Plan Management Navigator

Analytics for Health Plan Administration

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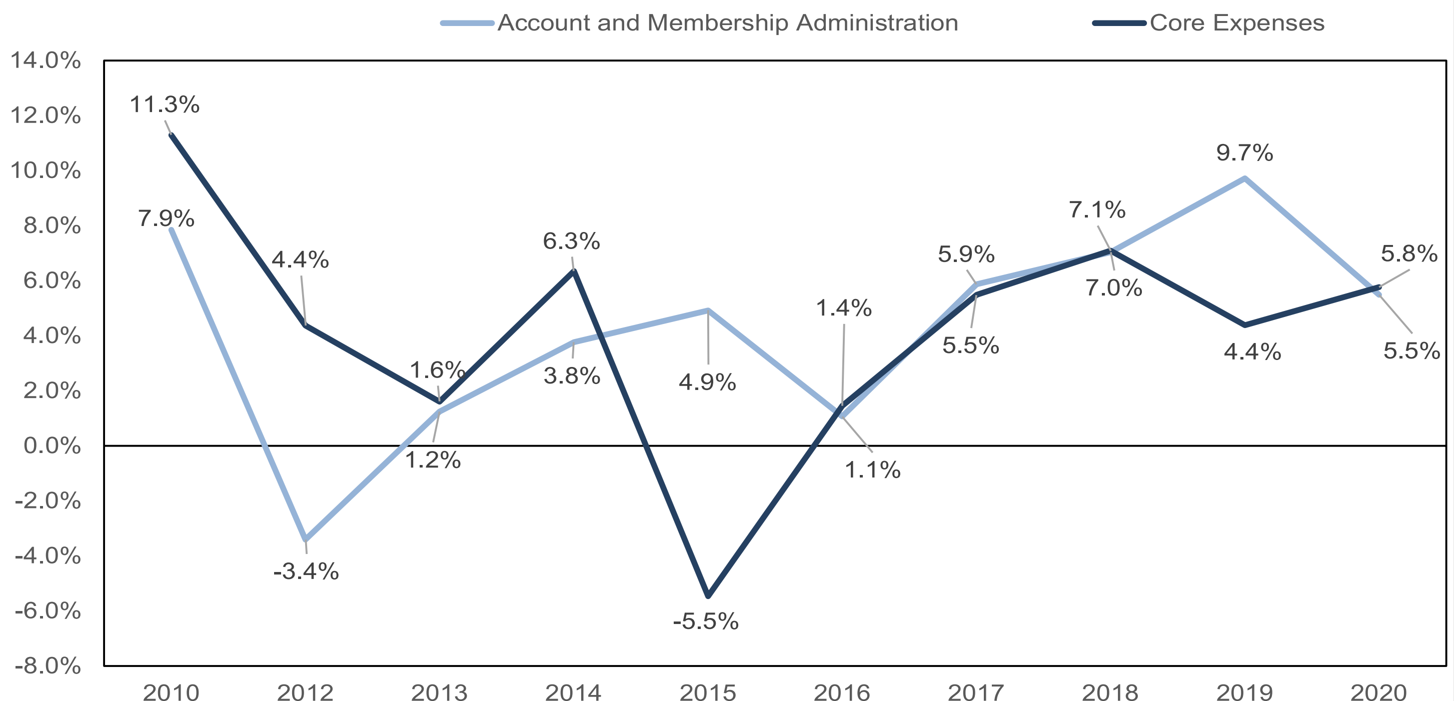
Growth in Core Expenses in Medicaid Plans Accelerates in 2020

"Core" per member administrative expenses in Medicaid-focused plans grew by 5.8% in 2020, an acceleration from 2019 of 4.4%. By contrast, the Account and Membership Administration sharply decelerated by 4.2 percentage points, from 9.7% to 5.5%.

Figure 1 displays both trends since 2010. Rates of change hold both plans and product mix constant in each year-over-year comparison. Cost trends in 2020 for both Core and Account and Membership Administration exceeded the average trends since 2010.

The cost trends for 2020 are based on the results of seven continuous plans serving 6.0 million members, of which 3.6 million were Medicaid or CHIP. This report is based on the results of this and new participants, which together served 11.1 million members of which 6.1 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 activities like Sales, Marketing, Rating and Underwriting, Advertising and Promotion and Broker Commissions from Core costs to preserve comparability between plans operating in different states.



