Center for American Progress

# Paper Cuts

## Reducing Health Care Administrative Costs

Elizabeth Wikler, Peter Basch, and David Cutler      June 2012

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# Introduction and summary

Administrative costs in the U.S. health care system consume an estimated $361 billion annually—14 percent of all health care expenditures in our nation. At least half of this spending is estimated to be wasteful.[1] In an era of government budget deficits and rising health care costs, the case for reducing the administrative complexity of health care is compelling. Successful efforts can result in significant financial savings while simultaneously improving system performance indicators and the quality of patient care.

Indeed, stakeholders throughout the U.S. health care system—including health insurance companies, hospitals, physician organizations, labor unions, the pharmaceutical industry, and federal, state, and local governments—all recognize the importance of reducing administrative costs.[2] In recent years, public and private groups have launched a variety of efforts to reduce administrative expenses, many of which, like the Health Insurance Portability and Accountability Act, laid critical groundwork for current initiatives passed under the Affordable Care Act and for future efforts. Yet more remains to be done to lower rising costs.

Administrative costs for private health insurance plans, for example, rose by 117 percent from 2001 to 2010.[3] During this same period, total national health expenditures rose by 74 percent.[4]

This paper outlines the nature of administrative costs affecting both health care payers and providers, and considers ways to contain these costs. Many such efforts are underway, including the ongoing implementation of the Health Insurance Portability and Accountability Act alongside several different elements of the Affordable Care Act. Continued progress in these areas is thus a central step to lower administrative spending.

Even still, many additional actions will be needed. In the pages that follow, we outline a three-pronged strategy for addressing administrative costs:

- **Integration:** embedding administrative simplification rules and systems into existing reform efforts
- **Coordination:** bringing together similar administrative processes by different health care participants to maximize efficiency
- **Leadership:** creating a new federal office dedicated to simplifying health care administrative plans

Tackling wasteful administrative costs in our health care system in these three ways would result in savings we estimate at $40 billion per year.

These savings are eminently achievable. By integrating new performance standards to promote adoption of electronic transactions such as requiring that electronic health records include utilization metrics for electronic billing and other administrative transactions, we can achieve roughly $26.1 billion in annual savings. By coordinating similar processes by different health care participants—such as physician credentialing and enrollment, quality and safety reporting, and enrollment and retention systems for public programs—we can save $7.7 billion each year. And by ensuring leadership at the federal government level through a new senior-level office dedicated to ensuring that administrative simplification plans are carried through and that innovative results are achieved, we can save potentially much more.

Taken together, these efforts could reduce excessive administrative costs by 25 percent, or $40 billion annually. That $40 billion is about 3.5 percent of projected spending on Medicare, Medicaid, and other mandatory federal health programs in 2015.[6] An aggressive agenda tackling administrative inefficiency would not only reduce unnecessary complexity and federal health expenditures but could also improve the quality of care provided.

Tackling excessive administrative costs offers a promising opportunity for reducing health care costs while improving the quality of care for all Americans.

# Administrative costs:
# Who pays how much?

Health insurance companies, health care providers (physicians and hospitals), and patients all bear the cost of health care administration. Currently, there are no estimates for the time or financial costs associated with administrative complexity born by patients, but a 2010 volume by the Institute of Medicine of the National Academies using both micro and macro analysis estimated the breakdown of administrative expenses between payers and providers. The macro studies compared administrative costs in the United States to those in Canada and other developed nations, finding higher levels of excessive administrative spending in the United States. The micro studies focused on specific health systems and created detailed inventories of administrative expenses. The results are telling. (see Table 1)

**TABLE 1**
## What we can gain from health care administrative reform

Estimates of annual administrative costs and possible savings by health care payers and providers

| Element | Share of revenue | Current costs | Possible savings |
|---|---|---|---|
| Insurer costs (claims processing, marketing, general overhead, and profit) | 12.3 percent—private, 3.5 percent—public | $105 billion—private $42 billion—public | $44 billion–$52 billion* |
| Provider costs (hospitals, physicians, nursing homes) | 13 percent—physicians, 8.5 percent—hospitals, 10 percent—other providers | $214 billion | $105 billion–$108 billion |
| Patient costs | | N/A | N/A |
| **Total** | | **$361 billion** | **$149 billion–$160 billion** |

* Costs for billing transactions only. Omits costs for marketing of insurance, estimated to be about 30 percent payer administrative costs.
Source: Institute of Medicine, "The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary," p. 148–150. Current costs are derived from multiplying estimated revenue for 2009 (as published by the Center for Medicare and Medicaid Services in 2007) by the percent revenue dedicated to billing and insurance related costs for each group.

According to the Institute of Medicine, private insurers spent $105 billion in 2009 on administrative costs, of which approximately 70 percent is associated with billing and insurance-related expenses (as opposed to marketing, profits, and so forth). Public insurance programs also spent $42 billion on administration. Studies comparing these figures to similar expenses in other developed nations and to public programs in the United States suggest that nearly half of this spending—between $44 billion and $52 billion—is unnecessary.[7]

Part of this excess spending is attributable to our largely private, multipayer health care system. Even so, the Commonwealth Fund reports that the United States spends between 30 percent and 70 percent more as a share of health spending on administrative processes than do other countries that have mixed public/private health systems, including Switzerland, Germany, and the Netherlands.[8]

Provider groups—including physicians, hospitals, and other health care providers—pay an even greater share of administrative costs. In 2009 provider groups spent approximately $214 billion on administration, half of which is considered to be excessive.[9] This is largely because they have to shoulder the costs—primarily in the form of staff time—of interfacing with multiple payers, clearinghouses, third-party administrators, and others in order to bill for services or conduct other basic transactions.[10]

> Physicians in the United States spend an average of 43 minutes per day, or three weeks per year, interacting with health care plans.

