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Bracing for Growth in Consumer-Directed Health Care

Fifth Third Bank's Stuart Hanson weighs in on the growth of consumer-direct health plans (CDHPs) and how hospitals can prepare for corresponding increases in patient out-of-pocket payments.

CDHP Numbers Continue to Rise

Consumer-directed health plans (CDHPs) continue to gather steam: The number of people enrolled in CDHPs—high-deductible plans with health savings accounts (HSAs) or healthcare reimbursement accounts increased 44 percent between 2007 and 2008, from an estimated 12.5 million to 18 million people, according to the 2008 *Mercer National Survey of Employer-Sponsored Health Plans*.

This same survey shows that employers continue to like CDHP offerings, especially large employers.

Survey: Employers' Interest in Offering Consumer-Directed Health Plans (CDHPs)

	Offered CDHP in 2007	Very likely to offer CDHP in 2010
All employers	7%	15%
Small employers	7%	15%
Large employers	14%	28%
Very large employers	41%	49%

Source: 2008 Mercer National Survey of Employer-Sponsored Health Plans. Reprinted with permission.

Rising CDHP numbers translate into steady increases in patients' out-of-pocket financial responsibility. The average annual out-of-pocket tab will rise to more than $1,000 per patient by 2012, up from $800 in 2008. Consumers spent more than $250 billion on out-of-pocket healthcare expenses in 2008.

A Fifth Third Bank study reveals that many hospitals have little experience with CDHPs. Healthcare executives interviewed reported that, on average, less than 3 percent of their revenue comes from patients in CDHPs (*The Impact of Consumer Directed Healthcare on Providers*, Oct. 2008.)

The prevalence of CDHPs varies by geography, ranging from Minnesota—where providers report that nearly 10 percent of their self-pay category is attributable to high-deductible plans—to Wyoming, where the impact of CDHPs is considered to be minimal.

Part of this disparity may reflect the fact that many providers find it difficult to determine which patients have high-deductible plans since their patient accounting and practice management systems often do not collect that information.

Because the CDHP movement has been increasing incrementally over several years, many healthcare providers are unaware of the urgent need to prepare for the dramatic impact that CDHP will have on their organizations as high-deductible plans become more common.

Two Primary Challenges of CDHPs

The first priority is that hospitals must understand CDHP penetration trends in their markets. Patient accounting systems should be modified to identify patients with high-deductible health plans, including whether those plans are associated with HSAs. The systems must track patients' payments after insurance and the source of payment (i.e., out-of-pocket or HSA.)

Ninety-five percent of hospital executives interviewed believe CDHPs require high skill levels for business office and patient access staffs, with the biggest skills upgrades needed in the registration and financial counseling areas.

At the same time, hospital leaders must begin addressing the two foremost challenges that CDHPs present: customer service issues and financial loss issues.

Many patients do not fully understand their high-deductible plans until they seek medical care. That puts hospital staff in the uncomfortable position of educating patients about their financial responsibilities, a task that is even more challenging if the hospital has difficulty obtaining accurate information about a patient's deductible status.

Of course, the hospital's goal is to protect itself from financial loss—and the best way to do this is to tell the patient what is owed and to attempt to collect or arrange for payment at the point of service. Although many hospitals lament that patients do not pay their healthcare bills, most people who seek medical care intend to pay for those services. In fact, I believe most patients would pay at the time of service if they knew what they had to pay.

Being prepared to give accurate information about a patient's financial responsibility and to seek payment before the patient arrives at the hospital or at the point of service definitely requires well-trained, experienced—and more highly paid—staff. Indeed, 95 percent of hospital executives interviewed believe CDHPs require high skill levels for business office and patient access staffs, with the biggest skills upgrades needed in the registration and financial counseling areas.

Providers should assemble a project team to examine their current collection practices, make recommendations that allow more money to be collected upfront, and implement new processes and tools to adapt to CDHP growth.

13 Strategies for Preparing for CDHPs

Interviews with healthcare executives identified the following best practices for preparing for CDHP growth:

> Increase staff training and, if necessary, reassign staff to improve upfront collections. Develop an "ask for the payment" mentality.

> Flexibility is key. Be prepared to accept cash, checks, e-checks, credit cards, and debit cards.

> Make it easy for patients to determine their account balances, whether they inquire via a web portal, look at the statements that are mailed to their home, or ask a staff member at the point of service. Accept payments during registration, at point of service, by mail, via telephone, and via web portal or kiosk.

> Resolve patients' prior debts before accepting new appointments.

> Establish a "high balance collection team" approach with special training and tools.

> Implement a routine, automated process for the electronic verification of insurance eligibility. Choose a vendor that charges a monthly flat fee or similar arrangement rather than on a per-transaction basis. This allows insurance to be verified on every relevant

account—and multiple times—without racking up additional fees.

> Implement an automated "patient portion calculator" that estimates total charges and reduces them by expected insurance payments. This provides an estimate of patients' financial responsibilities, which is essential to upfront collection.

> Identify patients for full or partial charity care, Medicaid, medical assistance, and/or write-off early in the revenue cycle. Concentrate efforts on those patients who will be able to pay and minimize efforts on those who cannot pay.

> Assign financial counselors to the emergency department to enroll eligible patients into public assistance programs.

> Offer extended payment plans. These are usually noninterest accruing, internally managed accounts with a predetermined payback structure. A typical plan has a 12-month to 36-month maximum payback period, with a minimum monthly payment of $50 or $100. The use of outside firms to manage extended payment plans on the providers' behalf may be appropriate, depending on the results of a cost-benefit analysis.

> Take advantage of payers' auto-adjudication capabilities upon patient checkout. There is a small, but growing number of payers that auto-adjudicate claims in real-time.

> Use credit bureau reports and credit scores to predict patients' abilities to pay. Look for healthcare-specific credit scores since payment predictability is often different between healthcare and non-healthcare expenditures. Various "recovery scoring" services are available to anticipate patients' likelihood of paying.

> Renegotiate any payer contracts that prohibit patient collection at any time.

Interviewed for this article: Stuart M. Hanson leads the healthcare solutions product team at Fifth Third Bank in Chicago (stuart.hanson@53.com)