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How to Think Clearly about Medicare Administrative Costs: Data Sources and Measurement

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Abstract The Centers for Medicare and Medicaid Services (CMS) annually publishes two measures of Medicare's administrative expenditures. One of these appears in the reports of the Medicare Boards of Trustees and the other in the National Health Expenditure Accounts (NHEA). The latest trustees' report indicates Medicare's administrative expenditures are 1 percent of total Medicare spending, while the latest NHEA indicates the figure is 6 percent. The debate about Medicare's administrative expenditures, which emerged several years ago, reflects widespread confusion about these data. Critics of Medicare argue that the official reports on Medicare's overhead ignore or hide numerous types of administrative spending, such as the cost of collecting taxes and Part B premiums. Defenders of Medicare claim the official statistics are accurate. But participants on both sides of this debate fail to cite the official documents and do not analyze CMS's methodology. This article examines controversy over the methodology CMS uses to calculate the trustees' and NHEA's measures and the sources of confusion and ignorance about them. It concludes with a discussion of how the two measures should be used.

A virulent debate has erupted in recent years about the level of Medicare's administrative costs. Both sides of the political spectrum have used figures and data sources that have completely muddled several important issues, including whether allowing insurance companies to participate in Medicare can cut Medicare's costs, whether converting Medicare into a voucher or "premium support" plan would reduce Medicare's costs, whether a "Medicare-like public option" for the nonelderly can cut the national health care bill, and whether extending Medicare to the nonelderly would reduce the nation's health care bill. The true size of Medi-

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care's overhead compared with that of the average health insurance company is a critical question in the debate about each of these issues.

Confusion about Medicare's administrative costs is widespread. This is caused partly by the annual publication of two different measures of these costs by the federal government: one in the report of the Medicare Boards of Trustees and another in the National Health Expenditure Accounts (NHEA). According to the latest trustees' report (Boards of Trustees 2012), Medicare's administrative expenditures comprise 1 percent of its total expenditures, but according to the latest NHEA (CMS n.d.a) the figure is 6 percent. The confusion has been aggravated in recent years by the publication of papers on the Internet claiming that the federal government fails to include in its definition of Medicare's administrative expenditures a variety of expenditures that clearly contribute to the administration of the Medicare program, such as the cost of collecting taxes and Part B premiums.

The purpose of this article is to clarify both sources of confusion—the publication of two measures of Medicare's administrative expenditures and the accusations that these measures fail to include all of Medicare's administrative costs. First, I provide a brief overview of the two official measures of Medicare's administrative expenditures, or overhead, both of which are prepared by the Office of the Actuary (OACT) within the Centers for Medicare and Medicaid Services (CMS). In short, the trustees' measure reports only the administrative costs incurred by the federal government (i.e., by CMS as well as other federal agencies that contribute to the operation of Medicare), while the NHEA reports those costs as well as the administrative costs incurred by Medicare Advantage plans and Part D plans. Second, I detail the debate about Medicare's administrative costs and present examples of statements by participants on both sides of the political aisle that are inaccurate or misleading, and I show that no one uses the official OACT reports but instead cites secondary sources or nothing at all. To make the case that these reports are in fact valid and sound, I turn in section 3 to explication of the methodologies used by OACT in both the trustees' reports and the NHEA. Finally, I conclude by showing how these measures can and should be used to clarify important policy design questions about the use of government versus private actors within the Medicare program and for health care reform more broadly.

Two Official Yardsticks

Medicare's administrative costs were $8 billion in 2011, or 1.4 percent of total Medicare spending of $549 billion that year.[1] Those figures come from the latest annual report of the Medicare trustees, prepared by OACT. As I document below, the $8 billion includes costs incurred directly by CMS (notably, the salaries of CMS staff and payments to insurance companies to process claims) as well as costs incurred by other federal agencies on Medicare's behalf (e.g., tax collection services provided by the Internal Revenue Service, Part B premium collection services provided by the Social Security Administration and the Railroad Retirement Board, and fraud prevention services provided by the Federal Bureau of Investigation).

The latest NHEA, also prepared by OACT, is for 2010. According to it, Medicare's overhead totaled $31 billion that year, far more than the $7 billion reported by the trustees for 2010. That $31 billion constituted 6 percent of total Medicare spending in 2010[2]—much higher than the 1 percent rate reported for that year by the trustees. The difference between the trustees' measure of overhead and the NHEA measure is due almost entirely to the fact that the NHEA defines Medicare's overhead to include not only the $7 billion in administrative expenditures reported by the trustees for 2010 but also the $24 billion in administrative expenditures incurred by the insurance companies that participate in Parts C and D.

The trustees' and NHEA measures closely tracked each other until the early 1980s and then diverged substantially as enrollment in Part C plans—and since 2006, Part D plans—grew (see table 1). Table 1 indicates the trustees' ratio had fallen to 2 percent by the late 1980s and is now down nearly to 1 percent. By contrast, the NHEA ratio bottomed out at 2.4 percent in 1983 and 1984 (data not shown), hovered around that level until 1995, and then more than doubled over the next fifteen years. By 2000 the NHEA ratio was almost twice that of the trustees' ratio—3.8 percent versus 2.0. The NHEA ratio has grown unusually rapidly since 2006, the year health insurance companies began to sell insurance for drug coverage under Part D. The NHEA ratio stood at 5.9 percent in 2010.

1. The 1.4 percent figure was calculated by the author from data presented in table II.B1 of the latest report of the trustees (Boards of Trustees 2012: 10). The trustees' annual reports provide figures for Medicare's expenditures and administrative costs, but the trustees do not do the math for the reader and report administrative spending as a percentage of total spending.

2. Administrative expenditures as a percentage of total expenditures are based on the author's calculations using data from the latest NHEA (CMS n.d.a).

