Plan Management Navigator
Analytics for Health Plan Administration

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Core Expense Growth Accelerates for Medicaid Plans in 2023

"Core" per member administrative expenses in Medicaid-focused plans grew by 5.3% in 2023, faster than the 2.4% growth in 2022. The growth in the Account and Membership cluster *decelerated* to an increase of 3.9% in 2023 compared to the 5.7% in the prior year.

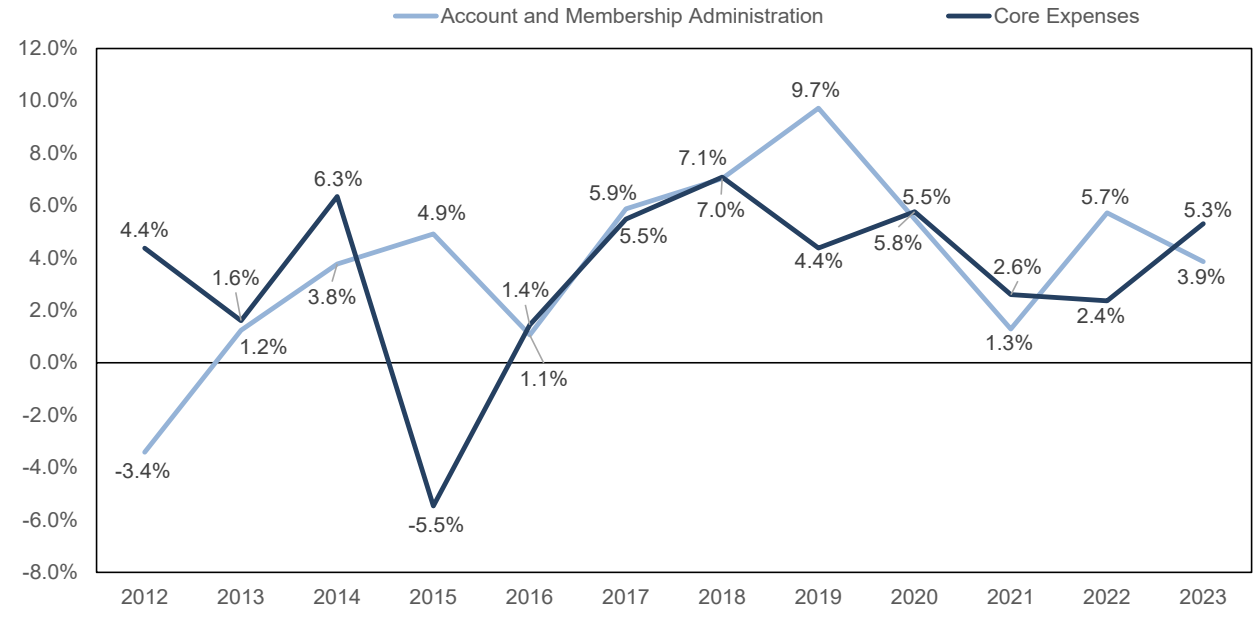
Figure 1 displays both Core and Account and Membership Administration trends since 2012. The rates of change reflected here hold constant both surveyed plans and their product mix in each year-over-year comparison. Cost trends in 2023 for Core expenses were above the average since 2012, while Account and Membership matched the 12-year average. (The 12-year average for Core expenses was 3.4%.)

The cost trends for 2023 discussed in this *Plan Management Navigator* are based on the results of ten continuous plans serving 7.4 million members in comprehensive products, of which 4.4 million were Medicaid or CHIP. This report as a whole, including the actual PMPM costs, is based on the results of the continuing plans plus new participants.

Together, 11 health plans serving 7.9 million members of which 4.8 million were Medicaid or CHIP participated in the *Sherlock Benchmarks* for Medicaid plans and are summarized in this *Navigator*.

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.

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, the proportion of Americans uninsured dropped from 13% in 2013 to 8% in 2023, approximately a 5 percentage point decline. This figure is based on US Census Bureau population surveys and analyses, *Health Insurance Coverage in the United States: 2023*, published annually, most recently in September 2024.

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 who were 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.

