On The Front Lines

Collision course: Consumer directed health care and compliance concerns

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With estimates of 46 million Americans without health insurance, the nation and the industry have been attempting ways to mitigate this large number. As a result, hospitals have been especially vulnerable to criticism concerning the availability of charity (or reduced fee) care it makes available to its patients, as well as to allegations of overly aggressive collection practices when patient responsible amounts go unpaid. In response, hospitals have been reviewing their registration, billing and collection policies and procedures, often at the behest of state agencies, and in some cases as the result of litigation.

While many hospitals have revisited Federal Poverty Guidelines (FPG) and Medicaid reimbursement rates, and used these levels as a guide to providing discounts to uninsured and under-insured patients, these positive approaches may fail to consider the impact when patients elect to chose new health insurance plans with high deductibles and are faced with paying hospitals and physicians for services that previously were covered by insurance (in full or with smaller deductibles and co-payments), or went unpaid and uncollected.

Enter Consumer Directed Health Care (CDHC)

Consumer Directed Health Care (CDHC) is here! Created largely to fill a void in the less costly health insurance premium market, CDHC plans offer both the individual and corporate employer a policy that combines a lower premium coupled with a higher out-of-pocket deductible. The two-pronged rationale provides a more affordable premium making it attractive to those uninsured but employed individuals, who either couldn't afford more traditional policies, or whose employers couldn't afford to offer such a benefit to its workers. The added attractiveness of the Health Savings Account (HSA) feature associated with these high deductible plans enables individuals to retain unspent contributions to these HSAs (either made by the individual or employer) in a manner similar to IRAs (Individual Retirement Accounts). With studies showing that "2.4 million people have enrolled in these plans,"[1] and with enrollment expected to be as high as "30 million by 2015 (or 17 percent of the enrolled population),"[2] healthcare providers will need to be able to recognize and administratively handle these emerging plans.

When consumers enroll in these plans, they usually are offered payroll deductions as a method to fund a portion of their anticipated high deductibles. The payroll deductions are then deposited to the consumer's HSA. These accounts also let an employer make contributions to an employee's HSA as part of a benefits package. Most HSAs come with check-writing or debit card features that allow a consumer to make payment of their responsible amounts when they become a patient purchasing health care. The use of the term "purchase" is deliberate, and is meant to contrast "using" medical care. The difference is embedded in the underlying principles associated with high deductible plans that the consumer becomes more price conscious when taking on the role of patient in "shopping for" rather than "just seeking" medical care.

From the Provider's Perspective

On the surface, these high deductible health plans may just appear to be another product line being offered by insurance plans, not dissimilar to when health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans were introduced in prior years. The provider community, however, will argue that in operational and financial matters ranging from electronic insurance eligibility and benefits verification, service authorizations, billing and payment processing, the introduction of these new product lines has been anything but smooth.

Another element of concern continues to be the collectability of patient deductibles, coinsurance and co-payment amounts that vary by insurance plan and contract. Until the introduction of high deductible health plans, the typical outpatient co-payment amount (usually ranging from $10-$50) was an amount seemingly better collected at physician offices, and with varying degrees of success in a hospital ambulatory setting. With high deductible amounts anticipated to now be in the $1,000-$2,500 range (per qualified individual and family), collecting that amount will become an issue for both patient and provider.

How much of any issue will depend on a variety of factors. First, the high deductible amount will need to be conveyed to the provider; hopefully, in an electronic

manner that confirms eligibility levels, and as important, the accurate amount remaining as the patient's deductible. Second, the payment vehicle, either check or debit card, will need to demonstrate that it has sufficient funds available to match the remainder of the deductible that is due to the provider, and what will happen, if the available balance is insufficient.

This, of course, presupposes that at every point-of-service, whether in the doctor's office or in various inpatient and outpatient hospital service areas, the patient amount due is known. Generally, for the traditional office visit, whether to an internist or specialist, the amount due will be known. It is no longer going to be the $10-$50 co-payment, however, but the full value of the visit and ancillary charges (if applicable). The next question will be whether the amount is the provider's full charge or their negotiated rate with that particular payer. It may be the full charge amount if an out-of-network provider is selected, and there isn't a benefit for providers outside of the network plan.

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If the service level is still a doctor's office visit or hospital clinic visit, the level of the payment due may still be in a "reasonable range" (i.e., $100-$300). If the setting changes to a minor (doctor's) office procedure, hospital ambulatory surgical procedure, diagnostic radiology or chemotherapy visit, however, the cost of the episode of care could range from $1,000-$5,000, and even higher. Sticker shock, not only for the patient, but the provider is a probable outcome.

