

## Reducing Administrative Costs in U.S. Health Care

David M. Cutler



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# Reducing Administrative Costs in U.S. Health Care

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**BROOKINGS**

# Abstract

Administrative costs account for one-quarter to one-third of health-care spending in the United States. This share is far greater than in other countries and exceeds all estimates of the amount necessary to perform the functions of health-care administration. This paper considers how administrative costs in health care could be reduced. The particular focus is on administrative costs where coordination among parties is required to achieve savings: (a) claims submission and adjudication, (b) prior authorization determinations, and (c) quality measurement and reporting. Underlying each of these areas is the need for data exchange among and between payers and providers. Examples from other industries show the importance of three key actions in reducing administrative costs: (a) developing uniform rules about information exchange, (b) using technology instead of manual processes, and (c) having payers and providers pay the additional costs when they choose to use nonstandard processes.

Establishing a health-care automated clearinghouse (ACH) is a key step in claims simplification; it would be modeled after the one in banking and could be operated at modest expense. Prior authorization could also be simplified, especially if prices are attached to payers that require additional information. Simplifying quality reporting involves furthering existing processes to develop uniform quality measures, and ensuring that payers that prefer to use separate measures pay the cost of doing so. Data interoperability is central to these areas, with recent legislation providing a foundation for interoperability.

The overall amount that might be saved with progress in these areas is about \$50 billion annually, or about \$150 per person per year. It would also result in greater satisfaction for both patients and providers.

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# Introduction

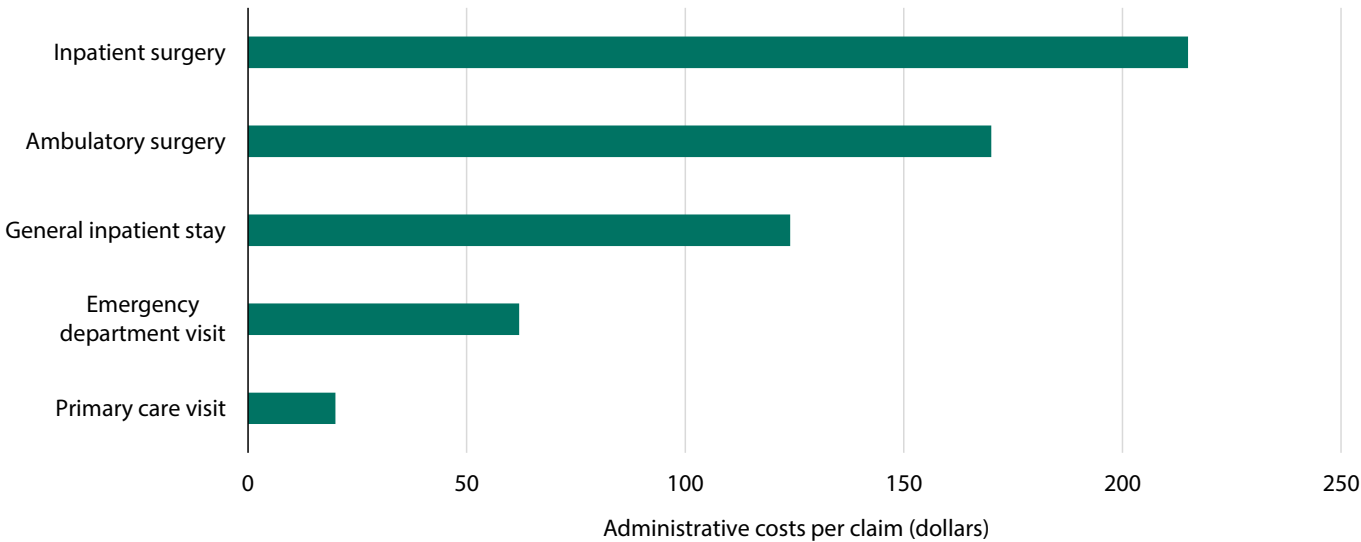
Administrative costs are estimated to account for one-quarter to one-third of the total U.S. spending on health (Woolhandler, Campbell, and Himmelstein 2003; Yong, Saunders, and Olsen 2010). This is twice what the country spends on caring for cardiovascular disease and three times what it spends caring for cancer (Cutler, Wikler, and Basch 2012). Every study that has looked at the situation has determined that administrative costs are higher than they need to be in order to deliver effective health care. This proposal considers how those costs could be lowered.

Administrative costs are defined as the nonclinical costs of running a medical system. The label “administrative cost” encompasses several different activities (see box 1). On the patient end, there are costs associated with submitting bills for payments and choosing health plans. While these costs typically do not involve money transfer, they are costs nonetheless. The biggest financial component of administrative costs is billing- and insurance-related (BIR) expenditures. This includes the costs of a provider verifying that a patient is eligible for services, prior authorization

procedures on both the provider and payer side, submitting bills and appropriate documentation, addressing denied claims, and remitting payment. Other administrative costs include marketing and enrollment (payer), credentialing costs (payer and provider), and the costs of quality measurement and assessment (both payer and provider). At the claim level, Tseng et al. (2018) estimated that provider administrative costs in the United States range from \$20 for a primary care visit to \$215 for an inpatient surgical procedure (figure 1). By comparison, the reimbursement for a routine visit in Ontario, Canada—which must cover both clinical and administrative costs—is about \$34 (Ontario Ministry of Health 2019).<sup>1</sup>

Some amount of administrative expense is necessary. In a system of private health insurance, some marketing and enrollment costs are unavoidable. Similarly, bills have to be submitted and payments transacted, neither of which are costless. Nevertheless, the United States spends more on administrative costs than comparable multi-payer systems pay. A number of studies have attempted to estimate “excess” administrative costs—generally defined as costs above the

FIGURE 1.  
Administrative Costs per Claim at a Major Academic Health System



Source: Tseng et al. 2018.

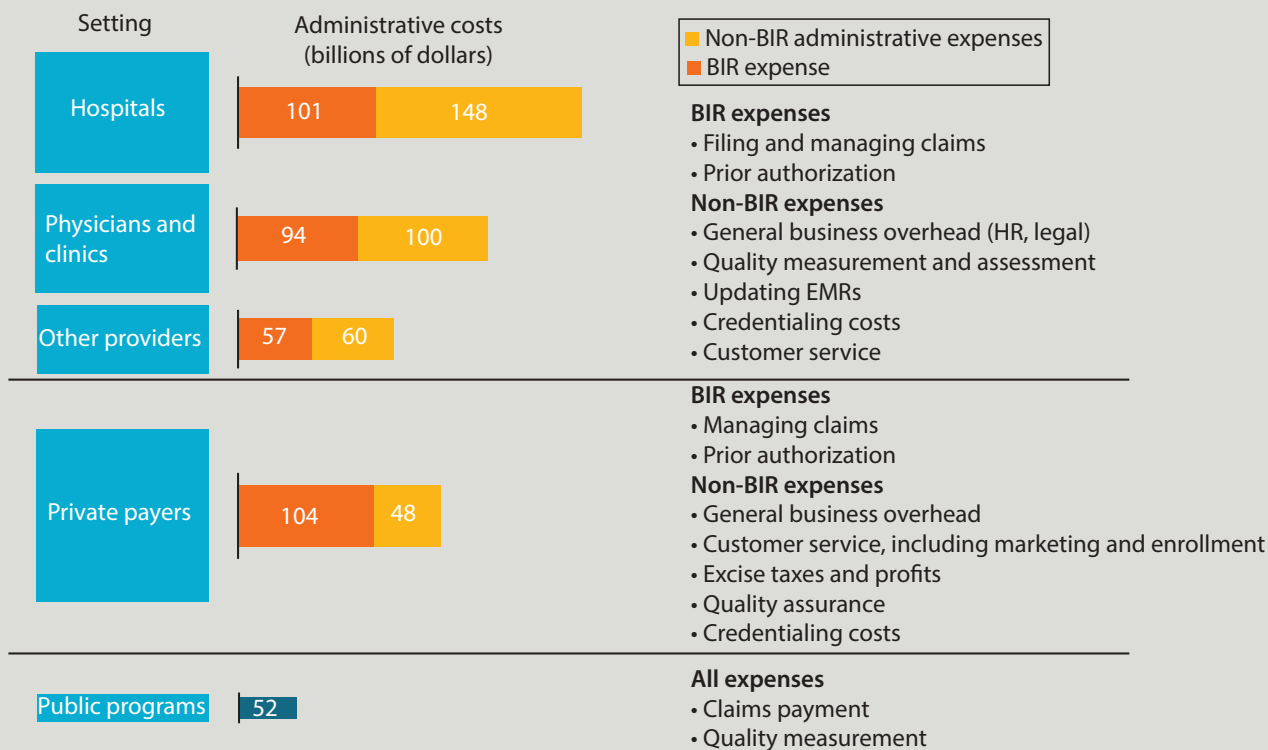
BOX 1.

