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DEBATE-COMMENTARY

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Health care administrative burdens: Centering patient experiences

1 | INTRODUCTION

Policy makers, physicians, and health care providers often bemoan excessive administration in US health care. It costs a lot of money. Its frustrating for providers to navigate. One study found that physicians spent twice as much time on paperwork as they did with patients.[1] Dealing with these administrative hassles is a leading cause of physician burnout.[2]

While the growing administrative burdens that health care providers must negotiate is well documented, we know much less about patients' experiences. As a result, Michael Anne Kyle and Austin Frakt's "Patient administrative burden in the U.S. health care system,[3]" is welcome and necessary. They find that nearly one-quarter of those surveyed report delayed or foregone care due to an administrative task. Figuring out which forms to fill out, which doctors their insurer will allow them to see, what will and will not actually be covered, as well as getting pre-authorizations for covered care and arguing over bills, consumes patients' time, money, and emotional energy. Access to care, of course, also hinges on access to health insurance, which entails its own set of burdens, ranging from trying to figure out which plan will actually meet your needs for a reasonable cost to the own peculiar set of bureaucratic obstacles to accessing public health insurance like Medicaid.

Kyle and Frakt's piece provides an important perspective: it shifts our attention away from how these administrative barriers are problematic for physicians and forces us to reckon with how these costs hurt patients. To date, there is relatively limited attention in medical and health care services research regarding how administrative burdens and barriers affect patients. To the extent research exists, it is subsumed within the broader access to care literature. The problem, however, is that this places analytic limitations on our ability to understand these burdens, as well as figure out how to reduce them.

The problem is not unique to health care. What Kyle and Frakt reveals in health care is true in other policy settings: seemingly small burdens can have bigger effects than we might anticipate. Burdens exist partly because they are taken for granted: we do not systematically evaluate their impact, assess their necessity, or seek alternatives. The administrative burden framework we developed to analyze these bureaucratic hurdles provides a way to comprehensively talk about, study, and address the administrative barriers in health care that patients face.[4] Consequently, in this article, we will define and provide an overview of burdens, as well as discuss what more we still need to learn about the consequences of health care administrative burdens for Americans.

See related article by Kyle et al.

2 | WHAT ARE HEALTH CARE ADMINISTRATIVE BURDENS?

Administrative burdens fit into three categories: learning, compliance, and psychological costs.[4] Learning costs are the search processes people engage in to figure out what services they might need and how they can access them. We should expect learning costs to be high in health care, as most people struggle to understand both health insurance and service options. Kyle and Frakt (2021) found that 57% of patients had devoted time to seeking information from their insurers or providers, as well as gathering information to share between provider. It could also include sorting out what provider or specialist you should see. We know from existing evidence that most people struggle to figure out the quality of health care providers, in part because we lack effective systems that provide those data.[5] It might also include figuring whether a provider is actually covered by your insurer. The cost of a mistake can be the difference between paying a normal co-pay or being forced into bankruptcy.[6] This can be shockingly difficult. Indeed, one in five emergency claims and one in six in-network hospitalizations include an out-of-network provider.[7] Congress recently passed legislation that ended some surprise billings, but it does not cover areas like ambulance or helicopter transportation.[8] In practice, these learning costs are so high, many people cannot overcome them. Indeed, Kyle and Frakt (2021) found that one in four reported missed or delayed care due to information seeking activities.

Compliance costs are the more stereotypical examples of peoples' negative encounters with bureaucracy. Its the paperwork and phone calls, as well as more broadly the time involved in navigating administrative hurdles. As Kyle and Frakt (2021) demonstrates, over half of respondents noted that in the prior year they had engaged in tasks like scheduling, obtaining prior authorizations, or resolving billing or premium problems. One recent analysis estimated that US workers spent the equivalent of $21.6 billion worth of time dealing with health care administration each year.[9] Getting pre-authorizations, as well as disputing health insurers post-hoc denials of those approvals, can be especially burdensome processes.[10] Kyle and Frakt (2021) found that a third of people reporting a billing problem or prior authorization requirement delayed or missed care. There is a growing sense that these costs far exceed the benefits of preventing access to unnecessary care.[11]

Of particular concern is that these burdens are sometimes designed to increase insurer profits rather than improve health care. In 2018, the Inspector General at the US Department of Health and Human services found "widespread and persistent problems related

to denials of care and payment" in Medicare Advantage plans, which are the private health insurance plans that 40% of Medicare beneficiaries now belong to[12,13] the report found that in appeals processes plans overturned 75% of their claim denials, totaling 216,000 claims in 2014–2016. Especially concerning is that only 1% of beneficiaries even appealed a denied claim. The implication is that burdens are deliberately used as an effective technique to restrict health coverage. This echoes what we have found in other areas: that burdens are a form of policy making by other means.

