Consumer-directed healthcare (CDHC) is poised to take the place of managed care. While this approach to healthcare insurance offers the hope of controlling spiraling health costs, it also could pose challenges to medical practices, especially those unprepared for the impact it will have on practice cash flow and receivables.

Consumer-directed healthcare plans shift more cost to guarantors. Whether private health insurance or employees who have employer-sponsored health insurance, CDHC plans make consumers responsible for higher deductibles and out-of-pocket costs. The idea is that patients become smarter shoppers for healthcare services when they feel more of the financial pinch of their healthcare choices.

The impact on medical practices could be significant, too. Perhaps the biggest challenge for providers is the need to do a better job of billing and collecting from consumers — patients, that is — to avoid an increase in bad debt and write-offs.

CDHC operates on a simple premise: shift more of the financial responsibility for healthcare back to patients. Before healthcare insurance became ubiquitous for Americans, financial responsibility originally rested with patients. Proponents of this new — and old — model of insurance contend that consumers who have control of the healthcare dollar will become value-driven shoppers for health services, prescriptions, procedures, and providers. With the control of healthcare spending more firmly in the hands of patients, providers will have to compete on both cost and quality. In doing so, CDHC advocates assert that it will promote cost-effective, high-quality medical care.

Though it’s hard to predict the changes to come in national health policy, this model seems poised to dominate the non-government healthcare insurance market in coming years. And if it works to slow the rate of healthcare inflation, expect it to stick around.

**Rising Costs of Healthcare**

No one doubts that change is needed; employers’ costs for employee healthcare seem to rise unfettered. The calls for the CDHC model are largely in response to managed care’s failure to stop the rising costs of U.S. healthcare. According to the 13th Annual National Business Group on Health (NBGH)/Watson Wyatt Employer Survey on Purchasing Value in Healthcare, a company’s average healthcare expenditure per employee was $7,211 in 2007 and expected to rise to $7,620 in 2008. Costs are predicted to increase by 8 percent in 2009. The impact of rising healthcare costs is a primary reason that the percentage of Americans covered by an employer-based health insurance plan has fallen to 53 percent compared with 68.4 percent in 2000. Even employees are balking at paying the $12,680 average premium for family coverage from employer-sponsored health insurance plans. That compares with an annual premium of $5,791 for similar family coverage in 1999. Individuals purchasing healthcare insurances for themselves and their families face similar or even higher premiums.

Employers and individuals purchasing their own health insurance are turning to CDHC in the hope it will control their healthcare benefits costs. The NBGH/Watson Wyatt report found that the two-year average cost trend for companies with a consumer-directed health plan was significantly below that of companies without such a plan (5.5 percent vs. 7.0 percent). Further evidence comes from the claims experience of insurance companies that offer these plans; for example, the medical cost trend for the CIGNA HealthCare consumer-driven healthcare plan is less than half that of CIGNA’s HMO and PPO plans.

Given these early successes, enrollment in CDHC plans is on the rise: 47 percent of the companies surveyed currently offer a CDHC plan — an increase from 39 percent in 2007 and 33 percent in 2006. Even more — 54 percent — plan to offer a CDHC plan by 2009. The U.S. Treasury Department estimates that by 2010, the number of consumers who have CDHC plans that are compatible with healthcare savings accounts (HSAs) will rise to 14 million nationwide.
Health Savings Accounts

CDHC plans attempt to address the high inflation rates for health insurance premiums and frustrations over the complexity of managed care restrictions by giving consumers more choice and flexibility — though not necessarily less cost — in health spending.

To go with the ‘stick’ of paying higher deductibles and out-of-pocket costs, most CDHC products offer a ‘carrot’: a tax-advantaged account for healthcare expenses called a health savings account (HSA). Regulated by the U.S. Department of Treasury, HSAs are used in conjunction with a ‘High Deductible Health Plan’ (HDHP). The minimum deductible for an HSA is $1,150 for self-only coverage and $2,300 for family coverage in 2009. The HSA serves to cover some or all of a patient’s medical expenses. Employers and employees can deposit money into these accounts and, with some limitations, the earnings accrue tax free.

