

Understanding Health Plan Administrative Costs



BlueCross BlueShield Association

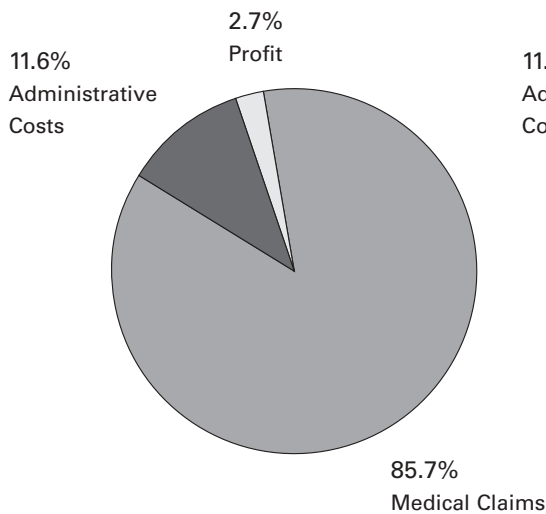
An Association of Independent Blue Cross and Blue Shield Plans

Summary

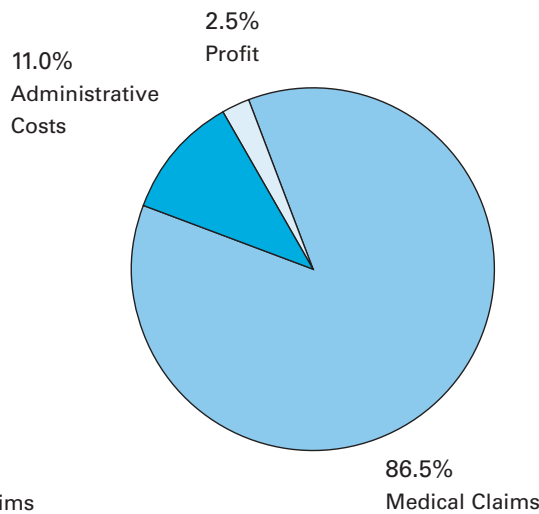
As part of its ongoing efforts to keep healthcare affordable and reduce the number of uninsured Americans, the Blue Cross and Blue Shield Association (BCBSA) asked Milliman USA, Inc. (Milliman) to study health plan administrative cost trends from 1998 through 2002 and examine the key drivers behind those costs. The Milliman report on administrative cost adds to the series of cost-driver research already completed for BCBSA, which includes pharmaceutical, hospital inpatient and outpatient, and physician costs.

In this study, Milliman found that while premiums for commercial business increased an average of 7.4 percent annually, administrative costs grew at a much slower average rate of 4.6 percent annually. The report shows that in 2001 85.7 percent of commercial premiums went to paying medical claims, with 11.6 percent going to administrative costs and 2.7 percent going to profits. In comparison, 86.5 percent of commercial premiums among Blue Cross and Blue Shield companies on average went to paying medical claims, with 11 percent going to administrative costs and 2.5 percent going to profits.

