S. HRG. 118–166

# IMPROVING CARE, LOWERING COSTS: ACHIEVING HEALTH CARE EFFICIENCY

## HEARING

BEFORE THE

## COMMITTEE ON THE BUDGET UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

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October 18, 2023

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Printed for the use of the Committee on the Budget

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# C O N T E N T S

WEDNESDAY, OCTOBER 18, 2023

OPENING STATEMENTS BY COMMITTEE MEMBERS



STATEMENTS BY COMMITTEE MEMBERS



WITNESSES



APPENDIX

# IMPROVING CARE, LOWERING COSTS: ACHIEVING HEALTH CARE EFFICIENCY

**WEDNESDAY, OCTOBER 18, 2023**

COMMITTEE ON THE BUDGET,
U.S. SENATE,
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:01 a.m., in the Dirksen Senate Office Building, Hon. Sheldon Whitehouse, Chairman of the Committee, presiding.

Present: Senators Whitehouse, Wyden, Kaine, Van Hollen, Grassley, Johnson, Marshall, Braun and R. Scott.

Also present: Democratic staff: Joshua P. Smith, Budget Policy Director; Melissa Kaplan-Pistiner, General Counsel; Anirudh Srirangam, Healthcare Policy Advisor; Dan RuBoss, Senior Tax and Economic Advisor and Member Outreach Director.

Republican staff: Krisann Pearce, General Counsel; Nic Pottebaum, Professional Staff Member; Ryan Flynn, Staff Assistant.

Witnesses:

Dr. Matthew Fiedler, Senior Fellow, The Brookings Institution

Dr. Leemore Dafny, Professor, Harvard Business School and Harvard Kennedy School

Dr. G. Alan Kurose, Chair, Rhode Island Foundation, and Former President, Coastal Medical

Mr. Theo Merkel, Director of Private Health Reform Initiative, Senior Research Fellow at the Paragon Health Institute, and Senior Fellow at the Manhattan Institute

Dr. Chapin White, Director of Health Analysis, Congressional Budget Office

## OPENING STATEMENT OF CHAIRMAN WHITEHOUSE [1]

Chairman WHITEHOUSE. I have the permission of the Ranking Member to proceed while he comes here from the Finance Committee. We will be having members in and out throughout the morning because this is a very busy day for hearings in Congress. In fact, I have three this morning. So, you'll see people come and go.

I do want to use this hearing to build a record for ways that we can save in the budget on health care costs. And so, today's hearing is about excess costs in health care, and ways we can reduce the budget by spending health care dollars more efficiently.

[1] Prepared statement of Chairman Whitehouse appears in the appendix on page 34.

As I point out often, and as this graph shows (insert footnote in editing), the United States (U.S.) continues to spend more on health care as a percentage of gross domestic product (GDP) than any other peer Organisation for Economic Cooperation and Development (OECD) country.

And at the same time, the vertical graph is life expectancy. And our national, the average life expectancy in this country is lower than that of most of our peer countries, parallel to Estonia.

We also spend more on health care per person, not just per GDP, over one and a half times more than the next closest country, Switzerland. We're spending $4 trillion a year. And the Centers for Medicare and Medicaid (CMS) actuary estimate that health spending will grow to 20 percent of GDP by 2031.

Not only is our life expectancy in America lower than you would expect compared to other OECD countries, for all the money we spend, but has actually declined over the last two years. An American's life expectancy is now the lowest it has been in two decades. We can do better than to be on par with Estonia, particularly when we're spending nearly double on health care as a percentage of GDP.

Put very simply, we get very little bang for 4 trillion bucks.

It is grim, but there are some signs of progress. And we'll hear today from experts about how we can do better. The Congressional Budget Office (CBO) has found that federal health care spending between 2010 and 2020 was more than a trillion dollars lower than CBO had projected prior to implementation of the Affordable Care Act (ACA).

And as this chart shows, CBO now projects the U.S. will spend $4.6 trillion less on the major federal health programs, mainly Medicare and Medicaid, over the next decade than was projected pre–ACA.

CBO also found growth slowed in spending per beneficiary. While there are many contributing factors, the deceleration shows that smart policymaking and reforms can help bend the cost curve. The Affordable Care Act fundamentally changed health care. And thanks to the payment modernization and care transformation it initiated, we're seeing reduced health spending. But our work isn't done.

Notwithstanding Medicare's new power to negotiate the price of some drugs, thanks to the Inflation Reduction Act, Medicare spending continues to grow faster than the rest of the federal budget. And our national health expenditures are rising rapidly still.

That's because our fragmented and endlessly complex health care system creates the perfect environment for inefficiencies to fester. It is where excess costs live and grow.

Today we will hear from experts about three areas of inefficiency that have increased health care costs for patients, families, and the Federal Government. And I would add, also, increased frustration.

First, we will hear about the dizzying web of administrative tasks, the billing, the reporting, and all the non-clinical work incidental to the actual delivery of care that providers face. We will hear how these burdens are responsible for over half a trillion dollars in health care spending every year, and annoyances like prior

approvals that I think for Accountable Care Organizations (ACOs) are not even necessary.

Our discussion on this is especially timely. Research released last week revealed possible savings between $40 and $60 billion a year just from fixing the mess of health care billing and claims.

Next, we'll hear about how consolidation in health care can raise prices for patients, leading to higher federal health spending. We'll also learn about potential solutions, like health cost databases that don't just bring much needed transparency into the opaque world of health prices, but also enable stakeholders to take actionable steps to control spending based on that data.

18 states, including Rhode Island, are already making use of tools like these known as All-Payer Claims Databases, to reduce patients' costs and improve care.

Then we'll hear from one of Rhode Island's leading health care experts, Dr. Al Kurose, about how our fragmented health system, with patients often navigating multiple providers at different sites instead of obtaining care from a primary care provider, results in worse care at higher cost.

We'll hear how delivery system reforms like Accountable Care Organizations can promote higher quality care with less money spent. Patients seeking care are often lost in the maze of our current fee-for-service system. Transitioning to value-based care, predicated on strong primary care, can help achieve the long-sought triple aim of better care, better health, and lower costs.

Within our current health care system there is no doubt that value-based care is the best solution. Value-based care rewards providers not based on how much care they deliver for patients but on how well they deliver it.

A decade on from the implementation of the ACA we have learned a great deal. We have learned that simplifying non-clinical work in health care, changing how we pay for health care, and transforming how we deliver health care can both lower costs and improve outcomes. If we do all of this more often and at scale, we can deliver the best and most accessible health care for America's patients.

With that, I will turn to my distinguished Ranking Member Chuck Grassley.

**OPENING STATEMENT OF SENATOR GRASSLEY**[2]

Senator GRASSLEY. Thank you for this very important hearing, Mr. Chairman, a very important subject of improving health care and lowering costs. And thanks to all of our witnesses for the time that you've put in, the extra time you put into educating Congress and preparing for this.

Health care might be one of the few markets in our economy where the consumer doesn't know the price before they buy it. And they rarely pay for it directly. Yet, Americans spend more than $4.3 trillion annually on health care. Our spending has more than tripled as a percentage of gross domestic product since 1960.

Growing health care costs don't just strain Americans' pocketbooks, they also are key drivers of widening budget deficits and the

[2] Prepared statement of Senator Grassley appears in the appendix on page 36.

Federal Government's unsustainable fiscal outlook. And it's not clear that we're getting our money's worth for all that spending.

Major health care programs' spending eats up 32 percent of federal revenue today, and it will be 45 percent of revenue by—mid-century. Our health care system has plenty of waste and inefficiencies that need fixing. Increasing transparency and competition, fighting fraud, and getting rid of red tape are some key areas to start with.

You should know what something costs before you buy it. That's common sense for any consumer. That transparency is what we need.

Until recently, we didn't apply sunshine to health care prices. I'm glad hospitals and health plans are now required to report their pricing data, but I'm not sure that it's in consumer-friendly ways in which it's put out, and may not be as effective as it was intended to be.

More transparency should also be applied to Pharmacy Benefit Managers, a very opaque middle people between pharmaceutical companies and the consumer. And I think this would lower patient and taxpayer prescription drug costs.

Another way to lower health care costs is to ensure taxpayer dollars are being used wisely. Last year alone our federal major health care programs lost over $130 billion to what we refer to around here as fraud, waste, and abuse.

I'm the author of a major and more recent update to the Federal Government's most powerful tool in fighting fraud, the False Claims Act. And since I got that adopted in 1986, we have seen the Federal Government recover more than $72 billion lost to fraud, and saved billions more by deterring would be fraudsters.

We should also be reducing unnecessary red tape and administrative burdens. Between 1975 and 2010, the number of physicians grew 150 percent while the number of health care administrators increased by 3,200 percent. This administrative growth is driven by regulations which take more compliance time and financial resources away from patient care.

We need policies, that promote the discovery of new cures and better treatments, not overly-administrative price controls that stifle innovation.

I worked for five years to allow the sale of over-the-counter hearing aids with Senator Warren of Massachusetts. Today, consumers can buy a pair of high quality and safe hearing aids at $3,000 less compared to a year ago.

I also support improving value in our health care system. But we need to accurately account for what's working and what's not working.

Recently, the Congressional Budget Office found that the Center for Medicare and Medicaid Innovation, a program created with a goal of lowering costs, did not lower Medicare costs. Let me emphasize, that's not Chuck Grassley saying that, the Congressional Budget Office has said that.

CBO says the program increased federal spending. I invited CBO to this hearing, and look forward to learning about their analysis today.

We should look to the market-based solutions similar to Medicare Part D, which I also led the team on Finance Committee to get adopted in 2003, because it lowers costs and improved care. In the first decade of Part D, the Congressional Budget Office found that this Part D program ended up costing taxpayers 36 percent less than projected.

Finally, we can't talk about waste and inefficiency in the health care system without discussing the country's fiscal situation. According to CBO, the federal budget deficit in the fiscal year that just ended clocked in at about $2 trillion. And future deficits are projected to be even higher, partly because of growing health care spending.

Health care spending can be made more efficient without compromising quality of care and reducing access, especially in rural America. I hope that we can build upon the ideas that we hear here today from this outstanding panel to address our country's fiscal challenges, while also improving health care for Americans.

Thank you.

Chairman WHITEHOUSE. Thank you very much, Senator Grassley.

Our witnesses today are, first, Dr. Matthew Fiedler, who is the Joseph A. Pechman Senior Fellow in Economics Studies at The Brookings Institution, where his research examines a range of topics in health care, economics, and policy.

Prior to joining Brookings, Dr. Fiedler served as Chief Economist on the staff of the Council of Economic Advisors, where he oversaw the council's work on health care, including implementation of the Affordable Care Act.

We'll then hear from Dr. Leemore Dafny. Dr. Dafny is the Bruce V. Rauner Professor of Business Administration at the Harvard Business School, and Professor of Public Policy at Harvard Kennedy School.

Professor Dafny's research focuses on competition and consolidation in health care markets. She previously served on the Panel of Health Advisors for the Congressional Budget Office, and was Deputy Director for Health Care and Antitrust in the Bureau of Economics at the Federal Trade Commission.

Then we'll hear from Dr. Al Kurose. Dr. Kurose worked as a practicing primary care physician in a community-based office for 20 years. In his second career as a health care executive and community leader he has continued his focus on innovative approaches to how care is delivered and paid for.

For 14 years, Dr. Kurose led Coastal Medical through its transition into an ACO and, indeed, a star performer in the Medicare Shared Savings Program. He'll be speaking to us today about lessons from that experience and the movement to accountable care that he and Coastal have been a part of.

Next will be Mr. Theo Merkel. He is the Director of the Private Health Reform Initiative and a Senior Research Fellow at the Paragon Institute, and Senior Fellow at the Manhattan Institute.

Previously, he served as Special Assistant to the President for Economic Policy at the National Economic Council in the White House, and served as legislative director here in the Senate for Senator Pat Toomey.

Our final witness today is CBO's own Dr. Chapin White, the Director of Health Analysis at the Congressional Budget Office. Dr. White first joined CBO in 2005 as a health economist, and went on to serve as a Senior Health Researcher at the Center for Studying Health System Change, as well as a Senior Policy Researcher at the RAND Corporation, before rejoining CBO in 2020.

My hope is that this hearing sets a foothold or a foundation for bipartisan discussions on ways that we can move legislation to reduce the costs of care and improve the quality of care in the health care system. And I hope we can focus on that, not only today, but in the months ahead as the Committee continues to rely on all of you for your expert advice.

Let me start with Dr. Fiedler. You all will have five minutes each. Your full statements will be made a matter of record.

**STATEMENT OF DR. MATTHEW FIEDLER, SENIOR FELLOW, THE BROOKINGS INSTITUTION[3]**

Dr. FIEDLER. Chairman Whitehouse, Ranking Member Grassley, and members of the Committee, thank you for having me here today. My name is Matthew Fiedler, and I am a health economist and a Senior Fellow at The Brookings Institution.

My testimony today examines ways that policy makers can reduce the administrative costs generated by interactions between health care providers and payers. These interactions, which include contract negotiations, claims transactions, prior authorization activities, and quality reporting, are costly. A reasonable estimate is that they generate administrative costs totaling around $0.5 trillion per year, equivalent to about 11 percent of annual health care spending.

Most of these costs are ultimately borne by consumers and taxpayers.

Importantly, administrative activities can be valuable. Billing processes compensate providers for delivering care. Prior authorization processes can help prevent delivery of inappropriate services. And audit processes can help uncover and deter fraud.

So, efforts to reduce administrative costs have to proceed thoughtfully.

In exploring reforms, it's worth considering both targeted policy changes and policy changes that would affect a broader swath of provider-payer interactions.

A good example of a targeted policy change 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' payments 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. And practices are expected—practices are estimated to spend thousands of dollars per physician, per year reporting the MIPS.

Yet, despite these large administrative costs, MIPS is likely not improving patient care. One problem is that clinicians can choose

[3] Prepared statement of Dr. Fiedler appears in the appendix on page 39.

the measures they are evaluated on, which makes it hard to meaningfully compare across clinicians. Plus, past studies of programs like MIPS have found little evidence that they improve performance. Since MIPS appears to be generating large administrative costs with few benefits, there is a strong case for eliminating MIPS and, ideally, replacing it with something more effective and less burdensome.

There are other targeted changes that could also reduce administrative costs with few tradeoffs, such as performing the processes to determine prices for out-of-network services under the No Surprises Act, and reforming the risk adjustment methods used in Medicare Advantage.

But my larger point here is that many seemingly narrow health care policy decisions affect administrative costs. And it is worth being attentive to those effects.

Turning to broader reforms, one salient feature of our health care system is that providers must deal with a menagerie of public and private payers, all of which set different rules. This may be a key reason that administrative costs are higher in the United States than in many other countries. And it suggests that standardizing billing, coverage, or quality reporting processes across payers could help reduce administrative costs.

Relative to the targeted reforms I just discussed, these approaches may offer greater savings potential, but may also present more significant risks and tradeoffs.

One target for standardization is the method that providers and payers use to exchange claims information. Some have proposed creating a central clearinghouse that would accept claims from providers in a standardized format and route them to payers, similar to approaches used in some other industries and some other countries' health care systems.

This approach would likely more fully standardize claims transactions than past federal efforts which have focused on establishing standards to govern bilateral provider-payer interactions. The key challenge would be ensuring that the clearinghouse was well run, as a poorly run clearinghouse could have few benefits or even do harm.

Policymakers could also consider trying to standardize the substance of some payer rules around billing, coverage, or quality reporting. This approach may have particularly great potential to reduce administrative costs. But, at least in some cases standardized processes might be less effective, whether because they lack tailored specific payer circumstances or are just poorly crafted.

For example, a standardized prior authorization process might be less effective in deterring inappropriate utilization, which could partially or even fully offset any administrative savings. Thus, the attractiveness of this type of standardization is likely to be highly case-specific.

Quality reporting may be one domain where the balance of costs and benefits favors aggressive standardization, such as by requiring all payers to rely on a standard set of quality measures reported through a central clearinghouse. This approach might not only reduce administrative costs, but also make the resulting data

more useful by increasing sample sizes, and facilitating comparisons across payers.

It is also questionable whether payers currently produce substantial value by tailoring quality measures to their specific circumstances, which may reduce the potential downsides of standardization.

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

Chairman WHITEHOUSE. Dr. Dafny.

**STATEMENT OF DR. LEEMORE DAFNY, PROFESSOR, HARVARD BUSINESS SCHOOL AND HARVARD KENNEDY SCHOOL[4]**

Dr. DAFNY. Chairman Whitehouse, Ranking Member Grassley, and distinguished members of the Committee, thank you for the opportunity to testify to you today.

My name is Leemore Dafny. I'm an academic health economist with longstanding research interests in competition and consolidation in the health care sector. Currently, I am a professor at the Harvard Business School and at the Harvard Kennedy School. Previously, I was a Deputy Director for Health Care and Antitrust in the Bureau of Economics at the Federal Trade Commission and a member of the Panel Health Advisors to the Congressional Budget Office.

The U.S. spends a larger share of its GDP, over 18 percent, on health care than any other country. Studies show that high prices, not the type or quantity of services consumed, nor the health of our population, are the primary driver of higher U.S. spending. International comparisons also show the U.S. lags other leading developed countries on most dimensions of health care quality.

My focus today is on health care providers, such as hospitals and physicians, who jointly account for half of our health care spending.

As you are aware, government programs like Medicare set prices for provider services, like hospital admissions. But the private sector relies on market-based prices, and those prices are high and growing. In the 90s, private prices were about 10 percent higher than Medicare prices. By 2012, they were 75 percent higher. And today, private insurers pay more than twice what Medicare pays on average for hospital care.

While public insurance programs don't pay these commercial prices, there are significant federal budgetary implications of high commercial prices. High commercial prices mean high employer-sponsored premiums, raising the cost of the tax exclusion for employer-sponsored coverage.

High commercial prices also impact the premiums and, therefore, the federal subsidies for enrollees purchasing subsidized plans through the health insurance marketplaces.

Consolidation is a key driver of rising prices in the health care industry. Scores of studies find that mergers and acquisitions result in higher commercial prices, with little, if any, evidence of improvement in quality. In addition, Medicare's payment policy has driven some of that consolidation, in particular, acquisition of physician practices by hospitals.

[4] Prepared statement of Dr. Dafny appears in the appendix on page 53.

Providers assert that high commercial rates are needed to cover the costs of Government-insured patients for whom care is reimbursed at lower rates, below their actual cost. This dynamic ignores the fact that costs are themselves affected by reimbursement. Economic research finds that hospital expenses fall when prices fall. And health care at the current pace of cost and price growth is untenable.

I have three recommendations to offer today:

First, establish a national All-Payer Claims Database, or APCD, which contains insurance claims from public and private insurers. Currently, researchers and regulators can't track what's happening in order to understand where and why we are paying more. The industry is running circles around us, mining the data to their benefit and exploiting loopholes. And it's too important and expensive for us to be this far behind.

The APCD could also be used by states, if they wish, to regulate commercial health care prices. Setting price ceilings or restrictions on price growth would not only address a symptom of consolidation, it would also prevent additional consolidation aimed at amassing market power to raise prices.

Second, invest in vigorous antitrust enforcement through increased funding for the Federal Trade Commission and the Antitrust Division of the Department of Justice.

While GDP increased in real terms by 55 percent between the year 2000 and 2022, the budget allocation to the Antitrust Division increased just 2.6 percent. If we are going to rely on private markets to deliver health care, and on commercial insurers to administer the majority of it, we need regulators to help protect and promote competition in these markets.

Third, align Medicare's payment rates across ambulatory settings. Stop paying more for the same health care services, like routine office visits and lab work, when they are delivered in hospital-owned practices or facilities. This preference not only increases Medicare and non-Medicare spending today, it fuels higher spending tomorrow because it drives more integration of hospitals with physicians and bolsters the market power of health care systems.

Adopting any and, ideally, all of these recommendations would mitigate the root causes of our nation's high provider prices, prices that lead to higher employer-sponsored insurance premiums, lower tax revenue, higher subsidies for plans purchased through the health insurance marketplaces, and higher Medicare spending.

I urge you to evaluate the recommendations closely, as your decisions can help us to achieve higher-value health care with a price tag the nation can afford.

Thank you.

Chairman WHITEHOUSE. Thank you.

I'll turn now to Dr. Kurose.

And I will note that in addition to his full testimony being made part of the record in these proceedings, we're also going to accept into the record a letter from the National Association of ACOs, and several ACOs, including Rhode Island's own Coastal and Integra,

encouraging Congress to extend Alternative Payment Model (APM) bonuses for physicians.[5]

So, that will be made a part of the record, without objection.

Dr. Kurose, please go ahead.

**STATEMENT OF DR. G. ALAN KUROSE, CHAIR, RHODE ISLAND FOUNDATION, AND FORMER PRESIDENT, COASTAL MEDICAL[6]**

Dr. KUROSE. Chairman Whitehouse, Ranking Member Grassley, and other members of the Committee, thank you for having me here today to discuss the topic of managing the care of patients and the health of populations to reduce the total costs of health care.

My name is Dr. Al Kurose. For the first 20 years of my career I saw patients every day as a practicing primary care internist.

For the last 15 years I've worked as a health care executive and community leader on care transformation and payment reform. My North Star has been pursuit of the Triple Aim of better care and better health at a lower cost. From 2008 until last year I served as the President of Coastal Medical, a large primary care practice in Rhode Island that transformed itself into a physician-led ACO that has been one of the top performers in the Medicare Shared Savings Program.

I have three main points I'd like to make today.

Number one, I believe that as an industry we can transform how health care is delivered and paid for in ways that will reduce costs and make things better for patients. In many cases I'll argue that we already know what to do.

Number two, primary care is the foundation of any high-performing health care system. And right now primary care is in crisis, and urgent help is needed.

Number three, advanced primary care by itself is, in my view, necessary but not sufficient to sustainably achieve the Triple Aim. Continued movement away from fee-for-service and toward value-based and prospective payment models is needed, particularly for specialists and hospitals where more skin in the game is needed when it comes to value-based payment.

The 2021 National Academy of Sciences, Engineering, and Medicine Report on Primary Care concluded that ACOs achieved modest cost savings, as well as improvements in quality and patient satisfaction. Smaller physician-led ACOs with a greater percentage of primary care physicians were the best performers. And Coastal Medical was one of them.

On the poster to your left the green line represents the average total cost of care for Coastal's Medicare beneficiaries from 2009 through 2019. You can see that upon entry into the Medicare Shared Savings Program in 2012, Coastal not only bent its curve for total cost of care, it broke it.

An important question to ask, then, is whether learnings from the success of smaller physician-led ACOs like Coastal are generalizable to larger systems of care. I will argue that many of them are. Coastal's Diabetes Management Program is a good example.

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[5] Document submitted by Chairman Whitehouse appars in the appendix on page 109.

[6] Prepared statement of Dr. Kurose appears in the appendix on page on page 70.

In that program, select patients are equipped with glucose meters that use cellular networks to automatically transmit blood sugar results in real-time to a multi-disciplinary care team that then engages with the patient if, and only if, intervention is required for a high or low blood sugar.

In the old model of care 10 or 15 years ago, a patient with a high sugar might have just written it down in their logbook and planned to discuss it at their next visit with their doctor in a couple of months. Now their phone is going to ring. And that proactive outreach by the care team to address the high sugar when it's happening may well prevent an emergency room visit or hospitalization that might otherwise occur a day or two later.

Clinical programs like this go well beyond what I first imagined when we started the ACO work back in 2012. Generally, such programs have been the result of cycles of iterative learning, which have been a characteristic feature of many of the most successful ACOs. It is these types of lessons about delivering the right care, in the right place, at the right time that I'm referring to when I assert that in many cases we already know what to do.

As I mentioned, primary care is in crisis. We have a perfect storm of an aging physician workforce, a shrinking pipeline of new primary care physicians (PCPs), widespread physician burnout, and a large cohort of baby boomers aging into Medicare. Workforce initiatives such as those coming out of the Health, Education, Labor, and Pensions (HELP) Committee and improved compensation of primary care physicians are important next steps.

I believe we also need to continue experimenting with expanding the primary care team, and to pay more attention to understanding and mitigating physician burnout.

Finally, primary care capitation as a payment model may help to take primary care teams off the hamster wheel of back-to-back visits, all day, every day.

In closing, I will reiterate my initial plea for more value-based payment for specialty and hospital care. Primary care cannot go it alone in this domain and sustainably succeed. That said, I remain cautiously optimistic because I believe that in many cases we already know what to do.

Thank you.

Chairman WHITEHOUSE. Thank you, Dr. Kurose.

Mr. Merkel.

## STATEMENT OF THEO MERKEL, DIRECTOR OF PRIVATE HEALTH REFORM INITIATIVE, SENIOR RESEARCH FELLOW AT THE PARAGON HEALTH INSTITUTE, AND SENIOR FELLOW AT THE MANHATTAN INSTITUTE [7]

Mr. MERKEL. Thank you, Chairman Whitehouse and Ranking Member Grassley, for convening this hearing and giving me the opportunity to testify.

The Federal Government spends more money in health care than any other area, exceeding $2 trillion in 2022. For context, this is now over twice as much as is spent on defense.

[7] Prepared statement of Mr. Merkel appears in the appendix on page 79.

The pace of growth is unsustainable. The CBO projects health care to absorb a larger and larger portion of GDP for the foreseeable future. Perhaps most problematic, we do not get a good return for our money.

For instance, Washington actually spent more on improper payments for health care, $150 billion last year, than proper payments for the Supplemental Nutrition Assistance Program, housing assistance, or transportation infrastructure.

A widely-cited study by the National Academy of Medicine estimated that 30 percent of all U.S. health spending does not actually improve health. Last year the OECD compared health spending in developed nations, and confirmed that the U.S. spends more on just about everything, but the key contributors to our outsized health spending are payments for hospital and physician services. Ironically, given last Congress' action on drug prices, we actually spend proportionally less on retail pharmaceuticals than every G7 country but the United Kingdom.

Well-intentioned but ultimately counterproductive Government policies increase prices and health spending by both inflating demand and decreasing supply haphazardly.

First, far from being parsimonious with our federal health care programs, we are one of the only nations that subsidizes health care largely without limit.

If Medicare is billed for a covered item or service, it will pay it.

If a state makes a Medicaid expenditure, Washington will match it.

If insurers selling Affordable Care Act plans raise premiums, the federal taxpayer covers the increase.

No matter how generous a health plan an employer chooses, it receives a tax break. Ultimately, we generously subsidize care that Americans need, but we also subsidize a lot of inefficient care and waste.

Second, federal and state policies limit supply by restricting who can provide health care items and services, and where they can provide them. This insulates providers and suppliers from competition, allowing them to command higher prices and remain inefficient. It also severely limits innovation, as it gives incumbent providers bureaucratic and political tools to prevent the type of disruption that we have seen in other sectors of the economy.

With only a few exceptions over the past several decades, Congress has either exacerbated these two fundamental issues or just tried to work around them with top-down approaches that rely on government technocrats to try to manipulate the system into efficiency. We are here today because those efforts have largely failed.

Given its size and importance, Medicare is often the epicenter of the policy debate. Since 1983 the reform of choice has been price controls, starting with hospitals, moving to physicians, and recently moving to prescription drugs. But price controls largely just attempt to approximate the cost of providing a service or producing an item. They avoid whether that service or item should be provided, and the value that it may offer relative to alternatives.

Simultaneously, despite the best efforts of the Center for Medicare and Medicaid Services, price controls are inevitably inaccurate

and hugely distort how care is delivered and where investment flows.

The Affordable Care Act put faith in a similarly top-down approach that an entirely new agency of well-intentioned bureaucrats, insulated from congressional meddling, would be able to engineer better payment methods. Yet, the CBO recently found that after a decade of work, the Center for Medicare and Medicaid Innovation managed to add to the deficit.

Fortunately, there are many ways to reduce wasteful spending while not reducing benefits on enrollees. I have a list of proposals in my written testimony. But to highlight a few principles:

One, shift financial risk away from taxpayers. This does not mean we need to shift risk to beneficiaries. It could be ACOs, other providers, insurers, states, or others. But our major health care programs should no longer simply write blank checks.

Two, get the government out of the business of dictating who should be paid, how much, and where. Site-neutral payment reforms being discussed in Congress would be a good incremental step.

Three, favor bottom-up solutions like enabling patients and employers through more coverage options and price transparency, instead of the top-down approaches that have repeatedly failed over time.

Thank you again for inviting me to testify. And I look forward to your questions.

Chairman WHITEHOUSE. And, finally, Dr. White.

## STATEMENT OF DR. CHAPIN WHITE, DIRECTOR OF HEALTH ANALYSIS, CONGRESSIONAL BUDGET OFFICE[8]

Dr. WHITE. Chairman Whitehouse, Ranking Member Grassley, and members of the Committee, I appreciate the opportunity to appear before you today.

In consultation with Budget Committee staff I've focused this testimony on Accountable Care Organizations, Capability Maturity Model Integration (CMMI), and the unexpected slowdown in federal health care spending.

Because ACOs voluntarily assume responsibility for the quality and costs of care for a defined group of patients, they have the potential to reduce unnecessary care, improve care coordination and patients' health, and reduce spending. Health care providers participating in ACOs, or other value-based payment arrangements, receive financial incentives to improve the efficiency and quality of care. Such incentives contrast with those found in Medicare's traditional fee-for-service program in which separate payments are generally made for each encounter or service delivered.

Fee-for-service, as many observers have pointed out, tends to create incentives for providers to deliver additional and more-complex services.

CMMI's goal is to identify approaches that reduce spending or improve the quality of care. And to do so, it operates models that test new ways to deliver and pay for health care, including models that establish value-based payment arrangements.

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[8] Prepared statement of Dr. White appears in the appendix on page 91.

The ACA established a permanent ACO program in Medicare known as the Medicare Shared Savings Program (MSSP). CBO has reviewed the evidence on the performance of the MSSP, and found that the program was associated with small budgetary savings in the early years of its operation. The more recent evidence is somewhat limited and challenging to interpret. It's become more difficult to find reasonable control groups to use. And providers have the ability to opt in and out of the ACO program.

What were CMMI's budgetary effects over its first decade of operation? As other folks have previewed, CBO has updated its estimate of the budgetary effects of CMMI, and currently estimates that CMMI's activities increased direct federal spending by $5.4 billion, or 0.1 percent of net spending on Medicare between 2011 and 2020. Specifically, CMMI spent $7.9 billion to operate models, and those models reduced spending on health care benefits by $2.6 billion.

That estimate reflects CBO's review of public evaluations of 49 models initiated in CMMI's first decade.

In terms of CBO's projections of CMMI's effects over the current baseline projection period from 2024 to 2033, CBO projects that CMMI will increase net federal spending by less than $50 million, which is a star in CBO's tables.

Over that period, the estimated effect of CMMI's activities transition from an annual net increase to an annual net decrease, reflecting ongoing growth in the number of certified models that continue to produce savings over time.

Legislative proposals that would affect CMMI could fall into one of three categories: modifications to specific models, changes to the parameters within which CMMI operates, and a repeal of CMMI's statutory authority, or rescissions of unobligated funding.

In general, CBO would analyze the evidence on specific models if the legislation related to a specific model, or when data are not available, or if the legislation is more general than that, CBO would rely on a general framework using information on CMMI's prior activities and performance. And, as always, the estimated effects would depend on the details of the legislation.

So, have alternative payment models contributed to the slowdown in health care spending?

The implementation of MSSP and the creation of CMMI have occurred during a period of unexpectedly slow growth in federal health care spending. Whether that slow growth is related to CMMI or other alternative payment models created under the ACA is not entirely understood. But, CBO's review of the effects of the MSSP and its estimate of the effects of CMMI in its first decade of operation suggests that they together were not factors in the broader slowdown.

Still, some researchers have posited that the existence of CMMI may have led to broader system-wide changes that are not attributable to a specific model.

Over the past decade, CBO has been tracking the slowdown of federal health care spending and has previously pointed to several contributing factors. Broader factors include decreases in the growth of Medicare's payment rates, reduced spending on patients

with cardiovascular disease, and a shift in the relative importance of technology in fueling the growth of health care spending.

Federal spending on Medicare and Medicaid programs also grew more slowly than CBO projected. A key factor underlying Medicare's slower-than-expected growth was slower growth in net spending on prescription drugs. For Medicaid, a key factor was less-than-anticipated spending for long-term services and supports.

Those are my prepared remarks.

Chairman WHITEHOUSE. Thank you very much, Dr. White.

Let me start with Dr. Kurose.

You and I lived through, me much less so than you, all the difficulties of transitioning Coastal Medical to an ACO and to a very successful ACO. But if you look through all those difficulties to the experience of your patients at the end of the day, how do you evaluate Coastal Medical's patient experience as a result of the successful transition?

Dr. KUROSE. You know, as somebody who practiced primary care for 20 years and ended that part of my career just as the ACO movement was really getting up and running, the things that I've seen happen at Coastal for patients really go way beyond what I could have imagined.

There is a whole variety of centralized clinical programs that improve access to care, timeliness of care. There are disease management programs for specific chronic conditions. There is—there are primary care urgent clinics nights, weekends, holidays. There is a whole multi-disciplinary team available to many of our patients, with members of the team including clinical pharmacists, social workers, navigators, co-located behavioral health providers.

And so I look at the movement to accountable care as really being the impetus to allow that great expansion of services to really deliver a level of care that we just couldn't do when I was in practice.

Chairman WHITEHOUSE. So, in order to save the millions for Medicare that Coastal has saved, you were not obliged to cut benefits to your patients; indeed, they saw new and improved services?

Dr. KUROSE. Yeah, I think that's an accurate statement. And we have sort of a truism that we repeated often at Coastal, which is that you have to spend more to save more. So, you have to invest in the human and technology infrastructure to really be able to execute population health management if you want to be able to deliver the kinds of services that we're talking about.

But it was the alternative payment models inherent in the ACO model that allowed us to generate that additional revenue, which we then reinvested to fund all that clinical programming, which ultimately improved efficiency, improved care, reduced total cost of care.

Chairman WHITEHOUSE. The bureaucratic system did not always entirely support that transition. One of the things that I think makes sense in a fee-for-service system is prior authorization, just to keep billings from going through the roof. But once there is, as you say, skin in the game, the rationale for prior approvals in a value-based system appears to diminish, if not entirely evaporate.

Were you obliged nevertheless to continue to see prior approvals, and if not, why not? Was that a success?

Dr. KUROSE. We certainly did, and Coastal still does, see requirements of that type. The sort of interim solution at Coastal was to create teams of people who could assist providers in that process so as to reduce the administrative burden and the time commitment to that particular aspect of the work.

But I agree completely with the underlying thesis that, when you incent provider organizations to be accountable for total cost of care, once you have that construct in place, then you may not need to have all these administrative processes.

One thing that I'll add is that it's important, as we try to build out and execute on these constructs, that we remember that the payment model that an organization sees has to be translated into an aligned compensation model for physicians if you really want to lock in that mindset that we're counting on to sort of control avoidable spending and improve efficiency.

So, knowing that there is alignment between organizational payment models and physician compensation, I think, is important if we expect to see the kind of outcomes you're alluding to.

Chairman WHITEHOUSE. Last point.

If I'm building a house or doing a major renovation, I hire a general contractor to manage the project for me. And I expect that general contractor to intermediate with electricians, drywall folks, carpenters, all the specialists who do the work of bringing the project to a successful conclusion.

Is that the way primary care presently works? And would it be useful to try to put primary care providers into more of a general contractor model so that they can intermediate between the patient and the specialists and coordinate care more effectively to the benefit of the patient?

Dr. KUROSE. So, that's an interesting analogy. And I think that there is a key role for primary care physicians to coordinate care when a patient has multiple complex conditions and requires the care of multiple specialists. I'm not sure all my specialty colleagues would like the general contractor analogy so much, but I think we could at least agree that what we need is regular communication.

And I think the other thing that primary care docs are uniquely positioned to do is to have a deeper understanding of what the patient's own priorities and goals of care are. And in that context, you know, the primary care doctor can really help to shepherd the care of a patient through what you alluded to earlier, I think correctly, as a very much fragmented system, that is also highly complex.

For those of us who work in health care, even when we have to help a family member try to navigate systems, even inside baseball players find it challenging at times. And so, I think that that's a really, really important aspect of the role of primary care that we need to preserve and expand.

Chairman WHITEHOUSE. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman, and thank you all for your testimony.

Common sense supports all of us wanting to get more value out of our health care system. I was proud to lead the effort to implement Part D, nationwide prescription drug benefit for seniors, a long time ago. We used a market-based approach. Competition access and affordability has been a key hallmark of Part D programs.

And I think it—compared to what figures were given by CBO at that time, it turns out to be a good steward of the taxpayers' dollars, in the first decade costing 50 percent less than CBO projected.

So, Dr. Merkel, what can we learn from Medicare Part D to apply to other federal health care programs?

Mr. MERKEL. Thank you for the question, Ranking Member Grassley.

One of my key takeaways from Part D is there is often, especially with entitlements, perceived unnecessarily to be this tension between providing benefits and getting value for both beneficiaries and taxpayers. I think Part D has been able to show that this tension does not need to exist.

How did it do that? It mandated benefits, but it also required that financial risk be shared between taxpayers through Medicare, but also other entities which are Part D plans. And very importantly for accountability, the accountability of Part D plans is not just to the Government or bureaucrats, but it's also to beneficiaries through choice. They can choose plans or switch plans if they're unsatisfied with the coverage options, and plans compete for beneficiaries.

The result has been seeking high value care. There has been high utilization of generic drugs. You know, the United States has higher utilization of generic drugs than many of our international competitors. That's in part because of the way that Part D works.

It's come in under budget, as you've noted, not just in the first decade but, as Dr. White noted, it's come in under budget again this most recent decade. And there's high beneficiary satisfaction.

Senator GRASSLEY. Yes. Dr. White, let me lead in with this, the Center for Medicare and Medicaid Innovation receives $10 billion of mandatory funding every decade. Despite this investment, CBO has found that CMMI has not lowered Medicare spending.

Separately, CBO has found that Medicare's Shared Savings Program was not a factor in slower growth of federal health care spending.

Are these models that I just referred to validated by independent third parties to determine if they save money?

And in addition to that question, if there are independent analyses, what do they say?

Dr. WHITE. Thank you, Ranking Member Grassley, for the question.

First, I want to clarify. On CMMI the CBO's conclusion was that it added to federal spending. Other researchers have come to the same conclusion, including Brad Smith, who is a former CMMI administrator, and Health Management Associates did a study. Avalere did a study. So, CBO's conclusion on CMMI is generally in line with the consensus.

On MSSP, CBO's conclusion was that it appears to produce net savings. And the evidence is fairly clear from the early years of the program. The evidence is a little harder to interpret in more recent years. But that conclusion, that the Medicare Shared Savings Program has produced small net budgetary savings, is consistent with and partly based on what outside researchers have said.

So, I think when I said that CMMI and MSSP were not a factor in the slowdown, it's more to say that CMMI, over the 2011 to 2020

period, added a bit to federal health spending. MSSP had net savings. Together, they were not a factor in the fairly large slowdown during the 2011 to 2020 period.

Senator GRASSLEY. Thank you, Mr. Chairman.

Chairman WHITEHOUSE. Senator Van Hollen.

**STATEMENT OF SENATOR VAN HOLLEN**

Senator VAN HOLLEN. Thank you, Mr. Chairman, and thank all of you for being here.

Dr. Dafny, I'm going to start by asking you a question related to the collection of data.

For many years, my state of Maryland has run an innovative payment model that started with regulating hospital pricing in the 1970s and now includes all-payer global budgets for hospitals in the state, with incentives to reduce total cost of care and improve efficiency and quality of care. So far, the model has been meeting the Medicare savings goals and improving care.

As part of this work, and it's ongoing work on pricing, rate setting, and global budgeting, Maryland's All-Payer Claim Database has strong hospital-based data. However, as you noted in your testimony, many states struggle to obtain data on Employee Retirement Income Security Act of 1974 (ERISA) plans because these plans are regulated by federal statute and the Supreme Court barred states from requiring self-insured plans to submit data to address state databases, making obtaining plan data more challenging.

How does greater access to claims data help regulators and policymakers address costs and health equity issues?

And will the U.S. Department of Health and Human Services (HHS) pricing transparency rules for insurers help fill the gaps in price information that many states experience, or are additional steps necessary to make sure that they have the information that meets their needs?

Dr. DAFNY. Thank you, Senator Van Hollen, for the question. And, also, thank you to the state of Maryland for running some very impactful experiments for us researchers to study and to act as a laboratory for other states.

You asked me how does it help for us to have access to a national All-Payer Claims Database? It helps enormously because we cannot study the effects of mergers and acquisitions without health insurance claims.

Right now, we rely on the largesse and interests of commercial insurance companies. That interest has been waning, and in order for us to assess the implications of a range of phenomena, including private equity consolidation, including the expanded geographic footprint of hospital systems, we desperately need access to these data.

You mentioned the critical reason for the Federal Government to act, and that is because of that 2016 Supreme Court decision that ruled that states cannot compel self-insured plans, which are regulated under ERISA, to supply their claims data. So, we really need your help to enable an All-Payer Claims Database.

And finally, you asked whether current efforts on price transparency are enough. And my answer to that is simply no, the transparency that is out there now. And that's for two reasons.

One is that what is transparent now, to the degree that it is transparent, as Senator Grassley mentioned, there are a lot of issues with how it's being reported, is just price. And in order to understand our nation's spending we need quantity, too.

So, we have the prices for every possible—or could theoretically have the prices for every possible combination of service, insurance plan, and provider, but we don't know how many of those triplets are actually being delivered. And without any access to information about the quantity, we're swimming in the dark.

And a second reason is that that data has been extremely difficult for researchers to assemble because it is spread out in a range of places and not uniformly reported.

Senator VAN HOLLEN. I appreciate that answer and look forward to working with you and others to try to address this issue.

Dr. Fiedler, a question for you about hepatitis C, but especially prescription models. And hepatitis C is a growing disease with a rate of reported acute cases increasing 400 percent between 2010 and 2020. There are approximately 2.5 to 3 million people living with the disease. It also has lots of side effects that lead to other complications.

But it is now curable with oral direct acting antivirals. However, even with the competition and generic drugs in the market, the cures can be incredibly expensive: $24,000 or more for a course of treatment.

Louisiana, with the support of CMS during the previous Administration, implemented an innovative subscription model wherein they negotiated a bulk price in order to get unlimited doses of medication for Medicaid and incarcerated patients. And they also set up a screening and prevention program.

My question to you is do you agree that that subscription model can work generally for diseases like this? And specifically, how can we at the federal level learn from that with respect to hepatitis C?

Dr. FIEDLER. Thanks for the question.

I think it generally can make a lot of sense for a payer to offer a manufacturer a somewhat larger total payment in exchange for a much lower per dose price that facilitates broader access. And I think a subscription model, as we've seen in Louisiana, can be a very good way of achieving that.

I also think that there is a particular logic to the sort of federally-run subscription model that's currently being discussed in the hepatitis C context, given where some of the access barriers we've seen here have come from.

There's something of a collective action problem among payers, where society as a whole would be better off if there was broad access to these drugs and we avoided the downstream complications and the infections that come from active infections. But since people bounce from payer to payer over time, no particular payer is really that motivated to be the one who makes the upfront investment in identifying cases and treating them.

I think it's also relevant that Medicaid is an important payer here, and historically, it's been a fairly stingy payer across a vari-

ety of domains. We have seen that specifically in the domain of the sort of coverage policies states have adopted with respect to hepatitis C.

Against that backdrop, I think having the Federal Government, you know, adopt the subscription model with respect to hepatitis C, and then make the drugs available at very low cost to Medicaid or other potential payers, has a strong rationale.

Senator VAN HOLLEN. Thank you. I appreciate that. We may draw upon your expertise. We're in the process of putting together legislation on that initiative.

Thank you, Mr. Chairman.

Chairman WHITEHOUSE. Thanks, Senator Van Hollen.

Senator Braun.

**STATEMENT OF SENATOR BRAUN**

Senator BRAUN. Thank you, Mr. Chairman.

The amount of time I've spent on this issue before I got to the U.S. Senate is a lot. I ran a business that, exactly what we're talking about, became the biggest issue once it was of a scale where it made a difference. And that started occurring back in 2008.

I was finally sick and tired of hearing how lucky I was that my premiums are only going up 5 to 10 percent a year. That's the way you measure it in the real world, in a system that's built upon remediation with a very inelastic demand once you get sick or have a bad accident—with zero, nearly zero consumer involvement.

It's easy to understand why we are where we are.

As pointed out, and I think very well, in both opening statements, we're at that place where it's a tapeworm on the economy. The providers are the same, whether it's a government payer or a private system payer. So, unless we fix the underlying system, don't expect much to change regardless of what we do here. Because you can't—when it's that big a part of your economy, it's not free market. It's like an unregulated utility, if you want to really see what we've got as a health care system.

Until we get our consumers engaged on primary health care with their own skin in the game, the ones that can afford it, you're probably going to have to have a system for those that can't. Because I think in this country everybody ought to deserve good health and well-being, but we've got a monstrous system that we've evolved into.

I'm going to hope we have, with the number of people here, a second round for questions. Do you think that looks possible, Mr. Chair?

Chairman WHITEHOUSE. It depends, but possible.

Senator BRAUN. Okay. So, I'm going to start here.

The largest sector of our health care economy is now hospitals, large corporate hospitals. Back as recently as 10 years ago that was maybe ⅓. Practitioners, doctors, and nurses were about ⅓, and the balance being split between insurance companies and pharma. Now, hospitals are just under 50 percent.

The number of doctors I have spoken to that regret that they've gotten into the business because they wanted their own enterprise, they never imagined working for a big company because they had to due to the arithmetic of their business.

I'm simply asking for one thing. That is transparency throughout the system, like we have in all other markets. Get rid of the barriers to entry that we've created here in government helping hospitals, keep doctors from owning their own hospitals and things like that. But I think that's where we need to focus.

Secondarily are the insurance companies, because they work together in an opaque system.

So, I've had a couple amendments, one recently with direct CMS, to publish a list of hospitals not in compliance with the price transparency rule that went through the court system to even get out there. That was done during the Trump administration. The other requires hospitals and insurers to share specific prices they negotiate across plans.

Mr. Merkel, I've got a question for you.

What other reforms should Congress consider when trying to take the biggest part of health care that is more and more corporate, embraces none of the aspects of free enterprise? Do you like those ideas, number one?

And what else can we do that would start the clock, at least where most of our health care dollars are being spent currently?

Mr. MERKEL. Thank you very much for your question.

I think that you have hit the nail on the head with your diagnosis of the problem. We're limiting supply at the same time that we're increasing demand through federal programs. And we are not enabling consumers and employers because we've just put them in the dark.

I would absolutely start with what you have said: giving consumers and employers price information to—basically, we have left these powerful tools on the table, which are consumers and employers seeking the best value for themselves. And as you have noted, unfortunately, what we did in the Trump administration, the compliance has been inadequate.

So, the legislation that you have put forth to codify those rules and, I think, increasing enforcement mechanisms to require them, as well as being clear who is being transparent and who is not, would go a long way.

Senator BRAUN. One brief follow-up question, and I'd like this to be answered by Dr. Fiedler.

Obamacare gave us, I think, some things that address the fact that everybody should have access. It should be at a price that you can afford.

What about some of the things that have been dysfunctional? Like, I think what came from that, too, was that doctors cannot own outpatient hospitals, nor can they grow ones that were in place.

Is that something that ought to be changed? Why was that ever done in the first place?

Dr. FIEDLER. I do think that there were previsions placing, limitations on physician-owned hospitals. I am generally of the view that, I think consistent with the question you're asking, that there's not a strong rationale for limits on the entry of new hospitals into hospital markets and, in particular, limits on who can own those hospitals.

I frankly think that this is probably not the main contributor to why hospital markets are as consolidated as they are. I think it's probably a fairly marginal factor. I think the underlying rationale for the provisions was that physician-owned hospitals may do a certain amount of cherry picking in terms of the patients they treat. And so, other hospitals were concerned that they would be left holding the bag.

I don't view that as a particular concern, and I think there's unlikely to be much harm done by removing some of these restrictions.

Senator BRAUN. Thank you.

Chairman WHITEHOUSE. Senator Marshall.

**STATEMENT OF SENATOR MARSHALL**

Senator MARSHALL. All right. Mr. Chairman, thank you so much for hosting this hearing. My first question is for Professor Fiddler—Fiedler, probably. My bad. Fiedler, right? Okay.

Prior authorization is the number one administrative concern to physicians. It adds to their burden of their day, having a patient scheduled for a hip replacement, have them in the preoperative area, and then finding out that the insurance company has not done the final prior authorization for that particular process. I hope—I assume you are familiar with prior authorization and how it's being used to ration care.

What is the prior authorization impact, do you think, on health care expenses? Does it actually slow down? Does it make it worse?

Any thoughts on prior authorization?

Dr. FIEDLER. I think prior authorization is very much a two-edged sword. On the one hand, I think exactly what you're talking about can create a lot of administrative hassles for providers but, frankly, for patients as well. If you're the patient in that situation where the prior authorization hasn't come through, that's a very real burden.

