Plan Management Navigator
Analytics for Health Plan Administration

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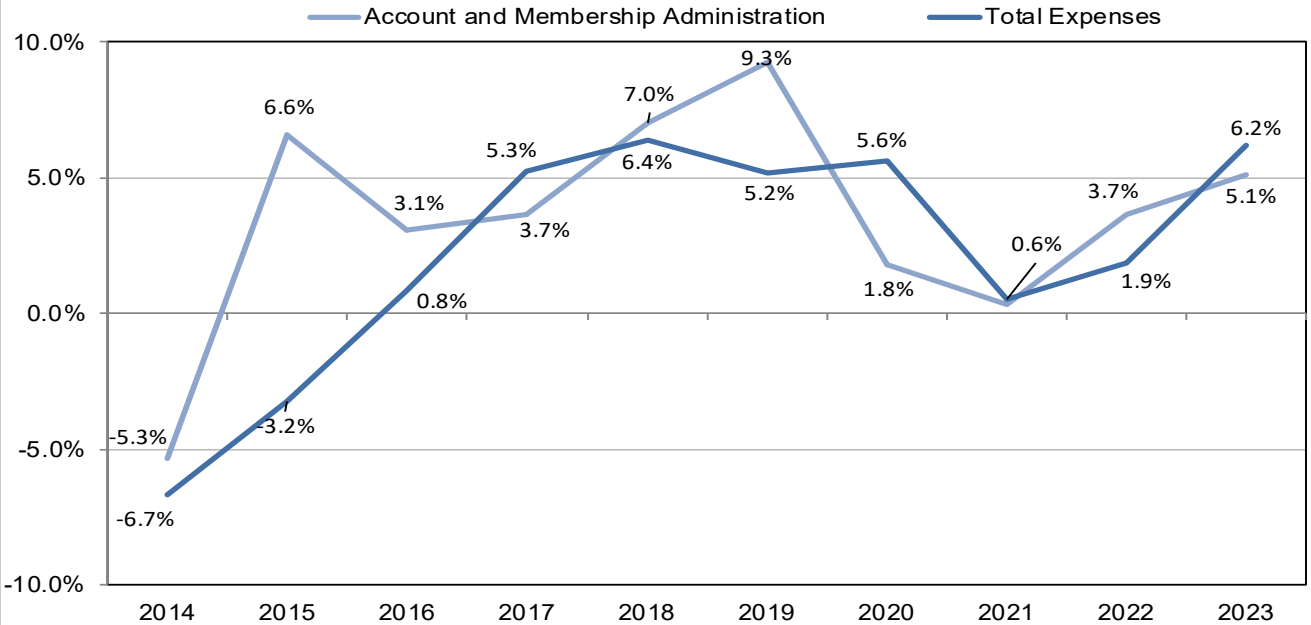
Per Member Administrative Expenses for Medicare Plans Accelerated in 2023

Administrative costs for Medicare-Focused plans grew by 6.2% from 2022 to 2023 accelerating from a 1.9% increase in the prior year. The largest cluster of functions, Account and Membership Administration, increased by 5.1%, shown in Figure 1, up from 3.7% in 2022. Eleven plans participated in the 2024 edition of the Medicare *Sherlock Benchmarks*, reflecting 2023 results.

The participating plans collectively served 1.7 million Medicare Advantage members. These single state or regional plans served about 17% of Medicare Advantage not served by the five largest share plans. An average of 38% of revenues of these companies were in Medicare Advantage and Medicare SNP ("Special Needs Plans") products, exceeded 20% of revenues in all cases, and was the plurality product in four cases. Eight plans participated in both the 2022 and 2023 benchmarking cycles and the results of these were used for trend purposes.

Figure 1. Sherlock Benchmark Summary
Medicare Plans' Rates of Change for Account and Membership Administration and Total, Constant Mix



Background on Medicare Advantage

Medicare Advantage ("MA") is chosen by an increasing proportion of beneficiaries to replace regular FFS Medicare. MA supplies additional benefits above regular Medicare but, unlike Medicare Supplement policies, those benefits are integrated with the standard benefits of traditional Medicare.

For the first time, in March 2024, the majority of Medicare beneficiaries elected Medicare Advantage. As of March 2024, 50.8% of Medicare beneficiaries chose Medicare Advantage compared with 48.7% in March of the previous year. As of March 2024, there were 66.6 million eligible for Medicare in March 2024, including those not purchasing Medicare Part B, a prerequisite to participation in Medicare Advantage. According to the CMS State/County Penetration file, Medicare Advantage plans served 33.8 million people, an increase of 6.5% from 31.8 million, year-over-year (please see Figure 2).

Membership in the traditional Fee-For-Service ("FFS") program decreased by 2.0% during that year, versus the 2.7% decline in 2023 and 3.4% in 2022. This was the eighth consecutive annual decline in FFS membership which began in 2017. Since 2016, membership in FFS Medicare has fallen by 5.6 million members, compared with a 15.6 million increase in Medicare Advantage.

