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Managing Patient Payments: A Balancing Act

By Katy Zillmer

A growing number of healthcare providers are considering how to reach patients as self-pay responsibility for their medical bills increases, including the option of offering patient loan financing programs at different stages of patient interaction.

The programs help providers lessen their financial burdens and lower bad debt.

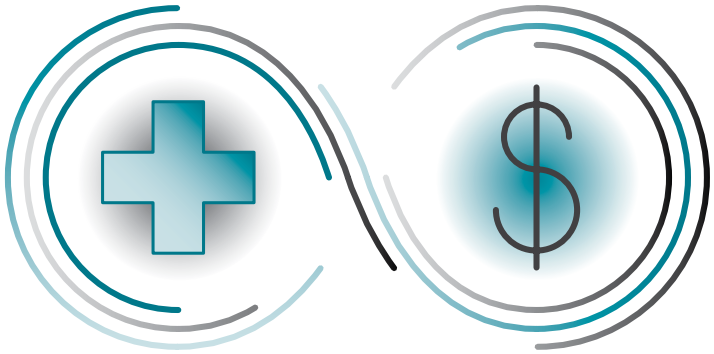
Bruce Haupt, president and CEO at ClearBalance,® a healthcare patient payment financing company, presented on Understanding Alternative Patient Financing Options at ACA International's Fall Forum and Expo in Chicago.

Healthcare providers use patient financing companies and often expect early-out collection agencies they work with to provide options as well.

"Offering patients an extended payment plan, such as the ClearBalance zero interest loan, doesn't shift the burden of collecting bad debt," Haupt said. "It's really to provide a better patient payment option and give the health system a better collection rate overall."

Patients' financial obligations for their medical bills represent 18 percent of revenue for healthcare providers, according to recent research on patient pay from athenahealth.

High deductible health plans are becoming more prevalent today and with that patients' financial responsibility for their healthcare also increases, even if their monthly premiums are lower.



According to athenahealth, the number of consumers in the U.S. with high-deductible health plans has increased 75 percent since 2010. More employers will offer only high-deductible health plans by 2018 and overall the popularity of the plans is pushing healthcare expenses out of reach for more and more consumers, according to athenahealth.

Providers offering patient financing options can tailor the programs based on their revenue cycle workflow and how they present the options to their patients.

"Revenue cycle leaders care very much about the patient and patient experience. We work with the provider to ensure financial counselors are trained in how to introduce the program. Ultimately, offering a patient loan program is a value-add that creates loyalty and patient satisfaction," Haupt said.

More and more consumers consider their healthcare in terms of price and want estimates for the cost and options for how to pay for it within their budget, much like purchasing a vehicle or home.

According to the ClearBalance Healthcare Consumerism study 2016 results, 91 percent of respondents said healthcare is an expense that requires financing of more than 12 months.

One in three respondents said they would delay care if a financing option wasn't available through their healthcare provider.

"Patient financing is absolutely intended to be a part of the hospital's payment policies for patients," Haupt said. "If you were considering going to a particular hospital for care or surgery, you're probably going to want to know the cost. That's what's happening today with tools for price estimation, for example. People want to know what their cost will be."

According to a 2016 Experian Health webinar "Providing Patients with Estimates: How Knowing What They Owe Can Boost Your Bottom

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Line" presented by product manager, price transparency, Elizabeth Serie, as consumers' out-of-pocket healthcare expenses increase, price transparency information for patients is becoming critical for them to access at any time; allowing them to make educated decisions on how much they spend.

Technology can help patients and providers be on the same page with determining the best cost of care; and providers can implement standardized processes and best practices to communicate with patients, Serie explained during the webinar.

According to Serie, providing patients' documentation in paper form in person or through mail or email after a visit can be a critical added step to ensure they can make an informed care decision. And, providers can have a copy of that information readily available when the patient comes in for their scheduled care.

