



Outpatient Outrage

**HOSPITALS CHARGE FEES FOR CARE
AT THE DOCTOR'S OFFICE**

U.S. PIRG
Education Fund

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AT THE DOCTOR'S OFFICE**



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Contents

INTRODUCTION	1
PATIENTS ARE GETTING FACILITY FEES MORE OFTEN	2
FACILITY FEES ARE COMPLICATING MEDICAL BILLS AND PATIENTS' LIVES.....	3
NO ONE, NOT EVEN OUR INSURANCE PLANS, SHOULD BE PAYING FACILITY FEES.....	5
STATES AND FEDERAL REGULATORS ARE TAKING ACTION.....	6
SPOTLIGHT: CONNECTICUT.....	12
RECOMMENDATIONS.....	14
CONCLUSION	15
APPENDIX A: 2021 CONNECTICUT FACILITY FEE DATA	16
ENDNOTES	17

Introduction

IMAGINE GOING TO THE SAME DOCTOR FOR

ten years. They do your annual physical, they check out your wrist when you injure it, they provide your prescriptions to control your high cholesterol. For each of these visits, you have paid your \$15 copay and gone home. A few days later your insurance sent your explanation of benefits that stated they covered your visit.

Now imagine going to the same doctor for this year's physical, paying your copay, and a few days later getting a second bill for \$100. You call the number on the bill, expecting them to acknowledge the error. But instead, you find yourself speaking to the local hospital billing department, not your doctor's office. It turns out that in the past year, the local hospital purchased your doctor's practice. They insist the bill is correct and explain the \$100 is the "facility fee", or "facility charge". You have never gotten this charge before, so you are confident that it is a mistake. The billing clerk goes on to say that you indeed owe that \$100 because the office is a hospital facility. When you call your insurance, they say they won't cover the charge, and that you should expect the fee going forward. With no recourse, you are on the hook for an extra \$100. You've just become an outraged outpatient – and unfortunately, you're not alone.

Hospitals charge these fees as well. But as health systems consolidate and hospitals buy up physician practices and clinics, more patients than ever are facing facility fees on bills for regular doctor visits. States and fed-

eral regulators are not doing enough to address this problem which is raising health care costs.

These added fees are unrelated to the cost of the care we receive, and can be based merely on changing ownership of the provider's office. There is no evidence that shows these fees improve the value or outcome of a doctor's annual check up, an X-ray taken at a diagnostic imaging center, or a mental health appointment conducted over the phone. Facility fees simply improve the profit line for health care companies that own the different care locations.

Because of facility fees, patients are paying more than their expected copay or coinsurance. If a patient has several appointments in a year, those additional fees can really add up. Even if insurers were to pick up the tab for facility fees, those costs incurred by thousands of patients likely would be passed on to patients in next year's premium. Added fees like facility fees contribute to the growing problem of health care costs.

This report explains why facility fees are increasing in frequency and explains the impact they have on costs. We'll review federal policy proposals and describe the steps some states have taken to address this growing problem. We also take a closer look at Connecticut, the state with the most comprehensive laws and public data on facility fees. We conclude with recommendations for protecting patients from this medical billing abuse.

Patients are getting facility fees more often

THE MOST LIKELY REASON PATIENTS ARE

getting a facility fee is because of consolidation. When hospitals acquire independent clinics and physician practices, the new owner can raise prices at those practices by charging facility fees under the new hospital affiliation.¹ As a result, individuals and families now face these additional charges in the same clinics and doctors' offices they have been going to for years.²

Patients are receiving bills with additional facility fees for routine visits and outpatient care. That means patients often receive facility fees for blood tests, COVID tests, x-rays and other simple outpatient tests and procedures.³ Patients get these fees even when nothing has changed about the location of the facility or the quality of care, type of treatment, or the doctors' skills since the hospital purchased the physician's office.⁴ The only difference for the patient is a new logo on the letterhead.

There are three additional instances where it seems particularly outrageous to charge fa-

Facility fees simply improve the profit line for health care companies that own the different care locations.

cility fees. Some patients report facility fees for evidence-based preventive services like vaccines, mammograms, and other screening services that in most health plans are legally supposed to come at no out-of-pocket cost to the patient.^{5,6} In other cases, the patient has merely been evaluated rather than getting treatment (known as "evaluation and management claims"), and the patient is already paying for the doctor's services through normal billing codes.^{7,8} And for telehealth appointments, which are virtual meetings, the patient has not even stepped into a facility at all.⁹

Facility fees are complicating medical bills and patients' lives

Facility fees make low-cost care more expensive.

