Doctors' offices are charging patients 10 times more by claiming to be hospitals

Even when patients never step into a hospital, they may be charged hospital "facility fees," and their care may be billed at higher rates.

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As U.S. hospitals buy up a growing portion of the doctors' offices in the United States, patients are paying a steep cost: Routine medical care is often being billed at the much more expensive rate for hospital care, instead of the lower cost for procedures in a doctor's office.

The higher rates along with hospital "facility fees" — tacked on even when patients never step into a hospital — can lead to bills 10 times costlier or more, according to research on patients' bills.

"The numbers are staggeringly large," said Blue Cross Blue Shield Association CEO Kim Keck, citing her organization's estimate that hospitals would bill $500 billion less over the next decade if they were federally banned from charging higher rates for the same service offered through a hospital system rather than an independent physician's office.

Doctor's offices tend to say there is nothing they can do. It's the hospital systems they are part of that charge hospital rates to insurance companies and therefore to patients.

Hospital systems, meanwhile, justify higher rates for doctor's office procedures by saying the charges are necessary to subsidize the enormously complex round-the-clock care that happens at their hospitals. Limiting their ability to charge those fees would undermine their overall finances, potentially leading to reductions in services, they said.

Insurers and lawmakers are looking into ways to curb the practice of charging hospital rates for routine care or tacking on hospital facility fees for care that was not in hospitals. But it's been going on for years with little progress made to stop it, and it is only getting more common as hospitals acquire more medical practices, now consolidating nearly half of all physicians in the U.S. into hospital systems, up from less than 30 percent in 2012.

Keck, who runs the umbrella organization for insurance companies that collectively cover more than 1 in 3 Americans, said insurers have a hard time detecting when hospitals are overcharging for procedures that actually took place in doctors' offices, meaning in most cases the insurer and the patient simply pay the higher bill without a fight. "The recourse is not really obvious," she said. "We as payers don't know where the service was provided, because the bill we get looks like you were in a hospital."

David Merritt, a Blue Cross Blue Shield vice president focused on federal policy, said patients, too, tend to have few options to avoid the fees. "There certainly is no federal protection or even state protection as far as I know," Merritt said. A patient might try to lodge a complaint. But usually the doctor's office won't budge, and the patient has no choice but to pay the bill.

Sometimes, the only recourse is to change providers.

That's what retired lawyer Craig Barbarosh did after he was billed $605.63 for a routine cardiology visit in January with a doctoraffiliated with University of California at Irvine's hospital system.

Barbarosh, who has served on the boards of multiple health care companies, switched to a doctor not employed by a hospital. For an appointment last month for the same care, he was charged a $60 co-pay. "I am not going to pay a hospital facility fee and 10 times more out of pocket for routine visits when there are plenty of highly qualified independent physicians," he said.

UCI Health confirmed in an email to The Washington Post that it does charge hospital fees at some of its outpatient clinics. "Hospital facility charges apply to these clinics because they operate as departments of a UCI Health hospital, even when located outside the physical hospital," the statement said.

"As hospital outpatient departments, these locations are subject to applicable hospital regulatory, safety and operational requirements," the email continued. "A facility charge covers the clinic's physical space, administrative support, equipment, and access to a health system's broader network."
The nonprofit Health Care Cost Institute looked at 57 proceduresthat can be performed in both doctors' offices and hospital outpatient settings, and it found that providers charged more for every one of them if they said the procedure happened in a hospital, as of 2022.

Certain nerve block injections, for instance, were given in doctors' offices about 60 percent of the time, at an average cost of $282. When providers billed those same injections claiming that they happened in hospital outpatient settings, they charged $1,530 for the same care.

Putting a cast on a broken bone cost an average of $83 in a doctor's office. In the three out of 10 instances where the provider billed it as an outpatient procedure, it cost on average $405.

More than 60 percent of radiation treatments were billed as outpatient care, at an average cost of $1,017, compared with $218 in a doctor's office.
As consolidation increases in the U.S. medical system, pushing more routine patients into hospital system care, these outpatient costs are going up.
In a paper filled with examples of diverging costs for the same procedures, Blue Cross Blue Shield research found that outpatient charges went up 27 percent between 2017 and 2022, compared with 2 percent for doctors' offices.

Both insurers and lawmakers have taken modest steps to address these diverging costs.

Elevance Health, a large insurer that runs Anthem commercial plans in 14 states as well as Amerigroup Medicaid and Medicare plans, announced last month that it will soon require hospitals to state the physical location where care was provided so the insurer can avoid paying hospital fees for nonhospital care.

"If you're at a hospital campus, there's just more overhead, as far as rates that make sense for them to be doing business. It's different from far down the street at a strip mall," Elevance Vice President Cynthia Pols said in an interview.

