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Medicare Plans' Administrative Expense Growth Decelerated in 2024

Administrative costs for Medicare-Focused plans grew by 3.6% from 2023 to 2024, a deceleration from the 6.2% increase in the prior year. However, the largest cluster of functions, Account and Membership Administration, accelerated its growth to 6.8% from the 5.1% of the prior year, shown in Figure 1. Eleven plans participated in the 2025 edition of the Medicare *Sherlock Benchmarks*, reflecting 2024 results.

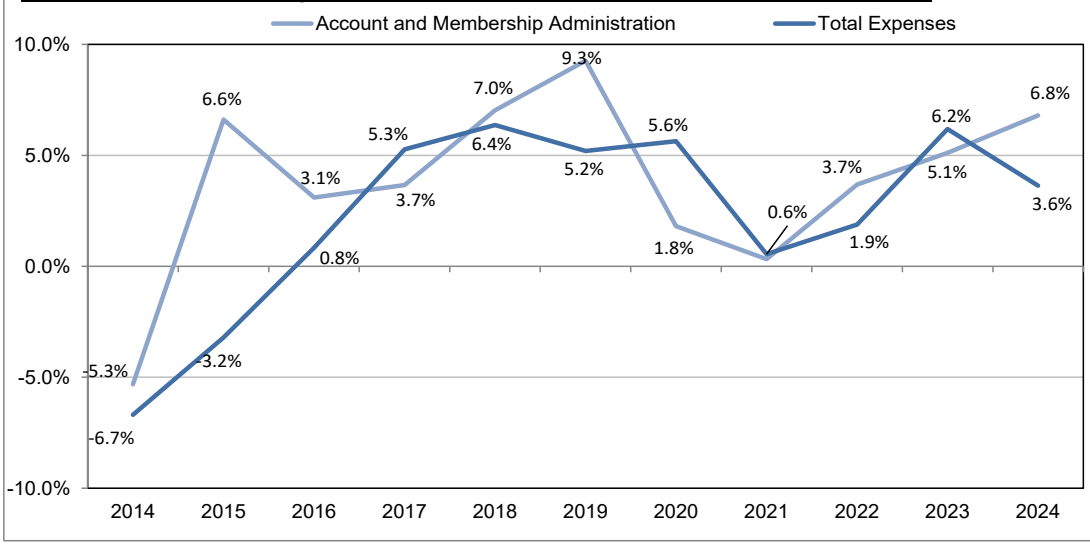
The participating plans collectively served 1.8 million Medicare Advantage members. These single state or regional plans served about 17% of Medicare Advantage not served by the five largest share plans. An average of 40% of revenues of these companies were in Medicare Advantage and Medicare SNP ("Special Needs Plans") products, exceeded 20% of revenues in all cases, and was the plurality product in four cases.

Nine plans participated in both the 2024 and 2025 benchmarking cycles and the results of these were used for calculating trends.

The nine continuously participating plans served 1.7 million Medicare Advantage and Medicare SNP members. In addition, they also served 382,000 Medicare Supplement members. Commercial comprised 7.3 million members, of which 4.3 million were ASO. Medicaid served 2.0 million people. Continuous plans served 11.3 million people in total.

In comparison, including two new plans, the universe as a whole served over 1.9 million Medicare Advantage and Medicare SNP members plus 395,000 Medicare Supplement members. Plans in the universe as a whole served 12.0 million people.