Often, different health care payers such as private health insurance companies have their own customized data requirements for transactions, necessitating manual input from providers and other physician office staff. Physicians in the United States spend an average of 43 minutes per day, or three weeks per year, interacting with health care plans. This is in addition to the 21 hours that nursing staff and 53 hours that clerical staff spend per physician per week on administrative transactions, particularly claims and prior authorizations.[11]

This time spent on excessive administrative processes is expensive, resulting in less clinical time, less time reviewing and acting on quality initiatives, higher overhead costs, and lower quality of care.[12] In fact, the U.S. Department of Labor's Bureau of Labor Statistics reports that in 2011 physicians, hospitals, and other care providers now employ more billing and posting clerks than any other industry.[13]

Table 2 outlines the administrative complexity in each phase of a health care provider's revenue cycle. It provides a snapshot of the current billing environment and does not reflect changes that could or will result from the implementation of the Affordable Care Act. As the length of the table attests, numerous administra-

tive steps are required, almost all of which can result in significant time expenditures and financial expenses.

## Our way-too-complex health care payment process

The eight stages of the health care provider revenue cycle in the United States

**① Providers negotiate with insurers on contracting and credentialing**

Time spent negotiating various contracts and filling out redundant credentialing forms;
lost clinical time due to approval process for credentialing applications

**② Patient schedules appointment and eligibility verification**

Patient effort to contact appropriate office personnel and negotiate insurance approval; providers,
insurers, and patients contend with retroactive additions and terminations of coverage that
complicate eligibility-verification process; plan customization and carve-outs add confusion
to determinations of covered services

**③ Patient visits and treatment**

Prior authorization requirements for treatments and services can be unnecessarily time consuming,
burdensome, and inconsistent across payers; administrative process for referrals is time consuming
and adds little to no clinical value

**④ Billing and claims submission**

Variation in claims requirements, lack of standardized codes, lack of uniform operating rules,
insurance company companion guide changes, and complexity in identifying the primary insurance
company responsible for payment

**⑤ Claims status inquiries and collections, remittance, and payment posting**

Nonstandard verification process in place to determine whether claim was
successfully received from provider in the format desired by insurance companies and other payers

**⑥ Denials and reconciling overpayments and underpayments**

Variation in use of denial codes across payers creates challenges for provider offices;
insurance company systems are outdated; uneven adoption of electronic capabilities creates room
for human errors

**⑦ Appeals**

Processes vary across insurers and many are conducted manually, which is costly and time consuming

**⑧ Reporting**

Inconsistent requirements across insurers, agencies, hospitals, and other programs

Source: Authors' research adapted from research conducted for the Employers Action Coalition on Health Care, "Analysis of
Administrative Simplification" (2009): 1–51. This table captures the complexity in administrative transactions under the current system
and does not reflect changes that will result from reforms passed under the Affordable Care Act, such as the implementation of
proposed operating rules.

# The Health Insurance Portability and Accountability Act

## The first attempt at standardization

Recognizing the high level of administrative expenses, the U.S. government enacted the Health Insurance Portability and Accountability Act in 1996. HIPAA was dedicated in part to streamlining administrative processing and costs in the health care system.[14] The law established nationwide standards for a core set of health care billing transactions such as claims submission and payment in order to facilitate the electronic transmission of information between providers and payers. Thus it was a critical first step toward a paperless, electronic system.

These standards specify the data that the electronic transactions should contain, as well as the formatting requirements for these transactions. Health plans, health care clearinghouses, and health care providers must adopt these standards only if they conduct administrative transactions electronically. Importantly, HIPAA did not mandate electronic administrative transactions. While the goal of HIPAA was salutary, the law has not yet produced significant levels of administrative savings—and even generated more administrative hassle for some stakeholders. There are several reasons for this, including:

• Poor policy design
• Weak implementation and enforcement
• Lack of strong leadership and coordination

Let's look at each of these failures briefly in turn.

## Poor policy design

The Health Insurance Portability and Accountability Act did not provide enough detail on what the electronic standards should be or how they were to be operationalized, which has limited its effectiveness in streamlining administration.[15] One transaction standard created under the law, for example, governs inquiries

between providers and insurance companies regarding a patient's enrollment status in a health plan and his or her eligibility for health services. This is known as HIPAA standard 270/271. Under the law this standard only requires that insurance companies respond with information on a patient's eligibility status and benefit coverage, which usually comes in the form of a yes-or-no answer.

In practice, however, health care providers need more information from health plans at the point of service such as the patient's cost-sharing requirements and how these financial liabilities vary by service. Currently, some insurance companies provide all this information and more to providers, while others do not, thereby creating more manual follow-up work for physician staff.

Moreover, in terms of operationalizing these standards, the Health Insurance Portability and Accountability Act focuses almost exclusively on the substantive content of the electronic standards but does not address the circumstances surrounding the transmission of this information such as data security and authentication, system availability, and connectivity requirements. For instance, the law allows each health plan to decide how many transactions it will accept in one file transfer and the hours that the system will be available to providers to conduct those transactions. In many cases, this variability in terms of content and process means that providers have to customize their billing processes for each health plan they accept.

## Weak implementation and enforcement

Implementation of these standards was slow and initially incomplete after the law was enacted in 1996. The first set of HIPAA electronic transaction standards was released in 2000, with the first update to these standards arriving nine years later. Slowing the process further, the U.S. Department of Health and Human Services has delayed the enforcement of these standards multiple times due to uneven adoption rates and unforeseen circumstances affecting patient coverage. In addition, although proposed rules were released, the agency has failed to adopt final rulings for some of the electronic standards addressed in the 1996 HIPAA legislation, including standards for health plan identifiers and claims attachments (documents such as X-rays and lab results sent electronically) The Affordable Care Act directs the secretary of health and human services to adopt national standards for these transactions over the next five years.

> The first set of HIPAA electronic transaction standards was released in 2000, with the first update to these standards arriving nine years later.

