



Monday Memo Issue Brief

Administrative costs in health plans: A systematic review of current studies

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ABSTRACT

Objective: To determine if suitable methodologies/frameworks exist to quantify and compare public and private insurance plans' administrative costs.

Methodology: Systematic review of all peer reviewed and industry studies that include explicit description of functions/activities included in health plan administrative costs for purposes of quantifying costs

Findings: Seven studies were reviewed that calculated administrative costs across public and private health plans. Functions included in administrative costs in each study varied widely; a common definition from a trade association or professional society was not commonly referenced or accessible to the industry. As a result, administrative costs for private/commercial plans were calculated at between 9 and 41 percent, expressed as either percentage of claims or premiums or other metrics, and calculated at 9 percent of premiums for Medicare, though each study applied different administrative costs in each case.

Conclusions: There appears to be no consistent definition of administrative costs among health plans as activities/functions vary widely from plan to plan, especially when comparing commercial, Medicare and Medicaid plans, and distinctions between individual and

group markets. Medicare plans have unique administrative costs and serve an individual market characterized by heavy utilization and higher premiums. Notably, marketing costs and certain fixed costs are less since they are subsidized/underwritten through CMS. By contrast, Medicaid is a joint federal-state program with a substantially unique enrollee population (incidence of disease, health status, literacy) and distinct delivery system distinctions combining public health services and traditional providers. Commercial plans serving group and individual markets represents a third category with wide variability in operating models, benefits design, and other administrative functions aligned with their portfolio of member services. Medicare and Medicaid are primarily publicly funded with modest participation by individual enrollees; commercial plans are privately funded through enrollee premiums and employer contributions, and are regulated by states. As a result, a single measure of administrative cost efficiency (ACE) would require measurement of costs per adjusted premium dollar (APD) inclusive of factors that adjust for differences between plan type, benefits offerings and other factors.

Implications: Additional research is needed to facilitate valid and reliable comparisons of health plan administrative costs and underlying drivers. While transparency and comparison of health plan administrative costs is worthwhile, a

common definition and framework inclusive of all relevant administrative activities is the necessary foundation on which evaluative comparisons may be drawn.

INTRODUCTION

An important topic in health reform is the administrative costs of health insurance plans-- whether through a public option, health exchanges, or commercial offerings. Comparing costs associated with payments to providers, enrollee services, marketing, quality measurement, medical management, regulatory compliance and other administrative costs across plans of varied enrollment, geography, ownership and programmatic scope is the focus of this analysis.

The administrative costs of Medicare are reported by CMS as below 4 percent (Centers for Medicare and Medicaid Services 2008) which is considered low when compared to the administrative costs of private insurance which, through multiple studies, has been estimated at between 9 and 41 percent*. However, the methodologies and source data between government reporting and other studies vary widely, especially when specific functions and costs are included in calculating costs by type, enrollment and ownership of plan. Further, the various reports and studies express costs as different metrics and the practice of measuring administrative cost as a percentage of premium is often less informative than measuring the actual administrative dollars spent per enrollee.

Reducing administrative costs of health insurance is an important focus for health reform as is the transparency of health plan comparative performance in containing these costs. However, given the variability of current data, it seems premature to advance an arbitrary administrative cost threshold as a basis for designating a plan's efficiency given the paucity of data upon which an appropriate administrative cost goal should be based.

METHODOLOGY

A systematic review of trade and peer reviewed studies of health plan administrative costs was conducted through PubMed; Federal and State sources such as the General Accounting Organization (GAO), the Centers for Medicare and Medicaid Services (CMS), and the Congressional Budget Office (CBO); trade organizations such as America's Health Insurance Plans (AHIP), the American Medical Association (AMA), the Council for Affordable Health Insurance (CAHI), and the Blue Cross Blue Shield Association of America (BCBSA); consulting firm research such as McKinsey and Company, IBM, and Accenture; as well as nonprofit policy organizations such as the Kaiser Family Foundation (KFF) and the Commonwealth Fund (CWF). Studies were limited to U.S. health plans and were published between 2003 and 2009.

Only studies that provided specific reference to activities and functions included in administrative cost calculations were included. Commentaries about administrative costs that did not provide primary data sources were excluded*. Based on these inclusion criteria seven studies were reviewed:

- Three from trade associations/consulting organizations
- Two from peer reviewed publications
- One from a non-profit private foundation
- One from the U.S. General Accounting Office

These studies are summarized in Table 1.

* In several cases, the source data for these studies was the National Health Expenditure (Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census 2008) which conducts a survey of the net cost of private insurance by calculating the difference between premiums earned and benefits incurred.

* See Table 1.

Table 1: Summary of studies that examine administrative costs of private and public health plans

