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REDUCING HEALTH CARE COSTS: DECREASING ADMINISTRATIVE SPENDING

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING REDUCING HEALTH CARE COSTS, FOCUSING ON DECREASING ADMINISTRATIVE SPENDING

JULY 31, 2018

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C O N T E N T S

STATEMENTS

TUESDAY, JULY 31, 2018

REDUCING HEALTH CARE COSTS: DECREASING ADMINISTRATIVE SPENDING

Tuesday, July 31, 2018

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Isakson, Cassidy, Young, Murkowski, Scott, Murray, Casey, Bennet, Warren, Kaine, Hassan, and Smith.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order. Senator Murray and I will each have an opening statement, then I will introduce the witnesses. We will hear from the witnesses, and Senators will then have 5 minutes to ask questions.

This is our third hearing on reducing healthcare costs. At our last hearing, Dr. Brent James testified that a minimum of 30 percent, and as much as 50 percent, of all healthcare spending is waste. Let us pause for a moment to realize what a remarkable statement that is. Dr. James has led a major healthcare system, is a member of the Institute of Medicine. We had a panel there that day of equally impressive witnesses, and nobody really disagreed with his estimate.

At that hearing, we focused on reducing what we spend on healthcare by examining two things: one, on reducing unnecessary healthcare tests, services, procedures, and prescription drugs, and two, how to increase preventive care. This time, today we are examining the cost of administrative tasks, which includes everything from the time spent filing or filling out insurance claims to buying software for an electronic health record system. Administrative costs are much higher in the United States than in other countries, according to a Dr. Ashish Jha, a witness at our first hearing. Administrative costs account for 8 percent of all healthcare spending in the U.S.; roughly, that is, $264 billion compared to 1 to 3 percent for other countries.

While many administrative tasks in the healthcare system come from outside the Federal government, such as insurance company or state requirements, the Federal government is clearly at fault for some of this burden. For example, there was a lot of excitement

over electronic healthcare records in Washington, D.C. Many said these records systems would make it easier for doctors and patients to access a patient's health records and share information with other doctors. Since 2011, the Federal government has spent $38 billion requiring doctors and hospitals to install electronic health record systems through the Meaningful Use programs in Medicare and Medicaid.

The Federal government provided payments to doctors and hospitals to buy those systems and also created specific requirements for how doctors must use the systems, penalizing doctors who did not comply. Unfortunately, health records systems have ended up being something physicians too often dread rather than a tool that is useful.

For example, Dr. Reid Blackwelder, a family physician who chairs a residency program with three clinics in the Tri-Cities of East Tennessee, is required to have an electronic health record system because he sees Medicare and Medicaid patients. He initially received payments from the Federal government to implement the electronic health records system, but now he has to pay a monthly maintenance fee to an electronic health records company, as well as paying for periodic upgrades to the system. All of these costs add up to being far more expensive than the record—the paper records he used to keep or the initial payments the government provided. But he still is not able to see the electronic health record of a patient discharged from a hospital across the street. That is because the hospital does not use the same software that Dr. Blackwelder does. So, instead he has to call the hospital and have paper copies of his patient records faxed over to his office.

There is technology that Dr. Blackwelder could buy to make his electronic health records system communicate with the local hospital records system so he would not have to have them fax the record to his office. However, he would to have pay $300 per month to the electronic health records company for each of the 88 doctors and nurses in his practice. What this means is that for his 88 doctors and nurses, Dr. Blackwelder would have to spend $26,400 every month, $316,800 a year, just to see his patients' electronic health records from the hospital across the street or other doctors.

The electronic health records system, which was supposed to make things easier and simpler, has instead made recordkeeping more expensive, and Dr. Blackwelder still cannot see the records of a patient released from the hospital he can see from his office window. So, this is just one example of how well-intentioned ideas from Washington, D.C. can turn out to add to the administrative burden that doctors face.

According to the American Hospital Association, there are 629 different regulatory requirements from four different Federal agencies that doctors, hospitals, and other healthcare providers have to comply with. These requirements range from credentialing doctors and nurses that participate in Medicare and maintaining compliance with privacy laws such as HIPAA, to making sure the right signs are hanging around a doctor's office.

The average community hospital needs 23 full-time employees just to keep up with the regulations about what a hospital needs to do to participate in Medicare, called conditions of participation

according to the American Hospital Association. When the Federal government adds just one more question or one more rule, it may not seem like it makes much of a difference, but added together, for doctors like Dr. Blackwelder and to hospitals, those questions and rules add up to more time spent on paperwork, less time actually treating patients, and an increase to the cost of healthcare.

The Trump administration is taking a look at what administrative tasks are required by the Federal government. I am glad to see that Seema Verma, administrator of CMS, which oversees Medicare and Medicaid, recently proposed streamlining many of the Agency's burdensome reporting requirements. This is one step. I look forward to hearing more about what the Federal government could do to reduce administrative tasks today. As we look at how to reduce healthcare costs, we should keep in mind that what may seem like a good idea or a magic bullet in Washington, D.C. may actually result in something very different for doctors, nurses, and hospitals.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you, Mr. Chairman. I am glad we are continuing our discussion on healthcare costs, an issue I know that families in my home State of Washington and across the country are greatly concerned about as many of them struggle to afford the care they need. And I look forward to hearing from all of our witnesses today about the way administrative costs fit into the big picture.

I believe there are opportunities here to help reduce healthcare costs by reducing complexity while maintaining quality and safety for patients. We know the current administrative system is fragmented with different Federal, state, and private protocols for things like billing, and measuring quality of care, and more, so I am interested to hear from our witnesses about ideas to simplify and align requirements while maintaining protections that ensure patients are getting safe, quality care and service.

Unfortunately, instead of pursuing policies to address high administrative costs, President Trump is pursuing a path of healthcare sabotage, including ideas that will make this problem actually worse. In fact, the Trump administration's Office of Management and Budget is currently reviewing a new sabotage step that will do even more to let insurance companies offer junk plans that not only undermine important protections for people with preexisting conditions, but also ignore requirements that insurers spend most of their money on patients, not on excessive administrative costs or executive bonuses. An analysis from the National Association of Insurance Commissioners shows the most popular short-term junk plans, like the ones President Trump wants to expand, spend on average half of their revenue on things that have nothing to do with patients' healthcare needs. In other words, President Trump wants to make it easier for insurance companies to discriminate against people with preexisting conditions and reward themselves for it with bigger executive bonuses. I think we can all agree we should be looking for steps to reduce administrative costs to make healthcare more affordable, and this idea from

President Trump, I believe, moves us in exactly the wrong direction.

Unfortunately, with this Administration's focus on sabotaging families' healthcare, efforts to raise healthcare costs have become par for the course. From day one, President Trump has focused on rolling back families' healthcare and protections for people with preexisting conditions, even though the people across the country have utterly rejected that backward agenda, like a year ago when they stood up and spoke out against the mean-spirited Trumpcare Bill that tried to spike premiums, gut Medicaid, and put families back at the mercy of big insurance companies who could jack up prices for people with preexisting conditions. Fortunately, those efforts failed, so President Trump now has decided to sabotage healthcare from the Oval Office instead.

He dramatically cut investments to help people understand their healthcare options and get covered. He pushed a partisan tax cut bill that meant lower rates for massive insurers and drug companies and higher premiums for families. He handed the reins back to insurance companies by looking for ways to make it easier to sell junk insurance that dodges patient protections like those for people with preexisting conditions, women, and seniors. He abandoned patients in the court of law by having his Justice Department take the highly unusual step of refusing to defend preexisting condition protections in court. And now many of us are concerned President Trump has nominated a Supreme Court justice who will strike down healthcare for millions of Americans.

Judge Kavanaugh's history on healthcare makes clear he is a serious threat to families' healthcare and protections for people with preexisting conditions. So, I hope Republicans join us in rejecting his nomination just like they joined us in rejecting Trumpcare when it threatened our families across the country. And I also hope they will come back to the table to work with us on legislation to bring down healthcare costs because I know that is what families in my state are counting on us to do, and I have no doubt patients across the country feel the same way.

The CHAIRMAN. Thank you, Senator Murray. We will now introduce the witnesses, and I will ask Senator Murkowski to introduce our first witness who has come a long way.

Senator MURKOWSKI. Thank you, Mr. Chairman, and I thank you for including on this distinguished panel this morning Becky Hultberg. Becky has not only been a great friend and assist to my staff and my office, but she has been a strong leader in Alaska. She is currently the president and the CEO of the Alaska State Hospital and Nursing Home Association. Prior to this, she served as the commissioner for administration under Governor Parnell, where she provided business support services to our state government. That department also oversees management of the state's active and retiree health plans for more than 80,000 covered lives. She has also served as the regional director of communication and marketing for Providence Health Services Alaska.

She has an extraordinary breadth of understanding of the associated healthcare costs in rural states, and recognizing some of the challenges that we have heard before this Committee as I have attempted to outline them, and the impact to our smaller facilities,

more remote facilities. Ms. Hultberg brings extraordinary experience to the Committee, and so I appreciate a great deal that we will have her voice added to this important discussion this morning as to how we can work to decrease administrative spending when it comes to the overall reduction in healthcare costs. So, thank you, Mr. Chairman, and I look forward to the comments that we will get from Becky this morning, and appreciate her making the long haul from Alaska to be here this morning.

The CHAIRMAN. Thank you, Senator Murkowski. Our second witness will be Matt Eyles. He is president and Chief Executive Officer of America's Health Insurance Plans, the national trade association representing health insurance providers. Previously, he held a number of other leadership positions at Fortune 200 companies, including Coventry Healthcare, Incorporated, a division of Aetna. Earlier he worked for the Congressional Budget Office.

Dr. David Cutler—sorry, next witness—he is a Harvard College Professor, Otto Eckstein professor, of applied economics at Harvard. He served on the Council of Economic Advisors of the National Economic Council during the Clinton administration, was senior healthcare advisor to the Obama presidential campaign, held a number of positions with the National Institutes of Health, the Academy of Sciences, and the Institute of Medicine.

Dr. Robert Book is our fourth witness. He is a health economist who advises—healthcare and economic expert for the American Action Forum, senior research director at Health Systems Innovation Network, LLC. He has a wide range of experience, including as a senior research fellow in health economics at Heritage Foundation, on the faculty of the Industrial College of the Armed Forces, senior association—associate of the Lewin Group.

Welcome again to our witnesses, and, Ms. Hultberg, if you would be begin, we will go right down the row. Welcome.

STATEMENT OF BECKY HULTBERG, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION, ANCHORAGE, ALASKA

Ms. HULTBERG. Good morning. My name is Becky Hultberg, and I am the president/CEO of the Alaska State Hospital and Nursing Home Association. On behalf of my member hospitals and skilled nursing facilities, thank you for having me here to testify today.

Healthcare providers face a variety of administrative burdens from state, local, and Federal regulations to billing and insurance-related administrative costs. I will focus my remarks today on the growing number of Federal regulations and the impact of this administrative burden on our healthcare system.

Healthcare providers and regulators share the same goals of improving quality and keeping patients safe. Providers recognize the importance of a stable regulatory framework that allows them to focus on patients rather than paperwork, and to invest resources in improving healthcare access, cost, and quality. We appreciate recent work done by CMS in addressing regulatory burden, but given the amount of Federal regulation and the pace of change, more must be done.

Close to 24,000 pages of hospital and post-acute care Federal regulations were published in 2016 alone. The American Hospital As-

sociation quantified the direct cost of compliance for America's hospitals in a recent report. Hospitals, health systems, and post-acute care providers must comply with 629 discrete regulatory requirements across nine domains, spending $39 billion annually in administrative activities related to regulatory compliance. For an average-sized community hospital of about 160 beds, this equates to spending of over $7 and a half million annually on regulatory compliance, 59 staff dedicated to this purpose.

For skilled nursing facilities the cost of complying with the requirements of participation issued in October 2016 exceeds $735 million annually, or nearly $100,000 per building. This is at a time when all-in margins for skilled nursing facilities are less than 1 percent.

We often discuss administrative burden in terms of direct costs, but it is important to recognize the opportunity cost as well. The opportunity cost is the next best thing you could have done with the financial and human resources spent on something or the value of the foregone alternative. It highlights the reality of scarcity, that when a dollar or a staff hour is spent on administrative cost, it is not available to spend on something else. Financial and human resources spent in regulatory compliance cannot be used for adding services, implementing patient safety initiatives, hiring doctors or nurses, or addressing community needs.

There are steps the Federal government can take to address the growing mountain of Federal regulations while ensuring patient safety. For hospitals, we recommend better aligning and applying regulatory requirements within and across Federal agencies and programs. Regulators should provide clear, concise guidelines and reasonable timelines for the implementation of new rules. Conditions of participation for Medicare, a significant source of the cost of regulatory compliance, should be evidence-based, aligned with other laws and industry standards, and flexible. Requirements for the Meaningful Use program should be streamlined and increasingly focused on interoperability. Finally, Congress, CMS, and the Office of Inspector General should revisit Stark Law and other requirements aimed at combating fraud to provide the flexibility necessary to support coordinated, high-quality, high-value care.

Skilled nursing facilities face new unfunded mandates to hire staff and establish compliance programs under the requirements of participation, that due to their sheer volume and specificity are difficult, if not impossible, to implement. CMS should revise the requirements of participation to make them more outcome-focused and patient-centered. We also recommend that the automatic revocation of CNA training, if a facility receives a significant civil monetary penalty, be addressed through changes to Federal statute. Finally, we urge Congress to address the requirement that 5 percent, or a minimum of five facilities, receive a Federal survey each year This requirement unfairly penalizes small states with few facilities, and I want to thank Senator Murkowski for her interest in this issue.

Rapid improvements in quality and patient are occurring at scale in our Nation's hospitals and skilled nursing facilities. Voluntary partnerships between CMS and providers to improve quality, like the Partnership for Patients and the American Healthcare Associa-

tion's Quality Initiative, are resulting in measurable improvements in patient care. Skilled nursing facilities are improving on 20 of 24 outcomes measured by CMS, and Alaska providers are exceeding national trends in several areas. Alaska hospitals reduced the rate of death from severe sepsis and septic shock from 20 percent to just under 5 percent in 2 years. Behind those statistics are real people—someone's mother, someone's friend, someone's child—alive today because of this collaborative work. We must focus our resources on the quality improvement partnerships yielding real results for patients.

The issue of administrative burden comes into sharp focus in rural America. Volume of regulation requires scale to implement, and rural areas lack scale. The Nation's hospitals and skilled nursing facilities simply cannot continue to effectively comply with an ever-growing burden of Federal regulations. For a large hospital, the opportunity cost of regulation may mean a program delayed, but for a small town, the choice may be much more difficult. The opportunity costs of regulatory burden for rural communities may be the loss of services.

I want to thank this Committee for your commitment to improving the Nation's healthcare system and for having me here today.

[The prepared statement of Ms. Hultberg follows:]

PREPARED STATEMENT OF BECKY HULTBERG

Good morning. My name is Becky Hultberg, and I am the President/CEO of the Alaska State Hospital and Nursing Home Association. On behalf of my member hospitals, health systems and skilled nursing facilities, thank you for the opportunity to testify today and for addressing this critical topic. Health care providers face a variety of administrative burdens, from state, local and federal regulations, to billing and insurance-related administrative costs. I will focus my remarks on the growing number of federal regulations and the impact of this administrative burden on our health care system.

Health care providers and regulators share the same goals of improving quality and keeping patients safe. Hospitals, health systems, and post-acute care providers recognize the importance of a stable regulatory framework. Such a framework would allow them to focus on patients, rather than paperwork, and to invest resources into improving health care access, cost, and quality. We appreciate recent work done by the Centers for Medicare and Medicaid Services (CMS) in addressing regulatory burden, such as the "Meaningful Measures" initiative, and changes to the Promoting Interoperability Program, but given the volume and complexity of new and existing federal regulation and the pace of regulatory change, more work remains to be done.

Close to 24,000 pages of hospital and post-acute care federal regulations were published in 2016 alone. The American Hospital Association (AHA) quantified the direct cost of compliance for America's hospitals in a 2017 report entitled, "Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers." Hospitals, health systems, and post-acute care providers must comply with 629 discrete regulatory requirements across nine domains, spending $39 billion annually in administrative activities related to regulatory compliance. For an average-sized community hospital (around 160 beds), this equates to spending more than $7.5 million annually on regulatory compliance, with 59 staff dedicated to this purpose. Larger hospitals spend as much as $19 million on compliance activities. The average community hospital spends over $750,000 annually just on the information technology investments required for compliance. To put these numbers into the context of patient care, the regulatory burden costs $1,200 every time a patient is admitted to a hospital.

The Requirements of Participation (RoPs) issued for skilled nursing facilities (SNFs) in October 2016 provide an example of the overwhelming burden of regulatory change. The implementation cost of the new rule is estimated at $831 million, with annual costs of compliance exceeding $735 million, or nearly $100,000 per building. This is at a time when all-in margins for skilled nursing facilities are only 0.7 percent, according to the Medicare Payment Advisory Commission.

Most often, we discuss administrative burden in terms of direct costs, however it is equally important to recognize opportunity costs. The opportunity cost is the next best thing you could do with the financial and human resources spent on something, or the value of the foregone alternative. It highlights the reality of scarcity, that when a dollar or staff hour is spent on administrative activities, it is not available for something else. Financial and human resources spent in regulatory compliance activities cannot be used for adding new services, implementing new patient safety initiatives, caring directly for patients, hiring physicians and nurses, or addressing needs within our communities.

Rapid improvements in quality and patient safety are occurring at scale in our nation's hospitals and skilled nursing facilities. Voluntary partnerships between CMS and providers to improve quality, like the Partnership for Patients and the American Health Care Association's Quality Initiative, are resulting in significant, measurable improvements in patient care. Alaska hospitals participate in the Washington State Hospital Association Hospital Improvement Innovation Network (HIIN), one of 16 such networks around the country. HIINs are sustaining and accelerating change, delivering real results for patients. As an example, working together, Alaska hospitals reduced the rate of death from severe sepsis and septic shock from 20 percent, to just under five percent in two years. Behind those statistics are real people, someone's mother, someone's friend, someone's child, alive today because of this work.

As part of the Quality Initiative, skilled nursing facilities are improving on nearly every metric. Nursing hours have been steadily increasing over the past five years. SNFs have shown national improvement in 20 of the 24 quality outcomes measured by CMS, and the re-hospitalization rates for all admissions, regardless of payor status, have been steadily decreasing. The proportion of patients admitted for post-acute care who are discharged back to the community has steadily increased over the past five years. This equates to 142,000 fewer hospitalizations, and $1 billion in savings to the health care system. SNFs in Alaska are doing better than the national average on overall Five Star rating, RN staffing rating, off-label antipsychotic use, and long-stay falls with injury.

These partnerships are examples of the power of collaboration in improving patient safety. We must focus our resources on the quality improvement partnerships yielding meaningful outcomes for patients.

All hospitals, health systems, and post-acute care providers feel the weight of burdensome administrative processes and regulations. As we consider both the direct and opportunity costs of administrative burden, it is helpful to consider the impact on our most vulnerable health care providers.

The issue of administrative burden comes into sharp focus in rural America. The volume of regulation and complexity of the regulatory framework requires scale to implement - and rural areas lack scale. Spreading these costs over a small population is increasingly difficult for our smallest providers. The nation's rural hospitals and skilled nursing facilities simply cannot continue to effectively comply with an ever-growing mountain of federal regulations. For a large hospital, the opportunity cost of a regulation may mean a program delayed, but for a small town, the choice may be much more difficult. The opportunity cost of regulatory burden for rural hospitals and skilled nursing facilities may be the loss of these services for the residents of that community.

The Federal government can take steps to address the growing volume of federal regulations, while ensuring patient safety. There should be better alignment and application of regulatory requirements within and across federal agencies and programs; as well as clear, concise guidelines and reasonable timelines for the implementation of new rules. Some examples for consideration include Medicare Conditions of Participation (CoP) for hospitals; the Promoting Interoperability Program; Stark Law and civil monetary penalties; and reforms in Post-acute Care (PAC).

Medicare Conditions of Participation.

CoPs for Medicare are a significant source of the cost of regulatory compliance and should be evidence-based, aligned with other laws and industry standards, and flexible. Medicare CoPs require providers to adhere to established health quality, safety, and operational standards to participate in the Medicare programs. There is tremendous value in the CoPs to ensure the safe delivery of care; however, the administrative components to certify that hospitals adhere to all standards present a growing burden to providers.