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



Background on Medicare Advantage

ATTRACTIVENESS OF THE PRODUCT

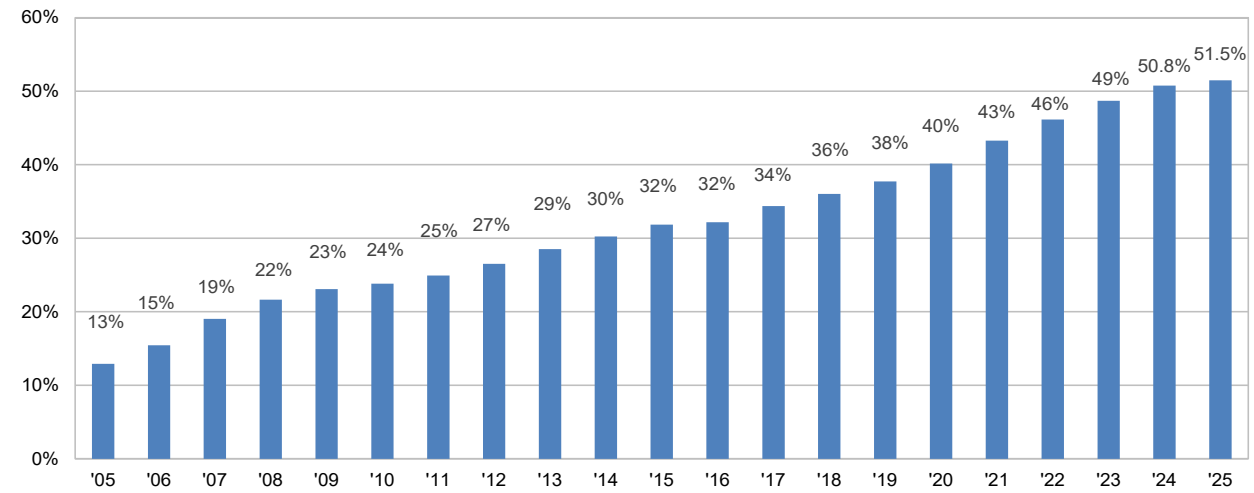
Medicare Advantage ("MA") is chosen by an increasing proportion of beneficiaries to replace regular FFS Medicare. MA supplies additional benefits above regular Medicare but, unlike Medicare Supplement policies, those benefits are integrated with the standard benefits of traditional Medicare.

In March 2024, Medicare Advantage achieved a major milestone with the majority of Medicare beneficiaries choosing Medicare Advantage at 50.8%. As of March 2025, this trend continued with the MA share of enrollment rising to 51.5%. There were 67.3 million people eligible for Medicare, including those not purchasing Medicare Part B, a prerequisite to participation in Medicare Advantage. According to the CMS State/County Penetration file, Medicare Advantage plans served 34.7 million people, an increase of 2.4% year-over-year from 33.8 million, (please see Figure 2).

Membership in the traditional Fee-For-Service ("FFS") program decreased by 0.4% during that March-ended year, versus the 2.0% decline in 2024 and 2.7% in 2023. This was the ninth consecutive annual decline in FFS membership which began in 2017. Since 2016, membership in FFS Medicare has fallen by 5.7 million members, compared with a 16.4 million increase in Medicare Advantage.

Taking the longer view, the total number of Medicare beneficiaries in 2025 increased by 24.0 million since 2005. Of those members, 29.1 million elected Medicare Advantage, while FFS membership declined by 5.0 million.

Figure 2. Sherlock Benchmark Summary
Medicare Advantage Share, March of Each Year



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

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

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

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

REVENUE PRESSURES

The KFF article also observed that the Medicare Payment Advisory Commission (MedPAC) made a change in its estimation methodology intended to take into account the effects of favorable selection.

According to MedPAC's March 2025 *Report to the Congress: Medicare Payment Policy*,

> "We estimate that, because of differences between MA and FFS in coding intensity and (favorable) selection, Medicare spends 20 percent more for MA enrollees than it would spend if those beneficiaries were enrolled in FFS Medicare, a difference that translates into a projected $84 billion—or 17 percent of total payments to MA plans…"

MedPAC's estimation is intended to capture the degree to which "risk-standardized spending of MA enrollees would be lower than the FFS average without any intervention from MA plans." It is based on calculation of "FFS spending in the year prior to MA enrollment." MedPAC acknowledges that this favorable selection may not be a stable phenomenon in that individual member costs may regress to the mean and, "it is possible that as MA grows, the favorability of the MA program will converge with the population remaining in FFS, and favorable selection will decrease." While we have no view on the merits or the process of MedPAC's estimation of favorable selection, the salient fact is that MedPAC believes favorable selection to exist. MedPAC was established by Congress to advise it on issues affecting the Medicare program. Central to its charge is advice on payments to private health plans.

HEALTH BENEFIT COST PRESSURES

At the same time, many Medicare plans have reported elevated medical expenses for 2024. Humana reported that during its 2024 third quarter earnings that its benefit ratio increased 300 basis points, year-over-year, "…primarily due to the continued impact of elevated Medicare Advantage…medical cost trends in the 2024 quarter and period."

Similarly, during its 2025 first quarter earnings call, UnitedHealth Group stated that it experienced an unexpected spike in health care costs. UHG stated, "Heightened care activity indications within UnitedHealthcare's Medicare Advantage businesses, which became visible as the quarter closed, (were) far above the planned 2025 increase which was consistent with the elevated levels in 2024. This activity was most notable within physician and outpatient services."

