and outsourcing were lower.

Corporate Services Cluster

On a constant-mix basis, the Corporate Services cluster was the only cluster to post a PMPM decline, down by 2.3%.

The Corporate Services *Function* was the only function in this cluster to decline and did so at a mid-single digit rate. Due to its relatively large size, however, the Corporate Services Function offset the increases in the all the other functions. The sub-functions of Outside Litigation, Purchasing, Imaging, Printing and Mailroom, Risk Management, and Other Corporate Services declined.

All factors for Corporate Services function were lower, including Staffing Ratios, Staffing Costs per FTE, Non- labor Costs per FTE and Outsourcing.

The Actuarial function posted the largest rate of change, a low double-digit increase. The other functions of Finance and Accounting, and Corporate Executive and Governance, and Association Dues and License / Filing Fees increased by low-to-mid single digits.

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 5.6%, holding the product mix constant.

All Sales and Marketing functions experienced increases. Marketing posted the largest increase, at low double-digit rates. The median for Marketing's staffing costs per FTE, propensity to outsource, and staffing ratio were higher, while non-labor costs per FTE was lower. Rating and Underwriting and Advertising and Promotion experienced similar rates of growth. Broker Commissions and Sales experienced single digit rates of growth.

Trends on an As-Reported Basis

When a plan reports costs in sequential years, the changes in those costs reflect both real changes and the effect of changes in product mix. As noted earlier, the continuously reporting plans shifted in favor of higher cost products like Medicare Advantage so that as-reported costs grew faster than when product mix is eliminated.

This section will highlight the key trend differences between the as-reported and constant mix trend calculations.

The Account and Membership cluster posted faster as-reported growth 10.1% versus 9.7% on a constant-mix basis. Information Systems grew faster on an as-reported basis, while the growth in Customer Services slowed. Claims and Enrollment decreased on both an as-reported and constant-mix basis.

Medical and Provider Management increased by 8.5% on an as-reported basis, faster compared to the constant-mix basis of 7.1%. Both Medical Management and Provider Network Management grew at a faster pace on an as-reported basis.

The Corporate Services cluster's as-reported decline was muted compared to constant-mix at 0.4% compared to an as reported decline of 2.3%. Finance and Accounting and Association Dues and License/Filing Fees grew at a faster rate on an as-reported basis.

Core expenses increased by 5.4% on an as-reported basis compared to 4.4% on a constant-mix basis.

Sales and Marketing costs increased by 6.0%, faster by 0.4 percentage points over the constant-mix basis. Rating and Underwriting, Sales, and Broker Commissions experienced faster growth on an as-reported basis compared to constant-mix.

Summary of Cost Drivers

The above comments are based on eight continuously participating plans and includes the effect of staffing and costs performed on an outsourced basis. The median *core* Medicaid staffing ratio was higher by 10% for continuously participating plans at 23 FTEs per 10,000 Medicaid members. Of the 14 functional areas with staff, eight had staffing ratio increases and six had declines.

The median core compensation per FTE increased by 6% but varied by function. Customer Services posted the largest increase within core functions, while Marketing was the largest increase in total functions. Of the 14 functions with staff, 10 experienced increases from a year ago. The median core compensation was $102,000 per FTE and compensation for all functions was $105,000 per FTE.

Propensity to outsource, at a median of 11% (core was 10%), was lower than last year. Of the 14 functional areas with staff, four increased outsourcing, while two functions were flat from last year, and eight were lower.

On a constant mix basis, Information Systems posted the fastest PMPM growth among core functions and was also the most important source of increase. Actuarial and Provider Network Management and Services followed in rate of growth, while Medical Management was the second most important source of increase.

Costs of Medicaid-focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 10 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. There were four plans that dropped out of the universe from a year ago with two additions. Therefore, it is not possible to perfectly compare the performance of plans participating in this and last year based on Figure 4 and Appendix A. 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. Comprised of activities central to health plan operations, it increased by 4.1% to a median of $18.01 PMPM. This compares to the as-reported and constant-mix increase of 10.1% and 9.7%, respectively, shown in Figure 3. 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 was $8.99 PMPM, 0.9% lower than last year's value of $9.07. This cluster grew on an as-reported basis for the continuously participating plans by 8.5%, while increasing by 7.1% on a constant-mix basis. This group of functions includes Provider Network Management and Services and Medical Management.