Taking the longer view, the total number of Medicare beneficiaries in 2024 increased by 23.3 million since 2005. Of those members, 28.2 million elected Medicare Advantage, while FFS membership declined by 4.9 million since 2005.

Lanlan Xu, et al., traced this movement towards Medicare Advantage in a *Health Affairs* article published in September 2023, noting "The share of Medicare beneficiaries enrolled in MA more than tripled between 2006 and 2022, accelerating since 2019, and our results show that this trend was mainly driven by beneficiaries who were previously enrolled in fee-for-service Medicare but switched to MA." The article continues, "…switching from MA to fee-for-service Medicare decreased, with the change rates accelerating since 2019. The share of switchers among all new MA enrollees rose from 61 percent in 2011 to 80 percent in 2022."

Kaiser Family Foundation (January 30, 2024) believes several factors contributed to the growth in MA, including:

- Supplemental benefits in MA such as dental, vision, gym memberships, and Over-The-Counter allowance cards.
- Popularity of Zero Premium MA plans.
- MA offers annual out-of-pocket limits, while FFS does not have a cap.
- Broker commissions' structure that incentivizes MA over complementary products to FFS such as Medicare Supplement and Stand-Alone Part D plans.
- Employers providing retiree health benefits increasingly emphasize MA plans.

The Lanlan Xu article also finds that "Healthier beneficiaries with no HCC diagnostic codes had modestly higher odds of switching from fee-for-service Medicare to MA but much lower odds of switching from MA to fee-for-service Medicare than beneficiaries with more HCC diagnostic codes."

The KFF article also observed that the Medicare Payment Advisory Commission (MedPAC) made a change in its estimation methodology intended to take into account the effects of favorable selection. According to MedPAC's March 2024 *Report to the Congress: Medicare Payment Policy*,

> "…we estimate that in 2024 the Medicare program pays roughly 22 percent more for enrollees in MA relative to what the program would have paid if those beneficiaries were in FFS. Our estimate of higher payments to MA plans is primarily driven by two factors—higher coding intensity in MA and a favorable selection of enrollees in MA plans…a difference that translates into a projected $83 billion in 2024."

When employing this new approach, that 22% modeled higher payment to MA, it is the same as the prior year and, in both years, favorable selection composed 9% of that higher payment.

This *Navigator* does not address the merits or the process of MedPac's estimation of favorable selection. In a nutshell, its estimation is intended to capture the degree to which "risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans." It is based on calculation of "FFS spending in the year prior to MA enrollment." MedPac acknowledges that this favorable selection may not be a stable phenomenon in that individual member costs may regress to the mean and, "it is possible that as MA grows, the favorability of the MA program will converge with the population remaining in FFS, and favorable selection will decrease." Irrespective of the above, the salient fact is that MedPac believes favorable selection to exist.

CMS announced in April 2024 that payments to MA plans will be cut by 0.16%. In its 2023 10K, UnitedHealth, outlined its potential responses to any resulting pressures on Medicare Advantage rates.

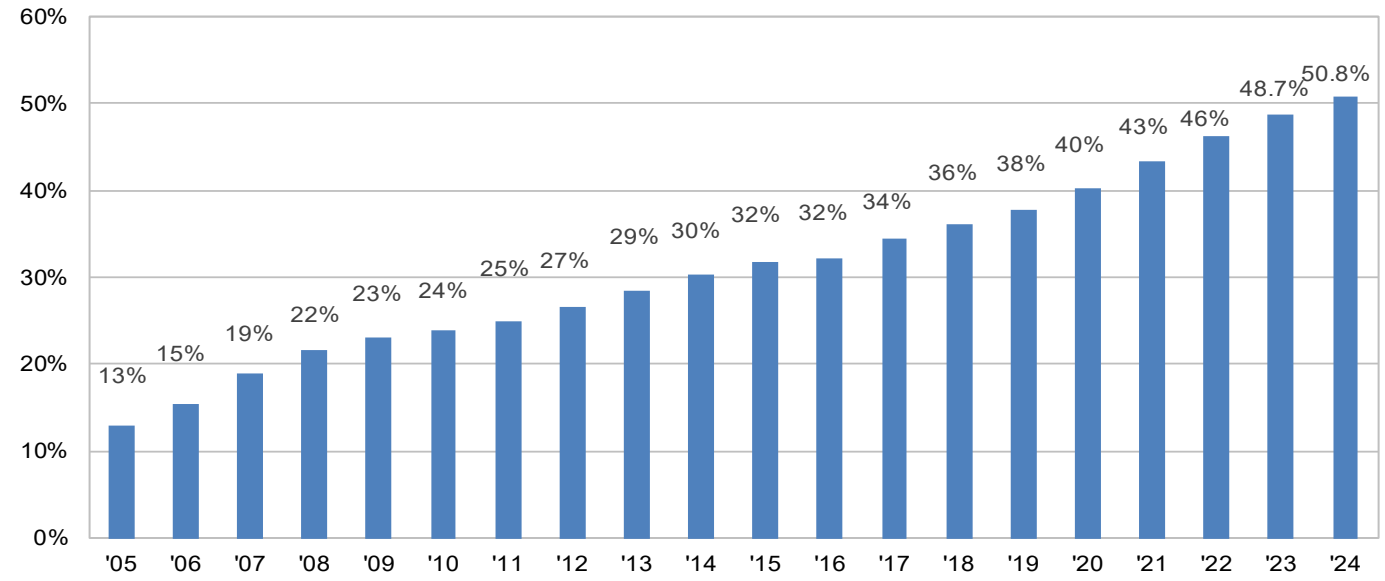
> "…over the years have at times resulted in industry base rates well below the industry forward medical trend. For example, the Final Notices for 2024 and 2025 rates resulted in an industry base rate decrease, both well short of an increasing industry forward medical cost trend, creating continued pressure in the Medicare Advantage program."

