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HEALTH CARE REFORM

Proposals Have Potential to Reduce Administrative Costs

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Health, Education, and
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The Honorable John Conyers, Jr.
Chairman, Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

The U.S. health insurance system is a complex and administratively expensive arrangement. It is characterized by a multitude of insurers, both private and public, each with its own eligibility requirements, benefit packages, provider rules, and claim forms. Currently, Americans receive health insurance from a wide variety of sources, including over 1,200 commercial insurers, about 550 health maintenance organizations (HMO), 69 Blue Cross and Blue Shield plans, thousands of self-insured plans operated by private employers, a federal-state program for the poor and disabled (Medicaid), and federal government programs (including Medicare and programs for the Departments of Veterans Affairs and Defense). Many believe that the complexity of this insurance system contributes to the nation's high per capita health care costs.

One of the aims of health care reform is to enhance administrative efficiency. To the extent that reform simplifies insurance administration, it may be able to reduce administrative costs. Any reductions in administrative expenses could then be used for other valuable purposes, such as expanding access and improving quality. Single-payer supporters say that a government-financed system is the most efficient way to administer health insurance.[1] Managed competition advocates say that administrative savings could come through pooling private insurance functions and insurance market reforms.[2] To assist the Congress in its deliberations on health care reform, you asked us to examine the administrative cost implications of alternative reform proposals, including a single-payer plan and three managed competition plans.

[1]"Single payer" describes a system in which all covered health care services are paid for by a single, publicly financed insurer, replacing the current mix of private and public payers. The McDermott bill advocates this approach.

[2]"Managed competition" describes a system in which consumers choose from among competing health plans and are given incentives to select the most cost-effective ones. New entities—health insurance purchasing pools—"manage" the market by selecting qualified plans, standardizing benefits, and providing comparative information. To varying degrees, the Clinton, Cooper, and Chafee bills are representative of this approach.

Background

The lack of a commonly accepted definition of "administration" and limited data on costs make it difficult to accurately measure and compare administrative costs. Administrative functions occur throughout the health care system, involving health plans, providers, and employers.[3] The most commonly recognized administrative expense, health insurance administration, consumed an estimated $44 billion in 1991, accounting for nearly 6 percent of total U.S. health spending. In addition, medical care providers face administrative costs, including those related to billing, marketing, and maintaining records, estimated at about 15 percent of hospital revenues and 8 percent of physician revenues.[4] Also, because approximately two-thirds of health coverage for nonelderly persons in the United States is employment-based, businesses have administrative costs. Employers' costs include selecting and contracting with health plans and tracking employee enrollment and premium costs.

Besides defining administration, it is even more difficult to judge the optimal level of administrative spending. The most efficient administrative system is not necessarily the least costly, because higher administrative expenses may be needed to control spending for medical services. Rather, the appropriate level of spending on health care administration can be viewed as the smallest amount necessary to achieve the overall goals of the system: expanding access, controlling costs, and maintaining high quality of care.

Substantial uncertainty underlies any analysis of health care reform's impact on administrative costs because it must project the effects of policies that have never been tried on the scale proposed. Many of the costs associated with administering a reformed system will depend on implementation details, which are not specified. For these reasons, we did not attempt to quantify cost implications. Instead, we assessed the general direction of anticipated changes in administrative costs. In general, our assessment relates to a period of operation after full implementation and excludes the initial cost to set up the basic system. We focus only on major administrative reforms that could significantly influence administrative costs. We recognize that there are a number of other administrative issues,

[3]For a typology of administrative costs and discussion of how administrative costs are incurred among various participants, see Kenneth E. Thorpe, "Inside the Black Box of Administrative Costs," Health Affairs (Summer 1992), pp. 41-55.

[4]Estimates of provider administrative costs vary due, in part, to differing definitions of administrative costs. See Congressional Budget Office, Staff Memorandum: Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates (Apr. 1993) and Canadian Health Insurance: Estimating Costs and Savings for the United States (GAO/HRD-92-83, Apr. 28, 1992).

such as costs associated with enforcement activities, that are beyond the scope of this report.

In this review, we examine how various administrative functions in the health care system could be affected by a change in the way insurance is purchased and care is paid for. We also identify various groups that carry out such functions and thereby incur administrative costs. Those groups include new entities called for in the reform proposals as well as existing sectors of the health care system. For simplicity, we focus on four groups: the public sector (including new public or nonprofit purchasing pools established in the managed competition proposals), health plans, hospitals and physicians, and employers. Appendixes I through IV summarize the administrative changes affecting each sector. A more comprehensive analysis would also include other providers of health care goods and services, such as pharmacies and nursing homes, and consumers.

To examine the implications of these reform proposals on administrative costs, we visited existing health insurance purchasing pools and interviewed government officials and trade associations representing employers, providers, insurers, and managed care plans. In addition, we reviewed relevant analyses conducted by the Congressional Budget Office (CBO), the Congressional Research Service (CRS), and the Office of Technology Assessment. Data on 1991 public and private insurance administration costs are from the Health Care Financing Administration's Office of National Health Statistics and represent the most recent year available. We conducted our review between January 1994 and March 1994 in accordance with generally accepted government auditing standards.

Overview of Reform Bills

As agreed, we studied health care reform bills proposed by President Clinton, Senator Chafee, and Representatives McDermott and Cooper.[5] Each of these bills is summarized below.

H.R. 1200: Representative McDermott's American Health Security Act of 1993

This proposal, introduced March 3, 1993, would provide universal coverage by 1995 through a federally mandated, state-administered single-payer health insurance program. The state programs would replace most existing private and public health insurance plans. The states would provide comprehensive health and long-term care benefits and prohibit out-of-pocket payments for acute care and preventive services. The state programs would reimburse physicians through negotiated fee schedules

[5]For a more thorough comparison, see CRS, Summary Comparison of Major Health Care Reform Bills, 94-71 EPW (Washington, D.C.: Jan. 6, 1994).

	and hospitals would receive prospectively set budgets. A national health budget would limit growth in health spending to the growth rate of the economy. The program would be primarily financed through increased federal payroll and income taxes and the imposition of a health security premium. (Companion bill: S. 491, introduced by Senator Wellstone.)
H.R. 3600: President Clinton's Health Security Act	This proposal, introduced by Representative Gephardt on November 2, 1993, aims to achieve universal health coverage by 1998. Most employers and individuals would be required to join regional health alliances; large employers (over 5,000 employees) would have an option of forming their own corporate alliance; and Medicare beneficiaries could continue to receive public coverage distinct from the alliance framework. Alliances would contract with at least three types of health plans. Premiums would be community-rated, pre-existing condition exclusions would be prohibited, and benefit packages would be standardized with supplemental coverage available. Employers would be required to pay 80 percent of the cost of the average premium, but no more than 7.9 percent of their annual payroll. Discounts and subsidies would be available to smaller employers, early retirees, and low-income individuals. The National Health Board would establish a national health budget, enforced through limits on health plan premium increases tied to overall economic growth. (Companion bill: S. 1757, introduced by Senator Mitchell.)
H.R. 3222: Representative Cooper's Managed Competition Act of 1993	Introduced on October 6, 1993, this proposal attempts to expand coverage by improving the affordability and availability of health insurance. Employers would be required to arrange for health coverage, but would not have to contribute toward the premium. Small employers and individuals would be offered private health coverage through health plan purchasing cooperatives; larger employers (more than 100 employees) would be excluded from the health plan purchasing cooperatives, but could form their own purchasing pools. Expenses for accountable health plans would be tax deductible only up to the cost of the lowest-cost basic plan in the area. Accountable health plans would offer standardized benefit packages at community rates, and pre-existing condition exclusions would be prohibited. A federal commission would recommend a uniform set of benefits, including cost sharing provisions, for congressional approval. Medicaid would be eliminated and replaced with federal subsidies for low-income individuals to purchase private health coverage through the health plan purchasing cooperative. Medicare beneficiaries would continue to receive publicly sponsored coverage. The

proposal would not set enforceable limits on the growth of health spending. (Companion bill: S. 1579, introduced by Senator Breaux.)

S. 1770: Senator Chafee's Health Equity and Access Reform Today Act of 1993

This proposal, introduced November 22, 1993, would require all individuals to purchase health insurance by 2005. Employers would be required to offer their employees enrollment in a qualified health plan, but would not have to contribute toward the premium. Small employers (fewer than 101 employees) and individuals would have the option of joining a state-established health insurance purchasing group or selecting another qualified health plan; larger employers could form their own purchasing groups. Tax deductibility of premiums paid for qualified health plans would be limited. Qualified plans would need to offer standard benefits, use community rating, and limit pre-existing condition exclusions. Individuals could select either the standard benefit package or a catastrophic benefit plan, both of which would require cost sharing. Federal vouchers to subsidize the purchase of private health coverage by low-income individuals would be phased in (contingent on savings in the Medicare and Medicaid programs). The proposal would not establish a national health care budget. (Companion bill: H.R. 3704, introduced by Representative Thomas.)

Results in Brief

All of the proposals we examined would shift many private insurance-related administrative functions to the public sector. They have the potential to reduce administrative costs by introducing other reform elements intended to improve access and efficiency. The single-payer approach would have a greater potential for administrative savings because insurance would be largely replaced by a government plan in each state. Administrative savings would result from eliminating the need to enroll employers and individuals, design and market benefit plans, and collect premiums. Administrative savings could also be achieved under the managed competition approach, but to a lesser extent because the structure of the health insurance system would remain essentially intact. Regional insurance pools would be created to consolidate enrollment, marketing, and premium collections currently performed by private health plans, thereby achieving economies of scale lacking in today's insurance market.

All of the proposals also include provisions to develop electronic health care information systems, expand coverage, subsidize premiums, and standardize benefit packages. Universal coverage and standardized benefits would be likely to reduce administrative costs by simplifying

eligibility, but would increase costs for coverage of the newly insured. Similarly, electronic information networks require a substantial initial investment in computer capability, but could simplify transactions, risk-adjustment calculations, and comparative quality assessments of plans and providers. Finally, under managed competition—depending on the method employed—the need for income eligibility determinations to administer subsidies could be a source of substantial new administrative costs. Because the proposals differ in the extent to which they adopt these features, each proposal's overall influence on administrative costs would also vary.

