

# CRITICAL ISSUES IN HEALTH REFORM

## Administrative Expenses

September 2009

AMERICAN ACADEMY of ACTUARIES



To better assess the potential for administrative cost savings under health reform options, it is important to understand the nature of the administrative functions and costs that are currently performed by health insurers.

Some provisions in health reform proposals aim to streamline or reduce the administrative costs associated with health insurance coverage. For instance, proponents of health insurance exchanges argue that they could potentially lower the costs of marketing and member enrollment, depending on how the exchange is structured. To better assess the potential for administrative cost savings under health reform options, it is important to understand the nature of the administrative functions and costs that are currently performed by health insurers. This paper discusses these various functions as well as how they can vary by different health insurance products and markets.

### The functions performed by a typical health insurance company can be broken down into four broad categories.

While health insurers may be organized in different ways, all of the functions included in Table 1 are performed by a company to remain financially sound, sell and administer business, manage risk and comply with regulatory requirements.

Sherlock Company (“Sherlock”)<sup>1</sup> conducts and publishes instructive, regular benchmarking studies of the health insurance industry. Functions in Table 1 have been grouped for consistency with Sherlock benchmarks. The data in Table 2 is from Blue Cross Blue Shield

### ADDITIONAL RESOURCES

Market Reform Principles  
[http://www.actuary.org/pdf/health/market\\_reform\\_may09.pdf](http://www.actuary.org/pdf/health/market_reform_may09.pdf)

Minimum Loss Ratios  
[http://www.actuary.org/pdf/health/loss\\_july09.pdf](http://www.actuary.org/pdf/health/loss_july09.pdf)

Health Reform Now  
[http://www.actuary.org/issues/health\\_reform.asp](http://www.actuary.org/issues/health_reform.asp)

**Table 1: Summary of Activities by Functional Categories**

Marketing	Provider & Medical Management	Account & Member Administration	Corporate Services
<ul style="list-style-type: none"> <li>■ Market research</li> <li>■ Plan/product design</li> <li>■ Marketing campaigns/sales</li> <li>■ Advertising &amp; public relations</li> <li>■ Broker relations &amp; commissions</li> <li>■ Rating &amp; underwriting</li> </ul>	<ul style="list-style-type: none"> <li>■ Provider network/contracting</li> <li>■ Provider and program quality admin and reporting</li> <li>■ Medical management</li> <li>■ Pharmacy management</li> </ul>	<ul style="list-style-type: none"> <li>■ Enrollment &amp; billing</li> <li>■ Claims and encounter administration</li> <li>■ Information technology</li> <li>■ Customer service</li> <li>■ Member communications</li> <li>■ Fraud controls</li> </ul>	<ul style="list-style-type: none"> <li>■ Finance &amp; accounting</li> <li>■ Actuarial</li> <li>■ Risk management</li> <li>■ Legal, compliance and filing</li> <li>■ Corporate executive &amp; governance</li> <li>■ Investment services</li> </ul>

Source: Developed by Solucia Consulting, consistent with the Sherlock Company's functional mapping.

<sup>1</sup> The Sherlock Company focuses on health plan finance, specifically providing benchmarking and data analysis for the management of administrative functions for health plans.



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**TABLE 2: Blue Cross Blue Shield Costs by Functional Area**

Administrative Costs	Per Member Per Month (PMPM) Costs			Percent of Premium Costs		
	25th Percentile	Median	75th Percentile	25th Percentile	Median	75th Percentile
Marketing	\$5.36	\$7.46	\$9.89	1.9%	3.0%	4.0%
Provider and Medical Mgmt	\$2.08	\$3.12	\$3.87	0.8%	1.1%	1.4%
Account and Member Admin	\$8.81	\$10.23	\$12.16	3.5%	3.8%	5.2%
Corporate Services	\$3.85	\$4.40	\$5.82	1.4%	1.9%	2.3%
<b>COMBINED</b>	<b>\$22.02</b>	<b>\$25.36</b>	<b>\$30.54</b>	<b>8.3%</b>	<b>10.4%</b>	<b>12.4%</b>

Source: Sherlock “Plan Management Navigator,” July 2008. The data is from 2007.

(BC/BS) plans (including plans of different sizes and both for-profit and not-for-profit plans).<sup>2</sup>

**The level of expenses can vary significantly by product and market.**

The Sherlock data shows that BC/BS companies’ expenses vary from a high of \$69.00 per member/per month (PMPM) for Medicare Advantage products to a low of \$19.07 PMPM for certain administrative services only (ASO)<sup>3</sup> plans.

