Health Cost Containment and Efficiencies
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Administrative Simplification in the Health System

Cost Containment Strategy and Logic

Administrative simplification refers to efforts to streamline administrative functions in the current health system.[1] Administrative simplification includes programs that:

- Promote or require use of standardized, common electronic or paper forms (e.g., for billing and coding);
- Improve the efficiency of provider-insurer transactions in claims processing and payment;
- Institute a single process for verifying provider (for example doctors, specialists, nurses) experience and education that is recognized by all parties, as opposed to having separate processes for each health plan, hospital and practice that requires providers to verify their credentials before hiring or paying them;
- Give providers and patients instant access to a patient's insurance coverage information (e.g., services covered, required copayments and caps on benefits) using a magnetic swipe card;
- Standardize medical management policies (e.g., preauthorization procedures); and
- Streamline government regulations and compliance requirements.

By streamlining and standardizing routine business processes, administrative simplification can help to reduce unnecessary and duplicative transaction costs and thus reduce overall health care expenditures.

Target of Cost Containment

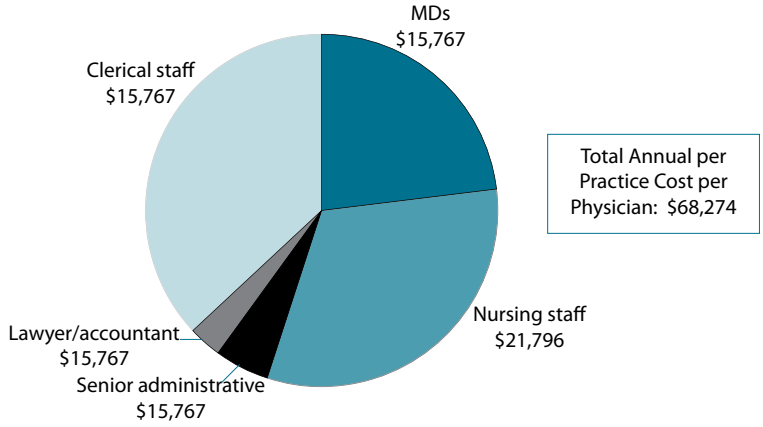
Evidence indicates that efforts to reduce administrative expenses have resulted in some efficiencies.

The primary goal of administrative simplification efforts is to lower costs by reducing duplication and unnecessary complexity in health care system operations. A 2009 report on improving health care purchasing in Minnesota observed, "Because routine administrative transactions such as checking patient eligibility for benefits, submitting bills for services, or making payments to providers occur every minute, every day, millions of times each year, even small inefficiencies add up to be significant costs and drags on health system productivity."[2]

Administrative simplification initiatives are aimed mainly at how health providers and insurers conduct business, especially with one another.

An example of administrative inefficiency concerns the way health care billings are processed. Studies suggest that paper billing—the traditional and still most widely used method—costs nearly twice as much ($1.58 per claim) as electronic billing ($.85 per claim).[3] Provider credential verification also typically is inefficient. One group has estimated that the average health plan spends approximately $500,000 annually on credentialing activities, and the average provider spends up to 6.5 hours annually.[4] Processing bills is another source of unnecessarily high administrative expenses. According to the American Medical Association, physician practices spend as much as 14 percent of their total collections to ensure accurate payment for services. This amounts to more than $68,000 per physician practice (Figure 1). Researchers estimate that provider and health plan administrative costs together account for 25 percent or more of the cost of private health insurance coverage.[5]

Figure 1. Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at $31 Billion*



*Based on an estimated 453,696 office-based physicians.
Source: L.P. Casalino et al., "What Does it Cost Physician Practices to Interact with Health Insurance Plans?" Health Affairs Web Exclusive, May 14, 2009, w533-w543.

Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 23, 2010, contains several administrative streamlining provisions. Examples include adopting a single set of operating rules for eligibility verification and claims status (effective Jan. 1, 2013); electronic funds transfer and health care payment and remit-

tances (effective Jan. 1, 2014); and health claims processing, enrollment and disenrollment, premium payments, and referral certification and authorization (effective Jan. 1, 2016).