According to the AHA's 2017 report on regulatory overload, hospitals spend, on average, $3.1 million annually for administrative compliance activities on hospital CoPs. Hospitals strive to be fully compliant with all the requirements all of the time, but that effort is made more difficult and onerous if the requirements lack clarity or conflict with the requirements of other standards-setting organizations. Accreditation bodies should streamline and modify standards so that they support integrated and coordinated care, and ensure that regulations are clear, well-vetted, and consistently enforced.

Promoting Interoperability Program.

Hospitals and health systems appreciate recently proposed changes to the Promoting Interoperability Program, formerly the EHR Incentive Program, that focus on relieving regulatory burden and the importance of interoperability. While hospitals support various proposals that introduce flexibility in the program's requirements, there are several areas of concern. In the FY2019 Inpatient Proposed rule, CMS asks for input regarding the opportunity to further advance interoperability of health information through the creation of CoPs for hospitals and critical access hospitals and conditions for coverage (CfCs) for other providers. Hospitals strongly oppose creating additional CoPs/CfCs to promote the interoperability of health information. A new mandate tied to CoPs is not the right mechanism to advance health information exchange. CMS should recognize impediments to information sharing and address them directly. Creating a CoP or CfC that would apply to only one set of actors is not an appropriate strategy. Further, it is not clear that such requirements would have any greater impact on interoperability than the existing ones; however, they could have unfortunate consequences for some hospitals and communities.

We do not recommend that CMS implement a CoP/CfC to increase interoperability across the continuum of care, because post-acute care providers were not given the resources or incentives to adopt health IT. Adding this requirement would place yet another unfunded mandate on these providers and would be workable only if all facilities were afforded the same opportunity to acquire certified EHRs that conformed to standards enabling the kind of interoperability CMS envisions.

Hospitals would benefit from additional time to implement and optimize the 2015 edition certified EHR technology. Experience to date indicates that the transition to a new edition of certified EHR technology is challenging due to lack of vendor readiness, the necessity to update other systems to support the new data requirements, and the time required to review and modify workflows and build performance. We are concerned that the 2019 transition will present additional challenges due to new reporting requirements, and the requirements to use EHR functionality that were not included in the 2015 edition certification criteria. At this time, hospitals lack widespread experience with the 2015 edition certified EHR. CMS should examine current experiences to inform proposed future program requirements.

Hospitals oppose the use of Stage 3 requirements in FY 2019. The level of difficulty associated with meeting all of the Stage 3 current measures is overly burdensome. Some of the measure thresholds require the use of certified EHRs in a manner that is not supported by mature standards, technology functionality, or an available infrastructure. The costs associated are significant for hospitals and health systems without demonstrable benefit, especially for smaller facilities with negative margins. Small hospitals are often forced to buy expensive upgrades totaling tens, if not hundreds of thousands of dollars, with reporting functionality they don't need. For a hospital barely staying afloat, that is a significant expenditure.

Stark and Anti-Kickback.

Congress, CMS and the Office of the Inspector General should revisit Stark Law and other requirements aimed at combating fraud to provide the flexibility necessary to support coordinated, high-quality, high-value care.

Hospitals and health systems are adapting to the changing health care landscape and new value-based models of care by eliminating silos and replacing them with a continuum of care to improve the quality of care delivered, community health, and overall affordability. However, portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the "Stark Law") and certain CMPs stand in the way. Congress should create a safe harbor under the Anti-kickback Statute to protect clinical integration arrangements so that physicians and hospitals can collaborate to improve care and eliminate compensation from the Stark Law to return its focus to governing ownership arrangements.

Post-Acute Care.

The PAC field continues to undergo a major transformation. In FY 2018, all long-term care hospitals will have transitioned to the new, two-tiered payment system, under which one out of two cases is paid a far lower "site-neutral" rate that is comparable to an inpatient prospective payment system (PPS) rate. Also underway are CMS's regulatory efforts to reform the skilled nursing facility and home health PPSs, with refined proposals for payment models expected for 2019.

Given the scope of the changes already underway for post-acute care, we urge Congress to reject new changes or payment cuts that would reduce payment accuracy or increase administrative burden for these services, as such changes could threaten access to medically necessary care. Instead, we encourage the facilitation of changes that will preserve access to medically necessary care, improve payment accuracy, and streamline excessive regulatory demands.

Skilled nursing facilities face huge new unfunded mandates to hire staff and establish compliance programs in the 2016 RoPs, that, due to their sheer volume and specificity, are difficult if not impossible to implement. The rule includes updated standards of practice, consideration for different types of residents in nursing centers, and other changes that CMS believes will improve care for residents. We support changes that focus on patient-centered care and improving outcomes. However, many provisions require SNFs to develop new infrastrucure and extensive documentation, along with adding new staff positions that create redundancy and add cost without demonstrable benefits to residents. Regulatory changes on issues ranging from pharmacy services to transitions of care mean well, but create a large unfunded mandate. Noncompliance with any of these changes puts a SNF's Medicare and Medicaid qualification on track for termination.

CMS implemented an 18-month moratorium for imposing the most severe remedies for noncompliance with eight out of 249 distinct regulatory citations, but providers still must implement these changes. Nurses and other clinical staff are being pulled from the bedside to develop and update more than 20 different written policies and procedures, and to complete other administrative tasks prescribed in the RoPs. For example, the new regulations require providers to copy and fax a detailed transfer notice to the Long-term Care Ombudsman every time a resident is transferred to the hospital for emergency care or a planned hospital-based procedure. Requiring this level of documentation beyond what is required in a resident's medical record or other resident communication takes staff away from patient care without improving outcomes or saving costs. CMS should revise the SNF RoPs to make them more outcome-focused and patient-centered.

Federal law regarding the RoPs unduly burdens small states. The federal survey requirement is carried out through state governments, with federal oversight surveys ensuring compliance. Federal law requires that CMS survey five percent of SNFs within a state, or a minimum of five facilities. With 18 facilities, our members have a far higher survey burden than the 1,202 facilities in California. This means they spend more time on paperwork, and less on patient care. We urge Congress to address this inequity by changing statute to create a single, consistent standard for all states. Thank you to Senator Murkowski for her interest in this issue.

Finally, we ask Congress to address the unintended consequences of the revocation of Certified Nursing Assistant (CNA) training programs when a SNF receives a CMP above a certain level. The recent increase in the use of CMPs as an enforcement tool is another well-intentioned idea with harmful unintended consequences. CNAs, who provide much of the care for SNF residents, are trained in programs run by SNFs. These training programs are revoked for two years when CMPs of a certain amount are issued, regardless of whether the CMPs were related to caregiving. The increase in the use of CMPs retrospectively and for citations unrelated to resident harm has resulted in many CNA training programs being revoked unnecessarily. These programs help to address the nationwide shortage of health care workers, while offering free job training to often economically disadvantaged individuals who would otherwise have to pay hundreds or thousands of dollars for similar career-track education. We recommend that the automatic revocation of CNA training be addressed through changes to federal statute.

Conclusion.

The federal regulatory framework is intended to protect patients, ensuring that they receive safe, high-quality care, a goal shared by providers. However, not all regulations achieve this objective, and well-intentioned guidance can cause harmful unintended consequences. Where regulations add cost, without any benefit to pa-

tients, they should be reviewed and modernized or eliminated. Where they are duplicative, they should be streamlined. A commitment to patient safety means a commitment to investing our time and resources into activities that demonstrably improve patient safety, not those that simply check a box or fill out a form. We look forward to continuing to partner with federal regulatory agencies in this work. Thank you for your commitment to improving the nation's health care system.

[SUMMARY STATEMENT OF BECKY HULTBERG]

The federal regulatory framework is intended to protect patients, ensuring they receive safe, high-quality care. Hospitals, health systems and skilled nursing facilities share this goal. However, not all regulations achieve this objective, and well-intentioned guidance can be costly and even have harmful unintended consequences. The volume of regulation, complexity of the regulatory framework, and pace of change is overly burdensome on hospitals, health systems and post-acute care providers.

- Close to 24,000 pages of hospital and post-acute care federal regulations were published in 2016.
- Hospitals, health systems, and post-acute care providers must comply with 629 discrete regulatory requirements across nine domains, spending $39 billion annually in administrative activities related to regulatory compliance.
- For an average-sized community hospital (around 160 beds), this equates to spending more than $7.5 million annually on regulatory compliance, with 59 staff dedicated to this purpose.
- To put these numbers in the context of patient care, the regulatory burden costs $1,200 every time a patient is admitted to a hospital.
- For skilled nursing facilities, the annual cost of compliance with the Requirements of Participation issued in October 2016 is estimated at $735 million, or nearly $100,000 per building. This is at a time when all-in margins for skilled nursing facilities are less than one percent.

Most often, administrative burden is discussed in terms of direct costs; however, it is important to recognize opportunity costs as well. The opportunity cost is the next best thing that could be done with the financial and human resources spent on something, or the value of the foregone alternative. Financial and human resources spent in meeting regulatory compliance cannot be used for adding services, implementing patient safety initiatives, hiring health care professionals, or addressing community needs. The opportunity cost of regulatory burden for rural hospitals and skilled nursing facilities may be the complete loss of these services in the community.

The Federal government can take steps to address the growing volume of federal regulations, while still ensuring patient safety. There should be better alignment and application of regulatory requirements within and across federal agencies and programs; as well as clear, concise guidelines and reasonable timelines for the implementation of new rules. Examples for consideration include Medicare Conditions of Participation for hospitals; the Promoting Interoperability Program; Stark Law and civil monetary penalties; and Post-acute Care regulatory reform. Collaborative, voluntary quality improvement programs like the CMS Partnership for Patients and American Health Care Association Quality Initiative are delivering meaningful results. Resources on patient safety should be spent where they are delivering the best outcomes for patients.

The CHAIRMAN. Thank you, Ms. Hultberg. Mr. Eyles, welcome.

STATEMENT OF MATT EYLES, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, DC

Mr. EYLES. Chairman Alexander, Ranking Member Murray, and Members of the Committee, I am Matt Eyles, president and CEO of AHIP, America's Health Insurance Plans. I appreciate the opportunity to testify on reducing healthcare costs and administrative

spending and on our industry's leadership in simplifying healthcare and protecting patients.

Every American deserves access to comprehensive, affordable coverage choices, without regard to preexisting conditions, that help to improve their health and financial security. AHIP and our members are strongly committed to advancing this goal. Our members invest in a wide range of initiatives to improve patient care and health and to protect patients from inappropriate or unnecessary treatments.

Our written testimony focuses on four areas. First, we provide an overview of how consumer premium dollars are invested in the commercial market. Our graphic analyses show that the vast majority of every healthcare dollar goes to pay directly for medical treatments and services. The rest largely fund programs and services that improve health, reduce, short- and long-term costs, and increase healthcare choices. Second, we review some of the administrative activities carried out by health insurance providers, including medical management, care management and care coordination, and fraud prevention. These all work together to improve the healthcare experience and reduce costs for consumers.

Third, we offer examples of how health insurance providers are working to simplify administration for doctors, hospitals, and nurses. Finally, we outline our recommendations on steps that can be taken, with help from industry partners and policymakers, to address barriers to simplifying processes and providing more value to patients.

Health insurance providers have a 360-degree view into how patients use their coverage and care. Based on that insight, our members have pioneered many innovative strategies for making healthcare more effective, efficient, and affordable. For example, several research studies show wasteful spending in healthcare. About two-thirds of physicians report that at least 15 to 30 of care is unnecessary. Health insurance providers use medical management tools to help patients get the right care at the right time in the right setting with a focus on better, smarter care.

We work with clinicians to help confirm treatment regimens ahead of time and ensure the use of the most cost-effective therapies. Prior authorization is one example of an effective medical management tool to ensure better, smarter care. Although it is applied to less than 15 percent of coverage services, it effectively addresses overuse and misuse of procedures in commercial and public programs. With prior authorization, our members analyze whether a treatment is safe and effective for a particular patient based on the best available clinical evidence.

Insurance providers also ensure the treatment is provided in the most appropriate care setting by a qualified license provider and it is provided with other needed services. AHIP is working with many others, including the AMA, to improve prior authorization processes, and by making prior authorization more fully electronic, we can further improve its effectiveness and efficiency.

Health insurance providers also have invested billions of dollars to monitor, detect, and eliminate fraud. AHIP is a founding member of the Healthcare Fraud Prevention Partnership, which includes the Federal government, state agencies, law enforcement,

and health plans. Since 2012, the HFPP has saved hundreds of millions of dollars through the detection and prevention of fraud.

We are also working with others to simplify operations and the consumer experience without sacrificing quality. For example, through a partnership with the Council for Affordable Quality Healthcare, AHIP members collaborate with other stakeholders to develop and adopt standard rules for electronic transactions. Because of this work, an increasing number of transactions are now electronic. However, there is more work to be done. A 2016 CAQH report estimated that more than 3 billion manual transactions occur each year between commercial health plans and providers.

Insurance providers have also played a leading role in developing web portals to provide easy access for physicians to multiple plans for key eligibility and determination information, such as copays, coinsurance, and deductibles. Portals also provide access to current information on claims status, reducing time and paperwork. To harmonize performance measures, our industry actively participates in the Core Quality Measures Collaborative to reward high-quality, evidence-based care. Our industry is working to encourage further improvements, including moving away from paper transactions, achieving interoperability for measuring quality, creating parity in privacy laws for physical and behavioral health, improving electronic transactions, and recognizing fraud detection and prevention expenses in MLR calculations.

Thank you for the opportunity to testify. I look forward to answering the Committee's questions.

[The prepared statement of Mr. Eyles follows:]

PREPARED STATEMENT OF MATT EYLES

Chairman Alexander, Ranking Member Murray, and Members of the Committee, I am Matt Eyles, President and CEO of America's Health Insurance Plans (AHIP). AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

We appreciate this opportunity to testify on our industry's leadership in simplifying health care and in efforts to protect patients; support doctors and hospitals in delivering high quality, evidence-based care; and reduce administrative costs. Our members are strongly committed to working with clinicians and hospitals to reduce complexity, improve value and patient health, and increase patient satisfaction.

Americans deserve affordable coverage choices that help to improve their health and financial security. To advance this goal, health insurance providers invest in a wide range of initiatives—some of which involve administrative spending—to improve patient care, enhance health outcomes, and protect patients from receiving inappropriate or unnecessary health care services and treatments that provide little to no value.

Health insurance providers don't just pay medical bills—we're partners, dedicated to better health and well-being for consumers. We believe all patients should be treated with safe, effective care. Essential tools like medical management that emphasize case management and care coordination help us deliver on that promise. When patients do better, we all do better. That's why we are committed to helping patients get better when they're sick, and stay healthy when they're well. It's why we work together with doctors, nurses, and hospitals to break down barriers and find real solutions, so that patients get the care they need, when they need it, and in the right setting without hassle.

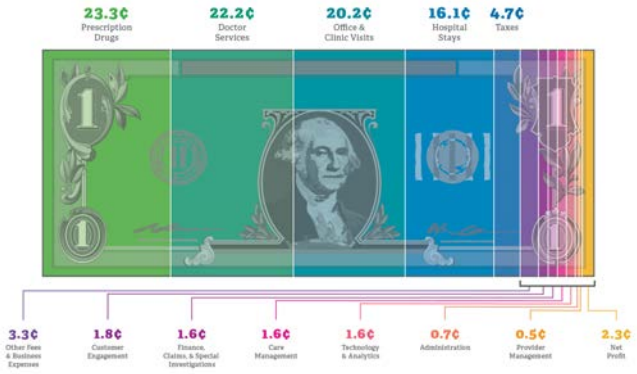
Our testimony focuses on the following topics:

- An overview of how health care dollars are spent and the reality that administrative costs are a small part of overall health care spending;
- Administrative activities carried out by health insurance providers, including medical management and fraud prevention, to improve the health care experience for consumers;
- Initiatives and collaborations through which health insurance providers are working to simplify administrative burdens for hospitals and clinicians; and
- Our commitment to working with other stakeholders and policymakers to address challenges and barriers to administrative simplifications that provide value to patients.

How Health Care Dollars Are Spent

Any discussion of administrative spending needs to begin with a clear understanding of where health care dollars are spent. A recent AHIP research project, in which we collaborated with Milliman to analyze administrative costs, provides a visual display of how premium dollars are invested for products in the commercial market. [1]

The graphic below shows that the vast majority of every premium dollar goes to pay for medical products and services. The rest largely goes to fund programs and services that patients and consumers truly value because they improve their health, reduce both short-term and long-term health care costs and increase the health care choices available to them.



Many Administrative Activities Improve the Health Care Experience for Consumers

Health insurance providers have a 360-degree view into how patients use their coverage and care and what works best for them. Based on that insight and to help improve the patient experience, our members have pioneered many innovative strategies that are strongly focused on making health care more efficient, effective, and affordable.

Medical Management: Promoting Better, Smarter Care

Health insurance providers are committed to high quality care for every patient. This commitment is clearly demonstrated in the medical management tools, case management and care coordination our members use on a daily basis to promote better, smarter care that is safe and effective for patients.

Several research findings show that such tools are needed to reduce wasteful spending:

[1] Where Does Your Health Care Dollar Go?, AHIP, May 2018.

- Sixty-five percent of physicians report that at least 15–30 percent of care is unnecessary. [2]
- The Institute of Medicine estimates that 10–30 percent of health care spending is wasted each year on excessive testing and treatment. [3]
- In 2014, between 23 and 37 percent of beneficiaries in Medicare used at least one low-value service for a total cost of $2.4 to $6.5 billion. [4]
- Just five low-value services account for more than $25 billion in unnecessary spending within Medicare. [5]
- Between $200 and $800 billion is wasted annually on excessive testing and treatment. [6]
- A study based on a review of insurance claims for 1.3 million people in Washington state found that nearly half of that sample—about 600,000 patients—underwent an unnecessary treatment, at a total cost of more than $280 million. These costs included laboratory tests for healthy patients ($80 million), heart tests for low-risk patients ($40 million), and redundant cervical cancer screenings ($19 million). [7]

To address these concerns and promote better, smarter care, health insurance providers have developed medical management approaches that help patients get the right care at the right time in the right setting, which prevents harm and reduces costs. Medical management includes smart-care tools based on several key principles:

- *Patient care should be based on proven clinical evidence.* Just like doctors use scientific evidence to determine the safest, most-effective treatments, health insurance providers partner with doctors and nurses to help identify the clinical approach for the patient that has better results, better outcomes, and better efficiencies and offer clinical decision support tools to encourage implementation.
- *Patients deserve safe, effective, and affordable care.* Health insurance providers work with doctors, nurses and other clinicians to design and develop approaches that help ensure necessary treatments, confirm treatment regimens ahead of time, prescribe and dispense appropriate drugs, and utilize the most cost-effective therapies. This helps ensure that patients receive the safest, most-effective care at the most affordable cost.
- *Patients benefit when health insurance providers partner with doctors, nurses, and hospitals.* Collaboration and innovation deliver real value for patients. Health insurance providers help clinicians stay informed as their patients move through the health system, and they reward doctors and hospitals that provide excellent and objectively high-quality care to patients based on specific quality measures and outcomes.

Medicare Advantage (MA) and MA Special Needs Plans, which provide coverage for dually eligible beneficiaries as well as those with chronic conditions, have invested heavily in care management to provide for the seamless delivery of health care services across the continuum of care and improve patient outcomes. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, manage chronic conditions, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious stage.

As part of their overall strategy for serving Medicare beneficiaries, MA plans are also implementing patient-centered innovations that include:

- Mitigating the harm of chronic diseases by focusing on prevention, early detection, and care management;
- Reducing beneficiary costs;

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[2] Over treatment in the United States. Lyu H, et al. PLOS One. Sept. 6, 2017.
[3] Best care at lower cost: the path to continuously learning health care in America. Institute of Medicine. September 6, 2012.
[4] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2018.
[5] Providers make efforts, but cuts to low-value care elusive. HealthcareDIVE. January 24, 2018.
[6] Best care at lower cost: the path to continuously learning health care in America. Institute of Medicine. September 6, 2012.
[7] Unnecessary Medical Care Is More Common Than You Think, ProPublica, February 1, 2018.

- Addressing the needs of vulnerable individuals, including low-income beneficiaries; and
- Applying clinical best practices to increase patient safety and limit unnecessary utilization of services.