## The Cost of Health-Care Administration

There are many components of administrative costs in health care. The figure shows the major categories. The largest component is termed billing- and insurance-related (BIR) costs and includes the costs of claims management, clinical documentation and coding, and prior authorization. Other administrative costs are associated with sales and marketing, quality measurement, and credentialing. The policies considered here are directed largely, but not exclusively, at BIR costs (e.g., quality assessment is not a BIR cost but is addressed). The rough magnitude of BIR and non-BIR administrative expenses in 2018 are presented in box figure 1.

BOX FIGURE 1.

### Estimates of Administrative Expenses



Source: Altarum 2018; Kahn et al. 2005; Yong, Saunders, and Olsen 2010.

Note: BIR refers to billing- and insurance-related expenses. EHR refers to electronic health records. Other providers include pharmacies, labs, and skilled nursing, long-term care, and rehabilitation facilities. Costs are in billions of dollars.



level of a comparable European country. Estimates suggest that one-half to two-thirds of BIR administrative costs are excessive (Jiwani et al. 2014; Shrank, Rogstad, and Parekh 2019; Woolhandler and Himmelstein 2017; Yong, Saunders, and Olsen 2010).

Administrative costs are baked into the health-care cost structure (Cutler and Ly 2011; Pozen and Cutler 2010). The money that providers spend on administration is passed along to insurers in the form of higher prices; when people note that U.S. medical spending is high because “It’s the prices, stupid” (Anderson et al. 2003), they should add a footnote: “\*A good

part of which is due to administration.” Insurers, in turn, pass these prices and their own administrative costs along to insuring businesses, who respond by raising employee premiums or reducing what they pay workers. Policyholders and taxpayers (in the case of the public medical system) ultimately pay for high administrative expense.

In addition to its burden on individuals, administrative costs affect the medical system in other ways. Providers dislike spending time on administrative tasks relative to time on caring for patients. Provider frustration thus grows with administrative hassles. At a time when the United States needs

more health-care providers, reducing administrative burden is one way to free up time for providing care (and possibly delay retirements). On the patient-end, people sometimes go without care because they cannot solve the administrative mystery. Administrative costs also make health-care markets more opaque: People make decisions about what medical care to use and which provider to see without any real knowledge of the price and quality of the alternatives.

The push to reduce administrative expenses is not new. Federal legislation has addressed administrative costs since the 1990s (see box 2). Broadly speaking, legislation has come in three waves. The initial wave of legislation focused on basic standards for electronic interchange. This includes the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which mandated development of standards for administrative transactions. The Patient Protection and Affordable Care Act (ACA) of 2010 continued in this vein, requiring standard operating rules for actions such as electronic funds transfers and claims attachments. Similarly, the Administrative Simplification Compliance Act of 2001 required bills to be submitted to Medicare electronically. Over a series of years, much of this standardization was achieved, though not all. For example, HIPAA called for a universal patient identifier, which has never been

implemented. Similarly, the ACA called for standardization and computerization of billing processes, but provider opposition combined with limited administrative capacity in the Centers for Medicare and Medicaid Services (CMS) restrained what was done.

Over time, policymakers realized that administrative simplification beyond claims submission could not be achieved when medical records were still being kept on paper. The Health Information Technology and Economic and Clinical Health Act (HITECH) of 2009 created an incentive program for providers to invest in electronic medical records (EMRs). The Act has been very successful in encouraging EMR use: over three-quarters of office-based physicians use EMRs, as do 96 percent of hospitals (ONC 2019).

Administrative simplification was one key use case in the HITECH Act, but attention moved away from administrative savings and onto ensuring that EMRs were useful for patient care—that physicians were alerted to possible drug-drug interactions, that they had access to patient histories, and the like. Interoperability of medical records and administrative tasks such as quality reporting necessarily took a back seat.

As the use of medical records has increased, legislation have turned to making those records interoperable. The Medicare

**BOX 2.**

**Federal Efforts to Promote Administrative Cost Savings**

Legislation	Component
Health Insurance Portability and Accountability Act (HIPAA), 1996	Standards for electronic data exchange (claim filing, encounter information, etc.) and code sets  Unique identifiers for employers, providers, health plans, and patients
Administrative Simplification Compliance Act (ASCA), 2001	Electronic submission of Medicare claims required
Health Information Technology and Economic and Clinical Health Act (HITECH), 2009	Funding for electronic health records, with an eye toward administrative savings
Patient Protection and Affordable Care Act (ACA), 2010	Required operating rules for transactions, standards for electronic funds transfer and claims attachments, adoption of unique health plan identifier
Medicare Access and CHIP Reauthorization Act (MACRA), 2015	Expands certified electronic health record technology to include interoperability
21st Century Cures Act, 2016	Requires CMS and the Office of the National Coordinator of Health Information Technology (ONC) to further expand interoperability;  ONC released a rule requiring standardized application programming interfaces (APIs) and prohibiting information blocking;  CMS has proposed a rule requiring electronic data exchange as a condition of participation in Medicare, requiring use of standard APIs, and requiring payers to establish and make portable a longitudinal health record





Access and CHIP Reauthorization Act of 2015, along with the 21st Century Cures Act of 2016, both pushed for medical records to be interoperable. Recent and proposed rulemaking by the Department of Health and Human Services has focused on defining interoperability and ensuring those records' accessibility.

In some ways, health-care administration is better than it once was. Figure 2 shows the extent of electronic interchange for many common BIR functions. Near-universal electronic interchange has been achieved for claims submission and eligibility and benefit verification. Adoption of electronic interchange of these transactions has saved nearly \$100 billion annually (Council for Affordable Quality Healthcare [CAQH] 2020). Yet electronic clinical data still do not flow smoothly, and even when they do, they often do not conform to specifications of varied quality measures, administrative requirements (e.g., prior authorization), and other requirements, reverting to the need for manual processes.

