Trouble Upstream: Using Insurance Discovery to Fight Bad Debt

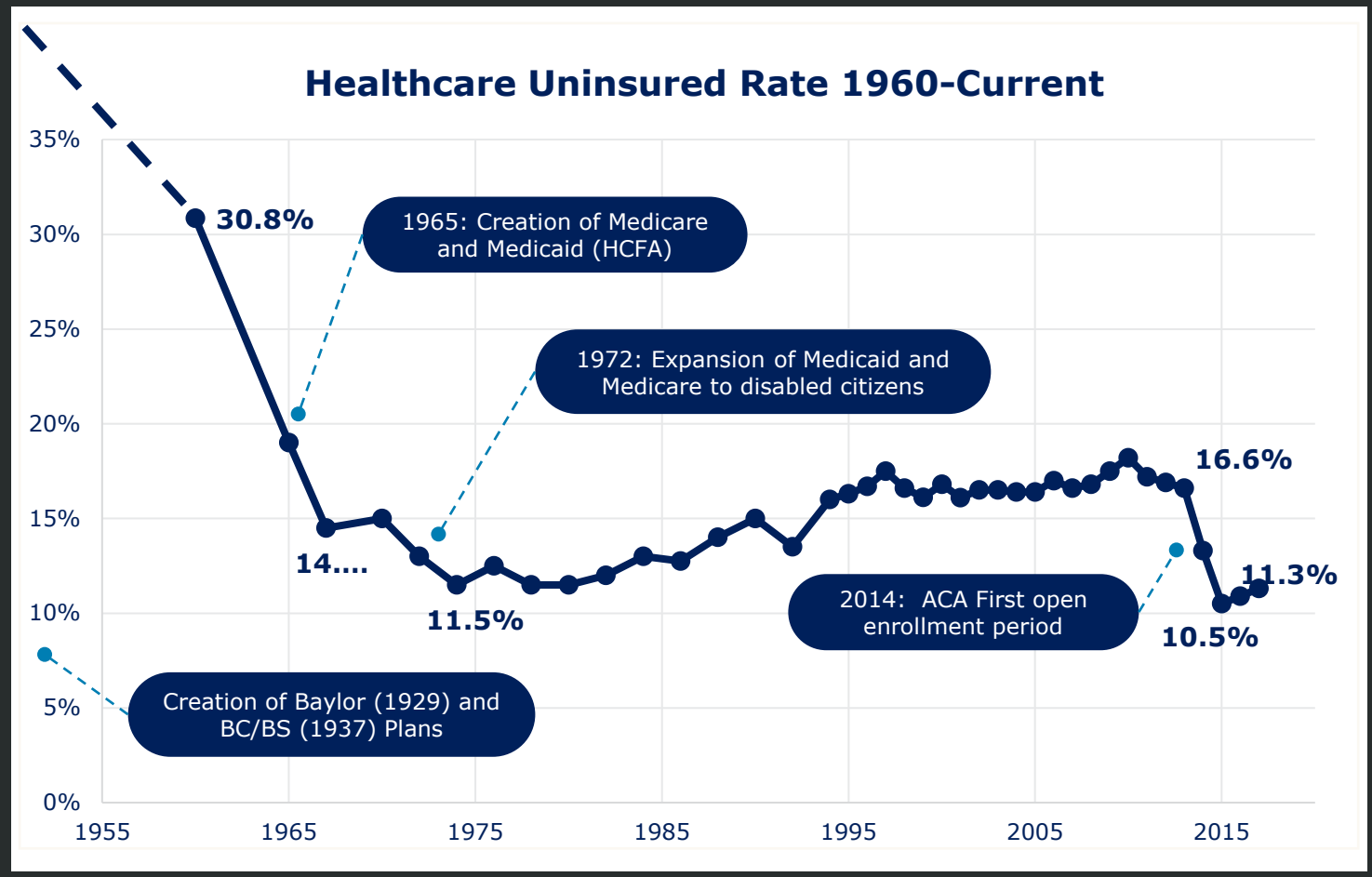
Kimberly Barefoot & April Wilson

Today's Agenda

1. Illustrate how insurance discovery leads to a reduction in bad debt
2. Learn how insurance discovery works with standard screening processes
3. Use automation to increase cash acceleration and reduce staff dependencies on coverage discovery processes
4. Discuss how insurance discovery processes reduce patient complaints and lower AR days

The Landscape

U.S. has the Lowest Uninsured Rate in History…



Sources: Source Book of Health Insurance Data, 1976–1977, from https://eh.net/encyclopedia/health-insurance-in-the-united-states/ ; Social Security Administration Archive (https://www.ssa.gov/policy/docs/ssb/v29n11/v29n11p3.pdf), Centers for Disease Control (https://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf)

But the Problem Goes Beyond the Uninsured…

Defining Underinsured

Out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income

OR

Out-of-pocket costs, excluding premiums, are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level

OR

Deductible is 5 percent or more of household income

Source: Commonwealth Fund – The problem of underinsurance and how rising deductibles make it worse

Uninsured vs. Underinsured: A Question of Access and Affordability

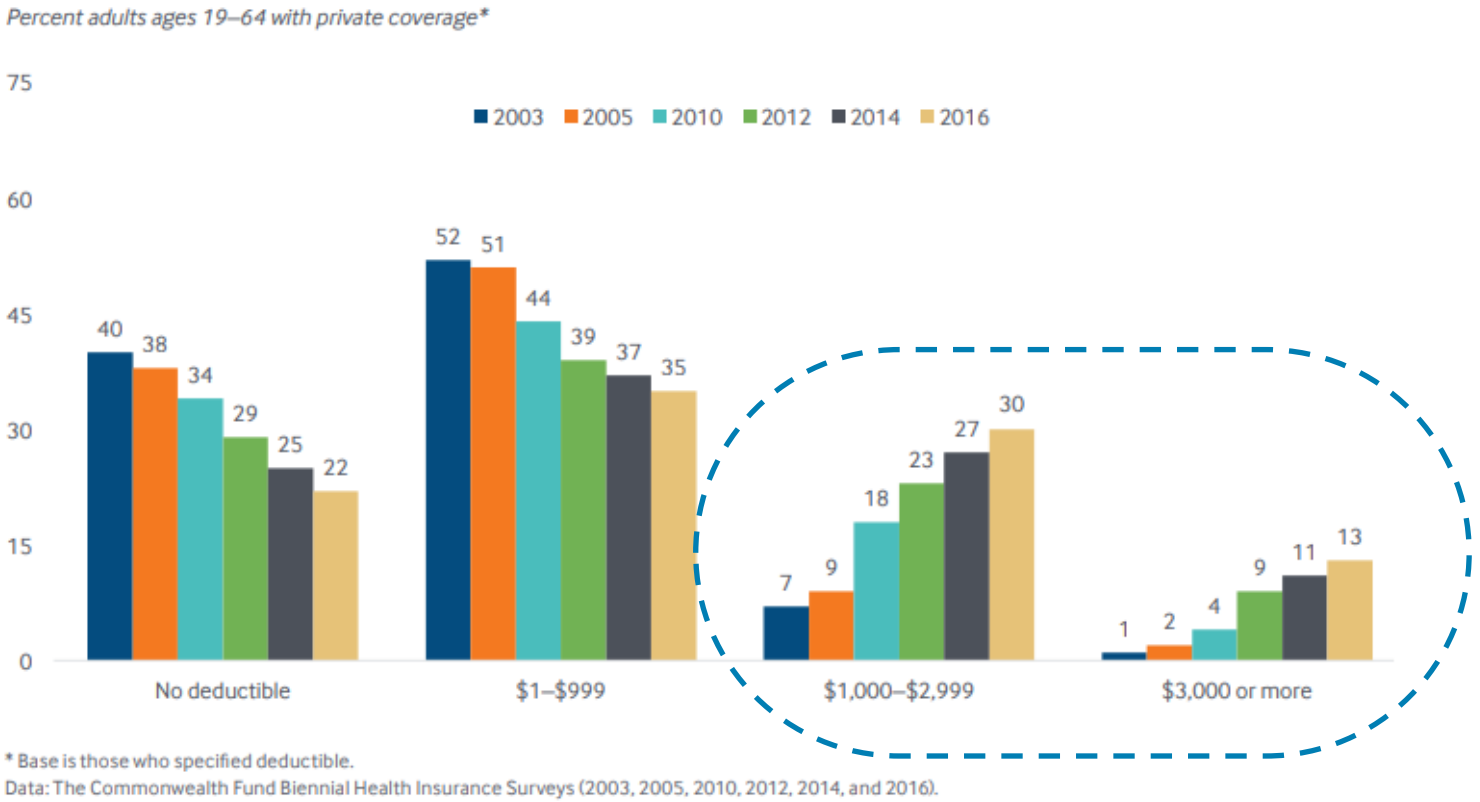
*Percent adults ages 19–64 insured all year who were underinsured**	2003	2005	2010	2012	2014	2016
Total	**12%**	**13%**	**22%**	**23%**	**23%**	**28%**
Insurance source at time of survey**						
Employer-provided coverage	10%	12%	17%	20%	20%	24%
Individual coverage^	17%	19%	37%	45%	37%	44%
Marketplace^^	—	—	—	—	—	44%
Medicaid	22%	16%	32%	31%	22%	26%
Medicare (under age 65, disabled)	39%	24%	45%	32%	42%	47%
Firm size (*base: full- or part-time workers with coverage through their own employer*)^^^						
2–99 employees	—	14%	16%	26%	26%	22%
100 or more employees	—	11%	16%	16%	14%	22%

* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. ** Adults with coverage through another source are not shown here. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace. ^^ Adults enrolled in marketplace coverage are not shown for 2014 because no one in the sample would have had marketplace coverage for the full year. ^^^ Does not include adults who are self-employed. — Data not available.

Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

Source: Commonwealth Fund
https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_oct_collins_underinsured_biennial_ib.pdf

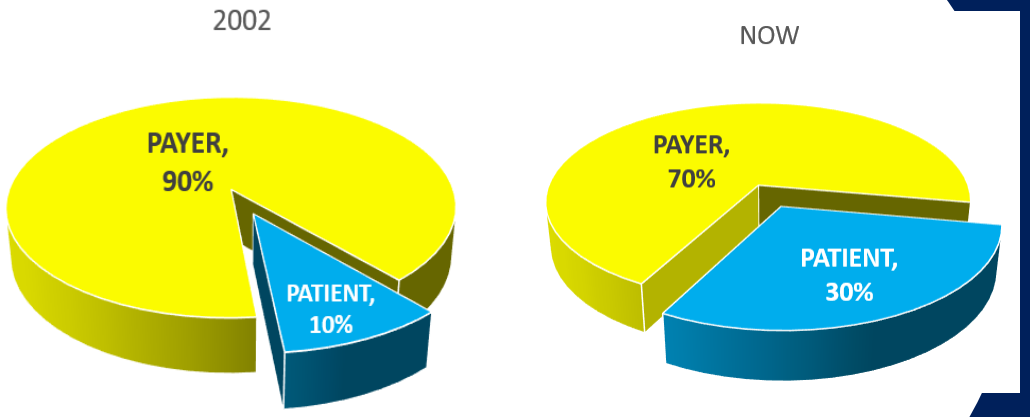
A Migration to High Deductible Health Plans is Growing Considerably

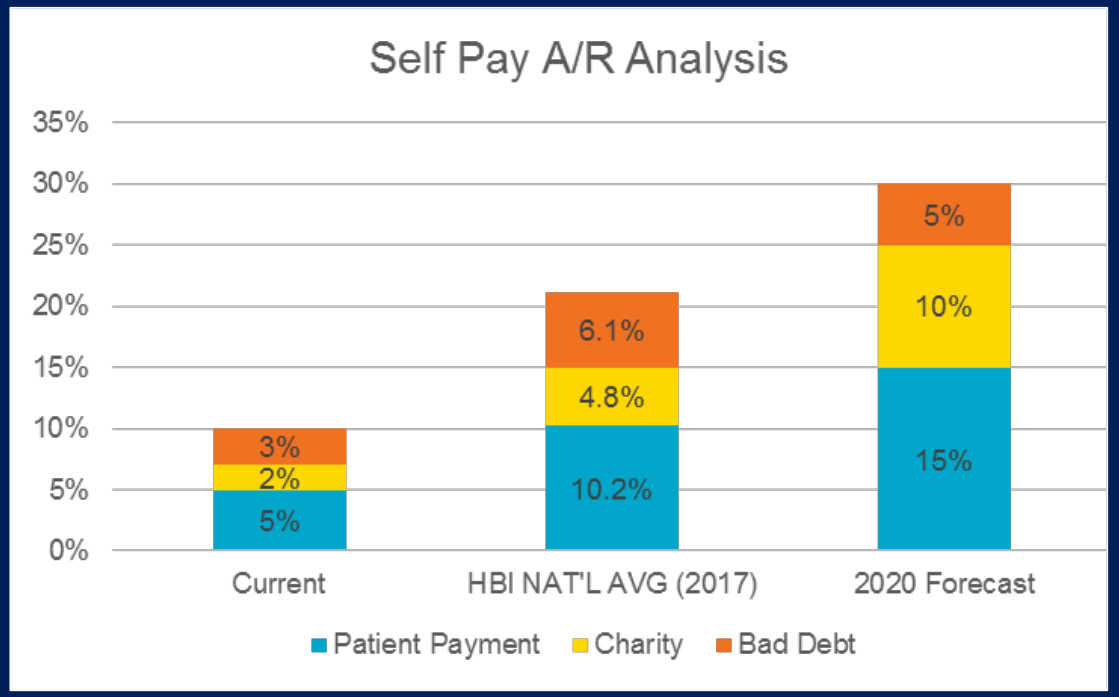


* Base is those who specified deductible.
Data: The Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, and 2016).

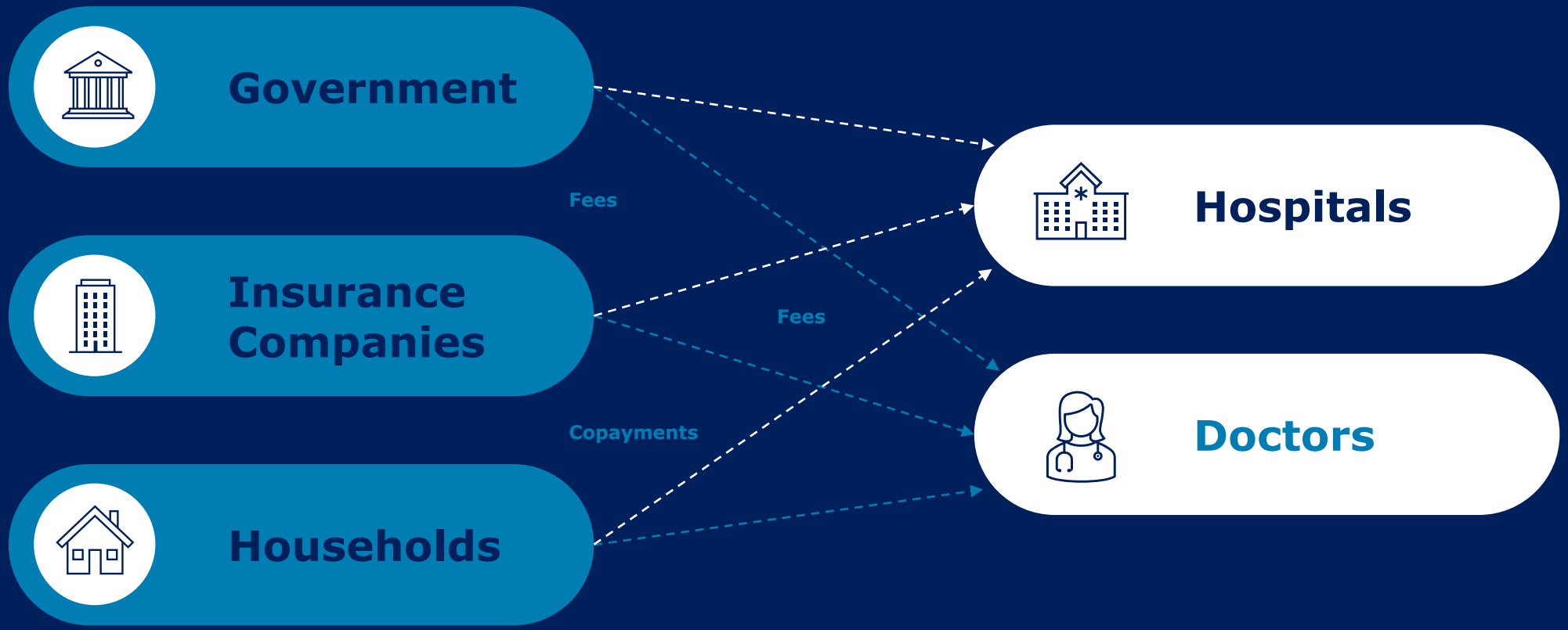
Source: Commonwealth Fund
https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_oct_collins_underinsured_biennial_ib.pdf

