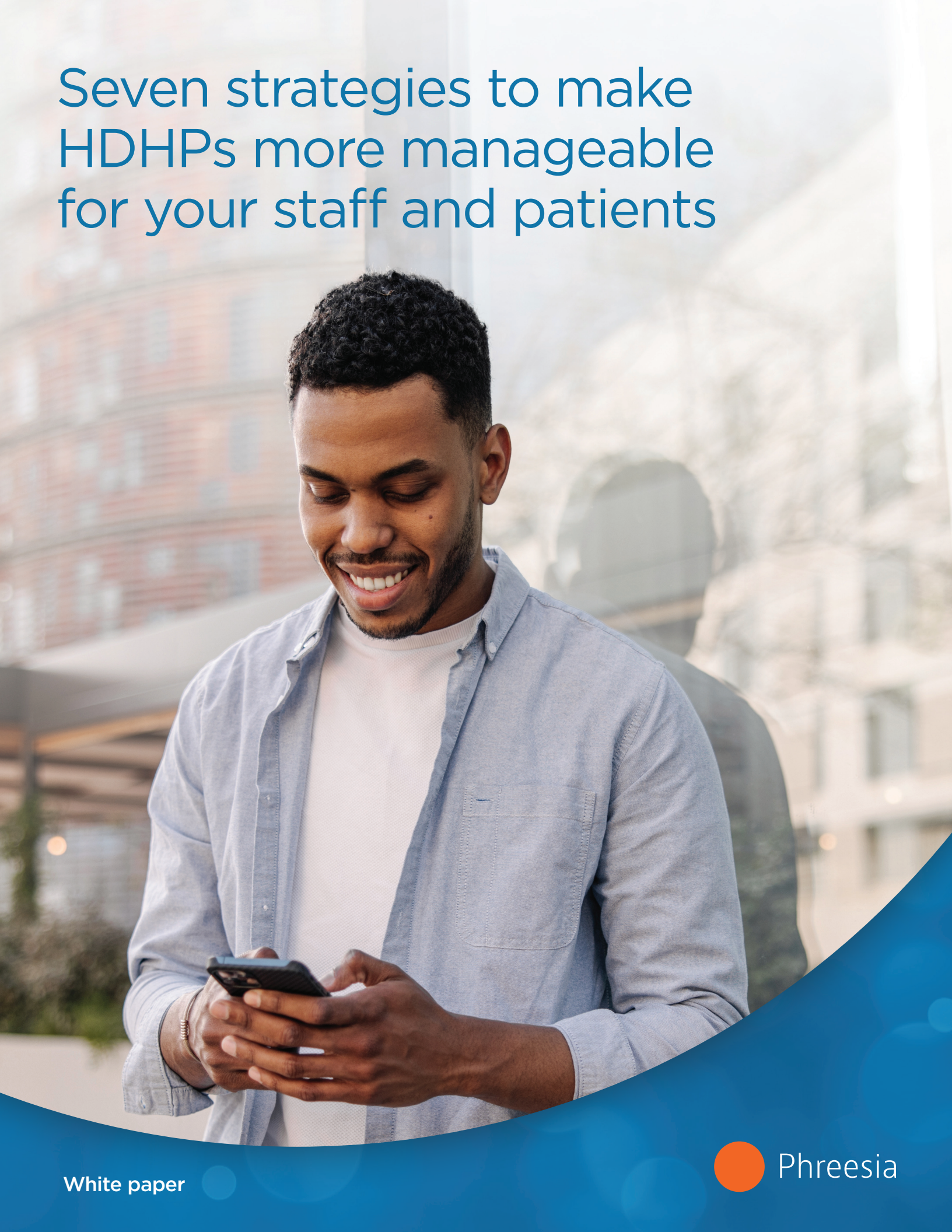
Seven strategies to make HDHPs more manageable for your staff and patients



White paper

Phreesia

Executive summary

For at least the past decade, employer-sponsored health insurance premiums have outpaced both wage growth and inflation,[1] exacerbating deepening fault lines in patients' ability to pay for their care. And as high-deductible health plans (HDHPs) become more prevalent, patients' financial responsibility is rapidly growing.

