The High Cost of Waste in Healthcare

It's time to eliminate prior authorizations.

BY JON A. HULTMAN, DPM, MBA

Waste in healthcare can be defined as any rule, regulation, or task that adds a cost to the system without adding value. In most cases, waste actually lowers value. We see the impact of waste on hospitals, physician practices, and third-party payers in the form of bloated bureaucracies, less time for patient care, and delays in patients receiving third-party approval for necessary care or prescriptions needed for on-going care. The biggest problem with every new idea that has been implemented by third-party payers in hopes of reducing reimbursement costs is that whenever something new is added, nothing old is removed. This creates incredibly complex processes composed of numerous rules and tasks that may actually cancel each other out. All of this serves to drive up costs for both payers and practitioners and creates aggravation, inferior care, and unnecessary delays for patients.

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Quality Control

To better understand this problem and find potential solutions, we can go back to the 1950s and study manufacturing. This can give us insight into the source of much of the high cost and low quality in healthcare. Maintaining "quality control" was traditionally one of the most expensive components of U.S. manufacturing. Conventional wisdom held that the highest level of quality could be achieved only if every item produced were carefully inspected. Items identified as "defective" would then be repaired before reaching the consumer. Companies utilizing this method of quality control determined that it resulted in high costs because it required so much time and so many inspectors. The method was also determined to be ineffectual because it did nothing to identify or prevent the actual causes of poor quality.

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Statistical Process Control

While the U.S. was using an "inspect every item" method of quality control, its foreign competitors had developed a lower cost method known as Statistical Process Control (SPC). Rather than inspecting every item, a small quantity of product was randomly sampled. When they found a defect that lay outside the limits of statistical tolerance, the entire process was halted (and not restarted) until the cause of that defect was found and fixed. This method not only resulted in lowering total costs but also continuously improved quality.

The primary difference between these two described methods of quality control is that SPC is preventative whereas "inspect every item" is reactive. One common maxim quoted by engineers describing past U.S. manufacturing processes is, "There was never time to do it right, but there was always time to do it over." Finding a way to do things "right" the first time not only saves money, it also produces a consistently higher quality product for the customer and produces it faster. "Focusing on the customer" and "doing things faster" go hand in hand, and in a highly competitive environment, provide significant competitive advantage.

Those engaged in the business side of medicine still use the "inspect every item" method of quality control. Consider the insurance forms necessary for reimbursement. Each one is first inspected by a member of the practice's staff and then, again, by the third-party payer's staff. Each item on every form is inspected, and often, the cost of inspection is equal to the amount of the payment—especially when the fee is of a lower dollar amount or when an inspection either results in denials or generates requests for additional information which, in turn, lead to even more "inspection" delays and letters by both the doctor and the third-party payer. When costs are fully quantified in terms of patient, physician, and third-party payers' time and out-of-pocket costs, it can be seen that the full impact of this "inspection process" can be far greater in terms of cost and quality than any money it was designed to save. The theory that such a process might somehow improve quality or save money is flawed.

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The irony is that while statistically proven methods are not being used in the "business of medicine," they are routinely used by doctors for the clinical practice of medicine. For example, consider the routine process for determining a patient's white blood cell count. This test employs the sampling method used in SPC. Blood is drawn, and from the sample, the number of white blood cells is extrapolated to calculate the number of white blood cells/cc throughout the entire body. Assume that the lab value for a patient's white count is 5,600. This count is an estimate, has a variance, and could be re-stated as 5,600 ± 300. There is a 99 percent probability that the "real" white count is somewhere within this range of 5,300 and 5,900.

Such statistical sampling is used regularly in the practice of medicine and the results are trusted even in life and death situations. An alternative to this sampling technique would be to withdraw all of a patient's blood and count every cell. This is equivalent to the "inspect every item" process once widely used in manufacturing and, unfortunately, still broadly used in healthcare today. This would be the most "accurate" method but comes at an extremely high cost—without adding any real value.

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If a process resulting in more accurate measurement, say 5,600 ± 200, were to become available at a lower cost, that process should replace the current one because it has less variation (i.e. by definition, is a higher quality method). If the test were to cost more, it would not be worth adopting because neither the diagnosis nor the treatment would be altered by this insignificant change.

