



Plan Management Navigator

Analytics for Health Plan Administration

Core Cost Growth Modestly Accelerated for Medicaid Plans in 2025

Per member Core administrative expenses of Medicaid-focused plans grew at a median of 5.6% holding product mix constant, the fastest since 2020. Account and Membership Administration led. Medicaid membership continued to decline, which may have contributed to growth in PMPM costs. Premiums grew by double digits, so administrative costs fell as a share of premiums

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Conclusions

- Core administrative expenses per member of Medicaid-focused plans, which exclude Sales and Marketing, grew at a median of 5.6% in 2025 among the nine continuously participating plans when product mix is held constant, faster than the 5.0% of 2024 and the fastest growth since 2020.
- Before adjusting for changes in product mix, Core costs per member grew at a median of 2.6%, down from 8.3% in the prior year. Total expenses, including Sales and Marketing, grew at a median of 2.8% at constant mix and 2.6% as reported.
- Premiums per member grew by double digits overall and for Medicaid HMO, so administrative costs fell as a share of premiums.
- Account and Membership Administration, the largest cluster, grew by 6.8% on a constant-mix basis, the fastest of the four clusters and its fastest growth since 2019. Claim and Encounter Capture and Adjudication grew by 23%, led by Payment Integrity, while Enrollment / Membership / Billing grew by high single digits and Customer Services by mid single digits.
- Medical and Provider Management and Corporate Services were both essentially flat, each declining by 0.3% at constant mix after growth of 7.1% and 4.1%, respectively, in the prior year. Medical Management declined while Provider Network Management and Services grew by high single digits. Finance and Accounting and the Corporate Services Function declined, while Corporate Executive and Governance grew by double digits.
- Sales and Marketing declined by 1.8%. Advertising and Promotion fell by low double digits and Sales by high single digits, while External Broker Commissions grew by low single digits.

- Staffing ratios declined by mid single digits at a constant product mix, while compensation per FTE grew by high single digits and Non-Labor Costs per FTE by double digits. Outsourcing increased by about one percentage point of combined FTEs.
- Medicaid membership of the continuous plans declined at a median of 3.5%, following the far larger declines of 2024, and the Medicaid share of their membership fell by about two percentage points. Medicare Advantage and Commercial Insured membership grew. Total membership declined at a median rate of 0.5%, possibly contributing to administrative expense growth.
- Median administrative expenses of all twelve participating plans were \$55.37 per member per month, 8.1% of premium equivalents. The PMPM was 5.7% above the value published last year while the ratio was 1.1 percentage points lower. Not all plans were the same in both years.

Administrative Expense Trends

Twelve plans participated in the 2026 edition of the Medicaid Sherlock Benchmarks, reflecting 2025 results. Nine of them also participated in the 2025 edition and were used to calculate trends; five of last year's fourteen plans did not return and three plans joined. Trends are medians of the nine continuous plans, values for the universe as a whole are medians of all twelve, and everything in this Navigator excludes Miscellaneous Business Taxes.

The participating plans collectively served 8.4 million people in comprehensive products, of whom 5.2 million were Medicaid HMO or CHIP members. Medicaid was 62% of their combined membership and an average of 56% of their revenues. Ten of the twelve plans offered Medicare Advantage or a Special Needs Plan, and eight offered commercial products.

The nine continuously participating plans served 6.5 million people in comprehensive products, of whom 3.9 million were Medicaid HMO and CHIP members. Medicare Advantage and SNP products served 873,000 members, Medicare Supplement 79,000, and commercial products 1.7 million, of which 769,000 were ASO.

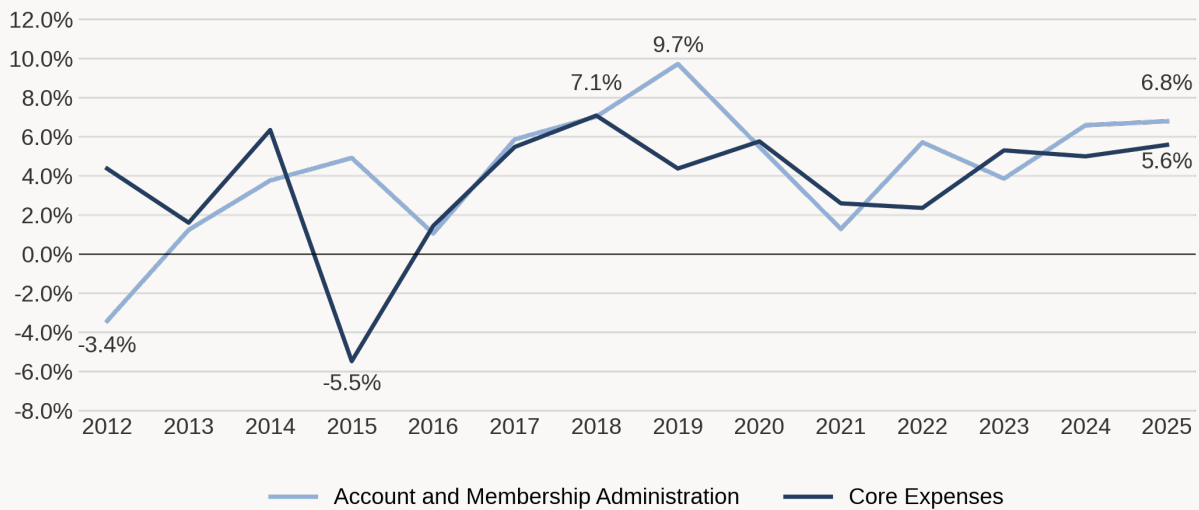
The term "Core" expenses excludes the Sales and Marketing cluster. State laws governing Sales and Marketing for Medicaid vary, so we separate such activities from Medical and Provider Management, Account and Membership Administration and Corporate Services to preserve comparability between plans operating in different states. The Sales and Marketing cluster is composed of Rating and Underwriting, Marketing, Sales, Advertising and Promotion and External Broker Commissions.

