High Deductible Health Plans: Increasing in Popularity with Consumers and What That Means for Hospitals

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To date, the Affordable Care Act (ACA) has resulted in an estimated 32 million newly-insured Americans since 2010; nearly one-third of which purchased coverage through exchanges. On the surface, it appears that this would be nothing but positive news for health care providers, as their ability to collect for billed services should be enhanced with more insured consumers seeking care. However, taking a closer look at the plans the newly insured are choosing reveals a growing issue in collections for providers: the increasing popularity of high deductible health plans (HDHPs).

Users of the insurance exchanges and corporate consumers of health insurance are starting to shift their health plan choices toward higher deductible options. The tiered structure of offerings on the exchanges allows consumers to choose their plans based on cost. This is leading to an increase in popularity for HDHPs which typically include lower upfront premiums but higher total costs for many services. The number of HDHP enrollees rose to nearly 17.4 million in January of 2014, up from 15.5 million in 2013, 13.5 million in 2012 and 11.4 million in 2011; an average annual growth rate of approximately 15% since 2011.1 As consumer preferences shift further towards these HDHP offerings, the need for hospitals to adapt their billing and collection strategy increases; otherwise bad debt and charity care could evaporate profits. Coinciding with the increasing interest of HDHP among consumers, more employers are offering HDHPs, and in some cases offering only HDHPs, to help control costs. This trend is expected to continue as companies react to the new laws governing their benefits and try to find ways to manage the increased cost of expanded coverage while avoiding penalties such as the “Cadillac” tax. The result is increased financial burden for patients and changes in their ability to pay and their willingness to forgo treatments due to cost.
Figure 1 demonstrates HDHP enrollment levels as a percentage of total enrollees, both on and off the exchanges. The data, collected by the U.S. Department of Health and Human Services and eHealth, Inc., capture both new and existing consumers of health care plans from the ACA open enrollment periods (Oct. 1, 2013 through March 31, 2014, and Nov. 15, 2014 through Feb. 15, 2015).

Silver, bronze and catastrophic plans contain deductibles that meet the IRS 2015 definition of HDHP. Of these new HDHP consumers, many are forgoing the typical mitigants for high deductibles such as health care savings accounts and flexible spending accounts. The consumers purchasing coverage on the exchanges are more likely to forgo savings accounts and in many cases are not even given the option. According to the National Center for Health Statistics, 36% of Americans under age 65 with private health plans are enrolled in an HDHP, and only one-third of those consumers are enrolled in plans linked to health savings accounts. With the out-of-pocket costs for patients increasing due to the popularity of HDHPs, and with so few purchasers taking advantage of savings plans, the risk of bad debts and charity care increases for health care providers.

As consumers become responsible for a greater portion of their health care costs, hospitals will see their role as collection agent grow. The need for an effective billing and collections department will result in increased overhead and more expenses for providers. Patients who receive services may be unable or unwilling to pay their high deductibles, putting further pressure on hospitals due to lost revenue from bad debts and charity care. Some patients may even go as far as deferring or avoiding preventative care, prescription medications and other treatments due to costs, resulting in even more lost revenue for hospitals.

How are Hospitals Coping?

Hope for hospitals is not lost, however. There are still benefits to the increased number of insured consumers and the preference for HDHPs is only another challenge for the industry as the effects of the ACA settle in. Many hospitals and systems have already started to put in place new programs and processes to offset some of the effects of HDHPs. Point-of-service collections, requiring whole or partial payment at the time of the
appointment, are becoming an increasingly popular way for hospitals to collect payments for procedures and visits. Some providers are offering medical bill financing services, either directly or through partnerships with third-party banks and lenders. These services allow consumers to make smaller payments over time to control the burden of upfront costs, often for negotiated total amounts with little to no interest.

Most hospitals are placing an increased focus on their collections services by implementing new processes and programs to help improve billing and collections departments. Additionally, having discussions with the patient about costs throughout the entire treatment process is important. Many providers have found that focusing on communication and consumer education with regard to health care decisions, both treatments and coverage options, has created better results with both patient satisfaction and bill collection. In cases where costs to collect become too burdensome, there are an increasing number of outsourcing options that providers can consider.

With risks on the horizon due to the growth in HDHPs, it is time to revisit charity plans and examine how bad debts are treated. Charity care plans will need to start incorporating patients that technically have health insurance but are currently unable to afford the full deductible to pay for their care. Communicating with patients from the beginning of treatment plans can lead to mutual agreement about payment plans and increase the likelihood of whole or partial collections. The billing discussions can lead to better budgeting on a per-patient basis and a more accurate forecast of charity care and bad debts. Forecasting, budgeting and managing the collections could be improved through separating the HDHP accounts from other insured patient accounts.

Guidelines should be established to determine how to set up payment plans, what incentives to offer, and how much of total cost could be forgiven. Identifying which patients qualify for income-based reductions, as well as those that would benefit from financing plans, can enhance efforts to recover outstanding billings. The more providers understand about their patient’s individual health care plans and financial situation early in the treatment cycle, the more accurately the provider can determine a collection plan and budget for discounts and assistance. Consideration should also be made to better define the distinction between charity care and bad debts. Providers will need to better understand and document what portions of outstanding statements are from HDHP patients, and when those amounts become bad debt and need to be written off.

What Does this Mean for Financing?

Because of the new challenges to revenue and collections in the health care space, lenders will become more focused on accounts receivable and census mix. Providers need to be aware of the shifting focus and make sure they are paying attention to those variables. Revenue management will be more closely tracked by ratings agencies, lenders and anyone looking at hospital credit. Historically, a lender’s focus on receivables has been on the aging schedule and net collections from the different payer sources. With the evolving landscape of insured private-pay patients, lenders will begin paying more attention to the charity care plans and analyzing bad debts. Being able to determine when a debt becomes uncollectable, distinguishing between the different types of payers and understanding the payment plan schedules will be an important conversation between lenders and providers.
Clear, defined processes and strategies regarding billing and collections from private payers have become essential for those involved in health care financing. It is important for providers to be aware of the challenges brought on by changes in health care plan preferences and to start implementing strategies to combat those risks.

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