PROFILES OF COST CONTAINMENT STRATEGIES
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Reduce Administrative Waste

Cost Driver Targeted: Administrative costs

OVERVIEW

In the United States, administrative costs comprise up to one-third of total health care costs, a much larger proportion than in other comparable countries in the Organisation for Economic Co-operation and Development (OECD). These costs are often attributed to the complexity of the largely private, multipayer system operating in the U.S. However, many other countries with lower administrative costs (including Switzerland, France, and Germany) use multipayer systems. These countries also have highly regulated, standard payment rates across payers, which reduces the administrative complexity of billing. However, there are other strategies to address the complexity of the U.S. system that do not require adopting standard payment rates.

Billing and insurance-related (BIR) costs are the largest component of administrative costs. Included in this category are eligibility determination, claims management, clinical documentation and coding, prior authorization, sales and marketing, quality measurement, and credentialing. The Council for Affordable Quality Healthcare (CAQH) reports that moving from manual to fully electronic transactions would yield the greatest savings per transaction for claim status inquiries ($11.71), although prior authorization ($9.64) and eligibility and benefit verification ($8.64) also present large opportunities for savings.

Administrative costs are an attractive target for cost reduction, as they are potentially low-hanging fruit and not directly related to patient care. However, a comprehensive approach to reducing administrative costs has not been implemented at the federal or state level. Congress has shown some interest in efforts to reduce administrative costs, although legislation has stalled.

We focus here on strategies states can employ to reduce BIR costs, including simplifying and standardizing insurance choices, streamlining the billing process, harmonizing quality metrics, and reforming the prior authorization process.

The Commonwealth Fund

- **Simplifying and standardizing insurance choices:** Myriad insurance plans exist in the individual and group markets within each state. Many of these plans differ in negligible ways yet contribute significantly to the complexity of the system. This strategy would reduce the number of plans in the market to highlight those that are meaningfully different and provide greater standardization. As a result, consumers (both individuals and employers) may better understand the differences and maximize their choices. Standardization not only reduces complexity but can promote competition as well. In the employer market, this strategy also lowers the cost of negotiating and drafting contracts, decreases sales and marketing activities, and alleviates switching costs. In the nongroup market, individuals can more easily navigate their choices in the Affordable Care Act marketplaces, which offer fewer, more structured choices.
- **Streamlining the billing process:** A proposed national approach for significant paperwork reduction would involve developing a centralized claims clearinghouse in the U.S. to allow providers to submit all claims to a single entity, as they do in Germany. Although this ambitious approach could not be implemented at the state level, there are strategies states could employ to streamline commercial claims processing. For example, states could require the interoperability of data across systems, further standardize and automate billing forms and processes, provide incentives for real-time adjudication of claims, and more fully realize the potential of prospective, value-based payments to reduce the need for billing and adjudication.
- **Harmonizing quality metrics:** A little more than half (53%) of all commercial dollars in the medical system have some value-based component, either tied to performance or designed to improve efficiency. Thousands of quality metrics are in use in the health system, and physician practices spend more than $15 billion annually to report quality measures. This strategy would involve determining a core set of quality measures and requiring insurers in the state to use them in value-based contracts with providers. With a new focus on equity measures, there may be an opportunity for states to harmonize efforts across payers.
- **Reforming the prior authorization process:** As health care costs have risen, so has insurers' use of prior authorization. According to a survey by the American Medical Association, physicians estimate they complete about 40 prior authorization requests each week. State strategies that have been implemented via legislation include requiring fully automated prior authorization processes, fast turnaround (within 48 hours) of prior authorization requests, and exclusion of some services from prior authorization. In June 2021, Texas adopted a new law that contains a provision referred to as "gold carding" clinicians. Under the new law, if a clinician orders a medical service such as a medication or service at least five times in a six-month period, and at least 90 percent of the prior authorization requests are approved, then the clinician is exempt from requirements for prior authorization for that medical service for the next six months. Additionally, some insurers are considering waiving prior authorization requirements for providers who take downside risk.

KEY STEPS IN DESIGN AND IMPLEMENTATION

Decide which administrative functions to address. States could employ a comprehensive approach to reducing administrative costs or choose to start with one or more strategies. Several states (including Connecticut, Maine, Massachusetts, Minnesota, Oregon, Rhode Island, Vermont, and Washington) have worked on harmonizing quality improvement metrics across insurers, with the process initiated as part of their CMS State Innovation Model (SIM) grants. Through legislation passed in 2008, Minnesota has aligned quality metrics, although insurers are not limited to using measures in the aligned set in their contracts with providers. In 2015, Rhode Island used its SIM grant funding to support a process to align quality measures and convene a group of stakeholders including insurers, providers, and consumers. In 2017, the function transitioned to the Office of the Health Insurance Commissioner, and regulations were promulgated requiring that all commercial payers use the aligned measure sets in any contract with a financial incentive tied to quality. The workgroup meets annually to review the measure sets and recommend changes.

