Research

The ACA Exchanges Increased Administrative Costs of Health Insurance

ROBERT BOOK | DECEMBER 21, 2016

Introduction

During the debate leading up to the passage of the Affordable Care Act (ACA), many advocates of that legislation argued that one of the benefits of establishing a government-run health insurance exchange in each state would be the reduction in administrative costs associated with private health insurance. These arguments were based partly on assertions of superior efficiency of government operations over those of the private sector, [1],[2] but primarily on the claim that having an exchange would eliminate the need for expenditures on marketing, and that[3] requiring a minimum Medical Loss Ratio (MLR) and reduction of executive pay[4] through limits on the deductibility of compensation (Section 9014) would limit the unrestrained pursuit of profit [5]. The predicted impact was that reducing administrative costs would lead to lower premiums and lower national spending on health care without having to reduce the quantity or quality of actual health care delivered.

This is not what has occurred. Aside from the well-established fact that premiums increased instead of decreased, administrative costs increased as well. While insurers indeed appear to have spent less on administrative costs, both on a per-covered-person basis and as a percentage of total premiums since the law went into effect, government spending necessary to set up and operate the exchanges vastly exceeded the amount saved by private-sector insurers, leading to an increase in total administrative costs. In fact, just the federal government's expenditures in establishing and operating the ACA exchanges – a function devoted solely to enrollment – vastly exceeds the *total* administrative costs, both for enrollment and operations – of private-sector insurers prior to the implementation of the exchanges.

In 2013, the year before the exchange provisions took effect, administrative costs averaged $414 per covered person per year in the individual market. In 2014, the first year in which exchanges operated, average costs for the entire individual market increased to an average of $893 per covered person-year. However, this obscures the full effect of the administrative cost of operating the exchanges, because these figures include both those covered in exchanges and those covered by Qualified Health Plans (QHPs) through off-exchange enrollment. For those covered in the exchange, just the federal government's administrative costs amounted to $1,539 per effectuated exchange enrollee, not including administrative costs incurred by insurers. Because insurers were instructed to report their costs for the entire individual market (both exchange and off-exchange) together, it is impossible to determine with certainty the relative administrative costs for both groups. Depending on what assumptions one makes, total administrative costs (both government costs and insurer costs) for exchange enrollees could range from $1,562 to $1,804 and costs for off-exchange enrollees could range from $265 to $414.

Background

In the context of health coverage, "administrative costs" is the difference between total premiums (or for a

government program like Medicare, total spending) and the cost of providing health care to beneficiaries. In some pre-ACA studies, administrative costs were taken to be simply the difference between total premiums collected and total claims paid.[6],[7]

This simplistic approach implicitly treated taxes – including excise taxes and state health insurance premium taxes – as administrative costs. This may be acceptable for answering some questions – for example, comparing costs across states or over time – but it is inappropriate for comparing, for example, private sector administrative costs to that of Medicare since the government by definition pays no taxes on Medicare operations or those of other health care programs.

Additionally, the traditional approach was ambiguous regarding health care costs that were not actual insurance claims. This led to inconsistent treatment of certain non-claim health-related costs. For example, many private insurers provide disease management services for patients with chronic conditions and/or on-call nurses for patients to consult by phone. Because these services are provided directly by the insurance company, they do not result in a claim being paid, so some studies (usually implicitly) treated these as administrative costs. However, these are services that involve the delivery of health care, so they are properly regarded as health care costs, akin to claims, rather than administrative costs.

Section 1001 of the ACA (adding Section 2718 to the Public Health Service Act) requires that insurers pay rebates if they do not attain a particular Medical Loss Ratio (MLR), or ratio of health care costs to premiums. Equivalently, it requires rebates if a given insurer's administrative costs exceed a particular percentage of premiums. One unintended (but convenient for researchers) consequence of this section was that it required the Department of Health and Human Services (HHS) to precisely define what was meant by a "medical loss" and what was meant by "administrative cost." The result was that health-related expenditures that do not result in claims (such as on-call nurse phone services, disease management programs provided directly by the insurer, and even certain IT expenditures intended to improve quality or reduce costs) are properly counted as health care spending rather than as administrative costs. In addition, all taxes, federal and state, are excluded from both the numerator and denominator of the Medical Loss Ratio – that is, they are considered to be neither health care costs nor administrative costs. As a result, "administrative cost" is defined more consistently and appropriately as the amount left over after subtracting from premiums both medical costs and taxes.

