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HEALTHCARE PAYOR AND PROVIDER PRACTICE

The next wave of change for US health care payments

The development of an automated payment network would reduce bad debt, cut administrative costs, and save billions of dollars.

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What are the prospects for an overhaul of the US health care payments system? The recent passage of comprehensive health insurance legislation only adds to the pressure for transforming the system that manages medical bills, claims, and payments. We foresee big changes in coming years, with billions of dollars of value at stake.

The June 2007 *McKinsey Quarterly* article "Overhauling the US health care payment system"[1] argued that the greater "electronification" of health care transactions, the growing adoption of standards, and increasing innovation by cross-industry entrants would lead to a major restructuring of the US health care payments value chain. Two and half years later, we are still waiting for that massive overhaul. But we believe that major change in the payments landscape is inevitable because of fundamental industry dynamics, such as the proliferation and increasing complexity of health care transactions, the increasingly prominent role of the consumer in payments, and the rising importance of medical and financial risk management for providers. And the pace of change will only accelerate with the rolling out of the new health care law, as more individuals become insured and begin to generate more health-related transactions and industry participants face greater pressure to reduce administrative costs.

We acknowledge that there has been progress in improving the health care payment system. There has been a steady conversion to electronic-data formats, thanks to the adoption of standards across different transaction types compliant with the HIPAA[2] (for example, claims submissions, eligibility checks, and remittance advice), along with the more widespread use of electronic formats and transaction-processing clearinghouses. We estimate that by 2012, about 80 percent of the projected eight billion core US health care transactions will be in electronic formats, excluding lab and pharmacy, which are already largely electronic.

Also, we have observed movement toward developing technical solutions to health care payments problems. There are numerous innovative approaches on the market aimed at improving the transparency and efficiency of payments, with companies offering products such as online bill-paying solutions, patient liability–estimation tools, point-of-sale consumer payments processing, and structured financing solutions. In addition, large health care IT players (for example, GE and McKesson) and a range of financial institutions (JPMorgan Chase and PNC Bank, for instance) continue to make significant investments in health care payments processing, while large payers and providers explore ways to partner to solve payments issues.

The transition to electronic formats, as well as technological innovation, has laid the groundwork for the more fundamental restructuring of health care payments outlined

[1] See Nick A. LeCuyer and Shubham Singhal, "Overhauling the US health care payment system," mckinseyquarterly.com, June 2007.

[2] Health Insurance Portability and Accountability Act.

in the 2007 article. But there is still much work to be done: the system remains highly fragmented and inefficient, consuming a disproportionate share of dollars compared with payments systems in other industries. Unlike scale utility approaches that have emerged in financial services or telecommunications, innovative solutions in health care have failed to take hold at scale—either because of misaligned incentives among stakeholders or because few players have the local-market position to drive adoption across a fragmented provider community. And consumer bad debt continues to rise, resulting in more than $65 billion in uncollected revenues in 2010, according to our latest estimates, putting enormous strain on provider economics. We will see more progress in coming years as industry participants address three major challenges.

Managing growing volume and complexity

The volume and complexity of health care transactions is rapidly expanding. We estimate that the number of HIPAA-compliant transaction sets will grow at a compound annual growth rate (CAGR) of about 8 percent in coming years. In addition, new regulations, such as 5010 and ICD-10 (aimed at creating better-defined data standards), are adding more complexity and forcing the expenditure of hundreds of millions of dollars in investments.

We also foresee an explosion of digitized, stored, and transferable clinical data. Today, less than 20 percent of clinical data is electronic, with little standardization across data fields. We see a rapid shift toward the greater use of electronic formats and standardization, in large part spurred by the electronic-health-record requirements in the American Recovery and Reinvestment Act of 2009.

The complexity of clinical data should not be underestimated—a typical patient-level clinical data set can include more than 800 discrete fields, compared with only about 20 to 30 for a financial transaction. Digitizing, standardizing, and normalizing this data so that they can be used for operational and clinical decision making will require large capital investments and create ongoing operating costs. Few health care industry players have the scale or sophistication to manage these issues on their own.

