# How Much Is Too Much?

## An Analysis of Health Plan Profits and Administrative Costs in California

California HealthCare Foundation

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### Introduction

Health insurance premiums in California are increasing much faster than most other areas of the state's economy. Between 2002 and 2007, premiums rose 86 percent compared to an overall inflation rate for the state of less than 20 percent.[1] At the same time, policymakers and the public are eager to identify ways to address rising health care costs, often pointing to health plan administrative costs as a potential target.[2]

In response to concerns about health insurance carriers' efficiency and accountability, policymakers have considered regulation to ensure that the percentage of premium income that carriers spend on medical care, known as the *medical loss ratio (MLR),* stays at or above a minimum level. For example, Senate Bill 1440, which passed both houses of the California legislature in 2008, would have required insurance carriers to spend at least 85 percent of premium income on medical care. Although Governor Schwarzenegger's 2007 health care reform proposals included a similar requirement, he vetoed SB 1440, citing a desire for "comprehensive" rather than "piecemeal" reform.[3] The impact of medical loss ratio regulation could be substantial; in 2006, almost half (12 out of 26) of full-service health plans regulated by the California Department of Managed Care had an MLR of less than 85 percent.[4]

Health insurance carriers receive income from premiums paid by employers and individuals, and from other sources, such as investment income.[5] The carriers use this income to pay both direct medical expenses (claims paid to doctors, hospitals, and other health care providers) and administrative costs (including marketing, enrollment, customer service, and billing). The residual that is left over is called *profit* in for-profit health insurance carriers, and can be paid to stockholders, used to finance capital investments, or transferred to reserves. Nonprofit health insurance carriers have no stockholders; the residual is known as *net income* and may fund capital investments and reserves. A proposal requiring carriers to spend at least 85 percent of premium income on medical care would in effect limit profits and administrative costs to 15 percent of premium income. (Throughout this report, the term *profit* is used to refer to both for-profit carriers' profits and nonprofit carriers' net income.)

To better understand the potential impact of policy proposals intended to restrain health insurance administrative costs and profits, the California HealthCare Foundation commissioned researchers from RAND Health to analyze three questions:

1. To what extent has recent (2002–2006) growth in premiums in California and nationwide been driven by growth in administrative costs and profits?
2. Are California health plans' administrative costs and profits "reasonable"?
3. What has been the effect of MLR regulations in other states?

This issue brief summarizes the findings and discusses implications for the design, implementation, and monitoring of MLR regulation.

## Can Administrative Costs and Profits Explain Premium Growth?

To examine whether administrative costs and profits are driving growth in premiums, the researchers analyzed annual reports from 2002 to 2006 filed at the California Department of Managed Health Care (DMHC). The DMHC regulates all health maintenance organizations (HMOs) that operate in the state as well as some preferred provider organizations (PPOs).[6] The analysis therefore primarily focused on HMOs, which provide coverage to the majority of insured Californians.[7] In 2006, enrollment for the 26 health plans represented was almost 19 million people, about 60 percent of all insured Californians. Among the health plans were eight for-profit firms, nine nonprofit private insurers, and nine public insurers (also called *local health initiatives)*. Estimates of national health expenditures from the Center for Medicare and Medicaid Services (CMS) were used to examine national trends in premiums, administrative costs, and profits.[8]

In California, revenues per enrollee increased about 10.6 percent annually (from $2,379 to $3,565) between 2002 and 2006, compared to 4.1 percent for the nation (from $3,329 to $3,919). See Table 1. MLRs for the health plans in California and nationwide remained relatively stable, and the 2006 MLR for California carriers (88 percent) was the same as for the nation.[9]

Compared with for-profit plans, private nonprofit plans had much higher revenues per enrollee ($4,508 versus $2,767 in 2006) and also experienced much larger annual growth in revenue (13.9 percent versus 5.7 percent). These large differences are likely linked to greater market presence of comprehensive HMO products among nonprofit plans. In contrast, for-profit plans tend to rely more on products with high and increasing consumer cost-sharing, thus lower—and less rapidly rising—revenues. Private nonprofit plans spent 90 percent or more of their revenues on medical costs, while the MLR of for-profit plans remained constant at 82 percent from 2002 to 2006. Public plans, whose enrollment includes a greater share of children with relatively low service use, tended to have lower revenues per enrollee than either for-profits or nonprofits, and spent 91 percent of revenues on health care.

