The Level Playing Field Myth: Comparing Administrative Costs for Public, Private Health Insurance

BY WILLIAM G. SCHIFFBAUER, ESQ.

The renewed public debate over the need for universal health insurance has rekindled the argument that Medicare, the nation’s single payer national health insurance program for seniors and the disabled, purportedly spends no more than 3 percent of each premium dollar collected on “overhead” or “administrative expenses.”

Single-payer and “public plan” option advocates erroneously cite a much higher figure of up to 13 percent of premium for the private insurance market. What advocates are doing is wrongly comparing what is in fact only one part of Medicare “administration” costs to the whole of private insurance “administration” costs.

The 3 percent figure attributed to Medicare administrative expenses is only the amount of funds spent for “claims administration” by Part A and Part B contractors. A credible comparison of the actual Medicare and private group health plan “overhead” costs requires an analysis of all comparable administrative functions and expenses for both types of health plans.

The purpose of this paper is to demonstrate that the claims administration is only a part of “overhead” or “administrative costs” for all health plans, including Medicare. In general, Medicare’s “overhead” cost for claims administration, as a percentage of the program’s “premium income,” is likely the same as claims administration costs in the private large group health plan market.

Administrative Expenses Defined

Research by the Congressional Research Service of the Library of Congress (“CRS”) suggests that Medicare’s percent of premium expenses for “claims administration” is very similar to the percent attributed to “claims administration” by large group health plans in the private market.

According to general insurance industry practice, and an analysis by CRS, “administrative costs” are comprised of several categories of expenses. These include: (1) claims administration; (2) general administration; (3) interest credit; (4) risk and profit charge; (5) commissions; and (6) premium taxes. See CRS, “Costs and Effects of Extending Health Insurance Coverage” at p. 46 (October 1988) (prepared for the U.S. House Committees on Education and Labor, and Energy and Commerce; and the U.S. Senate Special Committee on Aging).

Each of these categories of expenses for private health insurance has possible parallels to comparable Medicare costs as discussed in more detail below.

Claims Administration

“Claims administration” includes all those expenses related to claims payment. For example, this would include expenses for claims processors, supervisors, training, and related computer and overhead costs.
Private Health Plans. CRS attributes a 3 percent number to claims administration costs for large group health plans (10,000 or more enrollees). This number includes claims administration costs for both medical and prescription drug expenses. This “cost” increases as the size of the group decreases. As a percentage of costs, these expenses generally decline as the size of the covered group grows due to economies of scale. For a group of one-to-four covered individuals in the individual insurance market, CRS estimates that claims administration expenses equal 9.3 percent of each premium dollar.

Medicare. “Claims administration” is the function of Medicare contractors who serve as fiscal intermediaries in the administration of Parts A and B. It is this function that comprises the 3 percent “overhead” cost that is cited for the Medicare program. Also, it is important to note that Medicare contractors administer a “one-size-fits-all” plan design that is less costly than the multitude of private plan designs that must be reviewed and coordinated with in the private sector.

General Administration

The expenses of “general administration” include all of the costs of operating the health insurance plan other than the costs of “claims administration.”

Private Health Plans. These expenses include: sales and marketing (other than commissions); contract and legal staff work; enrollment; eligibility determinations; issuance of identification cards; underwriting; communications materials (such as Summary Plan Descriptions and other booklets); billing activities; customer service; accounting and data reports and analysis; wellness programs; quality improvement; utilization review; research and advice concerning laws and regulations; plan design advice and plan revision implementation; problem resolution and general accounting; salaries and wages; health and retirement benefits; payroll taxes; supplies; and amortization of buildings and facilities.

Importantly, these expenses would also include legal and administrative expenses in connection with compliance with federal and state laws and regulations, and efforts to detect and recover fraud and abuse, and enforcement of contract provisions including coordination of benefits.

Medicare. None of these “general administrative” expenses is counted in the 3 percent “overhead” cost cited for Medicare. These “general administrative” functions are clearly performed for the Medicare program; however, they are expensed elsewhere in the federal budget.

Additionally, there are the costs to CMS incurred for publishing and disseminating the multitude of Medicare’s publications, maintaining the Medicare Web site, and Medicare information call centers, all of which are designed to educate and inform beneficiaries of their benefits and rights under the public insurance program.

There are also resource costs attributable to the Department of Health and Human Services Office of the Inspector General, the HHS General Counsel, and the Department of Justice divisions that perform Medicare legal and litigation functions for HHS in the areas of enforcement, fraud and abuse, and secondary payer coordination.

Certainly, there are costs assigned for personnel who perform Medicare eligibility reviews; data analysis by the Office of the Actuary, Office of Management and Budget, and the OIG; and the Medicare Payment Advisory Commission (MedPAC), the advisory board that oversees the Medicare program, as well as costs for the maintenance and amortization of buildings and equipment.

The detection and elimination of fraud, waste, and abuse in the Medicare program is an especially important “administrative” cost that is incurred in addition to “claims administration.” The OIG utilizes headquarters staff and regional offices to investigate and report fraudulent activities on the part of health care providers, to oversee Medicare contractors’ compliance with requirements, and to pursue civil and criminal sanctions and other activities to protect the integrity of the Medicare program.

