December 2025

MODEL POLICY | Center for a Healthy America

PROTECT PATIENTS FROM DISHONEST BILLING ACT

PURPOSE OF THIS ACT

- Many patients are burdened by dishonest medical bills when a physician office within a hospital system falsely claims to be a hospital to charge them higher prices.
- The Protect Patients from Dishonest Billing Act prohibits hospital-owned off-campus physician practices from charging patients hospital facility fees and requires hospital-owned facilities to disclose the location of where patients received health services. By passing this model legislation, states can protect patients from dishonest medical bills.
- The Protect Patients from Dishonest Billing Act is modeled after legislation that was introduced at the National Council of Insurance Legislators in April 2025.

Section 1. Purpose

The purpose of this Act is to prohibit hospital-owned physician offices from imposing facility fees for evaluation and management (E/M) services and to require hospital-owned facilities to accurately bill for services. Such reforms will address escalating healthcare costs and improve the affordability of healthcare benefits for consumers.

Drafting Note: States may consider including this Act in the State's Public Health, Health and Safety, or Health Care Code section, or its Commercial or Consumer Affairs Code section. States may also consider placing the prohibition, billing, and reporting requirements of the Act in a health-related code section while making violations of the Act an unfair trade practice under the State's unfair trade practices provision. States should consider existing statutes that provide sufficient authority to promulgate the provisions of this Act in a regulation format and provide sufficient enforcement authority.

Section 2: Facility Fees

A. Definitions. For purposes of this [section 2]:

Drafting Note: States should review existing authority and align these definitions with other state-specific definitions, as appropriate, including Commissioner, Director, or Superintendent.

(1) "Affiliated with" means:

(a) employed by a hospital or health system; or

(b) under a professional services agreement, faculty agreement, or management agreement with a hospital or health system that permits the hospital or health system to bill on behalf of the affiliated entity.

(2) "Campus" has the meaning set forth in section 413.65(a)(2) of title 42 of the Code of Federal Regulations (or successor regulations).

Drafting Note: Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus. 42 CFR 413.65(a)(2). States should review existing state definitions of campus that should be used.

(3) "Facility fee" means any fee a hospital, healthcare facility, or health system charges or bills for outpatient hospital, healthcare facility, or health system services that is:

(a) intended to compensate the hospital, healthcare facility, or health system for its operational expenses; and

(b) separate and distinct from fees charged or billed by a healthcare facility for healthcare services.

(4) "Healthcare facility" has the meaning set forth in [state code] and includes hospitals and [entities that are separately licensed].

(5) "Healthcare provider" means any person, group, professional corporation, or other organization that is licensed or otherwise authorized in this state to furnish a healthcare service or provides the services of such individuals, groups, corporations, or organization, including but not limited to a medical clinic, a medical group, a home health care agency, a health infusion center, an urgent care center, and an emergent care center.

(6) "Healthcare services" means healthcare related items, services or products rendered or furnished by a provider within the scope of the provider's license, [certification], or legal authorization for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. The term includes, but is not limited to, durable medical equipment, infusion, imaging, hospital, medical, surgical, and pharmaceutical services or products.

(7) "Health system" has the meaning set forth in [state code].

(8) "Hospital" means a hospital currently licensed [or certified] under [state code].

(9) "Off-campus location" means any location that is not located:

(a) on the campus as defined in this section; or
(b) within the distance described in such definition of campus.

(10) "Outpatient hospital services" means any healthcare services that are furnished by a healthcare provider affiliated with or owned by a hospital, healthcare facility or health system and are furnished without an overnight stay at a hospital, healthcare facility or health system.

(11) "Physician practice" means a fixed medical facility, or a portion of a fixed medical facility that:

(a) is staffed by a physician;
(b) provides healthcare services to an individual who presents at, or is transported to, the facility;
(c) is not an ambulatory surgical facility, a clinical laboratory, a hospital, or a hospital emergency department.

Drafting Note: To define "physician practice," a state may consider referencing CMS's definition of "physician organization" as that term is described in 42 C.F.R. § 411.351.

B. Prohibition on facility fees:

Drafting Note: A state should use the state-specific term for a health insurance issuer and a group health plan. Consider including "as defined in [state code]" as necessary.

