And the Survey Says: We Want a Positive Clinical AND Financial Experience

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With the increase in consumer financial responsibility and the migration toward risk-based reimbursement, healthcare providers have no choice but to experience fundamental transformations in their patient relationships. With patients’ growing share of revenue responsibility, the provider-patient relationship has developed a meaningful second dimension—that of financial, which exists outside of the treatment room.

That financial relationship is not simply about what happens in the relatively short stay in a hospital but is linked to how the patient fares in the weeks and months thereafter. Compounding this shift, remaining plan-based revenue—revenue paid by government and commercial insurance plans—is rapidly shifting toward bundle structures and other outcome-based models where the provider rates are tied to patient outcomes across multiple, related encounters over extended time frames.

The transition is often seen as the opening act in making healthcare a true consumer service. As patients evaluate the full-service experience over time and across encounters, one dimension of that experience is their interaction with the business office and revenue cycle function of the hospital. These interactions are not part of the traditional industry scorecards, which focus on events related directly to treatment. The financial relationship often starts well before this and extends well after—months or years depending on the insurance and financial situation.

Consumer satisfaction has been shown to correlate to long-term financial success for the institution. Research shows that dissatisfied customers/patients pose a higher cost to serve, and they are unlikely to return as well. Consumers tend to share bad experiences broadly, leading to ripple effects with other customers and opportunities. To overcome a consumer’s bad experience, it can take a company or organization upward of ten positive interactions to change the poor opinion.
RESEARCH HIGHLIGHTS

Among the findings in surveying 500 random consumers (recent patients), the results are summarized:

- Of the respondents, 95% had health insurance, similar to the level in 2014, but up significantly from 2010 when the insured portion was 86%.
- Only about a third of all patients rate their last billing experience with their hospital a 5 on a 1–5 scale. More than 50% rate their experience a 3 or lower.
- Satisfaction is unchanged from the 2014 survey, indicating a potential slowing pace of industry improvement. Satisfaction rates had been steadily improving in the 2010–2014 timeframe.
- Overall, the net promoter score for patients and their hospitals was 17%, with 46% being promotors and 29% detractors.
- Patients giving their hospital business interaction a higher rating are strong promotors of their hospitals and clinicians. Those with negative experiences are strong detractors.
- Respondents in poorer health tend to be more disappointed in the billing process. Income, age and gender do not appear to drive satisfaction.
- Those in high-deductible insurance plans are more often surprised by the amount they owe, and these surprises tend to drive customer service activity.
- In an effort to understand their bills, younger consumers tend to utilize third parties more significantly than prior generations did. This could be the result of less experience or simply generational differences.
- Out-of-pocket financial exposure does appear to influence consumer choice of facility and provider.

SURVEY METHODOLOGY AND SAMPLE

For the fifth time in six years, Connance surveyed 500 healthcare consumers about their last hospital encounter and their experience with the hospital business office. To qualify for the survey, a respondent had to live in the United States, be at least twenty-seven years old and have been to a hospital within the past twelve months. The survey was launched and completed in August 2016, and respondents represented a broad panel of Americans (see figure 1 for full demographics).

INSURANCE COVERAGE

Among the 2016 panel, 95% had insurance of some form, and only 5% were uninsured.

This level of insurance is similar to the 2014 sample and shows the general improvement of insurance coverage as a result of federal healthcare reform. Since our initial survey in 2010, the uninsured level has fallen from 14% of the sample to just over 5%, or by almost two thirds (see figure 2).

Of those with insurance, 33% identified their coverage as a high-deductible type, up from 24% in Connance’s 2014 Consumer Impact Survey (see Figure 3). The more than 50% increase in share of high deductible is consistent with the national shift toward high-deductible plan design.
PATIENT SATISFACTION

This year’s survey continued to show opportunities to improve the patient billing experience. Thirty-three percent of respondents gave their business office experience a top score of 5 while 50% scored their experience 3 or lower (see figure 4).

Looking solely at the 95% who had insurance, 35% are Very Satisfied—a bit higher than the overall sample—and 50% scored their experience a 3 or lower.

