Addressing Unnecessary Spending in Health Care

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Arnold Ventures

Introduction

American families today are grappling with soaring health care costs, facing a system rife with inflated prices, lack of coordination, anti-competitive practices, and increasing consolidation among providers. Both Democrat and Republican voters agree that the status quo isn't working for patients seeking care or for the employers, taxpayers, and families paying for it.

With such a consensus among voters on the need for change, there is growing pressure on Congress to lower health care costs. While it's clear that waste, fraud, and abuse must be tackled, there is a deeper debate about how to achieve real savings. Much of the debate has been around Medicaid, which provides vital coverage to approximately 80 million Americans, including low-income families and individuals with disabilities.

But Congress does not need to cut Medicaid coverage to lower federal health care spending, this approach presents a false choice.

The truth is, there are numerous opportunities to reduce waste, fraud, and abuse in the health care system—efforts that can generate over $1 trillion in savings over 10 years—without cutting coverage or compromising the care that millions of Americans rely on.

It's possible to lower costs for taxpayers and improve care for patients. But this can only be done by tackling inefficiencies and abuses and taking on the powerful industries that benefit from them.

By confronting the entrenched special interests of hospitals, insurers, and pharmaceutical companies that take advantage of the system and drive up the cost of care, Congress can achieve significant savings while preserving coverage and ensuring better outcomes for patients. Here are five solutions:

1. **Advance Comprehensive Site-Neutral Payment Reforms**: Align payment rates for routine services across health care settings to ensure patients and taxpayers do not pay higher prices for care that can be safely provided in a lower cost setting.
2. **Require Site-of-Service Billing Transparency**: Increase transparency of where care is being delivered to help avoid inflated costs based solely on service location.
3. **Modify Risk Adjustment Payments to Medicare Advantage Insurers**: Address abusive and in some cases fraudulent billing practices that unnecessarily increase Medicare spending and taxpayer subsidies to health plans.
4. **Reduce the Payment Benchmark for Medicaid State-Directed Payments**: Recent regulation allows Medicaid to pay commercial rates as high as 300-400% of Medicare rates in managed care contracts. This policy would limit payments to what Medicare would pay in managed care contracts—similar to limits in fee-for-service.
5. **Extend Drug Price Inflation Penalties to Commercial Plans**: Apply penalties for price increases to commercial plans, not just Medicare and Medicaid, creating pressure to curb price hikes across the health care system.

Advance Comprehensive Site-Neutral Payment Reforms

Background: Right now, patients and taxpayers are charged billions more simply because of where they receive care. Medicare currently pays 2 to 4 times more for services provided in a hospital outpatient department than they do when that same service is delivered in a physician's office. Hospitals have been buying up physician practices and rebranding them as hospital outpatient departments to bill for the same services at the higher hospital rate—even when the doctor, patient, and service remain the same.

While Congress took initial steps to address this payment differential in the Bipartisan Budget Act (BBA) of 2015, most off-campus services delivered at "grandfathered" hospital-owned outpatient departments that existed before 2015 as well as low-complexity on-campus services that can be safely delivered in a physician office at a lower cost continue to be paid at the higher hospital rate.

Problem: Paying higher prices for the same services depending on the site of care increases spending for taxpayers and Medicare beneficiaries. This payment differential also creates a financial incentive for further consolidation as hospitals buy physician practices to charge higher prices for the same services. Increased hospital consolidation stifles competition, reduces choice, and drives up prices including in the commercial insurance market. Over time, care has shifted from lower-cost independent physician offices to higher-cost hospital outpatient departments, even for routine services like office visits or MRIs.

Solution: Enact comprehensive site-neutral payment reform by:

- Equalize payments for a specific set of low-complexity, routine services across settings (including on-campus facilities) by requiring Medicare to pay a site-neutral rate for certain services based on the lowest-cost setting where they are most commonly performed, whether a hospital outpatient department, ambulatory surgical center, or physician's office.
- A less comprehensive solution is to eliminate the grandfathering exemption for off-campus hospital-owned outpatient departments created prior to the 2015 BBA.

