BURDENSOME RED TAPE: OVERREGULATION IN HEALTH CARE AND THE IMPACT ON SMALL BUSINESSES

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT, INVESTIGATIONS, AND REGULATIONS

OF THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

HEARING HELD
JULY 19, 2023

Small Business Committee Document Number 118–021
Available via the GPO Website: www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
52–560 WASHINGTON : 2023

HOUSE COMMITTEE ON SMALL BUSINESS

ROGER WILLIAMS, Texas, *Chairman*
BLAINE LUETKEMEYER, Missouri
PETE STAUBER, Minnesota
DAN MEUSER, Pennsylvania
BETH VAN DUYNE, Texas
MARIA SALAZAR, Florida
TRACEY MANN, Kansas
JAKE ELLZEY, Texas
MARC MOLINARO, New York
MARK ALFORD, Missouri
ELI CRANE, Arizona
AARON BEAN, Florida
WESLEY HUNT, Texas
NICK LALOTA, New York
NYDIA VELÁZQUEZ, New York, *Ranking Member*
JARED GOLDEN, Maine
KWEISI MFUME, Maryland
DEAN PHILLIPS, Minnesota
GREG LANDSMAN, Ohio
MORGAN MCGARVEY, Kentucky
MARIE GLUESENKAMP PEREZ, Washington
HILLARY SCHOLTEN, Michigan
SHRI THANEDAR, Michigan
JUDY CHU, California
SHARICE DAVIDS, Kansas
CHRIS PAPPAS, New Hampshire

BEN JOHNSON, *Majority Staff Director*
MELISSA JUNG, *Minority Staff Director*

CONTENTS

OPENING STATEMENTS

WITNESSES

APPENDIX

BURDENSOME RED TAPE: OVERREGULATION IN HEALTH CARE AND THE IMPACT ON SMALL BUSINESSES

WEDNESDAY, JULY 19, 2023

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON OVERSIGHT,
INVESTIGATIONS, AND REGULATIONS,
Washington, DC.

The Subcommittee met, pursuant to call, at 9:38 a.m. in Room 2360, Rayburn House Office Building, Hon. Beth Van Duyne [chairwoman of the Subcommittee] presiding.

Present: Representatives Van Duyne, Williams, Alford, Crane, Bean, Mfume, and Gluesenkamp Perez.

Also Present: Representative Molinaro.

Chairwoman VAN DUYNE. Good morning, everyone.

I now call the Committee on Small Business to order.

Without objection, the Chair is authorized to declare a recess of the Committee at any time.

I will now recognize myself for an opening statement.

Welcome to today's hearing on the harmful impacts of overregulation in healthcare, which is hurting small businesses.

I want to thank our witnesses for joining us today, and I am eager to hear from you and discuss how we can cut through some of the red tape that I have heard so much about.

Unfortunately, burdensome reporting requirements and rising compliance costs, coupled with an overreaching regulatory landscape, have led to small healthcare providers having to close their doors for good. This is absolutely unacceptable.

As we have heard time and time again, overregulation can shutter the doors of any small business. But small healthcare providers are disproportionately impacted.

I will never forget the meeting we had—and you may have been there. There was a physician who had—had to sell her practice.

She said: You know, I went into so much debt in medical school. I know my patients. I know my patients' history. I spend time talking to them.

She said: But I could not afford to have my doors open. So I became an employee.

And she said: With all of these regulations, I am no longer practicing medicine. I am now following protocol.

She said: A monkey could do my job.

She almost cried. It was that impactful.

And, during the roundtable that I have hosted with doctors in north Texas, I have always made a point of asking them how much of their time is in front of a screen versus face to face. And I think at the last roundtable, one of the physicians said it is about 70 percent of her time is in front of a screen.

I said: Now keep in mind, when you walk into the exam room and you are having to be in front of computer—and we have all been there as patients—and your doctor is in front of a computer, and he is asking you questions, but he is not looking at you; he is typing into his computer.

And I said: If you consider that time, how much of your time is really face to face in front of the patient versus being on the computer and a screen.

And they said: If we do that, it is maybe 10 percent with the patient and maybe 90 percent.

And, you know, it is shocking to hear how much of their time is spent on compliance, time that they would strongly prefer to be spent with their patients. And I know, as patients, we would rather have that one-on-one time with our physicians.

In 2017, a report from the American Hospital Association revealed that the massive amount of regulations placed on healthcare providers cost them $39 billion each year. And to put this number in perspective, if you took an average community hospital with about 160 beds, that would be $7.6 million per year spent on compliance.

And, moreover, we know that the constantly changing regulatory environment causes issues with proper compliance and harms patient care. Frustratingly, the regulatory environment has only worsened since the AHA's 2017 report.

The Medical Management Association's 2022 Annual Regulatory Burden Report showed that 89 percent of respondents feel the regulatory burden has increased in the past year.

When regulatory costs reach the point that it is no longer feasible for small, private healthcare practices to keep their doors open, it leads to one thing, and that is consolidation.

And, when proponents of consolidation claim that healthcare mergers decreased costs and improve access to care, the reality is quite different. Far too often, consolidation decreases quality of care. It eliminates competition, which increases costs. And it removes the possibility of physicians owning their own businesses, thereby crushing the American dream.

Small healthcare providers have in recent years been hit on all sides. We know that, on top of severe overregulation, the COVID-19 pandemic played a significant role in consolidations as well. More than 22,000 physicians left independent practice to join bigger hospital systems after the onset of the pandemic.

Unfortunately, small providers bear a disproportionate amount of the regulatory burdens and administrative costs that are associated with healthcare compliance. And this leads to rising costs, increased administrative costs, and more consolidation. This leads to the elimination of many small providers.

And we cannot continue to allow overregulation to shut the doors of small care providers, and I am glad that our Committee is fo-

cused on finding solutions to provide better and more affordable patient care.

I ask unanimous consent to waive Representative Molinaro onto the Subcommittee for the purpose of asking questions in today's hearing.

And, with that, I would now like to yield to our distinguished Ranking Member from Maryland, Mr. Mfume.

Mr. MFUME. Thank you very much, Madam Chair. Good morning. Thank you for calling this hearing and for your leadership on this issue.

I want to also thank those witnesses who are here today as we try to put in context in a very real way why this is such a problem for so many of us.

As of 2021, healthcare spending consumed about 18 percent of the gross domestic product here in the U.S., nearly double the 9.6 percent average across other similarly developed nations. It also accounted for nearly a quarter, a whole quarter, of the government spending.

Yet, despite these high costs, both independent providers and patients have come to us and have complained over and over and over again about their situation.

The U.S. often archives worse health outcomes than many of our peer nations, which I still find hard to believe. We stand alone among our peers by not guaranteeing healthcare coverage as a right. And, while many factors underpin our country's high healthcare costs, none of them seem to carry such a healthy price tag as the administrative bloat permeating every interaction between a patient and their doctor.

In many ways, our pursuit of extensive healthcare plans and choices has given rise to a complex and fragmented multiplayer system that is very, very difficult to navigate for patients, difficult for doctors, and difficult for small businesses alike.

Our country, as has been stated in a lot of different areas and studies, spends between 15 and 30 percent of all national medical expenditures on administrative costs primarily through billing and insurance-related activity. Nearly half of that spending, between $250 billion and $570 billion a year, could be avoided through streamlined practices. In fact, one analysis found that the United States' administrative costs per capita is about $1,055 per year, over five times the average of similarly developed nations, those that I had referenced earlier.

Now not only do these costs get passed on to consumers through higher premiums, as most of you know, and out-of-pocket expenses, they are also passed on to independent physicians whose small businesses provide essential healthcare for Members of their community. However, and regrettably, this growing overhead pushes many physicians away from their private practice and toward hospital employment.

While private practice was once a shining cornerstone of the small business community, only 3 in 10 physicians now remain independent. And that is in part due to the administrative and financial burdens that I referenced a moment ago that we continually place on these small firms.

As a result, hospitals have become increasingly consolidated and corporate entities, which have absorbed numerous practices all across our nation, every State involved, and though this consolidation streamlines administration, it on the other hand decreases accountability and further accelerates the closure of independent practices.

It also endows hospitals with a sort of monolithic—excuse me—monopolistic pricing power in insurance negotiations. And most, if not all, studies show that more concentrated hospital markets have 5 percent higher insurance premiums than those that are less concentrated. And so, while administration is a major reason for growing costs, we can't undervalue regulations also in mitigating cost growth.

The Affordable Care Act made great strides in slowing the growth of insurance expenses and keeping small firms in the market. Between 2002 and 2012, the rate at which small firms offered health insurance declined by over 10 percent. And, between 2013 and 2020, that decline was just about 2 percent.

So, while we are still dealing with complex challenges in our healthcare system, it is important to recognize the essential role of regulation in ensuring that we provide stability to our markets and protection to our consumers, no matter where they may be.

Again, I want to thank the witnesses for coming to testify. We look forward to your comments. There will be obviously questions or observations, but we all look forward to a productive discussion this morning.

And, Madam Chair, I want to thank you and yield back my time.

Chairwoman VAN DUYNE. Thank you very much.

I would like to now yield to the Chairman of the full committee, Chairman Williams, for an opening statement.

Mr. WILLIAMS. Good morning—and I want to thank my fellow Texan, Congressman Van Duyne—for holding—holding today's Subcommittee hearing on regulations within the healthcare industry and its impact on small businesses, and to our witnesses for being here today.

Today's hearing is critical in examining the impact of the industry's overregulation on small businesses and small providers. We are eager to discuss what this committee can do to help minimize the regulatory landscape and ease the impact on small providers.

Throughout recent years and especially during the pandemic, we have seen how stifling regulations can suffocate any small business, especially those in healthcare. I have a business of hundreds of employees back in Texas. We supply healthcare. There are issues.

From burdensome reporting requirements to rising compliance costs, many small providers have been forced to close their doors or be brought by—bought by larger companies. So, far too often, consolidation decreases quality of care, eliminates competition, which increases costs, and removes the possibility of physicians owning their own business.

So I am looking forward to today's discussion. I hope this hearing shines a light on the burdensome red tape currently restricting our small healthcare providers.

So thank you again, Chair Van Duyne, and I yield back.

Chairwoman VAN DUYNE. Thank you very much, Chairman Williams.

We will now move to the introduction of the witnesses.

Our first witness here today is Dr. Brian Miller. Dr. Miller is a nonresident Fellow with the American Enterprise Institute here in Washington, D.C. In addition to his role at the American Enterprise Institute, he is a practicing hospitalist at the Johns Hopkins Hospital and Assistant Professor of Medicine in Business at the Johns Hopkins University.

Dr. Miller has previously served as a medical officer in the Office of New Drugs at the Center for Drug Evaluation and Research at the FDA and is a special advisor to the FTC's Office of Policy Planning.

Dr. Miller graduated from the University of Washington a with Bachelor of Science in Chemistry and Biochemistry and completed an internal medicine residency at Georgetown University Hospital with a public health residency at Johns Hopkins University.

Dr. Miller, thank you very much for being with us today, and we look forward to hearing from you.

Our second witness is Dr. Henry Punzi. Dr. Punzi is a Medical Director of Punzi Medical Center located in Carrollton, Texas. With over 40 years of experience, Dr. Punzi has firsthand knowledge of the impacts of overregulation within the medical industry. Dr. Punzi attended medical school at the University of Buenos Aires and completed his residency at the University of Texas Southwestern Medical Center.

I really appreciate you being here. I appreciate you participating, as well, in roundtables on healthcare within our district. And I look forward to hearing from you today.

I now recognize the Ranking Member from Maryland, Mr. Mfume, to briefly introduce our last witness appearing before us today.

Mr. MFUME. Thank you very much, Madam Chair.

Matthew Fiedler is a senior fellow at the Brookings Schaeffer Initiative on Health Policy. His research examines a range of topics in healthcare, economics, and healthcare policy.

Prior to joining Brookings in 2017, he served as chief economist of the Council on Economic Advisors where he overall the council's work on healthcare policy, including the implementation of the Affordable Care Act's health insurance and healthcare payment reforms. He holds a Ph.D. in economics from Harvard University and a B.A. in mathematics and economics from Swarthmore College.

Mr. Fiedler, thank you very much for joining us today. We look forward to your testimony.

Chairwoman VAN DUYNE. Thank you.

We appreciate all of you being here today.

And, before recognizing the witnesses, I would like to remind them that their oral testimony is restricted to 5 minutes in length. And, if you see the light turn red in front of you, it means your 5 minutes have concluded and you should wrap up your testimony.

I now recognize Dr. Miller for his 5-minute open remarks.

STATEMENTS OF BRIAN MILLER, M.D., MBA, MPH, NONRESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE, ASSISTANT PROFESSOR, JOHNS HOPKINS SCHOOL OF MEDICINE; ANTHONY PUNZI, M.D., FCP, FASH, MEDICAL DIRECTOR, TRINITY HYPERTENSION & METABOLIC RESEARCH INSTITUTE, PUNZI MEDICAL CENTER; AND MATTHEW FIEDLER, SENIOR FELLOW, SCHAEFFER INITIATIVE FOR HEALTH POLICY, ECONOMIC STUDIES PROGRAM, BROOKINGS INSTITUTION.

STATEMENT OF BRIAN J. MILLER, M.D., M.B.A, M.P.H.

Dr. MILLER. Thank you, Chair Van Duyne and Ranking Member Mfume and distinguished Members of the Subcommittee on Oversight, Investigations, and Regulations.

I am excited to be here today to talk about red tape and overregulation in healthcare. There is so much of it, it is actually sort of hard to know where to start, to be completely honest.

I am a practicing hospitalist at Hopkins. I am a nonresident fellow at AEI. I previously was a special advisor at the FTC. I also worked at the CMS Innovation Center, the FDA, the FCC. So I basically worked for every agency that regulates our industry.

Disclaimer, I am here today in my personal capacity. The views here are my own and don't necessarily reflect those of Hopkins, the American Enterprise Institute, or the Medicare Payment Advisory Commission, on which I am a commissioner.

So, thinking about consolidation, right, I looked up this little story because what does consolidation look like?

In June 2022, MaineHealth decided to remove Maine Medical Center from the Anthem, now Elevance, insurance network from a contract dispute. The CEO of Maine Medical Center, a physician, penned a nice op-ed in the local paper, and so I was curious. Right? I looked it up at the time, and the Healthcare Cost Institute, a nonpartisan research institute, said that the market was highly concentrated by FTC and Department of Justice standards.

A few months later, the plaintiff and the hospital settled. And I was like, oh, okay, just another fight between a big hospital and, you know, probably a local monopoly, for certain a local monopoly, and a big insurance company.

And then, I started digging into it. And I saw that the impoverished hospital that was the local monopolist received over $40 million in COVID relief funds and that, during the pandemic, they bought the D'Angelo's sandwich shop next door, despite crying poverty.

So that is sort of monopoly in action. Right? You are a monopolist, and you can beat up on other businesses or even beat up on the government. Consolidation is bad. It raises prices, lowers quality, results in a worse patient experience. I sort of argue that we did this to ourselves, and it is sort of our fault.

There was a move, and it was successful, to ban physicians from owning and operating hospitals. Now we have a concentrated hospital market in 90 percent of metropolitan areas. We are worried about small practices being able to compete with large delivery systems that have bought everything from clinics to home care. We

banned it through Stark Law. We banned physician owned-and-operated integrated care delivery.

The important thing I think also is, is that, for those practices that do remain, we regulate them into the ground. I looked this up. CMS has 2,466 quality metrics, over 2,000. There aren't even that many days in the year. CMS needs to go on a quality diet and actually have a lifecycle for quality metrics. Sort of a basic tenet of quality performance for running an organization is that for your internal measures, you need to see when they top out, when they are no longer working, and if they don't have an impact.

We talked about how physicians don't spend time seeing patients. The average physician spends, from a time motion study published in JAMA Internal Medicine, 15 percent of their day with patients.

So what does overregulations mean for small business? Well, it crushes small business. And, you know, one of the things that the American Association of Medical College CEO has commented on is a lack of diversity in the medical workforce. For physicians being able to own and operate their own business, regulating businesses into the ground is another barrier to entry.

Small practices are important. Why are small practices important? It is not just an economic concept. It is a real concept. I went to Northwestern for medical school. Great facility, quaternary care. You can get plastic surgery. You can get burns treated, everything, organ transplants. To go from one side of the campus to the other is over a quarter of a mile, and the outpatient clinic tower is 23 stories tall, not exactly easy to navigate.

A small practice allows greater customization of your care and also potential greater customization of the process of your care delivery.

Thank you, and I look forward to questions.

Chairwoman VAN DUYNE. Thank you very much.

I now recognize Dr. Punzi for his 5-minute opening remark.

STATEMENT OF HENRY ANTHONY PUNZI, M.D., FCP, FASH

Dr. PUNZI. Good morning, Chair Van Duyne, Mr. Mfume, all the Congressmen here.

It is a pleasure and an honor to be here in front of you.

My name is Henry Punzi, and I have been in the solo private practice of internal medicine since 1984 and have firsthand knowledge of the changes at CMS, as well as the insurance industry. I have also been doing clinical research since 1986 and have worked closely with the Food and Drug Administration and the National Institutes of Health.

As a result of numerous publications, studies from the—publications from these trials, I have been a national and international speaker and have worked with many pharmaceutical companies and have seen the regulatory aspect of the FDA.

