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REVENUE CYCLE MANAGEMENT · USA PHYSICIAN-OWNED

WHITEPAPER

Optimizing Patient Collections

in the Era of High-Deductible Health Plans

Patients are now one of the largest payers in healthcare, and the collection rate is moving in the wrong direction. What the data shows, and what actually changes it.

Prepared for: Practice owners, CFOs, revenue cycle directors, and patient financial services leaders

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Applies to: Medical and dental practices, groups, and health systems across the United States

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Who this is written for

This whitepaper is written for the people accountable for patient revenue: practice owners, chief financial officers, revenue cycle directors, patient financial services leaders, and billing managers. It assumes familiarity with the revenue cycle and concentrates on the portion of revenue that depends on patient payment behavior rather than payer adjudication.

How the data in this document is sourced

Every figure is attributed to a named primary source and dated. The core benchmark data comes from the KFF Employer Health Benefits Survey, Kodiak Solutions revenue cycle data, and Crowe Revenue Cycle Analytics. Where a commonly repeated industry figure could not be traced to a primary source, it was omitted rather than softened.

A framing note

This document treats patient collection as a design problem rather than a persistence problem. The organizations collecting well are not calling patients more often. They are communicating earlier, estimating more accurately, and removing friction from payment. Collection intensity applied to a poorly designed process produces complaints rather than cash.

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SECTION 01

Executive summary

Patient financial responsibility has grown steadily for a decade. Over the last two years, the share of it that providers actually collect has fallen sharply. Those two trends together are the reason patient collections has moved from a back-office function to a material determinant of practice revenue.

Kodiak Solutions reported that the patient collection rate for commercially insured patients fell to **34.4 percent in 2024, down from 37.6 percent in 2023**. That is a decline of more than three percentage points in a single year, on a base that was already low.

The exposure behind that rate continues to expand. The 2025 KFF Employer Health Benefits Survey found that **88 percent of covered workers with single coverage have a general annual deductible**, averaging **$1,886**, and that **34 percent face a single-coverage deductible of $2,000 or more**. Thirty-three percent of covered workers are enrolled in a high-deductible health plan with a savings option.

Collection difficulty also scales with balance size in a way that is easy to underestimate. Crowe Revenue Cycle Analytics, examining self-pay-after-insurance accounts across 1,413 hospitals, found collection rates of **32 percent on balances between $5,000 and $7,500, falling to 17 percent on balances between $7,501 and $10,000**.

34.4%	37.6%	$1,886	34%
Patient collection rate, 2024	The same rate in 2023	Average single-coverage deductible, 2025	Workers facing a $2,000+ deductible

What this whitepaper provides

- The current benchmark data on patient responsibility, collection rates, and bad debt, with sources
- Why patient revenue behaves differently from payer revenue, and why controls built for one fail on the other
- A stage-by-stage framework covering before, during, and after the visit
- A segmentation model for treating balances according to size and payment likelihood
- Metrics with benchmark targets, and a phased implementation roadmap

THE CENTRAL FINDING

Collection probability is set largely before the patient is billed. Once a balance has aged into a statement cycle without a prior financial conversation, the available levers are weak and expensive. The highest-return work in patient collections happens before the service is delivered.

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SECTION 02

The data: what has actually changed

Deductible exposure is broad, not concentrated

The common assumption is that high-deductible exposure affects a minority of patients. The 2025 KFF Employer Health Benefits Survey indicates otherwise. Among covered workers with single coverage, 88 percent have a general annual deductible, averaging $1,886. Thirty-four percent face a deductible of $2,000 or more. Thirty-three percent of covered workers are in a high-deductible health plan with a savings option.

For context on the broader cost environment, average annual premiums in 2025 reached $9,325 for single coverage and $26,993 for family coverage. Deductible exposure sits on top of that, which is the reason affordability pressure shows up even among patients with employer coverage and stable income.

The collection rate is falling, not holding

Kodiak Solutions reported the patient collection rate for commercially insured patients at 34.4 percent in 2024, down from 37.6 percent in 2023. A practice holding patient responsibility volume flat would have collected meaningfully less in 2024 than in 2023 without changing anything about its own process.

