



Gaming the System: How Hospitals Are Driving Up Health Care Costs by Abusing Site of Service

Unveiling the Impact of Broken Payment Incentives on Health Care Affordability

Introduction

Across America, people are experiencing a health care affordability crisis. Compared to peer countries, the U.S. is spending two or even three times as much per person for health care, and yet has some of the worst health outcomes and health care quality.^{1,2} In 2021, the U.S. spent about \$13,000 on health care for every single person in the nation, in total a staggering \$4.3 trillion.^{3,4}

Despite spending so much more, the U.S. has some of the highest rates of maternal mortality and premature deaths, and the lowest life expectancy compared to peer countries.⁵ High and irrational health care prices are a leading driver of the US health care affordability crisis, causing more than 100 million Americans to go into medical debt.⁶ Of those with medical debt, two-thirds are forced to cut back on spending for food, clothing, and other necessities, and nearly half of Americans report having to forgo medical care due to the cost.⁷

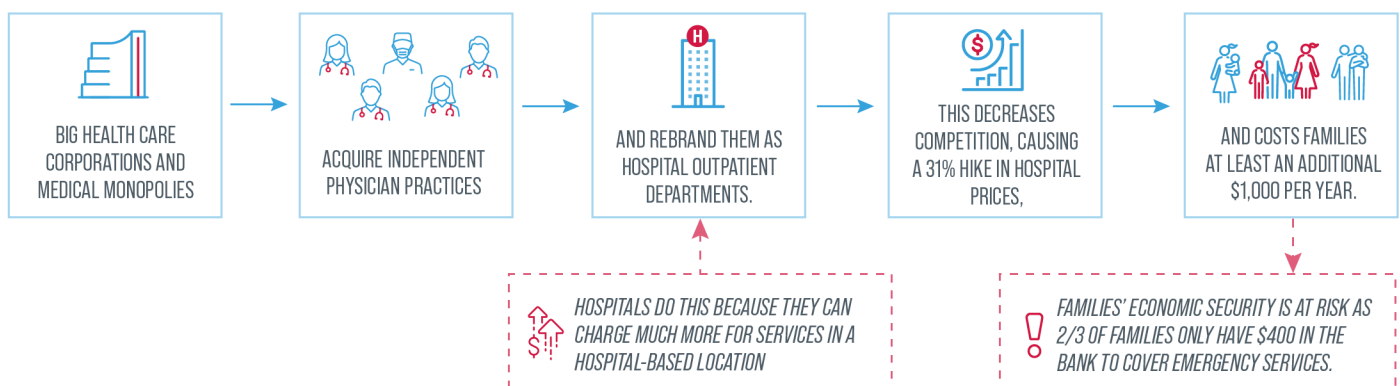
While far too many Americans must make impossible choices between seeking medical care and feeding their families, large hospital corporations are buying up local competition to increase health care prices year after year, generating high volumes of high-priced services, raking in billions of dollars in profits and operating revenues, and pushing too many American families to the brink of financial ruin.

Health care industry consolidation, particularly among large hospital corporations, is a major driver of our nation’s health care affordability crisis.⁸ With 90% of hospital markets now deemed highly concentrated, there are few truly competitive health care markets remaining and hospitals are able to set abusively high prices.⁹ Consolidation takes place without meaningful regulatory oversight or intervention and is a major driver of high and variable prices in the U.S. health care system.^{10,11} Just since 2015, hospital prices increased an average 31%, accounting for one third of national health spending and growing four times faster than workers’ paychecks.^{12,13} In fact, it is estimated that hospital consolidation costs the typical American family an average of \$1,000 per year.¹⁴

Making matters worse, most Americans would be surprised to know that, simply because of the legal definition of where care is delivered, the price for that care can vary significantly — regardless of the safety or clinical effectiveness of the site-of-care. Most Americans experience these hospital pricing abuses, for example, as astronomical and mysterious “facility fees” that are added to hospital bills and routinely increase costs for consumers by hundreds or even thousands of dollars.^{15,16}

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Big Health Care Corporations Game the System by Driving Out Competition To Price Gouge America’s Families