A second consequence of the MLR provision was that health care plans are now required to report their administrative cost calculations in detail to the Centers for Medicare and Medicaid Services (CMS), which makes the data used in this study available to researchers approximately two years after the year in which the costs are incurred.

Data

The primary data on administrative costs for private-sector health plans came from the CMS, which collects data from operators of private health plans, both for-profit and not-for-profit, for the purposes of enforcing the Medical Loss Ratio requirements. As of this writing, data is available on the CMS web site[8] for plan years 2011 through 2014. Since the government-run exchanges began with plan year 2014, we compare the data for 2013 and 2014 to determine the effect of the exchange system on administrative costs. Health plan operators are required to compile separate figures for various categories such as individual, group (employer-sponsored) and expatriate (employer-sponsored for non-US employees). We use only the data for individual plans. However, we use the data for individual policies sold both in the exchanges and outside the exchanges, because the CMS asks insurance companies to report data for all their individual plans together. It is possible for a Qualified Health Plan (QHP) to be sold off exchanges only. For this reason, the costs of operating the exchanges are in

effect being spread over more people than are covered in the exchanges. Therefore, the administrative costs of exchanges in this report may be artificially low.

The data for the federal government's cost of establishing and operating the exchanges came from the President's Budget and the annual CMS Budget Justification. Included were costs to the federal government of operating the federally-run exchanges, federal grants to states to establish their own exchanges or for expenses relating to coordinating with a federally-run exchange, and CMS' administrative costs related to those grants.

Specifically excluded were expenditures on premium subsidies and cost-sharing subsidies, as well as administrative costs (primarily in the IRS budget) associated with calculating and distributing those subsidies. These were excluded because they are not administrative costs of health plan exchanges *per se*; they are merely a means to subsidize coverage and could, in principle, have been implemented without the existence of the exchanges.

Expenditures made by the states from their own funds, as opposed to federal grants, were not included due to the difficulty of obtaining the requisite data. Fourteen states operate their own exchanges, and presumably at least some of these states expended funds in addition to federal grants provided for that purpose; to this extent, our figures for administrative costs will be underestimated.

Because the exchanges first sold coverage for the year beginning on January 1, 2014, we have allocated all federal spending on exchanges to that year, even if it was spent in prior years. One could argue that because these expenditures were intended to set up a new system, that they should be allocated over multiple future years. However, there were extensive problems with the administrative system for the exchanges enrollment system for 2014,[9] requiring much of the system to be rebuilt from scratch for 2015.[10] The CEO of Healthcare.gov has stated that the exchange back-end will not be completed until at least 2017.[11] At this time, we will work with the data available. However, we will do sensitivity analysis to determine whether administrative costs would still increase if federal costs were allocated to multiple future years.

Results

The main results are given in Table 1.

	2013 (No Exchanges)	2014 (With Exchanges)	
	Insurer Costs	Insurer Costs	Federal Costs
Direct Administrative Costs	$4.64 billion	$4.12 billion	$3.63 billion
Grants to States			$6.12 billion
Total Covered Person-Years	11.2 million	15.54 million *(on and off-exchange)*	6.34 million *(on-exchange only)*
Administrative Cost Per Covered Person-Year	$414	$265 *(on and off-exchange)*	$1,539 *(on-exchange only)*
		Combined Administrative Costs *(on and off-exchange)*	

	2013 (No Exchanges)	2014 (With Exchanges)	
	Insurer Costs	Insurer Costs	Federal Costs
Total Administrative Costs	$4.64 billion	$13.87 billion *(insurer plus federal)*	
Total Covered Life-Years	11.2 million	15.54 million *(on and off-exchange)*	
Administrative Cost Per Covered Life-Year	$414	$893	
Source: Centers for Medicare and Medicaid Services, President's Budget, author's calculations			

The total insurer administrative costs is the total of all costs considered "administrative" and attributed to the individual market (as opposed to employer-sponsored coverage) for purposes of MLR filings. That is, it is the total premiums collected, including subsidies if any, minus claims paid, other costs incurred to deliver or improve health care, certain costs incurred to reduce the cost of health care, and applicable taxes. By implication, it includes costs of claims processing, regulatory compliance, overhead, marketing, and profit, if any. A covered life-year is the total number of people covered each month during the given year, divided by 12. It is used instead of the raw count of people covered during the year, in order to account for people who were enrolled for only part of the year. Generally, enrollment is counted only in whole months.