These delays hampered adoption efforts across the U.S. health care system. Just one case in point: Some insurance companies created proprietary systems in the late 1990s and early 2000s to electronically process administrative transactions, but partly because of the delay in the release of the standards, each company employed a different system for collecting and processing provider data. Overwhelmed with the number of new systems in place, health care providers saw little value in instituting the workflow and staffing changes needed to shift toward electronic transactions.

There also was no promise that if providers implemented the new technology, all payers would be able to accept their transactions. As a result, providers—especially those in smaller practices—did not adopt the technology and continued to rely on manual processes, billing contractors, or health care clearinghouses to process transactions. The experience pointed out the interdependence of the different actors in the system: significant progress would require stakeholders to work together, from design to testing to implementation.

## Lack of strong leadership and coordination

The Health Insurance Portability and Accountability Act also fell short of its promise in part because the law did not create an effective leadership structure capable of overseeing administrative simplification. The law charged the secretary of health and human services with implementing and enforcing the majority of HIPAA provisions. But the department chose to base implementation efforts in the Centers for Medicare and Medicaid Services, even though the center was primarily focused on administering public programs.

There also was inadequate funding to implement or enforce the measures.[17] Similarly, enforcement structures were dispersed across offices within the Department of Health and Human Services.

Together, poor policy design, weak implementation and enforcement, and the lack of strong leadership and coordination by the Department of Health and Human Services crimped the initial promise of the Health Insurance Portability and Accountability Act of 1996. Serious fixes would not be put in place until 2010, when Congress passed and President Barack Obama signed the Patient Protection and Affordable Care Act.

# Administrative simplification efforts in the Affordable Care Act

Federal policymakers tackled administrative complexity again in the Patient Protection and Affordable Care Act in 2010. The law includes two sections (1104 and 10109) that enact operating rules for existing HIPAA transaction standards and adopt additional electronic transaction standards for those areas left previously unaddressed by HIPAA.

Operating rules complement transaction standards but are somewhat different. Standards address data content and format requirements for electronic transactions governed by HIPAA. Operating rules specify how HIPAA standards should be implemented across the health care system. For instance, existing HIPAA standards for health care eligibility inquiries and responses provide inadequate information about patient eligibility and cost sharing for particular services. The new operating rules will augment this standard by requiring not only that all payer groups provide comprehensive information on health insurance coverage and services covered but also data on patient financial liability.

In this way, standards and operating rules work in unison to make the transmission of electronic information more consistent across entities, clarify data-usage requirements, and streamline the technicalities of how entities exchange patient information.[18] In total, the Affordable Care Act calls for the development and implementation of operating rules for HIPAA transactions such as eligibility verification, electronic funds transfers, health care payment and remittance advice, referral certification and authorization, and others. This is similar to practices in other industries in our nation, notably financial services. (see box on next page)

## Operating rules and standards common in other industries

Specifying operating rules is common in other industries. Take financial services. In the 1970s the National Automated Clearing House Association—an organization of commercial banks, savings banks, credit unions, and savings and loan associations—created a set of operating rules to govern the nationwide processing of electronic payments. Early on, these organizations recognized that the existing computer systems did not have the capacity to process or sort the increasing number of paper checks used by business and consumers.

In response, the organization worked with the Federal Reserve and other financial regulatory agencies to develop a common set of rules—rules that are still in effect today—to process electronic payments, including salary and Social Security payments, in an efficient, safe, and consistent manner. In 2009 more than 19 billion electronic transactions worth $30 trillion were conducted through the Automated Clearing House network.[19]

Similarly, credit card companies such as MasterCard and Visa use operating rules to process billions of transactions each year, coordinating economic activity across diverse businesses, consumers, and financial institutions around the world. The same is true for railroads, construction, and countless other industries. It should be true for the health care industry, too.

### Operating rules in health care

Public and private initiatives supporting the widespread adoption of operating rules in health care helped pave the way for recent legislation. Minnesota and Washington launched efforts in 2007 and 2009, respectively, establishing statewide operating rules to standardize some HIPAA transactions. Meanwhile, dozens of private health insurance plans, provider organizations, and federal, state, and local government agencies have come together under the umbrella of the Council for Affordable Quality Healthcare, or CAQH, to develop the Committee on Operating Rules for Information Exchange, or CORE, which has generated a series of operating rules for health plan eligibility, claim status transactions, and other administrative transactions.

The Affordable Care Act directs the Department of Health and Human Services to appoint an outside organization to draft the operating rules for nonpharmacy-related HIPAA transactions. So far, it named the Council for Affordable Quality Healthcare as the authoring entity for the first two set of rules. (No operating rules were adopted for retail pharmacy services because current transactions standards provide enough detail for complete operationalization).[20] This collaboration aims to align existing efforts with new regulations slated for release over the next five years. The law requires that all health plans conducting administrative transactions either comply with these new simplification regulations or pay a financial penalty.

## Potential savings from operating rules

Recent evaluations of existing efforts to implement standardized operating rules find that they could result in increased use of electronic transactions and could thus lower administrative costs. In Minnesota, where policymakers adopted operating rules for four HIPAA transactions, annual savings of more than $56 million are projected starting in 2012.[21] At a national level this would be $2.8 billion in savings. Another study, conducted by IBM Corp. for the Council for Affordable Quality Healthcare, found that industrywide adoption of the Committee on Operating Rules for Information Exchange Phase I operating rules (a more limited set of operating rules dealing primarily with eligibility transactions) could result in $1 billion in savings annually for the country as a whole.[22]

The adoption of nationwide operating rules could yield even more savings. In January 2012 the Department of Health and Human Services finalized the first round of proposed operating rules, which govern eligibility for health plan and health care claims status transactions and go into effect in January 2013. The department expects the rules to save providers and health plans $13 billion to $15 billion over 10 years. Most of the savings will accrue to providers, but plans will save as well.[23]

These two rules are just the beginning. Savings are likely to increase as the Department of Health and Human Services continues to move forward in specifying operating rules for additional HIPAA transactions.

