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Issue Brief

How Health Care Reform Can Lower the Costs of Insurance Administration

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ABSTRACT: The United States leads all industrialized countries in the share of national health care expenditures devoted to insurance administration. The U.S. share is over 30 percent greater than Germany's and more than three times that of Japan. This issue brief examines the sources of administrative costs and describes how a private–public approach to health care reform—with the central feature of a national insurance exchange (largely replacing the present individual and small-group markets)—could substantially lower such costs. In three variations on that approach, estimated administrative costs would fall from 12.7 percent of claims to an average of 9.4 percent. Savings—as much as $265 billion over 2010–2020—would be realized through less marketing and underwriting, reduced costs of claims administration, less time spent negotiating provider payment rates, and fewer or standardized commissions to insurance brokers.

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Overview

The costs of insurance administration in the U.S. health care system totaled nearly $156 billion in 2007, and that figure is expected to double—to reach $315 billion—by 2018 (Exhibit 1).[1] Indeed, the United States leads all other industrialized countries in the share of national health care expenditures devoted to insurance administration. The U.S. share is about 7.5 percent, compared with 5.6 percent in Germany and 2 percent in Finland and Japan (Exhibit 2).[2] The McKinsey Global Institute estimates that the United States spends $91 billion more a year on health insurance administrative costs than it should, given its size and wealth.[3] The majority of administrative costs in U.S. government tallies are attributable to private health insurance. However, the totals are likely to be underestimates: they do not include costs incurred by providers in their interactions with health plans. A recent study estimated that such transaction costs in physicians' practices were as high as $31 billion a year.[4]

This issue brief provides an overview of the sources of health insurance administration costs, and it discusses how a mixed private–public approach to health care reform, now being discussed by Congress and the Obama

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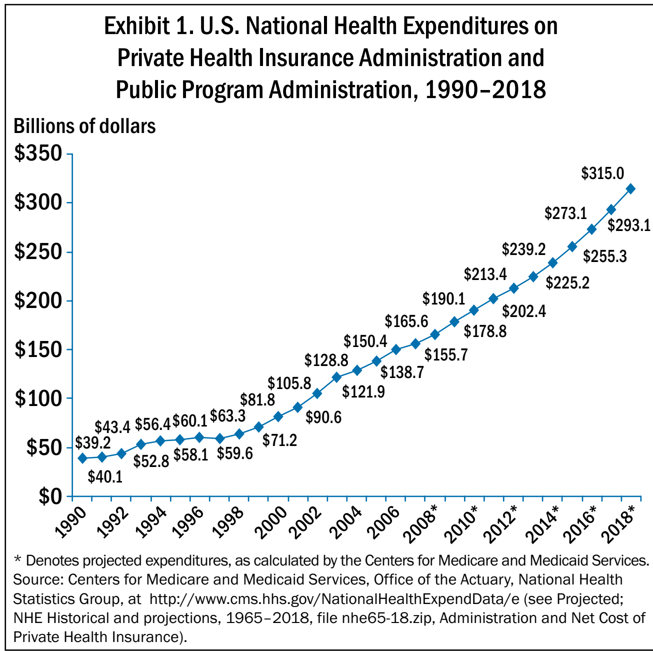


Exhibit 1. U.S. National Health Expenditures on Private Health Insurance Administration and Public Program Administration, 1990–2018

* Denotes projected expenditures, as calculated by the Centers for Medicare and Medicaid Services.
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/e (see Projected; NHE Historical and projections, 1965–2018, file nhe65-18.zip, Administration and Net Cost of Private Health Insurance).

Administration, has the potential to lower those costs.[5] In particular, a national insurance exchange with new insurance market regulations and a choice of private and public insurance plans would increase the transparency of insurance products, streamline insurance plan purchase and enrollment, and reduce administrative costs stemming from activities such as underwriting and marketing. If implemented with other major features of a reform plan—such as an employer requirement to offer coverage, expanded eligibility for Medicaid, a standard benefit package, and premium subsidies—the Lewin Group estimates that more than

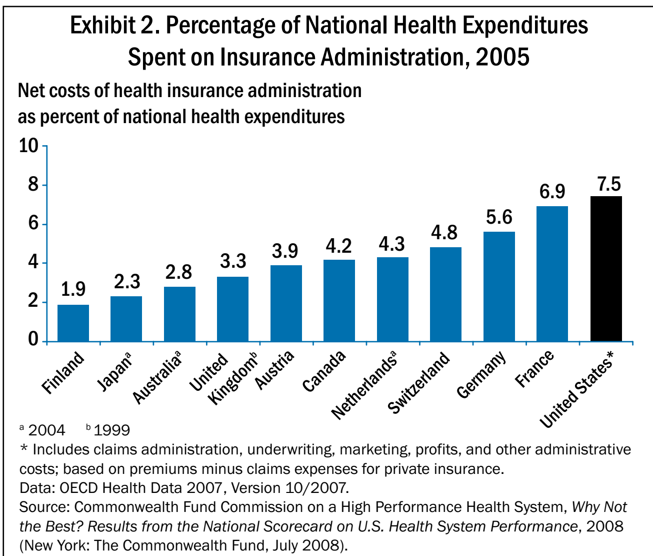


Exhibit 2. Percentage of National Health Expenditures Spent on Insurance Administration, 2005

[a] 2004 [b] 1999
* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.
Data: OECD Health Data 2007, Version 10/2007.
Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance*, 2008 (New York: The Commonwealth Fund, July 2008).