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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: 2020* (Issued September 2021), the proportion of Americans uninsured dropped from 13.3% in 2013 to 8.6% in 2020, a 4.8 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 then increased in 2020. During that year, Utah, Idaho, and Nebraska expanded Medicaid. Subject to qualifications noted on the chart, of the 13.8 million no longer uninsured since 2013, the 3.0 million additions to Medicaid beneficiaries composed about 22% of the newly covered people.

Additionally, the effects of COVID-19 likely increased Medicaid enrollment. According to US Census Bureau:

> "The Families First Coronavirus Response Act required states, as a condition of receiving increased Medicaid funding, to provide continuous coverage for those enrolled in Medicaid. A recent Centers for Medicare & Medicaid Services report showed that Medicaid enrollment increased dramatically in 2020, after declines in enrollment from 2017 to 2019. Specifically, annual Medicaid enrollment during the period February 2020 through January 2021 increased from 34.0 million to 40.2 million among adults aged 19 and older."

Figure 2. Sherlock Benchmark Summary

Health Insurance Coverage in the United States: Census Bureau

(Enrollment in Millions)

	2013		2014		2015		2016		2017		2018		2019		2020		2020 Chg.	Per. Chg.	Cml. Chg.	Per. Chg.
Any Health Plan	272	86.7%	283	89.6%	290	90.9%	292	91.2%	297	92.1%	296	91.5%	298	92.0%	298	91.4%	-0.8	-0.3%	26.1	9.6%
Any Private Plan	201	64.1%	209	66.0%	214	67.2%	216	67.5%	218	67.7%	218	67.3%	221	68.0%	217	66.5%	-4.3	-2.0%	15.5	7.7%
Employment-based	174	55.7%	175	55.4%	178	55.7%	178	55.7%	179	55.4%	178	55.1%	183	56.4%	177	54.4%	-5.8	-3.2%	2.8	1.6%
Direct purchase	36	11.4%	46	14.6%	52	16.3%	52	16.2%	35	11.0%	35	10.8%	33	10.2%	34	10.5%	0.9	2.6%	-1.7	-4.8%
Any Government Plan	108	34.6%	115	36.5%	118	37.1%	119	37.3%	112	34.8%	111	34.4%	111	34.1%	113	34.8%	2.7	2.4%	5.1	4.7%
Medicare	49	15.6%	51	16.0%	52	16.3%	53	16.7%	56	17.4%	58	17.8%	59	18.1%	60	18.4%	1.1	1.8%	10.8	22.1%
Medicaid	55	17.5%	62	19.5%	62	19.6%	62	19.4%	60	18.5%	58	17.9%	56	17.2%	58	17.8%	2.1	3.7%	3.0	5.5%
Military health care	14	4.5%	14	4.5%	15	4.7%	15	4.6%	11	3.5%	12	3.6%	12	3.6%	12	3.7%	0.4	3.5%	-1.9	-13.2%
Uninsured	42	13.3%	33	10.4%	29	9.1%	28	8.8%	26	7.9%	27	8.5%	26	8.0%	28	8.6%	1.8	7.1%	-13.8	-33.1%
Total	313		316		319		320		322		324		325		326		1.1	0.3%	12.2	3.6%

Source: Health Insurance Coverage in the United States: 2020, https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.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 yea 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."

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The Families First Coronavirus Response Act was signed into law on March 18, 2020.

Participation in Medicaid is likely sensitive to economic cycles, however they arise. According to the Bureau of Labor Statistics, the highest unemployment rate in 2020 was 14.8% during the month of April and compares to 3.6% in April 2019. Accordingly, employer-based coverage fell by 5.8 million people from 2019 to 2020 as Medicaid increased by 2.1 million people to 57.9 million. (Longer term trends for employer-based coverage increased by 2.8 million people from 2013 to 2020.)

Direct purchase of health coverage ("Coverage purchased directly from an insurance company, or through a federal or state Marketplace") increased by 871,000 people from 2019 to 2020. But from 2013 to 2020, the number of people obtaining health insurance under Direct Purchase fell by 1.7 million.

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 participating* plans, per member *core* costs grew by 5.8% higher than the prior year's 4.4% increase. This trend was also shown earlier in Figure 1.

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 such as Medicaid would show apparent deceleration. In 2020, cost trends did reflect a shift in favor of lower cost products, shown in slower cost growth on an as-reported basis 4.9% versus the constant-mix basis of 5.8% for *Core* Expenses.