Furthermore, these benefits may not all be financial. Widespread adoption could result in fewer consumer delays and/or problems in obtaining health services, and could produce efficiencies that would enable payers and providers to invest in other mechanisms such as automated processes that produce higher value benefits across the system. This is what happened in Minnesota in 2007, when four payers and five medical groups launched a pilot project that automated the prior authorization process for providers who used decision-support systems when ordering high-technology diagnostic imaging such as computed tomography scans, magnetic resonance imaging scans, and positron emission tomography scans.

Results showed that the number of unnecessary tests went down, as did the amount of time providers spent interacting with health plans. One participating medical group found that under the new system, the time spent gaining approval for nearly 2000 imaging services dropped from 308 hours to just five.[24] The pilot produced estimated savings of $84 million over three years.

At the national level, these savings could be significant. If just 85 percent of prior authorization requests and referrals were conducted electronically, savings could be between $4.5 billion and $12 billion—and even greater if automated.[25]

## Challenges ahead for the implementation of operating rules

Despite the potential savings promised by standardized operating rules, implementation of these operating rules will be challenging for all stakeholders, particularly health plans, due to potential coordination failures and mismatched incentives. One concern is that the recently enacted operating rules will come into effect at the same time that the industry is migrating to a new set of HIPAA standards (5010) and diagnostic codes (ICD-10). Although these mandates will enable more robust processing of administrative claims across the health care system, these conversions affect nearly all payer and provider transactions, requiring extensive staff training and financial investments.[26]

Payers and providers have largely been slow to adopt these new standards and code sets, which in part has led the federal government to delay enforcement of these mandates. Efforts to enact operating rules will require coordination with these potentially competing administrative reforms since additional delays would lessen the potential return on investment for providers and payers who adopt electronic transactions.

Enforcement mechanisms in the Affordable Care Act, including the financial penalties for noncompliant health plans, also will be critical to overcoming the potential mismatch in the costs and benefits of adopting the operating rules for electronic transactions and other simplification measures. Because insurance companies often simultaneously operate more than one claims system—a legacy of past mergers and acquisitions—many insurers will have to upgrade their computer systems, which can be a costly undertaking.

Furthermore, since providers would receive most of the benefit from simplification, there is less of an incentive for payers to execute these reforms. This dynamic could lead payers to underinvest in this area or to delay implementation. Providers have little leverage in this situation since they cannot credibly threaten to leave the networks of large, dominant insurers, even ones that have onerous submission requirements. What's more, until recently there was no consensus on the operating rules that health plans should adopt. Why should a plan invest in a system that may become obsolete if a different standard is adopted by others—or if no standard emerges?

If just 85 percent of prior authorization requests and referrals were conducted electronically, savings could be between $4.5 billion and $12 billion—and even greater if automated.

The Affordable Care Act should help overcome this mismatch by imposing a single, national set of operating rules and by financially penalizing payers that fail to adopt them. While many administrative simplification efforts detailed in the next section of this report primarily fall to providers to invest in implementation, systematic adoption of operating rules is primarily a payer-side measure that is the critical first step in reducing administrative expenses. Payers moving to a standardized electronic system for the processing of all administrative transactions guided by predictable operating rules will make it far more rational for other stakeholders, including providers, to adopt electronic billing systems.

That's why it is vital that the Department of Health and Human Services continues to aggressively implement the administrative simplification reforms passed under the Affordable Care Act, to advocate widespread adoption for all transactions, and to move swiftly to introduce similar reforms for other electronic transactions where it has the authority to do so.

# Recommendations: Coordinating opportunities for administrative simplification

While standardized operating rules are a central component of any effort to reduce wasteful administrative spending, additional actions are needed to achieve more substantial savings in administration. We propose a three-pronged approach to lowering administrative costs in the health care system:

• Integration
• Coordination
• Leadership

We advocate for policymakers to integrate administrative simplification initiatives into existing reforms, particularly those focused on digitizing providers' transactions. We also recommend that disparate efforts focused on similar goals be coordinated to minimize administrative burden on providers, payers, and other stakeholders. Such efforts should include provider enrollment and credentialing programs; quality and safety regulations at the national, state, and local levels; and enrollment procedures for public programs, namely Medicaid and the newly formed state health insurance exchanges.

Lastly, we call for strong leadership at the federal level exercised through a newly established office focused on administrative simplification. The legislative groundwork for this strategy is largely in place; therefore, it's imperative that policymakers and stakeholders harness the momentum in this area to reduce unnecessary complexity in our current health care system. Let's now look at each of these approaches to lowering administrative costs in more detail.

## Integration: Bringing providers online

The administrative simplification provisions in the Affordable Care Act, coupled with the standards put in place under the Health Insurance Portability and Accountability Act, ensure that a more uniform system for the electronic trans-

mission of health information will exist in the near future. To significantly reduce administrative complexity, however, these efforts need to be integrated with administrative reforms to ensure that all stakeholders transmit health care information electronically and in real time.

To this end, we propose two recommendations. First, integrate clinical and administrative functions within electronic health records. Second, introduce financial incentives for providers who transmit administrative information electronically.

The Healthcare Efficiency Index, which is now managed by the Council for Affordable Quality Healthcare, estimates that if 85 percent of common HIPAA transactions (claim submissions, eligibility, claim status, payment, and remittance transactions) were conducted electronically, the estimated amount of additional savings achieved each year could equal $21.9 billion—or 13 percent of current excess administrative costs.[27]

The Affordable Care Act includes financial penalties for insurance companies that do not comply with the new operating rules and standards. The missing component is provider participation. Medicare is already setting an important precedent in this direction. The Administrative Simplification Compliance Act, which went into effect in 2003, requires that all but the smallest provider practices send all initial health care claims to Medicare electronically; payments for claims not submitted electronically are prohibited. In addition, the Affordable Care Act states that all providers will have to receive Medicare payments electronically by 2014.