Collection probability declines with balance size

Crowe Revenue Cycle Analytics, analyzing self-pay-after-insurance accounts across 1,413 hospitals in 47 states, found collection rates of 32 percent on balances between $5,000 and $7,500, dropping to 17 percent on balances between $7,501 and $10,000. The same analysis found that statements carrying balances above $7,500 rose from 5.2 percent of statements in 2018 to 17.7 percent in 2021, and that self-pay-after-insurance accounts went from 11.1 percent of patient bad debt in 2018 to 57.6 percent in 2021.

Collection rate by balance size, self-pay after insurance (Crowe RCA)

Balance range	Collection rate	Implication
$5,000 to $7,500	32%	Roughly two-thirds uncollected
$7,501 to $10,000	17%	Rate nearly halves across one bracket

Bad debt is rising alongside it

Kodiak Solutions reported the median bad debt rate rising from 1.1 percent to 1.3 percent between 2024 and 2025, contributing to $48.4 billion in combined losses from final denials and bad debt, a 25 percent increase over the prior year.

What the balance-size data implies operationally

A collection process that treats a $200 balance and a $6,000 balance the same way is misallocating effort in both directions. The small balance needs frictionless self-service payment and almost no staff time. The large balance needs a financial conversation before the service, because once it exists as a statement the probability of full collection is already low.

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SECTION 03

Why patient revenue behaves differently

Most revenue cycle infrastructure was built for payer revenue, and it transfers poorly. The differences are structural and they explain why adding collection effort to an unchanged process produces limited return.

Structural differences between payer revenue and patient revenue

Dimension	Payer revenue	Patient revenue
Obligation	Contractual, enforceable	Depends on ability and willingness to pay
Amount certainty	Known from the fee schedule	Unknown until adjudication completes
Counterparty	One institution, many claims	Many individuals, one balance each
Failure mode	Denial, with a stated reason	Silence, with no reason given
Remedy	Appeal against defined criteria	Follow up, with declining returns over time
Cost to collect	Low per dollar	High per dollar, and rises with age
Relationship effect	None	Direct. Collection pressure affects retention

The three consequences that matter

1. The amount is uncertain at the moment it matters most

The best time to discuss a balance is before the service, when the patient can plan. That is also the point at which the exact amount is unknown, because adjudication has not occurred. This is the central tension in patient collections, and the resolution is a disciplined estimate communicated honestly as an estimate, not an avoidance of the conversation.

2. Failure is silent

A payer denial states a reason. A patient who does not pay provides nothing. The balance ages without information about whether the cause is confusion, dispute, hardship, or simple inattention. Those four causes require entirely different responses, and a process that cannot distinguish them applies the same escalation to all of them.

3. The relationship has value beyond the balance

Aggressive collection on a patient who could not pay costs more than the balance. It costs the future revenue from that patient and from their referrals, and in a local practice it costs reputation. This is not a reason to collect less. It is a reason to segment, so that effort is directed where it will succeed.

> **THE PRACTICAL CONCLUSION**
>
> Patient collections cannot be improved materially through back-end intensity, because by the time a balance is aging the information needed to resolve it correctly was never gathered. The leverage sits at estimate accuracy, pre-service communication, and payment friction.

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SECTION 04

Before the visit: estimates and financial clearance

Pre-service work determines most of what happens afterward. A patient who knows the approximate amount, understands why, and has been offered options pays at a materially different rate than one who receives an unexpected statement weeks later.

Verify coverage before estimating anything

An estimate built on unverified coverage will diverge from the final balance, and the patient will remember the number rather than the caveat. Eligibility should be verified at scheduling and again 24 to 48 hours before the service date. Coverage changes between those points more often than most workflows assume.

A usable estimate requires more than an active-coverage response. It needs deductible remaining, coinsurance percentage, copayment, out-of-pocket maximum and amount remaining, contracted rate for the planned service, and any known non-covered components.

