

Dealing with the Self-Pay Dilemma

Front-end focus key to manage financial challenges

Healthcare Registration, November 2011

The current health care environment and its onerous financial challenges give rise to the ancient query: which came first, the chicken or the egg? In context of the current state, or rather straits, of the health care industry, the query might be recast as: Who struggles most, patients or providers?

This circular query springs from the fact that patients who need medical care increasingly can ill afford that care, due to rising health plan premiums and cost-sharing obligations. The rising cost of health care coverage leaves many covered Americans underinsured, while some opt or are forced to forgo coverage altogether. And that captures only the most simplistic scenario.

For providers, as patient-pay dollar amounts continue to rise, health care provider organizations can ill afford not to collect those dollars. Yet, self-pay patient balances represent receivables that are among the most difficult to collect, as data show that the percentage of hospital self-pay receivables typically is triple, or more, of hospital self-pay revenue. (*see Healthcare Registration*, October 2011, vol. 21:1).

And so arises the query of who struggles most in the current economic environment, patients or providers. The answer could be argued either way or both ways.

Regardless of the answer, patient access professionals face an increasingly daunting task of managing front-end financial responsibilities in a way that strikes a balance between the financial challenges faced by their health care provider organizations and the patients they serve.

Background

First, a bit of background. Recent data from the Kaiser Family Foundation's annual employer health benefits survey provide additional perspective to the quandary patients and providers face in attempting to pay and receive payment for medical services.

The data show health care premiums for employer-sponsored family health plans increased 113 percent overall within the past decade, to \$15,073 in 2011, up from \$7,061 in 2001. Employee premium costs for family coverage increased 131 percent during the same period, up from \$1,787 in 2001 to \$4,129 in 2011.

Another perspective offered in the survey shows that, since 1999, employee health plan contributions increased at a rate more than triple the rate of wage increases. Survey data show wages rose 50 percent from 1999 to 2011, while employee contributions to health plan premiums shot up 168 percent from 1999 contribution levels.

In addition to higher premiums, the number of employees who are enrolled in employer-sponsored health plans with significant cost-sharing obligations continues to grow. Nationally, 22 percent of workers with employer-sponsored health care coverage pay \$1,000 or more in deductible, copayment or co-insurance payments.

That employee cost-sharing figure increases as the size of the firm diminishes. Among small firms, those with fewer than 200 workers, half of covered employees had deductible requirements of \$1,000 or more in 2011, compared to 16 percent five years ago. Slightly more than one-third of covered workers, or 31 percent, at large firms had deductibles of \$1,000 or more, compared to 10 percent with high deductible requirements in 2006.

Adding to the financial difficulties faced by health care provider organizations is that the number of uninsured patient admissions outstrips the number of insured admissions. According to data from the Agency for Healthcare Research and Quality, uninsured admissions climbed 27 percent between 1997 and 2008, while insured admissions increased by 5 percent.

Regardless of patients' insurance coverage or lack thereof, US hospitals continue to face steep rises in uncompensated care costs, which is the cost of writing off unpaid expenses as charity or bad debt. According to American Hospital Association data, US hospitals wrote off nearly 6 percent of expenses as uncompensated care in 2009, or \$39.1 billion, which was nearly double the \$20.7 billion written off as uncompensated care 10 years ago.

Stemming Revenue Losses

Despite a difficult financial environment for all involved parties, patient access professionals remain charged with significant responsibility in their role as partners in the revenue cycle management process. To tackle these challenges, patient access needs to focus on five key areas to help stem revenue losses due to front-end issues, according to Irene Barron, chief operating officer with nTelagent, Inc.

“We cannot continue to accept our bad practices and our bad debt,” Barron notes, particularly at a time when the national economy only promises to further aggravate the financial difficulties provider organizations face.

Health care reform measures, Barron says, offer no panacea. Rather, health care reform is likely to drive up hospitals' bad debt. Rising premium, copayment and deductible costs will exacerbate the problem as the number of patients who lack sufficient coverage will grow, along with number of patients who opt out coverage they can't afford. Among the unintended results, Barron says, will be more patients in hospital emergency departments, a place where they cannot be turned away regardless of insurance coverage or lack thereof, and regardless of ability to pay.

The precise implications of health care reform are unknown, but health care providers can better steel their organizations to withstand current and future financial difficulty by taking a proactive revenue cycle management approach that engages patient access. To effectively tackle and

manage financial issues on the front end, she says, requires a focus on registration data integrity, insurance verification, medical necessity, early attention to and management of small balances, and collection of patient-pay balances at the time of service.

Registration Data Quality

One of the first steps patient access can take to stem the flow of red ink is to focus on registration data integrity, according to Barron. Inaccurate registration data is a key cause of revenue losses.