Indeed, in 2015, Center for Medicare and Medicaid Services found that 56% of audited contracts for Medicare Advantage plans included improper payment denials.[12] Further, 45% of denial letters had erroneous information or excluded information that may have been necessary to appeal the denial. There was also evidence that insurers added additional burdens by requiring unnecessary prior authorizations.[13] While beneficiaries, if they overcome learning costs and realize they have been improperly denied care, have recourse to challenge these mistakes, it is an enormously time consuming and burdensome process to do so in the best of times, but especially for those whose cognitive skills are drained by illness or caregiving.[4]

Compliance costs also include financial costs. In the policy domain, this might include a financial fee to access a government service, such as a license fee. In health care, this includes co-pays for services. Co-pays were instituted in large part due to economic studies in the 1970s, that suggested these kinds of payments would provide enough of a barrier to discourage unnecessary, but not necessary, health care usage. The reality of the empirical evidence, however, is that co-pays prevent access to needed health care. In short, whatever benefits there are in reduced health care costs and service utilization may be offset by the negative health implications of individuals not accessing needed health care.[14,15]

Finally, there are psychological costs. This is the stress and frustration that comes from navigating these burdens, especially when the outcomes, our health and the health of our loved ones, might be harmed if we fail to do it effectively. One study found that, controlling for self-reported health and other demographics, those who spent more time on the phone with their insurers reported higher stress and burnout and were more likely to miss work with an estimated cost of $26.4 billion in additional absences and $95.6 billion in lost productivity.[16]

Broadly, there is evidence that administrative burdens affect psychological outcomes in different ways.[17] Lab-based experimental studies have shown negative physiological reactions to compliance burdens, like filling out complicated paperwork.[18] They also may be the more direct result of features embedded in health care processes. For example, requiring individuals to repeatedly document or retell traumatic events or diagnoses in the process of trying to obtain care can be psychologically painful. In one patient study, they found that "even patients with a longstanding diagnosis of HIV reported a fear of being questioned and forced to relive the story of how they were diagnosed….[H]aving to again describe how they contracted the disease elicited negative emptions including anger, guilt, shame, and severe anxiety."[19]

3 | UNEVEN DISTRIBUTION OF ADMINISTRATIVE BURDENS

Another lesson of administrative burden research is that burdens are not borne equally by individuals. Individuals with fewer resources may not have the same tools to overcome these hurdles.[20] Indeed, Kyle and Frakt (2021) finds exactly this. Those with lower incomes and lower educational attainment were more likely to report burdens that interfered with care. The group most vulnerable to these burdens were individuals with disabilities. Managing administrative hurdles when you are ill or facing a medical crisis is a Catch-22: those who need the most help are most vulnerable to falling before the administrative burdens placed in their way.[21]

One characteristic of a highly burdensome system is that a third-party market develops to help people manage those burdens. For example, private tax preparers help to ensure that most of those who are eligible receive the earned income tax credit. But if the services of private fixers are costly, they can reinforce inequalities. For example, the use of concierge care has become more common in US health care, in part, because it reduces peoples' burdens. Care is easier to access and there are fewer hoops to jump through, such as difficulty in getting appointments. But this can lead to tiered care and differential access issues.[22,23] Access to Medicare coverage for disabled individuals is another example.[24] Success at navigating the eligibility process is substantially improved if one hires a lawyer. Indeed, there is an entire field of law devoted to helping people navigate this eligibility process. The consequence is that those without the resource to get help have less chance of overcoming burdens, and some portion of resources intended for the disabled are redirected to lawyers instead.

4 | CONCLUSION: ADMINISTRATIVE BURDENS AS PART OF A PATIENT-CENTERED APPROACH

Health care administrative burdens are pervasive throughout our system. But the consequences of these burdens for patients is less well understood than it is for providers and overall health care spending. Kyle and Frakt's (2021) analysis is important, in part, because it provides some sense of the scale of the issue from the patient's perspective, revealing the potential of embedding administrative burdens in a more patient-centered approach to health care research. As he notes, many health care administrative burdens are not intended to produce negative outcomes. Indeed, the origins of preauthorization and cost sharing was to improve outcomes and reduce unnecessary costs. But a comprehensive approach to health care necessarily means understanding the trade-offs we have not fully recognized, such as how burdens affect patients, ranging from their access to health care to their subsequent well-being and health.

We know much about how pre-authorizations' impact on overall spending, as well as physician costs.[25,26] But we know comparatively little about how it affects the patient experience of the health system and their health outcomes. We know surprise medical bills exist, but

not the true "costs" of these bills for patients, such as their finances, their future access to health care, and even their trust in the health care system.[27] How much time do individuals, especially chronically ill individuals or their family members, devote to negotiating with insurers? Anecdotally, we know this is a problem. Almost everyone has a story, of their or a family member's struggles with a labyrinthine system, but we do not privilege their perspectives in systematic research.

Kyle and Frakt's work also provides a model for how to understand distributive impacts: to understand if some are more affected than others, we need to study from a group perspective, rather than just examine a specific burden. For example, those with chronic conditions or disabilities are more likely to encounter all kinds of burdens, of which the cumulative effect may be significant. Research then that does not just focus on particular burdens, such as pre-authorizations, but focuses on populations, such as those with disabilities will also be important to understand the broader impacts of health care administrative burdens.

In sum, we can easily sketch the administrative obstacles that people face in health care, but we actually know relatively little about the particular costs they face. And until we do, there is little we can do to address them.

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