HEALTH ADMINISTRATION COSTS IN THE UNITED STATES ARE TOO HIGH: A PROPOSAL TO REDUCE ADMINISTRATION COSTS AND LOWER THE UNITED STATES EXPENDITURE ON HEALTHCARE.

by

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Contents

INTRODUCTION

America is cited by the Institute of Medicine to be the "only wealthy, industrialized nation that does not ensure that all citizens have coverage"(16). In the United States most hospitals or facilities are owned and operated by the private sector. The private sector is not controlled by the state and the goal is to make a profit. Not only does the private sector own and operate facilities, it also provides the most common method for paying for the use of such facilities- health insurance. Health insurance is an insurance that pays for medical expenses, and is the common method of paying for care. An average family health insurance policy now costs about $13,000 (Fritze). It is no surprise that at least 15 percent of the U.S population is uninsured (Walt-DeNavas, Proctor, and Smith). For these people, mostly poor, old, children and veterans, the government provides Medicare, Medicaid, and Child Health Insurance Program (CHIP). Despite failing to provide healthcare coverage to all citizens, the nation still spends the most money per person on healthcare compared to every other nation.

In the United States approximately 60 percent of the population have private insurance, the rest of the population are either uninsured, on a government program, or non-group insurance (Collins, Nicholson, and Rustgi). The United States has thousands of health insurance companies, and with this volume comes a considerably substantial administration overhead cost. In other countries such as the United Kingdom, all citizens are covered by a single source-the government. The costs of administration in America is far greater than any nationalized or single-payer health insurance systems such as the system in Canada. Administration costs constitute a surprising percentage of our nation's healthcare and health insurance expenditure.

Today, American healthcare administrative costs are exorbitant due to inefficient and outdated administration in both the private insurance markets and hospitals. As possible alternatives to lower the cost of healthcare administration, this paper proposes the creation of a new standardized insurance administrative body, and the mandatory integration of electronic record keeping practices in hospitals and insurance billing industries.

The nation spends approximately 31 percent of its healthcare expense on administration functions. More specifically, health insurance companies on average spend 12 percent of customers' premiums on administration (Woolhandler, Himmelstein, and Campbell 768-775). American healthcare administration costs nearly doubles that of Canada. While administrative expenses have shifted from claim adjusting and general administration, companies are now spending more on underwriting, utilization reviews, medical management, nurse help lines, and negotiating fees with hospitals. Health providers such as hospitals and physicians are not immune to spending unnecessarily on administration costs either. In fact, a study of the hospitals in California found that 20-22 percent of hospitals private insurance spending was on billing and insurance related issues (Kahn, Kronick, Kreger, and Gans 1629-1639).

It is clear that administration costs in the United States is an unnecessary and wasteful expense. In this paper, I will analyze the source of administration costs, and propose an alternative that will help decrease these expenses. In the first section, I will define health administration costs and identify the source of our nation expenditure on administrative tasks. I will then discuss the private insurance sector, and how they accumulate administration costs. Next, I will explain how hospitals and health providers

spend unnecessarily on repeated medical procedures, billing and insurance related issues. After establishing where the source of our administration problem comes from, I will then provide two alternatives that will lower administration costs. The first alternative would develop a new outside body or entity that would be tasked with streamlining administration costs of health insurance companies and hospitals. The second will suggest the mandatory integration of electronic medical and billing systems that would digitalize patient's medical records and medical bills. At the end of this analysis, the reader will have a better understanding of the importance of reducing administration costs, and an easy alternative to accomplish this goal. The reader should also gain knowledge of how these costs can be drastically and realistically reduced without total overhaul.

BACKGROUND

In the United States, the debate over healthcare has been heard in various congresses and is currently underway in the Senate. Despite their differences in opinion, the one recurring issue for policy makers is the high cost of our healthcare system. The challenges facing our healthcare system are dynamic, and no single solution can solve such a challenge. Addressing the source of healthcare costs is another issue of magnitude, but the fact that almost a quarter of our healthcare expenditure goes to administrative functions instead of the actual service provided to patients, adds to the complexity of our inefficient healthcare system. Though the U.S. healthcare system is considered to be one the most technologically advanced in the world, it is also the most expensive. According to the World Health Organization's (WHO) ranking of healthcare

systems in the world, the U.S. ranked 37th out of the 191 ranked countries. France leads the world in health systems rankings and countries including Dominica, Chile, and the United Arab Emirates ranked higher than the United States (196). It is important to note that the WHO uses expenditure as one of its ranking criterion, and expenditure in the United States health system is extremely high. Despite these expenses, America is estimated to rank 50th out of the 223 ranked nations in life expectancy (162). Citizens of Hong Kong, Jordan and Singapore are estimated to live longer than Americans. From these statistics we see that even though more money per person is spent on healthcare in the United States than any other country, our health results are similar to that of third world countries such as Chile.

Other countries such as the United Kingdom and Germany spend far less per capita on healthcare costs than the United States, and yet can boast of better health results than Americans can. In addition to poor rankings in life expectancy, America also ranks 46th out of 224 ranked nations on infant mortality rates. Fewer infants die in countries such as Cuba, Taiwan, and Guam than in the United States. The WHO uses an analytical framework derived from Murray and Frenk, leading health economic experts and WHO advisors that developed intrinsic and instrumental goals of a health system. They use the intrinsic goals including the goal of fairness in financing and financial risk protection (28). The United States expenditure on healthcare is by far the most compared to other nations. Our nation spends the largest percentage of its GDP on healthcare, spending about 17.6 percent of the nation's income on healthcare (188). Expenditure is partially the reason the U.S ranks so poorly in world health system rankings.