Figure 1 displays the Core and Account and Membership Administration cost trends since 2012. The rates of change hold constant both the surveyed plans and their product mix in each year-over-year comparison. Core growth of 5.6% in 2025 was the fastest since 2020 and above the fourteen-year average of 3.7%, while Account and Membership Administration growth of 6.8% was the fastest since 2019 and above its average of 4.3%.

Figure 1

Medicaid Plans' Costs Rates of Change

Median Changes in PMPM Costs, Constant Mix, Continuous Plans



Background on Medicaid

One of the central purposes of the Affordable Care Act was to reduce the proportion of Americans without health insurance. As shown in Figure 2, based on the Census Bureau's Health Insurance Coverage in the United States: 2025, published in September 2026, the proportion of Americans who were uninsured dropped from 13% in 2013 to 8% in 2025, and has been 8% or 9% in every year since 2015.

Medicaid has historically been integral to this improvement. In 2014, the first year of the Affordable Care Act's coverage expansion, Medicaid grew by 12%, or 6.7 million people. Enrollment reached 62.4 million in 2015 and declined or was flat from 2016 through 2019. It then increased in each year from 2020 to 2023, to 62.7 million, as the Public Health Emergency suspended eligibility redeterminations. Redeterminations resumed in 2023 and led to declines: Medicaid coverage was 59.2 million in 2024, as the Census Bureau has re-estimated it, and fell by a further 1.4 million in 2025 to 57.8 million, 17% of the population. Employer-based coverage was essentially flat in 2025 at 180.7 million, and direct purchase fell by about 730,000.

Figure 2

Health Insurance Coverage in the United States: Census Bureau (000's)

Beneath each count, its share of the population; beneath each change, the percent change.

	2013	2014	2015	2020	2023	2024	2025	2025 Chg.	Chg. since 2013
Any Health Plan	271,606 87%	283,200 90%	289,903 91%	299,230 91%	305,200 92%	309,900 92%	311,200 92%	1,300 0%	39,594 15%
Any Private Plan	201,038 64%	208,600 66%	214,238 67%	217,896 67%	216,800 65%	222,100 66%	222,000 66%	-100 0%	20,962 10%
Employment-based	174,418 56%	175,027 55%	177,540 56%	178,737 55%	178,200 54%	180,500 54%	180,700 53%	200 0%	6,282 4%
Direct purchase	35,755 11%	46,165 15%	52,057 16%	33,869 10%	33,850 10%	36,260 11%	35,530 11%	-730 -2%	-225 -1%
Any Public Plan	108,287 35%	115,470 37%	118,395 37%	112,925 34%	120,400 36%	120,800 36%	121,100 36%	300 0%	12,813 12%
Medicare	49,020 16%	50,546 16%	51,875 16%	58,541 18%	62,550 19%	65,740 20%	67,910 20%	2,170 3%	18,890 39%
Medicaid	54,919 18%	61,650 19%	62,384 20%	58,778 18%	62,700 19%	59,220 18%	57,800 17%	-1,420 -2%	2,881 5%
Military health care	14,016 4%	14,143 4%	14,849 5%	12,132 4%	11,892 4%	13,458 4%	13,506 4%	48 0%	-510 -4%
Uninsured	41,795 13%	32,968 10%	28,966 9%	28,291 9%	26,440 8%	26,940 8%	26,670 8%	-270 -1%	-15,125 -36%
Total	313,401	316,168	318,869	327,521	331,640	336,840	337,870	1,030 0%	24,469 8%

Source: U.S. Census Bureau, Health Insurance Coverage in the United States: 2025 (P60-291), Table 1, for 2024 and 2025, with 2024 as re-estimated in that report with Vintage 2025 population controls; earlier years as published in each year's report.

Note: The Census Bureau counts individuals as uninsured "if they did not have health insurance coverage for the entire calendar year," and the estimates by type of coverage "are not mutually exclusive; people can be covered by more than one type of health insurance during the year."

Subject to the qualifications noted on the figure, of the 15.1 million net decline in the uninsured since 2013, the 2.9 million additions to Medicaid explained 19%, down from 31% a year earlier as Medicaid enrollment fell. Over the same period membership in employer-based coverage increased by 6.3 million people and Medicare by 18.9 million, while direct purchase declined by about 225,000.

The decline has continued into 2026. According to the Kaiser Family Foundation's Medicaid enrollment tracker, published September 25, 2026, 73.2 million people were enrolled in Medicaid and CHIP nationally as of June 2026, a decline of 5.1 million, or 6%, from June 2025.

