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 Growth Slows in Core Expenses in 2021

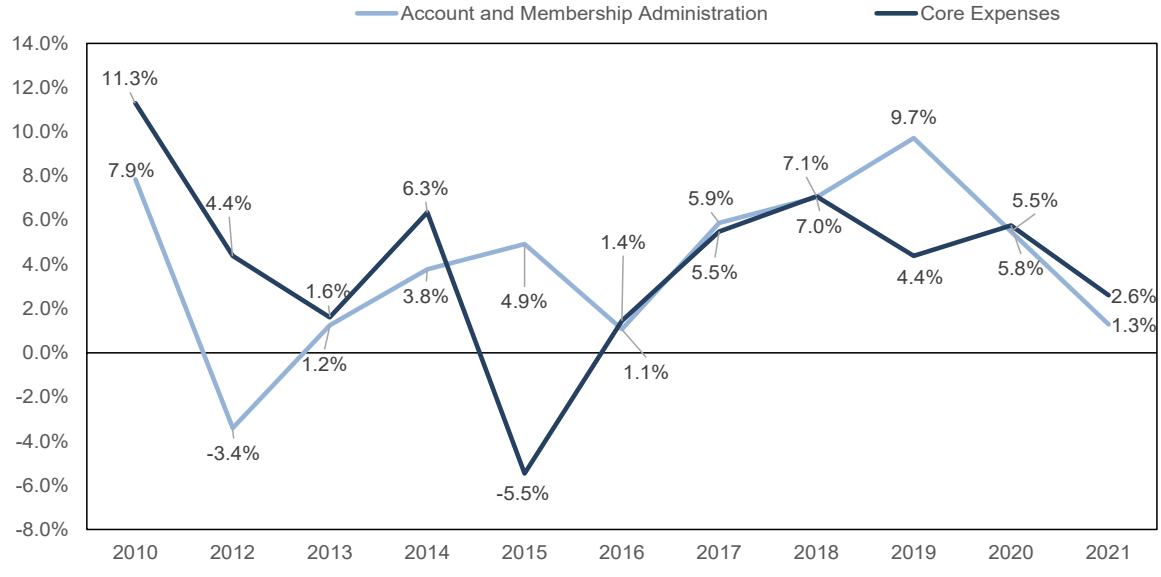
"Core" per member administrative expenses in Medicaid-focused plans grew by 2.6% in 2021, a deceleration from 2020's increase of 5.8%. Similarly, the Account and Membership Administration decelerated by 4.2 percentage points, from 5.5% to 1.3%.

Figure 1 displays both Core and Account and Membership Administration trends since 2010. The rates of change reflected here hold both surveyed plans and their product mix constant in each year-over-year comparison. Cost trends in 2021 for both Core and Account and Membership Administration were below average, both of which were approximately 4%, since 2010.

The cost *trends* for 2021 discussed in this *Plan Management Navigator* are based on the results of ten continuous plans serving 11.2 million members in comprehensive products, of which 6.3 million were Medicaid or CHIP. The report as a whole, including the actual PMPM costs, is based on the results of the continuing plans plus new participants. Together, 14 health plans serving 14.5 million members of which 8.1 million were Medicaid or CHIP participated in the Sherlock Benchmarks for Medicaid plans and are summarized in this *Navigator*.

As we use the term "Core" expenses, it is to exclude the Sales and Marketing cluster. State laws governing Sales and Marketing for Medicaid vary so we separate such activities from Medical and Provider Management, Account and Membership Administration and Corporate Services to preserve comparability between plans operating in different states. The Sales and Marketing cluster includes Rating and Underwriting, Marketing, Sales, Advertising and Promotion and Broker Commissions.

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 population surveys and analyses, *Health Insurance Coverage in the United States: 2021* (published annually, most recently in September 2022), the proportion of Americans uninsured dropped from 13% in 2013 to 8% in 2021, a 5 percentage point decline.

Medicaid has historically been integral to this improvement. In 2014, the first year of the Affordable Care Act, Medicaid surged by 12% or by 6.7 million people, increasing from 18% to 19% of the US population. The percent of people uninsured fell from 13% to 10%.

