VIEWPOINT

HEALTH POLICY

Reducing Administrative Waste in the US Health Care System

Robert P. Kocher, MD
USC Schaeffer Center, Los Angeles, California.

The US health care system is famous for its expense and its waste. In a 2019 study, Shrank et al[1] estimated that about 25%, or $760 billion to $935 billion, of the $3.6 trillion the US spends on health care annually is potentially wasteful. This equates to each person spending an unnecessary $2500 per year on health care. The largest category of wasteful spending in the US (about 30%) is administrative costs. Eliminating administrative expense has the benefit of lowering health care costs without affecting spending on patient care. It is the safest form of health care cost savings; virtually no one argues that administrative costs should remain high. Reducing administrative waste should be the highest priority for payers and policy makers given that everyone, including patients and clinicians, would benefit from lower health care costs.

The US health care system is administratively complex by design. Inherently, a multipayer system offering many variations of benefits, paying for care in a fragmented delivery system, and using a multitude of different payment models is administratively complex. Each health plan incurs cost to build sales and marketing function, deliver customer service, possess actuarial and benefit design functions, form a health care network, credential physicians and other health care practitioners, develop payment rules, set up payment operations, and ensure regulatory compliance. The Affordable Care Act (ACA) specifies that administrative costs cannot exceed 15% of premiums for commercial health plans. By comparison, Medicare spends about 5% of premiums on administration. Medicare achieves lower administrative expenses because it has no sales and marketing expenses, no network expenses, standardized benefit design, and simpler payment processes. The medical loss ratio rule of the ACA creates a perverse incentive for health plans because higher premiums enable higher administrative spending.

> It [administrative waste] is the safest form of health care cost savings; virtually no one argues that administrative costs should remain high.

Essentially, administrators for payers and health care centers are trying to accomplish a relatively straightforward goal: ensure that a patient is eligible for care based on their insurance and benefit design, the patient receives care from qualified clinicians, the care is appropriate and of high quality, and the correct amount is collected from the patient and paid to the clinicians. Completing this process requires an extraordinary amount of labor. Hospitals employ up to 1 full-time person per bed to support billing.[2] In total, nearly 4 full-time employees per physician work on administrative tasks, and this ratio is increasing.[3] Health care labor accounts for the majority of all health care costs in the US. Even though health care has been the largest source of new jobs in the US from 2001 to 2016, and accounted for 29% of all new jobs, labor costs were the largest driver of the 6% compound annual growth rate of health insurance premiums over this period.[3]

The costliest administrative task for payers and health care organizations is payments. According to an analysis from a single academic medical center, an estimated 62% of administrative costs were for billing and insurance.[2] The study also calculated that billing costs were $20.49 for a primary care visit, $61.54 for an emergency department visit, and $215.10 for an inpatient surgical procedure. As a percent of revenue, primary care physicians spent 14.5%, emergency departments spent 25.2%, and hospital surgical departments spent 3.1%.[2] Administrative costs in medicine are approximately 3 times higher than in other professions, such as law and accounting.[4]

Both payers and health care organizations have incentive to keep adding more people and creating new processes to gain temporary economic advantage. Payers add more prior authorization steps, increase first-pass claims denials, and use payments as a tool to collect additional data points on claims for short-term medical loss ratio gains. Health care organizations work with electronic health records to add decision support to guide clinicians to more highly paid diagnosis codes; hire scribes, coders, and chart reviewers to find more items to bill; and work with third parties to get more procedures authorized and denials overturned for short-term revenue gains. This give and take has led to spiraling costs because the return on investment for every additional hour of labor, for both sides, is positive, and neither side wants to cut costs or complexity because it would be costly if done unilaterally.

In 2010, the ACA tried to rein in administrative waste. As recognition of the high cost of billing and payments, section 1104 of the ACA required the US Department of Health and Human Services to promulgate rules to standardize many aspects of billing and payments. Specifically, the ACA called for a national system to determine benefits eligibility, coverage information, patient cost-sharing to improve collections at the time of care, real-time claim status updates, autoadjudication standards, and real-time and automated approval

Corresponding Author: Robert P. Kocher, MD, USC Schaeffer Center, 635 Downey Way, Verna & Peter Dauterive Hall, Los Angeles, CA 90089 (bkocher@venrock.com).

for referrals and prior authorizations. These actions were supposed to be implemented in 3 waves in 2013, 2014, and 2016. However, only the first 2 waves were implemented in 2013 and 2014. These regulations standardized eligibility, required real-time claims status, and created electronic fund transfer standards. The most cost-saving actions, autoadjudication of claims and prior authorizations, were supposed to be implemented in 2016 but were never enacted. Health care organizations opposed these rules because to make these processes work, payment systems would need to query clinical data systems to confirm patient data, accurately risk-adjust, and extract pay-for-performance quality metrics and they did not want to allow access to their systems by insurers. Interconnectivity of payment and clinical data systems could reduce the labor cost associated with data extraction, data review, and appeals for both payers and health care organizations.

