Reduce Patient Balances Sent to Collection Agencies

Approaching New Problems with New Approaches

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Before referring a patient balance to a third-party collections agency, healthcare providers typically mail four statements. Usually, each of these statements is very much like the others. In many cases, the only difference among statements is the contents of the “aging buckets” often presented across the bottom. For example, a $1,000 balance due simply moves to the right, from “current” to “31-60 days” and so forth. Perhaps the final statement includes a phrase such as “final notice,” but that’s often about all the differentiation used.

The problem with this approach is that it is inefficient and ineffective. Too many patient balances are forwarded on to collections, recovering only 15.3 percent of amounts owed to hospitals and 21.8 percent of clinic and other providers, according to ACA International’s Top Collection Market Survey for 2013.

Most patients want to pay off their medical balances in a responsible manner, as noted by the Medical Debt Collection Task Force in Best Practices for Resolution of Medical Accounts in January 2014. That report encourages all financial communications to be clear, concise, correct and patient friendly. However, without employing new, innovative techniques, even the clearest communication won’t solve the problem of low collection rates for these and other reasons:

- In the last 10 years, the average premium for family health insurance coverage has increased by 80 percent, with the average cost now $16,351 ($5,884 for individuals).

- In 2013, there was a 78 percent increase of covered workers enrolled in a plan with a general annual deductible. Additionally, more than 58 percent of workers covered at small firms (3-199 employees) had a deductible of $1,000 or more.

- Millions of additional people are securing insurance on the new exchanges, often with higher-than-average deductibles as compared to common workplace-type plans. As of July 2014, approximately 10 million newly insured patients have entered the healthcare system as a result of the Affordable Care Act.

- Lawmakers and regulators are considering legislation limiting how hospitals and debt collectors can collect medical debt.

In summary, the difficult problem of unpaid balances is likely to keep getting worse. To reduce balances
forwarded to collections agencies, healthcare providers need to change the way they communicate with patients and approach statement presentment more strategically. Through new innovative approaches, statements should communicate with patients on a personal level, deliver messages that encourage understanding, and support patients’ interest in making payments.

A Typical Scenario—Before Applying New Approaches

Most providers currently send patients similar statements up to four times in a row if the patient does not make payment. Consider the following illustration of a typical four-cycle billing period, particularly for the purpose of asking this question: “What steps could the provider take to increase collections earlier in the billing cycle?”

The statement thumbnails shown below demonstrate the common practice of varying little except the contents of the aging buckets, which are shown near the bottom of each statement. Listed below the statement thumbnails is a data table outlining: (a) the number of statements sent in each batch (statement one through four); (b) the approximate cost to send the batch of statements; and (c) the total balance outstanding (that is, the dollar value that each batch of statements is intended to collect).

In the data, particularly note the following typical—and costly—patterns:

- With the first batch of statements (a given months’ worth of statements), the company attempted to collect $57.3 million from patients. Assuming a generic cost of 60 cents per mailed statement, the total cost for sending these 102,214 statements was $61,328.

- This first round of statements resulted in the collection of $18.4 million, or 32 percent of the total balance due.

- That 32 percent reduction in amounts due represents the highest percentage return of any of the four statements—it’s all downhill from there. If the provider can raise the initial fraction collected from a third to half—or more—overall results will improve significantly.

- The second statement, which cost just as much per statement to send, nets a lower return. As is typical, even fewer patients responded to the third statement. When the fourth batch of statements is sent, $24.1 million of the original $57.3 million is still outstanding.
An Optimized Scenario

New approaches to statement presentation vary the content of each statement based on patient information and when in the billing cycle the particular statement occurs.

For example, it’s possible to apply “flexible logic” in the production of statements, so that patient-relevant messages about payment plans, other payment options, and online payment portals are most likely to have an impact. In addition to taking into account the age of the patient’s balance, the healthcare provider can optimize statements based on factors such as: services rendered, payment history, previous payment methods, propensity to pay, available assistance (Medicare, Medicaid), ZIP code, and other demographic information.

How much can varying statement presentation by cycle and patient data improve billing results?

Recently we conducted an internal study of a healthcare provider’s actual experience when first implementing cycle and segment-based changes in statement design and presentation:

- **Over the course of six months, the provider’s collection yield increased 10 percent.** Just over two-thirds (68 percent) was attributable to increased statement performance. The other 32 percent of improvement was due to an increasing number of patients choosing to pay online.

- **Additionally, statement costs decreased by 10 percent.** Taking improvements in yield and costs together, the provider’s annualized incremental benefit was $1.3 million.

From Optimized to Opportunity

Results need not stop there. Once you establish a better financial communication model with patients, you will have the tools in place to continuously reduce patient balances sent to collections and improve other financial results.

Consider establishing a patient revenue cycle task force to work with vendor consulting teams and further optimize the tools and processes in place. The team’s charter will be to review analytics dashboards, identify challenges and opportunities, and continually optimize messaging, segmentation, channel communication strategies and process changes based on results.

For example, by applying patient-centric messaging across all touch-points of the patient revenue cycle, creating campaigns that focus results in different patient segments, and using effective methods to drive payments forward in the revenue cycle, healthcare organizations can take patient financial performance to the next level, including:

- Improvements in the average time to collect
- Bad debt reduction
- Reductions in collection agency fees
- Improvements in patient satisfaction by delivering a better financial experience