Medicare Advantage plans work to identify the specific health care needs of their enrolled beneficiaries, so they can benefit from integrated care coordination, chronic disease management, and quality improvement initiatives. These activities promote more early detection of chronic conditions and the design of disease management programs, which studies show are improving care for beneficiaries. For example, a January 2012 article in Health Affairs reported that beneficiaries with diabetes in a Chronic Care Special Needs Plan had more primary care physician office visits and fewer preventable hospital admissions and readmissions than beneficiaries in traditional Medicare. [8]

These investments in medical management have proven to be effective. Extensive studies comparing Medicare Advantage to traditional Medicare have shown remarkable care improvements. A recent peer-reviewed study found that, on average, Medicare Advantage provides "substantially higher quality of care" by outperforming traditional Medicare on 16 out of 16 clinical quality measures, and achieving equivalent or higher scores on five out of six patient experience measures. [9] In other studies, Medicare Advantage plans have been shown to reduce hospital readmissions and institutional post-acute care admissions while also increasing rates of annual preventive care visits and screenings. [10], [11], [12], [13]

Moreover, in many geographies with high Medicare Advantage enrollment, spending in the traditional Medicare program actually goes down as providers adopt practice patterns and care

guidelines that positively "spillover" into their care of patients who remain in traditional Medicare. [14] The Medicare Advantage program also has a beneficiary satisfaction rate of 90 percent for plans, preventive care coverage, benefits, and choice of provider. [15]

Prior Authorization: Protecting Patients From Unnecessary and Inappropriate Care

Prior authorization is an example of an effective medical management tool that promotes better, smarter care delivery. Prior authorization is a pre-approval process that a clinician or a hospital must receive from an insurance provider before a patient receives the care or service. Prior authorization is applied to selected medical procedures, services or treatments to ensure that they are safe and effective for that particular patient based on the best available clinical evidence, are administered or provided in the appropriate care setting by a qualified, licensed provider and are provided with other support services that may be needed.

- While prior authorization is applied to a relatively small percentage (typically less than 15 percent) of covered services, procedures, and treatments, this tool benefits patients by:
- Encouraging evidence-based care;
- Ensuring safety and effectiveness of the treatment;

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[8] Cohen, Robb, Lemieux, Jeff, Mulligan, Teresa, Schoenborn, Jeff. Medicare Advantage Chronic Special Needs Plan boosted primary care, reduced hospital use among diabetes patients. *Health Affairs* 31(1):110–119. January 2012.

[9] Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038–2060. December 2017.

[10] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91–100. January 2017.

[11] Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S., et. al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Affairs* 34(1): 11–20. January 2015.

[12] Ayanian, John Z., Landon, Bruce E., Zaslavsky, Alan M., et al. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare. *Health Affairs* 32(7):1228–1235. July 2013.

[13] Lemieux, Jeff Sennett, Cary Wang, Ray, et al. Hospital readmission rates in Medicare Advantage plans. *American Journal of Managed Care* 18(2): 96–104. February 2012.

[14] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707–1715. September 2016.

[15] Morning Consult National Tracking Poll. March 11–16, 2016.

- Promoting appropriate use of drugs and services to avoid potentially dangerous effects;
- Ensuring care is delivered in the appropriate venue, at the appropriate time/frequency and by the most appropriate provider; and
- Promoting and encouraging a dialogue between the health insurance provider and clinician to ensure tailored, patient-focused treatment plans and promote adherence.

Prior authorization is used to target specific safety and efficacy concerns. Some examples of services or treatments that may require prior authorization include:

- Imaging tests with radiation for patients who may have already had high exposure to radiation from previous tests;
- Joint injections without evidence or clinical documentation showing a diagnosis of arthritis;
- Surgery for sleep apnea as first line treatment, contrary to evidence-based guidelines;
- Repeat spine surgery unsupported by history, physical findings, and imaging;
- Magnetic Resonance Imaging (MRI) for low back pain as a first line treatment, instead of physical or other therapy, as recommended by professional guidelines;
- Appropriateness/usefulness of prescribing antipsychotic medications for children and adolescents; and
- Use of addictive opioids that exceed the Centers for Disease Control and Prevention's (CDC) recommended limits.

Numerous state Medicaid programs also use prior authorization to address the overuse and misuse of opioids and mistreatment and diagnosis of low back pain by overusing high-tech imaging, recognizing the potential harm and costs associated with unnecessary exposure to radiation and unnecessary surgeries.

Similarly, the traditional Medicare program is implementing the use of evidence-based guidelines and prior authorization for outlier clinicians to address the overuse and misuse of imaging services, which can expose patients to unnecessary and potentially harmful radiation, unnecessary surgery and office visits, undue stress, and add wasteful costs to the health care system. [16]

In its June 2018 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that the traditional Medicare program more broadly adopt six tools used effectively by Medicare Advantage and other health plans to reduce low-value care, such as prior authorization, clinical decision support and provider education, and more accountable provider payment models. [17]

Fraud Prevention: Stopping Criminal Behavior to Protect Patients and Eliminating Wasteful Spending

Recognizing the importance of eliminating unnecessary spending from the health care system to reduce costs and improve affordability, and the committee's strong interest in this issue, we want to emphasize the value of investments made by health insurance providers in fighting health care fraud. The Federal Bureau of Investigation (FBI) estimates that health care fraud costs American

taxpayers between 3 and 10 percent of what is spent on health care, between $80 – 230 billion a year. [18]

The enormous costs of health care fraud are borne by all Americans, and eliminating fraud and abuse is a critical priority for health insurance providers as well as public programs. Our members have invested billions of dollars in initiatives to monitor, detect, and eliminate criminal behavior. Many health insurance providers have established their own designated investigation units comprised of highly trained professionals who employ sophisticated analytics that indicate when an investigation is warranted—to prevent, detect and remedy fraudulent and abusive conduct. When they find criminal activity, they work closely with law enforcement—

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[16] Imaging for Low Back Pain, American Academy of Family Physicians. *https://www.aafp.org/patient-care/clinical-recommendations/all/cw-back-pain.html*

[17] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2018.

[18] FBI–HealthCare Fraud *(https://www.fbi.gov/about-us/investigate/white—collar/health-care-fraud)*

local police, state police, the FBI, and the Drug Enforcement Administration (DEA)—to stop fraud and protect the American people. This work helps ensure that the care paid for is legal and warranted and, more importantly, protects consumers and patients from both physical and financial harm.

Our members' anti-fraud initiatives also include credentialing activities that identify providers who are not qualified, not appropriately licensed, or operating outside the scope of their expertise. Health insurance providers are committed to selecting the highest quality care providers to participate in their plan networks. They rely on independent experts and government partners to carefully review quality metrics, outcomes measures, credentialing, and other critical information to ensure that their customers have access to quality care providers.

Anti-fraud initiatives focus on:

- Identifying usage patterns indicative of substance abuse and implementing drug utilization programs that rely on data analysis and clinical assistance to provide interventions to help members obtain appropriate treatment for substance use disorders;
- Identifying patterns of provider overutilization or situations where providers perform, order, or deliver procedures that are not medically necessary or appropriate; and
- Identifying instances of medical identity theft, including assisting victims in correcting false information in their medical records.

Recognizing the important role fraud prevention initiatives play in protecting patients and preventing unnecessary spending, these activities—even though categorized as administrative spending—are, in fact, an investment and a highly effective use of our health care dollars.

The Healthcare Fraud Prevention Partnership (HFPP), of which AHIP is a founding member, is a voluntary public-private partnership between the Federal government, state agencies, law enforcement, private health insurance providers, and health plan associations. These entities and organizations work together to foster a proactive approach to detecting and preventing health care fraud through data and information sharing. The HFPP offers a forum that facilitates the sharing of identifiable federal, state, and public-sector data and best practices with partners from across the health care landscape.

AHIP has worked to help the Partnership recruit additional health care payers to help the HFPP gain broader coverage, access to more data, and greater effectiveness. The HFPP has grown to 105 partners with 217 million covered lives. Since its inception in September 2012, the HFPP estimates it has achieved $329 million in savings from its work across public and private payers.

Simplifying Administrative Burdens for Hospitals and Clinicians

Health insurance providers are working continually to streamline and simplify administrative processes as part of their broader focus on protecting patients and encouraging the delivery of high quality, evidence-based care. By collaborating with other stakeholders and leveraging best practices in technology, our members are taking important steps to simplify health care operations and the consumer experience. The following initiatives build upon congressionally approved requirements that are helping to reduce paperwork and streamline business processes across the health care system. [19], [20]

Reducing the Cost of Administrative Transactions and Simplifying Administrative Tasks

Through a partnership with the Council for Affordable Quality Healthcare (CAQH), our members are participating in an industry-wide collaboration, the Committee on Operating Rules for Information Exchange® (CAQH CORE), that works to reduce the costs associated with administrative transactions and simplify admin-

[19] The Health Insurance Portability and Accountability Act (HIPAA) of 1996 set national standards for electronic transactions (claims and encounter information, payment and remittance advice, claims status, eligibility, referrals, and authorizations and payment), code sets (for diagnoses, procedures, diagnostic tests, treatments, and supplies), and unique identifiers (health plan identifier, employer identification number, and national provider identifier).

[20] The Patient Protection and Affordable Care Act (ACA) of 2010 included additional requirements including the adoption of operating rules for each transaction, a standard unique identifier for health insurance providers, and standards for electronic funds transfer and electronic health care claims attachments to standardize business practices.

istrative tasks through the development and adoption of health care operating rules for electronic transactions. Common rules that simplify administrative transaction allow providers to have more time to spend in treating patients.

More than 130 organizations are participating in this effort, including health insurance providers, hospitals and clinicians, vendors, state and Federal government entities, standard development organizations, and other interested parties. [21]

Many important steps have been taken to date. For example, the Department of Health and Human Services (HHS) has adopted CAQH CORE operating rules for eligibility, claim status, electronic funds transfers (EFT), and electronic remittance advice (ERA) transactions. In addition, CAQH CORE has developed operating rules related to health care claims, prior authorization, enrollment and disenrollment in a health plan, and premium payments.

As a result of this work, an increasing number of transactions between health plans and providers are electronic, secure and more uniform, and the use of manual phone, fax and mail transactions has declined. Over the past four years, the transmission of benefit and eligibility verifications through fully electronic transactions has increased to nearly 80 percent; the adoption of electronic claim status inquiries has increased by 38 percent; and the use of manual ERA transactions has decreased by 81 percent. [22]

Although great strides have been made to reduce the cost of administrative transactions, we have more work to do. The CAQH Index recently found that a manual transaction costs $4.40 more on average than an electronic transaction and that completing all health care transactions electronically would yield $11.1 billion in savings annually. [23] To realize these cost savings, continued engagement and commitment from all public and private stakeholders are essential to ensure the broad adoption of CAQH CORE operating rules across the industry.

Web Portals: Streamlining the Exchange of Clinical and Administrative Data

Health insurance providers have played a leadership role in the development of web portals, through which physicians can reach multiple insurers simply and quickly via a common portal. These portals allow office staff easy access to determine key eligibility and benefit information (co-pays, co-insurance, deductibles) in real time, and provide access to current and accurate information on the status of claims to reduce the submission of duplicate claims.

Web portals are an industry-driven solution that has been adopted to streamline communications between clinicians and multiple health insurance providers. Portals can be used to exchange a broad range of clinical and administrative data, such as claim status, prior authorization, or provider directory information. Solutions offered by Availity and NaviNet, for example, serve as a one-stop solution that allow clinicians to exchange data with multiple health insurance providers in real time. These portals reduce the need for clinicians to call health insurance providers or use proprietary portals to update or verify clinical and administrative data, allowing them instead to access a network of health insurance providers in one place.

Emerging cloud-based solutions have further enhanced the ability of these portals to store and easily retrieve needed data. In addition, health care providers are leveraging cloud-based hosting of clinical data and analytic tools, helping to streamline work flows, and offer the ability to share data across the care continuum.

Core Quality Measures Collaborative: Harmonizing Performance Measures That Reward High Quality, Evidence-Based Care

Health insurance providers are at the forefront of efforts to develop and implement performance measures that reward the delivery of high quality, evidence-based health care services. To support this work, AHIP and many of our members are active participants in the Core Quality Measures Collaborative (CQMC), a voluntary effort created to promote the alignment and harmonization of performance measures across public and private payers. Other participants include the Centers for Medicare & Medicaid Services (CMS), primary care and specialty societies, and consumer and employer groups.

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[21] *https://www.caqh.org/core/list-participating-organizations*

[22] 2017 CAQH Index, A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings.

[23] 2017 CAQH Index, A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings.

To date, the CQMC has released eight consensus-based core measure sets: (1) accountable care organizations / patient-centered medical homes / primary care; (2) cardiology; (3)

gastroenterology; (4) HIV/hepatitis C; (5) medical oncology; (6) obstetrics and gynecology; (7) orthopedics; and (8) pediatrics. [24]

To solidify its independence, ensure its long-term sustainability, and continue to align its work with other stakeholders, the CQMC has engaged the National Quality Forum (NQF) to be its new operational home. AHIP, CMS, NQF staff, and CQMC members will work together to reconvene the core measure set workgroups for the inclusion of additional measures, update the existing measure sets and eliminate measures if duplicative or outdated, and develop strategies and tools to promote implementation of the measure sets. A 2017 AHIP survey, based on responses from 24 health insurance providers with 108.3 million enrollees, found that 70 percent had adopted some or all of these core measure sets into their provider contracts.

Our Commitment to Address Existing Challenges and Barriers

Health insurance providers are committed to working with other stakeholders and policymakers to address a number of significant challenges and barriers to administrative simplifications that provide value to patients.

Move Away From Paper Transactions. Many providers still use mail and fax for submitting eligibility data and documentation of rationale needed to approve claims. The 2016 CAQH Index Report estimates that more than three billion manual transactions are conducted annually between commercial medical health plans and providers. Electronic health care claims attachments are rarely utilized by physicians, as standards have not yet been finalized. Delays in the submission of these materials can lead to delays in approvals and denials. Health plans will continue to work with care providers to encourage the use of electronic transactions.

Achieve Interoperability to Support Quality Measurement. Physician reporting on quality measures is impeded by the lack of interoperability across electronic health records (EHRs) and the inability of some EHRs to support the retrieval of quality measurement data. To ensure that consumers have meaningful information on quality, it is important to improve the functionality of EHRs to allow quality data to be extracted and reported on a widespread basis. These efforts should be combined with steps to standardize the use of quality measures across public and private payers, and to streamline and reduce the overall number of quality measures. CQMC has been working to ensure that new measures can be reported from EHRs.

Achieve Interoperability to Improve Health Care Quality. Lack of interoperability is a significant remaining challenge to improving the quality of care and lowering costs. Consumers can and do face real risks—delays, voids in care, or unnecessary duplication of tests—when providers do not have full access to a patient's medical history. To ensure that patients receive safe and quality care, this information should be easily transferable and accessible regardless of the care setting. With the expansion of advanced payment models, more and more health insurance providers are exchanging timely, actionable data with physicians to help ensure they have access to information on treatments and services provided by all clinicians caring for the patient (such as emergency room visits, changes in prescribed drugs, etc.).

Create Parity in Privacy Laws for All Physical and Behavioral Health Conditions. Access to a patient's entire medical record, including behavioral health records, ensures that providers and organizations have all the information necessary to provide safe, effective treatment and care. 42 CFR Part 2 is an outdated, potentially harmful regulation that requires segmentation of substance use disorder records, furthering stigma and endangering patient lives. Individuals who suffer from substance use disorders are more likely to have comorbid mental and physical health conditions that can have complicated ripple effects on a patient's health and treatment that should be carefully coordinated and monitored. Siloing patient records concerning substance use disorders prevents such coordination, inhibits treatment, exposes patients to unnecessary risk, and increases system costs. Parity should be applied to all behavioral health and physical conditions regarding illegal disclosure of private health information under HIPAA.

Implement Electronic Transactions and Operating Rules. To continue the adoption of administrative simplification, remaining electronic transactions and operating rules should be implemented in a timely manner and should be designed to meet

[24] AHIP, CMS Collaborative Announces Core Sets of Quality Measures, AHIP press release, February 16, 2016.

and keep up with the industry's evolving business needs to truly lower administrative costs. Our industry continues to work with CAQH and the National Committee on Vital and Health Statistics (NCVHS) on the adoption of needed standards and operating rules.

Rescind HPID Regulations: In the near term, CMS should rescind regulations implementing the health plan identifier (HPID). AHIP and other stakeholders, including providers and clearinghouses, have testified before the NCVHS numerous times that there is no longer a need for HPID, as this need is served by the Payer ID, which is currently used in electronic transactions across the industry.

Recognize and include fraud detection and prevention expenses in the medical loss ratio (MLR) and rebate calculation. HHS has recognized the challenge of fraudulent actions in government programs and permitted the inclusion of fraud fighting costs in MLR calculations for those programs. We strongly recommend that HHS similarly allow these expenses to be included in MLR calculations in the individual and group markets.

Provide transparency into Federal exchange fee and align it with evolving exchange functions. CMS continues to collect a 3.5 percent user fee from issuers participating in the Federal exchange while simultaneously reducing the functions of CMS to support healthcare.gov— including reducing the outreach, education, and marketing budget for healthcare.gov. CMS is also working to implement enhanced direct enrollment with the goal of shifting more enrollment to issuer and web broker websites and away from healthcare.gov. Transparency into the total amount of user fees collected and their use will allow health plans and other Federally-facilitated Marketplace (FFM) business partners to better collaborate with the Center for Consumer Information and Insurance Oversight on how to improve FFM efficiency. Marketing and outreach activities should be given high priority to continue attracting new customers.

Finalize Certification Requirements and Electronic Transaction Attachment Standards. CMS should revise and finalize the requirements for health plan certification, which were proposed in 2014 and subsequently withdrawn in 2017 pending resolution of HPID requirements. Similarly, HHS should finalize requirements for electronic transaction attachment standards, for which proposed regulations are pending, to support real time electronic exchange of administrative data and reduce the need for manual follow-up or submission of attachments.

Improve Implementation Process for Standard Transactions and Operating Rules. More broadly, the process for adopting and modifying standard transactions and operating rules needs to be improved. The current process is too slow—taking years from initial inception to adoption of requirements to implementation—and cannot keep up with the evolving business needs of various industry stakeholders. We support efforts by the NCVHS to promote a more predictable, timely process.

Conclusion

Thank you for this opportunity to testify and share our perspectives on these important issues. We appreciate the committee's commitment to streamlining administrative functions and reducing administrative burdens for both providers and payers. We look forward to working with the committee, along with other policymakers and stakeholders, to reduce complexity and simplify health care to protect patients and support doctors and hospitals in delivering high quality, evidence-based care.

[SUMMARY STATEMENT OF MATT EYLES]

America's Health Insurance Plans (AHIP) and our members are strongly committed to simplifying administrative processes and advancing solutions that improve affordability, value, access, and well-being for the American people. Our industry invests in a wide range of initiatives—some of which involve administrative spending—to improve patient care, enhance health outcomes, and protect patients from receiving inappropriate or unnecessary health care services and treatments that provide little to no value.

Promoting Better, Smarter Care: Health insurance providers have developed medical management approaches that help patients get the right care at the right time in the right setting, which prevents harm and reduces costs. Our members use these tools every day to promote better, smarter care that is safe and effective for patients.

Protecting Patients From Unnecessary and Inappropriate Care: Prior authorization is one example of an effective medical management tool. It is applied to selected

medical procedures, services or treatments to ensure that they are safe and effective for that particular patient based on the best available clinical evidence, are administered or provided in the most appropriate care setting by a qualified, licensed provider, and are provided with other support services that may be needed to improve patient care and outcomes.

Stopping Criminal Behavior to Protect Patients and Eliminating Wasteful Spending: Health insurance providers have invested billions of dollars in fraud prevention initiatives to monitor, detect, and eliminate criminal and/or fraudulent behavior. This work helps ensure that medical care paid for is legal and warranted and, more importantly, protects consumers and patients from both physical and financial harm.

Reducing the Cost of Administrative Transactions and Simplifying Administrative Tasks: Through a partnership with the Council for Affordable Quality Healthcare (CAQH), AHIP's members participate in an industry-wide collaboration, the Committee on Operating Rules for Information Exchange (CAQH CORE), which supports the development and adoption of standardized health care operating rules for electronic transactions. As a result, an increasing number of transactions between health plans and providers are electronic, secure and more uniform, and the use of manual phone, fax and mail transactions has declined.

