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A critical aspect of health reform is program implementation—making certain that the structural components of reform can be made operational. Yet to date the consideration of how to make health care reform work has taken a backseat to what health care reform will look like. This failure to consider some basic infrastructure implementation issues carries with it the threat of scuttling virtually any form of health care reform that creates new organizations or new organizational relationships.

At the heart of the Clinton administration’s health care reform proposal is the creation of a set of new, complex organizations known as mandatory regional health alliances. These organizations could be designed as non-profit corporations, independent state agencies, or agencies of states’ executive branches. As envisioned by the administration, the health alliances will have a formidable set of powers. In addition to serving as the purchasing entity for all employers with fewer than 5,000 employees, the alliances will enroll all eligible persons in their service area; control access to all health plans; check new versions of plans; monitor plans’ marketing practices; contract and define the terms of the relationships with all qualifying health plans; define premium levels; collect and disburse federal subsidies; and use a risk adjustment mechanism to account for variations in health status in enrollment across health plans. These powerful entities will have to cope with numerous, complex implementation challenges.

Health alliances will face a formidable array of responsibilities exceeding those of the benefit managers and human resources departments they replace. These activities will duplicate some that will continue to be performed at the employer level. Just what functions will be left to employers is somewhat unclear. It seems likely that the burden of compliance will fall on the health alliances, but the actual division of labor may not be known

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until well after the Health Security Act becomes law. There are dangers and challenges in every task facing a health alliance. Exhibit 1 summarizes the functions of alliances and outlines potential implementation problems. The major change that will occur with the creation of mandatory alli-

<table>
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<th>Health alliance function</th>
<th>Potential implementation challenges</th>
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| Enrollment                                        | Processing hundreds of thousands of individual enrollment forms  
Making certain all data are accurate to ensure correct payment to providers, premiums for individuals, and risk adjustment  
Establishing a system to consistently and continuously update enrollment records                                                                                      |
| Collect premiums and pay health plans             | Establishing a procedure to collect and verify premium payments from employers and payroll deduction from employees  
Administer a program to calculate subsidies for low-wage employers and low-income individuals and families                                                                                     |
| Adjust health plan premiums for differences in risk| Develop and refine risk adjustment methods to correct for differences in the age, sex, family characteristics, and health status of the health plans’ subcontractors  
Develop a fund transfer system to reallocate premium dollars                                                                                                                                           |
| Inform consumers about the eligible health plans  | Verify all supplied information by each health plan  
Produce a summary of each health plan’s quality and consumer satisfaction  
Prepare a consumers’ guide to health plan selection  
Develop and maintain a capacity to run an open enrollment and respond to any questions  
Review and approve all health plan marketing material                                                                                                                                               |
| Manage customer services problems                 | Develop the capacity to act in lieu of the employer to respond to any and all subscriber queries (for example, denial of a request to change primary care physicians)  
Investigate and resolve any payroll deduction problems due to such events as a change in employment  
Develop a medical necessity program                                                                                                                                                                 |
| Administer the global budget                      | Monitor the financial position of the affected health plans  
Develop a process to apply the global budget to health plans                                                                                                                                                                      |
rances is a shift from group enrollment to individual enrollment. Record keeping and administrative complexity are far greater under a system of individual enrollment than under the more common current process of group enrollment. At a minimum, this change alone will increase the total health care system’s administrative burden. In effect, there will be a need for individual enrollment of over 100 million people, as compared with the tens of thousands of employer groups now processed. Further, one can speculate on how companies will respond to this change. They are likely to reorient their benefit or human resources staffs, shifting their functional responsibilities from designing health plans to maintaining records about employees’ selections, payroll deductions, contribution levels, registration for the semiprivate portion of workers’ compensation, and so forth. Current benefit managers likely will be laid off, and employers will turn to outside consultants to guide them through the new maze of regulatory obligations.

Whether the proposed 2.5 percent of premiums set aside for alliance administrative charges will be sufficient to pay for the design and operation of the information and financial management systems needed is highly questionable. This low charge for administrative overhead has been realized only by the Health Care Financing Administration’s (HCFA’s) Medicare contractors, and they provide a much smaller set of services than are envisioned by the reform proposal. The requirements facing each health alliance are enormous, and how these yet-to-be-created entities will manage such responsibility is a great unknown. Every experience to date with new, complex regulatory organizations has shown that the initial years of operation are extremely challenging. It is important for the architects of reform to recognize this reality and to plan for it. One way to do so is to consider the basic question of whether mandatory health alliances, particularly those with a 5,000-employee threshold, are necessary. Accountable health plans operating under new market rules might be able to achieve the same outcome with far less bureaucratic risk. It also is the case that smaller, self-selected, “voluntary” groups of smaller employers might be able to create more manageable health alliances carrying less operational risk. This would significantly reduce the potential for implementation failure and would focus alliance activities on that end of the market most in need of help: small employers. The dangers of embracing a broader construct are the political repercussions from the creation of a set of organizations that may face failure due to the weight of their administrative responsibilities.

