White Paper

The Impact of Consumer Directed Healthcare on Providers

October 2008

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Fifth Third Bank *commissioned the* **Boundary Information Group** *to complete a research report that examines and details the current and projected financial impact of Consumer Directed Healthcare and High Deductible Health Plans (CDH and HDHP) on healthcare providers.*

Executive Summary

The healthcare landscape is changing with the rise of Consumer Directed Healthcare (CDH). As the financial burden increasingly shifts to consumers in the form of higher co-pays and deductibles, the repercussions are affecting key stakeholders in every aspect of healthcare including providers, payors, employers, and third party service organizations. CDH is also expanding the role of banks as they offer services such as health savings accounts and tools to expedite collection, such as payment cards and on-line payments. Although the concept behind CDH is that it can slow the rise of healthcare costs, providers are vulnerable to this paradigm shift as the onus for more complicated "consumer debt" collection processing falls to them.

In order to understand the current and future impact on providers, Fifth Third Bank commissioned this study to examine the impact that CDH is having on providers' cash flow and operations. The findings presented in this white paper are the result of in-depth interviews of healthcare executives and industry thought-leaders representing the nation's hospitals and physicians.

The objective of this study was to determine if providers are, today, experiencing a negative impact to their cash flow and operations due to CDH, assess their preparedness for this shift, and report on what they are doing about increasing patient financial responsibilities.

Key findings of Research:

1. *Most providers are just beginning to feel the impact of CDH and HDHPs and few have adopted CDH specific "tools." Yet they sense that momentum is building and they will increasingly feel the impact and are preparing.*
2. *While CDH-related issues are similar to traditional patient self-pay processing issues, the negative impact of CDH is greater, because potential financial losses are so much higher.*
3. *Patients don't generally understand their high deductible health plans (HDHPs). Neither health plans nor employers consistently and effectively communicate the financial realities to consumers. Consequently, patients often arrive for care uninformed, unprepared and providers typically must "give them the bad news." This increases the time and expense providers incur registering, billing and collecting from patients. The resulting public relations issues that can occur also concern providers.*
4. *Coping successfully with CDH-related issues forces providers to employ higher paid, more experienced staff.*
5. *Adapting newer technologies is necessary. Legacy systems, in-place prior to CDH, do not generally handle higher "consumer debt" related workflow requirements well.*
6. *New vendors are emerging to deliver technologies that assist providers with CDH challenges, but providers are restrained by limited information technology (IT) budgets and prefer fully integrated CDH functionality from a single vendor.*

Introduction

> *"We (healthcare providers) who are in the primary business of providing healthcare have now become financing organizations."*[1]

As U. S. healthcare costs continue to dramatically escalate, Consumer Directed Health Care (CDH) is anticipated to be a positive force for change: for patients to gain greater control over their healthcare decisions; for employers to reduce their healthcare benefit expenditures; for insurers to increase their membership by making more affordable insurance available to more people; and, for financial institutions to expand their presence in the burgeoning healthcare industry.

CDH is expected to lower the overall cost of healthcare, as it fosters market competition among healthcare providers and empowers consumers to avoid utilizing unnecessary services. Data shows that the adoption of these plans is growing and is having an impact, although not necessarily a positive one for all.

CDH is also fostering the expansion of a services industry offering solutions that can: (a) empower consumers by providing quality and pricing information, self-pay calculators and expanded payment options; (b) lower employer fringe benefit/healthcare costs; and, (c) assist providers in receiving payments (debit cards, collection tools, etc.).

However, healthcare providers are also left to deal with the consequences of having to collect from a growing population of patients that must pay much more from their own pockets.

The term "provider" is defined in this report as the broad range of healthcare entities and organizations that includes hospitals, clinics, physicians, dentists, nursing homes, and home healthcare services, etc.

The information presented herein is based on in-depth interviews with providers and recognized industry leaders, extensive research of industry publications, and the broad industry experience of the authors.

[1] Eggert, Keith: Orlando Regional Healthcare, FL

In summary, the findings would suggest that many providers do not yet fully appreciate the implications of this change, nor are many of them, yet, dramatically impacted. But, industry forecasts indicate that there is a ground-swell building that may overwhelm them in the foreseeable future.

> *"HDHPs [High Deductible Health Plans] today are a single thorn in our flesh. The day is coming when they will become a Prickly Pear Cactus."*[2]

Interviews: CDH's Affects on Providers

In order to detail the current impact of CDH on providers, the authors conducted a series of interviews with revenue cycle executives in hospitals, clinics and physician practices across the United States. Participants were from a variety of different sized organizations in rural and metropolitan settings, as well as single hospitals, multi-hospital health systems, and medical practices.

The interview findings include:

1. Regional Differences Exist

While there is evidence that CDH, together with its Health Savings Accounts (HSAs), High Reimbursement Arrangements (HRAs) and High Deductible Health Plans (HDHPs) are on the rise; their impact is not yet evenly distributed throughout the country. In Minnesota, providers report that almost 10% of their self-pay financial class is CDH/HDHPs. While providers in areas such as New Mexico and Wyoming say that CDH/HDHPs account for only a "couple" of percentage points of their self-pay category.

