



Administrative Costs for Regional Alliances  
and Health Plans  
Under the Health Security Act

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The Academy's seven-member Administrative Costs Work Group prepared this paper. Members of the group represent all segments of the current health care market. The Academy's Health Practice Council has charged this work group with providing an expert, detailed analysis of the added costs and potential savings for payers and reviewing administrative requirements and cost savings.

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## EXECUTIVE SUMMARY

This monograph focuses on the functions necessary to administer health alliances and health plans under the Health Security Act of 1993. In some areas, the Act will require extensive new administrative structures. In other areas, the Act will largely eliminate current administrative requirements or replace them with less expensive requirements.

Overall the Academy work group found that during the first two to five years after implementation, the President's proposal would substantially increase administrative costs. As indicated in summary Tables 1 and 2, the primary reasons for the initial increase in administrative expenditures will be the need to educate consumers, the costs associated with establishing well-controlled integrated provider networks, and the substantial initial investments in new data collection, data analysis, and the affiliated electronic reporting hardware and software. In most other areas of administration, there will also be some initial cost increase associated with revising old procedures and establishing new ones.

After an initial surge, administrative costs will decline each year after implementation, reflecting the benefits being derived from initial capital investments and from standardization of benefit packages and information processing requirements. The Academy work group anticipates that (within five years after implementation) administrative costs will have declined to about the same percentage of health care costs as currently. However, the resulting distribution of administrative costs by function will be quite different than under the current system.

In some areas, administrative costs will fall below current levels following the transition period. After an initial increase in the cost of enrollment associated with going from an employer-group-based system to individual enrollment, the Academy work group expects enrollment costs to fall below current levels because of the elimination of agents' commissions and the introduction of standardized enrollment systems. With a fully developed electronic data interchange system and standardization, the cost of benefit administration, which will rise initially, should also fall below current levels.

In areas such as consumer education/communication, premium collection, provider/health plan coordination and data reporting and analysis, costs will remain above current levels. Some of these higher administrative costs,

**TABLE 1**  
**SUMMARY OF ADMINISTRATIVE COST IMPACTS**

| Function <sup>1</sup>  | Cost Relative to Current Cost    |                              |
|--|----------------------------------|------------------------------|
|  | During Initial<br>Implementation | Well After<br>Implementation |
| Plan Design  | -                                | —                            |
| Marketing  | +                                | -                            |
| Enrollment/Consumer Education                                    | ++                               | +                            |
| Benefit Administration   | +                                | —                            |
| Provider/Plan Relations  | ++                               | +                            |
| Premium Collection   | +                                | +                            |
| Alliance/Plan Coordination                                       | +                                | -                            |
| State and Federal Regulation                                     | +                                | 0                            |
| Data Reporting and Analysis                                      | ++                               | +                            |
| Electronic Data Interaction (EDI)                                | +                                | 0                            |
| OVERALL Administrative Cost <sup>2</sup>                         | + / ++                           | 0                            |
| NOTE: The symbols in the chart should be interpreted as follows: |                                  |                              |
| Substantial increase   | ++                               |                              |
| Some increase  | +                                |                              |
| No expected change   | 0                                |                              |
| Some reduction   | -                                |                              |
| Substantial reduction  | —                                |                              |

<sup>1</sup>The administrative cost categories are defined in the Introduction to this report.

<sup>2</sup>During the first and second year administrative costs will be very high. These costs will then decline sharply, reaching about the same percentage level as under the current environment after five years.

# ADMINISTRATIVE COSTS UNDER THE HEALTH SECURITY ACT



**TABLE 2**  
**PRIMARY REASONS FOR ADMINISTRATIVE COST IMPACTS**

| FUNCTION  | DURING INITIAL IMPLEMENTATION   | WELL AFTER IMPLEMENTATION  |
|---|---|--|
| Plan Design   | Reduction in number of designs will save costs in the short term, although grandfathering will perpetuate nonstandardization for many years.  | Plan design costs will be greatly reduced because of standardization of both basic and supplemental plans.   |
| Marketing   | Competition for individual consumers through advertising will intensify as health plans seek to establish market positions. Standardization and reduction in agent expenses will be a partial offset.   | As health plans establish their markets and consumers become more settled with their health plan relationships, marketing expenses will decrease.  |
| Enrollment/<br>Consumer<br>Education                                | Losses of economies from group enrollment through employers and development costs for individually enrolling the non-aged population in health plans will exceed savings. Communication focused on individual consumers rather than employers will increase costs dramatically.   | Per-participant enrollee costs will fall due to electronic processing and because plans will have adjusted to updating materials in standardized formats. Continuing education and communication efforts will be costly but will decrease over time as plans and alliances gain experience in these areas.   |
| Benefit<br>Administration   | EDI and standardization of forms and definitions requires significant development costs for alliances, insurers, and providers with no offsetting savings. Implementing new definitions for medical necessity and standardized benefits will increase costs, e.g., legal challenges, in the short run.                            | Fully developed EDI and standardization will reduce costs significantly from current levels. Outcomes research may mitigate the legal costs of medical necessity challenges.   |
| Provider/Plan<br>Relations  | Plans will have to establish efficiently managed networks to compete effectively in the new environment. This is likely to be true even for many existing managed care arrangements.  | Maintaining provider networks will be less expensive than developing them but will remain more expensive than in the current environment.  |
| Premium<br>Collection   | Alliances will have to determine subsidies and required contributions, coordinate with employers and corporate alliances, coordinate premiums within families, and determine basis of individual eligibility. Coordination and premium collection from individuals (instead of employers) and bad-debt collection will be costly. | The same comments as for the transition apply. Most of the transition costs should fall over time as new systems are put in place, but costs will remain above current levels.   |
| Administrative<br>Coordination<br>between<br>Alliances<br>and Plans | Plans should realize cost savings fairly quickly because they will have to negotiate with only one large entity (the alliance) rather than with many small and medium-sized employers. Setting up systems to administer risk adjustment will offset any savings from eliminating up-front underwriting.                           | If the alliances are efficient and practices across alliances consistent, there will be savings to plans from dealing with alliances rather than individual employers. If risk adjustment mechanisms are based on valid but not over complex methods of assessing risk and supported by EDI, they will be less expensive than current up-front underwriting practices. |
| State and<br>Federal Regulation                                     | Implementing new regulatory systems will incur additional costs while retaining some costs that may involve redundant functions in the short run.   | The new regulatory system will be different but is likely to have about the same cost as the current system.   |
| Data Reporting<br>and Analysis                                      | The National Health Board, alliances, and plans have extensive new responsibilities for data collection and analysis to provide consumers with information, provide data for development of protocols, etc.   | After intensive short-run investment in new methodologies, equipment and personnel, and the revamping of current procedures, data reporting and analysis costs will stabilize. On balance, however, data and analysis costs will remain well above current ones.   |
| Electronic Data<br>Interaction (EDI)                                | Substantial developmental and equipment costs will be incurred by forcing full implementation in this area faster than it is currently occurring.   | Maintenance costs will be no different than under current expectations for EDI developments already in progress. The cost savings would be realized sooner because of the accelerated development required under the Health Security Act.  |
| Overall Admini-<br>strative Costs                                   | The first two years will have significant implementation costs. Transition costs should fall over time as new systems are put in place.   | The savings from simplified products and benefit administration and EDI-related savings will be offset by additional costs associated with marketing to individuals, providing universal coverage, maintaining provider networks, and increased data collection.   |



however, should contribute to lower overall costs of health care. For example, increased coordination between plans and providers should contribute to better management of care and lower levels of overall utilization. Plan performance and outcome measures that will be improved under the new system will contribute to the quality of care and, at the same time, lead to the elimination of some unnecessary care.

Although administrative costs under the President's proposal probably will not ultimately exceed administrative costs under the current system, the work group does have some specific concerns. First, the President's proposal does not include incentives for alliances to aggressively pursue those who choose not to pay their premiums. It is important that the health alliances not be permitted simply to pass this cost on to health plans and, thus, to consumers. If this were to become the standard approach to bad debt, nonpayment of premiums could become a significant problem in the reformed environment.

Second, the President's proposal needs to distinguish clearly between the role of the alliances and the states. Its failure to do so could lead to costly regulatory duplication and state-to-state variations that would drive up the costs of insurers operating in multiple jurisdictions. One example of this in the President's proposal is the ambiguity about who will negotiate with health plans over premium rates. The health alliances' authority is unclear and, as currently written, the President's proposal could lead to states keeping their current rate filing regulations in place at the same time that alliances are negotiating rates with health plans to meet budget targets. Although duplicative and outdated regulatory requirements would disappear over time, in the short run they could be a serious problem and increase administrative costs.

Third, the President's proposal separates premium cap enforcement from solvency regulation. This sets the stage for a major administrative difficulty for states because the budget targets could require premiums to be set at too low a level to permit enforcement of the states' solvency safeguards.

Finally, the President's proposal would add the need to coordinate premium collections among family members and would require that alliances collect premiums from several different sources, including employers, individuals, state Medicaid programs, the payer(s) for federal low-income subsidies, and perhaps other federal or state welfare programs. The Academy work group is concerned with the administrative complexity and potential for administrative error. Weakness in an alliance's administrative structure for premium collection could lead to higher costs for plans and for the consumers whose premiums actually do get collected.

Although this monograph deals specifically with the President's proposal, it does point to a number of more general administrative issues that policy makers should consider carefully in putting forth any proposal that relies on a managed competition approach. These issues are:

- Duplication of regulation;
- Duplication of administrative function between alliances, plans, employers and states;
- Clarity in delineating responsibility for functions; and
- Incorporation of incentives for investing in systems that improve the quality of care and reduce administrative expenses.

Much of the analysis in this monograph is applicable to nearly all managed competition proposals, not just the specific one put forth by the President. Readers are encouraged to note the generic aspects of the problems cited throughout the report and apply the same principles to other managed competition proposals that have elements in common with the President's proposal.

The monograph also underscores two other particularly important points. First, the President's proposal demonstrates how important standardization can be both to reducing administrative costs and helping make the medical financing and delivery system more manageable overall. Greater uniformity of regulation among states can be an important part of standardization.