Resulting in part from this systemwide complexity, industry administrative costs will grow by about 10 percent annually over the coming years—higher than the rate of growth of medical inflation. Tackling these costs will require private-sector action. The US Congressional Budget Office (CBO) has only scored about $3 billion in administrative cost savings by 2014 from the Senate and House versions of the recently passed health care law. This amount will cover only a fraction of total industry administrative costs.

The pressure to manage costs should increase the willingness of industry participants to work together and to try new approaches. Cross-industry collaboration could finally spur the creation of payment utilities such as full-cycle-payment automation (described in our 2007 article). As noted there, we believe in the potential for cross-industry collaboration

Modifying consumer behavior

As consumers take on more of the risk associated with health care, the traditional relationship among consumers, providers, and payers is changing. With persistent medical inflation, employers continue to promote greater employee cost sharing to reduce their health care spending. Between direct payments to providers from both self-pay consumers and the insured (and their share of insurance premiums), individuals play a major role in the flow of health care funds. And the recent health care insurance law will only increase the role of individuals, as many previously uninsured people enroll in insurance plans, actively utilize health care services, and become responsible for balance-after-insurance payments.

The shift to a more consumer-oriented system poses challenges for providers as well. Few of them (with notable exceptions, such as dental practices) are able to estimate a patient's out-of-pocket expenses, present a bill at the point of service, and collect payment then and there. Instead, providers send a bill, often weeks after the event, and hope the patient pays. To complicate matters, patients typically receive an "explanation of benefits" statement from their insurer—not a bill, but an estimate of their liability after adjudication, which can be more confusing than helpful, since its timing and content are seldom coordinated with the provider's bill. Moreover, there are few deterrents to nonpayment. Providers are typically reluctant to pursue patients aggressively for fear of reputational risk. Although medical expenses sent to collections do show up on credit reports, many lenders discount them.

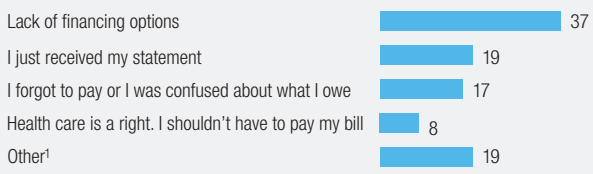
As a result, provider collection rates run at 50 to 70 percent for small-dollar liabilities for insured patients and fall to about 10 percent for self-pay patients. Uncollected revenues represent 4 to 6 percent of hospital gross revenues. We estimate that in 2010, bad debt will reach some $65 billion.

The prevailing assumption is that consumers are unable or unwilling to pay their health care bills. Our consumer research suggests otherwise. It reveals

Exhibit 1

Why don't they pay?

Stated reasons for nonpayment, % of insured respondents



[1] Includes responses that received <5% response (eg, "I don't pay my bills until the provider or a collection agency calls me," or "My provider doesn't accept my preferred method of payment").

Source: 2009 McKinsey survey of retail health care consumers

that the lack of financing options, inefficiencies in billing practices, and consumer confusion are all major drivers of nonpayment (Exhibit 1). In fact, our analysis suggests that the vast majority (more than 74 percent) of insured consumers are both able and willing to pay their out-of-pocket medical expenses for annual liabilities of less than $1,000 a year (Exhibit 2). Indeed, more than 90 percent are willing and able to pay if these liabilities are less than $500. Yet collection rates lag well behind these levels, even for relatively low-ticket payments.

