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Administrative Costs and Their Contributions Towards Increased Federal Health Care Spending

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Chairman Whitehouse, Ranking Member Grassley, and Members of the Senate Budget Committee, thank you for the opportunity to testify before you today. It is an honor to be invited to participate in today's discussion.

My name is David Cutler. I am professor of economics at Harvard University, where I have been engaged in research and teaching about health economics for over 30 years. I have conducted research on overall medical care spending and specifically on the component of medical spending attributable to administrative costs. I have published widely in this area.[1] The desire to reduce

[1] See, for example: Cutler DM, Pozen A, "Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Costs" *Inquiry*, 47(2), Summer 2010, 124-134; Cutler DM., Ly DP, "The (Paper)Work of Medicine: Understanding International Medical Costs." *Journal of Economic Perspectives*, 2011, 25 (2): 3-25; Cutler DM, Wikler E, Basch P, "Reducing Administrative Costs and Improving the Health Care System," *New England Journal of Medicine*, November 2012, 367(20): 1875-1878; Cutler DM, Wikler E, Basch P, "Paper Cuts: Reducing Health Care Administrative Costs," *Center for American Progress*, June 2012; Cutler DM, *Reducing Administrative Costs in US Health Care,"* Brookings Institution, March 2020; Sahni NR, Mishra P, Carrus B, Cutler DM, *Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare*. McKinsey &

administrative costs in the U.S. health care system spans the political spectrum. Similarly, the desire to improve the federal budget situation is universal. Thus, I hope the findings and recommendations I present are taken in this spirit.

The Nature of the Problem

The long term outlook for the federal budget is uncertain. Nearly 30% of federal spending is directed to health programs.[2] Thus, the budget outlook for the federal government is highly dependent on the path of future health costs.

Historically, the growth rate of medical spending exceeded the growth rate of the economy by 1-2% annually.[3] If this were to continue, the federal budget would become increasingly out of balance. Fortunately, the growth of medical spending relative to the economy has slowed. In 2022, health care took up the same share of GDP as it did in 2009 (Exhibit 1).[4] Since the advent of good health spending data in 1960, there is no other comparable time period where the growth of medical spending relative to the economy has been this slow. This slowdown has provided much needed relief to the federal budget as well as state and local governments, businesses, and households.

At the same time, there is more to be done. Not only is it important that the growth of medical spending not increase as rapidly as it has historically, but it should be possible to reduce

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Company. October 20, 2021.Sahni NR, Carrus B, Cutler DM, "Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care," *JAMA*, 2021 Nov 2, 326(17): 1677-1678; Sahni NR, Stein G, Zemmel R, Cutler DM, "The Potential Impact of Artificial Intelligence on Healthcare Spending," in Agrawal A, Gans J, Goldfarb A, *The Economics of Artificial Intelligence: An Agenda*, Chicago: University of Chicago Press, 2022; Cutler DM, Sahni NR, Gupta P, Peterson M, "Active steps to reduce administrative spending associated with financial transactions in US health care." *Health Affairs Scholar*, 2023, 1 (5): qxad053.

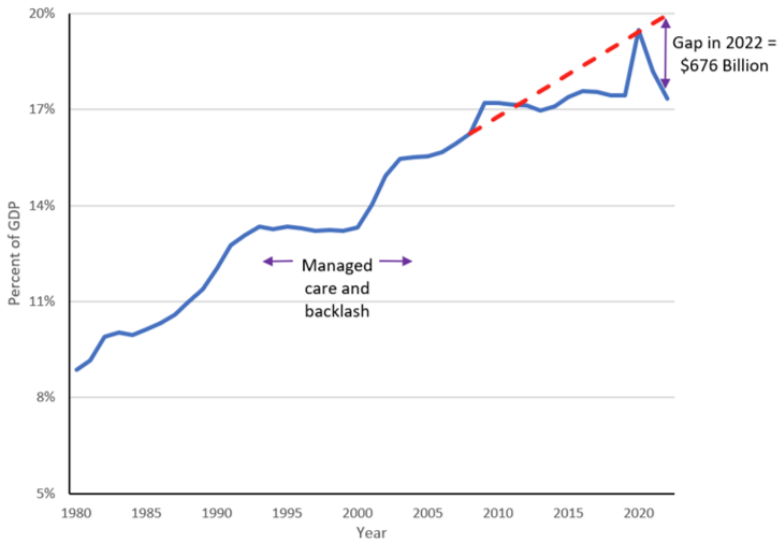
[2] Cubanski J, Biniek JF, Neuman T, "FAQs on Health Spending, the Federal Budget, and Budget Enforcement Tools," Kaiser Family Foundation, March 20, 2023.

