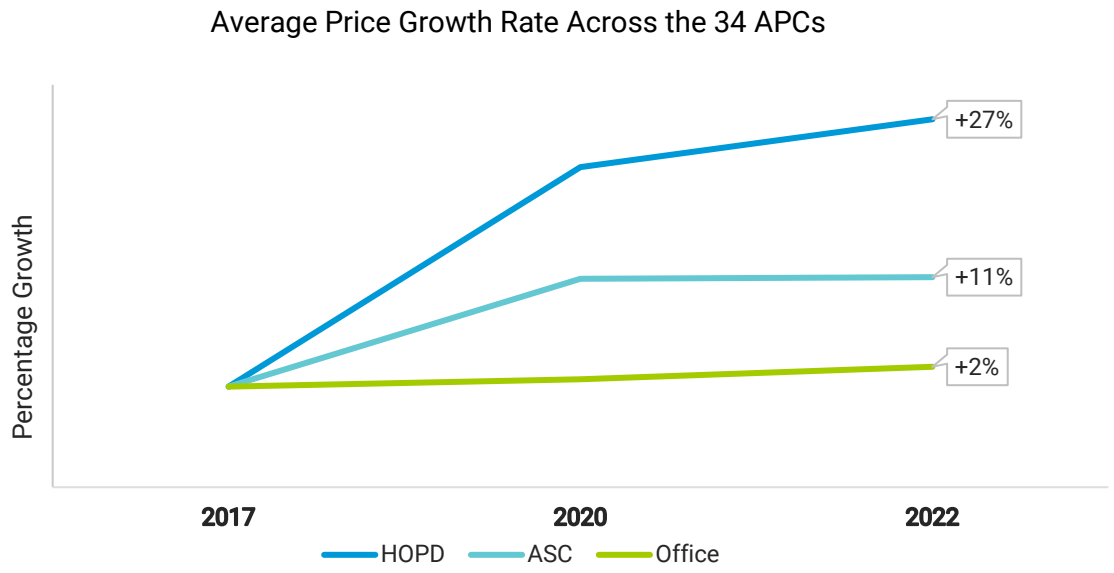
Hospital Outpatient Prices Far Higher, Rising Faster than Physician Sites

EXECUTIVE SUMMARY

Payment rates for common outpatient services differ widely based on the setting where the procedure is performed — whether in a hospital outpatient department (HOPD), an ambulatory surgery center (ASC), or in a physician's office. This study confirms and expands the results of a Blue Health Intelligence® (BHI®) issue brief from September 2023 on this critical affordability issue. There are five main conclusions based on our analysis of 123 million members from 2017 to 2022:

1. HOPD common procedure prices were substantially higher — in some cases, five times more expensive — than when performed in an ASC or office setting. While there is variability in prices and costs by site of care across census divisions, HOPD prices and costs were always higher.
2. HOPD prices grew rapidly, with a 27% average increase, compared to 11% for ASCs and 2% for physician offices.
3. For services provided in HOPDs, ancillary services (such as IV placement, anesthesia, or lab tests) comprise a greater proportion of the total price compared to the same procedures performed in other settings.
4. Rural providers account for less than 10% of all costs for the services examined, although they are more likely than urban areas to provide such services in a HOPD.
5. Site-neutral payments — billing the same amount for the same service across care delivery settings — would result in substantial savings for patients, businesses, and employees.



Issue: Outpatient services are commonly performed in three settings: HOPDs, ASCs, and physician offices. The negotiated prices that are paid for these services vary widely depending on the setting. BHI's September 2023 study calculated price differences for six commonly performed outpatient healthcare services and found that when those services are performed in an HOPD, the costs are substantially more than when performed in an ASC or a physician's office. To understand the implications of these differences more fully, this follow-up study examines the cost of thousands of different services provided in these three sites of care from 2017-2022. Healthcare systems acquiring more physician practices also is a likely factor in rising costs. Though not explored in this study, other research has shown this issue is a major factor in increasing prices.[1]

Approach: BHI used a national commercial data set of 123 million lives to evaluate how prices differ across sites of care. BHI adopted a similar methodology to that of a recent MedPAC study by using the Center for Medicare & Medicaid Services' (CMS) Ambulatory Payment Classifications (APC) to group and classify services. Each APC includes a set of services used to treat people with similar clinical conditions and have similar resource intensity. This allows an "apples to apples" comparison of services across sites of care.

Findings: Across thousands of services, prices are substantially higher when performed in the HOPD setting. Further, we found that for most of these procedures, the price difference grew much faster over time in HOPDs than it did in ASC or office settings. While our findings were similar for rural settings, they account for a small minority of services and costs.

INTRODUCTION

Billing practices for common outpatient services differ dramatically by site of care. HOPDs are the most expensive sites of care, which significantly affects the affordability of insurance coverage across markets. This was highlighted in a recent BHI Issue Brief[2] examining site-of-care billing practices for six commonly performed outpatient procedures.

For services delivered in an HOPD, there are two payments: one for the physician's professional fee and one for the facility fee. For services provided in a physician's office, there is a single grouped fee covering the physician's professional fee plus any associated costs of providing the procedure. In contract negotiations between a health plan and provider, it is common for health plans to pay a much higher rate, including the facility fee, for procedures delivered in HOPDs. Indeed, providers' growing bargaining power has widened the gap between payment rates for procedures provided in physician offices than those performed in HOPDs. For example, the following table shows a typical commercial payment rate for mammography, a common outpatient procedure, when performed in a physician's office versus a HOPD.

Mammography	
Office	
Professional and Technical Fee	$232
Total	**$232**
HOPD	
Professional Fee	$44
Facility Fee	$314
Total	**$358**

Opportunities to increase revenue by billing higher rates as HOPDs are a significant reason why hospital systems are acquiring local medical practices.[3,4,5] This study evaluates the impact of this shift in care on the commercial insurance market by examining a much broader list of common outpatient procedures than were considered in the first brief. Further, we examined geographic differences in site-of-care prices by census divisions and in rural and urban regions.

RESEARCH OBJECTIVES

This analysis addresses three questions:

1. Are there differences in site-of-care prices within a broader set of services?
2. Are the procedures' total prices (see below) higher by site of care than the price of the services alone?
3. Is there variation in site-of-care pricing across geographic areas?

This paper evaluates a broad set of services using CMS' APCs. Each APC includes a set of services that have similar clinical attributes and costs. The services in each APC are comparable and, thus, are useful in evaluating cost differences across sites of care[6].

MedPAC identified 68 APCs to evaluate site-neutral payments in its June 2022 report.[7] These 68 APCs were chosen by MedPAC because they are services that could be performed across the multiple care settings. Thirty-four of these APCs were selected based on having adequate procedure volumes in at least two of three care settings: HOPD, ASC, or physician office. Specific procedures were selected within each APC to further illustrate the impact of site-specific price differences.

Table 1. APC Examples with Site-Specific Volumes

APC	Description	HOPD	ASC	Office	Total
5112	Outpatient Orthopedic Procedures	69,872	70,148	25,595	165,611
5373	Outpatient Urologic Procedures	90,450	45,007	248,514	383,967
5443	Outpatient Nerve Injections	185,933	181,138	301,187	668,230
5521	Imaging Services (e.g., Bone X-Rays)	4,760,170	2,033	10,879,412	15,641,609
5522	Imaging Services (e.g., Ultrasounds)	5,712,466	5,819	12,123,929	17,842,206

*For results of the 29 remaining APCs, see Table 2 in the Appendix.

METHODOLOGY

- This brief includes commercial claims data for approximately 123 million members in the 2017, 2020, and 2022 coverage years. The study population includes members who reside in the U.S. who have medical and hospital benefits with commercial health insurance.
- Managed Medicaid and Medicare Advantage members were excluded from the study. The study did not adjust for disease severity across the three sites of care.

