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Healthcare Finance in America: Fixed and Variable Cost-Based Pricing

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Abstract

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Introduction

Healthcare financing in America is a mess. Patients and their families cannot discern the expected costs of treatment, nor can they understand the bills they receive. There is little actual competition among healthcare providers. There is increasing centralization and takeovers of physician clinics and medical practices. Many mergers and acquisitions create two or three large networks that dominate most regional healthcare markets. There is evidence that healthcare markets often behave as oligopolies and that competition at the local level does not benefit patients or their families. [1]

From a finance perspective, there is no control or limit on facility fixed costs. Rates are set prospectively without regard for actual costs. After switching to prospective payment systems, we now ignore the concept of “cost recovery” or cost reimbursement other than in governmental programs such as Medicare and Medicaid. [2] Patients in different insured or managed care plans, along with private pay patients, are charged radically different amounts for the same services. Hospital rate “chargemasters” are “black boxes” that are not available to

patients and are often not understood by the providers.

As argued recently in a legal case: “Hospitals use a complex, confusing, deceptive, and corrupt chargemaster-based billing system to allow them to price gouge various groups of vulnerable patients.” [3] There is no transparency concerning hospital rates or prices. There is no reconciliation of the facility costs charged to different plans, payers, or patients. Many citizens believe that healthcare is a public good, such that basic healthcare services should be available to all at a reasonable and predictable cost. In order to achieve this objective, change is required.

Objectives

The objectives of my proposal are to improve the transparency and accountability of America’s healthcare system. Improved accountability and transparency would provide patients and their families a clear advance indication of how patient charges are determined. It would help eliminate unneeded duplicate services and grossly overstated charges. My compromise proposal would help identify slack in the pricing and rate-setting processes and propose changes that might be acceptable to each political party.

Democrats’ proposal

Many of the current presidential contenders are proposing governmental rate or price caps, especially on pharmaceuticals. Democrats have always had an appetite for government control of the healthcare system, so price controls are a natural solution to consider. Democratic legislatures often favor local and regional cost commissions and planning boards. This proposal would implement regional healthcare planning boards that must approve healthcare rates and prices and any proposed expansions, reductions, or mergers. This option might appeal to Democrats, but it would be ineffective and burdensome if the underlying changes proposed below were not also included.

Republicans’ proposal

Republicans appreciated competitive markets and encouraged health insurers to compete before the ACA implementation, and they continue to do so under the ACA. A GOP-based proposal might be to encourage competitive healthcare markets by identifying a set of low-cost

high-quality (LCHQ) providers. LCHQ providers would consist of the best 25 to 30 percent of each region's providers. These providers would be eligible for favorable government financing and nonprofit tax-exempt status. Providers not identified as LCHQ would not be eligible for government financing (or guarantees) related to expansion of facilities or services offered by such providers. New facilities, new locations, or new services that are not LCHQ would not be eligible for nonprofit tax-exempt status. This would limit the expansion of the healthcare system to only the "best and brightest," which would ensure "expansion of the fittest." The majority of healthcare providers would stop trying to be the biggest game in town; the drive to acquire or merge would be limited to those who demonstrate that they control costs and provide high-quality services. Competition to achieve LCHQ status would prevail.

Compromise Proposal

My compromise proposal combines elements from each proposal above. The compromise provides a more efficient and effective solution based on separate treatment of providers' fixed and variable costs.

I was motivated to develop this proposal after reading news reports about a Denver-area hospital charging $1,800 to pierce a child's ears. Compared to the cost of piercings in most other settings, such a charge is exorbitant. This high charge consists of a variable portion that covers the cost of labor and materials associated with piercing, likely less than $100, and certainly a small proportion of the total. The remainder of the charge is a "facility charge" that represents the infrastructure of the healthcare provider associated with its fixed costs (e.g., physical structure, equipment, marketing, and other administrative costs). Such facility charges are undermining the healthcare system and patient perceptions of fairness, efficiency, and efficacy in our healthcare system.

Variable costs

The first component focuses on variable costs that would form the basis for a competitive market. It is relatively easy and straightforward to identify variable costs, using statistical and accounting tools, and then apply regionally based mark-up ratios to translate variable costs into patient charges based on diagnostic (DRG) or ambulatory (AVG) patient classifications. This plan would identify variable cost norms based on the LCHQ best practices in each regional market

and then use a regionally based mark-up percentage to cover fixed costs, inflation, and return of capital.

These all-inclusive rates would serve as rate-caps that would permit and encourage healthcare providers to compete based on rates and prices that are cost-based and more easily understood. My plan bases competitive rates on the variable portion of patient costs including an inflation factor, using regional medical price indices, and a return on capital matching the inflation factor, with a fixed maximum such as 5 percent. In other words, by encouraging competition based on variable cost based–rates, healthcare prices would be more transparent and more comparable across providers.

Minimal governmental intervention would be necessary to identify markup percentages applied to the LCHQ-based variable cost caps. Republicans should appreciate and encourage this component as pricing would be much more transparent and predictable and competition would be necessary.

Fixed costs

The second component specifies that providers would be limited to recovery of actual fixed costs. In other words, fixed costs should no longer distort healthcare prices, nor encourage expansions that stimulate rapid price increases. Fixed costs are more difficult to translate into patient charges, and they are more difficult to track across different payers, different plans, and different segments of the healthcare system. However, the key to improving our healthcare system's finances is better control of fixed costs in pricing and rate setting algorithms.

