Improving Self Pay At All Points of Service

Abstract

Healthcare providers are expected to provide healthcare, and they must also collect payment for it. Unfortunately, once patients leave the hospital, the chances that they will pay their portion of the bill drops dramatically. If hospitals take a proactive approach, collecting from patients at all points of service, they can keep this self-pay revenue from falling away.

This white paper will discuss the increase of such self-pay options as consumer directed health plans. It will explain why the revenue cycle must change to support this movement, and model an emerging approach for doing so. Finally, it will discuss the increasing use of technology to improve hospitals’ ability to collect from patients and present a viable technology solution.

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Improving Self Pay
At All Points of Service

Executive summary

Businesses of all sizes are struggling with increasing employee healthcare costs. Increasingly, employers are looking to employees to help shoulder the burden, and one of the fastest growing ways to do that is by shifting to Consumer-Directed Health Plans (CDHP). Sixty-one percent of large employers will offer a CDHP, and for 20 percent of them, it will be their only plan. The result: more consumer debt and less likelihood of payment.¹

Large U.S. employers estimate their healthcare benefit costs will increase an average of 8.9 percent in 2011, up from an average increase of 7 percent in 2010. Smaller employers project even greater costs. Eighty-six percent of respondents to the Council of Insurance Agents & Brokers’ 2010 Employee Benefits Market Survey said prices increased for small employers (those with 50 or fewer employees), with more than half the increases in the 11–20 percent range. Ninety-three percent of medium-sized employers (51 to 500 employees) had increases, with 58 percent seeing increases in the range of 6–15 percent.²

Traditional collection methods focus on recouping payment after treatment, after the patient has left the hospital. With the rise in self-pay, hospitals must adopt a different approach: Collection at all points of service. Technology will play a pivotal role in making that possible.

Introduction

U.S. healthcare costs are skyrocketing. As a percentage of GDP, they have increased to more than 17 percent and are expected to top 20 percent in the next nine years.³ The United States spent $7,538 per person on healthcare in 2008, well over double the $3,000 average of all Organisation for Economic Co-operation and Development (OECD) countries.⁴

And the more care costs, the more it costs to insure it. The result? Self-pay is on the rise.
CDHP on the rise

Healthcare providers are not alone in feeling financial pressures. For employees, insurance costs are going up. According to the Kaiser Family Foundation’s Employer Health Benefits 2010 Annual Survey:\(^5\)

- This year, the average worker is paying nearly $4,000 toward the cost of family health insurance coverage — an increase of 14 percent, or $482, over 2009.

- This jump occurred despite a 3 percent rise (to $13,770 on average) in total premiums for family coverage, including what employers themselves contribute.

- Since 2005, workers’ contributions to premiums have gone up 47 percent while overall premiums rose 27 percent. Wages, however, increased only 18 percent, and inflation rose 12 percent.

- Many employers are also raising annual deductibles. A total of 27 percent of covered workers now face annual deductibles of at least $1,000, up from 22 percent in 2009. Among small firms (3–199 workers), 46 percent face such deductibles.

Enter the high-deductible consumer directed health plan (CDHP). Devised to stabilize employers’ cost structures, CDHPs offload healthcare costs to the employee via higher deductibles and self-payments.

Nearly a fifth (18 percent) of respondents to a national survey of employer-sponsored health plans are eliminating high-cost or more generous health plan options as a way to move employees into lower-cost options, such as CDHPs.\(^6\)

According to a survey by the National Business Group on Health (NBGH), in 2011:\(^7\)

- Sixty-three percent of employers plan to increase employees’ share of premium costs, compared with 57 percent who did so this year.

- Forty-six percent plan to raise out-of-pocket maximums, up from 36 percent this year.

- Sixty-one percent of employers will offer a CDHP in 2011.

- Twenty percent of employers will offer only CDHPs, twice as many as in 2010.

