The Patient Costs Playbook

When High Deductibles Turn Patients Into Payers

A riveting ebook by rivet

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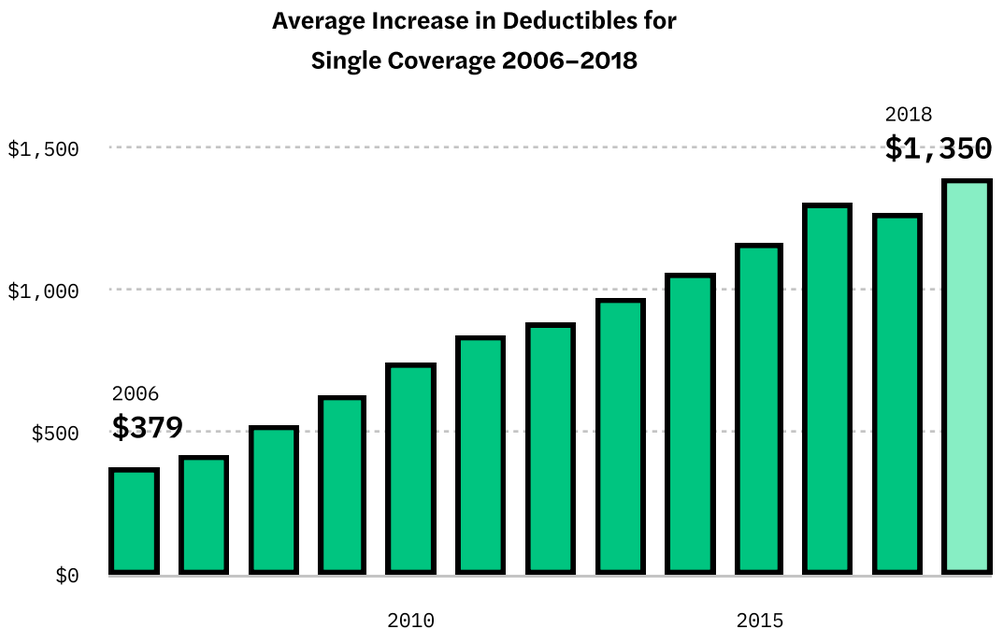
Patients as Payers: The New Reality

High deductibles are a burden for patients and providers.

In the U.S., the average annual deductible for a single person with an employer-provided health plan increased more than 250% between 2006 and 2018. This has shifted the burden on patients to become payers and on doctors to become debt collectors.



Source: Los Angeles Times

Why Doctors Are Worried

Now that an estimated 35% of their revenue comes directly from patients, doctors in private practice say getting reimbursed is their top concern for staying in business. Like other business owners, they collect a salary only after covering monthly expenses. But even group practitioners and hospitals aren't immune from worry about reimbursement.

For any type of practice, having too many patients who can't (or just don't) pay their bills isn't profitable—or sustainable. And the higher a patient's deductible, the less likely they are to pay any portion of their bill. That's why high deductibles are creating financial hardships for patients and healthcare providers alike.

The Solution: Prioritizing Patient Costs in the Revenue Cycle

In this ebook, we'll show you how to increase patient collection rates while also improving the patient experience by:

1. Zeroing in on patient financial clearance
2. Verifying eligibility and benefits
3. Giving patients your best estimate
4. Making it easy to pay
5. Collecting and tracking upfront payments

Section 1

Zero in on Patient Financial Clearance

Staff at every patient touchpoint play a role in increasing collections.

Among patients who don't pay their medical bills, a recent survey identified the top reasons as unknowing visits to out-of-network providers (32%), claims denials (26%), and high deductibles (26%). Collecting insurance information and assessing a patient's ability to pay before treatment can help eliminate denials, and give them a heads-up about out-of-network costs.

Your first step: Educate staff about the importance of collecting insurance information—and payments—up front. Connect the dots between patients paying their bills and your ability to make payroll. Then, coordinate across teams to implement a financial clearance process like the one outlined below for every patient touchpoint.