To mitigate these funding pressures, UnitedHealth noted that it can intensify "…medical and operating cost management, make changes to the size and composition of our care provider networks, adjust member benefits and implement or increase the member premiums… Additionally, we decide annually on a county-by-county basis where we will offer Medicare Advantage plans."

In addition, notwithstanding MedPac's view, payments to MA plans are in the short term affected by decisions of the Executive Branch. The *Wall Street Journal's* editorial page on October 1, 2024 noted that, in the face of projected higher beneficiary premiums, "CMS launched this summer a 'demonstration Project' to 'stabilize' the market that involved boosting payments to insurers." The WSJ states that the program is "expected to cost about $5 billion." So, according to CMS's press release issued on September 27, 2024, through a voluntary demonstration, total Part D beneficiary premium is projected to decrease by $7.45 per month in 2025.

Despite funding pressures as described by UnitedHealth, MA is expected to continue its growth. According to KFF, the Congressional Budget Office (CBO) projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to 64% by 2034".

Figure 2. Sherlock Benchmark Summary
Medicare Advantage Share



Overall Trends and Product Mix

Figure 3 shows year-over-year trends on both an as-reported and constant-mix basis. When the effect of mix changes is excluded, for the eight continuously participating plans, per member costs grew by 6.2%, notably faster than the 1.9% increase in the prior year. On an *as-reported* basis, these continuously participating plans' per member costs increased by 5.2%, sharply higher than 0.5% in the prior year. These changes, all other trends and PMPM costs exclude Miscellaneous Business Taxes.

Cost trends on an as-reported basis indicated a shift towards lower cost products as growth in Medicaid outpaced the growth in Medicare. This shift resulted in lower cost growth on an as-reported basis, 5.2% compared to 6.2% when product mix is held constant. Using either averages or medians, Commercial products declined in plan mix and declined in membership. Within this segment, ASO increased and insured declined. The within-Commercial change alone is a shift in favor of low-cost products.

Medicare and Medicaid are more complicated. Using median growth rates and mix changes, Medicare growth exceeded Medicaid. Using average growth rate and mix changes, Medicaid growth exceeded Medicare. As a whole, lower cost Medicaid grew at a median rate of 3.4% and a mean rate of 7.7%.

Conversely, the higher cost Medicare Advantage increased at a median rate of 4.0% and a mean rate of 3.3%. Within Medicare Advantage, the minor but expensive SNP product increased at a median rate of 15.7% and a mean rate of 66.9%. The rest of Medicare increased at a median rate of 3.8% and a mean rate of 2.8%. Commercial as a whole declined at a median rate of 3.7%, with insured decreasing by 7.6% and ASO increasing by 0.6%. Among continuous plans, Comprehensive membership increased at a median rate of 1.8%.

In aggregate, the proportion of members increased for both Medicare and Medicaid but slightly faster for Medicaid. Aggregate growth was nearly twice as fast. In summary, the rates of change shown in Figure 3 comport with cost growth emphasizing lower cost products both in the relative relationship of Medicare and Medicaid, and within Commercial.

The cost effect of the change in mix was muted by the higher costs to serve Medicare beneficiaries, approximately three times higher in both Account and Membership Administration and in Provider and Medical Management. It is also complicated by changes in the distribution system of the Medicare Advantage products.

The effect of mix on cost growth is modest but evident. There was significant variation among the plans in this shift.

Figure 3. Sherlock Benchmark Summary

Medicare Plans' Median Changes in Per Member Per Month Expenses

	2022 Increase		2023 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	4.5%	10.5%	5.6%	6.7%
Medical and Provider Management	2.1%	2.4%	7.0%	6.1%
Account & Membership Administration	3.8%	3.7%	6.4%	5.1%
Corporate Services	0.2%	1.6%	3.3%	3.5%
Total Expenses	0.5%	1.9%	5.2%	6.2%

The eight continuously participating plans served 1.6 million Medicare Advantage and Medicare SNP members. In addition, they also served 417,000 Medicare Supplement members. Commercial comprised 7 million members, of which 4 million were ASO. Medicaid served 2.4 million people. Continuous plans served 11.5 million people in total.

