

The Effect of Administrative Complexity on the Cost of Health Care in the United States

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Submitted in partial fulfillment of the requirements of the
King Scholar Program
Michigan State University College of Law
Under the direction of
Professor Arshagouni
Spring, 2006

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The Effect of Administrative Complexity on the Cost of Health Care in the United States

I. Introduction

“The cost of our health care system is spinning out of control and no one is applying the brakes.”¹ In recent decades the cost of health care has skyrocketed in the United States. It was projected that “[b]etween 2002 and 2012 national health spending is projected to grow at an annual rate of 7.3 percent, reaching \$3.1 trillion by 2012.”² This would bring health spending to an all time high of 17.7 percent of the gross domestic product by the year 2012, an overwhelming increase over its already alarming 14.1 percent share in 2001.³ At first blush this high percentage may seem to be a rational reallocation of resources considering the advances in modern medicine over the past decades. However, as will be explained *infra*, not only does spending in the United States far exceed the propionate spending in any other country, the healthcare delivery system in the United States is fraught with inefficiency and unneeded administrative complexity, the elimination of which would significantly lower the percentage of the gross domestic product.

It is hypothesized that a large component of the staggering increases in the cost of health care in the United States is attributable to the daunting administrative complexity that has been created in the health care system. “While the United States health care system provides technologically advanced clinical services to the majority of the populations, it has spawned an extraordinarily complex administrative structure that substantially increases the cost of services. In addition to expense, administrative complexity may also have a detrimental effect on patient services and may even lower the quality of care.”⁴ The United States is revered for its cutting edge technological advances in medicine. Unfortunately, the accompanying administrative

system is ever-increasing in complexity but that is failing to move into the 21st century with efficiency and organization to manage the increased level of complexity that exists.⁵ This failure to progress with technology has created the current situation of outdated administrative procedures trying to facilitate cutting edge services and technology.

The following example written in the context of how the health care system might be described in general business terms provides a frighteningly clear example of why the United States is failing to keep the reins tight on the cost of administration of health care services.

In this business, every customer purchases a different, custom-made product. Further, the business must manage and meet the differing needs of multiple customers simultaneously. It must provide every customer with the customized product or service he or she requires. The requirements of a particular customer may only vary slightly, or sometimes greatly, from the product or service needed by other customers. The price that this business charges its customers has little or no bearing on the amount that is actually paid by the customer---different customers may pay widely varying amounts for essentially the same product or service. The price paid by the customer also is frequently unrelated to the cost the business incurs in creating and delivering the product---for some customers, the business makes profit on each transaction and for others the business loses money on each transaction. Further, the vast majorities of customers do not pay for the product or service themselves; rather, they rely on their employer or some other third party to make payment on their behalf. These payment agents often require the customer to buy their product or service only from certain sources, or else require the customer to pay additional amounts for the products or service. And finally, the business never collects more than token amounts of cash at the time the product or service is provided. Instead it must send a bill to the customer's agent (no two of which will accept the same invoice information), then wait a substantial period of time to receive payment.⁶

Any moderately savvy business-person that can conceive of an efficient and successful business plan will readily recognize the various pitfalls illustrated in the example above. For example, following are the ramifications that spring from just one of the pitfalls that can be identified. The fact that each customer is offered a custom-made health package that may vary slightly or significantly from any other health care package is clearly a burdensome and daunting task when we consider the needs of all insured individuals in the United States. This personalized

variability burdens the health insurance companies that provide coverage. It also affects the ability of each company that contracts with health insurance companies on behalf of their employees to be efficient.⁷ These individualized contracts cause an administrative nightmare for billing personal and administrative staff, both within the physicians practice and the health insurance companies. Further lending to the confusion are non-standardized coding practices of physician groups, billing delays, and Federal and State regulations which provide additional daunting complexity to an already existing administrative nightmare.

A. Goals of the Paper

The goal of this paper is to make readers aware of some of the reasons that have been identified as to why health care administration has become so complex and how these this increased complexity lends itself to a substantial increase in health care costs. Additionally, this paper will address some possible solutions to the current state of complexity in health care administration and examine the likely effects that particular changes would have on the health care system in general.

Specifically, this paper will address the following topics:

1. The main areas of complexity in the administration of health care.
2. The degree to which complexity of administration in health care impacts' the cost.
3. How could administrative costs generally and specifically be reduced?
4. Potential legislative actions to reduce administrative complexity in health care.
5. The effect of lower administrative costs and the reality of who would benefit from such changes.
6. The effectiveness of HIPPA in simplifying administration and whether it has successfully lowered costs.

II. Overview: The Ever-Increasing Complexity of Health Care Administration in the United States

“On an average day in 1968, U.S. hospitals employed 435,100 managers and clerks to assist the care of 1,378,000 inpatients. By 1990, the number of patients had fallen to 853,000, while the number of administrators has risen to 1,221,600.”⁸ This is synonymous to 1 administrator for every 3.1 patients in 1968, compared to 1.4 administrators for *each* patient in 1990. This staggering increase in the level of administrators per patient is indicative of either the increasing complexity of health care administration generally or the rapidly decreasing efficiency of staff. The root of administrative complexity has been attributed by some to the expansion of health insurance and the takeover of third party payers⁹ that began in the 1940’s.¹⁰ With the onslaught of third party payers requests to assure the accountability of the funds they were expending on behalf of patients became more prevalent. The requests for accountability were the first sign of increased complexity in health care administration. With the passage of time requests came forth to adjust plans to the needs of each distinct payer and with this the plans became more individualized and unique. From the perspective of the individual payer whose specific needs are being facilitated by negotiating a specific plan different from all others, this seems logical. “But for the physician or provider that must deal with dozens or sometimes hundreds of different payers, they become a source of administrative nightmare.”¹¹

One of the foregoing questions in the minds of many is how health care managed to get to the current state of affairs; cutting edge technology with archaic administrative practices that are lacking in efficiency and the ability to manage the complexity in the current day.

While the public generally marvels at the scope and pace of innovation in high-profile medical technologies....We routinely take the latest medical technologies of the 21st century and embed them within a service delivery and patient flow

process—with its appointments...and so on—that has remained fundamentally the same since the 1950s.¹²

Although some attempts have been made to change the process of appointment scheduling and billing and coding procedures, little progress has been made. Many computerized systems that have attempted to make the administrative process more efficient have only resulted in more trials and tribulations, thereby causing greater complexity.¹³ Medical coding is only semi-standardized and not updated frequently within each clinic, coding staff is not being properly trained on data entry, and computer programs are written by computer programmers that lack medical familiarity. In combination the preceding problems have resulted in the medical administration wasting much time and money on inadequate systems run by inadequately trained administrators. Without any significant changes in how patient information is processed, appointments are scheduled, and billing accurately accounted for, the health care administrative process has struggled to keep up with the advances in medical technology.

