

***PATIENT FRIENDLY BILLING*SM**

Focus Group Research Summary

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*The PATIENT FRIENDLY BILLING*SM Task Force commissioned the American Hospital Association (AHA) to conduct a series of focus groups, with the objective... "to obtain structured feedback from consumers (patients, guardians, and family members) on how the collecting and communicating of financial information related to hospital episodes of care can be improved." Seventy-five people participated in a total of eight focus groups conducted in January 2001. The location and demographics of each group is described below:

Location/Date	Groups Conducted
Scottsdale, AZ January 9	1. Seniors, 65+; mixed gender 2. Mixed gender; ages 40-55
Los Angeles, CA January 10	1. Women; ages 40-50 2. Mixed gender; ages 45-60
Columbus, OH January 16	1. Mixed gender; ages 45-60 2. Hospital and physician office employees
Greensboro, NC January 31	1. Adult children/guardians 2. Clinic and physician office employees

- All participants had healthcare coverage.
- In the consumer focus groups, all participants (themselves or a family member) had an encounter with a hospital – either as an outpatient or an inpatient – within the past twelve months.

Statement of Limitations: This is a brief summary of the qualitative research – focus groups – conducted by HFMA and AHA. Focus groups afford the opportunity to observe and record spontaneous reactions – perceptions, opinions, and attitudes – from a selected group of participants on a variety of issues and topics. Focus groups are *not* a forum for correcting misinformation or misunderstanding on the part of the participants. The groups help develop insight and direction, rather than quantitatively precise or absolute measures. Therefore, focus group research should be considered in a qualitative frame of reference and the results of the study viewed as exploratory and directional in nature.

PATIENT FRIENDLY BILLINGSM Project
Focus Group Research Summary

The moderators were Rick Wade, Senior Vice President at the AHA and Lee Zacharias, Special Consultant to AHA's Reality ✓ public perception research initiative.

The moderators used a guide developed by members of the *PATIENT FRIENDLY BILLINGSM* Task Force to steer each of the focus group discussions. This guide assumed there would be a natural flow in discussing one phase to the next in the billing process. It is critical to note however, that matters dealing with coverage and billing are so complicated and confusing to even the most sophisticated consumers, that it is impossible to conduct a discussion moving smoothly from one billing issue to the next. The participants did not know who sponsored the focus groups, only that they were taking part in a national research project on how to make the medical billing system more efficient.

MAJOR THEMES AND POINTS

The major points and recurring themes brought out by the groups were:

- Both consumers and employees who work inside the billing system understand that billing problems are a reflection of the larger problems within the healthcare system.
- *Consumers view insurance companies as one of the major sources of the problems and confusion experienced by themselves as well as the providers of care. Consumers view insurers, HMOs and managed care companies as deceptive about coverage, vague about reasons for nonpayment, and non-communicative with both patients and providers. Consumers and employees seem to agree that insurance and managed care companies intentionally delay reimbursement to providers, and have inexperienced, ill-informed employees that provide inadequate and often inconsistent information to beneficiaries. Some perceive the quality of employees as reflective of the insurers' desire to make the system slow and frustrating. Public frustration with the health care billing system begins before care actually is delivered. The fragmentation and lack of communication between entities is clear. Most participants report that regardless of previous admissions to the hospital, personal and financial information had to be provided with each new encounter. For some, it was the physician's office that provided the information to the hospital; others received calls from the hospital prior to admission. As stated by one woman who's child had multiple hospitalizations "...you still have to go through all the hoops..." Many in the group expressed amazement that the healthcare billing system could not perform with the same technical proficiency as banks and supermarkets.*

PATIENT FRIENDLY BILLINGSM Project
Focus Group Research Summary

- One focus group objective was to determine whether or not patients and families received information about billing issues (i.e. what to expect, how they were handled, etc.) early in their hospital encounters or during their stays. Informing patients ahead of time, or in the course of care, would ease anxiety and confusion. This concept was not borne out of the focus groups. Few participants say that they spoke with someone regarding coverage and billing issues prior to their discharge, nor did they view this as an appropriate time to discuss such issues. Coverage is not top of mind for them... *“it’s...am I going to be okay.”* Their focus is on the process of care, not the process of billing.
- Emergency Room encounters are especially troubling for consumers. *“It’s not about helping the person, it’s how you’re going to pay for it.”* Many were familiar with a recent Discover Card TV ad that depicted good emergency room care as dependent on ability to pay. In general consumers felt that what was portrayed was probably not far from the truth.
- It is *extremely* difficult for consumers to clearly distinguish what was received from what sources and in what order. This applied not only to the “bill” itself but also to the multiple documents they get. Some said they received “something” from the insurance company within a few weeks after hospitalization. Others said their first communication was from the hospital. While some said they could tell what a particular document was – “Not A Bill”, but an “Explanation of Benefits” – few thought the document clearly stated either what occurred in the hospital or what, if anything, the patient was to do.
- For many, the multiple bills and statements received opened the door to an exercise of frustration and confusion. They described documents that were filled with codes and abbreviations impossible for a lay person to understand, much less being helpful in providing a meaningful summary of their episode of care. Further, it hampered them in any reasonably intelligent effort to be certain bills were accurate in terms of services they actually received. Their frustration was compounded by the fact that they, or their family, were not fully informed about all of the tests, physician consults and other services they actually received. This further crippled them in their ability to question accuracy or to be good advocates for themselves.
- Many consumers and professionals suspect that the bill goes through “too many hands” before it even reaches the insurance company – the hospital billing department, and numerous billing entities outside the hospital.
- Few focus group participants said they were informed or prepared for the numerous bills and documents they would receive from multiple sources.