As recently as 2021, more than half (55.7%) of U.S. employees with employer-sponsored health insurance were enrolled in HDHPs.[2] On the surface, high-deductible plans are a boon to patients: They keep premiums low, and they typically provide full coverage for in-network preventive services. They also usually offer patients the option to contribute to a health savings account—a tax-advantaged way to save money for qualifying medical expenses.

But they also put patients at risk of amassing medical bills they can't afford. In 2023, the Internal Revenue Service raised the minimum annual deductible for HDHPs to $1,500 for individual coverage and $3,000 for families. The IRS also increased out-of-pocket maximums to $7,500 for individuals and $15,000 for families.[3] Considering that half of adults nationwide would be unable to pay for an unexpected $500 medical expense in full,[4] a single surprise bill could present serious financial hardship for millions of Americans enrolled in HDHPs.

That's a sobering reality for healthcare organizations. Nearly 1 in 5 U.S. households cannot afford to pay for their medical care upfront[5]—and the longer a patient's balance goes unpaid, the greater the cost to collect.[6] Worse, rising out-of-pocket expenses may prompt patients to indefinitely delay getting care. A Kaiser Family Foundation (KFF) study found that half of U.S. adults with high health insurance deductibles postponed care in 2022 because of cost.[4] And when costs inhibit a patient from seeking care, their outcomes suffer—as does their healthcare provider's bottom line.

Undoubtedly, the growing dominance of HDHPs has made getting paid in full for medical services a lot harder than it used to be. Fortunately, there are tools and techniques that healthcare organizations can employ to restore reliability to their revenue cycle and make high-deductible health plans more manageable for their patients and staff.

Here are seven strategies that can help:

1. Help patients understand their financial responsibility
2. Give patients flexible, discreet ways to pay for their care
3. Help patients get full value from their insurance
4. Connect patients with financial assistance
5. Offer discounted bills
6. Schedule elective procedures before deductibles reset
7. Arm your employees—and tap into their strengths

1 Help patients understand their financial responsibility.

Many of the payment challenges healthcare organizations face with high-deductible plans are tied to patients' confusion about costs. Unexpected medical bills top the list of Americans' biggest financial worries, according to KFF research[7]—and when patients receive a surprise bill, they're less likely to pay it in full or pay promptly. And even when patients are able to pay a medical bill they didn't expect, the experience can damage their relationship with their physicians.

It's worth noting that the federal No Surprises Act, which took effect in 2022, has helped minimize the likelihood of patients unknowingly receiving high-cost care.[8] But since the Act didn't change the cost of care, the onus is still on providers to make sure that patients understand what they will owe at the time of service.

To avoid confusion and underpayment, healthcare organizations should provide financial information to patients earlier and reiterate costs more often—even before requesting payment. It's equally important to educate patients about common health insurance terms with which they may be unfamiliar. Consider these strategies:

- **Post insurance term definitions** at the front desk next to an easy-to-read financial policy
- **Use automated eligibility and benefits verification tools** to help patients understand their healthcare coverage and track how close they are to meeting their deductible
- **Simplify medical bills** to clarify patients' financial responsibility, including not only how much is owed, but also a summary of the services included in each bill

Staff also should remind patients that their payment obligations are set by their health plan and urge them to talk to their benefits manager or insurer if they have detailed questions. When financial terms are explained in detail before the time of service, patients are more prepared to pay when they arrive, helping to minimize waiting-room bottlenecks and avoid uncomfortable financial conversations during their visit.

2 Give patients flexible, discreet ways to pay for their care.

Managing a large, unexpected expense can be stressful under the best of circumstances. Confronting that surprise when dealing with an illness or a medical procedure is even tougher.

Healthcare organizations can help alleviate that stress—and get paid more consistently—by offering patients flexible ways to pay their medical bills. Payment plans, for instance, can divide patients' large balances into manageable monthly installments. In fact, one study found that more than 80% of patients would likely choose to make recurring medical-bill payments if their provider offers that option.[9] Knowing they won't have to come up with thousands of dollars on the spot can come as a huge relief to patients enrolled in high-deductible plans, and it reduces their risk of nonpayment.

