04-130 (11) Ch 10 4/8/04 9:43 AM Page 105

Chapter Ten

Administrative Costs

MYTH NO. 10: A SINGLE-PAYER NATIONAL HEALTH CARE SYSTEM WOULD REDUCE THE ADMINISTRATIVE COSTS OF U.S. HEALTH CARE

Advocates of single-payer health insurance frequently claim that private health insurance is inefficient because of the administrative costs associated with multiple insurance firms. A study by Steffie Woolhandler, a prominent member of the Physicians' Working Group on Single-Payer National Health Insurance, and her colleagues, estimates that administrative costs account for close to one-third of U.S. health care expenditures (31.0 percent), nearly twice as much as in Canada (16.7 percent).[1] Based on such studies, the Physicians' Working Group claims that a single-payer health care system would result in large savings by eliminating "the high overhead and profits of the private, investor-owned insurance industry and reducing spending for marketing and other satellite services."[2] However, over a number of years, Woolhandler's estimates of the proportion of health care costs consumed by administration has grown for both Canada and the United States. Either "inefficiency" in the Canadian system is growing at a rate similar to that for health care in the United States—or her definition of administrative costs has changed significantly.[3]

The Congressional Research Service has estimated administrative costs for Medicare at 2 percent of total program costs, compared to 9.5 percent for private insurance and 11.9 percent for HMOs.[4] Many single-payer advocates have used this estimate as an argument for forcing all Americans to join Medicare.

These estimates are misleading, however. Determining the administrative costs of any government program is difficult, if not impossible. And

04-130 (11) Ch 10 4/8/04 9:43 AM Page 106

comparisons with the private sector are problematic. Part of the reason is that government regulators can shift administrative costs to physicians or patients, just as tax collectors shift the cost of record keeping and data collection onto taxpayers. For example, a study by the American Medical Association estimated that a physician spends an average of six minutes on every Medicare claim (compared, say, to twenty minutes spent with the patient) and the physician's staff spends an average of one hour.[5]

ADMINISTRATIVE COSTS AND EFFICIENCY

In general, nobody knows how to measure administrative costs. For example, should we count as "administrative" all activities other than doctor-patient contact? What about keeping patient records? What about reviewing patient records? What about reviews of doctor behavior to make sure patients are not being abused and are receiving appropriate care? What about reviews of prescriptions in an effort to lower the rate of adverse drug reactions? What about paperwork and other procedures instituted to ensure appropriate use of MRI scans? Answers to all of these questions require subjective judgments.

A more basic objection is that minimizing administrative costs should not be our goal. Conventional wisdom holds that the less a health care system spends on administration, the more efficient it must be. Yet, the administrative costs of any health care system could be reduced by firing all of the administrators and abolishing all reporting requirements. Most systems would perform far less efficiently as a result. The real goal is not to get administrative costs as low as possible, but to make the overall system perform as efficiently as possible. To accurately measure the net cost (or gain) to society from administrative procedures, one has to compare the costs with the benefits they produce.

A similar observation holds for marketing and other costs of competition. Money could be saved, for example, by abolishing all car dealerships and advertising by auto producers. Additional money could also be saved by eliminating competition among different automakers (producing numerous models) by building a single model of automobile. Sally Pipes and Michael Lynch of the Pacific Research Institute put it like this:

> Most likely, administrative costs—marketing, selling and invoicing—were a lot lower for the East German Trabant than for a Honda or a Ford. But it does not logically follow that the Trabant is superior. Indeed, the opposite is the case. Multiple payers, or producers, whether in cars, housing, food, clothing or health care, produce product differentiation and spur competition that promotes the production of excellence. In the health care sector, multiple payers provide personalized health care options for U.S. citizens.[6]

04-130 (11) Ch 10 4/8/04 9:43 AM Page 107

We could simply pay taxes and have government provide us with a new automobile every few years. But the end result would be decreased efficiency and less consumer satisfaction, both of which are characteristic of socialist systems. If socialism worked, the economies of communist countries would not have collapsed.

