Plan Management Navigator

Analytics for Health Plan Administration

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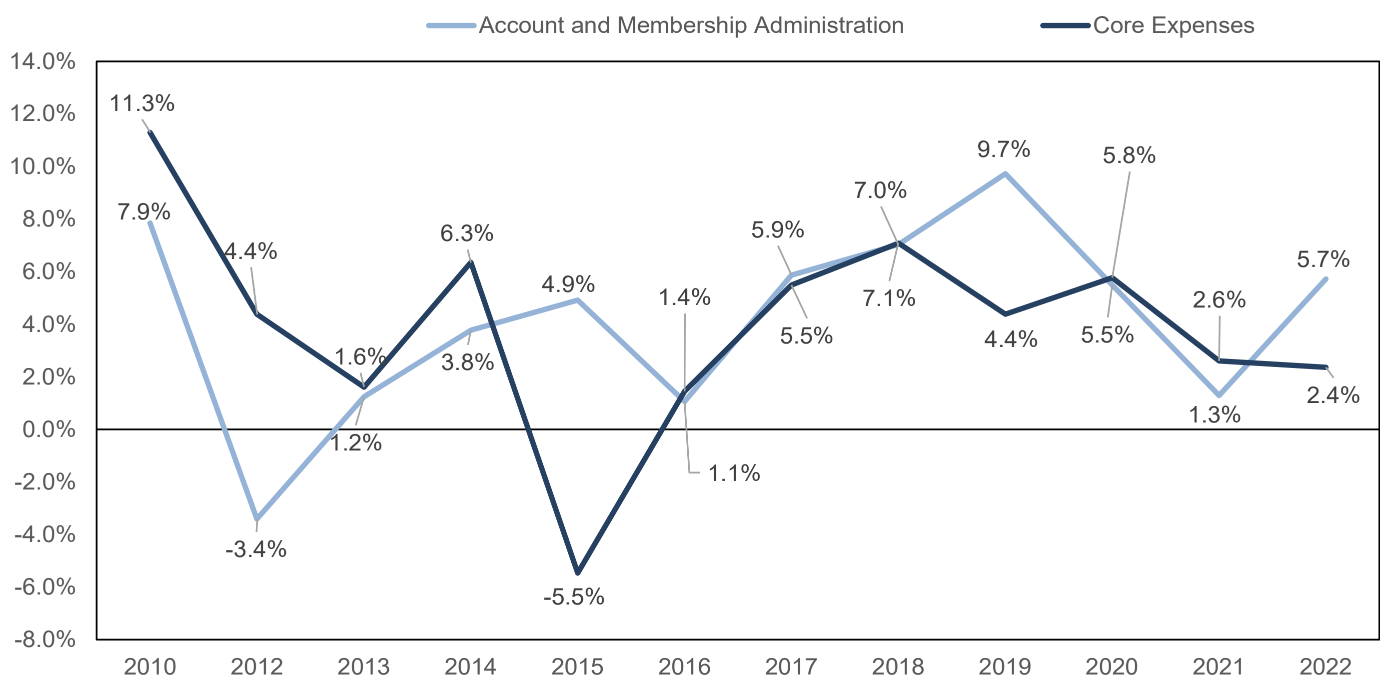
Growth in Core Expenses Decelerate for Medicaid Plans in 2022

"Core" per member administrative expenses in Medicaid-focused plans grew by 2.4% in 2022, slower than the growth in 2021 at 2.6%. The Account and Membership Administration accelerated to an increase of 5.7% in 2022, up from an increase of 1.3% in 2021.

Figure 1 displays both Core and Account and Membership Administration cluster trends since 2010. The rates of change reflected here hold constant both surveyed plans and their product mix in each year-over-year comparison. Cost trends in 2022 for Core expenses were below average, while Account and Membership was higher than average. (The average for both was approximately 4% since 2010.)

The cost trends for 2022 discussed in this *Plan Management Navigator* are based on the results of ten continuous plans serving 12.3 million members in comprehensive products, of which 7.4 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 15.5 million members of which 9.2 million were Medicaid or CHIP participated in the *Sherlock Benchmarks* for Medicaid plans and are summarized in this *Navigator*.



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The term "Core" expenses excludes 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.