[3] Hartman M, Martin AB, Whittle L, Catlin A; National Health Expenditure Accounts Team. National Health Care Spending In 2022: Growth Similar To Prepandemic Rates. *Health Affairs*. 2024 Jan;43(1):6-17. doi: 10.1377/hlthaff.2023.01360. Epub 2023 Dec 13. PMID: 38091522.

[4] Cutler DM, "National Health Expenditures: Reading Past The Headlines," *Health Affairs Forefront*. 2023, Dec 15; doi: 10.1377/FOREFRONT.20231214.983063

spending. Productivity growth in many industries has led to cost reductions, and there is no reason why health care has to be different.

Exhibit 1: Medical Spending as a Share of GDP



Source: Cutler DM, "National Health Expenditures: Reading Past The Headlines," *Health Affairs Forefront*. 2023, Dec 15; doi: 10.1377/FOREFRONT.20231214.983063

The most noticeable area where health care could become more efficient is in reducing administrative costs. Administrative costs are those expenses that are not directly associated with providing goods and services to people in need of care. There is no central account kept on the amount of administrative cost of United States healthcare system, but there are estimates of the overall magnitude. In recent studies with colleagues, I have estimated that health care administration accounts for $950 billion annually, or roughly one-quarter of medical spending.[5] To put this amount in perspective, this is roughly three times what the United States spends on

[5] Sahni NR, Carrus B, Cutler DM. "Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care." *JAMA*. 2021;326(17):1677–1678. doi:10.1001/jama.2021.17315; Sahni NR, Mishra P, Carrus B, Cutler DM, *Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare*. McKinsey & Company. October 20, 2021.

cardiovascular disease care every year,[6] and nearly four times what the United States spends on cancer care.[7]

The level of administrative cost in the United States is far higher than in other countries and exceeds other sources of excess cost in the United States. For example, administrative costs account for 39% of the difference in spending between the United States and Canada, greater than the additional spending accounted for by higher payments to pharmaceutical companies and more frequent use of services such as imaging and additional procedures.[8]

How Administrative Cost Reductions Would Affect the Federal Budget

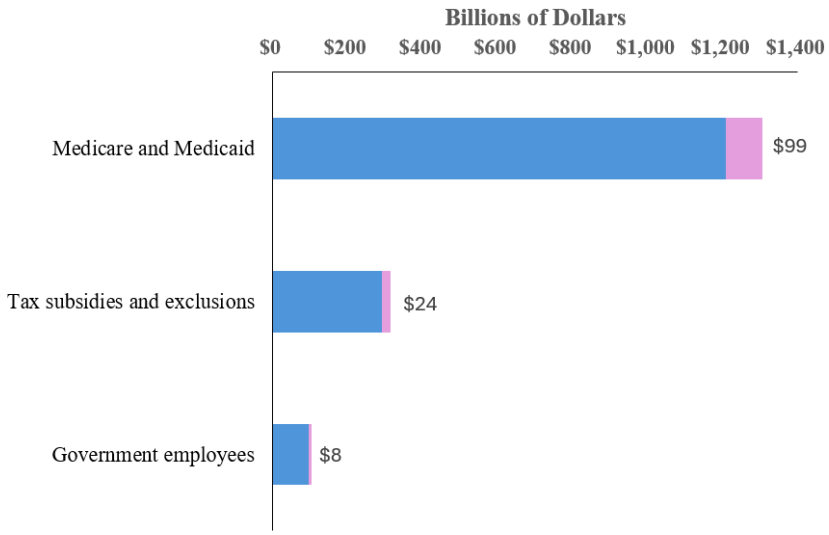
Because the federal government pays so much for medical care, the impact of administrative cost savings for the federal treasury would be immense. I have made rough calculations to estimate how large these savings would be. I emphasize that these are illustrative calculations designed to give a sense of scale rather than a detailed estimate.

