JULY 2025

Reining in Hospital Prices:

Modeling Reforms in Indiana, Massachusetts, and North Carolina

westhealth

UNITED STATES of CARE

ABOUT US OF CARE

United States of Care (USofCare) is a non-partisan non-profit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. By putting the needs of people at the forefront of our research and policy solutions, we can create a health care system that works for people.

In 2022, USofCare released a roadmap of 12 policy solutions that reflect what people want out of the health care system. These 12 solutions, titled the "United Solutions for Care", represent common sense policy reforms that garner broad public support across demographic, geographic, and partisan domains. USofCare, grounded in our listening work and the United Solutions for Care, advocates for policy reforms at the state and federal levels. Translating these policy solutions into meaningful reforms for legislative and regulatory uptake is central to our advocacy efforts.

ACKNOWLEDGEMENTS

This report was written in partnership with West Health, who we thank for their support in this critically important work. We would also like to thank Roslyn Murray and Erin Fuse Brown at the Brown University Center for Advancing Health Policy through Research (CAHPR) and Amy Killelea for the instrumental role they played in conducting this analysis and putting this report together.

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EXECUTIVE SUMMARY

Consumers, employers, and state and federal governments are increasingly bearing the brunt of the high prices charged by hospitals. Rampant provider consolidation – when hospitals merge with one another or acquire other provider practices – is exacerbating this problem. As hospital markets become more concentrated, monopolistic bargaining power allows hospitals to charge payers higher and higher prices. Payers then pass those higher prices onto consumers through higher out-of-pocket costs and premiums. As hospitals acquire physician groups and provider practices, patients are more likely to be hit with higher prices and facility fees, which are additional costs that hospitals charge on top of professional fees.

Increased facility fee exposure and hospital price hikes occur against a backdrop of broader economic concerns that have strained average household budgets. **Almost 40 percent of Americans could not afford an unexpected $400 expense without selling assets or borrowing money,** which is concerning given that the average facility fee can be hundreds of dollars.

United States of Care (USofCare) partnered with the Brown University Center for Advancing Health Policy through Research (CAHPR) to model the savings potential of the following three policy options to address hospital consolidation and resulting price hikes on consumers in three states (Indiana, Massachusetts, and North Carolina):

1. Site-Neutral Payments

A policy requiring a payer to charge the same rate for a service, regardless of where it is delivered, typically tied to Medicare payments in either the outpatient setting or the lower cost setting (i.e., doctors' offices or Ambulatory Surgery Centers).

2. Bans on Facility Fees

A policy prohibiting providers from collecting a facility fee for a subset of routine services.

3. Caps on Commercial Hospital Payments

A policy setting a price cap, typically tied to the Medicare hospital payment, for what hospitals can charge for a broader set of services and settings than those covered by site-neutral payment.

For each policy option, the research team estimated the following savings for consumers:

Reduction in out-of-pocket costs.

As payers are able to reduce the underlying prices they pay for a subset of services and/or settings, consumers should pay lower amounts for those services during the deductible phase of coverage or when coinsurance is applied to the service, both of which are pegged to the negotiated rate for the service.

Reduction in premiums.

Reduced prices also generate more savings for payers, who should pass those savings onto consumers in the form of lower premiums.

Each of the three policy options generated savings to consumers across all three states, with some variation based on how the policy was structured.

	Site–Neutral Payments		Facility Fee Bans	Commercial Payment Caps	
	Cap at 100% of Medicare	Cap at 400% of Medicare		Cap at 100% of Medicare	Cap at 400% of Medicare
AVERAGE TOTAL SAVINGS PER MEMBER PER YEAR					
Indiana	**$304**	**$57**	**$93**	**$2,832**	**$108**
Massachusetts	**$239**	**$23**	**$65**	**$1,402**	**$0**
North Carolina	**$175**	**$20**	**$25**	**$2,263**	**$39**
AVERAGE OUT-OF-POCKET SAVINGS PER MEMBER PER YEAR					
Indiana	**$122**	**$23**	**$37**	**$263**	**$10**
Massachusetts	**$61**	**$6**	**$16**	**$130**	**$0**
North Carolina	**$62**	**$7**	**$9**	**$210**	**$4**
AVERAGE PREMIUM SAVINGS PER MEMBER PER YEAR					
Indiana	**$182**	**$34**	**$56**	**$2,568**	**$98**
Massachusetts	**$179**	**$18**	**$48**	**$1,271**	**$0**
North Carolina	**$113**	**$13**	**$16**	**$2,052**	**$36**

The team also assessed the impact of each policy on hospital operating margins, finding that each policy can be structured to minimize impact on hospital finances.

POLICYMAKER CONSIDERATIONS

As policymakers identify legislative priorities for addressing hospital prices, they should consider:

- Implementing multiple policy options that work in tandem, including more than one of three policies modeled in this report or pairing pricing policies with policies that more directly curb hospital consolidation.
- Closely assessing state markets, including baseline hospital payment rates, before choosing Medicare thresholds to cap payments.
- Structuring hospital payment policies to reach the largest swath of the market.
- Tailoring policies to care settings and services that will have the biggest impact on consumers.
- Estimating each policy's impact on hospital budgets and operating margins using a data-based approach and using that data to design policies to reform, not destabilize, hospital financing (e.g., by exempting certain safety net hospitals from pricing reforms)
- Understanding the impact of federal and state budget volatility on policy approaches to address hospital costs and working with payers and hospitals to develop real-time assessment of fiscal health and budget outlook amidst a dynamic policy environment.
- Forecasting and planning for potential hospital responses to these policies, including potential cost-shifting, increasing service volume, shifting toward more profitable patients or services, or cutting back on operations.

1. *Increasing urgency for action to rein in hospital prices and consolidation*

THE PROBLEM

Hospital pricing practices are under intense scrutiny as consumers, employers, and state and federal governments are increasingly bearing the brunt of the high prices charged by hospitals.[1] Rampant provider consolidation – when hospitals merge with one another or acquire other provider practices – is exacerbating this problem. As hospital markets become more concentrated, monopolistic bargaining power allows hospitals to charge payers higher and higher prices. Payers then pass those higher prices along to consumers through higher out-of-pocket costs and premiums, with a large portion of premium dollars going towards hospital spending.[2] Despite claims to the contrary, evidence does not suggest that consolidation leads to improvements in care quality.[3]

Hospital consolidation – and the combination of mergers and hospital closures that consolidation spurs – has led to 2,000 fewer independent hospitals operating in the United States today compared to 1998.[4] In addition, hospitals and health systems that own office-based physician practices are increasing, with more than half of physicians employed by hospitals.[5] This means that even for primary care, practices are far more likely to be hospital-owned, with a 2021 study finding that 54.1% of primary care physicians were employed by a hospital.[6] Bigger hospital system footprints means that it is harder for consumers to find independent medical practices not tethered to a larger hospital system. And with that often comes higher prices.

As hospitals acquire physician groups and provider practices, patients are more likely to be hit with higher costs and facility fees, which are additional costs that hospitals charge on top of professional fees for certain health care services.[7] When a hospital acquires a physician practice, it can add a facility fee to the physician's professional fee, simply by characterizing the outpatient service as hospital-based, even though the physical location has not changed. As hospitals buy up more medical practices, hospital facility fees are appearing in more and more places. Increased hospital ownership of ambulatory settings and practices means that more outpatient care is being billed at hospital outpatient departments (HOPDs), which costs consumers and payers considerably more for the same service.

Hospitals have long claimed that facility fees are essential to pay for the high infrastructure and staffing costs needed to keep emergency responses available around the clock. However, these claims are harder to justify when facility fees are attached to services that are typically performed in provider offices, including for routine care accessed safely at either on or off-campus HOPDs.

Professional fee = what hospitals (and other providers) charge for specific services related to "professional" activities, such as a provider's time

Facility fee = additional fee that hospitals levy to cover hospital operating costs

As hospitals become large health system behemoths, their market power impacts consumer affordability in three major ways:

- Because there are fewer independent practices, consumers are more likely to receive care in a hospital-owned practice and be charged a facility fee for routine outpatient services, which can be an expensive surprise for many.
- Evidence suggests that hospital-owned physician practices are more likely to refer patients to hospitals for care, which could increase exposure to facility fees.[8]
- As hospitals have increased market power, they are increasingly the only hospital game in town and are able to demand higher and higher prices from commercial payers, who no longer have bargaining power. Payers often pass these higher prices on to consumers in the form of higher premiums.

Provider consolidation is causing significant affordability and access challenges for consumers, reducing the places people can get care while not leading to improvements in quality.

- ## Facility fee exposure, out-of-pocket costs, and premiums increase

  A growing body of research shows that provider consolidation is raising health care costs for consumers. As more sites of care fall under hospital ownership, consumers have more exposure to facility fees even for routine services. In addition, as hospital prices rise, consumers face increased out-of-pocket costs through deductibles and coinsurance, which are tied to the underlying cost of the service. One study found that between 2011 and 2017, outpatient surgeries saw a 53% increase in facility fee charges and consumer out-of-pocket expenses grew by 50 percent.[9] These additional charges and higher prices are expected to only increase as provider consolidation also increases. And finally, as overall hospital prices go up, commercial payers are more likely to pass those costs onto consumers in the form of higher premiums.[10]

- ## Quality either worsens or stays the same

  Evidence suggests that consolidation negatively impacts patient access and quality of care.[11] Multiple studies have found that patient quality metrics decreased following provider consolidation[12] as did patient satisfaction.[13] Instead of promoting integrated care delivery models or providing newly acquired off- and on-campus hospital outpatient departments (HOPDs) with additional expertise and resources to boost patient outcomes, consolidation has mainly impacted bargaining power and pricing dynamics, but not patient care or health outcomes.