A healthcare provider, healthcare facility, or health system shall not charge, bill, or collect a facility fee from a patient, [insurer/carrier], or [health benefit plan] for outpatient services billed using evaluation and management (E/M) Current Procedural Terminology (CPT) codes if such services are provided in an off-campus location that is solely a physician practice. This subsection shall not apply to outpatient services billed using evaluation and management (E/M) Current Procedural Terminology (CPT) codes if such services are provided in an off-campus location that is not a physician practice.

(1) A healthcare provider, healthcare facility, or health system shall not charge, bill, or collect a facility fee from a patient, [insurer/carrier], or [health benefit plan] for outpatient services billed using evaluation and management (E/M) CPT codes when such services are provided via real- time audio and/or visual interactive telecommunications [or appropriate state code reference to telehealth services.]

Drafting Note: A state may consider referencing Medicare for telehealth; e.g., telehealth as that term is described in section 1834(m) of the Social Security Act of 1934.

C. Transparency on facility fees

(1) A healthcare provider affiliated with or owned by a hospital or health system that charges a facility fee that is not prohibited by subsection (B) shall:

(a) provide notice in plain language to patients that a facility fee may be charged, indicate in the notice the range of the facility fees that could be charged, and require the healthcare provider to provide the notice to a patient at the time an appointment is scheduled and again at the time the healthcare services are rendered;

(b) provide notice of [any state required billing grievance process] and [any free/reduced cost care programs available];

(c) provide notice of the fee waiver process described in paragraph (C)(5); and

(d) post a sign, in English, that is plainly visible and located in the area within the facility where an individual seeking care registers or checks in, that states that the patient may be charged a facility fee in addition to the cost of the healthcare service. The sign must also include a location within the facility where a patient may inquire about facility fees, an online location where information about facility fees may be found, and a toll-free phone number that the patient may call to inquire about facility fees.

(e) Provide to a patient a standardized bill that:

(I) includes itemized charges for each healthcare service;
(II) specifically identifies any facility fee;
(III)identifies specific charges that have been billed to insurance or other payer types for healthcare services; and
(IV)includes contact information for filing an appeal with the healthcare provider to contest charges.

(2) The healthcare provider shall provide the required notice and standardized bill in a clear manner and, to the extent practicable, in the patient's preferred language.

(3) A healthcare facility that is newly affiliated with or owned by a hospital or health system on or after [date], shall provide written notice to each patient receiving services from such facility. In addition, the healthcare facility must provide the notice to any patient that received services from the healthcare facility in the past 12 months. The notice must include:

(a) the name, business address, and phone number of the hospital or health system that is the purchaser of the facility or with whom the facility is affiliated;

(b) a statement that, beginning on or after the date of the acquisition or affiliation, the facility bills, or is likely to bill, patients a facility fee that may be in addition to and separate from any professional fee billed by a healthcare provider at the facility;

(c) a statement that the healthcare facility cannot impose, or attempt to hold the patient liable for, any facility fee prior to the date of the acquisition or affiliation with the hospital or health system that is the purchaser of the facility or

with whom the facility is affiliated; and

(d) a statement that prior to seeking services at the facility, a patient covered by a [health insurance policy or health benefit plan] should contact the patient's [health insurer or plan] for additional information regarding the facility's facility fees, including the patient's potential financial liability, if any, for the facility fees.

Drafting Note: States should conform health insurance policy and health benefit plan to state's defined terms.

(4) A hospital, healthcare facility, or health system shall not collect a facility fee for healthcare services provided by a healthcare provider affiliated with or owned by a hospital or health system that is subject to any provisions of this section from the date of the transaction until at least thirty days after the written notice required pursuant to subsection (C)(3) of this section is mailed to the patient.

(5) Facility Fee Waiver Process. Each hospital, healthcare facility, and health system shall create a process by which patients may receive a waiver from, or reduced cost for, any facility fee charged to that patient that is not prohibited by subsection (B). Such process shall provide a minimum of 30 days for a patient to request a waiver or reduced fee, shall be provided in the patient's preferred language, and with any auxiliary aids necessary to ensure that the patient is able to fully access the waiver process. The [Department/Commission] shall issue rules implementing this waiver process, along with best practices and a model process, within [X days/weeks/months] of the passage of this [provision / Act].