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: 2022* (published annually, most recently in September 2023), the proportion of Americans uninsured dropped from 13% in 2013 to 8% in 2022, 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 immediately followed, Medicaid participation has declined in each year through 2019, to 17%, below pre-ACA levels.

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		2022		2022 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%	300,900	92%	304,000	92%	3,100	1%	32,394	12%
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%	216,400	66%	216,500	66%	100	0%	15,462	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%	178,300	54%	179,800	54%	1,500	1%	5,382	3%
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%	33,550	10%	32,800	10%	-750	-2%	-2,955	-8%
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%	117,100	36%	119,100	36%	2,000	2%	10,813	10%
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%	60,230	18%	61,570	19%	1,340	2%	12,550	26%
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%	62,050	19%	110	0%	7,131	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%	11,171	3%	-279	-2%	-2,845	-20%
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%	27,190	8%	25,940	8%	-1,250	-5%	-15,855	-38%
Total	313,401		316,168		318,869		320,372		322,490		323,668		324,549		327,521		328,090		329,940		1,850	1%	16,539	5%

Source: Health Insurance Coverage in the United States: 2022, https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.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."

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Due to Covid-19 adaptation compressing the economy and the temporary suspension of Medicaid eligibility redetermination from the Public Health Emergency (PHE) declaration, Medicaid participation increased in each year from 2020 to 2022. The increase from 2021 to 2022 was only 0.2% or by about 110,000 members. (Note, the PHE declaration and the suspension of Medicaid redetermination ended on May 11, 2023. According to Kaiser Family Foundation, about 7.5 million people have been disenrolled from Medicaid, as of September 26, 2023.)

Subject to qualifications noted on the chart, of the 15.9 million no longer uninsured since 2013, the 7 million additions to Medicaid beneficiaries explained about 45% of the decline. Participation in Medicaid is likely sensitive to economic cycles, however they arise. While the unemployment rate spiked to 14.7% in 2020, it dropped to approximate pre-pandemic levels in August of 2022 and has ranged from 3.4% to 3.8% since. Employer-based coverage increased slightly by 1.5 million people from 2021 to 2022 to 179.8 million as Medicaid increased by 110,000 people to 62.1 million. Longer term, membership in employer-based coverage increased by 5.4 million people from 2013 to 2022.

Direct purchase of health coverage ("Coverage purchased directly from an insurance company, or through a federal or state Marketplace") fell by 750,000 people from 2021 to 2022. From 2013 to 2022, the number of people obtaining health insurance through Direct Purchase fell by 3.0 million. Interestingly, in 2014 Direct Purchase membership increased from 35.4 million to 46.2 million, peaking at 52.1 million in 2015. Membership through Direct Purchase is now 32.8 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 ten *continuously participating* plans, per member *core* costs grew by 1.8%, slower than last year's increase of 3.0%. The two columns labeled "as-reported" reflect per member trends in continuous plans.

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 changes in mix effects between the comparison years thereby providing what we consider to be a more accurate measure of cost growth. So, 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.

In 2022, cost trends reflected a shift towards lower cost products, as per member Core cost growth was slower than as-reported growth. Core constant mix increase was 2.4% and as-reported increase was 1.8%. These expenses increased slower than in 2021.

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Sales and Marketing increased by 9.5% on a Constant Mix basis but increased by 4.5% on an As-Reported Basis. Total Expenses grew by 4.9% on a Constant Mix Basis and 3.7% on an As-Reported Basis. Sales and Marketing and Total Expenses increased faster in 2022 compared with 2021.

Comprehensive Total membership grew by a median rate of 2.9%, but led to a shift in product mix in favor of Medicaid. Medicaid Total grew by 8.5%. Medicaid CHIP, however, declined by a median of 11.3%. Medicaid HMO, a low-cost product, was the fastest growing product, increasing at a median rate of 8.5%.

Total Medicare, a high-cost group of products, increased by a median rate of 1.4%. This was due to Medicare Advantage SNP growth at a median rate of 3.0%. Medicare Advantage growth declined at median rate of 0.2%.

Medicare Supplement, a low-cost product, dropped by a median of 3.2%, notable since it is an alternative to Medicare Advantage.

Commercial Insured and Self-Insured ASO also experienced a median decline of 4.5%. Commercial Insured fell at a faster rate compared to ASO at 5.6% versus 0.9%, respectively.