The result is that for 2013, in the absence of government-run health exchanges, administrative costs averaged $414 per covered life-year. For 2014, with the assistance of government-run health exchanges, average administrative costs more than doubled, to $893 per covered life-year.

Since administration involves substantial fixed costs (that is, costs that do not vary with the number of customers, such as web site design), one might expect per-person costs to increase if the number of people decreases. However, the number of people covered increased; yet, administrative cost per person also increased.

It is worth noting that insurers' share of administrative costs were reduced by the exchanges. The insurer's administrative costs per covered life-year dropped from $414 in 2013 to $265 in 2014. So, in the end, the government did save private sector insurers $165 per customer; however, the government spent $628 per customer to do so.

The above figures represent totals for the entire individual market, including both coverage purchased through ACA exchanges and coverage purchased outside those exchanges. Breaking out the costs between these two sectors shows an interesting picture as well.

As of December 2014, there were 6.34 million "effectuated" enrollees in ACA exchange plans. While we were unable to obtain the monthly average enrollment, or month-by-month enrollment, we think this is a reasonable estimate of the equivalent person-year enrollment, though possibly it is on the high side. On one hand, enrollment increases throughout any given year because people enroll due to qualifying life events; on the other hand, enrollment decreases when people are dropped for non-payment of premiums or obtain coverage due to various changes in status. In 2014 in particular, it is reasonable to believe that enrollment was higher in the latter part of the year due to enrollment delays during the rollout of healthcare.gov, and extensions of the open enrollment period until March (for coverage beginning in April 2014). So, using December 2014 enrollment as

a proxy for the year might overstate enrollment (thus understating per-enrollee administrative costs), but since most of the cost is likely associated with the enrollment process, this is not terribly unreasonable.

The total federal cost for the ACA exchange program was $9.75 billion, to enroll 6.34 million people. This yields an administrative cost of $1,539 for the federal government, excluding administrative costs to the insurers for enrolling and serving those individuals. Thus, the federal administrative cost of merely establishing the exchanges to obtain enrollees is more than triple the total administrative cost ($414) to insurers of both enrolling and providing coverage for individuals prior to the establishment of ACA exchanges.

If we assume that insurer costs are on average similar for both on-exchange and off-exchange enrollees, then dividing the insurer administrative cost of $4.12 billion by the total of 15.54 million individual-market enrollees gives an average insurer administrative cost of $265 per enrollee, for a total administrative cost of $1,804 per covered person. While this is significantly lower than the $414 per enrollee they spend prior to the ACA exchanges, the reduction was made possible by the federal government spending substantially more than the insurers saved. This is, at best an extremely inefficient form of corporate welfare.

It is likely the case that insurer administrative costs differ for exchange and off-exchange enrollment. For the purpose of sensitivity analysis, we use an extreme example. Assume that off-exchange enrollment in 2014 has the same insurer administrative cost as off-exchange (i.e., all) enrollment in 2013; that is, $414 per enrollee. Multiplying by the number of off-exchange enrollees in 2014, subtracting that amount from total insurer administrative cost for 2014 and attributing the remainder of the total to the on-exchange enrollees produces an average insurer cost of $23 per on-exchange enrollee. This is likely unrealistically low, since the cost of sending an ID card and billing monthly premiums is likely to exceed this amount, and there are many other costs ranging from claims processing to collecting enrollment information. However, even in this extreme example, administrative costs in the exchanges would total $1,562 per enrollee, compared to $414 outside the exchanges. The difference is driven by the extremely high federal cost of operating the exchanges.

Many other studies of administrative costs report results as a percentage of total premiums (for private insurance) or of total program costs (for government health-care programs). This means that administrative costs are compared to the costs of providing actual health care. However, this is somewhat misleading, since different populations can have very different underlying health care needs, and high health care needs can mask inefficient administration. Administrative costs are generally incurred on a per-person basis, not a per-dollar-of-health-care-spending basis. The main way the level of health care spending can affect administrative costs is through the cost of processing claims. However, this is more a function of the number of claims rather than their value, and in any case, claims processing represents a very small proportion of administrative costs.[12] With those caveats, administrative costs increased from 14.3 percent to 23.8 percent of total premiums. These figures reflect both an increase in average premiums as well as an increase in the number of people covered in the individual market.

In this case, premiums increased substantially – from an average of $2,902 in 2013 to $3,651 in 2014.[13] As a result, administrative costs expressed as a percentage of total premiums would substantially understate the increase in administrative costs.

