

Administrative Costs: Introduction

HIAC Meeting Discussion, April 21, 2009

Since the vast majority of health care costs (at least 80% in RI) are medical expenses, and medical expenditure is commonly cited as the primary driver of growing health care expenses, it should not be surprising that the primary focus of the HIAC in this affordability project has been on strategies to control medical expenditure.

However, the rate review process must also consider the following remaining elements:

- Administrative Costs
- Profit/Contribution to Reserves
- Reserve Levels

OHIC commissioned a study, performed by The Lewin Group, to assess the reserve levels for United and BCBSRI and establish appropriate, carrier-specific targets, the results of which were reported to this group previously. These standards will be used as guidance for the annual rate review process. OHIC will work with Massachusetts DOI to do a similar study for Tufts.

While Rhode Island carriers' administrative costs are reviewed regularly by OHIC/DBR staff, no specific study has been done to determine appropriate administrative cost standards to be used in the rate review process. A quick exploratory assessment of the work required for such a study has demonstrated that this type of study would require significant outside expert/actuarial assistance (and a longer timeline).

Given the current time and budgetary constraints (standards are needed to support the carriers' rate submissions by the end of April), OHIC is considering a narrower approach to the question of administrative costs, focusing specifically on the trend of administrative costs, rather than digging into the detailed administrative baseline cost structures of each carrier. As such, we ask that the Council consider the following questions:

1. **Should the rate factor review process establish standards for administrative cost inflation rate(s)?**
2. **If so, what guidance can the HIAC provide toward such a standard?**

Should administrative costs be allowed to trend consistently with medical trend? Should a lower standard be established – for example, tied to general inflation or wage trends? Or should the rate review process remain silent on admin costs, thereby allowing market competition to prevail?

The HIAC will consider this question at the April meeting. The discussion will begin with brief presentations from each carrier, explaining their administrative cost trends over the past several years, and any suggested standards for HIAC to consider.

Four articles provide a helpful background for this discussion – and are summarized on the following two pages. The Commonwealth Fund article and the Minnesota example articulate an argument for more careful attention and oversight of administrative costs, while the Milliman and Price Waterhouse articles provide a different interpretation of administrative trends and presents them as reasonable, and well below premium trend. Given the tight timeline, we request that you review the attached materials, and any advance materials sent by the carriers, and come to the next meeting prepared with questions and suggestions.

1. Commonwealth Fund, January 2007

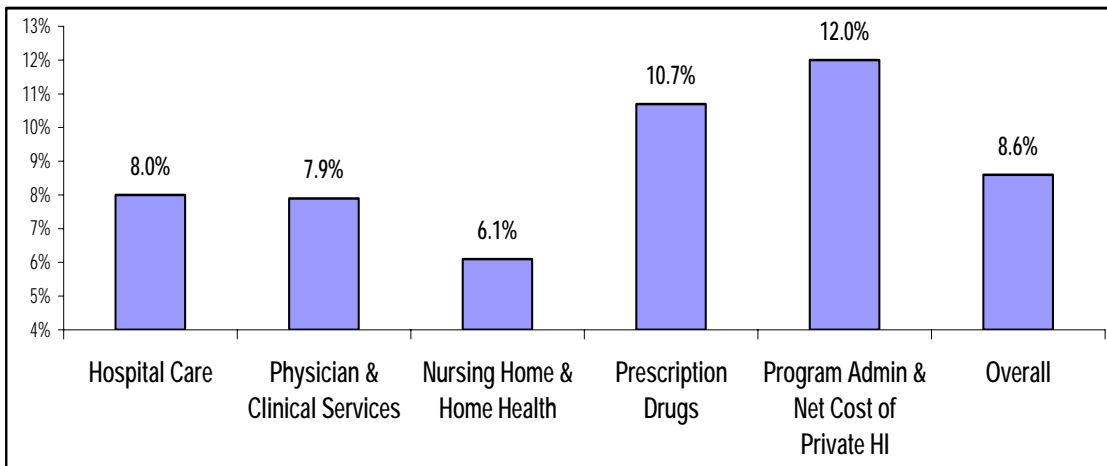
Karen Davis, Cathy Schoen, Stuart Guterman, Tony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum

