S12_Ep04_Facility Fee part 2

Dan: Hey there--

Kari Greene lives in Portland. She's got a couple of auto-immune disorders-- mostly under control these days. She sees her rheumatologist a couple times a year -- just to check in.

And last year she noticed a charge on top of the 40-dollar copay she was used to.

Eighty-eight dollars for an "observation room fee."

She says she called her insurance.

Kari Greene: And the person I spoke with was like, this seems weird.

Dan: She says they promised to investigate, but Kari never heard back. Eventually, she paid the bill and moved on with her life.

After Kari's appointment at the start of this year, the fee was there again. But instead of 88 dollars, now it was 99. Kari was pissed. She still is.

Kari Greene: I'm like, how? How dare you? it's such a slap in the face where you're like, I already paid my copay

Dan: Now they want a hundred bucks on top of that. For no reason Kari can see. And Kari's pretty sure it's not just her.

Kari Greene: That's the part that galls me it's like, there's this Scrooge McDuck back there going, Oh, we've got this doctor who works her little tushy off and she sees, five patients an hour.

And, we can add this charge on to every single one of these office visits.

Dan: Kari's definitely right that this isn't just her. We haven't found Scrooge McDuck and his swimming pool full of currency -- yet.

But:

Researchers and advocates have been talking for years about these kinds of extra charges -- called "facility fees."

They can get tacked onto office visits by hospitals, when the hospital owns the doctor's office.

And with hospitals buying more and more doctors' offices, those researchers say these fees keep popping up more and more often.

So we asked: Would anybody who had gotten a bill for one please share it with us? Kari was one of a bunch of people who responded.

And took time to talk with us.

Teresa: oh, it made me so mad, so mad.

Anne Gaffney: I mean, it's a 10 minute appointment for a prescription.

Amanda: I don't understand any of it.

where did this number come from?

Dan: We dug a little deeper with Kari's story, partly because it fit so closely with what we'd been hearing about: A fee that wasn't there one year, and the next it was. For a brief office visit -- Kari thinks maybe ten minutes-- in a normal setting.

Kari Greene: It's a regular doctor's office room. it's got the little bed with the paper on it, you know. And it's got the like blood pressure cuff thing on the wall, there's nothing that makes it special,

Dan: Except, when it comes time to bill, for the fact that a hospital owns it.

And our first question, of course, was: Can they really freaking DO that?!? How is that even allowed?

The "how" is long and complicated and honestly boring. But by and large, it's legal. They can do that.

Except, as far as we can tell -- for the most part -- in a few states. Especially Connecticut.

Legislators and policy-makers there have been working on this issue for a decade. And bit by bit, they've worked to outlaw charges like the ones on Kari's bills.

And other states have started working on following Connecticut's lead.

We talked with someone who's been tracking those efforts.

Christine Monahan: My name is Christine Monahan. I'm an assistant research professor at the Center on Health Insurance Reforms, which is part of Georgetown University's McCourt School of Public Policy.

Dan: Christine and her colleagues issued a report over the summer looking at efforts to restrict facility fees like these across all fifty states.

And she has some good news:

Christine Monahan: there's bipartisan interest in this issue. We are seeing these reforms bubble up across the states.

Dan: The less-good news: It could take other states a lot of years to catch up. And they're hitting opposition every step of the way.

We'll have a progress report. But first we'll go deeper with Kari's story, which turns out to have a twist.

This is An Arm and a Leg, a show about why health care costs so freaking much, and what we can maybe do about it. I'm Dan Weissmann. I'm a reporter, and I like a challenge. So the job we've chosen here is to take one of the most enraging, terrifying, depressing parts of American life, and bring you a show that's entertaining, empowering, and useful.

Kari's in her mid-fifties, works in public health. For a long time, she'd had problems that no doctor ever found a cause for: Joint pain, migraines, fatigue.

Then in 2020, she got COVID, and things took a turn. Weird sores. She says her fingers swole up like sausages.

Kari Greene: when these like Sores were showing up and like I couldn't move my hands and they were super fat that was at least something that I could be like, see, it's not just the joint pain. It's not just the fatigue.

It's not just the migraines. It's not just the, like, look at my hand. This is not normal. Right.

Dan: Friends helped her find her rheumatologist.

Kari Greene: she was able to figure out what was going on. And, she's, I, I mean, I will get weepy talking about her because she is just, rheumatologists are like detective doctors, you know, they

are amazing diagnosticians, they're incredible listeners

Dan: After a bunch of listening, a bunch of labs, this doctor got Kari a diagnosis -- diagnoses -- and some meds that help a lot. So, Kari is pretty devoted to this doctor.