MONOPOLY VERSUS COMPETITION

Regardless of how administrative costs are measured, an article of faith among single-payer advocates is that one insurer paying all bills is better than several insurers competing against each other. But is that really true? To test the assumption, consider the one group of Americans who have no choice of primary insurer: senior citizens on Medicare. Despite its political popularity, Medicare violates almost all of the principles of sound insurance. It pays too many small bills the elderly could easily afford themselves while leaving them exposed to thousands of dollars of potential out-of-pocket expenses, including drug costs. For instance, each year about 750,000 Medicare beneficiaries spend more than $5,000 out of pocket.[7]

To prevent financial devastation from these medical expenses, about two-thirds of Medicare beneficiaries acquire supplemental insurance through a former employer or direct purchase. However, most of these "Medigap" policies do not cover prescriptions and coverage is often incomplete among those that do. Moreover, having a second health plan to fill the holes in the first is wasteful. Seniors with Medigap insurance spend 30 percent more on health care than those without it.[8] To make matters worse, Congress recently passed legislation that will create another optional benefit, covering prescription drugs. Many seniors will soon be paying three premiums to three plans, with all the waste and inefficiency that implies.

As we shall see in chapter 18, dollar for dollar, drugs offer a better return on health care spending than other major therapies.[9] Yet Medicare's practice of covering very few prescription drugs encourages doctors and their patients to choose physician and hospital services instead of less costly, more appropriate drug therapies. Ironically, Medicare will pay to treat a stroke victim in a hospital, but will not pay for the drugs that might have prevented the stroke in the first place.

Medicare's benefit structure has failed to keep pace with modern medicine in other ways. Medicare will pay to amputate the leg of a diabetic, but not for the chronic care that could have made the amputation unnecessary. About 28 percent of all Medicare spending is for patients in the last year of life.[10] Yet, while spending billions on patients who are about to die, Medicare will not pay for the common sense care that would prevent many premature deaths.

04-130 (11) Ch 10 4/8/04 9:43 AM Page 108

Why is the Medicare program so bad? The answer is politics. Almost forty years ago, when Congress created Medicare, the insurance was quite adequate. In designing Medicare, Congress simply copied the standard Blue Cross plan of the day, in part to placate special interest pressures from doctor and hospital organizations. Through the years, medical science has changed, medical economics has changed, and private insurance has changed. But Medicare has not.[11] Once a huge spending program is in place, vested interest constituencies form around every part of it. Whereas private insurance can change and adapt to market conditions at the drop of a hat, even minor changes in Medicare take years.[12]

ADMINISTRATIVE COSTS OF PRIVATE INSURANCE

In general, critics have overestimated the size of private sector administrative costs and underestimated the benefits. The presence of multiple payers in the U.S. system reflects different tastes and preferences among consumers for such amenities as varied levels of copayment, choice of physician network, limited waiting for physician visits, and so forth. Additionally, all private health insurance companies use a portion of a policyholder's premium to assure the remaining funds are spent wisely, while providing quick and convenient service. In doing so, American health plans control moral hazard (the tendency to overconsume when the service is perceived as being free), rather than relying on waiting lines to ration services. Americans pay for the ability to receive medical services when needed rather than having to wait for treatment.

ADMINISTRATIVE COSTS OF PUBLIC PROGRAMS

As noted, a number of studies claim to show that the Canadian system is simply better at controlling administrative costs.[13] However, these studies only focus on inputs into administration—administrative salaries, costs of paperwork, and so forth. Health economist Patricia Danzon of the University of Pennsylvania's Wharton School of Business points out that a public insurer essentially performs most of the same functions found in private insurance. It must reimburse providers for services performed, collect "premiums" (usually from taxes) and attempt to control moral hazard (that is, limit utilization).[14] Likewise, public insurers incur overhead costs, but these are often difficult to analyze using traditional cost accounting methods. Government accounting practices invariably underestimate the real cost of government provision of goods and services. The true cost is often hidden in a complex bureaucratic reporting and tracking system. In both Canada and the United States, auditing expenses for health services are usually included in the budgets of other public agencies.