Exhibit 2 shows my calculations. There are three broad areas of the federal budget that would be particularly affected by administrative cost savings. Public health insurance programs are the first area. Medicare Advantage premiums are higher than they otherwise would be because of administrative costs. In addition, traditional Medicare physician and hospital payments could be lowered if provider costs were lower, as they would be if administrative costs were reduced. For the same reason, the federal contribution to Medicaid and CHIP could fall with administrative

[6] Birger M, Kaldjian AS, Roth GA, Moran AE, Dieleman JL, Bellows BK. Spending on Cardiovascular Disease and Cardiovascular Risk Factors in the United States: 1996 to 2016. Circulation. 2021 Jul 27;144(4):271-282. doi: 10.1161/CIRCULATIONAHA.120.053216. Epub 2021 Apr 30. PMID: 33926203; PMCID: PMC8316421.
[7] Mariotto AB, Enewold L, Zhao J, Zeruto CA, Yabroff KR. Medical Care Costs Associated with Cancer Survivorship in the United States. Cancer Epidemiol Biomarkers Prev. 2020 Jul;29(7):1304-1312. doi: 10.1158/1055-9965.EPI-19-1534. Epub 2020 Jun 10. PMID: 32522832; PMCID: PMC9514601.
[8] Cutler DM, Ly DP, "The (Paper)Work of Medicine: Understanding International Medical Costs." *Journal of Economic Perspectives*, 2011, 25 (2): 3-25.

cost savings. This bucket is the largest of the three, accounting for nearly $1.3 trillion of spending in 2023.[9]

Exhibit 2: Potential Savings in Administrative Costs, 2023



Source: Author's estimates based on data from the Congressional Budget Office and Office of Management and Budget.

The second broad area is tax subsidies for health insurance. This includes subsidies for the Affordable Care Act's insurance exchanges, the income tax subsidy to employer-provided health insurance,[10] and medical expense deductions through the income tax code. In 2023, these subsidies and tax expenditures totaled roughly $315 billion. Reducing administrative costs would reduce these subsidies as well, since part of private health insurance premiums goes to fund administrative costs in health insurance companies as well as in provider offices. Thus, lowering administrative costs would reduce what insurers need to charge customers.

[9] This estimate is net of offsetting receipts for Medicare, e.g. premiums paid by individuals for parts B and D. I do not include VA spending on health care because administrative costs are not associated with complexities in the billing and prior authorization process at VA facilities.

[10] There are also additional revenues from higher payroll taxes, but these would be offset by higher future Social Security payments when people retire. Thus, I do not include this amount.

The third broad area is medical spending for active and retired federal employees. This spending is roughly $95 billion annually, including military[11] and non-military employees.[12] Most of this is through private insurers – for example, the insurers that contract with the Office of Personnel Management to cover federal employees – and so would fall if administrative costs were lower, analogous to the subsidy argument above. Accounting for all three buckets of health, federal outlays, subsidies, and tax expenditures are roughly $1.7 trillion in 2023.

In my work, I have estimated that administrative savings of $265 billion annually are achievable using current technologies. I return to the source of these savings in the next section.[13] This amount is 7.6% of applicable personal health care expenditures.[14] In keeping with the rough calculation I am doing here, I assume that administrative savings would be 7.6% for each of the three major categories of spending noted above. In certain cases, this assumption is a lower bound. For example, in the ACA exchanges, the federal government pays three-quarters of premiums on average,[15] but 90% of exchange enrollees receive a subsidy.[16] For this 90% of the population, a dollar in lower premiums translates into a full dollar saved for the federal government. In addition, these savings are only for hospitals, physicians, and insurance companies. They ignore possible administrative savings in the host of other areas of medical care: pharmaceuticals, medical devices, nursing homes, home health care, and many other areas.