**Claims Processing**

Capitated systems such as health maintenance organizations (HMOs) will not require a claims processing capability per se (they will need to
maintain and operate a separate, different information management system, though), but the preferred provider organization (PPO) and fee-for-service options envisioned by the White House and likely to dominate as consumer choices will. Consequently, it is likely that claims processing functions will continue for the foreseeable future. Currently, thousands of different claims processing systems operate nationwide, each with different characteristics and relative efficiencies. Which one, if any, will be the model endorsed by the health alliances for qualifying health plans? Will all claims be processed in the same manner, or will different systems with different edits and decision rules operate? What organization(s) will design and maintain a new claims processing system? How will such a system efficiently accommodate claims volume that may run from the low end of one million claims to the high end of 200 million per health alliance? No system today can manage such a range in volume. Furthermore, the technical challenge of building the software will be formidable, and its costs will exceed those experienced by the Medicare program. Consider that over the life of the Medicare program the federal government has invested more than $1 billion for designing and implementing a claims processing system and is about to embark on another round of major investment. And Medicare is a standard program with a uniform benefit package and centralized rule making. Even so, Medicare now operates fourteen different claims processing systems to manage its workload. This has occurred largely as a consequence of the technical challenges of handling a wide variety of different types of claims and the difficulty of designing a claims processing system that can efficiently handle different volume levels. Imagine the Tower-of-Babel potential under a reform plan that envisions creating at least fifty different health alliance arrangements.

Underlying the claims processing system is the necessity of creating a claims feeder network—in today’s parlance, an electronic highway over which claims transactions can be communicated. Only the Medicare program, among all insurers, public and private, has been successful in transmitting more than half of its claims electronically. This suggests two outcomes: First, billions of claims still will have to be handled manually at a relatively high cost when health care reform occurs; and second, a telecommunications infrastructure linking every provider (such as hospitals, nursing homes, physicians, home health agencies, and pharmacies) to a claims processor and perhaps to a centralized master file will have to be created. The cost of building such a network, maintaining it, and extending it to nearly a million sites nationwide can be estimated conservatively in the billions of dollars. Not only is this cost missing from the estimated health care reform price tag, but little consideration has been given to the technical feasibility of the task, the privacy issues such a network entails, or the
cost-effectiveness of extending such arrangements to low-volume providers.

It will not be easy for the alliances and the health plans to meet the desire for standardized treatment of all health benefits. Converting to standardized claims forms and electronic formats will help, but the transition will be difficult. Medicare’s experience with systems conversions is instructive here. Every time a claims processing system was changed from a customized to a standardized form, services to beneficiaries and providers were disrupted for twelve to twenty-four months. The administration should consider ways to reduce this service disruption, including readily available system documentation, use of public domain claims processing systems, shared system maintenance, and the use of experienced systems teams to oversee conversions.

Medical Policy

Private and public health insurers now rely largely on local medical standards to determine which medical services are appropriate or medically necessary. This has occurred for many good reasons. Foremost is the observation that medicine is both a science and an art, with a wide range of uncertainty regarding treatment. Compounding this uncertainty is physicians’ resistance to intrusion into their decision-making autonomy. Both of these conditions will remain when health care reform occurs.

If uniformity of coverage and standard treatment of all medical services is desired as part of health care reform, a national policy on what is medically necessary is required. Absent such a policy, the current practice of local coverage determination not only will continue, but will expand. Each health alliance and health plan will need to establish its own coverage policy, leading to variation in coverage decisions depending on where one lives. At some point, reform advocates will have to decide whether a national or local coverage policy is preferable. Both options carry their own implementation challenges in gaining acceptance from physicians and consumers.

