

Increasing **Patient Balances** Present
Growing Challenge to Providers

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SURGERY CENTER EXCELLENCE



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Forbes writes that in 2011, 41 billion dollars in uncompensated care — medical care for which no payment is received — was reported.¹ Nearly 25% of that uncompensated care, \$10.25 billion, was attributable to patients *with* insurance coverage.² The amount of uncompensated care has nearly doubled since 2000.³

As insurance companies and employers continue to shift more of the burden for health insurance costs to consumers, collecting from patients will likely become even more difficult. The U.S. government predicted that consumer out-of-pocket health care expenses would reach an average of \$3,301 a year for each household by 2014, up from \$2,500 in 2009.⁴ According to ACA International, over the last 10 years, the average premium for family coverage has increased 80% and health care spending in the U.S. grew 3.7 % in 2012, to \$2.8 trillion, or nearly \$8,915 per person.⁵

With patients bearing more of the total cost of health care, providers nationwide are finding the days of writing off unpaid balances without significantly damaging the organization's bottom line are over.

"It wasn't that long ago that the industry relied primarily on monthly patient statements to collect patient balances, but now you're looking at a significant amount of money that cannot be ignored," says Carol Ciluffo, vice president of revenue cycle management for PINNACLE III, an ambulatory surgery center (ASC) management and development company based in Lakewood, Colorado. "The dramatic rise in patient deductibles and coinsurance percentages are driving patient balances to new heights. Times are tough and patient dollars are being pulled in so many different directions."

While it is in the nature of caregivers to empathize with patients and the challenges they face in their lives, allowing this mindset to get in the way of making sound financial decisions could ruin a facility.

"Letting patients walk out the door without paying what they owe is not going to yield anything positive for the financial health of the organization," Ciluffo notes. "Recent studies estimate nearly one-third of a provider's revenue will come from patients in the near future. Can your organization really afford to take a 33% cut in revenue?"

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— Carol Ciluffo, Vice President of Revenue Cycle Management, Pinnacle III

DIFFERENT SETTINGS, SAME STORY

Hospitals, ASCs and physician practices are all facing this question while experiencing pushback from patients who do not understand why their balances far exceed their expectations.

¹ <http://www.forbes.com/sites/brucejapsen/2013/01/07/unpaid-hospital-bills-rise-to-41-billion-annually/>

² <http://www.bloomberg.com/news/2013-10-14/patients-pay-before-seeing-doctor-as-deductibles-spread.html>

³ <http://www.forbes.com/sites/brucejapsen/2013/01/07/unpaid-hospital-bills-rise-to-41-billion-annually/>

⁴ <http://www.bankrate.com/finance/insurance/coping-with-out-of-pocket-health-care-cost-1.aspx>

⁵ <http://www.acainternational.org/products-health-care-collection-statistics-5434.aspx>

“They look at their insurance card, see a \$45 co-pay and think they should pay \$45 for the services they receive,” says Ryan Larson, director, revenue cycle, at Children’s Hospital Colorado in Aurora. “But that was before their doctor ordered some lab work and an X-ray, and the patient’s coverage changed from specialist to outpatient hospital benefits. Now the balance increases since what they owe is determined by their deductible, which is substantially higher than the co-pay.”

Larson continues, “I think that’s the most noticeable and challenging issue for us. There is not much we can do in terms of pricing strategies when you’re talking about such drastic differences in benefits between a specialist and outpatient hospital services. The hospital doesn’t determine those benefits; that’s up to the insurer or employer, but patients don’t understand how this works and it puts us in a contentious situation with the family.”

Pat Erhardt, financial manager for Parkview Orthopaedic Group in Palos Heights, Illinois, says her practice faces a similar challenge.

“The small amounts that patients pay for co-pays are no longer small dollars,” she says. “What used to be a \$20 co-pay for a specialist is now \$50-\$75, which can certainly add up over time. We get very little pushback from patients regarding their co-pays because they understand the cost per visit has risen and they clearly see the figure on their insurance card. What is relatively new — and isn’t always listed on their card — is the significantly larger deductibles.”

ACA International states that 58% of workers at small firms (2-199 employees) had deductibles of \$1,000 or more.⁶ Further complicating matters is working with the growing number of patients who have purchased and are using insurance for the first time. These patients present the biggest challenge with collections, Erhardt says.

