

Consumer Driven Health Care and Its Impact on Medical Practices



By now, most medical groups have realized an increasing number of High Deductible Health Plans (HDHP) among the insured patient population. These HDHPs oftentimes work in conjunction with an additional plan feature, such as a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). While these types of plans provide potential health plan premium savings and tax incentives for employers and insureds, they can cause significant collection challenges for the provider, and the avoidance of appropriate care by patients.

Current trends among medical practices demonstrate increasing accounts receivable, particularly patient responsible receivables. Recent benchmarks reveal that in many disciplines of medicine, the day's charges in accounts receivable (A/R Days) and other key revenue performance indicators are declining in performance. Receivables are up, and cash is down. This is occurring despite the fact that 37 states have passed prompt pay legislation. The key missing ingredient of prompt pay laws, however, is the patient payment requirements.

Effectively managing HDHPs, HSAs and HRAs requires a significant shift in thinking. Gone are the days of simply collecting a co-payment at the time of service. Most HDHPs do not have a co-payment until the deductible has been met. Many medical practices obtain insurance information when scheduling a patient or at the time of check in at the office. Most fail to identify deductible information or collect deductible amounts at the time of service, and instead bill the claim to insurance, wait for the explanation of benefits (EOB) and then bill the patient for the remaining balance applied toward the deductible. This can become more complicated when the patient has an HSA or HRA. Some plan administrators instruct their insureds not to pay service fees at the time of the visit unless the provider can adjudicate the claim immediately, or unless the provider knows its allowed amount in order to collect only the appropriate contractually agreed upon fees.

In addition, most plan administrators will not pay a claim from the HSA or HRA if funds have not yet been contributed and do not exist in the account.

In today's consumer driven health care environment, it is critical to identify plan types and understand what you can collect at the time of service. Most practices are not assertive enough when holding patients accountable to know their plan type and financial obligation. If the provider does not hold the patient accountable to identify this information, then the practice must implement other mechanisms to discover benefit details. Otherwise, the patient receives care and walks out the door – quite possibly without having paid anything, though bearing a significant payment responsibility.

Some providers have taken drastic measures to effectively manage this shift in health care reimbursement. Following are points to consider when evaluating how you may be able to re-engineer operations to better manage these plans:

- Verify benefits prior to service and identify plan type, deductible amounts, whether an HSA or HRA is part of the patient's benefit coverage and determine how much of the deductible has been met. (See article on p. 5)
- Shift thinking among front office staff to collect more than a co-payment. This requires training to ensure that your staff members are adept at interacting with patients regarding payment requirements.

- Shift billing department staff to the front office to serve in a role of patient financial counselor. This may be a controversial suggestion, however, if front office processes break down, the billing department or billing service will not be able to effectively perform its functions.
- The practice must have debit/credit card processing capabilities. Many HSA and HRA plans feature a debit card that can deduct funds from the patient's health care account at the time of service.
- Practice management (PM) software can help the process. If the PM system contains allowable amounts with your payers, it will be easier for the staff to identify the amount a patient should pay for a given service.
- Practices may need to make fees known upon request. As patients become more responsible for the health care dollars spent, they will shop providers based on price. This will become increasingly evident among providers who

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perform surgeries or other procedures that may be delayed by a patient without a threat of death or permanent disability. For example, the author of this article recently encountered an orthopedic surgeon who shared a story about a patient who needed a knee arthroscopy and decided to wait for the procedure due to a new HDHP that his employer had adopted. The patient told the surgeon he would wait until "he couldn't stand it any longer" before having the scope performed. Unfortunately, this scenario may become more common with preventative services as well.

- Practices must have written policies for consistency in payment processes. These should include a patient financial policy that communicates payment expectations to the patient. Internal guidance policies for staff are a must so that when a payment plan must be established, the staff member knows what should be paid at the time of service and the level at which to set the patient's payments based on the amount owed. Many practices collect a minimum of \$50 at the time of service and then establish payments for the remaining balance. As an example, let's say a patient owes \$500, all of which is applied to deductible. The practice collects \$50 at the time of service, leaving a balance of \$450. The patient agrees to pay \$10 per month on the remaining balance. How long will it take the practice to get its money? Three years and nine months. The cost of processing the statements and payments will exceed the amount received for each month's payment.
- Depending on your approach with patient accountability, you may consider rescheduling patients who are unable to pay at the time of service. The physician must buy in to this model, and, certainly, patients will be seen under emergency circumstances. However, if patients can continue to receive services without paying, they will.
- Many practices implement consumer health care credit card affiliations. The fees to the provider are higher than traditional credit processing fees, but you must consider the cost of collecting a patient balance over time versus getting the money at the time of service and paying the health care credit processing fee. Typically, the business case is not difficult to prove in favor of reducing the timing of collections, including utilizing a transaction mechanism with a small fee.

You must be prepared. Regardless of how diligent you are in managing consumer driven health care, you will still experience challenges. Patients may become confused or angry about more aggressive collections policies. Some patients will claim ignorance about their plan type or individual responsibility to pay.

More staff hours may need to be dedicated to collecting on the front end of the service. You will likely experience an increase in patients inquiring directly with the doctor about collection policies. It is typically best to remove the provider from the process, and for the physician to defer to the "business office" regarding any payment questions. This helps preserve the doctor/patient relationship and avoids circumstances where the physician feels pressured to "cave in" and offer the patient direction that is inconsistent with the practice's payment policies.

Consumer driven health care will continue to expand, and practices must be proactive to re-engineer thinking and develop improved policies and operational procedures in order to maintain cashflow and better manage accounts receivable. A reactive approach to this issue will most certainly have a negative impact on financial performance and the overall financial health of the practice.

Interested in learning more about HSAs, HRAs and other high deductible health plans? At the March 20, 2009 OSMA Practice Management Symposium, Todd Walker, Comprehensive Healthcare Advisors, and John Micha, OSMA Insurance Agency, will discuss in detail how these alternatives to address the high cost of health insurance can be a benefit to physicians as employers, but also pose a challenge as providers must collect higher patient balances. Symposium information will be available on the OSMA Web site and mailed to you this month. ☞

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Good News* About *Bad Accounts

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For additional information, please contact the NCS representative assigned to OSMA members, Rick Vonderbrink, at (513) 314-2000 or rvonderbrink@ncsplus.com.

