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# Health insurance maze a major financial burden on hospitals, doctors, businesses

**Original Reporting** | By Mike Alberti | Health care, Insurance

June 20, 2012 — According to the Centers for Medicare and Medicaid Services (CMS), nearly $850 billion was funneled through private health insurance companies in the United States in 2010, the most recent year for which detailed data is available, representing more than 5 percent of GDP. Most of that money went directly into health services, such as hospital care, physician reimbursement, and prescriptions drugs. The rest, some $102 billion, went into profits, marketing, and another broad category of expenses known as "administrative costs."

> Massachusetts General Hospital employs more than 300 staff members dedicated soley to billing. Toronto General Hospital, which is comparable in size, employs only three.

The United States spends significantly more than any other country on the administration of health care — broadly defined as the amount of time, effort, and money that is spent coordinating the provision of services and payment between patients, providers, insurers, employers, and the government.

According to James G. Kahn, a professor at the Institute for Health Policy Studies at the University of California San Francisco, the billions of dollars spent by *insurance companies* on administrative costs (a portion of the $102 billion mentioned above) are only the tip of the iceberg. Doctors, hospitals, and employers are burdened with the additional costs of navigating the complex health insurance system, Kahn said, "and those costs are then borne, indirectly, by patients."

Researchers have estimated that, all together, the costs add up to hundreds of billions of dollars a year, a huge share of total health care spending. "In all the discussion about the money spent on health care," Kahn said, "those costs have received a surprisingly small amount of attention."

## How much?

Over the last decade, there have only been a handful of academic studies that have attempted to estimate the amount of time and money that is spent on the administration of health care every year. Part of the reason for this is that, while the government and other groups do collect data on *total* administrative

costs in various settings, they do not separate out the portion of those costs that can be attributed to interacting with insurance companies, as opposed to other kinds administrative tasks, such as quality review.

Still, those studies that have been done provide a sense of the scale of the administrative costs associated with billing and insurance-related tasks. Most of that work has looked at the costs borne by physicians and hospitals. In a 2005 study, for example, Kahn and three colleagues used survey data to estimate the number of hours that hospitals, physicians, and clinical staff spent on administrative tasks associated with billing and insurance in California. They found that physician offices were spending between 13.9 and 14.5 percent of their total revenue on those tasks, while hospitals were spending between 6.6 and 10.8 percent of total revenue.

A more recent study, in 2009, produced similar results on the national level. The study found that physicians spent an average of three hours a week interacting with health insurance plans. For each physician in a medical practice, nursing staff, in the aggregate, spent an average of 23 weeks per year interacting with health plans, and clerical (non-clinical) staff, in the aggregate, spent an average of 44 weeks per year. The study estimated the total cost to each practice at $68,274 per physician per year. In a separate 2009 study, using a different methodology, other researchers estimated that cost at $85,276 per physician.

> Researchers estimate the total costs of billing and insurance related administrative tasks in the U.S. at more than $400 billion a year.

In 2010, Kahn synthesized the findings of these and other studies to estimate the total costs of the health care administration that is related to billing and insurance. The results became a chapter in a book published by the Institute of Medicine on health care costs. The number that he came up with was $361 billion, representing about 15 percent of total healthcare costs in 2009.

“When we finally had a number that we felt confident about, we kind of stepped back and said, ‘Wow,’” Kahn said.

Since his synthesis study was published, however, there have been some new estimates of the costs borne by physicians, which have made Kahn believe that his previous estimates were too low. He is currently updating his synthesis. Since his numbers are preliminary, he could not give an exact figure, but said, “We’re definitely looking at more than $400 billion.”

And that estimate does not include the costs borne by employers, which are even more difficult to parse. The only study that has attempted to estimate those costs, by Stephanie Woolhandler, a practicing physician and a professor at the City University of New York School of Public Health, and two colleagues, was published in the New England Journal of Medicine in 2003. Woolhandler estimated that the costs to employers of administering health insurance coverage for their employees was $15.9 billion in 1999.

While more recent data is not available, Woolhandler said that if her 1999 estimate were adjusted by the same rate that total employer health care costs have risen since then (about 130 percent, according to the Kaiser Family Foundation), the total for 2009 would be estimated at about $37 billion.

"That's certainly a low estimate," Woolhandler said. "It's the best we can do with the data we have, but the costs to employers are very hard to quantify. I think we can safely say that it's at least that much, and very likely significantly more."

## "A terrible maze"

According to Woolhandler, the vast majority of the health care administrative costs are due to the complexity of the insurance system.

"The system is a terrible maze," she said. "Every doctor has to get used to the headache that comes simply from trying to be paid."

In addition to Medicare and Medicaid, there are more than a thousand health insurance companies in the United States. Individual physicians may only accept insurance from a few of them, but most insurance companies offer several different plans, which provide different coverage at different costs.

