Uncompensated care has large impacts:

→ 1 in 3 Americans struggle to pay medical bills, and 70% of people with medical debt are insured, according to a Kaiser Family Foundation report.

→ Medical debts account for 52% of debt collection actions that appear on consumer credit reports, according to the Consumer Financial Protection Bureau (CFPB).

→ In households with at least one uninsured person, only 35% have the liquid assets to cover the cost of lower deductibles, only 22% can cover higher deductibles.

Undoubtedly, patients’ inability to pay for healthcare services is impacting cash flow. For example, uncompensated care (the sum of bad debt and financial assistance provided to patients) reached $46.4 billion at registered community hospitals in 2013. That represents 5.9% of a typical hospital’s overall expenses.

Many insured patients with large hospital bills have difficulty paying those bills, as their disposable income is typically outweighed by their out-of-pocket costs from deductibles, coinsurance and copays. With this growing issue impacting both underinsured and uninsured patients, the problem often compounds.

Facing overwhelming payments, patients tend to either delay medical care or skip it altogether to avoid sinking further into debt. This approach, however, often leads to higher expenses. By the time a patient comes into the emergency room or doctor’s office to seek treatment, the patient’s medical condition has frequently worsened and the required treatment at that point is much more intensive and expensive. The patient’s debt—and inability to pay—increases anyway.
When patients can’t afford to pay, all that uncompensated care makes managing your revenue cycle a true challenge.

Changes ushered in by the Affordable Care Act (ACA), coupled with an evolving consumer base, are driving two big trends that are changing how you provide care and remain financially solvent:

- Consumer Directed High-Deductible (CDHD) health plans are on the rise
- Patients now fund a large portion of their care, and they have economic and clinical choices in the healthcare marketplace

Let’s look at each trend in more detail, and then we’ll look at solutions.

**CDHD health plans are on the rise**

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<th>Figure 1. Open enrollment period: popularity of HDHP</th>
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<td><strong>2014</strong></td>
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* Data from U.S. Department of Health and Human Services
** Data from eHealthInsurance 2014 and 2015 Price Index Reports

As consumers purchase insurance through exchanges, and employers offer CDHD plans to reduce their premium expense, the cost burden for healthcare services has shifted to healthcare consumers. This rise in CDHD plans has been dramatic over the last few years, and since 2011, the industry has seen an average annual growth rate of 15% for CDHD plan enrollees.5

Lower upfront premiums in health plans typically mean higher out-of-pocket costs and higher deductibles that are difficult for most patients to pay. For example, according to the Henry J. Kaiser Family Foundation, "Since 2010, both the share of workers with deductibles and the size of those deductibles have increased sharply. These two trends together result in a 67% increase in deductibles since 2010, much faster than the rise in single premiums (24%) and about seven times the rise in workers’ wages (10%) and general inflation (9%)." The report also says that "81% of covered workers are in plans with a general annual deductible, which average $1,318 for single coverage..."6 Those deductibles must be paid before patients’ health plans will cover most elective services.

While the ACA puts limits on out-of-pocket deductible expenses—$6,600 for an individual and $13,200 for a family in 2015 before marketplace subsidies7—that remains cost-prohibitive for most
people. If they can’t afford the deductible, they typically either forego treatment or incur a debt that has detrimental impacts to their finances.

To make matters worse, industry reports indicate that when it comes to spending, cash-strapped consumers aren’t making medical bills a priority. Only 7% of consumers ranked medical bills as one of the two bills they prioritize paying, with mortgage/rent (72%), utilities (55%) and even cable/cell phone/Internet (8%) being viewed as higher priorities, according to a McKinsey & Company report.8

As a result, healthcare providers are increasingly required to play the role of lender and collection agency. That increases costs exponentially for providers as they are forced to expand their billing and collections departments to collect payment from individuals in addition to insurance companies.

Patient finance is a growing trend in the healthcare market. Many patients lack liquidity to fund their high deductibles and frequently cannot afford it. Providers, in turn, are looking to fund care through patient loan programs or payment plans, some of which are interest bearing. Many other industries offer ways to establish credit and payments. The healthcare industry has lagged for years in this regard, but is now emerging in this patient finance arena.

Healthcare is a business. If your organization fails to meet the needs of your customers, you’ll lose their business—perhaps before they have settled their debts.

People are taking control of their healthcare

The second big trend comes from the fact that patients are now shouldering more of their healthcare costs, so they are therefore acting more like consumers. Patients are shopping for healthcare as they would for a plane ticket or car. They expect value and efficient customer service, as well as more price transparency, options, flexibility and control.

With a quick online search, patients can investigate hospitals and other healthcare providers before deciding where to go. They can read reviews on social media. They can learn how much typical procedures cost so they are informed before they even set foot in a hospital. They can even customize their insurance options based on their health status and personal finances.

These processes often form the first and last impressions a patient receives about your organization. Just one bad experience can send them looking elsewhere, so as a provider, you generally have one chance to get it right.