The Collection Conundrum

In the best possible outcome scenario described above, the patient with a high deductible health plan chooses an in-network provider, who is able to electronically verify insurance eligibility and benefits, and prior authorization if required, as well as the remaining deductible amount (whether $50 or $1,500). The patient presents their debit card to pay the deductible amount due (whether $50 or $1,500); the provider has a debit card compatible device to process the transaction, and there is sufficient funds available to cover the cost of that day's care. [Note: Not all credit card transaction processing devices can accommodate debit cards.] Judging from the historical introduction of HMOs, PPOs, and POS plans, this ideal outcome will not always happen (especially in the early rollout periods), and the resulting actions (or inactions) are likely to trigger collection issues, and compliance concerns.

It is anticipated that the patient will have an amount due that is within the limits of the high deductible amount. If at the time service is being rendered, however, there is insufficient funds available in the HSA, the amount due will not likely be processed on the debit card. If an HSA checking account has been provided, the provider should have the technology to verify that the check is "good," and there is sufficient funding available to pay on this instrument and, in this case, that criteria would not be met. This may be due to the way payroll deductions or employee/employer contributions are made. According to the terms and conditions of the plan, the amount is due. The provider may require that this amount be paid at the time of service. Seemingly, the following options are available:

1. Render service and bill the patient. The question remains how the account will be paid. Maybe a partial amount due was authorized at the time of service, but how will the provider know when the balance will be sufficient to be transferred to the provider (and if that can be done electronically)?

2. Render service, bill the patient, and expect payment by cash, personal check or credit card (see also credit card considerations below).

3. Require cash, personal (non-HSA) check or credit card before rendering service. The key question to consider here is whether this is an acceptable provider condition of participation. Many providers will require full or partial payment when service is rendered in a nonemergent, nonlife threatening elective situation. The presentation of an under-funded HSA debit card or HSA issued check may void that condition of participation, and allow the provider to seek settlement of the account from another source.

4. Some HSA issued debit cards may provide for an associated line of credit or credit card feature to cover this type of situation. This would satisfy provider payment; however, it may raise truth-in-lending concerns, and require insurers and plan administrators to make certain the patient understands that they have, in effect, made a personal credit obligation, not to the provider, but to the issuer of the credit instrument. This would also require another level of integrated HSA account management to allow the patient to offset any temporary indebtedness (use of credit) with future HSA contributions by the employee or employer. This would seemingly be a timing issue, but the matter of interest (if any) also might have to be addressed.

5. Defer or delay a nonemergent, nonlife-threatening elective service. Though not a popular approach, this is used by

some providers currently. Again, the question of whether this action is consistent with conditions of participation has not yet been resolved.

Hospitals and physician offices have been challenged by the need to collect from their patients. While time-of-service payment capability is advocated, the complexities associated with consumer directed healthcare plans are likely to be viewed as a setback to the provider community.

Charity Care and Bad Debt Determinations

With the growing numbers of uninsured patients, hospitals have come under direct review related to the amount of charity care that is rendered. The challenges that were mounted posed a direct threat to the tax exempt status afforded not-for-profit voluntary hospitals. The question was raised as to how hospitals can be meeting their stated purpose of caring for community when fees charged to uninsured were higher than those charged to insured patients, and with patients seemingly unaware of hospitals financial aid policies and procedures. With reports of aggressive collection efforts making front page news, hospitals were put on the defensive.

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It might be hard to imagine the difficulties faced by providers in obtaining the information necessary to register a patient. Anyone who has visited an inner city emergency room or outpatient clinic, or seen how providers in border states, and those in high areas of undocumented patients render care, will know those difficulties; still, these providers render medical care. A good portion of this issue reflects the difficulties associated with the provider trying to collect demographic and financial information about its patients.

Hospitals can own some responsibility for not recruiting and training more qualified staff to be better able to handle the variations of healthcare insurance plans, as well as ensuring their staffs familiarity with internal policies and procedures, and not always using newer technology to assist in the registration process. Providers do face obstacles, however, and must deal with patients who often refuse to cooperate, or fail to provide proper demographic and financial information when requested not only to support charity care determinations, but to complete the basic registration itself.

More recently, providers, who in the past resisted attempts to use individual (patient) credit data and scoring, are now embracing the idea, not only to determine the patient's propensity to pay, but his or her wherewithal to pay as well. Many providers also have found that there is a correlation between credit data and scoring and potential eligibility for programs such as Medicaid, and they are using this information to further support the charity care process.[3]

While hospitals were able (and continue) to set their own policies and criteria for financial aid independently, the mounting industry pressure resulted in the American Hospital Association's (AHA's) involvement with the issuance of "a set of guidelines and a legal white paper on billing and collection practices."[4]

As other state hospital associations weighed in on the matter, the Association of America Medical Colleges (AAMC) issued a statement reflecting the complexity of the issues, "Important as they are, reforms in hospital billing and collection practices will only solve part of the problem. A more comprehensive and lasting solution requires that our nation find a way to provide health coverage to the 43 million uninsured Americans and the 30 million who do not have adequate coverage."[5]

