Appealing to Cash Pay Patients

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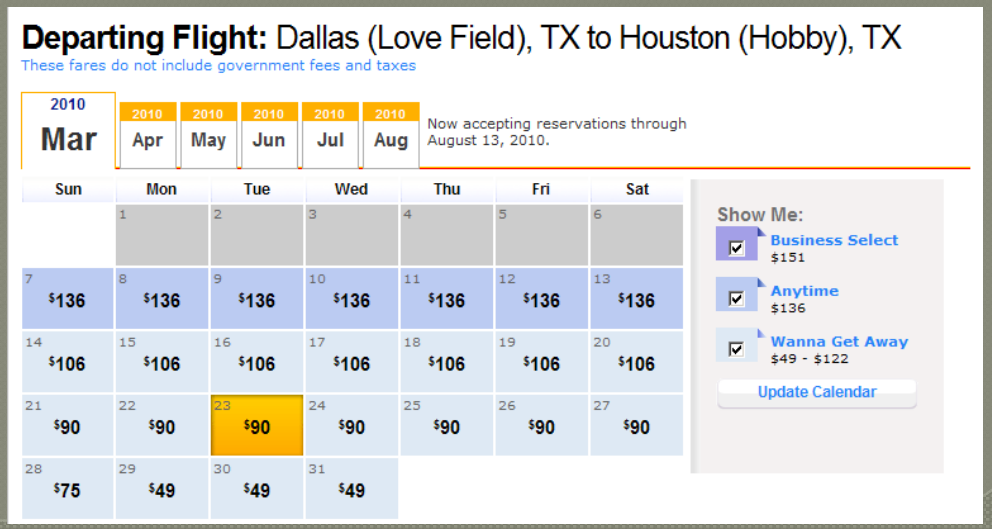
Objectives

- Understand trends, characteristics, and misconceptions of the rising number of uninsured.
- Describe the business case for appealing to cash pay patients.
- Identify problems with urgent care pricing based on maximizing insurance reimbursement.
- Develop a fair cash pay pricing model that does not jeopardize insurance contracts.
- Explain the pros and cons of various marketing tactics.

"How much does a visit cost?"

- Typical urgent care responses:
  - *"It depends on what the doctor finds…"*
  - *"Visits start at $75 and go up to $350…"*
  - *"We don't know until it goes to our billing company…"*
- Result is a "blind" transaction—patients who cannot predict prices will often forego care.



Urgent Care Billing Issues

- Pricing is conventionally set to maximize insurance reimbursement.
  - Insurance pays lower of “contract” or “billed charges.”
  - Fee schedule is typically 150-200% of Medicare; adjusting off 50% as “contractual allowance.”
  - Pricing bears little connection to the “value” of services rendered.
- *How fair is it to provide discounts to billion-dollar insurance networks but charge full price to the patients who can least afford it?*

Why appeal to self-pay patients?

- Growing numbers of uninsured consumers.
- Proliferation of high-deductible health plans and price-savvy consumers.
- Appeal to niche markets (Hispanic, tourists).
- Closed or monopoly insurance networks.
- Insurance (or Medicare) reimbursement below operating costs.
- Patients paying cash for privacy or convenience.

Profile of the Uninsured

- Approx. 46 million people ranging from:
  - 20-30 million uninsured during an entire 1-year period to;
  - 80 million uninsured at some point during a 2-year period.
- 80% of uninsured are adults in their prime working years
  - Of the 20% who are children, many are eligible for Medicaid/SCHIP but parents don't know they qualify.

Source: Henry J. Kaiser Family Foundation, 2009.

Profile of the Uninsured, cont'd.

- 66% are employed full-time but work:
  - In low-skill, low-pay service jobs.
  - In multiple seasonal or part-time positions.
  - In retail or service industries.
  - For small businesses (or are self-employed).

Source: Henry J. Kaiser Family Foundation, 2009.

Profile of the Uninsured, cont'd.

- Uninsured are disproportionally represented among:
  - Minorities and immigrants
    - 41% of Hispanics are uninsured
  - Young adults ages 18-29 (~28% uninsured)
  - Less educated and/or less skilled
    - 2/3 of uninsured are not college grads
    - 1/3 of uninsured didn't complete high school
  - Southern and Western states (less likely to provide Medicaid)

Sources: Gallop Organization, 2009.

Health Insurance Trends

- Approx. 60% of employers offer health insurance benefits, a decline of 15-20% since 2000.
- Employers are challenged by rising premiums and falling revenues in a soft economy.
  - Structural shift from full-time to part-time, seasonal, and contract workers.
- Employers are sharing a greater proportion of costs with employees through:
  - High deductible health plans.
  - Reduced premium contributions.
  - Rising co-pays and co-insurance.

