

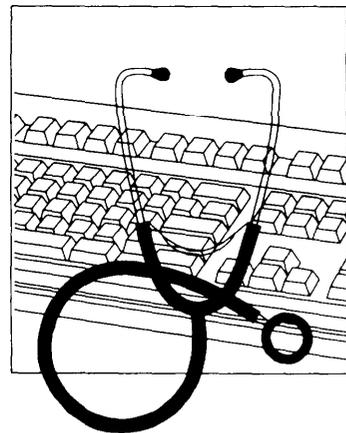
Effects of Administrative Changes Under Reform 5

Proponents of many health reform proposals in the 103d Congress claim that their bill will generate administrative savings. Examples include:

- The American Health Security Act of 1993 (S. 491) “would simplify and streamline the administration and financing of health care, and administrative costs would drop dramatically” (193).
- The Health Equity and Access Reform Today Act of 1993 (S. 1770) “establishes standardized forms and electronic information reporting and exchange requirements to eliminate bureaucratic red tape and reduce administrative costs and burdens” (194).
- The Health Security Act (S. 1757) would “lower administrative costs. . . [by] cutting through the paper jungle generated by some 1,500 insurance companies, and stripping away conflicting regulations imposed by a variety of federal, state, local and private agencies” (208).
- ▯ The Managed Competition Act of 1993 (H.R. 3222) would achieve “cost savings. . . through enhanced competition among health plans, malpractice reforms, electronic claims processing and administrative simplification” (187).

Some analysts have projected large administrative savings under certain reform proposals, further highlighting the importance of assessing the assumptions behind estimates. One analyst, for example, estimates that \$113 billion in administrative savings could be achieved in reduced insurer and provider overhead if the United States adopted a Canadian-style single-payer system (107).

This chapter addresses the two policies that underlie most estimates of administrative costs under reform-adopting a single-



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payer system and reforming the private insurance market. Analysts believe that a single-payer system may reduce administrative costs by replacing private insurers with a single payer (i.e., the government), and thus eliminate the overhead of private insurers and reduce the overhead of health care providers. Analysts estimate that reform of the private insurance market may reduce administrative costs by allowing small firms to purchase insurance through purchasing pools and limiting underwriting (an insurance company's determination whether and on what basis it will accept an application for insurance). However, these savings could be offset, to some extent, by administrative costs for new programs associated with pooling and related policies, such as health alliances or health plan purchasing cooperatives, and a national health board to establish a standard benefits package.

Other reforms also may affect administrative costs, such as requiring uniform paper claim forms or standardized electronic claim formats. Analysts do not feature these factors prominently in their analyses, if they consider such secondary factors at all, estimating they would produce only small savings. Accordingly, this chapter does not concentrate on these secondary factors beyond stating that there is little reliable evidence on potential savings from uniform claim forms and electronic claims processing.

Although frequent references are made to administrative waste in the current health care system, administrative spending can produce services that are viewed as valuable. Administrative costs for hospitals, for example, can be defined to include utilization review, assessments of the appropriateness of care, and patient information systems, all of which may improve the quality

of care. This chapter examines administrative costs as viewed in analyses of proposals by the following organizations or individuals: the Clinton Administration (32, 202), the Economic and Social Research Institute (ES RI) (107), Grumbach et al. (50), Lewin-VHI (87,89), the Congressional Budget Office (CBO) (165,168,172), the General Accounting Office (GAO) (178), and Woolhandler and Himmelstein (212). Analysts from these organizations appear to include in their definitions of administrative costs private insurance load (usually regarded as the difference between premiums and claims paid), the costs of operating public programs related to the delivery of health services, and provider overhead (usually hospitals and physicians).²

What analysts include in these three specific categories differs, however, and affects their estimates of the impact of reform. For example, while other analysts regard private insurance load as the difference between premiums and claims paid (including profit), CBO excludes taxes, which it considers to be an income transfer, and thus not real administrative costs.³ Excluding taxes lowers CBO'S estimate of administrative savings under a single-payer system. Variations in definitions of provider overhead are greater still, as outlined below, and contribute to wide ranges of estimated savings under reform.

Analysts estimate that under a single-payer system relatively large insurer and provider administrative savings could be achieved (ranging from \$47 billion to \$113 billion in 1991),⁴ often based on comparisons with Medicare and Canada's system. Estimates of insurer administrative savings based on the experience of other single-payer systems appear reasonable, though addi-

¹Danzon argues that standard accounting measures of administrative costs ignore certain real social costs (24). For example, estimates of public single-payer insurance administrative costs do not include the limited choice of type of insurance coverage.

²Employers and individuals also incur administrative costs in the health care system. These costs, however, are not generally estimated by analysts and are not included in national health expenditures (NHE).

³CBO estimates these taxes at \$1 billion in 1990, based on an unpublished estimate by GAO (165).

⁴The estimate of \$113 billion assumes that U.S. health spending as a percentage of gross domestic product (GDP) will fall to Canadian levels. Other high estimates of savings rely on optimistic assumptions about changes in provider activities under a single-payer system.

tional administrative functions (e.g., greater utilization review) may be performed in the United States under a single-payer system. Estimates of provider savings are less certain and vary widely due to an incomplete understanding of the administrative activities of physicians and hospitals.

Analysts project that administrative savings from insurance market reform would be offset partially or completely by new administrative costs growing out of reform, for little net effect on national health expenditures. The evidence supports this conclusion, since potential savings from reduced insurer administrative costs are limited and providers would continue to be reimbursed by a multitude of payers. Several analysts cite studies that compare administrative costs for small and large firms and assume that pooling small firms and limiting underwriting will reduce administrative costs. This assumption is intuitively reasonable, but there is little empirical evidence on the impact of pooling on administrative costs to support it.

This chapter first outlines analysts' assumptions about administrative costs in estimates of reform, focusing on their treatment of proposals that would implement a single-payer system or reform the private insurance market (table 5-1). Next it analyzes the theoretical and empirical evidence related to these assumptions. The chapter concludes with an analysis of the uncertainty surrounding estimates of changes in administrative costs.

ANALYSES OF REFORM PROPOSALS

■ Analyses of Single-Payer Proposals

Many analysts estimate that large administrative savings could be achieved if the United States converted from the current multipayer system of private insurers and public programs (e.g., Medicare and Medicaid) to a single-payer system. Ana-

lysts assume that under such a system, private insurer marketing, eligibility determination costs, and profits would be largely eliminated, reducing insurer overhead. They would be replaced with the overhead expenses of running a single-payer system. Health care providers would deal primarily with one payer, which according to analysts would lower their overhead costs as well. In most single-payer proposals, hospitals would be given budgets, physicians would be paid according to a fee schedule, and there would be no patient cost-sharing,⁵ further lowering provider overhead costs, according to analysts.

Although only CBO has analyzed the American Health Security Act (H.R. 1200/ S. 491), a single-payer proposal in the 103d Congress, other organizations have analyzed single-payer systems that have not been written into formal legislation (50,87,107,178,212). Like the American Health Security Act, the other systems analyzed are assumed to have hospital budgets, physician fee schedules, and no patient cost-sharing. CBO'S analysis of the American Health Security Act and five general analyses are presented here to highlight assumptions made about administrative costs under a single-payer system.

These examples illustrate that analysts:

- anticipate large administrative savings under single-payer proposals;
- often project savings based on comparisons with Medicare and Canada; and
- use different baselines for provider overhead under current policy.

The assumptions and conclusions of these analyses are summarized in table 5-2 and figure 5-1.

CBO'S Analysis of the American Health Security Act

CBO estimates that administrative costs would fall considerably under the American Health Security Act (170, 171). Insurer overhead would fall

⁵ Patient cost-sharing is the general set of financial arrangements under which a portion of the payment to a provider of health care services is the liability of the patient (may include deductibles, copayments, and coinsurance).

