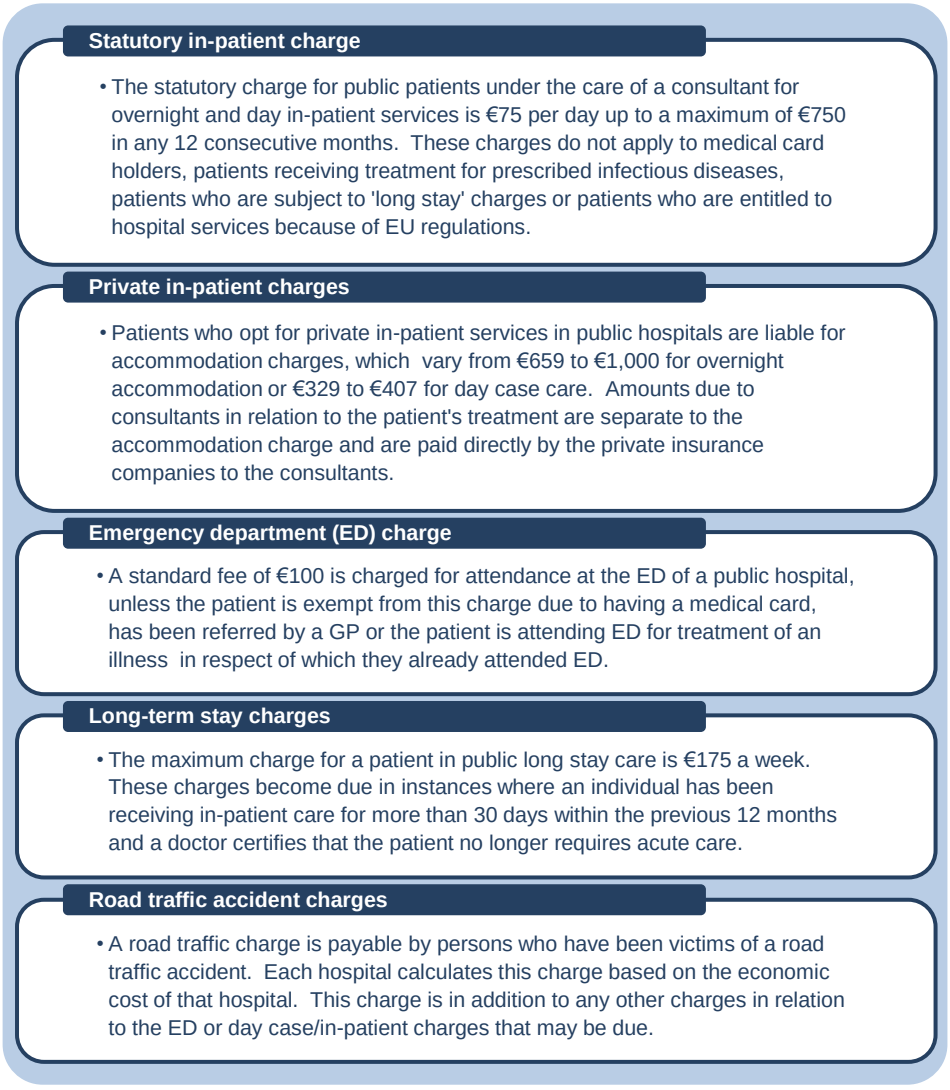
20 Management of Private Patient Income in the Health Sector

20.1 In 2014, just under 90% of the HSE's income was a grant from the Exchequer to fund the provision of health services in the State. The remaining 10% of its income is derived from excise duty on tobacco products, recovery of costs for services provided under EU regulations, patient income and a number of other minor income streams.

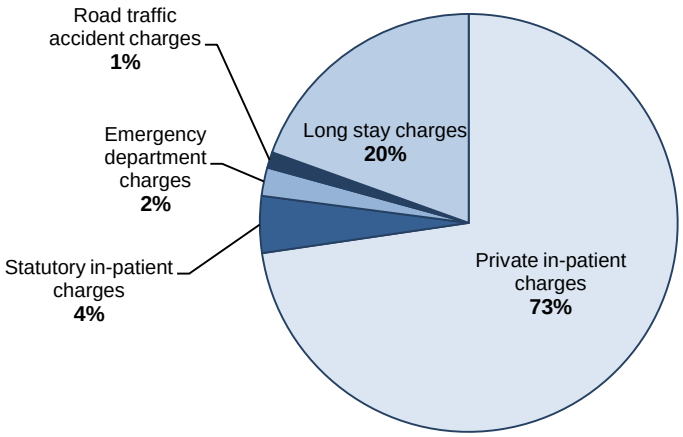
20.2 Patient income in statutory hospitals accounts for about 3% of the HSE's total current income and in 2014 totalled €410 million. Patient income in voluntary hospitals does not form part of the HSE's current income, but is taken into account in the funding of these hospitals by the HSE. The categories of charges are outlined in Figure 20.1.

Figure 20.1 Types of hospital charges



Source: Health Service Executive

Figure 20.2 Patient income by category, 2014



Source: HSE Financial Statements 2014

20.3 In the majority of cases, the HSE recognises patient income once the service to the patient has been delivered, for example, when the patient is discharged from hospital.[1] In 2014, 73% of patient income generated by statutory hospitals related to private in-patient charges (see Figure 20.2).

20.4 The private in-patient charge is due for payment by the patient. In practice, the majority of private patients hold health insurance. Around 95% of the income from private patients is recovered from private health insurers. The current practice is that rather than seeking payment from the patient who would then seek reimbursement from the private insurer, the hospital claims the amounts due directly from the insurer. Hospitals submit to the insurer claims which include

- details of amounts due to the hospital in relation to the accommodation charge
- details of amounts due to medical consultants in respect of treatment provided to private patients.

