Demystifying the Healthcare Collection Process

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The following information is provided as a supplement to the ACA International White Paper titled, *Healthcare Billing and Collections: The Industry Perspective*, released in June 2004. While the White Paper reviews the total scope of services provided by healthcare billing and collection companies and provides an overview of the process that healthcare providers go through when selecting a third-party receivables management company, this document will look specifically at the collection process for “bad debt” accounts. For an illustration of the process described below, please see the flowchart on page 7.

**Background**

Over the past year, the media, lawsuits against not-for-profit hospitals, and legislative activity on the state and federal level have all focused attention on the issue of the uninsured and underinsured in America. Many newspaper articles and television reports have included accounts of hospital and third-party collection agencies’ collection activities. Some of these reports create inaccurate impressions of the bad-debt collection process – specifically that collection activity is “aggressive” and “harassing” and routinely involves legal activity such as wage garnishment, bank account attachment, property liens and, in some cases, bench warrants for arrest.

The purpose of this document is to demonstrate that healthcare providers, and the collection agencies they employ, do not jump automatically to the post-judicial remedies described in many of these media reports. Instead, the focus from the beginning of the provider-patient relationship is on communicating about payment issues so that those who truly need assistance are directed to appropriate resources from the beginning. When the provider and the patient are not able to successfully communicate regarding the patient’s account, a third-party collection agency is often brought in to mediate the situation. The agency’s role is to find an appropriate solution to the amount owed by the patient – whether through patient payment or by gathering the information that the provider needs to determine the patient’s eligibility for charity or discount care.

**What is Self-Pay and Who are The Uninsured & Underinsured?**

Before commencing on a discussion of the collection process, it is important to understand the types of accounts that are typically referred to a third-party collection agency. While some agencies are involved in the billing and collection of balances owed by insurance companies and other third-party payors, most of the healthcare accounts handled by an agency are “self-pay” – meaning that the patient or another responsible party (such as a spouse, parent or guardian) is responsible for payment. Self-pay accounts are typically broken into two categories:

- **Self-pay after insurance**: The amount the patient is responsible for after the insurance company pays its portion of the bill. A co-payment or deductible amount.
- **True self-pay**: The patient either does not have any insurance coverage or their insurance does not cover a particular procedure or provider (such as an out-of-network hospital or an elective procedure) and therefore the patient is responsible for the full amount of the bill.
The media has equated “uninsured” with “impoverished” or “without financial resources.” However, there are many reasons that a person may fall into the uninsured/true self-pay category. For example, some self-employed professionals or small business owners choose to “go bare” (live without insurance) believing that it is more economical to pay for occasional healthcare services rather than to pay a monthly insurance premium. Unfortunately, this scenario often leads individuals to wait until a medical situation worsens before seeking care or treatment, at which point the treatment needed is often far more intensive and costly than basic preventative care.

The collection agency’s role is to open lines of communication with the patient or responsible party, evaluate the party’s available financial resources and ability to pay, make payment arrangements where appropriate and/or help the patient or responsible party identify alternatives such as charity care, Medicaid or discount programs if they qualify.

Healthcare Account Lifecycle – Before It Becomes “Bad Debt”

Before an account is referred to a collection agency, most healthcare providers have several “touch-points” with the patient where financial arrangements may be discussed:

- **Pre-registration**: Providers will typically contact a (non-emergency) patient prior to admission to complete a “pre-registration” questionnaire. During this process, insurance information is gathered and coverage is often verified. If the patient does not have insurance, or expresses concern over the ability to pay a co-payment or deductible, the provider often uses this opportunity to discuss available charity or discount options.

- **Admission**: Upon admission for service, providers either gather insurance information or confirm information provided during pre-registration. Charity or discount programs can best be explained during this step.

- **Billing**: After services are provided, the billing process begins. For patients with insurance, the insurance carrier is typically billed first and the patient receives a bill for a co-payment or deductible amount after the insurance makes payment. For patients without insurance, the bill is sent directly to the patient or responsible party. Upon receipt of the bill, patients without financial resources to pay in full have the opportunity to contact the healthcare provider to negotiate payment arrangements or request charity or discount program applications. The billing cycle may last for several months, with patients receiving several copies of a bill before the account goes to collections.

- **In-house collections**: Some providers have an “in-house” collections team that makes the first attempt in the bad-debt recovery process. Again, when patients are contacted via telephone or letter by a hospital’s collection staff, they have the opportunity to negotiate a payment arrangement (perhaps smaller monthly payments, a discount on the total due or other compromises) or request charity care information. Most providers are willing to work with patients to establish a reasonable payment plan when the patient is able to demonstrate a financial need for extended payment options.