Overall, the analysis suggests that medical cost increases account for most of the premium growth in California and nationwide during 2002–2006. Across all types of plans, medical costs explain nearly 86 percent of revenue increases in California and 89 percent of increases

**Table 1. Revenues, Administrative Expenses, and Medical Expenses for California Health Plans, 2002–2006**

| | REVENUE PER ENROLLEE | | MEDICAL LOSS RATIO | | REVENUE INCREASE | |
|---|---|---|---|---|---|---|
| | 2002 | 2006 | 2002 | 2006 | DUE TO ADMINISTRATIVE COSTS AND PROFITS | DUE TO MEDICAL COSTS |
| **California Health Plans** | | | | | | |
| All | $2,379 | $3,565 | 89% | 88% | 14% | 86% |
| For-profit | $2,219 | $2,767 | 82% | 82% | 18% | 82% |
| Nonprofit | $2,679 | $4,508 | 94% | 90% | 16% | 84% |
| Public | $1,403 | $1,467 | 91% | 91% | 0% | 100% |
| **U.S. Private Insurers** | | | | | | |
| All | $3,329 | $3,919 | 87% | 88% | 11% | 89% |

Sources: Insurance filings with the DMHC and estimates of national health expenditures from the CMS. Estimates are averages across the carriers in the sample and are weighted by the number of enrollees. In 2006, there were 1.44 million enrollees in public plans, 9.66 million enrollees in nonprofit plans, and 7.64 million enrollees in for-profit plans.

Notes: All dollar values shown are in 2006 dollars. The consumer price index was used to adjust for inflation.

nationwide. For both for-profit and nonprofit insurers in California, increases in medical costs explain roughly the same fraction of revenue growth (82 percent and 84 percent, respectively), while increases in medical costs explain nearly all of the increase in revenues per enrollee for public insurers.

Profits and administrative costs in California grew substantially during this period (see Table 2).[10] Profits per enrollee increased from $65 in 2002 to $178 in 2006 (29 percent annual growth), and administrative costs increased from $190 to $249 (7 percent annual growth). Such increases were especially large for nonprofit insurers, whose profits per enrollee increased from $8 to $189 (120 percent annual growth), and whose administrative costs per enrollee increased from $133 to $231 (15 percent annual growth). However, because administrative costs and profits per enrollee were small relative to medical costs, these increases did not contribute substantially to growth in revenues.

## Are Administrative Costs and Profits "Reasonable"?

There is no unimpeachable standard by which to judge the appropriateness of health plan administrative costs and profits. To begin to gauge "reasonableness," health plan profits and administrative costs were compared to several benchmarks.

- Profits as a percentage of revenues were compared for California health plans and the S&P 500

### DMHC, CDI, and Financial Data Availability

Oversight of health insurance carriers in California is divided between two state departments. The Department of Managed Health Care (DMHC) regulates health care service plans whose products have historically emphasized service delivery through health maintenance organizations (HMOs). The California Department of Insurance (CDI) has jurisdiction over health insurers whose products have historically emphasized the financial protection aspects of insurance, rather than the service delivery modality.[11]

The research team was interested in analyzing financial filings for insurance carriers regulated by both DMHC and CDI, particularly since experience may differ systematically between the two regulatory venues. The detailed plan-level data for the years 2002 to 2006 were readily available in an electronic format from the DMHC Web site. However, data on CDI-regulated insurers for the years 2002 to 2006 were not available in an electronic format or as summary reports either from CDI or from the National Association of Insurance Commissioners (NAIC). Consequently, the current analysis was limited to insurance carriers regulated under the Department of Managed Health Care, whose enrollment of approximately 19 million Californians represents 60 percent of the state's insured population.

