Collect Now or Pay Later

Capturing patients’ growing out-of-pocket charges to avoid downstream consequences
**Executive Summary**

Cost is arguably the biggest, most challenging issue plaguing the U.S. healthcare system. Every healthcare stakeholder – patients, providers, employers and insurers – is trying to rein in costs for various reasons. But spending continues to rise.

Healthcare expenditures account for nearly $0.18 of every dollar spent in the U.S. The $2.9 trillion (yes, trillion) Americans spend on healthcare already approaches $10,000 per person and is expected to account for 19.6 percent of the Gross Domestic Product within the next decade.

As overall healthcare spending increases, so too does patients’ financial responsibility. Out-of-pocket spending grew 3.2 percent to $339.4 billion in 2013, or 12 percent of total national health expenditures. Meanwhile, hospitals and health systems go on providing care, gallantly carrying out their missions, sometimes giving away non-emergent services to people who can and should pay.

Healthcare organizations looking for ways to limit accounts receivable (A/R), avoid bad debt, overcome shrinking reimbursements and keep margins from dipping into the red (if they aren’t there already) find some solutions in patients’ pockets.

**Situation Analysis**

The American Hospital Association reports that since 2000, U.S. hospitals have given away more than $459 billion in uncompensated care to their patients. Hospitals provided $46.4 billion of uncompensated care in 2014, and while the percent of uncompensated care relative to total expenses has hovered around 6 percent since 1984, the total dollar figures continue to climb, essentially doubling in the last decade.
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Part of the problem is patients have come to expect treatment with little to no upfront expense and receive an invoice after 30 days or later, after a claim has been billed to their insurer. If all patients paid their bills and paid them in a timely manner then this approach could work without risk or complication. But data shows that once a patient leaves the facility, regardless of whether the patient has insurance, the likelihood of collecting out-of-pocket portion decreases dramatically.

A McKinsey & Company study found that providers can expect to collect only 50 to 70 percent of an insured patient’s balance after treatment. For uninsured patients, providers can expect to collect only 5 to 10 percent after service.

And patient payments have become a bigger, much more important piece of the pie. Employers are increasingly choosing to offer high-deductible plans to hold down their costs, passing more of the financial burden to their employees. Workers, in turn, may benefit from lower monthly premiums, but are more accountable for the overall cost of their own care when factoring in co-pays, deductibles and other out-of-pocket expenses.

• From 2013 to 2014, enrollment in high-deductible, consumer-directed health plans jumped from 18 percent to 23 percent. It was the largest single-year increase since the products hit the market. (Mercer)
• The number of enrollees with health savings accounts and high deductible health plans (HDHPs) rose to nearly 17.4 million in January 2014 and has grown at a rate of approximately 15 percent annually since 2011. (AHIP)
• The portion of workers with annual deductibles — what consumers must pay out-of-pocket before insurance kicks in — is up to 80 percent from 55 percent just eight years ago. (Kaiser Family Foundation)
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Thresholds for out-of-pocket expenses are also getting larger. The Kaiser Family Foundation reports that the average employee contribution (premiums and out-of-pocket expenses) to his or her health plan now approaches $5,000 per year. Lower-premium plans on the federal marketplace exchange, which is an outlet for many individuals and families who do not have access to employer-sponsored benefits, carry maximum out-of-pocket expenses of $6,600 for an individual plan and $13,200 for a family plan.

The percentage of covered workers with an annual deductible of at least $1,000 increased to 41 percent in 2014, up from just 10 percent in 2006. (Kaiser Family Foundation)

Collecting nominal co-pays is one thing. Collecting an entire $6,600 deductible for a single episode of care is an entirely different challenge, one that demands an effective end-to-end collections strategy with a heavy front-end emphasis.

Fewer Uninsured but More Underinsured

The U.S. Department of Health and Human Services projected that hospitals would save $5.7 billion in uncompensated care costs in 2014, mostly in states that have expanded Medicaid, where for-profit hospital chains reported uninsured admissions to be down by 50 percent or more. That’s good news for hospitals. The bad news is the Affordable Care Act has done nothing to address the underinsured population.

Consumers are bearing more of the costs for their own healthcare whether they can afford it or not. Low-premium, high-deductible health plans provide enough coverage to help in a catastrophic scenario but have fewer associated benefits and can leave consumers in a difficult spot trying to cover high out-of-pocket expenses.