For the participating plans in the Medicare universe of the *Sherlock Benchmarks*, the average health benefit ratio increased by 290 basis points, while the median increased by 270 basis points, generally comporting with the experience of the publicly traded companies mentioned above.

Reflective of the gross margin compression, CMS observed on September 26th that "the total number of available MA plans nationally will decrease slightly from 5,633 in 2025 to approximately 5,600 in 2026." Similarly, the combined individual projections of MA plans imply a decline in MA membership and in their share of the eligible population, a conclusion disagreed with by CMS.

Administrative Expense Trends

Revenue and health care cost trend pressures highlight the importance of Medicare plan administrative cost management.

Figure 3 shows year-over-year trends on both an as-reported and constant-mix basis.

When the effect of mix changes is excluded, for the nine continuously participating plans, per member costs grew by 3.6%, notably slower than the 6.2% increase in the prior year. On an as-reported basis, these continuously participating plans' per member costs increased by 6.4%, faster than 5.2% in the prior year. These changes, all other trends and PMPM costs exclude Miscellaneous Business Taxes.

Cost trends on an as-reported basis indicated a shift towards higher cost products: growth in lower cost Medicaid was sharply lower coupled with gains in higher cost Medicare products. This shift resulted in faster cost growth on an as-reported basis, 6.4% compared to 3.6% when product mix is held constant. In aggregate, the proportion of members increased for Medicare, while falling sharply for Medicaid, and were up slightly for Commercial Insured and Commercial Total. The cost effect of the change in mix was the result of the higher costs to serve Medicare beneficiaries compared to lower cost Medicaid, over two times higher in both Account and Membership Administration and in Provider and Medical Management. While there was significant variation among the plans in this shift, the effect of mix on cost growth is evident.

Membership in higher cost Medicare increased by a median rate of 4%. Medicare Advantage also grew by a median of 4%, while the minor but high cost product of Medicare SNP declined by a median of 2%.

Lower cost Medicaid fell sharply by a median of 14%, primarily due to the resumption of Medicaid redeterminations. CHIP increased sharply, by a median rate of 47%, although only two continuous plans have this product, and Medicaid HMO fell by a median rate of 15%.

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

	2023 Increase		2024 Increase	
Functional Area	**As Reported**	**Constant Mix**	**As Reported**	**Constant Mix**
Sales and Marketing	5.6%	6.7%	6.6%	2.9%
Medical and Provider Management	7.0%	6.1%	4.3%	2.4%
Account & Membership Administration	6.4%	5.1%	12.5%	6.8%
Corporate Services	3.3%	3.5%	6.9%	-1.8%
Total Expenses	5.2%	6.2%	6.4%	3.6%

Commercial as a whole was flat on a median basis, but up by 7% on average. Commercial Insured fell by a median of 3% (but higher by 5%, on average), while ASO grew by a median rate of 2%. Among plans continuously participating in the *Sherlock Benchmarks*, Comprehensive membership declined at a median rate of 2%.

Trends Holding Product Mix Constant

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

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

Account and Membership Administration

This cluster of expenses had a PMPM cost increase of 6.8% on higher Compensation per FTE and Non-Labor Costs per FTE. For this *Navigator* analysis, Account and Membership Administration includes Pharmacy and Behavioral Health expenses. (They are analyzed separately in the Sherlock Benchmarks because of health benefit plan sponsor decisions and outsourcing.) The inclusion of trends in administrative activities of these two benefits increase median cost growth in this cluster by 0.9 percentage points. The inclusion to overall cost growth was an average of 0.4 percentage points. (The impact on the median rate of change was slightly lower.)

Customer Services was the fastest growing function in this cluster and overall. Compensation was responsible for this function's increase. The use of outsourcing increased in this functional area. The costs of every Customer Services sub-function (Member Services, Printed Materials and Other and Grievances and Appeals) increased.

Claims and Encounter Capture and Adjudication was the most important source of this cluster's growth. Expense growth was higher on increased Compensation per FTE and Non-Labor Costs per FTE. All its sub-functions were higher, with Payment Integrity sharply higher.

Information Systems was up on higher Compensation per FTE. The IS sub-functions of Operations and Support Services and Applications Maintenance contributed to growth, while Applications Acquisition and Development, and Security Administration declined.

Expenses for Enrollment / Membership / Billing decreased from the prior year, primarily on lower Staffing Ratio, and is this function's fifth consecutive annual decline. The Enrollment and Membership sub-function fell, while Billing increased. Outsourcing fell compared to last year.