Streamlining the Exchange of Clinical and Administrative Data: Health insurance providers have played a leading role in the development of web portals used by physicians to reach multiple insurers simply and quickly via a common portal. These portals allow office staff easy access to determine key eligibility and benefit information (co-pays, co-insurance, deductibles) in real time, and provide access to current and accurate information on the status of claims to reduce the submission of duplicate claims.

Harmonizing Performance Measures That Reward High Quality, Evidence-Based Care: Many AHIP members are active participants in the Core Quality Measures Collaborative (CQMC), a voluntary effort created to promote the alignment and harmonization of performance measures across public and private payers.

Recommendations: Our written testimony discusses several areas where health insurance providers are working with other stakeholders and policymakers to address challenges and barriers to administrative simplifications that provide value to patients. These efforts include (among others): moving away from paper transactions, achieving interoperability to support quality measurement and improve quality, creating parity in privacy laws for all physical and behavioral health conditions, implementing electronic transactions and operating rules, and recognizing fraud detection and prevention expenses in medical loss ratio calculations

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The CHAIRMAN. Thank you, Mr. Eyles. Dr. Cutler, welcome.

STATEMENT OF DAVID M. CUTLER, PH.D., HARVARD COLLEGE PROFESSOR; OTTO ECKSTEIN PROFESSOR OF APPLIED ECONOMICS, HARVARD UNIVERSITY, CAMBRIDGE, MASSACHUSETTS

Dr. CUTLER. Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for inviting me to testify today. My name is David Cutler. I am a professor of economics at Harvard where I have been teaching and working in healthcare for about 25 years—over 25 years—and I am delighted to talk about the role that the Administration, Congress, and others can play in reducing administrative expenses in U.S. healthcare.

Healthcare administrative expenses are a major drain on the economy. As much as 30 percent of the healthcare bill in the U.S.—that is about a trillion dollars a year—is devoted to administrative expense. That is approximately twice what the United States spends on caring for cardiovascular disease and 3 times what we spend treating cancer. Most of the expenses are for what are called billing and insurance related services, two-thirds of which are—occur in providers' offices, hospitals, doctors, skilled nursing facili-

ties, and the like. There are several reforms that would reduce administrative costs in the U.S. Some of these been—have been picked up by other witnesses. Let me just try and give them a little bit of a typology.

First is simplifying the complexity with which patients are coded. For example, when a patient visits the emergency department, there are 1 of 5 different codes that could be put in. The particular code depends on the past history of the patient and other conditions. So, as a result, an enormous amount of manpower, time, and energy is spent searching through the records and finding every possible condition a patient could have had so that he or she can be put into a higher category for reimbursement. This is wasted time, effort, and money that could be directed to other uses.

Second, which is something that has also been mentioned, particularly by Mr. Eyles, is standardizing preauthorization requirements. A great share of the cost of the administrative burden in the United States is documenting things associated with prior authorization, for example, if one service is going to be provided, what has to be done in advance and proof that what was done in advance actually occurred and had the requisite outcome. I have been in hospitals where they show me the procedures for billing radiology. Just radiology services at one hospital across all the different payers and the manuals that they have to comply with are over a foot thick. The reason is that each different insurer will have their own policies, and it is not just that. It is that each different payer working with that insurer will have their own policies related to preauthorization, and the net effect is that there is an army of coders and medical records keepers who are kept employed keeping up to date with that.

The third issue is the integration of medical records and billing systems, and this is something that Chairman Alexander mentioned in his opening comments, which is absolutely right, which is that in most industries, what happens is that computers take over for people, and what happens in healthcare administration is that people take over for computers. So, you have an electronic medical record system that keeps some information. You have a billing system that keeps separate information. They do not talk to each other, so, as a result, you have people involved in the one and people involved in the other, and it is extremely costly to do that. As the Chairman said and as Mr. Hultberg said, the automation—the requirements with regards to integration have not kept up with where we need to be, and that is a serious problem here.

The best guess of researchers is that we could eliminate at least half, if not more, of the administrative cost burden and, thus, reduce medical spending in the U.S. by about 8 to 15 percent if we were to simplify the administrative transactions associated with billing and insurance. The unfortunate circumstance, however, is that these changes will not occur on their own. Even the big players the private—in the private sector in healthcare are not big enough to make these changes occur without additional help from the biggest player, and that is the Federal government.

In fact, if you look at other industries that have successfully reduced administrative expense, they all have a common theme, which is that the single biggest player in the industry has been in-

timately involved with this. In the case of retailing—that is, selling goods to people—it was, to a great extent, the product of companies like Walmart that standardized billing packaging, and coding, and all sorts of things so that the transaction, which in healthcare involves several people on the providers' end and several people on the insurers' end, involves nobody in retail. The second example is the Federal Reserve, which standardized financial transactions in the 1970s and then has kept that system up to date over time. And that has also saved enormous amount of expense for banks and other financial institutions, and it could have only happened with the Federal government being involved.

What we see in industry after industry is that the big player has to take part or it does not happen. Therefore, what I recommend, and I will be very explicit because I believe in explicit goals and consequences, is that the Department of Health and Human Services, working with healthcare organizations, as Ms. Hultberg and Mr. Eyles suggested, develop and implement a plan to reduce the administrative burden in healthcare by 50 percent within the next 5 years. I believe that such a plan is achievable and attainable. I believe it would have enormous benefits for the economy, and, unfortunately, I do not think it will happen without actions by this Congress and the Administration. I encourage you to act rapidly.

Thank you for having me here, and I look forward to answering any questions you might have.

[The prepared statement of Dr. Cutler follows:]

PREPARED STATEMENT OF DAVID M. CUTLER

Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee, thank you for the opportunity to testify before you today. It is an honor to be invited to participate in today's discussion.

My name is David Cutler. I am professor of economics at Harvard University, where I have been engaged in research and teaching on health economics for over 25 years. I have conducted research on overall medical care spending and specifically on the component of medical spending attributable to administrative expense. The desire to reduce administrative costs in the U.S. health care system spans the political spectrum. Thus, I hope the findings and recommendations I present are taken in this spirit.

The Nature of the Problem

Administrative expenses are those expenses that are not directly associated with providing goods and services to people in need of care. There is no account kept on the amount of administrative expense of United States healthcare system, but there are estimates of the overall magnitude.

These estimates suggest that administrative expenses range from 15 to 30 percent of medical spending.[1,2] To put this amount in perspective, even the smaller estimates suggest that administrative costs account for twice what the United States spends on cardiovascular disease care every year, and three times what the United States spends on cancer care.[3]

Beyond the amount of money spent on administrative costs are the hassles associated with administration. The average U.S. physician spends 43 minutes per day

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[1] Yong PL, Saunders RS, Olsen L, eds. The healthcare imperative: lowering costs and improving outcomes—workshop series summary. Washington, DC: National Academies Press, 2010.

[2] Jiwani, Aliya, David Himmelstein, Steffie Woolhandler, et al., "Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence." *BMC Health Services Research.* 2014;14(556).

[3] Cutler, David M, Elizabeth Wikler, and Peter Basch. 2012. "Reducing Administrative Costs and Improving the Health Care System," *New England Journal of Medicine,* 367, 20, 1875–1878.

interacting with health plans about payment, dealing with formularies, and obtaining authorizations for procedures.[4] The time and frustration associated with administrative expenses leads to physician burnout and pushes some physicians to leave practice.[5]

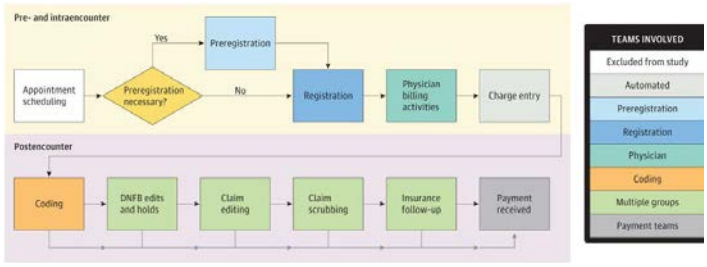
The level of administrative expense in the United States is far higher than in other countries, even those committed to pluralistic systems of insurance and private provision of medical care. For example, administrative costs account for 39 percent of the difference in spending between the United States and Canada, greater than the additional spending accounted for by higher payments to pharmaceutical companies and more frequent use of services such as imaging and additional procedures.[6]

The bulk of administrative expenses are for 'billing and insurance related' (BIR) services. When people think of administrative expense, they often jump to activities in insurance companies. This is a part of the total, but only a part. Two-thirds of administrative expenses occur in offices of physicians, hospitals, and other care providers.[7]

Administrative costs are a form of economic "arms race." Pushed by businesses and individuals to reduce spending, insurers introduce requirements providers must fulfill before they can get paid. These additional requirements cost the insurer money to enforce, but are worth it in the savings from not paying out additional claims. In response to new rules, providers hire additional personnel to maximize the amount they are reimbursed. Witnessing this, insurers beef up rules yet again, putting in place additional requirements for payment. The net effect is a spiral of cascading administrative costs on both side of the market, with no benefit to patients and no net benefit to insurers or providers.

A depiction of the processes involved in BIR services in provider offices is shown in Figure 1, taken from Tseng et al.[8] The activities include verifying a patient's eligibility for services; submitting bills in an appropriate format; reviewing those submissions; submitting documentation required for pre-authorization purposes; collecting copayment or coinsurance from patients; and providing quality information and other documentation about the outcome of the procedure. The typical hospital spends nearly 10 cents out of every dollar collected collecting that dollar; the typical physician's office spends even more.

Figure 1: Depiction of Administrative Costs



Source: Tseng et al., 2018.

[4] Casalino Lawrence P., Sean Nicholson, David N. Gans, et al. "What does it cost physician practices to interact with health insurance plans?" *Health Affairs,* 2009;28:w533-w543

[5] Shanafelt, Tait D., Omar Hasan, Lotte N. Dyrbye, et al., "Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014," *Mayo Clinic Proceedings;* 90; 12:1600–1613.

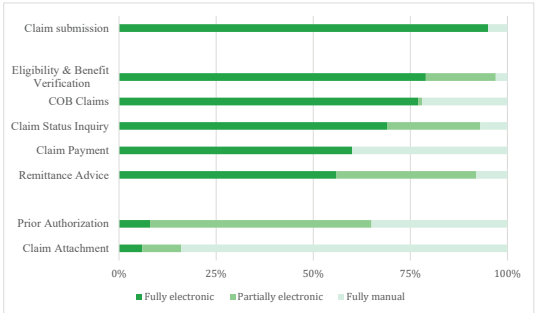
[6] Cutler, David M., and Dan P. Ly. 2011. "The (Paper)Work of Medicine: Understanding International Medical Costs." *Journal of Economic Perspectives,* 25 (2): 3–25.

[7] Yong et al., op cit.

[8] Tseng, Philip, Robert S. Kaplan, Barak D. Richman, et al., "Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System." *JAMA.* 2018;319(7):691–697.

Figure 2 shows the extent to which the activities in Figure 1 have been automated, using data from the Council for Affordable Quality Healthcare (CAQH).[9] Claim submission is almost entirely electronic, with 95 percent of claims submitted fully electronically. Other administrative transactions are between 50 and 75 percent fully electronic, including eligibility verification checking on claim status, and payment inquiries. The least automated activities are prior authorization and claim attachment (clinical information that needs to be submitted with a claim). Less than 10 percent of these transactions are fully electronic. CAQH estimates that the cost of conducting these tasks manually is two to ten times higher than the cost of conducting them electronically, so that savings from automating the transactions in figure 2 alone would exceed $11 billion annually.

Figure 2: Adoption of Fully Electronic Administrative Transactions, 2017



Source: CAQH, 2018.

Steps to Reduce Administrative Expense

The goal of policy is to reduce administrative costs, but to do so in a smart way. It is not that we want to eliminate the functions that administrative costs serve. Verifying that people are eligible to receive care, that reimbursement is accurate, and that fraud and abuse are prevented are important goals. Rather, the idea is to conduct these processes more efficiently.

Administrative costs are not a monolithic, so there's not a single solution that will reduce them. However, there are number of actions that would materially reduce administrative costs. The Institute of Medicine estimated that administrative costs could be reduced by half.[10] Comparisons with other industries suggest the reduction could be even larger. In physician's offices as a whole, there are 5.8 nonphysician employees for every physician; the comparable figures are 1.9 for law offices and 1.8 for accounting practices.[11] Let me describe three steps that could be taken to reduce administrative costs.

Reducing Severity Adjustments

A significant portion of administrative costs is associated with measuring the severity of a patient presenting for treatment. For example, a patient presenting to the emergency department for treatment will be coded into one of five different severity levels (99281–99285) based on the nature of the illness or injury of the patient and their past history. The underlying rationale for this differentiation is sound: it takes more resources for an emergency department to treat a more severely ill patient. However, the administrative requirement of billing in this system is extremely high. For example, a patient with a history of high blood pressure or diabetes will often move into a more severe category than one without those conditions. Thus, there are people whose job it is to search the records of every emer-

[9] CAQH, 2017 *CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings,* 2018.
[10] Yong et al., op cit.
[11] Cutler, David M., "The Good and Bad News of Health Care Employment," *JAMA Forum,* January 24, 2018.

gency department patient to look for whether every patient has a history of conditions which would bump the patient into a more lucrative reimbursement category.

The emergency department example carries throughout medical care system. For a large share of medical care goods and services, the health care system creates enormous administrative cost by differentiating payments according to the severity of the patient's illness and background.

The natural solution is to limit the extent of differentiation. For example, payers could have one code for emergency department admissions instead of five, and similarly for other medical care goods and services. CMS recently announced its intention to implement such a policy for evaluation and management visits, moving from five billing categories to just two.

There are two potential drawbacks to reduced differentiation of payments with severity of illness. First, removing additional payment for more severely ill patients makes some patients with severe illness unprofitable. This may induce providers to discourage such patients from seeking care, for example by turning them away or making it difficult to schedule appointments. I suspect this concern is minor, and in any case steps can be taken to manage it. Recall that most providers are willing to care for even patients who bring no revenue (the uninsured); their mission justifies this activity. Thus, selection is less of a concern with providers than with insurers. And some carve outs to the no-severity adjustment rule can be created. For uncommon but expensive items—complex surgeries, for example—it makes sense to retain a severity adjustment; the administrative costs are low relative to the amount of money involved in creating winners and losers. Finally, it is possible that alternative risk adjustment models could be employed that address most of what the severity adjustment covers but without the detail of measuring the full set of past conditions. For example, patient age, gender, and zip code are routinely collected and are correlated with a host of risk factors. Even a simple medical factor such as whether a patient was hospitalized in the past year would provide significant risk adjustment without involving high collection burden.

The second potential drawback is that severity-neutral payments will transfer resources from providers that see more complex patients to providers that see less complex patients. The key to addressing this concern is to ensure that enough of the savings from administrative simplification flow to providers, so that losses to such providers can be offset by enhanced revenues. Imagine that we reduce administrative costs in hospitals by half, or 5 percent of total hospital spending. Insurers could split the resulting savings with providers, for example cutting payments by only 2.5 percent. This additional surplus would almost certainly compensate the providers that lose money because their true patient mix is more severe than average.

On balance, therefore, I believe that current severity adjustments are substantially inefficient relative to a simpler system without such detailed risk adjustment but with workarounds for some limited number of cases.

Standardizing Pre-Authorization Requirements

A second reform that would reduce administrative costs is standardizing the documentation required for pre-authorization of services. A typical insurer will have a multitude of policies regarding what findings must be documented before it will authorize further treatment. For example, an MRI and physical therapy might be required before orthopedic surgery. Some such requirements are natural and beneficial, but there are far too many different requirements. It is not just that each insurer has their own pre-authorization requirements. Rather, each insurer has multiple different pre-authorization requirements, varying for each specific business they insure or public program they participate in. I once had a provider system show me the manual it keeps to bill radiology services alone; it was over a foot high.

Complying with these requirements involves enormous expense. Armies of computer programmers and manual reviewers are employed by both insurers and providers to keep up with the changes. Further, the information required for the pre-authorization is often not easily accessible. The relevant information is in the physicians' electronic medical record, but there is no easy way for the electronic medical record to convey that information to the insurer's billing system. As a result, the process involves people. A person in the provider's office accesses the electronic or paper medical record, xeroxes the relevant pages, and faxes them over to the insurer. Different people in the insurance company then need to look at the information and document that the information satisfies the necessary requirements.

Standardizing pre-authorization requirements would be a major step forward. One might imagine that insurers and providers could live with two options: a more gen-

erous policy for payers willing to spend more, and a more restrictive policy for payers on a tighter budget. Providers could then focus on a small number of metrics associated with demonstrating applicability of the services under these two regimes. Variation from the standard policies would not be prohibited but could be discouraged, perhaps by requiring the payer to pay for the additional administrative expense they impose for both insurers and providers by deviating from these rules.

Integrating Medical Record and Billing Systems

There is another way to view the previous example about the difficulty of pre-authorization requirements, and that is the inability of some computer systems to talk to others. Part of the reason for people to be engaged with billing is because electronic medical records which record clinical information have no way to communicate information to payment systems run by insurers. Thus, when an insurer requires documentation of a particular diagnosis or prior treatment, it requires people to be involved. Normally, we think of computers as making up for the limitations of people. In health care, it is people who make up for the limitations of computers.

By contrast to health care, consider what happens when a person shops at Walmart. When an item is scanned at the register, the register automatically alerts the inventory system, which in turn automatically re-orders new inventory from the relevant supplier. The supplier's computer processes this information and arranges for new inventory to be sent to the store (along with other inventory that needs to be restocked). All of this occurs without a single individual being involved. The goal should be the same in health care.

A related issue occurs with quality assessment required for many pay-for-performance systems. Almost all payers, including public programs, have some pay-for-performance incentives built into their contracts, for example additional money associated with meeting guideline care for people with chronic disease. Information on the quality metrics is often in the electronic medical record, but that is not the format it needs to be in for payment purposes. As a result, providers spend a good deal of time, effort, and money pulling information from electronic medical record systems and putting them in a format appropriate for pay-for-performance calculations.

Technologically, there is no reason why electronic medical record systems cannot interface with billing systems or automatically submit information for quality assessment. However, there are few incentives for existing firms to make this happen. Providers do not wish to give insurers access electronic medical records, because they consider them proprietary. Each individual insurer has little incentive to invest in a system that is more conducive to provider systems, since doing so for a single practice involves large costs and little gain. Makers of electronic medical record systems have incentives to keep their systems exclusive, so that it is more difficult for providers to switch from one company to another. Thus, we are in a situation where costs remain high even though everyone recognizes that they could be reduced.

The solution to the technological interoperability can be solved through either public or private actions. In the public sector, standards regarding health information technology could be modified so that select information flow from electronic medical record systems to billing systems is required. Most of the federal effort devoted to interoperability has focused on increasing access to clinical information by patients and providers. For example, everyone agrees that a person with a medical record at one organization who visits a provider at a second organization should be able to have their record read at the second provider. However, much less attention has been devoted to the links between medical records systems and billing systems.

A private sector solution might involve something like the credit card industry, where intermediaries read information from electronic medical records and send the compiled information to insurers in the appropriate format. The intermediaries would take a common set of information from providers—the universe of information that is required—and then parcel out the information as required. As an analogy, consider the world of retail trade. One of the amazing features about retail is that the smallest stores can process the same payment methods as the largest stores. The reason for this is that firms such as VISA and MasterCard have created a standardized transmission standard that takes credit card information and sends it to the customer's bank. Purchase authorization is provided almost instantaneously and with minimal administrative cost. To be sure, these intermediaries charge a good deal for the services they provide. But those costs are well below the comparable costs associated with intermediation in the fragmented health system.

What Federal Policy Can Do

Administrative costs have fallen in many industries throughout the economy. The retail sector was noted above. But credit cards are just the tip of the iceberg. Other examples include Universal Product Codes (UPCs) to make checkout less expensive, electronic sales for many goods, and employment of sophisticated information systems to reduce distribution and inventory costs. Another example is the financial services industry. Trillions of dollars are transmitted electronically each day, with barely any administrative cost. To a great extent, this is because the technology for doing so has been standardized.