$200 billion could be realized in administrative cost savings during 2010–2019.[6] Costs might be reduced even more through additional measures that further simplified transactions between health plans and providers.

Sources of Administrative Costs in U.S. Health Expenditure Accounts

Of the $156 billion spent on health care administration in 2007, about 60 percent, or $94.6 billion, was paid for by consumers and employers in the form of premiums to private insurance companies (Exhibit 3, Appendix Table 1). These latter costs—representing what insurance companies received in premiums, minus what was paid in medical claims—included payments for bills, advertising, sales commissions, underwriting, and other administrative functions; net additions to reserves; rate credits and dividends; premium taxes; and profits.[7] The remaining 40 percent included federal, state, and local governments' administrative costs for public health programs such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). It also included the administrative costs of private health insurance plans that contracted with the government.

Administrative costs in private health plans are a higher share of insurance expenditures than are administrative costs in public insurance programs like Medicare and Medicaid. Administrative costs represent 12.2 percent of private health insurance expenditures, compared with 6.1 percent of public program expenditures (Exhibit 4). The addition of prescription drug coverage to Medicare, sold through private plans, has added to public program administrative costs. Excluding spending on the Medicare Part D drug benefit, overall public administrative costs are 5.8 percent of total public spending on health care. In the Medicare prescription drug program, Part D administrative costs consume 11.3 percent of Medicare drug spending: private drug plan administrative costs average 10.6 percent of drug spending, while private Medicare Advantage drug plan administrative costs average 14.1 percent of drug spending.

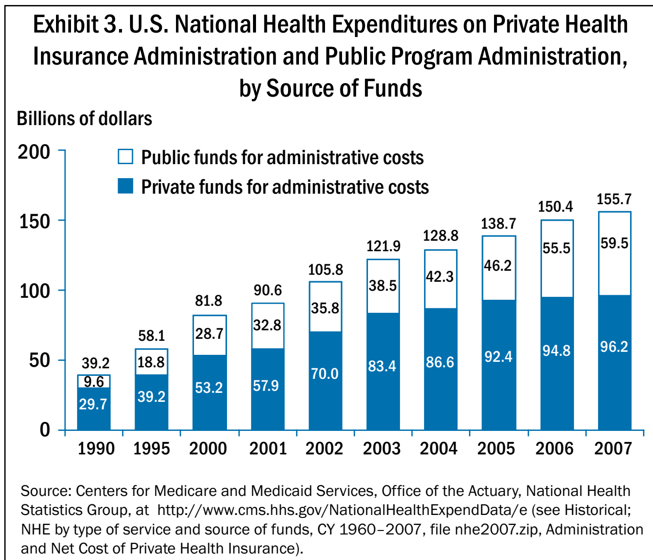


Exhibit 3. U.S. National Health Expenditures on Private Health Insurance Administration and Public Program Administration, by Source of Funds

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/e (see Historical; NHE by type of service and source of funds, CY 1960–2007, file nhe2007.zip, Administration and Net Cost of Private Health Insurance).

The High Costs of Private Insurance Administration

The administrative cost component of private insurance premiums runs from 5 percent to 40 percent, depending on the market and state in which the insurance policy is purchased. Insurance carriers currently sell policies in three different markets—large employer group, small employer group (firms with fewer than 50 employees), and individual—in each of the 50 states and the District of Columbia. Administrative costs and profits consume an estimated 25 percent to 40 percent of premiums in the individual market, 15 percent to 25 percent for companies with fewer than 50 employees, and 5 percent to 15 percent for firms with more than 50 employees.[8] The costs of commissions alone in the small-group market, where brokers play a key role in identifying pertinent insurance policies, run from 4 percent to 11 percent of premiums.[9]

Such variation in costs across markets boosts the administrative costs as a share of revenues even for the largest carriers in the country, which are selling in all three markets. Documents filed with the U.S. Securities and Exchange Commission show that the administrative costs of the largest health insurance companies averaged from 13 percent to 18 percent of premium revenue in 2008 (Exhibit 5).

Underwriting activities in the individual and small-group insurance markets are particularly costly. Because carriers selling policies in the small-group and individual insurance markets do not have complete information about their potential customers' health, they invest significant capital in attempting to identify risk and in designing underwriting models to determine whether premium revenues will exceed expected costs.[10] In states that have prohibited or limited underwriting, carriers have developed other mechanisms for weeding out applicants likely to incur high medical costs. These strategies include refusal to write a policy; selling to niche markets, such as small firms of lawyers and other professionals, that are potentially profitable; avoiding or "redlining" industries, such as taxi driving, that carry higher health risks; excluding coverage for individuals with preexisting conditions; and offering policies with differentiated benefits as a way of eliciting information about the health status of potential clients.[11]

From the perspectives of efficiency and equity, the advantages of group insurance such as large-employer-based coverage, Medicare, Medicaid, and CHIP are considerable. There are economies of scale inherent in selling plans to sizeable groups as opposed to individuals.[12] In addition, employer coverage forms a natural risk pool: people of all ages and health status enroll when they take a job rather than when they are sick, thereby reducing the potential for adverse selection and the associated costs of underwriting. The lack of underwriting in the large-employer-group market