Provisions under both reform approaches could have major cost-increasing and cost-reducing implications for governments, health plans, hospitals and physicians, and employers:

- For the public sector, administrative costs could increase under either approach as functions would be shifted from the private to the public sector. Under the single-payer proposal, each state would have the responsibility of administering the health insurance system, with the state's overhead costs limited to less than 3 percent of health spending. Under the managed competition approach, new public or nonprofit health insurance purchasing pools would be developed. The costs of operating the regional pools, when specified in the bills, would be capped at 1 or 2.5 percent of benefits, depending on pool size and responsibilities. The federal and state governments would also have greater regulatory responsibilities over financing and data collection.
- For health plans, a single-payer system could nearly eliminate administrative costs by limiting private insurers to selling supplemental coverage. Managed competition could also offer substantial administrative cost savings by grouping small firms and individuals into regional insurance pools and standardizing benefits and claims processing. To the extent that additional quality data requirements would be imposed on health plans, savings might be somewhat offset.
- For hospitals and physicians, administrative costs might decline. All of the proposals seek to streamline billing, collections, and benefits management. However, some providers are concerned that reform will impose new requirements to gather and transmit information on costs, quality, and health outcomes; such requirements could add to administrative costs. Still, a single payer would also eliminate the costs that providers currently incur as a result of dealing with multiple payment and utilization management sources.

- For employers, the costs of administering health coverage would depend on their size and whether they are currently offering insurance. In a single-payer system, employers could simply deduct a fixed-rate tax from payroll with no other direct involvement in providing health coverage. Under managed competition, costs could increase for newly covered employers and decline somewhat for firms participating in the regional purchasing pools. There would be little or no impact on other firms.

Proposals Shift Insurance Administrative Costs From Private to Public Sectors

The proposals we reviewed would shift many administrative functions from the private sector to government and new nonprofit entities. However, the scale of the public sector's new administrative role and the distribution of functions among public entities varies widely among the proposals. The single-payer proposal would establish state-based payers to replace the private administration of health insurance, whereas the managed competition proposals would maintain private insurance and create a system of health insurance purchasing pools.[6] Overall, the legislative proposals offered by Representative McDermott and President Clinton would entail a relatively larger expansion of the public sector role than those offered by Senator Chafee and Representative Cooper. As public and nonprofit entities would assume a greater role in providing health coverage or promoting competition among health plans, spending on administration might decline for private health plans, providers, and employers.

Single Payer

The single-payer approach would go further in the shift from private to public administration of health insurance; it would replace most private insurance coverage with government-administered insurance programs at the state level. Proponents of this approach contend that competition among private health plans creates duplicative and inappropriate administrative activities that increase costs. This approach proposes public administration of health insurance that replaces or eliminates the transactions, benefits management, marketing, and quality monitoring functions that the private sector currently undertakes.

In the McDermott plan, these insurance administration roles would be undertaken by the states, greatly expanding their current role in the health care system. The McDermott bill specifies that the states' administrative costs would be limited to 3 percent of health expenditures. States would

[6]Health insurance purchasing pools are referred to as "regional alliances" in the Clinton proposal, "health plan purchasing cooperatives" in the Cooper proposal, and "purchasing groups" in the Chafee proposal.

have the administrative responsibility of reimbursing health care providers for health services rendered and monitoring the use and quality of care.

Existing public insurance programs in the United States and Canada, which may serve as limited models of potential public sector administrative costs under a single-payer system, have relatively low administrative costs. Medicare, the primary source of health coverage for nearly all Americans over 65, enrolls about 35 million individuals and has administrative costs of about 2.1 percent of program expenditures.[7] Similarly, Medicaid, a state-based program serving about 25 million low-income Americans, has relatively low administrative costs equaling 4.0 percent of expenditures.[8] Ontario, the largest Canadian province, which administers a single-payer system to 9.4 million individuals, has average administrative costs of 1.3 percent of health care spending.[9]

With an almost complete shift from a mix of private and public health coverage to a single public payer, the administrative costs faced by private health plans, providers, and employers could be reduced:

- Private health plans would be virtually eliminated under the McDermott plan.[10] Because public insurance programs typically have lower administrative costs than private insurance plans, this shift could lead to significant net administrative savings. The Health Care Financing Administration estimated that in 1991, administrative costs accounted for about 14 percent of expenditures in private health plans compared to less than 3 percent for public plans. CBO estimates that the McDermott proposal would lower insurance administrative costs to 3.5 percent of health care spending by the year 2000.[11]
- Providers' administrative costs associated with insurance transactions could also be substantially cut through reduced paperwork and billing in a

[7]Like Medicare, the McDermott plan allows contracts with third-party carriers to reimburse physicians based on claims. However, the McDermott plan would not require the collection of copayments and deductibles for most services, whereas Medicare does.

[8]Unlike Medicaid, state single-payer system as proposed by McDermott would not need to make eligibility determinations because all citizens would receive coverage.

[9]The Canadian single-payer system is similar to the McDermott plan in that determining eligibility is not necessary and copayments and deductibles for acute care services are prohibited. However, in Canada little quality monitoring occurs, whereas the McDermott bill would require an enhanced data collection system to enable quality monitoring and to establish budgets.

[10]Limited private coverage would remain under the McDermott proposal in the form of supplemental insurance, which may only cover benefits not included in the comprehensive package specified in the bill.

[11]See CBO, analysis of H.R. 1200, The American Health Security Act, issued on December 16, 1993.

single-payer system. Expenses incurred by hospitals and physicians as a result of multiple claims and billing procedures could be lowered significantly by having one insurance entity in each state and using global budgets for hospital care. CBO estimates potential administrative savings of about 6 percent of revenues for hospitals, physicians, and other providers.[12]

- Employers' roles in administering health benefits could be reduced to paying an increased payroll tax set at a percentage of wages if the McDermott plan is enacted. This tax would be fairly easy to implement and would relieve employers of the costs associated with selecting among and contracting with multiple plans.

Managed Competition

The managed competition approach similarly, but to a lesser extent, would shift many private insurance functions to the public or nonprofit sector. In particular, the managed competition proposals would create health insurance purchasing pools to consolidate purchasing by many employers and individuals and bring economies of scale. Generally, these purchasing pools would contract with health plans, provide comparative information for consumers, enroll individuals, collect premiums, and distribute payments to health plans. Compared to the Cooper or Chafee plans, the purchasing pools proposed by the Clinton plan would be larger in both size and range of responsibilities.

The three managed competition proposals attempt to build on the experience of existing public and private purchasing pools. In 1993, Florida and Washington each enacted health care reform legislation that establishes voluntary regional purchasing pools. Other public-sector purchasing pools include the California Public Employees' Retirement System (CalPERS), the Health Insurance Plan of California, and the Federal Employees Health Benefit Program (FEHBP). Also, 45 states have private-sector purchasing pools, such as the Council of Smaller Enterprises, a nonprofit association for small businesses in Cleveland, Ohio, and the Business Health Care Action Group and the Employers Association Buyers' Cooperative, both in Minneapolis, Minnesota.

The health insurance purchasing pools differ in scale across the bills. The Clinton proposal represents a greater shift to the public sector than do the Chafee or Cooper plans. The Employee Benefit Research Institute

[12]Estimates of the cost implications of adopting a single payer system vary. Previously, we estimated potential administrative savings of about 10 percent for physicians and about 6 percent for hospitals under a Canadian-style single-payer system. See Canadian Health Insurance: Estimating Costs and Savings for the United States (GAO/HRD-92-83, Apr. 28, 1992), pp. 12-13.

estimates that at least 70 percent of the population would purchase their insurance through regional alliances.[13] The Cooper and Chafee purchasing pools would be significantly smaller in size because individuals would not be required to purchase coverage through the pools; participation would be targeted to firms with fewer than 101 employees, individuals, and Medicaid recipients.[14] The managed competition proposals also differ in several key features: (1) mandatory versus voluntary participation, (2) the size threshold for employer participation, (3) the requirement for employers to contribute to premiums, and (4) additional responsibilities beyond the basic purchasing pool functions previously described. Table 1 summarizes these differences among the proposals.

[13]This estimate recognizes that Medicare beneficiaries and workers in firms of 5,000 or more employees might not purchase insurance through the regional alliances. However, many workers in these large firms would instead enroll in regional alliances if their employer decides not to form a corporate alliance, they are employed part-time, or their spouse works for a smaller employer.

[14]About 45 million workers were employed by firms with fewer than 100 employees in 1990, and 28 million individuals received Medicaid in 1992.

Table 1: Distinguishing Features of Health Insurance Purchasing Pools in the Clinton, Chafee, and Cooper Proposals

	Clinton	Cooper	Chafee
Size threshold and participation	Mandatory for firms with fewer than 5,000 employees Larger employers may opt to join regional alliance or form a "corporate alliance"	Optional for firms with fewer than 101 employees[a] Larger employers could not join purchasing cooperative, but may form own purchasing pools	Optional for firms with fewer than 101 employees[b] Larger employers could not join small employer purchasing group, but may form own purchasing pools
Employer contribution to premiums	Required[c]	Not required	Not required
Additional responsibilities	Disseminate quality data Risk-adjust plan payments Administer subsidies Negotiate premiums Set provider fee schedules to enforce budgets	Collect, analyze, and disseminate quality data Risk-adjust plan payments	None specified

[a]All employers with fewer than 101 employees must contract with their area health plan purchasing cooperative to offer health plans, but are not required to pay for any coverage. However, eligible employers may claim a tax deduction for health benefits paid only if provided through the health plan purchasing cooperative, encouraging participation in the cooperative.

[b]All employers with fewer than 101 employees must offer qualified insured health plans, but are not required to contract with the small employer purchasing group or pay for any coverage. Eligible employers may claim a tax deduction for health benefits paid if coverage is provided through any qualified health plan.

