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Patient Payment Collection: Challenges for Payers and Providers

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Introduction

Increasing healthcare costs have forced hard choices on employer groups looking to continue to offer medical coverage to their employees in a cost-effective manner. Employer groups in turn have pushed health plans to offer products to manage premium increases.

In response to this challenge, health plans have developed new cost-management strategies. The first product strategy is an incremental change to established PPO products. The second, more innovative product is the Consumer-Directed Health Plan (CDHP). Both products shift financial responsibility to the patient with the intent to make the member/patient more sensitive to the cost of healthcare services, and, in the process, turn them into educated consumers of these services. However, for the provider, collecting payment from the patient is expensive, difficult, protracted and usually unsuccessful. This is already a significant problem today and will only get worse as CDHP adoption increases.

Payers, too, are experiencing unintended consequences in deploying these new products: Increased operational costs, provider conflict and potential legal and PR fallout from providers' opposition to products from which they cannot reasonably collect payment. Most importantly, the increased negative exposure could affect the sale of these products to employers.

To be successful with these strategies, payers must assist providers in the collection of patient liability at the point of service (POS). They must offer providers the infrastructure support and data that can bridge the gap between the need for "real-time" patient payment information and batch-mode adjudication systems.

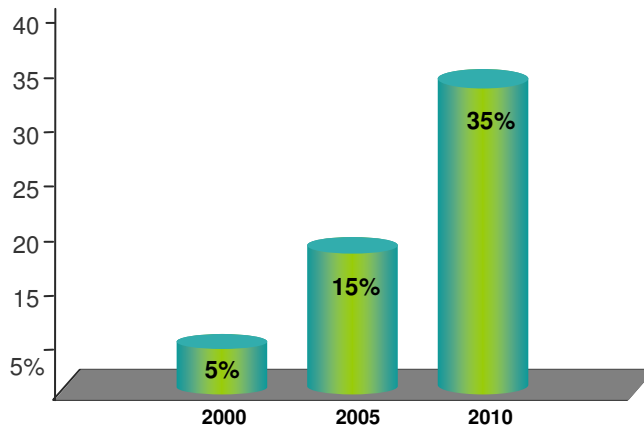
Market Challenge

Payers have developed two cost-management strategies that share a common theme and differ only in the degree of risk shifting to the employee. The first approach health plans have taken is to apply incremental changes to existing PPO products by raising the patient's out-of-pocket (OOP) contribution via higher co-pays, deductibles and co-insurance. As a result, many patients now encounter significant OOP expenses on top of the premium they (and the employer) pay.¹ The intent is to make the patient a cost-conscious consumer of healthcare services.

The second strategy, which is newer and more innovative, is the Consumer-Directed Health Plan (CDHP). Here the patient is responsible for paying for *all* expenditures until the deductible, usually several thousand dollars, is satisfied. In exchange for shouldering more of the cost, the employer and employee pay a smaller premium bill. In this scenario, the provider is seeking *all* reimbursement from the patient up to the deductible limit.

This product evolution has created a significant collection challenge for the provider practice. Patients' payment responsibility has grown by 300 percent in only five years (see chart below) - a relatively short period of time - and most providers are only now fully realizing the impact this payment shift has on their finances. As CDHP products continue to gain traction with employer groups, patient payment as a percent of a provider's total revenue will balloon to approximately 35 percent of the total by 2010.²

Patient Pay as a Percentage of Provider's Total Revenue



Source: McKinsey & Co.

For providers, collecting patient responsibility for services is time consuming, expensive (billing and collection) and most patient A/R either turns into bad debt or is factored out at pennies on the dollar.³ It is also exceedingly difficult to reconcile patient payments when payment is collected.

There is a direct link between the increase in patient responsibility for service and providers' increase in A/R and bad debt. Provider bad debt has increased by 75 percent in four years (2001-2005). This negative trend is solely attributable to the increase of patient A/R write offs. According to a McKinsey & Co. study, for many provider groups "unpaid Patient Bills" already amount to "10 percent or more of **net revenue**." For a physician practice, losses of that magnitude would easily exceed \$10,000 per physician per year.⁴

For payers, promoting products that create financial hardships for providers can only lead to more confrontation and conflict. This situation will inevitably bleed into the frenzy of healthcare "reform" in the political arena. This is not a desirable outcome for plans.

Without the proper information and tools to manage the patient payment process, providers will continue to see their A/R and bad debt rise to the point where they cannot continue to provide

service under these arrangements. It is not inconceivable that providers will consider pursuing legal remedies against payers for promoting products from which they cannot reasonably collect payment. Recent lawsuits taken against payers for other payment related issues by state medical associations and others provides a clear warning on this point.