Trends Overall and in Expense Clusters

Figure 3 shows year-over-year trends on both an as-reported and a constant-mix basis. The two columns labeled "as reported" reflect per member trends of the continuously participating plans. The two columns labeled "constant mix" reweight the product costs of the same plans so that their product mix is the same in each of the two comparison years. By eliminating the effect of changes in product mix between comparison years, constant-mix trends provide what we consider a more accurate measure of cost growth.

When the effect of product mix changes is excluded, Core costs per member of the nine continuous plans grew at a median of 5.6%, compared with 5.0% in the prior year. Total expenses, which add Sales and Marketing, grew at a median of 2.8%, compared with 3.6%. On an as-reported basis, Core costs grew at a median of 2.6%, compared with 8.3% in the prior year, and Total expenses by 2.6%, compared with 8.5%.

Figure 3

Medicaid Plans' Median Changes in Per Member Per Month Expenses

Continuous Plans, As Reported and Constant Mix

Clusters of Functions	2024 Increase		2025 Increase	
	As Reported	Constant Mix	As Reported	Constant Mix
Medical and Provider Management	7.9%	7.1%	0.2%	-0.3%
Account and Membership Administration	9.9%	6.6%	6.0%	6.8%
Corporate Services	8.5%	4.1%	0.9%	-0.3%
Subtotal: Core Expenses	8.3%	5.0%	2.6%	5.6%
Sales and Marketing	8.8%	0.0%	2.5%	-1.8%
Total Expenses	8.5%	3.6%	2.6%	2.8%

In 2024 the median as-reported Core growth of 8.3% ran more than three percentage points ahead of the constant-mix median of 5.0%, which last year's Navigator attributed to a shift in the product mix of the continuous plans toward higher cost Medicare products. In 2025 the as-reported median of 2.6% was below the constant-mix median of 5.6%. Plan by plan, as-reported growth was higher than constant-mix growth at seven of the nine continuous plans. So for most plans the shift in product mix added to reported costs per member.

Among the Core clusters, Account and Membership Administration grew by 6.8% at constant mix and 6.0% as reported. Medical and Provider Management declined by 0.3% at constant mix and grew by 0.2% as reported, and Corporate Services declined by 0.3% at constant mix and grew by 0.9% as reported. Sales and Marketing declined by 1.8% at constant mix and grew by 2.5% as reported.

Trends Holding Product Mix Constant

A trend analysis that eliminates the effect of product mix changes is, in our view, a more accurate representation of the underlying dynamics, so the discussion that follows is based on it. To make this calculation, we reweight the prior-year product costs of the continuing plans so that the product mix of the prior year matches that of the current year. Only plans that reported in both years are compared, and every trend is a median of the plans' changes.

Of the Core functions, Claim and Encounter Capture and Adjudication was the fastest growing and the most important source of growth, while Medical Management was the largest source of decline. In Sales and Marketing, Advertising and Promotion declined the most. Staffing ratios in this section include outsourced staffing and are expressed holding product mix constant. Cost drivers in this section are medians of the nine continuous plans.

Since some administrative expenses are sticky in the short term, declines in membership may contribute to increases in administrative costs per member. Please see our Short-Term Scale model at sherlockco.com/benchmarks/scale-calculators. Among the nine continuously participating plans, Medicaid HMO membership declined at a median of 3.5% and a mean of 4.9% in 2025, after median declines of 12.7% in 2024, and the Medicaid share of their comprehensive membership fell by a median of about two percentage points. Medicare Advantage membership grew at a median of 7.7% among the seven plans reporting it in both years, and Commercial Insured membership by 9.4% among five, while Commercial ASO membership was essentially flat. Comprehensive membership was flat, at a median decline of 0.5%.

Account and Membership Administration

The Account and Membership Administration cluster of expenses grew at a median of 6.8% per member, the fastest of the four clusters, after growth of 6.6% in the prior year. Compensation per FTE grew by mid single digits and Non-Labor Costs per FTE by double digits, while the cluster's Staffing Ratio was slightly lower and outsourcing rose by about one percentage point of combined FTEs. For this Navigator analysis, Account and Membership Administration includes Pharmacy and Behavioral Health administration. (They are analyzed separately in the Sherlock Benchmarks because of state contracting practices and outsourcing.) Pharmacy Administration declined at a median of 3.2% and Behavioral Health Administration grew by 3.4%. Excluding both, the cluster grew by 6.6%, and Core expenses grew by 4.4% rather than the 5.6% shown in Figure 3.

Claim and Encounter Capture and Adjudication was the fastest growing function in the cluster and the most important source of growth, up by 23%. Payment Integrity was the driver, up by 27% on a higher Staffing Ratio and higher Compensation per FTE, while Coordination of Benefits and Other Claims each grew by high single digits.

Enrollment / Membership / Billing grew by 7.2%, with Enrollment and Membership up by high single digits and Billing by mid single digits, on higher Non-Labor Costs per FTE. Customer Services grew by 4.4%: Member Services grew by 6.8% and Grievances and Appeals by 8.0%, while Printed Materials and Other grew sharply from a small base.