Table 1 Medicare Administrative Expenses as Percentage of Total Expenditures Reported by the Medicare Trustees and the National Health Expenditure Accounts, Selected Years

	Medicare Trustees' report	NHEA
1966	*	6.5%
1970	5.3%	5.2
1975	4.9	4.4
1980	3.0	3.0
1985	2.4	2.8
1990	2.1	2.7
1995	1.5	2.5
2000	2.0	3.8
2001	1.6	3.5
2002	1.8	3.3
2003	1.7	3.1
2004	1.9	3.6
2005	1.8	4.0
2006	1.5	5.3
2007	1.5	5.6
2008	1.4	5.3
2009	1.3	5.7
2010	1.3	5.9
2011	1.4	not yet published

Sources: Figures calculated by the author based on data reported in table II.B1 in Boards of Trustees 2012: 10 and CMS n.d.a

* The trustees' reports do not list data for years prior to 1970.

Confusion Generated by the Debate about Medicare's Overhead

Throughout the first three decades of Medicare's existence, neither of OACT's measures of Medicare's overhead was controversial. In 1999, for example, a coalition of groups and individuals from across the political spectrum signed an open letter to Congress urging Congress to raise Medicare's administrative expenditures from the 2 percent level reported by the trustees at that time to the level "found in the private sector" so that CMS would have the resources to apply to the fee-for-service program the managed care tools then in vogue within the insurance industry (Butler et al. 1999: 8). The coalition included the Heritage Foundation, the former Health Insurance Association of America (the trade group that represented the non-HMO wing of the health insurance industry at the time), the American Enterprise Institute, the Concord Coalition, Well-

point Health Networks, and AARP. Given the context, the trustees' measure was the correct one to use. It would have made no sense to use the NHEA measure. Had the coalition cited the NHEA measure, it would in effect have been urging Congress to raise the administrative costs of CMS as well as of the insurance companies that participated in Part C. Such a recommendation would have been nonsensical.

To take another example, the Congressional Budget Office (CBO) has used OACT's measures over the last two decades without stirring up any noticeable controversy. In a 1993 report in which the CBO estimated the impact of five bills introduced in Congress, including Rep. Martin Russo's (D-IL) single-payer bill, the agency noted that the NHEA displays data on Medicare's administrative costs (i.e., the costs incurred directly by the federal government) as well as administrative costs incurred by the "private health insurers" that participate in Medicare and that the former rate "is about 2 percent" (CBO 1993: 26). Thirteen years later the CBO published a report on proposals to turn Medicare into a voucher system. In that report the CBO (2006: 12), citing the 2006 trustees' report, wrote, "The administrative costs of the fee-for-service Medicare program (as reported by CMS) account for less than 2 percent of its expenditures."

The consulting firm Lewin Inc. has used Medicare's 2 percent overhead to model several state single-payer proposals (Lewin-VHI 1995; Lewin Group 2005). In a 1999 "chartbook" on the US health care system, the Ways and Means Committee of the US House of Representatives stated: "In 1993, Medicare's administrative costs represented about 2 percent of total program costs" (Committee on Ways and Means 1999: comment accompanying table 3.29).

The trustees' and NHEA's measures of Medicare's overhead have become controversial only recently. Beginning around 2005, conservative groups and individuals alarmed by the increasing visibility of the single-payer and public option campaigns began to promote the argument over the Internet (and entirely outside the peer-reviewed literature) that Medicare's overhead is higher than either of OACT's measures indicates. The groups include Milliman Inc. (Litow 2006), the Coalition for Affordable Health Insurance (CAHI) (Matthews 2006), the Manhattan Institute (Zycher 2007), the Heritage Foundation (Book 2009), the Cato Institute (Cannon 2009), the American Medical Association (n.d.), and America's Health Insurance Plans (Lemieux n.d.).

Although the allegations in the papers published by these groups vary slightly, the papers share a common theme, namely, that "the government" or "Medicare" (OACT is not identified) fails to include in its definition

of Medicare's overhead numerous expenditures incurred by CMS and by other agencies—such as the IRS, the Social Security Administration, and the Federal Bureau of Investigation—which contribute services essential to the administration of Medicare. The adjectives used by these papers to describe the administrative costs that are allegedly missing include "unreported," "uncounted," and "hidden."

Judging from how often they are cited, the three most influential papers of this genre are a 2006 paper published by Milliman Inc. and available on the CAHI website (Litow 2006), a paper published four days later by CAHI (which was "based in part" on the Milliman paper) (Matthews 2006), and a 2007 paper published by the Manhattan Institute (which in turn cited the Milliman and CAHI papers) (Zycher 2007). Almost every paper or comment published since 2007 that asserts that the official or commonly accepted figures for Medicare's overhead are too low and that offers some form of documentation cites at least one of those three papers (AMA n.d.; Book 2009; Cannon 2009; Goodman and Saving 2011).

The authors of all three papers state or imply that OACT has defined Medicare's overhead to consist only of claims-processing costs. "There are more costs in running Medicare than just paying claims," says the CAHI paper (Matthews 2006: 3). The Milliman and CAHI papers both state: "Medicare's unreported costs include parts of salaries for legislators, staff and others working on Medicare, building costs, marketing costs, collection of premiums and taxes, accounting including auditing and fraud issues, etc. These are currently included in the Federal Budget in various areas such as legislative, judicial, and Health and Human Services, but are not specifically earmarked to Medicare" (Litow 2006: 4; Matthews 2006: 6).[3]

The CAHI paper specifically alleges (Matthews 2006: 3), "The salaries of those professionals at . . . CMS, from Dr. Mark McClellan down, are excluded from Medicare's administrative costs estimates, as are the building costs to house that part of the leadership team." The Manhattan Institute paper endorses the Milliman and CAHI claim that OACT is ignoring numerous costs, and asserts, without further documentation (Zycher 2007: 7), "It is clear . . . that not all costs relevant for the admin-

3. The list of expenditures presented in the first sentence of this excerpt has been widely cited by others. In some cases the list is quoted verbatim (Cannon 2009), while in other cases it is quoted nearly verbatim (AMA n.d.). Among those who rely on this list, the most common method of describing it is to quote it selectively or to characterize it as, for example, "costs incurred by other government agencies in support of Medicare" (Book 2009).

istration of Medicare . . . appear in the Medicare budget." None of these statements is documented.