- ## Affordability and access challenges increase

  The negative effects of rampant provider consolidation disproportionately impact communities that are already more vulnerable to affordability challenges and access barriers.[14] Increasing prevalence of facility fees coupled with higher cost-sharing for hospital services exacerbate the nation's growing medical debt crisis, which researchers have found is primarily driven by hospital debt.[15] Structural barriers that influence site of care may contribute to the disparate impact of facility fees on certain communities. Black and Latino individuals are more likely to visit hospitals and HOPDs as usual sources of care, which could expose these communities to more facility fees and hospital price gouging.[16] People in rural areas are also more likely to be impacted by high hospital prices and facility fees. These people are more likely to lack health insurance coverage, have fewer provider choices, and are more likely to be older and have more health care needs than people who live in urban areas, all of which may increase their exposure to facility fees and higher hospital cost-sharing.[17]

Hospital facility fees, increased hospital cost sharing, and increased premiums are hitting consumers at a time when **prices of goods and services remains stubbornly high** and individuals and families worry about their household budgets.

All of this occurs against a backdrop of broader economic concerns facing many people because of the aftermath of an extended period of high inflation, stubbornly high prices for goods and services, and political volatility impacting global economic markets. Almost 40 percent of Americans could not afford an unexpected $400 expense without selling assets or borrowing money, which is concerning given that the average facility fee can be hundreds of dollars.[18] There is also a growing body of evidence suggesting that in addition to affordability challenges of facility fees, higher hospital cost sharing, and higher premiums, hospital consolidation also has broader economic impacts. The increasing costs to the health care system following hospital mergers have depressed employee wages in the surrounding geographic area and increased unemployment, not just for those working within health care, but for those in the surrounding area as well.[19]

STATE ROLE IN TACKLING HOSPITAL PRICING

Across the country, policymakers are taking on the affordability challenges that unchecked hospital consolidation and rising hospital prices are causing for their residents. State policymakers are specifically filling in a void left by fairly minimal federal action and have been motivated to tackle this issue because of the growing strain hospital pricing dynamics have on state budgets.

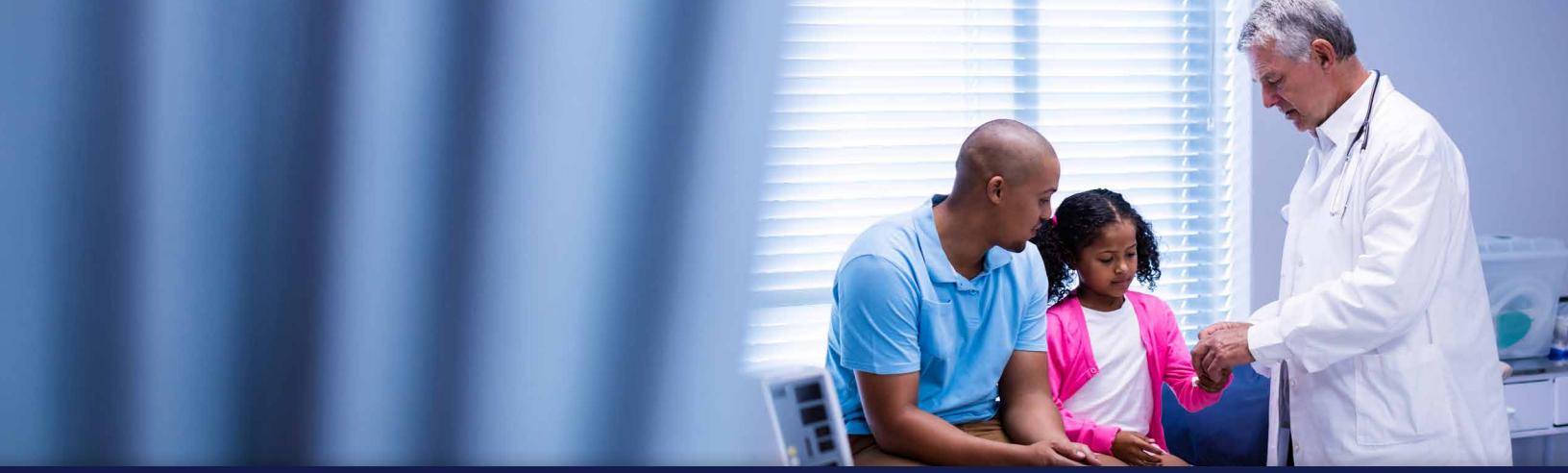
States have a number of policy levers available to them, which are discussed in more detail below. While ERISA preemption places limits on state authority to regulate private health insurance to the state-regulated private insurance market (individual plans, fully insured group plans, and public employee plans), ERISA does not preempt states' broad authority to regulate what hospital and providers charge, even if these policies affect self-funded ERISA plans.[20] States can also regulate hospital pricing for Medicaid and for state-employee benefits plans. The federal Centers for Medicare & Medicaid Services (CMS), however, sets the hospital pricing schedule for Medicare.

Table 1: State and Federal Authority to Regulate Hospital Pricing

Insurance market	Regulator with Oversight over Hospital Pricing Practices
Individual (including marketplace plans)	State
Small and large fully insured group	State
Self-funded group	State as long as the reform is structured as hospital price regulation. Self-funded plans are primarily federally regulated under ERISA and states cannot regulate them directly.
State and public employee benefits (even if self-funded)	State
Medicaid	State and federal
Medicare	Federal

While this research project focuses on state authority over the commercial group market (the rows highlighted in blue in Table 1) and the actions states can take to regulate hospital prices, including facility fees, in those markets, the findings discussed below are relevant for the entirety of the state-regulated private insurance market and could inform policies that would impact the individual market.

As more states tackle hospital pricing reform, there is a growing body of evidence documenting the savings that can be generated from these reforms.[21]



2. *Modeling three state policy options to address hospital prices in three study states*

United States of Care (USofCare) partnered with the Brown University Center for Advancing Health Policy through Research (CAHPR) to model the savings potential of the following three policy options to address hospital consolidation and resulting price hikes on consumers in three states (Indiana, Massachusetts, and North Carolina):

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3. Caps on Commercial Hospital Payments

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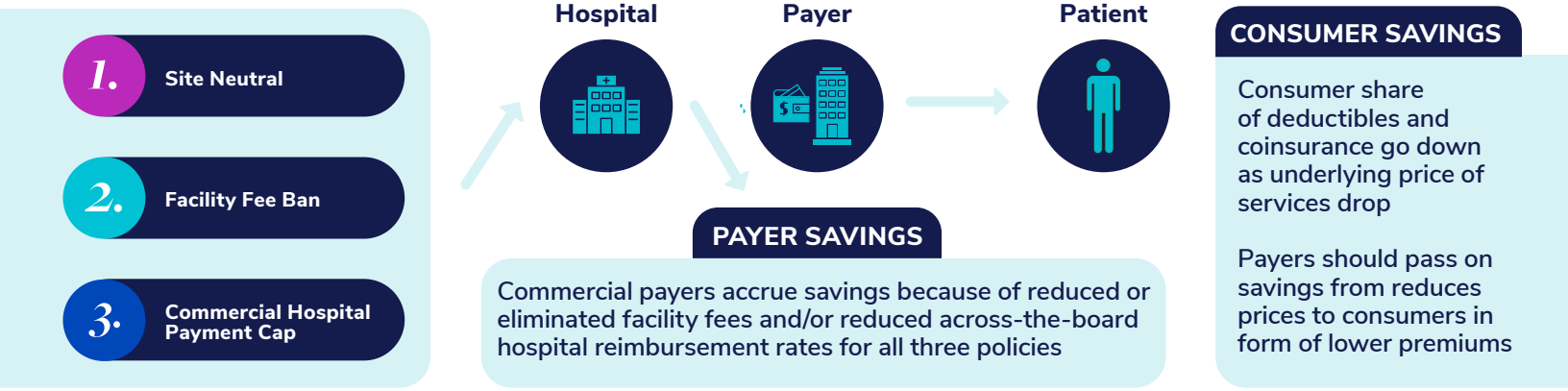
These policy options and focus states were chosen following an extensive environmental scan and in consultation with subject matter experts and state policy stakeholders.[22]

For each policy option, the CAHPR research team developed an analytic approach to estimate the savings from hospital pricing reforms. First, for the relevant set of services, the team calculated price reductions based on specified caps tied to Medicare or through the elimination of facility fees. These reductions were aggregated to the state level to estimate total savings for commercial purchasers and patients.

Savings accrue to consumers from implementation of these policies through reductions in out-of-pocket (OOP) costs and premiums. As payers are able to reduce the underlying prices they pay for a subset of services and/or settings, consumers will pay lower amounts for those services after they've met their deductible or when coinsurance is applied to the service, both of which are pegged to the negotiated rate for the service (see figure on the next page). Reduced prices also generate more savings for payers, who should pass those savings onto consumers in the form of lower premiums.[23] For each policy, we allocated total savings between out-of-pocket spending and premium reductions using data on average cost-sharing rates by state and type of service.