In comparison, including new plans, the universe as a whole served over 1.8 million Medicare Advantage and Medicare SNP members plus 424,000 Medicare Supplement members. Plans in the universe as a whole served 12.4 million people.

Trends Holding Product Mix Constant

Trends that are free of the distortion of the impact of product mix changes are a more accurate representation of their underlying dynamics so the discussion that follows is largely based on this. To hold constant the product mix, we reweight the continuing plans' expenses so that the product mix of the prior year matches that of the current year. Only those plans that reported in both periods are included in these comparisons.

Functions with notable increases, that is percent trends weighted by their dollar values, include Information Systems, External Broker Commissions, Medical Management, and Customer Services. The cluster trends described below are presented in order of their contribution to total cost increase. When we refer to staffing ratios, these include outsourced staffing and reflect Medicare Advantage staffing inferred from expenses in that product.

Account and Membership Administration

This cluster of expenses had a PMPM cost increase of 5.1%. For this *Navigator* analysis, Account and Membership Administration includes Pharmacy and Behavioral Health expenses. The trends in administrative activities of these two benefits reduced median cost growth by 2.4 percentage points.

Information Systems was the most important source of this cluster's growth, as well as to overall growth. Staffing Costs per FTE and Non-Labor Costs per FTE were key drivers of the increase in IS costs. All Information Systems sub-functions increased, led by Applications Acquisition and Development.

While Information Systems was the most important source of cost growth for the cluster, Customer Services experienced the fastest growth. It was also among the greatest contributors to overall cost growth. Again, Compensation and Non-Labor Costs were responsible for this function's increase. All Customer Services sub-functions (Member Services, Printed Materials and Other and Grievances and Appeals) increased.

Claims Adjudication posted an increase on higher non-labor costs and compensation. Its Payment Integrity sub-function increased year-over-year. Outsourcing is high in this subfunction but diminished in 2023.

Expenses for Enrollment / Membership / Billing were lower than the prior year, the fourth consecutive annual decline. Both sub-functions, Enrollment and Membership, and Billing, were lower with the decline in Enrollment and Membership more pronounced than in Billing. Lower Medicare Advantage staffing ratios were key for the decline in Enrollment costs, especially in Billing. Non-Labor costs and Staffing costs per FTE increased.

Sales and Marketing

The Sales and Marketing cluster's costs grew by 6.7% as Medicare Advantage staffing ratios increased.

External Broker Commissions was the second fastest growing function, but, due to its size, it was the most important source of growth for the cluster. Four of the plans reported growth in PMPM commissions costs for Medicare Advantage that were in double digits. While there was a shift towards Medicaid, broker commissions are not part of that product's costs.

The Sales function was the fastest growing function in this cluster, and the second most important contributor to the increase in this cluster. This function's growth was due to higher Medicare Advantage staffing ratio with outsourced FTEs were also higher. Staffing costs per FTE declined as Non-Labor Costs were higher. The sub-functions of Account Services and Other Sales were up from the prior year.

Advertising and Promotion was the third fastest-growing function in this cluster. This function's increase was due to higher Compensation and Non-Labor Costs, as Staffing Ratios declined. Media and Advertising increased as Charitable Contributions declined.

Rating and Underwriting and Marketing functional areas each increased by low single digit rates. Both increased their Staffing Ratios.

Medical and Provider Management

The Medical and Provider Management cluster had a PMPM increase of 6.1%. While Provider Network Management was the faster growing functional area, the larger Medical Management function contributed more significantly to the cluster's increase. The cluster's Medicare Advantage Staffing Ratio and Non-Labor costs per FTE grew, year-over-year.

Medical Management was up on Medicare Advantage Staffing Ratios and Non-Labor Costs per FTEs. Sub-functions that posted year-over-year growth were led by Health and Wellness, while Quality Components, Nurse Information Line, Medical Informatics, Utilization Review, and Other Medical Management also grew.

Provider Network Management and Services grew on higher Staffing Costs and Non-Labor Costs on a Per FTE basis. Provider Relations Services was the fastest growing sub-function, while Other Provider Network Management was up slightly.

CORPORATE SERVICES

The Corporate Services cluster was slowest growing, at 3.5%. The cluster's Compensation, Non-Labor Costs, and Outsourcing were higher, but Staffing Ratios were lower.

The Corporate Services function was the most important source of growth in this cluster. All factors of Non-Labor, Compensation, Staffing, and Outsourcing were higher for this function, year-over-year. Sub-functions that grew from the prior year include Human Resources, Legal, Purchasing, and Risk Management. Growth in the Legal sub-function of Fraud, Waste and Abuse was especially strong.

Actuarial was the most rapidly growing function for this cluster, on increased Staffing Ratios, Non-Labor and Compensation, while Outsourcing declined. Corporate Executive and Governance and Association Dues and Licensing Filing Fees were up by mid-single digits.

Finance and Accounting was the only function in this cluster to experience a PMPM decline in expenses. While its Staffing Ratio declined, Compensation increased modestly. Outsourcing declined as Non-Labor costs per FTE increased sharply.