In each of these industries and others, there is a common theme to reducing administrative costs: administrative costs fall when there is a dominant player that forces standardization. In retail trade, standardization came about to a great extent because of the activities of Walmart. Walmart required suppliers that wished to sell to it to adopt standards that reduced administrative costs.[12] The result was a streamlining of retailing as a whole. The Federal Reserve did the same for banking, working with financial institutions to create the Automated Clearing House system (ACH) in the 1970s and updating it over time. The financial transfer system now occurs entirely in the background.

There is only one organization in health care that is large as the Federal Reserve or Walmart, and that is the Federal government. The Federal government is the largest buyer of medical care, including Medicare, the Veteran's Administration, the Department of Defense, federal employees, and health insurance exchanges. The Federal government also pays for a good deal of Medicaid, though the program is run at the state level. Because of the centrality of the Federal government to payment, if the Federal government is not involved in administrative reform, it simply cannot happen.

What the Federal government does not have is the mandate to do so. The Department of Health and Human Services acts primarily as a payer. It enacts new payment systems for Medicare and other programs as it deems appropriate, but it generally does not think about trading off the value of these systems relative to the administrative costs they engender. More recently, the Federal government has assumed a role in health IT, through the HITECH Act. Meaningful use standards are a key part of federal activity, but these standards are generally focused on clinical use of IT systems, not how IT can contribute to administrative simplification.

Both payment reform and IT promotion are important areas. My suggestion is not that the Federal government not focus on these areas. Rather, I propose that each be coordinated with a third goal: creating and implementing a plan to reduce the administrative costs of medical care. To be as specific as possible, I propose that:

The Department of Health and Human Services, working with health care organizations, should develop and implement a plan to reduce administrative costs in health care by 50 percent within five years. The plan should include payment simplification, standardized pre-authorization policies, and integrated medical record and billing systems.

Congress can monitor progress on an ongoing basis. To ensure that the plan is brought to fruition, reductions in payments commensurate with a reduction in administrative costs of some magnitude, perhaps 25 percent, could be set to occur at the end of the five year period.

Of course, one should not have blind faith in the ability of the Federal government to coordinate in new areas. The disastrous opening of the Health Insurance Exchanges gives everyone pause about the wisdom of proposing federal action. On the other hand, the Federal government has been a leader in many areas. Payment reform had no widescale implementation before recent federal actions, and the rollout of many payment models has gone well. And within the area of administrative simplification, Medicare was a leader in requiring claims to be submitted electronically. That explains a good part of why claims submission is almost fully electronic.

The reality of the situation is this: unless the Federal government leads the way, the United States will continue wasting hundreds of billions of dollars annually on unnecessary administrative expenses. I urge Congress to act to prevent this.

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[12] Johnson, P. Fraser, and Ken Mark, "Half a Century of Supply Chain Management at Wal-Mart," Harvard Business School, 2012.

[SUMMARY STATEMENT OF DAVID M. CUTLER]

Health care administrative costs are a major drain on the economy. As much as 30 percent of the health bill in the US is devoted to administration, twice what is spent on cardiovascular disease and three times what is spent on cancer. Most of this expense is for billing and insurance related services, two-thirds of which occurs in provider offices.

There are several reforms that would reduce administrative costs in US health care. These include:

1. Simplifying the complexity with which patients are coded. A good deal of administrative complexity is associated with determining the severity of each patient, so that the patient can be placed in the highest reimbursement category. Reducing severity adjustments would eliminate the need for some administrative expense.

2. Standardizing Pre-Authorization Requirements. Pre-authorization requirements are particularly costly because they differ across insurers, and even within an insurer they differ across groups purchasing insurance. Having fewer pre-authorization possibilities would reduce provider and payer burden.

3. Integrating Medical Record and Billing Systems. Electronic medical record systems are generally not integrated with billing systems. As a result, transactions that require clinical information necessitate involvement of people in both insurers and providers. Requiring integration of medical record and administrative systems would reduce the need for costly workarounds.

The best guess of health care researchers is that administrative cost reforms could lower administrative expenses in half, thus reducing overall medical spending by 8–15 percent. However, these changes will not occur on their own. The health care industry is too fragmented for individual payers or providers to gain from changing billing and insurance processes.

In every industry that has successfully reduced administrative expense, the dominant industry player has paved the way for such savings. Examples include Walmart in retail and the Federal Reserve in financial transactions. The dominant player in health care is the Federal government. Unless the federal government pushes for administrative savings, administrative costs will remain a burden. I encourage Congress to pursue a plan along these lines:

The Department of Health and Human Services, working with health care organizations, should develop and implement a plan to reduce administrative costs in health care by 50 percent within five years. The plan should include payment simplification, standardized pre-authorization policies, and integrated medical record and billing systems.

Unless the Federal government leads the way, the United States will continue to waste hundreds of billions of dollars annually on unnecessary administrative expenses. I urge Congress to act rapidly.

The CHAIRMAN. Thank you, Dr. Cutler. Following Dr. Book's testimony, I am going to step out for an appointment, and Senator Murkowski will Chair the hearing for a while, and I thank her for that.

Dr. Book, welcome.

STATEMENT OF ROBERT A. BOOK, PH.D., HEALTHCARE AND ECONOMIC EXPERT; ADVISOR TO THE AMERICAN ACTION FORUM, WASHINGTON, DC

Dr. BOOK. Thank you, Chairman Alexander, and Ranking Member Murray, and Members of the Committee. Thanks for the opportunity to discuss my research on healthcare administrative costs.

To summarize, costs occur at three levels as we have heard: at the health plan, whether it is a private sector health plan or a government health plan inside the health plan; and at the provider level in the hospitals, the physician offices, and other providers;

and also at the patient level when patients have to schedule appointments, and read the bills and the EOBs they receive, and cross-match them to make sure everything is right, and send in a payment. There is a significant amount of research at the health plan level, there is a smaller amount of research on administrative costs at the provider level, and as far as I can tell, there is no research at the patient level, which is that it affects every one of us one way or another.

The primary problem that we have in this discussion is most reports give administrative costs as a percentage of total spending, including spending on direct patient care, and this is especially a problem in talking about administrative costs at the plan level. So, for example, someone might claim that Medicare's administrative costs are 2 percent or 5 percent and those in private insurance are 10 or 20 percent, and it sounds so much higher. It turns out Medicare, of course, has mainly patients who are age 65 and over or disabled or with end-stage renal disease, and, on average, they need more healthcare than people covered in private plans. So, they—we take administrative costs. We divide it by a much larger number, we get a smaller percentage and make them—and make them look very efficient, but really their administrative cost percentage is lower, not because they are more efficient, but because they have sicker patients, which, of course, has nothing to do with their administrative costs.

It turns out if we look at—if we look at—the correct way to do this is to look at it in terms of how much administrative costs there is per person because administrative costs do not scale with the dollar value of claims, and they do not even scale that much with the number of claims. If you look at claims processing in Medicare, it is only about a quarter percent of Medicare's entire budget. And doing that more efficiently or having fewer claims is not going to affect their administrative costs very much.

Expressed that way, Medicare's administrative costs, last time I did the calculations, averaged $509 per person, and private administrative costs that same year were $453 a person. So, they were a lot closer, and Medicare's actually turned out to be a little bit higher.

This issue occurs also when we compare systems in different countries, and that is either at the health plan level or at the provider level. So, there was one study that attempted to compare hospital administrative costs and noted, and they actually said this in the article, that hospitals employ—in some countries employ large numbers of physicians. That is not the way healthcare is organized in the United States. The hospital exists and does its job, and the physicians are paid separately.

Then they proceeded to report administrative costs as a percentage of total hospital expenditures. Well, if the hospital expenditures include payments of physicians, then the same administration is going to be a much lower percentage. So, naturally the countries that did that look so much more efficient, but really they were just being measured differently. And we actually do not—this tells us nothing about whether administrative costs are higher in one country or another because we have not made an appropriate apples-to-apples comparison.

Now, it is also a problem sometimes to identify and collect administrative costs. Budget documents were generally not designed for us researchers, and it is hard to track down—track down costs, and we end up making estimates. So, but I can tell you for sure if the—if the answer is a percentage, it is wrong because asking for a percentage in this case is simply asking the wrong question.

More recently I have looked into how the ACA affected administrative costs of private insurance. The exchanges were supposed to reduce the administrative cost of covering private sector individuals, and it turns out the insurance companies did save money. Administrative costs from the year before to the year after went from $414 per person to $265 a person, but the total went up $893 because the Federal government spent more money setting up the exchanges than they saved in administrative costs for the companies.

I would like to address one story that has been going around—I think it was mentioned at an earlier hearing in this series—that says that Duke University Hospital supposedly has 900 beds and 1,500 billing clerks. So, when I first heard this, I thought that seems like the wrong comparison because they also have a lot of outpatient care which has nothing to do with hospital beds. So, we checked on Duke's website, and, of course, hospital inpatient care represents about 2 percent of the visits in the Duke Health System. And I talked to Paul Vick, associate vice president of Duke Healthcare, and it turns out they do have a staff of 1,500. But in addition to billing, they handle appointment scheduling, patient registration, clinic check-in, medical records, health information, charge caption encoding, cash management payment accounting, and all sorts of other functions. And when we asked how many people actually handled just billing for Duke Hospital instead of all the other hospitals in the system, it turned out to be 15 full-time equivalents. Not 1,500. Fifteen.

Thank you. I think I am out of time, so thank you very much. I will be happy to answer your questions.

[The prepared statement of Dr. Book follows:]

PREPARED STATEMENT OF ROBERT A. BOOK

Chairman Alexander, Ranking Member Murray, and Members of the Committee:

Thank you for the opportunity to discuss my research on health care administrative costs. Administrative costs occur mainly at three levels: at the health plan level, whether it is a private-sector health insurance plan or a government-run program; at the provider level, that is, at hospitals, physician offices, pharmacies, and other providers; and at the patient level, when patients have to schedule appointments and read the bills and "explanation of benefits" documents they receive.

There is a significant amount of research on administrative costs at the health plan level, a smaller amount of research on such costs at the provider level, and as far as I can tell, little to no research at the patient level.

Administrative cost research is plagued by two problems:

First, most reports give administrative costs as a percentage of total spending, including spending on direct patient care. So, for example, someone might claim that Medicare's administrative costs are 2 percent or 5 percent, but private insurance has administrative costs of 10 percent or 20 percent. It sounds much higher. But the difference is, Medicare has patients who are aged 65 or older, or disabled, or who have end-stage renal disease. Private insurance mostly covers patients who are under age 65 and not disabled, and on the whole require lower levels of health care services. The result is that Medicare spends a lot more per patient on direct health care, which means administrative costs as percent of health care costs is almost guaranteed to be lower.

Using percentages might make sense if administrative costs scaled with the level of direct care spending, but it doesn't. The only component of administrative costs that is obviously related to the volume of health care is claims processing, but that is correlated with the number of claims, not their dollar value, and is also a very small share of total administrative costs. For example, in a previous study[1] I found that Medicare's spending on claims processing was about 4 percent of administrative costs, and less than one-quarter of one percent of total Medicare outlays.

Most of the administrative costs of operating a health plan are spent enrolling members, designing the plan rules, establishing provider networks, and other activities that are not processing claims and are not correlated with the number of dollars spent paying health care providers. The same applies to Medicare, to other government programs, and to private sector health plans.

In that study, I found that while Medicare's administrative spending was lower as a percentage of total claims, it was actually higher on a per-beneficiary basis. Medicare's administrative costs were $509 per primary beneficiary, and private plans had an administrative costs of $453 per beneficiary. So Medicare administrative spending was lower as a percentage because their average beneficiary needs more health care—but higher on per-beneficiary basis. (See Table 1.)

Expressing administrative spending as a percentage of total spending is inherently misleading. Medicare's administrative percentage is lower not because they are more efficient, but because their patients are, on average, sicker. Asking for a percentage is simply asking the wrong question.

The second problem in this sort of research is that it is sometimes hard to find administrative costs. Budget documents are not typically written for the benefit of those of us trying to track this information down. Most of the administrative costs of Medicare are in the budget for the Center for Medicare and Medicaid Services (CMS), but some of those costs are in the budgets of other agencies. For example, Medicare enrollment is the responsibility of the Social Security Administration (SSA), some of the revenue is collected by the Internal Revenue Service (IRS), and fraud enforcement is at least partly the responsibility of the Department of Justice (DoJ). Activities corresponding to all of these would appear directly in administrative costs of a private sector health plan.

In the case of private health plans, until 2016 we had the opposite problem. In order to calculate administrative costs, researchers would take total premium revenue and subtract total claims paid, and assume the rest was administrative costs. This is reasonable if one wishes to count taxes as administrative costs, and health services provided directly by the health plan (such as on-call nurses) to be administrative costs as well. But they really are not what we normally think of as "administrative." So, private sector administrative costs were overstated, just as government program administrative costs were understated

Since 2016, data as been available from reports that private sector health plans have been required to file in order to comply with the ACA's Medical Loss Ratio (MLR) requirements. This allows us to separate out taxes and plan-provided health care, and get a better estimate of administrative costs.

Under the ACA, Non-Medicare Administrative Costs Have Increased, Not Decreased

During the debate leading up to the passage of the ACA, proponents argued that one of the benefits of establishing government-run health insurance exchanges would be the reduction in administrative costs associated with private health insurance. These arguments were based partly on assertions of superior efficiency of government operations over those of the private sector,[2],[3] but primarily on the claim that having an exchange would eliminate the need for insurance companies to spend money on marketing. In addition, it was claimed that[4] requiring a minimum Med-

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[1] Robert A. Book, "Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance," Web Memo #2505, The Heritage Foundation, June 25, 2009, at *http://bit.ly/2LMNfsD.*

[2] Paul Krugman, "The Health Care Racket," The New York Times, February 16, 2007.

[3] Steffie Woolhandler, Terry Campbell, and David U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine,* August 2003; 349:768–775, at *http://www.nejm.org/doi/full/10.1056/NEJMsa022033#t=article.*

[4] Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform," Institute for America's Future (undated but apparently completed in December 2008), p.6, at *http://institute.ourfuture.org/files/Jacob—Hacker—Public—Plan—Choice.pdf.*

ical Loss Ratio (MLR)[5] and reduction of executive pay[6] through limits on the deductibility of compensation (Section 9014) would limit the unrestrained pursuit of profit[7]. The predicted impact was that reducing administrative costs would lead to lower premiums and lower national spending on health care without having to reduce the quantity or quality of actual health care delivered.

That is not what has occurred. Instead, total administrative costs increase. While insurers indeed appear to have spent less on administrative costs, both on a per-covered-person basis and as a percentage of total premiums since the law went into effect, government spending necessary to set up and operate the exchanges vastly exceeded the amount saved by private-sector insurers, leading to an increase in total administrative costs. In fact, just the Federal government's expenditures in establishing and operating the ACA exchanges—a function devoted solely to enrollment—vastly exceeds the total administrative costs, both for enrollment and operations—of private-sector insurers prior to the implementation of the exchanges.

In 2013, the year before the exchange provisions took effect, administrative costs averaged $414 per covered person per year in the individual market. In 2014, the first year in which exchanges operated, average costs for the entire individual market increased to an average of $893 per covered person-year. However, this obscures the full effect of the administrative cost of operating the exchanges, because these figures include both those covered in exchanges and those covered by Qualified Health Plans (QHPs) through off-exchange enrollment. For those covered in the exchange, just the Federal government's administrative costs amounted to $1,539 per effectuated exchange enrollee, not including administrative costs incurred by insurers. Because insurers were instructed to report their costs for the entire individual market (both on-exchange and off-exchange) together, it is impossible to determine with certainty the relative administrative costs for both groups. Depending on what assumptions one makes, total administrative costs (both government costs and insurer costs) for exchange enrollees could range from $1,562 to $1,804 and costs for off-exchange enrollees could range from $265 to $414.[8]

Comparing Across Countries

When comparing across countries, this problem of tracking administrative costs and the hazards of reporting those costs as a percentage are even more acute.

Administrative costs of government programs are difficult to track down for U.S. programs, and the same applies to programs in other countries. Few researchers really know how to interpret budget reports from a wide variety of countries, know what relevant data is in other places, and then find it. Some studies take reported administrative costs at face value, but these almost always include different things in different countries. One study[9] attempted to compare the entire administrative cost throughout the health care sector in the U.S. and Canada, and when they could not find certain components reported anywhere simply assumed percentages of revenue (for example, they assumed that one-third of physician office rent and equipment, and one-half of "other professional expenses" was due to administration), and sometimes extrapolated data from a single state to the entire U.S.

In addition, health systems that are organized differently will often end up with administrative costs falling in different parts of the health system, leaving sector-by-sector comparisons meaningless. For example, another study[10] attempted to com-

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[5] Bittany La Couture, "Medical Loss Ratio Under the ACA,"American Action Forum, September 15, 2015, at *https://www.americanactionforum.org/research/medical-loss-ratio-under-the-aca.*

[6] Frank Clemente, "A Public Health Insurance Plan: Reducing Costs and Improving Quality," Institute for America's Future, February 5, 2009, p. 6, at *http://www.ourfuture.org/files/IAF—A—Public—Health—Insurance—Plan—FINAL.pdf.*

[7] Edward M. Kennedy, "A Democratic Blueprint for America's Future,"Address at the National Press Club, January 12, 2005. *http://www.commondreams.org/views05/0112–37.htm;* Pete Stark, "Medicare for All," *The Nation,* February 6, 2006. *http://www.thenation.com/doc/20060206/stark;* Max Baucus, "Call to Action Health Reform 2009," November 12, 2008, p. 77 *http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf;* Hacker (2008), p. 6–8; Clemente (2009), p. 15.

[8] Robert A. Book, "The ACA Exchanges Increased Administrative Costs of Health Insurance,"American Action Forum, December 21, 2016, at *https://www.americanactionforum.org/wp-content/uploads/2016/12/2016–12–21–ACA–Admin-Cost. pdf*

[9] Steffie Woodlander, Terry Campbell, and David U. Himmelstein, "Costs of Health Care Administration in the United States and Canada," *New England Journal of Medicine,* 349(2003):768–775, at *https://www.nejm.org/doi/full/10.1056/NEJMsa022033.*

[10] David U. Himmelstein, et. al., "A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far," *Health Affairs* 33:9(2014):1586–1594.

pare hospital administrative costs across eight countries, but noted that in some countries, hospitals employ large numbers of physicians, which is not the case in the U.S., where the vast majority of physicians practicing in hospitals are not hospital employees. The authors then proceeded to report hospital administrative costs as a percentage of total hospital expenditures. In countries where hospitals employ most of the physicians who practice there, physician pay becomes part of the total expenditures. Naturally, those countries had lower percentages of administrative costs, because they were dividing by a larger number. Of course, those administrative costs didn't disappear—they were just accounted for differently, creating an illusion of efficiency.

This happens at the health system level as well. A hospital that has to bill for its services will have more administrative costs, however measured, than a hospital that receives an annual budget from a government agency. However, in the latter case, the government will have to determine the annual budget for the hospital—a task which, if taken seriously, will involve a complicated study of the mix of care the hospital will be called upon to provide and the resources needed to provide it. That study may be done mostly by people in the government agency, and those people will need to be paid. That pay—and all the other costs of that study—will count as administrative costs.

Likewise for office-based physicians. In some countries with single-payer government-run systems, physicians are paid a fixed salary and are expected to provide a certain level of service per year. Billing costs are replaced by reports about what services are provided, which may cost more or less than billing. In England, for example, patients are allocated to physicians by giving each physician a "catchment area"; if one lives in the catchment area (which may have many physicians) one may visit that physician (similar to a school assignments in the U.S.). Someone has to analyze population and health trends by geography and draw up the boundaries of the catchment areas, and update them periodically. Thus, the cost of acquiring patients for each physician is no longer with the physician (as marketing)—but it doesn't disappear, it just moves to the health plan level, and most likely increases.

Regulatory Compliance

In the U.S., one of the most substantial administrative costs at all levels of health care is regulatory compliance. Operators of health plans must file copious information with state and federal regulators, for example, in order to justify premiums as not too high (because of the burden on enrollees) and also not to low (because they might run out of money to pay claims).

Health care providers of all types are subject to regulations of all sorts. When HIPAA was passed in 1996, the privacy provisions caused substantial administrative costs for nearly all providers to develop new processes, as well as ongoing administrative costs of implementing these processes.[11] There does not appear to be any corresponding savings on other cost categories to offset these extra costs, and it is unclear if the privacy goals were achieved.

