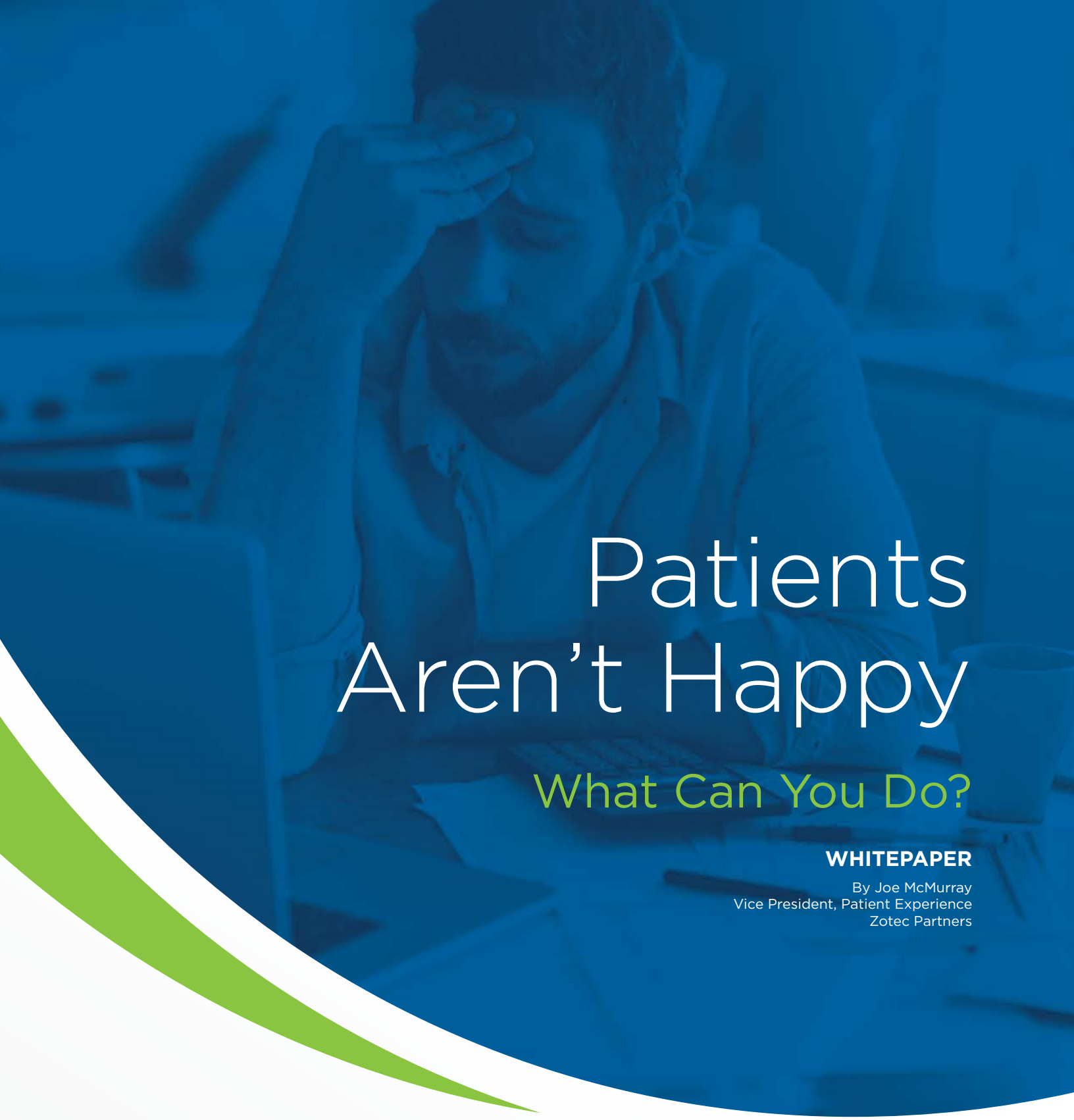

Patients Aren't Happy

What Can You Do?