These payment differentials — or site-specific payment differences — are problematic for two reasons. First, they incentivize large hospital corporations and health systems to drive care delivery to higher-cost sites, particularly from physician’s offices to hospital outpatient departments (HOPDs); second, they incentivize hospitals to buy up doctors’ offices and rebrand them as HOPDs to generate the higher payments.¹⁷ Importantly, these large hospital corporations leverage the broken incentives created by these payment differentials to sustain their business models: purchase hospitals and doctors’ offices to become large corporate health care systems that increase prices year after year and maximize service volumes for the highest-priced services.¹⁸ As discussed below in greater detail, these broken incentives are at odds with the goal of ensuring America’s families receive the affordable, high-quality care and improved health they deserve.

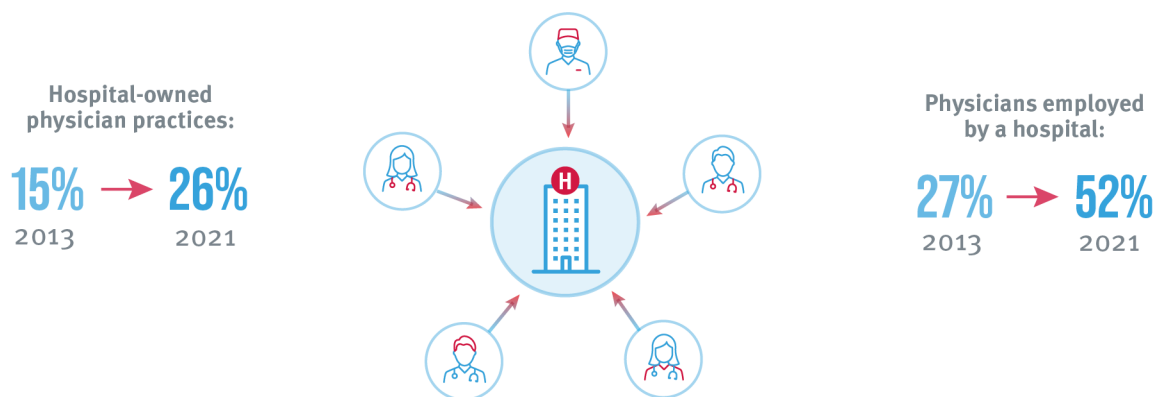
Site-Specific Payment Differentials Incentivize Medical Monopolies

Under the current hospital payment system, Medicare pays higher rates for medical services performed in HOPDs and other provider-based outpatient facilities than for the same services performed in a physician’s office or ambulatory surgical center (ASC).^{19,20,21} Because Medicare sets the benchmark for how other payers reimburse for health care, typically as a percentage of Medicare (e.g., 138% of Medicare), this payment distortion extends into the commercial market. For privately insured patients, hospitals charge higher prices than independent physician’s offices or other outpatient facilities for the same services. This results in patients being billed substantially more for routine care.²²

In addition to these higher prices, hospitals add “facility fees” for routine services that are often provided in hospital-branded departments.²³ The ability to charge more for hospital care, whether in Medicare or the commercial market, based solely on the site where care is delivered, creates a strong financial incentive for hospitals to consolidate local competition by buying physician offices and rebranding them as off-campus HOPDs and facilities so they can receive higher payments.²⁴ The drive toward higher cost has a direct negative financial impact on Medicare beneficiaries, overall Medicare expenditures, and privately insured consumers.^{25,26} For example, Medicare beneficiaries pay higher copays at HOPDs than at physician offices, and HOPDs are paid double what physicians are paid under Medicare’s physician fee schedule for the same service. This differential contributes to excess Medicare expenditures and threatens the solvency of the Medicare program.²⁷

Over the past decade, more and more formerly independent physician practices have become affiliated with major hospital systems. Between 2013 and 2021, the percentage of hospital-owned physician practices rose from 15% to 26% and the percentage of physicians employed by a hospital rose from 27% to 52%.²⁸ This vertical integration between hospitals and physicians

The Rise In Independent Physician Practices Becoming Affiliated With Major Hospital Systems



leads to a growing anticompetitive market in which hospitals increase market power. As a result, they can demand higher prices for all consumers, including those with private health coverage- where vertical physician-hospital integration can result in price increases of as much as 14% for a single service.^{29,30,31}