Peak Medicaid membership was in 2015 at 62.4 million when it served 20% of the US population. In the relatively strong economic environment that followed, Medicaid participation has declined in each year through 2019, to 17%, below pre-ACA levels. With Covid-19 adaptation compressing the economy, Medicaid participation increased in 2020 and continued growing in 2021. In addition, in 2020, Utah, Idaho, and Nebraska expanded Medicaid, while Oklahoma and Missouri expanded eligibility in 2021. The second largest increase occurred in 2021 with a 5.4% increase from the prior year, or by 3.2 million members. Subject to qualifications noted on the chart, of the 14.6 million no longer uninsured since 2013, the 7 million additions to Medicaid beneficiaries explained about 48% of the decline.

Figure 2. Sherlock Benchmark Summary

Health Insurance Coverage in the United States: Census Bureau

(000's)

	2013		2014		2015		2016		2017		2018		2019		2020		2021		2021 Chg.	Pct. Chg.	Cml. Chg.	Pct. Chg.
Any Health Plan	271,606	87%	283,200	90%	289,903	91%	292,320	91%	296,890	92%	296,206	92%	298,438	92%	299,230	91%	300,887	92%	1,657	1%	29,281	11%
Any Private Plan	201,038	64%	208,600	66%	214,238	67%	216,203	67%	218,209	68%	217,780	67%	220,848	68%	217,896	67%	216,366	66%	-1,530	-1%	15,328	8%
Employment-based	174,418	56%	175,027	55%	177,540	56%	178,455	56%	178,751	55%	178,350	55%	183,005	56%	178,737	55%	178,285	54%	-452	0%	3,867	2%
Direct purchase	35,755	11%	46,165	15%	52,057	16%	51,961	16%	35,499	11%	34,846	11%	33,170	10%	33,869	10%	33,555	10%	-314	-1%	-2,200	-6%
Any Government Plan	108,287	35%	115,470	37%	118,395	37%	119,361	37%	112,151	35%	111,330	34%	110,687	34%	112,925	34%	117,095	36%	4,170	4%	8,808	8%
Medicare	49,020	16%	50,546	16%	51,875	16%	53,372	17%	56,170	17%	57,720	18%	58,779	18%	58,541	18%	60,226	18%	1,685	3%	11,206	23%
Medicaid	54,919	18%	61,650	19%	62,384	20%	62,303	19%	59,814	19%	57,819	18%	55,851	17%	58,778	18%	61,940	19%	3,162	5%	7,021	13%
Military health care	14,016	4%	14,143	4%	14,849	5%	14,638	5%	11,436	4%	11,754	4%	11,755	4%	12,132	4%	11,450	3%	-682	-6%	-2,566	-18%
Uninsured	41,795	13%	32,968	10%	28,966	9%	28,052	9%	25,600	8%	27,462	8%	26,111	8%	28,291	9%	27,187	8%	-1,104	-4%	-14,608	-35%
Total	313,401		316,168		318,869		320,372		322,490		323,668		324,549		327,521		328,074		553	0%	14,673	5%

Source: Health Insurance Coverage in the United States: 2021, https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.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."

Regarding the most recent surge in Medicaid, 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." (Data sources differ from Figure 2.)

The Families First Coronavirus Response Act was signed into law on March 18, 2020. As of this writing, the Covid-19 Public Health Emergency remains in effect. The Department of Health and Human Services has stated that it will provide states a 60-day notice of the expiration of the Covid-19 Public Health Emergency.

Participation in Medicaid is likely sensitive to economic cycles, however they arise. While the unemployment rate spiked by 14.8% in 2020, it dropped to approximate pre-pandemic levels in August of 2022. Employer-based coverage fell slightly by 452,000 people from 2020 to 2021 as Medicaid increased by 3.2 million people to 61.9 million. Longer term trends for employer-based coverage increased by 3.9 million people from 2013 to 2021.

Direct purchase of health coverage ("Coverage purchased directly from an insurance company, or through a federal or state Marketplace") fell by 314,000 people from 2020 to 2021. From 2013 to 2021, the number of people obtaining health insurance under Direct Purchase fell by 2.2 million.