WHITEPAPER

By Joe McMurray
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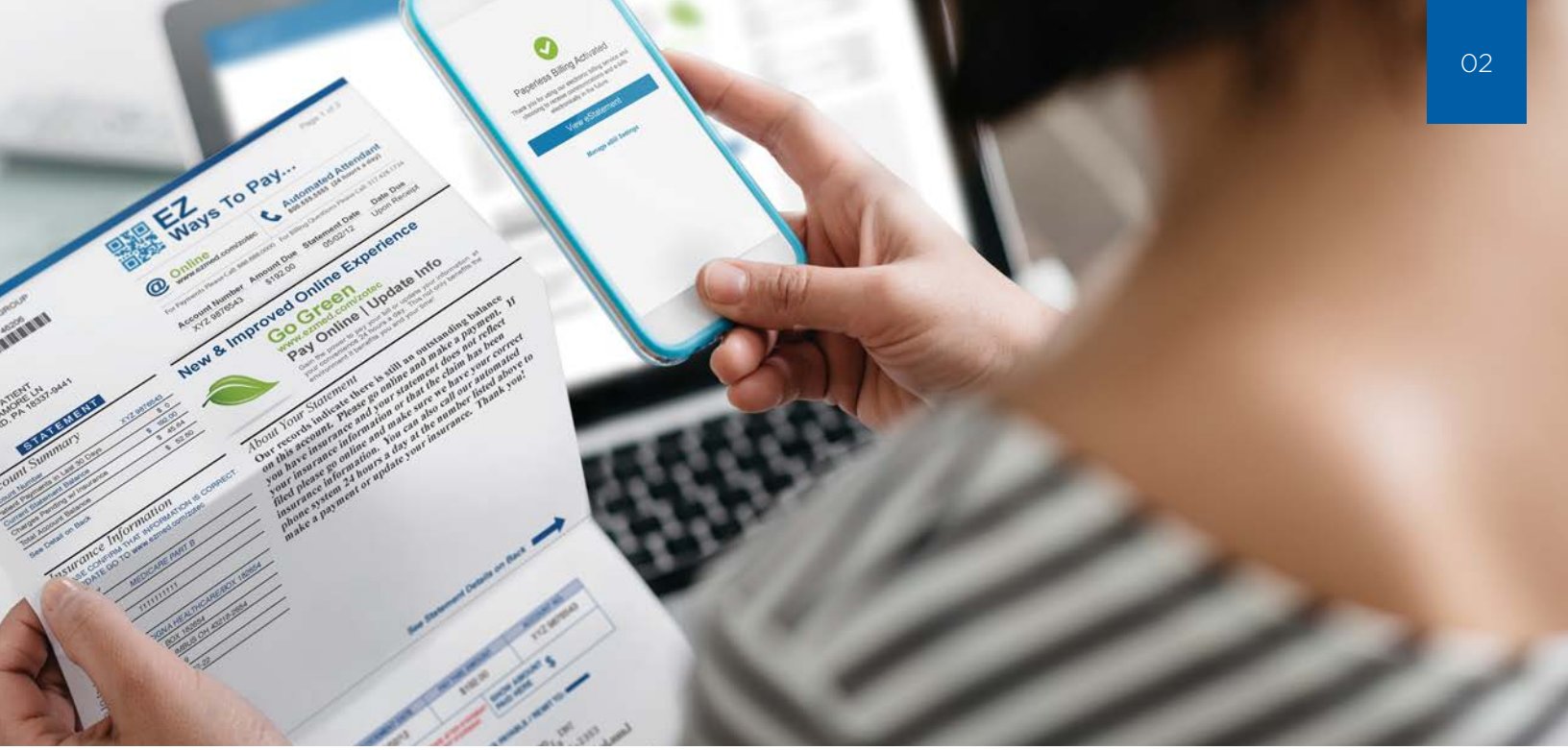
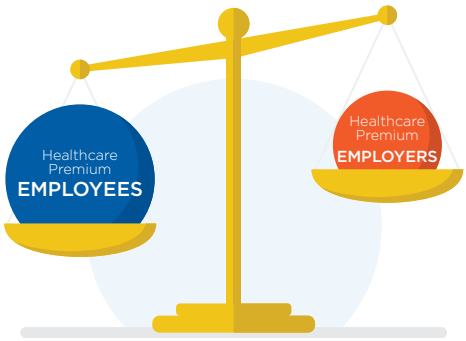


Patients Aren't Happy... What Can You Do?

