Plan Management Navigator

Analytics for Health Plan Administration

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Administrative Costs for Medicare Plans Continue to Accelerate in 2018

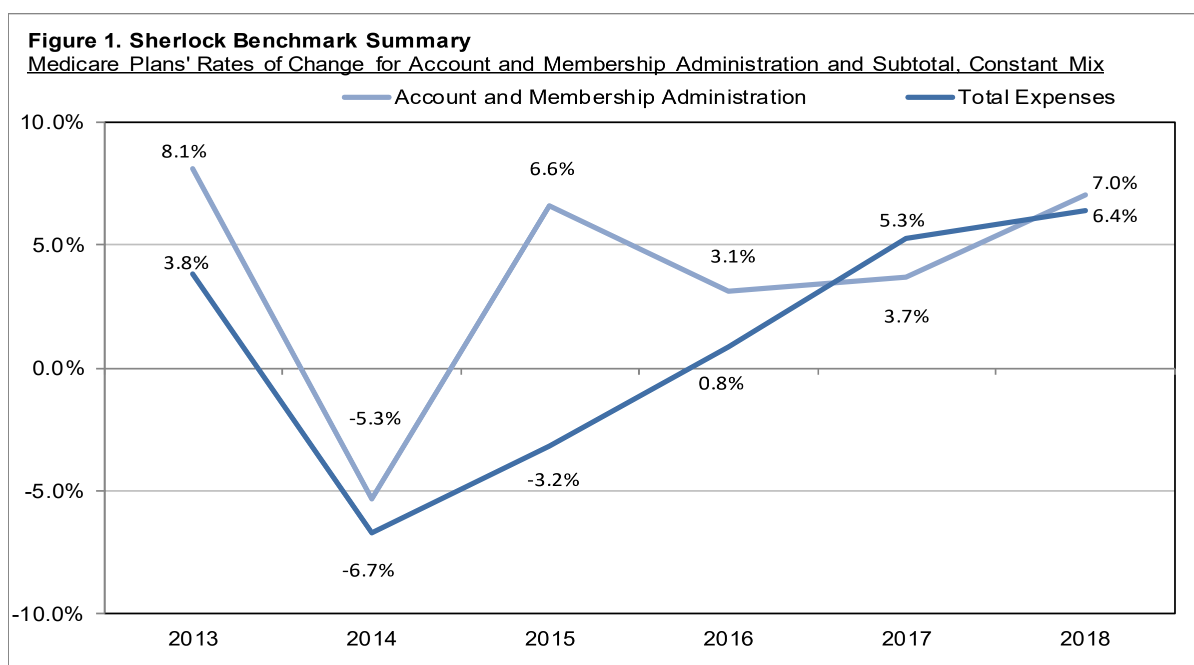
For 2018, Medicare-focused plans experienced administrative cost growth, excluding Miscellaneous Business Taxes, of 6.4%. Figure 1 shows Account and Membership Administration also trending higher in 2018 at 7.0%, up from last year's increase of 3.7%.

Eleven plans participated in this benchmarking study, collectively serving 4.6 million people. An average of 51% of the revenues of these companies were in Medicare Advantage or Medicare SNP ("Special Needs Plans") products. Seven plans were used for trend purposes.

Background on Medicare Advantage

Medicare Advantage ("MA") replaces regular Medicare for an increasing proportion of beneficiaries. MA supplies additional benefits above regular Medicare but, unlike Medicare Supplement policies, they are integrated with the standard benefits of traditional Medicare.

As of March 2019, according to the CMS State/County Penetration file, Medicare Advantage plans served 22.7 million people of the 64.5 million eligible. The proportion of eligible Medicare members selecting Medicare Advantage increased to 35.1% in March of 2019 from 34.5% in 2018 (please see Figure 2). Medicare Advantage membership increased by 7.4% from 21.1 million in March of 2018. By contrast, the number of people eligible for Medicare but electing the traditional Fee-For-Service ("FFS") program increased by 4.3% during that period.