As part of this analysis, we also examined the impact of each policy on hospital operating margins in each of the three states. Statewide hospital operating margins were calculated by aggregating total patient revenues and expenses across all hospitals in each state, subtracting total expenses from total revenues, and dividing this difference by total revenues. To estimate the impact of each policy on statewide hospital operating margins, savings estimates were deducted from patient revenues in both the numerator and denominator.

While our analysis provides meaningful estimates of potential savings from three policies targeting hospital facility fees, there are important limitations and caveats to consider. First, our data sources do not capture the full commercial market in each state, so we scale our estimates and assume that payments and patient mix are similar across represented and non-represented insurers. Second, our estimates of premium and out-of-pocket savings rely on average cost-sharing assumptions and may not reflect individual benefit designs or the actual pass-through of savings to enrollees, particularly those enrolled in self-funded insurance plans. Third, because of billing inconsistencies or errors, our approach likely underestimates savings. Additionally, per-member savings reflect population averages; actual impacts will vary based on individual service use. Finally, while we estimate changes in hospital operating margins, we do not model potential downstream effects, such as changes to service availability or staffing, which should be accounted for and monitored as part of policy development and implementation. For more information on the data sources used and methodology, please see Appendix I.

CURRENT LANDSCAPE OF EACH STATE DETERMINES POLICY SOLUTION IMPACT

Each of the three study states – Indiana, Massachusetts, and North Carolina – has a slightly different health care landscape and policy baseline, which may contribute to variable impacts of the three policy solutions modeled. For example, Indiana already has a facility fee ban in place, which prohibits hospitals from charging facility fees for outpatient services provided at their own off-campus facilities.[24] That legislation was initially slated to go into effect in January 2025 and was subsequently amended with more detail with an effective date of January 1, 2026.[25] The more recent Indiana law also includes a provision that would allow the state to revoke the nonprofit status of certain large hospital systems if their inpatient and outpatient commercial prices exceed the state average price. The effects are not included in the analysis below, but should be considered moving forward.

Similarly, commercial hospital prices relative to Medicare payments in Massachusetts are already well below the commercial prices in Indiana and North Carolina. This is the result of a number of factors, including that a dominant payer drives a lower commercial reimbursement rate that has helped to push the commercial rate for hospitals in the state to 195.3% of the Medicare rate for hospital services, one of the lowest relative rates in the country.[26] Medicare hospital payments also tend to be higher in Massachusetts than in other states because of a relatively obscure federal provision that takes into account wage data when setting Medicare hospital reimbursement.[27] This may skew the comparison of commercial rates relative to Medicare.

As states explore these policies, it's important to assess their own markets and current policies and regulations to determine which policy option will yield the desired impact.

Analysis of Policy 1: *Site-Neutral Payment Reforms*

A site-neutral payment policy aims to equalize reimbursement for certain services across settings (i.e. "same service, same price"). The policy is a disincentive to further provider consolidation and has gained traction in federal policy debates around Medicare payment reform. The policy would place limits on payments for outpatient services that can be provided safely outside of a hospital.[28] In the commercial market, paying a set price is not usually feasible because prices are determined through market negotiation. Placing a limit on how much hospitals can collect for services targets the highest prices, but allows for market negotiations to occur underneath those limits.

The Medicare Payment Advisory Commission (MedPAC) has developed the most comprehensive list of services that meet this definition. In 2023, MedPAC identified 57 ambulatory payment classifications (APCs)–or groups of services–that can be safely performed in a freestanding provider office and recommended aligning payment rates for these services with the Medicare office payment, regardless of the setting in which they were provided.[29] MedPAC also identified 9 service categories that can be performed safely in an Ambulatory Surgical Center (ASC) and recommended aligning payments for those services with the Medicare ASC payment (see Appendix II).[30] States are using this list of 66 "MedPAC services" in addition to evaluation and management services as a jumping off point to design site-neutral payment policies for the commercial market. Some states are assessing additional services not captured in the MedPAC list that may be more relevant for the commercial market.

The research team used 2022 Health Care Cost Institute (HCCI) professional and outpatient claims data from Indiana, Massachusetts, and North Carolina to estimate potential savings from the site-neutral payment policy as well as hospital operating margins impact. A comprehensive description of the modeling methodology is described in Appendix I.

Site neutral policy modeled in IN, MA, and NC

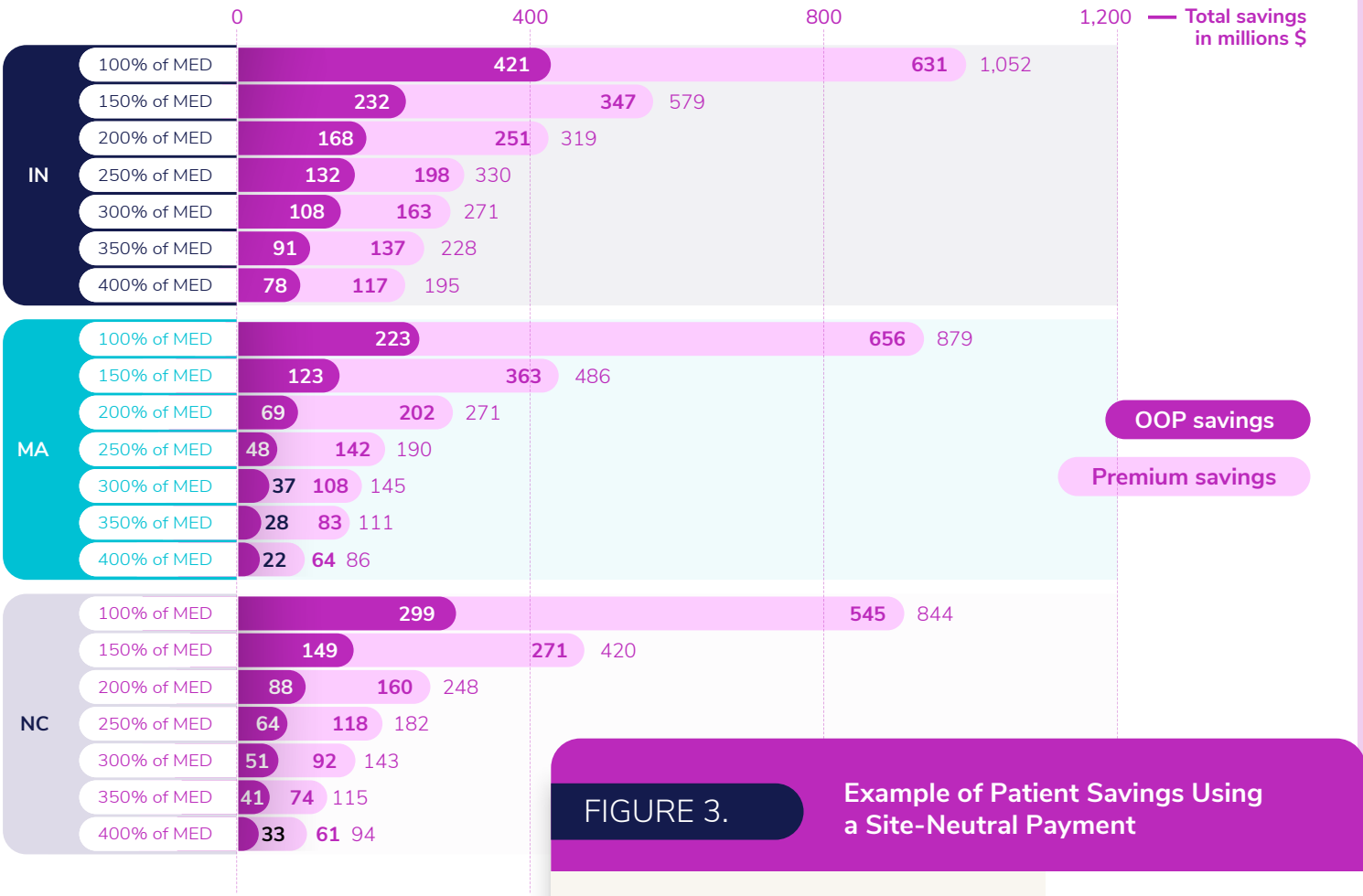
Require commercial payment rates for state-regulated private insurance plans to pay no more than a set proportion of the Medicare non-hospital payment rate for the 66 MedPAC services that can be performed safely in non-hospital settings (referred to below as "MedPAC services").

The non-hospital rate is defined as the Medicare physician fee schedule (MPFS) rate for services that could safely be delivered in the doctors' office or the Medicare ASC payment rate for services that could safely be delivered in the ASC. The non-hospital payment rate can be set at 100% up to 400% of the Medicare non-hospital rate, with differential savings depending on what proportion is used.