Of more concern to payers should be possible PR damage generated by publicized legal action over this matter, impeding the sale of these products. Increased patient financial responsibility also means additional increased use (and cost) of call centers as members and providers attempt to reconcile service charges and reimbursements coming from multiple sources (payer and patient).

Today's Approach

Banks and non-bank financial institutions are looking at increased patient financial responsibility as a tremendous opportunity to capture new revenue streams. However, the payment solutions and information systems used in the retail and financial services industries today do not support patient payment at point of service (POS). The challenge is enacting a real-time payment capture solution (with providers) that is dependant upon the output of batch claim processing systems (from payers).

Some banks and payment processors are looking at using the "Authorization & Hold" feature from MC/Visa. In this scenario, when the final charge is not known at POS an amount within the cardholders' spending limit is reserved for the transaction. The problem with applying this approach in healthcare is it is only good for 30 days and many claims are not adjudicated in this time frame. In addition, this feature is currently only valid for certain industries such as rental car and hotels.

Even if the existing payment systems worked in healthcare, the provider is at a loss to know the amount to collect from the patient because, in most cases, this information resides in the payer's system. Even collecting co-pays at POS is becoming more difficult with tiered co-pays replacing the flat "one-size-fits-all" amount. Short of real-time claim adjudication, patient payment estimators are considered as a stopgap solution to this issue. Unfortunately, these solutions are only practical and affordable for larger provider groups and facilities, if not provided by the payer or another third party.

In short, banks and non-bank financial institutions are not capable of providing the right solutions because they simply do not understand the healthcare ecosystem. Most financial institutions are more interested in selling/managing the Health Savings Accounts (HSA) or collecting merchant processing fees, not in how they fit within the healthcare billing and payment systems. An example that illustrates this point is the post mortem from an industry analyst on American Express' withdrawal from providing an HSA payment solution (HealthPay Plus):

"American Express may have underestimated the degree of investment that was required to play in the [health savings account] space, and it may have overestimated the speed of adoption that would occur. Complexities in a payment flow that involves insurers, employers, employees and health care providers, as well as in transaction verification, are challenges in the space."⁵

The Right Solution

The right solution must bridge the gap between the need for "real-time" patient payment information and the realities of batch claim processing. A vendor trusted by both payers and providers, which has strong contextual relationships on a national scale must deliver it. This means proven experience with managing critical data and business processes between the payer and provider, and continued access to that data and workflows.

Critical success factors for a patient financial responsibility solution include:

- Support for *all* payment types including: credit, debit, FSA (Flexible Spending Account), HSA cards and checks (eCheck conversion). This offers maximum payment flexibility for patients
- Accurate patient liability estimation at POS, which facilitates patient payment and minimizes or eliminates the need for follow-up billing
- Support for post-adjudication adjustments and/or patient payments, which eases the administrative task of finalizing patient accounts
- Integrated patient billing capability including online bill payment, which easily manages the payment collection process for post POS payments
- Recurring billing capability for patients who cannot pay in full at POS
- Integrated multi-sponsor support for reconciliation of patient and payer payments within practice management/patient accounting systems to eliminate time-consuming, manual processes in provider offices
- Good fit for existing provider office workflow
- Low/no requirement for additional staff or training
- Software as a service model for simple, low/no cost implementation

The right payment platform will also afford additional benefits to payers beyond enabling providers to manage patient payments. It will:

- Improve provider network financial health by facilitating member payments to providers
- Ease the provider contract renewal process by supporting timely, cost-effective patient payments
- Support efforts to drive CDHP products by eliminating provider resistance.
- Reduce in-bound call center volume concerning payments

Conclusion

The data on trends with provider A/R and bad debt leave no doubt that patient payment responsibility has created financial hardships for providers and downstream problems for payers. The continued accelerated adoption of CDHP products in the next few years will exacerbate this problem to point where disruptions in relations and business operations may result for all parties. It is clear that payment systems used by banks and non-bank financial institutions do not support patient payments at POS. The right solution must address healthcare's unique data flows and complex rules and must be vendor and payer agnostic.

NaviNet® is uniquely able to offer an effective, rapidly deployable solution for both plans and providers because of its position facilitating administrative and clinical workflows between provider offices and payers. NaviNet is already working with leading payers to deploy practical "real-time" patient financial responsibility solutions.

¹ Kaiser Family Foundation (2005) Employer Health Benefits 2005 Annual Survey

² McKinsey & Co; "Overhauling the US Healthcare Payment System," *The McKinsey Quarterly*, 2007

³ Understanding Your True Cost to Collect, *Healthcare Financial Management*. Report prepared in conjunction with ARC Group Associates, 2006

⁴ McKinsey & Co (2007) op. cit.

⁵ Cardline (2007) "AMEX Drops Healthcare Cards"