Myths About the Uninsured

- 46 million statistic is misleading
  - 50% had insurance at least part of the year
  - 19 million are not citizens of the United States
  - 18 million are under age 34 and in good health
  - 14 million are eligible for Medicaid/SCHIP
- There are 8.2 million “structural” uninsured
  - Make too much to qualify for federal benefits
  - Cannot afford private health insurance
- Many “uninsured” are actually “self insured”
  - 17.2 million make >$50,000/year
  - 9.1 million make >$75,000/year

Source: *Myth of the Uninsured,* American Spectator, March 20, 2009.

A Viable Market for Health Care?

Is “Cash Only” possible?

- Only when serving a niche or captive market:
  - Hispanic
  - Tourists
- Services must be unique, have strong competitive advantage, or have no competition;
- Otherwise, insurance plans will drive patients to competing practices.

Cash Pay and Medicare

- Medicare's "most favored nations clause" applies to "billed charges" not "cash collections."
- Medicare allows cash discounts proportional to savings in claims processing.

Cash Pay and Medicare, cont'd.

- Participating and non-participating providers are bound to treat Medicare patients at Medicare rates and submit a claim to Medicare for services.
- Medicare patients desiring to pay cash must agree:
  - There is no compulsion to enter into a cash transaction.
  - Provider would otherwise bill Medicare for services.
  - Provider and/or patient will not submit a claim to Medicare.
  - Agreement is not a "Private Contract" and provider may continue to bill Medicare for services.

Medicare Private Contract

- Applies to providers who have “opted out” of Medicare for a two-year period by sending an affidavit to their carrier and a notice to patients.
- Opt-out providers may not charge Medicare-eligible patients without a “private contract” (except for emergency/urgent conditions).
- Private contract outlines:
  - Patient will pay provider directly for services.
  - Contract is voluntary and patient may seek care from a Medicare provider elsewhere.
  - Medicare limits do not apply to charges.
  - Provider and/or patient will not submit a claim to Medicare.

Setting the Cash Price

- Create a coding distribution to profile services utilization of current patient base.
- Understand current insurance reimbursement by plan, code, and average patient.
- Evaluate discounts, write-offs, and collections per patient (aggregate and by level of service).
- Assess any global or flat fee contracts.
- Assess any insurance “most favored nations clauses.”

Setting the Cash Price, cont'd.

- Understand insurance billing and A/R carrying costs including:
  - Charge entry
  - Claims submission
  - Statement rendering
  - Cash posting
  - Third-party collections
  - Working capital
- Evaluate competitor's cash pay pricing.

Advantages of Cash Pay

- Improved cash flow resulting in reduced working capital.
- Savings of $10-15 per claim in billing, collections and posting costs.
- No accounts receivable carrying costs.
- No bad debt write-offs.
- Streamlined operational processes (no insurance verification results in faster service).

Tactics: %-Off Discount

- Percent discount (10-35%) off insurance fee schedule.
- Calculate charges and apply discount after services are provided.

Pros	Cons
Cash discounts more closely resemble insurance adjustments.	Lack of pricing transparency—cannot quote price until after the visit.
Prices are easy to calculate off charge ticket.	No advertising advantage—10 to 35% off of *what*?
Consistent margin—payment aligns with services provided.	Providers code to bill rather than code to services—may result in downcoding.