The marketplace for health insurance has become increasingly consumer-driven, with important implications for the way care is delivered and ramifications for payment methodology. It is no secret that employers have increasingly shifted more healthcare premium costs to employees over the years, with smaller networks of providers and limited employer contributions. These changes, also accompanied by the emergence of private health insurance exchanges, have given employees additional health insurance options; upfront costs versus coverage, cost-sharing levels, and provider access are just a few. Likewise, in the individual and small group markets, the Affordable Care Act's (ACA) health insurance exchanges place the purchasing decision for health insurance coverage in the hands of millions more patient consumers. [1]

Revenue Cycle Management (RCM) organizations, as well as larger in-house RCM departments, need to adapt to this new landscape and either build or purchase technological solutions to assist providers and patients with more user-friendly payment capabilities. These are needed to collect money in a frictionless encounter, but also to ultimately enhance the patient experience, create satisfied consumers, reduce patient frustration, and boost satisfaction ratings – despite the challenges that providers face.



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Changes in Consumer-Driven Healthcare

The new form of consumer-driven healthcare is delivered through high deductible health plans (HDHPs) and consumer driven health plans (CDHPs), which are plans that come with a health reimbursement arrangement or health savings account. Both types of health plans come with lower premiums and higher deductibles than a traditional health plan. These plans have often been thought of as a form of coverage intended for catastrophic events, and their adoption rates have been growing since their inception in 2004, not only with increasing employer options, but also due to increasing government options. [1] However the design and impact of HDHPs is still not widely understood, and continues to plague clinicians and patient-consumers alike. [2]

As medical groups take more money directly from patients due to HDHPs, they also take on increasing amounts of bad debt as patients default on outstanding balances. Even before patients default on outstanding balances, research suggests their frustration grows from the onset of the billing process.

Providers and RCM organizations that fail to prioritize the consumer will fall behind their competitors, both in terms of reputation and finances, because patient satisfaction is a core component of the value-based healthcare era. With the rise of high-deductible health plans, patient-focused care is here to stay and providers should continue to evolve and change if they are to thrive in this landscape. One of the ways to do so is using a blend of technology and processes to drive the revenue cycle.

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HDHP Statistics

As of 2016, HDHPs represented 29% of the total covered workers in the United States. [3]

In 2016, covered employees had an average deductible of $1,478 for single coverage, up from $1,318 in 2015. [3]

Average deductibles in the Marketplaces in 2016 amounted to $5,765 for bronze plans and $3,064 for silver plans. [6]

The HDHP model of consumer care has taken shape due to rising deductibles and copayments, according to data from the Kaiser Family Foundation. Additionally, many covered workers have copayments. [3]

Health insurance premiums are projected to increase by 5% in 2017 for employees. [7]

The number of consumer payments to healthcare providers increased 193% between 2011 and 2014. [5]

In 2016, 15.5% reported difficulty paying medical bills in the past 12 months. That compares to 10.3% of adults with a traditional health plan. [4]

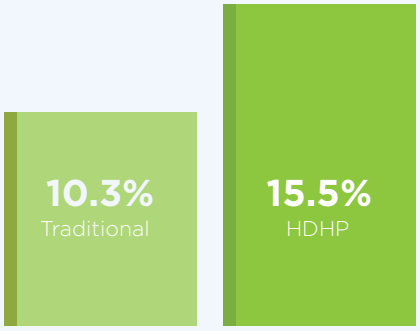
The percentage of privately insured American adults aged 8 to 64 with high deductible health plans (HDHP) has risen from 26.3% in 2011 to 39.3% in 2016 (an increase of nearly 50%). [4]

The HDHP Impact

HDHPs have forced institutions to become more consumer-conscious, changing their entire business models, as patients do their own price shopping and research in order to better understand their options. [8] But with HDHPs, patients have also began to forgo or delay care due to increased cost sharing, which often leads to patients presenting to health care providers and institutions later on in a far worse condition. This pattern has a negative effect on the supply side of health care, lessening the volume and revenue that physicians are able to generate. It also means that, later on, the burden and intensity of care per episode could be much greater and expensive. [9]

According to a recent study by the National Center for Health Statistics at the U.S. Centers for Disease Control and Prevention (CDC), both employer-provided policies and policies purchased by individuals are seeing significant recent increases in use of HDHPs. This is not surprising because HDHPs are less expensive than health insurance policies with lower deductibles and other patient-paid out-of-pocket costs. However, HDHPs become expensive when used, as the higher deductibles, copays, and other expenses like potentially higher prescription drug costs can easily overwhelm a typical person or family's budget. In fact, among privately insured U.S. adults with HDHPs in 2016, **15.5 percent reported difficulty paying medical bills in the past 12 months. That compares to 10.3 percent of adults with a traditional health plan.** [4]

