Statement of

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“Measuring the Burden of Administrative Costs”

*The views expressed here are my own and not those of either the American Action Forum or Libris Research LLC.

Chairman Alexander, Ranking Member Murray, and Members of the Committee:

Thank you for the opportunity to discuss my research on health care administrative costs. Administrative costs occur mainly at three levels: at the health plan level, whether it is a private-sector health insurance plan or a government-run program; at the provider level, that is, at hospitals, physician offices, pharmacies, and other providers; and at the patient level, when patients have to schedule appointments and read the bills and "explanation of benefits" documents they receive.

There is a significant amount of research on administrative costs at the health plan level, a smaller amount of research on such costs at the provider level, and as far as I can tell, little to no research at the patient level.

Administrative cost research is plagued by two problems:

First, most reports give administrative costs as a percentage of total spending, including spending on direct patient care. So, for example, someone might claim that Medicare's administrative costs are 2 percent or 5 percent, but private insurance has administrative costs of 10 percent or 20 percent. It sounds much higher. But the difference is, Medicare has patients who are aged 65 or older, or disabled, or who have end-stage renal disease. Private insurance mostly covers patients who are under age 65 and not disabled, and on the whole require lower levels of health care services. The result is that Medicare spends a lot more per patient on direct health care, which means administrative costs as percent of health care costs is almost guaranteed to be lower.

Using percentages might make sense if administrative costs scaled with the level of direct care spending, but it doesn't. The only component of administrative costs that is obviously related to the volume of health care is claims processing, but that is correlated with the number of claims, not their dollar value, and is also a very small share of total administrative costs. For example, in a previous study[1] I found that Medicare's spending on claims processing was about 4 percent of administrative costs, and less than one-quarter of one percent of total Medicare outlays.

Most of the administrative costs of operating a health plan are spent enrolling members, designing the plan rules, establishing provider networks, and other activities that are not processing claims and are not correlated with the number of dollars spent paying health care providers. The same applies to Medicare, to other government programs, and to private sector health plans.

In that study, I found that while Medicare's administrative spending was lower as a percentage of total claims, it was actually higher on a per-beneficiary basis. Medicare's administrative costs were $509 per primary beneficiary, and private plans had an administrative costs of $453 per beneficiary. So Medicare administrative spending was lower as a percentage because their average beneficiary needs more health care – but higher on per-beneficiary basis. (See Table 1.)

Expressing administrative spending as a percentage of total spending is inherently misleading. Medicare's administrative percentage is lower not because they are more efficient, but because their patients are, on average, sicker. Asking for a percentage is simply asking the wrong question.

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1 Robert A. Book, "Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance," WebMemo #2505, The Heritage Foundation, June 25, 2009, at http://bit.ly/2LMNfsD.

The second problem in this sort of research is that it is sometimes hard to *find* administrative costs. Budget documents are not typically written for the benefit of those of us trying to track this information down. Most of the administrative costs of Medicare are in the budget for the Center for Medicare and Medicaid Services (CMS), but some of those costs are in the budgets of other agencies. For example, Medicare enrollment is the responsibility of the Social Security Administration (SSA), some of the revenue is collected by the Internal Revenue Service (IRS), and fraud enforcement is at least partly the responsibility of the Department of Justice (DoJ). Activities corresponding to all of these would appear directly in administrative costs of a private sector health plan.

In the case of private health plans, until 2016 we had the opposite problem. In order to calculate administrative costs, researchers would take total premium revenue and subtract total claims paid, and assume the rest was administrative costs. This is reasonable if one wishes to count taxes as administrative costs, and health services provided directly by the health plan (such as on-call nurses) to be administrative costs as well. But they really are not what we normally think of as "administrative." So, private sector administrative costs were overstated, just as government program administrative costs were understated

Since 2016, data as been available from reports that private sector health plans have been required to file in order to comply with the ACA's Medical Loss Ratio (MLR) requirements. This allows us to separate out taxes and plan-provided health care, and get a better estimate of administrative costs.

Under the ACA, Non-Medicare Administrative Costs Have Increased, Not Decreased

During the debate leading up to the passage of the ACA, proponents argued that one of the benefits of establishing government-run health insurance exchanges 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,[2,3] but primarily on the claim that having an exchange would eliminate the need for insurance companies to spend money on marketing. In addition, it was claimed that[4] requiring a minimum Medical Loss Ratio (MLR)[5] and reduction of executive pay[6] through limits on the deductibility of compensation (Section 9014) would limit the unrestrained pursuit of profit[7]. The predicted impact was that reducing administrative costs would lead

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

3 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*.

4 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, at *http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf*.

5 Bittany La Couture, "Medical Loss Ratio Under the ACA," American Action Forum, September 15, 2015, at https://www.americanactionforum.org/research/medical-loss-ratio-under-the-aca.

6 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.*

7 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.

to lower premiums and lower national spending on health care without having to reduce the quantity or quality of actual health care delivered.

