

Consumer-driven Healthcare: Essential Points and Players

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DEFINING THE CONSUMER-DRIVEN PATIENT

The most representative definition of the “consumer-driven patient” is literally one that has open access to all providers, no longer selecting a physician solely from a list of “preferred providers.”

Consumer-driven healthcare is most often associated with a health savings account (HSA) but can also have a high-deductible plan without the benefit of an accompanying HSA. It is not uncommon to see deductibles in the thousands, arguably deeming this as “under-insured” or even “self-pay” in some situations or specialties.

The consumer-driven patient makes independent decisions and tends to perform intelligent, in-depth research while selecting his or her doctor. The patient pays attention to advertisements and speaks with friends and co-workers to compare physicians before actually being seen.

HOW HEALTH SAVINGS ACCOUNTS WORK

An HSA is an established tax-deferred fund to be used only for healthcare expenses as qualified by IRS Publication 502, along with a high-deductible health plan. With an HSA, some requirements are more liberal than those of its predecessor, the Medical Savings Account (MSA). For instance, the list of expenses that qualify as medical expenses with an HSA are more liberal than with an MSA.

An HSA is permanent and portable. You take it wherever you go, and access it as long as you have a high-deductible health plan in place. In addition, an important feature of an HSA is that either the employer or employee or both can contribute to the account.

To establish an HSA and have continued access to that account, a health plan with at least a \$1050 deductible is required. Both the deductible and allowable HSA contributions change annually. The maximum contribution allowed in 2009 is \$3000 for individuals and

\$5950 for a family. There is also a catch-up allowance of \$1000 for those that are 55+.

Once you reach age 65, all non-medical withdrawals are subject only to income tax. But any withdrawals considered non-medical before age 65 will result in a penalty.

There is, of course, an annual form to be completed at tax time and filed with one’s return. The list of qualified expenses is liberal, and at times it is seemingly left up to the account holder to truly determine the actual validity of the cost. Consider this: under the qualified heading there is the item: “Transportation—essentially and primarily for medical care.” So if an individual travels to a foreign country for an orthopedic procedure and has surgery immediately before or after a vacation in that country, it would be very easy to “justify” the airfare, hotel, etc. as qualifying, therefore listing it as a deduction on his or her annual tax return. For a more detailed list of all qualified medical expenses, consult IRS Publication 502.

Another important factor worth considering about HSAs is that a minor cannot have his or her own account and is normally included under the parent’s funding. Imagine a mother and small child sharing an account. It is already challenging enough to finance one HSA account, let alone two patients sharing the same fund. This common scenario places pediatric practices, for example, behind the eight-ball, especially when dealing with patient receivables.

MOMENTUM AND CONSIDERATIONS

There have been a few minor setbacks, but there is no doubt that HSAs and high-deductible plans are gaining momentum. The Bush administration was very enthusiastic regarding HSAs as evidenced by the Tax Relief and Healthcare Act of 2006 allowing for penalty-free rollovers of IRAs or other deferred income accounts to an HSA.

We have seen that about one out of every four employers is either considering or adopting high-deductible and/or HSA plans, mostly with the potential of substantial savings with premiums. How long this popularity will continue is another question, and depends upon the specific population as well as national trends toward more standardized coverage for all citizens. President Obama has certainly given healthcare top priority.

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PATIENTS' PERSPECTIVE

In the past, some patients have spent more time choosing a pair of jeans than selecting their physician. In addition, there is now an entire generation of patients who have only known co-pays and a list of physicians to choose from. These patients suddenly have a financial responsibility 100 times more than they are accustomed to. Think of the \$20 co-pay exploding to a \$2000 deductible. This is scary on every level. You will need to furnish patient education to assist with these changes. Just as with any other service, none of us want to pay unless and until we have to. This is the perfect opportunity to offer your assistance to determine a patient's responsibility while conveying your policies.

Another challenge is a decrease in appointments and an increase in no-shows. We have recently seen this pattern due to the economy. With the huge sticker shock, your patient with the mild cold may forego treatment until it turns into pneumonia. This was also typical of patients in the 1980s and 1990s with high-deductible "catastrophic" plans. Practices may see a higher percentage of no shows, especially for follow-ups. For example, the classic question, "If my throat feels better, why should I go back?"

Let your Web site speak for you as patients research during evening hours when you are not directly available. As prospective patients explore current physicians' offerings on a regular basis online, make sure your Web site is continually updated with seasonal and other information specific to your population.