The Corporate Services cluster costs were lower PMPM than last year at $6.69 versus $7.54, a decline of 11.3%. The as-reported increase for plans participating in both years was a decline of 0.4% and on a constant-mix basis a decrease of 2.3%. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities like Facilities, HR and Legal.

Core administrative expenses were $34.00 PMPM, 1.6% higher than last year's median of $33.48, shown in Appendix A. For plans participating in both years, as-reported and constant-mix growth in Core expenses was higher by 5.4% and 4.4%, respectively.

The Sales and Marketing cluster fell by 3.6% to a median of $8.48 PMPM (as-reported grew by 6.0% and constant-mix grew by 5.6%). Sales and Marketing functional areas includes Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Total Expenses grew by 2.5% to $42.42 PMPM (as-reported increased 5.8% and constant-mix was 5.5%).

Dispersion in Core Expenses, measured by the Coefficient of Variation, narrowed compared to last year. The dispersion in both Account and Membership Administration and Corporate Services tightened, while Medical and Provider Management became more scattered.

Figure 4. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2019 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$6.46	$8.99	$11.44	27%
Account and Membership Administration	14.52	18.01	19.56	25%
Corporate Services	5.93	6.69	7.51	22%
Subtotal: Core Expenses	$29.54	$34.00	$36.87	18%
Sales and Marketing	$4.87	$8.48	$11.11	51%
Total Expenses	$36.30	$42.42	$44.94	18%

Dispersion in Total Expenses also became more clustered, while dispersion in the Sales and Marketing increased.

Measured by the change in the difference between 25th and 75th percentiles, Corporate Services tightened but all other clusters, core expenses and total expenses broadened.

Costs of Medicaid-focused plans, PMPM by Product

The importance of considering each product's costs when evaluating a health plan's administrative costs is shown in Figure 5. The products vary greatly in their per member costs. For this reason, when we report results to participants, we often reweight product mix to eliminate the effect of any differences between those plans and their peers.

Note that Figure 5 displays total expenses by product, which *include* Sales and Marketing, except for the note at the bottom of that figure pertaining to Medicaid core expenses. The small differences between these Medicaid product costs and those in body of the figure include Risk Adjustment expenses plus other Sales and Marketing activities that meet *Sherlock Benchmark* definitions regardless of whether formally permitted by the states.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2019 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$26.92	$28.74	$36.06	27%
HMO	$26.97	$28.93	$37.15	30%
CHIP	$21.52	$25.14	$26.45	15%
Medicare Total	$105.11	$109.46	$154.55	58%
Advantage	$100.61	$102.09	$107.31	7%
SNP	$171.10	$228.89	$249.38	33%
Medicare Supplement	$29.49	$36.10	$44.99	56%
Commercial Insured Total	$43.50	$51.49	$61.16	23%
HMO	$41.45	$51.35	$61.83	25%
POS	$45.34	$49.92	$60.55	29%
Indemnity & PPO	$45.98	$52.56	$71.67	47%
Commercial ASO	$19.27	$20.75	$25.50	17%
Comprehensive Total	$36.30	$42.42	$44.94	18%
Note: Core Expenses of Medicaid				
Medicaid Total	$24.03	$25.80	$30.96	25%
HMO	$24.16	$26.08	$31.78	27%
CHIP	$19.27	$21.02	$22.95	12%

Median cost for Medicaid HMO was $28.93 PMPM and, for Medicaid CHIP, was $25.14 PMPM. For all ten participating plans, Medicaid HMO's average mix of members was 52% and its average mix of revenue was 43%. Medicaid CHIP's average member mix and revenue mix was 2% and 1%, respectively.

Note, Per Member Per Month *Core* expenses for Medicaid HMO and CHIP combined was $25.80. Medicaid HMO and Medicaid CHIP were $26.08 and $21.02, respectively. Core expenses exclude Sales and Marketing costs. Again, an estimate of the Sales and Marketing expenses associated with this product can be inferred from the note at the foot of the chart.

