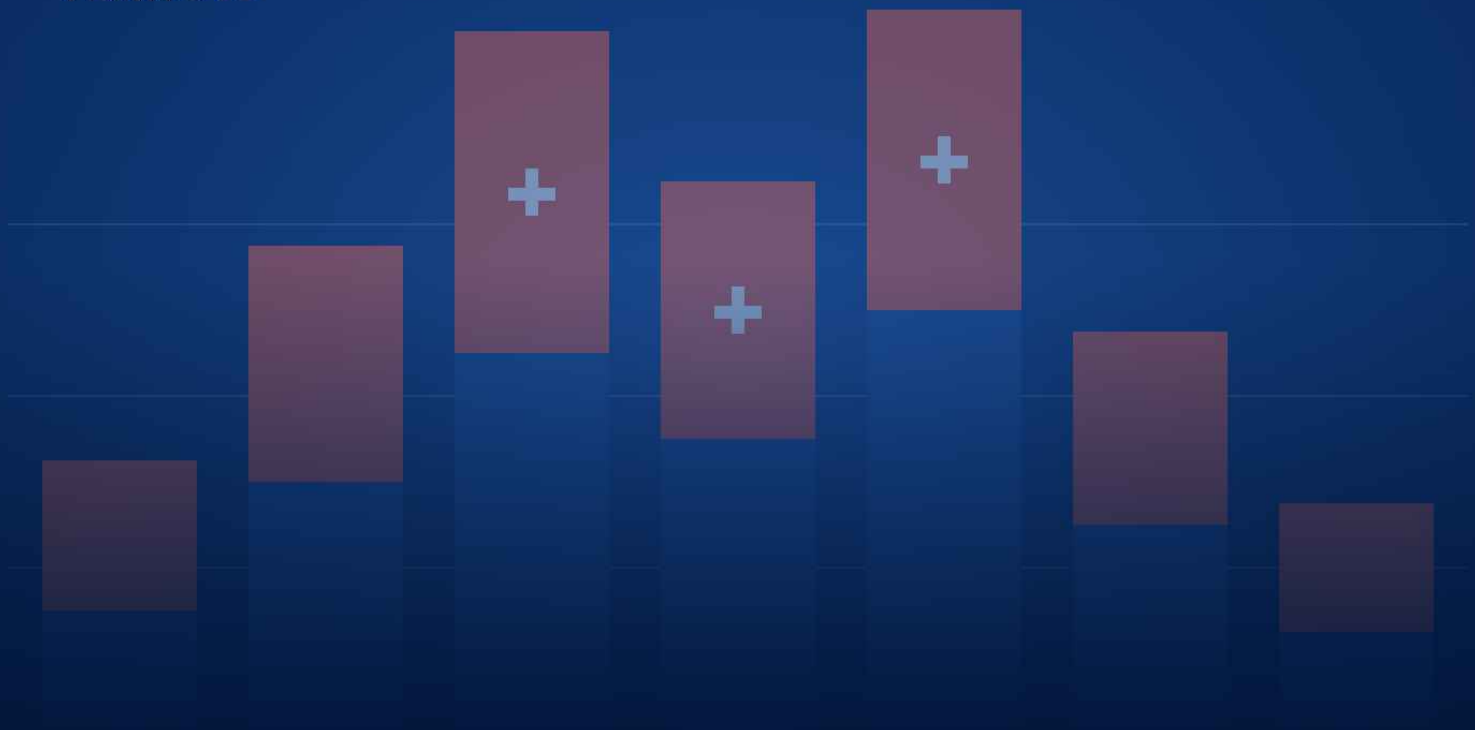
TEXAS 2036

MINI REPORT
HEALTH CARE · PATIENT COSTS



Facility Fees in Texas

How a quiet billing practice raises the price of everyday care, weakens transparency, and leaves Texans with **unexpected charges**.