- **Outsourcing prior to bad-debt placement**: In situations where the volume of accounts is too high for the provider's staff to make a personal contact with a
patient in an effort to resolve an overdue bill, the provider may have its own staff focus on the higher dollar accounts and augment the in-house efforts by sending the lower dollar accounts to an outsourcing company. These companies send letters or make phone calls in the name of the healthcare provider, in order to give the patient or responsible party every opportunity to discuss payment options prior to the account being placed with a collection agency.

At some point, typically between 90 and 180 days after the initial bill is sent, if the patient has not responded to repeated contacts through the billing or in-house collection process with either payment or communication to the hospital staff about the need for financial assistance, the healthcare provider may choose to send the account to a third-party collection agency.

**Healthcare Account Lifecycle – “Bad Debt” and the Collection Agency**

The collection agency’s goal is to establish communication with the patient or responsible party and either discuss payment options or help the party to identify other avenues, such as charity care, government assistance programs, etc. Collectors are skilled in evaluating a patient/responsible party’s available resources and ability (or inability) to pay. Collectors view themselves not as the “bullies” as often portrayed in the media, but rather as financial counselors – problem solvers who are working for both the healthcare provider and the patient/responsible party to resolve a debt and find an appropriate method of reimbursement.

The specific process (number and types of letters, phone calls, etc.) that a collection agency follows and any legal debt recovery methods employed (wage garnishment, property liens, etc.) are determined by agreement between the healthcare provider and the agency, within the parameters allowed by law. ACA International recommends that a healthcare provider and collection agency include the agreed upon “scope of work” description in a written contract. Written Business Associate agreements are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) whenever a healthcare provider shares protected health information with an outside entity. This HIPAA requirement has already established a need for a written understanding between a healthcare provider and its collection agency. Drafting a separate contract that includes the scope of work details is a natural extension of this process.

Once a collection agency becomes involved, there are again many opportunities for a patient to negotiate a discount or a payment arrangement with the agency or request information on the provider’s charity care or discount programs. Whether the agency’s first contact with the patient or responsible party is via telephone or letter, within 5 days of the initial contact, the agency must send the party a letter that includes the validation notice as required under the Fair Debt Collection Practices Act (FDCPA). This notice provides protection for both the consumer and the collector by ensuring that the debtor is held accountable for the correct amount, and insuring that the collector is contacting the correct person regarding the debt. The validation notice must include a statement advising the debtor of his or her right to dispute the validity of the debt or any portion thereof within 30 days after the receipt of the notice or to request verification of the debt.
In addition to requiring the issuance of the validation notice, the FDCPA also strictly regulates the frequency and times that a collector may contact a consumer, the communications that the collector may or may not have with third-parties, and the tone and content of contacts. For example, the FDCPA strictly forbids harassment or abuse, false or misleading representations, creating a sense of undue urgency, and unfair or deceptive practices.

**Healthcare Account Lifecycle – Credit Reporting**

Beyond the standard process of sending letters and making phone calls, some collection agencies may also credit report bad debt on behalf of their healthcare clients. Like the collection process itself, the reporting of bad debt is highly regulated. The Fair and Accurate Credit Transactions Act of 2003 (FACT Act) amends the Fair Credit Reporting Act (FCRA) and imposes new restrictions on the disclosure of medical information in consumer reports. The ability to furnish information about an account to a consumer reporting agency is often critical to securing payment. Many healthcare providers, however, have been reluctant to permit their collection agencies to report on medical accounts. The reluctance stems, in part, from the providers’ ethical obligation to confidentiality and patient privacy. The FACT Act resolves this issue in two ways.

First, the FACT Act expands the FCRA’s present definition of “medical information” to include information or data that relates to, “The payment for the provision of healthcare to an individual.” As a result, the restrictions on medical information will apply to data such as the name of the healthcare provider or an unpaid balance (which previously would appear without restriction on a consumer report). This is consistent with the definition of “payment” found in HIPAA’s Privacy Rule. The Health and Human Services Office of Civil Rights regards credit reporting as an ordinary payment activity.

Second, the FACT Act restricts how medical providers and their agents report information that relates to payment (or non-payment) for medical goods and services, as well as how that information appears on the credit report. Medical service providers and their agents will have to register as *medical information furnishers* with each consumer reporting agency to which they report data about consumers. These medical data furnishers will be required to identify healthcare accounts as “medical” when submitting the items to a credit reporting agency for inclusion on a consumer’s credit report.

Until March of 2005, and only on those consumer credit reports pulled by an individual other than the consumer, credit reporting agencies will encode and suppress the identifying information pertaining to the healthcare provider on any medical account. Commencing March 1, 2005, both the identifying information about the healthcare provider and identifying information about the data furnisher will be suppressed on any consumer credit report pulled by an individual other than the consumer. These changes in procedure will not impact a credit report pulled at the request of the consumer.