Trends Overall and in Expense Clusters

Figure 3 on the next page, shows year-over-year trends on both an as-reported and constant-mix plans. On an *as-reported* basis, for the ten *continuously participating* plans, per member *core* costs grew by 3.0% sharply lower than the prior year's 4.9% increase.

The two columns labeled "as-reported" reflect per member trends in continuous plans. Notably, a shift in favor of higher administrative cost products, such as Medicare Advantage and Medicare SNP, would lead to the appearance of faster growth, while a shift in favor of less expensive products such as Medicaid would show apparent slower growth.

The two columns labeled "constant mix" reweight the product costs for the continuously participating plans so that their mix is exactly the same in both periods. This is intended to eliminate the mix effects described above. So, in 2021, cost trends did reflect a shift in favor of higher cost products, per member Core cost growth was faster on an as-reported basis, 3.0%, versus the constant-mix basis of 2.6%.

Medicare Advantage Special Needs Plans was the fastest growing product at a median rate of 15.2%. As described later, the growth in this product, which often serves dual-eligible members, makes a difference because it is by far the most expensive product. Medicare Advantage membership itself increased by 0.9% so within MA there was a shift in favor of SNP. Medicare Advantage and SNP combined increased by 1.7%. Medicare Supplement, a low cost product, dropped by 2.8%, notable since it is an alternative to Medicare Advantage.

There was a similar shift in favor of lower higher cost products within Medicaid products. The second fastest growing product was Medicaid HMO at 15.0% while Medicaid CHIP was the fastest declining product at a median rate of 14.9%. Despite the drop in Medicaid CHIP, Medicaid Total grew by 13.7%.

Commercial also experienced a shift towards low cost products. Commercial Insured membership was down by a median of 6.7% and ASO was down by 4.4%. Commercial Total fell by a median of 7.6%.

Despite non-government products posting declines, Comprehensive Total membership grew by a median of 4.7%.

Figure 3. Sherlock Benchmark Summary

Medicaid Plans' Median Changes in Per Member Per Month Expenses

	2020 Increase		2021 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	4.2%	2.3%	1.2%	1.1%
Account and Membership Administration	3.6%	5.5%	1.9%	1.3%
Corporate Services	4.5%	2.5%	0.5%	0.2%
Subtotal: Core Expenses	4.9%	5.8%	3.0%	2.6%
Sales and Marketing	4.1%	2.2%	-1.3%	1.4%
Total Expenses	5.4%	4.3%	4.0%	4.2%

Trends Holding Product Mix Constant

As previously noted, trends that eliminate the impact of product mix changes is a more accurate representation of true 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.

Corporate Executive and Governance and Customer Services were the fastest growing Core functions, while Information Systems was the most important source of growth. While not included in Core, Sales and Marketing cluster increased mainly on higher External Broker Commissions.

Medicaid Staffing Ratios for Core and Total activities were lower. Core and Total Staffing Costs per FTE were higher. The tendency to outsource was also higher. Median Non-Labor Costs were lower for Core, but indeterminant in Total.

These metrics are calculated after converting outsourced staff, compensation and non-labor costs to internal equivalents. Staffing ratios are expressed holding product-mix constant; specifically, we will refer to Medicaid staffing ratios. (Medicaid staffing ratios 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 median PMPM increase of 1.3%, on a constant-mix basis. The cluster's Compensation per FTE, Non-Labor Costs per FTE, and outsourcing were higher than last year. The cluster's Staffing Ratio was lower.

Far and away, the fastest growing function in this cluster was Customer Services, with high Non-Labor Costs per FTE, and a slight decline in Staffing Ratios. The Member Services and Printed Materials sub-functions' costs grew in 2021.

Information Systems, however, was the most important source of this cluster's growth since its size dwarf's that of the other functions in this cluster. Information Systems compensation and Non-Labor Costs were higher, while Staffing Ratios were lower. The sub-functions of Operations and Support Services and Applications Acquisition and Development increased year-over-year, the latter especially sharply.

