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Health Reform's Impact on Accounts Receivable Partners

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After years of speculating about the viability of the Patient Protection and Affordable Care Act (the Act), the U.S. Supreme Court issued a landmark decision on June 28, 2012, largely upholding the health care reform, including the highly controversial individual insurance mandate.

The mandate will require most individuals to obtain health care coverage by 2014, or face a tax penalty. Individuals who do not have access to affordable employer health coverage will be eligible to purchase coverage through health insurance exchanges.

As the nation braces itself for change, accounts receivable professionals have mixed feelings on how the reform will affect health care collections moving forward.

"I don't think anyone has a definitive idea on how reform will affect any part of the health care system, let alone health care accounts receivable management," said Kevin Hough, president at Corpra Care Inc., in Houston, Texas. "The one item that stands out to me is that there is nothing in the Act about not having patient payment responsibility as a part of the revenue stream."

Now that the Act is affirmed, questions have increased about how this will impact the volume of accounts placed with collection agencies, average account balances and the collectability of such accounts.

"I foresee a higher volume of services with more patients insured, which will mean a higher volume of patient responsibility through co-pays and co-insurance, which are usually smaller balances," said Irene Hoheusle, vice president of collections at Account Recovery Specialists, Inc. in Wichita, Kan. "Though I also see higher balances of personal pay accounts due to higher deductibles."

Alternatively, Mark Edwards, president and CEO of Credit Bureau Systems, Inc. in Paducah, Ky., stated, "We expect to see fewer large balance accounts, and we may very well see fewer accounts in general as the not-for-profit hospitals rely more and more on scoring and propensity to pay models to meet their charitable care obligations." He added, "The fundamental shift in who is considered to be indigent under the Affordable Care Act will have a significant impact on account volumes as well."

Edwards stated that, in Kentucky, it is estimated that 294,000 new patients will be eligible for Medicaid the first year of implementation. Under the Act, a family of four with a household income of $94,000 will be eligible for Medicaid.

"That's quite a departure from the current federal poverty guidelines and the charity thresholds of most hospitals," Edwards said. "It will have an impact on account volume."

Brian Watkins, president of Southern Oregon Credit Service, Inc. in Medford, Ore., also predicts that overall account volume may decrease as more individuals and families are moved into government or capitated plans.

"Those with commercial plans will likely continue to see their deductibles increase," Watkins said. "This means larger balances for the working class, but less bad debt overall."

Many predict that reform will lead to a rise in deductibles and patient responsibility, hypothesizing that some individuals may need to resort to higher deductible health plans with less coverage, which will result in greater out-of-pocket expenses.

"After 2014, deductibles will probably be much larger in order to keep premiums lower," Hoheusle said. "There will be more self pay, especially on patients that used to have lower deductibles that now have double or triple the responsibility they had before."

Edwards also stated that he believes that the new insurance coverage requirements related to pre-existing conditions and the flood of newly insured citizens who have not had health care insurance before, who may be less healthy than the currently insured population, may drive up insurance premiums.

The ability of employers to either begin or continue to provide health insurance coverage to their employees will greatly impact the future of health care accounts receivables.

"The Act will affect the way corporations plan their futures, and thereby affect our economic recovery," Hough said.

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Report Compares Federal and State High-Risk Pools

The Affordable Care Act's Pre-Existing Condition Insurance Plan (PCIP) is the temporary, federal high-risk health insurance pool that will provide coverage to uninsured individuals with pre-existing health conditions until 2014, when new health care exchanges become available.

According to a Commonwealth Fund report released in mid-September, while the PCIP is serving its purpose as a "bridge" program until 2014, the program's high costs and relatively low enrollment numbers indicate that high-risk pools are not a viable long-term solution.

High-Risk Pool Experiences

Until exchanges are implemented in 2014, individuals with pre-existing conditions who are unable to buy coverage have two alternatives for purchasing health insurance. The choices are the federal PCIP, which is administered either by individual states or the federal government, or a state-based high-risk pool if they live in a state that offers them.

The report finds pronounced differences in how each program is structured and in the composition of enrollment. The federal PCIP is designed to offer immediate coverage to uninsured people with serious health conditions. There is no waiting period for coverage and premiums do not exceed the current market cost for a healthy individual. In contrast, state-based high-risk pools are somewhat harder to access, as they often have waiting periods and premiums that are as much as 200 percent of the average paid in the local individual market.

Both the federal and state high-risk pools operate at a loss because enrollees are sicker and the premiums paid are not enough to cover their medical costs, requiring significant subsidies to keep the programs running.

Still Unaffordable for Many

According to the report, an estimated 11.6 million uninsured Americans meet the criteria for high-risk pools. However, enrollment is only a fraction of that, indicating that premiums may be prohibitively expensive.

The PCIP does not subsidize premiums, and only a few state high-risk pools offer premium support for those with low incomes. However, the report predicts that once the insurance exchanges are up and running in 2014, premiums will become more affordable, as subsidies will be offered to people with annual family incomes below $92,200 for a family of four.

Moving Forward

The report finds that despite varied approaches to running high-risk pools, the outcomes are essentially the same: enrollment is low, and enrollment costs and plan operation costs are high, demonstrating the limited viability of these pools as a long-term solution. In contrast, the subsidized health plans that will be offered through exchanges created under the Affordable Care Act, the law's substantial expansion in eligibility for Medicaid, and new rules that prevent insurers from charging people more or limiting or denying coverage based on health will create pools large enough to offset and absorb enrollees' health care costs.