And, lastly, I am also an FAA senior Aviation Medical Examiner, performing pilot physicals, and work closely with the Federal Aviation Administration.

Now, as the prior witness said is what do all these government entities have in common is that I am surrounded by red tape, a lot

of regulations. And, as a result of this bureaucracy, to many physicians, medicine has lost a lot of what made it desirable.

So the key here is, as a physician in private practice, when I take time with my patient, that is the main thing I need to do. And there are some research that shows that it takes, for an average visit, about 15 minutes—that is kind of what has been allotted—of which 5 minutes is specifically about one complaint the patient has. And then there is 1 minute for the other five complaints that they have.

So you can imagine that the time I have speaking to all of you, I have got to examine a patient who is 77 years of age and get their medical history and physical.

So, as my medical students—I am a clinical assistant professor at UT Southwestern. So what I tell my students is medicine is an art and a science. So the key there is being able to do a good history and physical that allows me to identify 80 percent of the problems that the patient has, but I have to have time to do that.

The second thing I tell my students is that patients do not go to medical school to tell us what is wrong with them. That is the art of medicine. I have got to be able to extract that, and you can imagine that, in 5 minutes, that is significantly a challenge.

Now the other issue that plays into all of this is that many visits patients come in for certain issues that may not be related to their main complaint, and a lot of it has to do with mental health. And, within that period of time, it is very challenging to extract that from patients.

Now, on the flip side of that, when you look at the electronic medical record, data shows that typically for every hour that you are in contact with a patient, it takes about 2 hours of electronic health records to be able to kind of identify that.

So really we are putting the emphasis in the wrong place which is, as Chairman Van Duyne said, is that whenever I have gone the VA with my cousin, and the physician is looking at the screen, and we are behind him. And that really ends up being kind of a big issue for me particularly, since being in practice for many, many years.

Lastly, it is the prior authorizations. Right? There are typically about prior authorizations per week. Now that does not mean that you get them all resolved. So, from one week the another, you have 45 that you add on, and that just can kind of stockpiles. And the issue with prior authorizations is that the data suggests that patients end up dropping their treatment.

I have got many diabetic patients. Now with diabetes, a chronic disease, one visit does not really allow the patient to understand the disease process. So, if they end up dropping their medication because of prior authorizations, they sometimes don't come back. And that ends up driving the cost of healthcare.

I had a patient that I saw last week actually. And she was walking her dog, tripped, injured her right foot, went to the minor emergency center, had an X ray done, no fracture. She was still hurting 3 days later, saw the orthopedist. He was trying to get an MRI. It took about 2 and a half weeks to get that MRI approved. Immediately she was called, say put your foot in the boot because you have a fracture.

So those are things that we see on a day-to-day basis in my practice and in many practices. So I think the key here is that we have to be allowed to talk to the patient. Again, as I emphasize with my students, and my medical professor in Argentina always said: Henry, the history and physical, if you don't know what is going on with the patient, then you do it again, because sometimes people, when you talk to them, they give you more information that allows you to make the right diagnosis.

And that is what cause—decreases healthcare costs, making the correct diagnosis.

Thank you.

Chairwoman VAN DUYNE. Thank you very much.

And I now recognize Mr. Fiedler for his 5-minute opening remarks.

STATEMENT OF MATTHEW FIEDLER

Mr. FIEDLER. Madam Chair, Ranking Member Mfume, and Members of the Subcommittee, thank you for having me here today.

My name is Matthew Fiedler, and I am a health economist and a senior fellow with the Schaeffer Initiative on Health Policy at the Brookings Institution, where I study topics including health care provider payment and health insurance regulations.

My testimony will focus on ways that policymakers can make healthcare providers' interactions with health insurers, both public and private insurers, less burdensome.

As the other witnesses have alluded to, providers interact with insurance in many ways, including when negotiating contracts, collecting information about patients' coverage, obtaining prior authorization for care, submitting claims for payment, and reporting on quality of care. These activities are costly.

Insurance-related administrative costs are estimated to consume 13 percent of physician practices' revenue on average, plus somewhat smaller fractions of other providers' revenue. In total, that amounts to hundreds of billions of dollars per year, costs that are ultimately borne by patients and taxpayers in the form of higher prices. Due to economies of scale, these burdens probably hit smaller practices harder than larger ones.

It is important to recognize that administrative activities can be valuable. Billing processes are ultimately how providers are paid. Prior authorization processes can help prevent delivery of inappropriate services, and audit processes can help uncover fraud. So, if we are looking to reduce administrative burdens, we need to proceed thoughtfully.

In that spirit, I want to offer three targeted reforms that could reduce administrative burdens with relatively few tradeoffs. The first is eliminating Medicare's Merit-Based Incentive Payment System, or MIPS. Under MIPS, Medicare scores clinicians in several domains, including the quality and efficiency of their care. Clinicians' payment rates are then adjusted up or down based on their scores with the goal of encouraging high performance.

Much of the information used to score clinicians, particularly on quality, is reported by clinicians themselves, often at high costs. A

recent study estimated that practices spent nearly $13,000 per physician reporting to MIPS in 2019.

But, despite these large costs, MIPS is likely not improving patient care. One problem is that clinicians can choose which measures they are evaluated on, which makes it hard to meaningfully compare across clinicians. Plus, studies of past programs like MIPS have found little evidence that they actually improve care. Since MIPS appears to have large costs but few benefits, I suggest eliminating MIPS and, ideally, replacing it with a better-designed set of incentives.

The second reform is changing how provider-insurer payment disputes are resolved under the No Surprises Act, the law that protects patients from facing large surprise bills when they unexpectedly receive out-of-network care. Under the law, disputes over payment for out-of-network care are settled via arbitration. Unfortunately, arbitration is costly with fees that start at $900 per case.

At the arbitration volumes observed so far, providers and insurers will incur hundreds of millions in dollars in fees per year, not to mention the direct costs of participating in arbitration. Congress could avoid these costs, while still ensuring that providers are appropriately compensated for out-of-network care, by doing away with arbitration and instead directly specifying benchmark payment rates.

The third reform is improving the Medicare Advantage risk adjustment system, which adjusts payments to MA plans based on what health conditions their enrollees have. This system aims to ensure that payments to plans are commensurate with the cost of their enrollees' care. But plans have responded to this system by working to document evermore enrollee diagnoses. This has increased to payments to MA plans well beyond what the Medicare statute intends, but it also increases providers' administrative costs since MA plans often enlist providers to help hunt for diagnoses.

Reforms to risk adjustment could make it less susceptible to this type of gaming. One idea put forward by the Medicare Payment Advisory Commission is to increase the number of years of diagnosis data used in risk adjustment. This would increase how many diagnoses are captured without MA plans' special efforts, reducing administrative burdens. It would also reduce federal costs by reducing the gap between how many diagnoses get captured in MA versus traditional Medicare, the ultimate benchmark for MA payments.

In closing, I want to zoom out and talk briefly about a more ambitious potential reform. Providers appear to bear larger administrative burdens in the United States than in other countries likely at least in part because providers here must deal with a menagerie of public and private insurers, all of which set different rules.

Standardizing billing, quality reporting, or other processes across insurers could reduce administrative burdens. This approach would present real tradeoffs. In some cases, different insurers may have good reasons to set different rules, and standardization would only work well if the standardized processes were well-designed. But requiring greater standardization could likely reduce administrative burdens by much more than the other approaches I have discussed.

Thank you again for the opportunity to testify. I look forward to your questions.

Chairwoman VAN DUYNE. And I really appreciate all of you sticking to the 5-minute rule.

We are going to now move to Member questions under the 5-minute rule, and I recognize myself.

Dr. Punzi, you talked a little bit about this in your testimony. I know that we have talked extensively about this during our roundtable meetings.

But can you talk to me a little bit on—on the administrative burden that you are seeing in your office? You talked specifically about the percentage of time that you spend on that, but I am also interested in finding out about your staff's work on that——

Dr. PUNZI. Right.

Chairwoman VAN DUYNE.—versus actually patient work.

Dr. PUNZI. So I have five staff Members. One is specifically geared towards my research because, through the FDA, the amount of paperwork that is utilized for the studies has significantly increased. So she does specifically that.

And I have two employees, two medical assistants that help me out. And then they split half and half. So half is being able to see the patients. The other half is trying to do either prior authorizations with medications or prior authorizations with procedures, X-rays. So we are not really heavy procedure wise, but we have got to do that.

Now the advantage I have in my clinic is that I end up dictating. We still have to input data into the computer, but that is one of the advantages that I have being in practice for such a long time is I have got a service. Somebody will dictate. So it makes it a lot easier for me to be able to see the patient face to face and then do the dictation and get that the next day.

So I think that, when you talk about burden, is—is, yes, is it is getting worse from the point of view being able to identify whom it is that I need to talk to, especially when you do a prior authorization. It takes about three people. It is myself, my medical assistant, whoever is on the other side, and the insurance company and subsequently to the physician that you talk to that may not be an internist.

So a lot of times it ends up being kind of a challenge from that point of view.

Chairwoman VAN DUYNE. So part of the reason why I had these roundtables to hear from you, hear what some of the complaints, are but also to figure out solutions.

Dr. PUNZI. Yes.

Chairwoman VAN DUYNE. So, from your perspective, how would you advise, you know, the Members here, Congress to be able to respond to your criticisms——

Dr. PUNZI. Yes.

Chairwoman VAN DUYNE. But—also be able to provider better patient care, better access, and higher quality?

Dr. PUNZI. Two things that I can think of.

One is that, with regards to electronic health records, when I have a patient come to my office and request the records and when I read them, I really don't quite understand completely what the

patient had done. And the reason being is that a lot of these records are cut and paste. So it is very difficult. So it is not that it actually helps, but it helps documentation mainly from the point of view, the billing issue.

The second thing, for the prior authorizations, I think that it needs to be somewhat streamlined. They are talking about the reduction in waste. But, as a clinician, when I order a test or when I order medication, I think that is best practice for that particular patient. So I think that there needs to be a little bit more leeway.

I understand insurance companies have to make their profit. But I think at the same time is we need to come to consensus on being able to diminish either the time or the—or the investment in trying to get these things approved.

Chairwoman VAN DUYNE. So you are—so you are recommending that people who actually have medical degrees be the ones who are making the decisions on medical care?

Dr. PUNZI. That would be correct, Chairman.

Chairwoman VAN DUYNE. Dr. Miller, you know, you have heard about some of our conversations that we have had. We have talked about a lot about regulatory burden.

But how are small practices or solo practitioners expected to comply with these increased burdens?

Dr. MILLER. They are expected to comply, and they are unable to. And, therefore, they then sell their practice to the large health system down the street, which is the consequence. That is one of the reasons why I am a big fan that CMS needs to have a quality metric lifecycle.

If you have to comply with hundreds of quality metrics a year, you have to hire staff. You have to have IT infrastructure that can support that. That then changes how you practice, because you are practicing to document rather than practicing to treat the patient.

And so, if we eliminate some of the out-of-date quality metrics, put a cap on the number of quality metrics, and require CMS to regularly review quality metrics to see if they are still performing as intended and actually improving clinical practice whereas, in some cases, some of them have actually resulted in increased mortality, the Hospital Readmissions Reduction Program, for example, we could massively improve patient quality, actually allow physicians to spend time with their patients, and decrease paperwork.

Chairwoman VAN DUYNE. Excellent. Thank you very much.

I now recognize the Ranking Member for 5 minutes of questions.

Mr. MFUME. Thank you, Madam Chair.

One of you, I don't remember who, said something that I thought—should we—that we ought to take a look at in a different sort of way and that we are regulating practices into the ground.

Was that you——

Dr. MILLER. Yes.

Mr. MFUME. Okay. I just thought it was significant, and I didn't want it to go by without some attention. I am going to come back to it in a minute.

On the other side of that, a Kaiser Family Foundation survey found customer experiences with a lot of different problems of their own. With health insurance, they found that the majority of the insured adults said they have experienced many problems using their

healthcare insurance over the past year. Some of those problems are denied claims which, you know, debatable one way or the other; provider network problems which clearly can be dealt with—I know you talked, Mr. Fiedler, about standardization; I want to come back to that to see whether there can be some amplification there; and, of course, the good, old prior authorization problems.

Can you, Mr. Fiedler, sort of dive down into these authorization problems and network problems and speak also about this need for standardization and to some extent audit performances?

Mr. FIEDLER. Starting with prior authorization, I think one thing that is important to just recognize as a starting point is that——

Chairwoman VAN DUYNE. Can you speak——

Mr. FIEDLER.—prior authorization is actually much more common in private insurance than it is in Medicare. Traditional Medicare, for better and for worse, I would argue, actually makes fairly little use of prior authorization. And so it is really about Medicare Advantage plans and plans in the private market.

I think one of the challenges with prior authorization is there are very real tradeoffs here. There is no question it creates very large administrative costs for providers and for patients. At the same time, there is evidence that, in some cases, it can shift patients toward lower cost treatments or prevent delivery of unnecessary care that ultimately saves patients money.

So I think exactly how to strike that balance and how policymakers can strike that balance is a hard question that I think there are no ready answers to.

I do think one path you could think about going down is trying to standardize these processes across different payers. So, rather than every different payer having its own prior authorization process that requires submission of slightly different information and slightly different forms through a slightly different channel, you could think about whether there are ways to sort of harmonize these processes across insurers so at least, you know, that might reduce the administrative burden to some degree.

Mr. MFUME. And it was your testimony also that, with respect to arbitration, I thought I heard you correctly when you said you would advocate doing away with it.

Could you talk about that?

Mr. FIEDLER. I think the use of arbitration under the No Surprises Act is creating a lot of administrative burden for both providers and insurers to resolve these payment disputes. And we could do that in a much more direct way by setting payment benchmarks without compromising the accuracy and the appropriateness of the compensation for out-of-network care.

Mr. MFUME. And what about risk adjustment and the notion of changing the number of years, scaling them one way or the other? What are the benefits there?

Mr. FIEDLER. The benefits there are that if you start with more years of data, you are more likely to sort of just automatically capture the diagnoses that enrollees have rather than having MA plans and their providers go out to hunt for all these different diagnoses. And so that has the potential to reduce the amount of administrative burden involved in the risk-adjustment system.

It also would reduce overpayments to MA plans. We have quite a lot of evidence that we are paying MA plans a lot more than the Medicare statute intends at the moment, and that is ultimately obviously increasing federal costs quite a bit.

Mr. MFUME. Thank you.

Dr. Harris, I want to go back to your statement about that we are practically running practices in the ground, which I do not dispute at all. But I wanted to get your take on the concept of standardization, and does that have any value in doing just the opposite?

Dr. MILLER. Standardization of—you mean of the prior authorization process or quality metrics or all of the above?

Mr. MFUME. Of practices.

Dr. MILLER. Standardization—of the prior authorization practices?

I mean, I think having the insurance industry and physicians work together to create an automated or standard data interchange would be good. I would be reticent to have the government do that, given the history of the government running technology programs. Say setting up the ACA exchanges was one example that did not go well.

Mr. MFUME. Let me just jump in real quick because my time is just about up.

What about standardization of billing practices? Any thoughts?

Chairwoman VAN DUYNE. You can answer.

Dr. MILLER. May I?

I think standardization—do you mean billing practices like the actual claim form, because the claim forms are relatively similar already to begin with.

Mr. MFUME. I am just trying to get you to talk more about standardization across a number of different claims. And so, yeah, billing would be one of those and anything else, except that we are out of time. So I am going to have to come back in my next round.

But thank you very much.

Chairwoman VAN DUYNE. All right. Thank you.

I now recognize Mr. Bean from Florida for 5 minutes.

Mr. BEAN. Thank you very much, Madam Chair. Good morning to you.

And good morning, Small Business Committee.

You know, if somebody is in the hallway right now, they might just be listening to us singing in harmony up here, which doesn't happen very often because we are hearing on both sides, recognizing there is a problem. There is a problem.

People forget that doctors are small businesses. I used to be a community banker, and I had the privilege of banking several doctors and coaching them and trying to become efficient and it is tough. They get it from all angles and just to juggle what they do.

I used to have a joke that, you know, I used to say: What do doctors need to stay in business a long time? And the answer is they have to have lots of patients to stay in business a long time.

Thank you. I will be in town until tomorrow.

So but they are losing patients. And one of those, it is just the other day, one of them lost—sold out, just sold out. I talked to him.

And sure enough, he said: I just couldn't do it anymore. It is—it is so good to go home at 6:00 o'clock without having to worry.

And he said: Yeah, there is hoops I have to jump through.

But so it is just a toss-up question. Are—we seeing that we both agree on both sides that we agree that there is a problem. Is it always been—are we just saying it has always been this or are we seeing a massive pileup of regulations in the last couple of years due to COVID?

Anybody?

Dr. PUNZI. So I was reading that CMS put out 200 different kind of regulations during the time of COVID. And it is very hard to try to keep up with what is going on, let alone in your office with whatever's going on regulatorywise.

But I think if you look at physicians, about 2019, 75 percent of new graduates are going to be employed. So we are seeing a decrease in that. And I think going back to your comment is that it is that work-life balance, the only problem with that being in private practice. And, if I would get asked, "Do you want to sell out," you know, the grass is always greener on the other side. But the problem with that ends up being, all of a sudden, I am working for somebody else and now my patients are no longer my patients.

