ALLIANCE *for*
FAIR HEALTH
PRICING

The Price We Pay:

Unfair Billing in Health Care and a Policy Path Forward

Introduction

Health care prices are high and continue to climb, increasing costs for patients, consumers, employers and taxpayers. These prices are particularly high and tend to grow the fastest for care provided to those with private insurance. As health care systems grow larger through acquisitions of hospitals, medical practices, and other outpatient facilities, competition in these markets diminishes, and the consolidated health systems' negotiating power strengthens—a dynamic that drives prices ever higher. In fact, the ability to increase prices and overwhelm purchasers' abilities to effectively negotiate prices with clinicians is a central impetus behind the consolidation. Increasingly, price variation across health care systems, other clinicians, and geographic areas reflect differences in market power more than differences in the quality of care delivered.

The prices paid to clinicians vary along many axes, including across plan, clinician, service provided, and site-of-service, even within the same geographic area. At a detailed level, for example, a physician may be paid a different price by a single insurance plan for the identical service provided in one office versus another. And, since billing practices and negotiated prices are generally considered proprietary by clinicians and insurers, and since patients often do not know the full extent of particular services they will need, patients, consumers, and employers often have little understanding of price differences until they are directly affected, often after a patient receives care.

Unfair and aggressive, even predatory, billing practices by hospitals and providers can be a direct result of the consolidation of health systems, as corporate or nonprofit entities pursue greater revenues at faster rates. These practices push consumer and employer health care costs higher at accelerating rates. Revenue-enhancing strategies include: the explosion in the use of outpatient facility fees in hospital-owned medical practices as well as other clinical locations, upcoding of patient bills, erroneous or "phantom" billing, and overly aggressive collection efforts.

Such practices are placing growing financial burdens on consumers and can create barriers to effective access to necessary care. Consequently, understanding prices as well as the details of often evolving hospital and provider billing practices is necessary to develop public policies that protect patients and reduce overall health system costs.

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Abusive Billing Practices

Health care systems of all ownership types are increasingly employing opaque billing practices that raise concerns related to appropriateness, efficiency, affordability, and transparency for patients and purchasers. These billing practices are intended to increase provider revenue, and, as a result, they ultimately raise health system costs. Here we describe some specific examples.

Facility Fees

Hospitals have historically charged facility fees for inpatient care (over and above fees to cover services provided by clinicians) to cover their overhead costs. Meanwhile, clinicians have typically billed private insurers for outpatient care delivered in physician offices and other independent outpatient facilities in a single bill that covers both the service and associated overhead costs for the offices/facilities. However, in the last 15 years, hospital acquisitions of outpatient medical practices have been accompanied by considerable billing increases for both physician fees and separate hospital facility fees, with the add-on facility fees sometimes reaching into the thousands of dollars.[1] These facility fees are often justified as necessary to cover hospital overhead costs such as providing care 24 hours a day, seven days a week—even when the care is delivered in a setting that operates like a typical physician's office, distinct from any hospital campus. They may even be imposed for telemedicine visits for which patients do not set foot in any facility.[2] The fees are a growing source of hospital revenue,[3] and they provide increased incentive for hospital systems to buy greater numbers of medical practices and outpatient clinics—increasing consolidation and ultimately health care costs.

This pricing practice, a direct consequence of and incentive for health care consolidation, is materially increasing the total cost of obtaining outpatient care. As the Health Care Cost Institute (HCCI) and the Center for a Responsible Federal Budget have shown, the total price of an identical service provided to privately-insured patients is significantly higher when separate professional and facility fees are charged compared to professional fees alone.[4,5] The HCCI study compares prices of physician office visits and ultrasounds when they are billed with a professional fee alone versus when billed with a professional fee and a facility fee. The price differentials vary enormously by service, by health care system, and across the

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[1] Blumberg, et al. (2023, August). Facility Fees 101: What is all the Fuss About? https://www.healthaffairs.org/content/forefront/facility-fees-101-all-fuss.