State Examples

■ Several states have conducted studies to estimate the potential savings from various administrative simplification initiatives. For example, the Oregon Health Fund Board estimated that, over 10 years, developing and requiring all plans to use uniform forms and processes for administrative transactions could save $350 million in health-plan-related transaction costs. Limiting the allowable increase in the administrative portion of insurance premiums to a measure of general inflation could save as much as $1.4 billion over 10 years in health insurance premium costs. Minnesota's Center for Health Care Purchasing Improvement calculated that requiring providers and insurers to conduct all administrative transactions electronically using standard data and content could reduce overall costs in Minnesota's health care system (both public and private) by more than $60 million per year by 2013.

■ At least 15 states require or encourage use of a standard provider application for credentialing—a nationally recognized application and/or a state-specific one. West Virginia is among the most recent states to enact legislation that sets up a process designed to lead to a standard credentialing system.[6] In most cases, states have designated the standard provider application developed by the Council for Affordable Quality Healthcare (CAQH) as their required or acceptable provider credentialing form. Louisiana, New Jersey and Tennessee, for example, require or allow health plans to use either the standard CAQH application or a state-specific alternative. Vermont requires use of the CAQH application form.

■ An increasing number of states are encouraging or requiring health plans to provide enrollees with health insurance swipe cards. Swipe cards, which would replace paper ID cards, have magnetic strips that give patients and providers immediate access to information about a patient's health insurance benefits (e.g., deductibles and copayments). Most states are considering the uniform standards recommended by the Workgroup for Electronic Data Interchange (WEDI), a broad-based, national health care industry association. Utah enacted legislation in 2009 (HB 165) that moves the state toward a standardized swipe card and changes how hospitals and health care providers send information and billing to patients. Colorado's 2008 law (SB 08-135) requires health insurers to issue standardized, printed identification cards and authorizes the commissioner of insurance to adopt rules requiring insurers to use standard swipe cards or other appropriate technology in the future.

■ States are considering a standardized claims processing system for all payers. The Oregon Health Policy Commission recommended in its 2007 road map for health care reform that the state continue its efforts to create a statewide simplified and standardized claims processing system, using its influence as a purchaser and as a key regulator. Several states already require standard claims submissions. Maine, for example, requires providers to submit their claims to insurers in a standardized electronic format.

■ A 2005 Maine law was designed not only to reduce administrative costs, but also to ensure that savings are passed to health care purchasers.[7] The law establishes an administrative streamlining work group to "…facilitate the creation and implementation of a single portal through which hospitals can access and transmit member eligibility, benefit and claims information from multiple insurers." The work group is responsible for investigating ways to ensure that savings from implementation of the portal are passed to purchasers in the form of rate reductions by hospitals and other providers and by reductions in administrative costs by insurers and third-party administrators.

■ Several states have either passed a series of bills to streamline various administrative processes or have enacted comprehensive administrative simplification bills.

—A 2007 Minnesota law required all health care providers and payers to use a single electronic standard for the transmission, content and format of payment records, claims and eligibility verifications, beginning in 2009.[8] In 2009, the Legislature passed technology standards legislation (HF 384B) that prescribes a process for adopting rules to implement a standardized electronic swipe card all health plans must use.

—A 2008 Massachusetts law requires health insurers and providers to adopt statewide, uniform, consistent and standardized billing and coding processes by 2012.[9] The state is also considering ways to reduce duplicative or conflicting state regulatory requirements. State agencies that regulate health providers and plans are collaborating to consider the cost containment potential and feasibility of creating a uniform system and format for similar reports required by multiple state agencies. Examples of such filings include reports of injuries, adverse medical events, frequency of filing claims information and membership data. The Division of Insurance and the attorney general's office are responsible for holding hearings for insurance companies that submit rate increases above 7 percent, paying particular attention to the companies' administrative costs and executive compensation. The state also is considering moving health plan licensure from every year to every two years.