**U.S. Health Insurance Industry
Average Premium Dollar (2001)**



**Blue Cross Blue Shield
Average Premium Dollar (2001)**



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

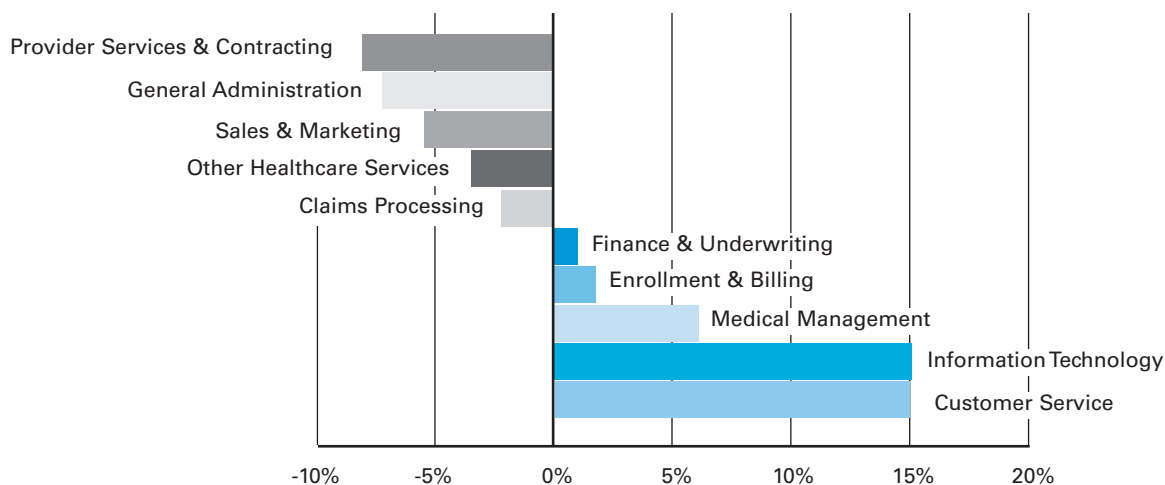
What are administrative costs?

To better manage healthcare expenses, it is important to identify how premium costs are allocated and the key forces behind rising healthcare costs. Health insurance premiums are broken down into three general categories: medical claims, profits and administrative costs.

Administrative costs are the costs associated with the different functions of a health plan or health insurance company that are necessary to ensure quality, cost-effective services are being provided to its members. The 10 most common administrative functions identified in the Milliman report are:

- Claims Processing
- Provider Service and Contracting
- Enrollment and Billing
- Customer Service
- Medical Management
- Finance and Underwriting
- Information Technology
- Sales and Marketing
- General Administration
- Other Healthcare Services

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



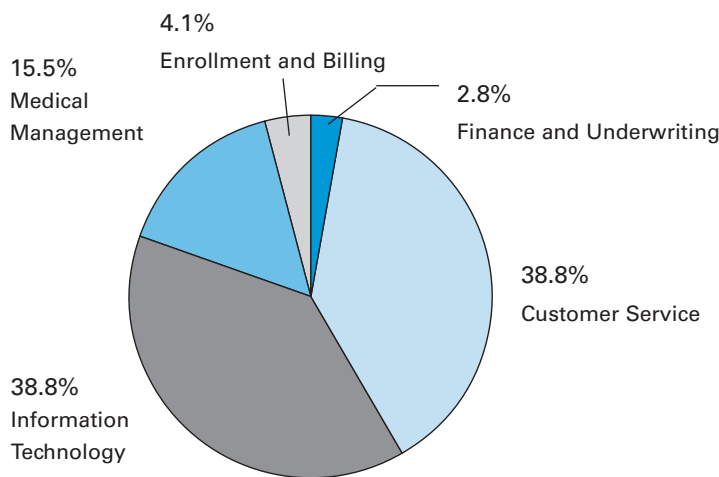
Source: Milliman USA, [Health Plan Administrative Cost Trends](#), 2003

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 administrative data at a very detailed level, categorizing employees by specific healthcare administrative functions.

Key findings from Milliman’s research include:

- 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.
- Spending on customer service grew at an average rate of 15 percent annually.
- Information technology costs also grew at an average rate of 15 percent annually.
- Milliman found that compliance with Y2K and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were significant factors in rising information technology costs.
- Health plans also are making significant investments in e-commerce to streamline administrative processes and have helped generate average savings of nearly 20 percent in claims, provider services and contracting and general administration.
- General administration (such as management and supervision, executive staffing, and employee legal support) costs declined on average by more than 8 percent.
- Costs for provider services and contracting have decreased on average by almost 9 percent.
- Costs associated with claims have dropped an average of more than 2 percent.