Researchers have identified significant shifts from physician offices to HOPDs for services such as chemotherapy administration, even though they can be provided in a physician’s office at a lower cost with the same quality and safety of care. Between 2012 and 2019, the share of chemotherapy administration services delivered in hospital outpatient settings increased from 35% to 51%.³² Because Medicare payment policy often establishes a standard that commercial payers and Medicaid then adopt, the broken payment incentives in Medicare payment are amplified across payers.^{33,34} Ultimately, the financial incentives created by site-specific payment differentials encourage hospitals to buy up local competition to increase prices and shift care to higher cost care settings. The result is lower wages and higher copays, premiums and cost sharing for America’s families and individuals.^{35,36}

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To further highlight the way the financial incentives of site-specific payment differentials drive care into higher cost settings and increase health care prices, Families USA reviewed data from the Health Care Cost Institute (HCCI) across a key set of services including drug administration, strapping and cast application and nerve injections.* These are examples of procedures that can be performed safely and effectively in physician offices, although they are increasingly provided in outpatient settings- the most expensive care setting possible- without a clinical requirement to do so.³⁷⁻³⁸

Table 1a (page 6) presents evidence that care delivery is shifting from lower-cost physician office settings to higher-cost outpatient settings across drug administration, strapping and cast application, and nerve injection. Table 1b (page 6) highlights the dramatic differences in prices when those services are delivered in the outpatient setting versus a physician's office. For example, between 2009 and 2017, drug administration services delivered in HOPDs doubled. During the same period, the price of drug administration in an outpatient setting increased by a staggering 57%.³⁹

Moreover, significant increases occurred in the prices and locations of care delivery for other services, such as nerve injection and strapping and cast application. The prices for those services in an outpatient setting increased by 47% and 44% respectively, over an 8-year period. Importantly, these prices are twice those for the same services in a doctor's office. For drug administration, the price in an HOPD was more than triple that for delivery in a physician's office.⁴⁰ Each of these services, which are increasingly performed in HOPDs, can be delivered with the same efficacy and safety in an independent doctor's office and at lower cost to the patient and the system.^{41,42,43}

*The Health Care Cost Institute published data on the price and site of service changes between 2009 and 2017 for 26 individual services identified by CMS and MedPAC as being safe, appropriate, and requiring the same resources and utilization in both outpatient and office settings. The data uses claims for individuals under 65 with employee sponsored insurance plans. Families USA identified a handful of those services to use as an example, compiled them into one data table, and calculated the total percent change in price and site of service over the timeframe.

Table 1a: Percent Increase of Procedures in the Outpatient Setting, 2009-2017

	2009: Percent of Procedures, Outpatient	2017: Percent of Procedures, Outpatient	Percent Change
Drug Administration, Level 5*	23.4%	45.9%	96.1%
Strapping and Cast Application, Level 2	9.2%	13.5%	46.7%
Nerve Injection, Level 2	23.5%	31.5%	34%

Source: HCCI, 2023. Families USA calculated percent changes based on HCCI original data.

Table 1b: The Increase In Procedure Prices In Outpatient Vs. Office Settings, 2009 - 2017