It's a new day—with patients looking for healthcare that is a value each step of the way with each encounter. They want to feel that they are truly being cared for as individuals—not just run through a system of impersonal protocols. This is a challenge as offices downsize in the effort to become more efficient with time and staff.

Customer service is absolutely huge. When you go into a department store, you notice when an employee greets you and when he or she does not. Clearly then, the value of your front desk staff cannot be underestimated. Often the first patient encounter, how the receptionist treats each patient on the phone, in person, and even in an e-mail is a determining factor of patient satisfaction. You may be the most stellar physician in the world, but an inappropriate employee can cost you more than you think.

We have also seen that patients now want to be more involved in the partnership of care as they want to ensure they get their money's worth. This approach actually adds to and enhances continuity of care, letting the patients be a more pivotal part of their personal healthcare experience.

PREVENTION AND ROUTINE WELL CARE

Consumer-driven plans often have certain covered services that patients may not be aware of. These services

are often paid at 100% before the deductible comes into play and are referred to as "First Dollars" and "Safe Harbor" [IRS Publication 502, section 223(c)(2)(C)]. As with everything else, each plan is different. Employers should inform their employees of that benefit, if available. Some examples of safe harbor preventive care screening services are:

- Well physicals;
- Substance abuse;
- Pediatric hearing or vision screenings;
- Screening for vision and hearing disorders in adults, treatment for hearing impairment in older adults; and
- Mammography and other preventive services.

WHO ELSE IS MARKETING TO THE CONSUMER-DRIVEN PATIENT?

Patients are hungry for resources and want to understand how this coverage works. Supply now meets demand—there is marketing everywhere—from CNN to your child's elementary school cafeteria. Information can often empower the patient to make the choice, focusing on options offered regarding procedures, self-triage, and of course, promoting the latest product that will help maintain and improve one's health.

When comparing your office with others, every other practice is now a resource for your patients, including urgent care facilities and self-pay practices. Retail medicine is absolutely fascinating and growing. These clinics are easy to access and often located in drugstores, so an individual can go shopping while his or her spouse is seen by the practitioner.

News channels present informative programs during weekend mornings, when your patients can receive self-help information. Add to that the direct-to-consumer marketing that pharmaceutical companies participate in via periodicals, television, and free samples.

Due to gatekeeper policies and low co-pays, the marketing approaches of many practices have become relaxed. Updated strategies demand that physicians indeed must compete for patients—existing as well as new.

Along with other actions, we need to focus on marketing strategies and tools that are patient interactive, such as Web sites, patient schedules, access, patient portals, and so forth.

Your role is to ensure that your practice and physicians are an imperative and trustworthy part of every existing and potential patient's decision making.

WHAT DO PAYORS HAVE TO SAY ABOUT CONSUMER-DRIVEN PLANS?

The payors' take depends upon whom you are talking to and the perspective that they are approaching from (e.g., utilization vs. negotiating with a physician for

higher reimbursement). Some payors state that not only is there lower utilization of emergency department and inpatient care, but their subscribers also tend to remain in network. Decision making is simplified when it means that the patient bears the financial responsibility for services received.

But when it comes to negotiating new contracts for physicians, payors state that consumer-driven healthcare is killing them because reduced premiums transfer to reduced income to the insurer.

One question to consider: At what point will insurers consider cost-shifting of rising premiums from a sicker population that tends to choose a co-pay HMO environment versus a healthier individual that may opt for a higher deductible? Insurers are going to have to shift that cost somewhere at some point.

MEDICAL TOURISM: A REAL COMPETITOR

In just the last three years, the number of U.S. citizens opting to go abroad for medical procedures has grown exponentially, from 500,000 in 2006 to 750,000 in 2007; by 2010, some predict up to 800,000 people will travel outside of the country for healthcare.^{1,2}

Some of the featured destinations for this type of care are Costa Rica, Greece, Thailand, and India. People have been traveling to Greece for healthcare since ancient times. India actually sees it as a growth industry.

In fact, some U.S. employers contract directly with physicians in other countries to perform major procedures, such as surgery. For example, one can go to India, visit the Taj Mahal, then have a procedure—or two or maybe even three. This is followed with a two-week “recuperation” vacation, and it’s still cheaper than having the procedures performed in this country. This is your competition.

