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Charge Master: Friend or Foe?

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Prices charged for imaging services can be found in the charge master, a catalog of retail list prices for medical goods and services. This article reviews the evolution of reimbursement in the United States and provides a balanced discussion of the factors that influence charge master prices. Reduced payments to hospitals have pressured hospitals to generate additional revenue by increasing charge master prices. An unfortunate consequence is that those least able to pay for health care, the uninsured, are subjected to the highest charges. Yet, differences in pricing also represent an opportunity for radiology practices, which provide imaging services that are larger in scope or superior in quality to promote product differentiation. Physicians, hospital executives, and policy makers need to work together to improve the existing reimbursement system to promote high-quality, low-cost imaging.

Introduction

Several recent articles and news stories have brought attention to wide variations in hospital charges across regions[1] and by type of service,[2] focusing on the seemingly inexplicable high prices for various medical products and services such as the $5 tablet of aspirin.[3] At the center of the debate about price variability is the charge master, an accounting tool and catalog of retail list prices for medical goods and services.

As reimbursement for medical care has evolved and costs have skyrocketed, reduced payments to hospitals by private payers and the government have pressured hospitals to generate additional revenue by increasing charge master prices.[4] Over the last 30 years, the amount that patients are charged for health care via the charge master has increased out of proportion to costs for providing care and the amount actually paid by private insurers and governmental entities (Medicare and Medicaid). An unfortunate consequence of increasing charge master prices is that those least able to pay for health care, the uninsured, are subjected to the highest charges because of a lack of bargaining power. This results in high health care debt, aggressive efforts at collection, and avoidance of needed services.[5] Hospital executives have responded that increasing charge master prices is their only option to compensate for reduced margins from the government and large private payers, as well as losses incurred treating the uninsured and high cost patients.

Imaging services are a highly visible target in the charge master discussion because they represent a highly used, costly technology in a country that spends a staggering 17.1% of its gross domestic product on health care.[5,6] Prices for imaging services are further becoming an area of contention because of consumer efforts at promoting price transparency, the shift toward high deductible health plans requiring participants to pay more out of pocket, and the continued efforts of private payers to control utilization and costs.[7,8] This article reviews the evolution of reimbursement in the United States and provides a balanced discussion of the factors that influence charge master prices and their consequences, both intended and unintended, on our health care system.

Evolution of Reimbursement in the United States

Payment for medical care wasn't always so complicated, even after the days when the tools of a physician no longer fit into a single leather bag. In the 1930s, the market for hospital services was first established during the Great Depression by companies like Blue Cross, via the American Hospital Association, and Blue Shield. Coverage by these companies expanded from 9% of total hospital expenses in 1948 to 27% within a decade.[4] At that time, insurance companies paid hospitals on a per diem basis, calculated as the average cost of a day of care plus a small supplement. Reimbursement for hospital services was based on "cost," where hospital charges tracked closely with production costs and were reimbursed by insurance companies without hospitals having to collect payments directly from patients.[9]

In the 1950s and 1960s, third-party systems joined the market with alternative payment plans, including sharing responsibility for the direct costs during each episode of care with patients.[10] When such indemnity insurance products required patients to pay a deductible, coinsurance, or both to a hospital directly, hospitals began using "billed charges" that accounted for the added expense of collecting payments.

Although government insurance programs initially adopted a similar cost-based fee-for-service system as private payers, first Medicare and then Medicaid abandoned this approach in favor of a prospective payment system. The new systems also did not tie

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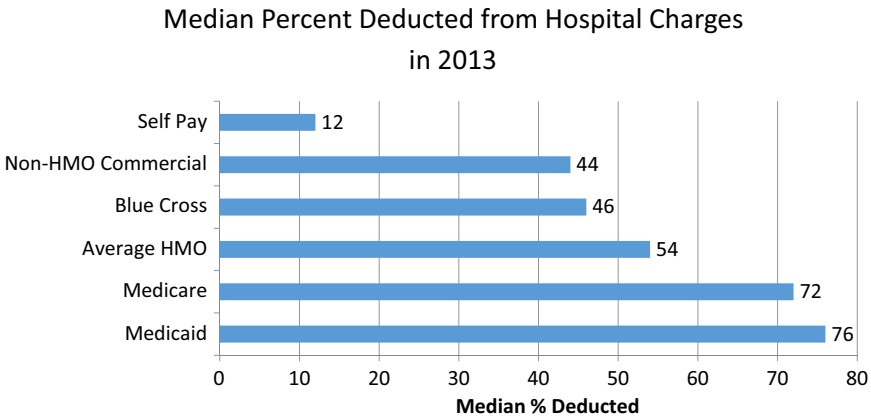

Fig. 1. Large difference in median percent deducted from hospital charges, ranging from 76% for Medicaid to only 12% off charge master price for patients who pay out of pocket.[16] HMO, health maintenance organization. (Color version of figure is available online.)

reimbursement to direct costs of care only.[11] This led to the coexistence of 2 major forms of hospital payment systems: prospective government rates and privately negotiated rates based on billed charges.

