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INSIDE

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It Is Not Insurance, It Just Looks Like It: 'We Make Them Self-Pay'

Growing numbers of patients are handing over what looks like valid insurance cards to registrars; in reality, they have no coverage at all. These patients pay monthly premiums to healthcare sharing ministries.

"These plans definitely are a source of heartburn for us," says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Emory Healthcare in Atlanta.

The authors of a recent report looked at five healthcare sharing ministries, all of which include disclaimers stating that they are not insurance.[1] "But people *believe* they have insurance. They go into the hospital saying, *'Here's my card,'"* says **JoAnn Volk**, a co-author of the report.

Some members expect the plan to pay hospitals directly, just like insurance. However, patients submit bills to the plan and potentially are reimbursed for some portion of it — or not, depending on the circumstances. "At the very least, it confuses consumers," says Volk, a research professor at the Georgetown University Center on Health Insurance Reforms. Some plans stipulate that members must exhaust all other possibilities before submitting expenses to be considered for reimbursement. In some cases, plans are very specific: Patients must prove they were denied financial assistance from the hospital. In many ways, the plans closely resemble health insurance. "They have a safe harbor that says they are exempt from any insurance regulations, as long as they follow the letter of the law," Volk notes.

Some plan operators state that they have a network of affiliated providers who give steep discounts to members. "Even if there is a disclaimer stating it's not insurance, every other part of it looks like insurance," Volk says. Plans use terms like "provider network" and "schedule of benefits." They offer bronze, silver, and gold plans, the same terminology used to categorize plans purchased on the Health Insurance Marketplace. The plans stop short of calling payments made by members "premiums," referring to them instead as a "monthly share."

"They will not call it a premium, but it sure feels like a premium," Volk adds. Healthcare sharing ministries work out fine for some patients who submit bills, comply with the requirements, and receive some amount of reimbursement. "But many people are being aggressively marketed with radio ads during open enrollment," Volk explains. If someone cannot afford premiums, certain insurance brokers will offer the plans as a more affordable option.

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A high-deductible plan, while not ideal, still is insurance, Volk says. This gives the member certain rights. "You can appeal a denial. You can go to the insurance commissioner and say they are not following the contract," she says. "None of that applies to healthcare sharing ministries."

Wes Lindsey, senior director of marketing and communications at Medi-Share Christian Care Ministry, one of the five healthcare sharing ministries analyzed in the report, says, "We go to great lengths to explain the differences between Medi-Share and health insurance. The term 'healthcare sharing ministry' is reflective of numerous organizations, very much in the same way that the term 'insurance' is. Medi-Share is one organization, among many. Healthcare sharing ministries are a unique solution to more than a million Americans who need an affordable alternative. Healthcare sharing ministries are not for everyone, but for our members who appreciate this community approach to healthcare and the providers who serve them, it works."

For patient access, healthcare sharing ministries cause many issues. The first one is figuring out that the card presented is not really insurance. "Our clinic in particular has struggled to come up with a reliable protocol to manage these plans prior to when the patient presents," Kraus laments.

Staff conduct precertification during preadmission calls, which means they do not always see the patient's insurance card. "Our precert vendor sometimes is unable to inform us what sort of coverage a patient has," Kraus explains.

Certain plans are not healthcare sharing ministries, but they are not really legitimate insurance plans, either. "They may technically be valid, but cover very little. We often don't find this out until the claim is denied," Kraus reports.

Other times, the patient's insurance is fraudulent. Hospital policy states that in these cases, the patients are considered to be uninsured. "This is upsetting to the patient," Kraus says. Payment plans, financial assistance, and charity are some possible options. "It's no different from dealing with the underinsured population in general," Kraus says.

The problem becomes more complicated if coverage is not verified beforehand for some reason. This can happen because the system is down, or if a registrar simply neglects to do it. Registration is decentralized, so not all registrars answer to patient access. "Access tries to develop good working relations with such departments, with varying degrees of success," Kraus offers.

The hospital's insurance verification vendor has not been particularly helpful. Patient access submits insurance data during the preadmit process. Despite this, problematic plans are not flagged until after the claim is submitted. One obstacle is that some plans with next-to-no coverage are underwritten by known insurance carriers. "There is no reason in principle why they can't supply us with the benefits. But it's never that simple," Kraus says.