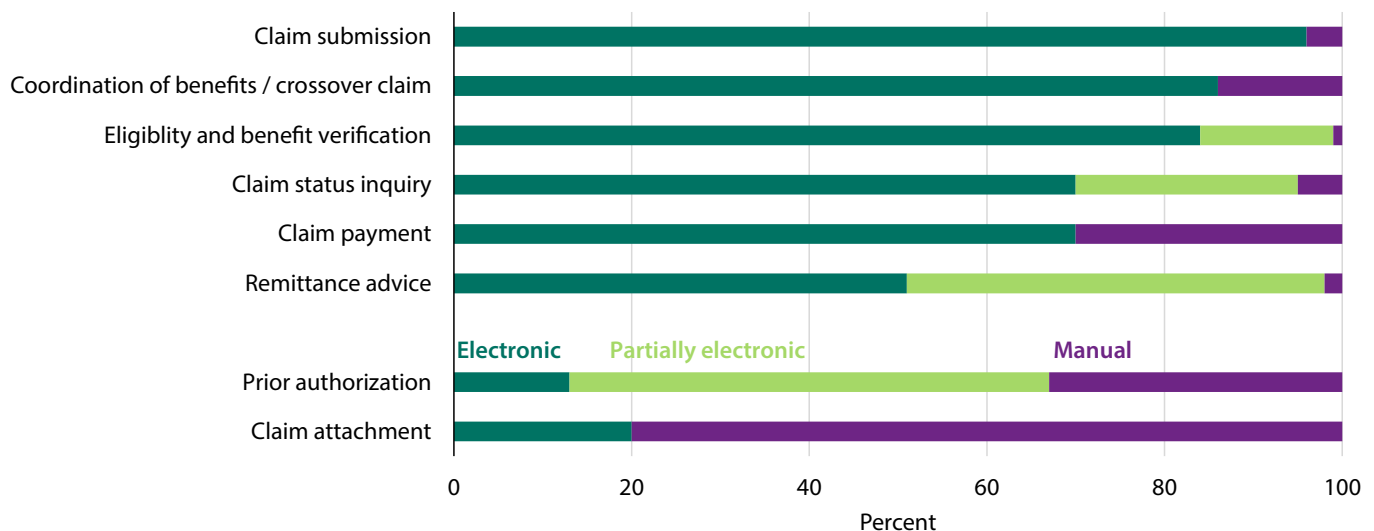
### AREAS OF FOCUS

Despite this progress, there are still areas where administrative costs remain high, and in some cases are rising. This analysis focuses on administrative costs that cannot be removed without coordination across multiple parties—for example, if a provider needs a large billing staff because payers impose different prior authorization rules. There are other administrative costs that are more general, such as human resources, accounting, business operations, and the like. This analysis does not explicitly consider such internal management issues.

Three administrative areas are predominant in administrative costs resulting from lack of coordination; see figure 3. First, while claims submission is now almost entirely electronic, the electronic process is more complex than it needs to be. Currently, each provider maintains a separate electronic pipe to each payer. For example, a hospital needs to build technology to submit bills to Medicare that is different from the technology it uses to submit bills to United or Aetna, which in turn is different from the technology it uses to submit bills to Medicaid. The reason for this is that different payers require different documentation and data standards—information about the patient, the diagnosis, and treatment, for example. Having to differentiate this information by payer raises costs relative to what they might be if the billing system were better integrated or if there were only one insurer.

Second, insurers now require more in the way of prior authorization than they used to, and this step is typically not automated. For example, an insurer might require that the health-care provider prescribe a less expensive drug before prescribing a more expensive one. If a claim for the more expensive drug is submitted without this authorization, the insurer will deny the claim until appropriate documentation is produced. The rising cost of pharmaceuticals, and of medical care more generally, has led insurers to increase their use of prior authorization. The information to document appropriate use may be in the provider's EMR, or in the EMR of a different provider, but it is not apparent to the payer or easy for the provider to assemble. As a result, prior authorization is generally done manually, by phone, or by fax (see figure 2), at very significant expense.

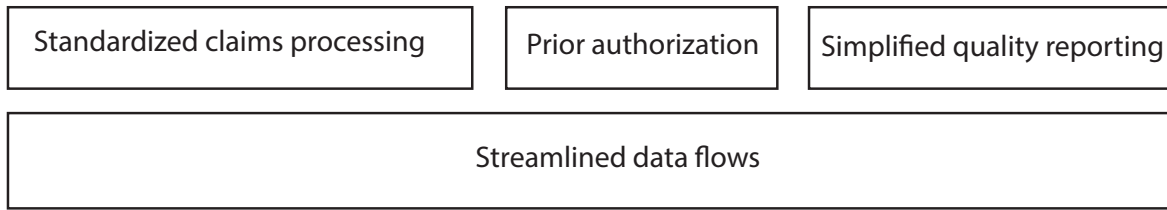
FIGURE 2.  
Extent of Electronic Interchange in Health Care



Source: CAQH 2020.

FIGURE 3.

## Areas Important for Administrative Simplification



Third, there has been a steady move toward more quality reporting by providers and payers. About half of all dollars in the medical system have some value-based component (Catalyst for Payment Reform 2019), and there are thousands of quality metrics in use in the health system, including public and private metrics. In part, the drive toward quality assessment is driven by a natural desire to understand how well the health system is working. Alternative Payment Models such as Accountable Care Organizations allow providers to share in cost savings, making it particularly important to ensure that cost savings do not come at the expense of health-care quality. However, measuring quality involves significant provider and payer expense. A key reason is that each payer can define their own quality measure specifications, resulting in significant time for each provider to conform to multiple sets of measures.

Underlying each of these areas of administrative expense is the need for interoperable data. All of these tasks involve standards-based data flows across institutions: from provider to provider, provider to payer, and payer to provider. Causing the right information to flow as and when it is needed is thus central to any system of administrative cost reduction.

### POTENTIAL SAVINGS

A number of studies have estimated total administrative costs in the United States and how much might be saved with various reforms. Using the estimates of Kahn et al. (2005) and Yong, Saunders, and Olsen (2010), adding up the values shown in box 1 indicates that the total cost of administrative expense in 2018 is roughly \$765 billion, of which roughly \$400 billion is for BIR functions.<sup>2</sup>

Estimates of how much of administrative costs are associated with the specific areas considered here vary widely because health-care expenses are not fully delineated by exact service. On the low end, CAQH (2020) estimates that \$35 billion is spent annually on claims-related activities—including claims submission and prior authorization.<sup>3</sup> This is almost certainly too low, however. CAQH asks its respondents to report labor costs for the transaction only, and not for the costs associated

with gathering information or the system costs of buying software or equipment. In the Kahn et al. (2005) study, only one-quarter of BIR administrative expenses were for the front-line personnel directly involved in xeroxing and faxing. The rest were for general business operations, other administrators such as medical receptionists and IT personnel, and physician time spent in support of billing processes. Using this ratio, the cost of claims-related activity and prior authorization are likely around \$140 billion annually.

With respect to quality reporting, a survey by Casalino et al. (2016) estimated that the typical practice spends 15 hours per physician per week complying with quality guidelines. The vast bulk of this time is spent entering information in the medical record for use only in quality reporting. At a national level, this time costs \$15 billion annually, making the total cost of the activities here about \$150 billion annually.

Possible savings from administrative simplification are on the order of one-third to one-half of current spending. Thus, a rough order of magnitude is that system savings from the ideas considered here would be \$50 billion to \$75 billion annually. This amounts to about \$175 per capita annually.

Beyond the areas considered here, there are other costs associated with health-care operations that could be streamlined. Blanchfield et al. (2010) estimate that costs per dollar of revenue are much higher in medical care than they are in other industries. Given that health-care organizations are often small and run by clinical personnel without significant operational training, it is likely that the overall administrative budget could be reduced even more.

*Why now?* The haphazard progress to date on administrative simplification raises an issue about whether progress is currently possible. Several factors suggest that now is a good time to address the administrative burden. The United States has just had a large increase in insurance coverage. With attention turning away from the need to cover more people and into the need to save money, it is important to think about the costs of operating medical care. (Of course, there may still be policy opportunities to enhance coverage—see box 3—

and the goal of enhancing coverage becomes more attainable when administrative costs are reduced.) In addition, technology has evolved to make addressing administrative costs more feasible. The idea that each actor needs to integrate their records with every other actor has given way to a world of application programming interfaces (APIs) and cloud-based services. Electronic interchange is easier everywhere in the economy than it was just a few years ago, and medical

care should ride this wave of technical progress. In addition, administrative simplification is one of the few areas of policy that are bipartisan. The Clinton, Bush, Obama, and Trump administrations have all taken steps to address administrative costs, as have members of Congress on both sides of the aisle. Finally, many of the required steps in administrative simplification do not require new legislation. This allows for more immediate action than would otherwise be the case.

### BOX 3.

## Is a Single-Payer System the Answer?

Across the world, countries with only one payer have lower administrative costs than countries with multiple payers—though even among multiple-payer countries the United States is an outlier in administrative costs. Would a single-payer system be the best at reducing administrative expenses in the United States? The answer is likely yes, but the exact savings would depend on many features of the implementation.

For simplicity, consider a proposal where everyone is insured through the traditional Medicare program—i.e., Medicare Advantage is eliminated. Note that if Medicare Advantage is retained the situation would still involve some of the complications we have now. Without private insurers, costs such as insurance sales and marketing, brokerage fees, and profits would disappear. These costs total about \$100 billion annually.