Part of this disparity may be accounted for by the fact that it is difficult for providers to determine which patients, in fact, have high deductible plans, since hospital patient accounting systems and medical practice management systems do not collect

[2] Lee Evins, WellStar Health System, GA

CDH information on a granular enough basis. In an attempt to track it better, several organizations are modifying their accounts receivable financial classifications to separately identify "Self-pay After Insurance" and some are considering splitting managed care financial classes into "Traditional" and "High Deductible" plans, while the extended use of "Payment Source Codes" is found to be helpful.

Depending on geography, providers are reporting the current annual growth rates of Consumer Directed Health Plans (CDHPs) to range from 5%, to 20%, with a few at the 30% and higher levels of growth.

2. Revenue Contribution - Low

Few providers' systems are specifically tracking HSA or HDHP revenue separately. But, interviewees estimate that the portion of revenue derived from these plans ranges between 1% and 3%, with the highest at 5% of total revenue. The overall reported average of revenue derived from CDH is estimated to be just below 3%, and increasing.

3. Collection Experience

Bad debt write-offs due to CDH are growing but the write-off and collection issues are just beginning to be a source of significant new losses. While some providers see very little impact, others estimate that CDH write-off experience lies between 40% and 50%. Accounts assigned to charity care are also reportedly increasing due to CDH collection related issues.

> *"(Most CDH issues are) in the Surgery Department. 40% (estimate) is being written off from these high deductible health plans at this time and it is growing."*[3]

> *"These (high deductible) plans are often not fully funded."*[4]

[3] Barbour, Robert: Montefiore Medical Center, NY
[4] Lee Evins: WellStar Health System, GA

4. Minimizing Impact - "Upfront"

Hospitals and clinics in several markets where CDH growth is not strong are not as predominantly requesting that patients make payments prior to receiving scheduled treatments. This may be because of competitive issues, or to best serve their community. However, these providers are in the minority and they are typically in the process of updating their approach to handling patients' out-of-pocket responsibilities.

Most healthcare providers are asking for upfront payments for patient-responsible co-payments and many are also asking for patients' deductibles, as well. There is a wide range of additional actions being taken by providers in order to collect more upfront, and to identify accounts for Medicaid enrollment, full or partial charity care, or early write-off. The additional effort to collect more of patients' financial responsibilities upfront is not just targeted at CDH. Most providers report that their reasons for the additional effort stems from the normal everyday health insurance plan growth trend of making patients share more of their healthcare costs in the form of higher co-payments and (standard) deductibles. They are comfortable that this approach will also serve to address CDH issues as they arise – with what they anticipate to be only minor adjustments.

> *"It used to be that, if a patient had insurance, we always allowed them to receive non-emergency scheduled services and tried to collect their co-pay and deductible at time of admission, or prior. Now insured patients with high deductible health plans, over a certain dollar range, must secure at least 50% of their responsible portion at the time of scheduling or prior to admission, or their service is postponed or cancelled."*[5]

The more innovative thought-leaders interviewed utilized current, proven techniques and technologies including:

- Electronically verifying insurance eligibility and benefit coverage

[5] Eggert, Keith: Orlando Health, FL

- Manually verifying insurance eligibility and benefit coverage via telephone calls to payors when electronic verification is unavailable or inadequate
- Estimating the total expected charges and calculating the patients' financial responsibility at registration
- Calling patients as early as possible to inform them of their payment responsibility
- Increasing staff and training to assist with financial assistance applications
- Increasing staff and training to assist with Medicaid Applications
- Increasing more skilled staff and providing training to assist in getting early qualification for Charity Care
- Postponing scheduled non-emergency treatment until financial obligations are addressed

> *"The most interesting part of this (CDH) has been the cancellation rate of certain services once the patient found out the amounts they actually owe. That, in and of itself, is a strategy that should have both a financial impact (less bad debt) and service impact (more appointments open for those who can pay but could not get seen due to lack of open slots)."*[6]

5. Provider Disadvantages

There are primarily two essential perspectives from which to assess the overall CDH-related negative impact to providers: customer service issues and financial losses.

On the customer service front, the impact is almost intuitive, since hospitals and clinic staffs have to become more aggressive about collections with larger dollars outstanding from their patients. Providers often perceive that they are made out to be the "bad guys," since they are the ones explaining the large patient financial responsibility and more aggressively asking for payment. Financially, the disadvantages to providers are varied in degree – from minimal to highly detrimental. Providers encounter increased staff costs in order to follow-up with patients in advance of treatment, as well as in subsequent collection efforts. While some merely encounter extra accounts receivable days outstanding, others experience significant write-offs.

> *"Providers are at a disadvantage from a financial standpoint, because patients are not always fully aware of their financial responsibilities and their (HSA/HRA) plans are frequently under funded. This lengthens the revenue cycle and frequently results in increases in charity care and bad debt expense."*[7]

Hospital-based physicians encounter unique challenges, since patients are directed to them only *after* hospital registration and they have no opportunity to request partial or full payment in advance of providing their services.

> *"There has been a definite financial impact. At a minimum, collection cycles have been extended. In radiology and other hospital-based physician practices upfront collection has been impractical. Hospital based physicians usually see patients in the hospital that have been registered by the hospital staff. But, since these practices are most often independent businesses and they do not have a separate additional registration process, there is no opportunity to collect any of the patients' portion."*[8]

Providers' reimbursement difficulties are frequently exaggerated by the variety of CDH plans. There seems to be no standard or easy way of identifying them. An example is when patients present what appears to be a typical insurance card; staff is often not readily able to determine an HDHP from the information provided on the card.