Furthermore, the incentives created in the Health Information Technology for Economic and Clinical Health Act, or HITECH Act, combined with the payment reforms embedded in the Affordable Care Act, provide two important pathways for encouraging providers to adopt electronic processing. For small provider groups not affected by HITECH or payment reforms, we urge the Department of Health and Human Services to require that software vendors and clearinghouses contracting with these provider organizations adopt HIPAA standards and operating rules or pay financial penalties.

## HITECH

The central focus of the Health Information Technology for Economic and Clinical Health Act is to incentivize providers and hospitals to adopt and optimally use electronic health records technology and to securely share electronic health information between providers and patients with the aim of making care better and safer. But as the acronym "HITECH" declares, the intent was never solely about improving clinical health; it was also intended to improve economic health. As the same infrastructure that stores and manages clinical information can be used for the efficient exchange of administrative information, HITECH creates a major avenue for future efforts on administrative simplification.

In many instances, a health care provider's electronic health records system is completely separate from its billing system. As a result, when clinical information is needed for billing purpose—say for proof that a particular condition was diagnosed before a therapy can be authorized—staff have to manually compile information from two incompatible systems in order to submit claims. A less costly and burdensome system would involve billing systems that are able to securely query clinical systems for standard pieces of information in order to automatically generate information necessary for reimbursement such as claims attachments.

As one example of this, the Western New York Beacon community—a network of providers and payers funded under HITECH and heralded for its advanced health information technology infrastructure—supports a partnership between its clinical health information exchange and its administrative transaction network to reduce errors, streamline transactions, and reduce both clinical and administrative costs.[28]

Although HITECH does not currently include any explicit measures to streamline administrative costs, subsequent rounds of the meaningful use criteria might do so.[29] The Certification Commission for Health Information Technology, a nonprofit group that certifies health information technology systems, could require that all electronic health record systems transmit and receive eligibility and claims information and payments electronically—either directly or via its integration with a practice management system, which would complement existing Medicare requirements regarding the electronic submission and payment of claims. HITECH regulations offer a useful vehicle for phasing in a requirement for the adoption of electronic administrative transactions, not just for Medicare transactions but across the system, as well, especially since the Affordable Care Act stopped short of mandating this requirement across all stakeholders.

In many instances, a health care provider's electronic health records system is completely separate from its billing system.

### Recommendation 1

Future extensions to the meaningful use criteria for electronic health records should include measures to integrate the recording and analysis of clinical services with the billing for those services.

To further encourage provider participation on administrative reform, policymakers should offer additional incentives to provider organizations seeking to establish accountable care organizations or participate in other payment reform initiatives authorized by the Affordable Care Act—provided that they meet administrative simplification guidelines. Under the Medicare Shared Savings Program, for example, the government will make bonus payments to providers in an accountable care organization if they meet certain quality benchmarks. One possibility would be for the government to provide additional payments to providers who meet specified administrative simplification benchmarks such as full utilization of all electronic transactions governed under HIPAA. This funding could help catalyze necessary investments among provider organizations, as well as all the vendors, clearinghouses, and other billing contractors with which they operate.

### Recommendation 2

As part of Medicare, there are numerous opportunities to adopt administrative simplification reforms, such as through the Shared Savings Program. Adoption of these reforms should be included in performance metrics as a measure of efficiency.

## Coordination: Maximizing efficiency by streamlining programs

Further administrative savings could be realized by coordinating and consolidating time-intensive and administratively complex processes within the health care system, including provider enrollment and credentialing programs, quality reporting, and public program enrollment. Current provider enrollment and credentialing systems are riddled with redundancy. The processes providers use to enroll in a health plan, to sign up for a plan's electronic funds transfer program, and to meet specific credentialing criteria are largely overlapping and uncoordinated across entities.[30] As of 2004, for example, physicians filled out an average of 15 to 20 credentialing applications each year—one for each of the health plans and provider systems with which they contracted.[31]

Credentialing in and of itself is important in that it verifies and validates a provider's clinical credentials, but under our current system the required fields and codes vary by payer—even though payers request largely similar information in each application. A study by the Medical Group Management Association found that each application requires an average of 69 minutes of staff time and nearly 12 minutes of physician time to fill out.[32] Moreover, it can take payers months to process applications, constraining a provider's ability to practice medicine and limiting patient access to care.

Section 10109 of the Affordable Care Act calls on the secretary of health and human services to evaluate administrative reforms, simplifying enrollment processes. We recommend that the secretary and the department work in collaboration with the private sector to design a single centralized, mandatory provider enrollment and credentialing system that would build on existing efforts and provide all essential data to necessary stakeholders. Under such a system, providers would be required to submit all pertinent information into a centralized database, and data would then be routed to the relevant organizations in the appropriate format and timeframe.

Credentialing organizations and other bodies should not require any additional data not captured in the centralized database. Such a unified system could be organized through the Council for Affordable Quality Healthcare's Universal Provider Datasource; the Medicare Provider Enrollment, Chain, and Ownership System; state medical licensing boards; or another entity.

Estimates suggest that standardizing just the credentialing system could produce an estimated $18 billion in savings over 10 years, so a system that captured other dimensions of provider enrollment procedures could feasibly save more.[33]

## Recommendation 3

To minimize administrative expenses related to provider enrollment and credentialing processes, the Department of Health and Human Services and the private sector should create a single centralized, mandatory provider enrollment and credentialing system that will provide all essential data to necessary stakeholders for both the private sector and public programs.

## Coordination: Standardizing quality and safety reporting initiatives

Government regulations, reporting requirements for quality and safety programs, and state licensure restrictions should be standardized to promote greater uniformity and lower compliance expenses.

Current reporting requirements—which differ across the public and private sectors and across state and federal levels—are complex and manually intensive for providers and payers alike. The Medicare Advantage program, for example, requires reporting on different measures than is required by the Medicare FFS program. The government, however, is already moving in the direction of simplification. Under the Affordable Care Act, policymakers launched the National Strategy for Quality Improvement in Health Care, which aims to create a set of national priorities for quality improvement to guide local, state, and national efforts. These priorities are already being put to use.

