Road Map
8 Ways to Plug High Deductible Health Plan Revenue Leaks
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According to a study by the National Business Group on Health, by 2015, nearly a third of large employers will offer only high-deductible health plans — up from 10 percent in 2010. More than eight of ten of these companies will offer at least one of these plans, an increase from 53 percent five years ago.¹

A high-deductible health plan (HDHP) is a health insurance plan with lower premiums and higher patient deductibles than a traditional plan. In order to take advantage of the tax benefits of a health savings account (HSA/FSA), you must have this type of plan. HDHPs make employees personally responsible for a higher portion of their family’s healthcare costs, with the goal of motivating them to comparison-shop for medical services — an admirable goal but one that many say is hard to achieve.

With an HDHP, consumers pay for all of their medical services — at the insurer’s negotiated rate — until they meet their deductible. After that, consumers typically pay co-insurance, which is a percentage of each service, normally from 10 to 35 percent — until they reach their out-of-pocket maximum. If payment isn’t collected at the time of service, the provider is left having to bill the patient for the remaining self-pay balances after a normal 20-40 day adjudication period. Most studies suggest the longer the self-pay account goes unpaid, the less likely it becomes that the provider collects.

Can your organization survive with those financial terms?

There’s no question that HDHPs are adding financial stress to healthcare organizations. But, there are strategies you can implement to help prevent revenue loss as a result of the growing use of HDHPs. Here are our top eight.
Perform Your Due Diligence

1. Pay attention to your eligibility responses
   EDI eligibility responses can be the key to understanding exactly which portion of the patient’s large deductible has been satisfied. Know and understand what your payer is sending you. Often the string of information sent back from the payer is dissected with only parts ever making into the billing system in the form of a message.

   If you’re not using eligibility responses, you might want to reconsider. Look at your current bad debt write-offs to determine how much is coming from patients with HDHPs. Understanding what your payers are sending back to you in those response messages, and how to leverage that information to your benefit, can reap significant returns.

2. Do your preservice homework
   You have heard it before and it’s true in this case: knowledge is power. Determining patient information, like deductible totals, before the service is provided puts you in a much better position to negotiate patient payment sooner. Waiting 20-45 days to reach out to your patient with a large balance statement is not a recipe for effective collection.

   In cases of hospital admissions or high-priced provider procedures, take the time to call payers, or learn what information is available via their web sites and collect this information in advance of the admission/procedure. Knowing the details ahead of time enables improved preadmission conversations with patients and sets up day of procedure expectations. Formulate a time-of-service payment policy that preadmission councilors can offer patients. Elements to consider include a 10% discount on HDHP, deposit-required policy, and estimated costs based on episode of care.
3. **Review your rate structure**

In this age of HDHP and consumer driven healthcare, there are fewer opportunities to capitalize on percent-of-charge payments. It might be better to align “rack rate” charges with expected payment to alleviate some of the patient “sticker shock” when they receive the bill.

For admissions, there is typically an *Episode of Care*. By reviewing past patient history, you can determine the “inclusive” charges for various procedures. Depending on the payer and the agreed upon contracts, the approved reimbursement is based on payer fee schedule agreements. Subtracting this reimbursement from your all-inclusive charges will provide you with the patient balance up front. This is the amount you need to discuss during the preadmission meeting.

4. **Know your patient payment method**

Understanding whether a patient has set up a pre tax Flexible Spending Account (FSA) or a Health Savings Account (HSA) provides you with tremendous leverage to talk through the payment methods and expectations before services are rendered. Understanding how each works will allow you to counsel the patient directly about the often missed nuances of each plan.

Payer negotiations (contracts) sometimes can vary in complexity. Knowing the details of these agreements for each payer is equally critical.
5. **Enable front-end collections**

Having the correct time-of-service systems in place to collect various types of co-payments is also crucial. Put in place methods to process payments at check out areas. In certain cases a PIN may be necessary to process FSA or HSA debit cards so have that information available. Having a PIN pad at each of your work areas will help streamline the payment process.

Take a look at your staffing and physical layout. Does it enable confidential discussions about payment options? Set up authorization guidelines for front-end collections staff - a written policy for HDHP is 10% discount, for example. Improve front-end controls for the potential increase in cash handling. Enable the front-end to see outstanding patient/dependent balances. Set up collection goals and bonus payouts based on the percentage of front-end collections. Get staff engaged and tuned into a common goal, balancing patient satisfaction and well being against your organizations' financial goals.

6. **Evaluate office/building logistics**

Review the configuration of hospital or office exit areas as well as the processes and procedures related to the facility’s patient check-out. This will help maximize the number of patients who pay at least a deposit for services prior to leaving the facility. Minimize the possibility of a patient leaving (knowingly or unknowingly) without being seen by a check out person.

7. **Provide detailed receipts**

Provide patients with a comprehensive receipt - not just a charge slip - so they can retain it for tax purposes, or for an audit by the HSA/FSA administrator. This will minimize calls from patients in February requesting information they already received. Also, having a receipt e-mailed to them for a visit is easier for them than having to carry around a paper receipt. Be prepared to provide both. It's also becoming increasingly important to provide a patient portal where patients can obtain this information online.
8. **Educate your patients**

One of the best methods to prevent revenue leaks is to have educated patients. Most of them can be easily confused by the maze of regulations and procedures surrounding healthcare financing. You can help clarify these details through mailings similar to Press-Ganey surveys and marketing campaigns containing some of the touchpoint definitions of HDHP. If collection at time-of-service is not possible, you can help by providing estimates of charges and patient responsibility. Have them sign, and then follow up with an e-mail detailing their payment responsibility so they can plan ahead.

It is not unusual for patients to be unaware of the details of their insurance plans until they receive that first “large balance” provider self-pay bill.

This forces you to:

- Appear to be the “bad guy” in this situation
- Explain provider reimbursement/contract rate methodology to the patient
- Justify cost and reimbursement rates of the hospital and practice
- Balance your decision on payment relief to the patient vs. having to deal with the negative patient experience and downstream ramifications.

HDHPs are now a permanent part of the healthcare landscape. Dealing with them by providing advance notification of charges, estimated reimbursement, patient responsibility, and requiring a deposit of payment at the time of service will improve the patient experience, increase point-of-service collections, and ultimately reduce your account receivables.
Sources

1. 2015 Large Employers Health Plan Design Changes Survey Report, National Business Group on Health
Once you’ve established a baseline, the next step is to make improvements by initiating a corrective action program that addresses your people, process, and technology.

**People**

Focus on training and education so everyone in the organization understands the depth and impact of the problem and what their role in solving it should be. Specific actions to take include:

- Establish accountability and self-reporting by root cause owner and process owner
- Set a zero to low tolerance for finger pointing and excuses
- Recognize improvement and determine consequences for unacceptable outcomes

**Workflow**

A thorough process review will help highlight redundancies and time-wasting tasks and will quantify the outcome or performance expectation for each task. The most effective way to improve the workflow process is to eliminate errors that could result in a denial.

Key points to include:

- Develop robust pre-visit/visit management process
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