Unlike a traditional health insurance product, any unspent funds in an HSA carry over to the next year and the interest accumulates tax free. Consumers can take the account to another employer if they change jobs. They also can invest their HSA in mutual funds or money-market funds. The idea is that an HSA encourages consumers to keep money aside for healthcare expenses before insurance coverage kicks in. Funds can be used tax-free for ‘qualified medical expenses’ and even for other expenses with a small penalty.

Different Coverages

Like any insurance product, CDHC doesn’t come in only one form. Each plan has its own rules about what’s covered — and what’s not. Some CDHC products carve out preventive service benefits from the account — the health plan pays for specific preventive services directly and not from the HSA.

If you are a medical provider, it’s critical that your reception staff know how to query the insurance company administering the CDHC product to determine the patient’s benefits eligibility. Billing staff also need to understand the plan’s payment policies, in addition to the allowables that may apply to services the patient receives. Medical practices also need to understand what they may and may not collect from the patient at the point of care.

Impact on Medical Practices

While being embraced by the federal government and employers as a means to stem rising healthcare costs, CDHC has a potential downside for medical practices. CDHC is built on the premise that consumers will save money for their healthcare — and make informed choices to access healthcare based on price as well as quality.

But, consumers have never really understood prices in the healthcare arena. A 2006 Consumer Attitudes Survey conducted by Great-West Healthcare showed that the average consumer could guess the price of a new automobile within five percent of the actual price, but the consumer’s perception of how much a routine doctor’s office visit costs was off by 52 percent. This lack of awareness may translate into more difficulty getting paid — and perhaps an inability for your medical practice to recoup all that you are due.

Expect Patients to React

These plans can contribute to patient frustrations in at least two ways. First, most patients with CDHC plans have a greater financial responsibility than they are used to. After years of making small copayments, patients will be asked for substantially higher amounts at the time of service. Expect many to be unaware of this increased financial responsibility, and most to be sore about it. Second, the responsibility is on the patient to pay (up to the deductible amount), not the insurer. That means the patient will be getting more billings from their physicians’ office — potentially another source of frustration. The presence of an HSA does not mean the patient has funded his or her HSA, nor does it mean that the HSA will have sufficient funds to cover any bills the patient incurs.

For physicians, the most significant patient reaction to CDHC may be that the tax-advantaged saving and portability of HSAs gives patients an economic incentive not to pay their medical bills — and certainly no incentive to pay promptly. If patients don’t pay their medical bills, they get to keep the money in their HSA, invest it, move it with them to another job and, with a penalty, even use it for non-medical expenses.
Improve Billing and Collections Processes

Patient collections already offer low returns. According to McKinsey and Company, the cost and complexity of consumer billing and collections are onerous, especially for physician’s offices. Physicians, the firm’s research shows, typically collect only about 40 to 50 percent of consumer responsibility. The report concludes that CDHC will lead to a rise of two to four percentage points in the providers’ bad debt expense (as a percentage of revenues) by 2012.23

To minimize bad debt from CDHC products, follow these steps:

Train staff. Teach your staff about CDHC. It’s important to recognize that this is a financing mechanism, not a change in the insurance company or how they price your services. In other words, an Aetna CDHC plan is still Aetna — and they will still pay you the allowance you’ve negotiated. The difference is that you’ll need to get more of the allowance from the patient versus Aetna. Reception and billing staff should be knowledgeable about the concept and how plans work. Unfortunately, just like managed care, most patients won’t understand the nuances of their health plan. Staff should know the basics of CDHC, as well as how to direct patients back to their health plan or employer for questions about benefit design.

Aim for price transparency. Patients who understand CDHC will seek cost estimates for healthcare. Be prepared to answer questions about the costs of services in your practice. There’s no better place to focus than non-emergent surgeries and procedures where you would be wise to collect all or, at least, a significant portion of the patient’s financial responsibility on a pre-service basis. Because CDHC products don’t eliminate the complexity of allowances by procedure code, you’ll need detailed information for each payer’s allowable by procedure code. Set up a spreadsheet with this information. Better yet, automate the pricing of the patient portion. Look for software that can calculate the patient’s portion at the time of service based on his or her healthcare plan. These products work by calculating insurance allowances before or at the time of service. Then, using applicable deductibles, coinsurance and other patient responsibilities, the software determines the patient’s portion. Beyond spreadsheets and software products, determine if your payers have adopted real-time claims adjudication (RTCA). RTCA essentially permits a medical practice to enter the billing information at the point of care, with the payer responding in “real-time” as to the amount the insurance company will pay and the amount that is to be collected from the patient. If you are already seeing a shift to CDHC in your practice, these solutions might quickly return your investment by eliminating payment delays and increasing time-of-service collections.