The quality metrics proposed under Stage 2 of the meaningful use criteria in HITECH, for example, come from this new national strategy list and will be aligned with those metrics used by the Medicare Physician Quality Reporting System. We recommend that policymakers lead public and private organizations in an effort to expand existing alignment efforts and harmonize national, state, and local regulations, reporting requirements for quality and safety programs, and licensure restrictions. Exact savings from harmonization of quality reporting have not been calculated, but United Health Group, a large private insurer, estimates that a more limited reform—common quality measurement standards and data aggregation rules—could save about $1 billion over 10 years.[34]

### Recommendation 4

Public and private organizations should work to harmonize and centralize national, state, and local regulations, reporting requirements for quality and safety programs, and licensure restrictions to align with those proposed under the National Strategy for Quality Improvement in Health Care. In addition to this standardization, public and private entities should seek to leverage health information technology so that quality reporting is integrated into patient care and automated through the use of electronic health records.

## Coordination: Ensuring continuity in public program enrollment to reduce churn

Ensuring continuity of enrollment within and across public and private health insurance plans can reduce administrative costs. Churning between public and private insurance plans is expensive both in terms of quality of care and administrative costs—affecting not just patients but also the state and local governments, managed care organizations, and providers that interact with these populations. Recent studies suggest that between 37 percent and 50 percent of adults who will be eligible for Medicaid coverage or insurance premium subsidies under the Affordable Care Act will experience a disruption in eligibility within the first year of coverage.[35] These disruptions are typically precipitated by changes to a person's health insurance coverage, employment status, or family structure.[36]

Churning makes care coordination difficult and increases administrative expenses associated with determining eligibility, and enrolling and re-enrolling eligible recipients. Enrollment costs alone range from $180 per application in California to $280 per application in New York. The precise aggregate costs associated with churn are hard to quantify, but if we multiply these application fees by the millions of people (an estimated 20 million) who will churn between Medicaid and the new state health insurance exchanges that become operational in 2014, the price tag climbs into the range of $3.7 billion to $5.8 billion annually.[37]

The Affordable Care Act anticipated enrollment issues related to the insurance expansion, and included specific provisions to streamline the enrollment process (sections 1413 and 2201). For instance, these sections call for the development of a single, streamlined, online application, as well as an automated renewal process for state programs. Implementing these provisions needs to be a top priority for state and federal policymakers. The new Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services in particular has already begun to publish guidance related to streamlining enrollment, and more rules and regulations are expected to follow.

More should be done. To further stabilize enrollment and minimize movement across Medicaid, the new health insurance exchanges, and the individual market for health insurance, policymakers should have low-income people sign up for their health plans for a year—the way that most everyone in the private market does. Processes for default enrollment could follow those for the low-income

Enrollment costs alone range from $180 per application in California to $280 per application in New York.

population in Medicare Part D, for example. As peoples' incomes change, the source of payment to the insurance plan may vary, but their coverage would not.

Furthermore, a recent report highlights that policymakers should further coordinate insurance coverage policies across markets to promote system efficiency. Examples of this kind of coordination include aligning coverage plans and administrative practices, as well as provider network requirements. These reforms would yield clinical and administrative benefits for patients, providers, and payers alike.[38]

Lastly, the new state health insurance exchanges offer another opportunity for administrative simplification. In addition to quality standards required by national law, national and state policymakers could require that all plans participating in exchanges meet certain benchmarks for administrative efficiency such as a minimum threshold of administrative transactions conducted electronically. This would reinforce the incentives for plans to adopt electronic transactions and would streamline automated processes across all markets.

### Recommendation 5

To minimize administrative expenses, the Department of Health and Human Services and state governments should coordinate coverage policies and administrative systems across Medicaid, the new state health insurance exchanges, and the private market, and should promote continuous enrollment policies.

## Leadership: Creating a new federal office to simplify health care administrative processes

Government leadership on administrative simplification is essential to achieve higher quality care at lower costs, and this will require a dedicated office directing these efforts.

The federal government must take a more active lead on administrative simplification in the health care system. Voluntary, industry-led reforms have made great strides—particularly in the development of operating rules and consolidation of credentialing data—but these reforms have been insufficient in promoting widespread adoption of electronic processing. Moreover, within the private sector

existing incentives have not been enough to propel any one actor—either a payer or provider organization—to take the lead on administrative simplification efforts.

Because the challenge is so large, the federal government's response needs to be commensurately large. We believe that responsibility for administrative simplification should be consolidated and allocated to a new office or agency within the Department of Health and Human Services with the sole mission of simplifying administrative complexity.

Currently, jurisdiction for administrative reform is dispersed across government agencies such as the Centers for Medicare and Medicaid Services and advisory bodies such as the National Committee on Vital and Health Statistics. Therefore, little coordination occurs and competing priorities win out within these offices. To ensure the success of existing and recently enacted reforms in this area, we believe there needs to be a centralized office with the authority to oversee and coordinate changes across the public and private sectors.

The Office of the National Coordinator for Health Information Technology could serve as a possible model. A new Office for Administrative Simplification would need to work with the chief technology officer at the Department of Health and Human Services, the Office of the National Coordinator for Health Information Technology, officials at the Centers for Medicare and Medicaid Services, and the Office of Science and Technology at the White House, as well as other public and private stakeholders.

## Recommendation 6

Administrative simplification measures should be allocated to a new office within the Department of Health and Human Services whose sole mission is to address administrative complexity.

# Potential savings from recommendations

The strategy outlined above has the potential to reduce administrative expenses by about $40 billion per year. About half of those savings would come from implementing the provisions of the Affordable Care Act surrounding operating rules for electronic transactions. The other large sources of savings include integrating electronic medical records with billing systems and minimizing turnover between Medicaid and private insurance plans. (see Table 3)

The biggest unknown comes from the impact that widescale implementation of electronic processes might have. Reducing the need for individualized approval of common requests, for example, could save a significant amount of time, money, and hassle. There are also potential efficiencies that could be gained on the clinical side. However, we do not attempt to estimate these broader opportunities for savings.