To keep costs down while maintaining quality, insurance networks direct patients to lower-priced outpatient settings for low-risk care.¹⁰ Services such as colonoscopies, blood work, and MRIs are typically offered in outpatient settings with lower cost-sharing for patients.¹¹ However, these effective cost-saving mechanisms are undermined when patients owe facility fees for outpatient services. The additional, unjustified fees come as a separate bill, which may have its own deductible or coinsurance.¹² This means patients are paying more out-of-pocket.¹³ One patient likened her \$50 facility fee to paying an additional, separate copay, which did not even count toward her deductible for the visit.¹⁴

The fee amount varies significantly and appears to have no correlation with the care provided.

Facility fees vary tremendously, adding as little as a few dollars or more than \$1000 to the bill.¹⁵ In some cases, the facility fee is greater than the charge for the actual care provided. One patient in Kansas went to the emergency room for back pain and received a bill for \$3.50 for a muscle relaxant - and over \$2,000 in facility fees from the doctor and the hospital.¹⁶ Providers negotiate medical charges, taking into consideration the site of service. For example, hospital rates are generally higher than clinic care. Those negotiated rates should be sufficient to cover medical treatment, whether care is being provided at a hospital, a doc-

Facility fees vary tremendously, adding as little as a few dollars or more than \$1000 to the bill.

tor's office, or an emergency room. Therefore, there is no justification for a 'facility fee'.

Given that 'facility fees' are unjustified add-ons, it is not surprising that studies find that the fees are not related to the cost of providing care. One study found that facility fees for outpatient surgeries increased by 53% from 2011-2017, while the bills that covered the cost of those same surgeries stayed stagnant.¹⁷

There is no apparent rhyme or reason for the amount of the charge, either: the same service might generate a different facility fee amount.¹⁸ One California family received two facility fees for different amounts when they visited the emergency room twice in one day for their daughter's dislocated elbow.¹⁹ As an emergency medicine professor who analyzed their bills noted, the billing was "arbitrary" - it would have to be, for the "[s]ame child, same hospital, same insurance, same diagnosis, same procedure, same day" to result in the nearly \$2,500 price difference between the two bills.²⁰ Similarly, patients seeing a physician with multiple offices may receive bills for different facility fee amounts depending on the location.²¹

There is no apparent rhyme or reason for the amount of the charge, either: the same service might generate a different facility fee amount.

The fees really add up.

Facility fees contribute to the high cost of health care in America. If patients have more than one or two appointments a year, facility fees can drive up patients' health care spending by hundreds or even thousands of extra dollars.

One patient shared with PIRG that her visit to a pain clinic for an injection in her back generated a \$399 facility fee - more than six times the \$60 specialist copay she was responsible for. She also had two follow-up appointments when the injection didn't work - both of which generated additional facility fees for the same amount. That means to get help for her back pain at an outpatient clinic where she expected to pay - at most - \$180 in copays, this patient was responsible for an extra \$1200 in facility fees.²²

Facility fees are hard to avoid.

Patients can't always avoid seeking treatment in a location that charges facility fees. Insurance requirements, such as referrals and prior authorization, limit patient choices. In less densely populated or rural areas, choices for health care providers are few.²³ In-network considerations and available appointments further restrict those choices.²⁴ One Texas patient shared with PIRG that she must drive an hour to see a doctor in her network. She has been fighting billing errors and facility fees from her provider for over a year - but has no other option to seek care elsewhere to avoid these fights in the future.²⁵

Patients get little notice and are bottom-line responsible for these extra charges.

Patients rarely receive advance warning of facility fees. As discussed later in the report, only a few states have requirements to provide advance notice. Usually patients only find out about the facility fee charge when they get the bill, after services have been provided.²⁶ When a facility fee suddenly appears on a bill, patients are shocked and feel tricked - no one told them about the extra financial liability they would incur.²⁷ One New York patient shared with PIRG that she had been going to the same annual check-up for 16 years - and only received a facility fee on her most recent visit. She said the fees were "predatory, and unpredictable."²⁸ Another patient in California described her dismay over a facility fee arising from a dermatologist visit:

"I spent 15 minutes with a medical student and 2 minutes with a doctor to confirm my prescription. I paid my \$80 specialist copay, and then I got two bills: one for the treatment (\$700), and one for the facility (\$160). My insurance handled the \$700, but told me to be careful about where I sought care in the future because they wouldn't cover the facility fee. I pay thousands of dollars a year in premiums to insure my family, plus a deductible. These extra fees are a legal scam that needs to stop."²⁹

The fees were "predatory, and unpredictable."