There are also significant differences in

expense levels between the individual/small group market and the large group market. For plans that are sold to individuals or to small employers, the insurer usually provides the full range of services and will therefore have higher administrative costs. For example, a review of recent BC/BS filings<sup>4</sup> in Florida and Rhode Island indicates administrative expenses for their products sold to small groups are about 12 percent to 13 percent of premium, with an additional 2 percent to 5 percent for commissions.

<sup>2</sup> A CBO analysis of data from the McKinsey Global Institute results in similar estimates of administrative costs as a share of premium. CBO estimates that of the 12 percent of premium that goes toward administrative costs and profit, 3.2 percent goes toward marketing expenses, 1.9 percent toward medical activities, 4.1 percent toward general administrative costs (including taxes), and 2.8 percent toward after-tax profit. Although these categories are slightly different from those used by Sherlock, the combined totals are similar. (Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, December 2008.)

<sup>3</sup> These are contracts with self-funded employers—usually ERISA plans that are pre-empted from most state insurance regulations.

<sup>4</sup> These filings are available online. (For Florida, see <http://www.florir.com/edms/>. For Rhode Island, see <http://www.ohic.ri.gov/>.)

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For products sold to large groups, it is common for the employer to assume some of the administrative functions that are typically performed in the small group market by insurers or brokers, primarily eligibility records, billing, plan design and pricing, and customer service. An example of an employer performing administrative functions and reducing the administrative cost component of the rate is BC/BS coverage provided through the Federal Employees Health Benefit Plan (FEHBP). Administrative expenses, including profit charges and other negotiated payments, for the BC/BS FEHBP offerings in 2007 were about 5.7 percent of premium. This is considerably less than the 10.4 percent median percent of premium shown in the preceding table.<sup>5</sup> Part of the reason for this is that FEHBP plans are generally exempted from state compliance requirements. Moreover, as an employer the federal government (through the Office of Personnel Management) takes on many functions that might otherwise be handled by the insurer, including enrollment, billing, employee communications (such as plan documents), and many of the sales/marketing functions. In addition to differences in services provided by insurers, sales and marketing costs for individuals and small groups tend to be higher, since there is more one-on-one contact, resulting in higher costs that may also be reflected as higher commissions.

### **State taxes and assessments can also be a significant component of health insurance premiums.**

The costs examined above do not include state premium taxes, assessments and fees that insurers are required to pay on premium they collect. Nationally, the typical premium tax is 2 percent, which is added to the cost of premiums. These taxes do not apply to self-funded plans because of the ERISA pre-emption of state regulation (Section 514). Insurance plans issued to individuals and small-group employ-

ees are subject to these taxes, increasing the expense gap between plans sold to individuals and small groups and those of self-funded employers.

In addition to premium taxes, some states charge assessments, which in some cases have nothing to do with insurance. For example, the state premium tax in New York is 1.75 percent of premium, (plus (in some areas) a 0.3 percent “MTA tax” to fund mass transit). Beginning in 2010 insurers will pay another assessment of almost 1.15 percent which goes to funding the state insurance department. Thus, in New York, an insured with a premium of \$600 per month is charged a monthly amount of \$19.20 for these taxes and assessments.

In addition, as a result of the New York Health Care Reform Act (HCRA) for indigent care, insurers are responsible for paying a fee amounting to a minimum of 9.63 percent of facility (inpatient and outpatient) charges, which is approximately \$7.00 to \$8.00 per month. There is also a charge for Graduate Medical Education, which adds \$15.00 to \$16.00 per month to premiums paid by individual Manhattan insureds and \$1.00 to \$8.00 per month to insureds in the remainder of the state. For a Manhattan resident, these charges (over \$40 per month in this example) total in excess of the administrative charges of the highest-cost BC/BS plans; even non-Manhattan residents pay more in taxes and fees than the median national administrative charges.

