

Impact of Business Operations and Policies on Healthcare Costs

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ABSTRACT

It is no surprise that the United States has a problem managing its healthcare costs. To get insurance to cover medical costs, people have to stay in-network, pay their premiums, yearly fees, meet their deductible—which is the maximum out-of-pocket cost—pay a copay—a fee for a physician visit or prescription refill—and finally pay their co-insurance: the percentage of a medical bill the customer has to pay. The United States has access to some of the best medicine in the world with state of the art MRIs, which much research and development happening in the United States, and “the U.S. has four times the number of MRIs per capita as Canada, and three times the number of cardiac surgeons” (Cutler, 2020). There are many reasons as to why healthcare costs are so high in this country, one major reason is inflated health administration costs. This paper examines what is the cause for high health administration costs, and aims to find policies that could be implemented to lower these costs.

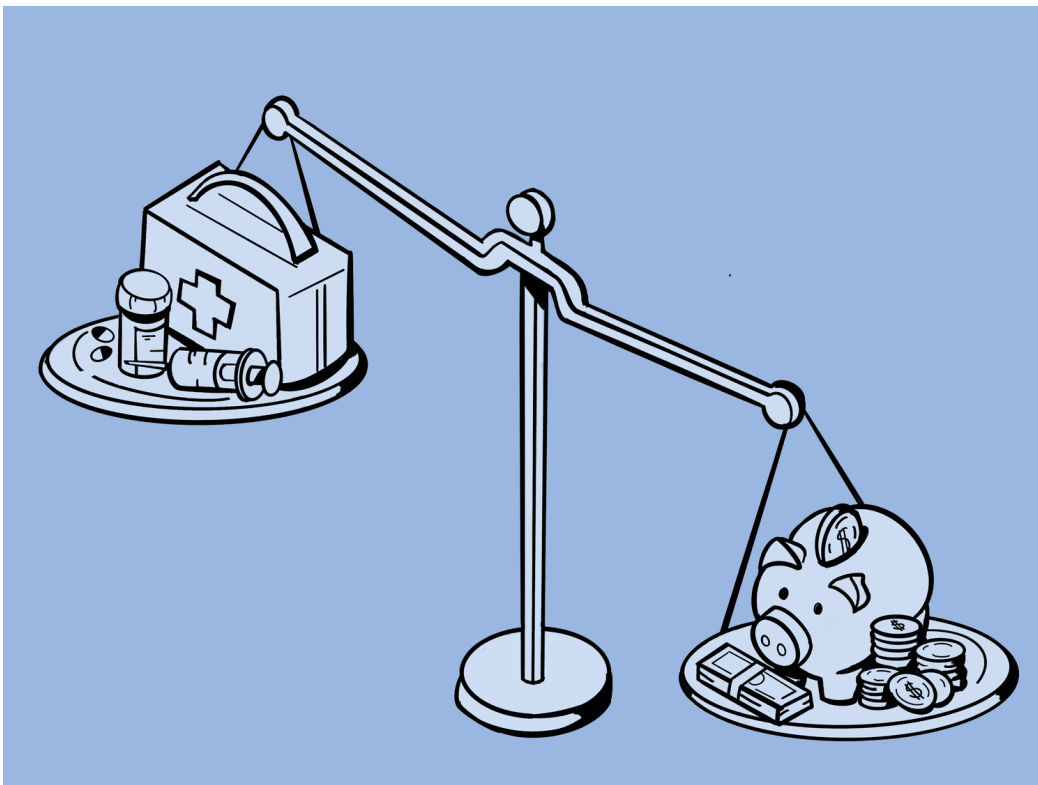


Figure 1. The Cost of Medicine is weighed by the benefits of Medicine with the costs being heavier. Probasco, J. (2022). Why do healthcare costs keep rising? *Investopedia*. <https://www.investopedia.com/insurance/why-do-healthcare-costs-keep-rising/>

Introduction

In 2015, America spent 17.8% (\$3.2 Trillion) of its Gross Domestic Product (GDP) on healthcare. As of 2021, this price has increased to \$4.3 trillion with the expected percentage to rise to 20.1% by 2025 (American Medical Association, 2023). This money ranges around \$10,000-\$13,000 per person from taxpayers and bonds (Branning, 2016). For other countries, such as France, Brazil, or the United Kingdom, their GDP percentage for healthcare would be just half of the percentage spent by the United States.