D. Annual Reporting:

(1) Each hospital, healthcare facility, and health system shall submit a report annually to [the Department/Commission] concerning facility fees charged or billed during the preceding calendar year. The report shall be in such format as [Department/Commission] may specify. The 6 [Department/Commission] shall publish the information reported on publicly accessible website designated by the [Department/Commission].

Drafting Note: States should consider the appropriate state agency with the authority to oversee this requirement.

(2) Reporting Requirements. Such report shall include, without limitation, the following information:

(a) The name and full address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed;

(b) The number of patient visits at each such hospital-based facility for which a facility fee was charged or billed;

(c) The number of patient waiver requests, with the number approved, the number denied, and the average amount and percentage of fee waived;

(d) The number of patient appeals as described in Section (C)(1)(e)(iv) of this act, with the number approved and the number denied;

(e) The number, total amount, and range of allowable facility fees paid at each such facility by Medicare, Medicaid, private insurance, and by individuals;

(f) For each hospital-based facility and for the hospital or health system as a whole, the total amount billed and the total revenue received from facility fees;

(g) The top ten procedures or services, identified by current procedural terminology (CPT) category I codes, provided by the hospital or health system overall that generated the greatest amount of facility fee gross revenue, the volume each of these ten procedures or services and gross and net revenue totals, for each such procedure or service, and, for each such procedure or service, the total net amount of revenue received by the hospital or health system derived from facility fees;

(h) The top 10 procedures or services, identified by current procedural terminology (CPT) category I codes, based on patient volume, provided by the hospital or health system overall for which facility fees are billed or charged [based on patient volume], including the gross and net revenue totals received for each such procedure or service; and (i) Any other information related to facility fees that the [Department/Commission] may require.

Section 3. Honest Billing

A. Applicability. This [section 3] applies to all healthcare facilities, including but not limited to hospitals, and includes the ultimate parent company of a health system, and all health carriers licensed in this State.

B. Definitions. As used in this [section 3]:

Drafting Note: States should modify to include definitions or cross-references with state law, as appropriate. Note that the definitions of healthcare facility, healthcare services, health system, and off-campus location, are intended to be the same as under the facility fee section. If both provisions are adopted in the same act, the definition sections for facility fees and honest billing may be merged and overlapping definitions omitted.

(1) "Campus" has the meaning set forth in section 413.65(a)(2) of title 42 of the Code of Federal Regulations (or successor regulations).

Drafting Note: Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus. 42 CFR 413.65(a)(2). States should review existing state definitions of campus that should be used. States should review existing state definitions of campus that should be used.

(2) "Covered person" means a policyholder, subscriber, enrollee or other individual, including a dependent of the policyholder or subscriber, participating in a health benefit plan [as defined in the state's code], including Multiple Employer Welfare Arrangements (MEWAs) but excluding limited benefit health plans, accident or indemnity plans, excepted benefit dental and vision plans, and short-term limited duration health plans.

Drafting Note: States should consider excluding, by reference to state law, all HIPAA "excepted benefits" from "health benefit plan" for purposes of this Section.

(3) "Healthcare facility" has the meaning set forth in [state code] and includes hospitals and [entities that are separately licensed].

(4) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health

maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

Drafting Note: A state should consider cross-referencing the appropriate definition of "health carrier" or "insurer" here and, if changed here, should make the same change throughout the provision. States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

(5) "Healthcare services" means healthcare related items, products, or services rendered or furnished by a provider within the scope of the provider's license, [certification], or legal authorization for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease. The term includes, without limitation, durable medical equipment, infusion, imaging, hospital, medical, surgical, and pharmaceutical services or products. For purposes of this section, the amount of any bill submitted to a health carrier with the expectation of payment (in whole or in part) is considered to be a bill for "healthcare services."

(6) "Health system" has the meaning set forth in [state code].

(7) "National Provider Identifier" or "NPI" means the standard, unique health identifier for health care providers that is issued by the National Plan and Provider Enumeration System in accordance with title 45, Part 162 of the Code of Federal Regulations.

(8) "Off-campus location" means any location that is not located: (a) on the campus as defined in this section; or (b) within the distance described in such definition of campus.

C. National Provider Identifier. Irrespective of 42 CFR section 162.410(a)(1), each off-campus location of a healthcare facility must apply for, obtain, and use, on all claims filed after [date] for reimbursement or payment for healthcare items or services provided in that off-campus location, a unique NPI that is distinct from the NPI used by the campus of the facility and any other off-campus location of the facility.