Other administrative costs could be lower but lowering them would require tackling the issues that are raised in this paper. For example, billing costs are reduced dramatically when providers do not need to file bills. But this requires non-fee-for-service payment such as in Accountable Care Organizations, which are but a small part of the current Medicare system. Similarly, quality assessment could be streamlined, but this would require the same harmonization measures as noted above.

Perhaps the major issue in single-payer health care is the trade-off between administrative costs and other ways of controlling use. Many single-payer proposals envision lower administrative costs such as those in the Canadian system. Such a system has other important features, however, that are necessary to offset administrative spending reductions. For example, Canada has very tight restrictions on technology acquisition; there are only one-quarter the number of MRIs per capita in Canada as there are in the United States (Organisation for Economic Co-operation and Development [OECD] 2017). Similarly, there is a budget for hospitals and a fee schedule for physicians, where fees are set so that a total spending target is met. The ability to do this in the United States is in some doubt: Certificate of need regulation in the United States was generally unsuccessful in lowering spending (Conover and Sloan 1998), and a one-time provision of the Medicare program that lowered physician fees when the volume of services provided rose (the sustainable growth rate) was considered unenforceable and ultimately was repealed.

If the United States does not implement the type of budget and technology regulation that other countries have, the impact of single-payer health care on administrative costs is less certain. Without any spending constraints, the fear is that reductions in administrative costs would lead to increases in the volume of services provided and thus higher spending. Of necessity, this could lead a single-payer system to the type of administratively costly constraints that are part of the current system: prior authorization requirements, for example.

The United States does not seem to be on the verge of enacting a single-payer system. For this reason, and because single-payer proposals are generally silent on their regulatory policies, this paper analyzes methods of reducing administrative expense in the current, pluralistic system.

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# The Challenge

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In most industries, government is not involved in the back office of administrative expense. However, the economics of health care are different than they are in other industries, and thus government intervention is more appropriate.

Administrative costs in the health-care system are a classic public good. Payers and providers may together agree that standardizing billing codes and quality reporting would be valuable, but no single actor has an incentive to pay for standardization when others will benefit as well. For example, if insurer A chooses to harmonize its policies with insurer B, that lowers administrative costs across the board and thus fees that all insurers collectively need to pay. However, insurer A will not take these cost savings to other insurers into account. As a result, insurer A will be discouraged from investing in harmonization.

Indeed, there are actually incentives the other way—to make information sharing as difficult as possible. Suppose there are two companies that make EMRs. It would be good for patients and providers if records could be ported from one system to another. That way, physicians could switch EMR systems more readily when one company has a better product. For exactly this reason, however, EMR companies would like to make it difficult to switch systems. Indeed, it is rational for an EMR company to spend money to make porting data *more* difficult, thereby limiting its vulnerability to competition. Similarly, health systems that have invested in an EMR have little interest in sharing their data with non-system providers, since sharing data makes it easier for patients to switch doctors. Health systems, too, will underinvest in interoperability. The ONC (2015) summarized anecdotal and survey data on the extent of information exchange and concluded that incentives for information blocking were materially important. Private studies have generally agreed (Savage, Gaynor, and Adler-Milstein 2019).

Health care is not the only industry where portability issues arise. For many years, telephone companies argued that the phone numbers people were assigned belonged to the telephone company, not to the individual.<sup>4</sup> Thus, if an individual wanted to switch from one service provider to another, they had to switch telephone numbers. This effectively made the cost of switching telecommunication

providers very high. The Telecommunications Act of 1996 required that telecom providers allow consumers to port their number from one carrier to another, and the Federal Communications Commission issued a series of orders implementing this provision. The same type of strong regulations are needed in health care.

A separate justification for government involvement relates to its status as a major health-care payer. Nearly half of medical care spending is paid for by federal, state, and local governments. The way that these programs operate necessarily affects the efficiency of the entire medical system. For example, Medicare, Medicaid, the Department of Defense, the Department of Veterans Affairs, Workers' Compensation, and other public programs use different payment systems and quality standards, which inevitably adds to the administrative costs of health care. To a first approximation, there are three big payers in health care: federal (Medicare), state (Medicaid), and private insurers. As one of the big payers, the federal government should take steps to lower the costs it faces, as should state governments.

Finally, public action is warranted because of an incompleteness in private contracts. Prices paid by insurers to providers are the subject of intense negotiation. Typically, the price depends on the insuring group and type of policy, for example a preferred provider organization (PPO) offered for the employer market. However, once a price is agreed on, it does not vary with the administrative requirements that the payer imposes. This creates a situation where payers make decisions that impose higher administrative costs on providers than is optimal for society as a whole, given the costs they impose on providers.

Consider a payer that is thinking about reducing the requirement that prior authorization is required for a particular procedure, or analogously harmonizing quality metrics with that of another payer. The payer recognizes that it will spend less on adjudicating claims for that procedure if it drops prior authorization. It also recognizes that providers will use the procedure more as a result. Thus, the payer's calculation is whether the administrative savings on its end are greater than the additional spending associated with higher use. The component that is not included in this

calculation is the administrative cost savings on the part of the provider; the provider will no longer need to incur the costs associated with prior authorization.

The ideal way to fully realize this cost savings is to attach a price to requiring prior authorization. Effectively, there could be two prices for each claim: one when the claim involves prior authorization, and a second (lower) price when it does not. If the price of prior authorization fully reflects the provider's costs of providing the information, the payer would

then make the efficient decision from society's perspective about whether prior authorization is worth the expense.

To the best of my knowledge, no current insurance arrangements have a price schedule depending on administrative expense. It is not entirely clear why this is the case. Conversations with providers and payers do not suggest an obvious reason for this omission other than the fact that price negotiations are very contentious, so introducing another element to them is difficult. The government may be able to help spur such contracts, however.

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# The Proposal

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**A**dministrative costs are economically substantial. They are also larger than is necessary for the effective functioning of the U.S. health-care system. The previous section discussed the reasons why this is the case: the public good nature of harmonized standards, the desire of individual firms to limit competition, the large government role as a health-care payer, and incomplete payer-provider contracts.

This section describes specific proposals for addressing these challenges and lowering administrative costs. Each proposal focuses on a particular problem with the institutions and practices that give rise to administrative costs. I propose to:

- Establish a clearinghouse for bill submission;
- Simplify prior authorization;
- Harmonize quality reporting; and,
- Enhance data interoperability in the health-care system.

## A CLEARINGHOUSE FOR BILL SUBMISSION

The first area for administrative simplification is the bill submission and notification process. I propose that Congress establish a clearinghouse for bill submission, analogous to those that already exist for banking. More than 6 billion medical claims are filed annually in the United States. While almost all of these claims are filed electronically, the system is not as efficient as it could be. The issue is sometimes posed as the need for a single claim form, but that is not correct. The HIPAA legislation of 1996 required standardized claims forms and that has now been achieved.

Nevertheless, the system still has some limitations. To begin, the information required by different payers can be different, even with the same form. For example, one insurer might require special revenue codes for particular specialties that are different from other insurers. In other cases, the physician's specialty may differ across insurers (medicine vs. gastroenterology, for example), which could necessitate a different set of codes. Or the codes given for claim denial may differ across insurers. And still other insurers are not required to use these standardized forms (e.g., workers' compensation and auto insurers).

In addition, many insurers require attachments to claims, and these attachments are generally not standardized. An attachment might involve a certificate of medical necessity, a discharge summary, or details of a lab report. As figure 2 shows, only 20 percent of claims attachments are standardized. One of the primary reasons why attachments are not standardized is that a federal standard has not yet been named by the Department of Health and Human Services as required under HIPAA and the ACA. Without an attachment standard, the exchange of medical documentation to support claims and prior authorization is likely to continue to be an unstandardized, manual process. The issue of claims attachments is closely related to that of prior authorization, so I consider them together in the next section.