Audit Focus

20.5 The audit sought to examine

- the impact of changes to the charging regime for private patients introduced in 2014
- trends in private patient debt and debtor days between hospitals
- the efficiency of the administrative system for collection of private patient charges
- the breakdown of the outstanding debt by stage and the operation of debt collection in a sample of hospitals to establish the reasons for delays at each stage.

20.6 The examination was conducted in five hospitals. Three are HSE managed hospitals – Cork University Hospital, University College Hospital Galway and Tullamore General Hospital and two are 'Section 38' hospitals funded by the HSE that are audited by the Comptroller and Auditor General (St James's Hospital and Beaumont Hospital).

1 There are some exceptions to this, including long stay patients who are charged on a weekly basis, or accruals at period end in respect of patients not yet discharged.

Changes to the Charging Regime

20.7 Legislation enacted in July 2013 that came into effect in January 2014 introduced revised rates for private in-patient services (see Figure 20.3).

Figure 20.3 Charges payable in respect of private in-patient accommodation services, 2013 and 2014

	HSE regional hospitals, voluntary and joint board teaching hospitals		HSE county hospitals and voluntary non-teaching hospitals	
	2013	**2014**	**2013**	**2014**
Overnight rate				
Private bed/single occupancy room	€1,046	€1,000	€819	€800
Semi private bed/multi-occupancy room	€933	€813	€730	€659
Day case rate	€753	€407	€586	€329
Statutory in-patient charge (per day)	€75	–	€75	–

Source: Health (Amendment) Act 2013 and HSE website.

20.8 While the rates payable were reduced, more patients became liable to pay the charges due to changes in relation to the basis for charging. There was uncertainty around the implementation of the charges in relation to both bed designation, and the location of the treatment.

20.9 About 80% of beds in public hospitals are designated for 'public' use with the balance designated as 'private' beds. Up to 2014, only private patients occupying a designated private bed were charged for accommodation. The 2013 legislation provided for charging for accommodation in relation to all private in-patients.[1] There was some uncertainty in the interpretation of the new legislation in this regard.

- In September 2013, the Department of Health (the Department) issued guidance to the HSE stating that private in-patients accommodated in public beds or undesignated beds would be subject to the private charge.
- In November 2013, on foot of clarification sought by the HSE, the Department in consultation with the HSE prepared a table of relevant charges which was issued to all public hospitals. This specified that no charge was to be raised for a private patient accommodated in a public bed where the patient was admitted on an elective rather than an emergency basis.
- In May 2014, the HSE sought further clarification from the Department and also obtained legal advice in relation to the legislation.
- In August 2014, the Department, following consultation with the Office of the Attorney General, responded to the HSE and noted that charges must be levied regardless of bed designation or whether the patient was admitted on an elective or emergency basis.

1 S55 of the Health Act 1970 provided for the charging in relation to in-patient services provided in private or semi private accommodation. This was replaced by S13 of the Health (Amendment) Act 2013. The 2013 Act makes no reference to services being provided in private or semi private accommodation.

20.10 In October 2014, the HSE's Chief Financial Officer wrote to all statutory and voluntary hospitals providing clarification in relation to the revised charging regime. As a result, hospitals generated additional invoices totalling in the region of €19.4 million for overnight in-patient accommodation provided during 2014.

20.11 There was also uncertainty in relation to whether patients treated on a therapy chair, a recliner or a trolley, as opposed to on a hospital bed, should be charged. This relates mainly to day case treatments.

- The guidance issued by the Department to the HSE in September 2013 and November 2013 did not include any reference to charges being raised in respect of private patients receiving in-patient treatment on equipment other than a bed.
- In August 2014, following clarification sought by the HSE, the Department noted that where in-patient services were provided, the charge must be levied irrespective of the type of equipment used.

As a result, hospitals generated additional invoices totalling approximately €6.3 million in relation to in-patient day case treatments provided in 2014.

20.12 There were technical problems which precluded the immediate submission of the additional invoices (totalling circa €25.7 million) to the insurance providers in some cases. The HSE is unable to confirm when the relevant invoices were submitted or whether the entire amount has been submitted as at September 2015.

20.13 The HSE's 2014 service plan provided for an increase of €30 million in hospital income in respect of the private patient charges following the introduction of the Health (Amendment) Act in January 2014. During 2014, there was a net increase of €66.2 million in income in HSE statutory hospitals and voluntary hospitals.[1]

20.14 The HSE noted that the main factor giving rise to the higher than budgeted income was the clarification obtained from the Department of Health during 2014 in relation to the implementation of the revised legislation. This was not available at the time the HSE prepared its service plan.

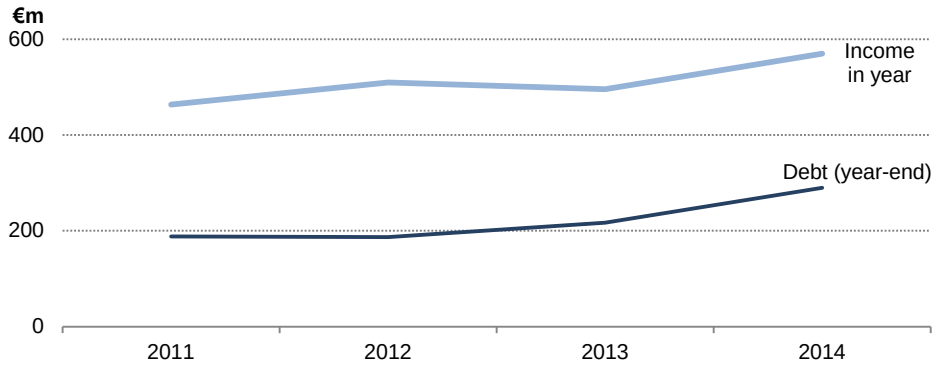
Trends in Debt Level

20.15 Private patient income due is recognised as a debt in the HSE's financial statements, and in the financial statements of the voluntary hospitals. At the end of 2014, the total debt outstanding from insurers in relation to private patient income stood at €290 million. This comprised €172 million in relation to statutory hospitals and €118 million for voluntary hospitals.