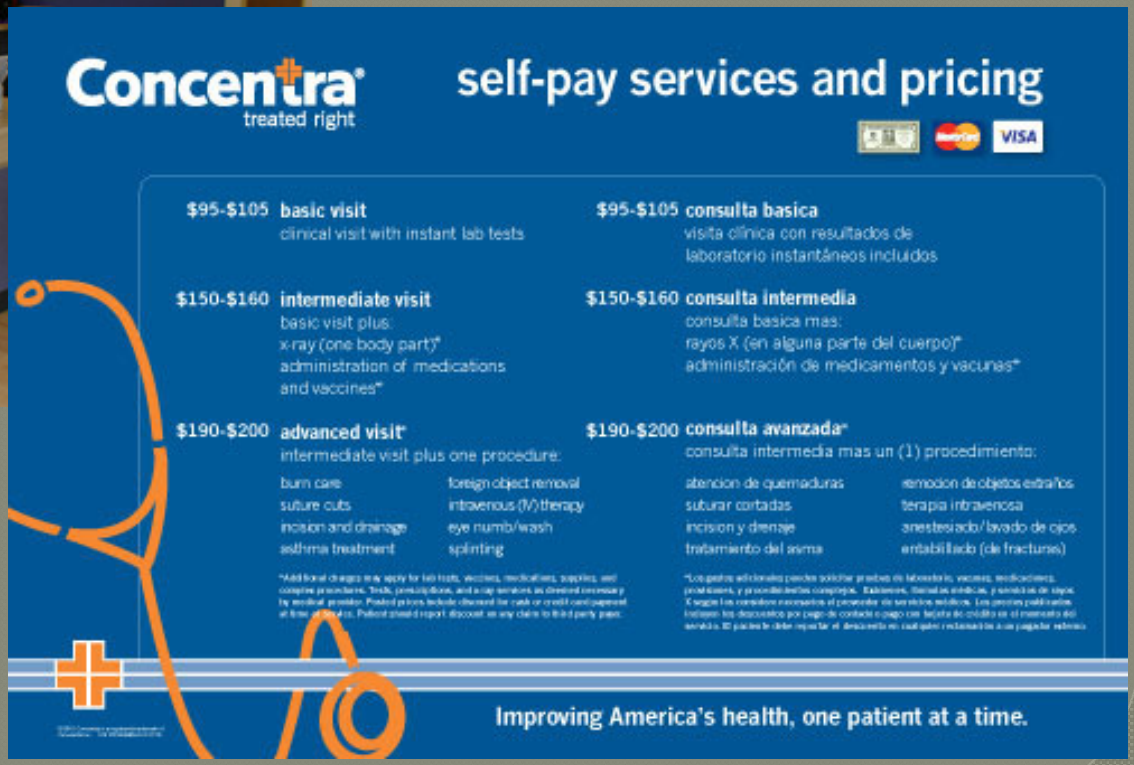
Tactics: Flat Price per Visit

- Posted flat price (or tiered flat price) per visit.
- Adjust “billed” charges to cash price.
- Strategy of many retail host model clinics.

Pros	Cons
Resembles insurance global fees—prices include all services.	Pricing does not align with charge ticket—adjustments will vary by patient.
Pricing transparency—easy for consumers to understand.	Based on average charges—like any global fee, center will lose money on some visits.
Emphasizes urgent care value proposition of access and affordability.	Requires ongoing analysis of utilization and reimbursement by charge tier.

Posted Menu Board

Solantic Walk-in Urgent Care,
Gainesville, Florida



Concentra Urgent Care
www.concentraurgentcare.com

Couponing Promotion

Hometown Urgent Care
Columbus, Ohio

Tactics: Membership Program

- Flat price or percentage discount requires patient to purchase a “membership.”
- Revenue per visit includes cash paid at time of service plus membership dues.

Pros	Cons
Cash discounts are offset by membership fee revenue, resulting in higher average reimbursement.	High utilization patients could undermine margins.
Reliable monthly cash flow from membership base.	Complexity in administration (credit card expirations, card verification, staff sales incentives).
Loyalty effect resulting in increased visit frequency.	Membership churn—patients join to get discount on current visit but then cancel.

Membership Program

- Patient motivation is discount on current visit.
- Opens up a sales opportunity to local employers.
- Developed internally or with vendor assistance.
- Downstream benefits—pharmacy discounts or PPO access—may support sales and/or reduce churn.
- Medical discount cards are not regulated as insurance—there is no actuarial risk.

Service (see below for inclusions*)	Cost with VALUECARE Membership	Avg. Cost Without VALUECARE Membership	Avg. Savings With VALUECARE
OFFICE VISIT-Standard	**$80**	**Approximately $160**	**You save $80**
OFFICE VISIT-With Additional Services (see below for inclusions*)	**$125**	**Approximately $275**	**You save $150**
ALLERGY TESTING	**$155**	**$600**	**You save $445**

Operational Considerations

- Train staff as to what types of services constitute what charges—develop conversion tables or “cheat sheets” as appropriate.
- Coding should be independent of charges—code to services, not price.
- Consider exclusions for lab, vaccines, medications, x-ray over-read, and ancillary services.
- Collect some cash in advance of a visit (prevents walk-offs).
- Patient receipt should show “billed charges” and discount off fee schedule to prevent insurance windfall on out-of-network claim.

Promotional Considerations

- Differentiate the urgent care based on price.
  - Transparent pricing supports urgent care's value proposition of accessibility/affordability.
  - Promote cash pay pricing in the center through marketing materials and staff incentives.
  - Positive brand associations can drive insurance visits.
- Identify populations of uninsured and other self-pay consumers.
  - Raise awareness through paid advertising and grassroots efforts.
  - Target employers and community organizations.

Contact Information

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