Blue Health Intelligence®

RISING PRICES FOR HOSPITAL OUTPATIENT CARE FAR OUTPACE MORE AFFORDABLE SITES

EXECUTIVE SUMMARY

From 2017 to 2022, prices for medical services commonly provided in outpatient settings were significantly higher when delivered in a hospital outpatient department, and they grew rapidly over the six years. By comparison, prices for the same services were significantly lower when delivered in an ambulatory surgery center or a physician's office, and price growth over time was relatively modest. These findings suggest that site-neutral payments — billing the same amount for the same service regardless of site of care — across care delivery settings would result in substantial savings for employers, employees, and patients.

Issue: The amount paid for common outpatient healthcare services differs significantly whether they are performed in a hospital outpatient department (HOPD), an ambulatory surgery center (ASC), or a physician's office.

A key driver of these cost differences is the acquisition of physician practices by hospitals over the past 20 years. By delivering care in HOPDs instead of office settings, providers can bill higher amounts to Medicare, including both a facility fee and a physician's fee. To address this, Congress passed the Bipartisan Budget Act of 2015. The law required that, except for emergency services, off-campus providers be paid under a Medicare Part B payment system rather than the outpatient prospective payment system (OPPS) for Medicare services.

While site-neutral payments for services paid by Medicare began in 2017, little is known about price trends for outpatient services in the commercial insurance sector.

Approach: To learn more, Blue Health Intelligence® (BHI®) used a national commercial data set of 133 million lives insured by a PPO product to answer the following question: For the period between 2017 and 2022, how did allowed costs change over time for six services commonly delivered in HOPDs, ASCs, and physician offices?

Findings: We found that the allowed costs for all six procedures were substantially higher when performed in the HOPD setting. Further, we found that for most of these procedures, the difference in allowed costs grew faster over time in HOPDs than it did in ASC or office settings.

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INTRODUCTION

There has been tremendous physician and facility consolidation over the last two decades[1, 2]. While this consolidation was initially spurred by policies encouraging clinical integration, the financial benefits of consolidation for both hospitals and physicians accelerated the trend. COVID-19 added fuel to the fire: Between January 2020 and January 2022, 12% of remaining independent physician practices were acquired, resulting in over 52% of physicians being employed by hospitals or health systems (an additional 20% are employed by non-hospital-based corporations)[3].

This consolidation has increased health system bargaining power, resulting in higher payment rates in provider contracts and higher commercial health insurance premiums. Medicare has been less impacted due to its national pricing policies. However, one additional consequence of consolidation did result in substantial growth in Medicare expenditures: hospital-acquired physician practices and providers began billing their services as HOPDs under Medicare's OPPS.

Under Part B, Medicare makes a single payment for services rendered in a free-standing physician's office or ASC. This single bundled payment is primarily comprised of a professional fee, which covers the work of the physician, and a technical fee, which covers the room, technology, and ancillary services (there are additional small fees for malpractice expense and geography). For services billed as delivered in an HOPD, there are two payments: one for the physician's professional fee and one for the facility fee using Part A. HOPD facility fees are meant to cover the higher costs associated with running a full-service hospital and are significantly higher than the reimbursement for the technical components associated with free-standing physician offices or ASCs.

Commercial health insurance payment policies are determined in contract negotiations between the health plan and the provider. However, it is also quite common for health plans to pay a much higher rate (including the facility fee) for procedures delivered in HOPDs. Indeed, the growing bargaining power of providers has widened the gap between payment rates for procedures provided in physician offices and the rates for those same procedures when provided in HOPDs. For example, the following tables show a typical commercial payment rate for mammography, a common outpatient procedure, when performed in a physician's office compared with the rate in an HOPD.

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Office Setting				
Claim Type	**Claim ID**	**Procedure Code**	**CPT Code Description**	**Allowed Cost**
Bundled Claim	12345	G0202	SCR MAMMO BI INCL CAD	$232.00
			Total Cost	**$232.00**

HOPD				
Claim Type	**Claim ID**	**Procedure Code**	**CPT Code Description**	**Allowed Cost**
Professional Claim	55677	77052	COMP SCREEN MAMMOGRAM	$3.50
		G0202	SCR MAMMO BI INCL CAD	$40.00
Facility Claim	77765	77052	COMP SCREEN MAMMOGRAM	$78.00
		G0202	SCR MAMMO BI INCL CAD	$236.00
			Total Cost	**$357.50**

Over the years, various legislative efforts such as site-neutral payment policies and fair billing laws, have sought to equalize reimbursement across settings. In 2015, Congress passed the Bipartisan Budget Act which required, for all non-emergency services, newly acquired off-campus providers to be paid under Medicare's Part B payment system rather than the OPPS and that all office visits be billed under Part B, regardless of setting.