The conclusion drawn by the Manhattan Institute paper is typical of these three papers (Zycher 2007: 3): "We find the administrative costs of Medicare to be about twice as large as a proportion of total Medicare outlays as commonly asserted, because the administrative costs reported in the Medicare budget do not include the costs of other federal government administrative functions reported in other parts of the federal budget." But as I demonstrate in the next section, with one exception ("salaries for legislators"), both the trustees' and NHEA's measures of overhead include all the costs mentioned in the above quote from the Milliman and CAHI papers. Obviously, the confusion manifested in the Milliman, CAHI, and Manhattan Institute papers goes beyond failing to distinguish the trustees' measure from the NHEA measure. The authors of these three papers, and of virtually every paper that cites them, are confused about a more fundamental issue: namely, where they should be looking for information about Medicare's administrative costs.

The most striking feature of these three papers is that the authors apparently do not know that the trustees' report is the original source of official information about Medicare's administrative expenditures. Each of the three papers makes a passing reference to the trustees' reports, but only to document a statement about where Medicare gets its revenues. The fact that the trustees' report contains information on Medicare's overhead is not mentioned, much less discussed, by these papers. The NHEA receives similar treatment. The Milliman paper mentions the NHEA, but only as a source for administrative costs generated by the *health insurance industry* (not Medicare). The CAHI paper makes no mention of the NHEA. Only the Manhattan Institute paper cites NHEA's data on Medicare's administrative costs, but it says nothing about OACT's methodology for defining those costs.

Instead of relying on the trustees' report or the NHEA, the three papers cite the "federal budget." They claim (by methods they do not describe) to have identified costs strewn throughout the federal budget that should be attributed to Medicare but are not. The Milliman and CAHI reports state, "The estimates of Medicare administrative and overhead costs are based on our examination of the federal budget and our judgment" (Litow 2006: 5; Matthews 2006: 6). That is the sum total of their "methodology" section. Milliman notes, "There is of course a subjective element to this allocation because costs are estimated from other parts of the federal budget. But this report has tried to be conservative in its allocations" (Litow

2006: 7). The Manhattan Institute paper is only slightly more informative about its methodology. It simply allocates to Medicare roughly 15 percent (Medicare's share of total federal spending in recent years) of the "general government" portion and, inexplicably, the "administration of justice" portion of the federal budget (Zycher 2007: 7). Inventing these crude, subjective attribution methods would not have been necessary, obviously, if the federal budget contained a useful description of how the government calculates Medicare's administrative costs. But it does not. Anyone interested in finding out how the government does that must turn to the trustees' report and the NHEA.

Confusion about Medicare's administrative costs is not limited to conservative groups and the insurance industry. Many advocates of single-payer and public option proposals, as well as critics of the administrative costs of the health insurance industry, are also confused. Judging from their statements, the vast majority of them do not know that the trustees' report and the NHEA exist, that both measures are accurate but measure different costs, and that the trustees' measure is the more appropriate one to use in the context of a debate about whether the fee-for-service Medicare program has lower overhead than the health insurance industry or whether a Medicare-for-all system or a Medicare-like public option would have lower overhead. Consequently, most single-payer and public option advocates misrepresent the official statistics or provide an outdated figure. For example, in a 2008 paper promoting a fee-for-service public option called Medicare Extra, Schoen, Davis, and Collins stated, "Medicare administrative overhead at 3 percent is low" (2008: 647). They offered no documentation for this statement. In fact, in 2007 the trustees' measure of Medicare overhead (which was the relevant measure in this context) was 1.5 percent (see table 1).

Similarly, in a 2009 issue brief on the subject of administrative costs within the American system, the Commonwealth Fund asserted, "Administrative costs in the Medicare program . . . are estimated to account for 2 percent to 5 percent of premiums [*sic*]" (Collins et al. 2009: 4), and cited a widely read study by McKinsey and Company (2008). But the 2–5 percent figure does not appear in the McKinsey report. In fact, the report contains no figures for Medicare's overhead as a percentage of anything—"premiums," revenue, or expenditures. The McKinsey report did say in a graph that Medicare's administrative costs were $20 billion in 2006, according to "CMS and McKinsey . . . analysis," and in the text that $6.4 billion was attributable to the "administration of traditional fee-for-service Medicare" in 2006 (McKinsey and Company 2008: 77). Nowhere did McKinsey

explain that the other $14 billion was attributable to the administrative costs of Medicare Advantage plans and Part D plans.

The lack of familiarity with the trustees' reports among those who assert that Medicare's overhead is low renders them unable to respond effectively to the claim that the government does not include CMS staff salaries, IRS costs, and other relevant costs in its definition of Medicare's administrative spending.

To illustrate the widespread ignorance of OACT's reports on both sides of the Medicare overhead debate, I close this section with descriptions of two recent multiblog debates. The first took place in 2009 between two prominent economists, Greg Mankiw (who headed the Council of Economic Advisers under President George W. Bush) and Paul Krugman (a columnist for the *New York Times*). Their exchange triggered much commentary by others. When the dust had settled, the CAHI and Manhattan Institute papers had been cited, OACT's work had been completely ignored, the single-payer and public option advocates had cited only secondary sources, and those advocates had introduced no evidence to rebut the claim that OACT fails to include "support from other government agencies." Consequently, onlookers were left uninformed about how to determine for themselves whether there is an official measure of Medicare administrative spending and, if so, what it includes.

