GAO

United States General Accounting Office

Report to the Honorable Nancy L. Johnson, House of Representatives

April 1992

CANADIAN HEALTH INSURANCE

Estimating Costs and Savings for the United States

147386

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GAO/HRD-92-83

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-247625

April 28, 1992

The Honorable Nancy L. Johnson
House of Representatives

Dear Ms. Johnson:

In June 1990, we issued a report on the health insurance system in Canada.[1] We described the health care policies designed to provide access and control costs, and their consequences for Canadians. We also estimated the difference between the current level of U.S. health care expenditures and the cost of having a new program with key elements of a Canadian-style system. In Canada, each provincial plan provides for universal insurance coverage with no deductibles or copayments, controls on provider reimbursement, and administration by a single, public payer. We found that if these features were applied in the United States, the administrative savings could offset the added costs. In your letter of November 5, 1991, you asked us to provide further information on the methodology we used in deriving our estimates.

Elements of a Canadian-style system continue to be reviewed as part of current discussions of health care reform. Analyses that attempt to estimate how U.S. health spending would change under a Canadian-style system all suggest significant potential for administrative savings. However, estimates vary more widely on the potential additional costs of increased utilization generated by the elimination of copayments. Appendix I provides a comparison of studies and the range of estimates.

Appendix II presents detailed information on the development of our savings and cost estimates for a Canadian-style system. To develop data on the potential savings, we compared U.S. administrative expenses of insurers, physicians, and hospitals to those in Ontario.

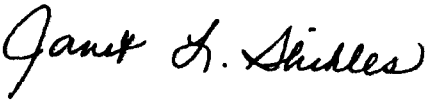
To calculate the potential new costs, we relied largely on empirical data from U.S. and Canadian experiences with providing "free" care to patients. Our estimates were derived primarily from government statistical sources supplemented by data from the American Medical Association, the Physician Payment Review Commission, and the Rand Corporation.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its

[1]U.S. General Accounting Office, Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90), June 4, 1991.

issue date. At that time we will send copies to interested congressional committees and will make copies available to others upon request. Michael Gutowski (Assistant Director) and Rosamond Katz (Evaluator-in-Charge) developed the information for this report. Please contact me on 512-7119 if you or your staff have any questions.

Sincerely yours,



Janet L. Shikles
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Abbreviations

AMA	American Medical Association
CBO	Congressional Budget Office
HCFA	Health Care Financing Administration
HMO	health maintenance organization
OMB	Office of Management and Budget
PNHP	Physicians for a National Health Program

Comparison of Estimates of Potential Costs of Adopting a Canadian-Style System

In addition to estimates presented in our report, other federal and private groups have recently issued studies of the cost implications of adopting a Canadian-style system. Recent analyses have been done by Physicians for a National Health Program (PNHP), the Office of Management and Budget (OMB), and Lewin/ICF.[1] Table I.1 compares their estimates of the potential impact of a Canadian-style single-payer system on 1991 health care spending in the United States. We also included an estimate, developed by the Congressional Budget Office (CBO), of a Medicare-style single payer system that contains many provisions similar to a Canadian-style system, but retains copayments by patients and other U.S. features.

The overall results of these studies vary significantly. The estimates range from a net savings of $69 billion (under a Medicare-style system with relatively optimistic assumptions) to net costs of $83 billion (under a Canadian-style system with relatively pessimistic assumptions). We estimated that national health spending would be reduced by $3 billion, or 0.4 percent of U.S. health expenditures, under a Canadian-style system.

Administrative savings estimates range from $31 to $67 billion under a Canadian-style system and $22 to $69 billion under a Medicare-style system. Estimates of additional costs from higher utilization of hospital and physician services range from $0 to $114 billion. In all of the studies, the potential administrative savings would be sufficient to cover the cost of extending insurance coverage to the currently uninsured. In some of the studies, the estimated administrative savings do not fully cover the added costs of increased utilization by those currently insured.