Sensitivity analysis

Using the raw count of covered lives changes the various figures for administrative cost per person/life-year by less than 3 percent.

If one assumes that federal grants to states will not be repeated, and that their impact should be spread over three years, the total administrative cost per covered life-year in the exchanges is reduced to $895 to the federal government and $1,160 total. If one assumes that all federal spending on the exchanges, including grants to states, should be spread over three years, the administrative cost would be $513 for the federal government and $778 total, per exchange-covered life-year. This is an extraordinarily generous assumption, since it not only spreads the start-up costs over three years, but it also spreads the first year's operational costs over three years and assumes that there will be no operational costs in subsequent years; this is known not to be the case. Even with that generous assumption, administrative costs are still higher than they were without exchanges. In fact, just the federal government's cost of operating the exchanges is still higher than the total of all administrative costs without exchanges.

One could also make various assumptions about the distribution of costs (including a portion of the federal costs) between the exchange and non-exchange sectors, but this would not produce values outside the ranges above, and would certainly not change the totals for the entire individual market.

Conclusion

Despite the promises of the ACA proponents, implementing a system of government-run health insurance exchanges did not reduce overall administrative costs, nor did it reduce premiums. In fact, administrative costs per covered person per year more than doubled, even as the number of people covered increased. While insurers did spend less per customer on administrative costs, federal spending more than made up the difference, making the exchanges into an expensive and wasteful subsidy to an industry that was not demonstrably in need of it. In fact, just the federal government's expenditures in establishing and operating the ACA exchanges – a function devoted solely to enrollment – vastly exceeds the *total* administrative costs, both for enrollment and operations – of private-sector insurers prior to the implementation of the exchanges.

PDF VERSION

[1] Paul Krugman, "The Health Care Racket," *The New York Times*, February 16, 2007.

[2] Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine*, August 2003; 349:768-775, at *http://www.nejm.org/doi/full/10.1056/NEJMsa022033#t=article*.

[3] Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform," Institute for America's Future (undated but apparently completed in December 2008), p.6. *http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf*

[4] Frank Clemente, "A Public Health Insurance Plan: Reducing Costs and Improving Quality," Institute for America's Future, February 5, 2009, p. 6, at *http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf.*

[5] Edward M. Kennedy, "A Democratic Blueprint for America's Future," Address at the National Press Club, January 12, 2005. *http://www.commondreams.org/views05/0112-37.htm*; Pete Stark, "Medicare for All," *The Nation*, February 6, 2006. *http://www.thenation.com/doc/20060206/stark*; Max Baucus, "Call to Action Health Reform 2009," November 12, 2008, p. 77 *http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf*; Hacker (2008), p. 6-8; Clemente (2009), p. 15.

[6] Benjamin Zycher, "Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?" Manhattan Institute for Policy Research, October 2007, at *http://www.manhattan-institute.org/html/mpr_05.htm*.

[7] Mark E. Litow, "Medicare versus Private Health Insurance: The Cost of Administration," Milliman, Inc. January 6, 2006.

[8] https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

[9] Ellis Hamburger, "Healthcare.gov's technical problems frustrate Americans," The Verge, December 6, 2013, at http://www.theverge.com/2013/10/20/4859316/healthcare-gov-woes; Paul Ford, "The Obamacare Website Didn't Have to Fail. How to Do Better Next Time, *BloombergBusinessweek*, October 17, 2013, at http://www.bloomberg.com/news/articles/2013-10-16/why-the-obamacare-website-was-destined-to-bomb.

[10] Steven Levy, "Why the New Obamacare Website Is Going to Work This Time," *Wired*, June 5, 2014, at https://www.wired.com/2014/06/healthcare-gov-revamp.

[11] House Committee on Energy and Commerce, Health Subcommittee, Feburary 24, 2015, at https://energycommerce.house.gov/news-center/fact-sheets/healthcaregov-ceo-president-obama-will-no-longer-be-office-when-hcgov-s-back.

[12] As an extreme example, consider that Medicare patients are by definition elderly, disabled, or patients with end-stage renal disease, and as such have higher average patient care costs than the privately-insured population. Claims processing represents only 4 percent of Medicare's administrative costs. In 2005, Medicare's administrative costs were only about 3 percent of total program costs, but $509 per beneficiary. The percentage of administrative cost is much lower than for individual coverage, but the dollar cost is much higher.

[13] These are average premiums per covered person-year, and as such include family premiums divided by the number of family members. As a result, they may not be comparable to average premiums reported in other contexts.