The debate began with a post by Mankiw (2009) titled "Medicare Has Lower Administrative Costs?" Mankiw cited the Milliman paper and a paper by Robert Book of the Heritage Foundation (Book 2009, which in turn cited the Milliman and Manhattan Institute papers). Krugman (2009) took issue with both Mankiw and Book, but instead of quoting from the trustees' report he cited a paper by Jacob Hacker (2008) promoting a public option. Hacker's paper did not cite the trustees' report either, nor did it contradict the claim that whoever measures Medicare's overhead is hiding numerous types of expenditures. Instead, it merely asserted that Medicare's overhead was "less than 2 percent" (6) and cited a secondary source—the Congressional Budget Office (2006). A reader of this exchange who had the stamina to click the mouse one more time to see what the CBO report said would have discovered that the CBO cited the latest trustees' report. However, the CBO did not reveal that the trustees' definition includes the administrative costs that Milliman, Book, and others claim are ignored. The truly diligent reader would have had to move on to the trustees' report to ascertain what it said.

The day after Mankiw and Krugman posted their comments, Ezra Klein, a public option advocate and a writer for the *Washington Post*,

sought to make sense of the Mankiw-Krugman debate on his blog. Klein concluded that Krugman and others who endorse the 2 percent figure "bandied about in debate" are wrong. Klein (2009) made arguments nearly identical to those promoted by Milliman et al.:

> An apples-to-apples comparison would not leave you with the 2 percent of total Medicare spending often bandied about in debate. That doesn't count, for instance, Medicare's premium collection, which is done through the tax code, and thus through the IRS. Nor does it count most of Medicare's billing, which is outsourced . . . to private insurers like Blue Cross Blue Shield and listed under vendor services rather than program administration. A more straightforward estimate, according to experts I've spoken to, would be in the range of 5 to 6 percent.

Both of Klein's examples—"premium collection" and "Medicare's billing"—were incorrect. If by "premium collection" Klein meant taxes, he was wrong; a portion of IRS costs are allocated to Medicare's overhead by OACT. If by "premium collection" Klein meant Part B premiums, he was wrong on two counts: (1) the Social Security Administration, not the IRS, calculates and collects Part B premiums for the vast majority of Medicare enrollees, and the Railroad Retirement Board does so for former railroad workers; and (2) a portion of the SSA's and the railroad board's costs are allocated to Medicare's overhead by OACT. Klein's statement that the cost of processing claims for the traditional Medicare program does not appear in Medicare's administrative expenditures is also incorrect. OACT does include the cost of claims processing, which is done by what used to be called "carriers" and "intermediaries" and are now called "Medicare administrative contractors."

A recent exchange on the *Health Affairs* blog will serve as my second illustration of the confusion. In an August 2011 post titled "Is Medicare More Efficient Than Private Insurance?" John Goodman and Thomas Saving set out to repudiate "the claim that Medicare's administrative costs are only 2 percent." They did not mention the trustees' or the NHEA measures nor in any other way indicate that they knew where the 2 percent figure came from. Nevertheless, they asserted that "the claim" ignores numerous costs, including "the cost of collecting taxes." Goodman and Saving (2011) even suggested that advocates of the 2 percent figure ignored the cost to Medicare of processing claims.

Diane Archer (2011) responded to the Goodman-Saving essay with a comment titled "Medicare Is More Efficient Than Private Insurance." She stated, almost correctly, that "administrative costs in Medicare are

only about 2 percent of operating expenditures" and, quite correctly, that "Medicare administrative cost figures include the collection of Medicare taxes, fraud and abuse controls, and building costs." But instead of citing one of the recent trustees' reports, she cited a 2011 "primer" on Medicare by the Kaiser Family Foundation. At page 5 of this primer the diligent researcher discovers this statement (Potetz, Cubanksi, and Neuman 2011):

> The costs of administering the Medicare program . . . [are] less than 2 percent of program expenditures. . . . Administrative costs include *all* expenses by government agencies in administering the program (HHS, Treasury, the Social Security Administration, and the Medicare Payment Advisory Commission). Also included are the cost of claims contractors and other costs incurred in the payment of benefits, collection of Medicare taxes, fraud and abuse control activities, various demonstration projects, and building costs associated with program administration. (emphasis added)

Unfortunately, no citation followed this statement.

OACT's Methodology

In this section I summarize the information about Medicare's overhead that CMS makes available in the trustees' reports and the NHEA and the process by which that information is assembled. For two reasons, I begin with the trustees' reports: (1) OACT prepares the trustees' reports first and uses the numbers from those reports to prepare Medicare's total and administrative spending figures for the NHEA; (2) because the trustees' measure does not mix the administrative costs of Medicare Advantage and Part D plans with the administrative costs of the original Medicare fee-for-service program, the trustees' measure is the appropriate one to use in analyzing several currently debated issues, such as whether converting Medicare to a voucher system would lower Medicare's costs and whether a Medicare-for-all system would have lower overhead than a system that relies on health insurance companies.

The US Treasury Department, which is responsible for administering the two Medicare trust funds, collects data on expenditures (including administrative expenditures) from the various agencies that contribute to the administration of Medicare. CMS is, of course, one of those agencies. The Office of Financial Management within CMS is responsible for reporting annually all of CMS's expenditures, including its own administrative expenditures, to Treasury.

Treasury sends the expenditure data from the various agencies to OACT, and OACT in turn uses that information to develop the trustees' report. CMS's annual statement of its expenditures (the document is called *CMS Financial Report*) is audited by independent outside auditors, by the Office of the Inspector General, and by the Government Accountability Office (GAO) (personal communication, C. McFarland, Deputy Director, Office of the Actuary, CMS, February 28, 2012). The US Treasury Department's annual report on US spending is audited annually by the USGAO (n.d.).