Claims increased by a low single digit rate, while Enrollment / Membership / Billing was lower 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 had been *excluded*, Total administrative expenses would have increased by 3.1% rather than the 4.2% that we show in Figure 3. However, if *excluded*, the increase in Account and Membership Administration would have been 3.5% rather than the 1.3% shown. This apparent contradiction is explained by the effects of a change in the operations of one of the continuous plans' Behavioral Health and our convention of using medians as our preferred measure of central tendency. Using averages does not result in this quirk and the effect of the inclusion of Behavioral health and Pharmacy Administration is to reduce the administrative cost trends. This is also the case on an as-reported basis.

Pharmacy and Behavioral Health administrative costs, PMPM, increased by a median of 1.8%. Pharmacy administration increased while Behavioral Health decreased.

Medical and Provider Management

Holding constant the product mix, PMPM expenses in the Medical and Provider Management cluster grew by 1.1%. The cluster's compensation and Non-Labor Costs per FTE were higher over the previous year, and the use of outsourcing was lower.

The Provider Network Management and Services functional area grew with the Provider Relations Services sub-function the sole unambiguous source of higher functional costs. The function's staffing ratio was higher over the prior year.

The PMPM costs for Medical Management declined from last year, and six of the ten continuous plans posted declines. The dispersion was such that the average change was a very slight increase. The Medical Management sub-functions that posted gains were Disease Management, Health and Wellness, Quality Components, and Utilization Review. On the other hand, Case Management, Nurse Information Line, Medical Informatics and Other Medical Management declined.

Medical Management Compensation and Non-Labor costs were higher, but outsourcing and staffing ratios were lower. The decline in Nurse Information Line may be emblematic of a more general return from the dislocations from Covid-19 adaptation.

Corporate Services Cluster

On a constant-mix basis, the PMPM Corporate Services cluster costs increased by 0.2%. Compensation and outsourcing were higher, but non-labor expenses were lower.

Corporate Executive and Governance posted the fastest growing and, while it is not an especially large function, was the most important source of this cluster's increase. Corporate Executive and Governance propensity to Outsource and Staffing Ratios were higher, while non-labor costs were lower.

Finance and Accounting increased at a high single digit rate. Staffing ratios declined, as did compensation. Outsourcing appeared to sharply increase. Many of the plans are associated with hospital systems so that, while we do not have data that can test this, outsourcing can reflect closer integration between sister affiliates.

Association Dues and License / Filing fees increased at a low single digit rate.

Conversely, Actuarial and Corporate Services *Function* each fell at a single digit rate. Two of the nine sub-functions within the Corporate Services function, Facilities and Imaging, were unambiguously lower and, while four more had median declines, the dispersion was too high to make a general statement.

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 increased by 1.4% PMPM, holding the product mix constant.

External Broker Commissions and Rating and Underwriting increased and, because of the size of Commisions, this function was the main driver in the cluster's increase. Besides these two, the remaining Sales and Marketing functional areas decreased by a low single digit rate.

The Sales and Marketing cluster's propensity to outsource was higher, and staffing ratio was lower. Rating and Underwriting Compensation was higher, outsourcing was higher but staffing ratio was lower.

Compensation was lower in Marketing and Advertising and Promotion, but higher in Sales. Non-labor costs declined in Sales. Outsourcing increased in Sales and Advertising and Promotion.

As-Reported Trends

This section will focus on key trend differences in as-reported trends that notably vary from the constant mix 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 higher cost products like Medicare SNP so that Core as-reported costs grew faster than when product mix is eliminated.

In 2021, Core expenses PMPM increased on an as-reported basis at a median rate of 3.0% PMPM versus 2.6% for constant-mix. Every cluster of Core expenses grew faster on an As-Reported basis. The Sales and Marketing cluster however declined on an As-Reported basis versus growth on a Constant Mix basis.

