Statewide Chargemaster: The Necessary Policy Reform to Better Healthcare Costs

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Abstract

Four different published articles are explored in the context of their support of revising healthcare expenses. These articles agree that healthcare costs are egregious and the hospital chargemaster is in forefront of these expenses. The average hospital chargemaster has been deceiving patients without their knowledge for years while leaving Americans in tremendous debt. This paper examines the need for a policy reform in the realm of hospital chargemasters to make healthcare costs affordable for all Americans.

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As most Americans know, healthcare costs have become outrageous. So much so, that the government was forced to explore new policy and develop "ObamaCare" in an effort to cut expenses and make affordable healthcare available to all Americans. America knows that healthcare is expensive, but most people do not know why it is so unreasonable. Patients surrender to the concept that it is exceedingly expensive and elect to obtain coverage. Or simply, opt out of coverage because they feel the risk of not having insurance is a better gamble then throwing away a large percentage of their monthly income on healthcare coverage. But the underlying question that needs to be addressed is, "Why is healthcare so expensive?"

The issue can begin to be tackled in the chargemaster of hospitals nationwide. What is a hospital chargemaster? It is a conduit by which all charges for services are billed to the patient (Wolf, 2006). Or simply, a way for hospitals to charge for the services they provide. However, the majority of Americans do not understand the scope of a chargemaster, nor comprehend healthcare costs to understand the details of appropriate expenses. As identified in the article "Bitter Pill: Why Medical Bills Are Killing Us" by Steven Brill, the chargemasters for hospitals on a national scale have become unruly. Patients are being expensed triple to four times the raw cost of supplies and procedures to help increase revenue for the hospitals. Countless hospitals are not getting the adequate funding from Medicare/Medicaid; thus, they are forced to compensate for these losses by inflating prices of the chargemaster (Brill, 2013). According to Stodolak (2008), "With many hospitals experiencing reimbursement shortfalls, some optimized their chargemaster prices to subsidize such losses and help

maintain their financial viability. Unfortunately, those techniques have caused individual chargemaster line item prices to become irrational and indefensible (p. 102)."

This raises the question, "How do hospitals get away with this embezzlement?" Stodolak (2008) conducted a study and found that hospitals across the country increased higher-than-average payer contribution items by twenty percent and then decreased the lower-than-average items by twenty percent (p. 102). This resulted in no overall increase in gross revenue but a favorable increase in net revenue, as much as 8.4 percent (Stodolak, 2008, p. 102). In other words, hospitals billed more for expensive items and reduced their costs for the inexpensive items to increase their profit margins overall to counteract the difference of not getting compensated by patients that are unable to pay their bills.

Hospitals argue that they have to inflate chargemaster items to make amends for losses in reimbursement, especially from Medicare/Medicaid. Moreover, it's contended that most patients without insurance will never be able to pay these costs; therefore, inflating prices would yield some chance of reimbursement (Stodolak, 2008). This will have a negative impact on the future for all parties. Hospitals are not profiting as much as they should, which in turn leads to hiring freezes and low compensation for employees. The government is affected by forfeiting outrageous healthcare costs that drive up taxes and increase national debt. Middle and lower class Americans are suffering financially by outrageous bills and/or abominable monthly insurance premiums.

A call for reform is imperative. The government hopes to cut healthcare costs with the Affordable Care Act, but there is no certainty that it will be enough. Statewide

hospital chargemasters need to be developed, which is a major departure from existing policy.

State level administration should develop individual chargemasters that reflect the state's costs of living in which all hospitals would be mandated to follow. These should be managed by state government instead of the federal government to allow each state to establish their chargemaster. Line item expenses would consider cost of living and the costs of medical equipment/supplies in their state. The federal government will oversee that these states are making hospitals follow the new chargemaster, but ultimately the state officials would be the responsible party.

One particular subject that will be drawn for explanation is regarding the process of this reform. The restructuring would have to begin from the ground level, a complete and total revision. Each state would have to decide what rational prices are for every item, including care delivery time. Every state's cost of living is different. Items in Alabama do not cost the same as items in New Jersey; for example, the price of gas. The variations in prices would need to be considered and rational prices would need to be developed. The best way to enforce this is, "to determine the rationality of prices within your chargemaster, ask yourself if you can explain to a consumer how an individual price was derived. Moreover, can you demonstrate to that same consumer how that price makes sense in relation to other items in the chargemaster?" (Stodolak, 2008, p. 103)

State level officials need to sit down with the hospital administrator representative from each hospital to determine the cost of these items. Before this meeting would take place, the head of each department of the hospital would have to meet and determine a rational price for care delivery time. They will rank a procedure one through five and

then decide how much they should charge per hour. All parties in each department, including nurses and physicians, would need to be involved to contribute their opinions and recommendations to how care delivery time would be weighted. This would be an example of upward power dynamics, meaning the subordinates would influence what the leaders of each department should propose to the hospital representative to present to state officials.