[1]These are not the only analyses of a Canadian-style system. The Pepper Commission estimated the net new costs to society of single-payer national health insurance to be $8 billion. Because detailed changes in spending were not provided in its report, the Commission's estimates are not included in table I.1. Similarly, Steffie Woolhandler and David Himmelstein developed some of the earliest estimates of administrative savings, but their work does not specifically address the added costs associated with expected increases in utilization.

Table I.1: Changes in U.S. Health Care Expenditures Under a Canadian-Style System: a Comparison of Estimates

1991 Dollars in billions

	Canadian-style system				Medicare-style system
	GAO[a]	PNHP[b]	OMB[c]	Lewin/ ICF[d]	CBO[e]
Administrative savings:	$(67)	$(67)	$(31-49)	$(47)	$(22-69)
Insurance	(34)	(27)	(17-30)	(23)	(26-27)
Physicians	(15)	(9)	(3-5)	(11)	(44)-5
Hospitals	(18)	(31)	(11-14)	(13)	
Added costs:	64	49	56-114	68	0-31
Newly insured	18	—	16-24	12	18-27
Currently insured	46	—	40-90	56	(17)-4
Net change	$(3)	(18)	$ 7-83	$ 21	$(69)-9

[a]U.S. General Accounting Office, Canadian Health Insurance: Lessons for the United States (GAO/HRD-91-90), June 4, 1991, p. 63.

[b]K. Grumbach and others, "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," Journal of the American Medical Association, May 15, 1991, pp. 2549-2554.

[c]Office of Management and Budget, "Comprehensive Health Reform: Observations About the Problem and Alternative Approaches to Solution," presented to the House Committee on Ways and Means, October 10, 1991, appendix 2.

[d]John Sheils and Gary Young (Lewin/ICF), "National Health Spending Under a Single-Payor System: The Canadian Approach," November 21, 1991, p. 8.1. Cost of higher utilization by the currently insured includes the response to eliminating cost sharing ($50 billion) and eliminating utilization management ($6 billion).

[e]Congressional Budget Office, Universal Health Insurance Coverage Using Medicare's Payment Rates, December 1991. This plan differs from a Canadian-style single-payer system by requiring patient copayments and continuing a residual Medicaid program. Data presented in this study are reported in 1989 dollars. We converted them to 1991 dollars using the consumer price index of medical care.

Estimates of Administrative Savings and New Costs Under a Canadian-Style System

In estimating the change in national health spending under a Canadian-style health system, we focused on three key sectors: insurance, physicians, and hospitals. As shown in table II.1, we estimate that additional expenditures of about $64 billion could be offset by administrative savings of about $67 billion. We also recognized the substantial cost stemming from increased utilization (of both necessary and unnecessary care) associated with a universal, "free" health care system.

Table II.1: Estimated Savings and Costs of Adopting a Canadian-Style System in 1991

Dollars in billions

	Insurance	Physicians	Hospitals	Total
Savings from reductions in administration	$(33.9)	$(14.8)	$(18.2)	**$(66.9)**
Added costs from higher utilization	1.8	27.2	34.9	**63.9**
Net change	$(32.1)	$12.4	$16.7	**$(3.0)**

Although data used to develop the components of our estimate were derived from various data sources and sometimes represent different time periods, we converted all figures to 1991 dollars based on our projections of 1991 national health expenditures. Health care expenditures for 1989 were the most current data available. Health Care Financing Administration (HCFA) officials told us they expected annual increases in health spending for 1990 and 1991 to be about 11 percent and 10 percent, respectively. Therefore, we estimated 1991 health expenditures at $737.0 billion in total, with $284.0 billion for hospital care, $143.5 billion for physicians' services, and $43.1 billion for insurance overhead.

Savings in Administrative Costs

We estimated that about $67 billion could be saved under a Canadian-style system by reducing administrative costs. The health insurance system in Ontario imposes minimal administrative and billing costs on the third-party payer, physicians, and hospitals. In the United States, however, nearly 6 percent of national health expenditures were accounted for by the administration of government health programs and private insurance in 1989. In addition, billions of dollars are spent annually by providers for billing and other administrative activities directly attributable to our system of financing health care.