PATIENT FRIENDLY BILLINGSM Project
Focus Group Research Summary

Few identified any source of assistance. Most begin inquiries with the physician's office or hospital billing department, but the quality and accessibility of the help varied widely.

- Focus group participants view the payment process as a struggle and conflict between providers and insurance companies. They see insurance companies constantly "gaming the system;" either delaying or denying payments to providers for any number of "excuses," such as coding errors. And consumers often feel caught in the middle between the doctors and hospitals and the insurer, managed care company or HMO.

MAKING PATIENT BILLING CLEAR, CONCISE, CORRECT AND FRIENDLY

- There was mixed reaction among participants about using the Internet for patient billing. Some thought tracking billing activities and facilitating communication among all parties would be easier on the Internet. All participants had serious concerns about security and privacy. And some are uncomfortable with the notion that communication among "people" is only electronic. The desire for a "human face" in all phases of health care is strong.
- Participants in each location had very similar ideas as to how the billing process could be improved.
 - Statements should explain what was done, by whom, when, what the "real cost" is and what is covered.
 - Provide a bill that can be read and understood by consumers – leave off the codes and the acronyms. (One hospital employee stated that her hospital started using fewer abbreviations and changed some of the language on the hospital bills. Patient calls with questions about their bills decreased by 37%).
 - Every procedure, activity and provider involved in an episode of care should be under the umbrella of the hospital bill thus preventing multiple bills received by patients.
 - Send statements or bills to the patient only when everything has been submitted to the insurance company.
 - There should be more uniform billing cycles among providers.

PATIENT FRIENDLY BILLINGSM Project
Focus Group Research Summary

- There should be greater oversight of insurance companies to ensure more timely payment to providers and to deter “the games” carriers play with providers.
- Explanation of Benefits (EOBs) and other forms should be standardized across all providers and payers.

Other Issues Discussed:

- Billing problems with out-of-network doctors, or others who provided care, are a particular characteristic of Emergency Room visits.
- Insurance companies delay payment to hospitals, hospitals “hassle” patients to pay bills, often sending them to a collection agency. This creates a climate of fear and intimidation that runs exactly counter to the image most hospitals work hard to sustain.
- Itemized bills that have items/procedures that patients never received or were unfamiliar with contribute to the widely held view of fraud and abuse by providers.
- Write-offs, adjustments, etc. done by the hospital make consumers very cynical about charges, and to them, are further indication of the fraud that exists in the system.
- An inadequate explanation by insurance company and/or providers of what is actually covered is often viewed as a deliberate device to foster denial of care or payment.

Additional Observation and Quotes by Focus Group Participants

- The views of senior citizens differ sharply from other “consumers.” Older Americans have more faith in the healthcare billing system. What’s more, in many ways Medicare works better in terms of billing system mechanics for both providers and recipients. And some hospitals, marketing aggressively to seniors, have created systems to avoid such things as repeated provision of the same information or to help them with billing problems. Frequently, the same convenience is not available to all patients.
- The attitudes of consumers are changing by generation. The “boomers” and younger consumers do not have faith in “the system” as their parents had. Younger generations will be more aggressive in demanding information and accountability for both billing and clinical service. Providers and insurers must adapt to this new reality.

PATIENT FRIENDLY BILLINGSM Project
Focus Group Research Summary

- A persistent view among consumers and families was a desire for more information about their care. Much of the public's irritation with the medical billing system is rooted in a lack of trust and confidence. Having more knowledge of, and voice in, the care process could well influence perceptions about billing.
- Some people see a need for an independent point of contact for consumers to help them sort out questions about coverage, services and billing.
- The public expects the medical billing system to be complex. They understand, though they may dislike, the bureaucracy of big corporations, government, doctors and hospitals. But much of their frustration is rooted in the inhumanity and lack of help patients and families encounter when trying to deal with the fragmented pieces of medical billing and coverage, as well as the care process.
- A patient's experience with the healthcare system often begins with the physician relationship and many still expect physicians to be their advocate. Many patient questions and problems could be handled in the doctor's office. But often the physician's offices are the least equipped in terms of staff and system knowledge to help.
- Many of those who handle billing for physicians' offices and clinics believe insurance companies discriminate. Those who question claims and follow up on inaccuracies get slower response and payment. Rarely do managed care and insurance companies provide "customer service."
- Some billing professionals also believe insurers mislead consumers... accusing doctors of overcharging them or coding improperly, thus heightening distrust and frustrations.

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