Keeping Healthcare Finances Healthy:
Overcoming the Out-of-Pocket Payment Predicament

A White Paper by The Midland Group

Every day, healthcare financial professionals deal with conditions that throb like a bad migraine—unreimbursed costs, uncompensated care, payment shortfalls, negative margins, unsustainable trend. Behind the unpleasant words are more unpleasant numbers. According to consulting firm McKinsey & Co., doctors and hospitals suffer $60 billion annually in unpaid medical bills. The American Hospital Association reports that in 2009 hospitals spent $39 billion on uncompensated care and that nearly one-third of hospitals lost money. Research from the Center for Healthcare Improvement shows that hospitals' total margins fell to unprecedented lows in the third quarter of 2008, and an informal estimate among physicians puts their average recovery rate at about 30 percent of billings.

For many institutions and practitioners it's now a question of survival. That question has no single answer in our multi-payer system of private insurance, state/federal programs and self-payment. One response is to boost success with payments for out-of-pocket expenses—the deductibles, co-insurance, co-pays and billed care for treatment provided and never paid. Unfortunately, customary recovery methods are time-consuming, only partially effective, administratively complex and sometimes distasteful. Savvy financial professionals are facing the problem by finding the right partner to help.

Revenue sources under stress

Typically, hospitals receive about 35 to 50 percent of their revenues from managed care and commercial insurance, 25 to 30

percent from Medicare and 5 to 15 percent from Medicaid. Patients' direct payments account for the remaining 5 to 10 percent. As healthcare financial professionals know too well, each of these revenue sources is under stress.

Managed care and commercial insurance

Health insurers have been determined and successful at shifting payment burdens onto insureds through higher deductibles and co-pays and more stringent coverage limits. Employers, on whom Americans customarily depend for health insurance, are following suit. BNET Business Network reports that employers who provide health benefits paid 73 percent of employees' healthcare costs in 2002, but only 65 percent in 2008. The number of employers providing any coverage at all fell 10 percent during the preceding decade.

Medicare and Medicaid

Medicare and Medicaid underpayments approached $32 billion for hospitals in 2007, up $2 billion from 2006. The American Hospital Association calculates that hospitals, as a group, are paid on average only 91 cents of every dollar spent treating Medicare patients, including Disproportionate Share Payments. For Medicaid patients, it's 88 cents.

As the nation ages, life spans increase and more Americans join Medicare, the financial shortfall of treating these individuals becomes more acute, especially in states and locales where the elderly comprise much of the patient base. Depending on their

classification, hospitals have been reimbursed 70 to 100 percent of Medicare beneficiaries' failure to pay deductibles and co-insurance since 2000. That payment backstop was targeted for phase out in 2007 and its continuation is by no means certain.

What is certain, however, is that beginning in January 2010, all physicians and facilities treating Medicare patients will be scrutinized by the Recovery Audit Contractor Program (RAC) to correct overpayments and underpayments for Medicare A or B services. RAC is intended to halt an estimated $10.8 billion in yearly Medicare overpayments. During the test phase, it reclaimed $992.7 million from Medicare providers, while compensating them $37.8 million for underpayments. For 1 million affected providers, consequences include greater diligence and expense to ensure accurate paperwork and the greater likelihood of overpayments being repossessed.

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Budget-cramped states are reducing Medicaid enrollments, trimming benefits, raising patient co-pays, lowering reimbursements and paying providers more slowly. Non-qualifying patients may become charity care, eliminating any hope of payment. Moreover, Medicaid applications and approvals vary state by state, compounding compliance costs and payment delays from treating patients who live elsewhere—a regular occurrence for trauma or tertiary care centers, hospitals in border states or vacation areas, those located along interstates, or facilities that are positioned near a mass accident or natural disaster. Regardless of insurance coverage, mobile patients can disperse and disappear leaving unpaid bills behind.

