ESTIMATED SAVINGS FROM ADOPTING SITE-NEUTRAL PAYMENT POLICIES FOR MEDICARE

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SUMMARY

Medicare pays more for services provided in hospital outpatient departments 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, since those plans typically use Medicare's system as a basis for paying doctors and hospitals (though generally at higher average rates of payment). Many experts have recommended that Medicare adopt site-neutral payment policies for services that are commonly delivered outside the hospital—at the lower payment rates applicable in non-hospital settings—with exemptions for rural hospitals. Adopting site-neutral payments would not only cut Medicare spending substantially, but also would reduce costs and premiums for private health insurance plans due to the links between Medicare's rates and private payment rates.

Adopting site-neutral payment policies for Medicare would yield savings for the Medicare program, for private insurance premiums, and for enrollees' out-of-pocket (OOP) costs that sum to $471 billion over the next 10 years. Medicare's savings would total $202 billion over the 2024-2033 period. Medicare enrollees would also save about $67 billion on their Part B premiums and another $67 billion on cost-sharing. Additionally, premiums for private health insurance plans would be about $107 billion lower over that period, which would amount to a reduction in aggregate premiums of 0.75 percent. That reduction in private insurance premiums would increase federal tax revenues by about $29 billion, bringing total federal savings from adopting these site-neutral payment policies to $231 billion. And enrollees in those private plans would save another $18 billion on their cost-sharing because of the lower payment rates—bringing total OOP savings for enrollees across Medicare and private plans to $152 billion. Table 1 summarizes those savings.

TABLE 1. Estimated Savings from Adopting Site-Neutral Payment Policies Under Medicare

($ Billions)

Federal Savings	Fiscal Years 2024-33
Medicare Savings	**202**
Revenue Increases	**29**
TOTAL	**231**
Private Premium Savings	**117**
Enrollees' OOP Savings	**152**
COMBINED SAVINGS	**471**

OOP = Out-of-Pocket Costs

Additional savings could accrue to the Medicaid program, which would be split between the federal government and state governments. And additional private-sector savings might arise if a site-neutral payment policy discouraged some future purchases of physician groups by hospitals—purchases which have increased the concentration of markets for physician services and pushed up private-sector prices for those services.

BACKROUND ON PAYMENT RATE DIFFERENTIALS AND PROPOSALS

One recent analysis of this issue described it well: "The Medicare program pays different rates for equivalent or identical services depending on where the service is performed. Generally, procedures performed in hospital outpatient departments are paid at a higher rate than the same procedures performed in a physician's office or an ambulatory surgical center."[1] Table 2 illustrates the differences, using the example of payments in 2022 for a simple chest x-ray.[2] If that service was provided in a free-standing doctor's office or an ambulatory surgical center (ASC), the total payment to the provider under Medicare was a little more than $26. But if that service was provided in a hospital outpatient department (HOPD), the total payment under Medicare rose to about $92—more than three times as much.

1 Committee for a Responsible Federal Budget, "Equalizing Medicare Payments Regardless of Site-of-Care" (February 23, 2021), https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.

2 Medicare's physicians fees come from https://www.cms.gov/medicare/physician-fee-schedule/search; Medicare's facility fees come from the "2022 Procedure Price Lookup Comparison File," which is available here: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppsannual-policy-files/2022.

TABLE 2. Comparison of Medicare Payment Rates in 2022
Chest X-Ray, Single View (CPT Code = 71045)

	Physician Office	Ambulatory Surgical Center	Hospital Outpatient Department
Physician Fee	26.65	9.00	9.00
Facility Fee	-	17.30	82.61
TOTAL	**26.65**	**26.30**	**91.61**

NOTE: Amounts reflect total payments to providers, including Medicare payments and cost-sharing liabilities

More complex services may require treatment in a facility, but Medicare still pays substantially more if that facility is an HOPD rather than an ASC. Table 3 below illustrates the differences using two examples: screening colonoscopies for patients who are not high-risk; and magnetic resonance images (MRIs) of an upper extremity joint without contrast dye. In the case of colonoscopies, Medicare's allowed amount for a hospital was 67 percent higher, and in the case of MRIs, the total hospital payment was 62 percent higher.