Scheduling Staff

Role: Collect Information

When patients call to schedule appointments, require schedulers to collect personal, insurance, and relevant procedural information such as:

- Patient name
- Date of birth
- Insurance company name
- Name of primary insurance holder
- Policy number and group ID
- Diagnosis codes for specific procedures
- Authorization or referral numbers
- Copy of physician's' orders

Pre-Registration Staff

Role: Verify & Document Information

Verifying insurance coverage collected at the time of scheduling will help eliminate denials, which decreases out-of-pocket expenses for patients—and increases your likelihood of getting paid. Pre-registration staff should contact insurance companies to verify:

- Policy number and group ID
- Effective dates of coverage
- Deductibles, copays, and non-covered amounts
- Benefits or coverage for specific procedures
- Medical necessity (if patient is relying on Medicare)

Registration Staff

Role: Verify Identity & Collect Payment

At check in, registration staff serve dual roles: as gatekeepers who ensure your practice gets paid, and as guides who help patients understand what they owe, how to pay, and where to seek financial assistance if they need it.

For same-day and emergency appointments, registration staff should follow the pre-registration checklist above. Otherwise, they can simply verify:

- Patient's identity and date of birth (from a government ID)
- Mailing address and telephone number
- Insurance information

They should also collect:

- Copies of insurance cards
- Copies of physician's' orders and authorization or referral numbers
- Upfront payments for insurance deductibles, coinsurance, copays, and a target percentage of non-covered charges
- Applications for financial assistance or extended payment plans (if patients are experiencing financial hardship and you have programs to help)

Clinical Staff

Role: Adhere, Communicate, & Refer
At every patient appointment, your clinical staff should adhere to the procedure(s) for which benefits have been verified. When changes are necessary, clinicians should quickly communicate to billing staff which services were performed.

When patients have questions about the cost of services, clinical staff should be prepared to refer patients to front-office and financial staff. Additionally, if your practice has an online portal where patients can access medical records and make payments, equip doctors with a fact sheet they can share with patients about how to access and use the system.

Deductible Relief Day

As the average deductible has increased, so has the amount of time it takes each year for patients to meet it. In 2006, when the average deductible was $370, most patients unknowingly "celebrated" Deductible Relief Day on February 28. In 2019, relief didn't come until three months later—on May 19. The longer it takes patients to meet their deductibles for the year, the less likely they are to meet their obligations for out-of-pocket costs.

Section 2

Verify Eligibility & Benefits

Confirming coverage before treatment helps your practice and your patients.

Knowing that 70% of nonelderly adults are underinsured (42% with individual plans and 28% with employer-provided plans), healthcare providers need to verify not only that patients have insurance, but that their benefits cover the specific services or treatment they seek.

The Rise in Uninsured, Nonelderly Adults 2003–2018

Source: Commonwealth Fund

Minimize Denials & Surprises

From PPO to HMO and HDHP, insurance policies—and their benefits and costs—vary widely. If a patient wrongly assumes eligibility for a non-covered service, they're less likely to pay (or be able to afford) out-of-pocket costs. And if you've already provided the service, you may be left holding more than the medical bag.

As mentioned in section one, verifying insurance coverage before treatment helps eliminate denials, and informs patients what they owe, so they're not surprised by your bill. When you verify benefits, here are some tips to help you get the most accurate and complete information:

Use the right service type.

Make sure you verify the right service type codes, and be aware of common service codes that result in denials such as:

- **Unbundling.** When services are charged separately that should have been charged under one code.
- **Upcoding.** When services are improperly switched by the provider to a more serious diagnosis, resulting in a more expensive treatment.
- **Mismatched diagnosis and treatment codes.** When a diagnosis is upcoded but the treatment is not.

Reverify benefits frequently.

When and how often should you re-verify eligibility? As a rule of thumb, your registration staff should re-verify deductibles, copays, and non-covered amounts when patients report they have a new insurance policy, when you haven't seen them in a while, and at the start of every calendar year.

Leverage your schedule to verify benefits automatically.

With specialized software for healthcare providers, you can automatically verify insurance benefits directly from your appointment schedule. This saves time for your staff and ensures you get paid.