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JULY 2026

Understanding Facility Fees and How they Impact Health Care Prices in Texas

How a billing practice is weakening transparency, increasing health care spending, and leaving patients with unexpected charges.

July 2026

KEY TAKEAWAYS

1 Facility Fees Are Transforming Routine Physician Visits Into Hospital-Priced Services

Facility fees are transforming routine physician visits into hospital-priced services — without changing the care delivered. When hospitals acquire independent practices and reclassify them as outpatient departments, patients face bills that can surge from $90 to nearly $600 for the same visit, often without any advance notice.

2 A Transparency Gap Is Driving Consolidation and Undermining Market Efficiency

Because acquired clinics bill under a hospital's single National Provider Identifier, insurers, employers, and patients cannot distinguish between a main hospital campus and a neighborhood clinic. This informational gap fuels hospital consolidation, limits competition, and prevents the market from functioning efficiently.

3 Texas Has a Clear Path Forward

States across the country have already demonstrated that facility fee reform works. Texas can draw on a proven set of policy tools — from disclosure requirements and unique provider identifiers to billing transparency mandates and site-neutral payment studies — to protect consumers, improve market efficiency, and reduce unnecessary health care spending.

What are Facility Fees?

Facility fees are overhead charges that hospitals bill in addition to the fees charged by physicians and other clinicians. When patients receive care in a hospital, they typically receive at least two separate bills: one from the hospital and one or more from the physicians or clinicians performing services.

Historically limited to on-campus hospital settings, these fees are increasingly applied to preventative care delivered in hospital-owned physician clinics off-campus. By billing these off-campus sites under the hospital's National Provider Identifier (NPI), hospitals can charge higher prices for services previously delivered at lower or no cost in independent offices — obscuring price transparency for patients and payers, and creating a financial incentive to acquire independent practices.

How Facility Fees Impact Texas

These administrative shifts have tangible consequences for Texas families. In one instance, a routine Type 1 diabetes visit for a child — previously $90 — surged to nearly $600 after an ownership change triggered a new facility fee.[1] Texas is witnessing a rise in hospital mergers alongside acquisitions of independent provider clinics. Through vertical integration, hospitals introduce facility fees on previously independent practices, leaving Texans with fewer options for care outside larger hospital systems.

$90 → $600

Cost of a routine pediatric Type 1 diabetes visit before and after a hospital ownership change triggered a new facility fee.

By formally designating acquired sites as "provider-based" hospital outpatient departments, hospitals can bill formerly independent clinics under the hospital's NPI, treating a remote doctor's office as if it were a department of the main hospital. This frequently occurs without changes to the clinic's location, staffing, or cost structure. Once finalized, hospitals can charge a professional fee alongside a new, separate facility fee, risking inflated total prices, unexpected cost-sharing, and bypassed zero-cost protections for preventative services.

Higher Costs for Common Services		VS	+
Ultrasound	$164		$339
Biopsy	$146		$791
Physician office visit	$118		$186

1. Julian Gill, "Hospital facility fees are driving up health care costs in Houston — and catching the eye of lawmakers," *Houston Chronicle*, February 14, 2025. https://www.houstonchronicle.com/health/article/hospital-facility-fees-driving-health-care-costs-19979090.php

SITE-NEUTRAL PAYMENT

Site-neutral payment is closely related to facility fees, but reflects a different policy lens. While facility-fee reform regulates how hospitals bill patients and commercial insurers, site-neutral payment focuses on how Medicare dollars are spent when the federal government is the payer.

The principle: Medicare should not pay more for a service simply because it was delivered in a hospital outpatient department rather than a physician's office. Today it does — distorting the market by subsidizing consolidation and creating a direct financial incentive for hospitals to acquire independent practices.

This payment structure results in fundamental inefficiency in how the federal government spends taxpayer money. As the direct payer, the government should act as a prudent purchaser, paying for the value of the service delivered — not the location where it takes place.

