Acknowledging the Importance of BAI Accounts

Hospitals should not underestimate the importance of excellent customer service in billing and collections for self-pay accounts, especially given that such accounts represent an increasing portion of hospitals’ overall patient populations.

Most healthcare providers view self-pay revenue as an unfortunate reality. It has the highest cost to collect, takes the longest to turn to cash, has the lowest cash yield, and carries unique compliance, auditing, and public relations requirements. It’s easy to see why self-pay is the revenue that healthcare CFOs and revenue cycle executives tend to deal with last and with frustration.

Yet without self-pay excellence, hospitals may find it difficult to achieve a healthy cash flow and competitive advantage. New insurance designs with higher patient portions are causing self-pay to increase quickly as a percentage of total revenue, intensifying the need for well-considered self-pay collection practices. If such practices are perceived to be insensitive, particularly at the time of discharge and later in the business office process, they could have a corrosive effect on the patient’s overall satisfaction with the hospital.

In most consumer businesses, strong customer loyalty leads to superior profitability. And this is becoming increasingly true for hospitals under the new emerging healthcare payment models. By acknowledging the relationship between patient satisfaction with the business office and overall loyalty to the hospital and its clinical staff, hospital leaders can take hold of a new lever to drive revenue and profits.

The New Self-Pay

Self-pay revenue—also called balance after insurance (BAI)—comprises revenue from uninsured patients and from patients with patient responsibility after insurance. It is growing across the industry, not only because the ranks of uninsured patients have been increasing, but also because many individuals with insurance have experienced an increase in payment responsibility through deductibles, copayments, and coinsurance.

According to America’s Health Insurance Plans (AHIP), as of January 2011, high-deductible health plans and health savings accounts (HSAs) covered more than 11.4 million lives—compared with 6.1 million in 2008 and only 1 million...
in 2005 (representing an annual growth rate of more than 50 percent since 2005). In January 2011, high-deductible health plans accounted for 10 percent of new health plan purchases.

Not only are more insured patients facing payment responsibility, but also the balances owed are getting larger. The Kaiser Family Foundation 2010 Employer Health Survey reported that 27 percent of those enrolled in employer-sponsored health plans have annual deductibles greater than $1,000, up from 10 percent in 2006. Those with deductibles of more than $2,000 increased to 10 percent now from 3 percent in 2006. And deductibles for members in PPO plans have increased more than 50 percent, on average, since 2006.

**Potential Effect on Overall Patient Satisfaction**

The higher cost to collect for self-pay accounts is, in many ways, a given for hospitals: Although hospitals can take steps to reduce this higher cost, there is little likelihood that they will achieve the same level of collections they enjoy with commercial insurance accounts, at the same cost. But as alluded to earlier, hospitals should focus on these accounts for other reasons, not the least being that insufficient attention to self-pay accounts runs the risk that the patients may become dissatisfied and decide not to use or recommend the facility or its clinicians to others.

And as the population of self-pay patients grows, particularly those with BAI accounts, the potential financial impact from loss of such patients increases in step.

There is evidence to suggest that this is a real risk. In a recent survey of more than 500 consumers in 47 states who had had a hospital visit within the past 24 months, respondents were asked to rate, on a scale of 1 to 5 (with 5 being the top score), their overall satisfaction with the hospital, with their clinical experience, and with their billing experience. The responses show some suggestive correlations.

Among the respondents who had some BAI responsibility, 22 percent rated the hospital billing experience a 5 in terms of satisfaction, and within this subgroup, 85 percent also were very satisfied with the hospital. The respondents who had some BAI responsibility, 22 percent rated the hospital billing experience a 5 in terms of satisfaction, and within this subgroup, 85 percent also were very satisfied with the hospital.

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*a. January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs), AHIP Center for Policy and Research, June 2011.*
A Disproportionate Cash Flow Impact

The shift of revenue from commercial insurers to self-pay BAI bills has several implications for provider cash flow.

First, it takes longer to convert balance after revenue to cash. Typically, the BAI bill is not sent until the insurance portion is resolved, and then it requires several letter cycles for payment.