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 2023. The suspension of Medicaid redetermination related to the PHE declaration ended in May 2023.

Subject to qualifications noted on the chart, of the 15.4 million net decline in uninsured since 2013, the 7.8 million additions to Medicaid beneficiaries explained 50.6% 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 pre-pandemic levels in 2022 and has ranged from 3.4% to 3.8% in 2023.

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		2023		2023 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%	305,200	92%	1,200	0%	33,594	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%	216,800	65%	300	0%	15,762	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%	178,200	54%	-1,600	-1%	3,782	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%	33,850	10%	1,050	3%	-1,905	-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%	120,400	36%	1,300	1%	12,113	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%	62,550	19%	980	2%	13,530	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%	62,700	19%	650	1%	7,781	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%	11,892	4%	721	6%	-2,124	-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%	26,440	8%	500	2%	-15,355	-38%
Total	313,401		316,168		318,869		320,372		322,490		323,668		324,549		327,521		328,090		329,940		331,640		1,700	1%	18,239	5%

Source: Health Insurance Coverage in the United States: 2023, https://www.census.gov/content/dam/Census/library/publications/2024/demo/p60-284.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."

Also, "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."

Employer-based coverage fell by about 1.6 million people from 2022 to 2023 to 178.2 million. At the same time, Medicaid increased by 650,000 people to 62.7 million. Longer term, membership in employer-based coverage increased by 3.8 million people from 2013 to 2023, while Medicaid grew by 7.8 million people.

Direct purchase of health coverage ("Coverage purchased directly from an insurance company, or through a federal or state Marketplace") increased by 1.1 million people from 2022 to 2023. From 2013 to 2023, the number of people obtaining health insurance through Direct Purchase declined by about 1.9 million. Direct Purchase was also down by 18.2 million from its peak in 2015.

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 5.4%, faster than last year's increase of 1.8%. The two columns labeled "as-reported" reflect per member trends in continuous plans. Meanwhile, 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 2022 and 2023. This adjustment is intended to eliminate the effects of changes in product mix between comparison years, providing what we consider a more accurate measure of cost growth.

Cost trends reflected a product mix shift towards higher cost products like Medicare, versus lower cost Medicaid. Generally, this shift would be expected to result in faster growth in as-reported costs compared to the constant-mix basis. Median changes in Core expenses aligned with this expectation, with as-reported growth at 5.4% and constant mix at a slower rate of 5.3%. Total expenses, however, conflicted with this as as-reported growth lagged constant-mix at 5.2% and 5.4%, respectively.

Averages yielded consistent results, Core as-reported expenses increased by 4.9%, compared to a slower 4.5% increase under the constant-mix approach. Total expenses grew by 6.4% on an as-reported basis, versus 5.2% under constant-mix.

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

	2022 Increase		2023 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	1.5%	2.4%	7.2%	6.1%
Account and Membership Administration	5.5%	5.7%	4.0%	3.9%
Corporate Services	1.5%	0.5%	3.6%	3.5%
Subtotal: Core Expenses	1.8%	2.4%	5.4%	5.3%
Sales and Marketing	4.5%	9.5%	9.4%	7.0%
Total Expenses	3.7%	4.9%	5.2%	5.4%

Membership in Medicare increased by a median rate of 5.5% and a mean of 13.4%. This outpaced Medicaid's median and mean increase of 2.2% and 5.4%, respectively. Membership in Commercial products increased by a median of 0.8% and a mean of 9.8%. Within this segment, Insured outpaced the lower cost ASO product at a median of 5.8% and average of 16.7%. ASO's median and mean were 0.6% and 2.6%, respectively.

For the core clusters in Figure 3, Medical and Provider Management increased by 7.2% on an as-reported basis versus 6.1% on a constant mix basis. Account and Membership's as-reported and constant-mix was higher by 4.0% and 3.9%, respectively. Corporate Services cluster was higher by 3.6% on an as-reported basis versus 3.5% on a constant-mix basis. The pattern of growth in each of the Core clusters comported with the shift in the mix towards more expensive Medicare. Similarly, Sales and Marketing was also higher by 9.4% on an as-reported basis and 7.0% on a constant-mix basis.