For many services, there is little or no evidence that the quality of care is higher when they are provided in a hospital setting.[3] In some cases, physician offices were simply purchased by hospitals and relabeled as an off-campus part of the hospital's outpatient department. The resulting higher payments provide one incentive for that organizational change.

In that light, the Medicare Payment Advisory Commission (MedPAC) and others have recommended establishing site-neutral payment policies for Medicare—and generally setting the site-neutral rates at the lower total payment levels that would apply for care provided outside a hospital. In 2020, the Trump Administration proposed such policies, which would have applied only to services "commonly performed in non-hospital settings" and would have exempted rural hospitals.[4] The Congressional Budget Office (CBO) scored that set of proposals as saving Medicare $141 billion over the 2021-2030 budget window that applied at that time.[5] That analysis implies that the proposals would reduce Medicare spending on HOPD services by

[3] 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.

[4] HHS Budget in Brief for FY 2021, page 82, https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf.

[5] See CBO's 2020 analysis of the Administration's proposals affecting Medicare, which is posted here: https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf. As discussed below, the $141 billion estimate combines the effects of two components of the site-neutral proposal (numbers 38 and 39).

about 11 percent, which is equivalent to a reduction in Medicare's payments for all hospital services of about 4 percent.

TABLE 3. Comparison of Medicare Payment Rates in 2022

	Ambulatory Surgical Center	Hospital Outpatient Department	Ratio
Colonoscopy (CPT Code: G0121)			
Physician Fee	187.22	187.22	100%
Facility Fee	410.63	810.48	197%
TOTAL	**597.85**	**997.70**	**167%**
MRI, Upper Extremity (CPT Code: 73221)			
Physician Fee	66.79	66.79	100%
Facility Fee	119.06	235.00	197%
TOTAL	**185.85**	**301.79**	**162%**

NOTE: Amounts reflect total payments to providers, including Medicare payments and cost-sharing liabilities

Physician Offices Located Off-Campus. As noted above, the higher payments made for comparable services when provided by HOPDs have provided an incentive for hospitals to purchase physician practices and incorporate them into their HOPDs—even if the physician offices are located away from the hospital's campus. Congress prohibited such off-campus Provider-Based Departments (PBDs) that were purchased after 2015 from billing Medicare as HOPDs, but allowed off-campus PBDs that had already been purchased or established to be grandfathered. As MedPAC has noted, however, those exempted PBDs "have no restrictions on expanding the range of services they provide. Therefore, if a hospital acquires a physician practice and adds it to an existing off-campus PBD that is excepted from the [2015 law], the services furnished by that practice would be paid at full [HOPD] rates."[6]

The Centers for Medicare and Medicaid Services (CMS) has made certain payments site-neutral through regulation. Specifically, Medicare has been paying a comparable amount for evaluation and management (E&M) visits provided in freestanding physician offices and in off-campus HOPDs since 2019. However, Medicare continues to pay a higher amount for such visits when they are provided in on-campus HOPDs. MedPAC reported that in 2018, the total payment for the most common type of E&M visit for an established patient "when provided in an HOPD was $166 ($52 for the fee schedule payment to the clinician plus $114 for the facility

[6] See page 166 of MedPAC's Report to Congress (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf.

payment to the HOPD), compared with $74 (the non-facility fee schedule payment) for this visit when provided in a freestanding office."[7]

In that light, the Trump Administration's proposal for site-neutral payments included a policy of paying all hospital-owned physician offices located off-campus the physician office rate—rather than the higher HOPD rate. In other words, PBDs established before 2016 would no longer be grandfathered. CBO's estimate of Medicare savings from that component of the proposal was $39 billion, or about 28 percent of the $141 billion in total savings to Medicare from site-neutral payments. This analysis incorporates that component of the proposal as an element of site-neutral payment policy.

