MANAGED CARE
OUTLOOK
The Insider's Business Briefing on Managed Healthcare
ASPEN PUBLISHERS
Volume 23, Number 24 • December 15, 2010

Post-Reform, a Different Kind of Revenue Cycle: As Health Insurance Plans Change, So Must Health Care Providers

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The self-pay challenge. The self-pay overload. The self-pay beast. The self-pay dilemma. The self-pay onslaught.

The expected increase in self-pay patient balances in a post-health care reform era has been given a number of names, but the end result is the same: Self-pay is predicted to increase 20 percent to 40 percent over the coming year with the passage of the Patient Protection and Affordable Care Act (PPACA).

Are health care providers ready for this? Do they have the right information at hand to help their patients?

Even before health care reform, health care providers already were struggling to adjust to the industry's new "retail-like" revenue cycle, with patients responsible for an ever-increasing portion of their bill. (For definition's sake, "self-pay" is the portion of the medical bill for which the patient is responsible for payment. This includes copayments and deductibles for insured patients and the full medical bill for uninsured patients.) Historically, the vast majority of self-pay accounts were made up of uninsured patients.

With the shift to "consumer-driven" health care plans (CDHPs) and health savings

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accounts (HSAs) that carry significantly higher copayments and deductibles than traditional insurance plans of the past, a greater portion of self-pay accounts is now derived from insured patients. Now, with health care reform and, in particular, PPACA, the impact on insurance premiums, deductibles, copayments, and coinsurance is even more significant. In fact, members of the insured population already are receiving updates to their coverage with increases in premiums and more being required out-of-pocket by the patient.

Consider this email we received from a colleague:

> "I have a health insurance policy that I purchased in July 2010 for family health care coverage. The policy has a $750 deductible, $300 emergency room (ER) copay, and $35 physician copay, and my premium is $293 per month. Not a bad premium.
>
> "I received a letter in the mail from the insurance company yesterday that stated my plan was no longer going to be available as of January 1, 2011, "based on provisions of the Patient Protection and Affordable Care Act of 2010." They offered me four new product options to replace my current plan.
>
> "The plan equivalent to what I have now has a $750 deductible, $250 copay (along with a $100 ER physician copay), and similar benefits to what I currently have. My premium for this new replacement plan would be $418 — a 43 percent increase to have the same coverage I have now (except with the new plan, I will owe a $100 ER physician copay separate from my hospital copay)."

Another option available to our colleague was what he termed the "bottom-of-the-barrel" plan: a $228 premium and a $3,050 deductible — and pretty much every other benefit on the list is "80 percent, subject to deductible," including the ER copayment and physician ER copayment.

Can you guess which plan he chose? (Hint: The one he could afford.)

Changes Abound

Beginning January 2011, insurance plan changes such as this will begin affecting health care providers and patients substantially. With 60 percent to 70 percent of hospital bad debt already being attributed to insured patients who have large out-of-pocket costs, the impact of rising self-pay portions due to reform will be far more than most health care providers are prepared to handle.

Businesses will continue to shift employees to CDHPs and high-deductible health plans (HDHPs). Some estimates show that CDHP and HDHP plans are expected to double to nearly 20 million plans, and the average deductible for an individual will be $3,500 ($6,500 for family); out-of-pocket expenses will average more as well.[1] Add to this the 30 million soon-to-be newly insured patients, who must meet their deductibles before insurance kicks in, and, well, that "self-pay overload" description starts to take form. (For this article, we will skip the issues with Medicare and Medicaid altogether.)

Hospitals and other providers that have not already addressed their upfront revenue cycle processes must do so immediately — for their own financial viability and to assist their patients in navigating the complex payment structure. As a Healthcare Financial Management Association report succinctly notes: "Healthcare reform is pushing providers to fix problems early in the revenue cycle, where they start."[2]

The Tendency to Ignore Front-End Collections

Hospital providers have notoriously worked accounts receivable "after the fact" through statement processing, early-out vendors, and primary collection agencies. Without preparing and making the necessary changes to allow for collections at point of service, the patient-due increases brought on by PPACA and other trends will become more than can possibly be handled — if the status quo continues. In other words, upfront patient-due collections must take priority as a revenue/payor source, right up there with third-party payors.

Because very little attention has been given to collections at point of service, few health care providers have a way of knowing what should be collected from patients. For example, existing managed care systems have focused on verifying that insurance pays correctly, while leaving the patient balance at point of service an unknown number.

To maintain financial viability, and not add a large increase to the number of accounts that fall into the "black hole of collections," hospitals need to immediately focus on implementing systems for their front-office staff to provide them with accurate information and streamlined tools for collections (along with discounting of services, insurance verification, charity care, payment plans, price transparency, medical financing assistance and enrollment, and other now-necessary front-end processes). Properly trained, well-equipped, confident patient access staff members are equally as critical.

A Look at the 80/20 Rule

Let's revisit our colleague's plan choices to understand why point-of-service systems are more important than ever. As his new plan highlights, many insurance providers are offering their insured customers a change to an 80/20 rule of the past, as an alternative to copayments or increased deductibles. On the surface, this sounds like a good plan; however, this introduces some complications. Remember that the 80 percent is for "approved" charges, not total charges. Therefore, the health care provider cannot collect anything from the patient at point of service *unless* there is a system in place to estimate what the "approved" charge will be.

Unfortunately, hospitals often hold their various, lengthy insurance contracts in bulky manuals, totally out of the patient access staff's reach — an inefficient, error-prone process that makes figuring out approved charges and coinsurance impossible at point of service. As an example, if my colleague were an ER patient under his new plan, a hospital without an automated contract management system at point of service would have no way of telling him what his copayment would be. It is no longer a fixed-dollar amount but 80 percent of the approved charge and subject to his deductible.

Where in the past a hospital was paid an approved charge less deductible or copayment, the hospital will now be paid 80 percent of the approved charge less the deductible, and the patient will owe 20 percent plus the deductible. To put this into perspective:

Current Scenario (Pre-Reform):
$1,500 approved charge – $500 deductible = Provider is paid $1,000, and patient owes $500.

New Scenario (Post-Reform, With 80/20 Rule):
$1,500 approved charge paid at 80 percent after deductible of $500 = Provider is paid $800, and patient owes $700.

Result: Less paid by the insurance carrier and more due from the patient.

In Sum: Upfront Collections a Must Beginning January 2011

Hospitals that identify what causes their bad debt, and embrace the necessary steps to change this otherwise constantly growing number, will be better positioned to succeed. A hospital's financial viability depends not only on having the right revenue cycle systems and policies in place but also on having the tools to enforce and monitor those systems.

In the face of reform, health care is going to be a bumpy ride for those facilities that aren't proactive in making the necessary changes to survive, beginning with upfront collections. What we know: Insurance payments will decrease. Patient-due portions will increase. Self-pay balances will rise. It is up to health care providers to get ready. ■

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