20.16 At the end of 2014, the total amount due from insurance providers was equivalent to 51% of the income recognised in the year (30% for statutory hospitals and 21% for voluntary hospitals). The comparable measure at the end of 2013 was 44%. The private patient insurance income and debt outstanding for the period 2011 to 2014 is set out in Figure 20.4.

1 There was an increase in private patient charges of €99 million and a reduction of €32.8 million in statutory in-patient charges following the introduction of the revised legislation, giving a net increase of €66.2 million in the year.

Figure 20.4 Private patient insurance income and debt, 2011 to 2014



Source: Health Service Executive

Note: In late-2012, the health insurance companies provided advances totalling €103 million, based on their estimates of private patients who had incurred charges for treatments in acute hospitals but where the claims process had not been finalised. For purposes of comparison, the debt outstanding at end 2012 has not been reduced by these advances, as the amounts received were deducted from patient charge payments by the insurers in the first six months of 2013.

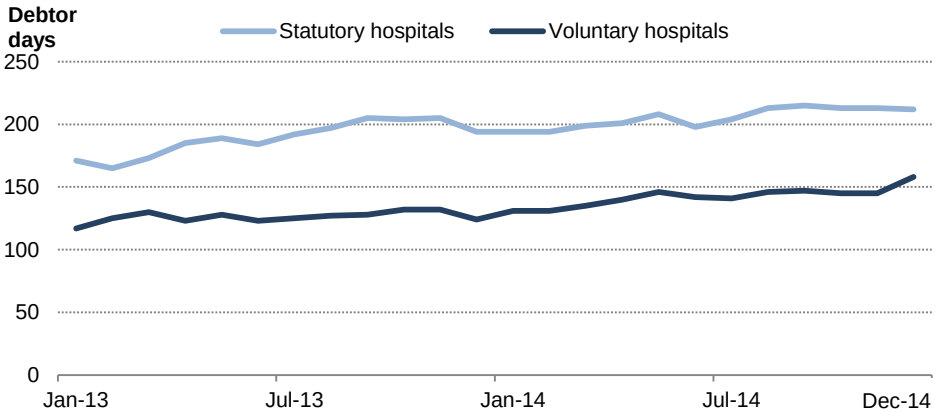
Measuring Debt Collection Performance

20.17 The HSE measures the timeliness of patient charge debt collection in terms of 'debtor days', calculated by dividing the private insurance debt outstanding at a point in time by the total amount of private patient income in the previous 12 months, multiplied by 365 days.

20.18 The debtor days measure is calculated for all hospitals by the Health Business Services (HBS) section of the HSE on a monthly basis and included as part of a consolidated monthly report circulated to relevant financial and operational managers.

20.19 At the end of 2012, total private patient debt outstanding equated to 134 debtor days. By the end of 2014, this had increased to 186 days – 212 days for HSE statutory hospitals and 158 days for voluntary hospitals. As outlined in Figure 20.5, HSE statutory hospitals are consistently slower in collecting patient related debt than are voluntary hospitals. Annex A shows the age of private in-patient debt and value of debt outstanding at end 2014 for each hospital.

Figure 20.5 Age of private insurance debt – 2013 and 2014



Source: Analysis by the Office of the Comptroller and Auditor General.

Efficiency of Claim Process

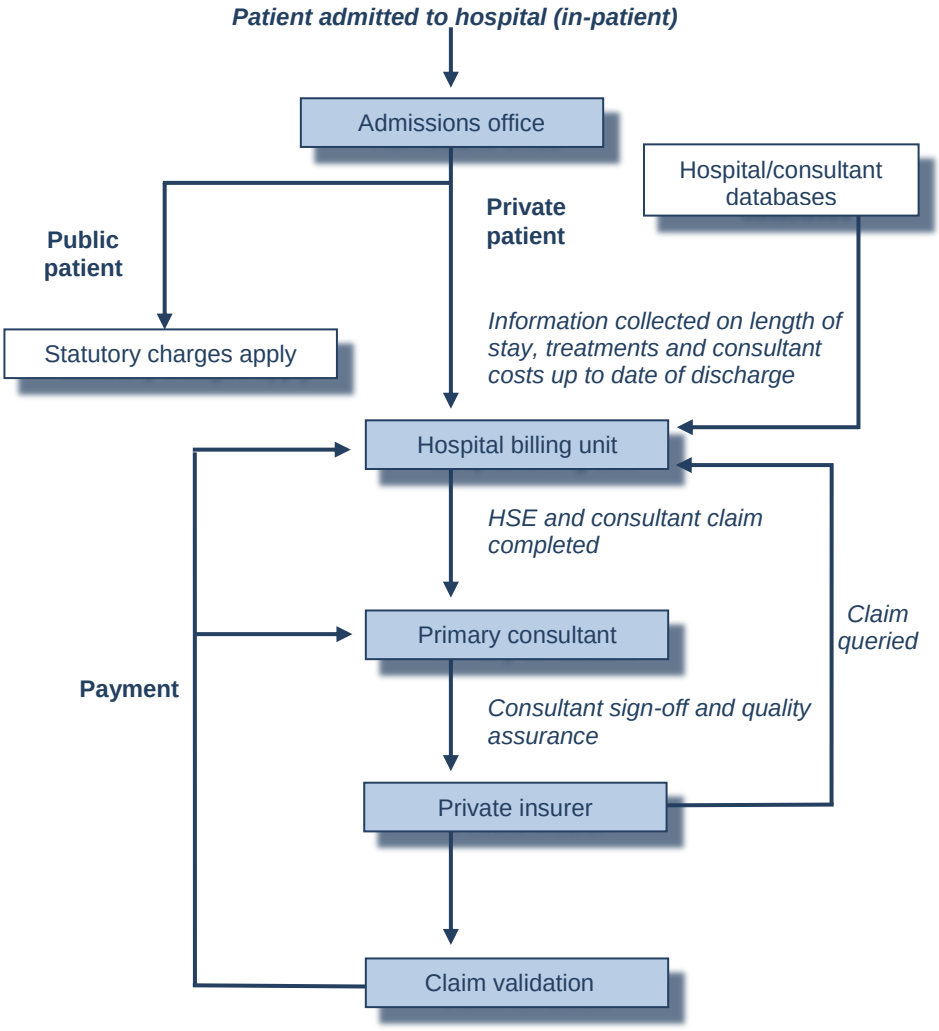
20.20 The process for the collection of private patient income is shown in Figure 20.6.