And I think that is the main key, again, is the art of medicine. They are no longer my patients. So now, all of a sudden, I have got to do things that I may not find that are appropriate at least from my perspective. I have got to see so many patients an hour. I have got to do these things.

And I think that is one of the challenges that you get into is that the grass is always greener on the other side.

Mr. BEAN. That is exactly right, but it is a challenge.

We—yesterday in a hearing put on by Chair Williams, we heard about the current administration, not just medicine but all, all small businesses, $375 billion in new compliance regulations. That is the cost.

Are we seeing it, Dr. Brian? Are we seeing the States jumping in, too? Is it just——

Dr. MILLER. Yeah.

Mr. BEAN.—States getting in on this regulations action, too?

Dr. MILLER. I think it is actually worse than all of what we are—it is actually really bad because the problem is every time we see a problem the healthcare policy, we design a static, regulatory, administrative, agency-driven solution. And then, a couple of years later, just like we heard about with surprise billing, that problem—that problem is still there. And the solution that we had is broken, and the solution is another administrative intervention.

So what we are experiencing now with all these small practices leaving is we are seeing the cumulative effect of 30 years of administrative, state-driven interventions in healthcare policy.

And the problem is that when people design these solutions, they are thinking about a static market. They are designing a solution that is not dynamic and not flexible over time.

Mr. BEAN. Very good.

Madam Chair, without objection, the physical therapists, the physical therapists' association of America, APTA, have said: Please enter this in the record. The list, they have got two pages of bullet points where they are being overloaded.

And, without objection, I would like to enter that in the record.

Chairwoman VAN DUYNE. Without objection.

Mr. BEAN. Thank you very much.

Now some will say: It's great. It is great.

In fact, let me go on to my last question. I was going to say: We—we like choice.

Americans like choice. And, if we streamlined all professions, we lose that choice. So we have got to—this is our lightning round. I have only got a few seconds left.

So, if we were to take out our Small Business lifesaver, what is an easy target we need to slash first?

Dr. Henry.

Dr. PUNZI. Actually it is going to be the issue of reimbursement.

Mr. BEAN. Very good. Okay.

Dr. Brian.

Dr. MILLER. Quality regulations.

Mr. BEAN. Very good.

Dr. Matt, jump in.

Mr. FIEDLER. I am actually going to go outside of administrative burden. It is how we pay hospitals when they buy up physician practices. We pay them a lot more.

Mr. BEAN. Very good. Thank you so much.

Madam Chair, so many questions, so little time.

So I yield back to you.

Chairwoman VAN DUYNE. Thank you very much.

I now recognize Ms. Gluesenkamp Perez from Washington for 5 minutes.

Ms. GLUESENKAMP PEREZ. Thank you.

And thank you to the Chairwoman and Ranking Member for holding this hearing.

We have heard a lot today about the administrative burdens that exist for small, independent healthcare providers.

I guess I would like to focus a little more on how that burden impacts particularly rural healthcare providers. Like we have seen just a real loss of our providers. We know that they are consolidating to bigger or leaving the market entirely.

So, Mr. Fiedler, if you could explain how the closure of independent physician practices might particularly impact access for rural and underserved communities.

Mr. FIEDLER. One of the things I think we know generally about administrative burdens is that there are economies of scale. And, obviously, if you are in a more rural area, taking advantage of those economies at scale is a lot harder.

And so we would expect these burdens to fall harder on smaller practices no matter where they are located. But that is going to be a much more acute problem in a rural area relative to an urban area in practice.

And in an urban area, you might end up with the variety of problems that come from the consolidation from a small practice that gets bought out; in a rural area, you might just end up with gaps where there is not care available at all.

So I think those are respects in which it potentially bites a lot harder in that settling.

Ms. GLUESENKAMP PEREZ. You look like you have something to say here.

Dr. MILLER. Definitely. First of all, I am from Washington State. So I am very excited.

I don't think that there are necessarily administrative scale efficiencies in most delivery systems. If anything, I see diseconomies of scale with administration where administration in large health systems or even moderate health systems just begets more administrators, more PowerPoints, more meetings, more committees to not actually solve clinical operational problems.

I think it is even harder with regulations in rural areas because you are faced with quality regulations. You are faced with conditions of participation. Then you have to make sure you are in network for all these insurers, and then you have new telehealth regulations. And then and it is just like one thing after another.

It makes it impossible to run a business, and so you sell out your business to the large health system down the street. This has happened in many rural areas. I practiced for a year in Cooperstown, New York, a village of 1,200 people with one stoplight. So, I know what it's like, and I think that we need to decrease regulatory burden so that rural healthcare can continue to exist.

Ms. GLUESENKAMP PEREZ. I guess I am interested in hearing a little bit more about what it might look like to take out the merit-based incentive program. Yeah, you feel this is a need that is already met by other programs?

Mr. FIEDLER. I think that we have other ways of incentivizing improved performance from physicians that actually are working in the Medicare program. A substantial fraction of Medicare physicians are now in accountable care organizations and other types of models where we actually do have clear evidence that those models are moving the needle at least in improving the efficiency of care and if not improving the quality of care.

I think moving our focus away from MIPS, which is an administrative disaster but not really improving patient cares, towards these models that are improving care would be the direction I would want to move.

Ms. GLUESENKAMP PEREZ. Uh-huh. I mean, it's striking. Right? We spend more and more on healthcare every year, and the quality of American health is the lowest. We are just not getting—we are not getting wellness out of this system.

I guess I am curious to anyone who has insight what some of the biggest expenses are and how Congress can work to ensure smaller firms are able to stay competitive.

Dr. PUNZI. So I think the biggest expense, as an individual practitioner, so I have got to do my rent. I have got to do my building maintenance. I have got to pay my employees. But then the issue ends up being reimbursement. So I have got to be able to make enough money to be able to do that and then maintain myself.

So, if the practitioner is worried about when his next payroll is coming and am I getting enough money to do that and when you talk about the issue of patients, losing patients, then that ends up being a significant challenge for me as a small business.

Ms. GLUESENKAMP PEREZ. So you are saying this is a cash flow, as well?

Dr. PUNZI. Reimbursement. So, basically, we know that, as years have gone down, you mentioned that you have had a de-

crease in quality of care, but we have also had a decrease in Medicare reimbursement.

So when I started back in 1984, I am getting paid less for Medicare patients now than I did almost 40 years ago.

Ms. GLUESENKAMP PEREZ. Thank you all so much for your time and insight.

Chairwoman VAN DUYNE. Thank you.

I now recognize Mr. Crane from Arizona for 5 minutes.

Mr. CRANE. Thank you, Madam Chairman—Chairwoman. Excuse me.

I appreciate the opportunity to be here today and thank you for everybody that has come to testify.

You know, when I listened to your testimonies, it sounds a lot like this place to me. The bureaucracy grows, more regulation, more red tape, and the focus is no longer where it should be on the very people we are supposed to be taking care of.

Would you gentlemen say that that is accurate?

Dr. PUNZI. I agree.

Dr. MILLER. Yes, sir.

Mr. CRANE. My question to start with is for all three of you. Is it possible in your opinion to shift back from this model that seems bent on consolidation, monopolization, topdown control, and back towards a healthcare system that is focused on our patients?

Sir, we will start with you.

Dr. PUNZI. I think we can. And, again, we go back to, as a small business, being able to survive and stay afloat. So I think that, if the issue of reimbursement really kind of improves, especially with the issue of CMS, I think that would be very helpful to allow individual physicians to stay in practice.

Mr. CRANE. Mr. Miller, Dr. Miller.

Dr. MILLER. Absolutely. We have to dive down into the deep regulatory weeds and sort of clean out the garden. We also have to look at sort of big-picture market dynamic questions like physician-owned hospitals and Stark Law.

Mr. CRANE. Sir.

Mr. FIEDLER. I think it is actually possible to make progress on these questions. I think part of that is reducing administrative burdens. I think part of that is addressing other problems in our system like the fact that if a hospital buys up the local physician practice, it can now charge more for those services than it could before, which is a powerful incentive pushing towards consolidation.

Mr. CRANE. Dr. Miller, which—if—and Mr. Bean was talking about this a second ago. If you had to take this light saber that he referred to and start with the top three regulations that you would like to see slashed, what would those be?

Dr. MILLER. The ban on physician-owned hospitals is number one. I would said CMS quality regulations in the fee-for-service practice program is number two. And then the third, because you asked about—Mr. Bean asked—or Representative Bean asked about the State level—is certificate of need.

Mr. CRANE. What about you, Dr. Punzi?

Dr. PUNZI. Again, I think the regulatory burden from the prior authorizations, I think that is number one. Number two is the issue of reimbursement. And third is the issue also that we have

to keep in mind as a physician, which is going to be medical liability.

Mr. CRANE. Dr. Miller, I thought it was sad when you pointed out that that study that showed that only 15 percent of a doc's time is spent each day with their patients.

Have you—how has that changed since you started practicing?

Dr. MILLER. It has gotten worse. As a hospitalist, I refer to myself as a desk jockey because I spend most of my time typing. And, in fact, when I was a resident, one of my colleagues was already planning their retirement.

Mr. CRANE. Wow. And you also said, sir, that you-all are now practicing to document and not practicing to treat patients. Is that correct?

Dr. MILLER. Absolutely.

Mr. CRANE. Do you feel the same way, Doc?

Dr. PUNZI. Yes, sir, same way.

Mr. CRANE. How do you think that that affects the accuracy at which you are able to treat your patients?

Dr. PUNZI. Again, going back to my professor, medicine is an art and a science. And I think that the ability to be able to do a good history and physical, and if you look at the time constraints, we can't do that.

As I tell my patient—as I tell my students, 80 percent of the diagnosis you can make by doing a good history and physical. And what that does is it allows me to identify what the problem is, take care of the patient at a much lower cost and within that one visit.

Dr. MILLER. I was just going to say it means I have two jobs: One, the hospital gets paid for, which is the documentation, and that is how the system gets reimbursed; and the other is treating the patients. So it means I have to divide my time.

Mr. CRANE. Thank you.

Sir, would you like to comment on any of those question?

Mr. FIEDLER. I agree. I think some of the quality reporting burdens are not generating value and are generating a lot of costs. So streamlining those, both in public programs and in private insurance, I think would be a high-value step.

Mr. CRANE. Thank you. I yield back my time.

Chairwoman VAN DUYNE. Thank you very much.

I recognize Chairman Williams from the great State of Texas for 5 minutes.

Mr. WILLIAMS. Thank you, Madam Chair.

And I am interested in two things. First of all, Dr. Miller, have you been to the Hall of Fame?

Dr. MILLER. I have not.

Mr. WILLIAMS. You need to go, go with Beth Van Duyne. She is going up there. I played with the Atlanta Braves, but I am not in the Hall of Fame. Let that clear out.

And also, listening to this testimony, back home in Texas—I am a car dealer. I own car dealerships. And it is almost like we are in the same business. You know, I am fixing cars. You are fixing bodies.

But I see that the same thing is happening in our industries: Margins are getting squeezed, more regulations, telling you what to charge. It is a disaster, and we need to fix it.

And so, Dr. Miller, you are not only practicing medicine at Johns Hopkins, but you have extensive experience working for government agencies.

As I am sure you are aware, when agencies pass regulations, they are supposed to be taking into account the impact on small business and take steps to lessen the additional burdens. Many times you hire somebody for compliance that has nothing to do with you—creating income for you.

Now, on this Committee, we have been looking to how seriously agencies are taking this important responsibility to insulate small businesses from government overreach. And, unfortunately, it seems like many agencies are falling short.

For example, earlier this year, we wrote a letter to the FTC about a rule that would have imposed significant new costs on eye doctors and hurt many small practitioners.

So, Dr. Miller, a question. Given your past experience with government agencies—and you have talked some about this today—again, how do you think we can ensure agencies take their responsibility to lessen the impact on small business as they develop new regulations, understanding that less regulation means more margins, more service, better business?

Dr. MILLER. I think aggressive, healthy, and intellectually curious oversight, especially of CMS. The rules are 2,000 pages long, and I think that that in and of itself says how challenging the space is.

Mr. WILLIAMS. Well, you have heard today this past administration has imposed $375 billion worth of regulations on small businesses. And to take care of that is $220 million man-hours. And we have got to fix that.

So today small providers, like all small businesses, are facing significant economic challenges: Inflation—we know about that—supply chain issues; and labor shortage, to name only a few.

And, unlike additional small businesses, however, small providers face an even heavier regulatory burden with distinct requirements to comply with Medicare, to comply with Medicaid, and private insurance companies, and all this while you are trying to provide quality to your patient, have a relationships, and foster meaningful physician-patient connections.

So, Dr. Punzi, can you walk us through how challenging it is to balance these various demands on your practice? You have done that, but just remind us what a problem it is.

Dr. PUNZI. So, again, the issue is right now—whenever you do a visit, just a regular visit, the average time is about 15 minutes, of which 5 minutes is one complaint. And then in some clinics is one complaint per visit. In this study, they had six complaints, of which five 1-minute address. And, again, I have 5 minutes here.

And you can imagine, as I mentioned earlier, if I have a 74-year-old patient that I have got to do a history on, it definitely ends up being challenging.

The other thing, too, is the administrative burden that comes after you see the patient. Instead of identifying what is wrong with the patient, now you have got to go and try to document what you have just done in a timely manner. And then the issue also ends up being billing. So now you have got to send the billing, and then

you may not get paid for 30 days, 60 days, sometimes 90 days. So those are the big challenges that I identify in my practice.

Mr. WILLIAMS. A lot of fix to this is competition.

Dr. PUNZI. Yes.

Mr. WILLIAMS. And whether it be my business or your business or your, it is competition. None of us shy away from that.

Dr. PUNZI. Uh-huh.

Mr. WILLIAMS. Competition will drive prices down, services up every time, won't it?

Dr. PUNZI. Absolutely correct.

Mr. WILLIAMS. Without government regulation.

So my last question, Dr. Miller, the consolidation of healthcare practices is on the rise, and small providers are becoming rarer and rarer. In rural America—and I have a rural district, Fort Worth. You know where it is, out West. In rural America, oftentimes small providers are the only healthcare option.

So what do you see, quickly, as the long-term consequences of this trend of consolidation continues? And how do you see telehealth potentially filling the void?

Dr. MILLER. The answer is that folks will have to drive 3, 4, 5 hours to see the doctor. Telehealth can help, but you can't—we are not technologically in a space where we can do remote surgery from 5 hours away. So that—the Star Wars/Star Trek world is probably about 40 years away. So we need to preserve rural options.

I think looking at repealing the ban on physician-owned hospitals or looking at Stark Law to allow physicians to own integrated care delivery is a great potential solution.

Mr. WILLIAMS. Free markets are—the start of business America is what the country was built on.

Thank you all for coming.

I yield back, Chairman.

Chairwoman VAN DUYNE. We do have a little bit of time left. So I want to run through a second round of questions if anybody has them.

When were you in Cooperstown?

Dr. MILLER. 2013.

Chairwoman VAN DUYNE. You have not—I actually—my dad did his internship and residency at Imogene Bassett Hospital in Cooperstown.

Dr. MILLER. That is where I was.

Chairwoman VAN DUYNE. So we were there for 3 years. It is a great community.

I don't have any further question. I am going to ask you. I am going to give everybody an opportunity: Was there a request that you prepared for that was not asked today that you want to—I am just going to go down the line.

Dr. PUNZI. I think, when you talk about rural healthcare, there is about 64 million patients that live in areas that are underserved. And two-thirds of the lack of physicians are in those particular areas.

And, again, as you had mentioned, the issue of getting to a physician, they are talking about drive time. So I think that is challenging. Hospitals in that scenario, the turnover rate for staff is about 20 percent.

So they have got many challenges, but the big thing is we have got to allow those patients to have access. And I think that physicians in private practice, in rural areas, if you make it attainable, if you make it viable from a financial point of view would definitely go a long way.

Chairwoman VAN DUYNE. Excellent. Thank you.

Dr. Miller.

Dr. MILLER. I would say the biggest regulation that we haven't addressed is Stark Law or physicians' self-referral law. So, if I am an orthopedist and I work for MedStar Health as an employee, I can self-refer for an MRI or a physical therapist or whatever within the MedStar system. But, if a physician does that, that is statutorily prohibited.

Stark Law is over—and rules are over 900 pages long. I know that because I fell asleep by the pool on vacation in Florida one year trying to get through it. And so I think that that is something that needs to be addressed, and taken apart to allow physician-owned-and-operated care delivery to compete fairly with these massive tax-exempt hospitals which have bought literally every part of the healthcare supply chain, from home care to ambulatory surgery centers to clinics to imaging centers to critical access hospitals to urban hospitals.

We should allow physicians to compete fairly on an equal playing field.

Chairwoman VAN DUYNE. Thank you.

Mr. Fiedler.

Mr. FIEDLER. As we talk about consolidation in the health care sector, I think one thing that is also driving that is that whoever buys up a bunch of physician practices can often charge a much higher price for the services than those practices were charging before. And so figuring out what the policy solutions are to that problem I think is a very real one.

This may be a place actually where regulations has not been aggressive enough. I think antitrust enforcement in particular should probably be taking a more careful look at some of these types of combinations than it does today.

Chairwoman VAN DUYNE. Thank you. I appreciate your testimony.

I now recognize Ranking Member Mfume from Maryland for 5 minutes.

