Population Health – Managing High Deductible Plans and Self Pay Patients

APPD Spring Meeting

April 8th, 2016

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Changes due to Affordable Care Act

- To date, the Affordable Care Act (ACA) has resulted in an estimated 32 million newly-insured Americans since 2010; nearly one-third of whom purchased coverage through exchanges.

- On the surface, it appears that this would be nothing but positive news for healthcare providers, as their ability to collect for billed services should be enhanced with more insured consumers seeking care. However, a closer look at the plans the newly insured are choosing reveals a growing collections concern for providers: the increasing popularity of high deductible health plans (HDHPs).

- Users of insurance exchanges and corporate consumers of health insurance are continuing to shift their health plan choices toward higher deductible options. The tiered structure of offerings on the exchanges allows consumers to choose their plans based on cost. This is leading to an increase in popularity for HDHPs, which typically include lower upfront premiums but higher total costs for many services.

- The number of HDHP enrollees rose to nearly 17.4 million in January of 2014, up from 15.5 million in 2013, 13.5 million in 2012 and 11.4 million in 2011; an average annual growth rate of approximately 15 percent since 2011.(1) As consumer preferences shift further towards these HDHP offerings, the need for providers to adapt their billing and collection strategy increases; otherwise, bad debt and charity care could evaporate profits.

- Coinciding with increasing consumer interest in HDHPs, more employers are offering HDHPs -- and in some cases only HDHPs -- to help control costs. This trend is expected to continue as companies react to the new laws governing their benefits, and try to find ways to manage the increased cost of expanded coverage while avoiding penalties such as the “Cadillac” tax.

The result is increased financial burden for patients, as well as changes in their ability to pay and their willingness to forgo treatments due to cost.

Average Patient Payment per Encounter

Patient Transaction Amounts, 2013-15

Month/Year	Average Patient Payment
January 2013	$139.78
July 2013	$132.22
January 2014	$139.71
July 2014	$143.83
January 2015	$155.82
February 2015	$174.31

Source: ZirMed. Used with permission.

- Published by HFMA
- Data is based on 20M patient payment transactions across the US

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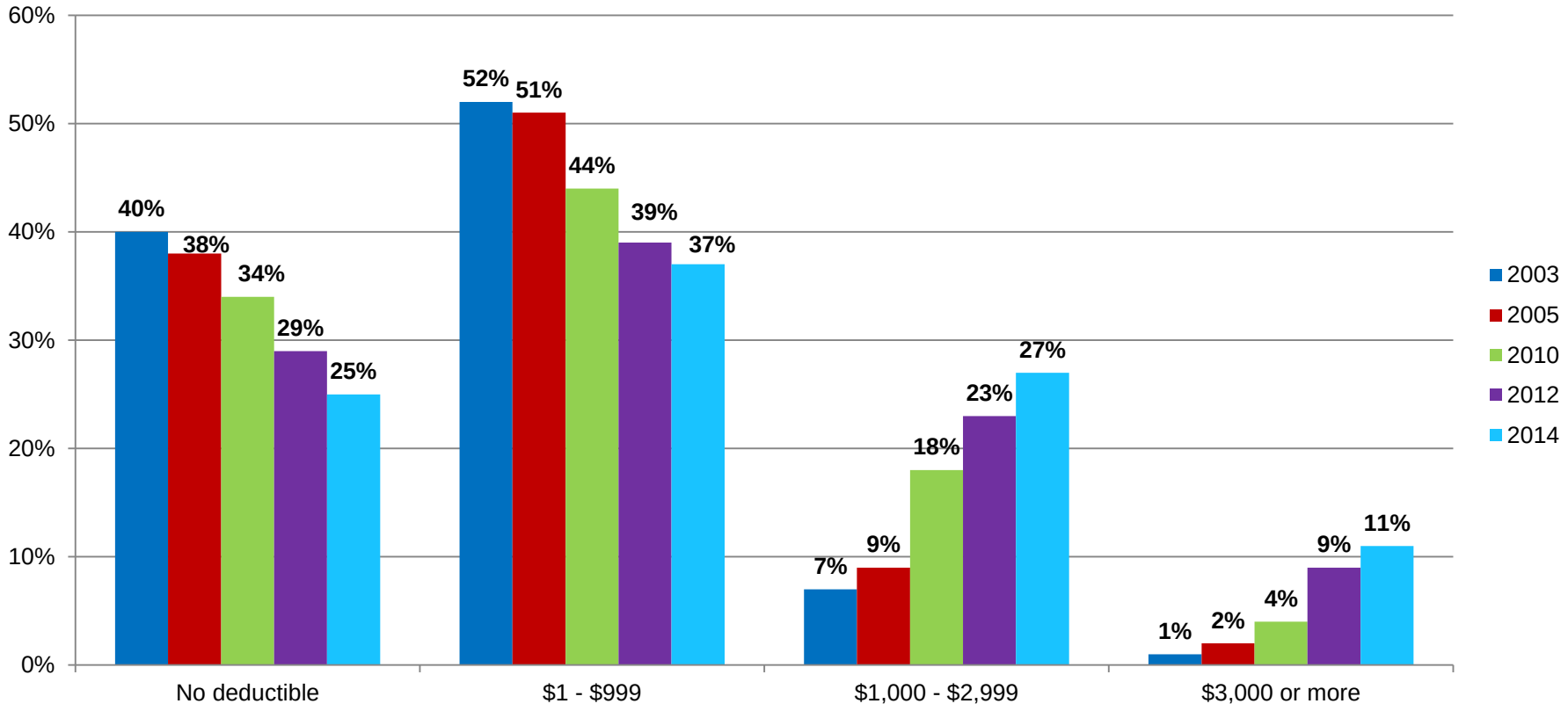
Insurance Deductible Levels
(as a % of total covered patients)



- Source: Commonwealth Fund Biennial Health Insurance Survey, as reported by HFMA

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Underinsured Patients

- Recent research conducted by HFMA indicates that “underinsured patients” (out-of-pocket expense, excluding premiums, is >10% of household income) are growing concern:
  - Approximately 31 million adults in 2014 were underinsured
  - Typical family of four in an average employer-sponsored PPO will pay $4,065 in out-of-pocket expense annually
  - 59% of “underinsured” adults are covered by an employer-sponsored health plan
  - 45% of “underinsured” adults skipped necessary care due to cost considerations

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Deferring/Reducing Care

- Largest ever study of employer-sponsored HDHPs conducted by Rand Research showed the following:
  - Employees who switched from a plan with a deductible <$1,000 to a plan with a deductible >1,000 reduced their health care spending by ~14%, with the exception of emergency room care
  - Employees in HDHPs eliminated some preventative care despite that fact that those services are not subject to a deductible. Notably impacts: cancer screening of all types and immunizations
  - Employees defined as “low income” or “chronically ill” cut back or deferred health care at levels similar to all employees surveyed
- A similar study by Truven Health Analytics looked at utilization for three years following change to HDHP and noted:
  - Lower utilization of professional visit, lab services, non-maternity admissions and ER visits
  - Higher utilization of generics
  - Reduced instance of diagnosis of chronic conditions for HDHP group

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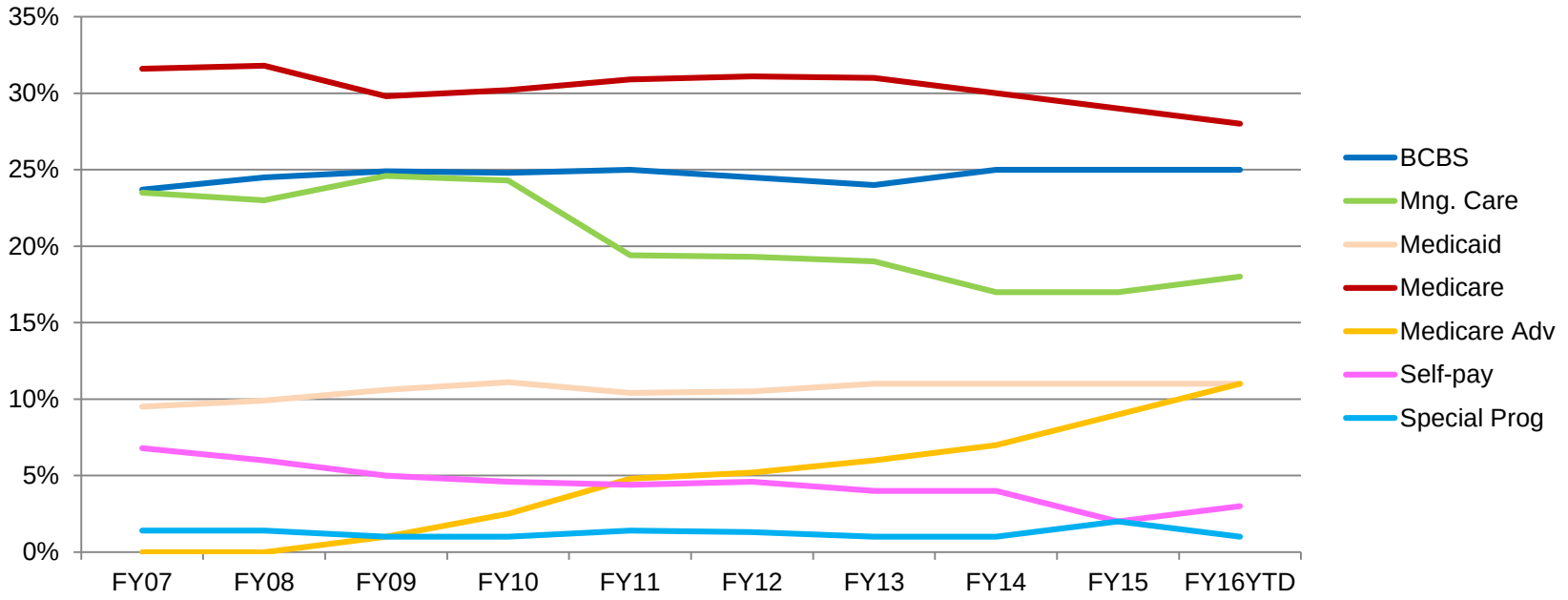
Duke Professional Payor Mix



- Medicare Advantage has grown from <0.5% of charges to 11% of charges at the expense of Medicare
- BCBS has grown to dominate the commercial market in NC
- Self-pay has become less than 2% of charges but is increasingly a significant and growing portion of A/R