[11] Congressional Research Service, "FY2024 Budget Request for the Military Health System," April 10, 2023.
[12] Budget of the United States Government, Office of Personnel Management, March 11, 2024.
[13] Sahni NR, Carrus B, Cutler DM. "Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care." *JAMA*. 2021;326(17):1677–1678. doi:10.1001/jama.2021.17315; Sahni NR, Mishra P, Carrus B, Cutler DM, *Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare*. McKinsey & Company. October 20, 2021.
[14] Personal health care spending net of VA spending, worksite spending, the Indian Health Service, SAMSA, and school health spending.
[15] CMS, 2022 Open Enrollment Report, Washington, D.C.: CMS.
[16] Ortaliza J, Amin K, Cox C, "As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere", Kaiser Family Foundation, September 7, 2023.

Taking all of this into account, I estimate that the federal budget would improve by $130 billion in 2023 if administrative costs were reduced by the amount that is feasible. This amount is immense. The 2023 estimate is 2.1% of total federal spending in 2023 and 0.5% of US GDP. Put another way, it is $384 per person or perhaps $1,500 per family.

Since medical costs are rising at roughly the rate of GDP growth, this number would trend forward at roughly the same rate as GDP growth. Using CBO projections of GDP growth,[17] if we could achieve these administrative cost savings, the cumulate benefit to the federal treasury would be roughly $1.4 trillion over the next decade.

These funds could be put to several uses. States might use the savings to increase Medicaid access – for example, not reducing Medicaid spending even as costs fall. Even if states did this for Medicaid and CHIP, total federal savings would still be $89 billion annually.

How Administrative Costs Might Be Reduced

In work with colleagues, I have devoted extensive effort to understanding why administrative costs are as high as they are.[18] As part of this, we have undertaken a 'deep dive' into financial statements from health care payers and providers to separate administrative costs into various functional categories.

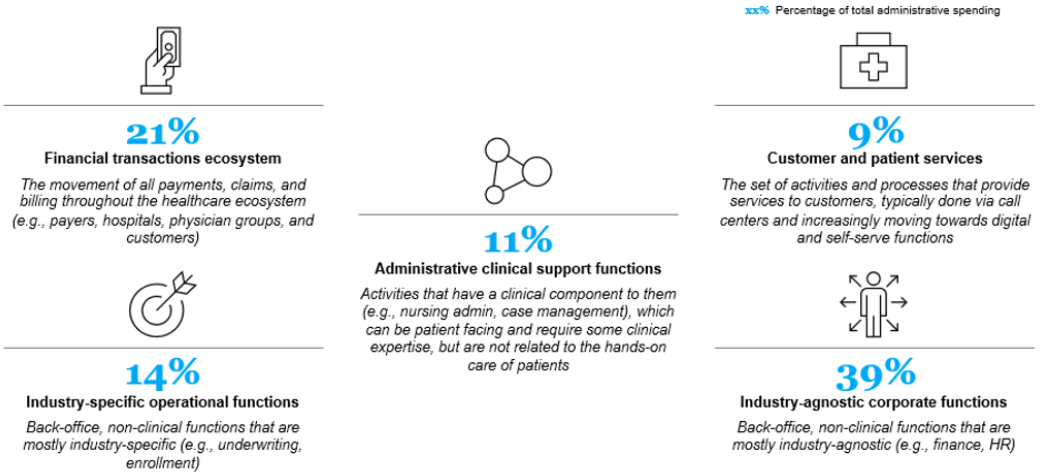
Exhibit 3 shows our findings. The largest category of administrative expense is what is termed "industry-agnostic" spending – HR, accounting, general administrative staff, and the like. In total, these amount to 39% of total administrative spending. These costs have to be incurred in

[17] Congressional Budget Office, *The Economic and Budget Outlook, 2024-2034,* Washington, D.C.: CBO, 2024.
[18] Sahni NR, Carrus B, Cutler DM. "Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care." *JAMA*. 2021;326(17):1677–1678. doi:10.1001/jama.2021.17315; Sahni NR, Mishra P, Carrus B, Cutler DM, *Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare*. McKinsey & Company. October 20, 2021.

all industries, but their share of total revenue is higher in health care than elsewhere. For example, many hospitals are not using state-of-the-art HR and accounting practices, which are both cheaper and more effective. Some progress can be made here, but the federal role is likely smaller. The central challenge in addressing these industry-agnostic costs is that many health care organizations are small, and small businesses are not as invested in managerial efficiency as larger businesses.