Administration costs can be defined as the cost of delivering insurance benefits, whether through private insurance or through government programs like Medicare. Administration costs are essentially made up of three types of costs. First, there is the cost of purchasing medical goods and services or reimbursing insurance beneficiaries for such purchases from health-care providers. Second, there are the costs of operating the respective insurance systems or purchasing goods and services that are not necessarily "medical" in nature, but that are necessary for the delivery of insurance benefits. An example is the cost of management or "administration" when defined loosely, which clearly is not a medical service, but without "administration," such a system of insurance could not operate. Finally there may be separate and additional costs or what economist would refer to as, "real resource" costs, whether incurred privately or publicly, necessary for the operation of a given insurance company and for the delivery of insurance benefits to patients.

Although administration activities are sometimes thought of as "waste," some administrative effort is needed and desirable in a well-functioning system. Hospitals are complex organizations, and administrative effort is needed to use inputs efficiently and produce good outcomes. Of recent, many physician practices have moved toward a larger medical groups and administrative effort is required to assure that the groups' functions efficiently. Administrative activities here include the work of the office manager, the receptionist, the billing staff, the information technology experts, and other personnel not directly contributing to the hands-on care of patients.

LITERATURE REVIEW

There is a wealth of scholarly contributions on various topics that can be used to analyze the costs of healthcare administration. Any credible work or research would have to draw from a 1999 analysis of healthcare administration costs in Canada and in the United States. To estimate the United States and Canada's health administrations cost, Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D., calculated the administration costs of health insurers, employers' health benefit programs, hospitals, practitioners' offices, nursing homes, and home care agencies in 1999. In their 2003 article, *Costs of Healthcare Administration in the United States and Canada,* they analyzed published data; surveys of physicians; employment data; and detailed cost reports filed by hospitals, nursing homes, and home care agencies. In calculating the administration share of healthcare spending, they excluded retail pharmacy sales and a few other categories for which data on administration costs were unavailable. Finally they used census surveys to explore trends over time in administrative employment in healthcare settings. Their findings, which I will discuss in the "Analysis" section is cited in over 30 scholarly articles and is predominantly used as a reference point to any scholar performing research in the field.

Some scholars have disagreed with Woolhandlers definition of "healthcare administration costs." Dr. Robert Book, a senior research fellow in Health Economics at The Heritage Foundation's Center for Data Analysis, claims that Medicare administration cost is higher, not lower than private insurance. Dr. Book feels that it is unfair to compare Medicare patients' administration costs to that of the private market, since patients are usually elderly, disabled, or have end-stage renal disease, and have higher

average patient care costs. He adds that the Center for Medicare and Medicaid Services estimate that administration cost range from 2.8 to 3.4 percent, but adding costs from other governmental agencies that support Medicare brings the total cost to about the 5.7 to 6.4 percent range. Despite this, the widely accepted fact is that Medicare and Medicaid have lower administration costs than private companies.

Woolhandler's and Books's works backbone this analysis because they help us define what a vast majority of experts classify as administration cost. Woolhandler et al. helps us define administration costs and separates these costs into three essential types of cost. An example is the cost of management or "administration" narrowly defined, which clearly is not a medical service, but without which a system of insurance could not operate.

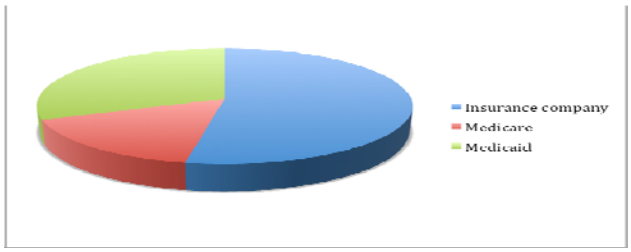
More recently, A Center for Medicare and Medicaid Services study estimated administration costs in the United States. The McKinsey Foundation also estimates administration cost of Medicare and private insurance companies. Through their research, they found how much was paid by each group: the consumers, employer based insurance and private insurance. Authors, such as Katharine Swartz, a professor of Health Policy and Economics at Harvard University, claims that small insurance groups spend a majority of their administration cost on underwriting. Public insurance's low administration costs can be linked to the absence of underwriting and profit. The Commonwealth Fund, in an analysis of the leading congressional reform bills, found how much health administration cost would decrease if everyone were covered through Medicare. They found that under all scenarios the nation would save over $265 billion over the next 10 years. The Commonwealth Fund, and the Center for Medicaid and

Medicare Services also have an abundant amount of information that relates to the objective of this paper. All the resources so far have supported my claim that change in our current handling of healthcare administration costs is needed, which in return will reduce the percentage of our GDP spent on healthcare.

These sources help strengthen the argument that eliminating underwriting, creating programs similar to a "single payer" health system, and reducing repeated medical procedures will drastically reduce health administration costs. These works support the goals of my recommendations, which are to reduce underwriting, repeated medical procedures, and utilization review complications, and these experts have suggested guidelines for such an alternative.

ANALYSIS OF POLICY

In 1999, Steffie Woolhandler and David Himmelstein found that in the United States private insurers dedicated $46.9 billion of the $401.2 billion they collected in premiums to administration costs. Their average overhead (11.7 percent) exceeded that of Medicare (3.6 percent) and Medicaid (6.8 percent) (See below chart).



Overall, public and private insurance overhead totaled $72.0 billion — 5.9 percent of total healthcare expenditures in the United States, or $259 per capita (Woolhandler, Himmelstein, and Campbell 768-775). This tells us that the public market operates with an efficient administration costs, while the private market struggles with administration costs.

