

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

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

July 19, 2023

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

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

1. **Health care providers incur substantial costs to interact with insurers, likely totaling hundreds of billions of dollars per year, costs that are ultimately borne in large part by consumers and taxpayers.** Costly activities include negotiating contracts, collecting information about patients' insurance coverage, obtaining prior authorization for care, submitting claims for payment, and reporting on quality performance. There are likely economies of scale in performing many of these activities, so the associated administrative burdens likely fall more heavily on smaller providers than on larger ones.
2. **Many administrative processes serve valuable purposes, so efforts to reform them can involve tradeoffs and should be approached thoughtfully.** For example, it is essential to have *some* set of procedures for compensating providers. Similarly, insurers' prior authorization requirements can prevent delivery of inappropriate services, and audit processes can be effective tools for identifying and deterring fraud.
3. **Certain targeted reforms could reduce administrative burdens with few substantive downsides.** One is eliminating Medicare's Merit-Based Incentive Payment System, which places large reporting burdens on clinicians, with few benefits. Another is replacing the cumbersome arbitration process that is used to determine payment rates for certain out-of-network services under the No Surprises Act with a simpler "benchmark" payment regime. A third is reforming Medicare Advantage's risk adjustment system to reduce plans' ability to increase their payments by documenting additional diagnoses.

---

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

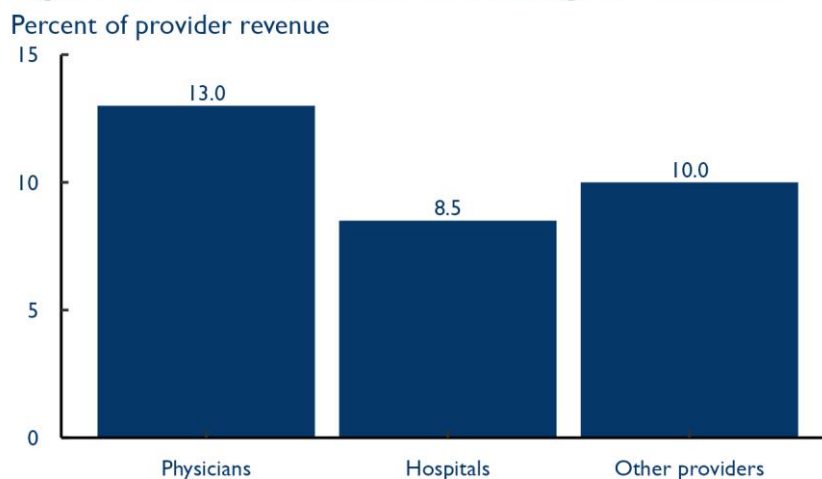
4. **Standardizing billing, coverage, and quality reporting rules across insurers could generate larger savings but would also present more significant tradeoffs.** Changes like these could help address a major reason that administrative burdens are larger in the United States than in other countries: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

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

### **Background on Insurance-Related Administrative Costs**

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

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



Source: Kahn (2010)

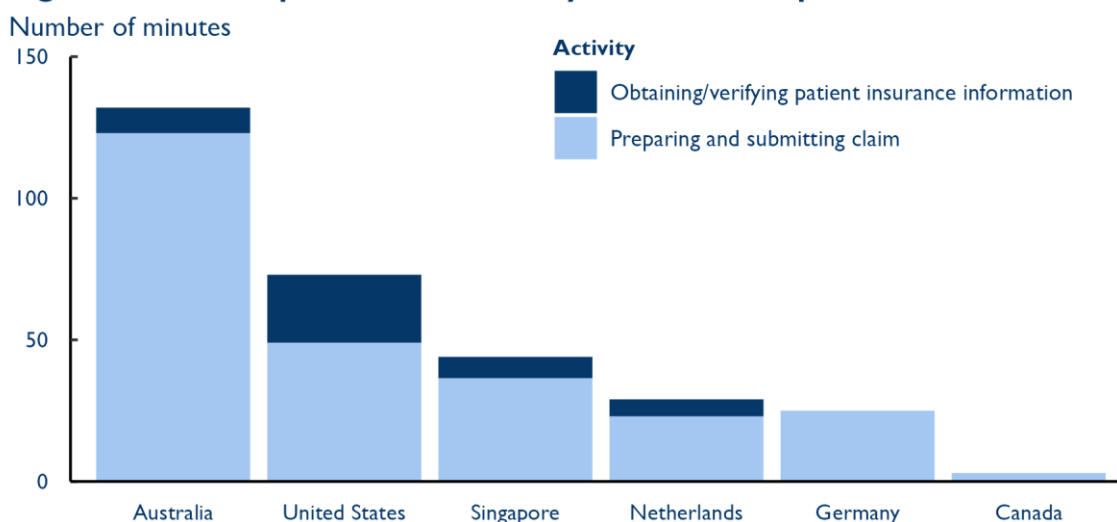
<sup>2</sup> James G. Kahn, “Excess Billing and Insurance-Related Administrative Costs,” in *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, ed. Pierre L. Yong, Robert S. Saunders, and LeighAnne Olsen (Washington, DC: National Academies Press, 2010). These estimates do not include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

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

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

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

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



Source: Richman et al. (2022)

Note: Estimates reflect all inpatient visits for countries other than Germany, for which estimates reflect inpatient surgical visits only. Estimates exclude time devoted to financial counseling.

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

<sup>4</sup> 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>.