D. Billing Requirements.

(1) A healthcare facility subject to this [section 3], with respect to healthcare services furnished to a covered person at an off-campus location, shall submit a claim for such healthcare services to a health carrier, and may not hold the covered person

liable for such healthcare services, unless those healthcare services are billed:

(a) using the separate unique NPI established for such off-campus location; and

(b) on a U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) 1500 form or its successor form, or a Health Insurance Portability and Accountability Act (HIPAA) X12 837P standard electronic claims transaction (or a successor transaction or form).

(2) A health carrier is not responsible to reimburse claims for healthcare items and services furnished to a covered person at an off-campus location if claims are not billed pursuant to this subsection.

(3) A covered person, with respect to healthcare services at an off-campus location furnished by a healthcare facility subject to this [section 3] and billed in compliance with this subsection, shall 9 be responsible for paying only the cost-sharing required by their health benefit plan. A covered person is not responsible for and may not be held liable by such healthcare facility to pay amounts in addition to the cost-sharing required by their health carrier.

E. Revalidation. A healthcare facility, healthcare provider, or other entity applying for revalidation as a healthcare provider under [state law] shall demonstrate that it has obtained one or more NPIs as required by this section as a condition of receiving revalidation, and upon receiving revalidation, shall use its unique NPI on every claim for payment in the manner required by this Act.

Drafting Note: A state should use the appropriate terminology in its laws or regulations (e.g., re-certification, approval, licensure, etc.) The intent is to require that a facility demonstrate its compliance with this Act as a condition to continue to provide services in the state.

F. Hold Harmless. Any healthcare facility or its designee that does not bill for professional healthcare items or services rendered to a covered person at an off-campus location as required by this Act may not hold the covered person liable to pay for such healthcare items and services. A violation of this section constitutes a violation of the [state's consumer protection act] subject to enforcement by the attorney general.

Section 4. Regulatory Authorization.

The [appropriate state entity] shall promulgate regulations necessary to implement this

Act, specify the format and content of reports, and impose penalties for noncompliance.

Section 5: Enforcement Mechanisms.

Drafting Note: A state should ensure that enforcement authority is clearly vested and harmonized with any grant of regulatory oversight or investigative authority. Enforcement mechanisms may include vesting enforcement authority with the state's Attorney General in addition to, or in lieu of, the Departmental authority outlined below. Similarly, a state may grant general authority to refer to the [appropriate state agency regulating healthcare systems] any entity violating this Act.

A. Any violation of any provision of this Act shall constitute an unfair trade practice pursuant to [section for state unfair trade practices statute].

B. The [Department/Commission] shall, after [any applicable state requirement for notice and hearing], impose any or all of the following, separately or in combination, on any healthcare provider or healthcare facility violating any of the provisions of this Act:

(1) an administrative penalty of not less than $1,000 per occurrence;

(2) probationary status, suspension, revocation, or denial of the issuance of, or renewal of, professional licensure or [a Certificate of Public Authority or similar certificate];

(3) conditional issuance of, or renewal of, [state required license, certificate, etc.];

(4) require increased cost-reduction benchmarks under [state cost benchmarking law];

(5) referral to the attorney general for investigation.

C. The [Department/Commission] may audit any healthcare facility or healthcare provider for compliance with the requirements of this Act. Until the expiration of [four (4)] years after the furnishing of any services for which a facility fee was charged, billed, or collected, each health care provider shall make available, upon written request of the [Department/Commission], copies of any books, documents, records, or data that are necessary for the purposes of completing the audit.

D. The [Department/Commission] shall recover from any healthcare facility or healthcare provider reasonable investigative fees and costs incurred if a violation of this Act is found through inquiry, investigation, or audit.

E. The [Department/Commission] shall publish the results of all audits conducted under this section and shall require any healthcare facility or healthcare provider that is found to be in violation of any provision of this Act to publish on the main page of its public website an account, including the amount of any penalties, conditions on licensure or any other penalty, regarding its violation and the steps it has taken to correct its violation.

Section 6. Severability.

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 7. Effective Date.

This Act shall be effective for healthcare claims submitted on or after [insert date].