Medical tourism Web sites often bear a resemblance to a travel guide—complete with pictures of palm trees and offerings of spouse and/or companion packages. One valid concern is the follow-up—more specifically, complications that may arise after returning home. The answer? Some companies are building in longer stays allowing ample follow-up time.

Medical tourism is accessible and more than affordable for most—a real contender and competitor for all patients.

CASH FLOW, ACCOUNTS RECEIVABLES, AND COLLECTIONS

With consumer-driven care on the rise, there are more high-deductible patients in play. This makes it more complex for managers to balance patient care and compassion with financial policies and collecting directly from the patient.

Let’s first think about the front desk. Your current staffers who are comfortable asking for a co-pay may not

be as comfortable asking for \$50 or \$200 or more at the time of check out. You may need to modify staff roles so that those most qualified and comfortable with asking the patients for their portion are directly involved. In this new scenario of high deductibles, your month-end reports will become ever more important as you analyze patient balances due. In the end, it will result in more concerted efforts on a daily basis with more patients.

We all know too well what it is like to collect at any point beyond the actual date of service. This has a huge impact on your cash flow and can immediately affect the bottom line. Payor agreements vary greatly with rules on collecting from a high-deductible subscriber—your patient. Some payor agreements state that practices are only allowed to collect \$50 or nothing at all until the payor has remitted the initial claim. There are also clauses that state that you may collect money as long as it has to do with the benefits administration, which, of course, it does. One can clearly see the mixed messages involved. A lot is left to interpretation. Here is one way to be aware of and proactive with patient amounts due: As you are authorizing benefits or confirming eligibility of patient benefits and referral procedures, confirm the deductible amounts met thus far at the same time.

Billing staff will need to stay on top of patient balances, which is a challenging mission requiring labor-intensive protocols on a daily basis. Being proactive and establishing payment plans from the beginning will help prevent some of the loss and better monitor patient receivables.

WHAT MEDICAL PRACTICES CAN DO TO HELP PATIENTS

The main thing to remember is that this is relatively new to both patients and staff. Patients want to be seen, you prefer that patients be seen, but you also want to maintain your ability to pay your electric bill. We can all work together toward this goal.

- Work with your patients to determine and educate them about their financial responsibility; this is incremental in the success of patient collections.
- Stress to your patients the benefit and importance of remaining with one group or physician for continuity of care, especially in primary care.
- For those patients with reduced or no prescription coverage, consider having enough samples to lessen their new financial burden. This is also a good way to keep your patients.
- Think of the individual that’s looking for a doctor at 8:00 at night. Make it easy for the patient to find your policies on your Web site. The more information you have on the Web site, the friendlier and the more accessible you are, the more apt the patient is to work something out.

- Consider adding a patient portal on your Web site, where a patient can pay his or her bill and set up a payment plan 24/7 without a phone call or conversation taking place.
- Inform patients with a high deductible of their responsibility and what your office policy is regarding their coverage. An excellent conveyer of your policies is “information while on hold,” which can be very productive while you have that captive audience. Here’s an example: “For patients with health saving accounts, be sure to call our billing office to confirm your plan and available benefits.” This is very accessible and welcoming.
- Provide copies of printed policies in the waiting room. Patients may not read everything, but if it is sitting there, they just may grab it.
- Provide privacy, not that little nook in the hallway where you have the doctors sign things throughout the day, for conversations regarding payment arrangements. Pride is one of the strongest emotions, and often it is not identified or it is disregarded due to our chaotic schedules.
- Document payment plans with original signatures. Patients will take a signed document more seriously than a casual conversation at the check-out desk. One option for a payment plan is to document the patient’s credit card information and charge the agreed upon

amount monthly according to the patient’s instruction. Just be sure to keep the credit card information in a locked and secure location.

- Consider referring patients to a bank, lending agency, or healthcare credit card agency to work with those larger balances. Patients may feel better about dealing with a bank than with their doctor’s office. And it takes it off your plate.
- Be aware of payor contracts, and note what financial information you can disclose to your patients. Realizing that the patient is shown the allowable on his or her explanation of benefits, seriously consider informing the patient exactly what’s due.

We all know that your first priority is the patient. Be accessible. Patients are very, very loyal to those that help them. This new coverage with a twist is another bump in the road that you will deal with until the next thing comes along. Your goal is to continue to provide stellar care while patients adapt and enjoy a strengthened partnership with their physician. ■

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