[c]Employers contribute 80 percent of the weighted average premium. This amount is limited by a cap of 7.9 percent of payroll. The cap on payroll is lower for small businesses (fewer than 75 employees) with low average payrolls (less than $24,000)—between 3.5 percent and 7.9 percent.

The administrative costs of the new health insurance purchasing pools would be explicitly limited in the Clinton and Cooper proposals. For the regional alliances established under the Clinton plan, overhead costs would be capped at 2.5 percent of premiums.[15] The health plan purchasing cooperatives in the Cooper plan would be limited to overhead costs of 1 percent of premiums. Tightly enforced caps on the pools' administrative

[15]CBO estimates that regional alliance administration would cost about $11 billion in 1998. Lewin-VHI estimates that administrative costs for regional alliances would be about $5 billion in 1998. See CBO, An Analysis of the Administration's Health Proposal (Feb. 1994) and Lewin-VHI Inc., The Financial Impact of the Health Security Act (Dec. 9, 1993).

expenses could force pools to shift responsibility for such items as premium collection to health plans. The Chafee proposal would not establish a specific administrative cost ceiling for purchasing groups.

Existing purchasing pools (which also vary in scale and responsibilities) may serve as limited models of the potential administrative costs of the proposed purchasing pools. Generally, the existing purchasing pools have administrative costs of 3 percent of benefits paid or less. The largest of these, CalPERS and FEHBP, have the lowest percentage of administrative costs, 0.5 percent and 0.15 percent, respectively, indicating that they may have achieved economies of scale not met by the smaller purchasing pools. This finding could also reflect differences in the range of functions performed by purchasing pools.[16]

The development of these new public and nonprofit purchasing pools could have a major impact on the portion of health insurance dollars spent to administer private, employment-based coverage. The most significant reduction would be noticed in the administrative costs of insurance plans for small employers.

- For health plans, the managed competition proposals would substitute a single contract with the purchasing pool for insurance contracts with a multitude of employers. Currently, administrative costs for health plans associated with the smallest employers are 40 percent compared to 5.5 percent for health plans associated with the largest employers.[17] By offering insurance through a pool, health plans' average administrative costs could more closely reflect those for health plans associated with larger employers.[18] Small employers could therefore see a reduction in their premium attributable to the decrease in health plans' administrative costs.
- Providers' administrative costs would not be significantly affected by the development of purchasing pools.

[16]The existing purchasing pools with administrative costs of 2 to 3 percent reflect the fixed cost and small enrollment of several publicly sponsored voluntary purchasing pools for small businesses. For additional information on existing purchasing pools, see Access to Health Insurance: Public and Private Employers' Experience With Purchasing Cooperatives (GAO/HEHS-94-142, May 31, 1994).

[17]See CRS, "Costs and Effects of Extending Health Insurance Coverage" (Washington, D.C.: Oct. 1988).

[18]Health plans' marketing costs could be increased when offering coverage through a purchasing pool. Currently, health plans focus marketing at the employer level because employers choose one or several plans to offer their employees. Under a purchasing pool framework in which individuals, rather than employers, select plans, the health plans could expand their advertising to attract individual enrollees. However, individuals might change plans less often because they no longer would need to change plans when they change jobs.

- Employers' roles in administering health coverage, if eligible to participate in the pools, could be reduced to making payments to the purchasing pools. Employers currently offering insurance would be relieved of having to deal with multiple health plans and administer health benefits. At the same time, proposals would require employers to track and report enrollment information on employees.

Improved Efficiency and Access Could Lower Administrative Costs

In addition to shifting insurance-related administration from the private to the public sector, the health care reform proposals contain several elements that, taken together, could reduce administrative costs. In some cases, these features would accelerate current trends designed to improve efficiency and access. These elements include (1) expanding coverage, (2) standardizing benefits, (3) developing electronic health care information systems, and (4) administering subsidies. Although all of the proposals share these features, they vary in degree and timing. While in some cases these elements may raise administrative costs, they are designed to facilitate other features of the proposals.

Universal Coverage

Using different timetables, the McDermott, Clinton, and Chafee bills each call for universal coverage of health insurance. Much of the health care received by the over 37 million Americans who are currently uninsured is uncompensated, prompting providers to recover additional compensation from the insured. By providing universal coverage and reducing uncompensated care, transaction costs related to determining insurance status and debt collection could be reduced. However, since uninsured individuals do not currently generate any plan overhead costs, placing these individuals in public and private insurance plans could add to insurance administrative costs.

The proposals resemble efforts initiated in several states to expand coverage to currently uninsured and underinsured populations. Hawaii has mandated that employers provide insurance coverage and established public programs for the nonworking uninsured.[19] Other states, such as Minnesota, Washington, and Florida have also enacted comprehensive reforms aimed at expanding health coverage.

Three of the four proposals would explicitly provide for universal coverage. However, they vary in the length of the phase-in period and

[19]See Health Care in Hawaii: Implications for National Reform (GAO/HEHS-94-68, Feb. 11, 1994).

whether universality is achieved through an employer mandate, an individual mandate, or establishing an entitlement.

- The McDermott bill would create an entitlement for all U.S. citizens to receive health coverage from the state government beginning in 1995.
- The Clinton bill would mandate that employers offer and contribute to health coverage. By 1998, all U.S. citizens would be required to enroll in a health plan offered through a regional or corporate alliance or through Medicare.
- The Chafee bill would require that all U.S. citizens purchase coverage from a qualified health plan. Employers would be required to arrange for, but not pay for, coverage. Vouchers to make coverage affordable to low-income families would be phased in, with the goal of achieving universal coverage by 2005 contingent upon savings from Medicare and Medicaid.
- The Cooper bill would not guarantee universal coverage, but would attempt to expand access by making insurance market reforms, pooling small businesses into purchasing groups, and providing subsidies to low-income families.

Universal coverage could simplify insurance transactions for providers because the hospital or physician would no longer need to confirm insurance coverage prior to rendering treatment. However, to the extent that benefits and payment rules would vary, the provider might still need to determine particular restrictions on the patient's coverage. (See the following discussion regarding standardization of benefits.) Furthermore, the physician or hospital could expect reimbursement for the care provided, lowering the cost of debt collection.[20]

As mentioned, individuals who are currently uninsured would receive health coverage through either public or private insurance programs, adding insurance administrative costs. Universal coverage under the McDermott plan would impose a smaller increase in insurance administrative costs for the newly insured than the Clinton and Chafee plans. In addition, the level of health care utilization of the newly covered would rise to that of the comparable insured population. This greater use of medical services could also increase provider administrative costs. However, it is not clear to what extent increased costs would offset the

[20]The provider could still be responsible for collecting any applicable copayments and deductibles from the patient. Thus, the McDermott bill, which would eliminate most copayments and deductibles, would more completely eliminate debt collection costs for providers than would the managed competition bills. "Balance billing" refers to patients being charged beyond the fee schedule rate assigned for any service provided.

administrative savings achieved by simplifying insurance determinations and debt collections.

Standardized Benefit Packages and Other Market Reforms

Efforts to standardize benefit packages could reduce administrative costs for providers, purchasers, and health plans. Currently, providers and their staffs sort through various payment rules and cross-check provisions with individual claims. Standardized benefit packages that have uniform payment rules could reduce this time-consuming and costly process. For employers, standardization could allow purchasers to more easily compare and select health plans. Health plans could also reduce their administrative costs through standardization by not having to customize plans; thus, reviews of claims would be simpler. Finally, the reform proposals include other insurance market reforms, such as eliminating pre-existing condition exclusions and community rating—strategies that could reduce insurer's costs for medical underwriting.

The proposals reflect current trends in which some states and purchasing groups have begun standardizing benefit packages. In 1993, CalPERS introduced a common benefit package for participating HMOs that included 13 standard benefits, 3 required benefits, and 4 optional benefits. Washington's 1993 health reform provides that a 5-member Health Services Commission will establish a uniform benefit package and set a maximum premium for it. Other states, such as Florida, Iowa, and North Carolina, have established standard minimum benefit plans for the small employer market.

A more comprehensive standard benefit package, such as proposed in the Clinton and McDermott bills, would more fully achieve administrative savings from standardization. (The Chafee and Cooper bills would defer the specification of the benefit package to a national board.) A less comprehensive standard benefit package would leave a large role for supplemental insurance policies that would lack the advantages of standardization. Thus, if a number of plans were used, providers would still need to keep track of various coverage rules and limits.

The single-payer proposal would most completely eliminate the variation among benefit plans because its uniform comprehensive package would replace the currently existing multiple packages. Supplemental coverage would be an option only for limited benefits, such as dental and vision services and copayments for drugs and long-term care. The single-payer

system would also most fully standardize the payment rates and rules for providers and prohibit balance billing for consumers.

Although the managed competition plans maintain multiple competing health plans, the standard minimum benefit package would reduce the variation among them. However, if the standard minimum package in these plans were set at a level lower than the typical coverage that would be purchased, then the administrative complexity for providers could persist. Also, the Clinton, Cooper, and McDermott proposals would prohibit balance billing, thereby further reducing the administrative costs of collecting reimbursement.

In addition to standardizing the minimum level of coverage, other insurance market reforms, such as community-rating premiums and eliminating pre-existing condition restrictions, could reduce administrative costs associated with medical underwriting. Currently, experience rating and pre-existing condition exclusions both require the health plan to determine the individual's health status through a physical exam or medical history review, or to determine the group's insurance experience through a review of claims. In contrast to the currently prevalent experience-rating, insurers would charge all groups the same amount for the same coverage under community-rating, without regard to the history of medical service use—and consequent costs—of a particular group.[21] Pre-existing condition exclusions are common in many health plans, prohibiting individuals with a medical condition, such as diabetes, from receiving coverage for that condition.

The Clinton and McDermott plans would prohibit pre-existing condition limits, whereas Cooper and Chafee would restrict their use. Each of the managed competition proposals would require community-rating for plans offered through the purchasing pools.[22] Lewin-VHI estimates that eliminating underwriting expenses and restricting pre-existing condition limitations would reduce health plan administrative expenses for small firms by as much as 30 to 50 percent.[23]

[21]Although the premiums paid by employers and individuals would be community-rated, the premiums paid by the purchasing pool to the health plan would be risk-adjusted in the Clinton and Cooper plans. Depending on the method used, risk adjustment might require medical history reviews or medical exams—similar to the current medical underwriting.