TABLE 5–1: Analyses of the Impact of Health Reform Proposals on National Health Expenditures Reviewed in This Report

Proposal	Analyses ^a			
	Applying government cost controls (chapter 2)	Encouraging managed competition (chapter 3)	Providing universal coverage to uninsured people (chapter 4)	Reducing administrative costs (chapter 5)
American Health Security Act of 1993 (H.R. 1200/S. 491) ^b	<i>CBO</i>		CBO	<i>CBO</i>
Comprehensive Health Reform Act of 1992 (H.R. 5919) ^c				<i>CBO</i>
Health Care Cost Containment and Reform Act of 1992 (H.R. 5502) ^c	CBO		CBO	<i>CBO</i>
Health Security Act (H.R. 3600/S. 1757) ^b	CBO Clinton Administration Lewin-VHI	CBO Clinton Administration Lewin-VHI Lewin-VHI	CBO Clinton Administration Lewin-VHI	<i>CBO</i> Clinton Administration Lewin-VHI
Health Security Act (H.R. 3600/S. 1757) ^b , Lewin-VHI scenario without government cost controls				
Managed Competition Act of 1992 (H.R. 5936) ^c		CBO ESRI	CBO	CBO
Managed competition plan, Starr version			Sheils et al	
National health plan, full savings scenario				ESRI
National health plan, administrative savings scenario				ESRI
Single-payer plan, CBO version with patient cost-sharing			CBO	
Single-payer plan, CBO version without patient cost-sharing			<i>CBO</i>	CBO
Single-payer plan, GAO version				GAO
Single-payer plan, Grumbach et al. version				Grumbach et al. Lewin-VHI^d
Single-payer plan, Lewin-VHI version				Woolhandler and Himmelstein
Single-payer plan, Woolhandler and Himmelstein version				CBO
Universal Health Care Act of 1991 (H.R. 1300)^c	CBO		CBO	

KEY: CBO = U.S. Congress, Congressional Budget Office; GAO = U.S. General Accounting Office, ESRI = Economic and Social Research Institute.

^aFull citations for the analyses are in appendix B.

^bBill numbers are for 103d Congress.

^cBill numbers are for **102d Congress**.

^dAnalysis was conducted by Lewin-ICF. The company was acquired and expanded in 1992. For purposes of this report all Lewin analyses are identified as Lewin-VHI

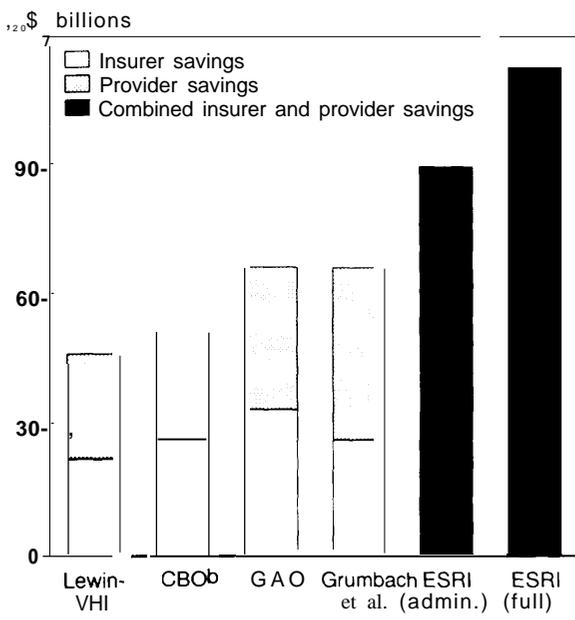
SOURCE: Office of Technology Assessment, 1994.

from the current level of about 7 percent of “covered services” to 3.5 percent and 3 percent under H.R. 1200 and S. 491, respectively.⁶ CBO also estimates that provider overhead would be reduced under both bills, stating that “hospitals, physicians, home health agencies, and other health care professionals could save about 6 percent of revenues by dealing with only one payer and eliminating copayments and other billing.”⁷

CBO does not explain its assumptions in its December 1993 memorandum, but in a previous general study examining the impact on administrative costs of a single-payer system with no copayments,⁸ CBO assumes that insurer overhead would fall to Medicare rates (“about 1.9 percent of the cost of covered services”) (165),⁹ (CBO estimates total administrative savings of \$52 billion in its general study of a single-payer system.) CBO does not state why administrative costs under the American Health Security Act would only approach, but not reach, the level of Medicare. CBO may assume that functions additional to those performed under Medicare would be performed under the act.

CBO defends its assumption of Medicare rates in its general study of a single-payer system. Although some have said that economies of scale in processing claims would yield lower insurer overhead rates for a national system, CBO states that these economies of scale are already fully realized under Medicare. Others have stated that a national system would have higher overhead costs than Medicare. They argue that the size of the average Medicare claim is higher than the national aver-

FIGURE 5-1: Estimates of Savings in Administrative Costs Under Six Analyses of a Single-Payer System, 1991



KEY: CBO = U S Congress, Congressional Budget Office ESRI= Economic and Social Research Institute, GAO - U S Congress, General Accounting Office

a Full citations for the analyses are in appendix B. Descriptions of assumptions behind estimates are in table 5-2

b Single-payer plan, CBO version without patient cost-sharing

SOURCE Office of Technology Assessment 1994

age, yielding low estimates of Medicare administrative costs when expressed as a percentage of total costs. CBO refutes the argument that the size of the average Medicare claim is higher than that

⁶ CBO does not state explicitly why the estimates of the two bills vary by a half percent, though it notes that S. 491 would prohibit coinsurance or copayments “for all items,” while H.R. 1200 “would prohibit coinsurance or copayments (rely for acute care or preventive services.”

⁷ CBO assumes that nursing homes would also save 6 percent of revenues under S. 491. The estimate of administrative savings under S. 491 and its analysis is similar to CBO’s estimate of H.R. 1300, a single-payer bill of the 102d Congress, with the exception that administrative costs fall to 3 percent more quickly under S. 491. (168)

⁸ Referred to in tables 5-1 and 5-2 as *single-payer plan, CBO version without patient cost-sharing*. CBO uses the term copayment to refer to patient cost-sharing.

⁹ For all services except long-term care, which would be covered by a residual Medicaid program.

TABLE 5-2: Key Assumptions in Estimates of Savings in Administrative Costs Under a Single-Payer System

Proposal	Analysis ^a	Estimate year(s)	Savings in administrative costs (\$ billions)	Key assumptions	
				insurer overhead assumptions	Provider overhead assumptions
American Health Security Act (HR. 1200)	CBO	1997-2003	NA	Administrative costs as a percentage of "covered services" would fall from current level of "about 7940" to 3.5% in 4 years ^c	Would fall by 6% of revenues, phased in over 2 years.
American Health Security Act (S. 491)	CBO	1997-2003	NA	Administrative costs as a percentage of "covered services" would fall from current level of "about 770" to 3% in 4 years	Would fall by 6% of revenues, phased in over 2 years
National health plan, administrative savings scenario	ESRI	1991	\$90 total	Assumes overall administrative costs would fall from current levels (19%-24%) to Canadian levels (8%-11%) but does not assume total health spending would fall to Canadian levels	See "Insurer overhead assumptions."
National health plan full savings scenario	ESRI	1991	\$113 total	Assumes health spending as a percentage of GDP and overall administrative costs would fall to Canadian levels. Estimates provider and insurer administrative savings together, (Assumes health spending would fall from 12.8% to 8.7% of GDP in 1991.)	See "Insurer overhead assumptions"
Single-payer plan, CBO version without patient cost-sharing	CBO	1991	\$52 total (\$26.8 insurers, \$25.2 providers)	^d assume[s] that the single payer would have Medicare's rate of program overhead costs as a percentage of insured services. In addition, overhead costs for other public programs would continue. ^d	<i>Physician</i> Assumes physician administrative costs (estimated at 8.3% of revenues) would fall to Canadian levels (2%) ^e <i>Hospital</i> , Assumes hospital administrative costs (estimated at 15% of revenues) would fall to Canadian levels (9%). ^f

TABLE 5-2: Key Assumptions in Estimates of Savings in Administrative Costs Under a Single-Payer System (cont'd.)

