findings brief

Compared to Canadians, U.S. Physicians Spend Nearly Four Times as Much Money Interacting with Payers

key findings

- In Canadian office practices, physicians spent 2.2 hours per week interacting with payers, nurses spent 2.5 hours, and clerical staff spent 15.9 hours. In U.S. practices, physicians spent 3.4 hours per week interacting with payers, nurses spent 20.6 hours, and clerical staff spent 53.1 hours.
- Canadian physician practices spent $22,205 per physician per year on interactions with health plans. U.S. physician practices spent $82,975 per physician per year.
- U.S. physician practices spend $60,770 per physician per year more (approximately four times as much) than their Canadian counterparts.

Introduction

As policymakers continue to look for ways to bend the cost curve, many have pointed to the administrative costs of health care in the United States as one potential target for reform. Physicians' interactions with health plans create an enormous cost burden on the system. As they function within a multi-payer system in the United States, physician practices have to coordinate with Medicare, Medicaid, and a multitude of private insurance plans. Complicating the process is the fact that many health plans require compliance with complex and highly structured processes for billing, submitting claims, and prior authorization for specialist visits, diagnostic imaging, and hospital services.

In a HCFO-funded study, led by Lawrence Casalino at the University of Chicago (now at Cornell University), the research team used a survey of U.S. physicians and practice managers to develop a national estimate of the administrative costs for U.S. private physician practices generated by their interactions with multiple health plans. In 2009, Casalino and his team published findings that estimated that at least $31 billion is spent annually in the United States on physicians', nurses' and other staff's interactions with health plans.[1] Building on his 2009 work, Casalino's team and Canadian colleagues Dante Morra and Wendy Levinson at the University of Toronto implemented a similar survey in Canada to create a comparison between administrative costs in the United States and those of a single-payer system like Canada. The results of this comparison, with Dr. Morra taking the lead, were published in the August 2011 issue of *Health Affairs*.[2]

"We included Canada in our study because we wanted to get a sense of the cost to physician practices of interacting with a multi-payer system of health insurance," said Casalino. "A simple way to do this is to compare the costs to U.S. practices of dealing with multiple

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payers to the costs to Canadian practices of dealing with a single payer."

Methods

The study sample included a randomly selected group of 423 physicians in Ontario, Canada (150 family physicians, 180 specialist physicians, and the business managers of 93 large group practices). Ontario was selected because approximately one third of the population of Canada resides in this province and their health care system is generally representative of the Canadian system. Of those 423 selected physicians, 114 were excluded. Insofar as the study focused only on physicians in office-based practice, those based in hospital or academic practices were not considered. Similarly, the sample did not include physicians who functioned mostly outside of the single-payer system by receiving self payments (namely cosmetic surgeons).

The surveys distributed in Canada included identical questions to the surveys distributed in the United States, although questions that were relevant to only the U.S. health care system were excluded (e.g., prior authorization). Two surveys were distributed, one to physicians and the other to practice business managers. The physician survey approximated time spent by individual physicians and staff working directly with them interacting with payers (direct physician time), while the administrator survey approximated time spent by staff working at the practice level (practice-wide time).

Total time spent by each physician and category of staff interacting with payers was calculated by adding total time per physician to practicewide time divided by the number of physicians in the practice. Total time per physician was converted to dollars per year by multiplying time by each individual's average hourly wage. Canadian costs were adjusted using the purchasing power parity exchange rate for 2006 (1.21). Canadian estimates were adjusted and weighted to match the payment rates, practice size, and specialty mix of U.S. and Canadian respondents.

Key Findings

Of the 309 physicians who met the inclusion criteria, 216 completed the survey. The response rate was higher for the Canadian survey than the U.S. survey (78 percent overall adjusted response rate compared to 57.5 percent).

The researchers found that Canadian physicians spent 2.2 hours per week interacting with payers, nurses spent 2.5 hours, and clerical staff spent 15.9 hours. These numbers were substantially lower than those reported in the U.S. survey, which found that physicians spent 3.4 hours per week interacting with payers, nurses spent 20.6 hours, and clerical staff spent 53.1 hours.

