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U.S. healthcare payments: Remedies for an ailing system

As American consumers shoulder more of the burden of healthcare costs, new models are needed to facilitate payment flows, combat growing bad debt, and improve efficiency across the value chain.

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The nature of U.S. healthcare payments is in flux. This industry, which handles transactions worth some $2 trillion a year (Exhibit 1), has outgrown its traditional model and is now a major source of inefficiency and a barrier to innovation within the healthcare system.

So what seems to be the trouble? Despite recent advances in standardization and automation, healthcare payment processing remains highly inefficient thanks to industry fragmentation, complex payment terms, and extensive manual processing. As a result, about $300 billion a year – 15 cents of every dollar spent on healthcare – is lost on claims processing, payments, billing and revenue cycle management, and bad debt.

The industry's infrastructure is also hindering innovation. The shift to a more consumer-centric healthcare model is changing the relationship between consumers, providers, and payors – a challenge that other countries with emerging private healthcare markets will also have to address. As consumers struggle to manage larger out-of-pocket liabilities and bad debt grows, providers are experiencing lower revenues and struggling to re-equip their business processes to better manage payments from consumers. In turn, providers' lower revenue yields threaten payors' contracted-provider discounts. These trends look set to continue even with the regulatory uncertainty around federal-level healthcare reforms, as employers shift cost to employees after years of high medical inflation.

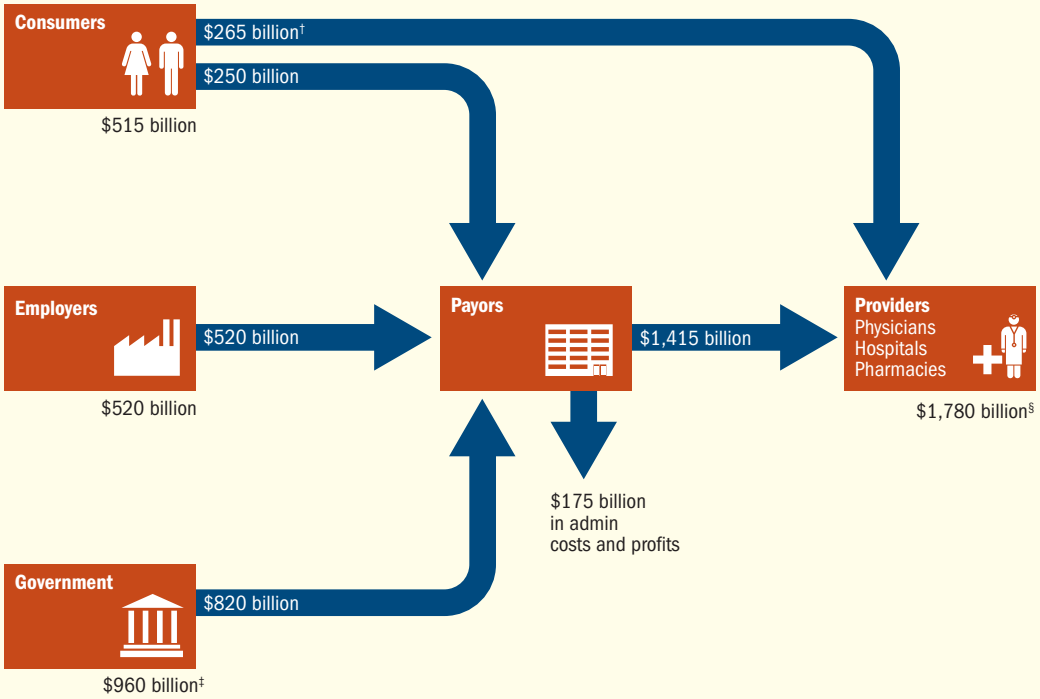
Solutions to many of these challenges already exist. Numerous experiments are under way in the market to improve transparency and develop new capabilities within the healthcare payments infrastructure, and innovative companies are offering well-developed technical approaches. Yet adoption has been slow. Despite industry consolidation, few players have the market density to move the market in a new direction.