6. Provider Advantages - Mixed

In locations where HSAs are prevalent and insurance cards with complete plan coverage details are issued to patients, there can be an advantage for providers in the form of receiving higher payment amounts at the time of service. However, in some geographic regions, patients are instructed by their health plans to wait until their claims are completely adjudicated and the patient portion is clearly known before any HSA reimbursement is made. Some

[6] Davis, Jerry: Emory Clinic, GA

[7] Eggert, Keith: Orlando Health, FL

[8] Edwards, Bart: McKesson Provider Technologies, FL

health plans also require such restrictions in their contracts with providers.

Often patients' HSA accounts will not contain sufficient funds to cover patients' complete financial responsibilities. This is especially true when patients have newly established plans where they have had insufficient time to accumulate the needed balances.

Most providers surveyed see no advantages for them in High Deductible Health Plans, in that these plans cause providers to perform additional laborious functions to identify, counsel, and attempt to collect what has become a significantly increased patient responsibility.

> *"If the patient has an HSA with money in it, payment occurs faster for services that are medical expenses recognized by the IRS, but are not covered by insurance…but patients may choose not to use their HSA funds, or there may not be sufficient funds in their accounts to cover the expenses."*[9]

7. Insurance Eligibility Verification

Verification of insurance eligibility, including benefit information, is a process that most providers are currently performing in one manner or another. Possible increased losses, attributable to CDH, are driving increased communications with payers.

The methodologies for verifying insurance are most often either telephone calls by providers' staffs to the individual insurance companies and fiscal intermediaries for Medicare, or automated eligibility checking via automated electronic eligibility and benefit inquiries/responses. These electronic transactions are being performed either on a real-time, immediate, basis or in groups of inquiries in batch processes.

> *"Not having electronic eligibility information requires extra work effort in the form of telephone contact with insurance companies and/or patients, and then having to make manual updates."*[10]

The best timing for performing insurance eligibility verification varies. Many providers perform their verification one or two days prior to patients' arrival for service. Others also perform eligibility checks on a variety of schedules such as after pre-registration, prior to scheduling, 10 to even 90 days after delivering services, or just prior to account assignment to a collection agency. Innovators use multiple checks at different times to yield additional opportunities to discover possible insurance coverage and determine patient responsibility and identify possible bad debt expense. Providers, whose cost for the eligibility checking service is not determined by the number of inquiries made, seem to perform more verification attempts and achieve better results.

> *"Yes, (we check eligibility) as often as possible prior to service. Of course, this is not always possible, especially for trauma centers."*[11]

8. Acceptable Forms of Payment

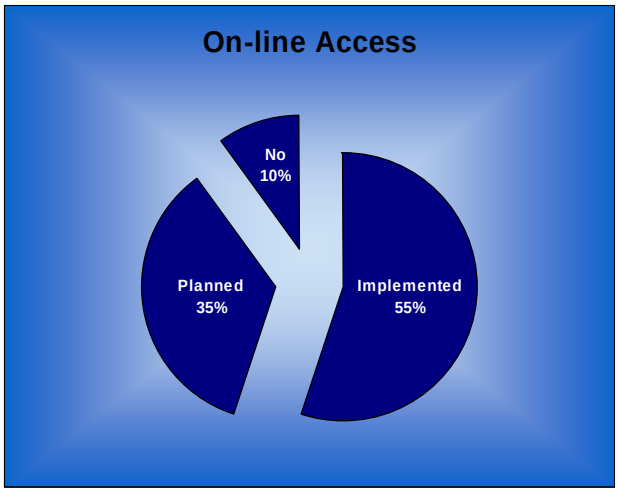
Although not doing so only as a response to CDH, most hospital and clinic healthcare providers accept patients' payments in the form of cash, checks, credit cards and debit cards, but new issues result from HSA account payment vehicles accessing funds that may or may not have sufficient balances to cover services delivered. Some providers do not accept debit cards, citing technical difficulties with deploying a PIN data entry keypad at bedside. This may become increasingly problematic, since many HSA service companies issue, or plan to issue, debit cards to their members.

9. On-line Capabilities Offered

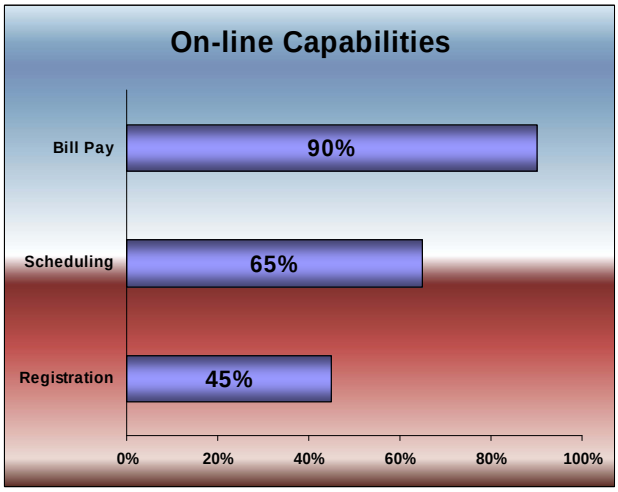
CDH increases patients' participation in, and their financial risk related to, services received. CDH members are often younger and more computer savvy than the general population served by providers. Patients are asking providers to be able to have more control of their healthcare costs by being able to view bills and make payments online, to register (or pre-register), and to schedule services online.

Many providers said they are in the process of planning to offer these on-line capabilities, if they are not already available for their patients.