Patients are The New Payer™, and the Yield of Patient Revenue is at Significant Risk…

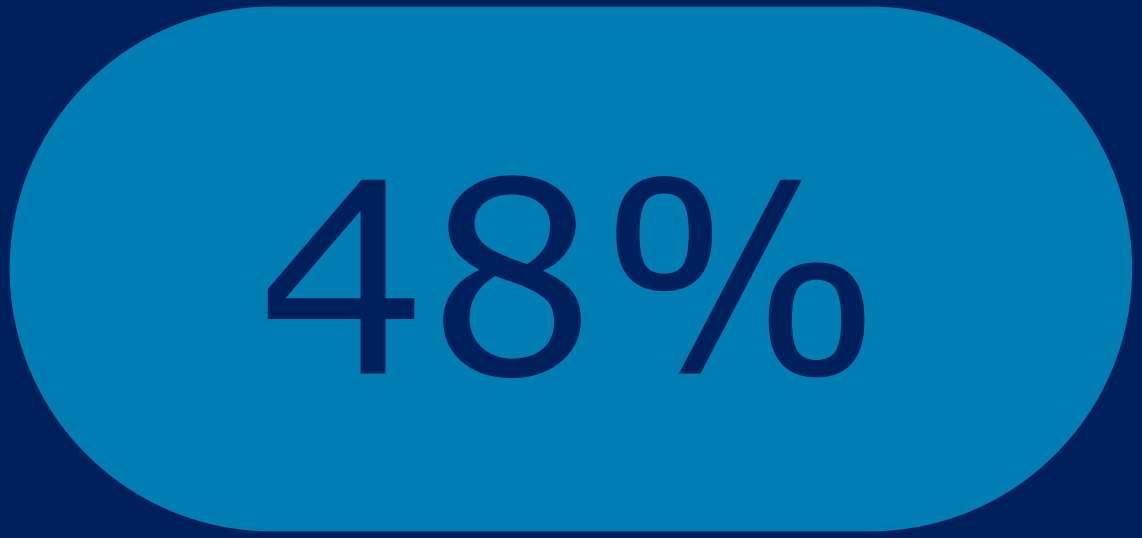




Consumers are Not Engaged in the Costs of Healthcare



Source: Cooper, R. & John, A. (2011). Microeconomics: Theory Through Applications. The Saylor Foundation. [Ch. 15.1 Supply and Demand in Health-Care Markets] https://open.umn.edu/opentextbooks/BookDetail.aspx?bookId=28 see also Jonathan's original url: https://saylordotorg.github.io/text_microeconomics-theory-through-applications/s19-01-supply-and-demand-in-health-ca.html



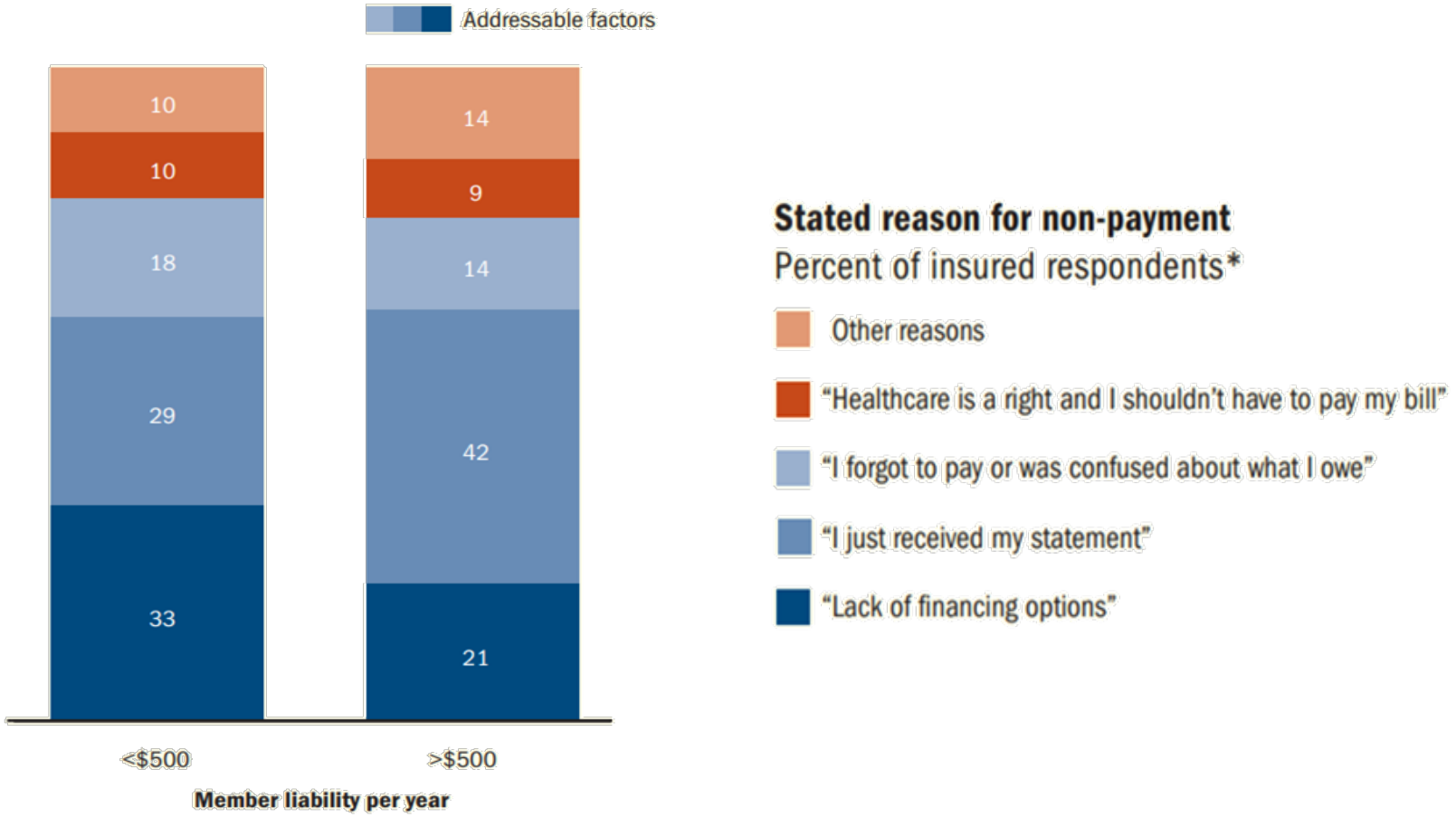
"Cost sharing levels under many health plans now **exceed** the resources that most families have on hand…
the Federal Reserve found that **only 48 percent** of Americans would be able to completely cover a hypothetical emergency expense costing **$400** without selling something or borrowing money."

Source: Medical Debt Among Insured Consumers: The Role of Cost Sharing, Transparency, and Consumer Assistance Jan 08, 2015 | Karen Pollitz

How Far Does $400 Take a Patient?

