Plan Management Navigator
Analytics for Health Plan Administration

Healthcare Analysts

Douglas B. Sherlock, CFA
sherlock@sherlockco.com

Christopher E. de Garay
cgaray@sherlockco.com

Erin Ottolini
erin.ottolini@sherlockco.com

John Park, CFA
jpark@sherlockco.com

Andrew L. Sherlock
asherlock@sherlockco.com

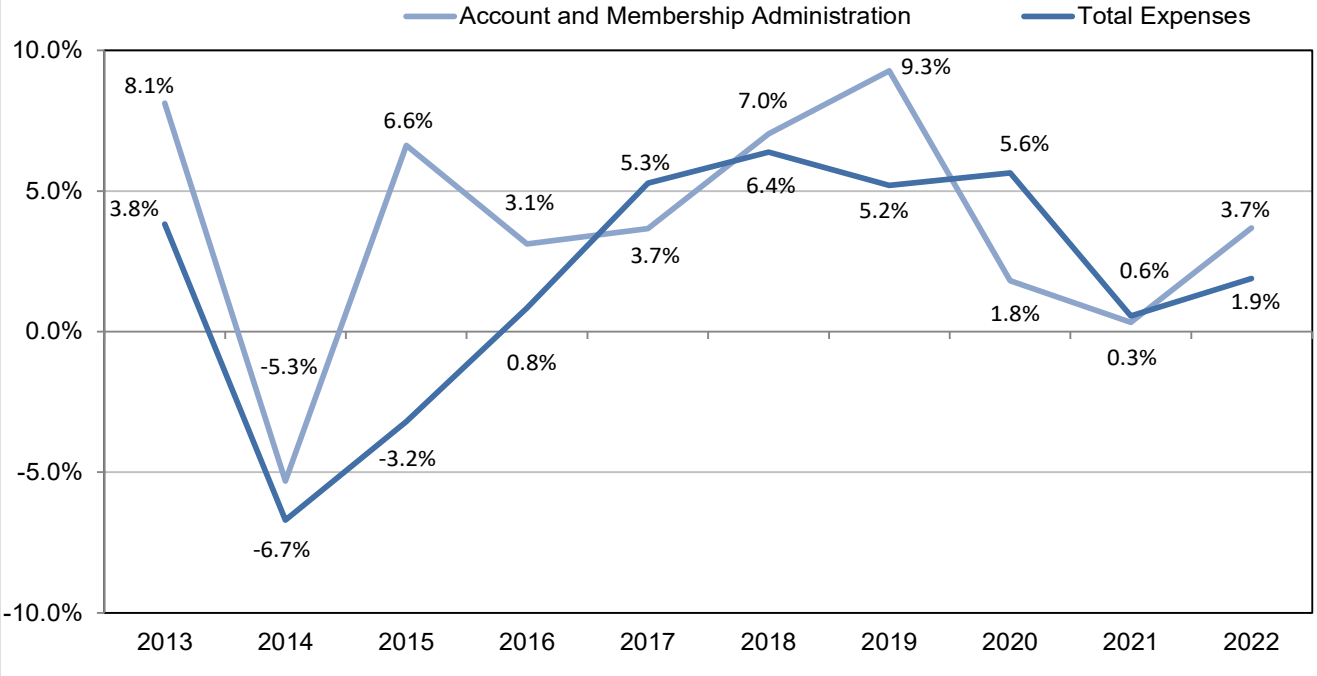
(215) 628-2289

Medicare Plans Accelerate Growth to Modest Rates in 2022

Medicare-Focused plans experienced a 1.9% increase in administrative expenses from 2021 to 2022 compared with a 0.6% increase in the prior year. The largest cluster of functions, Account and Membership Administration, increased by 3.7%, shown in Figure 1. This is a more modest growth than reported by the Blue Cross Blue Shield and Independent / Provider – Sponsored universes despite Sales and Marketing growth being faster. Eleven plans participated in the 2023 edition of the Medicare *Sherlock Benchmarks*, reflecting 2022 results.

The participating plans collectively served 1.7 million Medicare Advantage members. These single state or regional plans served 16.4% of Medicare Advantage not served by the five largest share plans. An average of 30% 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 several cases. Eight plans participated in both the 2022 and 2021 benchmarking cycles and 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.