### **The cost of capital is also factored into premiums.**

To ensure plan solvency in the event that plan expenditures exceed premiums, private plans are required to meet regulatory requirements for “free capital,” sometimes called “surplus” (defined as an excess of assets over liabilities) to cover potential deficits. State-regulated solvency requirements rely upon risk-based capital (RBC) formulas. Insurers are required to

<sup>5</sup> Financial information for the BC/BS FEHBP plan can be found at: [https://www.fbo.gov/index?tab=documents&s=opportunity&mode=form&id=5e8d01752786024c17b4ae5bb85592d1&cck=1&au=&cck=&\\_so\\_list\\_sort4a824465ae2333c1eb3b796be48491cb=posted\\_date%3Aasc](https://www.fbo.gov/index?tab=documents&s=opportunity&mode=form&id=5e8d01752786024c17b4ae5bb85592d1&cck=1&au=&cck=&_so_list_sort4a824465ae2333c1eb3b796be48491cb=posted_date%3Aasc)

meet solvency requirements so that they have free capital in excess of their regular claims and other reserves in the event of adverse experience. An insurer that is inadequately capitalized runs the risk of defaulting on claim payments. In most states, other insurance companies may be assessed a payment to cover these claims, a cost that will have to be reflected in higher insurance premiums.

For an insurance company to conduct business, it needs to raise this capital from investors or sponsors, and to provide ongoing service of the capital out of operating profits. Although not a component of administrative expense, the cost of capital must also be a component of premiums.

A typical minimum required surplus level might be 25 percent of premium or more. This capital requirement imposes two costs on insurers and their policy-holders:

1. If the insurer raises capital in the equity markets, the insurer must earn a competitive return on capital, which for equity capital can be 15 percent before tax. Even not-for-profit insurers will use a benchmark charge derived from capital yields in their pricing. The equity finance level of service on capital, with a 25 percent of premium capital requirement, results in a premium load of 3.8 percent.

2. Health care inflation requires ongoing increases in capital. If premiums are growing at, for example, 10 percent per year, to maintain the target level of 25 percent surplus, the company must earn 2.5 percent of premiums after tax in order to remain capitalized at a level satisfactory to regulators. If the company has a 35 percent income tax rate, premiums must include a margin of nearly 3.8 percent to meet the ongoing capital requirements.

Together, these two requirements would increase premiums by at least 7 percent. However, these costs are offset by amounts an insurer can expect to earn on its reserves and surplus. Total reserves and surplus in a health insurer can amount to 40 percent to 50 percent of premium. Assuming that the insurer earns 5 percent pre-tax, investment

yield will offset some of the cost of capital. The remainder, which could be anywhere from 4 percent to 8 percent, becomes an additional load included in premiums.

Because of the ERISA pre-emption, self-insured employers are not subject to solvency regulations. This difference in capitalization is another source of disparity between individual and small group plans when compared to self-funded employer plans.

### **Medicare does not perform many of the same functions as a typical private insurer.**

Commercial insurance plan costs are often adversely compared to Medicare because of higher administrative costs. However, Medicare performs very few of the many functions that are performed by a typical commercial insurer, and is not subject to state taxes, licenses and fees or capital requirements. When making comparisons, we recommend policy-makers consider the following:

- Per capita Medicare claims are two to three times those of commercial plans. Thus Medicare's administrative expenses will always appear to be lower when stated as a percentage of overall costs.<sup>6</sup>
- When Medicare costs are quoted, they usually include only amounts paid to outside vendors such as claims administrators. These don't include any of the "corporate services" types of expenses that exist, but are reflected in the federal budget as the cost of running Centers for Medicare and Medicaid Services.
- Enrollment and billing are handled by the Social Security Administration and are not reflected as costs related to Medicare.
- Medicare does not have to meet the same solvency or capital requirements that commercial plans are required to meet.
- Medicare does not negotiate with providers—reimbursement levels are legislated. Therefore, Medicare performs minimal medical management, network manage-

<sup>6</sup> 2009 Annual Report of the Boards of Trustees for the Federal Hospital and Federal Supplementary Medical Insurance Trust Funds, May 2009. Kaiser Family Foundation, 2008 Annual Survey of Employer Health Benefits, September 2008.

ment and quality functions as compared to the typical commercial plan.

- Medicare's controls for fraud and abuse are minimal compared to commercial carriers.
- Medicare incurs minimal marketing expenses.
- Medicare is not required to comply with state market conduct requirements applicable to insurance companies.

**Health insurers would continue to provide some of these services, even with the implementation of an exchange.**

Different models of health exchanges have been proposed, ranging from provision of information-only, to a model that is structured more like an insurance broker. The Massachusetts Connector Authority is an example of an exchange that acts like a broker: defining plan designs that meet the state's standards for credible insurance coverage, choosing and certifying participating health plans, providing information to the public and supporting enrollment. The Connector budget is between 3.5 percent and 4.5 percent of premiums, depending on covered population. Health plans continue to provide all of the non-marketing related services, as included in Table 1, to members who enroll through the Connector.