

The High Cost of Administrative Waste in the US

Ginamarie Gianandrea

Key Takeaways:

Administrative waste in the United States is estimated to cost over \$265 billion annually

The cost of administrative waste is largely attributable to fragmentation, inefficient payment processes, and burdensome quality reporting

The true cost of administrative waste is not purely financial: it includes intangible costs like those associated with increased provider burnout as well as the opportunity cost of forgone social goods and services

Unlike other areas of healthcare waste (e.g., failure of care delivery, overuse) where interventions have successfully yielded lower costs, there are few successful interventions that have decreased the cost of administrative waste

As long as one's waste is considered another's profit, there is little incentive to address administrative waste

Introduction: Perspectives on Administrative Waste

Simply defined, administrative waste can be described as spending on administrative tasks that "can be reduced or eliminated without adversely affecting the quality of care or health outcomes."¹ Administrative waste typically describes excess costs associated with administering health care, including: billing and insurance-related (BIR) costs, costs

¹ (Speer, McCullough, Fielding, Faustino, & Teutsch, 2020)



associated with reporting on quality measures,² and other administrative tasks such as sales, marketing, and credentialing.^{2,3}

A review of the literature will demonstrate that there is little controversy around the costs administrative waste poses to the US healthcare system. One of six major categories of waste as defined by the Institute of Medicine (IOM) in 2010,⁴ administrative waste is the largest proportion of healthcare dollars that can be considered waste. Indeed, Shrank et al estimate that not only is 25% of healthcare spending waste, approximately a third (\$265.6 billion) of that waste is attributable to administrative complexity.⁵ Even more concerning, their review of the literature revealed no interventions that have produced significant savings in this category. This suggests that administrative complexity is the largest driver of waste in the healthcare system with the fewest proven solutions.

Billing and Insurance-Related Costs

BIR costs, estimated at \$248 billion, are not only the largest component of administrative costs, but are larger than any other single category of waste.² BIR costs include “the costs of a provider verifying that a patient is eligible for services, prior authorization procedures on both the provider and payer side, submitting bills and appropriate documentation, addressing denied claims, and remitting payment” (Cutler, 2020).

Claims management is fraught with complexity, despite the increasingly automated nature of claims submission and processing. Providers often maintain multiple systems for the submission and management of claims because of differences in documentation

² (Cutler, 2020)

³ (Effros, Bentley, Palar, & Keeler, 2008)

⁴ (Institute of Medicine, 2010)

⁵ (Shrank, Rogstad, & Parekh, 2019)



and data requirements among payers. This results in higher costs related to what is otherwise an automated process.

Prior authorization is increasingly required by payers as a method to control medical costs but remains a largely manual process that requires increasing amounts of provider time and effort. Physician surveys suggest that prior authorization is not only very burdensome but has increased over time and is a contributor to provider burnout.⁴

Quality Reporting

Shrank et al estimate \$17.6 billion is wasted on activities related to quality measurement. While certainly a worthwhile endeavor from a population- and system-health perspective (as well as critical to value-based payment strategies), Cutler provides three reasons why quality measurement is particularly burdensome and expensive:

- *Proliferation of metrics, many of which are low value*
 - Imbalanced number of process-focused measures as opposed to health outcomes-focused measures
- *Lack of harmonization across payers and programs*
 - Over 2,000 measures are in use across CMS programs, 1,300 are in use by state agencies, and >500 are in use across commercial health plans
 - Even when measures are “aligned” across payers and programs, specifications used for data collection and reporting can differ – e.g., measuring HbA1c control at <7% or <8%, poor control at >9%
- *Inefficient data collection*
 - Administrative claims are a typical data source of many measurement programs, which increases reporting burden and creates a lag in generating performance results
 - Utilization of data captured in the electronic medical record (EMR) is not yet standard

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A 2016 survey⁶ of provider practices quantified the impact of quality measurement on administrative spend. Their findings indicate that an average of 15 hours of provider and staff time per week—over 780 hours per year—are spent on measurement, including tracking measures and measure specifications, developing data collection systems, and reporting. There doesn't seem to be a high return on investment of this time, either: Only 27% of physicians reported that measures were representative of care quality and only 28% used quality scores to improve performance. The estimated \$15.4 billion in annual costs to provider organizations aligns with findings elsewhere in the literature⁵ and emphasize not only the severity of the financial impact performance measurement is having in this area, but the additional burden on provider practices.

