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Anne Sharamitaro, Esq. - Vice President of Research • Rachel Seiler, MPH - Editor

Self-Pay Patients: A Cautionary Tale

Self-pay patients typically include the medically indigent patient population (i.e., the uninsured and underinsured) and other patients with out-of-network insurance policies.[1] The number of self-pay patients is on the rise, driven by the downturn in the economy and the rising number of patients with health savings accounts (HSAs) and other health plans with high deductibles.[2] A November 2009 survey conducted by the Healthcare Financial Management Association (HFMA) indicated that from 2008 to 2009, 97% of hospitals experienced an increase in the number of self-pay accounts receivable cases, and 35% of these experienced an increase of 10% or greater in self-pay patients.[3]

In response to the growing number of self-pay patients, and in the absence of a policy mandating a cap on charges for services provided to them, hospitals have gradually increased fee collection from this group of patients. A 2007 article published in *Health Affairs*, found that hospitals charged self-pay patients 307% over the Medicare allowable costs and approximately 2.5 times more than what most private and public health insurers pay.[4]

Hospitals have justified these price discrepancies with several explanations: (1) self-pay patients can negotiate pricing discounts in advance; (2) cost shifting is necessary to make up for under reimbursement from Medicare, Medicaid, managed care plans, and other insurers; and, (3) competitors charge similar rates to self-pay patients.[5] Hospitals also note that many self-pay patients below a certain minimum income threshold (e.g., the uninsured, patients who receive charity care) typically don't pay their bills.[6] As a consequence of hospital price discrepancies and patients' inability to pay, self-pay patients have filed a number of class-action lawsuits challenging disparities in charges for patient services, leaving hospitals vulnerable to crippling litigation and settlement costs.[7]

To avoid negative publicity, complaints, and increasing levels of uncompensated care, hospitals must adapt to a patient case mix composed of an increasing proportion of self-pay patients.[8] Traditionally, all self pay patients were considered indigent charity care cases, and collection processes would treat all self-pay patients the same, but today this isn't true. By screening patients financial situations upon registration hospitals can locate which patients truly need charity care, those that could fit into a government payment program, those to charge, and those patients who are unlikely to pay. By implementing screening practices, hospitals can avoid unpaid bills and lower charges billed to self-pay patients.[9] In addition, improved communication and providing clear and simple billing procedures can reduce tension and support a positive experience for both parties.[10] However, despite noted changes in the way hospitals handle self-pay patients, hospital financial experts agree the majority of self-pay patients remain vulnerable to perceived overcharging for hospital services.[11]

Some issues leading to high prices for self-pay patients reflect problems with the healthcare system at large. One solution to lower rates for self-pay patients includes decreasing the number of uninsured in America.[12] Another is to require hospitals to publish their rates charged for medical services, which would allow patients to comparison shop and establish pricing caps for healthcare providers.[13] Whatever the solution, as the economy continues to decline, it is likely that the constitution of the payor mix for hospitals will be comprised of an increasing proportion of self-pay patients, making it more important to address the issues posed by the inability of many of these patients to pay for medical services rendered.

1 "From 'Soak the Rich' to "Soak the Poor': Recent Trends in Hospital Pricing" by Gerard F. Anderson, Health Affairs, Vol. 26, No. 3, (May/June 2007), p. 781.

2 "Hospital or Banker?" by Michelle Ponte, HealthLeaders Media, July 31, 2009, http://www.healthleadersmedia.com/content/MAG-235769/Hospital-or-Banker (Accessed 1/8/10).

3 "The Changing Face of Self-Payment in Hospitals" Healthcare Financial Management Association, November 2009, p. 4.

4 "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing" by Gerard F. Anderson, Health Affairs, Vol. 26, No. 3 (May/June 2007), p. 780, 81.

5 "From 'Soak the Rich' to "Soak the Poor': Recent Trends in Hospital Pricing" by Gerard F. Anderson, Health Affairs, Vol. 26, No. 3, (May/June 2007), p. 784-785.

6 "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing" by Gerard F. Anderson, Health Affairs, Vol. 26, No. 3 (May/June 2007), p. 784-5; "Best Practices for Self-Pay Collections" by Tina Eller, Healthcare Financial Management Association, June 2008, p. 51.

7 "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in

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Hospital Pricing" by Gerard F. Anderson, Health Affairs, Vol. 26, No. 3 (May/June 2007), p. 781, 783-4, 787.

[8] "Collection Reform: Build Stronger Relationships with Self-Pay Patients" by Geoffrey J. Hakel, Healthcare Financial Management Association, September 2005, p. 134.

[9] "Best Practices for Self-Pay Collections" by Tina Eller, Healthcare Financial Management Association, June 2008, p. 50, 51.

[10] "The Changing Face of Self-Payment in Hospitals" Healthcare Financial Management Association, November 2009, p. 13.

[11] "Hospital or Banker?" Michelle Ponte, HealthLeaders Media, July 31, 2009, http://www.healthleadersmedia.com/content/MAG-235769/Hospital-or-Banker (Accessed 1/8/10).

[12] "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing" by Gerard F. Anderson, Health Affairs, Vol. 26, No. 3 (May/June 2007), p. 785.

[13] "From 'Soak the Rich' to 'Soak the Poor': Recent Trends in Hospital Pricing" by Gerard F. Anderson, Health Affairs, Vol. 26, No. 3 (May/June 2007), p. 786.

(Continued on next page)

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books], *"An Exciting Insight into the Healthcare Industry and Medical Practice Valuation"* [2002 – AICPA], and *"A Guide to Consulting Services for Emerging Healthcare Organizations"* [1999 John Wiley and Sons].

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows.

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the Senior Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia, and is a Fellow of the American College of Healthcare Executives. He has co-authored *"Research and Financial Benchmarking in the Healthcare Industry"* (STP Financial Management) and *"Healthcare Industry Research and its Application in Financial Consulting"* (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser's Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

Anne P. Sharamitaro, Esq., is the Vice President of **HEALTH CAPITAL CONSULTANTS** (HCC), where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the Journal of Health Law, published by the American Health Lawyers Association. She has presented healthcare industry related research papers before Physician Hospitals of America and the National Association of Certified Valuation Analysts and co-authored chapters in "*Healthcare Organizations: Financial Management Strategies*," published in 2008.