20.21 Once a patient is discharged, the hospital's billing office compile the claim which has two sections.

- Details of amounts claimed by the hospital – the hospital's accommodation charge.
- Amounts claimed in relation to consultants – including the primary consultant's fee, and the fees of any other consultants (secondary consultants) who treated the patient in hospital. A length of stay report is also included if deemed necessary.

20.22 The claim is then signed off by the consultant and submitted to the insurance company by the hospital billing unit for payment. The consultant's private fees are paid directly to the consultant. The HSE does not monitor the value of claims submitted to insurance companies in relation to consultants' fees.

Figure 20.6 Collection of private patient income from insurers



Source: Office of the Comptroller and Auditor General.

Claim Administration at the Hospital

20.23 The HSE stated that the practice of hospitals submitting comprehensive claims (in respect of amounts due both to the hospital and the relevant consultants) directly to the insurance companies on behalf of privately insured patients is done for administrative efficiency and convenience. It noted that in many cases, consultants use specialist companies or their own administration staff to compile information in relation to their fee claims submitted to the hospital billing unit.

20.24 The HSE and voluntary hospitals are currently engaging with the four main commercial health insurance providers to agree a memorandum of understanding on a submission and payment process that would enable the insurance companies to release payments to the HSE earlier and allow a defined timeframe for query and finalisation of claims. Under the proposed (revised) arrangements, hospitals and the private insurers will agree a timescale for submission of claims post patient discharge. The insurance company will pay a significant amount within the relevant agreed timeframe and there will be an agreed lead time to allow the insurance company to validate the claim and finalise payment of same.

20.25 The HSE noted that the agreements being negotiated with the insurers deal with a relatively narrow subset of the issues impacting the overall timeliness of claims processing.

Submission of the Claim

20.26 During 2012, the HSE commenced the implementation of a new electronic management system for claims, called Claimsure. The system allows for

- information in relation to patient admission, treatment and discharge to be downloaded from the hospital's patient administration system (PAS) to the Claimsure system
- integration with the hospital's billing system
- the capture of electronic patient and consultant signatures (optional for consultants)
- electronic processing and submission of claims to the four largest insurance companies.

20.27 The operation of the Claimsure system was examined on audit. This examination found that

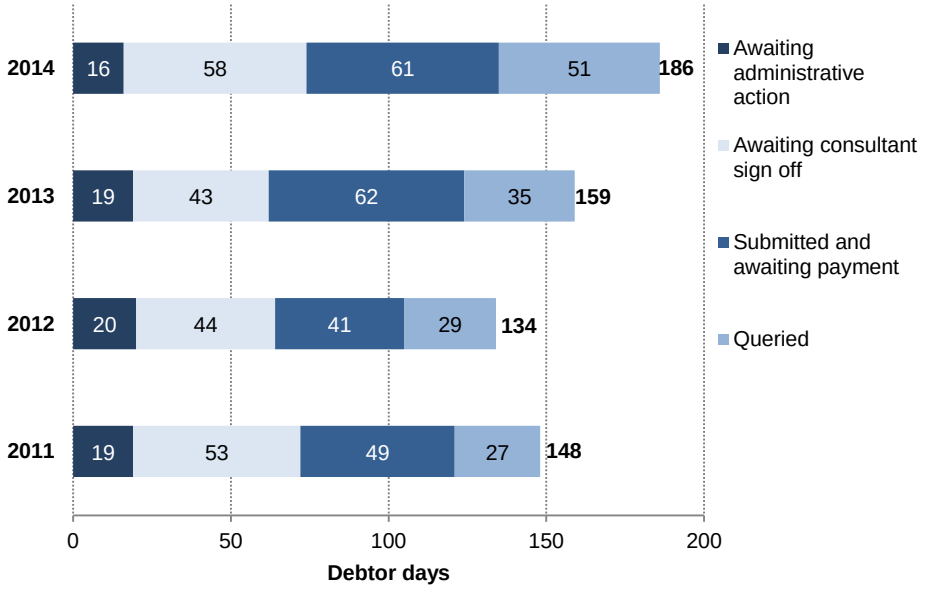
- A total of 44 hospitals use the Claimsure system. However, while 29 hospitals have integrated the Claimsure system with the patient billing system, 15 hospitals have not yet done so. Where the systems are not integrated, documentation in relation to patient admission and treatment is scanned on to the Claimsure system.
- Claimsure can facilitate fully electronic claims processing and submission. However, it is not being used in that way by the HSE and requires a significant level of manual intervention. While the current system allows for data to be downloaded from other systems in operation in the hospital, the submission of the claim may involve the printing of an invoice which is then scanned to the insurance companies, together with other supporting documentation.

