Impacts on Administrative costs 8

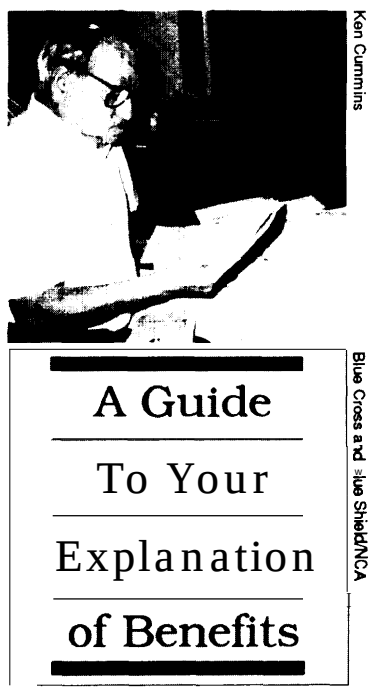
INTRODUCTION

For very small employers (one to four employees), health benefit administrative costs have been estimated to be as high as 40 percent of claims paid, compared with substantially lower percentages for larger firms (34). This percentage decreases as firm size increases (e.g., 25 percent for firms with 20 to 49 employees, 16 percent for firms with 100 to 499 employees, and 5.5 percent for firms with 10,000 or more employees) (34). The issue of administrative costs is important to the health care reform debate primarily because they are often perceived as waste (58,74,96). Yet discussion of the administrative efficiency of the health care system is hampered by the lack of a common definition of administrative costs, both in terms of *what* constitutes administrative costs and *whose* administrative costs are relevant to the discussion.

In their study of the administrative efficiency of the U.S. health care system, Woolhandler and Himmelstein examined four components of administrative costs—insurance overhead, hospital administration, nursing home administration, and physicians' billing and overhead expenses (96)-whereas Danzon maintained that:

> . . .a simple comparison of reported administrative costs can be grossly misleading. The true overhead of a health insurance system also includes all the hidden costs associated with insurance financing and operations as well as all insurance-induced distortions in the production and consumption of medical care (1 1).

Thorpe defines administrative costs as transaction-related costs, that is, benefits management, selling and marketing costs, and regulatory/compliance costs (74). These components can be examined across the health care delivery system since they are



incurred by health insurers, hospitals, nursing homes, physicians, firms and individuals. His definition is intended to facilitate the debate regarding administrative costs by permitting evaluation of them in terms of their "[s]ocial or economic cost: the value of resources used to produce administrative services as measured by their next-highest-valued alternative use" (e.g., to finance health coverage for uninsured persons) (74).

Review of the analyses of administrative costs demonstrates the importance of Thorpe's or a similar typology in furthering the debate over administrative costs. Differences in systems produce different incentives and different administrative costs. For example, Canada's global budgeting for hospitals provides fewer incentives to invest in health care information systems that collect patient cost data. This may reduce costs but it may also reduce the system's cost-management potential (82).

Underlying the debate, according to Lewin-VHI in its examination of the Canadian health care system, is a "[t]ension between product diversity and administrative cost" (34). Lewin-VHI maintained that the fundamental question behind the administrative costs debate is "[w]hether the costs of administering our multi-payer system are worth the benefits we derive from diversity in insurance products" (34).

Because studies to date have not used a common definition of administrative costs,[1] making comparisons of their findings with respect to the impact of a reform plan on these costs is extremely difficult. In order to arrive at estimates of administrative costs-savings that would accrue to the United States were one or another health care reform proposal implemented, studies have made some broad assumptions regarding what constitutes administrative costs, and about the ability to replicate (e.g., reduce U.S. administrative costs to the Canadian level) or implement a particular system in the United States. On the more technical level, for lack of better information, analyses of likely changes in administrative costs have used limited data or extrapolated from the experience of one geographic region (California) to another (United States) (24,34,96). Other assumptions include estimates regarding the maximum percent of claims expected to be submitted electronically, and the dollar savings associated with electronic claims submission.