In other industries, administrative standardization is driven by the largest participants. In banking, the Federal Reserve drove adoption of the Automated Clearing House for banking transactions, Walmart forced the adoption of universal product codes, and American Airlines and IBM created the Semi-Automated Business Research Environment that is used nearly universally to manage airline inventory and passenger names.[4]

Because the US health care system is so fragmented, there is not a clearly dominant entity to set administrative standards and force adoption. The federal government is the largest payer, but its market power is not concentrated because its payments flow through hundreds of different programs, including 50 unique Medicaid programs, Medicare, hundreds of Medicare Advantage plans, ACA insurance exchanges, federal employee health benefits, the military health system, Veterans Affairs, and the Indian Health Service. Each of these programs has governance over its administrative rules. Some programs, such as Covered California, use their local market power to force standardization of administrative elements, such as benefit design. The private sector alternatives lack either geographic reach or local market scale. The largest private sector entities are the payers United Healthcare and Anthem. However, neither of these companies are positioned to be administrative standard setters. United Healthcare lacks local market scale because it usually only accounts for 10% to 20% of patients for clinicians. Anthem lacks geographic scale because it only operates in 23 states. Only the Medicare system operates in all states and is accepted by nearly all health care organizations, which means changes to Medicare's administrative rules are adopted nearly universally. Medicare is also a large payer, through the Medicare Advantage program, to the largest commercial payers, which could enhance Medicare's ability to serve as an administrative standard setter. This makes Medicare the only participant with the market power to set administrative standards.

The federal government can use regulatory authority to reduce administrative costs. The opportunity today is both larger than in 2010 when the ACA targeted administrative simplification and more readily capturable as a result of improvements in information technology. The authority derived from the ACA should be used to implement the third wave of administrative simplification regulations, which requires autoadjudication of claims and prior authorizations and, as a by-product, creates long-awaited payment system and electronic health record interoperability. The Trump administration launched the Patients Over Paperwork program to reduce administrative burden. This program has simplified documentation for office visits and reduced reporting burden for many programs, and claims to have saved health care organizations an estimated $6.6 billion and 42 million hours of labor through 2021.[5] More opportunity likely exists to rationalize the more than 1700 metrics that Medicare collects, which is estimated to incur $15.4 billion in annual data collection and reporting costs.[6] There are additional opportunities that technology such as artificial intelligence may be capable of addressing, including a national clinician credentialing system; risk adjustment relying on data science models instead of physicians coding hierarchical condition categories; and identifying fraud, waste, and abuse.

Although the coronavirus disease 2019 pandemic is rightfully the highest priority for the US health care system at the moment, reducing administrative costs represents the largest opportunity to lower health care costs. These pressures will be intensified by the looming Medicare Trust Fund insolvency in 2026, higher than expected Medicaid and ACA premium subsidy payments as a result of millions of displaced jobs, an aging population, and underlying medical inflation exceeding gross domestic product growth. Fortunately, much can be done to reduce administrative costs.

ARTICLE INFORMATION

Conflict of Interest Disclosures: Dr Kocher reported being a partner at the venture capital firm Venrock, where he invests in health care technology and services business, serving as a board member for Premera and Devoted Health, and being a special assistant for health care and economic policy for President Obama and working on administrative simplification policies outside the submitted work.

REFERENCES

1. Shrank WH, Rogstad TL, Parekh N. Waste in the US health care system: estimated costs and potential for savings. *JAMA*. 2019;322(15):1501-1509. doi:10.1001/jama.2019.13978

2. Tseng P, Kaplan RS, Richman BD, Shah MA, Schulman KA. Administrative costs associated with physician billing and insurance-related activities at an academic health care system. *JAMA*. 2018;319(7):691-697. doi:10.1001/jama.2017.19148

3. Kocher B. People cost even more than drugs: the imperative for productivity. *HealthAffairs*. April 3, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190328.816788/full/

4. *Hearing of the Committee on Health, Education, Labor, and Pensions*, 115 Cong, 2nd Sess (2018) (testimony of David M. Cutler, PhD, professor, Harvard). Accessed January 4, 2021. https://www.help.senate.gov/imo/media/doc/Cutler.pdf

5. Verma S. Patients over paperwork. Center for Medicare & Medicaid Services. Updated August 2019. Accessed January 4, 2021. https://www.cms.gov/About-CMS/Story-Page/Patients-Over-Paperwork-fact-sheet.pdf

6. Wilensky G. The need to simplify measuring quality in health care. *JAMA*. 2018;319(23):2369-2370. doi:10.1001/jama.2018.6858