Definitions

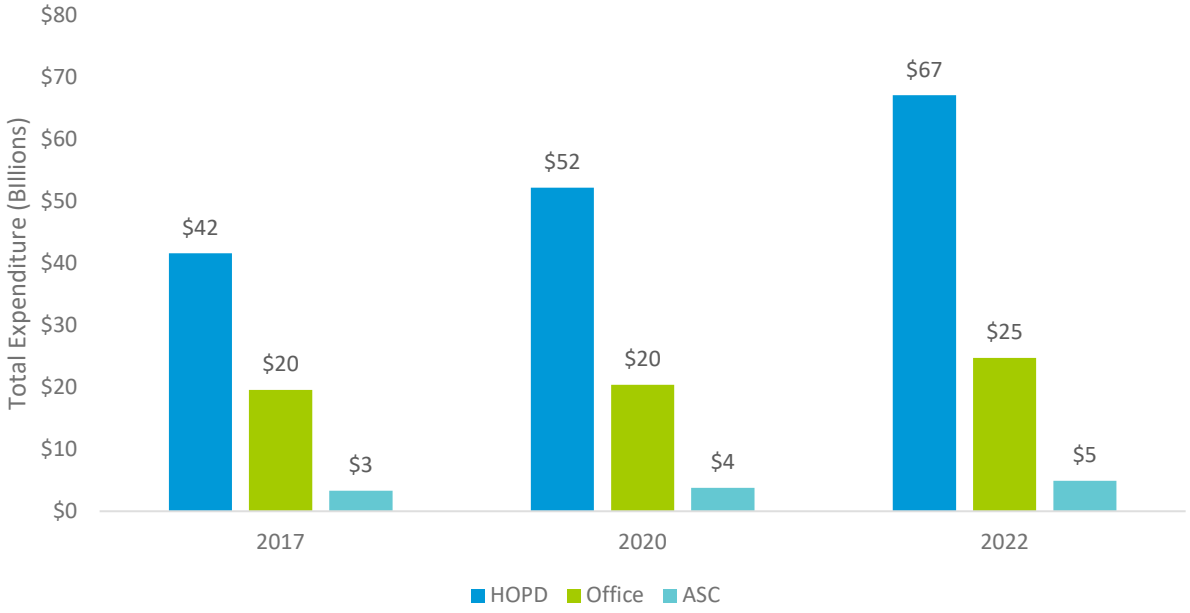
Type	Description
Average APC Price	The average price of services within a specific APC. The price is the rate negotiated between the provider and the insurer.
Average Service Price	The average price of a specific service within an APC.
Average Total Price	The average price associated with a targeted service is calculated by summing the expenditures for professional, facility, and ancillary procedures and dividing them by the total procedure volume. For example, a prostate biopsy may include anesthesiology, IV placement, and blood draws.
Total Cost	The sum of all professional, facility, and ancillary service costs.
APC Cost	The sum of all costs associated with each service within the APC.
Procedure Volume	The distinct count of outpatient procedures and professional services.

RESULTS

Expenditures, Volume, and Price for Common Outpatient Procedures: 2017-2022

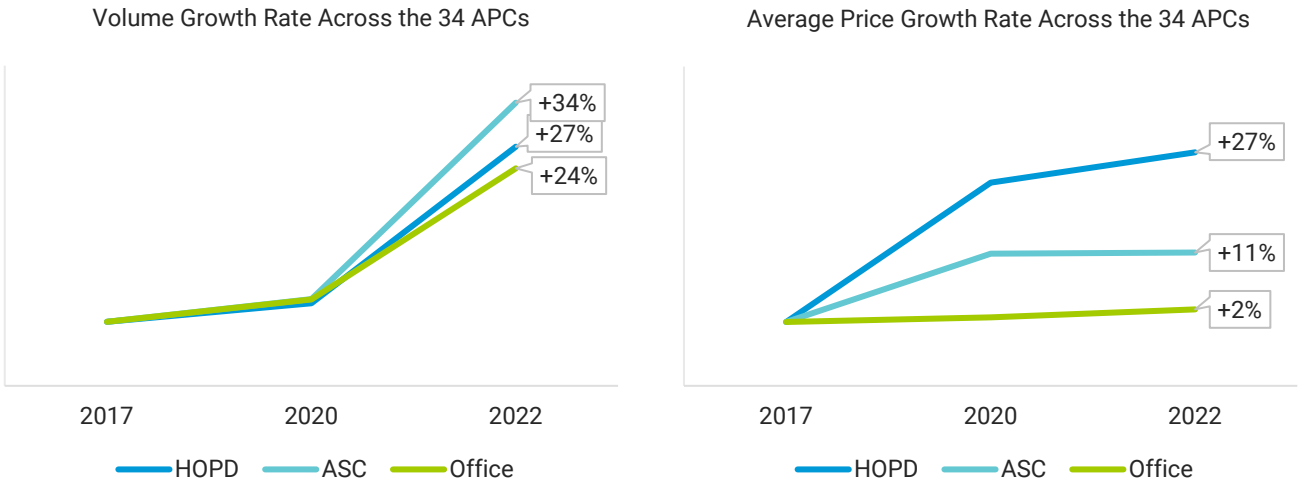
HOPD expenditures for the 34 APCs increased substantially more than ASC or office expenditures (Figure 1). Over these six years, HOPD services accounted for over 75% of the growth in expenditures across all settings. The growth in HOPD expenditures was driven by increases in both price and volume (Figure 2). Thirty-two of the 34 APCs in the study followed this trend. Level 1 and Level 2 Skin Procedures were the only exceptions; for these two APCs, HOPD expenditures were still higher, but office expenditures rose at a faster rate. Between 2017 and 2022, HOPD expenditures grew by 61%, while office expenditures only grew by 26%.

Figure 1. Total Expenditure Trends



Expenditures grew rapidly over the study period due to the growth in both volume and price. Overall, between 2017 and 2022, procedure volume grew 25%. This increase in volume is most likely due to elective procedures still on the rise post-COVID-19 pandemic.[8] The increase in volume between 2017 and 2020 is only 3%, while the increase between 2020 and 2022 was 21%.

Figure 2. Volume and Price Growth Rates



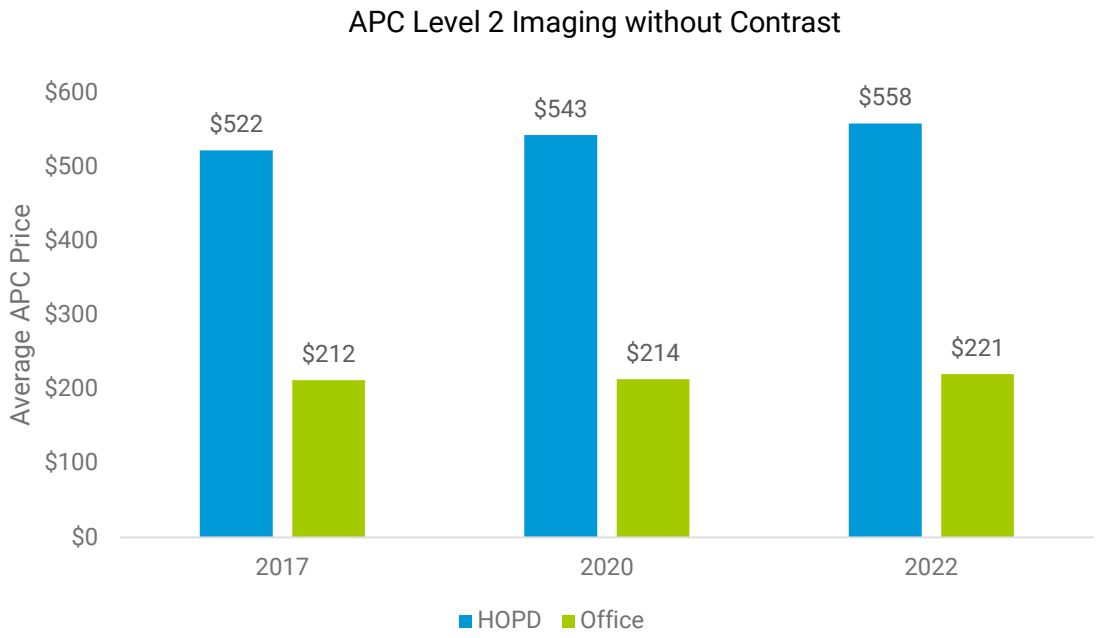
Consistent with the September 2023 study, not only were HOPD service prices much higher than in the other two settings but they also grew much faster, with a 27% average increase from 2017 to 2022. By contrast, prices for services provided in ASCs grew 11% over the same period, and prices for services provided in physician offices grew only 2%.