Healthcare spending can be broken as to the percentage each entity spent on healthcare. In 2021, 28.5% of healthcare spending came from private health insurance, but more importantly 10% of total healthcare expenditures came from out-of-pocket costs from consumers (American Medical Association, 2023). That is an alarming percentage, which might explain why countless people who seek medical care constantly worry if the next treatment option is worth the cost. Many of these people often skip or delay medical care when things get serious while others try to ration their medication in order to make it last longer. As a result, people lose lives due these dangerously frugal measures on their health. For example, a patient named Alec Smith had type 1 diabetes. With this chronic illness, a patient depends on insulin to prevent their blood sugar levels from spiking too high. In this situation, the cost of insulin was getting too expensive, so Mr. Smith rationed his insulin. His blood sugar spiked too high, and with no insulin, he developed ketones and went into diabetic ketoacidosis (DKA). Eventually, Alec Smith died due to complications of DKA. (Cutler, 2020). If a country is spending double the percentage of GDP compared to other countries and citizens are being forced to ration their medications, there is a massive national issue.

There are a variety of reasons why healthcare costs in the United States are at an all-time high. America indeed has access to some of the best medical technology available, as well as cutting-edge pharmaceutical research and development; however, despite those obvious benefits, America's healthcare costs are still over-inflated because of bloated administrative costs.

The Problem with Health Administrators

Health administrators share a big portion of healthcare spending. In fact, between 15-and 30% of healthcare spending goes into healthcare administration costs: a total of 645 billion to 1.29 trillion (Keating et al., 2022). The U.S. is the largest spender on health administration at a whopping \$1055 per capita. The second-largest spender, Germany, only spends about \$306 per capita on Healthcare administration costs (Keating et al., 2022).

One study compares the United States with Canada in terms of administration costs. The results are dramatic. Compared to its border country, Canada, the U.S. has 44% more administrative staff with U.S. physicians spending more time dealing with administrators than their Canadian peers. There are 2.2 million administrative staff workers in the United States per physician with 12% of premiums going towards paying health administrators. (Cutler & Ly, 2011).

There are two major reasons being these inflated costs. The first is due to inefficiencies in the healthcare system that require extra time and money for administrative staff to address. The second comes with the time-consuming process of dealing with insurance. In order to address this issue appropriately, policies have to be enacted to address these issues to make substantial change.

Administration Inefficiencies

Every hospital has a different interface, and a different method to handle medical records and payments. “Almost all hospitals have electronic medical records, but there is no federal requirement that they interface. Indeed, many providers take active steps to avoid electronic interchange, because keeping records local ensures that fewer patients will switch doctors” (Cutler, 2020). Administrators have to devote time and energy just to be able to send records to different systems (Cutler, 2020).

Insurance Bureaucracy

Physicians have to state a lot of credentials through applications, applications that take a lot of time for the administrative staff to review (Cutler & Ly, 2011). There is a lot of difficulty in figuring out how the medical bill is split. Administrators have to see what services the patient can have, how much of the patient’s deductible has been met, if the patient has paid their premium, if the doctor is in the network, and much more. On top of that, insurance tends to deny a lot of claims. Physicians have to fill out prior authorizations that often get denied because more documentation is needed, or the company feels the patient can take this treatment in a different manner that is much cheaper for the company (Cutler & Ly, 2011).

This is all in hopes of discouraging physicians from prescribing treatments that are more expensive for the company, and in general, delaying care to prevent immediate payment. Although many of these claims eventually do get approved, the time, money, and energy gone into fighting for approval of claims, and prior authorizations is a lot. (Cutler & Ly, 2011). While all this fight is happening, it is the administrative staff working to handle the paperwork of denying, and approving these claims and prior authorizations.