III. Factors Contributing to Increasing Administrative Costs

I look at the U.S. health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind boggling administered prices and other rules expressing distinctions that can only be regarded as weird.¹⁴

A. Mélange of Multiple Payers and Multiple Insurance Products

A major contributing factor to the complexity in health care administration is the existence of “multiple payers with multiple insurance products, each with different coverage, Co-payments, deductibles, eligibility standards, claims-filing requirements and record-keeping standards.”¹⁵ In 2004, the typical ten-physician practice is reported to have contracted with 20.5 different health plans annually.¹⁶ Each plan is negotiated separately and may have distinctly different terms than the other health plan contract. Robert Brandon, Vice President of Citizen

Action, stated, “with over 1500 insurance companies offering health policies to the public, it comes as no surprise that our healthcare system is bogged down in costly and wasteful paperwork.”¹⁷ Each of the insurance companies offer a variety of coverage combinations for services covered, services not covered, and the amount any patient is responsible to pay in the form of co-payments and annual deductibles.¹⁸ “For example CIGNA may offer an HMO plan; a point of service (POS) product; and a preferred provider (PPO) plan in a particular market. But within the HMO, different patients may have different coverage, co-payments and deductibles, depending on the nature of their employer’s contract with CIGNA.”¹⁹ This results in administration spending at least 5.5 hours on negotiating each separate contract, for 20.5 contract this equates to 112.75 hours just negotiating contract and incurring an estimated cost of \$33,800 in a ten-physician group.²⁰ To put this in perspective it must be considered that many larger medical groups actually have over 100 contracts; the cost for negotiating these contracts can reach \$700 million per year.²¹

B. Multitude of Payment Mechanisms

When comparing the cost of administration in the United States and Canada Steffie Woolhandler and David Himmelstein noted the very fragmented and complex payment system of the United State in comparison to the efficient and simply administered single-payer system utilized in Canada.²² This leads some analysts to wonder why such complexity is necessary in the health care system of the United States as compared to the Canadian system. The inherent complexity of the system in the United States is attributable to the lack of standardization discussed *supra* and the fact that those contracts are each individually contracted.

As has previously been noted the health insurance agreements and medical administration are wrought with a multitude of options that can be varied in each individual contract. Another

example of this variability is the near infinite number of mechanisms employed by insurance companies to pay physicians, practice groups and hospitals.²³ In the current system of medical administration payment mechanisms can range from capitation to fee-for-service to per diem payment schemes. Each payment mechanism has of course also been tweaked to vary the level of provider risk or to offer a variety of incentive plans or payment withholds.²⁴

Most insurers pay physicians through some type of fee-for-service basis calculated based on the number of services performed for any given patient. The problem is that each payer²⁵ establishes the amounts of the fees independently, with no standardization across the amount payers are paid for particular services. The result is “a hodgepodge of different payments for the same service.”²⁶ Such a hodgepodge of different costs may be prevalent in other industries where price varies based on factors such as timing of purchase or supply and demand. However in the health care industry where the costs are contracted for in advance this variability only leads to increased complexity and confusion due to the lack of standardization. Further complicating the payment system are unique “withholds” and “incentives,” that either reduce or increase the amount of the payment respectively. These variations in the payment received are a result of specific agreements between the insurance company and the third party-payer.²⁷ In the fee-for-service payment scheme some services have a more favorable payment to cost ratio, this discrepancy between services could potentially bias the choice of physician’s when they request the type of treatments needed for patients.

Capitated payment contracts are another type of payment system. In this system the insurer pays the physician or practice group per person. Capitated payment contracts essentially allocate a certain dollar amount per month for each patient that is assigned to the provider.²⁸ The dollar amount that is allocated per patient of course is negotiated anew for each contract. This

per capita amount is constant regardless of if the patient requires no services or a plethora of services in any given month. Under this capitated payment scheme the fewer services a patient requires in a month the more of the per capita payment the physician or practice group can retain. This could potentially lead to physicians' hand picking lower risk or healthier patients.

The per diem system is primarily associated with payment to hospitals. The per diem system is based on the premise that the hospital is paid a certain dollar amount by the insurer for each day that a patient is treated at the facility.²⁹ This single dollar amount must then be used to offset the cost of any procedures that a particular patient receives in any given day that they are being treated in the facility. This is problematic since more critical patients, or patients that have complicated or multiple presenting complaints may far exceed the per diem amount that the insurance company will pay the hospital. This causes the hospital then to have to cover this cost in excess of the per diem out of its own funds, or reallocate part of a payment received for another patient for whom the per diem was in excess of the required treatment cost. Further complicating this type of payment system is the decision of some insurance companies to set criteria for the number of days that they will pay a hospital for a particular condition, essentially setting quotas for the "time to cure". This puts the physicians in the difficult position of feeling pressure to "cure" the patient in a specified length of time or lose money for the hospital by keeping them beyond the allotted number of days for which the insurance will pay. The hospital is then faced with the conundrum of releasing patients before the doctors feel that they should leave the hospital or allowing the patients to remain hospitalized on the hospital's dime.

Each payment system on its face seems relatively straightforward, some, particularly the per diem system, seem as though they could actually lower administrative costs. However, the problem of administration does not lie solely in the facilitation of one particular payment system,

but instead in the co-existence of multiple systems. In essence any physician or practice group may be concurrently utilizing as many payment systems as insurance contracts they have entered into. Concurrent utilization of such widely varying payment systems is what yields the administrative complexity currently at issue

C. Severely Lacking Standardization of Procedures

Additional key problems that are causing administrative complexity are the “multiple standards for medical licensure, credentialing, hospital privileges, drug prescribing, coding for services and disease management protocols.”³⁰ The national health care system is severely lacking standardization. This lack of standardization is causing duplication of work in cases such as credentialing for hospital privileges and repetitive mistakes in the cases of prescriptions, coding and billing.

One example of duplicative work is the re-submission of mistakenly denied claims. Research conducted by the Medical Group Management Association’s (MGMA) research center estimated that 4.60 claims per full time equivalent physician are denied weekly, 73 percent of which are successfully resubmitted for payment.³¹ Each re-submission takes an average of 16 minutes for a support staff member to process; this accrues to an estimated yearly cost of \$9,248 in a 10-physician practice group.³² This is a prime example of unnecessarily duplicative work that could be easily eliminated if the health care system was more standardized.

The Group Practice Research Network also compiled data regarding the administrative complexity of needlessly repeating credentialing and certification processes that have likely been previously completed at former places of employment or are being concurrently filed for a variety of health plans, hospitals, care facilities and other organizations in which a physician may practice. This group reported that the average practice submits 17.86 credentialing applications

yearly per physician.³³ This costs a ten-physician practice approximately \$7,618 annually.³⁴ When broken down this corresponds to 69 minutes of time invested per application by a support staff member and an additional 11.27 minutes per application by the physician.³⁵ Hospitals and health plans claim that the duplicative credentialing procedure is necessary since each entity could be held corporally liable in the event that a doctor with inadequate credentials was allowed to be paneled and committed malpractice. However, the change that needs to be implemented is on a broader scheme that expecting one hospital to assume that a past employer had diligently credentialed a physician. To avoid the complexity inherent in the current process would require implementation of a national or state-wide subcontractor that would verify credentials and provide full reports for a small fee to each entity requiring such information.

Another wasted expenditure of time is redundant training and certification processes now necessary due to compliance various regulation, an example of which is The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Each separate service entity is individually creating HIPAA training procedures that physicians and staff must complete to verify that they have the appropriate HIPAA education and compliance strategies. The redundancy comes into play where physicians affiliated with separate entities working in a collaborative environment are required to complete multiple training modules that present the same material.³⁶ A further discussion of this duplicity is provided *infra*.

D. Daunting Federal and State Regulatory Requirements

Further adding to the complexity of health care administration is the implementation of federal and state regulations adding dense legal requirements to the already daunting task of compliance to health insurance rules. “Regulatory requirements...mandate compliance by threat of civil or criminal punishment, thereby encouraging ‘cover your bases’ excess rather than

adherence.”³⁷ These regulations include but are not limited to; Medicare and Medicaid regulations, The False Claims Act,³⁸ Stark II Laws,³⁹ Anti-Kickback Laws,⁴⁰ the corresponding and equally as complex Safe Harbor Rules,⁴¹ and HIPAA.⁴² A full discussion of the preceding regulations is beyond the scope of this paper. However, a brief discussion of select regulations is included below to illustrate the complex nature and ensuing confusion in administration and non-standardized compliance that frequently occurs.