Of the many types of health plans available to employers, CDHP is the only one that is growing, taking share away from HMOs and PPOs while increasing out of pocket payments for healthcare by employees. There’s one big problem, however: some individuals can’t (or won’t) pay for healthcare without employer subsidies.
Consumer debt on the rise

According to a recent survey, consumers were more likely to pay the mortgage, insurance, loans and utilities before their healthcare bills. They’re also more likely to pay for cable TV, Internet, lawn care and the newspaper. And this bill prioritization is not income driven — patients’ income levels do not relate to how likely they are to pay their healthcare bills.

Employers shifting healthcare costs to consumers that won’t pay them has created a dangerous cycle (Figure 1). Rising healthcare premiums, the recession and unemployment mean larger out-of-pocket liabilities and bad debt for consumers. Consumer bad debt means lower revenues and yields for providers. Providers must renegotiate contracted network discounts with payors (health plans) to remain profitable. Payors, in turn, increase premiums charged to employers and individuals, completing the cycle of rising consumer bad debt.

Providing for providers

Hospitals already bear $29 billion to $33 billion of the industry’s total $45 billion to $65 billion healthcare industry bad debt. Healthcare reform is the great unknown. It would extend coverage to as many as 30 million more uninsured; 3 million to 6 million in a public option. While this influx of new patients expecting coverage will increase costs and reduce margins for the healthcare system overall, it exacerbates an existing challenge facing hospitals: receiving payment before the patient leaves the facility.
Traditionally, hospitals did not collect patients’ self-pay obligation until after discharge. This old model relied on collecting only the co-pay at time of service, then determining and attempting to collect the balance post-service. But, the likelihood that patients will pay their portions of the bill drops dramatically once they leave the hospital.

In an industry plagued with rising costs which are increasingly shifted on patients who are increasingly unwilling or unable to pay, hospitals must take a proactive approach to securing payment: collecting from patients at all points of service.

A new model: Using technology to improve self-pay at all points of service

The emerging model addresses key phases of the revenue cycle: three points of service — pre-service financial clearance, point of service interaction and post-service settlement — and a fourth phase, performance analysis.

Pre-service financial clearance

In an effort to improve collection rates, hospitals have begun shifting to the left, moving from post-service patient accounting on the right (Figure 2), to pre-service financial clearance at patient access, on the left (Figure 3).

In this emerging model, registration staff performs all financial clearance functions before services are rendered. Demographic, financial and clinical data capture the move to pre-service, along with identity verification, eligibility verification, authorization, referral management and payment collection. Patient financial education and counseling also happen much earlier in the process. Functions addressed at this point in the revenue cycle include:

![Figure 2: Revenue Cycle — Traditional](image)

The traditional revenue cycle model focuses on most patient account management activity occurring AFTER services have been provided, when it is more difficult to collect, leading to bad debt.
1. **Stratifying payment potential.** A recent study found as much as 31 percent of self-pay revenue written off to bad debt collection actually met provider charity-eligibility guidelines.\(^9\) Using technology, successful organizations empower front line agents to conduct pre-registration charity screening interviews. Providers are integrating this step with current pre-registration workflow and applying it to all self-pays for quick, consistent application of financial aid, charity screening and enrollment across all patients. In doing so, they can determine earlier in the revenue cycle if a patient should be placed on a financial assistance pathway rather than the patient payment pathway (Figure 4). This enhances the hospital’s ability to collect payment for services rendered.

2. **Verifying eligibility** is important at every phase of the revenue cycle. Successful hospitals employ technology and workflows that check eligibility for every patient, at every point of service, including post-service. By incorporating eligibility discussions before and at the point-of-service, patient-access staff can have meaningful conversations with patients about what is owed.

This requires technology that extends beyond the traditional verification of insurance coverage. To ensure the most complete and accurate eligibility verification, providers need...
complete and accurate eligibility responses from a combination of EDI and web-based searches. Successful providers also use a combination of real time eligibility checking to ensure the latest information, and batch, which ensures ongoing checks for changes or updates in patient eligibility.