All this means that denials occur after the claim is filed. "The business office then has to deal with these accounts as they are identified in the collections process," Kraus explains.

Mary Rutan Hospital in Bellefontaine, OH, is seeing a surge of patients who are part of healthcare sharing ministries. "We are struggling to find solutions," says **David Kelly**, CHFP, MHSA, director of the revenue cycle. The patients come in thinking they have valid insurance. When told otherwise by registrars, they blame the messenger. "These plans are a big cause, in my opinion, of the increase in surprise bills in the news. But they aren't really being addressed by anyone," Kelly offers.

Most of the time, the problem is identified on the front end. Then, patients are treated as self-pay. For the

hospital, it is the lesser of two evils. "Accepting the 'insurance' often causes the plan to claim that you've agreed to their rates as reimbursement in full, which of course, without a contract, we don't agree to," Kelly notes.

The patient, newly classified as uninsured, is connected to a financial counselor. "It can definitely lead to surprise bills if we don't catch it on the front end and make changes on the back end," Kelly says. Sometimes, the problem is not caught quickly enough. Patients receive surprise bills, some of which go uncollected. "But, fortunately, we offer very generous payment plans," Kelly adds. "These prevent a lot of significant bad debt situations from arising." ■

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Once Hidden, Contracted Prices With Payers Will Be Posted

As of Jan. 1, 2019, hospitals have posted prices on websites. However, it turned out this change was of little value to consumers. Nevertheless, it is time for the next step: Soon, hospitals will be posting contractually agreed prices with payers.

"There is growing public outcry to disclose this information, both from patients and from self-insured employers," says **Ge Bai**, PhD, CPA, an associate professor at Johns Hopkins Bloomberg School of Public Health.

An executive order from the Trump administration issued on June 24 directs the Department of Health and Human Services to require hospitals and insurers to disclose negotiated rates for services and provide patients with out-of-pocket costs before procedures.[1] According to the order, "Shoppable services make up a significant share of the healthcare market, which means that increasing transparency among these services will have a broad effect on increasing competition in the healthcare system as a whole."

Neither hospitals nor insurers want this information out there. "Both sides claim that it is proprietary information and it would put them at a disadvantage in negotiations if it became public," says **Lovisa Gustafsson**, MBA, an assistant vice president at The Commonwealth Fund.

Making contracted prices public takes away hospitals' competitive advantage to negotiate with insurers for higher reimbursement. For insurers, the opposite is true; it makes it harder to negotiate lower prices. For this reason, contracts typically bar either party from releasing the rates publicly. "A change in law would supersede this and force them to make it public regardless of the contract language," Gustafsson says.

Disclosure of negotiated prices opens the door to comparison shopping. For elective procedures, patients can choose lower-priced hospitals. "Different insurers have different prices, and different self-pay patients end up paying different rates at the end of the day," Gustafsson notes.

However, the difference between contracted rates and rates charged to uninsured patients always has been top secret information. Once the rates are posted, that will change. Then, says Gustafsson, "we can have a discussion about if legislation is needed to put protections in place for patients from exorbitant self-pay bills." The contracted rates could provide a better benchmark for what reasonable prices should be for self-pay patients. "It would not, however, force hospitals to extend contracted prices," Gustafsson adds.

Some ambulatory surgical centers are disclosing their cash prices to compete for cash-paying patients. "To our knowledge, no hospital has done this," Bai reports. The executive order could change this. It is good news for some hospitals, the ones willing to compete with peers to provide patients with high-quality, low-price care. "But it's bad news for those hospitals that have gotten used to playing the price-gouging game built on price secrecy," Bai offers. Price transparency brings price competition, says Bai, "thereby reducing price, unless the hospital is a monopoly."

Even armed with new price information, patients will not be able to compare hospital costs as easily as the cost of a pair of sneakers. "A patient's visit to a hospital includes multiple services, what is customarily called an episode of care," explains **François de Brantes**, MD, MBA, senior vice president of

commercial business development at Remedy Partners.

Disclosed prices probably will be limited to individual procedures, according to de Brantes. "Hospitals should voluntarily post all-inclusive prices," he says. This could occur for common services such as joint replacements. Yet hospitals probably do not know all the information *they* need to create packaged prices. "They could work with their largest payers to come up with estimates," de Brantes suggests.