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

	2019 Increase		2020 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	8.5%	7.1%	4.2%	2.3%
Account and Membership Administration	10.1%	9.7%	3.6%	5.5%
Corporate Services	-0.4%	-2.3%	4.5%	2.5%
Subtotal: Core Expenses	5.4%	4.4%	4.9%	5.8%
Sales and Marketing	6.0%	5.6%	4.1%	2.2%
Total Expenses	5.8%	5.5%	5.4%	4.3%

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Medicare Advantage's share increased slightly while Medicaid increased more sharply. Commercial declined and it was especially pronounced for the higher cost insured products. Comprehensive Total Membership for the seven continuously participating plans increased by an average of 2.6%. Low cost Medicaid HMO increased by an average of 6.5%, while CHIP, at even lower cost, *decreased* by an average of 4.8% for a total Medicaid increase of 6.2%. High cost Medicare Advantage increased slightly by 0.9% and Medicare SNP grew by 14.6%, for a total Medicare increase of 4.2%. Five out of seven of the continuously participating plans served the Medicare Advantage and Medicare SNP populations: Commercial Total fell by an average of 2.7% with Commercial Insured down by an average of 6.2% and ASO down by 1.3%.

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 reported in both periods are compared.

Information Systems and Corporate Executive and Governance were Core functions with especially rapid increases. External Broker Commissions and Advertising and Promotion grew very rapidly among the Sales and Marketing expenses.

Core and Total Staffing Costs per FTE were higher and Medicaid Staffing Ratios were lower. Outsourcing increased for Core Expenses but not for Total Expenses, and Non-Labor Costs per FTE were higher for Total but Not for Core Expenses.

These metrics are calculated after converting outsourced staff, compensation and non-labor costs to internal equivalents. Staffing ratios are expressed holding product-mix constant. 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 that the plans offer. In addition to being the staffing ratio of the greatest interest to *Navigator* audiences, 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 5.5%, on a constant-mix basis.

Information Systems was the fastest growing function and most important source of growth for this cluster. This function's Medicaid Staffing Ratio was higher than last year. Its Non-Labor Costs per FTE and Staffing Costs per FTE, however, were lower. Information Systems sub-functions all increased except for Applications Maintenance.

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Enrollment / Membership / Billing grew by a mid-single digit rate. Enrollment / Membership / Billing Staffing Costs per FTE and Medicaid Staffing Ratios were higher. Conversely, Customer Services and Claim and Encounter Capture and Adjudication posted declines both functions by a low single-digit rate.

For the purposes of *Navigator*, we include Behavioral Health and Pharmacy administration in overall cost trends and those of Account and Membership Administration. If these activities were excluded, Total Administrative expenses would have increased by 4.2% rather than the 4.3% that we show in Figure 3. Likewise, the increase in Account and Membership Administration would have been 4.9% rather than the 5.5% shown. The median increase in Pharmacy and Behavioral Health administrative costs, PMPM, was 6.4%. Pharmacy administration increased while Behavioral Health decreased.

Corporate Services Cluster

On a constant-mix basis, the PMPM Corporate Services cluster costs increased by 2.5%.

Corporate Executive and Governance posted the fastest growth in this cluster and in total, by a double-digit rate. This function's Medicaid staffing ratio increased, while Staffing per FTE and propensity to outsource were lower.

The Corporate Services *Function* was the cluster's most important source of growth due to its relatively large size. All its sub-functions increased, except for Audit and Printing and Mailroom. Corporate Services function posted higher Medicaid Staffing Ratios, Propensity to Outsource, and Compensation per FTE. Non-Labor Costs per FTE, however, was lower.

The functions of Finance and Accounting, Actuarial, and Association Dues and License / Filing Fees also increased.

Medical and Provider Management

Holding constant the product mix, PMPM expenses in the Medical and Provider Management cluster grew by 2.3%.

The Provider Network Management and Services functional area grew at a faster rate than Medical Management, but due to its size, Medical Management was a greater driver in the cluster's increase.

The Provider Network Management and Services sub-functions of Provider Contracting and Provider Relations Services posted cost increases from the prior year. Other Provider Network Management and Services (report cards, in service, provider newsletters) did not. Provider Network Management and Services Compensation per FTEs increased, while Medicaid Staffing Ratio, Non-Labor Costs, and Outsourcing were lower.