As-Reported Trends

When a plan reports costs in sequential years, its per -member changes reflect both real changes and the effect of product mix differences. As noted earlier, the continuously reporting plans shifted somewhat towards lower cost products so that as-reported costs grew at a slower rate than when product mix differences are eliminated, 5.2% versus 6.2%. This section will highlight the functions with especially notable trend differences between the as-reported and constant-mix trend calculations. Recall that the change in product mix was present, it was not overwhelming, so the individual function differences tended to be minor.

Account and Membership cluster posted the largest variance between as-reported and constant-mix growth. The as-reported increase was 6.4%, while the constant-mix increase was 5.1%. On an as-reported basis, the Customer Services and Claims growth rates were marginally higher, while the decline in Enrollment was slightly slower. Information Systems, however, grew slightly slower on an as-reported basis. As previously noted, Account and Membership includes Pharmacy and Behavioral Health administration; administrative expenses in Behavioral Health and Pharmacy each decreased at a slower rate on an as-reported basis compared to a constant mix basis.

Sales and Marketing as-reported PMPM costs grew by 5.6% and compares to the constant-mix increase of 6.7%. Rating and Underwriting flipped from a slight increase on a constant-mix basis to a slight decline on an as-reported basis. Meanwhile, the External Broker Commissions experienced the largest variance from as-reported to constant-mix from mid-to-high single digit to a low single digit rate. Measured by the dollar value, of the difference between the broker commissions on an as -reported basis and on a constant mix basis represented nearly all of the total.

Medical and Provider Management cluster grew at a faster rate on an as-reported basis, 7.0% versus the constant-mix increase of 6.1%. On an as-reported basis, Provider Network Management and Services experienced a slightly slower increase, while Medical Management's posted a slight acceleration.

The Corporate Services cluster increased at a slower rate on an as-reported basis at 3.3% and compares to a 3.5% increase on a constant-mix basis. Actuarial's increase in expenses were reduced on an as-reported basis and reflected the largest difference from functions in this cluster and the second largest percent difference over all functions. The decline in Finance and Accounting was amplified on an as-reported basis. The increase in Corporate Services function was marginally slower, while Corporate Executive was slightly faster on an as-reported basis. The increase in Association Dues and License Filing fees was faster by one percentage points on an as-reported basis.

Enterprise Cost Drivers

We think that it is helpful to understand enterprise expenses by their drivers. PMPM costs can be thought of as the product of the staffing ratio and total costs per FTE. Similarly, 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 continuously participating plans and includes staffing and costs of activities performed on an outsourced basis.

The median compensation per FTE was approximately $109,000, 3.4% higher than last year's median. Compensation in 11 of the 14 functions with staffing increased, led by Information Systems and Advertising and Promotion.

Medicare Advantage median staffing ratios were higher than last year. The median was 60 FTEs per 10,000 Medicare Advantage members, 3.4% higher than last year. Of the 14 functional areas with staff, half were greater than last year. (The Staffing Ratio reflects both internal and outsourced staffing. Outsourced staffing is inferred, often calculated from invoice amounts. When calculated by product, we assume that all products have the same mix of staffing and non-labor costs.) Corporate Executive and Governance and Actuarial posted the largest percent increases from the prior year.

Median Non-Labor Costs per FTE were higher than last year among continuous plans, about $94,000 per FTE, up 11.9% from last year. Twelve of the functional areas experienced an increase in Non-Labor Costs per FTE. Corporate Executive and Claims were functions that experienced the largest increases.

We draw a distinction between non-labor and outsourcing activities in that the latter engages a vendor to supply services that are core to health plan operations and are usually performed by health plans using their own staff. Paying an actuary to calculate claim reserves each month is an example of outsourcing while paying an actuary to support evaluation of feasibility of entering a new product is consulting, a form of non-labor.

Overall propensity to outsource was lower, to 12.3% of the total FTEs from 12.8% last year, and eight of the fourteen functional areas with staff decreased the percent of their staff that was outsourced. Marketing and Advertising and Promotion experienced the largest percentage point declines.

Costs of Medicare-focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expense clusters for all 11 participating Medicare-focused plans. In this section we will touch on comparisons with the results reported last year, notwithstanding comparability limitations. The prior year's values are shown in Appendix A.

The comparability limitations of this figure are that this universe of Medicare-focused plans differs from that of last year in composition of the universe, and also in the product mix of the continuing participating plans. The Medicare universe had three plans drop out, and an equal number of additions. For the new plans and the ones that participated last year, we can know neither their trends nor their changes in product mix.

The product mix for all eleven plans in 2023 differed from the prior year's plans. There was more focus on Medicare Advantage, but less on both Commercial Insured and ASO.

The median total PMPM administrative expenses are $52.53, 10.1% higher than last year, shown in Appendix A. In comparison, the constant-mix increase mentioned earlier was 6.2%. With a median of $21.52, Account and Membership was greater by 8.3% while the constant mix increase was 5.1%.