Build the estimate on the right inputs

- **Deductible remaining,** not deductible amount. The distinction determines whether the patient owes most of the service cost or very little
- **Contracted rate,** not billed charge. Estimating from gross charges produces a number far above actual responsibility and destroys trust when the real bill arrives lower
- **Prior balance,** included explicitly. A patient surprised by an old balance appearing on a new statement disputes the whole thing
- **Known non-covered items,** identified separately so the patient understands which portion insurance will not touch

Communicate it as an estimate

Every estimate should state plainly that final responsibility depends on how the payer processes the claim and may differ. This is not legal protection language to be buried at the bottom. It is the single sentence that prevents the dispute the estimate was meant to avoid. An estimate presented as a guarantee converts a collection conversation into a credibility problem.

Price transparency as a supporting input

CMS requires hospitals to publish standard charges and provide a consumer-friendly display of at least 300 shoppable services, or all shoppable services if the hospital offers fewer than 300. Published standard charges are not patient-specific responsibility, and patients routinely conflate the two. The practical value of transparency data is as an input to the estimate conversation rather than a substitute for it.

The high-balance trigger

Define a dollar threshold above which an estimate automatically triggers a financial conversation before the service rather than a statement afterward. Given the collection rates on large balances, any estimate above a few thousand dollars should route to financial counseling as a matter of workflow, not judgment.

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SECTION 05

At the visit: point-of-service collection

Collection at or before the time of service is the highest-yield point in the entire patient revenue cycle, and it is consistently underused because it depends on front desk staff having a conversation most of them were never trained to have.

Why timing dominates

At the point of service the patient is present, the service is salient, and no statement has yet been issued to be set aside. Once the encounter ends, every subsequent contact competes with everything else in the patient's life and arrives with less context. The collection rate decline that follows is not a function of unwillingness so much as diminishing attention and increasing distance from the service.

What to collect, and when

Situation	Appropriate point-of-service approach
Copayment	Collect in full at check-in. This is standard and should never be deferred
Known deductible exposure	Collect the estimated amount, or a defined deposit, before the service
Prior balance on file	Raise at check-in with a payment option, not a demand
Large estimated balance	Route to financial counseling before the service date, not at the desk
Coverage unverified	Resolve coverage first. Collecting against an unknown creates a refund and a complaint

Training front-desk staff for the conversation

The constraint is rarely policy. It is that asking for money is uncomfortable, and staff who have not been given language default to not asking. Training should supply specific phrasing rather than general encouragement.

- Give staff scripted openings for each situation above, so the conversation is not improvised
- Train the transition from estimate to payment as a single continuous interaction, not two separate asks
- Equip staff to offer a payment plan in the same breath as the balance, so the patient hears an option rather than a demand
- Define clearly when to stop and route to financial counseling, so staff are not negotiating hardship cases at the front desk
- Measure point-of-service collection rate by individual staff member and coach from it. Unmeasured, this activity quietly stops

Remove payment friction at the desk

Card on file with patient authorization, tap-to-pay, QR codes that open a payment page on the patient's own phone, and the ability to enroll in a payment plan in under a minute all raise point-of-service collection without adding staff time. Friction at the moment of highest willingness is the most expensive friction in the process.

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SECTION 06

After the visit: statements and follow-up

Post-service collection recovers what pre-service work did not capture. Its effectiveness depends far more on clarity and timing than on frequency of contact.

Statement timing

Issue the first statement promptly after adjudication. Delay works against collection in two ways: the service becomes less salient, and the patient begins to assume insurance covered it. A practice that takes six weeks to issue a first statement has already surrendered part of the balance.

Statement design

Billing confusion is a leading cause of non-payment, and most statements are built for billing systems rather than for patients. A statement that requires interpretation gets set aside.

- **Lead with the amount owed and the due date.** Not the account number, not the billed charge
- **Show the arithmetic:** total charge, insurance payment, adjustment, patient responsibility. Patients who can follow the math dispute less
- **Identify what the balance is:** deductible, coinsurance, copay, or non-covered service. These mean different things to a patient
- **Put payment options on the statement itself,** including the payment plan option and how to start one
- **Give one phone number and one named contact point** for questions. A patient who cannot find who to ask does not pay

Follow-up sequence

Follow-up should escalate in channel rather than in tone, and should always carry a resolution path.