The primary purpose of reforms that directly address the current health care services paperwork burden, such as electronic billing, claims submission, and processing, is to reduce administrative costs. Other insurance marketplace reforms directly affect the provision of insurance (e.g., guaranteed issue and renewal of coverage; requirement that policies be community rather than experience-rated; prohibition or limitation on preexisting condition clauses; prohibition on use of health status as basis for denying coverage). To the extent that these reforms simplify insurance administration, they are also likely to reduce administrative costs. Most approaches to health care reform include some or all of these reforms; therefore, most approaches would likely facilitate some reduction in administrative costs.

The Workgroup on Electronic Data Interchange (WEDI) reported to the Secretary of the Department of Health and Human Services in July 1992 that electronic data interchange (comprised of electronic enrollment and certification; electronic eligibility and verification of coverage; electronic claim submission and processing; electronic claim inquiry; and electronic payment and remittance) could produce administrative costs-savings from $4.0 to $10.0 billion, assuming implementation commencing in 1994 with several years to phase-in provisions (97).

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[1] For example, many analyses of specific proposals—Lewin-VHI for Families USA regarding the Bush administration and Clinton campaign proposals (3); Lewin-VHI for the Heritage Foundation regarding the Heritage Consumer Choice Health Plan (35)-look only at insurance administrative costs, whereas Woolhandler and Himmelstein looked at provider and insurer costs.

IMPACTS OF SINGLE PAYER APPROACHES

Canada's systems of health care financing and payment streamline health care administration by ''centralizing the source of payment for all covered health care services within each province under a single government program with uniform coverage and reimbursement rules' (34). The substantial reduction in the number of payers and transactions (e.g., claims) processed in the Canadian system are thought to reduce costs tremendously. The question has been posed whether the United States could implement a system with the same level of administrative costs as experienced in Canada, and even if the Nation could do so, whether it would want to (34).

Estimates of the impact of a Single Payer system on administrative costs range from *savings* of $18.2 billion in 1989 (77)[2] to *savings* of $113.0 billion in 1991 (43) (table 5 in chapter 1; see also appendix B). The lower estimate of savings assumed universal coverage at Medicare rates, patient cost-sharing and retention of a residual Medicaid program (77). Thus, it assumed decreases in insurance and provider administrative overhead given a simplified system involving a single payer. Yet since this estimate was not for a Canadian-style system, it assumed that some costs that would not exist in the Canadian system would remain (e.g., those associated with Medicare's hospital payment methods and copayment collection). The higher savings estimate assumed that nearly one-half of the estimated savings in national health expenditures in 1991 ($241.0 billion, assuming health care spending of no more than 8.7 percent of GDP) would flow from adopting a Canadian-style system that would yield administrative costs-savings related to private insurance overhead, hospital administration, and physicians' billing and overhead expenses.

IMPACTS OF PLAY-OR-PAY APPROACHES

While some studies have discussed the administrative cost impact of an employment-based approach, few studies have focused on such savings as a major outcome of the implementation of such an approach. Requiring broader implementation of employment-based insurance would not in itself alter the number of transactions taking place in the system since it would generally maintain the current number of payers involved and increase the numbers of people filing claims under the system. However, were the scope of benefits narrowed or the market reforms and billing practices discussed above implemented, such changes could generate cost savings, although not of the magnitude estimated under the Canadian-style system, according to the Congressional Budget Office (77).

Lewin-VHI's analysis of the impact of the America n Academy of Family Physicians' employment-based proposal on administrative costs projected *savings* of $2.8 billion in 1993 (36,37). The same analysis estimated cumulative administrative costs-savings in current dollars of $40.1 billion from 1993 through the year 2000 (37) (table 5 in chapter 1). Lewin-VHI's analysis attributed the savings to the sum of: increased administrative costs associated with insuring previously uninsured persons; savings from insurance market reform (e.g., guaranteed issue and guaranteed renewal of coverage, prohibition on use of health status as basis for denying coverage); and electronic claim submission utilizing a uniform billing system. Thus, none of the savings are inherent in the Play-or-Pay approach that AAFP favored.