Scenario	Average Cost	Relevant Coverage	Patient Responsibility	**Amount Underwater:** Patient Responsibility minus $400
Physician Office Visit	$402	$25 copay	$25 copay	$0 underwater
CT Scan	$828	$1,500 deductible	$828 out of pocket	**$428 underwater**
ER Visit	$2,483	$250 copay + 20% coinsurance	$697 out of pocket	**$297 underwater**
Birth (Vaginal Delivery)	$9,625	$1,500 deductible + 20% coinsurance	$3,125 out of pocket	**$2,725 underwater**
Appendectomy (General Surgery, outpatient)	$13,589	$1,500 deductible + 20% coinsurance	$3,918 out of pocket	**$3,518 underwater**
Hip Replacement inpatient stay	$32,994	$1,500 deductible + 20% coinsurance	$7,799 out of pocket	**$7,399 underwater**

Patients Have **Lots** of Reasons to Not Pay a Bill Later…



Source: McKinsey: https://healthcare.mckinsey.com/sites/default/files/762679_US_healthcare_payments_Remedies_for_an_ailing_system.pdf

And Collecting Patient Payments Adds Cost to the Providers

“ ”

Moreover, costs are likely to be significantly higher when collecting from individual patients on a per-transaction basis than when collecting from payers (**as much as three times higher**).

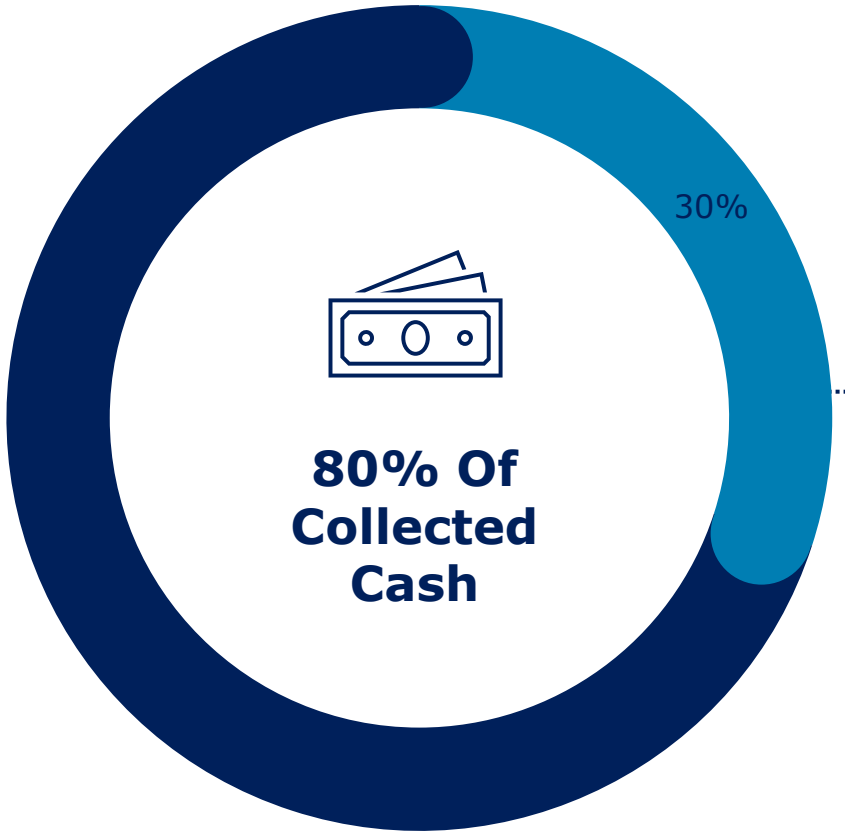
“ ”

On average, healthcare consumers pay **more than twice** as slowly as commercial payers.

Source: McKinsey - Hospital revenue cycle operations: Opportunities created by the ACA. May 2013. http://healthcare.mckinsey.com/sites/default/files/793544_Hospital_Revenue_Cycle_Operations.pdf

The Bottom Line

Self-Pay Accounts



1-5% of self-pay accounts* written off to bad debt have billable insurance coverage unknown to the hospital or its vendors

30% of self-pay accounts will generate over 80% of cash collected*

Critical to find the accounts that will pay — from both the patient *and* the payer

Benefits of a Unified Self-Pay Collections Process

Standardizes the collections process at the account level and maximizes revenue on all fronts

- **Increases reimbursements** by identifying Commercial, Medicare, and/or Medicaid eligibility on self-pay accounts
- **Improves cash flow and overall collections yield** by focusing your collectors on the most collectable self-pay accounts based on likelihood of payment
- **Reduces bad debt** by discerning true charity care from bad debt based on estimated percent of Federal Poverty Level (FPL)
- **Reduces overall vendor contingency fees** by sending less volume of accounts
- **Assists with 501(r) reporting requirements** by identifying which self-pay accounts can be segmented for collections and which accounts can be presumptively qualified for charity care

Optimized and Efficient Revenue Assurance

Locating Unknown Coverage and Underpayment	Report on Coverage and Claims that Drive Incremental Revenue	Safety Net for Revenue Leakage

Closely monitor relationships of provider, payer and patient.

Ensure efficient and timely reporting on payable coverage and claims

Leverage multiple delivery mechanisms based on workflow

Highlight demographic discrepancies between provider and payer

Focus on a holistic approach focused on identifying all valuable and unknown coverage and payments

Learning from the best

When one door closes…

How I found myself in healthcare

Breaking down silos

1

Physician, hospital, home health, free standing imaging with no standardized processes.

2

Even within physician billing we were split by specialty, pcp etc.

3

Was not easy to find payer trends and issues.

Knocking down barriers to success

1

The sharing of patient demographic and billing information across all our lines of business and multiple statements for a single patient episode.

2

One line would have updated insurance, the others would not.

3

Front end also did not have standardized processes between lines of business

4

Rapid growth of the company

KPI's to watch

1. Patient complaints and phone calls
2. Eligibility Denials
3. Timely filing denials
4. AR >90
5. Cash % of net rev trailing
6. Bad debt % net rev trailing