[2] Andrews, M. (2021, December). 'The Charges Seem Crazy': Hospitals Impose a 'Facility Fee' – For a Video Visit. https://kffhealthnews.org/news/article/telemedicine-hospital-facility-fees-video-visit/.

[3] Capps, et al. (2018, May). The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending." Journal of Health Economics https://pubmed.ncbi.nlm.nih.gov/29727744/.

[4] Health Care Cost Institute (2023, June). Facility Fees and How They Affect Health Care Prices. https://healthcostinstitute.org/images/pdfs/HCCI_FacilityFeeExplainer.pdf.

[5] Committee for a Responsible Federal Budget. (2023, February). Moving to Site Neutrality in Commercial Insurance Payments. https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.

country.[6] A separate study compared prices for other routine services commonly done in physician offices with no complexity or quality concerns. Taking professional fees and, where applicable, facility fees into account, this study found that the national median payment for an echocardiogram is approximately three times higher in a hospital-owned outpatient practice than in an independent physician office ($350 compared to $1,044).[7] The median price differential for mammograms is 38 percent ($192 compared to $265). The average price for a biopsy is over 5 times higher in a hospital-owned practice ($791 versus $146).[8] And while outpatient facility fees typically increase the total price of an ultrasound by only $35 in Arkansas, they typically raise the total price of an ultrasound by about $400 in California.[9]

When outpatient facility fees are charged, they frequently increase the out-of-pocket costs placed on the patients receiving care. Insurers may charge enrollees a co-payment for physician office visits, for example, while a deductible and co-insurance may apply to hospital care. When visiting a hospital-owned physician's office that charges a facility fee, the patient is likely to be charged cost-sharing for the professional fees plus cost-sharing for the facility fee. Consumers are often surprised by these two separate bills, especially when their physician's office has been purchased by a hospital system without their knowledge or when they visit a new clinician that does not inform them of the circumstance. Some insurers do not cover outpatient facility fees at all, burdening the patient with the entire cost of the fee.[10]

A very limited number of states currently regulate facility fees in any manner, with some states merely requiring clinicians to disclose to patients that facility fees will be charged (via signage at the place of service, email, or other mailings) and some states prohibiting these fees for specific types of services (e.g., telehealth).[11] As of early 2025, a number of states are exploring facility fee legislation along similar lines (e.g., New York, Indiana, Texas).[12] Currently, there is no federal regulation of facility fees for the privately-insured.

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[6] Health Care Cost Institute (2023, June). Facility Fees and How They Affect Health Care Prices. https://healthcostinstitute.org/images/pdfs/HCCI_FacilityFeeExplainer.pdf.

[7] Committee for a Responsible Federal Budget (2023, February). Moving to Site Neutrality in Commercial Insurance Payments. https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.

[8] Health Care Cost Institute (2023, June). Facility Fees and How They Affect Health Care Prices. https://healthcostinstitute.org/images/pdfs/HCCI_FacilityFeeExplainer.pdf.

[9] Health Care Cost Institute (2023, June). Facility Fees and How They Affect Health Care Prices. https://healthcostinstitute.org/images/pdfs/HCCI_FacilityFeeExplainer.pdf.

[10] The Alliance (2021, May). Understanding Facility Fees. https://the-alliance.org/wp-content/uploads/2021/05/Understanding_Facility_Fees_TA114-0116.pdf.

[11] Monahan, et al. (2023, July). Protecting Patients from Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform. https://georgetown.app.box.com/v/statefacilityfeereport.

[12] Abresch, S. (2025, January). Facility Fee Proposals Back on the Agenda This Year. https://www.ascfocus.org/ascfocus/content/articles-content/articles/2025/digital-debut/facility-fee-proposals-back-on-the-agenda-this-year. Georgeown CHIR. (2024, June). Facility Fee State Legislative Roundup: 2024 Session. https://chirblog.org/facility-fee-state-legislative-roundup-2024-session/.