[9] Dunn, Cynthia: MGMA Senior Consultant
[10] Edwards, Bart: McKesson Provider Technologies, FL
[11] Norris, Phil: Memorial University Medical Center, GA



Of the on-line access already made available for patients, most providers started with on-line bill payment.

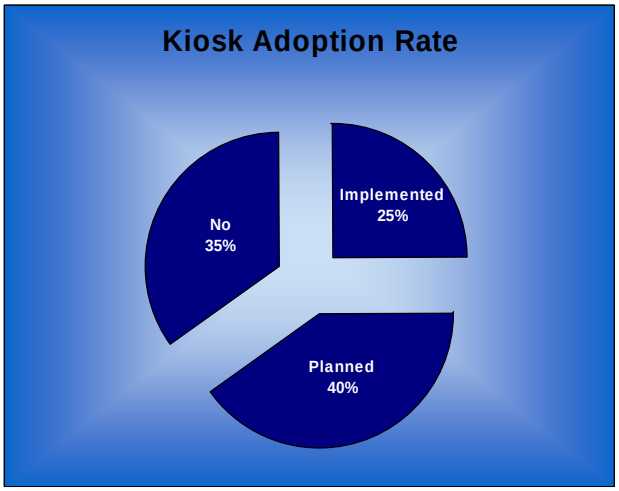


Making these and other services available to patients in an on-line manner was said to also reduce some of the staff labor, making it available for other functions, such as eligibility checking and additional follow-up.

10. Patient Kiosk Availability

One new technology that the more innovative providers interviewed said was increasingly attractive to cope with CDH is the availability of kiosks in providers' facilities, kiosks streamline everyday patient interactions, help to reduce wait times and boost patient satisfaction, while giving patients necessary information to better control their higher out-of pocket costs due to CDH. Kiosks also can buffer providers from having to be the "bearer of the bad news."

Interestingly, those providers who are not implementing kiosks cite the lack of cost justification. But, a greater number of providers are planning to implement kiosks than are not. Some providers have reported a reduction in front desk personnel through the use of kiosks, even in a relatively small physician practice.



> *"Kiosks allow customers to check in, pay a bill, get directions, fill out surveys and (much) more … without having to discuss private matters with a provider representative."*[12]

11. Upfront Collection Restrictions

As more and more providers move to collect more and more patient responsibilities prior to service, some of them encounter restrictions placed on what they may collect by the patient's health plan.

20% of those interviewed stated that they were restricted from collecting more than patients' co-payments up front and were required to wait until the claims were fully adjudicated before pursuing the remaining patients' portions after insurance. The geographic distribution was across the country, with higher restrictions being noted in CO, MN, NC, and NY and also among some other states' commercial insurers and Blue Cross Plans.

With reimbursement amounts owed providers increasingly shifting from payers to patients due to CDH, these restrictive clauses will potentially

[12]Corporate Director, PFS: Multi-facility Healthcare System, Name withheld by request.

dramatically increase risk and bad debt losses for providers. Several interviewees complained of the inequity of these clauses and asked that payors eliminate these restrictions, while some providers suggested that they might create a new charge for patients with CDH/HDHPs.

> *"All of our plans allow us to collect patient co-payments upfront. A few plans exclude collecting co-insurance upfront. Additionally, several plans counsel their members not to pay deductibles until claims are adjudicated. This is not as much of a problem for in-patients as it is for out-patients."*[13]

12. Upfront Information Availability

Actionable upfront information is more important than ever before, due to CDH/HDHPs. When providers check eligibility, 80% of them complain that the information they receive from the payor is problematic. It is either inaccurate, incomplete, untimely, or unavailable. Half of the 20% that are satisfied admitted that they are just beginning the process of implementation. That just leaves 10% who believe they are getting all the information they need. The recurring chief complaint is that it is difficult for providers to accurately know how much of patients' deductibles have been met at the time of service. But, there are several reasons for this shortcoming. Firstly, payors' systems are sometimes fragmented and claim information is not always shared across their various legacy systems. Also, payors' systems' eligibility and deductible files are frequently only updated with claim information once a day, but sometimes on a weekly, or even longer cycle.

A second complaint is that employers are often slow in reporting their insurance enrollments to their health plans. Terminated employees, for example, are often reported long after patients have received treatment and been discharged – sometimes a month or so late. In this scenario, providers' eligibility inquiries allow patients to make minimal (or no) payments up front, when much later, claims are surprisingly denied.

High on the wish list for most providers interviewed is an easy to use, accurate "price calculator" that will predict expected reimbursement from the health plan. It will then subtract that amount from the expected total billed amount, based on "allowable charges" to then estimate the patient's payment responsibility. Several price calculator products accept the input of anticipated services and look up their standard contract prices. Most of them factor in patients' co-payments and deductibles in order to estimate the remaining portions that will become the patients' total financial responsibility. Financial counselors may then request payment of all, or portions, of those amounts and perhaps consider the establishment of payment plans for receiving the remainder.

Next, on the providers' wish list, is a tool that will forecast patients' propensity to pay their portion of the bill. Several products in the marketplace offer this capability and it is usually built on a credit score, or on certain key elements of credit reports. One interesting concept providers asked for is a product with a "Healthcare Score," which is more predictive of how patients will respond to their healthcare-related payment obligations. Consumer behavior has been studied and it has been determined to be different between retail and healthcare payment obligations.