20.28 The HSE noted that while the Claimsure system is not yet being utilised as a fully electronic claim processing system, it represents a significant improvement over the previous manual system. It allows for timely resubmission of returned or rejected claims where further information is required and also allows the HSE to track payment of claims. The HSE also noted that full implementation of the functionality of Claimsure requires further engagement and agreement between the HSE/hospitals and the insurers around data governance, standard processes and related matters. A pilot project is currently underway in this regard.

Stages in Debt Collection Process

20.29 The timeliness of debt collection improved during 2012. Debtor days fell from an average of 148 days at the end of 2011 to an average of 134 days at the end of 2012. However, since then, debtor days have increased again. The increase has occurred at all stages apart from the initial administration process (see Figure 20.7).

Figure 20.7 Age of debt by stage in collection process, at year end 2011 to 2014



Source: Health Service Executive

Awaiting Administrative Action in Hospital

20.30 While hospitals aim to generate an invoice within five working days of the patient having been discharged, the HSE has adopted a target that all invoices (100%) will be generated within 15 days. At December 2014, the age of debt at this stage of the collection process was 16 days.

20.31 A sample of 44 of the highest value private insurance claims awaiting administrative action was reviewed as part of the examination. In the case of the associated hospital invoices generated, 73% were processed within five days of the patient being discharged, 87% within ten days and 91% within 15 days.

20.32 The examination found that the main reasons for delays were

- claims awaiting patient (subscriber) signature
- claims awaiting quality assurance review
- one hospital had required the consultant to prepare a report on the length of stay of the patient in all claims in excess of €10,000, which was intended to reduce subsequent queries from the insurance companies. These reports were outstanding in respect of all ten claims in that hospital reviewed as part of the audit.

Awaiting Consultant Sign-Off

20.33 At December 2011, income of €67 million was awaiting sign-off by consultants. The age of the debt as measured in debtor days was 53 days. Since then, the HSE has taken a number of initiatives to secure more timely sign off by consultants.

Time Limit on Sign-Offs

20.34 A Labour Relations Commission agreement, concluded in September 2012, included a commitment from all consultants to sign private insurance forms within 20 calendar days (14 working days) of receipt of all the relevant documentation. The agreement noted that persistent failure to comply with this requirement would be addressed by the employer and that the employer has full authority to take the necessary steps to resolve such matters.

20.35 In November 2012, the HSE National Director of Finance circulated a letter to all consultants asking them to comply with the 20-day limit. Follow-up communication was sent to the hospital consultants at the end of April 2013, informing them that hospital management have the authority to take formal action where there is continued non-compliance.

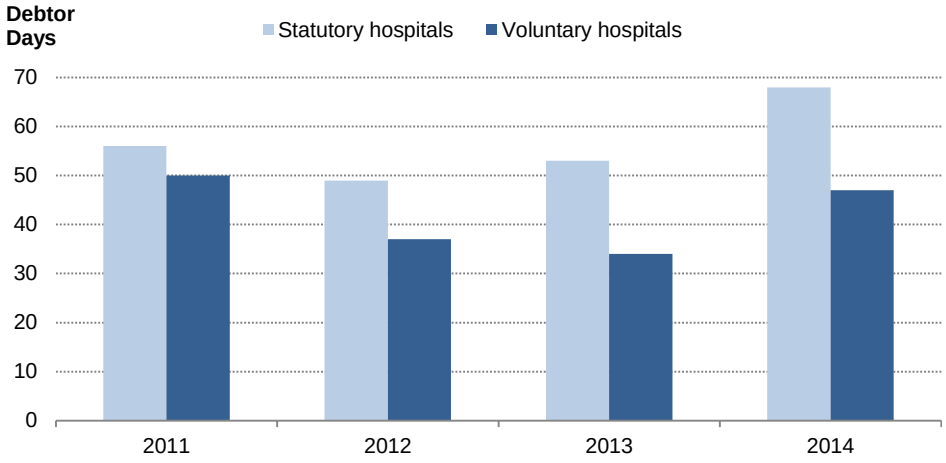
20.36 From January 2013 to September 2013, the HSE put in place quarterly targets for each hospital to allow for a phased reduction in the primary consultant days to 20 days.

20.37 In November 2013, the HSE increased the 20-day limit to a 30-day limit, in order to encourage hospitals that fell outside the 20 day limit, and to take into account the added efforts by consultants and other hospital staff to submit older claims during 2013. The 30-day limit for primary consultants' action remains effective.

Timeliness of Sign-Off by Consultants

20.38 At the end of 2014, claims had been, on average, with consultants for 58 days – 68 days in HSE statutory hospitals and 47 days in voluntary hospitals. Figure 20.8 shows the trend in age of debt awaiting consultant sign-off for the four year period 2011 to 2014.

Figure 20.8 Age of debt awaiting consultant sign-off, 2011 to 2014



Source: Analysis by the Office of the Comptroller and Auditor General

20.39 Timeliness of sign off by consultants varies greatly by hospital, ranging from a high of 163 days to a low of 15 days at December 2014. A full listing by hospital is included at Annex B.

20.40 Statistics relating to debtor days for each primary consultant were not available from the HSE.

20.41 A sample of the highest value claims for the top ten consultants (ranked by value of claims outstanding) awaiting consultant sign-off was reviewed in each of five hospitals visited as part of this audit. The examination found

- the majority of the claims examined were awaiting sign-off by consultant for more than two months
- hospitals were not always aware of the reasons for delays in consultant sign-off, as consultants are not required to provide explanations
- no formal action had been taken by the hospitals where consultants were consistently late in submitting claims.