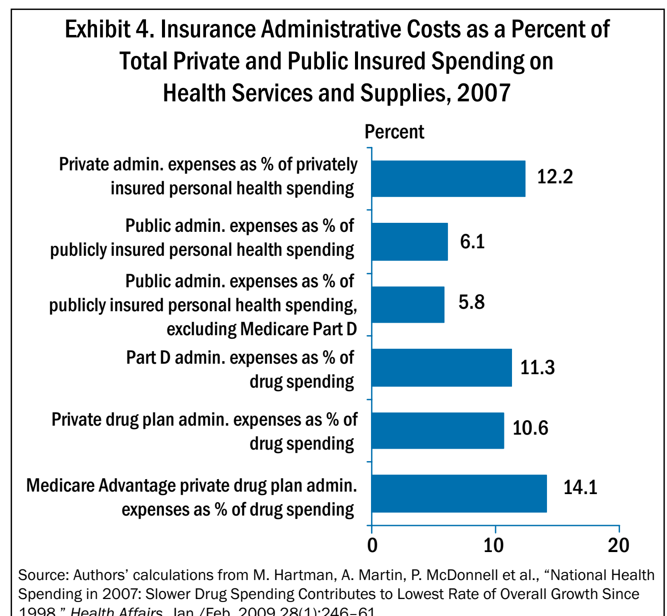
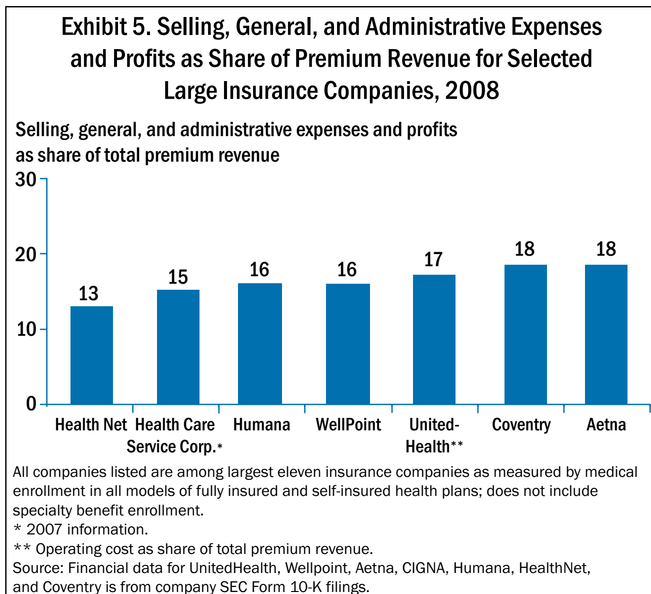


Exhibit 4. Insurance Administrative Costs as a Percent of Total Private and Public Insured Spending on Health Services and Supplies, 2007

Source: Authors' calculations from M. Hartman, A. Martin, P. McDonnell et al., "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," *Health Affairs*, Jan./Feb. 2009 28(1):246–61.



also ensures that workers are not excluded from coverage, or charged different premiums, on the basis of health status or age. Premiums in the group markets are more in line with actual medical expenditures than are those in the individual market.

Indeed, while it has largely been the sole option for people who lose employer-based coverage and do not qualify for Medicaid, the individual market has in fact provided coverage to less than 10 percent of the under-65 population, even as employer coverage has declined in recent years. The Commonwealth Fund Biennial Health Insurance Survey found that of people who ever thought about purchasing a plan on the individual insurance market during 2005–2007, a majority never wound up with a plan. They either could not find a plan that met their needs, could not afford the plan, or were turned down or charged a higher price because of a preexisting condition.[13]

Increased Growth in Medicare's Low Administrative Costs Linked to Participation of Private Plans

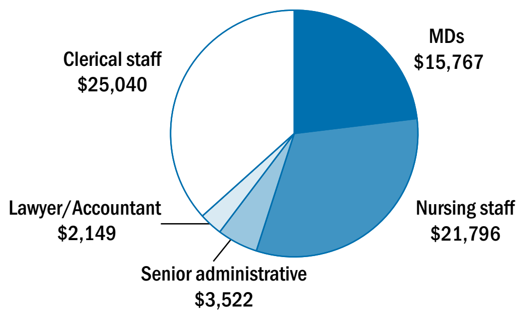
The absence of underwriting and profits has kept the administrative costs of public insurance programs near the level of large employers. Administrative costs in the Medicare program, for example, are estimated to account for 2 percent to 5 percent of premiums.[14] Indeed, the Lewin Group estimates that covering everyone through the Medicare program could potentially reduce U.S. expenditures on administrative costs by $55 billion annually.[15] Between 2005 and 2006, however, Medicare's annual administrative costs jumped from $12 billion to $20 billion, largely because of increased payments to cover the administrative costs of private health and drug plans participating in the program (Appendix Table 1).[16] The McKinsey Global Institute has estimated that $5 billion of the increase in Medicare administrative costs during that period could be attributed to payments for the administrative costs of private drug plans managing the new Medicare Part D benefit. The remaining $3 billion in increased administrative costs derived from private plans involved in the Medicare Advantage program. By contrast, the costs of insurance administration actually declined slightly over the period in traditional fee-for-service Medicare.[17]

