CBO TESTIMONY

Statement of
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before the
Subcommittee on Health
Committee on Ways and Means
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NOTICE

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I appreciate the opportunity to discuss the potential savings that might accrue from administrative simplification in the health care system. This issue has generated considerable interest because administrative costs are one factor accounting for the relatively high per capita costs of health care in the United States. Critics believe that these costs are unnecessarily steep, related in large part to the complexity created by a system with many payers. Under the current system, insurers must establish eligibility for each claimant and must often coordinate benefits with other insurers. Providers, in turn, must submit claims to many different insurers, each imposing a different set of requirements.

This statement presents estimates of what insurers and providers currently spend for administration. It also gives Congressional Budget Office (CBO) estimates of the amounts by which such expenses might be reduced under simplified systems. It draws on a staff memorandum, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," that CBO prepared in April 1993 for this Subcommittee.

Let me note several caveats about these estimates. First, they are for calendar year 1991, and they assume that the simplified systems were fully effective throughout that year. Second, the transitional costs of moving from the current system to a new one are not included. Third, they are not CBO cost estimates, which relate to specific bills and depend heavily on detailed

legislative language. Finally, though administrative savings are important, they are only one of many features to consider in evaluating a simplified system.

BACKGROUND

Administrative (or overhead) costs in the health care system take two forms--costs for insurers that are reported separately in the National Health Expenditure (NHE) Accounts, and costs providers of care incur that are not shown explicitly in the accounts. The administrative costs of providers are a component of the amounts spent for specific services, such as hospital care. Various analysts have estimated these costs in different ways.

For 1991, the costs of administration reported for insurers totaled $43.9 billion, or 5.8 percent of national health expenditures. These costs include expenses for marketing, underwriting, and claims processing, as well as amounts retained for reserves and profit.

CBO made two adjustments to the reported figures. The first adjustment was to correct for the six-year underwriting cycle characteristic of health insurance, in which insurance companies tend to build reserves for about three years and then deplete them for the next three years. To smooth these cyclical effects, the administrative expenses of insurers, as a share of insurance benefits, were averaged for 1986 through 1991. CBO then applied

this average to the value of insurance benefits in 1991. The second adjustment was to subtract premium taxes of about $1 billion paid by insurers, because they are not inherent costs of insurance. Thus, the adjusted administrative costs were $40.3 billion, or 5.4 percent of similarly adjusted national health expenditures (NHE/A).

If one considers only hospitals and physicians, the costs of administration for providers in 1991 are estimated at $137.2 billion, or about 18 percent of national health expenditures. For hospitals, estimated costs are $93.9 billion, including all expenses not directly related to patient care for personnel, buildings, equipment, supplies, and services. For physicians, estimated costs are $43.3 billion, again including all expenses not directly related to patient care--nonmedical personnel, rent, office equipment, supplies, and services.

Administrative simplification, however, would affect only that portion of providers' costs related to patient-specific financial accounting and billing. CBO's estimate of this portion of the administrative costs of providers for 1991 is about $31 billion, or 4.1 percent of NHE/A. Thus, the total that administrative simplification might affect, including costs for both providers and insurers, is $71.3 billion, which accounts for about 9.5 percent of NHE/A.

WHAT ARE THE POTENTIAL SAVINGS FROM ADMINISTRATIVE SIMPLIFICATION?

From an administrative standpoint, the simplest approach currently under consideration would be a Canadian-style single-payer system (SP2) with no deductibles or coinsurance. Under such a system, everyone would have first-dollar coverage from the same insurer. Consequently, the insurer would have no difficulty establishing eligibility, and there would be little if any need to coordinate benefits with other payers. Further, the marketing and underwriting expenses that make up a substantial part of the administrative costs for private insurers under the current system would be eliminated. Physicians and other medical professionals would submit claims for payment to a single insurer, with no need to bill patients for copayments. Hospitals and other institutional providers would receive annual budgets from the single payer. They would have little need to bill at all (only for amenities) or to maintain patient-specific financial accounting systems.