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Medical Management / Quality Assurance / Wellness increased on higher Staffing, Non-Labor Costs, and Outsourcing. Medicaid Staffing Ratios for this function, however, was lower.

Of the nine Medical Management subfunctions, all were higher except for Precertification, Case Management and Utilization Review. Nurse Information Line, Health and Wellness and Other Medical Management all increased by double digit rates.

Sales and Marketing

While Sales and Marketing is not included in *Core* expenses, it is still central to Commercial and Medicare products that are also offered by these Medicaid-focused plans. The Sales and Marketing cluster grew by 2.2%, holding the product mix constant. The remaining Sales and Marketing functional areas increased by a single digit rate. Sales was the only function to post a decrease.

All other Sales and Marketing functions experienced increases. Advertising and Promotion posted the fastest increase in this cluster, at low double-digit rates, closely followed by Broker Commissions.

The median Staffing Costs per FTE and Non-Labor Costs per FTE increased from last year. This cluster's Medicaid Staffing Ratio was lower.

As-Reported Trends

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 lower cost products like Medicaid so that Core as-reported costs grew slower than when product mix is eliminated, 4.9% versus 5.8% for constant-mix. This section will highlight the key trend differences between the as-reported and constant mix trend calculations.

The Account and Membership cluster posted slower as-reported growth, 3.6% versus 5.5%, on a constant-mix basis. Information Systems increased at a slower rate on an as-reported basis, with its sub-function of Operations and Support Services growing at a slower rate. The increase in Enrollment / Membership / Billing was slightly faster on an as-reported basis, while the as-reported declines in Customer Services and Claims were similar to the constant-mix basis.

Medical and Provider Management increased by 4.2% on an as-reported basis, faster compared to the constant-mix basis of 2.3%. The Medical Management function was most responsible for the faster as-reported increase, and was sharply higher on this basis. Provider Network Management and Services posted similar growth rates on both an as-reported and constant-mix basis.

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The Corporate Services cluster as-reported growth of 4.5% was faster than the constant-mix increase of 2.5%. Actuarial, Corporate Services Function, and Association Dues and License / Filing Fees were notably faster growing and likely responsible for the faster as-reported growth.

Core expenses increased by 5.8% on an as-reported basis compared to 4.9% on a constant-mix basis.

Sales and Marketing costs, which are not Core in this universe, increased by 4.1% on an as-reported basis and compares to a 2.2% increase on a constant-mix basis. Rating and Underwriting, Marketing and Broker Commissions experienced faster growth on an as-reported basis compared to constant-mix.

Summary of Cost Drivers

We think that it is helpful to understand functional expenses by their drivers. PMPM costs can be thought of as the product of the staffing ratio and total costs per FTE. The total costs per FTE is the sum of staffing and non-labor costs per FTE. The comments in this section are based on *median* values for the seven continuously participating plans and includes staffing and costs performed on an outsourced basis.

The median *Core* Medicaid staffing ratio was lower by 5% to 21 FTEs per 10,000 Medicaid members. Of the 14 functional areas with staff, half posted increases. (To be clear, this reflects both internal and outsourced staffing. Outsourced staffing is inferred, often calculated by the plans from invoice amounts using historical norms of total costs per FTE, then applied to the Medicaid product by assuming that all products have the same mix of staffing and non-labor costs.)

The median Core compensation per FTE increased by 2% to approximately $101,000. Of the 14 functions with staff, 9 experienced increases from a year ago. Compensation for all functions was about $102,000 per FTE.

Propensity to outsource, at a median of 8% (Core was 9%), was higher than last year for both total and core. Of the 14 functional areas with staff, eight increased outsourcing, while one function was flat from last year.

On a constant-mix basis, Corporate Executive and Governance posted the fastest PMPM increase among core functions. Information Systems, however, was the most important source of growth among core functions. Note, Information Systems was the second fastest growing core functional area. Association Dues and License / Filing Fees and Corporate Services Function followed in their growth rates.

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Costs of Medicaid-focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 11 participating Medicaid-focused plans. In this section we'll touch on comparisons with the results reported last year, notwithstanding important 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 three plans that dropped out of the universe from a year ago with four 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 7.6% to a median of $19.38 PMPM. It was the greatest percent increase among the clusters. This compares to the as-reported and constant-mix increase of 3.6% and 5.5%, respectively, shown in Figure 3, and Account and Membership Administration also had the fastest real grown among continuous plans. This cluster's size means that it has a substantial effect on overall trend. This cluster includes Information Systems, Enrollment, Claims and Customer Services.

