



Facility Fees and How They Affect Health Care Prices

Policy Explainer

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What is a facility fee?

When you receive care in a hospital, you will likely receive two bills: one from the physician(s) and other clinicians who provided your care (i.e., for their professional services) and one from the hospital. The hospital bill includes charges associated with care provided by the hospital (e.g., room and board, procedures, and evaluation and management) with overhead costs (e.g., equipment, space, and support staff) baked in. A component of the overhead cost is a “facility fee,” which supports the emergency room and other services the hospital must provide but which are not directly related to the care the patient received.



Increasingly, facility fees are also attached to non-hospital care that patients might receive in a setting that is owned by a hospital. This can result in the same service costing different amounts depending on whether you get it in an independent physician’s office or one that is owned by a hospital, [driving up costs for patients and the health system more generally](#).

Why would patients pay a facility fee for non-hospital services?

There is growing [concern](#) about patients being charged a “facility fee” even when they receive care outside a hospital. For example, news stories have reported patients receiving bills of [more than \\$500 for a pediatrician office visit](#) or [over \\$6,000 for a minor dermatology procedure](#).

If a physician’s office is owned by a hospital system, a patient may be charged a facility fee in addition to the bill from the physician who provides care. In these cases, the physician’s office is allowed to bill as though the care was received in a hospital (e.g., including a facility charge), despite no physical change in where patients are treated, or the care they receive. As [hospitals increasingly acquire physician practices](#), facility fees in these situations have become more common. In fact, the opportunity to charge a facility fee is one incentive for hospitals to acquire these practices, which then leads to [higher prices](#) for patients, employers, and insurers.

- ➔ HCCI data show meaningfully higher prices for the **same services** when they have a facility charge and a professional charge (i.e., for the physician’s service) compared to when there is only a professional bill.
- ➔ For example, below we show average prices for three common services when (1) there is only a professional payment and (2) there are professional and facility payments.*

		
Ultrasound	\$164	\$339
Biopsy	\$146	\$791
Physician office visit	\$118	\$186

*National data shown here. State data and methodological details available in the [Downloadable Data](#) available with this explainer.

Why is there controversy over facility fees for non-hospital services?

Proponents [argue](#) that facility fees—even for services provided outside of the hospital—are justified because:

- They are necessary to cover higher expenses associated with hospital licensing, accreditation, and regulatory requirements.
- Hospital investment in physician practices increases access for patients, who can make appointments more easily across the continuum of care, for example if they need a specialist appointment at the affiliated hospital.
- Hospitals provide unique benefits within a community.

Others contend that facility fees are problematic because:

- Unlike services provided in an inpatient hospital setting, many outpatient services (e.g., imaging, injections, and biopsies) [can and already do take place in doctors' offices safely without any changes to the care provided](#) (e.g., the patient will receive the same supplies, technology, staffing, duration, or intensity of care as they would receive in a hospital setting).
- They may incentivize integration between hospitals and physician groups, which generally leads to higher [prices](#) without [improvements in care](#). Higher prices tend to be passed on to patients through cost sharing and premiums, resulting in even greater affordability challenges for common services.

What are policymakers doing to address facility fees?

Policymakers have undertaken two main approaches to address (non-hospital) facility fees.

1. Require transparency around facility fees

[Some states](#), including Connecticut, Texas, Washington, and Minnesota, require physician clinics that charge a facility fee to notify patients that the clinic is licensed as part of a hospital and the patient may receive a separate facility charge, resulting in higher out-of-pocket costs.

Another approach to improve transparency around where the service delivered is [requiring facilities to bill under separate identifiers](#) for services provided in a clinic that may be associated with a hospital but is “off campus” versus in the main hospital. This would help researchers and policymakers identify, measure, and potentially address unjustified facility fees.

2. Implement site neutral payments in commercial insurance

“Site neutrality” policy requires that payments be the same for services provided, regardless of where the patient was treated. For example, a test like an ultrasound or a physician’s visit must have the same payment rate whether it’s provided in a physician’s office or a hospital outpatient department. This policy essentially eliminates the facility fee. [Connecticut](#) took this approach by prohibiting facility fees for select services that can be safely provided in a non-hospital setting.

Nationally, policy groups estimate that site neutral payments in commercial insurance could reduce national health expenditures by [\\$450 billion](#) over the next decade, including \$380 billion in premiums and \$70 billion in cost sharing. Site neutral payments may also to reduce vertical integration, which can mitigate rising prices for insurers and [downstream costs to patients](#).