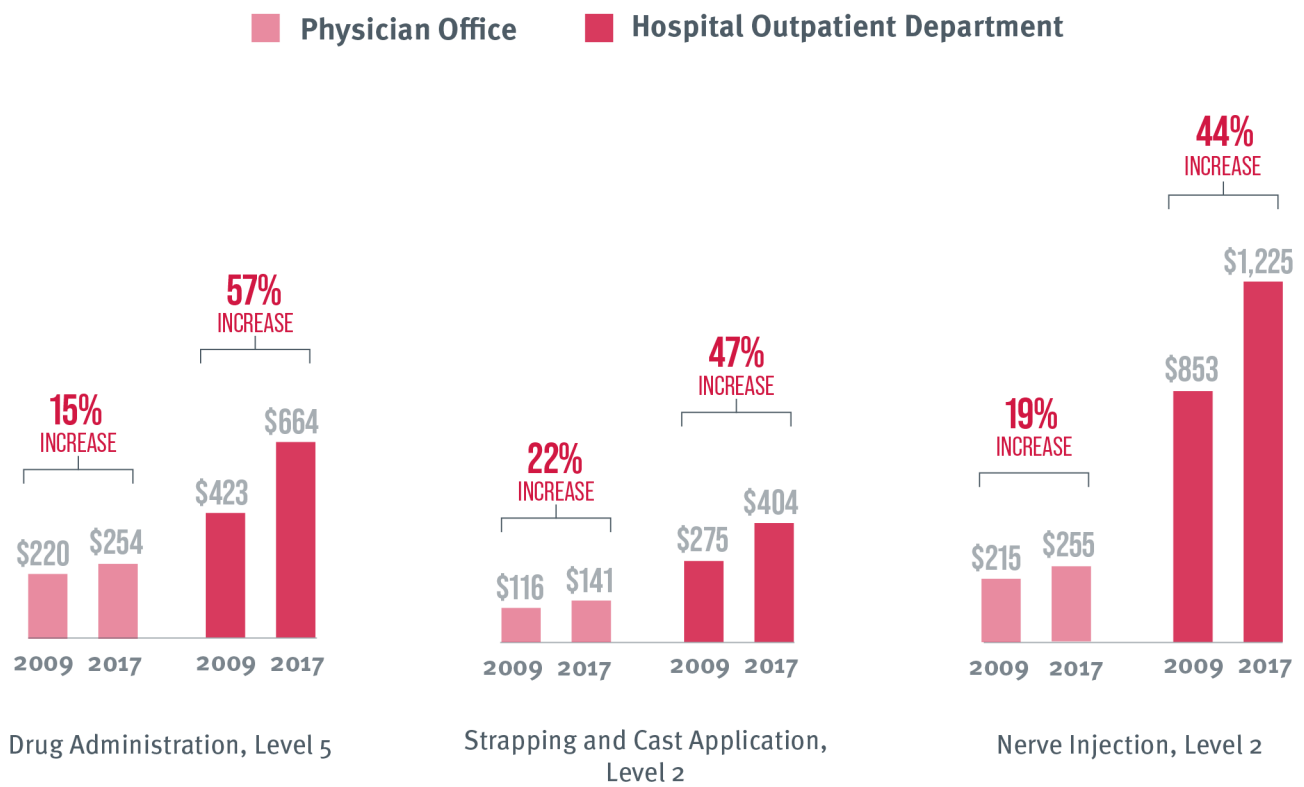
	2009: Average Price, Outpatient	2017: Average Price Outpatient	Percent Change	2009: Average Price, Office	2017: Average Price, Office	Percent Change
Drug Administration, Level 5	\$423	\$664	56.9%	\$220	\$254	15.4%
Strapping and Cast Application, Level 2	\$275	\$404	46.9%	\$116	\$141	21.5%
Nerve Injection, Level 2	\$853	\$1,225	43.6%	\$215	\$255	18.6%

Source: HCCI, 2023. Families USA calculated percent changes based on HCCI original data.

*The levels refer to ambulatory payment classifications, which reflect the severity of patient sickness and the corresponding level of care needed to treat the patient. The classification levels refer to Current Procedural Terminology Emergency and Management codes.

RISING AVERAGE PRICE Hospital Outpatient Departments Compared To Physician Offices, 2009 vs. 2017

Big health care corporations make more money by driving patients to outpatient departments where the cost of care is significantly higher compared to physician offices. These medical monopolies take advantage of site-specific payment differences by buying up doctors' offices and rebranding them as hospital outpatient departments to bill for higher cost care. This practice decreases competition and results in high, rising prices and unaffordable care, leaving America's families scrambling to make ends meet.