Site-neutral Policies Aim to Address the Price Differential Between Hospital-owned Settings and Independent Physician Offices

In both the Medicare program and the commercial market, hospitals are typically paid more for the same services provided in a hospital-based setting than when provided in a physician's office, even when the care being delivered is of low complexity and is commonly and safely done in physician offices. While this price differential between sites of service is not new, in recent years, fast increasing hospital and health system acquisitions of physician and other outpatient practices have led to large increases in outpatient care being billed as "hospital-based" care. In the commercial market, this often manifests as additional facility fees for unrelated hospital operating costs being tacked on to the professional fee for routine services, with the sum of these two fees generally significantly higher than the price charged by an independent physician practice providing the identical service. These price differentials have resulted in higher costs for Medicare beneficiaries, the privately-insured, employers, and taxpayers. Further, the ability to charge higher prices for so-called hospital-based services has created large financial incentives for more hospital and health system acquisitions of physician practices and outpatient clinics, increasing consolidation of the health care delivery sector into ever larger health care systems while further inflating prices for the privately-insured.

While policies to ban or otherwise address facility fees are garnering state (and some federal) attention, there are also efforts to advance site-neutral payment policies in the Medicare program at the federal level. Site-neutral reforms would go further than controlling facility fees alone since they would equalize total Medicare payments for routine services, regardless of whether they are provided in a hospital-owned outpatient practice or a physician's office. As a result, the site-neutral approach would result in lower health care costs for Medicare beneficiaries and taxpayers while also helping to decrease incentives for future health care consolidation. Comprehensive site-neutral payment reform in Medicare is estimated to save the federal government about $150 billion and reduce out-of-pocket costs for Medicare beneficiaries by about $90 billion over 10 years.[13]

Some states are considering site-neutral policies for the commercial market that would lower costs for the privately insured and employers as well.

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[13] Committee for a Responsible Federal Budget. (2021, February). Equalizing Medicare Payments Regardless of Site-of-Care. https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.

New York State legislators recently introduced a bill to implement site-neutral payments in the commercial market for services that are safely and commonly performed in a physician's office. Rather than simply banning facility fees for outpatient care, a commercial site-neutral policy would require the total price for a set of services, taking the sum of any professional and facility fees into account, to be the same, regardless of whether the service is provided in an independent physician office or a hospital-owned setting.[14]

Greater transparency in where services are being provided is necessary across all markets. Currently, many bills for care delivered in hospital-owned physician offices and outpatient departments are billed under the hospitals' single identifier, making it impossible for insurers and purchasers to see where the care is actually delivered. Federal and state action to implement site-of-service billing transparency policies—which would require each hospital-owned provider location to bill under its own unique National Provider Identifier—is critical to improving transparency over where care is delivered.

Upcoding of Clinician Bills

Beyond the increases in prices that are observed, there is evidence that upcoding of clinician bills is also increasing health care spending. Upcoding is the practice of intentionally charging patients for more expensive services than those actually provided. For example, a provider could charge for a longer office visit than occurred, using CPT code 99214 (which is the CPT code for an established patient visit of more than 30 minutes) instead of 99213 (which is the code for a 20-to-29-minute visit). Frequently, bills received by patients are summaries that do not itemize all the charges. The lack of billing detail, combined with the fact that consumers are generally unfamiliar with medical coding standards, means that upcoding is hard for patients themselves to identify. However, this practice can significantly inflate health care costs.

Emergency departments appear to be a particularly common source of upcoding. Recent research has indicated that about half of increased emergency department spending between 2012 and 2019 can be attributed to higher prices, but upcoding accounted for a large portion of the remainder. In a study of five states using claims data from Blue Cross Blue Shield-affiliated insurers, the authors found that upcoding was the largest contributor

[14] Fair Pricing Act. (2025). https://www.nysenate.gov/legislation/bills/2025/S705.

to price increases in one state and the second largest contributor in three more states.[15] Further, the authors' approach indicates that these findings are unlikely to reflect a reversal of undercoding in prior years, as some hospital advocates have suggested.