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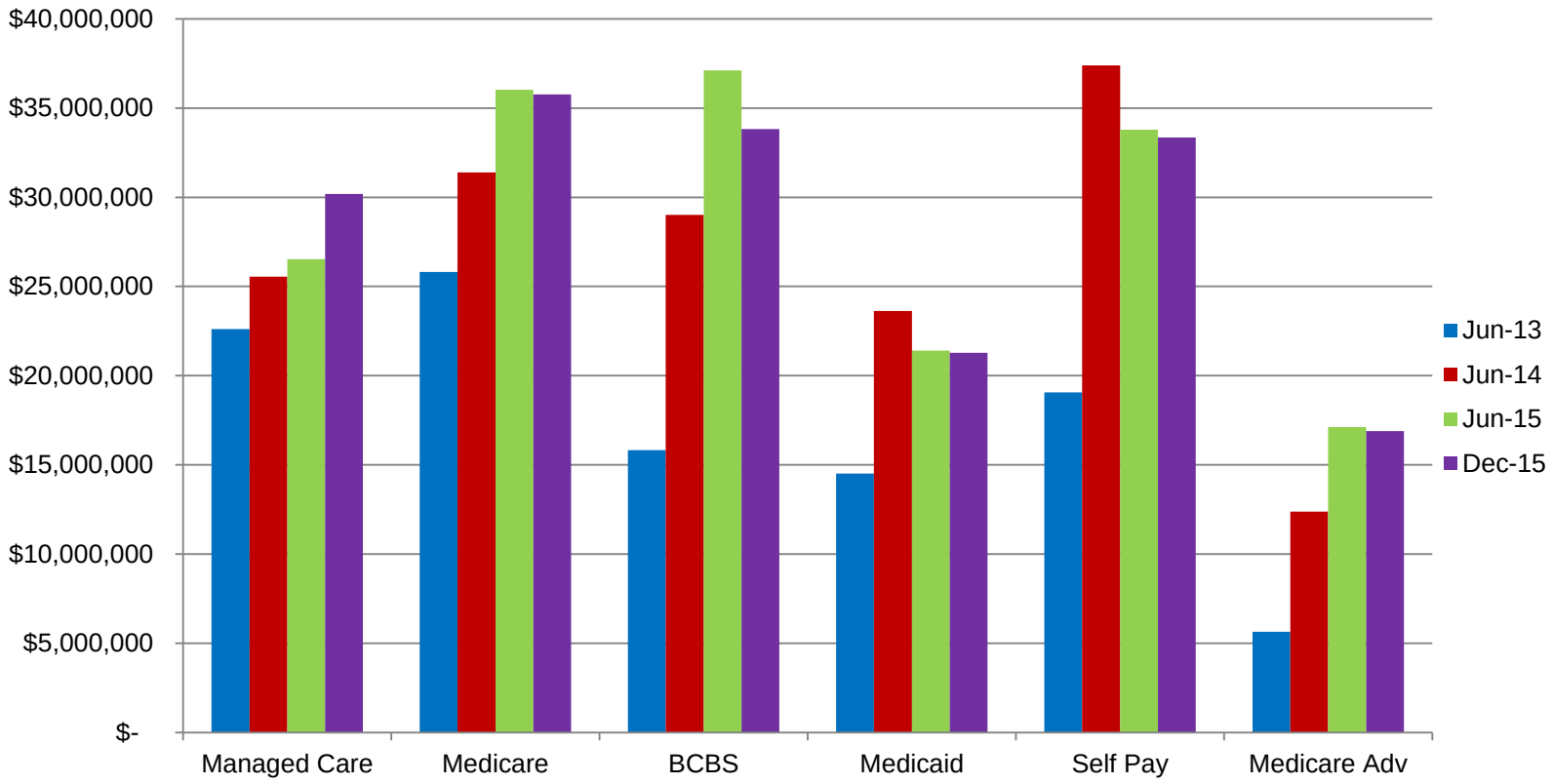
Duke Prof – Gross Accounts Receivable



Charge Growth

FY14	**4.5%**
FY15	**11.3%**
FY16YTD	**12.5%**

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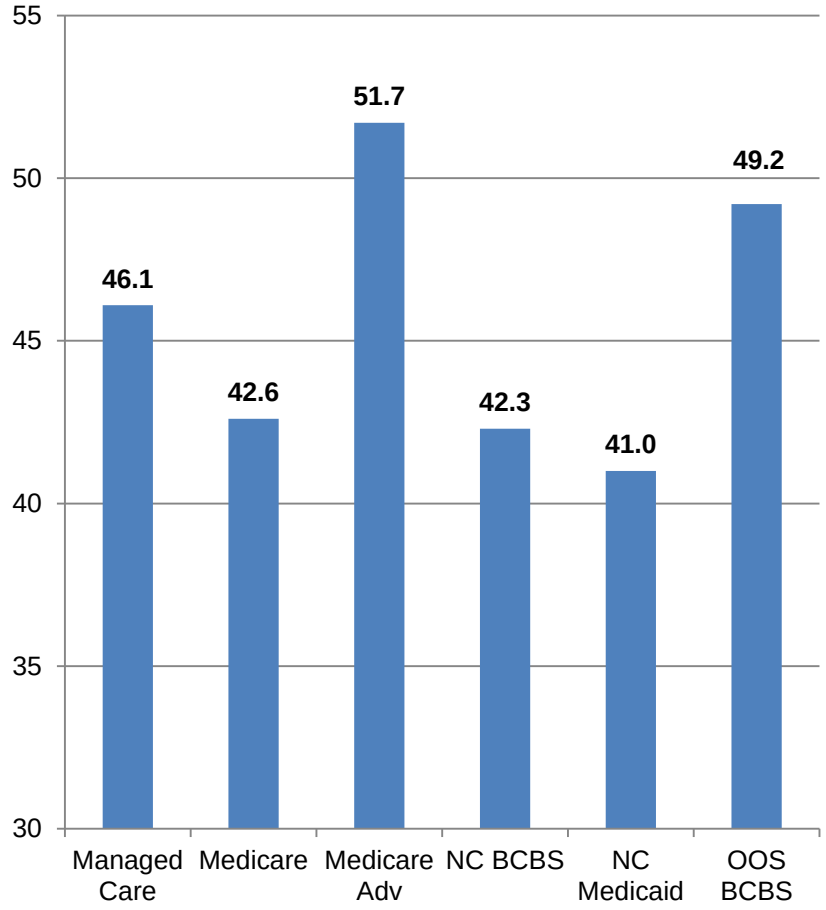
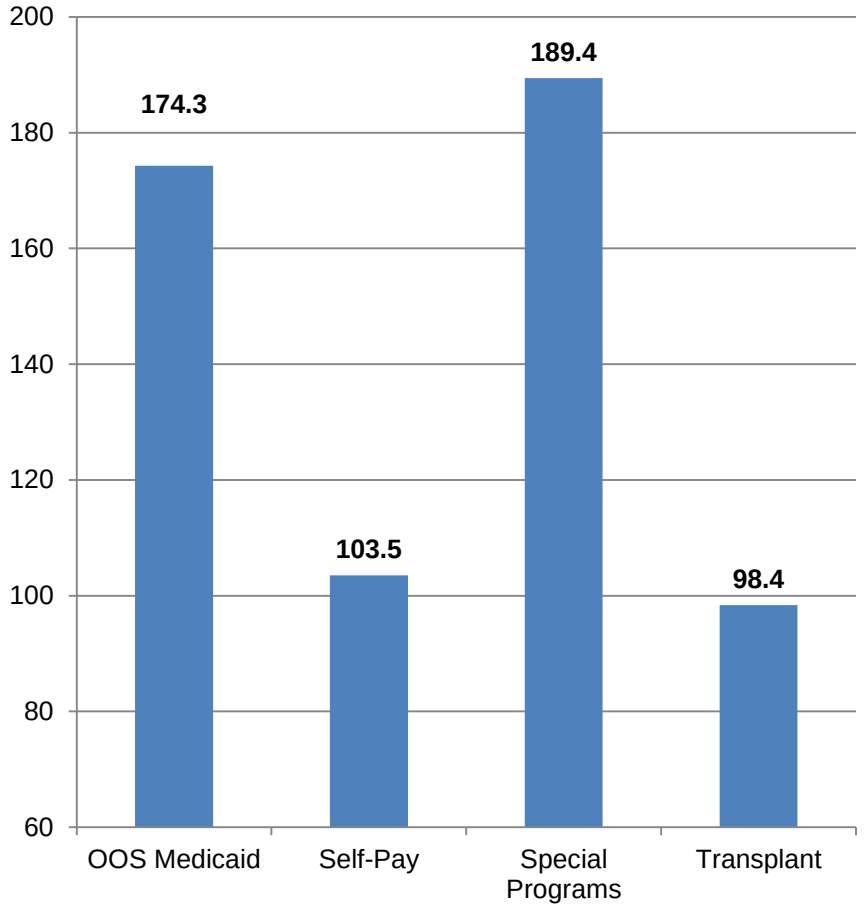
DRO By Payor – Hospital

As of December 2015





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DRO By Payor – Professional

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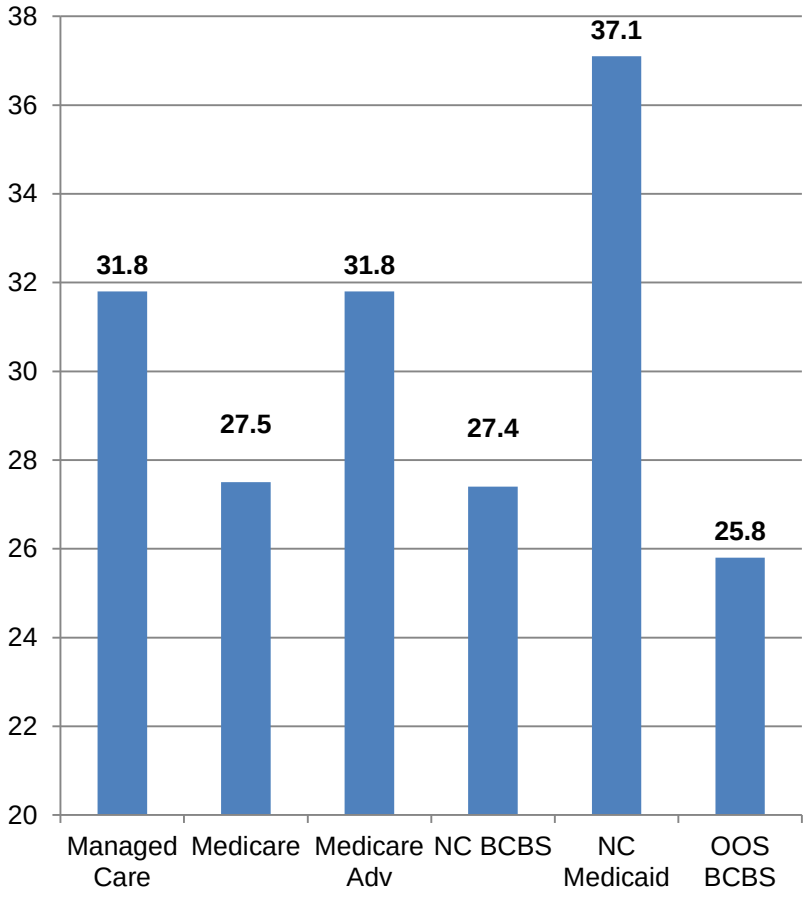

