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The Future of Health Care

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The current environment is changing for health care, and providers and their collection partners should be ready to take on whatever the future brings. With the results of the presidential election and the start of a new year, the health care industry is facing some interesting times. Some of the key issues facing the industry are regulatory and legislative issues on state and national levels, as well as media scrutiny. The current state of the health care industry brings more opportunities for partnerships between providers and collection agencies. At ACA International's Fall Forum in November, experts discussed the potential changes on the horizon and guided attendees through what is likely to happen.

Increased Self-Pay

Health care providers are currently seeing reduced insurance reimbursements and higher health care costs drive up self-pay accounts.

"In the past, the hospital self-pay wasn't as important when hospitals were focusing more on third-party insurance," said Tom Gavinski, vice president of health care at I.C. System, Inc. in St. Paul, Minn. "But today, providers just can't afford to ignore that self-pay because they need every dollar of reimbursement they can get."

The growth of patient self-pay receivables is expected to continue, so providers will need to adapt their practices to handle the growing volumes.

"We're making sure our staff is trained appropriately, ensuring our processes are current and accurate and there's no room for mistakes," said Kelly Howard, director of central accounts receivable services at Intermountain Healthcare in Salt Lake City, Utah. "We score our accounts and focus on those with the ability to pay."

Partnering with an agency for collecting outstanding medical debt can also help providers manage their self-pay accounts.

"We've had very good success outsourcing our accounts to collection partners, and we're able to focus more on self-pay," Howard said.

Increased Media Scrutiny

Last year, the actions of Accretive Health drew massive media attention. Not only did the situation increase anxiety and vulnerability for health care providers and their collection partners, the attention created a national wave of proposed standards on how patients should be treated within the health care market. State and federal legislators and regulators are paying close attention to patient collection activities, and providers must learn how to function under intense scrutiny.

Howard said that working with state and federal regulators is something her company has always done, so they have a long-term system in place to assist them when a media crisis or situation should arise.

"Intense media attention has not been a problem for us and presents no new challenges," Howard said. "A significant challenge, though, is dealing with policies directly related to health care reform, which has also led to increased media and special interest scrutiny."

Howard noted a key strategy for her company is their deliberate efforts to stay out of the political landscape and health care debates. Rather, Intermountain continues to reinforce a positive

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Health Care Law Delivers Higher Payments to Primary Care Physicians

Health and Human Services (HHS) announced the final rule implementing the part of the health care law that delivers higher payments to primary care physicians serving Medicaid beneficiaries. The new rule raises rates to ensure doctors are paid the same for treating Medicare and Medicaid patients and does not raise costs for states.

The final rule implements the Affordable Care Act's requirement that Medicaid pay physicians practicing in family medicine, general internal medicine, pediatric medicine and related subspecialists at Medicare levels in Calendar Years 2013 and 2014.

The payment increase goes into effect in January of 2013.