**TABLE 3**
## Savings on health care administrative costs

Compilation of savings estimates from administrative simplification reforms

| | Annual savings | Steps needed to achieve savings |
|---|---|---|
| Adoption of electronic transactions* | $21.9 billion | Implement the Affordable Care Act |
| Integrated administrative and clinical health systems | $4.2 billion | Expand HITECH certification criteria for electronic health records to include administrative provisions |
| National provider enrollment and credentialing program | $1.8 billion | Promote unified system across the payers and hospitals |
| Standardized reporting requirements | $0.1 billion | Align quality measures and standardize federal, state, and private-market reporting requirements |
| Stabilize enrollment in public programs | $3.7 billion–$5.8 billion | Coordinate benefits and enrollment across programs |
| Widespread automation Example: electronic adoption and automation of prior authorization | Not estimated $4 billion–$12 billion | Support public and private initiatives aimed at automating administrative processes for payers and providers |
| **Total savings** | **$35.7 billion to $45.8 billion** | |
| Percent of excess administrative costs | 24 percent to 28 percent | |

* Figures represent potential savings per year for the electronic processing of claim submissions, eligibility inquiries and requests, claims status requests, payment, and remittance transactions. Assumes uptake of 85 percent.
Sources include: U.S. Health Care Efficiency Index, UnitedHealth Group Estimates, McKinsey Report Overhauling the U.S. Healthcare Payment System, Milliman Electronic Transaction Savings Opportunities for Physician Practices

The savings we project are about one-quarter of the excess administrative cost as estimated by the Institute of Medicine.[39] To generate its figures of excess administrative costs, the Institute of Medicine relied on both macro and micro analyses. The macro studies compared administrative costs in the United States to those in Canada and other Organisation for Economic Co-operation and Development countries, finding higher levels of excessive administrative spending in the United States. The micro studies, on the other hand, focused on specific health systems and created detailed inventories of administrative expenses.

Our estimates on savings were largely derived from evidence presented in the micro studies. However, it may be that there are synergies across methods, so that when implemented as a whole the savings could be substantially larger, more closely matching the inefficiencies identified in the macro studies. Alternatively, it could be that other countries omit layers of administration that we have not envisioned reducing.

By another metric, the $40 billion number is about 3.5 percent of projected spending on Medicare, Medicaid, and other mandatory federal health programs in 2015.[40] Thus, an aggressive agenda tackling administrative inefficiency would not only reduce unnecessary complexity but could also reduce the cost of medical care overall and could allow physicians more time with patients.

# Conclusion

Administrative complexity exists at all levels of the health care system, resulting in inefficient spending and delays in care. To reduce this burden, we have developed a threefold strategy focused on integration, coordination, and leadership. We recommend that:

- Electronic capabilities for administrative transactions be integrated into health information technology initiatives so that all stakeholders can communicate electronically and in real time to improve care delivery
- Reporting and enrollment systems be coordinated across national, state, and local regulatory bodies to reduce redundant tasks that take away from patient care
- Policymakers exert leadership on administrative simplification reforms to ensure timely and innovative results

Taken together, these efforts could reduce excessive administrative costs by 25 percent, or $40 billion annually.

In a time of large budget deficits, tackling excessive administrative costs offers a promising opportunity for reducing health care costs while improving the care experience.

# Appendix

## Case studies of administrative burdens

To demonstrate the financial and time burdens associated with administrative complexity, we highlight the administrative inefficiencies found in three common billing and insurance related interactions:

- Claims submission and payment
- Eligibility verification
- Provider credentialing

Our analysis of each of these administrative inefficiencies follows.

## Claims submission and payment

### *Anatomy of the transaction*

After a health care provider renders a service for a patient, three interactions typically take place: The provider submits a claim to a payer; after a certain time period, the provider may submit an inquiry to the health plan regarding the status of the claim (a transaction similar to checking the status of a FedEx package during shipment); and lastly, a provider receives a payment, as well as remittance advice, which is the documentation that accompanies the payment and provides details on the type of service reimbursed and the payment rate used. Inefficiencies can arise in each step.

### *Administrative inefficiencies*

In the claims submission process, widespread variation results in human error, unnecessary claims denials, and excessive administrative costs. Different health plans, even within the same insurer, require different data such as complete member identification number, patient demographics, valid procedure and diagnostic

codes, and claimed amount of charges, so providers expend significant resources ensuring that the right information is submitted to the right payers.

In addition, there are no uniform mechanisms to highlight how these data requirements (such as claims codes) or the process and business rules associated with transmitting this data (such as the timeframe for submission) change from year to year across plans and payers.

In steps two and three, uneven adoption of health information technology and the shortcomings of federal legislation have limited the capacity of payers and providers to streamline costs through the use of electronic data transactions. Standards for claim inquiries, remittance, and plan identification were mandated under the Health Insurance Portability and Accountability Act of 1996. These standards were not implemented well, however, and the cost savings have not yet been realized. Other issues such as claims attachments were not implemented under the Health Insurance Portability and Accountability Act, though the Affordable Care Act does require them.

### Potential solutions

Innovations such as real-time claims adjudication systems could produce significant savings for stakeholders across the health care system.[41] Using real-time claims adjudication systems, physicians submit claims to a payer and expect that many of these claims will be immediately auto-adjudicated, which means that claims will be authorized or denied immediately and subsequent payment will proceed without delay. The potential savings are significant: A 10-physician practice in Texas saved $14,000 a year in billing costs using real-time claims adjudication. Another practice reduced accounts receivable by 13 percent and sped average payment collection from 45 days to 6 days.[42]

But adoption efforts have been hampered due to a lack of operating rules, incompatible electronic systems, and staff training costs; as a result, only 2 percent of claims were processed using real-time claims adjudication systems as of 2009.[43] Nevertheless, we anticipate that the new operating rules and standards for claims submission and electronic payments will provide a firm foundation for technological growth in the area of real-time claims adjudication.