Additional administrative savings likely to accrue to U.S. businesses (through a reduction in employer health benefit programs) and households (in time and cost of filing claims) have not been included. Also omitted was the value of hospital nurses' time spent on administrative duties.

Insurance Overhead

Half of our estimated total savings, roughly $34 billion, is found in insurance overhead. For private health insurance in the United States, overhead represents the difference between earned premiums and incurred benefits. It includes administrative costs, net additions to reserves, rate credits and dividends, premium taxes, and profits or losses. For U.S. public health insurance, overhead represents the administrative expenses of federal and state programs, such as Medicare and Medicaid. The data were obtained from HCFA.

Similar definitions are used by Health and Welfare Canada in its national health accounts, the source of the insurance overhead data for Ontario. Expenditures for "prepayment administration" measure the cost of having insurance coverage. For private health insurance,[1] this cost is determined by subtracting benefit payments from premium revenues. In the public sector, it represents provincial governments' administrative costs related to the provision of insured services and a small amount for federal government expenses.

To calculate the potential savings under a Canadian-style system, we assumed that the insurance overhead share of total health expenditures in the United States was reduced to the proportion obtained in Ontario. (See table II.2.) A savings of about $34 billion represents a 79-percent decline in our estimated 1991 spending for overhead costs of the health insurance sector.

[1]Private insurance is available to cover services not included in a provincial plan, such as prescription drugs for some, certain dental and vision care, and additional charges for a private hospital room. Most Canadians obtain this supplemental insurance through their employers.

Table II.2: Derivation of Administrative Savings Estimate for Insurance

United States	Ontario	Savings
Insurance overhead[a] = 5.8% of national health expenditures (1989)	Insurance overhead[b] = 1.2% of provincial health expenditures (1987)	5.8% - 1.2% = 4.6% of national health spending. 4.6% of $737 billion estimated U.S. health expenditures (1991) = $33.9 billion

[a]In the U.S. national health accounts, this item is listed as "administration and the net cost of private health insurance." See: Office of National Cost Estimates, "National Health Expenditures, 1988," Health Care Financing Review, Summer 1990, vol. 11, no. 4, pp. 47-48.

[b]In the Canadian national health accounts, this item is referred to as "prepayment administration." See: Health and Welfare Canada, National Health Expenditures in Canada 1975-1987, September 1990, pp. 184-185.

Physician Administrative Costs

The cost of physicians' services includes expenses for various nonphysician items, such as salaries, office expenses, and medical equipment and supplies.[2] The difference in expenditures for such items in the two countries is significant. American Medical Association (AMA) data show that 48 percent of every dollar earned by a self-employed U.S. physician in 1987 went to pay professional expenses.[3] By contrast, Revenue Canada Taxation data indicate that 36 percent of the gross earnings of self-employed physicians in Ontario were reported as professional expenses.

In both countries, the largest component of these expenses was for nonphysician personnel payroll. In 1987, physicians in the United States spent, on average, 50 percent more on this expense than did physicians in Ontario. We assumed that the difference in payroll expenses was attributable, in part, to differences in the two health insurance systems.[4]

[2]On average, malpractice liability premiums paid by physicians, although significantly higher in the United States, were a relatively small share of professional expenses in 1987: 12.1 percent in the United States and 3.2 percent in Canada.

[3]Our data mainly reflect spending for services provided by self-employed physicians, since salaries paid by hospitals to physicians are accounted for in the hospital care category. Payments for services provided by salaried physicians in health maintenance organizations (HMOs) are included in the physician category, but only 2 percent of U.S. physicians are salaried by HMOs. We thus calculate the potential savings on billing expenses, which are relevant to self-employed physicians only, against the entire amount of payments to the physician category.

[4]We recognize that some of this difference in personnel costs may also be associated with greater intensity of services performed in physicians' offices in the United States. However, we believe that these costs may be offset by savings in administration-related expenses (such as data processing, marketing, and postage) that were not accounted for in our calculation.