Information Systems grew at a median of 2.0%, the slowest of the cluster's four functions. Applications Maintenance grew by high single digits and Security Administration and Enforcement by mid single digits, while Applications Acquisition and Development declined by mid single digits and Operations and Support Services was up slightly.

Medical and Provider Management

The Medical and Provider Management cluster declined at a median of 0.3%, after growth of 7.1% in the prior year. Its Staffing Ratio fell by high single digits, offsetting growth of 6.7% in Compensation per FTE and of nearly 10% in Non-Labor Costs per FTE.

Medical Management / Quality Assurance / Wellness declined by 3.7%. Utilization Review fell by high single digits and Disease Management by low double digits, while Case Management, Quality Components and Other Medical Management were lower by low single digits.

Precertification, up by high single digits, and Medical Informatics, up slightly, were the exceptions.

Provider Network Management and Services grew by 8.7%, on Other Provider Network Management and Services, which grew sharply. Provider Contracting grew by low single digits, with Provider Configuration and Other Provider Contracting both higher, and Provider Relations Services was essentially flat.

Corporate Services

The Corporate Services cluster declined at a median of 0.3%, after growth of 4.1% in the prior year. Compensation per FTE grew by double digits and Non-Labor Costs per FTE by mid single digits, while the cluster's Staffing Ratio declined by low single digits.

Corporate Executive and Governance grew by 11.8%, with Strategic Expenses sharply higher and Other Corporate Executive and Governance up by mid single digits. Actuarial grew by low single digits.

Finance and Accounting declined by 3.6% and the Corporate Services Function by 6.2%. Printing and Mailroom fell by high teens, Facilities and Government Affairs by high single digits and Compliance by 4.2%, while Audit grew by mid double digits and Risk Management by high single digits. Association Dues and License and Filing Fees declined by low single digits.

Sales and Marketing

While Sales and Marketing is not included in Core expenses, it remains central to the Commercial and Medicare products that these Medicaid-focused plans also offer, and Medicaid itself includes such activities as health fairs and outreach. The cluster declined at a median of 1.8%, after being flat in the prior year, as Non-Labor Costs per FTE grew by double digits while the Staffing Ratio was slightly lower and outsourcing fell.

Advertising and Promotion declined by 12.8%, the largest decline in the cluster, on lower Media and Advertising spending. Sales declined by 8.4%, with Internal Sales Commissions and Other Sales lower, and Rating and Underwriting by 5.5%, with Risk Adjustment down by low double digits. Marketing was essentially flat, while External Broker Commissions grew by 3.2%.

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. This section notes the functions whose as-reported trends differ notably from the constant-mix trends.

Core expenses grew at a median of 2.6% as reported against 5.6% at constant mix, and Total expenses by 2.6% against 2.8%. Every cluster except Account and Membership Administration grew faster as reported than at constant mix.

Sales and Marketing grew by 2.5% as reported against a decline of 1.8% at constant mix, the greatest difference among the clusters. External Broker Commissions grew by 11.0% as

reported against 3.2% at constant mix, and Sales declined by 1.8% as reported against 8.4%. Rating and Underwriting declined at the same rate on both bases.

Account and Membership Administration grew by 6.0% as reported, slower than its 6.8% at constant mix. Enrollment / Membership / Billing grew by 4.2% as reported against 7.2%, while Information Systems grew by 3.8% as reported against 2.0%. Claim and Encounter Capture and Adjudication grew by 23% on both bases.

Corporate Services grew by 0.9% as reported against a decline of 0.3% at constant mix. Actuarial grew by 9.0% as reported against 1.3%, and Finance and Accounting was flat as reported against a decline of 3.6%. Corporate Executive and Governance was flat as reported but grew by 11.8% at constant mix.

Medical and Provider Management grew by 0.2% as reported against a decline of 0.3% at constant mix. Medical Management declined by 1.7% as reported against 3.7%, and Provider Network Management and Services grew by 7.8% against 8.7%.

Summary of Cost Drivers

We think that it is helpful to understand functional expenses by their drivers. PMPM costs can be thought of as the product of the staffing ratio and total costs per FTE, and total costs per FTE as the sum of staffing costs and non-labor costs per FTE. Levels in this section are medians of all twelve participating plans; changes are medians of the nine continuously participating plans, and both include staffing and costs of activities performed on an outsourced basis. Staffing ratios are expressed holding product mix constant. (Outsourced staffing is inferred, often calculated by the plans from invoice amounts using historical norms of total costs per FTE. When calculated by product, we assume that all products have the same mix of staffing and non-labor costs.)

Staffing ratios were lower. The median plan employed 21 FTEs per 10,000 Medicaid HMO members in its Core functions, and 27 per 10,000 members across all products and functions. Among the continuous plans, the staffing ratio at a constant product mix declined at a median of 6.1%. Declines were broad, led by Advertising and Promotion, Sales, Medical Management and Enrollment / Membership / Billing, while Claim and Encounter Capture and Adjudication was staffed more heavily than last year.

Median compensation per FTE across all functions was approximately \$120,000. Among the continuous plans, compensation per FTE grew at a median of 7.2%. Compensation was higher in every one of the fourteen functional areas with staff, with Corporate Executive and Governance, Claim and Encounter Capture and Adjudication and Sales posting the largest increases.