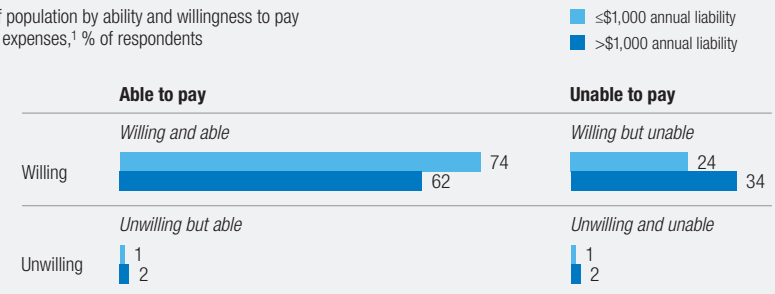
For annual member liabilities greater than $1,000 a year, the "willing and able to pay" segment drops to 62 percent. The pressure around health care expenses that consumers face will only worsen as rising deductibles and out-of-pocket expenses—as well as the explosion in chronic conditions requiring life-long health care—place heavier burdens on household finances. The industry thus faces a stark choice: improve retail-payment capabilities to help consumers manage their health care financing better or risk having rising costs overwhelm consumers' current willingness and ability to pay.

Our research suggests that the industry can address a significant portion of the bad debt in the system through approaches that not only make payments more convenient, less confusing, and easier to distribute over time through financing but also reposition medical bill payments in the household payment hierarchy. New payment solutions must tackle consumers' confusion and concerns head on. Automated payments, patient statements (instead of bills and explanations of benefits), structured payments plans or lines of credit, and even incentives and reward points based on principles from behavioral economics should all be considered in building a value proposition that consumers will readily adopt. Such innovative payments approaches could

Exhibit 2

Willing and able

Share of population by ability and willingness to pay medical expenses,[1] % of respondents



[1] Ability to pay based on consumers' family income and member liability; willingness to pay based on whether consumers paid medical bills and in cases of nonpayment, reasons given for that nonpayment.

Source: 2009 McKinsey survey of retail health care consumers

create nearly $60 billion a year in value as well as achieve substantial savings in the administrative costs associated with inefficient processing and collections.

A model will create value only if it succeeds in inducing more consumers to pay more of their medical bills than they currently do. It must therefore garner adoption beyond those who already pay their bills and who might self-select into a more convenient payment mechanism. It must also reposition health care expenses at the top of the household payment hierarchy, since these expenses typically fall at the bottom. For example, health insurance premiums follow mortgage or rent and utilities as the third most important expense for most households. Medical expenses, on the other hand, rank seventh (after cell phone and Internet bills), with only 7 percent of households rating medical expenses as a top priority within their household budgets.

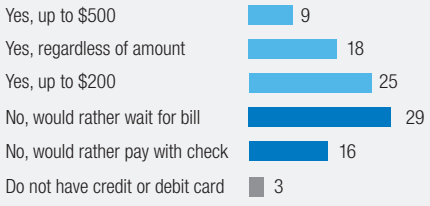
The payments hierarchy reveals that partnerships between insurers and providers could help improve collections, given the much higher importance of paying premiums. Such collaboration could take the form of integrating balance-after-insurance billing with the explanation of benefits or health statement (online or paper), with or without credit risk-taking by the insurer.

Further, we estimate that if currently insured consumers had access to more convenient payment mechanisms and structured payment or financing options to help them smooth spiky medical expenses into tight household budgets, only 10 percent of their bad debt would remain uncollectable. This approach could include card-based solutions. Our research suggests that 52 percent of consumers would be willing to use a credit or debit card in a health care transaction if a good-faith estimate of up-front costs were provided, at payment levels that cover the out-of-pocket costs of a typical physician visit or out-patient procedure (Exhibit 3).

Exhibit 3

Charge it, please

% of consumers willing to pay at point of service by credit or debit card, if a good-faith estimate is provided



Source: 2009 McKinsey survey of retail health care consumers

to create an at-scale payment-settlement utility that knits together health care transaction processing through clearinghouses, the automated clearinghouse payment network, and card network payments for retail payments.