APC and Specific Services Examples

The following analyses evaluate cost differences between care settings as well as pricing trends year over year. Overall price growth, especially in the HOPD setting, is highlighted in each APC example.

High Procedure Volume in HOPD and Office Settings

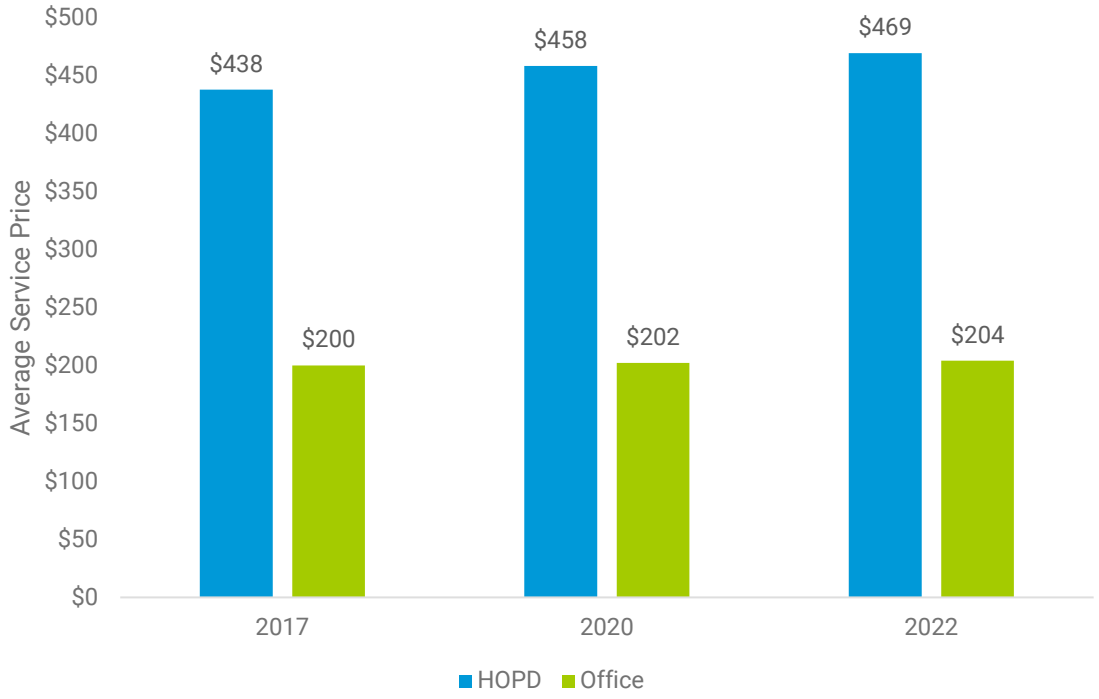
Figure 3a. Common Primary and Obstetrical Care Outpatient Imaging



This APC consists of X-rays and scans for primary care and obstetric and gynecologic (OBGYN) conditions (e.g., obstetric diagnostic ultrasounds). In 2022, procedures in this APC were performed 68% of the time in the office setting, while 32% were performed in the HOPD. That same year, the average HOPD APC price was over 2.5 times higher than the average office setting price. Between 2017 and 2022, the average APC price in the HOPD increased by 7%, while the average price in the office setting increased by just 4%.

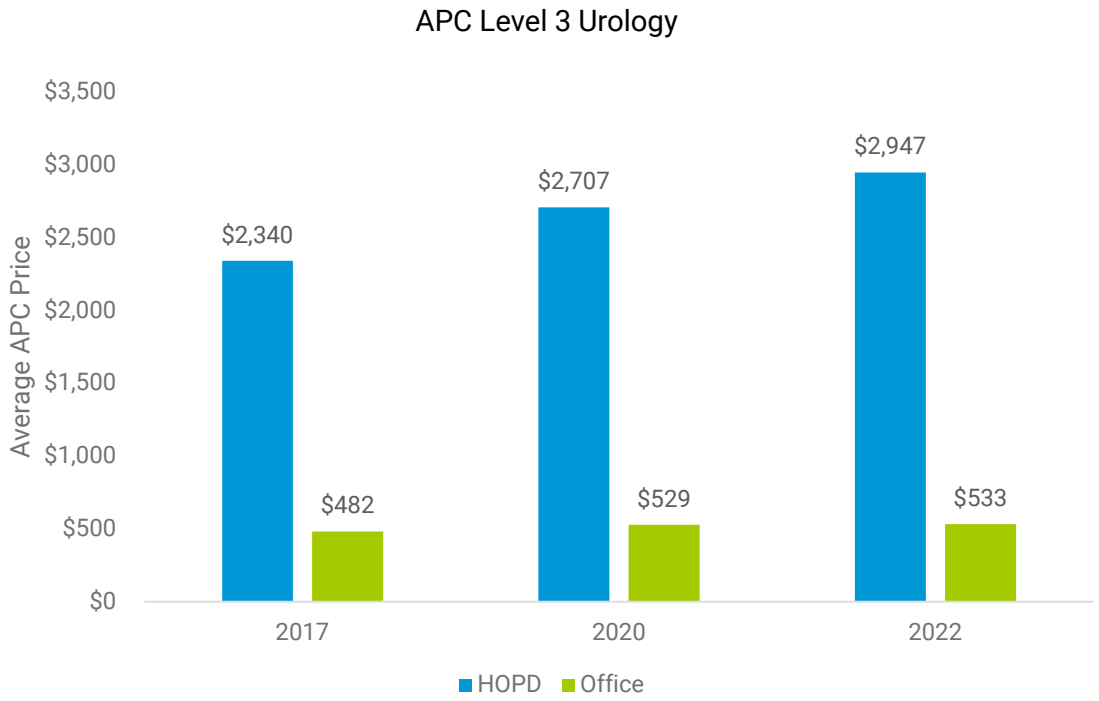
In 2022, the average total price of these procedures, including ancillary services, increased to $985 in the HOPD and $313 in the office setting. This was an increase of 85% in the average total price for a procedure rendered in the HOPD and a 45% difference in the total price for the same procedures performed in the office setting. (See the Appendix for the average total price figure for Level 2 Imaging without Contrast.)

Figure 3b. Obstetric Diagnostic Ultrasound



Routine obstetrical care includes an ultrasound of the fetus at approximately 20 weeks gestation. The prices for an OB-GYN diagnostic ultrasound in the HOPD are more than 200% higher than those in the office setting (Figure 3b). These prices increased faster in the HOPD setting: Between 2017 and 2022, the average service price in the HOPD increased by 7%, while the office average service price increased by only 2%.

