

Administrative Efficiency

Background Information Prepared for the Health Care Transformation Task Force by Minnesota Department of Health Staff November 13, 2007

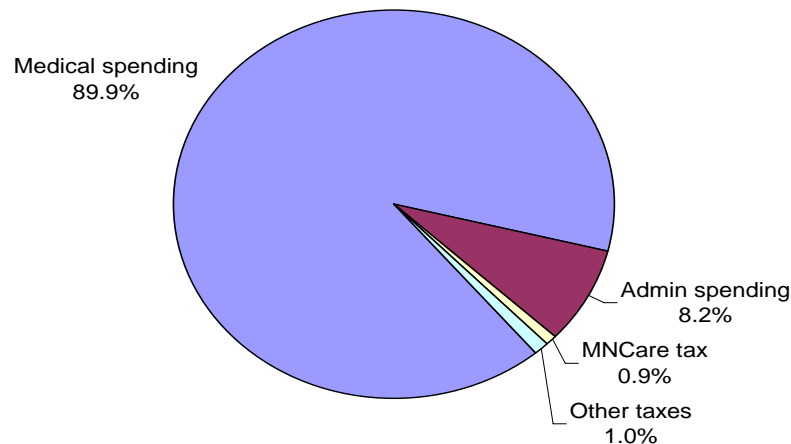
Introduction

The impact of administrative spending on overall health care costs is an important issue for policymakers. This background paper provides information on administrative costs incurred by health plans, hospitals, and physician clinics in Minnesota. We also discuss the potential cost savings of strategies aimed at making health care administration more efficient, including administrative simplification and increased use of health information technology.

Health Plan Administrative Costs:

Minnesota health plans reported spending a total of \$13.9 billion in 2006.¹ Figure 1 shows that administrative spending accounted for 8.2% of this total. Figure 2 illustrates that administrative spending as a share of total expenses has remained relatively stable in recent years, falling from 8.9% in 2002 to 8.2% in 2006.

Figure 1
2006 Minnesota Health Plan Spending
(Total Reported: \$13.9 billion)

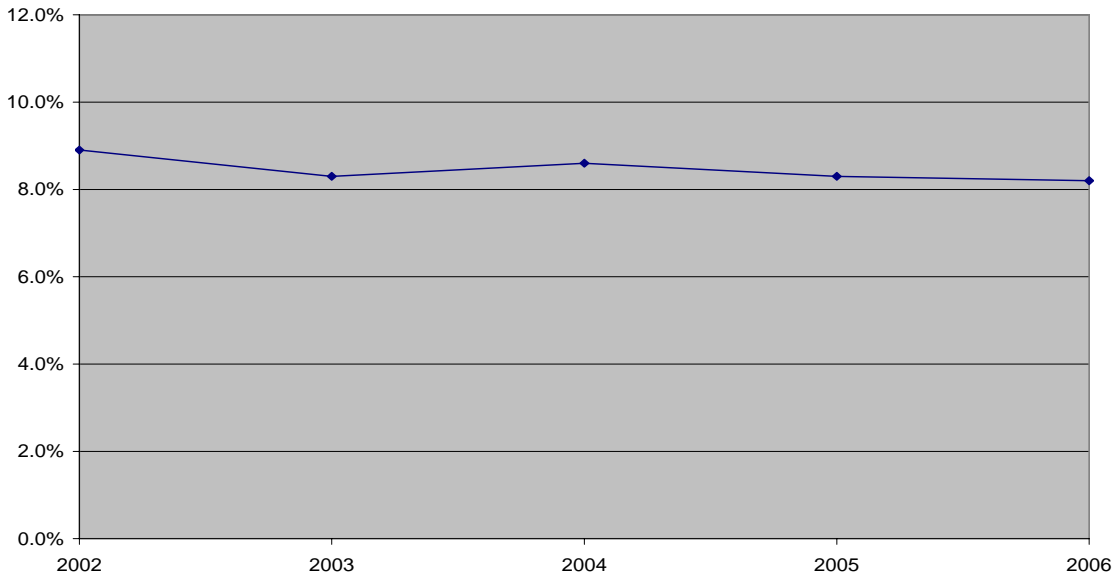


Notes: For companies with over \$3 million in annual premiums. Includes spending for all product lines (reporting of self-insured business is voluntary).