20.42 The HSE noted that the implementation of the revised legislation would have contributed to delays at the consultant sign-off stage in 2014 because the number of claims requiring consultant sign-off increased significantly. The level of additional medical information and length of stay requirements requested by insurance companies has also increased as a result of the new charging regime.

Timeliness of Payment by Insurance Companies

20.43 At the end of 2014, the value of claims that had been submitted to insurance providers (€175 million) as measured in debtor days was 112 days. This is accounted for as follows.

- €95 million, equating to 61 debtor days, is awaiting payment – the comparable debtor days in 2012 was 41.
- €80 million, equating to 51 debtor days, has been queried by the insurance company – the comparable debtor days in 2012 was 29.

20.44 The value of claims queried increased by 69% over the course of 2014. At the end of 2014, 28% of the total claims outstanding were under query by the insurance companies. Insurance companies withhold claims for various reasons including raising queries with the patient or the consultant.

- Queries with the patient can include requiring confirmation of the type and quality of their accommodation during their stay, and verification of other details included on the claim form.
- Queries with a consultant can relate to whether the patient had a pre-existing condition before their membership commenced, the length of stay of the patient, the registration of the consultant, the consultants' type of contract or the consultants' private bill.

20.45 The HSE noted that part of the reason that the value of claims queried had increased is directly attributable to the introduction of the new legislation.

20.46 The sample of the highest value claims from the top ten consultants by value, submitted to insurance companies, was reviewed in each of the five hospitals visited as part of this examination. The review found that the main reasons for claims being queried by the insurance companies related to

- Accommodation queries – related to the changes in the basis for accommodation charges.
- Length of stay queries – additional information is requested from consultants to justify the length of stay of the patient. In the past, justifications for lengths of stay were typically only requested for claims where the stay was greater than 15 days, but shorter stays are now being queried more frequently.
- Provision of medical notes – additional information may be requested to establish if the patient had a pre-existing condition before their insurance cover commenced, or to analyse why particular treatments are given to a patient.
- Awaiting consultant information – additional information can be sought in relation to the registration of the consultant, the consultant's type of contract or the consultants' private bill.

20.47 Hospital administration staff stated that they try to respond to queried claims in a timely manner. However, the following was noted from a review of claims under query.

- In a number of claims reviewed, there were significant delays by the hospital in resubmitting the claims after they were queried by the insurance company.
- In a number of cases, the insurance companies consulted with the primary consultants directly about information required. In these cases, the hospital's billing office would not be aware of the issue(s) giving rise to the delay in payment. It was also noted that it is the practice for insurance companies to contact the primary consultant three times to attain information, if required. If unsuccessful after the third attempt, the insurance companies reject the claim. However, the HSE have noted that such claims can be resubmitted to the insurance companies.

Deductions from Payments

20.48 Insurance companies notify hospitals on a monthly or bi-monthly basis of claims being paid in respect of the hospital's accommodation charges.[1] In some instances, the amounts being paid to hospitals include deductions in respect of overpayments on claims in previous months. The HSE does not monitor the level of deductions made by insurance companies on bills, so it was not possible to ascertain the level of deductions.

20.49 The HSE noted that, as part of the implementation of the memorandum of understanding currently being negotiated with the insurance companies, a monitoring framework is being considered and developed prior to being implemented – this will track the level of claims that are queried, returned or rejected by the insurance companies in order to ensure that valid reasons have been provided and/or investigated in each case.

Write-offs of Debt

20.50 In 2014, €4.6 million worth of private patient charges were written off by the HSE statutory hospitals. This represents 2.4% of the total private debt outstanding at year-end (before provisions) and 1.5% of the private in-patient charges raised in the year. Charges of €15.8 million that were raised in error were cancelled and €0.7 million of other adjustments were made.[2]

Accounting for Patient Income

20.51 There are differences between hospitals in the accounting treatment of bad and doubtful debts for private patient income. Hospitals recognise patient income when the service to the patient has been delivered. Known bad debts are written off in the period in which they are identified and specific provision is made for any amount which is considered doubtful. Hospitals also make a general provision for bad debts.

20.52 Provisions for doubtful debts vary between statutory hospitals and voluntary hospitals. Statutory hospitals and some voluntary hospitals continue to provide in full for debts over 12 months old.

20.53 The HSE estimates that approximately 95% of total private health insurance claims are processed and (ultimately) paid by the health insurance companies. Considering the high level of claims that are paid, and the significant delays in collecting such income, it may not be appropriate for hospitals to provide in full for doubtful debts over 12 months old.

20.54 The HSE and voluntary hospitals should review the policies in place for providing for doubtful debts and ensure that provisions are only applied in situations where there is a clear risk around the collectability of the balance outstanding.

20.55 The HSE noted that its current accounting policy for bad and doubtful debts is based on the requirements of the Department of Health Accounting Standards for Health Boards. In 2015, the HSE plans to undertake a review of the value of private health insurance claims outstanding for greater than 12 months that are paid by the insurance companies. This will inform a decision on how to provide for private insurance debt from 2015 onwards.

1 Statutory and voluntary hospitals are not notified when the insurance companies pay the private fees to the consultants.

2 Write-offs and other adjustments include cases where the maximum statutory in-patient charge has been reached; the patient does not have sufficient insurance cover; the patient had a pre-existing condition and the insurance company will not cover the costs.

Conclusions and Recommendations

20.56 There was avoidable uncertainty in hospitals about changes to the charging regime for private patients following the commencement of the new legislation in January 2014. Despite the provision of a six-month notice period, implementation instructions were only finalised in August 2014, following discussion and clarification involving the Department of Health, the HSE, the hospitals and the private insurers. As a result additional charges totalling circa €25.7 million had to be levied in respect of 2014.

