Plan Management Navigator
Analytics for Health Plan Administration

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Core Expenses in Medicaid Plans Experience Fastest Growth Since 2012

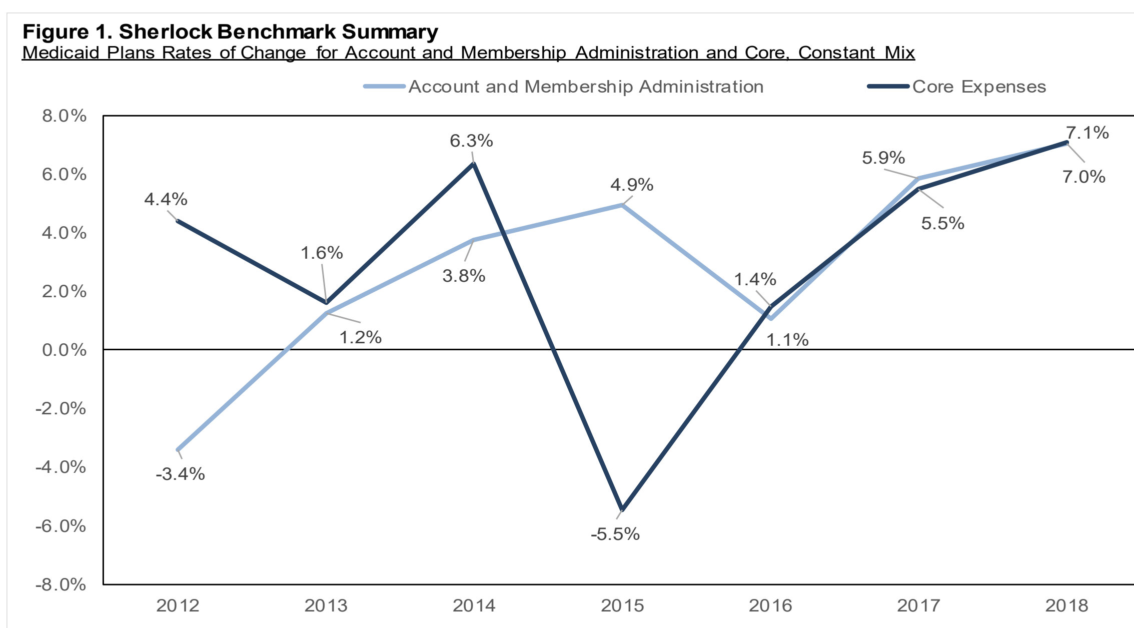
Core per member administrative expenses in Medicaid-focused plans grew by 7.1% in 2018. The largest cluster, Account and Membership Administration also posted its largest growth over the past seven years, up by 7.0%. Figure 1 displays both trends since 2012.

These trends are based on the results of seven continuous plans serving 5.9 million members, of which 3.3 million were Medicaid or CHIP. This report is based on the results of this and new participants, which together served 10.3 million members of which 6.5 million were Medicaid or CHIP.

Core expenses exclude the Sales and Marketing cluster. State laws governing Sales and Marketing for Medicaid vary so we separate activities like Sales, Marketing, Rating and Underwriting, Advertising and Promotion, and Broker Commissions from Core costs to preserve comparability.

Background on Medicaid

One of the central purposes of the Affordable Care Act was to reduce the proportion of Americans without health insurance. As shown in Figure 2, based on US Census Bureau analyses, *Health Insurance Coverage in the United States* (September 2019), the proportion of Americans uninsured dropped from 13.3% in 2013 to 8.5% in 2018, a 4.9 percentage point decline. Subject to qualifications noted on the chart, of the 14.3 million newly covered, the 2.9 million additions to Medicaid beneficiaries composed about 20.2% of the newly covered people. By contrast, the direct purchase of private plans sharply increased until 2015 and has receded to below 2013 levels.



