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Protecting Patients from Unexpected Outpatient Facility Fees:

States on the Precipice of Broader Reform

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Executive Summary

INTRODUCTION AND BACKGROUND

Facility fees are charges from hospitals, including hospital outpatient departments and clinics, and other institutional health care providers that ostensibly cover the institution's operational expenses for providing care. Hospitals bill facility fees separately from the professional claims physicians, nurse practitioners, and other health care professionals submit for reimbursement for their services and expenses. Accordingly, when hospitals acquire physician practices — as has been the trend in recent years — ambulatory services once provided by an independent practice often newly generate a second bill for the facility fee.

One result of the expansion of outpatient facility fees is higher commercial payments for outpatient services. Other outcomes include confusion and increased costs for consumers, such as greater out-of-pocket costs and higher premiums. As more consumers feel the effects of these charges and stakeholders and policymakers search for ways to contain health care costs, outpatient facility fees are receiving new public scrutiny.

This report analyzes current laws and regulations in 11 study states: **Colorado, Connecticut, Florida, Indiana, Maine, Maryland, Massachusetts, New York, Ohio, Texas**, and **Washington.** It is supplemented by insights from more than 40 qualitative interviews conducted between November 2022 and April 2023. Its findings provide a comprehensive look at outpatient facility fee billing in the commercial sector and potential policy responses.

FINDINGS

Consumer, Payer, and Regulator Frustrations with Outpatient Facility Fees

Consumer advocates, payers, and state regulators flagged a range of issues related to outpatient facility fees during research interviews. Both consumer advocates and regulators expressed concerns about the financial exposure facility fees create for consumers via increased out-of-pocket spending — driven by plans with high deductibles and other benefit design features that increase patients' exposure to cost-sharing — and higher premiums resulting from increased spending on ambulatory services. Several interviewees also flagged consumer confusion as a concern, noting that patients may not be aware that their established provider has become affiliated with a hospital and, as a result, they could receive a bill for a facility fee.

Payer representatives also characterized facility fees as a tool for maximizing hospital revenue. They criticized the opacity of facility fees, specifically the lack of transparency around when hospitals charge facility fees and how hospitals calculate the amount of the charge. These interviewees also chafed at hospitals' allocation of certain overhead costs, such as for on-call surgical suites, to off-campus clinics and on-campus primary care offices. On the other hand, hospitals argued that facility fees provide a necessary mechanism to pay for critical overhead costs, including round-the-clock staffing, personnel costs, security, and supplies.

In addition, payers, researchers, and regulators all noted that limitations in claims forms and how hospitals and health care professionals complete these forms when billing make it difficult to identify where care actually occurred. This means payers cannot always accurately make decisions about reimbursements and coverage that are fully informed by the location of care, while researchers and policymakers do not have enough information to understand and respond to the full scope and impact of outpatient facility fee billing. For example, some key factors include how billing providers complete

the address fields of claims forms and the practice of using National Provider Identifiers (NPIs) and Tax Identification Numbers (TINs) across multiple health system departments and locations. These practices result in incomplete data on facility fee billing practices and reimbursement, thus constraining states' ability to identify and enforce appropriate policy changes.

State Regulation of Facility Fees

Each of the states in this study have enacted laws regulating outpatient facility fees, ranging from outright prohibitions on fees for certain services or settings, to consumer out-of-pocket cost protections and disclosure requirements, to hospital reporting and provider transparency requirements. Some states have adopted different types of strategies at once. **Table 1** provides a broad overview of these state laws.

Our interviews also highlighted that some state agencies may be able to leverage their existing authority to address facility fees even without new legislation. For example, interviewees reported that state authorities may be able to demand information on facility fee charges and billing practices from health care providers and insurers as part of consumer protection investigations or require hospitals and health systems to agree not to charge facility fees to consumers as a condition of approving a merger or other transaction. On the other hand, interviewees acknowledged that state efforts, with or without legislation, can be hampered by factors such as limited enforcement capacity, regulatory capture, and poorly specified reporting requirements.

Looking Ahead to Further Action

Consumer advocates, payers, and regulators emphasized that the hospital industry is a powerful political and economic player at the state level, with the ability to water-down or completely scuttle efforts to rein-in facility fee billing practices or establish new reporting and transparency requirements for these charges. Nevertheless, many interviewees expressed their belief that changing dynamics at the state level, including greater engagement by business coalitions, new state agencies focused on health care costs and affordability, and bipartisan interest in facility fees, may create new momentum for significant reform.

In pushing forward, interviewees cautioned that advocates should be realistic about the effects reforms are likely to have. Because of hospitals' ability to leverage their market power in negotiations with commercial payers, interviewees were uncertain whether policy changes, even outright bans on facility fees, would ultimately realize meaningful savings in the commercial sector absent other constraints on provider reimbursement. At the same time, many interviewees emphasized that consumers may benefit significantly from limitations on outpatient facility fee billing due to their current out-of-pocket cost exposure to these charges.

CONCLUSION

The growth of outpatient facility fees — and consumers' financial exposure to these charges — derives from the intersection of the United States' increasingly consolidated health care provider market, highly complex health care billing systems, and frequently inadequate health insurance coverage. Addressing these issues is no small challenge, but it is a challenge more and more state policymakers and stakeholders appear ready to tackle.

A companion brief on this issue is available here.

Table 1. Outpatient Facility Fee Requirements in 11 Study States

	Regulatory Reform				
STUDY STATE	**1. Prohibition on Facility Fees** State prohibits providers from charging facility fees for specified procedures and/or care settings	**2. Out-of-Pocket Cost Protections** State limits consumers' financial exposure to outpatient facility fees in specified circumstances	**3. Consumer Disclosure Requirements** State requires specified providers and/or insurers to disclose that outpatient facility fees may be charged and/or the expected amount of outpatient facility fee charges or cost-sharing obligations, as applicable	**4. Hospital Reporting Requirements** State requires that hospitals make annual or one-time disclosures to the state on outpatient facility fee-related data	**5. Provider Transparency Requirements** State requires that health care providers register with national or state databases to better monitor where care is provided and/or who is providing care
COLORADO		No balance billing for facility fees for preventive services*	Hospitals and hospital-owned facilities,* freestanding emergency departments (EDs)	One-time study	Unique national provider identifier for off-campus locations
CONNECTICUT	Evaluation and management services on-* and off-campus, telehealth	No separate copayment on off-campus outpatient facility fees	Hospitals and hospital-owned facilities, insurers	Annual reporting	
FLORIDA			Hospitals and hospital-owned facilities, freestanding EDs		
INDIANA	Off-campus office settings owned by non-profit hospitals*			Annual reporting	
MAINE**	On- and off-campus office settings				
MARYLAND	Telehealth, COVID-19 testing and monoclonal antibodies		Hospitals and hospital-owned facilities	Annual reporting	
MASSACHUSETTS			Hospitals and hospital-owned facilities, insurers		Provider registry on ownership and affiliation
NEW YORK	Preventive services		Hospitals and hospital-owned facilities		
OHIO	Telehealth				
TEXAS	Drive-thru services at freestanding EDs		Freestanding EDs, insurers		
WASHINGTON	Telehealth (audio-only)		Hospitals and hospital-owned facilities	Annual reporting	

* Legislation has been enacted but requirement has not yet gone into effect. ** Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. It also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

Glossary

KEY TERMS AND CONCEPTS

Ambulatory or Outpatient Care	Health care services provided without admission to a hospital or when the patient is expected to stay less than 24 hours (even if overnight).
Facility Fee	Charges institutional health care providers bill that are ostensibly for facility operational expenses. These charges are distinct from a professional fee.
Professional Fee	Charges health care professionals, including physicians, nurse practitioners, physician assistants, and physical therapists, bill for their services. These charges typically account for the professional's practice overhead, including costs for rent, equipment and supplies, and clinical and administrative support staff, in addition to the professional's time and malpractice expenses.
Site Neutral	Paying the same amount for the same item or service, regardless of the location or type of setting where care is provided.
Horizontal Consolidation	When one type of entity in the supply chain purchases another entity at the same level, such as one hospital merging with another hospital; acquisition may result in some degree of clinical integration.
Vertical Integration	When one type of entity in the supply chain purchases another kind of entity, such as hospitals acquiring physician practices; acquisition may result in some degree of clinical integration.

FREQUENTLY ENCOUNTERED PRACTICE TYPES

Ambulatory Surgical/ Surgery Center (ASC)	A stand-alone health care facility that provides outpatient surgical services to patients that do not require hospitalization and for whom care is not expected to exceed 24 hours; may be owned by a hospital or health system or operated independently from a hospital.
Freestanding Emergency Department (EDs)	A stand-alone health care facility that provides emergency care; may be owned by a hospital or health system but is structurally distinct from a hospital.
Hospital-Based Facility or Setting	A health care setting that is owned or operated, in whole or part, by a hospital or health system.
Hospital Outpatient Department (HOPD)	An outpatient department of a hospital, including outpatient surgery centers, that fall under the same financial and administrative contracts as the hospital; for Medicare purposes, an HOPD must be located within 35 miles of a hospital's main campus.
Health Care Professional	Physicians, nurse practitioners, physician assistants, physical therapists, and other individually licensed or certified health care providers, whether employed or self-employer; may be referred to as individual or independent providers.