Medicare joins Medicaid as government-sponsored products. They serve seniors and the low-income population, respectively. There is some overlap between them in the case of Medicare Special Needs Plans ("SNP") products, which have many members that are dually eligible for both programs.

Medicare products are relatively high cost at $228.89 PMPM for Medicare SNP and $102.09 PMPM for Medicare Advantage. Average membership mix for Medicare Advantage was 8% and Medicare SNP was 1%. Average revenue mix for Medicare Advantage was 16%, Medicare Advantage SNP was 3%.

Note that Medicare Supplement is a lower than the median for comprehensive total at $36.10 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Four plans in the Medicaid universe offer the product and its mean product mix was 1%, while revenue mix was less than 1%.

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. 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 $51.35 PMPM. POS costs $49.92 PMPM, while Indemnity and PPO costs $52.56. Because of the modest per member Sales and Marketing expenses required for large groups ASO products have a median cost of $20.75 PMPM. The mean mix of Commercial products was 36% of the membership: Commercial Insured was 23% and Commercial ASO was 13%.

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

The ranking the products' administrative expenses by the percent of premiums is generally similar to the ranking of the PMPM costs with the exception of the Medicare products. Often, administrative activities correspond with population health care needs.

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 self-insured and fully-insured products.

Medicaid HMO was lower than comprehensive total on both a PMPM and percent of premium basis, at 7.3%. Medicaid CHIP was lower than comprehensive total on a PMPM basis, but at 10.9% is *higher* than average on a percent of premium basis.

Medicare SNP, the highest cost product on a PMPM basis, is tied for second highest on a percent of premium basis at 11.7%. Meanwhile, Medicare Advantage expenses, while about two times greater than Commercial HMO Insured products on a PMPM basis, is only somewhat higher on a percent of premium basis at 10.4%.

While Medicare Supplement is below comprehensive total when measured on a PMPM basis, at 13.0%, its cost ratio was the highest among the comprehensive products.

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2019 Results
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	6.8%	7.4%	8.9%	19%
HMO	6.6%	7.3%	8.9%	20%
CHIP	10.5%	10.9%	11.9%	12%
Medicare Total	9.8%	10.6%	11.8%	17%
Advantage	9.4%	10.4%	10.6%	10%
SNP	11.5%	11.7%	14.9%	24%
Medicare Supplement	9.8%	13.0%	18.0%	51%
Commercial Insured Total	8.8%	9.6%	11.2%	16%
HMO	8.1%	9.6%	11.0%	20%
POS	7.7%	7.9%	10.4%	32%
Indemnity & PPO	9.5%	11.7%	13.0%	22%
Commercial ASO	4.4%	5.4%	6.2%	26%
Comprehensive Total	7.8%	8.5%	9.0%	13%
Note: Core Expenses of Medicaid				
Medicaid Total	6.2%	6.7%	8.5%	20%
HMO	6.0%	6.7%	8.5%	21%
CHIP	9.3%	9.5%	9.9%	16%

Administrative expenses on a percent of premium basis for Commercial POS, HMO, and Indemnity and PPO were 7.9%, 9.6%, and 11.7%, respectively. These ratios, like the PMPMs, were generally higher than average.

Administrative expenses of Commercial ASO products are 5.4% 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 difference.

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

Figure 7 shows the ratios of administrative expenses to premiums or equivalents for expense clusters. Core administrative expenses increased by 0.09 percentage points to 6.6% over last year's median. At 1.3%, Corporate Services was lower by 0.24 percentage points than last year's median, while Medical and Provider Management grew by 0.03 percentage points to 1.8%. Account and Membership Administration increased by 0.48 percentage points to 3.6%.

Total expenses, including Sales and Marketing, had a median percent of premium of 8.5%, 0.18 percentage points higher than the prior year. Sales and Marketing declined by 0.10 percentage points to a median of 1.8%.

Comparisons Across Universes

Health plans in other *Sherlock Benchmark* universes also offered Medicaid products. In this section, we compare the results of Medicaid HMO offered by Medicaid-focused plans to this product offered by Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans to those organization. We define "focused" to be those plans that have a disproportionate commitment to the Medicaid product. The mean mix of members from Medicaid products for the Medicaid-focused plans was 55%.