The Sales and Marketing cluster was higher by 6.5% to $13.80, while up by 6.7% on a constant mix basis. The Corporate Services cluster was $8.39 PMPM, higher 18.5% with an increase of 3.5% on a constant mix basis. Lastly, the Medical and Provider Management cluster was greater in 2023 by 9.5% to $9.79, while the constant mix increase was 6.1%.

The dispersion of expenses in 2023 was higher than in 2022. The Coefficient of Variation increased by 34 percentage points to 52% for total expenses. Corporate Services grew by 59 percentage points to 87%, while Medical and Provider Management increased 51% percentage points to 79%. Sales and Marketing widened by 17 percentage points to 38%, while the dispersion in Account and Membership increased by 14 percentage points to 34%.

Dispersion measured difference between 75th and 25th percentiles slightly decreased for 2023. In total, this metric of dispersion narrowed by $1.46. Corporate Services and Medical and Provider Management narrowed by $1.07 and $0.49, respectively. Conversely, Sales and Marketing widened by $0.22 and Account and Membership increased by only $0.01.

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

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$13.16	$13.80	$16.32	38%
Medical and Provider Management	8.25	9.79	10.84	79%
Account and Membership Administration	18.71	21.52	22.15	34%
Corporate Services	6.98	8.39	8.87	87%
Total Expenses	$48.90	$52.53	$54.62	52%

Costs of Medicare-focused Plans, PMPM by Product

The importance of considering each product's costs in assessing performance is shown in Figure 5. The products vary greatly in their per member costs and, for each plan, the mix of those products affects total costs for the organization. For this reason, when we report results to participants, we often reweight product mix to eliminate the effect of any differences between the participants and the universe as a whole.

An example of the effect of mix is found in Figure 3. When comparing identical plans' cost trends in 2023, when they are weighted to reflect the average mix in 2023, expense growth accelerated from 5.2% as reported by the plans, to 6.2%.

For the universe as a whole, Medicare products are relatively high cost at $127.70 and $229.50 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. Compared to 2022, the PMPM costs for Medicare Advantage and SNP were each higher. The high administrative costs for these products reflect the high health care needs of the population that they serve: medical management and claims being obvious examples. Medicare Advantage's average membership mix was 18%, while the average revenue share was 36%. Medicare SNP's average membership mix and revenue mix were 1% and 2%, respectively. Total Medicare revenues were 38% of the total for the universe.

The median PMPM administration for the Medicare Supplement product was $46.56 and was offered by eight of the plans. The average member mix was 2% and revenue mix was 1%. Medicare Supplement is included as a Comprehensive product in the *Sherlock Benchmarks*, though it pays only when Medicare does not. It is a lower than average cost product.

Medicaid products, serving primarily qualified low-income beneficiaries, are generally the lowest cost to administer Comprehensive products of this universe. Medicaid HMO had median PMPM cost of $29.18, while the median PMPM for CHIP was $39.15.

Medicaid HMO's average share of members is 27% and its revenue share is 19%. Medicaid CHIP's average member mix was less than 1% and revenue mix was less than one-half of 1%.

The mean mix of Commercial Insured products was 27% of the membership and 37% of revenues. Administrative expenses for these products are higher than the median comprehensive administrative costs. The single most important Commercial Insured product was HMO at $59.51 PMPM. Indemnity and PPO cost $61.05, while POS cost $43.80.

Commercial ASO products represented a mean of 25% of Comprehensive members and 3% of revenues. While Insured Commercial products are higher cost than all of the products offered by these plans, the ASO products are much lower cost. The reason for this is that the ability of a group to self-insured is correlated with group size, and it is less expensive per member for health plans to serve larger groups than for smaller groups. For instance, to be an ASO group means to possesses the statistical advantages of larger size: this also means that its Sales and Marketing costs are spread through greater numbers of members. The costs of Commercial ASO products are accordingly lower. These products have a median cost of $31.32, half of commercial insured products. Total Commercial costs was $44.70 PMPM.

Two of the continuously participating plans offered Medicaid Managed Long Term Services and Supports (MLTSS). These products are offered to Medicaid beneficiaries that require long-term care. The fact that only two of the plans offer it, plus the preference of some of the plans not to include it as Comprehensive is why we do not show it among products shown in Figure 5. The median administrative cost for Managed Long Term Services and Supports (MLTSS) was $274 PMPM. It is similar in some ways to Medicare SNP with PMPM costs of $230.