Surprise Medical Bills & Balance Billing

A recent study found that 1 in 5 Americans received surprise medical bills after elective surgery, even though their primary surgeons were in-network. On average, these patients expected to pay $1,800 but ended up owing an additional $2,000.

Most surprise bills are the result of "balance billing," when a provider bills patients for the difference between their charges and the allowed amount paid by the insurance company. This can affect not only a patient's ability to pay for unplanned charges but also their willingness to pay.

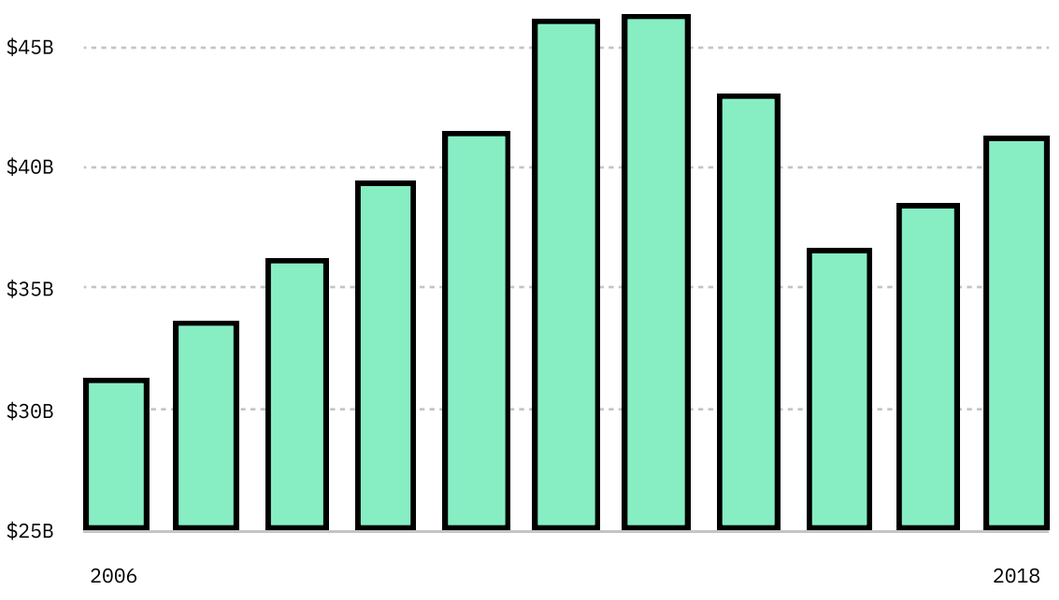
Section 3

Give Patients Your Best Estimate

To meet their financial obligations, patients need help planning ahead.

The lack of transparency in medical billing is difficult for patients who struggle to pay, but in the end, it also hurts healthcare providers who struggle to get paid. In 2018, community hospitals reported $41.3 billion in uncompensated care, which represents a 30% increase from 2006 when average deductibles for employer-provided plans was 250% less.

Uncompensated Care at Community Hospitals (in Billions) 2006–2018



Source: AHA Annual Survey Data

Who Needs an Estimate?

When patients understand their financial obligations, they're more likely to make good on their debts. While you can't anticipate every out-of-network charge or unexpected facility fee, you can give patients your best estimate to help them plan ahead.

Ideally, you should give every patient an estimate for out-of-pocket expenses before treatment. But if you need to prioritize staff time, focus on:

Patients with high-deductible plans.

For 2020, the IRS defines a high-deductible health plan (or HDHP) as "any plan with a deductible of at least $1,400 for an individual or $2,800 for a family." Because their deductibles are higher, patients with HDHPs are more consumer-minded and may want an upfront estimate as well as a breakdown of different (see also: more affordable) options for care.

Patients scheduled for high-ticket services.

Prepare estimates not only for those with the most expensive conditions facing the most expensive procedures but for anyone in need of a procedure over a certain cost threshold.

Patients with a poor payment history.

Research shows the higher a patient's outstanding balance with their primary care provider, the less likely they are to return for care within the next 24 months. Everything you can do to help them understand their financial obligations will improve not only your collection rates but also patient outcomes and satisfaction.

