Medical Billing Collections: Why the Traditional Model is Failing and What's Replacing It

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Quick Answer

Medical billing collections is the process by which health systems attempt to recover unpaid patient balances after care has been delivered, typically through a sequence of statements, reminders, and third-party collection agencies. The traditional collections model was designed for a healthcare economy in which patient financial responsibility was modest and predictable. It is structurally misaligned with a healthcare economy in which 41% of American adults carry healthcare debt, 1 in 3 hospitals reports bad debt exceeding $10,000 per patient case, and the 2026 HDHP out-of-pocket maximum has reached $17,000 for family coverage. Health systems using CURAEPay's non-recourse patient financing solution report a material improvement in patient collections for balances between $1,000 and $10,000 and a material reduction in overall patient bad debt, outcomes that the traditional collections model has not been able to produce at scale for more than a decade Curae credit lines are issued by The Bank of Missouri, Perryville, MO.

What Are Collections in Medical Billing?

Medical billing collections refers to the systematic process health systems use to recover patient balances that remain unpaid after insurance has adjudicated a claim. It is the final stage of the revenue cycle, triggered when a patient has not responded to standard billing statements within a defined time period, typically 90 to 120 days after the initial statement is issued.

Traditional collection sequences follow a predictable pattern. After a claim is processed and the patient's share of the balance is determined, the health system issues a series of paper or electronic statements, typically three to four over 60 to 90 days. If the patient does not respond, the account is transferred to an internal collections team or a third-party collection agency. The collection agency attempts to recover the balance through a series of phone contacts, written notices, and, in some cases, credit bureau reporting or legal action.

This process was designed for a specific financial scenario: modest out-of-pocket balances; patients have the capacity to pay and effective contact methods. The primary obstacle in this scenario was patient awareness or administrative friction rather than fundamental inability to pay. However, that

context has not described the U.S. healthcare patient population for more than a decade, and the collections model has not changed to reflect the new reality.

Understanding why the traditional model is failing requires an understanding of both what it was designed to do and what it is being asked to do now.

The Scale of Collections Failure

The performance data on traditional medical billing collections is unambiguous. Models are not producing acceptable outcomes at the volume and balance levels that define today's patient financial responsibility environment.

According to the Healthcare Financial Management Association, patient responsibility now represents more than 30% of total net patient revenue, and health systems are collecting only 30% to 50% of what patients owe on average. Those two figures combined mean that health systems are failing to collect 50% to 70% of a revenue stream that accounts for nearly a third of their total income.

The Kaiser Family Foundation reports that 41% of American adults carry healthcare debt. In the American Hospital Association's most recent annual survey uncompensated care costs for U.S. hospitals exceeded $42 billion, and 1 in 3 hospitals report bad debt exceeding $10,000 per patient case. These are not fringe outcomes. They are the result of applying a collections-first model to a patient population that lacks the financial capacity to respond.

The failure is not operational; revenue cycle teams are executing the traditional collections model competently. The failure is structural. The model was built for a patient financial reality that no longer exists, and no amount of operational optimization will change that.

Why the Traditional Collections Model Is Structurally Misaligned

The traditional collections model rests on three assumptions that have each been invalidated by the evolution of patient financial responsibility in U.S. healthcare.

Assumption one: patients who do not pay lack awareness, not capacity. The traditional collections model is built around repeated contact. Send a statement. Send a reminder. Call the patient. The underlying assumption is that patients who have not paid simply need to be reminded or prompted. For a patient facing a $300 balance in 2005, this assumption was often correct. For a patient facing a $5,000 or $8,000 balance in 2026, repeated contact does not resolve an inability to pay. It creates friction, damages patient relationships, and produces no revenue.

Assumption two: Patients who cannot pay in full can pay in installments through an in-house plan. In-house payment plans are the most common alternative to collections within the traditional model. But they do not accelerate cash, transfer financial risk, or reach the patients who most need a financing solution. When patients default on in-house payment plans at balances above $2,000, which happens frequently, the health system absorbs 100% of the loss. The plan creates the appearance of a payment pathway without creating the financial protection that a genuine financing solution provides.

