Joint Legislative Oversight Committee on Health and Human Services

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Mr. Chairman, members of the committee — thank you for the opportunity to be here this morning.

Affordability is top of mind for your constituents – our members and their dependents. Families feel it at the grocery store. Employers feel it in payroll. And nowhere is affordability more urgent than in health care. As the insurers, we stand between our members, businesses and government agencies which fund payments to providers. We work closely with businesses that struggle to offer affordable meaningful benefits to their employees. Our agents help families choose policies who struggle to adequately insure their families though the marketplace.

Today, you have asked the association to address a simple but meaningful step the General Assembly can take to lower health care costs for businesses, workers, and their families.

As healthcare provider systems change and adjust to the regulatory environment, you are right to look at hospital facility fees in non-hospital settings.

To be clear, there is a time and place where facility fees make sense.

Hospitals operate emergency rooms 24 hours a day, 365 days a year. They maintain trauma capacity, specialized equipment, and standby staffing. Facility fees were originally designed to help support these around-the-clock hospital operations that serve the community.

Patients are being charged facility fees for routine care delivered in hospital-owned outpatient offices — offices that operate during normal business hours and look no different than the independent practices next door.

In many cases, the difference in cost is dramatic.

For example, a patient receiving routine ultrasounds at a physician practice paid about $164 per visit. After that practice was acquired by a hospital system, a facility fee was added. The next visit cost $339 — more than double — for the same service, in the same building, by the same physician.

The Wall Street Journal reported that when an independent oncology practice in Charlotte was purchased by a large hospital system, monitoring charges for a breast cancer survivor increased from $76 to $400 because of a facility fee.

North Carolina Health News documented a case in the Triangle where visits were reclassified as "hospital outpatient" care, increasing costs by as much as $200 per visit.

And the Charlotte Ledger reported a $4,300 facility fee for an outpatient colonoscopy — nearly as much as the procedure itself.

These fees are allowed simply because the practice is owned by a hospital system.

And this problem is growing.

Each year, more independent practices are consolidated into large hospital systems. As consolidation increases, facility fees become more common — and routine care becomes more expensive.

On top of the added costs, a GAO report found that after consolidation quality does not improve – and may, in fact, even be lower.

Other states have acted. More than 20 states have passed some form of facility fee reform, with several prohibiting these fees in outpatient settings.

Last year, legislation passed the Senate that would address facility fees in outpatient settings. We estimate that passing this policy would reduce health care costs for North Carolina families by at least $200 million per year.

You are right to look at this issue. Patients do not understand having to pay a hospital facility fee when they are not receiving care in a hospital facility. In our opinion, the resulting optic adds to the mistrust of the entire healthcare system.

Returning to lower costs of care would mean lower costs to the state. It would mean lower premiums for employers. And it would mean greater affordability for families.

I want to remind you how this connects directly to monthly premiums. It is fairly simple:

Premiums are a reflection of the underlying cost of care. Insurance company rates are submitted to and approved by the NC Department of Insurance.

Every month, premium dollars go into a pool that pays for medical claims — doctor visits, hospital stays, prescriptions, and yes, facility fees. If the total cost of claims rises, premiums must rise to stay actuarily sound.

But the opposite is also true.

By law, insurers must spend 80 to 85 cents of every premium dollar on medical care. So, when the cost of care goes down, premiums naturally follow. By law, Insurance company administrative expenses are capped.

At the end of the day, this is about regulatory reform providing more affordability.

If a patient walks into a neighborhood doctor's office for routine care, they should pay for the care they receive — not an added fee simply because of who owns the practice. This policy does not reduce access. It restores the original intent to provide hospital funding for emergency rooms. It simply says that routine outpatient care should be priced like routine outpatient care.

You are right to be looking at the regulatory impact on healthcare. North Carolinians are asking us to make health care more affordable. This is a clear, targeted step you can take right now to do exactly that.

Thank you.

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