Insurance Administration Costs

In order to understand my policy alternatives for this issue, it will be important to first establish the difference between how administration cost is incurred and how it is distributed. According the Center for Medicare and Medicaid Services, in 2007 approximately $96 billion of the total $156 billion spent on administration costs in the United States were paid by consumers and employers to private insurance companies in the form of their premiums. The remaining 40 percent came from federal, state, and local governments' administration cost to provide programs such as Medicare and Medicaid. In the private insurance industry there are three different markets: large employer groups, small (50 or less) employer groups and the individual market (See Appendix A). Experts say that because carriers selling policies in the small-group insurance and individual markets do not have a complete analysis or information about their potential customers' health, they invest a significant amount in attempting to figure out risks of such consumers. Underwriting, or determining if premium revenues will exceed expected cost, is a "major source of expense for these types of markets" (Swartz 283-287).

Public insurance's low administration costs can be linked to the absence of underwriting and profit. For example, the McKinsey Foundation estimates that administration costs only account for 2 to 5 percent of Medicare premiums unlike the private companies who devote 5 to 40 percent of premiums to administration costs depending on market and state. The Commonwealth Fund also found that covering everyone through Medicare could reduce the expenditure on administrative cost by $55 billion annually (Collins, Nicholson, and Rustgi).

From Dr. Woolhandlers and Himmelstein, we see that a system such as Canadas', that covers its entire citizens with a "single payer" plan, have lower healthcare administration cost than the current U.S. healthcare market. "The gap between the United States and Canadian spending on healthcare administration has grown to $752 per capita. A large sum might be saved in the United States if administration costs could be trimmed by implementing a Canadian-style healthcare system" (Woolhandler, Himmelstein, and Campbell 768-775). If no actions are taken, it is estimated that by 2018 administration cost expenditure would be as high as $315 billion (See Appendix B). In order to cover a patient's stay at a hospital, the communication between an insurance provider, and a hospital can become. For example if a hospital has patients from 20 different carriers, then 20 different forms may need to be completed, or 20 different utilization reviews may need to be performed. Outside the United States, single-payer health insurance systems "collects all medical fees and then pays for all services through a single government (or government-related) source" (Slee, Slee, and Schmidt 106).

Underwriting is an expenditure seen only in the private sector of health insurance. There has yet to be a universal ranking or way to uniformly "label" the insurability of a patient. Insurance companies do not have a database or a scale that put a risk on each of their customers without performing expensive tests on the customer. This leaves carriers in the small group and individual insurance markets, less competitive. The idea of electronic medical records can be an efficient and useful tool in determining a customer's health. Eliminating underwriting is essential to any successful policy. Opponents of EMR claim patients right are threatened by the digitalization of their medical records, keeping this in mind it is important to note that one of the main goals of my policy

recommendations is to make sure that patient's rights are always protected, while lowering costs.

Providers Administration cost

Providers such as physicians and hospitals have their own set of administration costs. "Hospital administrative costs in the United States are higher than previous estimates and more than twice as high as those in Canada. Greater enrollment in HMOs, with more competitive bidding by hospitals for managed-care contracts, an important element of proposed managed-competition health care reforms, does not seem to lower hospital administrative costs" (Woolhandler, Himmelstein, and Lewontin 400-403). Billing and Insurance Related activities (BIR) account for the major part of providers' administration expenditure. "BIR is the method setup to move money from payer, *i.e. insurance companies* to provider, *i.e. hospitals* in accordance with the agreed-upon rules, *i.e. utility review*" (Kahn, Kronick, Kreger, and Gans 1629-1639). The total annual practice administration cost per physicians was about $68,000 (See Appendix C).

Administration tasks in hospitals can be separated into two main categories. First are BIR functions, secondly are all other functions that have the purpose of general management, measuring and improving health quality. For some functions, making a clear distinction is easier said than done. For example, the extent that provider contracting at an insurance company is an effort to identify and contract with high-quality providers, can be considered as part of quality improvement. On the other hand, the effort that is directed at reaching agreement on payment for services would fall under BIR.

Experts have conducted analysis that estimate the fraction of healthcare spending for hospital and physician care in California that is devoted to BIR activities. The study analyzed BIR cost from three sources: private insurance, physicians' offices and hospitals. The study discovered that in California acute care hospitals, 20.9 percent of revenue was spent on administration. BIR administration accounted for approximately 11 percent of that spending (Kahn, Kronick, Kreger, and Gans 1629-1639). Thus, BIR accounts for an estimated 30-50 percent of a hospital administration costs, the largest category in hospital administration. This analysis shows us that administration costs in California hospitals are extremely high, and sometime unnecessary. We can use this study as a guide, because it is assumable that California is not the only state affected by the high costs of BIR. Many States would benefit from streamlining and digitalizing the billing process in order to allow savings in administration costs.

Another reason that health insurance can not continue to operate at its current market is the abundant amounts of waste that the individual and small market groups incur that can be transferred back into the economy. Individual insurance providers devote 40 percent of premiums to administrative tasks, and small groups market devotes 25-27 percent, while large employer groups devote 5 to 10 percent (Schoen, Karen, and Collins 646-57). Medicare devotes only about 3 percent, which brings us to the one clear difference between the private market and Medicare, the absence of underwriting. Hence, any policy alternative should incorporate reducing or eliminating the need for underwriting. To further make this argument concrete is a recent findings by the Congressional Budget office (CBO) that finds that the administration costs under the public Medicare plans are less than 2 percent of expenditure, compared to about 11

percent of the spending by private plans under Medicare Advantage ("Designing a Premium Support System for Medicare "). Medicare Advantage is the same program offered by the government, but administered by the private sector. This is a perfect comparison of administration costs, since the public Medicare plan and Medicare Advantage plans are governed by similar rules and deal with the same population (See Appendix D). Therefore, any alternative would need to reduce or eliminate communication between multiple carriers that further complicate the system.