Institutional Provider	Inpatient hospitals, outpatient departments and clinics, emergency departments, and other facilities; may be referred to as organizational providers.
Off-Campus	When a facility's location is physically separate from a main hospital campus. Medicare and some state laws specify that there must be more than 250 yards between the main campus and an off-campus facility.
Provider-Based Status	A regulatory status under Medicare allowing a facility or organization to bill as a hospital.

BILLING TERMINOLOGY

UB-04 (aka CMS/HCFA 1450)	A federally maintained claims form used for billing purposes by institutional providers, often referred to as the institutional provider form. The same information is conveyed via the HIPAA X12 837I electronic claims transaction.
CMS 1500 (aka HCFA 1500)	A federally maintained claims form used for billing purposes by health professionals, often referred to as the individual provider form. The same information is conveyed via the HIPAA X12 837P electronic claims transaction.
Evaluation & Management (E&M) Codes	A subset of billing codes used to identify non-procedural health care services where health care practitioners diagnose and treat illnesses, injuries, and other conditions.
National Provider Identifier (NPI)	A federally assigned unique identification number for health care providers to use for administrative and financial transactions.
Place of Service (POS)	A code that indicates the type of setting where care was provided (e.g., an individual office, ASC, on- or off-campus HOPD, or inpatient hospital); used on the CMS 1500 form.

Introduction

News stories abound with reports of consumers facing unexpected "facility fee" costing hundreds or thousands of dollars for a simple office visit or other outpatient service at a practice affiliated with a hospital or health system.[1] Often in these stories, the consumer returned for routine care to a provider with whom they had a pre-existing relationship but suddenly faced this extra charge because the provider was acquired by a hospital or saw the consumer at a new hospital-affiliated location.

Outpatient facility fees also are garnering increasing attention in the context of ongoing state and federal efforts to contain health care costs. Public and private insurance have historically paid more for the same care delivered in hospital facilities than in independent physician offices or ambulatory surgical centers, creating incentives for hospitals to build and purchase outpatient practices. In response, federal lawmakers and regulators have begun reducing Medicare payments for certain services provided in a hospital outpatient department to match how much Medicare pays for the same care provided by an independent physician practice, thus moving that system toward "site neutrality." Bipartisan policymakers and stakeholders at both the state and federal levels are exploring the extension of these types of reforms to the commercial sector, where prices are significantly higher and vary based on the relative market power of payers and providers.

Through an analysis of current laws and regulations in 11 study states **(Colorado, Connecticut, Florida, Indiana, Maine, Maryland, Massachusetts, New York, Ohio, Texas,** and **Washington)** and more than 40 qualitative interviews conducted between November 2022 and April 2023, this report sheds much-needed light on outpatient facility fee billing in the commercial sector and potential policy responses. We highlight how these fees affect consumers and the health care system more broadly, gaps in existing knowledge about facility fee billing, and how public and private actors are responding to these issues. We also share insights into the political challenges involved in regulating outpatient facility fees and trends that are helping reform efforts gain traction.

For more information about how we conducted this study, see **Appendix 1**.

Background

Facility fees are the charges institutional health care providers, such as inpatient hospitals, hospital outpatient departments, and emergency departments, bill ostensibly to cover their operational expenses for providing health care services. Health care professionals, including physicians, nurse practitioners, physician assistants, and physical therapists, bill separately for their services. These professional fees often account for practice overhead, including costs for rent, equipment and supplies, and clinical and administrative support staff, in addition to the professional's time and malpractice expenses. Institutions submit facility fee charges to the patient's health insurer on the UB-04 (a.k.a., CMS/HCFA 1450) form, or the electronic equivalent thereof, while health care professionals submit their bills on the CMS/HCFA 1500 form. When a health care professional provides services in a hospital-based setting, including an outpatient department, both the hospital and health care professional will typically submit bills.

The practice of separately billing hospital and professional fees is an artifact of Medicare reimbursement practices. Medicare regulates total provider reimbursement for covered services by establishing payment methodologies for both fee types. When a health care professional provides care in a hospital-based setting, Medicare reduces its payment for overhead costs to the professional and also reimburses the hospital directly for its costs.[2] Traditionally, the total payment Medicare makes has been higher when care is provided at a hospital-based setting than a health care professional's office because Medicare's overhead payments to the hospital are higher than the overhead components of Medicare physician payments. Medicare similarly pays hospital outpatient departments more than independently licensed ambulatory surgical centers. Through both congressional and administrative action, Medicare has started to rein in these reimbursement discrepancies for evaluation and management (E&M) services (or "clinic visits") when provided at off-campus hospital outpatient departments. Paying the same rate for the same service regardless of the location of care (or "site of service") — outpatient department, medical office, or ambulatory surgical center — is commonly referred to as "site neutrality."

The situation in commercial insurance is different. Although commercial payers also use the separate billing forms for professional fees (CMS 1500 form) and hospital fees (UB-04 form), commercial prices do not typically follow a regulatorily determined fee schedule. Payers and providers establish commercial prices through negotiation, and these negotiated rates significantly depend on the relative market power of both parties. In recent years, as both insurance markets and the hospital sector have undergone significant changes, commercial payments to facilities for outpatient services have grown considerably. For example, per-person commercial payments to facilities for outpatient visits and procedures grew by 31.4 percent from 2015 to 2019, outpacing the growth in other service categories of professional services, prescription drugs, and inpatient care; after a steep pandemic-related decline, outpatient facility payments again grew faster than other categories in 2021.[3]

One important factor driving this increase in commercial spending on outpatient services is the vertical integration of delivery systems, which happens when hospitals establish or acquire physician practices and other outpatient providers. Between July 2012 and January 2018, hospital ownership of physician practices grew by 124 percent nationally while the number of hospital-employed physicians grew by 78 percent.[4] In 2021, hospitals or corporations employed 74 percent of all physicians in the United States.[5]

When hospitals acquire physician practices, the ambulatory services once provided by an independent practice often become, for billing purposes, outpatient services delivered in an off-campus hospital outpatient department.[6] The health care professionals still bill health insurers for their services on the CMS 1500 form, but the hospital can now bill for these services too, by charging facility fees on

the UB-04 form. Numerous studies have found site-based differences in commercial payments for ambulatory services, with allowed amounts for services delivered in hospital outpatient departments exceeding payments for services delivered in physician offices across a range of services and procedures.[7] Several studies have identified facility fees as an important factor in this differential.[8] Other studies have pinpointed vertical integration as a key factor in the growth of outpatient prices,[9] and researchers examining post-integration changes in prices estimate that facility fees represented 45 percent or more of price increases.[10] (In contrast, a competing study did not find an association between integration and increased billing of facility fees.)[11]

One result of these changes in delivery system ownership and prices is increased costs for patients, specifically greater out-of-pocket costs and higher premiums. One study found that patient cost-sharing increased 200 percent for elective procedures performed in hospital outpatient departments compared to procedures performed in physician offices.[12] An examination of Covered California, the state's health insurance marketplace, found that vertical integration in concentrated California markets — and the resulting shift to outpatient service delivery — was associated with a 12 percent increase in marketplace premiums.[13] Commercial payers similarly face higher prices for outpatient services as a result of vertical integration, with estimates ranging from a 14.1 percent increase for all services provided by acquired physician practices,[14] to a 5 percent increase in outpatient primary care prices.[15]

Motivations for Action: Widespread Frustration with Outpatient Facility Fees

OUTPATIENT FACILITY FEES INCREASE PATIENT COST-SHARING AND SYSTEM-WIDE SPENDING

In interviews, consumer advocates, regulators, industry stakeholders, and academics brought their specific perspectives to the question of whether and how outpatient facility fees pose problems for cost control and health care affordability. Frequently, they raised concerns about consumers' exposure to higher out-of-pocket costs and the overall growth of health care spending. Many interviewees further noted that consumers can be confused, angry, or surprised when they must pay a facility fee — particularly when a long-standing provider has become affiliated with a hospital system and begins charging facility fees for the first time. Consumers can also be surprised by facility fee charges for office visits or other services when they do not equate an office visit or telehealth appointment with visiting a hospital facility.[16]

> Consumers could face both a co-payment and a substantial and often unexpected hospital obligation for an outpatient visit.

One commonly held observation across interviewees was that the growing use of high deductibles, combined with the greater prevalence of facility fees, has increased financial risk for consumers. As one state official noted, although "these fees have been allowed for quite some time, … it was really [high-deductible health plans] becoming the norm that made [facility fees] more acute for the consumers." Some experts also noted that consumers can experience heightened financial vulnerability to post-deductible cost-sharing when hospitals charge facility fees on top of the practitioner's professional fees, because consumers could be responsible for separate cost-sharing obligations on each bill. (For a plan design example, see Figure 1.) For example, depending on their insurance plan's design, patients could face a copayment for the professional visit and coinsurance for the hospital's charges. And while insurance designs

commonly apply only copayments to physician care before the enrollee satisfies their deductible, patients often must first meet their deductible and then pay applicable co-insurance for hospital charges. As a result, consumers could face both a co-payment and a substantial and often unexpected hospital obligation for an outpatient visit.

Benefit designs may also include higher consumer cost-sharing for outpatient surgeries performed in a hospital than an independent facility. While insurers may intend to encourage consumers to seek care from lower-cost facilities, consumers living in consolidated health care markets may have limited or no independent facilities to choose. Similarly, consumers may want to preserve relationships with their current providers at higher-cost facilities. For example, one regulator recounted complaints from consumers about how some insurers in their state are pushing cancer patients to transition, mid-treatment, from hospital outpatient departments to less-expensive stand-alone chemotherapy centers to control costs.