Medical and Provider Management costs per member per month was $9.28 PMPM, 3.3% higher than last year's value of $8.99. This cluster grew on an as-reported basis for the continuously participating plans by 4.2%, while increasing by 2.3% on a constant-mix basis. This group of functions includes Provider Network Management and Services and Medical Management.

Figure 4. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2020 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$7.59	$9.28	$11.80	30%
Account and Membership Administration	15.27	19.38	20.82	22%
Corporate Services	5.64	6.87	7.31	30%
Subtotal: Core Expenses	$29.22	$32.47	$39.44	23%
Sales and Marketing	$5.61	$8.20	$9.72	45%
Total Expenses	$35.49	$41.99	$47.56	19%

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The Corporate Services cluster costs were lower PMPM than last year at $6.87 versus $6.69, an increase of 2.7%. The as-reported increase for plans participating in both years was an increase of 4.5% and on a constant-mix basis an increase of 2.5%. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities that include Facilities, HR and Legal.

Median Core administrative expenses were $32.47 PMPM, 4.5% lower than last year's median of $34.02, shown in Appendix A. (Average Core costs were higher by 2.3%.) For plans participating in both years, as-reported and constant-mix growth in Core expenses was higher by 4.9% and 5.8%, respectively.

The Sales and Marketing cluster fell by 3.3% to a median of $8.20 PMPM (as-reported grew by 4.1% and constant-mix grew by 2.2%). Sales and Marketing functional areas include Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Median Total Expenses decreased by 1.0% to $41.99 PMPM from $42.42 PMPM. For continuously reporting plans as-reported costs increased 5.4% and constant-mix growth was 4.3%.

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

Dispersion in Total Expenses became more scattered, while dispersion in the Sales and Marketing decreased.

Measured by the change in the difference between 25th and 75th percentiles, all clusters besides Medical and Provider Management and Sales and Marketing widened. Core Expenses and Total Expenses widened.

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 all the other Sales and Marketing activities that meet *Sherlock Benchmark* definitions regardless of whether formally permitted by the states.

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Median cost for Medicaid HMO was $29.40 PMPM and, for Medicaid CHIP, was $25.98 PMPM. For all eleven participating plans, Medicaid HMO's average mix of members was 59% and its average mix of revenue was 51%. Medicaid CHIP's average member mix and revenue mix was 2% and 1%, respectively.

Please see the note at the foot of this chart. Per Member Per Month *Core* expenses for Medicaid HMO and CHIP combined was $28.02. Medicaid HMO was also $28.02 and Medicaid CHIP was $23.68. Core expenses exclude Sales and Marketing costs. An estimate of the Sales and Marketing expenses associated with this product can be inferred this note.

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 $204.44 PMPM for Medicare SNP and $112.90 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 2%.

Note that Medicare Supplement has lower costs than the median for comprehensive total at $24.43 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Three plans in the Medicaid universe offer the product and its mean product mix was 1%, while revenue mix was less than 1%.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2020 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$27.56	$29.40	$37.98	28%
HMO	27.85	29.40	39.24	28%
CHIP	$21.76	$25.98	$28.68	50%
Medicare Total	$110.09	$124.88	$170.61	43%
Advantage	101.72	112.90	126.78	32%
SNP	$183.05	$204.44	$288.43	38%
Medicare Supplement	$20.08	$24.43	$29.58	38%
Commercial Insured Total	$45.71	$52.27	$61.88	20%
HMO	43.57	52.90	59.07	21%
POS	47.97	60.07	74.84	34%
Indemnity & PPO	$43.18	$58.01	$82.79	50%
Commercial ASO	$18.10	$23.01	$28.98	31%
Comprehensive Total	$35.49	$41.99	$47.56	19%
Note: Core Expenses of Medicaid				
Medicaid Total	$25.26	$28.02	$33.91	29%
HMO	25.62	28.02	35.78	29%
CHIP	$17.86	$23.68	$25.58	56%

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Commercial administrative expenses are both higher and lower than the median comprehensive total. The costs of Commercial *Insured* products are accordingly higher than the median for comprehensive products. This bifurcation 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. Because of the modest per member Sales and Marketing expenses required for large groups ASO products have a median cost of $23.01 PMPM.

The single most important Commercial Insured product is HMO at $52.90 PMPM. POS costs $60.07 PMPM, while Indemnity and PPO costs $58.01. The mean mix of Commercial products was 30% of the membership: Commercial Insured was 15% and Commercial ASO was 15%.

