CASH, CHECK OR CHARGE?

The Increasing Importance of Patient Payments in the Health Care Revenue Cycle
Executive Summary

Retail businesses do not provide goods and services without first receiving or securing payment. Not so in the U.S. health care system. Hospitals and physicians have historically cared for patients first and sought payment later. This practice is acceptable and even mandated by federal law in the hospital emergency room, but most patients expect to be treated with little to no up-front expense and receive an invoice after 30 days or later, after a claim has been billed to their insurer.

This unique process creates escalating amounts of uncompensated care provided by hospitals and physicians because they rarely are able to collect the full balance from patients. The American Hospital Association (AHA) reported that in 2008 uncompensated care cost U.S. hospitals $36.4 billion, an increase of 69 percent since 2000. Part of this figure is charity care, for which the hospital receives favorable tax incentives and partial reimbursement through government programs. The remainder is written off as bad debt, or patient balances forever lost.

Bad debt can be avoided by collecting the patient portion up front. The likelihood that a provider will be paid for its services drops immediately once a patient walks out the door. According to McKinsey & Company, providers can expect to collect only 50 to 70 percent of an insured patient’s balance after he or she is treated. For uninsured patients they can expect to collect only 5 to 10 percent after service.

New technologies and best practices for patient payments have surfaced because the status quo is unsustainable. More financial responsibility is shifting to patients, creating opportunity and urgency for hospitals to increase revenue and minimize bad debt write-offs.
High-deductible plans and health savings accounts have become an increasingly popular way for both insurers and patients to try to keep a lid on costs.

In 2009 the percentage of insured workers covered by HMOs decreased and enrollment in PPO plans was flat while consumer-directed health plans grew. (Mercer Consulting)

The percentage of covered workers enrolled in a health plan with a general annual deductible of at least $1,000 for single coverage grew from 10 percent in 2006 to 22 percent in 2009. (Kaiser Family Foundation)

The number of Americans covered by HSA-eligible plans has increased more than 30 percent since 2008. (America’s Health Insurance Plans)

Hospitals and physicians are facing higher costs to provide care because of malpractice insurance, rising equipment expenses and other factors. Insurance companies negotiate contracts to pay providers and must pass the increasing costs on to individuals (patients) in the form of higher premiums, co-payments and deductibles. The Kaiser Family Foundation reports that average annual insurance premiums have increased more than 130 percent in the last 10 years to $13,375. The portion paid by workers has increased at essentially the same rate.

Situation Analysis
The number one issue plaguing U.S. health care is cost. An argument can be made that insurance coverage fuels the national debate, but if coverage were more affordable then it would be a non-issue.

Consider this: In 1950 health care expenditures accounted for 4.5 percent of the gross domestic product. Today health care accounts for an estimated 17 percent of the GDP and the costs have outpaced the rate of inflation by at least double for more than a decade.

Hospitals and physicians are facing higher costs to provide care because of malpractice insurance, rising equipment expenses and other factors. Insurance companies negotiate contracts to pay providers and must pass the increasing costs on to individuals (patients) in the form of higher premiums, co-payments and deductibles. The Kaiser Family Foundation reports that average annual insurance premiums have increased more than 130 percent in the last 10 years to $13,375. The portion paid by workers has increased at essentially the same rate.

The number of Americans covered by HSA-eligible plans has increased more than 30 percent since 2008. (America’s Health Insurance Plans)

Situation Analysis
The number one issue plaguing U.S. health care is cost. An argument can be made that insurance coverage fuels the national debate, but if coverage were more affordable then it would be a non-issue.

Consider this: In 1950 health care expenditures accounted for 4.5 percent of the gross domestic product. Today health care accounts for an estimated 17 percent of the GDP and the costs have outpaced the rate of inflation by at least double for more than a decade.

Hospitals and physicians are facing higher costs to provide care because of malpractice insurance, rising equipment expenses and other factors. Insurance companies negotiate contracts to pay providers and must pass the increasing costs on to individuals (patients) in the form of higher premiums, co-payments and deductibles. The Kaiser Family Foundation reports that average annual insurance premiums have increased more than 130 percent in the last 10 years to $13,375. The portion paid by workers has increased at essentially the same rate.

High-deductible plans and health savings accounts have become an increasingly popular way for both insurers and patients to try to keep a lid on costs.