| Study | Methodology, data source, and results | Possible limitations |
|--|--|---|
| <i>Administrative Expenses of Health Plans</i> (Sherlock, Douglas of the Sherlock Company 2009) | <ul style="list-style-type: none"> Based on self reported data from 36 health plans, and NAIC administrative costs definition Calculated administrative costs as 9.18 percent (aggregate), 11.2 percent for small group, and 16.35 percent of individual market. Additional findings: <ul style="list-style-type: none"> Medicare is fee-for service therefore performs a limited number of administrative functions relative to private insurance plans Based on a PMPM basis, private insurance plans administrative costs are lower than Medicare | <ul style="list-style-type: none"> Though the study did not provide a list of plans participating, the methodology appears solid for comparing to the degree possible administrative cost distinctions across multiple plans. A major insight in its analytic is the relative costs range of administrative costs dependent on whether a plan's predominant enrollment is individual/group. |
| <i>The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way</i> (The Lewin Group 2009) | <ul style="list-style-type: none"> Based on the report "Insurance Company Administrative Expense Breakdown for Conventional Funding" Congressional Research Service 1990. (Hay Huggins Research 1988) to project to current costs broken down by type of product Concluded that administrative costs of individual market plans are 40.9 percent for small groups and 21.8 percent for large groups | <ul style="list-style-type: none"> Analysis is based on 1988 data which may have limited comparability to current situation |
| <i>Medicare Advantage Organizations: Actual Expenses and Profits Compared to Projections for 2005</i> (The General Accounting Office 2008) | <ul style="list-style-type: none"> Based on 120 MA contracts representing 78 percent of enrollment and ~3.9 M members reporting Medical and Non-Medical Expenditures and profits Calculated Medicare Advantage private plans administrative costs at 9.2 percent of revenue | <ul style="list-style-type: none"> Includes only Medicare Advantage (Part C) plans, not applicable to commercial non Part C plans.; represents a blending of Part C Fee for Service and Managed Care programs |
| <i>Accounting for the costs of health care in the United States</i> , McKinsey Global Institute, 2007 (McKinsey Global Institute 2007) | <ul style="list-style-type: none"> Based on an index ESAW (Estimated Spending According to Wealth) across:1) Hospital care 2) Outpatient care 3) Drugs 4) Administration and insurance 5) Public investment 6) Long term care 7) DME Calculated that insurance administrative costs represented 21 percent of total US expenditures | <ul style="list-style-type: none"> Derived metric, ESAW, is related to the nationwide costs and may not be easily used to evaluate health plan costs administrative costs Source is aggregated data from the NHE, CMS, OECD as well as other unspecified sources |
| <i>Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector</i> (Milliman Consulting for the Council on Affordable Health Insurance 2006) | <ul style="list-style-type: none"> Based on NHE and proprietary Milliman data Calculated private insurance plans' administrative costs at 16.7 percent of claims plus expenses Additional findings: <ul style="list-style-type: none"> Medicare has a higher inherent cost per beneficiary Medicare administrative costs do not reflect the cost of borrowing (in deficit spending situations) and as a result are closer to 5.2 percent | <ul style="list-style-type: none"> Milliman analytics include fixed and direct costs of administration blended for private plan enrollments inclusive of Medicare, Medicaid and commercial enrollees. |
| <i>The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals</i> (Kahn, et al. 2005) | <ul style="list-style-type: none"> Based on Milliman data for 73 insurers for 129 insurance plans (63 commercial, 43 Medicare, and 23 Medicaid) in California Broke out administrative costs into 13 functions as per Milliman data Estimated private insurance administrative costs at 9.9 percent of premiums | <ul style="list-style-type: none"> Data applicability to other regions is problematic as rates in CA are below national averages, the population is younger and provider networks are more tightly integrated (i.e. Kaiser, Palo Alto Medical Group, First Physicians, et al) |
| <i>Costs of Health Care Administration in the United States and Canada</i> (Woolhandler, Campbell and Himmelstein 2003) | <ul style="list-style-type: none"> Based on CMS data and Canadian National Health data estimated the administrative costs related to: health insurance, employers' health benefit programs, hospitals, practitioners' offices, nursing homes, and home care agencies Calculated that private insurance administrative costs were 11.1 percent of premiums | <ul style="list-style-type: none"> Based on aggregate data from CMS, the conclusions are applicable to public expenditures for covered enrollees in public programs such as Medicare, Medicaid; not applicable to private plans. |

FINDINGS

The range of methodologies and activities included in defining and quantifying administrative costs in health plans for public and private plans varies widely. A range of 9 to 41 percent in the literature reflects wide variation in methodologies and inclusion criteria for administrative costs captured in the seven studies. Comparisons of commercial plans to Medicare administrative costs are not readily available due to methodological limitations: the data to fully capture administrative costs for Medicare are not accessible, and a methodology to accommodate government subsidization of these costs not developed to date. As a result, there appears to be no threshold upon which an administrative cost “best practice” might be reasonably set given data limitations.

IMPLICATIONS

A credible threshold for a plan’s administrative costs cannot be set based on the paucity of research, the lack of a consistent definition of administrative costs, and methodology for capturing and normalizing data across the myriad of variables that would necessarily need consideration. To facilitate objective comparison of administrative costs between plans, two sets of variables would be useful to a model: characteristics of the plan’s scope of operation and characteristics of the plan’s operating model:

Variables about the Health Plan’s Scope of Operation

- S1—Market profile: Individual, group, government (military, Medicaid, Medicare D)
- S2—Enrollee characteristics: Size, health status (prevalence, incidence of disease, geography)
- S3—Benefits and services offered: FFS, PPO, POS, HRA, HSA
- S4—Medical Management programs: Health coaching, self-care services, credentialing, provider profiling, outcomes reporting
- S5—Geography scope: National, regional, local
- S6—Provider network structures: Integrated systems, small groups, national contracts
- S7—Regulatory environment: National, state

Variables about the Plan’s Operating Model

- O1—Technology- enabled automation: claims adjudication, call center/customer service, outcomes reporting, root cause analysis, fraud detection, administrative dashboard, quality surveillance, provider contracting, purchasing, enrollees satisfaction, complaints management, etc.
- O2—Functional integration: medical management, coverage-denial management, credentialing
- O3—Capital access and deployment: Source of capital, treasury, internal audit, budgeting, cash management, solvency & liquidity
- O4—In-sourcing vs. outsourcing: call center, medical management, long-term care, case management, etc.
- O5—Governance, Ownership: Fixed costs allocations to corporate/regional office vs. local plans, boards, advisory committees, etc.

The industry should work with the government to create a standard methodology for accurately and appropriately comparing health plan administrative costs for the purpose of informing public policy and equipping consumers, providers and employers for purposes of comparison.

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