$27.3 billion is hardly pocket change, but that is how much U.S. hospitals lost in uncompensated care in 2014, according to the United States Department of Health and Human Services. The cost of uncompensated care — the sum of a hospital’s “bad debt” and charity care — has been steeply rising since 2000, when hospitals lost about $21.6 billion, or 6.2 percent of their total expenses.

Although hospitals actively budget for charity care, bad debt — services for which hospitals anticipated but did not receive reimbursement — poses a massive challenge and incurs a steep cost to hospitals. Hospitals have systems that help identify patients’ insurance at the point of care, but capturing the identified coverage is not always possible, forcing hospitals to foot the entire bill.

As more individuals are insured, both through the federal and state marketplace exchanges and the recent expansion of Medicaid following the rollout of the Affordable Care Act, the national rate of uncompensated care has reasonably declined. According to Health and Human Services, hospitals saved approximately $7.4 billion in uncompensated care costs in 2014, with states that expanded Medicaid seeing approximately 74 percent of the total savings nationally compared to states that have not expanded Medicaid.

Despite these modest improvements, the tens of billions of dollars hospitals are losing each year represent a significant percentage of their expenses.

According to Gerry McCarthy, president of TransUnion Healthcare, between 1 and 5 percent of hospitals’ bad debt is covered by insurance. However, hospitals are unable to identify such coverage during the admissions and billing process. Importantly, this number is increasing.

TransUnion Healthcare, a credit services and management company based in Chicago, provides hospitals with solutions to help discover patients’ coverage that was initially not verifiable or inaccurately captured by hospital staff on the front-end. In the last 15 years, TransUnion’s products have helped more than 1,000 hospital and thousands of physician partners recover over $5 billion in uncompensated care, which resulted in more than $719 million in revenue delivered to its hospital clients.

Several main factors contribute to hospitals’ uncompensated care

One primary factor contributing to hospitals’ inability to collect certain payments for services is the increase in cost of high-deductible health plans. According to The Advisory Board Company, five to 10 years ago, $500 to $1,000 would have been considered a high deductible. In 2014, about 81 percent of enrollees in these types of plans had deductibles of more than $2,500.

This self-pay component puts a
heavy burden on individuals and families, and therefore, puts more pressure on providers to collect payments.

The high out-of-pocket costs patients are already obligated to pay is compounded with increased utilization of emergency department services for care that could have been more affordably provided in an outpatient setting. Patients who struggle to afford the cost of their care may simply not pay.

“We will be tracking this trend closely as we suspect that average deductibles could rise much more in the coming years,” Mr. McCarthy said in a statement. “The continued increase in deductibles will place even more importance on transparency of costs in the billing process and will require providers to offer payment plans that will demand a new level of effort to collect reimbursement.”

Emergency Department admissions additionally prevent hospitals from verifying insurance eligibility prior to treating patients. While hospital financial counselors can capture retroactive eligibility, some patients are noncompliant with the screening processes, according to Mr. McCarthy.

For example, if a patient provides the hospital with demographic information that is inconsistent with the payer’s profile of the patient, the hospital may find it difficult to identify his or her coverage. Additionally, certain payers don’t allow hospitals to verify insurance unless patients provide the insurance ID number at the time care is provided. The patient is then responsible to follow up with the hospital and provide insurance information creating a process and logistical nightmare for providers.

According to Mr. McCarthy, 800,000 of the more than 8.1 million newly insured under the Affordable Care Act dropped off in the first few months after enrolling, creating a “transient” patient population. This may be because they didn’t make required payments or follow through on paperwork. Although these patients’ insurance information is technically outdated, they might still present their insurance cards to hospitals, resulting in uncompensated care.

One of the biggest factors contributing to patients’ noncompliance with screening processes and dropping off of their insurance plans is a lack of understanding and education about their financial obligations regarding their deductible and insurance payments.