Proposal	Analysis ^a	Estimate year(s)	Savings in administrative costs (\$ billions)	Key assumptions	
				Insurer overhead assumptions	Provider overhead assumptions
Single-payer plan, GAO version	GAO	1991	\$67 total (\$34 insurers, \$33 providers)	"We assumed that the Insurance overhead share of total health expenditures in the United States [5.8% in 1989 ^g] was reduced to the proportion obtained in Canada [1.2% in 1987 ^h]",	Physician: Assumes physicians would save 10% of current revenues, based on comparisons with Ontario. (Examines differences in non-physician personnel, physician time spent on insurance claims, and outside billing services.) <i>Hospital:</i> Assumes hospital administrative costs (estimated at 15.4%) would fall to Canadian level (9.0%) ⁱ
Single-payer plan, Grumbach et al. version	Grumbach et al.	1991	\$67 total (\$27 insurers, \$40 providers)	Assumes insurer overhead (estimated at 5.9% of personal health expenditures in 1987 ^j) would fall to Canadian levels (1.4%) ^k	<i>Physician:</i> Assumes physician administrative costs (estimated at 8.3% ^l of expenses) would fall to Canadian levels (2%), ^m <i>Hospital:</i> Assumes hospital administrative costs (estimated at 20.2% of revenues) would fall to Canadian levels (estimated at 9.0% ⁿ).
Single-payer plan, Lewin-VHI version	Lewin-VHI	1991	\$468 total (\$22.5 Insurers, \$243 providers)	Assumes Medicare per capita overhead, with adjustments for claim level and elimination of hospital billing	Examines Individual provider overhead functions (labor and services not directly related to patient care) and determines which would be reduced under a single-payer system and by how much <i>Physician:</i> Assumes physician administrative costs would fall from the current level of 31.6% of revenues to 23.5% of revenues <i>Hospital:</i> Assumes hospital administrative costs would fall from the current level of 33.4% ^A of revenues to 28.7% of revenues,

(continued)

TABLE 5-2: Key Assumptions in Estimates of Savings in Administrative Costs Under a Single-Payer System (cont'd.)

Proposal	Analysis ^a	Estimate year(s)	Savings in administrative costs (\$ billions)	Key assumptions	
				Insurer overhead assumptions	Provider overhead assumptions ^b
Single-payer plan, Woolhandler and Himmelstein version (method 1)	Woolhandler and Himmelstein	1987	\$83.2 total (\$21.7 Insurers, \$61.4 providers)	Assumes Insurer administrative spending (estimated at 5.1% of covered spending) would fall to Canadian levels (1.2%)	<i>Physician:</i> Method 1 is based on physicians' reports of their overhead and billing expenses. Assumes physician administrative costs (estimated at 48.1% of costs) would fall to Canadian levels (34.4%). <i>Hospital:</i> Assumes hospital administrative costs (estimated at 20.2% of costs) would fall to Canadian levels (9.0%). ^p
Single-payer plan, Woolhandler and Himmelstein version (method 2)	Woolhandler and Himmelstein	1987	\$69.0 (\$21.7 Insurers, \$47.2 providers)	Same as method 1.	<i>Physician:</i> Method 2 is based on comparisons of clerical and managerial personnel. Assumes physician administrative costs (estimated at 25.1% of costs) would fall to Canadian levels (18.3%). <i>Hospital:</i> Same as method 1.
Universal Health Care Act of 1991 (H.R. 1300)	CBO	1995-2000	NA	Administrative costs as a percentage of "covered services" would fall from current level of "about 7%" to 3% in 5 years.	Would fall by 6% of revenues, phased in over 2 years,

KEY: CBO = U S Congress, Congressional Budget Office, GAO = U S General Accounting Office, ESRI = Economic and Social Research Institute; NA = Not available

^aFull citations for the analyses are in appendix B.

^bAs noted in text, all estimates of provider overhead savings may be imprecise due to difficulties in measuring current U S and Canadian provider overhead

^cSeveral of CBO'S assumptions about administrative costs in the H.R. 1200, S. 491, and H R 1300 bills appear to be found in CBO'S April 1993 report (Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates) It is not clear, however, why CBO does not assume that Insurer overhead under these bills would fall to Medicare levels as it does in the April 1993 report

^dAssumes residual Medicaid program for long-term care

^ePhysician administrative costs estimates are based on Grumbach et al s 1991 study and relate primarily to billing costs

^fHospital administrative costs estimates are based on GAO's 1991 study (1 75) and relate primarily to billing and management information systems.

^gGAO uses data from "National Health Expenditures 1988," *Health Care Financing Review* 11 (4) 47-48, summer 1990

TABLE 5-2: Key Assumptions in Estimates of Savings in Administrative Costs Under a Single-Payer System (cont'd.)

hGAO uses data from Health and Welfare Canada, National Health Expenditures in Canada 1975-1988 September 1990, pp. 184-185 The comparability of the U.S. and Canadian definitions of Insurer administrative costs is unclear

I Hospital administrative costs included are "general accounting patient accounts and admitting, medical records purchasing and stores and data processing" and are derived from American Hospital Association data for the United States and unpublished data from Health and Welfare Canada for Canada

J Grumbach et al use data from Health Care Financing Administration, "National Health Expenditures 1986 -2000," *Health Care Financing Review* 8(4) 1-36, 1987

k Grumbach et al use data from "National Health Expenditures "Ottawa, Ontario: Health and Welfare Canada, 1990.

l Grumbach et al. use data from an American Medical Association survey Includes billing expenses only.

' Grumbach, et al use data from written communication with Ontario Medical Association official Includes billing expenses only

' Study does not indicate what is Included under hospital administrative costs, but estimates appear to come from the study by Woolhandler and Himmelstein.

' Expense-based estimate of physician overhead. Per capita estimates presented in report were converted by OTA to dollar estimates of total savings to providers and insurers (These numbers do not add up due to rounding) Only this study (both method 1 and method 2) includes nursing home administrative savings (\$4.1 billion of savings attributable to reduced nursing home administrative costs), inflating overall estimates of administrative savings relative to other studies.

P Study Includes the following hospital administrative costs "hospital administration ("other"), advertising, association-membership fees, business machines, collection fees, postage, auditing and accounting fees, other professional fees, service-bureau fees, telephone and telegraph, indemnity to board members, travel and convention expenses, medical records and hospital library, and nursing administration "

q Personnel-based estimate of physician overhead

SOURCE Office of Technology Assessment, 1994

of the population at large, arguing that “the higher costs of the Medicare population are very closely tied to higher claim rates, rather than higher amounts per claim.”¹⁰

Although CBO does not explain its assumptions about provider overhead savings under the American Health Security Act, it appears to take them from its April 1993 analysis of a single-payer system with no copayments (165). In that study, CBO assumes that hospital administrative costs (mostly billing and management information systems) would fall from the estimated current level of 15 percent of revenues to the Canadian level of 9 percent,¹¹ and that physician billing costs would fall from the estimated current level of 8.3 percent of revenues to the Canadian level of 2 percent.¹²

Lewin-VHI's Analysis of a Single-Payer System

In its analysis of a single-payer system,¹³ Lewin-VHI estimates that administrative costs would decrease by \$47 billion (1991), with the savings coming almost evenly from reduced insurer and provider overhead (87, 147). For insurer overhead, Lewin-VHI assumes that a national system would operate with per capita administrative costs just below the levels of the Medicare program. It estimates administrative costs slightly below Medicare levels because it assumes utilization levels of the Nation population would be lower than those of the population currently covered by Medicare. Also, Lewin-VHI assumes that hospital budget-

ing would reduce insurer administrative costs of processing hospital claims.

For provider overhead, Lewin-VHI does not make comparisons with Canada, but instead estimates the extent to which individual physician and hospital administrative activities would decrease under a single-payer system. Lewin-VHI appears to base these estimates on its analysts' judgments rather than data. Lewin-VHI defines provider overhead broadly to include all activities other than those directly related to patient care (unlike CBO, which focuses on billing and collection costs). Lewin-VHI estimates that physician overhead would fall from the current level of 31.6 percent of revenues to 23.5 percent, savings of 8.1 percent of revenues. Hospital overhead would fall from 33.4 percent of revenues to 28.7 percent, savings of 4.7 percent of revenues.