Health care is unusual in that it does not use standards as consistently as other markets. Consider two examples. The first is banking. Some form of automated clearinghouse (ACH) has existed in banking since the early 1970s. The major issue in that industry is the need to move money across institutions. For example, an employer may want to transfer money from their account to their employees' accounts, or a customer may want to set a recurring payment for their utility bill. Banking has created a standardized, automated way to accomplish such transfers. The first part consists of an organization that sets rules about transmission. That organization is NACHA, formerly known as the National Automated Clearing House Association. The actual money transfer is handled by the Federal Reserve System or a private firm called The Clearinghouse. These organizations ensure the security and accuracy of money moving across institutions.

With the benefit of this clearinghouse system, the cost of administering banking transfers is trivial (roughly \$300 million annually compared to more than \$50 trillion transferred annually). The system is paid for by small assessments on money transferred and by annual fees paid by banks belonging to the system. Partly because it is so efficient, NACHA was tasked with establishing rules for electronic funds transfers in health care.

A second example is the international nonprofit, GS1, which administers the Universal Product Codes (UPC) that are printed on almost all consumer goods. Every good and service

has a unique Global Trade Item Number (GTIN); this is what the barcode encodes. Scanning a barcode triggers the GTIN lookup, which identifies the good and allows it to be matched to the appropriate price. It is also straightforward to use the GTIN to manage inventory.

The UPC system was set up in the early 1970s by a group of grocery stores that wanted to increase the efficiency of checkout. It spread from there and now includes more than 1 million businesses in more than 100 countries. Obtaining a GTIN is relatively inexpensive. In the smallest batches, the cost is \$250 up front, with an annual licensing fee of up to \$50. GS1 itself is not very expensive to operate; the total budget of GS1 is about \$35 million annually.

Use of electronic standards in banking and retail is strongly encouraged and almost required, although not formally so. Banks are not required to belong to NACHA nor to transfer money electronically. However, if a bank wants to use electronic funds transfers, Federal Reserve regulations require that the bank use the ACH system. Thus, over 98 percent of banks belong to the ACH. With respect to UPCs, many retailers will not carry products without a GTIN or will do so only rarely, such as for hand-made items. Thus, use of UPC codes is effectively universal.

For health-care claims, it makes sense to follow the banking model. Figure 4 shows an example of how such a system might work. Two tasks are important: The first is setting the standards for electronic transmission of billing information. The CAQH currently writes operating rules and could continue in that capacity. Second, there would be a new organization, a health-care clearinghouse that would receive batch claims submissions by payers and providers and route

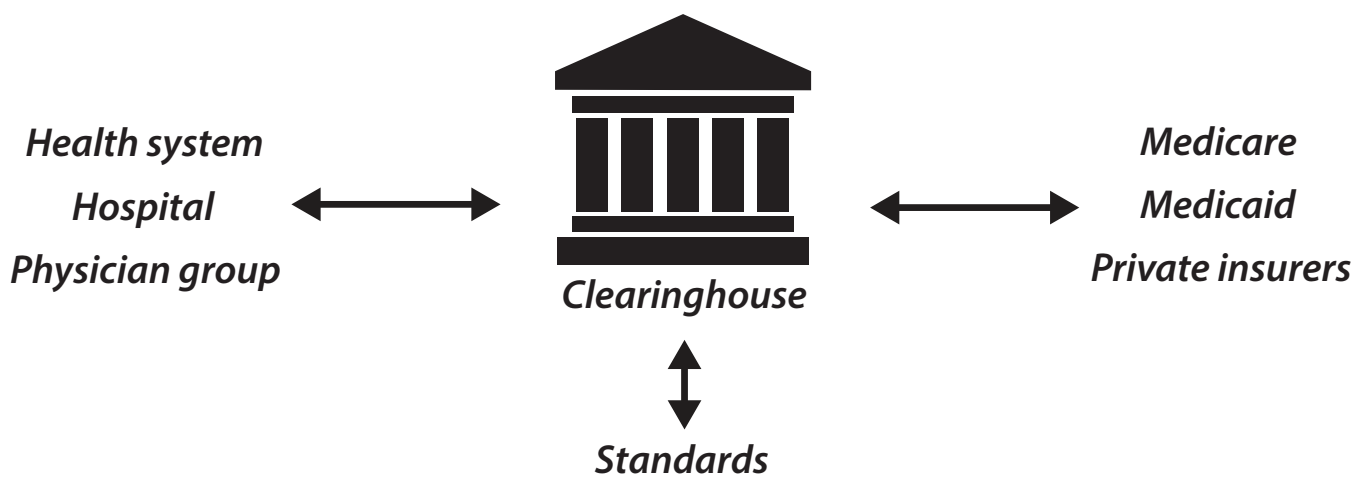
them to the appropriate counterparty. As in banking, the clearinghouse would ensure that claims are submitted by legitimate enterprises and that the submitted information conforms to privacy and security standards. If the health-care clearinghouse were as costly as its banking equivalent, the \$300 million annual cost would amount to roughly \$0.06 per claim.

Some areas of coordination are occurring. Since 2014, CAQH and health plans have worked to create a single place for the exchange of information on coordination of benefits (COB). Information on plan enrollment is updated regularly and used to determine the correct order of primacy for benefit coverage, which is then relayed to each health plan that insures the member and to relevant providers. The major issue is to build on these successes.

The key challenge in health care is achieving near-universal participation. One way to increase participation is to follow the lead of the Federal Reserve and require use of those standards by any payer or provider participating in public programs. This includes Medicare and its Medicare Advantage insurers, the ACA's insurance exchanges, federal employee insurance, the Department of Veterans Affairs, the Department of Defense, and other programs. State governments can do the same with Medicaid and other state programs. Since almost all payers and providers participate in government programs, this would cover most payers.

In addition, a pricing system could be set up that would cause insurers to recognize and pay the cost of having a separate claim submission process. CAQH estimates that the cost of electronic claim submission for a provider is about one dollar per claim. Thus, insurers that required submission outside

**FIGURE 4.**  
**Design of a Health-Care Automated Clearinghouse**



the clearinghouse might have to pay providers one dollar per claim to run a separate system. If this cost were in place, one would guess that most insurers would choose the ACH exchange.

## SIMPLIFYING PRIOR AUTHORIZATION

Prior authorization—the process of approving medical services on the basis of clinical or economic criteria—is understandably valued by payers but is also costly to implement. Prior authorization is required for many medical and pharmacy services, including medication choice (e.g., step therapy for medications), durable medical equipment, elective surgery, imaging (especially advanced images), inpatient hospitalization, and countless other types of health care. Below I propose best practices and policy changes to encourage less costly prior authorization.

The number of services for which prior authorization is required varies by insurance plan, but almost all insurers use prior authorization to some extent (Jacobson and Neuman 2018). The major exception is traditional Medicare, which currently uses prior authorization only for some durable medical equipment (e.g., certain types of power wheelchairs) but is considering doing so for cosmetic elective surgery and advanced imaging.

In surveys of physicians, prior authorization ranks very high on most burdensome administrative features (American Medical Association 2019). The typical Medicare Advantage plan denies 4 percent of prior-authorization requests, though some are subsequently overturned on appeal (U.S. Department of Health and Human Services 2018). Eighty-eight percent of physicians believe that the prior authorization burden has increased in the past five years. Prior authorization is one contributor to the widely noted phenomenon of physician burnout (del Carmen et al. 2019).

The total number of prior authorizations conducted annually is not known. Physicians who need to get prior authorization do so frequently, 30 times per week on average, though not all physicians are involved in prior authorization activities. Recognizing the burden of prior authorization, six major health-care organizations came together in 2018 to develop a consensus statement on prior authorization.<sup>5</sup> The statement highlights six areas of agreement:

1. Prior authorization should be applied selectively;
2. There should be regular review of prior authorization rules by payers, with an eye toward eliminating unnecessary rules;
3. There should be transparency and communication regarding prior authorization rules;

4. Prior authorization should minimize adverse impacts on continuity of care;
5. Prior authorization should become more automated; and,
6. Operating rules for prior authorization are also being drafted (e.g., by CAQH).