Out-of-pocket payments

Americans are bearing more of their medical expenses and the $250 billion that patients spent out-of-pocket on healthcare in 2005 is projected to reach $420 billion by 2015. The Center for Studying Health System Change reports that one in five families—57 million Americans —had difficulty paying medical bills in 2007, an increase of 14 million people since 2003. Potential for out-of-pocket shortfalls is mounting among all patient groups whether insured or not, over or under 65 and financially secure or struggling.

Among the adequately insured, cost-shifting continues without regard for the patient's ability to pay. Annual deductibles for individual and family coverage have risen an average of 21 percent and 29 percent respectively since 2002, BNET reports. The Robert Wood Johnson Foundation has determined that employees are paying 79.3 percent more for individual coverage and 76.4 percent more for family coverage since 1994. In a tussle of premiums versus paychecks, working Americans' average income has risen only 9.4 percent since 1994.

In 2007, approximately 28 percent of adults below the age of 65 (50 million people) were uninsured at least part of the year and the number of chronically uninsured approached 46 million. Into the economic downturn of 2009 that figure could be understated. Urban League research indicates that each 1 percent increase in unemployment adds 1 million uninsured

individuals, prompting University of North Carolina scholars to surmise that 52 million Americans currently lack health insurance.

Having health insurance doesn't guarantee patients can meet medical bills. In fact, 61 percent of adults with medical bill problems or accumulated medical debt were insured when their care was provided. The number of under-insured reached 25 million in 2007, up 60 percent since 2003.

Commonwealth Fund estimates that 75 million adults—42 percent of the under-65 population—had inadequate or no insurance in 2007. That figure was up 35 percent from 2003 and doesn't include updates for the 2009 economy. One aspect of these numbers is especially ominous. For the uninsured and under-insured, emergency rooms have become the source of primary care. Emergency room visits originate nearly 60 percent of uninsured stays in public hospitals, according to analyst Cliff Boyd—and the number of ER visits increased by 2.4 million in 2007.

Patients covered by Medicare face their own ongoing out-of-pocket payment crisis. Fidelity Investments calculates that a couple turning 65 in 2009 needs $240,000 to cover their portion of medical costs in retirement—up from $225,000 in 2008. As for Medicaid, the Center on Budget and Policy Priorities concludes, "Contrary to common assumptions, the out-of-pocket medical expenses that Medicaid beneficiaries pay are significant and they have been growing rapidly in recent years."

These trends signify a number of added consequences for hospital finances that are already floundering. The average respondent

to an American Hospital Association survey carried 49 days in accounts receivable, nearly 10 days of discharged-not-final-billed accounts and bad debt equaling 7.1 percent of net patient revenue. Analyst Joe Chumbler of Stephens, Inc. currently places accumulated healthcare debt at $25 billion; others say it is above $150 billion.

Forbes Magazine summarizes the healthcare CFO's situation: "The growing uninsured population and increasing out-of-pocket payment requirements from consumers are root causes for the recent acceleration in hospitals' bad debt expenses. Hospital margins and cash flow have been generally hurt by this trend."

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A reason for optimism

Faced with escalating challenges, hospitals must be proactive to stop the financial bleeding. Although vigorous cost management is commonplace, cutting staff, spending and service hurts quality and morale and saving their way into the black isn't always feasible. Some hospitals sell their receivables—even collateralize and retail them in financial markets—but buyers are few, conformities difficult and receipts often pennies per dollar. Not surprisingly, institutions are focusing on recovering balances due and they're seeing a reason for optimism.