The ten continuously participating plans served 4.4 million members with Medicaid CHIP and HMO. There were 761,000 members served under Medicare Advantage and SNP, while 113,000 served under Medicare Supplement. Commercial comprised 2.1 million members of which 966,000 was served under an ASO arrangement and 1.1 million were fully-insured. The ten plans served 7.4 million members with these comprehensive products.

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, Corporate Executive and Governance was the fastest growing function, while Medical Management was the most important source of growth. While not included in Core, Sales and Marketing cluster contributed to Total cost growth with Sales the fastest growing function and External Broker Commissions the most important source of growth.

For Core functions, Median Compensation per FTE and Non-Labor Costs per FTE were higher than last year. Outsourced FTEs and Medicaid Staffing Ratios were lower. 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.)

Medical and Provider Management

Holding constant the product mix, PMPM expenses in the Medical and Provider Management cluster grew by 6.1%. Growth was driven by higher Staffing Costs per FTE and Non-Labor Costs per FTE, while Outsourcing was higher.

Medical Management / Quality Assurance / Wellness PMPM expenses slightly outpaced the increase in Provider Network Management but was by far the largest source of growth for the cluster. Medical Management sub-functions that grew notably were Case Management, Nurse Information Line, Health and Wellness, Quality Components, Medical Informatics and Other Medical Management. The Medical Management Staffing Costs, Non-Labor Costs, and propensity to Outsource were higher than the prior year.

The Provider Network Management and Services functional area grew slightly slower than Medical Management. This function's Staffing Costs, Non-Labor Costs, and Outsourcing was higher than the previous year. Its higher sub-functions were Provider Relations Services, Provider Contracting and its subfunction of Provider Configuration.

Account and Membership Administration

The Account and Membership Administration cluster of expenses posted a median PMPM increase of 3.9%, on a constant-mix basis. The cluster's Median Compensation per FTE and Non-Labor Costs per FTE were higher than the prior year. Outsourcing declined, as did the Medicaid Staffing Ratio.

The most important source of this cluster's growth was Information Systems on higher Non-Labor Costs per FTE and Compensation per FTE, while Outsourced Staffing declined. All IS sub-functions were higher from the previous year, except for Benefit Configuration.

Customer Services was this cluster's fastest growing function mainly on higher Compensation and Non-Labor costs. Outsourcing was lower. Subfunctions Member Services and Grievances and Appeals were both higher than last year.

Enrollment / Membership / Billing cost was higher than last year with both subfunctions of Enrollment and Membership, and Billing higher than the prior year. Both Non-Labor and Compensation were higher than last year.

Claims Adjudication costs were lower than the previous year. COB and Subrogation sub-function costs particularly declined.

For the purposes of *Navigator*, we include Behavioral Health and Pharmacy administration in overall cost trends and those of Account and Membership Administration. If excluded from Account and Membership, the cluster would have increased by 3.7% rather than the 3.9% shown in Figure 3. If these activities had been excluded, Core administrative expenses would have increased by 5.1% rather than the 5.3% that we show in Figure 3. The PMPM Pharmacy and Behavioral Health administrative costs decreased at a median rate of 4.8%.

Corporate Services Cluster

On a constant-mix basis, the PMPM Corporate Services cluster costs increased by 3.5%. Median Compensation per FTE was higher than last year for this cluster.

Corporate Executive and Governance was the fastest growing and most important source of growth for this cluster.

Actuarial was the second fastest growing function in this cluster, followed by Association Dues and License and Filing Fees and Finance and Accounting. Conversely, the Corporate Services function was slightly lower than the prior year.

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 7.0% PMPM, holding the product mix constant.

Median Sales and Marketing cluster's Compensation per FTE and Non-Labor Costs per FTE were higher, year-over-year. Conversely, propensity to Outsource and Staffing Ratios were lower.

Sales was the fastest growing function, while External Broker Commissions was the most impactful to Sales and Marketing growth.

Rating and Underwriting and Marketing functional areas were higher than last year, while Advertising and Promotion was lower than the prior year.