A commonly heard theme was that it would be desirable for these new functions to come from one single vendor. But, unfortunately, no such vendor has put all of them together yet.

> *"We would like more robust (automated) methods of estimating bills, and therefore the patient portions."*[14]

> *"I would like to have analytics which provides a propensity to pay analysis. Not to exclude service of any kind to anyone, but to know who might be charity eligible, and to know how much effort to put into collection of the out-of-pocket amounts."*[15]

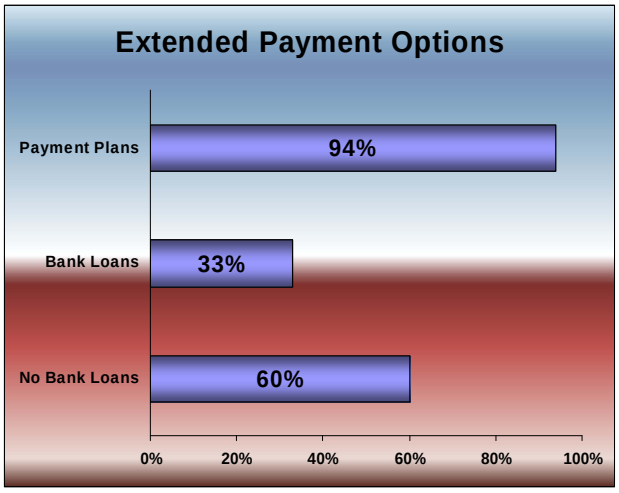
[13] Schreiner, Charlotte: Regions Hospital - MN

[14] Norris, Phil: Memorial University Medical Center, GA

[15] Evins, Lee: WellStar Health System, GA

13. Extended Payment Options

Almost all providers offer extended payment plan options for those patients who are unable to pay their obligations when they become due. In fact, at least one state (MN) requires that extended payment options and self-pay discounts be offered to patients.



There is some variation in the way that providers make these extended payment options available – essentially offering different numbers of months duration and minimum payment amounts (e.g. $50, $100, etc.) to satisfy the debt within the maximum number of months allowed. Most payment plan arrangements are managed internally within providers' offices with no interest charged. A few organizations utilize outside service organizations to manage their payment plans for a fee. But these longer-term plans typically accrue interest charges to the patients. One institution reports that one of its authorized credit card companies established a recurring patient payment option on their card.

Approximately one-third of providers offers bank loan arrangements or refers their patients to banks. However, these loans are typically only for specialized services, such as cosmetic, OB/GYN, bariatric surgery and other discretionary or non-emergency care. Among the providers who do not currently offer bank loans, 27% of them indicate that they are considering, or would consider, the inclusion of bank loans among their patients' options for payment.

> *"We offer internally managed payment plans for patients of up to 12 months with no interest, or up to 24 months with no interest if electronic funds transfer (EFT) is used. We outsource the management of payment plans, with interest, up to 36 months. We do not have a bank loans program for patients. Healthcare loans are different from retail loans. We are not interested in recourse loan programs. It is too cumbersome to recalculate our liability on a monthly basis. We may consider a non-recourse patient loan program."*[16]

14. New Technology Required

Essentially all providers have confirmed that they have not yet invested in new information technology specifically to help them with CDH. However, those same providers all discuss the variety of new technologies, process changes and purchased services that they are implementing to improve their general performance on the previously customary patients' out-of-pocket responsibilities such as co-pays, (non-high) deductibles, co-insurance and true self-pay. Providers unanimously believe that their actions to improve the collection of patients' responsibility accounts, in general, will also specifically apply to their performance on CDH accounts. But, they complain that there may be some additional work needed just for the CDH accounts such as more complicated eligibility verification phone calls to replace the automated electronic verification because of the lack of adequate electronic responses from payors.

> *"In general, we have invested in order to better manage all of our deductibles and patient balances CDH, or not."*[17]

> *"We continue to invest in new technology every year that benefits the collection of CDH. However, it is not just for CDH, in that whatever we do benefits the larger and more prevalent patient portions from non-CDH accounts."*[18]

15. New Skills Needed

95% of today's hospital and clinic executives interviewed believe there is a need for higher skill levels and training among business office and/or the patient access staffs due to CDH, with the biggest

[16] Eggert, Keith: Orlando Health, FL
[17] Ingold, Joseph: Bon Secours Health System, VA
[18] Schreiner, Charlotte:

skills upgrades needed in the registration and financial counseling areas.

However, almost all providers indicate that these skills are not just needed in response to CDH accounts.

In some cases, several provider organizations have been successful in placing the right people in the front-end, customer-facing, jobs by transferring them from other positions within their organizations. The good news is that nearly three quarters of the providers have already embarked on the path of staff upgrades and training, with many believing that they have already achieved satisfactory levels.

> *"The registration staff do need a different skill set today. They need to be more knowledgeable about insurance benefits and our hospital's contracts with the insurance companies. They need the ability to ask for money in a situation where people are not accustomed to paying. They will be more expensive and difficult to recruit."*[19]

> *"Is collecting consumer debt a core-competency of hospitals? No hospital can claim that core-competency. Really, our primary core competency is limited to delivering medical services."*[20]

16. Patients Don't Understand HDHPs

Interviewees stated that patients understand their responsibilities most often when it comes to elective and non-covered procedures. HSA and HDHP participants, however, are not clear on their actual out-of-pocket responsibilities. Their employers frequently do a poor job of explaining their health benefit plans and the limitations that will affect what they will owe. And, although insurers may provide printed literature on the health plan coverage, these just do not seem to result in adequate levels of patient understanding.