Providers' High Administrative Costs Stem from Interactions with Multiple Plans

Because the costs of provider interactions with health plans are not explicitly accounted for in the national health expenditure accounts (compiled by the Centers for Medicare and Medicaid Services' Office of the Actuary), several recent studies have sought to determine how much time physicians and hospitals spend on such activities. In a national survey of physician practices across the U.S., Lawrence Casalino and colleagues found that physicians spent an average of nearly three weeks per year on health-insurance-related activities—including prior authorization, pharmaceutical formularies, claims and billing, credentialing, contracting, and collecting and reporting quality data.[18] Nursing staff spent more than 23 weeks per physician per year interacting with health plans, and clerical staff spent 44 weeks. In converting time to dollars, Casalino et al. concluded that U.S. physician practices spent an average of $68,274 per physician per year interacting with health plans, or an estimated total of $31 billion annually (Exhibit 6). Practitioners—especially primary care physicians—in solo or two-person practices spent significantly more hours interacting with health plans

Exhibit 6. Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at $31 Billion[1]

Mean Dollar Value of Hours Spent per Physician per Year on All Interactions with Health Plans



Total Annual per Practice Cost per Physician: $68,274

[1] Based on an estimated 453,696 office-based physicians.
Source: L. P. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009, w533–w543.

than did their counterparts in practices with 10 or more physicians. Across practices, physicians and their staffs spent relatively little administrative time on submitting their own quality data or reviewing health plans' quality data.

A related study by Julie Sakowski and colleagues of a large multisite, multispecialty group practice in California found that clinicians spent more than 35 minutes per day performing billing and insurance-related tasks and that these activities also required the equivalent of 0.67 nonclinical full-time staff per full-time physician. The practice consequently incurred an annual cost of $85,276 per physician, representing 10 percent of operating revenue.[19] Similarly, Kahn and colleagues estimated that California hospitals spent 6.6 percent–10.8 percent of revenues on billing- and insurance-related transactions.[20]

Other potentially significant administrative costs not collected in national health expenditure accounts include those that result from reimbursement negotiations between insurers and providers. With the rise of managed care in the late 1990s, physician groups and hospitals became increasingly willing to negotiate rates with insurance plans in order to stave off reimbursement cuts and freezes.[21] But as Devers and colleagues report, such interactions are often contentious, can drag on for long periods of time, and sometimes result in disruptions in patient care.[22] Nevertheless, the cost of resources allocated to rate negotiation by either insurers or providers, and the extent to which such efforts ultimately lead to higher or lower premiums faced by employers and households, has been little studied.

How Health Care Reform Can Reduce Insurance Administration Costs

The Commonwealth Fund Commission on a High Performance Health System has considered ways in which all people in the U.S. could have access to high-quality and affordable health care. In its February 2009 report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, the Commission presented a comprehensive set of policy options not only to provide near-universal health insurance coverage but also to reform the U.S. health care system so as to achieve nearly $3 trillion in savings by 2020. Central to this package of reforms, as in many recent proposals and frameworks put forth by Congress and the Obama Administration, is the creation of a national insurance exchange that would largely replace the individual and small-group markets. It would offer families and businesses the choice of private or public plans, with a benchmark standardized benefit package (Exhibit 7).[23]

Under this framework, new insurance regulations would prevent carriers that sell insurance, whether inside or outside the exchange, from underwriting policies on the basis of health; instead, the regulations would require all carriers to offer policies to anyone who applies. Premium subsidies would be available on a sliding scale based on income; everyone would be required to have health insurance that was deemed affordable; employers would be obligated to offer coverage; and eligibility for Medicaid and CHIP would be expanded. Combined with health care system reforms, including changes to the ways in which providers are paid for services, the Commonwealth Fund Commission's report shows that it is possible to achieve near-universal coverage and improve health outcomes while also bending the cost-growth curve.

Such a mixed private–public approach could substantially reduce costs over time, particularly those

Exhibit 7. Options for a National Insurance Exchange Proposed in Leading Health Reform Proposals*

Features of Exchange	Path/Fork in the Road with Public Option	Obama Presidential campaign proposal[24]	Senate HELP proposal, as of 7/15/09[25]	Senate Finance Committee policy options[26]	House of Representatives Tri-Committee 7/14/09[27]	Coburn-Burr[28]
National/state/regional establishment and operation	National	Unspecified	State	National, regional, or multiple competing	National or state	State or regional
Guaranteed issue	✓	✓	✓	✓	✓	✓
Community rating	Adjusted	✓	Adjusted	Adjusted	Adjusted	
Plans offered	Private and public	Private and public	Private and public	Private and co-op**	Private and public	Private
Standard billing forms and standard procedures				✓	✓	
Risk adjustment for plans	✓		✓	✓		✓
Individual mandate	✓	✓	✓	✓	✓	
Shared responsibility/ employer play-or-pay	✓	✓	✓	Options under discussion	✓	
Premium subsidies to individuals	✓	✓	Up to 400% FPL	Up to 300% FPL	Up to 400% FPL	✓
Minimum benefit standards	FEHBP standard	FEHBP standard	Essential health benefits package	Four tiers	Four tiers	FEHBP standard
Who is eligible for the exchange?	Individuals and employers		Individuals and small employers	Individuals and small employers	Individuals and employers	