As-Reported Trends

This section will focus on key trend differences in as-reported trends that vary significantly 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 so that Core and Total as-reported costs, on average, grew faster than when product-mix is eliminated.

In 2023, Core expenses PMPM increased on an as-reported basis at a median rate of 5.4% PMPM versus 5.3% for constant-mix. All clusters grew faster on an as-reported basis compared to their growth on a constant-mix basis.

Sales and Marketing costs, which are not considered to be *Core* in this universe, increased by 9.4% on an as-reported basis and compares to a 7.0% increase on a constant-mix basis. This represented the greatest difference in clusters' median rate of change between as-reported and constant-mix. Both Rating and Underwriting and External Broker Commissions accelerated their growth to double digits on an as-reported basis. Sales, which was the fastest growing function on a constant-mix basis, had a deceleration on an as-reported basis, while Advertising and Promotion accelerated its decline on an as-reported basis compared to the constant-mix trend.

Medical and Provider Management increased by 7.2% on an as-reported basis, faster than its constant-mix growth of 6.1%. Both component functional areas of Provider Network Management and Medical Management / Quality Assurance / Wellness grew at faster rates on an as-reported basis.

The Corporate Services cluster's costs increased by 3.6% on an as-reported basis, marginally faster than the 3.5% increase on a constant-mix basis. The acceleration in the Corporate Services function on an as-reported basis outweighed the slight deceleration in all other functions in this cluster.

The Account and Membership cluster posted faster as-reported growth, 4.0% versus 3.9%, on a constant-mix basis. Both IS and Claims accelerated on an as-reported basis, while Enrollment and Customer Services posted slower increases.

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 trend 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 9% to over 18 FTEs per 10,000 Medicaid members. Of the 14 functional areas with staff, ten posted declines from 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 higher by 8% to approximately $106,000. Of the 14 functions with staff, 9 experienced increases from a year ago. Compensation per Total FTE was also higher by 8% to $107,000 per FTE.

Propensity to outsource, at a median of 11% for Core, was slightly lower than last year. Of functional areas with staff, 10 decreased their use of outsourcing.

Core Non-Labor Costs was $75,000 per FTE, higher by 19% over the previous year. Eleven out of the 14 functional areas with Staff increased in Non-Labor costs.

Costs of Medicaid-focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 11 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. Five plans dropped out of the universe from a year ago, while there was one addition. 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 was higher by 14.7% to a median of $20.89 PMPM, shown in Figure 4. The as-reported and constant-mix *increases* were 4.0% and 3.9%, respectively. This cluster includes Information Systems, Enrollment, Claims and Customer Services.

Medical and Provider Management costs per member per month was $10.83 PMPM, 10.3% higher than last year's value of $9.82. This cluster grew on an as-reported basis for the continuously participating plans by 7.2%, while increasing by 6.1% 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 PMPM costs were lower than last year at $7.34 versus $7.76 last year, a *decline* of 5.4%. The Corporate Services cluster increased for plans participating in both years on both an as-reported basis and constant-mix basis by 3.6% and 3.5%, respectively. Functions in this cluster include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities called the Corporate Services Function that include Facilities, HR and Legal.

Figure 4. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2023 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$8.24	$10.83	$13.29	41%
Account and Membership Administration	18.10	20.89	22.14	26%
Corporate Services	6.22	7.34	8.15	46%
Subtotal: Core Expenses	$34.78	$39.68	$41.60	29%
Sales and Marketing	$6.97	$9.39	$11.22	41%
Total Expenses	$39.40	$48.04	$53.03	25%

Median Core administrative expenses were $39.68 PMPM, 9.0% higher than last year's median of $36.41. For plans participating in both years, as-reported and constant-mix growth in Core expenses was 5.4% and 5.3%, respectively.

The Sales and Marketing cluster PMPM costs grew by 26.4% to a median of $9.39 PMPM. The clusters' increase was 9.4% as-reported and 7.0% on a constant-mix basis. Sales and Marketing functional areas include Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Median Total Expenses were 12.8% higher to $48.04 PMPM from $42.59 PMPM in the prior year. For continuously reporting plans, as-reported costs increased 5.2% and constant-mix growth was 5.4%.

