



Prescriptions

Medical Alert

Spring 2009

Many patients, especially those not accustomed to struggling financially, may be reluctant or even embarrassed to discuss these issues with their physicians.

Helping Patients Facing Financial Difficulties

As growing numbers of Americans lose their jobs and their health insurance, physicians are seeing more patients struggling to pay for health care for themselves and their families. However, there may be ways your practice can continue to serve patients facing financial difficulties, while still covering your own costs.

In the current economic climate, many patients are struggling to cover their health care costs, according to a 2008 study published by the Kaiser Family Foundation. Based on a survey conducted in October, the study found that one-third of Americans had difficulties paying medical bills over the past year, up from about one-quarter two years ago. In addition, 18% reported having trouble over the past year paying for medical bills totaling more than \$1,000. The survey also showed that significant numbers of patients are cutting down on or forgoing medically necessary care: 47% of respondents said a member of their family is skipping prescription medications, or postponing or cutting back on necessary medical care due to cost.

Even those who are insured could have problems covering rising co-payment and co-insurance costs for themselves and their family members. Yet, many patients, especially those not accustomed to struggling financially, may be reluctant or even embarrassed to discuss these issues with their physicians. There may be times, however, when a form of “economic triage”—or helping the patient to choose the most important treatments within his or her budget—may become necessary. This type of discussion may be especially useful for patients with chronic or acute illnesses who face regular, and often very high, medical costs.

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New Legislation Expands Children's Health Insurance Program

Following a long period of uncertainty about the future of the State Children's Health Insurance Program (SCHIP), President Barack Obama signed legislation on February 4 that expands the program to include millions more children living in low- to middle-income households.

To expand the SCHIP program, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provides additional funding to states to provide health insurance to children whose families earn too much to qualify for Medicaid, but lack access to other forms of insurance. Under the new legislation, the number of children covered under SCHIP is expected to grow from the current 7 million to around 11 million. The reauthorization is for 4.5 years, and it is expected to cost \$32.8 billion. The expansion of SCHIP will be funded almost entirely through an increase in the Federal tobacco tax of 62 cents per cigarette pack.



medical expenses and avoiding costly emergency room care.”

President Obama, who stressed his support for SCHIP during the election campaign, expressed satisfaction with the opportunity to sign the bill into law. “Today, with one of the first bills I sign...we fulfill one of the highest responsibilities we have: to ensure the health and well-being of our nation's children.”

Since it was created more than a decade ago, the President added, “the Children's Health Insurance Program has been a lifeline for millions of kids whose parents work full time, and don't qualify for Medicaid, but through no fault of their own don't have—and can't afford—private insurance. For millions of kids who fall into that gap, CHIP has provided care when they're sick and preventative services to help them stay well. This legislation will allow us to continue and build on these successes.”

CHIPRA passed the House of Representatives by a vote of 289 to 139 and the Senate by a vote of 66 to 32. Critics of the bill contended that the program was not adequately targeted to low-income children, and that the availability of SCHIP could encourage middle-income parents to move privately insured children to government-subsidized coverage. They also objected to a provision in the bill that allows states to extend SCHIP coverage to legal immigrants without requiring a five-year waiting period.

Following the approval of the bill in the Senate, House Speaker Nancy Pelosi described SCHIP as a program “which is critical to supporting hard-working families in these difficult economic times.”

By ensuring health care for these children, Pelosi continued, “families will get regular doctor visits and preventive care so that minor illnesses do not become more serious, saving parents out-of-pocket

A day after signing CHIPRA, President Obama also lifted a directive that would have penalized states that enrolled middle-income children in SCHIP without proving that they had enrolled 95% of lower-income children living in the state. Under the directive, middle-income families would have also been required to wait a year after losing private coverage before applying for SCHIP.

American Medical Association (AMA) president Nancy H. Nielsen, MD, PhD, also praised the passage of the legislation, which she said came at a time when the economic downturn has added more children to the ranks of the uninsured. “Years of hard work and commitment to reauthorize SCHIP with proper funding and expanded eligibility have finally paid off,” Nielsen said. “Now millions more American children will be able to get the health care they need to have the best chance to learn, develop and succeed in life.” *P*

Measuring the Efficiency of Your Practice

With growing reimbursement problems and increasing overhead costs, many physicians are seeking ways to maximize the efficiency of their practices. Financial assessments, when used as part of an overall analysis of your practice, can serve as helpful indicators of inefficiencies and other sub-standard operating procedures that could be improved to maximize the efficiency of your practice.

The following efficiency analyses can provide your practice with valuable insight into key details of daily operations:

One of the most basic yardsticks used for measuring efficiency is gross charges, or the total volume of services billed during a given period. Gross

charges may then be categorized by physician. But, these figures reveal little on their own, especially if physicians use varying fee schedules or have different payer mixes.