Despite this agreement, little progress has actually been made: Prior authorization is still conducted by phone or by fax. The vast majority of physicians still believe that prior authorization delays patients' access to appropriate care. And the American Medical Association complains that progress on prior authorization has been too slow. Just recently, America's Health Insurance Plans launched an initiative to work toward automating prior authorization (America's Health Insurance Plans 2020); the idea is to integrate prior authorization rules into physician's EMR systems, thereby allowing providers to submit the necessary information electronically.

The slow progress is creating pressure in legislatures to address the problem. The Improving Seniors' Timely Access to Care Act of 2019 bill (HR 3107) was introduced in the House of Representatives with 155 (bipartisan) sponsors. The bill prohibits Medicare Advantage plans from imposing prior authorization requirements for surgeries, the need for which becomes apparent during another surgery (e.g., if the physician begins surgery on the patient and discovers they need to do a different procedure than they had thought), promotes electronic adjudication of prior authorization, and mandates the collection of information on the timeliness and appropriateness of prior authorization. State legislators are becoming involved as well, in some cases requiring advance notification of new prior authorization rules and the ability to appeal decisions *ex post*.

A patchwork of state legislation is not likely to be successful, however, and could very well add additional time to the process. Rather, three steps could be taken to minimize the prior authorization burden:

### *1. Apply Prior Authorization Rules Selectively*

The most immediate step is to encourage payers to follow through on the selective application of prior authorization. Typical prior authorization rules are linear: Each time a physician wants to use a particular service, prior authorization rules kick in and require additional documentation. There is no obvious reason why such a rule is optimal. Indeed, linear rules can be harmful as well as administratively costly, such as when prior authorization is required on a monthly basis for medication for a chronic condition.

One can imagine several “nonlinear” rules that would be superior. One such rule would reduce the frequency of prior



authorization in cases of chronic disease. For example, monthly prior authorization could be replaced with annual or even less frequent prior authorization for medications for chronic conditions.

Likely more important would be exempting certain providers from prior authorization entirely. Some providers have a history of appropriate use of services. Based on annual, ex post audits, insurers could “gold card” those providers in subsequent years—and not require prior authorization for some or all services. In other cases, insurers could relax requirements for providers who install decision support criteria in their EMR systems; these criteria can substitute for payer prior authorization. For example, a provider might have an add-on to their EMR with imaging criteria from the American Radiological Association. The payer might then accept attestation that the image was judged necessary by the provider’s software in lieu of conducting its own prior authorization. Still other providers are paid under a risk contract, for example an Accountable Care Organization arrangement. In that setting, the provider is not paid more for additional use and thus the payer has little need to require prior authorization.

How can policymakers encourage more selective use of prior authorization? While traditional Medicare requires very little prior authorization, the federal government has other levers that could influence prior authorization. One such policy is urging Medicare Advantage and health-care exchange plans to be more selective in their use of prior authorization. For example, the CMS could create a catalog of prior authorization rules in Medicare Advantage plans and in the exchanges. It could encourage plans to conduct regular certification to determine if all of the rules are still needed. And it could sponsor studies about how much use is deterred with different types of prior authorization. In addition, the federal government could reform use of prior authorization in health plans for federal employees, the Department of Veterans Affairs, and the Department of Defense, thereby encouraging use of alternative methods.

## **2. Attach a Price to Prior Authorization**

A second step is to attach a price to prior authorization, so that payers take into account the cost to the provider of imposing administrative burdens. Provider–payer contracts would then have two prices: a “standard” price for a bill without prior authorization, and a “prior authorization supplement” price if the bill requires prior authorization.

Consider some specifics. CAQH (2020) estimates that the cost to providers of a manual prior authorization approval is \$10.92 per claim.<sup>6</sup> The Cleveland Clinic estimated their costs at about \$12 per claim (Robeznieks 2018). Responses to a surgical survey suggested that staff spend 25 hours per

week adjudicating 37 prior authorization requests (American College of Surgeons 2019). If staff time costs \$20 per hour, this is about \$14 per claim. As a rough average, suppose the cost is \$12 per claim. Payers and providers could thus agree that each prior authorization they conduct will trigger a payment of \$12 from payer to plan.

To do this, the level of payments would need to be adjusted as a whole so that the change would be revenue neutral. For example, suppose that there are two services, each of which costs \$20 of clinical staff and facility time. One of the services is subject to prior authorization, which requires \$12 of provider cost per claim, and one is not. Suppose further that half the claims are for each service. On average, payers need to reimburse \$26 per service: \$20 in clinical costs and \$12 in administrative cost for half the claims. A more efficient pricing system would reimburse providers \$20 for claims not subject to prior authorization and then include a \$12 prior authorization add-on for the claims that are subject to it. Effectively, the payment for claims without prior authorization should fall, while the claims that involve prior authorization would be paid more. The payer would then be incentivized to determine exactly which claims need to fall under prior authorization. The extent to which the base price would fall depends on the share of dollars paid that are subject to prior authorization, a fact which is not currently known.

## **3. Automate Prior Authorization**

The longer-range target is electronic prior authorization. Effectively, this involves having access to the whole patient history and using artificial intelligence to judge when a service is or is not appropriate. One way to do this is at the provider level. For example, a provider might embed a set of guidelines in its EMR (e.g., radiology guidelines from the American Radiological Association) and certify to the payer that all images it orders meet those guidelines. Alternatively, the automated prior authorization could be done at the payer level. This requires the insurer to have access to the full set of patient records. I come back to this in a subsequent section.

## **HARMONIZING QUALITY REPORTING**

Quality measurement is essential in any well-functioning health system. Without a good understanding of quality, there is no way to know if the health system is doing well or poorly, or trending in a favorable or unfavorable direction. This is particularly important in settings where payment is not fee-for-service.

That said, the current quality measurement system imposes a greater burden than is needed. Below I propose policy changes that would limit that burden. One concern is that quality measures are limited. Often, they are based on process (e.g., Did the patient receive a particular therapy?) when basing them on outcomes would be more appropriate (e.g.,

Did the patient recover?). Among other things, moving from process to outcomes will require a better way to measure health information (Safran and Higgins 2019).

Even when the measures are meaningful, however, quality assessment is hampered by the diversity of metrics. The CMS (2020) lists 2,267 quality metrics in use across its various programs. State and regional agencies have more than 1,300 quality metrics (Bazinsky and Bailit 2013). A study of 23 health insurers found 546 quality metrics in use (Higgins, Veselovskiy, and McKown 2013), many of which were dissimilar across insurers.

Even when the metrics are ostensibly the same, differences in the details of implementation make the experience more frustrating than valuable. For example, each of two plans may measure the quality of diabetes care. But one may use a cutoff for controlled HbA1c (i.e., a measure of blood glucose) that is different from the other. Furthermore, they may define who is a diabetic patient in different ways, for example depending on how long the patient is in the plan during the year. Not surprisingly, the administrative cost of participating in the quality metric system is high and rising.

In addition to the administrative cost, the diversity of quality reporting makes physicians pay less attention to quality metrics than they otherwise might. For example, the same physician might be in the highest-quality tier of one health insurer but the lowest-quality tier of another, depending on exactly how quality was measured and the sample of patients the provider sees from each insurer. Rather than accept the conclusion and work toward good care, the incentive is for providers to fight the measures and learn how to game the system.

Discerning the direction in which to change the quality reporting system is not difficult. Reports on the topic have been issued by the National Academy of Medicine (Blumenthal, Malphrus, and McGinnis 2015), CMS's Health Care Payment Learning and Action Network (CMS 2016), and the National Quality Forum (2016), among others. A few themes are clear.

### ***Quality metrics should be meaningful to clinicians and patients.***

The relevant outcomes for patients and clinicians may be somewhat different, but both need to be included in quality metrics. Patients care about their health improvement. Physicians also care, but they care a good deal about ensuring that patients who are more difficult to treat well are properly accounted for. The formation of both patient- and clinician-centered outcomes will thus need to have consensus determinations as to adequate metrics and risk adjustment.

### ***Measures should be harmonized across payers and calculated for the provider's practice as a whole.***

It does not make much sense to have a separate quality assessment at the provider level for patients insured by Medicare, Medicaid, and private insurance, since physicians rarely treat patients from these different plans differently. The ideal would be a single metric for the provider as a whole. Such a metric should come from the EMR—for example, the share of the practice's patients with diabetes for whom blood sugar is adequately controlled.