> "Billing is a nightmare," for physicians, who are required to document, in detail, "every minute of time spent with a patient," said Stephanie Woolhandler a professor at the City University of New York.

Navigating that system requires a huge administrative effort, Woolhandler said. Most physicians, even those in small, family practices, need to employ non-medical staff members to keep track of dozens of differing criteria depending on which insurance plan their patients are using. Nurses, physician assistants, and physicians themselves each are burdened with administrative tasks associated with billing and insurance.

"Billing is a nightmare," Woolhandler said. She explained that physicians and their staff members are required to document, in detail, "every minute of time spent with a patient" for billing purposes. Every procedure needs to be translated into the code used by the insurance company, she said, and in order to prove that each procedure was "medically necessary," physicians may also have to provide detailed documentation of a patient's medical history. "The system demands a huge amount of information all the time," Woolhandler said.

An additional level of complexity is added because the price and coverage of the insurance plans will often change every year, or sometime even more frequently than that, Kahn said.

"A doctor might have renewed the same prescription for the same patient every month for years, and then suddenly, he might get a call from the pharmacy saying that the insurance plan no longer covers that medicine," he explained. "Then you have to get on the phone and try to figure it out, and that's time you'd otherwise be spending with patients."

The complexity then pervades visits with patients, Woolhandler said, because physicians have to try and keep track of what procedures and medications are covered by the patient's insurance plan. "Every time I want to do something as simple as refer someone to a specialist, someone has to go through the effort of finding a specialist that is within [the patient's] network," she said. "I have to use my limited time with each patient discussing billing and insurance coverage, trying to help them make a decision about what kind of care they're going to get."

## A burden on hospitals

Hospitals face similar issues, though on a much greater scale. Hospitals often accept dozens, even hundreds of different insurance plans, requiring them to staff large departments of employees whose primary job is processing billing requests, sending them to the appropriate insurance companies, and filing appeals — often with more documentation — if the claims are denied.

> According to Karen Granoff of the Massachusetts Hospital Association, most large hospitals must have a massive infrastructure in place dedicated to interacting with insurance companies. "For every procedure they do, they have to fight to get paid," she said. "And hospitals do a lot of procedures."

Individual hospitals and hospital associations have long complained that the complexity and the opacity of the insurance system places an undue burden on them. In 2008, for example, the American Hospital Association released a report titled, "Redundant, Inconsistent and Excessive: Administrative Demands Overburden Hospitals." According to the report, hospital emergency departments spend the same amount of time doing paperwork as they spend caring for patients.

Karen Granoff, a senior director at the Massachusetts Hospital Association, explained that hospitals absorb administrative costs at every stage of the process. "First, hospitals have to figure out if the patient is eligible for care," she said. "Then, if they're covered, they need to make sure that all the correct authorization is in place if it's a special procedure, like an MRI. Then they figure out what kind of co-payment to collect, which depends not just on the plan but can also depend on the kind of procedure or on the doctor. Or if there's a deductible, then there will be the question of what the patient needs to pay up front."

Finally, the patient can be seen. And then the billing process starts.

"You have to code the procedure and submit it," Granoff went on. "If it's denied, there's an appeals process, but the appeals process is different for every insurer. And there's no guarantee on turnaround time: some insurers might take two weeks and some might take nine months." Handling the appeals process can require a remarkably large amount of staff time, she said.

According to Granoff, most large hospitals must have a massive infrastructure in place dedicated to interacting with insurance companies. "That isn't because the hospitals are inefficient, it's just that, for every procedure they do, they have to fight to get paid," she said. "And hospitals do a lot procedures."

## What about employers?

Most health insurance in the United States is provided through employers, who are involved in many aspects of the administration of insurance plans for their employees. Large businesses, where employees are frequently coming on and going off the insurance rolls, may employ several people simply to manage their health insurance plans. Many also pay consultants to advise them on what kinds of coverage to offer and how much to pay for it.

Small business owners are more likely to handle that administration themselves. According to several businesses and advocates, the simple act of choosing between the numerous types of insurance plans available represents a burden in time and resources. "Every small employer that provides health insurance is probably going to spend a lot of time one month of every year shopping around, comparing the plan you offer now to the others that are out there," said Ben Geyerhahn, the director of special projects at the Small Business Majority, an advocacy group.

> "The way we have structured our system pits these different groups against each other in terms of getting paid." — James G. Kahn of the University of California San Francisco.

And if an employee actually has to use the insurance that has been paid for, an employer will have the burden and cost of staff time devoted to overcoming the hurdles to reimbursement (see bottom box on next page).