With the increased deductibles, co-payments, co-insurance and out-of-pocket maximums due to the shift by employers to CDHP, patient-access staff must stay abreast of the latest coverage to estimate bills correctly and manage patients’ expectations.

Regular eligibility checks also allow management and registrars to catch errors or updates earlier, reducing denials and rework. In one organization, improving financial clearance procedures led to 84 percent compliance with pre-registration eligibility verification and lowered days in A/R by five.

3. **Verifying patient data and identity.** Half of all required billing elements on a claim originate at the point of access, so correct information at registration is vital to an efficient revenue cycle. Verifying patient identification earlier helps prevent data fraud and identity theft. Using technology to assign an appropriate propensity-to-pay score further identifies patients who can pay versus those that might need financial assistance, and helps determine appropriate payment plans and collection strategies.

4. **Estimating patient responsibility.** More than half of providers responding to an HFMA study said estimating charges is a significant barrier to collecting at time of service. Intuitive technology used to estimate patient billing allows staff to calculate the patient’s financial obligation for service and his/her ability to pay. Informing patients of their financial responsibility earlier (including asking for a deposit and setting up a payment plan) increases patient satisfaction while increasing the organization’s collections and reducing self-pay.

**Point-of-service interaction**

In a study by MasterCard, 82 percent of hospitals said their bad debt was increasing or staying the same. However, 10 percent saw a decrease in bad debt, which they attributed to implementing collection policies at the point of service. Although several pre-service activities — verifying eligibility, updating charity status and estimating patient bills — should be repeated or completed at point-of-service, the most important tasks in this phase include:
1. **Setting up payment plans.** Leading providers use technology and propensity-to-pay scoring systems to make the appropriate deposit and payment schedules. In addition, health systems increasingly employ retail consumer tactics to collect payment, including:

   - Deposits
   - Payment contracts that clearly set out payment schedules and expectations
   - Card-on-file (secure storage of credit cards), which improves future point of service collections

2. **Requesting payment.** Organizations now can equip registrars to conduct financial discussions with patients — discussions that, in the past, might have been reserved for dedicated financial counselors. This may also include educating staff on the goods and services your patients receive and an understanding of what your facility needs to be profitable. Another best practice: collecting patient payments at point of service anywhere in the hospital with an e-cashiering method that posts patient payments directly to the patient accounting system. One hospital that did this now receives credit card payments for 85 percent of all point of service cash collections and 97 percent of online payments, which reduced A/R by 11 percent (five days).

3. **Evolving your point-of-service policies.** Many organizations have made the move toward point-of-service collections, but have taken limited or low-risk approaches which often focus on co-pay, fee schedule and flat-rate collections. The barriers to expanding point-of-service collections to include co-insurance and deductible amounts commonly include challenges in accurately calculating the amount due, balancing patient satisfaction and higher collections, avoiding collection of the wrong amount and preventing credit-balance situations. Through the use of more complete, credible and defensible estimates, providers can expand their collection activities and address many of these barriers by providing patients with precise understanding of their responsibility which is specific to their plan of care.

**Post-service financial settlement**

When most of the collections work is done pre-service, post-service now becomes the point at which an organization ensures accuracy, patient account management consistency and efficiency in collections.