Figure 1. Summary of Benefits and Coverage for ConnectiCare Passage SOLO HMO Copay/Coinsurance $7,500 Deductible Bronze Insurance Plan

COMMON MEDICAL EVENT	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
IF YOU HAVE OUTPATIENT SURGERY	**Facility fee (e.g., ambulatory surgery center)**	$500 copayment/visit after plan deductible at an ambulatory facility 50% coinsurance after plan deductible at an outpatient hospital facility	Not covered	Preauthorization is required
	Physician/ surgeon fees	No charge after plan deductible at an ambulatory facility 50% coinsurance after plan deductible at an outpatient hospital facility	Not covered	None

ConnectiCare

Source: Figure adapted from https://www.connecticare.com/resources/solo-plans#2023-passage-solo-hmo-copay/coins.-$7,500-ded.-bronze.

Consumer advocates and payers also observed that out-of-network facilities could bill consumers the balance of any facility fee charge not covered by their insurer, thus creating significant financial exposure for these consumers given that facility fee charges are often much greater than the provider's fee. This may happen, for example, if a patient's established provider schedules their care at an out-of-network facility. Depending on the state, some consumer advocates and state regulators also reported that some health insurance plans might refuse to cover facility fees for outpatient care, thus leaving consumers fully responsible for these fees even for in-network care. "When the health plans do their benefit design, [and they have] a $40 copay for a doctor's visit, the patient gets billed for their $40 copay plus the facility fee," one regulator shared. "So, you thought your cost-sharing was going to be $40, and all of a sudden it's $150 … we don't have the authority to tell the plans they can't bake that into their benefit design."

> We are very worried about the prices that facility fees impose on the consumer, the carrier, and ultimately the premium."
>
> **— STATE HEALTH INSURANCE REGULATOR**

Regulators, other stakeholders, and academics also raised concerns about facility fees' impact on overall health spending. These interviewees generally perceived a large role for facility fees in overall spending, in part because they allow hospitals to seek reimbursement for their general overhead costs from a wider selection of services, ranging from E&M services to outpatient surgical procedures, and in part because of the significant growth in both facility fee prices and volume. One regulator stated, "There's no doubt that when you look at what is driving the price, it's not the physician fees, it's the facility fees." Another expressed concerns about the broad impact facility fees may have across the health care ecosystem, noting, "We are very worried about the prices that facility fees impose on the consumer, the carrier, and ultimately the premium." Nonetheless, for reasons we explain further below, it can be challenging to quantify how different proposals to regulate outpatient facility fees will affect health care spending and several interviewees anticipated systems-level savings may be difficult to capture in the commercial sector.[17]

OUTPATIENT FACILITY FEES PERCEIVED AS KEY WAY HOSPITALS MAXIMIZE REVENUE

A range of interviewees shared their conviction that hospitals often use facility fees to maximize revenue from commercial payers, believing that facility fee charges are more closely related to hospitals' market power than to legitimate overhead expenses. Consistent with this perception, one hospital executive expressed envy over the millions of dollars in facility fees charged by a competing hospital with more market power, noting, "I wish we could do that." Interviewees also suggested that as hospitals' market power has grown with both horizontal consolidation and vertical integration, they have positioned facility fees as a major revenue source. "When we would negotiate," said one payer, "we would say we weren't paying for revenue code 510, [which is] a facility fee for using the space … but they brought it back when they consolidated." "People like to blame insurance companies," this payer continued, "but when you peel back the onion, you see that hospitals control the negotiation table … Historically those fees were $50–$75 and over time they have become much more significant." Some interviewees were highly critical of hospitals' (perceived) use of facility fees as a revenue driver, with one consumer advocate characterizing them as "resort fees," or "scam billing," and another opining that hospitals target facility fees to "captive" services with vulnerable patients, such as oncology.

Hospital executives, in contrast, identified a variety of costs that payers do not otherwise reimburse, including costs related to regulatory compliance; round-the-clock staffing, nursing, and other personnel costs; liability coverage; security; and supplies. One hospital executive also maintained that hospitals make up losses from Medicare and Medicaid by charging facility fees to commercial payers. Yet several other interviewees questioned whether overhead costs that support more intensive inpatient and emergency services should be allocated to off-campus settings or office-based services. One payer advocate pointedly noted that outpatient settings "miles away" from a hospital campus, and routine preventive services delivered in on-campus physician offices, do not require the support of on-call surgical suites or helicopter pads. In our interviews and in public statements, hospital advocates also highlighted the financial vulnerability of safety net, critical access, and rural hospitals, suggesting that facility fees are necessary for their survival. Other stakeholders acknowledged the real concerns of some hospitals, as well as the need to cover legitimate overhead, but emphasized that many of the hospitals maximizing facility fee revenue are in robust financial health, pointing to hospital bond ratings and reserve levels as evidence of their well-being.

CLAIMS DATA ARE UNRELIABLE SOURCE FOR TRACKING SCOPE AND IMPACT OF OUTPATIENT FACILITY FEES

Claims provide a wealth of insight into health care trends, but payers, researchers, and policymakers seeking to monitor and respond to trends in outpatient facility fees face significant barriers to obtaining complete and accurate information from claims data. When patients receive services in a hospital-based setting, their claims typically include both a hospital bill and a professional bill for a single patient visit, each on the applicable claim form. But interviews revealed that limitations in the forms, as well as in how hospitals and professionals complete the forms, often obscure who is providing care where. This, in turn, undermines payers' ability to make reimbursement decisions that take such information into account and researchers and policymakers' ability to understand the precise scope and nature of facility fee billing and the effects of vertical integration.

From interviews, one of the biggest hurdles is "knowing exactly where care took place." Claim forms ask for the provider address, but interviewees reported that providers do not complete this in a uniform manner. Hospital claims for outpatient care might list the address of the health system's main campus or the location of their billing department (which could be offsite, even in an entirely different state), rather than the address of the physical office location where the care was provided. Even when the bill includes the physical address of the care location, payer and public claims databases may be poorly equipped to accurately differentiate separate floors or suites of the same building, though some are operated as hospital-based settings while others remain independent practices for billing purposes.[18] Both hospital and professional claims also must include a National Provider Identifier (NPI) and Tax Identification Number (TIN), but the NPI and TIN need not be specific to the location of care: multiple departments and locations owned or operated by a hospital or health system may submit claims bearing the broader organization's NPI and TIN. As a result of these issues, one regulator related that, when looking at claims, "too often it looked like everyone was getting all of their care through the flagship hospital." A state employee health plan representative similarly reported: "The brick and mortar location, that's just not there."

Interviewees also described how professional claims do not clarify these issues. Health care professionals may practice out of several different locations, which may be owned by different hospitals or health systems or be independent. Thus, the professional's NPI is not correlated with the location of care. The addresses listed on professional claims also appear to be unreliable. One researcher described preparing a list of physical addresses of certain facilities in their state and

searching for these addresses in a claims data set: "I couldn't find any of them." They had claims for care provided at these facilities, "but the rendering provider was in another state," and the address listed would be "an office building."

Professional claim forms have the benefit of including a "Place of Service" (or "POS") field that can indicate the type of setting in which the practitioner provided care — such as whether it is an on- or off-campus hospital outpatient department, a physician's office, or an ambulatory surgery center. If filled out consistently, this can allow payers and researchers to identify professional claims for services provided in an institutional setting. But this same field is not included on institutional claim forms; instead, these forms rely on a much more complex system that combines data from two separate fields to convey this type of information. Interviewees indicated that deciphering this information can be a significant challenge, even for experts who regularly work with claims data. Additionally, interviewees suggested that it can be difficult to reliably associate a professional claim and institutional claim for the same service. As a result, Place of Service codes cannot be imputed from the associated professional claim to clarify the setting of care for an institutional claim. This also means payers and researchers may not be readily able to identify all claims associated with a single service.

> Too often, it looked like everyone was getting all of their care through the flagship hospital."
>
> — STATE REGULATOR

Taken together, these data issues limit the ability of payers, researchers, and policymakers to understand the full scope and impact of facility fee billing. For example, as we discuss more below, a state may seek to limit facility fee payments when care is provided in certain off-campus locations, but only the hospitals may have a reliable sense of how many services or visits this will affect. Enforcement also may prove challenging due to this lack of transparency.

Action on Outpatient Facility Fees in the Eleven Study States

Each of the study states have enacted laws regulating outpatient facility fees, although the focus and scope of these laws varies dramatically. (See **Table 1**.) We categorize states' policy approaches into five general categories: (1) prohibitions on facility fees; (2) out-of-pocket cost protections; (3) consumer disclosure requirements; (4) hospital reporting requirements; and (5) provider transparency requirements. Within each of these categories, we further break down the range of state actions taken to date and insights from interviewees regarding the perceived impacts of these approaches. We also describe alternatives strategies that may achieve similar ends as the different types of legislation, depending on existing state authorities.

