ISSUE BRIEF

BlueCross BlueShield Association

FEBRUARY 2023

DELIVERING LOWER COSTS FOR PATIENTS AND TAXPAYERS THROUGH SITE-NEUTRAL PAYMENT REFORM

OVERVIEW

Medicare pays more for services provided in hospital outpatient departments (HOPDs) than it does when the same services are provided in a doctor's office or another setting outside of the hospital. That disparity affects payment rates under private health insurance plans, which typically use Medicare's reimbursement rates as a basis for paying doctors and hospitals—though generally at higher average rates of payment.

In 2015, Congress passed the Bipartisan Budget Act of 2015 (BBA), which established "site-neutral" payments under Medicare for services received at off-campus HOPDs, unless the location was already billing as a hospital department prior to the date of enactment. This policy restricted new HOPDs from charging patients more for the same medical services that cost less in other care settings. However, current off-campus HOPDs as of 2015, as well as those under construction, were grandfathered into receiving higher rates that are applicable to hospital settings, even though the services are not rendered at a hospital. This exemption also applies to physician practices that are purchased and then incorporated into pre-existing, grandfathered HOPDs.

While the 2015 law made progress on site-neutral payments, these exemptions result in patients and Medicare paying more for the same services without evidence of improvements in the quality of care. Patients who receive services from physician practices pay a lower out-of-pocket (OOP) cost-sharing amount based on Medicare rates for physicians but would pay higher OOP costs should that physician practice be acquired by a hospital and start charging higher rates set for hospitals.

BCBSA RECOMMENDS

To lower health care costs and generate a combined $471 billion in savings over ten years for the federal government, private health insurance premiums and—most importantly—consumers' OOP costs, BCBSA recommends that:

- **Policymakers enact federal legislation to eliminate the grandfathering provision of the BBA, which exempts certain hospital outpatient departments—except emergency departments—from billing limits established under the 2015 law.**
- **Medicare adopt site-neutral payment policies for services that are commonly delivered outside the hospital—excluding rural facilities—at the lower payment rates applicable in non-hospital settings.**
  - **Medicare's move to expand site-neutral payments will smooth the way for private plans to also implement site-neutral payment policies.**

HOPDS OVERCHARGE MEDICARE AND BENEFICIARIES FOR OUTPATIENT SERVICES

- Medicare pays more at an HOPD even when the exact services can be provided in a physician office without any appreciable difference in quality or customer experience. For example, over a three-year period, Medicare paid an additional $2.7 billion on services, and patients spent $411 million more in out-of-pocket costs, when four specific cardiology, orthopedic, and gastroenterology services were delivered in a hospital-owned setting.[1]

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- These overpayments extend to commercial insurers, who often contract with providers based on traditional Medicare rates, although at much higher levels. According to a 2019 study, the average price for a given service was always higher when performed in the HOPD setting, and average prices rose faster in the outpatient setting compared to the physician office setting.[2]

CURRENT POLICY ENCOURAGES ACQUISITION OF PHYSICIAN PRACTICES BY HOPDS

- The HOPD payment policy creates a strong financial incentive for hospitals to continue purchasing physician practices and for physicians to sell their practices, which gives these newly merged entities a stronger hand when negotiating payment rates with commercial insurers. In fact, the share of physician practices owned by hospitals more than doubled from 2012 to 2018.[3] In many cases, the same physician is still providing the same services to the same patients at the same location—but that location is now an HOPD and is eligible for a higher payment.

The share of physician practices owned by hospitals

MORE THAN DOUBLED
from 2012 to 2018

- This payment practice has led to a shift in the locus of care away from physician offices to HOPDs with higher billing rates. MedPAC's March 2018 report stated the hospital outpatient setting has had higher growth in program spending than any other sector in Medicare, and a large source of that growth "appears to have been the shift of services from (lower cost) physician offices to (higher cost) HOPDs."[4]

HOPDS CHARGE HIGHER PRICES, BUT DO NOT DELIVER HIGHER QUALITY CARE

- For many services, there is little or no evidence that the quality of care is higher when they are provided in a hospital setting, and MedPAC has found that patient severity has little effect on the costs incurred by HOPDs for services that can safely be provided in physician offices.[5]

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of physicians in the United States were practicing medicine independently.

1. Physicians Advocacy Institute. "Implications of Hospital Employment of Physicians on Medicare & Beneficiaries." November 2017. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI_Medicare%20Cost%20Analysis%20--%20FINAL%2011_9_17.pdf.
2. Hargraves, John and Reiff, Julie. Health Care Cost Institute. "Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices." April 2, 2019. https://healthcostinstitute.org/hcci-research/shifting-care-office-to-outpatient
3. Physicians Advocacy Institute. "Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012-2018." February 2019. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf.
4. MedPAC. "March 2018 Report to the Congress: Medicare Payment Policy." March 15, 2018. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar18_medpac_entirereport_sec_rev_0518-pdf/.
5. For example, see Marion Aouad, Timothy T. Brown, and Christopher M. Whaley. "Reference Pricing: The Case of Screening Colonoscopies." Journal of Health Economics, vol. 65 (May 2019). https://www.sciencedirect.com/science/article/abs/pii/S0167629618306209. Also see Medicare Payment Advisory Commission Report to Congress, June 2022, Chapter 6. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf.

- In a study for PAI, Avalere examined the impact of the COVID-19 pandemic on physician practice acquisition in 2019 and 2020, finding that 48,400 additional physicians left independent practice during the two-year study, and, by the beginning of 2021, only 30% of physicians in the United States were practicing medicine independently.

SITE-NEUTRAL POLICIES SIGNIFICANTLY LOWER COSTS

BCBSA commissioned a cost impact analysis by former Congressional Budget Office (CBO) economist Phil Ellis. In total, Ellis estimates[6] that expanding site-neutral payment policies as BCBSA recommends would yield a combined savings of $471 billion over the 2024-2033 period for the Medicare program, private insurance premiums and enrollees' out-of-pocket costs as noted in the table below.

Estimated Savings from Adopting Site-Neutral Payment Policies Under Medicare ($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024-2033
Federal Savings	13.4	15.1	16.5	18.4	20.1	22.2	25.3	28.9	33.1	38.0	231
Private Premium Savings	8.0	8.8	9.5	10.2	11.1	12.0	12.9	13.9	14.9	16	117
Enrollees' OOP Savings	8.8	9.9	10.9	12.1	13.3	14.7	16.7	19.0	21.8	25.1	152

6. Philip Ellis. "Estimated Savings from Adopting Site-Neutral Payment Policies for Medicare," Ellis Health Policy, February 2023. https://www.bcbs.com/sites/default/files/file-attachments/affordability/Phil_Ellis_Site_Neutral_Payment_Cost_Savings_Report_BCBSA_Feb_2023.pdf.