Source: MDH analysis of 2006 Health Plan Financial and Statistical Reports

¹ All health plans that do business in Minnesota are required to submit annual financial and statistical reports to MDH pursuant to Minnesota Statutes, Section 62J.38. These data are not directly audited by the Department of Health, but health plans must certify that their reports to MDH are in line with the audited financial statements that they provide to the Department of Commerce.

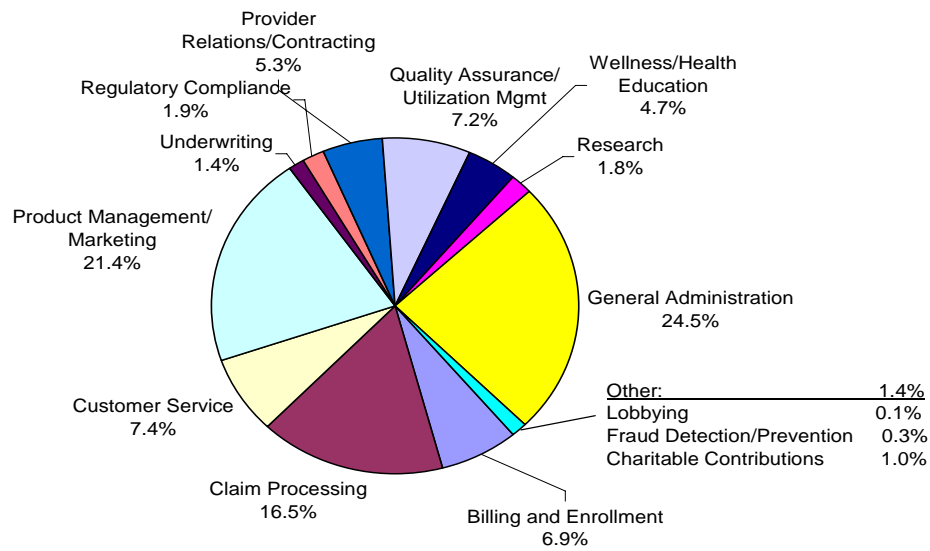
Figure 2
Administrative Spending as a Percent of Total Health Plan Spending, Minnesota



Source: MDH analysis of 2002-2006 Health Plan Financial and Statistical Reports

Figure 3 provides a breakdown of health plan administrative spending in 2006. The largest shares were for general administration (24.5%), product management and marketing (21.4%), and claims processing (16.5%).

Figure 3
2006 Administrative Spending by Minnesota Health Plans
(Total reported: \$1.14 billion)



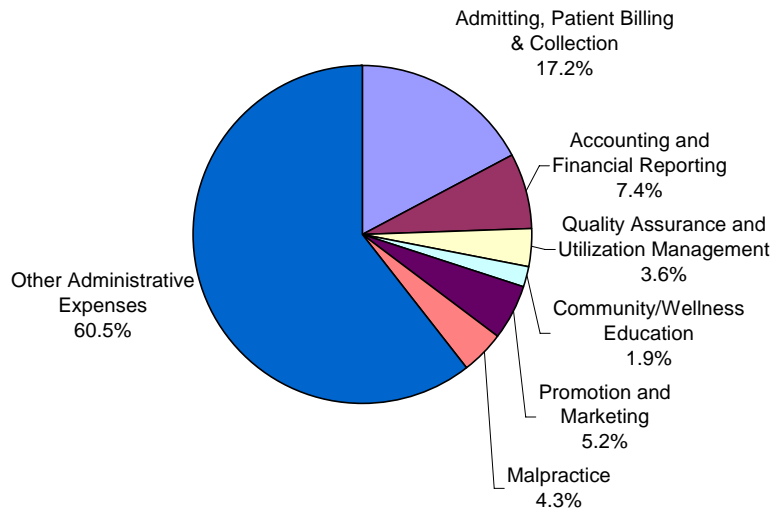
Source: MDH analysis of 2006 Health Plan Financial and Statistical Reports