[22]The Cooper and Chafee proposals would allow age as a factor in determining premiums.

[23]For firms larger than 50 employees, these changes would lead to little or no administrative savings. See Lewin-VHI Inc., "The Relationship Between Firm Size and the Health Care Cost of Workers" (Washington, D.C.: Mar. 14, 1994).

Health Care Information Systems

All four health care reform proposals have provisions that intend to reduce administrative costs and complexity by standardizing health care information and supporting the transmission of data by electronic networks. Although developing and maintaining the infrastructure for a health care information system may have high costs,[24] a uniform health care information system could reduce administrative costs overall.[25] Administrative savings could be achieved by standardizing the data collected and avoiding duplication by providing a common data repository available to governmental agencies, purchasing pools, and consumers. The health care information network could also realize additional goals of health care reform that would be more administratively complex without an integrated data network. Such goals include the comparison of providers and health plans for making premium adjustments and assisting consumers in making informed choices of plans and providers.

The provisions would accelerate current trends. For example, the American National Standards Institute recently approved a standard health insurance form that all companies are expected to use. Several initiatives are developing a common set of data elements for measuring quality. These include the "Health Plan Employer Data and Information Set" sponsored by the National Committee for Quality Assurance, and an outcomes measurement project initiated by the American Group Practice Association to collect data on six health conditions.[26] Finally, providers and health plans are increasingly transmitting and processing claims electronically. The proportion of providers who have the capability of filing claims electronically has increased steadily to 54 percent of physicians and 70 percent of hospitals by 1993. In early 1993, Blue Cross and Blue Shield Association, International Business Machines, and Medical Management Resources formed a joint demonstration project, EDI-USA, intended to create an electronic network for coordination between insurers and health care providers.

[24]A task force organized by the Department of Health and Human Services, the Workgroup for Electronic Data Interchange (WEDI), estimated that, to effectively participate in a standardized electronic data interchange environment, total one-time implementation costs for providers, payers, and employers would range from $5.3 billion to $17.3 billion. See Workgroup for Electronic Data Interchange, 1993 WEDI Report, Oct. 1993.

[25]WEDI estimates an annual administrative savings for the core transactions—claims submission, enrollment, payment and remittance, eligibility, and claims inquiry—to range from $8.2 billion to $19.7 billion. Blue Cross and Blue Shield estimates potential insurance claims administrative savings of as much as $1.5 billion if electronic data interchange is adopted.

[26]The six conditions are total hip replacement, total knee replacement, cataract extractions, diabetes, adult asthma, and low back pain.

All of the reform proposals have similar goals of developing a comprehensive health care information system.[27] The data could then be used to (1) compare providers, health plans, purchasing pools, and state programs; (2) detect fraud, waste, and abuse; (3) calculate premiums; and (4) determine where and how health care dollars are spent, enabling better cost and utilization controls. However, the proposals differ in who would be responsible for the system and when it would be implemented.

- The McDermott bill would have each state health program develop a uniform electronic database, using standard software designated by the national board, by the year 2000. A health identification card would be issued to all eligible individuals and the national board would assign unique provider numbers.
- The Clinton proposal calls for implementing, within 2 years of enactment, a comprehensive national data system. Each individual would have a health identification card and providers would have distinct identifiers. Eventually, the proposal envisions an electronic network whereby data would be collected electronically for each clinical encounter for use by employers, health plans, and regional alliances. The data would then be transmitted to regional centers for distribution to government agencies, purchasing pools, and consumers.
- The Cooper plan proposes that a national commission establish goals, standards, and timeframes for the electronic receipt and transmission of health plan information. At least annually, plans would provide health plan purchasing cooperatives with information in a standardized format on prices, health outcomes, and enrollee satisfaction.
- The Chafee proposal would phase in over 3 years a health care data interchange system that would make information available on a uniform basis to all participants in the health care system. Data clearinghouses would collect data directly from providers and consumers, rather than from health plans or third-party payers.

Subsidy Programs

Some analysts view the proposed subsidy programs as a potential source for significantly greater administrative costs, although there is considerable uncertainty about the level of resources required for program administration. Each of the managed competition bills would provide subsidies to low-income families. The Clinton plan also would offer subsidies and discounts for employers, unemployed and self-employed

[27]All of the plans also call for protection of privacy and confidentiality of the data provided by the health care information systems.

individuals, and families with incomes of up to $40,000.[28] (The McDermott proposal would be financed by increased payroll and income taxes as well as imposition of a health security premium. It would not include direct subsidies.)

Administrative costs would result from subsidy programs because families (and employers, under the Clinton plan) would need to report information regarding income, family or employer size, and health premium costs to alliances or the government to become eligible for subsidies. Subsidy administration would also require either the alliances or the government to (1) determine eligibility; (2) calculate the subsidy; (3) distribute the subsidy to the health plan, employer, or family; and (4) reconcile the premium contributions due to changes such as income or family size that occur throughout the year. This process could be comparable to the process that states undertake to determine eligibility for Medicaid or cash-assistance programs, although without the additional difficulty of an asset test.[29]

The managed competition proposals vary in the standards used to define who would be eligible for low-income subsidies:

- Under the Clinton plan, Medicaid recipients would be integrated into the regional alliance system and subsidies would be available to employers, unemployed and self-employed individuals, and families with annual incomes of up to $40,000.
- The Cooper proposal would provide full subsidies for health coverage to persons with incomes below the poverty level and partial subsidies to persons up to 200 percent of the poverty level. Federal spending on subsidies is contingent upon budget savings, with health plans bearing any shortfalls.
- In the Chafee plan, a voucher system would be phased in for persons to purchase private health insurance. By 2005, the eligibility level would be expanded to persons below 240 percent of the poverty level. The amount of federal funds for the voucher program would be contingent upon cost savings from Medicare and Medicaid.

[28]For further discussion of subsidies in the Clinton and Chafee proposals, see National Academy of Social Insurance, The President's Proposal for Health Care Reform: An Overview of the Administrative Structure (Washington, D.C.: Feb. 15, 1994); and Senator Chafee's Proposal for Health Care Reform: An Overview of the Administrative Structure (Washington, D.C.: Mar. 15, 1994).

[29]An asset test is difficult to implement because it requires verification of an individual's non-income assets. Thus, documentation of a person's payroll earnings or income tax would not be sufficient under an asset test.

The costs of administering subsidies would depend on the method used to determine eligibility. To the extent that Medicaid eligibility procedures remain intact, the process would be simplified. Under the Clinton plan, for example, persons receiving Aid to Families with Dependent Children or Supplemental Security Income would be deemed eligible to receive subsidies automatically, based on existing Medicaid eligibility procedures. Other persons seeking subsidies under the Clinton plan would undergo a different process to determine eligibility.

For the non-Medicaid population, the alliances in the Clinton plan would be required to develop a capability to collect and verify similar information from individuals and employers. The Cooper and Chafee proposals would require other federal government agencies to administer subsidies. A simplified approach to identifying those eligible for subsidies would be to link the administration of the subsidies with the tax system by having the Internal Revenue Service (IRS) estimate subsidies.[30] This could be administratively less expensive because, through their tax filings, employers and individuals already provide income and family size information necessary for determining subsidies. Also, the IRS has existing capacity to verify incomes. However, any system based on estimating income will require a reconciliation process to correct for changes that could occur during the year.

Finally, in addition to the family subsidies and discounts, the Clinton proposal would cap employers' contributions to premiums. For all firms with more than 75 employees, this cap would be set at 7.9 percent of payroll; for smaller firms, the cap would be set on a sliding scale between 3.5 percent and 7.9 percent based on average payroll. A firm meeting these payroll caps would pay less than the 80 percent share of the weighted adjusted premium. CBO estimates that as many as three-fourths of employers (representing about half of employment) would qualify for these caps. Determining eligibility for employer premium discounts resulting from these caps would require the employer to report basic size and payroll information to the regional alliances. However, like Social Security taxes and other payroll deductions, employers could add an accounting line-item to their payroll system with subsequent year-end reconciliation, minimizing the need for additional administrative costs.

[30]If the IRS would not directly determine eligibility, then states could assist eligibility decisions by confirming income tax records.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to interested parties and make copies available to others on request.

Please call Rosamond Katz, Assistant Director, on (202) 512-7148 if you have any questions regarding this report. Other major contributors include John Dicken and Trisha Kurtz, health policy analysts, and Craig Winslow, senior attorney.

Sincerely yours,

Mark V. Nadel
Associate Director, National and
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Contents

Abbreviations

CalPERS	California Public Employees' Retirement System
CBO	Congressional Budget Office
CRS	Congressional Research Service
FEHBP	Federal Employees Health Benefits Program
GAO	General Accounting Office
HHS	Health and Human Services
HMO	health maintenance organization
IRS	Internal Revenue Service
PPRC	Physician Payment Review Commission
PRO	peer review organization
ProPAC	Prospective Payment Assessment Commission
WEDI	Workgroup for Electronic Data Interchange

Implications for the Public Sector

Both the managed competition and single-payer approaches to health care reform call for an expansion of the public sector's administrative role in the health care system. Among the four bills we examined, many functions assigned to the public sector are similar. The public sector would assume many insurance functions currently performed by the private sector, and would perform additional functions designed to improve efficiency and expand access. Some functions incur relatively low costs, involving decisionmaking and methodology development, while others may be more expensive and require additional resources.

However, the scope of the public sector's new administrative role varies among the proposals. A single-payer system would establish state-based payers to replace the private administration of health insurance. The managed competition proposals, while maintaining private insurance, would create a system of health insurance purchasing pools.[1] Overall, the legislative proposals offered by Representative McDermott and President Clinton would more greatly expand the public sector role than those offered by Senator Chafee and Representative Cooper.