Sales and Marketing costs, which are not Core in this universe, *decreased* by 1.3% on an as-reported basis and compares to a 1.4% *increase* on a constant-mix basis. While this cluster is not Core, its change was the greatest difference. External Broker Commissions flipped from an increase on a constant-mix basis to a sharp decline on an as-reported basis. Sales and Advertising and Promotion experienced much faster declines, and Marketing had a faster decline but less dramatic. On the other hand Rating and Underwriting, which includes risk adjustment expenses, grew faster.

The Account and Membership cluster posted faster as-reported growth, 1.9% versus 1.3%, on a constant-mix basis. Both Information Systems and Customer Services increased at a slower rate on an as-reported basis, while the decline in Enrollment / Membership / Billing was greater on an as-reported basis. The change in the Enrollment trend was the greatest in this cluster. The rate of growth for Claims was nearly identical on both as-reported and constant-mix.

The Corporate Services cluster's as-reported growth of 0.5% was slightly faster than the constant-mix increase of 0.2%. The differences for the functional areas from constant-mix to as-reported ranged from a very modest increase in Finance and Accounting (the only increase) to a sharp decrease in Association Dues and License and Filing Fees. The difference in the Actuarial trend was similarly modest though it increased the decline. The Corporate Executive increase was more modest but the change itself remained in the mid-double digits.

Medical and Provider Management increased by 1.2% on an as-reported basis, marginally faster compared to the constant-mix basis of 1.1%. Provider Network Management and Services increased at a faster rate, while Medical Management posted a slower decline.

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 ten continuously participating plans and includes staffing and costs performed on an outsourced basis.

The median *Core* Medicaid staffing ratio was lower by 7% to 19 FTEs per 10,000 Medicaid members. Of the 14 functional areas with staff, eight posted declines. (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 4% to approximately $105,000. Of the 14 functions with staff, 8 experienced increases from a year ago, of which 7 were Core activities. Importantly, the functions with staff declines composed 84% of the Core staffing. Compensation for Core functions was about $105,000 per FTE, a 4% increase from last year.

Propensity to outsource, at a median of 10.7% for Core, was 1.1 percentage points higher than last year. Of the 10 Core functional areas with staff, seven increased outsourcing.

On a constant-mix basis, Customer Services and Corporate Executive and Governance posted the fastest growth. Meanwhile, Information Systems was the most important source of growth among core functions.

Costs of Medicaid-Focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 14 participating Medicaid-focused plans, as opposed to the 10 continuously participating plans in the prior discussion. This section touches 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. One plan dropped out of the universe from a year ago, and there were three 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.

Figure 4. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2021 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$8.26	$9.88	$11.71	24%
Account and Membership Administration	15.14	19.71	22.06	32%
Corporate Services	5.80	6.69	8.56	47%
Subtotal: Core Expenses	$28.85	$35.05	$41.70	29%
Sales and Marketing	$4.97	$7.64	$10.32	47%
Total Expenses	$35.39	$46.42	$52.62	26%

Account and Membership Administration is the largest cluster of expenses. Comprised of activities central to health plan operations, it increased by 1.7% to a median of $19.71 PMPM. This is not too different from the as-reported and constant-mix increase of 1.9% and 1.3%, respectively, shown in Figure 3. This cluster's size means that its growth 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 $9.88 PMPM, 6.5% higher than last year's value of $9.28. This cluster grew on an as-reported basis for the continuously participating plans by 1.2%, while increasing by 1.1% 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 $6.87 last year, a drop of 2.7%. The as-reported increase for plans participating in both years was an increase of 0.5% and on a constant-mix basis an increase of 0.2%, the slowest growing of the Core clusters. 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 $35.05 PMPM, 7.9% higher than last year's median of $32.47, shown in Appendix A. For plans participating in both years, as-reported and constant-mix growth in Core expenses was higher by 3.0% and 2.6%, respectively.

The Sales and Marketing cluster costs declined by 6.9% to a median of $7.64 PMPM (as-reported decreased by 1.3%, while constant-mix *grew* by 1.4%). Sales and Marketing functional areas include Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Median Total Expenses increased by 10.6% to $46.42 PMPM from $41.99 PMPM. For continuously reporting plans, as-reported costs increased 4.0% and constant-mix growth was 4.2%.