The federal agencies for which Treasury collects expenditure data, and which are therefore included in the trustees' reports on Medicare administrative spending, include the Treasury Department, the IRS, the SSA, CMS, the Department of Health and Human Services, the Medicare Payment Advisory Commission, the Area Agency on Aging, the Department of Justice, the Federal Bureau of Investigation, and the Railroad Retirement Board (see the appendix). In addition, the appendix lists "quality improvement organizations," which are private-sector organizations with which CMS contracts. The appendix also indicates that payments by CMS to insurance companies that process claims for Medicare's original fee-for-service program are included in the trustees' definition, as are the cost of buildings that house CMS staff and the cost of the numerous demonstration projects Congress requires CMS to conduct.

I have placed in the appendix phrases quoted directly from the latest trustees' report. I have appended my own translations to most of these phrases. As the source notes at the bottom of the appendix indicate, the quotes are taken from three different sections of the 2012 trustees' report: the statement of operations for the Hospital Insurance trust fund, the statement of operations for the Part B account within the Supplemental Medical Insurance (SMI) trust fund, and the text accompanying the Part D account within the SMI trust fund.[4]

Compare the items in the appendix with the following list of categories of Medicare administrative expenditures that Milliman (Litow 2006: 4) and CAHI (Matthews 2006: 6) allege "the government" ignores:

4. Although Medicare has four parts, it has only two trust funds. When Medicare began, it had a trust fund for Part A, called the Hospital Insurance (HI) trust fund, and another for Part B, called the Supplemental Medical Insurance (SMI) trust fund. The HI and SMI trust funds are still the only two trust funds maintained today. Part D was given a separate "account" within the SMI trust fund in 2004 (even though Part D coverage did not begin until 2006). Part B now also has a separate account within the SMI trust fund to distinguish it from the Part D account. Part C, also known as Medicare Advantage, has no separate fund or account. Health insurance companies that participate in Part C are paid from the accounts for Parts A, B, and D; that is, from the HI trust fund and from the two accounts within the SMI trust fund.

"Salaries for legislators";
"Staff and others working on Medicare";
"Building costs";
"Marketing costs";
"Collection of premiums";
"Collection of . . . taxes";
"Accounting including auditing and fraud issues."

It is not easy to create a clean crosswalk between the Milliman-CAHI list and the trustees' list. Milliman and CAHI use a typology that conveys information about the expenditure's function (e.g., "marketing") and no information at all about which agency or program generated the expense. This latter feature—conveying no information about the agency of origin—is, of course, consistent with the mistaken belief promoted by Milliman et al. that "the government" measures only some of the costs incurred directly by CMS. The trustees, on the other hand, use labels that tell the reader which agency or program generated the expense but that convey little information about the function of the expense (e.g., "Treasury administrative expenses").

However, even a cursory inspection of the two lists indicates the trustees include, with one exception, all categories of expenditures Milliman, CAHI, and their supporters allege are ignored by "Medicare" or "the government." The exception is "salaries of legislators." Reasonable arguments can be made for and against allocating a portion of the cost of running Congress to Medicare. I do not review them here. I note only that adding a portion of annual congressional costs would have little impact.[5]

Those who criticize the official reports on Medicare's overhead articulate additional criticisms that I have not reviewed above. For example, it is often argued that Medicare spends too little on fraud prevention and disease management, while the health insurance industry spends a more appropriate amount. In a similar vein, Cannon (2011) asserts, "Medicare also keeps its administrative expenditures down by conducting almost no quality-improvement activities." I do not examine those arguments here. This article addresses a slightly narrower question: Does OACT include in its definition of Medicare's administrative expenditures relevant types

5. By one estimate, total expenditures on Congress in 2010 were $5.4 billion (Barton 2010). Medicare accounted for 15 percent of total federal spending that year (Kaiser Family Foundation n.d.). If we attribute 15 percent of all congressional costs to Medicare, the cost of Congress's functioning as Medicare's "board" amounted to $800 million (15 percent of $5.4 billion). If we add $800 million to Medicare's 2010 overhead of $6.7 billion, Medicare's overhead would rise to $7.5 billion, or from 1.3 percent to 1.5 percent of total Medicare spending in 2010.

of expenditures, including those that Medicare's critics allege are missing? The question of whether Medicare should raise or lower spending on any particular type of administrative costs is beyond the scope of this article.

I end this review of issues raised by critics of the trustees' methodology with an examination of one other claim that is arguably outside the scope of this article: the argument that Medicare's current 1 percent rate would be higher if Medicare's administrative costs were divided into the lower medical costs of the nonelderly. Thus, if Medicare's annual per-enrollee expenditure were $10,000, and Medicare's overhead constituted 1 percent of this amount, or $100, and if annual per-enrollee spending for a nonelderly enrollee in a health insurance company were $4,000, then dividing Medicare's $100 overhead total into $4,000 would yield 2.5 percent, more than double Medicare's official 1 percent rate.

However, this argument makes an assumption that remains to be proved—namely, that administrative costs for health insurance programs are fixed; that is, they do not rise as the health status of insured enrollees falls. There are good reasons to hypothesize that this is not true, that per capita administrative costs do rise as the health status of an insured population declines. These reasons include the following: the number of claims per insured enrollee rises; the number of physicians and other providers seen by enrollees rises; the number of calls the insurer must take per enrollee from enrollees and providers asking questions about insurance coverage probably rises; and the cost of all forms of quality control—including peer review, auditing providers (and in Medicare's case, intermediaries), producing report cards, and prosecuting fraud—probably rises.