In its January, 2007 report, “Slowing the Growth of US Health Expenditure,” the Commonwealth Fund articulates an argument for more careful attention and oversight of administrative costs¹. The data and conclusions from this study are shown below:

The fastest-rising component of health spending in recent years has been insurance administrative overhead (Figure 3). Between 2000 and 2005, the net insurance administrative overhead—including both administrative expenses and insurance industry profits—increased by 12.0 percent per year, 3.4 percentage points faster than the average health expenditure growth of 8.6 percent. Because of their close link to labor costs, insurance administrative expenses might have been expected to increase at a rate closer to wage rates, instead of exceeding the rise in health care outlays.

Health Expenditure Growth, 2000-2005 for Selected Categories of Expenditures

Average annual percent growth in health expenditures



Source: A. Catlin et al., “National Health Spending in 2005: The Slowdown Continues,” *Health Affairs*, Jan./Feb. 2007 26(1):142–53.

Note that this analysis measures “Program Administration and Net Cost of Private Health Insurance,” which includes carrier administration and profit as a combined metric. Since the period measured (2000-2005) was a period of relatively strong carrier margins, it is possible that the high expenditure growth reported here is significantly driven by growth in profits, and that the administrative cost trend may have been closer to the overall average.

2. Minnesota

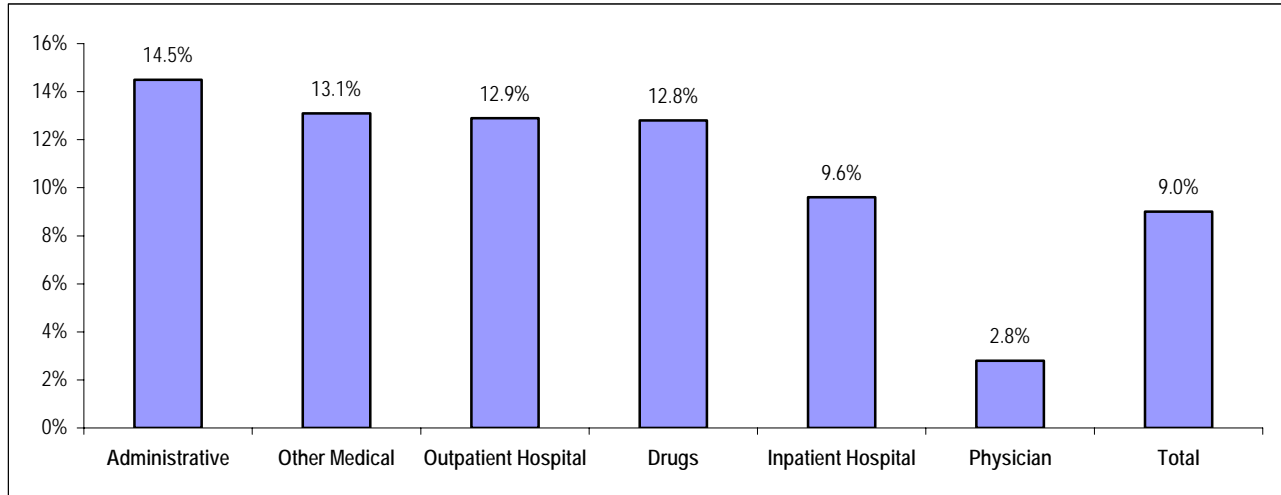
Within the Minnesota state government, there is a Health Economics group, which provides technical assistance in the development of state health care policy. In an August, 2005 Issue Brief, this group reported on health plan administrative costs², as described below:

¹ The Commonwealth Fund calculates “administrative overhead” to include both administrative costs and profits. This study does not break out commercial expenses vs. Medicare or Medicaid. The metric they use is total expenditure growth, comparing administrative overhead to other elements of health expenditures.