Kari Greene: anytime I consider switching, you know, when open enrollment comes around, I'm like, Okay, I see that I could spend a lot less money on

a different plan, but there's no way I'm giving her up.

Dan: These extr a fees aren't enough to send her away either. But Kari is doing what she can to avoid charges like this with another specialist she sees.

Kari Greene: My, my neurologist is in the same building and last year he was like, we can switch to telehealth. You don't have to come in.

Dan: But Kari says the rheumatology consult is different. More hands-on.

Kari Greene: rheumatologists really need to be able to touch your joints and manipulate. To be able to,

see, disease progression or even just be able to do, like, diagnostics.

Dan: So Kari's back at that office every six months, paying that extra fee.

She says she's lucky it's more of an annoyance than a real financial hardship for her, but when she's in the waiting room, she worries about the other folks she sees there.

Kari Greene: these are not young, healthy people who are like out in the workforce, like

just live in their best lives.

Dan: After her January visit this year, when the "observation room fee" went up from 88 dollars to 99, Kari called her insurance again, looped in the benefits person from her work.

The upshot: The insurer didn't have a problem with the charge. They said the hospital had the right to bill for it.

Kari Greene: But just because you have the right to do it, does that mean you should be able to do it?

Dan: And actually, here's the thing: Maybe the hospital DIDN'T have the right to do it, either.

Christine Monahan -- the Georgetown researcher who's been tracking efforts to clamp down on these kinds of fees?

She's also an attorney -- and she's a bulldog. She helped us really dig into Kari's bills and insurance paperwork. We waded deep into the alphabet soup.

Christine Monahan: She has a um, E/M CPT code on her EOB. Hospital's billing a G 0 4 6 3

Dan: I'll spare you more of that. But here's where Christine patiently led us: Based on written policies from Kari's insurance company, Christine thinks Kari probably never should have gotten charged for anything beyond that 40 dollar copay.

Christine Monahan: I think there's a good argument to kind of question why she should be paying more

Dan: Mmhmm. Dang.

Dan: Now, our producer Emily Pisacreta was on the call with Christine too -- to help make sure I didn't get lost.

And then it was time for Emily and me to test how well we'd followed Christine through that strong argument: By summing it up and running it by Kari's insurance company and the hospital.

We went back to documents Christine had dug up.

Emily: This is…

Dan: This is the, uh, this is the reimbursement policy manual.

Emily: The reimbursement policy manual.

Dan: YEP. That one. It's a section from the insurer's REIMBURSEMENT POLICY MANUAL-- which spells out what they do and don't pay for.

Christine had grabbed policy number 0h-Six-one: Clinic Services in the Outpatient Setting. Like Kari's doctor's office.

And it turned out to tell basically the whole story. Emily and I got excited, talking over each other.

Dan: Now that we're looking at it.

Emily: And they're like not allowed to this.

Dan: I mean, like I got confused even talking through it with Christine, but this seems crystal clear. They're like not allowed to do this.

Emily: Mmhmm.

Dan: Here's what it says:

"For clinic visits and services performed in the hospital outpatient setting, we do not allow split-billing"

And a couple sentences down that gets spelled out even more clearly:

"Do not split-bill clinic-based services, billing part of the service as a facility charge, and part of the service as a professional charge"

That sure looks like it means: Don't double-dip with a professional charge-- a bill for the doctor's service -- AND a facility fee.

We reached out to Kari's insurance company and the hospital that sent the bills. Asking them: Are we missing something here?

We haven't heard back.

Which leads me to think somebody may owe Kari some kind of refund.

Which feels very satisfying to know. But it's not exactly satisfactory.

Because as Christine said when we talked with her: This is not the sort of thing a regular person could be expected to run down, on their own time.

Christine Monahan: Most consumers are not going to know to look up the reimbursement policy.

Dan: Or how to interpret it. I mean, Emily and I look at this kid of stuff as part of our jobs. We're not brand new at it. But even with Christine leading us every step of the way, it took us some time to follow it all.

Christine Monahan: I think it, really just highlights how opaque all of this is and there may well be some insurers that are not paying these facility fees, or at least that say on paper that they are not going to, but it's a whole mishmash of different policies and they're not always followed. And the consumer is really left in the dark.

Dan: Which is why legislators in states from Connecticut to Colorado have started saying: Hey, maybe this shouldn't be a fight that individual people have to get into.

Maybe there should be RULES about fees like this.

Maybe there should be rules against them.

That's next.

This episode of An Arm and a Leg is a co-production of Public Road Productions and KFF Health News. That's a national newsroom that produces

in-depth journalism about health issues. Their reporters do incredible work, and I'm honored to work with them.