Drivers of Health Plan Administrative Costs



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

The role administrative costs play in overall premiums costs varies depending on the type of insurance product – fully insured or self-insured. Fully insured products consist of premiums that are paid directly to the insurance company. Fully insured products are regulated by each state in which the product is sold. The insurance company manages premiums paid, assumes all the risk associated with medical costs and pays claims as part of that risk. Typically, people think of insurance in terms of the fully insured model. About 70 percent of all health insurance is fully insured.

Thirty percent of people with commercial health insurance in the United States are covered by self-insured products. Self-insured typically means that the employer assumes the risk of medical claims and contracts with insurance companies to administer the coverage. Either the employer or the health plan maintains an account for paying claims.

An employer typically chooses between two types of self-insured models. An administrative service contract (ASC) model is an arrangement in which the insurance company administers the benefits contract on behalf of the employer and pays claims out of its own accounts. The insurer then bills the employer for the claims paid plus an administrative fee.

In an administrative services only (ASO) self-insured model, the health plan pays claims directly out of the employer's account. The employer contracts with an insurance company to manage the trafficking of claims, enrollment and eligibility as well as leasing the insurer's provider network.

In both cases, the employer assumes the cost of medical risk in a self-insured model. However, an insurer has a slightly higher business risk in an ASC model as they are paying the claim up front and billing for reimbursement. For that reason, administrative fees for ASC accounts are typically higher than those found in ASO arrangements. In all cases, self-insured products are regulated under the federal Employee Retirement Income Security Act of 1974 (ERISA).

For the purposes of this research, Milliman studied all commercial administrative costs for ASO, ASC and fully insured lines of business.

Blue Cross and Blue Shield Plan efforts to save administrative costs

Blue Cross and Blue Shield companies are currently working on behalf of employers and consumers to keep healthcare affordable, meet consumer demand for greater choices and help reduce the number of people without healthcare coverage. To meet that challenge, Blue Plans are continually finding ways to be more efficient healthcare finance specialists.

Some examples of how Blue Cross and Blue Shield companies are investing to better manage administrative costs and be responsive to consumer and provider demands:

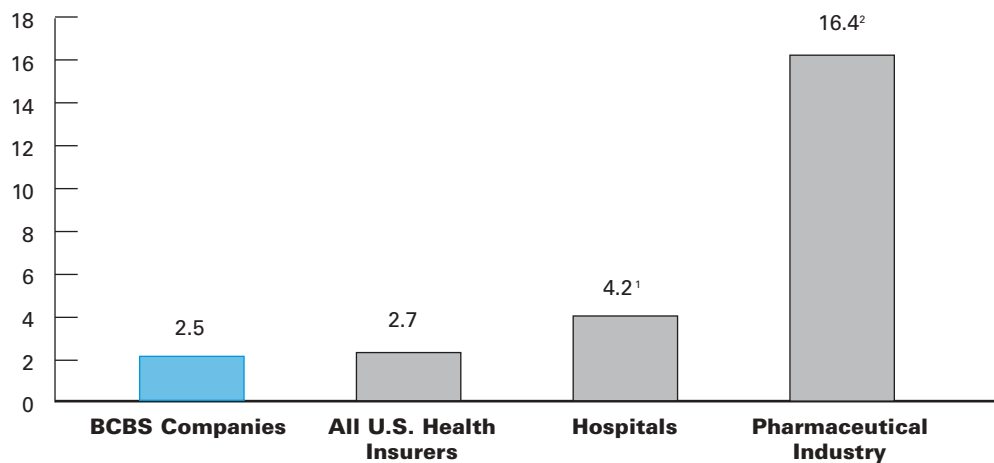
- Several Blue Plans have launched real time claims processing capabilities, enabling physicians to check eligibility (and sometimes claim status) in real time, and submit claims for payment in real time.
- Using the Internet, many Blue Cross and Blue Shield companies are providing 24-hour access to claims and eligibility information for consumers. A growing number of Blue Plans are making it easier for their members to check the status of a claim or get an explanation of what is and what is not covered by their benefit package.