The dispersion in Core Expenses, measured by the Coefficient of Variation, decreased compared to last year. Account and Membership Administration posted the largest decline in dispersion. Conversely, the standard deviation of Medical and Provider Management and Corporate Services increased. The Sales and Marketing cluster's dispersion declined, and Total expenses also decreased its dispersion from last year.

Dispersion measured by the difference between 25th and 75th percentiles also narrowed for Core expenses. The differences between 25th and 75th percentiles for both Account and Membership and Corporate Services cluster narrowed, while Medical and Provider Management increased. The differences increased slightly for Sales and Marketing but narrowed for Total expenses.

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 their peers.

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 among the participating plans.

Median administrative expense for Medicaid HMO was $33.03 PMPM and was $30.12 PMPM for Medicaid CHIP. For all eleven participating plans, Total Medicaid's average mix of members was over 58% and its average mix of revenue was 50%.

Shown in the note at the foot of the chart, Per Member Per Month Core expenses for Medicaid HMO and CHIP combined was $30.96, PMPM. Core Medicaid HMO was also $30.96 and Medicaid CHIP was $26.69. An estimate of the Sales and Marketing expenses associated with these products can be inferred as the difference between the footnote and the body of this figure.

Medicare, like Medicaid, is a government-sponsored product. Medicare products serve seniors as Medicaid serves low-income people, respectively. There is some overlap between the sponsors 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 $237.46 PMPM for Medicare SNP and $134.33 PMPM for Medicare Advantage. The average membership mix for Medicare Advantage was 7% and Medicare SNP was 1%. Average revenue mix for Medicare Advantage was 15%, Medicare Advantage SNP was 2%.

Note that Medicare Supplement has lower costs than the median for comprehensive total at $39.84 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Four plans in the Medicaid universe offer the product and its mean product mix and revenue mix was 2%.

Commercial administrative expenses are both higher and lower than the median for comprehensive total. This bifurcation depends on their financing mechanism and indirectly bears on group size. The costs of Commercial Insured products, because they serve individual and small group markets, are accordingly higher than the median for comprehensive products. 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 $27.61 PMPM.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2023 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$25.90	$33.03	$39.40	37%
HMO	25.75	33.03	39.85	37%
CHIP	$25.43	$30.12	$36.97	29%
Medicare Total	$134.33	$143.99	$167.33	32%
Advantage	124.92	134.33	164.34	34%
SNP	$223.86	$237.46	$275.13	24%
Medicare Supplement	$35.17	$39.84	$43.43	23%
Commercial Insured Total	$53.99	$59.35	$71.17	21%
HMO	53.65	59.51	59.95	19%
POS	57.28	70.76	89.24	43%
Indemnity & PPO	$55.24	$58.98	$74.65	43%
Commercial ASO	$26.02	$27.61	$32.17	24%
Commercial Total	$40.75	$44.82	$49.93	13%
Comprehensive Total	$39.40	$48.04	$53.03	25%
Note: Core Expenses of Medicaid				
Medicaid Total	$24.17	$30.96	$36.81	39%
HMO	24.17	30.96	36.88	39%
CHIP	$23.19	$26.69	$29.37	22%

The single most important Commercial Insured product for this universe is HMO at $59.51 PMPM. POS costs $70.76 PMPM, while Indemnity and PPO costs $58.98. The mean mix of Commercial products was 32% of the membership: Commercial Insured and ASO each served 16% of total membership in this universe, on average. Median Commercial Total costs PMPM were $44.82.

Costs of Medicaid-Focused Plans, Percent of Premiums by Product

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.

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. Where there are ranking differences, they primarily stem from percents tending to better reflect that correspondence than do PMPMs. On average, the administrative costs of Comprehensive products were 8.9% of premiums.

Medicaid HMO was lower than Comprehensive Total on both a PMPM and percent of premium basis, at 7.7%. Medicaid CHIP was lower than comprehensive total on a PMPM basis but, at 11.9%, is higher than average on a percent of premium basis.