Hospital Administrative Costs:

Information on hospital administrative costs is available through annual financial and statistical reports to MDH. Based on the data reported for 2005 (the most recent available), 10.8% of hospital operating expenses were for administrative costs, and an additional 2.3% went to taxes, fees, and assessments.

Figure 4 presents information on hospital administrative costs by category of spending. As shown in the figure, hospitals reported 60.5% of their total administrative spending in the “other administrative expenses” category. An additional 17.2% of administrative spending was for patient admitting, billing and collection, 7.4% for accounting and financial reporting, and 5.2% for promotion and marketing. The remaining categories each accounted for less than 5% of the total in 2005.

Figure 4
2005 Administrative Costs for Minnesota Hospitals
(Estimated Total \$1.0 billion)



Notes: Detailed administrative spending is reported only by hospitals with 50 or more licensed beds; this analysis assumes that administrative expenses for smaller hospitals are distributed by category the same as for larger hospitals. Excludes taxes, fees, and assessments.

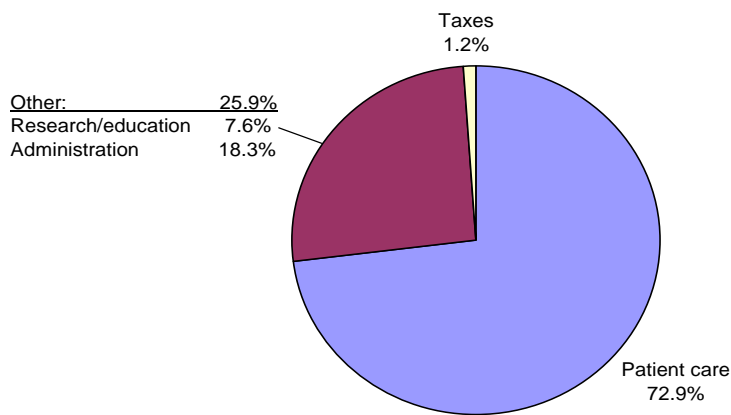
Source: MDH analysis of 2005 Health Care Cost Information System (HCCIS) data.

Administrative Costs of Physician Clinics:

Physician clinics in Minnesota provide annual financial and statistical reports to MDH under Minnesota Statutes, Section 62J.41. Figure 5 provides an illustration of expenses reported to MDH for 2004 (the most recent year of data currently available for analysis). Of total spending reported, 72.9% was for patient care, 25.9% for non-patient care (of which nearly one-third went to research and education, with the rest for administrative spending), and 1.2% for taxes.

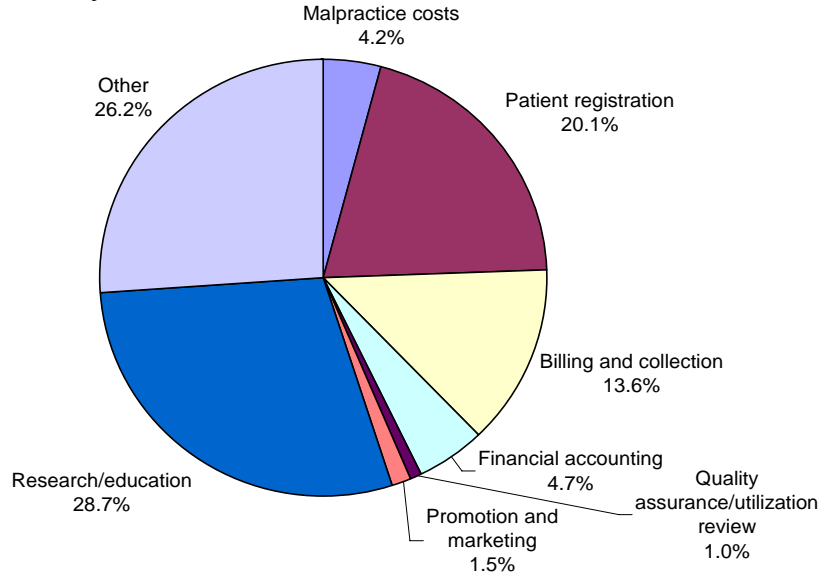
Figure 6 illustrates how clinic non-patient care dollars were spent. The largest shares were for research and education (28.7%), patient registration (20.1%), and billing and collection (13.6%), while 26.2% of non-patient spending was classified as “other”. The remaining categories each accounted for less than 5% of the total in 2004.