The two reforms address parallel challenges. Federal site-neutral payment is a fiscal tool for managing government spending; state-level facility-fee reform is a consumer-protection measure. Both rest on the same idea: billing should reflect the actual setting of care.

Harm to Patients

This billing model can impose significant financial penalties on Texans through increased cost-sharing, a burden often unavoidable due to a fundamental lack of transparency that prevents patients from identifying these fees before receiving care. Because acquired clinics utilize the hospital's NPI, a patient's visit is administratively classified as hospital-based care, even when the clinical setting and services remain effectively identical to their pre-acquisition state. As a result, patients may face unexpected out-of-pocket costs for preventative services typically intended to be provided at no cost. The separate facility fee can bypass standard zero-cost protections and may trigger patient deductibles, shifting the financial burden of hospital-level overhead onto patients for routine office visits.

Facility fees can vary widely, from just a few dollars to more than $1,000, and often lack a transparent connection to the complexity of the service provided. These charges frequently contribute to higher total health care expenditures and increased out-of-pocket costs, which can discourage patients from seeking necessary care. Given that 63% of Texans report postponing or skipping care due to cost, these additional fees risk further compounding existing affordability challenges.[2] Patients who reasonably believe they are visiting a standard clinic may instead face significant facility fees simply because ownership changed behind the scenes — and they are not required to be notified.

63%

of Texans report postponing or skipping care due to cost — affordability strain that facility fees risk compounding.

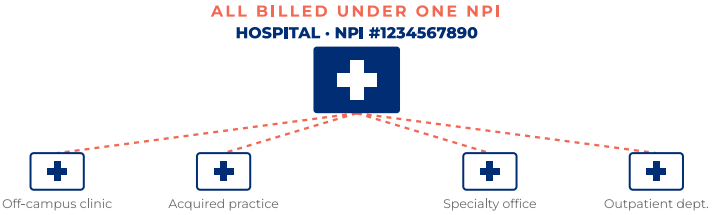
Harms to Payers and Insurance Markets

Healthy markets generally rely on clear price signals. The practice of billing off-campus clinics under a hospital's main NPI can create a transparency gap that may impact competitive dynamics in Texas. This billing structure decouples the relationship between price and service value by maintaining the professional fee while introducing an additional, often hidden, facility charge. Because claims are submitted under the hospital's NPI, insurers have little ability to distinguish between true hospital outpatient departments and routine physician clinics.

Congress recognized this problem in the most recent federal government funding bill and enacted a requirement for off-campus hospital outpatient departments to obtain a separate NPI — but that requirement applies only to Medicare claims.[3]

In the commercial market, this lack of site-of-service granularity persists, limiting the ability of payers to apply tailored reimbursement rules or steer care toward lower-cost settings. The absence of specific location data may hinder cost-mitigation efforts and affect the broader efficiency of the health care market.

THE NPI TRANSPARENCY GAP



Off-campus clinics share the parent hospital's NPI on commercial claims — leaving insurers unable to distinguish a main campus from a routine physician office.

2. Bethany Berg & Episcopal Health Foundation, "New EHF poll: rising health costs pushing Texans to skip care; diabetes and obesity among top concerns," *Episcopal Health Foundation News*, February 26, 2025. https://www.episcopalhealth.org/enews/new-ehf-poll-rising-health-costs-pushing-texans-to-skip-care-diabetes-and-obesity-among-top-concerns

3. U.S. Congress, "H.R. 7148 — Consolidated Appropriations Act," 119th Congress, 2026. https://www.congress.gov/bill/119th-congress/house-bill/7148/text

HARMS TO MARKET COMPETITION

$116 → $217

Average primary care visit cost in a physician's office vs. a hospital outpatient department — an 87% increase for the same service. (HCCI, 2022)

The ability to bill off-campus clinics under a hospital NPI can create financial incentives for consolidation that are not necessarily driven by improvements in patient care quality. This practice is associated with higher prices for routine services such as evaluation and management visits, diagnostic imaging, and minor procedures — often without any corresponding improvement in quality or complexity of care.

