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in the U.S. Health Care System in 2003:

The Cost to the Nation, the States and the District of Columbia, with State-Specific Estimates of Potential Savings

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Executive Summary

The U.S. wastes more on health care bureaucracy than it would cost to provide health care to all of the uninsured. Administrative expenses will consume at least $399.4 billion out of total health expenditures of $1,660.5 billion in 2003. Streamlining administrative overhead to Canadian levels would save approximately $286.0 billion in 2003, $6,940 for each of the 41.2 million Americans who were uninsured as of 2001. This is substantially more than would be needed to provide full insurance coverage.

These results are derived from detailed data on administrative costs in the U.S. and Canada in 1999 which appears in tomorrow's *New England Journal of Medicine.* This report updates the *New England Journal* estimates of nationwide administrative spending and potential savings to 2003. The complex and fragmented payment structure of the U.S. health care system increases administrative overhead in the U.S. relative to Canada, where a single-payer national health insurance program has existed since 1971.

The cost of excess health bureaucracy to the states is equally striking. Massachusetts, with 560,000 uninsured state residents, could save about $8.556 billion in 2003 ($16,453 per uninsured resident of that state) if it streamlined administration to Canadian levels. New Mexico, with 373,000 uninsured, could save $1.500 billion on health bureaucracy ($4,022 per uninsured resident). Maine, home to 132,000 uninsured residents recently passed legislation that seeks to cover the uninsured through a complex system of state subsidies. Unfortunately, the Maine legislation fails to capture the $1.325 billion in potential savings annually ($10,037) on administration that would have been achievable with a single payer reform.

Only a single payer national health insurance system could garner these massive administrative savings, allowing universal coverage without any increase in total health spending. Because incremental reforms necessarily preserve the current fragmented and duplicative payment structure they cannot achieve significant bureaucratic savings.

Introduction

This report compares the cost of health care bureaucracy in the U.S. to that in Canada in 2003. We also calculate the cost of excess bureaucracy in each of the 50 states and the District of Columbia. These state-by-state estimates represent the amount spent on administration and the potential savings through the implementation of a single payer, universal health care program similar to Canada's. This information should be useful to consumers, national and state legislators, health policy experts, economists, and others concerned with skyrocketing medical costs and declining access to medical care.

Administrative Costs 1969-1999

The administrative structure of the U.S. health care system consumes a large share of health spending. In 1999, administrative spending consumed at least 31.0 percent of health spending, according to a report in today's *New England Journal of Medicine*. In contrast, administrative costs in Canada, which has had a national health program since 1971, are about 16.7% of health spending.

In 1969 administrative personnel accounted for 18.2% of the health care work force in the U.S. By 1999 administration's share had risen to 27.3% of total employees – a 50% increase. This figure excludes the 926,000 employees in life/health insurance firms, and 724,000 employed in insurance brokerages. Overall, at least 31.0% of health spending was devoted to administration in the U.S. in 1999.

In contrast, administration's share of health employment in Canada (where a national health program has been in place since 1971) grew only 17% between 1971 and 1986, and has remained virtually unchanged since 1986. In 1996 administrative workers accounted for 19.1% of health employees vs. 27.3% in the late 1990s in the U.S. (both of these figure exclude health insurance company workers, who are far more numerous in the U.S. Administration consumed 16.7% of Canadian health spending in 1999.

Nationwide Administrative Costs in 2003

In 2003 bureaucracy will consume at least $399.4 billion ($1,389 per capita) out of total health expenditures of $1,660.5 billion ($5,775 per capita). This estimate is based on the conservative assumption that administrative overhead represents the same share of health spending on hospital care, nursing home care, physicians' services, home care, employers' costs to administer health benefits and insurance overhead now as in 1999 (ie. that administrative costs have not continued to rise). It excludes the administrative costs of health sectors for which administrative cost data were unavailable (e.g. drug stores, ambulance companies, and medical equipment suppliers).

Streamlining administration to Canadian levels would save $286.0 billion in administrative costs in 2003, $982 per capita (see Methodology section for details of calculations).