No one, not even our insurance plans, should be paying facility fees

OFTEN, INSURANCE PLANS DO NOT COVER facility fees, and the solution isn't to ask our insurance companies to do so.³⁰ If insurance were to take full responsibility for them, the extra charges would unnecessarily drive up costs. Facility fees add up quickly; one state employee health plan was charged an additional \$53-\$150 per COVID-19 test, racking up over \$340,000 in just a few months.³¹ The additional cost is frequently passed on to patients in the form of higher insurance premiums or cost-sharing.³²

Patients should not have to take on these added charges, either. High bills, copays,

deductibles, and other prices can deter people from seeking care.³³ Unjustified facility fees only add to patients' fear of charges they can't avoid and might not be able to pay. With more than one-third of Americans delaying care because of cost, we need to do better.³⁴

Medical billing and health care prices are already opaque. The addition of facility fees to patient bills without any change to the level or quality of care is just another way for the American health care system to make a buck and stick patients or our insurers with more charges.



Credit: nortonrsx via iStock

States and federal regulators are taking action

Federal solutions:

There are several federal proposals to address the added costs of facility fees. Members of Congress have introduced proposals that would:

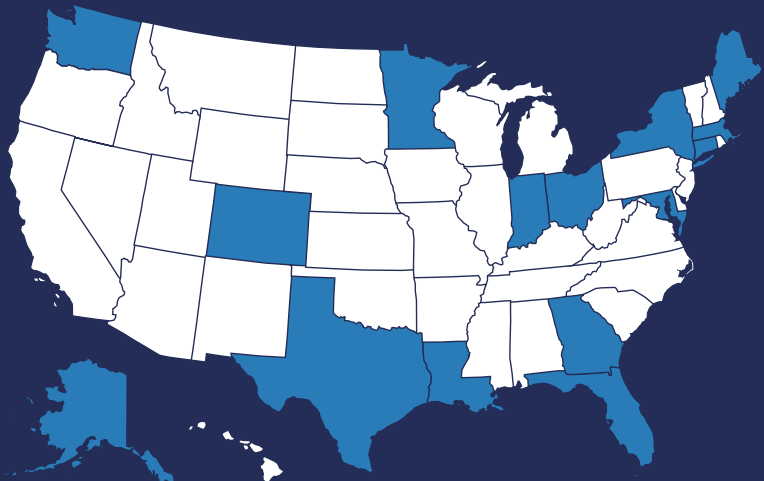
- Ban facility fees for certain services.³⁵ A budget estimate found that banning facility fees for certain Medicare services could save the program over \$700 million in the first ten years.³⁶
- Require separate hospital and non-hospital identification and billing codes.³⁷ Currently doctor offices owned by hospitals use the hospital's billing codes, which makes it difficult for insurers to know the appropriate charge amounts. With separate billing codes based on location, insurers would know the source

of the bill as either a hospital or another provider and pay an amount appropriate to the site of service. Insurers would be able to identify inappropriate facility fee charges. This policy would also prevent a simple change in ownership from triggering facility fees.

None of these proposals have advanced to the President's desk as of the writing of this report. However, the Federal Trade Commission (FTC) issued a proposed rule to "prohibit unfair or deceptive practices".³⁸ A group of advocacy organizations, including U.S. PIRG, urged the FTC to apply the rule to health care facility fees.³⁹ While the proposed rule may not put a stop to all facility fees, it could prohibit dishonest billing practices, such as billing facility fees for telehealth services.⁴⁰

15 states have passed laws on facility fees

Alaska	Maryland
Connecticut	Massachusetts
Colorado	Minnesota
Florida	New York
Georgia	Ohio
Indiana	Texas
Louisiana	Washington
Maine	



State action:

Meanwhile, state governments are leading the way by enacting a variety of policy reforms relating to facility fees. The chart below identifies 15 states and the strategies they have used to address the unjustified costs of facility fees. There are six kinds of reform states have undertaken:

- 1. Bans and restrictions.** These vary from state to state, but generally prohibit providers from charging facility fees for certain services or at certain locations.
- 2. Transparency and reporting.** Most hospitals report some financial information to the state. The relevant states below require information on facility fees in their reporting programs.
- 3. Patient notification.** Some states require public notice like signage or information on the provider's website about facility fee charges, while others ensure pa-

tients are informed of possible fees before scheduling an appointment.