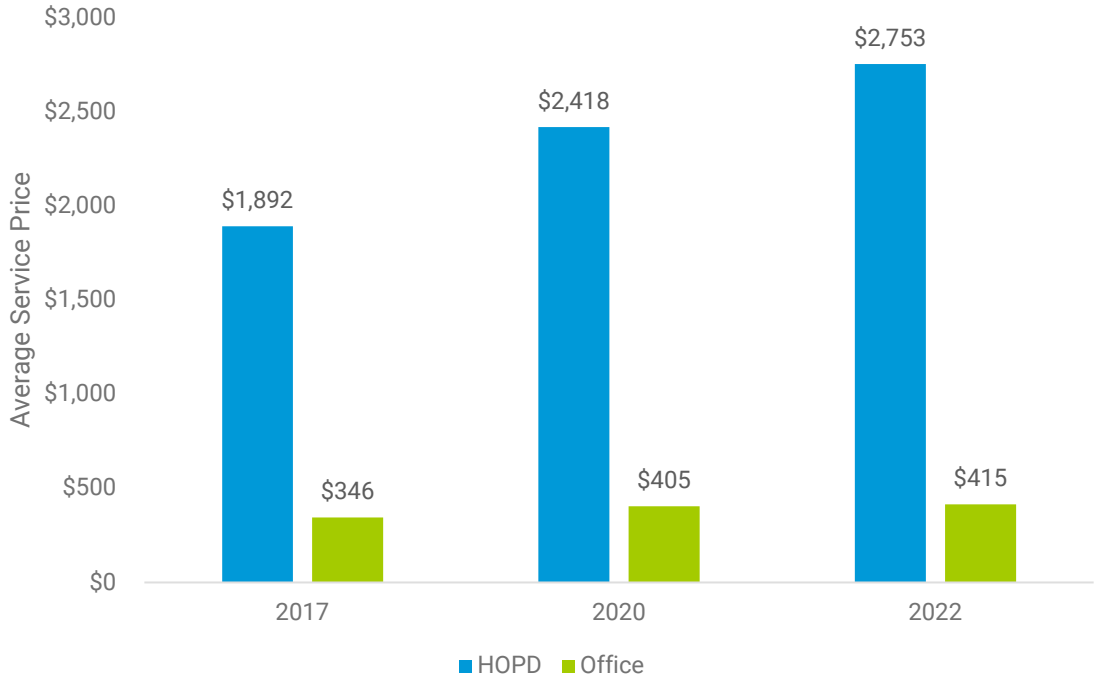
Figure 4a. Common Outpatient Procedures on the Bladder and Female and Male Genitalia



This APC consists of common outpatient procedures on the bladder and female and male genitalia. In 2022, 65% of procedures in this APC were performed in the office setting and 24% in the HOPD setting. While more procedures are occurring in the office setting, prices are significantly higher in the HOPD setting, with the average APC price that year being 450% higher than in the office setting. Between 2017 and 2022, the average APC prices in the HOPD increased by 26% but only increased by 11% in the office setting.

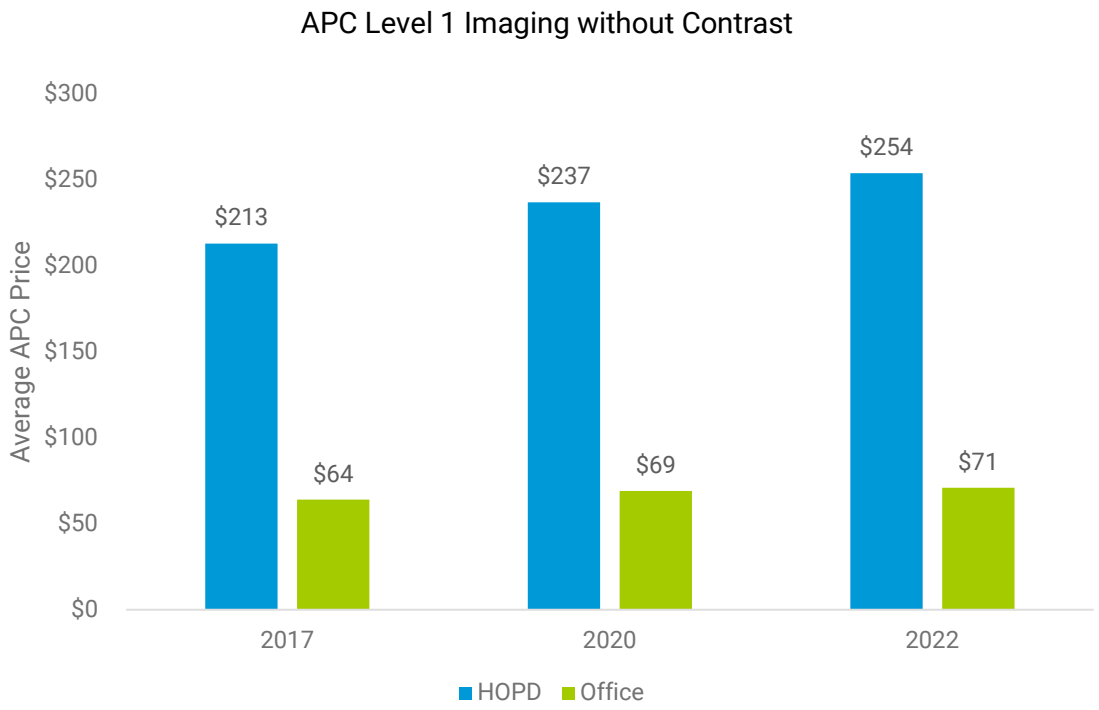
Average total prices in 2022, including ancillary services, for Level 3 Urology more than doubled to $5,674 in the HOPD setting while only increasing about $100 to an average total price of $636 in the office setting — a nine-fold price differential. Average total price trends increased 15% in the HOPD setting over the six years compared to a 7% increase in the office setting. (See the Appendix for the total price figure for Level 3 Urology.)

Figure 4b. Biopsy of Prostate



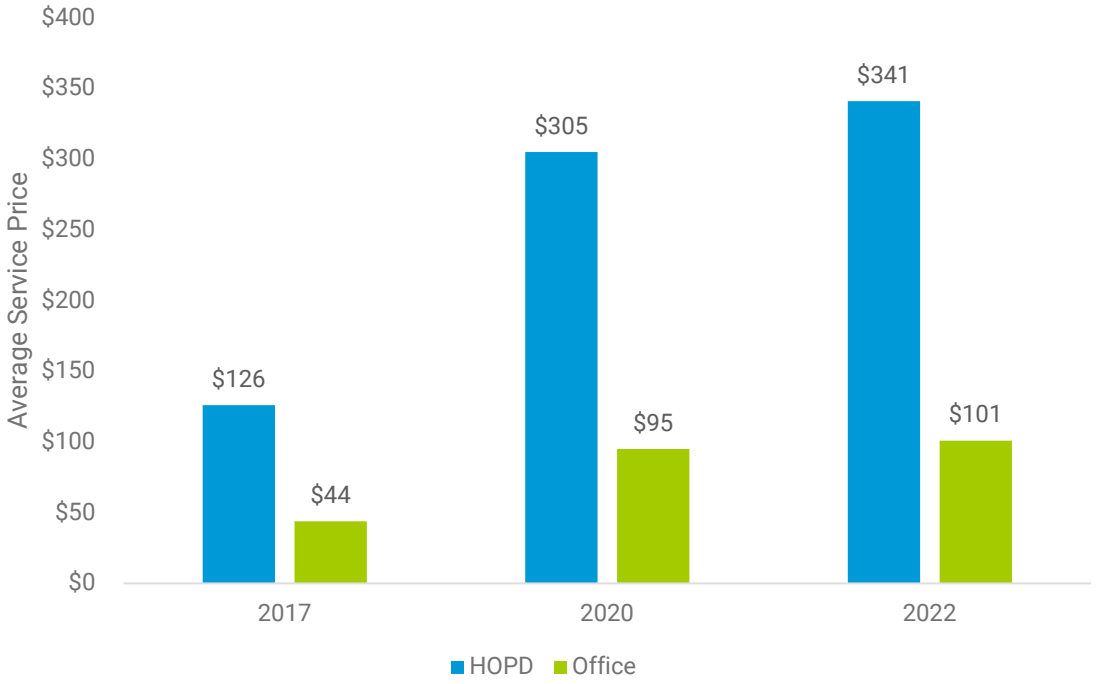
Biopsy of the prostate is a common outpatient procedure performed for diagnosing prostate cancer. The average service price for prostate biopsies was over six times higher in the HOPD versus the office setting (Figure 4b). Between 2017 and 2022, the price increased by 46% in HOPDs compared to a 20% increase in the office setting.

Figure 5a. Common Outpatient Imaging Studies



Common outpatient imaging studies include, for example, X-rays of the foot, shoulder, ankle, wrist, and chest. In 2022, the average APC price in the HOPD setting was 250% higher than those performed in an office setting. Approximately 70% of imaging occurs in the HOPD setting compared to 30% in an office setting. Over the six years, prices for these scans increased by 19% in the HOPD setting compared to 11% in the office setting.