Second, the discussion of enrollment and premium collection highlights the importance of an accurate system for tracking enrollment. Any reform scheme that places the enrollment function with an organization other than the health plans and premium payers can work smoothly only if plan enrollment is accurately recorded and all parties are immediately informed of any change in enrollment status. Otherwise, the systems for collecting premiums and paying providers break down. Premium payers are not certain they are paying for the correct persons or in the correct amount. Health plans are also uncertain of who is on their rolls at any given time and cannot process claims. To protect their financial interests, both premium payers and health plans will be forced to maintain duplicate recordkeeping systems and invent methods for the ongoing validation of those records. Uncertainty also will be created for the public and medical providers, both of whom will come to expect frequent disputes over who is responsible for paying particular medical bills.



## INTRODUCTION

The Health Security Act would alter significantly how insurance is provided to Americans under age 65. The Act would substantially change current insurance practices by requiring community rating and guaranteed issue and reissue. The Act would require that all Americans have health insurance coverage. And, finally, the Act would change the basic institutional structure through which insurers market health insurance and individuals obtain it.

As in the current environment, employers would continue to pay most of the cost of health insurance for their workers (80% of premiums). However, only the largest employers (those with 5,000 or more employees) would have the option of continuing to select health plans for their employees and dependents. These employers could continue to offer a range of health plans if they met federal government standards. Workers in other firms, as well as nonworkers, would individually choose their health plans from among those offered through the regional health alliance in their area, which would be the sole organization through which these individuals could obtain health insurance coverage.

**TABLE 3**  
**DEFINITIONS OF ADMINISTRATIVE FUNCTIONS**

| FUNCTION   | DEFINITIONS  |
|--|--|
| Plan Design  | Definition of health insurance benefit plans including services covered, deductibles and coinsurance, provider networks, underwriting (if permitted) and premium charged.  |
| Marketing  | Advertising and direct selling to employers or individual consumers based on product features (premiums, benefit design, provider networks, quality, service, etc.).   |
| Enrollment   | Choice by employer or enrollee of a benefit plan offered by an insurer, health plan or alliance. Detailed information on benefit plans available to potential enrollees and consumer assistance related to plans and enrollment procedures. Maintenance of eligibility records, including benefit plan chosen, applicable provider network, and dependents enrolled. |
| Benefit Administration                                 | Determination of appropriate claims liability under benefit plan provisions and the actual payments for that liability. Communications regarding claims and related matters.   |
| Provider/Plan Relations                                | Establishing provider networks based on negotiated reimbursement arrangements and rules for enrollee access (freedom of choice, required referrals, gatekeepers, etc.) Includes medical care management, performance and outcomes measures, administration, and data collection.   |
| Premium Collection                                     | Billing and collection of premiums based on eligibility of enrollee for coverage. Administration of employer and employee contributions (from multiple sources), and government subsidies for low-income enrollees and bad debt for non-collection of premiums.  |
| Administrative Coordination between Alliance and Plans | Design and marketing of benefit plans to employers and individual employees or other direct purchasers. Negotiations between employers or alliances and health plans on premiums, benefits, and provider networks.   |
| State and Federal Regulations                          | Regulatory functions, including premium and policy approvals, enforcement of solvency standards, administration of guaranty funds, enforcement of fair marketing standards, and resolving consumer complaints.   |
| Data Reporting and Analysis                            | Data collected includes claims, utilization, patient outcomes and satisfaction measures; enrollment and premiums; risk adjusters; provider fee schedules, capitations and other reimbursement arrangements; and projected and actual premium targets.  |
| Electronic Data Interaction (EDI)                      | Rapid, paperless exchange of information through telecommunications and other electronic networks using standardized formats.  |



This new system for providing health insurance for Americans under age 65 would be administered through four entities: the National Health Board (NHB), state agencies, health alliances, and health plans.<sup>1</sup> This paper focuses on administrative costs and examines only two of these entities—regional health alliances and health plans. These are the entities that would directly administer the system. Corporate alliances for employers with more than 5,000 employees are not included. In addition, the costs to the federal government and to the states of fulfilling their regulatory responsibilities are not considered, except to the extent that they affect alliance and health plan administrative costs.

There is no standard, accepted definition of administrative costs. For purposes of this paper, administrative costs have been divided into the 10 categories listed and defined in Table 3 below. Many of these categories would fall under any definition of administrative costs. Others would not always be included. For example, the work group has included marketing costs, which many analysts would not include. These costs are included because others have suggested that eliminating agents' commissions would generate administrative cost savings that would outweigh cost increases in other areas.

The descriptions and conclusions in this report are based on the health care system and terminology proposed in the Health Security Act.<sup>2</sup> Although the Act is extensive, it does not describe every aspect of the new system, and many significant administrative details are not addressed at all. Although it is appropriate that the legislation not address certain administrative and regulatory issues, this presents serious difficulties in analyzing administrative costs. In areas where the Act has insufficient detail to anticipate the exact nature of changes that will affect administrative costs, the work group used its knowledge of the current health insurance system to project the design of the system that would evolve. Thus, the conclusions in this report are most often a matter of expert opinion rather than the result of traditional, numerically based actuarial projection and analysis.

In arriving at its conclusions, the work group relied on the varied experience of its members, as well as on available data on the administrative costs of fee-for-service plans, HMOs, and Blue Cross and Blue Shield plans. The group also examined the experience of existing purchasing cooperative arrangements such as the Federal Employee Health Benefits Program (FEHBP) and California state employees health program (CalPERS). Finally, the work group reviewed the work of other analysts, such as that done for the Clinton administration by the Actuarial Research Corporation.

The report is organized as follows: The first several sections describe basic administrative functions as they are currently performed and as they would be performed under the Health Security Act. These functions include: plan design, marketing, enrollment, benefit administration, provider/plan relations, premium collection, administrative coordination between the alliances and plans, and state and federal regulatory requirements. In addition to addressing probable changes in administrative costs, each section includes a description of how the administrative function currently is performed and how it would be reformed if the Health Security Act were enacted.

The paper then addresses two issues that are critical to determining overall administrative costs and the administrative efficiency of the system proposed under the Health Security Act. The first issue is data reporting and data analysis requirements under the Act. The second is implementation of a nationwide system of standardized electronic data interchange (EDI). A number of the broader findings are highlighted in the conclusions.

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<sup>1</sup>Throughout this paper, the term health plan refers to the vendors who will market their products to regional and/or corporate alliances. They include insurance companies, Blue Cross and Blue Shield plans, health maintenance organizations (HMOs), and preferred provider organizations (PPOs).

<sup>2</sup>Throughout this paper, the Health Security Act is variously referred to as the Act, the President's proposal, and the Clinton proposal.



## PLAN DESIGN

*Current Environment.* Plan design is currently a key element in the marketing and pricing of health insurance. Health insurers, including HMOs, sell their health products in the open market where the decision to purchase is a voluntary one. Most sales are to employers. Smaller portions of the market are direct sales to individuals and sales through arrangements such as association groups where employers or individuals band together to purchase insurance through a common bond, e.g., a professional association, such as attorneys or real estate brokers, or farmers' purchasing cooperatives.

To compete in this market, insurers offer a large number of benefit designs with a fairly broad range of prices. The three basic plan types are fee-for-service arrangements, preferred provider arrangements, and HMOs.

Under fee-for-service arrangements, individuals are free to choose their medical providers. There is no penalty for choosing one physician over another, and covered individuals are generally able to go directly to a specialist without receiving prior approval. These plans may require second opinions before certain treatments are performed and may also require preauthorization for surgeries and hospitalizations. However, the medical providers used are completely at the discretion of the covered individual.

Under preferred provider arrangements, individuals are given a specified list of physicians that contract with an insurer. The individual must select from this list of preferred providers or receive less than full benefits for selecting a nonlisted provider.

HMOs are distinguished from other basic plan types because they use a gatekeeper/primary care physician to manage care. Individuals enrolled in HMO plans must first see one of the HMO's primary care physicians before seeing a specialist or seeking further treatment. The primary care physician determines the course of treatment and decides when and whether specialists will be consulted. Most HMOs maintain large facilities that house many physicians and a large number of other specialized medical technicians.

Within each of these basic types of plans, employers and individuals can buy coverage for varying types of medical services and select from a range of cost sharing options. Among the cost sharing options are varying deductibles, coinsurance, copayments and out-of-pocket maximums.

Deductibles are the specified amount of expenses for covered health care services that must be paid for by enrollees and their dependents before the health plan becomes financially responsible to cover health care expenses. Common deductibles are \$200, \$250, and \$500. Deductibles can be much higher, and some plans now use \$750 or \$1,000. Deductibles are applicable to a specified time period, generally a calendar year.

Coinsurance refers to a scheme for dividing costs for covered services between the plan and enrollee. Coinsurance is usually triggered after annual deductibles have been met. A common coinsurance scheme would have 80% of the covered medical expense paid by the plan and 20% by the enrollee.

A copayment is a fixed dollar amount that an enrollee pays for a specified covered service. An example is a flat \$10 fee that the enrollee pays for a physician's visit. Copayments are most common in HMO plans but are used by other plans as well.

An out-of-pocket maximum is the combined amount that an enrollee or his family must pay in deductibles and coinsurance annually before the plan begins to pick up 100% of covered expenses. Typical out-of-pocket maximums are \$750 and \$1,000 but can be much higher. The out-of-pocket maximum is designed to protect the enrollee against catastrophic medical expenditures.

The degree of cost sharing in a plan also can be affected by employers who may choose to pay the entire premium for their workers but often choose to pay only a portion.

Although there are hundreds of plan designs available in the marketplace at any given time, not all purchasers have access to all designs or to all designs at affordable prices. For example, employers and individuals in sparsely populated areas may not have access to an HMO, which is a plan design that works best in more densely populated areas. Some states do not permit the marketing of certain plan designs (in particular, those with very limited covered services) in their states, and most states mandate that certain benefits must be included in all plans. Plans offered through insurance companies must include these benefits. However, employers who choose to self insure are largely exempt from state regulation and have greater latitude in selecting the medical services they want to cover.