- 4. Bill contents and appearance.** Some states have required standardized information about facility fees on patient bills, and ensure facility fees are itemized on the bill to make it clearly identifiable.
- 5. Legislative studies.** State officials frequently rely on studies to identify problems, gather more data and provide legislative recommendations. Most states have little public data on facility fees available.
- 6. Miscellaneous protections.** Some states have explored other policy options indirectly related to facility fees that don't fall into any of the other categories. Some notable ones are described below.

Summaries of each state's legislation with more detail follow the chart.

State (Most recent year passed)	Bans/ Restrictions	Transparency/ Reporting	Patient Notification	Bill Appearance	Legislative Study	Misc. Protections
Alaska (2019)		x				
Connecticut (2023)	x	x	x	x		x
Colorado (2023)	x		x	x	x	x
Florida (2022)			x			
Georgia (2023)						x
Indiana (2023)		x				x
Louisiana (2018)			x			
Maine (2023)					x	
Maryland (2021)	x		x			
Massachusetts (2021)			x			x
Minnesota (2023)			x			
New York (2022)	x		x			x
Ohio (2019)	x					
Texas (2021)	x		x			
Washington (2022)	x	x	x			

1. *Alaska* has required some public reporting of facility fees since 2019.⁴¹
 - a. Reporting: providers must report prices, including facility fees, of the 10 most common services on an annual basis.⁴²
2. *Connecticut* has the most comprehensive laws on facility fees, enacted in stages from 2015 - 2024.⁴³
 - a. Bans/Restrictions: bans facility fees exceeding Medicare rates for uninsured patients, facility fees for telehealth services and non-emergency evaluation & management (E&M) claims at non-hospital locations, and for non-emergency outpatient services provided at a hospital^{44,45}
 - b. Reporting: hospital systems report annually on which sites (by address) charge facility fees, the top 10 services for which each location charges facility fees, the total charged amounts and range of allowable facility fees, and how much revenue the fees generate.⁴⁶
 - c. Patient Notification: written notice of any facility fee, including the likely amount, and notice at the time of scheduling an appointment.⁴⁷
 - d. Bill Appearance: bills in plain language, clear identification of the facility fee and amount, a comparison to the Medicare facility fee rate, the patient's right to request a lower rate and contact info for where to do so, and notice that the bill might have been lower at a facility that did not charge a facility fee. Providers are required to file a sample billing statement with the state every year.⁴⁸
 - e. Other protections: health systems that purchase independent practices give patients notice of the acquisition before charging any facility fees.⁴⁹
3. *Colorado* passed a law governing facility fees in 2023 with provisions that go into effect in 2024.
 - a. Bans/Restrictions: providers with 3 or more hospitals, except for critical access and rural entities, cannot charge or bill facility fees to patients for preventive outpatient services.⁵⁰
 - b. Patient Notification: plain language notice that patients may be charged a facility fee, including the amount, at the time of scheduling an appointment and when services are provided. This goes into effect in July 2024. Providers are also required to have public signage about facility fees.⁵¹
 - c. Bill Appearance: bills must be itemized and clearly identify facility fees, what has been charged to insurance carriers or other payers, and how to contest charges with the provider.⁵²
 - d. Other protections: notice to patients of a change in ownership of the health care facilities that includes information about the facility fee(s) they charge.⁵³
 - e. Study: state will review the impact of facility fees on consumers, employers, and Medicaid. The report is due to the relevant legislative committees by October 2024. It will include common billing codes and the number of patient visits that generated facility fees, the amounts billed versus paid, total revenue, and more.⁵⁴