Figure 5
2004 Physician Clinic Spending



Notes: Breakout of non-patient care into research/education and administrative cost was estimated using 1999 data.
Source: MDH analysis of data from Provider Financial and Statistical Reports for 2004.

**Figure 6
Physician Clinic Non-Patient Care Costs, 2004**



Notes: Split between research/education and “other” is estimated from 1999 data.

Source: MDH analysis of 2004 Provider Financial and Statistical Reports.

Administrative Spending in Perspective

Many people believe that administrative spending represents wasteful overhead that could be reduced or eliminated to make health care more efficient, affordable, and accessible. While there are no doubt many areas where greater efficiency is needed (such as uniform billing and coding, or electronic medical records), it is important to remember that many components of administrative spending actually help to hold overall health care spending down.

For example, money that health plans or providers invest in functions such as disease management or fraud prevention adds to administrative cost, but likely reduces total spending. In a hypothetical example, suppose that a health plan has administrative costs of \$100,000 and total spending of \$1,000,000. If the health plan invests \$20,000 in a disease management initiative that reduces medical costs by \$60,000, this is clearly a good investment in terms of reducing overall health care spending. Total spending in this case would be \$120,000 in administrative spending and \$840,000 in medical costs, or \$960,000 – a reduction of 4% in total spending despite the fact that administrative spending in this example increased by 20%, and the fact that administrative spending as a share of total spending rose from 10% to 12.5%. In other words, looking at administrative spending as a share of total spending is not always the most useful indicator of value or efficiency.

A 1995 report by the Minnesota Office of the Legislative Auditor (OLA) found that administrative costs incurred by health plans, hospitals, and physician clinics accounted for 15.2% of total health care spending in Minnesota. This report also included results of modeling conducted by Lewin-VHI Inc. of how administrative spending and total health care spending

would change under different scenarios of health care reform. The OLA report noted, “...reforms with the lowest administrative costs are not necessarily the least costly, since higher administrative costs sometimes help to control overall spending.”² Of the health reform scenarios analyzed by Lewin-VHI on behalf of OLA, some were estimated to result in significant administrative cost savings, but would have resulted in an overall increase in health care costs. Similar studies by nonpartisan agencies such as the Congressional Budget Office and the U.S. General Accounting Office also found that health care reforms (often using the example of a single payer system) would likely reduce administrative costs but that increases in medical spending would offset those savings, potentially resulting in a net increase in total health care spending.³

Potential Savings: Administrative Uniformity and Expanded Use of Health Information Technology

As noted above, simply reducing administrative spending is not necessarily an effective way to contain health care costs. However, there is considerable potential for health care transactions to be made more efficient and cost effective, and for expanded use of health information technology to improve health care quality and contain costs.