The characteristics of the purchaser also affect the range of choice in plan design. Large employers usually have the greatest range of plan design options. Options for small employers are more limited, but still relatively broad. However, certain options may be much more costly for smaller employers because the opportunity for adverse selec-

<sup>3</sup>Adverse selection refers to a purchaser of insurance selecting a plan with particular covered services and cost sharing characteristics because the purchaser, based on prior knowledge of health status, expects to utilize particular services.



tion is inversely proportional to the size of the group selecting insurance.<sup>3</sup> Individuals have the fewest options, and many types of coverage are prohibitively expensive because of the enormous opportunity for individual buyers to select coverage of services that they know they will use intensively.

*Health Security Act Environment.* Under the Health Security Act, the range of plan designs ultimately will be severely restricted. The Act will limit health insurance offerings to three standard benefit packages. It will permit supplemental insurance offerings, but here again the range of offerings will be severely limited.

In this new environment, the primary differences in plan design will be in the associated delivery systems. One option will be a fee-for-service plan; a second will be a PPO plan; and a third, a mixed HMO option, where at the point-of-service the enrollee can choose out-of-network providers. The services covered by each of the three plans will be the same. Moreover, each plan design will have its own cost sharing provisions which will not vary within that plan design. Cost sharing provisions will vary among the three plans. Thus, all fee-for-service plans will offer the same package of covered services and have the same deductibles and copayments. Similarly, all HMOs will cover the same services as the fee-for-service plan, but will have different cost sharing provisions than fee-for-service plans. HMO benefits will be richer than total benefits under the other two types of plans. The services covered will be the same, but cost sharing by the patient will be less.

Standardization of benefit packages and limiting the choice to only three packages will have a dramatic effect on health plan design costs. Although plan design costs are by no means the most important component of current administrative expenses, under the Health Security Act they would ultimately nearly disappear.

Not all the administrative savings from limiting the diversity of plan designs will be realized immediately. During the first 5 to 10 years of implementation there will be a much wider range of plan designs than ultimately permitted under the Act. In addition to the three basic plans, there will be phased-in plans, grandfathered plans, and two permissible supplemental plan designs. Employers and individuals also will be able to buy plans that insure services not included in the basic or two supplemental plans. Nonetheless, plan design costs will begin to fall even during the initial implementation period and will continue to fall after full implementation. The reduction may be small initially, but within 5 to 10 years after implementation insurers' expenditures on plan design should be negligible.

## MARKETING

*Current Environment.* Marketing in the current health insurance environment consists of a combination of employed marketing representatives, agents, and brokers paid by commission, consultants, and telemarketing. Many insurers<sup>24</sup> marketing programs also include advertising. Individual insurance is often marketed through direct-mail campaigns or through organizations such as the American Association for Retired Persons or professional associations.

The bulk of health insurance is sold to employers for their workers. In 1992, 88 percent of Americans under 65 with health insurance were covered through an employer-sponsored plan. The other 12 percent was purchased by individuals. Because most health insurance is sold to employer groups, the lion's share of marketing expenses is in the form of salaries or commissions paid to sales representatives and independent agents and brokers.

There is a widespread belief that the sales commissions make up a large proportion of total administrative costs and that eliminating these would greatly reduce such costs. Even for fee-for-service plans with fewer than 20 workers, which generally have administrative expense loads of approximately 35 percent, commissions account for only about 17 percent of total administrative costs, and for large plans, say those with between 100 and 500 workers, commissions account for only 10 percent of administrative costs.

It is true that commissions are a significant component of administrative costs. However, they are certainly not the largest single component. A recent study by Hay/Huggins showed that the cost of claims administration exceeded commission expenses by over 40% even for plans with fewer than 20 employees. And for plans with 100 to 499 employees, claims administration was two-and-one-half times more costly than paying sales commissions.

Clearly, eliminating commissions would reduce the administrative costs of the current system. However, there are other areas where even larger savings may be possible.

<sup>24</sup>The term insurer refers to any entity that accepts health insurance risk with regard to the establishment of one or more health plans of any type. Thus, insurers include commercial health insurers, Blue Cross and Blue Shield plans, HMOs, PPOs, and Physician Hospital Organizations (PHOs). Employers that self-insured their workers also function as insurers with regard to their health plans.



The current diversity of plan designs is an important part of both the pricing and marketing of health insurance and is driven by affordability. Employer expenditures for health care have been rising over the past couple of decades. As a result, expenditures are representing a growing portion of employee total compensation. It has been argued that growth in this area of compensation has resulted in the holding down of potential growth in wages and salaries. Plan design, which directly affects employer expenditures for health care, is therefore associated with potential employee wage and salary growths. Plan design is also associated with an insurer's ability to compete and with the ability of employers to afford to continue financing employer health care benefits.

Firm size is also associated with plan design. Large employer groups, whether insured or self-insured, have the greatest buying power in the market by virtue of their size. Larger employers have access to a great number of potential organizations that design plans. Many of the largest maintain professional staffs to do this. Larger employers may offer a wide range of choice. By comparison, small employers and individuals purchasing insurance may find a broad range of products but have almost no ability to negotiate premiums, benefit design, or provider networks. They may have some limited ability to join association groups if they meet the membership criteria. However, the association may disband or not control the increase in premiums if membership does not continue to be large and representative of the overall population.

Smaller employers select from available designs and work with agents and brokers who get large commissions, especially at the time of initial sale. Smaller employers most often select a single plan for their employees. Employers either choose one or more health plans that will be offered to their workers or design their own plans usually using the services of an agent, broker, consultant, or insurer.

Many plans currently advertise, but not all of them use agents. In addition, agents' fees for groups of 100 employees or more are not nearly as high. When agents' fees are high for smaller employers, the agents generally provide other services such as enrollment or customer service.

*Health Security Act Environment.* The Health Security Act will dramatically alter how health insurance is marketed. Employers will no longer select their workers' plan or the few plans from which their workers can choose. Instead, health insurance will be sold exclusively through regional health alliances, and individuals will be able to select any plan offered through their local alliance.

Some analysts expect considerable consolidation of health insurers and plans following health care reform. However, consolidation may take some time as many insurers feel their way in the new environment, and initially the number of plans to choose from will probably be fairly large. State certification will be required in order for plans to be offered through a regional alliance. Once certified, a plan could request any regional alliance in the state to include it among health plan offerings. In general, regional alliances could exclude state-certified plans only for egregious behavior, such as misrepresentation or fraud. In addition, a plan could be excluded from an regional alliance for having a premium that is more than 20 percent above the average premium for all plans in the regional alliance.

With only three basic choices of benefit packages, a fairly large number of health plans offering these packages, and a much smaller range of prices than currently, individual plan choices will depend heavily upon perceived differences in the quality of specialized services a plan offers, the range of choices of providers, and more general perceptions of what is the best buy, or the highest quality for the lowest price. At the same time, performance measures will be new, and may take some time to implement so that consumers will not necessarily have very complete information, and what measures are available may not yet be well understood by consumers.

Insurers will be competing for the attention of millions of consumers who are free to choose their own plan for the first time and, in the short run, large numbers are likely to be very aggressive in trying to differentiate their products from the products of competitors. All forms of media are likely to be used to attempt to make this differentiation, plans are likely to be willing to spend large sums on endorsements from a range of medical professionals as well as famous athletes. Health fairs and other public relations events may also be used to make personal contact with consumers in the guise of education. Telemarketing may also be used extensively to make personal contact with consumers.

This heightened market activity is likely to persist at least through the end of the first open season and may well continue throughout the year for several years into reform. However, consumers buy health insurance only once a year and, once people have settled into plans, many are likely to stay unless they are dissatisfied. So at some point, intense advertising may no longer be justified because there will be much less opportunity to convince people to change plans.

Over time, mass media advertising is likely to be replaced by frequent mail contact with the plan's enrollees—questionnaires on plan satisfaction, newsletters such as those many plans already sent subscribers, and thank-you letters for re-enrolling. In addition, sales representatives and agents likely will be replaced by service representatives



who will visit work sites, especially large ones. In addition, health plans are likely to substitute advertising for agents' commissions, especially during the open enrollment season each year. For large HMOs and health plans that currently deal with larger groups where commissions are a much lower percentage of premium, the advertising costs could be as large or larger than the current fees. Plans that have low or no agents' commissions, such as some Blue Cross and Blue Shield plans that currently compete on the basis of being able to obtain large discounts from providers, may need to incur larger marketing costs for the first time. As enrollments stabilize and the number of plans becomes smaller, marketing is likely to become more focused. Consumers are likely to begin relying more on published performance ratings, and marketing costs overall should fall below those of the current system.

## ENROLLMENT

*Current Environment.* For employer-sponsored plans in the current environment, enrollment is most often handled by the employer. For nearly all employer-sponsored plans, the health insurer or the third-party administrator for self-insured employers furnishes enrollment materials that the employer generally distributes.<sup>5</sup> These enrollment materials include benefit plan descriptions, disclosures of employee contribution costs, enrollment forms and, for managed care plans, service area and provider directories.

Employees of medium and large firms generally have at least two, and often three, basic plans from which to choose. In addition, employees may have the option of selecting supplemental dental or vision coverage. One of the basic plans is usually a fee-for-service or PPO plan and the other an HMO if one is available in the local area. Employers that offer multiple basic plans have an annual open enrollment period during which workers can change plans.

Smaller employers generally offer only one basic plan. Many do not offer supplemental dental and vision plans. With only one plan, there is no annual open enrollment period. Employees who decline coverage at initial employment and later wish to enroll are subject to individual screening of their health status, which is usually more rigorous than screening that would be done at time of initial employment.

The employer generally distributes enrollment materials provided by the plan and forwards completed materials to the insurer, third-party administrator or HMO, as appropriate. In addition, employers generally maintain records on employees for enrollment and eligibility purposes once employees are enrolled. These records include the location of an employee for multi-site operations and the basic and supplemental plans, if any, in which the employee is enrolled.

For small and many medium-sized employers that insure, questions arising during enrollment are generally handled by the insurer, the insurer's agent or a broker. For employers that self-insure, the plan administrator handles employees' questions during enrollment. Large employers often have their own professional benefits staff to assist employees, and other employers sometimes have personnel department staff that are available to assist.