Furthermore, consumer-friendly options like online payments, card on file and mobile payment services—such as Apple Pay® and Google Pay™—can give patients more control over their finances as they assume greater responsibility for the cost of their care. When providers can offer patients flexible payment options, it diminishes the time-consuming and costly need to chase down past-due balances with phone calls and mailed statements. It also improves the likelihood that patients will pay their bill in full,[10] which helps increase collections both at the point of care and after the patient leaves the office.

By using technology to streamline payments, healthcare organizations can save staff time, boost reimbursement potential and get paid faster.

3 Help patients get full value from their insurance.

One of the most unfortunate consequences of high-deductible health plans is the anxiety they cause patients about the cost of their care, often leading them to delay beneficial or even necessary services. In fact, sometimes patients are so confused about what their health plan covers, they skip care that doesn't even have an out-of-pocket cost.

Under the Affordable Care Act, for example, the vast majority of health plans—including HDHPs—are required to cover evidence-based preventive services and eliminate cost-sharing for preventive care. That means many clinical screenings, routine vaccinations, annual physicals and well-child visits, among other services, are fully covered by most patients' insurance plans. But oftentimes, patients don't realize they won't incur out-of-pocket costs for most preventive care. They may skip an important visit, thinking that they're saving money, but instead miss out on covered services that could help them avoid poorer health outcomes in the future.

But by using technology to track preventive service utilization, provider groups can easily identify patients who are past due for preventive care and let them know that those services are covered by their insurance. In addition, healthcare organizations can send automated recall messages that segment their patient population by demographics, clinical history and other variables to reach relevant patients at the right time and help them fully utilize their benefits.

Most medical offices are less busy at the start of the year when patients' health insurance deductibles reset.[11] By recalling patients to schedule overdue preventive visits during that time, provider organizations can bolster their cash flow and make it easier for patients to get the care they need at the time they prefer.

4 Connect patients with financial assistance.

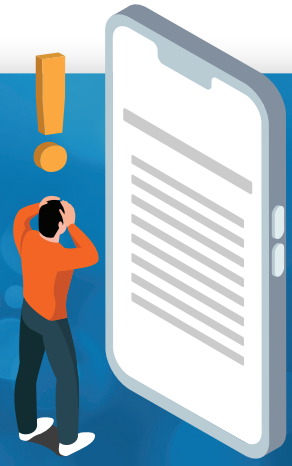
Nearly two-thirds of patients want to talk to their providers about out-of-pocket costs, but only 15% have done so, according to a Journal of General Internal Medicine study. Among patients who hadn't brought up care costs with their doctor, the most-cited reasons included "discomfort in discussing financial issues, insufficient time, a belief that there were no viable solutions to the patients' concerns, and lack of knowledge about costs," researchers found.[12]

Although initiating candid financial conversations may make patients feel uncomfortable, that doesn't mean resources aren't available. Vendors, nonprofits and government agencies alike offer scores of financial assistance programs to help patients cover the cost of their medical bills. Yet 64% of consumers are unaware that such programs exist.[13] When patients don't know how to access financial assistance, they may neglect to seek it—or simply assume they won't qualify for aid.

To close that knowledge gap, provider organizations should leverage technology to digitally screen patients for financial-aid eligibility during check-in. Hospitals and health systems with mandated financial assistance policies, for example, can screen patients during registration and automatically flag them for presumptive eligibility based on their household income, access to transportation and other social risks. And for healthcare organizations that aren't required to offer charity care, technology can help identify patients who might benefit from community-based resources, such as financial counseling or government-sponsored assistance programs.

Financial assistance makes healthcare more affordable for patients who need it most, and it also helps provider groups avoid bad debt. To that end, healthcare organizations should maintain a list of local financial assistance programs—perhaps even posting links to their website—to ensure that all patients are aware of the resources available to them and can easily apply for support.

When patients understand the types of aid available to them, they're more likely to apply for it—and less likely to delay important care.