Results

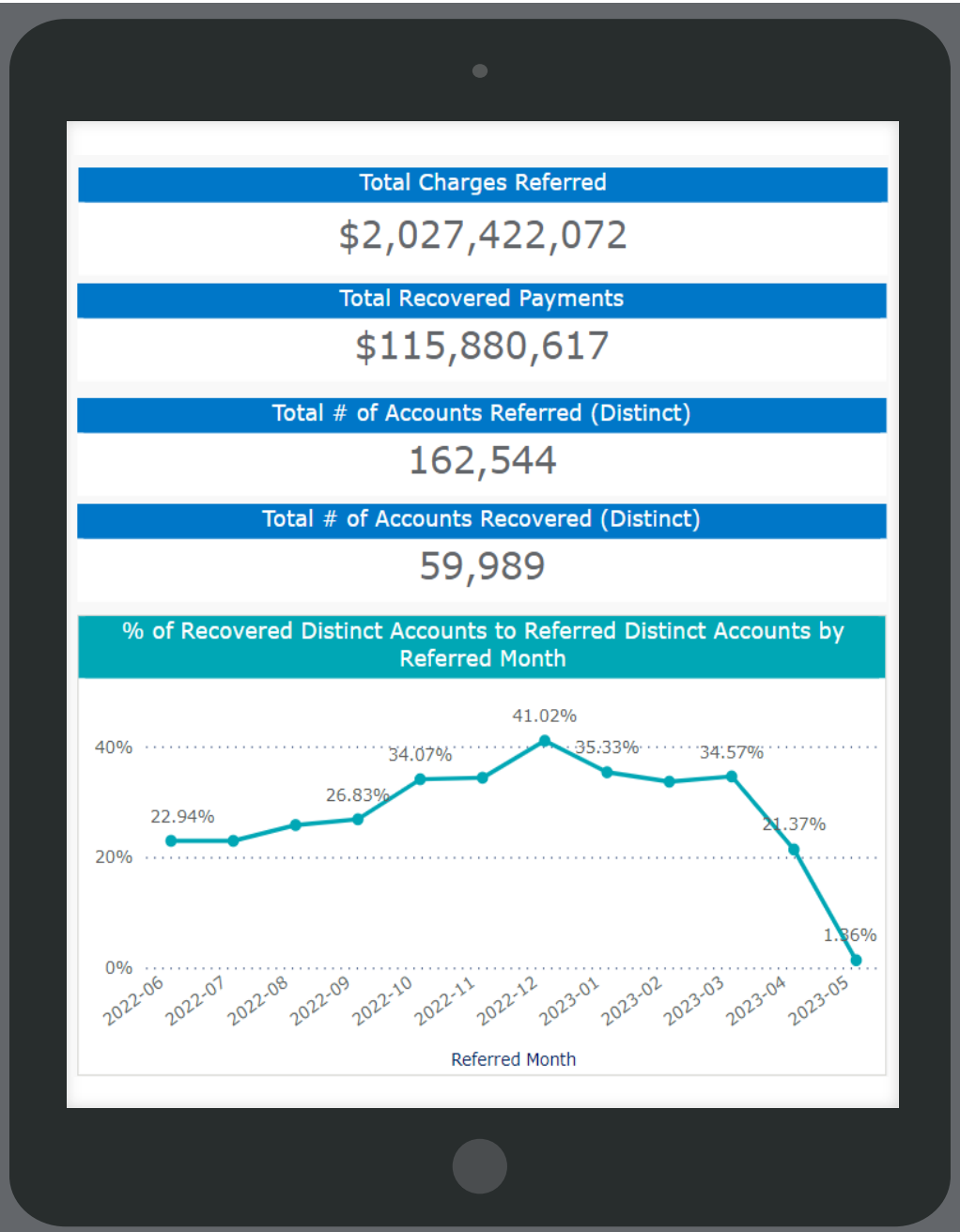
Banner Health Acute

Main Story

Banner Health | FinThrive

Banner Health Acute

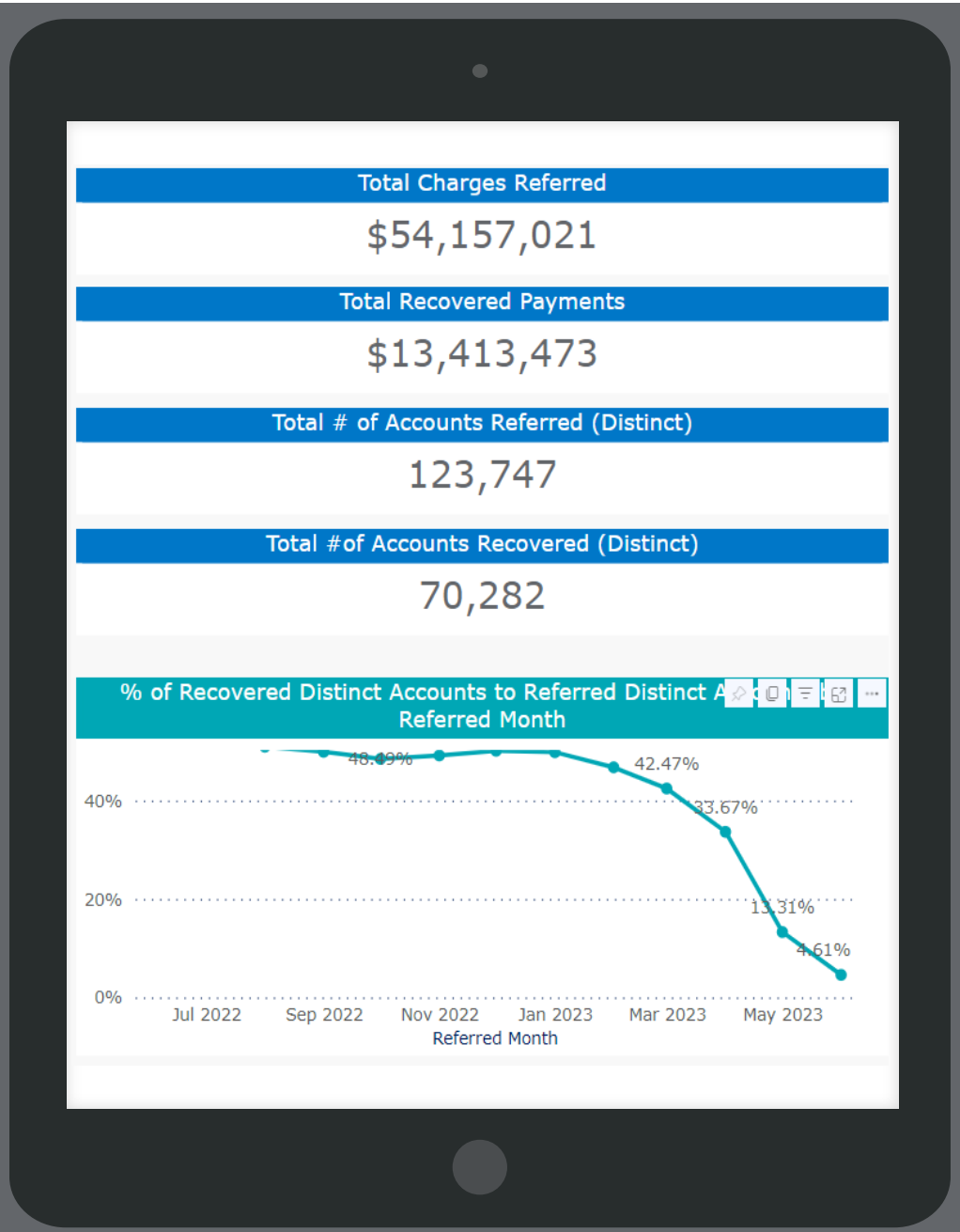
Main Story



Banner Health | FinThrive

Banner Health Ambulatory

Main Story

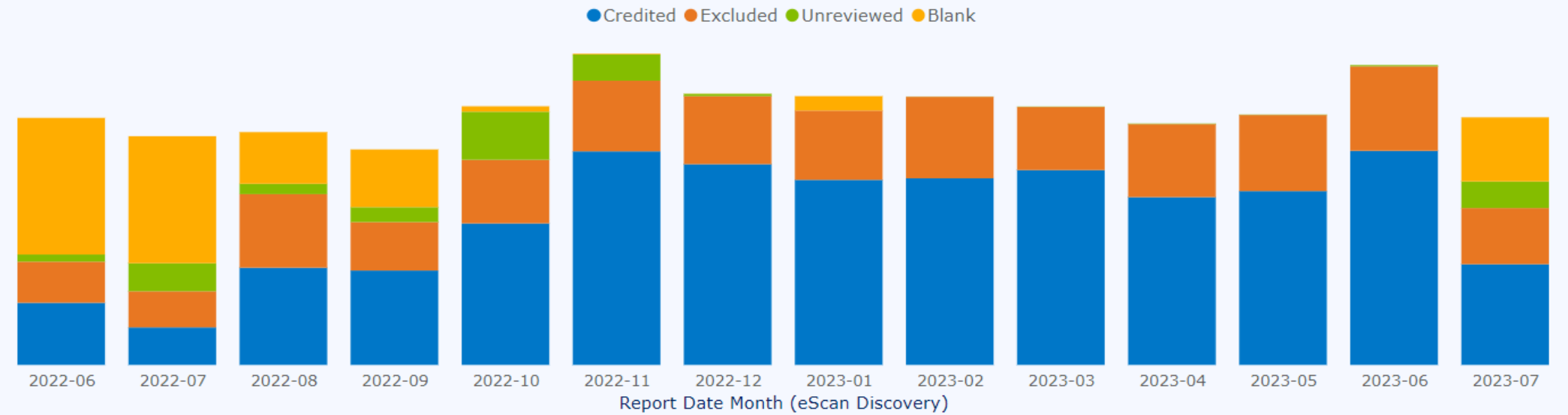


Acute Determinations Credited, Excluded and Pending