“The insurance jargon is hard to understand,” she says. “You have co-insurance, deductibles and adjustments. People see all this and they don’t have a clue what it means. We get a tremendous number of calls from people who don’t understand why they owe anything if they paid their co-pay.”

COLLECTION EFFORTS GO FROM PASSIVE TO PROACTIVE

For any facility facing the challenge of collecting more from patients, the message is clear: Inaction is no longer an option.

“The reality is people have to pay for their gas and groceries when they take possession of them — they don’t get to put those expenses on a tab and never pay for them — and a medical procedure must not be treated differently,” Ciluffo states. “The patient is receiving a service requiring provider compensation. Facilities need to understand patients are not going to offer to pay if the organization hasn’t made their expectations clear prior to performing the service. Once the expectations have been outlined, facility personnel need to follow through on them with each patient.”

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⁶ <http://www.acainternational.org/products-health-care-collection-statistics-5434.aspx>

⁷ http://www.mckinsey.com/App_Media/Reports/Financial_Services/US_healthcare_payments_Remedies_for_an_ailing_system.pdf

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Establishing clear expectations begins with developing a solid financial policy, Ciluffo says. “To determine the parameters of your financial policy, take a good look at your center’s financial reports. Identify what percentage of your outstanding receivables is attributable to patient responsibility. Map the trends. Are patient balances rising? How much are you writing off to collections? How much is the collection agency able to recapture for you? This type of analysis will often lead you to what your policy should dictate.”

Ciluffo continues, “Whatever policy you adopt, publish it, practice it, preach it and post it everywhere. Put it on your website next to your pay online button, in the patient packet, at your front desk. Make sure everyone in your organization knows the policy, understands why the facility developed it and is comfortable putting it into practice. The more places you post your policy and the more consistently the message is extended to patients by your staff, the more likely patients will be ready to follow the financial policy when they walk in the door.”

Parkview Orthopaedic Group decided to take a far more aggressive approach with its collections, and established a policy and process to support these efforts.

“We’ve gone from a manual system that had our staff making calls to remind patients about their balances to a completely automated system,” Erhardt. “Now patients receive three statements. If they don’t reply to those statements, a pre-collect letter is automatically generated. If they don’t reply with money within 30 days, their account is turned over to professional collectors.”

BROACH THE TOPIC EARLY

Ciluffo says an effective way to reduce the need to collect on the back end is to place greater emphasis on up front communication to patients about their financial responsibility.

“Working with patients to secure payment up front is critical to capturing facility revenue,” she asserts. “Providing an estimate of a patient’s responsibility and speaking with them about how they intend to cover their portion of the cost before they even walk in the door eliminates surprises. You are performing a higher level of customer service by extending them an opportunity to make financial decisions prior to receiving services rather than after the fact when they no longer have choices.”

Larson says it is often difficult for Children’s Hospital Colorado to provide estimates on the cost of care. “We have patients arriving from multiple states to receive multiple services. That lends itself to a little more difficulty. We may provide behavioral health with physical therapy and some genetic testing and not all of the care we end up providing is determined prior to the patient’s arrival. The complexity of care we extend presents challenges in presenting accurate estimates.”

He recognizes, however, the tremendous value in the hospital giving patients as accurate of an estimate as possible before their arrival. The hospital intends to hire a number of new staff members who will focus primarily on providing families with estimates.

“We hope by having staff dedicated to estimates, we can support families and educate them up front, as well as collect out-of-pocket portions prior to them coming for their visits,” Larson says. “Pre-service collections are not currently part of our process. I think pediatric hospitals have always been a little leery about collections since we provide care to children, but we are embracing it more now and working to balance how to be sensitive to the families with the need to collect what we are owed.”

Realizing patient responsibility was representing a growing portion of their clients’ accounts receivable, Pinnacle III renewed its focus on training front office staff and increasing patient communication prior to receipt of services. That renewed dedication led to a 36% increase in the collection of patient balances in the first quarter of 2014 compared to the first quarter of 2013.