An example of this is found in Minnesota. By law, providers in Minnesota are required to report on a publicly defined set of quality metrics. Health plans can choose whether to use those measures in their performance contracts but cannot insist on other metrics.

That said, there is also a need for separate plan-specific determinations of quality. Even given the set of physicians a plan contracts with, one health plan may do more to encourage access to primary care services than another—it may have lower copays, more reminders about appropriate services, fewer prior authorization requirements, and so on. Quality measurement at the plan level would provide information about this. Medicare Advantage does this and provides a natural model. The quality metrics in Medicare Advantage are determined by CMS and apply to all plans.

### ***Measures should be based on EMRs rather than separate records generated by clinical staff.***

The easiest way to reduce the time burden in quality measurement is to use information already gathered in electronic records, rather than re-record information into a separate quality assessment tool. As measures of quality reporting are designed, they should be developed with an eye toward using information in the EMR. In turn, the ability to form such measures easily can become a part of meaningful use of IT, which the federal government already regulates.

In any public good setting, some organization needs to play a leadership role in the harmonization and dissemination of metrics. Because public payers are so essential in quality selection and use, and the public sector uses so many different quality metrics, all parties agree that the federal government needs to be intimately involved in the effort. There are a number of mechanisms already in place for this consultation to occur. For example, CMS and America's Health Insurance Plans, in collaboration with the National Quality Forum, created a Core Quality Measures Collaborative to agree on a common set of quality metrics. This collaborative has already agreed on core measures in eight areas, including cardiology and gastroenterology. The measures so far are generally based on clinical processes rather than patient outcomes, but

one could imagine expanding on these measures to include outcomes as well.

One important question is how to encourage plans to adhere to the recommended quality standards. Many of the same issues arise here as they do with harmonizing the claim submission process. Requiring standard quality metrics for plans working with governments is one way to do so. Prices are another part of the answer. To the extent that payers want to deviate from recommended standards, they could pay a price to do so. The fee would go to compensate providers for the additional cost of compliance with nonstandard metrics.

A better-functioning quality assessment system might cut quality reporting needs in half or more. Based on the results of Casalino et al. (2016), the savings from this could be \$7 billion annually.

## DATA INTEROPERABILITY

Making health information flow seamlessly among providers, patients, and insurers is in many ways the “Holy Grail” of health care. With it, many things are possible; without it, options are inherently limited. This is true for both clinical decision-making and administrative simplification. Take just one example: authorization for knee surgery. Before authorizing surgery, an insurer might require proof that knee damage was of a particular severity (based on an MRI) and physical therapy had been attempted. However, the surgeon seeking authorization for the surgery might not have the entire history of medications or physical therapy notes in their EMR. Thus, there is a manual process to seek out these records and get them to the insurer. If health-care data flowed smoothly, that information would be readily at hand for both surgeon and insurer. Health information exchange is designed to achieve this.

The United States has a substantial and mixed history with health information exchange. The HITECH Act allocated money for health-care data exchange, some of which was allocated to state and regional Health Insurance Exchanges (HIEs). These HIEs were designed to foster information flow across providers (and are distinct entities from the insurance marketplaces where people enroll in plans). At their height, there were 119 HIEs. As funding dried up, however, that number fell (Adler-Milstein, Lin, and Jha 2016). Lack of funding for a public good does not mean that the activity is not worth it. If asked to voluntarily contribute to improving environmental quality, every household individually might say no, but as a collective we might all agree to tax ourselves to pay for the cost of improving the environment. Furthermore, some HIEs were actively opposed by providers and EMR vendors that benefitted financially from data remaining siloed.

Overall, the literature suggests some benefits from regional HIEs. The most common use case for HIEs has been to reduce clinical costs, for example to avoid duplicative imaging and to have ready access to patient history in emergency situations. A systematic review of the literature on HIEs found that they save money in this fashion (Adjerid, Adler-Milstein, and Angst 2018; Menachemi et al. 2018). However, the benefits have not been overwhelming.

No country has fully solved the interoperability issue, though countries in northern Europe, including Denmark, Finland, the Netherlands, and Sweden are rated in surveys as having the best eHealth infrastructure (HIMSS Analytic 2019). EMR adoption in these countries is more likely to be regional than provider-driven, thus reducing some of the interoperability concerns. Even in these countries, though, integrating information from different EMR systems remains a challenge.

There are multiple ways in which health-care data could become more interoperable. The classic way is through provider-to-provider transmission. One provider would keep the patient’s full record and other providers would push information to or pull information from that EMR. Until recently, this was virtually impossible given that there was no easy way for one provider to read from or write to another provider’s EMR.

More recently, two additional use cases have become apparent. The first is for patients to access their medical records directly. Apple and Android phones alike now offer the ability to download components of a patients’ medical records to a smartphone, such as information about medications and allergies. Having patients accumulate and transport their medical records is one way to work around providers who find it difficult to share records. The second use case is to have payers consolidate information. Payers are an appropriate focus because they receive claims for virtually all the care that patients receive, with the exception of completely uncovered services. Furthermore, payers who have this information would need to do significantly less prior authorization than they do currently. CMS has released proposed regulations that require payers to keep a longitudinal health record for each enrollee, but that regulation has yet to be issued.

Optimism about data interoperability is driven by technological changes that make data integration substantially easier than it once was. The past few years have seen the widespread development of APIs. An API allows one computer to link to information on another without knowing anything about how the second one works internally or where data are stored. The classic analogy is a wall outlet: Any lamp that meets minimum standards can plug into any wall outlet and operate, without detailed knowledge of the wiring behind the outlet or the source of the electricity. In retail, APIs are used by companies like Amazon and Walmart to allow

people to look up prices, see product reviews, determine store locations, and the like, without knowing the details of their internal system architecture.

Using APIs to access health-care data would generate substantial benefits (Huckman and Uppaluru 2015). For example, one large hospital system reported nearly 1,500 ways in which its individual hospitals' EMRs stored values for blood sodium (e.g., as NA, NA+, sodium, serum sodium, etc.). It would be impossible to write a computer code that pulled data from the EMR if one had to program this information for every individual EMR. However, the API can know how blood sodium is stored on the relevant computer and thus direct appropriate users to the right variable.

In order for the benefits of APIs to be realized, several hurdles will need to be overcome.

#### *Data access must be required.*

Payers and providers will have to be required to provide access to their data—as noted above, there are few incentives to do so voluntarily and many incentives to keep data private. The 21st Century Cures Act laid out a requirement to do this, and active and proposed regulations are moving this along. One key issue is prevention of excessive blocking of access to records. Is an insurer allowed to require hundreds of dollars in payment for a patient to access their own records? Can providers limit access to some record fields and not others? The information blocking issue noted above is very real and needs to be regulated.

#### *The data to be made accessible must be clearly delineated.*

EMRs store enormous amounts of data—as many as 30,000 items, according to anecdotal evidence. One would not necessarily need access to all those data fields right away. Some process needs to be found to determine the highest-value data items and work from there.

A particularly complex issue is how to address unstructured data. For example, many aspects of care are kept in a clinical note, not in data fields. In some cases, the value might not even be numeric, as when a physician enters the patient's symptoms in the clinical note. And even data fields may be recorded in

different ways—for example, with and without decimals or with text instead of numbers. Converting unstructured data to structured formats is possible but not easy. A number of companies have developed natural language processing tools to convert unstructured to structured data. In the future, these types of programs might be add-ons to the basic EMR.

#### *The funding system needs to be stable.*

One of the challenges for data interoperability, as it is for many aspects of administrative simplification, is funding. Many HIEs are funded by voluntary assessments. Such assessments tend to dry up in hard times. A “recognized coordinating entity” has been appointed by ONC to help share information across HIEs; it, too, is funded by a grant.