> *"Some employers have done a good job with explaining the HDHP programs, but many people do not understand them. A lot of education is also needed so that the provider's staff can explain and deal with these issues."*[21]

17. Information Requirements

The information needed by providers in order to appropriately collect for their services in CDH is substantially the same as it is in traditional insurance scenarios, with a few increasingly important exceptions. So, most providers' views are that if they could generally receive improved insurance information, the benefits would also accrue to their CDH accounts as well.

Relating to both CDH and non-CDH accounts alike, providers agree that they prefer that payors would deliver more accurate information about how much of the patients' deductibles have been met. Absent the ability to know patients' up-to-date deductible status via the insurance verification process results in providers' inability to know how much to actually collect. This failure tends to result in over collection, which causes bad will among patients and requires subsequent refunds.

Another requirement for more accurate information from payors often involves eliminating information reporting delays by employers that do not, in a timely manner, report the enrollment status changes of their employees. Frequently, employee terminations are not reported in a timely manner and, additionally, may not be processed timely by insurers. Obviously this creates situations where providers have verified coverage, performed services, and are later told that they will not be reimbursed because patients were not insured.

As for CDH-specific information needs, many providers have voiced the need for a way that their staffs can easily distinguish CDH plans from the traditional health plans. They want to "flag" these accounts to receive more careful attention and to allow better tracking and management analysis. Also, the nature of CDH plans, being different from traditional plans, does not allow for all of the necessary benefit information to be communicated in current automated formats, making it more difficult for providers' staffs to understand the limits of coverage.

[19] Magill, Shaun: Iowa Health System, IA
[20] Hawig, Scott: Duke University Health System, NC
[21] Dunn, Cynthia: MGMA, Senior Consultant

"… we need identification of any preexisting conditions that will not be paid…Also, we need eligibility responses from insurers in a complete and standard (uniform) fashion, so we can automate revenue cycle processes."[22]

"We would really like to be able to identify HSAs and HDHPs, and especially any detail on those plan types, more easily. Without telephone calls to insurance companies, they are frequently sometimes indistinguishable from the more standard health plans."[23]

18. Strategic Initiatives In Process

The more innovative providers interviewed were all undertaking numerous CDH specific initiatives.

"There are new additional strategic initiatives being planned. We have given considerable thought to this and all of the initiatives are underway: checking eligibility three times before the patient is seen, doing eligibility real-time to the extent possible and being prepared to increase skills at the registration counter and check-out counter as needed."[24]

"Strategically, we are reviewing our insurance and managed care contract portfolios, especially where we experience patient populations that cause a higher bad debt level than others, in the light of our overall reimbursement rate. We are starting to track, monitor and analyze these programs and their overall contribution to affect future contract negotiations."[25]

19. Tool Adoption Rate

The first, and smaller category, are those providers who believe they have already assembled the necessary tools and integrated them into their systems and workflows (less than 20%). These providers are frequently better resourced and have spent a great deal of time, research and implementation effort in selecting the various pieces of a solution tailored to their facility and managing the integration into their systems and workflows.

The second and larger category includes providers that don't believe they have all the appropriate tools and processes in place, yet. These providers indicate that they would welcome a fully integrated, flexible, toolset from just one source. "Utopia," and "One Stop Shopping," is how more than one provider describes such an offering. They cite the large benefit of only having one company to deal with, instead of many, and they believe that one service would be delivered in an integrated manner and not require so much of their resources to implement with their patient accounting and patient access systems.

Finally, cost is often mentioned as a key decision ingredient; in that these integrated services would need to be provided at a cost-justified price level.

"Yes…we would be interested in one stop shopping …There is clearly some value…to being able to deal with a single vendor."[26]

20. Role of Banks Grows

CDH is contributing to the "convergence" of healthcare and banking. Historically, providers have seen banks as entities that provide credit or basic treasury management services, such as disbursements or lockbox. In the past few years, banks have moved up the healthcare "value chain" to go beyond traditional bank services by offering HSAs and healthcare-specific revenue cycle management services.

Health Savings Accounts have opened an opportunity for banks to either partner with payors or even partially displace payors in efficiently managing financial details related to the healthcare expenditures of a consumer. Banks are offering HSAs along with on-line consumer management tools for quality and pricing information. Banks are also leveraging their core competencies to assist providers in collections by delivering payment options such as HSA debit cards, on-line payment portals and patient financing programs. In addition, banks are customizing their lockbox services to enable providers to process payments electronically, thus automating back office processes such as payment posting.

[22] Crosby, Sam: Virginia Hospital Center, VA
[23] Edwards, Bart: McKesson Provider Technologies, FL
[24] Barbour, Robert: Montefiore Medical Center, NY
[25] Ingold, Joseph: Bon Secours Healthcare, VA
[26] Carr, David: Barnes Jewish Healthcare, MO

In our survey, we asked the providers what they thought the role of banks should be in assisting them in managing CDH. Providers interviewed generally agreed that banks can and will bring higher levels of processing efficiency to healthcare. But, they expressed concern that banks will not adequately adapt to the unique requirements, considerations and limitations related to processing healthcare financial transactions.

One specific suggestion, heard frequently, is for banks to be more participative in providers' extended payment options for their patients.