I think the flipside of this is there are cases where prior authorization is used appropriately. We have evidence that it meaningfully reduces use of inappropriate services and therefore reduces claims spending, and premiums, and cost sharing for people.

Senator MARSHALL. Appreciate that.

I think you'd agree with me that if there was a streamlined, consistent process, that that would be very beneficial to both sides of that coin?

Dr. FIEDLER. I think there likely are opportunities to streamline these processes and that's a fruitful place to explore.

Senator MARSHALL. Okay. I'm going to go to Mr. Merkel next, and kind of following up with Senator Braun's questions regarding the physician-owned hospitals.

I may be the only person in the Senate or Congress that's ran a hospital, owned a hospital, a private practice, oversaw health departments. I understand health care, you know, pretty good.

I always thought to drive down the cost of health care, we needed more transparency, more innovation, and consumerism—making patients consumers again, promoting competition. Whether it's insurance companies or whether it's hospitals, Pharmacy Benefit Managers (PBMs), we've seen this huge consolidation of the indus-

try, partially because of over regulations. And basically, there is a moratorium on physicians to expand their hospitals or to have any new ones as well.

I would brag on the physician-owned hospital. They have better care, much better quality of care. They actually give away more care than most non-profits do, is a sense as well. In our particular case, we were the only hospital within 60 miles with a, you know, Level 2 emergency room. We took all comers.

So, Mr. Merkel, what is your experience of physician-owned hospitals and do you think that they would help drive the costs down or up, at the end of the day?

Mr. MERKEL. Thank you for your question, Doctor.

I think that, you know, with fee-for-service reimbursement and our entitlement programs being basically unlimited in how much taxpayer money that they will provide, you know, Congress, over the years, has tied themselves into a lot of knots on how to try to protect taxpayers while in that system. And industry incumbents take advantage of those concerns and will utilize those fears to try to block competition from things like physician-owned hospitals or through Certificate of Need laws.

I think both of those restrictions come from the same concern and demonstrate how industry incumbents basically use them to prevent competition.

Senator MARSHALL. Great.

I want to finish up with a question. Not much time left. We'll see if we can get through as many people as we can. We'll start with you, Dr. Dafny.

I'm certainly a believer that our country needs a bigger investment in primary care. Everybody—if you have a heart attack, if you're in an automobile accident, you go to the emergency room you're going to be taken care of, but we don't have as much meaningful access to quality primary care. Maybe we're spending half as a percentage of investment than many other countries are.

Dr. Dafny, what do you think the impact of more primary care would do on the overall costs of health care, the overall expenses of health care?

Dr. DAFNY. Thank you for the question, Senator Marshall.

I would say that as a country, we are extra—we spend far less on primary care than they do. That results in pushing more spending to specialists, who we know are more expensive.

I think it would be a tremendously valuable thing.

We ought to look at the compensation for primary care relative to specialists and to encourage more entry into that field. And would defer to the primary care physician to my left, should you want more detail.

Senator MARSHALL. Dr. Kurose, yeah, please go ahead. Okay.

Dr. KUROSE. I concur with all that. And I think that, particularly given the complexity and fragmented nature of our health care delivery system writ large, it's never been more important for the patients, particularly those with complex or chronic illnesses, to have a primary care physician that can help guide them through that system, make decisions, coordinate everything, and have them stay on top of things.

And you know, to me, that's foundational for a high performing health care system of any kind.

Senator MARSHALL. Great.

Certainly, I concur that in this instance we're certainly thinking that community health centers are a big part of that, an opportunity where you can deliver health care to where the patients are. Adding mental health support right there, nutrition coaching, those types of things.

And since there's no one else standing in line, Dr. White, what do you think about more primary care? How that would impact the costs of health care for this country?

Dr. WHITE. We have spoken to a number of experts about alternative payment models and ACOs. And they have pointed out that primary care is really central to ACOs in a very nuts and bolts sense. To get patients attributed to an ACO, they have to be receiving primary care services, so that's kind of foundational.

But there's also this phenomenon that physician-led ACOs are clearly more successful on reducing spending than hospital-led ACOs. And——

Senator MARSHALL. Imagine that.

Dr. WHITE [continuing]. And what we've gathered is that the physician-led ACOs tend to focus on shifting care away from the facility settings, the specialty care, imaging services. And so, I think that's generally consistent with what you're saying.

Senator MARSHALL. Okay. Thank you, Chairman. I yield back.

Chairman WHITEHOUSE. Thank you.

Senator, while you were in your other hearing, we also had a bit of a conversation about prior authorization. And Dr. Kurose and, I think, with other heads nodding, made the point that when you're in a fee-for-service system, there is some rationale for prior authorization to prevent just piling on with the billings. But once you move to a value-based system, like Accountable Care Organizations run, then the logic, the rationale for having prior authorization diminishes, if not evaporates.

So, I appreciated your questions about prior authorization. I wanted to fill you in on what the prior testimony had been.

And I do think that there is room, as we move towards more value-based care in our health care system, to make sure that the bureaucracies keep up with that, and you're not running legacy prior authorization systems that require doctors to maintain administrative staff that serve, actually, no real purpose because you've reoriented the incentives so that it really doesn't make sense to require a prior authorization.

Maybe there should be prior approvals for prior approvals.

Senator MARSHALL. We used to have that.

So, I certainly agree and concur that we need to go to these value-based models, and it would eliminate some of the need.

But in the meantime, 90 percent of the health care system is going to fight that, and it will take years to see that happening. And I think it's all the more important that we lean in on some type of a streamlined fix to the prior authorization issues, rather than punishing the 98 percent of physicians that are doing the right thing, and focus on those focus—on those folks that who indeed are abusing the system.

So, thank you. I appreciate those comments.

Chairman WHITEHOUSE. And I'm now delighted to recognize Chairman Wyden, who has stepped out of the Finance Committee briefly. And I thank you, sir.

**STATEMENT OF SENATOR WYDEN**

Senator WYDEN. I thank my colleague. And this is a very good hearing.

And particularly, what we're trying to do in the Finance Committee is look at the ways for the future to build around some of the things that just are common sense.

For example, in the PBM area, we're looking at reducing the role of middlemen. I just came from the Medicare, you know, hearing, and these marketing middlemen, based on today's numbers, are taking $6 billion out of the system, $1,300 a patient just on marketing.

So, I want us to look at the promising models, and that's what Chairman Whitehouse has given us a chance to do today. And I want to explore with all of you—I'll probably start with you, Dr. Kurose—chronic care.

When I was director of the Gray Panthers, which has now been maybe a year or two ago, as I've been saying, Medicare was an acute care program. It was—you know, you broke your ankle and then you went to the hospital, and that was Part A of Medicare. And if you had a horrible case of the flu, you went saw your doctor, that was Part B of Medicare.

That is not Medicare today. Medicare today is overwhelmingly chronic care: cancer, diabetes, and heart diseases, strokes. And people who have two or more of these conditions is now dominating the program.

And before he retired, Chairman Hatch worked with us—and Senator Whitehouse remembers this—on a bill to say, we're going to insure those acute care services, and therefore, we're going to start building around chronic care. And we passed a transformational chronic care bill, which included the country's first really big investment on the health side in telemedicine, in terms of laying out the infrastructure.

So, we passed it. And one day, I was sitting in my office after Chairman Hatch had moved on to, you know, other matters, and the Trump administration called and said, how would you feel about our using the telemedicine provisions as the basis for telemedicine services in COVID?

And I said, you're asking me how I feel? This is the coolest day I can remember. I've got the Administration asking me about something the Democrats and Republicans care about.

And that, in fact, was how we delivered COVID, COVID-related services to a great extent during the pandemic is using our telemedicine approach.

So, if you would, tell us why—as I understand, you've been interested in this field—why you think that chronic care coordination and building on these kind of models makes sense?

Dr. KUROSE. You know, I think when we look at segments of the patient population that are older with multiple chronic medical illnesses, they certainly have an outsized impact on the total cost of

care for the broader population. And I think there's an opportunity to really both control costs and improve patient experience, patient outcomes, efficiency of care.

I think what you're alluding to in terms of acute versus chronic illness goes to some extent to the distinction between sort of reactive care models and proactive care models. And I think, when you can have a proactive team-based approach to the care of chronic illnesses, experience is just demonstrating how effective that can be.

The timeliness of it is important. When you're proactive, you can often diagnose a problem earlier when the interventions that are required to return, restore wellness to the patient's condition—it's much more effective when you intervene early. So, right care, in the right place, at the right time is a big piece of chronic illness management.

It's also an opportunity, as I alluded to earlier, to incorporate the patient's values and their goals of care. When you have an engagement with a patient with multiple chronic illnesses, part of—a very important part of that is to understand that aspect of their care and give them agency as patients and decision-making power. And often, that will actually allow you to avoid unnecessary care, or care that the patient never wanted.

So, I think that those aspects of chronic care delivery are very much incented and facilitated in an ACO model like the Medicare program.

Senator WYDEN. My time is up. And I just wanted to say to you that we'll be back to you, because there are really two issues here.

One, Senator Whitehouse and I have been very involved in trying to update the Medicare guarantee. You know, Medicare is a guarantee. It's not a voucher. It's not a piece of paper. It's a guarantee. We've done that now, at least made a start with the chronic care additions to Medicare.

But I think, as we learn more about what chronic conditions are all about and how to treat them, maybe we're going to learn some things about how to prevent them in the first place. And I'm going to want to talk to you about that relationship as well.

Mr. Chairman, good work, as always, and your leadership on health care is long, long noted. And I look forward to working with you on the things we're talking about today.

Chairman WHITEHOUSE. Thank you, Chairman Wyden.

I have a number of questions I'll ask Dr. White. That creates a second round, so I'll recognize Senator Braun. And then I have another hearing to get off to, so I will close the hearing after those two rounds.

Dr. White, CMMI looked at some programs that were cost saving failures and others that were cost saving successes. Your CMMI report notes models that produced statistically significant savings, and that a third of the CMMI models that have produced statistically significant savings were ACO models—your colleague Dr. Kurose on the panel being one example.

You noted also that certain features of the pioneer ACO model have been incorporated now into the Medicare Shared Savings Program and that, beginning next year, CMS has announced that the Medicare Shared Savings program will also incorporate aspects of the other successful ACO model, the ACO investment model.

What are the qualities of those successful models that led to their success, and where did those ACO models succeed in achieving savings?

Dr. WHITE. Thank you for the question, Chairman.

At a high level, MSSP has operated——

Chairman WHITEHOUSE. Let me interrupt you for one second to say that Senator Kaine has arrived. And I amend my previous order for proceeding so that after Senator Braun, we'll recognize Senator Kaine.

Dr. WHITE. MSSP has operated one-side models for participating providers may earn shared savings, and also two-sided models, where providers can also incur financial penalties. And a key feature of the pioneer ACO model was that it incorporated a two-sided risk arrangement for all participants by the second performance year. And the main MSSP program is moving toward those two-sided models.

With the ACO investment model, one of its key features was that it provided prepaid shared savings, which was intended to support investment in infrastructure and the formation of ACOs, and especially in rural areas and underserved areas.

Now, our report was at a fairly high level focusing on budgetary impacts, so we didn't dig into the specific operational details of those models. But the two-sidedness and the funding for infrastructure investments are the features of those two ACO models that stood out to us.

Chairman WHITEHOUSE. There were winners in those ACO models. And the winning features of those models are now being propagated further into the Shared Savings Program; correct?

Dr. WHITE. That's fair to say.

Chairman WHITEHOUSE. What do experts that CBO hears from say about the importance of primary care in the context of successful delivery system reforms?

Dr. WHITE. Sure. I'll reiterate the fact that primary care is key to patient attribution in ACOs, but then, more broadly, physician-led organizations have the ability and the incentives to move care away from high cost specialty care facility settings and focus on management of chronic conditions. That is consistent with the ability to save money and reduce spending.

Chairman WHITEHOUSE. And, finally, is it correct that CBO communicated in a letter to our committee in March of this year that CBO now projects that the United States will have spent $6.3 trillion less between 2010 and 2033 than CBO's original projections proposed in its 2010 baseline?

Dr. WHITE. Yes.

And just to unpack that a little bit, this is from the letter that we sent in March of this year.

Over the 2010 to 2020 period, we spent $1.1 trillion less on health care than we projected in August of 2010. And looking forward from 2021 to 2033, we now project we will spend $5.2 trillion less on major health programs than we projected in the summer of 2010. That sums to the $6.3 trillion.

Chairman WHITEHOUSE. Great. With that, I will make that letter a matter of record. (insert footnote in editing)

Chairman WHITEHOUSE. And I will turn to Senator Braun, and then Senator Kaine.

Senator BRAUN. Thank you, Mr. Chairman.

We talked about hospitals earlier. They now occupy the biggest percentage of the health care dollar.

Insurance, though, cannot go unmentioned. When I redesigned my plan to make it to where we haven't had premium increases in 15 years, and threw the kitchen sink and everything at wellness, creating health care consumers at the time, insurance was never intended to take care of minor health care. Just like to doesn't work in any other area of insurance, it's for indemnification of a critical, unusual incident or issue. I don't think it was ever intended, just evolved that way, to cover everything.

Do we need insurance for primary health care? Or should it go back to what it was intended for: indemnification against critical illness or an accident?

I'm going to start with Dr. Fiedler. And why is that still a part of the system? It's kind of like the Darth Vader that keeps the glue of lack of transparency and everything there.

And then Dr. Dafny and Dr. Kurose. So, keep your answers at about a minute or so, so we respect the time.

Dr. Fiedler, you can start.

Dr. FIEDLER. I think one of the rationales for coverage of some of these more routine services is that they have the potential to prevent the need for more expensive services down the road. And so, I think——

Senator BRAUN. Prevention is worth—an ounce of that is worth a pound of cure.

Dr. FIEDLER. Right. And it may not be that there are cost savings, but it may be that the sort of benefits that they provide, together with the cost savings they generate, means they're worth it on net.

So, I think that is——

Senator BRAUN. But that doesn't work in any other arena of insurance on minor stuff. Then you're mixing indemnification and the cash flow that goes with it, and you're doing other things. Well, why couldn't that be done directly between patient and the provider and get rid of all the red tape and costs of processing a claim?

Dr. FIEDLER. I think another important reason that many of these services are being covered through insurance is because the insurer is actually playing a very important price negotiation function in the private market.

Senator BRAUN. So, I want to stop there. You've made your point. I think that is totally off base.

You've gotten rid of what works in every other market. People shop around to save 50 bucks on a big screen T.V. They're not doing any of that.

When I put that into my insurance plan, costs started going down by 50 percent. You throw the wellness tools, you have your cake and eat it, too. Dr. Dafny.

Dr. DAFNY. Thank you for the opportunity, Senator Braun, to answer this question.

I agree with you that insurance ideally does not have first dollar coverage. Right? It's supposed to protect against the unanticipable risks that one has.

However, what data show us is that when consumers have high deductibles, that they cut back on their care, but they cut back indiscriminately. They cut back on care that could reduce spending later on. And to the extent that employers and government payers then end up having to spend more because of those decisions early on, that's a reason to subsidize that kind of care.

Dr. KUROSE. To me, your question at least in part—and I'll see if you agree—raises a question of how should primary care be compensated?

And it seems like when you're moving away from the purpose of insurance as you described it, you could think about capitated models of payment for primary care that gives you a predictability on what the cost is.

Exactly how that gets funded and what the incentives are for patients is sort of a different question, but I think that the costs of primary care should be relatively predictable, and that paying prospectively on a per member per month, per member per year basis for primary care makes sense.

One of the things that I would add is that I think there is value in having primary care have skin in the game in terms of managing total cost of care because I believe that they play an important role in that, although they can't do it alone.

Senator BRAUN. I think there, that is a dilemma because you do, then, eliminate the market in that skin in the game.

And we've evolved that way. All I can tell you is I'm seeing more and more, unless you're saying people would not take care of their own well-being just because that's the way it's been, I think you're sticking to a model that's broken. And it has gotten us where we are today.

We need to get creative there. You bring health care costs down. I did it, and it's been working for 15 years. And we've got to be more creative and entrepreneurial in areas like that.

Mr. Merkel, do you want to weigh in quickly?

Mr. MERKEL. Yes. I would say that you're right. Insurers' raison d'etre is to insure against financial risk, and to the extent that we have required them to do more, they do that inefficiently. And while yes, currently, they're playing a role to negotiate prices, I think that they haven't done that particularly well.

And if we put more people—put more pressure on through giving consumers, and patients, and providers a more active role in doing that, I think we'd probably see better results in the long run.

Senator BRAUN. Thank you.

**STATEMENT OF SENATOR KAINE**

Senator KAINE [presiding]. Thank you to all the witnesses for being here today and helping the committee examine ways to both maintain quality, but reduce costs as we're doing so.

I care very deeply about this topic. I have a bill with Senator Bennett that I call the 'Medicare-X Choice Act.' And I want to talk about it a second.

Dr. Fiedler, I'll ask you a question about it.

Medicare-X Choice Act would create a public option that would expand upon the successes of the Affordable Care Act, making affordable coverage available for families, individuals, and small businesses.

It would direct CMS to devise an insurance policy that would cover the ACA essential benefits, and offer that policy on the exchange for individuals and small businesses.

An individual choosing to purchase that policy, if they qualified for the ACA subsidy, could apply that subsidy to bring down the cost of the premium. Because the CMS-devised policy would not need to cover a profit margin, fancy salaries, ads on T.V., return to shareholders, it would likely be a very affordable option for people. Wouldn't force people to buy a government policy, but I think folks looking at the exchange would find it to be a very attractive option.

The proposal would increase access to health care services in parts of our country that have historically faced challenges accessing care: rural Virginia, rural America, where often there's inadequate options or choice on the exchanges.

People—because CMS exists in every ZIP Code in the country, it could be available on every exchange in the country. Somebody moving from Virginia to Oregon, not knowing whether the insurance company that insures them in Virginia even offers policies in Oregon, wouldn't need to worry about whether the Medicare-X policy would be available because Medicare already operates in every ZIP Code.

My colleagues and I have differing opinions about how to achieve the goal of broadened access and reduced costs, but I do think we have the common goal of doing those things. And that was why I was so gratified when the Urban Institute issued a report last year stating that, if implemented, the Medicare-X Choice Act would reduce the number of uninsured people by about 1.1 million, save households about $10.9 billion a year, save the Federal Government $20.3 billion a year, and cut total spending on health care by $456 billion over a 10-year period.

Increased access to care is not only good for individuals. It's good for communities.

Dr. Fiedler, I'd like to ask you to speak about how the mechanics of Medicare-X would both increase access to care and reduce health care spending over the long term.

Dr. FIEDLER. Thank you for the question.

This is something that Dr. Dafny alluded to in her testimony, but a striking feature of our health care system is that private insurers pay much higher prices for the same health care services than Medicare does.

And that's a reflection of the fact that private insurers have to negotiate these prices with providers. And providers, in many markets, wield a lot of market power, whereas Medicare is able to pay lower prices by setting prices administratively.

Medicare-X would introduce a Medicare-like plan into the individual and small group markets. And because Medicare-X would pay these lower prices, it would offer lower premiums than existing plans. It would probably be due to the lack of a profit margin and probably somewhat lower administrative costs that would add to

the premium reductions. That's where the cost savings would come from.

You also asked about access. In terms of access, there would be sort of two main effects to think about.

One is that the lower premiums would cause some people who are uninsured today to take up coverage, which would improve their access to care.

And then, another is that the Federal Government would save a lot of money on the subsidies delivered to people who are currently insured. And the bill would then use some of those federal savings to enhance the subsidies available to people who have private coverage on the marketplace. And that would pull additional people into the market in coverage, and improve access to care.

Senator KAINE. Thank you, Dr. Fiedler.

You know, we don't have the votes to do Medicare-X yet, but I believe it's the next step forward, that we started on a path with the Affordable Care Act. I don't think we should just go on a different path, but I think we should take the next step forward on the path we began. And I think offering a Medicare-X policy on the exchanges and allowing people, as they shop, to do what Senator Braun said, to shop and try to find the most economical plans, I think that would be a good thing.

I want to—Dr. White, I have a question for you, and then we will close the hearing.

At a Budget Committee Hearing last month, I asked Dr. Marilyn Moon about a New York Times article that caught my attention. And I heard Senator Whitehouse referring to it.

The article was entitled 'A Huge Threat to the U.S. Budget Has Receded. And No One Is Sure Why.' And it was sharing the work of the CBO that between 2010 and 2020, Medicare costs were 9 percent lower than expected.

The article was interesting in advancing different scenarios. I asked Dr. Moon if she had thoughts about why this happened, and she speculated two factors.

One, that passage of the Affordable Care Act and an increase in people having insurance prior to joining Medicare might mean that people are a little bit healthier when they joined Medicare, and thus, their expenses might have been lower, at least initially.

And then, she also pointed out that there is a demographic aging bubble of a lot of people turning 65 at once—baby boomers like me, I turned 65 in February—and younger seniors tend to be healthier than older seniors. So, if you have a huge bubble of young seniors coming into Medicare, that can also affect costs.

Given that CBO was responsible for the work that has led to this, this interesting phenomenon and speculation, can you talk about the factors that CBO took into consideration when doing the analysis and how those factors could potentially change over the next 10-year budget cycle?

Dr. WHITE. Sure.

There's a lot to unpack in that question, but let me start with the baby boomers aging into Medicare. That's a demographic phenomenon that's very well understood. It's very predictable, and it's baked into our demographic factors. So, that is pretty straightforward to have a handle on.

In terms of people having health insurance under age 65 because of the ACA and then aging into Medicare, that sounds plausible. We haven't dug into that and pinned down the size of that. The ACA did so many other things, big things in Medicare, that that phenomenon, my sense is, is relatively small.

But one thing that I want to draw out is that the unexpected slowdown in Medicare spending actually started appearing well before 2014, when the coverage expansions went into effect. And so, this is really a long-running slowdown phenomenon.

And we know that we overestimated Part D spending. We know that Medicaid spending on long-term services and supports has turned down. We're taking those factors into account when we project going forward.

And I want to make a general point that we use the most recent historical evidence as our jumping off point. We look at our misses. We scrutinize those misses. When we come to understand our misses better, we explain for the world why we've updated our thinking.

That showed up in the CMMI report in a big way, and our predictions now, as always, we're trying to be in the middle of the distribution. It's as likely to be too high as too low. The future is always uncertain, but we're trying to take what we've learned and really dig into the phenomenon that Dr. Moon highlighted.

Senator KAINE. Great.

Well, thank you, Dr. White. The fact that the CBO manages to make Democrats happy or unhappy, and Republicans happy or unhappy—you know, I've railed at some CBO studies and been entirely comforted by others, and everyone around this table feels the same way. I think you're approaching the work that you do in this space with, you know, with intellectual integrity and an attempt to be evenhanded, and I appreciate that.

And I do think it's important. I applaud analyzing your misses because when you miss something, going back and trying to understand why gives you the ability to calibrate and then, you know, hopefully do a better job. I think the Samuel Beckett line is 'Ever tried. Ever failed. No matter. Try again. Fail better.'

And so, it sounds like that's the method that you follow.

The hearing is now concluded. I want to thank the witnesses for hearing—appearing before the committee. Your written statements wholly will be included in the record.

Without objection, I submit statements for the record from Milbank Memorial Fund, the Rhode Island Quality Institute, the National Association of Accountable Care Organizations, from Professor David Cutler and Nikhil Sahni, and a preprint publication in Health Affairs titled "Active steps to reduce administrative spending associated with financial transactions in US healthcare".[9]

Information for all senators, questions for the record are due by noon tomorrow, with signed hard copies delivered to the Committee clerk in Dirksen 624. Emailed copies will also be accepted.

We'll ask witnesses, if there are questions for the record that are submitted, to respond to those questions within seven days of receipt.

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[9] Documents submitted for the Record appear in the appendix on page 109.

With no further business before the Committee, this hearing is adjourned.

[Whereupon, at 11:43 a.m., Wednesday, October 18, 2023 the hearing was adjourned.]

**Opening Statement of Chairman Sheldon Whitehouse**
**Senate Committee on the Budget**
**"Improving Care, Lowering Costs: Achieving Health Care Efficiency"**
**October 18, 2023**

Ranking Member Grassley and members of the Committee, Today's hearing is about excess costs in health care and ways we can reduce the budget by spending health care dollars more efficiently.

As I point out often, and as this chart shows, the US continues to spend more on health care as a percentage of GDP than any other peer OECD country. The US also spends more on health care per person than any other peer country: over one and a half times more than the next closest country, Switzerland. Our national health expenditures total over $4 trillion a year. And the Centers for Medicare and Medicaid Actuary estimate that health spending will grow to 20 percent of GDP by 2031.

Yet the average life expectancy in this country is lower than that of many peer countries. It has even declined over the last two years and Americans' life expectancy is now the lowest it has been in two decades. We are on par with Estonia despite spending nearly double on health care as a percentage of GDP.

Put simply, we get very little bang for a *lot* of bucks.

It's grim, but there are some signs of progress. And we'll hear today from experts about how we can do better.

CBO has found that federal health care spending between 2010 and 2020 was more than $1 trillion *lower* than CBO had projected prior to implementation of the Affordable Care Act. And, as this chart shows, CBO now projects the US will spend $4.6 trillion less on the major federal health programs—mainly Medicare and Medicaid—over the next decade than projected pre-ACA.

CBO also found growth slowed in spending per beneficiary. While there are many contributing factors, the deceleration shows that smart policymaking and reforms can help bend the cost curve. The ACA fundamentally changed health care, and thanks to the payment modernization and care transformation it initiated, we're seeing reduced health spending.

But our work isn't done. Notwithstanding Medicare's new power to negotiate the price of some drugs, thanks to the Inflation Reduction Act, Medicare spending continues to grow faster than the rest of the federal budget, and our national health expenditures are rising rapidly, too.

That's because our fragmented and endlessly complex health care system creates the perfect environment for inefficiencies to fester. It is where excess costs live and grow. Today, we'll hear from experts about three areas of inefficiency that have increased health care costs for patients, families, and the federal government.

First, we'll hear about the dizzying web of administrative tasks—the billing, the reporting, and all the non-clinical work incidental to the actual delivery of care—that providers face. We'll hear how these burdens are responsible for over half a trillion dollars in health care spending every year. Our discussion on this is especially timely. Research released last week revealed possible savings between $40 and $60 billion a year just from fixing the mess of health care billing and claims.

Next, we will hear about how consolidation in health care can raise prices for patients, leading to higher federal health spending. We will also learn about potential solutions, like health cost databases that don't just bring much needed transparency into the opaque world of health prices, but also enable stakeholders to take actionable steps to control spending based on that data. Eighteen states, including Rhode Island, are already making use of tools like these, known as all-payer claims databases, to reduce patients' costs and improve care.

Then, we'll hear from one of Rhode Island's leading health care experts, Dr. Al Kurose, about how our fragmented health system—with patients often navigating multiple providers at different sites, instead of obtaining care from a primary care provider—results in worse care at higher costs. We'll hear how delivery system reforms, like accountable care organizations, can promote higher quality care with less money spent. Patients seeking care are often lost in the maze of our current fee-for-service system. Transitioning to value-based care, predicated on strong primary care, can help achieve the long-sought Triple Aim: better care, better health, lower costs.

Within our current health care system, there is no doubt that value-based care is the best solution. Value-based care rewards providers, not based on how *much* care they deliver for patients, but how *well* they deliver care.

A decade on from the implementation of the ACA, we have learned a great deal. We've learned that simplifying non-clinical work in health care, changing how we pay for care, and transforming how we deliver that care can lower costs and improve outcomes. If we do all of this more often and at scale, we can deliver the best and most accessible health care for all patients.

UNITED STATES SENATE
BUDGET COMMITTEE
RANKING MEMBER CHUCK GRASSLEY

**Opening Statement by Senator Chuck Grassley of Iowa**
**Ranking Member, Senate Budget Committee**
**Hearing on "Improving Care, Lowering Costs: Achieving Health Care Efficiency"**
**Wednesday, October 18, 2023**

**VIDEO**

[It's a] very important subject…improving health care and lowering costs. And thanks to all our witnesses for the extra time you've put in to educating Congress and preparing for this.

Health care might be one of the few markets in our economy where the consumer doesn't know the price before they buy it, and they rarely pay for it directly.

Yet, Americans spend more than $4.3 trillion annually on health care. Our spending has more than tripled as a percentage of gross domestic product since 1960.

Growing health care costs don't just strain Americans' pocketbooks. They also are key drivers of widening budget deficits and the federal government's unsustainable fiscal outlook. And it's not clear that we're getting our money's worth for all that spending.

Major health care program spending eats up 32 percent of federal revenue today, and it will be 45 percent of revenue by mid-century.

Our health care system has plenty of waste and inefficiencies that need fixing. Increasing transparency and competition, fighting fraud and getting rid of red tape are some key areas to start with.

You should know what something costs before you buy it. That's common sense for any consumer. Transparency is what we need.

Until recently, we didn't apply sunshine to health care prices.

I'm glad hospitals and health plans are now required to report their pricing data. But I'm not sure that it's in consumer-friendly ways in which it's put out and may not be as effective as it was intended to be.

More transparency should also be applied to pharmacy benefit managers, very opaque middle people between the pharmaceutical industry and the consumer. I think this would to lower patient and taxpayer prescription drug costs.

Another way to lower health care costs is to ensure taxpayer dollars are being used wisely.

Last year alone, our federal major health care programs lost over $130 billion to what we refer to around here as fraud, waste and abuse.

I'm the author of major and more recent updates to the federal government's most powerful tool in fighting fraud, the False Claims Act.

Since I got that adopted in 1986, we have seen the federal government has recover more than $72 billion lost to fraud and saved billions more by deterring would-be fraudsters.

We should also be reducing unnecessary red tape and administrative burden.

Between 1975 and 2010, the number of physicians grew 150 percent, while the number of health care administrators increased by 3,200 percent.

This administrative growth is driven by regulations, which takes more compliance time and financial resources away from patient care.

We need policies that promote the discovery of new cures and better treatments, not overly administrative price controls that stifle innovation.

I worked for five years to allow the sale of over-the-counter hearing aids with Senator Warren of Massachusetts.

Today, consumers can buy a pair of high-quality and safe hearing aids at $3,000 less, compared to a year ago.

I also support improving value in our health care system, but we need to accurately account for what's working and what's not working.

Recently, the Congressional Budget Office (CBO) found that the Center for Medicare and Medicaid Innovation – a program created with the goal of lowering costs – did not lower Medicare costs.

Let me emphasize, that's not Chuck Grassley saying that -- the Congressional Budget Office has said that. CBO says the program increased federal spending.

I invited CBO to this hearing and look forward to learning more about their analysis today.

We should look to market-based solutions similar to Medicare Part D, which I also led the team on the Finance Committee to get adopted in 2003 because it lowers costs and improves care.

In the first decade of Part D, CBO found that this Part D program ended up costing taxpayers36 percent less than projected.

Finally, we can't talk about waste and inefficiencies in the health care system without discussing our country's fiscal situation.

According to CBO, the federal budget deficit in the fiscal year that just ended clocked in at about $2 trillion. And future deficits are projected to be even higher, partly because of growing health care spending.

Health care spending can be made more efficient without compromising quality of care and reducing access, especially for rural America.

I hope we can build upon the ideas we hear today from this outstanding panel to address our country's fiscal challenges while also improving health care for Americans.

Thank you.

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**Testimony of Matthew Fiedler, Ph.D.**
**Joseph A. Pechman Senior Fellow in Economic Studies**
**Brookings Schaeffer Initiative on Health Policy**
**The Brookings Institution**

Before the United States Senate
Committee on the Budget

October 18, 2023

Chairman Whitehouse, Ranking Member Grassley, and members of the committee, thank you for inviting me here today. My name is Matthew Fiedler, and I am a health economist and the Joseph A. Pechman Senior Fellow in Economic Studies at the Brookings Institution, where I am affiliated with the Schaeffer Initiative on Health Policy.[1] My research examines a range of topics in health care policy, including health care provider payment and health insurance regulation.

My testimony will examine the administrative costs generated by interactions between health care providers and payers (including both public programs and private insurers), as well as how changes in public policy might help to reduce those costs. I will make five main points:

1. **A reasonable estimate is that the administrative costs generated by provider-payer interactions amount to around half a trillion dollars per year or around 11% of annual health care spending.** Most of these costs are incurred by providers while negotiating contracts, collecting information about patients' coverage, obtaining prior authorization for care, submitting claims for payment, and reporting on quality performance. Payers incur additional costs to perform their part in these interactions.

2. **Administrative costs are ultimately borne by consumers and taxpayers.** Costs incurred by providers are reflected in the prices that providers negotiate with private insurers; similarly, these costs require public programs like Medicare and Medicaid to pay higher prices to elicit adequate provider participation. Higher prices directly increase patient cost-sharing in many instances and, together with the administrative costs incurred directly by payers, increase premiums and program spending (as applicable).

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

[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. Portions of this testimony have been adapted from testimony I delivered before the House Committee on Small Business, Subcommittee on Oversight, Investigations, and Regulations on July 19, 2023.

4. **Certain targeted reforms could reduce administrative costs 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 determines 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 payments by documenting additional diagnoses. More generally, policymakers should be attentive to how policy choices across many domains affect administrative costs.

5. **Standardizing billing, coverage, and quality reporting processes across payers could generate larger savings but could also present tradeoffs.** The wide variation in rules across the menagerie of public and private payers that operate in the United States is likely one major reason that administrative costs are larger in the United States than in many other countries. Greater standardization could likely reduce these costs.

   One worthwhile goal is standardizing how providers and payers share claims information. One strategy policymakers could consider is creating a central clearinghouse that would accept claims from providers in a standardized format and route them to payers, an approach used in some other industries and in some other countries' health care systems. This approach would likely more fully standardize claims transactions than past federal efforts that have established transaction standards to govern decentralized provider-payer interactions. However, it would be essential that a clearinghouse be well-run, as a poorly run clearinghouse would likely generate few benefits or even do harm.

   Policymakers could also consider standardizing the *substance* of some payer rules related to billing, coverage, and quality reporting. This approach might generate larger administrative savings but would also limit payers' ability to tailor rules to their circumstances or experiment with novel approaches. Setting rules through a centralized process might also produce rules that are systematically better or worse than existing rules. These factors could cause standardization to produce offsetting costs, like greater use of inappropriate services, that would need to be weighed against administrative savings. Thus, the desirability of this type of standardization is likely to be highly case-specific. Quality reporting may be a domain where standardization would be particularly attractive, as it could likely both reduce administrative costs and increase the utility of the resulting quality data by increasing provider-level sample sizes and easing cross-payer comparisons.

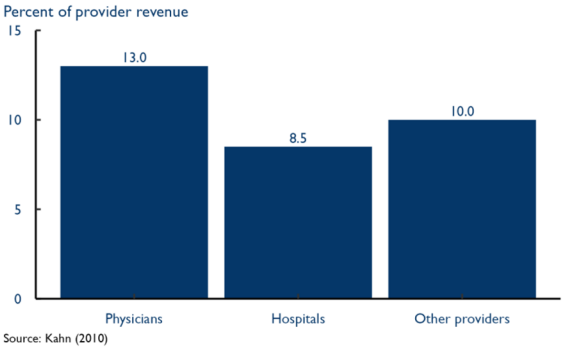
The remainder of my testimony examines these points in greater detail.

**Background on the Administrative Costs of Provider-Payer Interactions**

Health care providers devote substantial effort to interacting with payers; activities include negotiating contracts, collecting information about patients' coverage, seeking prior authorization for care, submitting claims for payment, and reporting on quality performance. Estimating these costs is challenging because it requires detailed information on provider costs and because, even when these data are available, it is not always obvious what costs are incurred for which purposes.

However, one synthesis of survey estimates concluded that provider costs associated with these activities total 13.0% of revenue for physician practices, 8.5% for hospitals, and 10.0% for other providers, as shown in Figure 1.[2] Other studies using more recent data (but that are narrower in scope or categorize costs somewhat differently) obtain estimates of a broadly similar magnitude.[3] Under current projections of health care spending, the estimates in Figure 1 imply that providers in the United States will incur $396 billion in such costs during 2023.[4]

**Figure 1. Provider Costs of Interacting with Payers**




Source: Kahn (2010)

Private insurers and public programs incur additional costs to play their part in provider-payer interactions. Commercial insurers reported costs for claims processing, cost containment, and

[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).

[3] Phillip Tseng et al., "Administrative Costs Associated With Physician Billing and Insurance-Related Activities at an Academic Health Care System," *JAMA* 319, no. 7 (February 20, 2018): 691–97, https://doi.org/10.1001/jama.2017.19148; Nikhil R. Sahni et al., "Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare" (McKinsey & Company, October 2021), https://www.mckinsey.com/~/media/mckinsey/industries/healthcare%20systems%20and%20services/our%20insights/administrative%20simplification%20how%20to%20save%20a%20quarter%20trillion%20dollars%20in%20us%20healthcare/administrative-simplification-how-to-save-a-quarter-trillion-dollars-in-us-healthcare.pdf?shouldIndex=false.

[4] These and subsequent calculations in this section use 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.

quality improvement activities equivalent to 2.9% of claims spending in 2021.[5,6] Unfortunately, comparable data are not available for other payer types. It is plausible that the corresponding percentage is higher for private insurers that deliver Medicare and Medicaid coverage since these programs generally pay lower prices for care, so the same per-claim administrative cost would represent a larger share of the cost of the claim.[7] These insurers may also make greater use of prior authorization and other utilization controls, which may also raise administrative costs.[8] On the other hand, this percentage is clearly smaller in traditional Medicare; *total* administrative spending for Medicare Part A and Part B (including expenses unrelated to traditional Medicare's interactions with providers) amounted to only 2.2% of traditional Medicare's claims spending in 2021.[9]

Nevertheless, the estimate for commercial plans can provide a sense of the magnitude of the costs that payers generally incur in connection with their interactions with providers.[10] Applying this estimate across all payers implies that payers' costs to interact with providers will total $89 billion in 2023 (under current projections of aggregate claims spending). Combined with the costs incurred by providers, this implies that the total administrative costs generated by provider-payer interactions in 2023 will be on the order of half a trillion dollars, the equivalent of about 11% of total expected spending on health care and health insurance services.

These administrative costs are ultimately borne, at least in large part, by consumers and taxpayers. In commercial insurance, 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, cost-

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[5] This estimate was derived from the medical loss ratio filings of individual, small group, and large group insurers.

[6] Some studies report far higher estimates of payer-incurred "billing and insurance-related" costs. These studies often include costs of payer activities that are not directly related to interactions with providers (e.g., marketing, underwriting, and premium collection) and sometimes include insurer-paid taxes and insurer profits. These broader measures can be relevant when considering proposals to change how insurance is provided but are less relevant to assessing proposals that would change how providers and payers interact. See, for example, James G. Kahn et al., "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals," Health Affairs 24, no. 6 (November 2005): 1629–39, https://doi.org/10.1377/hlthaff.24.6.1629; Kahn, "Excess Billing and Insurance-Related Administrative Costs"; Aliya Jiwani et al., "Billing and Insurance-Related Administrative Costs in United States' Health Care: Synthesis of Micro-Costing Evidence," BMC Health Services Research 14, no. 1 (November 13, 2014): 556, https://doi.org/10.1186/s12913-014-0556-7.

[7] Congressional Budget Office, "How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program: Working Paper 2020-08 | Congressional Budget Office," December 2020, https://www.cbo.gov/publication/56811.

[8] Matthew Fiedler, "Assessing Two Approaches to Closing the Medicaid Coverage Gap" (Brookings Institution, January 24, 2023), https://www.brookings.edu/articles/assessing-two-approaches-to-closing-the-medicaid-coverage-gap/.

[9] This estimate was derived from the 2022 Medicare Trustees report. See Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Trustees), "2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," June 2, 2022, https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

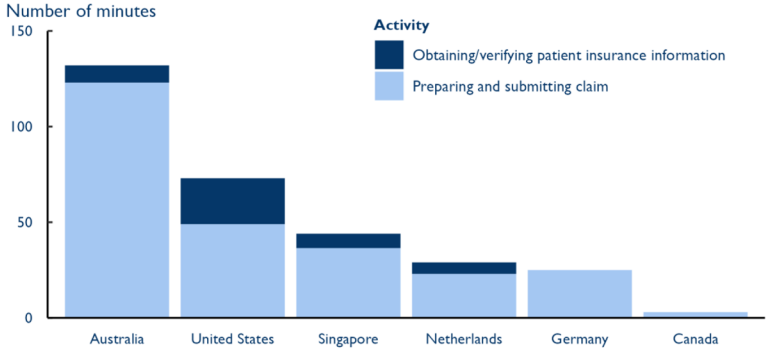
[10] A caveat is that this estimate includes some costs associated with some insurer activities that are not directly related to interactions with providers, like internal analytic activities and enrollee-facing wellness activities. On the other hand, this estimate may not fully reflect insurer spending on employees and non-labor inputs that are used both for interactions with providers and for other purposes.

sharing, or both.[11] Part of those costs is paid by consumers and part is paid by the federal government (which subsidizes most forms of private coverage via the tax code).

In public programs, increases in the administrative costs borne by providers require those programs to pay providers higher prices to elicit any given level of provider participation.[12] The costs are then ultimately financed by taxpayers or through premiums paid by program beneficiaries. The same is true of the administrative costs that programs incur directly.

The complexity of health care providers' interactions with payers appears 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.[13] 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 payers, 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

[11] Strictly speaking, this is only likely to be true of administrative burdens that increase the *marginal* cost of delivering a health care service or covering an additional enrollee, but that is likely generally the case in practice.

[12] 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.

[13] 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 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 the cost of labor and other types of inputs. 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 commercial market, the state's fee-for-service Medicaid program, and private insurers that operate Medicaid managed care plans, among others. Even within a given insurer and coverage type, rules may vary depending on what specific plan a patient is enrolled in.

**Targeted Steps to Reduce Insurance-Related Administrative Costs**

Given the size of the administrative costs generated by providers' interactions with payers, it is natural to ask whether these costs can be reduced. In looking for ways to do 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;[14] and audit processes can help uncover and deter low-value utilization.[15] Thus, policy efforts to reduce administrative burdens should be attuned to tradeoffs and proceed thoughtfully.

This section discusses 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. The next section considers some wider-ranging reforms.

*Eliminating Medicare's Merit-Based Incentive Payment System*

The Merit-Based Incentive Payment System (MIPS) was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); it adjusts most clinicians' Medicare payments upward or downward based in their performance in several domains, including cost and quality. While clinicians who participate in certain alternative payment models are exempt from MIPS, only a minority of clinicians participate in those models, so most are subject to MIPS.[16]

Unfortunately, there is little reason to believe that MIPS is achieving its goal of improving the quality or efficiency of patient care.[17] One fundamental problem is that MIPS allows clinicians to

[14] 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.

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

[16] 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.

[17] 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

choose many of the measures that they are evaluated on. In practice, different clinicians choose different measures, and they 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.

Measuring cost and quality performance at the level of individual clinicians or practices, as MIPS aims to do, is also 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 statistically 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 some of MIPS' distinctive shortcomings) have failed to improve care.[18]

MIPS does, however, impose large compliance burdens on practices. 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 how they want to be scored 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.[19] 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 physician fee schedule.[20] Even if this estimate overstates compliance costs by an order of magnitude, they would still be sizeable.[21]

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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.

[18] 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 (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.

[19] 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.

[20] 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, 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.

[21] There is some reason to suspect that this estimate overstates practices' actual costs. These estimated costs exceed the difference between the largest positive and largest negative MIPS payment adjustment applied for 2019. (See Centers for Medicare and Medicaid Services (CMS), "2019 Quality Payment Program Experience Report.") This implies that practices would have been better off simply ignoring their obligations under MIPS. Since few did, this

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.[22] In parallel, policymakers should strengthen incentives to participate in advanced alternative payment models and, ideally, streamline quality reporting requirements under those models.[23] 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.[24]

*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 the 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.[25] Each party to a dispute must pay the federal government an administrative fee to cover the costs of running the IDR process; this fee is currently $50 per party, but is slated to rise to $150 per party in 2024.[26] Arbitrators also collect substantial fees, which are paid by the losing party in a dispute; the median fee for a single determination is $549 in 2023, and the administration has proposed to increase the maximum fee arbitrators may charge starting in 2024, so this amount could rise in the future.[27] If IDR volume remains at anywhere close to the level observed to date in the coming years, then parties are likely to owe hundreds of million dollars in fees per year under the IDR process. This

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suggests that the costs faced by typical practices may not have been quite this large. Additionally, costs may have declined since 2019 as practices have gained experience and as CMS has tried to simplify the program.

[22] 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.

[23] 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/.

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

[25] 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.

[26] Internal Revenue Service et al., "Federal Independent Dispute Resolution (IDR) Process Administrative Fee and Certified IDR Entity Fee Ranges," *Federal Register* 88 (September 26, 2023): 65888.

[27] Internal Revenue Service et al.

is in addition to the 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. Higher fees 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.[28] 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.[29] (The insurer's historical median contracted rate is currently a factor 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.[30] These approaches could be revived in light of the dismal experience with IDR.

Some may worry that 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, 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" price (even if it were clear what that price is). Rather, arbitrators' main incentives are to: (1) minimize their costs of deciding cases; and (2) 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 is likely to wish to decide cases however it expects *other* arbitrators to decide cases. Otherwise, it

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[28] 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/.

[29] 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.

[30] 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 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 carefully consider 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 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.[31] 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 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 devote effort to reporting as many diagnoses as possible for their enrollees. Unsurprisingly, MA plans report far more diagnoses for their enrollees than those enrollees would accrue if enrolled in traditional Medicare.[32] In many cases, the additional diagnoses reflect conditions that beneficiaries do have, but that tend to go unrecorded in traditional Medicare. In other cases, the additional diagnoses are not supported by beneficiaries' medical records.[33] 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 5.9% (the statutory minimum).[34]

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. Much of these additional costs is incurred by plans, but some is incurred by health care providers because MA plans use a variety of strategies to enlist providers in the search for additional beneficiary diagnoses. For example, MA plans often offer bonus payments to providers who report additional diagnoses.[35]

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

[32] 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.

[33] 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.

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

[35] Medicare Payment Advisory Commission (MedPAC).

For this reason, some reforms that would reduce the susceptibility of the MA risk adjustment system to plans' diagnosis coding efforts could also reduce administrative costs. 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.[36] 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 plans' efforts to identify additional diagnoses and cause 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.[37] 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.[38] This may create opportunities for MA plans to profit by selectively enrolling healthier beneficiaries, something that already appears to be a substantial problem in Medicare Advantage.[39] Thus, this policy approach should be used judiciously.

**More ambitious steps: standardizing processes across payers**

The three targeted steps described above would achieve meaningful administrative savings while presenting few tradeoffs. There are likely other targeted changes that are worth considering. Indeed, the discussion above illustrates that many different policy choices affect administrative costs and that being attentive to those effects can pay dividends. But achieving large savings would require reforms that target more than just narrow slices of provider-payer interactions.

One approach to broader reform would be to standardize some billing, coverage, or quality reporting processes across the menagerie of public and private payers that operate in the United States. Variation in rules across different payers may be an important reason why providers bear heavier administrative burdens in the United States than in other countries.[40]

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[36] Medicare Payment Advisory Commission (MedPAC).

[37] 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.

[38] 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/.

[39] 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; Steven M Lieberman, Samuel Valdez, and Paul B Ginsburg, "Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments," USC Schaeffer Center White Paper, June 2023; Medicare Payment Advisory Commission (MedPAC), "Medicare and the Health Care Delivery System," June 2023, https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf.

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

*Standardizing information exchange through a claims clearinghouse*

One challenge is that different payers may require providers to transmit information in different formats or using different procedures. Standardizing these formats and procedures could make conducting some types of transactions less complex and thereby reduce costs.

Congress has taken important steps in this direction in the past. In 1996, Congress required the Department of Health and Human Services (HHS) to adopt standards to govern many types of electronic transactions between payers and providers as part of the Health Insurance Portability and Accountability Act (HIPAA). The Affordable Care Act built on the HIPAA provisions by directing HHS to also adopt standards for business rules governing use of the underlying transaction standards. Under the HIPAA authority, HHS has adopted standards governing various electronic transactions, including claims submissions, provider inquiries about plan benefits, and prior authorization requests. It also established standard code sets for referring to specific diagnoses or procedures as well as standard identifiers for providers and employers.

The HIPAA standards are valuable, but they have not fully standardized how different providers and payers exchange information. One problem is that the standards do not address all relevant types of information. Notably, there is currently no HIPAA standard governing claims attachments, which are used to transmit additional information that a payer needs to adjudicate a claims (e.g., medical records), despite the fact that HIPAA directed HHS to establish such a standard; this is likely one reason that transmission of claims attachments remain largely manual.[41] Although HHS is now in the midst of rulemaking aimed at establishing a standard, this experience illustrates how long-lasting, consequential gaps have sometimes arisen under the HIPAA standard-setting regime. Another problem is that different entities may implement the same standard in slightly different ways, partially undermining the benefits of having a standard.