Sales and Marketing

The Sales and Marketing cluster's costs grew by 2.9% as Staffing Costs per FTE increased.

External Broker Commissions was the cluster's fastest and most important source of growth, as well as overall. All nine plans reported growth in PMPM commissions costs.

The Rating and Underwriting function was the second fastest growing function in this cluster and followed in importance to expense growth, driven by higher Staffing Costs and Staffing Ratio. Both sub-functions of Risk Adjustment and Other Rating and Underwriting increased, year-over-year.

Sales expenses increased at a low single digit rate. The sub-functions of Account Services and Other Sales were key drivers in faster Sales expense growth, while Internal Sales Commissions declined.

Marketing costs per member *declined* by less than 1%. The decline in Member and Group Communication more than offset the increases in the other sub-functions of Product Development and Market Research and Other Marketing.

Advertising and Promotion expenses posted the largest rate of change, falling at a rate in the low teens, chiefly on a lower Staffing Ratio and Non-Labor Costs per FTE. Both sub-functions of Media and Advertising and Chartable Contributions were lower, year-over-year.

Medical and Provider Management

The Medical and Provider Management cluster had a PMPM increase of 2.4% with higher Compensation per FTE being key. The increase in Medical Management was the main driver in increased cluster costs as Provider Network Management costs were lower. Medical and Provider Management Compensation per FTE was key to higher costs.

Medical Management was up on Staffing Costs per FTE. Sub-functions that posted year-over-year growth were led by Medical Informatics, Precertification, Utilization Review, Other Medical Management, Case Management, and Nurse Information Line.

Provider Network Management and Services declined at a low single-digit rate with lower Non-Labor Costs central to the decline. The Provider Configuration sub-function was the only sub-function that was lower, measured by median rates. On average, Provider Contracting was also lower.

CORPORATE SERVICES

The Corporate Services cluster was the only cluster to decline, falling by 1.8%. The cluster's Medicare Staffing Ratio and Non-Labor Costs per FTE were the primary drivers in lower cluster costs.

While the median rate of change for Corporate Executive and Governance is a slight year-over-year increase, its average growth rate was a decline in the low teens. This function's Non-Labor Costs per FTE were lower compared to last year.

The Finance and Accounting function costs were lower by low a single digit rate due to reductions in Staffing Ratio and Non-Labor Costs. The sub-functions of Credit Card Fees and Fund Accounting for Self-Insured Groups were lower, while Other Finance and Accounting was only marginally higher.

Actuarial was higher at a high single digit rate. Meanwhile, Association Dues and Licensing Filing Fees was up at mid-single digit rate and Corporate Services Function increased by less than 1%.

As-Reported Trends

When a plan reports costs in sequential years, its per-member changes reflect both real changes and the effect of product mix differences. As noted earlier, the continuously reporting plans shifted towards higher cost products so that as-reported costs grew at a faster rate than when product mix differences are eliminated, 6.4% versus 3.6%. This section will highlight the functions with especially notable trend differences between the as-reported and constant-mix trend calculations.

The Corporate Services *cluster* experienced the largest variance between as-reported and constant-mix growth. The as-reported rate of change was an *increase* of 6.9%, while the constant-mix rate of change flipped to a *decrease* of 1.8%. Finance and Accounting flipped from a decline on a constant-mix basis to an increase on an as-reported basis. The growth on an as-reported basis was faster for the remaining functions, led by Actuarial and Corporate Services function, each faster by less than 2 percentage points. Expenses for Association Dues and License / Filing Fees and Corporate Executive and Governance each function was faster than the constant -mix growth by less than 1 percentage point.

Account and Membership cluster posted the largest increase on an as-reported basis, by 12.5% and compares to the constant-mix increase of 6.8%. On an as-reported basis, Information Systems, Customer Services, and Claims growth rates were faster than the growth on a constant mix basis. Conversely, the decline in Enrollment / Membership / Billing was lower.

As previously noted, Account and Membership *includes* Pharmacy and Behavioral Health administration; administrative expenses in Behavioral Health and Pharmacy each grew faster on an as-reported basis compared to a constant-mix basis.

Sales and Marketing as-reported PMPM costs grew by 6.6% and compares to the constant-mix increase of 2.9%. Marketing flipped from a decline on a constant-mix basis to an increase on an as-reported basis. Advertising and Promotion posted the largest variance between the two trend presentations with Rating and Underwriting and External Broker Commissions following. Sales growth decelerated slightly on an as-reported basis.

