"Reducing Health Care Costs:
Promoting Administrative Simplification and Efficiency"

by

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

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

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

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

Our testimony focuses on the following topics:

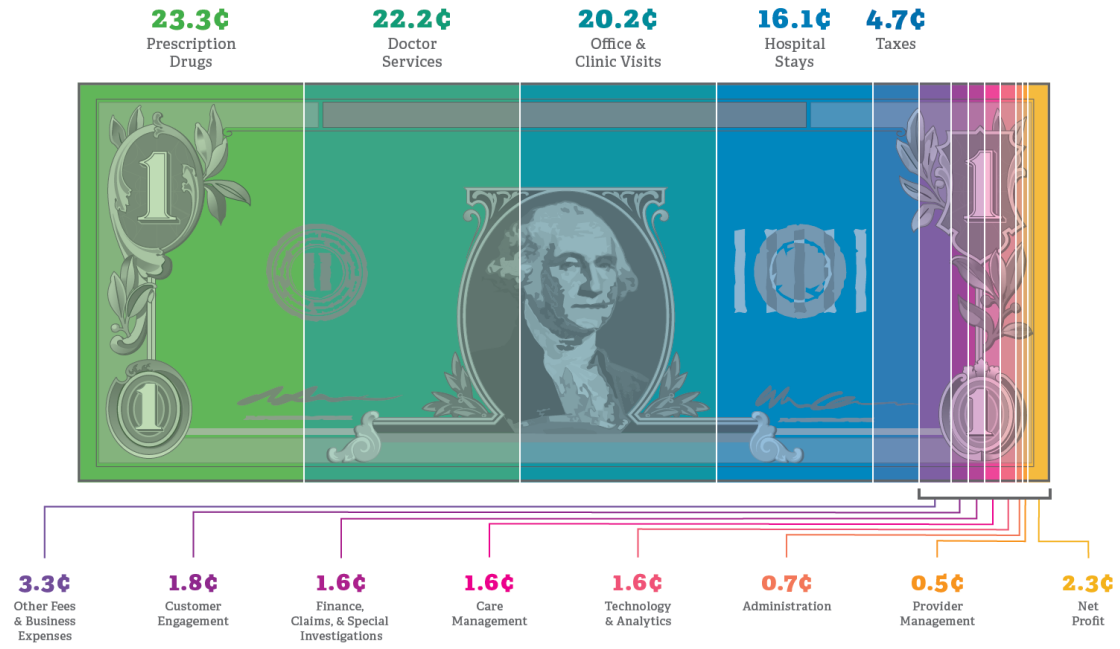
- An overview of how health care dollars are spent and the reality that administrative costs are a small part of overall health care spending;
- Administrative activities carried out by health insurance providers, including medical management and fraud prevention, to improve the health care experience for consumers;

- Initiatives and collaborations through which health insurance providers are working to simplify administrative burdens for hospitals and clinicians; and
- Our commitment to working with other stakeholders and policymakers to address challenges and barriers to administrative simplifications that provide value to patients.

How Health Care Dollars Are Spent

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

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



Many Administrative Activities Improve the Health Care Experience for Consumers

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

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

Medical Management: Promoting Better, Smarter Care

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

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

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

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

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

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

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

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

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

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

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

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

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

[8] Cohen, Robb, Lemieux, Jeff, Mulligan, Teresa, Schoenborn, Jeff. Medicare Advantage Chronic Special Needs Plan boosted primary care, reduced hospital use among diabetes patients. *Health Affairs* 31(1):110-119. January 2012.
[9] Timbie, Justin W., Bogart, Andy, Damberg, Cheryl et al. Medicare Advantage and fee-for-service performance on clinical quality and patient experience measures: Comparisons from three large states. *Health Services Research* 52(6), Part I: 2038-2060. December 2017.
[10] Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, et al. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.
[11] Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S., et. al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Affairs* 34(1): 11-20. January 2015.
[12] Ayanian, John Z., Landon, Bruce E., Zaslavsky, Alan M., et al. Medicare beneficiaries more likely to receive appropriate ambulatory services in HMOs than in traditional Medicare. *Health Affairs* 32(7):1228-1235. July 2013.
[13] Lemieux, Jeff Sennett, Cary Wang, Ray, et al. Hospital readmission rates in Medicare Advantage plans. *American Journal of Managed Care* 18(2): 96-104. February 2012.

