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Revenue Cycle Implications of Health Reform

By Emily Grace, Communications Specialist

The Patient Protection and Affordable Care Act was enacted in 2010 to provide quality, affordable health care for all Americans. While the Act is projected to insure an additional 32 million Americans, it may put additional financial and operational strains on health care providers.

At ACA International's 2011 Spring Forum event held this past March, Tony Maki, health care partner for Moss Adams LLP in Scottsdale, Ariz., discussed current provisions of the health care reform legislation and their impact on the revenue cycle. He also touched on the likelihood of possible additions or amendments.

The Two-Pronged Effect of Reform

For health care providers and collection agencies alike, health care reform has two distinct implications that may create change for their business.

"The first change is in client base, mainly the decreased number of uninsured patients," Maki said. "The other effect will be directly related with providing your employees with coverage."

With a goal of achieving universal coverage, health reform creates individual and employer mandates along with insurance market reform.

"Reform didn't change the delivery system of medicine, its purely about coverage," Maki said.

Changes Already Taking Place

While the effective dates for the many provisions included in the health care reform are staggered over the next several years, some requirements for tax-exempt charitable hospitals have already begun that may affect the revenue cycle.

Beginning in 2010, 501(c)(3) organizations must:

- Conduct community needs assessments.
- Adopt, implement and make available to the public a financial assistance policy.
- Limit the amount charged for emergency or medically necessary services to qualified individuals to the amount generally charged to insured patients for the same services.
- Not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the person is eligible for assistance.
- Pay an excise tax of \$50,000 if the requirements are not met.

"Twenty pages of regulations will probably be written to define extraordinary collection actions," Maki said. "The government is very good at putting terms out there and then not defining them very well."

Besides risking losing their 501(c)(3) status, a considerable excise tax will be assessed if these requirements are not met.

"The government is really coming down on charitable hospitals, and as a result of more regulations, we will see less of these hospitals," Maki said.

Decreased Bad Debt?

Expanded insurance coverage is expected to dramatically affect utilization and the number of true self-pay patients – those without any form of insurance coverage. Because of these factors, some in the health care industry have projected a reduction in bad debt leading to improved provider revenue.

"While the reduction in charity care represents good news in the short term, the below-cost reimbursement rates of government payers will challenge hospital economics in the longer term unless providers develop lower-cost delivery models," Maki said.

According to the Advisory Board Company, 79 percent of the increased hospital revenue is expected to come from reduced bad debt and the other 21 percent will be from increased utilization.

"While bad debt may decrease, I think it is still going to be there," Maki said. "It may not look like what it does today. The amount may be smaller, but I wouldn't rely on it for 79 percent of any increase."

The additional expenses of reform requirements must also be looked at when analyzing any increase in revenue.

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FTC Issues Final Policy Statement Regarding Collecting Deceased Debt

The Federal Trade Commission (FTC) recently finalized a policy statement regarding communications in connection with the collection of decedents' debts.

The Fair Debt Collection Practices Act (FDCPA) limits communication to people such as the deceased person's spouse and the executor or administrator of the deceased person's estate. The FTC recognized that imposing unnecessary restrictions on a debt collector's ability to collect a decedent's debt from the person authorized to pay those debts may cause debt collectors to pursue recovery by invoking the probate process. This imposes substantial costs on the estate and delays the distribution of assets to heirs and beneficiaries. To balance these interests and protect consumers from unfair, deceptive and abusive practices, the FTC issued a final policy statement regarding collecting from deceased consumers, which aims to merge the FDCPA's requirements with current trends in state probate law.

The final policy statement specifies the FTC will not take enforcement action under the FDCPA if a debt collector communicates about a decedent's debts with the individual's spouse, executor, administrator or anyone else who is authorized to pay the decedent's debts from assets in the estate. Individuals with authority to pay the decedent's debts may include personal representatives under the informal probate and administration procedures of some states, persons appointed as universal successors, persons who sign declarations or affidavits to effectuate the transfer of estate assets, and persons who dispose of the decedent's assets.

The final policy statement also clarifies how collectors can comply with the law when attempting to identify the person with the authority to pay the decedent's debt from the estate's assets.

The final policy statement encourages collectors to make a "good faith" effort to conduct record searches before contacting individuals other than the executor or administrator. This includes checking records of the probate court in the jurisdiction where the decedent resided.

Communications with family members and others to locate someone who is authorized to pay the decedent's debts must comply with the FDCPA. The final statement permits collectors to include in location communications that the collector is seeking to identify and locate the person who has the authority to pay the outstanding bills of the decedent. The location communications cannot make any other references to the decedent's debt.

The statement also advises collectors that during interactions with such parties, collectors may not engage in unfair, deceptive or abusive conduct in violation of the FDCPA or the Section 5 of the FTC Act.

According to the final statement, contacting survivors about a debt

shortly after the consumer passes away may violate FDCPA's prohibition on contacting family members and other third parties at unusual or inconvenient times or places.

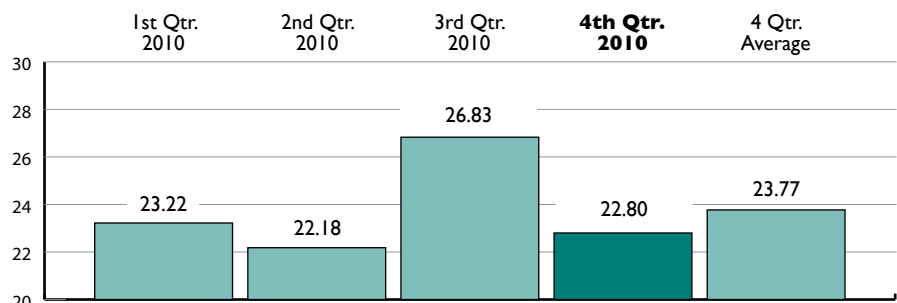
A collector may ask a person clarifying questions when seeking to identify and locate the person with authority to pay the decedent's debt, such as who is handling the decedent's affairs. A collector may not use inappropriate leading questions or engage in any conduct that may cause the contacted individual to mistakenly assert he or she has the requisite authority to pay the decedent's debt.