Table 1. Outpatient Facility Fee Requirements in 11 Study States

	Regulatory Reform				
STUDY STATE	**1. Prohibition on Facility Fees** State prohibits providers from charging facility fees for specified procedures and/or care settings	**2. Out-of-Pocket Cost Protections** State limits consumers' financial exposure to outpatient facility fees in specified circumstances	**3. Consumer Disclosure Requirements** State requires specified providers and/or insurers to disclose that outpatient facility fees may be charged and/or the expected amount of outpatient facility fee charges or cost-sharing obligations, as applicable	**4. Hospital Reporting Requirements** State requires that hospitals make annual or one-time disclosures to the state on outpatient facility fee-related data	**5. Provider Transparency Requirements** State requires that health care providers register with national or state databases to better monitor where care is provided and/or who is providing care
COLORADO		No balance billing for facility fees for preventive services*	Hospitals and hospital-owned facilities,* freestanding emergency departments (EDs)	One-time study	Unique national provider identifier for off-campus locations
CONNECTICUT	Evaluation and management services on-* and off-campus, telehealth	No separate copayment on off-campus outpatient facility fees	Hospitals and hospital-owned facilities, insurers	Annual reporting	
FLORIDA			Hospitals and hospital-owned facilities, freestanding EDs		
INDIANA	Off-campus office settings owned by non-profit hospitals*			Annual reporting	
MAINE**	On- and off-campus office settings				
MARYLAND	Telehealth, COVID-19 testing and monoclonal antibodies		Hospitals and hospital-owned facilities	Annual reporting	
MASSACHUSETTS			Hospitals and hospital-owned facilities, insurers		Provider registry on ownership and affiliation
NEW YORK	Preventive services		Hospitals and hospital-owned facilities		
OHIO	Telehealth				
TEXAS	Drive-thru services at freestanding EDs		Freestanding EDs, insurers		
WASHINGTON	Telehealth (audio-only)		Hospitals and hospital-owned facilities	Annual reporting	

* Legislation has been enacted but requirement has not yet gone into effect. ** Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. It also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

1. PROHIBITIONS ON OUTPATIENT FACILITY FEES

Multiple study states have limited the imposition of outpatient facility fees in certain circumstances. (See **Table 2**.) How far a facility fee prohibition should extend is both a technical and political challenge for states. As one interviewee put it, "a lot of it is about what seems to be fair." To many interviewees, there is no reason to pay more for care that can be safely and effectively provided in a non-hospital setting. This is consistent with an approach advocated by the Medicare Payment Advisory Committee (MedPAC), which has identified several dozen services that fit this definition for purposes of advancing site-neutral payments in Medicare.[19] In contrast, as discussed above, hospital executives and industry representatives maintain that their facilities face additional costs compared to independent practices that justify higher payments. So far, for the political reasons discussed in greater detail in this report's final section, even the broadest of state laws currently reach only a relatively narrow swathe of services.

Connecticut is widely viewed as having the furthest reaching facility fee prohibition nationwide.[20] It currently bars hospital-owned or -operated facilities that are located off-site from a hospital's main campus from charging facility fees for outpatient E&M or assessment and management (A&M) services. (This prohibition does not apply to freestanding emergency departments.)[21] Beginning July 1, 2024, this prohibition will extend to on-campus facilities, excluding emergency departments and certain observation stays.[22] Connecticut also prohibits facility fee charges for any telehealth services.[23] According to interviewees, the present form of the law was a "political compromise," as state officials and legislators sought a broader prohibition that would reach all off-campus outpatient services as well as certain on-campus outpatient diagnostic and imaging services as identified by the Office of Health Strategy. The new extension to on-campus facilities represents a meaningful expansion of the law's scope. The legislature also gave the state authority to impose civil monetary penalties for violations of the law.

Maine has also had limitations on facility fees in place since 2005. Maine's law specifies that all services provided by a health care practitioner in an office setting must be billed on the individual provider form (i.e., the CMS 1500 form). It defines office setting to mean "a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility."[24] Contemporaneous records suggest that the goal of this law was to eliminate differentials in payment based on the location of service.[25] Yet multiple stakeholders in Maine contacted for purposes of this report, including government officials, were not familiar with the law. One provider affirmed that the law prohibits them from charging facility fees for certain services, whether provided at on- or off-campus locations. They have interpreted the scope of services narrowly, however, to include E&M services but not more complex procedures or services where a physician is not directly involved at the point of care, like infusion therapy to treat cancer and other illnesses.

Other study states' prohibitions are narrower than either Connecticut or Maine's laws. **Indiana's** recently enacted facility fee law is structured similarly to Maine's law, but its application is limited to off-campus facilities owned by nonprofit hospitals. Whether authorities will interpret it to reach beyond E&M services remains to be determined, although the law expressly exempts oncology centers, among other specific types of facilities.[26] **New York** prohibits health care providers from billing facility fees for preventive care services as defined by the U.S. Preventive Services Task Force.[27] Other study states, including **Maryland,**[28, 29] **Ohio,**[30] **Texas**,[31] and **Washington,**[32] prohibit facility fees for certain telehealth, drive-thru, and/or COVID-19 related services. **Massachusetts** temporarily prohibited facility fees for telehealth services during the COVID-19 state of emergency.[33]

Table 2. Current Prohibitions on Outpatient Facility Fee Billing in Study States

STATE	Prohibition on Facility Fees
CONNECTICUT	Off-campus and hospital-based facilities cannot charge facility fees for outpatient services that use a CPT Evaluation and Management or Assessment and Management code, excluding emergency department services and certain observation stays. Prohibition will extend to on-campus hospital-based facilities beginning July 1, 2024.[1] Health care providers and hospitals prohibited from charging facility fees for all telehealth services.[2]
INDIANA	Effective July 1, 2025, health care providers owned in whole or part by an Indiana nonprofit hospital system may not bill facility fees for care provided in an office-based setting.[3]
MAINE	Health care practitioners cannot bill facility fees for services provided in an office setting, i.e., a location where a health care practitioner routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis, whether or not physically located within a facility.[4]
MARYLAND	Health care providers may not charge facility fees for telehealth services unless they are not authorized to bill a professional fee separately for the service.[5] Hospitals may not charge facility fees for administering COVID-19 vaccines and monoclonal antibody infusions and injections.[6]
NEW YORK	Hospitals, health systems, and other health care providers cannot bill a facility fee for preventive care services as defined by the United States Preventive Services Task Force.[7]
OHIO	Health care professionals cannot charge a facility fee for telehealth services.[8]
TEXAS	Freestanding EDs cannot charge a facility fee for drive-thru services, including testing and vaccinations.[9]
WASHINGTON	Distant sites and hospitals that are the originating site for audio-only telemedicine services may not charge facility fees.[10]

1 Conn. Gen. Stat. § 19a-508c; Conn. H.B. 6669 (2023).

2 Conn. Gen. Stat. § 19a-906.

3 Ind. Code Ann. § 16-51 (eff. July 1, 2025).

4 24-A Maine Rev. Stat. §§ 1912, 2753, 2823-B, 4235.

5 Md. Ins. Code § 15-139.

6 E.g., Urgent Memorandum from Dennis N. Phelps, Deputy Director-Audit & Compliance, Maryland Health Services Cost Review Commission, to Chief Financial Officers. All Hospitals Regarding Reporting and Charging for the Administration of COVID-19 Vaccines and Monoclonal Antibody Therapies. (2020, Dec. 14). Retrieved May 14, 2023, from https://hscrc.maryland.gov/Documents/COVID-19/COVIDVACCINESMEMOZZZ-1.pdf. This prohibition will expire on January 1st of the year following the year in which the Emergency Use Authorizations for the applicable tests, drugs, and biologicals ends. Urgent Memorandum from Dennis N. Phelps, Deputy Director-Audit & Compliance, Maryland Health Services Cost Review Commission, to Chief Financial Officers – All Hospitals, Regarding Continued Suspension of Telehealth Regulations– COMAR 10.37.10.07-1 and Other COVID-19 Related Temporary Approvals. (2023, Apr. 27). Retrieved June 27, 2023, from https://hscrc.maryland.gov/Documents/pdr/PolicyClarification/2021/2023.04.27%20_%20Continued%20Suspension%20of%20Telehealth%20Regulations.pdf.

7 N.Y. Pub. Health Law § 2830.

8 Ohio Rev. Code § 3727.49.

9 Tex. Health & Safety Code §§ 241.222; 254.1555.

10 Rev. Code Wash. § 48.43.735.

Depending on the scope of existing authorities, state officials need not necessarily wait for legislation to curtail some outpatient facility fee billing. State agencies overseeing provider transactions, such as mergers and acquisitions or certificate of need applications, may be able to force facilities to agree not to charge facility fees as a formal or informal condition of approval. Connecticut's Office of Health Strategy, for example, typically demands such concessions as a contingency of approving certificate of need applications when hospitals or health systems are acquiring or building new practices.[34]

Interviewees generally believe that prohibiting facility fee charges can reduce consumer confusion and financial exposure. At the same time, many doubted that bans on facility fees alone would drive meaningful cost containment, assuming hospitals would make up lost revenue through other charges. Indeed, to the extent state employee health plans and commercial payers reported eliminating facility fees in interviews, they explained that it was done in a budget neutral fashion with the goal of improving the "consumer experience" from a cost-sharing perspective. In this vein, many interviewees indicated the out-of-pocket cost savings to consumers justifies eliminating facility fees even if this reform does not lead to substantial systemic cost savings. As one interviewee observed, facility fees can be "significant life-changing amounts, especially to some people with limited financial needs to resources."