Ultimately, posting negotiated prices could work in the hospital's favor. "In an age of greater transparency, the advantage goes to those who disclose the most useful information to support consumer decision-making," de Brantes says.

Price transparency is popular among policymakers on both sides of the political aisle. The promise is that more competition will drive prices down. "It is a popular policy proposal being discussed on [Capitol] Hill during current cost control discussions," Gustafsson notes.

The discussion draft of legislation released in the Senate Committee on Health, Education, Labor, and Pensions included the establishment of a nationwide claims database, to be run by a nonprofit and include all prices paid *(http://bit.ly/2YksqaZ)*. "It is unclear how much this would help patients directly, as they may not be able to access the data themselves," Gustafsson says.

However, this proposal is one more step toward making the data available to policymakers, researchers, and purchasers. "Any efficiencies achieved through this would be passed onto patients through lower premiums or higher wages," Gustafsson says.

Once they are made public, negotiated prices could drive down prices for an entirely different reason. "There is a certain aspect of public shaming for a hospital that is making far more than anyone else," Gustafsson says. ■

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Hospitals Suing Patients for Unpaid Bills

Various hospitals are receiving media attention not for the care they provide but because of who they are suing — namely, their own patients. In addition to a little revenue, usually arriving in small negotiated payments over a period of years, these facilities are receiving bad publicity, too.

In Virginia, 36% of hospitals sued patients and garnished their wages in 2017 (an average of $2,783), according to a recent study.[1] In Connecticut, between 2011 and 2016, physician practices, hospitals, or collection agencies initiated 81,136 lawsuits in small claims courts against their patients to recover outstanding medical debts.[2]

"In my experience, people want to pay their medical bills," says **Andrew P. Cohen**, JD, a supervising attorney with Health Law Advocates in Boston, noting that certain patients simply cannot. "The amount owed and sheer number of bills from various providers can be very intimidating and, frankly, unaffordable."

Cohen says his firm has not seen hospitals suing patients over late bills. He attributes this to the state's Health Safety Net as a reimbursement mechanism, significant regulation of the hospital industry under state law, and a high insured rate. On the other hand, other types of providers (such as physicians' groups) do sue patients for uncovered medical bills. Increasingly, "skimpy" health insurance (higher deductibles, bigger copayments and coinsurance) puts more out-of-pocket burden on individuals, Cohen observes.

Better financial counseling would "absolutely help to prevent medical debt," Cohen offers. Many people end up with medical bills because of gaps in coverage when they should have been enrolled in a public program in the first place. "Hospitals need to utilize staff more proactively to screen patients for public program eligibility," Cohen suggests.

Screening patients in a timely manner can prevent medical debt because some programs cover bills retroactively for a limited time. "Even where a person is ineligible for public assistance, there are usually hospital-based charity care programs, even within for-profit institutions, that can help defray medical costs," he says.

Effective screening can engage patients in affordable payment arrangements. "Medical bills can be addressed up front before landing in collections," Cohen adds. ■

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Underinsured Patients Delaying Care

Of adults with health insurance, 29% were underinsured in 2018 (up from 23% in 2014), according to The Commonwealth Fund's Biennial Health Insurance Survey.[1] Those who bought plans on their own were most likely to be underinsured, with 42% reporting inadequate coverage.

"While rates of underinsurance are highest among people with coverage through the individual market, the greatest recent growth has occurred among people who have employer plans," says **Sara Collins**, PhD, lead author of the study and vice president for healthcare coverage and access at The Commonwealth Fund.

This is an important distinction, since 158 million Americans are insured by employer plans. People who are on an insurance plan all year, but are underinsured, are much more likely than those who are insured (but *not* underinsured) to delay or avoid needed healthcare because of the cost. "The drivers of this problem are high deductibles and cost-sharing relative to people's income," Collins explains. "This is leading many people to make decisions that are bad for their health."