While price transparency continues to be a priority, providers or early-out collection agencies working with consumers on their behalf can discuss patient financing options at pre-registration for care, time of service or after care to help ensure payment.

"My recommendation is to engage patients early in the process. Today there are lots of ways to do that," Haupt said. "A provider needs to think of patient financing as one component of their overall strategy to address the need to collect patient obligations and provide a good patient financial experience. It's just a piece, but they need to be clear how it fits in their strategy."

The Future of Patient Financing

Consumers want clear explanations of their bills and options after they receive care as much as they do when they evaluate costs at healthcare providers in advance, according to the 2016 Healthcare Consumerism Study by ClearBalance.

Fifty-five percent of the respondents in 2016 said they are sometimes or always confused by medical bills and 61 percent reported they are sometimes or always surprised by out-of-pocket costs they owe, according to the survey.

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Additionally, 65 percent of respondents said clear, easy-to-understand medical bills would have a positive impact on selecting a healthcare provider.

Patient financing options are important as healthcare providers are seeing reduced reimbursement for care, meaning patients have a greater responsibility for their bills and may not have the ability to pay for a high healthcare expense, especially if it is unexpected.

According to athenahealth's research, 50 percent of providers fail to receive at least $23,000 a year from patients. Forty percent of providers fail to receive more than $31,713 a year from patients.

There are best practices that can help improve collecting from patients, including evaluating patient pay measures such as time-of-service collection rate as well as the number of self-pay days in accounts receivable and bad debt write-offs, according to athenahealth.

According to Haupt in his presentation and ClearBalance Patient Pay Research from June 2014, payment plans can lower bad debt and provide better patient satisfaction. Reducing bad debt and improving patient satisfaction are the top two factors influencing providers' decisions to offer patient financing options followed by reducing accounts receivable days, immediate cash flow, eliminate collections costs and improving staff and physician satisfaction.

Providers can also identify tools such as training staff, developing a collection plan before a patient's office visit, time of service collections through card-on-file agreements or payment plans for large balances, and ongoing collection plans to help keep patient payments on track in a way that works for everyone, athenahealth concludes in its research.

For example, athenahealth reports payments plans for patients with high balances on their accounts "are essential for increasing overall collections, especially for practices whose patients are responsible for a substantial portion of the total cost of care."

Healthcare providers with uninsured patients or a high percentage that have high deductible health plans can also consider time-of-service collections and even a set down payment from the patient, according to athenahealth. Card-on-file agreements can also be helpful in collecting patient obligations at time-of-service. Even if the patient's bill amount is not known, providers and patients can agree to a payment range that will be collected.

"We really are in a two-payer market, with government and commercial payers in one bucket and patients in another," Haupt explained. Providers still must collect from commercial and government payers. As reimbursement tightens from that payer category, providers have no choice but to ensure they collect as much as possible from the second payer category – the patient – to maintain their financial health.

Overall, according to ClearBalance, many patients can only afford medical bills if they can pay for their expense over the long term and through a payment plan.

"Providers should consider patient financing because over time, it delivers better net collection," Haupt said.

Katy Zillmer is ACA International's communications specialist.

REPORT:

Uninsured Rates Decline Throughout U.S.

The uninsured rate among working-age adults dropped for every state and Washington, D.C. by 2015 after complete implementation of health coverage under the Affordable Care Act, according to a report from The Commonwealth Fund. "Uninsured rates for low-income adults also fell everywhere in the U.S., with Kentucky's 25-percentage-point drop leading the nation," according to a news release on the report.

Consumers in 38 states and Washington, D.C., "were less likely to say costs prevented them from going to a doctor when they needed healthcare. In 16 states and D.C., the percentage of people at risk for poor health outcomes who did not have a routine doctor's visit declined."

States that expanded Medicaid were expected to experience significant declines in their uninsured rates, but even those without an expansion as of January 2015 saw an uptick in the number of residents with health insurance.