As of March 2023, according to the CMS State/County Penetration file, Medicare Advantage plans served 31.8 million people, an increase of 7.7% from 29.5 million, year-over-year (please see Figure 2). There were 65.2 million eligible for Medicare in March 2023, including those not purchasing Medicare Part B, a prerequisite to participation in Medicare Advantage. The proportion of beneficiaries selecting Medicare Advantage increased to 48.7% in March 2023 up from 46.2%, in the prior year.

Membership in the traditional Fee-For-Service ("FFS") program *decreased* by 2.7% during that year, which was slower than the 3.4% decline in each of the prior two years. This was the seventh annual decline in FFS membership which began in 2017. Since 2016, membership in FFS Medicare has fallen by 5 million members, compared with 8.6 million increase in Medicare Advantage.

Taking the longer view, the total number of Medicare beneficiaries in 2023 increased by 21.9 million since 2005. Of those members, 26.2 million elected Medicare Advantage, while FFS membership declined by 4.3 million.

Medicare Advantage membership share grew despite some obstacles. First, 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. This reduction in payment made fewer resources available to supply the additional benefits by which MA plans are differentiated.

Moreover, according to an article published in *Health Affairs* in September 2016 by Garret Johnson et al., Medicare Advantage growth may be raising the bar for its performance by "moderating FFS Medicare costs" to which MA capitations are set. After all, health plan networks are generally not exclusive to a single plan, and if an MA health plan is able coach its provider network towards a more conservative style of care, Medicare's FFS program benefits.

The continued growth of these plans stems from the fact that MA plans enjoy a cost advantage in competing with a package comprised of Traditional Medicare and Medicare Supplement products. According to MedPAC's March 2023 Report to the Congress: Medicare Payment Policy, "For 2023, the average plan bid to provide Medicare Part A and Part B benefits was 17 percent less than FFS Medicare would be projected to spend for those enrollees under current payment policies, a record low."

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 make care delivery more efficient.*" (Emphasis added.) For instance, KFF states that "Nearly all Medicare Advantage enrollees are in plans that require prior authorization for some services."

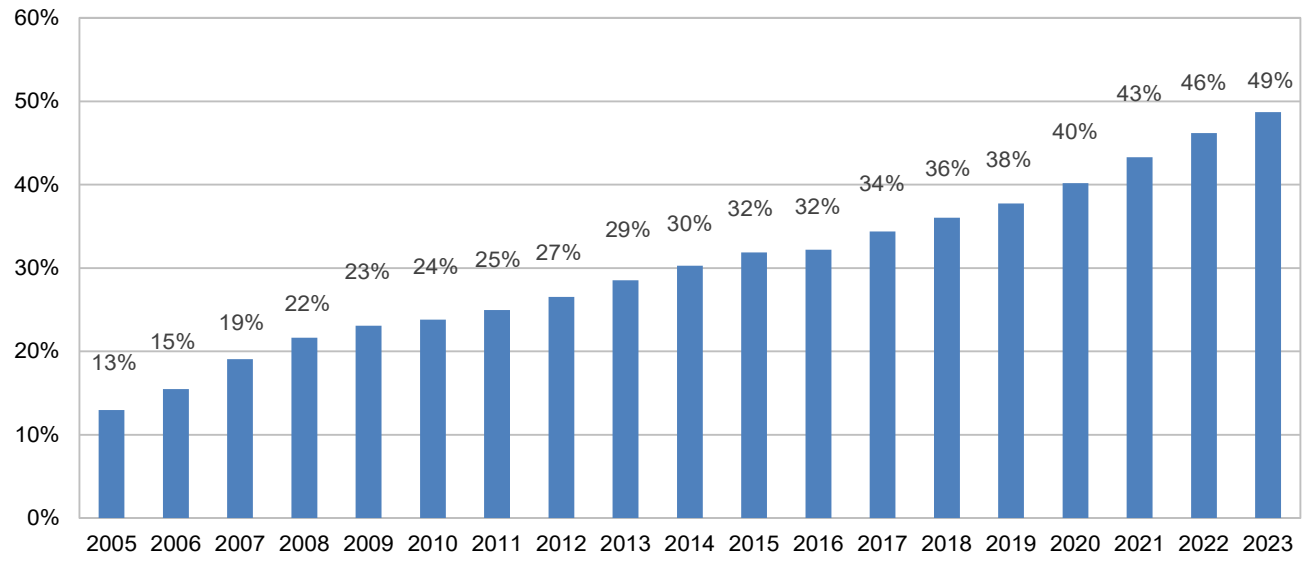
In addition, according to MedPAC, payments to MA plans exceeds FFS spending for each of the various types of MA plans.