Employers are offering plans to people with high cost-sharing to help lower the rate of growth in premiums. "But healthcare costs are the primary driver of premium costs," Collins says. In turn, those costs are determined by what private insurers pay hospitals and other providers. "To address the problem of underinsurance, we need to focus our attention on the overall cost drivers," Collins says. ■

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Formerly Limited, Patient Portals Offer More Online Options

About five years ago, Stanford (CA) Children's Health already had a patient portal in place at a time when most hospitals did not. The problem was patients could not do much with the system. "The only thing we had was some very rudimentary bill pay," says **Andrew Ray**, director of professional revenue cycle.

A third-party bill pay solution was used at the time. This caused problems because it was not integrated with any other systems used by the revenue cycle department. "It did a good job of transacting billing and payment information. But that was about it," recalls Ray of the third-party solution.

The portal wound up frustrating patients instead of helping them. Patients really wanted more control over their care, both clinical and financial. "We wanted to open that up more and didn't have the capability to do it. That got us moving toward the solution that we currently have," Ray says.

The organization had multiple electronic medical records (EMRs) and revenue cycle systems, but none of them were integrated. At the time, says Ray, "the level of investment it would have taken to have a single patient portal across all of those was daunting."

Nonetheless, hospital leaders decided to invest in a fully integrated patient portal. A single revenue cycle system and single EMR are now used across the entire health system. A "portal team" consists of a few IT employees. "The team does an awesome job in making sure we stay up to date on all the features and functionality," Ray notes.

Patients can pay bills, schedule appointments, and message their providers. "People want a single place to do all of that. They don't want to have 15 different logins," Ray says.

The patient access department at Paterson, NJ-based St. Joseph's Health is updating its payment portal. "Our patients love our portal, and we see it being used more and more," says **Sandra N. Rivera**, RN, BSN, CHAM, patient access director for St. Joseph's Health. The new portal will show outstanding balances and allow patients to set up their own payment plans.

At Stanford Children's Health, the portal experience continues to evolve; however, patients maintain ever-higher, even unrealistic, expectations. "People want their healthcare experience to be like making a restaurant reservation or checking into a hotel," Ray says.

Considering the complexities of a hospital bill, no portal can achieve this today. For now, Ray says the answer is a combination of portals and great customer service. Patient access staff and financial counselors field complex questions, either by phone or in person. Currently, about 5% of patients use the portal to schedule their own appointments.

"But this percentage is expected to grow as we expand," Ray adds.

New and existing patients can schedule primary care and obstetric appointments. Still, portals cannot answer all the questions patients ask about their hospital bills. "The way insurance benefits work have changed a lot in the past five years. I don't think patients are fully aware of what that means," Ray offers.

Some progress has been made with the level of detail provided in the portal. Initially, patients saw only a dollar amount. This did not work since there was no explanation about what the bill was for. Patients could not separate portions of the hospital bill to pay, either. Some just wanted to quickly take care of copays, but not the whole bill. In the first version of the portal, there was no way to do this. This meant the patient had to call in before *any* part of the bill could be paid.

"We started looking at the reasons patients were calling with questions," Ray says. Many calls involved setting up payment plans or recurrent billing, such as paying off a $5,000 balance over 12 months. Today, patients can do this themselves through the portal, which has eliminated about 15% of calls.

Overall, about 40% of patients are paying bills online. User-friendly graphics show how much insurance has paid already. "It helps patients to see *why* they have a balance in a way that's understandable to someone who doesn't work in medical billing all day," Ray says.

Lots of calls and frustration still come from bills that were not expected. "This is one of the biggest issues plaguing healthcare," Ray laments. Staff members are tweaking the portal to send more information to patients earlier. The goal is that when someone schedules an appointment, he or she also receives a good idea of what it will cost with their insurance factored in. "The big thing is trying to figure out how to use portals to take out the transactional part of the visit," Ray notes. "People appreciate doing some things in advance."

Many patients welcome the chance to sign consent forms or update addresses and phone numbers in the comfort of their homes. This also is a huge help to patient access in terms of productivity. "The more we are able to do that, the more we can open up time for the front desk personal relationship to become more interactive," Ray suggests.

Asking patients to sign multiple forms and correct outdated demographic or insurance information took up most of employees' time. Now, staff can offer price estimates and financial counseling. From the patient's perspective, this is much more important.

"The biggest sign of improvement has been decreased complaints," Ray reports.