The ACA imposed numerous new regulatory regimes on providers, including submitting more data (useful to us researchers, but costly to providers and therefore ultimately to patients and taxpayers). In

one case, proponents of new regulations claimed they would save money—a requirement for most providers to adopt electronic health records was supposed to reduce duplication of tests and diagnostic procedures by making results available to all of a patient's providers. The administrative cost of adopting these new systems has been incurred by providers, but there is no evidence of any savings.[12] In particular, hospitals continue to repeat tests previously done by other providers, perhaps to validate the results, or perhaps because they get paid for doing the tests again (or perhaps both). In this case, a known administrative costs was supposed to reduce actual health care costs, but it failed to do so.

An Urban Legend

I would like to take this opportunity to address one story that has been told in the context of administrative costs, just to illustrate the difficulty in coming by reli-

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[11] See, for example, Peter Kilbridge, "The Cost of HIPAA Compliance," *New England Journal of Medicine,* 348(2003):1423–1424.

[12] Joyce Frieden, "EHRs Don't Save Money or Time, Docs Say," MedPage Today, September 17, 2014, at *https://www.medpagetoday.com/practicemanagement/practicemanagement/47716.*

able facts to discuss this issue. About ten years ago, a prominent health economist, the late Uwe Reinhardt, told the Senate Finance Committee that:

I serve on the board of the Duke Health System, and we consolidated all our billing. We had 900 clerks, and we have 900 beds. I am sure we have a nurse per bed, but we have a billing clerk per bed. I think we have probably worked this down maybe a little, so do not hold me to that number. But that borders on the obscene. [13]

About a year later, one of my colleagues on the panel for this hearing raised the number of clerks to 1300, with the same 900 beds. [14] More recently, about a year ago, he cited figures of 900 beds and 1500 clerks. [15]

In trying to track down this story and verify the figures, I was unable to find the current number of billing clerks in the Duke Health System. I was, however, able to very that the Duke University Hospital indeed has 957 licensed inpatient beds. The Duke Health System includes two other hospitals (with consolidated billing, if Dr. Reinhardt's statement is correct), bringing the total number of beds in the Duke Health System, to 1,512. In fiscal year 2017, those 1,512 beds accounted for 68,523 total admissions.

However, like most hospital systems, Duke provides a large volume of outpatient care, which doesn't involve the use of any of those hospital beds. The Duke Health System also includes physician visits, and if they have truly consolidated their billing, those billing clerks would be responsible for those visits as well. In fiscal year 2017, Duke had a total of 1,482,650 hospital outpatient visits, and 2,291,037 physician visits.

That means that those hospital beds accounted for only 1.78 percent of Duke Health System visits.

In other words, measuring administrative (in) efficiency by comparing the number of billing clerks to the number of hospital beds is utterly meaningless. Those hospitals beds represent only a very small percentage of what those billing clerks are doing.

Conclusion

Administrative costs are a significant component of health care costs, but there is little accurate understanding of how to measure those costs. Part of the problem is that locating and identifying administrative costs in available data sources is difficult.

But a more serious concern is that many researchers and policymakers misunderstand the drivers of administrative costs. Most studies express administrative costs as a percentage of direct health care costs, and approach which necessarily misleads the reader. Administrative costs must be expressed as a dollar amount for each unit that causes those costs to increase. For example, administrative costs of operating a health plan—whether a non-profit or for-profit insurance plan or a government program—is better expressed on a per-enrollee basis. Administrative costs for providers should be expressed in terms of an appropriate measure of units of care delivered.

Furthermore, when comparing vastly different entities—such as health plans in different countries—one has to be very careful to make sure that like figures are being compared.

Finally, it is important to keep in mind that administrative cost is not all necessarily "waste." Patients need to be enrolled, providers need to be paid, and resources need to be distributed. All of those activities generate administrative costs, and all of those activities are essential to a well-functioning health care system.

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[13] U.S. Congress, Senate, Committee on Finance, *Health Care Reform: An Economic Perspective,* 110th Cong., 2nd Sess., Nov. 19, 2008, 34.

[14] Steven Landsburg, "Making Health Care Work," Dec. 15, 2009, [quoting David Cutler] at *http://www.thebigquestions.com/2009/12/15/making-health-care-work.*

[15] Kathryn Watson, "Why is health care so expensive in the first place?" CBS News, Jul. 5, 2017 [quoting David Cutler], at *https://www.cbsnews.com/news/why-is-health-care-so-expensive-in-the-first-place.*

TABLE 1. Administrative Costs of Medicare and Private Health Insurance

Year	Medicare			Private Health Insurance			Percent by which Medicare is higher
	Medicare Primary Beneficiaries	Total Non-Benefit ("Administrative") Spending	Non-Benefit ("Administrative") Spending Per Primary Beneficiary	Total Beneficiaries	Total Non-Benefit ("Administrative") Spending	Non-Benefit ("Administrative") Spending Per Beneficiary	
	(millions)	($billion)	(dollars per person)	(millions)	($billion)	(dollars per person)	
2000	37.06	14.10	$380	202.8	52.0	$256	48.4 percent
2001	37.32	14.40	$386	201.7	56.6	$281	37.5 percent
2002	37.68	15.84	$420	200.9	68.8	$342	22.7 percent
2003	38.11	16.50	$433	199.9	82.2	$411	5.3 percent
2004	38.64	20.14	$521	200.9	85.3	$425	22.7 percent
2005	39.21	19.94	$509	201.2	91.1	$453	12.3 percent

Sources:

1. CMS Medicare Denominator file and medicare Enrollment Database,, Prepared by Susan Y. Fu, center for Medicare and Medicaid Services, Office of Research, Development, and Information. Available from the author on request. "Medicare Primary Beneficiaries" excludes those who have another source of coverage (such as employer-sponsored insurance) and are thus subject to the medicare Second Payer (MSP) Program. Under MSP, Medicare pays only under very limited circumstances, and only to the extent, if any, by which Medicare's payment is more generous than the beneficiaries other coverage.
2. Author's calculations based on Zycher (2007).
3. Bureau of the Census, current Population Survey.
4. Centers for Medicare and Medicaid Service, National Health Expenditure Accounts, ***http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf,*** Table 12 (accessed June 25, 2009).

Originally appeared in: Robert A. Book, "Medicare Administrative Costs Are higher, Not Lower, Than for Private Insurance," Webmemo #2505, The Heritage Foundation, June 25, 2009, at ***http://bit.l/2LMNfsD.***

Table 2. Administrative Costs in the Individual Market

	2013 (No Exchanges)	2014 (With Exchanges)	
	Insurer Costs	Insurer Costs	Federal Costs
Direct Administrative Costs	$4.64 billion	$4.12 billion	$3.63 billion
Grants to States			$6.12 billion
Total Covered Person-Years	11.12 million	15.54 million (on and off-exchange)	6.34 million (on-exchange only)
Administrative Cost Per Covered Person-Year	$414	$265 million (on and off-exchange)	$1,539 million (on-exchange only)
		Combined Administrative Costs (on and off-exchange)	
Total Administrative Costs	$4.64 billion	$13.87 billion (insurer plus federal)	
Total Covered Life-Years	11.2 million	15.54 million (on and off-exchange)	
Administrative Cost Per Covered Life-Year	$414	$893	
Source: Centers for Medicare and Medicaid Services, President's Budget, author's calculations.			

Originally appeared in: Robert A. Book, ''The ACA Exchanges Increased Administrative Costs of Health Insurance,'' American action Forum, December 21, 2016, at ***https://www.americanactionforum.org/wp-content/uploads/201/12/2016-12-21-ACA-Admin-Costs.pdf***

[SUMMARY STATEMENT OF ROBERT A. BOOK]

Most reports give administrative costs as a percentage of total spending, including spending on direct patient care. For example, someone might claim that Medicare's administrative costs are 2 percent or 5 percent, but those of private insurance are 10 percent or 20 percent. It sounds much higher. But Medicare has mainly patients who are aged 65 or older, or disabled, and therefore require, on average, more health care than people covered by private insurance. Dividing by a larger number produces a smaller percentage.

Using percentages might make sense if administrative costs scaled with the level of direct care spending, but they don't. Medicare's administrative spending is actually higher on a per-beneficiary basis. Medicare's administrative costs were $509 per primary beneficiary, and private plans had an administrative costs of $453 per beneficiary. Expressing administrative spending as a percentage of total spending is inherently misleading. Medicare's administrative percentage is lower not because they are more efficient, but because their patients are, on average, sicker. Asking for a percentage is simply asking the wrong question.

Proponents of the ACA argued that one of the benefits of establishing government-run health insurance exchanges would be a reduction in administrative costs associated with private health insurance in the individual and small-business market. While insurers indeed appear to have spent less on administrative costs in this area, government spending necessary to set up and operate the exchanges vastly exceeded the amount saved by private-sector insurers. In 2013, the year before the exchange provisions took effect, administrative costs averaged $414 per covered person per year in the individual market. In 2014, the first year in which exchanges operated, average administrative costs increased to an average of $893 per covered person-year.

The problem occurs in international comparisons as well. One study attempted to compare hospital administrative costs, but noted that in some countries, hospitals employ large numbers of physicians, which is not the case in the U.S. The authors then proceeded to report administrative costs as a percentage of hospital expenditures, including physician pay for some countries but not others.

In the U.S., one of the most substantial administrative costs at all levels of health care is regulatory compliance. When HIPAA was passed in 1996, the privacy provisions caused substantial administrative costs for nearly all providers to develop new

processes, as well as ongoing administrative costs of implementing these processes. Proponents of a requirement for most providers to adopt electronic health records claimed it would save money by reducing duplication of tests and diagnostic procedures. The administrative cost of adopting these new systems has been incurred by providers, but there is no evidence of any savings.

Finally, it is important to keep in mind that administrative cost is not all necessarily "waste." Patients need to be enrolled, providers need to be paid, and resources need to be distributed. All of those activities generate administrative costs, and all of those activities are essential to a well-functioning health care system.

The views expressed here are my own.

Senator MURKOWSKI. [Presiding] Thank you all. Appreciate what you have contributed this morning, and we will begin with questions. Senator Young is first up, but he is not here, so Senator Isakson..

Senator ISAKSON. Thank you. Thank you, Senator Murkowski. I want to make sure I heard this right. Mr. Cutler, you said you thought we ought to have a goal of reducing administrative expenses by 50 percent within 5 years. Is that true? Is that the number I heard right?

Dr. CUTLER. That is correct.

Senator ISAKSON. You think that is doable.

Dr. CUTLER. I do think that is achievable.

Senator ISAKSON. What is the largest single thing you could do to accomplish reduction in administrative costs?

Dr. CUTLER. I think the three items I gave you would be the—would be the three, and those are simplifying the complexity with which we are coding patients so you do not have to search through for everything with the patient, everything that the patient ever had. Second is standardizing preauthorization requirements so you do not have to deal with enormously different systems for preauthorization from every insurer and every business that is buying insurance. And third is electronically integrating medical records and billing systems so that you do not have to have people take information from one system and put it in another. Those three would go a great deal of the way.

Senator ISAKSON. On the—on the last point in terms of software, are you familiar with Cerner?

Dr. CUTLER. Yes.

Senator ISAKSON. Are you familiar with Epic?

Dr. CUTLER. Yes.

Senator ISAKSON. Those are two of the bigger ones. Is that not correct?

Dr. CUTLER. That is correct.

Senator ISAKSON. Is it true that they are—they are not totally interoperable?

Dr. CUTLER. That is correct.

Senator ISAKSON. Does that not contribute tremendously to the cost?

Dr. CUTLER. Indeed. That is exactly the kind of thing I was—I was thinking of.

Senator ISAKSON. Well, good. You are making me look good. Thank you.

[Laughter.]

Senator ISAKSON. Let me just——

Dr. CUTLER. I appreciate you making me look good, too, Senator.

Senator ISAKSON. Well, good. That is two for two. Let me just make this point for everybody, especially the Members of the Senate on the panel. As Chairman of the Veterans Committee, we have just gone through a process of deciding to make our software interoperable with the Department of Defense. So, we have the Department of Defense health services and veterans' health services have been totally separate.

Dr. CUTLER. Yes.

Senator ISAKSON. Different software systems doing this, doing everything else. We have just signed what I understand is one of the largest contracts in the history of the Federal government to acquire Cerner, and for Cerner, which covers the DOD as well, to merge all veterans' healthcare and DOD healthcare into one service. Do you think that things like that will help reduce the overall cost when you merge two big systems?

Dr. CUTLER. I do believe so, especially if done in a way that you can view across—seamlessly across all the different systems so that you can really see what is needed for each particular patient, when you need it, and avoid all the integration hassles.

Senator ISAKSON. Georgia Tech in Atlanta has developed a system called FHIR. Are you familiar with that?

Dr. CUTLER. No, I'm not.

Senator ISAKSON. That is an acronym for interoperable software between different IT systems for healthcare so they can talk to each other. I found out after—I did Y2K in the State Board of Education for the State of Georgia with 187 school systems. We had to all comply with Y2K, and 20 years later, I end up in the United States Senate and Chairman of Veterans Committee, and we are merging Cerner and Epic, two large software systems.

But what I have basically come to learn is that the—all the great simplification that technology brings to information, it is complicated when you have two different sets of systems operating that stuff and they have to talk to each other. And so, I think one of the—I believe—I have come to believe that one of most important things we can do to reduce the cost of administration and recordkeeping, and I would think probably preauthorization, too, would be to have as much standardization and interoperability of software as possible so wherever the patient comes from and whatever hospital or physician is serving them, the system is common so they do not have to redo—re-scramble the egg all over again or unscramble the egg all over again. And I think that is one of the major costs we have seen, and that is why we are doing it in the VA, and I hope we are proven to be right at some point in the future.

Lastly, on preauthorization, how much preauthorization history—is that primarily on surgeries?

Dr. CUTLER. No, it actually occurs throughout the health—throughout healthcare. It is on surgeries. It is on radiology. It is on testing, on minor procedures, dermatological procedures. It happens all over.

Senator ISAKSON. It is designed to reduce the amount of healthcare claims that are filed?

Dr. CUTLER. It is designed to reduce the amount of healthcare claims, and there is nothing wrong with having some differences in policy. Some are more generous, some are less generous. The issue here is that there are so many different ones that it is virtually impossible to keep up with them. So, a typical provider might be facing thousands of different preauthorization requirements depending on exactly which company the patient is insured by and which individual employer sponsored—that patient works for because they may have customized their own preauthorization requirement.

Senator ISAKSON. What percentage—this is one quick question. I had a case number of years ago where somebody in my company had a—went to the dermatologist to have a mole removed, and it was tested. She had to have it tested. It came back benign, and the insurance we had at the time would not would pay for it, said we would have had to pay for it had it been malignant. That is a Catch-22 it seems like to me. Does that still go on?

Dr. CUTLER. Yes, it does.

Senator ISAKSON. Thank you very much. Thank you, Madam Chairman.

Senator MURKOWSKI. Thank you, Senator Isakson. Senator Murray.

Senator MURRAY. Thank you. Thank you to all of our witnesses for being here today, and let me start with you, Mr. Eyles. In April, your association commented on the Centers for Medicare and Medicaid Services' proposal to expand the availability of junk short-term plans. And you wrote that you are "concerned that substantially expanding access to short-term, limited-duration insurance will negatively impact conditions in the individual health insurance market, exacerbating problems with access to affordable, comprehensive coverage." And one of the reasons you stated was that short-term plans are "offered to consumers only after submitting information about their health status or prior medical conditions."

We have spent a lot of time here focusing on paperwork burdens that providers and insurers deal with in our healthcare system. One of the problems with the Trump administration's sabotage of our healthcare system is the paperwork burden it will impose on patients and families. So, can you tell us more about the information patients are often required to submit to purchase short-term plans?

Mr. EYLES. Sure. I mean, thank you, Senator Murray. I think—just as a basic starting point, I think it is important to note that we have supported access to comprehensive coverage, including coverage for preexisting conditions. Now, there are some instances where short-term plans are in the market and that they will be asking consumers for particular medical information. It will vary based on who the insurance provider is. The types of information that they will ask could be around preexisting conditions. It could be around use of medical services in the past. It could be around other risk factors. So, that is the type of information that would be asked for within short-term policies.

I think when we were talking about the impact on the individual market, that is why we expressed some concern about how this would impact the rest of the market. And we said that they should be short-term, of limited duration, and nonrenewable. And, most

importantly, we emphasized the need for clear disclosure to consumers. We want to make sure that there is no confusion as to what policy a consumer is buying. They need to know whether it is comprehensive coverage or a short-term plan. And in our comments back to the Administration, really emphasized the need for clear communication so that people understand what it is that they are buying.

Senator MURRAY. Okay. I appreciate that. I am glad our Committee is looking at a bipartisan way to look at administrative costs, but I hope that we can also work—make sure that we do not impose new paperwork burdens for our patients. Dr. Cutler, I am worried that in addition to imposing new burdens on patients, junk short-term plans will impose new burdens on providers that will in turn be passed, of course, on to patients in the form of higher healthcare costs. Talk to us about how the coverage in short-term plans compare to normal individual market coverage, and do patients typically have to pay more for their care out-of-pocket if they use short-term plans?

Dr. CUTLER. Thank you, Senator. Typically, the answer to that is yes. That is, the short-term policies will not cover as many services or they will not cover them as generously, and so it adds to this set of different policies that providers have to be aware of. And many times they will have particular limitations on, for example, medications that they might access or particular services that they might access, in which case the providers then have to spend much more in the way of resources trying to figure out where to direct the patient. So, all of this complexity really adds to expense without reducing what the needs of the patient—without affecting the needs of the patient, that is not by making the patient healthier.

Senator MURRAY. Right. And so, when hospitals and clinics receive less of their payment from insurers and more out-of-pocket, does that increase or decrease the amount of time they spend on bill collections from patients?

Dr. CUTLER. A much, much greater increase.

Senator MURRAY. Much.

Dr. CUTLER. Many hospitals now, because of the increase in high cost-sharing health plans, are devoting many more resources to collecting money from patients than they used to, and that has been a very big burden for a number of organizations.

Senator MURRAY. What is the likelihood patients will not pay, leaving hospitals with more uncompensated care?

Dr. CUTLER. That is also very high, Senator. The typical American family has $600 in its bank account, and so when faced with a deductible, let us say, of $3,000, or even a service that is not covered entirely, they do not have the resources on hand to pay for it. So, either they put it on a credit card, in which case it goes into general unsecured debt, or the provider institution works out some arrangement with them and then spends a lot of money collecting the amounts down the road.

Senator MURRAY. Okay. Thank you. So, I am really concerned if we expand the use of skimpy junk insurance plans, hospitals and clinics are going to have to do more work to collect bills, it sounds like. And when patients are unable to afford the huge bills they are stuck with, hospitals will have more uncompensated care, and that

increases costs for everyone, and obviously providers shift those costs back to patients. So, that is my concern with this and one I think we should all be aware of, so I appreciate your responses. Thank you, Madam Chairman.

Senator MURKOWSKI. Thank you, Senator Murray. Senator Young.

Senator YOUNG. Dr. Cutler, in your testimony you discussed an economic arms race between payers and providers that causes administrative costs to skyrocket as payers try to prevent unnecessary payments. In short, it works this way: insurers introduce requirements providers must fulfill before they can get paid, and in response to the new rules, providers hire additional personnel to maximize the amount they are reimbursed. It goes on and on and on, and consumers get stuck with the bill. Are there actions that Congress can take to incentivize payers and providers to avoid this escalation is my question, number one. And then question number two is whether Federal payers, like Medicare and Medicaid, are part of this problem.

Dr. CUTLER. Yes. Thank you, Senator. On the first question, yes, there is a good deal that could be done on standardization. Again, I want to just go back to the question Senator Isakson asked, which is how would one do it. So, the complexity of coding is a clear example of this where an insurer will require additional codes before it will pay a higher amount, and then the provider system will hire additional people to code those additional codes, and then seeing that the codes are still going up, the insurer puts in additional requirements, and so on. So, standardizing, or, in this case, eliminating, many of the severity adjustments would make a lot of sense because then you do not have to get in an arms race over that.

Second, to standardizing on the preauthorization requirements, again, you have the situation where it may be perfectly reasonable for one insurer in its thinking on its own to say I am going to have a tougher preauthorization requirement, and they do not recognize the enormous burden that is placed on the—on the providers and on the other insurers by now contributing to the cacophony of different things that a small provider system has to deal with.