- In 2009 the percentage of insured workers covered by HMOs decreased and enrollment in PPO plans was flat while consumer-directed health plans grew. (Mercer Consulting)
- The percentage of covered workers enrolled in a health plan with a general annual deductible of at least $1,000 for single coverage grew from 10 percent in 2006 to 22 percent in 2009. (Kaiser Family Foundation)
- The number of Americans covered by HSA-eligible plans has increased more than 30 percent since 2008. (America’s Health Insurance Plans)

THE UNDERINSURED
Consumers are bearing more of the costs for their own health care whether they can afford it or not, and this has created a new breed of patients: The underinsured. These patients have enough coverage to help in a catastrophic scenario but have fewer associated benefits and sometimes cannot afford their co-payments, deductibles and prescription costs. The group includes small business owners and other individuals who negotiate rates directly with insurers, and other workers who opt for lower monthly premiums through an employer-sponsored high-deductible health plan. PricewaterhouseCoopers estimates are there are 25 million Americans in this category, an increase of 60 percent since 2003.

PricewaterhouseCoopers estimates are there are 25 million “underinsured” Americans, an increase of 60 percent since 2003.
THE UNINSURED
Recent economic conditions have exacerbated hospitals’ financial struggles and cast a brighter light on uncompensated care. Estimates count the number of uninsured Americans at about 47 million. The economic recession beginning in 2008 triggered a rise in unemployment. At its peak in 2009 one in ten people nationwide was unemployed. Those who lost jobs usually lost the related insurance coverage for themselves and in many cases for their families. According to Thomson Reuters, about one in four American households had trouble paying for health care in 2008-2009, and more than 17 percent postponed or delayed care. When they finally did seek care, many went to the nearest hospital emergency department (ED) as a last resort, and because their symptoms worsened the care was more involved and more costly and some could not pay.

- More than half of hospitals reported fewer patients seeking elective care in 2009, and 60 percent said they saw an increase in uninsured ED volume. (AHA)
- More people signed on to the Medicare and Medicaid rolls, creating additional burden on federal and state budgets. The number of people covered by government health insurance was 87.4 million in 2008, up from 83 million in 2007 (U.S. Census Bureau) and many states reported record numbers of new Medicaid enrollees in 2009.
- HDHPs and HSAs get some credit for helping to contain costs, but medical debt is still a leading contributor to personal bankruptcy. According to a nationwide study by the American Journal of Medicine, 62 percent of all bankruptcies filed in 2007 were linked to medical expenses, and nearly 80 percent of those who filed had health insurance.

Insured or not, most patients share a common thread: In tough economic times the mortgage, groceries and other household expenses take precedence over a hospital or doctor bill.

The Retail Mindset
A big reason why health care is suffering more severely than other sectors of the economy during the recession is because hospitals and physicians do not operate with a retail mindset. Hospitals have especially struggled to maintain financial solvency. Elective services are down. Reimbursements have been cut. As previously noted, emergency visits and uninsured volumes are up. Investment income has all but vanished. Facilities are cutting jobs, cutting services, going bankrupt and closing altogether.
Fortunately HFMA and other leading industry groups recognize this and are educating providers about strategies for price transparency and collecting patient payments. And providers are listening, somewhat.

- None of the highest-performing hospitals and systems surveyed by HFMA in 2009 said they did not have any point-of-service collections effort. Only 29 percent, however, make payment mandatory.

Price transparency is more than just providing an estimate and requesting payment. Updating and simplifying complex billing practices helps patients better understand invoices, encourages payment and leads to a better overall patient experience.

Often the required cultural shift is the most daunting and stubborn obstacle to overcome in implementing a new or revamped collections strategy. Longtime employees get accustomed to doing things are certain way and can resist change. A patient access employee who has never had to ask patients for money may be reluctant to buy into what he or she considers a big role.

The already staggering amount of uncompensated care is ballooning. In an AHA survey 70% of hospitals reported a moderate or significant increase in uncompensated care in 2009 vs. 2008 as a percent of total gross revenues. More than half of hospitals surveyed by the Healthcare Financial Management Association (HFMA) reported negative total operating margins.

The numbers tell the story. Health care facilities must adopt a more proactive, retail-like mindset in order to survive.

Point-of-Service Collections
Please tell us about point-of-service collections at your organization.

<table>
<thead>
<tr>
<th>Payment at time of service is mandatory</th>
<th>29%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment plan options are available at time of service</td>
<td>71%</td>
</tr>
<tr>
<td>Point-of-service collections are not used at all</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: HFMA

High Performers
All Others
balances could eventually be enough to sink the entire ship. Every non-emergent patient should be required to make some payment prior to service because it directly affects a hospital’s ability to provide quality care.

Best Practices

In today’s environment the focus of the revenue cycle should be at the front end, beginning with the very first patient encounter. Payment requests should be made at any and all points during patient access.

- **Scheduling** – Calculate a patient estimate via phone and communicate the amount verbally. Offer to accept a deposit or take the full amount via debit or credit card. Email a PDF of the estimate and receipt to the patient.
- **Pre-registration** – Review the estimated cost with the patient during follow up. Request payment again, if necessary, and provide payment options, including any discounts to encourage early and full payment.
- **Registration** – Offer to accept payment in any form (cash, debit, credit, check, payment plan). Discuss past due balances, if applicable.
- **Admission** – Confirm all necessary co-payments and deductibles are paid. Deny elective services service if not paid.