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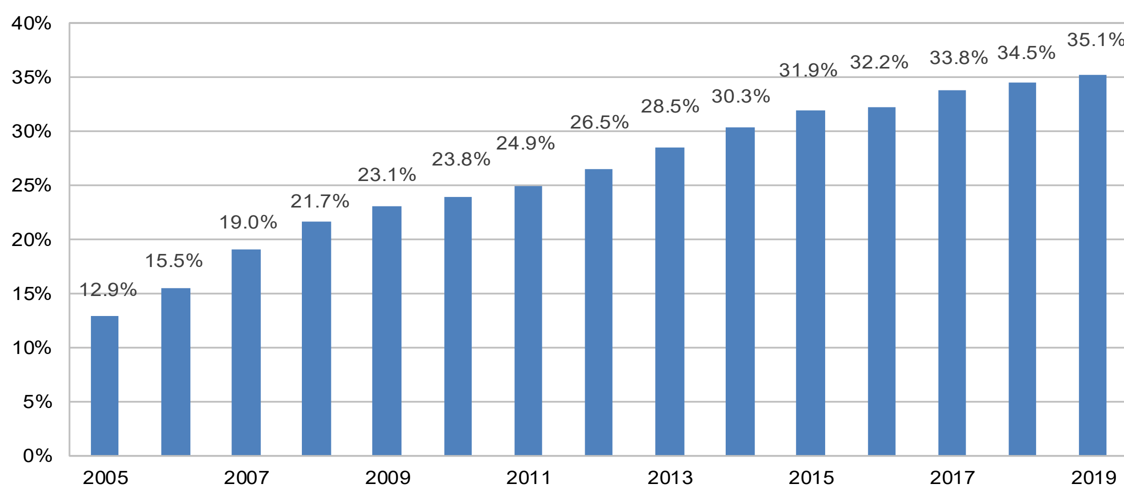
Taking the longer view, MA participation increased from 12.9% of total beneficiaries in 2005 to 35.1% in 2019. Since 2005, the net number of people joining MA plans generally exceeded those joining FFS Medicare. While there are 21.2 million more people eligible for Medicare, the number of people served by Medicare FFS is now 4.2 million higher than it was in 2005.

Medicare Advantage membership share increased notwithstanding that, according to *Kaiser Family Foundation*, the Affordable Care Act revised its methodology for paying plans to reduce the benchmarks under which health plans are paid. Moreover, according to a recent article published in *Health Affairs* by Garret Johnson et al., Medicare Advantage growth may be raising the bar for its performance by contributing in moderating FFS Medicare cost trends. The interaction between these two possible dynamics suggests that Medicare Advantage growth could, by stimulating lower costs for FFS, reduce the ability of MA plans to offer the additional benefits that attract seniors. In other words, this growth has overcome headwinds.

The *Kaiser Family Foundation* in 2013 noted the possibility of negative effects resulting from the Affordable Care Act but observed that they had not yet materialized. “When Congress debated the payment reductions in 2010, forecasters and analysts also projected that reductions would drive insurers to raise premiums, cut extra benefits and even pull out of the Medicare Advantage market as they did after the Balanced Budget Act of 1997. Thus far, however, the response by insurers to the ACA cuts has been more muted.” Notwithstanding, the CBO, as of June 2017, believes that membership in “Group Plan Enrollment” will be 31 million in 2027. Its classification “Group Plan Enrollment” includes Medicare Advantage, plus “cost contracts, and demonstration contracts covering Medicare Parts A and B.” In other words, 74% of the additional Medicare beneficiaries since 2005 are in Medicare Advantage, as opposed to 26% in traditional Fee-For-Service.



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Medicare Advantage provides payments for care beyond the scope of regular Medicare. So, the primary difference is that Medicare Advantage combines the traditional scope of benefits with supplemental benefits that beneficiaries tend to separately purchase. According to a *Kaiser Family Foundation* analysis of CMS's Medicare Current Beneficiary Survey ("MCBS") for 2011, only 19% of Traditional Medicare beneficiaries had no supplemental coverage. Including the effect of MA, only 14% lacked such coverage.

The increasing proportion of beneficiaries participating in MA may result from the needs of certain seniors coupled with the declining benefits offered by employers. According to a February 2015 AHIP analysis of the MCBS, MA members were more likely to have incomes less than $20,000 annually, and more likely to be from a minority population. Moreover, the proportion of large firms that offer retiree health benefits to active workers has declined from 40% in the late 1990s to 25% in 2014.