Although Lewin-VHI avoids the difficulties in assuming that U.S. provider overhead under a single-payer system would fall to Canadian provider levels, it may add new uncertainty with its judgments about how individual provider functions would change under a single-payer system (which are not based on data). In addition, Lewin-VHI acknowledges the difficulties of determining current administrative costs, pointing to the lack of comprehensive data on provider administrative activities. For estimates of baseline hospital overhead, Lewin-VHI relies on California hospital data. Estimating physician overhead is more problematic still, according to Lewin-VHI, since “[c]omprehensive data on physician overhead and administrative costs are largely unavailable” (87).

¹⁰ CBO reports that its examination of the National Medical Expenditure Survey for 1987 indicates that average health expenditures per person per year for the aged are 2.8 times higher than the national average, and claim rates (number of claims per person per year) for the aged are 2.5 times higher than the national average.

¹¹ CBO uses GAO estimates of hospital overhead for the two countries (175). This assumption appears to conflict with CBO's critique of the GAO report found in the appendix, however, which states, "...[O]nly about half of the savings estimated by GAO is the result of billing costs for hospitals in the United States that do not exist for Canadian hospitals. The rest might be obtained only if U.S. hospitals discarded the more detailed management systems they currently maintain, and this development seems unlikely."

¹² CBO bases these estimates on a study by Grumbach "al.(50).

¹³ Referenced in tables 5.1 and 5-2 as *single-payer plan, Lewin-VHI version*.

Economic and Social Research Institute's Analysis of a Single-Payer System

A study of a single-payer system by the Economic and Social Research Institute (ESRI) predicts that administrative savings could reach \$113 billion in the first year of reform, 1991 ("Full Savings Scenario") (107).¹⁴ To arrive at this estimate, ESRI first assumes that health spending as a percentage of gross domestic product (GDP) (12.8 percent in the U.S. in 1991) would fall to Canada's level (8.7 percent), for total savings of \$241 billion in 1991. Next, ESRI assumes that administrative costs as a percentage of health care spending would fall from the U.S. level, which it estimates is 19 to 24 percent, to the Canadian level of 8 to 11 percent.¹⁵

The assumption of this estimate that total U.S. health spending as a percentage of GDP would fall to Canadian levels appears unlikely, and is made by no other analyst. It is one of the key reasons why ESRI estimates very high administrative savings under a single-payer system. Furthermore, ESRI'S estimate of the difference in administrative spending as a percentage of health care spending between the United States and Canada is high and appears to rely on optimistic predictions of how provider behavior would change under a single-payer system.

Under a second single-payer scenario ("Administrative Savings Scenario") that does not assume that total U.S. health spending as a percentage of GDP will fall to Canadian levels,¹⁶ ESRI estimates that \$90 billion in 1991 in administrative savings would be achieved. While lower

than under the previous scenario, this estimate remains high relative to other studies.¹⁷ ESRI assumes that a single-payer system would operate at Canadian overhead rates, which are lower than Medicare rates, and that all provider activities not directly related to patient care currently performed in the United States but not in Canada would be eliminated.

Woolhandler and Himmelstein's Analysis of a Single-Payer System

Woolhandler and Himmelstein estimate administrative savings ranging from \$69.0 billion to \$83.2 billion in 1987 if the United States were to adopt a single-payer system (212).¹⁸ Estimates of insurer savings are based on comparisons of administrative costs for the United States and Canada.

Estimates of hospital overhead savings are also based on comparisons with Canada, using California data for U.S. estimates, Woolhandler and Himmelstein define hospital administrative costs broadly, including such expenses as advertising, medical records, and travel and convention expenses.

In estimating physician administrative savings, Woolhandler and Himmelstein note, "Only indirect or incomplete information is available on the billing costs of Canadian and U.S. physicians. We therefore used two different methods. . . . Their first approach compares U.S. and Canadian physicians reports of professional expenses devoted to administrative activities and contributes to their estimate of \$83.2 billion in total administrative

¹⁴ Referred to in tables 5-1 and 5-2 as *national health plan, full savings scenario*.

¹⁵ These estimates include private insurance, public program, and provider administrative expenses. The source cited for these percentages, "Himmelstein and Woolhandler, 1991," is not listed in the report's bibliography, but appears to come from "The Deteriorating Efficiency of the U.S. Health Care System," Woolhandler and Himmelstein.

¹⁶ Referred to in tables 5-1 and 5-2 as *national health plan, administrative saving Y scenario*.

¹⁷ ESRI estimates administrative costs as a percentage of NHE would fall approximately 12 percent. Other studies estimate decreased administrative costs as a percentage of NHE at 9.5 percent (50), 9.1 percent (175), 7.1 percent (165), and 6.4 percent (147). Percentages (except ESRI) as reported in a CBO April 1993 report (165).

¹⁸ Woolhandler and Himmelstein estimate savings based on comparisons of per capita administrative costs for the United States and Canada. This approach fails to control for differences in the level of spending on health services and may overstate savings (24). Woolhandler and Himmelstein's estimates are also inflated by the inclusion of nursing home administrative savings of \$4.1 billion. (No other analyst includes nursing home savings.)

savings.¹⁹ Their second approach compares the number of clerical and managerial personnel employed in physicians' offices in the United States and Canada and contributes to their estimate of \$69.0 billion in total savings.²⁰

Grumbach et al.'s Analysis of a Single-Payer System

Grumbach et al. estimate \$67 billion in savings in administrative costs in 1991 (50).²¹ They assume that insurer overhead expenses would fall to Canadian levels. For hospital administrative savings, Grumbach et al., like Woolhandler and Himmelstein, use California hospital data and make comparisons with Canada. For physician administrative savings, Grumbach et al. compare billing costs only for the United States and Canada, using a survey of the American Medical Association for U.S. estimates.

GAO's Analysis of a Single-Payer System

GAO estimates \$67 billion in 1991 in insurer and provider administrative savings under a single-payer system based on comparisons with Canada (178).²² GAO assumes insurer overhead as a percentage of NHE will fall to the levels of Canada's system.

GAO estimates provider savings based on data it analyzed on U.S. and Canadian hospital and physician administrative costs. For hospital overhead savings, it assumes billing and management information system costs would fall to Canadian levels. For physician overhead savings, it assumes that time spent by physicians in billing, expenses for outside billing services, and nonphysician personnel levels would fall to Canadian levels.

■ Analyses of Proposals That Reform the Private Insurance Market

Analysts have estimated that reforming the private insurance market by pooling firms into large purchasing blocs and limiting underwriting would generate administrative savings (88,89, 168,214). The pooling of firms is assumed to lower administrative costs by reducing sales expenses and facilitating economies of scale in providing insurance to small employers. Limiting underwriting is assumed to lower administrative costs by reducing insurers' expenses in determining the health status of insurance applicants. If reforms stabilize the insurance market, employers may change insurers less frequently, thereby lowering enrollment expenses. Some analysts conclude, however, that certain new administrative costs would be incurred under insurance market reform, such as for forming health alliances or health plan purchasing cooperatives.

Three organizations' analyses of the Health Security Act are presented here as examples of assumptions about the effect of insurance market reform on administrative costs.²³ The examples illustrate that analysts:

- may estimate savings from pooling and limiting underwriting, although these savings are partially or completely offset by new administrative costs, yielding a small net change; and
- are sometimes unclear in their assumptions about administrative costs.

Lewin-VHI's Analysis of the Health Security Act

Lewin-VHI estimates that changes in administrative costs under the Health Security Act would

¹⁹ Referred to in table 5-2 as *single-payer plan, Woolhandler and Himmelstein version* (method 1).

²⁰ Referred to in table 5-2 as *single-payer plan, Woolhandler and Himmelstein version* (method 2).

²¹ Referred to in tables 5-1 and 5-2 as *single-payer plan, Grumbach et al. version*.

²² Referred to in tables 5-1 and 5-2 as *single-payer plan, GAO version*.