The Single Payer Advantage

The huge gap in administrative costs between the U.S. and Canada arises from their differing mechanisms of paying for health care. While Canada has a single insurance plan, or "single-payer", in each province that pays the bills for everyone, the U.S. has a complex and fragmented payment structure built around thousands of different insurance plans, each with its own regulations on coverage, eligibility, and documentation.

The participation of private insurers raises administrative costs. The small private insurance sectors in Australia, Canada, Germany, and the Netherlands all have high overheads: 15.8%, 13.2%, 20.4% and 10.4% respectively, far higher than the 1% to 4% overhead of public insurance programs. Functions essential to private insurance but absent in public programs - e.g. underwriting, marketing, and corporate services - account for about two-thirds of private insurers' overhead. In addition, private insurers have incentives to erect administrative hurdles - by complicating and stalling payment they can hold premiums longer, boosting their interest income. Such hurdles also discourage some patients and providers from pursuing claims.

A fragmented payment structure is intrinsically more expensive than a single payer system. For insurers, it means the duplication of claims processing facilities and reduced insured-group size, which increases overhead.

Fragmentation also raises costs for providers who deal with multitudes of different insurance plans - at least 755 in Seattle alone. This means providers must determine each patient's insurance coverage and eligibility for a particular service, and keep track of varying co-payments, referral networks, approval requirements and formularies. In contrast, Canadian physicians send virtually all bills to a single insurer using a simple billing form or computer program, and may refer patients to any colleague or hospital.

The multiplicity of insurers also precludes paying hospitals on a lump sum, or global-budgeted basis as in Canada. Global budgets eliminate most billing, and simplify internal accounting since costs and charges need not be attributed to individual patients and insurers.

Administrative Waste: The Cost to the States

If the states were as efficient at administering health care as the Canadian provinces, they would save more than enough to fund universal coverage, without any increase in total health spending. Table 1 shows estimated spending for health administration in each state in 2003, as well as a minimum estimate of potential administrative savings under a single payer system. The table also displays the number of uninsured in 2001 (the latest data available) and the administrative savings available per uninsured resident.

California has the largest state health budget; personal health spending is estimated at $163 billion in 2003. That state would save at least $33.699 billion on health bureaucracy by instituting a single payer reform, $5,016 for each of the 6.7 million Californians who are uninsured. At the other end of the scale in terms of population, Wyoming, with an estimated 78,000 residents without health insurance, would save at least $376 million in 2003, $4,814 per uninsured resident of that state. The available administrative savings per uninsured resident vary widely – from $3,925 per uninsured resident in Texas to $17,771 in the District of Columbia. The variation reflects differences in uninsurance rates (with Texas having a very high percentage uninsured), and (to a lesser extent) differences in per capita health administration costs. Despite the range, in every state the potential savings on administration would be sufficient to cover the uninsured.

Our estimates are based solely on administrative savings, only one part of the potential savings under a Canadian-style national health insurance system. The Canadian single-payer health system is also better at controlling systemwide inflation. Health expenditures in the U.S. are currently rising three times as rapidly as the U.S. Gross National Product; in Canada they are rising at a rate only slightly greater than growth in the Gross National Product.

Since we to not include the savings that national health insurance would generate by controlling non-administrative health inflation, our estimates represent a lower bound of what could be achieved with a single-payer national health program.

Conclusion

In 2003 the U.S. will spend $399.4 billion ($1,389 per capita) on health bureaucracy, out of total expenditures of $1660.5 billion ($5,775 per capita). The states could save $286.0 billion dollars in 2003 if they streamlined administration to Canadian levels by adopting a single-payer national health insurance system. The potential savings are equivalent to at least $6,940 for each of the 41.6 million Americans uninsured in 2001.