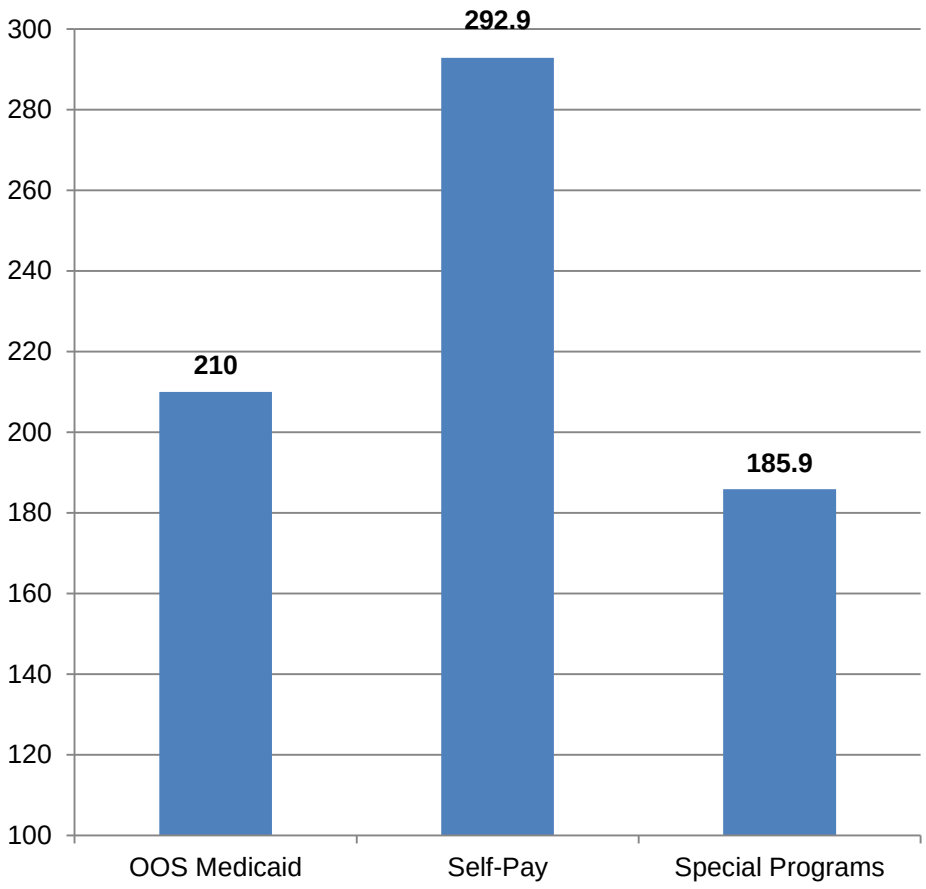

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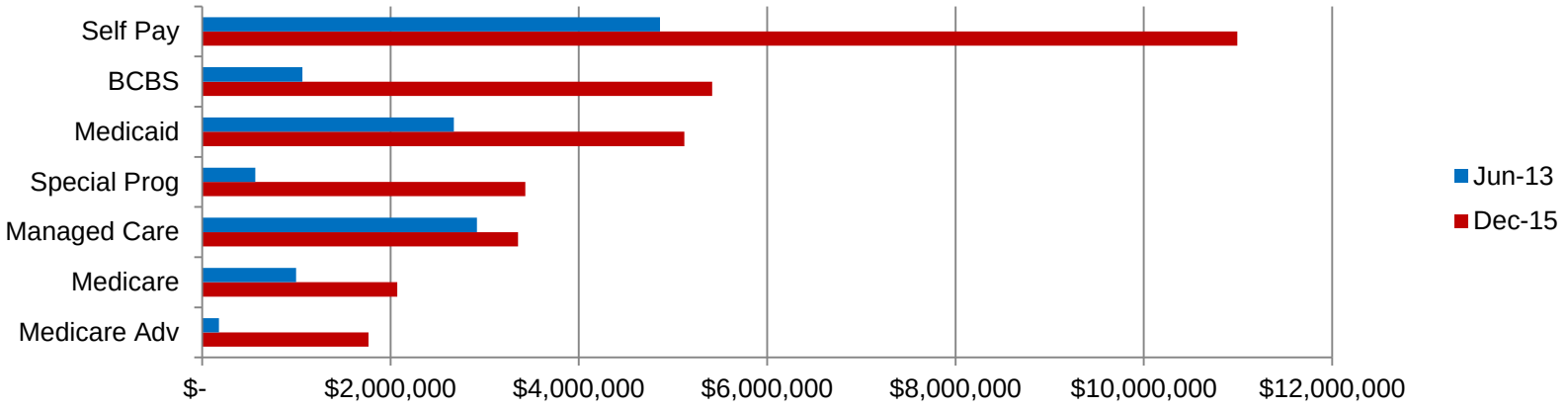
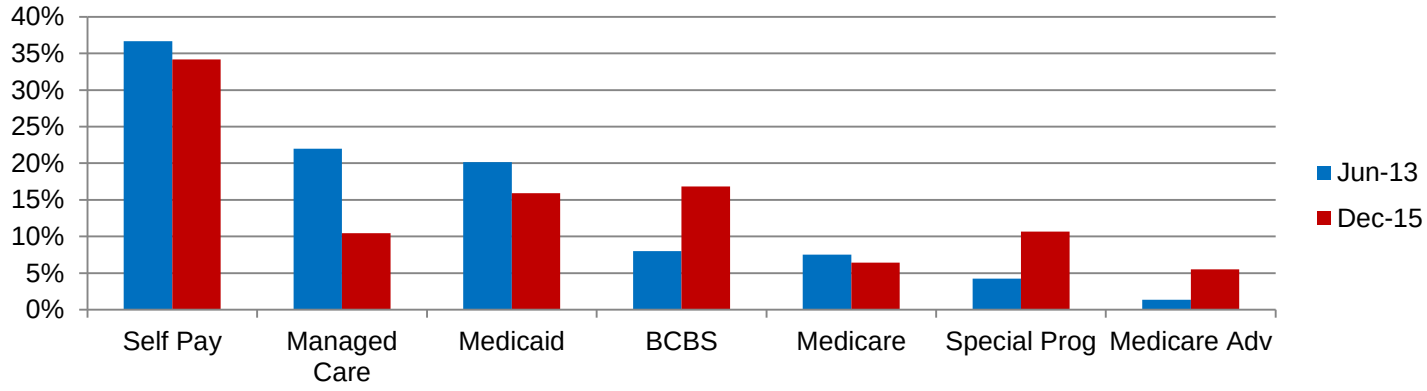
Deductible Analysis

- Reviewed 75 surgery cases from the month of January 2015 for patients with HDHPs. For each case, identified
  - Timing of claim submission by physician(s) and hospital
  - Amount of deductible impact by physician(s) and hospital
- Results of review
  - In 67 cases (89%) – only the physician had deductible impact. In the remaining cases, impact was shared by physician and hospital
  - On average, physician bill was submitted to payor 7 – 10 days before hospital bill submission
  - When reviewing the deductible impact as a % of covered charges for those 75 cases:
    - Physician –14.4% to 42.3% based on specialty (average deductible of $873)
    - Hospital – 1.78% (average deductible of $1,389)

Duke Prof - A/R >150 Days by Payor
(Total $ and % of >150 A/R)





Growth in A/R >150 days from June 2013 to December 2015 has been driven primarily by BCBS, Medicaid Pending and Self Pay. Medicare Advantage is a growing % of >150

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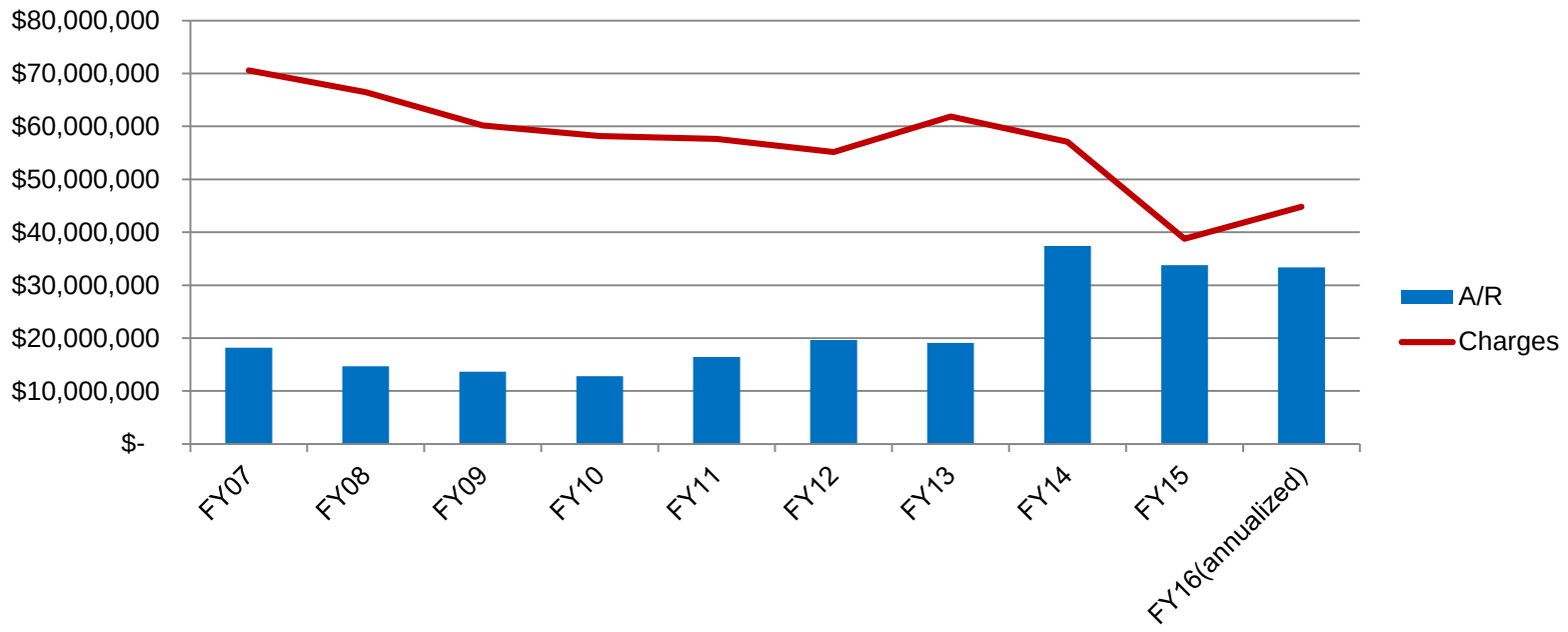
Duke Self-Pay Trends – Professional Charges and A/R



Charges represent gross charges for patients identified as “pure self-pay” at time of service. Pure self-pay charges have been decreasing over time; however, self-pay A/R is growing due to increases in residual self-pay.