RESEARCH OBJECTIVES

BHI examined the impact of hospital acquisitions of physician practices on the prices Blue Cross Blue Shield Plans paid for outpatient services in the commercial insurance market. We examined billing practices between 2017 and 2022 for 10 select services that were rendered in a physician's office, ASC, and/or HOPD, using a national data set of commercial PPO members. We specifically assessed whether allowed costs across the office, ASC, and HOPD settings differed and whether they were constant or changed during these six years.

BHI analyzed:

- Longitudinal commercial data to examine billing patterns of targeted services.
- The allowed cost differences for select services (see methodology) among HOPDs, ASCs, and physicians' offices.

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METHODOLOGY

To examine the difference in allowed costs for commonly rendered outpatient services across settings and over time, we analyzed national PPO commercial claims data for approximately 133 million members from 2017 through 2022 (we analyzed 2014 through 2022 for office visits). The study population comprised members who resided in the U.S. and had medical and hospital benefits and primary health care coverage through a large commercial insurance provider. Managed Medicaid and Medicare Advantage members were excluded from the study.

We selected the following procedures for analysis:

- Cataract surgery
- Chest X-ray
- Clinic visits
- Colonoscopy (diagnostic and screening)
- Ear tympanostomy
- Mammography
- Pulmonary stress test
- Rehabilitation
- Transthoracic echocardiography
- Upper extremity MRI

We selected the procedures due to their expected high volume in at least two of the following settings: HOPD, ASC, and physician office. MRIs, transthoracic echocardiograms, rehabilitation, and pulmonary stress tests did not have sufficient volume, so they are not broken out in detail within the brief. We also selected elective services for which patients might shop different providers or choose more cost-effective service locations. BHI performed the analyses at the CPT code-line level.

RESEARCH QUESTION

The analysis addressed two questions:

1. Do commercial insurers pay more for services rendered in HOPDs than those rendered in an ASC or office setting?
2. If they pay more, have the relative differences across settings changed over the most recent six years (for clinic visits, we evaluated services from 2014-2022)?

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Six of the 10 procedures chosen for this analysis had significant volume in at least two of the settings and are the focus of the analyses. They include:

Procedures Per 10,000 Members in 2022			
	Care Setting		
Procedure Category	**ASC**	**HOPD**	**Office**
Mammography	.19	547.8	377.0
Colonoscopy screening	11.2	15.2	1.3
Diagnostic colonoscopy*	79.1	87.3	12.2
Cataract surgery	19.7	7.3	1.6
Ear tympanostomy	4.6	8.6	2.6
Clinic visit	1.5	1,157.5	23,288.4

* A biopsy or excision occurred in addition to the colonoscopy.

Total Procedure Count for 2022			
	Care Setting		
Procedure Category	**ASC**	**HOPD**	**Office**
Mammography	1,086	3,069,370	2,112,281
Colonoscopy screening	62,768	85,295	7,152
Diagnostic colonoscopy	443,335	489,409	68,559
Cataract surgery	110,372	41,312	9,184
Ear tympanostomy	25,733	48,343	14,802
Clinic visit	8,672	6,485,708	130,485,018

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RESULTS

Allowed costs for services rendered in an HOPD were consistently and significantly higher than for those rendered in an ASC or office setting.

These higher costs are reflected in higher insurance premiums and higher out-of-pocket costs to consumers. While some procedures have larger cost differentials than others, HOPD allowed costs were higher across all six services evaluated. HOPD allowed costs also consistently increased across the study years.

Figure 1. Mammography Screening Allowed Costs per Procedure Between 2017 and 2022