By studying a hip replacement surgery, the team would need to determine how much they should charge the patient for the services of the operating room team including: surgeons, anesthesia personnel, nurses, technicians, and the physical room. The actual cost of time spent will also be evaluated. Should they charge a set amount of time every 30 minutes, every hour? Once the head of each hospital department defined these costs, the leaders would meet with the hospital representative and review their conclusions. The hospital representative would meet with the state level official and the representatives from each state hospital. Finally, the cost of living in each state would come into play. They would outline the costs for supplies, how much they cost in that particular state and decide what they should bill for procedures and care delivery time by averaging the conclusions of what each hospital representative proposed. This would require the leaders to scrutinize every individual cost to make the "statewide" chargemaster. It would be a lengthy and arduous task and would need updating periodically to reflect inflation of supply rates.

Not only would patients benefit from more rationalized prices, the federal and state government would as well. Patients will actually be able to afford their care and pay their healthcare bills. This would lead to more revenue for the hospitals due to full and

timely compensation for their services. According to Emily Davidson (n.d.), over 45 million Americans, 15% of the population, do not have health insurance. Of those 45 million people, nearly half have outstanding medical debts averaging $9,000 per person. Even the insured population is experiencing medical debt, with 75% of the people who filed for bankruptcy due to medical debt (Davidson, n.d.). With these staggering statistics, reasonable medical bills would alleviate most of these problems. Patients would have higher probability of paying back rational bills. For instance, a person may be suited to pay a bill of $2,000 compared to $50,000; subsequently, generating more profit for the hospitals due to the affordability of these bills.

Medicare/Medicaid costs would improve because each program would no longer have to produce as much funding to cover for unnecessary expenses. This would improve the funding for these programs at a federal and state level and ultimately fuel the funding for the expansion of Medicare/Medicaid that is bound to happen with the Affordable Care Act. As outlined in "Super Standardization: One Health System, One Chargemaster," hospitals would gain many benefits from a standardized chargemaster including: improved charge capture or the elimination of missing charges because each manager of that respective department would be more in tune with the charges and overlook details that should be charged, reduced risk of payer audits/penalties because it would clear each hospital's chargemaster of noncompliant charges that would trigger audits, and increased confidence in publishing the chargemaster which would enable the public to see the chargemaster and make sure expenses are appropriate and consistent with the new state level chargemaster (Barton & Bieker, 2007, p. 75, 76, 78).

This policy reform is an example of punctuated equilibrium. Chargemasters

have been stagnant for such time that most hospitals do not make an effort to update or revise. For the majority of the time, they are not even used as a foundation for pricing; however, the new proposal of this reform would take on dramatic change. The dated chargemasters would be eliminated and the new ones would be uniform and made public. This will create a huge adjustment period for the hospitals, especially within their finance department. The concern for reaching profit goals would be overwhelming at first. But after the initial shock and adjustment period, it would be expected that these hospitals would benefit from higher patient compensation. It is not necessarily critical to "win" over the hospital stakeholders, but if the benefits of this policy are clearly communicated and the founding reason of more sustainable healthcare costs for the general public is of conscious, then they would be more open to accept the policy. The reform should not change their revenue, if anything create improvements. The essential group to capture is the officials, especially at the state level. The government needs to understand the importance of this reform because they will be the body implementing the policy. The idea of reducing costs will need to be outlined in a clear manner, as the main attraction to why they should develop this policy reform.

The various stakeholders' interests are verbose and concentrated in nature. The patients and government at the state and federal level have similar interests because they both are amicable to reduced costs. However, the hospital interests are adverse. They would like to see inflated prices to increase their profit margins. Stakeholders are inclined to continue with their current finances because they haven't made any acknowledgment to revise their chargemasters.

The expectation for the efficacy of the policy reform is that the feasibility will be difficult, but it would make an enormous impact for the nation. It would not be painstakingly arduous to persuade the government, state and federal level, to accept this proposal because of the benefits for both parties. Convincing the hospitals would prove the most difficult part, but if it became a state policy then the hospitals would be mandated to abide.

Conclusion

Affordable healthcare is necessary. Americans are entitled to healthcare; however, healthcare is not free. The funding needs to come from somewhere and it can begin by coming from mandated statewide hospital chargemasters. These newly developed chargemasters will not only benefit the federal and state level government; but they will help produce appropriate revenue for the hospitals by making healthcare costs reasonable and feasible. Patients will be able to afford their care and pay their healthcare bills. Hospitals will get higher patient compensation. The public would be educated on healthcare costs and understand they are reflective of the variables aforementioned in this proposal. Medical costs will be reduced, hospitals will be compensated, and patients will be able to finally afford their care.

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