MA plans apparently enjoy a cost advantage in competing with a package comprised of Traditional Medicare and Medicare Supplement products. According to MedPAC's March 2019 Report to the Congress: Medicare Payment Policy, payments to MA plans exceeds FFS spending for each of the various types of MA plans. But their bids for Medicare covered services are 89% of what Medicare pays, and for MA HMOs, that ratio is 88%. (HMOs comprised 13.1 million or 58% of all Medicare Advantage beneficiaries.) MedPAC summarizes the sources of the respective cost advantages of the two alternatives as follows: "traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, *but it lacks incentives to coordinate care and is limited in its ability to modify care delivery.*" (Emphasis added.)

In addition to this apparent underlying cost advantage, MA plans enjoy subsidies not available through Medicare Supplement policies. In 2019, MA plans and HMO type plans were projected to be paid 107% of FFS spending for the traditional Medicare scope of benefits. (These both include quality bonuses which are projected to add on average 4% to the benchmarks in 2019.) This, along with the cost advantage noted in the previous paragraph, provides the means by which MA plans can fund the superior benefit package. Without these two advantages, presumably, some MA members would have to instead purchase supplemental policies or done without the benefits. So the higher payments have the effect of subsidizing supplemental benefits to the low income beneficiaries noted in the 2011 AHIP study.

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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 plans. On an *as-reported* basis, for the seven continuously participating plans, per member costs grew by 5.4% compared with 4.5% the prior year.

Cost trends on an as-reported basis reflected a shift in favor of higher cost products. This was manifest in higher cost growth on an constant- mix basis, 5.4% versus 6.4% when product mix is held constant. The effect of the mix change is to reduce as-reported cost trends by 0.9 percentage points.

High cost Medicare Advantage grew at a median rate of 4.1%, Medicare SNP grew at a median rate of 5.7%, while low cost Medicaid increased at a median rate of 1.1%. The Commercial Insured product membership fell by a median rate of 2.1%, while Commercial ASO grew at a median rate of 3.5%. Overall, commercial membership decreased by 1.9%. Comprehensive membership in continuous plans *fell* by a median rate of 1.5%.

Trends that eliminate the impact of product mix changes is a more accurate representation of trends so the discussion that follows is largely based on this. Advertising and Promotion, Provider Network Management, Medical Management, Information Systems, Actuarial, and Corporate Services Functions posted increases, while Enrollment and Association Dues fell for the year. Staffing Ratios and non-labor costs per FTE increased, while Outsourcing and Compensation were slightly lower.

Corporate Services

The Corporate Services cluster was the fastest growing cluster and posted its second fastest increase over the past five years at 10.1%. Actuarial was the fastest growing function on a higher staffing ratio, compensation, outsourcing and non-labor costs. Actuarial expense trends sometimes parallel that of Rating and Underwriting, which was also higher.

The most important increase for this cluster was in the Corporate Services *Function*. The sub-functions of Human Resources, Legal, Facilities, Imaging, Risk Management, and Other Corporate Services Function drove the increase in the Corporate Services functional area. Association Dues and License / Filing Fees was the only function in this cluster to decline.

Figure 3. Sherlock Benchmark Summary

Medicare Plans' Median Changes in Per Member Per Month Expenses

	2017 Data		2018 Data	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	4.1%	5.0%	6.2%	0.5%
Medical and Provider Management	4.7%	5.7%	8.9%	7.3%
Account & Membership Administration	6.3%	3.7%	7.0%	7.0%
Corporate Services	4.1%	5.1%	10.9%	10.1%
Total Expenses	4.5%	5.3%	5.4%	6.4%

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Medical and Provider Management

The Medical and Provider Management cluster was the second fastest growing cluster, at 7.3%. The Provider Network Management and Services functional area grew the fastest. The Provider Network functional area experienced higher staffing ratios and greater outsourcing, while compensation per FTE and non-labor costs per FTE were lower. The Provider Relations Services, Provider Contracting, and Other Provider sub-functions all posted increases.

The Medical Management functional area was the most important source of growth for this cluster and posted its fastest increase in the past five years. Both the staffing ratio and compensation increased, offset by lower outsourcing and non-labor costs per FTE. Nurse Information Line, Health and Wellness, Quality Components, and Other Medical Management posted gains in 2018. (The Other Medical Management sub-function is primarily focused on medical directors and medical policy.)

Account and Membership Administration

This cluster of expenses experienced a PMPM cost increase of 7.0%, the fastest rate in the past five years. Information Systems grew the fastest in this cluster and had the greatest effect on Account and Membership cluster growth because of its size. Claims and Customer Services also increased. Conversely, Enrollment fell by mid-single digits.