Mr. MFUME. Thank you mister—Madam Chair.

Just a couple of quick things and I am going to ask both Dr. Miller and Dr. Fiedler to, if you can communicate back to the committee or to me, because it is going to require a longer response, and it is probably going to be a much more thoughtful subject that I am sure you would want to expand on.

But beginning with you, Dr. Miller—and by the way, I am—I am glad that you indicated that your views are your own, and they don't represent Johns Hopkins or anybody else. Sometimes we get into a position where that is not always the case, and things leave out of this room that are not always factual.

And, you know, I served as a trustee at Johns Hopkins over top of the hospital and the university for 12 years. And so I know there are a lot of different views and visions and positions. So I am glad

that you indicated that yours today were your own thoughts on that matter.

I want to talk about what I thought was an interesting comment you made about the fact that we don't design responses the way we should to problems, and I think you said that most of them are being designed as state-sponsored or static. Is that—did you use the word "static"?

Dr. MILLER. I used the word "static," not "state-sponsored."

Mr. MFUME. Okay. Well, derived from a state activity or——

Dr. MILLER. No. Static versus dynamic.

Mr. MFUME. Okay.

Dr. MILLER. Thinking about whether a system is changing over time versus a system in place.

Mr. MFUME. Right. And you also said that the better systems would be the more dynamic and the flexible ones, as you just said, over time.

If you could just write back briefly to the Committee your thoughts, lay out how that would—should look if we were going down that path and trying to create more dynamic and flexible policies and practices and approaches, it would be helpful. It really would, and I would appreciate it.

And you also indicated that, as I think I—Mr. Punzi, you may have also—that more regulation was not the way to go. Am I paraphrasing correctly there?

Dr. PUNZI. It is kind of like my patients. A lot of times what they do is they add more medication on top of other medication without identifying what the old medication was for. Patients end up on 12, 13 medications. And they don't know why.

And I think, similar, regulations. We have got regulations on top of regulations, but we don't realize why the first one was done to begin with.

Mr. MFUME. And we don't have regulations that regulate the bad regulations. That is really the bottom line. I don't know that it is the numerical difference. I think it is the fact that some of these have just come about over time and have never gone away and so they add to the overall aggregate number.

Dr. Fiedler, can you explain on the other side of that how more regulation in health insurance space, in particular, could lead to better experiences for the population most affected? And, again, I am not advocating fewer regulations. I am advocating a consolidation or policing of the regulations that we have so that we can kind of get rid of the ones that are not working and, if we have to add good ones, then add them in.

Mr. FIEDLER. Everything is about tradeoffs. And so we want the good, and we don't want the bad, and exactly as you are asking, how do we get there?

And I think one of the ways to get rid of bad regulations is exactly the conversation we are having right now, bringing attention to these things.

As a process matter, I think that is probably the most effective way is having people both inside of government and outside of government who are bringing attention to where the problems are and identifying them.

I think the challenge is that, for any given regulation, there is someone who is on the losing side of it, even if consumers and other people are benefiting from that regulation.

So I think one of the challenges in some of these debates, maybe less so in healthcare but in healthcare, as well, is there are lots of people who want to tell you that any regulation, including the good ones, are bad and costing them money, even when they are generating a lot of value.

Mr. MFUME. Kind of like government programs. Once they get started, they just never go away, even if they are not effective.

So I am going to ask, as I asked one of your colleagues here, if you can jot down some thoughts that further expand on that and could submit them back to the Committee, that would be great.

Mr. FIEDLER. Thank you.

Mr. MFUME. Thank you, Madam Chair.

Chairwoman VAN DUYNE. Well, seeing no other further questions, I would like to thank our witnesses for their testimony and for appearing before us today.

Without objection, Members have 5 legislative days to submit additional materials and written questions for the witnesses to the Chair, which will be forwarded to the witnesses. I ask the witnesses to please respond promptly.

If there is no further business, without objection, the committee is adjourned.

[Whereupon, at 10:45 a.m., the Subcommittee was adjourned.]

APPENDIX

Testimony of Brian J. Miller, M.D., M.B.A., M.P.H.

Assistant Professor of Medicine and Business (Courtesy)
The Johns Hopkins University School of Medicine
The Johns Hopkins Carey Business School

Nonresident Fellow
American Enterprise Institute

Before the

U.S. House of Representatives Committee on Small Business
Subcommittee on Oversight, Investigations, and Regulations

On

"Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Business."

July 19, 2023

Chairwoman Van Duyne, Ranking Member Mfume, and distinguished members of the Subcommittee on Oversight, Investigations, and Regulations:

My name is Brian Miller, and I practice hospital medicine at the Johns Hopkins Hospital. As an academic health policy researcher, I serve as an Assistant Professor of Medicine and Business (Courtesy) at the Johns Hopkins University School of Medicine. My research focuses on how we can build a more competitive and vibrant health sector to make healthcare more flexible and personalized for patients. This perspective is based upon my prior regulatory experience at the Federal Trade Commission, Federal Communications Commission, U.S. Food & Drug Administration, and the Centers for Medicare & Medicaid Services. Through my role as a faculty member, I regularly engage with regulators, policymakers, and businesses in search of solutions to help create a better healthcare system for all. Today I am here in my personal capacity, and the views expressed are my own and do not necessarily reflect those of the Johns Hopkins University, the American Enterprise Institute, or the Medicare Payment Advisory Commission.

In my testimony today, I will focus on:

1. The increasing regulatory burden on health care providers
2. The important role of small providers in the health care system
3. Consolidation within the health care system and what we can do about it

1. The increasing regulatory burden on health care providers

To be a clinician in 2023 in America is an existential challenge. While a desire to heal and be present for the most challenging portion of our patients' lives is a driving force, as is the desire to achieve technical mastery of a trade, overregulation and the overreach of the administrative state has subsumed these positive drivers. Over two-thirds of physicians exhibit symptoms of burnout,[1] a problem well-acknowledged to raise costs.[2] This is no surprise and is multi-factorial, driven by increasing administrative burdens, declining Medicare reimbursement relative to the hospital industry, and the expected consequence of physicians spending less time with their patients. Time-motion studies of medical residents demonstrate that medicine residents spend 12% of their day in patient rooms.[3] Over 15 years ago, the typical primary care physician had an average visit length of 17.4 minutes,[4] yet today research demonstrates that for that same primary care physician to complete all of the chronic, acute, and preventive care required, the average workday would be 26.7 hours, inclusive of documentation.[5]

The rise of Donabedian quality measurement in the 1960s spread to the practice medicine after the Institute of Medicine's 2000 *To Err is Human* report[6] highlighted the large number of deaths due to medical error, frequently cited as the third leading cause of death domestically.[7] Unsurprisingly and with the best of intentions, the health policy community responded by proposing to measure quality, both through process measures (are clinicians and health systems doing what we want them to do?) and outcome measures.

The following two decades noted a proliferation of quality reporting programs, including those addressing physician practices. Ironically, quality metric product markets are themselves consolidated, with a handful of stakeholders securing large government contracts. The Yale Center for Outcomes Research and Evaluation received over one-

---

[1] Shanafelt TD, West CP, Dyrbye LN, et al. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic. *Mayo Clin Proc*. Dec 2022;97(12):2248-2258. doi:10.1016/j.mayocp.2022.09.002

[2] Han S, Shanafelt TD, Sinsky CA, et al. Estimating the Attributable Cost of Physician Burnout in the United States. *Annals of internal medicine*. Jun 4 2019;170(11):784-790. doi:10.7326/m18-1422

[3] Rosen MA, Bertram AK, Tung M, Desai SV, Garibaldi BT. Use of a Real-Time Locating System to Assess Internal Medicine Resident Location and Movement in the Hospital. *JAMA network open*. Jun 1 2022;5(6):e2215885. doi:10.1001/jamanetworkopen.2022.15885

[4] Tai-Seale M, McGuire TG, Zhang W. Time allocation in primary care office visits. Health Serv Res. 2007 Oct;42(5):1871-94. doi: 10.1111/j.1475-6773.2006.00689.x.

[5] Porter, J., Boyd, C., Skandari, M.R. *et al.* Revisiting the Time Needed to Provide Adult Primary Care. *J GEN INTERN MED* **38**, 147–155 (2023). https://doi.org/10.1007/s11606-022-07707-x

[6] Institute of Medicine (US) Committee on Quality of Health Care in America. To Err is Human: Building a Safer Health System. Kohn LT, Corrigan JM, Donaldson MS, editors. Washington (DC): National Academies Press (US); 2000.

[7] Makary M A, Daniel M. Medical error—the third leading cause of death in the US *BMJ* 2016; 353 :i2139 doi:10.1136/bmj.i2139

quarter of a billion dollars since 2008, out of over $1.3 billion spent on measurement development by CMS.[8] Across the economy, evidence shows that market concentration results in higher costs and lower quality. Thus, while generating quality metrics that raise operational costs for health care delivery, the Centers for Medicare & Medicaid Services (CMS) is also purchasing technical services in a concentrated market, likely at above market prices. Quality metric construction also remains a primarily academic measure, with few venues to practicing physicians to voice questions or concerns.

The direct return for taxpayers is unclear. International markets present a cautionary tale, with the United Kingdom's National Health Service implementing a pay for performance program tying performance on process and outcomes-based quality metrics to financial bonuses for primary care physicians. A subsequent study on spirometry performance within the chronic obstructive pulmonary disease (COPD) quality domain demonstrated that practices performed spirometry in accordance with accepted standards 31% of the time and 12% of results did not event support the diagnosis of COPD.[9]

Costs are very clear. Physician practice metric reporting costs an estimated $15.4 billion annually, 2.6 hours per week of physician time is spent on metric reporting, while office staff spend 12.5 hours weekly.[10] What is not mention is that this is all time that is no longer spent on patient care – clinic visits, phone calls, and urgent care. CMS now has 2,266 quality metrics in its measures inventory,[11] some of which like the hospital readmissions reduction program may, ironically, even increase mortality.[12] It is thus no mystery that the cost of running a clinical practice is increasing.

While the Trump Administration's "Meaningful Measures Initiative" created a cascade of measures, titrated down into goals, objectives, families, and individual measures and the Biden Administration's "Universal Foundation" of quality metrics[13] attempt to address this problem, neither separate nor together are they sufficient.

The inherent problem yet to be acknowledged is that quality metrics – like every animal, plant, or corporation – must have a lifecycle. Quality metrics "top out" and must be retired, others cease to change clinical operations, and still others are eventually found to be harmful.

---

[8] Castellucci M. CMS, Yale New Haven Health on hot seat over design of quality measures. Accessed 4/1/2023, https://www.modernhealthcare.com/article/20190119/NEWS/190119904/cms-yale-new-haven-health-on-hot-seat-over-design-of-quality-measures

[9] Strong M, South G, Carlisle R. The UK Quality and Outcomes Framework pay-for-performance scheme and spirometry: rewarding quality or just quantity? A cross-sectional study in Rotherham, UK. *BMC Health Serv Res*. Jun 28 2009;9:108. doi:10.1186/1472-6963-9-108

[10] Casalino LP, Gans D, Weber R, et al. US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures. *Health Affairs*. 2016/03/01 2016;35(3):401-406. doi:10.1377/hlthaff.2015.1258

[11] Wadhera RK, Figueroa JF, Joynt Maddox KE, Rosenbaum LS, Kazi DS, Yeh RW. Quality Measure Development and Associated Spending by the Centers for Medicare & Medicaid Services. *Jama*. Apr 28 2020;323(16):1614-1616. doi:10.1001/jama.2020.1816

[12] Wadhera RK, Joynt Maddox KE, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocardial Infarction, and Pneumonia. *Jama*. Dec 25 2018;320(24):2542-2552. doi:10.1001/jama.2018.19232

[13] Jacobs DB, Schreiber M, Seshamani M, Tsai D, Fowler E, Fleisher LA. Aligning Quality Measures across CMS — The Universal Foundation. *New England Journal of Medicine*. 2023;doi:10.1056/NEJMp2215539

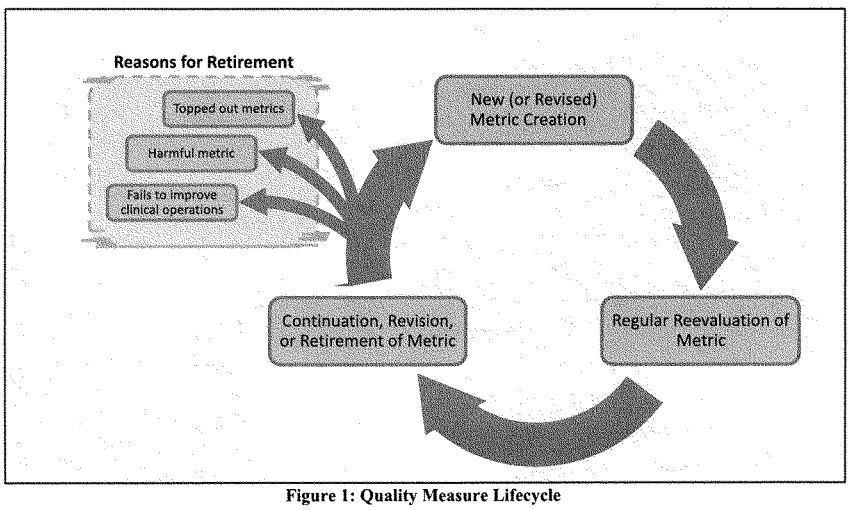


Figure 1: Quality Measure Lifecycle

Policymakers should require a cap on the number of metrics for CMS programs, require regular review and assessment of a minimum share of quality metrics (e.g. 10% annually), and a process for bottom-up quality metric innovation from practicing physicians. Further, policymakers should require that CMS contract with a minimum of three organizations for quality measure development, so as to avoid market concentration.

Quality reporting burdens are real and drive administrative activity. When I was an internal medicine resident, one of my colleagues was already planning their retirement by the second year of our three year residency.

2. The important role of small providers in the health care system

Many patients frequently seek care at large health systems, often for tertiary or quaternary care. I myself have trained in and recognize the value that many large health systems have in offering highly trained and specialized care.

To better illustrate the challenges of large health systems, I have included some statistics to illustrate their scale:

1. *Mayo Clinic Jacksonville*: 400 acre campus for outpatient and inpatient care, soon to undergo an expansion including a 179,000 square foot hotel.[14]
2. *Mayo Clinic Rochester*: "The five-block downtown Mayo campus is easily walkable, even in the winter, thanks to Mayo's extensive subway and skyway system."[15]
3. *Massachusetts General Hospital Yawkey Outpatient Center*: 380,000 square feet[16] (does not include the larger hospital)
4. University of Minnesota Medical Center: 1,700 beds[17]

[14] Kevin Punsky, "Mayo Clinic Invests in Major Hospital Expansion to Enhance Patient Experience," Mayo Clinic News Network, February 22, 2022, https://newsnetwork.mayoclinic.org/discussion/mayo-clinic-invests-in-major-hospital-expansion-to-enhance-patient-experience/.
[15] "Getting around Mayo Clinic in Rochester, Minnesota - Mayo Clinic," accessed July 18, 2023, https://www.mayoclinic.org/patient-visitor-guide/minnesota/getting-around.
[16] "Massachusetts General Hospital—Yawkey Center for Outpatient Care [Boston, MA] - HCD Magazine," HCD Magazine - Architecture & Interior Design Trends for Healthcare Facilities, August 31, 2007, https://healthcaredesignmagazine.com/architecture/massachusetts-general-hospital-yawkey-center-outpatient-care-boston-ma/.
[17] "University of Minnesota Medical Center | University of Minnesota Health," accessed July 18, 2023, https://bettercaremn.umn.edu/university-minnesota-medical-center.

The medical school at which I trained at occupies several blocks of downtown Chicago, see the following map:

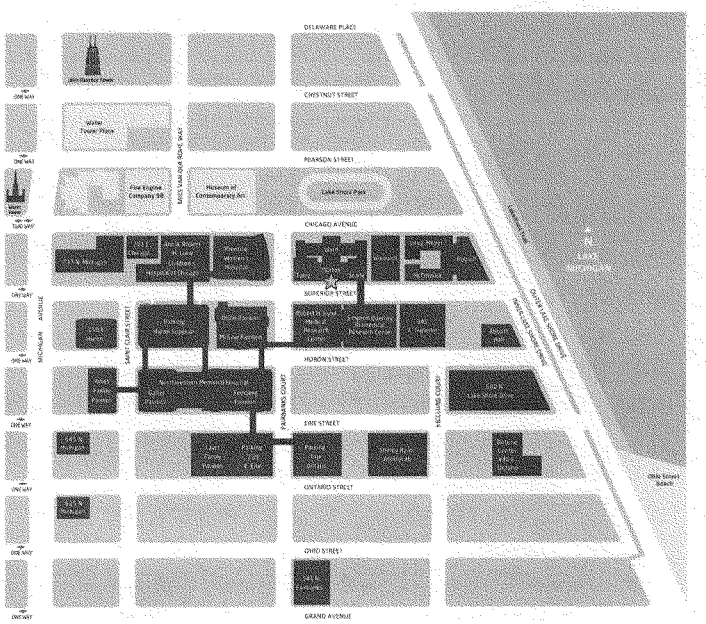


Figure 2: Map of Northwestern Medicine Downtown Chicago Campus[18]

What does this mean for consumers? Walking one quarter of a mile on the street between buildings and navigating a 23 story clinic building to make it to an appointment is neither convenient nor easy. Half of Medicare-Medicaid beneficiaries had one impairment in the activities of daily living (e.g. dressing, bathing, etc.),[19] and many other populations of patients have significant functional impairments or, more simply, are just not feeling well.