To date, Medicare has developed only a limited national medical policy. This challenge is as much political as it is technical. The politics of creating a national medical policy go to the very heart of the role physicians play in the health policy arena. Addressing physicians’ professional role and autonomy directly will touch a sensitive nerve in the physician community. Ignoring these, though, carries the danger of perpetuating the current byzantine nonsystem of determining what is and is not covered after the new standard benefit package is adopted.
If, as it appears, health alliances emerge from health care reform in a highly regulatory form, these agencies likely will perform complex negotiating and administrative tasks. The last time the federal government created a similar new set of organizations in the health field was under the Health Planning and Resources Development Act of 1975 (P.L. 93-641). That law created a complex web of consumer-dominated state and local health planning agencies, the remnants of which still exist in many states. The failure of these health planning and certificate-of-need programs has been well documented, and many reasons for their failure have been tendered. One factor certainly contributed: the lack of executive and management talent. Pitting the health planners against the institutional providers was akin to having a local high school football team play the Dallas Cowboys, with even less mercy being shown. Where will we find the talent to run and manage the health alliances? The risk of creating these entities is great enough without compounding it by staffing them with people who will spend their first few years on the job learning the health care acronym alphabet. With few exceptions around the country (some rate-setting and certificate-of-need programs), providers, insurers, and health professionals have demonstrated that they can outmaneuver, outspend, and overcome virtually any regulatory tactic. How will this be different under a health alliance arrangement? Government salaries, annual budget pressures, and constraining work rules will not attract the talent needed to make health alliances work, much less work well. The more likely outcome is creation of another complicated layer of bureaucracy at a not insubstantial cost.

Graduate schools have not been churning out health alliance managers in anticipation of health reform. In fact, no one knows what these managers will look like. The range of skills they are expected to possess is awesome. They must be mediators, negotiators, insurance experts, actuaries, benefit managers, and magicians. The talent of these managers does make a difference. In the late 1970s and early 1980s the states of Maryland and Washington had the same legislated rate-setting authority. Yet while Maryland is widely recognized for its success, few discuss Washington’s performance. There are many explanations for this. One compelling reason is that Maryland was successful in bringing together and sustaining over time a cadre of talented staff to administer and direct its rate-setting program. Such talent is not readily available throughout the country, and, consequently, other states have found it extremely difficult to duplicate Maryland’s success.

Talent alone is not enough, however; it must be backed by political will. In Maryland, for instance, the political will of the Maryland Hospital Association, employers, and the governor may have been another critical
success factor. Nationally, we must ask: If President Clinton should fail in his likely bid for reelection in 1996, will the political commitment to health reform survive his presidency? Is the structure of reform sufficiently robust that a decline in political support will permit it to continue functioning effectively? In the absence of evidence to the contrary, there is every reason to believe that health alliances will be in jeopardy if they lack presidential legitimacy and interest.

Government’s Incentive To Micromanage

Medicare, touted by some as a model of efficient government operation, is not without its shortcomings. Among them is the program’s complexity. Medicare has issued more than 20,000 pages of legislation, statutes, manual instructions, and directives, and each year the total grows. Medicare fiscal intermediaries and carriers receive on average a new instruction every five hours. Some of these are the result of technological change, but many more are the result of annual legislative changes. Whether to solve a perceived problem, or to ensure that a change in the program takes place in a given fashion, or even to cater to a special interest group, Congress has fallen into the habit of legislating detailed changes in the Medicare law. These changes can cost more than $50 million a year to implement. They portend a future for health care reform of endless rule making rather than decision making, setting a worrisome precedent of supplanting professional discretion with bureaucratic tinkering.

Compounding this interventionist tendency is another characteristic of government that suggests a challenge for program implementation: The federal government is an unreliable and unfaithful business partner. Last year’s deal is last year’s news. Congress is not purposely malicious; however, every year new crises or needs require it to revisit previous decisions. Legislation is amended to respond to this year’s crisis. If this causes havoc with the prior year’s solutions, so be it. Future-year interventions will have to respond to the newly triggered crisis. Health alliances need to prepare for such changes, especially since the speed of change can be expected to be particularly high in the initial years of the program.

Underlying this tendency to micromanage is the erosion of trust between the medical profession and the American public. To counter this loss of trust, health alliances and health plans are expected to maintain huge caches of data, monitor physician behavior, and overtly act to change it. I for one fear that the urge to collect information will exceed the purposes for which it was intended and that the risk of closer scrutiny and constraints on professional autonomy will be greater, not less, under health care reform.
Unintended Side Effects Of Managing Costs

To the extent that the government substitutes its artificial estimates of market reaction for actual market conditions, the magnitude of unanticipated provider responses will grow. And if the government misestimates the magnitude of behavioral response to its initiatives, it has a recourse that the private sector lacks: the power to tax. Past Medicare financial crises have been solved simply by increasing the payroll tax, reducing payments to providers, or both. This has occurred repeatedly and stands as a disturbing precedent for reform. Unlike the private insurance sector, which must explicitly build risk and reserve requirements into its rate structure, the government uses the power to tax to create its implicit reserve reservoir.

