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Bad patient debt continues to mount

By John Andrews, *Contributing Editor*

Bad debt is FINANCIAL poison – there's no mistaking that its proliferation in the real estate market brought about the economic collapse in 2008.

The high unemployment rate, foreclosures, individual bankruptcies and escalating costs of health insurance that came in the wake of the recession are now causing all kinds of grief for healthcare providers trying to collect revenues owed to them.

"It's obviously a big problem and it is getting worse," said Andrew Grobmyer, managing director for the Huron Consulting Group in Lake Oswego, Ore. "It is creating an additional strain within the provider community, more so than in the past."

A national unemployment rate hovering near 10 percent (and several states where it is even higher) has left many without health insurance of any kind, and those fortunate enough to keep their jobs are being hit with much higher premiums and deductibles from their employer-based benefit plans.

"It's a combination of people with no coverage that don't qualify for public assistance like Medicaid and those left with a high balance after insurance liability," Grobmyer said. "In many cases, the liability is more than the person can afford – patients have assumed responsibility for a greater portion of their healthcare debt and there are some people who just can't pay."

Tom Stampiglia, CEO of Austin, Texas-based Medical Present Value, agrees that "the driver is having a lot more patient responsibility." Compounded by a bad economy and tough job market, self-pay patients are presenting themselves in greater numbers, he said, while employers, strapped by high healthcare costs, are shifting more of their burden onto their employees.

MPV specializes in the physician sector, and Stampiglia says patient responsibility for payments could rise to as high as 30 percent of a practice's revenue in the near future.

"Not collecting from the patient rather than the payer contributes to the rise of bad debt," he said. "Physicians aren't equipped to talk to patients about their responsibility. Without the proper tools, they find financial discussions are very difficult to do. They may collect co-pays, but even then some have seen them as a bother because they traditionally have been low. But now with high deductible plans, it amounts to a couple hundred dollars or more."

QUALIFYING CHARITY CASES

Providers need to be proactive in identifying which patients represent the biggest potential cost drain and which are legitimate charity cases – especially important at a time when local and state governments are closely monitoring hospitals' level of charity care to ensure they are justifying their tax-exempt status.

Grobmyer advises providers to take a sensible approach toward identifying charity cases, conducting rigorous screening that qualifies "higher dollar, lower volume" patients and channels unfunded lower-dollar cases into the collection process.

"All that said, cooperative patients who meet the requirements of charity policy should receive charity care," he said. "An informed patient can proactively pursue it."

Given the context of charity care available, Grobmyer points out "there is risk associated with every patient who shows up" and that "the key is to understand the patient's financial situation upfront and engage them about payment."

Providers should "overlay the likely care scenario and work through a payment plan," he said. "Doing that upfront is a way to optimize cooperation and get the best outcome. The leading edge providers are doing this, but many are not."

COLLECTING CO-PAYS

Because health plans are shifting more financial responsibility onto the beneficiary, co-pay and deductible amounts have risen dramatically and collecting them has become much more consequential, Stampiglia says. But while providers are becoming more assertive at seeking out those patient-liable dollars, he contends they often lack the proper tools to figure out those payments.

Stampiglia

"What's tough is the meaningful part of the payment – 20 percent of the allowable can be hard to figure out without the proper technology," Stampiglia said. "That is where we come in. We have helped medical groups audit claims and put together a sophisticated technology to help them build a solution that focuses on the claims. Instead of valuing claims at the back end for auditing, we are able to place a value on services at or before the time they are rendered. So providers can say 'these are the procedures that we have planned' and actually pre-adjudicate the claim to solve for what the payer's allowable will be."

Until upfront co-pay and deductible collection is universal among providers, they will continue to rely on collection agencies to retrieve as many lost dollars as possible, Grobmyer said, emphasizing that the longer the debts go, the harder it is to recoup them. ▪