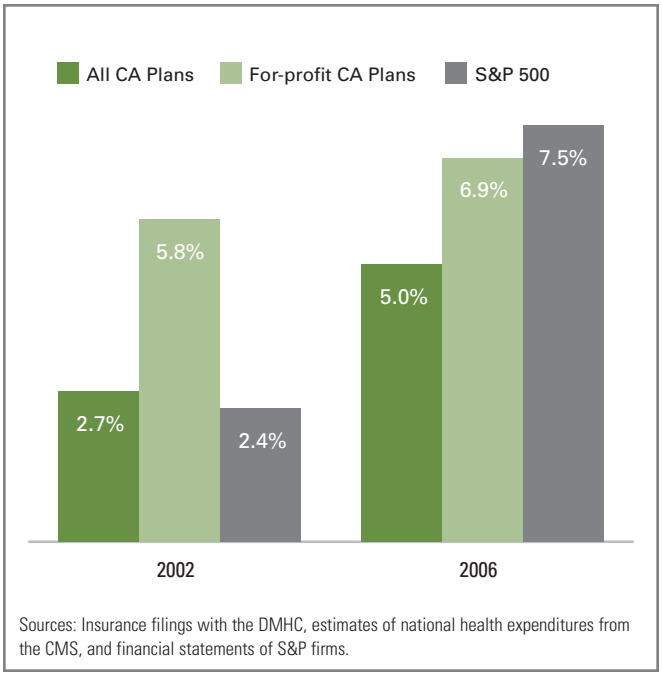
**Table 2. Breakdown of Per Enrollee Expenses for California Health Plans, 2002–2006**

| | PROFITS | | | ADMINISTRATIVE COSTS | | | MEDICAL EXPENSES | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2002 | 2006 | ANNUAL GROWTH | 2002 | 2006 | ANNUAL GROWTH | 2002 | 2006 | ANNUAL GROWTH |
| All | $65 | $178 | 29.0% | $190 | $249 | 7.0% | $2,124 | $3,138 | 10.0% |
| For-profit | $128 | $191 | 11.0% | $266 | $302 | 3.2% | $1,825 | $2,274 | 5.7% |
| Nonprofit | $8 | $189 | 120.0% | $133 | $231 | 15.0% | $2,538 | $4,088 | 13.0% |
| Public | $42 | $30 | –8.8% | $86 | $97 | 3.1% | $1,276 | $1,341 | 1.2% |

Sources: Insurance filings with the DMHC and estimates of national health expenditures from the CMS. Estimates are averages across the carriers in the sample and are weighted by the number of enrollees.

Notes: All dollar values shown are in 2006 dollars. The consumer price index was used to adjust for inflation.

**Figure 1. Profitability of California Health Plans and S&P 500 Firms**




Sources: Insurance filings with the DMHC, estimates of national health expenditures from the CMS, and financial statements of S&P firms.

(see Figure 1). Profits for California health plans as a whole are lower than those of the S&P 500 firms (5 percent of revenues versus 7.5 percent). However, the profit margin of for-profit plans in 2002 (5.8 percent) was higher than for S&P 500 firms as a whole (2.4 percent), although in 2006, the profit margins for these two groups were similar (6.9 percent for for-profit insurers and 7.5 percent for the S&P 500). These simple comparisons do not take level of risk into consideration. Conventional wisdom is that firms engaging in more risky enterprises require greater potential reward. If California health plans face less risk than the S&P 500 as a whole, they may be satisfied with a lower profit margin; but if the health plans face more risk, then they may demand a higher profit margin.

- Administrative costs of California health plans were compared to those of Medicare (see Table 3). Medicare is often cited as an efficient insurer, although reported Medicare program administrative costs exclude the costs of fiscal intermediaries that collect premiums and process claims and may understate the program's overall administrative burden. Medicare spends $471 per enrollee on administrative costs, which is above the average amount spent across all California health plans ($427) and slightly below the amount spent by for-profit plans ($493).[12] However, Medicare spends roughly 5 percent of revenues on administration, which is much lower than the average spent by all California health plans (12 percent) and by for-profit plans (18 percent). The apparent contradiction comes from the fact that the Medicare population is older than that covered by California health plans, and therefore Medicare enrollees incur higher medical expenses. Therefore, Medicare's administrative costs as a percentage of revenues are much lower.

The DMHC data were used to examine whether growth in administrative costs has been driven by salaries and marketing—two large spending categories sometimes identified as potentially wasteful. Although marketing and compensation account for over half of administrative costs, the share of administrative costs devoted to compensation remained fairly constant at 29 to 31 percent from 2002 to 2006, while the share of costs devoted to marketing fell slightly, from 34 percent in 2002 to 27 percent in 2006. Spending in these two categories has not contributed disproportionately to growth in total administrative costs. Yet, while growth in marketing and compensation have not outpaced overall administrative cost increases, neither have they lagged behind; both have increased, along with medical spending, at rates that exceed general inflation.