Trends Holding Product Mix Constant

As previously noted, a trend analysis that eliminates the impact of product mix changes is, in our view, 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.

Of the Core functions, Claims was the fastest growing and most important source of growth. While not included in Core, Sales and Marketing cluster contributed to Total cost growth with Advertising and Promotion the fastest growing and most important source of Sales and Marketing growth.

Figure 3. Sherlock Benchmark Summary

Medicaid Plans' Median Changes in Per Member Per Month Expenses

	2021 Increase		2022 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	1.2%	1.1%	1.5%	2.4%
Account and Membership Administration	1.9%	1.3%	5.5%	5.7%
Corporate Services	0.5%	0.2%	1.5%	0.5%
Subtotal: Core Expenses	3.0%	2.6%	1.8%	2.4%
Sales and Marketing	-1.3%	1.4%	4.5%	9.5%
Total Expenses	4.0%	4.2%	3.7%	4.9%

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For Core functions, Median Non-Labor Costs per FTE, Outsourcing, and Medicaid Staffing Ratios were higher than last year. For Total, all Median components of Compensation, Non-Labor Costs, Outsourcing, and Staffing Ratios were higher than the previous year.

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 offered by the plans. 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 5.7%, on a constant-mix basis. The cluster's Median Compensation per FTE, Outsourcing, and Medicaid Staffing Ratio was higher than the prior year. Non-Labor Costs per FTE, however, were lower.

Far and away, the fastest growing function and most important source of growth in this cluster was Claims with the Other Claims sub-function most responsible for growth. Median Claims Compensation, Outsourcing, and Staffing Ratio were higher than last year.

Customer Services also contributed to the cluster's increase, but grew at a mid-single digit rate. Both Member Services and Grievances and Appeals sub-functions contributed to growth. Median Customer Services Staffing Costs per FTE, Staffing Ratios, Non-Labor Costs, and Outsourcing all grew, year-over-year.

Enrollment / Membership / Billing was higher by a low single-digit rate. Median Compensation, Non-Labor Costs, and Staffing Ratio was higher, while Outsourcing was lower. Both sub-functions of Enrollment & Membership and Billing contributed to the year-over-year increase.

Conversely, Information Systems declined by less than 1%. The decline in Median Staffing Ratio and slight drop in Compensation was most responsible for the function's decline. The IS sub-functions of Operations and Support Services and Security Administration and Enforcement likely drove the IS decline from last year.

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*, Core administrative expenses would have increased by 1.6% rather than the 2.4% that we show in Figure 3. If excluded from Account and Membership, the cluster would have increased by 4.4% rather than the 5.7% shown.

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The PMPM Pharmacy and Behavioral Health administrative costs increased at a median rate of 14.1%. Pharmacy administration increased while Behavioral Health was flat.

Medical and Provider Management

Holding constant the product mix, PMPM expenses in the Medical and Provider Management cluster grew by 2.4%. Growth was mainly driven by higher Median Non-Labor Costs per FTE and Outsourcing. Staffing Ratio and Compensation, however, were lower.

The Provider Network Management and Services functional area grew the fastest and was the most important source of growth in this cluster. The function's median Staffing Ratio and Non-Labor Costs were higher than the prior year. The Provider Relations Services and Provider Contracting sub-functions were the drivers in growth.

Medical Management / Quality Assurance / Wellness PMPM expenses also increased, but at a rate that was approximately one fourth of the growth in Provider Network Management functional area. Notable Medical Management sub-functions that grew over the previous year were Precertification, Case Management, Health and Wellness, Utilization Review, and Other Medical Management. The Medical Management functional area's median propensity to outsource was higher than last year.

Corporate Services

On a constant-mix basis, the PMPM Corporate Services cluster costs increased by 0.5%. Median Non-Labor Costs per FTE was higher than last year for this cluster.

Actuarial was the cluster's fastest growing functional area, with Median Compensation per FTE and Staffing Ratios higher than the prior year.

The Corporate Services function followed in its rate of growth and was the most important source of growth for the Corporate Services cluster. Sub-functions that posted unambiguous increases from last year include HR, Audit, Printing and Mailroom, Risk Management, and Other Corporate Services. The Corporate Services Functional Area's Median Staffing Costs per FTE and Non-Labor Costs per FTE were higher than the prior year.