SITE-NEUTRAL PAYMENT SAVINGS: Consumer Out-of-Pocket (OOP) Costs and Premiums Impact

The savings accruing to consumers from reductions in OOP costs and premiums from implementing a site-neutral payment policy vary considerably depending on what percentage of the Medicare non-hospital payment the site-neutral rate is set (see Figure 2). In other words, more savings accrue to consumers the closer the site-neutral rate is to the Medicare rate for the non-hospital payment. Across the three states, the most dramatic consumer savings from reduced commercial OOP costs and premiums were achieved through capping prices at 100 to 200 percent of the Medicare non-hospital payment. For instance, if site-neutral reimbursement rates were capped at 100 percent of the Medicare non-hospital payment–regardless of where the service was provided–the estimated OOP savings for commercial payers in 2022 would have totaled $421 million ($122 per member per year (PMPY)) in Indiana, $223 million ($61 PMPY) in Massachusetts, and $299 million ($62 PMPY) in North Carolina. Corresponding premium reductions would have amounted to $631 million ($182 PMPY) in Indiana, $656 million ($179 PMPY) in Massachusetts, and $545 million ($113 PMPY) in North Carolina, assuming all insurer savings would be fully passed through to enrollees. Savings become far smaller and nearly negligible at 350 to 400 percent of the Medicare non-hospital payment because that is closer to the baseline commercial price in most states.

FIGURE 2. Estimated Total Savings from Site-Neutral Payment Policy for MedPAC Services that are Deemed Safe to Perform in Lower-Cost Settings in Indiana, Massachusetts, and North Carolina, 2022



For an individual patient, these savings could be significant. Figure 3 shows an example of how an individual patient would benefit from the savings from a site-neutral policy. The example represents a hypothetical scenario that applies to all three states and estimates the savings for an individual patient who has tonsils removed in an outpatient setting. In this example, the site-neutral payment policy would cap reimbursement for the service at 200 percent of the Medicare non-hospital payment. The patient, who has a 20% coinsurance obligation, would pay eight times more without the site-neutral payment policy (an over $1,000 difference), a significant amount for most consumers.

FIGURE 3. Example of Patient Savings Using a Site-Neutral Payment

Setting	Outpatient Hospital
CPT (Description)	42821 (Removal of Tonsils and Adenoids)
Patient OOP Obligation	20% Coinsurance
PAYMENT WITHOUT 200% SITE-NEUTRAL PAYMENT POLICY	
Current Commercial Price	$5,715
Patient Coinsurance Payment (20% of Price)	$1,143
PAYMENT WITH 200% SITE-NEUTRAL PAYMENT POLICY	
Medicare physician office price with 200% Site-Neutral Rate Medicare Non-Hospital Payment	$319
Commercial Price Under Site-Neutral Payment Policy (200% of the Medicare office price)	$638
Patient Coinsurance Payment (20% of Price)	$127.60
Patient OOP Savings (Coinsurance Payment Without Site-Neutral Payment – Coinsurance Payment With Site-Neutral Payment)	$1,015.40

APPLYING A MODIFIED SITE-NEUTRAL POLICY FOCUSING ONLY ON THE FACILITY FEE

A different way that policymakers can approach a site-neutral payment policy is to cap only the facility fee part of the payment for the MedPAC services at a percentage of the Medicare facility fee payment (as opposed to setting a limit for the entire payment pegged to the Medicare non-hospital payment). When services are delivered in a physician's office, Medicare pays a higher professional fee to account for practice expenses (e.g., supplies, equipment, and staff). For many routine, low-complexity outpatient services, it is more appropriate for hospitals to receive a facility fee closer in value to what physicians receive in office settings. To reflect this, we also modeled savings under a policy that caps facility fees for these services at a low percentage of the Medicare facility payment. While the savings are smaller—since the cap applies only to facility fees and only in hospital settings—states could still realize meaningful reductions in spending. The idea behind the modified policy is to align the facility practice expense payment plus the facility fee with the non-facility practice expense. Table 4 includes a breakdown of the pros and cons of the traditional site-neutral payment policy compared to the modified site-neutral payment policy.

Table 4: Pros and Cons of Traditional and Modified Site-Neutral Policies

Traditional Site-Neutral	Modified Site-Neutral
Pros: Accomplishes site neutrality. Greater savings because applied to all settings. Aligns with MedPAC's recommendations. Helps remove incentives to deliver these services in more expensive settings.	**Pros:** Aligns the facility practice expense and facility fee with the non-facility practice expense. May be relatively straightforward to implement, as hospitals are already reimbursed under Medicare outpatient prospective payment system (OPPS) for Medicare patients. Leaves professional fees untouched. More specifically addresses facility fees without a ban.
Cons: Likely would experience pushback from hospitals, physicians, and other providers. Because the cap is a combined rate, it may be more difficult to implement for independent physicians who bill separately from hospitals, potentially incentivizing vertical integration to streamline these processes.	**Cons:** Because physician fees are not part of the cap, they could increase over time, particularly for hospital-affiliated practices.

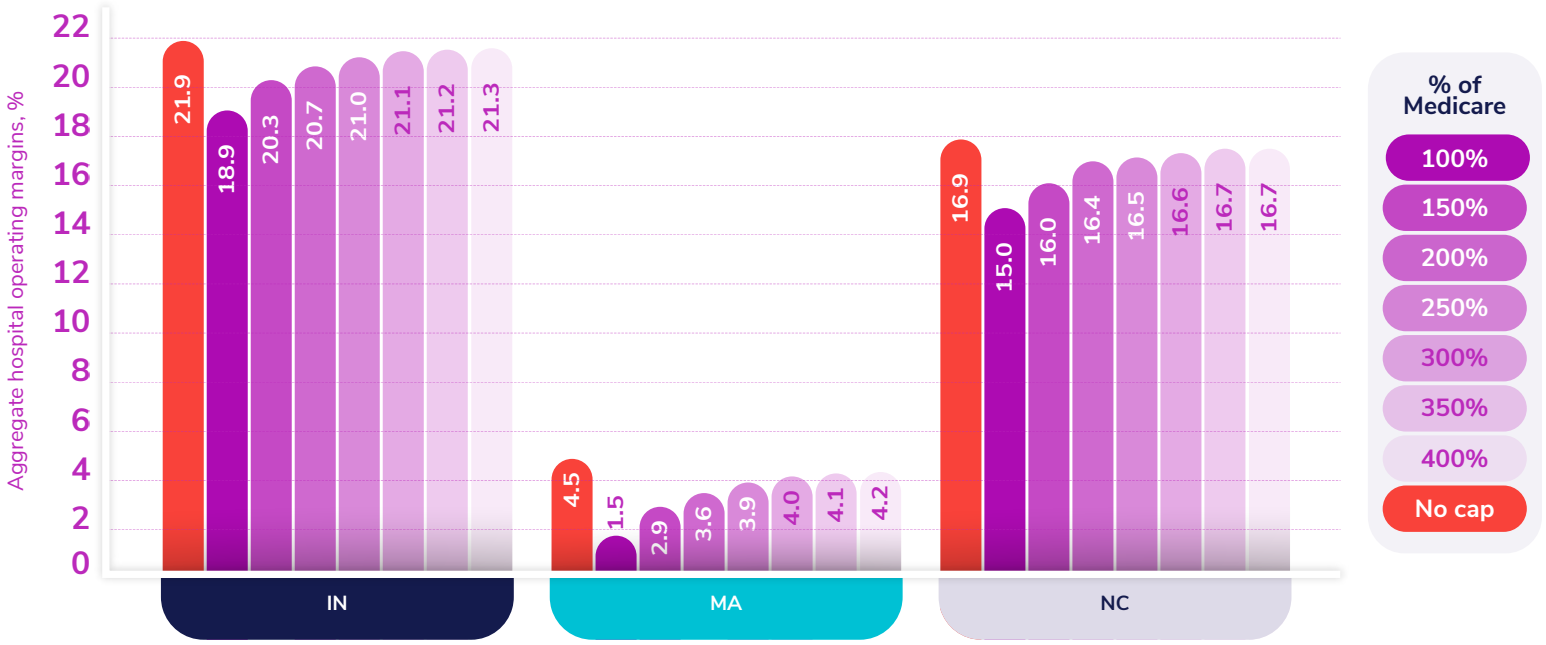
SITE-NEUTRAL POLICY IMPACT ON HOSPITAL OPERATING MARGINS

We also assessed how a site-neutral payment policy would impact hospital financial health. Using data from the National Academy for State Health Policy Hospital (NASHP) Cost Tool, operating margins were calculated the following way: (net patient revenue - operating expenses related to patient care) / net patient revenue. To account for lost revenue, the team subtracted savings from net patient revenue.31

Setting site-neutral payment rates at 100 percent of Medicare non-hospital rates for the MedPAC services – the lowest amount analyzed – would have had a fairly minimal impact on total operating margins, reducing margins by less than 5 percentage points for each state. Total operating margins (which include margins related to commercial reimbursement in addition to other payers) would have decreased from 21.9 to 18.9 percent in Indiana, 4.5 to 1.5 percent in Massachusetts, and 16.9 to 15.0 percent in North Carolina (see Figure 5).

FIGURE 5.

Estimated Hospital Total Operating Margins Under Site-Neutral Payment for MedPAC Services in Indiana, Massachusetts, and North Carolina, 2022



NOTES:

Hospital total operating margins are calculated as the difference between net patient revenue and operating expenses for all patient care, divided by net patient revenue and multiplied by 100 to express the result as a percentage.

The red bar shows aggregate hospital total operating margins at the state level in 2022.

The pink bars represent projected margins with site neutral payments, ranging from 100% to 400% of Medicare rates.

The impact of a site-neutral payment policy on commercial operating margins – which are often the primary revenue generator for hospitals32 – is slightly higher, but still fairly low. If reimbursement rates were set at 100 percent of the Medicare non-hospital rate for MedPAC services only, commercial operating margins would have dropped from 53.0 to 49.8 percent in Indiana, 18.9 to 13.6 percent in Massachusetts, and 41.0 to 38.4 percent in North Carolina. At 400 percent, neither total nor commercial margins change meaningfully in any of the three states).