This issue of whether the need for health care among an insured population affects administrative costs is an empirical question that has not been definitively answered. The CBO has considered this argument in at least one study and rejected it. In a report to Congress estimating the cost of a national single-payer bill (HR 1300), the CBO considered the argument that administrative costs are unrelated to health status, and therefore the administrative-costs-to-total-expenditures ratio of a single-payer program that included the nonelderly would be higher than Medicare's rate (which was 2 percent at the time). The CBO rejected that argument on the grounds that the higher utilization of Medicare enrollees was responsible for a significant portion of Medicare's 2 percent overhead and, because the nonelderly use health care less often, extending Medicare to nonelderly Americans would lower the overhead costs associated with insuring the nonelderly. The CBO (1993: 12 n. 22) stated: "CBO tabulations from the

National Medical Expenditure Survey for 1987 show that average health expenditures for the aged were $4,181, about 2.8 times higher than the nationwide average of $1,496. The differential was nearly matched by the differential incidence of medical visits (inpatient and outpatient combined), which were 2.5 times higher than the nationwide average for the aged population." In any event, the critics who assert the counterargument have offered no empirical evidence to support it.[6]

To sum up, the trustees' definition of administrative expenditures measures what it purports to measure. It includes, with one exception, every type of administrative expenditure mentioned by the critics who allege that "the government ignores" numerous categories of Medicare administrative costs. The exception—the cost of running Congress—is so small compared with total Medicare spending that attributing to Medicare a portion of congressional costs changes Medicare's overhead ratio by very little. The federal agencies responsible for the data OACT uses employ generally accepted and legally required accounting methods and are subject to annual audits.

The trustees' definitions of total spending (claims paid plus administrative costs) and administrative spending are, with minor alterations, incorporated into the NHEA. However, the NHEA defines Medicare's administrative spending to include not only the trustees' measure of administrative costs—the costs listed in the appendix—but the administrative costs (including profits) of the insurance companies that par-

6. The cost of raising capital is one other category of administrative expense that critics occasionally claim is ignored. I relegate discussion of this claim to a footnote for two reasons. First, the argument is rarely made. Second, it is extremely difficult to make sense of this argument and, therefore, difficult to know whether to take it seriously. Consider Milliman's phrasing of this argument: "Of course, the federal government also raises capital and borrows money to pay Medicare claims, and it even pays itself interest on some of that borrowed money. But it includes none of these costs in its administrative estimates; it simply takes . . . the money from taxpayers" (Litow 2006: 4). Milliman makes no attempt to estimate how much Medicare borrows or how much Medicare's overhead should be raised to reflect the "missing" capital costs.

Milliman's statement (and the rest of its paper) leaves unanswered numerous questions, some of which seem almost Zen-like in their abstractness. Are the HI and SMI trust funds net *borrowers* from the federal Treasury or net *lenders*? (Medicare's income from payroll taxes and Part B premiums has exceeded its income from general federal revenues every year since Medicare began, although that is projected to change in the future [see figure II.D2 in Boards of Trustees 2012: 24]). When one unit of government lends to or borrows from another, has total government debt been affected? Is Milliman recommending that some portion of the cost of financing the entire federal *debt* be attributed to Medicare, or that some portion of the previous year's federal *deficit* be attributed to Medicare? If the former, why should activities undertaken by the federal government decades ago be attributed to Medicare? If the latter, what happens in years when the federal government runs a surplus? In those years, would Medicare's "capital costs" cause a decline in Medicare's overhead? Is Milliman conflating "borrowing" with "tax collection," and if so, is it not asking "Medicare" to double count—to attribute the cost of collecting taxes to Medicare *and* to attribute a cost of "capital"?

ticipate in the Medicare Advantage and Part D programs.[7] OACT refers to the administrative costs of these insurance companies as "net costs." Net costs are defined as "the difference between benefits and premiums" (CMS n.d.b: 25).

OACT calculates the net costs of Medicare Advantage plans based on data the plans submit each year in their bids (CMS n.d.b: 26). Plans must declare in their bids what portion of total expenditures will be allocated to administration (including profit) and what portion to medical expenses (Medicare Payment Advisory Commission 2007). OACT calculates the net costs (the administrative costs) of insurance companies that sell Part D coverage expenditures (both Medicare Advantage plans and stand-alone Part D plans) using data from the Prescription Drug Event (PDE) file maintained by CMS (n.d.b: 26). The PDE file is based on reports that Medicare Advantage plans and stand-alone drug plans must submit to CMS each time a beneficiary fills a prescription (CMS n.d.c). The PDE file contains data on payments to plans as well as costs incurred by plans.

The net cost figures for both types of plans—Medicare Advantage and Part D—are added to the administrative costs of the federal government reported in the trustees' report to derive total Medicare spending for the NHEA report.

Selecting the Right Yardstick

Both of OACT's definitions of Medicare's overhead are valid even though they are different. The question is not which yardstick is more accurate but which yardstick is more appropriate for a given task.

If one wants to know what portion of Medicare expenditures is going to overhead, and if one is indifferent as to how much of that overhead is generated by Medicare Advantage and Part D plans and how much by the traditional Medicare program, the NHEA measure is the appropriate measure to use. Thus, for example, the NHEA measure was appropriately used by the CBO (1993) to estimate the impact of a single-payer system on system-wide administrative costs and by Woolhandler, Campbell, and Himmelstein (2003) in their study designed to estimate total administrative costs in the US health care system.

7. The NHEA's definition of Medicare's administrative costs appears in the following statement in a methodology paper that accompanies the NHEA data (CMS n.d.b: 25): "The Medicare program contains administrative costs borne by the federal government to pay for salaries and expenses related to the federal management of Medicare as well as the net cost of insurance for the private plans administering the Medicare Advantage program and Part D."

But if the issue at hand requires an estimate of the administrative expenditures of the traditional Medicare program, then the trustees' measure must be used. The most obvious examples are proposals that call on CMS to raise particular types of administrative expenditures. We have already encountered one such appropriate use—the 1999 open letter to Congress asking Congress to give HCFA more money to spend on managed-care-like administrative functions. The letter, signed by representatives of the Heritage Foundation and thirteen other organizations, correctly invoked the trustees' measure of overhead, not the NHEA's. The authors of the open letter were not asking Congress to enhance the administrative budgets of both HCFA and Medicare Advantage plans; they wanted Congress to fatten only HCFA's administrative budget so that HCFA would have the means to apply managed-care methods to the traditional Medicare program. Therefore, the trustees' measure was the appropriate one to use.

