WHITE PAPER

Reduce Patient Balances Sent to Collection Agencies

RevSpring™

Reduce Patient Balances Sent to Collection Agencies

Before referring a patient balance to a third-party collections agency, healthcare providers typically mail four statements. Each of these statements is usually very much like the statement sent before. In many cases, the only difference between cycle messages is found in the "aging buckets". The final statement may include a phrase such as "final notice," but that's often the only variation in messaging that's used.

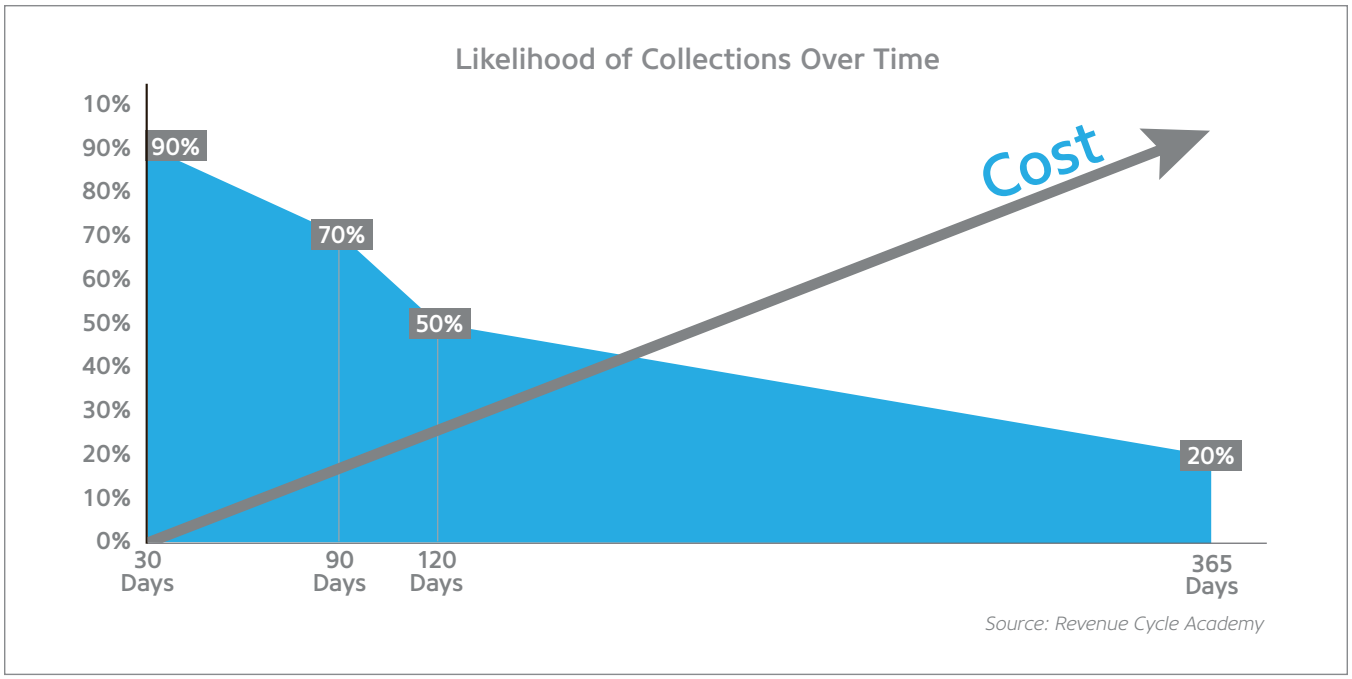
The approach is not only inefficient, it's ineffective—resulting in too many patient balances ending up in collections.

More than 25 percent of consumers had a medical bill turned over to a collection agency in the last year.