Growth in Family Health Premiums Outpaces Growth in Wages and Inflation

Annual premiums for employer-sponsored family health coverage reached $15,745 this year, with workers on average paying $4,316 toward the cost of their coverage, according to a recent survey from the Kaiser Family Foundation/Health Research & Educational Trust. This reflects a 4-percent increase in premiums from last year.

Although this year's rise in premiums is low compared with other years, it has outpaced the growth in workers' wages (1.7 percent) and general inflation (2.3 percent).

The survey also revealed significant differences in the benefits and premium contribution of workers in lower-wage firms (at least 35 percent of workers earn $24,000 or less per year) versus higher-wage firms (at least 35 percent of workers earn $55,000 or more per year).

According to the survey, workers at lower-wage firms on average pay $1,000 more each year out of their paychecks for family coverage than workers at higher-wage firms ($4,997 and $3,968, respectively), despite the fact that lower-wage firms pay less on average in total premiums.

In addition, the survey found that workers at lower-wage firms are more likely to face high deductibles than those at higher-wage firms. Specifically, 44 percent of covered workers at lower-wage firms face an annual deductible of $1,000 or greater, compared with 29 percent of workers at higher-wage firms.

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Under the Affordable Care Act, if larger companies do not provide sufficient health care coverage for their employees, they will have to pay a fine of $2,000 per employee not covered. In some cases, paying the fee may be less expensive than the company providing insurance for employees. Additionally, while the Act affords a tax credit to small employers who provide health coverage to their employees, the credit may not be enough to temper the employer's cost of coverage.

"We will continue to see deductibles escalate as employers try to keep costs under control," Watkins said. "The outcome of the reform will force more and more employers to choose to drop their insurance plans."

Edwards also predicts that more employers will choose to discontinue providing insurance to their employees, shifting more employees to the public option polices.

"This course of action could result in more accounts with a lower average balance than we are seeing now," Edwards said. "But it won't necessarily result in higher recovery rates due to the culture shift in American society that now presumes health care is an entitlement."

Watkins forecasts that recovery rates will also be tied to the employment rate.

"Balances will only be more collectible than they currently are if the employment outlook improves," Watkins said. "People have to have jobs in order to pay their bills."

To adjust to the volume and types of accounts collection partners may see after reform, adjustments may need to be made to scoring models and collection tactics.

"Scoring models could change, but the most significant impact will be in the area of tactics used to collect payment from the consumer," Edwards said. "Health care consumers who thought the Affordable Care Act meant free health care are going to be in for a rude awakening. Collectors are going to have to recognize the frustration that comes from that realization and counsel much more than demand."

Watkins stated that he believes that if account balances increase, payment-in-full will be less likely and a greater emphasis will be placed on working to establish payment plans. According to Hoheusle, collectors will need to look even closer at patient demographics and employers to determine collectible accounts and legal activity may increase in an attempt to recover payments.

Although no one can predict the absolute impact health reform will have on the health care and accounts receivable industry, some foresee new opportunities.

"I do see opportunities for our industry in the areas of presumptive charity assessments and eligibility screening, which will require many agencies to modify their business models," said Kecia Kesler, president and CEO of Account Recovery Specialists, Inc. in Wichita, Kan.

Some providers are preparing their organization for the potential influx of accounts that may occur and any extra administrative work that may come from the Act.

"We have already positioned ourselves to do more first-party billing and outsource work," Watkins said. "Part of the Act's requirements is for providers to cut administration costs, which may provide opportunities for collector partners in the early-out environment."

Until the new health care law is in full effect, it is hard to say for sure what the impact will be on patients, providers and their collection partners.

"One thing I do know," Kesler said, "is that the landscapes of traditional health care and health care collections are changing dramatically."

Number of Uninsured Declines

The U.S. Census Bureau's report, Income, Poverty and Health Insurance Coverage in the United States: 2011, showed that the number of people without health insurance coverage declined from 50 million in 2010 to 48.6 million in 2011. The number of people with health insurance increased to 260.2 million in 2011 from 256.6 million in 2010.

According to the report, the percentage of people covered by private health insurance in 2011 was not statistically different from 2010, while the percentage of people covered by government health insurance—both Medicaid and Medicare—increased. This was the first time in 10 years that the rate of private health insurance coverage had not decreased.

The Census Bureau's report also found that while the uninsured rate did not change for all age groups, there was a decline for people aged 19-25, 35-40, and 65 and older. Additionally, the uninsured rate for households with annual income less than $25,000 was higher (25.4 percent) than for households with income of $75,000 or more (7.8 percent).

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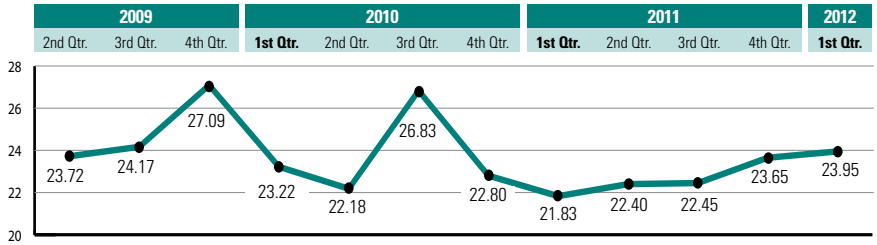
DATA WATCH

A/R Aging Up Again

U.S. hospitals reported a higher level of aging accounts receivable (A/R) in first quarter 2012, the fourth consecutive quarter in which the percentage of A/R aged greater than 90 days was on the rise. Nationally, hospitals reported 23.95 percent of total first quarter 2012 A/R was aged more than 90 days, up from 23.65 in fourth quarter 2011.



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