True Cost of Administrative Waste

The financial impact of administrative waste has been discussed at length, but there are both intangible costs and opportunity costs associated with administrative waste that should also be considered. There is cause for concern about the impact increased administrative complexity has on provider burnout and where the cost of administrative waste could be otherwise applied for greater social good.

Intangible Costs

Administrative burden is one of many factors contributing to physician burnout. A 2014 survey of over 1,700 physicians found that 24% of physicians' time was used on administrative tasks and suggested that increased administrative burden is linked to higher likelihood of physician dissatisfaction and burnout.⁷ Physician burnout has been associated with poorer patient care, increased costs, and poorer health of physicians.⁸

⁶ (Casalino, et al., 2016)

⁷ (Rao, et al., 2017)

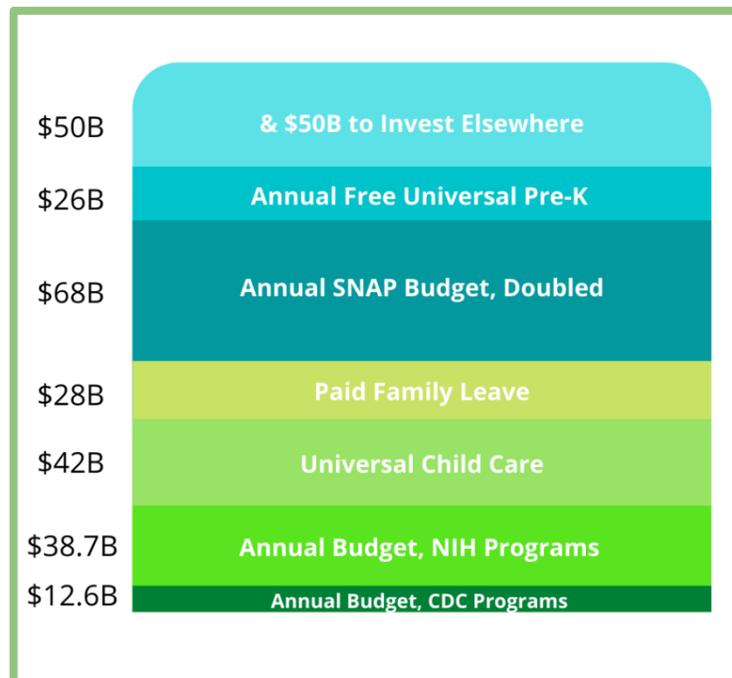
⁸ (West, Dyrbyre, & Shanafelt, 2018)

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Physicians surveyed cite prior authorization, clinical documentation, and medication reconciliation as the most burdensome administrative tasks⁶ – these are also frequently cited in the literature as areas that contribute to high levels of administrative waste.^{2,3}

Opportunity Costs

We should be motivated to address excess costs associated with administrative waste. By definition, the \$256B dollars attributed to administrative waste are not currently providing value to health. These dollars could be allocated elsewhere in the healthcare system or in any number of social goods which positively impact health outcomes (e.g., education^{9,10}, family & children’s services).^{11,12,13} A non-exhaustive list of goods and services that could be funded with these savings is shown at right.^{3,14,15}



Alternatively, \$256B is enough to allow ~\$2,000 to be returned to every American household.¹⁶

⁹ (Klebanoff Cohen & Syme, 2013)

¹⁰ (Picker, 2007)

¹¹ (Carlson & Keith-Jennings, 2018)

¹² (Keith-Jennings, Llobrera, & Dean, 2019)⁵

¹³ (Ruhm, 2000)

¹⁴ (US Department of Health and Human Services)

¹⁵ (National Institutes of Health (NIH))

¹⁶ (US Census Bureau, 2020)

Proposals for Reducing Administrative Waste

While evidence of savings in this area is limited, there are policy and market proposals that have been or could be considered. However, a preference for the status quo may prove to be a barrier in implementing any of these proposed solutions. As Don Berwick writes, “What Shrank and colleagues and their predecessors call “waste,” others call “income.” People and organizations (for profit and not-for-profit) [are] making big incomes under current delivery models”.¹⁷ Maintaining competitive advantage in the market – by protecting data, upcoding, and increasing use of processes such as prior authorization—incentivizes the system to continue on as-is, regardless of administrative costs that may be considered waste.¹⁸