A Commonwealth Fund report estimates that in 2012 there were 31.7 million people under age 65 who were underinsured, up from an estimated 25 million in 2009 (PricewaterhouseCoopers). A staggering 1 in 5 people (20 percent) under age 65 with middle incomes are believed to be either underinsured or without health insurance altogether.
The economic recession beginning in 2008 and federal policies implemented in the ensuing years have created new financial challenges for patients, and the healthcare organizations treating them.

- Nearly half of middle-class Americans skipped healthcare services or fell into financial hardship because of health expenses (Associated Press and NORC Center for Public Affairs Research).
- Use of hospital care among insured workers has been dropping since 2010 (Health Care Cost Institute).
- Nearly 30 percent of privately insured, working Americans with deductibles of at least 5 percent of their income had a medical problem but didn’t go to the doctor, skipped recommended medical tests, treatments or follow-ups (Commonwealth Fund).

Patients who skip needed medical care often exacerbate the original issue, costing themselves and their provider more in the long run. Insured or not, most patients share a common thread: In tough economic times the mortgage, groceries and other household expense payments take precedence over a medical bill.

**The Retail Mindset**

The numbers tell the story. Collecting patient payments is one of many mounting financial challenges for healthcare organizations. Providers must acknowledge the changing market around them and respond with more proactive, retail-like patterns. These concepts may seem like common sense to the rest of the world but in healthcare this approach requires a combination of significant investments in people, technology and internal process improvement.
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Often the required cultural shift is the most daunting obstacle to overcome in implementing a new or revamped collections strategy. Longtime employees get accustomed to a certain way of doing things and can resist change. A patient access employee who has never had to ask a patient for money may be reluctant to buy into what he or she considers a big role change. Management must see that tools and training are consistently put into practice, and can establish trust by soliciting input from employees on the front line. Earning commitment from everyone involved early in the process builds morale, camaraderie and enables an organization to achieve its objectives quicker.

Hospital patient collections efforts do not appear to be keeping pace with the growth in patient costs. Average collections from insured patients’ copayments and deductibles increased just slightly from the first quarter of 2014 to the first quarter of 2015. This is despite a 13 percent increase in the amount of insured patients’ balances moving to A/R (Crowe Horwath), in a market that saw employees’ share of healthcare costs—including premium contributions and out-of-pocket costs—increase more than 52 percent in just five years (Aon Hewitt).

**Fiscal Health is Mission Critical**

For some healthcare organizations, particularly faith-based, nonprofit systems, asking a patient to pay for care seems to go against the core purpose of community service. But not collecting out-of-pocket charges unnecessarily saddles the organization with uncollectable A/R that eventually turns to bad debt write-offs. Too much bad debt could ultimately lead to bankruptcy, which obviously prevents the hospital from being able to serve the community at all.

**Without a front-end collections strategy, missed co-payments and deductibles and uncollectable self-pay balances could eventually be enough to sink the entire ship.**

So what’s the right balance?

Successful healthcare organizations implement sophisticated, yet straightforward policies that support quality care and create positive patient experiences:

- They use data to determine with certainty who cannot pay versus those who will not pay.
- They adhere to price transparency initiatives, including providing upfront estimates of charges for every patient encounter.
- They ask every non-emergent patient who is able to pay to make some payment prior to or at the point of service.
- They continue providing charity care for patients who are truly unable to pay and connect others with financial assistance programs, where applicable.

No one expects to enter a grocery store, fill a cart full of food and take it home without going through the checkout line. In the same way, a driver wouldn’t expect a service station to fill the gas tank and send an invoice 60 or 90 days later. A retail business must protect its own financial interests to continue operating and serving its customer. The same goes for a hospital and its patients.
Components of a Successful Collections Strategy

**Payment Points**

While the healthcare revenue cycle spans an entire episode of care, the focus on patient payments should clearly be at the front-end, beginning with the very first patient encounter. Payment requests should be made at any and all points during the patient access process.

From the moment an appointment is scheduled, a debit or credit card can be taken via phone or via self-service web portal. Even standalone hospitals in the infant stages of a point-of-service collections program should be able to easily, quickly and accurately give price estimates, set policies that require minimum deposits and use them consistently.