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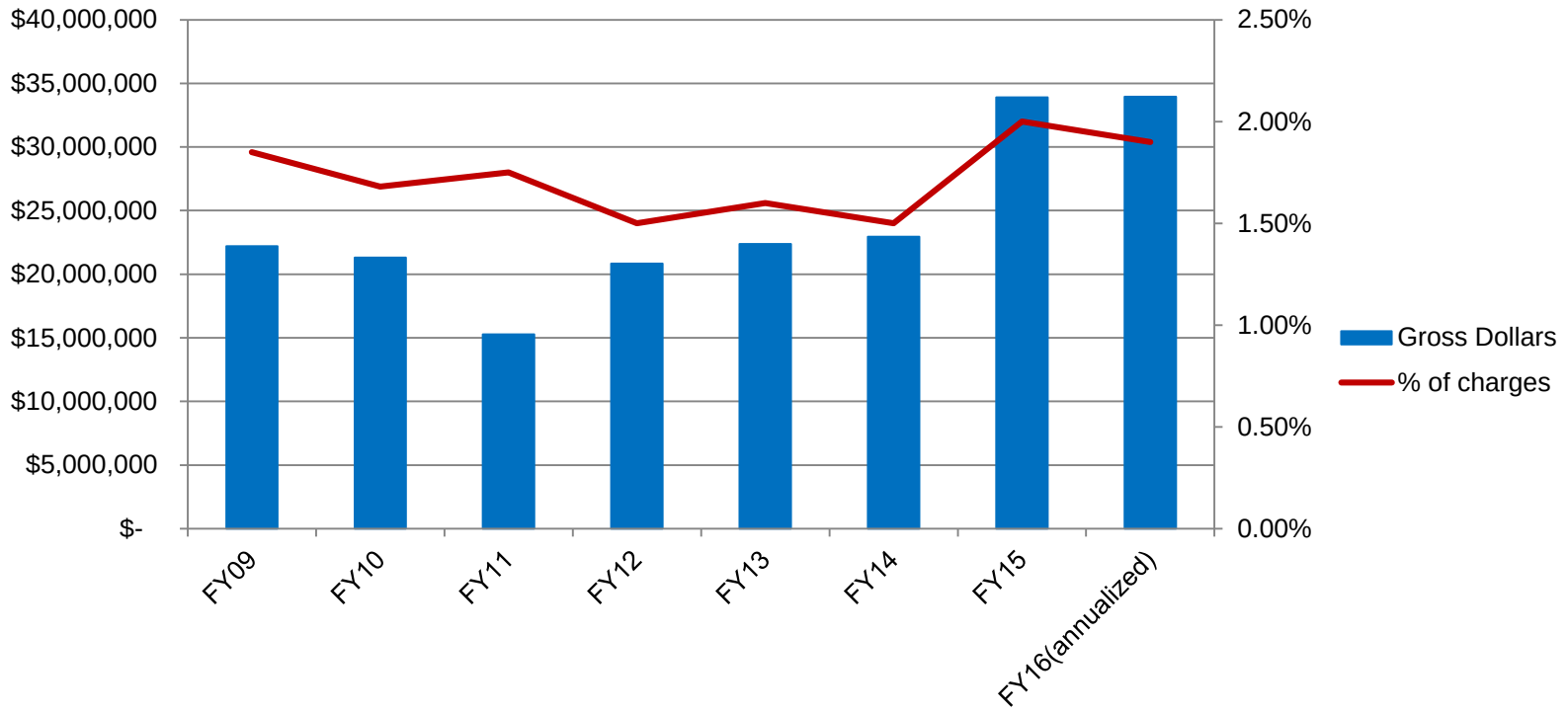
Duke Bad Debt Trend – Professional



Bad debt write-offs, as a % of charges and in gross dollars, have been increasing since late FY14

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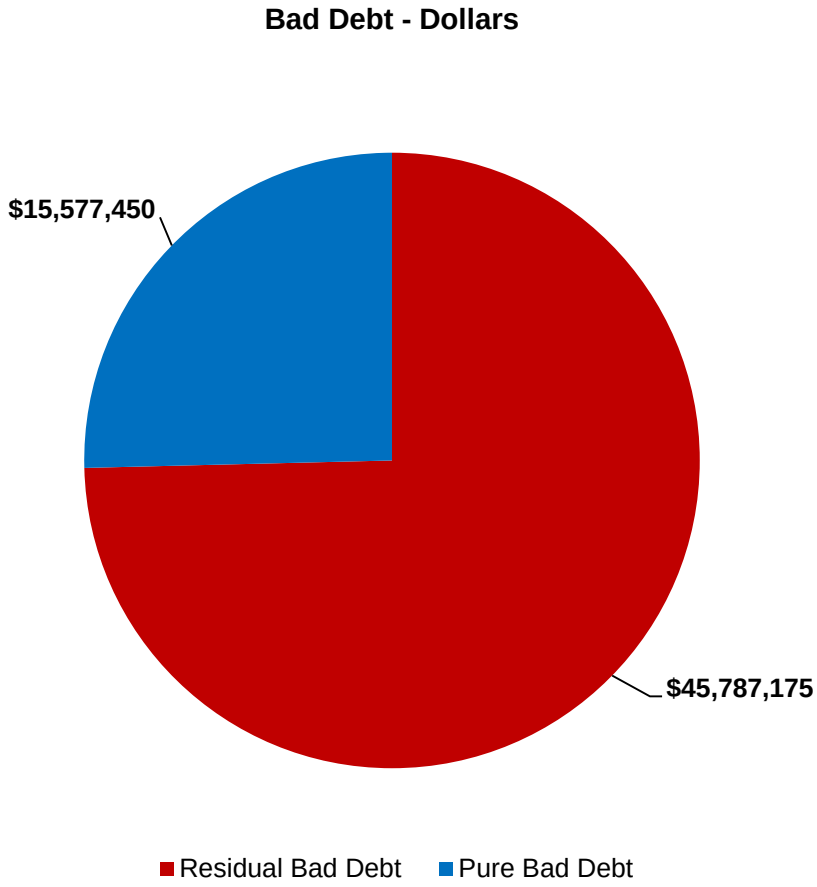
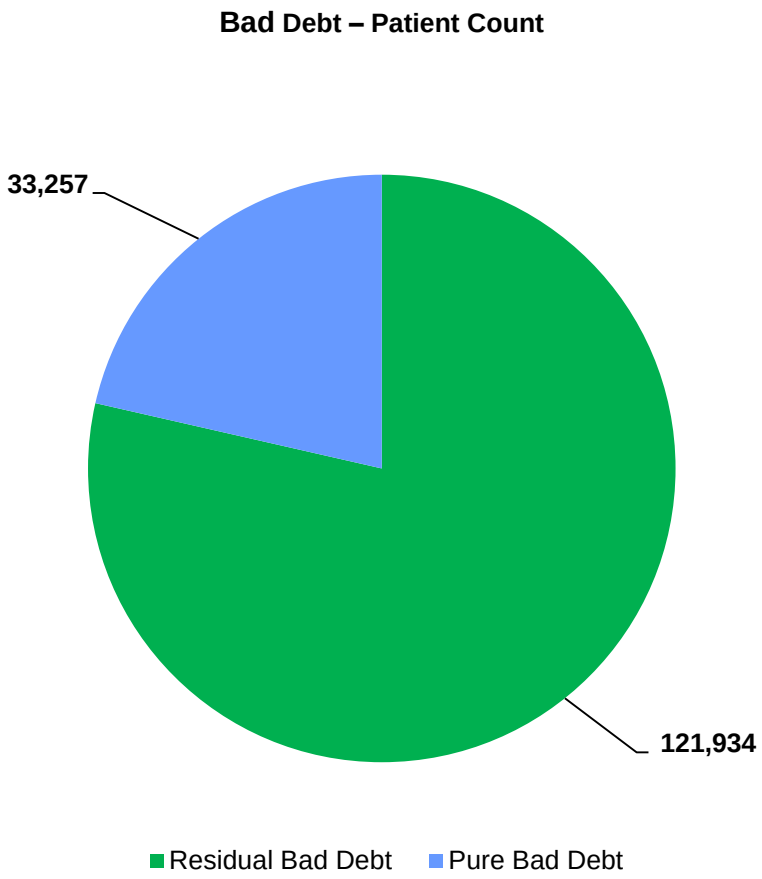
Duke Overall Bad Debt – Professional

July 1, 2014 – January 1, 2016 (net of patient discount and recoveries)





Historically, the split between pure and residual was closer to 50/50.

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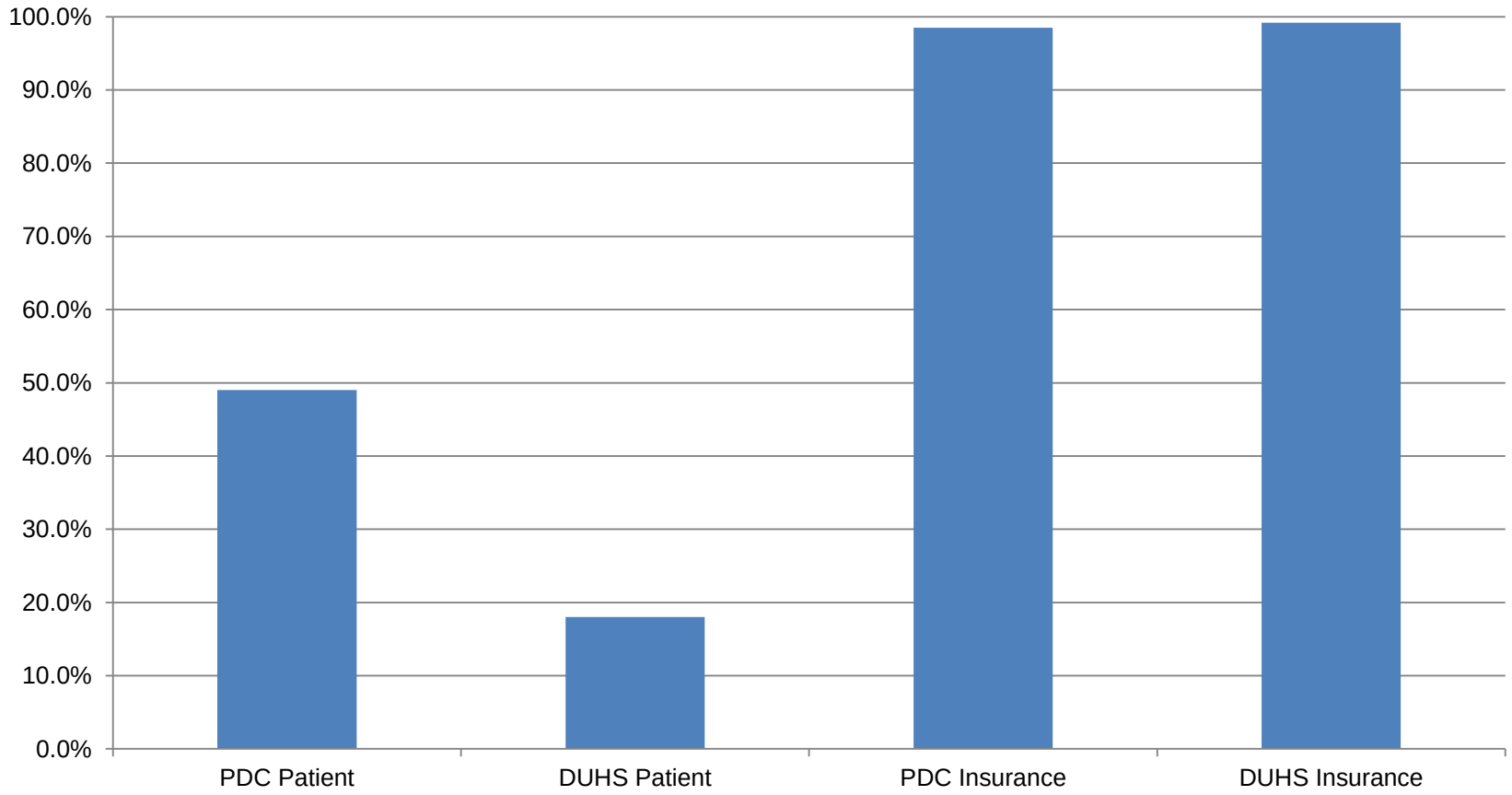
Collection Rates by Patient vs. Insurance Responsibility