## An inherent friction?

In the last several decades, there has been a significant effort on the part of policy makers to make the existing system of health care financing work more effectively and efficiently, such as the 1996 Health Insurance Portability and Accountability Act (HIPAA), which was intended to standardize some transactions, saving providers time and money.

But several researchers pointed out that administrative costs have continued to rise, and expressed doubts that certain provisions of the 2009 Affordable Care Act — which were intended facilitate the switch to "paperless" billing and payment — will have much of an effect, either.

As Woolhandler explained, that is because many of those costs are "built into" the health care system as it is currently structured, and cannot be removed without changing it drastically.

Kahn agreed, and explained the intractability of those costs in terms of the "friction" that exists between providers and employers, on the one hand, and health insurance companies, on the other.

"The way we have structured our system pits these different groups against each other in terms of getting paid," Kahn said. "Everybody has to fight to get paid for what they do. Doctors and hospitals have to fight for the insurance companies to pay them, and insurance companies have to make a profit, which means trying not to pay doctors and hospitals."

### "I never wanted to become an insurance expert"

Jan Naylor is the president of Naylor's Hardware, which has operated stores in rural Maryland and West Virginia for 128 years. She currently employs about 90 people full-time, and provides health insurance for all of them.

"We employ one woman who was in a car accident and needed surgery on her right arm for nerve damage," Naylor said. "Her doctor here sent her to a specialist in Pittsburgh, but the insurance company said that he wasn't in our network. So she tried someone else. Not in the network. All the while, her doctor was saying, 'You need to take care of this immediately, or the nerve damage is going to be permanent.'"

Naylor had to get involved by calling the insurance company and adjusting her employee's coverage. "It took forever," she said. "I was on the phone every day trying to take care of that."

And that was hardly an isolated incident. "It seems like every couple months I have to call and wrangle with them about something, whether its them denying to pay for something or trying to charge us for something extra," she said.

Naylor said that, at the same time that health insurance costs have been rising over the last several years, the administrative burden has increased, as well. "I took over the business 31 years ago, and I had to become an expert in all kinds of things that have nothing to do with hardware, like accounting and marketing," she said. "I never wanted to become a health insurance expert, though, but that's just part of being a business owner these days."

Kahn and Woolhandler both agreed that that kind of friction was likely a necessary byproduct of any health care system in which there are multiple, private insurers competing.

“When you have that kind of complexity, there are a lot of gears moving at the same time, and it’s inevitable that some of them aren’t going to fit together,” Kahn said. “That means there will be friction when things try to move.”

Nevertheless, most of the proposals to decrease administrative costs largely ignore this fundamental structural issue, and limit their proposals to incremental steps to save paperwork within the context of a friction-laden system. For example, a report that was released last week by the Center for American Progress, a liberal-leaning think tank, suggested several measures that would reduce administrative costs, such as expanding funding for electronic infrastructure in hospitals and doctors offices and creating a new federal office dedicated to simplifying the health care administrative process.

Yet if all of the authors’ recommendations were implemented, the estimated savings would only be about a quarter of the currently estimated excess administrative costs.

## See no evil, hear no evil

According to Woolhandler, an advocate for single-payer health insurance, efforts to “reach for the low-hanging fruit…ignore the root of the problem,” she said. “As long as you’ve got a multi-payer, for-profit insurance system, you’re going to pay for it in administrative costs.”

Researchers who have studied the excess administrative costs associated with a private, multi-payer health insurance system urge policy makers to look at a real-life example of an alternative, right across the border.

During the debate over health reform in 2008 and 2009, President Obama rejected proposals to move the United States toward a single-payer system. But Woolhandler, Kahn, and others who have studied the administrative costs associated with a private, multi-payer health care system continue to urge policy-makers to look at a real-life example of an alternative, right across the border.

In Canada, which has a single-payer system, hospitals receive a lump-sum payment each month from the government, which is negotiated annually based on the amount and cost of the services they provided the previous year. Physicians still have to bill for their services, but they only have to send their bills to one place — the government.

Toronto General Hospital, for example, has a billing department of three. “That’s just for the extra things, like if people want a television in their room,” said Jillian Howard, a spokesperson for Toronto General.

By contrast, the billing department at Massachusetts General Hospital — which is similar to Toronto General in terms of the number of hospital beds, total number of employees, and the kinds of services offered — has a staff of more than 300.

Kahn estimates that, if the United States were to move to a single-payer system along the lines of Canada's, the savings would be over $300 billion a year.

"You'd think peoples' eyes would light up at that," he said, but he has come to believe that many policy makers and advocates are simply willing to accept that those higher costs will be passed along to patients.

"If you're just ideologically committed to a free-market health insurance system," he said, "then the fact that it imposes hundreds of billions of dollars worth of inefficiencies every year doesn't seem to matter very much."

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