Healthcare executives indicate that, in the event a loan program is used, patients should be made clearly aware that responsibility has been transferred from providers to the lenders. This may tend to encourage a more favorable repayment behavior. These executives also indicate they experience fewer issues when patients seek and secure their own healthcare loans. However, they also believe they will be reimbursed sooner if they pre-qualify and introduce patients to a lending partner.

> *"Hospitals continue to get beat up over aggressive collection efforts and I would be concerned if banks would collect on the healthcare loan in the same manner they collect on a car loan."*[27]

And, lastly, many providers repeat the wish that banks offering HSAs would provide information in a more complete, consistent, accurate and timelier fashion than they have been doing so far. They cite the increasingly laborious nature of identifying, tracking and collecting HSA revenue.

Best Practices for Providers

While this white paper focuses on the effects of, and responses to, Consumer Directed Healthcare plans, many of the "best practices" that interviewed providers employ will also address many of the other forms of patient liability – not just CDH. Therefore, with perhaps only minor adjustments, the "best practices" that address the wider range of patient responsibilities also address CDH revenues.

No single provider, hospital or clinic that was interviewed implements all of the best practices presented in this paper. Some may find certain techniques ineffective, or not cost justifiable, in their particular setting, or just have not implemented them yet. The provider community is changing rapidly, as more and more providers are becoming increasingly assertive in their collection efforts.

While providers' responsibilities to the community and patient sensitivities are considered, interviewees said that they increasingly rely on sound customer service concepts as their guide.

A checklist of processes that are utilized by the most innovative thought-leaders interviewed in order to maximize revenues from patients' out-of-pocket responsibilities would include:

1. Expand and adjust financial classes and payment source codes in patient accounting or clinic practice management systems to support tracking of patients' payments after insurance from HSAs, HDHPs, etc.
2. Improve upfront collection efforts through increasing staff training, and by making a few appropriate staff reassignments. Emphasize co-payment and deductible collection and develop an "ask for the payment" mentality.
3. Accept all common forms of payment such as cash, checks, e-checks, credit cards, and debit cards.

   Flexibility and offering choices are the keys to making it easier, and therefore more likely, that patients will make payments. Where appropriate, offer and establish extended payment plans early in the cycle.
4. Accept payments at many different locations. Make it easier for patients to determine their account balance. Take payments at any time and in many places:
   a. Registration
   b. Point of Service
   c. In the mail
   d. Telephone, with a representative and/or Interactive Voice Response
   e. Internet
   f. Kiosk

[27] Magill, Shaun: Iowa Health System, IA

5. Assign (existing or additional) staff. Use all available tools to prepare paperwork to qualify for, and secure, financial assistance wherever possible. Improve the paperwork process to provide a basis for "Presumptive Financial Assistance."
6. Resolve patients' prior debts before accepting new appointments.
7. Establish a "high balance collection team" approach with special training and tools.
8. Implement a routine, automated process for the electronic verification of insurance eligibility. Select a vendor with which cost is not a function of the number of transactions (monthly flat fee arrangements are preferred) so that insurance can be verified on every relevant account and at multiple times throughout their life cycle.
9. Implement an automated "patient portion calculator" that estimates total charges and reduces them by expected insurance payments in order to provide estimates of patients' financial responsibilities.
10. Provide effective, highly trained, financial counseling and registration staff to meet with patients, inform them of their responsibility, identify effective payment methods and negotiate payment.
11. Assign financial counselors also in the emergency department, or elsewhere, to enroll patients for Public Assistance.
12. Offer extended payment plans. These are usually non-interest accruing, internally managed, accounts of a pre-determined structure. The structure typically is a 12 to 36 month maximum, with a minimum payment, such as $50 or $100. Outside firms may sometimes be used that can manage extended payment plans on providers' behalf, depending on staff availability and cost-benefit analysis.
13. Take advantage of any payors that provide "auto-adjudication" capabilities upon patient checkout. There is a small, but growing number of payors that auto-adjudicate claims in real-time.
14. Identify patients for full or partial charity care, Medicaid, medical assistance and/or write-off early in the revenue cycle. Concentrate effort on those patients who will be able to pay and minimize effort on those who cannot pay.
15. Team with an outside financial entity, or a financial institution, to offer (by referral) bank loans to selected patients.
16. Implement the use of credit bureau reports and credit scores to predict patients' abilities to pay. Healthcare-specific credit scores are being developed since payment predictability is often different between healthcare and non-healthcare expenditures. Various "recovery scoring" techniques and services are available to anticipate patients' or guarantors' probable payments.
17. Implement Electronic Remittance Advices (ERAs) directly from payors for automatic posting to patients' accounts or ERAs created from paper explanation of benefits (EOBs) that support automatic posting to patients' accounts, speed up cash application, and identify CDH-related discrepancies more quickly.
18. Automate Remittance Advices in a bank lock box by automatically converting images of paper EOBs into ERAs (ANSI 835s) for automated payment posting.
19. Renegotiate any payor contracts that prohibit patient collection at any time.

Several of the more experienced and higher resourced providers emphasized that more effort should be spent on the front-end to minimize non-productive downstream effort by identifying accounts much earlier in the process that qualify for Medicaid, medical assistance, full or partial charity care, or early bad debt write offs. This approach reduces the necessary collection and follow-up effort to only those accounts where such effort can be productive.