The bills also vary in how functions would be distributed among the new health insurance purchasing pools, federal agencies, and state governments. Generally, policysetting functions, such as designing the benefit package, developing quality measures and risk-adjustment factors, and establishing criteria for health plan participation, would be assigned to national entities. More labor-intensive, operational functions, such as contracting with health plans, enrolling individuals, providing comparative information, and collecting premiums and paying plans, would be assigned to the purchasing pools. But the locus of some functions, such as collecting and analyzing outcomes data and providing subsidies, varies among the bills. For example, each bill calls for expanded collection and analyses of data on the quality of health care. These functions would be performed by the health plan purchasing cooperatives in the Cooper bill, by the National Health Board in the Clinton bill, and by states in the Chafee and McDermott bills.

[1]Health insurance purchasing pools are referred to as "regional alliances" in the Clinton proposal; "health plan purchasing cooperatives" in the Cooper proposal; and "purchasing groups" in the Chafee proposal. We include the purchasing pools as quasi-public entities, although some of the legislative proposals intend that the purchasing pools may be privately administered. The Congressional Budget Office has deemed the Clinton alliances public, although the legislation specifies that regional alliances may be administered by a state agency, an independent public agency, or a nonprofit corporation. The Cooper and Chafee proposals envision privately administered purchasing pools, but for consistency we consider their administrative costs in this section.

Single-Payer Approach Places Administrative Responsibility on States

The McDermott proposal would require large new expenditures by state and federal agencies. It would replace private health insurance plans with a federally mandated, state-administered, comprehensive health insurance plan providing universal coverage.[2] Thus, states' major responsibilities would include paying health care providers, negotiating fee schedules and budgets, and establishing a uniform electronic claims database and quality review systems. The bill would limit administrative costs of the state agency managing the insurance system to less than 3 percent of total expenditures.

Existing public insurance programs in the United States and Canada, which have relatively low administrative costs, may serve as models of the public sector administrative costs possible under a single-payer system:

- Medicare, the primary source of health coverage for nearly all Americans over 65, is a national program that enrolls about 35 million Americans. It has administrative costs of about 2.1 percent of program expenditures. Like the McDermott plan, Medicare contracts with third-party carriers to reimburse providers based on claims. However, the McDermott plan would not require copayments and deductibles for most services, whereas Medicare does.
- Medicaid, a state-administered program serving about 25 million individuals, has relatively low administrative costs—4.0 percent of expenditures. An administrative difference between the McDermott plan and Medicaid is that a state single-payer system would not need to determine eligibility, whereas Medicaid does.
- The Canadian health system, which serves about 27 million people, is administered by each province at an average administrative cost of 1.2 percent of health spending.[3] It is similar to the McDermott plan in that it provides universal coverage (determining eligibility is not necessary) and copayments and deductibles for acute care services are prohibited. Whereas states under the McDermott bill would require an enhanced data collection system to enable quality monitoring and to establish budgets, the Canadian government does little quality monitoring.

[2]Limited private insurance would remain in the form of supplemental insurance, which would provide additional coverage beyond the benefits offered by the state plan.

[3]According to Canada's Department of National Health and Welfare, the administrative costs range from 0.9 percent in New Brunswick and Quebec to 1.7 percent in Prince Edward Island.

Managed Competition Would Incur More Moderate Increase in Public Administrative Costs

Compared to a single-payer approach, the three managed competition bills would shift insurance functions to the public sector to a lesser extent. The development of health insurance purchasing pools would be the primary source of additional public sector administrative spending, although their overhead costs would be explicitly limited in the Cooper and Clinton proposals. The Clinton alliances would cover a larger population segment and be responsible for more functions beyond the "core" ones common to all of the proposed purchasing pools.

The Clinton, Cooper, and Chafee bills agree on core purchasing pool functions. They tend to be operational in nature. These core functions include: (1) contracting with health plans, (2) enrolling individuals in those plans, (3) collecting and distributing premiums,[4] and (4) providing comparative information to consumers regarding health plan quality and price. In addition, the Clinton and Cooper proposals would assign extra responsibilities to the purchasing pools, such as making risk adjustments (Clinton and Cooper) and administering subsidies (Clinton).

The purchasing pools proposed by Clinton are also larger in size than the Cooper or Chafee purchasing pools. President Clinton's proposal would mandate universal coverage, with most workers, unemployed individuals, retirees not eligible for Medicare, and Medicaid enrollees purchasing their care through regional alliances. The Employee Benefit Research Institute estimates that at least 70 percent of the population would purchase their insurance through regional alliances.[5] In contrast, the Cooper and Chafee proposals would not mandate that workers purchase health coverage through the new purchasing pools. Those proposals would target participation to individuals, employers with 100 or fewer employees, and persons eligible for Medicaid.[6] Thus, a much smaller share of the population would purchase health coverage through the Chafee or Cooper purchasing pools.

Administrative costs of the new health insurance purchasing pools would be explicitly limited in the Clinton and Cooper proposals. The regional

[4]Collection of premiums by purchasing groups would be optional under the Chafee bill.

[5]Companies with more than 5,000 employees, accounting for 17 percent of the population, could remain outside of the regional alliances, although some experts believe that many of these large companies would also opt to join the regional alliances. Medicare enrollees would also remain separate from the alliance structure.

[6]Under the Cooper proposal, only health plans purchased through the health plan purchasing cooperatives would be tax deductible for employees with 100 or fewer employees. In the Chafee proposal, states would have the option of allowing Medicaid recipients to purchase coverage through the purchasing pools or maintaining Medicaid in its current form.

alliances established under the Clinton plan would be limited to overhead costs of 2.5 percent of premiums.[7] The health plan purchasing cooperatives in the Cooper plan would be limited to overhead costs of 1 percent of premiums.[8] The Chafee proposal does not set a specific administrative limit.

Existing purchasing pools may serve as limited models for administrative costs of the proposed pools. Core functions of the existing and proposed purchasing pools are similar. Generally, existing purchasing pools have administrative costs ranging from 0.15 percent to 3 percent of benefits. The largest of these, CalPERS and the Federal Employees Health Benefits Program, have the lowest percentage of administrative costs, indicating that they may have achieved economies of scale not met by the smaller purchasing pools, or that they perform fewer functions:[9]

- CalPERS may more closely resemble the regional alliances proposed by Clinton than other existing purchasing pools.[10] CalPERS enrolls about 900,000 individuals, similar in scale to the proposed purchasing pools.[11] Besides the core functions previously discussed, CalPERS performs some other functions contained in the managed competition proposals, such as negotiating with health plans and handling consumer complaints.[12] CalPERS' administrative costs are 0.5 percent of premiums. It has a staff of about 90, nearly three-fourths of whom perform enrollment functions.

[7]CBO estimates that health alliance administration would cost about $11 billion in 1998.

[8]A representative of the Cooper proposal indicated that these administrative cost limits were established on the basis of experience of existing employer purchasing cooperatives, such as the health benefits program administered by the California Public Employees' Retirement System. The administrative cost limit on the regional alliances in the Clinton proposal was based on estimates by the Actuarial Research Corporation.

[9]The existing purchasing pools with administrative costs of 2 to 3 percent reflect the fixed cost and low enrollment of several publicly sponsored voluntary purchasing pools for small businesses. For additional information on existing purchasing pools, see Access to Health Insurance: Public and Private Employers' Experience With Purchasing Cooperatives (GAO/HEHS-94-142, May 31, 1994).

[10]For more information on the recent experience of CalPERS, see Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

[11]The Clinton bill does not specify a population size for the regional alliance areas but would only require that the area include a population sufficiently large to give the alliance bargaining power with and promote competition among health plans. The Cooper and Chafee bills would require that the purchasing pool areas include populations of at least 250,000. Members of the Jackson Hole Group, which developed the theoretical basis of health insurance purchasing pools, recommend that these pools have an enrollment of about 1 million persons.

[12]The Clinton plan requires that regional alliances negotiate to contract with each health plan. The Cooper plan would prohibit the purchasing cooperatives from negotiating with health plans. The Chafee plan omits any reference to negotiating; it would perhaps permit but not require negotiations. The Clinton and Cooper plans would have the purchasing pools perform an ombudsman role for addressing consumer complaints.

- Other analysts have compared the proposed purchasing pools to FEHBP, which offers more than 400 health plans to about 9 million federal employees and their dependents. In particular, FEHBP has been cited as a model for enrolling a large group of individuals spread over multiple large employers and offering a choice of multiple plans. However, FEHBP does not perform other functions expected of the proposed purchasing pools, such as making risk adjustments, standardizing benefits, and comparing the quality of care of health plans. The U.S. Office of Personnel Management administered FEHBP in 1993 for $22 million, 0.15 percent of FEHBP benefit payments.

Subsidies, Data Systems, and National Boards Could Also Expand Costs

Additional sources of administrative costs for the public sector can be found in each proposal and its requirements. In particular, administering subsidies and collecting and analyzing data on quality of care would be potentially significant expansions of the public sector's administrative roles. Each proposal would also develop new national bodies to establish standards and policies and increase the regulatory functions of federal and state governments.[13]

Administrative Costs From Subsidies Depend on Eligibility System

Some analysts have cited subsidy programs as a potential source for significantly increased administrative costs, but there is considerable uncertainty about the level of resources required for program administration. Each of the managed competition bills would provide subsidies to low-income families. The Clinton plan would also offer subsidies and discounts for employers, unemployed and self-employed individuals, and families with incomes of up to $40,000.[14] (The McDermott proposal would be financed by increased payroll and income taxes and a health security premium. It would not include direct subsidies.)

Administrative costs would result from subsidies because families (and employers, under the Clinton plan) would need to report information regarding income, family size or number of employees, and health premium costs to the purchasing pool or the government to become

[13]Some of the other functions required of the purchasing pools, but not typically performed by existing alliances, would not necessarily impose significant additional administrative costs. For example, establishing fee schedules under the Clinton plan would be inexpensive if the regional alliances modify existing fee schedules developed by Medicare or states. Depending on the method used, risk-adjustment could also be relatively inexpensive if the data needed for making risk adjustments are already collected or are integrated with newly established data systems.