In addition, more of a U.S. physician's time is consumed with administrative aspects of insurance programs. Such activities include filing claims, responding to inquiries on the necessity of services or charges, contested claims, and other requirements of third-party payers. Based on data from a 1988 AMA survey, we calculated that physicians spend about 4.4 percent of their time on such insurance-related functions. According to Ontario Medical Association officials, billing and other claims-related activities place little demand on a Canadian physician, so we assumed that 1 percent of a physician's time was spent on reimbursement. Therefore, we assumed that U.S. physicians operating under a Canadian-style system would be substantially relieved of the administrative burden of insurance-related activities.

Finally, we accounted for expenses by U.S. physicians who meet some of their administrative requirements by contracting with an outside billing service. The 1988 AMA survey indicates that about 14 percent of U.S. physicians contract for such services at a cost of roughly $8 per claim.

Using these three components, we calculated that, if U.S. physicians could reduce their administrative requirements to that of their Ontario counterparts, they could save over 10 percent of their gross earnings. (The average U.S. physician would still have spent about $97,300 for professional expenses in 1987 compared to about $53,600 for an Ontario physician, due to differences in such factors as service intensity, office amenities, and liability insurance costs.) Reducing sector-wide spending by this percentage could garner a savings of $14.8 billion under a universal, single-payer system with controls on physicians' fees. (See table II.3.)

Table II.3: Derivation of Administrative Savings Estimate for Physicians

	United States	Ontario[c]	Savings
Nonphysician personnel	$42,500 per physician[a]	$28,033 per physician	$14,467 per physician
Physician's time	4.4%[b]	1%	3.4% of gross earnings = $8,704 per physician
Contracted billing services	$3,224 per physician[b]	None	$3,224 per physician
Total			$26,395 per physician, or 10.3% of average gross income. 10.3% of $143.5 billion estimated U.S. physician spending (1991) = $14.8 billion

[a]AMA Center for Health Policy Research, Socioeconomic Characteristics of Medical Practice 1989, p. 110.

[b]Calculated from data in AMA Center for Health Policy Research, SMS Report, "The Administrative Burden of Health Insurance on Physicians," vol. 3, no. 2, Mar. 1989, pp. 2-4.

[c]Derived from unpublished information provided by the Ontario Medical Association.

Hospital Administrative Costs

Hospital administration differs significantly under the Canadian and U.S. systems of financing care. In Ontario, prospective global budgeting requires far less administrative activity associated with admissions, billing, marketing, and certain record keeping. In the United States, where the reimbursement system is more fragmented, hospital administrative costs have been rising substantially due to cost-containment pressures and greater competition. If U.S. hospitals eliminated or reduced certain administrative functions to the level in Canadian hospitals, the administrative share of U.S. hospital costs could be lowered by 6.4 percent. (See table II.4.) Sector-wide, this represents an $18.2 billion savings. Even with these savings, U.S. hospitals would still be spending about $30 per capita more on administration than do Canadian hospitals.

To estimate the potential savings for U.S. hospitals under a Canadian-style system, we compared similar financial data on hospital expenses. For the United States, hospital administrative costs included general accounting, patient accounts and admitting, medical records, purchasing and stores, and data processing. We constructed a comparable figure from unpublished hospital data collected by the Canadian government.

We acknowledge in our report that Canadian hospitals may spend too little on the development of information systems. Because they do not need the

detailed cost accounting associated with a diagnosis-based reimbursement system, they may be forgoing information that could be used to improve the efficiency of hospital operations.

Table II.4: Derivation of Administrative Savings Estimate for Hospitals

United States	Canada	Savings
Administrative costs[a] = 15.4% of total hospital expenses (1988)	Administrative costs[b] = 9.0% of total hospital expenditures (1987)	15.4% - 9.0% = 6.4% of hospital expenses. 6.4% of $284 billion estimated U.S. hospital expenditures (1991) = $18.2 billion

[a]See an analysis of American Hospital Association Monitrend data by Health Economics Research, Inc., in the Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System, Report to the Congress, June 1990, p. 50. Administrative services included general accounting, patient accounts and admitting, medical records, purchasing and stores, and data processing.

