Plan Management Navigator
Analytics for Health Plan Administration

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Please see page 6 for our invitation to participate in the 2026 Sherlock Benchmarks.

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

Conclusions on Tactical Expenses

This is a very 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 2025 edition of the *Sherlock Benchmarks* reflecting year-ended 2024 financials. The *Sherlock Benchmarks* for Independent / Provider - Sponsored plans is this universe's 23rd annual edition.

Best-in-Class Plans had Tactical expenses that were lower by $9.56 PMPM, or lower by 30%. 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 $22.75 compared to $32.31 for the Peer Plans. The Best-in-Class Staffing Ratio was mainly responsible for the lower costs, at 14 FTEs per 10,000 members, compared to Peer Plans at 18 FTEs per 10,000 members. (Figure 1)

Best-in-Class plans' Staffing Costs per FTE were about $101,000, lower than the Peer plans' Staffing Costs of $122,000, or by 17%. Non-Labor Costs per FTE (e.g., those found in Information Systems and Facilities) were 10% lower for Best-in-Class plans at $89,000 compared to $99,000 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.

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	x	FTEs Per 10k Members	=	Costs PMPM
Best-in-Class Plans	*$88,501*		*$101,313*		*$189,814*		*14.38*		*$22.75*
Peer Plans	$98,669		$122,423		$221,092		17.54		$32.31
Dollar Variance	($10,168)		($21,110)		($31,278)		(3.15)		($9.56)
Percent Variance	-10.3%		-17.2%		-14.1%		-18.0%		-29.6%
Percent of Total Variance	14.1%		29.4%		43.5%		56.5%		100.0%
PMPM Dollar Variance	($1.35)		($2.81)		($4.16)		($5.40)		($9.56)

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

Low Information Systems costs were responsible for about a third of the overall Tactical difference. The Corporate Services function and Provider Network Management followed, contributing 16% and 14%, respectively, to overall low tactical costs.

Strategic Expenses were also Generally Lower

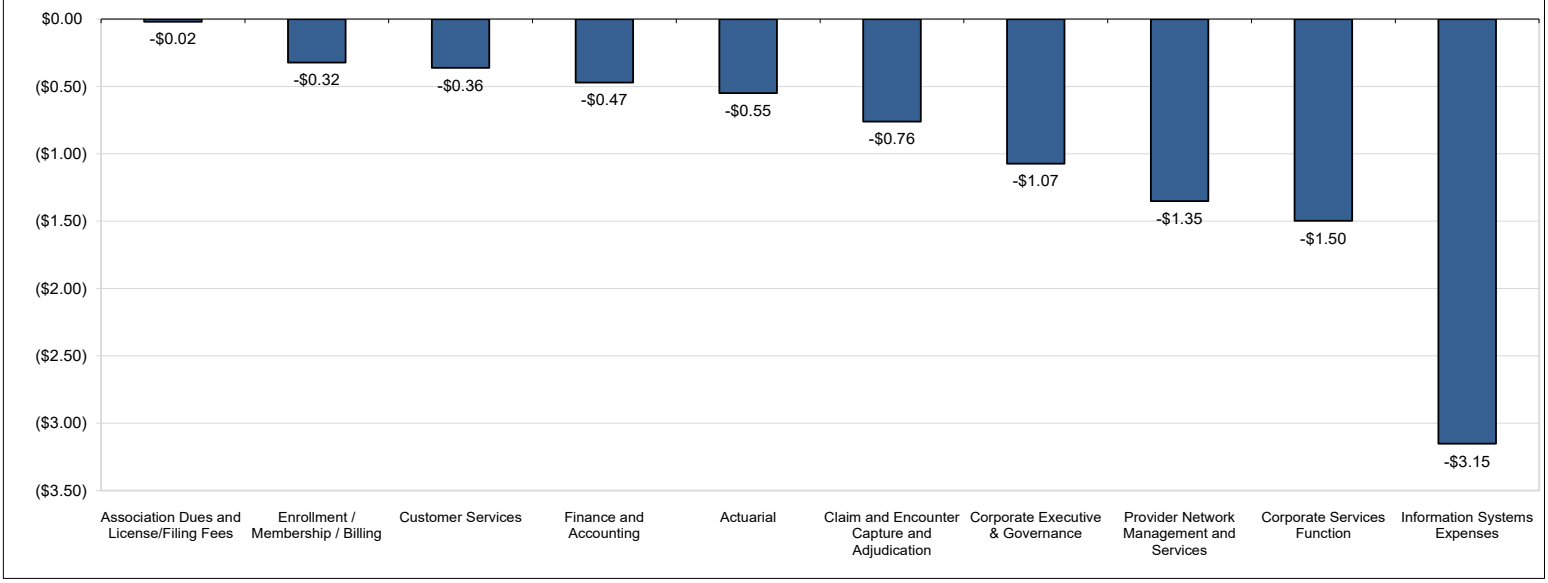
For Strategic expenses, Best-in-Class plans had *higher* costs in the Sales and Marketing cluster, but lower Medical Management expenses. Overall, Strategic costs were lower by $2.06.

