



January 2010 • Vol. 26 No. 1

www.acainternational.org

PUBLISHED FOR HEALTH CARE PROVIDERS BY
ACA INTERNATIONAL'S HEALTH CARE SECTION

Health Care Reform: What's Ahead

By Emily Grace, Communications Specialist

As one of President Obama's top initiatives, health care reform has taken center stage. The current unsustainable economic and health care trends have made action on health care payment reform a top priority.

"The problem is health care reform is changing daily," said Tom Gavinski, vice president of the health care division for I.C. System, Inc. in St. Paul, Minn., while presenting at ACA's Fall Forum in November 2009.

The exponential growth in health care expenditures, increasing numbers of uninsured/underinsured and rising insurance premiums are making affordability difficult for individuals and small businesses and in turn are driving health care reform.

Without reform, the Centers for Medicare and Medicaid Services projects national health care expenditures will reach \$4.4 trillion by 2018 and represent 20 percent of the U.S. economy as a percentage of gross domestic product (GDP). In 2007, health care expenditures were 16.2 percent of GDP.

The number of uninsured or underinsured is also expected to grow. According to the U.S. Census Bureau, 45.6 million people were without health insurance in 2007, and Gavinski believes that number will be well over 46 million for 2008.

Gavinski provided a breakdown of the uninsured:

- 70% have at least one full-time worker in their household
- 10% have at least one part-time

worker in their household

- 18% qualify for some government program but don't know it
- 22% are not citizens, 80% are legal residents
- 19% have household incomes of at least \$75,000
- 16% are 19 – 24 years old

"Most people think of the uninsured as the poor or undocumented immigrants," Gavinski said. "The reality is many people are electing not to have insurance. People don't want to pay the premiums and deductibles. They're taking the risk."

People are taking the risk because of quickly rising insurance premiums. Between 1999 and 2008 insurance premiums rose 119 percent, according to the Kaiser Family Foundation and the Health Research & Educational Trust's *Survey of Employer-Sponsored Health Benefits*. That increase far surpasses the 34 percent increase in worker's earnings and 29 percent increase in inflation.

With proposals currently being debated in both the House and the Senate, major components still need to be addressed. According to a *New York Times* article, "The fiercest fight is over the proposal by President Obama, and many Democrats, to create a public insurance plan to compete with private insurers."

The article states supporters of the public plan believe it would lower administrative costs and foster competition, while Republicans, and some conservative Democrats, say the

public option could drive insurers out of business and lead to a government takeover of health care.

"There is concern the public option will set up the framework for universal care down the road," Gavinski said.

Most of President Obama's health care goals are focused on bending the cost curve. His proposal concludes that standard short-term measures to address rising costs are not sufficient. Instead, his proposal states legislation must support necessary changes and improvements in health care by reforming payment systems, regulations and institutions that currently prevent patients from getting the best quality care at the lowest cost. By investing in prevention and wellness and improving safety and patient care, the plan hopes to reduce cost growth which will in turn assure affordable coverage.

"This is a huge paradigm shift in the health care industry," Gavinski said. "Currently health care providers are being reimbursed for treatment and not prevention."

When President Obama set his health care reform goals, he hoped to have legislation passed by August before Congress went on recess. When nothing was passed, legislators returned home and received a lot of feedback on the proposals from their constituents.

"The longer this drags on, the more water-downed this bill is going to become," Gavinski said.

Although health care reform may pass in 2010, it is going to take a

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Interim Final Rule to Strengthen HIPAA Enforcement Provisions

On Oct. 30, 2009, the Department of Health and Human Services (HHS) issued an interim final rule with request for public comments to strengthen its enforcement of the rules enforced under HIPAA. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) modified HHS authority to impose civil monetary penalties for violations occurring after the passage of the Act. The penalties under the HITECH Act increase the penalty amounts the Secretary of HHS may impose for violations of HIPAA.