[b]Estimate was derived from Health and Welfare Canada, "The Annual Return of Health Care Facilities—Hospitals" (unpublished). For comparison with U.S. administrative costs, we included expenses for general administration (except liability insurance, interest payments, and utilities), materiel management, central supply, and medical records and hospital library. Although detailed cost data for Ontario hospitals were not available, similar data from the Ontario Ministry of Health, Hospital Statistics, showed comparable results.

Added Costs From Expanding Utilization

We estimated in our report that adopting a Canadian-style system would generate new costs nearly equal to the savings in reduced administration. New costs stem from the higher level of utilization, or induced demand, expected under a "free" care system. We estimated total additional costs under a Canadian-style plan by measuring new costs stemming from (1) extending health insurance coverage to those currently uninsured and (2) eliminating cost-sharing provisions of health insurance plans for all.

Extending Insurance Coverage to the Uninsured

Our estimate of the cost of extending coverage to the uninsured was derived from a 1990 study prepared for HCFA by Lewin/ICF.[5] The study reported that despite their lack of health insurance, the uninsured use a substantial amount of health care services (accounting for about 11 percent of noninstitutionalized, nonelderly personal health care expenditures). However, on a per capita basis, spending by the uninsured is substantially less (about 60 percent) than spending by those with insurance.

[5]Jack Needleman and others (Lewin/ICF), The Health Care Financing System and the Uninsured, April 4, 1990.

If the insurance gap was closed by extending typical insurance coverage to this group, Lewin/ICF estimated that their expenditures for physicians and hospital care would grow by 42 and 40 percent, respectively. This estimate assumes that the level of health care utilization by previously uninsured individuals would rise to the level reported by insured persons with similar age, sex, income, and health characteristics.

Using the Lewin/ICF data, we estimated the difference between expenditures by the uninsured under the current system and expenditures if they were covered by insurance to be $8.1 billion for hospital services and $5.0 billion for physician services, in 1991 dollars. (See table II.5.)

Eliminating Copayments and Deductibles

Health care expenditures can be expected to increase if, as in Ontario, the publicly funded program prohibited direct patient cost sharing. Under a "free" care system, utilization of both physician and hospital care would expand to meet the demands for both needed and unneeded services made by both individuals and providers of care. Our estimates of the utilization response to "free" care are the largest and most uncertain components of our national cost assessment.

To develop our estimate of the potential cost of "free" care, we examined two sources of empirical evidence. One study showed the change in utilization of physicians' services in Canada after the program to publicly fund physician care (known as Medicare) was fully implemented in 1971. The other source is the Rand Health Insurance Experiment, a large-scale U.S. demonstration project conducted between 1974 and 1982. It provided data on the utilization of hospital and physicians' services under insurance plans with different cost-sharing requirements.[6] Although both sources are somewhat dated and have some problems, they do provide insight into the potential utilization response to the elimination of copayments and deductibles.

The Canadian provincial data show that the use of physician services increased, on average, by 3 percent between 1970 and 1971 (the initial year of the Medicare plan). This relative unresponsiveness of utilization may be due to the fact that changes in the Canadian health care system came

[6]Cost-sharing levels varied by required enrollee coinsurance and by out-of-pocket limits. Coinsurance rates were 0, 25, 50, and 95 percent. Limits on annual out-of-pocket expenses were 5, 10, or 15 percent of family income up to a maximum amount. An individual deductible plan required a 95-percent coinsurance payment (with limits) for physician care and free inpatient care. See: Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence From a Randomized Experiment," American Economic Review, vol. 77, no. 3, June 1987, pp. 251-277.

gradually: by 1961 all provinces had implemented universal hospital insurance and by 1970-71 they had implemented universal medical insurance. Between these years, there may have been a tendency to have physicians' services performed in hospitals to the extent possible. Thus, the level of unmet demand for physicians' services at the time of full implementation of medical care insurance might be lower than if the change to "free" care had occurred in both sectors at the same time.