These outpatient prices are not only high, but they are also increasing faster than inflation and people's incomes. Between 2009 and 2017, the prices of these three services, delivered in a hospital outpatient setting, increased nearly three times faster than inflation and twice as fast as increases in average annual income. In contrast, prices for the same services in doctors' offices are more aligned with increases in income and inflation.^{44,45} **When two-thirds of American families have only \$400 in the bank to cover emergency expenses at any given time, higher prices driven by big hospital corporations are a fundamental threat to the economic security of our nation's families.**⁴⁶

The Role of “Facility Fees” in Site of Service Payment Abuses and Driving Unaffordable Care

High health care prices, including hospital prices, cost individuals an estimated \$240 billion in wasteful spending each year.⁴⁷ As a result, workers see smaller or no increases in their wages, and it becomes more difficult for them to afford where they live, their daily expenses, send their children to college or be able to retire.⁴⁸ Hospitals that own and have rebranded doctors’ offices as off-campus HOPDs can charge “facility fees” in addition to the higher fees they bill for physician services.⁴⁹ The result is that consumers are billed not only for the visit with the physician but also for the use of the hospital facility where the visit occurred.⁵⁰ These bills together (the physician fee and the facility fee) total more than if the service was just provided in a physician’s office.⁵¹ For example, Medicare pays up to 80% more for a 15-minute office visit in an HOPD than a freestanding office, in part due to facility fees.⁵² The higher Medicare costs are then shifted onto seniors and families in the form of higher copays and cost-sharing.⁵³ Moreover, outpatient facility fees charged to commercial health plans are consistently higher than those outpatient facility fees charged to Medicare.⁵⁴ This is particularly problematic given that many private insurance plans fail to cover facility fees or apply facility fees to a separate deductible. The result is significant increases in out-of-pocket costs for the 176 million Americans who rely on commercial insurance for health coverage.⁵⁵

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The Skyrocketing Prices of Outpatient Services

Between 2009 and 2017, the prices of services,* delivered in a hospital outpatient setting, increased **nearly 3X faster than inflation** and **2X as fast as increases in average annual income.**

**Drug Administration, Level 5; Strapping and Cast Application, Level 2; Nerve Injection, Level 2*



How Facility Fees Affect America's Families

Kyunghee Lee

To treat her arthritis, Kyunghee Lee made annual visits to a rheumatologist for a steroid injection to relieve pain in her knuckles. For several years, each round of injections cost her \$30. In 2021, she arrived and the rheumatologist she regularly saw had moved to a new floor of the building. Just one floor up. She didn't think anything of the move until she received a bill for \$1,394. The infusion clinic that Lee went to had been moved from an office-based practice to a hospital-based setting, and therefore the price of the same services she has been relying upon increased a staggering 4,546 percent. Lee's most recent bill had a \$1,262 facility fee that accounted for most of the increase in cost, even though she saw the same doctor and received the same treatment as the years prior. Lee and her family didn't know what to do about the shot the next year when the story was reported. (by KFF⁵⁶)

Micharl Kark

Micharl Kark took his five-year-old son to a psychologist. It was a non-emergency behavioral health appointment for which Kark expected to receive a \$20 co-pay charge. Kark did receive a bill for \$20, along with a \$503 secondary bill. That \$503 was his portion of the \$793 facility fee bill the hospital had sent to his insurance. The doctor's office where the behavioral health visit occurred was located next-door to Children's Hospital Colorado, and it turned out that the Children's Hospital owned the building. The building's ownership is what resulted in the facility fee being applied. During the 45-minute visit no vital signs were taken and no surgery or blood work done. Kark stopped taking his son for the weekly appointment because the care was unaffordable. (story sourced from the Problem Solvers, Fox 31 Colorado⁵⁷)

Site-Neutral Payment Policy: A Bi-partisan Solution Hangs in the Balance

The American people want action. Bipartisan policy solutions can be enacted right away to end the broken financial incentives in the Medicare payment system by implementing site-neutral payment policies. Such policies would end hospital's ability to charge more for the same services and allow the same payments across physician office, hospitals and ASCs. Voters from both sides of the aisle broadly support Congressional action to address hospital pricing abuses: 85% of voters support a site-neutral payment policy.⁵⁸

Since 2014, Medicare Payment Advisory Commission (MedPAC) has issued clear recommendations to Congress on comprehensive site-neutral payment policy that would address underlying payment distortions and lower health care costs for our nation's families.^{59,60,61} MedPAC identified 57 ambulatory payment classifications (APCs) — groups of clinically similar health care services that use comparable resources and are reimbursed by Medicare at a higher rate when performed in a hospital outpatient or facility setting. For those APCs, it is clinically appropriate to align the higher-cost outpatient payment rates to the lower rates that would be paid if the services were delivered in a physician's office (called the physician fee schedule rate).⁶² The 57 APCs for which

85% of voters across the political spectrum support enacting a site neutral payment policy.