These potential administrative savings are far higher than recent estimates of the cost of covering the uninsured. For instance researchers from The Urban Institute estimate that covering all of America's uninsured with an "average" private insurance policy would cost $69 billion annually (Hadley and Holahan, *Health Affairs*, May/June, 2003). Thus, the $286.0 billion in administrative savings could cover all of the uninsured, with $217 billion left over to upgrade coverage for Americans who are currently under-insured – e.g. to offer first dollar drug coverage to seniors.

Methodology

We added six components of administrative expense (insurance overhead, employers' costs to administration health benefits, hospital administration, nursing home administration, practitioners overhead, and home care agency administration) to calculate total administrative spending by state in 2003.

Each state's 2003 spending by category of expenditure (e.g. hospitals, physicians etc.) was estimated by adjusting 1998 state-by-state expenditure data from the Office of the Actuary, National Center for Health Statistics (the most recent state-by-state health spending data available). This adjustment was carried out under the assumption that each state's health care cost increases since 1998 mirror those of the nation as a whole. Nationwide changes in health expenditures since 1998 were estimated using figures from the Office of the Actuary, National Center for Health Statistics.

Administrative spending on each component was then calculated by multiplying 2003 projected state spending in each of six areas (insurance overhead, employers' costs to administer health benefits, hospitals, nursing homes, practitioners' offices, and home care agencies) by the percentage of spending in each area devoted to administration in 1999. We assumed that administration would consume the same percentage of each type of spending in each state in 2003 as it did in the nation in 1999: 100 percent of insurance overhead and employers' costs to administer health benefits; 24.3

percent of expenditures for hospital care; 19.2 percent of expenditures for nursing home care; 35.0 percent of homecare expenditures; and 26.9 percent of spending on physicians' services. (For further details on the 1999 estimates of administrative spending in each category see: Woolhandler S, Campbell T, Himmelstein DU. *New England Journal of Medicine*.). This is a conservative assumption since administration's share has probably continued to grow since 1999.

Our figures for administrative costs exclude spending in health sectors for which no administrative cost data were available (e.g. retail pharmacies, ambulance companies and medical equipment suppliers). Hence, our dollar estimates understate total administrative costs in each state and in the nation.

For our estimate of total potential administrative savings we summed potential savings on each administrative component. Each state's savings on each component was calculated as the product of 2003 projected state spending in each of six areas (insurance overhead, employers' costs to administer health benefits, hospital administration, nursing home administration, practitioners overhead, and home care agency administration) and the ratio between per capita spending for that administrative component in Canada and the U.S. in 1999. For instance, in 1999 Canada spent $47 per capita on health insurance overhead while the U.S. spent $259. We assumed that this ratio (47:259) remained the same as both nations' health spending increased between 1999 and 2003, i.e. that Canadian administrative costs rose at the same rate as U.S. administrative costs.

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TABLE 1

POTENTIAL ADMINISTRATIVE SAVINGS BY STATE, 2003

Achievable with a Canadian-style National Health Insurance Program

	Projected 2003 Health Expenditures Current System[a] (in $ millions)	Administrative Expenses in 2003[b] (in $ millions)	Potential Administrative Savings in 2003[c] (in $ millions)	Uninsured Residents in 2001[d] (in thousands)	Administrative Savings Available per Uninsured Resident[e] ($'s)
United States[f]	1,660,500	399,356	285,961	41,206	6,940
Connecticut	22,144	5,976	4,225	346	12,212
Maine	7,068	1,884	1,325	132	10,037
Massachusetts	43,603	12,090	8,556	520	16,453
New Hampshire	6,656	1,773	1,277	119	10,733
Rhode Island	6,353	1,672	1,174	80	14,677
Vermont	2,963	774	552	58	9,513
Delaware	4,433	1,186	837	73	11,468
District of Columbia	6,226	1,816	1,244	70	17,771
Maryland	28,166	7,647	5,509	653	8,437
New Jersey	47,320	12,625	9,030	1,109	8,143
New York	122,958	33,664	23,437	2,916	8,037
Pennsylvania	73,293	19,932	14,053	1,119	12,559
Illinois	63,778	17,389	12,339	1,676	7,362
Indiana	30,641	8,367	5,902	714	8,266
Michigan	50,907	13,591	9,638	1,028	9,375
Ohio	60,353	16,530	11,644	1,248	9,330
Wisconsin	28,598	7,727	5,527	409	13,513

