FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Congress Must Act: Families Across America Should Pay the Same Price for the Same Health Care Services

Americans are struggling with an affordability crisis and rising health care costs, yet our health care system is full of wasteful spending that does not improve people's health.[1] One prime example of this is when big health care corporations make more money by driving patients to get care at outpatient departments, where the cost of care is significantly higher than at physician offices for the same services.[2]

THE PROBLEM

1. DISTORTED PAYMENT POLICIES

Medicare pays for outpatient care across sites of service in ways that promote care delivery in more expensive settings. Since commercial insurers and Medicaid often adopt Medicare payment policies, the broken payment incentives in Medicare are amplified across payers.[3]

2. DRIVE MEDICAL MONOPOLIES AND HIGHER COST CARE

Hospital-owned physician practices:

15% (2013) → 26% (2021)

Large hospital corporations take advantage of site-specific payment differences by buying up doctors' offices and "rebranding" them as hospital outpatient departments so they can charge more for care.[4] This practice decreases competition and leads to increased consolidation among large hospital corporations and physicians, driving higher health care prices and unaffordable care.

3. THE IMPACT ON FAMILIES AND PATIENTS

For families and individuals, these increasing prices mean higher premiums and out-of-pocket costs, including being charged "facility fees" that are typically associated with hospital visits **— even when care is provided outside a hospital.**

COST COMPARISON: DOCTOR'S OFFICE VS. HOSPITAL OUTPATIENT SETTING*

	DOCTOR'S OFFICE	DOCTOR'S OFFICE + HOSPITAL OUTPATIENT DEPARTMENT
ULTRASOUND	$164	$339
BIOPSY	$146	$791
PHYSICIAN OFFICE VISIT	$118	$186

* Source: Health Care Cost Institute, 2023. Figures are average prices of three common medical services using national health care claims data.

THE SOLUTION

Congress has the power to fix this. Bipartisan support is building for federal policymakers to enact comprehensive "site-neutral" payment reform that fixes underlying payment disparities and eliminates the ability of big hospital corporations to game Medicare's payment system.

SAME SERVICE, SAME PRICE

Implementing the Medicare Payment Advisory Commission's (MedPAC) comprehensive site neutral payment policy would ensure that our nation's families pay the same price for the same health care service regardless of where they get care.[5]

THE IMPACT

A same service, same price policy will generate savings by cutting waste. The Congressional Budget Office scored a site-neutral proposal from 2020 and determined that it would allow Medicare to save $141 billion.[6] Other analyses project Medicare would save between $150-$202 billion, including direct savings for Medicare beneficiaries.[7]

The savings generated from a comprehensive site-neutral payment policy should be reinvested in health care, bolstering essential providers and health care services that ensure families and individuals have access to high-quality, affordable care.

See the ways Congress can redirect these health care savings on the following pages.

OPTIONS FOR CONGRESS TO REDIRECT THESE HEALTH CARE SAVINGS INCLUDE:

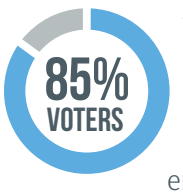
» **Supporting rural and safety-net hospitals,** particularly those at high risk of closure that would threaten access to care for vulnerable populations. This includes hospitals that serve a high proportion of patients who are uninsured, have public insurance, or have low-incomes. While many hospitals and large health systems are experiencing record high revenues and profits, rural and safety-net hospitals who serve the most vulnerable patients often operate with razor thin operating margins and are closing at an alarming rate.[8] Reinvesting site-neutral savings in such hospitals could be achieved through the following options:

1. Institute across-the-board payment adjustments for certain safety-net and rural hospitals under the Medicare Physician Fee Schedule, the Outpatient Prospective Payment System, or the Inpatient Prospective Payment System, and/or by applying a "stop loss" policy as modeled by MedPAC to ensure sustainable Medicare revenue for safety net and rural hospitals as site neutral payments are implemented.[9]
2. Delay certain disproportionate share (DSH) hospital payment reductions by two years, which CBO estimated would cost $6.4 billion.[10]
3. Extend the provision of cost-based reimbursement to cover more vulnerable hospitals, as is currently done with Critical Access Hospitals (101% of reasonable costs).[11]

Importantly, waiving new site-neutral policies for certain hospitals should not be considered: Site-specific payments are generally unrelated to the actual cost of providing care, so waiving such payments would continue to encourage hospital system consolidation and other forms of industry gaming that harm the health and financial security of families with higher out-of-pocket costs.