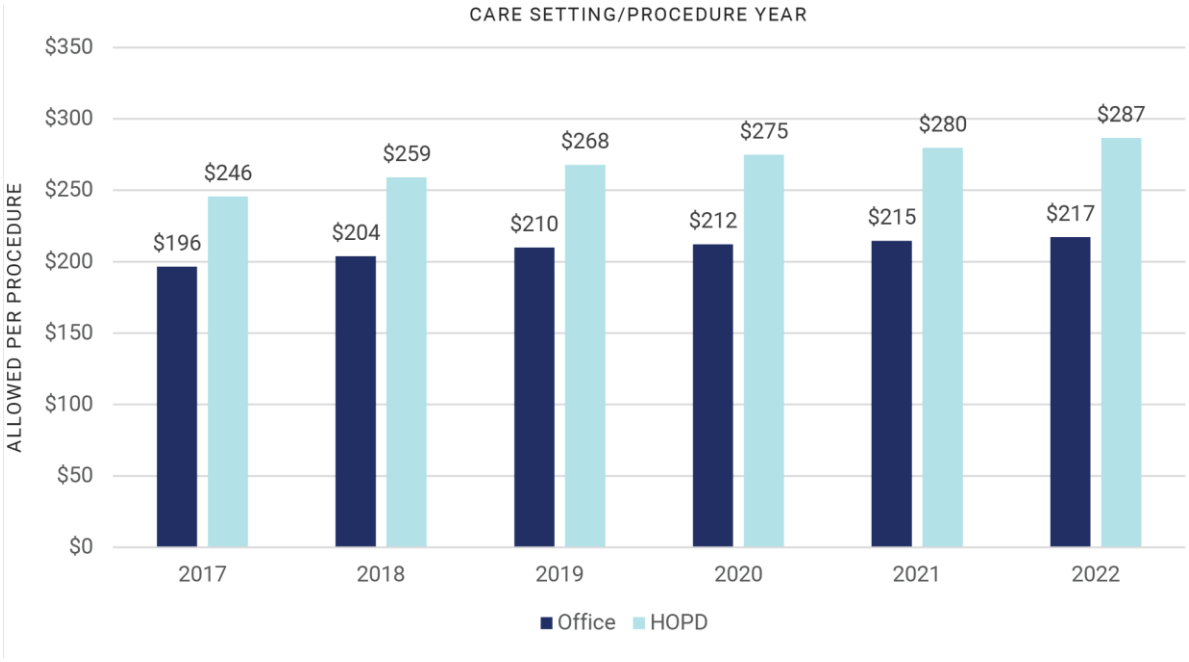

Figure 1 shows changes in allowed costs for mammography between 2017 and 2022 in office and HOPD settings. ASC allowed costs are not shown because mammography, performed in an ASC, makes up less than .02% of total mammography procedures.

Mammography services were the closest in terms of allowed costs across settings; however, HOPDs still had the highest costs. In 2022, mammography HOPD costs were 32% higher than those rendered in an office setting. Again, the cost differentials grew faster in the HOPD setting.

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Figure 2. Colonoscopy Screening Allowed Costs per Procedure Between 2017 and 2022