IMPACTS OF APPROACHES EMPLOYING INDIVIDUAL VOUCHERS OR TAX CREDITS

As in Play-or-Pay approaches (see above), administrative savings are not inevitable under approaches employing individual vouchers or tax

[2] This Congressional Budget Office study was revised in April 1993 (81).

credits; some would even expect administrative costs to increase as a result of having individuals instead of groups choose among plans. Consequently, Individual Vouchers or Tax Credits approaches frequently incorporate reforms related to the insurance market and the paperwork burden in order to directly or indirectly affect administrative costs generated by the health care system.

Estimates of changes in administrative costs resulting from the implementation of Individual Vouchers or Tax Credits proposals range from *increased spending* of $2.1 billion in 1991 (6,35), to *savings* of $4.3 billion in 1993 (3). Estimates of future impacts of the Bush Administration proposals ranged, in current dollars, from $60.5 billion in savings from 1993 through the year 2000 for electronic claims and insurance market reforms (3) to $74.4 billion in savings, also from 1993 through the year 2000, for automating health care information (93) (table 5 in chapter 1).

The variation in the estimates appears to reflect different assumptions regarding the impact of electronic claims processing and, where examined, other broader insurance marketplace reforms on the level of administrative overhead rather than the impact of the approach per se. For example, possible increases in administrative costs due to monitoring individual compliance with requirements to buy coverage as contained in the Heritage Foundation plan do not appear to have been considered in the estimates (35).

IMPACTS OF MANAGED COMPETITION APPROACHES

Managed Competition approaches are expected to achieve administrative costs-savings through insurance market reforms and health care delivery system restructuring. However, any such savings could be offset by substantially increased costs associated with the generation and provision of quality-of-care information to consumers. Making this information available is said to be an essential feature of Managed Competition, in that it would permit potential purchasers of health insurance to compare plans on quality as well as price (29). All available analyses of administrative costs impacts of Managed Competition approaches are flawed in that they do not include the costs of providing such information. According to Lewin-VHI, there are no studies analyzing the administrative costs-savings that might result from "the unique features of managed competition" but it would likely reduce insurer and provider administrative costs "by extending large-group economies of scale to employee groups of all sizes and by reducing the number of insurers that providers must work with' (63). Thus, Sheils and his colleagues, using Lewin-VHI's analytic model and an approach to Managed Competition based largely on Starr's proposal, estimated that Managed Competition could save $11.2 billion in *insurer* administrative costs in 1993 (63) (table 5 in chapter 1). The analysis assumed that insurer administrative costs would be 3.6 percent of covered claims; this percentage was based on current administrative cost data for insured groups having 10,000 or more members. The analysis noted that State insurance premium taxes, if continued to be permitted, and the ''expanded use of utilization review and case management under managed competition' could increase administrative costs. However, the latter would likely be offset by decreased utilization of health care services (63). Even gains to providers due to standardized coverage would likely be offset by the costs of complying with utilization management programs (63). In an article intended to be a comment on the analysis by Sheils and his colleagues about the various impacts of Managed Competition, Long and Rodgers used an assumed administrative costs-savings of 8 percent in their most optimistic analysis of potential savings to the Federal Government (40); this estimate of administrative costs-savings was not Long and Rodgers' own, but was based on assumptions made in a draft of the report by Sheds and his colleagues (41). However, Long and Rodgers did

not estimate a dollar figure for administrative savings alone (40).

SUMMARY

Most analyses assume that administrative costs-savings will be realized in any of the approaches to reform under consideration. Policymakers should be aware, however, that not all of the projected administrative costs-savings are due to inherent features of the approach to health care reform. For example, neither Play-or-Pay nor Individual Tax Credits or Vouchers approaches to universal coverage would automatically lessen or increase the administrative burden of the current system. Rather, the analyses typically rely on features of proposals explicitly addressed to administrative costs (e.g., electronic billing) in order to derive savings. Further, at least in part because of differences in the definitions of administrative costs, no analysis appears to have fully thought through the administrative burdens associated with various approaches and proposals. The magnitude of any savings or increase will most likely depend upon the degree to which the system moves to electronic systems, reduces the number of payers involved and transactions processed, and does not involve offsetting increases in utilization, utilization review, case management services and activities geared to quality improvement.