1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), public law 104-191,

amend[s] the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, *to simplify the administration of health insurance* and for other purposes. (Emphasis added)⁴³

Despite its stated purpose to simplify administration, HIPAA has in fact created a whirlwind of administrative confusion, duplication and inefficiency as hospitals, universities, and other physician practices attempt to comply with its many rules and regulations.⁴⁴

For example at the Children’s Hospital of Michigan in the Psychiatry and Psychology Department staff from the Children’s Hospital, the Detroit Medical Center, Wayne State University School of Medicine, Wayne State University research staff adhering to protocols under the Institutional Review Board, and Psychiatry and Behavioral Medicine Professionals staff all work in the same area under the same Chief of Staff. Each of the aforementioned entities has developed their own HIPAA training modules for anyone in contact with patients or patient charts. Since the staff on this floor all co-mingle and may inadvertently speak with a patient being seen by a provider from another practice entity it has been deemed necessary that

each employee working on that floor complete each of the separate, yet materially identical HIPAA training modules, to fulfill the requirement of each separate practice entity.⁴⁵ Imagine that each training modules takes at the least ten minutes per employee coupled with the administrative tasks of verifying that each employee has completed the training. This is a prime example of a situation where a standardized requirement would avoid wasted time and administrative complexity. “Studies have shown that a tremendous amount of money can be saved by reducing duplicated and unnecessary administrative functions.”⁴⁶ Had HIPAA planned for a standard training tool to be used for training and testing of all health care workers, unnecessary waste of precious time and accordingly money could be saved.

2. The False Claims Act

The False Claims Act⁴⁷ imposes liability of between \$5,000 and \$10,000 plus three times the amount of damages caused to the government for certain acts upon a person who:

- (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
- (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
- (4) has possession, custody, or control of property or money used, or to be used, by the Government and, intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;
- (5) authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(6) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or

(7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.⁴⁸

On example of a physician being brought up on False Claims charges occurred in *United States v. Krizek*.⁴⁹ In this case a psychiatrist was brought up on charges of violating the False Claims Act⁵⁰ by billing for sessions of durations that were longer than that actually performed and documented in the charts. Dr. Krizek was a doctor specializing in psychiatry. His wife, Blanka Krizek, was responsible for his billing for ten years. The accusations against Dr. Krizek did not allege that he was not a competent provider or that he did not actually see the patients on the dates for which he was billing. In fact, investigation findings showed that Dr. Krizek saw all the patients for which he billed, and that the dates of service provided were all accurate.⁵¹ The government's case hinges on the question of whether Dr. Krizek properly used the 90844 Current Procedural Terminology (CPT) code, for 45-50 minutes of individualized psychotherapy accurately.⁵² "In sum, the government claims that whenever Dr. Krizek would see a patient, regardless of whether he simply checked a chart, spoke with nurses, or merely prescribed additional medication, his wife...would, on the vast majority of occasions, submit a bill for CPT code 90844."⁵³ The government states that this CPT code is only to be used when 45-50 minutes are spent speaking directly to the patient, not including time taken to make phone calls, write prescriptions, or any of the other tasks that may be accomplished in furtherance of a particular patient's appointment. Admittedly, Dr. Krizek's coding practices were inaccurate; he on more than one occasion billed for more than 24 hours of services in a single day. However, this case is illustrative of the lack of clarity of the intended use of particular CPT codes. Other physicians

testified that the 90844 CPT code was initially conceived and being implemented to include not only face-to-face contact with patients, but also time spent working on the case before and after seeing the patient.⁵⁴ This type of ambiguity in procedures and the corresponding legislative repercussions well illustrates the problems inherent in current regulations. If the CPT codes were provided to physicians with clear regulations as to their usage, then such ambiguity would not be prevalent.

3. Miscellaneous Other Regulatory Nightmares

Administration of Medicare is yet another daunting task. One “measure of the extent of that regulation (and the complexity that attends it) is that there are more than 130,000 pages of regulations governing the Medicare program—many more than the regulations governing the US tax code.”⁵⁵ Provider-groups must also comply with the Occupational Safety and Health Administration (OSHA) regulations, which serve to protect staff from hazardous wastes and regulate the environmental conditions of the work place.⁵⁶ Furthermore, the Clinical Laboratory Improvement Act (CLIA) requires practice groups to go through inspections at their own expense to verify that the quality of the laboratory meets stringent criteria.⁵⁷ Finally, the National Practitioner Data Bank “mandates reporting...of disciplinary actions taken against physicians by hospitals, medical groups, health plans and state licensing boards, as well medical liability settlements or judgments.”⁵⁸ This database was designed to serve as a registry for “bad doctors” that have been disciplined.

The preceding examples of the complicated legislations and regulations serve important purposes but also add onto the mounting administrative complexity in health care. Health care administration is not only dented by keeping up with technological advances, billing, coding, payer, payment, and patient concerns, it is additionally hampered by convoluted these

regulations that are hard enough to understand let alone comply with. This climate of fear of violating regulations that are barely comprehensible has led to a paranoia that has in turn decreased the efficiency of health care. These regulations have led us to a state of affairs where “[e]ach piece of medical terrain is meticulously inspected....[and] the focus on micromanagement has obscured the fundamentally inefficient structure required to implement such policies.”⁵⁹

IV. The Devastating Costs of Administrative Complexity

“During those rare quiet moments in the medical group, do you hear the sound of money disappearing down the drain? Listen and you’ll hear the murmur of dollars and cents wasted on unnecessary or redundant administrative tasks that provide little or no benefit to the practice’s patients.”⁶⁰ It has been reported that health care spending was \$1.5 trillion in 2002 and will grow at an annual rate of 7.3 percent yearly reaching \$3.1 trillion by 2012.⁶¹ Isolating what portion of these estimated figures is attributable to administrative inefficiency, complexity and duplication is difficult considering that no recent studies have specifically tracked these costs. However, some reports discussed *infra* have made estimates based on self-report of physician practices and projections based on growth trends.⁶²

One recent report in *Health Affairs*,⁶³ based only on the administrative costs of health insurance that is covered by public and private health insurance, provided reports of administrative costs beginning in 1970 and projections through 2012. These reports estimated that by 2012 administrative costs would reach a startling \$222.6 billion.^{64 65} Considering that the cost of health care in the United States is projected to be \$3.1 trillion in 2012, the administrative costs for only health insurance administration (not including other administrative costs) would then comprise over seven percent of the total cost of health care. The increases in the

administrative costs of health care were detailed beginning in 1970 when the United States spent a reported \$2.8 billion on the administrative costs associated with health care.⁶⁶ This figure skyrocketed to \$12.1 billion in 1980, more than four times the figure reported just a decade earlier. The administrative costs associated with health care had grown to \$40 billion by 1990, and had nearly tripled in the following twelve years to \$110.9 billion in 2002.⁶⁷ Based on these figures, on average the administrative costs of health care are approximately tripling every ten years. While the rate has shown some declining features (quadrupling in the period from 1970 to 1980 and only estimated to double from 2002 to 2012), the prognosis for health care costs is still very frightening. Additionally, administrative costs are rising faster than general health care costs (with a reported increase of 7.3 percent annually).⁶⁸

Another recent report in *Managed Care Magazine*⁶⁹ published in 2002 incorporated federal data, data collected for Millman USA's 2001 HMO Intercompany Rate Survey, and data from Millman USA Health Cost Index. This report "estimate[d] that per-capita health care costs for all payers – government, insurance carrier, and consumer – will increase 44 percent by 2006, thirteen percent higher than what the Office of the Actuary predicts."⁷⁰ This group estimates that of this increase the consumer will be receiving the majority of the impact with a 55 percent increase from 2001 through 2006 in their out of pocket expenses (equivalent to \$2500 for a family of four).

