



# Analyze This

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## Some Hospitals Require Prepayment for services. Others make vast changes to their billing.

Area hospitals have created and implemented a new policy requiring many patients to pre-pay their portion of the deductible or co-pay for any medical services rendered. Other hospitals are changing their policies and procedures for collecting and assisting in medical bills. We have provided the public statements made by some of the area hospitals. We hope that you will read and pass on to your employees this valuable information.

### From Mountain Star:

*An increasing number of insured patients are not paying the portion of hospital bills that are their responsibility. In 2003, 25% of insured patients who used MountainStar hospitals failed to pay their co-pays, deductibles, and co-insurance. This is a growing problem: total unpaid (charity and uncollected funds) at the six MountainStar Health Care hospitals has risen 79% from 2002 to 2004.*

*With the growing number of insured patients not paying their portion of hospital bills, MountainStar Health Care hospitals typically collect co-pays, deductibles,*

*and/or co-insurance at the time of the service or before they leave the hospital.*

### From IHC:

*“For decades, IHC has provided care to residents of the Intermountain region with medical needs, regardless of ability to pay—and that will continue,” said Bert Zimmerli, IHC Senior Vice President and Chief Financial Officer. “We’re making some additional enhancements to make our processes even more patient-friendly.” In 2004 IHC expanded its 30-year-old program that provides charitable medical care... Changes to IHC’s charitable financial assistance program include the following:*

- *IHC will not use a court proceeding to collect an unpaid medical bill unless there is evidence of fraud or an indication of ability to pay coupled with refusal to pay. Currently, out of millions of patient encounters every year, only one out of 1,000 patient bills are delinquent to the point where a court action is needed for collection. Most bills are resolved through insurance, individual payments, or by the patient applying for charitable financial aid.*

- *For patients who choose to make extended payments on their bill, IHC has reduced the interest charged on those*

*accounts from 14.5 percent to eight percent. Those currently on a payment plan have already had their interest rates reduced. Patients with a documented financial need can be set up on a payment plan with zero interest.*

- *Several Citizens Advisory Groups will be established in different parts of the state to review and give input into IHC’s billing and collection processes. This group will be comprised of volunteers from diverse segments of the community.*

- *IHC has established an information “help line” for questions regarding charitable financial assistance. The toll-free number is 1-800-442-1128 or 1-801-442-1128 in Salt Lake County. Inquiries can also be submitted online at [www.ihc.com](http://www.ihc.com).*

- *An ombudsman’s office will be established to be an advocate for patients with billing problems or other concerns.*

- *IHC will also continue to let patients and the community know that charitable financial assistance is available through a variety of means.*

We at Fringe Benefit Analysts work each day to provide the necessary information for optimal service from hospitals, please feel free to call us to discuss further any of these new terms and what they mean to you, the consumer.

## UBA Benchmark Survey Employers Still Expect Double-Digit Costs; CDH Premiums Lowest

EVEN THOUGH employers expect a continual slow decline in the double-digit cost increases of the past six years in their health costs, they still anticipate average expense hikes of 12.2% (before any plan changes) next year. This was one of a series of findings from the recent UBA/Ingenix 2005 Health Plan Survey of 12,176 health plans sponsored by more than 8,700 employers. "This finding reflects little confidence that a substantive solution to rising costs has been found," says David LoCascio, UBA Co-Founder. Average premiums have increased to \$327 for single coverage, with employees contributing an average of \$53 of



significantly larger percentage of employers are considering adding such a plan next year.

Employee choice continues to proliferate. Over one-third of all employers now offer their employees two or more plans from which to choose. In addition, 63.9% of employees are enrolled

just what is happening with health plan costs, but why it's happening."

Other important findings include:

- The median single PPO deductible is now \$500; in-network and out-of-network coinsurance is 80% and 60% respectively.
- HMO premiums on average are approximately 5% lower than PPO premiums.
- Employers continue to explore a number of cost-containment strategies for prescription drug benefits: only 10.9% of all plans still have two copay tiers, while plans requiring four-copay tiers have become nearly twice as prevalent.

## ANNOUNCEMENTS

### CMS Extends Drug Subsidy Application Deadline One Month

Employers with retiree healthcare plans have until October 31, 2005 to submit applications to the Centers for Medicare & Medicaid Services (CMS). The one-month extension is automatic and employers do not have to request it. The subsidy is available to employers who retain retiree prescription drug coverage at least equal to what Medicare will provide. CMS also notes that employers may get workers' protected health information without violating HIPAA Privacy.



the cost. Average premiums for family coverage were \$927, with employees contributing an average of \$381 of costs. However, amidst employers' efforts to encourage employees to become better healthcare consumers to help control rising costs, the survey found that health plan premium increases for all plans averaged 9.6% in 2005 (after any plan adjustments) vs. 3.4% for consumer-driven health plans. Currently, only 2.6% of surveyed employers offer consumer-driven plans (high-deductible plans with an HRA or HSA), with 1.9% of all employees enrolled in the plans. A

in PPO plans, which provide benefits for services received from non-network providers, while only 20.1% of employees are enrolled in HMO or EPO plans, which typically provide no such non-network benefits.

"With employer health plan information reported for over 2,600 cities from virtually every state in the country, differences in plan design and plan costs between various regions and industry groups become apparent," says LoCascio. "This unique level of additional information provides important factors in determining not