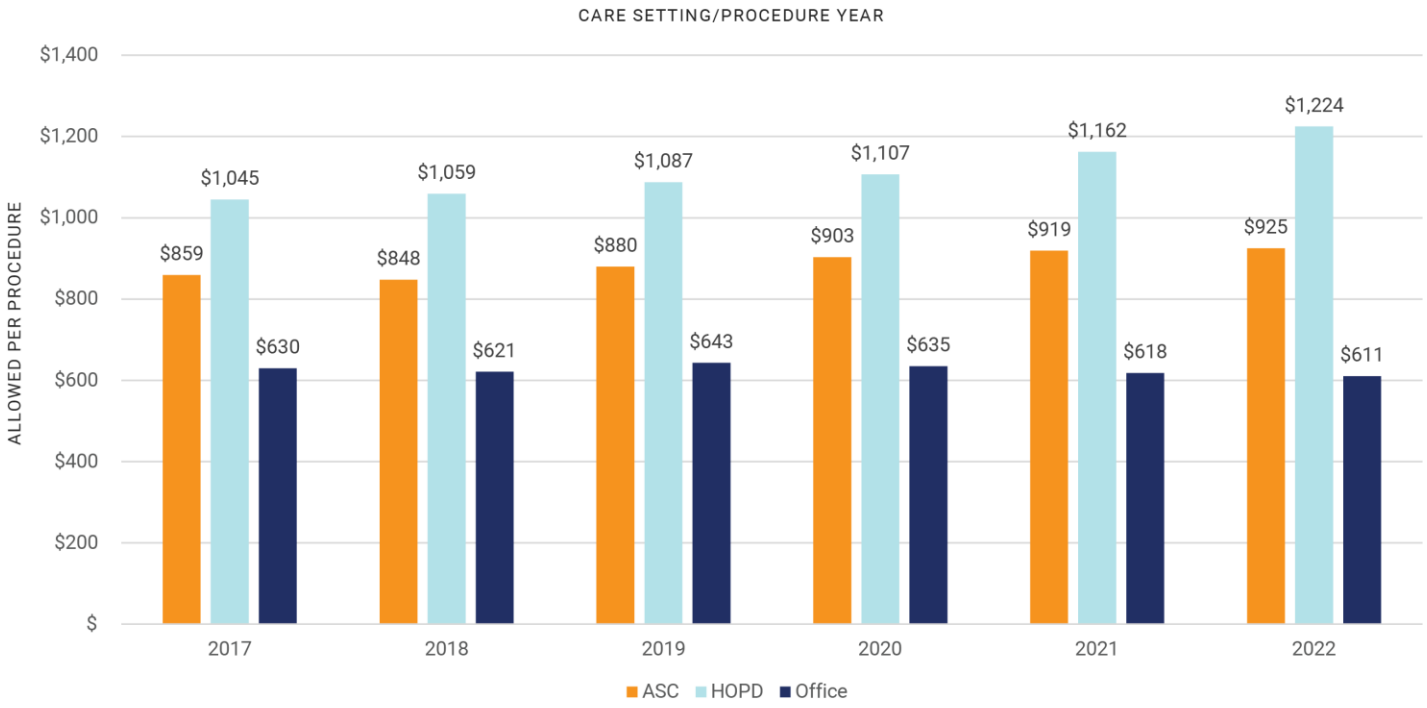

Figure 2 shows changes in allowed costs for colonoscopy screenings between 2017 and 2022 in ASC, HOPD, and office settings. Out of the total procedure volume for 2022, 55% occurred in an HOPD, 40% in an ASC, and 5% in the office setting.

Allowed costs for colonoscopy screenings rendered in an HOPD were 32% higher than those performed in an ASC. Colonoscopies were also conducted more often in the HOPD setting than in the ASC and office settings. Between 2017 and 2022, allowed costs increased by 18% for colonoscopy screenings in an HOPD setting, but only by 8% for the same timeframe in an ASC. Costs for colonoscopy screenings in the office setting were even lower – only half as much as in an HOPD. Moreover, those costs declined slightly from 2017.

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Figure 3. Diagnostic Colonoscopy Allowed Costs per Procedure Between 2017 and 2022

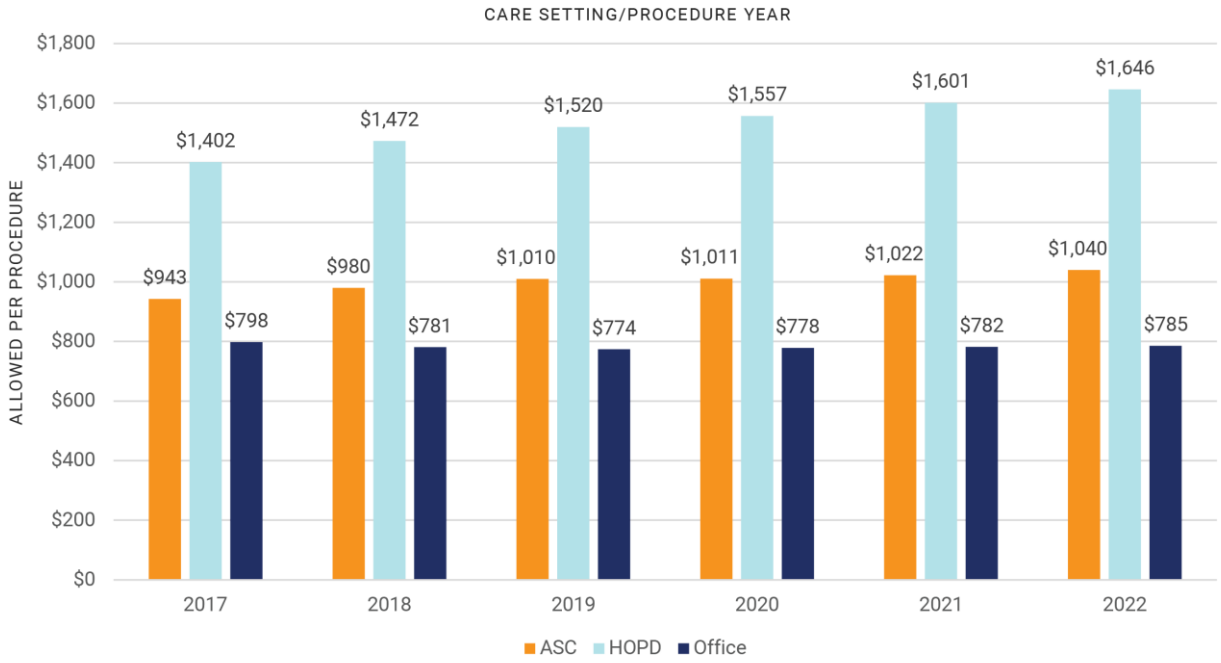

Figure 3 shows changes in allowed costs for diagnostic colonoscopies. Out of the total procedure volume for 2022, 49% occurred in an HOPD, 44% in an ASC, and 7% in the office setting.

