Plan Management Navigator
Analytics for Health Plan Administration

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Please see page 5 for our invitation to participate in the 2025 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 2024 edition of the *Sherlock Benchmarks* reflecting year-ended 2023 financials. The *Sherlock Benchmarks* for Independent / Provider - Sponsored plans is this universe's 22nd annual edition.

Best-in-Class Plans had Tactical expenses that were lower by $12.10 PMPM, or lower by 36%. Their mean costs were $21.55 compared to $33.65 for the Peer Plans[1]. 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 21 FTEs per 10,000 members. (Figure 1)

Best-in-Class plans' Staffing Costs per FTE were $97,000, lower than the Peer plans' Staffing Costs of $111,000, or by 13%. Non-Labor Costs per FTE (e.g., those found in Information Systems and Facilities) were 9% *higher* for Best-in-Class plans at $90,000 compared to $82,000 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 about 35% of the overall Tactical difference. The Provider Network Management and Corporate Executive and Governance functions followed, together contributing 29% of the low Tactical difference.

Figure 1. Independent / Provider - Sponsored Best-in-Class Plans
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	*$89,787*		*$96,681*		*$186,468*		*13.87*		*$21.55*
Peer Plans	$82,319		$110,633		$192,952		20.93		$33.65
Dollar Variance	$7,468		($13,953)		($6,484)		(7.06)		($12.10)
Percent Variance	9.1%		-12.6%		-3.4%		-33.7%		-36.0%
Percent of Total Variance	-9.0%		16.7%		7.8%		92.2%		100.0%
PMPM Dollar Variance	$1.08		($2.02)		($0.94)		($11.16)		($12.10)

**Tactical expenses exclude Misc. Business Taxes, Sales and Marketing cluster and Medical Management expenses.*

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

Strategic Expenses were also Generally Lower

Best-in-Class plans also had lower costs in the Strategic areas of the Sales and Marketing cluster and the Medical Management function.

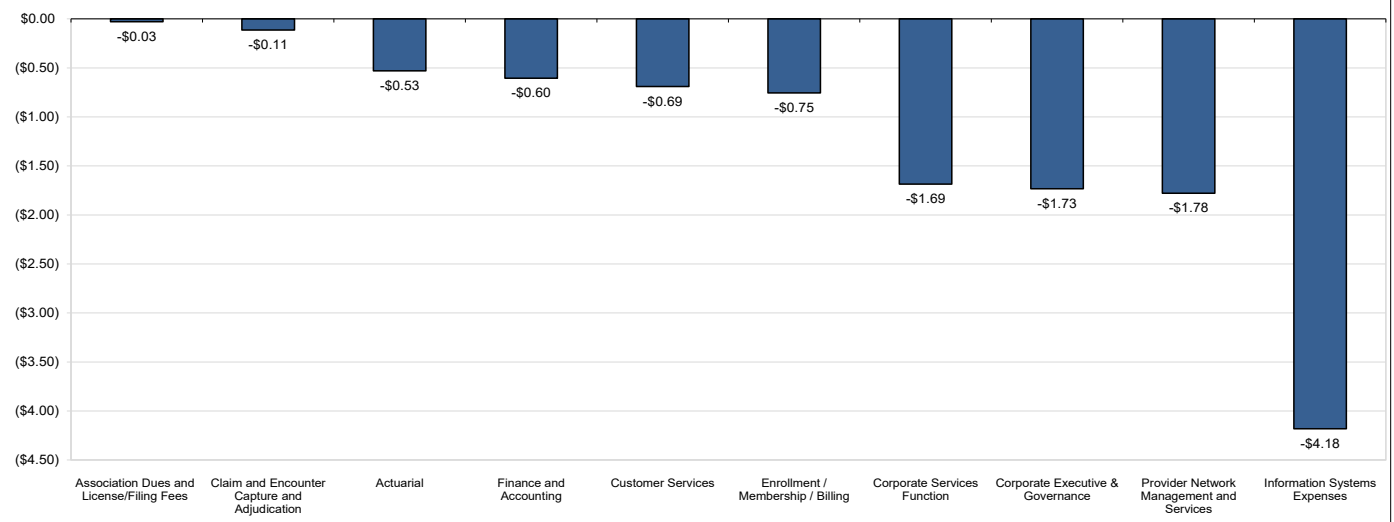
The Sales and Marketing cluster of expenses was lower by 17% for Best-in-Class plans. All functional areas within this cluster were lower for Best-in-Class plans except for External Broker Commissions.

Lower Sales and Marketing costs corresponded with lower membership growth. Comprehensive membership for the Best-in-Class plans increased by a median rate of 4.2%, Peer plans' had a greater increase of 5.3%. Similarly, the average increase for Best-in-Class plans was 4.5%, while Peer plans increased 5.3%. The difference was more nuanced at the product-mix of the Best-in-Class plans. The Peer plans' median growth was 2.5% while the mean growth was 9.9%.

Best-in-Class plans had Medical Management costs that were lower by 53%. All Medical Management sub-functions were lower for Best-in-Class plans.

Median gross profit margin for insured products was 10% for the Best-in-Class plans, compared with 9% for Peer plans. (Insured products are Commercial Insured, Medicare Supplement, Medicare, and Medicaid. Gross profit margins are premiums less health benefits, all divided by premiums). Peer plans' margins were at 10% when reweighted at the mix of Best-in-Class plans. Looking at mean values both sets of plans had gross profit margins of 9%. When reweighted, the mean Peer plans' margin was slightly lower than Best-in-Class plans at 8%.

Figure 2. Independent / Provider - Sponsored Best-in-Class Plans
Functional Area Components of Low Cost Variances From Mean, PMPM, Mix-Adjusted



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

Based on the results of Sherlock Company's 2024 Scale Study, only 0.6% of Independent / Provider - Sponsored plans Tactical administrative expenses were subject to scale. The median size of the Best-in-Class plans was 79% larger than that of the Peer plans. Using the marginal scale approach described in the November 2024 *Plan Management Navigator*, adjusting the Peer plans to match the size of the Best-in-Class plans was modeled to reduce their PMPM advantage by $0.11 PMPM.

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 4% lower compared to its Peer plans, while the median was higher by 4%. (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 18 percentage points and 31 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 could not impact comparisons: product mix was adjusted to eliminate its effect. We describe this method in the next section of of this *Navigator*.

EXPOSURE TO INDIVIDUAL MARKET

We think this difference in exposure to the higher cost Individual market segment likely has little effect on the relative performance of the two groups of IPS plans. Best-in-Class plans appear to have slightly more 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 it. We touch upon them separately.

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 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 isolate 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 Peer 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 a broader notion of performance is that high-cost functions might 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 Participate in the 2025 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 2025 study will be the 28th consecutive year, reflecting a cumulative experience of over 1,000 health plan years. Health plans serving at least 145 million Americans are either licensees or participants in the *Sherlock Benchmarks* from June 2022. Participating plans have included most Blue Cross Blue Shield plans, large public companies, Independent / Provider-Sponsored health plans, Medicare plans and Medicaid plans.

For the most recent cycle of the *Sherlock Benchmarks*, of the 33 U.S.-based Blue Cross Blue Shield primary licensees, fourteen plans serving approximately 41.3 million people, participated in the *Sherlock Benchmarks* for Blue Cross Blue Shield Plans.

For the universe of Independent / Provider – Sponsored Plans, twelve plans serving 9.9 million people participated in the most recent cycle. Participants in this year's *Sherlock Benchmarks* serve about 41% of all members in the Health Plan Alliance and 59% of members served by Alliance of Community Health Plans.

Report publication normally begins in late June 2025 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.*