FY2015

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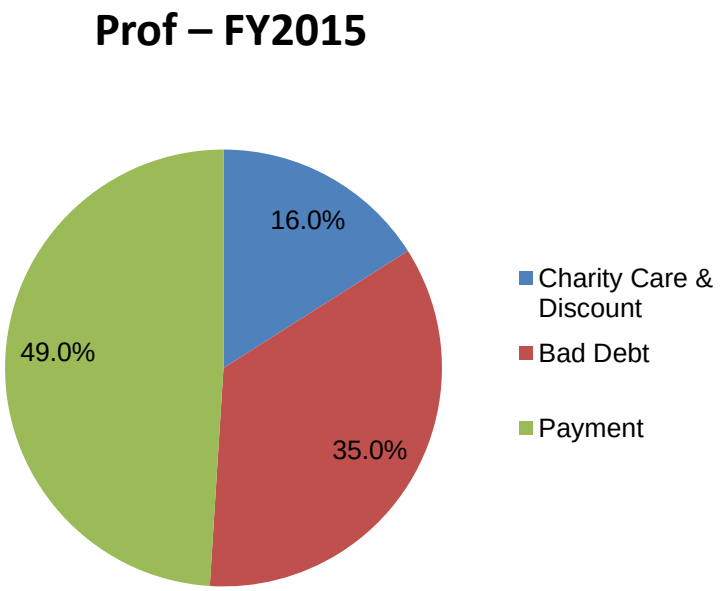
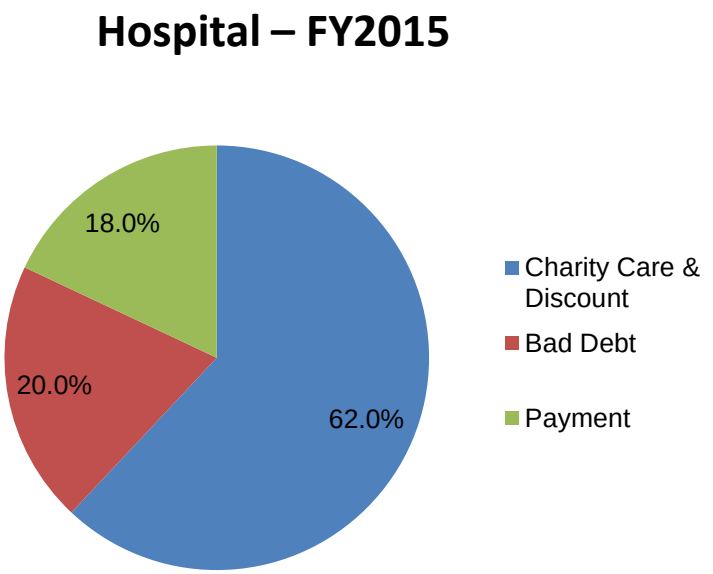
Resolution of Patient Responsibility





Higher levels of charity care for Hospital due to higher patient discount rate (72% vs. 50% for Prof) and charity care policy presumptive provisions for ED services, as well as increased utilization of charity care policy for higher balances associated with hospital services.

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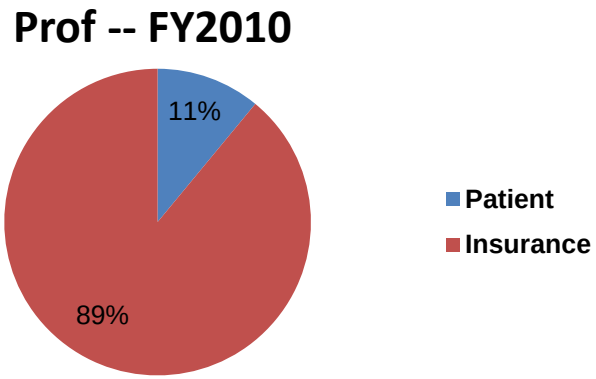
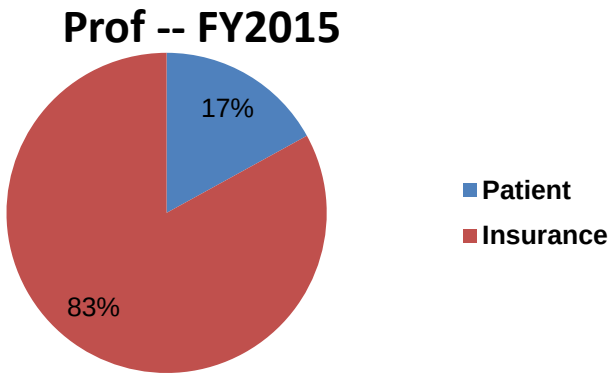
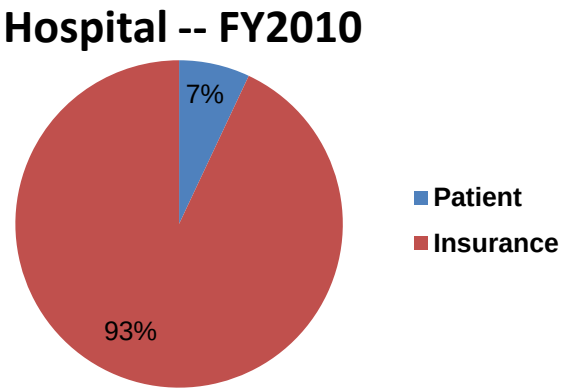
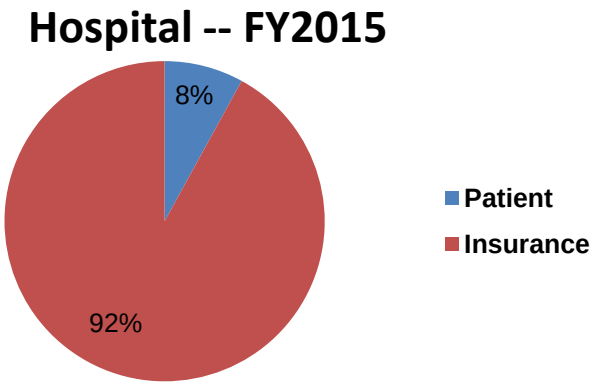
Impact on Accounts Receivable









Higher growth for Professional because Hospital has higher level of charity care write-offs, And those write-offs are taken early in the A/R resolution cycle.

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Financially “At-Risk” Patient Pathways

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Objectives

- Offset the growing challenges of understanding insurance coverage by providing enhanced patient support, including educating patients regarding insurance benefits and financial risks
- Control the growth in bad debt expense for both PDC and DUHS
- Optimize specialty appointment availability for Duke Primary Care patients and those residing in a Duke county
- Construct a framework for the management of patients with high deductible health plans

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Strategies

- Deliver enhanced pre-service patient education on benefits, estimated liability and alternatives (as appropriate)
- Build on existing “Out of County Self-Pay and Medicaid” workflows and infrastructure
- Augment individual provider override process with Clinical Review Board
- Position the organization to respond to high deductible health plan issues and enhance policies around patient liability

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Patient Financial Pathways

Service	New to Duke Self pay and Medicaid Duke County*	New to Duke Self pay and Medicaid Outside Duke County*	Out of Network (OON)
Primary Care	• Patient scheduled • Enhanced patient education on payment expectations • Financial review for potential coverage • Patient estimated liability requested at check-in • Check out with financial review of future services/appointments	• Patient not accepted / scheduled • Patient education and scripting on options within their county / state	• Identified at time of call to schedule • Routed to Central Financial Services (CSF) • Patient education on benefits and scripted education on options within their network • If patient wishes to pursue -100% of patient estimated liability is required up front • Appointment scheduled • Check out with financial review of future services/appointments and estimated liability collected
Specialty Care	• Physician referral required • Financial review for potential coverage • Estimate created • Patient education on payment expectations and process • Appointment scheduled • Patient liability requested at check-in Check out with financial review of future services/appointments	• Physician referral required • Financial review for potential coverage • Estimated created • Clinic Review Board determines acceptance of patient based on review of medical records and estimate of services required. • Patient education on payment expectations and process • 100% of patient estimated liability is required up front • Appointment scheduled • Check out with financial review of future services/appointments and estimated liability collected	• Identified at time of call to schedule • Routed to Central Financial Services (CSF) • Benefits verified and estimate created • If MD referred , referring MD notified patient OON • Patient education on benefits and education on options within their network • If no OON benefit –treated as self pay • Appointment scheduled and 100% of deposit collected on patient liability prior to service • Check out with financial review of future services/appointments and estimated liability collected *Note: If MD referred **and** patient cannot pay deposit –case is reviewed by Clinical Review Board*

*Duke County = Counties with a Duke Primary Care Clinic; Duke Market

Patients with a Self Pay / Bad Debt Balance

Scheduling and Education (Phase I)		Collection and Scheduling (Phase II)
• Patient with bad debt or self pay balance (**> $500 >60 days) will be identified at scheduling • Patient account routed to Central Financial Services (CFS) Work queue when appointment is scheduled • CFS will review the account and contact the patient and provide enhanced financial counseling to include but not limited to: ➢ Review balance with patient; collect on balance ➢ Screen for coverage ➢ Discuss payment plans ➢ Screen for other programs and Charity *Note: patient account will route no more than every 30 days*	*Migrate to* →	• Patient with bad debt or self pay balance (**>$500 >60 days) will be identified at scheduling • Patient call will be routed to Central Financial Services (CSF) for enhanced financial counseling prior to scheduling • Enhanced financial counseling to include but not limited to: ➢ Review balance with patient; collect on balance ➢ Screen for coverage ➢ Discuss payment plans ➢ Screen for other programs and Charity • Patient appointment scheduled *Note: Routing can be accomplished electronically with technology such as West*

