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PERSPECTIVE: ADMINISTRATIVE COSTS OF PRIVATE HEALTH INSURANCE PLANS

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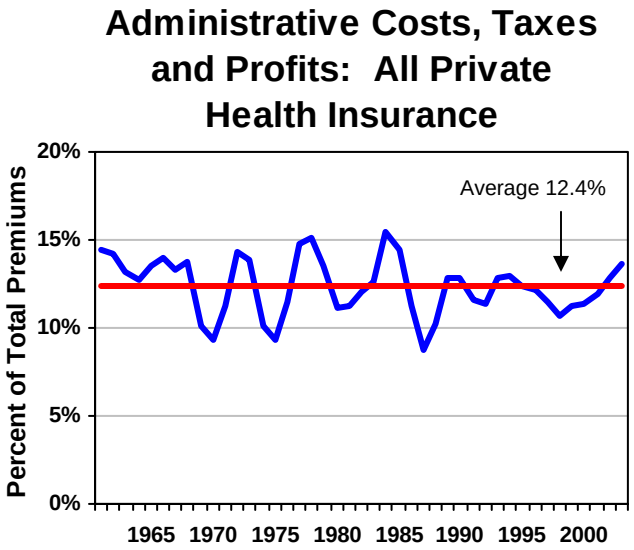
According to the national health spending estimates from the Center for Medicare and Medicaid Services (CMS), the administrative costs, taxes, profits, and other non-benefit expenses of private health plans have averaged about 12 percent of premiums over the last 40 years. This includes all types of health insurance purchased privately, ranging from employer-based coverage to individually purchased plans, Medigap and long-term care insurance. (These figures do not include private health plans operating in Medicare or Medicaid.)



Source: CMS Office of the Actuary, January 2005

The CMS data do not provide a breakdown of the components of non-benefit spending. But it seems likely that there has been a shift in the composition of administrative costs. Prior to the 1990s, administrative costs were dominated by claims-paying expenses. In recent years, claims-paying costs have almost certainly fallen as a share of premiums. However, health insurance plans now spend more on disease and care management programs, nurse help lines, member information services (such as websites dedicated to health education and self-management), and "network management," which consists of negotiations and communications with hospitals, physicians and other health providers under contract with health insurance plans.

Premium taxes -- sales taxes on health insurance -- range as high as 3 percent, although they vary from state to state and from product to product. These taxes mostly affect smaller employers and individual purchasers of health insurance. (Large employers that "self-insure" are usually exempt.)

Finally, capital costs and returns have fluctuated over the years. In the 1970s and 1980s, actuaries observed a 6-year cycle of underwriting profits and losses. By the mid-1990s, competition from new managed care plans held down premiums and margins. However, since the beginning of the legislative and consumer "backlash" against managed care in the late 1990s, premiums have increased substantially. Margins have recovered, although they seem less volatile than in earlier

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decades. In recent months, new health insurance products, such as high-deductible plans coupled with Health Savings Accounts (HSAs), have entered the marketplace. These plans focus on consumer decisionmaking to help control benefit costs.

Single-payer health reform advocates tout Medicare's low administrative cost rate, which was estimated by CMS to be 3 percent in 2003. However, it is particularly difficult to compare the reported administrative costs of Medicare with those of private health insurance plans.

First, Medicare's "capital costs" are not included in government estimates of Medicare spending. Here is a simplistic, but revealing example: federal net interest payments to the public -- the government's overall capital cost -- totaled $160 billion in fiscal year 2004. In that year, Medicare benefits (net of premiums collected from beneficiaries) comprised about 12 percent of federal non-interest spending. Therefore, Medicare's share of the government's debt-service costs could be estimated at about $19 billion in 2004. Adding these payments alone would boost Medicare's administrative cost rate by almost 7 percentage points, to just under 10 percent.

Second, Medicare's "benefit cost per claim" is likely higher than that of private plans serving the non-elderly population. However, high-cost claims can be just as easy to process as smaller claims. For example, it might cost $50 to process either a $5,000 claim or a $1,000 claim. If Medicare's claims-paying methods were applied to a younger population with lower benefit costs per claim, its reported administration rate would be higher simply because the "denominator" -- the overall claims cost -- was smaller.

Third, many private health plans allocate costs from their health improvement and care management efforts to "administration," not "benefits." Yet these initiatives can have a powerful payoff in improved health and reduced overall claims costs. For example, if Medicare's new disease management programs succeed at reducing expensive claims, Medicare's reported administrative cost rate would rise. (Administrative costs to implement disease management programs and evaluate outcomes would go up, but overall costs -- the denominator again -- would be lower.) Yet this would be a very good thing, for beneficiaries and for taxpayers! On balance, placing too much emphasis on ultra-low administrative cost rates can be penny-wise and pound-foolish.

References:

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