Median Non-Labor Costs per FTE across all functions were approximately \$95,000. Among the continuous plans, Non-Labor Costs per FTE across all functions grew at a median of 10.5%. Eleven of the fourteen functional areas were higher, led by Provider Network Management and

Services, Enrollment / Membership / Billing and Sales, while Rating and Underwriting, Medical Management and Corporate Executive and Governance declined.

The propensity to outsource increased. Outsourced staff were a median of 14% of combined FTEs across all functions among all plans, and among the continuous plans, the outsourced share rose by a median of 0.9 percentage points. Claim and Encounter Capture and Adjudication and Corporate Executive and Governance had the largest increases, while Customer Services, Information Systems, Actuarial and Advertising and Promotion outsourced less.

Costs of Medicaid-Focused Plans, by Cluster, PMPM

Figure 4 shows the values of administrative expense clusters for all twelve participating Medicaid-focused plans, as opposed to the nine continuously participating plans in the prior discussion. This section touches on comparisons with the results published last year, notwithstanding limitations on comparability. The prior year's values are shown in Appendix A.

The comparability limitations are that this universe of Medicaid-focused plans differs from that of last year in composition and in product mix. Five plans that participated last year did not participate this year and three plans joined, so nine of the twelve are the same. For the new plans and the departing ones, we can know neither their trends nor their changes in product mix. Trends among the continuous plans, described above, are the better measure of change.

Median Total expenses were \$55.37 PMPM, 5.7% higher than the \$52.40 published last year, while the constant-mix increase among the continuous plans was 2.8%. Median Core expenses were \$47.40, 6.5% higher than last year's \$44.49, against a constant-mix increase of 5.6%.

Account and Membership Administration, the largest cluster, had a median of \$24.61 PMPM, 6.5% higher than last year's \$23.10, in line with its constant-mix growth of 6.8%. This cluster includes Information Systems, Enrollment, Claims and Customer Services. Medical and Provider Management was \$12.49 PMPM, 0.5% lower than last year's \$12.55, against a constant-mix decline of 0.3%. Corporate Services was \$7.80, 5.0% higher than last year's \$7.43, while it declined by 0.3% at constant mix. Sales and Marketing was \$8.78, 13.8% lower than last year's \$10.19, against a constant-mix decline of 1.8%. The differences between the two measures reflect the change in the composition of the universe.

The dispersion of Core expenses in 2025 was wider than in 2024. The Coefficient of Variation of Total expenses rose by four percentage points to 25%, and that of Core expenses by three points to 25%. Corporate Services widened by six points to 39% and Account and Membership Administration by four points to 30%, while Medical and Provider Management narrowed by two points to 28%. Sales and Marketing rose by two points to 46%.

Dispersion measured as the difference between the 75th and 25th percentiles widened for Total expenses, by \$4.46 to \$16.28, and for Core expenses, by \$4.06 to \$12.29. Medical and Provider Management and Corporate Services widened, while Account and Membership Administration and Sales and Marketing narrowed.

Figure 4

Medicaid Plans' Costs by Functional Area Cluster, 2025 Results*Median Per Member Per Month Expenses*

Clusters of Functions	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	\$10.67	\$12.49	\$14.58	28%
Account and Membership Administration	20.70	24.61	25.78	30%
Corporate Services	6.16	7.80	9.13	39%
Subtotal: Core Expenses	\$36.79	\$47.40	\$49.08	25%
Sales and Marketing	\$5.88	\$8.78	\$11.68	46%
Total Expenses	\$43.93	\$55.37	\$60.21	25%

Costs of Medicaid-Focused Plans, PMPM by Product

The importance of considering each product's costs in assessing a health plan's administrative expenses 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 this reason, when we report results to participants, we often reweight the universe product mix to eliminate the effect of any differences between a participant and its peers.

Figure 5 displays Total expenses by product, which include Sales and Marketing, except for the note at the foot of the figure, which pertains only to Medicaid Core expenses. Sales and Marketing activities are reflected in the Sherlock Benchmarks if they meet its definitions, regardless of whether the specific activities are of a type allowable by the states. For instance, Risk Adjustment expenses are included in the Medicaid product costs as Sales and Marketing in this figure but not as a Core cost.

Median Total expenses for Medicaid HMO were \$39.23 PMPM and \$31.44 for Medicaid CHIP. Compared with the medians published last year, Medicaid HMO was 2.2% lower and CHIP, offered by six plans, was 3.8% higher. For all twelve participating plans, the average membership mix of Medicaid products was 63% and the average revenue mix was 56%.

Shown in the note at the foot of the figure, Core expenses for Medicaid HMO and CHIP combined were \$37.21 PMPM, with Medicaid HMO at \$37.14 and CHIP at \$28.02. An estimate of the Sales and Marketing expenses associated with the product can be inferred as the difference between the note and the body of the figure, about \$1.90 PMPM for Medicaid as a whole.

Medicare, like Medicaid, is a government-sponsored product. Medicare products serve seniors as Medicaid serves low-income people, and the two overlap in Medicare Special Needs Plans, many of whose members are eligible for both programs. Medicare products are relatively high cost, at medians of \$245.40 PMPM for Medicare SNP and \$128.49 for Medicare Advantage, and were offered by ten of the twelve plans. The average membership mix of Medicare Advantage was 9% and of SNP 1%, while their average revenue mixes were 15% and 3%.