In 2022 for diagnostic colonoscopy, where providers performed a biopsy or other procedure in addition to the colonoscopy, allowed costs in an HOPD were 58% higher than those in an ASC. Costs for diagnostic colonoscopies rendered in the office setting were lower – the allowed costs were less than half of the costs for the same procedure rendered in an HOPD. Costs in the office setting also remained fairly flat. Between 2017 and 2022, costs in an HOPD increased by 17%, whereas costs in an ASC only increased by 10%.

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Figure 4. Cataract Surgery Allowed Costs per Procedure Between 2017 and 2022

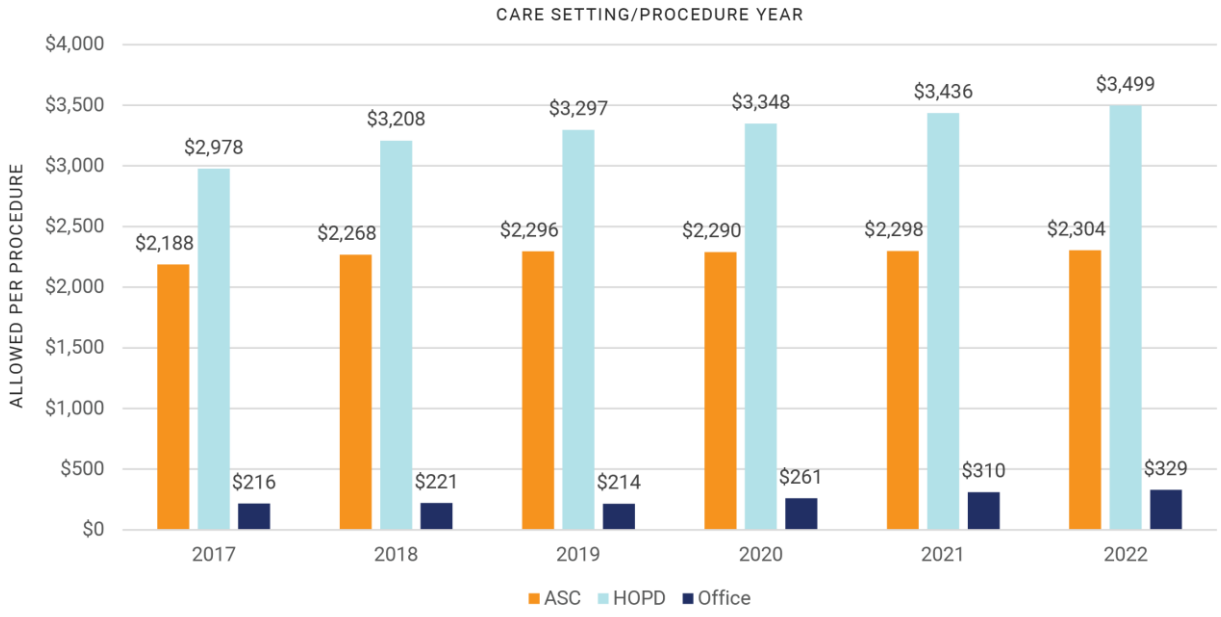

Figure 4 shows changes in allowed costs for cataract surgery between 2017 and 2022 in ASC, HOPD, and office settings. Out of the total procedure volume for 2022, 26% occurred in an HOPD, 69% in an ASC, and 6% in the office setting.

In 2022, cataract surgery allowed costs in an HOPD setting were 56% higher than in an ASC. Allowed costs for cataract surgeries performed in the office setting were substantially lower than the costs when the surgery was performed in an HOPD or ASC. While the number of cataract surgeries performed in the office setting is relatively small, it has been demonstrated to be safe in nearly all cases[4]. Between 2017 and 2022, allowed costs in HOPDs increased by 18%, whereas those in an ASC only rose by 6%. Allowed costs in the office setting also increased.