"Uninsured rates in several states that had not expanded, including Florida, Georgia, Louisiana, Montana, North Carolina, South Carolina, and Texas, dropped between seven and nine percentage points between 2013 and 2015, as people gained coverage by enrolling through the [Affordable Care Act] marketplaces and by learning they qualified for their state's existing Medicaid program," according to the news release.

The Commonwealth Fund report also ranks states by out-of-pocket health spending compared to their income.

For example, in 2014/15, 18 to 19 percent of people under age 65 in Arkansas, Idaho, Louisiana, Mississippi, Montana, Oklahoma, and Tennessee spent a high percentage of their earnings on out-of-pocket healthcare costs. In contrast, 10 to 11 percent of consumers in Connecticut, Delaware, the District of Columbia, Maryland, Massachusetts, Minnesota, New York, Rhode Island, and Vermont had high out-of-pocket expenses relative to their income.

"These findings reveal that states have come a long way in the past few years and uninsured rates are at historic lows. It's important to hold on to these gains and continue to make progress in ensuring that people can get and afford the healthcare they need," said Commonwealth Fund President David Blumenthal in the news release. http://ow.ly/ekbL307yX3w

NEWS & NOTES

U.S. Adults Avoid Healthcare Because of Cost

Adults in the U.S. are more likely to avoid healthcare because of the costs and to face challenges paying for housing and food than those in other high-income nations, according to The Commonwealth Fund. 33 percent of U.S. adults avoided recommended care, seeing a doctor when sick or did not fill a prescription because of the expense, according to the survey. http://ow.ly/qwlm307yPCI

Survey: Physicians are Dissatisfied with Electronic Health Records

Physicians are dissatisfied with the use of electronic health records implemented with the passage of the HITECH Act, according to a survey from peer360. 68 percent of the 1,053 physicians participating in the survey said usability is their biggest challenge with EHRs. http://ow.ly/7EwO307yT6M

OIG Finds Vulnerabilities in CMS' Two-Midnight Rule

A review by the U.S. Department of Health and Human Services Office of the Inspector General shows the Two-Midnight Rule requiring inpatient payments for Medicare beneficiaries has produced some changes in the billing practices, but vulnerabilities still exist. "Hospitals are billing for many short inpatient stays that are potentially inappropriate under the policy; Medicare paid almost $2.9 billion for these stays in FY 2014," according to the OIG. http://ow.ly/wNpP307yVLJ

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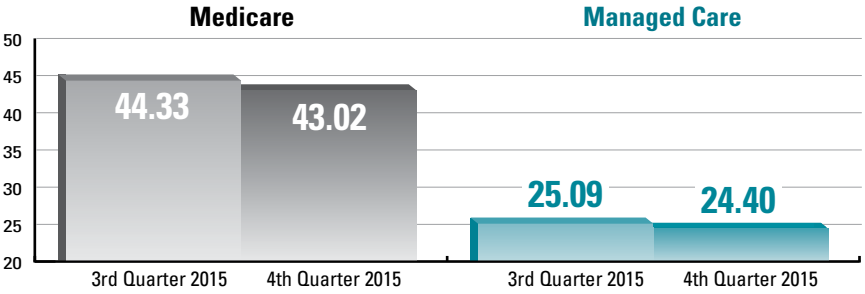
datawatch

Hospitals Report Little Change in Revenue

The percentage of Medicare and managed care revenue for U.S. hospitals in the fourth quarter of 2015 remained nearly the same as the third quarter, according to the *Hospital Accounts Receivable Analysis Report on Fourth Quarter 2015*. "In fourth quarter 2015, Medicare made up 43.02 percent of U.S. hospitals' total gross revenue, down only slightly from 44.33 percent in the third quarter. Managed care revenue also declined slightly in the fourth quarter, to 24.40 percent of total gross revenue, down from 25.09 percent of total third-quarter gross revenue."



Data Source: *Hospital Accounts Receivable Analysis report on Fourth Quarter 2015 vol. 30, no 1.*

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