Stage	Channel and content
Statement 1	Full statement with arithmetic, options, and contact point
Digital reminder	Text or email with a direct payment link. Highest response rate per unit of cost
Statement 2	Repeat statement with payment plan offer made explicit
Outbound contact	Live call offering plan enrollment and assistance screening, not demand
Pre-escalation review	Screen for financial assistance eligibility and unresolved disputes before any escalation

Distinguish the four reasons a balance is unpaid

Confusion is resolved by explanation, dispute requires review, and hardship requires assistance screening or a plan. Only inattention responds to reminders, and it is the only one of the four for which escalation is appropriate. A sequence that cannot tell them apart escalates all four identically.

The pre-escalation screen

No account should move to escalation without a financial assistance screen and a check for unresolved billing questions. Escalating a patient who qualified for assistance, or who had raised a legitimate question that was never answered, produces a complaint and no revenue.

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SECTION 07

Payment options, plans, and financial assistance

Payment method availability

Every unavailable payment method is a balance that waits. Patients compare healthcare payment experiences against retail and banking, and the gap is where balances age.

- Online portal with no login required to make a payment, reachable from the statement
- Text-to-pay with a direct link, which consistently outperforms email for response rate
- Mobile wallets and card payment at the point of service
- Card on file with patient authorization, for recurring balances and plan payments
- Automated recurring payments for enrolled plans, so the patient acts once rather than monthly
- Paper and phone payment retained, since a meaningful share of patients will not use digital channels

Payment plans

Payment plans convert a balance with low collection probability into one with a scheduled path. Given the collection rates on balances above $5,000, a plan on a large balance is usually the difference between partial collection and write-off.

Design element	Practical guidance
Eligibility	Define by balance threshold so staff are not deciding case by case
Enrollment friction	Must be completable in a single interaction, including self-service
Minimum payment	Set against the balance, not a flat figure. A flat minimum makes large balances unworkable
Automation	Auto-debit on an authorized method. Manual monthly payment has high attrition
Default handling	Define what happens on a missed payment before it occurs, and communicate it at enrollment
Visibility	Offer on the statement and at the point of service, not only on request

The most common design error is offering plans only reactively, after a patient has said they cannot pay. Offering the plan proactively at the first statement treats it as a normal option rather than a concession.

Financial assistance

Financial assistance screening is part of the collection process, not an alternative to it. An account that qualifies for assistance and instead ages into bad debt produces no revenue and a poor experience.

CMS explains that nonprofit hospitals must provide financial assistance to eligible patients who cannot afford care, subject to applicable requirements, and advises patients to review the organization's financial assistance policy for eligibility requirements, application procedures, and deadlines. The Consumer Financial Protection Bureau notes that financial assistance programs may provide free or discounted care and can apply to uninsured and underinsured patients.

- Screen systematically at a defined balance threshold rather than only when a patient asks
- Make the policy and application reachable without a phone call
- Screen again before any escalation decision
- Track application and approval rates, because low application volume against a known patient mix usually indicates an access problem rather than an eligibility one

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SECTION 08

Segmentation: treating balances differently

A single collection workflow applied to every balance over-serves small accounts and under-serves large ones. Segmentation directs effort where it changes the outcome.

Segment by balance size first

A working segmentation model

Segment	Primary approach	Staff involvement
Small balances	Frictionless self-service. Text-to-pay, one-click, no login	None. Fully automated
Moderate balances	Statement plus digital reminder sequence, plan offered proactively	Exception handling only
Large balances	Pre-service financial conversation; plan or assistance screening by default	Financial counseling, before the service
Recurring or chronic care	Standing payment arrangement established once, applied ongoing	Setup only, then automated
Disputed	Route out of the collection sequence entirely until resolved	Dedicated resolution owner

Why balance size is the right first cut

Because collection probability moves with it steeply. The Crowe data showing 32 percent collection between $5,000 and $7,500 and 17 percent between $7,501 and $10,000 means a single bracket nearly halves the expected recovery. A process that does not distinguish these is optimizing for neither.

