

Shifting From Hospital Outpatient Departments to Physician Offices Equates to Significant Cost Reductions

Employers are continually seeking to manage health care costs as part of overall expense oversight efforts. According to [recent research from the Employee Benefit Research Institute](#), one way to do this might be to focus on the use of hospital outpatient departments (HOPDs) vs. physician offices (POs) for physician-administered outpatient drugs (PAODs).

Physician-Administered Outpatient Drugs (PAODs)

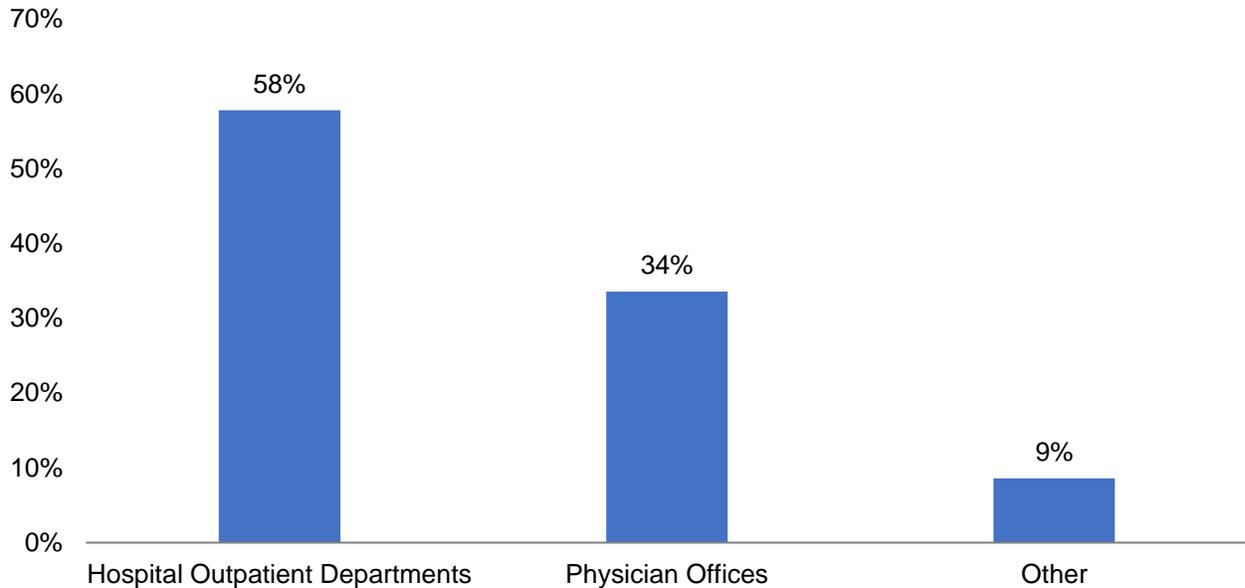
An increasing number of medications are being developed as either injectables or intravenous drugs. Physicians often administer these medications; thus, they are largely paid for via the medical benefit. A subset of these physician-administered outpatient drugs (PAODs), known as specialty medications, provide a highly sophisticated treatment, generally when there are few or no other treatment options available. Some of the benefits of specialty medications include the reduction of the number relapses, prevention of disability progression; symptom management; maintenance and/or improvement of quality of life; and, sometimes, disease remission or cures. These specialty medications have piqued the attention of employers, more so than PAODs overall, because of their relatively high costs.

In evaluating prices for the top 72 PAODs, EBRI finds an annual median price differential — or markup — of more than \$5,000 for PAODs provided within HOPDs vs. POs. This markup reaches as much as \$78,700 for one specific oncology injection. Together, these 72 medications account for nearly one-half of all claims and nearly three-quarters of all spending on PAODs paid via the medical benefit.

The average unit price differential of the PAODs was 200 percent. In other words, on average, plan payments to HOPDs were triple what plan payments were to POs for the same unit of medication. The median unit price differential was 100 percent, or double for HOPDs vs. POs.

This is important because just over one-half of PAODs are administered in HOPDs, while one-third are administered in a PO and 9 percent are received in other settings, such as a patient's home. If POs replaced HOPDs, savings would be \$80.21 per member, per year, for the 72 drugs examined. In the aggregate, employers and workers would collectively save \$10.3 billion annually if price differentials between HOPDs and POs were eliminated for the 72 PAODs examined.

Distribution of Various Physician-Administered Outpatient Drugs, by Site of Service



Source: Authors' analysis of IBM MarketScan administrative enrollment and claims data.

Over the full sample of PAODs, aggregate savings would be \$14.1 billion each year, or \$110.03 per member, per year, for all PAODs if price differentials between HOPDs and POs were eliminated. In other words, employers could cut spending by \$14.1 billion by shifting patients away from more costly HOPD settings or by negotiating site-neutral pricing for specialty medications. This represents 1.5 percent of total health care spending on workers and their families.

Estimated Savings	
Top 72 Physician-Administered Outpatient Drugs (PAODs)	\$10.3 billion
All Physician-Administered Outpatient Drugs	\$14.1 billion
Potential Savings From HOPD Markup of 72 PAODs (per member, per year)	\$80.21
Percent of Aggregate Spending	1.1%
Potential Savings From HOPD Markup of All PAODs (per member, per year)	\$110.03
Percent of Aggregate Spending	1.5%

Data and Study Sample

This study makes use of the 2019 IBM® MarketScan® Commercial Claims and Encounters Database (CCAЕ). The CCAЕ database contains member enrollment information as well as adjudicated inpatient and outpatient medical and pharmacy claims. We constructed an analytical dataset of adults (ages 18–64) who were continuously enrolled in employment-based health plans in 2019. Members in capitated plans were excluded. A total of 10.8 million individuals met these criteria.

Conclusion

There are a number of actions these third-party payers can take:

- They can exert pressure on hospitals to shift from discounted charge contracts based on a multiple of Medicare to some other prospective case rate. However, increasing consolidation of health care providers makes it harder for employers and insurers to exert any kind of pricing pressure on hospitals.
- In the absence of such market power, employers and insurers can attempt to engage patients through increased price transparency. However, price transparency by itself has been found to be insufficient in reducing hospital prices unless combined with plan design changes intended to steer patients to less costly sites of treatment. Furthermore, recent public policy efforts to address pricing transparency found that 34 percent of hospitals have not posted usable pricing data and another 12 percent posted data that fell well short of the requirements.¹
- Employers and insurers could move patients from HOPDs to other sites of treatment by removing the HOPDs from their network. Such an arrangement is most common in staff-model health maintenance organizations (HMOs) but can be applied more generally to any network plan. Providers could respond by lowering their prices so that they may return into the network. This strategy has its limitations as well. It may not work well in areas with limited provider choices or in areas where powerful hospital systems limit payers' ability to exclude certain high-cost provider locations from their network.

Ultimately, employers and workers bear the brunt of cost differences when HOPDs perform services that can be provided in less costly POs.

About EBRI: The Employee Benefit Research Institute is a private, nonpartisan, nonprofit research institute based in Washington, DC, that focuses on health, savings, retirement, and economic security issues. EBRI does not lobby and does not take policy positions. The work of EBRI is made possible by funding from its members and sponsors, which include a broad range of public, private, for-profit and nonprofit organizations. For more information go to www.ebri.org or connect with us on [Twitter](#) or [LinkedIn](#).

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Endnotes

¹ See <https://www.wsj.com/articles/methodology-how-the-wsj-analyzed-hospital-pricing-data-11625583571>.

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