Similarly, the trustees' report would be the appropriate one to use to ask whether CMS (as opposed to Medicare Advantage or Part D plans) should spend more money on fraud prevention.

The trustees' measure is also essential in any analysis of proposals that require a comparison of total spending—administrative plus medical expenditures—by Medicare and the health insurance industry. The major issues in this category are as follows:

1. Whether insuring more Medicare beneficiaries through Medicare Advantage plans and Part D plans would raise or lower Medicare's total costs;
2. Whether converting the entire Medicare program to a voucher (or premium support) program would raise or lower Medicare's total costs;
3. Whether expanding the traditional Medicare program to all Americans (which would be the equivalent of creating a national single-payer program) would lower system-wide administrative costs; and
4. Whether a public option modeled on the traditional Medicare program would lower system administrative costs.

To illustrate, consider the questions raised by the first issue listed above. If we want to know whether paying insurance companies more to participate in Medicare would cut Medicare's costs, we would need to know the total costs of both the traditional Medicare program and health insurance companies. Total costs for any health insurance program or company consist of two categories: medical costs and administrative costs. Thus an analysis of a proposal to raise the proportion of Medicare beneficia-

ries insured through the Medicare Advantage and Part D programs must estimate the impact of the proposal on traditional Medicare's medical and administrative expenditures and on the medical and administrative expenditures of the health insurance industry—in this case, that portion of the industry participating in Medicare Advantage and Part D.

Assume, for example, that the *administrative* costs of the insurance industry are 20 percent of its expenditures and traditional Medicare's are 1 percent, and that the industry's *medical* costs are equal to those incurred by Medicare (this might be so because lower utilization rates achieved by health plans are offset by lower fees and prices paid by Medicare). Given these facts, we would conclude that insurance companies have total costs—medical plus administrative—substantially in excess of traditional Medicare's and are therefore incapable of lowering expenditures of the entire Medicare program.

Barbara Cooper and Bruce Vladeck (a former administrator of CMS) (2000: 49–50) succinctly described the need for such a calculation in a paper aptly subtitled "Theory Meets Reality, and Reality Wins":

> In a world of voluntary enrollment, managed care plans do not have to be just more efficient than FFS [fee-for-service] Medicare, they have to be a lot more efficient. To begin with, the administrative costs of Medicare's FFS program are small; combining Parts A and B, Medicare's retention is less than 3 percent [*sic*]. The traditional Medicare program has no marketing costs, and it doesn't require any return on invested capital. So, for starters, setting aside for the moment problems of risk selection, capitated plans—with administrative expenditures in the range of 8–25 percent—have to incur medical expenditures 10–25 percent less than FFS plans do just to break even.[8]

A comparison of the behavior of the NHEA measure with that of the trustees' measure over the nearly half century since Medicare was enacted suggests that the problem identified by Cooper and Vladeck is real and should be taken far more seriously by policy makers than it has been to

8. A 1993 report by *Mathematica* evaluating the performance of HMOs within Medicare offered a warning much like Cooper and Vladeck's but without their explicit comparison of Medicare's overhead with that of private plans. The report stated that HMOs incur "administrative expenses for marketing, utilization management, negotiation of provider contracts, claims processing, quality assurance, compliance with HCFA and state requirements, and other costs that are not borne by FFS [Medicare]"; "these expenses are about 13 percent of total costs, on average, for Medicare risk plans"; and these costs are "clearly a drain on [HMO] profits" (Brown et al. 1993: 17). The report estimated that HMOs would have to cut medical spending by at least 10 percent to offset their overhead costs and break even.

date. The NHEA measure tracked the trustees' measure quite closely for the first twenty years of Medicare's existence. But since the mid-1980s, which is when the percentage of Medicare beneficiaries insured by insurance companies began to rise beyond the negligible levels of the 1970s, the NHEA measure of Medicare's overhead has risen dramatically while the trustees' measure has continued to decline. As of 2010, the latest year for which data from both measures are available, the NHEA measure was 4.5 times larger than the trustees' measure—5.9 versus 1.3 (see table 1). This enormous disparity between two measures that used to be almost identical should long ago have triggered inquiries within Congress and the US health policy community as to whether the higher administrative costs associated with the growing privatization of Medicare are justified.

To take one more example, the trustees' yardstick is the correct tool to use in analyzing the arguments made for and against the public option. During the debate that preceded the enactment of the Affordable Care Act, proponents of the public option claimed it would be Medicare-like and would enjoy traditional Medicare's low overhead. For that reason, and because the public option would also be endowed with the authority to pay providers the relatively low rates paid by Medicare, proponents claimed the public option's total expenditures—administrative plus medical—would be much lower than the total expenditures of the insurance industry (Hacker 2008). Assessing this claim requires, among other tasks, measuring the relative overheads of traditional Medicare and the insurance industry as well as their relative expenditures on medical care. The trustees' measure is the appropriate one to use in determining the overhead of the traditional Medicare program. The NHEA measure would not be appropriate because it mixes the overheads of the traditional Medicare program with the overhead of the insurance companies that participate in Medicare Parts C and D.