Difficulty Paying Medical Bills



15.5 percent reported difficulty paying medical bills in the past 12 months. That compares to 10.3 percent of adults with a traditional health plan. [4]

According to the Employee Benefit Research Institute, HDHPs are still less popular than traditional health plans, but the margin isn't as askew as it was ten years prior. The report states that employees have grown more satisfied over time with high-deductible health plans and consumer-driven health plans (or those that can be paired with a health-savings account), however both kinds of HDHPs are still below 50 percent satisfaction rates, which means there is still a very large number of employees who don't like these plans. [9]

The trend doesn't show signs of stopping, either. According to a recent study from the National Business Group on Health that polled 133 companies, **health insurance premiums are expected to increase by 5 percent in 2017 for employees.**[7]

The Business-to-Business-to-Consumer Payment Model (B2B2C)

RCM processes are not what they used to be. In this increasing business-to-business-to-consumer payment model, providers have to send the insurance company a claim and get it adjudicated. The insurance company may well come back to the provider saying a patient owes the deductible, so the provider then bills the patient for that deductible while the insurance company provides the allowed amount in the remit.

Does that sound complex? It is. Especially since research from the Employee Benefit Research Institute also suggests patient consumers could be frustrated before they even have a medical encounter, due to a lack of transparency about the cost of medical procedures and a lack of understanding about their HDHP deductibles.[9] This in turn creates friction in the billing process, and could have a negative impact on patient satisfaction ratings. So now, there are patients that are less happy with their healthcare benefits, coupled with the fact that they are scared and in need of medical services.

What is a Patient's Propensity for Friction?

Today's buzz words in medical billing revolve around the patient's "propensity to pay," but as important is whether a patient has a "propensity for friction". **Friction can be defined as any irregularity to an otherwise smooth payment process.** For example, when hospitals or physician groups fail to effectively document encounters and/or obtain the necessary information from patients to avoid payer denials, they risk creating diversions in the payment process that can harm the patient-provider relationship and create friction. If a patient calls and complains, that might be considered as a friction point in the RCM process, which also depends on how clean the data is, how the carrier processes the claims, or the ability of a patient to pay. Friction is any exception to the payment process. In the context of this example, data shows that 30 percent of all claims are either inappropriately denied or inappropriately paid. Of that 30 percent, half of claims are not followed up on. In those cases, a provider is essentially walking away with nothing.[10]

30% of all claims are either inappropriately denied or inappropriately paid. Of that 30%, half of claims are not followed up on.

Patient satisfaction ratings fall by an average of more than 30% from post-discharge through the billing process.[12]

Friction...From the Beginning?

With the rise in premiums and deductibles, it's not far-fetched to think that many patient consumers are unhappy about the billing process even before they have a medical encounter, which could create friction right from the start. Not only that, research suggests there are many reasons why patients are refusing to pay their bills.

The billing experience is directly and increasingly germane to overall patient satisfaction, mainly due to the fact that it is the last interaction – and impression – a patient has with the provider. If the experience is negative, it could impact whether or not the patient will return to that provider in the future.[11] The influence is not usually positive — **patient satisfaction ratings fall by an average of more than 30 percent from post-discharge through the billing process.[12]**

Medical bills, with their many known complexities, have created low expectations among patients believing they are not accurate, which in turn gives patients a reduced sense of responsibility for paying them. In fact, in a McKinsey & Co. Research Study, 40% of patients do not pay medical bills simply because they do not understand them. (13)

The amount of the deductible also affects the outcome of patient payments, according to an analysis of 400,000 claims by the Advisory Board, which found that the higher their deductible, the less likely patients are to pay what they owe. While more than two-thirds of patients with a deductible of less than $1,000 were likely to pay at least some portion of what they owe, just 36 percent of those with deductibles of more than $5,000 did so, the analysis found. (14)

As a result, providers and their RCM partners have a responsibility to help patients navigate through these complex billing and insurance processes. Patients that are satisfied with billing are five times more likely to recommend an organization than those who are not. (15) Equally important is a thorough and open process whereby RCM companies can report on all metrics, such as patient wait time, first call resolution, self-service rates and contact quality. Recording calls also serves to mitigate any negative perceptions hospitals and physician groups may have about how the patient is treated, additionally, it serves as a training method to minimize patient friction moving forward.