Health plan deductibles continue to rise as the struggle to collect from patients increases:

- 51% of covered workers in 2017 have an annual deductible of $1,000 or more for single coverage, up from 34% in 2012 [1]
- Patients experienced an 11% increase in average out-of-pocket costs during 2017, rising from $1,630 in Q4 2016 to $1,813 in Q4 2017 [2]
- Patients are now the third-largest responsible payor after Medicare and Medicaid [3]
- 68% with medical bills of $500 or less did not pay off the full balance during 2016, up from 49% in 2014, and headed to 95% by 2020 [4]

According to Healthcare Business Insights (HBI) Revenue Cycle Academy research, the likelihood of collectability drops off dramatically after the first 90 days. And the collectability outlook after day 90 or



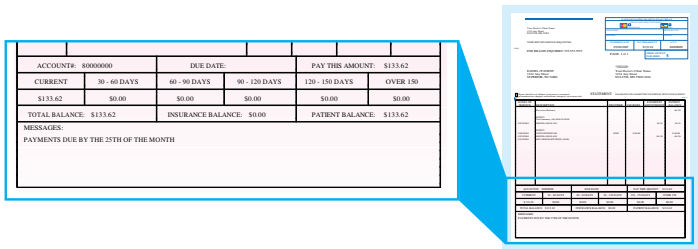
120 days, when most balances end up in collections, is bleak.

Compounding the issue is the escalating cost associated with aging balance collection efforts. When collection efforts are managed internally, every cycle and tactic used by your organization increases the costs and reduces your margin on the balance collected. Once passed to a collection agency, not only is the likelihood of collectability dismal, so is the percentage of the collected dollar you keep. Collecting early, when balances are in your control, is critical.

To reduce balances sent collection agencies, healthcare providers need to change the way they communicate with patients and approach financial communications more strategically—going beyond the look-and-feel of the statement to focus attention on driving the actions we want patients to take. Revenue and margins depend on it.

The Old Way

Most providers continue to send statements month after month if the patient does not make payment. Consider the following illustration of a typical four-cycle billing period. The statements demonstrate the common practice of varying little except the contents of the aging buckets, which are shown near the bottom of each statement.



	1	2	3	4
Number of Statements	104,214	66,439	58,261	52,129
Cost to Send	$61,328	$39,863	$34,956	$31,289
Amount Receivable	$57.3 M	$38.9 M	$30.3 M	$24.1 M

Listed below the statement thumbnails is a data table outlining: (a) the number of statements sent in each cycle for aging balances, (b) the approximate cost to send those statements; and (c) the remaining balance outstanding reflected on the statements in each cycle.

If we accept that only 10%–25% of all statement cycles result in a payment, 75%–90% of billing costs in each cycle are the result of balances not effectively collected in earlier cycles. If we can increase yield (the percentage of dollars collected in every cycle), we not only accelerate revenue, we reduce downstream costs.

Not shown above is the burden applied when balances go to collections. In this example scenario, assuming just 15% of balances are forwarded, on a typical recovery of 15% with a 25% collection agency commission, that's $3.4M in added costs. Clearly, whatever steps can be taken to reduce balances forwarded will improve the financial health of the organization.

Lack of Action Should Change the Call to Action

New approaches to statement messaging vary the content of each statement based on patient information and the age of the balance.

For example, the first cycle statement might demonstrate some understanding of the patient who is receiving it. We expect the patient can pay the $500 balance, and history or demographic data suggest that the best or desired channel for this patient to pay is online.

However, if the patient doesn't pay on the first cycle, when the second statement is sent, we change it up. Rather than wait 90 to 120 days to suggest payment options, the second cycle statement begins to promote options. Third and forth cycle statements make it clear to the patient where they stand with their outstanding balance.

Using strategic messaging based on patient history, demographics and balance age, we've been able to reduce the number of statements that move to 4th cycle by more than 6%.

Using dynamic messaging on statements, driven by insights about the patient and their balance, every patient can receive the most relevant, situational messages about payment plans, other payment options, online payment portals, etc., that are most likely to engage action.

In addition to considering 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.

- Within a matter of months, the provider's collection yield increased 20 percent
- Revenue increased by $2.35M
- Cost reductions in statement printing alone was nearly $25,000 in the first year

How much can the variation of statement content by patient and by cycle improve billing results?