[14]For further discussion of subsidies in the Clinton and Chafee proposals, see National Academy of Social Insurance, The President's Proposal for Health Care Reform: An Overview of the Administrative Structure (Washington, D.C.: Feb. 15, 1994); and Senator Chafee's Proposal for Health Care Reform: An Overview of the Administrative Structure (Washington, D.C.: Mar. 15, 1994).

eligible for subsidies. Subsidy administration would also require either the purchasing pools or the government to (1) determine eligibility; (2) calculate the subsidy; (3) distribute the subsidy to the health plan, employer, or family; and (4) reconcile the premium contributions due to changes such as income or family size that occur throughout the year. This process would be comparable to the process that states undertake to determine eligibility for Medicaid or cash-assistance programs, although without the additional difficulty of an asset test.[15]

The managed competition proposals vary in the standards used to define who would be eligible for low-income subsidies and the processes they would use for determining eligibility:

- Under the Clinton plan, Medicaid recipients would be integrated into the regional alliance system and subsidies would be available to many low-income individuals. Medicaid recipients who also receive Aid to Families with Dependent Children or Supplemental Security Income (totalling 17 million individuals combined) would be deemed eligible to receive subsidized premiums and reduced cost-sharing requirements.[16] Other individuals would be responsible for a share of premium payments but subsidies would be available for families with annual incomes of up to $40,000.
- The Cooper proposal would provide full subsidies for health coverage to persons with incomes below the poverty level and partial subsidies to persons up to 200 percent of the poverty level. Federal spending on subsidies would be contingent on savings from Medicaid and other health spending, with health plans bearing any shortfalls. If the individual were to choose a plan other than the lowest-cost plan offered by the health plan purchasing cooperative he or she would be responsible for a share of the difference in premium costs.
- In the Chafee plan, persons below 90 percent of the poverty level would receive vouchers to purchase private health insurance beginning in 1997. By 2005, the eligibility level would be expanded to persons below 240 percent of the poverty level. The amount of federal funds for the voucher program would be contingent on cost savings from Medicare and Medicaid.

[15]An asset test is difficult to implement because it requires verification of an individual's nonincome assets. Thus, documentation of a person's payroll earnings or income tax would not be sufficient under an asset test.

[16]To cover premium costs, the alliances would receive a payment equal to 95 percent of current state and federal Medicaid expenditures for this group, updated for inflation.

The costs of administering subsidies would depend on the method used to determine eligibility. To the extent that Medicaid eligibility procedures remain intact, the process would be simplified. Under the Clinton plan, persons receiving Aid for Families with Dependent Children or Social Security Insurance would be deemed automatically eligible to receive full subsidies based on existing eligibility procedures for these programs. Other persons seeking subsidies under the Clinton plan would undergo a different process to determine eligibility. However, the Cooper proposal would eliminate Medicaid and therefore would require a new eligibility determination process for this population. The Chafee proposal would maintain Medicaid,[17] but for other low-income persons a separate process would be necessary to determine eligibility for vouchers based on income.

For the non-Medicaid population, a simplified approach to identifying those eligible for subsidies would be to link the administration of the subsidies with the tax system, by having the Internal Revenue Service estimate subsidies. This would be administratively less expensive because, through their tax filings, employers and individuals already provide income and family size information necessary for determining subsidies. Also, the IRS has existing capacity to verify incomes. However, under the Clinton proposal, the alliances or states would be required to develop a capability to collect and verify information from individuals and employers. The Cooper and Chafee proposals would require other federal government agencies to administer subsidies.

States that are developing reform bills are also addressing the issue of subsidy administration. Florida's approach suggests that the impact on purchasing pool staff could be minimized. Under the Florida plan, insurance agents' role would be prominent in the purchasing pools' operations. In addition to enrolling employers, the bill would make them responsible for helping individuals complete a simplified eligibility determination process based on income tax forms, pay stubs, or documented participation in another means-tested public program. By using existing resources, Florida is attempting to reduce the administrative burden. A private contractor would review eligibility applications to verify the information, certify eligibility, and calculate the premium contributions. (The contractor would be expected to develop automated systems to facilitate eligibility determination and premium collection.)

[17]States could choose to either maintain Medicaid in its current form, develop Medicaid managed care arrangements, or integrate Medicaid into private purchasing groups.

Finally, in addition to the family subsidies and discounts, the Clinton proposal would cap employers' contributions to premiums.[18] For all firms with more than 75 employees, this cap would be set at 7.9 percent of payroll; for smaller firms, the cap would be set on a sliding scale between 3.5 percent and 7.9 percent depending on their average payroll. If a firm were to exceed these payroll caps, then it would pay less than the 80-percent share of the weighted adjusted premium.[19] CBO estimates that as many as three-fourths of employers (representing about half of employment) would qualify for these caps.[20] Determining eligibility for employer premium discounts resulting from these caps would require the employer to report basic size and payroll information to the regional alliances. However, like Social Security taxes and other payroll deductions, employers could add an accounting line-item to their payroll system with a subsequent reconciliation for changes that may have occurred during the year.

Data Systems: Start-Up Would Be Costly but Could Simplify Functions

Currently, information on private health plans and quality of care is fragmented among many private insurers, managed care organizations, and health care providers.[21] However, the managed competition proposals would require data assessing health plans to make payment risk adjustments and provide comparisons of health plans' costs, quality of care, and enrollee satisfaction. A health care information network would meet many such requirements.

Development of an infrastructure for a health care information network, one that provides for the electronic transmission and collection of health care data, would be a potentially major administrative expense. For example, in the Clinton proposal, the federal government would develop regional data centers linking providers, health plans, alliances, and state-level quality programs through an electronic computer network. The Chafee and Cooper proposals also call for similar public investments in establishing health information networks.

Although initially these systems might require a large public sector investment, once they were established they could simplify many administrative functions, such as comparing quality of plans, making risk

[18]Additional subsidies would also be available for self-employed and unemployed individuals.

[19]The federal government would subsidize the regional alliance for the differential.

[20]Large employers forming corporate alliances would not be eligible for these discounts.

[21]More than 30 states, including Pennsylvania, Florida, and California, require health care providers to provide basic information, such as billed charges and lengths of stay, to the state.

adjustments, and developing cost containment policies. Without a coordinated data network, these functions could require large additional administrative expenses. In addition, the Clinton proposal would eliminate Medicare Peer Review Organizations (PROs) as a quality monitoring program. PROs cost the federal government about $450 million in fiscal 1993.[22]

New National Organizations Develop Standards and Guidelines

Each of the proposals would also create a new federal entity to perform a range of policy functions, including setting standards for alliances and states.

- In the Clinton proposal, a National Health Board would be responsible for maintaining uniform benefits and policies for supplemental insurance, establishing risk-adjustment and quality management factors and methods, developing a health data information system, setting national budgets, and providing other state assistance, oversight, and guidelines.
- In the Cooper proposal, the major functions of the Health Care Standards Commission would include registering health plans eligible to be offered by health plan purchasing cooperatives, recommending a uniform benefit package, setting quality data standards and risk-adjustment factors, and other general oversight and standards.
- In the Chafee proposal, a Benefits Commission would be created to make recommendations to Congress about changes in the benefit packages.
- In the McDermott proposal, many of the proposed federal responsibilities would be administered by a newly created Health Security Standards Board. This board would establish a national health budget, set data reporting standards, decide on modifications to the standard benefit package, and make other guidelines, policies, and procedures for the state programs.

The costs of administering these national boards and commissions are difficult to estimate, but would likely be a small share of total health spending. Some experts have cited the Physician Payment Review Commission (PPRC) and the Prospective Payment Assessment Commission (ProPAC) as potential models for these national boards.[23] PPRC and ProPAC each had fiscal 1993 budgets of about $4.4 million. Each has 13 to 17 commissioners that meet several times annually and a full-time staff of 26. The scale of the National Health Board established by the Clinton plan would be larger than either PPRC or ProPAC, but PPRC and ProPAC may be

[22]The McDermott proposal would also eliminate Medicare PROs.

[23]PPRC and ProPAC make recommendations to Congress regarding Medicare's physician and hospital reimbursement and other health financing policy issues.

comparable to proposed advisory councils. For example, the Quality Advisory Commission would have 15 appointees meeting several times annually and a full-time staff. Like ProPAC, the National Quality Board could have a highly professional staff, be data intensive, and address policy issues.

More Regulatory and Financing Roles for State and Federal Governments

Besides the new national commissions established to oversee the purchasing pools and set standards and guidelines, state and federal regulatory roles would expand under the managed competition proposals. In particular, states would assume additional roles in regulating health plans, the Department of Health and Human Services would administer new programs, and (in the Clinton proposal) the Department of Labor would be responsible for certifying corporate alliances and auditing both corporate and regional alliances. However, states and the federal government would gain some offsetting administrative savings. Under the Cooper (and McDermott) plan, they would be relieved of Medicaid.

Under the managed competition proposals, the states would maintain their traditional role for regulating private health insurers. Predominantly, states have focused their monitoring on the solvency of health plans.[24] Each proposal would require the states to additionally certify that health insurers meet eligibility requirements. These requirements would include financial stability, capacity to deliver care within their geographic area, accordance with the uniform benefit packages, and ability to provide required data to the government and purchasing pools. Another major function of the states would be to oversee the purchasing pools, including developing geographic boundaries and a governance structure.[25]

In addition to the new national commissions and boards, the Departments of Health and Human Services and Labor would have expanded roles:

- HHS, in addition to continuing to administer Medicare and public health programs, would be required in the Clinton plan to monitor the transition to the reformed health system and oversee new programs for graduate medical education. However, uncertainty about HHS' role exists, depending on the size and responsibilities of the new national entities (such as the National Health Board). If these new national entities were relatively small, then HHS might need to assume other responsibilities.

[24]For a review of the states' current capacity in this area, see Health Insurance Regulation: Wide Variation in States' Authority, Oversight, and Resources (GAO/HRD-94-26, Dec. 27, 1993).

[25]See Health Care Reform: Implications of Geographic Boundaries for Proposed Alliances (GAO/T-HEHS-94-108, Feb. 24, 1994).

