GUEST EDITORIAL

How to Slash Your Accounts Receivable

Quick, what's the largest asset on your balance sheet? Almost certainly it's accounts receivable. Many physicians fail to appreciate that aggressive management of accounts receivable is key to any practice's financial success.

Collecting balances due has always been a problem for physicians. After all, most of us receive woefully deficient business training, if we get any at all.

BY JOSEPH S. EASTERN, M.D.

One result of that is that we extend more credit than any other business except banks and mortgage/finance companies. That's insane! Like every other business, we should strive to minimize the credit we extend by keeping our accounts receivable at as low a level as possible.

This is, of course, easier said than done. The traditional advice for minimizing accounts receivable has always been that any amount collectable at the time of service should be collected. But some patients inevitably brandish the old "I forgot my checkbook" excuse and escape without paying. And some fees, in particular the patient-owed portion of most insurance plans, are difficult if not impossible to calculate at the time of service and must be billed later.

The problem is once patients have left your office, according to one study, your bill drops to 19th out of 20 on their payment priority list. So why not do what a growing number of businesses, including every hotel, motel, and country inn on the planet, already do: Ask each patient for a credit card, take an imprint, and bill balances to it as they accrue.

Geoff Anders, president of the Health Care Group Inc., suggested this in a talk he gave at a recent meeting, and it hit me like the proverbial "whack on the side of the head": Why haven't we all been doing this for years?

After all, patients think nothing of handing a credit card to a busboy in a restaurant or blithely shoot credit card numbers into a black hole in the Internet. So why should they object to doing the same thing with their medical bills?

Beginning last January, every patient entering our office has been handed a letter at the check-in desk explaining our new policy of asking for a credit card number on which any outstanding balances will be billed. (See box.) At the bottom is a brief consent for the patient to sign, and a place to write the credit card number and expiration date.

Some did object initially—mostly older people. But when we explain that we're doing nothing different than a hotel does at each check-in, and that it will work to their advantage as well by decreasing the bills they will receive and the checks they must write, most come around.

This policy was optional last year, but we made it mandatory in January. Why did we do this? Because in only 1 year our accounts receivable totals have dropped by nearly 50%. They are now the lowest they have ever been, in all categories, in my 24 years of practice.

Credit card companies have begun to appreciate this largely untapped segment of potential business for them. Soon, you may begin receiving help from them in setting up a system similar to mine, as well as other payment plans for your patients. A few credit companies are even promoting cards to finance private-pay portions of health care expenses. It's time for physicians to do more of what we do best—treat patients—and leave the business of extending credit to those who do that best. ■

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How the Policy Works in Practice

Here are my answers to common questions I've received from physicians about my credit card policy:

► **Don't your patients object to signing, in effect, a blank check?** Some did object initially—mostly older people. But when we explain that we're doing nothing different than most restaurants and online businesses, and it will work to patients' advantage by decreasing the bills they will receive and the checks they must write, most come around. And they're not "signing a blank check"—all credit card contracts give cardholders the right to challenge any charge against their account, and we remind them of that.

► **Once you've collected the credit card information, how do you keep it secure?** We keep it in the patient's chart, where it is guarded with the same level of security as the rest of that patient's privileged information. Some offices prefer to store it all in one place such as a Rolodex-type container, or an Excel computer file that is protected by locked cabinets, passwords, and other precautions.

► **Couldn't this be considered "balance billing" and therefore illegal?** This is not "balance billing," which is asking patients to pay the difference between your normal fee and the insurer's normal payment. If you have a contract with the insurer, that's illegal—or more precisely, it's a breach of your contract. What you charge to the patient's credit card is the portion of the insurer-determined payment not paid by the insurer. For example, you bill $200, the payer approves $100 and pays 80% of that. The remaining $20 is what you charge to the credit card.

► **How do you handle patients who refuse to hand over a number, particularly those who say they have no credit cards?** We used to let refusers slide, but as of Jan. 1, we've made the policy mandatory. Patients who refuse without a good reason are asked, like any patient who refuses to cooperate with standard office policy, to go elsewhere. Everybody has credit cards in this day and age, except deadbeats with such awful credit that you don't want them anyway. My office manager does have authority to make exceptions on a case-by-case basis, however. One surgeon I know asks "no credit card" patients to pay a lawyer-style "retainer" of $500 which is held in escrow and used to pay receivable amounts as they come due. When presented with that alternative, most suddenly remember that they do have a credit card after all!

What to Tell Patients

Here is the credit card policy letter that I use in my office. It is accompanied by a form requesting the patient payer's credit card number, the expiration date, and the name that appears on the credit card, as well as a space for signature authorization to bill the patient's card and the date.

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill.

This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Copays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask us.

Defensive Medicine, Malpractice Nab 10% of Premium Dollars

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — The costs of malpractice insurance and defensive medicine account for about 10 cents of every dollar spent on health care premiums, several speakers said at a press briefing sponsored by America's Health Insurance Plans.

Medical liability and defensive medicine represented the "lion's share" of cost increases in the physician and outpatient areas, Michael Thompson, principal at the New York office of PricewaterhouseCoopers (PWC), said at the briefing. Litigation and defensive medicine also accounted for about a third of the costs associated with poor-quality health care, said Mr. Thompson, noting that the cost of poor-quality care was spread throughout the health care system.

Karen Ignagni, AHIP president, said efforts must be made to reduce the amount of poor-quality care being given. "We have a system where 45% of what's being done is not best practice," she said. "No public or private entity could operate at that rate."

The rate of increase in health care premiums was 8.8% in 2004-2005, down significantly from 13.7% in 2001-2002, noted Jack Rodgers, managing director at PWC. One factor contributing to the slowdown was a decrease in the rate of cost increases for prescription drugs, said Mr. Thompson. Part of the reason for that decrease is employers' increasing use of three- or four-tiered drug programs, in which patients pay a larger share for brand-name drugs, especially if there are generic equivalents. In 2000, only 27% of patients were in drug plans with three or more tiers; in 2004, 68% were, he said, adding that cost trends were also aided by a drop in the number of state mandates being added each year, from 80 in 2000 to fewer than 40 in 2004.

Outpatient costs rose significantly last year, Mr. Rodgers said, accounting for more than a third of the 8.8% increase in premiums, he noted.

Despite these problems, Mr. Thompson said in an interview that he did not expect premium increases to go higher next year. Part of the stabilization will likely be due to consumers having to pay more for their health care costs and becoming more aware of prices as a result, he added. ■