MedPAC recommends the physician fee schedule rates represent more than 70% of total Medicare volume, accounting for \$11.4 billion in annual Medicare spending.⁶³ MedPAC recommended an updated list of 66 APCs to Congress in early 2023.⁶⁴

Importantly, Congress enacted a narrow site-neutral payment policy through the 2015 Bipartisan Budget Act (BBA), which mandated that new off-campus provider-based hospital departments be paid at the lower, physician fee schedule rate. However, the legislation included a number of exemptions from the policy, including emergency departments, ambulatory surgery centers, on-campus outpatient departments and off-campus physician offices that were built prior to November 2nd, 2015. These so called "grandfathered" provider-based departments are not subject to the site neutral payment policy.⁶⁵ Ultimately, the BBA of 2015 applied only to a small number of health care facilities and more work is needed to fully address this payment distortion driving unaffordable health care for American families.⁶⁶

Moreover, enacting MedPAC's recommendations would significantly reduce the total cost of national health care spending, lower out-of-pocket costs for consumers and stop hospitals from

billing facility fees in inappropriate care settings. MedPAC estimated that Medicare would have seen \$6.6 billion in savings in 2019 alone had its site- neutral payment policy been enacted- including an additional \$1.7 billion in reductions to patient cost- sharing.⁶⁷ The Congressional Budget Office estimated in early 2020 that a site- neutral policy would save Medicare approximately \$140 Billion over the next decade.⁶⁸ And in early 2023, the Committee for a Responsible Budget estimated that implementing a comprehensive site neutral payment policy for both Medicare and the commercial market would reduce health care spending by \$153 billion over the next decade, including lowering premiums and cost-sharing for Medicare beneficiaries by \$94 billion and for those in the commercial market between \$140 billion and \$466 billion.⁶⁹

Importantly, health care providers should be reimbursed at a level that supports the most efficient, highest quality care irrespective of where it is provided. This is a foundational principle for the efficient allocation of resources and shifting to a value-based health care system.⁷⁰ We urge Congress to take swift action to implement bipartisan, comprehensive site neutral payment policies, as recommended by MedPAC to end the longstanding broken financial incentive that encourages medical monopolies to buy up local competition, increase prices and shift care delivery into higher- cost care settings.

Conclusion

For decades, hospitals have leveraged site of service payment differentials, pushing the delivery of routine care to higher cost care settings, and driving up health care spending with no meaningful improvement in care quality or safety. These big health care corporations leverage broken financial incentives in health care payment to support a business model that is fundamentally at odds with the health and financial security of our nation's families. Policymakers must act quickly and decisively to advance bipartisan solutions that uproot these broken incentives and hold big health care corporations accountable for providing the affordable, high- quality care they purport to deliver and that our nation's families deserve. Advancing site neutral payment policy is a critical step in lowering health care costs and aligning the business interests of the health care sector with the health and financial security of our nation's families.

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Endnotes

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This publication was written by:

Frederick Isasi, Executive Director, Families USA

Sophia Tripoli, Senior Director, Health Policy and Director, Center for Affordable Whole-Person Care, Families USA

Hazel Law, Policy Analyst, Families USA

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Sara Brandenburg, Communications Coordinator

Nichole Edralin, Associate Director, Design and Publications

Kasey Hampton, Senior Manager of Storytelling and Engagement

Jude McCartin, Chief of Staff

Aaron Plotke, Senior Policy Analyst

Tony Viardo, Senior Director, Communications



1225 New York Avenue NW, Suite 800, Washington, DC 20005
202-628-3030 info@familiesusa.org FamiliesUSA.org facebook / FamiliesUSA twitter / @FamiliesUSA