Here I want to call attention to one other issue involving administrative spending that neither the trustees' measure nor the NHEA measure addresses. A complete analysis of any proposal to expand or reduce the participation of insurance companies in Medicare, to enact a public option, or to create a Medicare-like program for the entire country should estimate the effect of the proposal on administrative costs of providers, not just those of public and private insurers. Insurers are not the only entities within a health care system that generate administrative costs. In the United States, clinics and hospitals spend approximately one-fourth of their revenues on administration, while nursing homes spend one-fifth and home care agencies spend one-third of their revenues on administra-

tion (Woolhandler, Campbell, and Himmelstein 2003). Research suggests that providers incur higher administrative costs in multiple-payer than in single-payer systems (Woolhandler, Campbell, and Himmelstein 2003; Pozen and Cutler 2010; Morra et al. 2011), and research and anecdotal evidence suggests the spread of managed care has raised the administrative costs of providers (Segal 1996; Alexander and Lemak 1997). Thus a thorough analysis of, for example, the further privatization of Medicare would seek to determine not only whether the administrative costs of private plans exceed those of traditional Medicare but whether the conversion of Medicare from a primarily one-payer model to a multiple-payer program would drive up the administrative costs of providers and whether exposing more patients and providers to the managed-care methods of private plans would do so. Neither of OACT's yardsticks measures provider overhead. That means, obviously, that analysts who seek to measure the impact of any proposal on provider overhead must look beyond the OACT measures discussed in this article.

Conclusion

The true size of Medicare's administrative costs is relevant to several hotly contested issues, including proposals to expand the participation of insurance companies in Medicare (either by expanding the Medicare Advantage plan or converting Medicare into a voucher or premium-support program) and to extend the traditional Medicare program to all Americans. Assessing the impact of these and related proposals requires, among other tasks, determining how these proposals will affect medical and administrative costs of Medicare and of private insurers. One of these tasks—measuring Medicare's overhead costs—has already been done by OACT. Both the trustees' and NHEA reports contain reliable measures of Medicare's administrative costs.

The trustees' measure should be used to estimate the effect of proposals that are based on the traditional Medicare program. The NHEA measure should be used to estimate the effect on administrative spending of proposals that rely on, or are comparable to, the entire Medicare program.

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Appendix A: Excerpts from the 2012 Medicare Trustees' Report That Describe Components of Medicare's Administrative Expenditures

1. "Treasury administrative expenses" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1). Treasury is where the IRS, the collector of taxes for Medicare, including the HI payroll tax that funds Part A, is housed.
2. "Salaries and expenses, SSA" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1). A footnote for this entry in the statement of operations for the HI states, "For facilities, goods, and services provided by SSA." Social Security Administration activities that support Medicare include maintaining a databank on who is eligible for Medicare and deducting Part B premiums from monthly Social Security checks.
3. "Salaries and expenses, CMS" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1). A footnote to this entry in the statement of operations for the HI fund states, "Includes administrative expenses of the intermediaries." A nearly identical statement ("Includes administrative expenses of the carriers and intermediaries") appears in a footnote to the entry for CMS in the statement of operations for the Part B account within the SMI fund. These footnotes are saying that this entry includes the costs incurred by the private plans, formerly known as "intermediaries" and "carriers" and now called "Medicare administrative contractors," with which CMS contracts to process claims for Parts A and B. Do not confuse these intermediaries and carriers with the plans that participate in Medicare Advantage. The administrative costs of these plans appear only in the NHEA measure of Medicare's administrative costs.
4. "Salaries and expenses, Office of the Secretary, HHS" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1). The Department of Health and Human Services is the agency within which CMS is housed.
5. "Medicare Payment Advisory Commission" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1).

6. "AOA [Agency on Aging] MIPPA [Medicare Improvements for Patients and Providers Act of 2008] funding" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1). This represents money authorized by the Affordable Care Act of 2010, in the form of an amendment to MIPPA, for more public education about the benefits available under Medicare.
7. "CMS program management—Patient Protection and Affordable Care Act" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1).
8. "Quality Improvement Organizations" (Boards of Trustees 2012: HI trust fund p. 51, table III.B1, and Part B account in the SMI trust fund p. 90, table III.C1).
9. "Fraud and abuse control expenses." The following items appear beneath this heading: "HHS Medicare integrity program," "HHS Office of Inspector General [OIG]," "Department of Justice," "FBI," "HCFAC [Health Care Fraud and Abuse Control] DOJ Discretionary, CMS," "HCFAC OIG Discretionary, CMS," and "HCFAC Discretionary, CMS") (Boards of Trustees 2012: HI trust fund p. 51, Table III. B1).[1]
10. "Transfer to Medicaid." This "represents amount transferred from the Part B account in the SMI trust fund to Medicaid to pay the Part B premium for certain qualified individuals, as legislated by the Balanced Budget Act of 1997" (Boards of Trustees 2012: Part B account in the SMI trust fund p. 90).
11. "Railroad Retirement administrative expenses" (Boards of Trustees 2012: Part B account in the SMI trust fund p. 90). The Railroad Retirement Board assists in the administration of Medicare in several ways, including enrolling railroad retirees in Medicare and deducting Part B premiums from benefit payments.
12. "Experiments and demonstration projects designed to determine various methods of increasing efficiency and economy in providing health care services, while maintaining the quality of such services, under HI and SMI" (Boards of Trustees 2012: HI trust fund p. 55).[2]

1. The text accompanying the statement of operations for the Part B account states that expenditures on "fraud and abuse control activities" are included in Part B administrative expenses (Boards of Trustees 2012: 94).

2. A nearly identical statement appears in the text explaining the statement of operations of the Part B account (Boards of Trustees 2012: 94).

13. "Construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of HI" and "Part B" (Boards of Trustees 2012: HI trust fund p. 55).[3]
14. "All expenses incurred by the Department of Health and Human Services, the Social Security Administration, and the Department of the Treasury in administering Part D are charged to the account. Such administrative duties include making payments to Part D plans, the fraud and abuse control activities, and experiments and demonstration projects designed to improve the quality, efficiency, and economy of health care services. In addition, Congress has authorized expenditures from the trust funds for construction, rental and lease, or purchase contracts of office buildings and related facilities for use in connection with the administration of Part D. The account expenditures include such costs" (Boards of Trustees 2012: Part D account in the SMI trust fund pp. 118–119).

3. See note 2.