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Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance

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Many advocates of a public health plan—either a "single-payer" plan or a "public option"—claim that a public health plan will save money compared to private health insurance because "everyone knows" that the largest government health program, Medicare, has lower administrative costs than private insurance. Some even claim that switching every private insured American to Medicare or something like it could save the nation enough money to cover all currently uninsured Americans.

Advocates of a public plan assert that Medicare has administrative costs of 3 percent (or 6 to 8 percent if support from other government agencies is included), compared to 14 to 22 percent for private employer-sponsored health insurance (depending on which study is cited), or even more for individually purchased insurance. They attribute the difference to superior efficiency of government,[1] private insurance companies' expenditures on marketing,[2] efforts to deny claims,[3] unrestrained pursuit of profit,[4] and high executive salaries.[5]

However, on a per-person basis Medicare's administrative costs are actually *higher* than those of private insurance—this despite the fact that private insurance companies do incur several categories of costs that do not apply to Medicare. If recent cost history is any guide, switching the more than 200 million Americans with private insurance to a public plan will not save money but will actually increase health care administrative costs by several billion dollars.

Fuzzy Math. Medicare patients are by definition elderly, disabled, or patients with end-stage renal disease, and as such have higher average patient care costs, so expressing administrative costs as a percentage of total costs gives a misleading picture of relative efficiency. Administrative costs are incurred primarily on a fixed or per-beneficiary basis; this approach spreads Medicare's costs over a larger base of patient care cost.

Even if Medicare and private insurance had *identical* levels of administrative efficiency, Medicare would appear to be more efficient merely because of an artifact of the arithmetic of percentages—Medicare's identical administrative costs per person would be divided by a larger number for patient care costs.

Imagine, for a moment, that Fred and Jane each have a credit card from a different bank. Fred charges $5,000 a month, and Jane charges $1,000 a month. Suppose it costs each bank $5 to produce and send a plastic credit card when the account is opened. That $5 "administrative cost" is a much lower percentage of Fred's monthly charges than it is of Jane's, but that does not mean Fred's bank is more efficient. It is purely a mathematical artifact of Fred's

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charging pattern, and it would be silly to compare the efficiency of bank operations on that basis. Yet that is how many analysts compare Medicare with private insurance.

Background. Administrative costs are customarily expressed as a percentage of total costs, that total being the sum of administrative costs and health benefit claims paid. In the case of Medicare, the cost to the Centers for Medicare and Medicaid Services (CMS) of operating the Medicare program has ranged in recent years from 2.8 to 3.4 percent; adding in costs incurred by other government agencies in support of Medicare brings the total to a range of 5.7–6.4 percent.[6]

In the case of private insurance, administrative costs are measured by the difference between premiums collected and claims paid. The result is that this includes some costs that are not really "administrative."

For example, many private insurers provide disease management services for patients with chronic conditions and/or on-call nurses for patients to consult by phone. Because these services are provided directly by the insurance company, they do not result in a claim being paid. In addition, most states impose a "premium tax" on health insurers; this tax is obviously not a health benefit claim. However, because all non-benefit costs are defined as "administrative," these and other similar expenditures are reported as administrative costs. In recent years, these so-called "administrative costs" have accounted for 11.4–13.2 percent of total health insurance premiums.[7]

Why Measuring Administrative Costs as a Percentage Is Misleading. Administrative costs can be divided broadly into three categories:

1. Some costs, such as setting rates and benefit policies, are incurred regardless of the number of beneficiaries or their level of health care utilization and may be regarded as "fixed costs."
2. Other costs, such as enrollment, record-keeping, and premium collection costs, depend on the number of beneficiaries, regardless of their level of medical utilization.
3. Claims processing depends primarily on the number of claims for benefits submitted.

Claims processing is the only category that is at all sensitive to the level of health care utilization, and it is more correlated with the number of claims than on the cost or intensity of service provided on each claim. Furthermore, it represents only a very small share of administrative costs. For example, in the case of Medicare, the total claims processing expenditure in FY 2005 was $805.3 million,[8] which represented 4.04 percent of Medicare's