Figure 7. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2019 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.5%	1.8%	2.4%	31%
Account and Membership Administration	3.1%	3.6%	4.2%	21%
Corporate Services	1.3%	1.3%	1.6%	26%
Subtotal: Core Expenses	6.0%	6.6%	8.0%	17%
Sales and Marketing	1.2%	1.8%	2.1%	46%
Total Expenses	7.8%	8.5%	9.0%	13%

Since the product and cost definitions are the same, it is possible to directly compare Medicaid HMO products offered by our Medicaid universe with similar products offered by the Blue Cross Blue Shield and Independent / Provider – Sponsored universes. Collectively, these plans serve 7.2 million Medicaid HMO members or approximately 13% of all eligible beneficiaries.

Shown in Figure 8, most of the comparisons align with the conclusion that focus helps drive down Medicaid health plan administrative costs. For instance, Blue Cross Blue Shield Plans Median core costs were $39.89 PMPM, or $13.80 greater than Medicaid-focused plans and, at 8.2% of premiums, were 1.5 percentage points higher. Likewise, Blue Cross Blue Shield Plans had total median expenses of $43.04 PMPM and was $14.10 higher than of Medicaid plans. Blue Plans' total administrative expenses as a percent of premiums at 8.8% was higher by 1.5 percentage points.

The results were similar compared with the universe of Independent / Provider – Sponsored plans. On a percent of premiums basis, Median core administrative expenses of Independent / Provider – Sponsored plans were higher by 1.3 percentage points at a median of 8.0% of premiums. Likewise IPS plans' total expenses, including Sales and Marketing, were on a percent of premium basis, 1.5 percentage points higher than Medicaid plans at 8.8%. Independent / Provider – Sponsored plans posted a median of $29.09 PMPM total administrative expenses, higher than Medicaid plans by $0.15. The one outlier was Core Independent / Provider – Sponsored plans PMPM, which were lower by $0.11 PMPM than the Medicaid-focused plans, with a median of $25.97.

Figure 8. Sherlock Benchmark Summary
Medicaid HMO Product Characteristics by Universe, 2019 Results

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$24.16	$23.12	$36.46	$25.14
Median	26.08	25.97	39.89	27.58
75th Percentile	31.78	50.58	59.55	38.14
Coefficient of Variation	27%	75%	49%	51%
Percent of Premiums and Equivalents				
25th Percentile	6.0%	7.2%	8.0%	6.3%
Median	6.7%	8.0%	8.2%	7.9%
75th Percentile	8.5%	8.7%	11.1%	8.8%
Coefficient of Variation	21%	28%	35%	28%
Total Costs				
Per Member Per Month				
25th Percentile	$26.97	$25.62	$39.02	$27.21
Median	28.93	29.09	43.04	30.38
75th Percentile	37.15	56.59	62.14	40.98
Coefficient of Variation	30%	75%	47%	50%
Percent of Premiums and Equivalents				
25th Percentile	6.6%	7.9%	8.6%	7.0%
Median	7.3%	8.8%	8.8%	8.4%
75th Percentile	8.9%	9.8%	11.6%	9.6%
Coefficient of Variation	20%	30%	32%	26%
Plans Offering Medicaid	10	3	3	16
Medicaid HMO Members (millions)	5.36	0.23	1.66	7.24
Comprehensive Total Members (millions)	8.37	4.63	47.41	60.41

How We Performed This Analysis

This analysis is based on the eighteenth 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 893 health plan years over 23 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 analysis of Medicaid plans is based on a peer group of ten plans who collectively served 8.4 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 837,000 people under comprehensive products and the median membership was 554,000. The geographic reach extended from coast to coast.

Medicaid HMO and CHIP combined were 5.5 million members and composed 65% of the combined comprehensive membership and 61% of revenues for comprehensive products. The average Medicaid revenue and membership proportion was 44% and 55%, respectively.

Eight out of ten plans served at least one type of Medicare product, Medicare Advantage or Medicare SNP. The average Medicare revenue and membership proportion was 19% and 9%, respectively. There were about 616,000 Medicare members served by these plans.

