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Cash is king

More hospitals and systems are using credit scores and financial records in collection strategies—and they're asking patients to pay upfront

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Hospitals have always known why patients visit. Increasingly they now know exactly which patients will be able to pay for those visits.

Income and credit scores have long been factors when consumers go to buy a car, home or apply for a credit card. Now consumers' financial profiles—credit card balances, income and overdue bills—are taking hold in healthcare.

Hospitals have grown more sophisticated and aggressive when it comes to calculating the patient's share of a medical bill, whether households have cash or credit to cover the debt, and how readily patients will pay, if at all. The push, fueled in part by a burgeoning industry in healthcare consumer credit, is changing when and how hospitals seek to collect what patients owe, from \$50 copayments to deductibles 20 times that amount.

For patients who cannot afford care, hospitals armed with estimated bills or financial profiles can more readily waive bills as charity, executives say. But those who can pay face more-pointed requests to settle bills before leaving the hospital, they say. Credit scores also allow hospitals to triage unpaid bills and focus collection efforts on those most likely to pay when reminded.

Tenet Healthcare Corp., Dallas, which owns 57 hospitals in a dozen states, now sorts patient debt into 15 categories based on how likely it is Tenet will get paid. The exhaustive model, developed by a Tenet subsidiary, replaced one phased out last fall that boosted revenue by \$39 million a year and used just four categories.

Riverside Health System, in Newport News, Va.—where insured patients accounted for \$14 million in unpaid bills last year—uses credit scores to weed out the most difficult bills for collection agencies. For accounts considered easier to collect, Riverside sends bills under the name of its own collections arm, Peninsula Credit & Collections Service, which exists only on letterhead. The system created Peninsula 18 months ago to stand out from hospital bills that may otherwise be tossed aside, says Richelle Fleischer, administrative director of revenue-cycle management at Riverside.

Last November, SSM Health Care, St. Louis, began to use medical credit scores supplied by a major company during the registration process to separate patients eligible for free or discounted care from those able to pay. “We really want to be consistent and

fair” across the Catholic system's 15 hospitals, says Sheila Kuenzle, SSM's network vice president of revenue cycle. Previously, the system used medical credit scores to classify bills for collection.

Healthcare and revenue-cycle executives say such strategies improve efforts to identify patients who need financial aid, better inform paying patients of their costs and options, and allow hospitals to collect cash more efficiently and quickly. “It allows us to be smarter and better safeguard the hospital,” says Susan Aaron, assistant vice president for revenue management at 318-bed Holy Name Hospital in Teaneck, N.J., where an effort to identify patients' out-of-pocket liability boosted cash from elective admissions by more than 200% in 2008.

Behind the push, executives say, are growing numbers of health plans with hefty deductibles or coinsurance. The ongoing recession has added to the pressure. “The prior assumption was that if you had insurance you were a good credit risk,” Fleischer says. “The weakening economy is undermining that assumption.”

Consumer concerns

But the industry's push to collect could further jeopardize households' financial stability at a time when a growing number of people are struggling with medical bills, says Karen Pollitz, a research professor at Georgetown University's Health Policy Institute, who studies private insurance regulation and has testified to Congress on legislation to expand affordable coverage.

Confronted by hospitals to settle medical bills with available credit lines, patients may quickly find such debt—compounded by credit card interest rates—unmanageable, Pollitz says.

Insurance may provide patients little protection from catastrophic medical bills, putting households at risk of financial distress or bankruptcy, particularly for the acutely or chronically ill, Pollitz says.

Health insurers are “very creative in how they can erode the actuarial value of a policy,” Pollitz says. Household medical bills can escalate rapidly when patients need more than routine care and run into clauses that limit benefits or exclude certain spending from applying to deductibles, says Pollitz, who notes rising rates of medical debt and bankruptcy. “Good insurance can nonetheless leave you exposed to thousands of dollars for covered services every year,” she says.

Commonwealth Fund research published online by the journal *Health Affairs* in June 2008 estimated that 72 million adults struggle to pay medical bills or carried medical debt in 2007, the most recent data publicly available (Nov. 3, 2008, p. 6).

