

SICK OF IT:

As nonmedical staffers grow in number // and insurance bureaucracy sprawls // is the business of getting better // getting caught up in the overhead?

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Trouble in Triplicate

■ BY LINDA KESLAR // PHOTOGRAPHS BY DWIGHT ESCHLIMAN

Since his wife's stroke nearly five years ago, Doug Garr has spent countless hours on the phone in a seemingly endless back-and-forth with physicians' offices, hospitals and insurance companies. Often, he's pointing out mistakes that inflate his wife's already astronomical account balances. "We've received bills from doctors we've never heard of, for procedures that never took place," says Garr, a writer in Manhattan. "Billing administrators seem unconcerned when I tell them I've been left on hold forever. Invoices are so dense with codes and abbreviations, it's a wonder anyone can decipher them."

What Garr and his wife, Meg Perlman, have encountered is familiar to anyone who has had to deal with serious illness. Aside from worries about treatment and recovery, there's the crucial question of who will pay for care: Sorting out the typically messy details is largely left to harried medical consumers and claims administrators. But the way all this works is at least as frustrating to those sending out patient bills and trying to get insurance companies and HMOs to pay their share. A typical hospital or physician group contracts with dozens of health plans, each of which has its own forms for documenting the details of diagnosis and treatment, and the complexity of interactions with payers seems to grow exponentially.

At the Massachusetts General Physicians Organization in Boston, for example, the administrative staff has had to expand by a third in just six years, according to James Heffernan, the MGPO's chief financial officer. Heffernan now



PATIENT AND INSURER INFORMATION

1. NAME OF REFERRING PHYSICIAN
 2. CLINICAL CATEGORY
 3. RESERVED FC
 4. NAME OF REFERRING PHYSICIAN
 5. RESERVED FC
 6. DATE OF REFERRAL
 7. NAME OF REFERRING PHYSICIAN
 8. RESERVED FC
 9. NAME OF REFERRING PHYSICIAN
 10. RESERVED FC

AIM FORM
 APPROVED BY NAT UNIFORM CLAIM COMMITTEE
 1. MEDICARE (Medicare #)
 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S ADDRESS (No. Street)
 4. CITY
 5. PATIENT'S ADDRESS (No. Street)
 6. CITY
 7. ZIP CODE
 8. OTHER INSURER'S POLICY OR GROUP NUMBER
 9. OTHER INSURER'S DATE OF BIRTH
 10. OTHER INSURER'S STATE OF RESIDENCE
 11. OTHER INSURER'S EMPLOYER'S NAME OR SCHOOL NAME
 12. OTHER INSURER'S INSURANCE PLAN NAME OR PROGRAM NAME
 13. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 14. DATE OF CURATIVE TREATMENT
 15. NAME OF REFERRING PHYSICIAN
 16. RESERVED FC
 17. NAME OF REFERRING PHYSICIAN
 18. RESERVED FC
 19. NAME OF REFERRING PHYSICIAN
 20. RESERVED FC

1500 HEALTH INSURANCE CLAIM FORM
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 18. RESERVED FC
 19. NAME OF REFERRING PHYSICIAN
 20. RESERVED FC

1500 HEALTH INSURANCE CLAIM FORM
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needs more than 300 back-office staff members to bill for the services of the organization's 900 physicians. Those administrative staffers operate in a theater of the absurd, in which insurance companies reject 15% of claims the first time they're submitted (no matter what) and one payer can reimburse 17 different amounts for exactly the same service (every one of which is correct because of the payer's myriad variations in its payment policies). "I printed out the payment policy manual just for radiology, with all of the codes and requirements for each payer, and it was seven inches thick," says Heffernan. "I actually carried that around to professional meetings for a while just to make my point."