My proposal ensures full recovery of Medicaid-eligible fixed costs, regardless of hospital or non-hospital location. A set of "pass-through agencies" would manage fixed costs and monitor reimbursement of providers' fixed costs. These new regional agencies, called Healthcare Cost Commissions (HCC), would identify each provider's actual fixed costs and would approve proposed changes to those fixed costs. HCCs would monitor whether each provider recovers its fixed costs each year and would collect and retain any excesses. On a short-term basis, HCCs would provide financing to cover shortages for a maximum of three years. After that time, if the provider cannot "true-up" its accounts, the HCC would exert more stringent controls.

HCCs would operate as planning commissions, similar to Certificate of Need [4] authorities, but "with teeth" and would eliminate unwarranted expansion and duplication of services. HCCs would not be able to hold funds longer than four years and would be required to distribute any retained funds to projects or organizations that would improve access to rural healthcare or preventive services in any location. Democrats should appreciate this component with its strict governmental controls. All citizens should appreciate the elimination of overcharging for fixed costs and using any such overages for rural services or preventive care.

HCCs would control and rationalize the rampant expansion of healthcare providers' facilities and attempts to take over independent providers and medical practices. This proposal limits the huge expansion in providers' fixed costs and in the charges related to fixed costs, such that the rate of increase in healthcare prices would decrease. This proposal removes the distinction between hospital and non-hospital facilities while removing the incentive to provide all healthcare services in a hospital facility. Removing this distinction would decrease the incentive to merge with or acquire other providers, which may decrease total fixed costs in the region and it would encourage providing more services in non-hospital settings with attendant lower costs.

Regional public utilities

This proposal reorganizes the healthcare system as a public utility with pricing based on an approved rate base. It regulates healthcare finances on a regional basis—not necessarily on a state or local basis. For example, the Quad cities in Illinois and Iowa or Kansas City (Missouri and Kansas) constitute a regional market, as does the entire corridor along Lake Michigan from North of Milwaukee to East of Gary, Indiana. A regional healthcare market now extends along the Rocky Mountains from Wyoming to New Mexico. Similar examples abound elsewhere; large regional markets also exist within states, such as in Los Angeles, San Francisco, and Seattle. Even though there are two large regional markets in California, they are dissimilar and better managed as regional utilities and not by a single state agency.

Rural areas have different cost structures and labor markets and should be separated and treated differently from urban market areas. Furthermore, rural areas generally provide a limited array of services. Each HCC would be responsible for access in its surrounding rural areas, as negotiated with its adjacent HCC neighbors. Rural providers would not be subject to the same limits imposed in metropolitan regions; there would be more flexibility.

Cost benefits

Each HCC would cover its overhead by including a separate component in the allowable fixed costs to cover its anticipated operating costs. The costs of the HCC agencies would be less than the current administrative costs associated with rate negotiations, rate discounts, and billing issues associated with in-network and out-of-network providers as my plan eliminates many of these administrative burdens. The HCC overhead should be at least cost-neutral, with the potential to generate significant overhead reductions.

Looking Forward: Distinguish Between the Variable and Fixed Costs of Healthcare

This variable and fixed cost framework would have a major impact on redesigning America's healthcare system. It would lead to reshaping the dialogue around healthcare reform. It would eliminate price gouging in the emergency room, as described in a 2013 study that found that ER's charge on average between 1 and 12.6 times what Medicare pays for emergency care. These ER bills were more than 340 percent of what Medicare covers, specifically $4 billion in ER charges versus $898 million in Medicare allowable amounts. [5]

References

[1] Ozcan YA, Luke RD. A national study of the efficiency of hospitals in urban markets. Health Services Research 1993;27(6):719-739.

[2] Green, EP. Payment systems in the healthcare industry: An experimental study of physician incentives. Journal of Economic Behavior & Organization 2014;106(4):367-378.

[3] Nation G. Hospitals use the pernicious chargemaster pricing system to take advantage of accident victims: Stopping abusive hospital billing. Drake Law Review 2018;66(3):645.

[4] Certificate of Need (CON) was an effort to contain costs, improve quality, and increase access under federal Public Law 93-641 as part of the Health Planning and Resource Development Act of 1974. CON was generally ineffective because it had no linkages to ongoing

costs or prices, nor did it include analyses of historical fixed and variable costs or rates proposed by CON applicants.

[5] See: https://www.fiercehealthcare.com/finance/emergency-care-costs-rise-health-care-cost-institute?mkt_tok=eyJpIjoiT0RCbE9Ua3dPR1UwTURVMSIsInQiOiJDUTFydkNFRWFCXC9Ic1c1ZUNMWUIrSVwvMkQ0VHdvZlwvRlRjcjF1MGhwV1FtMUF2aks4VlNUZ1BDNnVqUkJcL0plYTNKUVwveGFONVJ1UFwvNGFqSlFrK2lvOU1vWW1qXC9hK3dlY0F6VTJEWjNWYnA5N0JcL3duNm94cE9GTXNMc3VkWnlmIn0%3D&mrkid=745430&utm_medium=nl&utm_source=internal