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Trends Overall and in Expense Clusters

Figure 3 shows year-over-year trends on both an as-reported and constant-mix basis. On an *as-reported* basis, for the seven *continuously participating* plans, per member *core* costs grew by 7.1% equaling the prior year's increase.

The two columns that are labeled "as-reported" reflect per member trends in continuous plans. Implicit in this calculation is that a shift in favor of higher administrative cost products, such as Medicare Advantage and Medicare SNP, would lead to the appearance of accelerated growth, while a shift in favor of less expensive products would lead to deceleration. Because the growth on an as-reported basis matched the constant-mix basis at 7.1%, expensive and cheaper products offset one another.

Comprehensive Total Membership for the seven continuously participating plans increased by an average of 1.2%. High cost Medicare Advantage increased by 6.3% and Medicare SNP grew by 11.0%. Six plans served the Medicare Advantage population, while only three served SNP members. Commercial Total increased by an average of 2.6% with commercial insured up by an average of 8.2%, but ASO was down by 2.4%. Low cost Medicaid HMO declined by an average of 1.1% and CHIP grew by 5.9%.

Trends that exclude the impact of product mix changes are a more accurate representation of trends so the discussion that follows is largely based on this. Provider Network Management, Claim and Encounter Capture and Adjudication, Corporate Services Function were functions with notable increases. On average, Core Medicaid staffing ratios were slightly lower, while compensation per FTE, non-labor costs per FTE, and the propensity to outsource increased. (These metrics are calculated after converting outsourced staff, compensation and non-labor costs to internal equivalents. Staffing ratios are expressed holding product-mix constant.)

Figure 2. Sherlock Benchmark Summary
Health Insurance Coverage in the United States: Census Bureau
(000's)

	2013		2014		2015		2016		2017		2018		2018 Change	Percent Change	Cml. Change	Percent Change
Any Health Plan	271,606	86.7%	283,200	89.6%	289,903	90.9%	292,320	91.2%	296,890	92.1%	296,206	91.5%	-684	-0.2%	24,600	9.1%
Any Private Plan	201,038	64.1%	208,700	66.0%	214,238	67.2%	216,203	67.5%	218,209	67.7%	217,780	67.3%	-429	-0.2%	16,742	8.3%
Employment-based	174,418	55.7%	175,027	55.4%	177,540	55.7%	178,455	55.7%	178,751	55.4%	178,350	55.1%	-401	-0.2%	3,932	2.3%
Direct purchase	35,755	11.4%	46,165	14.6%	52,057	16.3%	51,961	16.2%	35,499	11.0%	34,846	10.8%	-653	-1.8%	-909	-2.5%
Any Government Plan	108,287	34.6%	115,470	36.5%	118,395	37.1%	119,361	37.3%	112,151	34.8%	111,330	34.4%	-821	-0.7%	3,043	2.8%
Medicare	49,020	15.6%	50,546	16.0%	51,875	16.3%	53,372	16.7%	56,170	17.4%	57,720	17.8%	1,550	2.8%	8,700	17.7%
Medicaid	54,919	17.5%	61,650	19.5%	62,384	19.6%	62,303	19.4%	59,814	18.5%	57,819	17.9%	-1,995	-3.3%	2,900	5.3%
Military health care	14,016	4.5%	14,143	4.5%	14,849	4.7%	14,638	4.6%	11,436	3.5%	11,754	3.6%	318	2.8%	-2,262	-16.1%
Uninsured	41,795	13.3%	32,968	10.4%	28,966	9.1%	28,052	8.8%	25,600	7.9%	27,462	8.5%	1,862	7.3%	-14,333	-34.3%
Total	313,401		316,168		318,869		320,372		322,490		323,668		1,178	0.4%	10,267	3.3%

Source: Health Insurance Coverage in the United States: 2018, https://census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

Note: According to the 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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Corporate Services

On a constant-mix basis, the Corporate Services cluster posted the most rapid PMPM increase, up by 10.1%, and second fastest over the past five years. The Corporate Services *functional* area (within the Corporate Services Cluster) represented the only source of growth in this cluster, up by mid-single digits but, because of its size, offset the declines in the other functions. All sub-functions within the Corporate Services function increased except for Audit, Purchasing, and Printing and Mailroom. This function's average inferred staffing ratio and non-labor costs per FTE increased. Staffing costs per FTE and percent of FTEs outsourced were lower.