One potential reform is to go beyond standard setting and establish a single, centralized clearinghouse that would accept claims from providers, route those claims to payers, and route payers' responses back to providers.[42] The clearinghouse would ensure that information exchanged in each direction was formatted in accordance with relevant standards. Similar systems are used in other economic sectors, like banking, and in the health care sectors of some other countries that have multi-payer health care systems, including Germany and Japan.[43]

Creating a clearinghouse has several potential benefits. First, because all claims would travel through the single clearinghouse, idiosyncratic variation in how different entities implement existing standards would be eliminated. Second, the rules and procedures adopted by the

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[41] CAQH, "2022 CAQH Index," December 2022, https://www.caqh.org/sites/default/files/2023-05/2022-caqh-index-report.pdf.

[42] 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/; Sahni et al., "Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare"; Nikhil R Sahni et al., "Active Steps to Reduce Administrative Spending Associated with Financial Transactions in US Healthcare," *Health Affairs Scholar*, October 11, 2023, qxad053, https://doi.org/10.1093/haschl/qxad053.

[43] Cutler, "Reducing Administrative Costs in U.S. Health Care"; 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/.

clearinghouse would, in effect, provide new *de facto* standards where standards do not exist. Third, providers and payers would no longer need to establish bilateral conduits to communicate.

To achieve these benefits, the clearinghouse would need to be well-governed, as it would need to establish well-designed processes, execute those processes efficiently and effectively, and react nimbly to changing circumstances. Indeed, a clearinghouse that performed poorly at these tasks might not only fail to improve on the status quo but actually make claims processing more burdensome than it is today. Any benefits of a clearinghouse would also need to be weighed against the cost of operating it, which would presumably need to be financed through fees on the providers and payers using the clearinghouse, although these costs might be offset by reductions in the costs of private-sector clearinghouses that currently perform similar functions.

*Standardizing substantive features of payer payment, coverage, or quality reporting policies*
While variation in approaches to information exchange is one source of excess administrative costs, another factor is that different payers have *substantively* different payment, coverage, and quality reporting rules. For example, some hospital-payer contracts use diagnosis related groups, while others are based on a hospital's chargemaster.[44] Similarly, different payers apply prior authorization to different services or require different standards to be met for a service to be covered.[45] And different payers require providers to report on different quality measures.[46]

These differing rules may require providers to submit different information to different payers for the same service, which may be burdensome even if the process for submitting any given piece of information is fully standardized. Moreover, even where differences in different payers' rules and standards do not *require* providers to submit different information (or otherwise behave differently) with different payers, providers may still have strong *incentives* to do so. Customizing reporting (or underlying care delivery) in this way likely adds administrative costs.

For these reasons, standardizing payment, coverage, or quality reporting processes across payers might generate meaningful administrative savings.[47] However, this type of standardization could also present tradeoffs. Under such a system, payers would be less able to tailor rules to their particular circumstances or experiment with new approaches, which could create offsetting costs, such as increases in the use of inappropriate services. Standardized rules might also differ in systematic ways from existing rules, which could be good or bad depending on the quality of the

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[44] 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.

[45] Aaron L. Schwartz et al., "Measuring the Scope of Prior Authorization Policies: Applying Private Insurer Rules to Medicare Part B," *JAMA Health Forum* 2, no. 5 (May 28, 2021): e210859, https://doi.org/10.1001/jamahealthforum.2021.0859; Aaron L. Schwartz et al., "Coverage Denials: Government And Private Insurer Policies For Medical Necessity In Medicare," *Health Affairs* 41, no. 1 (January 2022): 120–28, https://doi.org/10.1377/hlthaff.2021.01054.

[46] Aparna Higgins, German Veselovskiy, and Lauren McKown, "Provider Performance Measures In Private And Public Programs: Achieving Meaningful Alignment With Flexibility To Innovate," *Health Affairs* 32, no. 8 (August 2013): 1453–61, https://doi.org/10.1377/hlthaff.2013.0007.

[47] Cutler, "Reducing Administrative Costs in U.S. Health Care"; Richman et al., "Billing And Insurance–Related Administrative Costs"; Sahni et al., "Active Steps to Reduce Administrative Spending Associated with Financial Transactions in US Healthcare."

process used to set the new standardized rules and the degree to which the private incentives underlying the existing rules are aligned with society's interests.

In sum, the desirability of this type of standardization is likely to be highly case-specific and dependent on the particulars of the proposal under consideration. I do, however, want to touch on one domain where greater standardization may be particularly likely to be beneficial.

That domain is quality reporting. 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.[48]

Policymakers could reduce these costs by establishing a standardized set of quality measures for different categories of providers, require providers to report on those measures to a centralized database, and require all payers to rely on those measures rather than collecting their own bespoke quality measures.[49] Standardizing quality reporting may have few downsides since it is unclear whether the current quality reporting regime is creating substantial benefits (consistent with my skepticism about the benefits of MIPS and similar programs, discussed above). 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**

Interactions between health care providers and payers generate hundreds of billions of dollars in administrative costs annually in the United States. 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 payers that operate in the United States, although steps like these present more substantial tradeoffs than the more targeted changes.

[48] 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.

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

**TESTIMONY OF LEEMORE S. DAFNY, Ph.D**

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**Before the**

**U.S. Senate Committee on the Budget**

**On**

**"Improving Care, Lowering Costs: Achieving Health Care Efficiency"**

**October 18, 2023**

**I. High and rising provider prices are driving higher health care spending**
**II. Consolidation within and across health care subsectors is a key driver of higher prices and total costs of care**
**III. Federal antitrust enforcement requires more resources and legislative support to have greater impact**
**IV. Recommendations**

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## I. High and rising provider prices are driving higher health care spending

The U.S. spends 18.3 percent of its GDP on health care, a larger share than any other country. U.S. provider prices are extremely high by international standards (see Figure 1), and studies show that these high *prices*, not the quantity of services consumed nor the underlying health of our population, are the primary driver of higher spending in the U.S. International comparisons of health care quality also show the U.S. lags other leading OECD nations on most dimensions.[1] We are not receiving the highest possible value for our dollars – far from it.

Figure 2 depicts where we spend our health care dollars. My focus today is health care providers, such as hospitals, physicians, and clinics, who jointly account for just over half of health care spending. Whereas public insurance programs set the prices they pay to health care providers, commercial insurance plans negotiate rates with providers who are then included "in network"; covered services performed by in-network providers are accessible to enrollees at much lower out-of-pocket cost than services provided by out-of-network providers. The growth in health care spending for the commercially insured population is largely due to growth in these negotiated rates, also called "commercial prices."[2]

Commercial prices are much higher than prices for publicly-insured patients,[3,4] and the gap is widening. Commercial prices were around 10 percent higher than Medicare in the late 90s, but

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[1] Anderson, GF et al. "It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt," *Health Affairs* 2019 38(1):87–95; Commonwealth Fund, "Mirror, Mirror: Comparing Health Systems Across Countries,"; G. Claxton et al., "How Have Healthcare Prices Grown in the U.S. Over Time?," Peterson-Kaiser Health System Tracker (May 8, 2018); M. Laugesen and S. Glied, "Higher fees paid to US physicians drive higher spending for physician services compared to other countries," *Health Affairs* 30, no. 9 (2011): 1647–56.

[2] Zack Cooper, Stuart Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *Quarterly Journal of Economics* 2019 134(1): 51–107. Health Care Cost Institute, "2018 Health Care Cost and Utilization Report," Presentation, Feb. 2020.

[3] Zack Cooper et al.," Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-14," *Health Affairs* 2019 38(2): 184–189.

[4] Cooper et al. (2019), *supra* note 2. Private insurers administer benefits for a large portion of Medicare and Medicaid-insured beneficiaries, and for these enrollees, insurers and providers must agree to the terms, including price, under which a provider is included in-network. However, for Medicare Advantage plans, CMS requires providers that participate in Traditional Medicare to accept its fee-for-service price schedule for any out-of-network care, reducing the ability of most providers to negotiate for Medicare Advantage rates that are much higher. See

by 2012 were 76 percent higher and are even higher today.[5] A recent (2020) study found that *average* commercial prices for inpatient and outpatient services were *double* Medicare reimbursement rates, while prices for professional services – e.g., physician services rendered with hospital-based care – were 60 percent larger.[6]

While public insurance programs do not pay these commercial prices, there are significant federal budgetary implications of high commercial prices. Most directly, high commercial prices mean high employer-sponsored premiums, raising the cost of the tax exclusion for employer-sponsored coverage. High commercial prices also impact the premiums, and therefore the federal subsidy dollars, for enrollees purchasing subsidized plans through the Health Insurance Marketplaces. There are important indirect effects as well. The organizational structure and market concentration within the health care industry, which serves enrollees of all insurance programs, is heavily influenced by commercial prices and vice versa. These factors affect the quality and quantity of care provided to publicly-insured enrollees, as well as the site where that care is delivered – which directly affects the price the federal government pays.

Providers defend their negotiation of higher commercial rates by saying they must cover the costs of government-insured and uninsured patients, for whom care is reimbursed at rates below their actual costs. This dynamic ignores the fact that costs are themselves affected by reimbursement: economic research finds that hospital expenses fall when prices fall.[7] In other countries, this type of gap does not exist or is smaller, and cross-subsidization reduces pressures on providers to pursue efficiencies. If it is possible to negotiate higher commercial rates, that is an easier path than redesigning care to reduce costs and overall spending. It is also essential for payers, both public and private, to support providers in this work – for example through reimbursement arrangements that allow funding for case management that prevents costly care.

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Laurence Baker, Kate Bundorf, Aileen Devlin, and Daniel Kessler, "Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays," *Health Affairs* 35, no. 8 (2016): 1444–51; Vilsa Curto et al., "Health Care Spending and Utilization in Public and Private Medicare," *American Economic Journal: Applied Economics* 2019 11(2): 302–32.

[5] Selden TM, Karaca Z, Keenan P, White C, Kronick R. "The growing difference between public and private payment rates for inpatient hospital care," *Health Affairs* 2021 Dec; 34(12): 2147–50.

[6] Michael Chernew, Andrew Hicks, and Shivani Shah. "Wide State-Level Variation In Commercial Health Care Prices Suggests Uneven Impact Of Price Regulation," *Health Affairs* 2020 39(5): 791-799.

[7] White C, Wu VY. "How do hospitals cope with sustained slow growth in Medicare prices?" *Health Serv Res.*2014;49(1):11–31. Stensland J, Gaumer ZR, Miller ME. "Private-payer profits can induce negative Medicare margins," *Health Affairs* 2010 29(5):1045–51.

## II. Consolidation within and across health care subsectors is a key driver of higher prices and total costs of care

Increases in commercial prices have coincided with massive consolidation within and across health care provider sectors. There were nearly 1,600 hospital and hospital system mergers over the 20 years from 1997 to 2017, involving thousands of hospitals. This merger and acquisition activity has increased the absolute size and geographic footprint of hospital and health care delivery systems – and with it, their market power and political heft.[8] Merger and acquisition activity in physician markets has also increased, and the share of physicians employed in practices wholly or partly owned by hospitals has increased from below 20% in the mid-2000s, to 30% in 2012 and 50% in 2018.[9,10]

Given that consolidation has coincided with substantial growth in commercial prices and spending, the question of whether consolidation has *caused* these increases has attracted significant attention from researchers as well as various stakeholders. To date, the most conclusive research derives from analyses of "structural changes" in markets—i.e., mergers and acquisitions, divestitures, and exits. I summarize the results of these studies below. However, it is important to recognize that a good deal of consolidation to date is non-structural, that is, it results from the swift growth of large firms.

Some of the large-firm growth may well be due to anticompetitive conduct (in addition to mergers and acquisitions). For example, some dominant hospital systems' contracts forbid insurers from using financial incentives to "steer" patients to other (typically smaller and less expensive) providers[11] and/or may prohibit insurers from contracting with only a subset of the

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[8] Hospital merger count is based on data from the American Hospital Association and summarized by M. Gaynor in https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/.

[9] Carol Kane, "Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees," White paper, American Medical Association, 2019, https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf; Carol Kane and David Emmons, "New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment," White paper, American Medical Association, 2013, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/health-policy/prp-physician-practice-arrangements_0.pdf; Michael Furukawa et al., "Consolidation Of Providers Into Health Systems Increased Substantially, 2016–18," *Health Affairs* 2020 39(8): 1321–1325.

[10] Commercial health insurance markets have grown increasingly consolidated as well. By 2021, 75 percent of metropolitan areas were "highly concentrated" as defined in the FTC/DOJ *Horizontal Merger Guidelines.* American Medical Association, "Competition in Health Insurance: 2022 Update," Although I limit my attention in this testimony to provider consolidation, I note that there is evidence on the effects of insurer consolidation as well. In particular, studies find more competition among insurers leads to lower premiums for employer-sponsored coverage as well as plans offered on the Health Insurance Exchange. For additional details see L. Dafny, "How Health Care Consolidation Is Contributing to Higher Prices and Spending, and Reforms That Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets," Testimony to the U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, April 29, 2021.

[11] Hospital systems that know they are indispensable in their markets sometimes agree to participate in insurance products in which there are no out-of-pocket differences among providers, but refuse to participate in products in

dominant system's providers (e.g., blocking an insurer from including just some of the system's specialists in-network).[12] Such "all or nothing" contracting can enable a system to allocate services efficiently across different facilities, but it can also be a means for a system with market power to potentially expand its reach by "tying" access to its providers in more competitive markets to access to its most highly-valued providers.[13]

Below, I provide a brief summary of the empirical evidence on the effects of provider consolidation.[14] I emphasize studies published in peer-reviewed, academic journals.

**A. Expansion of hospital systems within and across geographic areas increases prices**

Hospitals account for over 30 percent of U.S. health care spending and 5.7 percent of GDP.[15] The landscape of the U.S. hospital industry has changed significantly in the past half-century, with the share of hospitals operating independently declining from 90 percent in 1970 to 33 percent in 2019. This consolidation has occurred both within and across geographic markets. By 2019, nearly one-third of hospitals belonged to systems with 20 or more other hospitals.[16]

Researchers have studied the effects of hospital mergers for several decades now, and there is substantial, robust evidence showing that hospital mergers, on average, lead to higher commercial prices.[17] This research, which has focused on mergers among hospitals serving patients in the same geographic area, finds that combinations of close rivals yield the largest price effects.[18] Joining forces with a competitor enables the merged system to negotiate a higher price with insurers, who can no longer turn to the competitor if they fail to agree on price with

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which there are "tiers" with different co-payments, based upon the prices of the providers. These conditions can render tiered products unviable in that market.

[12] *See*, e.g., E. Mitchell, "Seizing on the Sutter Health Settlement to Create Competitive Health Care Markets Nationwide," https://www.milbank.org/2020/01/seizing-on-the-sutter-health-settlement-to-create-competitive-health-care-markets-nationwide/.

[13] That is, under an all-or-none contract, the dominant system requires insurers, as a condition of contracting with its most highly-valued hospitals and medical groups, to also contract with the system's less highly-valued providers (even of the price and quality of those providers are such that the insurer would otherwise choose not to contract with them).

[14] For more comprehensive summaries, see RAND: Liu et al., 2022.

[15] Figures from Centers for Medicare and Medicaid Services, National Health Expenditures, for CY 2021.

[16] Fulton et al.,"The Rise of Cross-Market Hospital Systems and Their Market Power in the US," *Health Affairs* Nov 2022 41(11): 1652-1660.

[17] For additional discussion and study citatons, see M. Gaynor, "Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets," Testimony before the Committee on the Judiciary, Subcommittee on Antitrust, Commercial, and Administrative Law, U.S. House of Representatives, March 7, 2019 and Z. Cooper, "Consolidation and Corporate Ownership in Health Care", Testimony before the Seante Committee on Finance, June 8, 2023.

[18] For a recent example, see Brand et al, "In the Shadow of Antitrust Enforcement: Price Effects of Hospital Mergers from 2009-2016," *Journal of Law and Economics,* forthcoming.

one of the hospitals. Studies also find that in markets that are more consolidated, price levels are higher and price growth is steeper.[19]

While most research on the impact of hospital consolidation focuses on "within market" or horizontal mergers, recent studies have evaluated the effects of so-called "cross market" hospital mergers, or combinations occurring among hospitals in different, sometimes adjacent, geographic markets.[20] This research shows that acquisitions of hospitals, even by hospital systems without a local presence, often leads to substantial price increases both for acquired hospitals and for acquiring hospitals located in the same state.

Importantly, numerous studies fail to find systematic evidence of benefits to consumers from mergers in terms of clinical outcomes or patient experience, and many studies link more hospital competition to higher quality.[21] While some research finds evidence of modest cost savings from hospital consolidation – specifically mergers of hospitals in different geographic areas - the substantial body of evidence that prices increase on average after hospital mergers implies that such savings are typically not sufficiently large or not "passed through" via lower prices.[22] To sum it up: due to consolidation we are paying more for our hospital care, and there is no evidence that we are getting more in return.

Researchers have also found evidence that hospitals in more concentrated markets are less likely to receive fixed, prospective payments – a payment methodology that creates incentives for providers to control costs – and more likely to receive payments linked to billed charges.[23] This pattern shows that hospitals with market power are better-positioned to reject cost-containing payment innovations by insurers.

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[19] For a summary, see M. Gaynor and R. Town, "The Impact of Hospital Consolidation - Update." Policy Brief No. 9, The Synthesis Project, Robert Wood Johnson Foundation, Princeton, NJ, June 2012.

[20] L. Dafny, K. Ho, and R. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *RAND Journal of Economics* 50, no. 2 (2019): 286–325, https://doi.org/10.1111/1756-2171.12270; M. Lewis and K. Pflum, "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions," *RAND Journal of Economics* 48, no. 3 (2017): 579–610, https://doi.org/10.1111/1756-2171.12186.; Matt Schmitt, "Do Hospital Mergers Reduce Costs?," *Journal of Health Economics* 52 (2017): 74–94, https://doi.org/10.1016/j.jhealeco.2017.01.007.

[21] E.g., D. Kessler and M. McClellan, "Is Hospital Competition Socially Wasteful," *Quarterly Journal of Economics* 115, no. 2 (2000): 577–615; Studies of quality competition in the U.K. include Z. Cooper et al., "Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms." *The Economic Journal* 121, no. 554 (2011), 228–260., and M. Gaynor et al, "Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service," *American Economic Journal: Economic Policy* 5, no. 4 (2013): 134–66. Cooper et al. studied the introduction of greater competition among hospitals into the English National Health System and find that heart attack mortality decreased the most in areas with the greatest increases in competition. Gaynor et al. study the same English NHS reforms but examine a broader set of quality and efficiency measures and find that hospital competition improves quality without lowering costs.

[22] Schmitt, Matt, "Do Hospital Mergers Reduce Costs?" Journal of Health Economics, 2017, Vol. 52, pp. 74-94.

[23] Specifically, hospitals are less likely to be paid based on patients' diagnoses and conditions (as under Medicare's Prospective Payment System), and more likely to be paid based on their list charges, giving hospitals an incentive to render more care and to increase list charges. Cooper et al. (2019), *supra* note 3.

Researchers have also examined the effects of consolidation on health care workers. These studies find that wage growth for health care workers declines in the wake of hospital and insurer mergers that result in large increases in market concentration.[24] The economics underlying these findings is straightforward: just as market power enables suppliers to charge more for their output (i.e., health care services or insurance plans), it also enables them to pay less to employees, particularly those with industry-specific skills.[25] The wage growth slowdowns attributable to hospital mergers are attenuated in markets with stronger labor unions. Health care worker unions have garnered national attention in recent months, owing to the strike by 75,000 employees of Kaiser Permanente and the announcement on October 13 by physicians at a major Midwest system, Allina, that they had voted to unionize. Steps toward unionization have also been taken by physicians-in-training throughout the country.

To the extent that hospital consolidation leads to lower wages and poorer terms of employment, it will exacerbate burnout among health workers, an issue of growing concern for our nation.[26]

**B. Consolidation of physicians also leads to higher prices and spending**

Physician markets have also experienced extensive consolidation in recent years. Figure 3 depicts the number of publicly announced physician mergers and acquisitions between 2012 and 2022. Perhaps the most significant phenomenon affecting physician markets in the past decade has been the acquisition of physician practices by hospitals. The American Medical Association, the professional association of physicians, reports the share of physicians working directly in hospitals or in practices with partial or full hospital/health system ownership increased from 29 percent in 2012 to 41 percent in 2022. Other sources place the current share at over 50 percent.[27] Another significant trend is the growth of physician employment by corporations such as insurers (notably Optum, a subsidiary of United Healthcare, the nation's largest health insurer), private-equity firms, and companies like CVS Health, Walgreens, WalMart, and Amazon.

Research on physician mergers and consolidation mirrors the findings from the hospital consolidation literature, although the body of research is smaller. Physician prices are higher in

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[24] E. Prager and M. Schmitt, "Employer Consolidation and Wages: Evidence from Hospitals," *American Economic Review*, 2021, Vol. 111(2), pp. 397-427. L. Dafny et al, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry," *American Economic Review*, 2012, Vol. 102(2), pp. 1161-1185.

[25] Prager and Schmitt find the effects of mergers on wage growth are stronger among those with industry-specific skills, such as nursing and pharmacy workers. Consistent with economic theory, they find no effect of mergers on wage growth among unspecialized workers whose roles are not unique to the hospital setting, such as cafeteria workers. They are unable to examine physician incomes using their data sources.

[26] See, for example, "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce," Department of Health and Human Services, 2022.

[27] A study commissioned by the Physicians Advocacy Institute and performed by Avalere Health reports 52.1 percent of physicians were employed by a hospital or health system in January 2022.

more concentrated physician markets.[28] There is evidence that physician prices increase following mergers in the same specialty and geographic area, and when generalists are integrated with specialists in the same organization.[29] In addition, many studies find higher prices and spending following hospital acquisition of physician practices. For example, one study based on detailed commercial claims data finds average price increases of 14 percent.[30] Importantly, these affiliations are associated not only with price increases but also with a shift of patients toward higher-priced hospitals and higher-priced services – yielding an increase in spending even if prices were held constant.[31] A study published just last month found that when primary care physicians are part of large health care systems, patients have more specialist visits and higher total spending; more care is also provided within the integrated system, yet the authors found no change in readmission rates.[32]

Evidence of improvements in patient outcomes with physician consolidation is elusive. One recent study finds only negligible effects of vertical integration of hospitals and physicians on a set of health outcome measures.[33] Other research likewise finds either no relationship or a positive but small relationship between vertical integration of hospitals with physicians and measures of quality.[34] One recent working paper finds the recent increase in integration of gastroenterologists with hospitals has led to significant changes in care processes – including

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[28] A. Dunn and A. Shapiro, "Do Physicians Possess Market Power?" *Journal of Law & Economics* 57, no.1 (2014):159-193; L. Baker et al. "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits," *JAMA* 312, no. 16 (2014): 1653–62.

[29] T. Koch and S. Ulrick, "Price Effects of a Merger: Evidence From a Physicians' Market," *Economic Inquiry* 59, no. 2 (2021): 790–802. L. Baker et al., "Does Multispecialty Practice Enhance Physician Market Power?" *American Journal of Health Economics,* Summer 2020.

[30] Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," *Journal of Health Economics* 59 (2018): 139–152. The authors estimate hospital acquisitions of physician practices increase prices by 14% on average, with about half the increase attributable to higher unit prices and half to payment rules that reimburse services performed at or billed through a hospital at a higher rate. *See also*, Caroline Carlin, Roger Feldman, and Bryan Dowd, "The Impact of Hospital Acquisition of Physician Practices on Referral Patterns," *Health Economics* 25 (2016): 439–454; Hannah T. Neprash *et al*., "Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices," *JAMA Intern Med.* 175, no. 12 (2015): 1932–1939; James Robinson and Kelly Miller, "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California," *JAMA* 312, no. 16 (2014): 1663–1669.

[31] L. Baker, M. Kate Bundorf, Daniel P. Kessler, "The effect of hospital/physician integration on hospital choice," *Journal of Health Economics*, Volume 50, 2016, Pages 1-8.

[32] A. Sinaiko et al, "Utilization, Steering, and Spending in Vertical Relationships Between Physicians and Health Systems. JAMA Health Forum. 2023;4(9).

[33] Thomas Koch, Brett Wendling, and Nathan E. Wilson, "The Effects of Physician and Hospital Integration on Medicare Beneficiaries' Health Outcomes," *Review of Economics and Statistics*, March 2020.

[34] Marah Short and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review* 77, no. 6 (2020): 538–48,; Rachel Machta, et al., "A Systematic Review of Vertical Integration and Quality of Care, Efficiency, and Patient-Centered Outcomes," *Health Care Management Review* 44, no. 2 (2019): 159–173.

greater use of anesthesia with deep sedation – and a substantial increase in post-procedure complications and spending.[35]

A number of studies have shown that Medicare's preferential reimbursement for services delivered in hospital-owned sites is a key driver of physician-hospital integration.[36] One study attributes a sizeable share of the overall increase in hospital employment of physicians between 2009 and 2013 to a change in Medicare reimbursements in 2010 that led to a further relative increase in payments for services performed in hospital-owned sites, observing that "organizational structure responds to profit incentives."[37]

As private-equity firms acquire more physician practices, research on the prevalence and repercussions of these transactions is growing. Private-equity firms typically acquire multiple practices over time, and often amass significant market share within certain specialties and geographic areas. Once they acquire practices, they tend to increase volume and spending by insurers. For example, one recent study of 578 dermatology, gastroenterology, and ophthalmology physician practices that had been acquired by private equity companies found an 11 percent increase in price per claim, as well as a 38 percent increase in visits by new patients, as compared to 2,874 similar independent practices.[38] Another study found statistically significant commercial price increases following private-equity acquisitions in 8 of 10 specialties studied.[39] A study of the effect of private-equity acquisition of ophthalmology practices on Medicare enrollees finds an increase of 22 percent in the use of higher-cost treatments.[40]

Recently, the FTC sued U.S. Anesthesia Partners, the dominant provider of anesthesia services in Texas, and private-equity firm Welsh, Carson, Anderson & Stowe, alleging that they executed a "multi-year anticompetitive scheme to consolidate anesthesiology practices in Texas" that

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[35] Saghafian et al, "The Impact of Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices," *National Bureau of Economic Research Working Paper Series* No. 30928, 2023.

[36] For example, in 2019 the payment rates for a midlevel (Level 4) office visit for an established patient were $110.28 if provided in an independent physician office and $195.86 if provided in a hospital-affiliated site of care. *MedPAC Report to Congress,* March 2020 Ch. 15. Relevant studies include Dranove D, Ody C. Employed for higher pay? how Medicare payment rules affect hospital employment of physicians. Am Econ J Econ Policy. 2019;11(4):249-271; Post B, Norton EC, Hollenbeck B, Buchmueller T, Ryan AM. Hospital-physician integration and Medicare's site based outpatient payments. Health Serv Res. 2021;56(1):7-15; Song Z, Wallace J, Neprash HT, McKellar MR, Chernew ME, McWilliams JM. Medicare Fee Cuts and Cardiologist-Hospital Integration. JAMA Intern Med. 2015 Jul;175(7):1229-31; and Saghafian et al., 2023, *supra* note 35.

[37] Dranove and Ody, 2019, ibid. Note that hospital-affiliated physicians do not need to treat patients in a hospital outpatient department in order to bill a "facility fee."

[38] Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. "Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization," *JAMA Health Forum*. 2022;3(9): e222886.

[39] Private-equity investments are common in other healthcare sectors as well, including hospitals and nursing homes. For an overview see "The Growth of Private Equity in US Health Care: Impact and Outlook," *NIHCM Expert Voices* Brief, May 2023.

[40] Y. Singh et al, "Increases in Medicare Spending and Utilization following Private Equity Acquisition of Retina Practices," *Opthalmology* 2023.

resulted in growing monopoly power and prices "double the median rate of other anesthesia providers in Texas."[41] This marks the first lawsuit of its kind by federal enforcers, signaling their concern about serial acquisitions or "rollups" that engender market power as well as the strategies adopted by some private-equity backed provider organizations.

### C. Consolidation in other provider sectors is also linked to higher prices and lower quality

In the interest of brevity, my testimony focuses on the two largest and best-studied provider sectors: hospitals and physicians. However, there are studies of provider consolidation in other subsectors, and many studies of which I am aware echo the results obtained in the hospital and physician consolidation. These include studies of kidney dialysis centers and nursing homes.[42]

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As I highlight below, studies such as those described in the sections above are increasingly difficult to perform, as researchers have limited and expensive access to data – particularly commercial claims data. These studies are critical for understanding the drivers of price and spending growth for commercial and public insurers alike, and for illuminating important changes or stasis in modes of health care delivery and outcomes.

## III. Federal antitrust enforcement requires more resources and legislative support to have greater impact

Americans rely on the federal antitrust enforcement agencies to enforce our competition laws, which prohibit both anticompetitive conduct and mergers. This is not the setting for a comprehensive discussion of U.S. antitrust enforcement, however it is important to acknowledge that (1) substantial anticompetitive consolidation has occurred notwithstanding the existence of federal agencies tasked with preventing it; (2) there have been recent efforts to reinvigorate enforcement, including the release of draft Merger Guidelines by the DOJ and FTC ("the Agencies") which highlight the Agencies' plans to investigate and challenge the types of transactions that are driving consolidation of health care providers.

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[41] "FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas," news release, September 21, 2023.

[42] "How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry," with Ben Heebsh, Ryan McDevitt, and James Roberts, Quarterly Journal of Economics, February 2020. A. Gupta et al. Does private equity investment in healthcare benefit patients? Evidence from nursing homes. No. w28474. National Bureau of Economic Research, 2021; T. Wollman, "How to get away with merger: stealth consolidation and its real effects on US healthcare," *National Bureau of Economic Research* working paper, February 2022.

There are many reasons for the rise of consolidation in health care provider sectors in spite of antitrust enforcement, including

- Limited visibility and timeframe to investigate smaller proposed mergers and acquisitions because federal pre-merger reporting is required only for transactions that exceed high dollar and party size thresholds, and many provider merger fall beneath these thresholds. Even if the agencies become aware of so-called "non-reportable" transactions, the parties may legally merge before an Agency has reviewed the transaction. Unwinding consummated transactions is notoriously difficult, reducing the odds of a resolution that restores competition.
- Judicial and Agency interpretations of the Clayton Act, which prohibits mergers and acquisitions when "the effect may be substantially to lessen competition, or tend to create a monopoly," as well as the high legal burden the government faces for challenging anticompetitive transactions and conduct.[43]
- Stagnating budgets for the Agencies despite a growing and consolidating economy, more and larger transactions, and an increase in resources required to investigate or challenge them.

In light of stagnating budgets, the Agencies have devoted an increasing share of their resources to preventing further structural consolidation, leaving ever limited resources to investigate and challenge anticompetitive *conduct*.[44] Some current examples in health care include "all or none" and "anti-steering" clauses in contracts demanded by dominant provider organizations, efforts by such organizations to impede patients' access to unaffiliated, lower-cost providers of some services, and referral of profitable patients to within-system providers and unprofitable patients elsewhere.[45]

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[43] For additional discussion of potential changes to the antitrust statutes which would facilitate vigorous enforcement, see L. Dafny, "How Health Care Consolidation Is Contributing to Higher Prices and Spending, and Reforms That Could Bolster Antitrust Enforcement and Preserve and Promote Competition in Health Care Markets," Testimony to the U.S. House Committee on the Judiciary Subcommittee on Antitrust, Commercial and Administrative Law, April 29, 2021.

[44] The antitrust agencies can and have investigated conduct by dominant actors in the health care system that may lessen competition. For example, DOJ successfully challenged a health insurer's use of most favored nation (MFN) and "MFN+" provisions that contractually required hospitals to not negotiate lower prices—and sometime specified higher prices—to the dominant insurer's rivals. DOJ, "Justice Department Files Motion to Dismiss Antitrust Lawsuit Against Blue Cross Blue Shield of Michigan After Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts," Press release, Mar. 25, 2013. In another action, the DOJ successfully ended a dominant hospital system's use of "anti-tiering" provisions that prevented insurers from using narrow and tiered networks to steer patients to the system's rivals. DOJ, "Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions," Press release, Nov. 15, 2018.

[45] See, for example, Cutler et al, "Vertical Integration of Healthcare Providers Increases Self-Referrals and Can Reduce Downstream Competition: The Case of Hospital-Owned Skilled Nursing Facilities," *NBER Working Paper 28305*, updated 2023.

Even if antitrust enforcement is reinvigorated and proves successful, it will be insufficient to address the harmful consequences of consolidation that has already taken place, or to address the lack of competition inherent in some markets that are too small to support multiple competing providers. For these reasons, I am among the set of health care economists calling for some form of price regulation, specifically caps on the highest commercial prices.[46] There are a number of ways to implement such caps, which could be applied to bind prospectively, could apply to either or both in-network and out-of-network providers, and could be based on commercial or Medicare rates.[47] Price caps can also be complemented with restrictions on the rate of price growth permitted for providers of varying price levels, and flexible oversight to address evasion.

It will be most feasible for states to experiment with such caps or limits on price growth, and some are already taking steps toward doing so.[48] However, any such efforts will be significantly hampered without access to data about the prices actually being paid for commercial services as well as the quantity and nature of services being delivered. This is infeasible without action by federal legislators to facilitate the creation of an All Payer Claims Database, as I discuss next.

**IV. Recommendations**

1. **Establish and fund an All Payer Claims Database (APCD).**

   A national APCD will enable regulators and researchers to track and analyze the effects of consolidation. This database would contain health care claims submitted by self-insured group health plans, federal insurance programs, and fully insured individual and group health plans. *States cannot achieve this goal without federal intervention* owing to the fact that self-insured plans are regulated under the federal ERISA statute, and a 2016 Supreme Court decision barred states from requiring self-insured plans to supply insurance claims to a state APCD.[49] While some states that had already built APCDs before the decision continued to

[46] For details, see Michael Chernew, Leemore Dafny, and Maximillian Pany, "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market," *Policy Proposal 2020-08*, The Hamilton Project, Brookings Institute, March 2020.

[47] For a review of alternative proposals to address prices, including price regulation, see "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," Congressional Budget Office Report, September 29, 2022.

[48] For a survey of healthcare antitrust enforcement and regulation by states, see C. Capps, T. Shvydko, and Z. Zabinski, "Healthcare Antitrust Enforcement and Regulation by the States," Stigler Center, *The Economics of US Healthcare: Competition, Innovation, Regulation, and Organizations*, Ch. 7.

[49] The case is *Gobeille v. Liberty Mut. Ins. Co*. The No Surprises Act enacted in December 2020 required the formation of a State All Payer Claims Databases Advisory Committee, "charged with advising the Secretary of Labor regarding the standardized reporting format for the voluntary reporting by group health plans to State All Payer Claims Databases." The Committee offered recommendations regarding standardizing data format and submissions, data privacy and security issues, and "voluntary data submission processes." The Act also authorized grants to support State APCDs, but funds for these grants have not been appropriated to date.

operate them, and others are underway, without data from self-insured plans it is impossible for states to obtain a comprehensive assessment of utilization, spending, and prices. In addition, developing and maintaining APCDs on a state-by-state basis is expensive and duplicative, requiring each state to establish data standards and an infrastructure.[50] Finally, access to APCDs by researchers and regulators has been limited to date; legislation to develop and govern a national APCD could facilitate such access and speed the ability of researchers, regulators, and policymakers to use the data to develop actionable insights. The APCD would also be of great value to states in implementing surprise billing reforms.

2. **Increase funding for federal antitrust enforcement agencies.**

Notwithstanding substantial economic growth and an increase both in reported transactions and in the degree of consolidation across a range of industries – heightening the need for merger reviews as well as non-merger or "conduct" investigations – funding for the antitrust enforcement activities of the FTC and the DOJ has stagnated over the past several decades. For example, while GDP increased in real terms by over 55 percent between 2000 and 2022, the budget allocation to the Antitrust Division increased just 2.6 percent.[51]

Approximately *half* of enforcement actions by the FTC are in the health care sector. The FTC also requires funding to complete "6(b)" studies, which provide valuable insight into industries and practices; two such studies in the health care space are currently underway, including a study to assess the impact of physician consolidation.[52] The DOJ also devotes significant resources to healthcare matters, including two successful challenges of proposed health insurer mergers in 2017. The draft Merger Guidelines released jointly by the Agencies in July 2023 signal that the Agencies' intent to increasingly investigate and challenge conduct as well as transactions that are common in the health care industry. In addition to ensuring that Agency funding reflects the bipartisan aims of the Merger Modernization Act, additional appropriations are sorely needed to support increased enforcement and to modernize the information technology essential to performing data- and document-intensive investigations.

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[50] As of 2021, 18 states had legislation mandating the creation and use of APCDs or were establishing an APCD, and others were in various stages of development, per the Agency for Healthcare Research and Quality. However, grants to support state APCDs, legislated under the No Surprises Act, have not been appropriated.

[51] Growth in real GDP calculated using seasonally adjusted data for calendar years 2000 and 2022, reported by the St. Louis Federal Reserve Bank in chained 2017 dollars. Growth in real appropriations to the Antitrust Division of DOJ is calculated using annual appropriation amounts reported by DOJ, for fiscal years 2000 and 2022, deflated by the Consumer Price Index obtained from https://www.usinflationcalculator.com/.

[52] "FTC to Study the Impact of Physician Group and Healthcare Facility Mergers," FTC news release, Jan. 14, 2021.

3. **Support "site-neutral" payment reform for Medicare**

Higher Medicare reimbursement for hospital-affiliated services has led to an increase in hospital-physician integration, which in turn drives greater utilization of hospital-affiliated services, higher commercial prices, and higher total spending by all payers. Given that Medicare's payment structure is often mimicked by private insurers, inaction by the federal government is exacerbating a situation that drives higher spending and greater expansion by hospitals.

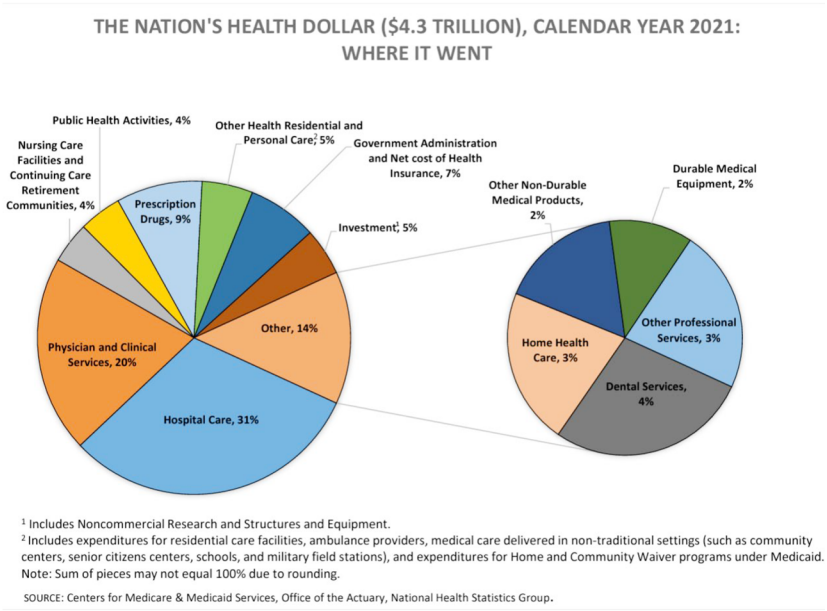
The Medicare Payment Advisory Commission (MedPAC) has studied this issue extensively and made a set of recommendations on aligning payment rates across ambulatory settings.[53] Taking steps toward site neutral payments can reduce the incentive to consolidate and to continue providing care in expensive settings.

[53] June 2023 Report to the Congress: Medicare and the Health Care Delivery System.

**Figure 1. International Medical Prices for Selected Services as a Percentage of U.S. Price**


Source: Chernew, ME, Dafny, LS, Pany, MH. "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health Care Market," *Policy Proposal 2020-08*, The Hamilton Project, Brookings Institute, March 2020. The chart compares the median prices paid by a sample of private health insurance companies for specific health care services in nine countries.

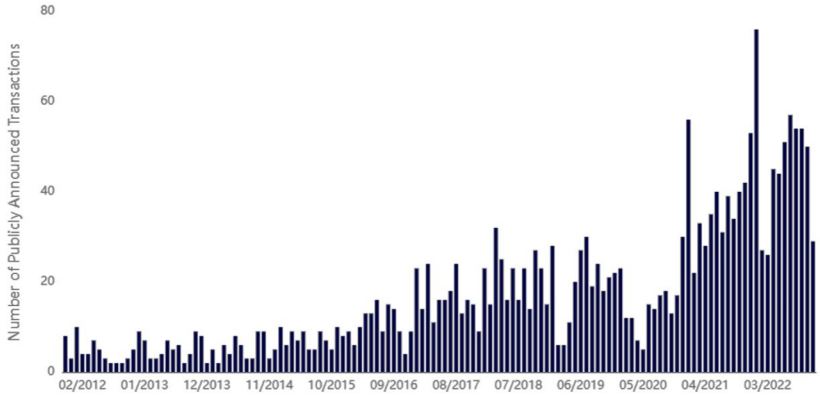
**Figure 2. U.S. Health Care Spending, By Category, 2021**




[1] Includes Noncommercial Research and Structures and Equipment.
[2] Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

**Figure 3. Physician Group Mergers and Acquisitions by Month, 2012-2022**




Source: *Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes: Baseline Trends and Framework for Analysis - Report One*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 2023, Figure 3-3 p. 18. Original Data Source, LevinPro HC, Levin Associations, December 2022.

**Testimony of G. Alan Kurose, MD MBA FACP**

Before the United States Senate
Committee on the Budget

October 18, 2023

Chair Whitehouse, Ranking Member Grassley, and members of the Committee, thank you for inviting me to address the topic of managing patient care and population health to reduce healthcare costs. Happily, when done correctly, such efforts also typically improve the patient's experience of care and their health outcomes. But this work is far from simple.

My name is Dr. Al Kurose. In my first career as a primary care internist, I saw patients every Monday through Friday in the same suburban community office practice for almost twenty years. Fifteen years ago, I transitioned to a second career as CEO of Coastal Medical, a large primary care practice in Rhode Island that transformed itself into a nationally recognized, tech-enabled, data-driven Accountable Care Organization (ACO) with consistently high performance on cost, quality, and patient experience of care. For the last two and a half years, Coastal has been a part of the Lifespan Health System. I served as Senior VP of Primary Care and Population Health for the system for most of that time. I am grateful for the many innovative federal programs, such as Meaningful Use, the Medicare Shared Savings Program (MSSP), CPC+, and others that have been crucial enablers of much of this rewarding and complex work.

I also served for the last five years as a co-chair of the RI Health Care Cost Trends Steering Committee, a publicly convened group of payers, providers, employers, patient advocates, and regulators collectively committed to controlling the growth of healthcare costs in Rhode Island. I currently serve as Board Chair of the Rhode Island Foundation, one of the twenty largest community foundations in the country. The opinions expressed here are my own.

I will make three main points.

1. Despite the daunting complexities we face and our track record to date, as a healthcare industry, I believe **we *can* transform how care is delivered and paid for in ways that will reduce costs and make things better for patients.** In many cases, we already know what to do. Executing sustainably and at scale is challenging.

2. **Primary care is the foundation of any high performing healthcare delivery system and right now, primary care is in crisis**. Access to primary care is a problem in many if not most communities, and provider burnout is rampant. Help is needed in the form of workforce development, enhanced compensation, robust team-based care, and primary care capitation.

3. **Primary care is *necessary but not sufficient*** to sustainably achieve the Triple Aim of better care and better health at a lower cost. The efforts of primary care driven models of

> accountable care, by themselves, to control total cost of care can be overwhelmed by the effects of pricing and the economic behavior of other providers. I believe **continued incremental movement away from fee-for-service payment and toward prospective payment and value-based payment models - for hospitals, specialists, and primary care - will be needed** to sustainably mitigate unrelenting increases in U.S. healthcare costs.

**Have ACO's been effective, and which models have performed best? What has Coastal's experience been?**

The 2021 National Academy of Sciences Engineering and Medicine (NASEM) Report "Implementing High Quality Primary Care" summarizes the available evidence on effectiveness of ACO's as follows:

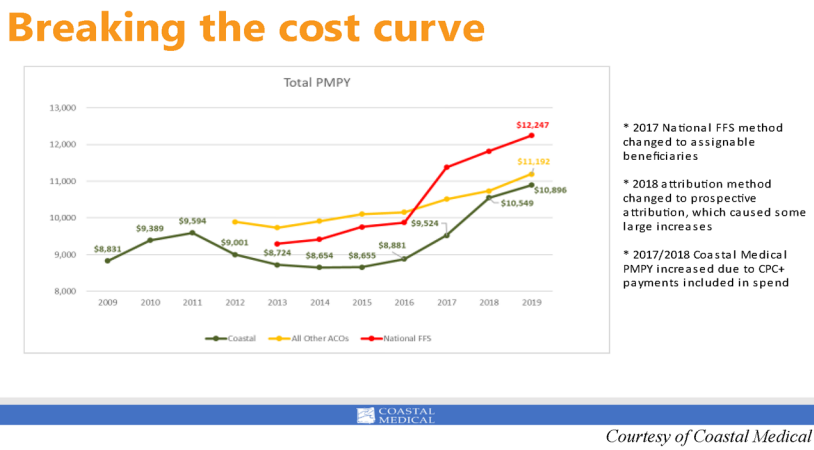
> "In general, research on the impact of ACO's shows modest savings in total spending alongside quality and patient satisfaction improvements…Research has demonstrated that ACO's with a higher share of PCMH (Patient Centered Medical Home) practices and a greater percentage of PCP's (Primary Care Physicians) perform better on cost and quality outcomes. Similarly, physician-led ACO's, compared to hospital-integrated ACO's, produce greater savings."

Dranove and Burns in their 2021 book *Big Med* add the observation that in the Medicare Shared Savings Program "Smaller ACO's (with a mean number of beneficiaries less than ten thousand) achieved greater net savings per beneficiary than larger ACO's." This finding highlights the challenge of managing the total cost of care of populations at scale. They also make a salient observation echoed by many ACO's:

> "What none of these analyses (of CMS ACO savings) addressed was how much money, time, and energy providers had to invest up front to reap these savings."

The issue of new costs for ACO's - both one-time and recurring - was highly relevant at Coastal, which early on built out new human and technological infrastructure to an extent disproportionate to its relatively small MSSP ACO population size of 10,000 beneficiaries at the time. One advantage was that Coastal took an all-payer approach early in its journey of accountable care. The second was that Coastal's ACO experience was fortunately significantly more positive than the MSSP average. Early on, Coastal was able to reinvest 85% of value-based revenue to support value-based care, with the remaining 15% allocated to physician and staff incentive compensation. In terms of impact on total cost of care, Coastal not only "bent" it's cost curve for population total cost of care starting in 2012, it "broke" it (see green line in the graph below).

**Fig. 1. *Breaking the Cost Curve*, 2019**

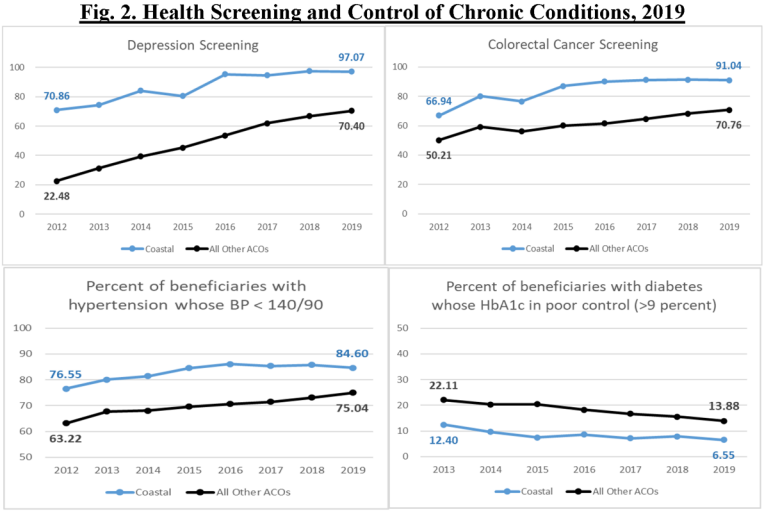



*Courtesy of Coastal Medical*

At Coastal, some of the largest cost savings were related to observed reductions in visits to hospital emergency departments, admissions to hospitals, and readmissions to hospitals. Coastal's hospital admissions in the MSSP were reduced by 25% in the first three years.

From 2012 to 2019, Coastal also achieved steady improvements in health screening and control of chronic conditions, as exemplified in the graphs below.