Medical and Provider Management cluster grew at a faster rate on an as-reported basis, 4.3% versus the constant-mix increase of 2.4%. On an as-reported basis, Medical Management's increase was faster on an as-reported basis, while the decline in Provider Network Management slowed slightly.

Enterprise Cost Drivers

We think that it is helpful to understand enterprise expenses by their cost drivers. PMPM costs can be thought of as the product of the staffing ratio and total costs per FTE. Similarly, the total costs per FTE is the sum of staffing and non-labor costs per FTE. The comments in this section are based on *median* values for continuously participating plans and includes staffing and costs of activities performed on an outsourced basis.

The median compensation per FTE was approximately $113,000, 8.6% higher than last year's median. Compensation in 11 of the 14 functions with FTEs increased, led by Corporate Executive and Customer Services.

Medicare Advantage median staffing ratios were lower than last year. The median was 61 FTEs per 10,000 Medicare Advantage members, 6.0% lower than last year. (The Staffing Ratio reflects both internal and outsourced staffing. Outsourced staffing is inferred, often calculated from invoice amounts. When calculated by product, we assume that all products have the same mix of staffing and non-labor costs.)

Of the 14 functional areas with staff, ten were lower than last year. Advertising and Promotion and Actuarial posted the largest declines from last year.

Median Non-Labor Costs per FTE were higher than last year among continuous plans, approximately $113,000 per FTE, up 11.7% from last year. Four of the functional areas experienced an increase in Non-Labor Costs per FTE. Marketing and Claims were functions that experienced the largest increases.

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

Overall propensity to outsource was lower, to 10.8% of the total FTEs from 11.4% last year. Only one of the fourteen functional areas with staff decreased outsourcing but, measured by averages, this increases to 13 functions.

Costs of Medicare-focused Plans, by Cluster, PMPM

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

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

The product mix for *all* eleven plans in 2024 differed from the prior year's plans. There was more focus on Medicare Advantage and in both Commercial Insured and Commercial ASO, while less focus on Medicaid.

The median total PMPM administrative expenses are $57.21, 8.9% higher than last year, shown in Appendix A. In comparison, the constant-mix increase mentioned earlier was 3.6%. With a median of $24.10, Account and Membership was greater by 12.0% while the constant mix increase was 6.8%.

Figure 4. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2024 Results
Per Member Per Month

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	$13.88	$15.46	$17.96	40%
Medical and Provider Management	8.39	9.07	11.50	47%
Account and Membership Administration	22.03	24.10	27.59	21%
Corporate Services	6.96	7.97	10.28	56%
Total Expenses	$53.51	$57.21	$61.22	33%

The Sales and Marketing cluster was higher by 12.1% to a median $15.46, while up by 2.9% on a constant mix basis. The Corporate Services cluster was $7.97 PMPM, *lower* by 5.0% with a decrease of 1.8% on a constant mix basis. Lastly, the Medical and Provider Management cluster was *lower* in 2024 by 7.3% to $9.07, while the constant mix increase was 2.4%.

The dispersion of expenses in 2024 was lower than in 2023. The Coefficient of Variation declined by 18 percentage points to 33% for Total Expenses. Medical and Provider Management narrowed by 32 percentage points to 47%, while Corporate Services declined by 31 percentage points to 56%. Account and Membership Administration coefficient of variation declined by 13 percentage points to 21%, while Sales and Marketing increased its dispersion by 1 percentage point to 40%.

However, dispersion measured as the difference between 75th and 25th percentiles increased for 2024. In total, this metric of dispersion increased by $1.99. Account and Membership and Corporate Services cluster increased by $2.11 and $1.44, respectively. Sales and Marketing increased by $0.93, while the Medical and Provider Management cluster difference grew by $0.52.

Costs of Medicare-focused Plans, PMPM by Product

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

An example of the *effect* of mix is found in Figure 3. When comparing identical plans' cost trends in 2024, when they are weighted to reflect the average mix in 2024, expense growth almost halved from 6.4% as reported by the plans, to 3.6%, holding mix constant.

For the universe as a whole, Medicare products are relatively high cost at $126.45 and $216.46 PMPM for Medicare Advantage and Medicare Special Needs Plans, respectively. Compared to 2023, the PMPM costs for both Medicare Advantage and SNP were lower.

The high administrative costs for these products reflect the high health care needs of the population that they serve: medical management and claims functions being obvious examples. Medicare Advantage's average membership mix was 18%, while the average revenue share was 40%. Medicare SNP's average membership mix and revenue mix were 1% and 2%, respectively. Total Medicare revenues were 42% of the total for the universe.