By comparison, net collections may provide a more accurate indication of the efficiency of your practice. In practices that measure net collections, physicians may be more likely to ensure that charges are submitted on time, and office staff may be more likely to follow up on outstanding patient bills. But, again, this measure also has its limitations, as the net collections of individual physicians will vary according to the patients seen. For example, physicians who have more pediatric or elderly patients, or physicians who tend to perform procedures with lower reim-

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These conversations may be initiated with questions such as, “Are you finding your prescription costs manageable, or should we consider generic alternatives?” If patients have delayed treatments or failed to react promptly to screening reminders, you may want to ask them directly if financial considerations played a role in these delays. It may be necessary to explain to patients why these screenings are vital to their health and why following dosage instructions is essential when taking prescription medications. These discussions may also provide an opportunity to remind patients that they may be able to use diet and exercise strategies to maintain and even improve their health, thus cutting down on the number of medications they require and the frequency and severity of their health problems.

In some cases, those without health insurance may be eligible for public assistance, especially if they have young children. Provide such patients with contact information for agencies that can provide more information about their insurance options. In some cases, it may also be necessary to refer patients to public clinics or foundations that may provide assistance for specific types of screenings, such as those for diabetes or certain types of cancer.

Depending on the scope of the problem in your practice, you may want to consider appointing a staff member to act as a financial counselor to patients

who are having difficulties paying their bills. Counselors may help patients arrange payment plans or find other sources of assistance for their medical debt problems, while still helping them get the care they require. In other cases, it may be possible to negotiate discounts for patients who anticipate future problems in covering the cost of care due to the loss of a job or insurance. Occasionally, the counselor or the physician may choose to advocate for the patient, appealing to insurers to cover a particular treatment or drug following an initial refusal, or to nonprofit groups that can help patients obtain medications or treatments not paid for by insurance at reduced or no cost.

While you certainly want to continue to treat long-standing patients, it is important to set limits on the scope of unreimbursed services you are able to provide. Do not encourage patients to use the phone and e-mail to avoid recommended office visits. Remind patients with chronic illnesses that you need to see them regularly to ensure that their existing health problems are under control, and that no new issues have arisen as a result of their condition. Starting these conversations can seem awkward at first, but having an upfront discussion about financial challenges can go a long way toward helping patients get the care they need at a more affordable price, while reducing the practice’s number of unpaid bills. *P*

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bursement rates, are more likely to have lower net collections for the same number of hours worked.

Yet another way to measure practice efficiency is by numbers of patient visits and the distribution of those visits over a given period of time. This can help in determining whether visits are being scheduled in a way that maximizes the resources of the practice. For example, a practice may want to ensure that at least one physician has enough room in his or her schedule on any given day to see walk-ins, but that the other physicians are as fully booked as possible.

Another approach that may provide a more standardized view of practice efficiency is to assign relative value units (RVUs) to services rendered. RVUs take into account a variety of factors that can affect the measurement of efficiency, such as the work performed, practice expenses, and malpractice expenses. There are various methodologies that employ RVUs, including the Resource-Based Relative Value Scale (RBRVS) developed by the Centers for Medicare & Medicaid Services. Because this scale is based on Medi-

care rates, measuring productivity using the RBRVS eliminates from the equation varying fee schedules and payer mixes associated with individual physicians.

The efficiency of individual physicians is difficult to quantify. However, these measurements can reveal, for example, that one physician is ordering significantly more tests than another or that certain physicians are less vigilant in their coding methods than others. Such comparisons can be a helpful starting point for reviewing issues such as fee schedules, payer mixes, and the number of patients seen, as well as determining what individual physicians, and the practice as a whole, can do to improve efficiency and, ultimately, practice performance.

When considered as part of an overall analysis of your operations, these measurement tools can provide useful information and a general indication of specific areas that may require changes. Even small improvements to maximize the efficiency of your practice can save valuable dollars that could prove helpful with increasing costs. *P*

Primary Care Physicians Reasonably Satisfied with Their 2007 Incomes

Primary care physicians saw their incomes rise in 2007, and practice overhead costs appear to be stabilizing, according to a survey conducted by *Physicians Practice* magazine and recruitment firm Merritt, Hawkins & Associates.

The survey found that primary care physicians saw their 2007 salaries rise 6.5% to \$171,500, down from an 11% increase to \$161,000 in 2006. Results also showed, however, that 43.75% of family practice physicians were satisfied with their earnings in 2007, an increase of 11.05% compared with the previous year.

When asked whether they received a bonus in 2007, 47.24% of the physicians surveyed said they received no bonus. Of those who received bonuses, 64.4% said the bonus was equal to between 1% and 10% of their total income, and just 14.85% said their bonus represented between 11% and 25% of their total compensation.

In addition, the survey found that just over 55% of the physicians reported that practice overhead amounted to more than half of practice revenues in 2007, down from 62% in 2006. Researchers noted that, according to the Medical Group Management Association, healthy overhead for a medical practice should be no more than 50%. Whereas 5.2% of physicians surveyed in 2006 indicated their overhead amounted to 80%–100% of income, the number who put themselves in that category in 2007 fell to 2.7%.