

## Front-End Discounting in Today's Market

*Patient access role in averting revenue losses*

*By Irene Barron*

**C**ollecting patient-pay balances at the time of service increasingly is becoming an accepted business practice at more and more health care provider organizations across the country.

Time-of-service collections are more common for two key reasons:

1. Health care provider organizations recognize and embrace the benefits of integrating patient access as a key component in effective revenue cycle management, educating, and training front-end employees to handle essential financial management responsibilities on the front end, including identifying and collecting patient-pay balances at the time of service. Patient access employees, therefore, are becoming more comfortable in determining patient-pay balances and requesting payment from patients.
2. Patients, particularly insured patients, recognize and embrace the fact that they are responsible for paying a portion of their medical care costs. Insured patients often enroll in health care plans that require greater out-of-pocket costs in exchange for lower monthly premiums. As health care consumers, patients also understand that payment for services is expected at the time those services are provided, rather than after the fact, as with other services they purchase.

Indeed, in today's retail-like health care environment, where patients are responsible for an increasing

amount of the bill, the following critical questions must be answered upfront:

- For the health care provider:
  - How much will I be paid?
  - Who is going to pay me?
  - How am I going to get paid?
- For the health care consumer:
  - How much will it cost?
  - What is my financial responsibility?
  - What are my payment options?

As requesting and collecting patient-pay balances at the time of service becomes more common, so does the practice of offering patients a discount if payment is made in full at the time of service. Such discounts will vary, depending upon the service, the patient's insurance coverage or lack thereof, and other specific factors unique to each patient's situation.

In implementing discounting methods, however, it is important for health care provider organizations to carefully consider discounting methods and formulas. Such formulas should not be applied in a "one size fits all" fashion, as the following scenario reveals. This scenario outlines two approaches and outcomes in applying a discount for payment in full at the time of service (*see Exhibit 1*).

<b>Exhibit 1. Scenario: Cost of CT of Head with Contrast—\$ 2,500</b>				
<b>Ability to Pay</b>	<b>High</b>	<b>Moderate</b>	<b>Low</b>	
	<b>10% Discount</b>	<b>20% Discount</b>	<b>40% Discount</b>	<b>60% Discount</b>
<b>Uninsured</b>	<b>\$2,250</b>	<b>\$2,000</b>	<b>\$1,500</b>	<b>\$1,000</b>
Having “capacity to pay” goes hand in hand with the insurance plan an individual will choose due to the cost for lower deductibles.				
<b>Insured</b>				
Approved insurance payment at 60%	\$1,500	\$1,500	\$1,500	\$1,500
Contractual adjustments	\$1,000	\$1,000	\$1,000	\$1,000
Deductible	\$1,000	\$2,000	\$3,000	\$3,000
Coinsurance at 10%	\$125	\$125	–	–
Patient due	\$1,625	\$1,625	\$1,500	\$1,500
Insurance pays	\$625	\$0	\$0	\$0
Total facility reimbursement	\$1,625	\$1,625	\$1,500	\$1,500
In the example above, giving a 60% “one size fits all” discount means the facility loses a minimum of \$500 from all insured patients who choose not to use their insurance.				

## The First Scenario

John has had headaches for months. After John makes numerous trips to his family physician, the doctor orders a computerized tomography (CT) scan of John’s head to rule out anything serious. An appointment is scheduled at the local hospital.

Upon arrival on the day of his test, John goes through the registration process and is asked for his insurance information. Because he is financially savvy, John remembers his insurance carrier has just notified him that his deductibles and copayments have been increased in order to maintain his premiums at a lower amount, and he now has a \$3,000 deductible. John asks the patient access representative, “Exactly how much does this test I’m having cost?”

The patient access employees at the hospital where John will receive the CT scan have been well trained on the costs of procedures. They know that, for insured patients, deductibles, copayments, and coinsurance must be collected from patients at the time of service, and that uninsured patients are offered a 60 percent discount if they pay in full at point of service.

With total confidence, the patient access representative replies, “The scan costs \$2,500. However, if you don’t have insurance, I can offer you a 60 percent discount if you pay in full today.”

John does some figuring in his head and tells the front-end employee, “All right, then, I’m going to go ahead and pay you upfront for the test.”

The patient access employee informs John he owes \$1,000—because he has not provided her with any insurance information, is willing to pay in full at point of service, and is registered as an uninsured patient. John pays the \$1,000 and the employee writes John a receipt.

John is pleased with his business decision. He feels he has just saved \$1,500. The patient access employee also is pleased, because she just collected a substantial amount of money at the point of service—no bill or payment plan needed.

## A Second Look

Now, let’s revisit this scenario within the context of the full picture. The problem in the first scenario is what the patient access employee did not know because she did not fully pursue her initial query about John’s insurance coverage.

What the patient access employee did not know is that John does have insurance coverage and that his insurance carrier has a contract with the hospital that provides coverage for 60 percent of total charges. Had the front-end employee obtained John’s insurance information, the amount covered by John’s insurance would have been \$1,500, which John would have owed as he has a \$3,000 deductible. In extending the discount prior to confirming insurance coverage, the patient seized the opportunity to take advantage of less out-of-pocket financial liability while the hospital lost \$500 in reimbursement on the account.

Is this an unusual event? Absolutely not! In an effort to increase cash on hand, hospitals have developed policies for upfront collections that include deep discounts for “prompt payment” or payment in full at point of service. Due to the pairing of increased patient-pay deductible and copayment amounts nationwide and negative changes in the economy, patients have become more aware of what their out-of-pocket costs will be if they do—and if they don’t—use their insurance. In many cases, when savvy patients evaluate whether they would be better off acknowledging or withholding their insurance information, the loser is the hospital.

