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Regulating Outpatient Facility Fees:

States Are Leading the Way to Protect Consumers

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In recent years, health care consumers, payers, and policymakers have brought attention to the growing prevalence of hospital outpatient facility fees in the United States. As hospitals and health systems expand their ownership and control of ambulatory care practices, they are typically charging new facility fees for services delivered in these outpatient settings. Consumers, too, are facing greater financial exposure to these charges as insurance deductibles increase and payers develop new benefit designs that increase patients' exposure to cost-sharing, particularly in hospital outpatient settings.

Consequently, state policymakers, spurred on by consumer advocacy groups and a budding contingent of employers and business groups, are pursuing reforms that would limit hospitals' ability to charge outpatient facility fees and/or better protect consumers from such bills.

This issue brief explores why and how many states are taking on the regulation of outpatient facility fees. Its findings are informed by an analysis of current laws and regulations across 11 study states—**Colorado, Connecticut, Florida, Indiana, Maine, Maryland, Massachusetts, New York, Ohio, Texas,** and **Washington**—and more than 40 qualitative interviews with key stakeholders and experts between November 2022 and April 2023. For a more in-depth examination of this issue, a companion report is available here.

Key Findings:

- Concern is growing that hospital outpatient facility fees are adding to consumers' and employers' health care costs—both through higher out-of-pocket charges and rising insurance premiums.

- States have been at the forefront of protecting consumers from unwarranted outpatient facility fees in the commercial market. The five reforms most commonly adopted by states are described in Table 1. These include:
  1. Prohibitions on facility fees;
  2. Out-of-pocket cost protections for consumers;
  3. Consumer disclosure requirements;
  4. Hospital reporting requirements; and
  5. Provider transparency requirements.

- Despite strong opposition from hospitals, state action to constrain outpatient facility fees is clearly gaining momentum.

Why Action on Facility Fees Is Needed

Facility fees are the charges institutional health care providers, such as hospitals, bill ostensibly to cover their operational expenses for providing health care services. Hospitals submit these charges separately from the professional fees physicians and certain other health care practitioners, such as nurse practitioners, physician assistants, and physical therapists, charge to cover their time and expenses. Traditionally, public and private payers pay more in total for the same services provided in a hospital—including, importantly, hospital-owned outpatient departments—than care provided in an independent physician's office or clinic.

This payment differential both encourages and exacerbates the effects of vertical integration in the U.S. health care system, as hospitals and health systems increasingly acquire physician practices and other outpatient health care providers. When a hospital acquires or otherwise affiliates with a practice, ambulatory services provided at the practice often newly generate a second bill, the facility fee, on top of the professional fees the practitioners charge. As hospitals expand their control over more physician and other outpatient practices, they can also exert greater power in their negotiations with commercial health insurers and extract even higher charges.

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

The growth in outpatient facility charges increases overall health care spending, resulting in higher premiums. Our research also suggests that insurance benefit designs are increasing consumers' direct exposure to these charges. Rising deductibles, which can subject consumers to several hundred dollars or more in facility fee charges for a single outpatient service, appear to be one factor. Even when a consumer has met their insurance deductible, a separate facility fee from the hospital, on top of a professional bill, may trigger additional cost-sharing obligations for the consumer, such as a separate co-insurance charge on the hospital bill. Commercial insurers also may impose higher cost-sharing on patients for receiving hospital-based care.

Consumers are often caught off guard by outpatient facility fee charges and may question why they are getting billed by a hospital for a run-of-the-mill visit to the doctor. Hospitals maintain that they need to impose these charges because of the extra costs they incur and services they provide—such as round-the-clock staffing, nursing and other personnel costs, and security—even though individual patients may not pose any additional costs or use the hospital's services. In contrast, payers and a range of policy experts view facility fee billing as a way hospitals leverage their market power and take advantage of the United States' complex and opaque payment and billing systems to increase revenue.

