VIEWPOINT

Addressing Health Care's Administrative Cost Crisis

Brooke Istvan, MBA; Kevin A. Schulman, MD; Stefanos Zenios, PhD

Tackling administrative waste in the health care system presents a perfect opportunity for a second Trump administration that is focused on achieving efficiencies in the federal government and alleviating the pain that inflation has caused on the pocketbooks of consumers. The cost and structure of health care (the largest sector of the US economy and 29% of net federal outlays) is a primary target.[1]

Transactions or Billing Costs and Insurance-Related Costs

For patients with employer-based insurance, health insurance premiums represent 25% of the median family household income before families have to pay thousands of dollars more in cost sharing to use their health insurance.[2] The US spends almost twice the average of other Organisation for Economic Co-operation and Development (OECD) countries on health care, but this includes the cost of clinical services and the cost of administering the system. What has been largely missing from the national discussion is a recognition of the administrative cost crisis—the US spends approximately 10 times more on average than any other OCED country on health care administrative expenses.[3] It is estimated that two-thirds of these costs are related to transactions or billing costs and insurance-related costs.

In the US, a primary care physician spends $20.49 to receive payment for a service that generates approximately $100 in revenue.[4] Improving administrative efficiencies has the potential to save at least $265.6 billion annually, lowering the cost of insurance for employers and potentially the premiums and cost of care for patients.[5]

A focus on administrative costs could have a direct effect on patients in a visible way. Navigating complex plan rules are some of the most frustrating aspects of interacting with the US health care system. In one survey, 24.4% of respondents reported delayed or foregone care due to an administrative task.[6] Another study found the cost of lost productivity by employees dealing with health insurance administration was $21.57 billion and a total annual loss of $96 billion in productivity and employee satisfaction costs resulting from health insurance administration.[7]

Burden of Administrative Tasks

Administrative tasks are also burdensome for clinicians. One study[8] finds that prior authorization alone annually consumes an amount of time equivalent to the annual working time of 100 000 registered nurses. Nurses and physicians alike report burnout attributed to the increasing number of administrative tasks required to receive payment for services.

A Trump administration seeking market solutions (with core expertise in financial transactions, entrepreneurship, and innovation) could offer a fresh perspective on solving these challenges. President-elect Trump has already announced the creation of the Department of Government Efficiency that has a stated focus of saving money by reducing administrative waste. The crux of the issue is that the conditions necessary for the transaction efficiency seen in other sectors of the economy (such as banking and financial markets) are lacking in health care.

Potential Solutions

Many industries and markets have addressed this challenge. In fact, researchers[9] have recently cataloged 82 different firms and markets ranging from finance to food services that have faced some aspect of this transformation at scale. In this research, 57% of the solutions were conducted within the private sector, 22% were conducted through the public sector, and 21% were developed through public-private partnerships.[9] The most commonly represented industries were finance (22%) and public services (22%).[9] From this work, there are a few observations to inform a path toward more efficient administration of health care.

The standardization of business contracts that govern transactions is an essential element of reducing transaction costs. In the 1960s, mortgages were sold as custom products, much as health insurance is today. But, when Fannie Mae and Freddie Mac were charged with increasing liquidity in the home mortgage market, they faced a morass of all these one-off products. Their first task was to spend a year standardizing mortgage agreements, an effort that continues to benefit consumers today; 90% of mortgages use the contracts from one of these agencies.[10] Fast forward, it is easy to imagine a single computable contract template that could simplify the contracting process between health plans and physicians.

Standardization does not have to reduce innovation. In fact, it can accelerate innovation. In the mobile phone market, a billion phones each year are sold and must be standardized to be produced at scale. But, if the latest version of a phone is not new and improved, no one will rush out and buy the new version. So, the industry works hard to innovate. Standardization and innovation relate at a market level in which mobile phone manufacturers work through a standard setting organization to select the technology for the next version of the phone. This model has been tested at scale and has led to enormous value for consumers (and to some of the world's most successful firms).

Use of Artificial Intelligence

Although there is significant excitement about the role of artificial intelligence (AI) in both improving the quality of care and automating away administrative burdens, there is little evidence that technology has led to efficiency gains in the health care market. What is missing is a structure to drive the entire market toward lower transaction costs. Currently, each health plan (of which there are 317 987) can set its own strategy for efficiency using AI. But the strategy of

the different plans can conflict. In the 1950s, each airline was responsible for their own flight operations. But, on June 30, 1956, United Airlines flight 718 (a Douglas DC-7) and Trans World Airlines flight 2 (a Lockheed L-1049 Super Constellation) collided in uncongested airspace over the Grand Canyon, sparking the development of the Federal Aviation Administration (FAA) and a single air traffic control model for the US. The FAA saved lives and generated administrative efficiencies for the airlines that now had access to centralized flight planning.