Expenses related to claims processing and enrollment account for large shares of administrative spending in the state. Recent changes to Minnesota’s Health Care Administrative Simplification Act⁴ were aimed at reducing these costs. Starting in 2009, all health care providers and group purchasers must exchange the following information *electronically* and *using a single standard*:

- eligibility verification
- claims
- payment and remittance advice

It is difficult to pin down the cost savings potential of these changes, but a 2006 survey from America’s Health Insurance Plans cites the average cost of processing an electronic claim (\$.85) at nearly half that of a paper claim (\$1.58). This suggests that the transition to uniform, electronic health care transactions has considerable long-term savings potential.

Minnesota’s Health Information Exchange will allow for the secure electronic exchange of important clinical information between providers and payers. The Health Information Exchange will enable doctors to get medical information about a specific patient more quickly and cost-effectively than relying on phone, facsimile, couriers or the mail. Initially, the Minnesota Health Information Exchange will provide the connectivity needed to obtain medication histories, lab orders and test results across health systems. Future electronically based services will include radiology reports, Minnesota Department of Health disease surveillance reporting, and electronic prescriptions.

² Minnesota Office of the Legislative Auditor, “Health Care Administrative Costs,” February 1995.

³ See discussion in Chapter 2 of the 1995 OLA report.

⁴ Minnesota Statutes 62J.536

A recent report prepared for the State of Oregon estimated the potential savings of a fully interoperable electronic health record system⁵. The system analyzed in this study was a more comprehensive version of Minnesota's Health Information Exchange; for example, it assumed completely standardized electronic communication among all payers and providers in the state. The system would also include clinical decision support. There were several sources of potential savings:

- Avoided services; (e.g., ambulatory visits due to adverse drug events and fewer duplicative tests)
- Lower product and services costs
- Increased productivity of doctors and nurses
- Improved efficiency of administrative processing

The study considered the costs and benefits over a twelve year period, and estimated the net potential savings at between \$1 billion and \$1.3 billion annually. An estimated 35% of these savings were from avoided services and 65% were from improved clinical and administrative efficiencies. These savings represent 4.3%-5.9% of Oregon's total health expenditures. If we assume similar potential savings in Minnesota, implementing an interoperable electronic health record system would save between \$1.4 and \$1.9 billion per year.⁶

It is important to emphasize that these are *net long-term* savings. Implementing this system statewide will obviously involve significant investment in start-up and maintenance costs; the Oregon study estimated the average cost of implementing and maintaining the system at between 1.9% and 3.2% of total health expenditures in the state. In Minnesota, this would translate to an average annual cost of between \$594 million and \$1.01 billion.

Other Sources of Potential Administrative Savings

The insurance market reform and payment reform proposals being considered by the Transformation Task Force may also lead to some administrative cost savings. For example:

- Guaranteed issue and the elimination of health status as an underwriting factor in the small group and individual health insurance markets will reduce health plans' underwriting costs. Health plans reported that underwriting costs were about 1.4% of total administrative costs in 2006, or about \$16 million.
- Broader adoption of section 125 plans and implementation of a health insurance exchange would reduce costs associated with premium billing, since a larger share of the population would be paying for health insurance through withholding from their paychecks.
- Payment reforms that simplify provider pricing have the potential to significantly reduce the costs that health plans and providers currently incur to negotiate reimbursement rates.

⁵ David M. Witter, Jr. and Thomas Ricciardi, "Potential Impact of Widespread Adoption of Advanced Health Information Technologies on Oregon Health Expenditures," Report prepared for Oregon Health Care Quality Corporation and Office for Oregon Health Policy and Research, September 2007.

⁶ Minnesota Department of Health estimate of 2007 health expenditures, based on 2005 expenditures (\$29.4 billion), projected to 2007 (\$31.4 billion) using the Center for Medicare and Medicaid Services estimate for health care expenditure growth

- If Minnesota achieves universal health insurance coverage, providers' costs associated with billing and collection for uninsured patients would fall. Providers would still need to bill for amounts not covered by health insurance (e.g., deductibles or copayments), so it is unclear how much of current spending on this function would disappear.

In comparison to the potential savings associated with improved administrative efficiency through the use of information technology, these other sources of savings are likely to be relatively small.