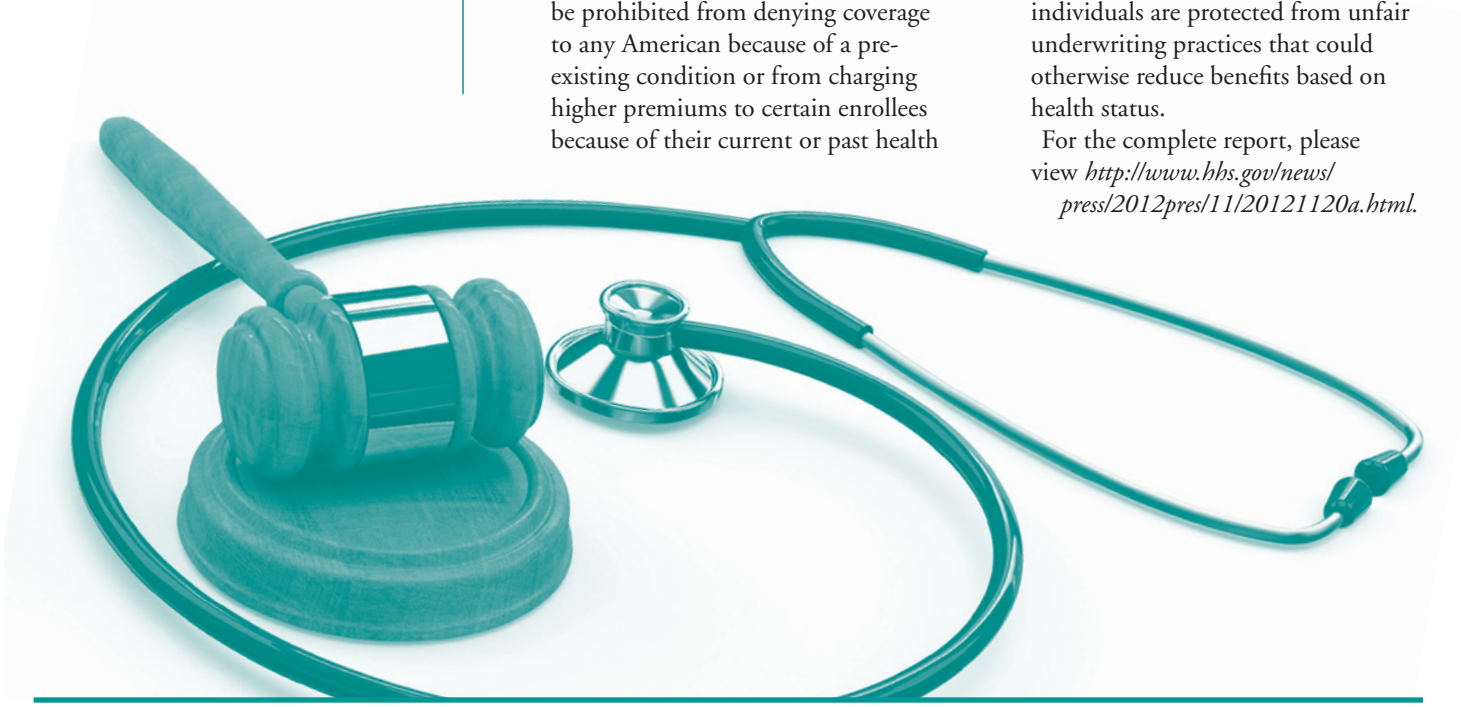
Obama Administration Moves Forward to Implement Health Care Law

On Nov. 20, 2012, the U.S. Department of Health and Human Services announced that the Obama administration moved forward to implement provisions in the health care law that would make it illegal for insurance companies to discriminate against people with pre-existing conditions. The provisions of the Affordable Care Act also would make it easier for consumers to compare health plans and employers to promote and encourage employee wellness.

The Obama administration has issued the following:

- A proposed rule that, beginning in 2014, prohibits health insurance companies from discriminating against individuals because of a pre-existing or chronic condition. Under the rule, insurance companies would be allowed to vary premiums within limits, only based on age, tobacco use, family size and geography. Health insurance companies would be prohibited from denying coverage to any American because of a pre-existing condition or from charging higher premiums to certain enrollees because of their current or past health problems, gender, occupation, and small employer size or industry. The rule would ensure that people for whom coverage would otherwise be unaffordable, and young adults, have access to a catastrophic coverage plan in the individual market.
- A proposed rule outlining policies and standards for coverage of essential health benefits, while giving states more flexibility to implement the Affordable Care Act. Essential health benefits are a core set of benefits that would give consumers a consistent way to compare health plans in the individual and small group markets. A companion letter on the flexibility in implementing the essential health benefits in Medicaid was also sent to states.
- A proposed rule implementing and expanding employment-based wellness programs to promote health and help control health care spending, while ensuring that individuals are protected from unfair underwriting practices that could otherwise reduce benefits based on health status.

For the complete report, please view *http://www.hhs.gov/news/press/2012pres/11/20121120a.html.*



Report Compares Insurance Coverage Between Workers in Large and Small Firms

According to a Commonwealth Fund report, 49 percent of workers in companies with fewer than 50 employees were offered and eligible for health insurance through their employer in 2010, down from 53 percent in 2003. In comparison, 90 percent of workers in firms with 100 or more employees were offered and eligible for health insurance in both 2003 and 2010.