2. OUT-OF-POCKET COST PROTECTIONS

Two study states have adopted relatively narrow restrictions that limit consumers' exposure to out-of-pocket costs while continuing to allow hospitals to charge facility fees in at least some circumstances. **Connecticut's** laws go the farthest. The state prohibits insurers from imposing a

Public/Private Payer Action in Massachusetts

Massachusetts does not have a statutory prohibition on facility fees, but multiple payers have negotiated the elimination of certain outpatient facility fees in their contracts with health care providers. This includes the state employee health plan and at least one major commercial payer in the state, and interviewees believed other commercial payers there have followed suit.

The Massachusetts state employee health plan restricted facility fees under the leadership of a former state official who sought to protect plan members from double-billing. At her direction, the state began including language in their solicitations for third-party administrator service providers stating: "The [Group Insurance Commission] strongly prefers NOT to pay facility charges for ambulatory and outpatient E&M visits that result in total reimbursement to the facility and physician combined in excess of the reimbursement payable to the physician in an independent office setting for which no facility fee is charged. Please confirm your ability to not reimburse providers for these charges."

A Massachusetts commercial payer restricted outpatient facility fees after local newspapers, the Massachusetts Attorney General's Office, and the Health Policy Commission highlighted concerns about their effects on consumers. Emphasizing that regulators and the general public were unhappy and legislative action was on the horizon, the payer was able to negotiate the elimination of outpatient facility fee charges from most of their provider contracts. Plan executives acknowledged that they were able to make this change in part because "plan-provider relations" in Massachusetts tend to be relatively collaborative. Interviewees in other study states indicated similar outcomes may be hard to achieve in their markets.

separate copayment on facility fees for outpatient services provided at an off-campus location, for services and procedures for which these fees are still allowed, and bars providers from collecting a greater facility fee than the insurer has agreed to pay if a consumer has not met their deductible.[35] Connecticut also makes it an unfair trade practice for a health care provider to request payment from an enrollee for a facility fee beyond the patient's cost-sharing obligations under their health plan or to report a consumer's failure to pay a facility fee bill to a credit reporting agency when a health insurer has "primary responsibility" for payment.[36]

More narrowly, beginning July 1, 2024, **Colorado** will prohibit health care providers from balance billing consumers any amount beyond what is covered by the consumer's health insurance for any facility fee charges for preventive services provided in an outpatient setting.[37]

We also sought to explore the extent to which state essential health benefit package rules or benefit mandates require state-regulated health plans to cover facility fees when the underlying service is covered, which could limit in-network providers' ability to balance bill consumers for facility fee charges. Our findings were largely inconclusive, however. Multiple state insurance regulators indicated they had not previously considered this issue; on first blush, some tentatively thought coverage would be required while others did not. Some interviewees also observed that mandates for insurers to cover facility fees could create adverse incentives, encouraging providers to increase the amount and frequency of facility fee charges. In at least one instance, a state interpreting an existing benefit mandate found the mandate did not require insurers to cover all facility fees, thereby potentially exposing consumers to a full facility fee charge without the benefit of insurance. In this case, New York's Department of Financial Services issued guidance in 2008 that the state's post-mastectomy breast reconstruction surgery mandate does not require insurers to pay facility fees for surgeries when performed in physician offices.[38]

3. NOTIFYING CONSUMERS ABOUT OUTPATIENT FACILITY FEE CHARGES

Nine study states have codified some form of a facility fee disclosure requirement to alert consumers that they may face greater financial liability from seeking care in hospital-based settings. Like facility fee laws more generally, the scope and specificity of these rules vary significantly across the states. (See **Table 3**.)

Some state laws require only that facility fees be enumerated among other price or cost information listed online,[39] or that certain types of facilities display signs warning facility fees may be charged.[40] Others require facilities to provide written notice to patients upon or shortly after scheduling care. For example, **Maryland** requires that if a hospital charges an outpatient facility fee, they must provide the patient with a written notice disclosing a variety of information including the amount or estimated range of the facility fee, if their provider can be seen at another location that does not charge a fee, and how to file a complaint about an outpatient facility fee. Hospitals may not charge a facility fee if patients are not given this notice.[41] **New York** enacted similar requirements effective this year.[42]

Other study states, like **Massachusetts** and **Washington,** combine multiple approaches, including both signs and written disclosures.[43] **Connecticut** again has the most comprehensive approach: various disclosures must be made upon scheduling care, in writing prior to care, via signs at the point of care, and in billing statements after care is provided.[44] Hospitals also must warn existing patients when they acquire a new practice about how they may be charged new facility fees.[45] The state additionally requires that health insurers maintain a website and toll-free telephone number

Table 3. Consumer Disclosure Requirements in Study States

STATE	Requirement
COLORADO	Effective July 1, 2024, health care providers affiliated with or owned by a hospital or health system that charges facility fees must disclose facility fees in multiple formats and circumstances, including before and at the point of care, in signage at the facility, in standardized billing statements, and when a facility is newly affiliated with or owned by a hospital.[1] Freestanding EDs must provide written and online disclosures of facility fee charges.[2]
CONNECTICUT	Hospitals, health systems, and hospital-based facilities must disclose facility fees in multiple formats and circumstances, including before and at the point of care, in signage at the facility, in standardized billing statements, and when a facility is newly affiliated with or owned by a hospital.[3] Insurers must maintain a website and toll-free telephone number enabling consumers to request and obtain cost information, including facility fee estimates.[4]
FLORIDA	Hospitals must disclose information related to facility fees as part of good faith estimates.[5] Hospital-based off-campus EDs must post facility fee-related signage.[6]
INDIANA	Ambulatory surgical centers must post facility fee information online.[7]
MARYLAND	Hospitals must provide written and oral notices when charging a facility fee for outpatient clinic services, supplies, or equipment, excluding ED services.[8]
MASSACHUSETTS	Health care providers must disclose the allowed amount and amount of any facility fees, or estimates thereof, upon request.[9] Insurers must explain any facility fee a consumer may be responsible to pay in its evidence of coverage and maintain a website and toll-free telephone number enabling consumers to request and obtain cost information, including facility fee estimates.[10]
NEW YORK	Hospitals, health systems, and other health care providers must provide advance written notice if a facility fee will be charged.[11]
TEXAS	Freestanding EDs must disclose facility fees in multiple formats and circumstances, including in writing at the point of care, in signage at the facility, and online.[12] Insurers must disclose cost-sharing information related to facility fees upon request.[13]
WASHINGTON	Hospital-owned off-campus clinics and provider offices disclose information regarding facility fees in multiple formats and circumstances, including before care and in signage at the facility.[14]

1 Colo. Rev. State § 6-20-102(3) (eff. July, 1, 2024).
2 Colo. Rev. Stat. § 25-3-119.
3 Conn. Gen. Stat. § 19a-508c.
4 Conn. Gen. Stat. § 38a-477e.
5 Fla. Stat. § 395.301.
6 Fla. Stat. § 395.1041.
7 Ind. Code Ann. §§ 16-21-17-1; 16-21-17-2.
8 Md. Health-Gen. Code § 19-349.2.
9 Mass. Ann. Laws ch. 111, § 228.
10 Mass. Ann. Laws ch. 176O, §§ 6, 23.
11 N.Y. Pub. Health Law § 2830.
12 Tex. Health & Safety Code §§ 241.223, 241.252, 254.155, 254.1556, 254.156.
13 Tex. Ins. Code § 1662.001 et seq.
14 Rev. Code Wash. § 70.01.040.

through which consumers can obtain information on in-network health care costs, including any facility fee for which they would be responsible.[46] **Colorado** recently enacted a similar provider disclosure framework as Connecticut (not including the health insurer provisions),[47] building on previous disclosure requirements that applied only to freestanding emergency departments.[48]

Outside of legislation, state attorney general offices may be able to require disclosures on a case-by-case basis, if they find that the surprising nature of facility fee bills amounts to be a violation of state consumer protection laws, as authorities in Massachusetts have found. Such a determination in one case could have spill-over effects as other providers proactively adopt disclosures to avoid similar charges. Just as state agencies build facility fee restrictions into transactions and other approvals, these agencies also could require, formally or informally, that hospitals and health systems agree to make consumer disclosures to receive approval of a merger, acquisition, or certificate of need application.

Disclosures may reduce consumers' confusion upon receiving a facility fee bill, but interviewees were largely skeptical that this information changes consumer behavior on a meaningful scale. Interviewees generally agreed that consumers are going to seek care where they have established relationships or where their medical team advises them to go, regardless of any warnings that they may incur additional fees for doing so. As one state regulator put it, people "end up going to a place because their doctor has recommended the place to them … [Or] they don't really pay much attention to [the fee] until they get the bill. And even when they get the bill, they … still will not walk away from the provider, because they are used to seeing that provider."

Although one payer described it as "comical" to expect consumers to understand what facility fees are and why they are being charged, a few stakeholders raised the prospect that disclosures and greater transparency around facility fees generally can increase awareness of the issue as a public policy concern. For example, one consumer advocate predicted that facility fee notices are "going to really annoy people" and "build … antipathy around medical billing," which "leads to reforms."

