Administrative Costs in Vermont's Health Care System - Research Issues

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The Joint Fiscal Office has begun to look at administrative costs in Vermont's health care system with an eye toward identifying potential savings. The work involves several steps and requires a number of research decisions. What follows is a brief summary of the issues we have encountered in developing a research agenda:

1. How should we identify and categorize administrative costs?

Analysts identify and categorize administrative costs in different ways and focus on different types of institutions. Providers use yet other definitions and often include a broader measure of administration overhead. For example:

- Hospitals and nursing homes include in their overhead and administrative costs items such as cafeteria services, custodial services, and central supplies.
- As more and more physician practices become affiliated with hospitals, administrative costs of physicians become more intertwined with those of hospitals.

We have uncovered four major ways to characterize administrative costs that do not align at this point. We have begun to work with them and need to develop an analytical framework. The four major sources include

1. Work done by Ken Thorpe creating a typology;
2. A study by Banner Health, a nonprofit in Arizona;
3. A study of administrative costs broadly defined in eight nations published in the September 2014 issue of *Health Affairs*; and
4. The beginnings of Vermont-specific characterizations tracked by the Green Mountain Care Board in analysis of budget submissions for Vermont community hospitals.

Each study has its own outlook and shortcomings. For example, in the review by Banner Health (a nonprofit in western states including Arizona and Colorado), after an 8-week pilot, teams suggested measures that could potentially save 18 to 24 percent of its hospital general and administrative (G&A) expenses. After one year, hospitals realized savings of 6 to 8 percent of total G&A expenses. See Dahlen and Bailey (2013).

Other sources of data regarding administrative costs might come from ACA reporting requirements, but exactly what data are available to us is unclear.

2. What administrative costs could be reduced, what needs to be preserved, and what costs could be reduced through more streamlined processing and billing, either with or without a "fewer-payer" system?

One issue is the separation of "administrative costs" from costs associated with direct medical care. Some of the administrative costs may be designed to streamline or improve care, and that growth area should be encouraged. There is a "gray" area, as population health management and IT overlap with best practice management and medical care.

3. If the work were to focus on billing alone, what administrative costs could be reduced under the current system?

The most commonly cited areas regarding billing practices include the following:

A. Universal claims forms. As established in HIPPA, the universal claims forms in use today allow payers to request additional data from providers. The ACA requires more detailed rules for processing administrative interactions, and Cutler, Wikler, and Basch (2012) claims that U.S. providers could save about $11 billion per year nationwide if those rules were fully implemented.

B. Administrative costs in Medicaid. Nationwide, monthly eligibility rules require much administrative work and results in churning of Medicaid enrollees. At issue is what can be done at the state level and what would require federal changes.

Cutler claims that if the federal government allowed and encouraged states to have an annual open-enrollment period, as private insurers do, coupled with 12-month continuous eligibility policies for nonelderly adults, giving them continuous access to Medicaid coverage even if family income fluctuates throughout the year, it could save providers in the U.S. nearly $3 billion annually in administration. Vermont would likely see smaller savings because the Medicaid program in Vermont no longer looks at assets and allows annual eligibility unless financial circumstances change.

4. How do administrative costs in Medicare and Medicaid compare to those in the private market?

It is tricky to compare administrative costs in public programs to those in private insurance. At first blush, the "administrative costs and net cost of private insurance" data reported in the National Health Expenditures series, for example, show that Medicare administrative costs historically have been about one-quarter the size of administrative costs and net cost of private insurance. But an uninformed comparison would be misguided.

Comparison between administrative costs in Medicare and private insurance may be inappropriate for four reasons (Merlis 2009).

1. Medicare administrative costs do not include some program-related costs incurred by other federal agencies, such as prosecution of Medicare fraud by the Justice Department.

2. Medicare shows a lower percentage of administrative costs relative to benefit costs than private insurance in part because overall Medicare benefit spending is larger. As a result, the fixed costs of administration are spread over more dollars of benefit spending.

3. Some analysts say that Medicare spends too little on useful administrative activities such as disease management, member education, and customer service.

4. Private insurers have some costs that public programs need not incur such as marketing, underwriting, and achieving some surplus as a cushion against future losses or to fund capital spending.

Medicaid typically has higher administrative costs as a share of benefits than Medicare, but the Medicaid program requires frequent, careful attention to the eligibility of its beneficiaries.

References

Cutler, Wikler, Basch. "Reducing Administrative Costs and Improving the Health Care System." *New England Journal of Medicine*, Nov 15, 2012. 367:1875-1878 http://www.nejm.org/doi/full/10.1056/NEJMp1209711

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Additional material

1. Thorpe 1993, narrow definition, excludes cafeteria and custodial services, for example

Five types of administrative costs
- Transaction or encounter related – billing, processing claims
- Benefits management – management IT
- Selling and marketing – strategic planning, advertising
- Regulatory or compliance – waste management, credentialing, COBRA
- Population health management – case management, utilization review

Six types of providers
- Insurance providers
- Hospitals
- Nursing homes (often omitted because their costs are unlikely to change)
- Physicians
- Employers
- Consumers/individuals

2. Vermont Community Hospitals budget, 2014; from Mike Davis, GMCB

General Services (Uncategorized)	0.4%
Administration	21.1%
Central Services & Supplies	2.6%
Dietary	4.6%
Fiscal Services	33.7%
Housekeeping	3.6%
Interns & Residents	4.1%
Laundry & Linen	1.1%
Maintenance of Personnel	0.2%
Medical Care Evaluation	2.6%
Medical Library	0.1%
Medical Records	3.7%
Medical Staff Education	0.2%
Nursing Administration	2.6%
Nursing Education	0.6%
Operation of Plant & Maintenance	12.5%
Pharmacy	4.8%
Research	0.1%
Social Service	1.6%
Total General Services	100.0%