Of all comprehensive members, 27%, or 2.2 million, were served under a commercial product. Approximately 775,000 were served under some form of self-insurance arrangement, comprising 9% of 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 constant set of plans 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 2020 *Sherlock Benchmarks* reconciles these two presentations.

- 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.

Note on the Sherlock Benchmarks

With the increase in unemployment since mid-March, the secondary effects of the coronavirus may lead to declines in health plan membership and shifts in product mixes. Commercial membership, especially insured, is especially susceptible to declines, while Medicaid and Medicare Advantage may increase in proportion or even in numbers of enrollees.

The *Sherlock Benchmarks* can assist in adapting and achieving operational efficiency driven by the recently volatile operating environment. Moreover, the benchmarks can assist in budgeting for changes in membership and product-mix and for projecting for changes in staffing needs.

The analysis in this *Navigator* is excerpted from the Medicaid edition of the 2020 *Sherlock Benchmarks*. In addition to the Medicaid universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Independent / Provider – Sponsored plans, Larger Health plans, and Medicare - focused plans. Collectively, these plans serve approximately 63 million members. Much more information on health plan costs and operational drivers is available by licensing the *Sherlock Benchmarks*.

Tables of Contents, report formats, citations, quality assurance and other information can be found on the following page.

https://sherlockco.com/sherlock-benchmarks/

In addition, the Sherlock Company website has an application that allows you to try out the Benchmarks for no charge.

https://sherlockco.com/test-drive/

If you are interested in licensing these materials 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 at sherlock@sherlockco.com.

Appendix A. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2018 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$7.69	$9.07	$11.19	25%
Account and Membership Administration	14.73	17.30	19.23	29%
Corporate Services	6.54	7.54	9.33	26%
Subtotal: Core Expenses	$30.97	$33.48	$37.28	21%
Sales and Marketing	$7.42	$8.79	$11.31	42%
Total Expenses	$40.13	$41.39	$45.95	20%

Appendix B. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2018 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.5%	1.7%	2.6%	39%
Account and Membership Administration	2.9%	3.1%	4.1%	38%
Corporate Services	1.4%	1.6%	1.9%	38%
Subtotal: Core Expenses	5.9%	6.6%	8.3%	34%
Sales and Marketing	1.3%	1.9%	2.1%	46%
Total Expenses	7.6%	8.3%	9.6%	32%

Appendix C. Sherlock Benchmark Summary

Major Functions Included in Each Administrative Expense Cluster

Sales & Marketing

1. Rating and Underwriting
   - (b) Risk Adjustment
   - (c) All Other Rating and Underwriting
2. Marketing
   - (a) Product Development and Market Research
   - (b) Member and Group Communication
   - (c) Other Marketing
3. Sales
   - (a) Account Services
   - (b) Internal Sales Commissions
   - (c) Other Sales
4. External Broker Commissions
5. Advertising and Promotion
   - (a) Media and Advertising
   - (b) Charitable Contributions

Provider & Medical Management

6. Provider Network Management and Services
   - (a) Provider Relations Services
   - (b) Provider Contracting
     - (1) Provider Configuration
     - (2) Other Provider Contracting
   - (d) Other Provider Network Management and Services
7. 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

8. Enrollment / Membership / Billing
   - (a) Enrollment and Membership
   - (b) Billing
9. Customer Services
   - (a) Member Services
   - (b) Printed Materials and Other
10. Claim and Encounter Capture and Adjudication
    - (a) Coordination of Benefits (COB) and Subrogation
    - (e) Other Claim and Encounter Capture and Adjudication
11. 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

12. Finance and Accounting
    - (a) Credit Card Fees
    - (b) All Other Finance and Accounting
13. Actuarial
14. Corporate Services Function
    - (a) Human Resources
    - (b) Legal
      - (1) Compliance
      - (2) Government Affairs
      - (3) Outside Litigation
      - (4) Fraud, Waste and Abuse
      - (5) All Other Legal
    - (c) Facilities
    - (e) Audit
    - (f) Purchasing
    - (g) Imaging
    - (h) Printing and Mailroom
    - (i) Risk Management
    - (j) Other Corporate Services Function
15. Corporate Executive & Governance
16. Association Dues and License/Filing Fees

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