Secondary segmentation

- **Payment history.** A patient who has always paid promptly needs a reminder, not a sequence. Treating them identically to a first-time balance wastes contact capacity
- **Coverage type.** High-deductible plan early in the plan year is a predictable large-balance situation, and can be flagged at scheduling rather than discovered at billing
- **Service type.** Elective and scheduled services allow a pre-service financial conversation. Emergent care does not, and the workflow should differ accordingly
- **Prior assistance eligibility.** A patient who qualified before is likely to qualify again and should be screened automatically

On predictive payment scoring

Analytics can estimate payment likelihood from history, balance size, coverage, and demographic data to prioritize outreach. Used carefully it directs limited staff capacity toward accounts where contact changes the outcome.

Two cautions apply. A low predicted payment probability should route an account toward assistance screening and plan offers rather than earlier escalation, or the model simply accelerates writing off patients who needed help. And scoring models require sufficient volume and clean historical data, which many independent practices do not have.

The segmentation test

If a $150 balance and a $6,000 balance receive the same statements, the same reminders, and the same escalation timeline, segmentation is not yet in place regardless of what the policy document says.

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SECTION 09

Technology and automation

Technology in patient collections does two things: it removes friction at the moment of payment, and it handles volume so staff capacity can go to the balances where a conversation changes the result.

The core stack

Capability	What it changes
Real-time eligibility verification	Makes estimates accurate enough to be worth giving
Estimate generation	Produces consistent estimates from eligibility and contract data rather than staff calculation
Payment portal	24/7 payment without staff involvement. Removes the single largest friction point
Text-to-pay	Highest response rate per unit cost in the follow-up sequence
Automated reminder sequences	Consistent follow-up without consuming staff time
Payment plan automation	Self-service enrollment and auto-debit. Removes plan attrition from missed manual payments
Digital assistance applications	Raises application rates by removing the phone call barrier
Propensity scoring	Directs staff capacity toward accounts where contact matters

Where automation should stop

Automation handles the transaction. It does not handle the conversation. Patients with complex coverage, genuine hardship, disputed balances, or unusual billing circumstances need a person who can explain the situation and exercise judgment. An organization that automates the exception path alongside the routine path produces faster escalation of exactly the accounts that needed human attention.

The right division is that technology absorbs the volume so that the people are available for the complexity, not that technology replaces the people.

Integration requirements

The practical constraint in most organizations is not capability but reconciliation. When eligibility, estimates, claims, payments, and assistance applications sit in systems that do not share data, staff answer patient questions by assembling information manually, and different departments give different answers to the same question.

- Estimates should draw from the same eligibility and contract data that billing uses, so the estimate and the bill are built on one source
- Payment activity should post to the patient account in near real time, so a patient who just paid is not sent a reminder
- Counseling conversations should be documented in the system of record, so the next person to speak with the patient sees what was already said
- Assistance application status should be visible to anyone handling the account, so an account under review is not escalated

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SECTION 10

Metrics, benchmarks, and governance

Patient collection metrics and what each one tells you

Metric	Reference point	What it measures
Patient collection rate	34.4% national, 2024	Share of patient responsibility ultimately collected
Point-of-service collection rate	Track and improve	Collected at or before the visit. The highest-leverage metric
Estimate-to-bill variance	Within 10%	Estimate accuracy, and therefore whether estimates build or erode trust
Days in patient A/R	Track separately from payer A/R	Patient payment velocity. Blending it with payer A/R hides the problem
Bad debt rate	1.3% median, 2025	Balances written off as uncollectible
Payment plan enrollment rate	Track by balance band	Whether plans are offered proactively or only on request
Plan completion rate	Track and improve	Whether plan terms are realistic. Low completion means terms are too aggressive
Assistance application rate	Track against patient mix	Low volume usually indicates an access barrier, not low eligibility
Digital payment adoption	Track and improve	Friction removed. Correlates directly with speed of payment
Billing inquiry volume	Lower is better	Proxy for statement clarity and estimate accuracy

Segment every one of these

Report each metric by balance band, service line, and location. A blended rate conceals small balances collecting well while large balances are not, which points to entirely different interventions.