Conversely, Finance and Accounting, Corporate Executive and Governance, and Association Dues and License / Filing Fees were functional areas that posted year-over-year declines.

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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 9.5% PMPM, holding the product mix constant. Median Sales and Marketing cluster's Compensation per FTE and Propensity to Outsource were higher, year-over-year.

Advertising and Promotion was the fastest growing function and most impactful to Sales and Marketing growth. Median Staffing Costs per FTE was higher than the prior year.

External Broker Commissions grew at a mid single-digit rate as Sales increased slightly. Conversely, Rating and Underwriting and Marketing functions each fell, year-over-year.

As-Reported Trends

This section will focus on key trend differences in as-reported 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 lower cost products like Medicaid so that Core as-reported costs grew slower than when product-mix is eliminated.

In 2022, Core expenses PMPM increased on an as-reported basis at a median rate of 1.8% PMPM versus 2.4% for constant-mix. Every cluster of Core and Total expenses grew faster on a constant-mix basis compared to as-reported, except for the Corporate Services cluster.

Sales and Marketing costs, which are not considered to be *Core* in this universe, increased by 4.5% on an as-reported basis and compares to a 9.5% increase on a constant-mix basis. This represented the greatest difference in clusters' rate of change between as-reported and constant-mix. Sales flipped from a slight increase to a low single-digit decline on an as-reported basis. Advertising and Promotion increased at a faster rate on an as-reported basis, while the increase in Broker Commissions sharply decelerated. Meanwhile, Rating and Underwriting slightly accelerated its decline as Marketing slowed its modest Constant Mix drop on an As-Reported basis.

Medical and Provider Management increased by 1.5% on an as-reported basis, slower than its constant-mix growth of 2.4%. Both functional areas of Provider Network Management and Medical Management / Quality Assurance / Wellness grew at slower rates on an as-reported basis.

The Account and Membership cluster posted slower as-reported growth, 5.5% versus 5.7%, on a constant-mix basis. As-reported Information Systems experienced faster declines, while Claims, Customer Services, and Enrollment / Membership / Billing posted slower increases.

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The Corporate Services cluster's costs increased by 1.5% on an As-Reported basis, faster than the 0.5% increase on a Constant Mix basis. As-Reported cost growth in each function either increased more slowly or declined more rapidly than on a Constant Mix basis. Illustrating that organizations arrive at their own trends quite differently, the mean change for the Corporate Services cluster would have indicated a slower growth rate from an as-reported compared to constant-mix, similar to the other clusters.

Actuarial and Corporate Services Functional area growth slowed on an As-Reported basis, while Finance and Accounting, Corporate Executive and Governance, and Association Dues and License Filing Fees declined at faster rates.

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 higher by 7% to over 20 FTEs per 10,000 Medicaid members. Of the 14 functional areas with staff, nine posted increases over the prior year. (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 marginally lower by 0.1% to approximately $104,000. Of the 14 functions with staff, 11 experienced increases from a year ago. Total Compensation per FTE *increased* slightly to $106,000 per FTE.

Propensity to outsource, at a median of 11% for Core, was 1.6 percentage points higher than last year. Of functional areas with staff, seven increased their use of outsourcing.

Costs of Medicaid-Focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 15 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.

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Bear in mind that this universe of Medicaid-focused plans differs from that of last year in product mix and in populations. Four plans dropped out of the universe from a year ago, while there were five 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 decreased by 6.3% to a median of $18.21 PMPM, shown in Figure 3. This contrasts against the As-Reported and Constant Mix *increases* of 5.5% and 5.7%, respectively. This cluster includes Information Systems, Enrollment, Claims and Customer Services.

Medical and Provider Management costs per member per month was $9.82 PMPM, 0.6% lower than last year's value of $9.88. This cluster grew on an As-Reported basis for the continuously participating plans by 1.5%, while increasing by 2.4% on a constant-mix basis. This group of functions includes Provider Network Management and Services and Medical Management / Quality Assurance / Wellness.

The Corporate Services cluster costs were higher PMPM than last year at $7.76 versus $6.69 last year, an increase of 16.0%. The Corporate Services cluster increased for plans participating in both years on both an As-Reported basis and Constant Mix basis by 1.5% and 0.5%, respectively. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities called the Corporate Services Function that include Facilities, HR and Legal.