Personnel costs (salaries, health, and retirement benefits) for employees of HHS who have Medicare responsibilities (such as the Administrator of the Medicare program, and others who are charged with responsibilities for administering Part A, Part B, Part C for the Medicare Advantage program, Part D for the prescription drug program, and Treasury’s administration of the trust funds) should be included as “general administrative” expenses. Those personnel expenses, however, are administered by the Office of Personnel Management.

Finally, costs associated with the Medicare appeals system and the use of administrative law judges should be included in this category of expenses similar to the costs associated with the appeals system for private health plans.

CRS attributes a cost of less than 1 percent of premium for “general administration” of a large group health plan arrangement in the private sector.

Those types of expenses for Medicare have never been tallied and compared to private sector costs; but rather, are buried in various agency budgets and paid for out of general tax revenues.

Reserves and Interest Credit

Conventionally insured health plans must hold reserves for claims that are incurred, but not yet reported and paid, to prevent extreme fluctuations in premiums, and for other purposes. The insurance carrier earns investment income on these reserves and, in turn credits the interest to the reserve account.

Private Health Plans. Large group health plan arrangements (insured and self-insured) must hold assets sufficient to pay benefits as costs are incurred. For insured health plans each of the fifty states requires insurance companies to hold reserves adequate to pay claims.

Medicare. Shortfalls in the Medicare Trust Fund are paid for out of general tax revenues. The financial requirement to pay future benefits is not accounted for in the “claims administration” figure but should be accounted for in comparable “general expenses” in comparing administration costs.
Risk and Profit Charge

The actual claim costs for a group health plan are subject to some fluctuation and unpredictability. The goal of any competent health insurance business is to ensure that over a certain measured period of time, the premiums received would at least equal the amount of all claims and all expenses.

Private Health Plans. The insurance industry classifies as “profit” or “surplus” those amounts that are in excess of all claims and expenses. State laws also regulate the premium rate that may be charged for “insured” arrangements and require that the rate bear a “reasonable relation” to benefits and expenses. CRS attributes an “administrative cost” equal to just over 1-percent for risk and profit charges of a large group health plan arrangement.

Private health plans are subject to financial stability regulations, and must also raise and generate capital to support risk and administration functions.

Insurance companies organize either as “stock” companies or as “mutual” companies. A “stock” company is owned by its investor stockholders and must incur the initial and ongoing expenses of issuing stock to raise capital and meet federal and state regulatory requirements. A “mutual” company is owned by the policyholders and is also subject to federal and state regulation with respect to financial reporting obligations and accounting for capital.

Medicare. For the Medicare program, “capital” is raised by general tax revenues on an “as needed” basis, and fixed, discounted premiums assessed on beneficiaries. Comparable “profit and loss” information is reported as data related to the Medicare Trust Fund Accounts.

Commissions

To the extent that insurance is purchased through an intermediary, such as an agent or broker, there is a cost attributable to such activity. Agents and brokers not only educate and assist potential “insureds” regarding their insurance needs and the most suitable types of insurance coverage, they also provide services relating to enrollment and various questions about coverage and other problems that may arise.

Private Health Plans. CRS attributes an “administrative cost” of one-tenth of a percent for large group health plans because large group arrangements generally do not use agents (but may use brokers). However, such large plans generally incur expenses to employ consulting firms to assist in some benefits design and administrative service functions.

Medicare. For Medicare, each state operates a health insurance assistance program (known as “SHIP”) that is partly funded by federal monies. These agencies provide comparable services for seniors regarding the Medicare program. For the Medicare program, the costs of the SHIP programs should fall into this category of administrative expense. Medicare also operates online Web site information and issues various publications to assist beneficiaries with understanding the program.

Premium Taxes

Group health plans that are “insured” arrangements are subject to taxes imposed by states on the basis of a percent of the premium charged for the coverage. Insurers must also make contributions to fund state guarantee associations and other state risk pool arrangements.

Private Health Plans. Most large group health plans, however, self-insure and under the federal Employee Retirement Income Security Act of 1974 (“ERISA”) are not subject to state regulation or premium taxes. In the case of “insured” group health plans, the state premium tax is at least 2 percent of the premium. Some municipalities have begun to assess premium taxes, as well. Revenues received from these taxes go to directly to the general fund of the taxing authority. For “insured” large group health plan arrangements, CRS attributes an “administrative cost” for premium taxes of 2.1 percent.

Private health plans are also subject to other taxes such as property taxes, federal and state income taxes, and various licensure fees.

Medicare. Like large, self-insured group health plans, however, Medicare is not subject to state regulation or premium and risk pool assessments and so would not have this “administrative cost.” Neither is Medicare subject to other taxes such as property and income taxes (federal or state) or other licensure fees.

Conclusion

Popular comparisons of Medicare and private group health plan “overhead” costs wrongly compare only a part of administrative expenses related to the Medicare program to the whole of private sector administrative expenses for comparable large group health plans.

In addition, single-payer and “public plan” advocates argue that the “level playing field” consists only of: community rating, guarantee issue, limits on marketing, standardized and defined benefits, reserve requirements, and transparency.

However, a truly level playing field involves much more. Medicare’s “overhead” costs for claims administration, as a percentage of the program’s “premium income,” are really about the same as claims administration costs in the private large group health plan market.

A credible comparison of Medicare and private group health plan “overhead” or administrative costs requires an analysis of comparable administrative functions and a true accounting of all related expenses to accurately assess the efficacy of a “public plan” option.