1. **Confirm before billing.** As employers change the coverage they offer employees and move to CDHP, hospitals must vigilantly monitor changes in such things as plan enrollment, data collection, coverage limits, and dependent coverage. Constant enrollment changes in governmental plans like Medicare Advantage and Medicaid HMOs only increase the likelihood of errors and rework. With 27% of all payor denials and delays resulting from coverage issues, providers cannot afford to skip steps that affect final adjudication. Enabling technology incorporated into a claims management solution, allowed one hospital to prevent delayed adjudication of almost $14 million in billed charges. Another hospital incorporated post-service eligibility checks and recouped $500,000 in additional Medicaid revenue each month.
2. **Patient account management.** HFMA’s Patient Friendly Billing Guidelines, and billing information that is consistent from the final bill to the patient statement, sets patient expectations for financial responsibility. Easy-to-read statements improve patient satisfaction and increase willingness to pay earlier in the revenue cycle. Consolidating a family’s outstanding payments up to a single guarantor view helps the guarantor better manage his/her accounts overall. Plus, it is important for health systems to adopt a consolidated approach to billing, by combining multiple bills from the lab, physician and hospital in order to present a cohesive financial billing picture to the patient.

Online account management reduces patient billing questions and phone calls, lowering costs, improving patient satisfaction and accelerating post-service payment collection.

Online payment plans are good for both patients and providers: Evidence across hospital systems shows online bill payment lowers self-pay days in A/R by 10 percent and processing costs by $10 per transaction.

3. **Efficient collections.** The highest return comes from bills paid in the first 30 days. Predictably, the longer a receivable is outstanding, the less its value (Figure 5). At 60 days, the value of overall hospital receivables drops to 75 percent of the bill. At 90 days, it drops to 60 percent. After six months, the value is a mere 25 percent.

On a per-patient basis, it costs less to collect from a large insurer with millions of patients than to bill a single individual. On average, consumers pay more than twice as slowly as all payors but Medicaid. Not surprisingly, uninsured patients’ collection rates are substantially lower than insured patients are — at just 5 percent to 10 percent. What is surprising is that patients owing less than $500 are willing and able to pay 92 percent of the time — but healthcare collection rates are just 65–75 percent.

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**Figure 5: Cost of Collection Increases Over Time**
Self-pay accounts often are segmented by account age, size, propensity to pay, alphabetical order, payor or self-pay categories. Providers design collection approaches for each self-pay segment. A key question: How much should be outsourced?

Retaining high balance, low risk accounts may seem a good idea, but technology, training, telecommunications staffing and overhead may erode any potential margin. Many leading providers find it better to outsource post-service accounts for maximum collection potential of their portfolio.

Examples of post-service technology that helps secure the highest collections return include:

- Online payments and payment plans: Promote the payment website on paper statements and automate patient payment posting to the HIS via a single patient payment feed (including cash, e-cashiering and online web payments in a single feed)
- Re-verification of eligibility for accounts greater than $500 through Medicare, Medicaid
- Using an outsourcing partner that can offer automated call distribution systems with predictive dialer: This system eliminates inefficient dialing and waiting for an answer — improving collection efficiency. By placing a telephone call to the next prioritized account in the queue and awaiting an answer, the call is instantly transferred to the reimbursement specialist when the telephone is answered. The dialer uses artificial intelligence to determine the timing and volume of calls it makes and to monitor staffing and productivity. This system is used to contact patients and guarantors, as well as third-party payors

**Performance analysis**

After improving self-pay strategies through all points of service, analyzing performance allows an organization to identify trends and optimize revenue streams. Drilling down into self-pay data helps hospitals better understand:

- Which patients are most likely to pay (for example, OB/GYN patients are most likely to pay given the need for repeat services)
- Which physicians bring the highest — and the lowest — yield patients
- Which zip codes have patients that pay bills by the second statement
- Which referring doctors have patients with the highest propensity to pay

This information is valuable to hospital executives looking to expose root causes, understand performance trends and optimize revenue streams.
Conclusion

Healthcare reform notwithstanding, the cost of providing care in the U.S. will continue to grow. Employer costs to provide it will continue to escalate. Employees will be forced to take on larger portions of that expense.

The answer for providers? A new revenue cycle model that supports a new approach to collections. The enabler? Technology.

Notes


7 National Business Group on Health, op. cit.


12 HFMA (2009) op.cit.

13 2008 McKinsey consumer healthcare payment surve