Another report in *Health Affairs*⁷¹ also detailed the impact of the increased costs of health care on the health care consumer. In this publication, focusing on important trends in job-based health benefits in the year 2002, it was reported that health care costs increased 12.7 percent from spring 2001 to spring 2002, the highest increase reported since 1990.⁷² The study reported that this equated to a jump from \$30 to \$38 for single coverage or a jump from \$150 to \$174 for

family coverage for the more than 175 million Americans that are covered by job-based health insurance.⁷³

The most comprehensive study of the cost of health care administration was published in the *New England Journal of Medicine* in 1991.⁷⁴ This study compared four major components of administrative costs of health care in the United States and Canada for fiscal year 1987. The four areas included insurance overhead, hospital administration costs, nursing home administration costs, and physicians' overhead and billing expenses. The results, all in US dollars, reported that the United States spent \$500.3 billion on health care generally, compare this to the modest \$35.9 billion Canada spent on health care generally in the same period.⁷⁵ Of these totals the US spent an estimated \$96.8 billion to \$120.4 billion on health care administration, Canada spent only an estimated \$3.00 billion to \$3.98 billion on administrative costs.⁷⁶ Even when adjusting these figures to account for the differences in population size the comparative cost of the US health care system remain staggering; per capita the US spends between \$400 and \$497 while Canada spends only \$117 to \$156 on administrative costs.⁷⁷ This cost accounts for 19.3 to 24.1 percent of the US health care costs in comparison to 8.4 to 11.1 percent.⁷⁸ "If the U.S. health care administration had been as efficient as Canada's, \$69.0 to \$83.2 billion (13.8 to 16.6 percent of total spending on health care) would have been saved in 1987."⁷⁹

More alarming was the comparison between the changes in health care administrative costs between 1983 and 1987 in the United States as compared to Canada. It was reported that administrative costs rose from 21.9 percent to 23.9 percent in the United States, while in Canada over the corresponding time period they fell from 13.7 percent to 11.0 percent.⁸⁰ "After adjustment for inflation, the divergence was even more striking. The costs of the health care

bureaucracy in the United States rose by \$32.2 billion....Administrative costs in the Canadian health care system fell by \$161 million during this period.”⁸¹

An examination of the trends of medical practices’ methods of staffing and their practices’ expenses over a period of the preceding years brings to light some potential consequences of the administrative complexities of the United States health care system.⁸² In the past quarter of a century multi-specialty groups, groups that are not hospital or integrated delivery system owned, have increased staffing 61 percent (from 3.42 full time equivalent employees to 5.51) in an effort to keep up with the astounding changes in administrative complexity.⁸³ More specifically, an examination of changes in the years 1980-1985 in comparison to 1986-1991 reveals a significant impact of the rise of managed care to dominate the health care system.⁸⁴ While in the years 1980-1985 little change in staffing was noticed when analyzed for year-to-year changes, when managed care became the forerunner year-to-year change in staffing increased dramatically over the subsequent period from 1986-1991.⁸⁵

David. N. Gans examined the five-year trends in median revenue and an expense per full time equivalent physician for multi-specialty groups from data compiled 1997-2002. These trends showed that while the total gross charges by physicians increased 54 percent from \$625,269 in 1997 to \$962,078 in 2002, that the total revenue only increased 30 percent in that time period.⁸⁶ Correspondingly, multi-specialty groups reported a 38 percent jump in operating costs per full time equivalent physician.⁸⁷ Administrative supplies and services were reported to have increased 18 percent over this time period.⁸⁸ However, the compensation of support staff along with the corresponding cost of their benefits was reported separately from administrative costs and was slated as a 33 percent increase. This comprised the largest monetary increase reported of \$46,157, a jump from \$139,221 in 1997 to \$185,378 in 2002. Surely the stunning 19

percent increase in administrative costs coupled with the 33 percent increase in the cost of support staff in comparison to the 30 percent increase in net revenue per full time equivalent is indicative of the diminishing returns in this highly complex, administratively laden health care system.

To further demonstrate the phenomenal effect of administrative complexity one recent report calculated in September of 2004 by multiplying the number of hours staff and physicians reported working on particular tasks by their calculated hourly compensation to project that “[a] ten-physician practice spends \$247,594 per year on a select number of unnecessarily complex or redundant administrative tasks.”⁸⁹ Of this total the time it takes staff to “verify patient coverage, co-payments and deductibles for thousands of varying health plans”⁹⁰ was estimated to cost nearly \$40,000. The time taken to resubmit denied claims was estimated to cost \$9,248.⁹¹ The cost of the time taken to negotiate complex and individualized contracts was estimated to be \$33,800.⁹² Finally, \$8,085 was allocated to “support staff, physician and nonphysician provider time to submit credentialing applications.”⁹³

V. How to Rein in the Skyrocketing Costs of Healthcare

The first step to understanding the skyrocketing administrative costs of health care is to recognize what complexity is and how it is related to administrative costs. “A complex adaptive system is a collection of individual agents who have the freedom to act in ways that are not always totally predictable, and whose actions are interconnected such that one agent’s actions change the context for other agents.”⁹⁴ In such a complex interrelated system, the control of individuals is not always feasible. Therefore, the focus of adaptation must be on the system within which these individuals operate. Specifically, the focus must be on regulation, standardization, organization, efficiency, and avoidance of redundant or overlapping tasks. If the

system is efficient and regulated the complexity of individual behavior may not change, however, the effect of each individual behavior will be more easily isolated and corrected before it has a staggering ripple effect on the system.

A. A Seemingly Simple Solution: More Efficiency, Less Complexity

1. Leaping into the 21st Century: Make Progress in Internet Based Services

It is amazing that in the 21st century, in a time of astounding advances in technology that some aspects of health care services are still running in essentially the same manner they were in the 1950's.⁹⁵ In this day and age where technologically savvy individuals may be “wired,” or “wireless” as technological advances may have it, from the time they wake up in the morning until they turn in for the night, getting minute by minute updates on stock prices, weather, and sports scores that patient medical information is not readily available for any treating physician at the click of a mouse. Imagine the efficiency of health care in an utopist technologically advanced state, the one we are more than capable of leaping into with the right administrative and regulatory initiatives. In this system a patient could be greeted by the receptionist who scans the patients' medical card, thereby reading all information about this patient, prompting the receptionist as to what type of appointment was booked for that particular date, if any co-payment will be due, if any vaccinations or laboratory tests need to be scheduled, and the date of the next anticipated appointment.⁹⁶ Imagine further that this scan of the card prompts an electronic page to the physician that is scheduled to see this patient, without a receptionist interrupting an appointment or test that the physician is currently occupied with, and without the receptionist leaving the front desk un-staffed. Now lets follow this patient into the doctor's office, his computer has automatically been prompted by the scan of the patients card on an

adjacent computer in the network to bring up this patients medical records,⁹⁷ without having to shuffle through a paper chart and straining to read old, faded, or illegible progress notes and laboratory reports, the physician has a comprehensive and organized summary of this patients needs at his fingertips.⁹⁸ Further dream about the physician that is on call and is faced with a patient emergency at 4:00am, however clearly does not take home all the patient charts for his practice and therefore under the current system is forced to ask many repetitive and time consuming questions of the patient or family member to assess the patient's medical history. Under a technologically advanced system the physician would be able to get out of bed, walk to his computer and log on to a secure server that would allow him to bring up the patient's medical records, while multitasking and assessing verbally over the phone the patient's current presenting complaint.⁹⁹ While the technology for this utopia is at our finger tips, the implementation and upgrading of such comprehensive systems are not only time consuming or costly, there is also resistance to change from physicians and hospital administration that fear the stability of electronic records and the ability to resist hackers and system troubles. However, when these fears are compared to the cumbersome use of handwritten patient charts that can be misplaced, misfiled, damaged or ruined the transition does not seem to be such an unreasonable leap of faith.