Sources: See endnotes.
* For greater detail on each of the policies and bills, see Appendix Table 2.
** In the Finance Committee policy options, all state-licensed insurers in the individual and small-group markets must offer plans through the exchange.

related to insurance administration. A national insurance exchange, coupled with the requirement that all individuals must have health insurance, would reduce underwriting by broadly pooling risks and restricting carriers from underwriting on the basis of health and other characteristics. A standard benefit package would be established, the transparency of prices and benefits covered would be increased, and broker and marketing functions would be reduced through a centralized authority that "connected" applicants with health plans and facilitated enrollment. The exchange would help improve portability of coverage, reducing churning in two ways: it would enable individuals who leave their jobs to keep their coverage; and it would facilitate the continued coverage of low-income individuals and families whose eligibility for subsidies or public programs, like Medicaid and CHIP, fluctuated.

Moreover, substantial reductions in administrative costs would likely stem from the inclusion of a public health insurance option in the exchange. Such a plan would operate with few broker or marketing costs, no costs associated with underwriting, and premium margins invested in reserve funds. There would be no negotiating of rates between providers and the public health insurer and therefore no associated costs; like Medicare, the public plan would be standard and available nationally to any provider willing to participate. The plan would thus provide an incentive for competing private plans to streamline their operations.

In its recent report, *Fork in the Road: Alternative Paths to a High Performance U.S. Health System*, Commonwealth Fund researchers examined three variations on a mixed private–public approach to providing near-universal coverage and reforming the

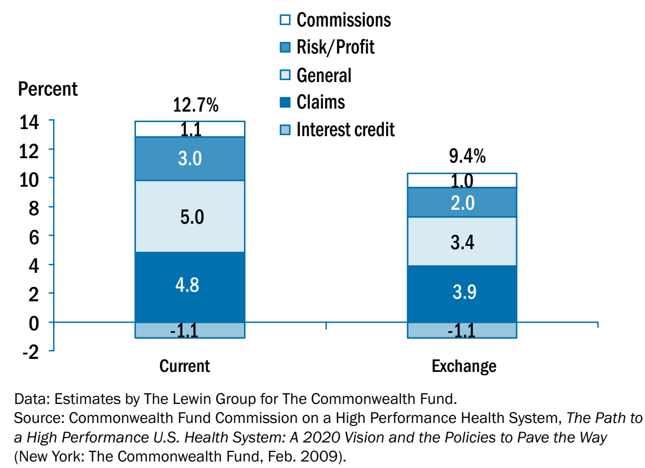
health care system (Exhibit 8).[29] The major differences between the three approaches involved the inclusion of a public plan in the national insurance exchange and the way in which the public plan would reimburse providers. Specifically, in the first option the public plan would be included in the exchange and would reimburse participating providers with Medicare payment rates. In the second option, the public plan in the exchange would reimburse providers with intermediate rates set midway between current Medicare and private plan rates, and the plan would be offered alongside private plans and subject to the same market rules.[30] In the third option, only private plans would be offered to employers and individuals.

The Lewin Group assessed the effects of the three different options on insurance coverage and costs over 2010–2020. Under all scenarios, administrative costs would be lower in the exchange, falling from an average of 12.7 percent of claims across individual and employer plans to 9.4 percent (Exhibit 9). Savings

Exhibit 8. Policy Provisions Under Three Reform Scenarios

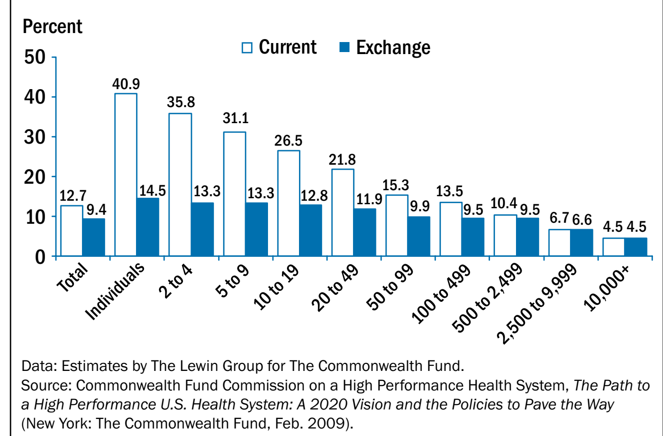
	Public Plan with Medicare Rates	Public Plan with Intermediate Rates	Private Plans
Requirements for Coverage			
Individual mandate	X	X	X
Employer shared responsibility	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings	Insure workers or pay 7% of earnings
Insurance Exchange			
Plans offered	Public and private	Public and private	Private
Replaces individual insurance market	X	X	X
Income-related premium assistance in exchange	X	X	X
Community rating	X	X	X
Guaranteed access and renewal	X	X	X
Minimum benefit standard	X	X	X
Provider Payment Reform			
Payment on value, not volume	Required for public plan; voluntary for private plans	Required for public plan; voluntary for private plans	Voluntary for private plans
Cost restraints on provider prices	Medicare level for public plan; commercial level for private plans	Midpoint between Medicare and commercial level for public plan; commercial levels in private plans	Unchanged
Medicaid at Medicare rates	X	X	X
Coverage of the uninsured	Bought in at Medicare level	Most bought in at midpoint level	Bought in at commercial level
Changes to Current Public Programs			
Retain current Medicare benefit structure	X	X	X
End Medicare disability waiting period	X	X	X
Expand Medicaid/CHIP	X	X	X
System Reform			
Comparative effectiveness	X	X	X
Health information technology	X	X	X
Public Health	X	X	X

