Health Care Consumerism
"The Human Element"

Presented by
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About the presentation

- As healthcare financial leaders, we are focused on the creation of and the accelerated collection of net revenue.

- In this new age of consumerism and the need to attract and satisfy customers, we need an additional focus on:

The Human Element

- What is it that the patient wants ?
- What is it the patient expects ?
  - relative to the delivery of care for the price they are being asked to pay.

Survey data

- **94%** of consumers believe that health care costs are a threat to their personal financial security.
- **73%** of consumers are confused about how the health care system works.
- **52%** of consumers believe that over half of the dollars spent on health care are wasted.

Source: Deloitte 2009 survey of health care consumers

About the presentation

- Through a survey of the industry, focusing on the financial aspects of the patient's care we will compare and contrast a variety of perspectives to discuss consumerism through the eyes of the patient.
- Define the objective
- Explore the historical development of the financial aspects of the delivery of care
- Review the shifting burden of cost
- Consumerism and the retail business of healthcare
- Case studies (the patient perspective)
- Are we meeting the needs of the consumer

Audience participation is encouraged

When health care finance was simple. Changes most of us have lived through.

- Remember when the physician made their own decisions about the type of services and setting of care and it was all medically necessary?

- Remember when most services were inpatient?

- Remember the explosion of outpatient services following the implementation of DRG reimbursement?

- Remember when a patient stayed in the hospital until they were ready to go home, and not discharged to a Rehab facility?

- Remember the days before CPT-4 and HCPCS codes, where the claim simply said. "Laboratory Services or Radiology Services?

When health care finance was simple
Changes most of us have lived through

- Remember when insurance paid for everything?
- In those days, reporting was general and easier and the patient did not pay for anything…..patients did not care because they did not have to pay…..
- BUT, the insurance companies/employers cared because they had to pay.
- Over the last two decades there has been a dramatic shift in the authority (CMS), complexity and reimbursement methodology that has created the consumerism which we are faced with today…

because someone has to pay!

The complexities of today

- The Revenue Cycle Process begins when the patient requests an appointment/service and ends with the final collection of all fees for the services rendered.

- The Process has a lot of variation and is complex.

- There are hundreds of insurance companies with thousands of different benefit packages covering our patients.

- Because a patient is eligible for insurance does not mean they are covered for the services provided.

The complexities of today

- For Billing and Reimbursement purposes, services are described by a combination of procedure and diagnosis codes that require a high level of specificity to distinguish the type and reason for the service.
- The specific codes may not be known prior to service being rendered
- The prices will vary with the specificity of the procedure codes
- The actual reimbursement is usually very different than and unrelated to the price.

The complexities of today

- Many insurance companies do not actually pay the claim, some are simply acting as a clearinghouse on behalf of the payer to review and recommend payment to an employer.
- Each insurance company has their own methodology of how to determine if the services are covered (Bundling) and at what rate they will reimburse. (In/Out of network, Inpatient versus Outpatient, Hospital Clinic versus Physician Office).
- With each rule of adjudication, the patient's share of the expense can be impacted.
- After each service is reconciled with the insurance response, any balance not paid is assumed to be the patient's responsibility.

The shifting burden
Employer/Insurers to Providers

We all know that good healthcare is priceless. Getting help for a sick child in the middle of the night, a routine checkup that becomes anything but routine, wanting the "best" when it comes to our health and the health of our loved ones. But Healthcare is not **price-free!**

- Insurers needed a way to get out from under the rising costs.
- Consumers had little desire or need to know what their medical services actually cost.
- Insurers negotiated lower fees with providers.
- Subscribers only paid the co pay and didn't care

The shifting burden
Employers/Insurers to Patients

The creation of high deductible plans

- More employers are forcing their workers into "so-called" consumer driven plans, which typically require members to pay for care with money from a personal savings account until a high deductible is met.
- Transfer the cost to the patient so they will have incentive to find affordable quality care.
- Employers are adding higher deductibles to PPOs rather than charging more for their coverage.
- **The median deductible for PPO plans jumped to about $1,000 in 2008 from $500 in 2007.**

The shifting burden
Conclusions

- Patients prefer their traditional employer based health insurance, which includes indemnity coverage, PPOs and HMOs.
- Insurers prefer high deductible plans tied to HSAs because their risk doesn't kick in until someone is really really sick or injured.
- Employers prefer high deductible plans tied to HSAs because they will lower the cost of providing health benefits.
- Providers have to work harder to delight the customer and collect the cash.

Retail

Is Health Care a retail industry?

The Theory

As more consumers begin to seek the best care at the lowest cost, the ensuing competition among providers will lead to lower prices and improved quality of care.

The Issue

Few people would buy a car, a TV or an airline ticket without knowing how much it costs. With a point and click, people can find the price of anything. For healthcare they do not know what they are buying and what sort of quality to expect in return.

There's no Carfax for healthcare

Retail vs. Healthcare

Consumer vs. Patient

- Consumer identifies a need
    - Patient is told by provider that he needs service

- Consumer can research different products-models/accessories to match his need
    - Patient is told by provider/insurer what service they can have and where they can have it.

- Consumer can compare prices
    - In an emergency, price is irrelevant.
    - For non emergencies, price comparison is limited.

- Consumer can decide what to purchase and when
    - Patient's care is managed by provider/insurance

Retail vs. Healthcare

Consumer vs. Patient

- Consumer knows the price he is going to pay and what he is going to get for that price
    - Patient is provided an estimate based on an average.
    - Actual cost may be higher than patient can afford or want to spend.
- Consumer does not get goods until payment is made
    - Patient can generally obtain service without payment.
- Consumer can make due with a lesser good if necessary, no retail purchase is life threatening
    - Often, time is of the essence or condition can worsen.
    - There may be no alternative for the prescribed treatment.

Retail vs. Healthcare
Consumer vs. Patient

- Goods will normally have a return policy/warranty.
  - No guarantees in healthcare, can perform procedure again at additional cost.
- Consumer can return the product if not satisfied
  - No returns, no exchanges police for healthcare.
- Consumer can share outcomes with others (e.g. BBB or Angie's list)
  - Providers frown on or will try to quash any ratings from patients.

Conclusions

- Retail Healthcare only works when convenient
- Intensity and severity obviate consumer choice

About the presenter

- Sheldon Mandelbaum, JD, MBA, brings the industry a distinctive perspective, blending his 30 years of health care finance expertise working for large hospitals and medical groups with his legal education and training.
- A member of the State Bar of Michigan, Health Law section, Sheldon is now developing compliant strategies relative to physician documentation and coding to maximize net revenue for physicians and hospitals that will withstand payer scrutiny.
- Most recently, Sheldon successfully aligned the clinical providers of the Henry Ford Medical Group with the operational and financial teams of Henry Ford Hospital to create an innovative patient centric delivery model to maximize net revenue and enhance patient satisfaction.
- Sheldon participated in the HFMA National Patient Friendly Billing Committee and is a member of HFMA Eastern Michigan chapter.

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