His point, of course, is that the current system has become needlessly—and often ridiculously—complicated and costly. David Himmelstein of Harvard Medical School says more than 30 cents of every health care dollar is spent on the kinds of things Garr describes: administrative costs, mostly involving how care is financed by a dizzying array of public and private entities. (Those expenses are up from 25% of overall costs in 1990, says Himmelstein, a physician and one of the first researchers to investigate administrative costs.) In Perlman's case, perhaps \$90,000 of the \$300,000 spent during the first year after her stroke went for billing, medical claims review and other related costs, rather than to pay her doctors, nurses and physical therapists.

Finding ways to limit administrative costs could make a huge dent in the \$2 trillion spent annually (as of 2005) on health care in the United States. That sum amounts to 16% of the country's gross domestic product, making the U.S. system by far the most expensive in the world. Yet in most debates about the rising cost of health care, it's the aging population and the technology explosion that get most of the attention, with many experts admitting there are

few good ways to control mushrooming clinical expenditures. Because tens of millions of baby boomers are entering their later years, total outlays for care are almost certain to go up, and patients will always want to benefit from advances—the latest drugs, diagnostic technologies and surgical breakthroughs. After all, when one's health is at stake, money is no object.

Far less of the debate focuses on the deep layer of bureaucracy—all of those insurance companies and government agencies, each with its own detailed requirements for which physicians, treatments and drugs it will or won't cover. James G. Kahn, a professor at the Institute for Health Policy Studies at the University of California, San Francisco, estimates that about \$250 billion of such administrative costs could be squeezed out of the system annually—enough, perhaps, to provide insurance to the roughly 45 million Americans who are currently uninsured. Though there's no concerted national effort to control such costs, everyone who has a stake in the system—from patients, physicians and hospitals to health insurers, federal and state governments, and businesses small and large—is doing battle with the problem every day. Successes are few, but a handful of promising approaches are pointing the way toward larger solutions.



“The problem is that once you’ve seen one RHIO, you’ve seen one RHIO. There’s just no uniformity. For this to work, members must be willing to give up something.”

All health care organizations, of course, would like to eliminate excess overhead costs, and most seem to understand that part of the answer lies in automating processes and redesigning the way work gets done. “But change has to be adopted across entire systems,” says Steven Spear, a senior fellow at the Institute for Healthcare Improvement in Cambridge, Mass. Not every organization is able—or willing—to undertake a major overhaul. One that has is ThedaCare, a four-hospital group in Wisconsin that has adopted management techniques pioneered by Toyota Motor Corp.

In the auto industry, “lean manufacturing” aims to cut waste and defects by improving processes, which might then speed up the production cycle, shrink inventories and create just-in-time parts delivery. ThedaCare began implementing Toyota-inspired processes five years ago, and since then has staged hundreds of “rapid improvement” projects in which teams of employees analyze a specific service or activity within a workweek. They make changes they think will streamline the process, and they report results by Friday. In the administrative arena, these lean tactics have been used to automate medical equipment purchasing and improve scheduling.

These initiatives, collectively known as the ThedaCare Improvement System, are helping to enhance quality while reducing costs, says John Toussaint, a physician who served as ThedaCare’s chief executive until April, when he left to launch the ThedaCare Center for Creating Value in Healthcare, which focuses on reducing costs for providers, businesses and individuals. “Administrative costs are only one element of health care delivery, but we’ve found thousands of ways to cut them,” Toussaint says. By eliminating overlapping responsibilities among employees involved in ThedaCare’s accounts receivable process, for example, the organization reduced receivables

by \$12 million in six months. And using the ThedaCare Improvement System to remove administrative hurdles in human resources has reduced the average time it takes to hire someone from 38 days to 18. All told, implementing lean management tools has saved the organization \$23 million during the past five years—without cutting jobs and while improving service to patients.

Still, in a system that has net revenue of \$550 million annually, “there are millions and millions of dollars left to go,” says Toussaint. He says he could take these reforms only so far, however, in large part because none of ThedaCare’s dozens of payers has been willing to sit down and work with the company. “It’s not malicious,” Toussaint says. “The marketplace is just totally dysfunctional, and we’re thrown in with everyone else who’s not as efficient. I can lower my prices 20%, and it will never get to the consumer.”