There are any number of reasons for inaccurate registration data. Chief among them, Barron says, are:

- an out-of-date master patient index (MPI). Data in the MPI can change as patients change employers or become unemployed, which results in insurance coverage changes;
- incomplete or inaccurate insurance data, as patient access employees encounter and must decipher a wide variety of complicated health plan contracts with confusing benefit plans;
- registration systems that lack the capability to effectively edit for user errors, such as errors in patient name and/or address, or errors in entered insurance data;
- lack of knowledge and training on hospital policies and procedures to outline patients' payment options, negotiate payment with patients, collect patient-pay balances or access insurer contracts; and
- disparate systems that are unable to interface and integrate data components.

A focus on registration data integrity is essential, Barron says, as even minor errors can be costly, due to rework through to payment denials. To underscore the importance of complete and accurate patient demographic data, Barron notes that more than 30 percent of all US mail is improperly addressed, resulting in delayed mail delivery or, in some cases, no delivery at all.

In addition, statistics show the average cost of returned mail is \$6.80, to manually handle, process and update the data base with correct address information, Barron says. Of note, however, is that statistics also show an undeliverable mail piece is returned to senders an average of three times before the address is updated in a database, pushing the average cost of each piece of returned mail to more than \$20.

These returned mail statistics reveal the need for patient access to ask patients at each visit for core data required for the patient record, including patient addresses, and to confirm and revise any existing data as needed. In addition to averting the cost of returned mail, accurate registration data is critical to avoid the costs of revenue write-offs due to avoidable payment denials.

Insurance Verification

Insurance, by definition, is the practice by which a company provides a guarantee of compensation for specified loss, damage, illness or death in return for payment of a premium, Barron says. Verification, by definition, is the process of establishing the truth, accuracy or validity of something.

Combined, insurance verification is a critical patient access process that, properly managed, would result in an accurate system of guaranteeing payment from health plans for the medical treatment of patient illness or injury, Barron notes.

Thus, a front-end insurance verification process is essential to identify and resolve a variety of issues that could lead to payment denials, Barron explains. Effective insurance verification processes and systems allow front-employees to:

- Determine if patients have active coverage;
- Determine if insured patients have benefits available;
- Identify whether patients have other insurance coverage and, if so, which is primary and which is secondary;
- Provide patient deductible, copayment and/or co-insurance amounts;
- Determine if Medicare plans are managed care plans;
- Provide skilled nursing days and/or hospice information; and
- Provide edits when insurance information is entered inaccurately.

For instance, systems with an effective insurance verification application will flag and display data errors during the process, Barron says. As example, electronic insurance verification queries may display if a Medicare patient is not found within the system, if a patient name is invalid and/or missing, if commercial insurance coverage data entered is incomplete, or if a patient's date of birth entered at registration fails to match the patient date of birth in the insurer's database, among others.

The imperative to effectively verify patient insurance is revealed in AHA data that show lack of patient eligibility for medical services is the most frequent reason for payment denials, Barron notes. Further, the imperative for providers to fully embrace the responsibility to verify patient insurance on the front end is revealed in AHA data that show insurers have an average claims processing error rate of 19.3 percent, resulting in an estimated waste of \$17 billion a year.

Failure to accurately and adequately verify insurance can lead to denials due to incomplete or invalid information. Although denials can be appealed, such appeals are costly and, in many instances, providers may not have appeal rights, Barron notes.

Medical Necessity

The bulk of payment denials fall into a few major categories, according to recent AHA hospital survey data. The most common reason for payment denials is lack of medical necessity. Hospitals reported to AHA that 53 percent of their denials were medical necessity denials.

To avert medical necessity denials, Barron says, determining medical necessity must be a process that occurs at or prior to registration. Determining medical necessity is required for all payer types, and, particularly, Medicare. The reason, she notes, is that payment received for services that payers later determine were medically unnecessary will be treated as overpayments and result in demands for repayment, with interest.

Determining medical necessity for Medicare beneficiaries prior to service is a critical patient access function, as medical necessity determinations trigger whether front-end employees must secure a signed advance beneficiary notice of non-coverage (ABN). A signed ABN must be on file so that if Medicare denies coverage due to lack of medical necessity, a facility then can bill the patient for those services. Lacking an ABN and receiving a payment denial for services Medicare deems medically unnecessary results in bad debt write-offs, as providers cannot pursue payment from beneficiaries who were not alerted prior to service of the potential for payment denials.

In addition, for Medicare providers, if a pattern of payment for medically unnecessary claims is shown, providers can face consequences that range from monetary fines through to exclusion from the Medicare program or criminal prosecution, Barron notes.