Under a Canadian-style single-payer system, total administrative costs would be about one-quarter of current costs, a reduction equal to 6.9 percent of NHE/A (see Table 1). This estimate takes account of the additional administrative costs associated with the higher use of services that would occur under a system with universal first-dollar coverage. In 1991, the savings would have been about $52 billion, nearly evenly divided between insurers and

TABLE 1. ESTIMATED CHANGES IN SPENDING FOR ADMINISTRATIVE COSTS, 1991 (In billions of dollars)

	SP2	SP1	AP2
	Providers		
Actual	31.0	31.0	31.0
Estimated	5.9	21.2	26.6
Change	-25.2	-9.8	-4.4
As a Percentage of NHE/A	-3.4	-1.3	-0.6
	Insurers		
Actual	40.3	40.3	40.3
Estimated	13.5	16.0	43.1
Change	-26.8	-24.3	2.8
As a Percentage of NHE/A	-3.6	-3.2	0.4
	Total		
Actual	71.3	71.3	71.3
Estimated	19.3	37.2	69.7
Change	-52.0	-34.1	-1.6
As a Percentage of NHE/A	-6.9	-4.6	-0.2

SOURCE: Drawn from Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," Staff Memorandum (April 1993).

NOTES: SP2 = Canadian-style single-payer plan; SP1 = Single-payer plan with copayment requirements; AP2 = All-payer plan without universal coverage; NHE/A = Adjusted national health expenditures.

The CBO memorandum also examines an all-payer plan with universal coverage (AP1).

providers. To capture these savings for the taxpayer, though, it would be necessary to reduce payment rates to providers by the amount of their savings on administrative costs.

A system that did not require copayments from patients, however, would have to rely solely on controls on providers to restrain use of services. This drawback could be overcome under a system that involved patient-specific billing for hospital services (instead of annual budgets) and that required copayments from patients. Patient-specific financial accounting systems for hospitals can foster more cost-effective and higher-quality care. Moreover, health care costs are lower when copayments are required from patients because they use fewer services. This kind of system, though, would have higher administrative costs than a Canadian-style system.

Under a single-payer system with copayment requirements (SP1), total administrative costs would be about half of what they are under the current system, reducing NHE/A by about 4.6 percent, or $34 billion in 1991. The savings on insurance administration would be nearly as large as under SP2. Compared with the Canadian-style system, administrative costs would fall because use of services would be lower, but these savings would be offset by the administrative costs of a residual Medicaid program that would cover the copayment liabilities of low-income people. By contrast, savings on the

administrative costs of providers would be substantially lower because providers would have the expense of billing both the insurer and patients.

Single-payer systems, however, would have the disadvantage of eliminating consumer choices about benefit packages and sources of coverage. With multiple insurers, consumers have some choice in these areas, giving insurers greater incentives for service and innovation than might exist under a single-payer system.

One form of multipayer system that could achieve some administrative simplification is an all-payer system--under which multiple insurers would all adopt the same rates and policies for payment. In such a system (AP2), savings on administration would be small, only about 0.2 percent of NHE/A, or $1.6 billion in 1991. Essentially no savings on insurance administration would accrue because insurers' expenses for marketing, underwriting, and coordinating claims would not change significantly; instead, these costs would be somewhat higher because use of services would increase. Billing-related costs for providers would fall to about 85 percent of current levels, assuming that uniform payment rates and policies for insurers would simplify the claims process somewhat. Overall, total administrative costs would be about 98 percent of current levels.

Potential savings from simplified systems in later years, however, might be overstated by the estimates in Table 1 because of the move to electronic billing using standard claims forms that is already under way. According to a 1992 report from the Administration's Workgroup for Electronic Data Interchange, electronic billing might cut costs for both insurers and providers under the current system by $4 billion to $10 billion when fully in place. That shift would somewhat reduce the potential for further savings from simplification.

HOW DO CBO'S ESTIMATES COMPARE WITH OTHERS?