Once a patient arrives at the facility, there should be multiple locations within the facility equipped to collect payment, from self-service kiosks to registration desks. Every point with an internet connection should be set up with software for processing payments, and each staff member should be trained and comfortable doing so.
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Payment Options
Patients are growing more accustomed to making pre- and point-of-service payments. Younger people who have only known HDHPs probably expect it. Still, dealing with the cost of a visit can be a frustrating step for someone focused with his or her personal health. Offering flexible payment options increases the likelihood patients will pay something up front and creates a better overall patient experience.

A hospital is essentially the only place where people of any socioeconomic status can easily obtain an interest-free loan for services rendered. Most hospitals double as lenders and can even have more outstanding A/R on the books than their banking neighbors have in their loan portfolios.

Patient payment plans are good customer service and a good method for securing payment from patients who cannot pay in full. Hospitals should be sure to set up payment plans correctly using a credit or debit card that has been verified as active and belonging to the patient or guarantor. Before setting up any payment plan the hospital should verify the patient’s identity, address, and credit history, and immediately process the first payment with the patient present.

Staff Training
The most innovative technology and best processes won’t help a healthcare organization achieve its mission if front line employees are not engaged. Staff must be trained well so they are comfortable asking for payment. Scripting and role-playing will help prepare staff for any type of patient in any scenario. Many organizations have also found success motivating employees with incentives and measuring and rewarding performance based on collected amounts against total opportunities to collect.

Front line employees carry out the hospital’s collection policies and set the proper expectations with patients. They should understand the “big picture” and how their performance impacts not only hospital revenue, but also patient satisfaction and the employee’s own job satisfaction.

Technology
A complete range of healthcare IT solutions are available to help organizations improve patient collections at every conceivable point in the revenue cycle. The best, most effective solutions are integrated with other revenue cycle management (RCM) software and hospital information systems to streamline workflows and maximize return on investment.

A survey by Black Book Market Research found that 90 percent of hospital CFOs fear that outdated, non-integrated RCM systems will force the hospital to outsource end-to-end functions, or purchase a newer RCM solution by 2016.
TECHNOLOGY-ENABLED UPFRONT COLLECTIONS

PATIENT PAYMENT ESTIMATION
Accurately estimate patient prices based on the hospital chargemaster, payer contract rates and patient insurance eligibility and benefits information, where applicable.

PATIENT ACCOUNT HISTORY
Present past due balances each time an estimate is created for a patient account, so an employee can see and potentially collect total outstanding A/R. This is especially helpful in identifying “frequent flyer” patients who regularly visit without paying.

CREDIT REPORTING AND SCORING
Segment patients based on credit history to help front-end staff make important decisions of how to handle payment.
- Those who can pay and will – analyze income and payment history to indicate patient has the ability to pay and will respond favorably to a request for payment.
- Those who can pay but won’t – patients who have enough income to make payment but have a negative credit history. Financial counseling with these patients may be difficult.
- Those who truly cannot pay – patients who do not have enough income to pay and may be eligible for Medicaid, Medicare or charity care programs.

CHARITY CARE ANALYSIS
Determine patient eligibility for charity care based on income and other factors so that the neediest receive free care, not those who leave in a BMW.

eCASHIERING
Process payments of any tender, at any physical or online location, at any point in the revenue cycle.
- Cash – post cash payments directly to a patient’s account electronically instead of using paper receipts and manual processes.
- Credit card – process credit card information via phone, online patient portals or physically swipe at kiosks or hospital payment points.
- Debit card – save bank processor fees with secure debit transactions.
- E-checks – process verified payments at a fraction of the cost of debit or credit cards.
- Discounts – allow staff to offer incentives for self-pay patients, prompt payment, etc., according to the hospital’s policies.
- Payment plans – set up recurring payment plans with automated payment and detailed exception reporting for improved plan management.
Conclusion
Moody's Investors Service summarized well the increasing importance of patient payments in a 2014 report, saying, “Today’s high deductibles are tomorrow’s bad debt.” It is a harsh reality for healthcare organizations that continue to operate without an effective, proactive patient collections strategy, and the market is trending against them.

Those looking to avoid the crippling effects of repeated missed payment opportunities, however, have an easy-to-follow blueprint from the retail sector: Ask for payment prior to or at the point of service.

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