	Projected 2003 Health Expenditures Current System (in $ millions)	Administrative Expenses in 2003 (in $millions)	Potential Administrative Savings (in $ millions)	Uninsured Residents in 2001 (in thousands)	Administrative Savings Available per Uninsured Resident ($'s)
Iowa	14,716	3,978	2,777	216	12,857
Kansas	13,441	3,610	2,562	301	8,511
Minnesota	28,862	7,885	5,793	392	14,777
Missouri	30,539	8,440	5,931	565	10,498
Nebraska	8,821	2,362	1,637	160	10,233
North Dakota	3,854	1,073	745	60	12,415
South Dakota	4,005	1,104	780	69	11,305
Alabama	22,541	6,205	4,459	573	7,781
Arkansas	12,319	3,341	2,360	428	5,515
Florida	87,077	23,578	17,071	2,856	5,977
Georgia	39,293	10,765	7,805	1,376	5,672
Kentucky	20,895	5,718	4,042	492	8,216
Louisiana	23,729	6,622	4,680	845	5,538
Mississippi	13,044	3,609	2,537	459	5,527
North Carolina	38,773	10,552	7,472	1,167	6,403
South Carolina	18,780	5,057	3,569	493	7,240
Tennessee	31,474	8,690	6,256	640	9,775
Virginia	31,994	8,566	6,130	774	7,920
West Virginia	10,129	2,743	1,939	234	8,286
Arizona	21,673	5,848	4,296	950	4,522
New Mexico	7,745	2,108	1,500	373	4,022
Oklahoma	15,734	4,273	3,038	620	7,899
Texas	98,742	27,082	19,469	4,960	3,925

	Projected 2003 Health Expenditures Current System (in millions)	Administrative Expenses in 2003 (in millions)	Potential Administrative Savings (in millions)	Uninsured Residents in 2001 (in thousands)	Administrative Savings Available per Uninsured Resident ($'s)
Colorado	19,568	5,231	3,802	687	5,534
Idaho	4,937	1,289	919	210	4,378
Montana	4,122	1,115	784	121	6,477
Utah	8,567	2,241	1,607	335	4,798
Wyoming	2,019	534	376	78	4,814
Alaska	3,011	787	565	100	5,650
California	162,943	45,041	33,699	6,718	5,016
Hawaii	6,612	1,798	1,325	117	11,321
Nevada	8,058	2,134	1,577	344	4,585
Oregon	15,811	4,069	2,938	443	6,631
Washington	27,912	7,265	5,254	780	6,735

Notes:

a. U.S. figure is for total health expenditures; state figures are for personal health expenditures, which exclude a few expense categories such as research and construction. 2003 state estimates were calculated from 1998 state-specific health spending adjusted for the national rate of health expenditure growth between 1998 and 2003, and for changes in state population.

b. Administrative spending was calculated by multiplying 2003 state (or, for the U.S., national) spending in each of six categories (insurance overhead, employers' costs to administer health benefits, hospitals, nursing homes, practitioners' offices, and home care agencies) by the percentage of spending in each area devoted to administration in 1999.

c. Potential administrative savings were calculated for each of six categories (insurance overhead, employers' costs to administer health benefits, hospitals, nursing homes, practitioners' offices, and home care agencies) by subtracting estimated per capita costs for that category in Canada from the per capita cost for the category in the state (or the U.S. as a whole), and multiplying by the state's population. The potential administrative savings in the six categories were then summed.

d. Estimates of the number of uninsured residents in each state are from the March 2002 Current Population Survey. Although CPS uses a nationally representative survey, it may not provide precise estimates for smaller states.

e. Calculated by dividing potential administrative savings in 2003 by the number of uninsured state residents as of 2001.

f. State figures may not sum to national totals due to rounding error and the exclusion of non-resident military personnel.