Although CBO's estimate of potential savings on administrative costs under a Canadian-style single-payer system is smaller than those in most other recent studies, the differences are not large (see the fourth column of Table 2). In the case of insurance administration, the differences stem primarily from the relatively minor adjustments CBO made to current costs (for the insurance cycle and premium taxes) and from different assumptions about whether private supplementary insurance and certain public health programs would continue. For example, the other estimates assumed that private insurers would cover some services not covered by the single payer, while the CBO estimate does not. For providers' administrative costs, the differences primarily stem from CBO's assumption that certain services, such as those

TABLE 2. COMPARISON OF CBO AND OTHER ESTIMATES OF SPENDING CHANGES UNDER A CANADIAN-STYLE SINGLE-PAYER SYSTEM, AS A PERCENTAGE OF NATIONAL HEALTH EXPENDITURES, 1991

Study	Changes in Overhead Costs for				Newly Induced Spending	Overall Change in National Health Expenditures
	Insurers	Hospitals	Physicians	Total		
GBHW[a]	-3.8	-4.4	-1.3	-9.5	1.7	-7.8
GAO[b]	-4.6	-2.5	-2.0	-9.1	8.7	-0.4
SYR[c]	-3.0	-1.8	-1.5	-6.4	10.6	4.2
CBO[d]	-4.2	-1.8	-1.1	-7.1	12.2	5.0

SOURCE: Congressional Budget Office.

NOTES: The CBO estimate assumes that average payment rates for physician and certain other services would be reduced by about 13 percent, while average rates for hospitals would be unchanged. The other estimates assume that average payment rates would be unchanged for all services.

These estimates do not include the effects of cost containment provisions--such as effective expenditure caps or price and utilization controls--that are in some recent proposals.

a. K. Grumbach, T. Bodenheimer, D. Himmelstein, and S. Woolhandler, "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," *Journal of the American Medical Association*, vol. 265, no. 19 (May 15, 1991).

b. General Accounting Office, *Canadian Health Insurance: Lessons for the United States* (June 1991).

c. J. Sheils, G. Young, and R. Rubin, "O Canada: Do We Expect Too Much from Its Health System?" *Health Affairs*, vol. 11, no. 1 (Spring 1992).

d. Congressional Budget Office, "Single-Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates," Staff Memorandum (April 1993).

provided by long-stay hospitals, would be financed outside the single-payer plan, and that administrative simplification would affect only billing costs.

Although administrative costs would be lower under a Canadian-style system, total spending on health might be higher. CBO estimates that national health expenditures would increase by 5 percent if the system had no explicit spending caps. Estimates by others suggest smaller increases or even decreases. The primary reason for this difference is that CBO's estimate of the increase in use of services under a system of universal first-dollar coverage is larger than was assumed in the other studies. CBO's estimate of the overall effects would be even larger (an increase of about 7 percent) had it assumed--as did the other studies shown in Table 2--that average payment rates for providers would be unchanged under the single-payer system. Instead, CBO's assumptions imply that average payment rates for physician and certain other services would be about 13 percent lower, while average rates for hospital services would be unchanged.

CONCLUSION

A good deal of uncertainty surrounds the potential savings that might be achieved with administrative simplification. CBO's estimates suggest that earlier attempts to gauge the magnitude of these savings might have been too optimistic. A review of the literature on this topic shows that estimates of the

potential administrative savings have tended to fall each time the methodology for estimating was refined.

Nevertheless, potential savings from administrative simplification are appreciable. Administrative costs that might reasonably be affected by simplification amount to nearly 10 percent of national health expenditures. CBO estimates that administrative costs might be reduced by nearly 7 percent of health spending (or by $52 billion in 1991) under a Canadian-style single-payer system. Potential savings in later years might be somewhat less because administrative costs may be relatively lower anyway as a result of the ongoing move to electronic billing. The administrative savings that might be achieved under other systems--such as a single-payer system with copayment requirements or an all-payer system--would be smaller. However, these alternative systems would offer other advantages that might warrant their higher costs of administration. Administrative costs are only one of many factors to consider as the Congress debates modifications to the current health care system.