

Reining in Hospital Prices:

LIMITING FACILITY FEES FOR ROUTINE SERVICES



People from across the political spectrum overwhelmingly support policy solutions to lower the high cost of care. United States of Care partnered with a research team at the Brown University Center for Advancing Health Policy through Research (CAHPR) to understand the cost savings associated with implementing three state policy options designed to lower health care costs, including placing limitations on facility fees. These surprise fees are charged by hospitals – on top of professional fees paid to providers – when services are delivered in their facilities.

In addition to saving patients' billions of dollars, we found that site neutral payments would also have minimal effects on hospital finances, delivering a win-win-win for patients, state budgets, and the health care system more generally. Our analysis also evaluates the cost savings associated with advancing site neutral payment policies and commercial hospital payment caps.

The Problem

While hospitals have long charged facility fees for services delivered in a hospital setting, rampant consolidation in recent years, and in particular hospitals' acquisition of physician offices, has resulted in the proliferation of facility fees for routine services that can be – and are – delivered in an office setting. Hospitals have increasingly purchased independent physician offices and converted them to “hospital outpatient departments” (HOPDs), which has allowed hospitals to increasingly charge these fees simply because the facility is classified as an HOPD rather than an independent physician office. In some cases, people are being charged these fees for telehealth appointments when they've never even stepped foot in a facility.

About half of adults report not being able to pay for a \$500 unexpected medical expense, an amount not uncommonly charged by hospitals in the form of facility fees, which often have a disproportionate effect on underserved communities. To make matters worse, insurance often doesn't cover these facility fees, which may nearly double the cost of care for patients seeking care at an HOPD compared to an independent physician office. As a result, skyrocketing facility fees can exacerbate medical debt and may cause people to delay or skip medical care entirely.

The Solution

Banning facility fees for certain routine services is a straightforward way to lower costs and disincentivize consolidation. Doing so for specific services, such as evaluation and management (e.g. patient office visits), telehealth, and preventive care services, delivered in both on- and off-campus settings, would provide significant relief for patients.

The Evidence

We modeled the impacts of this type of facility fee ban in Indiana, Massachusetts, and North Carolina and evaluated the results for both patients' costs and hospital finances. **We found that eliminating facility fees for certain routine services delivered in on- and off-campus HOPDs could result in \$681 million in savings for patients in those three states alone, underscoring the need for other states and the federal government to advance similar reforms.** The table on the following page shows what patients' savings would be.

State	Patients' out-of-pocket cost savings (per member per year (PMPY))	Patients' premium reduction savings (PMPY)	Patients' combined savings (PMPY)	Total patient savings (cumulative)
Indiana	\$37	\$56	\$93	\$322.5 million
Massachusetts	\$16	\$48	\$65	\$237.1 million
North Carolina	\$9	\$16	\$25	\$120.6 million
CUMULATIVE PATIENT SAVINGS ACROSS STATES				\$661 million

While these bans would meaningfully lower people's health care costs, **they would have a minimal impact on hospitals' total operating margins**. All percentages below represent aggregate hospital operating margins before and after establishment of a facility fee ban:

INDIANA: **21.9%** → **21.0%** MASSACHUSETTS: **4.5%** → **3.7%** NORTH CAROLINA: **16.9%** → **16.7%**

The impact on hospital finances is lessened as the rate increases, but so, too, does the impact on patient affordability.

Facility Fee Ban Patient Cost Savings

The hypothetical scenario to the right – applicable across all three states – shows how a patient with 10% coinsurance could save \$28.60 in out-of-pocket costs if facility fees were banned. In this example, **the patient would pay seven times as much without the ban as they would if the ban were in place.**

Considerations for Policymakers

Banning facility fees is a meaningful and commonsense way policymakers can lower costs for patients and employers. States have also taken action to address facility fees in other ways, such as by requiring patient notification of facility fees, standardizing provider billing requirements, and empowering regulators to hold hospitals accountable to ensure they remain compliant with the law. These solutions can also be paired with other policies aimed at lowering costs and limiting the harmful impacts of consolidation.

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