Deductibles of less than $1,000

Two-thirds of patients were likely to pay at least some portion of what they owe.[14]

Deductibles of more than $5,000

Just 36 percent of those with deductibles of more than $5,000 did so.[14]

Meeting the Trends: The RCM Response

In today's fast-paced consumer healthcare environment, providers aren't the only ones who should be meeting consumers where they are. Companies like Zotec that specialize in revenue cycle management and patient experience methodologies can (and must) also begin to offer easier and preferred payment functionality by tracking patients' propensity to pay. RCM companies also have a responsibility in creating solutions around this process, especially since they more deeply understand what's needed to make the revenue cycle run smoothly. That includes understanding preferred methods of communication each patient demographic prefers, in order to determine their propensity to pay, or their propensity for friction.

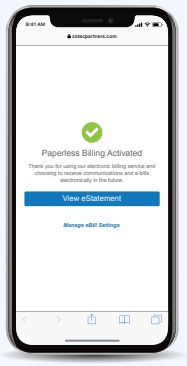
Driving reimbursement requires that RCM organizations avoid investing collection resources on accounts that, regardless of the efforts taken, either won't pay, or would assuredly pay anyway. Propensity to pay algorithms should identify accounts where extra efforts generate additional net cash returns, in other words.

The need to embrace the new consumer driven-reality also means a greater utilization of technology from RCM companies to collect as much up front as possible when appropriate. Bringing patients into the process much earlier also helps eliminate some of the missteps that can occur along the way with collecting payments. Processes in place during the time-of-service paired with understanding patients' propensity to pay is helpful and drives front desk staff through what is required, versus allowing them to decide.

How Technology and Processes Can Reduce Patient Friction

Technology can minimize the likelihood of friction on many levels. Claims denials are one example of ways that technology can reduce payment friction, due to inaccurate or incomplete information. Zotec utilizes proprietary edit engines to ensure claims have all the necessary information in order to be accepted into the adjudication policy of the carrier.

If providers successfully take advantage of RCM technology that has the ability to determine an estimated amount of friction, they can then fine-tune the best next steps to boost a patient's likelihood of paying. **For instance, millennial patients may want a text telling them to pay online. On the other hand, older patients over 70 may want to receive a text because their grandkids are texting, but they may still want to hand-write a check and mail that in.**



Text-to-pay

Traditional billing cycle

Time-of-Service Collections Can Bolster Reimbursement

Healthcare payments do not work the same way as other consumer-driven industries. For example, if an individual fails to make a credit card payment repeatedly, this would impact their Fair Isaac Corporation (FICO) score. Healthcare reimbursement solutions that use credit bureau data to determine a patients' propensity to pay is no longer acceptable, since if a patient does not make a payment for a healthcare service they received, this will not impact their FICO score, according to a recent Forbes article citing data from the Consumer Financial Protection Bureau (CFPB).[16] This makes it exceedingly difficult for providers to exercise disincentives when collecting payments.

Zotec believes in starting the billing process early with patients, educating them about their deductible and why they owe the money.

Zotec employs technology that educates providers and patients up front, which also leads to patients having a greater propensity to pay during the time of service and beyond.

For patients with credit scores below 550, propensity to pay ranges from 39% for account balances below $100 to 8% for account balances from $1,000 to $5,000. For patients with credit scores greater than 800, propensity to pay ranges from 98% for account balances below $100 to 97% for account balances from $1,000 to $5,000. Additionally, patients take their time to pay their bills in full, with mixed views between providers and patients on the amount of time in between.[17] A 2017 Navicure survey found 51 percent of providers say it takes an average patient more than three months to pay their full balance. However, only 18 percent of patients claim it took them longer than three months to pay their last balance, indicating a lack of consensus between the two parties on this topic.[18] To curb these issues, Zotec believes in starting the billing process early with patients, educating them about their deductible and why they owe the money. Instead of sending two or three statements in the hopes that patients will pay them, which is how providers have been used to contacting patients, Zotec employs technology that educates providers and patients up front, which also leads to patients having a greater propensity to pay during the time of service and beyond.