## Eligibility verification

### *Anatomy of the transaction*

Eligibility verification is the process of determining whether an individual patient has health insurance coverage and is eligible for specific medical services prior to or at the point of care.

### *Administrative inefficiencies*

The diversity of benefit plan designs, inconsistent electronic capabilities, and nonexistent or poorly designed data reporting requirements produce excessive administrative costs during the process of eligibility verification. Employers, payers, and providers all contribute to this complexity.

Across the country, employer demand has risen for customized health benefit plans—including increased use of benefit carve-outs and specialty services—to lower health care costs. The increased variety of plans drives up costs, which are compounded by the often-long notification periods afforded to employers who retroactively add or terminate employees from their plans. In a survey conducted in 2009, employers in Massachusetts reported being generally unaware of the administrative costs associated with custom plan designs and expressed a willingness to standardize plan options.[44]

Insurers also drive up costs in the system since some companies rely on outdated computer systems to process transactions between payers and providers.

To handle the administrative complexity of this multipayer environment, providers hire clerical staff—or contract out to intermediary organizations such as clearinghouses, companies created to process and submit electronic claims for providers.[45] Yet as of 2009, no single clearinghouse had the capability of processing claims for all payers, and so providers often have to rely on multiple clearinghouses for billing transactions. Thus, even an industry predicated on simplification creates more complexity.[46]

Meanwhile, many providers still rely on manual processes for eligibility verification requests, as well as other transactions, which results in excessive costs. Compared to electronic transactions, verifications conducted via telephone took seven minutes longer and cost about $2.60 more per verification for providers.[47]

## Potential solutions

Possible solutions are in place today in some states and on the horizon in others. The newly established operating rules in this area will standardize these transactions across all payers nationally, reducing variation and facilitating the use of new technologies. The New England Healthcare Exchange Network in Massachusetts and Rhode Island and the Utah Health Information Network have long offered standardized eligibility verification solutions in their regions. In addition, America's Health Insurance Plans—the health insurance industry's trade association—has piloted multipayer electronic verification portals in New Jersey and Ohio, which are now being used in many states.

Another promising way to expedite the eligibility verification process can be found in machine-readable health ID cards, which quickly and accurately transmit policyholder information directly to a provider's electronic patient management system at the point of service. In 2007 the Workgroup for Electronic Data Interchange, a nonprofit organization started by the Department of Health and Human Services in 1991 to improve health care efficiency, released a set of uniform standards for the use of machine-readable cards. Although health insurance groups such as UnitedHealthcare have already implemented more than 30 million ID cards that meet these requirements, many providers lack the technological capabilities to utilize the benefits of this innovation and so continue to use photocopies and other manual processing methods.[48] Utah and Colorado recently enacted laws requiring payers and providers to adopt standardized swipe card technologies.

## Credentialing

### Anatomy of the transaction

Provider credentialing is the process through which health insurers, hospitals, and other health care organizations collect and verify a provider's demographic information, medical qualifications, and practice history.

### Administrative inefficiencies

Complexity arises in credentialing from three sources: the number of regulatory agencies and organizations involved; the variation in information requested across plans; and the separation between payer credentialing and hospital privileging processes. State and federal regulatory bodies, as well as other accred-

iting organizations such as the Joint Commission, the National Council for Quality Assurance, and URAC (formerly the Utilization Review Accreditation Commission), set the standards for the credentialing process. But there is little formal coordination across these groups, producing redundant and expensive data collection at the local, state, and federal levels.

In addition, providers have to contend with separate but parallel credentialing systems across public and private payers, as well as hospitals, each with its own inefficiencies. Medicare, for example, operates an internet-based credentialing system called the Provider Enrollment, Chain and Ownership System. This system was launched by the Centers for Medicare and Medicaid Services in 2003 to centralize the provider enrollment process, which had previously been inconsistently administered by contractors. Since its launch, providers have blasted the system as "archaic and constrained," complaining about long approval times, poor system interface, and bad policies (at the outset, only physicians and nonphysician practitioners, instead of their billing staff, were allowed to access the system).[49]

In response to these complaints and in anticipation of a new policy that will tie Medicare Part B payments to Provider Enrollment, Chain and Ownership System enrollment in July 2011, the Department of Health and Human Services began a review of the program in June 2010. The results are to be released late in 2012.

Some Medicaid agencies have taken a different route, supporting the implementation of the Universal Provider Datasource, a widely used tool created by the Council for Affordable Quality Healthcare to centralize provider information for credentialing programs across payers. Currently, more than 1 million providers are enrolled in the Universal Provider Datasource, and 12 states and the District of Columbia utilize its form as their standard credentialing application.

Although the Universal Provider Datasource has cut claims processing time from months to days, it remains a limited tool. It cannot complete the credentialing process end to end since it does not offer required primary service verification services (the ability to check that a physician claiming a residency in a particular hospital actually completed the residency there, for example), although it is evaluating the potential to develop this capability, and it relies on providers to manually update their information every few months.

Lastly, hospitals continue to support an entirely separate credentialing system to grant hospital privileges. Even though this process collects largely the same

information collected for insurance companies, the applications are separate. Such fragmentation stands in the way of administrative efficiency.

### Potential solutions

Some state governments and private-market stakeholders have introduced reforms in an attempt to streamline this process. The most notable example is the Universal Provider Datasource described above. As noted in the text, we advocate that all credentialing programs, as well as other provider enrollment processes (such as those required to receive electronic funds transfers), be consolidated into one unified operation.

## About the authors

**Elizabeth Wikler** is currently a doctoral candidate in the Harvard doctorate program in Health Policy.

**Peter Basch** is a practicing physician and serves as the medical director for Electronic Health Records and Health IT Policy at MedStar Health. Basch is also a Senior Fellow at the Center for American Progress.

**David Cutler** is the Otto Eckstein professor of applied economics at Harvard University. Culter is also a Senior Fellow at the Center for American Progress.

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