²³ For general discussion of how administrative costs may change under reform, see GAO's May 1994 report (GAO/HEHS-94-158), "Health Care Reform: Most Proposals Have Potential to Reduce Administrative Costs," and the American Academy of Actuaries' May 1994 issue paper, "Administrative Costs for Regional Alliances and Health Plans Under the Health Security Act."

have relatively little impact on total health spending. According to its analysis, administrative costs under the Health Security Act would increase by \$6.9 billion in 1998, or just 0.5 percent of what Lewin-VHI estimates total health spending will be then.

Lewin-VHI assumes the Health Security Act would reduce insurer administrative costs by “1) reducing the practice of medical underwriting; 2) restricting pre-existing condition limitations; and 3) reducing large premium variations across insurers that often lead to frequent changes in coverage” through pooling (89). It estimates that small-firm insurance load would approach the average load of large firms, using as its baseline a Hay/Huggins study comparing administrative costs for small and large firms under current policy. Lewin-VHI projects that insurance load spending by employers would decrease by 30 percent.²⁴ It also estimates small provider administrative savings due to standardized insurance benefits and reduced physician adjudication expenses.

Lewin-VHI estimates that insurer and provider administrative savings would be offset by the costs of alliances and new federal administrative costs. To estimate alliance administration costs, it assumes that there would be, on average, one alliance per one million people, or approximately 255 alliances. Each alliance would have a staff of

200 persons at a cost of \$100,000 per person, or \$20 million per alliance. Lewin-VHI does not explain how these assumptions were developed. For new federal administrative costs, Lewin-VHI uses estimates by the Administration.²⁵

Clinton Administration's Analysis of the Health Security Act

The Administration does not appear to estimate administrative costs separately under the Health Security Act. Instead, it projects NHE based on legislated or expected growth rates of insurance premiums, expenditures in government programs, and other expenditures. The act, however, makes two specific references to administrative costs. The first is that health alliance administrative costs are limited to 2.5 percent of premiums.²⁶ The second is that for the first year up to 15 percent would be added to the calculated cost of the standard benefit package for the administration of health plans and health alliances and for state premium taxes.²⁷

It estimates of federal spending under the Health Security Act, Administration officials have included small increases in spending for new federal administrative costs (32).²⁸ (It is not clear, however, what federal administrative costs the Administration includes in its estimates.)

²⁴ Specific administrative costs examined were claims administration, general administration, interest credit, risk and profit, commissions, and premium taxes. Lewin-VHI estimated administrative costs savings using a similar approach in its 1992 study of the “Bush plan.” In that study, Lewin-VHI estimated that insurance overhead as a percentage of claims for firms with one to four employers would fall from 40 percent under current policy to 18.9 percent under the Bush plan (versus 12.5 percent under the Health Security Act). Although Lewin-VHI estimates greater administrative savings to small firms under the Health Security Act than under the Bush plan, its description of its assumptions for both estimates are very similar. Lewin-VHI writes of the Bush plan, “The Bush plan would reduce administrative costs by: 1) reducing the practice of medical underwriting; 2) restricting pre-existing condition limitations; and 3) reducing large premium variations across insurers that often lead to frequent changes in coverage” (88). It is unclear why Lewin-VHI’s estimates of administrative savings under the two proposals differ despite apparently very similar assumptions about both proposals’ impacts on the insurance market.

²⁵ New federal program administration costs were estimated at \$1.7 billion in 1998. (89).

²⁶ “In no case shall a [regional alliance] administrative percentage exceed 2.5 percent.” (section 1352 (c))

²⁷ The calculated average benefit “shall be increased by an estimated percentage (determined by the Board, but no more than 15 percent) that reflects the proportion of premiums that are required for health plans and regional alliance administration. . . and for state premium taxes.” (section 6002 (b) (2) (D)) This 15 percent figure is an allowance for the first year, not a limit on the administrative costs of health plans.

²⁸ “New Federal Administrative and Start-Up Costs” are estimated at \$1.8 billion in 1998. (32)

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Administration officials may believe that under the Health Security Act insurer overhead would decrease through pooling and limited underwriting, and that provider overhead would decline in response to uniform benefits packages and electronic claims processing. Administration analysts, however, do not estimate these savings separately (202).

CBO'S Analysis of the Health Security Act

CBO'S analysis of the Health Security Act contains little discussion of administrative costs (172). Its approach may be similar to the Administration's approach. It is unclear whether CBO believes the bill would increase or decrease total administrative costs, and whether CBO believes that pooling of small firms would reduce their insurance load.

Although CBO makes no specific estimates of costs for the alliances, it indicates that they would perform such tasks as "collecting, maintaining, and updating large amounts of information on individuals, employers, and health plans." CBO does not say whether these functions could be performed within the capped allocation of 2.5 percent of premiums. It makes small estimates of "other administrative and start-up costs," although it is not clear what costs it includes.

CBO'S Analysis of Private Insurance Market Reform Proposals of the 102d Congress

CBO estimates the effects on national health expenditures of three proposals from the 102d Congress that would reform the private insurance market. In its analysis of the Managed Competition Act of 1992 (H.R. 5936), CBO assumes that pooling small firms through health plan purchasing cooperatives would reduce administrative costs.²⁹ CBO writes, "The health plan purchasing

cooperatives created by H.R. 5936 would reap some economies of scale in providing insurance to individuals and small groups." CBO, though, estimates no administrative savings for the Comprehensive Health Reform Act of 1992 (H.R. 5919), which would allow pooling but not mandate membership by small employers in health plan purchasing cooperatives, or for the Health Care Cost Containment and Reform Act of 1992 (H.R. 5502), which would limit underwriting with no pooling. CBO writes about these two bills, that "incremental changes in administrative practices would not reduce either insurers' or providers' administrative costs" (168). CBO does not define what it views as "incremental changes in administrative practices," and it is unclear from these analyses of bills from the 102d Congress how CBO would estimate the impact on administrative costs of other proposals that would reform the insurance market.

REVIEW OF THE EVIDENCE

Following is a review of the empirical evidence on potential administrative savings under reform. Included are baseline numbers on administrative costs, evidence on insurer and provider overhead under a single-payer system, and evidence on administrative costs under private insurance market reform.

■ The Baseline Numbers

In 1991, private insurance overhead and public program administration costs were estimated at \$43.9 billion by HCFA in the widely used national health accounts (86). This amounted to 5.8 percent of national health expenditures or 6.2 percent of personal health expenditures.³⁰ Private insurance overhead was estimated at \$35.1 billion, or 4.7 percent of NHE, and the cost of administering

²⁹ The Managed Competition Act of 1992 would make membership in health care purchasing cooperatives mandatory for firms with fewer than 100 employees (but would not mandate purchase of insurance through the health care purchasing cooperatives).

³⁰ Personal health expenditures are services and products associated with individual health care, such as hospital services, physician services, drugs, and nursing home care. Excluded is research and construction, public health, and administrative costs.

state and federal public programs was estimated at \$8.1 billion, or 1.1 percent of NHE (86).³¹ Provider administrative costs are also counted in estimates of NHE. They are not estimated separately, however, but instead are included with total physician expenditures.³²

■ Evidence on Administrative Costs Under a Single-Payer System

Many analysts estimate that large administrative savings could be achieved if the United States adopted a single-payer system, based on comparisons with Medicare and the Canadian health care system (see table 5-2 and figure 5-1).³³ To assess these estimates, two questions must be answered: 1) Are there differences in administrative spending between the current U.S. multipayer system and a single-payer system? 2) Would these differences be captured if the United States converted to a single-payer system?

Two elements make up analysts' estimates of reduced administrative costs under a single-payer system, insurer savings and provider savings. For insurer savings, analysts assume that a single-payer system in the United States would operate at Medicare³⁴ or Canadian³⁵ overhead rates. To understand if there are real differences in insurer overhead for these systems and the U.S. system,

this section compares estimates of insurer overhead for the various systems and addresses issues of comparability of public and private insurance systems.