POLICY RECCOMENDATIONS

Before any policy can be developed, the stakeholders will first need to be identified. Primarily the stakeholders in my policy alternatives include: private insurance companies, public taxpayers, American citizens, medical technology industries, governments and policy makers. There are three goals of any suggested alternative: streamline the healthcare administrative process, determine a standardized utilization review for all insurance companies, and reducing the expenditure on healthcare in the United States as a whole. Below, I will present two recommendations; the first will create a standardized insurance administrative body that will eliminate underwriting costs to insurance companies. The second recommendation will be the mandatory integration of electronic record keeping in hospitals and the insurance billing industry that will reduce administrative waste in hospitals.

Administration Body

The first alternative to reduce health administration costs is to develop an outside agency or bureau, governed by the health department of the federal government, that would consolidate all individual, small and large employee group markets into one. This agency would handle all utilization reviews and create a standardized process for hospitals to follow. Utilization review (UR) is the process used by employers or insurance companies to review treatment to determine if it is medically necessary. With a law that requires the individual and small market to not deny coverage due to pre-existing conditions, this alternative effectively streamlines the healthcare administrative process. The administrative rigor of interacting with various carriers would be streamlined into one body. Financially it will be beneficial for the both sides, since the private market would reduce its administration costs significantly, while being able to focus on the quality of service provided. Overall there will be a transfer of wealth from the various insurance companies to the economy. This savings can in turn be spent on improving the overall health of Americans.

While how members of the agency are selected is important, it is not as essential as the goal of decreasing the burden of health administration cost on our healthcare system. It is known that physicians and hospitals spend a fair share of time and money with billing issues, but the savings from addressing only issues with billing would cause minimal impact on the excessive expenditure on administration. For this reason, streamlining the UR process into a standardized process that this agency can be held accountable for, will be best at achieving the purpose of this alternative. This issue is difficult for healthcare consumers to easily adapt to since it deals with sensitive issues

about a patients care. Once the public understands that the insurance companies use utilization review as a way to compete in the market, rather than the patient's best interest at the core of the decision, the public will be more receptive of the benefits of my proposed bureau.

The U.S Department of Health and Human services has an agency that is dedicated to research on healthcare quality, cost, outcomes, and patient safety. The Agency for Healthcare Research and Quality (AHRQ) can collaborate with my proposed agency to determine a nationally accepted guideline to treatments. Allowing a national guideline that can be renegotiated annually to consider new findings or research would ease the strain of administration on our healthcare system. The mandatory integration electronic medical records and electronic billing systems would make the mission of the body easier by providing access to cost of treatment, and patients treatment history, to best determine what is standard. I will discuss this alternative in the latter part of this paper.

United Kingdom citizens get their health insurance through a National Health Service (NHS), a publicly funded healthcare system. The NHS provides healthcare to anyone normally residing in the United Kingdom with most services free at the point of use. The NHS in England is controlled through their Department of Health, and local management or administration of care has been relegated to a particular authority called the NHS primary care trust (PCT) ("About").

This version of the United Kingdoms' body can be compared to my proposed body for us here in the United States. The PCT administers primary care and public health to British citizens. The PCT oversees 29,000 general practitioners and 18,000 NHS dentists, and commission service from other providers. A team of Executive Directors headed by

a Chief Executive manages all PCTs. These directors are members of the Trust's Board, together with non-executive directors appointed after open advertisement. The Chairman of the Trust is a non-executive director. Other board members may include representatives from the Trust's Professional Executive Committee (PEC) elected from local general practitioners, community nurses, Pharmacist dentists etc. This is a good example, of how the United States should structure the proposed administration body.

From our earlier discussions we are able to assume that the United Kingdom would have lower administration costs, since most of its citizens are covered by one program. Experts have agreed that the more participants in a healthcare system, the cheaper it is to administer such a system. In a similar study to that of Woolhandler et al, Rowena Jacobs, a U.K Department of Health policy researcher estimated that PCT's spend only 1.3 percent of total expenditure on administration, and U.K hospitals spend only 4.0 percent on administration (Jacobs, Martin, Goddard, Gravelle, and Smith 211-17). These rates are significantly lower than Woolhandler et al estimation of the U.S expenditure of about 25 percent on administration in hospitals and 17 percent for the insurance providers.

How money is saved and who saves money is what is most important in this policy alternative. Hospitals, nurses, physicians, patients and the insurance companies are all involved in the process of a utilization review. Relieving the burden on these individuals will save money to each of the industries that hire these individuals. Understanding utilization review is complex since the American Board of Medical Specialties (ABMS) represents the vast majority of medical specialties with 24 members. The ABMS is a not-for-profit organization made up of a 24 member boards that certify

physicians in a wide variety of medical specialties. The ABMS does not itself certify physicians, but rather is the umbrella board that establishes standards and provides information, support and guidance to its Member Boards. This means that there would need to be at least 24 different specialties to develop standards for. Within those specialties are also numerous diagnoses that may need to be standardized. The ABMS will be another crucial collaboration for the proposed body.

The small and individual markets of the insurance company may lose its ability to compete in the market, since they will no longer be single-handedly responsible for determining the length of hospital stays and other utilization information. The savings that these industries would accomplish, from not having to hire people to research nearly 24 different specialties, and communicate to hospitals and physicians would provide the incentives that the companies need to give up that particular form of competition. They can use this money to improve on quality of their service. Hospitals and Physicians also save money from this proposal because they would need less underwriting nurses and individuals to communicate with different carriers. These savings can be put back into running a more efficient organization. Overall, the U.S will lower its current expenditure on health administration from about 20percent that it is now. For these reasons, a standard body that handles utilization reviews for all insurance companies in the nation will reduce our health administration costs.

Electronic Medical and Billing Records.