Under the interim final rule, the following penalties for HIPAA violations will apply on or after Nov. 30, 2009:

- For violations without knowledge (and would not have known through reasonable diligence), the minimum civil penalty is \$100 per violation.
- For violations based on reasonable cause, the minimum civil penalty is \$1,000 per violation.
- For violations based on willful neglect and are subsequently corrected, the minimum civil penalty is \$10,000 per violation.
- For violations based on willful neglect and are not corrected, the minimum civil penalty is \$50,000 per violation.

Note the maximum penalty for the above violations shall not exceed \$50,000 per violation, and the maximum penalty for multiple violations is \$1.5 million per calendar year.

Hospitals' Self-Pay Receivables Increase

An overwhelming 97 percent of hospitals participating in Healthcare Financial Management Association's (HFMA) *Healthcare Financial Pulse* study reported an increase in self-pay receivables compared to the prior fiscal year.

The study reports more than one-third of hospitals experiencing an increase saw an increase of 10 percent or greater. It goes on to state small hospitals were the most likely to have the greatest percentage of increases.

Due to the economic climate, the report states, "hospitals face increased challenges working with these patients on payment issues."

To combat the changing payment

environment, 72 percent of respondents report devoting moderate or substantial efforts toward point-of-service collections. Although hospitals are shifting their resources, only 50 percent of hospitals doing so are reporting decreased cost-to-collect performance indicators.

According to the report, "Respondents are indicating that difficulty in estimating the cost of services to be received remains the most significant barrier to more extensive point-of-service collections."

For more information about HFMA's Healthcare Financial Pulse Project visit their Web site at www.hfma.org/pulse.

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minimum of three years to implement any changes and obtain the necessary infrastructure. In the interim, Gavinski believes there will be increases in consumer driven health plans with higher deductibles and co-pays.

"There is going to be continued participation in higher deductible plans holding people more accountable and responsible for their health care expenditures," Gavinski said.

This trend will mean higher amounts of self-pay dollars to collect. With the unemployment rate hitting the highest percentage since April 1983 at 10.2 percent, self-pay accounts are going to get harder to collect. Gavinski does not believe hospitals are equipped to efficiently deal with these accounts.

"Hospitals are dealing with declining reimbursement from Medicare and Medicaid, reduced utilization and squeezed profit margins," said Gavinski. "Cost

cutting will need to be implemented, including the reduction of full-time employees."

He believes hospitals can turn to their partners to help with self-pay collections, insurance follow-ups/denials, patient scoring, Medicaid eligibility and charity identification.

Ultimately there are three possibilities for health care reform. A comprehensive health care bill could be passed, bits and pieces of legislation could be passed, or nothing could be passed.

"If health care reform collapses or we only get piecemeal legislation, self-pay collections are going to continue to increase and hospitals need to be ready for that," Gavinski said.

The information provided in this article is current as of date of production, Nov. 25, 2009.

FTC Extends Enforcement of Red Flags Rule until June 1, 2010

At the request of Members of Congress, on Oct. 30, 2009, the Federal Trade Commission (FTC) announced it is delaying enforcement of the Red Flags Rule until June 1, 2010, for financial institutions and creditors subject to enforcement by the FTC.

Financial regulatory agencies, including the FTC, developed the Rule, which was mandated by the Fair and Accurate Credit Transactions Act of 2003 (FACTA). The Red Flags Rule requires creditors and financial institutions with covered accounts to implement programs to identify, detect and respond to the warning signs, or “red flags,” that could indicate identity theft.

Health care providers may be subject to the Rule if they are “creditors.” The definition of “creditor” is broad and includes businesses or organizations that regularly defer payment for goods or services or provide goods or services and bill customers later. Health care providers are among the entities that may fall within this definition, depending on how

and when they collect payment for their services.

For example, a health care provider who regularly bills patients after the completion of services, including for the remainder of medical fees not reimbursed by insurance, may be deemed a creditor. Similarly, health care providers who regularly allow patients to set up payment plans after services have been rendered are creditors under the Rule. Health care providers are also considered creditors if they help patients get credit from other sources — for example, if they distribute and process applications for credit accounts tailored to the health care industry.