Exhibit 9. Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

Exhibit 10. Cost of Administering Health Insurance as a Percentage of Claims Under Current Law and the Proposed Exchange, by Group Size



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

would be realized through less marketing, elimination of underwriting activities, reduced costs of claims administration, fewer resources spent negotiating provider-payment rates, and fewer or standardized commissions to insurance brokers. Private plans offered through the exchange to individuals and small groups could have much lower administrative costs than in the current individual and small-group markets. The Lewin Group estimated that average administrative cost as a share of claims costs would fall from 41 percent to 14.5 percent for individuals, and for small employers from 22 percent to 36 percent under the current system to 12 percent to 13 percent (Exhibit 10).

Savings in administrative costs are estimated to be largest in the two scenarios in which the exchange offers a choice of a public plan (Exhibit 11). About $265 billion in administrative savings are projected over 2010–2020 in the Public Plan with Medicare Payment Rates scenario, compared with savings of $223 billion in the Public Plan with Intermediate Payment Rates scenario and an increased cost of $32 billion in the Private Plans scenario. Still, given the reduction in administrative cost in private plans purchased through the exchange, the higher costs of the Private Plans scenario are lower than they would have been had universal coverage been attempted under current insurance market arrangements.

If the insurance market reforms included more standardized reporting, coding, and quality metrics, together with electronic billing of claims and more standardized benefit designs, they would have the potential to reduce insurance-related administrative costs for physicians and hospitals as well as for health plans. As the recent studies by Casalino et al., Sakowski et al., and Kahn et al. show, providers spend a great deal of time interacting with health plans; these costs account for about 10 percent to 12 percent of total practice revenue in physician practices and 7 percent to 11 percent of hospital revenues.[31]

The public health insurance option would simplify physician interaction with insurers by applying uniform processes and coverage for its substantial market share. Building on the health information-technology provisions in the American Recovery and Reinvestment Act of 2009, the public plan option could require providers to further automate charting and claims, which would reduce claims denials, ensure coding compliance, and reduce days in accounts receivable. If standardization could cut such insurance-related overhead in half, the savings would amount to $15–$20 billion in savings per year for physicians and $25–$40 billion a year for hospitals.[32] The insurance industry has stated its support for comprehensive reform, including a redesign of administrative processes, and acknowledges that the standardization of certain procedures, such as determination of eligibility and submission of claims, could result in substantial

Exhibit 11. Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2020

Dollars in billions

	Public Plan at Medicare Rates	Public Plan at Intermediate Rates	Private Plans
Affordable Coverage for All: Coverage Expansion and National Health Insurance Exchange			
• **Net costs of coverage expansion**	–$160	+$770	+$1,135
• **Reduced administrative costs**	–$265	–$223	+$32
Total System Cost of Coverage Expansion and Improvement	–$425	+$547	+$1,167
Payment and System Reforms			
• **Payment Reforms**	–$1,011	–$986	–$907
• **Information Infrastructure and Public Health**	–$1,557	–$1,530	–$1,446
Total Savings from Payment and System Reforms	–$2,568	–$2,516	–$2,353
Total Net Impact on National Health Expenditures, 2010–2020	–$2,993	–$1,969	–$1,186

Data: Estimates by The Lewin Group for The Commonwealth Fund, April–May, 2009.
Source: C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork in the Road: Alternative Paths to a High Performance U.S. Health System* (New York: The Commonwealth Fund, June 2009).

savings on administrative costs for physicians and hospitals.[33]

Beyond lowered administrative costs and reduced complexity, a mixed private–public approach to health reform would yield additional benefits. Providers could spend more time in patient care, thereby increasing their levels of job satisfaction and improving patients' experiences with the health care system. Employers, particularly small employers, would benefit from the increased transparency and streamlined enrollment offered by the exchange and from the lower premiums enabled by lower administrative costs; such cost reductions would be especially helpful in the context of a requirement that employers provide coverage for their employees or pay a fine or tax. Individuals would see lower premiums; the *Fork in the Road* report found that households could see average premiums drop by as much as 25 percent under the Public Plan with Medicare Payment Rates scenario (Exhibit 12).[34] Individuals would have simpler interactions with the health care system, resulting from increased portability of coverage, greater transparency in the market, guaranteed issue, and standardization of benefits (leading to fewer claims denials). State and federal governments would benefit from the portability of coverage, the decreased churning among low-income individuals and families, and the greatly reduced costs of running high-risk pools.

Conclusion

As Congress and the Obama Administration endeavor to reform the nation's health care system, paying for reform will play a central role in the debate. It is therefore essential to identify areas in the health system where savings might be achieved. The high and climbing costs of insurance administration—in excess of $91 billion a year according to the McKinsey Global Institute—represents one such area of potential savings.