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Figure 5. Ear Tympanostomy Allowed Costs per Procedure Between 2017 and 2022

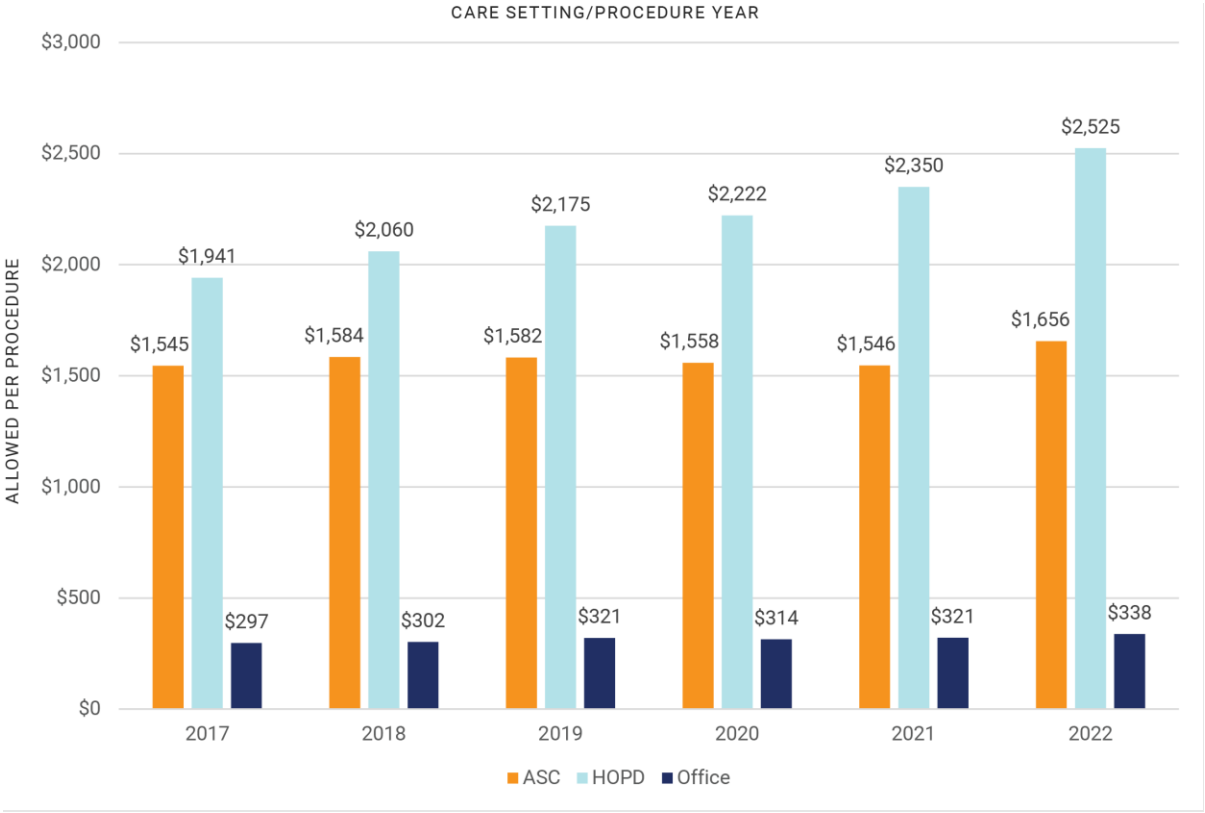

Figure 4 shows changes in allowed costs for ear tympanostomy between 2017 and 2022 in ASC, HOPD, and office settings. Out of the total procedure volume for 2022, 54% occurred in the HOPD, 29% in an ASC, and 17% in the office setting.

In 2022, ear tympanostomy allowed costs in an HOPD were 52% higher than in an ASC. Allowed costs for ear tympanostomies performed in the office setting, as with cataract surgeries, were substantially lower than the costs when the procedure was performed in a HOPD or ASC. Like cataract surgeries, this procedure can be safely rendered in the office setting[5]. Between 2017 and 2022, costs in an HOPD increased by 30%, whereas costs in an ASC grew by 7%. Costs in the office setting only increased slightly.