Before we start talking about efforts to regulate facility fees, we wanted to hear the case FOR them. We asked the American Hospital Association to make that case.

They sent us a statement from Molly Smith, their group vice president for policy, and she recorded it as a voice memo. Here's the bulk of it:

Molly Smith: The cost of care delivered in hospitals and health systems and any associated sites of care operated by the hospital takes into account the many unique services that only they provide to their communities. This includes the cost of maintaining standby capacity for traumatic events and delivering 24/7 care to all who come through the emergency department, regardless of ability to pay or insurance status.

They provide access to critical healthcare services that may not be otherwise available, especially in low income, rural, and other medically underserved communities. Hospital facilities also treat patients who are sicker and have more chronic conditions than non hospital facilities, which requires a greater use of resources.

In addition, hospital facilities must comply with a much more comprehensive scope of licensing, accreditation, and other regulatory requirements than do other sites of care. Facility fees are one way that hospitals may bill for overhead costs to maintain all of the essential services they provide to their patients and communities

Dan: Molly Smith also takes a long swipe at insurers, including Medicare, for not paying enough.

And I think it's fair to sum this up as: Operating a hospital is expensive. Facility fees are one way we try to get money to meet those expenses.

Which, according to Christine Monahan from Georgetown, is what hospitals tell state legislators when facility-fee regulations get proposed.

Christine Monahan: Hospitals will come in and tell horror stories about how devastating it will be to their finances if we were to do even the itsy bitsiest of reforms, and it can be hard for advocates and policy makers to go in and fact check those statements by the hospitals.

Dan: Because they don't have the data. Hospitals have it, but there's a lot they're not required to share.

Christine Monahan: The hospitals continue to have all of that information kind of in a black box about like exactly how much revenue are they getting, where are the facility fee revenues going, how much are going to profits, how much are going to cost, and if so, what are the costs,

Dan: That's a LOT of unknowns.

Christine Monahan: It can be scary to policymakers when a hospital industry comes in and says, this is going to ruin us and they don't have the data to come back and say, well, no, it really won't.

Even if they may be very skeptical that that what the hospitals are saying is accurate.

Dan: Mm. That is super interesting. There's like this information asymmetry.

Christine Monahan: Yes. Yeah, we've been calling it an information monopoly .

Dan: Look, here's just one example: How often are hospitals charging facility fees for visits to doctors offices? Like actual offices that aren't anywhere near the hospital, but that the hospital now owns?

Where could you find that out, if you were a state official? Well, a lot of states have databases with all insurance claims that got paid. Maybe you could look at insurance claims that included facility fees.

But how would you know where a particular appointment happened? The claim has a provider number. But a hospital doesn't have to use a new provider number for every location, every doctor's office.

Christine Monahan: Often they will be using a single identifier number for all their claims, or maybe a single health system might have a handful of identifier numbers. And they'll put those identifier numbers on the claims forms. And they might use the same identifier for if you're at the hospital, or if you're out 20 miles away in a physician's practice that they've recently acquired.

Dan: So to start with, policy-makers may have no way of knowing where these fees are even being charged.

So when Connecticut started passing laws in 2014, the first ones were really just about information. Requiring hospitals to post signs about them. And commissioning a study.

The next year, Connecticut passed a much bigger bill. It prohibited a lot of facility fees for regular office visits -- what’s called "evaluation and management" services on insurance forms. And required hospitals to make annual reports on facility fees.

And in a separate law, Connecticut banned facility fees for telehealth.

That's a step Christine says a lot of other states have followed.

Christine Monahan: I mean, how egregious is it to get a facility charge for a telehealth visit where you did not leave your home?

Um, that just does not make any sense. And so that's really easy pickings as far as hospital reforms go for regulated policymakers to look at and say, this, this doesn't make sense

Dan: Since then, Connecticut has passed a dozen more laws-- requiring new disclosures here, tightening loopholes there.

And the state still may not have closed them all. We heard from a listener in Connecticut who was trying -- and failing -- to find a place he could get a stress test that wouldn’t charge him a facility fee.

But even if more loopholes get closed, there's a problem. One economist we talked with said: Outlawing fees like this, it's like squeezing part of a balloon. Other parts of it just get bigger.

Christine Monahan agreed.

Christine Monahan: hospitals, particularly those with more market power, are best able to then, you know, shift their revenue somewhere else. If you say you can't impose a facility fee for XYZ services, okay, we're going to start imposing facility fees on these other services, or maybe we're just going to increase rates overall. And so it may not necessarily contain total system costs because of the balloon effect.