Solving the challenge of consumer payments

According to our modeling of the 2010 flow of health care funds, consumers now pay more in health care costs than do employers. This cost is split among direct payment of noncovered services, out-of-pocket expenses after insurance, and the consumers' share of premium expenses. Uncompensated care from 46 million uninsured Americans continues to be an issue, but one that will be mitigated by reform. In fact, the fastest-growing portion of bad debt stems from what insured patients fail to pay after insurers have paid their portion of medical bills. This category will likely grow as more insured patients enter the market following passage of the new health care law. For example, at one multifacility hospital system, we found that, for insured patients, "balance after insurance" is growing at 30 percent a year; for patients without insurance (those who pay for services from their own pockets), that figure is only 19 percent.

This trend will place balance-after-insurance collection issues front and center in the health care payments landscape. Physician practices and hospitals alike could do better through innovative patient financing, better front-end retail-revenue-cycle approaches, and consumer-friendly collections. In particular, there will be greater pressure on physicians regarding balance-after-insurance collections as reform accelerates the shift from in-patient to out-patient and from hospitals to physician- or clinic-based settings. Many of these smaller practices are poorly equipped to deal with the resulting retail-revenue-cycle challenges given current mind-sets, workflow practices, and capabilities.

The need to deal with these issues opens the door for greater penetration of point-of-service, retail-oriented payments approaches. For the physician segment, *how* these solutions are provided, in particular, is what matters—solutions with bundled financing options or ASP[3] models that are integrated into the physician's workflow and require little capital investment will probably see the most uptake.

In addition to transactional efficiency, industry dynamics will likely drive the need for innovative financing methods that better meet the requirements of health care consumers. There is little doubt that millions of households will continue to struggle with managing health care costs, despite consumers' willingness and ability to pay their bills (see sidebar, "Modifying consumer behavior"). Coming up with compelling consumer payment solutions will require financial intermediaries to step in and provide financing and structured-payment options.

[3] Application service provider.

Integrating medical and financial risk management

As the health care industry moves toward outcome-based, bundled payments, providers must increasingly leverage payment and clinical insights to better understand and manage medical risk. Most providers remain woefully ignorant of the economics relating to patient segments, service lines, geographies, and payers. To understand profitability at a detailed level in an outcome-focused world, providers must have access to and analyze normalized clinical, claims, and payments data.

To get there, several things must happen. First, electronic-health-record adoption and data standardization must continue. By applying CBO data, we estimate that 55 percent of hospitals and 85 percent of physician practices will reach the basic stages of meaningful use by 2014.

Second, the health information exchange (HIE) infrastructure must expand to provide connectivity. There are already 150 to 200 HIEs across the country, supported by a broad ecosystem of technology players, ranging from large-scale providers, such as Cerner, IBM, and Misys; to smaller ones, such as dbMotion and Medicity; to publicly backed approaches, such as the open-source software advanced by the Nationwide Health Information Network (NHIN). Larger hospital systems are also increasingly building out private HIEs that can help them better integrate care and manage their referral network, in some cases in collaboration with payers.

Finally, relevant clinical data will need to be integrated with claims information, charge data, and remittance information in a way that enables analytics on issues such as cost management, physician management, reimbursement optimization, and service line profitability. As with other transaction-processing and analytic capabilities in health care, developing these solutions will likely require innovative cross-industry collaborations involving some combination of intermediaries and infrastructure providers (payers, IT vendors, and financial institutions) and analytics service providers.

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Over time, it should be possible to automate the full cycle of information and payment flows in health care, from the submission of claims to the receipt of payments and reconciliation. The development of an automated payment network would reduce bad debt, cut administrative costs, and save billions of dollars. It would also create the infrastructure needed to sustain the health care payments system in a more retail-oriented world. Beyond such a network, the integration of payments with clinical data (such as claims histories and pharmacy records) promises to provide the infrastructure and analytical basis for the next generation of innovation in provider incentives and payments, such as evidence-based "pay for value" reimbursement models. The momentum behind this transition is growing as

the rising incidence of diabetes, obesity, and other chronic conditions requiring long-term care changes the underlying nature of health care financing risk. The need for a system that helps players to address these issues—and consumers to manage the financial aspects of their health care—is becoming ever more pressing. The incremental progress we have seen over the past few years is indicative of much greater change ahead.

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