That is not what has occurred. Instead, total administrative costs increased. 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 on-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.[8]

Comparing Across Countries

When comparing across countries, this problem of tracking administrative costs and the hazards of reporting those costs as a percentage are even more acute.

Administrative costs of government programs are difficult to track down for U.S. programs, and the same applies to programs in other countries. Few researchers really know how to interpret budget reports from a wide variety of countries, know what relevant data is in other places, and then find it. Some studies take reported administrative costs at face value, but these almost always include different things in different countries. One study[9] attempted to compare the entire administrative cost throughout the health care sector in the U.S. and Canada, and when they could not find certain components reported anywhere simply assumed percentages of revenue (for example, they assumed that one-third of physician office rent and equipment, and one-half of "other professional expenses" was due to administration), and sometimes extrapolated data from a single state to the entire U.S.

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8 Robert A. Book, "The ACA Exchanges Increased Administrative Costs of Health Insurance," American Action Forum, December 21, 2016, at https://www.americanactionforum.org/wp-content/uploads/2016/12/2016-12-21-ACA-Admin-Costs.pdf

9 Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine*, **349**(2003):768-775, at https://www.nejm.org/doi/full/10.1056/NEJMsa022033.

In addition, health systems that are organized differently will often end up with administrative costs falling in different parts of the health system, leaving sector-by-sector comparisons meaningless. For example, another study[10] attempted to compare hospital administrative costs across eight countries, but noted that in some countries, hospitals employ large numbers of physicians, which is not the case in the U.S., where the vast majority of physicians practicing in hospitals are not hospital employees. The authors then proceeded to report hospital administrative costs as a percentage of total hospital expenditures. In countries where hospitals employ most of the physicians who practice there, physician pay becomes part of the total expenditures. Naturally, those countries had lower percentages of administrative costs, because they were dividing by a larger number. Of course, those administrative costs didn't disappear – they were just accounted for differently, creating an illusion of efficiency.

This happens at the health system level as well. A hospital that has to bill for its services will have more administrative costs, however measured, than a hospital that receives an annual budget from a government agency. However, in the latter case, the government will have to determine the annual budget for the hospital – a task which, if taken seriously, will involve a complicated study of the mix of care the hospital will be called upon to provide and the resources needed to provide it. That study may be done mostly by people in the government agency, and those people will need to be paid. That pay – and all the other costs of that study – will count as administrative costs.

Likewise for office-based physicians. In some countries with single-payer government-run systems, physicians are paid a fixed salary and are expected to provide a certain level of service per year. Billing costs are replaced by reports about what services are provided, which may cost more or less than billing. In England, for example, patients are allocated to physicians by giving each physician a "catchment area"; if one lives in the catchment area (which may have many physicians) one may visit that physician (similar to a school assignments in the U.S.). Someone has to analyze population and health trends by geography and draw up the boundaries of the catchment areas, and update them periodically. Thus, the cost of acquiring patients for each physician is no longer with the physician (as marketing) – but it doesn't disappear, it just moves to the health plan level, and most likely increases.

Regulatory Compliance

In the U.S., one of the most substantial administrative costs at all levels of health care is regulatory compliance. Operators of health plans must file copious information with state and federal regulators, for example, in order to justify premiums as not too high (because of the burden on enrollees) and also not to low (because they might run out of money to pay claims).

Health care providers of all types are subject to regulations of all sorts. When HIPAA was passed in 1996, the privacy provisions caused substantial administrative costs for nearly all providers to develop new processes, as well as ongoing administrative costs of implementing these processes.[11] There does not appear to be any corresponding savings on other cost categories to offset these extra costs, and it is unclear if the privacy goals were achieved.

The ACA imposed numerous new regulatory regimes on providers, including submitting more data (useful to us researchers, but costly to providers and therefore ultimately to patients and taxpayers). In

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10 David U. Himmelstein, et. al., "A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far," *Health Affairs* **33**:9(2014):1586-1594.

11 See, for example, Peter Kilbridge, "The Cost of HIPAA Compliance," *New England Journal of Medicine*, **348**(2003):1423-1424.

one case, proponents of new regulations claimed they would save money – a requirement for most providers to adopt electronic health records was supposed to reduce duplication of tests and diagnostic procedures by making results available to all of a patient's providers. The administrative cost of adopting these new systems has been incurred by providers, but there is no evidence of any savings.[12] In particular, hospitals continue to repeat tests previously done by other providers, perhaps to validate the results, or perhaps because they get paid for doing the tests again (or perhaps both). In this case, a known administrative costs was supposed to reduce actual health care costs, but it failed to do so.