Insurer Administrative Costs

Total insurance overhead in the United States was estimated to be 6.2 percent of personal health expenditures in 1991 .³⁶ Private insurance load specifically was estimated at 14.4 percent of private health insurance expenditures (86). The Health Care Financing Administration (HCFA) estimates private insurance load using a variety of data sources, which makes an assessment of its estimate difficult.³⁷

Medicare overhead was estimated to be 2.1 percent of expenditures in 1991. Estimates of Medicare overhead represent administrative spending as a percentage of total program costs, which HCFA calculates by using expense reports from Medicare and the Department of Treasury. In addition to direct expenses of HCFA,³⁸ this estimate includes expenses to the Department of Treasury, the Social Security Administration, and the Public Health Service incurred in the provision of Medicare services.³⁹

Canadian overhead was estimated to be 1.4 percent of personal health expenditures in 1990

³¹ Administrative costs of private philanthropic programs were estimated at \$0.6 billion.

³² Administrative costs incurred by employers and individuals in the health care system, though, are not included in NHE.

³³ Analysts presumably do not make comparisons with Medicaid because its eligibility determination expenses may be higher than those of a national program.

³⁴ CBO assumes Medicare overhead as a percentage of claims would apply (excluding residual Medicaid program for long-term care) ([65]; Lewin assumes Medicare per capita overhead (with adjustments for claim level and no hospital billing) would apply (147).

³⁵ ESRI (107) GAO (178) and Grumbach et al. (50), and Woolhandler and Himmelstein (212).

³⁶ Personal health expenditures rather than NHE, is used here to be consistent with analysts' treatment of administrative costs and to facilitate comparisons with Medicare and Canadian administrative costs estimates.

³⁷ The sources HCFA uses include the Health Insurance Association of America, National Underwriter Company, Blue Cross Blue Shield Association, Group Health Insurance Association of America, HCFA survey of self-insured and prepaid health plans, Department of Labor Consumer Expenditure Survey, and Visiting Nurse Association (6 I).

³⁸ Administers Medicare program. Part of the Department of Health and Human Services.

³⁹ Included as part of Medicare administrative expenses are "Treasury administrative expenses," "salaries and expenses, SSA," "salaries and expenses, HCFA, [includes intermediaries], " "salaries and expenses, Office of Secretary," "construction," "fess (mal Standards Review Organization," "Payment Assessment Committee," "policy and research," "public Health Service," "Office of Personnel Management expenses," and "physicians payment review." (15, 186).

(50).⁴⁰ The Canadian government derives estimates by compiling provincial reports on administrative spending.⁴¹ Included in estimates are provincial governments' administrative costs for providing insured services, federal government expenses, and private insurance load for supplemental insurance (178). Although the broad categories of administrative costs appear to be the same as those included in U.S. estimates, the numbers are not entirely comparable due to differing accounting methods for certain specific items (47,121,125). Other comparability issues that arise when estimating savings based on comparisons of private and public insurers include:

- Private insurance overhead includes premium taxes, which is an income transfer rather than a real expense, but public programs do not include premium taxes. Savings will be overstated if taxes are not subtracted from private overhead.⁴²
- The private insurance market is said to experience a 6-year cycle of fluctuating profitability,⁴³ affecting insurance load for any given year (42). Savings will be overstated or understated if private insurance overhead (premiums minus claims) is estimated on the basis of a single year.⁴⁴

Even in light of the comparability problems highlighted above, however, the administrative expenses of the Canadian system and Medicare appear to be lower than those of the entire U.S. system. Private insurers have certain administra-

tive costs that public insurers do not, such as marketing, profits, and costs for determining eligibility. Adopting a single-payer system will likely yield administrative savings as these private insurer costs are eliminated. Precisely estimating savings is difficult, however, and there are several reasons why assumptions that overhead rates would fall to Canadian levels (ESRI, GAO, Grumbach et al., Woolhandler and Himmelstein) or to Medicare levels (CBO,⁴⁵ Lewin-VHI⁴⁶) may be incorrect:

- The United States may not administer a nationwide single-payer system with the same efficiency as Canada or Medicare.
- Functions additional to those of the Canadian system or Medicare may be performed, such as greater utilization review or more extensive data collection.
- Average claim size may differ in the United States from those in Canada and those under Medicare, increasing or decreasing administrative costs as a percentage of claims. Lower average claim size in a national U.S. system (due to different benefits or utilization), for example, would lead to higher administrative costs as a percentage of claims.
- The Medicare program covers a limited set of benefits to a subset of the population, whereas a nationwide single-payer system may have broader benefits that would be available to the entire population.

⁴⁰ Grumbach et al. Cite "National Health Expenditures," Ottawa, Ontario: Health and Welfare Canada, 1990.

⁴¹ Canadian officials report that what individual provinces include as administrative costs varies somewhat. Reports from provinces are not detailed enough for Health Canada, the organization that estimates total Canadian health spending, to completely adjust for variance in accounting methods (121).

⁴² CBO recognizes this.

⁴³ Gabel reports that health insurers typically experience 3 consecutive years of underwriting gains followed by 3 consecutive years of losses. Premiums charged by insurers tend to reflect this cycle of losses and gains (Gabel, et. al, "Tracing," 1991),

⁴⁴ CBO and Lewin-VHI recognize this.

⁴⁵ CBO assumes Medicare overhead rates in its analysis of a general single-payer proposal (excluding residual Medicaid program for long-term care) (165). In its estimate of H.R. 1200 and S. 491, however, CBO estimates that insurance overhead will be higher than the Medicare overhead rate (170,171).

⁴⁶ Lewin-VHI adjusts Medicare rates for claim size and the elimination of hospital billing.

Provider Administrative Costs

Analysts' estimates of provider savings under a single-payer system have been as high as \$61.4 billion in 1987 (212).⁴⁷ By comparison, the highest estimate of insurer administrative savings is \$34 billion in 1991 (table 5-2) (178). Estimates of savings from reduced provider overhead appear less certain than estimates of insurer savings. Intuition indicates having physicians reimbursed by a single-payer rather than a multitude of insurers and eliminating hospital billing through hospital budgets would reduce provider administrative costs. Estimating precise provider savings is difficult, however, since estimates of provider overhead under the current U.S. system are uncertain, and there is little empirical evidence of how much U.S. providers would save under a single-payer system.

Current provider administrative costs

Definitions of what constitutes provider administrative costs vary by analyst, contributing to widely differing estimates of savings under a single-payer system. For example, one analyst defines hospital administrative costs to include expenses for billing and management information systems (178),⁴⁸ while another defines hospital administration more broadly, including expenses for such functions as utilization review, medical records, and libraries (213).⁴⁹ The narrower defi-

inition resulted in an estimate of hospital administrative savings of \$18.2 billion in 1991, while the broader definition resulted in an estimate of hospital savings of "about \$50 billion" in 1990.

There is no standard or widely accepted definition of provider overhead. Although HCFA estimates private insurance and Medicare overhead annually, no comparable benchmark of provider overhead exists.

Varying data sources contribute to the wide range of estimates of provider overhead. For example, analysts estimate hospital overhead using California data (50,87,2 12), nationwide data from the American Hospital Association (178), and nationwide data from Medicare reports (21 3). Furthermore, analysts acknowledge difficulties in estimating provider overhead because of the inadequacy of data.⁵⁰

Varying definitions, coupled with varying data sources, produce estimates of U.S. hospital administrative costs that range from 15.4 percent (178) to 33.4 percent (87) of revenues (table 5-2).

Estimates of physician overhead range from 8.3 percent (165)⁵¹ to 48.1 percent of revenues (21 2). Here too, the use of different data sources and definitions may lead to different estimates.

Estimates of physician overhead are based on data from the American Medical Association (50,178,21 2), the Medical Group Management Association (87), and the Census Bureau's Cur-

⁴⁷ Office of Technology Assessment calculation based on study's per capita estimates. Study includes savings in nUrSing administrative costs (\$4.1 billion), which is not included in other studies.

⁴⁸ GAO includes "genera] accounting, patient records, patient accounts and admitting, medical records, purchasing and stores, and data processing," and estimates overhead at 15.4 percent of total hospital expenses in 1988.

