Getting in front of inefficiencies in the healthcare industry.

With the constant changes and increasing costs taking place in the healthcare industry, words like “efficiency”, “control”, and “patient satisfaction” don’t typically come to mind. It’s true that some factors are a bit uncontrollable, but there are always ways to make improvements. It’s all about understanding the facts and trends in the industry and then putting together a plan to do something about it. We talked to healthcare practice administrators and patients and compiled research to garner new insights around some of the key areas of focus for practices.

- Administrative costs
- Bad debt
- Patient attrition
- Patient payments
- Communication expectations

We also explored some of the different approaches being used by administrators to get a better handle on their operations. The goal is to point healthcare practices in the right direction when it comes to improving cash flow and customer satisfaction and retention.
Administrative costs in the US are disproportionately high.

It should surprise absolutely no one at this point, administrative costs associated with U.S. healthcare are high, but what might come as a surprise is how high they are relative to total medical costs, as well as, similar costs in other countries. In what is perhaps the best known research, The New England Journal of Medicine, analyzed a broad range of data from 1999 to discover that about 30% of health care expenses in the U.S. could be attributed to administrative costs.¹

A more recent study conducted in 2011 by The Commonwealth Fund had administrative costs associated with various medical facilities at around 25% or $215 billion of total healthcare costs (Figure 1). This number is more than double similar administrative costs in Canada.² That same study also found no link between higher administrative costs and better-quality care.³ That means, a reduction in those costs to the levels of Canada, would have meant a savings of $158 billion in 2011 alone.

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Figure 1: Administrative costs by medical facility type.

- For-profit hospitals
- Nonprofit hospitals
- Public hospitals
- Teaching hospitals
- Rural facilities

Administration costs account for 25% of health care expenses in the U.S.
Costs continue to rise and there’s no end in sight.

Reasons for higher administrative costs in U.S. healthcare include factors like higher physician fees, more-advanced technology, as well as costs associated with coding, billing, and other similar activities. Perhaps what’s most strange when it comes to billing, is that even with all the efficiencies that technology can bring, these costs don’t ever seem to go down.

In fact, in research done for the Boston University School of Public Health, Elsa Pearson found that from 2009 to 2012 costs related to billing actually increased from 14% to almost 17%.4 This increase could be due in part, to the fact that so many healthcare practices still maintain outdated processes. Take for example, that of the 30 billion healthcare transactions each year, 15 billion are faxes.5

Use of outdated technology and redundant processes around administrative tasks like billing can lead to wasted time, delays in payments, missed appointments, and increased costs. According to PricewaterhouseCoopers, the average organization spends about $20 in labor to file each paper document. When just one of those files is misplaced the average health organization spends approximately $120 in labor searching for it and if it isn’t located, $220 to recreate it.6

The complexity of the U.S. healthcare system can be a burden in itself and even the most efficient practices are always looking for new ways automate, streamline, or otherwise reduce waste. Beyond the common administrative costs associated with billing, there’s a related cost that just about every practice must face – bad debt.
The debt situation is bad and getting worse.

In 2016, 68% of patients failed to fully pay off medical bill balances. This figure, according to credit reporting agency, TransUnion was up from 53% in 2015, and 49% in 2014. By 2020 estimates have that number closer to 95%. This issue is not seen solely in medical practices. The TSYS Healthcare survey revealed just how common bad debt is across most practices. The majority (54%) of offices reported that between 3% and 9% of all accounts go to bad debt.

The costs associated with bad debt are real, and the longer they take to recover, the steeper they are. Take large facilities for example. According to a survey conducted by healthcare business consultancy, Sage Growth Partners, 36% of hospital executives surveyed said their systems had bad debts totaling more than $10 million. Half of those hospitals believe they can recover no more than 10% of it. That’s a loss of $9 million. In the TSYS survey we asked how much time our respondents estimated it would take to recover bad debt. The results were somewhat startling, showing that most respondents expect their debt recovery to take three months or longer (Figure 2). This is lost cash flow that could be used for new equipment, technology, education, office improvements, or other needed updates and improvements. It also means wasted time trying to chase down debt.

Figure 2: Estimated time to recover bad debt.

- 0-3 weeks (9%)
- More than 1 month (14%)
- More than 2 months (21%)
- 3+ months (56%)
Increased patient responsibility means increased risk for practices.