—Washington enacted comprehensive administrative streamlining legislation in 2009.[10] The Health Care Efficiency Act requires development and implementation of a uniform provider credentialing process; a uniform standard document and data set for electronic eligibility and coverage verification; code standardization; and common and consistent time frames for reviewing requests for medical management protocols (e.g., prior authorization and preadmission requirements).

■ Several states have established or are considering creating advisory groups or offices responsible for identifying ways to reduce administrative expenses. Maine established an Administrative Streamlining Workgroup authorized by a 2005 law.[11] In a 2008 report, the Oregon Health Fund Board recommended that the Division of Insurance convene a work group to develop uniform forms and processes for administrative transactions.[12]

Non-State Examples

■ A national group, the Committee on Operating Rules for Information Exchange, is working to build consensus among health care industry stakeholders on a set of operating rules for administrative interoperability between health plans and providers to streamline provider-plan transactions. It currently is working to develop rules for immediate electronic verification of patients' health plan coverage; determination of claims status; processing prior authorizations; and standard medical identification cards. Among the government agencies participating in CORE are Louisiana Medicaid and the Minnesota Department of Human Resources.

■ Humana Health launched a swipe card pilot program in two Florida cities in 2007. Since then, the project has spread statewide and to seven other states. United Healthcare also has adopted swipe card technology; more than 20 million of its members have electronic ID cards.

Evidence of Effectiveness

Limited evidence indicates that efforts to reduce administrative expenses have resulted in some efficiencies. Unfortunately, most of the literature on administrative streamlining focuses more on estimates of current administrative expenditures rather than on demonstrated savings from administrative simplification. Existing evidence comes mainly from the private sector; no studies of the results of state administrative simplification efforts were found. The results of three private sector initiatives are discussed below

■ IBM assessed the results achieved by health plans that adopted some initial CORE rules for administrative interoperability described previously. It found that electronic verification of patients' benefit coverage (e.g., deductible and copayments) took about seven minutes less than telephone verification, saving about $2.10 per verification.[13]

■ Blue Cross and Blue Shield of South Carolina's Web-based tool, My Insurance Manager Web Precert, allows providers to receive immediate resolution of some pre-certification requests, verifying member eligibility for procedures, medications and other services. In 2007, it reported that the system created efficiencies credited with savings of $1.4 million.[14]

■ UnitedHealthcare is testing immediate claims adjudication, which allows a claim to be submitted to an insurer and settled before a patient leaves the office. The company reported that a 10-physician Texas practice participating in the pilot program saved $14,000 in billing costs in a year. Another practice reduced accounts receivable by 13 percent and decreased the average time to collect insurer and patient payments from 45 days to six. For some practices, however, implementing real-time claims adjudication is complicated and can require a change in physician office billing and collections procedures.[15]

Although administrative streamlining appears to have resulted in some savings, for the most part it has not yet reduced costs for purchasers. A comprehensive research report concluded, "Evidence is lacking on whether improvements in the efficiency of insurance companies will be translated into reductions in premiums for their customers."[16] The report continued: "Similarly, it is uncertain whether improvements in hospital efficiency will be translated into reductions in charges for services." It found no evidence to prove that any specific interventions would reduce overall costs.

Several states have either passed a series of bills to streamline various administrative processes or have enacted comprehensive administrative simplification bills.

Challenges

■ Significant cost savings from administrative reforms have not been realized or appeared in the form of lower costs for purchasers for several possible reasons.

■ Many efforts to streamline administrative functions are relatively new and have not been widely enough adopted to realize overall savings.

■ Programs designed to reduce overhead often have significant front-end costs (e.g., new computer systems and training personnel). As a result, a net benefit may not be realized for several years.

■ It can be difficult for payers to capture the savings associated with efficiencies realized at the provider or plan level. Plans and providers may retain the savings rather than pass them along to payers.

■ Some targets of administrative simplification account for a relatively small part of health care costs. For example, a Washington report on administrative simplification found that, while "provider credentialing is a source of administrative variation and waste that generates provider frustration, it does not appear to be a major source of cost to providers, plans or hospitals."[17]

■ Some health policy analysts have argued that a greater overhaul of the system beyond simply streamlining current administrative functions is needed to realize savings. This might include substantially reforming the health care payment system, limiting the number of allowable benefit designs and prohibiting exclusion of preexisting conditions, or establishing a single payer system.