Legislative Efforts

<i>Legislation</i>	<i>Year</i>	<i>Intended Impact</i>
Health Insurance Portability and Accountability Act (HIPAA) ¹⁹	1996	Administrative simplification provision set national standards for electronic transactions, code sets, unique identifiers, and operating rules
Administrative Simplification Compliance Act (ASCA) ²⁰	2001	Required electronic billing for Medicare payments
Health Information Technology and Economic and Clinical Health Act (HITECH) ²¹	2009	Provided funding and technical assistance to bolster health IT infrastructure, including increased use of electronic health records
Patient Protection and Affordable Care Act (ACA) ²²	2010	Section 1104 called for uniform standards to simplify payments and transactions, including enabling immediate determination of patient

¹⁷ (Berwick, 2019)

¹⁸ (Kocher, 2021)

¹⁹ (Centers for Medicare & Medicaid Services, 2017)

²⁰ (US Department of Health and Human Services, 2020)

²¹ (US Department of Health and Human Services, 2009)

²² (Patient Protection and Affordable Care Act (ACA or Affordable Care Act), 2010)

		eligibility and cost sharing as well as automatic adjudication of claims and prior authorizations
Medicare Access and CHIP Reauthorization Act (MACRA) ²³	2015	Consolidated multiple quality measurement programs under single program
21st Century Cures Act ²⁴	2016	Required the Office of the National Coordinator for Health Information Technology (ONC) to advance health IT capabilities and define expectations for data sharing

Standardized Claims Processing

Section 1104 of the Affordable Care Act called for uniform standards and operating processes that would enable automatic adjudication of claims and prior authorizations, which were not enacted as planned.¹⁶ To address this gap and further increase efficiency related to billing and payment, Cutler argues for creation of a national clearinghouse for claims. This model would 1) standardize operating procedures for electronic transmission of claims data and 2) create a clearinghouse entity responsible for processing claims, with data moving bidirectionally between payers and providers. To incentivize adoption, CMS would require payers and providers participating in public programs to participate, facilitating adoption among most stakeholders.⁴

Streamline Performance Measurement & Reporting

Administrative complexity could be mitigated through changes to requirements and processes related to performance measurement. Alignment of measures and measure specifications used by payers, particularly in the commercial market, could reduce the amount of time spent documenting data that has little use clinically or for quality improvement. Additionally, improved interoperability could automate collection and risk

²³ (Centers for Medicare & Medicaid Services, 2015)

²⁴ (ONC, 2021)



adjustment of performance data, reducing the burden of reporting. Cutler estimates that improvements to quality measurement could cut costs in half – a \$7B savings to the system.

Increase Adoption of Value-Based Payment Models

Some argue that we could avoid issues that cause administrative waste if we successfully moved towards value-based models of payment. Increased adoption of VBP models—particularly models with risk sharing—would reduce billing and insurance related costs by eliminating claims-based payment and burden associated with prior authorization. As Shrank articulates: “In value-based models, in particular those in which clinicians take on financial risk for the total cost of care of the populations they serve, many of the administrative tools used by payers to reduce waste (such as prior authorization) can be discontinued or delegated to the clinicians, reducing complexity for clinicians and aligning incentives for them to reduce waste and improve value in their clinical decision-making. As more clinicians transition into value-based payment arrangements with financial risk, administrative burden and oversight could be reduced for all health care constituencies, including payers, hospitals, and physician practices; adoption of global prepayment mechanisms for patients and populations rather than fee-for-service payments would be expected to accelerate reductions in administrative complexity.”

Conclusion

While it is generally agreed that administrative waste is an issue worth addressing, there have yet to be any meaningful interventions implemented to reduce administrative waste. This is not due to a lack of solutions, but disincentives across stakeholders to implement them. As Don Berwick notes, “Some of the very methods for waste reduction that Shrank et al cite would reduce profit for the healthcare organizations that use

them”: Payers will continue utilizing their own billing and coding systems and prior authorization requirements to protect competitive advantage, while providers will hire staff to support billing, maximize reimbursement, and manage measurement systems. As long as one’s “waste” is another’s income or profit, there is little incentive for improvement.

Discussion Questions

1. If there are not meaningful incentives to reduce costs associated with administrative waste, will change require government action and/or regulation? Given the extent of legislative action taken to date, would additional government action or regulation be impactful?
2. Some argue that reducing administrative waste undermines a healthcare organization’s ability to compete in the market. Are there solutions not considered here that support competition and reduce waste?
3. Alternatively, would a single payer system solve the issue of administrative waste by eliminating fragmentation and streamlining payment processes?
4. Are increased adoption of fully capitated, value-based payment models a worthwhile middle ground between a single payer system and our current system?
5. Are incremental changes (e.g., streamlining billing, prior authorizations) enough, or is the system fundamentally inefficient?

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