This is not to say that large health systems do not have an important place in American health care, as they do. Rather that small physician groups may be more accessible, more conveniently located (akin to retail chains), and may be more able to customize clinical care itself and the *processes for the delivery of care*.

We should work to preserve this choice for patients.

[18] "Living in Chicago," accessed July 18, 2023, https://www.feinberg.northwestern.edu/admissions/why-northwestern/chicago.html.
[19] Maiss Mohamed et al., "A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)," *KFF* (blog), January 31, 2023, https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.

3. Consolidation within the health system

Consolidation of health care markets is a significant problem for patients, employers, and policymakers. Hospital care comprises around 31% of annual health spending, with physician care representing another 19%. Researchers note that over 90% of metropolitan statistical areas representing highly concentrated hospital markets.[20]

The harms of hospital consolidation are well-documented, with consolidation leading to higher prices,[21] borne by patients as higher cost-sharing payments and higher health insurance premiums.[22,23] Patients also experience other losses: a lack of quality gains from hospital mergers and – unsurprisingly – decrements in patient experience.[24] Higher health care costs also hurt workers, as rising costs for health benefits can suppress wages or be transferred to workers in the form of higher premiums and cost sharing.[25]

To add insult to the injury, 58% of hospitals are tax-exempt institutions, an exemption conservative estimated at $27.6 billion.[26] Many have large boards driving weak oversight, with some noting challenges with spending and accountability at IRS-designated charitable institutions in highly concentrated markets with UPMC operating a corporate jet for executives and business development as far back as 2008,[27] while Atrium health noted 380 flights on private jets from 2008 – 2012 for executives and 29 flights on private jets for its health system CEO.[28] Still, the others note that the Mayo Clinic decorated its lobby with 13 Dale Chihuly glass sculptures weighing 6,000 pounds and comprised of 1,375 pieces of glass.[29]

It is in this environment that policymakers rightly express concern about market concentration, noting that hospitals have successfully lobbied to prevent physician-owned and -operated enterprises from competing with them, through the ban on physician-owned hospitals and Stark Law, which functionally prohibits physician ownership and operations of integrated care delivery in a small business setting.[30] Repealing the ban on physician-owned hospitals has the potential to expand access,[31] lower costs, and improve quality.[32]

Consolidation is a vexing problem, with Congress' foot historically – accidentally – on the accelerator. The lack of site neutral payment – wherein payers pay the same amount for a service regardless of where it is performed – has also driven clinic – hospital consolidation. The nonpartisan Committee for a Responsible Federal Budget estimated that full implementation of site neutral payment would save Medicare $217 to $279 billion over the next decade,[33] noting that full implementation of site neutral payment would eliminate payment policy arbitrage as a rationale for hospitals' purchase of clinics.

---

[20] Fulton BD. Health Care Market Concentration Trends In the United States: Evidence And Policy Response. *Health Affairs* 2017;36(9):1530-1538. doi: 10.1377/hlthaff.2017.0556

[21] Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *Quarterly Journal of Economics* 2019;134(1):51-107. doi: 10.1093/qje/qjy020

[22] Boozary AS, Feyman Y, Reinhard UE, Jha AK. "The Association Between Hospital Concentration And Insurance Premiums in the ACA Marketplaces." *Health Affairs* 2019;4:668-674. doi: 10.1377/hlthaff.2018.05491

[23] Trish EE, Herring BJ. How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health insurance Premiums? *J Health Econ* 2015;42:104-11. doi: 10.1016/j.jhealeco.2015.03.009

[24] Beaulieu ND, Dafny LS, Landon BE, Dalton JB, Kuye I, McWilliams JM. Changes in Quality of Care after Hospital Mergers and Acquisitions. *N Engl J Med.* 2020 Jan 2;382(1):51-59. doi: 10.1056/NEJMsa1901383.

[25] "Health Insurance Costs Are Squeezing Workers and Employers," *Center for American Progress* (blog), November 29, 2022, https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/.

[26] Jamie Godwin, Scott Hulver Published: Mar 14, and 2023, "The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020," *KFF* (blog), March 14, 2023, https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/.

[27] HealthLeaders, "UPMC Sees Jet as a Key Tool in Quest for Global Reach," accessed July 18, 2023, https://www.healthleadersmedia.com/strategy/upmc-sees-jet-key-tool-quest-global-reach.

[28] "Carolina Health System Interview with Charlotte Observer," accessed July 18, 2023, https://atriumhealth.org/documents/news/chs-interview-with-charlotte-observer.pdf.

[29] "Glass Chandeliers by Dale Chihuly," *Mayo Clinic Proceedings* 76, no. 11 (November 1, 2001): 1176, https://doi.org/10.4065/76.11.1176.

[30] Miller BJ, Ehrenfeld JM, Wu AW. Competition or Conflict of Interest—Stark Choices. *JAMA Health Forum.*2021;2(2):e210150. doi:10.1001/jamahealthforum.2021.0150

[31] Miller BJ, Moffit RE, Ficke J, Marine J, Ehrenfeld JM. "Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals." *Health Affairs Forefront* April 12, 2021.

[32] Cho T, Meshnick AB, Ehrenfeld JM, Miller BJ. "Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review." *Mercatus Center at George Mason University* Arlington, Virginia. September 7, 2021.

[33] Committee for a Responsible Federal Budget. Equalizing Medicare Payments Regardless of Site-of-Care. (2021). https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care

4. Conclusions: together we can fix these problems

Health policy is at a turning point – government intervention to solve problems begets more government intervention. Increasing regulatory barriers and administrative complexity raise barriers to entry, crushing small businesses and raising the cost of services for purchasers. In order to preserve the vital role for small practices, policymakers should direct CMS to cap the number of quality metrics and create a quality metric lifecycle, with onboarding, off-ramps, and routine metric performance evaluation. CMS should be required to contract with a minimum of 3 measurement development organizations, and create a direct channel for bottom up innovation from practicing physicians. Finally, policymakers should expand access and lower costs by repealing the ban on physician-owned hospitals, considering reforms to Stark Law, and implement site neutral payment.

Henry A Punzi, MD, FCP, FASH
Trinity Hypertension & Metabolic Research Institute
Punzi Medical Center
1932 Walnut Plaza
Carrollton, Texas 75006

July 19, 2023

U.S. House of Representatives
Committee on Small Business
Honorable Beth Van Duyne, Chair
Subcommittee on Oversight, Investigations, and Regulation
Hearing on:
"Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses."

I am pleased to offer this written testimony to the U.S. House of Representatives 's Subcommittee on Oversight, Investigations and Regulations: *"Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses."* I commend this Subcommittee for tackling this timely issue.

Definitions:

Small Businesses: Businesses that have a limited number of employees, typically fewer than 500, and operate independently of larger corporations. Small businesses are typically privately owned and operated and have a single owner or a small group of owners.

Prior authorization: It is a management process used by insurance companies to determine if a prescribed product or service will be covered. This means if the product or service will be paid in full or part. This process involves many people-primarily patients, health care professionals and the patients' health insurance companies.

Customer: a person who purchases goods and services.

Patient: a person receiving or registered to receive medical treatment

I am here to discuss the burdensome prior authorizations that impact my small practice and know that there is much to be done at the federal level to provide regulatory relief.

I am a solo practitioner with 4 full-time and one part-time employee. My practice falls under the definition of a small business. I also perform other non-medical tasks which help with run my office such as administrative and payroll duties, purchasing of office and medical supplies and CMS compliance officer. These task takes time away from patient care and the addition of the current healthcare quality improvement infrastructure adds an unnecessary layer of burden to offices such as mine.

In 1965 Congress passed legislation establishing the Medicare and Medicaid programs. Under these programs, Americans 65 and older were qualified to receive hospital insurance (Part A) and voluntary supplemental insurance (part B). In anticipation of the need to assess and direct the care for Medicare patients, Congress established a set of conditions entitled: Conditions of Participation "which required the hospital to implement several elements, such as Staff credentialing, 24-hour nursing, and utilization review. This has snowballed to encompass all medical providers as of 2023.

Patient-Physician conversations are complex, multidimensional, and multifunctional. A study by Tai-Seale (1999-2000) revealed the median visit length of 392 routine office visits was 15.7 minutes covering a median of 6 topics. About 5 minutes were spent on the longest topic whereas the remaining topics each received 1.1 minutes. I personally allot 30-45 minutes per patient in my practice because we have the added burden that for many of my patients, English is their second language. In 2022, 83.4% of adults had a visit with a doctor or other health care professional. This led to 1 billion visits with 320.7 visits per 100 persons and 50.3% of these visits were made to primary care physicians. The average primary care physician in the United States sees between twenty and thirty patients per day, according to a study published in the Annals of Family Medicine. The study, which surveyed over two thousand primary care physicians, found that the number of patients seen per day varied widely depending on the type of practice, with solo practitioners seeing an average of nineteen patients per day and physicians in group practices seeing an average of twenty-six patients per day. In a recent study, physicians were asked about the time they spent with their patients. According to the results, most physicians said that they felt their time with patients was limited. In 2018, most physicians saw 11-20 patients per day. Some reports have estimated that for every hour of direct patient contact, physicians spend an additional 2 hours working on reporting and desk work.

During a typical 11.4-hour workday, primary care doctors spend 5.5 hours on electronic health records (EHR) tasks while in the office and an additional 1.4 hours outside of clinic hours, in the early morning or after 6:00pm, including 51 minutes on the weekend.

This results in physicians spending an additional 2 hours on EHR and desk work for every hour of direct clinical face time with patients.

If we use the current data and I see 15-20 patients daily and use an average of 15.7 minutes, this adds up to between 12 and 16 hours per day of patient care.

When I prescribe a medication for my patient and the pharmacy must send a request to the insurance company and when they deny its use to their "customer". This starts the arduous process of "prior Authorization" (PA). An average practice completes 45 PA's per week taking almost 2 business days (14 hours each week) completing the PA's. I do not have this luxury in my practice but 35% of physicians surveyed have staff who work exclusively on PA's. A 2023 AMA survey demonstrated that 94% of doctors say prior authorization leads to delays in patient care. One in three doctors (33%) say prior authorization has led to serious adverse events with their patients. A majority of doctors (62%) said prior authorization has led to additional office visits, with 64% saying prior authorization has resulted in patients needing immediate care including emergency department visits.

As of March 2023, there were 65,748,297 people enrolled in Medicare of which more than 30,400,000 (49%) are enrolled in Medicare Advantage Plans. In Texas 50% of Medicare eligible patients are in a Medicare Advantage Plan.

Eighty four percent of practices surveyed by MGMA report having to reauthorize existing Medicare-covered services for those Medicare beneficiaries who had switched plans. Sixty percent of practices report that there are at least three different employees involved in completing a single PA. Ninety seven percent of medical groups report that their patients experienced delays or denials for medically necessary care (e.g., prescription medicine, diagnostic tests, or medical services) due to prior authorization requirements.

Conclusion:

The authority to prescribe the correct medications has been taken away from the physician. Health plans continue to inappropriately impose bureaucratic prior authorization policies that conflict with evidence-based clinical practices, wasting vital resources, jeopardize quality care and harm patients. 4 in 5 doctors (80%) said patients gave up on treatment because of problems getting authorization from insurers. A solid majority of doctors (58%) said prior authorization hurt the job performance of their patients. My predominantly Hispanic population with English as a second language cannot advocate for themselves. I must and will advocate for the patients beyond the exam room. With 80% of prior authorizations ultimately approved it raises serious concerns that insures are reducing their cost at the expense of the patients by relying on the ability of time-consuming prior authorization to deter prescribing. We need to eliminate as much of the RED TAPE as possible and spend our time and attention focused on the overall well-being of the patient encompassing mental health issues that could be identified with more time spent with the patient. Spending time with our patients and improving their outcomes would lower overall health care costs.

Bibliography:

Dugdale DC. Epstein R, Pantilat SZ. Time and the Patient-Physician Relationship. *J Gen Intern Med.* 1999 14(1): S34-S40.

Morjoua Y, Bozic KJ. Brief history of quality movement in US healthcare. *Curr Rev Muscoloskelet Med.* 2012. 5:256-273.

Tai-Seale M, McGuire TG, Weimin Z. Time allocation in primary care office visits. *Health Serv Res.* 2007 42(5):1871-1894.

National Center for Health Statistics. Percentage of diagnosed hypertension for adults 18 and over, United States 2019-2022. National Health Interview Survey. 7/17/2023

National Center for Health Statistics. National Ambulatory Medical Care Survey: 2019 National Summary Tables.

Arndt BG. Beasley JW, Watkinson MD, et al. Tethered to the HER. Primary care physician workload assessment using HER event log data and time event monitor. *Annals of Family Medicine*. 2017. 15 (5.) 1-8.

Sinsky C, Colligan L, Li L. et al. Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Annals of Internal Medicine.* 2016, 165 (11) 753-760.

MGMA. Spotlight prior authorization in Medicare Advantage. May 2023.

Testimony of Matthew Fiedler, Ph.D.
Senior Fellow, Schaeffer Initiative on Health Policy
Economic Studies Program, Brookings Institution

Before the United States House of Representatives
Committee on Small Business
Subcommittee on Oversight, Investigations, and Regulations

July 19, 2023

Chair Van Duyne, Ranking Member Mfume, and members of the subcommittee, thank you for inviting me here today. My name is Matthew Fiedler, and I am a health economist and a Senior Fellow with the Schaeffer Initiative on Health Policy at the Brookings Institution.[1] My research focuses on a range of topics in health care policy, including health care provider payment and health insurance regulation.

My testimony will examine the administrative costs that health care providers incur to interact with health insurers (including both public insurers like Medicare and Medicaid and private insurers), as well as how public policy can reduce those costs. I will make four main points:

1. **Health care providers incur substantial costs to interact with insurers, likely totaling hundreds of billions of dollars per year, costs that are ultimately borne in large part by consumers and taxpayers.** Costly activities include negotiating contracts, collecting information about patients' insurance coverage, obtaining prior authorization for care, submitting claims for payment, and reporting on quality performance. There are likely economies of scale in performing many of these activities, so the associated administrative burdens likely fall more heavily on smaller providers than on larger ones.

2. **Many administrative processes serve valuable purposes, so efforts to reform them can involve tradeoffs and should be approached thoughtfully.** For example, it is essential to have *some* set of procedures for compensating providers. Similarly, insurers' prior authorization requirements can prevent delivery of inappropriate services, and audit processes can be effective tools for identifying and deterring fraud.

3. **Certain targeted reforms could reduce administrative burdens with few substantive downsides.** One is eliminating Medicare's Merit-Based Incentive Payment System, which places large reporting burdens on clinicians, with few benefits. Another is replacing the cumbersome arbitration process that is used to determine payment rates for certain out-of-network services under the No Surprises Act with a simpler "benchmark" payment regime. A third is reforming Medicare Advantage's risk adjustment system to reduce plans' ability to increase their payments by documenting additional diagnoses.

[1] The views expressed in this testimony are my own and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

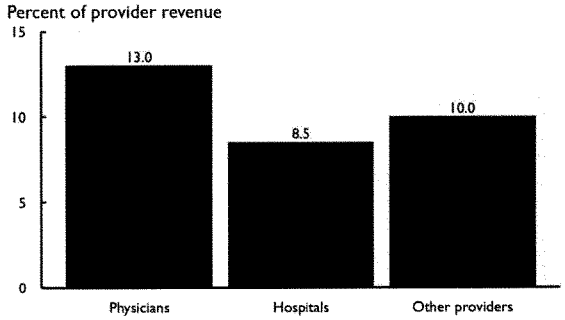
4. **Standardizing billing, coverage, and quality reporting rules across insurers could generate larger savings but would also present more significant tradeoffs.** Changes like these could help address a major reason that administrative burdens are larger in the United States than in other countries: the wide variation in rules across the United States' many public and private insurers. However, mandating greater standardization would also limit insurers' ability to tailor rules to their unique circumstances or experiment with novel approaches. Setting rules through a centralized process might also produce rules that are systematically better or worse than current rules.

The remainder of my testimony will examine these points in greater detail.

Background on Insurance-Related Administrative Costs

Health care providers devote substantial effort to interacting with health insurers; activities include negotiating contracts, collecting information about patients' coverage, seeking prior authorization for care, submitting claims for payment, and reporting on quality performance. One widely cited synthesis of survey estimates concluded that "billing and insurance-related" costs consume 13.0% of revenue for physician practices, 8.5% for hospitals, and 10.0% for other providers, as shown in Figure 1.[2] Under current health care spending projections, these estimates imply that health care providers in the United States will incur $396 billion in such costs this year.[3] Public programs and private insurers incur additional costs to play their part in provider-insurer interactions.