> You pay for the courtesy of going to the building owned by the hospital."
>
> **— FORMER STATE OFFICIAL**

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.

State Strategies to Regulate Outpatient Facility Fee Billing

While federal lawmakers and regulators have begun reining in payment discrepancies based on the site of care under Medicare, states are at the forefront of tackling outpatient facility fee billing in the commercial sector. Our analysis of the laws and regulations currently on the books in 11 study states demonstrates the range of reforms available (Table 1). Specifically, we identify five types of reforms states are beginning to adopt: (1) prohibitions on facility fees; (2) out-of-pocket cost protections; (3) consumer disclosure requirements; (4) hospital reporting requirements; and (5) provider transparency requirements. At the same time, our research shows how much more states can still do, both with respect to strengthening existing reforms to be more protective of consumers and adopting additional types of reforms.

1. Prohibitions on Outpatient Facility Fees: Stopping Charges Before They Happen

Several study states have prohibited facility fee charges in some circumstances, although the scope of these laws varies significantly. **Connecticut, Indiana,** and **Maine** have gone the furthest, prohibiting facility fees for selected outpatient services typically provided in an office setting. Some states have targeted more specific services, including telehealth services **(Connecticut, Maryland, Ohio,** and **Washington)**, preventive services **(New York)**, and Covid-19 related services **(Maryland, Texas,** and, during the public health emergency period, **Massachusetts).**

Maine's law is the oldest facility fee prohibition among the study states. It specifies that all services provided by a health care practitioner in an office setting—"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"—must be billed on the individual provider form. A Maine health care provider confirmed that this law means hospitals cannot charge facility fees for office-based care, even when provided in a hospital-owned practice. This provider has narrowly interpreted the scope of services to which the law applies, however. As such, they do not charge facility fees for Evaluation and Management (E&M) services,[1] but do charge facility fees for 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. **Indiana** uses the same office-setting framework in its recently enacted law, which will go into effect July 1, 2025, and more narrowly prohibits facility fee billing for off-campus facilities owned by non-profit hospitals. **Connecticut** currently bars hospital-owned or -operated facilities from charging facility fees for outpatient E&M and assessment and management (A&M) services at off-campus locations. Beginning July 1, 2024, this prohibition will extend to on-campus locations as well, excluding emergency departments and certain types of observation stays.

In interviews, stakeholders emphasized that prohibitions on outpatient facility fees can provide significant financial protection to consumers, who otherwise may need to pay a significant portion, if not all, of a facility fee charge, depending on their insurance coverage. The impact on insurance premiums may be more muted, however, as hospitals with market power may make

[1] Evaluation and Management (E&M) services are non-procedural services where health care practitioners diagnose and treat illnesses, injuries and other conditions. Examples of E&M services include diagnosing a sinus infection and prescribing antibiotics, or an office visit focused on managing an ongoing and complex condition such as diabetes.

up for the lost revenue by securing higher rates for other services in their negotiations with commercial payers. (This is different from Medicare, where the government sets payment rates for health care providers.)

2. Out-of-Pocket Cost Protections: Limiting Consumer Charges for Facility Fees

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** prohibits insurers from imposing a separate copayment for outpatient facility fees provided at off-campus hospital facilities (for services and procedures for which these fees are still allowed to be charged) and bars health care providers from collecting more than the insurer-contracted facility fee rate when consumers have not met their deductible. More narrowly, health care providers in **Colorado** will not be allowed to balance bill consumers for facility fee charges for preventive services provided in an outpatient setting beginning July 1, 2024.

It is unclear to what extent coverage requirements such as state benefit mandates and the essential health benefit package require coverage of facility fees when the underlying service is covered. Multiple state insurance regulators suggested in interviews they had not previously considered this question. While coverage requirements would protect consumers from balance billing of facility fees when they receive care at an in-network facility, some interviewees cautioned that such rules could encourage health care providers to increase the frequency and amount of facility fee charges where they apply.