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Figure 6. Clinic Visits Allowed Costs per Procedure between 2014 and 2022

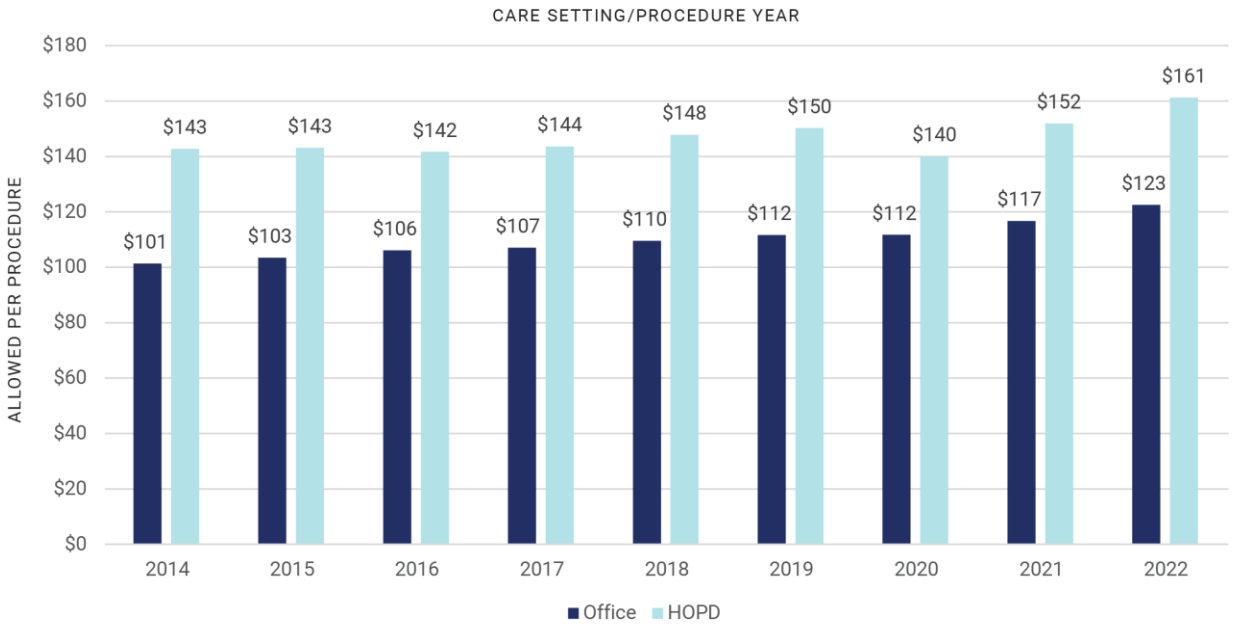

Figure 6 shows changes in allowed costs for physician visits between 2014 and 2022 in office and HOPD settings. ASC allowed costs are not shown because clinic visits that take place in an ASC make up less than .006% of all clinic visits.

Clinic visits (evaluation and management services) are some of the most common services performed in the outpatient setting. When these services are billed in the HOPD setting, they are substantially more expensive than when billed in an office setting. In 2022, clinic visits in an HOPD cost an average of $161, 31% more than those that occurred in an office setting. However, unlike the other services examined, allowed costs grew faster in the office setting than in the HOPD.

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SCREENING COLONOSCOPY – A DEEPER DIVE ON HOPD BILLING PRACTICES

While this study focused on line-item billing practices, there are opportunities to increase reimbursement in the HOPD setting by unbundling services such as anesthesia or IV fluids. To assess the potential impact of unbundling on total allowed costs, we examined screening colonoscopy (CPT G0121) across settings. This analysis looked at all related services billed on the same date as a screening colonoscopy.

Figure 7. CPT Line Item vs. Total Facility Cost for Colonoscopy Screenings (G0121)