Another perspective on Medicare medical necessity issues is the contrast in the costs to gather medical necessity information prior to service and the costs to gather information related to a denied claim after service, as outlined in industry data. Barron says this data reveal that costs to gather medical necessity information prior to service range from 83 cents to \$19, while the costs to gather such information after a claim denial ranges from \$53 to \$117. Other medical necessity impact benchmarks noted in the data, Barron says, include that:

- the average Medicare medical necessity denial rate is 1.5 percent to 18 percent, depending on the type of service;
- the average outpatient facility per-claim denial write-off range is from \$696 to \$1,590; and
- the average annual hospital revenue lost due to medical necessity payment denials with no ABN program is \$960,000.

Of note is that the above cited write-offs and revenue losses are based on expected Medicare reimbursement had the service been covered and paid. Actual revenue losses would be higher than projected here, as claims revenue collected from beneficiaries who sign an ABN typically is greater than Medicare reimbursement.

Medical necessity also is a major issue in the government's focus on combating health care fraud and abuse, Barron notes. As example, a May 2011 report on the recovery audit contractor (RAC) program notes that medical necessity is a top reason for claim denials by RACs. Further, Barron says, the Healthcare Financial Management Association (HFMA) identifies RAC medical necessity audits as a significant risk for health care provider organizations, as RAC medical necessity auditors are projected to demand more than 1 million records this year as part of their reviews.

Small Balance Accounts

Although the pallor of the current economic environment may make broaching payment issues with patients uncomfortable, at best, discussing and securing payment from patients, particularly for small-dollar balances, is best practice, according to Barron. Often, small balances end up as write-offs, as the cost to collect those balances is high, with collection agencies receiving from 20 percent to 35 percent of debt amounts collected.

In addition, Barron notes, small-dollar balances add up. As example, she says, many providers that once considered \$10 or less a small balance now categorize balances as high as \$100 as a small balance. Rather than write-off those (now higher) small balances, Barron says, such balances should be pursued for payment by registration employees at the time of service.

Barron suggests provider organizations, with patient access leaders, take stock of small-dollar balance write-offs to identify the current losses and, in turn, the potential increased revenue if those dollars are collected up front.

Time-of-Service Collections

As noted at the start of this article, patients increasingly are responsible for a portion of their medical bills, and that portion continues to grow. As example, Barron says, insurance coverage for a CT scan that in the 1980s cost \$1,000 often required that patients pay 20 percent of that cost, or \$200. In the 1990s, the patient-pay portion increased to 20 percent of the cost, plus a \$100 deductible.

In 2010, for a CT scan cost of \$2,500, a typical insurance-approved amount might be \$1,375, with the patient-pay responsibility requiring payment of a \$500 deductible, plus 20 percent coinsurance, according to an nTelagent insurance vs. patient responsibility payment scenario. In this scenario, the patient would be required to pay a total of \$775, while the insurance payment would be \$600, or less than the patient-pay amount.

In 2011, the payment landscape has changed again -- and dramatically so, as outlined in another nTelagent insurance vs. patient responsibility scenario. As patients opt for higher deductibles to contain escalating premium costs, high-deductible plans with deductibles starting at \$2,500 are common. Thus, a patient who receives a CT scan with an insurance-approved cost of \$1,375 often must underwrite the entire cost for that service, with zero dollars paid by the insurer.

This shift of health care consumers taking on a growing -- and sometimes the greater -- portion of health care bills creates an imperative for health care provider organizations to determine up front what patients will owe, according to Barron. This upfront payment determination then needs to be accompanied by a request for payment.

To effectively work with patients to determine and collect patient-pay balances at the time of service requires that front-end employees receive training and tools that will allow them to succeed in this process. A key tool registration employees need to effectively collect from patients at the time of service, Barron says, is a contract calculator that allows registration employees to:

- access total charges,
- determine approved charges,
- verify insurance,
- calculate accurately and consistently patient-pay balances, and
- request and collect payment at the time of service.

Uncollected deductibles and coinsurance make up from 60 percent to 70 percent of US hospitals' bad debt, Barron says. For patient access employees to collect those self-pay balances, however, front-end employees not only need to know how to collect, but what to collect.

In Summary

According to Barron, patient access employees are the bank tellers of health care. Effective patient access and, in turn, revenue cycle management, requires that front-end employees gather complete and accurate registration data and identify payment issues before they become denials or write-offs, in compliance with federal regulations and insurer requirements.

Key, Barron says, is for patient access leaders to take a proactive approach to managing data and, in turn, dollars that help secure and sustain financial viability for health care provider organizations.

Reader's Resource

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