Recent analysis from the Health Care Cost Institute (HCCI) underscores the scale of these differences. Reviewing 46 services commonly performed in both an independent physician's office and a hospital outpatient department, researchers found prices were higher in hospital outpatient departments for every service studied.[4] In 2022, a primary care visit averaged $116 in a physician office but $217 in a hospital outpatient department — an 87% increase for the same service.

HCCI also found that for primary care visits in an outpatient setting, the physician component made up less than half (47%) of the total cost. For the $217 cost, only $103 was for the physician component while the remaining $114 was the outpatient facility fee.

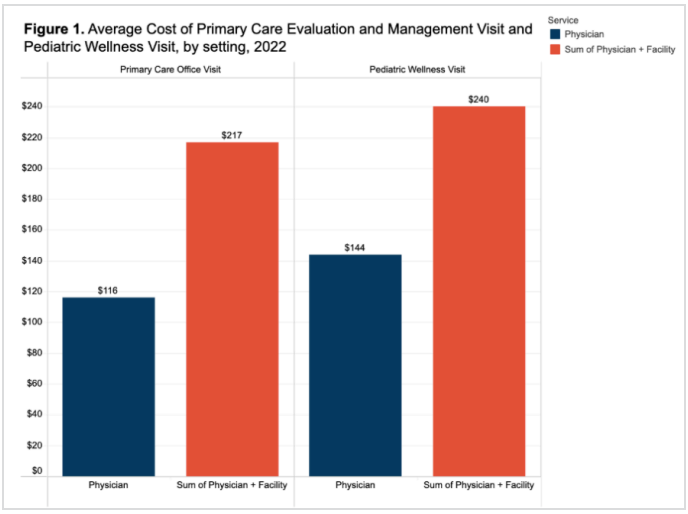
This distortion fuels a self-reinforcing cycle of consolidation. As systems acquire more clinics to capture facility-fee revenue, they gain greater market leverage to set prices with insurers, leaving independent physicians unable to compete. Routine, preventative care shifts into the most expensive setting possible — inflating system costs and eroding the purchasing power of employers while raising out-of-pocket costs for families forced to pay hospital premiums for standard health services.

POLICY OPTIONS TO ADDRESS FACILITY FEES

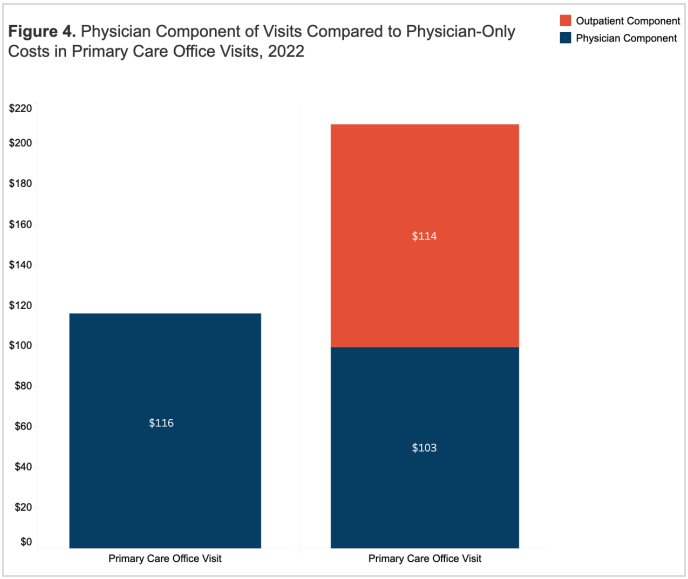
States have adopted a range of strategies to limit facility fees and improve transparency. Several — including **Connecticut**, **Maine**, and **Indiana** — have prohibited facility fees for routine evaluation and management services in office-based or off-campus outpatient settings, while others have enacted narrower bans for telehealth (**Maryland**, **Ohio**, **Washington**) or preventive care (**New York**). Some states also protect consumers by limiting separate copayments or balance billing for facility fees, as seen in **Connecticut** and **Colorado**. Nearly all study states require some form of disclosure, with **Colorado** and **Connecticut** implementing the strongest rules through advance written notice, clear signage, and notifications when a practice begins charging facility fees.