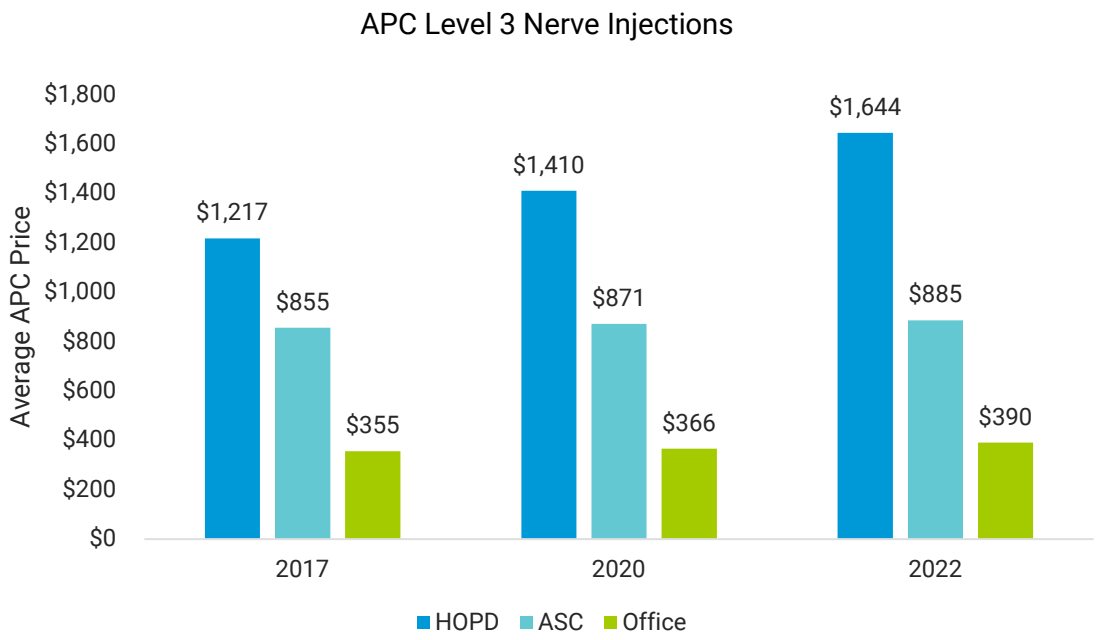
Figure 5b. Chest X-Ray



Chest X-rays are common outpatient imaging studies performed to evaluate symptoms and conditions, such as shortness of breath and chest infections. In 2022, the average service price was over three times higher in the HOPD. The average service price for chest X-rays grew 170% in the HOPD setting and 130% in the office setting between 2017 and 2022.

High Volume in HOPD, ASC, and Office

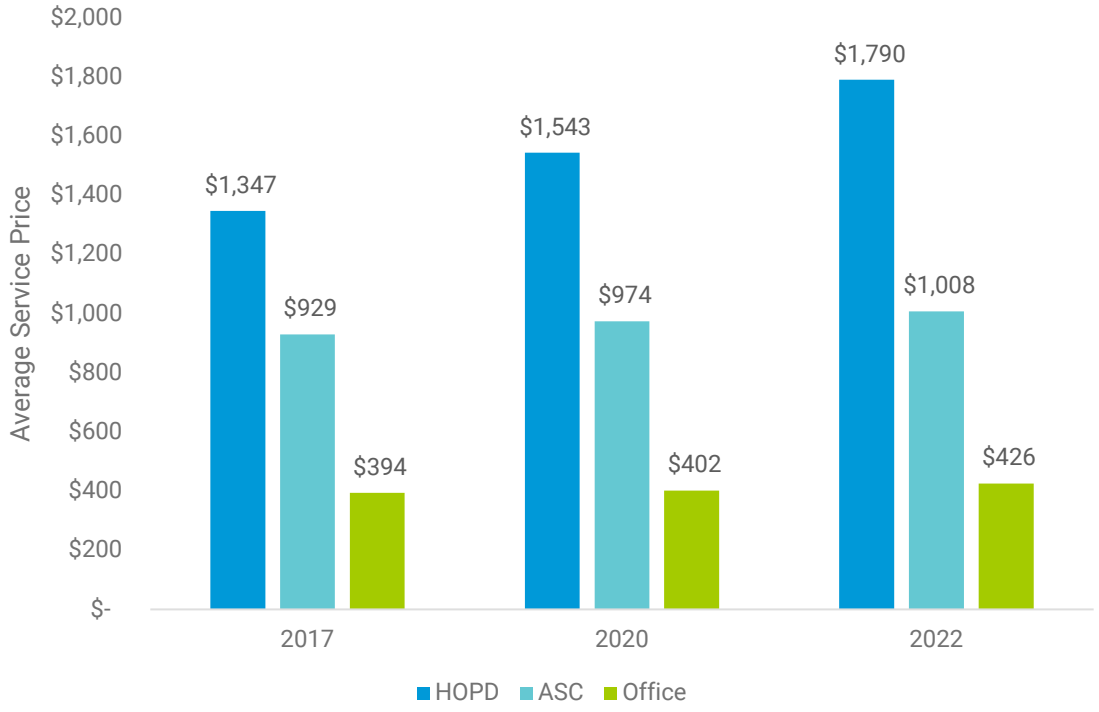
Figure 6a. Common Outpatient Epidural and Nerve Block Injections



APC Level 3 Nerve Injections primarily consist of epidural and nerve block injections. This APC has substantial volume across all three settings: 45% in the office, 28% in the HOPD, and 27% in the ASC. In 2022, the average APC prices in the HOPD were 85% higher than in the ASC setting and 300% higher than in the office setting. Between 2017 and 2022, APC prices in the HOPD rose by 35%, office prices rose by 10%, and ASC payments increased by 4%.

The average total prices, including ancillary services, were $5,700 in the HOPD, $2,368 in the ASC setting, and $559 in the office setting in 2022. There was a 250% increase in the average total price for a service rendered in an HOPD, 168% increase in an ASC, and only a 40% increase in the office setting. (See the Appendix for total prices of Level 3 Nerve Injections.)

Figure 6b. Corticosteroid Backpain Injection

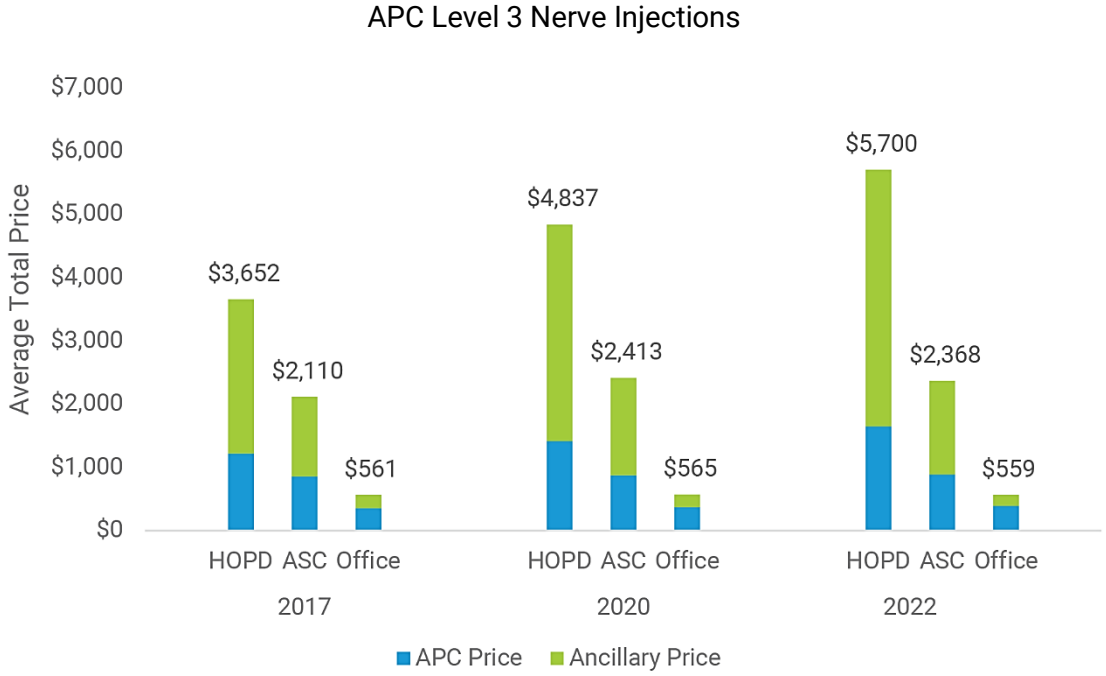


Corticosteroid injection, a common treatment for back pain, is a procedure in the APC Level 3 Nerve Injection. In 2022, the difference in average service pricing between the HOPD and ASC settings was 77% and 320% in the office setting.