2. The Trials and Tribulations of Billing and Coding

The current billing system relies too heavily on impersonal systems that are not programmed to allow for the complexity of individualized insurance plans and very personalized billing needs. Some of the problems inherent in the current billing system have been historically linked to complexities and confusion attributable, at least in part, to the multiple non-complementary coding systems that exist.¹⁰⁰ Specifically, the International Classification of

Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and the CPT system used throughout healthcare services are infrequently and irregularly updated. Even when the coding systems themselves are updated there is often a substantial time lag before the incorporation of the update is reflected in actual practice of coding and billing.¹⁰¹ It is paramount that physicians be prudent in utilizing the correct billing codes for the type and duration of session that is documented. In *United States v. Krizek*,¹⁰² a psychiatrist violated Medicaid and Medicare regulations and was brought up on charges of violating the False Claims Act¹⁰³ by billing for sessions of durations that were longer than that actually performed and documented in the charts, in some cases culminating in over 24 hours of billed services in a single day.¹⁰⁴ Cases such as *Krizek* serve as an example of the consequences of the complexity and misunderstandings of the use of coding and billing systems.

In addition billing across health services has been riddled with complexities inherent in the separation of job responsibilities.¹⁰⁵ For example, imagine the following scenario as a typical example of the billing for one individual encounter with a patient. A provider will see the patient and provide treatment, which is documented in the patient's chart. Often the service provider is not familiar with the type of insurance the patient is covered by or the specific billing requirements of that particular type of coverage provider. Therefore, in this first step the service provider may already negligently complete a treatment note without complying with the documentation requirements to support any given billing code.

The patient chart and encounter form are then typically given to a secretary or receptionist; the form may or may not have been completed with a billing code by the service provider. In this second step we encounter the hazard of an ill-informed service provider "guessing" at the appropriate billing code, or a receptionist that did not render or witness the

services provided “guessing” at the type of session that occurred. To further complicate matters, many types of insurance will only cover so many sessions of a particular type, therefore lending the profession to “creative billing techniques.”¹⁰⁶

Additionally, data entry and billing audits typically do not occur at the same site, and communication between sites is frequently poor and inconsistent, therefore not allowing for the ready correction of errors. “If this information is not communicated across departments (e.g., from billing to clinical and vice versa) and is not translated into changes in practice in the clinical programs providing services, the same mistakes can be made repeatedly.”¹⁰⁷

“To ensure compliance...education for billers that improves their ability to discriminate among clinical services, and education for clinicians that underscores the critical nature of their documentation and coding choices”¹⁰⁸ are fundamentally important. As the preceding discussion detailed, there are many complexities inherent in the health care billing and coding system.¹⁰⁹ These complexities could be alleviated not only by the standardization of billing codes and simplification of health insurance generally, but also by technological advances, as described *supra*, that would relieve many input errors, and alert data entry and administrative personnel when errors are occurring repeatedly.¹¹⁰

3. Eliminate Repeating Substantially Similar Certification and Credentialing

A single physician submits an average of 17.86 credentialing applications per year according to one source costing a ten-physician practice approximately \$7,618 annually.¹¹¹ Many times the credentialing has been completed at former places of employment previously or is being concurrently filed for a variety of health plans, hospitals, care facilities and other organizations in which a physician may practice. Considering that most credentialing standards within a particular specialty are generally substantively similar and only minute differences that

usually have more to do with the insignia on the top of the page, all this time spent duplicating work seems to be a waste of time.

To simplify the credentialing and certification process it would seem a natural suggestion that each state develop and mandate the use of a single credentialing application which would suffice for each health plan, hospital, and facility.¹¹² This application may have to be re-submitted on an annual or bi-annual basis, as is often the case currently; however it would avoid the redundancy of submitting a separate slightly distinct application for each facility in which a physician may practice. Every organization would then be required to credential physicians using “a single ‘public utility’ organization to conduct verification of the credentials of all health care providers seeking to practice in facilities or health plans in each state.”¹¹³ Each time a physician changes or adds a practice location, which now would prompt a lengthy credentialing application process, the new facility could contact the “public utility” and request verification of credentials which could be automatically provided. This would significantly cut the number of administrative hours wasted on unnecessary duplication of substantially similar credentialing processes.¹¹⁴

B. Legislative Action: Is It The Only Route to Decreased Complexity and Lower Costs?

1. The Lofty Dream and Hard Reality of Implementing National Healthcare

“Administrative savings will require significant changes in the way America's private insurance system operates, with the greatest savings achieved by a system that eliminates private insurance and replaces it with a wholly public program.”¹¹⁵ The current state of affairs in the United States healthcare system leaves many wondering if the drastic change to a national healthcare system may be the only answer to the current administrative nightmare.

“Periodically, the level of frustration with the complexity of the current financing system reaches a point where calls for a single-payer national health insurance program become more prominent.”^{116 117} The current system of “multiple payers with multiple insurance products, each with different coverage, co-payments, deductibles, eligibility standards, claims-filing requirements and record-keeping standards”¹¹⁸ makes some long for the seeming simplicity of a national system. As recently as 2003, approximately 8000 physicians¹¹⁹ endorsed a proposal for a single-payer system.¹²⁰ The dilemma of healthcare also became a large focus of the Clinton presidency culminating in the unveiling of a national healthcare reform in September 1993.¹²¹

Steffie Woolhandler and David Himmelstein in a series of articles have looked to the difference between the United States and Canadian healthcare systems.^{122 123} The comparison of costs between the two neighboring countries is staggering: “In 1999, health administration costs totaled at least \$294.3 billion in the United States, or \$1,059 per capita, as compared with \$307 per capita in Canada.”¹²⁴ This analysis found that Canada’s single-payer insurance system to be definitively more efficient than the multiple payer system of the United States. Specifically, the authors recognized the high overhead costs of private insurers in the United States as compared to the public insurance system of Canada. Furthermore, the ménage of insurers in the United States was cited as “intrinsically costlier than a single-payer system.”¹²⁵ However, despite the seemingly drastic comparisons between the two neighboring systems while “[s]ome see an obese bureaucracy gobbling billions of dollars; to others, administrative costs [still] appear not unreasonable.”¹²⁶

“If administrative costs are high, much may be saved by fundamental reforms that move toward a Canadian-type system.”¹²⁷ The ability of the Canadian healthcare system to implement a global budget¹²⁸ was attributed with making a marked difference in the level of administrative

efficiency. Such a global budget is precluded in the United States by the presence of multiple insurers. The Canadian global budget allows authorities to negotiate budgets based on performance and past budget negotiations. In comparison the current system in the United States centers around multiple negotiations that start anew each time a contract expires.¹²⁹ Additionally, “[t]he existence of global budgets in Canada has eliminated most billing and minimized internal cost accounting, since charges do not need to be attributed to individual patients and insurers.”¹³⁰ The benefits of a system similar to that implemented in Canada are numerous, however the realistic ability of such a system to exist or operate at the same level of efficiency in the United States has been challenged by many.¹³¹

The U.S. health care administration, weird though it may be, exists for fundamental reasons, including a pervasive popular distrust of centralized authority, a federalist governmental structure, insistence on individual choice (even when, as it appears to me, choice sometimes yields no demonstrable benefit), the continuing and unabated power of large economic interests, and the virtual impossibility (during normal times in a democracy whose Constitution potentiates [sic] the power of dissenting minorities) of radically restructuring the nation’s largest industry.¹³²

In response to the cries for single-payer health reform, the need for reform, albeit a different type of reform, has also been echoed by William Jessee, president and chief executive officer of MGMA, when he noted in his analysis of healthcare’s administrative complexity; “the concept of a government run single-payer system has long been anathema to the health care industry, and has become a political ‘third rail’ that makes it unlikely that this concept will, in fact, come to reality in the near future.”¹³³ Jessee suggests that instead of a single-payer system, we should focus on a single payment system.¹³⁴ This “single payment system” would maintain the existence of numerous health insurance providers and the financing primarily through employers. However, this new system would shift the focus of competition between insurance providers from individualizing service and contracts to efficiency and service.¹³⁵ This plan

would implement standardization among credentialing criteria, verification of coverage, fee schedules, coding and patient care.