KEY FACTORS AFFECTING ESTIMATES FOR PRIVATE SPENDING

In its 2020 analysis, CBO did not estimate effects on private sector spending related to those proposals—because if the agency had done so, the estimate would have included effects on federal revenues stemming from them. However, a reasonable case can be made that such effects would arise, at least to some extent. Of course, there are uncertainties about what the effects on private sector prices and spending would be if Medicare adopted site-neutral payment policies. The uncertainties involved can be divided into those related to estimating effects on private-sector prices and those related to estimating the quantity of relevant services provided by HOPDs under private insurance.

Effects on Private-Sector Prices. A primary argument for spillover effects on private-sector prices is that private insurers generally use Medicare's payment system and simply vary their average level of payments compared with Medicare's rates—such as paying 150 percent of Medicare's fee schedule—while using the same ratios of payments across different services as are set by Medicare. From that perspective, a reduction in Medicare's fees to hospitals for services commonly performed in other settings would have the same proportionate effect on private sector prices for those services. A counter-argument is that, unlike Medicare, insurers have to negotiate their payment rates with hospitals—and some hospitals may have enough bargaining leverage to force insurers to continue paying higher rates for HOPD services (rates which reflect the higher costs of care overall in the hospital setting).[8]

A recent study by Clemens and Gottlieb sheds important light on the question of how changes in Medicare's rates affect commercial pricing—and its findings tend to support the argument that commercial prices move largely in parallel with Medicare's fee schedule.[9]

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[7] See page 111 of MedPAC's Report to Congress (March 2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar19_medpac_ch4_sec.pdf.

[8] An alternative formulation of this viewpoint might be that hospitals would accept a reduction in commercial fees for services subject to a site-neutral payment policy – but would seek and obtain offsetting increases in other payment rates, reducing or perhaps even eliminating savings under commercial insurance.

[9] Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments," *Journal of Political Economy*, vol. 125, no. 1 (February 2017), https://www.journals.uchicago.edu/doi/10.1086/689772.

As the authors put it, the "benchmarking of private payments to Medicare's menu can generate a mechanical relationship between changes in Medicare's relative payments and corresponding private payments. Over the long run, renegotiations of insurer-physician contracts should tend to reverse mechanical price changes that the parties find deleterious. The extent of these subsequent revisions is an empirical question to which our analysis can speak."

Their study examined changes in Medicare's fee schedule and found that an increase in Medicare's fees of $1.00 led to an increase in private payment rates of $1.16, on average. The study used several years of data, in order to capture any offsetting effects of subsequent contract renegotiations. The authors found that private payment rates were about 45 percent higher than Medicare's rates, on average, in the period they examined. A full pass-through of Medicare's price changes to private rates would thus have raised private rates by $1.45 for each $1.00 increase in Medicare's rates. Their finding that the average effect was $1.16 thus suggests that about 80 percent of Medicare's price changes ($1.16/$1.45) were ultimately passed through to private prices, with the remainder offset vis subsequent renegotiations.

Quantities of Relevant HOPD Services. The effects on spending of changing prices for private insurance plans also depend on the quantities of those services that are provided. In particular, deriving an estimate for private insurance premiums that is comparable to CBO's estimate for Medicare requires a comparison of utilization rates for the relevant HOPD services between commercial plans and fee-for-service Medicare.

Studies from several years ago suggest that those utilization rates were broadly similar in percentage terms, at least for some services commonly provided outside the hospital. For example, a study by the Health Care Cost Institute using private-sector claims data found that the overall share of relevant services that were performed in HOPDs was about 11 percent in 2009 and rose gradually to about 13 percent in 2017.[10] For echocardiograms, roughly 30 percent were provided by hospitals—with payments in that setting averaging between $1,100 and $1,300 in 2017, compared with $300-$350 for office-based echocardiograms. By way of comparison, an earlier analysis of fee-for-service Medicare claims by MedPAC found that about 35 percent of echocardiograms were provided by HOPDs in 2012.[11] And a more recent MedPAC analysis of Medicare claims found that the share of office visits provided in HOPDs had risen from about 10 percent in 2012 to about 13 percent in 2019.[12]

In recent years, however, private insurers have taken further steps to discourage enrollees from receiving those services from hospitals—which implies that the share of spending affected under private plans would be lower than observed for Medicare over the coming decade. For example, Anthem (now Elevance) announced in 2017 that it would stop

[10] John Hargraves and Julie Reiff, "Shifting Care from Office to Outpatient Settings: Services are Increasingly Performed in Outpatient Settings with Higher Prices," Health Care Cost Institute (April 2, 2019), https://healthcostinstitute.org/in-the-news/shifting-care-office-to-outpatient.