Shifting rote tasks to portals is a way to keep up with outpatient volumes, which are growing about 10% annually. "Self-service tools are a way to expand our capacity without increasing staffing," Ray says. ■

Expect Scrutiny on What Registrars Say or Do Not Say About Charity Care

If registrars are not already well aware of the need to comply with charity care regulations, a recent announcement will get the point across. Hospitals in Washington state were required to pay $2.2 million in refunds, forgive as much as $20 million in medical debt, and work to repair the credit of thousands of low-income patients who did not receive charity care to resolve multiple lawsuits.

When it comes to 501(r) compliance, "there are a lot of hoops to jump through and all sorts of foot faults you can run into," says **Daniel J. Hennessey**, Esq., a shareholder at Stevens & Lee in King of Prussia, PA. Hennessey has developed policies and procedures on behalf of multiple tax-exempt hospitals. It is important to include registrars in this process. "Sometimes, it looks good on paper, but it's not feasible in real life," Hennessey notes.

The IRS is required to conduct a "desk" review of every tax-exempt hospital at least once every three years. "Some of those 'soft' audits have resulted in real audits," Hennessey says. There are some common issues that cause problems:

• Sometimes, the IRS notifies hospitals that one of the dozens of required elements is missing. For example, policies must specify the maximum amount the hospital can charge patients who qualify for financial assistance. "If that's not handled with care, that can result in a full IRS audit," Hennessey warns.

• Billing and collection procedures, and the types of actions the hospital can take in cases of nonpayment, are not always included in the hospital's financial assistance policy as required. It also is acceptable for it to be within a separate billing and collection policy, which investigators will want to see. "Oftentimes, that requirement slips through the cracks," Hennessey says.

• Financial assistance policies must indicate which providers in the hospital are covered by the policy. "That is the requirement we get the most pushback on from clients who ask, *'Do we really need to do this?'"* Hennessey reports.

Many providers are not covered because they are independent medical

staff physicians, not hospital employees. However, the status of individual providers can change continually. "Keeping that up to date and accurate is kind of a nightmare. Some hospitals have neglected to do that," Hennessey says.

Recently, the IRS clarified that hospitals can list departments or groups as opposed to listing every single individual provider separately. Quarterly updates are acceptable, too. "They've provided some leeway to the requirement, which was pretty stringent as it was originally written. But it's still an onerous requirement, to say the least," Hennessey says.

• Debt collection practices are noncompliant sometimes. "This is another area where hospitals could get into trouble," Hennessey cautions. Before undertaking aggressive debt collection, hospitals must make a reasonable effort to determine if patients are eligible for financial assistance. Hospitals have to wait 120 days after that point.

"But it's not enough to just let the time pass," Hennessey says. During this waiting period, there is much work for hospitals. Staff must send notices on the availability of charity care and document all efforts to contact the patient. "It's a balance between compliance and public relations and, also, cost/benefit," Hennessey says. At some point, hospitals might conclude that aggressive debt collection or litigation is simply not worth the cost.

Hospitals are responsible for what debt collectors do on their behalf. If the agency staff do something impermissible, says Hennessey, "It's the hospital that's held accountable."

Hospitals are ensuring their compliance with 501(r) in two ways, says **Laurice Rutledge Lambert**, JD, an associate in the Atlanta office of Baker-Hostetler:

• By using automated programs to determine a patient's ability to pay for services. If it indicates a patient has a low likelihood of being able to pay, the hospital will flag the individual as someone who may need financial assistance. "Usually, the hospital's financial assistance team will then reach out to the individual, either in person or by phone," Lambert says.

• By creating multiple touch points to ensure patients are aware of their financial assistance programs. Some hospitals leave no stone unturned spreading the word. Patient admission packets, signage in ED and outpatient waiting rooms, and billing statements all include it. "Doctors and nurses discuss financial options during the discharge process," Lambert adds.

Charity screening often is not performed or not handled correctly. According to Lambert, this happens for one major reason: lack of resources. Revenue cycle staff must determine if a patient is eligible for financial assistance or even just encourage patients to apply for it. Many hospitals simply do not have the resources.

"As a result, eligible patients are not aware of the program or do not apply for assistance," Lambert says.

The 501(r) regulations do not stipulate a certain dollar amount of charity care, or that patients with any specific income level must be given charity care. That is up to the hospital.