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

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

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

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

### **Options to Reduce Insurance-Related Administrative Costs**

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

---

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

<sup>7</sup> Congressional Budget Office, “The Prices That Commercial Health Insurers and Medicare Pay for Hospitals’ and Physicians’ Services.”

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

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

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

### *Eliminating Medicare’s Merit-Based Incentive Payment System*

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

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

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

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

---

<sup>9</sup> Maggie Shi, “Monitoring for Waste: Evidence from Medicare Audits,” April 2023, [https://mshi311.github.io/website2/Shi\\_MedicareAudits\\_QJeresubmission\\_2023\\_04\\_20.pdf](https://mshi311.github.io/website2/Shi_MedicareAudits_QJeresubmission_2023_04_20.pdf).

<sup>10</sup> 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>.

<sup>11</sup> 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>.

<sup>12</sup> This estimate was obtained using CMS’ estimate of the total number of MIPS-eligible clinicians in 2019 and the Medicare Trustees’ estimate of total spending under the physician fee schedule in that year. See Centers for Medicare and Medicaid Services (CMS), “2019 Quality Payment Program Experience Report,” October 2021,

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

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

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

---

<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>.

<sup>13</sup> Centers for Medicare and Medicaid Services (CMS), "2019 Quality Payment Program Experience Report."

<sup>14</sup> 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/doi/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](http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec_rev_0518.pdf?sfvrsn=0); Eric C. Schneider and Cornelia J. Hall, "Improve Quality, Control Spending, Maintain Access — Can the Merit-Based Incentive Payment System Deliver?," *New England Journal of Medicine* 376, no. 8 (February 23, 2017): 708–10, <https://doi.org/10.1056/NEJMp1613876>; Vinay K. Rathi and J. Michael McWilliams, "First-Year Report Cards From the Merit-Based Incentive Payment System (MIPS): What Will Be Learned and What Next?," *JAMA* 321, no. 12 (March 26, 2019): 1157–58, <https://doi.org/10.1001/jama.2019.1295>.

<sup>15</sup> 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/NEJMs1613412>; Jose F. Figueroa et al., "Association between the Value-Based Purchasing Pay for Performance Program and Patient Mortality in US Hospitals: Observational Study," *BMJ* 353

In sum, I see little reason to believe that MIPS generates benefits that justify its substantial costs. With colleagues, I have argued for repealing MIPS and replacing it with small, targeted incentives for practices to undertake specific high-value activities: (1) using a certified electronic health record, which can help advance broader federal efforts to ensure that clinical data can flow across providers when needed; and (2) reporting data to a clinical registry, which can help facilitate valuable clinical research.<sup>16</sup> In parallel, policymakers should strengthen incentives to participate in advanced alternative payment models and, ideally, streamline quality reporting requirements under those models.<sup>17</sup> 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.<sup>18</sup>

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

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

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

---

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

<sup>16</sup> 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.

<sup>17</sup> 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/>.

<sup>18</sup> Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2018.

<sup>19</sup> 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>.

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

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

It is plausible that these costs will wane somewhat over time. The fees that apply for 2023 are markedly higher than the fees that applied for 2022, which may help to reduce IDR volume. Additionally, IDR volume may decline as the parties gain experience with the process. This is because going to IDR only makes sense if the two parties have divergent beliefs about what price the arbitrator will ultimately select; otherwise, they would both be better off reaching an agreement at a price close to the price that they expect the arbitrator to pick and avoiding the costs associated with IDR.<sup>21</sup> 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.<sup>22</sup> (The insurer's historical median contracted rate is currently a criterion that arbitrators are supposed to consider in IDR.) Another approach would have been to set the benchmark price equal to a multiple of the price Medicare pays for the service.<sup>23</sup> These approaches could be revived in light of the dismal experience with IDR.

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

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

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

---

<sup>21</sup> 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/>.

<sup>22</sup> 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>.

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



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

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

#### *Making the Medicare Advantage risk adjustment system more resistant to plan “coding” efforts*

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

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

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

---

<sup>24</sup> Fiedler, Adler, and Ippolito, “Recommendations for Implementing the No Surprises Act.”

<sup>25</sup> 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](https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf).

<sup>26</sup> 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>.

<sup>27</sup> Medicare Payment Advisory Commission (MedPAC), “Medicare Payment Policy,” March 2023.

in the search for additional beneficiary diagnoses. For example, MA plans often offer bonus payments to providers who report additional diagnoses.<sup>28</sup>

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

Another approach is to exclude diagnoses that are particularly susceptible to plans' coding efforts from use in risk adjustment. CMS recently took a step in this direction when it updated its risk adjustment methods for the 2024 benefit year, but it would be worth looking for other opportunities in this vein.<sup>30</sup> 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.<sup>31</sup> This may create opportunities for MA plans to profit by selectively enrolling healthier beneficiaries. Thus, this policy tool should be used judiciously.

#### *A more ambitious step: increasing standardization across insurers*

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

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

---

<sup>28</sup> Medicare Payment Advisory Commission (MedPAC).

<sup>29</sup> Medicare Payment Advisory Commission (MedPAC).

<sup>30</sup> 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>.

<sup>31</sup> 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/>.

<sup>32</sup> Richman et al., "Billing And Insurance-Related Administrative Costs."

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

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

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

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

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

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

---

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

<sup>34</sup> Cutler, "Reducing Administrative Costs in U.S. Health Care."

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

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

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

## Conclusion

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

---

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

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

<sup>37</sup> Casalino et al., “US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures.”

<sup>38</sup> Cutler, “Reducing Administrative Costs in U.S. Health Care.”