Myth vs. Reality: Past Due Patient Payments

This whitepaper examines some of the most common misperceptions about patient payments and collections.
Approximately 32 million Americans were contacted by collection agencies about unpaid medical bills in 2012. Nearly half of all reported collections are medical debt, and 62% of all personal bankruptcies in the U.S. are as a result of medical expenses. 78% of those filers had some form of health insurance, putting to rest the myth that unpaid medical bills are just a problem of the uninsured. Along with the swiftly transforming healthcare environment, increased patient payment responsibility has forced many healthcare organizations to take a hard look at their revenue cycle for areas to become more proactive and efficient. Any opportunity for improvement, however, may be overshadowed by common myths and misperceptions concerning patient payments and collections.

Bringing these myths to light and understanding the realities can help your practice move forward in optimizing the revenue cycle and maximizing patient payments.

Myth #1: We don’t have the time to pursue delinquent accounts.

Reality: You do have the time. It’s just a matter of rearranging and reassigning responsibilities to bring that free time to the surface. Extra clerical work levied by payers make it seem as though there isn’t enough time to also reach out to past due patients. However, you can adopt technologies that extend your reach beyond manual efforts from the staff. Automated patient balance notifications can be working with your staff in a complementary role – reaching out about balances due and providing an opportunity for patients to resolve their balance on the call. Make automation do the work for you, refocusing your staff from outbound communication into a team equipped to handle inbound responses from patients ready to make payment or ask questions.

Myth #2: Sending statements is cheaper than making patient balance calls.

Reality: According to the Medical Group Management Association (MGMA) Health Care Consulting Group, it costs $11 to $12 to send out a statement. That’s a figure that continues to rise along with postal rates. However, automated notifications can be sent for significantly less. And how many of those mailed statements go unopened? A call is a lot harder to ignore than a paper statement. Also, staff time in coordinating these mailings is saved and can be diverted to higher delinquency accounts. How much can your business save by realigning staff workloads and areas of focus?

Myth #3: Patients only want paper statements.

Reality: Patients need to be given every opportunity to pay. Give them multiple ways to resolve accounts, including enabling payment over the phone. In today’s technology-laden and fast-paced world, sending only a paper statement is obsolete. Patients want ease, convenience and choices. You can give it to them on the device they are most likely holding in their hand at this moment, directing them to your online portal or offering immediate transfer for on-the-spot resolution of their outstanding balance.

Myth #4: Patients can’t be reached by phone during the day.

Reality: While it’s true that during the day is usually the hardest time to reach someone, automated patient balance notification strategies are not hampered by the business hour schedule limitations of manual callers. Automated calls can be sent when patients are most receptive and likely to respond, typically in the evenings and even when your office is closed. If they don’t answer in the evening, the message is automatically adjusted depending on live answer or answering machine/voicemail pick up. Calls sent during the day, to those who might choose to transfer into the practice to make payment, can be throttled to ensure the practice is properly staffed to handle incoming responses.
Myth #5: We should only begin reaching out to patients when a balance is 30 days past due.

Reality: Start at 20 days! Most practices work on a 30-day billing cycle and only investigate delinquent accounts once a month, on the aging A/R listing. But who says you have to, or should, wait until 30 days to start contacting a patient about a past due balance? Early outreach is essential to resolving more patient balances. Your best chance of collecting is early in the cycle where many patients just need a nudge or a quick reminder. Automated patient balance notifications allow you to reach out to hundreds within minutes at any point in the A/R cycle, especially those first few critical days when patients have a stronger emotional connection to their service.

Myth #6: We must focus all of our collection efforts on the severely past due.

Reality: This approach leaves too large a gap from the time service was rendered to the time you expect to be paid. You’re missing the best opportunity to easily bring in revenue. The average recovery of an account that reaches 90 days past due is only 74%. At 120 days it’s only 65%. Connecting with those early-out patients before they become severely delinquent will ensure you are collecting a much greater rate than waiting until later in the A/R cycle. This also helps you and the patient put the balance behind them so you can both concentrate on their continued care.

Myth #7: The collections process is just too uncomfortable for the patient and the practice.

Reality: Automation relieves the pressure for both. While past due balances can be disconcerting for a patient and unpleasant for staff members to discuss with them, a level of comfort is attainable with automated patient balance notifications. A patient who is embarrassed about their past due payment would most likely not want to speak with someone on your staff. From the practice’s perspective, a staff member will not be looking forward to making every past due call.

Myth #8: We can just let a collections agency take care of our past due balances.

Reality: Collection agencies are not the answer. Only 64% of practices that turn over outstanding debt to a collection agency are 100% satisfied with the results. Those practices that are dissatisfied declared agencies’ dismal collection results, high agency fees and overly aggressive approach with their patients unacceptable. Even with all of that, some practices still aren’t paid. Practices that have partnered with a collections agency collect only 34% of their outstanding balance on average. And that’s before subtracting high agency fees.
Myth #9: My patients would not use or respond to the automated technology.

Reality: Technology is playing an increasingly integral role in the patient payment process. Payments by phone, patient portals, recurring ACH payments and paperless billing are all widely available to and taken advantage of by today’s average patient. Think about the hesitancy in first using debit cards over writing checks. Now, how many personal checks are you seeing? Selecting a vendor that makes patient data security a priority ensures that communications are sent and payments are received securely. Since patients are usually never far away from a handheld device, they are more likely to use the technology as a matter of convenience.

Adopting new technology when it comes to patient balances can allow your practice greater reach in the A/R cycle. You can accomplish your A/R goals without sacrificing patient relationships and valuable staff time. Partner with an automation vendor that can guide you through the best strategy for collecting patient payments.