Every health care provider has an identification code for billing. Some large hospital systems use the same code for the entire system, while others use many codes. Hospital systems commonly use the hospital address as the location of care on every bill they submit, even if the care didn't happen at the hospital.

A new federal law will require a separate code in some cases for off-site locations, starting in 2028. Experts aren't sure how much of an effect the new coding will have, but it's a step toward giving insurers some transparency into where the care actually took place.

Unlike private insurers, Medicare — one of the largest payers in the U.S. health care system — has rules against paying different rates to hospitals and independent doctors for certain procedures. Advocates have called for expanding those rules to more procedures.

One study found that applying Medicare rules to commercial insurers too, which Congress could do, would save employer-sponsored insurance plans more $847 billion over a decade, thereby bringing premiums about 5 percent lower than they would be without such a rule. But legislative proposals to make that a reality have gone nowhere.

Georgetown University's Center on Health Insurance Reforms has tracked nine states with laws to limit the fees.

Connecticut, Maryland, Mississippi, Ohio and Washington ban doctors in most cases from charging a hospital facility fee for telehealth visits, when the patient never sets foot in any facility at all. Texas prohibits the fees for drive-through services such as vaccines, and New York bans them for preventative care.

Indiana and Ohio ban some doctors' offices not located at hospitals from charging the fees. Maine and Connecticut go the furthest, banning the fees for most routine office care.

The American Hospital Association, which fiercely opposes legislative efforts to block facility fees, said outpatient facilities charge more for the same procedure because they tend to treat sicker patients compared with nonaffiliated doctors, and they adhere to higher safety standards.

Jason Kleinman, the hospital lobby's director of federal relations, gave as an example a hospital-affiliated clinic charging more to administer a drug. "The drug itself might be the same exact drug, but everything that goes into making sure the office is set up safely, that the drug is prepared safely … — if I'm a patient, I want to make sure I'm being treated with the safest conditions," he said. He warned that hospitals would have to consider cutting money-losing services, like burn units and behavioral health in certain regions, if restrictions on facility fees cut into their overall profits. "You can't keep providing the same level of care with less resources," he added.

Research has generally not found that consolidating medical practices into hospital systems improves the quality of patient care, though it has been shown to increase costs.

Jessie and Michael Francis, who live in Pasadena, Maryland, have had a slew of unexpected medical bills this year. First, Michael went to the emergency room in January, worried he had a kidney stone. In the spring, their daughter needed ear tubes and their son a tonsillectomy. They were already overwhelmed by the bills when Jessie needed a hysterectomy this month.

She had to do a test before her surgery at Anne Arundel Medical Center to make sure she could tolerate the anesthesia, and the only option that was in-network for her insurance plan was a medical office building in the same large complex as the hospital itself. The doctor warned her that there might be a facility fee for visiting the building. She shared paperwork with The Post showing that the doctor's office said the hospital facility fee would be somewhere between $95 and $210. The hospital did not respond to questions from The Post.

"I felt trapped by that, but I couldn't afford to pay however much it would be out of network," she said on the day after her surgery as she recovered at home, still wincing each time she coughed.

She's waiting to see how much she'll be billed. Her doctor advised her to take six weeks off of work, but as a therapist, she loses income every day she's not working. She decided she couldn't afford to take longer than a week.

"There's a lot of fear. A lot of stress. A sword of Damocles feeling," Michael said, about the bills hanging over them.

Michelle Fishman-Cross, a now-retired history professor in New York City, went to New York University Langone's Perlmutter Cancer Center, a building that houses oncology offices and is not a hospital, for a routine follow-up visit with her oncologist after completing breast cancer treatment. At the time, her insurance co-pay for specialist visits was under $60, so she was confused to receive a bill for $465. She shared with The Post the messages that she exchanged with NYU Langone's billing department, in which the staff said she was charged for hospital care, even though she argued that she had never been in a hospital.

In response to questions from The Post, NYU Langone said in an email, "Certain outpatient locations that provide more advanced specialty services, such as cardiac and cancer care, are classified as hospital outpatient settings … because the level of resources and staff there is more consistent with a hospital setting."

After the unexpected bill, Fishman-Cross canceled her next follow-up appointment. "I didn't go after that. I refused. I had to find a different oncologist," she said.

Recently, she learned that her new oncologist's office was purchased by NYU Langone.

"Now when you go in, they give you the warning that your insurance might not cover our office fee," Fishman-Cross said.

She said she hasn't seen an NYU Langone hospital facility charge appear on her bill yet. But she has to see her doctor four times a year, and she's bracing for the fee coming back. She doesn't think she can switch doctors again. "At this point, I would have no choice," she said.