**Fig. 2. Health Screening and Control of Chronic Conditions, 2019**




*courtesy of Coastal Medical*

The data presented above ends with 2019, by design. Beginning in 2020, the pandemic created significant volatility in utilization of services and cost performance and impacted patient and provider behavior in numerous complex ways for ACO's and the entire delivery system. In Rhode Island, COVID-19 restrictions caused an abrupt reduction in the use of in-person health care in 2020, which in turn caused a sharp drop in per capita spending on healthcare. Utilization rebounded in 2021, with large year over year increases in commercial and Medicare spending. Labor shortages, diminished clinical revenue, wage increases for staff, and fluctuating demand for services were commonly voiced challenges across a broad range of provider types. I've chosen to largely exclude pandemic-related issues from this testimony, in favor of pattern recognition and lessons learned over a longer period of less turbulent times. But I would be remiss not to mention that it is well accepted that the pandemic exposed longstanding inequities in access to care and health outcomes and revealed the economic fragility of many types of providers, including primary care. It also drove large numbers of healthcare workers at every level from the profession.

***How* Have Coastal and Similar ACO's Been Able to Impact Costs, Patient Experience and Outcomes?**

There is an oft-repeated truism that when it comes to managing total cost of care for populations, that "there is no silver bullet." What then is the solution? Part of the answer, based on the experience of Coastal and other physician led ACO's, seems to be an extensive portfolio of centralized clinical programs that go beyond what most small traditional primary care offices can offer. At Coastal, that portfolio includes:

- "Coastal 365" urgent primary care clinics open weeknights, weekends, and holidays
- Disease management programs for patients with congestive heart failure, COPD, diabetes, and hypertension
- Nurse care managers who manage panels of high-risk patients and round on patients in hospitals and nursing homes, as well as patient navigators and social workers
- A Transitions of Care team that reaches out to patients after discharge from a hospital, emergency department, or nursing home to reconcile medications, ensure appropriate primary care and specialty follow-up, and solve any problems with access to care
- Pharmacy programs that include a prescription refill program and antibiotic and narcotic stewardship, as well as participation in disease management and home visit programs
- Integrated behavioral health program
- Non-operative orthopedic/musculoskeletal health program
- Multidisciplinary home visit program
- Strong affiliation with HopeHealth, a high performing palliative care and hospice provider

Each ACO customizes their portfolio of programs based on available resources and patient needs. Benefits of such programs go well beyond controlling utilization and costs to improve experience of care and health outcomes for patients, especially those with chronic illnesses.

ACO's also need new specialized business capabilities that again go beyond what would be in scope for a more traditional primary care practice. At Coastal these include:

- Extensive capacity to measure and report quality measures
- New patient facing technologies for communication and clinical monitoring
- Analytics based on claims and the electronic medical record (EMR) to generate actionable reports
- A centralized team to manage and track referrals to specialty care
- A centralized team to answer patient calls and schedule appointments across all open offices to optimize care in the outpatient setting
- Actuarial support to inform the viability of contracted payment models specific to each covered population of patients.

Again, each ACO builds out such capabilities differently, based on available resources and needs.

**At the Highest Level, How Does the Experience of Physician-led ACO's Speak to the Challenge of Managing Care to Control Costs?**

The answer here goes to my first main point which is that as a healthcare industry, **we *can* transform how care is delivered and paid for in ways that will reduce costs and make things better for patients,** and in many cases, we already know what to do. The MSSP experience tells us that executing at scale is challenging, but that smaller physician-led ACO's *have* developed capabilities and implemented programs that have moved the needle on managing total cost of care. We can apply the lessons learned from that experience more broadly – to both different types of provider organizations – and to different payer populations. At Coastal, many (not all) of the lessons from the MSSP experience were transferable to Medicare Advantage, Medicaid, and commercial ACO care models and payment models, and the converse was also sometimes true as value-based care lessons from experience with Blue Cross Blue Shield of RI and other payers helped inform Coastal's work under the MSSP.

The portfolio of clinical services that Coastal offers today goes well beyond what I could ever have imagined when I was practicing primary care physician there in the early 2000's. Management of chronic illness at Coastal today truly improves quality of life for patients, and all patients benefit from more timely and convenient access to care that now also includes telemedicine. The right care in the right place at the right time helps patients get better sooner, more safely, and with less expense. Under value-based payment, this offers a classic opportunity to do well by doing good.

A particularly cogent example of the value of providing the right care in the right place at the right time is found in Coastal's Diabetes Management Program. That program utilizes a team-based care model with pharmacists, nurses, and specially trained medical assistants; and remote patient monitoring featuring glucose meters that use cellular networks to automatically transmit blood sugar results and make them available to the care team in near to real time. This allows the team to reach out and interact with a diabetic patient in a timely manner if their sugar is getting too high or too low. By identifying this type of problem early, and speaking to the patient by phone or videoconference, the clinical team can explore the cause of the problem, and in many cases recommend immediate action to remedy the issue. In this way, the team can often help a patient to resolve a situation that might otherwise worsen and require an emergency department visit or hospital stay without such timely intervention. In the old model of primary care, more than a few patients in this circumstance might have simply entered the high or low blood sugar reading in their log book to be reviewed at the time their next visit in a few months, losing the opportunity to prevent a potentially significant health episode before that time.

**Why has Primary Care Access Become So Problematic, and What Can We Do About It?**

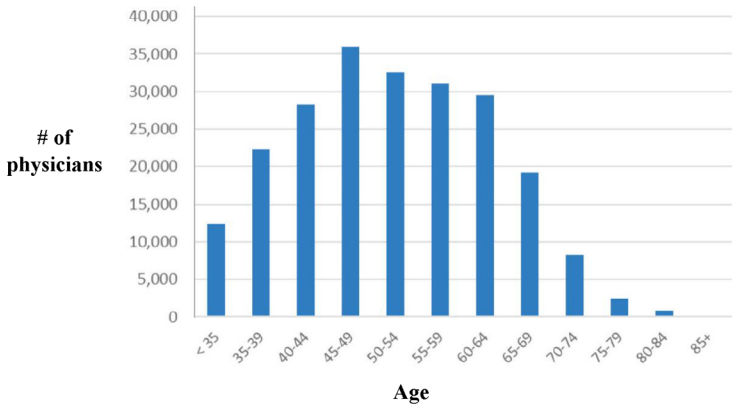
The 2021 NASEM report referenced above convincingly asserts that "high quality primary care is the *foundation* of a high-functioning health care system…and people in countries and health systems with high quality primary care enjoy better health outcomes and more health equity". The authors go on to assert that this foundation is crumbling in the U.S.:

> "Visits to primary care are declining, and the workforce pipeline is shrinking, with clinicians opting to specialize in more lucrative health care fields."

Chairman Sanders, in the Senate HELP Committee Hearing on September 21st, addressed the current crisis of access to primary care by stating "Everybody here knows we have a crisis. When you go home, your constituents will tell you, "I can't find a doctor."" He referenced an opinion piece by Elizabeth Rosenthal in *The Washington Post* in which she stated that more than 100 million Americans don't have usual access to primary care. That number has doubled since 2014.

A look at the age distribution of primary care physicians (PCP's) in the US in 2017, taken from the 2021 NASEM report referenced earlier, shows that PCP workforce demographics are clearly skewed to middle age and older, with 25 percent of PCP's being 60 years and older.

**Fig. 3. Age distribution of US primary care physicians**




*Source: Peterson, et al., 2018 as cited in 2021 NASEM Report*

These PCP workforce demographics are of particular concern given the demographic "bulge" in the US population of baby boomers that began turning 65 in 2011. In addition, the "great resignation" in healthcare associated with the pandemic only exacerbated workforce shortages since the time this data was collected. These factors appear to have created a perfect storm to precipitate the crisis of access in primary care that is now squarely upon us.

As to what can be done to address this crisis of access, workforce development initiatives such as those supported by the legislation coming out of the HELP Committee and enhancements to PCP compensation as recommended in the NASEM report both resonate strongly as requisite immediate next steps.

I will add two more. First, given the magnitude of the mismatch between current and future primary care supply and demand addressed above, we will need to experiment further with disruptive innovations in primary care delivery. Strengthening and expanding the care team so that clinicians other than the physician can deliver more patient care will take some of the pressure off of PCP's, and current leadership at Coastal has already moved forward on this work. Looking ahead as an industry, scope of practice regulations in some states may need to be modified to enable such changes in practice. Patient expectations may also need to change as some of the more routine interactions of patients with their PCP may become a thing of the past.

Requisite in this care transformation work will be listening carefully to PCP's, many of whom are experiencing significant burnout. Restoring professional satisfaction and a sense of personal agency amongst practicing PCP's is a "must have". In that context, care redesign must be collaborative, and driven by insights from the doctors and the rest of the clinical team.

Implementing primary care capitation as a substitute for fee-for-service payment can also improve the professional experience of PCP's by relieving the pressure of a schedule packed with back-to-back visits, all day long. Under primary care capitation, provider organizations are paid a risk adjusted fixed amount by the insurer "per member per month" (PMPM) for each patient receiving primary care, regardless of whether or not they receive in person care or other services during that time period. When providers are compensated for caring for a panel of patients instead of for each visit they provide, they are then empowered to spend more time on the care of the patients who need them the most, whether that be to call a patient or a family member or a consulting physician, or to see the patient for what would have been a billable visit under fee for service. The pressure to maintain a full schedule of visits to maintain a satisfactory income is relieved, and physicians can use their judgment about how to best spend their time in caring for the patients they serve.

Nesting a primary care capitation payment model within a larger contract structure with accountability for total cost of care and quality (such as the MSSP) preserves a complete set of Triple Aim incentives. A related point worth making is that value-based payment models at the organization level, with their built-in incentives intended to influence physician behavior, are not always translated into how physicians are compensated. And if those incentives aren't translated into physician compensation, they aren't as likely to be effective. This potential disconnect is increasingly relevant for primary care physicians given the observed consolidation in primary care, with one study referenced in the 2021 NASEM report indicating that 44% of PCP's were working in a practice owned by a hospital or health system as of 2017.

**What Else Can Be Done in Terms of Care Delivery to Mitigate the Unrelenting Increases in U.S. Healthcare Costs?**

In the preceding sections of this testimony, the focus has been largely on primary care and physician led ACO's. But it is important to remember that primary care only receives about 5% of total revenue in U.S. healthcare, and Coastal's positive experience notwithstanding, many ACO's of all types have learned the hard way that going at risk for total cost of care can be hazardous if your scope of influence over the care of your covered population of patients is limited. And the influence of primary care as a stand-alone *is* limited.

Early in my administrative career I heard about the balloon analogy for healthcare costs, which says if you squeeze one part of the cost balloon, it will bulge out somewhere else. In the work of the RI Cost Trend Steering Committee, we have seen this play out. One year, pharmaceutical costs are a big driver of cost trend, with utilization stable but prices rising. The next year, outpatient hospital services are a big cost driver. And as noted above, the pandemic was highly disruptive to management of cost and utilization performance. Providers and payers had to absorb those impacts on value-based payments and adapt accordingly.

Advocacy for aligned financial incentives across as many parts of the healthcare ecosystem as possible seems to be a logical approach to moving forward on containing costs. In practical terms, this translates to a recommendation for **continued incremental movement away from fee-for-service payment and toward prospective payment and value-based payment models - for hospitals, specialists, and primary care.** Thank you again for the opportunity to offer this testimony for your consideration.

Testimony Submitted to
the Senate Budget Committee:

"Improving Care, Lowering Costs:
Achieving Health Care Efficiency"
October 18, 2023

Theo Merkel
Director, Private Health Reform Initiative and Senior Research Fellow, Paragon Health Institute
Senior Fellow, Manhattan Institute

Thank you, Chairman Whitehouse and Ranking Member Grassley, for convening this hearing and giving me the opportunity to testify.

The growth in health care spending and the value we receive from it is one of the primary domestic challenges facing our nation and perhaps the preeminent issue for any committee tasked with overseeing the federal budget.

The current rate of health care spending growth is unsustainable, for both American families and for the federal government. It is widely acknowledged a significant portion of health care spending does not actually improve Americans' health, yet well-intentioned but misguided government policies exacerbate wasteful expenditures. Decades of policymakers have sought to avoid the primary factors driving wasteful spending, preferring Washington-driven micromanagement that has failed to bring spending growth to a sustainable rate while distorting the delivery of care and the timing and direction of innovation.

Fortunately, there are numerous steps that Congress can take to slow the unsustainable growth in health care spending while preserving benefits for enrollees in important government programs. However, the longer Congress waits to relearn the lessons of the past, the more difficult the task will become.

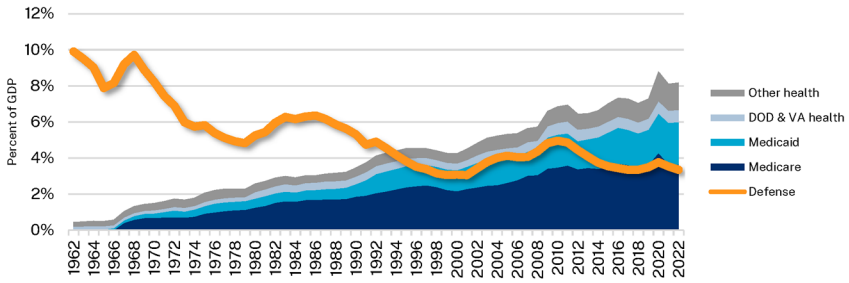
## The current rate of health care spending growth is unsustainable.

Health care spending has grown relentlessly as a percentage of gross domestic product (GDP) in the modern era, increasing from 5 percent in 1960 to over 18 percent of GDP today.[1] Average annual premiums for employer sponsored insurance for a family of four has increased by 45 percent from $15,475 to $22,463 over the past decade.[2] The federal government now spends more taxpayer money in health

[1] "NHE Summary, including share of GDP, CY 1960-2021," Centers for Medicare and Medicaid Services, Accessed October 13, 2023, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical
[2] "Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage," KFF, Accessed October 13, 2023, https://www.kff.org/interactive/premiums-and-worker-contributions-among-workers-covered-by-employer-sponsored-coverage/

care than any other area, exceeding $2 trillion in 2022[3] – for context this is now over twice as much as is spent on defense. The Congressional Budget Office (CBO) projects health spending to continue to outpace the overall growth of the economy for the foreseeable future.[4]

Figure 1: Federal health versus defense spending as a percentage of GDP
Source: OMB Historical Tables




Dedicated revenues such as the payroll tax and premiums cover only a small fraction of these expenditures, with dire implications for the national debt. My Manhattan Institute colleague Brian Riedl has shown that Medicare alone and the interest on the debt to finance it, even after subtracting dedicated revenues, is on pace to add $80 *trillion* to the deficit over the next 30 years.[5] In research for Paragon Health Institute, Paul Winfree applied a model used by the International Monetary Fund to estimate that these deficits would compromise the government's ability to borrow money within the next 25 to 50 years.[6]

**We do not get a good return for our government's health care expenditures.**

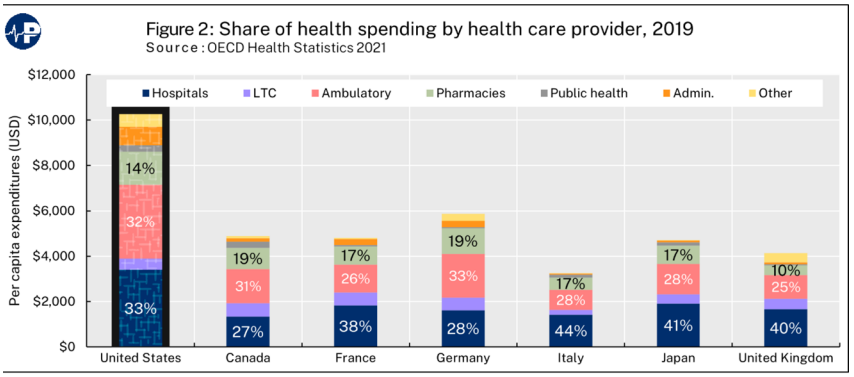
Growth in health care spending can be a good thing if it produces commensurate value for those consuming health care resources. However, research has repeatedly shown that a significant amount of health care spending does not improve health.

[3] "Table 15.1 – Total Outlays for Health Programs: 1962-2028," Office of Management and Budget, Accessed October 13, 2023, https://www.whitehouse.gov/omb/budget/historical-tables/
[4] "The 2023 Long-Term Budget Outlook," Congressional Budget Office, June 28, 2023, https://www.cbo.gov/publication/59014
[5] Brian Riedl, "Spending, Taxes & Deficits: A Book of Charts (page 53)," Manhattan Institute, November 2022, https://media4.manhattan-institute.org/sites/default/files/BudgetChartBook-2022-1.pdf
[6] Paul Winfree, "The Contribution of Federal Health Programs to U.S. Fiscal Challenges and the Need for Reform," Paragon Health Institute, January 2023, https://paragoninstitute.org/wp-content/uploads/2023/01/20230109_Winfree_FiscalSustainabilityofHealthPrograms_FINAL_202301310949.pdf

For instance, Washington spends more in *im*proper payments for health care, $150 billion last year,[7] than *proper* payments for the Supplemental Nutrition Assistance Program,[8] housing assistance,[9] or transportation infrastructure.[10] A widely cited study by the National Academy of Medicine estimated that 30 percent of all U.S. health spending does not improve health.[11]

Last year, the Organisation for Economic Co-operation and Development (OECD) released a comparison of health spending in developed nations by type – hospital, physician services, and pharmaceuticals – and confirmed the U.S. spends more on everything.[12] Higher spending was due to both higher volumes and higher prices.

Ironically, given last Congress' action on drug prices, the U.S. spends proportionately less on retail pharmaceuticals than every G7 country but the United Kingdom. This has compounded over the past decade as hospital and physician expenditures have annually averaged over 2 percent growth, adjusted for inflation, while pharmaceutical spending has averaged 0.6 percent. These facts reinforce that the forces driving excess spending are not secluded to one or two types of items or services.




[7] GAO-23-106285, "Improper Payments: Fiscal Year 2022 Estimates and Opportunities for Improvement," Government Accountability Office, March 29, 2023, https://www.gao.gov/products/gao-23-106285
[8] "Supplemental Nutrition Assistance Program Participation and Costs," U.S. Department of Agriculture Food and Nutrition Service, September 8, 2023, https://fns-prod.azureedge.us/sites/default/files/resource-files/snap-annualsummary-9.pdf
[9] "Fiscal Year 2023 Budget in Brief," Department of Housing and Urban Development, https://www.hud.gov/sites/dfiles/CFO/documents/2023_BudgetInBriefFINAL.pdf
[10] "What does America spend on transportation and infrastructure? Is Infrastructure improving?" USA Facts, Accessed October 13, 2023, https://usafacts.org/state-of-the-union/transportation-infrastructure/
[11] Mark Smith, Robert Saunders, Leigh Stuckhardt, J. Michael McGinnis, "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," National Academies Press, May 10, 2013, https://nap.nationalacademies.org/catalog/13444/best-care-at-lower-cost-the-path-to-continuously-learning
[12] "Understanding differences in health expenditure between the United States and OECD countries," OECD, September 2022, https://www.oecd.org/health/Health-expenditure-differences-USA-OECD-countries-Brief-July-2022.pdf

**Well-intentioned yet counterproductive government policies exacerbate wasteful spending.**

Largely well-intentioned, but ultimately counterproductive government policies inflate inefficient health spending. First, the U.S. is one of the few nations that subsidizes health care largely without limit.

If Medicare is billed for a covered item or service, it will pay it. If a state makes a Medicaid expenditure, Washington will match it. If insurers selling *Affordable Care Act* plans raise premiums, the federal taxpayer will cover the increase. No matter how generous a health plan an employer chooses, it will receive a tax break.

The contributions that Americans make out-of-pocket to health care, as a percentage of overall health spending, are less than every other G7 nation but France.[13] As Milton Freidman noted, the people least likely to carefully seek out value are those who spend other people's money on people other than themselves.[14] This characterizes much of our health care system, with providers determining care for individuals with coverage underwritten partially or entirely by taxpayers. Ultimately, our federal programs end up generously subsidizing care that Americans need, but also subsidizing a lot of inefficient and wasteful care.

Second, in addition to inflating demand with massive subsidies, federal and state policies restrict supply by limiting who can provide health care items and services and where they can provide them. This also insulates providers and suppliers from competition, often allowing them to command higher prices and remain inefficient.[15] Furthermore, these policies limit innovation by giving incumbents bureaucratic and political tools to prevent the type of disruption that has been seen in other sectors of the economy.

**Top-down reforms such as price controls and the Center for Medicare & Medicaid Innovation have not worked.**

With few exceptions, over the past several decades Congress has either exacerbated these two fundamental issues or has directed government technocrats to attempt to mitigate the worst effects. The reason for this hearing today is those efforts have largely failed.

Given its size and importance, Medicare is often the epicenter of the policy debate. Since 1983, price controls have been the technocratic reform of choice, starting with hospitals, moving to physicians, and recently moving to prescription drugs. As

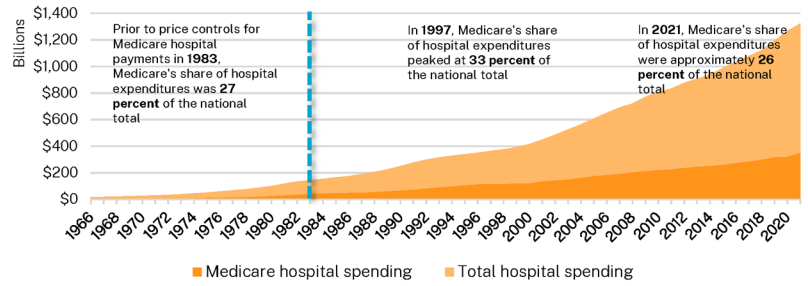
[13] "Health spending, Out-of-pocket, % of health spending, 2022 or latest available," OECD Data, Accessed October 13, 2023, https://data.oecd.org/healthres/health-spending.htm
[14] "Milton Friedman – The Four Ways to Spend Money," Free to Choose Network, Youtube, Accessed October 13, 2023, https://www.youtube.com/watch?v=XsRk9RThGt0
[15] Martin Gaynor, "What to do about Health-Care Markets? Policies to Make Health-Care Markets Work," The Hamilton Project, March 2020, https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf

applied to the Medicare program, price controls attempt to approximate the cost of providing a service or producing an item and limit reimbursement to that amount plus what is deemed politically to be an appropriate profit margin. As Medicare is the nation's dominant purchaser, even most private payers use similar payment methods and rates as a starting point in negotiations. There are serious flaws with this approach that has now been the dominant form of reimbursement for forty years.

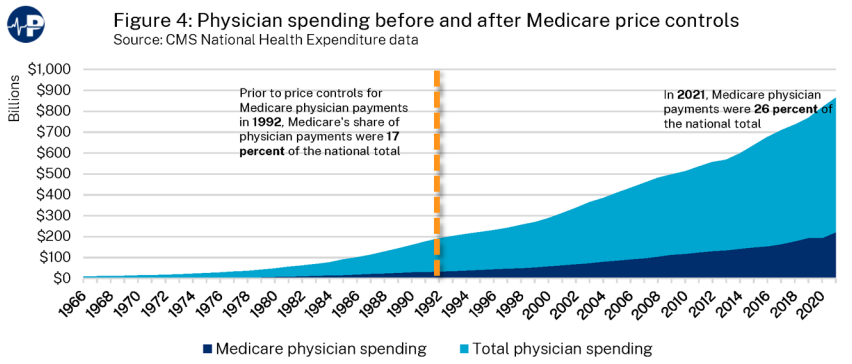
First, price controls avoid whether or not a service or item *should* be provided. Importantly, reimbursement tethered to cost inherently promotes innovation that is more expensive as opposed to that which would reduce cost and inevitably receive a lesser rate. This is compounded by procedural aspects of fee-for-service reimbursement, where it is easy to simply add codes for innovations that add cost and difficult to design appropriate reimbursement for innovations that reduce cost.[16] In the complex field of medical care with variations in quality, regional patterns of practice, and geographic variations in the distribution of providers, national price controls are bound to distort the delivery of care even if costs could be estimated perfectly[17] – which is impossible because the available information is always imperfect despite the best efforts of the Centers for Medicare and Medicaid Services (CMS).

The method of reimbursement and inevitable misvaluing of items and services has implications for the flow of investments. Resources that should be directed to create value for patients and consumers are instead rerouted to opportunities of lesser value but with favored payment or simply arbitrage opportunities created by flawed payment. Finally, the inertia created by requiring change to be approved through bureaucratic or political processes stalls advancement by enormous amounts of time.

Figure 3: Hospital spending before and after Medicare price controls
Source: CMS National Health Expenditure data




[16] Eli Cahan, Bob Kocher, and Roger Bohn, "Why Isn't Innovation Helping Reduce Health Care Costs?" Health Affairs, June 4, 2020, https://www.healthaffairs.org/content/forefront/why-isn-t-innovation-helping-reduce-health-care-costs
[17] "Kathryn Langwell, "Price Controls: On the One Hand....And on the Other," Health Care Financing Review, Spring 1993, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193364/




Figures 3 and 4 show hospital and physician spending before and after the imposition of Medicare price controls in 1983 and 1992 respectively. While it may be possible to make nuanced claims to the trajectory of Medicare spending or overall spending on these services prior and after imposition, it is impossible to say that this policy lever has made growth in either spending categories sustainable even after decades of refinement. On the other hand, it is possible to conclude with confidence that in the meantime price controls have distorted the delivery of care and the trajectory of innovation to a significant degree, favoring the status quo at the time the policy was adopted.

The *Patient Protection and Affordable Care Act* (ACA; Public Laws 111-148; 111-152) in part acknowledged the drawbacks of the Medicare price control regime but put faith in a similar top-down approach through which a generously funded new agency of well-intentioned technocrats, insulated from Congressional meddling, would be able to engineer more efficient payment methods. Yet after a decade of work the CBO recently found the Center for Medicare and Medicaid Innovation (CMMI) has *added* to the deficit.[18] Only six out of the 49 models evaluated generated statistically significant savings, and the demonstration that produced the most savings ironically did so through adding administrative costs – prior authorization for non-emergency medical transportation.

Many CMMI demonstrations sought to coax providers and other entities into taking on financial risk – a very worthy goal. Unfortunately, a major lesson of ten years of experience was a quite predictable one: When given the option between financial

[18] "Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation," Congressional Budget Office, September 18, 2023, https://www.cbo.gov/publication/59274

risk and no risk, providers and other entities prefer no risk.[19] The voluntary nature of most CMMI demonstrations left them vulnerable to selection bias – with most participants being those who predicted it would financially benefit them.

**There are numerous productive ways to reduce wasteful spending while not reducing benefits for enrollees.**

1. **Shift financial risk away from taxpayers**

To the extent the federal government continues to subsidize health care spending with few or no limits, it will be difficult to incentivize stakeholders to systematically reduce low-value care and constrain health care cost growth over time. Shifting financial risk away from taxpayers does not require shifting it to or limiting protections for enrollees and beneficiaries. Insurers, accountable care organizations, other providers, states, and others can be better positioned to assume risk. In fact, significant progress could be made by just eliminating particularly egregious policies that have actually inflated taxpayer risk relative to original program intent.

**Medigap:** Traditional Medicare fee-for-service is an outdated benefit with different cost-sharing obligations for separate inpatient and outpatient coverage and no limit to out-of-pocket expenditures for beneficiaries. Enrollees therefore usually opt into Medicare Advantage (MA) plans that have more modern benefit structures or purchase separate wrap-around coverage known as Medigap.

MA plans receive a capitated payment to provide all Medicare Part A and B benefits to enrollees and must also cap overall out-of-pocket liabilities. MA plans may reduce cost-sharing for enrollees but are at risk for additional expenditures. Therefore, there is an incentive to promote care coordination and high value care in cost efficient settings while discouraging low value care.

Medigap plans on the other hand reduce cost-sharing obligations but do not bear the cost of covering the standard Medicare benefits or additional spending that the plan may encourage. A study commissioned by the independent Medicare Payment Advisory Commission (MedPAC) found that enrollment in Medigap increased average Medicare expenditures by 27 percent per enrollee.[20]

Congress should mitigate incentives to promote excess and low-value spending by Medigap; the CBO has estimated reforming Medigap design would save $100 billion over seven years.[21]

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[19] Brad Smith, "CMS Innovation Center at 10 Years – Progress and Lessons Learned," The New England Journal of Medicine, February 25, 2021, https://www.nejm.org/doi/full/10.1056/NEJMsb2031138

[20] Christopher Hogan, "Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly, A report by Direct Research, LLC, for the Medicare Payment Advisory Commission," August 2014, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/august2014_secondaryinsurance_contractor.pdf

[21] "Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance," Congressional Budget Office, December 7, 2022, https://www.cbo.gov/budget-options/58647

**Medicaid and provider taxes:** Medicaid is jointly financed by the federal government and states, with state expenditures being matched by federal payments at rates set under law. On average, the federal government reimburses about two-thirds of state Medicaid expenditures. States have primary oversight over Medicaid expenditures, and in theory federal exposure to wasteful spending should be limited by the shared obligation of states to finance the program.

Unfortunately in practice, states utilize financing gimmicks to minimize their actual program expenditures, essentially receiving federal reimbursement on illusory state contributions.[22] This undermines the program design and leaves federal taxpayers at significant risk for wasteful or excessive Medicaid expenditures – not to mention schemes where federal Medicaid dollars effectively go to non-health expenditures.[23] The CBO has estimated it would save federal taxpayers $500 billion over the next decade to limit just one financing scheme by ending the safe harbor that allows states to tax providers and then return that equivalent amount in Medicaid payments up to 6 percent of net patient revenue.[24]

2. **Get the government out of the business of dictating who should be paid how much and where**

Many of the ways that price controls and barriers to entry distort care and increase prices are difficult to see. For instance, consider a hypothetical scenario where an investment could be made in a competitor to a high-priced hospital, but the project requires political approval through Certificate of Need. Instead, the investment goes to a safer bet to expand a clinic that specializes in a procedure with a Medicare price that has not been adjusted downward to reflect recent advancements in productivity. These types of distortions happen every day impacting how care is provided, which investments are made, and even what careers Americans pursue, but are largely unseen and are often impossible to quantify.

In other cases, distortions are more obvious and observable. Medicare will pay a different rate for the same service depending on the setting where care is provided. Over time research has shown hospitals take advantage of this payment differential, purchase lower cost physicians' offices, and convert them into outpatient departments that then provide the same service at a higher price.[25]

Similarly, certain providers receive Congressionally mandated discounts on outpatient prescription drugs through the 340B program yet continue to charge

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[22] "Medicaid Provider Taxes Inflate Federal Matching Funds," Committee for a Responsible Federal Budget, September 28, 2023, https://www.crfb.org/papers/medicaid-provider-taxes-inflate-federal-matching-funds
[23] Daniel Hatcher, "Medicaid Maximization and Diversion: Illusory State Practices that Convert Federal Aid into General State Revenue," Seattle University Law Review, Spring 2016, https://scholarworks.law.ubalt.edu/cgi/viewcontent.cgi?article=2003&context=all_fac
[24] "Limit State Taxes on Health Care Providers," Congressional Budget Office, December 7, 2022, https://www.cbo.gov/budget-options/58623
[25] Michael Chernew, "Disparities in payment across sites encourage consolidation," Health Services Research, February 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7839635/

payers, including Medicare, a higher price. Research[26] has repeatedly[27] shown that 340B eligible hospitals "have an incentive to increase margins by expanding their patient base" and purchasing oncology practices and other office-based providers.[28]

While a whole scale reevaluation of the current price control regime and barriers to competition would be beneficial, Congress can take incremental steps in the meantime to limit obvious flaws.

**Site neutral payment:** There have been various positive proposals put forth to eliminate or reduce payment disparities for certain services across care settings, summarized recently in a policy brief by Joe Albanese of Paragon Health Institute.[29] This includes proposals to equalize Medicare Part B drug payment across doctor's offices and hospital outpatient departments as included in the *Lower Costs, More Transparency Act* jointly introduced by the House Energy and Commerce, Ways and Means, and Education and Workforce Committees. Ideally Congress would pursue even more wide-reaching reforms such as the policy considered in an Energy and Commerce Committee discussion draft that would equalize payment for a wide range of services across hospital outpatient departments, ambulatory surgical centers, and physicians' offices.

**Medicare and 340B:** As Brian Blase of Paragon Health Institute and I recently summarized in a comment letter to CMS:

> "[Outpatient Prospective Payment System] payment for 340B drugs is flawed. Despite 340B-covered entities receiving discounts of 25 to 50 percent on drugs, Medicare and its beneficiaries pay the same rate for these as for other drugs (there also is no legal requirement to pass along these savings to needy patients)."[30]

In 2017, CMS finalized a rule that reduced Medicare payment to the cost of procurement under 340B, annually saving $1.6 billion in total drug payments including $320 million in reduced beneficiary cost-sharing. Unfortunately, the Supreme Court invalidated the policy over procedural concerns. While CMS still has the ability to accommodate the Court's concerns in a revised rule, Medicare requires that certain regulatory changes be done in a budget neutral manner. This would result in Medicare savings on drug payments translating into higher payments

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[26] Sunita Desai and Michael McWilliams, "Consequences of the 340B Drug Pricing Program," New England Journal of Medicine, February 8, 2018, https://www.nejm.org/doi/full/10.1056/NEJMsa1706475
[27] Jung, Jeah et al, "Impact of the 340B Drug Pricing Program on Cancer Care Site and Spending in Medicare." Health Services Research, October 2018, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6153182/
[28] Barbara Wynn, Peter Hussey, Teague Ruder, "Policy Options for Addressing Medicare Payment Differentials Across Ambulatory Settings," RAND Corporation, 2011, https://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR979.pdf
[29] Joe Albanese, "Reducing Overpayment in Medicare through Site-Neutral Reforms," Paragon Health Institute, June 7, 2023, https://paragoninstitute.org/wp-content/uploads/2023/06/Reducing-Overpayments-in-Medicare-Through-Site-Neutral-Reforms-FINAL-LAYOUT-AW4.pdf
[30] Brian Blase and Theo Merkel, "Re: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022, CMS-1793-P, RIN 0938-AV18," Paragon Health Institute, September 8, 2023, https://paragoninstitute.org/wp-content/uploads/2023/09/Paragon_340B_remedy_rule_pub_comment_FOR_RELEASE_V1.pdf

throughout the Part B fee schedule. As recommended in Paragon Health Institute's report "Turning the Tide on Red Ink," Congress should enact this 340B reform in statute and save taxpayers and beneficiaries billions over the next decade.[31]

3. **Favor bottom-up solutions instead of top-down approaches that have repeatedly failed over time**

Well-intentioned technocrats in Washington will never be as motivated to seek value as those with well-aligned incentives such as patients, providers, employers, or others who bear financial risk. Congress should take action to give these Americans the tools to make value conscious decisions in health care.

**Increasing coverage options:** The ACA significantly limited what types of private health insurance Americans can buy and provided large subsidies for those that meet certain income thresholds without an alternative source of coverage. The results have been underwhelming, with a recent actuarial analysis from Paragon Health Institute showing the policy changes prompted by the law have led to half the anticipated coverage gains in private insurance at three times the projected cost per new enrollee.[32] The exchanges appear to have reached a steady state of enrollment, where less than 20 percent of enrollees purchase coverage completely with their own money. However, ensuring the availability of lower cost, quality options outside of the ACA can allow more individuals to obtain insurance coverage if ineligible for premium subsidies.

To this end, Congress should prevent the current Administration from restricting the availability of short-term limited-duration insurance contracts to just three months from the current length of 364 days with an option to renew up to three years. The misguided proposed rule would remove flexible coverage options, strip coverage from the sick, and increase the number of uninsured.[33] Furthermore, there is no evidence that availability of these coverage options has led to a deterioration in the availability or the price of ACA plans.[34]

Congress could also make significant progress expanding coverage options for small businesses. Only 32 percent of small businesses offer insurance coverage to their employees, down from 45 percent in 2002. Currently, small businesses can join together for the purpose of providing health insurance if there is a commonality of interest. This provides regulatory advantages and economies of scale that enable lower cost, quality coverage. However, current opportunities are limited by a narrow

[31] Brian Blase and Joe Albanese, "Turning the Tide on Red Ink," Paragon Health Institute, March 2023, https://paragoninstitute.org/wp-content/uploads/2023/05/Turning-the-Tide-on-Red-Ink_Brian-Blase_Joe-Albanese_FINAL_202303072031.pdf
[32] Daniel Cruz and Greg Fann, "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Cost," Paragon Health Institute, September 2023, https://paragoninstitute.org/research-paper-page-cruz-fann-shortcomings-of-the-aca-20230914/
[33] "Paragon leads comment letter opposing Biden admin's misguided proposed rule limited short-term health plans," Paragon Health Institute, September 7, 2023, https://paragoninstitute.org/public-comment-stldi-coverage-20230907/
[34] Brian Blase, "Short-term Plans, Long-term Benefits," Paragon Health Institute, September 2023, https://paragoninstitute.org/wp-content/uploads/2023/09/Short-Term-Insurance-Long-Term-Benefits_FOR-RELEASE-V1.pdf

regulatory interpretation. As Kev Coleman explains in a Paragon Health Institute issue brief, "a group of carpentry firms may qualify…but a homebuilder group composed of carpenters, electricians, plumbers, and painters would not."[35] Congress should relax the definition of commonality of interest and revisit the conditions to allow any employer, including sole proprietors, within a state or metropolitan area to join together for the purposes of offering health insurance.

**Price transparency:** Public policy experts have long claimed that health care is "different" than almost every aspect of the American economy, immune to the normal feedback loop where the value of goods and services is established by numerous, repeated, and ongoing voluntary transactions between consumers and suppliers. Over decades, some of the same experts successfully advocated for policies – namely third-party payment, high barriers to entry, and robust government subsidization – that reinforced the same outcome they predicted. The result has been a U.S. health care system almost engineered to be opaque, preventing individuals from seeking out the cost of care even if they were motivated to do so.

Surveys have shown unambiguously that Americans want to know the price of care before it is rendered.[36] Research has demonstrated that in the rare instances when motivated shoppers have pricing information, they are able to obtain cost savings.[37] Research by Larry Van Horn and others has demonstrated the magnitude of the opportunity, with significant price variation for services within regions and cash alternatives that average 40 percent lower than prices negotiated by commercial insurers.[38]

The Trump Administration launched a significant initiative to require hospitals and insurers to publicly post prices, including payer specific negotiated rates.[39] Fully implemented, the potential impact could save tens of billions of dollars per year in the commercial market alone, according to a recent analysis by Stephen Parente.[40] However, compliance with the rules as of the date of this testimony is underwhelming. The House of Representatives has begun to consider legislation that would codify and improve upon these important transparency regulations. The Senate should follow suit, with special attention given to enhancing compliance.

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[35] Kev Coleman, "Small Business Health Insurance Equity Through Association Health Plans," Paragon Health Institute, April 26, 2023, https://paragoninstitute.org/wp-content/uploads/2023/04/AHP-Policy-Brief-FINAL-202304251653.pdf

[36] "New Poll Shows Bipartisan Supermajority of Nearly 90% of Americans Support Healthcare Price Transparency," PatientRightsAdvocate.org, April 25, 2023, https://www.patientrightsadvocate.org/blog/new-poll-shows-bipartisan-supermajority-of-nearly-90-of-americans-support-healthcare-price-transparency

[37] Zach Brown, "An Empirical Model of Price Transparency and Markups in Health Care," August 2019, http://www-personal.umich.edu/~zachb/zbrown_empirical_model_price_transparency.pdf

[38] R. Lawrence Van Horn, Aurther Laffer, and Robert Metcalf, "The Transformative Potential for Price Transparency in Healthcare: Benefits for Consumers and Providers," Health Management, Policy & Innovation, 2019, https://hmpi.org/2019/12/09/the-transformative-potential-for-price-transparency-in-healthcare-benefits-for-consumers-and-providers/?pdf=2210

[39] Theo Merkel, "Health Care Price Transparency," Paragon Health Institute, August 2023, https://paragoninstitute.org/wp-content/uploads/2023/08/Health-Care-Price-Transparency-Merkel-FOR-RELEASE-V1.pdf

[40] Stephen Parente, "Estimating the Impact of New Health Price Transparency Policies," Journal of Health Care Organization, Provision, and Financing, February 17, 2023, https://journals.sagepub.com/doi/10.1177/00469580231155988

These are just a few opportunities Congress has before it to improve the value of health care spending. Thank you again for the opportunity to testify, and I look forward to your questions.

Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress



TESTIMONY

# Alternative Payment Models and the Slowdown in Federal Health Care Spending

**Chapin White**
**Director of Health Analysis**

Before the Committee on the Budget
United States Senate

OCTOBER 18 | 2023

Chairman Whitehouse, Ranking Member Grassley, and Members of the Committee, I appreciate the opportunity to appear before you today. In consultation with Budget Committee staff, I have focused this testimony on accountable care organizations (ACOs), the Center for Medicare & Medicaid Innovation (CMMI), and the unexpected slowdown in federal health care spending.

## Why Might ACOs or CMMI Have Contributed to Reducing Federal Health Care Spending?

Because ACOs voluntarily assume responsibility for the quality and costs of care for a defined group of patients, they have the potential to reduce unnecessary care, improve care coordination and patients' health, and reduce spending. Health care providers participating in ACOs or other value-based payment arrangements receive financial incentives to improve the efficiency and quality of care. Such incentives contrast with those found in Medicare's fee-for-service program, in which separate payments are generally made for each encounter or service delivered.[1] Reimbursing on a fee-for-service basis tends to create incentives for providers to deliver additional and more-complex services, potentially contributing to the high costs and uneven quality of health care.

CMMI's goal is to identify approaches that reduce spending or improve the quality of care. To do so, it operates models that test new ways to deliver and pay for health care, including models that establish value-based payment arrangements with providers.

## What Are the Effects of the MSSP on Medicare Spending?

The Affordable Care Act (ACA) established a permanent ACO program in Medicare known as the Medicare Shared Savings Program (MSSP). The Congressional Budget Office reviewed evidence on the performance of the MSSP and found that the program was associated with small net budgetary savings in the early years of its operation.[2] To arrive at that assessment, CBO largely relied on peer-reviewed literature that compared changes in spending among beneficiaries attributed to ACOs with changes in spending among a control group of beneficiaries not attributed to an ACO. More recent evidence is limited and is challenging to interpret. It has become increasingly difficult to find a reasonable control group to use in evaluations, and evaluations are complicated by providers' ability to opt in and out of the program.

## What Were CMMI's Budgetary Effects Over Its First Decade of Operation?

CBO has updated its estimate of the budgetary effect of CMMI and currently estimates that CMMI's activities increased direct spending by $5.4 billion, or 0.1 percent of net spending on Medicare, between 2011 and 2020.[3] Specifically, CMMI spent $7.9 billion to operate models, and those models reduced spending on health care benefits by $2.6 billion. The estimate reflects CBO's review of published evaluations of 49 models initiated in CMMI's first decade after it was established under the ACA, as well as corresponding historical budget data.

## What Are CBO's Projections of CMMI's Effects Over the Current Baseline Projection Period?

CBO estimates that over the current baseline projection period, 2024 to 2033, CMMI will increase net federal spending by less than $50 million. Over that period, the estimated effect of CMMI's activities transitions from an annual net increase to an annual net decrease, reflecting ongoing growth in the number of certified models that continue to produce savings over time.

## How Does CBO Estimate the Effects of Legislative Proposals to Change CMMI?

Legislative proposals that the Congress could consider that would affect CMMI fall into one of three categories: modifications to specific models, changes to the parameters within which CMMI operates, and a repeal of CMMI's statutory authority or rescissions of unobligated funding. In general, CBO's analysis considers available evidence on specific models. When such data are not available or the legislation is not related to a specific model, CBO relies on a more general framework using

1. The basis under which Medicare Advantage plans pay providers is not entirely clear and probably differs by insurer and plan. Those types of plans cover 51 percent of Medicare beneficiaries.

2. Congressional Budget Office, *Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation* (September 2023), Box 1, www.cbo.gov/publication/59274.

3. Congressional Budget Office, *Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation* (September 2023), www.cbo.gov/publication/59274.

information about CMMI's prior activities and performance. Estimated effects would depend on the details of the legislation.

## Have Alternative Payment Models Contributed to the Slowdown in Health Care Spending?

The implementation of the MSSP and the creation of CMMI have occurred during a period of unexpectedly slow growth in federal health care spending. Whether that slow growth is related to CMMI or other alternative payment models created under the ACA is not entirely understood, but CBO's review of the effects of the MSSP and its estimate of the budgetary effects of CMMI's first decade of operation suggest that they were not factors. Still, some researchers have posited that the existence of CMMI may have led to broader systemwide changes that are not attributable to a specific model. Such changes may have led to increases or decreases in federal health care spending, which are not reflected in CBO's estimates of the budgetary effects of CMMI.[4]

Over the past decade, CBO has been tracking the slowdown in federal health care spending and has previously pointed to several contributing factors.[5] Broader factors include decreases in the growth of Medicare's payment rates, reduced spending on patients with cardiovascular diseases (because of better management of those conditions and greater use of medications to control risk factors), and a shift in the relative importance of technology in fueling the growth of health care spending. Federal spending on the Medicare and Medicaid programs also grew more slowly than CBO projected. A key factor underlying Medicare's slower-than-expected growth was slower growth in net spending on prescription drugs; for Medicaid, a key factor was less-than-anticipated spending for long-term services and supports.

4. Ibid., p. 4.

5. For additional details, see Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), www.cbo.gov/publication/44513; Congressional Budget Office, letter to the Honorable Sheldon Whitehouse on CBO's projections of federal health care spending (March 17, 2023), www.cbo.gov/publication/58997; and *Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections* (December 18, 2020), pp. 13–15, www.cbo.gov/publication/56908.

Michael Cohen and Chapin White prepared this testimony, with contributions from Joyce Shin and with guidance from Berna Demiralp, Sean Dunbar, Tamara Hayford, Sarah Masi, and Asha Saavoss. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the testimony makes no recommendations. Jeffrey Kling reviewed the testimony. Rebecca Lanning edited it, and Jorge Salazar prepared it for publication. The testimony is available at www.cbo.gov/publication/59660.

**Dr. Matthew Fielder Responses to Questions for the Record from Chairman Whitehouse**
**"Improving Care, Lowering Costs: Achieving Health Care Efficiency"**
**October 18, 2023**
**Senate Budget Committee**

*In your testimony, you discuss the administrative burdens that prior authorization requirements place on providers. What can be done to ensure the delivery of appropriate health care services while minimizing the burdens and costs associated with prior authorizations?*

As with other administrative processes, there are opportunities to reduce burden by standardizing how providers and payers share information. The Biden administration has ongoing rulemaking aimed at requiring prior authorization to shift to more standard, electronic processes. There are some related private sector efforts underway as well. There is some potential here.

Another question is how to address cases where prior authorization is used inappropriately. I am particularly concerned that there are instances where insurers use prior authorization requirements as a tool to make their plans less attractive to enrollees who need specific high-cost therapies (and thereby avoid those enrollees). This may be a particular concern in the individual market and Medicare Advantage, and it suggests a need to improve risk adjustment systems in these markets. Better risk adjustment could make this type of selection behavior less appealing and thus remove one driver of inappropriate use of prior authorization (and other problematic insurer practices).

*HIPAA enacted standards for electronic data exchanges. ASCA required the electronic submission of Medicare claims. The ACA required standards for electronic funds transfers and claims attachments. MACRA implemented interoperability into electronic health records. And yet, 26 years later, providers are still burdened by billing- and insurance-related administrative tasks and the associated costs. Why does this problem persist?*

There are several different factors that account for this outcome. Some of this reflects deficiencies in the standards regime set up by HIPAA and its successors, which is incomplete in various ways. To take one example, there is currently no HIPAA standard governing claims attachments, which carry supplemental information (like medical records) that payers sometimes require to process a claim. HHS has now proposed such a standard, but this is a good example of the types of gaps that have sometimes persisted in the HIPAA regime. Different entities may also implement the standards in slightly different ways, keeping standards from having their intended effects.

But there are also more structural drivers that would persist even with a perfect standards regime. First, health care itself is complex, which under fee-for-service payment means that billing tends to be complex as well. Second, a lot of complexity comes from the fact that different payers establish *substantively* differ rules about what they cover and how they pay for it. Addressing these structural drivers requires solutions that go beyond establishing transaction standards. Of course, those types of reforms also present larger challenges and tradeoffs.

*Your testimony focused on the administrative burdens borne by providers and insurers, but our health care system also places substantial administrative burdens on patients. For example, patients may spend significant time and resources obtaining the appropriate information or resolving billing issues, posing barriers to their access to care. How much should we worry about those types of burdens, and what might we about them?*

We should absolutely worry about administrative burdens placed on patients. As with other administrative processes, administrative processes that involve patients can also serve useful functions, so reform can involve tradeoffs. But I want to highlight a few potential opportunities.

First, consistent with my prior responses, insurers likely sometimes design plans with features that create hassle costs for patients (such as narrow networks or stringent prior authorization requirements) in an effort to avoid higher-cost enrollees. Improving risk adjustment could, at the margin, discourage insurers from adopting these types of plan designs.