Report findings:

- Low-wage workers are more likely to report skipping needed health care due to cost, and also to report higher rates of medical bill problems, compared to higher-wage workers. In 2010, 54 percent of low-wage workers in small businesses skipped needed health care because of cost, compared to 34 percent of higher-wage workers. Low-wage workers also reported higher rates of medical bill problems, with 52 percent in small firms and 48 percent in large firms struggling with medical bills.
- Buying insurance on their own is often not a viable option for workers who cannot get health insurance through their employer: of workers who shopped for plans on the individual market, 34 percent found it very difficult or impossible to find the type of coverage they needed; 55 percent found it very difficult or impossible to find an affordable plan; and 28 percent were turned down, had a health condition excluded, or were charged a higher price based on their health.
- Workers in small firms were more likely to be dissatisfied with their health insurance, with 29 percent rating it fair or poor, compared to 16 percent of those at larger businesses.
- Workers in larger firms had more choice when it came to selecting a plan—66 percent reported having two or more to select from, while only 36 percent of workers in small firms reported having a choice of plans.

To view the complete report, please visit *http://www.commonwealthfund.org/News/News-Releases/2012/Nov/Only-Half-of-Workers-in-Small-Firms-Offered.aspx.*

The Future of Health Care

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public image of its health system, and quietly and effectively manage their lobbying efforts.

Like the collections industry as a whole, the health care market is becoming increasingly interested in managing relationships with consumers, media, regulators and legislators. Providers are trying to proactively address the preconceived ideas that hospitals are charging too much for health care or not properly caring for the less wealthy.

"It's frustrating for health care providers when they're trying to do their jobs, yet they have to deal with such intense scrutiny from everybody," Gavinski said. "That's why it's important for collection partners to be able to preserve the brand of hospitals and maintain their reputation to minimize the complaints and scrutiny."

Provider and Agency Partnerships

When working together to collect health care debt, providers and collection agencies must carefully balance patient satisfaction and paying the bill.

"When we outsource accounts to an agency, the biggest piece for us is making sure they support our mission, vision and values," Howard said. "It's important to find the appropriate balance between collections, customer service and quality. They must provide excellent customer service, but have good collection tactics as well."

Collection agencies are generally viewed as an extension of the health system they are working on behalf of. The way patients are treated by collection partners reflects back to the providers. A patient can have a positive experience with the hospital and a great clinical outcome, but then when it comes time to pay the bill and the account goes to collections, the whole experience can easily turn sour if handled inappropriately.

"Patient satisfaction is going to be much more critical as the health care model moves from a volume-driven model to a quality-driven model," Gavinski said.

Collection partners can help fill a void for providers by helping them accomplish collection efforts that they are unable to do themselves, especially in areas of new collection technologies.

"We do a great job with the clinical side of business, but we cannot stay on top of technology. When an agency comes in, they need to be able to do things better," Howard said. "They should have everything available to make collecting more efficient."

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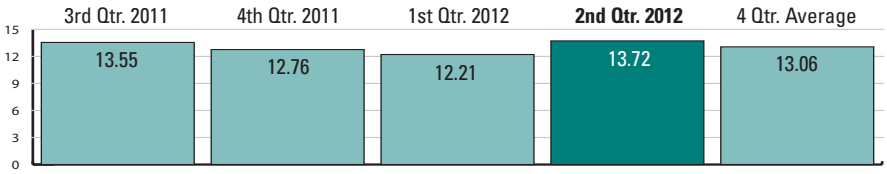
DATA WATCH

Average Cost to Collect

U.S. hospitals took a day and a half longer to submit claims in the second quarter of 2012, pushing the discharge-to-bill (DTB) average to 13.72 days. The bill time benchmark is to submit claims within ten business days, and hospitals have been unable to hit that benchmark for over a year.

With another bump in the DTB time average, U.S. hospitals also were unable to hit the benchmark for the most recent four-quarter period. The most current four-quarter bill time average now stands at 13.06 days.



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