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

Prior Authorization: Protecting Patients From Unnecessary and Inappropriate Care

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

While prior authorization is applied to a relatively small percentage (typically less than 15 percent) of covered services, procedures, and treatments, this tool benefits patients by:

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

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

- Imaging tests with radiation for patients who may have already had high exposure to radiation from previous tests;
- Joint injections without evidence or clinical documentation showing a diagnosis of arthritis;
- Surgery for sleep apnea as first line treatment, contrary to evidence-based guidelines;
- Repeat spine surgery unsupported by history, physical findings, and imaging;

[14] Johnson, Garret, Figuero, Jose F., Zhou, Xiner, et al. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9): 1707-1715. September 2016.
[15] Morning Consult National Tracking Poll. March 11-16, 2016.

- Magnetic Resonance Imaging (MRI) for low back pain as a first line treatment, instead of physical or other therapy, as recommended by professional guidelines;
- Appropriateness/usefulness of prescribing antipsychotic medications for children and adolescents; and
- Use of addictive opioids that exceed the Centers for Disease Control and Prevention's (CDC) recommended limits.

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

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

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

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

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

[16] Imaging for Low Back Pain, American Academy of Family Physicians. https://www.aafp.org/patient-care/clinical-recommendations/all/cw-back-pain.html
[17] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2018.

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

The enormous costs of health care fraud are borne by all Americans, and eliminating fraud and abuse is a critical priority for health insurance providers as well as public programs. Our members have invested billions of dollars in initiatives to monitor, detect, and eliminate criminal behavior. Many health insurance providers have established their own designated investigation units comprised of highly trained professionals who employ sophisticated analytics that indicate when an investigation is warranted—to prevent, detect and remedy fraudulent and abusive conduct. When they find criminal activity, they work closely with law enforcement—local police, state police, the FBI, and the Drug Enforcement Administration (DEA)—to stop fraud and protect the American people. This work helps ensure that the care paid for is legal and warranted and, more importantly, protects consumers and patients from both physical and financial harm.

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

Anti-fraud initiatives focus on:

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

[18] FBI-HealthCare Fraud (https://www.fbi.gov/about-us/investigate/white_collar/health-care-fraud)

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

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

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

Simplifying Administrative Burdens for Hospitals and Clinicians

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

Reducing the Cost of Administrative Transactions and Simplifying Administrative Tasks

[19] The Health Insurance Portability and Accountability Act (HIPAA) of 1996 set national standards for electronic transactions (claims and encounter information, payment and remittance advice, claims status, eligibility, referrals, and authorizations and payment), code sets (for diagnoses, procedures, diagnostic tests, treatments, and supplies), and unique identifiers (health plan identifier, employer identification number, and national provider identifier).
[20] The Patient Protection and Affordable Care Act (ACA) of 2010 included additional requirements including the adoption of operating rules for each transaction, a standard unique identifier for health insurance providers, and standards for electronic funds transfer and electronic health care claims attachments to standardize business practices.

Through a partnership with the Council for Affordable Quality Healthcare (CAQH), our members are participating in an industry-wide collaboration, the Committee on Operating Rules for Information Exchange® (CAQH CORE), that works to reduce the costs associated with administrative transactions and simplify administrative tasks through the development and adoption of health care operating rules for electronic transactions. Common rules that simplify administrative transaction allow providers to have more time to spend in treating patients.

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

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

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

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

[21] https://www.caqh.org/core/list-participating-organizations
[22] 2017 CAQH Index, A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings.
[23] 2017 CAQH Index, A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings.

Web Portals: Streamlining the Exchange of Clinical and Administrative Data

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

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

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

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

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

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

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

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

Our Commitment to Address Existing Challenges and Barriers

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

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

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

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

private payers, and to streamline and reduce the overall number of quality measures. CQMC has been working to ensure that new measures can be reported from EHRs.

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

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

Implement Electronic Transactions and Operating Rules. To continue the adoption of administrative simplification, remaining electronic transactions and operating rules should be implemented in a timely manner and should be designed to meet and keep up with the industry's evolving business needs to truly lower administrative costs. Our industry continues to work with CAQH and the National Committee on Vital and Health Statistics (NCVHS) on the adoption of needed standards and operating rules.

Rescind HPID Regulations: In the near term, CMS should rescind regulations implementing the health plan identifier (HPID). AHIP and other stakeholders, including providers and clearinghouses, have testified before the NCVHS numerous times that there is no longer a need

for HPID, as this need is served by the Payer ID, which is currently used in electronic transactions across the industry.

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

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

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

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

Conclusion

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