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

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

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2020 Results
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	6.8%	8.4%	9.1%	19%
HMO	6.8%	8.2%	9.2%	19%
CHIP	10.9%	11.5%	15.6%	60%
Medicare Total	10.3%	11.5%	13.4%	32%
Advantage	10.5%	10.7%	13.3%	39%
SNP	10.3%	14.5%	18.1%	36%
Medicare Supplement	8.9%	9.0%	12.4%	36%
Commercial Insured Total	8.8%	9.3%	10.0%	15%
HMO	8.1%	9.2%	11.0%	21%
POS	7.2%	8.8%	11.4%	40%
Indemnity & PPO	8.6%	9.9%	15.4%	49%
Commercial ASO	4.6%	6.3%	7.8%	33%
Comprehensive Total	8.0%	8.7%	9.3%	14%
Note: Core Expenses of Medicaid				
Medicaid Total	6.3%	7.3%	8.4%	21%
HMO	6.2%	7.1%	8.4%	22%
CHIP	8.9%	10.1%	14.7%	67%

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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 8.2%. Medicaid CHIP was lower than comprehensive total on a PMPM basis, but at 11.5% is *higher* than average on a percent of premium basis.

Medicare SNP, the highest cost product on a PMPM basis, is also the highest on a percent of premium basis at 14.5%, but this difference relative to other products is far less than on a PMPM basis. Meanwhile, Medicare Advantage expenses, while over two times greater than Commercial HMO Insured products on a PMPM basis, is only somewhat higher on a percent of premium basis at 10.7%.

While Medicare Supplement is below comprehensive total when measured on a PMPM basis, at 9.0%, its cost ratio was slightly greater than comprehensive total.

Administrative expenses on a percent of premium basis for Commercial POS, HMO, and Indemnity and PPO were 8.8%, 9.2%, and 9.9%, respectively. These ratios, like the PMPMs, were higher than comprehensive total of 8.7%.

Administrative expenses of Commercial ASO products are 6.3% 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 difference.

Costs of Medicaid - Focused plans, Expense Clusters as a Percent of Premium

Figure 7 shows the ratios of administrative expenses to premiums or equivalents for expense clusters. Core administrative expenses decreased by 0.12 percentage points to 6.5% compared with last year's median, shown in Appendix B. Corporate Services cluster fell by 0.02 percentage points to 1.3%. Medical and Provider Management was up by 0.16 percentage points to 1.9%, while Account and Membership Administration was higher by 0.09 percentage points to 3.7%.

Figure 7. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2020 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.7%	1.9%	2.5%	28%
Account and Membership Administration	3.1%	3.7%	4.1%	20%
Corporate Services	1.1%	1.3%	1.6%	22%
Subtotal: Core Expenses	6.2%	6.5%	8.5%	20%
Sales and Marketing	1.0%	1.7%	2.2%	43%
Total Expenses	8.0%	8.7%	9.3%	14%

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Total expenses, including Sales and Marketing, had a median percent of premium of 8.7%, 0.28 percentage points higher than the prior year. Sales and Marketing declined by 0.12 percentage points to a median of 1.7%.

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 59%.

Figure 8. Sherlock Benchmark Summary

Medicaid HMO Product Characteristics by Universe, 2020 Results

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$25.62	$22.07	$41.55	$24.36
Median	28.02	26.35	45.74	28.85
75th Percentile	35.78	33.07	49.93	37.50
Coefficient of Variation	29%	25%	26%	31%
Percent of Premiums and Equivalents				
25th Percentile	6.2%	8.0%	11.3%	6.7%
Median	7.1%	9.6%	12.0%	8.4%
75th Percentile	8.4%	11.3%	12.8%	10.3%
Coefficient of Variation	22%	26%	18%	28%
Total Costs				
Per Member Per Month				
25th Percentile	$27.85	$24.57	$41.83	$26.51
Median	29.40	27.73	46.02	29.91
75th Percentile	39.24	37.79	50.21	40.90
Coefficient of Variation	28%	27%	26%	29%
Percent of Premiums and Equivalents				
25th Percentile	6.8%	8.5%	10.6%	7.2%
Median	8.2%	10.2%	11.5%	9.1%
75th Percentile	9.2%	13.0%	12.4%	10.2%
Coefficient of Variation	19%	28%	22%	27%
Plans Offering Medicaid	11	6	2	19
Medicaid HMO Members (millions)	5.94	0.43	0.25	6.62
Comprehensive Total Members (millions)	11.12	6.22	20.56	37.90

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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 6.62 million Medicaid HMO members or approximately 11% of all eligible beneficiaries.