Figure 1. Provider Costs of Interacting with Insurers



Source: Kahn (2010)

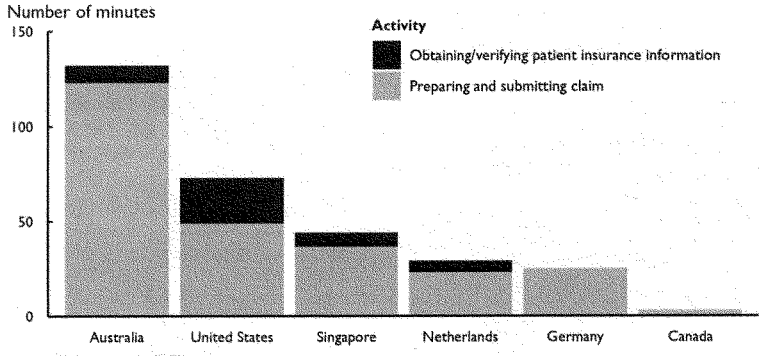
[2] James G. Kahn, "Excess Billing and Insurance-Related Administrative Costs," in *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, ed. Pierre L. Yong, Robert S. Saunders, and LeighAnne Olsen (Washington, DC: National Academies Press, 2010). These estimates do not include costs associated with quality reporting. For an estimate of those costs, see Lawrence P. Casalino et al., "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures," *Health Affairs* 35, no. 3 (March 2016): 401–6, https://doi.org/10.1377/hlthaff.2015.1258.

[3] This calculation uses the most recent National Health Expenditure projections. See Centers for Medicare and Medicaid Services, "National Health Expenditure Projections, 2022-2031," June 2023, https://www.cms.gov/files/zip/nhe-projections-tables.zip.

These administrative costs are ultimately borne, at least in large part, by consumers and taxpayers. In private insurance markets, the prices negotiated between insurers and providers are likely to reflect the administrative costs borne by providers, at least in the long run. Those higher prices, as well as the administrative costs incurred directly by insurers, are then reflected in premiums and cost-sharing. Part of those costs is paid by consumers and part is paid by the federal government (which directly or indirectly subsidizes most forms of private coverage). In public programs like Medicare and Medicaid, higher administrative costs mean that these programs must pay providers higher prices in order to ensure a given level of access to care for program beneficiaries.[4]

The complexity of health care providers' interactions with insurers appear to vary widely across countries. One recent study collected detailed data on the number of minutes of work that is required to collect payment for inpatient services in six countries.[5] The United States was second only to Australia in the total time required, as depicted in Figure 2.

Figure 2. Time Required to Collect Payment for an Inpatient Claim



Source: Richman et al. (2022)
Note: Estimates reflect all inpatient visits for countries other than Germany, for which estimates reflect inpatient surgical visits only. Estimates exclude time devoted to financial counseling.

This finding likely reflects, at least in part, the fact that the United States relies on a menagerie of public and private insurers, each of which sets its own rules for interactions with providers. Indeed, in a typical market, a provider is likely to have to deal with traditional Medicare, several private

[4] For empirical evidence on this point, see Abe Dunn et al., "A Denial a Day Keeps the Doctor Away," *The Quarterly Journal of Economics*, June 28, 2023, qjad035, https://doi.org/10.1093/qje/qjad035.

[5] See Barak D. Richman et al., "Billing And Insurance–Related Administrative Costs: A Cross-National Analysis," *Health Affairs* 41, no. 8 (August 2022): 1098–1106, https://doi.org/10.1377/hlthaff.2022.00241. A notable strength of this study relative to others is that measures the *time* required to complete billing-related tasks in different countries, which is a reasonable measure of the complexity of those processes, not just the cost of those processes, which may be affected both complexity and prevailing wage levels. The authors also present estimates of cost differences, which generally show larger differences between the United States and other countries, consistent with other research in this area. See, for example, David U. Himmelstein et al., "A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far," *Health Affairs* 33, no. 9 (September 2014): 1586–94, https://doi.org/10.1377/hlthaff.2013.1327.

insurers operating Medicare Advantage plans, still more private insurers that offer private plans in the group and individual markets, the state's fee-for-service Medicaid program, and private insurers that operate Medicaid managed care plans. Even within a given insurer and coverage type, rules may vary depending on what specific plan a patient is enrolled in. I consider how policymakers might grapple with the resulting inefficiencies later in my testimony.

Larger providers likely benefit from economies of scale in their interactions with insurers, so these administrative burdens likely loom larger for smaller providers than for larger ones. For example, setting up systems to perform these functions may involve fixed costs like learning the relevant rules, devising compliance plans, and purchasing software, costs that larger providers can spread over a much larger volume of cases. For similar reasons, larger providers may be able to invest more in identifying or implementing more efficient processes. Coping with variation across insurers may be particularly costly for smaller providers because developing plans to comply with each unique set of rules requires incurring a new set of fixed costs.

These economies of scale may be one force that encourages consolidation in the health care sector (although other factors, such as the fact that large providers are typically able to negotiate higher prices with private insurers and the fact that Medicare often pays more for services delivered in hospital outpatient departments than in physician offices likely play a larger role).[6] Importantly, consolidation motivated by economies of scale can be a good thing; greater administrative efficiency may sometimes outweigh the corresponding increase in market power. But where economies of scale exist purely because of inefficient administrative requirements, it will generally better to reform those requirements than to mitigate their costs via consolidation, especially because many health care markets in the United States are already highly concentrated.[7]

Options to Reduce Insurance-Related Administrative Costs

Given the size of the administrative costs generated by providers' interactions with insurers, it is natural to ask whether these costs can be reduced. In considering options for doing so, it is important to recognize that administrative spending is not inherently wasteful. Administrative processes serve important purposes: billing processes are needed to compensate providers for delivering care; prior authorization requirements can prevent delivery of inappropriate services;[8]

---

[6] For a review of evidence on how consolidation affects prices, see Congressional Budget Office, "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services," January 20, 2022, https://www.cbo.gov/publication/57422. For a discussion of how Medicare's methods of paying for hospital outpatient services encourage consolidation, see Loren Adler, Matthew Fiedler, and Benedic Ippolito, "Assessing Recent Health Care Proposals from the House Committee on Energy and Commerce," May 12, 2023, https://www.brookings.edu/articles/assessing-recent-health-care-proposals-from-the-house-committee-on-energy-and-commerce/.

[7] Congressional Budget Office, "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services."

[8] Zarek C. Brot-Goldberg et al., "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," Working Paper, Working Paper Series (National Bureau of Economic Research, January 2023), https://doi.org/10.3386/w30878.

and audit processes can help uncover and deter low-value utilization.[9] Thus, policy efforts to reduce administrative burdens should be attuned to tradeoffs and proceed thoughtfully.

In the remainder of my testimony, I will first discuss three targeted policy changes that could reduce administrative costs with few substantive downsides: (1) eliminating Medicare's Merit-Based Incentive Payment System; (2) reforming the No Surprises Act's method for determining payment for certain out-of-network services; and (3) making the Medicare Advantage risk adjustment system more resistant to plans' diagnosis coding efforts. I then consider an approach that has the potential to generate much larger administrative savings but may involve more significant tradeoffs: standardizing billing, coverage, and quality reporting rules across insurers.

Eliminating Medicare's Merit-Based Incentive Payment System

Clinicians who serve Medicare beneficiaries generally must participate in the Merit-Based Incentive Payment System (MIPS) unless they participate in an "advanced" alternative payment model (e.g., certain accountable care organization models). MIPS was created by the Medicare Access and CHIP Reauthorization Act of 2015 and took effect in 2017. In 2020, nearly 4 times as many Medicare clinicians were in MIPS as compared to advanced APMs.[10]

Under MIPS, practices are scored on their performance on measures of clinical quality, their use of electronic health records that meet the Department of Health and Human Services' certification standards, their participation in certain "practice improvement activities," and the cost of the care their patients receive. Based on a practice's overall score, its payments under Medicare's physician fee schedule may be adjusted upward or downward by as much as 9%, although actual adjustments have typically been far smaller than this and will likely remain so going forward.

Much of the information used to compute a practice's MIPS score—notably its performance on quality measures—is reported by the practice itself. Practices are also responsible for deciding *which* quality measures to report, as well as which activities they want to be scored on in other MIPS domains. These activities are costly. A recent study that interviewed practices about their MIPS compliance costs estimated that practices spent nearly $13,000 per physician to comply with MIPS in 2019, on average, with some evidence that smaller practices incurred larger costs.[11]

If this estimate is representative of all MIPS participants, then total compliance costs in 2019 amounted to $12 billion or 13% of total provider revenue under the Medicare physician fee schedule.[12] This estimate should be interpreted cautiously since accurately measuring costs via

---

[9] Maggie Shi, "Monitoring for Waste: Evidence from Medicare Audits," April 2023, https://mshi311.github.io/website2/Shi_MedicareAudits_QJEresubmission_2023_04_20.pdf.

[10] Centers for Medicare and Medicaid Services (CMS), "2020 Quality Payment Program Experience Report," August 2022, https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2013/2020%20QPP%20Experience%20Report.pdf.

[11] Dhruv Khullar et al., "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-Based Incentive Payment System," *JAMA Health Forum* 2, no. 5 (May 14, 2021): e210527, https://doi.org/10.1001/jamahealthforum.2021.0527.

[12] This estimate was obtained using CMS' estimate of the total number of MIPS-eligible clinicians in 2019 and the Medicare Trustees' estimate of total spending under the physician fee schedule in that year. See Centers for Medicare and Medicaid Services (CMS), "2019 Quality Payment Program Experience Report," October 2021,

interviews can be challenging. Indeed, these estimated costs exceed the difference between the largest positive and largest negative MIPS payment adjustment applied for 2019; this implies that practices would have been better off simply ignoring their obligations under MIPS, something few did, which suggests that the the costs faced by typical practices may not have been quite this large.[13] Moreover, costs may have declined since 2019 as practices have gained experience and as CMS has tried to simplify the program. But even if this estimate overstates practices' actual compliance costs by an order of magnitude, these costs would still be sizeable.

Unfortunately, despite the substantial costs that MIPS generates, there is little reason to believe that MIPS is meaningfully improving the quality or efficiency of patient care.[14] A fundamental problem is that MIPS allows clinicians to choose many of the measures that they are evaluated on. In practice, different clinicians choose different measures and likely do so at least in part based on which measures they expect to perform best on. This makes it impossible to use MIPS scores to meaningfully compare clinicians and, thus, doubtful that MIPS can motivate better outcomes.

Even if this issue were addressed by standardizing quality measures (something CMS has recently taken some tentative steps toward doing), MIPS would likely continue to struggle. Measuring cost and quality performance at the level of individual clinicians or practices, as MIPS tries to do, is challenging. Patients' outcomes are shaped by the efforts of many different providers, which makes it difficult to determine who is responsible for what, plus it can be hard to construct reliable performance estimates at the provider level. This is a recipe for weak, incoherent incentives, and it is likely why a plethora of programs that have adjusted providers' payment rates based on provider-level measures of cost and quality performance (including programs that avoid MIPS' distinctive design flaws) have failed to meaningfully improve care.[15]

---

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1653/2019%20QPP%20Experience%20Report.pdf; Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, "2023 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," April 2023, https://www.cms.gov/oact/tr/2023.

[13] Centers for Medicare and Medicaid Services (CMS), "2019 Quality Payment Program Experience Report."

[14] For more discussion of these points, see Matthew Fiedler et al., "Congress Should Replace Medicare's Merit-Based Incentive Payment System," *Health Affairs Blog* (blog), February 26, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180222.35120/full/; Matthew Fiedler, "Medicare Physician Payment Reform after Two Years: Examining MACRA Implementation and the Road Ahead," § Committee on Finance (2019), https://www.finance.senate.gov/imo/media/doc/08MAY2019FIEDLERSTMNT.pdf; Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy" (Medicare Payment Advisory Commission, March 2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec_rev_0518.pdf?sfvrsn=0; Eric C. Schneider and Cornelia J. Hall, "Improve Quality, Control Spending, Maintain Access — Can the Merit-Based Incentive Payment System Deliver?," *New England Journal of Medicine* 376, no. 8 (February 23, 2017): 708–10, https://doi.org/10.1056/NEJMp1613876; Vinay K. Rathi and J. Michael McWilliams, "First-Year Report Cards From the Merit-Based Incentive Payment System (MIPS): What Will Be Learned and What Next?," *JAMA* 321, no. 12 (March 26, 2019): 1157–58, https://doi.org/10.1001/jama.2019.1295.

[15] See, for example, Eric T. Roberts, Alan M. Zaslavsky, and J. Michael McWilliams, "The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities," *Annals of Internal Medicine* 168, no. 4 (February 20, 2018): 255–65, https://doi.org/10.7326/M17-1740; Andrew M. Ryan et al., "Changes in Hospital Quality Associated with Hospital Value-Based Purchasing," *New England Journal of Medicine* 376, no. 24 (June 15, 2017): 2358–66, https://doi.org/10.1056/NEJMsa1613412; Jose F. Figueroa et al., "Association between the Value-Based Purchasing Pay for Performance Program and Patient Mortality in US Hospitals: Observational Study," *BMJ* 353

In sum, I see little reason to believe that MIPS generates benefits that justify its substantial costs. With colleagues, I have argued for repealing MIPS and replacing it with small, targeted incentives for practices to undertake specific high-value activities: (1) using a certified electronic health record, which can help advance broader federal efforts to ensure that clinical data can flow across providers when needed; and (2) reporting data to a clinical registry, which can help facilitate valuable clinical research.[16] In parallel, policymakers should strengthen incentives to participate in advanced alternative payment models and, ideally, streamline quality reporting requirements under those models.[17] The Medicare Payment Advisory Commission (MedPAC) has similarly argued for eliminating MIPS and replacing it with a voluntary program under which providers' performance could be assessed using information already reported on physician claims.[18]

Reforming the No Surprises Act's mechanism for determining payment for out-of-network care

The No Surprises Act limits patients' exposure to "surprise bills" when they receive certain out-of-network care, including out-of-network emergency services and services delivered by an out-of-network physician at an in-network facility. Under the law, insurers must cover these services and apply only in-network cost-sharing, while providers cannot bill patients for more than the in-network cost-sharing. The payment the provider receives from the insurer is then determined via negotiations between the two parties or, if they cannot agree, via an Independent Dispute Resolution (IDR) process: a "baseball style" arbitration process in which the insurer and provider each make an offer and the arbitrator chooses between the offers based on statutory criteria.

The IDR process has created substantial administrative costs for both providers and insurers. From April 15, 2022 through March 31, 2023, more than 334,000 IDR cases were initiated.[19] Each party to a dispute must pay the federal government an administrative fee to cover the costs of running the IDR process; this fee stands at $350 per party in 2023.[20] Arbitrators also collect substantial fees, which are paid by the losing party in a dispute; these fees can range from $200 to $700 for a single dispute in 2023. If IDR volume remains at anywhere close to the level observed to date, then parties are likely to owe hundreds of million dollars in fees under the IDR process in 2023.

(May 9, 2016): i2214, https://doi.org/10.1136/bmj.i2214; Ashish K. Jha et al., "The Long-Term Effect of Premier Pay for Performance on Patient Outcomes," *New England Journal of Medicine* 366, no. 17 (April 26, 2012): 1606–15, https://doi.org/10.1056/NEJMsa1112351.

[16] Fiedler et al., "Congress Should Replace Medicare's Merit-Based Incentive Payment System"; Fiedler, Medicare physician payment reform after two years: Examining MACRA implementation and the road ahead.

[17] For a recent review of the evidence on this point, see J. Michael McWilliams, Alice Chen, and Michael E. Chernew, "From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-Based Payments" (Brookings Institution, October 13, 2021), https://www.brookings.edu/research/from-vision-to-design-in-advancing-medicare-payment-reform-a-blueprint-for-population-based-payments/.

[18] Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2018.

[19] Department of Health and Human Services, Department of Labor, and Department of the Treasury, "Federal Independent Dispute Resolution Process – Status Update," April 2023, https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf.

[20] Centers for Medicare and Medicaid Services, "Amendment to the Calendar Year 2023 Fee Guidance for the Federal Independent Dispute Resolution Process," December 23, 2022, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/amended-cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf.

This is in addition to any expenses that they will incur to conduct negotiations prior to entering IDR or that they will incur during the IDR process (e.g., to respond to arbitrators' inquiries).

It is plausible that these costs will wane somewhat over time. The fees that apply for 2023 are markedly higher than the fees that applied for 2022, which may help to reduce IDR volume. Additionally, IDR volume may decline as the parties gain experience with the process. This is because going to IDR only makes sense if the two parties have divergent beliefs about what price the arbitrator will ultimately select; otherwise, they would both be better off reaching an agreement at a price close to the price that they expect the arbitrator to pick and avoiding the costs associated with IDR.[21] As providers and insurers gain a better understanding of how arbitrators tend to decide cases, divergent beliefs may become rarer. Nevertheless, the IDR process seems likely to generate substantial administrative costs for the foreseeable future.

These administrative costs are avoidable. During the debate that led to the No Surprises Act, policymakers considered approaches under which payment for an out-of-network service subject to the law's protections would equal a statutorily specified "benchmark" price. For example, one bill specified that an insurer would be required to pay the median contracted rate it had paid for the service before enactment of the No Surprises Act.[22] (The insurer's historical median contracted rate is currently a criterion that arbitrators are supposed to consider in IDR.) Another approach would have been to set the benchmark price equal to a multiple of the price Medicare pays for the service.[23] These approaches could be revived in light of the dismal experience with IDR.

Some may worry that reviving the "benchmark" approach would result in providers being paid less appropriate prices than under IDR. But this concern is likely ill-founded. Notably, policymakers could set the benchmark so that the overall level of payments to providers is at whatever level they deemed appropriate; for example, if they wished, they could set a benchmark that would ensure that providers are paid the same amount, on average, as under IDR.