Nevertheless, we believe the momentum behind the consumer-centric model will soon reach a tipping point, and more and more players will be willing to adopt new solutions. In a sector where hundreds of billions

Note: This article is based in part on "Overhauling the U.S. healthcare payment system," Nick A. LeCuyer and Shubham Singhal, *The McKinsey Quarterly*, June 2007.

Exhibit 1

Financial flows in U.S. healthcare*



* All figures are estimates for 2007 and are approximate

† Not including an additional $45–$65 billion in consumer bad debt

‡ Approximately $140 billion of this is spent on government public health and research

§ Includes an additional $100 billion from foundations

Source: Centers for Medicare & Medicaid Services; Office of the Actuary; McKinsey analysis

of dollars of value are at stake, we foresee big changes in the coming years.

We now turn to a brief explanation of key dynamics of the U.S. healthcare market and implications for players.

Nearing the tipping point

Physicians, hospitals, and labs have designed their payment systems around business-to-business relationships, spending $100 billion or more a year on managing the submission of claims. Transactions typically move in batches, with claims submitted long after patients have been treated. While conversion to electronic formats is increasing thanks to the adoption of standards across different transaction types, the prevalence of transaction-processing clearing houses for facilitating transfers, and the growing acceptance of electronic formats by physician practices, many transactions are still paper based. Only about 40 to 60 percent of claims are submitted electronically, for instance.

Despite its inefficiencies, this wholesale-oriented infrastructure worked in an environment where patient liabilities constituted a small portion of the total amount collected by the provider. Payors and providers managed their relationships through contract negotiations and well-established processes for claims submission, adjudication, and payment. Although providers typically collected only a fraction of the amount due from patients, the levels of bad debt could be tolerated. However, such a system does not work as well for a consumer-centric payments model in which providers' revenue comes increasingly from consumers rather than third-party payors.

The challenge of consumer-to-provider payments

As individuals take on more of the financial risk associated with healthcare, the traditional relationship between consumers, providers, and payors is changing. The shift goes beyond the growth of consumer-directed health plans (CDHPs) with savings vehicles such as health savings accounts (HSAs). After nearly a decade of medical inflation in the high single digits, employers

are pushing for greater cost sharing to mitigate their healthcare expenditure. Out-of-pocket payments for insured patients are set to grow from around $250 billion today to some $420 billion by 2015. Added to this is a large pool of "self-pay" consumers made up of almost 46 million Americans who have no health insurance.

The shift to a more consumer-oriented system poses challenges for providers. Healthcare lacks the kind of modern payment system found in retailing. Few providers (with notable exceptions such as dental practices) are able to estimate a patient's out-of-pocket expenses, present a bill at point of service, and collect payment there and then. Instead, they send a bill, often weeks after the event, and hope the patient pays.

To complicate matters, patients typically receive an "explanation of benefits" (EOB) 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 non-payment: providers are typically reluctant to pursue patients aggressively for fear of reputational risk and, although medical expenses sent to collections do show up on credit reports, many lenders disregard them.

As a result, provider collection rates run at 50 to 70 percent for small-dollar liabilities for insured patients and fall to just 5 to 10 percent for self-pay patients. Uncollected revenues represent between 4 and 6 percent of hospital gross revenues. In total, bad debt now stands at some $45 billion to $65 billion across the industry, a rise of 8 to 13 percent in just two years (Exhibit 2).

This growth increasingly derives from unpaid liabilities incurred by insured patients rather than monies owed by the uninsured. The economic crisis is likely to accelerate the growth of bad debt as households face hard times in the years to come.

Implications for consumers

The prevailing assumption is that consumers are unable or unwilling to pay their healthcare bills. Our consumer research suggests otherwise. It reveals that the lack of financing options, inefficiencies in billing practices, and consumer confusion are all major drivers of non-payment (Exhibit 3 on page 44).