> *In addition, MA benchmarks, which represent the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits, continue to be well above projected FFS spending levels. In 2023, MA benchmarks averaged an estimated 109 percent of projected FFS spending (including quality bonuses but not accounting for MA coding), 1 percentage point above the level in 2022.*

This, along with the cost advantage noted previously, provides the means by which MA plans can fund their superior benefit package.

Because of these factors, according to MedPAC, "the average MA plan enrollee has access to nearly $2,350 in extra benefits annually that FFS enrollees cannot access without purchasing additional health insurance coverage or paying for the services on an out-of-pocket basis." That $196 monthly rebate is primarily the reduction is cost sharing ($76) and Non-Medicare supplemental benefits ($50).

Figure 2. Sherlock Benchmark Summary
Medicare Advantage Share



Kaiser Family Foundation has a similar conclusion, noting that, "More than 7 in 10 Medicare Advantage enrollees (73%) are in plans that do not charge a premium (other than the Part B premium), with the remaining quarter paying an average premium of about $57 per month. More than 9 in 10 enrollees are in plans that also provide access to a variety of supplemental benefits, such as eye exams, dental and fitness benefits."

Notwithstanding of the headwinds noted earlier, the superior value proposition of MA contributes to its increasing appeal. According to the Kaiser Family Foundation, "The Congressional Budget Office (CBO) projects that the share of all Medicare beneficiaries enrolled in Medicare Advantage plans will rise to 62 percent by 2033."

Overall Trends and Product Mix

Figure 3 shows year-over-year trends in administrative expenses on both an as-reported and constant-mix plans. When the effect of mix changes is excluded, for the eight continuously participating plans, per member costs grew by 1.9%, higher than last year's 0.6% increase. On an *as-reported basis*, these continuously participating plans' per member costs increased by 0.5%, which was slightly slower than the 0.7% in the prior year. These changes, all other trends and PMPM costs exclude Miscellaneous Business Taxes.

Cost trends on an as-reported basis reflected a slight shift in favor of Medicaid, a lower cost product. This was manifest in lower cost growth on an as-reported basis, 0.5% versus 1.9% when product mix is held constant. The effect of the elimination of mix changes between the years is to increase constant-mix cost trends by 1.4 percentage points.

Continuously participating plans served 1.5 million Medicare Advantage and Medicare SNP members. In addition, they also served 415,000 Medicare Supplement members. The universe as a whole served over 1.7 million Medicare Advantage and Medicare SNP members plus 556,000 Medicare Supplement members.

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

	2021 Increase		2022 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	-0.5%	1.6%	4.5%	10.5%
Medical and Provider Management	1.2%	1.0%	2.1%	2.4%
Account & Membership Administration	0.8%	0.3%	3.8%	3.7%
Corporate Services	-5.8%	-3.7%	0.2%	1.6%
Total Expenses	0.7%	0.6%	0.5%	1.9%

Among continuous plans, Comprehensive membership increased at a median rate of 2.9%. The faster rate of Constant-mix growth suggests that membership must have shifted in favor of lower cost products. Thus Medicaid HMO, actually grow at a median rate of 16.6%. While Medicaid CHIP fell by 11.3%, the total growth in the Medicaid products was 15.4%. Medicare Advantage increased by 1.0%, while Medicare SNP fell by 0.4%. Medicare Supplement declined slightly, by 0.3%. Commercial Insured membership fell by 5.5% and Commercial ASO decreased by 0.3%, as Commercial Total was down by 3.5%.

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. That fact and that they are not included in Comprehensive products by the universe are why we limit our observation to the fact that PMPM costs were $267 PMPM. But the product is notable as similar in some ways to Medicare SNP with PMPM costs of $182.

Trends Holding Product Mix Constant

Trends that eliminate 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 Claims, Advertising and Promotion, Broker Commissions, Medical Management, and Corporate Executive and Governance.

Sales and Marketing

The Sales and Marketing cluster's costs grew by 10.5% on substantial growth in Medicare Advantage staffing ratios.

Advertising and Promotion was the fastest growing function in this cluster and among every cluster. It was the most important reason for the PMPM cost increase for this cluster. It also posted its second fastest growth over the past five years. Growth in this function was primarily driven by Staffing Ratios and Non-Labor Costs per FTE. Both sub-functions of Media and Advertising and Charitable Contributions posted year-over-year growth.