04-130 (11) Ch 10 4/8/04 9:44 AM Page 109

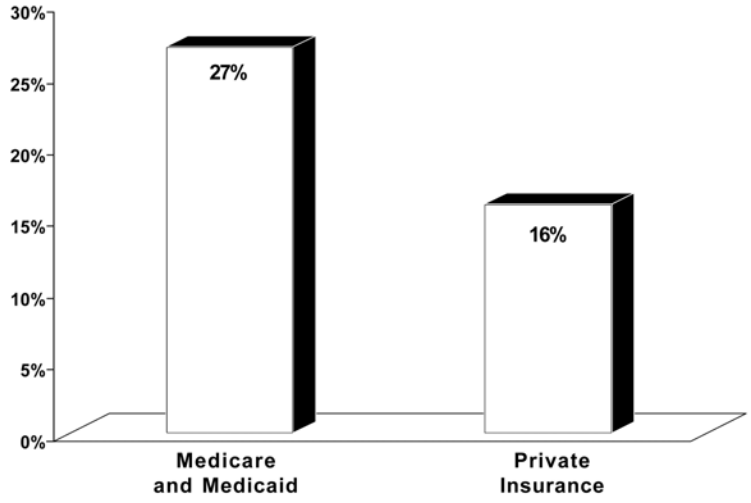
Collecting taxes or lobbying for additional funding are not included in the overhead expense of public programs, whereas collecting premiums and marketing would count toward the cost of a private health insurer.

Cost comparisons also usually ignore the effects of administration on the efficiency of the health care system in meeting consumer needs, says Danzon. One cannot legitimately calculate administrative costs of single-payer health systems without including adverse effects on patients. These include the excessive time patients spend waiting for treatment, lost productivity caused by lack of advanced medical equipment, and reduced quality of life when certain procedures are unavailable. For example, the physician fee structure found in Canada is designed to limit the volume of procedures performed in doctors' offices. As a result, patients are often forced to make multiple visits to get the same services they could receive in one visit.

Actuary Mark Litow (M&R) estimated the hidden costs (inclusive of taxes) in public programs. He found that Medicare and Medicaid spend 26.9 cents for every dollar of benefits, compared to 16.2 cents spent by private insurance (see figure 10.1).[15] Thus, he estimates that government spends 66 percent more than the private sector per dollar of benefits delivered.

FIGURE 10-1

Administrative Costs as a Percent of Medical Expenditures in the United States



Source: Mark Litow and the Technical Committee of the Council for Affordable Health Insurance (CAHI), "Rhetoric vs. Reality: Comparing Public and Private Health Care Administrative Costs," Council for Affordable Health Insurance, March 1994.

04-130 (11) Ch 10 4/8/04 9:44 AM Page 110

GOVERNMENT DISTORTIONS OF PRIVATE INSURANCE

Federal tax policy distorts the health care market by subsidizing health insurance purchased through an employer and penalizing individuals who manage their own health care dollars and pay medical bills directly. Under our tax system, employees (through their employers) can spend unlimited amounts on third-party health insurance, all tax free. At the same time, funds that middle-income employees set aside as self-insurance to pay small medical bills typically face a 25 percent income tax, a 15.3 percent payroll tax (FICA, or Federal Insurance Contributions Act tax) and a 4, 5 or 6 percent state and local income tax.[16] In short, government takes almost half the deposit before it goes into the employees' saving account.

As a result of federal tax policies, most employees are overinsured. They use third parties to pay for routine checkups, diagnostic tests and other small medical bills that could more efficiently be paid out of pocket. Too much insurance encourages people to be wasteful health care consumers. It also adds to administrative costs.[17]

REDUCING ADMINISTRATIVE COSTS WITH MEDICAL SAVINGS ACCOUNTS

A handful of countries have chosen a different way. In Singapore, workers are required to deposit 6 percent of their salaries each year in personal medical savings accounts (MSAs), also called Medisave accounts. When Singapore residents need medical care, they pay the bills from their Medisave funds and avoid many of the administrative burdens of health insurance. They also have catastrophic insurance, which is mainly how they pay hospital bills.[18]

MSAs also exist in South Africa, where they are typically used to pay expenses below the insurance deductible of about $1,200. Since their introduction in 1994, MSA plans have captured about 65 percent of the private insurance market there. These plans have pioneered the use of debit cards to withdraw funds from MSAs to pay for medical services, further reducing administrative costs. Discovery Health, a private insurer, is developing the same type of system for pharmaceutical purchases. Information from a Discovery Health card (and the drug prescribed) is entered into the pharmacy computer. The pharmacy then sends this information electronically to Discovery Health. The insurer checks the patient's MSA balance, verifies drug coverage and any deductible and authorizes payment to the pharmacy.[19]