- The Department of Labor, under the Clinton proposal, would also face an expanded role in regulating corporate alliances created at the option of employers with more than 5,000 employees. Currently, the vast majority of these large employers have self-insured health plans that are exempt from state insurance regulation by the Employees' Retirement Income Security Act. The Clinton proposal would require the Department of Labor to establish a new guaranty fund for corporate alliances, similar to the guaranty funds states currently maintain for state-regulated health plans. It would also certify corporate alliances, ensuring that they have sufficient financial reserves, and audit corporate and regional alliances.

Finally, federal and state administrative costs would be affected by changes in the Medicaid and Medicare programs.[26] Medicaid would be eliminated in the Cooper and McDermott proposals. In 1991, the federal share for administering Medicaid totaled $2.3 billion while the state and local shares totaled $1.7 billion. Under the managed competition proposals, Medicare would continue largely in its present form.[27] However, in the McDermott single-payer plan, Medicare would also be eliminated. Administrative costs for Medicare totaled $2.6 billion in 1991.

[26]Some experts argue that enabling Medicaid beneficiaries to purchase private insurance coverage through purchasing pools would increase overall administrative costs because private insurance plans have higher average administrative costs (about 14 percent) than do public insurance plans (about 3 percent).

[27]Under the Clinton plan, states could decide to include Medicare beneficiaries in the regional alliances at the state's option and HHS' approval. Many of the bills would make financing changes to Medicare, and the Clinton plan would add prescription drug coverage, but overall the administrative costs of Medicare would likely remain similar to current administrative costs.

Implications for Health Plans

Health care reform could have a major impact on the portion of health insurance dollars spent to administer private, employment-based coverage. Managed competition would likely lower the administrative costs included in health plan premiums, which the Health Care Financing Administration estimated to average 14.4 percent of private insurance expenditures in 1991. Pooled purchasing and other market reforms could bring administrative costs closer to the level experienced by larger employer groups. The accelerated development of electronic filing of billing claims could also provide administrative savings for health plans. Costs would be raised, however, by requirements to maintain detailed encounter data. The single-payer approach would go even further in its impact on health plans: it would save systemwide administrative costs by replacing most private insurance with government-administered insurance programs at the state level.

Currently, health plans' administrative costs vary by the size of the group covered. Administrative expenses account for a large portion of small group insurance costs. High costs for marketing, underwriting, and administering coverage absorb much of the premium for small firms and individuals. An analysis by the Congressional Research Service showed that for the smallest plans, administrative expenses are about 40 percent of claims; for the largest plans they are 5.5 percent of claims.[1]

Therefore, the impact of managed competition proposals on insurance administrative costs would differ for large and small group coverage. For the health plans of larger groups, administrative costs would be largely unchanged under the Chafee and Cooper bills, but could increase under the Clinton proposal. An analysis of the Clinton proposal conducted by Actuarial Research Corporation projected that average administrative costs for corporate alliances (private firms with more than 5,000 employees) would be 8.3 percent of benefits paid.[2] This represents an increase of about 1 percent from the current average for very large firms; it

[1]General administration, risk and profit charges, and commissions account for three-fourths of the expenses for the smallest plans but about one-third for the largest plans. Although for small plans many of the general administration and commission expenses are fixed dollar amounts, risk and profit charges as a percentage of claims drop sharply as the number of employees increases. Claims administration charges also have some economies of scale. For small plans, charges exceed 9 percent; for large plans, charges drop to 3 percent because most claims are processed in a similar manner. See CRS, "Costs and Effects of Extending Health Insurance Coverage," Oct. 1988.

[2]This percentage includes taxes, as well as risk and profit charges. Gordon R. Trapnell, "Cost of Administration for Health Purchasing Alliances and Participating Plans," Actuarial Research Corporation, Sept. 1993.

could be attributed to the new data requirements to monitor outcomes and quality.[3]

For smaller group plans, the impact of reform on administrative costs would derive primarily from: (1) the substitution of a single large group policy covering an entire insurance pool for multiple policies covering most employers and individuals, (2) the accelerated use of electronic data submissions, (3) the increased data requirements and quality control functions to be performed, and (4) compliance with other regulations.

Gaining Economies of Scale

Administrative charges in the premiums that small employers pay could be lowered if they were to purchase insurance as part of a pooling mechanism. The reform proposals would replace small employers' contracts with purchasing pools so that health plan enrollment in an area would stem from one very large group. Although the size of that group would vary by state population and the number of alliances established, the health plans' administrative costs would likely reflect those of larger employers. For the highest cost functions—enrollment, premium collection, and claims processing—the proposals could substantially lower health plan costs. For example, fee-for-service plans with large numbers of beneficiaries could take advantage of economies of scale in claims processing and general administrative functions.

Alliances could be structured in a manner similar to that of the FEHBP. Administered by the U.S. Office of Personnel Management, this program offers a wide choice of health plans to all federal employees. In 1991, the administrative costs to health plans participating in FEHBP averaged 7 percent of premiums. However, because the administrative functions of plans offered through the Clinton alliances would be greater than for plans serving FEHBP, plan costs would be higher.

Increased Use of Electronic Data Interchange

Increasingly, health plans are minimizing paperwork by receiving electronic claims submissions from providers. Each of the reform proposals would encourage the accelerated development of electronic

[3]In addition, employers forming corporate alliances would be responsible for an additional 1 percent surtax on premiums.

data interchange, providing savings to health plans.[4] For example, Blue Cross and Blue Shield plans processed 444 million claims electronically in 1992—60 percent of their claims.[5] A task force of insurance industry representatives organized by HHS estimated that widespread use of electronic data interchange to standardize claims procedures has the potential to save $1.4 to $5.4 billion annually for health plans.[6]

Additional Data Collection

There could be additional administrative costs, estimated at roughly 1 percent, for plans to cover detailed, sophisticated data requirements and compliance with outcomes monitoring. Depending on the reform proposal adopted, data requirements for health plans would be set to meet the needs of auditing outcomes, health risk adjustment, and monitoring the adequacy of provider networks. For example, under the Clinton proposal, plans would need to provide the alliances with data about the costs, quality, and outcomes of care for the plan as a whole and for each individual provider. Although many health plans have already moved toward using more detailed data, some have not. Therefore, even with standardization and automation, data collection and processing could become significantly more expensive than currently found in the health insurance system.[7] In addition, if health plans were held accountable for quality of care provided to their enrollees, they might more closely monitor and manage both quality and cost of care from each provider. They might be more inclined to manage the provision of health care by physicians in order to control expenditures. Preadmission certification, physician profiling, and mandatory second opinion programs might require large administrative investments.

Other Regulatory Impacts

Managed competition could improve the efficiency of the health plan market by lowering transaction and selling costs. Health plans' administrative costs would be reduced by standardizing benefits, premiums, and claims activities. With a standard insurance product replacing individually-tailored benefit packages, claims processing costs

[4]However, barriers remain to implementing electronic data interchange in the health care environment. Connecting 6,000 hospitals and 600,000 physicians with many payers is a large-scale logistical problem. In addition, many of the systems currently in place are incompatible and lack standards to coordinate among them. Finally, the financial incentives for providers to make the investment in electronic data interchange capability are weak.

[5]Blue Cross and Blue Shield estimated that it could potentially save $1.5 billion by processing claims electronically. In the Medicare program, about 75 percent of Part A and 50 percent of Part B claims are submitted electronically.

[6]1993 WEDI Report, WEDI (Oct. 1993), pp. 9-20.

[7]Additional administrative costs would result from the need to audit the accuracy of the data.

associated with cross-checking unique policy provisions would be eliminated. Depending on the method used for risk-adjusting premiums, community-rating rather than experience-rating might lower administrative costs because it is less data intensive. Where purchasing pools collect premiums, the costs associated with debt collection would be eliminated. If large premium variations across insurers were reduced, there might be less frequent changes in coverage. In addition, purchasing pools would restrict direct sales and other marketing activities. There would be no salespersons' commissions because the transactions would be directly between the purchasing pool and employer; they would not involve brokers.

Implications for Hospitals and Physicians

In general, health care reform is expected to reduce overall administrative costs for most physicians and hospitals. Both the single-payer and managed competition approaches would likely reduce providers' paperwork, billing, and utilization review expenses. At the same time, data reporting requirements could represent a significant new cost for many providers.

Provider administrative costs are influenced by a variety of factors, including the type of management information system used, uniformity of reimbursement system, percentage of bills filed electronically, malpractice experience, extent of market competition, and state and federal laws. Administrative costs under the current system have been estimated at about 8 percent of physician revenues and 15 percent of hospital revenues. Some analysts contend that dramatic reductions in provider administrative costs will be difficult to achieve. For hospitals in particular, cost containment pressure over the past decade has already stimulated efforts to eliminate inefficiency. Still, the potential savings is projected to be about 10 percent in hospitals' administrative costs and about 20 percent in physicians' administrative costs, gained from further efficiency improvements.[1]

Under reform, administrative spending might continue to rise with the growth of data reporting requirements from health plans and the government. All of the proposals would require the collection of detailed data (at the point-of-service or clinical encounter level) and electronic transmission to entities that compile, analyze, and disseminate the information. Proposals that require providers to report on all patient encounters may cause many health maintenance organizations to incur substantial costs of revising data systems not now based on individual encounters. Many HMOs do not organize their data systems in ways that identify resources used in specific encounters between each enrollee and the HMO provider.

These data reporting requirements might initially increase providers' administrative costs but could provide long-term savings. In a 1993 report,[2] the Workgroup for Electronic Data Interchange estimated that providers' one-time implementation costs for establishing or upgrading existing computer systems to a standardized capability would range from $3.8 billion to $11.2 billion. (These costs include hardware, software,

[1]William B. Schwartz and Daniel N. Mendelson, "Eliminating Waste and Inefficiency Can Do Little to Contain Costs," Health Affairs (Spring (I) 1994), pp. 224-238.

