



Plan Management Navigator

Analytics for Health Plan Administration

Best-in-Class Independent / Provider - Sponsored Plans: Factors of Performance

Early November 2026

Conclusions on Tactical Expenses

This is a brief summary of our analysis of “Best-in-Class” Independent / Provider - Sponsored (IPS) plans compared with their IPS peers; the complete document was provided to our participants. Our analysis is based on the 2026 edition of the *Sherlock Benchmarks* reflecting year-ended 2025 financials. The *Sherlock Benchmarks* for Independent / Provider - Sponsored plans is this universe’s 24th annual edition. Best-in-Class plans are those with low costs.

Figure 1

IPS Best-in-Class Plans Summary

Sources of Tactical Variances, Mix-Adjusted

	Non-Labor Costs Per FTE	Staffing Costs + Per FTE	Total Costs = Per FTE	FTEs Per 10k × Members	= Costs PMPM
Best-in-Class Plans	\$109,660	\$106,692	\$216,352	14.92	\$26.89
Peer Plans	\$85,428	\$134,073	\$219,501	23.67	\$43.30
Dollar Variance	\$24,232	(\$27,381)	(\$3,149)	(8.76)	(\$16.41)
Percent Variance	28.4%	-20.4%	-1.4%	-37.0%	-37.9%
Percent of Total Variance	-23.7%	26.8%	3.1%	96.9%	100.0%
PMPM Dollar Variance	\$3.90	(\$4.40)	(\$0.51)	(\$15.90)	(\$16.41)

Note: Tactical expenses exclude Miscellaneous Business Taxes, the Sales and Marketing cluster and Medical Management expenses.

Best-in-Class Plans had Tactical expenses that were lower by \$16.41 PMPM, or lower by 38%. By “Tactical”, we mean all health plan administrative costs for comprehensive products excluding Miscellaneous Business Taxes, the Sales and Marketing cluster of expenses and the Medical Management function.

Their mean costs were \$26.89 compared to \$43.30 for the Peer Plans.¹ The Best-in-Class Staffing Ratio was mainly responsible for the lower costs, at 15 FTEs per 10,000 members, compared to Peer Plans at 24 FTEs per 10,000 members (Figure 1).

¹ Costs are standardized for member months (i.e., PMPM) even if not stated.

Best-in-Class plans' Staffing Costs per FTE were about \$107,000, lower than the Peer plans' Staffing Costs of \$134,000, or by 20%. Non-Labor Costs per FTE (e.g., those found in Information Systems and Facilities) were 28% *higher* for Best-in-Class plans at \$110,000 compared to \$85,000 for Peer plans.

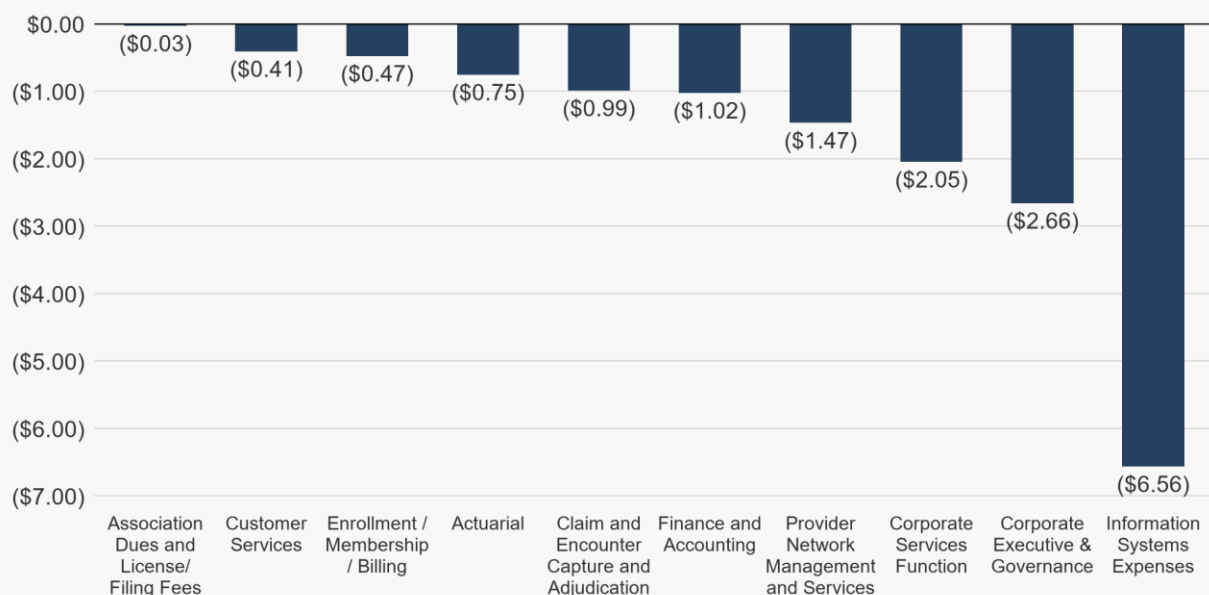
It appears that Best-in-Class plans operate in a culture of conservative administrative expenses since every cluster of Tactical expense was lower than its peers. Also, *every* Tactical functional area was lower than the Peer plans (Figure 2). Similar to previous years, the function contributing the most to superior performance was Information Systems.