The Rand study indicated that physician expenditures for people in the "free" plan were 31 percent higher than for those in a plan requiring 25-percent coinsurance. For several reasons, we believe this figure may overstate the utilization response expected if the United States eliminated cost sharing for physician care. First, because most insured Americans are currently enrolled in plans with coinsurance rates of less than 20 percent, the level of induced demand may not be as high as under the Rand 25-percent scenario. Second, since the experiment covered only people between the ages of 14 and 61 years of age, it does not capture the relatively low utilization response expected from current Medicare enrollees, a group that already faces little cost sharing for physicians' services. Finally, because "free" care in the Rand experiment was available for a limited time only, participants may have been motivated by a "fix-as-much-as-possible-while-it's-free" psychology.

Given these weaknesses, the estimates from Canada and Rand do not serve as precise indicators of the expected physician utilization response to a Canadian-style system in the United States. We were unwilling to either totally accept or reject the high response suggested by the Rand study or the low response actually experienced in Canada. Therefore, we averaged the estimates and assumed a 17-percent increase in physician expenditures.

In estimating the utilization response to "free" hospital care, we used Rand's finding of a 10-percent difference between the "free" care group and the 25-percent coinsurance group. Comparable Canadian data were not available.

To estimate the additional cost of eliminating copayments and deductibles, we calculated 17 percent of physician expenditures and 10 percent of hospital expenditures for each population group. As shown in table II.5, for the uninsured population, these increases were applied to the level of spending after closing the insurance gap. Table II.6 shows that, for the currently insured, these estimates of increased utilization were applied to

our estimate of 1991 physician and hospital spending by this group. For both groups we adjusted the additional expenditures for physician and hospital services downward by 10.3 percent and 6.4 percent, respectively, to account for the lower administrative costs expected under a Canadian-style system. Taken together, we estimate additional costs of $18.2 billion for expanded services to the newly insured and $45.7 billion for services to the currently insured.

Table II.5: Cost of Covering the Uninsured Under a Plan Without Cost-Sharing Requirements (1991)

Dollars in billions

	Physicians	Hospitals	Insurance[e]
Expenditures without insurance[a]	$12.0	$20.1	—
Increase under a typical insurance plan[ab]	5.0	8.1	—
Increase from eliminating copayments[c]	2.9	2.8	—
Administrative adjustment[d]	(0.8)	(0.7)	—
Net change in expenditures	$7.1	$10.2	$0.9

[a]Jack Needleman and others (Lewin/ICF), The Health Care Financing System and the Uninsured, April 4, 1990. We converted 1988 dollars to 1991 dollars using an average inflation rate of 10.75 percent per year.

[b]A typical health plan would cover hospital care, physician care, and prescription drugs with a $200 deductible and 20-percent coinsurance. Utilization of physicians and hospital services by the newly insured is estimated to rise by 42 and 40 percent, respectively.

[c]Utilization response to the elimination of copayments and deductibles is assumed to increase physician and hospital expenditures by 17 and 10 percent, respectively.

[d]Additional costs incurred by expanding coverage are adjusted to reflect lower provider administrative costs under a Canadian-style system. New costs for physician and hospital care were reduced by 10.3 and 6.4 percent, respectively (see tables II.3 and II.4).

[e]Based on Ontario data, insurance overhead costs were estimated at 2 percent of total physician and hospital expenditures by the uninsured.

Table II.6: Cost for the Currently Insured Stemming From the Elimination of Cost-Sharing Requirements (1991)

Dollars in billions

	Physicians	Hospitals	Insurance[d]
Expenditures with copayments[a]	$131.5	$263.9	—
Increase from eliminating copayments[b]	22.4	26.4	—
Administrative adjustment[c]	(2.3)	(1.7)	—
Net change in expenditures	$20.1	$24.7	$0.9

[a]Represents total expenditures for 1991 less spending by the uninsured.

[b]Utilization response to the elimination of deductibles and coinsurance is assumed to increase physician and hospital expenditures by 17 and 10 percent, respectively.

[c]Additional costs incurred by expanding coverage are adjusted to reflect lower provider administrative costs under a Canadian-style system. New costs for physician and hospital care were reduced by 10.3 and 6.4 percent, respectively (see tables II.3 and II.4).

[d]Based on Ontario data, insurance overhead costs were estimated at 2 percent of additional physician and hospital expenditures by the currently insured.

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