Second, administrative burdens on patients—such as difficulties in navigating narrow provider networks or stringent prior authorization processes—are sometimes side effects of insurer efforts to control costs. Giving insurers other ways to control costs could reduce the need for these strategies and, in turn, the hassles they create. For example, making provider markets more competitive or adopting commercial market price regulation could allow insurers to secure lower prices *without* restoring to narrow networks and, thus, lead to broader networks on average.

Third, some problems arise because plan features that create administrative burdens reduce utilization and, thus lower premiums; if these lower premiums are salient when enrollees choose plans, but the administrative burdens are not, this can cause too many people to opt for these more burdensome plan designs. In principle, this suggests that burdens could be reduced by helping consumers better understand the features of the coverage they are buying. In practice, this strategy may not be especially effective, as past transparency efforts in this vein have shown dismal results, but steps like ensuring that insurer provider directories are accurate can help at the margins.

Switching gears slightly, I do want to highlight another type of administrative burden: the administrative burdens required to enroll and stay enrolled in coverage. Particularly with the current focus on unwinding the pandemic-era Medicaid continuous enrollment protections, there has been growing recognition that administrative burdens can be an important factor that keeps people from obtaining coverage they are eligible for. Here, it is worth exploring ways to make enrollment (and re-enrollment) processes more automatic so that less work is required from enrollees as well as to remove certain unnecessary requirements from the enrollment process.

Responses to Questions for the Record
Submitted by Leemore Dafny, PhD
to Senator Sheldon Whitehouse
November 6, 2023

Question #1

In your testimony, you describe the consequences of high commercial prices on high employer-sponsored premiums, and the associated federal budgetary implications. Could you also describe the effects of high health care prices on workers' wages throughout the economy? Could you provide citations to the empirical evidence supporting this point?

Response

Higher prices drive higher commercial insurance premiums. Most of the commercially insured receive coverage through employer-sponsored health plans. Economic theory predicts – and empirical evidence confirms - that higher costs for employee benefits results in lower wages and/or fewer jobs.

The evidence includes the following studies *(key findings in parentheses)*:

- Arnold, Daniel and Christopher M. Whaley, Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. Santa Monica, CA: RAND Corporation, 2020. *("We find that hospital mergers lead to a $521 increase in hospital prices, a $579 increase in hospital spending among the privately insured population and a similar, $638 reduction in wages…Overall, our results show how rising health care costs caused by provider concentration are passed to workers in the form of lower wages and less generous benefits.")*
- Baicker, Katherine, and Amitabh Chandra. "The Labor Market Effects of Rising Health Insurance Premiums." Journal of Labor Economics 24, no. 3 (2006): 609–34. *( "We estimate that a 10 percent increase in health insurance premiums reduces the aggregate probability of being employed by 1.6 percent and hours worked by 1 percent, and increases the likelihood that a worker is employed only part-time by 1.9 percent. For workers covered by employer provided health insurance, this increase in premiums results in an offsetting decrease in wages of 2.3 percent.")*
- Currie and Madrian, 2000. *(This paper summarizes the theoretical predictions regarding employee benefits as well as the empirical evidence prior to 2000. One significant work is Gruber, Jonathan. "The Incidence of Mandated Maternity Benefits." The American Economic Review 84, no. 3 (1994): 622–41. This study finds evidence that the cost of health benefits is shifted onto workers via their wages.)*

Questions for the Record
From: Chairman Sheldon Whitehouse
To: Mr. Theo Merkel
"Improving Care, Lowering Costs: Achieving Health Care Efficiency"
October 18, 2023
Senate Budget Committee

**Question #1**

*Ranking Member Grassley repeatedly stressed his support for transparency-oriented solutions during his opening remarks. But patients are often unable to shop for prices for health services in the same way they might for consumer goods. For example, an unconscious patient experiencing an emergency cannot shop for a cheaper ambulance ride to the emergency room. How can price transparency alone help drive cost savings? Should we not couple price transparency with delivery reforms?*

Thank you for such a great question that allows me to address some common misconceptions about price transparency in health care.

First of all, transparency should absolutely be coupled with additional reforms. As I noted in my testimony, the two biggest factors driving inefficient spending are well-intentioned yet counterproductive policies that haphazardly inflate demand and limit supply. Policy reforms that address these issues are of utmost importance. That said, while transparency is not the only action Congress should be taking on health care, pursuing transparency now is still a worthy endeavor even if other reforms are not immediately achievable.

You have noted that not all health care spending is shoppable because patients may experience emergency situations not conducive to shopping. Research has found that 73 percent of the 100 highest-spending inpatient care categories and 90 percent of the 300 highest-spending outpatient care categories were "shoppable."[1] That said, fortunately for anyone in a circumstance like the one you describe, patients are not the only ones who "shop."

Employers, insurers, and other payers can be viewed as bulk purchasers of health care. When provider networks are being designed and prices are being negotiated, employers and insurers have an incentive to get better prices both for care commonly referred to as "shoppable" and the type of care that an individual patient would not be able to compare at a moment of need. This is one of the reasons why employers in particular are one of the most outspoken advocates of price transparency and payers in general are key to reducing excess health care spending.

However, purchasers are also not the only ones who can play an active role. As the transparency rules have been implemented, efficient providers are comparing their prices to competitors and proactively making the case to payers to drive more volume to them. This is exactly the type of competitive behavior that should be happening routinely but was almost impossible until the transparency rules were enacted.

[1] Chapin White and Megan Eguchi, "Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle, National Institute for Health Care Reform, October 2014, https://www.nihcr.org/analysis/improving-care-delivery/prevention-improving-health/reference-pricing2/

Finally, price competition drives down prices for all providers and benefits all patients and payers, regardless of whether they comparison shop or not. As great as it would be for everyone to be motivated to shop for the best deal on health care services whenever they are needed – that is not a reasonable expectation nor is it necessary for competition to work. In fact, it does not work that way in any other market that I am aware of. Luckily, there are plenty of active shoppers that will compare prices. In most markets, suppliers actively compete to obtain the marginal consumer and most of the population piggy backs off of their diligence.

For instance, I rarely look at the price of eggs or milk before I buy them. That said, I have enough confidence that my grocery store is sensitive to all the people that do price shop that I am not at high risk of being overcharged for these common goods.

**Question #2**

*Can you cite any empirical evidence that price transparency solves information asymmetry and promotes competition?*

As the Congressional Research Service (CRS) has summarized, "Most research suggests that when better price information is available prices for goods sold to consumers fall."[2] While a little too dated to cover recent developments in health care research, the CRS review provides a summary of the evidence that in other sectors price transparency "leads to lower and more uniform prices, a view consistent with predictions of standard economic theory."

Evidence specifically from the health care sector is more limited given public policy – primarily by incentivizing third party payment, limiting barriers to competition, and providing substantial subsidies – has eliminated almost all organic incentive for providers and suppliers to publicly display prices. That said, there is a limited but growing amount of research in the health care sector as well:

- Zach Brown of the University of Michigan found access to price information in New Hampshire through its HealthCost website "reduced the cost of medical imaging procedures by 5% for patients and 4% for insurers" with "significant supply-side effects in the long run when information is available to all individuals." (Zach Brown, Equilibrium Effects of Health Care Price Information," The Review of Economics and Statistics, October 2019, https://www-personal.umich.edu/~zachb/zbrown_eqm_effects_price_transparency.pdf)

- Christopher Whaley of the University of California, Berkley and a team of researchers look at individuals who had access to the Castlight Health price transparency platform from 2010-2013 and found "use of price transparency information was associated with lower total claims payments for common medical services." (Christopher Whaley, Jennifer Chafen, Sophie Pinkard, Gabriella Kellerman, Dena Bravata, Robert Kocher, and Neeraj Sood, "Association Between Availability of Health Service Prices and Payments for These Services," JAMA, October 22/29, 2014, https://jamanetwork.com/journals/jama/fullarticle/1917438)

- A working paper by Sebastian Linde of the Medical College of Wisconsin and Ralph Siebert of Purdue University reviewed over 2,000 hospitals and found price transparency laws reduced charges by 3.9 percent, reduced negotiated price paid by insurers by 15.9 percent, and lowered hospitals' operating

[2] "Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Healthcare Sector," Congressional Research Service, July 24, 2007, https://fas.org/sgp/crs/secrecy/RL34101.pdf

costs by 4.7 percent. (Sebastian Linde and Ralph Siebert, "Exploring the Heterogeneous Effects of State Price Transparency Laws on Charge Prices, Negotiated Prices, and Operating Costs, CESifo Working Papers, October 2021, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3943031)

- A study of insurer-initiated price transparency programs found they reduced costs on magnetic resonance imaging by 18.7 percent per test and decreased use of more expensive hospital based facilities from 53 percent in 2010 to 45 percent in 2012. Furthermore, "price variation between hospital and nonhospital facilities…was reduced by 30 percent after implementation. (Sze-jung Wu, Gosia Sylwestrzak, Christiane Shah, and Andrea Debries, "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition, Health Affairs, August 2014, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0168)

- Hans Christensen, Eric Floyd, and Mark Maffett evaluated laws that required hospitals to disclose their charges (not their actual negotiated rates) and found a resulting reduction in charges of approximately 5 percent. (Hans B. Christensen, Eric Floyd, Mark Maffett, "The Only Prescription Is Transparency: The Effect of Charge-Price-Transparency Regulation on Healthcare Prices," Management Science, January 29, 2020, https://pubsonline.informs.org/doi/epdf/10.1287/mnsc.2019.3330)

- James Robinson and Timothy Brown of the University of California, Berkley observed when patients were given both pricing information and the incentive to shop through reference pricing, surgical volume increased by 21.2 percent at low-price facilities and decreased by 34.4 percent at high-priced facilities. Prices charged by these facilities decreased by 4.6 percent at low-priced facilities and 18 percent at high priced facilities. (James C. Robinson and Timothy Brown, "Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery," Health Affairs, August 2013, https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0188)

- In 2013, the Commonwealth of Kentucky launched a program to educate public employees on the cost of care and provide incentives to choose lower cost options. By mid-2018 Kentucky reported $13.2 million in savings with the average savings to the state per claim that was "shopped" being $546. (Jared Roads, "How health care incentives are saving money in Kentucky," The Dartmouth Institute for Health Policy and Clinical Practice, March 8, 2019, Available at: https://thefga.org/wp-content/uploads/2019/03/RTS-Kentucky-HealthCareIncentivesSavingMoney-DRAFT8.pdf)

- Ge Bai, Pavan Patel, Marty Makary, and David Hyman have also shown that providers whose primary revenue source is cash-pay patients voluntarily engage in price transparency to reduce information disadvantage of consumers and gain market share. (Ge Bai, Pavan Patel, Martin Makary, David Hyman, "Providing Useful Hospital Pricing Information To Patients: Lessons from Voluntary Price Disclose," Health Affairs, April 19, 2019, https://www.healthaffairs.org/content/forefront/providing-useful-hospital-pricing-information-patients-lessons-voluntary-price)

Questions for the Record
from Senator Charles E. Grassley
for Mr. Theo Merkel
"Improving Care, Lowering Costs: Achieving Health Care Efficiency"
October 18, 2023
Senate Budget Committee

Question #1:
*Since the Affordable Care Act (ACA) was implemented, consumers have sought health insurance options outside the ACA's regulations. This includes the Centers for Medicare and Medicaid Services (CMS) allowing transitional health plans to continue to exist under three different presidential administrations. Additionally, states like Iowa and South Dakota have enabled health insurance products to be offered by non-profit agriculture organizations. Why are state and federal regulators allowing non-ACA options and why are consumers choosing them?*

The results of the private market reforms of the Affordable Care Act (ACA) have been underwhelming. Paragon Health Institute recently released an actuarial analysis that showed on net only 1.6 million Americans have gained private health insurance as a result of those reforms at the cost of over $60 billion in federal subsidies in 2021 – $36,800 per individual newly insured.[1] The underlying inefficiency was exacerbated by policy changes since 2014, notably the defunding of cost-sharing reduction payments in 2017 and the subsidy enhancements under the American Rescue Plan Act, increasing the average federal subsidy cumulatively by 45 percent. When it comes down to it, the higher price of insurance and limited value potential enrollees see from it has led to very few Americans willing to purchase ACA plans with their own money. Only 21 percent purchased ACA-regulated plans without a taxpayer subsidy in 2022.

Some states have responded to individuals' desire to have lower cost, higher quality options of coverage through increasing access to short-term renewable insurance and plans offered by non-profit agriculture organizations. A review by my colleague Chris Pope at Manhattan Institute found renewable plans offer savings of up to 46 percent on premiums and often feature broader networks of doctors and hospitals.[2] Far from negatively impacting the private market as feared by advocates of the ACA, my Paragon Health Institute colleague Brian Blase has shown states with regulations favorable to renewable insurance options had higher enrollment, more plan offerings, and lower premiums in the ACA market.[3]

Question #2:
*Sunshine on health care prices is badly needed. Beginning in 2021, hospitals and health plans were required to report price data to the federal government as a result of new federal rules. If price*

[1] Daniel Cruz and Greg Fann, "The Shortcomings of the ACA Exchanges," Paragon Health Institute, September 2023, https://paragoninstitute.org/research-paper-page-cruz-fann-shortcomings-of-the-aca-20230914/
[2] Chris Pope, "Renewable Term Health Insurance," Manhattan Institute, May 2019, https://media4.manhattan-institute.org/sites/default/files/R-0519-CP.pdf
[3] Brian Blase, "Short-term Health Plans, Long-Term Benefits," Paragon Health Institute, September 2023, https://paragoninstitute.org/wp-content/uploads/2023/09/Short-Term-Insurance-Long-Term-Benefits_FOR-RELEASE-V1.pdf

*transparency in health care was being used to the fullest extent possible, how much money would it save and for whom?*

The full implementation of the price transparency regulations promulgated during the Trump Administration would be a significant step forward to enable various stakeholders, most notably patients and employers, to put more downward pressure on health care prices and spending.

As I noted in a recent report for the Paragon Health Institute, patients are the most straightforward beneficiaries.[4] In just one example highlighted in *Health Affairs*, a patient was able to save $1,000 on two tests by comparing prices at locations within the same hospital network just 20 minutes away. However, enabling patients to shop for their own care is just one way price transparency will encourage competition.

Employers, insurers, and other payers can be viewed as bulk purchasers of health care. When provider networks are being designed and prices are being negotiated, employers and insurers have an incentive to get better prices both for care commonly referred to as "shoppable" and the type of care that an individual patient would not be able to compare at a moment of need. This is one of the reasons why employers in particular are one of the most outspoken advocates of price transparency and payers in general are key to reducing excess health care spending.

Purchasers and patients are also not the only ones who can play an active role. As the transparency rules have been implemented, efficient providers are comparing their prices to competitors and proactively making the case to payers to drive more volume to them. This is exactly the type of competitive behavior that should be happening routinely but was almost impossible until the transparency rules were enacted.

Stephen Parente of the University of Minnesota looked at price variation and available cash prices for commonly shoppable services and found an opportunity for $80 billion in savings by 2025 if the rules are fully implemented.[5] While this was an upward bound on savings for the services studied, it only focused on shoppable services and the commercial market. As noted previously, payers and providers have an incentive to drive competition on more than just commonly shoppable services, and there could be spillover effects beyond the commercial market.

Question #3:
*In the Congressional Budget Office's report on the Center for Medicare and Medicaid Innovation, six of the 49 models saved money. Did any of the six models use prior authorization? If so, why did requiring prior authorization result in Medicare savings?*

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[4] Theo Merkel, "Health Care Price Transparency," Paragon Health Institute, August 2023, https://paragoninstitute.org/wp-content/uploads/2023/08/Health-Care-Price-Transparency-Merkel-FOR-RELEASE-V1.pdf

[5] Stephen Parente, "Estimating the Impact of New Health Price Transparency Policies," The Journal of Health Care Organization, Provision, and Financing, February 17, 2023, https://journals.sagepub.com/doi/full/10.1177/00469580231155988

The *Center for Medicare and Medicaid Innovation* (CMMI) demonstration that saved the most money and maintained high quality for beneficiaries tested prior authorization in fee-for-service Medicare of repeated non-emergency medical transportation.[6] In fact, it saved almost as much as all the other models that saved money combined.

Because taxpayers bear almost all the financial risk in the traditional Medicare program, prior authorization can be an essential tool to prevent inappropriate services. In the case of this specific model, it looked at a type of service prone to abuse in states that had higher than average utilization. The model simply used prepayment review to ensure claims met Medicare's criteria for the benefit, and this had the effect of reducing repeated non-emergency medical transportation in the participating states by 72 percent![7] It is a dramatic display that, far from having too much administrative burden, in some cases the lack of investment of Medicare into commonsense safeguards can cost taxpayers and beneficiaries significantly.

Some have indicated that the Maryland All-Payer Model also purportedly achieved savings according to the CMMI evaluation, but it is important to note this is only in comparison to the previous waiver under which the program was operating.[8] As Chris Pope from Manhattan Institute has noted, the Maryland All-Payer Model costs federal taxpayers billions of dollars annually through Medicare payments above and beyond what hospitals in every other state receive.[9]

Question #4:
*The ACA attempted to offer a public option-like health plan through the marketplace called co-ops. To date, 20 co-ops have gone bankrupt, wasting over $2 billion in taxpayer dollars. This has disrupted thousands of Americans' health insurance coverage, and impacted providers. How would a public option impact federal deficits?*

As noted above, the results of the individual market reforms in the ACA have been underwhelming at high cost to the taxpayer. Beneath the surface of the larger shortcomings were a series of other experiments with similarly disappointing results including co-ops (20 of 23 bankrupt),[10] the multistate plan option (disbanded due to lack of participation),[11] and the basic health plan (currently only adopted by two states).[12]

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[6] "Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation," Congressional Budget Office, September 18, 2023, https://www.cbo.gov/publication/59274
[7] Andrew Asher, Kara Contreary, Geraldine Haile, and Jared Coopersmith, "Evaluation of the Medicare Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport," Mathematica, May 2021, https://www.cms.gov/priorities/innovation/data-and-reports/2021/rsnat-finalevalrpt
[8] Douglas Holtz-Eakin and Andrew Strohman, "The National Implications of Maryland's All-Payer System, American Action Forum, March 2, 2020, https://www.americanactionforum.org/research/the-national-implications-of-marylands-all-payer-system/#_edn8
[9] Chris Pope, "When the Government Sets Hospital Prices: Maryland's Experience," Manhattan Institute, June 2019, https://media4.manhattan-institute.org/sites/default/files/R-0619CP.pdf
[10] Phil Galewitz, "Obamacare Co-Ops Down From 23 to Final '3 Little Miracles'", KFF Health News, September 9, 2020, https://kffhealthnews.org/news/obamacare-co-ops-down-from-23-to-final-3-little-miracles/
[11] "Multi-State Plan Program and the Health Insurance Marketplace," U.S. Office of Personnel Management, Accessed October 26, 2023, https://www.opm.gov/healthcare-insurance/multi-state-plan-program/
[12] Sabrina Corlette, Jason Levitis, Erik Wengle, Rachel Swindle, "The Basic Health Program," Urban Institute, April 26, 2023, https://www.urban.org/research/publication/basic-health-program

The impact of a public option will depend on the design. The three states – Washington, Colorado, and Nevada – that have moved forward with versions of a public option since 2019, and those that have implemented it, have seen higher costs and less enrollment than hoped.[13]

Perhaps the most commonly proposed public option at the federal level, broadly reflected in the design of the *Consumer Health Options and Insurance Competition Enhancement Act (CHOICE) of 2021*, would rely on Medicare price controls and mandatory participation of all Medicare and Medicaid providers as in-network – with a caveat that there would be a to be determined opt out process designed by the Secretary of Health and Human Services.

There are two likely scenarios from this design. One, if the opt-out process is broad, these plans will function largely like the current ACA exchange offerings, often resembling Medicaid Managed Care-lite, with narrow networks and limited access to providers. The difference will be that taxpayers will bear at least the initial start-up costs. While theoretically the *CHOICE Act* requires repayment of start-up costs over 10 years, we have seen from the co-op experience that repayment depends on the ability of the plan to make a profit and survive for 10 years.

In a scenario where the public option utilizes price controls and forces essentially all providers to accept them as payment in full – at the threat of removal from the Medicare and Medicaid programs – Congress would be eliminating any façade of private market competition in the exchanges. By using the coercive power of the federal government to tilt the playing field so far in the direction of the public option, private carriers would struggle to maintain market share and more small employers would likely drop coverage.

If Congress were to go in this direction, which I advise against, it would have to face the consequences of effectively ending private insurance options in another segment of the market, further eroding employer sponsored insurance, and further contributing to provider discontent from being forced to accept price controls. Furthermore, the distortionary impacts of price controls on delivery of care and the direction of investment and innovation that I described in my testimony would be more pronounced as they would impact an even larger segment of the health care sector.

[13] Megan Messerly, "These states tried an Obamacare public option. It hasn't worked as planned.," POLITICO, December 27, 2022, https://www.politico.com/news/2022/12/27/health-care-costs-public-option-00075150

Congressional Budget Office
*Nonpartisan Analysis for the U.S. Congress*

**ANSWERS TO QUESTIONS FOR THE RECORD**

Following a Hearing on

# Alternative Payment Models and the Slowdown in Federal Health Care Spending

Conducted by the
Committee on the Budget
United States Senate

October 27 | 2023

*On October 18, 2023, the Senate Committee on the Budget convened a hearing at which Chapin White, the Congressional Budget Office's Director of Health Analysis, testified about alternative payment models and the slowdown in federal health care spending. After the hearing, Ranking Member Grassley submitted questions for the record. This document provides CBO's answers. It is available at* www.cbo.gov/publication/59689.

## Ranking Member Grassley's Questions About CBO's Projections of Federal Health Care Spending

**Question.** During the hearing, you stated that the Congressional Budget Office currently estimates the federal government from 2010–2033 will spend $6.3 trillion less on major health care programs compared to an August 2010 CBO estimate. You stated $1.1 trillion was attributed to the 2010–2020 period and $5.2 trillion was attributed to the 2021–2033 period. What makes up the $6.3 trillion difference? Are there different reasons for changes in estimates for the 2010–2020 period and the 2021–2033 period? How much does CBO attribute the lower estimates to Medicare Part D and why?

**Answer.** CBO's 2010 projections for the 2010–2020 period overestimated spending on function 550 (Health, mostly for the Medicaid program) and function 570 (Medicare, net of premiums and other offsetting receipts) by $1.1 trillion. The difference between projected and actual mandatory outlays was $635 billion for function 550 and $431 billion for function 570. Legislative changes increased CBO's estimate by $15 billion for function 550 and by $106 billion for function 570, but those increases were more than offset by technical changes that decreased the agency's estimate. Most of CBO's overestimate of spending for Medicare and Medicaid stemmed from an overestimate of spending per beneficiary and not an overestimate of the number of beneficiaries.

There were two significant sources of error in CBO's 2010 projections. The first significant source of error was less-than-anticipated spending on prescription drugs in Medicare Part D (the program that covers the cost of beneficiaries' outpatient prescription drugs). Actual Medicare Part D net outlays were about $333 billion lower over the 2010–2020 period than CBO projected in its August 2010 baseline. That amount represents about 30 percent of the $1.1 trillion difference. The agency identified two reasons for the slower-than-expected growth in prescription drug spending, both nationally and in Part D. First, as existing brand-name drugs lost their patent protection, they faced new competition from generic drugs, and a significant share of prescriptions shifted to less expensive generic formulations. Second, fewer new brand-name drugs, which would have been more expensive, were introduced than CBO had anticipated.

The second significant source of error in CBO's 2010 projections was slower-than-anticipated growth in spending on long-term services and supports (LTSS) in Medicaid. The slower growth in spending was driven by two factors. First, the number of users of non-institutional LTSS grew more slowly than it did from 2000 to 2010. Second, states have increasingly shifted patients from institutional to noninstitutional settings (where care is provided at a lower cost), and more institutional services have been delivered by managed care plans (which actively seek to control costs). Both of those alternative-care delivery mechanisms are generally less costly on a per user basis.

CBO's February 2023 projections of spending on the major federal health care programs for the 2021–2033 period were $5.2 trillion lower than what the agency had projected in June 2010 for that same period. Medicare accounted for about one-third of the $5.2 trillion difference, and Medicaid, the Children's Health Insurance Program, and the Affordable Care Act marketplace subsidies accounted for about two-thirds of that difference. CBO's 2010 projections for the 2021–2033 period did not have a separately identifiable estimate of net spending in Part D.

One reason for the lower projection for the 2021–2033 period is that CBO previously overestimated spending on major health care programs over the 2010–2020 period. Another reason is that in 2010, the agency's long-term projection methods had not yet been updated to reflect the significantly slower rate of growth in federal spending on major health care programs in recent decades.

**Question.** Major health care program spending takes up 32 percent of federal revenue today, and it will be 45 percent of revenue by 2053. CBO projects spending on Medicare to account for more than four-fifths of the increase in spending on federal health care programs over the next 30 years. CBO has also said that Medicare's

increased spending largely stems from rising health care costs per person and demographic trends. How much of this increased spending is due to rising costs per person and how much is related to demographic trends? Does adding new procedure codes play a role?

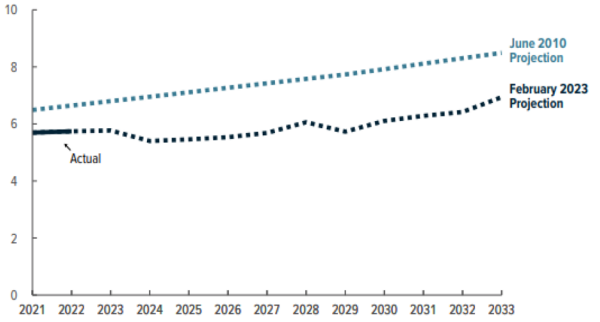
**Answer.** Over the 2023–2053 period, growth in health care costs per person accounts for over two-thirds of the increase in spending, measured as a percentage of gross domestic product (GDP), on the major health care programs.[1] Over that same period, about one-third of the projected increase in total spending on the major health care programs, measured as a percentage of GDP, is attributable to the aging of the population.

CBO's long-term projections of federal health care spending are driven, in part, by the continued emergence of new technologies and by rising incomes, which allow for the adoption and diffusion of such technologies. The agency does not project the number of procedure codes or the emergence of specific procedure codes.

1. The analysis of the causes of the growth in spending on the major health care programs encompasses gross spending on Medicare and does not reflect receipts credited to the program from premiums and other sources.

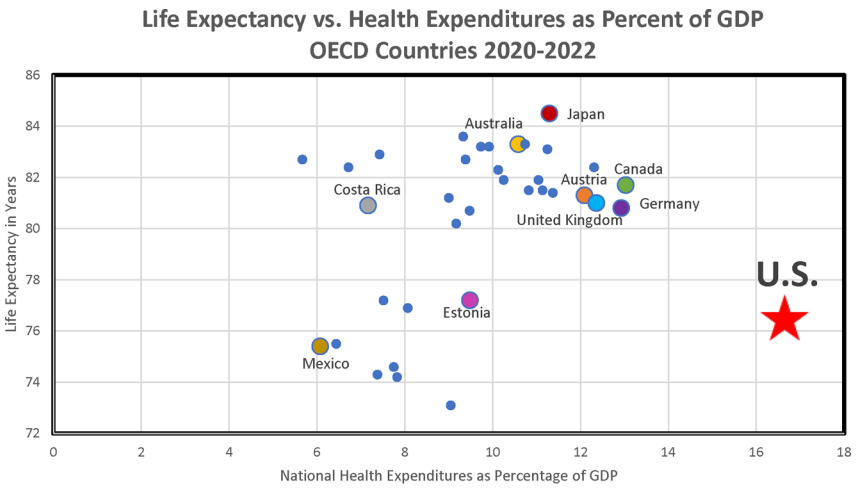
## CBO's Projections of Federal Outlays for the Major Health Care Programs

Percentage of Gross Domestic Product




Data source: Congressional Budget Office.

The June 2010 projection values for 2021 to 2033 reflect CBO's past projections as published in *The Long-Term Budget Outlook* (June 2010), www.cbo.gov/publication/21546. Actual amounts are reported through 2022; the February 2023 projection values for 2023 through 2033 reflect CBO's current projections as published in the *Budget and Economic Outlook: 2023 to 2033* (February 2023), www.cbo.gov/publication/58848. Outlays for the major federal health care programs consist of federal spending for Medicare (net of premiums and other offsetting receipts), Medicaid, and the Children's Health Insurance Program, as well as subsidies for health insurance purchased through the marketplaces established under the Affordable Care Act.




Source: OECD (2023), Health spending (indicator). doi: 10.1787/8643de7e-en;
Life expectancy at birth (indicator). doi: 10.1787/27e0fc9d-en

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

March 17, 2023

Honorable Sheldon Whitehouse
Chairman
Committee on the Budget
United States Senate
Washington, DC 20510

*Re: CBO's Projections of Federal Health Care Spending*

Dear Mr. Chairman:

You asked the Congressional Budget Office to gauge the accuracy of its projections of federal health care spending over time. In particular, you would like information about several aspects of the agency's work: how CBO's 2010 projections compare with actual spending and the agency's current baseline; why the 2010 projections overestimated or underestimated actual spending; how health outcomes and spending on health care in the United States compare with those measures in other countries; and how CBO incorporates past errors into its current and future baseline projections and estimates of the costs of legislation. This letter addresses those questions. In brief, these are the agency's findings:

- CBO overestimated mandatory spending for health care in its projections for the 2010–2020 period. Over that period, mandatory outlays for the two broad budget categories covering the major health care programs (mostly Medicare and Medicaid) were 9 percent lower than CBO projected in 2010.

- Most of the overestimate for the Medicare and Medicaid programs stemmed from an overestimate of spending per beneficiary, not an overestimate of the number of beneficiaries. Less-than-anticipated spending for prescription drugs in Medicare Part D and for long-term services and supports (LTSS) in Medicaid were two significant sources of error in CBO's 2010 projections.

- The rate of growth in federal mandatory spending on health care per beneficiary has slowed sharply since 2005. For example, Medicare spending per beneficiary grew at an average annual rate of 6.6 percent between 1987 and 2005, 3.1 percent between 2007 and 2012, and 2.2 percent between 2013 and 2019. Several developments may have contributed to that slowdown in spending growth, and the findings of several research papers do not fully account for that trend, in CBO's assessment.

- The United States spends a larger share of its gross domestic product (GDP) on health care than other advanced economies and performs worse on various measures of health outcomes than many of those same countries. In 2019, U.S. health expenditures were 17.6 percent of GDP, nearly 7 percentage points higher than the average of other comparably wealthy countries.

- By examining the accuracy of its past projections, CBO identifies opportunities to improve its current and future projections and cost estimates. The agency regularly publishes reports explaining how it has assessed the accuracy of its projections and the changes it has made as a result.

Fuller explanations for each of those findings is provided below.

**How do CBO's August 2010 baseline projections of federal health care spending compare with actual spending over the 2010–2020 period?**

CBO's baseline projections from August 2010—the first projections published after enactment of the Affordable Care Act—spanned the period from 2010 to 2020. At that time, the agency estimated that mandatory outlays for the two broad budget categories covering the major health care programs—function 550 (Health), mostly for the Medicaid program, and function 570 (Medicare, net of premiums and other offsetting receipts)—would be $11.7 trillion over the 2010–2020 period (see Table 1 on page 11).[1] Actual mandatory outlays for those categories turned out to be $10.6 trillion over that period, or 9 percent less than the amount CBO

[1] Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), www.cbo.gov/publication/21670. CBO's analysis of spending in this letter focuses on mandatory, or direct, spending. Such outlays are generally governed by statutory criteria and are not normally constrained by the annual appropriation process. For discretionary spending (which stems from authority provided in annual appropriation acts), differences over time between projected and actual outlays result largely from differences between projected funding and actual appropriations.

projected in 2010; the difference between projected and actual mandatory outlays was 12 percent for function 550 and 7 percent for function 570. For 2019, the last year covered in the agency's August 2010 projections that was unaffected by the coronavirus pandemic, mandatory outlays for budget functions 550 and 570 turned out to be $1.2 trillion, which was 17 percent lower than the agency had projected in 2010.

Changes to CBO's baseline projections are grouped in three categories: legislative changes, which result from enactment of new laws; economic changes, which stem from updates to the agency's economic forecast; and technical changes, which reflect all other updates to the agency's projections. Of the $232 billion difference between projected and actual mandatory outlays in 2019, only $16 billion is attributable to legislative and economic changes. The rest of the difference ($216 billion) stems from technical changes: $123 billion in function 550, and $94 billion in function 570.

Disentangling the reasons that estimated spending has differed from actual spending since the August 2010 projections is difficult. In a previous analysis, CBO discussed how the slowdown in the growth of health care spending and an overestimate of the number of people receiving premium tax credits through the health insurance marketplaces contributed to downward technical revisions to CBO's projections.[2] For this analysis, CBO looked in more detail at trends in Medicare and Medicaid spending since the 2010 projections. For both programs, the agency estimates that most of the projection errors resulted from an overestimate of spending per beneficiary and not an overestimate of the number of beneficiaries. In 2019, the actual number of Medicare and Medicaid beneficiaries turned out to be only 1 percent higher and 2 percent lower, respectively, than CBO estimated in its August 2010 projections.

For the Medicare program, the largest difference between CBO's August 2010 baseline projections of net spending in 2019 and actual net spending was an overestimate of net spending for Medicare Part D (the program that covers the cost of beneficiaries' outpatient prescription drugs). In a 2014 report, CBO identified two reasons for the slower-than-expected growth in prescription drug spending, both nationally and in Part D. First, as existing brand-name drugs lost their patent protection, they faced new competition from generic drugs, and a significant share of prescriptions shifted to less

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[2] Congressional Budget Office, Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections (December 2020), p. 13, www.cbo.gov/publication/56908.

expensive generic formulations.[3] Second, fewer new brand-name drugs, which would have been relatively more expensive, were introduced than CBO had anticipated.

For the Medicaid program, identifying the precise causes of the differences between CBO's August 2010 baseline projections of spending in 2019 and actual spending in that year is more difficult—mainly because of the major changes to Medicaid during that period. One contributing cause is less-than-anticipated spending for long-term services and supports, which help people with functional or cognitive limitations perform routine daily activities for an extended period. LTSS can be provided in an institutional setting (such as a nursing home) or a noninstitutional setting (such as a person's home or an adult day care center).

From 2000 to 2010, growth of LTSS spending averaged 5 percent annually; that growth was largely driven by 11 percent average annual growth in noninstitutional LTSS. Between 2011 and 2020, average annual growth of LTSS spending fell to 1 percent, and average annual growth in spending for noninstitutional LTSS declined to 4 percent. The slower growth in spending since 2010 has been driven by two factors. First, the number of users of noninstitutional LTSS grew more slowly than it did from 2000 to 2010. Second, states have increasingly shifted patients from institutional to noninstitutional settings (in which care is provided at a lower cost), and more institutional services have been delivered by managed care plans (which actively seek to control costs). Both of those alternative care-delivery mechanisms are generally less costly on a per user basis. As a result, spending for institutional LTSS in 2019 was lower than such spending in 2010.

**How do CBO's 2010 long-term projections of federal health care spending for the 2021–2033 period compare with actual spending in 2021 and 2022 and with current baseline spending projections?**

CBO's 2010 projections of federal outlays for the major health care programs beyond the 2010–2020 period were presented in its 2010 *Long-Term Budget Outlook*.[4] Federal outlays for the major health care programs consist of outlays for Medicare (net of premiums and other offsetting receipts), Medicaid, the Children's Health Insurance Program (CHIP), and

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[3] Congressional Budget Office, *Competition and the Cost of Medicare's Prescription Drug Program* (July 2014), www.cbo.gov/publication/45552.

[4] Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010), www.cbo.gov/publication/21546.

premium tax credits.[5] The health care projections in the *Long-Term Budget Outlook* reflect the agency's forecast for the next 30 years under the assumption that current laws governing taxes and spending generally remain the same. (The 2010 *Long-Term Budget Outlook* focused on projected health care outlays over the next 25 years, but CBO changed the length of its projection period to 30 years beginning in 2016.)

CBO's 2010 projections of federal outlays for the major health care programs in 2021 and 2022 can be compared with actual outlays for those years. In the long-term projections it made in 2010, CBO estimated that federal outlays for the major health care programs would account for 6.5 percent of GDP in 2021 and 6.6 percent of GDP in 2022. Actual outlays for those programs turned out to be 5.7 percent of GDP in both years.

Additionally, CBO's 2010 projections of federal outlays for the major health care programs over the 2023–2033 period can be compared with CBO's current baseline projections. In its long-term projections made in 2010, the agency estimated that those outlays would increase from 6.8 percent of GDP in 2023 to 8.5 percent of GDP in 2033. CBO now expects federal spending on those programs, measured as a percentage of GDP, to grow more slowly over that 10-year period, increasing from 5.8 percent of GDP in 2023 to 6.9 percent of GDP in 2033 (see Figure 1 on page 12).

Those sets of comparisons show that the rate of growth in federal spending on the major health care programs has slowed significantly since 2010 and that growth is expected to remain slower (relative to CBO's 2010 projections) over the next decade.

**What factors account for the recent slowdown in federal health care spending?**

In recent years, the growth of federal health care spending per beneficiary has slowed substantially. Between 1987 and 2005, for instance, Medicare spending per beneficiary grew at an average annual rate of 6.6 percent. But between 2007 and 2012, that rate was 3.1 percent.[6] The average annual

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[5] Those major health care programs are mandatory. That scope of spending is narrower than the spending reported for 2010 to 2020 in Table 1, which comprises all of mandatory spending in budget functions 550 and 570.

[6] CBO omitted the growth rate for 2006 from the comparisons because that was the year in which Medicare Part D was introduced.

growth rate in the years that followed (before the pandemic began in 2020) was even lower, at 2.2 percent.[7]

To better understand what factors contributed to that slowdown, CBO reviewed several research papers. The findings from those papers do not fully account for the widespread slowdown in federal health care spending, in CBO's assessment.[8] The agency previously pointed to two factors—both of which are discussed in the research papers—that are known to have contributed to that recent trend.[9] Those factors are decreases in the growth of Medicare's payment rates, which are set through laws and regulations, and reduced spending on patients with cardiovascular diseases. The latter outcome stems from better management of such conditions, including greater use of medications to control risk factors, such as hypertension and diabetes.[10]

Recent research has suggested a potential third reason for the slowdown: a shift in the relative importance of technology in fueling the growth of health care spending. Historically, the pace of diffusion and the adoption of new technology have been key drivers of increases in health care spending,

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[7] CBO calculated those amounts using data through 2019 from the Centers for Medicare & Medicaid Services. In particular, see the entries for "growth rates," "per enrollee," and "Medicare" in Centers for Medicare & Medicaid Services, National Health Expenditure Data, Historical, Expenditures, "Table 21: Enrollment and Per Enrollee Estimates of Health Insurance: United States, Calendar Years 1987–2021" (accessed March 9, 2023), https://tinyurl.com/23tm6xdf.

[8] See, for example, Melinda B. Buntin and others, "Trends in and Factors Contributing to the Slowdown in Medicare Spending Growth, 2007–2018," *JAMA Health Forum*, vol. 3, no. 12 (December 2022), pp. 1–12, https://tinyurl.com/5n8ay43e; Laura M. Keohane, Lucas Stewart, and Melinda B. Buntin, *The Slowdown in Medicare Spending Growth for Baby Boomers and Older Beneficiaries: Changes in Medicare Spending Levels and Growth by Age Group, 2007–2015* (Commonwealth Fund, December 2019), https://doi.org/10.26099/sy0d-xs78; David M. Cutler and others, "Explaining the Slowdown in Medical Spending Growth Among the Elderly, 1999–2012," *Health Affairs*, vol. 38, no. 2 (February 2019), pp. 222–229, https://tinyurl.com/y4nau678; Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, "Is This Time Different? The Slowdown in Health Care Spending," *Brookings Papers on Economic Activity* (Fall 2013), pp. 261–323, https://tinyurl.com/3vz5k35c; Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), www.cbo.gov/publication/44513; and Alexander J. Ryu and others, "The Slowdown in Health Care Spending in 2009–11 Reflected Factors Other Than the Weak Economy and Thus May Persist," *Health Affairs*, vol. 32, no. 5 (May 2013), pp. 835–839, www.healthaffairs.org/doi/full/10.1377/hlthaff.2012.1297.

[9] Congressional Budget Office, Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections (December 2020), p. 13, www.cbo.gov/publication/56908.

[10] David M. Cutler and others, "Explaining the Slowdown in Medical Spending Growth Among the Elderly, 1999–2012," *Health Affairs*, vol. 38, no. 2 (February 2019), pp. 222–229, https://tinyurl.com/y4nau678.

but one recent study found that their contribution from 2009 to 2019 was notably smaller than it had been over a longer period starting in 1970.[11] That finding is consistent with a shift toward the diffusion of cost-saving technologies—such as those used to treat cardiovascular diseases.[12]

**How do health outcomes and spending on health care in the United States compare with those measures in other countries?**

Despite the recent slowdown in health care spending, the United States continues to spend a higher share of its GDP on health care—as it has for many decades—than other advanced economies. In 2019, U.S. health expenditures were 17.6 percent of GDP. That amount was nearly 7 percentage points higher than the average of other comparably wealthy countries and 5.9 percentage points higher than health care spending in Germany, the country with the next-highest spending among that group of wealthy nations.[13] Spending is much higher in the United States despite similar inputs and levels of health care utilization, which indicates that the prices paid for health care in the United States are higher.[14] Those higher prices reflect a mix of factors, including higher prices for labor, medical devices, and prescription drugs, as well as higher administrative costs (such as those related to processing claims and updating patients' medical records).[15]

Other high-income countries perform similarly or better on many—but not all—health outcome measures. For instance, among a group of nine high-

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[11] Shelia D. Smith, Joseph P. Newhouse, and Gigi A. Cuckler, *Health Care Spending Growth Has Slowed: Will the Bend in the Curve Continue?* Working Paper 30782 (National Bureau of Economic Research, December 2022), www.nber.org/papers/w30782.

[12] Congressional Budget Office, Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections (December 2020), p. 13, www.cbo.gov/publication/56908.

[13] Matthew McGough and others, "How Does Health Spending in the U.S. Compare to Other Countries?" (Peterson-KFF Health System Tracker, posted February 9, 2023), https://tinyurl.com/bdf6pdzv. For information about how differences in the prices paid for health care services by country affect differences in countries' spending for that care, see Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (September 2022), www.cbo.gov/publication/58222.

[14] Congressional Budget Office, *Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services* (September 2022), www.cbo.gov/publication/58222.

[15] Gerard F. Anderson, Peter Hussey, and Varduhi Petrosyan, "It's Still the Prices, Stupid: Why the U.S. Spends So Much on Health Care, and a Tribute to Uwe Reinhardt," *Health Affairs*, vol. 38, no. 1 (January 2019), pp. 87–95, https://doi.org/10.1377/hlthaff.2018.05144; and Irene Papanicolas, Liana R. Woskie, and Ashish K. Jha, "Health Care Spending in the United States and Other High-Income Countries," *JAMA*, vol. 319, no. 10 (March 2018), pp. 1024–1039, https://doi.org/10.1001/jama.2018.1150.

income countries, the United States had the highest maternal mortality rate and lowest life expectancy at birth.[16] The United States also lagged behind other nations on performance measures related to access to care and avoidable hospital admissions. For other measures, like those related to 30-day mortality rates for acute myocardial infarction and stroke, the United States landed near the top of the rankings among those same countries.[17] In general, using summary health outcome measures to assess the efficiency of national health systems is difficult because many outcomes are affected by other factors that are not attributable to the health care system and that cannot easily be controlled for in most available measures.

**How does CBO review the accuracy of its projections and incorporate observed trends into current and future projections and cost estimates?**

CBO frequently analyzes its projections of spending and its analyses of legislation to identify errors and opportunities to improve. Every year, the agency compares its projections for the most recent fiscal year with actual outlays and analyzes the extent of and sources of errors. CBO publishes a document summarizing that analysis.[18] Periodically, the agency also analyzes its projections over a longer period; that type of analysis was most recently published in 2019.[19]

Using the findings from those analyses, CBO identifies opportunities to refine its methodology and improve its projections. For example, in its March 2020 baseline, CBO updated its projections of spending growth under different parts of the Medicare program; as a result, the agency decreased its projection of the program's outlays by 1.3 percent over the 2021–2030 period. That revision in part reflected the agency's examination of actual spending during the early part of the 2020 fiscal year and growth

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[16] Nisha Kurani and Emma Wager, "How Does the Quality of the U.S. Health System Compare to Other Countries?" (Peterson-KFF Health System Tracker, posted September 30, 2021), https://tinyurl.com/374m998e.

[17] Organisation for Economic Co-operation and Development, *Health at a Glance 2019: OECD Indicators* (November 2019), https://doi.org/10.1787/4dd50c09-en.

[18] Congressional Budget Office, *The Accuracy of CBO's Budget Projections for Fiscal Year 2022* (January 2023), www.cbo.gov/publication/58603.

[19] Congressional Budget Office, *An Evaluation of CBO's Past Deficit and Debt Projections* (September 2019), www.cbo.gov/publication/55234.

rates in spending for various medical services—both of which were lower than expected.[20]

Assessing estimates of legislation can be challenging for various reasons. In some cases, for example, the agency cannot isolate the effects of legislation in administrative data from other underlying changes affecting outcomes. Despite those challenges, at times CBO has been able to compare its estimates with actual outcomes. In 2017, for instance, CBO published a report discussing how projected marketplace subsidies and spending for Medicaid beneficiaries made eligible by the Affordable Care Act differed from actual amounts.[21] Two other examples are a report that the agency published in 2012 on the relationship between increased use of prescription drugs and decreases in spending on medical services for the Medicare population and a report from 2014 analyzing why CBO's estimate of outlays for the Medicare Part D program differed from actual outlays.[22] CBO used the findings from the 2012 and 2014 reports in its later estimates of legislation (including the 2022 reconciliation act) that affected utilization of prescription drugs.

By examining actual spending and evaluating the experiences of other programs, CBO is sometimes able to discern what adjustments to make to key estimating inputs to improve its projections. For instance, when CBO analyzed the reasons underlying the difference between its cost estimate for the Medicare-Eligible Retiree Health Care Fund and actual expenditures from the fund, it found that fewer eligible military retirees and their dependents initially used some of the benefits covered by the fund.[23] On the basis of that experience, as well as experience with other federal programs (including Part D), CBO expects that full participation in new government programs will happen with a longer delay.

In addition to routinely updating the baseline by reviewing and incorporating the latest data on Medicare spending, CBO reevaluates its long-term projections by examining historical spending trends over an

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[20] Congressional Budget Office, *Baseline Budget Projections as of March 6, 2020* (March 2020), www.cbo.gov/publication/56268.

[21] Congressional Budget Office, *CBO's Record of Projecting Subsidies for Health Insurance Under the Affordable Care Act: 2014 to 2016* (December 2017), www.cbo.gov/publication/53094.

[22] Congressional Budget Office, *Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services* (November 2012), www.cbo.gov/publication/43741.

[23] Congressional Budget Office, *A Review of CBO's Estimate of Spending From the Department of Defense's Medicare-Eligible Retiree Health Care Fund* (October 2020), www.cbo.gov/publication/56653.

extended period. That process, together with changes to CBO's projection methods, resulted in the agency's revising downward its estimate of additional cost growth at the end of the 30-year projection period used in the 2022 *Long-Term Budget Outlook*. (Additional cost growth is the amount by which the growth rate of nominal health care spending per person, adjusted to remove the effects of demographic changes, exceeds the growth rate of potential GDP per person.) Using that revised growth parameter, CBO projected that federal spending on Medicare as a share of GDP would be about one-half of one percentage point lower in 2052 than what the agency would have projected using its earlier estimate of additional cost growth.[24]

I hope this information is helpful to you. If you have any additional questions, please contact me.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable Chuck Grassley
Ranking Member
Senate Committee on the Budget

[24] Congressional Budget Office, *The 2022 Long-Term Budget Outlook* (July 2022), www.cbo.gov/publication/57971.

Table 1.