Employers take responsibility for seeing that new employees are enrolled and that the insurer is informed when employees terminate. Workers are responsible for informing their employer of changes in enrollment status because of birth, death or divorce, and employers, in turn, inform the insurer or plan administrator. For children over age 18 who retain their dependent status, insurers often require separate documentation of full-time student status.

Finally, when a worker terminates employment, the employer is responsible for providing the employee with information on eligibility and enrollment for continuation of coverage under the employer's health plan. Insured health plans also may need to furnish terminating employees with information on state mandated options for converting the group insurance coverage to individual coverage.

*Health Security Act Environment.* Under the Health Security Act, employers would no longer select a plan or small number of plans from which their workers would choose. Instead, individuals would select their own plan from among all plans offered through their local alliance.

Health plans participating in the alliance would be responsible for providing their plan descriptions in a standardized format to the alliances. The alliances would compile and package the information for use by consumers. Although the alliance would be the primary distribution point for plan descriptions and other enrollment materials, it seems likely that employers would continue to be used to distribute enrollment materials to their workers.

<sup>5</sup>Very few employers that self-insure, even very large ones, totally administer their own plans. They use outside, third-party administrators that specialize in benefit plan management.



Each year there would be an open enrollment period during which all eligible individuals and families would have the option of changing plans. For multiple-earner families, the alliance would be responsible for any coordination of choice of plans and implementation of any rules regarding plans under which spouse's children were permitted to be covered.

The information provided to consumers by the alliance would include a description of the benefits for each of the three standard benefit packages including applicable deductibles and cost sharing for which the individual or family would be responsible. Plus, for each health plan participating in the alliance, the alliance would provide:

- Information on the plan's service area, facilities, provider arrangements, and other relevant network information/limitations;
- The premium that would be charged for the plan; and
- Measures of the past performance and medical outcomes for the plan.

Limiting the basic benefit packages to three will not only greatly facilitate comparative pricing but will also simplify the presentation of information on plans. Nonetheless, the enrollment materials could be fairly extensive. Since plans would generally have networks, for nearly all plans the materials would need to include specifics on the location of providers, clinics, and other medical facilities in the network. Depending upon the size of the geographic area covered by the alliance, these data could be critical to consumer choices. Moreover, depending upon the particular populations served, alliances might make different choices about the need for detailed information on provider networks and locations of providers.

It is difficult to anticipate how many plans would be offered through the average regional alliance. It seems reasonable that in densely populated areas at least 20 plans would be offered and, initially, the number might be substantially larger. In the Washington, D.C. area, all federal government employees have at least 24 plans among which to choose; some have more choices. State employees in California also can choose from 24 plans. Over time, many insurance industry analysts believe that plans would begin to consolidate and the number of plans offered would decrease. This is happening in California where a voluntary alliance was recently put in place.

Based on the experience of the Federal Employees Health Benefits Program (FEHBP) and the California Public Employees Retirement System (CalPERS), some analysts believe that selecting a plan from among many will be easy for most consumers. They point out, for example, that the 24 plans offered through CalPERS are described using a 50-page booklet, and the plans do not have standardized benefits.

The Academy work group does not agree that most consumers will find selecting a plan an easy task. This would be the first time that most Americans would be offered such a large number of choices of health plan, the first time the many consumers would be shopping for health care as they do for other consumer products, and the first time that a substantial minority of Americans would be making any choices at all about their health insurance coverage.

This would also be the first time that most Americans would be exposed to outcome measures for health plans. Although plan performance and outcomes measurers are available and currently being used by a limited number of plans (mostly HMOs), it may be difficult to agree upon the best set of measures to present. Some measures may be difficult for consumers to understand, and others could be subject to widespread misinterpretation.

It would be the regional alliance's responsibility to educate consumers generally and to provide special assistance to those with limited reading, writing, and English language skills. The communication problems that alliances are likely to face will be far more severe, especially in some locations, than those faced by CalPERS or the FEHBP programs that deal with a reasonably well-educated working population accustomed to dealing with forms and bureaucracy on a daily basis.

Many consumers will receive assistance from outside the alliance. Most employers are likely to opt out of any involvement in their workers' health insurance as quickly as good labor relations will permit. Providing health insurance is not a business most employers want to be in. However, in the short run many medium to large employers probably would maintain some role in communication and enrollment out of concern for the welfare of their employees. These employers would ensure that all employees received enrollment materials and might hold information fairs to help employees understand their choices. As noted above, health plans, as part of their marketing strategies, are also likely to be eager to assist consumers, especially groups, that the plan seeks to attract.

The work group believes the process of education will extend well beyond the initial enrollment period and that it is essential to the success of the Health Security Act. Consumer complaints and dissatisfaction will become a major issue if there is not a clear understanding of how to use the information presented by the alliances.

In addition to disseminating enrollment materials and assisting consumers, alliances would be required to set up rigorous and complete database systems for communication with actual and potential enrollees and health plans and for recording and updating enrollment status. These systems would be used first to distribute the information dur-



ing the period of enrollment each year. The database system would be modified at the end of the enrollment period each year to enter the plan selected and the enrollment category (single enrollee, one adult and spouse, etc.) for each person in the alliance's region. For some alliances this could be several million people. Finally, information on enrollment would be provided to individual health plans through direct linkage between the computer systems of the plan and the alliance.

During the year, the alliance's database would be used for communication with enrollees as needed and for informing plans of changes in their enrollment. For example, in the case of a plan insolvency, the alliance would need to advise enrollees that their plan was terminating and advise them of any enrollment actions that had been taken on their behalf or that they had to undertake. Records for individuals and families who move out of the alliance's area during the year will also have to be purged, and health plans informed of the change. Enrollment records also will need to be updated for deaths and changes in family unit status due to births, divorces, and children reaching adulthood.

Giving all Americans plastic health insurance cards appears to be simple. However, whether the cards will simplify the lives of consumers, providers, and health insurers will depend critically upon how well alliances can record and track changes in enrollment status. The cards will be much less useful if providers and insurers cannot rely on them to provide accurate information on the plan in which the patient is currently enrolled.

In the short run the administrative costs associated with enrollment and related communication with enrollees will increase. Both the alliances and the health plans will have to incur development costs for new data systems. The task of standardizing materials for consumers though straightforward may become fairly substantial if, during the first year or two, alliances change their specifications frequently as they experiment with the best way to present information, and different alliances require different formats and different level of detail. Initial consumer education is likely to be costly if consumer dissatisfaction is to be avoided, especially among certain groups. Also, during the transition, when alliances and plans are first dealing with mass individual enrollment, the current economies of group enrollment through employers will have been lost.

Over several years, the system-wide administrative costs associated with enrollment should fall. Employers that currently provide health insurance will be out of the business of selecting plans, of continually needing to shop for better deals as health care costs rise, and of dealing with the associated labor relations. Compatible computer systems will be in place, and online procedures for transferring data well worked out. Systems will also be in place for automatically informing plans of changes in enrollment through new births, and much of the population will have become accustomed to informing the appropriate parties when their enrollment status changes. Consumer education should also become less expensive.

Ultimately, the new enrollment system should reach the range of costs currently observed in the FEHBP and other similar programs. However, the costs are likely to remain somewhat greater. Nonworking individuals, marginal workers, non-English speakers and the most poorly educated will be more difficult to enroll and require more assistance than is needed by a group such as federal government workers.

## BENEFIT ADMINISTRATION

*Current Environment.* Under the current system, at the time of enrollment the plan administrator furnishes enrollees with information on how to file a claim and how to appeal a claim decision. The plan administrator also provides some means for answering enrollees' questions about specific claims and about specific benefits and services covered under the plan. Enrollees<sup>6</sup> also may have to contact the plan before receiving a service to receive preauthorization, which is now widely required by all types of plans, for some surgeries, hospitalizations, and certain other medical procedures. If the plan is an HMO or provides medical services through a network of preferred providers, enrollees may also need to communicate with the plan when obtaining out-of-network services, for example, when traveling.

The actual processing and payment of claims is done by the insurer, plan administrator, or HMO using eligibility information on file or after employer certification. Although all plans must determine the appropriate claims liability under the plan's specific provisions and actually pay for that liability, how the liability is determined and paid differs greatly among fee-for-service arrangements, capitated payment arrangements, and HMOs with salaried medical staff.

<sup>6</sup>The term enrollee is used to refer to any person or dependent covered by a health plan. The term encompasses the terms subscriber, contract holder, policyholder, plan member, covered spouse, and dependent.



Fee-for-service plans, as their name suggests, make reimbursements based on the medical provider's actual bill for each specific service. These plans require the completion of a claim form. In some cases providers, at their option, file the claim for the patient. Hospitals universally file the claims for patients, while practices vary widely among doctors and other types of service providers. Some file no claims, others file claims only for patients enrolled in popular plans in the local area, and others file all or nearly all claims. When the provider files the claim, the patient is billed directly for any amount not reimbursed by the insurer. Many insurers and plan administrators use electronic clearinghouses or bulk accumulation processes to minimize the number of checks and mailings to volume providers.

If the patient files the claim along with appropriate documentation, payment for covered services is made to the provider if benefits have been assigned to the provider by the patient. Otherwise, benefits are paid to the patient, who must pay the medical provider directly.

Many PPOs and similar arrangements and some HMOs use reimbursement methods similar to fee-for-service plans, except that provider fees are discounted. For these plans, it is typical, if not universal, for the provider to file all claims for reimbursement. The primary and often the only differences between PPO-type plans and fee-for-service plans are that the PPO has negotiated discounted fees with providers in exchange for a greater number of patients for the providers in the network. The primary difference between PPO-type arrangements and HMOs that reimburse on a discounted fee-for-service basis is that HMOs use a gatekeeper or personal physician to manage care while PPOs do not.

PPOs and many HMOs have capitated payment arrangements with providers. Under these arrangements, the provider is paid a set rate per plan participant and provides whatever care is required. Plans that use capitated reimbursement schemes may not use them with all types of providers. For example, physicians may be paid on a capitated basis while hospitals in the network are paid on a discounted fee-for-service basis or through a system similar to the DRG system used for Medicare.

Finally, staff HMOs pay their on-site medical staff and technicians a salary and have varying arrangements with hospitals and other outside providers.