Determine type of state involvement. States could legislate that insurers use streamlined administrative functions or they could work collaboratively with stakeholders to achieve one or more of these goals. A state's choice of approach will depend on policymaker and stakeholder interest, the political environment, insurance and provider markets, and state resources.

Assess legal and market barriers. States will need to research the environment and determine the extent to which the market has harmonized and automated BIR functions. In addition, some strategies may require assessing legal barriers that may exist, including but not limited to state and federal data sharing and data privacy laws. Some efforts will likely require legislation to compel insurers to adopt certain reforms.

Convene a working group. These working groups may include representatives from major insurers and provider organizations, as well as consumer advocates and employers. Depending on the strategy pursued, state agencies (including the department of health, the insurance commissioner, the Medicaid agency, and others) could be involved. Alternatively, a state-based nonprofit entity or collaborative could help convene the stakeholders.

Monitor effectiveness of the intervention and ensure administrative savings are shared. Most of the strategies discussed here have not been implemented or evaluated. By evaluating the impact of their strategies, states can ensure that any waste eliminated from the system is captured and results in lower costs for purchasers and consumers.

EVIDENCE OF IMPACT

In general, evaluation data from implemented initiatives are lacking. A recent report used an analysis of profit and loss statements and categorized administrative simplification strategies into efforts limited to within an organization, those requiring partnership between two or more organizations, and those requiring wholesale changes to the health care industry. The authors found that the first two types of strategies could save those organizations $210 billion annually without an impact on access or quality.

In another report, CAQH recently found that a manual health care transaction costs $4.40 more on average than an electronic transaction and that completing all health care transactions electronically would yield $11.1 billion in savings annually.

In addition, economists have modeled potential reforms of various administrative activities and report that substantial savings could be realized. In a recent simulation, Scheinker et al. found that significant reforms to physician billing and BIR could result in savings ranging between 27 percent and 63 percent, although these savings were projected on a national level. Cutler's estimates range from $50 billion to $75 billion annually for a series of reforms implemented nationally. The modeling for individual approaches has important but smaller projected impacts. For example, the modeling around limiting choice of insurance products, conducted only for the individual market, found savings of approximately 1.3 percent of commercial spending, while implementing real-time adjudication of claims had a somewhat larger impact of 3.6 percent of commercial spending, or $45 billion annually.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

These strategies are best suited for states that have:

- fewer insurers
- a history of collaborative private–public partnerships around health care reform
- a willingness to dedicate resources to a convening activity.

Smaller states with several insurers may find it easier to either pass legislation in this area or work collaboratively with stakeholders to determine the best strategies. States with a history of collaborative work with insurers will be better positioned to play a convening role, and insurer stakeholders will be more likely to want to participate.

Convening workgroups and establishing standards for the various administrative tasks requires significant time and resources. Coordinating with the federal government will likely also take time and may not be feasible for some of the strategies. However, the more encompassing the approach, the greater the savings.

EQUITY CONSIDERATIONS

In general, consumers are not well served by the complexities of our health care system. Streamlining many of these administrative functions will improve access to care for individuals, especially those with low health insurance literacy. These administrative simplification approaches likely have very little negative impact on equity and could improve access to services for certain populations, depending on the strategy.

For example, in considering prior approval reforms, 21 states currently have laws prohibiting the use of prior authorization for medication-assisted treatment for either public or private insurers or both. In addition, most consumers have difficulty navigating the choices they have for health insurance, whether through an employer plan or in the individual marketplace. Implementing greater standardization and reducing choice of insurance products will likely help consumers in making better decisions for themselves and their families.

In addition, there is some evidence that states can also improve equity with greater standardization. One area where states may want to proceed carefully is around the harmonization of quality measures. In an effort to seek common ground, states could lose measures that are more focused on underrepresented populations.

POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

No state has implemented a comprehensive strategy to reduce administrative waste, so any state wishing to do so will be charting new territory and will need to overcome the reluctance of insurers (particularly national insurers) as it does so. Some pioneer states have already aligned quality measures and passed legislation to streamline prior authorization.

In addition, ensuring that these strategies result in actual cost savings to purchasers and consumers is important. For example, if prior authorization reform decreases the need for administrative employees at provider organizations and compliance staff at insurers, states will need to consider how to capture these savings. They may need to implement caps or reductions, or both, on provider rates and insurer premiums in conjunction with action in this area.

RESOURCES

State Health Access Data Assistance Center, *Aligning Quality Measures Across Payers* (SHADAC, May 2015).

Beth Waldman and Michael Bailit, *Considerations for State Development of Performance Measure Sets* (Robert Wood Johnson Foundation and State Health and Value Strategies, Sept. 2014).

CAQH, *2020 CAQH Index Closing the Gap: The Industry Continues to Improve, But Opportunities for Automation Remain* (CAQH, Feb. 2021).