BILLING CHALLENGES - HIGH DEDUCTIBLE HEALTH PLANS AND OUT OF CONTROL COPAYMENTS

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As if the business of medicine didn't already present enough challenges for practices, the advent of high deductible health plans and rapidly increasing insurance copayments has created another layer of difficulties for billing. High deductible health plans (HDHP) have gained popularity in the past few years as employers have looked for ways to reduce the cost of employee benefits. Participation with a qualified HDHP is also a requirement for Health Savings Accounts, Health Reimbursement Accounts and other tax advantaged options.

We are also seeing a significant increase in the copayment levels that are part of insurance contracts. Copayments of $40 to $60 are now common. In some cases, the copayment is actually higher than the allowance by the insurance company for the service that was rendered. Both of these trends have put an additional burden on front desk staff and billing personnel to collect funds as early as possible in the process to avoid impacting the cash flow of the practice.

The introduction of health maintenance organizations (HMO's) and preferred provider organizations (PPO's) in the 1970's initiated the concept of copayments for medical services. Previously, in most cases, patient responsibility was in the form of coinsurance, a percentage of the allowable amount as determined by the insurance company. Initially copayments were low – in some cases even zero. Over the past thirty years, we have seen a gradual increase to the level that they are at today. Physicians haven't seen an increase in reimbursement as a result of higher copayments, rather insurance companies now pay less. The following example illustrates how this works. Insurance Company XYZ allows $52.00 for a 99213, a level three follow-up visit for an established patient. If the patient has a $10 copayment for their plan, the patient will pay $10 and Insurance Company XYZ will pay $42. If the patient has a $50 copayment for their plan, the patient will pay $50 and Insurance Company XYZ will pay $2.

Failure to collect copayments at the time of service not only delays cash flow but also add expense to the practice. Industry estimates show that the cost of sending a bill to a patient is $7.50 per bill. This includes the cost of the bill, postage and staff time. We strongly suggest that patients be asked to pay their copayment prior to the time they see their physician. We know of practices that will refuse to see patients in non-emergent cases when the patient is unwilling to pay their copayment. Front desk staff have heard every possible excuse as to why paying the copayment isn't possible. We suggest that practices make it as easy as possible for patients to pay in the office which means accepting both credit and debit cards. There are many new credit card processing companies offering medical practices low pricing for accepting credit and debit payments. Many practices have begun to charge patients a "billing fee" of $10 to $20 if they fail to make their copayment at the time of service.

Patients with high deductible health plans present another challenge. For calendar year 2010, the minimum deductible is $1,200 for single coverage with a out-of-pocket maximum of $5,950. In order to accelerate cash flow, we recommend that practices determine the deductible status of patients with HDHP as of the day that they are seen. The patient should be asked to pay for any services that would be applied to the deductible. This avoids the practice waiting to have the insurance company respond to the claim, stating the service was applied to the deductible and then billing the patient.

Both of the scenarios above should be addressed in the Financial Policy of the practice. We recommend that every medical practice have a Financial Policy which outlines the patient's financial obligations. The Financial Policy should be presented to every new patient and it should be a requirement that the patient sign and agree to the terms.

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The Financial Policy should include the following:

1. Requirement of copayments to be paid at time of service.
2. Payment requirements for patients with no insurance.
3. Type of payments accepted in the practice - cash, check, credit and debit cards.
4. Fees that will be charged for returned checks.
5. Submission of claims to insurance carriers is done as a courtesy to patients, but ultimate financial responsibility resides with the patients. The Financial Policy will outline those insurance companies with whom the practice participates.
6. Availability of payment plans for patients who cannot afford to make payment in full.
7. Obligations of patients with respect to referrals and pre-certifications.

Practices can tailor their Financial Policy to their specific needs and requirements. We believe that a Financial Policy will be of significant benefit to practices as they face new challenges in collecting balances from patients.

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