To improve oversight, states such as **Connecticut**, **Indiana**, **Maryland**, and **Washington** require annual reporting on facility-fee billing, while **Colorado** has launched a statewide data study. States have also strengthened provider transparency by requiring unique national provider identifiers for off-campus locations (**Colorado**) or maintaining ownership and affiliation registries (**Massachusetts**).

HEALTH CARE COST INSTITUTE ANALYSIS



Source: Health Care Cost Institute (HCCI), 2022.



Source: Health Care Cost Institute (HCCI), 2022.

HOW OTHER STATES ADDRESSED FACILITY FEES

SERVICE BANS

Prohibit facility fees on routine office-based or off-campus visits.

CONNECTICUT · MAINE · INDIANA

TARGETED BANS

Narrower limits on telehealth or preventive-care facility fees.

MARYLAND · OHIO · WASHINGTON · NEW YORK

COST PROTECTIONS

Cap separate copayments or block balance billing for facility fees.

CONNECTICUT · COLORADO

DISCLOSURE & NOTICE

Require advance written notice, signage, and patient notifications.

COLORADO · CONNECTICUT

Together, these reforms demonstrate the policy options available to increase transparency, prevent unexpected charges, and reduce unnecessary spending — offering a useful roadmap for Texas.

4. Bianca Silva Gordon & Katie Martin, "Facility Fees: What Are They and How Do They Impact Health Care Prices?," *Health Care Cost Institute Report*, May 6, 2025. https://healthcostinstitute.org/all-hcci-reports/facility-fees-what-are-they-and-how-do-they-impact-health-care-prices/

Policy Options for Texas

1. Require Clear, Advance Disclosure of Facility Fee Charges

Adopt a comprehensive disclosure framework that ensures patients receive clear, advance notice when a facility fee will be charged. This should include written notice when an appointment is scheduled or at least 10 days before service, a clear explanation of the fee and its cost-sharing implications, and notification when a previously independent practice becomes hospital-owned and begins charging facility fees.

2. Require Hospitals to Use Location-Specific NPIs on All Claims

Build on the federal Medicare standard already in place, which the Congressional Budget Office estimates will save $2.3 billion over ten years, by requiring any off-campus outpatient department to use its location-specific NPI on every claim, not just Medicare claims. This would enable accurate site-of-service reporting across all payor types.

3. Mandate Annual Reporting on Facility Fee Billing and Revenue

Require hospitals and health systems to submit annual reports on total facility fees billed and collected, the specific services associated with those fees, the number of visits and patients affected, and pay-level detail for transparency across commercial, Medicaid, and Medicare Advantage plans.

4. Evaluate the Feasibility of Site-Neutral Payment in Texas

Direct the Texas Health and Human Services Commission and the Texas Department of Insurance to study the potential for adopting site-neutral payment policies for Medicaid and commercial health benefit plan issuers, including their impact on health care spending, consolidation incentives, and patient cost-sharing.

5. Improve Statewide Data Infrastructure

Direct The University of Texas Health Science Center at Houston to use the Texas All-Payor Claims Database to conduct a statewide study examining patient cost-sharing obligations for facility fees across all payor types, and differences in total charges between hospital-affiliated and independent providers, including how professional fees change when facility fees are added.

6. Prohibit Facility Fees on All or Certain Services in Hospital Outpatient Departments

Either prohibit facility fees for all services delivered in hospital outpatient departments, or prohibit them for routine, low-acuity services specifically, including evaluation and management visits, basic imaging, lab work, and telehealth. A targeted prohibition would reduce unnecessary costs while preserving hospitals' ability to charge facility fees when hospital-level resources are genuinely needed.

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