

# Hospital Strategies for Addressing Out-of-Pocket Expense

**E**merging coverage models and enhanced information sources are giving individuals greater financial control over their health care while providing them with the opportunity to make more informed choices. All too often for hospitals, however, this trend is resulting in a pressing challenge: the need to develop proactive processes for understanding a patient's out-of-pocket responsibility and collecting it before it becomes a bad-debt headache. With this in mind, this HFMA roundtable discussion, sponsored by JPMorgan Healthcare Solutions, describes how some healthcare financial executives are developing new payment estimation and collection protocols and training staffs and patients in their use.

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## High-deductible plans contribute to increases in self-pay activity. How significant are these plans to hospital business office operations these days?

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**Alberto Casas:** Right now there are more than 6 million covered lives enrolled under consumer-directed high-deductible health plans. As a percentage of the total population, that's not too significant. But the projected growth is very significant; we expect up to 30 million covered lives in these plans by 2012.

**Robert Golden:** These policies have made a tremendous impact on us. The biggest change we have seen is in our after-insurance balances. Generally speaking, we used to see balances that ranged in the neighborhood of \$250 to \$500, which was the patient's out-of-pocket responsibility. Now it is not unusual to see balances that are between \$1,000 and \$2,500. So a higher percentage of our bad debt now is in that after-insurance category.

**Debbie Welle-Powell:** When these plans were introduced in 2003, we were dumbfounded because the health plans didn't communicate the structure and design of the products they were selling. We would ask the patient for their copay and the patient would say, "I have no copay." After several patient encounters, I went online to one health plan's products, and the information I found told the patient: "Do not pay anything at time of service. If the provider asks, you do

not have to pay. Wait until the deductions are made from your custodial account." That lack of understanding on our part created conflict at the point of service, which doesn't bode well for patient satisfaction. Providers have spent 10 years working at getting better about asking for the copay and now we find no copays required for these patients; our physician offices were not geared up for the change.

We recently did a sampling of our hospital accounts receivable, in which we defined high-deductible plans as those with deductibles of \$10,000 or more. We learned that our collection rate from patients for high-deductible plans was 43 percent versus 87 percent for those with lower deductibles. So collecting higher amounts from the patient presents a problem for us.

**Paul Sinkhorn:** We are watching to see what is happening with high-deductible plans, but I can't say I have any hard data on the level of occurrence at this point. I do think our preparations to respond to them tie in with the overall approach our organization already is taking as it relates to making changes on the front end so we are improving our ability to identify and communicate patient responsibility in advance of service and improving validation of insurance benefits. Regardless of whether our interactions are with patients participating in a high-deductible plan or who have a traditional level of copay, we're making investments to improve these areas.

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### How can a hospital recognize if a patient has a high-deductible plan from the outset?

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**Casas:** As the dollar value of patient out-of-pocket collections increases, we see our provider clients looking for ways to efficiently identify a patient's coverage status pre-service or point of service. Furthermore, providers are exploring solutions that will allow them to estimate patient out-of-pocket responsibility while offering flexible payment options with the ultimate goal of accelerating collections while reducing bad debt. Despite this fact, automated eligibility verification systems have less than a 20 percent adoption rate across the country and payment estimation solutions are still in their infancy. This is creating an emerging marketplace for key industry stakeholders, including financial institutions, systems vendors, and payers.

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### How does your organization cope with the challenge of estimating patient financial responsibility?

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**Sinkhorn:** We want to help patients understand, prior to the service being scheduled, what their financial responsibility is going to be. As such, our process is to perform insurance and benefit validation in advance of services.

We determine patient financial responsibility amounts after benefit validation and confirmation with the payer on the portion of the deductible that has been met. Some of this information is available electronically, and we also access it through web query and phone calls. The payment estimate is not always 100 percent precise because there is always concern for the currency of information and its validity. However, the process itself is incredibly valuable for helping to identify issues that may prevent the patient from meeting a particular coverage requirement or other factors that could affect payment. We have recently created

an Excel-based pricing estimator tool that enables our staff to more accurately estimate patient liability. This information has increased the confidence of the staff when communicating patient liability information.

**Welle-Powell:** We use software to estimate patient responsibility; a staff member talks with the patient to get the necessary insurance information. At that point we analyze the account, so we can do the best job at explaining what we think the visit is going to cost him or her. As an example, patients who have an out-of-network deductible and an in-network deductible sometimes do not understand their financial obligations.

**Tracy Berry:** Providing a meaningful cost estimate for the patient can be really challenging. We evaluated several products and are planning to purchase an automated price-estimating tool that will use information from our insurance contracts to develop estimates. Until that tool is available to us, we are providing ball-park estimates for some of our high-volume outpatient procedures based on historical information.

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### What are the challenges in conducting patient financial assessments at preregistration and/or time of service?

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**Casas:** There are many unknowns at the point of care from the vantage point of a provider. In most cases, the provider does not know exactly what to charge a patient for service because the plan contracts are so complex. Secondly, the provider does not know how much the patient has paid toward the deductible, so it is difficult to know how much the patient will be responsible for. Most providers have to wait for claims to be adjudicated and paid by the insurer. This could be several days out, which impacts days in accounts receivable. Then they bill that patient for the remainder, which now could be up to thousands of dollars.

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### What are some of the processes that you have in place to help individuals understand their financial options?