One way in which emergency room bills may be upcoded is through the case complexity designation. Typically, emergency rooms assign complexity on a scale of 1 to 5 (with 5 being the most complex). As some consumers have found, itemized bills have at times revealed simple cases (such as suspected bronchitis) coded as level 5 instead of a level 1.[16] Such coding can often lead to substantially higher facility fee charges (over and above any higher clinician claims), depending on hospital billing practices. Even entering a hospital through an emergency room (as instructed) after hours for an uncomplicated live birth can lead to an inflated bill for level 5 emergency department services.[17] Data from multiple sources indicate that the number of emergency department visits coded as level 4 or 5 have increased substantially over the last 20 years.[18, 19] Only a portion of that increase has been shown to be attributable to expectations based on the complexity and severity of the patients receiving care.[20] Beyond service and facility fees, emergency rooms frequently charge "trauma response fees," ostensibly charges for assembling trauma teams to address high complexity cases. However, these fees sometimes are billed to low complexity cases, which can add many thousands of additional dollars to the final bill.[21]

A recent study of five states estimated changes in Medicare Severity Diagnosis-Related Group coding from the 2011-19 period, finding that the highest-coded discharges increased by 41 percent.[22] However, they estimated that if clinicians had not changed their coding behavior over this time period, that increase would have been only 13 percent. The increased use of high-intensity codes increased hospital payments by $14.6 billion over the period, with $5.8 billion of those higher payments coming from private insurance plans and $4.6 billion coming from Medicare.

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[15] Ho, et al. (2023, August). Price Increases Versus Upcoding as Drivers of Emergency Department Spending Increases, 2012-19. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01287.

[16] Kliff, S. (2019, April). How to Fight an Outrageous Medical Bill, Explained. https://www.vox.com/2019/3/22/18261698/how-to-fight-expensive-medical-bill.

[17] Bichell, R. (2021, October). How Billing Turns a Routine Birth into a High-Cost Emergency. https://kffhealthnews.org/news/article/how-billing-turns-a-routine-birth-into-a-high-cost-emergency/

[18] Ho, et al. (2023, August). Price Increases Versus Upcoding as Drivers of Emergency Department Spending Increases, 2012-19). https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01287#:~:text=Each%20state%20registered%20a%20shift,and%20rising%20Elixhauser%20comorbidity%20scores.

[19] Ruxin, et al. (2023, December). Trends by Acuity for Emergency Department Visits and Hospital Admissions in California, 2012 to 2022. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812897.

[20] Janke, et al. (2022, December). Trends in Treat-and-Release Emergency Care Visits with High-Intensity Billing in the US, 2006-19. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00484.

[21] Gold, et al. (2018, July). A Baby was Treated with a Nap and a Bottle of Formula. His Parents Received an $18,000 Bill. https://www.vox.com/2018/6/28/17506232/emergency-room-bill-fees-health-insurance-baby.

[22] Crespin, et al. (2024, December). Upcoding Linked to up to Two-Thirds of Growth in Highest-Intensity Hospital Discharges in 5 States, 2011-2019. https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00596.

A separate study of upcoding in Medicare alone from the Department of Health and Human Services Office of the Inspector General found that hospital stays billed to Medicare at the highest level of severity increased by approximately 20 percent between fiscal years 2014 and 2019, with parallel declines in stays billed at lower severity levels.[23] The researchers also found that a large share of the highest severity admissions had short stays and single diagnoses qualifying for the higher payment level. There was considerable variation in severity level coding across hospitals.

Phantom Billing

Phantom billing refers to the practice of billing for care that a patient never receives. Anecdotal evidence of this type of mistaken or fraudulent billing abounds; however, its frequency is extremely difficult to quantify. The consistently opaque nature of medical billing means the practice has low risk of detection. With most consumer bills structured as summaries of care received and the complex nature of medical coding, it is extremely challenging for patients to detect phantom billing when it occurs. And since insurers receive information on care received directly from clinicians' administrative agents, the carriers also have no ready mechanism for identifying it.