**Table 3. Administrative Costs and Profits Per Enrollee for Medicare and California Health Plans, 2006**

| | DOLLAR AMOUNT | PERCENTAGE |
|---|---|---|
| Medicare | $471 | 5% |
| All California health plans | $427 | 12% |
| For-profit California health plans | $493 | 18% |

Source: Insurance filings with the DMHC and estimates of national health expenditures from the CMS. Estimates are averages across the carriers in the sample and are weighted by the number of enrollees.

Notes: All dollar values shown are in 2006 dollars. The consumer price index was used to adjust for inflation.

## What Can California Learn from Other States?

Information on MLR regulations from 45 states was collected from each state's Department of Insurance (DOI) and categorized into one of five groups, depending on the type of market affected: none; individual market only; small-group market only; individual and small-group only; or entire market (individual, small-group, and large-group).[13] See Table 4. Only six states mandated minimum MLRs for all segments of the health insurance market, stipulating minimum MLRs ranging from 50 percent to 75 percent.[14] The latest of these states enacted its MLR regulations in 1999. The analysis showed:

- California's recent proposal to restrict insurance carriers to a minimum MLR of 85 percent is unique both because it is more stringent than existing regulations in any other state and because no state has recently chosen to regulate the MLR for the entire health insurance market.
- Existing MLR regulations have had little effect in states that have enacted those regulations. There is little relationship between the presence of extensive MLR regulation and insurers' average loss ratio.[15] In particular, the mean loss ratio for insurers reporting in the 18 states without MLR regulations (83.3 percent) was similar to the mean loss ratio for insurers reporting in the six states that regulate the entire market (81.4 percent), although none of these states required the MLR to be higher than 75 percent.

**Table 4. MLR Regulation for Health Insurance Markets**

| AFFECTED MARKET SEGMENT | NUMBER OF STATES | MLR RANGE | YEARS ENACTED |
|---|---|---|---|
| None | 18 | N/A | N/A |
| Individual only | 13 | 50–72% | 1962–2001 |
| Small-group only | 2 | 60–80% | 1992–2001 |
| Individual and small-group only | 6 | 65–82% | 1991–1993 |
| Entire market | 6 | 50–75% | 1974–1999 |
| **Total** | **45** | **N/A** | **N/A** |

Source: Interviews with state insurance regulators.

## Issues to Consider

The analysis identified issues to consider when determining whether and how to regulate insurers' administrative costs and profits.

**What spending levels are appropriate?** There are no definitive answers about the "right" level of spending on medical care versus other costs. Not all administrative costs are wasteful and not all medical spending provides real value. Most observers agree that there is room for improvement in the efficiency with which American health care is financed and provided, but perspectives differ regarding the causes and remedies. If administrative spending is the source of the majority of inefficiencies, then regulating MLRs will be a useful way to improve efficiency. However, if medical spending accounts for the bulk of inefficiencies—through inappropriate service use, pricing that does not reflect cost, or both—then MLR regulation could be ineffective or even counter-productive. Therefore, it is crucial to analyze the magnitude and source of inefficiencies in the health care system and to determine to what extent MLRs are a meaningful measure of efficiency.[16]

**How should a requirement be applied?** A minimum MLR could apply separately to each product issued by an insurance carrier, or to a carrier's entire book of business (Senate Bill 1440 would have required the insurer as a whole to spend at least 85 percent of premium income on medical expenses). If accompanied by public reporting, clear definitions, and benchmarks to assist in interpreting MLRs, a requirement that a minimum MLR apply separately to each product could benefit consumers. However, there are two disadvantages to this approach. First, since medical costs are more variable at the product level, particularly for products with low enrollment, insurance carriers would be subject to more variability in ensuring that each plan meets the minimum threshold. Second, since many administrative costs for an insurance carrier are not specific to an individual product, allocating

these costs among the products would be difficult and could make the measure harder to enforce.

**How would carriers respond?** Firms would have at least three options in meeting a minimum threshold. First, they could reduce premiums by accepting lower profits. This would initially benefit consumers, although it could hurt them in the long term if firms decide to leave the state and the remaining coverage options are less competitive. Second, insurance carriers could reduce their administrative costs—ideally by cutting spending on wasteful administrative activities—presumably the intent of the proposed regulations. However, carriers could opt instead to reduce spending on administrative costs that benefit enrollees and improve efficiency, such as customer service representatives, innovation in design of health benefits, health care contracting, or utilization reviews. Finally, insurance carriers could increase medical spending to reach the threshold. The 12 firms that would be affected by the proposed regulations would need to spend roughly $82 per enrollee, or $836 million in the aggregate, to reach the threshold. These amounts represent a 3.6 percent total increase in medical spending. To the degree that this increase is devoted to cost-effective medical care, the MLR regulations will improve efficiency. However, if firms choose to reach the threshold by spending on cost-ineffective medical care or by allowing unit prices paid to rise, then the regulations could actually reduce efficiency.