3. Consumer Disclosure Requirements: Notifying Consumers About Outpatient Facility Fee Charges

All but two study states require health care providers—typically hospitals and hospital-owned facilities and sometimes freestanding emergency departments—and/or health insurers to notify consumers that they may be charged a facility fee in certain circumstances. For example, **Connecticut** and, as of July 1, 2024, **Colorado** require providers to disclose certain information about their facility fee billing practices upon scheduling care, in writing before care, via signs at the point of care, and in billing statements. Upon acquiring a new practice, hospitals in these states also must notify patients that they may be charged new facility fees. Other study states have adopted a subset of these requirements, such as requiring disclosures before care is provided and/or in signage at the facility. Some states require consumers to be more proactive, requiring only that information about facility fee charges be available online or provided upon request by hospitals and/or health insurers.

Interviewees generally did not believe that these disclosures would drive many consumers to seek care in settings that do not impose facility fees, observing that consumers tend to prioritize their existing provider relationships and seek care where their providers refer them. They did think disclosures can reduce consumer confusion when they receive a facility fee bill, however. Some interviewees also suggested that consumer disclosure requirements could generate broader support for reforms by increasing awareness of the extent of facility fee billing.

4. Hospital Reporting Requirements: Disclosing How Much Hospitals Charge and Receive in Outpatient Facility Fees

Five study states have adopted public reporting requirements to better understand how much hospitals charge and receive for outpatient care. Four of these states—**Connecticut, Indiana, Maryland,** and **Washington**—have enacted annual reporting requirements, while **Colorado** recently required a study that includes collecting facility fee data from hospitals (among other sources) with a report due in the fall of 2024.[2]

The value of public reporting requirements depends on what information the state collects. More detailed information, broken down by facility, payer, and service, will offer policymakers a deeper and more nuanced understanding of the scope of facility fee billing and trends over time. Agencies charged with collecting this data also must have the authority, capacity, and will to ensure hospitals comply and to effectively analyze the data.

> Connecticut's law has been good from the exposure standpoint, on what the real problems are, specifically the opacity of facility fees and the lack of a rational basis for what the charges are."
>
> **— FORMER STATE OFFICIAL**

5. Provider Transparency Requirements: Who Is Providing Care Where?

Colorado and **Massachusetts** have taken steps to bring more transparency to the questions of where care is being provided and by whom. Unfortunately, existing claims data often conceal the specific location where care was provided and the extent to which hospitals and health systems own and control different health care practices across a state. This makes it challenging for payers, policymakers, and researchers to effectively monitor and respond to outpatient facility fee charges.

In an effort to understand where care is provided, **Colorado** requires every off-campus location of a hospital to obtain a unique identifier number (referred to as a national provider identifier or NPI) and include that identifier on all claims for care provided at the applicable location. Federal lawmakers and other states are considering similar proposals. One challenge **Colorado** has faced, however, is tracking the affiliations between different locations, all now represented by unique NPIs. A recently enacted law requires **Colorado** hospitals to report annually on their affiliations and acquisitions, which may help address this gap. **Massachusetts** does not have a unique NPI requirement but maintains a provider registry that includes information on provider ownership and affiliations among other data, enabling the state to better monitor trends in consolidation and integration.