Banner Health

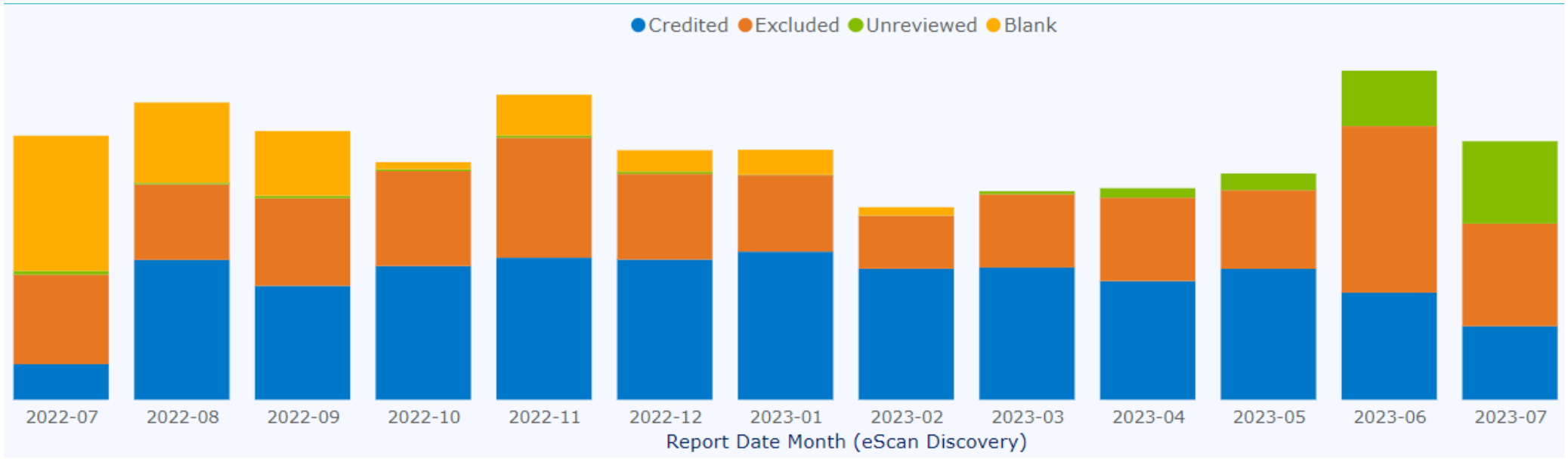
Determination Trend

Refreshed Date
07/26/2023



Ambulatory Determinations Credited, Excluded and Pending

Determination Trend



Acute Recovery Over Time Based on Account Referral Date

Banner Health

Recovery Over Time

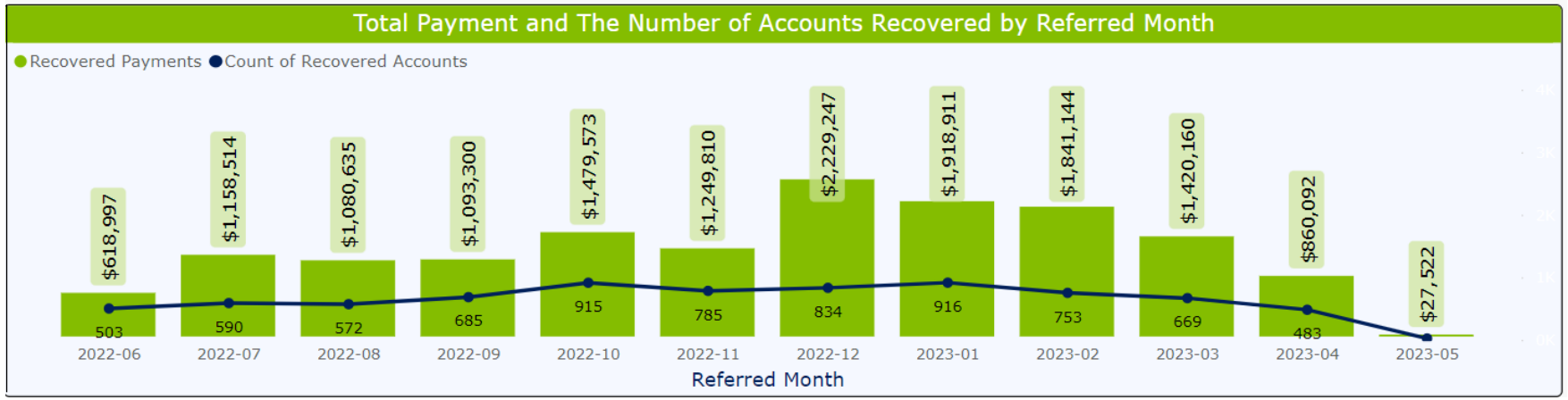