² Includes all lines of business including all lines of business (Commercial, Medicare, Medicaid) in their analysis.

“In the two-year period from 2002 to 2004, administrative spending was the fastest growing category of spending... The primary drivers of increased administrative spending were product management and marketing, claim processing, and spending for wellness and health education.”

Minnesota Private Insurance Spending Growth* by Service Category, 2002-2004



*Growth rates calculated as annual growth per person with private insurance. "Other Medical" includes skilled nursing facilities, home health care, emergency services, services of health professionals other than physicians and dentists, durable medical goods and chemical dependency/mental health services.

Source: August, 2005 Issue Brief, Minnesota Department of Health Economics

Note that the measure used above is spending growth, which does NOT include any estimate of profit, and therefore more closely resembles the standard that Rhode Island must consider – however, this data is for Minnesota carriers only.

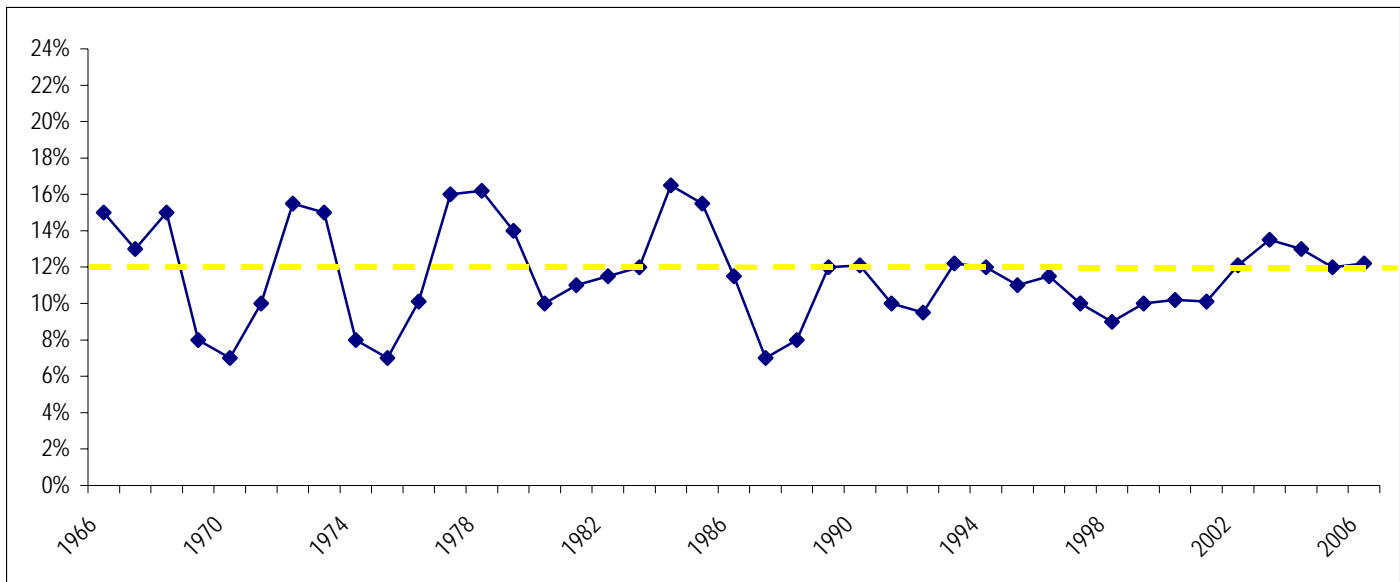
3. PriceWaterhouseCoopers

Price Waterhouse Coopers recently performed a study, entitled “The Factors Fueling Rising Health Care Costs, 2008, on behalf of AHIP (Association of Health Insurance Plans). The section addressing administrative cost growth is summarized below:

“Although administrative costs are a component of premiums, they are not a key driver of health insurance premiums...the very stable contribution of administrative costs over time is illustrated [below]. Not only has the long-term trend been slightly downward, but the volatility and nature of administrative costs have changed over time, due to the role of managed care and information technology.

