Key Trends in Healthcare Patient Payments
For the purposes of this white paper, “patient payment optimization” is the combination of solutions, processes, goals, and plans that allow provider organizations to optimize patient billing and collections in order to improve specific performance metrics.

HEALTHCARE PROVIDERS AND THEIR PAYMENT PROCESSING PARTNERS SHOULD SHARE AN IMPORTANT COMMON GOAL: Any patient can pay at any point in the revenue cycle process (before, during or after an encounter) via any payment type (check, e-check, credit/debit card, online bill pay, payment plan) through any payment outlet (point of service, web, phone, mail, payment plan, kiosk).

In order to accomplish this shared goal, providers need to plan for how best to optimize payment processing and collections across their continuum of systems, transaction processors, and payment processing workflows. This white paper examines some key trends in patient payments in the U.S. healthcare market.

Shifting Responsibility

Among the major trends affecting healthcare payments are the continued increase in patient responsibility, continued uncertainty about the timing and extent of regulatory changes and resulting healthcare reform, and the transition from paper-based processes to electronic transactions and workflow.

Increased patient responsibility for healthcare payments is perhaps the single most outstanding feature; in the last few years, financial accountability has shifted significantly to consumers.

As a result, both patient liability and bad debt are on the rise and healthcare providers are experiencing unprecedented revenue and margin pressure. Hospitals and clinics have become like retail organizations, which need to provide their consumers with access to payment capabilities at point of service, via the web, through payment plans, and more.

Healthcare providers are well aware of the unique complications inherent in this industry: lack of knowledge about what to bill patients at various points in the revenue cycle process; the need to calculate patient responsibility based on suspect payer information and challenging-to-calculate fee estimates; and, the desire to calculate a patient’s propensity to pay score in order to determine which collections route is likely to provide optimal revenue. Additionally, patient accounting systems and clinical information systems have been late to turn their focus from clinical applications (such as electronic health records, and administrative applications like admissions and scheduling) to their revenue cycle, collections, and payment processing modules.

Healthcare provider organizations have had a very challenging few years where systems and transaction processing capabilities are finally catching up to the market need to interact with patients in a more direct collections relationship. Healthcare providers, however, are not providing the level or the sophistication of payments services that consumers expect. Given the challenges healthcare faces that are unique to the market, and the novelty of providing retail-like payment processing capabilities, it’s not surprising that this is a main focal area for the revenue cycle and financial departments in almost every healthcare provider organization. Most need updated systems that can enable significant process improvements as well as integrate patient payments into workflow.
In the last few years, financial accountability for healthcare payments has largely shifted to consumers.

The Rise of High Deductible Health Plans

As employers look for new ways to handle rising healthcare costs, High Deductible Health Plans (HDHPs), which shift financial accountability to consumers, have matured in the last few years. The U.S. market has experienced a ten-fold increase in the past seven years in the number of covered lives under HDHPs — to more than 11.4 million people and growing (as of June 2011).

According to America’s Health Insurance Plans (AHIP), the growth in HDHPs is a major contributor to current expectations that out-of-pocket payments for insured patients are expected to grow from $250 billion in 2009 to $420 billion by 2015, a 68 percent increase in five years.¹

In some hospitals, the rate of bad debt for insured patients is increasing at well over 30% per year.

Effects on Patients and Providers

As patient accountability increases under HDHPs, patient medical liability grows as well. Medical liabilities for self-pay patients — those without insurance who pay for services from their own pockets — are now growing at 19 percent per year.²

In stark contrast, for insured patients, McKinsey has estimated that the rate of bad debt is increasing at well over 30 percent each year in some hospitals. Consumers now pay more in healthcare costs than employers, and that consumer bad debt for medical expenses were $65 billion in 2010.³

Regardless of whether they are covered under a traditional or high deductible plan, consumers now shoulder a greater upfront cost burden. Significantly, this changes the payments role for providers as well.

Providers must now collect payment directly from the consumer, not the insurer. They must now bill patients, often for some fairly sizable amounts. Today, this is mainly a manual process, in contrast to the almost completely automated process of submitting a claim for reimbursement through an insurer.

This can be problematic because the payment systems and processes in use today in most hospitals and clinics are not engineered for easy, smooth and convenient patient payments. As a result, these processes often do not meet the high expectations of today’s consumer.

¹ AHIP Center for Policy and Research, 2005-2011 HSA/HDHP Census Reports; June 2011 report, p. 2
³ Ibid
In fact, the process of transacting directly with consumers presents a whole new set of challenges for providers who must now calculate **patient responsibility** as a first step towards rationalizing their payments system. Patient responsibility is a compound of two sub-components: **eligibility** and **estimation**.

For **eligibility** verification, providers must ascertain the following:

- Is the patient insured?
- Are they an eligible member of a health plan today, for these specific services delivered by accredited providers?
- If so, per that plan, what are the terms for how we bill the patient and the payer?
- What is the patient’s copay and/or deductible (deductible balance)?
- If not insured, can they pay - or is this charity care?