Encouragement springs from the data. In aggregate, the combined unpaid debt is a daunting amount, however if you look at the numbers by patient and by year, the situation is approachable. According to the Center for Studying Health System Change:

- Forty percent of patients struggling to pay medical bills in 2007 had out-of-pocket expenses of $500 or less and 59 percent had $1,000 or less.
- A survey of families with unpaid medical bills found that 25 percent had medical debt of less than $800 and three-quarters owed $5,000 or less.
- Much of the debt was recent: 42.8 percent was incurred within the previous year—24.6 percent within the last two years—and 22.9 percent within the last five years. Only 9.2 percent of families with unpaid medical bills had incurred their debt more than five years earlier.
- Approximately 44.7 percent expected to pay off their medical debts within the next year, while one-fourth thought it would take four years or longer.

In summary, a typical payment situation can involve recovering a manageable sum of money over a reasonable time. The challenge is to do it.

Customary approaches

Historically, hospitals have taken three approaches to improving cash collections. Each approach is important and necessary to consider, however all have drawbacks that often make them difficult to implement.

Improving procedures with technology

A typical first approach is for hospitals to improve their upfront procedures—transcribing patient information more accurately, identifying patients eligible for payment assistance, outlining payment alternatives at time of service. In turn, this approach also typically involves investing in new or add-on technologies.

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It's an understandable first impulse because the potential is promising. Current computer systems can scan a patient's insurance coverage, financial resources and credit standing and newer technologies can do even more, such as search for available balances on credit cards or home equity loans. Many systems run identification checks to prevent fraud and discover discrepancies in addresses or contact information. Some even integrate with a hospital's charge master and prepare an estimated bill, facilitating payment discussions before treatment.

Unfortunately, many hospitals that adopted this approach regretted doing so. A nearly universal lament is that technology vendors don't always deliver on all their promises. What is presented as a single vendor solution often entails many vendors contributing

parts of a module, leaving the hospital dependent on unrelated parties for prompt, accurate and consistent data. In particular, a system's capacity to determine insurance eligibility is often exaggerated, necessitating phone calls that it was supposed to preclude. Furthermore, since customer service can be spotty, fixing these problems can become the hospital's nightmare.

The initial investment can also be prohibitive—especially in ever-tightening budgetary environments—and many arrangements include per transaction fees that never end. Even the most dependable and affordable systems require the hospital's already stretched IT staff to install and maintain connectivity and success depends on thorough, sometimes expensive training of employees in jobs with high turnover.

Managing receivables in-house

Another option is for hospitals to use internal staff at time of service or after discharge to contact patients, discuss terms, arrange payments and track progress. Managing receivables in-house often proves problematic right away.

Hospital billing systems are not set up to manage hundreds, perhaps thousands, of patient accounts under time-limited terms. A poorly administered program can multiply days in arrears, as well as fail to provide accurate accounting. Hospitals that administer in-house payment plans seldom charge interest, reducing incentive for patients to pay their entire bill promptly. Small facilities often lack personnel trained for successful resolution, and at community hospitals they may be reluctant to approach friends and

neighbors about past due bills. In addition, these are typically low-paying jobs with high-turnover, making recruiting difficult and patient contact inconsistent. Bottom line—in-house resources are likely the least cost effective and reliable means of improving payments.

Selling receivables

Few prospects are more enticing to harried hospital business managers than selling self-pay receivables or balance after insurance accounts to a financial institution and be done with them, especially if the terms seem attractive. However, what they generally encounter is an array of fees and frustrations.

Financial institutions often cherry pick accounts they deem most likely to be paid, so they might not accept receivables the hospital would most like to sell. Further, willing patients who need extra time to pay may appear to be unsound credit risks; so the purchasing institution might refuse probable pay accounts, or it might stipulate payment terms the patient can't accommodate.

To hedge risks they do accept, financial institutions purchase receivables at large discounts and require hospitals to maintain reserve balances equaling 20 to 30 percent of receivables purchased. The selling hospital takes an

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immediate loss and ties up valuable operating funds while being continually hit with setup fees, statement fees and per transaction fees until the account is settled. If the account isn't settled, hospitals must generally agree to buy it back, paying the purchasing institution the outstanding principal, interest and late fees.