[11] See Table 3-8 on page 76 of MedPAC's Report to Congress (March 2014), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar14_ch03.pdf.

[12] See Table 6-1 on page 166 of MedPAC's Report to Congress (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v2_SEC.pdf.

paying for MRIs and CT scans performed on an outpatient basis in hospitals across the country.[13] And in 2019, UnitedHealthcare announced that it "will not pay for certain planned surgeries delivered at outpatient hospital settings unless it determines the site is medically necessary after a review."[14]

Private insurers may also have limited their costs for HOPD services by requiring enrollees to pay higher cost sharing when using those services—which not only discourages enrollees from getting care at the more expensive site, but also tends to reduce or perhaps eliminate the difference in the insurers' costs between settings. By contrast, the fee-for-service Medicare program has uniform cost-sharing requirements, which generally expose beneficiaries to 20 percent of the difference in costs between services—and a large share of enrollees have supplemental insurance which fully covers that cost-sharing.

ESTIMATED SAVINGS FOR MEDICARE AND PRIVATE INSURANCE

Updating CBO's estimate of savings for a site-neutral payment policy to cover the 10-year budget window that will apply this year (2024-2033), the proposal would save Medicare an estimated $202 billion. Those savings represent 11.2 percent of Medicare's spending on HOPD services over that period—or about 4 percent of total Medicare spending on hospital inpatient and outpatient services combined. For enrollees, the reductions in Medicare's payments and spending would also reduce their Part B premium payments by about $67 billion and would reduce their cost-sharing liabilities by another $67 billion.[15]

The effects of site-neutrality on total hospital payments under private insurance would be smaller than the 4 percent reduction estimated for Medicare, for the two main reasons discussed above. First, spending under private insurance plans on HOPD services that are commonly provided outside the hospital probably represents a smaller share of private hospital spending that has been observed under Medicare. While there is considerable uncertainty about the extent of that gap, a reasonable assumption is that the spending involved is about half as large (as a proportion of total hospital payments under private insurance). Second, it also seems reasonable to assume that contract renegotiations with hospitals would offset 20 percent of those savings (based on the study discussed above). Combining those factors, the savings from site-neutrality under private insurance would amount to about 1.6 percent of total hospital spending.

[13] Shelby Livingston, "Anthem's New Outpatient Imaging Policy Likely to Hit Hospitals' Bottom Line," *Modern Healthcare* (August 26, 2017), https://www.modernhealthcare.com/article/20170826/NEWS/170829906/anthem-s-new-outpatient-imaging-policy-likely-to-hit-hospitals-bottom-line.

[14] Shelby Livingston, "UnitedHealthcare Outpatient Surgery Policy Threatens Hospital Revenue," *Modern Healthcare* (October 17, 2019), https://www.modernhealthcare.com/payment/unitedhealthcare-outpatient-surgery-policy-threatens-hospital-revenue.

[15] For enrollees with Medigap plans that cover their cost-sharing requirements, the savings would generally come in the form of lower premiums for those plans – which would be spread across all policyholders. Note also that the savings estimates for Medicare include effects on payments for Medicare Advantage plans.

Using those assumptions, adopting site-neutral payment under Medicare starting in 2024 would yield an estimated reduction in costs and premiums for private-sector insurance plans of $117 billion over 10 years—which amounts to a cut in costs and premiums of 0.74 percent (relative to projections made under current law). About 25 percent of those savings would accrue to the federal government as increased revenues related to employer-sponsored insurance and reductions in costs for federal tax subsidies for marketplace plans.[16] As a result, federal revenues would increase by about $29 billion over 10 years, and total federal savings under this option would come to $231 billion.