Total Price Comparison

Ancillary services performed on the same day as the principal service greatly increase the price and cost differences across the care setting. In 2022, ancillary services accounted for 73% of the total billed cost, including facility fees in the HOPD setting versus 37% in the office, and 32% in the ASC settings. Some of the more frequently billed ancillary services include routine blood draws, tests such as complete blood counts, electrocardiogram tracing, urinalysis, etc. A specific APC example is shown below in Figure 7.

Figure 7. Average Total Price for Common Outpatient Epidural and Nerve Block Injections

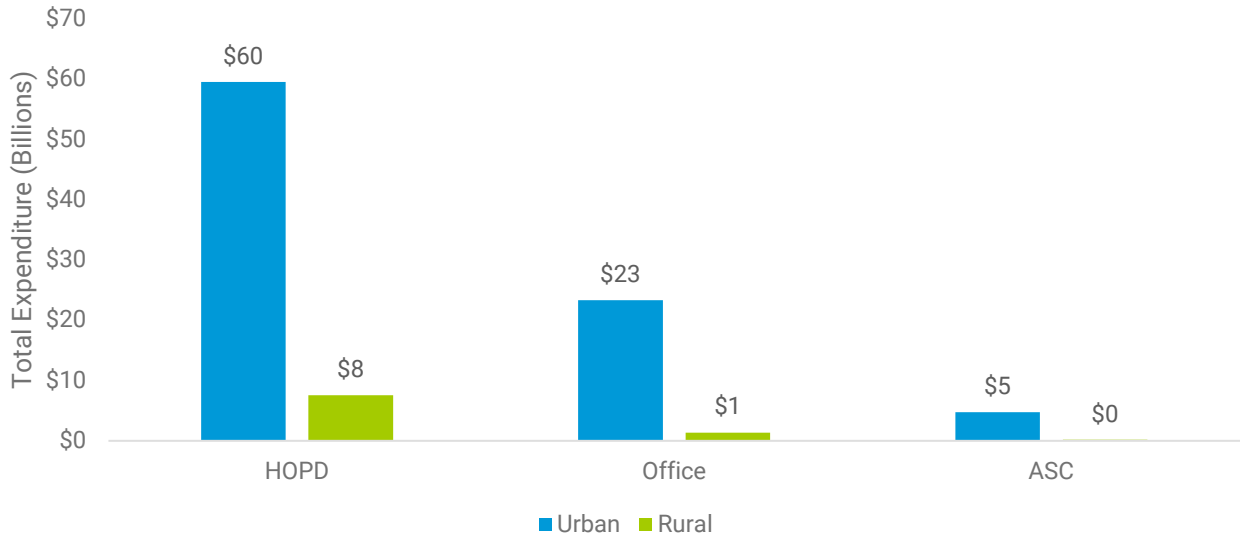


The average total price for epidural and nerve block injections were substantially higher in the HOPD setting. In 2022, ancillary services added 71% to the total procedure cost in the HOPD compared to 63% in the ASC setting and 30% in the office setting.

Geographic Findings

One question often raised in site-neutral payment policies is the impact such policies would have on rural hospitals. In 2022, with the consolidation of rural providers and their medical staff by larger healthcare systems, nearly 90% of the total expenditures for the 34 APCs in rural areas occurred in the HOPD setting while in the urban areas ~70%. Additionally, rural providers only accounted for 9% of the total expenditures across the country for the 34 APCs (Figure 8).

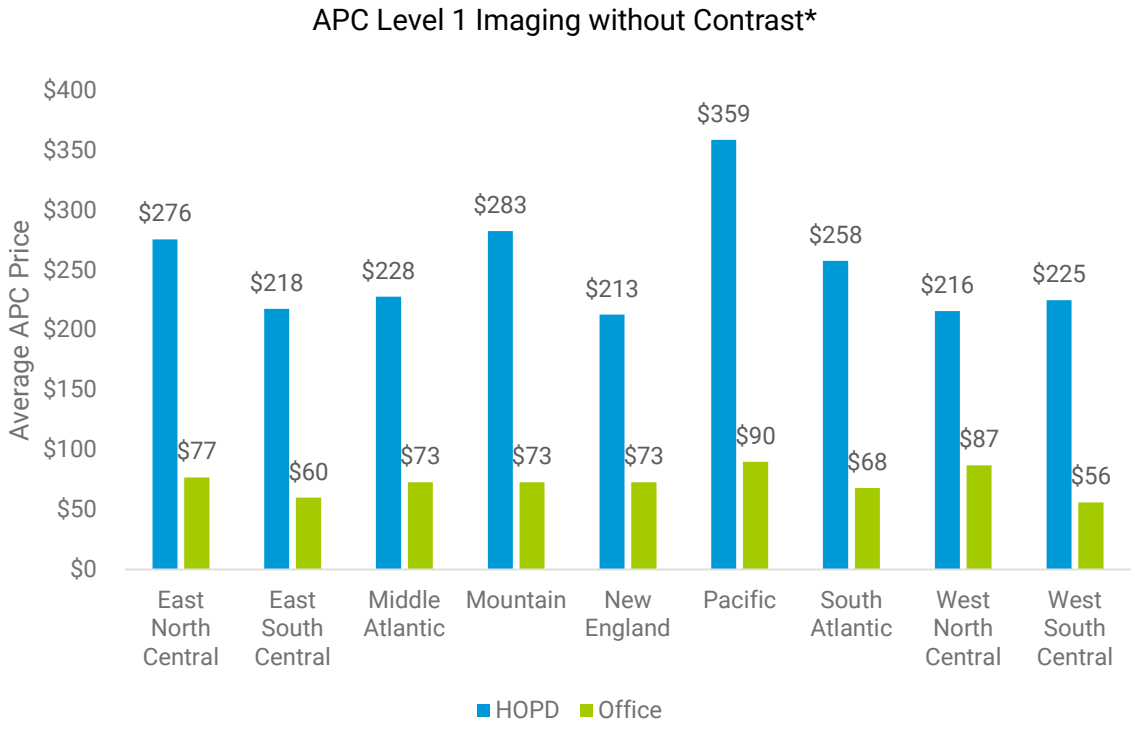
Figure 8. 2022 National Total Differences by Site of Care for Urban and Rural Areas



All Census Divisions Have Substantial Pricing Differences Across Sites of Care

One final issue that was examined was whether there are areas of the United States that are closer to achieving site-neutral pricing. While there is substantial site-specific variation in price across census divisions (see the map in the Appendix), HOPDs consistently charge more in every division (see example below).

Figure 9. Common Outpatient Imaging Studies by Census Division



**Note: ASC has been excluded from the figure above due to low volume.*

CONCLUSION

Some hospital outpatient facilities are often overpaid because they are not properly identified in claims submitted to insurers. H.R. 5378, recently passed by the U.S. House of Representatives, included a provision requiring a separate identification number for each of these facilities, which will help improve the accuracy of claims and reduce outpatient costs. The Congressional Budget Office estimated that such a provision in the law would generate savings of $400 million over ten years.

Expanding on BHI's earlier study of differences in prices and costs for six select procedures by site of care, this study gives a more comprehensive view of the impact that site of care has on outpatient healthcare costs.