As BAI balances grow, the cash yield rate tends to drop. The exhibit below shows typical yield rates by balance band for BAI accounts. To show the relative impact, the exhibit is indexed with small balance accounts set at 100. As the exhibit shows, a provider can expect the cash yield rate on an $800 BAI bill to be 30 percent lower than the cash yield on a $100 BAI bill. In effect, the net cash on one $800 bill will be 30 percent less than had there been eight $100 BAI bills.

The cost to collect on a BAI bill is much higher than it is to collect from a commercial payer. Although industry benchmarks are hard to come by, the cost to collect on a commercial payer account is typically less than 5 percent of the collected balance, with best operations running well below 3 percent. Meanwhile, the cost to collect for the most efficient BAI operations is 5 to 8 percent of cash collected, with some operating at 10 percent or higher. Larger self-pay bills also cost more to collect as they tend to take longer to resolve and have lower net yield rates.

To illustrate the impact, the exhibit on page 93 examines the cash value of three different $1 million revenue portfolios. The commercial payer revenue is assumed to have a 90 percent yield rate and 4 percent cost to collect. The 90 percent yield rate reflects the leakage due to underpayments and denials. The BAI revenue is shown to have different yield rates and costs to collect based on the size of the bill.

In this simplified example, if all $1 million in revenue were paid by a commercial payer and the yield were 90 percent with a 4 percent cost to collect, the provider would net $864,000 in cash. Using the assumptions for yield and cost
also in influencing longer-term business development.

**An Expanded Role in Improving Patient Satisfaction**

Routinely, when senior executives speak to “patient satisfaction,” they focus on the piece of activity around clinical delivery and questions in the HCAHPS survey. Yet as the survey findings suggest, hospitals could benefit from broadening this focus to include revenue cycle processes.

Many business offices survey customers about service performance, asking questions such as, “Did the billing representative adequately answer your question, and was he or she polite?” This is a great start.

Additionally, the collection budget for the two self-pay operations would look very similar—a 3 percent difference. Without detailed mix data, a manager comparing the two operations could inaccurately assume that the team working the larger-balance portfolio is underperforming. After all, for the same budget, cash is down almost 17 percent. This top line review would overlook the mix difference in the underlying portfolio.

Interestingly, as shown, a $1 million self-pay portfolio weighted with small BAI accounts yields $633,000, a cash flow reduction of $231,000 (or 27 percent less) compared with the all-commercial-payer portfolio. If the self-pay portfolio is weighted with larger BAI accounts—that is, fewer $100 bills and more $1,000 bills—net cash falls to $521,700, or $342,300 less than collected under all-commercial-payer scenario (40 percent less) and $111,000 less than under the scenario involving smaller self-pay balances (17 percent less).

### RELATIVE COST TO COLLECT ON COMMERCIAL VERSUS SELF-PAY ACCOUNTS

<table>
<thead>
<tr>
<th></th>
<th>All Commercial Payer</th>
<th>Small Balance Self-Pay Mix</th>
<th>Large Balance Self-Pay Mix</th>
<th>Collection Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Revenue</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>90% yield/cost to collect 4%</td>
</tr>
<tr>
<td>% Paid by Commercial Payer</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Self-Pay Composition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of $100 S-P Bills</td>
<td>$900,000</td>
<td>$675,000</td>
<td>$562,500</td>
<td>80% yield/cost to collect 5%</td>
</tr>
<tr>
<td>Number of $500 S-P Bills</td>
<td>$36,000</td>
<td>$42,000</td>
<td>$40,800</td>
<td>55% yield/cost to collect 8%</td>
</tr>
<tr>
<td>Number of $1,000 S-P Bills</td>
<td>$864,000</td>
<td>$633,000</td>
<td>$521,700</td>
<td>30% yield/cost to collect 11%</td>
</tr>
</tbody>
</table>

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Billing Follow-Up as a Precursor to Future Service

Business office interactions after discharge, in some instances, can be considered pre-service encounters for the next event. Many clinical events, and therefore their bills, are part of a predictable clinical sequence that links one event to another weeks or months in the future. A simple example of this is an orthopedic procedure leading to rehab services.