For example, consumers who obtain commercial health insurance for the first time may have a hard time comprehending various provisions of the ACA, such as the penalties associated with the individual mandate, eligibility for subsidies and the potential requirement for repayments due to underestimations of annual income, according to Mr. McCarthy.

Newly insured patients might also be unaware of the materials and information they are supposed to present to the hospital when they are being admitted, resulting in the hospital’s inability to verify insurance eligibility at the point of service, according to Mr. McCarthy. In many cases, patients are unresponsive to collection attempts and other efforts the hospital makes to contact them, leading to millions of dollars in leakage and an increase in hospital’s bad debt.

“When patients are uneducated about their insurance requirements they don’t know the right information to share with providers,” says Mr. McCarthy. “They promise the hospital they will follow up with the necessary information, but they often never do.”

A growing insured population under the PPACA and Medicaid expansion has significant impacts on coverage discovery

The expansion of Medicaid has had a substantial effect on coverage discovery. With Medicaid expansion comes a dramatic increase in retroactive eligibility, according to Mr. McCarthy. Medicaid coverage may be effective retroactively for up to 90 days before the month of application if the individual would have been eligible during those 90 days, according to Medicaid.gov. Hospitals can bill Medicaid for services during
that 90 day time period, but this process is often done manually and hospitals end up losing out on compensation for care during that window.

In states that expanded Medicaid, approximately 8 percent of hospitals’ uncompensated care costs are attributable to not receiving payments from retroactive eligibility, compared with 3.5 percent of uncompensated care costs in hospitals in states that have not expanded Medicaid.

“How hospitals in states that expanded Medicaid need to implement a post-Medicaid scrub to pick up this coverage, but this is falling into uncompensated care,” says Mr. McCarthy.

**What can hospitals do to improve the eligibility verification process to ensure the collection of dues?**

Hospitals and health systems can follow several approaches to improve the eligibility verification process to reduce the leakage of uncompensated care, such as the implementation of automated coverage discovery programs and patient education.

With TransUnion’s eScan platform of solutions and reports, hospitals can discover additional coverage after all other internal and third-party eligibility processes are exhausted. The coverage discovery solution leverages proprietary technology with hundreds of query permutations to deliver a series of automated and customizable reports that identify billable coverage for accounts that are not or cannot be captured on the front-end. eScan’s platform identifies patient accounts covered by Medicaid, Supplementary Security Income, Medicare, TRI-CARE and commercial insurance at the time of service, and monitors accounts continuously for up to three years from the date of service.

“Data is processed by running an entire file of all uncompensated care accounts for a hospital against all potential payers. eScan utilizes proprietary technology to triangulate and find coverage for those patients,” says Mr. McCarthy.

Another TransUnion solution that helps hospitals identify billable coverage is ClearIQ. This platform makes the patient registration process simpler and more efficient by automatically providing both the patient and hospital with clarity regarding patients’ financial obligations.

ClearIQ verifies patients’ demographic information through a standard registration interface. It confirms how much money is left on a patient’s deductible and aggregates the patient’s procedure and benefit information to produce a credible estimate of what he or she will likely have to pay out of pocket. ClearIQ runs a financial analysis to see what the patient can afford to pay based on this estimate, allowing hospitals to suggest reasonable payment plans to help ensure patients provide reimbursement for the services provided. Since patients gain more insight and confidence about what they owe up front, they are more likely to understand their financial obligations and hospitals can reduce bad debt.

In addition to incorporating new technological tools to the registration and revenue cycle processes, hospitals can increase face-to-face education with patients about their responsibilities. According to Mr. McCarthy, hospital staff registering patients can hold counseling sessions that take patients through the information needed to find coverage. They can also use this time to identify who has the right to receive charity care and determine payment plan options for patients.

Hospitals can also run ID verification to eliminate potential attempts at medical fraud, another source of uncompensated care.

“Hospitals are working on razor-thin margins, and uncompensated care can be the difference between profitability and not,” says Mr. McCarthy. “Hospitals want to provide the best care for the community. We want to help them achieve their goals throughout the system.”