The other sub-functions of Finance and Accounting, Actuarial, and Corporate Executive and Governance decreased by low-to-mid single digits. Association Dues and License/Filing Fees, a small function, dropped by low double digits.

Account and Membership Administration

The Account and Membership Administration cluster of expenses posted a PMPM increase of 7.0%, on a constant-mix basis. Claim and Encounter Capture and Adjudication increased at the fastest pace among functions in this cluster. This function's average staffing ratio, compensation, non-labor costs, and outsourcing were all higher than the previous year.

Customer Services followed in growth, at high single digits. The Customer Services functional area experienced higher average staffing ratios with compensation and non-labor costs per FTE also higher. The propensity to outsource also increased in Customer Services.

Enrollment / Membership / Billing posted a low single digit increase, while Information Systems was the only function decreasing, falling by less than 1%.

Figure 3. Sherlock Benchmark Summary

Medicaid Plans' Median Changes in Per Member Per Month Expenses

	2017 Results		2018 Results	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Medical and Provider Management	6.8%	5.7%	6.8%	6.9%
Account and Membership Administration	8.6%	5.9%	7.0%	7.0%
Corporate Services	11.8%	12.0%	10.9%	10.1%
Subtotal: Core Expenses	7.1%	5.5%	7.1%	7.1%
Sales and Marketing	5.0%	5.2%	5.2%	1.8%
Total Expenses	5.1%	4.8%	7.0%	6.2%

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Medical and Provider Management

Holding constant the product mix, PMPM expenses in the Medical and Provider Management cluster grew by 6.9%. Provider Network Management and Services grew at the fastest rate, but the larger Medical Management / Quality Assurance / Wellness function fell slightly by less than 1%.

All Provider Network Management and Services sub-functions posted cost increases from the prior year. The average staffing costs per FTE was higher than last year, while outsourcing and staffing ratios were also up. Non-Labor Costs per FTE, however, were lower.

Medical Management / Quality Assurance / Wellness sub-functions that declined from the prior year includes Precertification, Case Management, and Other Medical Management. Inferred staffing ratios and use of outsourcing declined, while compensation and non-labor costs were higher.

Sales and Marketing

While Sales and Marketing is not included in *Core* expenses, it is still central to Commercial and Medicare products offered by these Medicaid-focused plans. The Sales and Marketing cluster grew by 1.8%, holding the product-mix constant, the second fastest rate in the past five years.

The increase in Advertising and Promotion was the only driver of Sales and Marketing growth, up by low double-digits. All other Sales and Marketing functional areas declined by low single-digit rates. Advertising and Promotion's compensation, non-labor costs, and staffing ratios were higher. The propensity to outsource was also higher.

Differences from Constant-Mix and As-Reported

For the most part, there is a correspondence between the constant-mix and as-reported renderings. There are a few differences, however, between as-reported and constant-mix trends.

On an as-reported basis, within the Corporate Services cluster Association Dues and License / Filing Fees still posted the largest rate of change, but Actuarial was the fastest growing function. Finance and Accounting flipped from a single digit decrease to a less than 1% increase.

Claims continued to be the fastest growing and largest source of growth within Account and Membership Administration and in overall trends.

Under Medical and Provider Management, the Medical Management functional area flipped from a slight decline on a constant-mix basis to a slight increase.

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All functional areas within Sales and Marketing that posted declines on a constant-mix basis, flipped to single digit increases on an as-reported basis.

Summary of Cost Drivers

The above comments are based on seven continuously participating plans and includes the effect of staffing and costs performed on an outsourced basis. The average *core* Medicaid staffing was slightly lower by 0.1% for continuously participating plans, at 22 FTEs per 10,000 Medicaid members. (On average, *total* inferred Medicaid staffing ratio was higher by 1.5%.)