Refresh Date: 07/26/2023

Referred Mo

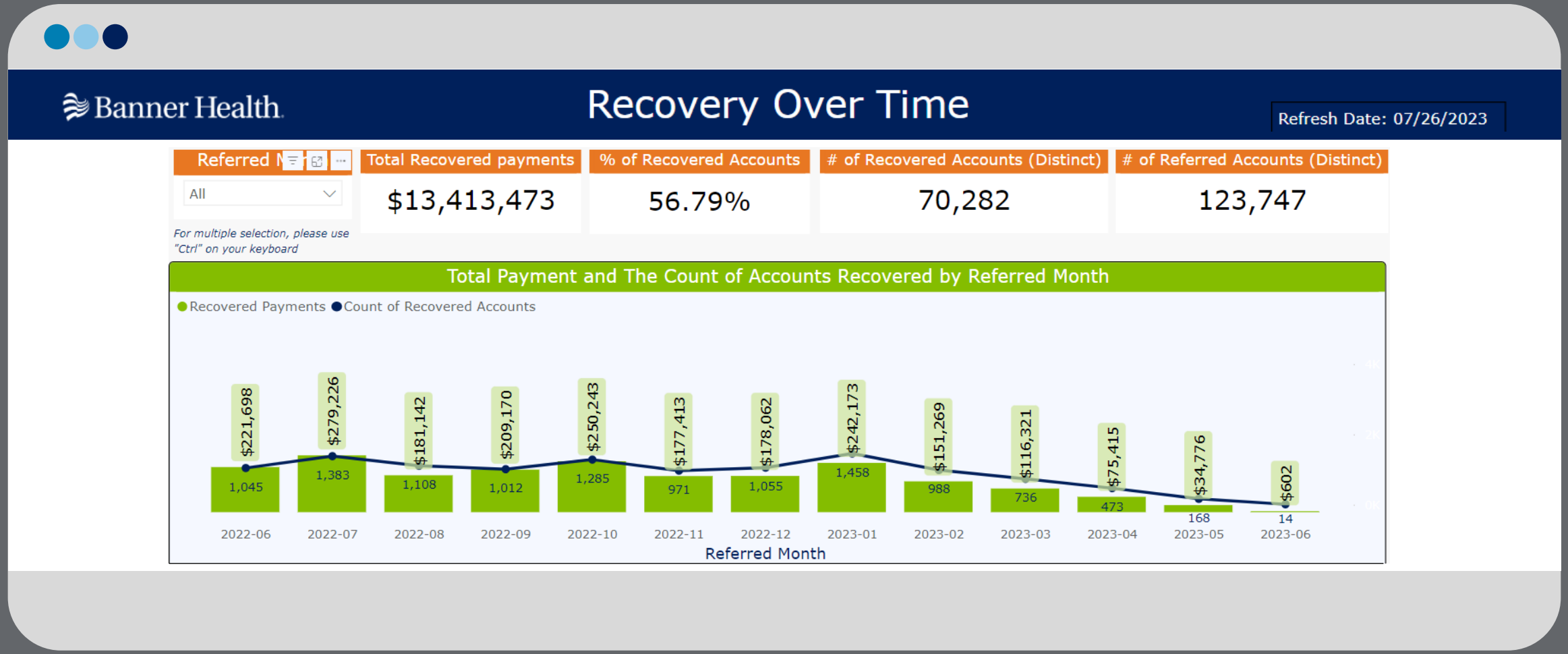
All

For multiple selection, please use "Ctrl" on your keyboard

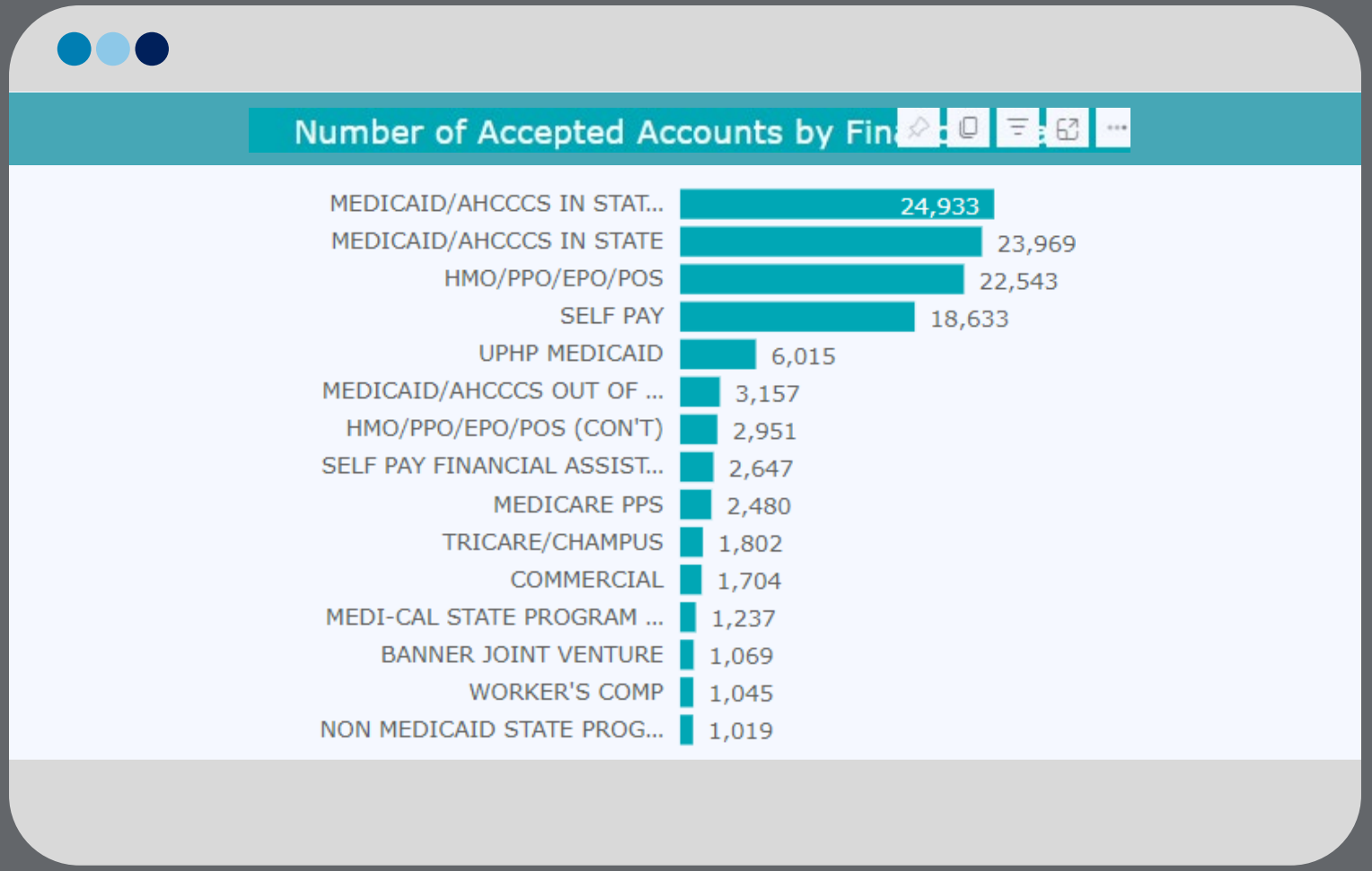
Total Recovered payments	% of Referred Accounts	# of Recovered Accounts (Distinct)	# of Referred Accounts (Distinct)
$115,880,617	36.91%	59,989	162,544