The staffing ratio for Information Systems was higher, as well as staffing costs per FTE, outsourcing, and non-labor costs per FTE.

The Applications Acquisition and Development sub-function posted the fastest growth for Information Systems. Both staffing ratio and compensation per FTE were higher, but outsourcing and non-labor expenses were lower.

Sales and Marketing

The Sales and Marketing cluster grew by 0.5%. All sub-functions experienced growth in this cluster, led by Advertising and Promotion. The Media and Advertising sub-function was the main driver. The propensity to outsource and compensation per FTE were higher for Advertising and Promotion, while the staffing ratio and non-labor costs were lower.

Marketing was the second fastest growing function in the Sales and Marketing cluster, followed closely by the Sales sub-function. Both sub-functions posted higher staffing ratios and staffing costs per FTE, while outsourcing was lower.

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Costs on an As-Reported Basis

The difference in the Sales and Marketing costs between as-reported and constant-mix is especially notable. On an as-reported basis costs increased by 6.2%, nearly 6 percentage points faster than the constant-mix growth. This reflects the higher marketing commitments of Medicare resulting from a shift in favor of this product. External Broker Commissions increased at a more rapid rate in favor for as-reported trends compared to constant-mix.

Medical and Provider Management increased by 8.9% on an as-reported basis, faster compared to the constant-mix basis by 1.6 percentage points. Medical Management grew at a faster pace on an as-reported basis, while Provider Network Management also grew slightly faster.

The median change in Account and Membership increased by 7.0% and equaled the constant-mix growth. Notably, Claims grew faster on an as-reported basis. Enrollment decreased both by an as-reported and constant-mix basis, but the drop was slower on an as-reported basis.

At 10.9%, the Corporate Services cluster grew faster on an as-reported basis, by 0.8 percentage points. Finance and Accounting was a driver in the difference, growing faster on an as-reported basis.

Summary of Cost Drivers

The above comments are based on continuously participating plans and includes the effect of staffing and costs performed on an outsourced basis. Overall, it appears median Medicare Advantage staffing ratios are higher than last year among continuing plans. The median was 54 FTEs per 10,000 Medicare Advantage members.

Of the 14 functional areas with staff, ten experienced median increases. The largest increases included Finance and Accounting, Provider Network Management and Services, and Sales.

The median compensation per FTE was about $93,000. The median compensation per FTE was flat and varied by function. Eleven functions increased slightly, but the higher compensation area of Corporate Executive and Governance declined by low double-digit rates.

Propensity to outsource was flat, overall. However, nine out of the 14 functional areas with staff increased outsourcing.

The Advertising and Promotion and Actuarial functions grew at the fastest rates, but Information Systems and Corporate Services Function had the largest effect in total cost growth. The Medicare Advantage staffing ratio, propensity to outsource, and compensation per FTE were higher for Information Systems and Corporate Services function. Non-Labor costs per FTE for Information Systems grew, while falling for Corporate Services function.

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Costs of Medicare-focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expenses for all 11 participating Medicare-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 Medicare-focused plans differs from that of last year in product mix and in populations. The Medicare universe had four plans drop out, but had four 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 participated last year, we can know neither their trends, or their changes in product mix.

The actual total PMPM administrative expenses are $55.45, 39.3% higher than last year's values, shown in Appendix A. (Note, the product mix for *all* eleven plans in 2018 had more Medicare Advantage and less Commercial ASO than *all* eleven plans in 2017.)

The Account and Membership Administration cluster was higher by 27.5%, while the Corporate Services Cluster was up by 27.2%. The Medical and Provider Management and Sales and Marketing clusters were higher by 24.8% and 10.8%, respectively.

Dispersion for Total expenses, measured by the Coefficient of Variation, was higher by single digits year-over-year. Dispersion increased for all clusters but were generally in the single digits besides Corporate Services cluster's low double-digit increase.

Account and Membership Administration was the single greatest cluster of expenses at a median value of $21.43 versus $16.81 from last year and composed almost 40% of the total. This cluster's size means that it has a substantial effect on overall comparisons. This cluster includes the central activities of Information Systems, Enrollment, Claims and Customer Services.