On the other extreme, if a new, *cheaper* test gave a range of 5,600 ± 4,000, the estimate would be worthless for clinical purposes because the variance would be too extreme. The bottom line: quality improvement can be monitored statistically by measuring the size of variance and focusing on ideas for reducing that variance to an economic minimum—the optimum point in clinical care at which the cost of any additional reduction in variance becomes greater than the benefit that will be achieved from it. It is at this point that the reduction will not change the treatment recommended or the outcome of that care. Physicians need to understand this concept of statistical variance in order to effectively challenge third-party payers who decide not to cover a "higher quality" test or service.

One would have to wonder how long third-party payers are willing to

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continue with the growing complexities, high costs, and declining quality associated with an "inspect every item" reimbursement process, especially in this computer age when processes could be greatly simplified and improved to a point where the administrative costs borne by hospitals, third-party payers, and physician practices could be dramatically lowered. Improved processes would also increase the quality of care because they would provide physicians and their staffs with more time to treat patients.

Just how extreme have reimbursement processes and their administration become? From 1970 to 2009, the number of physicians increased 150%, healthcare spending/capita increased 2,300%, and the number of hospital administrators increased 3,200% (Table 1)! The 150% growth in the number of physicians would be expected because this number is roughly in keeping with the population growth during this same time period; however, how does one explain the 3,200% increase in the number of hospital administrators during this time period—especially because at this time, there was a major focus on keeping patients out of hospitals and *reducing* the length of their stays when hospitalization was unavoidable?

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If the slope of the line shown in Table 1 (the portion of the line which depicts the growth of administrators between 1970 and 1985) were to have continued at that slower growth rate, by 2009 it would have intersected the Y-axis around 750% growth—substantially lower than the actual 3,200% reached at that point in time.

Key Benchmarks

Key benchmarks that may explain some of this rapid growth would include the 1982 implementation of Prospective Payment System (DRGS), the 1996 Health Insurance Portability & Accountability Act, and the 2009 Health Information Technology for Economic and Clinical Act (HITECH Act 2009). Add to these the host of reimbursement "hurdles" introduced by third-party payers over those years—with prior authorizations heading the list. None of these hurdles or complexities appear to have reduced the cost or increased the effectiveness of healthcare, and in fact, they may have actually contributed to the rising costs—especially for hospitals and physician practices. What is clear is that these barriers have hurt quality by shifting more medical support staff from treating patients to "treating paper" and by taking physicians away from pa-

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tients for a significant amount of time to perform tasks that add no benefit to patient care or the healthcare system.

To better understand how the inspection method of reimbursement increases costs and decreases quality, let us take a closer look at one specific requirement—the one for prior authorization. This is just one of the many ineffective, costly, and time-consuming tasks that have been added to the reimbursement process. It was stated in *Medical Economics,* July 8, 2014 that: "Prior authorizations are not just a frustrating impediment to providing patients with quality care. To physicians, they represent hundreds of millions of hours of lost productivity and billions of dollars in revenues with little benefit to patients. Doctors face numerous frustrations in caring for patients, but few are as infuriating—or expensive—as prior authorizations."

Over the years, many have opined that prior authorizations cost payers more money than they save. As for the dollar cost, according to a 2011 study published in *Health Affairs,* a physician spends an annual average of nearly $83,000 interacting with insurance plans, and much of this interaction involves issues related to prior authorization. The healthcare system ultimately ends up spending more on this process than it saves. Unfortunately, the cost for doctors and patients is not considered by payers when calculating the total cost of these authorizations. Even though prior authorizations have existed for many years, most of what is known about the cost to practices or the healthcare system as a whole is anecdotal. Some experts surmise that in-depth studies have not been conducted by payers because enactment of randomized, controlled trials might be considered an admission of uncertainty by payers; plus, those involved with such studies may have a vested interest in the success of their prior authorization programs and, thus, be biased.

According to the 2018 *Medical Economics* "Payer Scorecard" survey, 78% of physicians said that the requirement for prior authorizations was the most challenging issue they experienced in dealing with payers. One survey specifically targeting the "prior authorization issue" was conducted by the American Medical Association in 2010. This survey revealed that physicians were spending an average of 20 hours a week (a number that some doctors say is too low) on prior authorization activities. With approximately 835,000 practicing physicians in the nation, this represents 868.4 million hours devoted, annually, to this one administrative task.