4. *Florida* passed a price transparency law in 2022 that included some facility fee notice requirements.
 - a. Patient Notification: any good faith estimate must include facility fees, their purpose, and notice that you may pay less at other facilities. The estimates are only required upon request.⁵⁵
5. *Georgia* passed a limited facility fee law in 2023 that goes into effect in 2024.
 - a. Other: protects insurers from paying facility fees for telehealth services unless that hospital is the originating site. There is no specific prohibition on billing the patient for any fee not paid by the insurer.⁵⁶
6. *Indiana* passed a relatively comprehensive facility fee law in 2023 which focuses on data transparency.
 - a. Reporting: hospitals report net patient revenue and total paid claims from facility fees, including inpatient and outpatient information by payer.⁵⁷
 - b. Other: requires providers in office settings to use “individual provider” forms rather than hospital forms for billing. This will inform insurers when the bill comes from a non-hospital facility and flag inappropriate facility fees or extraneous charges.⁵⁸
7. *Louisiana* amended its medical billing disclosure requirements to include potential facility fee charges effective in 2018.⁵⁹
 - a. Patient Notification: off-campus facilities must post a notice that patients may receive a facility fee bill charged separately from the physician bill.⁶⁰
8. *Maine* passed a study bill in 2023.
 - a. Study: the state health agency will report to the legislature annually on facility fees, using claims and other data already reported to the agency. The first report is due January 1, 2024.⁶¹ The law also created a task force to review how facility fees are collected and used, look at the effects of facility fees on health care costs, and make recommendations for further action.⁶² The task force released its final recommendations in January 2024, including: transparency and reporting, notice requirements, limitations on fees charged for telehealth services and based on location and other kinds of services, and patient billing complaint processes.⁶³
9. *Maryland* passed a Right-to-Know law regarding facility fees in 2020 which took effect in 2021.⁶⁴
 - a. Bans/Restrictions: Restricts facility fees for outpatient services *unless* patient notice is given in compliance with state requirements and the patient signs an acknowledgment of the notice.
 - b. Patient Notification: written notice to the patient at the time of scheduling the appointment of any facility fee as well as that the cost might be greater at this facility compared to those that do not charge facility fees. The consumer must acknowledge that notice before services are provided. Use a template form for the patient notice, including the amount, range, or estimate for the facility fee, additional contact information, and context for the fee.

10. *Massachusetts* passed legislation in 2021 that goes into effect in 2025.⁶⁵
 - a. Patient Notification: notice of any facility fee at the time of scheduling a health care service, including the expected amount.⁶⁶
 - b. Other protections: insurers must explain their facility fee coverage to enrollees.⁶⁷
11. *Minnesota* has had consumer notification requirements regarding facility fees in provider-based clinics since 2019 with updates in 2023, but has no other protections or requirements.⁶⁸
 - a. Patient Notification: notice prior to telehealth and non-emergency services that they may be charged a facility fee that results in higher out-of-pocket costs because the location is associated with a hospital. Also requires public notice on provider websites. These notices are required by provider-based clinics but not for services such as imaging and lab work if the service providers are not employed by the health care facility or clinic.⁶⁹
12. *New York* passed a law in 2022 that relies on an interplay between consumer notice requirements and prohibitions on facility fees to protect patients.⁷⁰
 - a. Bans/Restrictions: bans facility fees for preventive services. For other services, it restricts facility fees not covered by insurance *unless* the patient is given notice in accordance with the law.⁷¹
 - b. Patient Notification: notice in plain language in writing at least a week in advance of an appointment, or on the date of service if the appointment was made more recently; must include the amount and purpose of the fee, whether it is covered by insurance or how to apply for financial assistance if uninsured.
 - c. Other protections: patient notification of any new business relationship with hospitals or health systems that will result in charging facility fees.⁷²
13. *Ohio* passed legislation in 2022 with a limited ban.⁷³
 - a. Bans/Restrictions: bans facility fees for telehealth services.⁷⁴

14. *Texas* passed a series of laws and amendments from 2015 - 2021 regarding facility fees.⁷⁵

- a. Bans/Restrictions: bans facility fees for drive-through vaccination (and other health service) locations.⁷⁶
- b. Patient Notification: freestanding emergency medical care facilities must post signs in multiple places including patient rooms and the bill payment area to indicate that they may charge a facility fee. Notice must also be posted on their website.⁷⁷ Also requires a disclosure statement to the patient with the facility's median fee, range of fees, and facility contact information.⁷⁸

15. *Washington* has had a law on the books regarding facility fees since 2012, and updated it in 2021. The state also passed a telehealth ban in 2022.⁷⁹