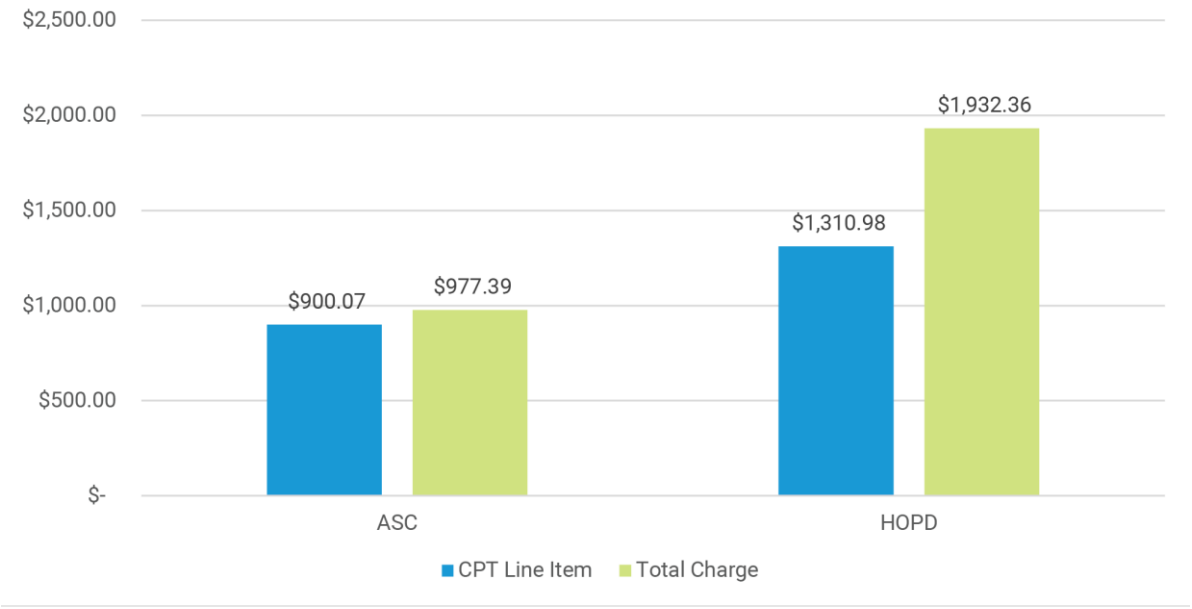

Figure 7 shows the impact of unbundling services for colonoscopy in ASC and HOPD settings. A breakdown of the additional procedures billed as part of colonoscopies can be found in the appendix.

We found that in the HOPD setting, but not in the ASC, providers billed separately for some items typically covered under the technical component of services rendered in an office setting. These additional facility fees resulted in 47% higher facility-allowed costs than when considered at the line-item level, substantially increasing the difference between HOPD- and ASC-allowed costs.

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SUMMARY

Our analysis of national Blue Cross Blue Shield data found that allowed costs for common outpatient services were consistently higher in the HOPD setting than for those rendered in an ASC or office location. For all of the examined procedures except clinic visits, allowed costs also grew faster in the HOPD setting.

Our study was not intended to answer the question of why the cost of services rendered in the HOPD setting was consistently higher than in other settings. However, several possible reasons should be considered. These include market forces resulting from physician and hospital consolidation, hospitals passing on the higher costs of delivering care regardless of settings, the financial impact of COVID-19 on providers and insurers, and variation in severity of illness across settings. Future studies will address the root cause of these pricing differences and other questions.

In conclusion, our findings suggest that if commercial payers implemented site-neutral payments across settings, then employers, employees, and patients would realize substantial savings through lower premiums and out-of-pocket costs.

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APPENDIX

Below is a list of services often billed for in a bundled payment for colonoscopy screenings. These additional services contribute to the increased cost of colonoscopies when looking at the full claim and not just the line-level CPT code.

Other Services Billed on a Colonoscopy Screening Claim		
CPT_AND_HCPCS_CD	**Description**	**% of Total**
	UNKNOWN	36.44%
J2704	INJ, PROPOFOL, 10 MG	26.49%
J7120	RINGERS LACTATE INFUSION	11.56%
43239	EGD BIOPSY SINGLE/MULTIPLE	8.62%
J2250	INJ MIDAZOLAM HYDROCHLORIDE	7.08%
J3010	FENTANYL CITRATE INJECTION	6.14%
J7030	NORMAL SALINE SOLUTION INFUS	4.58%
J2001	LIDOCAINE INJECTION	3.79%
88305	TISSUE EXAM BY PATHOLOGIST	3.65%
81025	URINE PREGNANCY TEST	2.91%

Below is a breakdown of revenue codes within the unknown line item:

Unknown CPT Revenue Code Lines		
Revenue Code	**Description**	**% of Total**
370	ANESTHESIA - GENERAL CLASSIFICATION	25.99%
710	RECOVERY ROOM - GENERAL CLASSIFICATION	23.48%
250	PHARMACY - GENERAL CLASSIFICATION	19.72%
272	MEDICAL/SURGICAL SUPPLIES AND DEVICES - STERILE SUPPLY	10.99%
270	MEDICAL/SURGICAL SUPPLIES AND DEVICES - GENERAL CLASSIFICATION	7.03%
258	PHARMACY - IV SOLUTIONS	6.64%
271	MEDICAL/SURGICAL SUPPLIES AND DEVICES - NON-STERILE SUPPLY	1.55%
371	ANESTHESIA - ANESTHESIA INCIDENT TO RADIOLOGY	1.29%
259	PHARMACY - OTHER PHARMACY	1.21%
636	PHARMACY - DRUGS REQUIRING DETAILED CODING	1.08%

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