Beyond Time of Service

Follow-up protocols to patients, based on their propensity to pay or propensity for friction, are essential to collecting payment, and following up with the patient-consumer should go far beyond traditional methods, which used to include a statement, pre-collection letter and collection write-off. Patient outreach tools have the capability to generate improved patient revenues for physician groups.

Effective direct-to-patient outreach methods should include a dedicated patient portal, texting, and patient phone calls using a blend of live customer service professionals and interactive voice response technology woven into the traditional billing cycle of bills and statements. **Texting, for example, is a preferred method of communication for a large portion of patients, and using a platform that patients relate to will increase the likelihood for payments.**

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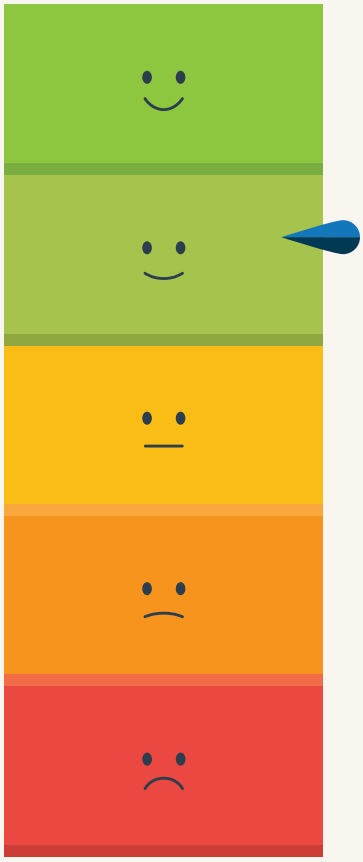
Direct-to-Patient Outreach Checklist

- ☐ Dedicated patient portal
- ☐ Texting support
- ☐ Live customer service professionals
- ☐ Interactive voice response technology
- ☐ Traditional billing cycle of bills & statements

There are also multiple ways for patients to pay for their bills, including the ability to set up auto-deductions from their bank accounts. Giving patients multiple ways to receive a bill, view and update their account, and make payment directly from their smartphones is key in these follow-up interactions, and giving physician groups the ability to connect with consumers – especially younger generations that conduct business from their personal devices – is revolutionary for the healthcare market.



Turning Patient Complaints into Compliments

Maintaining patient satisfaction is critical in today's competitive healthcare environment, with a large impact on volume and reimbursement levels for providers. **Many times patient satisfaction surveys are tied to a patient's clinical experience, but studies have shown that the billing process can also have a big impact on those results.**[19] As well, with a gamut of social media channels, patients have another platform to voice their opinions related to the healthcare service they receive. Generally speaking, unhappy patients are more likely to voice displeasure, than those who are satisfied and promoting great service.

In many instances providers typically have little to no contact with patients during the period after a medical encounter, aside from billing activities, which suggests a link between business office activities (including paper statements or communication about billing) versus a patient's overall impression of their encounter.

Effective RCM solutions employ a number of strategies to maintain and track patient satisfaction, from live customer service support to online reputation monitoring. Each strategy is a necessary component in monitoring and improving the patient experience.

Patient support

First and foremost, communicating with providers about ways they can directly address patient issues and inquiries helps resolve the patient escalation process quickly.

Often patients will also contact third party RCM providers directly, in which case support from live customer service representatives can also quickly and effectively resolve a patient inquiry or issue.

Online monitoring

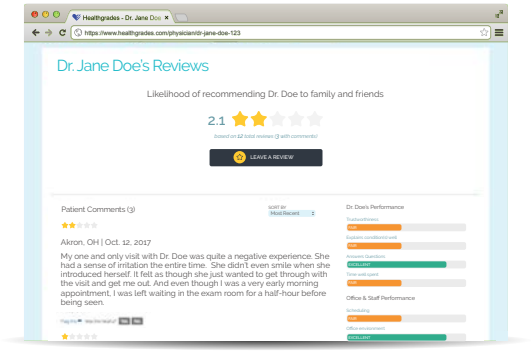
Given the immediate access to information from social media and online review platforms, RCM companies and their clients are facing the reality that public complaints can potentially damage an organization's reputation. The need to address and proactively manage patient complaints is a critical component of the patient experience, and too often overlooked or not considered by providers.