Low Information Systems costs were responsible for 40% of the overall Tactical difference. Corporate Executive and Governance, the Corporate Services function, and Provider Network Management followed, contributing 16%, 12%, and 9%, respectively, to overall low tactical costs.

Figure 2

IPS Best-in-Class Plans Summary

Functional Area Components of Low Cost Variances From Mean, PMPM, Mix-Adjusted



Strategic Expenses were also Lower

For Strategic expenses, Best-in-Class plans had lower costs in both the Sales and Marketing cluster and the Medical Management function. Overall, Strategic costs were lower by \$4.65 PMPM.

The Sales and Marketing cluster of expenses was lower by 1% for Best-in-Class plans. Sales, lower by 39%, was the largest contributor to low Sales and Marketing cluster expenses, while External Broker Commissions was *higher* and was the largest offset to lower costs.

Lower costs for the Sales and Marketing cluster places in context that Best-in-Class plans lagged Peer plans in membership growth. Comprehensive membership for the Best-in-Class plans declined by a median rate of 0.7%, while Peer plans *grew* by a median of 3.0%. The average decline for Best-in-Class plans was 0.6%, while Peer plans grew by 4.8%. At the product mix of the Best-in-Class plans, the Peer plans' median membership growth fell to 1.2%, but their average growth was essentially unchanged at 4.7%.

Best-in-Class plans had Medical Management costs that were lower by 43%. All subfunctions of Medical Management were lower than those of the Peer plans except for Nurse Information Line.

Median gross profit margin for *insured* products was 7% for both Best-in-Class and Peer plans. Peer plans' median margin was 5% when reweighted at the mix of Best-in-Class plans. (Gross profit margins are premiums less health benefits divided by premiums.) Insured products are Commercial Insured, Medicare Supplement, Medicare and Medicaid.

Possible Extraneous Characteristics

We considered six characteristics of the sets of IPS plans that could contribute to improved performance in Best-in-Class versus Peer plans that are unrelated to cost management within management's control. These were the effects of scale, cost of living, outsourcing, product mix, exposure to the individual market, and strategic investments in Sales and Marketing and Medical Management.

Economies of Scale

Economies of scale may have played a role. The median membership size for Best-in-Class plans was 121% greater than the Peer plans.

However, based on preliminary results of Sherlock Company's 2026 Scale Study for IPS plans, only 22% of Tactical administrative expenses show a statistically significant relationship to scale. These subject-to-scale expenses have a BCG slope of 74%. That is, doubling the size of the enterprise would be expected to lead to expenses that are subject to scale falling to 74% of their pre-doubling value. Using these findings as a basis for a cost model, we estimate that if the size of a health plan operating at \$43.30 (Tactical PMPM costs for Peer plans) increased by the amount required to match the size of the Best-in-Class plans, costs would have been expected to be lower by about \$2.48 PMPM, or 15% of the measured difference between the two sets of plans.

Cost of Living

Local costs of living differences may have conferred an advantage on the Best-in-Class plans: the mean wage index for Best-in-Class plans was 15% lower compared to its Peer plans, and the median was 17% lower. (We employ the Hospital Wage Index used by CMS).

Outsourcing Differences

Outsourcing is unlikely to have had a meaningful effect on comparisons. In general, Best-in-Class plans had slightly higher average and median outsourcing of Tactical activities than Peer plans. However, the Information Systems function was outsourced at about the same mean rate for both sets of plans, 18%, while the median rate was much lower for the Best-in-Class plans, at 1% compared to 17%. Note that outsourcing may include services supplied by parent health systems.

Product Mix Differences

Our values were adjusted so that product mix did not impact comparisons: product mix was adjusted to eliminate its effect. We describe this method in the next section of this *Navigator*.