External Broker Commissions was the third fastest growing function in this cluster but, due to its size, was the second most important source of Sales and Marketing cluster growth. Rating and Underwriting, Marketing function, and Sales function all grew by mid-to-low single digits.

Account and Membership Administration

This cluster of expenses experienced a PMPM cost increase of 3.7%. For this *Navigator* analysis, Account and Membership Administration includes Pharmacy and Behavioral Health expenses. The trends in administrative activities of these two benefits reduced cost growth by a median rate of 0.9 percentage points.

Claims posted by far the highest median growth mainly on Staffing Ratios. Staffing ratios increased as did outsourcing. Both COB and Subrogation and Other Claims sub-functions posted increases over the prior year.

Customer Services experienced a distant second fastest growth for this cluster. Again, Staffing Ratios increased, with Outsourcing and Non-Labor Costs also higher. Member Services sub-function was an important source of growth, while Grievances and Appeals also contributed.

Information Systems also increased from the prior year. Staffing Costs, Non-Labor Costs, and Outsourcing all increased for this functional area. Most sub-functions increased with Applications Maintenance, especially Benefit Configuration, posting the most consistent growth from the prior year.

Enrollment / Membership / Billing was very slightly lower than the prior year. This function experienced lower Staffing Ratios, and Staffing Costs per FTE, and Outsourcing. The Billing sub-function declined faster than its Enrollment and Membership counterpart.

Medical and Provider Management

The Medical and Provider Management cluster also experienced a PMPM increase, by 2.4%. Medical Management was the sole reason for the increase in this cluster.

Medical Management function experienced an increase over the previous year. Median Non-Labor Costs per FTE were higher. Sub-functions that posted year-over-year growth were led by Health and Wellness, while Precertification, Case Management, Disease Management, and Other Medical Management also grew. Conversely, Nurse Information Line, Quality Components, Medical Informatics, and Utilization Review declined from the prior year.

Provider Network Management and Services did not generally increase. Staffing Ratio and Outsourcing declined while Staffing Costs per FTE were higher. Other Provider Network Management declined, while Provider Contracting grew.

Corporate Services

The Corporate Services cluster was slowest growing cluster, by 1.6%. The cluster's Compensation and Non-Labor Costs were higher, but Staffing Ratios and Outsourcing were lower.

Corporate Executive and Governance increased the fastest in this cluster. Staffing ratio and Staffing costs per FTE declined, as Outsourcing and Non-Labor Costs increased. Note this function includes Strategic Planning and Consulting Services that are enterprise-wide.

Actuarial followed with an increase in Staffing Costs per FTE.

The Corporate Services functional area also posted a gain over last year. Sub-functions that grew from the prior year include Human Resources, the Legal activity of Fraud, Waste and Abuse, Audit, Risk Management, and Other Corporate Services. Staffing ratio for the function was lower, Staffing Costs per FTE were higher, as were Non-Labor costs.

Conversely, Finance and Accounting and Association Dues and License / Filing Fees experienced declines in per member costs from the previous year.

As-Reported Trends

When a plan reports costs in sequential years, the per member changes reflect both real changes and the effect of product mix differences. As noted earlier, the continuously reporting plans shifted in favor of lower cost products so that as-reported costs grew at a slower rate than when product mix is eliminated, 0.5% versus 1.9%. This section will highlight the functions with especially notable trend differences between the as-reported and constant-mix trend calculations.

Sales and Marketing cluster experienced the largest variance in costs between as-reported and constant-mix. The as-reported rate growth was 4.5% compared to a growth of 10.5% on a constant-mix basis. The function with the largest difference from constant-mix to as-reported was External Broker Commissions, from a high single digit increase to a slight decline.

Account and Membership cluster's growth was faster on an as-reported basis, with growth of 3.8%, compared with a constant-mix increase of 3.7%. Enrollment / Membership / Billing posted a faster *decrease* on an as-reported basis compared to a constant-mix basis. The growth in IS was zero on an as-reported basis compared with growth on a constant mix basis. As previously noted, Account and Membership *includes* Pharmacy and Behavioral Health administration. Administrative expenses in Behavioral Health and Pharmacy each grew at a faster rate on an as-reported basis compared to a constant mix basis.

Medical and Provider Management cluster grew at a faster rate on a constant mix basis compared to an as-reported basis, 2.4% versus 2.1%, respectively. On an as-reported basis, Provider Network Management and Services experienced a slightly faster decline in per member expenses, while Medical Management's cost growth slowed slightly.