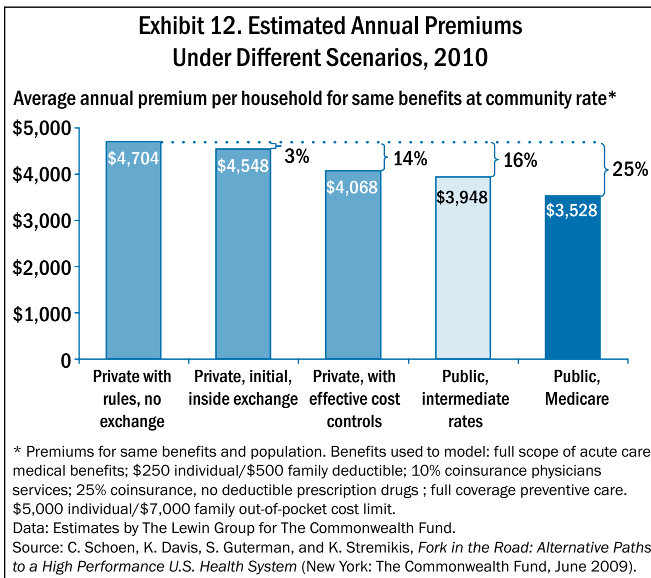


Exhibit 12. Estimated Annual Premiums Under Different Scenarios, 2010

* Premiums for same benefits and population. Benefits used to model: full scope of acute care medical benefits; $250 individual/$500 family deductible; 10% coinsurance physicians services; 25% coinsurance, no deductible prescription drugs ; full coverage preventive care. $5,000 individual/$7,000 family out-of-pocket cost limit.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork in the Road: Alternative Paths to a High Performance U.S. Health System* (New York: The Commonwealth Fund, June 2009).

Previous analyses by Commonwealth Fund researchers, highlighted in this brief, show that the creation of a national insurance exchange that restricts underwriting and includes both private and public plan choices, in the context of comprehensive reform, could save up to $265 billion in insurance administrative costs over 10 years. In contrast, an insurance exchange that included only private plan choices is estimated to increase administrative costs by $32 billion over 10 years. The consequence of such a difference in administrative savings would be directly experienced by families, employers, and the federal government, in the form of higher premiums, which in turn would require larger subsidies to make such premiums affordable. The creation of a national insurance exchange that offers the choice of both private and public health insurance plans presents a singular opportunity to reduce administrative costs substantially over time, provide access to high-quality, efficient care for all Americans, and move the health care system further down the road to high performance.

NOTES

1 M. Hartman, A. Martin, P. McDonnell et al., "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998," *Health Affairs*, Jan./Feb. 2009 28(1):246–61; A. Sisko, C. Truffer, S. Smith, et al., "Health Spending Projections through 2018: Recession Effects Add Uncertainty to the Outlook," *Health Affairs* Web Exclusive, Feb. 24, 2009:w346–w357.

2 The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance*, 2008 (New York: The Commonwealth Fund, July 2008).

3 McKinsey Global Institute*, Accounting for the Cost of U.S. Health Care: A New Look at Why Americans Spend More*, December 2008. Of this total $91 billion in excess administrative costs, the Institute attributes about two-thirds, or $63 billion, to private payers. The remaining $28 billion above U.S. expected spending is for the administrative expenses to support Medicare, Medicaid, and other public programs.

4 L. P. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009:w533–w543.

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[30] Under the first two options, the public plan would be financially self-sustaining, with premiums set to cover projected medical outlays and administrative overhead. Public-plan premiums would be set to enable a premium reserve fund, and premium subsidies to low- or moderate-income enrollees would be available both for private and public plans—but benchmarked to the most efficient plan. The agency or board overseeing the public health insurance plan (e.g., the Centers for Medicare and Medicaid Services or a new agency within the U.S. Department of Health and Human Services) would be

separate and distinct from the public or quasi-public authority that sets the rules and runs the insurance exchange. The public plan would be subject to the same laws and regulations as self-insured private plans. For further detail, see Schoen et al., *Fork in the Road*.

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Appendix Table 1. Public Program and Private Health Insurance Administration

	2007	2006	2005	2004	2003	2002	2001	2000	1995	1990
Total administrative costs in millions of dollars	**155,739**	**150,356**	**138,655**	**128,843**	**121,907**	**105,842**	**90,640**	**81,797**	**58,091**	**39,249**
Administrative costs as percent of total NHE	6.9%	7.1%	7.0%	6.9%	7.0%	6.6%	6.2%	6.0%	5.7%	5.5%
Private funds for administrative costs	96,210	94,837	92,433	86,559	83,424	70,020	57,869	53,067	39,247	29,670
Net cost of private health insurance	94,625	93,316	91,067	85,290	82,219	68,796	56,631	51,983	38,578	29,078
Other private funds, including philanthropy	1,585	1,522	1,366	1,269	1,206	1,223	1,238	1,085	669	592
Public funds for administrative costs	59,530	55,519	46,222	42,284	38,482	35,822	32,772	28,730	18,844	9,579
Federal Funds (total)	40,231	36,789	28,332	25,162	22,147	20,918	18,515	17,089	9,125	5,465
Medicare	21,582	19,503	12,005	10,612	8,665	8,831	8,575	8,496	4,534	2,916
Workers' Compensation	47	41	38	35	30	26	24	21	17	13
Medicaid and CHIP	15,207	14,192	13,587	12,167	11,599	10,715	8,999	7,893	4,203	2,278
Medicaid (Title XIX)	14,371	13,470	12,899	11,526	10,975	10,127	8,546	7,551	4,203	2,278
Medicaid CHIP Expansion (Title XIX)	198	180	178	153	139	119	106	91	0	0
CHIP (Title XXI)	638	542	511	489	484	469	347	250	0	0
Department of Defense	3,088	2,766	2,441	2,100	1,621	1,129	705	488	202	152
Maternal/Child Health	4	4	4	4	4	4	4	4	4	3
Veterans' Administration	183	166	140	125	112	93	90	81	75	44
Vocational Rehabilitation	40	39	39	39	38	39	37	36	26	26
ADAMHA/SAMHSA	62	59	58	61	59	64	63	53	51	22
Indian Health Services	20	20	20	19	19	17	19	17	13	12