Then integrating billing systems and medical records systems, which, again, is an area where standardization—the Federal government has responsibility for the standardization through the High Tech Program, and it has not done so in this dimension, which I think has been a lost opportunity so far. So, I think in all of those, there are areas where the Federal government will have to be uniquely involved in it.

In terms of the Federal payers, I think they vary enormously. The Medicare program probably involves less administrative cost for providers than the Medicaid program does. And the reason is that preauthorization requirements could be minimal in Medicare with the exception of Medicare Advantage where the private insurers will do what they do. But the preauthorization is relatively small, and other than— you still have things associated with complexity, but by and large, it eliminates some of those costs.

I think Medicaid is somewhat different in part because patients churn a lot from one plan to another, from one type of system to another. That churn creates difficulties for a lot of providers be-

cause it is not entirely clear who is going to be insuring the patient when that patient comes to use services, or even if at all, if that patient is going to be insured at all. So, it is something where the difficulty of getting universal insurance coverage has played havoc on providers, not just in terms of lost revenue, but in terms of increased expense associated with having to monitor patients, collect from them based on whatever plan they are in, and see through all the other parts of it.

Senator YOUNG. Thank you. And in your response to me, Doctor—in your response to me, Doctor, you referenced the coding and the severity levels. And you have discussed in your testimony the potential for severity neutral payments whereby providers are not paid more, with some exceptions, for more severe cases. Would agreements between payers and providers to allow providers to share in some of the savings for agreeing to severity neutral compensation from payers require new legislation or regulation to your knowledge?

Dr. CUTLER. It would—one could have private agreements like this that would not. In order to really be effective, you would have to do it for the vast part of the healthcare system because it is very difficult to have different payers with different requirements and save a lot on administrative expense. So, the greatest gains would come from standardization and harmonization, which necessarily involves the Federal government.

In fact, the reason why many providers and insurers in the private sector have not gone there, and maybe Mr. Eyles will agree or disagree, is because if the Federal government is acting a different way, it just makes no sense to do something different from that. So, it has to be in concert particularly with Medicare, but also with Medicaid, in order to get maximum effectiveness.

Senator YOUNG. Mr. Eyles.

Mr. EYLES. Sure, and that is a good point, Dr. Cutler. As we think about standardizing prior authorization, I think it is also important to note that there are a number of private efforts that are within also the congressional purview. So, what is happening with the Council for Affordable Quality Healthcare is that they have created a committee with over a hundred organizations looking at how can you standardize these processes and these transactions to get a more simplified way of operating so you can do these in real time. So, right at the point of treating an individual patient or a point of prescribing. And so, there are efforts that are happening, but that is not to say that more cannot be done.

Senator YOUNG. Thank you.

Senator MURKOWSKI. Thank you, Senator Young. Senator Hassan.

Senator HASSAN. Thank you, Madam Chair, and thank you, Ranking Member Murray, and thank you to all the witnesses for being here today. We are talking a lot this morning about administrative burdens in the healthcare system, how they affect doctors, hospitals, insurers, and the government. But I think it is important that we remember the most significant part of this whole discussion, which is patients and their families. I am the mother of a son with very complex medical needs. At various times—Ben is a wonderful young man, 30 years old, who happens to have very severe

cerebral palsy and a lot of the medical complications that go with that. And also because he does not speak or use his fingers or communicate very clearly to the outside world, although he is cognitively understanding everything. He is time consuming.

We have been very fortunate because Ben has had some incredible providers and caregivers, but I have experienced firsthand what it is like to be forced to jump through administrative hoops, being stuck in the middle between multiple providers and insurers because we have private insurance, but Medicaid also covers Ben, or sometimes dealing with an insurance company employee who simply does not have the expertise to understand the significance of the medical record he is looking at. I have also been there when the insurance all of a sudden decides to switch him from one medication that works for him that he has been on for years to another medication. Ben has about—at various times has had about 10 doctors and about 20 medications.

I hear from Granite Staters who experience these frustrations, too. It is hard as a patient or a family member to spend all day on the phone, wondering, for example, if a prior authorization went through. It is particularly hard when you are juggling a job, caring for kids, and all the other daily activities that families have. I will also note that we have talked about the importance of integrating electronic medical records for purposes of administrative fees, but I can tell you how important it is to patient safety. At 3:00 in the morning when your hospital that owns your physician's practice tells you that they cannot get access to your son's primary care health record because they are on different electronic systems, and all of a sudden the doctor saying to you, do you remember 15 years ago when your son had that one pneumonia whether we used this antibiotic or that antibiotic. It is pretty scary.

When we are talking about administrative burdens, I think we really—what really would make a difference is to eliminate these burdens for patients and their families, not just for their time and effort, but also for good patient outcomes. So, could all of you just address, and we will just go down the line. We will start with you, Ms. Hultberg. What can Congress do to help reduce administrative burdens in the healthcare systems for patients and their families?

Ms. HULTBERG. Thank you for that excellent question. To echo what some of the other panelists have said, I think more alignment within private payers around things like preauthorization, around billing. And to Dr. Cutler's point earlier, not just private payers, but Federal payers as well. From a hospital perspective, the Federal government in its—with the many ways it funds healthcare does not handle all of these things consistently. So, I think there is a role for the Federal government in looking at Federal payers, how do we—how do Federal payers manage preauthorizations, billing requirements. And there is much more of a role for health insurance plans in taking ownership of this issue and taking steps to streamline these requirements to make it easier for patients.

Senator HASSAN. Thank you. Mr. Eyles.

Mr. EYLES. Thank you for sharing your story. I think it is really important to recognize the impact on patients, and I know as we have been talking about this that is where we need to start. Thinking about the burden on families and caregivers, I think getting to

a truly interoperable system where those medical records are able to be accessed at any point in time and any place, and being able to do so in an electronic fashion, and tap into them. I think Senator Isakson touched on some of the interoperability challenges.

Health plans are committed to being part of the solution, but we can only be one part because it has to work between plans, it has to work between providers, and it also has to work between the Federal government. So, aligning a lot of those standards and making it simpler, more automated in real time would alleviate a lot of that burden to have to bring in the patient in the first place and really allow it to happen with the provider.

Senator HASSAN. Thank you. Dr. Cutler.

Dr. CUTLER. I echo everything that was said. I also just want to make one comment, which is that while the Federal government has been slow to act in some of these areas, a number of states have made progress in terms of trying to increase the interoperability, and particularly around issues of the ownership of the records and your right to access to records everywhere. So, and I know Senator Smith comes from a state where that has been—probably has done as much as any state on those lines. And so, I think we can do much more with the sort of technology backbone, but also with the personal interactions, to make sure that people have access to their records which belong to them.

Senator HASSAN. Thank you. And I know I am running out of time, but could I ask Dr. Book to just comment quickly?

Dr. BOOK. Thank you. Your story illustrates exactly what I mentioned in my testimony about the administrative burden on patients that no one seems to talk about very often. I think I have experienced that for myself. I think a lot of other people have experienced it. And it is—and it is not just in healthcare, too. It is a—it is a—I experienced an issue like this with the IRS where one side—one person says I have paid and then I get a letter saying I did not pay.

Simply putting this under one organization may not solve it, but there is one thing we could do is establish a safe harbor from, say, antitrust concerns that might inhibit different information systems companies from talking to each other——

Senator HASSAN. Yes.

Dr. BOOK.——so they would not be afraid that they would be prosecuted for collusion because they—they talk to each other about a standard data interchange format.

Also, there are a lot of restrictions on patients' access to their own data. I have an implanted defibrillator that is constantly tracking data on me. The company that made it used to have a web portal where patients could get their own data, and that was shut down because it was found to violate some regulation. I do not see why there should be a regulation that prevents patients from accessing their own data at three in the morning or any other time.

Senator HASSAN. Well, I appreciate that very much. Thank you, Madam Chair, for letting me go over, and I will submit a question on transparency and outcomes which I think is important as costs, too. Thanks.

Senator MURKOWSKI. Thank you, Senator. It is such an important question. When we think about the administrative burden it

sounds so technical, but at the end of the day, it all comes back to the individual, the patient, and their families.

Ms. Hultberg, I wanted to ask you about the rule that you briefly referenced. This is this minimum rule of five where CMS requires at least 5 percent, but no fewer than 5, skilled nursing facilities in a state every year get surveyed. So, in the State of Alaska, we have got 17 facilities, so we are in a situation where we get the benefit, I guess, of about 30 percent surveys. CMS surveys five each year, so it is about 30 percent. You put that in a state like California. I do not know how many facilities they may have, but I—we all know that it is well over 17.

You mentioned in your testimony that the rural areas simply lack scale, and with this particular regulation you can see how the lack of scale forces even greater costs on a facility because of these requirements . You have got civil penalties that you have to deal with and just the reality of undergoing the frequency of these surveys. Can you speak just briefly to this issue of scale in our rural facilities and how regulations just like this can add to the already heightened costs?

Ms. HULTBERG. Sure. Thank you for the chance to answer that question, Senator. So, you very accurately described the minimum of five rule. I actually do happen to know that California has 1,200 skilled nursing facilities. So, that means they receive a Federal survey once every 20 years. Mine receive one every 3 to 4 years.

Why is that important? That is important because the Federal surveyors have two responsibilities. Their responsibility is to oversee the state surveyors who conduct annual surveys of our facilities and to do the check to check the facility itself. So, these surveys tend to have a high number of deficiencies. Not all those deficiencies are related to patient care. And there is a tremendous burden on the facility after a survey in then writing up very detailed plans of correction for each individual item found in the survey. Those are resources, often clinical staff, nurses, or others that could be devoted to patient care. They could be——

Senator MURKOWSKI. This goes back to your opportunity costs.

Ms. HULTBERG. Absolutely, Senator. It could be devoted to other things. Why is it hard in a rural facility? Well, imagine a rural facility where you have maybe 11 beds and you have five surveyors descend on your facility for a week. Now, they are going to find—they are going to find things that you are going to have to write up and address. It is a tremendous direct cost. It is, as you said, a tremendous opportunity cost. So, we think that there should just be a one standard framework for surveys that is consistent across states.

Again, our facilities welcome the opportunity to correct things related to patient care, but many of these things are not. As an example, we had a facility working really hard to serve culturally appropriate food to its elders. They received a deficiency for serving too much fish.

[Laughter.]

Senator MURKOWSKI. There is no such thing as too much fish.

[Laughter.]

Ms. HULTBERG. I was not aware there was in Alaska either. But those are the kinds of things that are costing resources, staff, time,

dollars, and put particular burdens on those small facilities that have less available.

Senator MURKOWSKI. Let me ask about this rural healthcare strategy. CMS announced this several months ago and wants to focus on this rural healthcare strategy. I sent a letter to Administrator Verma suggesting that there is no one rural lens, that a rural healthcare strategy needs to be a little bit broader. Can you—can you speak to that aspect of it, that if we just think of rural—you got urban, you got rural, and treat them differently that way. But explain to—explain to the Committee here the challenges that you face there.

Ms. HULTBERG. Senator, excellent point. When we think about rural, our definitions are different. A rural hospital in Colorado might be a hundred beds and that is considered rural. And then we look at a community like Wrangell where they have an eight-bed hospital plus some swing beds, so the needs of those facilities are going to be very different. We appreciate CMS' focus on rural and their desire to have a rural lens to look at hospitals and other healthcare providers, but we think it needs to not just be a single rural lens, as you noted, but it really needs to consider the different geographies, the different patient populations, the different types of facilities.

I think that the operative word there is "flexibility." When you look at a state like Alaska, our needs are going to be much different than a state like Iowa. So, I think there are many examples that I could point to of ways that CMS could take that philosophy, develop more flexibility, and then be more responsive to the needs of our communities, whether it is the electronic health records, direct supervision, or other areas.

Senator MURKOWSKI. Well, we would welcome that input as they do work forward on this strategy so that there is a full appreciation of that, so thank you. Senator Smith.

Senator SMITH. Thank you, Madam Chair and Ranking Member Murray, and thank you so much to all of our panelists for being here today. It is very interesting.

I am going to just brag on Minnesota a little bit. We are a national leader when it comes to delivering high-quality care, and we also have been innovator and a leader when it comes to reducing administrative costs, and one innovation is Minnesota's Healthcare Administrative Simplification Initiative. And what it has done is to launch a series of reforms to standardize and automate healthcare transactions, and it is saving tens of millions of dollars in Minnesota.

Dr. Cutler, I wanted to—you raised this I think. I wanted to ask you a little bit more about this. I am wondering how innovations like this at the state level can inform the kind of changes that we need to make at the Federal level. It strikes me that there are so many—states have so much to do with how these programs are implemented, how insurance companies are regulated. They have a pretty vital role to play. Could you just speak about that a little bit?

Dr. CUTLER. Yes, absolutely. So, there are a number of areas where states can make enormous progress, and you mentioned Minnesota, which I believe is justifiably proud—should be justifi-

ably proud. I think also places like Utah nearby, but with a different obviously background, have also made progress there. So, those are very good in that they provide great examples to work from. They show concrete savings. They show satisfaction on the provider system. They show how insurers, and providers, and patients locally can come together.

They also reach a limit in terms of what they can do. So, for example, they cannot do things that affect Medicare because that is Federal, and they typically cannot do that. They also cannot do things that affect the ERISA market, the large firm market where the employees are self-insured, because those are not affected by state insurance regulations. So, I think they provide significant savings and proof of concept with which we can then use to build both nationally and in other—and in related domains.

Senator SMITH. They can kind of—they could show us ways of demonstrating what works, experimenting, and then that could inform——

Dr. CUTLER. That is correct.

Senator SMITH.——what we do at the Federal level, though certainly it cannot solve the issues at the Federal level. Mr. Eyles, would you—I see you are nodding your head. Would you like to comment on that?

Mr. EYLES. Sure. I think that is a very good observation that you can learn a lot from the state level. But when you think about just how healthcare operates in different regions of the country, how it is practiced, whether it be in the upper Midwest, or in California, or in other places, to scale it on a national level, I think that really is informative in terms of the steps that the Federal government could take or that Congress could take to move things forward. But it is hard to sort of replicate exactly what Minnesota would have done in every other state.

Senator SMITH. Thank you for that. I am—I am quite interested in this as a way of demonstrating what we might be able to do as we try to figure out how to tackle the big kahuna that we need to tackle here in this Committee and at the Federal level. I have actually been working on some legislation to figure out how to support these kinds of public/private partnerships at the state level as a way of demonstrating success, and I look forward to talking with some of the other Members of my Committee, this Committee, on this as well as we move forward.

I would like to go to this question of preauthorization that Senator Hassan was talking about the impact that this has on people. And I cannot tell you the number of Minnesotans that have told me about their frustration, getting caught in this Catch-22 of trying to get the care that they know that they or their family member need while at the same time they are hung up getting the documentation together. Mr. Eyles and Dr. Cutler, both of your testimonies raised this issue as an opportunity for simplification reforms. And, Mr. Eyles, I would just wonder if you would support the kind of standardizing of prior authorization protocols that Dr. Cutler was talking about across products and payers. Do you think that something like that could work?

Mr. EYLES. I think it has potential. I think it is important to look at exactly which population is being served by each program. You

know, Medicaid is a little different than Medicare, is a little different than the commercial marketplace. But I think there are elements certainly that could be standardized, and I know that our members, again working through examples with CAQH and others to create that standardization, to make it easier for providers to take patients out of it, I think have a lot of potential.

Senator SMITH. Thank you. And, Dr. Cutler, do you see— where do you see the resistance to this kind of standardization, prior authorization?

Dr. CUTLER. You know, it is—resistance? I am trying to think of the right word because "resistance" is not quite what going is through my mind. It is really more a reluctance, and to a great extent it comes from the insurers because they all have customized their own systems and they put them in place, and then you say—and they do it for each individual business that they insure and so on. And then you say, well, we ought to have standardization, they say, but—yes, but what will happen to what I put in place.

It is the sort of cost of change is what staring them in the face, and they are a little bit——

Senator SMITH. Sure.

Dr. CUTLER.——perplexed about how to deal with that. It reminds me a little bit about providers when they were faced with the choice of buying electronic medical records or not. Most of them had a difficult time implementing it, but then once it was implemented, they are extremely glad they did so, and they believe they provide better patient care.

Senator SMITH. Right.

Dr. CUTLER. The evidence shows that.

Senator SMITH. Right.

Dr. CUTLER. It is just a question of getting over the hump that says, yes, we can do this, and then we will achieve these benefits.

Senator SMITH. There is such incredible inherent complexity in the way that America uniquely provides healthcare to people, and most complexity is there for some reason that made sense some time, but the question is how do you clear that all out for the benefit of the patients and their families. Thank you very much, Madam Chair.

Senator MURKOWSKI. Thank you, Senator Smith. Senator Cassidy.

Senator CASSIDY. Thank you, Madam Chair. Gentlemen and lady—I am sorry—I have got a bunch of questions, so if I hustle you along, it is not to be rude. Obviously, I am very interested in this topic. I have—on my website I have "Making Healthcare Affordable Again," and one of the things we address is administrative costs.

Now, some of this, I have to admit, there is kind of cognitive dissonance. Dr. Cutler, you mentioned how kind of ascribing to the Federal government the role of making things less administratively burdensome, and I am thinking, man, I must be dropping acid. Not that I have ever dropped acid——

[Laughter.]

Senator CASSIDY. For the record I have not.

[Laughter.]

Senator CASSIDY. But in one of the briefings we were given, the American Hospital Association has a report, "Regulatory Overload," 629 different regulatory requirements from four different Federal agencies.

Dr. CUTLER. Yes.

Senator CASSIDY. I am sure Mr. Eyles could give me the same thing for insurance. Having practiced medicine, it is incredible how much the Federal government loads upon us, and I almost—my jaw dropped when you said most providers are pleased about the electronic health record. Actually, I read the leading cause of burnout for physicians is the electronic health record. So, I am not sure who is finding it so—who is so enamored because the electronic health record is just so burdensome. Somebody put their testimony 30 minutes of clicking for every 5 minutes of seeing a patient. They said 30/30. I find is 30 minutes of clicking for every 5 minutes of seeing a patient. It is just a parallel reality if we are going to say that patients—that docs enthralled with this. And I say that not to chide or to confront, but just to observe.

Dr. Book, I like your perspective. We have not looked at the administrative burden upon the patient or the physician. We have looked upon it on the system. Yes, the physicians some, but nearly as much. One model we talk about in our white paper is the direct primary care model in which a patient pays a monthly fee, and the doc does not bill insurance companies for those services covered by the monthly fee, and the patient does not have otherwise a deductible or copay, coinsurance; rather, it is just that monthly fee. Senator Cantwell and I have a bill that would promote this. Any thoughts about direct primary care? Are you familiar with that?

Dr. BOOK. I am not familiar with it before, but it sounds like it has potential. I think the question I would want to know is will that—is what percentage of the healthcare system will be affected by that. That could be obviously effective for a large percentage of patients, but the real—the real dollars—the large dollars are going into very sick patients needing specialty care.

Senator CASSIDY. You mentioned that.

Dr. BOOK. Trying to confuse us.

Senator CASSIDY. The way it works is that you would still have catastrophic coverage on top. It started in Washington State; hence, Senator Cantwell's interest. But for that kind of ambulatory service, I have a headache on Friday afternoon, I do not go to the ER; rather, I go see the doc with whom I have a contract.

Dr. BOOK. Right.

Senator CASSIDY. That seems to work for the both the patient and the doc. It gets them out of the ER.

Dr. BOOK. Like I said, that sounds like it has potential, and I would be happy to look at it and answer and say something for the record—write something for the record later if you would like.

Senator CASSIDY. Got you.

Senator CASSIDY. Dr. Cutler, you had mentioned the issue with prior authorization and how Medicare does not have prior authorization, but Medicare has an ungodly amount of waste, fraud, and abuse. Go down to South Miami and there is mansions built upon waste, fraud, and abuse from Medicare.

Dr. CUTLER. Yes.

Senator CASSIDY. There is that tension of the prior auth with the absence of Medicare, yes, but a lot of—now, I like your concept could we standardize. But, Mr. Eyles, for you to suggest it is not burdensome upon the patient, when I would see—when I was doc, when I would see patients, my nurse would just put the phone on speaker as she heard over and over again, "Your call is very important to us, please hang on," and 45 minutes later that very important call get answered. And, yes, it would be then approved. Frankly, docs perceive the prior auth is used merely as an obstacle by which they will not prescribe a certain therapy even if it is indicated, just to say that.