Medicare Supplement, at a median of \$37.83 PMPM, costs less than the median comprehensive product. We include it as a comprehensive product in the Sherlock Benchmarks though it pays only when Medicare does not. Three plans offered the product, and its average membership and revenue mixes were each about 1%.

Commercial administrative expenses are both higher and lower than the median comprehensive product, depending on the financing arrangement. Commercial Insured products, at a median of \$62.45 PMPM, are higher than the comprehensive median of \$55.37. The largest Commercial Insured product for this universe was HMO, at \$69.28 PMPM; POS cost \$78.92 and Indemnity and PPO \$87.56. Commercial ASO products, at \$32.37, cost about half as much as Commercial Insured. The ability of a group to self-insure is related to group size, and it is less expensive per member to serve larger groups: their Sales and Marketing costs are spread over greater numbers of members. Commercial products were an average of 26% of membership and 17% of revenues, and Commercial ASO alone 12% of membership. Median Commercial Total costs were \$47.13 PMPM.

Figure 5

Medicaid Plans' Costs by Product, 2025 Results*Per Member Per Month*

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid				
HMO	\$35.82	\$39.23	\$46.79	27%
CHIP	\$23.63	\$31.44	\$38.85	33%
Medicaid Total	\$35.04	\$39.11	\$46.33	28%
Medicare				
Advantage	\$120.90	\$128.49	\$164.44	26%
SNP	\$170.77	\$245.40	\$280.57	30%
Medicare Total	\$132.69	\$145.61	\$180.20	22%
Medicare Supplement	\$37.73	\$37.83	\$63.80	55%
Commercial Insured				
HMO	\$47.65	\$69.28	\$78.85	28%
POS	\$78.27	\$78.92	\$83.51	7%
Indemnity & PPO	\$60.61	\$87.56	\$113.36	41%
Commercial Insured Total	\$51.18	\$62.45	\$78.93	28%
Commercial ASO / ASC	\$29.69	\$32.37	\$34.03	10%
Commercial Total	\$43.40	\$47.13	\$54.06	18%
Comprehensive Total	\$43.93	\$55.37	\$60.21	25%
Note: Core Expenses of Medicaid				
HMO	\$31.45	\$37.14	\$42.72	30%
CHIP	\$19.66	\$28.02	\$35.79	39%
Medicaid Total	\$31.81	\$37.21	\$42.72	31%

Costs of Medicaid-Focused Plans, Percent of Premiums by Product

When analyzing administrative expenses as a percent of premiums, most of the differences between products that are evident in PMPM comparisons diminish. Per member administrative costs for any product are partly explained by the health care needs of the population served and by the costs to distribute the product, so expressing costs as a percent of premiums or equivalents reduces the effect of the differences in health care needs while much of the difference in distribution cost remains. The percent of premium ratios use premium equivalents for Commercial ASO products, which is not GAAP but enhances comparability between self-insured and insured products. At a median, administrative costs of comprehensive products were 8.1% of premiums.

Medicaid HMO, at 7.4% of premiums, and CHIP, at 8.9%, were on either side of the comprehensive median, while both were well below it on a PMPM basis. Sales and Marketing expenses tend to be far lower for these products, reflecting state policy.

Medicare SNP, the highest cost product on a PMPM basis, was 12.2% of premiums, and Medicare Advantage, nearly twice the PMPM cost of Commercial HMO, was 10.7% against Commercial HMO's 10.9%. Indemnity and PPO and POS products were 11.9% and 8.8%, respectively. While Medicare Supplement is below the comprehensive median when measured PMPM, at 14.9% its cost ratio was the highest of the products in this universe, reflecting its role as a secondary payer.

Administrative expenses of Commercial ASO products were 5.1% of premium equivalents, and Commercial Total was 8.1%. The lower Sales and Marketing costs of self-insured groups are the key reason for the difference.

Figure 6

Medicaid Plans' Costs by Product, 2025 Results

Percent of Premium Equivalents

Product	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medicaid				
HMO	6.2%	7.4%	8.7%	27%
CHIP	8.5%	8.9%	11.7%	26%
Medicaid Total	6.5%	7.5%	8.7%	26%
Medicare				
Advantage	9.6%	10.7%	13.1%	25%
SNP	7.8%	12.2%	15.0%	38%
Medicare Total	9.3%	11.2%	14.0%	24%
Medicare Supplement	11.6%	14.9%	25.7%	74%
Commercial Insured				
HMO	8.0%	10.9%	12.1%	29%
POS	7.6%	8.8%	10.9%	36%
Indemnity & PPO	9.7%	11.9%	13.6%	40%
Commercial Insured Total	8.8%	10.1%	12.0%	26%
Commercial ASO / ASC	4.7%	5.1%	6.0%	21%
Commercial Total	7.0%	8.1%	9.1%	22%
Comprehensive Total	6.7%	8.1%	9.5%	21%
Note: Core Expenses of Medicaid				
HMO	5.6%	6.7%	8.4%	30%
CHIP	7.4%	8.3%	10.1%	29%
Medicaid Total	5.8%	6.9%	8.4%	29%

Costs of Medicaid-Focused Plans, Expense Clusters as Percent of Premium

Figure 7 shows the ratios of administrative expenses to premiums or equivalents for the expense clusters. Core administrative expenses were 6.3% of premium equivalents at a median, 1.5 percentage points lower than last year's 7.8%, shown in Appendix B, as premiums and

premium equivalents per member grew at a median of 13.8% as reported while Core costs per member grew at a median of 2.6%.