	2007	2006	2005	2004	2003	2002	2001	2000	1995	1990
State and Local Funds (total)	19,299	18,730	17,890	17,122	16,336	14,904	14,256	11,641	9,718	4,114
Workers' Compensation	7,691	7,648	7,634	7,640	7,482	7,009	7,072	5,293	5,169	2,317
Medicaid and CHIP	11,436	10,911	10,086	9,312	8,683	7,724	7,012	6,176	4,409	1,690
Medicaid (Title XIX)	11,070	10,589	9,783	9,034	8,413	7,468	6,816	6,025	4,409	1,690
Medicaid CHIP Expansion (Title XIX)	86	80	80	67	59	49	44	36	0	0
CHIP (Title XXI)	281	242	224	211	211	207	152	114	0	0
Maternal/Child Health	160	159	158	157	159	160	161	160	131	99
Vocational Rehabilitation	11	12	12	12	12	12	12	12	9	7

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage (NHE by type of service and source of funds, CY 1960-2007, file nhe2007.zip, see Administration and Net Cost of Private Health Insurance).

Appendix Table 2. Options for a National Insurance Exchange Proposed in Leading Health Reform Proposals

Features of Exchange	Path/ Fork in the Road at Public Rates	Obama Presidential campaign proposal[35]	Senate HELP proposal as of 7/15/09 [36]	Senate Finance Committee policy options[37]	House of Representatives Tri-Committee bill as of 7/14/09 [38]	Coburn-Burr[39]
National/state/regional establishment and operation	National	Exchange, but unspecified national/ regional/state	State exchanges	National, regional, or multiple competing exchanges	National or state	State exchanges
Guaranteed issue	Yes	Yes	Yes	Yes	Yes	Yes
Community rating	Yes	Eliminate barriers to coverage for people with preexisting medical conditions	Rating based on age, family composition, tobacco use, plan value, and geography	Rating based on age, tobacco use, family composition, and geography	Rating based on age, family composition, and geography	Limits on preexisting condition exclusions
Plans offered	Private and public	Private and public	Private and public	Private and co-op	Private and public	Private
Standard billing forms and procedures				Yes	Yes	
Risk adjustment for plans	Yes		Yes	Yes		Yes
Individual mandate	Yes	Yes	Yes	Yes	Yes	No
Shared responsibility/ employer play-or-pay	7% of payroll	Yes	$750/year per uncovered full-time worker, $375/year per uncovered part-time worker; or at least 60% premium contribution; small business exclusions	Under consideration	Sliding scale based on payroll from 2% to 8% of payroll; or at least 72.5% contribution to premium for individuals, 65% for families; small business exclusions	
Premium subsidies to individuals	Assistance based on affordability of lowest cost plan as a percent of income	Yes	Premium credits on sliding scale up to 400% FPL for purchasing in exchange; no subsidies for those with employer-based coverage that meets minimum qualifying criteria and affordability standards	Sliding-scale refundable tax credits to individuals 100%–300% FPL	Premium and cost-sharing credits on a sliding scale up to 400% FPL; premium credit starting premiums greater than 1.5% of income and phasing out at 11% of income; no subsidies for those with employer-based coverage	Tax credits to purchase insurance; additional subsidies for low-income people

Features of Exchange	Path/ Fork in the Road at Public Rates	Obama Presidential campaign proposal[35]	Senate HELP proposal as of 7/15/09 [36]	Senate Finance Committee policy options[37]	House of Representatives Tri-Committee bill as of 7/14/09 [38]	Coburn-Burr[39]
Minimum benefit standards	Based on FEHBP standard option	Based on FEHBP standard option	Essential benefit package defined by the Secretary of HHS on the advice of a temporary independent commission	Four benefit categories; all plans must provide comprehensive set of services both inside and outside the exchange	As specified by new Health Benefits Advisory Council, all plans must provide at least the basic package inside and outside the exchange Coverage purchased on individual market does not qualify unless grandfathered	Based on FEHBP standard option
Who is eligible for the exchange?	Initially open to individuals and small employers, with large employers phased in over 5 years		Individuals and small businesses	Individuals and small businesses	Individuals, employers phased in over time, starting with the smallest groups	
Insurance market regulations	National regulations apply inside and outside the exchange	National regulations apply inside and outside the exchange	National regulations apply inside and outside the exchange Participating plans provide incentives to providers to deliver care more efficiently	National regulations apply inside and outside the exchange All state-licensed insurers in the non-group and small markets must participate	Exchange replaces individual market Insurers must meet a specified medical loss ratio	

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