## Comparison of CBO's August 2010 Projections and Actual Amounts of Mandatory Outlays for Budget Functions 550 and 570, by Fiscal Year

Billions of Dollars

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Total, 2010–2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Functions 550 and 570 | | | | | | | | | | | | |
| Actual amounts | 750 | 790 | 752 | 793 | 859 | 966 | 1,043 | 1,064 | 1,072 | 1,163 | 1,338 | 10,590 |
| August 2010 projections | 751 | 798 | 778 | 831 | 930 | 1,026 | 1,148 | 1,224 | 1,287 | 1,395 | 1,489 | 11,656 |
| Differences | | | | | | | | | | | | |
| Legislative changes | 0 | 12 | 20 | 16 | 3 | -1 | 5 | 4 | -1 | -10 | 74 | 121 |
| Economic changes | 0 | 1 | 2 | 4 | 7 | 4 | -2 | -11 | -4 | -6 | -3 | -8 |
| Technical changes | -1 | -21 | -48 | -57 | -80 | -63 | -108 | -153 | -210 | -216 | -223 | -1,179 |
| **Total Differences** | **-1** | **-8** | **-26** | **-38** | **-71** | **-60** | **-105** | **-160** | **-215** | **-232** | **-151** | **-1,066** |
| Function 550—Health (mostly Medicaid) | | | | | | | | | | | | |
| Actual amounts | 304 | 310 | 286 | 301 | 354 | 426 | 455 | 473 | 490 | 519 | 569 | 4,486 |
| August 2010 projections | 304 | 315 | 299 | 309 | 380 | 449 | 522 | 574 | 612 | 657 | 700 | 5,121 |
| Differences | | | | | | | | | | | | |
| Legislative changes | 0 | 0 | 2 | 1 | -2 | -5 | -5 | 0 | 3 | -4 | 24 | 15 |
| Economic changes | 0 | 0 | 0 | 3 | 6 | 6 | 0 | -6 | -9 | -11 | -11 | -23 |
| Technical changes | 0 | -5 | -15 | -12 | -30 | -23 | -63 | -95 | -116 | -123 | -145 | -627 |
| **Total Differences** | **0** | **-5** | **-13** | **-8** | **-26** | **-23** | **-67** | **-101** | **-122** | **-138** | **-132** | **-635** |
| Function 570—Medicare | | | | | | | | | | | | |
| Actual amounts | 446 | 480 | 466 | 492 | 505 | 540 | 588 | 591 | 582 | 644 | 769 | 6,104 |
| August 2010 projections | 447 | 483 | 479 | 522 | 550 | 577 | 626 | 650 | 675 | 738 | 788 | 6,535 |
| Differences | | | | | | | | | | | | |
| Legislative changes | 0 | 11 | 18 | 14 | 4 | 4 | 10 | 4 | -4 | -6 | 50 | 106 |
| Economic changes | 0 | 1 | 2 | 1 | 1 | -1 | -2 | -5 | 5 | 5 | 8 | 15 |
| Technical changes | -1 | -15 | -33 | -45 | -50 | -40 | -45 | -57 | -94 | -94 | -78 | -553 |
| **Total Differences** | **-1** | **-3** | **-13** | **-30** | **-45** | **-37** | **-38** | **-59** | **-93** | **-94** | **-20** | **-431** |
| **Memorandum:** | | | | | | | | | | | | |
| Percentage Difference | | | | | | | | | | | | |
| Functions 550 and 570 | 0 | -1 | -3 | -5 | -8 | -6 | -9 | -13 | -17 | -17 | -10 | -9 |
| Function 550 | 0 | -2 | -4 | -3 | -7 | -5 | -13 | -18 | -20 | -21 | -19 | -12 |
| Function 570 | 0 | -1 | -3 | -6 | -8 | -6 | -6 | -9 | -14 | -13 | -2 | -7 |

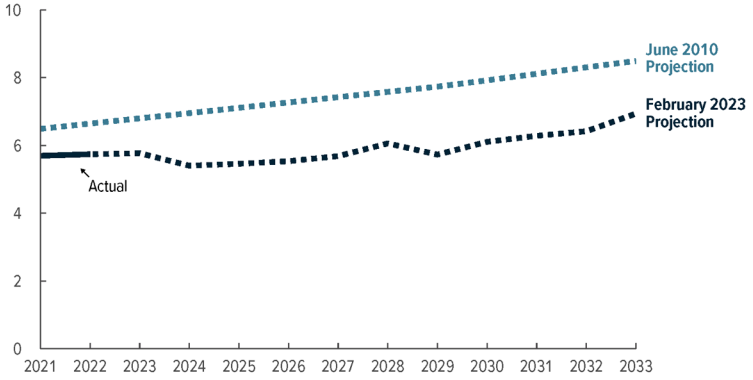
Data source: Congressional Budget Office.

CBO's analysis of spending in this letter focuses on mandatory, or direct, spending. Such outlays are generally governed by statutory criteria and are not normally constrained by the annual appropriation process. For discretionary spending (which stems from authority provided in annual appropriation acts), differences over time between projected and actual outlays result largely from differences between projected funding and actual appropriations. Outlays for function 570 are net of premiums and other offsetting receipts.

Figure 1.

## CBO's Projections of Federal Outlays for the Major Health Care Programs

Percentage of Gross Domestic Product




Data source: Congressional Budget Office.

The June 2010 projection values for 2021 to 2033 reflect CBO's past projections as published in *The Long-Term Budget Outlook* (June 2010), www.cbo.gov/publication/21546. Actual amounts are reported through 2022; the February 2023 projection values for 2023 through 2033 reflect CBO's current projections as published in the *Budget and Economic Outlook: 2023 to 2033* (February 2023), www.cbo.gov/publication/58848. Outlays for the major federal health care programs consist of federal spending for Medicare (net of premiums and other offsetting receipts), Medicaid, and the Children's Health Insurance Program, as well as subsidies for health insurance purchased through the marketplaces established under the Affordable Care Act.

October 18, 2023

The Honorable Patrick McHenry
Acting Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
Democratic Leader
U.S. House of Representatives
H-204, The Capitol
Washington, DC 20515

The Honorable Charles Schumer
Majority Leader
U.S. Senate
S-221, The Capitol
Washington, DC 20510

The Honorable Mitch McConnell
Republican Leader
U.S. Senate
S-230, The Capitol
Washington, DC

**Re: Extend Medicare Advanced Alternative Payment Model Incentive Payments**

Dear Acting Speaker McHenry, Leader Jeffries, Leader Schumer, and Leader McConnell:

On behalf of the 23 undersigned physician and health care associations and over 600 health systems, hospitals, physician practices, health clinics, and accountable care organizations (ACOs), thank you for your leadership in ensuring that physicians and other clinicians have adequate resources to care for the health of the U.S. population. As Congress considers priority end-of-year legislation, we ask that you bolster and advance the ongoing transition to value-based payment models by extending the 5 percent advanced alternative payment model (APM) incentive payments for clinicians that were authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Eight years ago, Congress passed MACRA to shift how Medicare pays clinicians for health care services. Key goals were to encourage keeping patients healthy, reducing unnecessary care, and lowering costs for both patients and taxpayers. APMs have demonstrated that when physicians and other clinicians are held accountable for costs and quality and provided flexibility from fee-for-service (FFS) constraints, they can generate savings for taxpayers and improve beneficiary care.

Recognizing that FFS payments alone are not sufficient to cover the expenses associated with building and maintaining the necessary infrastructure to engage in wholescale care delivery redesign, MACRA included 5 percent incentive payments to enable clinicians to transition to advanced APMs (i.e., down-side risk APMs). This strategy has proven successful as participation in advanced APMs has grown by more than 173 percent with nearly 300,000 clinicians.[1]

The advanced APM incentive payments have allowed clinicians to cover some of the investment costs of moving to new payment models, including expanding care teams, developing programs to improve beneficiary care, and adopting population health infrastructure. Incentives also help to improve care for patients by giving clinicians financial resources to expand services beyond those covered by traditional Medicare.

With the eligibility to earn advanced APM incentive payments set to expire at the end of 2023, progress towards value-based care could stall further. Absent Congressional intervention, physicians and other clinicians will be more likely to remain in MACRA's Merit-based Incentive Payment System (MIPS), which is burdensome, presents participants with financial costs associated with compliance and quality assurance measures, and does little to accurately assess improvements in health care outcomes. Moreover, some physicians currently in advanced APMs may be pushed back into MIPS because of increasing qualification thresholds, while others may choose to voluntarily shift back to MIPS because the program will continue to offer opportunities for high

[1] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2433/2021%20QPP%20Experience%20Report.pdf

performing APMs to qualify for MIPS adjustments in the coming years. The prospect of remaining in, or moving to, MIPS is particularly daunting as clinicians are slated for a 3.36 percent Medicare Part B payment cut stemming from the provisions in the Calendar Year 2024 Medicare Physician Fee Schedule Proposed Rule. Unless Congress intercedes, these payment reductions will take effect on January 1, 2024.

In recognition of our commitment to helping physicians and other clinicians move away from MIPS and advance Medicare's transition to accountable care, we urge you to include Section 3 of the Value in Health Care Act (H.R. 5013) in any end-of-year legislative package. This bipartisan legislation includes a two-year extension of MACRA's original 5 percent advanced APM incentives and adjusts the one-size-fits-all approach to revenue qualification thresholds to ensure that physicians and other clinicians continue to participate in APMs. These two crucial policy changes will help facilitate the continued transition to advanced APM arrangements while gradually increasing the associated revenue qualifications for incentive payments.

Lastly, Medicare's advanced APM incentives are a good return on investment. In 2022, ACOs produced $1.8 billion in savings that was returned to Medicare.[2] This savings is significantly more than the $644 million paid in incentives this year.[3] APMs may also be helping to slow the growth in health care spending in Medicare and beyond. The Congressional Budget Office (CBO) released data earlier this year showing that actual 2022 federal spending on Medicare and Medicaid was 9 percent lower than original projections.[4] Some of the features that characterize participation in APMs, such as improved care management and more efficient use of technology, are among factors that may have contributed to these lower-than-expected costs.

We ask you to advance this important legislation, which will give our organizations the flexibility and financial security needed to innovate care, improve the health of our populations, and lower health care costs.

We appreciate your consideration of this matter.

Sincerely,

American Medical Association
AMGA
National Association of ACOs
Accountable for Health
American Academy of Neurology
American College of Physicians
American Society for Radiation Oncology
America's Essential Hospitals
Association of American Medical Colleges
Federation of American Hospitals
National Rural Health Association
Primary Care Collaborative
America's Physician Groups
Health Care Transformation Task Force
Premier Inc.
American Academy of Family Physicians
American Association of Orthopaedic Surgeons
American Osteopathic Association
American Society of Nephrology
Association for Clinical Oncology
Association of Community Cancer Centers
Medical Group Management Association
Partnership to Empower Physician-Led Care

cc:
Chairwoman Cathy McMorris Rodgers
Chairman Jason Smith
Chairman Jodey Arrington
Chairman Ron Wyden
Chairman Sheldon Whitehouse
Ranking Member Frank Pallone
Ranking Member Richard Neal
Ranking Member Brendan Boyle
Ranking Member Mike Crapo
Ranking Member Charles Grassley

[2] https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high
[3] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2517/QPCount_IncentivePayments.pdf
[4] https://www.cbo.gov/system/files/2023-03/58997-Whitehouse.pdf

**Health Systems, Hospitals, Physician Practices, Health Clinics, and ACOs**

**Accountable Care Coalition of Direct Contracting, LLC**: AZ, CA, CO, CT, FL, GA, IL, MA, MI, NJ, NM, NY, OH, PA, TN, TX, UT, VA

**Avera Health**; Sioux Falls, SD, MN, IA, NE

**Banner Health**; Phoenix, AZ, CA, CO, NE, NV, WY

**Bellin and Gundersen Health System**; Madison, WI, MN, IA, MI

**Bluestone Physician Services**; Stillwater, MN, WI, FL

**Caravan Collaborative ACO 22;** AL,AR,AZ,CA,CT,FL,GA,HI,IA,ID,IL,IN,KY,LA,MI, MN,MO,MT,NC,ND,NE,NJ,NM,NY,OR,PA,SD,TX,WA,WI,WV,WY

**Caravan Collaborative ACO 50;** AR,CA,CO,GA,GU,IA,ID,IL,IN,KY,LA,MA,MI,MN,MO,MT,NC,ND,NE,OH,OR,TX,WA,WI,WV,WY

**Care New England Medical Group**; East Greenwich, RI, MA, CT

**CareConnectMD ACO**; CA, MI, SD, OH, IN, NY, TX, GA, FL, SC, NC, NE

**Clover Health;** NJ, FL, OK, NE, MO, IL, GA, KS, NM, TX

**Collaborative Health Systems**; AZ, CA, CO, CT, DC. FL, GA, IL, MA, MD, MI, NJ, NM, NY, OH, PA, TN, TX, UT, VA, WI

**CommonSpirit Health**; IL, AR, AZ, CA, CO, GA, IA, IN, KS, KY, MN, ND, NE, NM, NV, OH, OR, PA, TN, TX, UT, WA, WI

**Community Care of Brooklyn**; New York, NY

**Essentia Health**; Duluth, MN; WI; ND

**Evolent Care Partners / The Accountable Care Organization, Ltd;** CA, FL, IN, KS, KY, MI, NC, NY, TX, UT

**HarmonyCares ACO;** Troy, MI, OH, PA, VA, FL, TX, WA, MO, WI, IL, IN, GA

**Health Choice Care**; Miami, FL, HI, MO, NC, RI

**ilumed, LLC**; Jupiter, FL, SC, AL, WV, KY, OH, TX, NJ, NY, TN

**Imperium Health**; Louisville, KY, OK, AL, LA, FL, PA, CA, UT, NV, VA, AR, AK, TX, TN

**Intermountain Health**; UT; ID, NV, CO, MT

**Jefferson Health**, Philadelphia, PA & NJ

**Lumeris**; MO, OH, CA, GA

**On Belay Health Solutions;** MA; OR, CA, SD, NE, TX, FL, GA, TN, VA, IN, OH, PA, NJ, ME, RI

**Prominence Health**; CA; NV; TX; FL; DC; SC; OK

**Providence;** AK, WA, OR, CA, MT, TX, NM

**Responsive Care Solutions**; Sarasota, FL; MN, OH, AK, DE, TN, CO

**Saint Alphonsus Health Alliance**; Boise, ID & OR

**Southeast Medical Group, PC**, Atlanta, GA; AL & TN

**Trinity Health Integrated Care, LLC**; MI, IL, OH, PA, DE, IN, ID, FL, NY

**Trinity Health Mid Atlantic**; PA, DE

**Trinity Health**; MI ID, NY, PA, FL, DE, IL, OH, IA, CT, MA

**Upstream**; NC, VA, SC

**USMM Accountable Care Partners**; MI, OH, PA, VA, FL, GA, TX, MO, WA, WI, IL, IN

**Valley Health System**; VA; WV

**Vanderbilt Health Affiliated Network**; TN, KY

**VillageMD**; OR, NV, AZ, CO, TX, IL, IN, MI, KY, GA, FL, NJ, RI, MA, NH

**Votion ACO**; FL, GA, AL, TX, SC, MI, OK, TN, MS

**Wellvana;** TN VA, WI, MI, GA, FL, CA, TX, LA, NY, SC, NC, AR, MO, OH, OK, KS, AZ, NM

**Aaron M. Roland, M.D.;** Burlingame, CA

**Abimbola M. Banjo M.D. P.A.**; Pleasanton, TX

**Access Family Medicine of Sacramento**; Sacramento, CA

**Accountable Care Coalition of Georgia, LLC.**

**Accountable Care Coalition of Northeast Partners, LLC**

**Accountable Care Coalition of Southeast Texas, Inc.**

**Accountable Care Coalition of Southeast Wisconsin, LLC**
**Advance Family Practice, LLC**; Florida
**AdvantagePoint Health Alliance, LLC**
**AdvantagePoint Health Alliance, LLC** - Blue Ridge
**AdvantagePoint Health Alliance, LLC** - Bluegrass
**AdvantagePoint Health Alliance, LLC** - Hot Springs
**AdvantagePoint Health Alliance, LLC** - Laurel Highlands
**AdvantagePoint Health Alliance, LLC** - Northwest
**AdvantagePoint Health Alliance, LLC** - Tennessee Valley
**AdvantagePoint Health Alliance, LLC** - Western North Carolina
**AdventHealth**; Orlando, FL
**Adventist Health**, Roseville, CA
**Advocate Health**; Oak Lawn, IL, WI, GA, NC, SC
**agilon health**, Texas
**Aledade Accountable Care 101, LLC**
**Aledade Accountable Care 102, LLC**
**Aledade Accountable Care 103, LLC**
**Aledade Accountable Care 12, LLC**
**Aledade Accountable Care 128, LLC**
**Aledade Accountable Care 143, LLC**
**Aledade Accountable Care 147, LLC**
**Aledade Accountable Care 149, LLC**
**Aledade Accountable Care 15, LLC**
**Aledade Accountable Care 16, LLC**
**Aledade Accountable Care 22, LLC**
**Aledade Accountable Care 25, LLC**
**Aledade Accountable Care 34, LLC**
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**Aledade Accountable Care 38, LLC**
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**Aledade Accountable Care 80, LLC**
**Aledade Accountable Care 90, LLC**
**Aledade Accountable Care 91, LLC**
**Aledade Accountable Care 92, LLC**
**Aledade Accountable Care 93, LLC**
**Aledade Accountable Care 94, LLC**
**Aledade Accountable Care 98, LLC**
**Aledade Accountable Care 99, LLC**
**Aledade Arkansas ACO, LLC**

**Aledade Delaware ACO LLC**
**Aledade Duwamish ACO, LLC**
**Aledade Florida Central ACO, LLC**
**Aledade Kansas ACO, LLC**
**Aledade Louisiana ACO, LLC**
**Aledade Mississippi ACO, LLC**
**Aledade Primary Care ACO LLC**
**Aledade West Virginia ACO, LLC**
**Aledade**, Bethesda, MD
**Aledo Family Medicine;** Aledo, TX
**Alicia W Grossmann M.D. Pa**; Austin, TX
**Alignment Health**; Orange, CA
**Alleghany Health**; Sparta, NC
**Allen Parish Community Healthcare;** Kinder, LA
**Altamonte Family Practice**; Florida
**Amin Medical Center**; Skippack, PA
**AMITA Health ACO**, Chicago, IL
**AmpliPHY of Kentucky ACO LLC**
**Andre K.S. Tse, M.D. PA**; Jacksonville, NC
**AnMed**; Anderson, SC
**Ann Arbor Endocrinology**; Ann Arbor, MI
**Ann H. Snyder, M.D., PA;** McKinney, TX
**Anna Abalos, M.D.;** Roseville, CA
**Antone Internal Medicine and Associates**; Southfield, MI
**Apex Primary Care**; Florida
**Apple Hill Podiatry Associates PC**; Pennsylvania
**Aquino Integrative Internal Medicine**; Roseville, MI
**Arbor Ypsi Foot & Ankle Center**; Ann Arbor, MI
**Arcadia Solutions, LLC**; Burlington, MA
**Arcare**, Augusta, AR
**Archbold Medical Center**; Thomasville, GA
**Arkansas Health Network**; Little Rock, AR
**Arthur Powell, M.D.**; Bingham Farms, MI
**Ascension Saint Thomas**; Nashville, TN
**Ascension**; St. Louis, MO
**Associated Endocrinologists**; Farmington Hills, MI
**Associated Family Physicians, Inc.**; Sacramento, CA
**Associates in Internal Medicine**; West Bloomfield, MI
**Associates in Physical Medicine & Rehab**; Ypsilanti, MI
**Assurity DCE, LLC**; Trinity, FL
**Atlantic Accountable Care Organization**; Morristown, NJ
**AtlantiCare**; Atlantic City, NJ
**Auburn Hills Medical Clinic**; Auburn Hills, MI
**Auburn Medical Group, Inc.;** Auburn, CA
**Azelvandre Family Practice**; Florida
**Baptist Health Quality Network**; Coral Gables, FL
**Baptist Health South Florida**; Miami, FL

**Barrett Hospital & Healthcare**; Dillon, MT
**Bay Family Medical Group**; San Mateo, CA
**Baycare Healthcare Partners**; Springfield, MA
**Be Well Medical Center**; Berkley, MI
**Beartooth Billings Clinic**; Red Lodge, MT
**Beaumont ACO**; Southfield, MI
**Bellin Health Partners**; Wisconsin, MI
**Bensalem Medical Practice**, PC; Bensalem, PA
**Beth Hanrahan, MD LLC**; Florida
**Better Health Group**; Tampa FL
**Bibb Medical Center**; Centerville, AL
**Billings Clinic**; Billings MT
**BJC Accountable Care Organization**; St. Louis MO
**Block, Nation, Chase & Smolen Family Medicine**; Florida
**Bloom Healthcare**; Wheat Ridge, CO
**Bluerock Care**; Washington, DC
**Bluestem Health**; Lincoln, NE
**BoiceWillis Clinic, P.A.**; Rocky Mount, NC
**Bond Clinic, P.A.**; Winter Haven, FL
**Bradon Kimura MD Inc**; Kealakekua; HI
**Bridges Health Partners, LLC**; Warrendale, PA
**Bucks Family Medical Associates P.C.**; Newtown, PA
**BuxMont Medical Associates, PC**; Warrington, PA
**Cancer Care Associates of York Inc**; Pennsylvania
**Capital Family Medicine**; Raleigh, NC
**Capital Family Physicians, P.A.**; Raleigh, NC
**Capitol Internal Medicine Associates;** Carmichael, CA
**Caravan Rural Health ACO**, Colorado
**Cardiology and Vascular Associates, P.C;** Bloomfield Hills, MI
**CareConnectMD, Inc.**; Costa Mesa, CA
**Carilion Clinic**; Roanoke, VA
**Carle Health**; Champaign, IL
**Carrboro Family Medicine Center, PA**; Carrboro, NC
**Cary Healthcare Associates, P.A.**; Cary, NC
**Cary Internal Medicine and The Diabetes Center**; Cary, NC
**Cary Medical Group**; Cary, NC
**Casillas Medical and Wellness**; Florida
**Central Bucks Family Practice**; Jamison, PA
**Central Florida ACO, LLC**; New Port Richey, FL
**Central Montana Medical Center**; Lewistown, MT
**Central Virginia Coalition of Healthcare Providers, LLC dba JerichoREACH ACO**
**Centrus Health Kansas City**; Westwood, KS
**Centry Valley Community Partners LLC**; Modesto, CA
**Chambersburg Health Services**; Pennsylvania
**Charles E Schalger, MD LTD d/b/a Family Health Associates**; Pennsylvania
**CHESS Health Solutions**; Winston-Salem, NC
**Cheyenne Regional**; Cheyenne, WY

**CHI Health Partners**; Omaha, NE
**Christiana Care Quality Partners ACO, LLC d/b/a eBrightHealth ACO**; Wilmington, DE
**Christie Clinic, PLLC**; Champaign, IL
**Christine Meyer, MD And Ass**; Exton, PA
**Christopher Greater Area Rural Health Planning Corporation**; West Christopher, IL
**Christus Health**; Texarkana, TX
**City Healthcare**; Florida
**Civitas Networks for Health**; National
**Clark Fork Valley Hospital**; Plains, MT
**Clarkston Internal Medicine**; Clarkston, MI
**Clarkston Medical Group**; Clarkston, MI
**Clarkston Medical Group**; Oxford, MI
**Clermont Medical Center**; Florida
**Cleveland Clinic**; Cleveland, OH, FL, NV
**Clover Fork Outpatient Medical Project**; Evarts, KY
**CNY Family Care, LLP**; East Syracuse, NY
**CNYAIM / IHANY**; Syracuse, NY
**Coal Country Community Health Center**; Center, ND
**Coastal Carolina Quality Care, Inc.**; New Bern, NC
**Commonwealth Primary Care ACO LLC**; Phoenix, AZ
**Commonwealth Primary Care**; Richmond, VA
**Community Care Collaborative**; Huntingdon Valley, PA
**Community Health Center of Lubbock, Inc.**; Lubbock, TX
**Community Health Provider Alliance**, Denver, CO
**Community Healthcare Partners ACO**; Munster, IN
**Community Memorial Healthcare**; Ventura, CA
**Community Memorial Hospital; Hamilton**, NY
**Complete Care Family Medicine Associates**; Florida
**Cone Health**, Greensboro, NC
**ConnectAmerica**; Bala Cynwyd, PA
**Conrad and Lieberman**, MDs; Chester, PA
**Coordinated Healthcare Services, P.A.;** Plano, TX
**Core Physicians, LLC / NH Cares ACO**; Exeter, NH
**Coulee Medical Center;** Grand Coulee, WA
**Cumberland Center for Healthcare Innovation, LLC (CCHI)**; Cookeville, TN
**Dallastown Medical Associates LLP**; Pennsylvania
**Dana Kerner LLC**; Southampton, PA
**David Bene, MD**; Pennsylvania
**David Fivenson, MD, Dermatology, PLLC**; Ann Arbor, MI
**David Paul Adams, M.D., P.A.**; Cary, NC
**Dawei Zheng, M.D.;** Sacramento, CA
**Deaconess Care Integration LLC**; Evansville, IN
**Delaware Valley ACO**; Radnor, PA
**Delikat Family Practice**; Florida
**Dennis S. Gray, M.D.**; Louisville, KY
**Devamani Gowda, M.D.;** Roseville, CA
**Dewitt Clinic**, Alvin, TX

**DHR Health**; Edinburg, TX
**Dina Sverdlov, M.D.**; San Mateo, CA
**Doctors ACO, LLC**; Athens, GA
**Doctors Emergency Service, PA**; Annapolis, MD
**Dominion Medical Associates, P.A.**; Austin, TX
**Douglas Young, M.D., Inc;** Sacramento, CA
**Dover Shores Family Practice, LLC**; Florida
**Doylestown Medical Associates, P.C.**; Doylestown, PA
**Doylestown Value Partners**; Doylestown, PA
**Drs. Borders and Associates**; Lexington, KY
**Drs. Elias & Oakley, MD PA**; Florida
**Duke Connected Care;** Durham, NC
**Duly Health and Care**; Wheaton, IL
**Eastpointe Family Physicians**; Eastpoint, MI
**Elkins Park Family Medicine**; Elkins Park, PA
**Equality Health Direct**; Phoenix, AZ
**Esse Health ACO**; St. Louis, MO
**Evolent Care Partners**; Raleigh, NC
**Family First Health Corporation**; Pennsylvania
**Family First Primary Care, PLLC**; Wake Forest, NC
**Family Health Care Center**; Royal Oak, MI
**Family Health West**; Fruita, CO
**Family Medical Center of Georgetown, P.A.**; Georgetown, TX
**Family Medical Center**; Florida
**Family Medical Center;** Orlando, Florida
**Family Medical Specialist of Florida, PLC**; Florida
**Family Medicine & Ambulatory Care Center;** Fair Oaks, CA
**Family Medicine Clinic, PC**
**Family Medicine Clinic**; Pearsall, TX
**Family Practice**; Warren, MI
**Feasterville Family Practice, LLP**; Holland, PA
**First Care Health Center**; Park River, ND
**Florida Accountable Care Services**; Winter Park, FL
**Folsom Lake Primary Care;** Folsom, CA
**Fort HealthCare, Inc**; Fort Atkinson, WI
**Franciscan Missionaries of our Lady Health System**; Baton Rouge, LA
**Fred Tehrani MD LLC**; Philadelphia, PA
**Freedom Healthcare Alliance**; Charleston, SC
**Gammons Medical**; Warren, MI
**Geisinger Medical Group**; Danville, PA
**Geisinger**; Wilkes Barre, PA
**Generations Family Practice, P.A.**; Cary, NC
**Genesis Health System**; Davenport, IA, IL
**Gettysburg Family Practice Inc**; Pennsylvania
**Gill Medical and Geriatrics Associates**; Scottsburg, IN
**Glatt Medical Limited Partnership**; Burlingame, CA
**Glendive Medical Center, Inc.**; Glendive, MT

**Grand View Health**; Sellersville, PA
**Granger Medical Clinic, PC;** Salt Lake City, UT
**Greater Louisville Internal Medicine;** Louisville, KY
**Greater Louisville Internal Medicine**; Prospect, KY
**Green and Seidner Family Practice Associates**; Landsdale, PA
**Greenhaven Family Practice;** Sacramento, CA
**Greentree Primary Care**; Clarksville, IN
**GS Peter Gross DO PC**; Philadelphia, PA
**Guam Seventh-day Adventist Clinic**; Tamuning, Guam
**Hancock Health;** Greenfield, IN
**Hanover Family Practices Associates LLC**; Pennsylvania
**Hazel Park Medical Center**; Hazel Park, MI
**Health Choice**
**Health Choice Community Partners**
**Health Partners for the Elderly;** Parkway Lutz, FL
**Healthcare Partners of the North Country ACO**, Watertown, NY
**HealthChoice LLC**; Memphis, TN
**Heart of Texas Community Health Center, Inc dba Waco Family Medicine**, Waco, TX
**Hematology Oncology Consultants**; Troy, MI
**Hendricks Regional Health**, Danville, IN
**Henry Ford Physicians Accountable Care Organization dba Mosaic ACO**; Detroit, MI
**Holy Redeemer Family Medicine**; Bensalem, PA
**Hospital Physicians Network**; Farmington Hills, MI
**Houston Methodist Coordinated Care**; Houston, TX
**Howard County Medical Center;** St. Paul, NE
**IHC Quality Partners**; Canton, OH
**Imperial Center Family Medicine and Immediate Care**; Durham, NC
**Independent Physicians of Wisconsin/Medpoint**; Milwaukee, WI
**Indian Valley Family Practice**; Souderton, PA
**Indiana Lakes Accountable Care Organization**; Goshen, IN
**Innovation Care Partners**; Scottsdale, AZ
**Innovative Healthcare Collaborative of Indiana**; Evansville, IN
**Inspira Health;** South New Jersey
**Integra Community Care Network**; Providence, RI
**Internal Medicine & Cardiology Associates**; Florida
**Internal Medicine MD, LLC**; Florida
**Internal Medicine Pediatrics Associates, P.A**; Cary, NC
**Internal Medicine Physicians**; Farmington Hills, MI
**Internal Medicine Primary Care Physicians**; Bloomfield Hills, MI
**Internal Medicine Specialists**; West Bloomfield, MI
**inVio Health Network**, Greenville, SC
**Iowa Primary Care Association**; Des Moines, IA
**Jacksonville Children's and Multispecialty Clinic, PA**; Jacksonville, NC
**Jacobs And Van Cleeff Internal Medicine, PC**; Cary, NC
**Jericho Reach**, Central VA
**John C. Chow, M.D.;** San Mateo, CA
**John R Medical Center**; Madison Heights, MI

**John T. Littell M.D. PA**; Florida

**Johnson Memorial Health**, Franklin, IN

**Jose I Sosa, M.D.**; Pearsall, TX

**Joseph A Marotta, M.D. PA**; San Antonio, TX

**Juan P. Suarez, MD**; Florida

**Kemper And Kemper, MDs**; Louisville, KY

**Kenan & Wang, LLC;** Sacramento, CA

**Kendall Wong, M.D.**; Odessa, TX

**Kernersville Primary Care**; Kernersville, NC

**Kevin Stephens M.D. PA;** Austin, TX

**Keystone Accountable Care Organization**; Danville, PA

**Keystone Rural Health Center;** Pennsylvania

**Kim kuhar DO internal medicine, PC**; Silverdale, PA

**Kingswood Internal Medicine**; Bloomfield Hills, MI

**Kolender Medical**; Bingham Farms, MI

**Krzysztof W. Warszawski, M.D.**; Garden City, MI

**Kurtis Fox, M.D.;** Colfax, CA

**Lagrange Family Care Doctors**; La Grange, KY

**Lake Howell Health Center (Hoffman)**; Florida

**Lakes Internal Medicine**; West Bloomfield, MI

**Lakowsky and Batlin Medical Corp.**; Burlingame, CA

**Lancaster General Health Community Care Collaborative**, Lancaster, PA

**Langdon Prairie Health**, Langdon, ND

**Langdon Prairie Health**; Langdon, ND

**Lebanon Internal Medicine Associates, P.C.**; Pennsylvania

**Lebanon Valley Family Medicine Inc**; Pennsylvania

**Lee Health;** Fort Meyers, FL

**Legacy Community Health Services, Inc.**; Houston, TX

**Legends Medical Clinic PLLC**; Round Rock, TX

**Leo Toupin, M.D. PA**; Austin, TX

**Lewerenz Medical Center & Longevity Health Institute**; Rochester Hills, MI

**LHS Health Network**; Camden, NJ

**Lifepoint Health;** Brentwood, TN

**Lifetime Family Care**; Madison Heights, MI

**Lily Enayati, M.D.;** San Mateo, CA

**Lincoln Medical Associates;** Lincoln, CA

**LMG Family Practice**; Landsdale PA

**Logan Health**; Flathead County, MT

**Lost Rivers Medical Center**; Arco, ID

**Loyola Physician Partners**; Maywood, IL

**LTC ACO**; Pennsylvania

**Luminis Health**, Annapolis, MD

**Lycoming Internal Medicine**, Jersey Shore, PA

**Main Line Health**; Bryn Mawr, PA

**MaineHealth**, Portland, ME

**Maria's Healthcare Service**; Shelby, MT

**Marshall Health Network**; Huntington, WV

**Martin Podiatry PC**; Pennsylvania
**Mass General Brigham**; Boston, MA
**McAuley Health Partners ACO, LLC**; Ann Arbor, MI
**McDermott-Sitzman Association**; Washington, DC
**McDonough District Hospital;** McDonough County, IL
**McKenzie Health System**; Sandusky, MI
**McKenzie Health**; Watford City, ND
**MD Valuecare, LLC**; Richmond, VA
**Medical Associates of NWA, P.A.**; Fayetteville, AR
**Medical Associates of Southern KY**; Glasgow, KY
**Medical Office of Tara L Cuda, DO**, Philadelphia, PA
**Memorial Community Health Inc**.; Aurora, NE
**Memorial Community Hospital and Health System**; Blair, NE
**MercyOne Population Health Services Organization**, Iowa
**MercyOne**, Des Moines, Iowa
**Meritas Health**, Kansas City, MO
**Methodist Alliance for Patients and Physicians,** Dallas, TX
**Methodist Patient Centered ACO**; Dallas, TX
**Methodist Physicians Clinic**; Omaha, NE
**MHP Palliative Care**; Farmington Hills, MI
**Michael Fox, D.O., DABAM;** Livonia, MI
**Michigan Premier Internists**; Southfield, MI
**Mid-Atlantic Collaborative Care, LLC**
**Middletown Medical**; Middletown, NY
**Millennium Affiliated Physicians**; Farmington Hills, MI
**Millennium Physician Group**; Florida
**Mission Health Partners**; Asheville, NC
**Mobile Physician Associates**; Los Angeles, CA
**Mohammad N. Alocozy, M.D**; Sacramento, CA
**Mon Health System**; Morgantown, WV
**Monticello Medical Associates** - Monticello, KY
**Monument Health**; South Dakota
**Morris Hospital and Healthcare Centers**; Morris, IL
**Mount Carmel Health Partners**; Columbus, OH
**Mount Sinai Health System;** New York, NY
**Mount Sinai Morningside, Mount Sinai Health System**, New York, NY
**Mountain View Hospital**; Idaho Falls, ID
**MultiCare Connected Care**; Tacoma, WA
**MUSC Health Alliance**; Charleston, SC
**Myrtue Medical Center**; Harlan, IA
**Nathan J, Hershberger, PLLC**; Florida
**Nebraska Health Network**; Omaha, NE
**Nebraska Medicine**; Omaha, NE
**Neil A. Patterson, M.D., P.A.**; Florida
**New Britain Family Practice**, New Britain, PA
**New Era Healthcare Henrico**, VA
**New Liberty Hospital Corporation**; Liberty, MO

**New Providence Internal Medicine Associates/Primary Care Partners**; Providence, NJ
**Next ACO, LLC**; Trinity, FL
**NOMS Healthcare, LLC**; Sandusky, OH
**NorCal Endocrinology & Internal Medicine**; Roseville, CA
**Nor-Lea Hospital District**; Lovington, NM
**North Austin Family Medicine, PA;** Austin, TX
**North Carolina Internal Medicine, PC**; Cary, NC
**North Raleigh Medical Center;** Raleigh, NC
**North Star Family Medicine P.A.**; Round Rock, TX
**Northern Light Health**; Brewer, ME
**Northern Medical Group**; Poughkeepsie, NY
**Northfield Hospital + Clinics**; Northfield, MN
**NW Momentum Health Partners ACO**; Olympia, WA
**Oakland Family Practice**; Madison Heights, MI
**Ochsner Health**; New Orleans, LA; MS; TX
**Odessa Consultants, PLLC**; Odessa, TX
**Odessa Memorial Healthcare Center**; Odessa, WA
**Office of Dr. Meyers**; Bloomfield Hills, MI
**Office of Imad George M.D.**; Livonia, MI
**Office of Langnas and Stashefsky;** Madison Heights, MI
**Office of Mary Ferris M.D.**; Warren, MI
**Ogden Clinic, PC;** Ogden, UT
**Olmsted Medical Center**; Rochester, MN
**On Point Medical Group**; Denver, CO
**OneCare Vermont ACO**; Colchester, VT
**OneHealth Nebraska**; Lincoln, NE
**Optimus Healthcare Partners ACO**; Summit, NJ
**Optum**; Eden Prairie, MN
**Orlando Health**; Florida
**Orlando Primary Care, PA LLC**; Florida
**Osceola Women & Family Medicine Specialists**; Florida
**Pankaj J Patel, M.D., P.A;** Midland, TX
**Parkside Family Medicine**; Philadelphia, PA
**Patient Quality Alliance**; Pocatello, ID
**Paul E. Bristol, M.D.**; Austin, TX
**Paul M. Izes, D.O.**; Southampton, PA
**Paul R. Ehrmann, D.O.**; Troy, MI
**Pentahealth Primary Care**; Downingtown, PA
**Pentahealth**; West Chester, PA
**Peter R. Honig, D.O.P.C.**; Philadelphia, PA
**Physician Organization of Michigan ACO**; Ann Arbor, MI
**Physician Performance LLC**; Woburn, MA
**Physicians Primary Care of SW FL**; Fort Myers, FL
**Piedmont Adult and Pediatric Medicine Associates**; Gastonia, NC
**Pinellas County Primary Care & Hospitalists, PLLC**; Florida
**Pinnacle Physicians Group**; Feasterville-Trevose, PA
**Port Lavaca Clinic Associates, P.A.**; Port Lavaca, TX

**Pottstown Medical Specialists, Inc.**; Pottstown, PA
**Preferred Medical Group**; Madison Heights, MI
**Premier Ankle & Foot Specialists PC**; Pennsylvania
**Premier Internists**; Farmington Hills, MI
**Primary Care Centers of Eastern Kentucky**; Hazard, KY
**Primary Care Development Corporation**; New York, NY
**Primary Care Specialists of Orlando - Orange Avenue**; Florida
**Primary Partners ACO**; Florida
**Primary Partners Alliance**; Clermont, FL
**Primary Partners**; Clermont, FL
**Privia Health**; Arlington,VA
**Privia Medical Group**, North Texas
**Progressive Health Care, P.C.**; Taylor, MI
**Prospect Medical Holdings**; Los Angeles, CA
**PSW**, Washington State
**Pullman Regional Hospital;** Pullman, WA
**Purisima Family Medicine;** Half Moon Bay, CA
**Rajanikant Pandya, M.D**; Midland, TX
**Rajesh J Patel, M.D., P.A.**; Odessa, TX
**Raleigh Adult Medicine;** Raleigh, NC
**Raleigh Family Practice, P.A;** Raleigh, NC
**Raleigh Medical Group;** Raleigh, NC
**Rancho Health Management**; Riverside, CA
**Redford Clinic**; Redford, MI
**Reed Relations Consulting, LLC**; Catawissa, PA
**Reid Health**; Eastern IN & Western, OH
**Revere Health**, Provo, UT
**Richmond Quality ACO**; Staten Island, NY
**Rittenhouse Internal Medicine**, Philadelphia, PA
**Ritu Suri MD LLC**; Englewood NJ
**Riverwood Healthcare Center**; Atikin, MN
**RMG Gastroenterology**; Raleigh, NC
**Rochester Medical Group;** Rochester Hills, MI
**Rocklin Family Practice & Sports Medicine**; Rocklin, CA
**Rocky Mount Family Medical Center, P.A.**; Rocky Mount, NC
**RSI Medical**; Wendell, NC
**Rush Health**, Chicago, IL
**Ryan Medical Associates, P.C.**; Warren, MI
**Saint Francis Health System**, Tulsa, OK
**Samaritan Healthcare**; Moses Lake, WA
**Sammy Lerma III, M.D., PA;** Bastrop, TX
**Sanjay Pethkar MDSC**; Plainfield, IL
**Sayed A. Hussain, M.D.;** Roseville, CA
**Schaefferstown Family Practice Inc.**; Pennsylvania
**Scottsdale Imaging Services, LLC**; Scottsdale, AZ
**Scripps Accountable Care Organization**, LLC; San Diego, CA
**SDI Services, LLC**; Arizona

**Select Health Network**; Mishawaka, IN
**Sellersburg Internal Medicine & Pediatrics**; Sellersburg, IN
**Sergio B Seoane M.D.;** Florida
**Shah And Associates Family Practice**; Cary, NC
**Shenandoah Medical Center**; Shenandoah, IA
**Shroff Cardiology & Internal Medicine Clinic Pa**; Big Spring, TX
**Shylesh Ganta, M.D., P.A;** Midland, TX
**Sidney Health Center**; Sidney, MT
**Silver Pine Medical Group**; Sterling Heights, MI
**Silver State ACO**; Las Vegas, NV
**SMP Health - St. Kateri**; Rolla, ND
**SOMOS ACO**; New York, NY
**SoNE Health**; Windsor, CT
**South Macomb Internists**; Warren, MI
**South Texas Internal Medicine Associates;** San Antonio, TX
**Southeast Health Statera Network**; Dothan, AL
**Southeastern Health Partners**; Greenville, SC
**Southern Atlantic Healthcare Alliance**; Cary NC
**Southwest Diagnostic Imaging, LLC**; Scottsdale, AZ
**Southwest Healthcare Services**; Bowman, ND
**Southwest Internal Medicine Specialists**; Florida
**Southwest Medical Imaging, Ltd**; Scottsdale, AZ
**Space Coast ACO, LLC**; New Port Richey, FL
**Stephen J. Carney, M.D.;** Burlingame, CA
**Stephen J. Shields, MD PA;** Florida
**Stephen Williams Internal Medicine MD PC**; Troy; MI
**Sterling Physicians**; Sterling Heights, MI
**Stratum Med**; Champaign, IL
**Subodh K Mallik, M.D.;** Ft. Stockton, TX
**Summit Health**; Berkeley Heights, NJ
**Summit Healthcare Regional Medical Center;** Show Low, AZ
**Summit Physician Services**; Pennsylvania
**Suncoast Premier Medical, LLC**; Florida
**Sunflower Medical Group P.A.;** Kansas City, KS
**Suresh Prasad, M.D. PA;** Odessa, TX
**Sutter Health**; Sacramento, CA
**Tandigm Health**; West Conshohocken, PA
**Tandigm Value Partners**; Southeastern, PA
**TC2**; Macon, GA
**TeamHealth**; Knoxville, TN
**The Center for Health Affairs**; Cleveland, OH
**The Doctor's In, Inc**.; Roseville, CA
**The Iowa Clinic**, Des Moines, IA
**The South Bend Clinic**; South Bend, IN
**The Wright Center for Community Health and Graduate Medical Education**; Scranton, PA
**Think Whole Pearson Healthcare**; Omaha, NE
**Thomas Hopkins, M.D.**; Roseville, CA

**Thundermist Health Center**, Warwick, RI
**Tommy T. Kuo, M.D.**;San Mateo, CA
**Torrance Memorial Integrated Physicians, LLC**; Torrance, CA
**Total Family Healthcare**; Florida
**Traci Thompson, MD PA**; Florida
**Triad HealthCare Network**; Greensboro, NC
**Triad Internal Medicine**; Asheboro, NC
**Triad Primary Care, PLLC**; Greensboro, NC
**Trinsic**; Denver, CO
**TriState Health**; Clarkston, WA
**Tryon ACO, LLC**; Charlotte, NC
**Twin Lakes Family Medicine**; Bloomfield Hills, MI
**UC San Diego Health**; San Diego, CA
**UMass Memorial Health**; Worcester, MA
**UNC Senior Alliance/UNC Health**; Chapel Hill, NC
**United Hospital District; Blue Earth MN**
**UnityPoint Accountable Care**; Des Moines, IA
**University Internal Medicine, Inc**; Pawtucket, RI
**Vanderbilt University Medical Center**; Nashville, TN
**Versailles Family Medicine**; Versailles, KY
**Vikram Vadyala, M.D.;** Midland, TX
**Virginia Care Partners**; Richmond, VA
**Vista Complete Care**; Auburn, CA
**Vital Medicine PC**; Livonia, MI
**Vraj Medical LLC**; Florida
**Vytalize Health**; Hoboken, NJ
**Wake Internal Medicine & Pediatrics**; Raleigh, NC
**Wake Internal Medicine Consultants, Inc.**; Raleigh, NC
**Wakely**, an HMA Company (Nationwide)
**WellSpan ACO**; York, PA
**WellSpan Medical Group**; Pennsylvania
**Wellvana Health**; Nashville, TN
**Wesley R. Barnes, M.D.**; Royal Oak, MI
**West Florida ACO, LLC**; Tampa Bay, FL
**Western Wake Wellness;** Cary, NC
**Westland Clinic;** Westland, MI
**Westland Healthcare**; Westland, MI
**WinnMed**; Decorah, IA
**Winona Health**; Winona, MN
**Winter Garden Health and Wellness**; Florida
**Winter Park Family Practice**; Florida
**Wrightstown Family Medicine**; Newtown, PA
**Xin-Nong Li M.D., Inc.**; Fair Oaks, CA
**Yorktowne Urology PC**; Pennsylvania
**You and Your Health Family Care**; Florida
**Zia ACO, LLC**; Taos, NM

**Written Statement for the Record**
**Of**
**The National Association of ACOs**
**For the**
**Senate Budget Committee**
**Hearing on**
**"Improving Care, Lowering Costs: Achieving Health Care Efficiency"**

**October 18, 2023**

The National Association of ACOs (NAACOS) appreciates the opportunity to submit a statement to the Senate Budget Committee in response to the hearing "Improving Care, Lowering Costs: Achieving Health Care Efficiency." NAACOS represents more than 400 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health systems and physician provider organizations across the nation to improve quality of care for patients and reduce health care cost. NAACOS members serve over 8 million beneficiaries in Medicare value-based payment models, including the Medicare Shared Savings Program (MSSP) and the ACO Realizing Equity, Access, and Community Health (REACH) Model, among other alternative payment models (APMs). NAACOS appreciates the committee's leadership and commitment to improving access to health care and lowering costs. Our comments reflect the views of our members and our shared goals.

## APMS ARE A PLATFORM FOR INNOVATION AND COST SAVINGS

A major pathway for improving access to health care and lowering costs is through advancing APMs. Over the last two decades, APMs have demonstrated that when providers are accountable for costs and quality and provided flexibility from fee-for-service (FFS) constraints, they are able to generate savings for taxpayers and improve beneficiary care. This emphasis on outcomes allows physicians and other clinicians to:

- **Improve care coordination and prioritize primary and preventive care.** APMs allow providers to build care teams that include nurses, care managers and social workers. This increases access and support for patients. With ongoing health care shortages, clinicians need to increasingly rely on broader care teams to maintain access. For example, many ACOs utilize care managers that help patients manage their chronic conditions. The care managers help with medication and symptom management, coordination with practitioners to improve care delivery, and educate the patients about how to best manage their conditions.
- **Keeping patients healthy.** APMs allow clinicians to provide services that are not otherwise billable under FFS such as wellness programs, patient transportation, meals programs, and cost

sharing reductions. This allows providers to use innovative tools to improve patient outcomes. For example, ACOs often utilize care management visits following an inpatient stay to allow clinicians to better manage the patient's medications, assess their home for safety risks, and coordinate follow up care. This results in reduced readmissions and ensures that patients' needs are met at home.

- **Coordinate care across the continuum.** APMs require providers to align sites of service by ensuring that patients receive the right care in the setting that is best suited for their social and clinical needs. Through coordination, APMs allow providers to share resources while remaining independent.

**ACOs are the Largest and Most Successful Model Leading Medicare's APM Transformation**

In 2023, there are 588 ACOs coordinating care for 13 million Medicare beneficiaries. ACOs are a voluntary alternative to the fragmented FFS system that gives doctors, hospitals, and other health care providers the flexibility to innovate care and holds them accountable for the clinical outcomes and cost of treating an entire population of patients.

With primary care as the backbone, ACOs employ a team-based approach that allows clinicians to ensure patients receive high quality care in the right setting at the right time. The ACO model also provides an opportunity for providers to work collaboratively along the continuum while remaining independent. Importantly, ACOs provide shared savings opportunities and enhanced regulatory flexibility that allows clinicians to maintain financial security while practicing medicine more freely.

It's clear these payment system reforms have been a good financial investment for the government. In the last decade, ACOs have generated more than $21 billion in savings with $8.2 billion being returned to the Medicare Trust Fund while maintaining high quality scores for their patients. The growth of APMs has also produced a "spill-over" effect on care delivery across the nation, slowing the overall rate of growth of health care spending. Earlier this year, the Congressional Budget Office (CBO) reported that actual Medicare and Medicaid spending between 2010–2020 was 9 percent lower than original projections.[1] While there are several influences for these changes in spending, improved care management and more efficient use of technology were factors highlighted by CBO. Moreover, providers in APMs help make the Medicare program stronger by reducing improper payments. Using enhanced data and analytics, ACOs regularly identify and report instances of fraud, waste, and abuse.