[2]Workgroup for Electronic Data Interchange, 1993 WEDI Report (Oct. 1993).

communications equipment, installation, and some limited vendor training.) In the long run, however, data collection activities in an electronic environment were projected to reduce administrative costs by eliminating the need for random case-by-case reviews; decreasing the time spent duplicating information and correcting errors common in a paper environment; and monitoring, in a more systematic manner, the quality and appropriateness of care. WEDI estimated that providers' gross annual savings for 11 transactions would range from $9.1 billion to $15.5 billion.[3]

Some providers are concerned, however, that collecting quality data and developing the infrastructure necessary to implement the health information systems envisioned under reform may be more complicated, time consuming, and costly than anticipated. There is considerable uncertainty surrounding the development of acceptable measurements of quality. Choosing appropriate quality indicators and adequately measuring provider performance is not a well-developed area of health policy and is subject to change. Therefore, if the government were to mandate a limited (but accessible and inexpensive) health care information system, it may overlook data needed to report on various aspects of care, such as outcomes, appropriateness, satisfaction, access, and practice patterns.

Although more providers are investing in computer technology, most do not yet have information systems capable of capturing detailed encounter data. Capitated providers, who are paid a set amount per enrollee rather than per service provided, in particular would need to make a greater investment in information systems because they lack a claims-based infrastructure. For example, Henry Ford Health System's Health Alliance Plan, an HMO, invested over $1 million in an encounter database to capture clinical information on its members. Still, the plan found numerous problems with the integrity of the data; those problems impaired the validation and reporting process.

Single Payer

The McDermott bill's elimination of the multiple-payer system would significantly change the way providers are reimbursed. Hospitals would receive payments based on state-approved annual operating budgets, rather than on the volume and type of services provided. Physicians would be reimbursed using a fee schedule similar to Medicare's resource-based relative value scale. Payments to HMOs would be based either on budgets or set amounts per enrollee. For covered services, no deductibles or

[3]WEDI's list electronic data interchange transactions are claims submission, enrollment, payment and remittance, eligibility, claims inquiry, materials management, prescription ordering, coordination of benefits, test order and results, referrals and authorization, and appointments and scheduling.

copayments would be applicable and no "balance billing" would be permitted. That is, patients could not be charged beyond the set rate for any service provided.

With a single-payer system, providers' administrative costs would be lowered through reduced paperwork and billing. Both the direct and indirect costs associated with insurance transactions (expenses that hospitals and physicians incur as a result of multiple claims and billing forms and the personnel paid to deal with them) would be lowered significantly by having one insurance entity in each state. Also, the prohibition of patient cost sharing for most medical services eliminates the need to bill patients. Previously, we estimated potential administrative savings of about 10 percent for physicians and about 6 percent for hospitals under a Canadian-style single-payer system.[4]

Still, a single-payer system would not eliminate all provider administrative costs. There remain necessary tasks, such as maintaining patient records and complying with government regulations, that add to providers' overhead costs. As noted previously, additional data collection for quality assurance and utilization review purposes would be required. But that requirement might not erode the single-payer savings if a streamlined health care information system would subject providers to more uniform standards of medical review.

Managed Competition

Under managed competition, spending on transactions between payers and providers would also be likely to decline, even with the multiple organization framework. Administrative savings would stem primarily from anticipated growth in prepaid health plans, and, in fee-for-service plans, from limits on patient cost sharing and mandatory use of common claim forms and expanded electronic processing. Again, new data reporting requirements might offset some of these savings.

Under the Clinton proposal, traditional HMOs (including point-of-service plans) are expected to grow from about one-quarter to about one-third of the private insurance market. Because the delivery of care is integrated with insurance in these arrangements, providers in prepaid HMOs would avoid some of the administrative duties of fee-for-service providers. They would carry out the same provider-type administrative functions but fewer insurance-type administrative functions. Growth in the proportion of

[4]Canadian Health Insurance: Estimating Costs and Savings for the United States (GAO/HRD-92-83, Apr. 28, 1992), pp. 12-13.

providers in prepaid HMO plans has the potential, therefore, to reduce costs of transactions and other administrative activities.[5]

In addition, some aspects of the proposals would also reduce administrative costs for fee-for-service providers by limiting patient cost sharing. Allowing copayments as a utilization control requires more paperwork for hospitals, physicians, and other providers because they would have to bill the insurer or patient. Furthermore, proposals that end physician balance billing would also reduce administrative costs.

Managed competition would not be likely to eliminate case-by-case review by insurers. Many utilization review practices such as requiring physicians to get permission from a patient's insurer before performing certain operations, or auditing how a patient was treated, would continue for the time being. Increased competition pressure to hold down costs might, in fact, increase the use of utilization reviews, but utilization review requirements might become more standardized.

[5]An alternative view is that HMOs tend to have higher administrative costs than other health plans. One recent study of hospital costs showed that in states where HMOs enroll more than 25 percent of the population (California, Massachusetts, Minnesota, and Oregon), average administrative costs accounted for 25.6 percent of total costs, as compared with 24.6 percent of total costs in states with lower HMO enrollment. See Steffie Woolhandler, David U. Himmelstein, and James P. Lewontin, "Administrative Costs in U.S. Hospitals," New England Journal of Medicine, Aug. 5, 1993, pp. 400-403.

Implications for Employers

For most employers, the proposed reforms would have a limited impact on administrative costs. Currently, nearly two-thirds of nonelderly Americans receive health insurance through an employer. In addition to their share of premiums, employers incur costs in administering health benefits for employees and their families. Although it is difficult to quantify, interaction with the health care system requires employers' time and effort. Insured and self-funded employers incur expenses associated with tracking employee hiring and termination, conducting internal analyses, designing benefit plans, and complying with regulations. Companies that provide no health insurance for their workers avoid these costs and the costs of premiums.

In the McDermott proposal, taxes would be collected by a government agency to be paid to health care providers. The employers' role would be reduced to paying an increased payroll tax, an established percentage of wages. This would require almost no new administrative costs. Also, costs associated with selecting, contracting, and negotiating with multiple plans would be alleviated.

Under managed competition proposals, employers currently providing health insurance would experience little change in their direct administrative costs by purchasing coverage through a purchasing pool.[1] The following discussion shows that the aggregate effect of managed competition on employers' administrative costs would depend on the degree of participation in purchasing pools. Because of its mandate and high employer size threshold for alliance participation, the Clinton proposal would likely generate greater potential savings than that of the Chafee or Cooper proposals. However, under the Clinton plan, employers may need to provide additional data, including information to enable the administration of subsidies.

Smaller Employers

Under the Chafee and Cooper bills, employers with fewer than 100 employees would be required to offer health benefits, but would not be required to contribute toward premiums. The Chafee proposal would allow small employers the option of joining a regional purchasing group or using a qualified health plan, while the Cooper proposal would require that they participate in a health purchasing cooperative. By contrast, the Clinton proposal would require that employers with up to 5,000 employees

[1]By using a regional insurance pool, individuals could retain their health plan and providers when they change employers. In small firms, employees tend to change jobs frequently. Job tenure in firms of 25 to 99 employees is about half that in large firms.

obtain insurance through regional alliances. (This mandate would cover about 70 percent of the population).

For firms that currently provide health insurance, buying through a purchasing pool would generate both cost savings and new costs. On the one hand, employers would be relieved of the bother, confusion, and extra time spent in finding and securing coverage. Their role would be to conduct open enrollments, collect employee contributions through payroll deductions, and remit payments to the purchasing pool. With a process similar to IRS withholdings, employers could withhold premium contributions for all employees using rates requested on forms similar to the W-4.

On the other hand, the data processing and reporting functions associated with payroll may be more complex for some employers. Today, most small- and medium-sized employers deal with premiums from only one or two plans offered to their employees. Under managed competition, the premiums would be different for each plan and in each purchasing pool; they would also vary by family structure. For example, under the Clinton plan, employers would pay a fixed percentage of the weighted average premium for each full-time employee and a prorated amount for each part-time employee. Those whose workers are in one regional alliance could pay three premiums based on the number of full-time equivalent employees in each of the family categories; the number would be increased by three for each regional alliance in which employees live. In addition, in order for alliances to determine employer subsidies and track health plan enrollment, employers would have to give the alliance wage and hours data each month or quarter. Employers would also report total annual deductions to employees and the alliance.

Larger Employers

Under the Cooper and Chafee proposals, employers with at least 100 employees would be required to arrange for coverage, but they would not gain coverage through the small-employer purchasing pools. Their administrative expenses would not be substantially affected by reform. As they do currently, they would be able to deal directly with one or more health plans and provide for the payroll deduction of premiums. To the extent that incremental changes in administrative practices would be adopted—such as a standardized benefit package to make plan comparisons easier—administrative costs for medium and large employers could be reduced somewhat.

Under the Clinton proposal, employers that cover more than 5,000 full-time workers would have the option of providing coverage directly or through regional health alliances.[2] The bill would require that "corporate alliances" enroll all eligible persons and offer a choice of at least three plan options, one of which may be a self-insured plan. Large employers' administrative costs could increase by forming a corporate alliance if they must do more to set up their own programs and negotiate with plans. Also, there may be more costs associated with coordinating employer payments,[3] operating across state lines, and meeting new regulatory requirements.

Because large employers would not be required to form a corporate alliance in the Clinton plan, they would be able to purchase coverage through the regional alliance structure. The regional alliance would be advantageous for many large employers because: (1) employers' premium cost would be subject to a 7.9 percent of payroll cap, (2) some companies would pay no risk adjustment to their premiums if their workforce demographics were similar to the alliance population, and (3) companies would not have to pay an annual assessment of 1 percent of payroll to the federal government. As noted earlier, for employers participating in a regional alliance, the predominant administrative cost would be tracking eligible enrollees and paying alliances. Employers would no longer need to contract with insurers or administer a self-funded plan.[4]

[2]The administration estimates that about 1,200 companies have more than 5,000 workers. Between 15 million and 29 million workers would be able to enroll in corporate alliances.

[3]Married couples working for both a corporate and regional alliance employer would be able to select the alliance for coverage. The corporate alliance would remit payments to the regional alliance if a regional alliance coverage were chosen, and vice versa.

[4]Self-funding would reduce plan costs by 3 percent, with most savings achieved through reductions in premium taxes.

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