In order to properly **estimate** fees, providers must first ascertain:

- What services does the consumer need? Can clinical workflow be translated into diagnosis and service codes that can generate accurate fee estimates?
- What can we bill their insurer for, or if they are self-pay/uninsured, what do we bill patients for these services?
- What is an estimate of those fees against a fee schedule for their insurer (insurance-adjusted fee estimate)?

Often, providers also are calculating a propensity to pay score whether the patient is insured or not. If an insured patient has a high deductible balance and therefore, a high patient responsibility, or if the patient is self-pay, a combination of other transactions like credit score, mortgage balance inquiry, address verification, and more can help determine a patient’s propensity to pay, give insight into payment options, and determine if a patient is a candidate for payment plans or charity care.

Clearly, patient responsibility can only be calculated after the provider can ascertain their eligibility status, plus the amount the patient owes for copay and their deductible balance, plus the information on their estimated fees. Therefore, the healthcare provider should be providing the patient with all of this information and establishing a payment method as soon as possible, ideally while the patient is still present.

**AN EMERGENCY ROOM VISIT WITH HDHP COVERAGE**

As an example, let’s examine a mini-case study, where a patient presents in the emergency room, requiring x-rays and a couple of procedures. They are insured, though they are responsible for a $50 copay for emergency care, and a $2,500 deductible per year, which they have not begun to use. The estimate for radiology and ER fees is $1,200. Based on this information, it is very likely that this patient will owe the entire amount of their bill.

**Gaps in Healthcare Payments Efficiency**

The current systems infrastructure in most provider organizations is not designed to provide the necessary level of detailed, accurate and timely payment processing service to patients. Hospitals and clinics often have manual processes for verifying eligibility, requesting payment, collecting and posting payments and managing exceptions. Where electronic transaction processing does exist, they often are not integrated into systems and require manual workarounds.

Clearly, all of these issues add significant time, effort and cost. Because of this, the provider community should address some significant gaps in healthcare payment efficiency:

- **Heavy reliance on paper-based payments:** The healthcare industry as a whole still transacts with high volumes of paper checks, in spite of the fact that patients today require capabilities for web, phone, credit card and e-check payments, as well as payment plans.
• **Low utilization of back office processing:** Healthcare providers rarely take advantage of lockbox facilities, and even less often utilize remote deposit capabilities.

• **Lack of payment estimates provided at point of care:** A 2009 McKinsey Quarterly survey of retail healthcare consumers showed that 52 percent of consumers would pay from $200 to $500 or more by credit or debit card when they visit a physician, if an estimate was provided at the point of care.\(^4\)

Intriguingly, the McKinsey study found that 74 percent of insured consumers indicated that they are both able and willing to pay their out-of-pocket medical expenses up to $1,000 per year and 90 percent would pay for medical expenses up to $500 per year.\(^5\)

When asked why they would opt not to pay a medical bill, the survey respondents indicated that a lack of options for payment plans, poor timing of bills and difficulties coping with confusing statements or policies were major barriers to paying.

Clearly, providers are in a position to lower many healthcare consumers’ barriers to paying. One approach would be to adopt new approaches to make payment more convenient and less confusing. A second approach would involve helping consumers distribute their healthcare costs over time.

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### Impact of Healthcare Reform

In addition to this fairly long list of challenges, numerous healthcare reforms will impact patient collections and performance metrics:

• **Government reforms:** government acts that include incentive payment plans and shared savings programs, and of course, margin and revenue pressure via revised fee schedules

• **Industry reforms:** consolidation via mergers and acquisitions and the centralization of billing operations

• **Payment reforms:** new payment types and business models resulting from government and industry reforms; new payment formats in use by healthcare that will hopefully help automate payment processing (e.g. the ACH format CCD+)

Healthcare reforms — government, industry, and payment reform — all put additional pressure on healthcare providers to work diligently to maintain “revenue integrity” in what is becoming a state of perpetual change for our industry.

One key focal point of revenue integrity initiatives must be patient payment optimization.

### Summary:

• Patient responsibility is increasing dramatically

• Patients will pay

• Provider organizations have numerous challenges to address patient payment process optimization

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**ABOUT THE AUTHOR**

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Eyestone has 18 years of experience in healthcare information technology, consulting, revenue cycle process improvement and treasury services.

He has worked with the largest provider organizations, payers, national labs and pharmacies in the country to build payment processing networks, optimize payment transaction processes, and help drive key financial and operational performance metrics.

He is an expert in revenue cycle, patient and payer payment processing, and healthcare system and workflow improvement, especially as these processes need to optimize the use of Treasury Solutions and Merchant Services.

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\(^4\) Ibid  
\(^5\) Ibid  
\(^6\) Ibid