Dispersion in Core Expenses, measured by the Coefficient of Variation, generally widened compared to last year. Corporate Services cluster experienced the largest increase in dispersion, followed by Account and Membership and Sales and Marketing. Medical and Provider Management was the only cluster to narrow in dispersion. Both Core and Total increased in dispersion.

Measured by the change in the difference between 25th and 75th percentiles, all clusters increased except for Medical and Provider Management. Dispersion in Core 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 total 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 the universe product mix to eliminate effects of any differences between participants and its 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 the Medicaid product costs in the note and those in body of the figure include Risk Adjustment expenses as well as all other Sales and Marketing activities that meet *Sherlock Benchmark* definitions regardless of whether the activities are permitted by the states.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2021 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$26.09	$28.57	$33.60	34%
HMO	26.09	28.56	34.11	34%
CHIP	$24.20	$25.30	$28.92	15%
Medicare Total	$124.44	$146.77	$188.34	25%
Advantage	111.17	120.04	150.18	25%
SNP	$182.88	$203.45	$216.75	44%
Medicare Supplement	$24.13	$25.43	$32.47	18%
Commercial Insured Total	$45.38	$49.48	$55.42	21%
HMO	44.57	48.38	51.99	20%
POS	43.59	54.19	74.98	50%
Indemnity & PPO	$51.30	$58.70	$65.33	42%
Commercial ASO	$22.16	$25.04	$31.71	34%
Commercial Total	$36.40	$37.68	$44.14	16%
Comprehensive Total	$35.39	$46.42	$52.62	26%
Note: Core Expenses of Medicaid				
Medicaid Total	$24.55	$26.99	$31.20	35%
HMO	24.55	27.00	31.20	35%
CHIP	$21.20	$22.40	$24.70	15%

Median cost for Medicaid HMO was $28.56 PMPM and, for Medicaid CHIP, was $25.30 PMPM. For all fourteen participating plans, Medicaid HMO's average mix of members was 58% and its average mix of revenue was 46%. Medicaid CHIP's average member mix and revenue mix was about 1% and less than 1%, respectively.

Shown in the note at the foot of the chart, Per Member Per Month Core expenses for Medicaid HMO and CHIP combined was $26.99. Core Medicaid HMO was also $27.00 and Medicaid CHIP was $22.40. Core expenses exclude Sales and Marketing costs. An estimate of the Sales and Marketing expenses associated with this product can be inferred from this figure.

Medicare, like Medicaid, are government-sponsored products. These products 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 eligible for both programs.

Medicare products are relatively high cost at $203.45 PMPM for Medicare SNP and $120.04 PMPM for Medicare Advantage. Average membership mix for Medicare Advantage was 7% and Medicare SNP was 2%. Average revenue mix for Medicare Advantage was 14%, Medicare Advantage SNP was 5%.

Note that Medicare Supplement has lower costs than the median for comprehensive total at $25.43 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Five plans in the Medicaid universe offer the product and its mean product mix and revenue mix was 1%.

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 $25.04 PMPM.

The single most important Commercial Insured product for this universe is HMO at $48.38 PMPM. POS costs $54.19 PMPM, while Indemnity and PPO costs $58.70. The mean mix of Commercial products was 32% of the membership: Commercial Insured and Commercial ASO each served 16% of total membership in this universe on average. Median Commercial Total costs PMPM were $37.68.

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. On average, the administrative costs of Comprehensive products were 8.6% of premiums.

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 7.2%. Medicaid CHIP was lower than comprehensive total on a PMPM basis, but at 12.5% is *higher* than average on a percent of premium basis.