Looking across the six years of survey, there is an interesting trend in the percentage of consumers rating their experience a 5 and those rating their experience 3 or less (see figure 5). The share of respondents giving their experience a 5 (Very Satisfied) rose from 20% in 2010 to the 33% in 2014, but then has plateaued in the 2016 edition. Similarly, the share of respondents rating their experience 3 or less fell from 63% in 2010 to 50% in 2014 and then plateaued in 2016. It appears that performance has leveled off in the eyes of consumers over the past couple years, perhaps signaling that providers, while getting better, have not fundamentally changed the patient experience enough to really record the breakthrough.

NET PROMOTORS AND SATISFACTION WITH BUSINESS OFFICE INTERACTIONS

Across the sample, the net promotor score for this sample of 500 patients was 17%, composed of 46% of surveyed being promotors net of the 19% who were detractors (see figure 6).

When the population is split into those with superior business office interactions and those with less satisfying ones, the net promotor situation is profoundly different. In the 2016 survey, those giving their business office experience a top score of 5 had a hospital net promotor score of 80; those giving their business office interactions a score of 1 or 2, the lowest options, had a net promotor score of -63. This situation is consistent with all prior Connnace consumer surveys (see figure 7).

Consistent with research findings in traditional consumer service industries, uniquely superior or uniquely negative experiences will impact patients’ views on the hospitals and their likelihood to recommend. For people who indicated their last interaction changed their perspective on recommending the hospitals, 51% gave the business office a top score and 20% a 1, the lowest possible score. By comparison, among respondents who said their billing interactions had minor impact on their likelihood to recommend, only 19% gave the business office a top score and 4% a 1. Similarly, of those who said their interaction had no effect, 34% gave the experience a 5, the top score, and 3% a 1, the bottom score (see figure 8). In essence, extreme expenses influence future activity.

In a similar vein, among patients most likely to return to their facility for non-emergent procedures, 39% gave their business office interaction a top score of 5 and 5% a score of 1 or 2. By comparison, among those not likely to choose the facility again, 8% gave their business office interaction a top score and 43% a score of 1 or 2.
HEALTH INSURANCE TYPE, BALANCE DUE, AND PATIENT RESPONSE

With the rapid increase in high-deductible insurance, patients are facing significantly different levels of financial responsibility.

For many, the size of their financial exposure is an important surprise. Among the 36% who identified as having high-deductible insurance, 49% owed more than $500 for their last hospital event. By comparison, among those who identified as not having a high-deductible plan, only 11% owed $500 or more. Among the high-deductible cohort, almost 55% were surprised by the amount they owed compared to 11% among the other cohort (see figure 9).

Interestingly, when patients see the balance being greater than their expectation, they are more likely to engage business office resources. About 53% had already engaged customer service resources and 15% more were planning to. By comparison, among those whose balance matched expectations, less than 20% had already or planned to utilize customer service resources (see figure 10).

Patients, however, did suggest that the amount they might owe for hospital care would influence their choice of provider. Overall, 39% suggested that out-of-pocket costs would very likely influence their choice of hospital, and only 7% indicated that out-of-pocket costs would have little influence (see figure 11). This phenomenon is not apparently impacted by balance due for the last visit or plan type.

IMPLICATIONS FOR PROVIDERS

The 2016 consumer satisfaction survey confirmed many themes from prior years but added some important new ideas for healthcare providers:

- While the survey showed improved satisfaction with the business office of hospitals, the gains from 2010 seem to be leveling off.
- Satisfaction is again connected to the respondent’s sense of health—those with more health issues tend to be more dissatisfied.
- There continues to be a correlation between good business office interactions and net promotor scores for hospitals and clinicians.
- Those who are surprised by their balances tend to utilize business office resources more significantly.
- People in high-deductible plans tend to be more surprised by the amount owed.
- Younger patients are more engaged generally in the financial process, seeking information early and through multiple avenues over the course of their encounters.

As balances due from patients continue to rise, these trends will be drivers of provider operating costs and create the potential for process breakdown. They suggest the potential for elevated call volume, for protracted processes, and significant back-and-forth between patient and provider.

The proactive provider team may, however, see in this feedback a road map for improving the patient experience. Engage patients before they arrive regarding the process and their expected expense overall and out-of-pocket. Set expectations and then meet them. Target explanations to first-time customers. These are all possible basic levers to breakthrough performance—values that ultimately drive lower operating costs, stronger loyalty to the institution, and word-of-mouth momentum among your patients and community.