All systems need upkeep and management. To manage this, it helps to have stable funding. Such funding is common to other standards organizations: NACHA is funded by assessments on banks and fees for obtaining standards documents. GS1 is funded by user fees to obtain a GTIN. The most successful HIEs are also funded by assessments. For example, the Indiana State HIE is funded by charges to payers and providers for the services it provides: transmitting data from labs to physician records, submitting required forms to state agencies, and providing notification to Accountable Care Organizations about which patients are due for which services. A key challenge for health-care interoperability is creating a financing system that provides enough funds on an ongoing basis.

The way to finance such a system depends on who the service is benefitting. If payers are required to keep longitudinal information on enrollees, as in proposed regulations, an organization that enhances records management at the payer level would have a good use case. Similarly, to the extent that federal regulations require more interoperability by EMR systems, EMR vendors would have incentives to contribute to such a system. Many providers are under risk arrangements, and they too could benefit from efforts that made it easier to track care longitudinally. Over time, stable industry funding based on high value return is much preferred to the vagaries of congressional authorization and administrative discretion.

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# Questions and Concerns

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## ***1. Are there privacy and security concerns from increasing health-care data interoperability?***

Yes, there are. Any time that data are made more accessible electronically, privacy is a concern. The ONC has put out a plan for health-care security and privacy, including elements of cybersecurity endorsed by the Department of Justice and National Institute of Standards and Technology. In general, ONC suggests maintaining strict security practices at each place where data are handled and encrypting information internally and when sent.

## ***2. How much investment is required to make these changes occur?***

The public investment required to achieve these administrative savings is likely not large. The only new public institution would be a health-care ACH, estimated earlier at \$300 million annually. By contrast, the HITECH Act, which created the financial incentives for providers to invest in EMRs, cost about \$30 billion. Put another way, the bulk of the costs required for administrative simplification have already been paid. The required amounts now are what is needed to convert that into administrative savings.

Payers would likely have to spend the most to harmonize their systems. This includes CMS and state Medicaid agencies. The cost of this for public payers is likely in the low billions. These are one-time costs, for example in redoing their computer systems, while the savings would be ongoing. In typical industries it has been found that administrative savings driven by technologies like automation can pay for themselves in one year if done with appropriate strategic focus and investment.

## ***3. Will there be employment losses from the program?***

Administrative simplification is likely to involve some labor disruption. Administrative requirements are currently handled by people. If those services are automated or no longer needed, those jobs could disappear. Fortunately, the disruption is unlikely to be major. The people who work in health-care administration have many other job opportunities; this simplification would not be equivalent to the closing of a mine or a steel mill. Furthermore, health care should not be seen as a jobs program. The extra cost of administrative labor is a huge financial hardship, and it discourages some people from seeking needed care. That said, one should not deny that there would be employment implications from administrative simplification.

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# Conclusion

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**H**ealth-care administrative simplification requires that both technical and policy challenges be surmounted. The technical challenges have been diminished by enormous advancement in the capacity to manage information flow. The U.S. health system uses some of this capability, but not enough. A good share of what needs to be done in health care is to bring the technology of health-care administration up to the level of other industries in the economy.

The economic case is vital, too. The problem with the economics of health-care simplification is that administrative costs are so fully baked into the system that they cannot be separately identified. Thus, the savings that any actor realizes

by simplifying the administrative burden is only a small fraction of the total gain to society. Policy can help make these gains clearer by pushing for private contracts to itemize the costs of administrative complexity, and by clarifying who is responsible for data collection and exchange, so that those parties will see the economic value of services that reduce collection costs.

Reforming America's antiquated system of administrative transactions could be a huge boon for patients, physicians, and payers. Estimates suggest that savings on the order of \$50 billion to \$75 billion annually are possible. Realizing these savings is vital for the sake of the health-care system and the economy more generally.

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# Author

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David Cutler has developed an impressive record of achievement in both academia and the public sector. He served as Assistant Professor of Economics from 1991 to 1995, was named John L. Loeb Associate Professor of Social Sciences in 1995, and received tenure in 1997. He is currently the Otto Eckstein Professor of Applied Economics in the Department of Economics and was named Harvard College Professor in 2014 until 2019. Professor Cutler holds secondary appointments at the Kennedy School of Government and the School of Public Health. Professor Cutler was associate dean of the Faculty of Arts and Sciences for Social Sciences from 2003-2008.

Honored for his scholarly work and singled out for outstanding mentorship of graduate students, Professor Cutler's work in health economics and public economics has earned him significant academic and public acclaim. Professor Cutler served on the Council of Economic Advisers and the National Economic Council during the Clinton Administration and has advised the Presidential campaigns of Bill Bradley, John Kerry, and Barack Obama as well as being Senior Health Care Advisor for the Obama Presidential Campaign. Among other affiliations, Professor Cutler has held positions with the National Institutes of Health and the National Academy of Sciences. Currently, Professor Cutler is a Research Associate at the National Bureau of Economic Research, a member of the Institute of Medicine, and a Fellow of the Employee Benefit Research Institute. He advises many companies and groups on health care.

Professor Cutler was a key advisor in the formulation of the recent cost control legislation in Massachusetts, and is one of the members of the Health Policy Commission created to help reduce medical spending in that state.

Professor Cutler is author of two books, several chapters in edited books, and many published papers on the topics of health care and other public policy topics. Author of *Your Money Or Your Life: Strong Medicine for America's Health Care System*, published by Oxford University Press, this book, and Professor Cutler's ideas, were the subject of a feature article in the *New York Times Magazine*, *The Quality Cure*, by Roger Lowenstein. Cutler's most recent book, *The Quality Cure*, pursues these themes. Cutler was recently named one of the 30 people who could have a powerful impact on healthcare by *Modern Healthcare* magazine and one of the 50 most influential men aged 45 and younger by *Details* magazine.

Professor Cutler received an AB from Harvard University (1987) and a PhD in Economics from MIT (1991).

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# Endnotes

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1. This cost is for an intermediate visit, using code A007.
2. While the Kahn et al. (2005) data are somewhat old, recent evidence suggests they may still be accurate. Minnesota requires insurers to provide information on administrative costs in the state. According to their filings (Minnesota Department of Health 2019), 20 percent of administrative costs are for claims management, compared to 16 percent in the Kahn et al. study. Ten percent of administrative costs are for quality assurance and utilization management. Kahn et al. does not break this out directly, but it is likely about 10 percent.
3. This estimate omits the cost of eligibility and benefits verification. The CAQH estimates of the costs of prior authorization include only medical claims, not pharmacy claims. Including pharmacy claims would likely double the prior authorization costs.
4. See a Hamilton Project proposal by Gans (2018) for discussion of similar interoperability issues with online platforms.
5. Those organizations are America's Health Insurance Plans, the Blue Cross Blue Shield Association, the American Medical Association, the Medical Group Management Association, the American Hospital Association, and the American Pharmacists Association.
6. By contrast, the cost to payers of conducting a prior authorization is estimated at \$3.32 per claim.



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## Highlights

In this paper, David Cutler of Harvard University proposes several reforms to reduce administrative health-care costs, which far exceed the costs what is necessary to deliver effective health care. Cutler focuses on improving the coordination of information exchange between payers and providers, particularly through claims submission and adjudication, prior authorization determinations, and quality measurement and reporting processes.

## The Proposal

**Establish a clearinghouse for bill submission.** Standardizing the electronic transmission of billing and claims submissions would facilitate consistency in the information required across payers and improve administrative efficiency.

**Simplify prior authorization.** Applying prior authorization rules selectively, attaching a price to prior authorization, and automating prior authorization could help reduce the high costs associated with implementing prior authorization.

**Harmonize quality reporting.** Quality metrics should be meaningful to clinicians and patients, harmonized across payers, and developed using information gathered in electronic medical records.

**Enhance data interoperability.** Easing the exchange of health information not only aids in clinician decision-making, but also reduces administrative costs associated with information coordination between providers, patients, and insurers.

## Benefits

Cutting administrative health-care costs is advantageous to physicians, insurers, and patients. Lower administrative costs would reduce prices, enable physicians to spend more time caring for patients, reduce prices borne by insurers, and decrease patients' discouragement from accessing health care due to administrative hurdles. The proposed reforms to health-care administration could save \$50 billion annually, or about \$150 per person per year.



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