Exhibit 3: Decomposition of Administrative Expenses

Cost drivers were regrouped into 5 functional focus areas that represent majority of administrative spending...



Source: Sahni NR, Mishra P, Carrus B, Cutler DM. *Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare*. McKinsey & Company. October 20, 2021

The second big area is the financial transactions ecosystem, which accounts for 21% of administrative spending. This includes the cost of providers dealing with payers, filling out and submitting billing forms, handling prior authorization, and following up on other requests for information. As we detail in our McKinsey report, the numbers here are enormous. The average cost to handle a claim is roughly $2-$4 for private payers and $10-$15 for providers; more complex claims cost more. These costs are incurred for the roughly 9 billion medical claims that are submitted annually. Prior authorization is even more expensive. Combined payer and provider

costs of prior authorization are about $60-$80 per approval request, about two-thirds for private payers and one-third for providers.

The remaining categories of administrative cost include industry-specific operational functions such as underwriting and enrollment management in health insurance companies (14%), clinical support functions such as nursing administration (11%), and customer and patient services, which includes the call center (9%). Each of these could be reduced through use of best practices, though again the small size of many health care organizations makes this more complex than in some other industries.

Addressing the administrative costs of the financial transactions ecosystem is where policy has the biggest role to play. The contrast between health care and other industries is particularly apparent in this area. In most industries, wholesalers and retailers have a collaborative relationship. For example, Walmart works together with its suppliers to achieve lower costs and higher quality. Information between the two parties flows without any human involvement. In health care, in contrast, there is antagonism between the 'wholesaler' (provider) and 'retailer' (insurer). This is true even when it would make sense to have a collaborative relationship. For example, insurers typically have prior authorization requirements that are invariant across providers – every time they receive a request for use of a particular therapy, they ask for documentation, regardless of the quality and cost experience of the provider. The inability to develop collaborative relationships makes costs far higher than they need to be.

Health care also differs from other industries in the lack of interoperable data. Consider again the prior authorization process. The information that the provider transmits to the payer in response to prior authorization requirements is generally in the provider's electronic medical record. Thus, it would be conceptually straightforward for the payer to access the information

electronically when it receives the authorization request and issue an immediate approval or rejection. Alternatively, the payer could make clear the approval criteria in advance, so that the information can be transmitted electronically from the provider's office at the time of the initial request. But neither of these occurs. The result is a manual and very expensive process.

In addition to financial expense, the inefficiency of the financial system creates additional stressors for patients and providers. At a time of clinical need, patients and their clinicians are often stuck negotiating for approval or waiting for treatment to begin.

Some solutions to these problems can be bilateral – actions taken by a single payer working with a single provider. For example, payers and providers could agree to use 'gold carding' or another method (e.g., ex post auditing of only some cases) to limit prior authorization to certain cases. As one example, a payer may conclude that a certain IVF facility is a "Center of Excellence" and not request prior authorization for every cycle that the facility undertakes. Policy can encourage such experimentation, including by incentivizing or requiring such efforts in the Medicare Advantage program.

Other solutions will require more robust efforts across payers and providers. For example, billing and prior authorization are so costly in part because different insurers require different information to process a bill. This can include different clinical information requirements or simply trivial differences such as whether the state a person lives in is spelled out fully ("Rhode Island") or abbreviated ("RI"). If the requirements of different payers in a market were harmonized, the costs of claims processing would fall.