The most salient feature of this system would “be to implement a single mechanism for contracting with payers.”¹³⁶ This was proposed to be achieved by having associations of physicians negotiate contracts with all payers, thereby eliminating the current patchwork of contracts each negotiated independently. However, anti-trust laws currently prohibit this type of contracting thereby making the proposed shift seem like a quite lofty goal. Jesse however notes that, “[w]hile a single-payer system...would require many changes...it is an attractive goal to strive toward, promising reduced cost, improved care, and better access to care for all Americans.”¹³⁷ In comparison to the drastic legislation and changes that would need to be made to implement a national system of healthcare similar to that of Canada, the issues inherent in the single payment system may not be too great to overcome.

2. A Stepping Stone: Uniformity in Administration at the State Level

Louis Brandeis, in his 1932 dissent in a case heard before the Supreme Court¹³⁸ made very astute and globally relevant comments regarding “interaction between state and federal regulation...observing that ‘states play the courageous role of being social laboratories for a nation.’ Specifically, Brandeis noted that ‘states provide workshops of democracy which can conduct experiments with novel social and economic concepts without jeopardizing the security of the rest of the country.’”¹³⁹ This type of stateside experimentation, observed in 1932 by Justice Brandeis, is again being utilized in an attempt to alleviate the problems of administrative complexity in healthcare.

Simplification initiatives by the Medical Group Management Association (MGMA) have had a limited, yet positive, effect in participating states: The Governor’s Office of Health

Planning and Finance in Kansas is working with both state and national MGMA to organize online surveys of administrative problems.¹⁴⁰ Louisiana has passed the Credentialing Process Simplification Act as a new law; “It mandates use of either the state’s standardized credentialing application form or the Council for Affordable Quality Healthcare form. It also has provisions for the use of electronic submissions of the data, allowing...providers to move toward a centralized credentialing verification organization concept.”¹⁴¹ Massachusetts has similarly moved to a more standardized credentialing process using a uniform application, with the help of MGMA.¹⁴²

The existences of multiple standards in healthcare that vary by state, region, or county have been cited as having an extraordinary effect on the complexity and efficiency of healthcare administration.¹⁴³ The multitude of standards need to be re-evaluated and replaced with more congruent standards being implemented at least on a state wide level, and when possible nationally.

Healthcare in America is an amalgam of ‘ways of doing things’ from centuries ago, from decades ago and from years ago. Unfortunately, the sum of what has been inherited does not add up to a well-functioning system. A very diffuse payment mechanism, a multitude of providers, and a public with some very difficult medical-social problems do not lend themselves to a very rational system of healthcare. The gaps and seams are showing. America is dissatisfied in major ways, even as people use more healthcare services than ever.¹⁴⁴

The Healthcare Financial Management Association (HFMA) “supports enacting legislation to simplify healthcare administrative processes by implementing standardized electronic formats that all participants in the healthcare delivery system could use.”¹⁴⁵ The HFMA also details some initiatives that they believe any legislation should include. These initiatives include total industry-wide compliance, establishing a commission to report to Congress on the state of the health care industry,¹⁴⁶ electronic transactions, initial focus on standardizing only the core

healthcare transactions,¹⁴⁷ data maintenance, federal preemption, and implementation of strategic time tables.¹⁴⁸ HFMA strongly supports the creation of a commission that “would address the following core transactions: enrollment, eligibility, billing/claims, coordination of benefits, billing follow-up, first report of injury, and payment/remittance.”¹⁴⁹ A legislative standard, along with a commission to oversee its implementation, may indeed be the most reasonable answer to simplification of healthcare in the United States.¹⁵⁰

In reflecting upon the factors recognized *supra* as contributing to the complexity and cost of healthcare administration it can be observed that nearly all sources cited the lack of standardization as problematic and contributing to the administrative inefficiency of the current system. The implementation of standardized and widespread mandates would alleviate this problem and thereby provide some relief of the current level of inefficiency.

VI. The Truth of Decreased Complexity

A. The Actual Effects of HIPAA: Confusion and Increased Complexity

The administrative simplification provisions of HIPAA were enacted to preempt existing states laws. This design was based on the fact that prior to HIPAA state law governed access to patients protected health information and medical records, however, while some states had enacted numerous regulations, some had enacted none.¹⁵¹ As a means to cure this inconsistency HIPAA was simply to supersede the less stringent preexisting state laws, while allowing more stringent laws to remain in effect.

The goal of HIPAA was administrative simplification, while its effect was mass hysteria and confusion among health services organization and groups. After the enactment of HIPAA organizations struggled to understand the lengthy and complex language of the HIPAA statute in an effort to figure out how this affected them what needed to change in their specific practice in

order to remain HIPAA compliant. Task forces were compiled to “understand” HIPAA and disseminate the information to others in the group; in larger health care organizations mandatory lectures provided some remedial insight in an hour-long presentation. PowerPoint presentations, online training modules, and HIPAA hotlines became a mainstay of larger health care facilities. In correspondence with some health care workers it was noted that the best way to shirk duties was to tell supervisors that you could not complete the task because you were told it may not be in compliance with HIPAA. The fear that bureaucracy had instilled in physicians coupled with the utter lack of understanding of what HIPAA really meant resulted in numerous uncompleted tasks and many unanswered questions.

Additionally, misunderstandings as to the scope of HIPAA led too much unneeded administrative paranoia and work shortly after it was first enacted. Many organizations erring on the side of caution and misunderstanding the requirements of HIPAA put into effect administratively complex and inefficient practices in an attempt to comply with HIPAA, however in reality they had altogether missed making changes in the areas that HIPAA most affected. “Specifically, the preemption provision contravenes creates an additional body of law rather than reducing all privacy law into one body. It creates a preemption analysis that is abstruse and unworkable, thereby increasing the administrative costs.”¹⁵²

B. Who Will Reap the Rewards of Lower Cost of Administration?

One of the largest concern that come to mind for many payers and provider groups is whether they will actually reap the benefits of decreasing the complexity of health care administration. Specifically, it may be feared that by decreasing the complexity of administration and thereby lowering the costs of health care that the insurance companies will simply operate at a greater profit margin and that the cost to payers and physician groups will

only improve minimally, if at all. The foregoing scenario leaves no incentive for payer and provider groups to put forth time and energy to help solve the problems of administrative complexity. This may lead many to take a “why bother” attitude, assuming that any efforts they put forth to lessen their own burden many be in vain and instead result in making the rich richer.

The issue of who will truly reap the rewards of lower cost due to less administrative complexity will become a salient point as decisions are made on policy that will attempt to combat the skyrocketing cost of health care in the United States. As policy and procedures begin developing, methods to prevent the proverbial ‘bad guys’, the insurance companies, from taking more money from the poor should be carefully examined and addressed. One-way to prevent such a scenario would be the adoption of a national health care system as discussed *supra*.¹⁵³ A system of national healthcare would pull the rug out from under the current multiple-contract, multiple-insurance provider scenario in which the insurance conglomerates hold the power and could easily reap the rewards of cost savings by decreasing administrative complexity. However, other solutions such as single-payer healthcare systems also discussed *supra*¹⁵⁴ have also been suggested as a method of controlling the ability of insurance companies to take advantage of payer and provider groups. Exploration and explanation of the exact legislative and policy solutions that may prevent insurance companies from reaping the rewards of decreased cost via less administrative complexity are beyond the scope of this paper. These issues however need to be addressed within any policy that is implemented as the efforts to harness the current healthcare system.