⁴⁹ Woolhandler, Himmelstein, and Lewontin's 1993 analysis of hospital administrative costs only under a single-payer system. (This analysis differs from Woolhandler and Himmelstein's study of insurer, physician, and hospital administrative costs under a single-payer system referred to in tables 5-1 and 5-2 as *single-payer plan, Woolhandler and Himmelstein inversion*.) Categories of administrative costs included in the hospital administrative costs analysis are "administrative and general," "nursing administration," "central services and supply," "medical records and library," "employee benefits department (salary costs only)," "administrative and general—home health," and "skill led-nursing-facility utilization review."

⁵⁰ Lewin-VHI notes, for example, that "comprehensive, nationwide data on administrative costs in U.S. hospitals do not exist." (Sheiks, Young, and Rubin, "0 Canada," 1992) On physician administrative costs, Woolhandler and Himmelstein write, as noted above, "Only indirect or incomplete information is available on the billing costs of Canadian and U.S. physicians." (Woolhandler and Himmelstein, "Deteriorating" May 5, 1991).

⁵¹ Primarily billing costs.

rent Population Survey (212). Two analysts estimate physician overhead using an American Medical Association survey of billing services costs and time spent by physicians in billing (50,178). Specifically, this survey asked physicians how much time they spent per month on activities related to billing Medicare and Blue Shield (5).

Estimates of physician overhead based on surveys such as this may increase levels of uncertainty, since physicians may have difficulty estimating the time they spend on administrative activities accurately (84). Directly observing physicians and recording time spent on administrative activities may yield better estimates of overhead costs (47).

Provider administrative savings under a single-payer system

Estimates of provider administrative savings vary because of uncertainty about provider administrative activities under a single-payer system. No empirical evidence documents how U.S. providers would behave under a single-payer system. (Provider expenses related to Medicare have not been isolated.) As a result, most analysts must rely instead on comparisons with Canada, and assume that under a single-payer system administrative expenses of U.S. hospitals and physicians would fall to Canadian provider levels.

Comparisons with Canada are problematic, however, because Canadian estimates may not be comparable with U.S. estimates. Furthermore, it is difficult to scrutinize estimates of Canadian provider overhead because they are based on unpublished information.⁵²

Finally, it may be unreasonable to assume that U.S. provider overhead would drop to Canadian levels. Certain functions (such as utilization re-

view) that are currently performed in the United States may continue even if hospitals were paid through budgets and physicians were reimbursed by the government at a set rate for services performed. As noted in the previous section and in table 5-2, GAO assumes that nonphysician personnel would be reduced to Canadian levels, though it is unclear that current differences stem solely from the two countries' health financing systems. CBO, which assumes Canadian provider overhead rates would apply to the United States, attempts to avoid overstating savings by comparing only those functions that relate to the ways that health care is financed, particularly billing and collection expenses. Lewin-VHI avoids comparisons with Canada and instead estimates which individual administrative functions of the current system would be reduced, and to what extent. Although Lewin-VHI's approach recognizes that administrative activities of U.S. providers may be unique, it is not based on data and may yield somewhat arbitrary estimates of savings.

Evidence on Administrative Costs Under Private Insurance Market Reform

Many proposals would reform the insurance market by limiting underwriting and permitting or requiring small firms⁵³ to purchase insurance through purchasing cooperatives. As discussed earlier, analysts appear to assume that health alliances or health plan purchasing cooperatives for small firms would reduce insurance administrative costs, but that these savings would be offset somewhat—or completely—by new administrative costs associated with insurance market reform.

In estimating savings from pooling, several analysts assume that there are differences in administrative load for large and small firms and that

⁵²GAO estimates Canadian physician overhead using "unpublished information provided by the Ontario Medical Association" and hospital overhead using unpublished data from Health and Welfare Canada (178). Grumbach et al. estimate Canadian physician overhead through data collected by written communication with D. Peachy, MD, Ontario Medical Association and hospital overhead through data collected by written communication with L. Raymer, Health and Welfare Canada (50).

⁵³The term *firm* refers to employers or groups, not insurance companies.

the load for small firms could be reduced by reforming the insurance market. This assumption raises two questions: does insurance load actually differ for small and large firms, and will proposals that would reform the insurance market reduce this small-firm load?

Theoretically, large firms may have lower administrative costs than small firms because:

- *Fixed costs are distributed over a larger number of individuals.* Enrollment (commissions, marketing) and underwriting costs may be a fixed amount per employer group. For larger firms, these costs are spread across more members, resulting in lower administrative costs per claim.
- *Turnover is lower.* Small firms may have higher administrative costs because they change insurers more frequently than large firms. Large firms, which change insurers less frequently, may have lower costs for commissions, marketing, general administration, and underwriting (157).
- *Economies of scale are greater.* Certain functions, such as processing claims, may be performed at a lower cost per claim for larger groups.
- *Risk margins are lower.* Insurers retain a portion of premiums as reserves or risk margins. Risk margins may be lower for large firms because total claims are more predictable (185).
- *Administrative support needs are lower.* Large firms may be more likely to have benefits managers to perform such services as communicating with members, which insurers themselves

perform for small firms. These services may be reflected in higher administrative costs for small firms (185).

Empirical evidence appears to support the assumption that administrative costs for large firms are lower than for small firms. A study by Hay/Huggins found that administrative expenses of small firms (1 to 4 employees) are 40 percent of claims (28.6 percent of premiums), while those of large firms (10,000 or more employees) are 5.5 percent of claims (5.2 percent of premiums) (183).⁵⁵ An unpublished study by the Health Insurance Association of America (HIAA) concludes that administrative expenses of small firms (fewer than 25 employees) are 33 percent of claims (25 percent of premiums), while those of large firms (2,500 or more employees) are 6.4 percent of claims (6 percent of premiums) (58).

However, these studies have some limitations. Neither study has a published methodology, making a critical evaluation of their methods difficult. Further, both studies are based on a small number of insurers whose experiences may not be applicable to the market as a whole.⁵⁶

Data sources for both studies are problematic as well. Private insurer expense reports are not traditionally broken down by firm size, making a comparison of administrative costs difficult (9). Both studies attempt to divide administrative expenses into specific categories, such as claims administration and commissions, even though insurers do not normally track or post administrative costs in those categories.⁵⁷ HIAA reports that there is “little consistency among insurers when looking

⁵⁴ Underwriting Practices of insurers to screen out small firms with health risks may lead to rapidly rising rates and high turnover.

⁵⁵ The Hay/Huggins study was based on insurer rating manuals, rather than insurer cost data on administrative costs. Rating manuals contain formulae which are used to charge administrative expenses to various sized firms, based on such factors as claim amounts as well as certain fixed costs. Rating manuals are based on the experience of insurers in providing administrative services to firms, though it is unclear if administrative charges generated by them precisely match actual administrative costs incurred by firms. If the difference between administrative charges and actual costs were great, however, other insurers would presumably enter the market with administrative charges closer to firms' actual costs.

⁵⁶ The Hay/Huggins study was based on three insurers (18); the HIAA study was based on five insurers (HIAA members) (57).

⁵⁷ Categories of administrative costs in the Hay/Huggins study, for example, are “claims administration, general administration, interest credit, risk and profit, commissions and premium taxes.” Lewin-VHI uses this detailed breakdown as its baseline in estimating savings under reform. (88,89)

at expenses across group size” (58). It notes difficulties in dividing insurers’ aggregate expenses by group size and into finer categories such as claims processing expenses.⁵⁸

Although both the Hay/Huggins and HIAA studies conclude that large firms have lower administrative costs under current policy; neither offers evidence to indicate insurance market reform would actually lower the administrative costs of small firms. Very little evidence exists on the effect of pooling or limiting underwriting on administrative costs. No published study has compared administrative costs of firms before and after the implementation of insurance market reform. Several states, however, have established health care purchasing cooperatives for small firms, which may provide evidence on the effect of pooling in the future.

