Physicians and their staffs spend the equivalent of weeks—and $31 billion—each year processing health insurance paperwork, according to a study funded by the Commonwealth Fund and the Robert Wood Johnson Foundation. The survey of 895 physicians and practice administrators nationwide asked respondents about the amount of time their practice’s staff spent on various administrative activities, including prior authorization, drug formularies, claims and billing, credentialing, contracting, and collecting and reporting quality data.

The researchers found that physicians spent an average of 3 hours a week—or nearly 3 weeks a year—on administrative activities. Nursing staff spent more than 23 weeks per physician per year, and clerical staff spent 44 weeks per physician per year, interacting with health plans. More than three in four respondents said the costs of interacting with health plans have increased over the past 2 years (Health Affairs doi:10.1377/hlthaff.28.4.w533). Overall, all of the cost of these interactions amounted to $31 billion annually.

While these benefits to physicians’ offices’ interactions with health plans—which may, for example, help to reduce unnecessary care or the inappropriate use of medication—it would be useful to explore the extent to which these benefits are large enough to justify spending 3 weeks annually of physician time ... on physician practice–health plan interaction,” the study’s lead author, Dr. Lawrence P. Casalino of Cornell University, said in a statement.

“It would also be useful to explore ways to make the interactions more efficient, both on the health plan side and in physician offices.”

Physicians in solo or two-person practices spent many more hours interacting with health plans than did those in practices with 10 or more physicians; this was especially true in primary care, the researchers found.

And all physicians and staff members spent much more time on authorization, formularies, claims and billing, and credentialing. The survey did not include submitting quality data or on reviewing quality data provided by health plans.

“To get to a health care system that is high-quality and delivers better value for everyone, we have to address the skyrocketing price of health care’s administrative activities, including prior authorization, drug formularies, claims and billing, credentialing, contracting, and collecting and reporting quality data.”

The researchers found that physicians were only about money, it would be a much less happy world, and the quality of care would be much lower than it is. Physicians don’t expect the government to help them buy stethoscopes, examining tables, treadmills for stress tests. They know these are essential to their work as professionals, and I think that is where we are heading with electronic health records as well.

**CPN:** Everyone is curious to see how HHS defines the “meaningful use” criteria outlined in the Recovery Act. Is the adoption of building around this term, and what is the schedule for issuing a definition?

Dr. Blumenthal: I think there is a consensus building. We haven’t pinned it down finally. We [are] discussing this issue before our Health Information Technology Policy Committee. I think at that point some of the major options will be on the table for review and for public comment. We will ultimately have to go through a regulatory process to finally determine the effective definition, but I hope that over the summer, the HHS view of the definition will become clear. It will then have to go through the government clearance process and the regulatory process, which will include copious public comment and undoubtedly will result in some modifications.

**CPN:** Can you say where there is consensus so far?

Dr. Blumenthal: I don’t want to get into specifics, but I will tell you that I think the consensus is clear around one thing, and that is that we should concentrate on performance and usability rather than on technical specifications. We should be constantly linking our definition of meaningful use to clinically meaningful capabilities and performance attributes.

**CPN:** You and the president frequently have said that health IT is a tool, not a fix for our health care system. What can we reasonably expect from health IT in terms of reducing health care spending? And can physicians expect to realize any of those savings within their own practices?

Dr. Blumenthal: I think you’re correct in my view of the role of health information technology. There are three essential components for achieving the president’s goal and the administration’s goal and, I think, the public’s goal for a higher-performing health system. The first is better information on what works and what doesn’t in the daily practice of medicine. The second is the ability to apply that knowledge rapidly to practice. And it’s in that setting that I think health care information technology becomes a vital tool. It enables practitioners to access in real-time and have the benefit of ...”