If the Health Security Act’s cost containment provisions fail, two options are on the table. First is the introduction of state-specific price controls. This outcome seems probable since it is highly unlikely that insurance companies will be able to constrain the rate of growth of health insurance premiums to the level of an adjusted Consumer Price Index (CPI), given that current medical inflation is twice that rate. One might even speculate that the true cost control agenda of the health care reform architects is the use of price controls. Political practicality may be the reason why the administration did not embrace such methods openly and directly. Yet, as proposed, the current set of cost control mechanisms will in all likelihood be difficult to achieve, politically and operationally. Holding costs to an adjusted CPI is an achievement that so far has eluded all governments that have pursued it. The net result may be the pursuit of price controls as the approach of choice by the states. It is a curious solution to embrace. Experience in the health sector and, for that matter, elsewhere in the economy does not leave one sanguine about the prospects of successful cost containment using price controls. The Health Security Act could be strengthened if the set of default cost control approaches available to a state when premium caps fail were expanded to include other options, particularly market-based approaches. Limiting states to regulatory price controls carries with it another whole set of implementation and policy problems.

The second path available to Congress if proposed cost control features fail is the power to tax. While politically difficult, this approach can be used in conjunction with alternative cost control methods. Thus, the financing of health reform does not end with the methods currently proposed by the Clinton administration. Future tax increases are a likely prospect, both to pay for unanticipated program costs and to make up the shortfalls created by unsuccessful cost containment.

It also is the case that the logic and order of government decision making can produce perverse and counterintuitive policy decisions. In Medicare,
payment safeguard activities (medical review, audit, coordination of benefits) yield paybacks of about $12 for every dollar spent. Yet, given the peculiarities of the appropriations process and congressional jurisdictions, Congress cuts spending for these activities rather than investing in them. Even the U.S. General Accounting Office (GAO) has testified repeatedly that such decision making is foolish and wasteful. But it continues, and nothing in the president’s proposed health care reform initiative suggests that there will be any change. If anything, the prospect of repeating Medicare’s experience in fifty or more health alliances is almost assured.

Managing Administrative Simplification

Among the many laudable goals of health care reform is a reduction in the current system’s complexities and administrative burdens. While attractive, the goal is easier to state than to achieve. For instance, a review of the president’s proposal reveals that if implemented, it would create fifty-nine new federal programs or agencies, expand twenty existing bureaucracies, impose more than seventy-five federal mandates, and require major changes in the tax code.

For many years the health insurance industry has worked closely with first the Bush administration and now the Clinton administration to improve, streamline, and simplify the current health care transaction process. There is near-universal agreement on what needs to be done: Standardize forms and make possible electronic claims transmission, electronic remittance advice and funds transfer, uniform data sets, and built-in privacy protection. This is a situation in which the goals are running ahead of the capacity to achieve them in a reasonable time frame and at a reasonable cost.

The administration’s proposal makes a series of heroic assumptions about the quality and quantity of data available in the insurance industry and about the ease with which this information can be translated into uniform records. Simply put, while doable, the technical challenge is daunting, the cost will be in the billions of dollars, and the time necessary to successfully standardize current systems will take a decade (if experiences in Medicare, Medicaid, and many large insurers have any validity). There are now more than 400 electronic formats used to transmit claims and thousands of different claims processing systems. All will have to be converted to the desired format, while assuring consumers that the systems used will safeguard their privacy. The message and challenge for the health alliances is that the information they will need to make informed decisions is unlikely to be available when they need it. As a result, second-best, synthetic estimates will be used, leading to potentially dangerous policy conclusions.
regarding the quality and performance of the health plans serving the health alliance's enrollees.

The administration could begin to ease this situation by embracing the recommendations of the Workgroup for Electronic Data Interchange (WEDI). This task force has laid out an aggressive plan to move the health insurance industry to agree on a uniform set of standards for electronic communication. The Clinton administration could encourage adoption of the Workgroup’s recommendations by the use of tax incentives and other legislative inducements preceding the passage of health reform. In this way, building a sufficient data and telecommunications infrastructure might be under way in advance of reform, rather than being initiated and pursued as a catch-up strategy afterward.

Concluding Thoughts

Relying on powerful, mandatory regulatory health alliances is a strategy fraught with implementation risks. There are alternatives, including the use of voluntary health alliances as information clearinghouses and purchasing entities for firms with fewer than 100 employees, that carry far less implementation risk. If we are going to reform the U.S. health care system, thinking through these types of formidable implementation challenges is both a necessary and an essential task. It is not too late to begin.

NOTES