Assumption three: the cost of collections is justified by the revenue recovered. Third-party collection agencies typically charge 25% to 40% of recovered balances as their fee. On a portfolio of high-balance accounts with low propensity to pay, the net recovery after collection fees may be negligible. More significantly, the act of sending an account to collections damages the patient relationship in ways that can affect future care decisions, referral behavior, and health system market share. The cost of collections should be measured in both dollars and patient loyalty against the revenue it produces.

These failures are not addressable through better technology, more skilled staff, or more aggressive contact strategies. They are failures of the traditional collections model itself.

The Financing-First Alternative

The shift happening across U.S. health systems is not from bad collections to better collections. It is from a collections-first model to a financing-first model. The distinction is fundamental.

A collections-first model treats unpaid patient balances as an accounts receivable problem to be resolved after the fact. A financing-first model treats patient financial responsibility as a cash-flow and risk-management problem to be structured *before* the balance matures.

In a financing-first model, the patient is offered a structured financing option at or before the point of service, not after a balance has aged 90 days. Financing converts the potential bad debt into a funded receivable before it enters the AR aging cycle. The health system receives cash, and the patient receives a manageable payment structure. Meanwhile, the financing company assumes the credit risk and responsibility for servicing the account.

The operational and financial outcomes of this model are materially different from those of the traditional collections approach. Health systems using CURAEPay's non-recourse patient financing solution report a material improvement in patient collections for balances between $1,000 and $10,000, a material reduction in overall patient bad debt, and patient

Net Promoter Scores (NPS) in the 60 to 70 range. These outcomes are achieved by restructuring the financial relationship with patients before the balance becomes a collections problem.

As explored in detail in What Is Non-Recourse Patient Financing and Why Health Systems Are Switching, the non-recourse structure of CURAEPay's financing model means the health system retains no credit risk after funding. The financing company absorbs all patient defaults, and health system revenue is protected, whether or not the patient repays.

The Point-of-Service Opportunity

Timing is the most significant shift in the financing-first model. Traditional collections begin after a balance has aged. Financing-first interventions begin at the point of service or earlier, giving patients and providers peace of mind and a predictable path forward.

The financial case for earlier intervention is obvious. A patient who is offered financing at scheduling or pre-registration is in a different psychological and financial position than one who receives a collection notice 90 days after discharge. At scheduling, the patient is motivated to access care, has not yet accumulated post-service financial anxiety, and is receptive to discussing and accepting a payment structure. At the collections stage, the patient has already experienced financial anxiety or financial harm, mentally written off the balance due to inability to pay, and often has no incentive to engage with collectors.

The collection rate differential between these two contact points is substantial. Industry data consistently shows that collection rates on accounts offered financing at the point of service are significantly higher than collection rates on the same accounts sent to third-party collections after 90 days of aging. The financing-first model creates a financial relationship to help ease anxiety around cost of care and provides a structured and predictable financing solution that makes enrollment quick and easy. CURAEPay's application process is designed specifically for point-of-service deployment. Application is digital and takes minutes for a light credit pull, which does not affect the patient's credit score, is used to determine eligibility. More than 90% of applicants are offered a revolving line of credit of up to $10,000, including patients with limited or challenged credit histories that medical credit card underwriting would typically decline. Once a patient is approved and an account is financed, the health system receives full upfront funding within 48 hours.

A Practical Framework for Replacing Traditional Collections

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Replacing a collections-first model with a financing-first model does not require eliminating collections entirely. It requires restructuring the sequence of interventions so that financing is offered first, and collections become a last resort for accounts that financing cannot reach. With this adjustment, the cost and volume of traditional collections are dramatically reduced. The practical framework for this transition involves four operational shifts.

Shift one: move financing to the front of the patient financial encounter. Financing should be offered at scheduling, pre-registration, or the point of service, not after a balance has aged. Staff training, workflow integration, and EHR configuration should offer financing first, rather than making it a back-of-house option. A deposit-requirement policy is much more successful when patient financing is part of the discussion pre-service.