The Massachusetts General Physicians Organization, too, has been making progress in its fight to control administrative costs, in part by participating in the kind of coordinated, systemwide approach that Toussaint craves. The New England Healthcare Electronic Data Interchange Network, or NEHEN, is funded by 54 hospitals and eight health plans and promotes electronic data exchanges among payers and providers. It’s a kind of information technology pipeline intended to streamline the flow of data among many regional entities while safeguarding patient privacy. Now, 10 years after it was established, more than 4.5 million health care “transactions”—including claims, referrals and verifications of insurance eligibility and benefits—pass through the NEHEN network each month.

“NEHEN has taken the whole issue of how to move bits and bytes between payers

5

Years since ThedaCare, a four-hospital group in Wisconsin, adopted management techniques pioneered by Toyota

20

Number of days by which ThedaCare reduced the average time to hire personnel

33

Number by which ThedaCare reduced the questions on its patient registration forms

23

Savings in millions of dollars during the past five years, none of which involved job cuts

0

Number of commercial insurers that have been willing to work with ThedaCare in further streamlining processes

and providers to a pretty efficient level,” says Heffernan. Whereas before NEHEN it might have cost \$5 to process an insurance eligibility transaction by hand, such exchanges today can happen electronically for “pennies per transaction,” says Sira Cormier, project manager for NEHEN in Waltham, Mass. (The MGPO now processes 93% of its claims electronically, compared with 75% just two years ago, and a much smaller proportion before that.)

NEHEN is one of the first examples of a health data exchange network now commonly known as a regional health information organization, or RHIO. Since 2004, when President Bush established the Office of the National Coordinator for Health Information Technology, the federal government has awarded more than \$139 million in grants and contracts to create RHIOs as electronic hubs linking hospitals, physicians, insurers, pharmacies and laboratories. The intention was to create a free flow of medical records and administrative data within a geographic region. According to a Harvard University study, the federal government, states and private organizations have launched more than 145 RHIOs in recent years. But most have struggled to establish themselves, and only 20 have achieved even modest success, notes the study. Problems include building trust among members, choosing information technology criteria and creating a sustainable business model that will keep the RHIO going after initial funding dries up.

“The problem is that once you’ve seen one RHIO, you’ve seen one RHIO,” says Dan Rode, vice president of the American Health Information Management Association. “There’s just no uniformity. For this to work, members must be willing to give up something.” RHIOs in California, Colorado, Indiana, New York and other states, for example, have all adopted different strategies, governance models and electronic architectures, and in contrast to NEHEN, they’ve focused mainly on exchanging clinical rather than administrative data. “With



clinical data exchange, it’s much harder to determine immediately whether you’re reducing costs,” Cormier says. “We started with a common goal—reducing costs—and administrative transactions gave us an easy target that made business sense.”

Another imperative is to educate physicians about how much their supplies and equipment cost; otherwise, not knowing what the facility already has or which vendor may offer the best price, they may inadvertently inflate expenses, says Joe Lavelle, executive vice president of the Medical Center of Central Georgia in Macon. At the MCCG’s electrophysiology lab, which treats heart rhythm problems, supply costs had been higher than those of other hospitals handling similar patient volume and case severity for those procedures. But by sharing cost and utilization information with its electrophysiologists and cardiologists, the heart center has saved more than \$1.7 million during the past year. The MCCG also implemented an ordering and management system that generates and processes physician requests electronically, allowing administrators to negotiate efficiently with suppliers. Now other cardiology services are following suit.

Yet even such coordinated efforts may not be enough to

overcome the tendency, within a large organization, of different departments to adopt their own systems, software and protocols. “You’ll go in and find a wide variety of equipment, and of types and versions of application software,” says Mel Van Howe, a principal at the Copperwood Group, a Novi, Mich., consulting firm.