Proposed Solutions

One major way the U.S. can reduce its health administration costs is through complete standardization. Having each health company, and each healthcare system do its own thing, creates an inefficient system that hampers proper patient care and inflates health administration costs unnecessarily. Each healthcare system can work together to figure out a standardized process for submitting electronic records, handling payments, and managing prior authorizations and claims. There have been several proposals to make this happen.

Streamlining Claims Requests

The creation of a “centralized claims clearinghouse would standardize the electronic transmission of billing information to reduce the costs of operating disparate systems across providers and payers” (Keating et al., 2022). The federal government would set up two entities.

The first agency would set up the operational standards needed to facilitate secure electronic transmission of records and payments that healthcare systems would need to follow, while the other would be an independent body that would take all claims from insurance, hospitals, physicians, providers, and other third-party healthcare players. They would route these claims appropriately. If this happens, “\$300 million could be saved annually (or roughly \$0.06 per claim), were Congress to establish such a clearinghouse” (Keating et al., 2022). However, that only spares 0.02%-0.04% of healthcare spending on administrative costs. This is a step in the right direction, however, more effective policies are needed to make substantial change.

Digitizing and Reducing Prior Authorizations

Another proposal is to completely digitize handling prior authorizations. Currently, prior authorizations are handled by phone and fax. According to a survey of around 1000 physicians, 91% of physicians reported prior authorizations delaying care, with many practices completing 33 prior authorizations per week. It is no surprise as a result that “Eighty-eight percent of physicians believe that the prior authorization burden has increased in the past five years. Prior authorization is one contributor to the widely noted phenomenon of physician burnout” (M Cutler, 2020). They have also testified that it takes two business days of physician, and staff time to complete all of these prior authorizations (American Medical Association & American Medical Association, 2020). It becomes a bigger nuisance when those claims get denied and physicians have to fill out the prior authorizations again just to get a treatment approved for a patient. A digital platform should be created where healthcare providers have to respond to prior authorizations within 20 seconds and send their decision on the authorization within 2 business days (American Medical Association & American Medical Association, 2020).

Many people also advocate for reducing the need for prior authorizations to reduce administration costs. One example is reducing prior authorizations requirements for certain medications, diagnostics, or treatments for patients with chronic conditions (M Cutler, 2020). Others suggest a “gold-card” system where practices with a history of providing appropriate, cost-effective care—through practices such as recommending reasonably priced medications, preventing over-screening, etc.—do not have to fill out as many prior authorizations (M Cutler, 2020). This paper also suggests that these benefits should extend practices that have a decision criterion for treatments, and practices should attach a price for completing prior authorizations (M Cutler, 2020).

Credentialing Standardization

The final policy proposal is the standardization of different aspects of healthcare. For example, each health plan has its own set up of directories to provide information to its constituents about in-network practices. “Maintaining these directories poses a significant administrative burden, and inaccuracy is a recurring issue. [The] CAQH [(Council for Affordable Quality Healthcare)] estimates that the maintenance of directories costs US physician practices up to \$2.76 billion annually [according to CAQH Explorations (2019)]” (Keating et al., 2022). However, by having just one director for all health providers to use, this will “save more than \$1.1 billion per year, according to [CAQH Explorations (2019)]” (Keating et al., 2022).

Conclusions

These solutions mentioned above do have a possibility of mitigating the problem of rising health administration costs. The federal government is a major player that has the power to implement these possible solutions into reality. However, they could face lobbying from major health companies. “The federal government sees its role as providing insurance to people—Medicare and Medicaid in particular—but not looking out for the system as a whole. That thinking will need to change if progress is to be made” (Cutler, 2020). Hence, the real major step to achieve this goal is to bring support and convince the federal government and major companies that there are real financial benefits to these institutions as well by having a healthcare system that has a more efficient system of health administration. It is unclear what effects these proposals will have on our healthcare system as they have yet to be properly implemented. However, this is a step in the right direction towards reforming a healthcare system to meet the needs of patients and their providers.

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