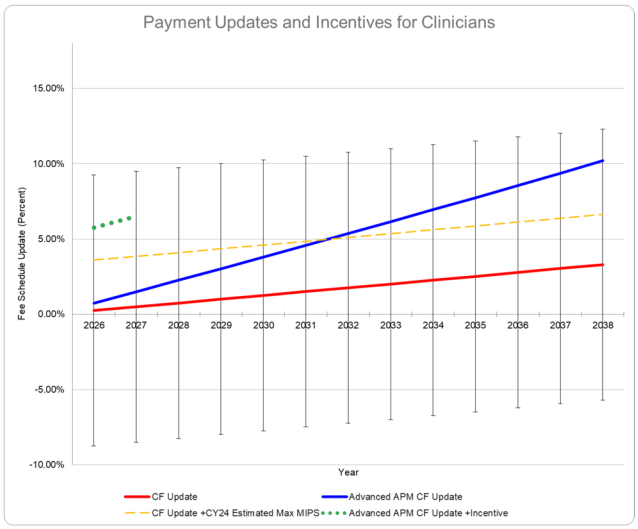
**Regulatory and Statutory Barriers Limiting Growth of APMs**

APMs have allowed physicians and other clinicians to change care delivery and improve care coordination while reducing costs. APMs are becoming more rooted in our health care system but growth has been slower than Congress' original goal. It is essential to remove barriers to participation and give additional flexibility and tools to innovate care. Specifically, Congress should:

- Ensure incentives promote value-based care.
- Improve existing APMs to encourage adoption and ensure current participants remain in APMs.
- Improve approaches to test and scale innovation.
- Establish parity between APMs and Medicare Advantage.

***Ensure Incentives Promote Value-Based Care***

Beginning in Payment Year 2026 (Performance Year 2024), incentives will favor clinicians who are not participating in advanced APMs and remain in MIPS. As demonstrated in the chart below, clinicians in MIPS will be provided a 0.25 percent conversion factor update (red line) and can receive an additional positive payment adjustment in MIPS. While maximum potential incentives under MIPS are 9 percent, the maximum MIPS adjustment is estimated to be around 3 percent. Accordingly, the total potential payment adjustment is an estimated 3.25 percent (yellow dashed line). Conversely, clinicians in advanced APMs will only receive a 0.75 percent conversion factor update (blue line). Modeling these changes out several years, 2032 will be the first year in which incentives again favor clinicians in advanced APMs.




Additionally, the thresholds to qualify as an advanced APM are too high under current law. In the 2024 Medicare Physician Fee Schedule proposed rule, CMS estimated that between 30,000-84,000 clinicians may no longer qualify as advanced APM participants because of increasing qualification thresholds and expiring incentives. Additionally, CMS has proposed changes to the determination process that could increase burdens and serve as a disincentive for some specialists to join ACOs.

In the short-term, **Congress should extend APM incentives & adjust qualifying thresholds.** Appropriate financial incentives help attract physicians and other clinicians to participate in advanced APMs and reward those that continue to move forward on their value transitions. While Congress included a 12-month extension of MACRA's advanced APM incentive payment in the Consolidated Appropriations Act of 2023, this short-term extension will expire at the end of 2023. Lawmakers should support the bipartisan Value in Health Care Act (H.R. 5013), which includes a two-year extension of MACRA's original

5 percent advanced APM incentives and adjusts the one-size-fits-all approach to qualification thresholds to ensure that providers will continue to participate in APMs.

A short-term extension would allow time **for Congress to work with stakeholders to redesign physician payment incentives to promote value**. A three-tier system would provide increased flexibility and financial incentives for the adoption of value. The participation tracks should be:

- **Fee-for-service (MIPS) —** Clinicians that are not participating in any APM. MIPS should be revised so that the program does not incent remaining in FFS. Specifically, Congress should structure MIPS to have adequate payment adjustments for physicians but no additional incentives unless clinicians are taking steps to move to value.
- **APMs —** Currently, clinicians in non-risk bearing APMs or advanced APMs that do not meet qualifying APM participant (QP) thresholds for incentive payments remain in MIPS. This creates an additional burden as the clinicians must be responsible for MIPS quality reporting obligations and quality reporting obligations in the APM as well. This creates a disincentive to participate in APMs and holds FFS as the gold standard, rather than value-based payment. A new approach should exempt clinicians in ACOs, or other APMs, from MIPS quality reporting since they are already being measured on cost and quality in their model. Financial incentives should recognize the up front and ongoing investments needed to be successful in APMs.
- **Advanced APMs —** Clinicians participating in risk-based models. This track should have the strongest financial incentives and flexibility.

***Improve existing APMs to encourage adoption and ensure current participants remain in APMs***
While APMs have offered numerous benefits to providers and patients, more can be done to attract more providers and meet the unique needs of certain beneficiary populations. Congress should work with CMS to address some of the existing challenges in APMs and MSSP, the only permanent APM.

- **Delay implementation of digital quality reporting to address operational issues that will increase costs and burdens.** ACOs will be required to report quality via electronic clinical quality measures (eCQMs) or MIPS CQMs by 2025. While ACOs ultimately want to achieve a more seamless, efficient, and technology-enabled quality reporting system that is highly interoperable and relies on near real-time data to enable improved patient care, the current lack of interoperability means ACOs will face many challenges and increased administrative burden and costs to try and support this work in the near term. Congress must work with CMS to ensure the agency does not move forward with new quality requirements before testing with a pilot.
- **Safeguard ACO benchmarks.** The financial benchmark is an ACO's projected level of spending for its patients. The benchmark is unique to each ACO and is determined by historical spending, patients' relative sickness, and national and regional spending trends. Despite the success of ACOs, CMS has not addressed the "ratchet effect," where ACO benchmarks are lowered with each new agreement period because they continue to lower costs for their assigned populations. Starting next year, CMS is adding a prospective growth rate specific to ACOs called the Accountable Care Prospective Trend (ACPT). This would update MSSP benchmarks annually to account for national spending growth and keep benchmarks realistically attainable. According to CMS analysis, the ACPT will harm nearly one third of ACOs. Congress must work with CMS to establish effective ACO benchmark changes that provide more transparency, address the ratchet effect to ensure long-term participation, and account for regional variations in spending to prevent arbitrary winners and losers.
- **Strengthen nonfinancial incentives within the model**. Current law allows CMS to waive certain Medicare FFS requirements in MSSP and other APMs. This is a critical component of APMs as it

allows providers to operate with fewer restrictions leading to a reduction in provider burden and increased care innovation. However, the waivers to date have been limited. For example, MSSP only has waivers for telehealth and the 3-day rule for skilled nursing facility. The telehealth waiver is far more limited than the flexibilities provided to clinicians during the public health emergency. Moreover, the Innovation Center has tested several waivers in ACO demonstrations, yet those waivers have not expanded to the permanent program, MSSP. Congress should work with CMS to rapidly expand waivers. Congress should direct CMS to establish a common set of waivers for APMs and create a process to accept public nominations for waivers.

- **Address unique payment challenges for providers serving rural and underserved populations.** Rural providers have achieved successes in APMs despite significant barriers and limitations. ACOs and other APMs focus on achieving savings on historical spending. This approach may not be appropriate for rural populations where lower cost settings may not be available or underserved populations who may have historical lower costs due to lack of access. We need a new paradigm where APMs focus on increasing or maintaining access over cost reductions. While cost is an important component of any APM, we should consider approaches for maintaining costs or reducing growth in spending. NAACOS recently provided recommendations to the House Ways and Means Committee on how to improve access to health care in rural and underserved areas.[2]
- **Consider approaches to bring more providers to total cost of care models.** Previous models have been designed to offer APMs to a certain type of provider (e.g., episode payment models for specialists). After more than ten years of payment model design innovation, we have learned that concurrent episode models and total cost of care models results in a complex set of overlapping rules, leading to provider and patient confusion and increased burden. Rather than designing models for specific types of providers, we should focus on total cost of care. With the primary care team as the foundation for coordinating ongoing patient care, the ACO can support patients with referrals to specialists in the community and transitions between hospitalizations, procedures, post-acute care and back to the home. NAACOS has considered approaches for increasing participation of specialists, rural providers, post-acute and long-term care providers in total cost of care arrangements. To do so, changes need to be made to attribution, benchmarks, and data shared with providers. Congress should direct CMS to work with stakeholders to design approaches to meet the needs of various types of providers within total cost of care arrangements.

***Improve Approaches to Test and Scale Innovation***

The Innovation Center has been successful in testing innovative payment arrangements and increasing adoption of APMs. The successes of the Innovation Center are not captured within current evaluation approaches. For example, CBO estimates that CMMI's activities increased direct spending by $5.4 billion in the first 10 years and another $1.3 billion by 2030. However, CBO's report focuses only on savings achieved and does not account for many aspects of value-based payment models such as provider burden relief, patient experience, clinical transformation, and the spill-over effect that occurs when providers apply value principles across all patient populations. The Innovation Center's evaluation criteria and criteria for model expansion have similar challenges. Congress should work with CMS to ensure that promising models have a more predictable pathway for being implemented and becoming permanent and are not cut short due to overly stringent criteria. Specifically, Congress should:

- **Broadening the criteria by which CMMI models qualify for Phase 2 expansion.** The criteria should consider if the model reduces provider burden, increases patient satisfaction, offers additional benefits and services to patients that are not billed to Medicare, expands

participation to more provider types, results in clinical care transformation, or is adopted in private sector value arrangements.

- **Directing CMMI to engage stakeholder perspectives during APM development.** The Innovation Center could leverage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide input on models in development.

***Establish parity between APMs and Medicare Advantage program requirements***

Recognizing ACOs' and MA's shared goals of improving the quality of care and cost savings to patients, it's imperative to build parity between the two programs. Misaligned incentives are harmful to advancing value as they increase provider burden, create confusion and disincentives for patients, and generate market distortions that favor one entity over another. Parity can be better provided in the programs' benchmark and risk adjustment policies, quality measurement, and marketing requirements. ACOs should be allowed to provide comparable benefits to those offered to MA patients, such as telehealth visits, transportation benefits, home visits, etc. Without parity, providers are forced to spend time managing the various program requirements rather than managing patient care. Congress should direct the Government Accountability Office (GAO) to evaluate how to create more parity between APMs and MA. Additionally, Congress should explore opportunities to incent MA plans to enter risk-bearing arrangements with providers.

We thank the committee for this opportunity to provide feedback on this important hearing. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement on improving health care access and lowering costs. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

[1] https://www.cbo.gov/publication/58997#:~:text=CBO%20overestimated%20mandatory%20spending%20for%20health%20care%20in,9%20percent%20lower%20than%20CBO%20projected%20in%202010.
[2] https://www.naacos.com/assets/docs/pdf/2023/NAACOSWaysMeansRuralRFI10052023.pdf

# Active steps to reduce administrative spending associated with financial transactions in US healthcare

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**Abstract**

US healthcare administrative spending is roughly $1 trillion annually. A major operational area is the financial transactions ecosystem, about $200 billion in spending annually. Efficient financial transactions ecosystems from other industries and countries exhibit two features: immediate payment assurance and high use of automation throughout the process. The current system has an average transaction cost of $12 to $19 per claim across private payers and providers for more than 9 billion claims a year;

each claim takes four to six weeks to process and pay. For simple claims, the transaction cost is $7 to $10 across private payers and providers; for complex claims, $35 to $40. Prior authorization on roughly 5,000 codes has an average cost of $40 to $50 per submission for private payers and $20 to $30 for providers. Interventions aligned with a more efficient financial transactions ecosystem could reduce spending by $40 billion to $60 billion. About half is at the organizational level (scaling interventions being implemented by leading private payers and providers) and half at the industry level (adopting a centralized automated claims clearinghouse, standardizing medical policies for a subset of prior authorizations; and standardizing physician licensure for a national provider directory).

**Keywords:** Healthcare spending; administrative spending; claims processing; prior authorization

## INTRODUCTION

US healthcare administrative spending – defined as all activities in support of the delivery of care, including payment transactions, back-office corporate and operational functions, customer and patient services, and administrative clinical support – is about $1 trillion annually.[1] A central question in healthcare is how to reduce this amount. In this article, we focus on the roughly $200 billion in annual spending related to interactions among patients, providers, and payers involving claims processing, payment, patient collections, and prior authorization. We refer to this spending as the financial transactions ecosystem.[1]

We look at the criteria that must be met to optimize the financial transactions ecosystem and offer examples of US service industries and healthcare systems abroad that have done this successfully. We then break down the financial transactions ecosystem from an operational productivity lens – specifically service throughput, cost efficiency, and quality outcomes. We conclude with a review of the organizational- and industry-level interventions available today.

We note that the author team is drawn from the academic and management consulting worlds. We base our insights on data from both academic sources and industry experience. A technical appendix delineates the information sources we employ.

## WHAT OTHER US INDUSTRIES AND COUNTRIES HAVE ACHIEVED

Industries with efficient financial transactions ecosystems share two features: immediate payment assurance and high use of automation throughout the process. By payment assurance, think of a meal at a restaurant where the customer uses a credit card. The restaurant needs immediate assurance that the payment will be transferred, not immediacy in the dollars transferred. Obtaining immediate payment assurance in healthcare could free up more than $200 billion on hospital and physician group balance sheets, materially alleviating working capital and debt required to fund operations. In addition, lowering processing costs through automation could improve the cash flow of providers and payers. Both features will require greater use of technology and the harmonization of processes across private payers and providers.

Examples from other US service industries and from healthcare systems in other countries suggest this is possible through joint private and public sector action.[2-8] For example, the banking system in the United States collaborated in the 1970s to form an automated clearinghouse, which reduced transaction costs, shifted innovation to product design and other areas, and eventually enabled same-day transactions.[2] In the airline industry, the private sector collaborated to build an automated booking platform called Sabre, which eventually was adapted to support other airlines, travel agents, and hotels.[3]

Even healthcare has examples of more-efficient financial transactions ecosystems. In Israel, patients do not pay providers directly. Instead, co-payments are withdrawn monthly from patients' bank accounts and sent to their insurance plans, which then reimburse providers, creating payment assurance for all stakeholders.[4] In Singapore, the central government manages an information hub for healthcare data across multiple payers (both private and public), enabling patients to log on to one site where they can see their comprehensive health records and pay their bills as required.[5] Estonia operates a centralized single payer health system in which a fully automated claims process features data transferring directly from patient records into a billing platform, also allowing providers to monitor the status of their claims in real time.[6]

There are also examples of more efficient financial transactions ecosystems within the US healthcare system. With prescription drugs, in the 2000s, both the public and private sectors innovated to enable a common infrastructure for the processing of electronic prescriptions. In the later part of the decade, some came together into a single network which allowed for immediate transfer of Rx information about a patient

and ability to see the patient's cost at the time insurance is provided, all at a very low transaction cost.[7] Further, nearly 20 states have created all-payer claims databases to collect information on claims to monitor cost and quality.[8]

## CHALLENGES IN THE HEALTHCARE FINANCIAL TRANSACTIONS ECOSYSTEM

The US healthcare system is more complicated than other US services industries and healthcare systems in other countries, with more than 6,000 hospitals, 900 payers, and 11,000 non-employed physician groups (defined as hospital-affiliated and independent practices with 5 or more physicians).[9-11] Such large numbers of participants inevitably complicate many administrative processes, including financial transactions.

Much research has focused on the financial transactions ecosystem but unlike these studies, we took an operational productivity lens.[1,12-18] We examine three dimensions: service throughput, cost efficiency, and quality outcomes.

***Service throughput.*** Nearly 9 billion claims are processed annually, or roughly 30 per insured life in the United States.[19,20] On average, about 80 percent of these claims are either auto-adjudicated or adjudicated with a minor adjustment. With regard to prior authorization, we estimate that private payers have in place about 5,000 prior authorization codes across procedures, diagnostics, drugs, and sites of care. Of these, more than 90 percent of prior authorizations are ultimately approved by private payers, but fewer than 25 percent are auto-determined.

***Cost efficiency.*** We estimate that the average cost to process a single claim is $2 to $4 for private payers and $10 to $15 for providers. For simple claims (80 to 90 percent of the total), the cost is roughly $7 to $8 per claim, including both private payers and providers; for more complex claims, the joint cost is $35 to $40 (for example, a caesarean section, where the claim could include multiple clinicians such as an OB/GYN and anesthesiologist, multiple payers such as commercial and Medicaid, and multiple conditions such as post-surgery HAI). Labor is the dominant source of costs, accounting for more than half of total costs for private payers and up to 90 percent of costs for providers. Other types of costs include technology infrastructure, spanning both the software and hardware needed to facilitate the claims process.

In general, prior authorization remains a labor-intensive process, with an average cost of $40 to $50 per submission for private payers and $20 to $30 for providers. There are also a number of indirect costs such as physician burnout and employee turnover associated with the administrative burden of dealing with prior authorization.[21]

***Quality outcomes.*** On average, a claim can take four to six weeks to process and pay. This starts with one to two days for a provider to submit a claim. Private payers process many claims in one to three days. Some claims require additional steps, such as manual intervention, which result in an additional one to two weeks. A few claims take several months because of back-and-forth between the payer and the provider. Following payer approval, it may take a few weeks for a provider to be paid, an amount of time usually within prompt-pay statutory rules.

The overall timing of payment has substantial balance sheet consequences for providers. For example, for every week of reduced time-to-payment, working capital on hospitals' balance sheets would fall by about $25 billion to $40 billion, money that could then be used for other productive investments.

For all the benefits associated with prior authorization in cost management and appropriate care, there are also drawbacks, including delays in care and workforce burden.[22-25]

Further, all the financial transactions processes require additional data sets, such as provider directories. These directories need regular updating, with more than 1 million professionally active physicians today and an average turnover rate of 6 to 7 percent annually as doctors move to other organizations or retire.[26] Generally, physicians have to update some component of their job information – such as location, specialization, or work status – every 6 to 12 months. Each update can take up to a few hours. Overall, physicians have to submit roughly 18 credentialing applications between payers, hospitals, and other facilities annually, creating frustration for both physicians and private payers.[27,28] Inaccuracies in these provider directories can inhibit patient access and diminish member experience, just as with prior authorizations.

## THE SAVINGS POTENTIAL OF AVAILABLE INTERVENTIONS

Previous research has estimated the savings opportunity on the overall financial transactions ecosystem.[1,13,29-31] Our approach differs from these analyses by specifically dividing interventions into two levels: organizational and industry (see the technical appendix for more information on how estimated savings by level were made) (Figure

2). By organizational level, we mean interventions that individual organizations can control and implement on their own or through bilateral collaboration between organizations. Industry-level interventions are those that require broader, structural collaboration across the healthcare sector.

***Organizational-level interventions***

While there are many organizations involved in US healthcare, this article focuses on three stakeholder groups: private payers, hospitals, and physician groups. These stakeholders represent roughly two-thirds of US healthcare administrative spending.[1] Along with internal innovation and performance management, a vendor ecosystem has recently emerged.

***Private payers***. For private payers, best-in-class claims processing is *automated* (around 95 percent of claims are adjudicated without manual intervention); *accurate* (with improved precision of adjudication to minimize adjustments and reworks); and *efficient* (claims requiring manual intervention have clear performance targets, and the people tasked with handling them have the necessary training and tools). Achieving these ends can result in lower administrative spending through reduced call volumes, increased labor productivity, and lower employee attrition. It can also improve the patient and clinician experience through faster processing times and less back-and-forth on adjustments. Despite recent advances, most private payers continue to have inefficient payment processes, driven by legacy claims platforms, limited improvement

in process efficiency and automation, and skill and performance management gaps in their workforce.

The focus on improving the operational productivity of administrative functions could also complement the longstanding need of payers to root out fraud, waste, and abuse (FWA) – a problem costing more than $60 billion annually.[32] A useful system of FWA detection would run in real time, alongside the billing and prior authorization systems. Given that the savings accrue to medical spending, we did not include them in this analysis. However, examples such as what the credit card industry has accomplished show reducing FWA is possible.[33]

Leading private payers are generally improving operational productivity in five ways: improving data quality, removing global processing issues, targeting isolated processing issues, building micro-automations, and streamlining manual processing (Figure 1). Evidence from successful examples suggests that extending these interventions to all private payers could reduce spending by 20 percent to 25 percent, or $7 billion to $10 billion annually.

Take the case of one national payer with consistently strong performance. Seeking to improve performance, the payer identified two areas of interventions that would yield the greatest impact: minimizing rework driven by adjusted claims and increasing claims automation. To reduce the volume of claims adjustments, the payer focused on finding the most important sources of inefficiency, such as provider and member data discrepancies and prior authorization record matches. This effort decreased the number of claims that were adjudicated but then required an adjustment by 40 percent (from over 5 percent to less than 3 percent). To improve auto-

adjudication, the payer used AI-enabled interventions like claim logic refinement and natural language processing for medical record processing. This initiative increased the auto-adjudications rate from 87 percent to more than 92 percent.

***Hospitals and physician groups***. For hospitals and physician groups, claims processing is commonly referred to as revenue cycle management and is divided into three areas: the front end, which includes patient scheduling and insurance verification; the mid-cycle, which includes utilization management and appropriate documentation; and the back end, which includes accounts-receivable management, underpayment and denials recovery, and appeals management.

The preparation of claims for submission to payers is costly. Part of this cost reflects the complexity that hospitals and physicians face in preparing an accurate bill in a timely fashion; our experience shows that a substantial portion of initial claims have errors versus what would be found in a detailed audit reviewing the associated activities (greater than 15 percent).

Despite advances in technology and the vendor ecosystem, hospitals and physician groups still face challenges, including technology adoption; staff capacity constraints and skill gaps; management and optimization of vendor partners; and changing payer medical policies.

Revenue cycle management is labor-intensive, whether carried out internally or outsourced. Leading hospitals and physician groups are generally improving operational productivity in five ways: reducing denials and account receivables follow up spend; eliminating manual work through digital workflows; automating documentation

processes; improving clinical documentation accuracy; and streamlining financial clearance and prior authorization processes (Figure 1). Evidence from highly optimized revenue cycle operations suggests that extending these interventions to all hospitals and physician groups could reduce spending by 15 percent to 20 percent, or $15 billion to $20 billion annually.

Take the example of one large health system's attempt to improve payer denial overturn rates and reduce write-offs. The health system developed a large payer benefit plan policy dataset through natural language processing to better manage billing interventions and implemented a denial management optimization algorithm to more expeditiously respond to payer denials. The health system also built out a revamped organizational structure that centralized the non-patient-facing case management staff to improve efficiency. These interventions improved the overturn rate – the rate of successful appeals to denials – from 16 percent of all pre-billing medical necessity denials (excludes all denials with a dollar value of less than or equal to zero) to 32 percent.

**Industry-level interventions**

Industry-level interventions generally play two types of roles: *acceleration* of organizational-level interventions and *augmentation* of organizational-level interventions. We focused on three industry-level interventions that could accelerate and augment the operational productivity interventions private payers and providers are undertaking.

***Adopting a centralized automated claims clearinghouse***. Private payers and providers use a number of claims clearinghouses based on region and line of business. Generally, national and larger regional private payers and hospitals have worked to lower costs per claim by working with external vendors and allocating more internal resources to the claims process. Physician groups, smaller hospitals, and smaller private payers, lacking the resources of larger organizations to address the claims process, face higher transaction costs per claim. One potential intervention is a more centralized, automated clearinghouse that could accelerate the standardization of the financial transactions ecosystem. That could allow smaller organizations to achieve similar transaction costs per claim as the larger organizations. In addition, the use of incentives to promote the centralized clearinghouse could reduce transaction costs further. We estimate that accelerating standardization and decreasing transaction costs to match those of the most efficient organizations could reduce spending by 10 percent to 12 percent, or $10 billion to $15 billion annually.

A historical barrier to this intervention is the need for the appropriate technology infrastructure. With recent technology advances, it could be technically feasible to migrate to a central clearinghouse, but questions about governance and ownership will need to be addressed first. One such example is who owns it. The banking industry developed its centralized claims clearinghouse through the private sector, while healthcare systems in other countries have built clearinghouses through the public sector. Important factors to consider when choosing an ownership model include speed to launch, ability to standardize, operational ability, and motivation for ongoing innovation.

Eventually, additional savings could come from introducing data such as electronic medical records into the clearinghouse, which could reduce transaction costs for other financial transactions, such as prior authorization.

***Standardizing medical policies for a subset of prior authorizations***. The primary goal of prior authorization is to assess the medical necessity and coverage of healthcare services and procedures according to established criteria or guidelines under the provisions of payer programs to prevent excess and unnecessary utilization. Benefits of prior authorization can include flagging newer, better treatments, improving the quality of care (for example, in evolving specialties such as oncology where the standards of care are being refined). Overall, the administration of prior authorization is complex not only because of the total number of prior authorizations but also because private payers may have different policies for the same treatment or drug, depending on how permissive the policy is. For example, approval to administer an MRI for back pain may vary from payer to payer and even from insurance product to product offered by a payer.

In our experience, there is opportunity to simplify and standardize common policies across the industry for a subset of prior authorizations, while leaving others to be customized by private payers. The primary goal is to focus standardization on policies that have clear evidence – for example, when should a medication refill be approved? Complex decisions associated with expensive treatments and uncertain clinical presentation could remain the decision of the individual payer.

We estimate that some standardization, which will decrease the staff required to review prior authorizations at both private payers and providers, could reduce spending by 3 percent to 5 percent, or $1 billion to $3 billion annually. About half of this staff is clinical, including physicians and nurses. Relieving this burden could allow clinicians to spend more time on patient care – an increasingly important consideration given ongoing physician and nursing shortages.[34]

One barrier to moving in this direction is that differentiation in medical policies is part of the value proposition for private payers when vying for customers and managing medical costs. Employers who purchase insurance and patients may also object to the change, to the extent that they choose plans based on variation in prior authorization requirements. Another challenge is the ongoing maintenance of this system as new treatments arise and older ones are discontinued.

***Standardizing physician licensure for a national provider directory***. There are more than 1 million professionally active physicians in the United States.[26] On average, each contracts with more than 20 private payers.[35] Each payer has its own process for ensuring a physician is in its provider directory. This is needed to establish the back-and-forth mechanisms for financial transactions.

Separately, each physician undergoes a credentialing process, usually state-driven (as some raise concerns about lower quality care provision and de-emphasizing localized standards of care), although there are some basic, consistent national components.[36] These include graduating from a school accredited by the American Medical Association, passing a comprehensive national medical licensing examination,

and meeting standards for work history and health status. Standardizing the licensure process would reduce the amount of time physicians spend to comply with state regulations, especially when changing states or hospital affiliations.[37] The private sector has created systems like the Federation Credentials Verification Service to aid physicians in this process, with the goal of reducing compliance time and costs.[38] We estimate that fully standardizing physician licensure to decrease nonclinical staff needed for this process could reduce spending $7 billion to $10 billion annually. In addition, creating one centrally managed directory could further reduce spending by $1 billion to $2 billion annually.

## CONCLUSION

We estimate that the total reduction in spending from these initiatives would be $40 billion to $60 billion annually, split roughly half at the organizational level and half at the industry level. Put another way, the savings are a bit more than 1 percent of total US healthcare spending. The total is not trivial. Ongoing operating costs are factored into the savings – that is, the savings are net of new spending needs. In addition, there will be start-up costs to achieving these run-rate savings, normally 0.7 to 1.0 times the total.[1] Another benefit of these interventions is potentially freeing up tens of billions of dollars on balance sheets.

For the most part, carrying out these interventions requires no new technology. Rather, the interventions push stakeholders to prioritize operational productivity – specifically service throughput, cost efficiency, and quality outcomes.

The current financial transactions ecosystem has arisen in part by design and in part by accident. Many healthcare organizations view their data as proprietary and patients value data privacy; thus, data sharing is limited. Private payers have legacy computer systems and are hesitant to invest in newer systems without a clear purpose. There have been public sector efforts to address the situation, though they have not been fully implemented. The Health Insurance Portability and Accountability Act of 1996 required a common claims form, which led in part to the creation of supplemental claims forms. The Affordable Care Act of 2010 called for a national system to determine benefits eligibility, coverage information, patient cost-sharing to improve collections at the time of care, real-time claim status updates, auto-adjudication standards, and real-time and automated approval for referrals and prior authorizations. But many of these approaches were never enacted.[39]

Traditionally, such needs have taken a back seat to more pressing clinical or financial concerns. In part, this is because the potential savings from these actions have been hidden. But our analysis suggests that the potential savings could be substantial. Thus, the financial transactions ecosystem deserves more attention than it has received.

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**Figures**

**Figure 1:** Example organizational level solutions to reduce administrative costs associated with financial transactions

**Figure 2:** Net annual savings opportunity by intervention level

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**Figure 1:** Example organizational level solutions to reduce administrative costs associated with financial transactions

**Private payer**

| Example interventions | Description | Impact of these interventions upon organization | Opportunity for impact from industry-level interventions |
|---|---|---|---|
| **Improving data quality** | Develop and implement data protocols across intake, standardization, and integrity improvement; utilize 3rd party data sets to improve quality of payer-collected data | High | High |
| **Removing global processing issues** | Address issues that impact all claims types (e.g., no PA match, coordination of benefits pends) to improve auto-adjudication rate and enable claim-type specific interventions | High | Medium |
| **Targeting isolated processing issues** | Identify high-value claim types (e.g., C-section live birth) where targeted rule modifications can drive meaningful impact on auto-adjudication rate | Medium | Low |
| **Building micro-automations** | Automate manual, time-consuming routines (e.g., manual field updates, pricing) by developing simple automations and attended bots | Medium | Low |
| **Streamlining manual processing** | Enhance frontline performance through improved training, performance management, and agile staff deployment | Low | Low |

**Hospitals and physician groups**

| Example interventions | Description | Impact of these interventions upon organization | Opportunity for impact from industry-level interventions |
|---|---|---|---|
| **Reducing denials and account receivables follow up spend** | Use automation and vendors to drive efficiencies across back office functions (e.g., denials management, A/R management) | High | Medium |
| **Eliminating manual work through digital workflows** | Automate millions of manual queries per year such as eligibility / benefit verifications (e.g., EDI 27 0 271) and AR claim status checks | Medium | Medium |
| **Automating documentation processes** | Automate outpatient and simple inpatient coding and audits for certified coding staff to review; adopt computer-assisted coding | Medium | Low |
| **Improving clinical documentation accuracy** | Adopt ambient dictation, improve documentation audit and query effectiveness with AI-enabled workflow | Medium | Low |
| **Streamlining financial clearance and prior authorization processes** | Centralize integration points across payers onto one platform to streamline PA for providers | Low | Medium |

Source: Authors' analysis

*Figure 1*
*165x93 mm ( x DPI)*

**Figure 2:** Net annual savings opportunity by intervention level

| Intervention level | Example interventions | Example challenges | Spending base affected $ billions | Savings potential Percent | Reduction in spending $ billions | |
|---|---|---|---|---|---|---|
| Organizational | Private payer solutions (e.g., improving data quality, removing global processing issues) | • Legacy claims platforms<br>• Skill and performance management gaps in workforce | $40<br>*Spending on financial transactions ecosystem* | 20-25% | $7–$10 | ~50% of total savings |
| | Providers (e.g., streamlining prior authorization, eliminating manual claim status activity, generating first-level denial appeals) | • Technology adoption and integration barriers with numerous stakeholders<br>• Staff capacity constraints and skill gaps<br>• Management and optimization of vendor partners | $90<br>*Spending on financial transactions ecosystem* | 15-20% | $15–$20 | |
| Industry | Adopting a centralized automated claims clearinghouse | • Agreement on standardized payment process<br>• Technology infrastructure<br>• Ownership (public or private) | $165<br>*Spending on claims processing across all stakeholders* | 10-12% | $10–$15 | ~50% of total savings |
| | Standardizing medical policies for a subset of prior authorizations | • Medical policies as competitive differentiator<br>• Ongoing addition / sunsetting of policies<br>• Possible creation of additional lobbying | $35<br>*Spending on prior authorization across all stakeholders* | 3-5% | $1-$3 | |
| | Standardizing physician licensure for a national provider directory | • State regulations<br>• Frequency of updating | $140<br>*Spending on industry-specific operational functions all stakeholders* | 5-8% | $8–$12 | |
| **Total** | | | | | $40–$60 | |

Note: All dollars represent net savings annually, accounting for ongoing operating expenses. In our experience, one-time implementation costs would be 0.7-1.0x of annual run-rate savings
Source: Sahni, N. R., Mishra, P., Carrus, B., & Cutler, D. M. (2021, October 20). Administrative simplification: How to save a quarter-trillion dollars in US healthcare. McKinsey & Company; Authors' analysis

*Figure 2*
*165x93 mm ( x DPI)*


**MILBANK MEMORIAL FUND**

**STATEMENT FOR THE RECORD**
**for the**

**UNITED STATES SENATE**
**COMMITTEE ON THE BUDGET**

# HEARING
# ON EXCESS HEALTH COSTS

**October 18, 2023**
**Washington, DC**

For further information contact:
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President, Milbank Memorial Fund

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The Milbank Memorial Fund (MMF) is a national foundation that improves population health by connecting leaders and decision-makers with the best evidence and experience. We appreciate the chance to deliver this statement to the members of the Budget Committee in conjunction with the hearing on Excess Health Costs.

You will hear testimony today on three drivers of excess health costs in the US health care system, compared to other countries: administrative costs due to multiple insurers, excess prices- particularly for commercial insurers – caused by rapidly consolidating providers who obtain negotiating leverage; and excess utilization encouraged by a fee for service system that overvalues diagnostic and surgical services relative to disease prevention and care coordination. You will hear examples of how those problems can be prevented or addressed – with antitrust practices, regulatory oversight and provider payment reform.

Underlying both our pricing and utilization disadvantages is a fundamental undervaluing of primary care services in this country. Primary Care is the only part of the health care delivery system where an increased supply is associated with better health outcomes and improved health equity. Well-resourced and organized primary care teams can, as you have heard today, prevent, diagnose and efficiently coordinate care in patient-centered ways, directing services to higher value providers and reducing unnecessary utilization.

Yet part of the well-documented underperformance of the US health care system relative to other countries is because we spend a smaller portion of our health care budget on primary care compared to other countries, and we underpay our primary care clinicians relative to specialists, resulting in excess specialists and insufficient primary care clinicians.

The 2021 National Academy of Sciences Engineering and Medicine (NASEM) Report "Implementing High Quality Primary Care" declared primary care to be a common good, attributed its historical undervaluing to Medicare policy and recommended action steps for federal, state and private sector actors in five areas: payment and financing, access, workforce, health information technology and accountability.

In its payment and financing recommendations, the report called on CMS to pay primary care clinicians more and differently, increase the portion of Medicare spending going into primary care and reform the way Medicare assigns economic value to the services for which it pays.

Specifically, the MMF, based on the NASEM recommendations and analysis conducted with the Commonwealth Fund, calls on Congress to take the following steps regarding the Medicare program.[1]

1. **Increase payment for primary care services**. To address the undervaluation of primary care services, Congress could create two fee schedules: one for the evaluation and management of patients — everyday diagnosis, treatment, counseling, and patient or family support (known as E&M services) — and one for everything else. A dedicated E&M fee schedule would protect against payment for primary care–related services being decreased to accommodate fee increases for other specialty services, which is required to keep the overall fee schedule budget-neutral.

[1] https://www.commonwealthfund.org/blog/2023/how-congress-can-strengthen-primary-care-through-medicare-payment-reform

2. **Develop a partial capitated per-member per-month payment model**. In addition to fixing the fee schedule, per-member per-month payments would provide clinicians a fixed amount per patient paid in advance, allowing clinicians to innovate, budget, and more easily integrate others kinds of care, like behavioral health or telehealth, into primary care. To ensure the payments are sufficient and address current under-compensation, they should represent a 30 percent to 50 percent increase in current revenues.

   For this to work, Medicare will need data from patients about who they consider to be their primary care provider. As an incentive for patients to designate a primary care clinician, Congress could waive any cost sharing for office visits when patients indicate their primary care clinician on an annual basis.

3. **Modernize the Medicare Physician Fee Schedule**. Create a new expert panel that simplifies the Medicare Physician Fee Schedule, collapsing the current 8,000 service codes into "clusters" of related services (e.g., eliminate 21 different types of colonoscopies). Congress also can task the experts with identifying ways the Centers for Medicare and Medicaid Services (CMS) can determine rates using objective, empirical data rather than the current process, which relies on flawed estimates of clinician time and work.

4. **Increase overall spend on primary care**. Congress could direct CMS to require its payers and plans to measure and annually report the portion of total spending going to primary care, with the goal of increasing that proportion over time.

Primary care is growing more fragile when it is most needed. The 2023 MMF Scorecard on the Health of Primary Care[2] documented the weak state of primary care in the US:

- In 2010 one of every three physicians in the US was a primary care clinician. In 2020 one of every five new physicians was entering primary care.
- Between 2010 and 2020, the percentage of the population reporting no usual source care increased by almost twenty percent, even as insurance coverage increased.

My experiences as the country's first health insurance commissioner, overseeing the commercial health insurance market in Sen. Whitehouse's beloved home state of Rhode Island taught me two things:

- Excess provider negotiating power must be directly overseen, and
- Commercial insurers derive their provider payment rates and policies completely from Medicare's.

Now, ten years of payment reform experimentation in Medicare in the wake of the Affordable Care Act have taught us that voluntary Medicare payment reforms are insufficient to drive needed delivery system changes; the economic forces documented in the hearing have grown too large and too entrenched.

The toll of higher health care prices and excess utilization on the federal budget – and by extension all employers and Americans – will not be addressed until strengthening primary care is made an explicit priority for direct congressional action.

Thank you for the Committee's work and for the opportunity to provide MMF's perspective on these important issues.

[2] https://www.milbank.org/publications/health-of-us-primary-care-a-baseline-scorecard/

Rhode Island Quality Institute

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***Statement for the Record***

**Leveraging Health Information Exchanges, All-Payer Claims Databases, and the Learning Health System Approach to Enhance Healthcare Cost Transparency and Efficiency**

I serve as the Chief Executive Officer of a state-designated entity operating a Health Information Exchange (HIE). Moreover, I hold a tenured faculty position in Medical Science at Brown University, am an elected Fellow of the American College of Medical Informatics, and am a certified health informatics professional. I am submitting this statement for the record to emphasize the crucial role that HIEs, when integrated with All-Payer Claims Databases (APCDs) and guided by the principles of the Learning Health System, play in enhancing healthcare cost transparency, reducing waste, and improving the quality and efficiency of healthcare delivery across the nation.

In the complex landscape of American healthcare, transparent and accessible information regarding medical expenses is fundamental to empowering patients, facilitating informed decision-making, and driving down the overall cost of care. HIEs stand at the forefront of this revolution. By connecting healthcare providers, payers, and patients, HIEs enable the efficient exchange of critical health information, especially in times of need. In addition to empowering healthcare professionals to make evidence-based decisions, this approach plays a vital role to identify and eliminate waste within the healthcare system. Data-driven analyses can enable healthcare systems to pinpoint inefficiencies, reduce unnecessary tests and procedures, and optimize resource utilization. This streamlined approach aligns with the Quintuple Aim's goals of improving population health, enhancing patient experiences, improving provider well-being, and fostering care team collaboration. Through systematic waste identification and elimination, we can create a more efficient, cost-effective, and patient-centered healthcare system.

Moreover, the integration of APCDs enriches the data available within HIEs. APCDs, by collecting and storing healthcare claims data from all payers, offer comprehensive insights into healthcare utilization and costs. When harmonized with HIEs, APCD data allows for a detailed analysis of regional and national trends, identifying areas of resource overutilization and providing opportunities to reduce waste. By understanding these patterns, we can optimize healthcare practices and redirect resources where they are needed most.

Crucially, the Learning Health System approach revolutionizes healthcare by emphasizing continuous learning and improvement. By integrating research, data analysis, and real-time feedback, healthcare providers can identify best practices and areas for cost reduction. This iterative process not only enhances the quality and efficiency of healthcare delivery but also fosters a culture of collaboration, ensuring that knowledge and best practices are shared across the healthcare ecosystem.

As a healthcare and biomedical informatics leader, I strongly advocate for the widespread adoption of HIEs, APCDs, and the Learning Health System approach. Leveraging these innovations, we can instigate transformative change in our healthcare system. I urge the Senate to support initiatives promoting sustainable funding and seamless integration of HIEs and APCDs. This support will pave the way for a healthcare ecosystem where transparency, efficiency, and affordability take precedence, ensuring a better future for all.

Together, let us work towards a future where every American has access to clear and understandable healthcare cost information, empowering them to make informed decisions about their well-being. Let us embrace the principles of the Learning Health System to ensure that our healthcare system not only meets but exceeds the expectations of our citizens.

**STATEMENT FOR THE RECORD**

**of Nikhil R. Sahni[1] & David M. Cutler[2] to:**

**THE UNITED STATES SENATE**

**COMMITTEE ON THE BUDGET**

**HEARING ON:**

**Improving Care, Lowering Costs: Achieving Health Care Efficiency**

**Chairman Sheldon Whitehouse**

**October 18, 2023**

1. Nikhil R. Sahni is the leader of McKinsey & Company's Center for US Healthcare Improvement, where he is also a partner, and a Fellow in the Department of Economics at Harvard University.
2. David M. Cutler is the Otto Eckstein Professor of Applied Economics in the Department of Economics at Harvard University, where he has spent over three decades attempting to improve the US healthcare system.

Thank you Chairman Whitehouse and Ranking Member Grassley for the opportunity to offer these perspectives and for the Committee's attention to this important topic. We are proud to offer our fact-based research to the Committee. While we are not endorsing any specific legislative remedy, we do believe an understanding of US healthcare administrative spending will help the Committee better understand how to improve care and lower costs to achieve healthcare efficiency.

For the past decade, we have researched administrative spending in the US healthcare system, specifically why known savings opportunities have not been captured. Over that time, we have written a series of papers that reframe the challenges in a way that offers stakeholders actionable approaches, cited in the body of this Statement.[1-4] We highlight five key points for the Committee.

- **There are known savings opportunities in US healthcare administrative spending but much more remains to be done to capture them.** Research shows the potential to save 20 to 40 percent of the nearly $1 trillion spent annually on administrative spending, or roughly $265 billion annually by our estimates.[1-10] Progress has been halting, highlighting the challenges that stakeholders face in taking action.[3]

- **Administrative spending analyses should better reflect how organizations operate.** Healthcare leaders have told us that typical research findings on administrative spending do not align with how their organizations actually operate. As a result, it has been hard to benefit fully from this research and make administrative savings actionable. In our work, we found that five operational functional focus areas comprise 94 percent of administrative spending: financial

transactions ecosystem, industry-agnostic corporation functions, industry-specific operational functions, customer and patient services, and administrative clinical support functions.[1,2]

- **There is no "big bang" solution; capturing the $265 billion opportunity will require continued and sustained effort.** While there is general appeal of a "big bang" solution to capture the savings opportunity, the reality is that progress will most likely be made through a series of interventions. In our work, we identified more than 30 known interventions – those proven in healthcare organizations or other industries with today's technology – that could reduce administrative spending by up to $265 billion on an annual basis without negatively affecting quality or access.[1,2] The majority of these savings will be achieved at the organizational level (i.e., under the control of one organization) versus the industry level (i.e., where concerted action is required to realize savings).

- **The financial transactions ecosystem is a pain point for patients and clinicians and has opportunities for savings.** One of the most visible administrative functional focus areas is the financial transactions ecosystem, accounting for roughly $200 billion in annual spending.[1] We defined the financial transactions ecosystem as all interactions among patients, providers, and payers involving claims processing, payment, patient collections, and prior authorization. We estimated that the average claim has a joint transaction cost of $12 to $19 across private payers and providers, where the majority of that amount is labor cost.[3] A focus on immediate payment assurance and high use of automation throughout the process – something already seen in other US services industries and international healthcare systems – could

reduce this transaction cost to unlock $40 billion to $60 billion in annual run-rate savings, of which roughly half is at the organizational level and half at the industry level.

- **Some healthcare organizations are successfully carrying out the interventions necessary to realize savings, but more could be done.** Our research shows that some healthcare organizations are carrying out the interventions identified. We found four common themes among the organizations that have been most successful in pursuing administrative simplification programs: making administrative simplification a strategic priority (for example, a top three strategic goal in a given year); committing to transformational change (not just incremental steps); engaging the broader partnership ecosystem; and allocating resources disproportionately. A key challenge is extending these approaches to medium and smaller-sized organizations, many of which would like to act but may not have the internal resources or capital to do so. The development of a vendor ecosystem over the past decade increases the likelihood that these organizations could achieve similar results to those of their larger peers in the near term. In addition, there is a role for industry-level interventions that could focus on accelerating and augmenting organizational-level interventions.

In the rest of this Statement for the Record, we summarize our work and additional research, the basis for these perspectives.

Thank you for the Committee's work and for the opportunity to provide our perspective on these important issues.

## SUMMARY OF OUR PERSPECTIVES

We summarize our research and that of others on administrative spending and how it might be addressed. Together with others, we have written a number of articles on the administrative burden in healthcare, which we believe provide a framework for actions at the organizational and industry levels.[1-4]

**There are known savings opportunities in US healthcare administrative spending but much more remains to be done to capture them.**

The size and importance of administrative spending – generally defined as "all activities in support of the delivery of care" – in the US healthcare system is well-documented.[1-15] We estimated that total spending on administrative functions was nearly $1 trillion in 2019, or roughly 25 percent of total US healthcare spending.[1,2] For comparison, previous research on this topic estimated administrative spending from 15 percent to 35 percent.[11-13] Research on average estimates that 40 percent of administrative spending is wasteful spending – that is, spending that could be reduced without negatively affecting the delivery of care.[5-10] Taking an operational lens and cataloguing only known interventions, we estimated savings of 25 percent, or $265 billion.[1,2]

Overall, administrative spending has increased over time, along with spending on clinical care. Over the years, the federal government has made several attempts to address specific aspects of administrative spending. For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required a common claims form. The Affordable Care Act of 2010 (ACA) called for a national system to determine benefits

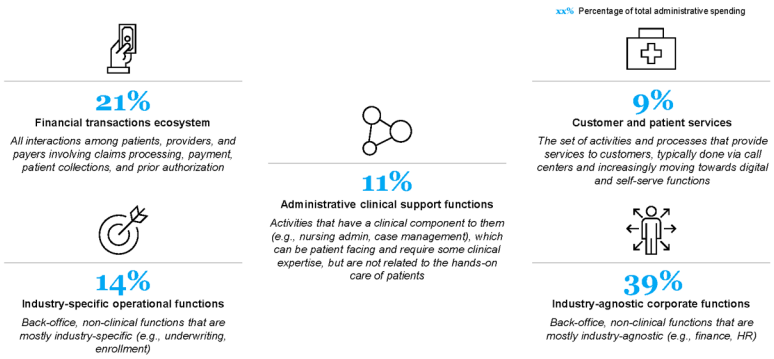
eligibility, coverage information, patient cost-sharing to improve collections at the time of care, real-time claim status updates, auto-adjudication standards, and real-time and automated approval for referrals and prior authorizations.[14] While organizations worked to compile with these changes, the magnitude of spending as a proportion of overall healthcare as well as the estimated savings opportunity have remained consistent for many decades.[5-13]

**Administrative spending analyses should better reflect how organizations operate.**

A common refrain among leaders of healthcare organizations is that the way many researchers have characterized administrative spending fails to show how organizations actually conduct their operations and thus where the savings opportunity lies. A typical way to categorize administrative costs is in terms of functional categories such as "finance" and "IT". However, this is not helpful, because it is not actionable. For example, reducing finance costs may require additional IT input. Thus, it was unclear to organizations how they should respond to these analyses.

To address these issues, we developed a framework of five functional focus areas representing 94 percent of administrative spending in 2019.[1] These areas correspond to actionable areas of administrative spending for healthcare organizations. Exhibit 1 details these five areas. They are:

**Exhibit 1:** 5 functional focus areas represent 94% of administrative spending

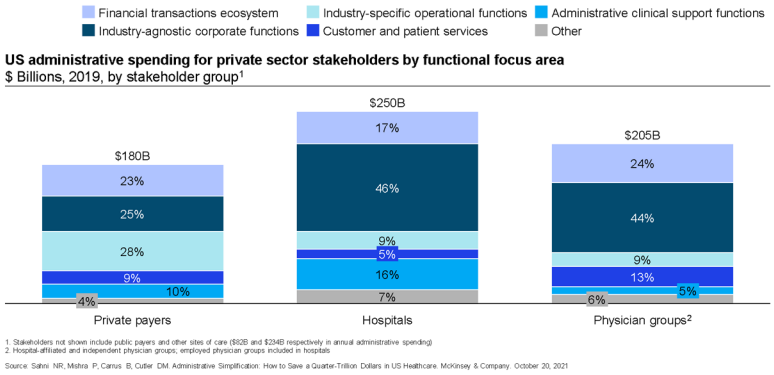



Source: Sahni NR, Mishra P, Carrus B, Cutler DM. Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. McKinsey & Company. October 20, 2021

- *Financial transactions ecosystem (21 percent of administrative spending)*: All interactions among patients, providers, and payers involving claims processing, payment, patient collections, and prior authorization.
- *Industry-agnostic corporate functions (39 percent)*: Back-office, non-clinical functions that are mostly industry-agnostic, such as finance or human resources.
- *Industry-specific operational functions (14 percent)*: Back-office, non-clinical functions that are mostly industry-specific, such as underwriting, enrollment, quality reporting, and accreditation.
- *Customer and patient services (9 percent)*: The set of activities and processes that provide services to customers, typically done via call centers and increasingly moving toward digital and self-service functions.