When a consumer does notice a charge that seems, on its face, to be excessive, there are numerous barriers to effective investigation. Itemized bills must be requested, and it is not unusual for hospitals and other health systems to use their own internal billing codes, so frequently consumers must know to request a bill with the more broadly accessible and understood CPT codes.[24] Administrators working for hospitals and large systems may be slow to respond to such straightforward requests, delaying progress for months. And the large number of separate charges may be confusing to those without billing or clinical expertise. Additionally, frequent long delays before any bills are sent can further impair detection of inappropriate charges, as patient memories of detailed services received fade.

Once an inappropriate charge is identified, the patient can challenge the charges with the clinician directly, via the insurer, or through a state consumer protection agency. However, this process can be circuitous and time-consuming. While a challenge proceeds, the clinician administrators are likely to proceed with a collections strategy for the unpaid medical bill—a process that can impact the patient's credit rating in addition to leading to stressful communications from debt collectors.[25]

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[23] Office of Inspector General (2021, February). Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny. https://oig.hhs.gov/oei/reports/OEI-02-18-00380.pdf.

[24] Sable-Smith, B. (2022, October). A Billing Expert Saved Big After Finding an Incorrect Charge in Her Husband's ER Bill. https://kffhealthnews.org/news/article/hospital-emergency-room-billing-error-splint-broken-arm/.

[25] Consumer Financial Protection Bureau. (2024, June). CFPB Proposes to Ban Medical Bills from Credit Reports. https://www.consumerfinance.gov/about-us/newsroom/cfpb-proposes-to-ban-medical-bills-from-credit-reports/#:~:text=Since%20the%20March%202022%20report,which%20medical%20bills%20impact%20a.

Phantom billing practices can sometimes be identified by combining anecdotal patient reports with large and sudden changes in aggregate billing for particular procedures or types of medical equipment. For example, multiple Medicare beneficiaries reported bills for urinary catheters that were never ordered or received.[26] At the same time, catheter payments grew from $153 million in 2021 to $2.1 billion in 2023—alerting stakeholders and regulators to potential widespread fraud.[27] And while the data are more readily available to look at such trends under the Medicare program, the same types of abuses likely are occurring under private insurance as well. There has been limited prosecution of phantom billing[28]—though only a fraction of phantom billing cases are thought to be discovered.

Predatory Debt Collection Practices

As health care markets become increasingly consolidated and prices climb, patients, employers, workers, and their families face increasing exposure to medical debt. Higher prices for medical services translate into higher insurance premiums for consumers as well as higher out-of-pocket costs when they use care. As prices rise, those needing significant amounts of care find that obtaining services becomes ever more unaffordable, making them less likely to be able to pay the full share of their hospital bills.

In recent years, hospitals and health systems (both for profit and nonprofit) appear to have become more aggressive in their collections efforts, placing a growing financial burden on those with health problems and potentially intensifying barriers to necessary care. Meanwhile, the medical debt collection business has grown into a multibillion-dollar industry, estimated at about one-third of total debt collection industry revenue.[29]

An investigation by Kaiser Health News indicates that most US hospitals have collection policies that include legal action (lawsuits, liens on property, garnishing of wages), selling patient accounts to debt buyers, and reporting patients to credit rating agencies.[30] They also found that about 20 percent of hospitals nationwide have policies that deny nonemergency care to patients with existing debt. A large share of hospitals (almost 40 percent) do not disclose their collection practices. Although charity care (providing free or discounted care to those unable

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[26] Blake, S. (2024, April). Medicare Recipients Lose Thousands to 'Phantom Billing' https://www.newsweek.com/seniors-medicare-phantom-billing-scam-fraud-1885736.

[27] Kliff, et al. (2024, February). Staggering Rise in Catheter Bills Suggests Medicare Scam. https://www.nytimes.com/2024/02/09/health/medicare-billing-scam-catheters.html.