VII. Conclusion

“The 18th century German philosopher Goethe noted, ‘[t]o put idea into action is the most difficult thing in the world.’ One of the by-products of the complexity of health care

organizations is their remarkable resilience in the face of pressure; even with the pressure is one for positive change.”¹⁵⁵ It is human nature to fear change, it is uncertain, and uncertainty often breeds resistance. However, in the face of the skyrocketing costs of health care and the frightening disarray and complexity of the administration of health care services, some change must be implemented in order to prevent further deterioration of this already crippled system.

Healthcare in the United States has always been admired for its cutting edge technology and techniques; it would be a disgrace to hamper the further progress of such great innovation because of soaring administrative costs. “For these reasons, careful scrutiny of how the United States administers its health care system, with an eye to how it can be improved within the limits imposed by history, politics, and economics, is useful.”¹⁵⁶ While a drastic change to a system more similar to the Canadian system may not be reasonable for implementation in the United States, and even if implemented may never transform the U.S. system into the cost effective and efficient system found in Canada, some change is obviously needed.¹⁵⁷ Standardized legislative action, the creation of a national oversight commission to monitor and regulate healthcare administration, the implementation of unvarying electronic billing and recording systems, and uniform and non-duplicated credentialing and certification applications would all lend a significant hand in reforming the current U.S. healthcare system. A complete overhaul of the U.S. system would be staggeringly effective, but also unreasonable to implement, however, simple steps as described above to reform the current system could save the United States million of dollars annually and save a struggling healthcare system.

¹ Mick L. Diede, and Richard Liliedahl, *Getting on the Right Track: Converging forces are an economic train wreck waiting to happen. Avoiding a disaster requires an understanding of the interconnection of health care's stakeholders and the global consequences of their actions.* MANAGED CARE (2002), <http://www.managedcaremag.com/archives/0202/0202.edge.html>.

² Stephen Heffler, Sheila Smith, Sean Keehan, M. Kent Clemens, Greg Won, & Mark Zezza, *Health Spending Projections for 2002-2012.* 21 HEALTH AFFAIRS 2, 54-65, 54 (2003).

³ *Id.*

⁴ See David. N. Gans, *On the Edge: Examining Industry Trends. Administrative Complexity: Money down the drain.* 4 MGMA CONNEXION 1 (2004).

⁵ *Id.*

⁶ William F. Jessee, *Administrative Complexity in Medical Practice: Its Impact on Costs, Practice Operations and Patient Care.* Aug. 18, 2003, <http://www.mgma.com/simplify.cfm>.

⁷ A task that can result in many negotiations along with contracts in excess of 100 pages that must be read and understood, often requiring the expertise of legal counsel

⁸ D. Hurley, *Administration: 25% of hospital spending hospital administrative costs.* 34 MEDICAL WORLD NEWS 9, 58 (1993).

⁹ The term third party payer refers to the current status of health insurance where most patients' health insurance is financed not by them directly, but on their behalf by an employer.

¹⁰ Jessee, *supra* note 6.

¹¹ *Id.*

¹² P. Plsek, *Complexity and The Adoption of Innovation In Health Care*, Jan. 27-28, 2003, available at <http://www.nihcm.org/Plsek.pdf>.

¹³ Michele Bitoun Blecher, *System error: Critics of HCFA's ill-fated computer system claim is waster time and money*, 72 Hospitals & Health Networks 2, 66 (1998).

¹⁴ Henry J. Aaron, *The Costs of Health Care Administration in the United States and Canada – Questionable Answers to a Questionable Question.* 349 N. ENGL J. MED 8, 801-03, 801 (2003).

¹⁵ Gans, *supra* note 4.

¹⁶ Christina Pope, *The Cost of Administrative Complexity, Administrative intricacies add no value to health care – but the costs keep adding up.* MGMA CONNEXION 2004 36-41, 37.

¹⁷ Lynn Wagner, *Insurers' trade group offers its own numbers to fend off administrative costs charges.* MODERN HEALTHCARE, May 4, 1992 at 20.

¹⁸ Jessee, William F. *Simplifying insurance product design.* MGMA e-connexion issue 44, December 2003.

¹⁹ Jessee, *supra* note 6.

²⁰ Pope, *supra* note 16, at 37.

²¹ Jessee, *supra* note 6.

²² Steffie Woolhandler & David Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System* 324 N. ENGL J. MED 18 1253-58, 1256 (1991).

²³ Jessee, *supra* note 6.

²⁴ See generally Gans, *supra* note 4.

²⁵ Usually a third party payer contracting on behalf of those that will be insured

²⁶ Jessee, *supra* note 6.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ See e.g., Gans, *supra* note 4.

³¹ Pope, *supra* note 16, at 38.

³² *Id.*

³³ *Id.* at 39.

³⁴ *Id.*

³⁵ *Id.*

³⁶ See, further discussion *infra* in section D. Regulatory Requirements, 1. The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

³⁷ Gans, *supra* note 4.

³⁸ 31 U.S.C. §3729 (2005).

³⁹ 42 U.S.C. §1395 (2005).

⁴⁰ 42 U.S.C. §1320a-7b (2003).

⁴¹ 42 U.S.C. § 1320a-7b (b) (3) (A) (2003).

⁴² Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 (1996), available at <http://aspe.hhs.gov/admsimp/pl104191.htm>.

⁴³ *Id.*

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- ⁴⁴ See Sarah B. Ratner, *HIPAA's Preemption Provision: Doomed Cooperative Federalism*. 35 JOURNAL OF HEALTH LAW 4, at 523-42 (2002).
- ⁴⁵ Interview with Michelle Rose, Coordinator, Department of Psychiatry and Behavioral Neurosciences, School of Medicine, Wayne State University, in Detroit MI. (Mar. 3, 2005).
- ⁴⁶ Christopher F. Weinheimer, *Administrative Simplification Crucial to Healthcare Reform*. 47 Healthcare Financial Management 11, 10 (1993).
- ⁴⁷ 31 U.S.C. §3729 (2005).
- ⁴⁸ *Id.*
- ⁴⁹ *U.S. v. Krizek*, 909 F. Supp 32 (D.D.C. 1995).
- ⁵⁰ 31 U.S.C. 3729 (2005).
- ⁵¹ See, *U.S. v. Krizek*, 859 F. Supp 5, 9 (D.D.C. 1994).
- ⁵² *Id.*
- ⁵³ *Id.* at 10.
- ⁵⁴ See *id.* at 12-13.
- ⁵⁵ Jessee, *supra* note 6.
- ⁵⁶ U.S. Department of Labor, Occupational Safety and Health Administration, available at <http://www.osha.gov>.
- ⁵⁷ Jessee, *supra* note 6.
- ⁵⁸ *Id.*
- ⁵⁹ Steffie Woolhandler & David Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System* 324 N. ENGL J. MED 18 at 1256 (1991).
- ⁶⁰ Gans, *supra* note 4.
- ⁶¹ Heffler et. al., *supra* note 2.
- ⁶² Jessee, *supra* note 6.
- ⁶³ See generally Heffler et. al., *supra* note 2.
- ⁶⁴ *Id.*
- ⁶⁵ K. Davis, Time for Change: The Hidden Cost of a Fragmented health insurance system. Testimony before the Senate Special Committee on Aging, March 10, 2003.
- ⁶⁶ Heffler et. al., *supra* note 2.
- ⁶⁷ *Id.*
- ⁶⁸ *Id.*
- ⁶⁹ Diede, *supra* note 1.
- ⁷⁰ *Id.*
- ⁷¹ J. Gabel et al., *Job-Based Health Benefits in 2002: Some Important Trends*, HEALTH AFFAIRS, Sep/Oct 2002 at 143-151.
- ⁷² *Id.*
- ⁷³ *Id.*
- ⁷⁴ See generally, Steffie Woolhandler & David Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*. 324 N. ENGL J. MED 18 at 1253-58, 1255 (1991).
- ⁷⁵ *Id.*
- ⁷⁶ *Id.*
- ⁷⁷ *Id.*
- ⁷⁸ *Id.*
- ⁷⁹ *Id.*
- ⁸⁰ *Id.* at 1256.
- ⁸¹ *Id.*
- ⁸² Gans, *supra* note 4.
- ⁸³ *Id.*
- ⁸⁴ *Id.*
- ⁸⁵ *Id.*
- ⁸⁶ *Id.*
- ⁸⁷ *Id.*
- ⁸⁸ The nature of the supplies and services were not reported in detail.
- ⁸⁹ MGMA CONNEXION, March 2005 at 26.
- ⁹⁰ *Id.*
- ⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ Plsek, *supra* note 12.