Under both capitated and salary arrangements, there is no need to process claims for most services. If the HMO uses services outside the network, there is a claims processing procedure for reimbursing these outside providers. However, even for outside services, HMOs often have prepayment arrangements that obviate the need for claims processing.

As a result of different delivery systems and reimbursement schemes, the cost of processing claims varies greatly. This is generally a major administrative expense for fee-for-service plans and other plans that use fee-for-service reimbursement arrangements. For each claim the insurer must determine whether each service is covered under the plan, the maximum amount that the plan pays for the service, and the amount payable by the insurers under the terms of the plan.

This task is made even more complex because most insurers that market fee-for-service plans market many different plans. Each plan design covers somewhat different services and has different deductibles, copayments, and maximum out-of-pocket limits. Claims processors must take all these variables into account in determining the liability of the plan vs. the liability of the individual enrollee.

For HMOs and other plans with capitated payment arrangements or salaried medical staff, claims processing is a more modest, or even a minor administrative expense. Even these plans have some expenses for benefit administration, however. A single HMO may market several different plans with different required payments from enrollees (for example, different flat rates for a physician's visit or other routine medical services). Even though the enrollee may not see the paperwork, claims processing may also be required for specialized out-of-network services and for hospitalizations.

For medical providers, benefit administration is also complex and often burdensome. For fee-for-service plans, providers must deal with many idiosyncratic claims forms from different insurers. They must also deal with Medicare, which has its own special forms, and with the claim filing requirements of other public programs.

For hospitals the situation is equally or even more complex. They must not only deal with differing discounts and differing reimbursement rates for different plans, but also cope with Medicare's unique reimbursement system and with uncompensated and charity care. To deal with their complex billing problems, many hospitals use sophisticated computerized billing systems that require specialized staff to maintain, training and retraining of medical staff, and constant updating.

*Health Security Act Environment.* Much as in today's environment, under the Health Security Act, providers will file claims for reimbursement or accept payment through capitation or salaries. When treatment or a claim is received, the insurer will verify the enrollee's eligibility and then determine the proportion of the cost to be paid by the plan and the enrollee.



Although this process is superficially the same, there would be several important differences. First, regardless of their current practice, all providers that are not part of capitated or salaried arrangements would file the patient's claims for the patient. Second, since ultimately there would be only three basic benefit packages and limited supplemental coverage, it would be much easier for medical providers to calculate immediately any direct payment required of the patient. This would reduce billing and collection costs for providers. Third, claims forms throughout the system would be standardized, removing yet another burden for providers who currently file claims for their patients.

The benefits of standardization that would accrue to medical providers would be even more important for health plans using fee-for-service payment arrangements. With only three basic plans and a limited number of supplemental plans, claims processing would be transformed from a highly complex operation to the fairly simple task of verifying enrollment status and assuring that any utilization review requirements of the plan were followed. Although this maybe somewhat oversimplified, the potential for administrative savings here would be substantial.

Offsetting some of the positive administrative changes will be a number of increased requirements for both providers and health plans. Providers are likely to have to submit additional data with claims forms. In order for health plans to report plan performance and outcomes measures to the alliance, providers will have to report the necessary data elements to the plan. At least a part of this reporting would likely be done as part of filing a claim for reimbursement. In addition, certain highly specific diagnostic data may need to be reported to the plan if a risk adjustment/reinsurance mechanism is relied upon, which makes retrospective payments to health plans for very high-cost cases. These data should not be burdensome to provide, although they may add new administrative costs if alliances require auditing of some fraction of the data for accuracy.

Other changes in provider/health plan arrangements are also likely to increase the costs of benefit administration at least in the short term. Fee-for-service plans are likely to move toward negotiating with providers at least to the extent of requiring more data to justify services. Greater reliance will likely be placed on primary care physicians as case managers and screeners and, wherever permitted in law and regulation, fee-for-service plans are likely to require referrals from primary care physicians and pre-approval for many specialized treatments and procedures. As plans introduce more safeguards to assure the necessity of treatments and care, providers are likely to become more cautious about providing care without first verifying eligibility and assuring that the patient has complied with proper procedures under the plan.

In the more competitive environment that the President's proposal is intended to create, it will be more important than today to deal efficiently with benefit administration. Health plans are not likely to want to contract with medical service providers of any type who cannot electronically transmit data. Doctors and other providers will almost have to invest in the electronic recording and transmission of data if they have not already done so.

Finally, one requirement of the Act would create an entirely new cost for most HMOs. The Act requires that HMOs all provide a point-of-service option. This will add to the cost of benefit administration. Currently, out-of-plan services are not routinely available under many HMOs. Even if relatively few elect this new option, plans will have to have a system for administering these and dealing with the claims they generate. Joint ventures between commercial insurers and HMOs may alleviate much of this added HMO expense. Such joint ventures have already begun in some areas of the country.

Overall, benefits administration is an area where there will be substantial administrative savings. The savings will come through the standardization of benefit packages, uniform claims forms, and the universal use of electronic data interchange (EDI) technology.

In the short run, however, benefit administration costs are likely to rise. Much of what the Health Security Act requires in the benefit administration area is already happening to one degree or another. For example, insurers and providers are already investing heavily in EDI technology. However, the Act would substantially accelerate the current rate of change in some areas and move costs into the present that might otherwise be spread over many years. In addition, it will take time to retool claims processing operations, and investments in new technology will be required by some participants at all levels of the health insurance and health delivery system.

Not all the savings from limiting plans to three standard packages will be realized immediately. Some current plans will be grandfathered. This will perpetuate the current diversity of plans for some time into the future. In addition, supplemental coverage will be permitted, which will include wraparound plans and plans with additional coverages not included in the standard plans.

During the early years of legislatively defined standardized benefit plans, added legal costs are also likely as the courts attempt to define precisely the benefits specified in the law and whether certain services are, in fact, covered. Moreover, no matter how standardized the benefit plans are, appeals and significant claim issues will continue to arise over medical necessity and appropriateness of care. Over time, however, the requirement for measurement of medical outcomes may help limit the number of such disputes.



## PROVIDER/PLAN RELATIONS

*Current Environment.* As in other administrative areas, the relation between plans and providers differs depending upon whether the plan is fee-for-service, a PPO-type arrangement or an HMO. Fee-for-service plans have little or no contact with providers, except for verifying claims information and, even here, the interaction is usually minimal. Physicians may be required to document second opinions before performing certain procedures, and they may assist patients in obtaining preauthorization for treatment by communicating directly with plan personnel. In addition, hospitals, physicians, and other providers may appeal claims on behalf of the patient.

In addition to the above interactions, PPOs and HMOs, at a minimum, negotiate with providers over the form and level of payment for services. These plans may also track each provider's total charges and their practice patterns in an effort to manage overall costs and assure that services are medically necessary. In addition, some managed care-type plans work closely with providers to address administrative and medical care management issues as well as data collection needs. Some plans place particular emphasis on working with medical professionals to manage very high cost cases.

For staff HMOs and other highly managed health programs, the distinction between plan administrators and medical providers becomes blurred. Physicians and administrators often work as a team to assure efficient care and may work closely with hospital staff to manage costly cases. In addition, HMOs and PPOs are increasingly including financial incentives in their reimbursement schemes to encourage cost-effective treatment.

In another recent development, HMOs and a few other providers are beginning to collect information on plan performance. This places an additional administrative burden on providers, who must record data on individual patient encounters, and on administrators, who must compile and tabulate the data. In order to measure and report comparable and accurate health plan performance information to purchasers and the public, the National Committee for Quality Assurance (NCQA), in conjunction with employer and health plan representatives, has developed a set of standardized measures for plans to collect and report information on quality, access, satisfaction, membership and utilization. These measures combine information from enrollment data, claims, and encounter information. This is only one effort currently underway, but it typifies the type of activity that is now ongoing in the field. If, as is likely, the trend toward providing performance measures spreads to other provider arrangements, medical providers in general may have increased contact with plans as plans attempt to improve provider performance and seek to limit their enrollees' use of unsatisfactory providers.

*Health Security Act Environment.* Several provisions in the Health Security Act are likely, either directly or indirectly, to increase significantly the amount of interaction between plans and providers.

First, plans will no longer have the option of competing through variations in plan design. Without the flexibility to offer more or less costly benefit packages through design variations, insurers of all types will be under increased pressure to manage effectively care in order to reduce costs and remain competitive. This will be as true for HMOs as for fee-for-service and other plans. Under the Health Security Act, HMOs will be required to provide benefits that would be roughly 20% more expensive than those required of fee-for-service plans.

Increased price competition will encourage more widespread use of techniques designed to better manage care.

Activity to establish networks designed to effectively manage care would not be limited to insurers that currently do not have networks. PPOs and other plans that currently use only discounting to reduce costs also would be likely to begin implementing enhanced managed care techniques. As a result, many insurers would be likely to initiate provider relations programs that would include:

- Working with providers to establish clear and consistent measures of performance;
- Establishing financial incentives to achieve health plan goals, including budgets, plan performance standards, and medical outcomes;
- Reporting on results; and
- Using results to change bad or reinforce good performance.

Some HMOs and a few other plans already have programs similar to these in place. However, even these insurers will need to significantly enhance their systems. Insurers that do not have networks either will have to build them, acquire them from others who are leaving the market, or undertake joint ventures with existing networks or HMOs.



In setting up new networks and enhancing existing ones, insurers could take a number of different approaches to establishing clear, comprehensive cost control guidelines and implementing reimbursement systems to encourage strict adherence. An approach some health plans might use is to contract with one or all the provider groups on a capitated or incentive basis wherein income to the providers would vary directly with plan results. These arrangements would require a detailed utilization and cost review process to correctly allocate income. Feedback mechanisms would be essential to determine if the most cost-effective measures are being used.

Other health plans might choose to have providers on salary or implement fixed fees. These salaries and fees would have a variable element tied to performance, and feedback mechanisms would be needed to determine effective performance.

Either of these approaches, or the many possible variations, would require extensive communication with providers to be effective. After setting up the review process, the health plan would have to ensure efficient and timely application of the process. Although none of this is totally new, if the intent of the Act is realized, such arrangements would become much more prevalent and would add to administrative costs.