Profits as a percent of premiums

Health insurance company profits comprise the smallest portion of the premium dollar. Milliman's report found that profits for the U.S. health insurance industry average 2.7 percent in 2001. The same year, profits for Blue Cross and Blue Shield companies averaged 2.5 percent.

Comparatively, profits for hospitals average 4.2 percent¹ and 16.4 percent in the pharmaceutical industry².

Average Healthcare Industry Profits (2001)



Source: ¹American Hospital Association; *Hospital Statistics*, 2003

²Forbes.com, *The 2002 Global 500*

Milliman USA, *Health Plan Administrative Cost Trends*, 2003

Health insurer profits are comprised of retained earnings, money allocated to reserves and dividend payments to policyholders or shareholders. Allocation of money in these three areas can vary from company to company and is based on the company's corporate form. Not-for-profit companies reinvest retained earnings – or the dollars remaining after reserves.

In addition to retained earnings, mutual companies may also pay dividends to policyholders. For-profit companies pay dividends to investors, whether publicly traded or privately owned.

A portion of insurer profits is invested in reserves. Reserves are funds set aside to be used in the event of unforeseen medical claims or catastrophic events. These funds are regulated by each state and based on a model set by the National Association of Insurance Commissioners (NAIC).

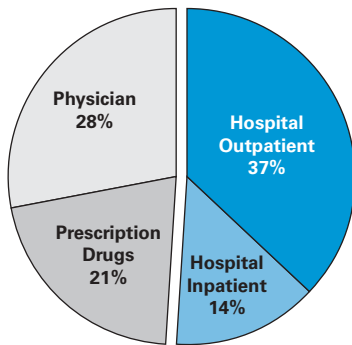
Blue Cross and Blue Shield Association's licensure standards are higher than the minimum requirements of the NAIC Model Act and higher than nearly all state regulatory minimum requirements. This is to assure that the Blue Brands continue to represent financially strong companies. Strong reserve levels support the ability of Blue Plans to make more timely claims payments and to provide quality service, products and provider networks.

Medical claims as a percentage of premium

On average, approximately 86 percent of premium dollars are spent on medical claims – 87 percent of the average BCBS premium dollar. In 2001, BCBS companies collectively paid more than \$140 billion in medical claims.

Today, U.S. medical costs are rising as much as five times the rate of inflation with the fastest growth in hospital outpatient and prescription drug costs. More than half (51 percent) of the growth in health-care spending goes to hospital inpatient and outpatient costs.

Medical Factors Driving Private Insurance Spending Growth, 2001



Source: Center for Studying Health System Change, “Tracking Health Care Costs”, 2002

Research commissioned by BCBSA has identified some of the major drivers of rising healthcare costs, including:

Hospital Inpatient	Labor costs, with nursing shortage Technology Market Structure
Hospital Outpatient	Technology Market Structure Physician & Specialist Supply
Physician	Technology Provider Market Structure
Prescription Drugs	Increase in the number of prescriptions Price increases Shift to higher costs drugs

In addition, a survey of BCBS Plans illustrates concern that rising malpractice insurance premiums are fueling the rise in the practice of defensive medicine, increasing utilization and adding excessive pressure to rising healthcare costs. Rising malpractice insurance rates may also be contributing to reduced access to care as physicians leave expensive malpractice markets, according to the survey.

Conclusion

This Milliman report on health insurers administrative costs adds to the ongoing series of BCBSA commissioned research designed to bring greater national focus to the drivers behind rising healthcare costs. The Milliman research confirms some conclusions about rising healthcare costs:

- Healthcare costs will continue to rise
- Our challenge is to act now to slow the rate of increase to keep healthcare affordable
- The only way it can be done is if we all – insurers, hospitals, physicians, employers, drug companies, consumers and the government – work together.

The purpose of BCBSA's research and the drive behind its campaign is to break down healthcare costs into more manageable components, leading to a collaborative effort to find workable solutions that keep healthcare affordable now and reduce the number of uninsured.



**BlueCross BlueShield
Association**

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Blue Cross and Blue Shield Plans

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