The Medicare Payment Advisory Commission (MedPAC) has identified a number of potential services that could be included in such a policy. President Trump included similar policies in his FY21 budget, and Senators Cassidy (R-LA) and Hassan (D-NH) developed a bipartisan legislative framework for comprehensive site-neutral payment reforms in late 2024 that would also reinvest a portion of the savings into rural and safety-net hospitals.

10-YEAR SAVINGS: $157B (CBO). The savings achieved by this policy can be dialed by paying for a more or less expansive set of services on a site-neutral basis. Eliminating the grandfathering exemption alone saves about $30-40B (CRFB, CBO).
Site-neutral payment would also reduce out-of-pocket costs for Medicare beneficiaries, with comprehensive reform reducing cost-sharing and premiums for Medicare beneficiaries by more than $90 billion over ten years (CRFB).

Require Site-of-Service Billing Transparency

Background: As hospitals buy up physician practices, there is less transparency about where services are being delivered–for example, on a hospital's main campus or at an off-site clinic that resembles a physician office–because of how providers bill. Health care providers—including physicians, hospitals, and other facilities—are assigned a 10-digit numerical identifier known as National Provider Identifiers (NPI), which is used to bill for health care services in both Medicare and the commercial market. Currently, off-campus hospital outpatient departments—which in most cases resemble physician offices and could be paid a lower rate than hospitals for the same services—can bill under the same NPI as the main hospital who owns them, making it difficult for payers to track where services are being provided and to pay appropriately.

Problem: Allowing off-campus outpatient departments to bill under the same NPI as the main hospital campus results in a lack of transparency over where care is delivered and leads to patients being charged excessively high hospital prices for care that is being provided in a lower-cost setting, such as off-site clinics or hospital-owned physician offices. Paying higher prices for the same services depending on the site of care increases health care costs for consumers, patients, employers, and taxpayers.

Solution: Require each off-campus outpatient department of a Medicare provider to obtain and bill under a unique, separate NPI on claims for health care services. This policy would also have spillover benefits to the commercial market. The bipartisan Lower Costs, More Transparency Act—passed by the House in 2024—included site-of-service billing transparency.

While this policy is a step towards site-neutral payments and may allow insurers to pay more appropriately for care, it does not directly equalize payment rates across settings as site-neutral reform would.

10-YEAR SAVINGS: $2.3 billion (CBO).

Modify Risk Adjustment Payments to Medicare Advantage Insurers

Background: Medicare Advantage (MA) is an alternative to traditional Medicare (TM) run by private insurance companies. More than half (54%) of all Medicare beneficiaries are now enrolled in MA, up from 26% in 2010, and enrollment is projected to continue growing. The Medicare program pays MA insurers a risk-adjusted set amount to pay for their enrollees' care. Enrollee risk scores are based on recorded diagnoses that insurers submit for their enrollees, and insurers receive higher payments for enrollees with higher risk scores. This creates strong financial incentives for MA insurers to make their patients appear sicker than they actually are relative to similar beneficiaries in TM. Health risk assessments (HRAs) and chart reviews are two tactics that MA insurers use to add diagnosis codes. They are a major driver of upcoding and often result in additional reported diagnoses for which patients receive no care.

Problem: While the MA program was created with the intention of delivering efficiencies and cost-savings to the Medicare program, it has never produced savings relative to TM and in fact costs the program substantially more per enrollee than TM, contributing to Medicare's fiscal challenges and threatening its solvency. Upcoding is a major driver of overpayments to MA insurers.

MedPAC estimates that upcoding will result in about $40 billion in excess payments to MA insurers in 2025 alone. Numerous lawsuits, audits, and investigations have documented widespread, abusive and in some cases fraudulent billing practices by MA insurers. In some cases, insurers are coding diagnoses for which a beneficiary receives no treatment.

The billions in overpayments to MA insurers each year due to upcoding increase Medicare spending and threaten the solvency of the Medicare trust fund. They also increase Medicare premiums for all beneficiaries, including beneficiaries in TM who are not even enrolled in MA plans.