Analysis of Policy 2: *Facility Fee Bans*

The second policy option modeled would eliminate facility fees for a narrower subset of outpatient services that could be provided safely in non-hospital settings, not the entire range of 66 APCs covered in the site-neutral policy above. In this model, we analyzed the impact of banning facility fees for (1) evaluation and management (E&M) services, (2) telehealth services, and (3) preventive services.[33] These services were chosen because they are routine, most often provided in office settings, and are services for which a surprise facility fee bill can seem particularly unfair to consumers because hospital facilities were not needed or used. A number of insurers also do not cover the facility fee for these services, foisting the entire fee onto the consumer. For these services, we analyzed claims from both on-campus and off-campus HOPDs and assessed savings attributed to the ban across both settings.

Facility fee ban policy modeled in IN, MA, and NC

Prohibit any facility fee in HOPD on-campus and off-campus settings for subset of routine services that can be safely delivered in lower-cost settings.

Routine services defined as:

Evaluation and management (E&M) services: provider visits and services that involve evaluating and managing patient health (e.g. patient office visit).

Telehealth services: services provided remotely to patients via video and/or audio conferencing.

Preventive services: services recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Health Resources and Services Administration.

FACILITY FEE BAN SAVINGS:

Consumer Out-of-Pocket (OOP) Costs and Premiums Impact

Eliminating facility fees for E&M, preventive, and telehealth services delivered in on-and off-campus HOPDs would generate meaningful savings for consumers in Indiana, Massachusetts, and North Carolina in on- and off-campus hospital outpatient departments (See figure 6).[34] Under a facility fee ban for E&M, preventive, and telehealth services at on-campus hospital outpatient departments, estimated out-of-pocket savings in 2022 would have been $129.0 million ($37 per member per year (PMPY)) in Indiana, $60.2 million ($16 PMPY) in Massachusetts, and $43 million ($9 PMPY) in North Carolina. Corresponding premium reductions would have totaled $193.5 million ($56 PMPY) in Indiana, $176.9 million ($48 PMPY) in Massachusetts, and $77.6 million ($16 PMPY) in North Carolina, assuming all insurer savings would be fully passed through to enrollees.

Because this policy targets a more limited set of services, the overall savings would likely be smaller than those achieved under broader site-neutral payment caps, especially caps set at lower percentages of the Medicare rate, ranging from 100 to 300 percent. Still, it represents a concrete step toward lowering prices and spending for routine services.

FIGURE 6.

Estimated Total Savings in Millions from Facility Fee Bans for E&M, Preventive, and Telehealth Services and at On-and Off-Campus HOPDs in Indiana, Massachusetts, and North Carolina, 2022

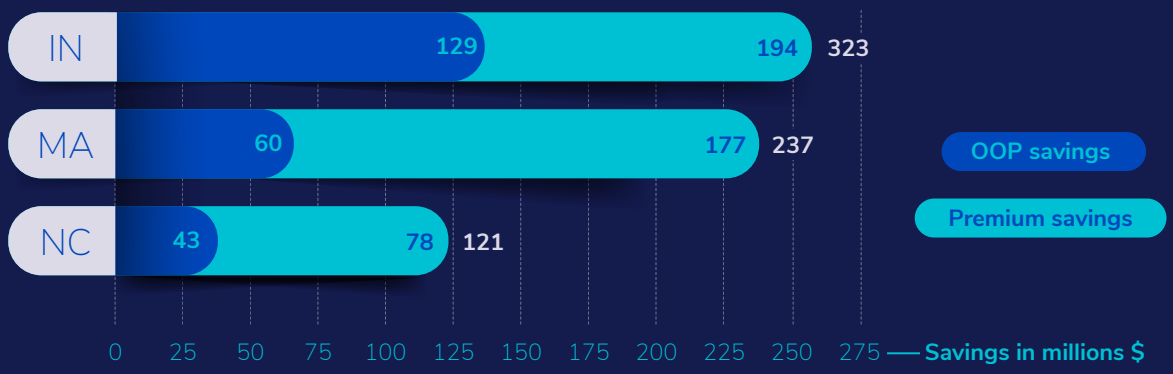


FIGURE 7 Facility Fee Ban Patient Example

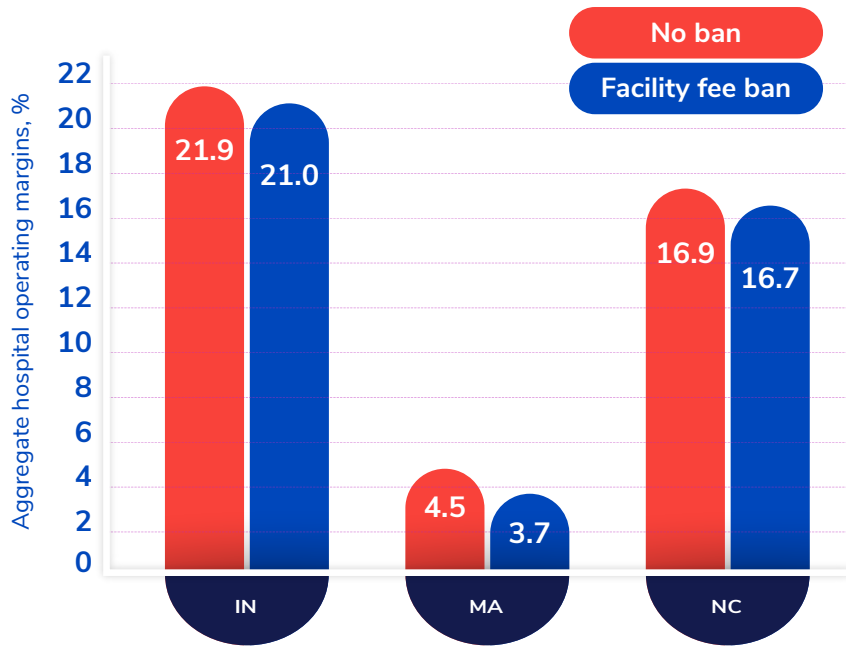
Setting	**Outpatient Hospital**
CPT (Description)	**99212 (Established Patient Office Visit)**
Patient OOP Obligation	**10% Coinsurance**
PAYMENT WITHOUT FACILITY FEE BAN	
Current Commercial Price	**$329**
Commercial Facility Fee	$286
Commercial Professional Fee	$43
Patient Coinsurance Payment (10% of Price)	**$33**
PAYMENT WITH FACILITY FEE BAN	
Commercial Price with Facility Fee Ban	**$43**
Commercial Facility Fee	$0
Commercial Professional Fee	$43
Patient Coinsurance Payment (10% of Price)	**$4.30**
OOP Savings (Coinsurance Payment Without Ban - Coinsurance Payment with Ban)	**$28.60**

Figure 7 shows how a facility fee ban would hypothetically impact an individual patient who had a routine office visit in a hospital outpatient setting. The example represents a hypothetical scenario that applies to all three states. For a patient with a 10% coinsurance, eliminating the facility fee would save them $28.60 in OOP costs.

We looked at the difference between on-campus and off-campus HOPDs and found minimal consumer savings from just eliminating facility fees in off-campus HOPD settings. While this finding could be partly attributed to discrepancies in hospital billing and coding practices that make it difficult to identify facility fee by setting, it is also an important data point for states as they look to tailor a policy response that best addresses consumer harm. Facility fee policies that focus solely on off-campus outpatient HOPDs may not yield significant consumer OOP and premium savings.

FACILITY FEE BAN IMPACT ON HOSPITAL OPERATING MARGINS

FIGURE 8 Estimated Hospital Total Operating Margins Under a Facility Fee Ban for Preventive, Telehealth, and E&M Services in Indiana, Massachusetts, and North Carolina, 2022



We found that eliminating facility fees for E&M telehealth, and preventive services, on- and off-campus, would have a minimal impact on both total operating margins (see Figure 8) as well as commercial operating margins.

NOTES:

Hospital total operating margins are calculated as the difference between net patient revenue and operating expenses for all patient care, divided by net patient revenue and multiplied by 100 to express the result as a percentage.

- The red bar shows aggregate hospital total operating margins at the state level in 2022.
- The blue bars represent projected margins with a facility fee ban.

Analysis of Policy 3: *Commercial Hospital Payment Caps*

The third policy option modeled is a cap on ALL commercial hospital payments. Payment caps are a form of reference-based pricing.[35] This policy is broader than the former two, aimed at reducing hospital facility fees for all inpatient and outpatient services. A commercial payment cap may be better able to address underlying price hikes associated with monopolistic contracting practices by hospitals and health systems in heavily consolidated markets. While payment caps are similar to site-neutral payment policies, the main problem these policies are trying to solve are a bit different. Site-neutral payment policies primarily curb unfair hospital charging practices that result from hospital acquisition of outpatient settings. Payment caps are a broader policy tool and are better able to target monopolistic price-setting behavior by capping what a hospital can charge commercial payers.