## Ten Questions to Consider in Offering Discounts

What is the solution to averting revenue losses while improving cash flow through improved time-of-service collections of patient-pay balances? Although offering discounts is both a common and appropriate policy for uninsured patients, hospital decision makers must ensure that the discounts being offered are not encouraging insured patients to present as uninsured to secure a discount that results in their paying less out of pocket than if they provided their insurance information.

In general, comparing your facility’s discount policy to your insurance contracts will enable health care provider organizations to avoid becoming “the loser” in the patient-insurance carrier-hospital arena. Consideration should be given to offering discounts according to a patient’s ability to pay, as well as according to the dollar amount of the service being performed. The method and formulas for offering discounts should never be “one size fits all.”

A smart, strategic approach to offering discounts—one that addresses the current economic environment and, in turn, patients’ motivation to get the best price for their medical care—can make all the difference. In reviewing or implementing discounting policies, health care provider organizations should consider the following ten questions.

### 1. What is your patient’s capacity to pay?

This should not be based on a credit score or the history of how the patient has paid in the past, but rather the patient’s current financial situation.

### 2. What is the cost of the service being performed?

Offering a discount on outpatient surgery or inpatient services is a much different consideration

than discounting an outpatient test or non-emergent emergency department visit. Discounts for lower-cost services should be less than discounts for high-dollar services. For example, offering a 50 percent discount to a patient who does not have insurance—but has a \$20,000 outstanding bill—is not likely going to result in the patient paying in full.

### 3. What is the average percentage allowed under your current health plan contracts?

Offering a higher discount than is normally allowed through a managed care payment is costly. To discount a higher percentage than is typically owed from the patient according to contracts is to encourage your patient to not use his or her insurance coverage.

### 4. How much are the average deductibles and/or copayments for patients covered by your top five health plan contracts?

Does the patient have an incentive to give you his or her insurance coverage? Or does it cost the patient more out of pocket to use insurance coverage?

### 5. Do you have a solid charity policy, and is it being applied to all patients?

Both insured and uninsured patients may qualify for charity. Insured patients with high deductibles and/or copayments should be considered for charity care write-offs if it is determined they truly do not have the ability to pay their out-of-pocket portion of their medical expenses.

### 6. Are your patient access employees trained to encourage use of insurance coverage?

Do front-end employees have a means to determine if a patient has presented with insurance in the past, and if the patient should qualify for insurance or federal assistance based on age or employment status?

### 7. Are you giving patient access employees the tools needed to work “financially smart” with patients?

Once you have reviewed and revised your discounting policies, be sure you have a system in place that guarantees all staff members have the tools they need to consistently and accurately handle patient discounts, along with all other point-of-service activities.

Is information on deductibles and/or copayments, out-of-pocket payments, coverage eligibility, patient capacity to pay, charity care determination, and discounting available at their fingertips? If not, you are

preventing your most valuable resource (the patient access professionals) from collecting all possible cash at point of service, and detracting from their ability to help patients receive all the financial assistance for which they qualify.

### **8. When were your contracts last negotiated?**

The market has changed. In past years, deductibles and copayments were minimal in comparison to the payment being made to the facility by the insurance company. More and more remittances are showing the total charges applied to a deductible. The result of outdated or poorly negotiated contracts is a win for the insurance carrier and a loss for you and/or the patient.

With the passage of the Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on February 23, 2010, now is the ideal time for hospitals to review—and renegotiate, if necessary—all contracts with insurance companies. Many of the PPACA's significant provisions go into effect six months after the bill's signing, or September 23, 2010. Health care provider organizations that delay reviewing and renegotiating contracts as appropriate could find their institutions losing substantial dollars due to outdated contracts or inappropriate discounting policies.

### **9. Is it financially smart for your facility to discount the insured patient's deductible and/or copayment in order to obtain payment at point of service?**

Discounting patient-pay balances for insured patients at point of service can generate immediate cash flow and, thus, increase your cash on hand as it encourages your patient to take care of his or her portion due at point of service. The federal ruling on discounting for the insured has stated that, as long as discounting is done at point of service to encourage payment, this is perfectly acceptable.

Note, however, that there are guidelines that must be followed when the patient is insured. Ensure you are following the guidelines laid out in health plan contracts for discounting. Most guidelines

apply only to the deductible and/or copayment. In addition, allowing your insured patients to not use their insurance puts your facility at risk of being in violation of your health plan contracts and having very little negotiation power when contracts are renegotiated.

### **10. Are you applying a “one size fits all” discount to a market that has increased deductibles and/or copayments, is characterized by an unemployment rate that is at its highest in recent history, and is complicated by multiple other variables that make every patient different?**

In applying a “one size fits all” discount, you are missing out on higher reimbursement levels from health plans, and you are discouraging payment by patients who have extremely expensive deductibles and/or copayments. Instead, you are encouraging patients to take advantage of your discount, rather than allowing your facility to be paid by the insurance carrier and collecting the actual portion of what is due from the patient.

### **In Summary**

Consider carefully your answers to the above ten questions. The responses may dictate that you make some adjustments to discounting policies—and change is never easy.

In the long run, however, adopting a wise, strategic discounting approach that takes into consideration the multiple and varied factors of each patient's financial situation will help ensure your facility—and your patients—reap the benefits of smart discounting. ■

### *Reader's Resource*

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