Steady decreases in Medicare payments, coupled with low reimbursement levels from state Medicaid programs, placed increasing financial pressure on hospitals, particularly those with a high proportion of public patients. Medicare payments fell well short of the cost of providing medical services, especially in comparison with reimbursement for other payers, mainly private insurers (Fig 1). To maintain profit margins, hospitals increased charges to privately insured patients and the gap between private payments and costs grew from 15%-32% over 10 years.[12] In response, private payers subsequently began transitioning toward contracts based on lower fee schedules or negotiated rates rather than "retail" charges. Private third-party payers also consolidated with employer-sponsored insurance programs in a transition toward the managed care structures that became prevalent in the 1990s.[13] Such programs allowed health plans to gain more clout and obtain greater discounts from hospitals through negotiated contracts.

Further increasing the gap between hospital payments and charges was the significant increase in Medicaid enrollment coupled with the Balanced Budget Act of 1997, lowering growth in Medicare payments.[14] The overall effect of these trends resulted in payments from public programs and many private third-party payers being increasingly less than what hospitals believed to be appropriate for the services provided.[15]

Although most insurers now have contracts based on prospective payment or negotiated fees, increasing billed charges increases revenue from payers not under contract, payers with contracts in which payment rates are linked to charges, and services outside the scope of fixed- or negotiated-price contracts. Private payers have a default payment rate (e.g. 40% of billed charges) for services not covered by fee schedules or other fixed payment amounts, which may affect up to 30% of all services.[4] Some types of hospital admissions are exempted from prospective payments and in turn are highly influenced by billed charges. Additionally, payments for the facility component of outpatient services can be directly billed based on charges. Hospitals continue to rely significantly on charge-related sources of revenue; the average standalone hospital's operating margin was only 2.1% in 2013.[17]

What Determines Price for Imaging?

Prices charged for imaging services can be found in the charge master, a catalog of retail list prices for medical goods and services. This catalog contains all billable procedure codes performed at a hospital along with descriptions of the codes and the hospital's list prices. Although the codes are derived from the American Medical Association's Current Procedure Terminology and International Classification of Diseases procedure coding systems, list prices vary between hospitals because they reflect a combination of factors including the hospital's costs, accounting system (measured cost), payer mix, and relative strength in the marketplace to set prices. Costs other than that of direct patient-related care can be combined in the accounting system and allocated across billable services, increasing the total cost and introducing hospital-specific variation in "service costs." These additional costs help explain the variability in charges between different providers in the same region for the same procedure.

Point: Charge Master as Foe

Fragmentation among payers and providers in the US health care system has led to tremendous inefficiency in payment and reimbursement for medical care. Although the Health Insurance Portability and Accountability Act of 1996 attempted to impose a standard for procedure coding and processing, each hospital still has its own charge master, which is updated at least once a year. The update process can vary from a single, percentage-based increase (or rarely decrease) to targeted updates for particular items or procedures. By strategically aligning updates with consideration to the patient population, hospital mission, market strength, and advertising, hospitals can extract more revenue and profits for any given sales volume.

Two unintended results of the system are rapid expansion of administrative expenses and loss of relationship between billed charges and actual reimbursement for third-party payers. Each hospital uses unique guidelines to update their charge master. Considering that this work is by cadres of highly skilled analysts, backed by computer systems and the mantra "no margin, no mission," it is not surprising that administrative expenses have come to form more than 25% of total cost of care in the United States since 1999.[18] As hospitals (outside of California) are not required to post their charge masters for public view, both small and large physician groups are free to negotiate actual reimbursement with dozens of third-party payers individually based on their own distinct rules for and levels of payment. Billing departments have transformed into huge enterprises that continually audit past and simulate future revenues.

Examples of harm induced by the charge master system are plentiful and highly publicized, such as in Steven Brill's recent