Increasing patient obligation is creating a new economy in healthcare, one that is putting additional pressure on hospital margins. Without action, that pressure may erode net margins altogether.
The U.S. healthcare market is rapidly changing, particularly around the patient billing and payment experience. As patients become increasingly responsible for a larger portion of their medical bills, this has a direct impact on health system economics. Hospitals must learn to adapt in order to compensate for a fundamental change in revenue mix from payer to patient.

This white paper examines trends in the market and shares insights designed to optimize patient financial engagement in order to increase payments, drive yield, and improve patient engagement.
Patient obligation is on the rise—and there’s no sign of it slowing

A new healthcare economy is here, and it’s putting more responsibility on the shoulders of patients. Greater access to insurance through the Affordable Care Act and Medicaid expansion programs have increased overall health system revenues and decreased pure self-pay obligations. At the same time, the rapid expansion of high deductible plans nationally has drastically increased balances owed after insurance. Payment rates on these higher balances have consistently decreased over time. Patients with high deductible plans often face economic turmoil similar to the experience of being uninsured when an unplanned medical event occurs.

Out-of-pocket payments for insured patients were expected to grow from $250 billion in 2009 to $420 billion by 2015, a 68% increase in only six years.

This growing patient obligation is having a destructive impact on the bottom lines of health systems and consumers alike—and it can no longer be ignored. According to America’s Health Insurance Plans (AHIP), the growth in HDHPs is the major reason that out-of-pocket payments for insured patients were expected to grow from $250 billion in 2009 to $420 billion by 2015, a 68% increase in only six years.

Health insurance deductibles on the rise

Annual deductible growth through 2015, based on share of workers and employer size.

Source: Kaiser Family Foundation. Refers to single-coverage, employer-sponsored plans. Small employers are those with 3-199 workers, large employers are those with 200 or more.
The Self-Pay Gap

As patient obligation continues to surge, the effects on health system economics are profound. Not only is patient obligation rising, but the share of net patient revenue that is patient obligation is shifting as well. Without significant increases in the payment rate on patient obligation, health systems will see diminishing or even negative margins due to this dynamic alone.

In the example that follows, we show the impact to a typical health system of a shifting revenue mix due to rising patient obligation.

1. Revenue Mix
   (Post-contractual insurance adjustments)

   Current  |  Near Future
   ---      |  ---
   Patient  |  15%  |  20%
   Payer    |  85%  |  80%

2. Collected Revenue
   (Assumes a 40% payment rate on patient balance)

   Current  |  Near Future
   ---      |  ---
   Patient  |  6%   |  8%
   Payer    |  85%  |  80%

3. Patient Revenue Disposition
   (Assumes 40% bad debt and 20% charity rates)

   Current  |  Near Future
   ---      |  ---
   Payment  |  6%   |  8%
   Charity  |  6%   |  8%
   Bad Debt |  3%   |  4%

4. Total Expenses

   Current  |  Near Future
   ---      |  ---
   87%      |  87%

5. Cash Margin

   Current  |  Near Future
   ---      |  ---
   4%       |  1%

IN THE “CURRENT” SCENARIO:

- Patient revenue comprises 15% of total revenue
- Disposition of patient revenue is assumed at a common industry rate of 40% payment, 40% bad debt and 20% charity
- Assuming collection of payer revenue is, for illustrative purposes, 100%, total collected revenue is $91MM per $100MM of total revenue
- We assume $87MM of expenses to get to a typical cash margin of 4%

IN THE “NEAR FUTURE” SCENARIO:

- Patient revenue as a share of total revenue increases by 5 percentage points
- Holding all other assumptions constant, cash margin dwindles to only 1%
- Holding all-else constant, an increase of just 7% points (from 15% to 22%) in patient share of total revenue would create negative margin.
Yesterday’s ‘innovations’ are now table stakes

In the face of these challenges, the best health systems have implemented new tools and strategies to optimize the patient revenue cycle — but those approaches merely brought healthcare to the 20th century. Today’s 21st century consumer demands much more.

20th century solutions have focused on:

• Ensuring that online payment options and channels are available to patients
• Increasing the operational efficiency of those payment options and channels
• Optimizing work effort with generic scoring and operational segmentation
• Increasing front-end collection activities
• Creating a clearer, more efficient statement experience through paper statement consolidation

Hospitals are now banks, too

Whether they recognize it or not, most major health systems have unwittingly become the largest consumer lenders in the markets they serve. Given this reality, they are faced with two options for sustainability: operate more like a lender, or partner with a lender.

Operating like a smart and fair lender means:

• Focusing on yield (% of total patient obligation collected) in addition to operational efficiency metrics like ‘days AR’ and ‘days cash on hand’
• When appropriate, spending a little more in cost structure to collect significantly more cash
• Assessing interest to at least cover your cost of capital on longer term payment plans

Generating fair lender outcomes demands:

• Billing transparency — providing clarity and effective dispute resolution
• Payment flexibility — offering seamless payment options, not just channels, to disrupt traditional billing without impacting payer billing processes
  - Tailored and customizable financing plans
  - Tailored and customizable discounts

TO BRIDGE THE SELF-PAY GAP, HEALTH SYSTEMS MUST DRIVE YIELD

Online bill pay is a foregone conclusion.

Digital statements aren’t enough.

Patient portals and basic payment plans help save costs, but they’re only a part of the solution.

To survive the ‘payer to patient’ revenue shift underway nationally, health systems must drive patient payment yield.

And to do that health systems must engage consumers in a different way.