The largest driver of the difference in time spent between U.S. and Canadian physicians and nurses was the need to obtain prior authorization. U.S. physicians spent an average of one hour per week obtaining prior authorization, and U.S. nurses spent 13.1 hours per physician per week. For clerical staff, the large difference in time spent interacting with payers between U.S. and Canadian staff can be attributed mainly to claims and billing tasks.

When converted into U.S. dollars and adjusted to reflect purchasing power and differences in specialty mix, Canadian physicians spent $22,205 per physician per year on interactions with a single payer. This number is approximately one fourth (27 percent) of the amount spent by physicians in the United States who interact with multiple payers ($82,975 per physician per year[3]). The adjusted difference in cost burden totals $60,770 per physician per year.

Study Limitations

The estimates of total time spent interacting with health plans by physicians and staff relied on self-reported survey responses, as opposed to direct observations. The researchers note that it would have been prohibitively expensive to collect such a large sample of data using direct observation.

Additionally, all the responses from Canada were collected from a single province, Ontario, which could affect the generalizability of the findings to the entire population. However, the researchers chose Ontario because it is the single most populous province in Canada, thus most representative of the entire population.

Policy Implications

The study's results identify a $27.6 billion potential for savings if the U.S. system could more closely align its administrative functions with Canada's. The greatest area for potential reduction is in the time that nurses and clerical staff spend interacting with payers, billing, and obtaining prior authorization.

However, higher administrative costs in the U.S. health system are not necessarily wasted dollars. A multi-payer system confers benefits, including competition and choice. Moreover, although not yet reliably calculated, cost savings may be achieved with a multi-payer system through efficiencies resulting from health plans' managing care for their beneficiaries. This is an area of potential future research.

The study provides useful and timely insight for policymakers. Interactions between physician practices and health plans could be more efficient in the United States. For example, standardizing transactions and conducting them electronically (as opposed to over the phone or via mail) could reduce the time spent on these activities by physicians and non-physician staff. A number of respected organizations[4] have recommended creating mandatory standards of interactions, making all standard interactions electronic, using a single credentialing process, using a single quality measurement process, and using automated verification of eligibility. These changes have the potential to reduce the administrative cost of health care in the United States.

The Patient Protection and Affordable Care Act (ACA) encourages a simplification of these interactions, and also supports different payment methods including

bundled payments and pay-for-performance. Moving away from a fee-for-service would reduce administrative burden, because individual claims for each service provided would not need to be filed with health plans. While the administration of care between the U.S. and Canadian systems differ, there are opportunities for U.S. physicians to achieve greater efficiencies and potential savings.

"We hope that our results will lead to intensified efforts to make interactions between U.S. payers and physician practices more efficient," Dr. Casalino explained.

Conclusion

Administrative costs are a significant driver of rising health care costs in the United States. U.S. physicians are spending approximately four times as much on administrative costs of interacting with health plans as their Canadian counterparts. While there are unmeasured benefits to a multi-payer system, evidence suggests there is potential for savings on health care costs by simplifying the interaction between health care providers and payers.

For More Information

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Endnotes

1. Casalino LP, Nicholson S, Gans DN, Hammons T, Morra D, Karrison T. What does it cost physician practice to interact with health insurance plans? Health Affair. 2009 Jul/Aug; 38(4): w533-w543.

2. For complete findings see Morra D, Nicholson S, Levinson W, Gans DM, Hammons T, Casalino LP. U.S. physician practices versus Canadians: spending nearly four times as much money interacting with payers. Health Affair. 2011 Aug. 30(8): 1443-1450.

3. The researchers explain that this figure is slightly higher than the figure reported in their original *Health Affairs* publication because the original figure included only interactions with private health plans. The updated figure includes interactions with private health plans, Medicare, and Medicaid.

4. The Institute of Medicine, The Massachusetts General Physicians Organization, UnitedHealth Group and the broad-based Healthcare Administrative Simplification Coalition.