The Corporate Services cluster increased at a slower rate on an as-reported basis at 0.2% and compares to a constant mix increase of 1.6%. All functions within this cluster either slowed their rate of growth on an as reported basis or accelerated their rate of decline. The increase in both the Actuarial and Corporate Executive and Governance functions experienced the largest decline in growth rates from a constant mix basis to an as-reported basis.

Cost Drivers

We think that it is helpful to understand 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.

The median compensation per FTE was approximately $105,000, higher than last year's median. Compensation in 10 of the 14 functions with staffing increased led by Corporate Services function and Finance and Accounting.

Medicare Advantage median staffing ratios were lower than last year. The median was 58 FTEs per 10,000 Medicare Advantage members. Of the 14 functional areas with staff, nine posted declines. (To be clear, this reflects both internal and outsourced staffing. Outsourced staffing is inferred, often calculated from invoice amounts by assuming that all products have the same mix of staffing and non-labor costs.) The largest percent declines in median values were in Corporate Executive and Governance and Enrollment.

Median Non-Labor Costs per FTE were higher than last year among continuous plans, about $91,000 per FTE. Six of the functional areas experienced an increase in Non-Labor Costs per FTE. IS and Medical Management were functions that posted the largest increases.

Overall propensity to outsource was higher, to 13% of the total FTEs, and eight of the fourteen functional areas with staff increased the percent of their staff that was outsourced. Claims and IS posted the sharpest increases.

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 two plans drop out, but also had three additions. Therefore, based on these charts, it is not possible to accurately compare the performance of plans participating this and last year. For the new plans and the ones that participated last year, we can know neither their trends, or their changes in product mix. The product mix for all eleven plans in 2022 differed from the prior year's ten plans. There was a larger proportion of Commercial ASO, but lower focus in Commercial Insured, Medicare, and Medicaid.

The median total PMPM administrative expenses are $47.73, 2.2% higher than last year's values, shown in Appendix A. This is not deeply dissimilar to the 1.9% constant mix increase that we reported earlier. Account and Membership grew by 2.6% as the constant mix increase was 3.7%.

The Sales and Marketing cluster was higher by 6.3%, also the fastest growing cluster on a constant mix basis. Conversely, Corporate Services cluster and Medical and Provider Management cluster decreased by 3.1% and 1.4%, respectively. These latter two clusters were the slowest growing on a constant mix basis.

The dispersion of expenses in 2022 was marginally higher than in 2021. The Coefficient of Variation increased by 1.4 percentage points to 18% for total expenses. Sales and Marketing cluster dispersion fell by 1.7 percentage points to 21%, while Account and Membership dispersion tightened by 1.5 percentage points to 20%. Medical and Provider Management dispersion increased by 4.0 percentage points to 28% and Corporate Services widened by 0.3 percentage points to 28%.

Dispersion, measured difference between 75th and 25th percentiles, slightly decreased for 2022. In total, this metric of dispersion narrowed by $0.26 entirely due to a decline in Sales and Marketing of $1.50. Account and Membership was flat, while the differences in percentiles for Medical and Provider Management and Corporate Services increased.

Sales and Marketing, the second largest cluster, had median costs of $12.96 and is $0.77 higher than $12.19 last year. This function includes Rating and Underwriting, Sales, Marketing, broker Commissions and Advertising.

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

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$12.07	$12.96	$15.01	21%
Medical and Provider Management	7.17	8.93	10.25	28%
Account and Membership Administration	17.83	19.87	21.28	20%
Corporate Services	5.80	7.08	8.75	28%
Total Expenses	$46.22	$47.73	$53.40	18%

Account and Membership Administration is the largest cluster of expenses at a median value of $19.87, higher by $0.51 than last year's median of $19.36. This cluster composed 42% of total expenses. 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.

The Corporate Services cluster costs was lower at $7.08 PMPM versus $7.31 PMPM last year. 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.

Medical and Provider Management costs per member per month were $8.93, while last year's value was $9.06, a decline of $0.13 PMPM. 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 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.