Commercial hospital payment caps modeled in IN, MA, and NC

Cap commercial payments for hospital inpatient admission and outpatient procedures based on a percentage of Medicare rates

FIGURE 9

Estimated Total Savings from Capping Hospital Prices for All Commercial Lives in Indiana, Massachusetts, and North Carolina, 2022

Commercial payment caps could yield significant savings for consumers, particularly when the caps are pegged to the Medicare payment or close to it (See Figure 9). Capping payments at 100 percent of Medicare payments across all hospitals in each state would have reduced out-of-pocket spending by $911 million ($263 PMPY) in Indiana, $479 million ($130 PMPY) in Massachusetts, and $1,013 million ($210 PMPY) in North Carolina. Corresponding premium reductions could have totaled $8.9 billion ($2,568 PMPY) in Indiana, $4.7 billion ($1,271 PMPY) in Massachusetts, and $9.9 billion ($2,052 PMPY) in North Carolina, assuming all insurer savings would be fully passed on to enrollees. Both out-of-pocket savings and premium reductions would have declined at higher payment caps. The relatively lower savings in Massachusetts likely reflects the different market dynamics resulting in lower hospital commercial prices relative to Medicare payments in that state described above.

FIGURE 10

Example of Patient Savings from Commercial Price Caps

Setting	**Inpatient Hospital**
DRG (Description)	**470 (Major Hip/ Knee Joint Replacement)**
Patient OOP Spend	**20% Coinsurance**
PAYMENT WITHOUT 200% CAP	
Current Commercial Facility Price	**$33,301**
Patient Coinsurance Payment (20% of Price)	**$6,660**
PAYMENT WITH 200% CAP	
Medicare Facility Payment	**$15,561**
Commercial Facility Price Under Price Cap (Cap at 200%)	**$31,123**
Patient Coinsurance Payment (20% of Price)	**$6,224.59**
OOP Savings	**$435.61**

To put these savings in context, figure 10 provides an example of how this policy could impact an individual patient. If a patient received a hip replacement during an inpatient hospital stay and owes 20% of the prices of the service through coinsurance, the price would decline by $2,178.04 if the price were capped at 200 percent of the Medicare payment, $435.61 of which would be experienced through lower OOP costs.

APPLYING A MODIFIED COMMERCIAL PAYMENT CAP, EXCLUDING CERTAIN SAFETY NET HOSPITALS

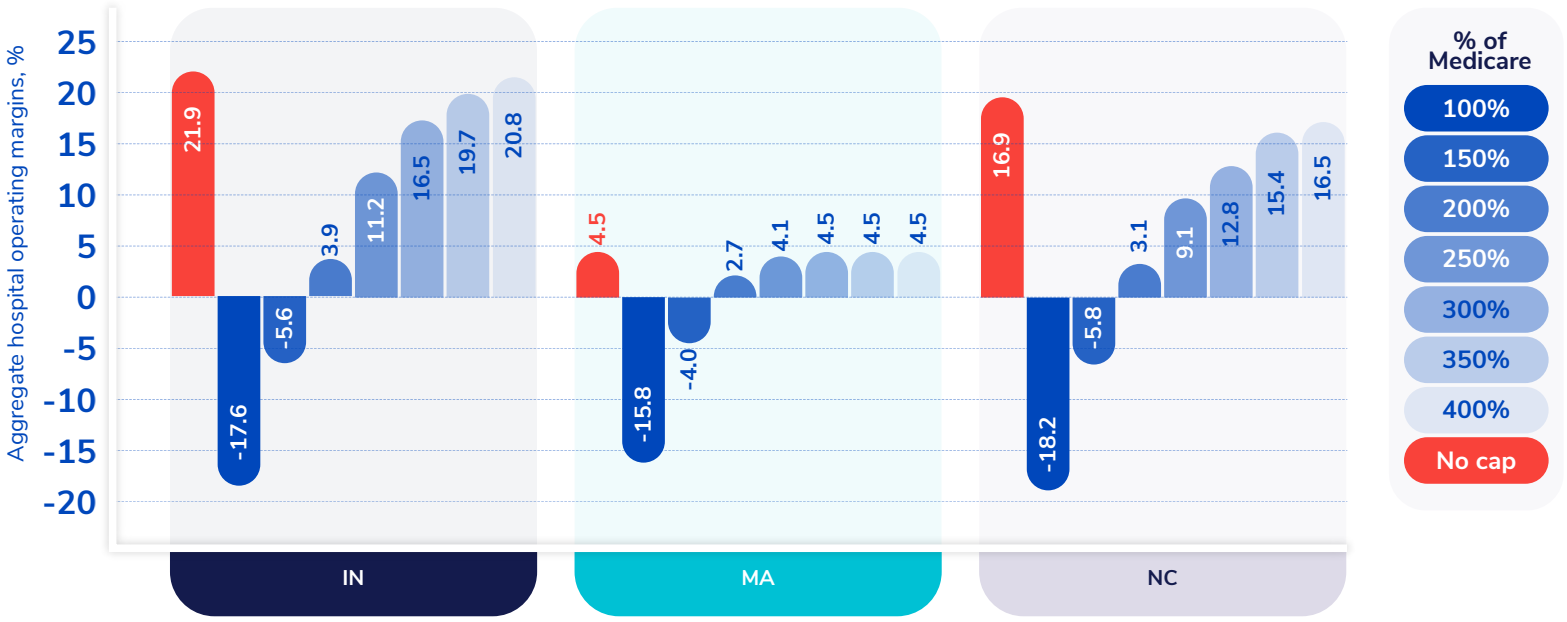
We also modeled savings for commercial payment caps that exclude critical access hospitals—small, rural facilities that often operate at or near financial losses and may be unable to absorb further reductions. Several states with payment cap policies have chosen to exempt these hospitals for this reason.[36] Because critical access hospitals account for a small share of overall hospital revenue at the state level, excluding them has minimal impact on statewide savings or average statewide hospital margins. States should consider any exclusions to commercial payment caps carefully. Each hospital market is different, with different justifications for excluding or including safety net hospitals.

COMMERCIAL PAYMENT CAP IMPACT ON HOSPITAL OPERATING MARGINS

For the same reason commercial payment caps yield the greatest consumer OOP and premium savings, these caps would also have a significant impact on statewide hospital operating margins. At cap levels of 100 or 150 percent of Medicare, statewide hospital operating margins turn negative, suggesting that caps at these levels could significantly hinder hospitals' ability to cover their costs and remain financially viable (see Figure 11). However, the financial impact to hospitals would lessen as the cap increases. Total margins become positive at 200 percent or above.

FIGURE 11

Estimated Hospital Total Operating Margins Under Hospital Payment Caps for All Commercial Lives in Indiana, Massachusetts, and North Carolina, 2022



NOTES:

Hospital total operating margins are calculated as the difference between net patient revenue and operating expenses for all patient care, divided by net patient revenue and multiplied by 100 to express the result as a percentage.

The red bar shows aggregate hospital total operating margins at the state level in 2022.

The blue bars represent projected margins under different hospital payment caps, ranging from 100% to 400% of Medicare rates.

3. Next steps for reform implementation

The findings above should inform policymaker action to rein in hospital prices at both the state and federal levels. While this paper evaluates the impact on affordability and average hospital operating margins within three example states, federal policymakers can look to these findings as proof points that, if explored on a larger scale, these policy interventions would achieve significant and meaningful savings for consumers across the country depending on how they are structured. As policymakers identify legislative priorities for addressing hospital prices, they should:

- **Consider implementing multiple policy options working in tandem,** including implementing more than one of the three policies modeled. Each of the three policy options described above can be implemented as a standalone policy; however, states could also consider implementing policies together to achieve maximum impact. For instance, pairing a site neutrality policy with a facility fee ban would equalize payments across settings while at the same time protecting consumers from a surprise fee attached to a specific set of routine services.[37] Policymakers could also consider pairing payment reforms with reforms aimed at curbing or better regulating hospital consolidation.

- **Closely assess state markets,** including baseline hospital payment rates, before choosing Medicare thresholds to cap payments. Each of the three states modeled had different baselines for commercial hospital costs, which meant that the impact of each policy option varied. Massachusetts hospitals, for instance, have relatively high Medicare prices and smaller differentials between commercial and Medicare prices at baseline, which means that each of the three policy interventions (pegging commercial prices to Medicare prices) will have a relatively smaller impact, and no impact when set at high proportions of Medicare rates (see Figure 11). The savings included in Table 12 are averages per member per year. Some consumers will see much higher savings depending on their utilization of hospital services within a plan year, while others may only see savings from reduced premiums.

TABLE 12:

Average Savings Across the Three Policies in Indiana, Massachusetts, and North Carolina, 2022

	Site–Neutral Payments		Facility Fee Bans	Commercial Payment Caps	
	Cap at 100% of Medicare	Cap at 400% of Medicare		Cap at 100% of Medicare	Cap at 400% of Medicare
AVERAGE TOTAL SAVINGS PER MEMBER PER YEAR					
Indiana	$304	$57	$93	$2,832	$108
Massachusetts	$239	$23	$65	$1,402	$0
North Carolina	$175	$20	$25	$2,263	$39
AVERAGE OUT-OF-POCKET SAVINGS PER MEMBER PER YEAR					
Indiana	$122	$23	$37	$263	$10
Massachusetts	$61	$6	$16	$130	$0
North Carolina	$62	$7	$9	$210	$4
AVERAGE PREMIUM SAVINGS PER MEMBER PER YEAR					
Indiana	$182	$34	$56	$2,568	$98
Massachusetts	$179	$18	$48	$1,271	$0
North Carolina	$113	$13	$16	$2,052	$36

To yield consumer OOP and premium savings, states with lower relative commercial hospital prices may consider either setting their site-neutral payment or hospital payment caps at a lower proportion of Medicare payments or pursuing more targeted policies that aim to eliminate specific hospital pricing practices, such as a ban on facility fees for a subset of services. States may also consider hospital pricing policies for certain segments of their markets, such as state employees, as opposed to the entirety of the state-regulated market. In addition, states may want to assess their safety net hospital landscape and consider possible tailored exemptions to mitigate financial harm for hospitals with unique considerations, including rural hospitals.