Finally, hospitals face an ongoing concern about whether the financial institution is treating their patients with the tact and consideration consistent with their reputation as a compassionate healthcare provider.

Providers have often resorted to collection agencies and legal remedies. These alternatives strain relationships with patients in the community, involve discounting debt and paying fees and often yield payment rates as low as 10 percent—if there's payment at all.

In a nutshell, customary approaches toward improving payment results can fall short and modest increases in receipts might not validate time and resources spent. Fortunately, this situation has a solution.

> Above all, the partner should be able to do what the hospital has difficulty doing — quickly build a reliable and predictable monthly cash flow while recovering 100 percent of the principal balance of each patient account.

The successful solution

To turn a stagnant pool of receivables into an income stream, financial executives are seeking an outside accounts management partner for considerate, capable and comprehensive service. They discover the key is in recognizing the best partner and the key word is—literally—SIMPLE.

- Scalable: The partner should be able to adjust quickly to changes in the hospital's volume—from shifting patient census to modifications in facilities, clinics and services.
- Immediate: The partner should offer straightforward contract terms and be able to deploy on-site immediately with minimal disruption to the hospital's technology and staff. At the outset, the partner should be able to assess patient balances and preliminarily identify whether they are likely recoverable, suitable for arranged payments, need a discounted settlement, or are apt to be written off.
- Measurable: The partner's results should be measurable and every account clearly documented either directly into the facility's patient accounting system or through reports customized to the needs of the facility, or both.
- Professional: The partner's team should be professionally trained, well-supervised and adequately equipped. A comprehensive professional partner will offer a total range of expertise, be thoroughly skilled and tested on HIPPA, be able to accommodate other languages and use a reliable accounts management system that employs every tool from computerization to lock boxes for payments.

- Low cost: The partner should share in the hospital's successes, not its revenues. Its goal should be to deliver 100 percent of the principal balance to the institution. That means no late fees, no prepayment fees and no special charges to the institution that divert the patient's payment. The partner should offer straightforward, flexible and affordable terms to the hospital and the patient as opposed to cookie-cutter solutions for special circumstances.

- Effective: Above all, the partner should be able to do what the hospital has difficulty doing— quickly build a reliable and predictable monthly cash flow while recovering 100 percent of the principal balance of each patient account. The partner should be able to represent the hospital tactfully and empathetically—suggesting payment plans, agreeing on arrangements and remitting balances due. They should identity patients who are likely to be eligible for charity or public programs and refer those patients back to the hospital at no charge. In particular, the partner should offer patients flexibility in adjusting payments if their financial situation changes. The partner should be experienced enough to anticipate potential problems and confident in outlining all payment options the hospital will accept, including prompt payment discounts and same as cash options.

In particular, hospitals seeking an outside accounts management partner should be convinced of one thing without reservation—that their chosen partner brings a complete and unwavering commitment to their shared goal of full resolution of all medical bills.

Conclusion

The healthcare payment predicament is real, serious and ongoing—and the dominant trend is for more Americans of all ages and income levels to pay more for treatment. Financial professionals see the effects on their institutions and they're committed to recovering those crucial out-of-pocket dollars. As a result, a growing number of institutions are taking action with the help of an accounts management partner. Their professional partner helps to assure a better outcome for everyone—both for patients who meet their obligations with dignity through structured, affordable payments and for providers who see the improvement to their bottom line.

Founded in 1989, The Midland Group is an acknowledged leader in providing revenue cycle assistance to medical facilities of all sizes and specialties nationwide. Its expertise includes public benefits eligibility, financial counseling, Social Security disability appeals, third-party billing and liens, and extended payment options for hospital and clinic patients. Midland's growing client list exceeds 130 healthcare facilities ranging from short-term acute care hospitals, psychiatric hospitals, and outpatient mental health facilities, to specialty and rehabilitation hospitals, outpatient surgery centers, and both general practice and specialty physician groups.

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