For More Information

Eibner, Christine, et al. *Controlling Health Care Spending in Massachusetts: An Analysis of Options*, Option #13, "Reduce Administrative Overhead." Santa Monica: RAND Health, August 2009; http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf.

Washington State Office of the Insurance Commissioner. *Report to the Governor and Legislature: Top Five Health Care Administrative Simplification Priorities and a Plan to Achieve Those Goals.* Olympia: WSOIC, Dec. 1, 2008; http://www.insurance.wa.gov/legislative/reports/SimplificationRpt.pdf.

NCSL has posted supplemental materials and 2010 updates on this topic online at http://www.ncsl.org/?tabid=19926.

Notes

1. Single payer systems, which involve a substantial restructuring of the health care payment and administrative systems, are the subject of another brief in this series.

2. "Center for Health Care Purchasing Improvement, *Annual Report: January 2008 – December 2008*, Minnesota (St. Paul, Minn.: CHCPI, May 2009); http://www.health.state.mn.us/divs/hpsc/chcpi/legrpt2009.pdf.

3. AHIP Center for Policy and Research, *An Updated Survey of Health Care Claims Receipt and Processing Times, May, 2006 (*Washington D.C.: AHIP Center for Policy and Research, May 2006; http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf.

4. Washington State Office of the Insurance Commissioner, *Report to the Governor and Legislature: Top Five Health Care Administrative Simplification Priorities and a Plan to Achieve Those Goals*, (Olympia: WSOIC, Dec. 1, 2008); http://www.insurance.wa.gov/legislative/reports/SimplificationRpt.pdf.

5. Healthcare Administrative Simplification Coalition, *Bringing Better Value: Recommendations to Address the Costs and Causes of Administrative Complexity in the Nation's Healthcare System* (Washington, D.C.: HASC, July 2009); http://www.ahima.org/dc/documents/HASCReport20090717.pdf.

6. 2009 W.Va. Acts, Chap. #110.

7. Maine 2005 Me. Laws, Chap. 394 (Laws of Maine); http://www.legislature.maine.gov/legis/bills_122nd/LD.asp?LD=1673.

8. Minn. 2007 Minn. Laws, Chap. 147.

9. 2008 Mass. Acts, Chap. 305.

10. 2009 Wash. Laws, Chap. 298.

11. 2005 Me. Laws, Chap. 394 (Laws of Maine).

12. Oregon Health Fund Board, *Aim High: Building a Healthy Oregon*, Final Report (Salem, Ore.: OHFB, November 2008); http://www.oregon.gov/OHPPR/HFB/docs/Final_Report_12_2008.pdf.

13. Council for Affordable Quality Healthcare, "Industry Collaboration: Simplifying Administrative Complexity," PowerPoint presentation, Institute of Medicine Public Meeting 10: The Healthcare Imperative: Lowering Costs and Improving Outcomes, Strategies that Work, Washington D.C., July 17, 2009; http://healthitextensionservice.igloocommunities.com/documents/instituteofmedicinehealthreform/industrycollaborationsimplifyingadministrativecomp.

14. Blue Cross and Blue Shield of South Carolina website; http://www.blueadvocacy.org/plans/view/blue_cross_and_blue_shield_of_south_carolina.

15. Victoria Stagg Elliott, "Practices See Slow Progress in Instant Claims Adjudication," *amednews*, Aug. 17, 2009; http://www.ama-assn.org/amednews/2009/08/17/bil20817.htm.

16. Christine Eibner et al., *Controlling Health Care Spending in Massachusetts: An Analysis of Options* (Santa Monica: RAND Health, August 2009),160; http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf.

17. Washington State Office of the Insurance Commissioner, *Report to the Governor and Legislature: Top Five Health Care Administrative Simplification Priorities and a Plan to Achieve Those Goal*s.

About this Project

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

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