The increase in premiums PMPM was widespread among the continuously participating plans. Medicaid HMO increased at a median rate of 16.1%, Medicare Advantage increased by 10.5%, and Commercial Insured and Commercial ASO increased by 5.7% and 33.0%, respectively. We have not explored the reasons for the increases, which can arise from factors such as responses to changes in the competitive environment or higher health care costs. The increase in Commercial ASO is a clear example of the latter. Higher health care costs resulting in higher premiums may also stem from a change in the typical health status of the served population. For instance, if healthier Medicaid beneficiaries leave the pool, the sicker beneficiaries are charged commensurate with their heightened intensity of health needs.

Account and Membership Administration was 3.5% of premiums, 0.7 percentage points lower than last year, and Medical and Provider Management was 1.7%, 0.5 points lower. Corporate Services, at 1.3%, was little changed. Sales and Marketing was 1.3%, 0.5 points lower. Total expenses, including Sales and Marketing, were 8.1% of premiums, 1.1 percentage points lower than the prior year.

Figure 7

Medicaid Plans' Costs by Functional Area Cluster, 2025 Results

Median Percent of Premium Equivalents

Clusters of Functions	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.6%	1.7%	2.5%	28%
Account and Membership Administration	3.0%	3.5%	4.3%	26%
Corporate Services	1.0%	1.3%	1.4%	39%
Subtotal: Core Expenses	5.7%	6.3%	8.2%	21%
Sales and Marketing	1.0%	1.3%	1.8%	44%
Total Expenses	6.7%	8.1%	9.5%	21%

Comparisons Across Universes

Health plans in other Sherlock Benchmarks universes also offer Medicaid HMO products. In this section we compare the results of Medicaid HMOs offered by Medicaid-focused plans with the same product offered by the Blue Cross Blue Shield plans and the Independent / Provider-Sponsored plans that are not in this universe. We define “focused” as having a disproportionate commitment to Medicaid: the median plan in this universe drew 59% of its members from Medicaid HMO. The three sets shown in Figure 8 are mutually exclusive, and together they serve 6.6 million Medicaid HMO members, 11% of the 57.8 million people the Census Bureau counted with Medicaid coverage in 2025.

Since the product and cost definitions are the same, it is possible to directly compare the universes. As shown in Figure 8, the Medicaid-focused plans’ Core costs for Medicaid HMO were \$37.14 PMPM at a median, \$3.88 higher than the Blue Cross Blue Shield plans’ \$33.26 and

\$0.57 lower than the Independent / Provider-Sponsored plans' \$37.71. On Total costs, which add Sales and Marketing, the Medicaid-focused plans' \$39.23 was \$1.04 higher than the Blues' \$38.19 and \$1.31 lower than the IPS plans' \$40.54.

Calculated on a percent of premium basis, the order reverses. The Blue Cross Blue Shield plans' Core Medicaid expenses of 9.1% of premiums were 2.4 percentage points higher than the Medicaid-focused plans' 6.7%, and their Total expenses of 10.4% were 3.0 points higher than the Medicaid-focused plans' 7.4%. The Independent / Provider-Sponsored plans' ratios were narrowly higher than those of the Medicaid-focused plans on both bases, by 0.4 and 0.2 percentage points. Expressed PMPM, the Medicaid-focused plans have costs between the other two universes; on a percent of premium basis, they have the lowest.

The Blues column reflects three plans and the IPS column four, since the other Blue Cross Blue Shield and Independent / Provider-Sponsored plans that offer Medicaid HMO are participants in this universe and are counted here only once.

Figure 8

Medicaid HMO Product Characteristics by Universe, 2025 Results*Medicaid Plans, Independent / Provider-Sponsored Plans and Blue Cross Blue Shield Plans*

	Medicaid Plans	IPS Plans	BCBS Plans	Combined Plans
Core Costs				
Per Member Per Month				
25th Percentile	\$31.45	\$33.43	\$29.71	\$31.60
Median	37.14	37.71	33.26	35.23
75th Percentile	42.72	47.41	34.28	41.96
Coefficient of Variation	30%	36%	15%	31%
Percent of Premiums and Equivalents				
25th Percentile	5.6%	6.7%	8.7%	6.0%
Median	6.7%	7.1%	9.1%	7.3%
75th Percentile	8.4%	7.7%	11.9%	9.0%
Coefficient of Variation	30%	19%	32%	32%
Total Costs				
Per Member Per Month				
25th Percentile	\$35.82	\$35.79	\$34.37	\$35.34
Median	39.23	40.54	38.19	38.19
75th Percentile	46.79	51.21	38.72	45.20
Coefficient of Variation	27%	37%	13%	28%
Percent of Premiums and Equivalents				
25th Percentile	6.2%	7.1%	9.8%	6.6%
Median	7.4%	7.6%	10.4%	7.7%
75th Percentile	8.7%	8.4%	13.8%	9.6%
Coefficient of Variation	27%	19%	35%	34%
Plans Offering Medicaid HMO	12	4	3	19
Medicaid HMO Members (millions)	4.99	0.50	1.07	6.56
Comprehensive Total Members (millions)	8.38	5.08	20.48	33.94