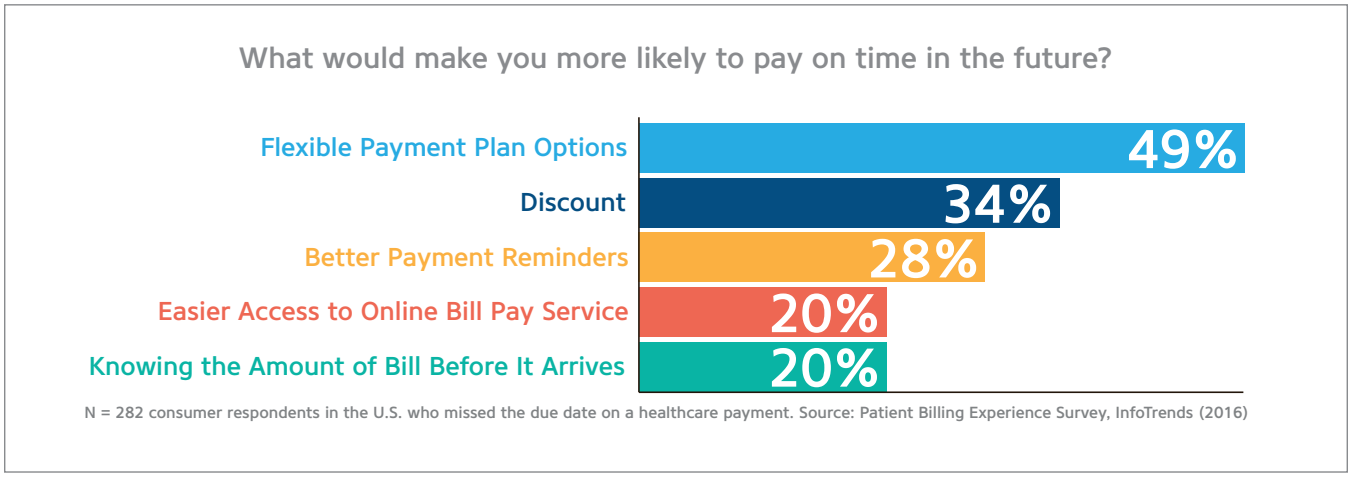
Recently we conducted an internal study of a healthcare provider's actual experience when first implementing cycle and segment-based changes in statement design and presentation:

Communicate with Patients on Their Terms

Why do balances end up in collections? We asked 1,000 patients across the US why they've missed payments.

- 50% patients that we surveyed indicated that they missed a healthcare payment because they did not have enough money.
- Another 20% simply forgot to pay.
- When patients must prioritize their household bills, they will more commonly prioritize paying their utility bills over healthcare bills.
- The more visits a patient has per year, the more likely they are to miss a payment.

So, we asked, what would make them more likely to pay on time? The remedies are as varied as the causes, as shown in the diagram below:



It's clear that the same, static tactics are not enough to solve today's, complex challenges as it relates to patient payments. Just as everyone has a very personal healthcare experience, each patient has different financial needs and preferences that affect how, when, and if they pay their bill. Understanding patient history, current situation and preference, and applying more dynamic and targeted communication strategies can move the needle on results.

Simple Strategies Drive Real Improvements

Here are just a few examples where providers have been able to increase revenue, reduce cost, and reduce bad debt by taking patient financial communications more dynamically—and more strategically.

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—increasing yield in earlier cycles and reducing balances sent to collections.

Large university health system in IL

- **25% increase in patient revenue**
- **34% decrease in bad debt**
- **$1.2M in bad debt reduction by rethinking communication strategies for small balance accounts**
- **10% cost reduction**

Large university health system in WI

- **20% increase in dollars collected before collections**
- **$2.35M increase in revenue**
- **$25K in cost savings (primarily statement cycle reduction alone)**

Large Southeast health system

- **5% bad debt reduction in year [1]**
- **$12M bad debt reduction by year [2]**
- **10% cost reduction**

References

1 – Kaiser Family Foundation
2 – TransUnion
3 – National Association of Healthcare Access Management
4 – June 2017 TransUnion analysis

RevSpring leads the market in financial communications and payment solutions that inspire patients to pay. Since 1981, the company has built the industry's most comprehensive and impactful suite of patient engagement, communications and payment solutions backed by behavior analysis, propensity-to-pay scoring, contextual messaging and user experience best practices. Using proprietary data analytics to tailor the engagement workflows to fit individual circumstances and preferences, we improve the financial experience and outcomes for providers and their patients.

Disclaimer: The contents of this resource are not intended to serve as legal or any other advice.

COPYRIGHT © 2019 REVSPRING