Patients also lose a powerful advocate to challenge insurers when hospitals turn to consumers for payment. “It's understandable that hospitals feel like they need to get paid,” Pollitz says. “On the other hand, who has the means to go toe to toe with an insurance company: a hospital or a sick person?”

Mark Rukavina, executive director of the Access Project, a Boston-based patient-advocacy group, says he fears that hospitals armed with more consumer credit information will collect first and screen for charity later. “People should be aware of and fully informed of charity care.” Patients should also be clearly informed that hospitals will

screen their credit scores, he says, noting charity applications disclose credit checks with varying degrees of transparency. "It's often unsettling for people to discover that the hospital has run their credit score, and it arouses suspicion," he says.

Feeling the recession

Riverside, which owns five Virginia hospitals, began roughly 18 months ago to classify bills as charity or debt using credit scores. Fleischer says the information more efficiently identified patients eligible for free care or discounts. As a result, charity-care expenses climbed to \$3 million per month from about \$2 million.

Fleischer says she had expected a corresponding drop in bad debt, as unpaid bills once mistaken as losses were identified as charity. That did not happen. Bad debt held steady at \$3 million a month, in part because of mounting losses from unpaid bills for insured patients, a trend she credits to the economy.

It remains unclear exactly how much the recession has left households uninsured or unable to afford medical care, but there are signs that the number of Americans without means to pay for medical care has surged in some areas of the country.

Unemployment stood at 9.4% last month (a slight dip compared with June figures) but up sharply from 4.9% when the recession began in December 2007. But in states hardest hit by job losses—Michigan, Nevada, Oregon, Rhode Island and South Carolina—unemployment exceeds 12%. For each 1% increase in unemployment, the health policy not-for-profit Kaiser Family Foundation estimates 1.1 million lose health benefits and another 1 million end up enrolled in safety net insurance.

One major health system that owns 22 hospitals in states along the Atlantic Coast cautioned bond investors in March that its operations had suffered from the recession. Job losses rose faster in some of Catholic Health East's markets than for the nation as a whole, leaving more patients uninsured, unable to pay medical bills or unwilling to undergo lucrative elective procedures, the system reported in a debt offering. Executives with the Newtown Square, Pa.-based system declined to comment.

Meanwhile in Texas, Baylor Health Care System, Dallas, has seen commercial managed care and other private insurance ebb among its patients while revenue from Medicaid and patients has grown, particularly at the system's flagship in Dallas, 923-bed Baylor University Medical Center, Dallas, and 214-bed Baylor Medical Center at Garland (Texas), according to analysts with Moody's Investors Service.

In the nine months between July 2008 and the end of March 2009, the share of Baylor's revenue from commercial health plans slid to 61.3% from 63.3%, while Medicaid's share rose to 6.8% from 5.3%; revenue from patients increased to 3% of the total from 1.9%, the system's financial statements show. In a written statement, Baylor spokeswoman Nikki Mitchell says the system "has not made any recent changes to its collection policies and procedures."

Playing catch-up

An industry has mushroomed around hospitals' efforts to collect more from patients. Consumer-credit firms and collection agencies have expanded into healthcare while health systems have edged into the consumer credit business.

In June, consumer credit giant TransUnion launched software that estimates how much a patient will owe and how much of that figure the patient is able to pay.

TransUnion first began to market its credit scores to hospitals in late 2004 with software that identifies and enrolls patients eligible for financial aid and also ranks medical bills by the likelihood they will be paid.

Martin Callahan, vice president of sales for the company's healthcare division, says sales have grown 35% in the past two years. Hospitals are "really trying to play catch-up with financial services," he says.

In December, another major consumer credit bureau, Experian, acquired healthcare revenue and billing company SearchAmerica for \$90 million. Based in Maple Grove, Minn., SearchAmerica scores patients' ability to pay their medical bills, using information on patients' income and credit lines.

