VIEWPOINT

Administrative Expenses in the US Health Care System
Why So High?

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A variety of studies over the last 2 decades have found that administrative expenses account for approximately 15% to 25% of total national health care expenditures, an amount that represents an estimated $600 billion to $1 trillion per year of the total national health expenditures of $3.8 trillion in 2019.[1] Billing and coding costs, physician administrative activities, and insurance administrative costs are the primary drivers of these expenses.[2,3] In a new study, Sahni et al[4] estimated that administrative spending was $950 billion in 2019, of which 94% was in 5 functional focus areas: financial transactions ecosystem, industry-agnostic corporate functions, industry-specific operational functions, customer and patient services, and administrative clinical support functions.

Even though administrative costs are often portrayed as inherently wasteful, some administrative activities, such as patient scheduling or staff hiring, would be required to manage any system. As a result, much of the contemporary administrative expense literature focuses on comparisons with comparatively more frugal nations, as well as analysis of "wasteful" administrative expenses. It seems clear by these comparisons that US health care–related administrative expenses are high.[5] Moreover, administrative costs in the US health care system may be underestimated because estimates are typically focused on hospital and insurer costs. Whole segments of the health care sector (eg, employee benefit consultants or employer human resources costs) may be omitted from some estimates because they are often paid for by the employer and do not appear on hospital or insurer financial statements.

High administrative costs in the US reflect some unique aspects of the US health care system and those aspects reflect more specific societal values. For example, in part, high administrative costs stem from the value individuals in the US place on choice.[1] A desire for choice gives rise to fragmentation of payers, which in turn generates complexity in billing and expenses related to plan choice (such as marketing costs). Some of these costs might be lowered with standardization of key administrative functions (such as standardized claims forms) or improved information technology capabilities (interoperability of medical records is of high importance), but other costs, such as marketing, are inherent when there is choice among plans.[6]

A broader way of thinking about high administrative costs in the US health care system is that they reflect the way in which the system deals with the inherent problems with health care markets. Specifically, because health care expenditures are uncertain, individuals need insurance. Without any countervailing force, insurance distorts market outcomes, causing utilization and prices to increase.

The US health system relies heavily on market-based solutions to address these issues. For example, in the commercial sector, there is reliance on competing insurers to manage utilization and negotiate with competing health care organizations for the best price.

Efforts to control utilization give rise to utilization management activities (such as prior authorization) or benefit designs that charge patients out of pocket when they seek care. Because competing insurers have different benefit designs, health care organizations and clinician practices must invest in activities to accommodate the out-of-pocket provisions of the different insurers and to collect patient fees. Additionally, efforts to control utilization through alternative payment models often require risk-adjustment systems, which create more administrative costs. Because there are multiple insurers seeking competitive advantage, these activities are difficult to standardize.

Similarly, efforts to control prices create administrative costs. These are in part related to negotiation, and those costs expand as the effects of the negotiations ripple through the system. For example, in efforts to negotiate better prices, insurers must be able to "threaten" to (and often do) exclude some clinicians or health care centers from their network. As a result, administrative dollars are spent to help find in-network clinicians or health care centers or steer patients to the lower-priced clinicians or health care centers in the network. Several industries have emerged to manage network and benefit complexity (eg, firms that support patients as they navigate their network and their benefit design, as well as firms that support employers in designing benefits and choosing insurers). The associated administrative costs are spread across payers, clinicians and health care centers, employers, and even patients.

The prescription drug market provides a microcosm of the issue. Patents for new drugs are granted to allow innovative firms to charge high prices and thus encourage innovation. However, when patents are combined with insurance, the resulting prices can be exorbitant. Insurers, in an effort to counteract the market power of manufacturers, develop institutions to offset some of the manufacturer market power. These institutions (eg, pharmacy benefit managers, which have market power to possibly command high fees) generate administrative costs related to formulary development, utilization management, and the bewildering system of rebates and related efforts to avoid plan cost-sharing provisions.

Overall, these market-driven activities may be worthwhile (the reductions in spending may justify the

administrative expense), but nevertheless, they generate administrative costs. Other countries handle these activities in a more centralized way, standardizing or otherwise regulating dimensions of competition such as prices, benefit designs, or both. As a result, the administrative costs are reduced.

It is tempting to conclude that the US health system should move away from a market-based system to reduce administrative costs. Yet, it is important to acknowledge that government-run systems (and government intervention in market systems) may generate their own administrative costs associated with myriad regulations that govern health care organizations and markets. Moreover, while on balance government-run programs are generally administratively less costly, they have other drawbacks. Most important, government systems may prevent some individuals from obtaining the coverage or receiving the care they desire. The programs may limit choice and fail to incent efficiency or patient-centeredness. Government-managed cost containment (eg, price setting) runs the risk of adversely affecting access or quality of care. The extent to which those problems arise, and level of concern over whether some people are constrained in their behavior, depends on the perception of how well the government system (and the politics that will inevitably govern it) will function. Nonetheless, there may be some value in coordinated cost containment (eg, standardized plan designs or forms of payment).

Thus, efforts to control administrative costs must weigh savings with what may be lost. The challenge is finding the appropriate balance between market mechanisms and government intervention. At a minimum, policy needs to pay more attention to the administrative cost ramifications of different actions. Doing so will likely lead to more standardization and government involvement than currently exists in some aspects of health care. This is particularly important for areas that are more easily standardized, such as claims submissions and reporting requirements. It may also lead to simplifying, standardizing, scaling back, or redesigning existing initiatives, such as quality measurement, risk adjustments, payment models, and prior authorization rules. Overall, attempts to address administrative costs in a sustainable and permanent way will require careful consideration of how the US health system is designed, how much is standardized, and how the system balances the use of market mechanisms with the costs they sometimes entail.

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