Table 4 shows those effects by year. The figures for enrollees' OOP savings combine the effects of reductions for Medicare beneficiaries in their Part B premiums and reductions in their cost-sharing liabilities resulting from the reductions in Medicare's payments for HOPD services that are commonly provided outside the hospital, as well as savings on cost-sharing for private plans enrollees stemming from the reduction in payment rates.

TABLE 4. Estimated Savings from Adopting Site-Neutral Payment Policies Under Medicare
($ Billions by Calendar Year)

	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	**2024-33**
Federal Savings											
Medicare Savings	11.4	12.9	14.2	15.9	17.4	19.2	22.1	25.4	29.3	34.0	**202**
Revenue Increases	2.0	2.2	2.4	2.6	2.8	3.0	3.2	3.5	3.7	4.0	**29**
TOTAL	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	16.0	**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**
COMBINED SAVINGS	28.3	31.5	34.5	38.2	41.7	45.9	51.7	58.3	66.1	75.2	**471**

OOP = Out-of-Pocket Costs

OTHER POTENTIAL EFFECTS ON SPENDING AND PREMIUMS

The estimates shown above do not include effects on Medicaid spending—which could plausibly arise, but are more difficult to estimate. A large share of Medicaid spending on acute care is now administered by managed care companies, but they probably use the same basic payment system as Medicare and commercial plans to pay for outpatient hospital care and physician services. For that reason, Martin Gaynor of Carnegie Mellon University has posited that Medicare's adoption of site-neutral payment policies "would likely increase the probability

[16] The vast majority of these effects would stem from reductions in costs for employer-sponsored insurance, which are not treated as taxable compensation and thus are effectively subsidized by the federal government. Reductions in those costs would shift the composition of compensation from non-taxable health benefits to taxable wages, holding total pre-tax compensation about the same – and resulting in higher federal revenues.

that Medicaid and private insurance also change their policies, thereby substantially magnifying the benefits of the policy change."[17]

Little information is readily available about state payment policies regarding site-neutrality, or about Medicaid enrollees' use of HOPDs for services that are commonly provided outside the hospital. In general, Medicaid plans probably manage the use of HOPD services in a manner that is similar to private health insurance plans. If Medicare's adoption of site-neutral payments had the same proportional effects on Medicaid spending as for private insurance—reducing its costs by about 1.6 percent of the program's hospital spending—then total program savings would be roughly $50 billion over 10 years, of which the federal government would capture about $30 billion.

Another effect of site-neutral payment that Gaynor highlighted is a reduction in the incentives for hospitals to purchase physician practices. In turn, that would reduce growth in the concentration of physician markets—growth which puts upward pressure on prices for physician services. Those purchases may also encourage physicians to refer patients to HOPDs more often for follow-on care. As one recent analysis put the matter, "site-of-service payment differentials are not the only factor driving hospitals to acquire physician practices, [but] they likely do play some role and are perhaps the most straightforward to address. Embracing a policy of site-neutral payments could thus save Medicare a considerable sum of money while simultaneously generating savings for private payers by addressing one driver of provider consolidation."[18]

Quantifying the effects of site-neutrality on concentration is difficult, but CBO also identified Medicare's current payment policies as a factor causing more concentration in the markets for physician services.[19] Additionally, CBO reviewed the evidence on the impact of higher concentration on private-sector prices for those services and found that a 10 percent increase in concentration leads to an increase in physicians' prices of 0.8 percent. Private insurers are projected to spend nearly $4.9 trillion over the next decade on physician services—so even a small change in percentage terms would amount to considerable sums of money. More research is thus needed to help establish the empirical effects of site-neutral payment policies on consolidation among doctors.

[17] See page 19 of Martin Gaynor, "What to Do about Health-Care Markets? Policies to Make Health-Care Markets Work," *The Hamilton Project* (March 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf.

[18] Loren Adler and others, "CMS' Positive Step on Site-Neutral Payments and the Case for Going Further," Brookings-Schaeffer Initiative for Health Policy (August 10, 2018), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/08/10/cms-positive-step-on-site-neutral-payments-and-the-case-for-going-further/.

[19] CBO, "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," (September 29, 2022), https://www.cbo.gov/publication/58222.