- a. Bans/Restrictions: bans facility fees for audio-only telehealth services.⁸⁰
- b. Reporting: hospitals with provider-based clinics that charge facility fees provide information in their end-of-year financial reports to the state. Data must include the number of non-hospital locations and the number of patient visits that generate facility fees, the total revenue of facility fees per location, and the range of the charges at each clinic.⁸¹
- c. Patient Notification: notice that patients may be charged a facility fee that results in higher out-of-pocket costs because the location is associated with a hospital. They must also have public signage, including on their website.⁸²

SPOTLIGHT: Connecticut

CONNECTICUT HAS ONE OF THE MOST comprehensive sets of laws around facility fees, enacted in stages from 2015-2024.⁸³ Any state considering facility fee policy proposals should consider the steps taken in Connecticut while undertaking its own solutions.

The first step was gathering data. Connecticut's transparency reporting programs for facility fees collect data on:

1. the locations and providers that charge facility fees;
2. the number of patient visits that generate these fees;
3. the number, range, and amount of facility fees by payer mix;
4. the total fees charged; and
5. the total revenue generated by the fees.

Providers generated over \$430 million dollars in facility fees from 1.1 million patient visits in the state.

In addition, each hospital and health system must report on the ten procedures that generate the most revenue from facility fees and for which facility fees are charged. This includes the billing code, patient volume, and the gross and net revenue from each service.⁸⁴

Using 2021 data from this comprehensive program (see Appendix A),⁸⁵ Connecticut hospital filings show that providers generated over \$430 million dollars in facility fees from 1.1 million patient visits in the state. Some hospitals only had one location

Range of average facility fees in Connecticut (2021)



that charged these fees, but more than 40% of the health systems that charged facility fees generated them at 10 or more different addresses. The facility fee ranged from \$98 per patient visit to over \$1000, depending on the health system. Patients' bills with facility fees increased by an average of nearly \$400.

Using this information, Connecticut implemented facility fee billing standards and required patient notification to lower health care costs. The state also banned facility fees for certain kinds of care and locations. These restrictions passed in stages - first prohibiting facility fees for telehealth services and non-emergency care in non-hospital facilities, and more recently prohibiting these extra charges for outpatient care provided at a hospital.

Connecticut's laws cover nearly all of the reform approaches: limitations on when facility fees can be charged, data collection on

costs, patient notice requirements, and bill appearance. They go a step beyond facility fees as well, requiring patient notice of ownership changes that often precede a location starting to charge these fees. The gradual approach used in Connecticut allowed for effective use of the data the reporting program gathered annually. The multi-pronged legislation protected Connecticutians in different ways: restrictions on facility fees prevent these charges in many cases, and notice requirements ensure patients can make informed decisions about their health care costs. A standardized appearance on bills helps patients understand what they are paying for, and when they receive a charge they should not have to pay.

Because Connecticut has a robust and public data collection system, the information was useful in justifying the solutions and guiding lawmakers to fit the policy reform to the problem.

Recommendations

WITHOUT MORE ACTION AT THE STATE AND

federal level, patients will continue to face unjustified facility fees, and the prevalence of these fees will grow as hospitals and other consolidated providers take advantage of their concentrated market power, billing privileges and consolidated structures.

In order to lower health care costs and protect patients, we need to:

1. Ban facility fees.

Facility fees are unnecessarily adding costs to patients and insurers, with no added benefit in quality of care. A change in provider ownership is not a justification for an added fee that patients have little ability to avoid. There is no excuse for tacking on additional, inconsistent fees that only serve to raise the overall cost for patients.

Banning facility fees for certain providers and services, or banning facility fees in phases, may be more politically feasible. For example, bans on facility fees for a virtual telehealth appointment may be easier to accomplish as a first step. Regardless, policymakers should focus on the ultimate goal of creating an honest billing system. Patients should know what to expect and understand their bill, and should only pay for the costs of the care they received.