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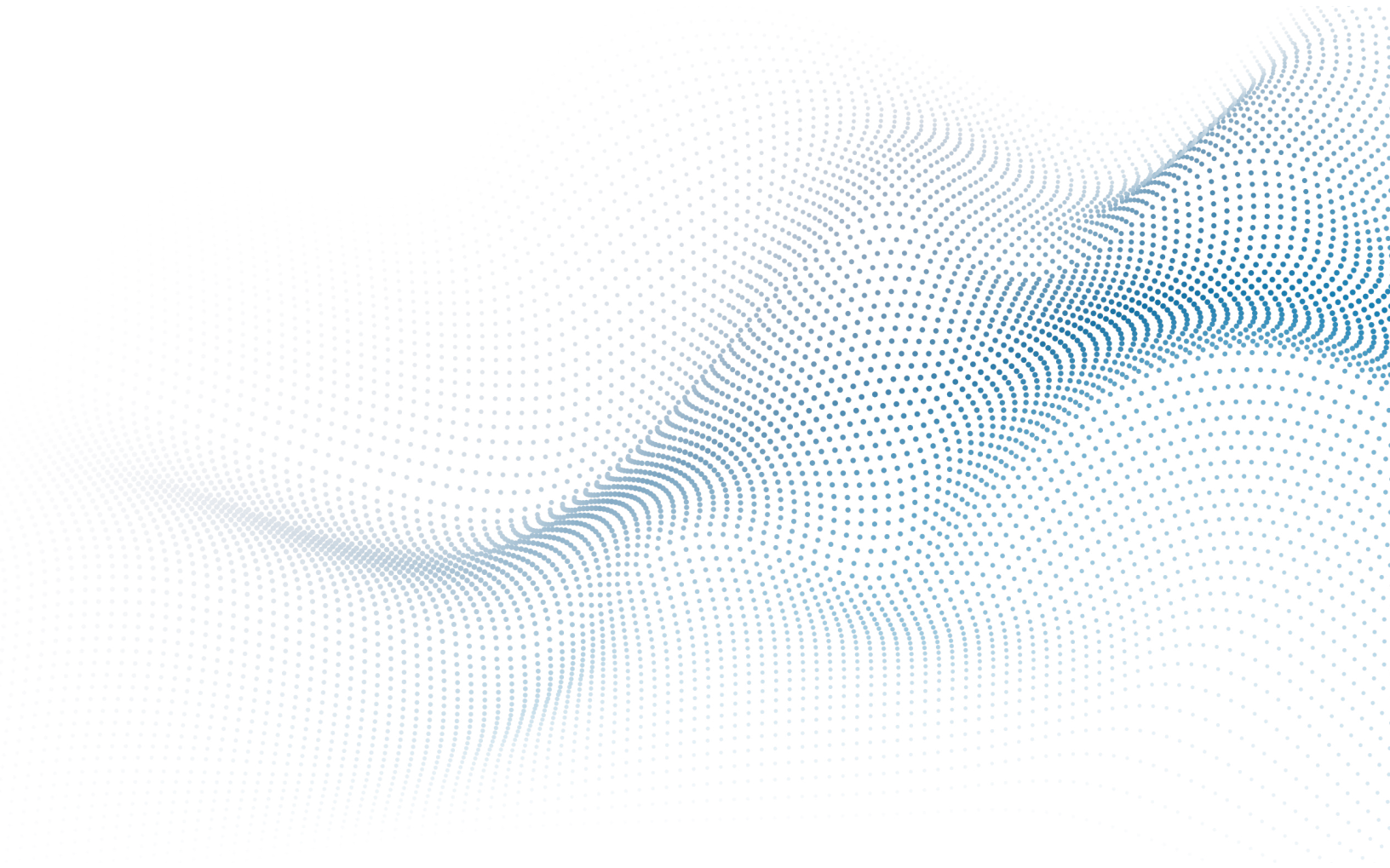
[2] Similar to Colorado, Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. Unlike Colorado's law or other laws discussed in this section, however, Maine's law does not require any new reporting by hospitals, although 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.

Looking Ahead: Growing Momentum Despite Hospital Pressure

The hospital industry remains a powerful force, leveraging significant influence over policymakers, regulators, and other stakeholders to stifle reforms that would reduce their revenue or restrict their operations. Yet interviews revealed that cracks are forming in hospitals' defenses as momentum grows for reform. Hospitals are facing public criticism on a range of issues, from their facility fee charges, to debt collection practices, and for exploiting their non-profit tax status. The growing prevalence of facility fees specifically, and the financial toll they can take on unsuspecting consumers, is catching the eye of journalists, regulators, and policymakers. As more information on hospital prices and costs come to light through public and private transparency initiatives, the employer community also is increasingly engaging on the issue of outpatient facility fees and other issues affecting the cost of health care for their businesses and their employees. And states are building their internal capacity to tackle these topics, including establishing new offices and expanding the authority of existing departments to look at health care costs and affordability.