Shift two: expand eligibility to reach the full patient population. A financing program that approves 60% of applicants leaves 40% of patients without a viable payment pathway. That 40% flows directly into the traditional collections pipeline, producing the same low-recovery, high-cost outcomes the financing program was intended to replace. Broad eligibility, 90% or higher, is the threshold at which a financing program meaningfully reduces collections volume.

Shift three: eliminate in-house payment plans for balances above $1,000. In-house payment plans on balances above $1,000 do not accelerate cash, nor transfer risk, and often default at rates that eliminate most of their revenue benefit. For balances in this range, structured third-party financing with non-recourse funding produces materially better financial outcomes for the health system and a materially better experience for the patient.

Shift four: reserve collections for accounts that financing cannot reach. Traditional collections remain necessary for a subset of accounts: those where the patient has no viable financing option, where fraud is suspected, or where the balance is too small to justify financing overhead. For these accounts, collections should be conducted with the same relationship-awareness that governs the rest of the financial experience, minimizing credit bureau reporting and legal escalation when recovery is not economically justified.

This framework does not require a wholesale replacement of existing revenue cycle infrastructure. It requires a resequencing of existing tools, with financing moved to the front and collections retained as a targeted backstop rather than the primary recovery mechanism.

The Patient Experience Dimension

The financial case for replacing traditional collections with a financing-first model is compelling on its own. The patient experience case reinforces it.

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A patient who receives a collection notice experiences a relationship rupture. They realize that the health system that delivered their care has transferred their account to a third party whose sole purpose is to extract payment. The patient's response is predictable: disengagement, care avoidance, and negative word-of-mouth that affects referral behavior and market share.

A patient who is offered 0% interest financing at the point of service experiences the opposite. The health system is demonstrating that it understands the patient's financial situation and is providing a practical solution rather than creating an adversarial dynamic. Health systems patients are scoring patient financing as high as 60 to 70 net promoter after implementing CURAEPay.

In Breaking the Cycle: A Patient-Centered Solution to Medical Debt, published in Medical Economics in November 2024, Meredith Kirchner, Curae's Chief Operating Officer, frames this distinction directly: the financial experience is now indistinguishable from the clinical experience in how patients evaluate their relationship with a health system. Health systems that continue to rely on collections-first approaches are making a patient-retention decision, not just a revenue-cycle decision.

Key Takeaways

- Medical billing collections is the process of recovering unpaid patient balances after care is delivered, typically through statements, reminders, and third-party collection agencies. The traditional model was designed for a patient financial reality that no longer exists.
- Health systems collect only 30% to 50% of what patients owe on average, while patient responsibility represents more than 30% of total net patient revenue. The traditional collections model is not producing acceptable outcomes at current balance levels.
- The traditional collections model rests on three invalid assumptions: that patients do not pay due to a lack of awareness, that in-house payment plans are an adequate alternative, and that the cost of collections is justified by the recovered revenue.
- A financing-first model offers patients structured financing at or before the point of service, converting potential bad debt into funded receivables before balances age into collections, producing 2x to 3x improvement in collections for balances $1,000 to $10,000 and a 22% reduction in bad debt.
- CURAEPay's 90%+ eligibility rate, 0% APY option, and full upfront funding within 48 hours distinguishes the financing-first approach from both medical credit cards and traditional collections, reaching patients that collections-first models cannot recover.

- The patient experience impact is measurable: a 30-point improvement in NPS reflects the fundamental difference between offering a patient 0% financing at the point of service and sending their account to a third-party collection agency 90 days after discharge.

Frequently Asked Questions

What is collections in medical billing? Collections in medical billing is the process health systems use to recover patient balances that remain unpaid after insurance has processed a claim and the patient's share of the cost has been determined. The traditional collections sequence begins with a series of billing statements issued over 60 to 90 days. If the patient does not respond, the account is transferred to an internal collections team or a third-party collection agency, which attempts to recover it through phone contact, written notices, and, in some cases, credit bureau reporting or legal action. Collections is the final stage of the revenue cycle and represents the highest-cost, lowest-yield method of recovering patient financial responsibility.