- **Consider how to structure hospital payment policies to reach the largest swath of the market.** For instance, specifically capping hospital prices and not payer reimbursement rates could insulate a policy from ERISA preemption, allowing it to apply to the entire commercial market. At the same time, a state may have limited ability to require self-funded employers to pass savings generated from any of the policies mentioned above to employees in the form of lower premiums.
- **Consider tailoring policies to care settings and services that will have the biggest impact on consumers.** The modeling above demonstrates that hospital payment reforms may have variable impact depending on the specific setting or suite of services targeted. For instance, applying either a site-neutral payment policy or facility fee ban policy to only off-campus HOPDs could yield relatively little savings for consumers as compared to broadening the policy to include on- and off-campus HOPDs. Similarly, focusing a facility fee ban on solely telehealth services will have a much smaller consumer impact than widening the policy to capture other routine services, including E&M and preventive services. In addition, states should assess the extent to which they are able to require plans to pass through savings from reduced hospital costs to consumers through premium reductions. This may be difficult to do for self-funded plans because of ERISA preemption, but could be a policy option for the fully insured market.
- **Estimate impact on hospital budgets and operating margins** using a data-based approach and use that data to design policies to reform, not destabilize, hospital financing (e.g., by exempting certain safety net hospitals from pricing reforms). Each of the three policy options described above has an impact on both total and commercial hospital operating costs. The impact on hospital margins is the average impact at the state-level, and the impacts will likely vary by individual hospital based on their rates relative to Medicare, payer mix, and other aspects. While the thrust of each policy option is to rein in hospital pricing not tethered to patient need or efficient care delivery, hospitals may contend that pricing cuts will impact their ability to continue to deliver high-quality care, particularly in underserved areas. Assessing the differential impact of setting site-neutral and commercial payments at varying proportions of Medicare rates is essential to picking the appropriate rate that will drive down costs for consumers while ensuring hospitals remain financially viable. States may also consider exempting certain hospitals from policies if they play an outsized role in providing access through the safety net and may be more sensitive to the financial impact of the three reforms described above. This could include exempting critical access hospitals and/or rural hospitals from payment caps.
- **Consider federal and state budget volatility** in designing policy approaches to hospital costs and work with payers and hospitals to develop real-time assessment of fiscal health and budget outlook amidst a dynamic policy environment.
- **Forecast potential hospital responses to these policies.** For example, hospitals may try to make up for lost revenue through cost-shifting, increasing service volume, shifting toward more profitable patients or services, or cutting back on operations.

CONCLUSION

Developing policies to address hospital pricing dynamics that are harming consumers is a complex endeavor, made even more difficult by volatility in state economic dynamics and federal health policy. However, it is clear that consumers would benefit from the reforms described above through reduced OOP costs and premiums. In most cases, impact on hospital operating margins would be fairly limited, and policies could be structured to limit impact on certain safety net hospitals. State and federal policymakers should use the analysis included in this report to inform their policy development and tailor policies that are best suited to protect consumers from unaffordable hospital costs while also recognizing the vital role hospitals play as part of the health care safety net.

APPENDIX I: *Methodology*

CAHPR used the following methodologies to calculate three primary measures for each policy option: 1) impact on consumer out-of-pocket costs; 2) impact on premiums; and 3) impact on hospital operating margins.

Policy 1: *Site-Neutral Payment Reforms*

The team used the 2022 Health Care Cost Institute (HCCI) professional and outpatient claims data from Indiana, Massachusetts, and North Carolina to estimate potential savings from site-neutral payment. This policy would cap total payments for a subset of services—those that can be safely delivered in lower-cost settings—at a fixed percentage of the Medicare payment made in lower-cost settings (the "Medicare non-hospital payment"). These services include evaluation and management (E&M) services and procedures that are associated with 66 ambulatory payment classifications (APCs)—groups of services within the outpatient prospective payment system. The Medicare Payment Advisory Commission (MedPAC) identified that E&M services and 57 of the 66 APCs could safely be performed in doctors' offices, as these services were already conducted in the office setting more than half the time. MedPAC identified that the remaining 9 APCs were too complex for doctors' offices but could safely be performed in Ambulatory Surgery Centers (ASCs).

The Medicare non-hospital payment is defined as the Medicare physician fee schedule (PFS) payment for E&M services and 57 of the APCs, and as the Medicare ASC payment for the remaining 9 APCs. The team restricted the analysis to claims from the doctors' office (place of service [POS] code 11), ASC (POS code 24), and on-campus (POS code 22) and off-campus (POS code 19) hospital outpatient department. The team first estimated price reductions if payments for E&M services and the 66 APCs were capped at a percentage of the Medicare non-hospital payment, applied across all care settings (e.g., 100% of the Medicare PFS rate for services that could safely be delivered in the doctors' office or 100% of the Medicare ASC payment rate for services that could safely be delivered in the ASC). Then, the team aggregated the price reductions across service types and settings to estimate overall statewide savings. Finally, the team used data on average patient cost-sharing for these outpatient services to estimate the portion of savings that would be experienced directly by patients through lower out-of-pocket spending and estimated that the remaining would be passed through as premium reductions. Because HCCI data represent only a subset of the commercially insured population in each state, the team adjusted for representativeness using claims volume estimates from Transparency in Coverage (TiC) data.

Policy 2: *Facility Fee Bans*

The team used 2022 HCCI outpatient claims data from Indiana, Massachusetts, and North Carolina to estimate potential savings from implementing a facility fee ban on preventive, telehealth, and evaluation and management (E&M) services. For these services, the team analyzed claims from both on-campus and off-campus HOPDs. For telehealth services, the team also included claims where care was delivered at the patient's home (POS code 10) or another remote location (POS code 02), but where a facility fee was still billed—suggesting that the provider was located in an on- or off-campus hospital outpatient department. We used the American Medical Association (AMA) billing guide for private payers for a list of Affordable Care Act (ACA) preventive services procedure codes. To estimate potential savings from facility fee bans, the team aggregated facility fees paid for preventive, telehealth, and E&M services delivered in on-campus and off-campus hospital outpatient departments by state. Because HCCI data represent only a subset of the commercially insured population in each state, the team adjusted for representativeness using claims volume estimates from the TiC data.

Policy 3: *Commercial Hospital Payment Caps*

The team used 2022 hospital-level pricing data from the Employer Hospital Price Transparency Study (Round 5.1) to estimate potential savings from commercial-wide hospital payment caps. Using data on hospital-level standardized inpatient and outpatient prices, as well as prices relative to Medicare payments, the team calculated the Medicare-equivalent average payment per inpatient admission and outpatient procedure at the hospital level. Then the team identified the cap based on a percentage of the average Medicare payment per inpatient admission or outpatient procedure. For hospitals with prices above the cap, the team estimated price reductions and accounted for a slight increase in service use due to price reductions experienced through reductions in out-of-pocket spending. To estimate how total savings would be split between out-of-pocket savings and premium reductions, the team assumed that, on average, out-of-pocket spending represents 9.3% of total payments for inpatient and outpatient hospital services among commercially insured enrollees, based on data from the HCCI 2022 Health Care Cost and Utilization Report. This means that 9.3% of the total savings would go toward reducing deductibles, coinsurance, and copays, with the remaining 90.7% passed on through lower premiums, assuming carriers pass on all savings to enrollees.

Hospital operating margins impact

The impact of each policy option on hospital operating margins was calculated in a uniform way across the three policy options. Using data from the National Academy for State Health Policy (NASHP) Hospital Cost Tool, state-level operating margins were calculated first by aggregating net patient revenue and operating expenses across all hospitals with available data in the state. Then, by using the following formula: (net patient revenue - operating expenses related to patient care) / net patient revenue. To account for lost revenue under each of these cap scenarios, the team subtracted "total statewide savings" from net patient revenue in both the numerator and denominator.

LIMITATIONS

The following data limitations were identified:

- The data sources used do not capture all commercial claims within each state for a given year. To address this, the team used data from other sources to apply estimates to the broader commercial population. However, this approach assumes that commercial rates and patient mix are similar for the portions of the commercial population not captured in the data sources used.
- The extent that any premium savings accrued to payers are passed onto consumers could vary by market segment and may also depend on the structure and competitiveness of health insurance markets. Consequently, the assumption that enrollees receive the full savings—part through reduced out-of-pocket spending at the point of service and the rest through lower premiums—may overestimate the benefits for individuals and families.
- Estimates of out-of-pocket and per member savings rely on assumptions about average cost-sharing and may not reflect variation across market segments and plan designs.
- The methods used to estimate savings differ between commercial hospital payment caps and site-neutral payment caps. The team applied commercial hospital payment caps at the hospital level, while applying site-neutral payments at the claims level for specific services. As a result, savings under commercial caps may appear low or nonexistent in some cases, even though high-cost claims (above the average) would likely decline under such a policy.
- Errors or inconsistencies in provider billing practices may lead to an underestimation of potential savings. For instance, a provider may report a service as having been delivered in a physician's office when it actually occurred in an off-campus hospital outpatient department, potentially inflating the professional fee—as is often observed in Medicare billing. In such cases, we may not fully capture savings from policies aimed at eliminating off-campus facility fees. Additionally, for services billed in outpatient hospital settings or ASCs, we may have excluded cases lacking a clearly matched professional and facility claim. Finally, inconsistencies and gaps in claims data that make it difficult to accurately match telehealth service codes with facility fees. Without a reliable way to determine whether this is due to billing practices or coding errors, some services may have been omitted from the analysis, resulting in a conservative estimate of savings.