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2021 Results
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	6.6%	7.2%	8.6%	22%
HMO	6.6%	7.2%	8.5%	23%
CHIP	11.8%	12.5%	15.8%	22%
Medicare Total	11.2%	12.1%	12.9%	18%
Advantage	10.5%	12.2%	13.9%	30%
SNP	10.1%	11.4%	13.4%	21%
Medicare Supplement	10.3%	11.1%	12.2%	21%
Commercial Insured Total	8.8%	9.6%	10.0%	17%
HMO	8.5%	9.0%	9.7%	17%
POS	6.5%	8.1%	11.5%	55%
Indemnity & PPO	9.7%	10.4%	12.4%	44%
Commercial ASO	5.7%	6.4%	8.2%	32%
Commercial Total	8.4%	8.9%	9.0%	14%
Comprehensive Total	8.1%	8.6%	9.5%	17%
Note: Core Expenses of Medicaid				
Medicaid Total	6.3%	6.6%	8.0%	25%
HMO	6.2%	6.6%	8.0%	25%
CHIP	10.1%	10.1%	13.5%	27%

Medicare SNP, the highest cost product on a PMPM basis, is higher than most products on a percent of premium basis at 11.4%, 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 more narrowly higher on a percent of premium basis at 12.2%.

While Medicare Supplement is below Comprehensive total when measured on a PMPM basis, at 11.1%, its cost ratio was greater than that of the Comprehensive total.

Administrative expenses on a percent of premium basis for Commercial POS, HMO, and Indemnity and PPO were 8.1%, 9.0%, and 10.4%, respectively. These ratios, like the PMPMs, were at an average of 9.6%, higher than Comprehensive total of 8.6%.

Administrative expenses of Commercial ASO products are 6.4% 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. The median value for administrative costs as a percent of premium equivalents for all Commercial products was 8.9%.

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

Figure 7 shows the ratios of administrative expenses to premiums or equivalents for Medicaid plans' expense clusters. Core administrative expenses increased by 0.25 percentage points to 6.8% compared with last year's median, shown in Appendix B.

Corporate Services cluster increased by 0.10 percentage points to 1.4%. Medical and Provider Management fell by 0.03 percentage points to 1.9%, while Account and Membership Administration also dropped by 0.03 percentage points to 3.7%.

Sales and Marketing declined by 0.05 percentage points to a median of 1.6%. Total expenses, including Sales and Marketing, had a median percent of premium of 8.6%, 0.11 percentage points lower than the prior year.

Figure 7. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2021 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.7%	1.9%	2.4%	27%
Account and Membership Administration	3.2%	3.7%	4.2%	24%
Corporate Services	1.2%	1.4%	1.7%	39%
Subtotal: Core Expenses	6.4%	6.8%	7.9%	22%
Sales and Marketing	1.0%	1.6%	1.9%	43%
Total Expenses	8.1%	8.6%	9.5%	17%

Comparisons Across Universes

Health plans in other *Sherlock Benchmark* universes also offer Medicaid products. In this section, we compare the results of Medicaid HMOs offered by Medicaid-focused plans to this same product offered by Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans. 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%.

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. Combining all the universes, these plans collectively serve 9.1 million Medicaid HMO members or approximately 15% of all beneficiaries.

Figure 8. Sherlock Benchmark Summary
Medicaid HMO Product Characteristics by Universe, 2021 Results

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$24.55	$19.28	$33.42	$23.68
Median	27.00	22.09	34.02	27.18
75th Percentile	31.20	26.30	34.63	32.10
Coefficient of Variation	35%	31%	5%	33%
Percent of Premiums and Equivalents				
25th Percentile	6.2%	7.6%	10.5%	6.4%
Median	6.6%	8.7%	10.8%	6.9%
75th Percentile	8.0%	9.4%	11.2%	9.2%
Coefficient of Variation	25%	22%	9%	26%
Total Costs				
Per Member Per Month				
25th Percentile	$26.09	$21.82	$35.46	$25.74
Median	28.56	25.33	35.65	28.69
75th Percentile	34.11	29.57	35.84	34.69
Coefficient of Variation	34%	30%	2%	32%
Percent of Premiums and Equivalents				
25th Percentile	6.6%	8.5%	9.8%	7.1%
Median	7.2%	9.6%	10.2%	7.4%
75th Percentile	8.5%	10.4%	10.6%	9.6%
Coefficient of Variation	23%	20%	11%	23%
Plans Offering Medicaid	14	3	2	19
Medicaid HMO Members (millions)	8.04	0.38	0.67	9.09
Comprehensive Total Members (millions)	14.51	5.48	25.92	45.91

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 administrative costs were $34.02 PMPM, or $7.02 greater than Medicaid-focused plans. Likewise, Blue Cross Blue Shield Plans had *total* median Medicaid expenses of $35.65 PMPM and was $7.09 higher than of Medicaid plans.