Shown in Figure 8, most of the comparisons generally 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 $45.74 PMPM, or $17.72 greater than Medicaid-focused plans and, at 12.0% of premiums, were 4.9 percentage points higher. Likewise, Blue Cross Blue Shield Plans had *total* median Medicaid expenses of $46.02 PMPM and was $16.62 higher than of Medicaid plans. Blue Plans' total Medicaid administrative expenses as a percent of premiums, at 11.5%, was higher by 3.3 percentage points.

Independent / Provider – Sponsored plans' Medicaid costs relative to the Medicaid focused plans were more ambiguous. Their median core costs were $1.66 PMPM *lower* than the Medicaid-focused plans. On a percent of premium basis, however, IPS plans' core costs were higher by 2.5 percentage points to a median of 9.6%. Total expenses, which includes Sales and Marketing, was lower by $1.67 PMPM, but higher on a percent of premium basis by 2.0 percentage points to 10.2%.

How We Performed This Analysis

This analysis is based on the nineteenth 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 929 health plan years over 24 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 eleven plans who collectively served 11.1 million people in comprehensive products. Seven of this year's participants also participated in the prior year.

The average plan participating in the Medicaid *Sherlock Benchmarks* this year served 1.0 million people under comprehensive products and the median membership was 542,000. The geographic reach extended from coast to coast.

Medicaid HMO and CHIP combined were 6.1 million members and composed 55% of the combined comprehensive membership and 59% of revenues for comprehensive products. The average Medicaid revenue and membership proportion was 48% and 61%, respectively.

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All but one plan served at least one type of Medicare product, Medicare Advantage or Medicare SNP. The average Medicare revenue and membership proportion was 18% and 8%, respectively. There were about 712,000 Medicare members served by these plans.

Of all comprehensive members, 38%, or 4.2 million, were served under a commercial product. Approximately 2.5 million were served under some form of self-insurance arrangement, comprising 59% of total commercial members.

The panel of plans that participated in the *Sherlock Benchmarks* for Medicaid plans was formed mainly in the Spring of 2021. Survey materials were distributed to the participants in the first week in June and completed surveys were received back to us beginning in July. Sherlock Company performed a number of validation procedures with the active collaboration of the participating plans. Sherlock Company's compilation and report publication (including company specific summaries) followed in September.

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 fees 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 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.

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- 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 2021 *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

Federal and state governments, faced with the acute threat and uncertain magnitude of the coronavirus, shut down much of the US economy in early 2020. Since most working age people receive health insurance through their employers, as anticipated, commercial health plan enrollment declined, and the mix of membership shifted towards Medicaid and Medicare. One potential cost variance that we had feared was that a decline in overall membership could have led to negative operating leverage and, happily, this did not occur.

A second potential source of cost variance also did not occur, significant increases in direct expenses for adaption, such as heightened facility cleaning, information systems support and customer services. Few plans reported such expenses and those that did reported modest costs. We suspect that many of those organizations that did not report COVID-19 adaptation costs found that the amounts were too small to be measurable.

The *Sherlock Benchmarks* can assist in adapting and achieving operational efficiency driven by the volatile operating environments. 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 2021 *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 36 plans serve approximately 54 million members. Much more information on health plan costs and operational drivers is available by licensing the *Sherlock Benchmarks*.

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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.

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 (sherlock@sherlockco.com).

Appendix A. 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	5.94	6.69	7.51	22%
Subtotal: Core Expenses	$29.54	$34.02	$36.87	18%
Sales and Marketing	$4.87	$8.48	$11.11	52%
Total Expenses	$36.30	$42.42	$44.94	18%

Appendix B. 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%	6.7%	8.0%	17%
Sales and Marketing	1.2%	1.8%	2.1%	46%
Total Expenses	7.8%	8.5%	9.0%	13%

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Appendix C. Sherlock Benchmark Summary

Functions Included in Each Administrative Expense Cluster

Core Functions:

Provider & Medical Management

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

Corporate Executive and Governance

Association Dues and License/Filing Fees

Non-Core Functions:

Sales & Marketing

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

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

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

External Broker Commissions

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

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