Monitoring online review sites such as Google Reviews, HealthGrades, and Yelp, as well as social media platforms such as Facebook and Twitter, gives doctors the chance to quickly address any negative feedback from patients, and potentially reverse the damage from a patient satisfaction standpoint.

In a recent 2016 survey conducted by SoftwareAdvice, 60% of survey respondents said it was important for doctors to respond to a bad online review. The same survey found that 84% of patients who post to the sites also use online reviews when evaluating physicians. What's more, 47% of respondents said they would opt for an out-of-network physician with comparable qualifications to an in-network provider if the former had more favorable reviews. (20)

Online reviews could also play a role in patient retention, since patients often research online review sites as a first step during the path to treatment, noted by 77% of respondents who said they used such sites before selecting a doctor, with quality of care being the most important review metric they considered when deciding which provider to use (28%). (20)

Tracking, quantifying, and reporting the online reviews can also help providers gauge areas of improvement in their business related to key performance indicators that directly tie back to patient satisfaction. With an online reputation management system in place as part of the patient experience, these performance metrics can enhance improvements related not only to the clinical side, but also the patient billing side of the equation, creating improvement benchmarks related to satisfaction ratings.



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Conclusion Summary

The dynamics of healthcare have changed, inserting the patient into the billing process more than ever before. This is just the start of consumer involvement, and providers must not only be in tune with patient proclivities, but also with the changes that are forthcoming as the healthcare industry tries to adjust to the market, which is constantly evolving. Having a greater understanding for their patients' propensities while using a blend of technology and processes to drive the revenue cycle is critical to ensuring success, especially since research suggests that more patients are frustrated even before they have a medical encounter. It is also vital that revenue cycle management (RCM) companies adapt to this new landscape, working closely with providers to offer technologies and processes with more patient-friendly payment abilities. Because patient satisfaction is now a core component in the value-based healthcare era, providers and RCM companies that don't make the effort to put their patient consumers first will lose their competitive edge, potentially damaging their reputation and finances in the long run.

So...your patients are unhappy. What will you do to collect payment with little to no friction in order to enhance the patient experience and create more patient satisfaction and increase your satisfaction ratings?

References

1) http://www.aha.org/research/reports/tw/14june-tw-consumerchc.pdf

2) "Understanding Marketplace health insurance categories". HealthCare.gov. Retrieved 7 July 2017.

3) http://www.kff.org/report-section/ehbs-2016-summary-of-findings/

4) https://nonprofitquarterly.org/2017/06/09/cdc-americans-high-deductible-health-plans-skyrocket-since-aca/, https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf

5) https://www.instamed.com/blog/trends-impacting-the-healthcare-payments-market/

6) http://www.kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/

7) https://www.cnbc.com/2016/08/11/expect-your-health-insurance-costs-to-rise-in-2017.html

8) http://www.heritage.org/health-care-reform/report/competitive-markets-health-care-the-next-revolution

9) https://www.axios.com/vitals-2471858768.html

10) http://www.beckershospitalreview.com/finance/21-statistics-on-high-deductible-health-plans.html

11) http://www.beckershospitalreview.com/finance/avoiding-friction-in-the-age-of-high-deductible-health-plans-how-innovative-solutions-can-help-providers-succeed.html

12) Karen Cheung-Larivee, "Billing Process Linked to Long-term Patient Satisfaction," Fierce Healthcare, December 14, 2011

13) http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/engaging-consumers-to-manage-health-care-demand

14) https://www.advisory.com/-/media/Advisory-com/Research/FLC/Resources/2015/CFO-Brief-POS.pdf

15) David G. Morrisey, "The True Cost of Alienating Patients," Physicians Weekly, August 23, 2012

16) https://www.forbes.com/sites/nickclements/2017/03/14/credit-scores-will-improve-as-credit-reports-exclude-negative-information/#7773338813df

17) http://www.healthleadersmedia.com/finance/consumerism-spurs-need-patient-credit-checks

18) http://www.beckershospitalreview.com/finance/survey-75-of-provider-organizations-offer-a-cost-estimate-upon-request-yet-less-than-25-of-patients-request-one.html

19) http://www.beckershospitalreview.com/finance/executive-briefing-how-billing-and-collections-impact-the-patient-and-what-providers-can-do-to-protect-their-bottom-line.html

20) http://www.softwareadvice.com/resources/how-patients-use-online-reviews/

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