Why could this not be integrated into the electronic medical record? Why does my nurse have to be on the phone as opposed the insurance company just being able to otherwise access?

Mr. EYLES. Well, I think the challenge right now, Senator Cassidy, is really around interoperability of electronic medical records.

Senator CASSIDY. Now, I thought, though, Humana gets all my billing data, for example, because when I tour their MA plan, they truly do download all my billing data.

Mr. EYLES. And——

Senator CASSIDY. Why do they not use that?

Mr. EYLES. Well, and that may be for some plans, and it may not be for all electronic medical record systems, right? I think that may be a good example of something that we can learn from in terms of how we could scale that and apply that more broadly. But right now——

Senator CASSIDY. Okay. Now, let me stop you. Dr. Cutler, you had mentioned that there is increased overhead associated with private plans, and yet what I have read is that in countries such as the Netherlands, which only use private plans, they still have half of our administrative overhead. So, it does not seem inherent that it is going to be the Federal government because, as Dr. Book convincingly tells me, the overhead associated with Medicare is actually more costly than private plans. There is something the Netherlands does, though, that it is different. Any comments on that?

Dr. CUTLER. Yes, in most countries—the Netherlands is an example, Germany is another example where they have competing private plans—private plans are highly regulated. So, they do not impose, for example, preauthorization requirements.

Senator CASSIDY. It kind of goes back to the standardization of what you would do.

Dr. CUTLER. It goes back to standardization and to they do not have the different—all the different severity codes and all of that, so they have eliminated a lot of the administrative costs.

Senator CASSIDY. Got you. And so, two more things about that. Mr. Eyles, I have heard of something called a real-time benefit analysis. Going to the interchange between Senator Murray and Dr. Cutler, the patient does not know how much something costs. By the way, I will note these horror stories under Obamacare policies, not under limited programs. But that said, a real-time benefit analysis where you can press a button and the patient automatically knows how much they owe relative to their coinsurance and copay. I am told some insurers have this, have not just yet implemented. Why would this not be more broadly available?

Mr. EYLES. Most of these tools are available through our members. The vast majority, well over 80 percent of them have these types of tools. The question is are they being used at the point at which care is being delivered.

Senator CASSIDY. I was told specifically they have not yet been deployed in the sense that when I go to my MRI, that I can click and it is on my coinsurance to the doctor, boy, I have 200 bucks left to pay. Dr. Cutler, you are nodding your head. Are you familiar with which I speak of?

Dr. CUTLER. Yes, in fact, that is true. A number of them have—some of them—some of the plans do not have it. A number have it, and either they do not make it available or it is only available in very difficult to access circumstances.

Senator CASSIDY. Yes, it seem like we need to make an app for that, right, Dr. Book?

Dr. CUTLER. Absolutely.

Dr. BOOK. I can tell you from my personal experience that sometimes they get it wrong. There was a provider who told me I still had some left on my deductible when I had actually fulfilled my entire out-of-pocket limit for the year. So, the information they get is not always correct. I am not sure why that is.

Senator CASSIDY. It needs—it is still beta version, but it——

Dr. BOOK. Well, no, it is a great concept, and it works if go to the pharmacy, but it does not seem to work anywhere else.

Senator CASSIDY. I am way over. Thank you, Madam Chair, for your indulgence. Actually, I have one or two more, but I will let it go.

Senator MURKOWSKI. I think we will have an opportunity for a second round real quick. Senator Warren.

Senator WARREN. Thank you. So, the cost of healthcare is too high, we are looking for ways to bring it down, and today we are focused on administrative costs. I actually want to zero in on how much private insurance companies spend on administration compared to public programs like Medicare.

There has been a lot of debate about how to do this comparison. The 2018 Medicare trustees report states that administrative costs for Medicare are $8.1 billion. That is somewhere between 1 and 2 percent of overall expenditures. That is a whole lot lower than the administrative costs in private insurance, which seem to range somewhere between 10 and 12 percent, depending on who you ask, who paid for the study, and what data you are using. But some people argue that Medicare beneficiaries have higher medical costs than the younger, healthier people who are on private coverage, which makes administrative costs look artificially small as a share of Medicare costs, so we should use dollar amounts instead.

Dr. Book, you have made this argument, and you have done an analysis that claims Medicare actually spends more dollars per beneficiary. I think you were just quoted by Senator Cassidy on that, that Medicare actually spends more dollars per beneficiary on administrative costs than private insurance. Is that right??

Dr. BOOK. That is correct, yes.

Senator WARREN. Yes. So, I want to dig in to how you reach that conclusion. You argue that we should add to Medicare administrative costs the costs of all the other ways that the Federal govern-

ment supposedly subsidizes Medicare by doing things like keeping records, writing laws, collecting revenues at the IRS.

Dr. BOOK. So——

Senator WARREN.——maintaining Federal buildings, paying salaries in Congress, the list goes on and on. Your analysis specifically says that you want to take a flat percentage of expenses, "the general government function." This is in your work, "the general government function part of the Federal budget" and relabeling that as Medicare administrative costs.

In other words, Dr. Book, you are saying that because we are sitting here today discussing Medicare at this hearing, we should count as Medicare costs a piece of the salary of every Member of this Committee, a piece of what it costs to keep the lights and the air conditioning on in this hearing room, a piece of what it costs to run the electricity to your microphone, a piece of the salary for the Capitol Hill police officer at the door, and all as part of Medicare's administrative costs?

Dr. BOOK. I was trying to do an apples-to-apples comparison between the cost of operating Medicare and the cost of operating private sector——

Senator WARREN. I am just looking at what you said. So, the—a piece of the Federal government function.

Dr. BOOK. Right, I understand. I understand that. And the items you mentioned, yeah, are included, but they are tiny. They are pennies. What is more important is private insurance companies have to send out bills——

Senator WARREN. Well, they are only pennies—I am sorry, let me stop you there.

Dr. BOOK. Private——

Senator WARREN. Dr. Book, I am just trying to get how you calculated this. They are only pennies because I just picked out a few things.

Dr. BOOK. Right.

Senator WARREN. You added it up over the range of the entire Federal government. Look, I am all for trying to use the best data possible when trying to figure out what something costs.

Dr. BOOK.——data, I could tell you if you would like.

Senator WARREN. But this approach does not have any credibility at all. This is just a game to inflate the numbers.

Dr. BOOK. May——

Senator WARREN. I want to look at some of the numbers that are not in dispute. Mr. Eyles, you work for AHIP, the trade association for insurance companies. So, you are here working today for the insurance companies. The five largest for-profit insurers in the country reported roughly $20 billion in profit last year. Can you tell me how does that compare to the profits the Federal government makes on Medicare and Medicaid?

Mr. EYLES. I think it is important to look at the context of profits overall.

Senator WARREN. How does it compare?

Mr. EYLES. I could not say. I do not know that——

Senator WARREN. You could not say? Let me tell you, it compares to zero because the Federal government does not make a profit——

Dr. BOOK. Actually, Medicare loses money.

Senator WARREN.——on Medicare or Medicaid, or, for that matter, on the Veterans Health Administration, or the Indian Health Service, or TRICARE, because these programs are about providing healthcare, not raking in money for profits or handing out dividends to shareholders.

You know, we can go back and forth on whether administrative costs in Medicare are 2 percent or 7 percent.

Dr. BOOK. They are not a percent. They are a——

Senator WARREN. But one thing is perfectly clear. When giant for-profit companies divide up who gets what out of the premium dollars that they rake in, they never forget to set aside a few billion dollars for themselves. And I think that is why it is time to crack down on the shady practices that insurance companies use to juice their profits at the expense of families that are struggling to get by. And I think it is time to ramp up the fight for Medicare for all so that everyone is covered, no one goes broke because of a medical bill, and we start treating healthcare like the basic human right that it is, not like a profit center for multibillion dollar corporations.

Thank you, Madam Chair.

Senator MURKOWSKI. Thank you, Senator Warren. Senator Scott.

Senator SCOTT. Thank you, Madam Chair. I have decided to pass on my time to Dr. Cassidy. He was doing such a fantastic job. I do want to make a quick comment on the Medicare for all. Having spent about 25 years in the insurance industry, one of the things I think we ought to do, and I think that Dr. Book was starting down that path, is to understand and appreciate the overall cost that the government bears for every single program that we have. So, when we are spending $4 trillion as the government, bringing in $3 trillion dollars as the government, the taxpayers are the ones that are losing the elasticity in their paychecks because their money is coming to Washington, compelled to do so for programs that perhaps could be better provided through the private sector if we look at the overall cost structure.

You cannot not look at every facet of what causes something to cost what it does in the government perspective. You just cannot articulate with great specificity the real challenge that the taxpayer has for all of the nuances that the government brings with it when it provides healthcare or any other service. Dr. Cassidy?

Senator CASSIDY. Hey, thank you, Senator Scott. I just cannot help but, in all due respect to Senator Warren, comment on a couple of things. Dr. Book, your analysis has total credibility with me, and I will say it because the first time I saw that the DOJ was doing a major anti-fraud thing on all the rip-offs in South Florida and Louisiana on Medicare, and I realized that Blue Cross would have done that on their own ticket, and instead it is the Federal—it is the DOJ doing it for CMS made me realize that was not being included as part of their—as part of it.

As regards to Medicare for all, again, I cannot help but just mention that the Urban Institute—pretty liberal— MRCADS, as well as the Tax Policy Center have all come in with numbers roughly the same, roughly that we would—it is just quite remarkable—Medicare for all under conservative estimates would increase Federal budget commitments by approximately $32.6 trillion dollars in

the first 10 years of full implementation, would have to double corporate and individual taxes. It still would not be enough to pay for everything. So, just to say that there has to be a little bit note of reality as opposed to wishful thinking and all this.

Now back to the questions I had kind of on my own. Mr. Eyles, a major—and Ms. Hultberg, a major part of the administrative overhead associated with all of this is negotiating prices. Somebody pointed out to me that Medigap policies proliferate. Even on the Obamacare individual markets they are very limited, and partly is that Medigap policies are able to piggyback onto Medicare pricing. All that effort to negotiate has been done, to Dr. Cutler's point, and so you can just say I am going to pay you Medicare pricing, and then the insurance company can come in and immediately has a provider panel.

Now, Mr. Eyles, what would you think if, say, on the individual exchanges in a state where you only have one or two insurance companies, like Louisiana—effectively a monopoly—you could say, okay, we are going to allow insurers to come in and to use Medicare pricing or a multiple, 1.2, 1.3 times Medicare pricing, and they are immediately in business to provide competition to the stakeholders. Why is it important? It has clearly been shown when you have only one or two dominant insurers, costs go up. If you have more competition, cost goes down. And they may get after what Dr. Cutler says in these countries like the Netherlands, one of the ways, I am sure, they regulate is by pricing. I see he is nodding his head. First, as a provider, Ms. Hultberg, what would you think of that?

Ms. HULTBERG. I am going to defer a detailed answer on that—to that to the insurance colleague next to me. I will note a couple of things, though, with respect to Medicare. First of all, Medicare does not cover costs in my state. So, as we talk about——

Senator CASSIDY. It could be a multiple.

Ms. HULTBERG. It—and "multiple" is fair, and there are—there are insurance companies currently who are basing pricing off a multiple of Medicare. So, but I do think that as we have this conversation, whether it is Medicare for all or some other variation of Medicare pricing, it is really important to note that often Medicare does not cover costs, and in my state it is pretty, generally speaking——

Senator CASSIDY. I cannot help but say that under Graham-Cassidy, the amendment that we had put up, Medicaid in Alaska would have been—had their true costs recognized. For some reason, your governor strongly opposed having his true costs recognized, but that is up to him. Mr. Eyles?

Mr. EYLES. I mean, let me start by saying we support having access to choice and competition within the marketplace, and we think that is really important. I think right now, the knowledge about the Medicare fee schedule, about what is what Medicaid is paying is available out there. I think we want to make sure that plans are negotiating with physicians in the most effective way, that they we are moving the system towards paying for value, not just looking at what Medicaid or Medicare might be paying. So, I mean, there is——

Senator CASSIDY. Well, let me interrupt because the problem is all that requires a heck of a lot of negotiating and putting together a provider panel, and right now we have whole counties in Iowa where they do not have a single insurer. So, I do not want the best to be the enemy of the adequate. Dr. Book, any thoughts upon what I just offered?

Dr. BOOK. Yes, sir. I think it is interesting to note how Medicare makes its prices. They do not negotiate with providers. They just set prices by regulation.

Senator CASSIDY. But they do look at cost reports.

Dr. BOOK. They look at cost reports, and they—also for physicians services, they survey about a hundred physicians for each code they are reviewing and ask them to evaluate the service they are reviewing compared to some other service and answer a few questions on a five—on a multiple choice five-part scale whether it is more, about the same, or more difficult, or less difficult.

Senator CASSIDY. But most—but the physician does not have to take Medicare. And granted, there are some places where they take less Medicare——

Dr. BOOK. Right.

Senator CASSIDY.——and you could pay multiple. But the point is we have got a problem——

Dr. BOOK. The insurance company can choose to pay a multiple if you have a Medicare patient.

Senator CASSIDY. We have concentration among insurance companies——

Dr. BOOK. Right.

Senator CASSIDY.——and they can set rates to physicians and to other providers.

Dr. BOOK. Right.

Senator CASSIDY. We do not have the insurer. I guess I am trying—looking for a solution. Dr. Cutler, any comments on this?

Dr. CUTLER. Yes. So, I think getting more firms into insurance and more competition is clearly very good and beneficial, and I think anything we can do to make it easy. I do not know—my sense is that is less of an issue than some other things are, but let me—but let me not state that so assertively. I do think that we ought to be moving Medicare payments away from just the fee-for-service levels.

Senator CASSIDY. Oh, I get that totally. I am saying that, just——

Dr. CUTLER. Right. So, I think one would want to think about some kind of transition that says here are the rates you have access to now, and then here is how we are going to move it over time.

Senator CASSIDY. Okay. Mr. Eyles, last question. CalPERS has used reference pricing very effectively to lower expenses, and just for context, they do a survey of providers. They find the range for hip replacement or knee replacements, $20 to $50,000. Quality is equal, so they say to their beneficiaries we will give you $20K. If you will go someplace else you pay the delta, but in the meantime we are going to give you $20K, and that is all we are going to pay. Turns out everybody lowers their prices, and we end up paying the same across the board. It seems to have worked.

Can we use more of that? It is effectively price transparency, but brought into relevance to the patient, which sometimes it is bringing it into relevance. Would it— what are your thoughts about insurance companies is that more, and I will open that up to the other panel if you all can answer——

Mr. EYLES. Sure.

Senator CASSIDY.——because we are all over time.

Mr. EYLES. Thanks, Senator Cassidy. I mean, I think there is interest at looking at innovative pricing models to make sure that we are getting the most value. I think the question really will come down to things like participation in networks, and will you have access to an adequate range of providers, and can you make it work for the patient, and do they have real-time transparency. There is a lot of considerations to think about, but I think anything that provides greater transparency to the patient and understanding about what the difference is between quality is a good thing. So, I think we are—there is interest in those kinds of activities.

Ms. HULTBERG. Senator, I would like to just to add that I think in the situation of California, you are dealing with a very large market both of covered lives and of providers. And as we have this conversation, what we cannot forget is the safety net providers who are—that are—like hospitals, open 24 hours a day. We need to make sure that as we—as we look at things like competition and price transparency that we are also addressing our safety net and ensuring that we do not lose our safety net.

Senator CASSIDY. Sir.

Dr. CUTLER. Senator, if I could just offer one comment, which is the reference pricing has been a huge success. It is been a great success there. What they do is very intensive. So, they call up the patient and they say, hey, look, you are scheduled for elective hip replacement. If you go to this institution where it is scheduled at, it is $60,000. The other one is $20,000, so, therefore, you are going to pay the $40,000. If you do not do that, if you just say, look, there is a high-deductible policy and so on, then people do not switch where they go.

It goes back to we were talking about—what Senator Murray was asking about earlier. People do not understand the insurance policies at all, so they actually do very little price shopping. In a typical high-deductible policy, there is essentially zero price shopping. It is when it is much more intensive that I go to you and say, Mr. Cutler, you can either pay $40,000 or pay your standard $200, and I can show you the quality metrics, which one would you like. Then you can get people to switch. So, unfortunately, it works well, but it is not as easy as we would like it to be.

Senator CASSIDY. Dr Book.

Dr. BOOK. I think what Dr. Cutler is saying is that there are administrative costs to implementing something like that, and in some cases, those administrative costs might be well worth it. We tend to think of administrative costs as waste, but sometimes those administrative costs are spent on very useful things, and that is an example of it where you are calling someone up and explaining the situation, something they might not be able to look up themselves because providers usually dare not post prices in advance, okay?

And making more information is costly, but it may be well worth it.

Senator CASSIDY. In our white paper, we advocate making that—the providers post in advance, but I will leave it——

Dr. BOOK. That will be good, yes.

Senator CASSIDY. Madam Chair, thank you, and, Senator Scott, thank you.

Senator SCOTT. The least I could do.

Senator MURKOWSKI. Thank you. Senator Murray, follow-ups?

Senator MURRAY. I just will submit additional questions for the record.

Senator MURRAY. But I want to thank all of our witnesses for being here today and for your insightfulness. Thank you.

Senator MURKOWSKI. Thank you. Just very briefly to wrap up on the—on the prior authorization because I think Senator Hassan spoke to it. There has just been—there is so much frustration that goes on, not only on the patient side, but administratively. And it just seems that it is one of these situations where you—in order to meet the requirements, you have got to make sure that you are either putting your administrative assistant on speakerphone for 45 minutes. It is kind of this—it is not harassment, but maybe it is harassment. You just have to stay on. And it requires greater burden to provide the authorization that will effectively work to reduce the cost. But it seems to me that there is a line here when you're bringing on people to handle this.

Will the standardization that has been suggested by you, Dr. Cutler, and others have echoed, that will help? Is that enough? In other words, are we at a—are we at a point that we have effectively started a secondary business here with just dealing with the insurance companies to get the sign off and to get that approval? Is it just standardization that will address this, or is there more to this, because this is something that everyone is complaining about. Dr. Cutler?

Dr. CUTLER. I think of standardization and of IT integration as being related. That is, you both want to standardize so you do not have 10,000 different requirements, and you also want to make it easy to transfer the information from the medical record as proof that the preauthorization requirement has been met so it can be seamless. The physician says I would like to do X. The insurance policies are clear because there is standardization about them, and then the systems can automatically provide verification that X was done, and then you do not need the people involved. So, I think it is—you get part of the way there just by standardizing, and then another part of the way through easy interchange.

Senator MURKOWSKI. I understand all that. I recognize that. But in my mind, I still go back to Wrangell where we have eight beds, where your staff is limited, and yet the requirements are as significant as they are for a major hospital in Seattle. And so, back to the issue of scale and why a rural strategy is going to be important to recognizing that we are just not equally situated.

Even with the interoperability and the—and the full integration of electronic medical records, I do not know if you have additional suggestions, Ms. Hultberg, that speak to these smaller facilities that still bear pretty extraordinary costs.

Ms. HULTBERG. I do think, to echo Dr. Cutler, that technology is a piece of this. Technology can be a help, but right now it is sometimes a hindrance, so I think we have to figure out this technology piece. Also recognizing that there may be other steps that we need to take to really enable us to continue to have a rural healthcare infrastructure that is meaningful.

But as an example, Wrangell, this little tiny medical center on an island, is going to spend $65,000 this year on upgrading to meet Stage 3 Meaningful Use. They are not going to see patient benefit for those dollars. They are having to purchase a software package with functionality they do not need, and earlier this year, Wrangell had less than 10 days' cash on hand. So, $65,000 in this Committee room where you deal with billions of dollars may not seem like a lot, but for Wrangell Medical Center it is really important, and for the residents of that community it is really important.

One of the things we encourage is revisiting our current framework for electronic health records, removing some of those barriers, ensuring that we have interoperability, which was the promise of electronic medical records that has not been realized. And then I think we may see enough improvement that could be sufficient.

Senator MURKOWSKI. Very good. Thank you. The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

Senator MURKOWSKI. The HELP Committee will meet again on Wednesday, August 15th, when we will hear from Dr. Francis Collins from the National Institutes of Health. So, we thank you all for being with us and providing such great testimony to the Committee today.

With that we stand adjourned.

[Whereupon, at 11:41 a.m., the hearing was adjourned.]

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