Significantly, this number does not count any time spent by other staff members on this same task. According to the AMA survey, approximately 64% of physicians waited at least one business day for a decision to be made regarding a prior authorization, and 30% said they waited three or more days. More significantly, while awaiting these authorizations, patients are unable to undergo treatment. These delays have a negative impact on both the patients' experience and on their care. For many practices, the burden of the prior authorization process sometimes even causes preferred therapy to be abandoned—a consequence even worse for the patient than the waste of time and money resulting from this requirement.

Prior authorization is also now required for more drugs than ever before, and each health plan has its own policies and forms—making it difficult for providers to keep up. This is compounded by the fact that prior authorization rules and requirements for each plan are also changed with regularity. No authorization means no payment; insurers will not pay either for drugs or procedures if the correct prior authorizations are not received. In addition, most contracts restrict a doctor from billing the patient. The end result is that prior authorization denials result in declines in provider and patient satisfaction as well as delays in patient care and lost revenue. Despite the insurer's effort to save on cost—without even considering

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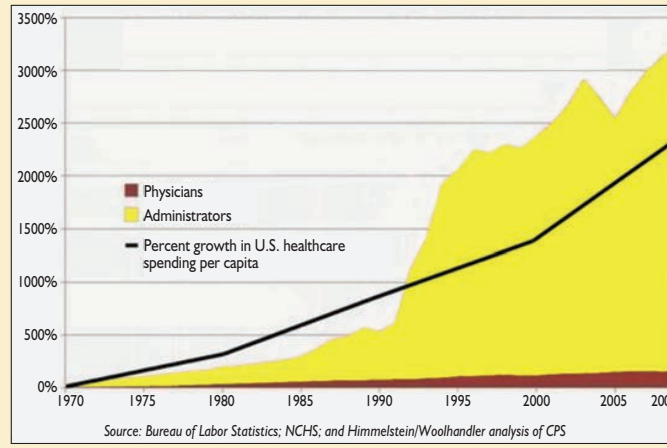
TABLE 1:

Growth of Physicians and Administrators 1970–2009*



Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS

*2300% increase in U.S. healthcare spending per capita between 1970-2009 *(Source: Health Care Costs: A Primer, The Henry J. Kaiser Family Foundation)*

"It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication, somehow think that we can afford to pay for doctors, hospitals, medication, and a government bureaucracy to administer it." —Thomas Sowell

*Using data from the Bureau of Labor Statistics, the National Center for Health Statistics, and the United States Census Bureau's Current Population Survey

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the cost to patients or physician practices—it is not clear whether insurance companies themselves are even saving money with this requirement in the long run.

The most dire impact of prior authorizations is felt by the patients themselves who are delayed in getting their medications or treatments. For them, prior authorization delays can create major interruptions in necessary and effective care. When treatment is delayed, patients must determine whether the process is stalled at the doctor's office, the insurance company, or the pharmacy. In AMA's 2010 survey, nearly all physicians noted that wait times for prior authorizations corresponded with delays in necessary care—adding to the risk of adverse events. Significantly, 78% of physician respondents to the survey said that required prior authorizations could even result in patients forgoing necessary treatments. Also, 92% of the doctors responded that prior authorization harms the quality of clinical outcomes and that the handling of each one generally leads to several hours of lost productivity. All of this negatively impacts the patient's treatment and end results.

Gayathri Raju, DO, summed up many physician frustrations with prior authorizations in the December 10, 2018, issue of *Medical Economics* under the heading of, "Physicians, not payers, should control prior authorizations." In this short article, he stated, "Since when did physicians allow insurance companies to decide what medicines a patient can have? The idea of a 'prior authorization' is demeaning, and intensely frustrating. This is why doctors are burned out. We want our medical associations to reverse this so that an insurance company needs my prior authorization to change any medicine that I prescribed." Dr. Raju may have a point about medical associations needing to address this problem. Short of refusing to accept any form of insurance, health policy experts agree that there seems to be little that an individual physician—or even a large medical group—can do at this point to address the negatives associated with prior authorizations.

John F. Hoadley, PhD, research professor at Georgetown University's McCourt School of Public Policy in Washington, D.C., stated, "The solutions are probably at a higher level than any individual doctor, or for that matter, any individual health plan." Because of this, it makes sense that what will most likely be required is a broad coalition of all healthcare associations. They will need to team up and approach third-party payers to address this problem and develop processes similar to those that manufacturing has embraced—ones that rely on statistical sampling rather than "inspecting every item." This new approach to quality control will actually increase quality, lower costs, and improve patient care. **PM**

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