Five main findings emerged from this study:

1. HOPD common procedure prices were substantially higher — in some cases, five times more expensive — than when performed in an ASC or office setting. While there is variability in prices and costs by site of care across census divisions, HOPD prices and costs were always higher.
2. HOPD prices grew rapidly, with a 27% average increase, compared to 11% for ASCs and 2% for physician offices.
3. For services provided in HOPDs, ancillary services (such as IV placement, anesthesia, or lab tests) comprise a greater proportion of the total price compared to the same procedures performed in other settings.
4. Rural providers account for less than 10% of all costs for the services examined, although they are more likely than urban areas to provide such services in a HOPD, which is an accurate reflection of the reality of their markets.
5. Site-neutral payments — billing the same amount for the same service across care delivery settings — would result in substantial savings for patients, businesses, and employees.

While this study was not designed to answer why these changes are happening, the consolidation of providers is a likely factor in these escalating costs. First, as hospital systems acquire more physician practices, they bill for more services as HOPDs, even though the actual delivery site has not changed. Second, market powers have shifted with this consolidation, allowing providers to negotiate higher reimbursement rates. Finally, in addition to unbundling professional and facility fees from bills, hospital systems appear to be more artful in adding ancillary services to their invoices.

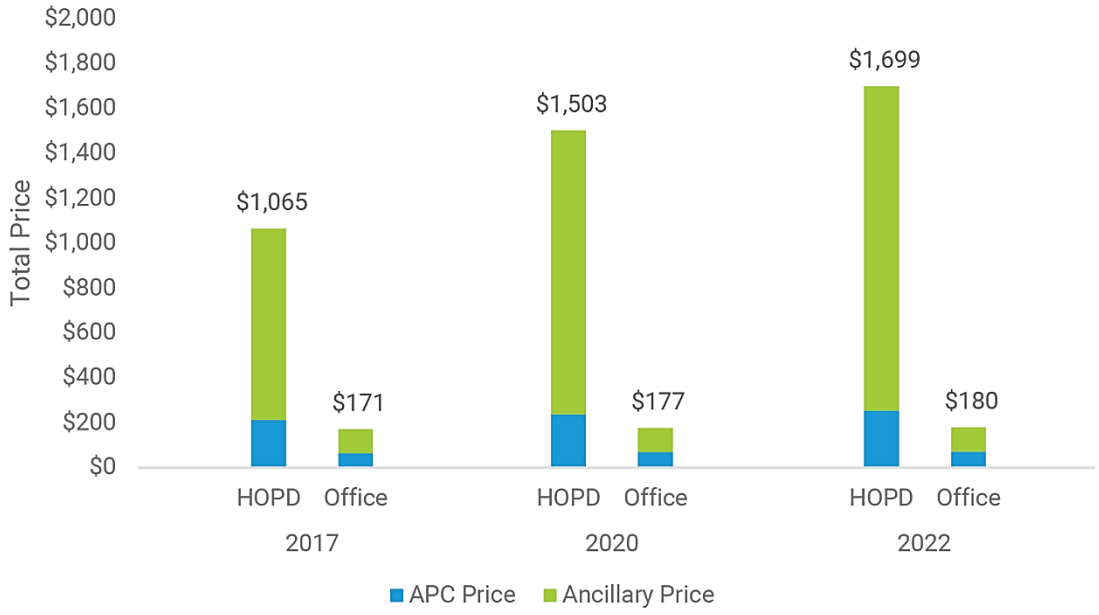
A main effort to address the price differences across sites of care is to move to site-neutral payments, using non-HOPD settings as the preferred price benchmarks. Although HOPD use is higher in rural areas, it appears there are limited ambulatory options available. Additionally, about 90% of spending among the APCs included in this study occurred in urban areas. The consistent finding of higher prices in HOPDs across census divisions suggests that the benefits of site-neutral payments would be widely felt.

Finally, our findings suggest that if commercial payers implemented site-neutral payments across settings, then employers, employees, Plans, and patients would realize substantial savings through lower premiums and out-of-pocket costs. Similar studies performed on Medicare data found that adopting site-neutral payment policies would yield savings for the Medicare program, private insurance premiums, and enrollees' out-of-pocket (OOP) costs that sum to $471 billion over the next 10 years[9].