On the other hand, health care providers who require payment before or at the time of service, are not creditors under the Red Flags Rule. In addition, if a provider only accepts direct payment from Medicaid or similar programs where the patient has no responsibility for the fees, the provider is not a creditor. Simply accepting credit cards as a form of payment at the time of service does not

make a provider a creditor under the Rule.

Every health care organization and practice must review its billing and payment procedures to determine if it’s covered by the Red Flags Rule.

The FTC is delaying the enforcement of the Red Flags Rule to give creditors and financial institutions more time to review guidance offered by the FTC regarding the development and implementation of a written Identity Theft Prevention Program. Per Congress’ request, the Red Flags Rule is set to take effect June 1, 2010.

The FTC’s Red Flags Web site offers resources to help entities determine if they are covered and, if so, how to comply with the Rule. The site includes an online compliance template that enables companies to design their own Identity Theft Prevention Program, as well as articles directed to specific businesses and industries, guidance manuals and Frequently Asked Questions to help companies navigate the Rule.

View the FTC’s Red Flags Web site at <http://www.ftc.gov/redflagsrule>.

Hospital Financials Have Recovered to Pre-Recession Levels

The median profit margin of U.S. hospitals increased from near zero in the third quarter of 2008 to more than 8 percent in the second quarter of 2009, according to an analysis of hospital financial performance published in November 2009 by Thomson Reuters.

The recovery has been broad-based, with all classes of hospitals - small, medium and large community hospitals, teaching hospitals and major teaching hospitals - showing positive median margins.

The study tracks two dozen key financial indicators, using proprietary and public data to dissect the balance sheets of more than 400 hospitals nationwide.

It evaluates trends in revenue and profit, employment levels, closures, inpatient volume, days cash on hand, and case mix to gauge the fiscal health of the nation’s hospitals.

Key findings:

- Median total margins were at 0.37 percent in Q308. In Q209, they reached 8.4 percent.
- About 20 percent of hospitals had negative total margins in Q209 - which is similar to the rate seen before the recession began in late 2007. This is an improvement from Q109 when 30 percent of hospitals were operating with negative margins and Q308 when half of U.S. hospitals

were operating in the red.

- Hospitals’ median days-cash-on-hand has increased significantly from 90 days in Q109 to 146 days in Q209.
- Total labor costs are down approximately 2.25 percent in Q209.
- Mean patient discharge volumes for all hospitals began declining shortly after the recession started - but moved into positive territory in Q209.

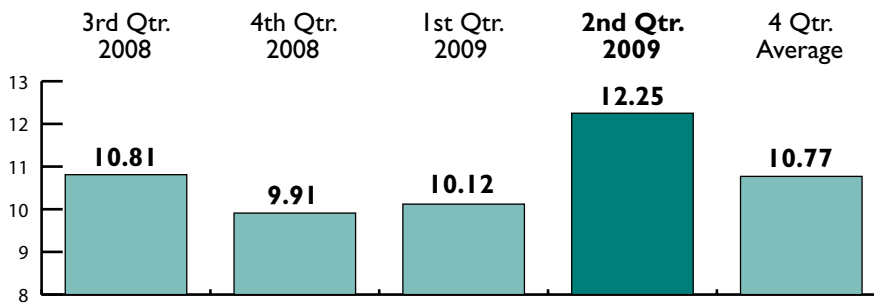
The full report can be downloaded (registration required) at http://img.en25.com/Web/ThomsonReuters/HospContFinancialRecovResPaper_1009v2.pdf.



DATA WATCH

Days from Discharge-to-Bill

Discharge-to-bill (DTB) performance declined again for U.S. hospitals in the second quarter of 2009. The average bill time for all payer types was 12.25 days, up from 10.12 days in the prior quarter. The 2.13 day jump in DTB average contributed to a four-quarter DTB average of 10.77 days. The benchmark is to bill claims within ten business days after discharge.



Source: HARA Report on Second Quarter 2009, vol.23, no.3, 2009, with permission from Aspen Publishers, Inc., www.aspenpublishers.com.

PULSE is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

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