Bruce Nelson, vice president of marketing at SearchAmerica, says hospitals and health systems dictate when and which employees have access to patients' financial information, such as credit scores. "Most of our customers do not make this information available to registrars," Nelson says in an e-mail.

SearchAmerica modifies software to grant employee access according to clients' requests, Nelson says. Hospitals primarily use information to identify and enroll low-income patients in financial assistance or publicly subsidized insurance, he adds.

In November 2008, Tenet spun off its revenue-cycle division into Conifer Health Solutions to go after what its executives estimate to be a \$20 billion to \$38 billion market nationwide for hospital billing services.

Stephen Mooney, president of Conifer Revenue Cycle Solutions, says the subsidiary recently brought in an economist to join the company's industrial engineer and statistician in an effort to further expand and refine how it profiles consumers to improve collections.

Conifer overhauled its credit score for patients in 2008 to weigh 44 demographic and financial factors instead of eight used in its original model. The more comprehensive analysis originally classified patients into 272 categories, which are winnowed down to 15 based on how consumers respond to collection efforts, Mooney says.

Conifer began to profile how quickly commercial insurers pay bills and how often they deny claims this year, Mooney says. Hospitals can use such information in contract negotiations or to anticipate delays.

Early next year, Mooney says Conifer is expected to test the use of consumer credit scores as patients schedule or register for care at Tenet hospitals. In a written statement, a Tenet spokesman declines to say whether the system would deny or delay care based on the scores. "Tenet treats patients who come to the emergency room regardless of their ability to pay," according to the statement. "For nonemergency care, Tenet, along with Conifer, helps patients determine their out-of-pocket expenses so that they can make an informed decision about their treatment options."

Seeking cash upfront

Healthcare executives say patients are more likely to pay before or during a hospital visit rather than after.

At Holy Name Hospital, emergency room registration employees now collect cash once patients have been triaged and stabilized by doctors and nurses.

The effort to boost on-the-spot collections from patients at Holy Name has targeted easily identifiable copayments in the emergency room and out-of-pocket payments for elective and same-day surgeries, Aaron says.

Changes have been “really, really very successful,” Aaron says, and Holy Name expects to gradually expand the effort. Cash payments from emergency room patients surged to \$53,000 in the final five months of 2007 as employees began collecting bills before patients left the hospital, compared with \$1,895 for the prior seven months.

For all of 2008, cash payments from emergency room patients added \$186,900 to the hospital's bottom line. This past June, employees converted to registration and billing software from handwritten receipts in a bid to improve efficiency, Aaron says.

Meanwhile, cash from elective admissions increased to \$205,000 for 2008 compared with \$59,000 for the prior year.

While such amounts might appear small when compared with Holy Name's 2008 operating revenue of \$260.3 million, they are more significant in light of the hospital's razor-thin operating margin of \$1.8 million.

Aaron says that Holy Name will begin collecting from patients who visit the radiology department, particularly for more expensive diagnostic imaging such as CT scans. She is also considering strategies that will predict a patient's entire bill and score how likely that person is to pay. Such information will help the hospital collect deposits for medical care, she says. In some cases, Holy Name already delays some elective procedures or nonurgent care when patients don't make deposits, but only after consulting with physicians, she says. “We try to avoid that.”

For urgent or emergency care, hospital employees talk to patients after treatment but can do nothing should they refuse to pay. “We send them a bill and pray for payment,” Aaron says.

At Riverside, meanwhile, the system is now considering screening credit scores, income and available credit as patients schedule care to secure deposits from patients who are unlikely, but able, to pay, Fleischer says.

It is insured patients with available resources who Fleischer says she hopes to target with earlier credit screening. Emergency room services and medical care deemed urgent by physicians would be exempt from deposits, but required for other procedures, she says. “If it's clinically urgent, they pass go,” Fleischer says. “It's on the not-clinically-urgent that I'm going to ask questions.”

Without a down payment, “you're choosing not to have your healthcare today because you're choosing not to pay your financial obligation,” Fleischer says. She says she expects to lose some patients to nearby competitors. “I think we will get people walking out,” Fleischer says. “We'll have to stand firm.”

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