What Will Affect the Accuracy of Your Estimate?

While it's possible to provide average charges for expected services, it's impossible to provide a breakdown of actual costs before a procedure. Let patients know your estimate is just that—your best approximation of costs. Many factors may affect the accuracy of an estimate, including:

Different services performed at the time of treatment.

Doctors make diagnoses and order treatment based on available information. During the course of a procedure, new information or an emergency situation may result in different (or additional) services that weren't anticipated—and that will nullify your estimate.

Changes in benefits between verification and estimate.

Despite the best efforts of your front office staff to verify and re-verify eligibility, benefits can change quickly and unexpectedly. If a patient loses their job, gets divorced, or if their employer switches health plans without advance notice, your estimate won't reflect these changes.

Not using the right allowables, modifiers, or other discounts.

Allowed rates differ for every health plan, so make sure you're using the right allowable for the right plan based on your most recent payer contract. Additionally, modifiers provide a way for physicians to indicate how a procedure was altered. Using them correctly is critical for preparing accurate estimates, and for ensuring you don't lose revenue for services provided. If you offer discounts for cash or upfront payments, be sure your estimate communicates to patients that they could pay less if they opt for these incentives.

Executive Order on Price & Quality Transparency

In June 2019, President Trump issued an executive order on price and quality transparency in healthcare. It directs federal agencies to develop rules and guidelines to help patients get more accurate estimates, especially for out-of-pocket costs. Insurance payers and healthcare providers have expressed concerns about disclosing negotiated rates. With legal challenges pending, it's uncertain whether the executive order will have the intended effect for healthcare consumers.

Shameless Rivet Plug

Rivet combines eligibility checks with your practice's claims data and contracted rates to provide the most accurate estimates on the market. As you submit more claims, your estimates get even more precise.

See Rivet in Action

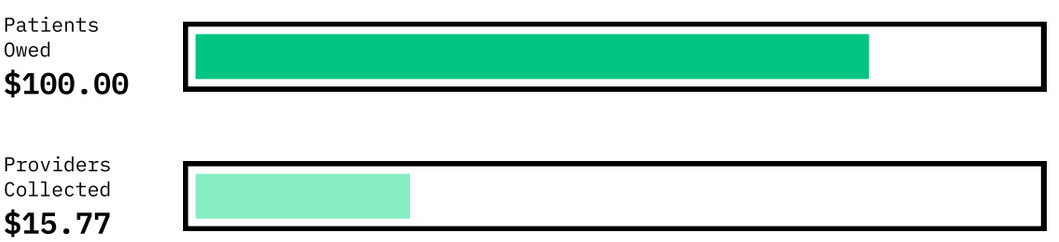
Section 4

Make It Easy to Pay

To meet their financial obligations, patients need help planning ahead.

According to research by the Medical Group Management Association (MGMA), healthcare providers send an average of 3.3 billing statements before receiving payment. Once bad debts are turned over to collections, providers only recover an average of $15.77 for every $100 owed (which is like getting tipped on a dine and dash).

When Bad Debts Go to Collections



Source: MGMA

Reduce Barriers to Improve the Patient Experience

The challenge is finding ways to help patients make good on their balance before it goes to collections. You can start by addressing common barriers that make it harder for patients to pay—and harder for you to collect.

As patients navigate their new role as healthcare payers, it's up to providers to help them succeed. On top of worrying about how to afford care, many patients are also dealing with the stress and uncertainty of serious illness. Here are mutually beneficial solutions to help them meet their financial obligations for care:

Be transparent about charges.

According to one survey, more than 60% of patients said their medical bills were confusing or very confusing. In yet another patient survey, nearly half reported not understanding medical costs, which increased negative feelings about their provider and decreased collection rates.

In addition to helping patients understand their insurance coverage and out-of-pocket expenses before treatment, take steps to make your billing statements easy to read and free of jargon whenever possible. Itemize all charges and provide totals for both the insurance company's portion and the patient's responsibility.

Communicate using modern platforms.

Give every patient options for how they prefer to receive billing statements. Some may still prefer paper, but many will appreciate the convenience of digital statements or reminders sent by email, text, or through a patient portal. Encourage patients to opt for electronic methods because they increase collection rates. Allow them to pay online or over the phone.