20.57 There were technical problems in submitting the additional invoices to the insurers for payment. The HSE is unable to confirm the proportion of additional invoices actually submitted for payment to the insurers as at September 2015.

Recommendation 20.1

Where significant changes to the hospitals charging regime are introduced, the key stakeholders (the Department of Health, the HSE, the hospitals and the private insurers) should be engaged at an early stage to clarify and reach agreement on the implementation of changes.

Accounting Officer's response

Agreed. The HSE will continue to engage with the Department of Health, hospitals and private insurers around necessary changes to improve the charging regime.

20.58 Delays in collecting income due from private health insurers means that the Exchequer is effectively meeting the funding gap at hospitals until payment is made. At the end of 2014, the total private patient debt outstanding from insurance companies was €290 million. The age of the debt, as calculated in debtor days, was 186 days. This measure reflects the equivalent number of days' income that would be required to accumulate the current outstanding debt level.

20.59 While the Claimsure system in use can support fully electronic claims processing and submission, utilising its full functionality requires further engagement and agreement between the HSE/hospitals and the insurers. As a result, a significant level of manual intervention is currently required.

Recommendation 20.2

The HSE should implement a fully electronic claim submission and payment system. Such a system would reduce the administrative burden associated with submission of claims and facilitate more timely payment.

Accounting Officer's response

Agreed. A pilot project in relation to electronic claiming has commenced in one hospital and aims to pilot the technical and process methodologies underpinning electronic claiming and also to test the feasibility of introducing full electronic claiming in the acute sector. It is anticipated that the pilot project will be completed by May 2016. If the pilot project is successful, electronic claiming will then be implemented in all of the public acute hospitals.

20.60 At the end of 2014, claims had been with consultants for an average of 58 days – 68 days in HSE statutory hospitals and 47 days in voluntary hospitals. This is well above the target of 20 days agreed with consultants as part of the Labour Relations Commission agreement in September 2012, and the revised temporary target of 30 calendar days adopted by the HSE in November 2013. The HSE noted that because the changes resulted in an increase in the number of claims requiring consultant review, the implementation of the revised legislation contributed to delays at the consultant sign-off stage in 2014. The HSE does not currently produce management information in relation to the value and age of debt awaiting sign off for each individual consultant. Instead, this information is produced at the hospital level.

Recommendation 20.3

The HSE should develop management reports which measure individual consultants' compliance with the target times for sign off of insurance claims. Such reports would allow the HSE and the hospitals to monitor performance more accurately and to take action, where required.

Accounting Officer's response

Agreed. The HSE's Income Reporting Unit is working to streamline and develop a range of management reports that will strengthen our ability to monitor performance and take remedial action on a more proactive basis.

20.61 The value of claims queried by insurance companies increased by 69% over the course of 2014. The sharp increase in queried claims appear to be the result of the changes in the charging regime introduced at the beginning of 2014 and additional information being requested from consultants to justify the length of stay of the patient.