Moreover, there is no reason to believe that the IDR process will do a good job of tailoring prices to particular cases. Arbitrators have no clear economic incentive to want to arrive at the "right" prices (even if it were clear what those prices were). Rather, arbitrators' main incentives are: (1) to minimize their costs of deciding cases; and (2) to maximize their future volume.

The first incentive will tend to encourage arbitrators to reach decisions by applying simple rules rather than by carefully considering the facts of any particular case; the guidance arbitrators have received is compatible with this approach, as they have broad latitude to decide how to weigh the statutory factors. The second incentive will tend to reinforce the first incentive since, under the law, arbitrators are generally selected by mutual agreement of the two parties. Thus, an arbitrator

---

[21] For more discussion of this point, see Matthew Fiedler, Loren Adler, and Ben Ippolito, "Recommendations for Implementing the No Surprises Act" (Brookings Institution, March 16, 2021), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/03/16/recommendations-for-implementing-the-no-surprises-act/.

[22] Lamar Alexander and Patricia Murray, "Lower Health Care Costs Act," Pub. L. No. S. 1895 (2019), https://www.congress.gov/bill/116th-congress/senate-bill/1895.

[23] See, for example, Loren Adler et al., "State Approaches to Mitigating Surprise Out-of-Network Billing" (Brookings Institution, February 20, 2019), https://www.brookings.edu/research/state-approaches-to-mitigating-surprise-out-of-network-billing/.

is likely to wish to decide cases however it expects *other* arbitrators to decide cases. Otherwise, it is likely to be perceived as more favorable to either providers or insurers than the "typical" arbitrator and will run the risk of being vetoed by the disfavored party in future cases.

Even if arbitrators do give careful consideration to the circumstances of a particular case, it is far from clear that this will lead to the "right" prices. Notably, apart from the insurer's historical median contracted rate, the most concrete factor that arbitrators are supposed to consider is the provider's recent contracted rates. These recent rates are often highest for the providers that were most aggressive about using their ability to surprise bill patients as leverage in contract negotiations with insurers.[24] There is little reason to want to favor these providers over others.

Making the Medicare Advantage risk adjustment system more resistant to plan "coding" efforts

Under the Medicare Advantage (MA) program, the federal government establishes a payment rate for each participating plan based on a bid submitted by the plan and a "benchmark" based on traditional Medicare spending in the plan's county. That payment rate reflects what the plan would be paid to cover enrollees with the same risk profile as traditional Medicare enrollees. Actual payments are then "risk adjusted" to ensure that payments to the plan are commensurate with the cost of serving the beneficiaries who actually enroll in the plan. To facilitate risk adjustment calculations, MA plans submit information to CMS on what medical diagnoses their enrollees have, which CMS uses to calculate average "risk scores" that are used to adjust payments.

This system gives MA plans a strong incentive to report as many diagnoses as possible for their enrollees. Consistent with this, MA plans report far more diagnoses for their enrollees than those enrollees would accrue if enrolled in traditional Medicare.[25] In many cases, the additional diagnoses reflect conditions that beneficiaries actually have, but that tend to go unrecorded in traditional Medicare. In other cases, the additional diagnoses are not supported by beneficiaries' medical records.[26] MedPAC estimates that MA plans' diagnosis coding efforts increase the risk scores of MA enrollees by 10.8% above what they would be if they were enrolled in traditional Medicare. CMS does apply a "coding intensity adjustment" to the risk scores of MA enrollees that is intended to offset plans' coding efforts, but it is currently just 5.91% (the statutory minimum).[27]

While the most important effect of MA plans' coding efforts is to increase how much CMS pays MA plans, these activities also increase administrative costs. Some of those additional costs are incurred by health care providers because MA plans use a variety of strategies to enlist providers

[24] Fiedler, Adler, and Ippolito, "Recommendations for Implementing the No Surprises Act."

[25] For an up-to-date review of this evidence, see Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2023, https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.

[26] Department of Health and Human Services, "Department of Health and Human Services Agency Financial Report Fiscal Year 2022," November 2022, https://www.hhs.gov/sites/default/files/fy-2022-hhs-agency-financial-report.pdf.

[27] Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2023.

in the search for additional beneficiary diagnoses. For example, MA plans often offer bonus payments to providers who report additional diagnoses.[28]

For this reason, some reforms that would reduce the susceptibility of the MA risk adjustment system to plans' diagnosis coding efforts could also reduce providers' administrative burdens. One longstanding recommendation from MedPAC is to begin using two years of data on beneficiary diagnoses for risk adjustment purposes, rather than one year as is done at present.[29] The logic of this proposal is that using two years of data will increase the likelihood that beneficiary diagnoses are captured even without the special efforts undertaken by MA plans. That may reduce the return to MA plan efforts to identify diagnoses, causing them to reduce the intensity of those efforts. (Using two years of data is also likely to increase the number of diagnoses captured in traditional Medicare and, thus, reduce the coding advantage held by MA plans.)

Another approach is to exclude diagnoses that are particularly susceptible to plans' coding efforts from use in risk adjustment. CMS recently took a step in this direction when it updated its risk adjustment methods for the 2024 benefit year, but it would be worth looking for other opportunities in this vein.[30] It is important to recognize that excluding diagnoses from risk adjustment does involve tradeoffs. While it reduces how susceptible the risk adjustment system is to plans' coding efforts, it may also reduce how effective the system is in adjusting for true differences in health status across populations.[31] This may create opportunities for MA plans to profit by selectively enrolling healthier beneficiaries. Thus, this policy tool should be used judiciously.

A more ambitious step: increasing standardization across insurers

The three targeted steps described above would achieve meaningful administrative savings while presenting few substantive tradeoffs. Achieving larger savings would require more wider-ranging reforms. One approach would be to standardize some billing, coverage, or quality reporting rules across the menagerie of public and private insurers that operate in the United States health care system. Variation in rules across different insurers may be an important reason why providers bear heavier administrative burdens in the United States than in other countries.[32]

One way to achieve greater standardization would be to implement a single payer system, which would, by definition, implement a single set of administrative processes. Notably, unlike some other approaches, this approach would nearly eliminate the need for providers to collect

[28] Medicare Payment Advisory Commission (MedPAC).

[29] Medicare Payment Advisory Commission (MedPAC).

[30] Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," March 31, 2023, https://www.cms.gov/files/document/2024-announcement-pdf.pdf.

[31] Matthew Fiedler, "Comments on Part C and Part D Payment Policies," March 8, 2023, https://www.brookings.edu/articles/comments-on-part-c-and-part-d-payment-policies/.

[32] Richman et al., "Billing And Insurance-Related Administrative Costs."

information about their patients' insurance coverage. But there are also proposals that could achieve greater standardization even within the context of our existing multi-payer system.[33]

Under one such proposal, the federal government would standardize the information providers must submit to obtain payment for each specific service.[34] Claims would then be processed through a single clearinghouse that would accept claims from providers, adjudicate those claims under the standardized rules, and then route payments from insurers to providers. Importantly, the actual *prices* paid for services could (and presumably would) still vary across providers and insurers in largely the way they do today; only the billing process would be standardized.

An important question is how insurers' rules about which services they cover (and under what circumstances) would operate under such a system. Insurers could be allowed to continue to apply their own coverage rules, including prior authorization requirements and requirements applied at the time of claims submission. This approach would limit the savings under such a proposal since these rules are an important source of administrative burden. Alternatively, coverage rules could be standardized and centralized as well; this would likely be a much larger undertaking than merely standardizing the billing process since coverage rules often take account of the full circumstances of a particular case, which makes then harder to automate. Similar questions would arise with respect to insurers' post-payment audit procedures.

Another important question is how to address non-fee-for-service payment arrangements like capitation, global budget, or shared saving arrangements. In principle, such arrangements could operate outside of the standardized system. (Indeed, because they do not require providers to take action on a service-by-service basis, administrative burden may be less of a concern.) On the other hand, policymakers could elect to standardize these arrangements as well, perhaps by establishing a small number of template arrangements that providers and insurers could choose from.

While this type of standardization and centralization could generate meaningful administrative savings, particularly in its more ambitious forms, it could also present tradeoffs. Under such a system, insurers would no longer be able to tailor their rules to their particular circumstances, and they would lose the ability to experiment with new approaches. The public sector entity responsible for establishing the standardized would also have different incentives than existing private insurers. This could lead it to set systematically different rules than those that exist under our current decentralized system, rules that might be better or worse than existing rules.

These tradeoffs might not be particularly important if only the billing process was standardized. Even in private insurance, payment methods often closely (though not exactly) mirror Medicare's payment methods, so setting Medicare-like processes as the standard might greatly simplify the

---

[33] For some recent examples, see Emily Gee and Topher Spiro, "Excess Administrative Costs Burden the U.S. Health Care System" (Center for American Progress, April 8, 2019), https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/; David M. Cutler, "Reducing Administrative Costs in U.S. Health Care" (The Hamilton Project, March 10, 2020), https://www.hamiltonproject.org/publication/policy-proposal/reducing-administrative-costs-in-u-s-health-care/; David Scheinker et al., "Reducing Administrative Costs in US Health Care: Assessing Single Payer and Its Alternatives," *Health Services Research* 56, no. 4 (2021): 615–25, https://doi.org/10.1111/1475-6773.13649.

[34] Cutler, "Reducing Administrative Costs in U.S. Health Care."

billing system while only modestly affecting its substantive performance.[35] On the other hand, standardizing rules about what services plans cover (and under what conditions) could have much larger effects. Different plans often adopt meaningfully different coverage rules, which have important consequences for utilization and costs. For example, traditional Medicare makes much less use of prior authorization than Medicare Advantage plans, and this is likely one reason that utilization in traditional Medicare is higher than in Medicare Advantage.[36]

Quality measurement is another area where greater standardization is possible. While I previously discussed the burdens created by MIPS, Medicare's quality reporting rules are not the only ones that providers must contend with; private insurers have similar programs, and these programs also generate large administrative costs.[37] One potential approach would be for policymakers to establish a standardized set of quality measures for different categories of providers, require providers to report on those measures to a centralized database, and require insurers to rely on those measures rather than collecting their own bespoke quality measures.[38]

Standardizing quality reporting might have fewer downsides than standardizing billing processes and coverage rules since (consistent with my skepticism about the benefits of MIPS) it is less clear whether the current quality reporting regime is creating substantial benefits. Indeed, it is plausible that centralization would make quality reporting more effective by increasing the number of patients observed for each provider and easing cross-payer comparisons.

Conclusion

Health care providers in the United States incur hundreds of billions dollars in annual costs to interact with health insurers. While much of this administrative spending may be necessary, there are likely opportunities to reduce it. As discussed above, three specific opportunities include eliminating Medicare's Merit-Based Incentive Payment System, replacing the mechanism used to determine certain out-of-network payment rates under the No Surprises Act, and making the Medicare Advantage risk adjustment system more resistant to plans' diagnosis coding efforts. Larger savings could potentially be achieved by standardizing the administrative processes used by the menagerie of public and private insurers that operate in the United States, although steps like these present more substantial tradeoffs than the more targeted changes.

---

[35] Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments," *Journal of Political Economy* 125, no. 1 (December 16, 2016): 1–39, https://doi.org/10.1086/689772; Zack Cooper et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics* 134, no. 1 (February 1, 2019): 51–107, https://doi.org/10.1093/qje/qjy020.

[36] Gretchen Jacobson and Tricia Neuman, "Prior Authorization in Medicare Advantage Plans: How Often Is It Used?" (Kaiser Family Foundation, October 24, 2018), https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage-plans-how-often-is-it-used/; Vilsa Curto et al., "Health Care Spending and Utilization in Public and Private Medicare," *American Economic Journal: Applied Economics* 11, no. 2 (April 2019): 302–32, https://doi.org/10.1257/app.20170295.

[37] Casalino et al., "US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures."

[38] Cutler, "Reducing Administrative Costs in U.S. Health Care."

APTA Private Practice. A Section of the American Physical Therapy Association | 1421 Prince Street Suite 300 Alexandria, VA 22314 | (800) 517-1167 | www.ppsapta.org | APTA American Physical Therapy Association

APTA Private Practice

Small business professionals restoring function to America - one patient at a time.

Examples submitted for the Small Business Committee Oversight Hearing, *"Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses."* -- July 19, 2023

General impact statement: Given the current pressures on therapy providers, including recent year-over-year fee schedule cuts, rehabilitation therapists are united in seeking opportunities to reduce administrative burden without compromising patient safety or quality of care as a way to mitigate the impact of these payment cuts for therapy providers and our physician colleagues, as well as to best serve our patients expeditiously and without financial risk to their therapist providers.

MEDICARE

PTA supervision

Background: Medicare allows for general supervision of physical therapist assistants (PTAs) by physical therapists and occupational therapy assistants by occupational therapists (OTAs) in all settings, except for outpatient private practice under Part B, which requires direct supervision. While therapy providers must comply with their state practice act if state or local practice requirements are more stringent than Medicare's, the standard in 48 states i general supervision of OTAs and PTAs, making this outdated Medicare regulation — which arbitrarily applies only to private practice — more burdensome than almost all state requirements. The inconsistency of supervision policies between settings limits employment opportunities for PTAs and OTAs as well as jeopardizes the needs of Medicare beneficiaries in medically underserved and rural communities that rely so heavily on their services.

Statement for the Record: Standardizing a "general supervision" requirement under Medicare for private practice will help ensure continued patient access to needed therapy services and give small therapy businesses more workforce flexibility to meet the needs of beneficiaries. Reducing this overburdensome supervision requirement would enable PTAs in outpatient therapy settings to provide care to patients at the top of their license (following a physical therapist's plan of care). According to an independent report published by Dobson & Davanzo in September 2022, this change in supervision is estimated to save $271 million over 10 years.

Plan of care signature requirement relief

Background: Medicare Part B guidelines permit Medicare beneficiaries to receive therapy evaluation and treatment services with or without a physician order. The PT, OT, or SLP may evaluate that patient, formulate a plan of care, and commence treatment. Under current certification requirements, the therapy provider must submit the plan of care to the patient's physician and have it signed within 30 days in order to receive payment—regardless if that patient arrived at physical therapy with an order for therapy services.

Statement for the Record: The time and resources spent by both therapists and physicians in procuring a timely signature adds unnecessary cost, potentially delays essential services, and fails to contribute to improved quality of care. We could reduce administrative burden for both the physicians and the physical therapists by clarifying a new care coordination model such that when outpatient therapy services are provided under a physician's order, the plan of care certification requirements shall be deemed satisfied if the qualified therapist submits the plan of care to the patient's referring physician within 30 days of the initial evaluation. The order would confirm the physician's awareness of the therapy episode and proof of submission of the plan of care would demonstrate the coordination and collaboration between the physician and the therapist. In the case where a patient went directl to a physical therapist for care, the existing model could remain in place to ensure a "closed loop" of communication and care coordination. In either case, a physician would continue to have the authority to modify the plan of care from the physical therapist.

APTA Private Practice
1421 Prince Street
Suite 300
Alexandria, VA 22314
(800) 517-1167
www.ppsapta.org
APTA American Physical Therapy Association

Medicare credentialing

Background: Currently, Medicare credentials a Medicare enrolled physical therapist to practice at an individual outpatient therapy practice location. If the practice has multiple locations, the physical therapist must be credentialed at each location.

Statement for the Record: Credentialing of therapists in a multi-location practices per address is wasteful and unnecessary. Instead, a provider credentialed by Medicare at one location of a practice should be considered a credentialed to provide care at all of the locations of that practice group.

PRIVATE INSURANCE/MEDICARE ADVANTAGE

Prior authorization for MA plans and private insurance

Background: Health insurers, including many Medicare Advantage (MA) plans, require providers to obtain prior authorization for certain medical treatments or tests—including physical therapy care—before they can provide care to their patients. In a 2018 report, the Department of Health & Human Services' (HHS) Office of the Inspector General raised concerns that prior authorization was being used to limit services and payment, after an audit revealed that MA plans ultimately approved 75% of requests that were originally denied. In April 2022 another HHS OIG report found that "Although some of the denials that we reviewed were ultimately reversed by the [MA Organizations (MAOs)], avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs."

Statement for the Record: Prior authorization frequently results in administrative burdens for providers which diverts precious time away from patient care and delays approval for necessary physical therapy services. As evidenced by both OIG reports, it is not uncommon for therapists to follow all required guidelines from the MA plan and still receive rejections. Furthermore, it is not clinically appropriate to ration care solely based upon the volume of services. In many cases, the patient understands that delaying care may severely hinder their recovery, but is wholly unaware of the presence of prior authorization and utilization management hurdles that result in physical therapists and other providers being forced to decide between furnishing an uncovered service at their own expense or risk the patient's health and well-being by waiting for a plan to authorize medically necessary care. The *Seniors Timely Access to Care Act* which got a lot of attention last Congress is soon to be reintroduced in order to address this issue and reduce some of the remaining administrative burdens.