When it came to relatively smaller medical bills, the survey found that 37% of Americans said they could not pay for an unexpected medical bill that exceeded just $100 without going into debt. When it came to relatively higher medical bills, just 23% of Americans said they could pay a bill of more than $2,000.9

Analysis done by Harvard health economist, Michael Chernew seems to back up this data. He found that more than 90% of medical bills under $75 were paid within a year, while just 67% of bills above $200 were paid within a year.10

Further contributing to the issue of bad debt is the recent shift in patient responsibility. According to Health Affairs, average patient obligation increased 20% per visit between 2012 and 2016.11 An even more alarming statistic comes from the 2018 Employer Health Benefits Survey conducted by Henry J Kaiser Family Foundation. It states, the average deductible among covered workers in a single coverage plan with a general annual deductible is $1,573, up more than 80% since 2009.12
The TSYS survey also revealed some interesting insights about patients’ views on payments. For instance, when it comes to payment options, patients prefer in-person and online. This is much more interesting when you consider that less than half of practices surveyed said they offer online payment options. Additionally, there seems to be some confusion around healthcare bills (Figure 3).

**Figure 3:**
In general, do you understand your healthcare bills from your practitioners’ offices?

- To a Great Extent (44%)
- Somewhat (47%)
- Very Little (7%)
- Not at All (2%)
Practices need to get a handle on patient satisfaction.

In our research we found that patients with accounts that go to bad debt are more likely to leave a practice altogether. In fact, medical practices list “pricing or billing issues” as the number one reason patients leave. When we broke down the numbers, we found that 61% of medical practices reporting “pricing or billing issues” as the biggest reason patients provide for leaving.

We also followed up with patients to confirm why they left a practice. When asked, the number one reason patients who have left a practice gave was, “pricing or billing issues” (32%). Interestingly, the second reason given varied greatly between practices and patients.

Practices believed that the second reason patients leave is because of a “lack of understanding of billing and insurance” while patients told us, a “lack of concern and feeling neglected” were the next biggest reasons they left a practice.

It’s a simple formula: practices that deliver excellent quality of care, retain their patients. In fact, those patients will tell others about their experience. In this perfect scenario, patient retention and new patient rates increase without impacting acquisition costs, ultimately improving profitability. Conversely, dissatisfied patients will talk about it even more.
According to a report, on average satisfied patients share their experience with as many as five people, while unsatisfied patients will complain to nine or more people. Add online reviews to the conversation and word can spread even faster and more broadly, which can greatly impact the bottom line. According to industry estimates, in the U.S., losing a patient due to dissatisfaction can result in more than $200,000 in lost revenue over the lifetime of the practice.

In terms of customer satisfaction with payments it looks like there is somewhat of a disconnect between higher ups (administrator/office manager) and office staff when it comes to estimating patient satisfaction with payments. For the most part they agreed that patients were satisfied with the process, but there was a big discrepancy when it came to whether patients were less than satisfied with the payments process. For instance, 22% of administrators and 38% of office managers estimated patients were very satisfied with the payments process, while 25% of office staff felt patients were moderately dissatisfied. Knowing that 32% of all patients who have left practices have reported doing so due to “pricing or billing issues” may support the beliefs of office staff vs. office managers. Additionally, nearly
60% of practice staff members who say customers are satisfied with payments have only 0–2% of accounts going into collections, so it appears as though staff members may be more attuned to their patients when it comes to payments. Either way, it’s important for any practice to have a good understanding of how patients really feel about payments, considering it’s the number one reason they give for leaving. From there they can figure out ways to ensure that their patients fully understand their responsibilities and options sooner in the process, or plan to minimize the risks for issues and bad debt.
In order to understand how effective some of the more common payment methods are, we asked practices about them. We also explored some of the emerging trends in payments in the medical world. The biggest issue is potentially that many practices are not set up to take the full payment at the time of the patient visit, only well after. This is counter to fact that when we asked patients about their preferred form of payment, 62% answered, "credit card/debit card", with "check" at a distant second (16%). Successful practices proactively begin the payment process using pre-payment strategies to better estimate costs and either collect or set up recurring payment or billing options immediately following an appointment or treatment. Practices are now also using technology to access insurance details and understand exactly how much a patient will owe. In some cases, allowing for pre-appointment/procedure payment or the establishment of a payment plan on the spot.

What is the most preferred form of payment for patients?