Dr. David Allen, the Kentucky network medical director for Aetna, estimates that it costs Aetna close to five times more to process a claim submit-

04-130 (11) Ch 10 4/8/04 9:44 AM Page 111

ted on paper than it does a claim submitted electronically.[20] Several companies are experimenting with technology that would put a patient's entire medical record online.[21] This would allow physicians immediate access to each patient's complete medical history. Putting medical records online could be costly. But it might be less costly than the current system under which physicians often treat patients without access to their records and spend far too much of their time dealing with paperwork.[22]

Most medical bills could be paid by patients from health savings accounts (HSAs) with debit cards, relying on third-party insurance to pay only catastrophic expenses.[23] In August of 2003 the U.S. Internal Revenue Service paved the way for widespread the use of debit cards to access personal health accounts.[24] This development is especially important since swiping a debit card across a health care provider's card reader bypasses much of the administrative burden of insurance billing and collecting. It is no coincidence that most of these innovations are occurring in the United States or in countries with less regulated health care systems.

Some patients in United States already have HSAs of one sort or another. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 created a five-year demonstration for MSAs, but imposed unnecessary restrictions on them.[25] Although 750,000 accounts were allowed by the pilot project, only an estimated 70,000 were actually created.

In a revenue ruling in June 2002, the IRS clarified the use of health reimbursement arrangements (HRAs) under section 105 of the IRS code. Within one year about 1.5 million people were enrolled in these consumer-driven health plans, and such plans are estimated to make up 20 percent of the group market by 2005 and possibly as much as 50 percent by 2007.[26]

The Medicare Prescription Drug and Modernization Act (2003) created HSAs, which have virtually none of the regulatory restrictions of MSAs and which will replace them. In principle, HSAs are available to 250 million (nonelderly) Americans. Like most personal health accounts, they will allow employees to pay directly for medical expenses in conjunction with a high-deductible health plan.[27] Unused funds will roll over from year to year for future use and accumulated balances will be available for medical expenses in retirement.[28]

NOTES

1. 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, no. 8 (August 21, 2003): 768–75.

04-130 (11) Ch 10 4/8/04 9:44 AM Page 112

2. See Steffie Woolhandler et al., "Proposal of the Physicians' Working Group on Single-Payer National Health Insurance."

3. See Steffie Woolhandler and David U. Himmelstein, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," *New England Journal of Medicine* 324, no. 18 (May 2, 1991): 1253–58. This study put administrative costs in the U.S. health care system at between 19.3 percent and 24.1 percent of total spending, compared to between 8.4 percent and 11.1 percent of health care spending in Canada. For a critique of the study's methodology by the HIAA, see *Medical Benefits* 8, no. 10 (May 30, 1991): 5. A few years later, they found administrative costs accounted for an average of 26 percent of total U.S. hospital costs. See Steffie Woolhandler and David Himmelstein, "Cost of Care and Administration at For-Profit and Other Hospitals in the United States," *New England Journal of Medicine* 336, no. 11 (March 13, 1997): 769–74.

4. "Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993," figure 3.29, table 3.29, prepared by the Congressional Research Service, "Medicare and Health Care Chartbook," Ways and Means Committee, U.S. House of Representatives.

5. See the American Medical Association Center for Health Policy Research, "The Administrative Burden of Health Insurance on Physicians," *SMS Report* 3, no. 2 (1989).

6. Sally C. Pipes and Michael Lynch, "False Promise of Single-Payer Health Care: A Close Look Inside the 'California Health Security Act,'" Pacific Research Institute, 1998.

7. U.S Department of Health and Human Services, "Medicare and Medicaid Statistical Supplement, 1999," *Health Care Financial Review*, Publication No. 03417, Centers for Medicare and Medicaid Services, U.S Department of Health and Human Services, November 1999, figure 19, p. 37.

8. Most studies have found that the increased spending is due to perverse insurance incentives and not to worsening health among seniors. For a discussion, see Susan L. Ettner, "Adverse Selection and the Purchase of Medigap Insurance by the Elderly," *Journal of Health Economics* 16, no. 5 (October 1, 1997): 543–62; and Michael D. Hurd and Kathleen McGarry, "Medical Insurance and the Use of Health Care Services by the Elderly," *Journal of Health Economics* 16, no. 2 (April 1997): 129–54. Also see Sandra Christensen and Judy Shinogle, "Effects of Supplemental Coverage on Use of Service by Medicare Enrollees," *Health Care Financing Review* 19, no. 1 (Fall 1997), U.S. Department of Health and Human Services.