The second alternative that can be financed by the savings of consolidating administration to one entity is the development of electronic medical records (EMR) and billing software (EMB) that can be properly distributed to all providers and hospitals. The Veteran Affairs (VA) hospitals have developed a protocol system that has proven to be successful. An essential reason that EMR and EMB have failed to become widely adopted by physicians and hospitals is the lack of interoperability between the current softwares. The FCC defines interoperability in healthcare as the ability of different information technology systems and software applications to communicate, to exchange data accurately, effectively, and consistently, and to use the information that has been exchanged ("Tech Topic 1" Interoperability ").

Another setback for physicians and doctors is the financial investment in the hardware and software required for EMR. They end up yielding a "positive externality" for the insurance companies. With EMR, insurance companies are better able to access a patient's risk, by having an exact account on the patient's medical records. If this policy is to be effective, any insurance company's ability to deny "due to previous conditions" would have to be abolished, and insurance companies would have to accept everyone. Though this would not eliminate underwriting, electronic medical records available to all insurance companies, with consent from the patient, will allow companies to best determine risks. The government might look to implement a "price cap" on what insurance companies should charge the riskiest patients. As mentioned earlier, EMR and EMB will give insurance companies and the government a strong resource to base policies and recommendations on utilization reviews.

The alternative to gradually switch our healthcare system to function with the use of EMR and EMB will be a vital step to achieving lower administration costs. A realistic example of how this would work is to imagine a Medicare patient who has their record digitalized and accessible at any hospital. Any procedure the government has assisted in paying for is also digitalized; therefore the physicians will be aware and may not have to repeat the procedure. The insurance companys' benefit because they can be billed electronically, and price negotiation may be likely to occur, as now the cost can be tracked nationally.

The incentive to this policy is to remove the start up costs from the hands of the physicians and insurance companies, who are not likely to invest, since the biggest "gainer" is difficult to determine. This change saves every stakeholder in the health industry money, from the insurance companies to the government. If the insurance companies agree to join the administrative body, they will have access to the re-standardization of health technology. In the same way television was brought to the digital era in 2009, so should healthcare administration, record keeping, and billing. America's health system is affected by wasteful spending, lack of preventive care, and objective pricing on care. All three of these issues can be addressed with the implementation of standard EMR and EMB across all hospitals in the nation. Wasteful spending would be reduced and eventually eliminated because a record of previous tests and their results would be available at every patient visit. Preventive care would be easier to maintain, since physicians can get reminders through the digital record of what preventive measures a patient may need. Nurses and nurse's aids can then call, email or send letters to patients until the measure is done. The electronic billing system would

allow the insurance companies to bargain with physicians that provide service at a competitive price since pricing trends would be also digital.

The impact of electronic medical records has been analyzed by plenty of experts and there are opposing views on the realistic overall improvement in mortality, costs, and hospitals length of stay. It is important for the reader to be aware that in evaluating benefits or impact of EMR, a particular condition of a patient would have to be identified and tracked. In order to evaluate the effectiveness of EMR, an evaluator may for example look at how a heart condition patient whose physician uses EMR responds to their doctors electronically ordering medication, test, therapies and other clinical decisions. Porter Research, a healthcare information technology industry research firm, found in an analysis that improvement in "Patient Safety" and "Physicians Access to Clinical Information" were the highest ranked implementation goals ("EMR Implementation In Community Hospitals: Critical Factors for Success"). This will be a good starting point to begin to measure the impact of EMR.

In a retrospective cross-sectional study to examine the association between EMR and inpatient mortality, complications, cost and length of stay in four medical conditions, the authors found that "among the conditions sampled, improving EMR sophistication may be associated with improvements in mortality, complication rates and costs" (Amarasingham, Plantinga, Diener-West, Gaskin, and Powe 108-14). Complete clinical data were available for 167,233 patients, and 41 of the 72 hospitals were included in the analysis based on sufficient survey response. Patients less than 50 years of age who were admitted with myocardial infraction, congestive heart failure, and coronary artery bypass grafting, and pneumonia were the characteristics of the sample.

The researchers concluded that hospitals with higher EMR automation scores had lower odds of inpatient mortality overall. The EMR automation scores were derived from a combination of electronic notes and records, decision support, order entry, and results reporting. According to the study, having the EMR to make more sophisticated decisions, to enter orders for medication, therapy, etc, and reporting the results of those orders were all linked with lower hospitals costs.

In another analysis in 2002, researchers performed a cost-benefit study to analyze the financial effects of EMR system in ambulatory primary care settings from the perspective of the healthcare organization. The primary outcome measure was the net financial benefit or cost per primary care physicians for a 5-year period. They found that the net benefit from using EMR for a 5-year period was a savings of $86,400 per provider. These savings came in drug expenditures, improved utilization of radiology tests, better capture of charges, and decreased billing errors (Wang 397-403).

CONCLUSION

Health administration costs in the United States as defined by Woolhandler et al. are problematic. It is unacceptable that the United States spends 31 percent of its healthcare expense on administration tasks. Insurance companies spend about 12percent of customer's premium on administrative function. Hospitals in California spend between 20-22 percent of their private insurance budget on billing and insurance related issues.. These administration costs adds to the high expenditure on healthcare in the United States, and is partially the reason that our nation ranks 37th out of the 191 ranked countries on the World Health Organization rankings of healthcare systems.

When we compare the United States healthcare system, to that of other countries such as Canada and the United Kingdom, it is clear that the difference is the United States does not cover its entire population under a single payer plan. Insurance companies have to spend money on underwriting, and hospitals spend money to communicate with the insurance companies or performing utilization review. Plenty of the United States healthcare problems can be attributed to the lag of digital progression and fragmentation in the insurance industry.

In this paper, I proposed two recommendations that if enacted properly will efficiently reduce heath administration costs in the United States and ultimately reduce expenditure on healthcare. I recommend the establishment of a standardized insurance administration body, which would be tasked with utilization reviews. I also recommend the mandatory integration of electronic medical and billing systems, to reduce administration tasks, and repeated medical procedure for the healthcare provider. The

benefits of both recommendations have been well documented by research and similar body's exists in other countries.