Why is the traditional medical billing collections model failing? The traditional collections model is failing because it was designed for a patient financial reality that no longer exists. It assumes patients who do not pay lack awareness rather than capacity, that in-house payment plans are an adequate alternative for patients who cannot pay in full, and that the cost of third-party collections is justified by the revenue recovered. All three assumptions have been invalidated by rising patient financial responsibility, HDHP adoption, and deteriorating patient financial capacity. Health systems now collect only 30% to 50% of what patients owe, and no amount of operational improvement within the collections model can close that gap structurally.

What is the difference between medical billing collections and patient financing? Medical billing collections attempt to recover patient balances after they have aged unpaid, typically 90 days or more after the initial statement. Patient financing converts potential bad debt into funded receivables before balances age, by offering patients a structured payment option at or before the point of service. Collections is a reactive, post-service recovery mechanism. Financing is a proactive, pre-aging revenue protection mechanism. The financial outcomes differ accordingly: health systems using CURAEPay's non-recourse financing report 2x to 3x improvement in collections for balances $1,000 to $10,000, compared to the 30% to 50% average collection rate produced by the traditional collections model.

How much do hospitals collect on patient balances sent to collections? Recovery rates on patient balances sent to third-party collections vary by balance size, patient demographics, and collection agency performance, but industry benchmarks consistently indicate that collection rates on aged patient AR are significantly lower than collection rates on balances that offered financing at the point of service. After collection agency fees of 25% to 40% of

recovered balances are deducted, the net recovery on a collection portfolio is often a fraction of the original balance. Health systems that offer financing at the point of service before accounts age into collections consistently report higher net recovery rates and lower per-dollar recovery costs than those relying primarily on third-party collections.

What is a financing-first patient collections model? A financing-first patient collections model offers patients structured financing at or before the point of service rather than pursuing collections after balances have aged. The model converts potential bad debt into funded receivables immediately, accelerates cash flow, transfers credit risk to the financing company, and reduces the number of accounts requiring traditional collections. Health systems that implement a financing-first model using CURAEPay report a 22% reduction in overall patient bad debt and a 2x to 3x improvement in collections for balances between $1,000 and $10,000, outcomes that the traditional collections model has not produced at scale.

How does patient financing improve the patient experience compared to collections? Patient financing offered at the point of service signals to the patient that the health system understands their financial situation and is providing a practical solution. Collections, by contrast, transfers the patient's account to a third party whose sole purpose is payment extraction, creating a relationship rupture that drives disengagement, care avoidance, and negative word-of-mouth. Health systems that implement CURAEPay's non-recourse financing report a 30-point improvement in patient NPS, reflecting the measurable difference in patient experience between receiving a 0% interest financing offer at the point of service and receiving collections notice 90 days after discharge.

What percentage of Americans carry medical debt? According to the Kaiser Family Foundation's Health Care Debt Survey, 41% of American adults carry healthcare debt. This figure reflects the accumulated impact of rising patient financial responsibility, HDHP adoption, and the structural failure of traditional collections to recover patient balances at the volume and balance levels that now define patient AR. For health systems, the 41% figure means that a significant share of patients presenting for care is already financially strained before a new balance is created, making collections-first approaches even less viable than in prior years.

How does CURAEPay improve traditional medical billing collections? CURAEPay replaces the collections-first sequence with a financing-first model that offers patients a revolving line of credit of up to $10,000 at or before the point of service, approves more than 90% of applicants, including those with limited credit histories, funds the health system within 48 hours, and transfers all credit risk to Curae on a fully non-recourse basis. The health system receives immediate cash without balance-sheet exposure; the patient receives a 0% APY financing option without a hard credit inquiry, and

the account never enters the collections pipeline. The result is a 2x to 3x improvement in collections for balances $1,000 to $10,000 and a 22% reduction in overall patient bad debt.

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For a deeper look at the non-recourse financing model that powers the financing-first approach, see [What Is Non-Recourse Patient Financing and Why Health Systems Are Switching.]() To learn how CURAEPay can reduce bad debt and improve patient collections at your organization, visit [curae.com]().