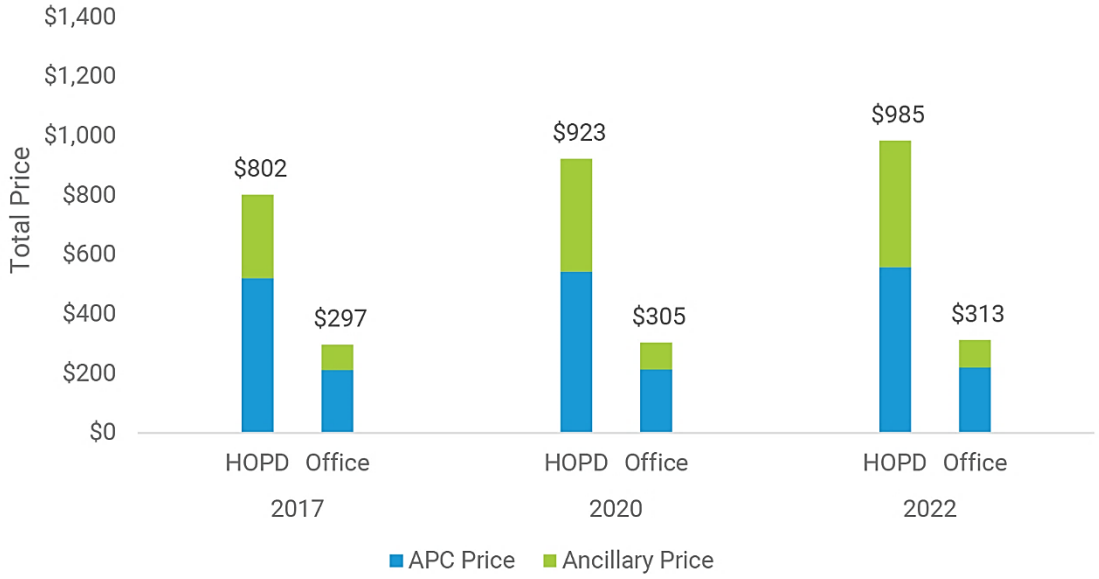
APPENDIX

Average Total Price Graphs

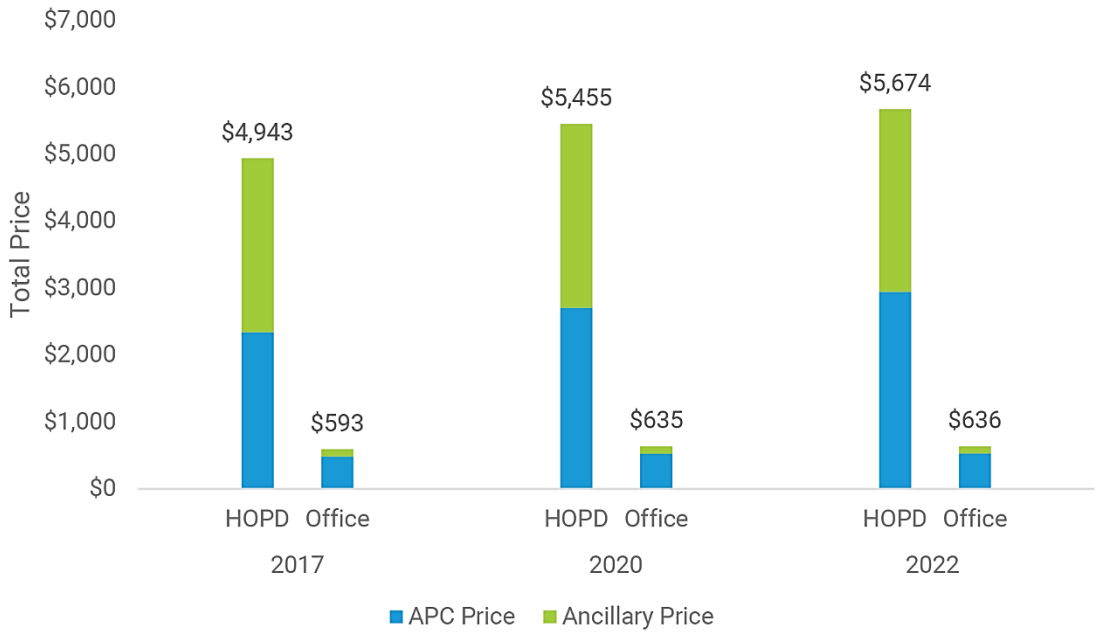
Level 1 Imaging without Contrast



Level 2 Imaging without Contrast



Level 3 Urology



Census Division Map

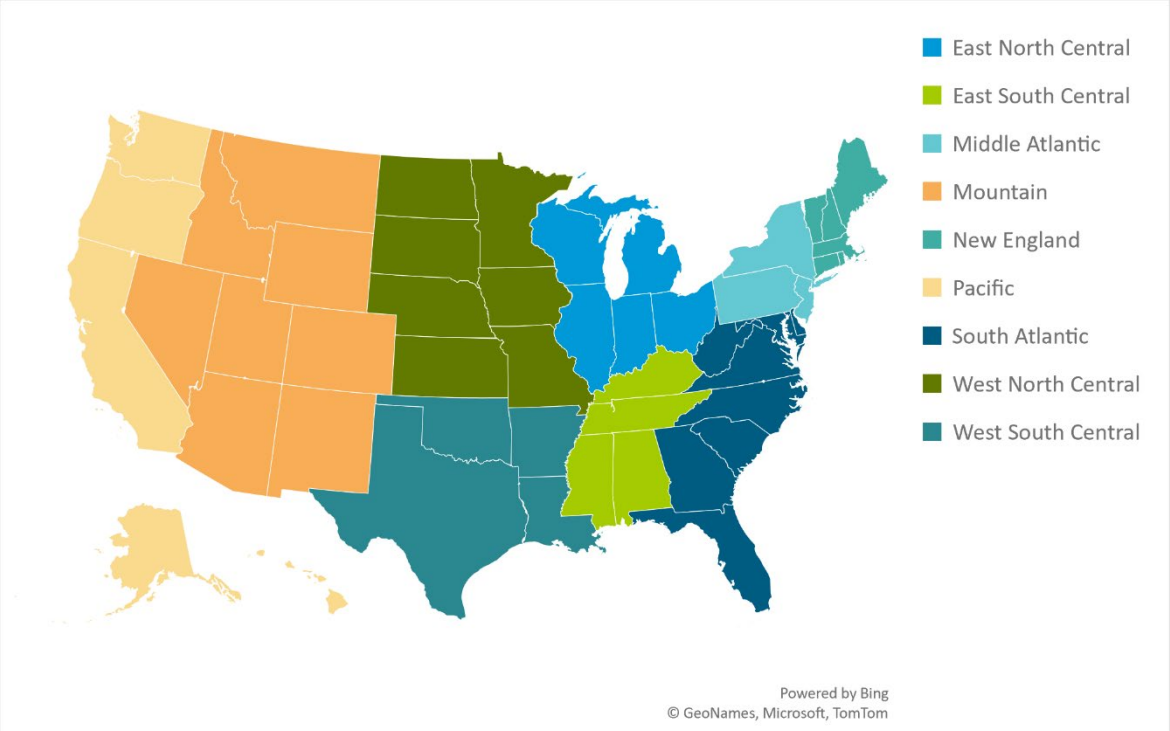


Table 2. 34 APC Detail

		Procedure Distribution			Average APC Price			Average Total Price		
APC	APC Description	HOPD	ASC	Office	HOPD	ASC	Office	HOPD	ASC	Office
5051	Level 1 skin procedures	3%	0%	97%	$460	$632	$156	$1,155	$2,414	$279
5052	Level 2 skin procedures	13%	1%	86%	$906	$654	$256	$2,068	$1,904	$429
5054	Level 4 skin procedures	21%	11%	67%	$3,160	$1,896	$1,172	$8,448	$2,999	$1,711
5071	Level 1 excision/biopsy/ incision and drainage	20%	2%	78%	$1,453	$710	$202	$3,520	$1,758	$481
5112	Level 2 musculoskeletal procedures	42%	42%	16%	$3,036	$2,055	$876	$6,062	$2,795	$1,042
5151	Level 1 airway endoscopy	7%	0%	93%	$638	$740	$249	$1,472	$2,821	$404
5153	Level 3 airway endoscopy	25%	4%	71%	$3,016	$1,256	$542	$9,575	$5,320	$721
5163	Level 3 ENT procedures	39%	28%	33%	$2,567	$1,671	$456	$5,695	$2,523	$812
5164	Level 4 ENT procedures	45%	35%	20%	$5,324	$3,783	$1,250	$12,700	$6,464	$6,016
5311	Level 1 lower GI procedures	39%	46%	15%	$1,698	$991	$510	$2,673	$1,127	$616
5312	Level 2 lower GI procedures	42%	50%	9%	$2,746	$1,550	$1,303	$4,387	$1,720	$1,435
5371	Level 1 urology and related services	12%	1%	87%	$1,111	$763	$188	$4,124	$3,308	$665
5372	Level 2 urology and related services	13%	7%	80%	$1,438	$651	$369	$2,928	$1,016	$523
5373	Level 3 urology and related services	24%	12%	65%	$2,947	$1,351	$533	$5,674	$1,664	$636
5411	Level 1 gynecologic procedures	27%	0%	73%	$503	$666	$114	$1,062	$1,421	$190
5431	Level 1 nerve procedures	37%	34%	29%	$3,230	$1,731	$665	$6,166	$2,656	$1,043
5441	Level 1 nerve injections	5%	1%	94%	$738	$1,011	$126	$2,190	$4,356	$337
5442	Level 2 nerve injections	33%	18%	49%	$1,562	$835	$289	$7,381	$3,565	$511
5443	Level 3 nerve injections	28%	27%	45%	$1,644	$885	$390	$5,700	$2,368	$559
5491	Level 1 intraocular procedures	22%	71%	8%	$3,448	$1,948	$364	$5,553	$2,097	$519
5521	Level 1 imaging w/o contrast	30%	0%	70%	$254	$201	$71	$1,699	$8,073	$180
5522	Level 2 imaging w/o contrast	32%	0%	68%	$558	$237	$221	$985	$2,027	$313
5523	Level 3 imaging w/o contrast	38%	0%	61%	$1,235	$295	$499	$2,074	$7,014	$568
5524	Level 4 imaging w/o contrast	42%	0%	58%	$1,388	$772	$361	$3,022	$4,188	$463
5593	Level 3 nuclear medicine	45%	0%	55%	$2,344	$1,184	$654	$4,090	$7,806	$1,094

		Procedure Distribution			Average APC Price			Average Total Price		
5611	Level 1 therapeutic radiation treatment preparation	51%	0%	49%	$2,006	$639	$243	$22,041	$10,214	$1,239
5671	Level 1 pathology	46%	0%	54%	$332	$212	$201	$5,465	$3,386	$301
5721	Level 1 diagnostic tests and related services	22%	0%	78%	$467	$925	$115	$1,699	$6,507	$300
5722	Level 2 diagnostic tests and related services	26%	0%	74%	$770	$1,316	$189	$2,132	$4,185	$407
5723	Level 3 diagnostic tests and related services	23%	0%	77%	$1,321	$807	$327	$3,424	$3,052	$726
5724	Level 4 diagnostic tests and related services	20%	0%	80%	$2,540	$661	$386	$3,040	$12,290	$548
5731	Level 1 minor procedures	29%	0%	71%	$56	$166	$42	$2,036	$4,771	$150
5732	Level 2 minor procedures	16%	0%	84%	$84	$104	$19	$5,250	$6,492	$238
5823	Level 3 health and behavior services	2%	0%	98%	$234	$136	$123	$394	$372	$131

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