Such disarray inevitably leads to inefficiency and higher costs. One solution, which some 10% of the nation’s hospitals have adopted, is to put their entire electronic infrastructure in the hands of an outside expert. For example, Princeton HealthCare System, a central New Jersey group that runs a 300-bed teaching hospital as well as psychiatric and long-term care facilities, is in the third year of a five-year IT outsourcing contract among whose goals is to implement a clinical information system across all of the group’s hospitals and other facilities. When the contract is successfully completed, electronic patient records will be available instantly throughout the system, improving patient care.

Other innovations also have the potential to reduce administrative costs. A number of organizations are experimenting with “smart” cards that hold patient records on an embedded computer chip. During the past two years, Mount Sinai Medical Center and nine other New York City metropolitan hospitals have given thousands of patients the wallet-size plastic cards. Though there are up-front costs for technology to read the cards, and each patient must have a photo taken and fill out forms, the hope is that the card will make it easier to verify a patient’s identity and reduce mistakes that lead to insurance claim denials and medical errors. Paul Contino, vice president for informational technology at Mount Sinai, says the hospital is currently evaluating the pilot program to determine the administrative savings produced by the cards as well as the benefits of a portable medical record.

There are also national efforts to reduce complexity and costs. The three-year-old Healthcare Administrative Simplification Coalition, a group of payers, government agencies, providers and employers, is exploring ways to standardize billing and payment, insurance product design, and payer and provider contracting, among other initiatives. “Only recently have there been enough people saying we really need to do something about administrative costs because it would be a lot easier to save a few billion dollars by standardizing and streamlining these processes than to make changes on the clinical side—getting 800,000 to 900,000 physicians to change their practice patterns, for example,” says William Jessee, a physician and the president of the Medical Group Management Association, a co-founder of the coalition.

In a related effort, the Council for Affordable Quality Healthcare, an alliance of health plans and trade associations,

has been working for more than five years to help standardize the physician credentialing process. It has now registered more than 570,000 doctors’ credentials through a form available on the group’s Website. Other CAQH initiatives include CORE, the Committee on Operating Rules for Information Exchange—which helps participants verify a patient’s insurance coverage—and a new attempt to simplify claims transactions.

States are getting involved as well. Legislation in California, Massachusetts and Ohio that was designed to ensure universal coverage for state residents is also supposed to reduce administrative hassles and costs. In Colorado last year, the governor signed into law a bill requiring provider contracts to be drafted in plain language with a standard set of terms—a move toward simplification that should trim costs.

Yet some groups, including the American College of Physicians, are impatient with piecemeal solutions and the slow pace of change. They would like the United States to sweep away the overly complex current system and replace it with a pluralistic system that includes the government and private payers, or with something similar to the Canadian health care system, in which the government is the sole payer. On this side of the border, they point to Medicare, which spends about 4¢ of every dollar on paperwork and claims processing. “The only strategy for reducing administrative costs that really makes sense is to move toward a single-payer system,” says UCSF’s Kahn.

But none of the health reform proposals being floated by presidential candidates calls for a single-payer system, and it appears likely the nation will have to make do with less comprehensive fixes. Kahn thinks legislation requiring standardized health benefits packages would help, and Niccic McKay, a professor at the University of Florida who has analyzed administrative costs at hospitals, points to multiple ways the processes could be streamlined. “There are so many things that could be done at the federal policy level, just in terms of standardization, that could make things better,” she says. “The problem is getting everyone to cooperate.” ■

→ DOSSIER

1. “Analyzing Administrative Costs in Hospitals,” by Niccic McKay and Christy Lemak, *Health Care Management Review*, 2006. This landmark study integrates costs accounting, finance and organizational theory to define health care administrative costs.
2. “Fixing Health Care From the Inside, Today,” by Steven J. Spear, *Harvard Business Review*, 2005. The author examines the new tactics health organizations have adopted to manage quality and efficiency.
3. “The State of Regional Health Information Organizations: Current Activities and Financing,” by Julia Adler-Milstein et al., *Health Affairs* online, 2007 [<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.1.w60v1>]. This up-to-date look at the challenges confronting regional health information exchanges finds fewer than two dozen functioning at even a modest scale.