I look forward to better understanding how this board can further drive down administration cost, it is my goal to eventually reduce cost of administration to about 7 percent of our healthcare expenditure. I feel there needs to be further discussion on EMR and EMB and how it affects the insurance companies to compete if every company has access to the records. I strongly believe that banning any denial due to "pre-existing" conditions is a way to limit any manipulation of this technological advancement.

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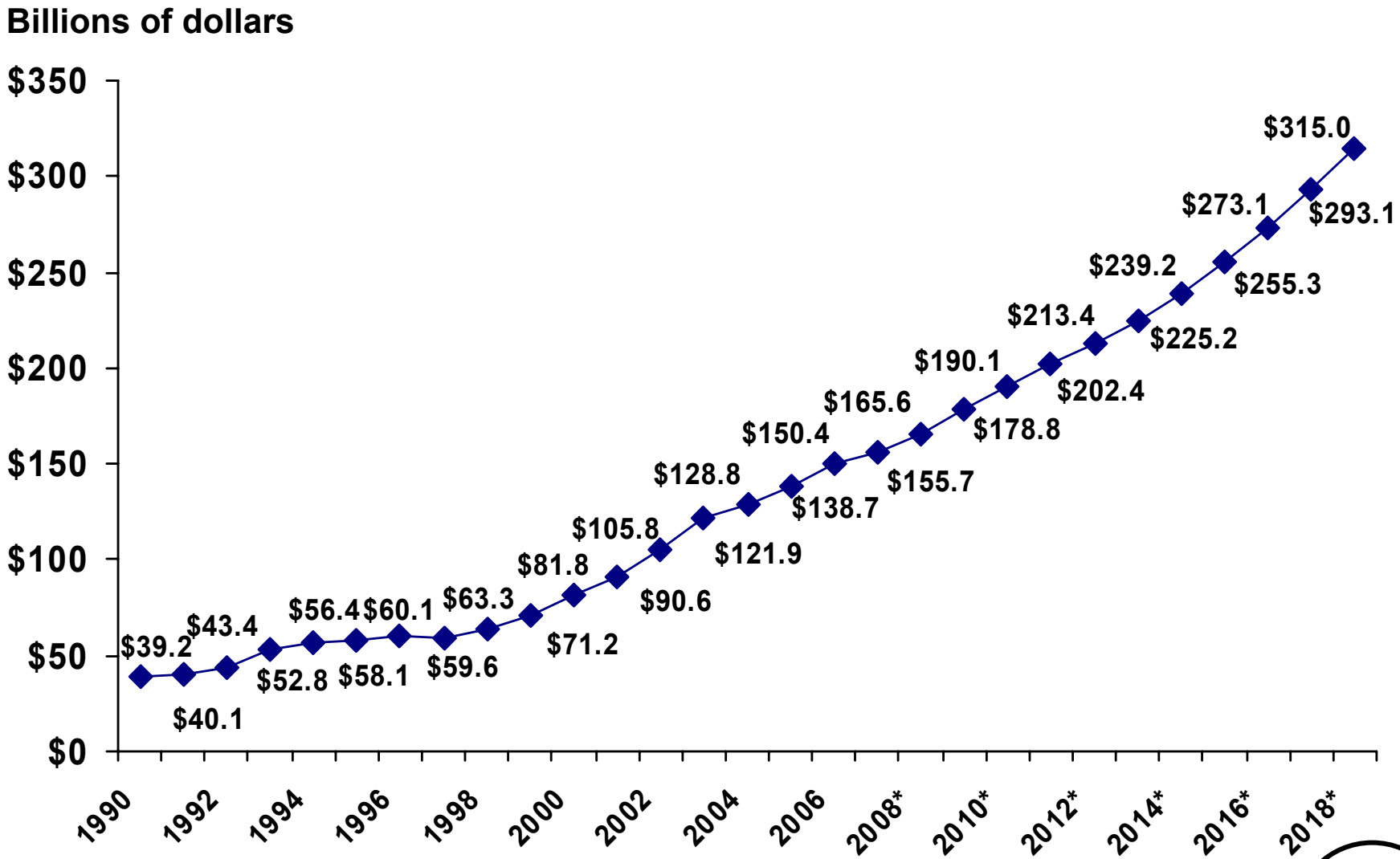
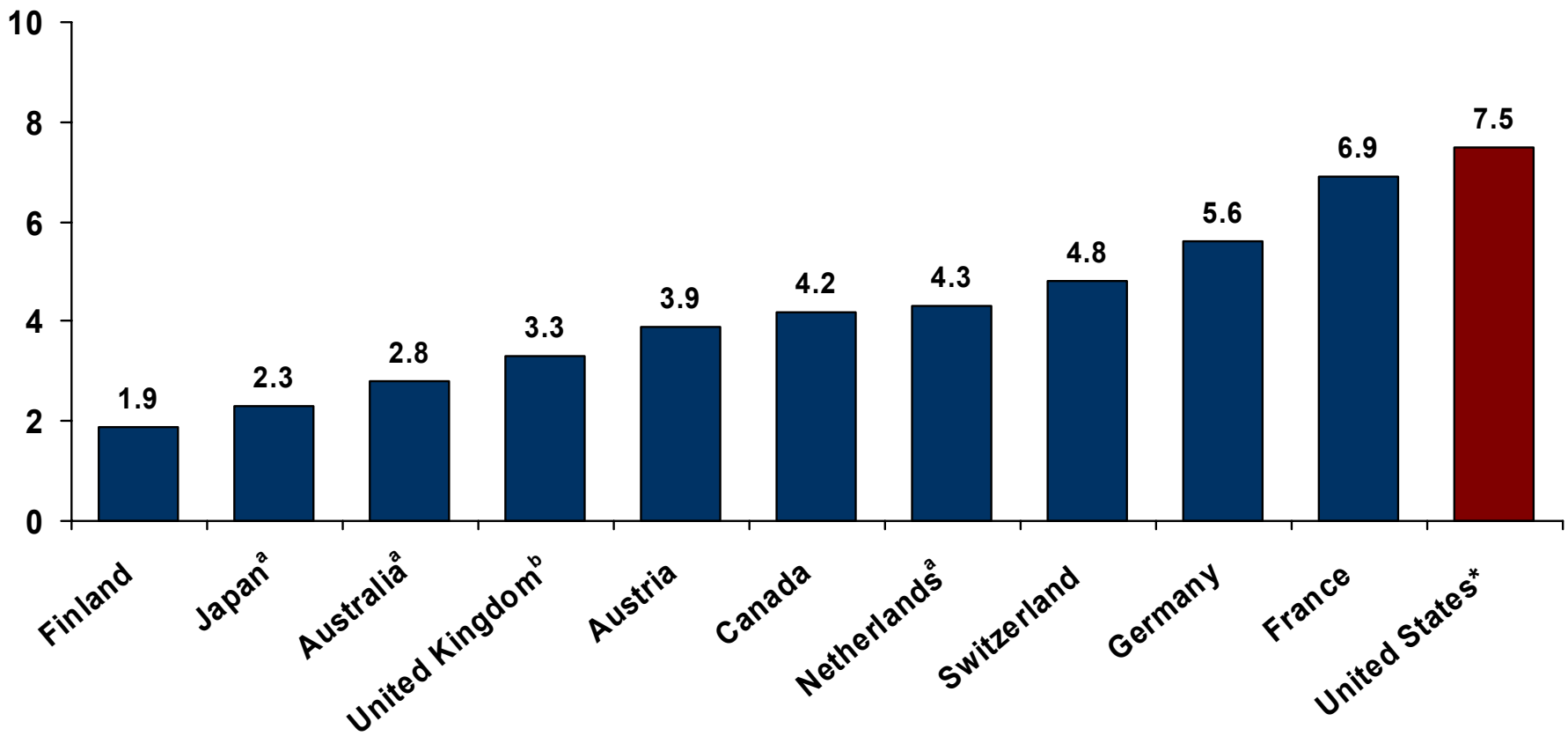
Exhibit 1. U.S. National Health Expenditures on Private Health Insurance Administration and Public Program Administration, 1990–2018