The two metrics most often missing

- **Estimate-to-bill variance.** Without it, nobody knows whether estimates are helping or creating disputes. A program issuing inaccurate estimates is worse than one issuing none, because it trains patients to disregard the number
- **Days in patient A/R, tracked separately.** Blended into total A/R, patient balance aging is invisible, and it behaves nothing like payer aging

Governance

- Name an owner for patient financial performance distinct from payer revenue cycle ownership
- Review the metric set monthly with segmentation, not as a single blended figure
- Set a floor on point-of-service collection rate that triggers staff coaching when missed
- Audit a sample of estimates against final bills quarterly, and feed findings back to whoever generates them

The governance failure to watch for

Patient collections is frequently owned by whoever has capacity rather than by a named role with authority over estimates, statements, plans, and assistance. Those four levers sit in different departments in most organizations, which is why the process is inconsistent even when each department performs well individually.

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SECTION 11

Implementation roadmap

Phase	Actions	Typical duration
Phase 1 Measure	Establish patient collection rate, point-of-service rate, days in patient A/R, and bad debt rate as separate measures. Audit a sample of estimates against final bills. Review statement design from the patient's side	3 to 4 weeks
Phase 2 Remove friction	Payment portal without mandatory login, text-to-pay, payment options printed on the statement, self-service plan enrollment. These are configuration changes with immediate effect	4 to 8 weeks
Phase 3 Move upstream	Eligibility verification before every encounter, estimate generation from verified coverage and contracted rates, high-balance threshold routing to financial counseling pre-service	6 to 12 weeks
Phase 4 Train and script	Front-desk scripting for each collection situation, plan offer language, escalation boundaries, point-of-service rate measured by staff member with coaching	Concurrent with Phase 3
Phase 5 Segment	Balance-band segmentation of statements, reminder sequences, and escalation timelines. Proactive plan offers at defined thresholds. Systematic assistance screening	6 to 10 weeks
Phase 6 Optimize	Propensity scoring, personalized outreach timing, continuous estimate accuracy improvement, quarterly write-off review	Ongoing

Why this sequence

Phase 2 comes before Phase 3 deliberately, even though upstream work has higher theoretical value. Friction removal is configuration rather than workflow change, produces measurable results within one billing cycle, and builds the internal case for the harder upstream work that follows. Starting with estimates and financial clearance, which require process change across scheduling and registration, often stalls before producing a visible result.

The barriers to anticipate

- **Staff discomfort with asking for payment.** The most common and most underestimated barrier. It is addressed with specific language, not with policy or encouragement
- **Estimate accuracy concerns.** Teams avoid giving estimates because they fear being wrong. The resolution is honest framing as an estimate plus measured variance, not avoidance
- **Legacy billing systems.** Older platforms may not support self-service plan enrollment or card on file. Identify this in Phase 1, because it determines what Phase 2 can actually deliver
- **Inconsistent policy across locations.** Multi-site organizations frequently have different practices at each site, which produces different patient experiences and makes the metrics uninterpretable
- **Treating assistance as revenue loss.** Assistance screening resolves accounts that would otherwise become bad debt. Framing it as a concession guarantees underuse

Scale note

An independent practice can implement Phases 1, 2, and 4 with existing staff and modest technology changes. Phases 3 and 5 benefit substantially from an RCM partner, because eligibility verification at volume and consistent segmented follow-up are capacity problems rather than knowledge problems.

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SECTION 12

Frequently asked questions

What is the current patient collection rate in healthcare?

Kodiak Solutions reported a patient collection rate of 34.4 percent for commercially insured patients in 2024, down from 37.6 percent in 2023. Individual organization performance varies considerably by patient mix, balance distribution, and process maturity.

How common are high deductibles?

The 2025 KFF Employer Health Benefits Survey found that 88 percent of covered workers with single coverage have a general annual deductible, averaging $1,886, and that 34 percent face a single-coverage deductible of $2,000 or more. Thirty-three percent are in a high-deductible plan with a savings option.

Why do collection rates fall as balances grow?

Affordability. Crowe Revenue Cycle Analytics found collection rates of 32 percent on self-pay-after-insurance balances between $5,000 and $7,500, falling to 17 percent between $7,501 and $10,000. Beyond a certain point a balance exceeds what a patient can pay from available funds, and the response is a payment plan or assistance rather than a more intensive collection sequence.