Dan: the, if I'm running a hospital, I'm like, well, my costs are this. Like, I'm gonna like, my, my, my, my revenue goal is this. Like, you're telling me I can't charge that. What else can I charge? How else am I gonna get that money?

Christine Monahan: Yeah.

Dan: And as Christine alluded to in that exchange: not all hospitals are created equal. Some are big and rich, running surpluses -- profits -- in the hundreds of millions of dollars a year. Others -- smaller hospitals, rural hospitals -- struggle to keep their doors open. Some do close every year.

Christine and her colleagues found, the big ones can use their poorer counterparts as political shields.

Christine Monahan: We spoke with a few hospital executives as part of our research last year. And, you know, one hospital executive we spoke with, he, represents kind of a smaller, less market powerful hospital, and he expressly acknowledged they carry the water for other hospitals in their state before the state legislature.

Dan: So, when a state like Indiana passed restrictions on facility fees in 2023, the law only applied to the state's biggest hospitals.

Indiana's story illustrates Christine's point that this isn't a partisan issue -- where Democrats hold majorities in Connecticut, Indiana is solidly Republican. The Employers Forum of Indiana has led the charge there.

Their story also illustrates Christine's point that change happens slowly.

Gloria Sachdev is executive director of the Employers Forum of Indiana. When she started the job in 2015, she went around to meet with employers..

Gloria Sachdev: I asked them, what is your biggest pain point? And all of them said, healthcare costs, they're not sustainable. They've been going up, you know, four or five, six, seven, 8 percent every year.

Dan: The group spent years conducting studies. Among their finidngs: Indiana hospitals charged more than hospitals in other states. And more than independent medical practices that offered some of the same services. Oh, also: Hospitals were buying up those practices, and jacking up prices.

Gloria Sachdev: And nothing was changing about the service. It was just that they owned it now and were able to tack on a hospital facility fee.

Dan: In 2020, the Employers Forum started lobbying for changes. Restricting facility fees was one of several issues. And it got maybe the most pushback.

Gloria Sachdev: the Indiana Hospital Association was fairly masterful at, uh, bringing forward Physicians from all across the state, they had school nurses showing up.

Dan: School nurses who were employed by local hospitals.

Gloria Sachdev: They said, Oh my gosh, you know, the, we'd have to shut down the school nurse program.

Dan: The Employers Forum lost that round. Getting a win took three years. And the bill that passed was narrowly tailored. It wouldn't apply to smaller, financial-strapped hospitals: Just the state's five largest hospital systems. And it only applied to "off-campus" locations — like a doctors office the hospital just happened to own.

Gloria Sachdev: So if they're in a strip mall, you know, 20 miles away. They can't charge a hospital facility fee.

Dan: According to this year's report from Christine Monahan's team at Georgetown, Indiana is now one of nine states with some restrictions on facility fees.

Another dozen states have passed other laws, including ones that require hospitals to disclose data. Data that may help advocates and policy-makers chip away at the information monopoly-- the one that Christine calls an obstacle to change.

Christine Monahan: we are making baby steps, um, in a very difficult environment. And so I count that as progress.

Dan: We'll have links to Christine Monahan's reports in our newsletter. You can check to see what steps your state has taken so far. We'll also link to reports on facility fees from the Public Interest Research group, which has also been pushing for reforms. .

We'll also highlight some other stories we're watching right now.

I'm telling you: Our newsletter is pretty good. You might want to sign up!

You can do that at arm and a leg show dot com, slash, newsletters.

Thank you for sharing your stories, and your bills, with us for this series. We've learned more from you than we've been able to share so far. We'll keep looking for ways to bring that to you.

We'll have a new episode for you in a few weeks right here.

Till then, take care of yourself.

This episode of An Arm and a Leg was produced by me, Dan Weissmann, with help from Emily Pisacreta and Clai re Davenport -- and edited by Ellen Weiss.

Big thanks to the many experts who talked with us about facility fees, especially Patricia Kelmar of the Public Interest Research Group and medical-bill coding expert Shelley Safian.

Adam Raymonda is our audio wizard. Our music is by Dave Weiner and Blue Dot Sessions. Gabrielle Healy is our managing editor for audience. Bea Bosco is our consulting director of operations.

Sarah Ballama, who has been our operations manager since early 2022, just left to take a very cool full-time job in another state. Sarah, we'll miss you so much!

Lucky for us, the amazing Lynne Johnson has come aboard to run the operations side for us. Welcome, Lynne! And thanks so much for joining us.

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Zach Dyer is senior audio producer at KFF Health News. He's editorial liaison to this show.

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