* Denotes projected expenditures, as calculated by the Centers for Medicare and Medicaid Services.
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/e (see Projected; NHE Historical and projections, 1965–2018, file nhe65-18.zip, Administration and Net Cost of Private Health Insurance).

THE COMMONWEALTH FUND

Exhibit 2. Percentage of National Health Expenditures Spent on Insurance Administration, 2005



[a] 2004 [b] 1999

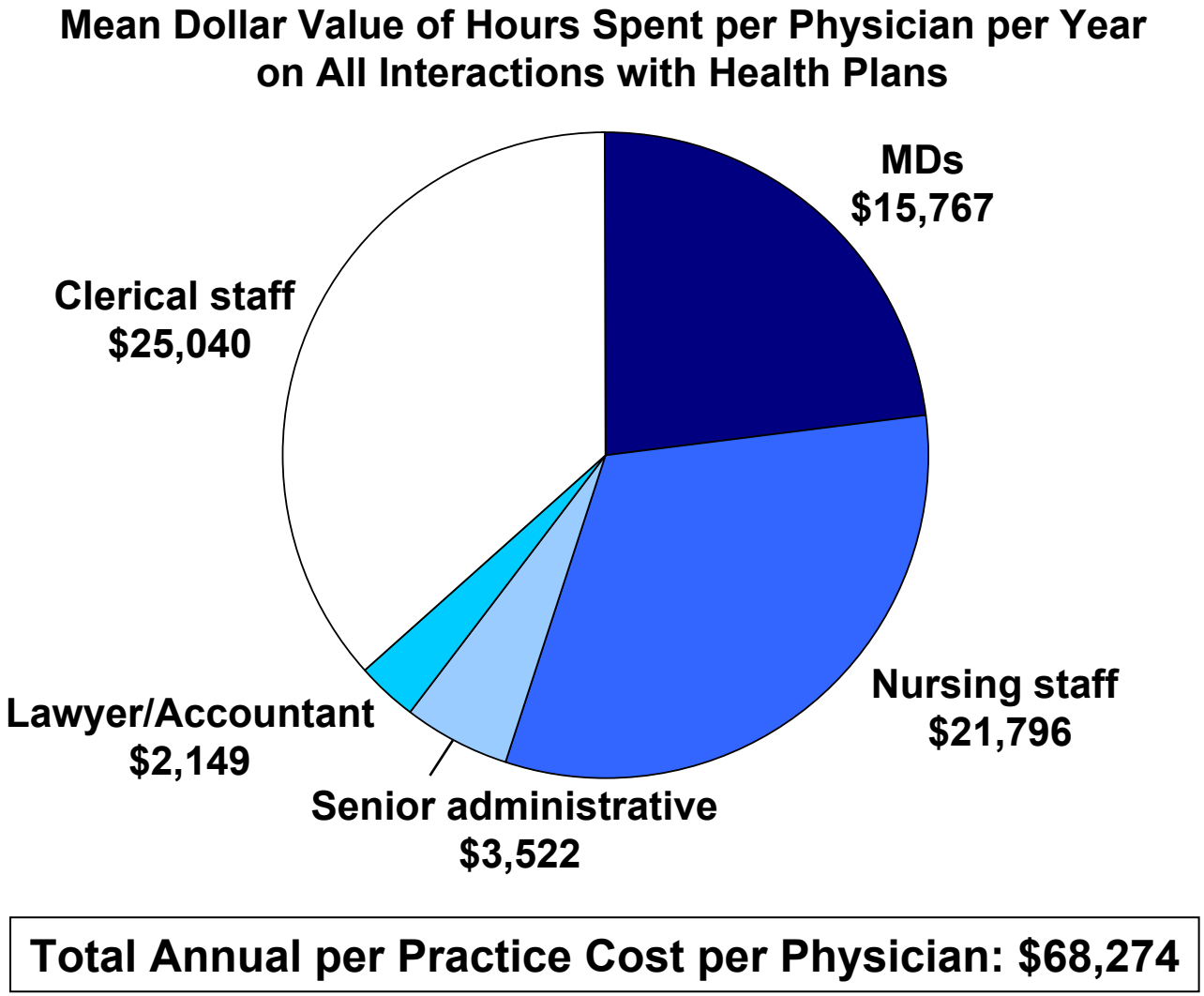
* Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