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

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	$104.64	$134.60	$148.30	28%
Advantage	$103.60	$127.70	$141.45	27%
SNP	$221.98	$229.50	$247.36	26%
Medicare Supplement	$36.36	$46.56	$53.42	28%
Medicaid Total	$25.92	$29.18	$33.91	22%
HMO	$25.60	$29.18	$33.71	23%
CHIP	$34.46	$39.15	$40.63	17%
Commercial Insured Total	$59.34	$60.56	$65.27	35%
HMO	$53.65	$59.51	$59.95	40%
POS	$43.65	$43.80	$57.52	28%
Indemnity & PPO	$58.98	$61.05	$65.37	11%
Commercial ASO	$28.66	$31.32	$33.81	25%
Commercial Total	$43.57	$44.70	$50.24	50%
Comprehensive Total	$48.90	$52.53	$54.62	52%

Costs of Medicare-focused Plans, Percent of Premiums by Product

When analyzing administrative expenses by percent of premiums, most of the differences in the products visible in PMPM comparisons diminished. As we mention in other *Navigators*, per member administrative costs in any product can be explained in part by the underlying needs of the population served and also by the costs to distribute the product. Expressing costs as a percent of premiums or equivalents reduces the effect of the differences in costs due to health care needs, while much of the distribution system cost differences remain.

Medicare SNP costs, which are nearly four times the PMPM of Commercial HMO Insured, is 11.9% of premiums, only about 28% higher on a percent of premium basis. Medicare SNP, at twice the PMPM of Medicare Advantage, is slightly lower on a percent of premium basis.

Medicare Advantage costs, while about twice as high as Commercial HMO Insured PMPM, is 12.0% of premiums, only 28% higher than Commercial HMO ratio of 9.3%. The POS and Indemnity & PPO products had ratios of 9.1% and 10.7%, respectively.

Medicaid HMO was below average in PMPM costs and was, at 7.7%, also below average in percent of premiums. Sales and Marketing expenses tend to be far lower for these products reflecting state policy.

The administrative expenses of Commercial ASO products are 7.0% of premium equivalents. It also operates at low costs PMPM. The lower Sales and Marketing for self-insured groups is key reason for this. Total Commercial was 8.5% of premium equivalents.

While Medicare Supplement is lower than average cost when measured PMPM, at 23.9%, its cost ratio was the highest among the comprehensive products. Medicaid CHIP also had lower PMPM cost than average but, at 14.4%, was higher than average. These examples reflect that the per member administrative costs reflect the underlying health care needs of the population served by each product. In the case of Medicare Supplement and CHIP health care needs are more modest leading to a higher relative percents than relative PMPMs. In the case of Medicare Supplement, this reflects that it is a secondary payor; in the case of CHIP, this reflects the tendency for health care costs for children to be modest.

Figure 6. Sherlock Benchmark Summary

Medicare Plans' Costs by Product, 2023 Results

Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	10.6%	11.4%	12.7%	20%
Advantage	10.7%	12.0%	12.5%	20%
SNP	10.4%	11.9%	17.9%	35%
Medicare Supplement	20.0%	23.9%	28.9%	31%
Medicaid Total	7.6%	7.8%	9.2%	19%
HMO	7.5%	7.7%	9.2%	20%
CHIP	13.0%	14.4%	17.9%	32%
Commercial Insured Total	9.4%	10.3%	11.2%	26%
HMO	9.2%	9.3%	12.5%	45%
POS	8.9%	9.1%	9.6%	21%
Indemnity & PPO	10.1%	10.7%	10.8%	11%
Commercial ASO	5.2%	7.0%	7.6%	25%
Commercial Total	8.2%	8.5%	9.4%	35%
Comprehensive Total	8.6%	9.1%	9.7%	24%

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

Figure 7 shows the ratios of administrative expenses to premiums or equivalents. Administrative expenses had a median of 9.1% of premiums, 0.1 percentage points higher than last year.

Sales and Marketing increased slightly to 2.5%, while Medical and Provider Management and Corporate Services cluster increased by 0.05 percentage points to 1.7% and 0.01 percentage points to 1.4%, respectively. Account and Membership Administration also increased slightly to 3.6%.

Dispersion, measured by the Coefficient of Variation, increased, while the differences between 25th and 75th percentiles narrowed in 2023 versus 2022.

Figure 7. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2023 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.3%	2.5%	2.8%	19%
Medical and Provider Management	1.4%	1.7%	1.9%	48%
Account and Membership Administration	3.4%	3.6%	3.8%	16%
Corporate Services	1.2%	1.4%	1.7%	51%
Total Expenses	8.6%	9.1%	9.7%	24%

Comparisons Across Universes

Health plans in other Sherlock Benchmark universes also offer Medicare products. In this section, we compare the results of the Medicare Advantage products offered by Blue Cross Blue Shield Plans and Independent/Provider-Sponsored plans to those of organizations focused on Medicare. Together, these three universes serve 2.5 million Medicare Advantage members, about 7% of all Medicare Advantage members, and 24% of all MA members not served by the largest five organizations. Not included in the comparisons are members served through SNP products.

Since the cost definitions and activities are the same, it is possible to directly compare ourthe Medicare Advantage universe with Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans. Sometimes focus leads to cost advantages, and we can observe this in this year's benchmark values. Shown in Figure 8, Medicare plans PMPM expenses were $11.06 lower than Blue Cross Blue Shield Plans. Measured as a percent of premiums, they were 2.6 percentage points less.

The advantage was ambiguous when compared to the Independent / Provider - Sponsored plans. The Medicare plans were higher by $0.06 on a PMPM basis, but lower on a percent of premium basis by 1.5 percentage points.