Figure 6. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2023 Results
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	6.7%	7.7%	8.9%	26%
HMO	6.5%	7.7%	8.9%	27%
CHIP	8.0%	11.9%	13.8%	45%
Medicare Total	11.4%	13.8%	15.2%	28%
Advantage	12.0%	12.4%	15.2%	34%
SNP	12.6%	16.3%	18.7%	28%
Medicare Supplement	13.0%	14.9%	17.5%	25%
Commercial Insured Total	9.6%	10.4%	11.5%	21%
HMO	9.2%	9.2%	10.3%	24%
POS	7.7%	9.9%	13.5%	55%
Indemnity & PPO	10.4%	10.8%	12.0%	37%
Commercial ASO	4.8%	5.9%	7.3%	31%
Commercial Total	7.9%	8.7%	9.5%	20%
Comprehensive Total	8.3%	8.9%	10.2%	21%
Note: Core Expenses of Medicaid				
Medicaid Total	5.8%	7.2%	8.5%	30%
HMO	5.7%	7.2%	8.5%	30%
CHIP	7.2%	10.0%	11.4%	36%

Medicare SNP, the highest cost product on a PMPM basis, is higher than most products on a percent of premium basis at 16.3%, but this difference relative to other products is far smaller than on a PMPM basis. Meanwhile, Medicare Advantage expenses, while over two times greater than Commercial HMO Insured products on a PMPM basis, is narrowly higher on a percent of premium basis at 12.4%.

While Medicare Supplement is below comprehensive total when measured on a PMPM basis, at 14.9%, its cost ratio was greater than that of the Comprehensive total. This product often incurs administrative costs with fewer corresponding health care costs because it is a secondary payor.

Administrative expenses on a percent of premium basis for Commercial HMO and POS were 9.2% and 9.9%, respectively, while Indemnity and PPO was 10.8%. These ratios, like the PMPMs, were higher than Comprehensive total of 8.9%.

Administrative expenses of Commercial ASO products are 5.9% 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 a 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 0.5 percentage points to 7.6% compared with last year's median of 7.1%, shown in Appendix B.

Account and Membership Administration increased by 0.4 percentage points to 3.8%, while Medical and Provider Management was higher by 0.2 percentage points to 1.9%. Corporate Services cluster, however, decreased by 0.1 percentage points to 1.4%.

Figure 7. Sherlock Benchmark Summary

Medicaid Plans' Costs by Functional Area Cluster, 2023 Results

Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.6%	1.9%	3.0%	40%
Account and Membership Administration	3.3%	3.8%	4.8%	23%
Corporate Services	1.3%	1.4%	1.5%	34%
Subtotal: Core Expenses	6.3%	7.6%	8.4%	24%
Sales and Marketing	1.2%	2.0%	2.2%	42%
Total Expenses	8.3%	8.9%	10.2%	21%

Sales and Marketing increased by 0.5 percentage points to a median of 2.0%. Total expenses, including Sales and Marketing, had a median percent of premium of 8.9%, 0.5 percentage points higher than the prior year.

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 employing Medicaid products in the Medicaid-focused plans was 58%.

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 6.04 million Medicaid HMO members or nearly 10% 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, 2023 Results

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$24.17	$24.22	$28.97	$24.27
Median	30.96	26.40	30.78	28.61
75th Percentile	36.88	27.10	32.60	34.41
Coefficient of Variation	39%	18%	17%	37%
Percent of Premiums and Equivalents				
25th Percentile	5.7%	7.3%	8.8%	7.0%
Median	7.2%	7.6%	8.8%	7.4%
75th Percentile	8.5%	8.3%	8.8%	8.8%
Coefficient of Variation	30%	16%	1%	25%
Total Costs				
Per Member Per Month				
25th Percentile	$25.75	$25.70	$33.28	$25.81
Median	33.03	28.67	34.89	31.68
75th Percentile	39.85	29.79	36.49	38.09
Coefficient of Variation	37%	19%	13%	34%
Percent of Premiums and Equivalents				
25th Percentile	6.5%	7.8%	9.9%	7.5%
Median	7.7%	8.2%	10.0%	7.9%
75th Percentile	8.9%	9.1%	10.2%	9.9%
Coefficient of Variation	27%	16%	4%	23%
Plans Offering Medicaid	11	4	2	17
Medicaid HMO Members (millions)	4.72	0.55	0.77	6.04
Comprehensive Total Members (millions)	7.76	4.24	21.76	33.76