*** Amount and days to be determined*

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Summary of changes to current workflow:

- All “new to Duke /new to service” self-pay and Medicaid patients must be physician referred for Duke Specialty appointments
- Physician referred self-pay and Medicaid patients from outside a Duke county require review/approval by a Clinical Review Board. Payment of estimated liability will be required before scheduling
- Out of Network patients will receive financial counseling, including education on benefits and payment expectations. Full payment of estimated liability will be required before scheduling
- Patients with existing bad debt balances will received additional education and financial counseling prior to scheduling
- Check-out process will include education on liability and payment expectations for future services

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Out of Network Health Plans

- For calendar year 2016, we have 959 scheduled appointments (~500 unique patients) with coverage for which Duke is out of network
- Most (if not all) of these visits will result in patient being billed after denial by payor
- Appointment by Specialty (>15 total appointments)

Specialty	Appointments
General Internal Medicine	65
Family Medicine (without OB)	62
Medical Oncology without Infusion	36
Neurology: General	31
Dermatology	21
Obstetrics / Gynecology	18
Pediatrics: General	17
Ophthalmology: Retinal	16
Urology	16
Endocrinology / Metabolism	16
Ophthalmology: Glaucoma	16

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Self-Pay Update/Payment Plans

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Examples/Scenarios – Current Process

- Pure Self-pay Patient (“in county”)
  - Scheduled and routed to FCC for review
    - No MD override review
  - Estimate of patient liability is performed in certain cases
    - Estimates performed for patients certain high dollar services
    - Estimates and payment are requested upfront
  - At arrival, self-pay balance is requested – physician has option to not see patient if no payment is made
  - Upon discharge, FCC works with patient to screen for potential coverage, complete charity application or establish a payment plan
  - Patient is routed to FCC work queue every 30 days for review of payment history and possible coverage

- Pure Self-pay Patient (“out of county”)
  - Same as above, but referral required

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Examples/Scenarios – Current Process

- Pure Self-pay Patient (“out of county”)
  - At scheduling, referring physician required to initiate “out of county referral”
  - New “out of county referrals” are routed to central financial screening
    - FCC screens patient for potential coverage
    - FCC assembles clinical notes, coverage assessment and referral details and forwards to physician
  - Physician reviews patient data and accepts or declines referral
    - Historically, we have accepted >85% of referrals
  - If approved, appointment is scheduled

- Out of Network Patients
  - Attempt to identify at scheduling; however, not always consistent and no policy to defer scheduling

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Patient Payment Plans

- Available to all patients, for any patient balance (uninsured, residual after insurance)
- Offered as option of first resort when patient indicates concern regarding payment ability
- Primary attraction to patient is non-interest bearing nature of arrangement
- Single payment plan across all Duke Health entities, in conjunction with SBO (single business office) feature within MaestroCare/Epic
- After initial set up of payment plan, any subsequent patient balances are automatically swept into existing plan and monthly payment amount modified to meet term parameters of policy

Payment Plan Policy Parameters

Balance	Maximum Term
< $2,000	12 months
$2,000 to $5,000	24 months
$5,001 to $7,500	36 months
$7,501 to $10,000	48 months
< $10,000	72 months

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Payment Plan Overview

- Across Duke Health:
  - 25,150 patients with existing payment plans
  - $43.7 million in outstanding balances
  - $1,737 average balance
  - 23 months average term remaining
  - $82 average monthly payment

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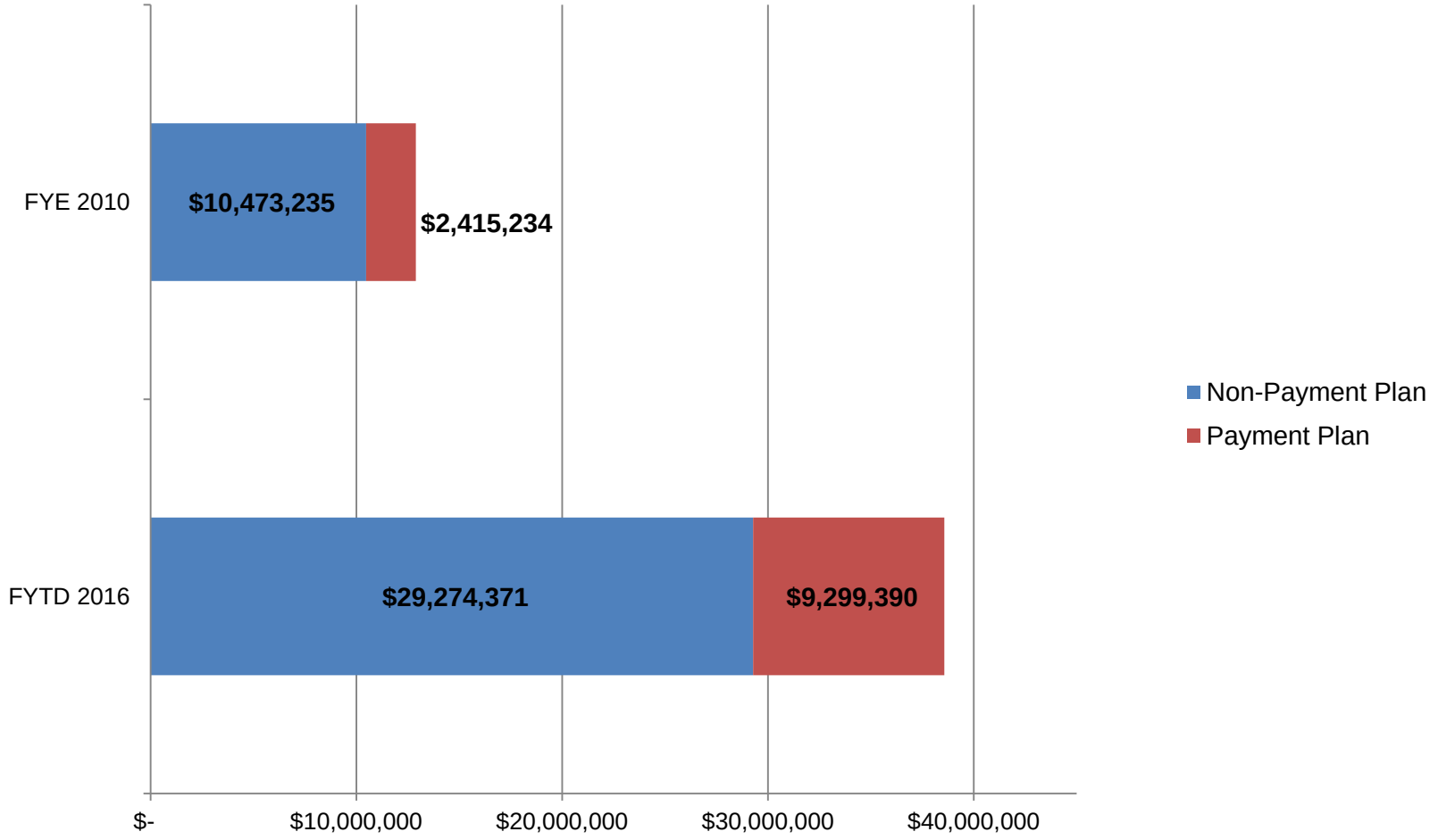
PDC Self-Pay A/R Payment Plan vs. Non-Payment Plan



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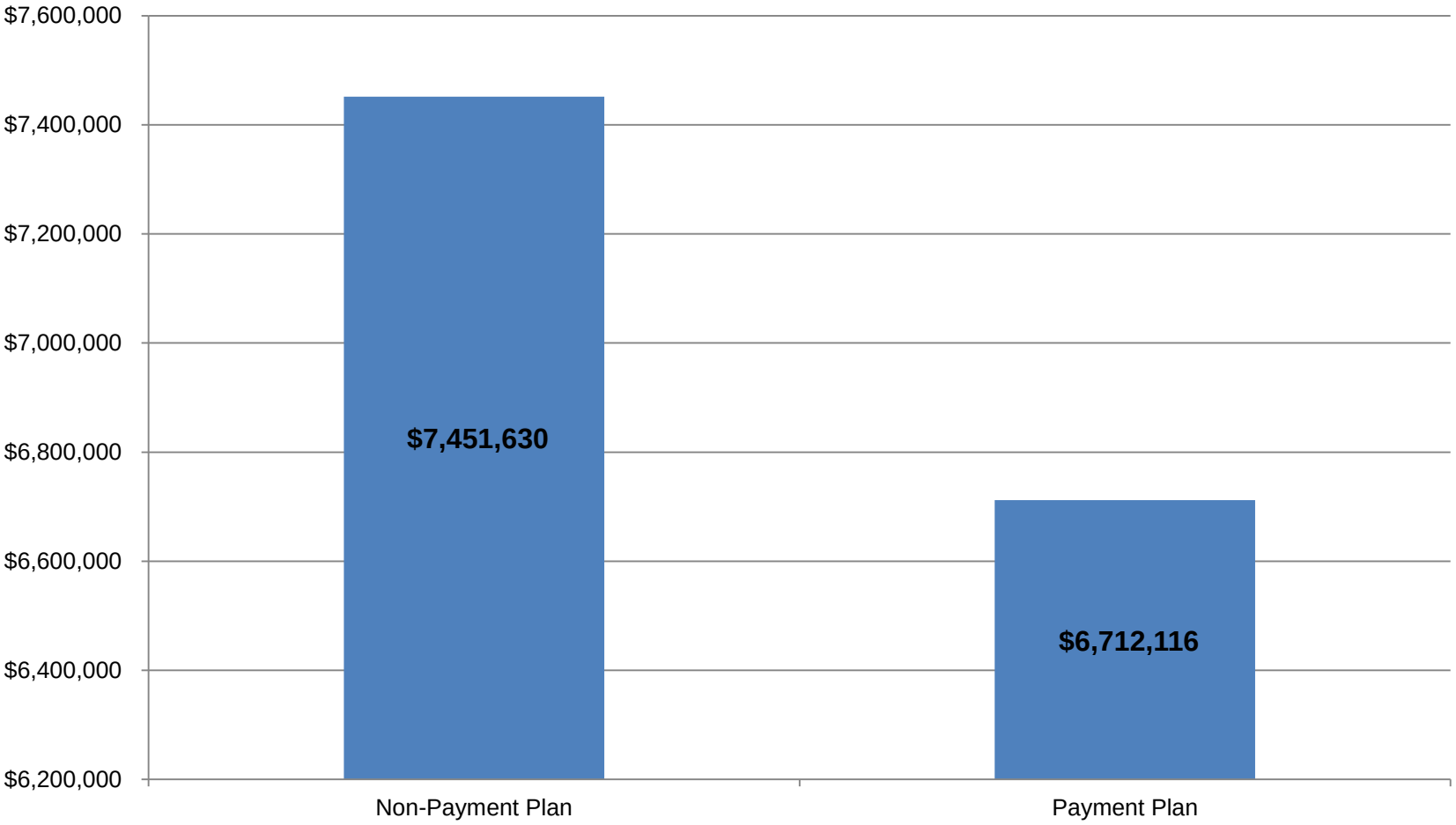
PDC – Self-Pay A/R >120 Days