Most of the plans in our set of Medicare focused plans are drawn from IPS and BCBS universe but were selected based on their higher commitment to Medicare Advantage. The sets shown in Figure 8 are however mutually exclusive.

Figure 8. Sherlock Benchmark Summary

Medicare Advantage Product Characteristics by Universe, 2023 Results

	Medicare Plans	IPS Plans	BCBS Plans	Combined Plans
Total Costs				
Per Member Per Month				
25th Percentile	$103.60	$108.57	$114.73	$104.42
Median	127.70	127.64	138.76	128.67
75th Percentile	141.45	186.34	169.68	152.73
Coefficient of Variation	27%	41%	32%	33%
Percent of Premiums and Equivalents				
25th Percentile	10.7%	11.6%	10.8%	10.7%
Median	12.0%	13.5%	14.5%	12.4%
75th Percentile	12.5%	19.2%	17.4%	14.7%
Coefficient of Variation	20%	41%	34%	34%
Plans offering Medicare	11	6	7	24
Medicare Advantage Members (millions)	1.70	0.19	0.58	2.47
Comprehensive Total Members (millions)	12.38	5.23	31.83	49.44

How We Performed This Analysis

This analysis is based on the twenty-first annual edition of our performance benchmarks for Medicare-focused health plans. The *Sherlock Benchmarks* (*Sherlock Expense Evaluation Report* or *SEER*) represent the cumulative experience of more than 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 Medicare-focused plans possessing the ability to compile high-quality, segmented financial and operational data. This 21st analysis of Medicare plans is based on a peer group of 11 plans who collectively serve 12.4 million people in which a disproportionate amount of plan revenues came from Medicare products. Of the eleven plans, eight were repeat participants from a year ago.

The average plan participating in the Medicare *Sherlock Benchmarks* this year served 1.1 million people and the median membership was 654,000. The geographic reach extended from coast to coast.

Health plans included in the Medicare universe emphasized Medicare Advantage (including SNP), and collectively served 1.8 million members. It composed an average of 38% of revenues and 18% of membership for comprehensive products. The median Medicare revenue and membership proportion was 37% and 14%, respectively.

Medicaid products comprised an average of 19% of revenues and an average of 28% of membership, offered by 8 plans, or 2.6 million members.

An average of 37% of revenues and 52% of membership was Commercial, or 7.6 million. Approximately 4.3 million of the Commercial members were served under some form of self-insurance arrangement, comprising approximately 57% of the total Commercial members.

The *Sherlock Benchmarks* universe of Medicare plans is remarkable because of the high national concentration of Medicare members in relatively few health plans. According to Kaiser Family Foundation and CMS figures, the five largest health plans serving Medicare Advantage serve 69.2% of the total. Of the 10 million not served by those plans, the *Sherlock Benchmarks* for Medicare include the results of 16.3% of Medicare Advantage members. If the additional 772,000 members served through other *Sherlock Benchmarks* universes are included (they are actually referenced and detailed in an exhibit in the Medicare universe) approximately 24% of those members are included in the *Sherlock Benchmarks*.

Figure 9. Sherlock Benchmark Summary
Share of Medicare Advantage Members

	2023	2024
Eligibles[1]	65,202,430	66,624,189
Total MA Membership[1]	31,753,651	33,828,266
Share of Eligibles in MA	*48.7%*	*50.8%*
UnitedHealthcare[2]	8,942,883	9,398,295
Humana[2]	5,545,949	6,018,288
CVS Health[2]	3,322,716	4,080,860
Elevance Health[3]	2,053,000	2,017,000
Kaiser Permanente[1]	1,847,966	1,893,296
Total, Five Largest	21,712,514	23,407,739
Share of Five Largest	*68.4%*	*69.2%*
MA Membership other than Five Largest		10,420,527
Sherlock Benchmark Participant Membership		1,696,890
Share of Membership other than Five Largest		16.3%

[1] State County Penetration Files, March, CMS
[2] Medicare Advantage in 2024: Enrollment Update and Key Trends, Kaiser Family Foundation, August 8, 2024
[3] Elevance Health, 10-Q,1st Quarter 2024

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 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 variation in employer benefit designs and the propensity of the administration of these health benefits to be outsourced by plans accepting these management responsibilities, the Benchmark reports carve them out. Pages 22 - 24 in Tab 2 of Volume I of the 2024 *Sherlock Benchmarks* reconciles these two presentations.

- Medicare Part D is not discussed, but there were five plans that offered this product. In other universes, 71% of Blue Plans offered Medicare Part D. The median administrative cost for this product in the Medicare Advantage universe was $14.58 PMPM and the mean was $18.73.
- 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

Now in its 27th consecutive year, 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 52 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.

These *Plan Management Navigator* results are excerpted from the Medicare edition of the 2024 *Sherlock Benchmarks*. We reported on the Independent / Provider – Sponsored and Blue Cross Blue Shield universes earlier this summer and will be reporting on the results of the Medicaid universe in several weeks. 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.