Median Core administrative expenses were $36.41 PMPM, 3.9% higher than last year's median of $35.05. (Last year's values are shown in Appendix A.) For plans participating in both years, As-Reported and Constant Mix growth in Core expenses was higher by 1.8% and 2.4%, respectively.

The Sales and Marketing cluster PMPM costs declined by 2.7% to a median of $7.43 PMPM. As-Reported *increased* by 4.5% and grew by 9.5% on a Constant Mix basis. Sales and Marketing functional areas include Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Figure 4. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2022 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$7.45	$9.82	$11.97	29%
Account and Membership Administration	14.86	18.21	22.03	37%
Corporate Services	5.86	7.76	8.56	41%
Subtotal: Core Expenses	$30.59	$36.41	$38.53	31%
Sales and Marketing	$5.84	$7.43	$10.07	44%
Total Expenses	$35.02	$42.59	$49.11	28%

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Median Total Expenses were 7.3% less to $42.59 PMPM from $45.96 PMPM. For continuously reporting plans, as-reported costs increased 3.7% and constant-mix growth was 4.9%.

The dispersion in Core Expenses, measured by the Coefficient of Variation, increased compared to last year. Medical and Provider Management experienced the largest increase in dispersion, followed by Account and Membership Administration. However, dispersion in the Corporate Services cluster decreased. Sales and Marketing cluster also decreased its dispersion. Total expenses increased its dispersion from last year, but by less than Core expenses.

On the other hand, measured by the change in the difference between 25th and 75th percentiles, Core expenses dispersion decreased. The differences between 25th and 75th percentiles for Sales and Marketing and Total expenses declined.

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 we often reweight the universe product mix to eliminate effects of any differences between participants and its peers.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2022 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$26.08	$33.74	$38.72	38%
HMO	26.08	33.74	39.10	38%
CHIP	$23.90	$28.48	$32.85	21%
Medicare Total	$126.33	$152.31	$172.56	35%
Advantage	112.90	128.71	164.39	25%
SNP	$173.14	$221.77	$280.59	39%
Medicare Supplement	$28.94	$34.71	$43.13	35%
Commercial Insured Total	$47.10	$56.42	$66.05	25%
HMO	46.47	55.90	68.81	43%
POS	56.04	66.15	77.70	33%
Indemnity & PPO	$55.47	$63.29	$68.81	29%
Commercial ASO	$22.25	$27.38	$36.53	28%
Commercial Total	$37.77	$40.80	$47.36	16%
Comprehensive Total	$35.02	$42.59	$49.11	28%
Note: Core Expenses of Medicaid				
Medicaid Total	$23.62	$30.86	$34.93	40%
HMO	23.63	30.82	35.42	40%
CHIP	$18.89	$21.63	$29.64	27%

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Figure 5 displays total expenses by product, which *include* Sales and Marketing, except for the note at the bottom of that figure pertaining only to Medicaid core expenses. Sales and Marketing activities are reflected in the *Sherlock Benchmarks* if they meet its definitions regardless of whether the specific activities are of a type allowable by the states. For instance, we include Risk Adjustment expenses in the Medicaid product costs as Sales and Marketing in this figure but not as a Core Cost, though this activity is universal by the participating plans.

Median expenses for Medicaid HMO was $33.74 PMPM and was $28.48 PMPM for Medicaid CHIP. For all fifteen participating plans, Total Medicaid's average mix of members was over 56% and its average mix of revenue was 52%.

Shown in the note at the foot of the chart, Per Member Per Month *Core* expenses for Medicaid HMO and CHIP combined was $30.86. Core Medicaid HMO was $30.82 and Medicaid CHIP was $21.63. Core expenses exclude Sales and Marketing costs. An estimate of the Sales and Marketing expenses associated with this product can be inferred as the difference between the footnote and the body of this figure.

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

Medicare products are relatively high cost at $221.77 PMPM for Medicare SNP and $128.71 PMPM for Medicare Advantage. The average membership mix for Medicare Advantage was 6% and Medicare SNP was 1%. Average revenue mix for Medicare Advantage was 12%, Medicare Advantage SNP was 2%.

Note that Medicare Supplement has lower costs than the median for comprehensive total at $34.71 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Six plans in the Medicaid universe offer the product and its mean product mix and revenue mix was 2%.

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 among 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 $27.38 PMPM.