Solution:

- Fully account for upcoding in MA by increasing the statutory minimum coding intensity adjustment that reduces payments to MA plans based on the coding differential between MA and TM. This policy should be implemented in a way that accounts for coding differences across MA plans, as some MA insurers code much more aggressively than others.
- Exclude HRAs and chart reviews as sources of diagnoses and use two years of diagnostic data for MA risk adjustment.

10-YEAR SAVINGS: Increasing the coding intensity adjustment could reduce Medicare spending by up to $1T (CBO). The coding intensity adjustment can be dialed to achieve a specific level of savings. Improving risk adjustment by excluding information from HRAs and chart reviews and using two years of data would save $124B (CBO).

Reduce the Payment Benchmark for Medicaid State-Directed Payments

Background: Medicaid is an important safety-net program that provides coverage to roughly 80 million Americans. Medicaid's complex financing rules have created opportunities for large corporations with political influence, such as hospital systems, nursing homes, and managed care organizations, to increase their payments and drive up federal costs.

States that use Medicaid managed care plans are generally not permitted to specify the amount or how contracted providers are paid, unless directing the payment furthers the state's overall Medicaid program goals and objectives (e.g., value-based payments)—payments made under this exception are called "state directed payments." CMS finalized a rule in 2024 that articulated its long-standing policy that state-directed payments to hospitals and nursing homes could be paid up to average commercial rates. Only a few states have approved state-directed payment at this level, though many states are considering similar approaches since the rule was finalized.

Problem: Allowing the Medicaid program to pay average commercial rates to hospitals and nursing homes increases Medicaid program costs and puts upward pressure on commercial prices in states. A significant body of research has found that commercial hospital rates are on average over twice what Medicare would pay for the same service (KFF). Commercial rates often exceed Medicaid and Medicare rates because many providers have consolidated market power that allows them to set prices without competition. Additionally, average commercial rates are higher than equivalent Medicaid allowable payments made in fee-for-service, which are limited to the Medicare rate, creating an incentive to move to managed care.

Solution: Align payment parameters in Medicaid fee-for-service and managed care and lower the benchmark for state-directed payments to what Medicare would pay. We anticipate the impact on the number of people with health insurance coverage to be minimal.

10-YEAR SAVINGS: $120 billion (CBO).

Extend Drug Price Inflation Penalties to Commercial Plans

Background: Prescription drug manufacturers pay a penalty when a drug's price increases faster than the rate of inflation in both Medicare and Medicaid. These penalties slow the growth of both "list" prices (i.e. the sticker price for a drug before discounts) and "net" drug prices (i.e. prices health plans pay for drugs after rebates) over time. The copayments that consumers pay in Medicare Part D and in many commercial plans are based on list prices. Health plans pay net prices for brand-name drugs and impact plan premiums and overall spending on prescription drugs.

Problem: Brand-name drug list and net prices have grown much faster than inflation for commercial plans. This has raised health care spending, which increases premiums to employers and premiums and out-of-pocket spending for employees. This impedes access and adherence to needed medications. While Medicare now has an inflation penalty that discourages excessive drug price growth, commercial plans do not.

Solution: Extend the drug price inflation penalty to commercial plans to reduce health care costs for families and employers.

10-YEAR SAVINGS: About $40 billion (derived from several CBO publications on inflation penalties here and here).[1] These are savings to the federal budget and are adjustable depending on the base year set to begin the penalty. Savings for employers and families would be much greater.

1 On August 5, 2022, CBO estimated the inflation penalty that included both Medicare and the commercial sector. The savings to Medicare were $52 billion and the increase in revenues were $38 billion, which resulted in a total of $100 billion reduction in deficits. When the commercial sector inflation penalty was removed, CBO estimated on September 7, 2022 that the savings to Medicare was $56 billion and the increase in revenues (with no commercial rebate) was just $6.8 billion, which results in a $60 billion reduction in deficits. We subtracted these two scores to get a $40 billion savings from the commercial inflation penalty as a standalone policy.