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On

Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care

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My name is Noah Benedict. I'm the President and CEO of Rhode Island Primary Care Physicians Corporation (RIPCPC), an Independent Practice Association that represents 168 primary care providers and manages the care of over 200,000 Rhode Islanders.

Alleviating administrative burdens in medicine is of the utmost importance. Administrative burdens have a wide-ranging impact on providers and patient care. If left unaddressed, this issue will continue to challenge our healthcare system, adversely impacting the cost and quality of the care we deliver.

I. Increasing administrative burden in healthcare, much of which is ineffective

Administrative requirements and subsequent costs in healthcare operations are an increasing burden impacting both providers of care and the patients they serve. Despite generations of technical advancements and administrative cost reductions in other industries, administrative productivity in healthcare has stagnated. Administrative costs are defined as the nonclinical costs of running a medical entity or system. They include two primary categories - billing and insurance-related expenses (which include claims management, clinical documentation and coding, and prior authorization) and non-billing and insurance-related expenses (which are general business overhead expenses).[1] Administrative spending is significant and accounts for between 15 and 30 percent of medical spending, although some of these estimates only include the category of billing and insurance-related expenses.[2] These expenses consume critical resources that otherwise could be used on direct patient care. As a comparison, the estimates of U.S. spending on administrative costs annually account for twice the spending on care for cardiovascular disease and three times the spending on cancer care.[3]

The United States (US) healthcare system spends an estimated $2,500 per person per year on excess administrative costs that do not deliver clinical value [4], a staggering amount. Administrative costs are incurred by all parties within the healthcare system such as hospitals, physicians, ancillary providers, and payers. While a portion of administrative spending can be deemed necessary, various studies and research has shown that some administrative spending is ineffective and wasteful, contributing to an excess of healthcare spending in the United States. A review of relevant studies indicates at least half of total administrative spending is likely ineffective and wasteful. (7.5-15% of national health spending or $285–$570 billion in 2019).[5] At RIPCPC, on average, each provider requires .2 FTE support daily to manage prior authorizations. That equates to $12,480 per year per provider and roughly $2.1 million dollars for our 168 primary care providers in straight administrative support.

The practice of medicine has changed. Years ago, medicine was very personalized and relationship-centric. Physician recommendations were sacrosanct. In addition to meeting the care needs of patients, physicians and other healthcare providers now spend a growing amount of time determining what testing, prescription drugs, ancillary providers, and hospitals will be approved based on insurance policy. Healthcare services are often interrupted by bureaucratic payer policies and procedures. For example, payers rely on prior authorizations to address inappropriate prescribing and unnecessary variations in care, commonly for expensive medications and procedures. Prior authorization refers to the process of approving medical services on the basis of clinical or economic criteria.[6] Payers use the prior authorization process to control costs, but prior authorization processes are time-consuming and frequently require lengthy assessments and documentation. In addition, payer application of prior authorizations can be inconsistent from one patient to the next, or from one payer to the next. Physician offices and hospital systems are now hiring staff to solely facilitate the prior authorization process for their patients. Some of these authorizations can only be done by clinical staff members. At RIPCPC, I can

provide an example of how this impacts a valuable patient resource: our pharmacists. On a daily basis, prior authorizations and medication denials distract these critical care team members from titration of medicine responsibilities, providing drug information support for providers, polypharmacy management, and exploring cost-effective therapeutic alternatives. Looking at our expenses, the pharmacy costs associated with managing these administrative burdens are $23,000 per provider per year, and $3,8 million dollars for our 168 primary care providers. This is staggering, especially considering that an investment of that amount in pharmacy would traditionally bring back a 3.5:1 return on investment.

Unfortunately, this pre-approval by insurers often delays or interrupts medical services and decisions, delays which can be associated with poor patient outcomes. While the intent of prior authorization is to reduce the amount of ineffective care provided, they add administrative burden and unreimbursed costs to physician offices and appear to be increasing over time, a troubling trend. Any activities that distract providers from focusing on patient care risk an adverse outcome.

II. Administrative burden impact on physicians and other providers

U.S. physicians devote 13-24 percent of working hours to administrative tasks, as compared to their Canadian counterparts at 8 percent.[7] While Canada mostly has a single-payer system which may explain some of the difference, the U.S. administrative burden continues to grow without producing commensurate value. Doctors often spend as much time documenting patient visits as they do actually caring for patients, spending up to 20 hours a week on administrative paperwork. Primary care physicians reported spending more time on administrative duties compared with other physicians, negatively affecting their ability to deliver high-quality care. Physicians burdened with a higher percentage of time spent on administrative duties had lower levels of career satisfaction and higher levels of burnout.[8] Prior authorizations, clinical documentation, and medication reconciliation were rated the most burdensome tasks.

The 2022 AMA prior authorization physician survey reported some concerning results.[8]

- 94% reported care delays associated with prior authorizations.
- 80% report that prior authorizations can at least sometimes lead to treatment abandonment.
- 31% report that payer prior authorization criteria are rarely or never evidence-based.
- 33% report that a prior authorization has led to a serious adverse event for a patient in their care.
- 89% report a perception of a somewhat or significant negative impact prior authorization has on patient clinical outcomes.
- 35% report they have staff that work exclusively on prior authorization.
- 88% report the burden associated with prior authorizations as high or extremely high.
- 62% report that prior authorization has led to additional office visits.

Akin to the AMA results, a RIPCPC provider survey underscores the extent of the issue:

- 73% of providers reported an average wait time for a prior authorization to be at least 2 days.
    - Of the 73%, 38% of providers reported an average wait time for a prior authorization to be at least 3 - 5 days.
- 31% of providers report that for patients whose treatment requires prior authorization, the process OFTEN leads to patients abandoning their recommended course of treatment.
- 51% of providers report prior authorizations OFTEN delay access to necessary care.
    - Of the 51%, 27% of providers report prior authorizations ALWAYS delay access to necessary care.
- 62% of providers report that prior authorizations have a SIGNIFICANT NEGATIVE impact on those patients whose treatment requires prior authorization, potentially leading to compromised health outcomes.
- 97% of our providers describe the burden associated with prior authorizations as high or extremely high, indicating that this is a pressing issue that requires attention.
- 91% of providers report that in the past five years, prior authorizations have increased significantly.

III. Administrative burden also harms patients

Prior authorization processes exist for many different conditions and diagnoses. Research has indicated that this process within cancer care can have negative associations with patient outcomes. In 2022, a cross-sectional, anonymous patient experience survey was conducted regarding cancer-related services. 22% of patients did not receive recommended treatment because of prior authorization, with most respondents experiencing a delay in recommended oncology care.[10] Delays were also associated with increased patient anxiety and patient administrative burden.[11]

Similarly, a Kaiser Family Foundation survey reported some alarming results on consumer problems with prior authorization.[12]

- 16% of all insured adults in the past year experienced prior authorization problems.
- 22% of adults insured under Medicaid experienced prior authorization problems in the past year, compared to 11% with Medicare, and 15% with employer-sponsored coverage.
- Among adults who had more than 10 physician visits in the past year, 31% experienced prior authorization problems.
- 26% of people who sought treatment for or took prescription medication for a mental health condition in the past year (e.g., depression, anxiety) experienced prior authorization problems in the past year, compared to 13% of insured adults who did not seek mental health treatment.
- 23% of insured adults who sought treatment or took prescription medication for diabetes experienced prior authorization problems in the past year, compared to 14% of other insured adults.

- 19% of adults who currently take at least one prescription medication experienced prior authorization problems, compared to 8% of those who do not take prescription medication.
- Insured adults who received health care in an emergency room in the past year were about twice as likely to have experienced prior authorization problems, compared to those who did not use the ER (25% vs. 13%).

Furthermore, a 2023 study in JAMA Network Open found that 73% of cancer patients who faced prior authorization experienced a delay in care of two weeks or more. Most patients (67%) had to become personally involved and 20% spent 11 or more hours on the process to get the care they needed. The experience was rated as bad by 40% and as horrible by 32% of patients, significantly increasing anxiety and delaying needed care where timeliness especially matters.[13]

Specific to RIPCPC, there are many examples of prior authorizations leading to adverse outcomes. One of the chronic conditions often impacted is asthma. Inhaled corticosteroids, known as ICS treatment for asthma, are critical to the management of this chronic condition. When prior authorization is mandated for this medication, delays ensue, asthma exacerbations occur, and patients end up in the hospital. Our providers estimate that 2 to 3 of the exacerbations per month are a result of a lapse in ICS use, primarily due to formulary changes or prior authorization requirements. When patients are off the medication for a week due to a delay in the prior authorization process, they initially feel fine and then falsely believe they now don't need the medication. This is not the case, and shortly after the medication has fully left their system, an exacerbation occurs, and they end up in the hospital. This is one example of many that occur on a regular basis, this is truly a patient safety issue.

Additionally, a 2022 report by the Office of the Inspector General shockingly found that 13% of prior authorization denials by Medicare Advantage plans were for "services that our physician reviewers determined were medically necessary" and "likely would have been approved for these beneficiaries under original Medicare rules.[14] This is simply unacceptable and must be remedied.

IV. Value-Based Care Leads to Administrative Simplification

The administrative complexity of health care is profound.[15] Opportunities exist for policymakers and payers to introduce new provider payment models to facilitate administrative simplification. Value-based care correlates the amount health care providers earn for their services to the outcomes they deliver for their patients, as compared to fee-for-service which rewards the volume of services provided. Value-based care principles encourage the adoption of globally capitated payment models. According to McKinsey & Company, a savings opportunity of $1.05 B annually could be realized with a centralized claims clearinghouse, standardized medical policies, and adopting globally capitated payment models for segments of the care delivery system.[16]

In a globally capitated model, capitation payment for services delivered by different providers or at different levels of care is combined into a single prospective payment to an integrated care organization or a large physician group. The provider is then responsible for delivering all needed care for a defined population and distributing payments to its constituent providers from the capitation pool. The core concept is that total payment does not vary based on the actual services provided to individuals in the population served.[16] A global capitation payment is a relatively simpler transaction, involving less administrative burden for both payers and providers as compared to fee-for-service payment. With the

appropriate quality and compliance guardrails in place, payers can simplify the transactional costs that accompany the care provided by their medical providers. More than 9 in 10 primary care physicians felt they spent too much time on administrative work.[17] With the introduction of new payment models, over time payers can reward high-quality, cost-efficient providers with a streamlined, less costly administrative burden. Furthermore, providers in Accountable Care Organizations (ACOs) that assume global risk or total cost of care contracts, are capable of identifying the best and most efficient treatment path for patients without the added administrative layer of prior authorizations.

V. Recommendations

The administrative burden imposed by payers has become a challenge for healthcare providers and their patients. Studies have shown that much of this burden is ineffective and, in some cases, causing harm. Patient safety and quality of life concerns must be a critical area of review within existing administrative policies. A new framework for administrative policies and procedures should be pursued considering the following recommendations:

- Mandating an industry-wide effort to reduce the volume of administrative tasks borne by healthcare providers and return to a basic set of administrative functions.
- Pursuing alternative payment models for providers to reduce administrative burden.
- Reducing the complexity and time to respond to prior authorization requests and requiring payers to adopt an expedited appeal process.
- Requiring only qualified physicians can make adverse determinations.
- Requiring payers to publicly report their prior authorization statistics.
- Requiring prior authorization to be valid for the length of treatment for those with chronic conditions.
- Should a patient change insurance companies, requiring payers to honor a patient's prior authorization for a minimum of 90 days.
- Requiring payers within the same marketplace to adopt a universal prior authorization program.
- Require payers to waive prior authorizations on prescription drugs and services ordered by providers with a proven track record of prior authorization approvals and physician organizations and systems of care in full-risk contract arrangements.
- Implement a 'Gold Carding' program for:
    - Provider groups that are in value-based care and risk contractual arrangements.
    - Providers who have a 90% prior authorization approval rate over a six-month period for particular medical services.

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