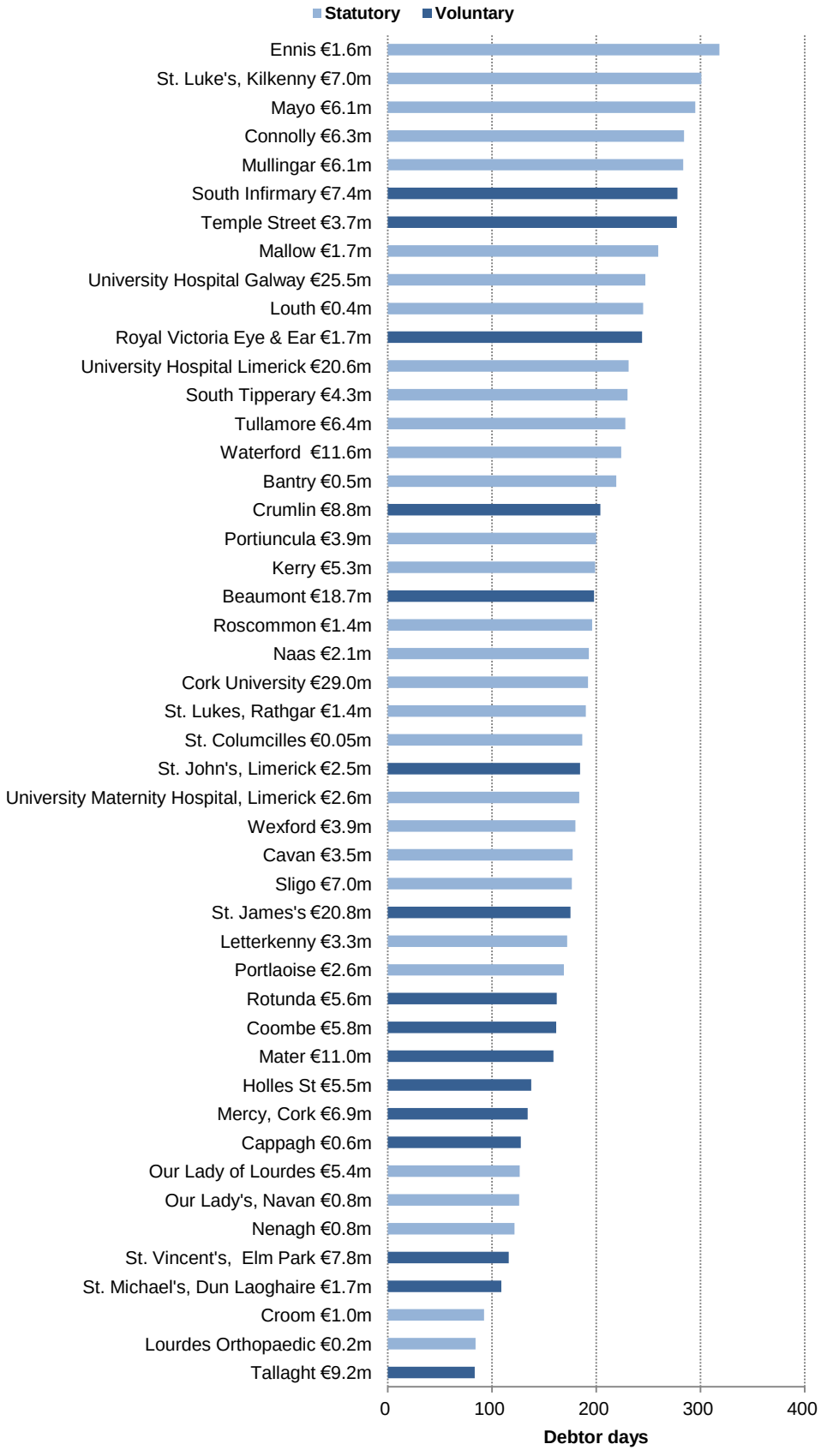
Recommendation 20.4

The HSE should agree clearly defined terms of payment and payment processes with the insurance companies. This will ensure that the claims being submitted by the hospitals are complete and can be processed efficiently by the insurance companies with a minimum of queries arising post submission.

Accounting Officer's response

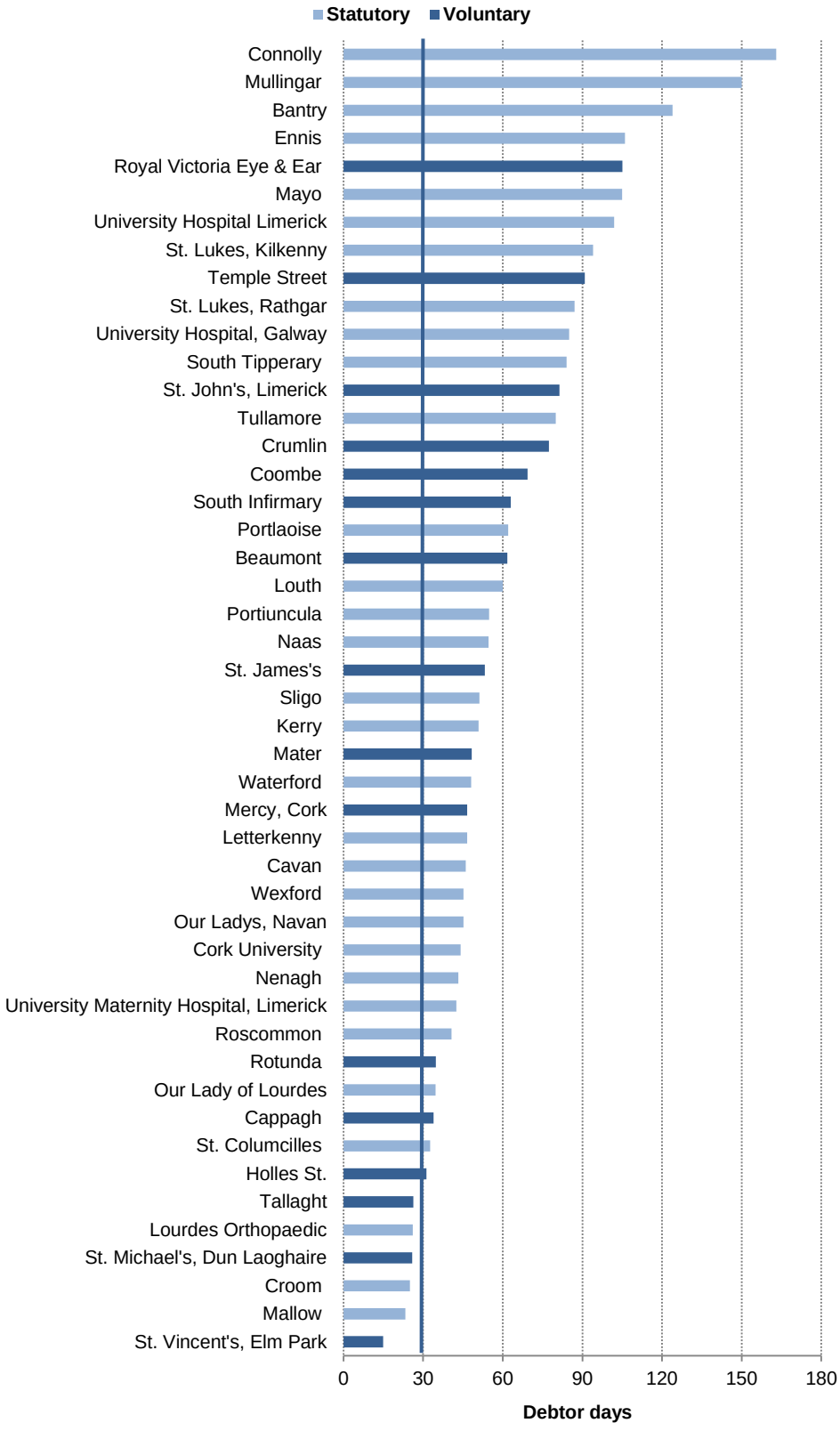
Agreed. The memorandum of understanding being developed with the private health insurance companies will define the terms of engagement with the hospitals in relation to the processes and timelines for submission, validation and payment of claims. The memorandum will also clearly define key terms such as what constitutes a valid claim, a queried claim and a returned claim.

Annex A Age of private in-patient debt in hospitals, at 31 December 2014



Source: Analysis by the Office of the Comptroller and Auditor General.

Annex B Age of private in-patient debt in hospitals, awaiting consultant action at 31 December 2014



Source: Analysis by the Office of the Comptroller and Auditor General.