One area of large benefit would be to have a "spring cleaning" for prior authorization. The typical payer has several thousand prior authorization codes – roughly half for medical services and half for pharmaceuticals. In many cases, these codes were appropriate at one point, but they

may not be appropriate any longer. For example, prior authorization was (arguably) appropriate for anti-hypertensive medications when some drugs were branded and others were generic. Now that all of the leading medications are generic and overuse of antihypertensives is extremely low, there is no justifiable reason for prior authorization of generic anti-hypertensives. However, payers have never gone through their systems to determine which prior authorizations are still necessary and which are not. The problem is further compounded by the fact that different insurers have different prior authorization criteria for the same drugs, even generic drugs such as anti-hypertensives. For example, one payer may require prior authorization for one subset of drugs, while another may require prior authorization for a different set of drugs. The same insurer may even have different approval criteria for different plans, a legacy of when those rules made sense. But they were never updated.

My colleagues and I estimated that about half of prior authorization requirements could be eliminated through a systematic, coordinated focus on best practices in cases where there is close to universal agreement on what that best practice involves.

The major difficulty is enforcing the universal use of standards. At present, there is no requirement that any participants standardize their claims processing. Thus, we have a cacophony of different systems in use. In other industries, standardization is often imposed by large players.[19] For example, electronic standards for transferring money are set by the federal government and a consortium of large banks. All banks that want to transfer funds electronically are required to use this system. The result is that trillions of dollars are transferred across banks annually, at extremely low cost. A second example is retail, where the Universal Product Code (and its associated UPC bar) is ubiquitous. Any store that wished to have its own UPC alternative would rapidly find that

[19] Cutler DM, *Reducing Administrative Costs in US Health Care,"* Brookings Institution, March 2020.

it had to pay more for suppliers to offset the higher cost that such a policy would impose. The situation in health care is the equivalent of every payer requiring its own UPC code.

Again, policy could be helpful here. The federal government could commit to a standard and enforce its use by all parties. There would be a one-time cost as parties have to update their operations to handle this, but the ongoing savings would dwarf these costs.

Given the recent problems with Change Healthcare, one should be cautious about centralizing any aspect of health care information transmission. That said, since the federal government ultimately gets involved when big things go wrong, it seems inevitable that the federal government will have to get more involved in health care data transmission. Policy should explore this area carefully. If there are ways to improve the efficiency of the health care transmission system while promoting maximum security, it would be good to move in that direction.

The Outlook for Reducing Administrative Costs

The fact that administrative costs in health care have remained so high for so long is a cause for concern. If we have not fixed the problem yet, what assurances do we have that it can ever be addressed? I believe there are several reasons for optimism. The first is related to the hearing today. There has never been as much policy attention devoted to administrative costs as there is at present. This examination and consideration of legislative solutions is welcome news for the health sector and everyone who pays in to it or uses services from it.

Second, there is increasing realization by payers and providers that some form of administrative simplification efforts will be required. Payers and providers universally report high levels of dissatisfaction with the prior authorization process, and both groups are looking for alternatives to the current process. In addition to high costs, the process leads to significant burnout

among clinical personnel and anxiety among patients and providers.

Third, technological advances, particularly in generative AI (i.e., ChatGPT and related products), are making the prospect of administrative cost savings more feasible.[20] Currently, administrative tasks are manual; a medical records specialist transfers information from one computer system to another. AI can streamline this process substantially, for example by pre-populating a significant share of the billing information from the medical record. Since electronic interaction is cheaper than human interaction, this would save significant amounts of time and money.

A large share of insurers are exploring the use of AI for aiding in prior authorization. At the moment, this is solely on the insurer end – using AI to come up with a cheaper and more rapid way to approve or deny claim prior authorization requests. The key will be to link AI systems across payers and providers, so that as many people and as much time as possible can be removed from the process. Many providers express interest in learning about AI for prior authorization, but they are not sure where to start. If the health care industry could develop a robust and easy-to-afford AI system that works for both payers and providers, it could materially change the administrative costs of health care.

For all these reasons, I am optimistic that the country can reduce the administrative burden of health care significantly. This would provide much needed financial relief for households, businesses, and governments at all levels.

[20] Sahni NR, Stein G, Zemmel R, Cutler DM, "The Potential Impact of Artificial Intelligence on Healthcare Spending," in Agrawal A, Gans J, Goldfarb A, *The Economics of Artificial Intelligence: An Agenda*, Chicago: University of Chicago Press, 2022.