When is the best time to collect from a patient?

At or before the time of service. The patient is present, the service is salient, and no statement has yet been issued and set aside. Point-of-service collection also costs substantially less per dollar than post-service collection, which becomes more expensive as the balance ages.

Should we give patients estimates if we cannot be exact?

Yes, provided the estimate is built on verified coverage and contracted rates and is communicated clearly as an estimate that may change after adjudication. An inaccurate estimate presented as a guarantee is worse than no estimate, because it creates a dispute. A reasonable estimate presented honestly improves both collection and trust.

How do we reduce bad debt?

Move the financial conversation before the service, offer payment plans proactively rather than only on request, screen systematically for financial assistance at a defined balance threshold, and remove payment friction. Kodiak reported the median bad debt rate rising from 1.1 to 1.3 percent between 2024 and 2025, so the trend is working against organizations that do not change their process.

What should we measure first?

Patient collection rate, point-of-service collection rate, days in patient accounts receivable tracked separately from payer A/R, and estimate-to-bill variance. The last two are the ones most commonly missing, and both are necessary to interpret the first two.

Are payment plans worth the administrative effort?

For balances above a few thousand dollars, a plan is frequently the difference between partial collection and write-off, given the collection rates at those balance levels. The administrative burden is largely removed by self-service enrollment and auto-debit on an authorized payment method.

How does price transparency affect patient collections?

CMS requires hospitals to publish standard charges and a consumer-friendly display of at least 300 shoppable services, or all shoppable services if fewer are offered. Published standard charges are not patient-specific responsibility, and patients often conflate the two. Transparency data is useful as an input to the estimate conversation rather than as a replacement for it.

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SECTION 13

Sources and references

All figures cited in this whitepaper are drawn from the following primary sources, each dated and attributed to the organization that produced the underlying data.

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8. **KFF,** "The Burden of Medical Debt in the United States," February 2024. At least $220 billion in US medical debt; approximately 14 million adults owing more than $1,000 and about 3 million owing more than $10,000, based on 2021 Survey of Income and Program Participation data.

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This whitepaper is provided for general educational and informational purposes and does not constitute legal, billing, or compliance advice. Patient billing, collection, financial assistance, and price transparency obligations vary by organization type, state, payer contract, and applicable federal and state regulation, and they change over time. Healthcare organizations should validate collection policies, patient communications, financial assistance practices, and escalation procedures against current CMS guidance, applicable federal and state law including debt collection regulation, their own payer contracts, and qualified professional advice. Benchmark figures represent industry aggregates and are not performance guarantees. Patient estimates should never be presented as guarantees of final responsibility.

Further reading from StafGo Health

- The Role of Patient Financial Counseling in Healthcare Revenue Cycle Management
- How to Improve Net Collection Rate in Healthcare Organizations
- How Healthcare Providers Can Improve Front-End Revenue Cycle Processes
- Revenue Integrity Programs: Building a Sustainable Financial Framework
- Key Performance Metrics in Medical Revenue Cycle Management

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Find out what your patient balances are actually worth

StafGo Health offers a free, no-obligation RCM audit covering your patient collection performance, estimate accuracy, statement workflow, and aged patient A/R, with a written findings summary.

What a free RCM audit covers

- A 90 day lookback comparing clinical activity against billed charges to quantify uncaptured revenue
- Denial analysis segmented by payer, category, and point of origin
- Payment variance against your contracted rates, with underpayments identified
- A/R aging review by payer and bucket, including recoverable legacy balances
- A written findings summary with prioritized recommendations

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Request an audit: stafgo.com/contact-us

About StafGo Health. StafGo Health is a USA physician-owned and managed revenue cycle management company providing end-to-end RCM services to medical and dental practices across the United States. Our services include credentialing and fee negotiation, insurance verification, prior authorization management, coding and billing, A/R and denial management, payment posting and EFT reconciliation, patient billing and support, legacy A/R resolution, credit A/R resolution, and practice transition planning. All services are delivered under HIPAA-eligible processes.