Even if it could be stated conclusively that pooling and limiting underwriting reduce administrative costs, potential savings appear to be relatively small. Total private insurance overhead in 1991 was estimated at \$35.1 billion, or 4.7 percent of NHE (86). If private insurance overhead, estimated at 16.8 percent of claims (14.4 percent of premiums) in 1991, fell to the levels of large firms as estimated by Hay/Huggins, total savings would be \$23.6 billion (3.1 percent of NHE).⁵⁹ These savings would be achieved only if differences in

insurer administrative costs for small and large firms were completely eliminated (an assumption no analyst reviewed makes⁶⁰). Any savings from reduced provider administrative costs would likely be limited under reform plans that maintain the private insurance market because physicians and hospitals would continue to be reimbursed by a multitude of payers.

Any savings from reduced overhead for small firms may be offset partially or completely by new administrative costs. Under several proposals, new administrative organizations would be created such as health plan purchasing cooperatives and health boards, that would, among other things, negotiate with and monitor plans and update benefits packages. Several reform proposals include programs with new data gathering and reporting requirements to measure the quality of health care. The costs of operating quasi-public or private health plan purchasing cooperatives and federal programs related to pooling and limiting underwriting would depend on the functions performed and the personnel and materials needed to perform them.⁶¹ Administrative costs may increase if health plan purchasing cooperatives assume tasks currently performed by employers, such as negotiating rates with insurers.⁶²

^{58p} Anthony Hammond, policy research actuary, HIAA, who supervised the study, supplied OTA with a copy of a memorandum that briefly outlines the report’s methodology.

⁵⁹ OTA calculation. Hay Huggins estimates administrative costs of large firms at 5.5 percent of claims. If all private insurance expenditures had administrative costs equal to 5.5 percent of claims, total administrative costs would have been \$11.5 billion. $(.055 = x/209.3; x = 11.5)$. Savings is $\$35.1 - 11.5 = \23.6 billion.

⁶⁰ For example, Lewin-VHI assumes in its analysis of the Health Security Act that small-firm (one to four employees) overhead would fall to 12.5 percent of claims, not to 5.5 percent, the overhead level of large firms.

⁶¹ The California Public Employees’ Retirement System (CalPERS) has charged employers five tenths of a percent of premiums to cover CalPERS’ operating expenses (182). Costs Of administering the FEHBP program (Federal Employees Health Benefits Program) in 1988 was \$10 million, or approximately one tenth Of a percent of premiums (177). These figures do not include the administrative costs of the health plans. Unlike alliances or health plan purchasing cooperatives outlined in reform proposals which would primarily assist private firms in purchasing insurance, CalPERS and FEHBP serve public employees. For more discussion of state health plan purchasing cooperatives, see GAO’s May 1994 report, “Access to Health Insurance: Public and Private Employers’ Experience With Purchasing Cooperatives” (GAO/HEHS-94-142).

⁶² Administrative costs, as defined in the HCFA’S national health accounts, do not include costs incurred by employers in contracting for and administering health insurance to employees. These functions, if performed by health care purchasing cooperatives, would be included by analysts in their estimates of administrative costs under reform.

The complexity of private insurance market reform adds uncertainty to estimates of administrative costs under specific proposals. The potential impact of specific policies remains unclear. For example:

- Administrative costs may increase under a system of health care purchasing cooperatives as employer transactions with insurers are replaced with a greater number of individual transactions (36,1 58). Costs also may decrease as cooperatives communicate with insurers on behalf of many firms, reducing marketing costs.
- Frequent changing of insurers, which may cause higher administrative expenses, may decrease if premiums become more predictable, or increase if annual open enrollment is permitted.
- Profits of insurers may decrease in response to greater competition, or increase as a result of insurers greater market clout with providers.
- Savings from eliminating underwriting may be offset by new costs to health alliances of making risk adjustments to health plans.
- Proposals may shift individuals from fee-for-service plans to managed care plans, which may have differing administrative costs.

In summary, reform proposals that would maintain the current private insurance market appear unlikely to generate large administrative savings. Lack of evidence on the impact of pooling and limiting underwriting and the difficulty of estimating potential new costs related to insurance market reform make precise estimates of administrative costs under reform uncertain.

FINDINGS AND POLICY IMPLICATIONS

In 1991, administrative costs of private and public insurance programs (i.e., insurer overhead) under the current system were estimated at \$43.9 billion (86). This represents the maximum savings that could have been achieved by reducing insurer overhead under any of the reform proposals in 1991. Physician and hospital overhead (i.e., provider overhead) is not measured separately in the national health accounts and other estimates have limitations. Using the most conservative estimates of provider overhead generates an estimated overhead of \$55.1 billion in 1991.⁶³ Thus, completely eliminating insurer and provider administrative costs (as estimated using these data sources) would save \$98.9 billion, or 13.2 percent of national health expenditures in 1991. Of course, under no system would administrative costs be completely eliminated, but this provides a boundary for assessing estimates. Savings beyond this level are probably unrealistic.

The significance of administrative costs to estimates of changes in NHE varies by type of proposal. Predictions of administrative savings under single-payer proposals are relatively large, ranging from \$47 billion (1991 dollars) (87) to \$113 billion (1991 dollars) (108).⁶⁴ (The high estimate unrealistically assumes that total U.S. health spending would fall to Canadian levels.) Estimates of savings in insurer administrative costs under a single-payer system range from \$21.7 billion (1987 dollars) (21 2) to \$34 billion (1991 dollars) (178).⁶⁵ Predictions of savings appear plausible since administrative expenses of private insurers (including marketing, profits, and enroll-

⁶³ of ffile of Technology Assessment calculation. Grumbach et al. 's estimate of physician billing costs of 8.3 percent of physician revenues was used (50); GAO's estimate of hospital administrative costs of 15.4 percent was used (178). These estimates were multiplied by HCFA national health accounts estimates of hospital and physician expenditures for 1991. (86) (8.3 percent (\$ I 42.0) + 15.4 percent (\$288.6) -\$56.2 bill ion.)

⁶⁴ Only CBO has estimated [he specific sing] e-payer proposals of the 103d Congress, H.R.1200 or S. 491 (but does not include specific dollar estimates of administrative savings). Studies that included specific estimates of administrative savings referred to here are those that studied the impacts of a single-payer system in the United States with no patient copayments, global budgets for hospitals, and negotiated fee schedules for physicians.

⁶⁵ ESRI Which generated the estimate of \$ 113-billion total savings, does not break this estimate down into insurer and provider savings.

ment costs) would be replaced with the lower costs of a public single-payer. Estimates of reduced insurer administrative costs are informed by the experience of the Canadian system and Medicare and fall into a fairly narrow range. It is possible, however, that functions additional to those performed in Canada and under Medicare would be performed under a national U.S. single-payer system. Hence, actual insurer administrative savings may be less than analysts predict.

Estimates of reduced provider administrative costs under a single-payer system range from \$24.3 billion (1991 dollars) (87) to \$61.4 billion (1987 dollars) (21 2). It appears intuitively reasonable that physician and hospital costs incurred in billing would be reduced as the current system of multiple payers and billing requirements is replaced by a single-payer. Estimates of provider administrative savings are more uncertain than estimates of insurer administrative savings, however, due to varying definitions of provider overhead and an incomplete understanding of the administrative activities of physicians and hospitals. In addition, although Canada provides a model of provider administrative costs under a

single-payer system, it is unclear how the functions performed by U.S. providers would change under reform.

Analysts estimate that administrative costs will change very little under proposals to reform the current private insurance market. This judgment appears reasonable, since the multipayer insurance system would be maintained, with providers continuing to be reimbursed by many parties. Analysts estimate some administrative savings if small firms were to purchase health insurance through cooperatives. Although this assumption appears plausible as purchasing pools and limits on underwriting may lead to economies of scale and reduced turnover, no studies have documented the impact of pooling on the administrative costs of small firms. Analysts estimate these savings will be offset, partially or completely, by new administrative costs associated with the reforms, such as the costs of running the purchasing cooperatives. Estimates of these new administrative costs are uncertain because it is difficult to determine exactly what administrative functions would be performed, and at what cost.