5 Offer discounted bills

For many patients in HDHPs, the chances of meeting their deductible within any given year are slim. In fact, 44% of patients in HDHPs have less in savings than their total deductible amount.[14] That presents a particular challenge for providers looking to collect balances in full at the time of service: If patients know they can't pay for the total cost of their care, they may feel discouraged and avoid making a payment at all.

The solution? Incentivize patients by offering them a cash discount. Research shows that 93% of patients would be likely to take advantage of a lump-sum discount for paying their bill in full, if their provider offered that option.[9]

In years past, it was commonly assumed that healthcare organizations could not offer discounts to insured patients, even when those patients paid their entire bill upfront. But times have changed, and many providers realize that offering payment discounts improves patients' likelihood of paying their financial responsibility in full.

6 Schedule elective procedures before deductibles reset.

When year-end approaches, some patients either will have met their deductible or will be within striking distance, making elective procedures they may have delayed earlier in the year suddenly more financially appealing. Some patients also may gain tax benefits if they can schedule an elective procedure before the end of a year in which they've used many other medical services.

Certainly, the last few months of the year can be an opportunity for providers to drive revenue and better serve patients on high-deductible plans—but only for healthcare organizations that plan ahead.

To capture those patients before the calendar year turns over, provider groups should use a third-party vendor to identify patients who have opted to put nonemergency procedures on hold. Automated reminder messages should then be sent to those patients to remind them that their deductibles will reset soon and encourage them to schedule an appointment before December 31.

In addition to automated reminders, healthcare organizations should ramp up their digital marketing efforts to more easily recall patients before deductibles reset. Consider communicating with patients through social media or by sending out a blog or newsletter with a short article about the January deductible reset to spotlight the financial benefits of scheduling procedures before the end of the year.

Be aware that patient demand for year-end procedures can make for heavy workloads, so healthcare organizations should proceed with caution. When sending automated recall messages, be mindful of staff capacity—and **consider reminding patients about the deductible reset** well before December to maintain a balanced schedule through the end of the calendar year. Accommodating as many patients as possible in the fall can make cash-flow challenges during the winter months much easier to weather.

7 Arm your employees—and tap into their strengths.

As out-of-pocket costs rise, administrative and billing staff have been tasked with more efficiently collecting from patients. But the healthcare staffing crisis isn't making that easy, and insurance plan rules can be quite challenging for staff to understand and explain. What's more, research shows that most patients prefer to digitally pay their medical bills,[15] rather than mailing a check or being asked to pay by a staff member during or after their visit.

Healthcare organizations need to equip their staff with the tools they need to collect well, and that all starts with the right technology and training. Provider groups should implement digital tools that can help staff assess patients' financial responsibility, reconcile payments and verify insurance at the time of service—and adequately teach them how to use those tools. In addition, healthcare leaders should train staff on how to handle common payment questions and scenarios to help them feel more comfortable with the collection process.

Remember, too, that the technology to support front-office processes has evolved dramatically in recent years. Healthcare organizations should communicate regularly with their PM or EHR vendor and proactively assess third-party solutions to take full advantage of tools like mobile and online payments, payment plans, card on file and real-time eligibility verification. By leveraging technology and engaging patients in more modern billing approaches, healthcare organizations can increase collections while successfully guiding patients through the payment process.

Most importantly, healthcare leaders should routinely seek input from their front-office team members. Administrative staff are the front lines of patient service, and their perspectives on patient concerns and the effectiveness of the organization's financial policies can help leaders continually refine their patient-communication and collections procedures as times change and health plans evolve.

About Phreesia

Phreesia is the trusted leader in patient activation, giving providers, health plans, life sciences companies and other organizations tools to help patients take a more active role in their care. Founded in 2005, Phreesia enabled more than 120 million patient visits in 2022—more than 1 in 10 visits across the U.S.—scale that we believe allows us to make meaningful impact. Offering patient-driven digital solutions for intake, outreach, education and more, Phreesia enhances the patient experience, drives efficiency and improves healthcare outcomes.

To learn more, visit **phreesia.com.**

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