Hospitals in the infant stages of a point-of-service collections program may not have the ability to easily, quickly and accurately produce price estimates. These facilities should set minimum deposits based on type of encounter or procedure and use them consistently at all of these patient access points.

Payment Points

Any and every pre-service interaction with the patient should include an opportunity to process a payment. From the first point of scheduling a debit or credit card can be taken via phone. Patient self-service Web portals are another method of collecting pre-service payments. Still relatively new to health care, Web portals are sometimes preferred by younger patients who are accustomed to purchasing online.

Once a patient arrives at the facility, there should be multiple physical locations within the facility equipped to collect payment, from self-service kiosks to registration...
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 their own job satisfaction.

PAYMENT OPTIONS
Sometimes patients concerned about their health can be surprised and frustrated by the cost of a visit. Offering flexible payment options increases the likelihood the patient will pay something up front and creates a better overall patient experience.

A non-traditional example is interest-free medical finance cards. These cards are similar to credit card accounts but carry zero interest typically for up to two years. And because they are offered and managed by third parties the hospital assumes no financial risk or added liability. It can be a welcomed, convenient option for patients unable to pay for a scheduled procedure.

PAYMENT PLANS
Health care is virtually 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 patient A/R on the books than their banking neighbors have in loans. Patient payment plans are a common 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, however, 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 and address and immediately process the first payment with the patient present.

STAFF TRAINING
The latest technology and best processes won’t help the hospital achieve its mission if the employees are not engaged. Front end hospital personnel must be trained so they are comfortable asking for payment. Scripting and role playing will help prepare staff for any type of patient in any scenario. Employees should be motivated with incentives to perform and management must continually evaluate individual performance based on the opportunity to collect vs. actual collected amounts.

Technology
Innovative solutions have been developed to help the health care industry act in a more retail manner in terms of pre-service payments. Some banks and other new companies are marketing payment processing software, but there are many nuances that go along with estimating and processing health care patient payments. The best solutions are those that have been designed specifically for the health care environment. Hospitals and providers need solutions that are integrated with other revenue cycle management software and hospital information systems or practice management systems to streamline workflows and maximize return on investment.

More than 40 percent of systems considered by HFMA as high-performers in the revenue cycle said front end technology or software provides the greatest financial return on investment. Following are examples of the newest and most valuable tools on the market.

- **Patient Payment Estimation** – accurately estimate patient prices based on the hospital chargemaster, payer contract rates and patient eligibility and benefits information, where applicable. Many hospitals use spreadsheets and manual processes for payment estimation. Integrated technology is much faster and much more accurate.

- **Patient Account History**– brings past due balances forward 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** – segments patients based on credit history to help front end staff make important decisions of how to handle payment.
- **Those who can pay and will** – 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** – determines patient eligibility for charity care based on income and other factors so that the neediest receive free care, not those who leave in a Mercedes.

- **eCashiering** – solution for processing patient 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** – take 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** – editable fields within a system to allow staff to discount for self-pay patients, prompt payment, etc., according to the hospital’s policies.

- **Payment plans** – use e-cashiering software to set up recurring payment plans with automated payment and detailed exception reporting for improved plan management.

---

**Relative Performance of Investments in Terms of Financial Return**

In your opinion, which investments have provided the greatest financial return?

<table>
<thead>
<tr>
<th>Front-end technology/software</th>
<th>High Performers</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>43%</td>
</tr>
</tbody>
</table>

*Source: HFMA*
Case Studies

Hospital Doubles Patient Payments in Six Months

Pekin Hospital, a 125-bed facility in Central Ill., implemented a patient payment estimation solution to respond to patients’ price transparency requests and increase up-front collections. The software was first implemented in the CT department discharge area and because of its immediate impact was quickly deployed for use with all outpatient visits for Emergency Room, MRIs and surgeries.

Results:

• During the first six months the CT department alone surpassed its total prior year cash collections.

• “We have just five people collecting, but new technology and more efficient processes have literally doubled our results,” said Tonya Hundt, Reimbursement Specialist for Pekin Hospital. “We run PPE after scheduling and begin asking patients for payment over the phone, then again when they arrive, if necessary. We know it’s accurate, so we are confident in providing a printed estimate when they come through the door. It increases revenue, saves time and actually creates a more comfortable overall experience for our patients.”