- *Administrative clinical support functions (11 percent)*: Activities that have a clinical component (for example, nursing administration and case management), which can be customer-facing and require some clinical expertise, but are not related to the hands-on care of patients.

**Exhibit 2:** Mix of functional focus areas by stakeholder group




1. Stakeholders not shown include public payers and other sites of care ($82B and $234B respectively in annual administrative spending)
2. Hospital-affiliated and independent physician groups; employed physician groups included in hospitals

Source: Sahni NR, Mishra P, Carrus B, Cutler DM. Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. McKinsey & Company. October 20, 2021

We can apply this framework to different stakeholder groups to better understand their administrative spending mix (Exhibit 2). For example, among private payers, industry-specific operational functions (28 percent), industry-agnostic corporate functions (25 percent), and financial transactions ecosystem (23 percent) account for the majority of spending and are of roughly equal size. For hospitals, industry-agnostic corporate functions (46 percent) represent the largest focus area, followed by the financial transactions ecosystem (17 percent) and administrative clinical support functions (16 percent). Physician groups have a similar distribution.

**There is no "big bang" solution; capturing the $265 billion opportunity will require continued and sustained effort.**

There are a number of ways to estimate the healthcare savings opportunity associated with administrative spending. Some include international comparisons; some compare certain processes in healthcare to other US services industries.[5-10] The difficulty with these approaches is that they do not properly account for the nuances of the US healthcare system. For example, unlike other countries, the US healthcare system is multi-provider (more than 6,000 hospitals and 11,000 non-employed physician groups with more than five physicians) and multi-payer (more than 900 private payers) to encourage competition.[16,17] Having such a large number of organizations increases the complexity of the system due to the greater number of communication and transaction nodes and thus could necessitate a higher baseline of administrative spending.

Underlying this structure is a predominantly fee-for-service payment model, although value-based models are catching on in some areas. No matter which payment model is used, stakeholder groups continue to put checks and balances on each other to ensure the other party is acting appropriately. The implication is that certain portions of administrative spending are necessary (for example, for service delivery and technology) and others unnecessary (such as excess spending on antiquated systems).

Furthermore, the US healthcare system is highly regulated, requiring administrative spending by organizations to comply with certain rules. These regulations range from compliance requirements such as HIPAA to quality-focused areas like Star ratings reporting in Medicare Advantage, a private-sector alternative to traditional

Medicare. For example, research has found that physicians spent 2.6 hours per week on quality measure reporting, much of which is not synchronized across payers.[19] That is the equivalent in time to caring for up to nine patients.

To estimate the magnitude of savings that might be realized, we took an approach that recognized that healthcare is inherently different from other industries, and that multi-payer healthcare systems have different administrative spending than single-payer healthcare systems. We sized the opportunity by cataloguing known interventions that have been used in a variety of industries, including healthcare. These interventions met one of three criteria: proven but not fully scaled changes across US healthcare, changes related to technology that will fully come to market within the next three years, and transformational changes that are analogous to those implemented in other US industries. We then estimated the savings that we judged to be most reasonable if each of these interventions was expanded nationally.

The list of known interventions is in Exhibit 3. We grouped these criteria into one of three categories based on where stakeholders must reach "agreement" to effectuate change:

- "Within": Interventions that can be controlled and implemented by individual organizations alone, without requiring other organizations to make changes
- "Between": Interventions that require agreement and collaboration between two organizations, such as a payer and hospital, but not broader, industry-wide change
- "Seismic": Interventions that require broad, structural agreement and changes among many organizations across the US healthcare system

**Exhibit 3:** Known interventions that collectively could save $265 billion annually without negatively affecting quality and access

| Functional focus area | "Within" interventions | "Between" interventions | "Seismic" interventions |
|---|---|---|---|
| **Financial transactions ecosystem** | • Simplify products offered<br>• Streamline claims submission process<br>• Automate adjudication<br>• Transcribe medical records before submission<br>• Clarify Explanation of Benefits<br>• Sunset old prior authorizations<br>• Prescreen prior authorizations using digital support | • Improve data management and coordination<br>• Improve coordination and clarity on claims-related communications<br>• Streamline claims payment tracking and recovery process<br>• Align incentives between payer and provider through risk-sharing models<br>• Increase proportion of automated prior authorizations<br>• Conduct targeted "gold carding" | • Adopt centralized automated claims clearinghouse<br>• Standardize medical policies<br>• Modularize benefits<br>• Adopt globally-capitated payment models |
| **Industry-agnostic corporate functions** | • Promote operational excellence using traditional levers<br>• Build for "functions of the future" | | |
| **Industry-specific operational functions** | • Promote operational excellence using traditional levers<br>• Build smart services<br>• Empower a function through foundational data investments | | • Prioritize high-value interoperability use case<br>• Standardize physician licensure<br>• Streamline quality reporting |
| **Customer and patient services** | • Reduce transactional volume through proactive issue outreach and interface improvements<br>• Improve handle time and issue resolution via artificial intelligence<br>• Outsource to lower-cost, highly skilled locations | • Build strategic payer-provider platforms to reduce demand | |
| **Administrative clinical support functions** | • Digitize manual administrative activities<br>• Enable management of larger spans<br>• Digitize and automate case and disease management processes<br>• Integrate suite of tools and solutions<br>• Improve operational discipline and ensure "top of license" practices | | |

Source: Sahni NR, Mishra P, Cerrus B, Cutler DM. Administrative Simplification: How to Save a Quarter-Trillion Dollars in US Healthcare. McKinsey & Company. October 20, 2021

Applying roughly 30 "within" and "between" interventions and a handful of "seismic" interventions, we estimated **$265 billion** of net annual run-rate savings for the US healthcare system using today's technology without negatively affecting quality or access.[1,2] Indeed, many of these interventions would improve nonfinancial aspects of healthcare, such as improved healthcare quality, increased access, better patient experience, and greater clinician satisfaction.

The interventions span all five operational functional focus areas. We estimated that 37 percent of the savings, or roughly $100 billion annually, would come from greater attention to industry-agnostic corporate functions, and 23 percent of the savings, or roughly $65 billion annually, would come from greater attention to the financial transactions ecosystem.[1]

**The financial transactions ecosystem is a pain point for patients and clinicians and has opportunities for savings.**

We have recently focused on the financial transactions ecosystem, which represented $200 billion in administrative spending in 2019.[1] We defined this functional focus area as all interactions among patients, providers, and payers involving claims processing, payment, patient collections, and prior authorization. We broke this down into two components, claims processing, which accounted for $165 billion of the total, and prior authorization, which was the remaining $35 billion.[3] This functional focus area is a prominent topic of discussion in the industry given the high visibility of these interactions for patients, clinicians, and healthcare organizations.[20,21]

The question we have explored is how to make these processes more efficient and accurate. We started by defining a common end-state. Industries with efficient financial transactions ecosystems share two features: immediate payment assurance and high use of automation throughout the process. By payment assurance, think of a meal at a restaurant where the customer uses a credit card. The restaurant needs immediate assurance that the payment will be transferred, not necessarily immediacy in the dollars transferred. In addition, lowering processing costs through automation could improve the cash flow of providers and payers.

An understanding of the basic facts can help ensure interventions are matched with the greatest opportunities:

***Claims processing***

Nearly 9 billion claims are processed annually, or roughly 30 per US insured life.[22] On average, about 80 percent of these claims are either auto-adjudicated or

adjudicated with a minor adjustment. We found that the average claim costs private payers and providers a combined $12 to $19.[3] This transaction costs breaks down to $2 to $4 for private payers and $10 to $15 for providers for a single claim. For simple claims (80 to 90 percent of the total), the cost is roughly $7 to $8 per claim, including both private payers and providers; for more complex claims, the joint cost is $35 to $40 (for example, a caesarean section, where the claim could include multiple clinicians such as an OB/GYN and anesthesiologist, multiple payers such as commercial and Medicaid, and multiple conditions such as post-surgery healthcare-associated infections). Labor is the dominant source of costs, accounting for more than half of total costs for private payers and up to 90 percent of costs for providers. On average, a claim can take four to six weeks to process and pay.[3]

***Prior authorization***

Prior authorization is a specific function within the medical management operations of private payers and revenue cycle management functions of hospitals and physician groups. In the market-based US healthcare system, prior authorization has come about as a check and balance between these stakeholder groups. Its primary goal is to assess the medical necessity and coverage of healthcare services and procedures according to established criteria or guidelines under the provisions of payer programs to prevent excess and unnecessary utilization. Prior authorization also could flag if newer, better treatments are available, improving the quality of care (for example, in evolving specialties such as oncology where the standards of care are being refined). This process plays an important role in the US healthcare system, so there will always be necessary administrative spending on this function.

Prior authorization affects a small subset of procedures; for example, more than 90 percent of commercial enrollees are in plans that limit prior authorization to less than 25 percent of medical services.[23] The prior authorization process starts when a physician determines that a patient needs a service, such as surgery, and contacts the patient's payer to ascertain if that particular service requires a prior authorization. The subsequent steps include payers checking on whether the procedure is medically necessary, providers attaching relevant documentation, and back-and-forth conversations to adjudicate the result.

Research has also shown that there are indirect costs of prior authorization, such as a contributing factor to physician burnout and employee turnover, perhaps resulting from the amount of paperwork providers are required to do, and delays in care.[24-28] While we acknowledge this, we are focused on the direct, administrative spending associated with prior authorization.

Overall, the administration of prior authorization is complex not only because of the number of such claims but also because private payers may have different policies for the same treatment or drug. For example, approval to administer an MRI for back pain may vary from payer to payer and even from insurance product to product offered by a payer. We estimated that private payers have in place about 5,000 prior authorization codes across procedures, diagnostics, drugs, and sites of care.[3] Of these, more than 90 percent of prior authorizations are ultimately approved by private payers, but fewer than 25 percent are auto-determined. In general, prior authorization remains a labor-intensive process, with an average cost of $40 to $50 per submission for private payers and $20 to $30 for providers.[3]

***Solutions***

**Exhibit 4:** Example organizational-level interventions to reduce administrative costs associated with financial transactions ecosystem

**Private payer**

| Example interventions | Description | Impact of these interventions upon organization | Opportunity for impact from industry-level interventions |
|---|---|---|---|
| **Improving data quality** | Develop and implement data protocols across intake, standardization, and integrity improvement; utilize 3rd party data sets to improve quality of payer-collected data | High | High |
| **Removing global processing issues** | Address issues that impact all claims types (e.g., no PA match, coordination of benefits pends) to improve auto-adjudication rate and enable claim-type specific interventions | High | Medium |
| **Targeting isolated processing issues** | Identify high-value claim types (e.g., C-section live birth) where targeted rule modifications can drive meaningful impact on auto-adjudication rate | Medium | Low |
| **Building micro-automations** | Automate manual, time-consuming routines (e.g., manual field updates, pricing) by developing simple automations and attended bots | Medium | Low |
| **Streamlining manual processing** | Enhance frontline performance through improved training, performance management, and agile staff deployment | Low | Low |

**Hospitals and physician groups**

| Example interventions | Description | Impact of these interventions upon organization | Opportunity for impact from industry-level interventions |
|---|---|---|---|
| **Reducing denials and account receivables follow up spend** | Use automation and vendors to drive efficiencies across back office functions (e.g., denials management, A/R management) | High | Medium |
| **Eliminating manual work through digital workflows** | Automate millions of manual queries per year such as eligibility / benefit verifications (e.g., EDI 27 0 /271) and AR claim status checks | Medium | Medium |
| **Automating documentation processes** | Automate outpatient and simple inpatient coding and audits for certified coding staff to review; adopt computer-assisted coding | Medium | Low |
| **Improving clinical documentation accuracy** | Adopt ambient dictation, improve documentation audit and query effectiveness with AI-enabled workflow | Medium | Low |
| **Streamlining financial clearance and prior authorization processes** | Centralize integration points across payers onto one platform to streamline PA for providers | Low | Medium |

Source: Nikhil R Sahni, Pranay Gupta, Michael Peterson, David M Cutler, Active steps to reduce administrative spending associated with financial transactions in US healthcare, Health Affairs Scholar, 2023

As Exhibit 4 shows, private payers are undertaking a number of interventions to improve automation and efficiency of their financial transactions, including improving data quality; removing global processing issues (for example, coordination of benefits pends given it affects all claims); targeting isolated processing issues; building micro-automations; and streamlining manual processing. Hospitals and physician groups are similarly implementing a number of interventions: reducing denials and account-receivables follow-up spend; eliminating manual work through digital workflows; automating documentation processes; improving clinical documentation accuracy; and streamlining financial clearance and prior authorization processes. For private payers and providers combined, at the organizational level, these interventions could result in annual run-rate net savings of $20 billion to $30 billion.[3]

At the industry-level, interventions such as blanket reductions in reimbursement rates, for example, are unlikely to effectively result in capturing the savings opportunity. Instead, the focus should be on those interventions which could *accelerate* or *augment* the organizational-level interventions. Looking to other industries, examples applied to healthcare could include adopting a centralized automated claims clearinghouse, standardizing medical policies for a subset of prior authorizations (for example, where clear evidence suggests an MRI for back pain is appropriate), and standardizing physician licensure for a national provider directory. For other industries, standardization is a common theme and can be quite attractive. However, in healthcare, scaling of intelligent and personalized processes is a larger driver of savings. The options for this have increased recently with newer technologies like artificial intelligence (AI). Thus, industry-level interventions are better positioned when focused on an outcome (e.g., low transaction costs for a claim) that sparks innovation on behalf of the patient.

Also, as seen when similar interventions have been attempted in other industries, there can also be unintended consequences which prevent the full capture of the savings opportunity and could stifle innovation. Therefore, these interventions should be considered in the context of how it is benefiting patients, healthcare organizations, and the industry at large. Some combination of these types of industry-level interventions could accelerate and augment the administrative savings opportunity by another $20 billion to $30 billion in annual run-rate net savings.[3]

**Exhibit 5:** Net annual savings opportunity for financial transactions ecosystem by intervention level

| Intervention level | Example interventions | Example challenges | Spending base affected $ billions | Savings potential Percent | Reduction in spending $ billions | |
|---|---|---|---|---|---|---|
| Organizational | Private payer solutions (e.g., improving data quality, removing global processing issues) | • Legacy claims platforms<br>• Skill and performance management gaps in workforce | $40<br>*Spending on financial transactions ecosystem* | 20-25% | $7–$10 | ~50% of total savings |
| | Providers (e.g., streamlining prior authorization, eliminating manual claim status activity, generating first-level denial appeals) | • Technology adoption and integration barriers with numerous stakeholders<br>• Staff capacity constraints and skill gaps<br>• Management and optimization of vendor partners | $90<br>*Spending on financial transactions ecosystem* | 15-20% | $15–$20 | |
| Industry | Adopting a centralized automated claims clearinghouse | • Agreement on standardized payment process<br>• Technology infrastructure<br>• Ownership (public or private) | $165<br>*Spending on claims processing across all stakeholders* | 10-12% | $10–$15 | ~50% of total savings |
| | Standardizing medical policies for a subset of prior authorizations | • Medical policies as competitive differentiator<br>• Ongoing addition / sunsetting of policies<br>• Possible creation of additional lobbying | $35<br>*Spending on prior authorization across all stakeholders* | 3-5% | $1-$3 | |
| | Standardizing physician licensure for a national provider directory | • State regulations<br>• Frequency of updating | $140<br>*Spending on industry-specific operational functions all stakeholders* | 5-8% | $8–$12 | |
| **Total** | | | | | $40–$60 | |

Note: All dollars represent net savings annually, accounting for ongoing operating expenses. In our experience, one-time implementation costs would be 0.7-1.0x of annual run-rate savings
Source: Nikhil R Sahni, Pranay Gupta, Michael Peterson, David M Cutler, Active steps to reduce administrative spending associated with financial transactions in US healthcare, Health Affairs Scholar, 2023

**Some healthcare organizations are successfully carrying out the interventions necessary to realize savings, but more could be done.**

There are examples of healthcare organizations realizing the full potential of administrative simplification. Reviewing these successes, we found four common themes: making administrative simplification a strategic priority (for example, a top three strategic goal in a given year); committing to transformational change (not just incremental steps); engaging the broader partnership ecosystem; and allocating resources disproportionately.

Nonetheless, the relative number of organizations pursuing these approaches at the scale likely required to move the industry remains limited. The US healthcare system is huge and fragmented: more than 900 private payers, more than 6,000 hospitals, and more than 11,000 non-employed physician groups with more than five

physicians.[16-18] Adequate internal resources and capital to invest in interventions can prove to be more difficult for medium and small-sized organizations.

A promising development has been the growth of a vendor ecosystem over the past decade that aids in such efforts. For example, from 2014 to 2021, the overall number of venture capital–backed healthcare AI start-ups increased more than fivefold, many of which are tackling administrative opportunities.[29] This may create savings opportunities for healthcare organizations that may have been unavailable in the past few decades, given the cost of existing solutions.

**Conclusion**

Overall, we believe that known interventions in healthcare could lead to substantial savings in administrative spending using today's technology. Applying the more than 30 known interventions could save up to $265 billion in annual run-rate savings, without negatively affecting quality and access to care for patients. Pursuing such savings should be a high priority for private and public sector leaders in healthcare.

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The OrthoForum
Benchmarking. Networking. Innovation.

October 18, 2023

Senator Sheldon Whitehouse
Chairman
Senate Committee on the Budget
530 Hart Senate Office Building
Washington, DC 20510

Senator Chuck Grassley
Ranking Member
Senate Committee on the Budget
135 Hart Senate Office Building
Washington, DC 20510

**RE: "Improving Care, Lowering Costs: Achieving Health Care Efficiency" Senate Budget Committee Hearing**

Dear Chairman Whitehouse and Ranking Member Grassley:

The OrthoForum appreciates the Committee holding this hearing on creating a more efficient healthcare system through lowering costs while improving care. We believe that any discussion about improving quality of care while also reducing costs in the modern healthcare system must consider the harmful effects of private equity firms' acquisitions of healthcare providers. As an association comprised of physicians, who are on the front lines of providing patient care, our membership has first-hand experience with the negative impact of these deals. Our membership has observed that often after a private equity firm takes over an independent physician group, the quality of care for patients goes down, the cost of care to public and private payors goes up, and employee working conditions worsen.

The OrthoForum is a national physician specialty organization that is committed to protecting and growing the independent orthopaedic group practice of medicine. Our organization was established to meet the unique challenges that integrated orthopaedic group practices face in today's health care environment. Currently, we represent ~35% of all independently owned orthopaedic practices in the United States.

Our member groups face many federal and state policy issues that impact their ability to provide quality and cost-effective care to their patients. In response to this, we are committed to developing and supporting policies that serve to strengthen and defend the independent practice of orthopaedic medicine. In doing so, we place the highest priority on patient access, efficient treatment processes, and reduced cost.

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Chairman Whitehouse and Ranking Member Grassley
October 18, 2023

Impact of Private Equity Acquisitions of Independent Health Care Providers

We believe that everyone benefits when physicians have control over the delivery of care and can work directly with their patients to make medical decisions and deliver patient-centered care. Private equity firms do not share this ideal. They seem to be more concerned with maximizing investor profits than advocating for patients. Unfortunately, current U.S. tax law incentivizes private equity firms to acquire health care providers and gives them an advantage over other would-be acquisition partners by providing the firms with substantial tax breaks.

Private equity firms have been particularly active in acquiring independent physician groups. Currently, more than half of all specialists in several U.S. markets are owned by private equity firms, according to a recent study by the American Antitrust Institute, the Petris Center at the University of California, Berkeley, and the Washington Center for Equitable Growth.[1] As the *New York Times* summarized, the study found that "[i]n more than a quarter of local markets — in places like Tucson, Ariz.; Columbus, Ohio; and Providence, R.I. — a single private equity firm owned more than 30 percent of practices in a given specialty in 2021."[2] The article added, "In 13 percent of the markets, the firms owned groups employing more than half the local specialists."[3]

The OrthoForum's experience—consistent with independent research, public reports, and even a recent investigation by the Federal Trade Commission (FTC)[4]—is that, after a private equity firm takes over an independent physician group there are generally adverse effects. These effects often include decreased quality of care for patients, increased cost of care for public and private payors, and deteriorating working conditions for employees.

Regarding higher costs, there is significant evidence that private equity acquisitions of health care providers result in higher prices without any evidence of an increase in quality or access to care. For example, a recent study concluded that, after hospital outpatient departments and ambulatory surgery centers contracted with a physician management company (PMC), prices paid to anesthesiologists increased, and were substantially higher if the PMC received private

[1] Richard M. Scheffler et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

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[3] *Id.*

[4] Press Release, Federal Trade Commission, FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas (Sept. 21, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across.



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equity investment.[5] Consistent with the study's findings, the FTC recently brought a lawsuit against private equity firm Welsh Carson, highlighting the harmful price effects of private equity acquisitions of independent physician groups. According to FTC Chair Lina Khan, "private equity firm Welsh Carson spearheaded a roll-up strategy and created [U.S. Anesthesia Partners (USAP)] to buy out nearly every large anesthesiology practice in Texas. . . . [T]hese tactics enabled USAP and Welsh Carson to raise prices for anesthesia services—raking in tens of millions of extra dollars for these executives at the expense of Texas patients and businesses."[6]

As for decreased quality and access to care, while there are many examples, the 2021 sale of an independent physician group at Dartmouth College to private equity backed One Medical, is instructive. In 2012, Dartmouth Health Connect, a primary care physicians office, was opened by the college in connection with Boston startup Iora Health. The office was originally intended to offer accessible and affordable healthcare to college students and the surrounding area. It began with two full-time physicians, a nurse, and other health professionals. After the private equity-backed takeover of the group, however, all that remains is one physician assistant with responsibility for approximately 1,300 patients.[7] In our experience, aggressive cuts in staff-to-patient ratios result in decreased quality of and access to care for patients. Furthermore, they result in job losses and increase stress for health care sector workers, contributing to burnout, among other negative impacts.

This issue is particularly important and appropriate for the Senate Budget Committee to consider, as lower quality of care and increased costs have a direct and significant negative impact on federal government spending and, in turn, all American taxpayers. In 2022, 18.7% of Americans were covered by Medicare.[8] When private equity-owned health care providers offer lower quality care for higher prices, this contributes to significant increases in the overall cost of care for Medicare patients, putting additional and unnecessary strain on the federal budget.

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[5] Ambar La Forgia et al., *Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners*, 182 JAMA Intern Med. 396, (2022), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2789280.

[6] Federal Trade Commission, *supra* note 4.

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Chairman Whitehouse and Ranking Member Grassley
October 18, 2023

We commend the Committee for holding this important hearing and urge you to continue to work on addressing these critical policy issues related to the cost and quality of patient care.

Sincerely,

The OrthoForum



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**Testimony For the Record of**

**Marilyn Bartlett, CPA**
**Senior Policy Fellow**
**National Academy for State Health Policy**

**and**

**Chris Deacon, J.D.**
**Principal Owner**
**VerSan Consulting, LLC**

**On Behalf of Patient Rights Advocate**

**For the**

**U.S. Senate Committee on the Budget**

**On**

**"Improving Care, Lowering Costs: Achieving Health Care Efficiency"**

**October 18, 2023**

PatientRightsAdvocate.org is a nonprofit organization that promotes healthcare price transparency on behalf of all patients - workers, employers, unions, and taxpayers. We are dedicated to protecting and expanding Americans' right to Healthcare Price Transparency. That right includes the right to know and compare actual prices before patients get care and the right to choose fairly priced care they can afford.

Fully unleashed price transparency would unleash competition, level out price variations, and lower healthcare costs for all patients, employers, unions and workers. Continued noncompliance impedes the ability of employer and union purchasers, patients, and technology developers to analyze and compare prices. Complete prices allow consumers to make informed decisions and protect patients and purchasers from errors, overcharges, and fraud.

Below, we provide several examples of how employers and unions have used pricing and claims data to save on healthcare costs.

Also below we include PatientRightsAdvocate.org's response to a Request for Information from the House Budget Committee and the Oversight Committee for actionable insights into improper payments, provided reforms tailored for the Federal Employee Health Benefit Program (FEHBP) that provides health benefits for over 8 million employees and their dependents. What is particularly noteworthy is that these anticipated savings are rooted in refined oversight and improved management practices, with little to no disruption for eligible members and zero cost shifting to members. There is empirical evidence supporting the efficacy of these proposed measures, drawn from successful case studies at both state and federal tiers.

**Employer and Union Plans Utilizing Pricing and Claims Data to Save on Healthcare Costs**

Osceola, Florida School District Health Plan

The Osceola School District Health Plan covers 6,500 employees, analyzed its claims data, identified overcharges, and eliminated middle players in favor of a transparent, independent health plan administrator. The school district contracted directly with local, price transparent hospitals and partnered with RosenCare, a price transparent healthcare service in the area.

As a result of implementing a transparent model, the district saved $21 million over two years, a 30% reduction in its healthcare budget. Those savings enabled the district to put more money into classrooms, pay raises for teachers, and better-quality care at a much lower price. Employees enjoy no copays, premium holidays, and easy access to preventative care which allows them to identify and treat health conditions before they worsen.

SEIU 32BJ

The labor union SEIU 32BJ, which provides health coverage for around 200,000 union members and their families in the Northeast, has saved approximately $100 million per year in healthcare costs by analyzing its claims data, eliminating price-gouging providers from its network, and directly contracting with price transparent providers. These savings have allowed the union to boost member wages by the largest amount in the union's history and

give them each $3,000 bonuses.

After analyzing its claims data, SEIU 32BJ determined New York-Presbyterian Hospital was charging it 358 percent more than Medicare for the same care, significantly higher than competing hospitals. Its claims data showed massive price fluctuations for the same care, including C-sections that ranged from $17,000 to $55,000, depending on the hospital. In a move that other unions and employers can emulate, the union decided to drop New York-Presbyterian from its health plan network, delivering significant savings to its members.

Kraft Heinz Co. versus Aetna, Filed June 30, 2023, Eastern District of Texas, Link

Kraft Heinz is accusing Aetna of breaching its fiduciary duties by leveraging its status as a third-party claims administrator to benefit itself financially, pursuing claims processing practices that harmed Kraft, pocketing millions in undisclosed fees, and failing to deliver Kraft's own claims data upon request.

Owens & Minor v. Anthem Health Plans, Filed January 2023 Eastern District of VA, Link

Owens & Minor, a medical device manufacturer, has sued Anthem Blue Cross Blue Shield for breach of fiduciary duty, breach of contract, and breach of good faith covenant by refusing to disclose claims data to the O&M upon request.

Bricklayers Union, Sheet Metal Works Union, et al., vs. Anthem/Elevance, Empire, et al., Filed December 2022, District of Connecticut, Link

Several labor trusts allege that the defendants breached their fiduciary duties by failing to deliver their requested claims data, failed to apply promised discount rates to services and failed to pass on promised discounts to each plan, as proven with comparisons to publicly available price transparency data.

"Pursuant to The Hospital Price Transparency final rule, hospitals are required to post their standard charges and negotiated rates on their websites. While many hospitals in the United States remain out of compliance with this requirement, Yale New Haven Hospital and all Hartford HealthCare facilities have posted their negotiated rates with Anthem and other insurers. Because those hospitals posted their negotiated rates on their websites in accordance with the Hospital Price Transparency final rule, Plaintiffs were able to compare the publicly available negotiated rates between Anthem and the respective hospitals posted on the hospitals' websites to the allowed amount as determined by Anthem to the claims data in Plaintiffs' possession, the first meaningful Plan claims review Plaintiffs have been able to undertake.

After reviewing the underlying claims data for numerous claims where care was provided at Yale New Haven Hospital or at a Hartford HealthCare facility, the aggregate findings of that review showed that in most cases: (a) the minimum network provider discount promised in the Funds' ASOs with Anthem were not met; (b) the negotiated rate posted by both hospital systems and the allowed amount of the claims Anthem repriced for Plan participants did not

match; (c) the vast majority of the reviewed claims paid by the Plans did not receive a network provider discount anywhere near the 50.0% discount promised in the respective ASOs; and (d) the Plans often paid a much higher amount for covered health care than the publicly posted rate Anthem negotiated with the relevant facility, sometimes even more than the amount billed by the provider."

Mass. Laborers' Health and Welfare Fund v. Blue Cross Blue Shield of Mass. (2022), District of Massachusetts, 1st Cir., Link

Trustees of health-benefit plan sued Blue Cross Blue Shield of Massachusetts alleging it violated its fiduciary duties by failing to process claims correctly, overpaying benefits, neglecting to recoup overpayments properly, and refusing to provide information needed by the Fund to verify claims were priced appropriately. District Court ruled against health plan in dismissing case due to lack of standing, and on appeal PRA and the Department of Labor filed amicus briefs arguing Blue Cross is a fiduciary. 1st Circuit has upheld dismissal.

Montana State Employee Health Plan – Video Link

Montana's State Health Plan saved $121 million and avoided insolvency by accessing transparent claims and pricing data and contracting at reference based pricing, which ties the prices paid for healthcare services to a multiple of what Medicare pays for the same care.

In 2014, Montana's State Health Plan, which covers approximately 30,000 state government employees and their families, lost nearly $29 million. Its $60 million of reserves were expected to fall to a deficit of $9 million by 2017. Yet the plan reversed its trajectory and boosted its reserves by $121 million over projections. Rather than being depleted, the plan's reserves roughly doubled.

The state hired Marilyn Bartlett, a seasoned forensic accountant, to manage the plan and reverse its dire fiscal outlook. Bartlett analyzed the plan's claims data and discovered hospitals in the state were routinely charging it up to six times more than the Medicare rate for the same care.

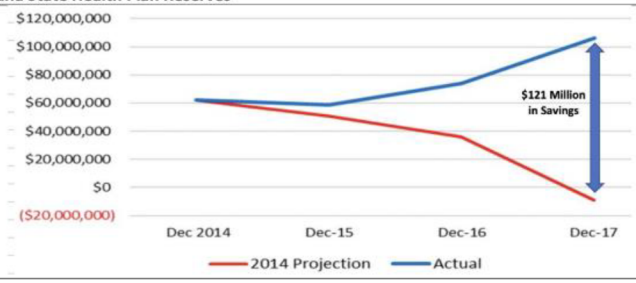
To overcome this hospital price gouging that was bankrupting the plan, Bartlett implemented a reference based pricing model that would make it impossible for hospitals to overcharge. Bartlett's analysis concluded the plan could afford to pay hospitals an average of 234 percent of the Medicare rate for inpatient and outpatient services – a benchmark that also allowed state hospitals to make a fair profit.

Such a common billing reference controls for wide hospital price variations and prevents hospital upcoding, erroneous charges, and billing fraud. It also helps control future price trends, as payments are limited to annual Medicare rate increases. Bartlett used her negotiating leverage over hospitals that didn't want to lose their consumers to competitors and overcame fierce industry lobbying to successfully sign up all hospitals in the state to the new model.

The ensuing $121 million in savings came with no difference in employee healthcare service or mix in health plan population. The savings had no material financial impact on state hospitals. And they came with no premium increases for plan employees. The plan was so successful that its reserves exceeded those in the state's general fund.

Transparent claims and pricing data and reference based pricing transformed Montana's State Health Plan from a money pit to a revenue generator, saving taxpayers money and strengthening state social services. An independent actuarial review confirmed these financial accomplishments.

**Fig 1: Montana State Health Plan Reserves**




*Source: National Academy for State Health Policy*

## Executive Summary:
## Response to House Budget Committee Request For Information

In direct response to the August 30, 2023, RFI from the House Budget Committee on improper payments, we outline comprehensive reforms for the Federal Employee Health Benefit Program (FEHBP). Serving 8.2 million individuals and accounting for $58 billion in annual expenses, the FEHBP's surging costs necessitate swift action. Using insights from industry experts Christin Deacon and Marilyn Bartlett (CVs attached), we propose the following measures:

1. **Government-wide reforms to reduce improper payments:**

   **Robust Payment Integrity Solutions**: Introduce advanced analytics for early detection and prevention of improper payments. This approach has the potential for savings of $20 billion over 10 years.

2. **Agency and program-specific reforms to improve program integrity :**

   **FEHBP Carrier Accountability & Contract Management**: Rather than using the standard procurement process, FEHBP employs Carrier Letters for obtaining TPA services. This limits contract management, performance monitoring, and accountability. Employing strict contract provisions, as outlined in Attachment A, will offer leverage over TPA performance. Tighter contractual terms could enhance enforcement, addressing issues that OIG audits haven't managed to solve.

3. **Best practices to improve identity verification and information sharing across government:**

   **Dependent Eligibility Verification**: Deploy regular audits to ensure the legitimacy of dependent benefits, thus reinforcing program integrity.

4. **Improving management of state-administered federal programs:**

   (i) **Direct Contracting with Health Systems**: Given the considerable buying power of FEHBP, direct contracting with health systems and hospitals can be considered. Examples from large employers like Walmart and Boeing show potential annual savings between 10% and 20%.

   (ii) **Reference Based Pricing**: Setting hospital reimbursements as a multiple of Medicare rates instead of TPA or Carrier negotiated rates can drive significant savings for the FEHBP. Conservatively, an 18% yearly savings on hospital spending can be expected, with examples like the State of Montana achieving $47.8 million in 3 years savings.

5. **Ways to strengthen or establish accountability:**

   **Strengthened Accountability Through Dual-Tier Audits**: Establish rigorous oversight by implementing dual-tier audits—both internal and third-party. This will ensure accountability for both fraud perpetrators and those not effectively managing taxpayer resources and go well beyond the current model of limited audits that are highly restricted and non-comprehensive.

| Proposal | 1 Yr. Savings Est. | 10 Yr. Savings Est. |
|---|---|---|
| Payment Integrity | $1B | $20B |
| Conract Management and Standardization | TBD | $5B-$10B |
| Dependent Eligibility Verification | $.5B | TBD |
| Direct Contracting/RBP | $2B-$5B | $20B |
| Total | $3.5B-$7.5B | $50B+ |

These strategic initiatives present a roadmap to realize substantial savings, enhance efficiency, and guarantee the fiscal sustainability of the FEHBP. Background and Experience of authors in appendix.

**Payment Integrity Solutions for FEHBP**[i]

To safeguard the financial stability of the FEHBP and capture potential annual savings of $1B-$2B, we urge the immediate deployment of comprehensive Payment Integrity Programs. Such initiatives, proven effective in case studies, are pivotal for enhancing oversight, ensuring accountability, and reining in improper payments.

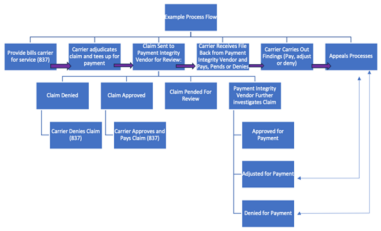
**Background**: The FEHBP, under the stewardship of insurance carriers acting as third-party administrators, has historically prioritized rapid claim settlements over rigorous scrutiny. This approach, although designed to expedite services, inadvertently exposes the system to potential fraud, waste, and abuse. OIG's consistent observations highlight the decentralized architecture of the FEHBP and a notable lack of a dedicated program integrity function.

**Introducing Payment Integrity**: An all-encompassing payment integrity program by *independent* third party (non-carrier contracted) offers a viable solution encompassing both pre and post-payment claim reviews to significantly improve operational efficiency and fiscal prudence, ensuring the FEHBP's longevity.

**Resources and Proposed Deployment:** Contrary to typical OIG audits, payment integrity reviews adopt a comprehensive approach, scrutinizing the entirety of claims, utilizing advanced methods like inferential analytics, predictive modeling, and expert medical claim evaluations. This proactive process aims to assist FEHBP carrier partners in pinpointing savings opportunities and elevating their role as financial stewards.

Key review concepts for deployment include:

- **Prepayment Review**: After the regular carrier adjudication, an independent entity assesses the claim. The review, often completed within 24 hours, utilizes various edits and algorithms to determine if the claim should pend, pay, or deny.
- **Post-payment Review**: Post-claim approval, the independent entity evaluates the claim to validate that all pre-payment findings were applied correctly.




Given the FEHBP's substantial scale, this initiative may seem challenging, yet the majority of FEHBP members are clustered in specific geographic areas which would allow the program to target the highest member concentrations in a phased approach.[ii] The inherent carrier concentration in the FEHBP, especially with the dominant role of BCBS and its regional affiliates, makes this initiative not only achievable but highly practical.

**Case Study Highlights:**

1. **New Jersey Public Employee Health Plan:** One of the largest public-sector purchasers, this plan contracted with a third-party independent payment integrity company, realizing savings of over $152 million since February 2021. The initiative deployed advanced tools and focused on areas like DRG coding, place of service appropriateness, and inpatient psychiatric services.
2. **RAC Program:** Another exemplar is the RAC program which, though post-payment, successfully recouped over $162M in FY 2019.

**Standardize and leverage all ASO Contracts Rather than Utilization of Carrier Letters to Govern Contractual Relationships and Governance of Carriers**

Currently, OPM "contracts" with carriers in a manner that is neither efficient nor in the FEHBP's best interests and gives carriers a significant role in shaping the terms of their participation. Each year OPM issues a "call letter" to health plans interested in participating in the FEHBP and carriers submit their benefit and rate proposals. OPM then enters into individualized contracts with each carrier on an entity-by-entity basis which leads to a lack of uniformity in oversight and accountability. Throughout the year, OPM also issues "carrier letters" which may set forth updated policies, reporting requirements, contractual expectations, etc. This process, starting with OPM's "call letter" and the discordant terms that follow largely allows carriers to dictate terms, rather than OPM setting forth conditions favorable to FEHBP.[iii] It should also be noted that this approach to managing contracts is unparalleled in the health plan landscape, in stark contrast to every other large employer and public sector health plan that enables them to leverage standardized agreements to optimize efficiency.

**The Path Forward:** The benefits of a standardized contract system are vast:

- **Enhanced Oversight and Efficiency:** Standardized contracts offer OPM and the Office of Inspector General (OIG) a streamlined framework for monitoring and evaluation, fostering more effective oversight.
- **Market Efficiency:** For carriers, uniform contract terms provide clarity and reduce the administrative overhead of adjusting to varying contractual requirements.
- **Optimized Resource Utilization:** By establishing a consistent contractual foundation, OPM can better allocate its resources, focusing on areas that bring maximum value to the FEHBP.

**Implementation Strategy:** A phased transition towards contract standardization over a span of 1-2 years would be practical. This ensures carriers, some of whom have partnered with FEHBP for decades, have ample time to adapt. Aspects that need standardization encompass:

- **Definitions:** Establishing clear terminologies.
- **Carrier Responsibilities:** Including standardized Fraud, Waste, and Abuse (FWA) Programs
- **Financial Terms:** Ensuring transparency in payments, fees, and more.
- **Data Rights and Ownership:** Emphasizing FEHBP/OPM's primacy over all data.
- **Audit Rights and Review:** Furnishing clear audit guidelines.
- **Overpayment Recoveries:** Setting clear recovery parameters favorable to FEHBP.
- **Medical Plan Rebates:** Transparent tracking and reporting mechanisms.
- **Performance Guarantees:** Shifting towards more impactful guarantees.
- **Eligibility Criteria:** Uniform eligibility standards across carriers.

**Contract Standardization Conclusion and Opportunities:** While quantifying the financial impact of this standardization might be challenging, the operational and integrity enhancements are undeniable. By setting a precedent in the healthcare market, FEHBP's move towards contract standardization could influence the industry at large, pushing it towards greater transparency and fairness.

**Dependent Eligibility Verification Audit Crucial for FEHBP's Financial Integrity and Sustainability**

**Payment Integrity Solutions for FEHBP**

**Dependent Eligibility Verification**

Addressing the critical eligibility concerns, it is imperative that a comprehensive Dependent Eligibility Verification Audit (DEVA) for the Federal Employees Health Benefits Program (FEHBP) take place immediately, with ongoing verification controls put in place as soon as possible. Taking into account the persistent OIG and GAO recommendations, instituting this audit could lead to significant savings, ranging from $360M to $1B annually, by preempting future claims costs from ineligible members.


**Background:** Despite longstanding concerns, the Centralized Enrollment Clearing House, while obtaining enrollment details from carriers and agencies, does not oversee dependent eligibility – a responsibility traditionally passed to the carriers. Industry insights reveal that approximately 10% of dependents on employer-sponsored plans might not be eligible.

OPM's framework is dependent on an intricate web of over 160 government employing offices—and 87 health insurance carrier contracts—to verify and enroll FEHB members. This system's fragmented nature, coupled with the fact that the FEHBP has lacked a consistent eligibility verification mechanism since 1960, further accentuates the susceptibility to errors and fraud.

**Recent Reports and Findings:**
- A 2020 OIG audit laid bare the urgent need for an eligibility audit, estimating savings up to $1 billion.[iv]The report shed light on the lack of concrete controls to prevent ineligible family member coverages. In its wake, OPM issued guidance in 2021 but December's 2022 GAO Report echoed these yet to be addressed concerns and presented a suite of recommendations to OPM.

**Resources and Proposed Deployment:**
Executing a DEVA for FEHBP necessitates a structured, tiered approach. Drawing parallels with the Payment Integrity Initiative, the OPM should enlist one or more specialized vendors to oversee this audit. These audits, predominantly automated, can follow a phased structure to prevent overburdening systems. Collaboration strategies, like aligning specific carriers with designated DEVA vendors, could streamline the process, minimize integration hassles, and maintain uniformity.

**Opportunities:**
The potential windfall from a DEVA for FEHBP is monumental, given the program's history and the absence of an ongoing monitoring mechanism. The tangible benefits go beyond mere financial savings; it's about upholding the integrity of the program and preserving benefits for those genuinely eligible. With estimates suggesting potential savings of up to $1B by dodging future ineligible claims, now is the time to act.

**Improving management of state-administered federal programs**

FEHBP, with its unparalleled scale and vast repository of data has the ability to lower healthcare prices immediately and substantially for FEHBP and all purchasers by default. Instead of relying solely on traditional carrier-negotiated rates across its vast spectrum (87 carriers and 17,877 plans), the FEHBP can adopt diversified purchasing strategies, including Reference-Based Pricing (RBP), Direct contracting and other purchasing strategies driven by data.

**Cost-Savings with Direct Contracting and RBP:** By contracting directly with hospitals and establishing reimbursement rates pegged to Medicare, FEHBP could harness significant financial benefits. Conservatively estimated, this could mean a reduction of at least 18% in hospital expenditures annually.

- **Reference Based Pricing** – (RBP) is a healthcare purchasing strategy where reimbursements to healthcare providers are set based on a predetermined benchmark, most commonly Medicare rates. For the FEHBP, leveraging the Medicare reference price is both logical and efficient, given that it's a rate already established by federal agency for other federal programs. This alignment not only streamlines administrative processes but also ensures that the prices paid are consistent with federally-acknowledged valuations of services.

    - FEHBP is no stranger to RBP. Currently, for members over 65 who choose FEHBP over Medicare, the program prices all claims at the Medicare rate. However, there's room for expansion and better monitoring. If the program could encompass more age brackets, it could further reduce FEHBP's expenditure. Tentative estimates indicate potential savings ranging from $2-5 billion, contingent on the program's breadth.
    - *Montana's Success Story:* The State of Montana Employee Group Benefit Plan's move to adopt such a model has brought about savings of $47.8 million over three years. The model was implemented through direct contracts to prevent any member balance billing. Even more impressive, they haven't had to raise employee contributions since 2017 and have returned over $50 million from surplus plan reserves back to the state.
    - *Oregon's Legislative Move:* With legislation capping hospital payments to a multiple of Medicare rates, the State of Oregon saved $112.7 million in 2021 alone for its educators and public employees' benefit programs.

- **Data-Driven Insights with RAND 5.0 Study:** FEHBP could gain in-depth insights into its current hospital claims payments by participating in the RAND 5.0 study. This study would "reprice" the claims as a multiple of Medicare, facilitating comparisons with state and national medians, evaluating hospital rates, and generating actionable data for FEHBP.

Prices paid to hospitals during 2020 by health plans, including the FEHBP, for both inpatient and outpatient services averaged 224 percent of what Medicare would have paid, with wide variation in prices among states. States where FEHBP has the most concentration of employees show even higher prices (see figure). Even modest reductions of price, or broader adoption of RBP beyond Medicare-aged population would result in substantial and immediate savings.

| State and No. of Employees | Avg. Price as % of Medicare |
|---|---|
| California 172,553 | 285% |
| Virginia 155,682 | 278% |
| Maryland 149,453 | NA |
| Texas 148,453 | 252% |
| Florida 99,212 | 310% |

By adopting RBP more broadly and leveraging data-driven strategies, FEHBP can streamline costs, ensuring its long-term financial health and the welfare of its members.

**Conclusion and Proposal for Establishment of a Centralized Program Integrity Office:**

With the staggering $247 billion in improper federal payments in 2022, the need for transformative and concrete solutions is more urgent than ever. Our series of detailed initiatives and reforms have revealed a pressing need for a centralized entity, leading us to advocate for the establishment of a Program Integrity Office.

This proposed office is not a new concept; it has been consistently recommended by the Office of Inspector General (OIG)[v], but regrettably, it has yet to be realized. The implementation of this office is crucial. It will act as a hub for executing comprehensive reforms and initiatives such as robust payment integrity solutions, stringent FEHBP carrier accountability, meticulous dependent eligibility verification, and strategic direct contracting with health systems.

By consolidating these multifaceted initiatives under one umbrella, the Program Integrity Office will be pivotal in curbing improper payments, fortifying program integrity, enforcing stringent accountability, and ultimately, protecting taxpayer dollars against waste, fraud, and abuse.

**Proposal to Establish a Program Integrity Office with the aim to:**

1. Enhance Oversight & Accountability: This office will centralize efforts to detect, prevent, and address improper payments, ensuring stringent oversight and improving accountability of federal programs and FEHBP carriers.

2. Develop Comprehensive Anti-Fraud Strategies: Formulate advanced strategies to mitigate fraud, waste, and abuse, focusing on sectors with escalating prescription drug costs and improving the antifraud function of FEHBP carriers and contractors.

3. Strengthen Identity Verification: Establish best practices to enhance identity verification and confidential information sharing across federal entities, reducing the risk of fraudulent activities.

4. Optimize Management of Federal Programs: Advocate for enhanced management and integrity in state-administered federal programs by learning and incorporating lessons from state and local governments.

5. Validate and Rectify: Ensure rigorous validation of data related to fraud, waste, and abuse and take appropriate actions where necessary, supporting the mission to curb improper payments and protect taxpayer dollars.

Whether or not the optimal outcome of establishing the Program Integrity Office is achieved, the proposed initiatives must nonetheless be pursued diligently. These reforms should be executed in a manner most advantageous to the FEHBP, to protect the interests of taxpayers, members, and other stakeholders and uphold the integrity and value of federal programs, ensuring responsible stewardship of public resources.

[i] Several OIG audits have found Program Integrity Risks in the FEHBP:
https://www.oversight.gov/report/OPM/FEHB-Program-Integrity-Risks-Due-Contractual-Vulnerabilities
https://www.oversight.gov/sites/default/files/oig-reports/OPM/FY2023-Top-Management-Challenges-Report.pdf

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[ii]

[iii] See 2023 Call Letter from OPM stating that the emphasis for FEHBP program for PY 2024:

> "OPM's focus for the upcoming plan year are on the following critical Program priorities: Fertility Benefits, FEHB and Medicare Coordination, and Pharmacy Benefit Design. Recognizing that several Biden-Harris Administration initiatives from the 2023 plan year will span beyond one plan year and that there may be more action that Carriers can take on these initiatives, OPM is continuing to emphasize the importance of Gender Affirming Care and Services, Maternal Health, Prevention and Treatment of Obesity, and Mental Health and Substance Use Disorders."

Interestingly, despite numerous OIG reports regarding eligibility issues, payment integrity issues, etc., OPM has chosen not to emphasize those issues as priorities.
https://www.opm.gov/healthcare-insurance/healthcare/carriers/2023/2023-04.pdf

[iv] https://www.oversight.gov/sites/default/files/oig-reports/OPM/FY2023-Top-Management-Challenges-Report.pdf
Office of Personnel Management, Family Member Eligibility Verification for Federal Employees Health Benefits Program Coverage, Benefits Administration Letter 21-202 (April 15, 2021
[v] https://www.oversight.gov/sites/default/files/oig-reports/OPM/Final-FY2022-Top-Management-Challenges-Report.pdf