Of the 14 functional areas with staff, nine had staffing ratio increases and five had declines. The largest rate of growth is found in Sales, while Advertising and Promotion followed.

Average core compensation per FTE increased by 1.4% but varied by function. Finance and Accounting posted the largest increase, while the Claims area followed. Including the functions within the Sales and Marketing cluster, 10 of the 14 functions with staff experienced increases from a year ago. The average core compensation was $94,000 per FTE and compensation for all functions averaged $96,000.

Propensity to outsource, at 13%, was slightly higher than last year in total. 10 out of the 14 functional areas with staff increased outsourcing.

Claims posted the fastest PMPM growth among core functions followed by Provider Network Management and Services. The most important sources of cost growth, that is, rates of increase weighted by their dollar values, were Claims and the Corporate Services function.

Costs of Medicaid-focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 12 participating Medicaid-focused plans. In this section we'll touch on comparisons with the results reported last year, notwithstanding certain limitations. The prior year's values are shown in Appendix A.

Bear in mind that this universe of Medicaid-focused plans differs from that of last year in product mix and in populations. There were five plans that dropped out of the universe from a year ago with five additions. Therefore, it is not possible to perfectly compare the performance of plans participating in this and last year based on these charts. For the new plans, and the ones that only participated last year, we can know neither their trends, or their changes in product mix.

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Account and Membership Administration is the largest cluster of expenses and is comprised of activities central to health plan operations, increased by 5.8% to a median of $17.30 PMPM. This compares to the as-reported and constant-mix increase of 7.0%, seen in Figure 3. This cluster's size means that it has a substantial effect on overall trend. This cluster includes the Information Systems, Enrollment, Claims and Customer Services.

Medical and Provider Management costs per member per month was $9.07 PMPM, 27.2% higher than last year's value of $7.13. This cluster grew on an as-reported basis for the continuously participating plans of 6.8% and 6.9% on a constant-mix basis. This group of functions includes Provider Network Management and Services and Medical Management.

The Corporate Services cluster costs were higher PMPM than last year at $7.54 versus $6.75, an increase of 11.7%. The as-reported increase for plans participating in both years is 10.9% and on a constant-mix basis is 10.1%. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities like Facilities, HR and Legal.

Core administrative expenses were $33.48 PMPM, 16.2% higher than last year's median of $28.82, shown in Appendix A. For plans participating in both years, as-reported and constant-mix growth in Core expenses was 7.1%.

The Sales and Marketing cluster grew by 14.3% to a median of $8.79 PMPM (as-reported was 5.2% and constant-mix was 1.8%). Sales and Marketing functional areas includes Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

Total Expenses grew by 7.9% to $41.39 PMPM (as-reported was 7.0% and constant-mix was 6.2%).

Figure 4. Sherlock Benchmark Summary

Medicaid Plans' Costs by Functional Area Cluster, 2018 Results

Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$7.69	$9.07	$11.19	25%
Account and Membership Administration	14.73	17.30	19.23	29%
Corporate Services	6.54	7.54	9.33	26%
Subtotal: Core Expenses	$30.97	$33.48	$37.28	21%
Sales and Marketing	$7.42	$8.79	$11.31	42%
Total Expenses	$40.13	$41.39	$45.95	20%

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Dispersion in Core Expenses, measured by the Coefficient of Variation, tightened compared to last year. Dispersion also tightened for Account and Membership, while becoming more scattered for Medical and Provider Management and Corporate Services. Dispersion in Total Expenses spread slightly, while dispersion in the Sales and Marketing cluster tightened.

Costs of Medicaid-focused plans, PMPM by Product

The importance of considering each product's costs when evaluating health plan administration is shown in Figure 5. The products vary greatly in their per member costs. For this reason, when we report results to participants, we often reweight product mix to eliminate the effect of any differences between them. Note that Figure 5 displays total expenses by product, which *include* Sales and Marketing, except for the note at the bottom of the figure.

Medicare and Medicaid are government-sponsored products serving seniors and the low-income population, respectively. The median for Medicaid products fall between commercial insured and self-funded commercial ASO. Median costs for Medicaid HMO was $33.70 PMPM and Medicaid CHIP was $23.96 PMPM. For all twelve participating plans, Medicaid HMO's average mix of members was 53% and its average mix of revenue was 46%. Medicaid CHIP's average member mix and revenue mix was 1%.

Figure 5. Sherlock Benchmark Summary
Medicaid Plans' Costs by Product, 2018 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	$27.15	$32.95	$36.77	24%
HMO	$27.41	$33.70	$37.63	25%
CHIP	$20.97	$23.96	$25.38	23%
Medicare Total	$93.51	$104.85	$171.18	56%
Advantage	$84.54	$89.57	$100.81	29%
SNP	$171.85	$192.45	$271.62	31%
Medicare Supplement	$30.94	$34.24	$47.61	42%
Commercial Insured Total	$39.71	$46.27	$50.34	17%
HMO	$41.02	$44.26	$50.19	18%
POS	$44.38	$55.60	$66.88	30%
Indemnity & PPO	$44.60	$55.86	$81.26	42%
Commercial ASO	$20.10	$21.89	$25.96	17%
Comprehensive Total	$40.13	$41.39	$45.95	20%
Note: Core Expenses of Medicaid				
Medicaid Total	$25.85	$29.09	$32.53	22%
HMO	$26.11	$29.58	$32.53	23%
CHIP	$18.89	$21.62	$21.74	29%

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Medicare products are relatively high cost at $89.57 PMPM for Medicare Advantage and $192.45 PMPM for Medicare Special Needs Plans ("SNP"). Average membership mix for Medicare Advantage was 9% and Medicare SNP was 2%. Average revenue mix for Medicare Advantage was 17%, Medicare Advantage SNP was 7%.

Note that Medicare Supplement is a lower than the median for comprehensive total at $34.24 PMPM. We include this as a comprehensive product in the *Sherlock Benchmarks* though it pays only when Medicare does not. Half of the plans in the Medicaid universe offer the product and its mean product and revenue mix was 1%.

The mean mix of Commercial products was 34% of the membership: Commercial Insured was 22% and Commercial ASO was 13%. Commercial administrative expenses are both higher and lower than the median comprehensive total, which depends on their financing mechanism and indirectly bears on group size. An ASO group possesses the statistical advantages of larger size, which also means that their Sales and Marketing costs are spread through a greater number of members. The costs of Commercial *Insured* products are accordingly higher than the median for comprehensive products. The single most important Commercial Insured product is HMO at $44.26 PMPM. POS costs $55.60 PMPM, while Indemnity and PPO costs $55.86. Because of the modest per member Sales and Marketing expenses required for large groups ASO products have a median cost of $21.89 PMPM.

Note, Per Member Per Month *Core* Medicaid Total expenses were $29.09. Medicaid HMO and Medicaid CHIP were $29.58 and $21.62, respectively. Core expenses exclude Sales and Marketing costs.

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

Ranking the administrative expenses by the percent of premiums is generally similar to the ranking of the PMPM costs with the exception of the Medicare products. Often, administrative activities correspond with population health care needs.

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 9.7% is *higher* than average on a percent of premium basis.

Medicare SNP, the highest cost product on a PMPM basis is the second highest on a percent of premium basis at 13.4%. Meanwhile, Medicare Advantage expenses, while about two times greater than Commercial HMO Insured products on a PMPM basis, is only somewhat higher on a percent of premium basis at 9.2%.

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While Medicare Supplement is below comprehensive total when measured on a PMPM basis, at 14.2%, its cost ratio was the highest among the comprehensive products.

Administrative expenses on a percent of premium basis for Commercial HMO, POS and Indemnity, and POS were 8.7%, 11.1%, and 12.5%, respectively. These ratios, like the PMPMs, were higher than average.

Administrative expenses of Commercial ASO products are 6.1% 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.

Figure 6. Sherlock Benchmark Summary

Medicaid Plans' Costs by Product, 2018 Results

Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid Total	7.0%	7.4%	9.2%	40%
HMO	6.9%	7.3%	9.2%	40%
CHIP	8.6%	9.7%	10.8%	16%
Medicare Total	9.3%	10.4%	12.9%	31%
Advantage	8.5%	9.2%	10.6%	27%
SNP	10.5%	13.4%	16.3%	33%
Medicare Supplement	11.0%	14.2%	20.7%	39%
Commercial Insured Total	8.5%	9.1%	10.0%	16%
HMO	8.4%	8.7%	10.0%	19%
POS	8.6%	11.1%	13.6%	36%
Indemnity & PPO	9.7%	12.5%	13.3%	26%
Commercial ASO	5.3%	6.1%	6.6%	16%
Comprehensive Total	7.6%	8.3%	9.6%	32%
Note: Core Expenses of Medicaid				
Medicaid Total	6.3%	6.5%	8.6%	38%
HMO	6.3%	6.5%	8.6%	39%
CHIP	7.6%	8.7%	9.2%	21%

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

Figure 7 shows the ratios of administrative expenses to premiums or equivalents for expense clusters. Core administrative expenses matched last year's median of 6.6%. Corporate Services cluster also matched last year's median at 1.6%, while Medical and Provider Management was higher by 0.1 percentage points to 1.7%. Account and Membership Administration fell by 0.4 percentage points to 3.1%.

Total expenses, including Sales and Marketing, had a median percent of premium of 8.3%, 0.2 percentage points lower than the prior year. Sales and Marketing fell by 0.1 percentage point to a median of 1.9%.

Comparisons Across Universes

Health plans in other *Sherlock Benchmark* universes also offered Medicaid products. In this section, we compare the results of Medicaid HMO offered by Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans to those organizations focused on Medicaid. 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 53%, while the 25th and 75th percentiles were 31% and 77%, respectively.

Since the data definitions are the same, it is possible to directly compare Medicaid MCO products offered by our Medicaid universe with similar products offered by the Blue Cross Blue Shield and Independent / Provider – Sponsored universes. Collectively, these plans serve 7.6 million Medicaid HMO members or approximately 13% of all eligible beneficiaries.

Figure 7. Sherlock Benchmark Summary
Medicaid Plans' Costs by Functional Area Cluster, 2018 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.5%	1.7%	2.6%	39%
Account and Membership Administration	2.9%	3.1%	4.1%	38%
Corporate Services	1.4%	1.6%	1.9%	38%
Subtotal: Core Expenses	5.9%	6.6%	8.3%	34%
Sales and Marketing	1.3%	1.9%	2.1%	46%
Total Expenses	7.6%	8.3%	9.6%	32%

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Shown in Figure 8, compared with the Medicaid universe, Medicaid HMO Core expenses for Blue Cross Blue Shield Plans were $60.38 PMPM, or $30.80 greater than Medicaid-focused plans and at 13.1% of premiums, were 6.6 percentage points higher.

Independent / Provider – Sponsored plans were *lower* by $10.57 PMPM versus the Medicaid-focused plans, with a median of $19.01. On a percent of premiums basis, however, Independent / Provider – Sponsored plans were higher by 2.1 percentage points at a median of 8.6%.

Total expenses, including Sales and Marketing, produced similar results to differences in Core Expenses. Blue Cross Blue Shield Plans had median expenses of $69.35 PMPM, and was $35.65 higher than Medicaid plans. Blue Plans' percent of premiums at 15.0% was higher by 7.7 percentage points. Independent / Provider – Sponsored plans posted a median of $20.44 PMPM, lower by $13.27. On a percent of premium basis, IPS plans were 2.1 percentage points higher at 9.5%.

Figure 8. Sherlock Benchmark Summary

Medicaid HMO Product Characteristics by Universe, 2018 Results

	Medicaid	IPS	Blue	Combined
Core Costs				
Per Member Per Month				
25th Percentile	$26.11	$17.74	$51.83	$22.75
Median	29.58	19.01	60.38	28.08
75th Percentile	32.53	24.38	68.94	35.84
Coefficient of Variation	23%	43%	40%	45%
Percent of Premiums and Equivalents				
25th Percentile	6.3%	7.1%	11.0%	6.4%
Median	6.5%	8.6%	13.1%	8.3%
75th Percentile	8.6%	9.6%	15.3%	8.9%
Coefficient of Variation	39%	21%	47%	38%
Total Costs				
Per Member Per Month				
25th Percentile	$27.41	$18.79	$62.23	$23.97
Median	33.70	20.44	69.35	31.70
75th Percentile	37.63	26.49	76.48	38.62
Coefficient of Variation	25%	45%	29%	45%
Percent of Premiums and Equivalents				
25th Percentile	6.9%	7.5%	13.1%	7.0%
Median	7.3%	9.5%	15.0%	9.1%
75th Percentile	9.2%	10.5%	16.9%	10.3%
Coefficient of Variation	40%	21%	36%	38%
Plans Offering Medicaid	12	7	2	21
Medicaid HMO Members (millions)	6.42	0.44	0.79	7.64
Comprehensive Total Members (millions)	10.31	4.10	17.05	31.45

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How We Performed This Analysis

This analysis is based on the seventeenth 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 more than 858 health plan years.

Each peer group in the *Sherlock Benchmarks* is established to be relatively uniform. So, within that constraint, it is open to all Medicaid-focused plans possessing the ability to compile high-quality, segmented financial and operational data. This analysis of Medicaid plans is based on a peer group of twelve plans who collectively serve 10.3 million people in comprehensive products. Seven of this year's participants participated in the prior year.

The average plan participating in the Medicaid *Sherlock Benchmarks* this year served 859,000 people under comprehensive products and the median membership was 581,000. The geographic reach extended from coast to coast.

Medicaid HMO and CHIP combined were 6.5 million members and composed 63% of the combined comprehensive membership and 58% of revenues for comprehensive products. The average Medicaid revenue and membership proportion was 46% and 54%, respectively.

All twelve plans served at least one type of Medicare product, Medicare Advantage or Medicare SNP. The average Medicare revenue and membership proportion was 22% and 10%, respectively. There were about 837,000 Medicare members served by these plans.

Of all comprehensive members, 28%, or 2.9 million, were served under a commercial product. Approximately 1.1 million were served under some form of self-insurance arrangement, comprising 37% of total commercial members.

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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 set 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 them to the health benefits incurred by the self-insured group. In this way, premium equivalents sum to all of the expenses of health insurance, including profits earned by the health plan, analogous to actual 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 Core 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 *Sherlock Benchmark* Reports carve them out. Pages 24 - 26 in Tab 2 of Volume I of the 2019 *Sherlock Benchmarks* reconciles these two presentations.

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- 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. These taxes are primarily related to the Affordable Care Act. For commercial insured products in this universe, the median PMPM value of such taxes was $12.85 and the mean was $10.81, or almost 3% of premiums. Such costs are essentially zero for ASO products. By way of comparison, in 2010, the median Miscellaneous Business Tax for commercial insured products offered by Medicaid plans was $1.20 PMPM.

  The ACA fees include Comparative Effectiveness Research Fees (CERF), Transitional Reinsurance Fee, Risk Adjuster User Fee, Exchange User Fee and Annual Fee on Health Insurers. The Exchange User Fee only applies to Exchange members, was the highest ACA fee with a median of $26.69 PMPM. The CERF and Risk Adjuster Fee had median values of $0.15 PMPM and $0.20 PMPM, respectively. The median Annual Fee on Health Insurers was $4.04 PMPM.

  On a constant-mix basis, per member Miscellaneous Business Tax costs increased by 210.2% PMPM, compared with a decrease of 61.7% in 2016. The large increase was due to the expiration of the Moratorium on the Annual Health Insurer Fee at the end 2017.

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Note on the Sherlock Benchmarks

While health plan managers are responsible for the health care for many your members, they manage the administrative services necessary for all of them.

In the current environment, optimizing administrative expenses is a high priority for health plan managers. The surge in expenses of adapting to the Affordable Care Act and the bulge in Exchange and Medicaid members stemming from the ACA have passed. Plus, administrative expenses visibility has been heightened by the rhetoric of presidential candidates.

These results are excerpted from the Medicaid edition of the 2019 *Sherlock Benchmarks*. In addition to the Medicaid-focused plan universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Independent / Provider – Sponsored plans, Larger plans, and Medicare plans. We reported on the Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans over the summer and the Medicare plans last week.

Tables of Contents, report formats, citations, quality assurance and other information can be found on the following page.

https://sherlockco.com/sherlock-benchmarks/

In addition, the Sherlock Company website has an application that allows you to try out the Benchmarks for no charge.

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 at sherlock@sherlockco.com.

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Appendix A. Sherlock Benchmark Summary

Medicaid Plans' Costs by Functional Area Cluster, 2017 Results

Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	$6.27	$7.13	$8.00	22%
Account and Membership Administration	10.82	16.35	17.01	31%
Corporate Services	5.41	6.75	7.47	25%
Subtotal: Core Expenses	$27.46	$28.82	$31.22	21%
Sales and Marketing	$7.12	$7.69	$10.65	45%
Total Expenses	$32.57	$38.35	$39.71	19%

Appendix B. Sherlock Benchmark Summary

Medicaid Plans' Costs by Functional Area Cluster, 2017 Results

Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.4%	1.6%	1.7%	27%
Account and Membership Administration	2.5%	3.5%	4.1%	27%
Corporate Services	1.3%	1.5%	1.7%	21%
Subtotal: Core Expenses	5.9%	6.6%	7.4%	18%
Sales and Marketing	1.6%	2.0%	2.5%	42%
Total Expenses	7.6%	8.4%	9.2%	15%

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Appendix C. Sherlock Benchmark Summary

Functions Included in Each Administrative Expense Cluster

Core Functions:

Provider & Medical Management

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

Medical Management / Quality Assurance / Wellness
- (a) Precertification
- (b) Case Management
- (c) Disease Management
- (d) Nurse Information Line
- (e) Health and Wellness
- (f) Quality Components
- (g) Medical Informatics
- (h) Utilization Review
- (i) Other Medical Management

Account & Membership Administration

Enrollment / Membership / Billing
- (a) Enrollment and Membership
- (b) Billing

Customer Services
- (a) Member Services
- (b) Printed Materials and Other

Claim and Encounter Capture and Adjudication
- (a) Coordination of Benefits (COB) and Subrogation
- (e) Other Claim and Encounter Capture and Adjudication

Information Systems Expenses
- (a) Operations and Support Services
- (b) Applications Maintenance
  - (1) Benefit Configuration
  - (2) All Other Applications Maintenance
- (c) Applications Acquisition and Development
- (d) Security Administration and Enforcement

Corporate Services

Finance and Accounting
- (a) Credit Card Fees
- (b) All Other Finance and Accounting

Actuarial

Corporate Services Function
- (a) Human Resources
- (b) Legal
  - (1) Compliance
  - (2) Government Affairs
  - (3) Outside Litigation
  - (4) Fraud, Waste, and Abuse
  - (5) All Other Legal
- (c) Facilities
- (e) Audit
- (f) Purchasing
- (g) Imaging
- (h) Printing and Mailroom
- (i) Risk Management
- (j) Other Corporate Services Function

Corporate Executive and Governance

Association Dues and License/Filing Fees

Non-Core Functions:

Sales & Marketing

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

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

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

External Broker Commissions

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

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