**How will costs impact insurer actions?** The costs of compliance and the ability of insurance carriers to game the system should be considered when adopting MLR regulations. If the costs associated with compliance are high, then MLR regulations could actually increase administrative costs. Moreover, insurance carriers are more knowledgeable about their administrative costs and profits than regulators, and could try to find ways to game the regulations by, for example, re-categorizing or redistributing certain types of spending. The possibility of gaming will depend on how precisely the regulation and its definitions are worded and on each carrier's organizational and financial structures—how integrated the health plan and health care delivery systems are, for example. In interviews, DMHC staff suggested that they are not concerned about companies gaming the system under current regulations. However firms may have increased incentives to game if more stringent regulations are imposed.

## Conclusions

The absence of readily available financial performance data for Department of Insurance-regulated carriers makes it impossible to analyze historical trends or estimate the potential impact of MLR regulation for a small but important part of California's health insurance market. Among DMHC-regulated health plans, profits and administrative costs increased substantially between 2002 and 2006, but it was increases in medical costs that drove premium growth during that time. Assessing the reasonableness of current levels of administrative costs and profits is highly dependent on the benchmark by which health plans are judged. Therefore, it is unclear whether there is a strong case to be made for regulating MLRs. However, if MLR regulations are implemented, the state should establish uniform reporting requirements that assure publicly accessible financial data and medical loss ratios for all of the state's insurance carriers. State regulatory agencies should also take steps to monitor a range of potential effects of the regulation, including consumer satisfaction, medical care cost growth, health plan entry and exit, and the regulatory burden on insurance carriers and the state.

## Appendix 1. MLR for California Health Plans, 2006

| PLAN NAME/TYPE | ENROLLMENT | MLR |
|---|---|---|
| **Nonprofit** | | |
| California Physicians' Service (dba Blue Shield of California) | 2,621,060 | 83.07% |
| Community Health Group | 91,836 | 84.66% |
| Kaiser Foundation Health Plan, Inc. | 6,758,447 | 92.47% |
| On Lok Senior Health Services | 1,011 | 81.45% |
| Scripps Clinic Health Plan Services, Inc. | 37,483 | 94.76% |
| Sharp Health Plan | 48,466 | 90.29% |
| Sistemas Medicos Nacionales, S.A.de C.V. | 16,477 | 68.93% |
| WATTSHealth Foundation, Inc. | 1 | 76.48% |
| Western Health Advantage | 85,548 | 90.37% |
| **Profit** | | |
| Aetna Health of California, Inc. | 314,692 | 82.27% |
| Blue Cross of California | 4,397,820 | 79.88% |
| Chinese Community Health Plan | 13,231 | 85.64% |
| Cigna HealthCare of California, Inc. | 312,960 | 93.23% |
| Great-West Healthcare of California, Inc. | 53,380 | 73.55% |
| Health Net of California, Inc. | 2,146,892 | 84.90% |
| PRIMECARE Medical Network, Inc. | 220,236 | 79.89% |
| Universal Care, Inc. | 179,410 | 84.40% |
| **Public** | | |
| Alameda Alliance for Health | 90,198 | 85.81% |
| Contra Costa Health Plan | 63,474 | 92.91% |
| County of Los Angeles–Department of Health Services | 159,426 | 80.97% |
| County of Ventura (dba Ventura County Health Care Plan) | 11,143 | 87.36% |
| Local Initiative Health Authority for L.A. County (dba L.A. Care) | 795,658 | 94.88% |
| San Joaquin County Health Commission (dba Health Plan of San Joaquin) | 76,035 | 87.51% |
| Santa Clara County (dba Valley Health Care) | 58,340 | 90.42% |
| Santa Clara County Health Authority | 96,570 | 87.16% |
| Santa Cruz – Monterey Managed Medical Care Commission | 88,296 | 92.44% |

Source: 2006 insurance filings with the DMHC.

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RAND is a nonprofit institution that helps improve policy and decision-making through research and analysis.