Data: OECD Health Data 2007, Version 10/2007.

Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008).

THE COMMONWEALTH FUND

Exhibit 6. Total Annual Cost to U.S. Physician Practices for Interacting with Health Plans Is Estimated at $31 Billion[1]



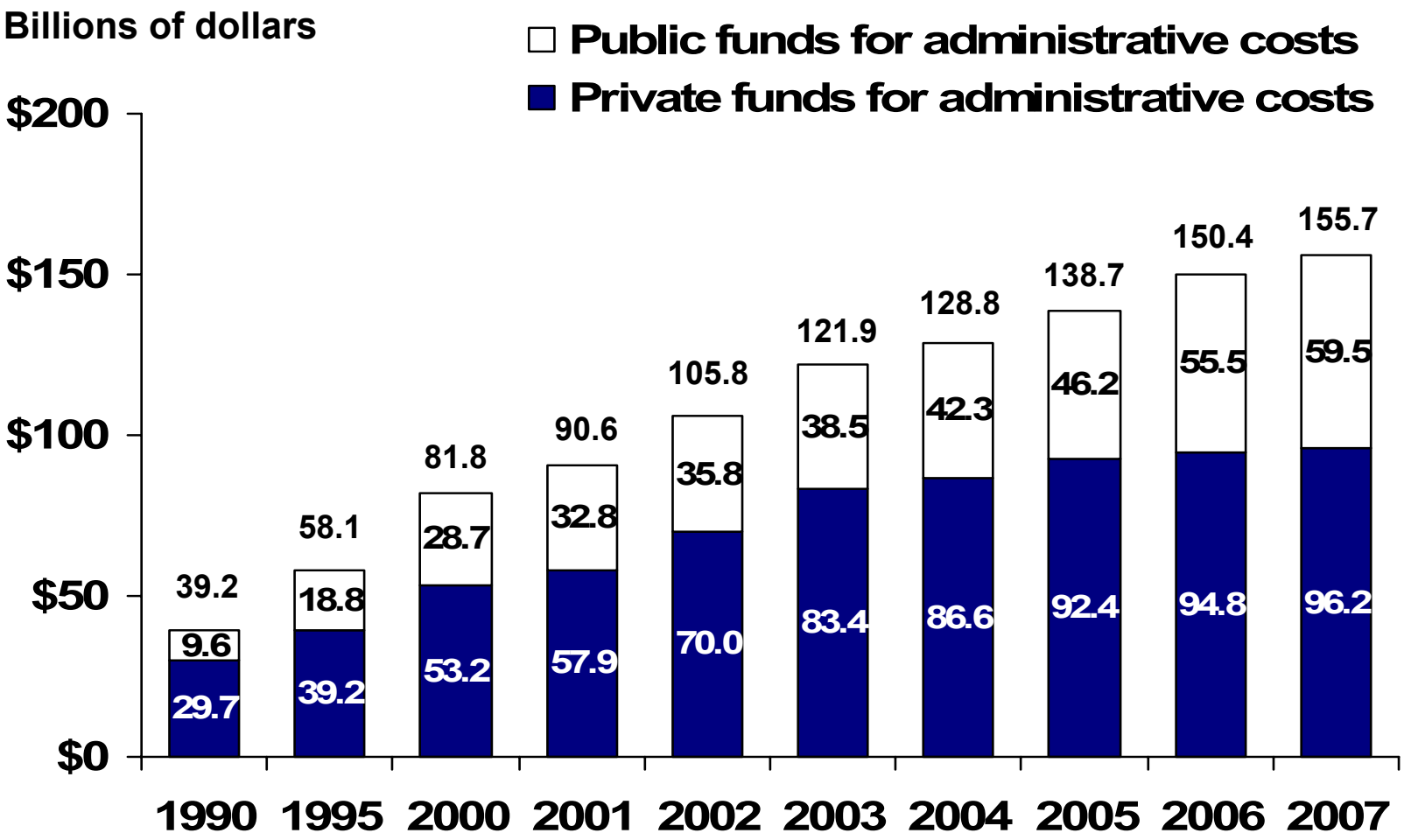
Total Annual per Practice Cost per Physician: $68,274

[1] Based on an estimated 453,696 office-based physicians.

Source: L. P. Casalino, S. Nicholson, D. N. Gans et al., "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009, w533–w543.

THE COMMONWEALTH FUND

Exhibit 3. U.S. National Health Expenditures on Private Health Insurance Administration and Public Program Administration, by Source of Funds



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/e (see Historical; NHE by type of service and source of funds, CY 1960–2007, file nhe2007.zip, Administration and Net Cost of Private Health Insurance).

THE COMMONWEALTH FUND