[28] United States Attorney's Office (2023, October). Hospitalist Companies Agree to Pay Nearly $4.4 Million to Settle False Claims Act Allegations. https://www.justice.gov/usao-edmi/pr/hospitalist-companies-agree-pay-nearly-44-million-settle-false-claims-act-allegations.

[29] Congressional Research Service. (2025, April) An Overview of Medical Debt: Collection, Credit Reporting, and Related Policy Issues. https://www.congress.gov/crs-product/IF12169.

[30] Levy, N. (2022, December). Investigation: Many US Hospitals Sue Patients for Debts or Threaten Their Credit. https://www.npr.org/sections/health-shots/2022/12/21/1144491711/investigation-many-u-s-hospitals-sue-patients-for-debts-or-threaten-their-credit.

to afford it) is offered at many hospitals, this analysis also highlighted the tremendous difficulty patients face in learning about and applying for that assistance.

Recent examples of such aggressive approaches to medical debt include Allina Health, a large nonprofit health system in Minnesota and Wisconsin. The Allina system implemented a policy that denied all care delivery to anyone with $4,500 or more in medical debt until the debt was completely paid off.[31] The policy was at least temporarily halted in 2023, following a New York Times exposé and the Minnesota attorney general's announcement of an investigation. However, those already denied care were not reinstated. Some of those originally denied included children, people with incomes low enough to qualify for Medicaid or charity care, and chronically ill patients. Similar stories are widespread across the country.[32]

As out-of-pocket costs rise with the growing health care prices, medical debt has become more prevalent among the insured.[33] A recent analysis shows that approximately 8 percent of people insured for the whole year had medical debt in 2021, as did 14 percent of people insured for part of the year.[34] In addition, the same study found that higher levels of medical debt occur among people of color, with 13 percent of non-Hispanic Black people and 10 percent of non-Hispanic people who are non-White, non-Black, and non-Asian holding medical debt, compared to 7 percent of non-Hispanic White and 8 percent of Hispanic people.

Aggressive billing and collections practices are utilized by many hospitals, including nonprofit hospitals and health systems like Allina Health. Nonprofit hospitals receive substantial federal, state, and local tax breaks; however, there are no federal regulations setting minimum charity care spending in return.[35] In fact, studies have indicated that nonprofit hospitals do not provide more charity care as a share of hospital expenses than do for-profit hospitals.[36] One of these studies found that nonprofit hospitals spent $2.3 dollars on charity care for every $100 in total expenses, compared to $3.8 dollars in for-profit hospitals and $4.1 dollars in government hospitals.[37] The other study found no significant difference between nonprofits

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[31] Kliff, et al. (2023, June). This Nonprofit Health System Cuts Off Patients with Medical Debt. https://www.nytimes.com/2023/06/01/business/allina-health-hospital-debt.html.

[32] Silver-Greenberg, et al. (2022, December). Profits Over Patients: They Were Entitled to Free Care. Hospitals Hounded Them to Pay. https://www.nytimes.com/2022/09/24/business/nonprofit-hospitals-poor-patients.html.

[33] Crowe. (2022, August). Hospital Collection Rates for Self-Pay Patient Accounts. https://www.crowe.com/-/media/crowe/llp/widen-media-files-folder/h/hospital-collection-rates-for-self-pay-patient-accounts-report-chc2305-001a.pdf.

[34] Rakshit, et al. (2024, February). The Burden of Medical Debt in the United States. https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/.

[35] Lown Institute (2024, March). Hospital Community Benefit Spending: Improving Transparency and Accountability Around Standards for Tax-Exempt Hospitals. https://lownhospitalsindex.org/wp-content/uploads/2024/03/lown-institute-fair-share-policy-brief-20240321.pdf.

[36] Bruch, et al. (2021, September). Charity Care: Do Nonprofit Hospitals Give More than For-Profit Hospitals? https://pmc.ncbi.nlm.nih.gov/articles/PMC8481424/.