"But once the hospital determines the parameters, it must fall into line with all procedural requirements," Hennessey says.

That said, to qualify as a charitable institution, hospitals must maintain a reasonably generous charity care policy. "If it's drawn too narrowly, it could jeopardize your status as a charitable institution," Hennessey cautions.

There has been a long-standing debate on what is sufficient when it comes to charity care.

"The federal government has not promulgated a bright line requirement," Hennessey says.

Some states require specified amounts of charity care for hospitals to qualify for tax exemptions. Certain local taxing authorities, school districts, municipalities, and other parties have challenged hospitals' state tax exemptions on these grounds.

"In some cases, exemptions have been revoked," Hennessey says. ■

Focus on Charity Care 'Now More Than Ever'

Registrars at Cape Coral (FL) Hospital are seeing many more patients who are uninsured. Other patients are underinsured due to high-deductible plans. "We have an increased focus on charity care now more than ever," says **Jamie Bruner**, MHSA, manager of registration services. Patient access uses this process to identify the need for financial assistance early:

• Either the patient or the physician's office calls central scheduling to make the appointment. At that point, insurance has not been verified, making a second call from patient access necessary.

• Patient access calls the patient to review their coverage and out-of-pocket expenses in detail.

"Many patients do not have a complete understanding of coinsurance, deductibles, and copays," Bruner says, noting all this information is reviewed with the patient. "It is during this conversation that we learn whether or not the patient will need assistance through our financial assistance program."

For urgent or emergent services that cannot be postponed, staff complete the application on the patient's behalf. "We determine how much assistance we are able to offer," Bruner says. Patients receiving simple diagnostic services that

do not require an appointment are counseled at the time of service. Self-pay patients who come to the ED can complete a financial assistance application before discharge or admission. Patient access builds a relationship with the patient from the first impression forward. "We communicate that we care and are here to help," Bruner says. "Technology has greatly enhanced our ability to plan for patients who need a revenue cycle patient advocate."

The patient access team receives information faster than ever with automated processes and electronic price estimation tools. "We can better prepare and, in turn, better prepare patients for their expected out-of-pocket expense," Bruner reports.

Staff who financially screen, counsel, and educate patients are in a patient access team lead role already. These employees need two skills to succeed in their jobs: technical expertise and excellent customer service. "Only staff who are determined to be skilled for this type of financial counseling are used to assist patients," Bruner says.

Patients appreciate receiving a price estimate, financial counseling, and financial screening all at the same time. "This type of assistance should not be offered in a fragmented way," Bruner offers. ■

Financial Talks Do Not Always Start Smoothly

To really be transparent on hospital prices, good conversations are needed with highly trained, service-oriented staff. "Patients often feel overwhelmed. They don't fully understand the message that is being communicated," says **Kaylin Fogarty**, director of patient access at Tufts Medical Center in Boston.

Usually, when things go poorly, Fogarty says it is because registrars fail to properly introduce themselves, do not provide the patient with a clear purpose of the call at the beginning of the conversation, or start the discussion at the wrong time.

"We try to avoid having any financial discussions with patients close to their admission date," Fogarty explains. The night before an inpatient admission or surgical procedure is not the right time to talk about money.

"Often, patients are not aware of their cost-sharing," Fogarty says. Some are surprised (and skeptical) that they owe anything at all. "If this is the first time they are hearing this, they often question if the information is accurate," Fogarty notes.

Sometimes, patients receive false reassurance after they hear that a procedure is "authorized" by insurance. That does not mean it is going to be 100% covered. "It takes some additional explanation of how insurance plans are set up and how benefits can vary from plan to plan," Fogarty says.

Regardless of how upset or frantic the patient sounds at first, registrars try their best to stay calm and helpful. "Patient access team members really put themselves in the patient's shoes," Fogarty says. Staff members do not rush the conversation; they take time to listen to the patient. Then, they explain how the price was calculated. Sometimes, additional research is needed.

"It's important to explain any additional resources that may be available to the patient, including payment plans and secondary insurance," Fogarty says.

Staff bear in mind nobody wants an unexpected expense and do what they can to help. "Even though it may seem as though we have the hospital's finances in mind, we also have the patient's well-being in mind," Fogarty adds. ■

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