4. HOSPITAL TRANSPARENCY: DISCLOSING HOW MUCH HOSPITALS CHARGE AND RECEIVE IN OUTPATIENT FACILITY FEES

Four study states require hospitals to annually report data related to facility fees to state authorities. **Washington** was the first state to adopt such a requirement in 2012.[49] Hospitals operating off-campus clinics or provider offices that are licensed as part of the hospital and provide diagnostic and therapeutic care must include information about any separate facility fee charges billed at those off-campus locations as part of year-end financial reports to the state Department of Health. Specifically, such hospitals must report the number of facilities that charge separate fees from professionals, the number of patient visits for which a facility fee was charged, the annual revenue from facility fees, and the minimum and maximum fee charge paid by public or private payers at each facility.[50]

Connecticut's law — which has been amended twice since it was first adopted in 2015[51] — is more expansive than Washington's. For off-campus facilities, hospitals must currently report to the state's Office of Health Strategy the actual name and address of each facility charging a facility fee, the number and total amount of allowable facility fees paid at each facility (broken down by payer mix), the total amount of facility fees charged by each facility, and the top ten procedures or services that generated the greatest amount of facility fee gross revenue and for which facility fees were charged

based on patient volume.[52] Beginning later this year, hospitals and health systems must also report information from on-campus facilities, disaggregating on-campus data from off-campus data.[53]

More narrowly, **Maryland** requires each hospital to report to the state Health Services Cost Review Commission a list of outpatient services for which the hospital gets paid a hospital charge (inclusive of any facility fees), which generally are subject to state rating regulations. The commission, in turn, must post this list on its website and share it with the insurance department and attorney general's office.[54] Additionally, starting this year, **Indiana** will require hospitals to annually report to the state Department of Health top-line information about the net patient revenue from and total number of paid claims for outpatient facility fees, broken out by payer. Indiana will simultaneously collect information about hospital revenue and claims for inpatient facility fees and inpatient and outpatient professional fees.[55]

Colorado has taken a slightly different approach to better understand facility fee charges. It recently enacted a law that calls for the one-off public collection and analysis of an array of hospital, provider, and payer data and policies related to facility fees. A steering committee must review this information and issue a report to the legislature on the impact of hospital outpatient facility fees in 2024.[56, 57]

> We don't get any explanation of why they charge what they charge, or who they're charging what they're charging."
>
> — STATE REGULATOR

Interviewees suggested that the value of reporting requirements can turn on the specificity and comprehensiveness of the data, as well as the authority, interest, and capacity of the state agency collecting it. Under the best circumstances, state officials, policymakers, and other stakeholders can leverage publicly collected data to better understand the extent to which hospitals charge and insurers reimburse facility fees, including at different locations, identify policy responses, and build support for reform. One expert commented that Connecticut's law has been good at exposing "what the real problems are, specifically the opacity of facility fees and the lack of a rational basis for what the charges are, and exposing a driver of cost in the health care system." Yet Connecticut's data still had significant limitations that were addressed only in the most recent changes to the state's law, which will go into effect in October 2023. These limitations included that the reporting requirements applied only to off-campus facilities. Additionally, state officials indicated that they wanted greater flexibility over the data that is reported: "It's better not to put the data collection design in the legislation." Despite strong hospital opposition to any attempts to change existing data collection requirements, the latest adjustments to the law's reporting requirements grant additional flexibility to the state to determine what is included on the reporting forms.

Interviewees in Washington expressed frustration with their state's data. As one official commented, "we don't get any explanation of why they charge what they charge, or who they're charging what they're charging." The state Department of Health also is not charged with analyzing the data and it lacks any enforcement authority to demand compliance short of withholding Medicaid dollars, a measure considered too extreme to be used. Our own review of Washington's data further revealed limitations in the information hospitals disclose. For example, because hospitals report data on all their affiliated facilities on one line of the state reporting form — despite the statute seeking reports of patient visits, facility fee revenue, and facility fee allowed amounts ranged by payer "at each … clinic"[58] — it is impossible to determine the types of facilities

charging these fees and whether certain facilities and services are associated with higher per-patient amounts. (See example reporting form in **Appendix 2**.) Additionally, some hospitals inexplicably claim to be exempt from the reporting requirements for a single year in spite of reporting facility fee charges for preceding and subsequent years.

Yet Washington's data still highlights the seeming arbitrariness of facility fee billing in the commercial sector. This includes a high degree of variability between hospital systems in any given year. For example, in 2018, one hospital reported a maximum facility fee charge for a single patient visit of $29,856.44 while other hospital systems reported maximum charges of less than $300 during that same time period. Hospital systems' reported revenue also vary widely from year to year. One hospital system reported that its total facility fee-related revenue for off-campus clinics and offices shot up more than 1,000 percent in a single year.[59]

Absent an explicit facility fee reporting requirement, state agencies may be able to collect and publicize some information about facility fees through more general powers. In **Massachusetts** and Connecticut, for example, interviewees reported that the state attorney general offices have at times demanded information on facility fee charges and billing practices from health care providers and insurers, either as part of investigations under their consumer protection authority or in support of policy-making. Massachusetts' Health Policy Commission has also monitored the expansion of facility fee billing as part of its "standard watch-dogging" of provider transactions. Interviewees reported that this attention has helped discourage hospitals from charging facility fees in newly acquired or built practices in the state. For example, the commercial payer discussed above described how the Health Policy Commission's emphasis on the issue of facility fees in annual cost trend reports since 2015 helped it eliminate outpatient facility fee charges from many of its provider contracts: "Now, one could see that as being zero for eight, because they didn't get [legislation passed]. But I would argue that it actually had the desired result by putting a kind of vice clamp around the issue, so that hospitals needed to act." Some interviewees also suggested that a state department of insurance could gather information about facility fees through their insurance rate review process, to the extent the department had authority to look at underlying provider reimbursement rates — an idea growing in popularity.[60]

5. PROVIDER TRANSPARENCY: WHO IS PROVIDING CARE WHERE?

To improve transparency in health care claims data, one study state, **Colorado**, requires every "off-campus location of a hospital" to obtain a unique NPI, and use this unique NPI on all claims for care provided at that off-campus location.[61] As discussed above, absent a unique NPI requirement, different facilities or practices owned by the same hospital or health system generally can submit claims under the hospital or health system's NPI rather than a location-specific NPI. When told of Colorado's law, a state employee health plan representative from a different study state was envious: "I 100 percent see the value. I would love to have that level of specificity in terms of where a service is provided." Legislators in other study states — including **Connecticut** [62] and **Maine**[63] — are considering similar proposals,[64] as are members of the U.S. Congress.

When Colorado lawmakers debated the unique NPI requirement during the state's 2018 legislative session providers criticized the proposal as overly burdensome, but interviews suggest this concern was not borne out through implementation. Since implementing its requirement, Colorado officials reported seeing "a dramatic shift in how billing is processed," with much more usable information. Nonetheless, both public and private stakeholders observed that the state all payer claims database has lacked an effective mechanism for tracking how all the different

locations, represented by unique NPIs, are affiliated with each other. Researchers and regulators in the state have tried several workarounds to try to determine hospital ownership and affiliation of off-campus facilities with varying and largely limited degrees of success. (Payers may have proprietary systems that allow them to do so, although we did not discern the extent of this in interviews.) A recently enacted Colorado law that requires hospitals to annually report information on current affiliations and physician practice acquisitions, among other information, may help address this gap.[65]

Massachusetts, with its Registry of Provider Organizations, offers an alternative and more comprehensive approach to the practice ownership question. The provider registry, overseen by the Health Policy Commission in collaboration with other state agencies, includes publicly available data on health system organizational structure; provider ownership and affiliation(s); health care professional staff employment by type of professional, specialty, and "principal practice location"; and information about health system revenue sources and expenditures, including funds used for advertising, payroll, and any other "non-clinical functions." Providers also must identify whether a practice can bill as a facility under Medicare. State officials spoke positively of the amount and detail of information the state collects through the provider registry, while acknowledging some confusion and pushback from providers regarding the financial and physician employment reporting requirements.

Looking Ahead to Future State Legislative Action: Overcoming the Power and Influence of the Hospital Industry

Interviewees consistently indicated that states pursuing facility fee legislation face a big obstacle to reform: robust opposition from the powerful hospital industry. Even when state legislators enact facility fee laws, the hospital industry's influence can extend to state oversight agencies charged with enforcement. But momentum is growing for reform, with more information about hospital costs and charges becoming available and stakeholders increasing their engagement on the issue. As a result, a growing number of state legislatures and agency officials are studying facility fees and debating whether and how to respond.

HOSPITAL POWER AND INFLUENCE

It is hard to overstate the sway of the hospital industry, and the vehemence with which the industry leverages its power to protect hospitals' financial interests. While speaking figuratively, interviewees often invoked violent action when discussing the industry's response to regulation. For example, hospitals will "fight tooth and nail," are "screaming in the ears [of officials in the governor's office]," and will not "take less money without a knockdown drag out fight." Interviewees also shared anecdotes of hospitals wielding their power to influence policymakers and stakeholders alike. In 2020, for instance, the hospital industry reportedly threatened to pull nurses out of public schools if Indiana pursued facility fee reforms. They also had "patients calling from oncology clinics saying 'I'm worried my clinic is going to close and I'm going to die,'" and crowded the halls of the state legislature with hundreds of protestors. In other study states, interviewees offered examples of how hospital executives leveraged their personal relationships

> Hospitals are not going to take less money without a knockdown drag out fight."
>
> — EMPLOYER REPRESENTATIVE

with policymakers, university boards, municipal leaders, and the business community to protect the industry's interests and reputation. Some interviewees also observed how insurers can be "beholden to the health systems," as they often need to keep major hospitals in their networks and themselves have little direct incentive to contain health care costs.