Verify, verify, verify. The time is now to ensure that you’re verifying insurance coverage and benefits eligibility before the healthcare service is provided. Add demographic verification to your pre-service processes to ensure that the address on record for the patient is accurate. Increasingly, practice management vendors are automating this process by pulling data directly from your scheduling system, querying the databases of insurers and the U.S. Postal Service, and reporting accounts where the demographic information is incorrect or cannot be verified. Your practice will garner a positive return on investing in insurance, benefits, and demographic verifications through reductions in claim denials and fewer statement mailings submitted to incorrect or out-of-date addresses. You’ll also be able to determine and collect the correct amount due from the patient prior to or at the time of service.

Swipe the cards. Sign up with a credit and debit card processor so that you will be able to accept credit and debit cards. Patients’ HSAs are often tied to debit cards that can be used for healthcare purchases. Ask for the patient’s ‘benefit card’ or ‘HSA card’ at check-out, and process the payment.

Improve time-of-service collections. Verify each CDHC plan’s rules about time-of-service collections. Develop a process to collect coinsurances and unmet deductibles as well. Offer financing options to patients who do not have the funds to cover their high deductibles. These and other time-of-service collections strategies will prevent the high patient balances that will inevitably cause your receivables to balloon.

Review contracts. Go beyond collecting copayments and time-of-service payments. Determine if you can collect coinsurance and deductibles at the time of service, particularly for surgeries and procedures. Some CDHC products require that accounts be fully adjudicated before you can bill patients. Try to negotiate something different than a ‘hold and settle’ arrangement in future payer contracts. The ideal is to have contracts that permit you to collect all out-of-pocket amounts at the time of service.
Tighten the patient collections cycle. If you’re in the habit of sending a dozen or more statements before getting serious about collections, figure that some patients with CDHC products could already be on to their next employer and using their HSA and its funds elsewhere. The average practice has less than a one-in-four chance of collecting after a statement is mailed to a patient. By the time a fourth statement is sent, the collection rate falls to roughly four percent.14 It’s a good practice to send three statements and then start a pre-collections process by the 90-day mark.

Clean up billing statements. Develop clear and concise billing statements that use layperson’s language to state what the patient owes and when it is due. Avoid sending billing statements that merely inform patients that an insurance claim has been filed — they’ll just get used to receiving paperwork from you that isn’t really a bill and consequently, may not recognize an actual bill when they receive it.

Beef up billing office response. Payments from HSAs are typically processed on a per-claim basis. That is, your staff may swipe the patient’s HSA card once for all the services received during a visit, but the third party administrator managing the HSA may choose to release funds one service at a time. As patients receive statements for multiple services and have to authorize each service individually, expect more calls coming into your billing office. Make sure the billing office’s direct line is clearly marked on billing statements and offer the billing office as an option if you use an automated phone attendant and distributor. Otherwise, front office staff will spend more time transferring these calls (and less time verifying patient insurance and other critical tasks). Send out statements more than once a week to avoid a large concentration of phone calls — and the resulting bevy of voicemails — that comes along with a once-weekly transmission of statements. Offer e-mail response to billing questions via your practice’s Web site.

Improve internal data management. Health plans will demand more information about quality and outcomes as a way to steer beneficiaries with CDHC products to some physicians and away from others. If you have an electronic health record (EHR), marshal its power to provide timely information about your quality of care — it will help in dealing with another trend: pay-for-performance.

Improve service quality and access. As patients pay higher portions of their healthcare costs, their expectations for excellent service quality and timely access will increase. Take steps to improve everything from your staff’s phone manners and the look of your reception area, to reducing time-to-next-appointment waits.

Consumer-directed healthcare is the wave of the future. The model may not be popular with patients, and it may not make physicians happy either, but it will be around for as long as it continues to meet the needs of employers that fund health insurance for employees and individuals seeking a cost-effective solution to health insurance. Get prepared for the coming wave to avoid getting drowned.