1. Paul Krugman, "The Health Care Racket," *The New York Times*, February 16, 2007.
2. 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* (June 25, 2009).
3. Frank Clemente, "A Public Health Insurance Plan: Reducing Costs and Improving Quality," Institute for America's Future, February 5, 2009, p. 25, at *http://www.ourfuture.org/files/IAF_A_Public_Health_Insurance_Plan_FINAL.pdf* (June 25, 2009).
4. Edward M. Kennedy, "A Democratic Blueprint for America's Future," address at the National Press Club, January 12, 2005, at *http://www.commondreams.org/views05/0112-37.htm* (June 25, 2009); Pete Stark, "Medicare for All," *The Nation*, February 6, 2006, at *http://www.thenation.com/doc/20060206/stark* (June 25, 2009); Max Baucus, "Call to Action Health Reform 2009," November 12, 2008, p. 77, at *http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf* (June 25, 2009); Hacker, "The Case for Public Plan Choice," p. 6–8; Clemente, "A Public Health Insurance Plan," p. 15.
5. Clemente, "A Public Health Insurance Plan," p. 6.
6. Benjamin Zycher, "Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?" Manhattan Institute for Policy Research, October 2007, at *http://www.manhattan-institute.org/html/mpr_05.htm* (June 25, 2009); Mark E. Litow, "Medicare Versus Private Health Insurance: The Cost of Administration," Milliman, Inc., January 6, 2006; at *http://www.cahi.org/cahi_contents/resources/pdf/CAHIMedicareTechnicalPaper.pdf* (June 25, 2009).
7. Centers for Medicare and Medicaid Service, "National Health Expenditure Accounts," Table 12, at *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf* (June 25, 2009).

Administrative Costs of Medicare and Private Health Insurance

	Medicare			Private Health Insurance			
Year	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 per Beneficiary *(dollars per person)*	Percent by which Medicare Is Higher
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%

* Derived from CMS Medicare Denominator file and Medicare Enrollment Database. Extract prepared by Susan Y. Hu, Centers for Medicare and 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) rules. 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 beneficiary's other coverage. Since these individuals derive nearly all of their health benefits from private insurance, they are included as private beneficiaries instead..

** Author's calculations based on Benjamin Zycher, "Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured?" Manhattan Institute for Policy Research, October 2007, at *http://www.manhattan-institute.org/html/mpr_05.htm* (June 25, 2009).

† U.S. Census Bureau, Housing and Household Economic Statistics Division, Current Population Survey.

‡ Centers for Medicare and Medicaid Service, National Health Expenditure Accounts, Table 12, at *http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf* (June 25, 2009).

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administrative costs—which is, in turn, only 0.234 percent (less than 24 cents for every $100) of total Medicare outlays.[9]

Clearly, only an extremely small portion of administrative costs are related to the dollar value of health care benefit claims. Expressing these costs as a percentage of benefit claims gives a misleading picture of the relative efficiency of government and private health plans.

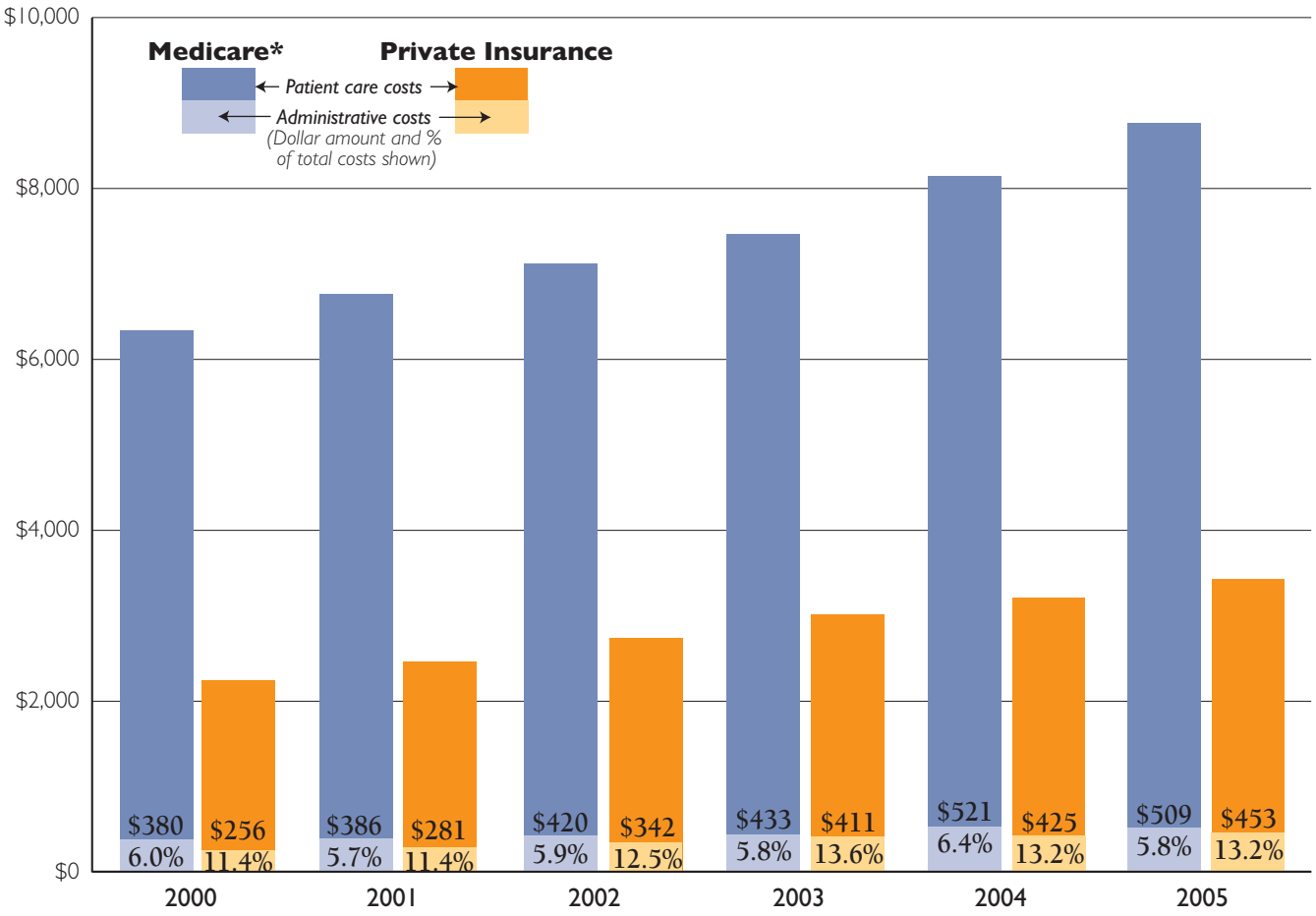
Medicare beneficiaries are by definition elderly, disabled, or patients with end-stage renal disease. Private insurance beneficiaries may include a small percentage of people in those categories, but they consist primarily of people are who under age 65 and not disabled. Naturally, Medicare beneficiaries need, on average, more health care services than those who are privately insured. Yet the bulk of administrative costs are incurred on a fixed program-level or a per-beneficiary basis. Expressing administrative costs as a percentage of total costs makes Medicare's administrative costs appear lower not because Medicare is necessarily more efficient but merely because its administrative costs are spread over a larger base of actual health care costs.