The median PMPM administration for the Medicare Supplement product was $60.10 and was offered by nine of the plans. The average member mix was 2% and revenue mix was about 1%. Medicare Supplement is included as a Comprehensive product in the *Sherlock Benchmarks*, though it pays only when Medicare does not.

Medicaid products, serving primarily qualified low-income beneficiaries, are generally the lowest cost to administer Comprehensive products of this universe. Medicaid HMO had median PMPM cost of $34.32, while the median PMPM for CHIP was $28.95. Medicaid HMO's average share of members is 19% and its revenue share is 13%. Medicaid CHIP's average member mix was less than 1% and revenue mix was less than a quarter of 1%.

The mean mix of Commercial Insured products among Medicare plans in our universe was 30% of the membership and 37% of revenues. Administrative expenses for these products are higher than the median comprehensive administrative costs. The single most important Commercial Insured product was HMO at $66.80 PMPM. Indemnity and PPO cost $67.42, while POS cost $58.36. Total Commercial costs was $48.19 PMPM.

Figure 5. Sherlock Benchmark Summary
Medicare Plans' Costs by Product, 2024 Results
Per Member Per Month

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	$111.17	$140.02	$151.99	20%
Advantage	$110.55	$126.45	$146.05	20%
SNP	$175.47	$216.46	$267.59	30%
Medicare Supplement	$38.72	$60.10	$64.88	38%
Medicaid Total	$31.19	$34.43	$40.34	16%
HMO	$31.13	$34.32	$40.34	15%
CHIP	$25.03	$28.95	$32.88	38%
Commercial Insured Total	$62.88	$67.83	$72.18	18%
HMO	$51.08	$66.80	$74.55	26%
POS	$52.83	$58.36	$66.13	22%
Indemnity & PPO	$63.30	$67.42	$68.40	13%
Commercial ASO	$29.74	$35.37	$37.74	20%
Commercial Total	$45.78	$48.19	$52.20	29%
Comprehensive Total	$53.51	$57.21	$61.22	33%

Commercial ASO products represented a mean of 31% of Comprehensive members and 4% of revenues. While Insured Commercial products have higher administrative cost than all of the products offered by these plans, the ASO products are much lower cost. The reason for this is that the ability of a group to self-insured is related to group size, and it is less expensive per member for health plans to serve larger groups than for smaller groups. For instance, to be an ASO group means to possesses the statistical advantages of larger size: this also means that per group Sales and Marketing costs are spread through greater numbers of members. The costs to administer Commercial ASO products are accordingly lower. These products have a median cost of $35.37, a little more than half of commercial insured products.

Two of the continuously participating plans offered Medicaid Managed Long Term Services and Supports (MLTSS). These products are offered to Medicaid beneficiaries that require long-term care. The fact that only two of the plans offer it, plus the preference of some of the plans not to include it as Comprehensive is why we do not show it among products shown in Figure 5. The median administrative cost for Managed Long Term Services and Supports (MLTSS) was $295 PMPM. It is similar in some ways to Medicare SNP with PMPM costs of $216.

Figure 6. Sherlock Benchmark Summary
Medicare Plans' Costs by Product, 2024 Results
Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicare	10.3%	11.5%	12.5%	21%
Advantage	10.4%	11.3%	12.1%	21%
SNP	9.6%	11.3%	14.0%	34%
Medicare Supplement	20.4%	28.0%	29.3%	44%
Medicaid Total	7.3%	9.3%	10.6%	27%
HMO	7.1%	9.3%	10.6%	28%
CHIP	10.1%	11.3%	12.4%	30%
Commercial Insured Total	10.6%	11.1%	12.5%	14%
HMO	9.9%	11.6%	13.1%	42%
POS	8.4%	9.9%	10.0%	20%
Indemnity & PPO	10.8%	11.1%	11.4%	12%
Commercial ASO	6.3%	7.0%	8.1%	20%
Commercial Total	8.2%	8.7%	10.1%	23%
Comprehensive Total	8.9%	9.3%	11.1%	18%

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

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

Medicare SNP costs, which incurs over three times the PMPM costs of Commercial HMO Insured, is 11.3% of premiums, *lower* on a percent of premium basis. Medicare SNP, at almost twice the PMPM of Medicare Advantage, is the same on a percent of premium basis.