Not all health care would be provided through networks, of course. Fee-for-service plans would continue to exist and, as is currently the case, would have the least direct contact with providers. However, even here, contact with providers likely would increase. These plans, by law, would still permit enrollees free choice of providers. However, to compete in the new environment, they would need to establish the best possible utilization controls within the constraints of the law. Many utilization control practices, which are already in widespread use, probably would become nearly universal, including required second opinions, preauthorization of surgeries and non-emergency hospitalizations, and required referral to specialists from primary care physicians. Here again, increased oversight by plans would require greater communication between providers and plans to assure that patients follow proper procedures in seeking treatment and extra reporting to verify that proper plan procedures were, in fact, followed.

Second, the Health Security Act requires all plans to provide alliances measures of the plan's performance and medical outcomes. The alliance would distribute this information to prospective enrollees during the annual open enrollment period. As with other types of plans, providers would need to report outcomes to fee-for-service plans. This, too, would increase provider/plan interaction and add costs for both the plan and the provider. Developing the data systems for providing consumers with outcomes measures also will be expensive, although some of this work is already being done by some HMOs and other insurers.

Third, in order to control aggregate health care spending, the Act would require the National Health Board to set regional budget targets. To stay within these targets, the Act authorizes the alliances to establish caps on premiums. Implementation of the premium caps also would lead to greater communication between providers and plans. Plans subject to the caps would pay less than the fee schedule's rates for services in the alliance's region. For patients in fee-for-service plans, providers probably would want to know if reimbursements were to be at reduced rates. Based on such information, providers might alter treatment plans to minimize their potential income loss. At a minimum, plans whose premiums have been capped might want to track providers' behavior to protect their performance ratings.

In response to premium caps, other insurers might be encouraged to establish networks. In order to perform their role effectively in enforcing alliance budget targets through premium caps, it would be critical for plans to establish and monitor systems that ensure that claims under their plan are within the target. To do this would require the cooperation of providers, which might be able to be successfully achieved only through a network.

Many analysts would view most of these developments as highly positive from the standpoint of squeezing overutilization out of the system and encouraging more efficient quality care. And, indeed, the potential for savings in utilization may be substantial. However, from the perspective of this report, the increased interaction of providers and plans will increase, not decrease, administrative costs.

All the interactions, reporting requirements, and negotiations described above would increase administrative costs for plans and providers. Initially, the costs would be large. Many providers of all types (physicians, hospitals, and medical laboratories) would have to establish new procedures to comply with alliance and plan reporting requirements, and many might need to invest both in staff to record information not currently required and in electronic equipment to handle data recording and transmittal. This might be particularly true in less populated areas and among providers that are not currently volume providers.



## PREMIUM COLLECTION

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*Current Environment.* Currently, most insurance is sold to employers. The insurer collects premiums directly from the employer, who contracts with the insurer for the insurance and is responsible for paying all premiums.

For small employers, the insurer usually ensures, through credit checks and other means, that the employer is financially viable before selling the insurance. In addition, employers with groups of 50 or fewer workers are generally list billed. This means that each month the employer receives an invoice that lists each covered worker and the premium that is being paid for that worker. This makes it easy for the employer to ensure that the billing is correct and acts as a reminder to the employer to inform the insurer when new employees are to be added to the rolls and terminated employees deleted.

Larger employers receive periodic enrollment lists from the insurer that they can check against their own enrollment data. These employers must reconcile eligibility files, premium reports and payments to be sure proper premiums have been reported and paid.

Although employers are responsible for paying the total premium, most require their employees to pay some portion, which the employer typically deducts from the worker's paycheck. Employers that offer two or more plans or make supplementary dental and vision care available at the employee's option may deduct different amounts from an employees' paychecks depending upon the particular plans the employee selects. Even employers that only offer a single plan usually deduct different amounts from employees' paychecks based on whether the employee selects individual or family coverage.

Employers who self insure almost always use third party administrators who set up accounts for paying claims into which the employer makes regular payments. These employers often require employee contributions as well and make payroll deductions for employees that select the self-insured plan or plans.

Since the insurance contract is between the insurer and the employer, the insurer bears the burden for any non-collection of premium. When premiums are not collected, state laws generally require insurers to provide benefits to insured individuals until notification of cancellation for non-payment is provided.

Individuals who purchase health insurance for themselves have a high perceived need for the insurance and are usually highly motivated to pay their premiums. Premiums are generally paid directly to the insurer on a monthly or quarterly basis.

*Health Security Act Environment.* Under President Clinton's proposal, the premium collection system would be entirely revamped. Alliances would be responsible for the billing and premium collection function. Alliances would have to determine subsidies and required contributions, coordinate with employers and corporate alliances, coordinate premiums within families, and determine the basis of individual eligibility. Additionally, they would be responsible for disbursing the appropriate premium amounts, along with the eligibility information, to each health plan. The alliance, by virtue of the above functions also would become responsible for bad debt and uncollectible premiums.

As under the current system, health plans would have to continue to maintain up-to-date lists of enrollees to determine coverage eligibility and claims payment. They would also have to reconcile premiums received from the alliances with enrollment lists furnished by the alliance on regular basis and resolve any differences. However, plans would no longer have to maintain departments specifically dedicated to preparing billings and collecting delinquent premiums.

Under the new system, employers would not have to maintain records on plan participation. They would, however, have to maintain records of amounts to be deducted from the paycheck of each of their workers. Moreover, unlike under the current system, where employers decide what amount workers will contribute to their health insurance coverage, under the new system they will have to rely on the alliances to provide them the information on each individual employee's payroll deduction. Since the employer would not know which plan an employee is enrolled in and how the employee has selected to pay his premium, there would be no way for the employer to verify deductions. Employers would have to rely on workers to point out any errors that the alliance would be responsible for correcting. Larger employers would probably link directly into the alliance computer systems; others would receive invoices.

The functions required in this area would be more extensive and more complicated than under the current environment. Coordination of premiums for families would be required for the first time. In addition, the alliance would need to determine the source(s) of premium payment for each enrollee. Under the Health Security Act, enrollees can choose to make payment directly or through the employer or any member of the family. In addition, eligible enrollees will receive subsidies through Medicaid or other state and federal assistance as specified in the Act. Employers would also have to have information for appropriate withholding. The premium information in the alliance's database would have to be updated whenever an enrollee change in status affected the source of collection



of the enrollee premium, such as when an enrollee becomes unemployed, or family circumstances change.

The systems needed by alliances to track premium payments would necessarily be more complex than current ones used by insurers, and reconciliation of enrollment and premium data would also be more expensive.

The bad debt collection function of the alliance would probably also be more expensive than currently. In the current environment, most bad debt is nonpayment of medical bills by people with no insurance. Under the Health Security Act, providers would no longer have large unpaid medical bills since everyone would be insured. Bad debt, then, would not appear in the system as nonpayment of medical bills, but rather as nonpayment of premiums. Thus, the burden of nonpayments within the system would be transferred from providers to regional alliances.

Global enrollment will likely generate more uncollectible premium than currently. Many more individuals with no regular employer would be covered. Individuals who do not voluntarily elect to be covered would also be covered under the current system and may not be highly committed to paying for coverage under the new system. Many smaller employers that do not now provide health insurance for their workers will be required to contribute 80% of the cost of such coverage. Some may not have adequate resources to pay. Finally, individuals can elect to pay their share of the premiums themselves rather than through a payroll deduction. This, too, could increase nonpayment of premiums and premium collection costs.

Even if the alliances fail to collect premiums, they cannot deny consumers coverage under the President's proposal. The alliances can, however, pass bad premium debt on to health plans, and ultimately to paying consumers, through administrative loading. As currently structured, the Health Security Act does not contain any incentives for the alliances to expend significant effort to collect premiums. To minimize administrative loading, any final legislation should include incentives for premium payment and for bad debt collection in the absence of payment. Premium payment under the new system may also be administratively more costly for employers.

Overall, premium collection will be a more costly administrative expense than under the current system. As the Health Security Act is currently drafted, this would be true both at initial implementation and well after implementation. In fact, the cost could actually increase over time if nonpayment of premiums becomes a serious problem and this cost is merely passed on to plans as an additional administrative expense of the alliance.

## ADMINISTRATIVE COORDINATION BETWEEN ALLIANCES AND PLANS

*Current Environment.* Currently no states have mandatory regional health alliances such as those included in the Health Security Act. There are, however, a number of existing arrangements that approximate some aspects of regional alliances as conceived in the Clinton proposal. These include the Federal Employees Health Benefit Program (FEHBP), the

California Public Employees Retirement System (CalPERS), the Minnesota State Employees, the Council of Smaller Enterprises (COSE), and the Wisconsin Employee Trust Funds (Wisconsin ETF).<sup>7</sup>

These particular arrangements are not described here. However, the work group did examine the operation and administrative costs of these purchasing cooperative type arrangements to gain insight into how administrative costs generated by the alliances created under the Health Security Act might differ from those costs in existing arrangements.

*Health Security Act Environment.* The most fundamental structural change proposed in the Health Security Act is the creation of regional alliances through which the bulk of the population under age 65 would be required to purchase their health insurance. The administrative ramifications of shifting responsibility for enrollment from employers and health plans to the alliances are described above, as is the transfer to alliances of the premium collection function.

The Health Security Act gives the health alliance responsibility for several other functions, two of which may have important ramifications for administrative costs. These are administration of risk adjustment mechanisms and regional budget targets.

<sup>7</sup>In addition to the arrangements listed here, there are many voluntary purchasing alliances for small employers created by state law that are currently in operation. One is the Health Insurance Plan of California and there are two in Minnesota. They have been in operation for less than two years. Health alliances have been authorized in Texas, Florida, Ohio, and North Carolina, but these are still in the planning or implementation phases.

# ADMINISTRATIVE COSTS UNDER THE HEALTH SECURITY ACT



Each alliance will be responsible for administering a risk adjustment mechanism designed to equalize the impact on premiums of differences in the average health status of enrollees in different plans. In the current environment, there is generally no need for such a mechanism. Most insurers, though not all, can underwrite to avoid the worst health risks. In addition, insurers can set rates, sometimes within limits set by state law, based on health status so that insured groups pay premiums roughly commensurate with their expected medical expenses.

Under the Health Security Act, health plans will not be permitted to underwrite. They will be required to accept all applicants who can pay the premium. Moreover, each plan will be required to charge a single community premium rate (differing only by family coverage status) to all enrollees.