⁸ <http://www.healthcarefinancenews.com/blog/eligibility-determination-and-future-patient-payments?single-page=true>

A facility should be careful with selecting who will speak to patients about financial issues, Ciluffo advises. “If you place people who are meek, mild and so shy they can’t even make eye contact with your patients in this role, they are going to fail. Reassess who you have assigned to your front desk and consider providing collections training to your personnel.”

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DELIVER ORGANIZATION-WIDE EDUCATION

While the individuals who are in these roles must know the ins and outs of the facility’s collections policy, they are not the only staff members who should receive an education on it.

“In the past, many facilities, physicians and administrators were wary about addressing financial information with their patients,” Ciluffo says. “But patients don’t just confine relaying their financial concerns to the front desk. They will raise concerns to managers and physicians because those are the people with whom they have developed a rapport. It may not make sense for clinical personnel to get into the details, but they need to be well-versed enough to ensure they do not undermine the facility’s policy. Communicating a ‘don’t worry about it’ attitude or even implying that ‘it will be taken care of,’ is doing a disservice to the patient. Everybody has to know, get on board with, and follow the policy.”

Similarly, physicians and administrators have not always been transparent about the facility’s finances. However, people are more inclined to follow policy when they understand what brought the guidelines into play. Ciluffo points out, “You obtain buy-in from staff when you provide education to them on the facility’s patient balances and the impact those balances have on the facility’s profitability. Share data with them whenever possible. When staff have a clear picture of the impact of not collecting what patients owe, it really hits home. It affords them an opportunity to become part of the solution rather than unknowingly contributing to the problem.”

To help ensure staff can speak in an educated manner about billing practices, Larson says Children’s Hospital Colorado conducts internal education throughout the organization through presentations at faculty meetings, department meetings, and in one-on-one training sessions. Their training addresses how billing on a CMS-1500 or UB-04 form determines benefits and provides examples of actual bills families have received from the hospital.

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ACCOMMODATE PATIENTS AS MUCH AS POSSIBLE

An increasing focus on collections doesn’t require a decreasing focus on sensitivity toward patient needs; in fact, it should serve as motivation to explore even more ways to help patients, Ciluffo says.

ACA International states that in 2012, 41% of adults (ages 19-64) reported they had medical debt or trouble paying medical bills.⁹ McKinsey estimates that if consumers had access to more convenient payment mechanisms

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and structured payment or financing options available, only 10% of bad debt would be uncollectable. These consumer centric payment solutions could create \$40-60 billion a year in value to the U.S. health care sector.¹⁰

“Try to extend as many potential opportunities to patients as are available to achieve the result you want,” Ciluffo notes. “Offer a variety of payment options including online bill pay and recurring payments from credit cards or checking accounts. And if you have the ability to be a bit flexible with how you collect large balances, patients appreciate your willingness to work with them.”

Children’s Hospital Colorado recognized the value of offering payment plans. “We’ve put some procedures in place for payment plan requirements that define a sliding scale which is somewhat dependent upon family income,” Larson says.

Ciluffo adds, “Payment plans can really make a difference to a patient. When you purchase a new car, you can either buy it outright or lease it. With the dramatic increase in patient deductibles, offering some options for them to choose from works best. Most people don’t have \$5,000 or \$10,000 they can remit in one lump sum. If you have the ability to accept 30-50% at time of service, then have patients pay the rest over several months, you are providing them with more manageable terms than if you demanded full payment up front. Doing so may give them the additional time they need to secure alternative methods of funding (e.g., a personal loan) if they need to extend the payment term out for a longer period of time than your facility can reasonably offer to them.”

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“BUSINESS” CAN’T BE A DIRTY WORD

As caregivers, it can be difficult to find the right balance between delivering high-quality care and making sure patients pay for the services they receive from you. But that’s exactly what organizations need to do if they want to survive and continue to provide care, Ciluffo states.

“It’s bigger than just putting a process in place; it needs to be a culture shift,” she says. “Health care has a high human compassion component, but it is a business, and can only survive if it is a well-run business. If you don’t get on top of collecting from patients now, you are going to quickly find yourself in a precarious situation which may limit your ability to provide care in the future. And that’s a travesty for everybody.”

¹⁰ http://www.mckinsey.com/App_Media/Reports/Financial_Services/US_healthcare_payments_Remedies_for_an_ailing_system.pdf