62% credit card or debit card
Collecting patient payments during the visit is the most preferred, and most efficient way for practices to get paid. With the growth in payment technology, new trends have emerged that are rivaling these foundational methods. These trends include P2P apps, which are essentially virtual money instead of paper, and contactless and mobile payments, which allow consumers to pay quickly by simply tapping their card or phone near the payment terminal. Mobile payments will continue to increase in popularity. As of 2018, 77% of the U.S. population owned a smartphone, and many are now choosing to conduct ecommerce transactions primarily through their mobile device. Accordingly, the mobile payments experience will continue to play a central role how payments are made. As this trend continues, more and more practices are already adopting complementary payment technologies.
Online payments can speed up payments. As stated, when it comes to payments, patients prefer to do so in person and online. When it comes to online payments, patients pay faster than those who use checks. In fact, 54% of patients make online payments within just 48 hours of receiving a reminder. This is much more interesting when you consider, that less than 50% of practices surveyed said they offer online payment options. Practices that don’t offer online payments are forced to send paper bills or wait for patients to come back. Practices that offer online bill pay allow for much quicker and more convenient payments.
Payment/Auto-pay plans are highly efficient.

Today, the most efficient payment plans are facilitated by what is known as card-on-file, which is the ability to securely store a credit card which can be used in a future transaction or if patient wants to call in and make a payment. A practice in Illinois worked with TSYS to implement a card-on-file program and it boosted patient collections and reduced accounts receivable by 28% in just six months. While many providers use this program, about 20% agreed that a credit card on file was the best method for decreasing patient days in accounts receivable. Further evidence that getting paid for services as quickly as possible is very important to payment collections and cash flow.

In the case of practice management systems, most have capabilities to automate payments by posting directly to the patient’s account rather than manually entering each transaction. This creates efficiency in auto-posting payments to the patient ledger and saves staff time at the end of the day. Creating a process to take payments, offering payment plans and using an automated system for posting, saves time and creates a better workflow for staff and patients.

One of the more interesting learnings around payment plans was that patients of all income levels take advantage of them, and perhaps most surprisingly those making more than $75,000 utilize payment plans slightly more frequently than those making less than $75,000 (21% vs. 18.5%). Taking advantage of an interest-free payment plan on a medical bill can be a smart way for patients to budget and make their resources work harder.
Third-party billing

Third party billing companies are used by just 29% of practices surveyed, but most estimated shorter collection times on debt outstanding for three or more months, and fees charged back to the practice mostly stayed under 7% (figure 4).

Figure 4: Percentage of collections charged to practice.

- 0%-2% (31%)
- 4%-7% (48%)
- 8%-10% (7%)
- More than 10% (7%)
Financing

When it comes to financing, only 30% of practices surveyed say they offer it and there appears to be no relationship between whether practices that offer financing and patient accounts going to bad debt.
Patient Expectations and Communications

The last area of exploration for the TSYS Healthcare survey was patient/practice communication, which is an important component of client satisfaction and bill payment.

For practices that cited poor communication as a main driver of why patients leave, there seems to be correlation with higher percentage going to collections. In fact, 33% of practices that cited poor communication as a main driver for attrition also reported 10% or more patients going to bad debt. Satisfaction levels around patient communication were also somewhat low.
In a recent Hanover Research study, 80% of patients said they preferred text or email reminders to phone calls. Contacting patients via their preferred method is an effortless way to accommodate their needs and improve communication. Whether it’s a text, email, phone, or postcard, the preferred communication method for reminders, follow-up, billing, and more, reduce no-shows and greatly improve the patient experience. The result is an increase in the percent of active patients, which translates into more revenue for the practice. For practices that don’t use automated patient communications, reaching out to patients for general recall and reminders becomes part of the administrators’ never-ending to-do list. Every moment spent making phone-call reminders is time that could be spent focusing on other priorities. On average, dentists save approximately one week’s worth of work with automated recall and reminder software.
Conclusion

There’s a solid foundation of knowledge about the administrative costs associated with medical practices. We started there and then conducted two surveys through a third party to better understand payments, billing, and bad debt on the practice side and on the patient side with the goal of providing insights that will hopefully shed some light on how costs, bad debt, and communication all tie into the patient experience and how in some cases, changes in one area can impact the other areas positively.

Consider your own practice and what kind of improvements or efficiencies you can bring to it, and if you’d like to talk to a TSYS Healthcare Practice expert about how we might be able to help your practice give us a call.
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