An Urban Legend

I would like to take this opportunity to address one story that has been told in the context of administrative costs, just to illustrate the difficulty in coming by reliable facts to discuss this issue. About ten years ago, a prominent health economist, the late Uwe Reinhardt, told the Senate Finance Committee that:

> I serve on the board of the Duke Health System, and we consolidated all our billing. We had 900 clerks, and we have 900 beds. I am sure we have a nurse per bed, but we have a billing clerk per bed. I think we have probably worked this down maybe a little, so do not hold me to that number. But that borders on the obscene.[13]

About a year later, one of my colleagues on the panel for this hearing raised the number of clerks to 1300, with the same 900 beds.[14] More recently, about a year ago, he cited figures of 900 beds and 1500 clerks.[15]

In trying to track down this story and verify the figures, I was unable to find the current number of billing clerks in the Duke Health System. I was, however, able to very that the Duke University Hospital indeed has 957 licensed inpatient beds. The Duke Health System includes two other hospitals (with consolidated billing, if Dr. Reinhardt's statement is correct), bringing the total number of beds in the Duke Health System, to 1,512. In fiscal year 2017, those 1,512 beds accounted for 68,523 total admissions.

However, like most hospital systems, Duke provides a large volume of outpatient care, which doesn't involve the use of any of those hospital beds. The Duke Health System also includes physician visits, and if they have truly consolidated their billing, those billing clerks would be responsible for those visits as well. In fiscal year 2017, Duke had a total of 1,482,650 hospital outpatient visits, and 2,291,037 physician visits.

That means that those hospital beds accounted for only 1.78 percent of Duke Health System visits.

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12 Joyce Frieden, "EHRs Don't Save Money or Time, Docs Say," *MedPage Today*, September 17, 2014, at https://www.medpagetoday.com/practicemanagement/practicemanagement/47716.

13 U.S. Congress, Senate, Committee on Finance, *Health Care Reform: An Economic Perspective,* 110th Cong., 2nd Sess., Nov. 19, 2008, 34.

14 Steven Landsburg, "Making Health Care Work," Dec. 15, 2009, [quoting David Cutler] at http://www.thebigquestions.com/2009/12/15/making-health-care-work.

15 Kathryn Watson, "Why is health care so expensive in the first place?" CBS News, Jul. 5, 2017 [quoting David Cutler], at https://www.cbsnews.com/news/why-is-health-care-so-expensive-in-the-first-place.

In other words, measuring administrative (in)efficiency by comparing the number of billing clerks to the number of hospital beds is utterly meaningless. Those hospitals beds represent only a very small percentage of what those billing clerks are doing.

Conclusion

Administrative costs are a significant component of health care costs, but there is little accurate understanding of how to measure those costs. Part of the problem is that locating and identifying administrative costs in available data sources is difficult.

But a more serious concern is that many researchers and policymakers misunderstand the drivers of administrative costs. Most studies express administrative costs as a percentage of direct health care costs, and approach which necessarily misleads the reader. Administrative costs must be expressed as a dollar amount for each unit that causes those costs to increase. For example, administrative costs of operating a health plan – whether a non-profit or for-profit insurance plan or a government program – is better expressed on a per-enrollee basis. Administrative costs for providers should be expressed in terms of an appropriate measure of units of care delivered.

Furthermore, when comparing vastly different entities – such as health plans in different countries – one has to be very careful to make sure that like figures are being compared.

Finally, it is important to keep in mind that administrative cost is not all necessarily “waste.” Patients need to be enrolled, providers need to be paid, and resources need to be distributed. All of those activities generate administrative costs, and all of those activities are essential to a well-functioning health care system.

Table 1. Administrative Costs of Medicare and Private Health Insurance

Year	Medicare			Private Health Insurance			Percent by which Medicare is higher
	Medicare Primary Beneficiaries (millions)	Total Non-Benefit ("Administrative") Spending ($billion)	Non-Benefit ("Administrative") Spending Per Primary Beneficiary (dollars per person)	Total Beneficiaries (millions)	Total Non-Benefit ("Administrative") Spending ($billion)	Non-Benefit ("Administrative") Spending PerBeneficiary (dollars per person)	
2000	37.06	14.10	**$380**	202.8	52.0	**$256**	48.4%
2001	37.32	14.40	**$386**	201.7	56.6	**$281**	37.5%
2002	37.68	15.84	**$420**	200.9	68.8	**$342**	22.7%
2003	38.11	16.50	**$433**	199.9	82.2	**$411**	5.3%
2004	38.64	20.14	**$521**	200.9	85.3	**$425**	22.7%
2005	39.21	19.94	**$509**	201.2	91.1	**$453**	12.3%

Sources:

1. CMS Medicare Denominator file and Medicare Enrollment Database, Prepared by Susan Y. Fu, Center for Medicare & Medicaid Services, Office of Research, Development, and Information. Available from the author on request. "Medicare Primary Beneficiares" excludes those who have another source of coverage (such asemployer-sponsored insurance) and are thus subject to the Medicare Second Payer (MSP) program. Under MSP, Medicare pays only under very limited circumstances, and only to the extent, if any, by which Medicare's payment is more generous than the beneficiaries other coverage.
2. Author's calculations based on Zycher (2007).
3. Bureau of the Census, Current Population Survey.
4. Centers for Medicare & Medicaid Service, National Health Expenditure Accounts, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf, Table 12 (accessed June 25, 2009).

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Table 2: Administrative Costs in the Individual Market

	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)*	
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

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