Exposure to Individual Market

We believe exposure to the Individual market segment has little impact on the relative performance of the two groups of IPS plans, since Best-in-Class plans appear to have about the same exposure to the Individual market segment as Peer plans. Individual members averaged 37% of Commercial Insured membership for both sets of plans.

Strategic Investments

The strategic investments (Sales and Marketing and Medical Management) could not have affected Tactical comparisons because they were excluded. We touched upon their results earlier.

How We Performed this Analysis

First, we separated Tactical from Strategic expenses in each plan. “Tactical” costs are costs of Comprehensive products other than those in the Sales and Marketing cluster and Medical Management function, which we refer to as “Strategic.” In making Strategic costs less of a focus of this analysis, we are recognizing that they have impacts outside of current period administrative costs. They may have costs most readily associated with longer-term objectives such as increasing membership and market share and reducing health care costs.

We then ranked the plans to identify those whose expenses are Best-in-Class. We define “Best-in-Class” plans as those whose Tactical costs are in the lowest 25th percentile. Plans not in the Best-in-Class subset are referred to as “Peer” plans. To do this, we eliminate the potentially distorting effect of product mix differences on the cost comparisons. Since function costs are reported by product by the plans, we compared each plan against its universe by reweighting the product costs in each function of the IPS universe to match the mix of each plan. Plans were then ranked by the differences between their expenses and each of their re-weighted IPS universe costs. We selected the lowest cost IPS Plans as the 25% with the most favorable cost comparisons.

Because each of the plans included in the dataset and in each of the subsets differ in product mix, we employed a composite approach to summarize the characteristics of each subset. To compare the two sets, we used the Best-in-Class product mix weighting.

After that reweighting, we then isolated and measured the specific contributing functional cost differences to overall Tactical performance. In this way, we identified differences in total, by cluster and by function.

Since Total Costs per FTE and PMPM costs together imply a mix-adjusted staffing ratio, we were also able to infer the effect of differences in staffing ratios on costs. Outsourced FTEs were included and were inferred from payments to outsourcers. The subset staffing ratios were drawn from the Best-in-Class and Peer plans respectively, and each subset reflects the same reweighting of plan values, using the same process as costs as described in the previous paragraph.

Our approach may enable health plans to identify areas where their performance can emulate those of Best-in-Class. Notwithstanding our referring to low-cost plans as Best-in-Class, we recognize that a health plan's long-term objective is cost levels that are *optimal* for its corporate objectives. The implication of this notion of performance is that high-cost functions would demonstrate the value of their higher costs through other objective metrics of superior performance. Put a different way, the differences between a plan's costs and those of its Best-in-Class peers, if intended to achieve the plan's corporate goals, represents a form of investment upon which an ROI should be expected.

Contact

This look at the characteristics of Best-in-Class plans has the virtue of being mutually exclusive and collectively exhaustive. Because we have polled the plans to develop this analysis, the data is subject to controls for quality and comparability. While the results are relatively objective and strongly emphasize the quantitative, the process is complex. We hope that you feel free to address any questions to:

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Invitation to the 2027 Sherlock Benchmarking Study

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 53 million Americans and provide costs and their drivers on key administrative activities. The Benchmarks are reported in multiple universes of health plans: Larger Plans, Blue Cross Blue Shield, Independent / Provider-Sponsored, 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.

The 2027 study will mark the 30th consecutive year of the *Sherlock Benchmarks*, reflecting a cumulative experience of nearly 1,100 health plan years.

Since June 2023, the *Sherlock Benchmarks* have been used by health plans serving, without duplication, 200 million insured Americans. Twelve U.S.-based Blue Cross Blue Shield primary licensees, serving approximately 41.2 million people, participate in this year’s Sherlock Benchmarking Study for Blue Cross Blue Shield Plans. Together, these Plans serve 58% of all Blue Cross Blue Shield Plan members not served by publicly-traded Plans.

Participation is similarly broad among the Independent / Provider – Sponsored universe. Health plans serving 53% of the members served by the Alliance of Community Health Plans (excluding ACHP’s staff model plans) participate in 2026’s *Sherlock Benchmarks*, as do health plans serving 58% of the members served by the Health Plan Alliance.

Report publication is expected to begin in late June 2027, with timing varying by universe. Because actionable outputs require relatively granular inputs, participation does call for some effort on the part of plans. The cost, however, is relatively modest.

The *Sherlock Benchmarks* are also available to license. Please reach out to Douglas Sherlock at sherlock@sherlockco.com or 215-628-2289 if you are interested in either participation or licensing. *You will be among good company.*