Beyond their market power and political connections, hospitals can shape the course of debate over facility fees and health care prices through their information monopoly. As discussed above, there are significant gaps in publicly available information about the scope of facility fee charges and payments in the commercial sector and how hospitals calculate these charges and use the funds. Hospitals leverage this information disparity to shape the public narrative about the impact of facility fee reforms. Other stakeholders and policymakers may be skeptical of hospitals' framing and arguments, but often lack the information and technical savvy to combat them. As one consumer advocate observed: "What we're really trying to avoid is getting into technical arguments where we don't have the upper hand in knowing about billing, knowing about their business models," preferring to focus on concerns about consumer experience, affordability, and access. In response to these concerns in interviews, hospital industry representatives expressed sympathy with patients charged unexpected facility fees, but they emphasized that "anecdotes make really bad policy." At the same time, hospitals leverage anecdotes themselves. Hospital executives explained how their independent hospital will "carry the water" for the larger health systems to explain why hospitals purportedly need to charge facility fees. Similarly, consumer advocates in other states pointed to how the hospital industry will seek to justify facility fees by highlighting the financial needs of safety net or rural hospitals, "when really a lot of their hospitals are platinum, fancy resort hospitals."

A GROWING REFORM MOVEMENT

Despite their long-standing influence, several cracks are forming in hospitals' defenses. Increased scrutiny from the general public, key stakeholders, and policymakers, are all contributing to growing bipartisan interest in regulating hospital billing practices, including with respect to outpatient facility fees.

> [The employer community is] a slumbering giant that has been awakened, and that's important."
>
> — CONSUMER ADVOCATE

News stories focusing on "egregious facility fees" appear to be raising public awareness and can galvanize support for action. Indeed, the increasing prevalence of facility fees themselves means even state officials and lawmakers may personally relate to this problem. Hospitals are also facing public criticism on a range of other issues, including aggressive debt collection practices, misuse of the non-profit status many enjoy, and anti-competitive practices. Accordingly, interviewees reported that hospitals often face a multitude of bills regulating their conduct in any given legislative session and lawmakers may expect hospitals to give way on at least one issue. As one interviewee put it, hospitals do not evoke sympathy when they are "fighting every single accountability measure."

Public and private initiatives to increase transparency around hospital prices and costs are also giving stakeholders and policymakers new material to build support for facility fee reforms and rebut hospital opposition. In particular, this information has newly animated engagement by employer and business coalitions on facility fees and other health care cost issues. Although the employer community did not actively support efforts to pass facility fee legislation in several study states, business coalitions have been the driving force for reform in other study states where there has been recent legislative action, including Indiana and Texas. Per one interviewee, "that's a slumbering giant that has been awakened

and that's important." Activating individual employers nonetheless remains a "heavy lift," that requires the investment of significant time and resources.

States have also created new offices and agencies charged with looking more closely at health care costs,[66] or empowering state insurance regulators to consider the cost and affordability of health care services.[67] Traditionally, hospitals have been regulated by state health departments. According to interviewees, these agencies prefer to keep their mandate focused on "licensing and safety" and "don't want anything to do with billing and pricing." Nor do stakeholders necessarily want health department officials to have such responsibility because of the influence they perceive hospitals to hold over these agencies. Instead, interviewees argued that giving an agency other than a state health department the authority and the resources to "dive into the prices that are being charged" can "help with facility fees and outrageous prices in general."

As these forces convene, facility fee reforms are attracting bipartisan support. Although the first states to act on facility fees were relatively progressive states, facility fee legislation has been pushed by both Democratic and Republican lawmakers in recent years. Interviewees suggested that the successful enactment of facility fee legislation in conservative states — as since happened in Indiana — will likely inspire action in other traditionally red states.

Conclusion

The growth of outpatient facility fees — and consumers' financial exposure to these charges — derives from the intersection of the United States' increasingly consolidated health care provider market, unnecessarily complex health care billing systems, and frequently inadequate health insurance coverage. Addressing these issues is no small challenge, but it is one more and more state policymakers and stakeholders are trying to tackle. This report explores the effects facility fees have on consumers and profiles how some states have tempered these effects or are seeking to limit facility fees. Although these efforts, if successful, are expected to benefit consumers most by reducing their out-of-pocket cost exposure, such reforms are also an important step in the path towards more broadly containing health care costs and promoting health care affordability, by seeking to simplify and rationalize how a segment of claims are paid.

Appendix 1

About This Study

We began our research by conducting an environmental scan of relevant scholarly work and media coverage of facility fee charges and related issues, including vertical integration within the health care industry and health care payment practices. We also reviewed multiple resources summarizing state laws and legislation regarding facility fees and conducted our own search for state facility fee laws in LexisNexis.

Based on our preliminary research, we identified 10 study states reflecting a mix of geographic and political diversity on which to focus: Colorado, Connecticut, Florida, Indiana, Maryland, Massachusetts, New York, Ohio, Texas, and Washington. Several of these states had enacted legislation to regulate facility fees, while others had more modest laws on the books or were actively pursuing relevant legislation, some of which has since been enacted. During the course of our research, we determined that Maine had enacted relatively robust, but little-known facility fee legislation in 2005, so we added it as an 11th study state.

For each of our study states, we conducted an in-depth review of their existing laws and regulations pertaining to facility fees in LexisNexis, as well as pending legislation in StateNet. We also identified and reached out to six or more stakeholders in each study state for interviews, and conducted at least one and up to six interviews for each state. In total, we conducted 43 interviews with 67 stakeholders (in some instances, more than one interviewee participated in a single interview). Interviewees represented a range of perspectives, including government officials from a mix of state agencies; a state lawmaker; consumer/patient advocates; employer representatives; staff and leadership of health insurers, hospitals, and their respective trade groups; and other academic, policy, and billing experts.

This report reflects our analysis and interpretation of our legal scan and interview findings. We focus our findings on outpatient facility fee charges. As we discuss in greater detail in the report, outpatient facility fees present a number of unique concerns about consumer fairness, price differentials when the same care is provided in different settings, and incentives for vertical integration. In contrast, while some interviewees expressed concern with the amount facilities may charge for inpatient care and how these amounts are calculated, including the level of intensity assigned to a particular course of care, these concerns and regulatory responses largely differ from those outpatient facility fees raise.

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Appendix 2

Washington State's Facility Fee Example Reporting Form, April 2023

Washington State Department of HEALTH

DOH 346-094 April 2023

Hospital Owned Provider-Based Clinic Reporting

1	Fiscal Year Ended: License #	
2	Hospital Name:	
a	The number of provider-based clinics owned or operated by the hospital that charge or bill a separate facility fee	7
b	The number of patient visits at each provider-based clinic owned for which a facility fee was charged or billed for the year	11,253
c	The revenue received by the hospital for the year by means of facility fees at each provider-based clinic	253,150
d	The range of allowable facility fees paid by public or private payers at each provider-based clinic	$100-233

Please submit to DOH either by email or Managed File Transfer (MFT):
email: hos@doh.wa.gov
MFT: https://mft.wa.gov/webclient/Login.xhtml

Facility fee means any separate charge or billing by a off-campus provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

Source: Retrieved from https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-financial-data/hospital-facility-fees.

Endnotes

1 *See, e.g.,* Work, M.C., *May Clinic Patients See Facility Fees Appear Where They Weren't Before.* Post Bulletin. (2023, Apr. 28). Retrieved May 26, 2023, from https://www.postbulletin.com/health/mayo-clinic-patients-see-facility-fees-appear-where-they-werent-before; Hawryluk, M. *States Step in as Telehealth and Clinic Patients Get Blindsided by Hospital Fees.* KFF Health News. (2023, Apr. 3). Retrieved May 14, 2023, from https://kffhealthnews.org/news/article/states-step-in-as-telehealth-and-clinic-patients-get-blindsided-by-hospital-fees/; Low, R. *Family's $2,500 Hospital Charge Reduced After Problem Solvers Get Involved.* KDVR Fox31. (2023, Jan. 11). Retrieved May 25, 2023, from https://kdvr.com/news/problem-solvers/family-charged-hospital-fee-for-more-than-2000-reduced-after-problem-solvers-get-involved/; Lawlor, K., *Hidden Charges, Denied Claims: Medical Bills Leave Patients Confused, Frustrated, Helpless.* Portland Press Herald. (2022, Aug. 21). Retrieved May 25, 2023, from https://www.pressherald.com/2022/08/21/hidden-charges-denied-claims-medical-bills-leave-patients-confused-frustrated-helpless/; Low, R. *Dad Charged $503 'Facility Fee' for Kid's Doctor Visit.* KDVR Fox31. (2022, Jan. 21). Retrieved May 25, 2023, from https://kdvr.com/news/problem-solvers/facility-fee-surprise-medical-billing/.

2 Individual practitioners must identify the "place of service" (or "POS") — i.e., the type of setting where care was provided, such as an individual office, on- or off-campus hospital outpatient department, or inpatient hospital — when billing Medicare, so Medicare can adjust the payment accordingly.

3 2021 *Health Care Cost and Utilization Report.* (2023, Apr. 1). Health Care Cost Institute. Retrieved May 12, 2023, from https://healthcostinstitute.org/images/pdfs/HCCI_2021_Health_Care_Cost_and_Utilization_Report.pdf.

