EBRI FAST Facts
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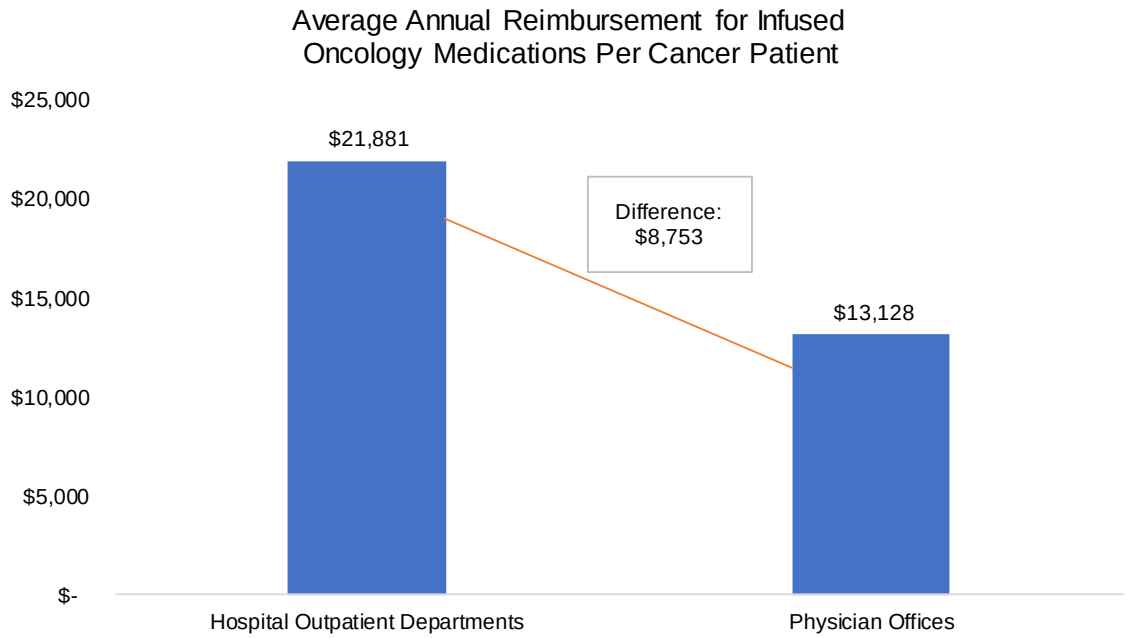
Higher Oncology Medicine Costs, Equivalent Value: Evaluating Treatment in Hospital Outpatient Departments vs. Physician Offices

Payments from third-party payers for infused oncology medicines are higher when care is provided in hospital outpatient departments (HOPDs) compared with physician offices (POs). Some have speculated this is due to differences in patient characteristics and treatment regimens between the two sites of care, but recent research from the Employee Benefit Research Institute (EBRI) finds this isn't true.

> This study employed a novel analytical approach that distinguishes differences in the cost of drugs due to price alone from differences attributable to drug mix and treatment intensity for cancer patients. The study was based on 18,195 users of the top 37 infused cancer drugs prescribed to employment-based and commercially insured patients in 2016.

In evaluating prices for the top 37 infused cancer drugs, EBRI finds they averaged 86.2 percent more per unit in hospital outpatient departments than in physician offices. For every drug examined, HOPDs charged more on average with statistically significant relative differences ranging from 128 percent to 428 percent.

Nearly one-half of the cancer patients in the study were treated in HOPDs. Over the full sample of drugs, actual payments averaged $13,128 in POs and $21,881 in HOPDs, a difference of $8,753. If payers reimbursed hospitals at the same rate they reimbursed physician offices, the average payment per cancer patient would have dropped by 45 percent. That means over one year, employers and insurers could save $9,766 per covered cancer patient without affecting quality of care.



The study's findings have implications for private third-party payers, including employers and commercial insurers. To counter higher HOPD pricing, employers can aim to negotiate contracts with hospitals for site-neutral payments to ensure that costs for the same treatment are not higher in the HOPD relative to the PO. In the absence of countervailing market power, third-party payers can engage cancer patients through plan design to guide them to less costly sites that are clinically appropriate for their care. Shared decision-making tools can be used to help explain treatment site options in plain language.

Insurers use both value-based insurance design (VBID) and reference pricing to vary patient cost-sharing based on the choices that they make regarding use of health care services. However, one thing to consider is whether cancer patients receiving oncology services will be sensitive to cost-sharing, since they are some of the highest-cost claimants. They not only are more likely than the average person to reach their deductible, they are also more likely to reach their out-of-pocket (OOP) maximum. Hence, higher patient cost-sharing may not be effective unless clinically appropriate VBID or reference pricing tools remain in force for patients who exceed OOP maximums.

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