Shown in Figure 8, the comparison of Medicaid costs for the universes of Medicaid, Blue Cross Blue Shield, and Independent / Provider-Sponsored plans. Blue Cross Blue Shield Plans Median core administrative costs were $30.78, lower by $0.18 PMPM compared to the Medicaid plans. On a Per Member Per Month basis, Independent / Provider – Sponsored plans' Medicaid Core costs were $26.40, $4.56 PMPM, lower than those in Medicaid-focused plans.

Similarly, IPS Total administrative expenses of $28.67 PMPM, which includes Sales and Marketing, was $4.36 lower than that of Medicaid focused plans. On the other hand, Blue Cross Blue Shield Plans had Total median Medicaid expenses of $34.89 PMPM, higher by $1.86 PMPM versus the Medicaid plans.

Calculated on a percent of premium basis, Blue Cross Blue Shield Plans' Core administrative expenses, at 8.8% of premiums, were 1.6 percentage points higher than those of Medicaid focused plans. Based on Total expenses, Blue Cross Blue Shield Medicaid administrative expenses were 10.0%, higher than those of the Medicaid plans by 2.4 percentage points.

Compared to Independent / Provider – Sponsored Plans when analyzed on a percent of premium basis, IPS plans' Core costs were higher by 0.4 percentage points, 7.6% versus 7.2%. Similarly, IPS plans' Total administrative costs were higher on a percent of premium basis by 0.6 percentage points, 8.2% against 7.7% for the Medicaid focused health plans.

Product focus can lead to lower overall costs. As shown above, the record here is ambiguous. A possible explanation of the higher PMPM costs and the lower percents displayed by Medicaid focused plans is that Medicaid focused plans may serve a less healthy population with ostensibly similar products. While this possibility corresponds to our earlier observation that administrative expenses often track health care costs we are unable to test this hypothesis.

How We Performed This Analysis

This analysis is based on the twenty-second 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 over 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 eleven plans who collectively served 7.8 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 705,000 people under Comprehensive products and the median membership was 572,000. The geographic reach of this universe extended from coast to coast.

Medicaid HMO and CHIP together served 4.8 million members and composed 62% of the combined Comprehensive membership and 58% of revenues for Comprehensive products. The average Medicaid revenue and membership proportion was 50% and 58%, respectively.

Nine out of eleven plans served at least one type of Medicare product, Medicare Advantage or Medicare SNP. The average Medicare revenue and membership proportion was 17% and 8%, respectively. About 776,000 Medicare members were served by these plans.

Of all comprehensive members, 27%, or 2.1 million, were served through a commercial product. Approximately 966,000 were served under some form of self-insurance arrangement, comprising 47% of total commercial members.

The panel of plans that participated in the *Sherlock Benchmarks* for Medicaid plans was formed in the Spring of 2024. 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 October.

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, also called the 50th percentile, 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 plan product mix changes between the years.

- Percent of premium ratios are calculated on a *premium-equivalent* basis. That is, in the case of ASO arrangements, we build to a premium from fees by adding fees to the health benefits incurred by the self-insured group. In this way, premium equivalents sum to all of the expenses of health insurance, including profits earned by the health plan, analogous to premiums on insured products. While not in accordance with GAAP, this approach has two advantages: comparability of ASO ratios with those of insured products offered by these plans, and an intuitive appeal to most readers.

- Expenses exclude capital costs and investment income. Specifically excluded expenses include interest and similar debt capital costs and other capital formation costs (debt or equity), including transaction costs, and interest payments to providers under "prompt pay" laws.

- 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 of 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 segment them. Pages 24 - 26 in Tab 2 of Volume I of the 2024 *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 52 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.

These *Plan Management Navigator* results are excerpted from the Medicaid edition of the 2024 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 2024 edition Brochure is found here.

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, 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%

Appendix B. 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%

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) Fund Accounting for Self-Insured Groups
  - (c) 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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