Ambulatory Recovery Over Time



Acute Number of Accepted Accounts Over Time



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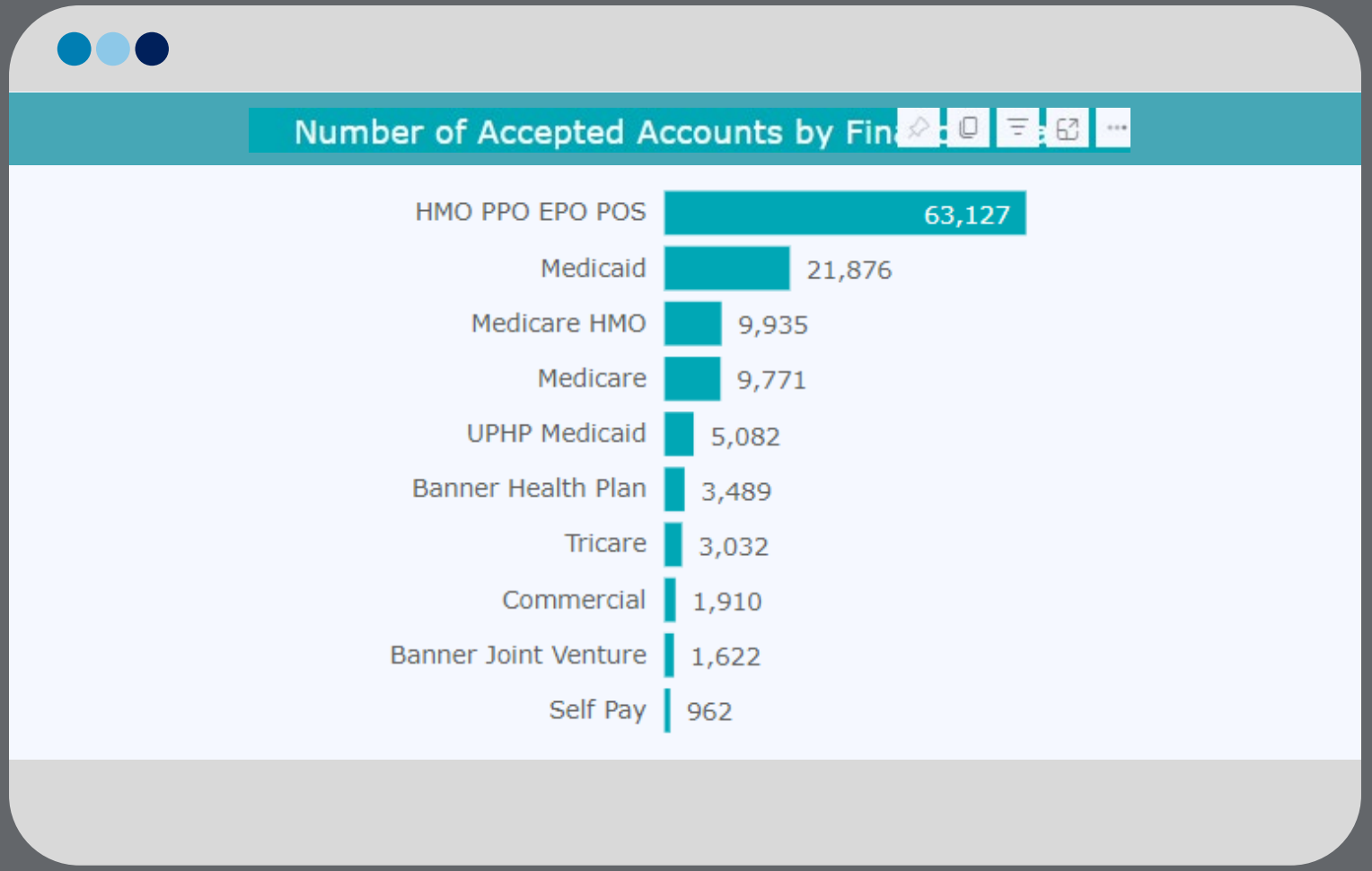
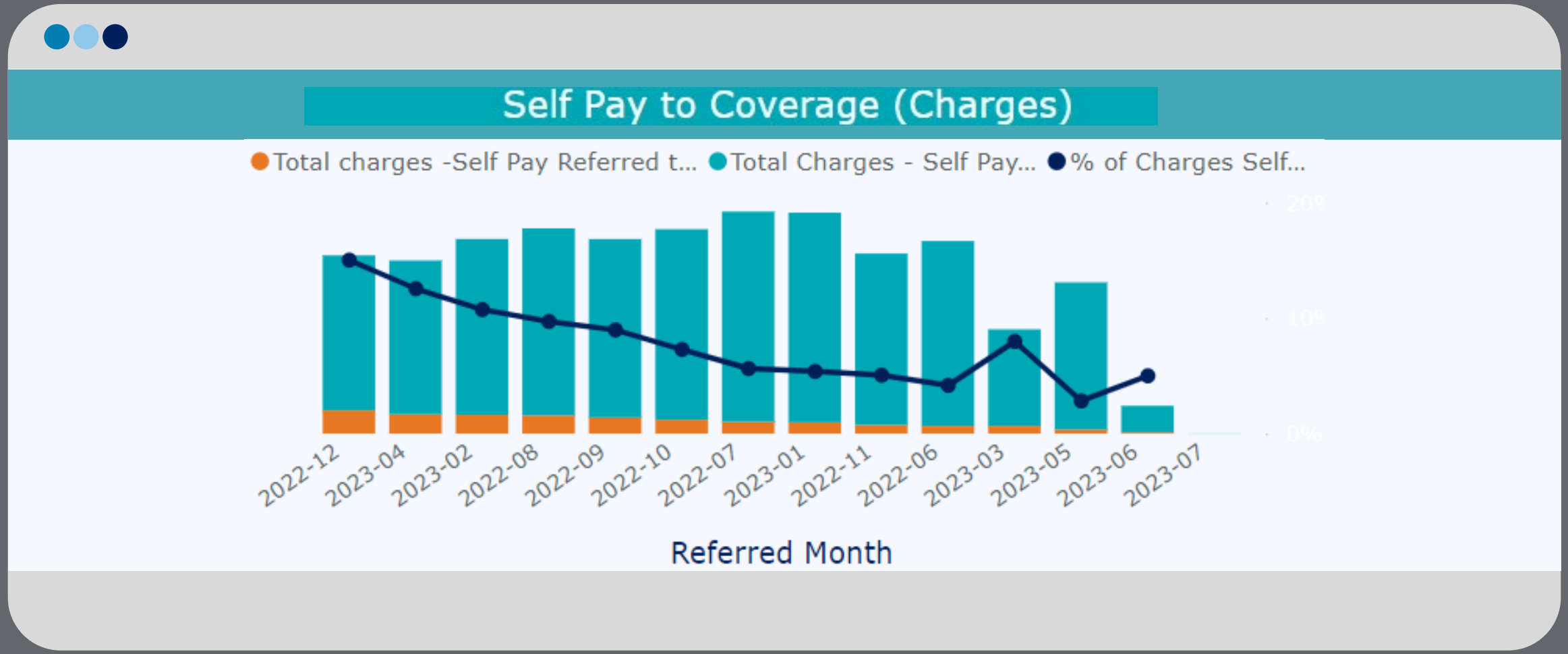
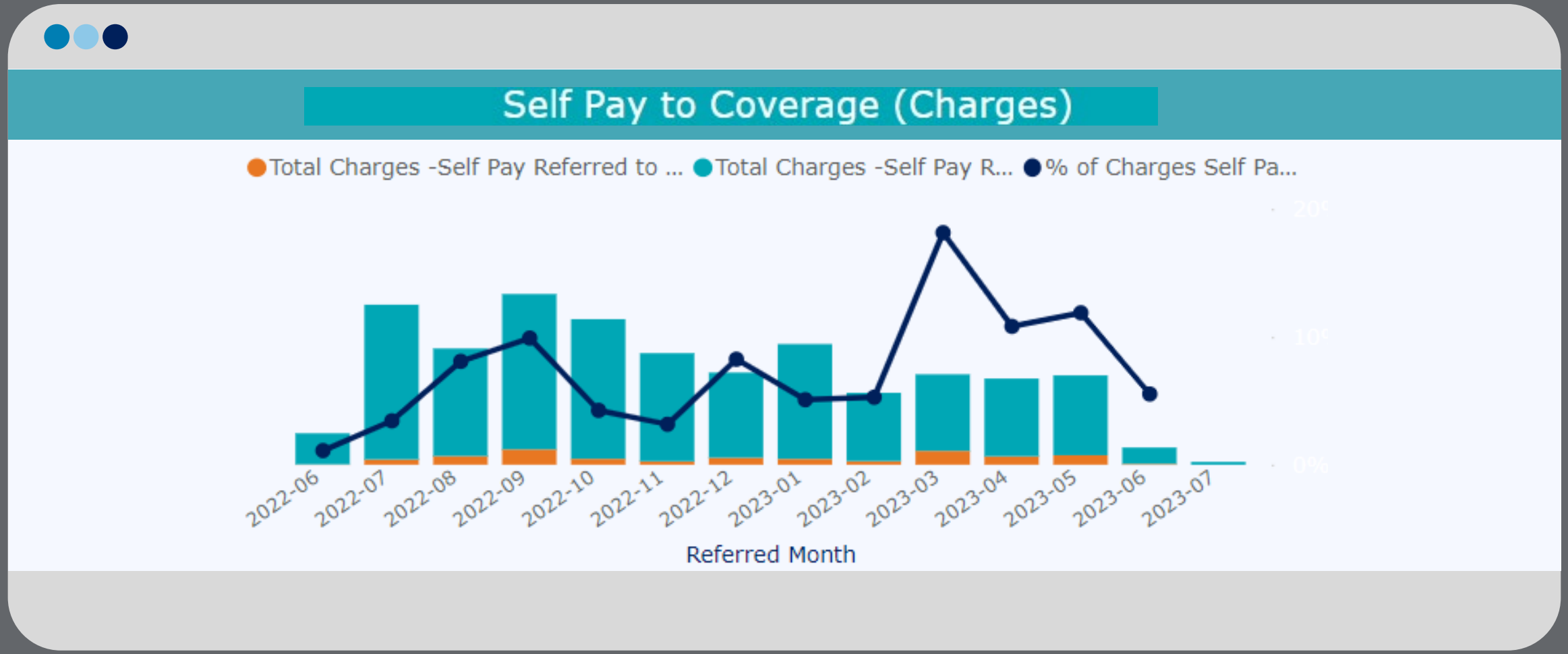


Acute Coverage Discovery for Self Pay/Conversion Rate



Ambulatory Coverage Discovery for Self Pay/Conversion Rate



Leveraging multiple vendors

Still a fairly new process, continuing to learn every day. Ultimate hope in introducing another vendor is to make sure we are not missing anything. Added safety net in capturing any additional coverages.

Engage front end in quality and providing additional feedback to enhance info capture up front as opposed to back-end vendors

Timing of when vendors find coverage, overlap, prevent by appropriate staffing and meeting productivity

Payer mapping – challenging and tedious with any vendor. Payers named different in all systems.

Impact to front-end registration

- Current process verifies insurance on file and looks for state Medicaid only
- Not doing Insurance Discover at front end
- Update systems for future visits
- Back end, screen at 30 days, 45 days and them Medicaid and PFA prior to bad debt placement

How it was received

Staff

- Created a dedicated team to work insurance discovery.
- Excited to see the money they are bringing in by working the products, can see the impact they make with cash, even though they are not on the AR teams.
  - Competitions between AR and self-pay were not always impactful to self-pay staff
  - Being able to see their impact was a morale booster

Patients

- Reduced patient complaints and phone calls
- Improved statement accuracy – patient received correct bill the first time

Success metrics

- Eligibility Denials
- Timely filing denials
- AR >90
- Cash Factor (cash/net rev) FinThrive dashboard
- Bad debt % net rev trailing – PBM dashboard

What's next? Where are you going from here?

1

Working on creating bots that will do the more simple and straight forward payers from the coverage discovery vendors.

- Currently working with FlyWire on our first one.
- Challenge is mapping the payers as we have one to many.

2

Continue and increase partnership with our front-end leaders on common trends with payers and eligibility checks between front and back-end products.

3

Upcoming implementation of a new software that will combine Acute, Ambulatory, and Imaging accounts receivable.

Collaboration with our Insurance Discovery vendors to continue our current processes with the new system. Banner values our vendor input, so we coordinate our build and go lives with active vendor participation.

Thank you

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