4 *Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012–2018.* (2019, Feb. 3). Physicians Advocacy Institute. Retrieved May 12, 2023, from http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-Avalere-PAI-Physician-Employment-Trends-Study-2018-Update.pdf?ver=2019-02-19-162735-117.

5 *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019–2020.* (2021, June 1). Physicians Advocacy Institute. Retrieved May 12, 2023, from http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3D%3D.

6 Under Medicare, facilities must meet certain requirements to bill as a hospital outpatient department — referred to as having "provider-based status." These requirements include that the facility practice under the hospital's licensure and that a certain degree of clinical and financial integration exist between the facility and hospital. Hospitals may but are not required to attest that they meet these requirements. *See* 42 C.F.R. § 413.65. A 2016 analysis by the U.S. Department of Health and Human Services' Office of Inspector General found that more than three-quarters of a 50 hospital sample may have been billing Medicare improperly for facilities that did not meet all of the requirements to have provider-based status; CMS committed to improving its monitoring of provider-based billing in response. Levinson, D.R. *CMS Is Taking Steps to Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain.* (2016, June). U.S. Department of Health & Human Services, Office of Inspector General. Retrieved May 25, 2023, https://oig.hhs.gov/oei/reports/oei-04-12-00380.asp. State laws and commercial practices may vary regarding what facilities qualify as a hospital outpatient department.

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Site of Care. (2016, Mar. 1). American Journal of Managed Care. Retrieved May 12, 2023, from https://pubmed.ncbi.nlm.nih.gov/26978238/; Reschovsky, J.D. & White. C. *Location, Location, Location: Hospital Outpatient Prices Much Higher than Community Settings for Identical Services.* (2014, June). National Institute for Health Care Reform. Retrieved May 13, 2023, from https://www.nihcr.org/analysis/improving-care-delivery/prevention-improving-health/hospital-outpatient-prices.

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11 Godwin, J., Arnold, D., Fulton, B., & Scheffler, R. *The Association Between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence.* (2021, Jan.–Dec.). Inquiry. Retrieved May 14, 2023, from https://pubmed.ncbi.nlm.nih.gov/33682524/.

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16 Although many facility fee bills are surprising to consumers, they are not specifically prohibited by the federal No Surprises Act, which protects consumers from being balance billed when they see out-of-network health care providers for reasons that are outside of their control, such as emergency care. *See* Hoadley, J., Lucia, K., & Fuchs, B. *Surprise Billing Protections: Help Finally Arrives for Millions of Americans.* (2020, Dec. 17). The Commonwealth Fund. Retrieved May 25, 2023, from https://www.commonwealthfund.org/blog/2020/surprise-billing-protections-cusp-becoming-law.

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18 Alternatively, the same suite may be processed as separate locations if different nomenclature or abbreviations are used on different claim forms. For example, "Suite 10," versus "Ste. 10," versus "Floor 10."

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21 Conn. Gen. Stat. § 19a-508c(l).

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28 Md. Ins. Code § 15-139 (facility fees for telehealth services are still allowed when the provider is not authorized to separately bill a professional fee for the service, however); Md. Code Regs. § 10.37.10.07-1(K) (same).

29 Urgent Memorandum from Dennis N. Phelps, Deputy Director-Audit & Compliance, Maryland Health Services Cost Review Commission, to Chief Financial Officers – All Hospitals, Regarding Reporting and Charging for the Administration of COVID-19 Vaccines and Monoclonal Antibody Therapies. (2020, Dec. 14). Retrieved May 14, 2023, from https://hscrc.maryland.gov/Documents/COVID-19/COVIDVACCINESMEMOZZZ-1.pdf. Maryland's COVID-19-related protections will expire on January 1st of the year following the year in which the Emergency Use Authorizations for the applicable tests, drugs, and biologicals ends. Urgent Memorandum from Dennis N. Phelps, Deputy Director-Audit & Compliance, Maryland Health Services Cost Review Commission, to Chief Financial Officers – All Hospitals, Regarding Continued Suspension of Telehealth Regulations – COMAR 10.37.10.07-1 and Other COVID-19 Related Temporary Approvals. (2023, Apr. 27). Retrieved June 27, 2023, from https://hscrc.maryland.gov/Documents/pdr/PolicyClarification/2021/2023.04.27%20_%20Continued%20Suspension%20of%20Telehealth%20Regulations.pdf.

30 Ohio Rev. Code § 3727.49.

31 Tex. Health & Safety Code §§ 241.222; 254.1555.

32 Rev. Code Wash. § 48.43.735.

33 Bulletin 2020-04 from Insurance Commissioner Gary D. Anderson to Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations Regarding Emergency Measures to Address and Stop the Spread of COVID-19 (Coronavirus). (2020, Mar. 16). Retrieved May 14, 2023, from https://www.mass.gov/doc/bulletin-2020-04-emergency-measures-to-address-and-stop-the-spread-of-COVID-19-coronavirus/download.

34 *See, e.g.,* Larson, A., *HHC's Acquisition of 2 Surgical Centers Approved, with a Condition – It Can't Charge 'Facility Fees'.* (2023, May 12.). Hartford Business. Retrieved May 13, 2023, from https://www.hartfordbusiness.com/article/hhcs-acquisition-of-2-surgical-centers-approved-with-a-condition-it-cant-charge-facility.

35 Conn. Gen. Stat. § 38a-477bb. The law does not specify whether insurers may impose other forms of cost-sharing, such as coinsurance.

36 Conn. Gen. Stat. § 20-7f.

37 Colo. H.B. 1226 (2023) (adding Colo. Rev. Stat. § 6-20-102(2)).

38 Opinion of General Counsel (OGC) Opinion Number 08-10-06. *RE: Post-Mastectomy Breast Reconstruction Surgery Mandate.* N.Y.S. Department of Financial Services. (2008, Oct. 16). Retrieved May 14, 2023, from https://www.dfs.ny.gov/insurance/ogco2008/rg081006.htm.

39 *E.g.,* Fla. Stat. § 395.301; Ind. Code Ann. § 16-21-17-1; Tex. Health & Safety Code § 327.001 et seq.

40 *E.g.,* Fla. Stat. § 395.1041; Tex. Health & Safety Code § 241.252; Tex. Health & Safety Code § 254.155.

41 Md. Health-Gen. Code § 19-349.2.

42 N.Y. Pub. Health Law § 2830.

43 *E.g.,* Mass. Ann. Laws ch. 32A, § 27; Mass. Ann. Laws ch. 111, § 228; Mass. Ann. Laws ch. 176O, § 6; Mass. Ann. Laws ch. 176O, § 23; Rev. Code Wash. § 70.01.040.

44 Conn. Gen. Stat. § 19a-508c(b), (c), (f), (h), (j).

45 Conn. Gen. Stat. § 19a-508c(k).

46 Conn. Gen. Stat. § 38a-477e(a).

47 Colo. H.B. 1226 (2023) (adding Colo. Rev. Stat. § 6-20-102(3)).

48 Colo Rev. Stat. § 25-3-119.

49 Wash. H.B. 2582 (2011).

50 Rev. Code Wash. § 70.01.040(4).

51 Conn. S.B. 811 (2015); Conn. S.B. 683 (2021); Conn. H.B. 6669 (2023).

52 Conn. Gen. Stat. § 19a-508c(m).

53 Conn. H.B. 6669 (2023).

54 Md. Health-Gen. Code § 19-349.2(h).

55 Ind. Code Ann. § 16-21-6-3.

56 Colo. Rev. Stat. § 25.5-4-216.

57 Similar to Colorado, the Maine legislature recently passed a bill that would establish a task force to study facility fee billing and make a report to the legislature with recommendations. Unlike Colorado's law or other laws discussed in this section, however, Maine's bill does not require any new reporting by hospitals, although it also would require the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024. Maine S.P. 720, L.D. 1795 (2023-2024).

58 Rev. Code Wash. § 70.01.040(4).

59 This report was updated on July 21, 2023 to correct an error in the description of the health system to which a large single-year increase in facility fee revenue was attributed. Previously, the report described a health system as reporting an increase in revenue from $391,858 to $3,577,690 while patient visits slightly decreased. After publication, authors found an error in the first year of revenue data such that the currently reported amount is $3,391,858. The post has been corrected to refer to another health system who reported a large increase in facility fee revenue, from less than $500,000 in 2018 to over $7 million in 2019. All of Washington's facility fee reports can be found on the state's Department of Health website: https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-financial-data/hospital-facility-fees.

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61 Colo. Rev. Stat. § 25-3-118(1). Colorado's Medicaid statute extends this requirement to any non-individual ("organization") health care provider. Colo. Rev. Stat. § 25.5-4-420. Ohio law requires freestanding emergency departments to use their "assigned" NPI on all health care claims, but does not specifically require that this be an NPI unique to that location. Ohio Rev. Code § 3727.49(C).

62 Conn. H.B. 6634 (2023).

63 Maine H.B. 988 (2023–2024).

64 While not a study state, Nebraska recently enacted a unique provider identifier requirement as well. Neb. L.B. 296 § 12 (2023).

65 Colo. H.B. 1226 (2023) (amending Co. Rev. Stat. § 25.5-4-402.8).

66 Melnick, G. *Health Care Cost Containment Commissions: How Eight States Address Cost Growth.* (2022, Apr.). California Health Care Foundation. Retrieved May 13, 2023, from https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf.

67 The Commonwealth Fund (2023).

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