The Sales and Marketing cluster of expenses was *higher* by 7% for Best-in-Class plans. External Broker Commissions was entirely responsible for high Sales and Marketing cluster expenses.

Higher costs for the Sales and Marketing cluster may have slowed the decline in membership for Best-in-Class plans. Comprehensive membership for the Best-in-Class plans declined by a median rate of 2.0%, slower than the median decline of 3.2% for Peer plans. The average decline for Best-in-Class plans was 0.9%, while Peer plans declined by 2.8%. However, at the product-mix of the Best-in-Class plans, the Peer plans' median membership fell by 3.2%. But, at the Best-in-Class mix, Peer membership *grew* on average by 4.1%.

Best-in-Class plans had Medical Management costs that were lower by 40%. All sub-functions of Medical Management were lower than the Peer plans except for Disease Management and Utilization review.

Figure 2. IPS Best-in-Class Plans Summary
Functional Area Components of Low Cost Variances From Mean, PMPM, Mix-Adjusted



Median gross profit margin for *insured* products was 12% for Best-in-Class plans and 6% for Peer plans. (Gross profit margins are premiums less health benefits divided by premiums.) Insured products are Commercial Insured, Medicare Supplement, Medicare and Medicaid. Peer plans' margins were at 6% when reweighted at the mix of Best-in-Class plans.

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. 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 88% greater than the Peer plans.

However, based on results of Sherlock Company's 2025 Scale Study for IPS plans, only 53% of Tactical administrative expenses are subject to economies of scale. These subject-to-scale expenses have a BCG slope of 83%. Using these findings as a basis for a cost model, we estimate that if the size of a health plan operating at $32.31 (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 $2.69 PMPM, or 28% of the measured difference between the two sets of plans.

Cost of Living

Local costs of living differences were unlikely to have conferred an advantage on the Best-in-Class plans: the mean wage index for Best-in-Class plans was 9% lower compared to its Peer plans, while the medians between the two groups were equal. (We employ the Hospital Wage Index used by CMS).

Outsourcing Differences

Outsourcing may have contributed to favorable comparisons. In general, Best-in-Class plans had higher average and median outsourcing than Peer plans. The Information Systems function was outsourced at a mean and median rates of 12 percentage points and 4 percentage points higher for the Best-in-Class plans, respectively. 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 the greater exposure to the higher cost Individual market segment has little impact on the relative performance of the two groups of IPS plans. Moreover, the cost difference between the segments appears to be modest. Notably, Best-in-Class plans appear to have *greater* exposure to the Individual market segment.

STRATEGIC INVESTMENTS

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

How We Performed this Analysis

First, we separated Tactical from Strategic expenses in each Plans. "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 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 measure 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 2026 Sherlock Benchmarking Study

The *Sherlock Benchmarks* are the "gold standard" of health plan administrative benchmarks. The *Sherlock Benchmarks* is a unique window for health plans to gauge with accuracy and granularity whether their administrative costs are competitive with their peers. With the Benchmarks, plans can measure their costs relative to others that are similar in business model, product focus and business mix. They can prioritize the functions that contribute to those differences, and identify cost factors such as staffing ratios, compensation levels and non-labor costs that affect those functions.

The 2026 study will be the 29th consecutive year, reflecting a cumulative experience of over 1,000 health plan years. Since June 2023, without duplication, the *Sherlock Benchmarks* have been used by health plans serving 198 million medical members.

Since June 2023, without duplication, 20 Blue Cross Blue Shield plans serving 56 million people participated in the Benchmarks. In addition, others that licensed but did not participate. At least 69% of all primary licensees are recent users or participants in the Benchmarks.

Also, 19 Independent / Provider - Sponsored plans serving 13 million people participated in the *Sherlock Benchmarks* over that period. At least 14 of the more than 40 Health Plan Alliance members either participated in or licensed the Benchmarks. Similarly, at least 12 of the 30 member plans of the Alliance of the Community Health Plans are users of the *Sherlock Benchmarks* though license or participation since June of 2023. The use cited here does not include editions licensed by consulting firms in service to specific health plans whose identities were not disclosed to us.

For the most recent cycle of the *Sherlock Benchmarks*, are based on validated surveys of 32 health plans serving 59 million Americans.

Report publication is anticipated to begin in late June 2026 but varies by universe. Participation entails efforts on the part of the plans since actionable outputs require relatively granular inputs. However, the cost 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.*