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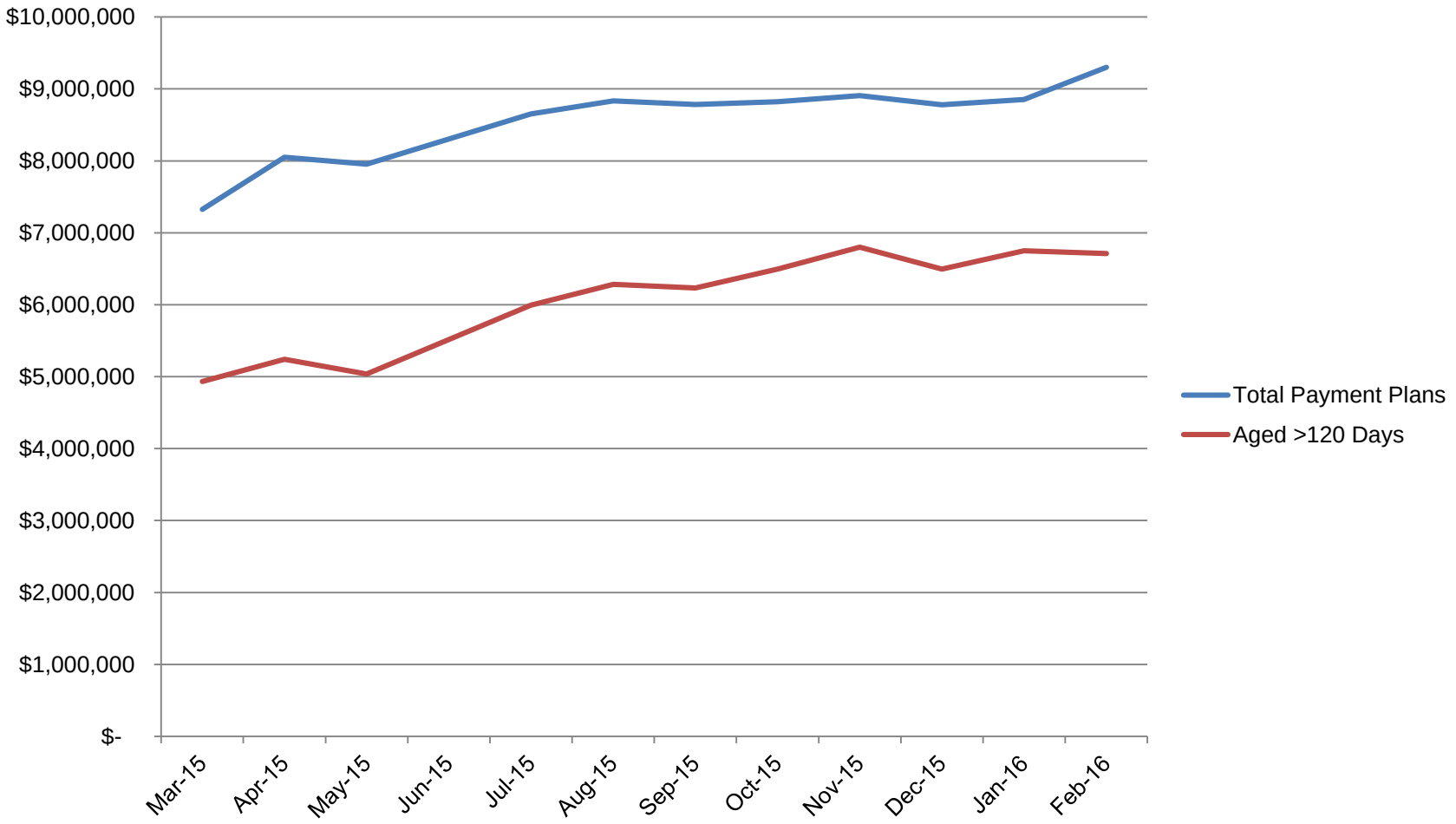
PDC Payment Plans
Rolling 12 Month Growth



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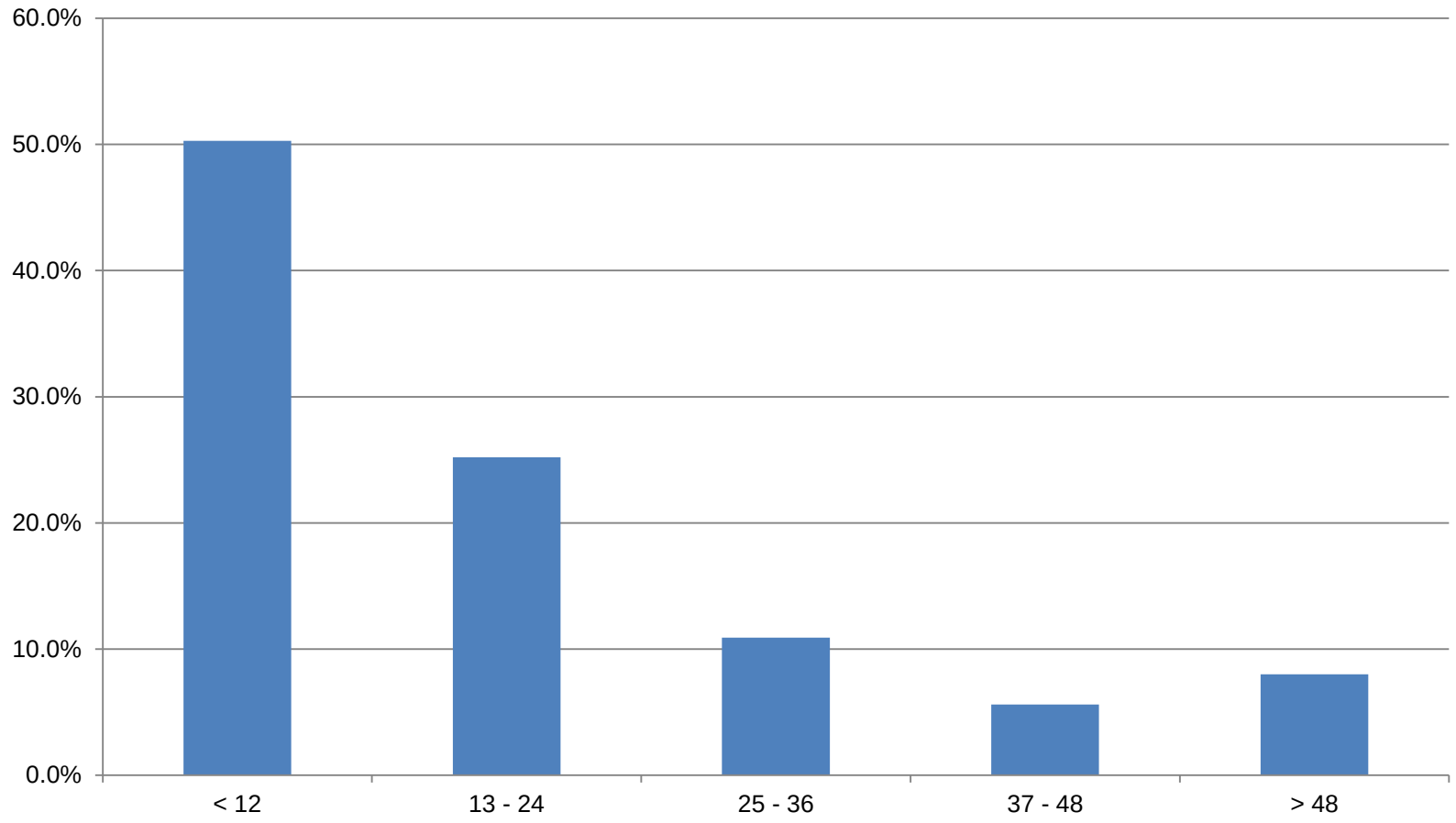
Payment Plans – Distribution by Term Remaining (Months) PDC & DUHS Combined



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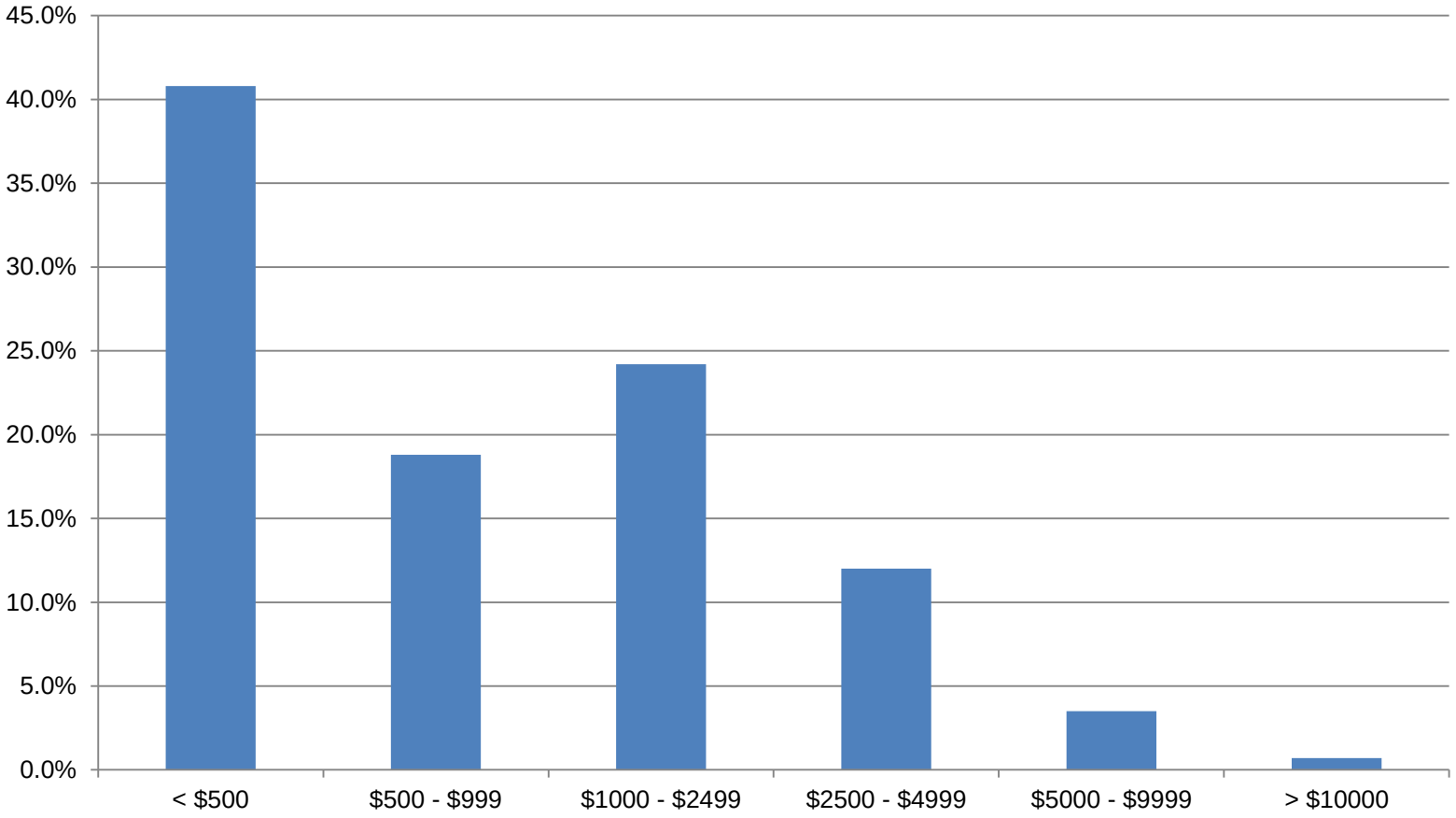
Payment Plans – Distribution by Current Balance (DUHS & PDC Combined)