Figure 4. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2018 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$9.00	$13.93	$21.02	59%
Medical and Provider Management	7.48	9.16	11.73	35%
Account and Membership Administration	18.09	21.43	26.29	42%
Corporate Services	6.38	8.89	10.14	43%
Total Expenses	$43.19	$55.45	$71.40	42%

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The Corporate Services cluster costs were higher than last year at $8.89 PMPM versus $6.99 PMPM. Activities include Corporate Executive, Actuarial, Finance and Accounting, and a group of other activities like Facilities, HR and Legal; collectively called the Corporate Services *Function*.

Sales and Marketing, the second largest cluster, had median costs of $13.93 and compares to $12.57 from last year. This function includes Rating and Underwriting, Sales, Marketing, broker Commissions, and Advertising.

Medical and Provider Management costs per member per month were $9.16, while last year's value was $7.34. This group of functions includes Provider Network Management and Services and Medical Management.

Costs of Medicare-focused plans, PMPM by Product

The importance of considering each product's costs is shown in Figure 5. The products vary greatly in their per member costs and, for the products that are responsible for most of their business, the Coefficients of Variation were generally significantly less than the 42% for Comprehensive Total. 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.

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

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	$82.16	$101.49	$112.03	22%
Advantage	$74.19	$90.95	$112.03	23%
SNP	$126.45	$155.00	$199.51	41%
Medicare Supplement	$33.36	$42.53	$53.36	33%
Medicaid Total	$25.55	$31.70	$41.46	33%
HMO	$25.73	$31.70	$42.48	35%
CHIP	$23.96	$25.01	$25.12	5%
Commercial Insured Total	$43.05	$48.66	$60.52	30%
HMO	$44.61	$47.12	$63.18	30%
POS	$40.68	$46.24	$56.52	33%
Indemnity & PPO	$43.85	$49.28	$56.79	24%
Commercial ASO	$19.29	$21.89	$27.78	44%
Comprehensive Total	$43.19	$55.45	$71.40	42%

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Medicare and Medicaid are government-sponsored products serving seniors and the low-income population. Medicare products are relatively high cost at $90.95 and $155.00 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. Medicare Advantage average membership mix was 35%, while the average revenue share was 48%. Medicare SNP average membership mix and revenue mix were 1% and 3%, respectively. We suspect that the greater dispersion in SNP results stems from the newness of the product.

Among the comprehensive insured products, Medicaid products fall between commercial insured and commercial ASO. Medicaid HMO, has median PMPM cost of $31.70, while the median PMPM for CHIP is $25.01. Medicaid HMO's average share of members is 18% and its revenue share is 16%. Medicaid CHIP's average member mix and revenue mix were less than 1%.

The median for the Medicare Supplement product was $42.53 and is offered by four of the eleven plans. The average product mix and revenue mix are below 1%. Medicare Supplement is included as a Comprehensive product in the *Sherlock Benchmarks*, though it pays only when Medicare does not.

The mean mix of Commercial products was 46% of the membership. Administrative expenses for these costs are lower than the median comprehensive administrative costs. The magnitude of the difference depends on the financing mechanism, which indirectly depends on the group size. Thus, an ASO group possesses the statistical advantages of larger size, which also means that its Sales and Marketing costs are spread through greater numbers of members. The costs of Commercial *Insured* products are accordingly higher. The single most important Commercial Insured product is HMO at $47.12 PMPM. Indemnity and PPO costs $49.28 while POS costs $46.24.

ASO products represented a mean of 17% of comprehensive members. These products' costs are lower as noted above. Thus, these products have a median cost of $21.89.

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

Ranking the administrative expenses by the percent of premiums sometimes varied with the ranking of the PMPM costs. Ratios are calculated based on premium equivalents for ASO products.

While Medicare Supplement is lower than average cost when measured PMPM, at 18.5%, its cost ratio was the highest among the comprehensive products. By contrast, its PMPM costs were similar to commercial insured.

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Conversely, Medicare SNP, three times higher PMPM than Commercial HMO Insured, is 8.4%, less than HMO Insured and is lower than average for comprehensive products as a whole. Medicare Advantage costs, while about two times higher than Commercial HMO Insured PMPM, is 10.4% of premiums, slightly lower than Commercial HMO ratio of 10.8%. Slightly higher, compared with lower PMPMs.

The POS and Indemnity & PPO products had ratios of 10.6% and 11.9%, respectively. Medicaid CHIP had lower PMPM cost than average but at 10.6%, was higher than average.