» **Increasing payments to primary care providers** to support and sustain a robust and comprehensive primary care system through an extension of the Primary Care Incentive Payment Program. The Affordable Care Act authorized this program, which provided a quarterly 10% Medicare bonus payment for primary care providers from 2011 to 2015, and a Medicaid primary care payment bump that required all Medicaid programs to pay for certain primary care services at Medicare payment levels for calendar years 2013-2014. CBO scored these sections of the ACA at $11.8 billion.[12]

- **Extending Medicare benefits to include dental, vision and hearing** coverage to meet the whole-person health needs of families and older adults. CBO scored a comprehensive dental, vision and hearing benefit in Medicare as part of H.R. 3, projecting the total benefit to cost $358 billion over 10 years (dental at $238 billion, vision at $30 billion, and hearing at $89 billion).[13]
- **Expanding financial assistance to low-income Medicare beneficiaries** to ensure low-income seniors and people with disabilities can afford the life-saving care that they need. Congress may consider proposals such as adding an income-related out-of-pocket limit to Traditional Medicare and expanding eligibility for financial assistance with Medicare Parts A and B premiums and cost-sharing. The Kaiser Family Foundation projected that adding an income-related out-of-pocket limit would cost $118.7 billion over 10 years.[14]
- **Investing in targeted programs to bolster our nation's health care workforce,** close the workforce shortage gap, and meet the health needs of families and individuals. Options for this include:
  - Creating and appropriating funding for a graduate nursing education program to provide payments for qualified advanced practice registered nurse training costs, as proposed in bipartisan legislation from Senators Hassan (D-NH) and Braun (R-IN).
  - Increase funding for the Teaching Health Center Graduate Medical Education (THCGME) program, which has been successful at developing a primary care workforce that is trained in and remains in underserved communities.[15] Reauthorization of funding for the THCGME program at current funding levels for the next 10 years requires an investment of $1.3 billion.[16] A proposal to permanently authorize and expand the program introduced in the 118th Congress costs $4.8 billion.[17]



Americans want Congress to lower health care prices and increase competition in the U.S. health care system. In fact, 85% of voters believe that Congress should limit hospital outpatient fees to the same price charged by doctors in the community, and 75% of voters believe that Congress should stop hospitals from engaging in business tactics that reduce competition.[18]

Enacting a comprehensive site-neutral payment policy is a critical step to infuse competition back into the U.S. health care system and to make health care more affordable for our nation's families. Such a policy would help ensure that the business interests of the health care sector are truly aligned with the financial security and health outcomes of patients across the country.

Endnotes

[1] Gallup, "Record High in U.S. Put Off Medical Care Due to Cost in 2022," January 2023,https://news.gallup.com/poll/468053/record-high-put-off-medical-care-due-cost-2022.aspx. See also William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA 322, no. 15 (2019): 1501–1509, https://jamanetwork.com/journals/jama/articleabstract/2752664.

[2] Committee for a Responsible Federal Budget, "Moving to Site Neutrality in Commercial Insurance Payments," February 14, 2023, https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance#_edn9.

[3] Eric Lopez Tricia Neuman, Gretchen Jacobson, and Larry Levitt, "How Much More than Medicare Do Private Insurers Pay? A Review of the Literature," (KFF, April 15, 2020), https://www.kff.org/medicare/issue-brief/how-much-more-thanmedicare-do-privateinsurers-pay-a-review-of-the-literature/. See also, Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments," *J Polit Econ* 125, no. 1 (February 2017): 1–39, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5509075/.