Bottom line: Consumers expect healthcare services on their terms, and providers must adjust. After all, healthcare is a business. If your organization fails to meet the needs of your customers, you’ll lose their business—perhaps before they have settled their debts.
The answer: Double down on patient engagement to maximize reimbursements

Uncompensated care, high deductibles and consumerism threaten your revenue cycle performance. To meet the challenges of optimizing self-pay collections—while providing a positive patient experience—follow these seven best practices of top-performing healthcare organizations.

1. Establish funding mechanisms prior to treating patients

Communicating payment options to patients early in the process can prevent bad debt—and negative feelings—later. Bad debt is directly related to the failure of the financial clearance process, so make establishing funding a mandatory step prior to treating patients. Determine the patient’s financial position and ensure that those who need assistance get it.

2. Ensure prior authorizations are in place prior to performing clinical procedures

Implement a system that will notify registrars of any pre-authorization requirements by the insurance carrier and whether patients’ benefits are limited or exhausted. The process should inform the registrar of options to offer the patient before a procedure takes place, based on the patient’s financial status. That empowers registrars to reduce bad debt prior to service, and helps to eliminate back-end costs and write-offs.

Additionally, put into place escalation, or “stop the line,” protocols to ensure standard work and alignment are in place from all fronts as patients access their benefits and onboard to care.

3. Implement technology solutions to streamline processes

Keep in mind that a lack of standard work in the revenue cycle can lead to a large number of insurance denial and payment issues.

However, you can streamline your processes by using tools to determine insurance eligibility, verify patient identity, estimate out-of-pocket costs, financially screen for charity programs, and determine propensity to pay. A comprehensive screening process lets you determine any eligible patient funding program—be it insurance, charity, payment plans or self-pay—before you classify an amount owed as bad debt.

4. Use propensity-to-pay analytics

Patients should pay within their ability, and those without the ability to pay should be screened for financial assistance. Propensity-to-pay analytics separates patients who refuse to pay from those who don’t have the ability to pay, so that you can work on payment options.

Once you know which patients have the means to pay, you can prioritize the self-pay accounts that should receive the most attention, and detail specific actions to collect payment (for example, escalation, letter, bill or phone call) and at what intervals.

Additionally, you can implement predictive analytics for self-pay accounts prior to classifying a bad debt to find unrealized charity eligibility and fundable (high propensity-to-pay) self-pay accounts. Use the same analytics to review existing bad debt accounts and reclassify those that qualify for charity care.
5. Accelerate the self-pay collection process

Many healthcare organizations opt for a more passive self-pay collection process during the initial months after a patient bill drop; they simply send bills and then wait for people to pay.

However, you’ll find that moving the dunning cycle up from day 31 to day 1 makes a difference. The business office, or their “early out” partner, calls patients to clarify coverage and payment options, thus immediately engaging customers in the process.

Additionally, organizations that implement online bill payment, communication, and financial-assistance application programs are generally more successful and improve customers’ overall experiences, while also increasing cash recovery and reducing bad debt.

6. Screen self-pay patients for unknown coverage

A patient’s eligibility for insurance coverage may change over time for many reasons, including data entry errors, plan changes and undisclosed coverage. Many hospitals discover self-pay patients with insurance coverage as late as 120 days after the patient’s discharge.

Before making a bad debt placement, conduct a final commercial or public-payer insurance coverage check, and enhance your ability to convert self-pay status to payer coverage, thus turning a potential bad debt into insurance revenue.

7. Provide a web-based patient payment portal

Many hospitals have introduced web-based payment portals, but many such portals lack robust functionality that consumers expect when they conduct business online.

To optimize a patient portal, hospitals need to provide the same features that patients see when accessing other services to make a purchase, pay a bill or check their balance. Patients typically want to be able to:

- Understand when and to whom bills have been sent
- See recent payments applied to an account
- Request itemized statements
- Make a payment using a credit card or debit card
- Set up a payment plan
- Update personal information
- Communicate via email with hospital billing staff

Take patient engagement outside of the examination room

Patient engagement shouldn’t be relegated only to doctors and other clinicians. You should review the patient experience throughout the revenue cycle—from the moment patients contact your organization until they have paid their final bill.

Patient satisfaction is not simply about quality and continuity of care—it includes transparency about financial obligations, mutual agreements as to how the care will be funded, and effective communication throughout the process.

The defining experiences—those first-impression encounters with registrars, schedulers and other revenue cycle specialists—are often what patients remember most. Creating a consumer-focused culture from the front door to the back office can dramatically improve patient satisfaction levels and positively impact your financial performance.
How TransUnion Healthcare is helping healthcare providers

TransUnion Healthcare solutions help providers focus on who matters most—patients—by finding coverage and funding throughout the care continuum, and by helping patients avoid having to be subject to collections. TransUnion Healthcare’s revenue cycle management solutions maximize reimbursement and cash flow for healthcare organizations. Our solutions focus on three key areas:

→ Patient access
→ Financial navigation
→ Revenue recovery

Find out how TransUnion Healthcare can help improve your revenue cycle management program. Call 888-217-8928 or visit transunionhealthcare.com today.


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