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The single most important Commercial Insured product for this universe is HMO at $55.90 PMPM. POS costs $66.15 PMPM, while Indemnity and PPO costs $63.29. The mean mix of Commercial products was 35% of the membership: Commercial Insured served 16% and Commercial ASO served 19% of total membership in this universe on average. Median Commercial Total costs PMPM were $40.80.

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 8.4% 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 7.3%. Medicaid CHIP was lower than comprehensive total on a PMPM basis but, at 11.7%, is *higher* than average on a percent of premium basis.

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2022 Results
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	6.4%	7.4%	8.6%	28%
HMO	6.3%	7.3%	8.6%	28%
CHIP	11.0%	11.7%	13.3%	21%
Medicare Total	10.2%	12.4%	16.3%	28%
Advantage	11.0%	12.7%	16.4%	29%
SNP	9.1%	12.5%	14.9%	40%
Medicare Supplement	11.2%	13.9%	19.1%	43%
Commercial Insured Total	9.2%	9.6%	10.4%	20%
HMO	8.6%	9.3%	13.3%	37%
POS	8.3%	9.3%	11.1%	38%
Indemnity & PPO	9.7%	10.2%	11.7%	23%
Commercial ASO	4.9%	6.3%	8.5%	32%
Commercial Total	7.1%	8.7%	9.2%	18%
Comprehensive Total	7.7%	8.4%	9.5%	21%
Note: Core Expenses of Medicaid				
Medicaid Total	5.5%	6.7%	7.9%	31%
HMO	5.5%	6.6%	7.9%	31%
CHIP	9.1%	9.7%	10.3%	21%

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Medicare SNP, the highest cost product on a PMPM basis, is higher than most products on a percent of premium basis at 12.5%, but this difference relative to other products is far smaller than on a PMPM basis. Meanwhile, Medicare Advantage expenses, while over two times Commercial HMO Insured products on a PMPM basis, is narrowly higher on a percent of premium basis at 12.7%.

While Medicare Supplement is below comprehensive total when measured on a PMPM basis, at 13.9%, its cost ratio was greater than that of the Comprehensive total.

Administrative expenses on a percent of premium basis for Commercial POS and HMO were both 9.3%, while Indemnity and PPO was 10.2%. These ratios, like the PMPMs, were higher than Comprehensive total of 8.4%.

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. The median value for administrative costs as a percent of premium equivalents for all Commercial products was 8.7%.

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 0.3 percentage points to 7.1% compared with last year's median of 6.8%, shown in Appendix B.

Corporate Services cluster increased by 0.1 percentage points to 1.5%. Medical and Provider Management fell by 0.2 percentage points to 1.7%, while Account and Membership Administration also dropped by 0.2 percentage points to 3.5%.

Sales and Marketing declined by 0.1 percentage points to a median of 1.5%. Total expenses, including Sales and Marketing, had a median percent of premium of 8.4%, 0.2 percentage points lower than the prior year.

Figure 7. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2022 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.6%	1.7%	2.5%	32%
Account and Membership Administration	3.1%	3.5%	4.6%	30%
Corporate Services	1.2%	1.5%	1.8%	33%
Subtotal: Core Expenses	6.0%	7.1%	8.2%	25%
Sales and Marketing	1.2%	1.5%	2.0%	41%
Total Expenses	7.7%	8.4%	9.5%	21%

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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 over 56%.

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 10.47 million Medicaid HMO members or nearly 17% of all Medicaid beneficiaries. Expressed on a PMPM basis, the Medicaid-focused plans have higher costs while, on a percent of premium basis, they tend to have lower costs.

Figure 8. Sherlock Benchmark Summary
Medicaid HMO Product Characteristics by Universe, 2022 Results