[4] Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System (MedPAC, June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[5] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy (MedPAC, March 2023), https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/.

[6] Congressional Budget Office, Proposals Affecting Medicare--CBO's Estimate of the President's Fiscal Year 2021 Budget, March 2020. https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf.

[7] Philip Ellis, Savings Estimates for Options to Reduce Spending on Health Care and Private Insurance Premiums (Ellis Health Policy, January 2023), https://www.bcbs.com/sites/default/files/file-attachments/affordability/EHP%20-%20Savings%20Estimates%20-%20BCBSA%20-%2001-18-2023-Final.pdf.

[8] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy March 2023. See also Government Accountability Office, Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services* (GAO, December 2021), https://www.gao.gov/products/gao-21-93.

[9] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (MedPAC, June 2023), See pages 25-27 of PDF. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[10] The CBO score is based on title III of the REACH Act, which includes a two-year delay in planned DSH payment reductions, certain hospital reporting requirements within Medicaid, and a required GAO report. For more information, see Congressional Budget Office, *At a Glance: H.R. 2328, Reauthorizing and Extending America's Community Health Act*, September 18, 2019. https://www.cbo.gov/system/files/2019-09/hr2328.pdf.

[11] See, for example, page 5 of CMS, *Information for Critical Access Hospitals*, April 2023. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsht.pdf. Cost-based reimbursement refers to providers being reimbursed by health care payers based on the providers' reported costs associated with delivering patient care. In the case of critical access hospitals (CAH), Medicare will pay a CAH 101% of its reported costs associated with the delivery of outpatient, inpatient, laboratory and therapy services, as well as post-acute care in the hospital's swing beds. For more information, see Medicare Payment Advisory Commission, *paymentbasics: Critical Access Hospitals Payment System*, October 2022. https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_CAH_FINAL_SEC.pdf.

[12] The CBO score is based on sections 5501 (Medicare Primary Care Incentive Payment Program; $3.5 billion) and 1202

(Medicaid Primary Care payment increase; $8.3 billion) of H.R. 3590. For more information, see https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf.

[13] The CBO score is based on Title VI of H.R. 3, which would add new benefits to Medicare for dental, hearing, and vision services, including dentures, glasses, hearing aids and preventive services. For more information see, https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf.

[14] Kaiser Family Foundation, *Options to Make Medicare More Affordable for Beneficiaries Amid the COVID-19 Pandemic and Beyond* (KFF, December 2020), https://www.kff.org/report-section/options-to-make-medicare-more-affordable-for-beneficiaries-amid-the-covid-19-pandemic-and-beyond-tables/.

[15] See, for example, Caitlin Smith Davis et al., *Evaluating the Teaching Health Center Graduate Medical Education Model at 10 Years: Practice-Based Outcomes and Opportunities*, Journal of Graduate Medical Education, October 2022, https://meridian.allenpress.com/jgme/article/14/5/599/487458/Evaluating-the-Teaching-Health-Center-Graduate.

[16] According to CBO, S.1895 appropriated $126 million for Teaching Health Centers that operate graduate medical education programs for each fiscal year from 2020 through 2024. For more information, see page 14 of https://www.cbo.gov/system/files/2019-07/s1895_0.pdf.

[17] Committee Democrats, Energy and Commerce Committee, U.S. House of Representatives. https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/wysiwyg_uploaded/PALLON_005_xml.pdf.

[18] Arnold Ventures, *New Poll: Majority of Voters Support Aggressive Congressional Action to Lower Hospital Prices*. (Arnold Foundation Survey Study #14460, March 23, 2023), https://www.arnoldventures.org/stories/new-poll-majority-of-voters-support-aggressive-congressional-action-to-lower-hospital-prices?x-craft-preview=FZfdMAYpOB&token=WENwOldeHSblx2pRQ6y01tk_BGY5flyX.

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VAL 2023-118