CDH May Increase E.D. Usage

Interestingly, patients are more likely to prepay a physician than a hospital. Perhaps this is because the relationship with the physician seems more personal. Some physicians have set up better processes to request and collect payments at the time of service, either at registration and/or checkout.

If physicians choose to shift the collection burden back to patients by asking for full payment up front, hospitals may see more patients with high-deductible plans in the emergency department (E.D.) as patients try to avoid out-of-pocket expense, even though they know they will go beyond their deductibles. Hospitals can then expect to have a more difficult time collecting.

Provider's Systems Not CDH-Ready

Most healthcare information technology vendors, such as hospital information systems (HIS) and medical practice management systems (PMS) have not significantly adapted their offerings to support CDH initiatives. To obtain information technology support needed for the additional billing and collection efforts related to CDH and discussed in this report, providers must still look to third party vendors which provide revenue cycle tools and services that integrate with, but remain external to, their HIS and PMS technologies.

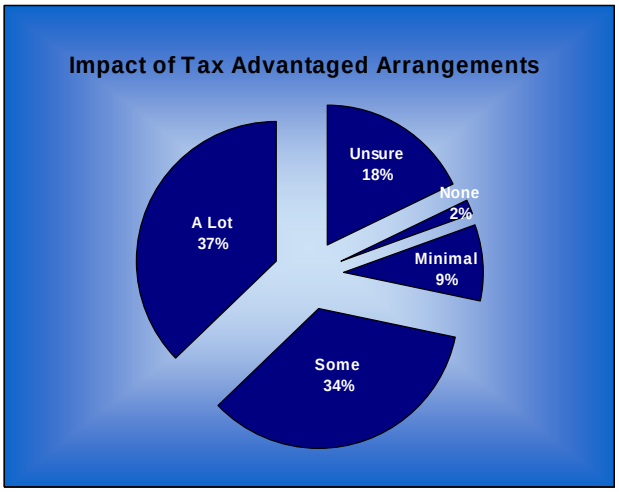
CDH Industry Directions and Realities

"Rising numbers of uninsured patients, a small but growing number of patients with health savings accounts, increased out-of-pocket expenses by nearly all patients, and continued cuts in reimbursement by health insurers are bringing new stresses to the bottom lines of health care providers. These providers, in turn, are calling on their Revenue Cycle Management (RCM) vendors to offer them new capabilities to meet their needs. In response, niche I.T. companies are being rewarded because traditional vendors are partnering with or acquiring the smaller companies to offer the services providers demand."

Interview, Joseph Goedert, News Editor,

"Health Data Management Magazine"

WEDI, the Workgroup for Electronic Data Interchange, recently published the results of a survey they completed. The survey was titled *WEDI Health Savings Accounts (HSA) Survey*. The resulting analysis included answers from all respondents who took the survey in the 61-day period from July 27, 2007 to September 25, 2007. The following graph depicts the findings when representatives of payors, providers, and financial institutions were asked: "What impact Tax Advantaged Arrangements will have on your organization?" It is telling that only 10% of respondents said that they would have little or no impact.



When interviewed, one multi-hospital system's CFO stated: "Collections are so difficult in these cases that we refuse to honor high-deductible plans. We carve it out of our managed care contracts and advise insurers to notify patients on their insurance cards. For a patient with a $5,000 deductible, we would potentially have to collect payment from three different parties: the insurer, the HSA account, and the patient."

CFO Interviewed in HFMA White Paper "Examining the Implications of Consumer-Directed Health Care"

Eighty-five percent of healthcare CEOs surveyed said that it was very likely, or at least somewhat likely, that consumer-driven health care will have the widespread effect of reducing overall healthcare costs by 2011, according to Futurescan: Healthcare Trends and Implications 2006-2011, a report by the Society for Strategy and Market Development of the American Hospital Association and the American College of Healthcare Executives.[28]

So, with these expected benefits fueling CDH's rapid growth and its significant negative impact on reimbursement, providers can expect to be required to adjust their processes and methods in order to minimize any negative financial consequences.

Conclusion

The adoption of Consumer Directed Healthcare plans is rising year over year and the proportion of payments from patients is expected to rise over the next few years from 15% to 21%. The results of this research indicate that although the rate of CDH growth may vary geographically, all providers agree that the number of patients with high co-pays and deductibles is increasing and many are ill prepared today to handle the additional collection efforts that will be required. Providers agree that if they do not implement best practice solutions and offer alternative payment methods, then they will soon see an adverse effect on their cash flow and bad debt.

[28] Futurescan: Healthcare Trends and Implications 2006-2011. By American Hospital Association, Society for Healthcare Strategy and Market Developments

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About Fifth Third Bank

Fifth Third Bancorp is a diversified financial services company headquartered in Cincinnati, Ohio. As of March 31, 2008, the Company has $111 billion in assets, operates 18 affiliates with 1,232 full-service Banking Centers, including 107 Bank Mart(R) locations open seven days a week inside select grocery stores and 2,221 ATMs in Ohio, Kentucky, Indiana, Michigan, Illinois, Florida, Tennessee, West Virginia, Pennsylvania, Missouri and Georgia. Fifth Third operates five main businesses: Commercial Banking, Branch Banking, Consumer Lending, Investment Advisors and Fifth Third Processing Solutions. Fifth Third is among the largest money managers in the Midwest and, as of March 31, 2008, has $212 billion in assets under care, of which it managed $31 billion for individuals, corporations and not-for-profit organizations.

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