Medicare Advantage costs, while almost twice as high as Commercial HMO Insured PMPM, is 11.3% of premiums, *lower* than Commercial HMO ratio of 11.6%. The POS and Indemnity & PPO products had ratios of 9.9% and 11.1%, respectively in line with that of MA.

Medicaid HMO was below average in PMPM costs and was, at 9.3%, equal to the median in percent of premiums. Sales and Marketing expenses tend to be far lower for these products reflecting state policy.

The administrative expenses of Commercial ASO products are 7.0% of premium equivalents. It also operates at low costs PMPM. The lower Sales and Marketing for self-insured groups is key reason for this. Total Commercial was 8.7% of premium equivalents.

While Medicare Supplement is higher than average cost when measured PMPM, at 28.0%, its cost ratio was the highest among the comprehensive products sold by this universe. Medicaid CHIP had lower than median PMPM costs but, at 11.3%, was higher than the median percents of premium equivalents. These examples reflect that the per member administrative costs reflect the underlying health care needs of the population served by each product.

By contrast, Medicare Supplement and CHIP health care needs are more modest leading to a higher relative percents than relative PMPMs. For 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 9.3% of premiums, 0.1 percentage point higher than last year.

Sales and Marketing and Corporate Services Cluster were relatively unchanged at 2.5% and 1.4%, respectively. Account and Membership was higher by 0.4 percentage points to 4.0%, while Medical and Provider Management was lower by 0.2 percentage points to 1.5%.

Dispersion, measured by the Coefficient of Variation, declined while the differences between 25th and 75th percentiles increased in 2024 versus 2023.

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 3.0 million Medicare Advantage members, about 9% of all Medicare Advantage members, and 28% 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 the Medicare Advantage universe with Blue Cross Blue Shield Plans and Independent / Provider – Sponsored plans. Shown in Figure 8, Medicare plans PMPM expenses were $17.83 lower than Blue Cross Blue Shield Plans. Measured as a percent of premiums, they were 2.5 percentage points less.

The advantage was ambiguous when compared to the Independent / Provider - Sponsored plans. The Medicare plans were higher by $8.82 on a PMPM basis, but lower on a percent of premium basis by 1.1 percentage points.

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

Figure 7. Sherlock Benchmark Summary
Medicare Plans' Costs by Functional Area Cluster, 2024 Results
Percent of Premium Equivalents

Functional Area	25th Percentile	Median	75th Percentile	Coefficient of Variation
Sales and Marketing	2.3%	2.5%	3.1%	24%
Medical and Provider Management	1.4%	1.5%	1.8%	35%
Account and Membership Administration	3.6%	4.0%	4.2%	16%
Corporate Services	1.2%	1.4%	1.6%	36%
Total Expenses	8.9%	9.3%	11.1%	18%

How We Performed This Analysis

This analysis is based on the twenty-second annual edition of our performance benchmarks for Medicare-focused health plans. The *Sherlock Benchmarks* (*Sherlock Expense Evaluation Report* or *SEER*) represent the cumulative experience of more than 1,000 health benefit organization years.

Each peer group in the *Sherlock Benchmarks* is established to be relatively uniform. So, within that constraint, it is open to all Medicare-focused plans possessing the ability to compile high-quality, segmented financial and operational data. This analysis of Medicare plans is based on a peer group of 11 plans that collectively serve 12.1 million people in which a disproportionate amount of plan revenues came from Medicare products. Of the eleven participating plans, nine also participated last year.

The average plan participating in the Medicare *Sherlock Benchmarks* this year served 1.1 million people and the median membership was 638,000. The geographic reach extended from coast to coast.

Health plans included in the Medicare universe emphasized Medicare Advantage (including SNP), and collectively served 1.9 million members. It composed an average of 38% of revenues and 18% of membership in comprehensive products. The median Medicare revenue and membership proportion was 37% and 15%, respectively.

Medicaid products comprised an average of 14% of revenues and an average of 19% of membership, or 2.0 million members. It was offered by 6 plans.

Figure 8. Sherlock Benchmark Summary

Medicare Advantage Product Characteristics by Universe, 2024 Results

	Medicare Plans	IPS Plans	BCBS Plans	Combined Plans
Total Costs				
Per Member Per Month				
25th Percentile	$110.55	$101.88	$134.57	$113.29
Median	126.45	117.63	144.28	138.08
75th Percentile	146.05	173.57	178.34	152.39
Coefficient of Variation	20%	36%	32%	29%
Percent of Premiums and Equivalents				
25th Percentile	10.4%	9.4%	11.6%	9.9%
Median	11.3%	12.3%	13.8%	12.1%
75th Percentile	12.1%	17.2%	17.1%	15.9%
Coefficient of Variation	21%	36%	46%	38%
Plans offering Medicare	11	7	8	26
Medicare Advantage Members (millions)	1.78	0.49	0.71	2.98
Comprehensive Total Members (millions)	12.09	5.73	33.39	51.21

An average of 41% of revenues and 70% of membership was commercial, or 7.9 million. Approximately 4.6 million of the commercial members were served under some form of self-insurance arrangement, comprising approximately 58% of the total commercial members.