In the previously cited survey, more than 33 percent of respondents with BAI responsibility indicated that they had spoken or would speak with a business office representative after discharge. A hospital’s business office is not simply a cost center; for self-pay patients, it is often the primary point of contact for communications with the hospital for an extended period after discharge. Patients call the business office with questions. And the business office is in steady contact with patients by mail, with notices regarding eligibility, balances due, and other financial information. Each of these communications could be another touch point—another opportunity to promote the organization and shape the patient’s experience.

Credit card companies recognized that in the monthly billing statement there was another opportunity to sell something. Since then, they have promoted everything from day planners to vacations. Amidst service or product breakdowns, many retailers try to find a way to turn the interaction into a selling opportunity and loyalty-building event. Healthcare business offices can take a lesson from their example.

Simply put, hospital business office staff should view every patient encounter, including encounters with patients who have BAI responsibility, as an opportunity to serve as an ambassador for the organization, providing a positive experience that will make patients more inclined to want to return to the hospital for future healthcare services. And many of these patients have conditions that make their need for future services predictable as to when and how they will occur.

Hospital business office staff should view every patient encounter as an opportunity to serve as an ambassador for the organization.

A good approach to picking where to focus efforts is by working backward from the corporate strategy. More and more, clinical systems are setting priorities for areas of focus by specific care groups or delivery settings. For example, a hospital could identify opportunities where billing personnel could help motivate patients to take the “next step.” This could be as simple as asking if patients have had their follow-up physician visit or are “on track” with their recovery. Uncertain comments weeks after discharge could be an indication that some clinical follow-up might be appropriate. Clinicians should be involved to provide professional guidance and ensure that the business office is working to support the institution’s long-term healthcare mission.

The hospital also should review the timeline for patient interactions to identify places where a current message could be modified or where an offer for a specific service could be added. Offers could be as simple as free parking for a next visit, credit in the cafeteria, or a notice of upcoming seminars or meetings consistent with their health situation. The goal is simply to connect the revenue cycle to the clinical and community activities of the hospital.

The impact from such efforts will probably be modest at first. Business office staff should follow up with patients who respond and ask why they did. Response rates and patterns should be measured and the information used to target the next round of ideas and options.
**Impact on Product-Line Profitability**
Hospital finance managers routinely analyze revenues and costs to understand product line profitability, including which services are profitable and which are not. Such analyses often include the assumption that revenue will convert fully to cash—no adjustment is made for self-pay bad debt or extra costs to collect. Given the new insurance plan designs, managers should consider the need for such adjustments.

A good starting point is to develop a “map” of the primary sources on BAI revenue. Is BAI connected to a single commercial payer, plan type, or even employer group? The composition of BAI revenue should also be analyzed because small and large balances perform differently. These data can be used to improve the accuracy of profitability calculations.

Performing such a cash analysis is not practical, however, for every product line and every combination. A good approach is to look first at the product lines that are seen as highly profitable and to look at operations that might be seen as marginal or close to breakeven. There’s no need to focus attention on the well-known problem of money lost on uninsured admissions from the emergency department.

**Testing New Ways to Improve Culture and Service**
Consumer marketing organizations are proficient at monitoring consumer trends and adjusting their actions based on the results of their analysis. Online retailing has taken this practice to the next level, with trending data that seem to change hourly. Health care is more slowly evolving to become a consumer-oriented business.

But this transformation is occurring. Revenue cycle operations are adding many new media to traditional phone and print operations. Online account management systems, email interactivity, and even texting are moving into the mainstream of patient access and self-pay follow-up. These areas are all potentially great venues for marketing and consumer engagement. And innovative new approaches can be easily tested quickly in these areas and implemented without major disruption.

Many ideas will fail, and only a few will work. But every success will be a step toward improved revenue and cash flow and will bring new insight into how to manage the consumer experience more broadly. Over time, patterns will emerge, illuminating which messages, media, and programs are of greatest interest to patients. Remember: In talking about his efforts to invent the light bulb, Thomas Edison often quipped that he didn’t fail 10,000 times—he simply learned 10,000 approaches that did not work. ●

**About the author**
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