If you have a patient portal, make sure patients know about it. When surveyed about how to increase engagement in their own care, 57% of patients said they'd like online access to their medical information, but 64% said they don't use online portals because they didn't know one was available (35%) or their doctor hadn't talked to them about it (31%).

Offer flexible payment options with incentives.

In addition to accepting multiple forms of payment (cash, check, credit card), give patients options for payment plans. Experts advise that standard payment plans only result in a moderate increase in provider revenue, but when combined with prompt payment discounts of 10–20%, they incentivize patients to pay. Additionally, allowing patients to set their own payment terms, such as the amount they pay each month (within reason), can improve both their ability and willingness to pay.

Emphasize upfront payments.

Do you know how many patients leave their provider's office without paying for services rendered that day? According to MGMA, it's 30%. That matters because once a patient leaves, your likelihood of collecting payment drops an average of 62%.

The most important step you can take toward increasing patient reimbursement rates is to collect copays and at least a portion of non-covered amounts at the time of service—which are usually around 20% of the total bill. To do so effectively, you need an accurate way for front-office staff to calculate amounts owed and collect payment so you don't lose time and money issuing refunds.

Emergency Medical Treatment & Labor Act

Known for short as EMTALA, this act was passed by Congress in 1986 in an attempt to guarantee access to emergency services regardless of a patient's ability to pay. It requires emergency healthcare facilities that participate in Medicare to provide medical screening for treatment of any emergency condition, including active labor. Patients must be treated and stabilized before providers can discuss payment.

Section 5

Collect & Track Upfront Payments

The sooner you collect patient payments, the more you'll collect.

Not only are patients more likely to pay at the point of service, they're more likely to pay with immediate payment methods (cash or credit card) versus by check, which is less secure. Paying a portion of their out-of-pocket costs upfront can also help improve patient satisfaction because when they get their bill, they're left owing less.

The Data You Need Before, During, & After Collections

Once you commit to collecting more upfront payments, measure their net effect on your revenue. Here are steps you can take to make sure the early bird (your practice) really does catch the worm (increased collections):

Set a target for upfront collection rates.

Without exception, your practice should collect 100% of patient copays at check in. How much you collect for non-covered services may depend on each patient's ability to pay. Use your financial clearance process to guide your decision making, and set a minimum collection target such as 20%.

Post signage in your waiting and check-in areas informing patients that prearranged payment is due at the time of service. If you've done your part to verify benefits, provide an estimate, and communicate costs to patients, they shouldn't be surprised when you request payment.

Assign a transaction code for upfront payments.

When patients pay at the point of service (whether by cash, credit card, or check), assign a transaction code for upfront payments so your financial staff can distinguish between upfront and backend payments.

Report on total collected versus total identified.

At the end of each month, see how you're doing against your target for upfront collections, and measure their effect on your overall collection rate.

Healthcare Consumerism

HDHPs and HSAs were intended to increase patients' awareness of healthcare costs, as well as their willingness to shop around for more affordable care. But with surprise medical bills—and without cost transparency—it can be difficult for even the most conscientious patients to meet their financial obligations. As a healthcare provider, anything you can do to help patients understand what they owe, and make it easier to pay, will be mutually beneficial for your patients and your practice.

Implement Software to Increase Patient Collections

Rivet is a modern solution that maximizes payments from patients and payers, making it easy to get your practice the money it deserves.

Buying healthcare should be as simple as buying anything else. With Rivet, you can confidently quote costs and collect upfront with ease—improving the patient experience and lowering patient AR in the process. With Rivet you can:

- **Check eligibility.** Understand patient responsibility instantly with automatic eligibility and benefits verification checks.
- **Give super accurate estimates.** Use your claims data, contracted rates, billing rules, and customer eligibility for the perfect estimate.
- **Communicate costs.** Send estimates via secure text, email, or paper with the click of a button.
- **Collect upfront payments.** Enable one-touch, mobile payments to simplify the payment process for your patients and practice.

Learn more at **RivetHealth.com**