PATIENT BUSINESS “TABLE STAKES”

• Paper statements
• “Consolidated” statements
• Recurring payments (non-interest bearing)
• Online 1x bill pay
• Point of sale collections
• Mobile payments
• Generic scoring

A 1% point increase in patient yield is worth $2MM in cash collections per $1B in Net Patient Revenue*

*Assumes 20% of net patient revenue is patient revenue
Billing Transparency

Understanding a traditional medical bill is difficult and frustrating. For a single episode of care, patients often receive multiple and contradictory bills at different points in time. These bills are static snapshots of a highly fluid process and usually tell a disjointed or incomplete story leaving the consumer to contend with uncertainties on several fronts:

- Are insurance payments and adjustments accurately reflected?
- How about all non-insurance payments, such as co-payments?
- What happens when there is ‘found’ insurance or a late charge that changes the previous balance due?

Further, the patient is left to reconcile an array of bills with an equally confusing Explanation of Benefits (EoB) that may span a different time period entirely. And in the event the patient identifies a discrepancy, she then must place a call to the provider during business hours to resolve the issue. Traditional resolution processes often require multiple phone calls, a lot of iteration and in-depth transaction research, making things really difficult for a typical consumer to manage. This results in a painful billing experience and risks quickly undoing any patient goodwill earned during the clinical experience. Moreover, this is a cumbersome and costly process to maintain for the health system. And since consumers are unlikely to pay bills they don’t understand, nobody wins.

WHAT’S NEEDED TO CREATE A COMPELLING BILLING EXPERIENCE FOR CONSUMERS

- A point-of-service tool that provides patients with clarity on estimated patient liability and arms staff with the functionality required to manage up-front payment requirements and tailored financing offers
- A single platform that enables patient self-servicing and is available at any time from any online device for any account on any billing system maintained by a provider
- One interactive bill for a household or an extended household inclusive of all periodic charges
- An easy, HIPAA-compliant account consolidation tool so users can link or delink guarantors at will
- Visit-level summary information with drill-down capability to see line-item details
- Longitudinal portrayal of all charges, adjustments and payments since visit inception
- Automatic and dynamic balance and status updates refreshed daily
- Automatic alerts when changes occur so that consumers can immediately take appropriate action
- Easy dispute resolution functionality so consumers can make online inquiries and providers can quickly resolve disputed accounts
- Automatic offer management tools so providers can easily create unique experiences for each consumer
- Direct links to payer and HSA sites for easy reconciliation and balance tracking

In short, understanding a typical medical bill resulting from today’s three-party billing model is far more difficult than what’s demanded in nearly any retail environment. The healthcare billing process comes with nuanced complexities that are unlikely to change anytime soon, but health systems should not let these intricacies stymie their desired consumer experience.

Health systems must harness technology to deliver the modern billing experience consumers expect while automatically accommodating the realities of healthcare’s three-party billing model and overcoming the limitations of legacy billing systems.
Payment Plans

Most health systems offer some sort of payment plan option but practices vary wildly and offer limited opportunities for better patient payment outcomes. Providers are typically limited by their legacy billing systems which were built in a different era for a different purpose: payer billing. And financing offered to patients by third parties is of poor value to both the patient and the health system.

For some health systems, working with a lender and taking patient obligation off the balance sheet may be the best option, but only in cases where the provider maintains complete control of the patient relationship.

As health systems build payment plan capabilities, they should carefully consider:

1. **Health system economics:** How is the health system paid for assets (and how much)? Are third parties motivated to drive yield or just collect what would have been paid anyway? If assets are purchased, is it on a recourse basis (bad debt is returnable to the health system) or a non-recourse basis?

2. **Regulatory environment:** Are all payment plans FCRA and Truth in Lending Act compliant? Are payment solutions certified PCI compliant from end to end?

3. **Automation:** Does the third party solution automatically integrate with the core billing system to create a seamless experience for patients and little to no disruption for staff? Does the solution easily and automatically account for downstream finance plan balance adjustments?

4. **Patient economics & experience:** What are the terms offered to the patient? How much choice does the patient have? What control does the health system maintain over the experience? Is the provider-patient relationship enhanced or severed? What control does the patient have over the experience? Are terms transparent?

---

**PAYMENT PLANS & DISCOUNTS: CURRENT STATE**

Manual, not well governed, nor Truth in Lending Act Compliant

Billing systems severely limit credit risk management capabilities including interest assessment, loan duration, and other key terms

Third party financing is expensive to the health system, severs the patient-provider relationship and remains full recourse to the health system (i.e. no risk shift)

---

**PAYMENT PLANS & DISCOUNTS: WHAT’S NEEDED**

**Analytically Derived and Customized Offers:**

Offers to one patient should be different to another patient to accommodate different consumer needs and risk levels

Offers to one patient should vary over time as a patient’s context changes

**Example Automated Offer Variables:**

Automated discounts
Finance plan duration limits
Minimum payment amounts
Interest rates
Interest-free periods

**Example Differentiators:**

Insurance Carrier
Balance
Total Balance Outstanding
PTP (Risk) Assessment
Income Assessment
Account status in billing system (e.g. past due, prior BD, etc.)
VisitPay is the product of a passionate group of former consumer finance people now working for the good of the healthcare industry.

Our company was established after our founders made a discovery while working in revenue cycle management for a large health system. They found an entire industry that was using outdated and inadequate systems to manage patient revenue — making it impossible for providers to adequately service their patients.

We spent the next three years working closely with several health systems to identify and evaluate over 80 pain points imposed by today’s payer-focused billing processes. Then we applied proven thinking and approaches from consumer finance and payment processing to create a simple, powerful technology that fixes those issues without disturbing payer billing.

The result was VisitPay, the only online financial engagement platform that simplifies the entire billing experience for both patients and health systems — providing unmatched transparency, choice and control.