Calculated on a percent of premium basis, Blue Cross Blue Shield Plans' Core administrative expenses, at 10.8% of premiums, were 4.2 percentage points higher than those of Medicaid focused plans. Based on Total expenses, Blue Cross Blue Shield Medicaid administrative expenses were 10.2%, higher than those of the Medicaid plans by 3.0 percentage points.

The same favorable comparison is apparent against Independent / Provider – Sponsored Plans when analyzed on a percent of premium basis. IPS plans' core costs were higher by 2.1 percentage points, 8.7% versus 6.6%. Similarly, IPS plans' total administrative costs were higher on a percent of premium basis by 2.4 percentage points, 9.6% as against 7.2% for the Medicaid focused health plans.

The exception to this is in the PMPM comparisons with IPS plans. Independent / Provider – Sponsored plans' Medicaid Core costs were $22.09, $4.91 PMPM lower than those in Medicaid-focused plans. Also, IPS Total administrative expenses of $25.33 PMPM, which includes Sales and Marketing was, at $28.56, lower than that of Medicaid focused plans by $3.23 PMPM. We do not have a good, general explanation of this except to note that there is about a 3% cost of living difference between the IPS and the Medicaid plans that may explain 13-22% of the difference. Other than that, perhaps the remaining difference is simply the result of these particular IPS plans' superior performance: we know that two of them are extremely strong performers against their universe of IPS plans.

How We Performed This Analysis

This analysis is based on the twentieth 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 963 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 analysis of Medicaid plans is based on a peer group of fourteen plans who collectively served 14.5 million people in comprehensive products. Ten 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 674,000. The geographic reach of this universe extended from coast to coast.

Medicaid HMO and CHIP combined were 8.0 million members and composed 56% of the combined comprehensive membership and 59% of revenues for comprehensive products. The average Medicaid revenue and membership proportion was 46% and 59%, respectively.

All 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 1.1 million Medicare members served by these plans.

Of all comprehensive members, 35%, or 5.1 million, were served under a commercial product. Approximately 2.8 million were served under some form of self-insurance arrangement, comprising 55% of total commercial members.

The panel of plans that participated in the *Sherlock Benchmarks* for Medicaid plans was formed mainly in the Spring of 2022. 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 prior year 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 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 many readers.

- Expenses exclude capital costs and investment income. Among the specifically excluded expenses are 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 2022 *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

The *Sherlock Benchmarks* are the health plan industry's metrics informing the management of administrative activities. They are based on validated surveys of health plans serving 63 million Americans and provide costs and their drivers on key administrative activities.

The *Benchmarks* are reported in multiple universes of health plans: Medicaid-focused, Medicare-focused, Independent / Provider-Sponsored, Blue Cross Blue Shield, and Larger Plans.

The *Sherlock Benchmarks* are the "gold standard" of health plan administrative cost benchmarks. Health plans use them to determine whether their administrative costs are competitive, to prioritize for improvement among numerous specific activities and to identify cost drivers such as staffing ratios that, overall and within functions, can help implement those improvements. Since June of 2019, health plans serving at least 210 million people have licensed the *Sherlock Benchmarks*.

These *Plan Management Navigator* results are excerpted from the Medicaid edition of the 2022 *Sherlock Benchmarks*. We reported on the Independent / Provider – Sponsored, Blue Cross Blue Shield, and Medicare universes earlier this year. 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 https://sherlockco.com/sherlock-benchmarks/

Our 2022 edition Brochure is found at
https://sherlockco.com/Benchmarks_Brochure.pdf

In addition, the Sherlock Company website has an application that allows you to try out the Benchmarks free of 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 (sherlock@sherlockco.com)

You will be among good company.

Appendix A. 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%

Appendix B. 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%

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
  - (c) Grievances and Appeals
- 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

This Page Intentionally Left Blank