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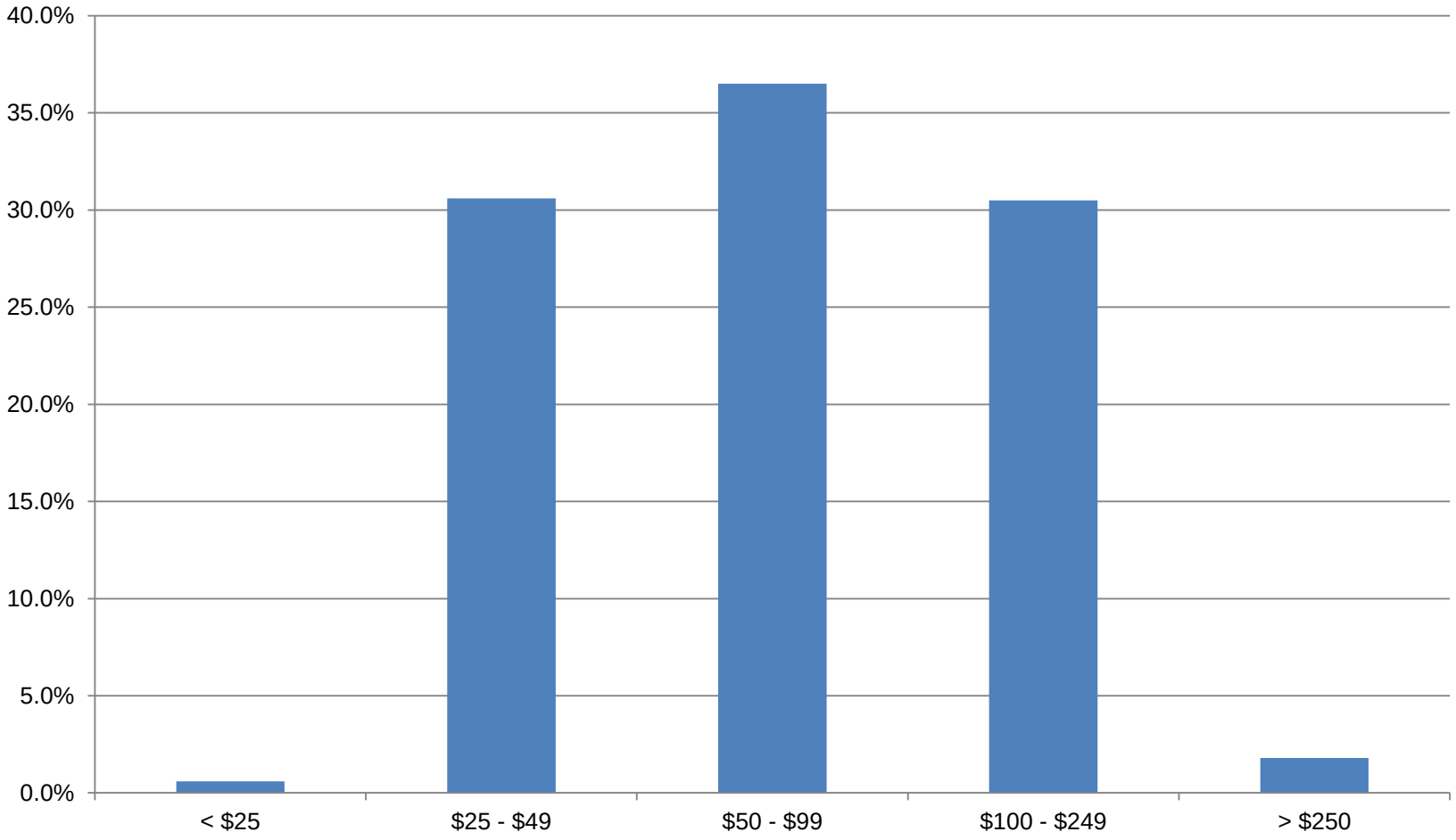
Payment Plans – Distribution by Monthly Payment Amount (PDC & DUHS Combined)



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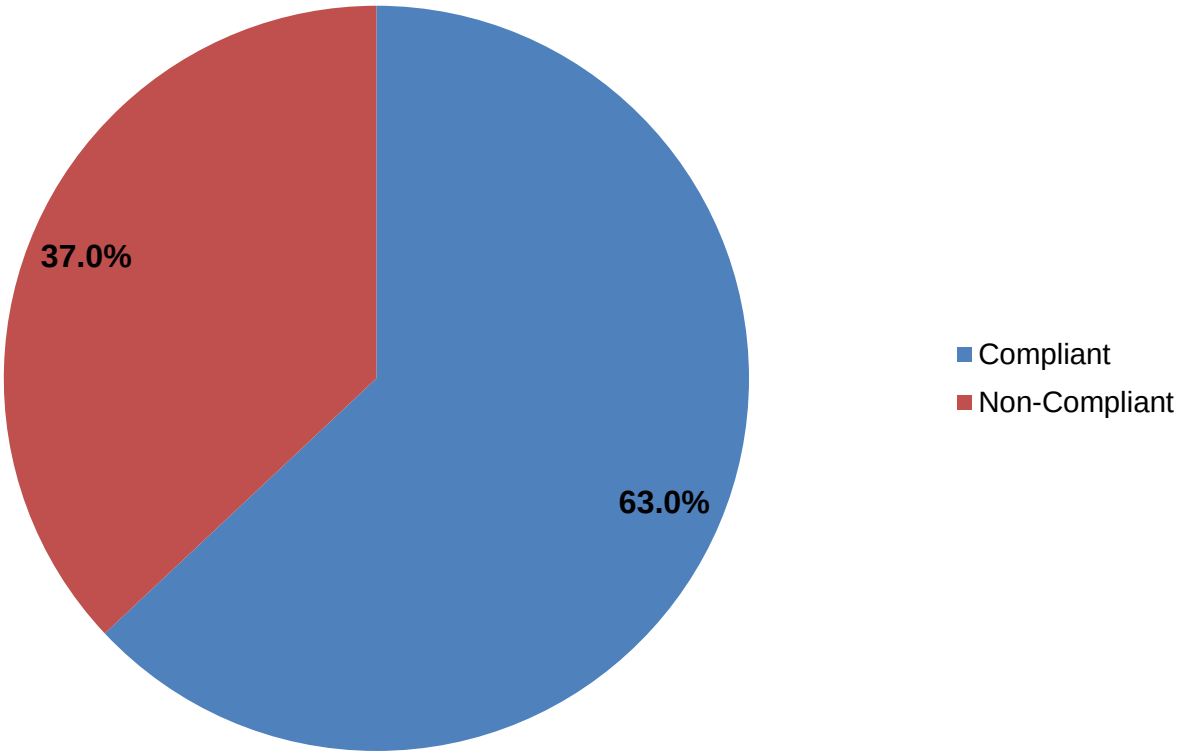
Plans Payment– Patient Compliance with Payment Plan Terms



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Recommendations

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Items to Consider

- While this is a financial policy, the discussion and eventual recommendation should be clinically driven and supported
- The eventual policy decision needs to be consistent for all access points and clinical areas or it will confuse patients, staff and providers
- Some of our decisions will have staffing and/or budget impacts and may be dependent on system optimization efforts
- Nothing is under discussion that would include urgent/emergent cases nor appear to be inconsistent with DUHS' vision, mission and not-for-profit status

Patient Pathway Recommendations

- Note: recommendations only focus on new patients to Duke or new to a service line

- Self-Pay/Medicaid
  - Within a Duke County
    - Schedule through current workflow but enhance estimate process and provide additional education both pre- and post-visit
      - Note: Specialty care will require a physician referral prior to scheduling
    - Payment will be **requested** at check-in
  - Outside a Duke County
    - Primary care patients will be educated and re-directed with their county/state
    - Specialty care will require a primary physician referral, Clinic Board review and approval and full payment of estimate prior to scheduling

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Patient Pathway Recommendations

- Out of Network
  - Primary Care
    - Patients will be identified at point of contact (prior to scheduling) and provided additional education regarding benefits, alternatives and estimate of cost
    - Full payment **required** prior to scheduling
  - Secondary Care
    - Same as above but additional requirement of physician referral
    - If patient cannot pay estimate and is MD referred, Clinical Board may review and approve for scheduling

- HDHP
  - With the previous workflows in place and operational, we can more efficiently expand the process to include HDHP patients

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Final Comments on HDHPs

- Many providers have already started to put in place new programs and processes to offset some of the effects of HDHPs. Point-of-service collections, requiring whole or partial payment at the time of the appointment, are becoming an increasingly popular way for hospitals to collect payments for procedures and visits.

- Some providers are offering medical bill financing services, either directly or through partnerships with third-party banks and lenders. These services allow consumers to make smaller payments over time to control the burden of upfront costs, often for negotiated total amounts with little to no interest.

- Most providers are placing an increased focus on their collections services by implementing new processes and programs to help improve billing and collections departments. Having discussions with the patient about costs throughout the entire treatment process is important. Many providers have found that focusing on communication and consumer education with regard to healthcare decisions, both treatments and coverage options, has created better results with both patient satisfaction and bill collection.

- With risks on the horizon due to the growth in HDHPs, it is time for providers to review their charity plans and examine how bad debts are treated. Charity care plans will need to start incorporating patients that technically have health insurance but are currently unable to afford the full deductible to pay for their care.

- Communicating with patients from the beginning of treatment plans can lead to mutual agreement about payment plans and increase the likelihood of whole or partial collections. The billing discussions can lead to better budgeting on a per-patient basis and a more accurate forecast of charity care and bad debts. Forecasting, budgeting and managing the collections could be improved through separating the HDHP accounts from other insured patient accounts.

Questions

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