The use of AI could improve efficiency if implemented through a single transaction model across all health plans, both public and private. This model could be organized thorough the public sector (similar to the FAA) or the private sector (similar to the Swift transaction model in banking).

One rebuttal to this argument is that the Trump administration will be committed to deregulation, and this proposal to build a robust transaction platform for health care seems to be moving in a different direction. But we see the 2 as consistent. First, this approach would entail significant deregulation. Thousands of conflicting and overlapping Medicare and Medicaid payment regulations could be eliminated to build a single, common transaction model for US health care. It would not require 100 000 pages of payment rules to implement the digital transaction platform we propose.

Second, there is no question that the transaction platform has been a barrier to innovation in the health care market for both products and services. There is a generational opportunity to simplify payment rules and processes, moving beyond the cumbersome payment processes created for physicians and hospitals almost half a century ago to a functional and flexible system. Simplifying the transaction process could allow the entry of new products and services at scale, many powered by AI, which will improve health outcomes for patients and lower health care costs.

Conclusions

Change is hard in any market, but addressing the administrative waste inherent in health care transactions is a clear opportunity to reduce the costs of health care services for patients and improve the quality of patient experiences with the health care system.

ARTICLE INFORMATION

Author Affiliations: Graduate School of Business, Stanford University, Palo Alto, California (Istvan, Schulman, Zenios); Division of Hospital Medicine and Clinical Excellence Research Center, Stanford Medical School, Stanford University, Palo Alto, California (Schulman).

Corresponding Author: Kevin A. Schulman, MD, Clinical Excellence Research Center, Stanford University, 453 Quarry Rd, Palo Alto, CA 94304 (kevin.schulman@stanford.edu).

Published Online: January 15, 2025. doi:10.1001/jama.2024.27670

Conflict of Interest Disclosures: Ms Istvan reported receiving personal fees from the US Department of Health and Human Services. Dr Schulman reported receiving funding from Gates Ventures, the Ludy Family Foundation, the Hirsch Family Foundation, and the Government, Business, and Society Initiative at Stanford University. No other disclosures were reported.

REFERENCES

1. Cubanski J, Fuglesten Biniek J, Neuman T. FAQs on health spending, the federal budget, and budget enforcement tools. Published March 20, 2023. Accessed December 19, 2024. https://www.kff.org/medicare/issue-brief/faqs-on-health-spending-the-federal-budget-and-budget-enforcement-tools/

2. Schulman K, Narayan A. Employer-based health insurance and employee compensation. *JAMA Health Forum*. 2023;4(3):e225486. doi:10.1001/jamahealthforum.2022.5486

3. Turner A, Miller G, Lowry E. High US health care spending: where is it all going? Published October 4, 2023. Accessed December 18, 2024. https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going

4. Tseng P, Kaplan RS, Richman BD, Shah MA, Schulman KA. Administrative costs associated with physician billing and insurance-related activities at an academic health care system. *JAMA*. 2018;319(7):691-697. doi:10.1001/jama.2017.19148

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

6. Kyle MA, Frakt AB. Patient administrative burden in the US health care system. *Health Serv Res*. 2021;56(5):755-765. doi:10.1111/1475-6773.13861

7. Pfeffer J, Witters D, Agrawal S, Harter JK. Magnitude and effects of "sludge" in benefits administration: how health insurance hassles burden workers and cost employers. *AMD*. 2020;6:325-340. doi:10.5465/amd.2020.0063

8. Sahni NR, Istvan B, Stafford C, Cutler D. Perceptions of prior authorization burden and solutions. *Health Affairs Scholar*. 2024;2(9):qxae096. doi:10.1093/haschl/qxae096

9. Istvan B, Nielsen P, Eluhu M, et al. Applying precedents thinking to the intractable problem of transaction costs in healthcare. Accessed December 4, 2024. https://hmpi.org/hmpi_issue/december-2024-volume-9-issue-3/

10. Sandling J, Richman BD, Favaro K, Zenios SA, Schulman KA. Reducing administrative costs in US healthcare: using precedent thinking to develop pathways to innovative solutions. Published February 11, 2024. Accessed December 19, 2024. https://www.pymnts.com/cpi-posts/reducing-administrative-costs-in-u-s-healthcare-using-precedent-thinking-to-develop-pathways-to-innovative-solutions/