VALUE OF ACCESS TO PHYSICAL THERAPY

- Utilization of physical therapy improves physical function which allows seniors to be more involved members of their communities and to continue to have a positive economic impact (as employees, volunteers, or consumers)
- Continued access to care results in more efficient plans of care that have better results (delays in care can result in poorer outcomes or higher overall cost—either because that episode of care will take longer, or because the functional outcome will be reduced and result in future functional limitations which will require further interventions)
- Access to PT is an important non-pharmacological approach to pain management

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

Everett E. Vokes, MD, FASCO
Board Chair
Association for Clinical Oncology

Statement prepared for:
House Committee on Small Business Subcommittee on Oversight, Investigations, and Regulations
Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses

July 19, 2023

The Association for Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, "Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses." ASCO appreciates that the Subcommittee is holding today's hearing and has provided this opportunity to address the administrative burdens that threaten oncologists' ability to deliver high-quality cancer care that patients deserve.

ASCO is a national organization representing more than 45,000 physicians and other health care professionals who care for people with cancer, including many who run their own practices. ASCO members are dedicated to conducting research that leads to improved patient outcomes and are also committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans.

Step Therapy
Step therapy is a utilization management tactic often referred to as "fail first," where patients are required by their insurance provider to try and fail medications chosen by a payer before the payer will cover the medication originally prescribed by the patient's health care provider. Step therapy policies are generally inappropriate for use in oncology due to the individualized nature of modern cancer treatment and the lack of interchangeable clinical options. Step therapy can lead to disease progression and irreversible damage to a cancer patient's health, undermines and threatens the doctor-patient relationship, and further exacerbates health inequities.

ASCO joined other organizations on a letter to the Centers for Medicare and Medicaid Services (CMS) regarding the 2024 Medicare Advantage Plan and Part D Rule, urging CMS to move swiftly to reinstate the step therapy prohibition in Medicare Advantage (MA) plans for Part B drugs as described in the September

17, 2012, memo *Prohibition on Imposing Mandatory Step Therapy for Access to Part B Drugs and Services.* ASCO is concerned that CMS asserts in this proposed rule that, "the requirements in the 2019 rule, in combination with current MA program regulations, ensure access to Part B drugs and limit the potential for step therapy policies to interfere with medically necessary care." We respectfully disagree that the current allowances made for step therapy in Medicare Part B meet this standard, instead creating unnecessary burdens and irreparable consequences when it comes to the health and wellness of patients. We continue to urge the administration to protect patients' access to care and expeditiously reverse the harmful decision to allow MA plans to implement step therapy.

Additionally, ASCO has endorsed the *Safe Step Act* (H.R. 2630/S. 652), led by Representatives Brad Wenstrup (R-OH), Raul Ruiz, MD (D-CA), Mariannette Miller-Meeks, MD (R-IA) and Lucy McBath (D-GA) and Senators Lisa Murkowski (R-AK), Maggie Hassan (D-NH), Roger Marshall, MD (R-KS), and Jacky Rosen (D-NV). This legislation puts important patient safeguards from step therapy protocols in place for ERISA-governed health plans by requiring exceptions when the treatment is contraindicated, expected to be ineffective, likely to cause adverse reaction, or the patient is stable on treatment already selected.

Specifically, the legislation would require employer sponsored health plans to:

- Establish a clear and convenient process for physicians to appeal a step therapy protocol.
- Make information on the appeals process readily available on the plan's website, including the exception requirements and any necessary forms and contact information.
- Grant patient exceptions to step therapy under five critical circumstances.
- Expedite care by requiring a timely decision for appeals — 72 hours, or within 24 hours if life threatening.

ASCO urges Congress to pass the *Safe Step Act* to ensure that patients have access to effective and timely treatments, and that physicians are able to decide the right treatment for their patients at the right time.

Prior Authorization

An ongoing source of frustration across the oncology care team is overly burdensome prior authorization requirements. ASCO recently published the results of a survey of our members in the United States to assess the impact of prior authorization on cancer care.

Nearly all survey participants reported a patient has experienced harm because of prior authorization mandates, including significant impacts on patient health such as disease progression (80%) and loss of life (36%). The most widely cited harms to patients reported were delays in treatment (96%) and diagnostic imaging (94%); patients being forced onto a second-choice therapy (93%) or denied therapy (87%); and increased patient out-of-pocket costs (88%).

The survey responses also reflected the difficulties of the prior authorization mandates. Nearly all respondents report experiencing burdensome administrative requirements, delayed payer responses, and a lack of clinical validity in the process. The survey also found that, on average:

- It takes a payer five business days to respond to a prior authorization request.
- A prior authorization request is escalated beyond the staff member who initiates it 34% of the time.

- Prior authorizations are perceived as leading to a serious adverse event for a patient with cancer 14% of the time.
- Prior authorizations are "significantly" delayed (by more than one business day) 42% of the time.

Over the past several years, Members of Congress have become increasingly concerned about the use of prior authorization in MA plans. The House of Representatives unanimously passed the *Improving Seniors' Timely Access to Care Act* (S. 3018/H.R. 3173) in September 2022. This bipartisan legislation, developed with input from ASCO, finished the 117th Congress with 380 combined cosponsors — 53 senators and 327 representatives — supporting the legislation. Importantly, more than 500 organizations representing patients, health care providers, the medical technology and biopharmaceutical industry, health plans, and others endorsed the legislation.

While the legislation did not move forward last Congress, ASCO is optimistic that the CMS Electronic Prior Authorization proposed rule, which was published in the Federal Register on December 13, 2022, takes steps to improve the prior authorization requirements that will improve beneficiary access to necessary and lifesaving services and ease the administrative burden on physicians and payers. This rule aligns with many of the provisions included in the legislation, which, if passed, would have gone into effect in 2024.

Both this proposed rule and the legislation:

- Establish an electronic prior authorization program.
- Standardize and streamline the prior authorization process.
- Increase transparency around MA prior authorization requirements and their use.

We strongly urge CMS to address two overarching concerns with the proposed rule in order to maintain current regulatory and legislative momentum to address prior authorization:

1) expedite the implementation timeline of provisions finalized in this rule for all plans and require compliance with finalized proposals in contract year 2024.
2) include drugs—which are currently excluded—in the electronic prior authorization program and application programming interface (API) requirements.

ASCO appreciates the more than 230 Representatives and 61 Senators who signed letters to CMS urging the agency to finalize and implement the proposed rule, as well as urges CMS to expand on the rule to allow for some real-time electronic prior authorization decisions, require a response within 24 hours for urgently needed care, and increase transparency.

Copay Accumulators

In addition to prior authorization and step therapy, copay accumulators are another utilization management technique that has a negative impact on providers, their practices, and their patients.

In recent years, health insurance companies, employers, and pharmacy benefit managers (PBMs) have shifted costs for specialty prescription medicines to patients. To help patients afford the cost of their prescriptions, pharmaceutical manufacturers or charitable organizations often offer copayment assistance, which can reduce or eliminate the patient share of payment for medications. This has led to a

rise in insurers and PBMs implementing "copay accumulator" programs, which can negate the intended benefit of patient assistance programs, remove a financial safety net for patients who need specialty medications, and result in increased out-of-pocket costs and poorer health outcomes.

Copay accumulators prevent patient assistance funds from applying toward a patient's annual out-of-pocket maximum or deductible, lack transparency, increase costs for patients, result in poorer health outcomes, and increase administrative burden for providers.

The *Help Ensure Lower Patient (HELP) Copays Act* (H.R. 830/S. 1375), led by Representatives Buddy Carter (R-GA-1), Nanette Diaz Barragan (D-CA-44), Mariannette Miller-Meeks, MD (R-IA-1), and Diana DeGette (D-CO-1) and Senators Tim Kaine (D-VA) and Roger Marshall, MD (R-KS), would prohibit the use of copay accumulators and require health plans and PBMs to count the value of copay assistance toward a patient's cost-sharing requirements. ASCO urges Congress to pass the *HELP Copays Act* to protect patients from harmful insurance and PBM practices that raise patient out-of-pocket drug costs.

Administrative Burden and Burnout

Oncology care teams face significant clinician burnout, leading to early retirement or individuals leaving the field. Burnout in oncology has been linked to provider shortages and the increased demand for health care services from an aging population. Providers of all types, including those working in small practices, report stress and burnout directly stemming from increased administrative and financial burdens from payer policies, such as prior authorization, step therapy, and copay accumulator programs.

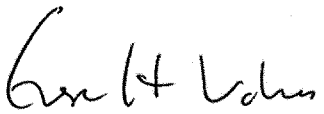
PBM policies are also contributing to workforce burnout. Data collected during the 2018 ASCO Practice Survey showed PBMs may reduce access and quality of care while increasing burdens on providers. For example, three-quarters of practices surveyed said PBMs interfered with patient care and/or made it difficult to deliver care, and 56% say that PBMs disrupted practice workflow. The significant erosion of time spent delivering care stands in direct opposition to the most common reason clinicians cite as their motivation for entering practice: helping patients.

To address burnout and support small practices, ASCO recommends continued federal investments for programs authorized under the *Dr. Lorna Breen Health Care Provider Protection Act* that aid physicians in combatting and coping with burnout in the workplace. ASCO also recommends enactment of policy solutions to address administrative burdens, which impede the delivery of quality patient care and lead to burnout. Legislative solutions include the previously mentioned *Safe Step Act* (H.R. 2630/S. 652) and the *Help Ensure Lower Patient (HELP) Copays Act* (H.R. 830/S. 1375), as well as the *Pharmacy Benefit Manager Transparency Act* (S. 127). Advancement of pending regulatory solutions under CMS on prior authorization could also reduce burdens for providers.

Finally, ASCO consistently opposes the imposition of any mandatory demonstration projects on oncology practices, particularly those that carry significant risk of harm to patients with cancer. We will continue to urge the Centers for Medicare and Medicaid Innovation (CMMI) not to adopt mandatory models of any nature.

ASCO is pleased to serve as a resource to you and your colleagues as you continue to investigate overly burdensome regulations that are impacting ASCO members and their practices. Should you have any follow-up questions or concerns, please do not hesitate to contact Katie Gifford at katie.gifford@asco.org.

Sincerely,



Everett E. Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

July 18, 2023

The Honorable Beth Van Duyne
Chairwoman
House Committee on Small Business
Oversight, Investigations & Regulations Subcommittee
2361 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kweisi Mfume
Ranking Member
House Committee on Small Business
Oversight, Investigations & Regulations Subcommittee
2069 Rayburn House Office Building
Washington, D.C. 20515

Re: MGMA Testimony — "Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses"

Dear Chairwoman Van Duyne and Ranking Member Mfume:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this hearing on "Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses." We appreciate the opportunity to provide feedback on this important topic.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA has long advocated that policymakers scale back regulatory burden for medical practices, arguing that these requirements divert time and resources away from delivering patient care. Yet, as indicated in MGMA's annual regulatory burden surveys, the onerous requirements imposed on medical groups continue to rise, further impeding a practice's ability to ensure high-quality, timely patient care. MGMA's diverse membership uniquely situates us to offer the following feedback regarding the impact of regulatory burden on small medical group practices.

Background

Research published by *Health Affairs* found that administrative spending accounts for between 15 and 30% of medical spending. Separately, *Health Affairs* also noted that not all administrative spending adds value, citing the redundancy of quality and pay-for-performance systems. Medical groups constantly face a barrage of administrative and regulatory burdens that divert resources away from patient care. Eighty-nine percent of medical groups report that the overall regulatory burden on their practices has increased over the past 12 months and 97% of medical groups report that a reduction in regulatory burden would allow for reallocation of resources toward patient care. MGMA is encouraged by the Subcommittee's willingness to examine the impact of burdensome red tape on small businesses. We support policies that promote innovative, high-quality, and cost-effective care delivery untethered from excessive, one-size-fits-all regulations.

Ongoing challenges

Reducing burden in the Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced the sustainable growth rate formula with the Quality Payment Program (QPP). This was intended to stabilize payment rates in the Medicare fee-for-service (FFS) system and incentivize physicians to transition into value-based payment models. The QPP created two reporting pathways to facilitate the transition to value-based care: the Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). While MACRA was a step in the right direction, the reporting burden for medical groups under the QPP program is substantial — 64.56% of MGMA members surveyed for the 2022 annual regulatory burden report found QPP reporting to be extremely or very burdensome. Both MIPS and APMs contain specific policies that increase administrative burden, without adding value.

MIPS reporting

There are a multitude of factors contributing to increased administrative burden under MIPS. The MIPS reporting program requires that clinicians report on quality measures that are not clinically relevant to them. The cost reporting measure holds clinicians accountable for costs outside of their control. It is a time-consuming and laborious process to comply with these requirements. Compounding these issues is the lack of adequate and timely feedback by CMS on measure performance. Without receiving appropriate feedback about which patients are assigned to them and what costs outside of their practice they must account for, physicians are unable to correct issues and improve compliance.

A study from the Weill Cornell Medical College found that MIPS scores inconsistently relate to performance on process and outcome measures. The study found that physicians treating more medically complex patients were more likely to receive low MIPS scores despite providing high-quality care. Medical groups report that MIPS reporting requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities.

Small practices are disproportionately impacted by MIPS policies as they often do not have the same resources, staff, and capital as large systems. In 2022, the Small, Underserved, and Rural Support (SURS) technical assistance program ended due to a lack of congressional funding. This program was vital in assisting small practices' compliance with the constantly evolving policies in MIPS and its expiration further exacerbates small practices' ability to meet program requirements.

In the 2024 proposed Medicare Physician Fee Schedule (PFS), CMS proposes to increase the MIPS performance threshold from 75 points in 2023 to 82 points for 2024. This increase from an already high 2023 threshold will result in penalties for many small practices as the mean MIPS score for small groups was 73.71 points in 2021, according to the most recent QPP Experience Report. CMS estimates that 46% of MIPS eligible clinicians would receive a negative payment adjustment for the CY 2024 performance period/2026 MIPS payment year if the proposed PFS policies are finalized.

APM development and reporting

A major barrier medical groups face in transitioning to value-based care is the lack of clinically relevant APMs available to them. Seventy-eight percent of medical groups reported Medicare does not offer an APM that is clinically relevant to their practice, with 61% of members being interested in participating in a clinically relevant model. The Centers for Medicare & Medicaid Innovation (CMMI) and private sector entities under the Physician-Focused Payment Model Technical Advisory Committee (PTAC) can develop APMs. Unfortunately, CMMI, who possess the sole responsibility to test and implement the APM, has yet to

test any of the models PTAC has recommended. Small practices especially find it hard to join APMs and need support through investments, resources, and tools to transition to value-based care.

In conjunction with a shortage of APMs, 76% of MGMA members reported that the CMS implementation of value-based payment reforms has increased the regulatory burden on their practice. The qualifying participation (QP) threshold to participate in an APM is unreasonably high, and CMS has recently proposed in the 2024 PFS to increase the threshold. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS. Shifting requirements and ambiguous incentives work in concert to add confusion and instability to APM participation.

Supporting medical groups through stabilizing physician reimbursement

While medical groups grapple with administrative burdens stemming from the QPP, they continue to face challenges related to high rates of inflation, staffing shortages, and reimbursement challenges. Physician practices cannot continue to divert financial and staff resources away from patient care to comply with duplicative MIPS requirements. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities. The researchers concluded that if physicians see an average of four patients per hour, then the 53 hours spent on MIPS-related activities could be used to provide care for an additional 212 patients per year. The same study found that MIPS cost practices $12,811 per physician to participate in 2019. Moreover, the American Medical Association's analysis of Medicare Trustees report data found that Medicare physician payment has ultimately been reduced by 26% when adjusted for inflation over the past 20 years. A congressional solution, such as the bipartisan *Strengthening Medicare for Patients and Providers Act*, is needed to better support physician practices while policymakers examine commonsense ways to reform physician payment and address pervasive administrative burden.

Reducing prior authorization requirements and burdens

Prior authorization requirements are routinely identified by medical groups as the most challenging and burdensome obstacle to running their practices and delivering high-quality care. Increasing prior authorization requirements are detrimental to both practices and the patients they treat. Prior authorization requests disrupt workflow, increase practice costs, and result in dangerous denials and delays in care. In 2018, MGMA partnered with several provider groups and health plans to publish a *Consensus Statement on Improving the Prior Authorization Process*. These organizations agreed that selective application of prior authorization, volume adjustment, greater transparency and communication, and automation were areas of opportunity to improve upon. However, since the time this consensus statement was released, medical groups report little progress in any of these areas.

MGMA is increasingly alarmed by reports of rising prior authorization requirements — 98% of medical groups recently reported that prior authorization requirements had stayed the same or increased over the previous 12 months. Seventy-seven percent of groups reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests. Sixty percent of groups surveyed reported that there were at least three different employees involved in completing a single prior authorization request. Group practices are already facing significant workforce shortage issues — this situation is simply unsustainable.

Despite feedback from MGMA to multiple administrations and Congress over the years regarding the unnecessary administrative burden, cost, and delay of treatment associated with prior authorization, little has been done to adequately address these concerns. These requirements disproportionally impact small businesses and medical groups who do not have the resources, infrastructure, and personnel to process these prior authorization requests. Especially, if the requests are ultimately approved. It is critical that Congress step in and provide much-needed relief from these arbitrary and burdensome requirements.

Conclusion

We thank the Subcommittee for its leadership on this critical issue. We look forward to working with you and your congressional colleagues to craft commonsense policies that will allow medical group practices to continue providing high-quality patient care without unnecessary administrative barriers. If you have any questions, please contact Claire Ernst, Director of Government Affairs, at cernst@mgma.org or 202-293-3450.

Regards,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs