HEALTHCARE ADMINISTRATIVE COSTS AND COMPETITION POLICY

BY BARAK D. RICHMAN & DR. KEVIN A. SCHULMAN[1]

1 Respectively, Katharine T. Bartlett Professor of Law, Duke University School of Law, Clinical Excellence Research Center, School of Medicine, Stanford University; and Professor of Medicine, Clinical Excellence Research Center, School of Medicine, Graduate School of Business, Stanford University.

CPI ANTITRUST CHRONICLE MAY 2023

Visit www.competitionpolicyinternational.com for access to these articles and more!

HEALTHCARE ADMINISTRATIVE COSTS AND COMPETITION POLICY

By Barak D. Richman & Dr. Kevin A. Schulman

Even though the U.S. healthcare system exhibits higher administrative costs than any other OECD nation, they have not received substantial attention from policymakers despite their enormous cost and impact on the market. We argue that competition policy could meaningfully reduce these administrative costs. We first describe how efforts to deploy electronic health records departed from pro-competition principles by failing to understand how healthcare firms would direct business processes exploit their incumbent positions in the market. We then argue that there is an urgent need to reduce costs and increase competition by standardizing and digitizing business processes across the health sector. High administrative costs in the health sector is not an inevitable consequence of a private payer system. To the contrary, it is a product of poorly conceived policies and a lack of competition and innovation.

Administrative costs in the U.S. healthcare sector represent between 25 percent to 31 percent of total expenditures,[2] a proportion twice that in Canada and significantly greater than in all other Organization for Economic Cooperation and Development member nations.[3] Moreover, the rate of growth in administrative costs in the United States has outpaced that of overall health care expenditures and is projected to continue to increase without reforms to reduce administrative complexity.[4]

The primary culprit of these wasteful administrative are costs are often attributed to billing and insurance-related ("BIR") activities.[5] BIR costs are now garnering greater attention for at least two reasons. One is the recent emergence of empirical evidence that quantifies the magnitude of BIR costs, including the particularly embarrassing feature that BIR costs in other nations are far lower.[6] A recent study estimates the amount of money lost to high transactions costs in the U.S. is at least $250 billion annually.[7] These are just the static costs lost during the transaction process and do not include the opportunity costs from ancillary innovation that would emerge from BIR solutions.

The second reason is that other industries have managed to execute financial transactions at far lower costs. For example, paying for services with a commercial credit card requires only 2-3 percent of the cost of the transaction.[8] Since transaction costs add no value to health-care delivery, they represent prime targets for reducing wasteful health care spending.

If high costs are invitations to entry, we believe the persistence of high costs – especially when other markets prove that lower costs are technologically possible – is an indication of entry barriers in this market. Unfortunately, until recently, the nation's high administrative costs in healthcare have not been deemed to be a problem that should be addressed through competition policy. We will argue that this is a mistake. Not only do we know that efforts to reduce administrative costs would be accelerated in the face of greater competition, but we also know, as we discuss below, that competition policy levers can meaningfully help achieve this result. In fact, addressing the enormous growth of administrative costs is one of the most attractive areas for innovation across the health sector.

I. BILLING COSTS IN HEALTHCARE

Transactions in healthcare are complex. Most services are paid for through public or private health insurance, so-called third-party billing, which means patient-consumers do not directly negotiate with providers for the cost of services. Although there are good reasons why most healthcare is purchased through intermediary payers (e.g. the provision of financial security, the inability of most consumers to identify necessary and valuable healthcare services), it means that financing healthcare must endure a complicated transaction sequence.

The typical healthcare payment goes through the following steps. First, a provider must establish that a patient is an eligible member of a health insurance plan — and thus a path to payment is secured — before the service is provided. Next, after delivering the healthcare service, the provider must then determine how to submit a bill to the patient's payer in accordance with the complex contract provisions that detail the unique payment process for that plan (each private health plan negotiates a contract with each healthcare provider in their network; the public plans can have national payment models administered through private health plans, or they can delegate plan administration to private health plans through Medicare Advantage or Medicaid Managed Care programs). After bill submission, the health plan then reviews the bill to make sure that they are financially responsible under the plan contract and for the amount billed, and it then pays the provider or denies payment based on its reading of the plan terms. Frequently, a cycle of rebilling and adjustments ensue.

---

2 DU Himmelstein, M Jun, R Busse, et al. *A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others By Far*. 33 Health Aff. 1586-1594 (2014).

3 *Id.*; A Jiwani, D Himmelstein, S Woolhandler & JG Kahn. *Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence.* 14 BMC Health Serv Res. 556 (2014).

4 DM Berwick, AD Hackbarth. *Eliminating waste in US health care*. 307 JAMA. 1513-1516 (2012).

5 P Tseng, RS Kaplan, BD Richman, MA Shah & KA Schulman, *Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System*, 319 JAMA 691-697 (2018); JG Kahn, R Kronick, M Kreger, DN Gans. *The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals*. 24 Health Aff 1629-1639 (2005).

6 Barak D. Richman, Robert S. Kaplan, Japees Kohli, Dennis Purcell, Mahek Shah, Igna Bonfrer, Brian Golden, Rosemary Hannam, Will Mitchell, Daniel Cehic, Garry Crispin & Kevin A. Schulman, *Billing And Insurance–Related Administrative Costs: A Cross-National Analysis*, 41 Health Affairs 8, 1098-1106 (2022).

7 McKinsey & Company. *Administrative Simplification: How to Save A Quarter-Trillion Dollars in US Healthcare*. (Oct. 2021); Sahni NR, Carrus B & Cutler DM. Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care. *JAMA*. 2021;326(17):1677–1678. doi:10.1001/jama.2021.17315

8 Daly L. Average credit card processing fees and costs in 2021. The Ascent, https://www.fool.com/the-ascent/research/average-credit-card-processing-fees-costs-america/ (Apr 13, 2021)

It is striking to contrast this transaction sequence with the typical credit card purchase. Credit cards also involve financial intermediaries, but any credit card user can readily and intuitively understand why the credit card intermediaries involve much lower transaction costs. At the point of sale, both the buyer and the seller in a credit card transaction are automatically verified, and the payment is instantly engineered. There is no technological barrier that prevents healthcare transactions from being similarly automated, but legacy decisions around the business processes of billing have prevented and still impede the implementation of common-sense digital strategies. In turn, these payer business decisions have prevented meaningful competition from improving our inefficient and expansive system for financing healthcare.

First, the U.S. healthcare sector lacks a digital infrastructure to manage healthcare transactions. Consider the obvious lack of digital tools imprinted on health insurance cards: they have no bar codes, no magnetic strips, and no EMV security chips. Nothing in these cards can do what credit cards do (critically, other nations do have health insurance cards with these capabilities[9]). Instead, the card is completely analog, and healthcare providers must manually enter the card's information onto their own electronic system. Although many of the billing processes have become digitized over the last decade – after all, healthcare providers enter insurance information into a computer, rather than into paper files – this digitized part of the billing process is built atop analog business processes that preceded the large-scale implementation of electronic health records ("EHRs").

Second, the U.S. healthcare sector lacks business models that can utilize new billing technologies. Policy and industry leaders have exhibited little understanding of how innovation can (and how it cannot) generate new payment processes that generate efficiencies. The presumption was that "paper kills" and that converting paper records to electronic records would automatically make transactions less costly and cumbersome.[10] There was little recognition that innovative business processes needed to emerge in order to achieve efficiencies and even less recognition of what is needed to foster those business process improvements.

Many of these errors can be placed at the feet of the Health Information Technology for Economic and Clinical Health ("HiTECH") Act, enacted as part of the American Recovery and Reinvestment Act of 2009. HiTECH invested $38 billion of government funds to make EHRs widespread, but it did nothing to replace the analog foundation of medical financing. Thus, despite promising to revolutionize medical billing,[11] HiTECH only transformed how many organizations stored their internal records while leaving the underlying analog transaction architecture unchanged. Consequently, the rise of electronic health records failed to reduce administrative costs for providers,[12] and it instead fostered the rise of legacy firms who quickly gained market share in the lucrative EHR industry without making transaction markets more efficient or open.[13]

II. COMPETITION POLICY TO REDUCE ADMINISTRATIVE COSTS IN HEALTHCARE

Policymakers can reverse the failures of the past. However, tackling the challenge of high transaction costs in healthcare requires an explicit recognition of the underlying market-wide problems and a cohesive strategy that addressees them.

Perhaps the real shortcoming in the HiTECH Act was its failure to identify the problem that needed to be solved. Many early analyses of electronic health records focused on their impact on medical record rooms and charge capture for providers, not changes in billing processes. Even a comprehensive analysis by the National Academy of Medicine after HiTECH implementation focused on the firm-level benefits, not market level benefits, of digital technology.[14] Policymakers failed to recognize that high administrative and billing costs are products of a market failure, one that requires a policy intervention.

9 https://en.wikipedia.org/wiki/Carte_Vitale.

10 David Merritt, ed., Paper Kills 2.0: How Health IT Can Save Your Life and Your Money (Forward by Newt Gingrich & Tom Daschle, 2010). (Center for Health Transformation, 2010).

11 https://www.whitehouse.gov/the-press-office/2011/09/12/presidential-proclamation-national-health-information-technology-week ("Health informatioin technology connects doctors and patients to more complete and accurate health records. Tools like electronic health records and elecrtreonic prescriptions help patients and provides make safer, smarter decisions about health care. This technology is critical to improving patient care, enabling coordination between provides and patients, reducing the risk of dangerous drug interactions, and helping patients access prevention and disease management services. … Better technology can also cut costs for providers by reducing paperwork and duplicative tests.").

12 Tseng (2018).

13 https://www.definitivehc.com/blog/most-common-inpatient-ehr-systems.

14 https://nam.edu/perspectives-2014-return-on-information-a-standard-model-for-assessing-institutional-return-on-electronic-health-records/.

The market failures that generate high billing costs stem from the organization of healthcare billing. Prior work has identified three factors that cause these market failures: architectural complexity, contractual complexity, and compliance costs.[15] Architectural complexity arises when each plan and each provider negotiate for a unique contract for health care services. The resulting massive redundancy — a form of prisoners' dilemma — is staggering. For example, United Healthcare alone loaded over 40,000 different health plans into their price transparency platform.[16] Contractual complexity is the detailed requirements outlined in each contract, and in their on-line coverage manuals and tools. For example, Blue Shield of California has a 450-page HMO/Medical Group Procedures manual for 2023, which was amended twice in the month it was published.[17]

Each payer similarly imposes its own set of contracts, payment mechanics, and financing infrastructure onto each provider with which it contracts. These are all separate, analog systems that individually are cumbersome to manage, and together multiply the collective administrative burden for providers who must navigate this complexity across the many different payers in a market. Finally, compliance costs are the costs of ensuring that the billing policies follow the rules for public and private health plans (non-compliance with rules for billing private health plans can trigger civil liability, but non-compliance in billing public health plans can bring more severe criminal penalties). Since 2010, providers who participate in the Medicare and Medicaid programs are required to establish billing compliance programs by statute.[18]

While it is easy to envision the factors driving up costs in this market model, few have understood the totality of these forces, and fewer still have developed strategies to bring these costs down. The source of costs is clearly not a firm level challenge but a market level challenge. The banking sector encountered similar market-wide inefficiencies until a regulator intervened. Local banks benefited from proprietary transaction models (you originally had to visit your bank branch to use your ATM card), but the development of a large-scale digital platform for efficient transactions has been a long-time goal of federal policy makers. When regulators established the protocols for a common payment system, industry was compelled to develop new business models in response. The efficiencies achieved in credit card transactions in the retail sector are due to collaborations and standard settings across banks, retailers, and other intermediaries. Moreover, the common standards invite other entities to provide innovations to supplant the technology of incumbents. In fact, this market is not static, with FinTech and digital payment models continuing to drive down costs and increase access to financial services for consumers.

The solution is coordination: establishing a common digital infrastructure, payment model, and technological standards for all payers and providers. But coordination will be hard to achieve because, like the health sector itself, healthcare policy is fragmented. No single organization in government owns or has oversight of the transaction platform in healthcare. While public and private insurance organizations largely use the same platform for payment, neither has oversight over the market.

For example, the Centers for Medicare and Medicaid services, provides insurance coverage to almost 150 million Americans. They have a statutory authority to address administrative simplification under the 1996 Health Insurance Portability and Accountability Act, but enforcement falls to the National Standards Group at the Center for Medicare and Medicaid Services ("CMS"). This office, policing transactions for a $4.7 Trillion market, monitors compliance with the Transactions and Code Sets ("TCS"); the National Employer Identifier Number ("EIN"); the National Provider Identifier ("NPI"); and the Operating Rules ("OPR").[19] Yet the only enforcement actions undertaken by this group are investigations of complaints and random compliance reviews. For the first quarter of 2023, the agency reported 17 valid complaints under its operating authority.[20] This is a sharp contrast to the world of banking, where the Federal Reserve has driven a seemingly relentless focus on transforming the transaction process.

Meanwhile, billing procedures in the insurance community are well established, and each health insurer touts its costly transaction model as a core feature of its business. Even new entrants into the market, such as highly touted Oscar, focused on a digital presence for patients but the same back-end administrative processes for providers.[21] Accordingly, no individual insurer can offer a digital model that can transform

15 Scheinker D, Richman BD, Milstein A & Schulman KA. Reducing administrative costs in US health care: Assessing single payer and its alternatives. Health Serv Res. 2021 Aug;56(4):615-625.

16 https://transparency-in-coverage.uhc.com/.

17 https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/Provider_Content_EN/Guidelines_ resources/manuals.

18 https://oig.hhs.gov/compliance/physician-education/compliance-programs-for-physicians/.

19 https://www.cms.gov/files/document/administrative-simplification-enforcement-slides-2021.pdf; https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/HIPAAEnforcementStatistics.

20 https://www.cms.gov/files/document/enforcement-data-first-quarter-2023.pdf.

21 https://www.hioscar.com/blog/our-post-election-thoughts-on-healthcare.

the sector. Until the entire sector – or our political leaders – identify transaction costs as a market-wide distortion, technology adoption will proceed with little or no productivity gains.[22]

These experiences suggest that a true common transaction platform, one with public protocols and allows entry from entrants, is an essential foundation for an efficient healthcare market. Such a platform would enable a transition from analog billing processes to a pure digital transaction payment model in healthcare, and enormous benefits would result. It would usher in new tools that can directly address the $250 billion in annual spending considered "waste" by researchers.[23] It would also lead to downstream savings through electronic methods of fraud detection (credit card fraud is detected by algorithms culling through transactions in real time; health care fraud is currently detected through manual review of paper charts). Finally, such a platform would drive competition in the market, reducing barriers to entry for firms by offering new service models for patients. The quality of services would also improve because it'd be easier for firms to develop novel technologies and services to access the payment system.

The banking sector has had the Federal Reserve as a quarterback for digital transformation, but healthcare lacks an obvious federal analog. While CMS has some statutory authority to address administrative simplification, it has never been an agency tasked with overseeing the entire health care market. In fact, CMS acts at times in ways that hurt value in the private health care market.[24] It is possible that CMS, together with the Office of the Assistant Secretary for Planning and Evaluation ("ASPE") could collaborate on novel governance efforts. More likely, Congress would need to delegate new authorities to HHS to accomplish this effort. Given likely resistance by incumbents in the market, there would need to be a strong push by employers and patient advocates to bring this concept forward. Scholarship from the newly awakened competition policy community could be critical to the success of such efforts.

III. CONCLUSION

Electronic health records were envisioned as a technological revolution, and the HiTECH Act was described as a transformative investment that would move us from hand-written notes to a digital process, thus accurately documenting patient encounters while reducing the administrative burden for providers. Yet, despite this massive public investment, the economic benefits envisioned were not achieved. This failure was not a failure of technology but a failure to understand the underlying factors driving up administrative costs in the U.S. healthcare market.

We are at an interesting juncture in healthcare policy. Digitization has spawned new waves of intermediaries that optimize pieces in an overwhelmingly complex process, but optimizing inefficient processes simply escalates costs and creates ever larger barriers to entry. It is time for those involved in competition policy to address the specific failings in the billing market, develop structures that force a new level of standardization, and foster an architecture that invites entry and competition. There are few opportunities in healthcare as important and as overlooked as the transaction platform underlying healthcare financing, and few areas where thoughtful competition policy could be so beneficial.

22 https://hbr.org/2017/11/the-it-transformation-health-care-needs.

23 Sahni. 2021.

24 Richman BD & Schulman KA. A cautious path forward on accountable care organizations. JAMA. 2011 Feb 9;305(6):602-3.

CPI COMPETITION POLICY® INTERNATIONAL

CPI Subscriptions

CPI reaches more than 35,000 readers in over 150 countries every day. Our online library houses over 23,000 papers, articles and interviews.

Visit competitionpolicyinternational.com today to see our available plans and join CPI's global community of antitrust experts.