9. Frank Lichtenberg, "Pharmaceutical Innovation, Mortality Reduction and Economic Growth," National Bureau of Economic Research, NBER Working Paper W6569, May 1998.

10. James D. Lubitz, and Gerald F. Riley, "Trends in Medicare Payments in the Last Year of Life," *New England Journal of Medicine* 328, no. 15 (April 15, 1993): 1092–96.

11. Andrew J. Rettenmaier and Thomas R. Saving, "Reforming Medicare," National Center for Policy Analysis, NCPA Policy Report No. 261, May 2003.

12. Rettenmaier and Saving, "Reforming Medicare."

13. Woolhandler, Campbell and Himmelstein, "Costs of Health Care Administration in the United States and Canada."

04-130 (11) Ch 10 4/8/04 9:44 AM Page 113

14. Patricia M. Danzon, "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs* 11, no. 1 (Spring 1992.

15. Mark Litow and the Technical Committee of the Council for Affordable Health Insurance, "Rhetoric vs. Reality: Comparing Public and Private Health Care Administrative Costs," Council for Affordable Health Insurance, March 1994.

16. See John C. Goodman, "Characteristics of an Ideal Health Care System," National Center for Policy Analysis, NCPA Policy Report No. 242, April 2001.

17. Matt Hamblen, "Smart Cards Enter Health Care Community," *Enterprise Network News*, December 9, 1997. For a white paper on smart card technology, see Soon-Yong Choi and Andrew B. Whinston, "Smart Cards: Enabling Smart Commerce in the Digital Age," KPMG and the Center for Research in Electronic Commerce, University of Texas at Austin, May 1998, available at http://cism.bus.utexas.edu/works/articles/smartcardswp.html.

18. Thomas A. Massaro and Yu-Ning Wong, "Medical Savings Accounts: The Singapore Experience," National Center for Policy Analysis, NCPA Policy Report No. 203, April 1996. Also see Mukul G. Asher, "Compulsory Savings in Singapore: An Alternative to the Welfare State," NCPA Policy Report No. 198, National Center for Policy Analysis, September 1995.

19. Shaun Matisonn, "Medical Savings Accounts in South Africa," NCPA Policy Report, no. 234, National Center For Policy Analysis, June 2000.

20. Cheryl Jackson, "Insurers Test Direct-Deposit Pay For Claims" *American Medical News* 44, no. 12 (March 26, 2001.

21. Tom Spring, "Put Your Medical Records Online. Doctors Launch a Private Medical Registry to Provide Patient Information in Emergencies," *PC World* (December 3, 1998). Also see Elisa Batista, "The Push for Online Medical Info," *Wired News* (May 9, 2000).

22. Joseph Conn, "Instant Response: Online Claims Authorization System Speeds Up Resolution," *Modern Physician* (December 1, 2000).

23. See John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," NCPA Policy Report No. 168, National Center for Policy Analysis, January 1992.

24. Ron Lieber, "Employers Offer New Pretax Perk," *Wall Street Journal*, September 2, 2003. For awhile there was a question about whether the IRS would allow medical expenses paid with a debit card to be tax-exempt without prior approval by a plan administrator. The IRS settled this question with a favorable revenue ruling.

25. Victoria Craig Bunce, "Medical Savings Accounts: Progress and Problems under HIPAA," Cato Institute, Policy Analysis No. 11, August 8, 2001.

26. Jon R. Gabel, Anthony T. Lo Sasso, and Thomas Rice, "Consumer-Driven Health Plans: Are They More Than Talk Now?" *Health Affairs* (November 20, 2002) (Web exclusive).

27. The deductibles are $1,000 per individual, $2,000 per family.

28. For a discussion of HRAs, see Devon Herrick, "Health Reimbursement Arrangements: Making a Good Deal Better," NCPA Brief Analysis No. 438, National Center for Policy Analysis, May 8, 2003.

04-130 (11) Ch 10 4/8/04 9:44 AM Page 114