Medicaid was below average in PMPM costs and was, at 7.2%, also below average in percent of premiums. Commercial ASO products are 6.0% of premium equivalents. It is also relatively low cost PMPM. The lower Sales and Marketing for self-insured groups is key reason for this difference.

Costs of Medicare-focused plans, Expense Clusters as a Percent of Premium

Figure 7 shows the ratios of administrative expenses to premiums or equivalents. Administrative expenses had a median of 9.6% of premiums, 1.1 percentage points higher than last year.

Figure 6. Sherlock Benchmark Summary

Medicare Plans' Costs by Product, 2018 Results

Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	8.3%	10.3%	11.8%	23%
Advantage	8.4%	10.4%	12.0%	23%
SNP	7.1%	8.4%	11.2%	50%
Medicare Supplement	12.3%	18.5%	25.0%	45%
Medicaid Total	7.0%	7.2%	9.5%	22%
HMO	6.9%	7.2%	9.5%	22%
CHIP	9.7%	10.6%	12.0%	21%
Commercial Insured Total	10.0%	11.1%	11.5%	27%
HMO	9.6%	10.8%	11.5%	29%
POS	9.8%	10.6%	12.4%	26%
Indemnity & PPO	9.5%	11.9%	12.7%	25%
Commercial ASO	5.1%	6.0%	7.5%	76%
Comprehensive Total	8.1%	9.6%	10.8%	22%

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Sales and Marketing was 2.2% of premiums, lower than last year by 0.5 percentage points. Account and Membership Administration increased by 0.5 percentage points to 3.9% of premium. Medical and Provider Management grew by 0.2 percentage points to 1.7% of premiums. Corporate Services increased by 0.1 percentage point to 1.6% of premiums.

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. We define "focused" to be those plans that have a disproportionate commitment to the Medicare product. The mean percent of revenues from Medicare products for the Medicare-focused plans was 51%, with 32% and 62% at the 25th and 75th percentile values, respectively.

Not included in the comparisons in Figure 8 are members served through SNP products, Medicare Advantage products served by Medicaid Plans, and Medicare Cost contracts. These products serve 33,000 members in the Medicare universe and 361,000 members in all universes.

Since the data definitions are the same, it is possible to directly compare our Medicare Advantage universe with Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans. Together, these three universes serve 2.1 million Medicare Advantage members, or about 9% of all Medicare Advantage members, as of March 2019.

Shown in Figure 8 on page 12, compared with the Medicare plans, Blue Cross Blue Shield Plans cost $21.14 more than the Medicare Plans and, measured as a percent of premiums, were 2.1 percentage points more. The IPS plans were lower on a PMPM basis by $0.48, but higher on a percent of premium basis by 1.5 percentage points. Both scale and focus may affect the relative performance of these health plan sets.

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

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	1.9%	2.2%	3.4%	40%
Medical and Provider Management	1.3%	1.7%	1.9%	24%
Account and Membership Administration	3.1%	3.9%	4.5%	23%
Corporate Services	1.2%	1.6%	1.6%	25%
Total Expenses	8.1%	9.6%	10.8%	22%

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How We Performed This Analysis

This analysis is based on the sixteenth 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 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 Medicare-focused plans possessing the ability to compile high-quality, segmented financial and operational data. This 16th analysis of Medicare plans is based on a peer group of eleven plans who collectively serve 4.6 million people. Of the eleven plans, seven were repeat participants from a year ago.

The average plan participating in the Medicare *Sherlock Benchmarks* this year served 415,000 people and the median membership was 364,000 million. The geographic reach extended from coast to coast.

Medicare Advantage (including SNP), were 789,000 members. It composed an average of 36% of the combined comprehensive membership and 51% of revenues for comprehensive products. The median Medicare revenue and membership proportion was 41% and 23%, respectively. Medicaid products comprised an average of 18% of membership, offered by 7 plans.