2. Collect data on the frequency and cost of facility fees.

To build political will to support a ban on facility fees, we need comprehensive data on the scope of facility fees. Although 21 states have all-payer claims databases (APCDs) with information on health care costs, the collected data does not capture all charges from providers. For example, APCDs do not capture claims - including facility fees - from uninsured people or from some self-insured employee benefit plans.⁸⁶ Medicare and some states require hospitals to report financial information, but those programs do not necessarily capture facility fee charges and payments.⁸⁷

Policymakers should establish data collection systems to fully capture the impact of facility fees on patients and insurers. Even a one-time study to collect data on facility fee charges and payments would help provide context for public policy solutions. A facility fee reporting program should include:

- which facilities charge this fee (including addresses and provider identification number),
- what service(s) trigger the charge,
- total amount charged by site/provider (including averages and the range of fees),

- total facility fees collected,
- the number of patient visits that generated facility fees, and
- the amount charged to and paid by each payer group (such as Medicare, Medicaid, Veterans Health, commercial insurance, and uninsured patients).

Better data doesn't solve the issue, but it can help lawmakers make more informed decisions about the best way to solve the high cost of unjustified facility fees - and transparency makes it plain that no one should be paying them.

3. Inform patients about facility fees and whether their insurance will cover that charge in advance.

Disclosure of facility fees is an intermediary step to protect patients while a state pursues other more comprehensive and effective solutions. Providers should inform patients of facility fees at the time of scheduling care, and again at the office on the day of service. The notice should include the fee amount and help the patient understand whether their insurance will cover that fee. In addition, any facility fee should be clearly identified in a standardized line-item format on a bill so patients can know the reason for the charge and the amount they were actually billed.

However, notice is not sufficient. Notice ensures patients can take appropriate steps to budget or avoid excess fees when possible, but does not solve the problem.

Conclusion

FACILITY FEES ARE CLEAR PROFIT-GAMBITS that take advantage of patients without providing a tangible or valuable benefit. They add thousands of dollars to patient bills and arbitrarily raise health care costs. Policymakers at the state and federal level have the ability to step in to protect patients from unnecessary facility fees. While we applaud

those states that have taken the lead, they can and should do more.

Patients deserve protection from add-on fees that they cannot avoid and are unwarranted by the care they received. We need action to put an end to facility fees, dishonest billing and unjustified health care costs.

Appendix A:

2021 Connecticut Facility Fee Data

This data is compiled from the 2021 tables filed with the Connecticut Office of Health Strategy, available on their website: <https://ohsnotificationandfilings.ct.gov/Home/Index>.

System/Hospital Name	Total Revenue from Facility Fees	# of Facilities Listed	# of patient visits that charged a facility fee	Facility Fee Revenue per Patient
Bridgeport Hospital	\$15,124,487	10	36,780	\$411
Bristol Hospital	\$1,763,850	1	19,624	\$90
Charlotte Hungerford Hospital	\$9,785,007	11	35,064	\$279
CT Children's Medical Center	\$22,624,091	17	41,808	\$541
Greenwich Hospital	\$12,066,880	4	14,648	\$824
Hartford Hospital	\$38,386,669	17	61,519	\$624
Hospital for Special Care	\$201,974	1	2,070	\$98
Hospital of Central Connecticut	\$24,854,179	9	83,294	\$298
John Dempsey Hospital	\$11,438,057	6	51,194	\$223
Lawrence and Memorial Hospital	\$2,711,247	3	16,644	\$163
Middlesex Health	\$7,768,823	4	20,384	\$381
Midstate Medical Center	\$8,112,102	1	30,073	\$270
Nuvance Health	\$27,833,959	10	68,453	\$407
Prospect ECHN	\$9,812,811	4	50,079	\$196
Prospect Waterbury, Inc.	\$6,875,508	3	8,554	\$804
St. Vincent's Medical Center	\$13,856,637	10	32,738	\$423
Stamford Hospital	\$110,212,046	10	137,310	\$803
Trinity Health of New England	\$43,719,331	38	41,872	\$1,044
William W. Backus Hospital	\$12,411,773	5	71,623	\$173
Windham Community Memorial Hospital	\$329,559	1	2,246	\$147
Yale New Haven Hospital	\$55,087,814	34	279,164	\$197
Totals:	\$434,976,804	199	1,105,141	\$394

*The following entities filed affidavits attesting they charged \$0 in facility fees in 2021: Connecticut Childbirth and Women's Center, Day Kimball Hospital, Gaylord Hospital Inc., Griffin Hospital, Hebrew Home and Hospice, Masonicare Health Center, Natchaug Hospital, Silver Hill Hospital Inc., and The Connecticut Hospice Inc.

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