[37] Bai, et al. (2021, April). Analysis Suggests Government and Nonprofit Hospitals' Charity Care is Not Aligned with Their Favorable Tax Treatment. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01627.

and for-profits.

Nonprofit hospitals and health systems are subject to community benefit requirements, which include charity care and limits on extraordinary collections efforts. However, a recent review of federal regulations related to community benefit reveals that these rules are both vague and rarely enforced.[38] For example, the federal government has not revoked the nonprofit status of a hospital for insufficient provision of charity care in the last 10 years, despite the enormous variation in the provision of community benefits required for tax exempt status.[39] Consequently, there has been little in the way of ramifications for health systems minimizing community benefit responsibilities while aggressively pursuing debt collection from financially strapped patients facing ever-climbing health care prices.

Policy Options Are Available to Reduce Abusive Practices

While addressing these issues is challenging, an array of policy strategies exist that can reduce the use of abusive practices while increasing the information available to consumers, policymakers, and regulators. These options include, but are not limited to:

- Requiring **site-of-service billing transparency** so that purchasers may easily identify whether a claim is associated with care provided in a hospital, an ambulatory surgery center, or a physician's office setting. Currently, site-of-service is frequently masked by use of a single hospital's National Provider Identifier (NPI) on all claims for services provided in any system-owned site.[40] Implementation and enforcement of unique identifiers for each clinician and site-of-service is an important first step in billing practice oversight.
- Banning outpatient **facility fees** for public and private payers, at least for a set of services commonly and safely provided in physician offices, such as those delineated by MedPAC.[41]
- Aligning payment rates across different sites of services, often referred to as "**site-neutral payments.**" This approach can most readily be implemented in the Medicare program because CMS has administrative authority to do so and

[38] The Commonwealth Fund. (2023, September). State Protections Against Medical Debt: A Look at Policies Across the U.S. https://www.commonwealthfund.org/publications/fund-reports/2023/sep/state-protections-medical-debt-policies-across-us.

[39] Government Accountability Office. (2023, April). IRS Oversight of Hospitals' Tax-Exempt Status. https://www.gao.gov/assets/gao-23-106777.pdf#page=10.

[40] Monahan, et al. (2023, July). Protecting Patients from Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform. https://georgetown.app.box.com/v/statefacilityfeereport.

[41] Medicare Payment Advisory Commission. (2023, June). Aligning Fee-for-Service Payment Rates Across Ambulatory Settings. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf.

service prices are already regulated by the federal government.[42] In fact, there are existing federal legislative efforts to enact comprehensive site-neutral reforms in the Medicare program. However, the policy could also have significant advantages for the privately-insured, particularly if some form of price limits were implemented at the same time.[43]

- Improving **ownership transparency** by requiring the disclosure of individuals or entities that have an ownership stake in health care providers. Such transparency would allow policymakers and researchers to better understand and assess the impact of emerging forms of consolidation that often entail more complex and opaque ownership relationships.
- Implementing policies that **limit consolidation**, including eliminating or significantly lowering the financial threshold of acquisitions that trigger federal antitrust oversight review.[44]
- Strengthening **enforcement of nonprofit hospital community benefit requirements**, including the provision of charity care and limits on aggressive debt collection practices.

No single policy will eliminate all abusive billing practices used by many large, consolidated hospitals and health systems. However, these policy options are important steps in limiting the impact of aggressive billing practices on consumers, advancing transparency, and reducing health care costs for patients, consumers, employers, and taxpayers.

[42] Fierce Healthcare. (2021, June). Supreme Court Declines to Hear AHA's Appeal of Site-Neutral Payments Decision. https://www.fiercehealthcare.com/hospitals/supreme-court-declines-to-hear-aha-s-appeal-site-neutral-payments-decision.

[43] Committee for a Responsible Budget (2023, February). Moving to Site Neutrality in Commercial Insurance Payments. https://www.crfb.org/papers/moving-site-neutrality-commercial-insurance.

[44] Fuse Brown, et al. (2021, April). Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions. https://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-14.pdf.