In 1966, claims were submitted on paper and many functions that health plans perform today did not exist. Today, pharmacies have to process claims electronically on the spot, all providers have computer systems, and patients get information on the internet. Plans now manage networks, negotiate contracts and provide a spectrum of patient care management and consumer support services that did not exist in 1966. Interestingly, while these value-added services have continuously evolved and increased over time, the administrative share of health care costs continues to cycle at about roughly the same average level...”

Administrative Cost as Percent of Private Health Insurance Costs (1966-2006)



Source: National Health Expenditure Historical and Projections, 1965-2016 at the website:
http://www.cms.hhs.gov/NationalHealthExpendData/03_NatioanlHealthAccountsProjected.asp

Note that the analysis presented above is focused on administrative costs as a percentage of total costs. Thus, while this metric “flattens out” over the past several years toward approximately 12%, this only demonstrates that administrative costs have inflated at roughly the same rate as medical costs – in the range of 8-14 percent per year. The study does not evaluate whether it is appropriate for administrative costs to trend at a level consistent with medical cost trend, and significantly higher than wages.

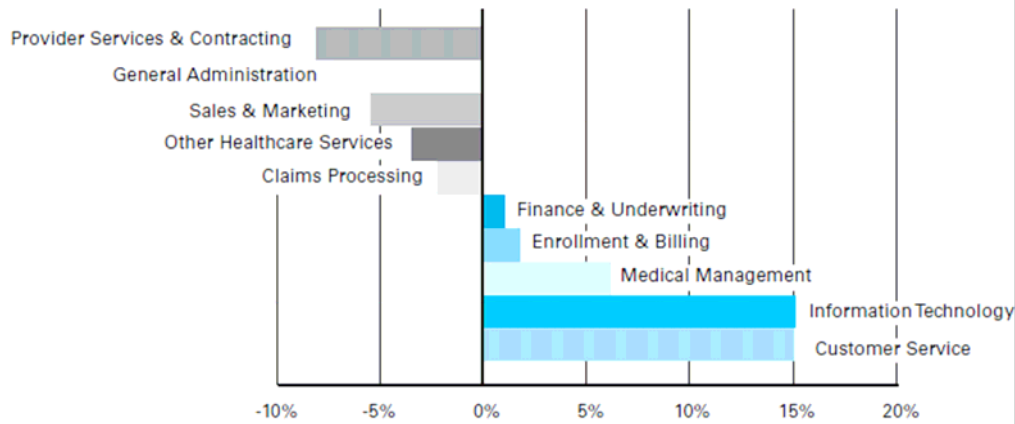
4. Milliman USA

Milliman USA also performed a study of health plan administrative cost trends from 1998 through 2002, on behalf of the BCBS Association³. The results of this study are shown below:

Average health insurer administrative costs grew 4.6 percent during the period studied -- slower than overall premiums, which grew 7.4 percent. Almost 80 percent of the increase in health plan administrative costs is a result of increased spending on customer service information technology.

³ The definitions, and units of measure, used in this study are not clear from the report we reviewed. “For this study, Milliman used the Milliman Health Plan Operations Benchmarks from approximately 88 organizations. The sample used to formulate the benchmarks is representative of a wide range of organization types, membership sizes, and geographic regions. Milliman tracks admin data at a very detailed level, categorizing employees by specific healthcare functions.”

Health Plan Administrative Costs: Average Annual Change (1998-2002)



Source: Milliman USA, [Health Plan Administrative Cost Trends](#), 2003

Note that this Milliman study does specifically evaluate administrative cost trend, excluding profits. It also provides a different result than the Commonwealth Fund or Minnesota metrics, demonstrating a much lower trend than the other two studies. However, the time period is dated (1998-2002) – it is unclear what a more recent update of this specific analysis would demonstrate.