How We Performed This Analysis

This analysis is based on the twenty-fourth annual edition of our performance benchmarks for Medicaid-focused health plans. The Sherlock Benchmarks (Sherlock Expense Evaluation Report or SEER) represent the cumulative experience of more than 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 Medicaid-focused plans possessing the ability to compile high-quality, segmented financial and operational data. This analysis of Medicaid plans is based on a peer group of twelve plans that collectively served 8.4 million people in comprehensive products. Nine of this year's participants also participated in the prior year.

The average plan participating in the Medicaid-focused Sherlock Benchmarks this year served 698,000 people under comprehensive products and the median membership was 612,000. The geographic reach of this universe extended from coast to coast.

Medicaid HMO and CHIP combined for 5.2 million members and composed 62% of the combined comprehensive membership. The average Medicaid revenue and membership proportions were 56% and 63%, respectively.

Ten of the twelve plans served at least one Medicare product, Medicare Advantage or Medicare SNP. The average Medicare revenue and membership proportions were 18% and 10%, respectively, and there were about 963,000 Medicare members served by these plans.

Of all comprehensive members, 26%, or 2.2 million, were served through a commercial product. Approximately 887,000 were served under some form of self-insurance arrangement, 41% of the commercial total.

The panel of plans that participated in the Sherlock Benchmarks for Medicaid plans was formed in the spring of 2026. Survey materials were distributed to the participants in June and completed surveys were received back to us beginning in July. Sherlock Company performed a number of validation procedures with the active collaboration of the participating plans. Sherlock Company's compilation and report publication, including company-specific summaries, followed in September.

Reporting Conventions

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

- The trends reported in this analysis are median changes, and when we refer to PMPM or percent of premium ratios, these too are medians. This convention reduces the effect of outlying values on overall trends and values. Since each median value is calculated independently, the components cannot be summed.
- References to growth rates hold the universe constant in the comparison years unless otherwise noted. Rates of change identified as “as reported” are of health plans participating during both comparison years. When we refer to “constant mix” we are calculating rates of change for that same set of plans after reweighting each plan's product costs to eliminate the effect of product mix changes between the years.
- Percent of premium ratios are calculated on a premium-equivalent basis. That is, in the case of ASO arrangements, we synthesize premiums 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 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 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 in Navigator include administrative expenses associated with pharmacy and behavioral health while the Sherlock Benchmarks do not. Because of variation in contracting for these benefits and the propensity for their administration to be outsourced, the Benchmark reports carve them out. Tab 2 of Volume I of the 2026 Sherlock Benchmarks reconciles the two presentations.
- 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 29 health plans serving approximately 53 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, Emerging Plans, 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 Medicaid edition of the 2026 Sherlock Benchmarks. We earlier reported on the Blue Cross Blue Shield, Independent / Provider-Sponsored, Larger Plans, Emerging Plans and Medicare editions. Detailed health plan costs and operational drivers are available by licensing the Sherlock Benchmarks.

Tables of contents, report formats, citations, quality assurance and other information can be found at sherlockco.com/sherlock-benchmarks. The Sherlock Company website has an application that allows you to try out the Benchmarks free of charge at sherlockco.com/test-drive.

If you are interested in licensing these materials or have questions about them or about this Plan Management Navigator, we hope you will not hesitate to contact us at sherlock@sherlockco.com. You will be in good company.

Medicaid Plans' Costs by Functional Area Cluster, 2024 Results*Median Per Member Per Month Expenses*

Clusters of Functions	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	\$11.35	\$12.55	\$14.63	30%
Account and Membership Administration	20.07	23.10	26.31	26%
Corporate Services	6.51	7.43	8.95	33%
Subtotal: Core Expenses	\$38.80	\$44.49	\$47.03	22%
Sales and Marketing	\$6.04	\$10.19	\$13.17	44%
Total Expenses	\$47.47	\$52.40	\$59.29	21%

Appendix B

Medicaid Plans' Costs by Functional Area Cluster, 2024 Results*Median Percent of Premium Equivalents*

Clusters of Functions	25th Percentile	Median	75th Percentile	Coefficient of Variation
Medical and Provider Management	1.8%	2.2%	2.9%	31%
Account and Membership Administration	3.3%	4.2%	4.9%	25%
Corporate Services	1.0%	1.4%	1.7%	31%
Subtotal: Core Expenses	6.8%	7.8%	9.3%	22%
Sales and Marketing	1.2%	1.8%	2.1%	43%
Total Expenses	8.4%	9.2%	10.7%	20%

Major Functions Included in Each Administrative Expense Cluster

Core Functions:

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) Management Consulting
 - (c) Other Corporate Executive and Governance
16. Association Dues and License/Filing Fees

Non-Core Functions:

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