The *Sherlock Benchmarks* universe of Medicare plans is remarkable because of the high national concentration of Medicare members in relatively few health plans. According to *Kaiser Family Foundation* and CMS figures, the five largest health plans serving Medicare Advantage serve 68.9% of the total. Of the 11 million not served by those plans, the *Sherlock Benchmarks* for Medicare include the results of 16.5% of Medicare Advantage members. If the additional 1.2 million members served through other *Sherlock Benchmarks* universes are included (they are actually referenced and detailed in an exhibit in the Medicare universe) approximately 28% of those members are included in the *Sherlock Benchmarks*.

Figure 9. Sherlock Benchmark Summary
Share of Medicare Advantage Members

	2024	2025
Eligibles[1]	66,624,189	67,322,203
Total MA Membership[1]	33,828,266	34,656,942
Share of Eligibles in MA	*50.8%*	*51.5%*
UnitedHealthcare[2]	9,398,295	9,902,837
Humana[2]	6,018,288	5,721,711
CVS Health[2]	4,080,860	4,078,959
Elevance Health[2]	1,977,357	2,226,608
Kaiser Permanente[2]	1,893,296	1,951,484
Total, Five Largest	23,368,096	23,881,599
Share of Five Largest	*69.1%*	*68.9%*
MA Membership other than Five Largest		10,775,343
Sherlock Benchmark Participant Membership		1,775,749
Share of Membership other than Five Largest		16.5%

[1] *State County Penetration Files, March, CMS*
[2] *Medicare Advantage in 2025: Enrollment Update and Key Trends, Kaiser Family Foundation, July 28, 2025*

Reporting Conventions

We employ some 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 measure of central tendency 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 called "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 product costs to eliminate the effect of product mix differences between their years.
- Percent of premium ratios are calculated on a premium-equivalent basis. That is, in the case of ASO/ASC arrangements, we synthesize premium rates by adding to fees 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/ASC ratios with those of insured products offered by these Plans, and an intuitive appeal to general readers.
- Expenses and revenues exclude capital costs and investment income. We specifically exclude interest and similar debt capital costs, profits and capital formation costs (debt or equity) such as 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 behavioral health while the *Sherlock Benchmarks* do not. Because of variation in contracting by employers for these benefits and that the administration of these health services is sometimes outsourced by Plans who accept these management responsibilities, the Benchmark reports carve them out. Pages 22 - 24 in Tab 2 of Volume I of the 2025 *Sherlock Benchmarks* reconciles these two presentations.

- Medicare Part D is not discussed, but there were four plans that offered this product. In other universes, 64% of Blue Plans offered Medicare Part D. The median administrative cost for this product in the Medicare Advantage universe was $16.24 PMPM and the mean was $15.24.

- 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 calculated before the effect of Miscellaneous Business Taxes.

Note on the Sherlock Benchmarks

The *Sherlock Benchmarks* are the health plan industry's metrics informing the management of administrative activities. They are based on validated surveys of 32 health plans serving 58 million Americans and provide costs and their drivers on key administrative activities. The Benchmarks are reported in multiple universes of health plans: Blue Cross Blue Shield, Independent / Provider-Sponsored, Larger Plans, and Medicare and Medicaid.

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 2025 *Sherlock Benchmarks*. We earlier reported on Blue Cross Blue Shield, Independent Provider-Sponsored and Larger plan editions, and will be reporting on the results of Medicaid plans in the next month. Detailed 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 2025 edition Brochure is found here.

https://sherlockco.com/Brochure/

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, 2023 Results

Per Member Per Month

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

Appendix B. Sherlock Benchmark Summary

Medicare Plans' Costs by Functional Area Cluster, 2023 Results

Percent of Premium Equivalents

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

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) Fund Accounting for Self-Insured Groups
    - (c) 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
    - (a) Strategic Expenses
    - (b) Other Corporate Executive and Governance
16. Association Dues and License/Filing Fees

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