As a result of these changes, and the resulting encoding of the provider’s identity and contact information, healthcare providers will no longer face the dilemma of having to choose between furnishing data on a credit report or protecting patient confidentiality.
Healthcare Account Lifecycle – Legal Collection Techniques

The collection agency will typically attempt to make several contacts with the patient via telephone or letter over a period of several months before an account is returned to the healthcare provider for its determination of whether further collection activity should be pursued or if the account should be pursued through legal action. Typically, legal collection procedures are only pursued when it appears that the debtor has the means to pay and they have been unresponsive to previous attempts from the provider and the agency to resolve the account. It is important to note that collection remedies such as wage garnishment, property liens, bank account attachments, etc. are a “last resort” used only if authorized by state law and in most states, only if the account obligation has been reduced to final judgment.

In many cases, even when a patient is unresponsive, the healthcare provider may first retain an agency to conduct an asset search and determine whether a patient is in a position to pay based upon available public records. Information to that effect will be given to the provider so that, in cases where the patient does not have demonstrable financial resources, the provider may cease collection activity before the expense and effort of legal collections is incurred. An informal survey of ACA members who specialize in healthcare collection indicated that only 4.57 percent of accounts forwarded to a collection agency as bad debt are ever pursued through the legal process.

When a provider determines that legal collection activities are indeed appropriate, an agency may facilitate the legal collection process between the provider and a collection attorney. Once an account is reduced to judgment, the provider will work with the collection attorney to determine what type of post-judicial collection remedies are appropriate under the circumstances.

Note about bench warrants: A recent Wall Street Journal article referred to a practice known as “body attachments” (more commonly known as bench warrants). This article inferred that the body attachments were part of the standard debt collection practice and that the patients were essentially being put under arrest for not paying their debts. In reality, a “bench warrant” gives the court the authority to enforce an order directing the consumer to appear and answer questions about their financial circumstance. Collection agencies do not have the independent legal right to use this type of remedy. This remedy can only be issued by a court at the request of an attorney, and only after a judgment has been obtained against the consumer for the balance owed. In the collection process, this measure is used only as a last resort when all other attempts to obtain information about the consumer’s financial ability to pay the judgment have failed. ACA estimates that fewer than 4 percent of all health care accounts are reduced to judgment and that an undetermined fraction of these accounts give rise to a court order for a consumer to appear before the court to explain his or her financial circumstances.

Conclusion

Historically, healthcare providers have not considered themselves to be “credit grantors” in the traditional sense of the term – and rightfully so. Their primary mission is to provide
quality, timely healthcare to their community. The public also perceives healthcare debt differently from other types of debt such as mortgages, car loans or credit card bills. The thinking is that other debts are entered into voluntarily, whereas healthcare debt is often unexpected and unwanted. However, the reality is that collected revenue is necessary in order for a healthcare provider to meet their mission. Providers need to be compensated for the care they provide in order to keep up with technological advances, hire and train qualified staff, and maintain facilities.

This reality, coupled with the current public relations environment, is forcing healthcare providers to be as sophisticated in their credit granting and payment-related customer service efforts as any other type of credit grantor. Patients may not incur healthcare debt willingly, but once the service is provided (and often before), the patient is given many opportunities to explain their financial situation, employment situation, etc. and ask for assistance. The key to successfully resolving healthcare debt is often as simple as open communication. When, for whatever reason, the patient or responsible party is reluctant to communicate their situation with the healthcare provider, the collection agency often is able to succeed in starting a dialogue, evaluating the patient’s true financial situation and ability to pay, and helping to find a solution that is fair to both the patient and the provider.
Flowchart Illustrating the Movement of a Healthcare Receivables Account from a Healthcare Provider to a Billing and Collection Company

**PROVIDER**
- Admitting/registration process
- Gather patient info & distribute Free Care info

**BILLING EFFORTS**
- Insurance Companies
- Patients

**Close Account**
- Pmt recvd in reasonable time frame
- Yes
- No
- Account Sent to Collection Agency
- Yes
- No

**Coll. Agency Activity**
- Call Seeking Insur. Info
- Call Arrange Payment
- Bill Insurance Companies
- Send Letter Seeking pymt or insurance information
- Evaluate for Charity Care or Discounts

**Patient Pays**
- Yes
- Account Resolved
- No
- Account returned to provider as uncollectible. Include indication of patient ability to make payment.

**Provider decides if it should use legal means to collect**

- Yes
- No

All activities performed within guidelines dictated by HIPAA, FDCPA GLB, FCRA & other state specific laws

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