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

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	$101.55	$126.33	$137.98	30%
Advantage	$101.51	$115.84	$136.43	30%
SNP	$141.91	$182.10	$215.44	29%
Medicare Supplement	$32.01	$44.36	$49.10	26%
Medicaid Total	$26.08	$28.49	$35.97	19%
HMO	$26.08	$28.49	$35.95	19%
CHIP	$24.61	$28.48	$31.79	23%
Commercial Insured Total	$49.49	$57.17	$62.37	16%
HMO	$49.38	$55.90	$62.33	17%
POS	$42.50	$48.02	$58.07	26%
Indemnity & PPO	$55.67	$60.26	$63.10	23%
Commercial ASO	$27.67	$30.03	$33.19	20%
Commercial Total	$40.23	$41.86	$47.48	13%
Comprehensive Total	$46.22	$47.73	$53.40	18%

An example of the effect of mix is found in Figure 3. When comparing identical plans' cost trends in 2022, when they are weighted to reflect the average mix in 2022, expense growth accelerated from 0.5% to 1.9%.

For the universe as a whole, Medicare products are relatively high cost at $115.84 and $182.10 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. Compared to 2021, the PMPM costs for Medicare Advantage was higher, while Medicare SNP was lower. The high administrative costs for this product reflects the high health care needs of the population that it serves: medical management and claims being obvious examples.

Medicare Advantage's average membership mix was 12%, while the average revenue share was 28%. Medicare SNP's average membership mix and revenue mix were 1% and 2%, respectively. All Medicare comprehensive revenues were 30% of the total.

Medicaid products, serving low income people, fall below commercial insured and commercial ASO among the costs of various comprehensive products. Medicaid HMO, has median PMPM cost of $28.49, while the median PMPM for CHIP is $28.48. Medicaid HMO's average share of members is 26% and its revenue share is 21%. Medicaid CHIP's average member mix was less than 1% and revenue mix was less than one-half of 1%.

The median PMPM administration for the Medicare Supplement product was $44.36 and is offered by seven 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.

The mean mix of Commercial Insured products was 28% of the membership and 42% of revenues. Administrative expenses for these products are higher than the median comprehensive administrative costs. The single most important Commercial Insured product is HMO at $55.90 PMPM. Indemnity and PPO costs $60.26 while POS costs $48.02.

Commercial ASO products represented a mean of 30% of comprehensive members and 3% of revenues. While Insured Commercial products are higher cost than average, the ASO products are much lower cost. This financing mechanism segmentation indirectly depends on the group size. 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 ASO products are accordingly lower. These products have a median cost of $30.03. Total Commercial was $41.86 PMPM.

While not included in Comprehensive products and not shown in Figure 5, the median administrative cost for Managed Long Term Services and Supports (MLTSS), a product that is somewhat similar to a SNP product, is $267 PMPM. Only two of the plans reported this.

In addition, some of the plans provided a segmentation of their Medicare Advantage into HMO and PPO/POS. They further segmented their costs into individual and group. Based on these plans, we offer the following anecdotal observations.

- The Sales and Marketing cluster costs are slightly higher for HMO versus PPO/POS; individual runs slightly higher in both products.
- Rating and Underwriting costs are lower for individual products of both HMO and PPO/POS because of the greater risk adjustment expenses for groups.
- Sales and broker Commissions are higher for HMO versus PPO/POS.
- Sales and broker Commissions are higher for individual versus group in both products.
- Medical and Provider Management are higher for PPO/POS than for HMO. While Provider is less for PPO/POS, Medical Management is higher.
- Individual Medical and Provider Management is less than group for both HMO and PPO/POS. It is lower in both functions.
- Account and Membership Administration is lower for group than for individual in both products: Customer Services and Information Systems are the reason in both cases.
- PPO/POS has lower Enrollment and Customer Services, but generally higher Claim and Encounter Capture and Adjudication.

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.

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

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	10.0%	12.1%	12.9%	35%
Advantage	10.0%	12.0%	12.9%	35%
SNP	9.3%	10.9%	13.1%	24%
Medicare Supplement	17.8%	22.7%	26.0%	29%
Medicaid Total	7.1%	7.4%	7.8%	18%
HMO	7.0%	7.3%	7.8%	19%
CHIP	11.7%	12.9%	14.0%	14%
Commercial Insured Total	9.4%	9.9%	11.3%	17%
HMO	9.0%	9.3%	12.4%	24%
POS	7.7%	8.9%	9.7%	21%
Indemnity & PPO	10.1%	11.4%	11.6%	24%
Commercial ASO	5.5%	7.3%	7.5%	20%
Commercial Total	7.9%	8.7%	9.0%	15%
Comprehensive Total	8.3%	9.0%	10.0%	20%

Medicare SNP costs, over 3.3 times higher PMPM than Commercial HMO Insured, is 10.9% of premiums, only about 17% higher on a percent of premium basis. Medicare Advantage costs, while just over two times higher than Commercial HMO Insured PMPM, is 12.0% of premiums, 28% higher than Commercial HMO ratio of 9.3%. The POS and Indemnity & PPO products had ratios of 8.9% and 11.4%, respectively.