Hospital Improves Collections and Patient Satisfaction

Following Advocate Health Care’s corporate initiative to achieve patient pricing transparency, 354-bed Advocate Illinois Masonic Medical Center analyzed its manual processes for estimating patient financial liability and found much room for improvement. The charge data master and paper spreadsheets was difficult to interpret. Patients were only notified of price estimates and/or discounts verbally, staff scripting widely varied and there was no firm record-keeping system existed for discussions with patients.

An automated patient payment estimator product improved up-front payments and enabled employees to perform more effectively as they carried out the mission of the hospital and the system.

“We tracked collections quarterly and saw an immediate increase in cash flow in the first three months,” said Michael Sciarabba, the hospital’s director of access services. “It provided a tangible return to the bottom line. I also think it was a good move from a customer service standpoint. Our front end staff was more educated on the organization’s financial policies and more comfortable discussing with patients, so they set the proper expectations.”

ROI EXAMPLE: PATIENT PAYMENT ESTIMATION

<table>
<thead>
<tr>
<th>Hospital:</th>
<th>250 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly outpatient encounters:</td>
<td>10,000</td>
</tr>
<tr>
<td>Average outpatient claim value</td>
<td>$1,500</td>
</tr>
<tr>
<td>Patients commercially insured:</td>
<td>50%</td>
</tr>
<tr>
<td>Uninsured/Self-pay patients:</td>
<td>7%</td>
</tr>
</tbody>
</table>

VALUE

• $251,250 ADDITIONAL OPPORTUNITY TO COLLECT CREATED MONTHLY using an up-front patient payment estimation solution

• $11,531.25 SAVED by avoiding in-house cost to collect insured and self-pay patient A/R after service

ROI EXAMPLE: ECASHIERING

<table>
<thead>
<tr>
<th>Hospital:</th>
<th>250 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly outpatient encounters:</td>
<td>10,000</td>
</tr>
<tr>
<td>Average outpatient claim value</td>
<td>$1,500</td>
</tr>
<tr>
<td>Average patient payment:</td>
<td>$206</td>
</tr>
</tbody>
</table>

Total number up-front collection points: 10 (throughout scheduling/pre-registration, registration, admissions, financial counseling and other areas)

VALUE

• $8,500 IN REDUCED UP-FRONT EQUIPMENT COSTS, or an 85% savings vs. point-of-service credit card terminals

• $440 IN REDUCED MONTHLY EQUIPMENT MAINTENANCE COSTS, or an 88% savings vs. point-of-service credit card terminals

• $10,300 IN MONTHLY CREDIT CARD TRANSACTION FEE SAVINGS by moving payment mix from existing unverified payment types at high rates (e.g. credit card via phone) to more preferred transaction types at lower rates (e.g. credit swiped with CVC and AVS checked)
CONCLUSION

Hospitals are drowning in bad debt, but a lifeline is floating in patient access.

If every patient paid his or her financial responsibility prior to service, then hospitals and physician practices would dramatically reduce billions of dollars in uncompensated care and could devote more time and resources to patient care instead of chasing unpaid patient invoices.

Let’s say only 25 percent of the $36.4 billion in uncompensated care provided by hospitals in 2008 was written off as bad debt. And let’s say through more proactive pre-service collections efforts hospitals improved collections by 30 percent. That would be $2.73 billion in additional revenue, or, extrapolated out across the nation’s approximately 1,800 community hospitals, more than $1.5 million in additional revenue per hospital per year.

The business of health care has changed. Providers stand to reap much-needed revenue by changing their mindsets and modifying their strategies for up-front collections. If health care facilities can implement the tools and processes to behave more like retail businesses, they will quickly improve their financial standings and strengthen their long-term sustainability. Only then will they will be able to effectively carry out the core mission of patient care and community service.

CREDITS

• American Hospital Association: Annual Survey of Hospitals, 2009
• Kaiser Family Foundation: “Employer Health Benefits 2009 Annual Survey”
• Mercer Consulting: US Health Plan Survey, 2009
• America’s Health Insurance Plans: 2009 HSA Census
• PricewaterhouseCoopers Health Research Institute: 2009 Top Issues
• Thomson Reuters: Center for Healthcare Improvement survey, 2009
• American Hospital Association: National survey 2009
• American Journal of Medicine: “Medical Bankruptcy in the United States,” 2009
• Healthcare Financial Management Association: “Strategies for a High-Performance Revenue Cycle,” 2009
• Passport Health Communications Inc. internal research
ABOUT PASSPORT HEALTH COMMUNICATIONS INC.

Passport Health Communications Inc. creates software and solutions to enable hospitals and health care providers to improve business operations and secure payment for their services. Founded in 1996 and headquartered in Franklin, Tenn., the organization is among the nation's fastest-growing Software-as-a-Service companies. Its eCare® brand of revenue cycle management solutions are available across multiple platforms and are delivered to one in three U.S. hospitals and more than 5,000 other health care facilities in all 50 states.