Administrative Costs per Person. When administrative costs are compared on a per-person basis, the picture changes. In 2005, Medicare's administrative costs were $509 per primary beneficiary, compared to private-sector administrative costs of $453. In the years from 2000 to 2005, Medicare's administrative costs per beneficiary were consistently higher than that for private insurance, ranging from 5 to 48 percent higher, depending on the year (see Table 1). This is despite the fact that private-sector "administrative" costs include state health insurance premium taxes of up to 4 percent (averaging around 2 percent, depending on the state)—an expense from which Medicare is

8. Centers for Medicare and Medicaid Services, "Justification of Estimates for Appropriations Committees, Fiscal Year 2009," February 2008, p. 27, at *http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY09CJ.pdf* (June 25, 2009).
9. Author's calculations based on *ibid*.

Outlays per Beneficiary: Medicare v. Private Insurance

Medicare patients have higher average patient care costs, so expressing administrative costs as a percentage of total costs gives a misleading picture of the relative efficiency. Administrative costs per patient are only slightly higher for Medicare than for private insurance. However, patient care costs are much higher for Medicare, so administrative costs are a lower percentage of Medicare's total costs than private insurers' total costs.



*Medicare primary beneficiares only. This excludes those who have another source of coverage (such as employer-sponsored insurance) and are thus subject to the Medicare Second Payer (MSP) rules. 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 beneficiary's other coverage. Since these individuals derive nearly all of their health benefits from private insurance, they are included as private beneficiaries instead.

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exempt—as well as the cost of non-claim health care expenses, such as disease management and on-call nurse consultation services.

It is worth noting that some of the additional private-insurance costs cited by pubic plan advocates, such as marketing and profit, are included in the above figures for private-insurance administrative costs. Directly provided health services and state health insurance premium taxes are also included.

Even without these costs, Medicare administrative spending is *still* higher—suggesting that Medicare's administration is even more inefficient compared to private insurance than is suggested by its higher per-beneficiary administrative costs.

Getting the Math Right. Health care reform is a complex problem, of which administrative costs is only one component. However, for policymakers and ordinary Americans to understand these issues,

journalists, analysts, and advocates have an obligation to avoid "playing with numbers"—either through inadvertent misunderstanding of what the numbers represent or through a deliberate choice of misleading numbers that appear to support a desired policy.

The fact is that, in recent years, Medicare administrative costs per beneficiary have substantially exceeded those costs for the private sector, this despite the fact that, as critics note, private insurance is subject to many expenses not incurred by Medicare. Contrary to the claims of public plan advocates, moving millions of Americans from private insurance to a Medicare-like program will result in program administrative costs that are higher per person and higher, not lower, for the nation as a whole.

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