## Endnotes

1. California HealthCare Foundation, *California Employer Health Benefits Survey,* December 2007.

2. A recent poll by the Kaiser Family Foundation found that 66 percent of Americans believe that reducing waste and fraud in the health care system would do "a lot" to lower health care costs. See www.kff.org/kaiserpolls/upload/7784.pdf.

3. SB 1440 veto message, leginfo.ca.gov/pub/07-08/bill/sen/sb_1401-1450/sb_1440_vt_20080930.html, accessed on October 7, 2008.

4. What share of health insurance carriers would be affected by a particular policy proposal depends on the proposal's specific requirements. For example, SB 1440 as passed August 31, 2008 by the California Senate would allow insurance carriers to: average their costs across all products, whether regulated by the Department of Managed Health Care or the Department of Insurance; exclude taxes from their aggregate premiums; and include as health care benefits certain costs (programs determined to improve quality of care, disease management, telephone medical advice lines, and provider pay-for-performance payments) that may historically have been categorized as administrative costs. SB 1440 Senate Floor Analysis, www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sb_1440&sess=CUR&house=B&author=kuehl, accessed on August 31, 2008.

5. The term premiums is used to refer more generally to payments received by the health insurer for health care benefits, such as premiums, co-payments, capitation payments, and payments from Medicaid and Medicare.

6. For an overview of California's regulatory environment for health coverage, see Debra L. Roth and Deborah Reidy Kelch, *Making Sense of Managed Care Regulation in California,* California HealthCare Foundation, November 2001, available at www.chcf.org/topics/healthinsurance/index.cfm?itemID=12861. In addition to HMO enrollment, DMHC regulates PPO plans offered by Blue Cross of California and California Physicians' Service (Blue Shield of California) in which roughly 2.5 million people are enrolled.

7. Only health plans characterized as full service were included in the analysis; the researchers excluded dental and vision plans as well as firms that failed to submit one or more reports between 2002 and 2006.

8. Total premiums received by insurers were identified by using CMS's estimates of private insurers' spending on "health and health services," which CMS calculates as the total amount of premium income received. Spending on medical claims was identified using CMS's estimates of private insurers' spending on "personal health expenditures." Combined spending on administrative costs and profits was identified using CMS's estimates of private insurers' spending on "administrative costs and net cost of private health insurance." These total estimates were converted to per-enrollee figures by dividing the costs by the number of persons with private insurance. The number of insured persons was derived from estimates from the Medical Expenditure Panel Survey.

9. Although the MLR is defined as the percentage of premium income spent on medical care, this research reports the percentage of total income, which includes interest and investment income spent on medical care, administration, and profits. These three categories sum up to total income, not premium income. On average, these other sources of income account for less than 2 percent of the income received by a health insurer.

10. *Profits* are defined as revenues minus medical and administrative costs. Because nonprofits and public health plans do not earn profits, the more appropriate term might be net income. However, the term profits is used in this paper for both for-profit and nonprofit plans.

11. Roth and Kelch, *Making Sense of Managed Care Regulation in California.*

12. CMS calculates Medicare administrative costs by summing administrative expenses spent by Medicare itself (this information obtained from the trustees report) with administrative expenses associated with private organizations, such as Medicare Advantage and private prescription drug plans (this information is estimated by CMS itself). These estimates do not include any administrative costs associated with fiscal intermediaries involved in the collection of premiums and the processing of claims.

13. The five states whose information could not be obtained were Connecticut, Indiana, Maryland, Nevada, and Wyoming. No information on Washington, D.C., MLRs was obtained.

14. These six states are Colorado, New Hampshire, New York, North Carolina, North Dakota, and South Dakota.

15. Average 2002 to 2006 loss ratios for the 45 states in the analysis were based on insurer year-level data obtained from the NAIC. The NAIC data are based on health insurance firm reports filed with the state's DOI. The health insurance providers in the NAIC data provided coverage for 31 percent of insured Americans under age 65 in 2005. State-level MLRs were computed as mean loss ratios of insurers reporting in a particular state weighted by total revenue of each insurer. It is important to note that the MLR of an insurer reporting in a particular state reflects the MLR for all transactions of the insurer and not just the transactions in that particular state. Loss ratios for insurers reporting in Alaska could not be computed due to missing information.

16. For example, see James C. Robinson, "Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance," *Health Affairs,* Vol. 16, No. 4, 1997, pp. 176–187.