At implementation of the Act, health plans will have populations with different mixes of health risks based on past underwriting and premium rate setting practices. In addition, as the new system evolves, some plans may tend to attract better or worse health risks based on perceived differences in their quality or simply because of differences in network preferences of healthier and less healthy individuals.

The risk adjustment mechanisms administered by the regional alliances would attempt to level the playing field by transferring some of the premiums from plans with better health risks to plans with poorer health risks. This means that plans will not be competing on their ability to attract good health risks. With appropriate risk adjustments, those plans that manage medical care well will be able to charge lower premiums regardless of how many poor health risks they insure.

Another Academy work group alternative is studying risk adjustment mechanisms. That group has completed one monograph and will complete a second in the near future. The discussion here is limited to the administrative process through which any risk adjustment mechanism will be implemented and the likely administrative costs to alliances and health plans.

Under the Health Security Act, the National Health Board will be responsible for selecting a risk adjustment methodology. States can then adopt the NHB's methodology without change or would have the option to alter it before adoption. The alliances would be responsible for implementing the methodology and administering premium transfers among plans.

The administrative cost associated with the risk adjustment will depend upon a number of factors, such as the complexity of the mechanism, the degree of state-to-state variation in methodologies adopted, and the size of the dollar amounts transferred among plans.

In implementing a risk adjustment mechanism, burdens would be placed on plans and alliances in at least three ways. First, plans will be required to collect, compile, and perhaps audit the data needed by the alliance to calculate a risk adjustment index for each plan. These data might well include data that are not normally compiled currently, and assuring the quality of the data will be extremely important because of the potential size of these plan-to-plan transfers of premiums. The alliance might need to do some independent verification of data and would then need to manipulate the data to calculate index values for plans in the aggregate and each individual plan.

Second, plans may need to undertake more extensive data analysis and collect data in addition to what the alliance requires because of the importance of risk adjustment in determining the premium rate the plan will have to charge. In today's world, plans only need to know the risk characteristics of those they insure or expect to insure. In the new environment, plans would have to anticipate how much the characteristics of their expected enrollees will differ from the enrollees of other plans in order to anticipate the amount of risk adjustment debit or credit to their premium income. Initially, it may be difficult for plans to anticipate the magnitude of these transfers. However, failure to make a reasonable estimate could lead to the plan's badly miscalculating the premium rate it needs to charge to cover its expected liabilities for health insurance claims.

Finally, there would be some administrative expense involved in collecting and redistributing funds and, with large sums at stake, an appeals process may be required to reconcile disputes between the health alliance and individual plans.

A second major function of alliances, implementing budget targets for the region, also could have a significant affect on administrative expenses. The National Health Board will set regional budget targets. The alliance would then be responsible for determining if total medical expenses for its region will fall within the target given plan's quoted premium levels and predicted enrollment in lower and higher cost plans. If the alliance expected that its region would exceed its budget target, the alliance would negotiate premiums with health plans or levy an assessment on high-cost health plans. Plans that were required to lower their premiums or pay assessments could pass these costs directly back to medical providers for the plan.

Although this scheme seems straightforward, in fact, it is complex, even if the difficulty of making the necessary estimates is ignored. The Health Security Act offers few guidelines for how alliances are to negotiate premium decreases and make assessments on plans. The negotiations could be complex and expensive for both the plans and the alliance. Moreover, plans would have an incentive to anticipate assessments and downward premium adjust-



ments and set their initial premiums at somewhat higher levels. If premiums were set at somewhat higher levels, plans that had to reduce them could do so by reducing their payments to providers. Controlling behavior designed to avoid the adverse consequences of budget targets could become both a major headache and a new administrative cost for alliances in dealing with the health plans and for health plans in dealing with providers.

Overall, in the short run administrative costs are likely to rise somewhat as plans gear up for the data collection and resolve reporting problems associated with risk adjustment and struggle with methods for implementing and enforcing budget targets with their providers. Over time, as data collection becomes routine for risk adjustment, and insurers and providers work out well-defined strategies for dealing with budget targets, savings from elimination of underwriting and limiting negotiations to large regional alliances instead of negotiating separately with hundreds of employers should contribute to lowering the administrative cost of the new system.

## STATE AND FEDERAL REGULATORY REQUIREMENTS

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*Current Environment.* Insurers currently incur administrative expenses because of compliance and reporting requirements in state and federal laws and regulations. Commercial insurers, including Blue Cross and Blue Shield plans, and some HMOs must:

- File, and usually negotiate, premium rates for individual health insurance plans with state regulators and, in some states, file and negotiate rates for small employer group plans;
- Establish and maintain minimum reserves in accordance with state solvency standards and meet any state requirements for surplus asset levels;
- File extensive annual financial statements with state regulatory authorities;
- File all contractual and benefit forms, meeting any state mandates for required benefits; and
- Respond to periodic ad hoc data reporting requests from state insurance departments and other governmental entities.

Many states have different or additional requirements for Blue Cross and Blue Shield plans, which usually receive favored tax treatment, and most states also regulate HMOs separately. Federally certified HMOs are subject to yet a different set of regulatory requirements.

This system requires costly compliance and is made even more complex by the lack of uniformity among states. National carriers are now dealing with as many as 51 different jurisdictions whose rules continue to diverge as more states implement their own versions of health care reform.

*Health Security Act Environment.* The Health Security Act does not specifically eliminate most current state compliance requirements. The Act specifically preempts certain state laws that regulate benefit packages (state mandates) and elevates a number of regulatory functions to the National Health Board at the federal level. These federal functions, however, are often new, and in most instances the Act gives states the option of imposing additional requirements or modifying the federal ones.

Furthermore, the Health Security Act would also generate an entirely new layer of state regulatory and quasi-regulatory activities related to alliances. The states would be responsible for establishing alliances and overseeing them once established. Since many alliances will be billion dollar enterprises, states would likely create rigorous financial reporting and compliance requirements. Capital and surplus requirements may be established in many states, the solvency of alliances would need to be monitored, and regular financial reporting to the state will be required. Because the alliances are required to pay premiums even if they are not able to collect them, states might require alliances to establish contingency funds for bad debt so that plans can be paid premiums until the alliance can pass the bad debt charges on to plans in the form of alliance administrative charges.

Under the Health Security Act, alliances would be required to be audited by a qualified certified public accounting firm. Audits of the alliance would be used to determine sufficiency of financial and operational controls, achieve-



ment of national standards for health care, quality of data, and operational efficiency. The cost of independent audits would be paid by the alliance from its administrative loading charge on premiums.

Although the Act does not specifically eliminate duplicative functions, it is likely that some current state regulation would be eliminated over time. Moreover, most analysts anticipate that eventually the number of health plans and insurers offering plans will decline. Some insurers are likely to withdraw from the market, particularly if they have only a modest amount of health business. Other insurers are expected to consolidate, a trend that already appears to have begun. Fewer health insurers will lower total expenditure for complying with state financial reporting and a number of other types of state regulation. The cost to alliances of state oversight is expected to be modest and should decline over time as alliances stabilize as financial institutions.

Overall, then, the administrative costs associated with state and federal regulatory functions can be expected to increase for health plans and alliances in the short run, while some duplicative state regulation is still in place, and alliances are establishing procedures for reporting their financial status to the state regulatory authority and acquiring whatever surplus and contingency funds are required. Over the longer term, elimination of duplicative regulation and a smaller number of insurers will lead to lower expenses for state regulatory compliance than currently.

## DATA REPORTING AND ANALYSIS

The sections above described some of the effects the Health Security Act will have on costs in particular areas of plan administration. This section examines across all administrative functions to focus on the overall data collection and analysis requirements that would be necessary to implement the Act.

Under the Health Security Act, the National Health Board (NHB), the alliances, and the health plans all have extensive responsibilities for data collection and analysis. It is the NHB's responsibility to develop and implement the health information system by which the NHB would collect, report and regulate the collection and dissemination of health care information. In addition, the NHB is to specify the form and manner in which individuals and entities are required to collect or transmit health care information to the NHB and the frequency of data submission.

After the NHB sets the standards and requirements for its data needs, the alliance would be responsible for collecting and comparing the data. Health plans, which would have primary responsibility for collecting and submitting the information in a standardized, summary format, would provide the data to the alliances.

The specific responsibilities for which the NHB will require data from alliances and plans include:

- Determining the national per capita baseline premium target;
- Determining the alliance per capita premium target;
- Determining the national inflation factor, regional alliance inflation factor, and corporate alliance inflation factor;
- Evaluating the adequacy of premium credits and income discounts; and
- Collecting and interpreting transition data in order to develop initial baseline premium targets.

In addition to providing data to the NHB, the alliances would be responsible for:

- Collecting data, if necessary, to develop a fee schedule for providers;
- Developing risk adjustment factors;
- Providing enrollment projections by health plan;
- Determining that premiums set by the health plans based on enrollment projections meet the alliance per capita premium target;
- Evaluating and comparing quality measures, cost/utilization data, and consumer survey data;
- Evaluating and determining underserved areas; and
- Verifying and evaluating premiums collected and premium credits provided.



Finally, the health plans' responsibilities would include:

- Collecting and summarizing required data for reporting purposes to the alliance and NHB;
- Evaluating and collecting data for corporate alliances that may be separate and different from that collected for regional alliances;<sup>8</sup>
- Verifying enrollment projections used by regional alliances;
- Verifying that appropriate risk adjusters have been applied to the health plan's submitted premium rates;
- Determining the impact on health plan cost for a given year if required to use the regional alliance fee schedule;
- Collecting and summarizing membership survey information;
- Verifying and auditing premiums received and plan-specific adjustments; and
- Collecting all additional data needed to operate the plan, internally control costs, and negotiate effectively with providers of care.

The range of tasks and issues associated with such a massive new, ongoing data collection system would be broad. First, each of the system's functionaries (the NHB, alliances, and health plans) would have to determine what data were needed to fulfill their individual responsibilities. This task would not be a simple one. Virtually all the functions of the NHB and alliances are new. There are no standard methodologies for accomplishing these new functions, and complicated new methodologies would have to be developed even before specification of data needs could begin.