Medicaid HMO was below average in PMPM costs and was, at 7.3%, also below average in percent of premiums. Sales and Marketing expenses tend to be far lower for these products reflecting state policy decisions.

The administrative expenses of Commercial ASO products are 7.3% of premium equivalents. It also operates at low costs PMPM. The lower Sales and Marketing for self-insured groups is key reason for this difference. Total Commercial was 8.7% of premium equivalents.

While Medicare Supplement is lower than average cost when measured PMPM, at 22.7%, its cost ratio was the highest among the comprehensive products. Medicaid CHIP had lower PMPM cost than average but, at 12.9%, was higher than average.

Broadly speaking, the 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 diminished leading to a higher relative percents than 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.

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 9.0% of premiums, 0.3 percentage points higher than last year.

Sales and Marketing increased the most, by 0.4 percentage points to 2.5%, while Medical and Provider Management was unchanged at 1.6%. Conversely, Corporate Services cluster dropped by 0.03 percentage points to 1.4% and Account and Membership Administration declined slightly by 0.01 percentage points to 3.6%. Measured by the Coefficient of Variation and the differences between 25th and 75th percentiles dispersions widened in 2022 versus 2021.

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

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.1%	2.5%	2.9%	20%
Medical and Provider Management	1.4%	1.6%	1.7%	34%
Account and Membership Administration	3.4%	3.6%	4.0%	22%
Corporate Services	1.1%	1.4%	1.5%	29%
Total Expenses	8.3%	9.0%	10.0%	20%

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 13% of all Medicare Advantage members, and 25% 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 our 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 $43.66 lower than Blue Cross Blue Shield Plans. Measured as a percent of premiums, were 5.0 percentage points less.

The advantage were similar compared to the Independent / Provider - Sponsored plans. The IPS plans were higher by $44.89 on a PMPM basis, and higher on a percent of premium basis by 4.3 percentage points.

The plans in our set of Medicare focused plans are actually 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, 2022 Results

	Medicare Plans	IPS Plans	BCBS Plans	Combined Plans
Total Costs				
Per Member Per Month				
25th Percentile	$101.51	$106.22	$150.25	$109.83
Median	115.84	160.73	159.50	140.09
75th Percentile	136.43	185.00	170.39	166.00
Coefficient of Variation	30%	29%	24%	29%
Percent of Premiums and Equivalents				
25th Percentile	10.0%	11.9%	16.2%	11.6%
Median	12.0%	16.3%	16.9%	13.4%
75th Percentile	12.9%	17.0%	18.7%	17.0%
Coefficient of Variation	35%	28%	26%	32%
Plans offering Medicare	11	5	11	27
Medicare Advantage Members (millions)	1.65	0.14	0.72	2.51
Comprehensive Total Members (millions)	13.63	4.13	40.80	58.56

How We Performed This Analysis

This analysis is based on the twentieth 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 approximately 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 20th analysis of Medicare plans is based on a peer group of 11 plans who collectively serve 13.6 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 1.2 million people and the median membership was 826,000. The geographic reach extended from coast to coast.

Health plans included in the Medicare universe emphasized Medicare Advantage (including SNP), and collectively served 1.7 million members. It composed an average of 30% of revenues and 12% of membership and for comprehensive products. The median Medicare revenue and membership proportion was 27% and 12%, respectively.

Medicaid products comprised an average of 21% of revenues average of 27% of membership, offered by 7 plans.

An average of 43% of revenues and 58% of membership was commercial, or 8.9 million. Approximately 5.1 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 possess 68.4% of the total. Of the 10 million not served by those plans, the *Sherlock Benchmarks* for Medicare include the results of 16.4% of Medicare Advantage members. If the additional 862,000 members served through other *Sherlock Benchmarks* universes are included (they are actually referenced and detailed in an exhibit in the Medicare universe) approximately 25% of those members are included in the *Sherlock Benchmarks*.