The controversy also includes the concern over the charge structure hospitals use to calculate bills to non-insured (and under-insured) self-pay patients. With much said about the way in which the self-pay, or "unaffiliated" (with any consumer group or insurance plan) patients pay full (or retail) charges, this practice was rooted in the long established practice of hospital's needing to ensure that charges exceeded cost to comply with Medicare reimbursement regulations. Providers now are closely examining their cost structure, as they grapple with ways to demonstrate public policy responsiveness, while not running afoul of reimbursement regulations. The same also could be said for the notion that somehow Medicare regulation had not conveyed the premise that providers should apply consistent collection efforts to both Medicare and nonMedicare patients. This has left many providers instinctively pulling back from commencing justifiable legal action on accounts in collection fearing a public relations backlash from being perceived as overly aggressive.

Compliance Concerns

Healthcare providers will need to examine their corporate compliance plans to ensure that adequate attention is paid to effectively handling the situations posed by the emergence of CDHC. The major concerns are as follows.

1. **Charge structure -** ensure consistency with reimbursement and cost reporting regulations; while addressing the public policy concerns over cost-of-care for those deemed to be uninsured and under-insured;

2. **CDHC payer contracts -** review conditions of participation as they relate to establishing payer and patient responsibility, and providing electronic eligibility systems to verify coverage and extent of deductible remaining unpaid as of the current date of inquiry;

3. **Patient registration -** ensure that proper recognition and assignment of an insurance plan codes correctly reflects the coverage benefits and patient responsible amounts;

4. **Patient payment responsibility -** clearly define parameters to promote understanding of amounts due, and the

payment vehicles and conditions associated with making those payments; and

5. **Provider CDHC charity care and collection practices -** develop well-defined parameters to promote a clear understanding of policies and procedures to prevent complaints and promote customer satisfaction with all insurance plans.

While existing compliance plans likely address registration, billing and collection, as well as reimbursement and cost-reporting concerns, the changes in practices and protocols associated with CDHC are strong indicators that providers should reexamine their current plans and make changes as indicated. The training of staff also is a critical component to prevent lapses in performance that might trigger adverse patient, payer or public reactions.

With the increasing availability of CDHC, employers will find the need to recognize the impact of the Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations. With the potential for the exchange of even more medical and benefits information between employer and provider, both will be challenged with regard to administrative costs, as well as preserving privacy.[6]

Conflict Resolution

With the emergence of new alliances among the banking, credit granting, human resources/benefits consulting and insurance companies poised to blanket the CDHC market, one has to wonder whether this is "consumer directed" healthcare, or healthcare being marketed directly to the consumer. While the preventive actions noted above should mitigate or prevent problems from occurring in the first place, there are likely to be some unintended consequences associated with CDHC.

With the increasing prevalence of CDHC, consumers are expected to inquire more about the cost and prices for healthcare. Some patients will forego testing and other services, so as to allow their HSA account balances to grow for use on other than healthcare services. "Those with CDHPs may be more aware of what their costs are, but the 'Consumerism in Health Care Survey' indicated some of these cost-conscious consumers are more likely to avoid needed care."[7] Others, however, may simply not be satisfied with the selection of this type of healthcare insurance plan. The survey revealed that "those enrolled in HDHPs [High-Deductible Health Plans] and CDHPs are less satisfied with their health plan than those with comprehensive health insurance, and are less likely to recommend the new plans to a friend or colleague."[8]

Technology may support the types of benefit transactions available with CDHC insurance plans. "The ultimate level of convenience for employees is to have one health care card that serves as the health plan ID card with debit functionality, linked to various benefit accounts."[9] Even if we reach that level of technological support, the overall level of uninsured patients continues to threaten how the healthcare system will work. In recent Healthcare Finance Management Association (HFMA) news stories, it was reported that there was a "5.1 percent decline in employees accepting health insurance." The data contained in a Robert Wood Johnson report noted that "...employers continued to pay 82 percent of the cost of health insurance during a five-year period...[while] premiums employees paid skyrocketed 42 percent after being adjusted for inflation."[10]

Even with all of the rush to CDHC, there are other skeptics. "Consumer information about healthcare costs, quality and treatment alternatives could help stem health costs, but some are overselling the potential of consumer empowerment to reshape the healthcare system...."[11] In the final analysis, it will likely come down to the individual deciding, that if they can afford health insurance, which plan will be right for them. As this occurs, payers and providers will continue to be challenged to ensure that they can properly handle all of the related transactions efficiently and effectively. In the end, however, it will be up to the patient. *Caveat emptor.* Let the buyer beware! ■

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