Once data requirements were determined, individual data items would need to be defined. The magnitude of the problem of the defining specific data elements can hardly be overstated. Many of the data elements that will be needed do not currently have standard definitions.

Defining data elements relating to insurance transactions is often elusive, and developing definitions in the provision of health care is even more elusive. The ideal objective is to develop a data collection format that will produce uniform definitions of data elements so that the data can be collected and compared on a consistent basis. The problem with attaining this objective is that many health plans reimburse providers using different methods. Some plans reimburse on a fee-for-service basis, others capitate primary care physicians and yet others capitate for all services. Under capitation arrangements, it is sometimes difficult to collect fee-for-service equivalent data from providers. While many plans require providers to submit claim forms, under a capitation arrangement, there is no real auditing of the claim forms to ensure that they are completed for each service and accurately coded. Thus, there may be an understatement of services provided when a plan capitates services, which, in turn, may distort the plan's performance relative to other plans.<sup>9</sup>

Even this simple example of accurately recording the medical services provided illustrates how difficult it will be to develop consistent definitions and, then, ensure that actual data collected accurately reflect those definitions. There are many other examples.

Currently, many plans count services differently and decisions will need to be made concerning: whether utilization should be tracked on an admission basis or hospital day basis (and define what constitutes an admission or a day); whether newborn days should be included or excluded; and whether physician services should be collected on a procedure or per-case basis. No matter what decisions are made, they will have a significant impact initially across all plans and on all providers. Many health plans will have to change their current claims and accounting procedures as will many providers.

Plan performance and medical outcomes measures will present a special challenge. The difficulty of developing effective measures is obvious. What may not be so obvious is the danger of being inundated with data. Much of the challenge here will be to choose those data elements that can most effectively measure results and can easily be explained to and interpreted by the consumer. Collecting more data than could be usefully analyzed, a likely temptation in this area, will increase administrative costs. The cost of collecting data must be balanced against the benefits gained from the data.

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<sup>8</sup>Corporate alliances, which are not discussed in this paper, would have data collection responsibilities similar to those of the health plans and regional alliances.

<sup>9</sup>Many HMOs are currently seeking solutions for these problems in order to construct performance and outcomes measures for their own internal use and for the benefit of their participants. Nevertheless, collecting comparable data for all plans will remain a problem for some time.



Developing the data and analytic requirements for each of the innumerable responsibilities listed at the beginning of this section raises issues of both short-term coordination and long-run oversight of data collection itself. It is unclear how well coordinated multiple data collection efforts would be, and any lack of coordination can impose substantial costs on health plans and alliances. Because data needs and definitions vary over time, it will be important to put a process in place to carefully review and update data needs.

Other data collection issues are also of concern. In the short-term, updating both software and hardware will be costly but very necessary to collect the reliable data needed for quality measures and risk adjusters, among other things. In the long term, the stability of the data requirements (changes in definitions, in formats, addition and subtraction of data items) will present serious dilemmas. On the one hand, outdated and unneeded data elements should be removed from the data requirements to save collection and processing costs. On the other hand, any change in data requirements inevitably generates costs for updating software systems.

There are also important issues of timing for data collections. Health care information is dependent on reporting of claims, enrollment and other utilization data, which may take six months or more to fully compile. In addition, premiums may need to be set early in the third quarter of the year. For example, 1995 premiums probably need to be based on 1993 data. The population covered by a health plan in 1993 and the basis for the premium projections may have changed significantly by 1995. An adjustment based on demographic and risk adjustment factors would need to be made. As discussed previously, the accuracy of these adjustments would depend on the development of the methodology and the ability of health plans to collect the necessary elements.

Because much of the data collected would need to be summarized and presented in a format easy to understand for audiences of different technical abilities, the actual presentation of data would be quite important. The information presented to consumers would have to be explained and summarized in a format much different from that presented to the NHB, which would use the information to evaluate the cost effectiveness of plans. Thus, significant effort could be needed at the alliance level to develop and update alternative protocols for the same data to ensure that the information would be understandable to the consumer, but detailed enough to be useful to decision makers.

A far-reaching concern for the entire data collection and management system will have to be the integrity and accuracy of the data. The Health Security Act does not specifically identify who will be responsible for auditing the data received from the health plans. However, with so much at stake for each plan, auditing will be necessary to ensure that the results presented are factual and accurate. Because data on quality and risk adjustment would play such an important part in the rating and comparison of plans, there is certainly a need for an auditing process that ensures accuracy and consistency of data across all plans. The auditing process would result in an additional and new expense under health reform.

The issues addressed above identify some of the major data analysis issues that would arise from health reform. There are also several issues dealing with the data collection during the transition phase and what data may be collected in order to determine baseline premium targets by the regional alliance. A separate report altogether could be developed on these data collection issues. The issues relating to transition would need to be addressed in a relatively short period of time and in great detail.

At the same time that substantial new data collection would be needed to operate the reformed system, few, if any, existing data requirements would be eliminated. States would continue to need the data they currently require for monitoring financial solvency. In addition, health plans currently collect data in order to make their business decisions and would continue to do so.

## ELECTRONIC DATA INTERCHANGE (EDI)

The Health Security Act outlines the creation of a national health database that requires the collection and reporting of data relating to administration, clinical outcomes, plan performance, financial monitoring, and reporting to consumers. The Act also requires implementation of a standardized electronic data interchange (EDI), which would greatly influence the way data are collected and disseminated, as well as how claims are paid. The automation of information and financial transactions can significantly reduce these administrative costs.

Much work has already been done within the private sector on EDI. The use of EDI can encompass a wide spectrum of services from claim payments to consumer surveys. However, in order for EDI to be effective, there must be consistent standard formats from which the data can be transmitted.



To date, four core health care EDI transactions exist (claims payment, enrollment, claims submission, and eligibility). These transactions were developed by the American National Standards Institute (ANSI) Accredited Standards Committee X12. Other health care transactions are under development, including claims status, health care services review, and patient information exchange. These are expected to be released for implementation sometime in 1994. It is estimated that about 30 percent of insurers are currently implementing the core EDI transactions.

WEDI initially estimated that the use of EDI would save between \$13 and \$26 billion a year over the present system (\$8 to \$20 billion for the four core transactions). However, there is an initial cost to set up the EDI network, which could range between \$5 and \$17 billion. The reason for such a significant start-up cost is that many of the existing health care entities (e.g., insurers, HMOs, hospitals, and physicians) do not have the capability within their current transaction systems to use EDI. In addition, the volume of information that would be required under the Health Security Act would increase the demands for data and of the administrative systems for most organizations.

While EDI has been implemented in other industries, the unique characteristics of the health industry would make it a difficult process to implement EDI and result in additional expense. These unique characteristics include multiple sites of care, systems incompatibilities, complexity, lack of standards, and no financial incentives.

Under the Health Security Act, health plans that choose to participate in an alliance would need to meet certain criteria, including the use of EDI, for claims payment. Before implementing EDI on a national scale, there are several issues that must be addressed by policy makers, providers, and payers.

The first of these is the issue of confidentiality. To date, no absolutely secure solution has been developed to ensure the confidentiality of the information that would be transmitted through an EDI system. Each American would have a Health Security Card that would contain a limited amount of information about that individual. This card would be a key component to the Health Security Act in the transmission of information via an EDI system. It is important that the information included on this card and via the transmission of claims be protected to the maximum extent possible. Such protection of necessity entails extra cost.

A second consideration is the uniform data requirements of EDI standards. In order to achieve the projected savings, a common set of data requirements and format must be developed. Without this consistency, many current problems, such as plan incomparability, would continue and savings would be diminished.

A third consideration is that there would be a need for additional data requirements to assist in management decisions. The introduction of EDI would minimize the cost for claims processing, but managed care organizations require other forms of provider communications to conduct business. Within a claim payment record, additional information should be included in order to support these activities, including payment authorization, referral authorization, copayment collection, case management, and outcomes performance measurement. These are all items that are important to a managed care organization and should be addressed when developing a uniform claims payment record. The importance of this issue increases when one considers that many managed care organizations have and would continue to reimburse providers under capitation arrangements that may not include supplementary risk-sharing payments to providers.<sup>10</sup>

A fourth area of consideration is the creation of a claims clearinghouse. Under the Health Security Act, an electronic network of regional centers to collect enrollment, financial, and utilization data would be created. For claims processing, these regional centers would be known as claims clearinghouses. Considering these clearinghouses would be regional in nature, one can view the clearinghouse as being a very powerful entity that would have access to valuable plan cost structure information and control the dissemination of utilization data. It is likely these entities could become quite large and influential and at some point would require some form of accreditation and continual monitoring—a cost not found in the current system.

Regardless of whether health reform legislation is enacted, the development and implementation of EDI standards and collection of information in electronic format will continue. Many private and public initiatives are underway. However, many of the issues summarized here would continue and may take many years to resolve.

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<sup>10</sup>Under some provider reimbursement arrangements, physicians risk share is based on separate funds, usually relating to hospital services. Depending on the balance of the fund at year-end, the provider may receive (or pay to the health plan) an amount from the surplus (or deficit) of this fund based on a predetermined risk-sharing formula.



## CONCLUSION

The President's Health Security Act would fundamentally change the way consumers obtain their health insurance. The associated administrative functions would be eliminated, replaced, revised, or performed by different entities under health alliances. This redefinition of functions under alliances is not designed solely to reduce administrative expenses, but rather to contain overall health care expenses and improve access and patient outcomes.

The Academy work group has concluded that substantial increases in administrative costs will occur with some functions—educating consumers, establishing provider networks and building data base capabilities—especially over the first five years of alliance operations. However, by the end of the 5-year period, significant savings would result through paybacks on capital investments, standardization of benefits, more cost-effective provider networks, and electronic data interaction. After five years, administrative costs will have returned to approximately the same percentage of health care costs as today.

The work group has identified four major concerns about the design of the Health Security Act: nonpayment of premiums, regulatory duplication and inconsistencies, conflict between health plan solvency and premium cap enforcement, and difficulty in coordinating benefits and premium contributions between family members.

The conclusions drawn by the work group are based specifically on the Health Security Act but are generally applicable to other managed competition proposals that include health alliances or other purchasing pools.

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