These forces are generating broad interest in tackling hospital pricing generally, and outpatient facility fee charges in particular. While addressing these issues is no small challenge, it is a challenge more and more policymakers and stakeholders are willing to tackle.



Key Sources

LITERATURE

Billig, J.I., Lan, W., Lu, Y., Chung, K.C., Kuo, C., & Sears, E.D. The Increasing Financial Burden of Outpatient Elective Surgery for the Privately Insured. (2020, Sept.). Annals of Surgery. Retrieved May 14, 2023, from https://pubmed.ncbi.nlm.nih.gov/32740255/.

Capps, C., Dranove, D., & Ody, C. The Effects of Hospital Acquisitions of Physician Practices on Prices and Spending. (2018, Ap. 22). Journal of Health Economics. Retrieved May 13, 2023, from https://pubmed.ncbi.nlm.nih.gov/29727744/.

Cooper, Z., Craig, S., Gaynor, M., Harish, N.J., Krumholz, H.M., & Van Reenan, J. Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007-2014. (2019, Feb.). Health Affairs. Retrieved May 13, 2023, from https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05424.

Galarraga, J., Mutter, R., & Pines, J.M. Costs Associated with Ambulatory Care Sensitive Conditions Across Hospital Settings. (2015, Feb.). Academic Emergency Medicine. Retrieved May 13, 2023, from https://pubmed.ncbi.nlm.nih.gov/25639774/.

Scheffler, R.M., Arnold, D.R., & Whaley, C.M. Consolidation Trends in California's Health Care System: Impacts of ACA Premiums and Outpatient Visit Prices. (2018, Sept.). Health Affairs. Retrieved May 14, 2023, from https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0472.

STATE AUTHORITIES

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

Maine S.P. 720, L.D. 1795 (2023-2024).

Colo. Rev. Stat. §§ 6-20-102, 25-3-118, 25-3-119, 25.5-4-216, 25.5-4-402.8.

Conn. Gen. Stat. §§ 19a-508c, 19a-906, 20-7f, 38a-477bb, 38a-477e.

Conn. H.B. 6669 (2023).

Fla. Stat. §§ 395.301, 395.1041.

Ind. Code §§ 16-21-6-3, 16-21-17-1; 16-21-17-2, 16-51.

Mass. Ann. Laws ch. 32A, § 27.

Mass. Ann. Laws ch. 111, § 228.

Mass. Ann. Laws ch. 176O, §§ 6, 23.

Mass. Div. Ins. Bull. 2020-04, https://www.mass.gov/doc/bulletin-2020-04-emergency-measures-to-address-and-stop-the-spread-of-covid-19-coronavirus/download.

Md. Health-Gen. Code § 19-349.2.

Md. Ins. Code § 15-139.

N.Y. Pub. Health Law § 2830.

N.Y.S. Dep't of Fin. Servs. Op. of Gen. Couns. No. 08-10-06, https://www.dfs.ny.gov/insurance/ogco2008/rg081006.htm.

Ohio Rev. Code § 3727.49.

Rev. Code Wash. §§ 48.43.735, 70.01.040.

Tex. Health & Safety Code §§ 241.222, 241.223, 241.252, 254.155, 254.1555, 254.1556, 254.156, 327.001 et seq.

Tex. Ins. Code § 1662.001 et seq.

Urgent Mem. from Dennis N. Phelps, Deputy Director-Audit & Compliance, Md. Health Servs. Cost Rev. Comm'n (2020, Dec. 14), https://hscrc.maryland.gov/Documents/COVID-19/COVIDVACCINESMEMOZZZ-1.pdf.

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For additional sources relied on for this issue brief, please see our companion report.

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