In communications with individuals who have the authority to pay the decedent's debt, the final statement emphasizes collectors must avoid creating the misleading impression that the individual is personally liable or could be required to pay using his or her own assets, or assets held jointly with the deceased person.

The FTC's final policy statement is available at <http://ftc.gov/os/2011/07/110720fdcpa.pdf>.

Percentage of A/R Over 90 Days

U.S. hospitals in the fourth quarter of 2010 reined in the percentage of accounts receivable (A/R) aged greater than 90 days, securing benchmark-level performance for this financial indicator. The A/R aging benchmark is to hold A/R aged more than 90 days to 25 percent or less of total A/R.



Source: HARA Report on Fourth Quarter 2010, vol.25, no.1, 2011, with permission from Aspen Publishers, Inc., www.aspenpublishers.com.

Raising Medicare's Eligibility Age

Raising Medicare's eligibility age from 65 to 67 in 2014 would generate an estimated \$5.7 billion in net savings to the federal government, but would result in an estimated net increase of \$3.7 billion in out-of-pocket costs for 65- and 66-year-olds, and \$4.5 billion in employer retiree health care costs, according to a new Kaiser Family Foundation projection of the potential change suggested by several deficit-reduction plans.

The Kaiser study also estimates the change in Medicare eligibility would raise premiums by three percent for those who remain on Medicare and for those who obtain coverage through health reform's new insurance exchanges. The study assumes both full implementation of the health reform law and the higher eligibility age in 2014 in order to estimate the full effect of both the law and the policy proposal.

Among the estimated five million affected 65- and 66-year-olds, about two in three would pay an average of \$2,200

more for their health care in 2014 than they would have paid if covered under Medicare, the study estimates. Nearly one in three, however, are expected to have lower out-of-pocket spending,

**Raising the age of
Medicare eligibility to age
67 would result in \$31.1
billion in gross savings.**

mainly due to the health reform law's coverage expansions through Medicaid and the premium tax credits available to low- and moderate-income Americans.

With health reform, virtually all 65- and 66-year-olds would be expected to obtain alternative sources of coverage. According to the new analysis, 42 percent are projected to obtain coverage through employer-sponsored plans, 38 percent through

plans offered through health reform's insurance exchanges and 20 percent through the expansion of Medicaid for low-income adults.

The study projects that raising the age of Medicare eligibility to age 67 in 2014 would result in \$31.1 billion in gross Medicare savings in 2014 because Medicare would no longer be covering 65- and 66-year-olds. The gross savings are estimated to be partially offset by increases in federal spending for individuals who would be covered by Medicaid (\$8.9 billion) and for individuals receiving premium tax credits and cost-sharing subsidies in the exchanges (\$9.4 billion). The gross savings also would be offset by a \$7 billion reduction in Medicare premium receipts from 65- and 66-year-olds who would no longer be enrolled in the program.

For more information, visit the Kaiser website at: <http://www.kff.org/medicare/med032911nr.cfm>.

Implications of Health Reform

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"I believe the cost of implementing many of the reform provisions will require hospitals to spend a lot more money on infrastructure and IT," Maki said.

The additional expenses and the need to control costs may lead to an increase in outsourcing.

"Utilization of collection agency services will continue to be in big demand," Maki said. "Outsourcing is more cost effective than performing these functions internally."

Will Reform Be Reformed

No one knows if health care reform will be fully implemented,

amended or repealed. "If the current president gets re-elected, that could be highly likely; but if Republicans take a majority, significant compromises will take place," Maki said.

The government has made substantial progress already in implementing reform and a Kaiser Family Foundation poll showed many of the provisions are popular with Americans.

- No pre-existing condition exclusions for children (72% favorable).
- Small business health insurance tax credits (71% favorable).
- No out-of-pocket costs for

preventative services (70% favorable).

- No cancellation of coverage except for fraud (68% favorable).
- Drug rebates for Medicare beneficiaries (64% favorable).
- High risk pool for people with pre-existing conditions (61% favorable).
- Extend dependent coverage to age 26 (53% favorable).

"The public wants many of the things the government is doing," Maki said. "The government just needs to figure out how to implement and pay for it."

Five Percent of Patients Account for Half of Medical Spending

Health care spending in the U.S. reached nearly \$2.5 trillion in 2009, or 17.6 percent of the gross domestic product, according to a new data brief issued by the National Institute for Health Care Management Foundation. The Foundation also found a concentration of expenditures, with five percent of the population responsible for almost half of all spending. At the other end, half of the population accounts for just three percent of spending.

According to the analysis, “the proportion of expenditures accounted for by the highest spending groups has actually declined somewhat over

the past two decades as high medical spending has spread to a broader swath of the population.” The spending by the top five percent decreased from 56 percent in 1987 to 48 percent in 2008.

“This flattening of the spending distribution is consistent with the well-documented increase in population risk factors – most notably, obesity,” the analysis reports.

The full analysis can be found on the NIHCM Foundation website at: <http://www.nihcm.org/component/content/article/450>.

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Kim Rath, editor
Emily Grace, associate editor

ACA International
P.O. Box 390106
Minneapolis, MN 55439-0106

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