An average of 46% of membership was commercial, or 2.6 million. Approximately 1.0 million of the commercial members were served under some form of self-insurance arrangement, comprising approximately 39% of the total commercial members

Figure 8. Sherlock Benchmark Summary

Medicare Advantage Product Characteristics by Universe, 2018 Results

	Medicare Plans	IPS Plans	BCBS Plans	Combined Plans
Total Costs				
Per Member Per Month				
25th Percentile	$74.19	$84.54	$81.40	$77.51
Median	90.95	90.47	112.08	98.79
75th Percentile	112.03	168.69	124.79	122.09
Coefficient of Variation	23%	43%	41%	38%
Percent of Premiums and Equivalents				
25th Percentile	8.4%	9.2%	9.7%	8.9%
Median	10.4%	11.9%	12.5%	11.4%
75th Percentile	12.0%	16.7%	15.0%	13.7%
Coefficient of Variation	23%	49%	53%	47%
Plans offering Medicare	11	9	10	30
Medicare Advantage Members (millions)	0.76	0.31	1.04	2.11
Comprehensive Total Members (millions)	4.56	6.24	36.70	47.50

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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 Total Administrative costs reported here will differ from those reported in the Benchmarks. The values reflected in *Navigator* include administrative expenses associated with pharmacy and mental health while the *Sherlock Benchmarks* do not. Because variation in employer benefit designs and the propensity of the administration of these health services to be outsourced by plans accepting these management responsibilities, the Benchmark reports carve them out. Pages 22 - 24 in Tab 2 of Volume I of the 2019 *Sherlock Benchmarks* reconciles these two presentations.

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- Medicare Part D is not discussed here since no plans offered it. Interestingly, 71% of Blue Plans offered Medicare Part D, while no Independent / Provider – Sponsored plans offered this product.
- 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, the median PMPM value of such taxes is $10.87 and the mean is $12.86, or approximately 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 was $2.25 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 $21.76 PMPM. The Risk Adjuster Fee and the CERF had median values of $0.26 PMPM and $0.20 PMPM, respectively. The median Annual Fee on Health Insurers was $6.18 PMPM.

  On a constant-mix basis, per member Miscellaneous Business Tax costs increased by 171.0% PMPM, compared with a decrease of 61.4% in 2016. The large increase was due to the expiration of the Moratorium on the Annual Health Insurer Fee in 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 Medicare edition of the 2019 *Sherlock Benchmarks*. In addition to the Medicare-focused plan universe, we also survey and report on universes of Blue Cross Blue Shield Plans, Independent / Provider – Sponsored plans, Larger plans, and Medicaid plans. We reported on the Blue Cross Blue Shield Plans and Independent / Provider – Sponsored Plans a few weeks ago and we will be reporting on the results of the Medicaid plans in the next few weeks.

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
Medicare Plans' Costs by Functional Area Cluster, 2017 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$8.88	$12.57	$14.34	57%
Medical and Provider Management	6.18	7.34	8.20	29%
Account and Membership Administration	14.38	16.81	19.98	35%
Corporate Services	5.70	6.99	8.73	31%
Total Expenses	$37.56	$39.80	$52.80	34%

Appendix B. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2017 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.0%	2.7%	3.2%	37%
Medical and Provider Management	1.3%	1.5%	1.7%	27%
Account and Membership Administration	3.2%	3.4%	3.9%	28%
Corporate Services	1.3%	1.5%	1.6%	21%
Total Expenses	8.1%	8.5%	9.9%	21%

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Appendix C. Sherlock Benchmark Summary

Major Functions Included in Each Administrative Expense Cluster

Sales & Marketing

1. Rating and Underwriting
   - (b) Risk Adjustment
   - (c) Other Rating and Underwriting
2. Marketing
   - (a) Product Development and Market Research
   - (b) Member and Group Communication
   - (c) Other Marketing
3. Sales
   - (a) Account Services
   - (b) Internal Sales Commissions
   - (c) Other Sales
4. External Broker Commissions
5. Advertising and Promotion
   - (a) Media and Advertising
   - (b) Charitable Contributions

Provider & Medical Management

6. 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
7. 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

8. Enrollment / Membership / Billing
   - (a) Enrollment and Membership
   - (b) Billing
9. Customer Services
   - (a) Member Services
   - (b) Printed Materials and Other
10. Claim and Encounter Capture and Adjudication
   - (a) Coordination of Benefits (COB) and Subrogation
   - (d) Other Claim and Encounter Capture and Adjudication
11. Information Systems Expenses
   - (a) Operations and Support Services
   - (b) Applications Maintenance
     - (1) Benefit Configuration
     - (2) Other Applications Maintenance
   - (c) Applications Acquisition and Development
   - (d) Security Administration and Enforcement

Corporate Services

12. Finance and Accounting
   - (a) Credit Card Fees
   - (b) Other Finance and Accounting
13. Actuarial
14. 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
15. Corporate Executive & Governance
16. Association Dues and License/Filing Fees

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