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**Sinkhorn:** We have engaged some external partners to help us bring best practices to our processes as they relate to the front end. We are still in the process of fully implementing some of these recommendations, but one development is that we are creating dedicated positions of "pre-access financial advocates." In addition to explaining the payment options that are available and

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**Tracy Berry** is senior vice president, revenue management, Centura Health, Englewood, Colo.

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**Paul Sinkhorn** is director, revenue cycle, Jewish Hospital & St. Mary's HealthCare, Louisville, Ky.

**Debbie Welle-Powell** is vice president, payer strategies and legislative affairs, Exempla Healthcare, Denver.

working with patients to address any payment questions, the advocates help patients find an avenue for financial assistance when appropriate.

One of the greatest challenges to having an effective financial aid screening program is when there is information that needs to be validated and completed in order to determine eligibility. When supporting documentation is needed from a patient to meet financial assistance requirements, such as proof of income, then we can work with the patient in advance of service to ensure this expectation is understood. The more we can help patients identify materials for enrollment that they may bring with them on arrival, then the greater the likelihood will be that they will be able to complete the application before they leave our facility and our staff will be able to make a financial assistance determination.

I think it also is important to note that even when it is determined that financial assistance isn't warranted, just having this financial conversation and engaging the patient with an opportunity for dialogue goes a long way toward both helping to foster an expectation of payment and communicating responsibility for resolving an account.

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**Encouraging the actual provision of payment can be a challenge. How are some of you addressing pressures to secure patient payment—or qualify patients for assistance—before services are rendered?**

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**Golden:** We once considered putting this process on the back end. We wanted to have the clinicians move patients through to financial staff for a conversation as they were being discharged, with the goal of collecting payment at that time. However, the clinical team was very reluctant to do this.

We then agreed it was more appropriate to move that payment conversation to the front end and have financial counselors visit with people in advance when possible. We initially tried having the discussion when patients arrived for their admissions. However, that left staff scrambling to determine how much the patient should pay. Also, at that point during the patient's experience, it's very difficult for staff to make sure there is an understanding of what will be owed through the health plan and to secure a commitment with money in hand.

So eventually we moved the conversation to the pre-registration process through our access center. Making this change has worked well. I would say we doubled or tripled

the amount that we received via our access center as part of the preregistration process as opposed to at the time of admission. It is a far more proactive approach.

**Welle-Powell:** Before appointments are scheduled for diagnostic services or outpatient surgery, we verify what the patient will owe and have a conversation: "You will owe \$500. How will you be paying that?" For visits to the physician's office, the amount might be \$50, so we say, "Do you want to pay that now, or do you want to pay when you come in? We accept credit cards and cash." We will always work with the patient on some type of reasonable payment plan.

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**What staff training has been needed to help staff deal with payment discussions involving high-deductible plans?**

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**Sinkhorn:** It is not a strategy specific to those with high-deductible plans but really a broader effort for all conversations regarding patient payment responsibility. We are working to implement an infrastructure where we provide both pre-access staff and financial advocates with very specific scripting for how we want financial discussions with patients to occur. A standardized approach will give these members of our team the support they need to be successful in their interactions and ensure patients receive a consistent message.

**Berry:** Some of our focuses this fiscal year actually are educating our staff about how to ask for money and increasing point-of-service collections. We are making progress, but we still have quite a way to go. One challenge is organizational culture. We are a faith-based organization committed to supporting the underserved



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and poor. We have a long history of providing care to all of our patients, regardless of their ability to pay.

Sometimes, staff can feel uncomfortable asking patients for money.

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**Are payment discussions different with patients based on the type or amount of responsibility—for example, small copay versus high deductible? If so, how?**

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**Golden:** The discussion differs based on the urgency of the situation, not the amount of money the patient will owe. For example, if we have a physician who calls and says, “We need to run an MRI on this patient. It appears that we’ve got a significant issue with this individual that could be disabling,” that is urgent. If that person is not in a position to make any payment, then we will check on the patient’s eligibility for financial assistance of some type.

For patients who are coming for an elective procedure, we request a deposit before the service is provided. This amount doesn’t have to be the patient’s entire out-of-pocket share. For the balance, we will allow the patient to submit a charity application after the fact.

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**Financial institutions, clearinghouses, and patient accounting system vendors are involved in payer-provider transactions. Do they have a role in patient-provider transactions?**

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**Casas:** Yes, the only way that enhanced patient payment solutions will be widely adopted is if the multiple constituents

along the revenue cycle cooperate. To ensure that solutions are fair among provider, payer, financial institution, clearinghouse, and patient accounting system, there needs to be broad acceptance and deployment of standards that offer interoperability. As a financial institution, we have the core competencies in payment systems, security infrastructure, and data capture, storage, and mapping required to empower payment estimation and capture solutions before, during, and after the patient encounter. We are investing significantly in these offerings and continue to engage key stakeholders to drive toward an industry solution.

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**Do you foresee a time when it may be the norm for hospitals to charge interest on self-pay debt from those with an ability to pay? Why or why not?**

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**Welle-Powell:** We do not charge interest today. It is hard enough to collect the principal amount due, particularly with the growing cost sharing patient liability. If a patient’s balance is not paid by the due date, we work aggressively to establish contact and develop a payment plan. The challenge is that patients want the “old payment plan,” paying \$20 a month. That doesn’t work today for hospital care.

**Berry:** At this point we do not charge interest until an account reaches bad debt. We work accounts internally for up to 210 days. If an account is paid during that time, we do not charge interest. Once it is designated as bad debt, our bad debt vendors do charge interest.



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