⁹⁵ *Id.*

⁹⁶ See generally, Health Management Technology, No. 1 Vol. 26 (2005) at 56.

⁹⁷ C.f. Patient Care Technology Systems available at http://www.pcts.com/pcts_ortracker.asp.

⁹⁸ See generally, Baxter Patient Care System available at http://www.baxter.com/products/medication_management/patient_care_system/index.html.

⁹⁹ C.f. Global Care Quest available at http://www.gcq.ucla.edu/index_pc.html.

¹⁰⁰ William F. Jessee, *Special Report: Simplifying Billing and Payment Processes*. MGMA CONNEXION, March 2004, <http://www3.mgma.com/articles/index.cfm?fuseaction=detail.main&artcileID=12781>.

¹⁰¹ Jessee, *supra* note 6.

¹⁰² *U.S. v. Krizek*, 909 F. Supp 32 (D.D.C. 1995).

¹⁰³ 31 U.S.C. 3729 (2005).

¹⁰⁴ This case was prosecuted as a violation of the False Claims Act.

¹⁰⁵ See Anne Fisk, (2003). *Regulatory Compliance Issues in Behavioral Health*. 133 JOURNAL OF HEALTHCARE QUALITY, at 3-4, available at http://www.nahq.org/journal/ce/articles.html?article_id=163.

¹⁰⁶ Interview with Georgia Michalopoulou, Ph.D., Chief of Staff, Department of Psychiatry and Psychology, Children's Hospital of Michigan, in Detroit MI. (Mar. 30, 2005).

¹⁰⁷ See Fisk, *supra* note 105 at 3-4.

¹⁰⁸ *Id.*

¹⁰⁹ Jessee, *supra* note 100.

¹¹⁰ Wagner, *supra* note 17.

¹¹¹ Pope, *supra* note 16, at 39.

¹¹² William F. Jessee, *Special Report: Simplifying Credentials Verification*. MGMA CONNEXION, April 2004, <http://www3.mgma.com/articles/index.cfm?fuseaction=detail.main&artcileID=12860>.

¹¹³ Pope, *supra* note 16, at 37.

¹¹⁴ See generally, Weinheimer, *supra* note 46.

¹¹⁵ Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*. 11 YALE J. ON REG. 455, 459 (1994).

¹¹⁶ Jessee, *supra* note 6.

¹¹⁷ *Accord*,
 There is a warp and woof to the continuing American discussion about the nature of health insurance. On about a twentyyear cycle during this century, we have considered and rejected joining our industrialized neighbors in treating health care as a public good through national statutory health insurance. Our regular refusal, after acrimonious debate, to enact statutory health insurance may be attributed to America's unique culture of individualism and distrust of government. Alternatively, we may hold responsible the entrenched and powerful institutions that benefit from the lack of national health insurance, and that work assiduously to prevent the passage of national health reform.

John V. Jacobi, *The Ends of Health Insurance*. 30 U.C. Davis L. Rev. 311, 314 (1997).

¹¹⁸ Gans, *supra* note 4.

¹¹⁹ Jessee, *supra* note 6.

¹²⁰ See The Physicians' Working Group for Single-Payer National Health Insurance, *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*. 290 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION at 798-805 (2003).

¹²¹ C.f. Weinheimer, *supra* note 46.

¹²² See generally, Steffie Woolhandler & David Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*. 324 N. ENGL J. MED 18, 1253-58 (1991).

¹²³ See also, Steffie Woolhandler, Terry Campbell & David Himmelstein, *Costs of Health Care Administration in the United States and Canada*. 349 N. ENGL J. MED 8, 768-75 (2003).

¹²⁴ *Id.*

¹²⁵ *Id.* at 773.

¹²⁶ Steffie Woolhandler, David Himmelstein & James P. Lewontin, *Administrative Costs in U.S. Hospitals*. 329 N. ENGL J. MED 6, 400-403, 400 (1993).

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- ¹²⁷ *Id.*
- ¹²⁸ A global budget is generally defined as a fixed aggregate sum of cash that is intended to cover the total cost of health care annually.
- ¹²⁹ Woolhandler et. al., *supra* note 123.
- ¹³⁰ *Id.*
- ¹³¹ *See, e.g.* Aaron, *supra* note 14.
- ¹³² *Id.* at 802.
- ¹³³ Jessee, *supra* note 6.
- ¹³⁴ *Id.*
- ¹³⁵ *See, Id.*
- ¹³⁶ *Id.*
- ¹³⁷ *Id.*
- ¹³⁸ *New State Ice v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).
- ¹³⁹ Angelo A. Stio III, *State Government: The Laboratory For National Health Care Reform*. 19 SETON HALL LEGIS. J. 322, 323 (1994) quoting *New State Ice v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).
- ¹⁴⁰ Pope, *supra* note 16, at 38.
- ¹⁴¹ *Id.*
- ¹⁴² *Id.*
- ¹⁴³ *Accord*, Gans, *supra* note 4.
- ¹⁴⁴ Robert S. Verhey, *Provider Response to Healthcare Reform*. 21 W. ST. U.L. REV. 107, 108 (1993).
- ¹⁴⁵ John P. McGuire, *Administrative Simplification Eases the Billing and Payment Process*. 48 HEALTHCARE FINANCIAL MANAGEMENT 10, 10 (1994).
- ¹⁴⁶ *See also* Richard L. Clarke, *A meaningful first step toward reform: Healthcare Administrative Simplification Act of 1993*. 47 HEALTHCARE FINANCIAL MANAGEMENT 7, 12 (1993).
- ¹⁴⁷ McGuire, *supra* note 145.
- ¹⁴⁸ *See id.*
- ¹⁴⁹ Clarke, *supra* note 146.
- ¹⁵⁰ However, see section VI, A, 2 for discussion of the actual effect of HIPAA legislation, passed without the implementation of a commission for oversight.
- ¹⁵¹ Sarah B. Ratner, *HIPAA's Preemption Provision: Doomed Cooperative Federalism*. 35 JOURNAL of HEALTH LAW 4, at 523.
- ¹⁵² *Id.*
- ¹⁵³ *See supra* Section V, B, 1.
- ¹⁵⁴ *See supra* Section V, B, 2.
- ¹⁵⁵ Plsek, *supra* note 12.
- ¹⁵⁶ *See, e.g.* Aaron, *supra* note 14, at 802.
- ¹⁵⁷ *See id.*