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$23.63	$24.20	$28.42	$23.93
Median	30.82	24.98	29.68	29.49
75th Percentile	35.42	25.77	32.24	34.79
Coefficient of Variation	40%	9%	13%	36%
Percent of Premiums and Equivalents				
25th Percentile	5.5%	7.0%	9.6%	6.0%
Median	6.6%	7.1%	9.7%	7.3%
75th Percentile	7.9%	7.2%	9.7%	8.9%
Coefficient of Variation	31%	5%	1%	29%
Total Costs				
Per Member Per Month				
25th Percentile	$26.08	$26.39	$33.58	$26.23
Median	33.74	27.09	35.88	32.51
75th Percentile	39.10	27.79	36.86	38.12
Coefficient of Variation	38%	7%	10%	34%
Percent of Premiums and Equivalents				
25th Percentile	6.3%	7.6%	10.8%	6.8%
Median	7.3%	7.7%	11.3%	7.7%
75th Percentile	8.6%	7.8%	11.5%	9.3%
Coefficient of Variation	28%	3%	6%	28%
Plans Offering Medicaid	15	2	3	20
Medicaid HMO Members (millions)	9.11	0.41	0.95	10.47
Comprehensive Total Members (millions)	15.54	3.46	27.54	46.55

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Shown in Figure 8, the comparison of Medicaid costs for the Medicaid, Blue Cross Blue Shield, and Independent / Provider-Sponsored universes. Blue Cross Blue Shield Plans Median *core* administrative costs were $29.68, lower by $1.14 PMPM compared to the Medicaid plans. On a Per Member Per Month basis, Independent / Provider – Sponsored plans' Medicaid Core costs were $24.98, $5.84 PMPM lower than those in Medicaid-focused plans.

Similarly, IPS Total administrative expenses of $27.09 PMPM, which includes Sales and Marketing, was $6.65 lower than that of Medicaid focused plans. On the other hand, Blue Cross Blue Shield Plans had *Total* median Medicaid expenses of $35.88 PMPM, higher by $2.14 PMPM versus the Medicaid plans.

Calculated on a percent of premium basis, Blue Cross Blue Shield Plans' Core administrative expenses, at 9.7% of premiums, were 3.1 percentage points *higher* than those of Medicaid focused plans. Based on Total expenses, Blue Cross Blue Shield Medicaid administrative expenses were 11.3%, higher than those of the Medicaid plans by 4.0 percentage points.

Compared to Independent / Provider – Sponsored Plans, when analyzed on a percent of premium basis, IPS plans' core costs were higher by 0.5 percentage points, 7.1% versus 6.6%. Similarly, IPS plans' total administrative costs were higher on a percent of premium basis by 0.5 percentage points, 7.7% against 7.3% for the Medicaid focused health plans.

How We Performed This Analysis

This analysis is based on the twenty-first 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 about 1,000 health benefit organization 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 fifteen plans who collectively served 15.5 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 675,000. The geographic reach of this universe extended from coast to coast.

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Medicaid HMO and CHIP combined were 9.2 million members and composed 59% of the combined comprehensive membership and 65% of revenues for comprehensive products. The average Medicaid revenue and membership proportion was 52% and 56%, respectively.

Almost all plans offered at least one type of Medicare product, Medicare Advantage or Medicare SNP. The average Medicare revenue and membership proportion was 14% and 7%, respectively. There were about 819,000 Medicare members served by these plans.

Of all comprehensive members, 34%, or 5.3 million, were served through a commercial product. Approximately 3.1 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 in the Spring of 2023. 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.

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- 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 2023 *Sherlock Benchmarks* reconciles these two presentations.

- Medicare Part D is not discussed, but there were six plans that offered this product. In other universes, 53% of Blue Plans offered Medicare Part D. The median administrative cost for this product in the Medicare Advantage universe was $16.35 PMPM and the mean was $20.13.

- 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 surveys of health plans who provide costs and their drivers on key administrative activities. The surveys are subject to validation procedures and collectively serve 63 million Americans.

The *Benchmarks* are reported in multiple universes of health plans: Medicare-focused, Medicaid-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.

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These *Plan Management Navigator* results are excerpted from the Medicaid edition of the 2023 *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 2023 edition Brochure is found here.

https://www.sherlockco.com/docs/Brochure/2023%20Benchmarks%20Brochure.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.

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Appendix A. 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	22%
Account and Membership Administration	15.14	19.43	20.36	32%
Corporate Services	5.80	6.69	8.26	47%
Subtotal: Core Expenses	$28.85	$35.05	$40.59	28%
Sales and Marketing	$4.78	$7.64	$10.32	48%
Total Expenses	$35.39	$45.96	$50.75	26%

Appendix B. 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%

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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
- (c) Grievances and Appeals

Claim and Encounter Capture and Adjudication
- (a) Coordination of Benefits (COB) and Subrogation
- (d) Payment Integrity
- (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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