APPENDIX II: *Medpac Service List*

SERVICE TYPE	AMBULATORY PAYMENT CLASSIFICATION (APT)/ CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE	APC/CPT DESCRIPTION
57 APCS ALIGNED WITH PFS RATES	5012	Clinic visits
	5693	Level 3 drug administration
	5694	Level 4 drug administration
	5524	Level 4 imaging w/o contrast
	5593	Level 3 nuclear medicine
	5522	Level 2 imaging w/o contrast
	5523	Level 3 imaging w/o contrast
	5521	Level 1 imaging w/o contrast
	5052	Level 2 skin procedures
	5691	Level 1 drug administration
	5373	Level 3 urology and related services
	5443	Level 3 nerve injections
	5054	Level 4 skin procedures
	5442	Level 2 nerve injections
	5724	Level 4 diagnostic tests and related services
	5692	Level 2 drug administration
	5441	Level 1 nerve injections
	5722	Level 2 diagnostic tests and related services
	5611	Level 1 therapeutic radiation treatment preparation
	5051	Level 1 skin procedures
	5822	Level 2 health and behavior services
	5053	Level 3 skin procedures
	5734	Level 4 minor procedures
	5071	Level 1 excision/biopsy/incision and drainage
	5372	Level 2 urology and related services
	5723	Level 3 diagnostic tests and related services
	5733	Level 3 minor procedures
	5823	Level 3 health and behavior services
	5101	Level 1 strapping and cast application
	5721	Level 1 diagnostic tests and related services
	5153	Level 3 airway endoscopy
	5731	Level 1 minor procedures

SERVICE TYPE	AMBULATORY PAYMENT CLASSIFICATION (APT)/ CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE	APC/CPT DESCRIPTION
57 APCS ALIGNED WITH PFS RATES	5371	Level 1 urology and related services
	5671	Level 1 pathology
	5164	Level 4 ENT procedures
	5741	Level 1 electronic analysis of devices
	5055	Level 5 skin procedures
	5481	Laser eye procedures
	5151	Level 1 airway endoscopy
	5111	Level 1 musculoskeletal procedures
	5163	Level 3 ENT procedures
	5732	Level 2 minor procedures
	5743	Level 3 electronic analysis of devices
	5102	Level 2 strapping and cast application
	5161	Level 1 ENT procedures
	5152	Level 2 airway endoscopy
	5413	Level 3 gynecologic procedures
	5411	Level 1 gynecologic procedures
	5412	Level 2 gynecologic procedures
	5162	Level 2 ENT procedures
	5742	Level 2 electronic analysis of devices
	5502	Level 2 extraocular, repair, and plastic eye procedures
	5501	Level 1 extraocular, repair, and plastic eye procedures
	5735	Level 5 minor procedures
	5821	Level 1 health and behavior services
	5621	Level 1 radiation therapy
	5811	Manipulation therapy
9 APCS ALIGNED WITH ASC RATES	5312	Level 2 lower GI procedures
	5491	Level 1 intraocular procedures
	5431	Level 1 nerve procedures
	5311	Level 1 lower GI procedures
	5492	Level 2 intraocular procedures
	5112	Level 2 musculoskeletal procedures
	5462	Level 2 neurostimulator and related procedures
	5503	Level 3 extraocular, repair, and plastic eye procedures
	5504	Level 4 extraocular, repair, and plastic eye procedures

SERVICE TYPE	AMBULATORY PAYMENT CLASSIFICATION (APT)/ CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE	APC/CPT DESCRIPTION
E&M SERVICES	99202	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 15-29 minutes.
	99203	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 30-44 minutes.
	99204	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 45-59 minutes.
	99205	Office visit for a new patient requiring a medically appropriate history and/or examination, typically taking 60-74 minutes.
	99211	Office visit for an established patient, which may not require the presence of a physician, typically taking 5-10 minutes.
	99212	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 10-19 minutes.
	99213	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 20-29 minutes.
	99214	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 30-39 minutes.
	99215	Office visit for an established patient requiring a medically appropriate history and/or examination, typically taking 40-54 minutes.

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22: See supra note 1.

23: For the purposes of the analysis, the research team assumed that all of the savings accrued to payers from lower hospital prices would be passed onto consumers. In practice, unless payers are required to pass on savings, this may be an overestimate. While state regulators could require premium savings pass through for the state-regulated market, they would not be able to require this for self-funded plans because of ERISA preemption.

24: United States of Care, A Comparison: Connecticut and Indiana's 2023 Facility Fee Legislation (2023), https://unitedstatesofcare.org/wp-content/uploads/2023/09/CT_IN-Facility-Fee-Comparison-Chart.pdf

25: Indiana House Bill 1004, 2025 Gen Assemb (Ind 2025), https://iga.in.gov/legislative/2025/bills/house/1004/details

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27: 42 U.S. Code § 1395ww; Department of Health and Human Services, Nantucket Office of the Inspector General, Nantucket Cottage Hospital Did Not Accurately Report Certain Wage Data, Resulting in Overpayments to Massachusetts Hospitals (March 2017), https://oig.hhs.gov/oas/reports/region1/11500502.pdf.

28: The federal Medicare program has been incrementally moving toward site-neutrality, and since 2015 has required that payments for a subset of clinical services provided in off-campus HOPDs align with non-HOPD physician payment rates. More recent congressional proposals would expand Medicare's site-neutral payment policy to a wider universe of services and settings. Senator Bill Cassidy and Senator Maggie Hassan, Lowering Health Costs for Seniors Framework (November 2024), https://www.cassidy.senate.gov/wp-content/uploads/2024/10/Site-Neutral-Policy-Framework-Final.pdf.

29: MedPAC, Report to the Congress: Medicare and the Health Care Delivery System (June 2023), https://www.medpac.gov/document/june-2023-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

30: Medicare covers physician services provided in doctors' offices under the Medicare Physician Fee Schedule (MPFS). Throughout this report, the "non-hospital" rate refers to the MPFS. Services delivered in hospital outpatient departments incur both a professional fee (under the MPFS) and an additional facility fee. The facility fee is determined by the outpatient prospective payment system (OPPS) and reflects the costs associated with the facility, such as medical supplies and equipment. Because providers are increasingly offering low-complexity, low-intensity services in the hospital outpatient setting, there has been a federal push to eliminate the facility fee for services could safely be performed in a doctor's office.

31: NASHP's calculation of operating margins focuses on revenues and expenses related to hospital patient care and hospital operations only. It does not include expenses related to other income received (e.g., cafeteria, research, investment expenses). It is therefore able to provide a clearer look at whether hospitals are financially viable based solely on their core mission delivering patient care.

32: Zachary Levinson, Jamie Godwin, and Tricia Neuman, Hospital Margins Rebounded in 2023, But Rural Hospitals and Those with High Medicaid Shares Were Struggling More Than Others (December 2024), https://www.kff.org/health-costs/issue-brief/hospital-margins-rebounded-in-2023-but-rural-hospitals-and-those-with-high-medicaid-shares-were-struggling-more-than-others/.

33: American Medical Association (AMA), Preventive Services Private Payer Coding Guide (2020), https://www.ama-assn.org/system/files/2020-09/private-payer-coding-guide.pdf.

34: Across all three states, eliminating facility fees would yield the most significant OOP cost and premium savings as applied to preventive services, a surprising finding given the ACA prohibition on cost-sharing for these services. The finding may also reflect a potentially broader insurer compliance issue with ACA preventive services requirements that is beyond the scope of this report but worthy of future analysis/discussion. Consumer Representatives to the National Association of Insurance Commissioners (NAIC), Preventive Services Coverage and Cost-Sharing Protections Are Inconsistently and Inequitably Implemented (August 2023), https://healthyfuturega.org/wp-content/uploads/2023/08/NAIC-Letter.pdf.

35: United States of Care, Leveraging Reference-Based Pricing to Contain Hospital Prices (2025), https://unitedstatesofcare.org/wp-content/uploads/2025/05/Reference-Based-Pricing-One-Pager.pdf

36: Roslyn Murray, Christopher Whaley, Erin Fuse Brown, and Andrew Ryan (2024). Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy. Health affairs (Project Hope), 43(12), 1680–1688. https://doi.org/10.1377/hlthaff.2024.00691.

37: Roslyn Murray, Haroon Janjua, and Christopher Whaley, supra note 21.

38: American Medical Association (AMA), Preventive Services Private Payer Coding Guide (2020), https://www.ama-assn.org/system/files/2020-09/private-payer-coding-guide.pdf.