Figure 9. Sherlock Benchmark Summary
Share of Medicare Advantage Members

	March	
	2022	2023
Eligibles[1]	63,852,613	65,202,430
Total MA Membership[1]	29,477,423	31,753,651
Share of Eligibles in MA	*46.2%*	*48.7%*
UnitedHealthcare[2]	7,903,784	8,942,883
Humana[2]	5,033,104	5,545,949
CVS Health[2]	3,105,056	3,322,716
Elevance Health[3]	1,921,000	2,053,000
Kaiser Permanente[1]	1,796,616	1,847,966
Total, Five Largest	19,759,560	21,712,514
Share of Five Largest	*67.0%*	*68.4%*
MA Membership other than Five Largest		10,041,137
Sherlock Benchmark Participant Membership		1,646,220
Share of Membership other than Five Largest		16.4%

[1] *State County Penetration Files, March, CMS*
[2] *Medicare Advantage in 2023: Enrollment Update and Key Trends, Kaiser Family Foundation, August 9, 2023.*
[3] *Elevance Health, 10-Q,1st Quarter 2023*

Reporting Conventions

We employ a number of conventions to make the metrics most beneficial for the audience of *Plan Management Navigator*.

- The trends reported in this analysis are median changes, and when we refer to PMPM or percent of premium ratios, these too are medians. This convention reduces the effect of outlying values on overall trends and values. Since each median value is calculated independently, the components cannot be summed.

- References to growth rates hold the universe constant in the comparison years unless otherwise noted. Rates of change identified as "as-reported" are of health plans participating during both comparison years. When we refer to "constant-mix" we are calculating rates of change for that same constant set of plans after reweighting each plan's values to eliminate the effect of product mix differences between the years.

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

- 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 2022 *Sherlock Benchmarks* reconciles these two presentations.

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

- Miscellaneous Business Taxes are a special case among administrative expenses since, short of recapitalization or elimination of commercial insured business, such expenses are impossible to manage. So, expense trends, along with the PMPM and percent of premium ratios, are generally calculated *before* the effect of Miscellaneous Business Taxes.

Note on the Sherlock Benchmarks

The *Sherlock Benchmarks* are the health plan industry's metrics informing the management of administrative activities. They are based on surveys of health plans who provide costs and their drivers on key administrative activities. The surveys are subject to validation procedures and collectively serve 63 million Americans.

The Benchmarks are reported in multiple universes of health plans: Medicare-focused, Medicaid-focused, Independent / Provider-Sponsored, Blue Cross Blue Shield, and Larger Plans.

The *Sherlock Benchmarks* are the "gold standard" of health plan administrative cost benchmarks. Health plans use them to determine whether their administrative costs are competitive, to prioritize for improvement among numerous specific activities and to identify cost drivers such as staffing ratios that, overall and within functions, can help implement those improvements.

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

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

In addition, the Sherlock Company website has an application that allows you to try out the Benchmarks free of charge.

https://sherlockco.com/test-drive/

If you are interested in licensing these materials or if we can answer any further questions about them or you have questions about this *Plan Management Navigator*, we hope you will not hesitate to contact us (sherlock@sherlockco.com)

You will be among good company.

Appendix A. Sherlock Benchmark Summary

Medicare Plans' Costs by Functional Area Cluster, 2021 Results

Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$9.37	$12.19	$13.80	23%
Medical and Provider Management	7.24	9.06	10.18	24%
Account and Membership Administration	16.92	19.36	20.36	21%
Corporate Services	5.90	7.31	8.56	28%
Total Expenses	$43.31	$46.69	$50.75	17%

Appendix B. Sherlock Benchmark Summary

Medicare Plans' Costs by Functional Area Cluster, 2021 Results

Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	1.9%	2.1%	2.5%	20%
Medical and Provider Management	1.4%	1.6%	1.9%	31%
Account and Membership Administration	3.3%	3.6%	4.1%	16%
Corporate Services	1.1%	1.4%	1.6%	20%
Total Expenses	8.5%	8.7%	9.5%	12%

Appendix C. Sherlock Benchmark Summary

Major Functions Included in Each Administrative Expense Cluster

Sales & Marketing

1. Rating and Underwriting
   - (b) Risk Adjustment
   - (c) All 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
   - (c) Grievances and Appeals
10. Claim and Encounter Capture and Adjudication
    - (a) Coordination of Benefits (COB) and Subrogation
    - (d) Payment Integrity
    - (e) Other Claim and Encounter Capture and Adjudication
11. 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

12. Finance and Accounting
    - (a) Credit Card Fees
    - (b) All 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 & 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 and Governance
16. Association Dues and License/Filing Fees