How does the system work?

The payments system for insured patients works like this:

1 A patient is treated by a doctor, hospital, or other healthcare provider.

2 The provider submits a claim to a third-party payor: a national insurance plan such as Aetna, United, or Wellpoint, or a local payor such as a regional Blue Cross Blue Shield plan. (If the patient is uninsured, the provider attempts to collect the money or steers the patient toward options such as Medicaid or charity care.)

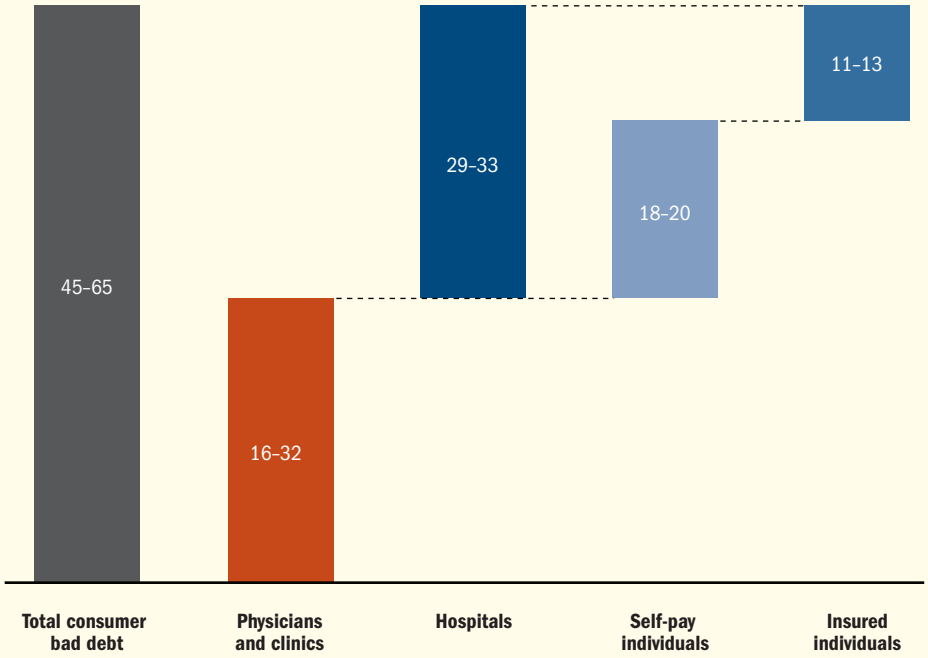
3 The payor processes and adjudicates the claim, taking into account the patient's insurance coverage (benefit design) and its own contracting relationship with the provider. Once the claim is adjudicated, the payor remits its portion of the claim to the provider, usually 30 to 60 days after the claim is submitted.

4 Based on the remittance from the payor, the provider works out how much of the claim is owed by the patient and bills him/her accordingly.

5 The patient pays (or not).

Exhibit 2
Growing consumer bad debt across the system

Breakdown of U.S. healthcare industry bad debt, 2007
U.S.$ billions, estimates



Source: American Hospital Directory; MGMA; McKinsey analysis

In fact, our analysis suggests that 92 percent of insured consumers are both able and willing to pay their out-of-pocket medical expenses for annual liabilities of less than $500 per year. Yet collection rates lag well behind (Exhibit 4 on page 45). For annual member liabilities greater than $500 per year, the "willing and able to pay" segment drops from 92 to 54 percent. The pressures consumers face can only worsen as rising deductibles and out-of-pocket expenses and the explosion in chronic conditions requiring life-long healthcare place heavier and heavier burdens on household finances. The industry thus faces a stark choice: improve retail payment capabilities to help consumers manage their healthcare costs better, or risk having rising healthcare costs overwhelm consumers' willingness and ability to pay.

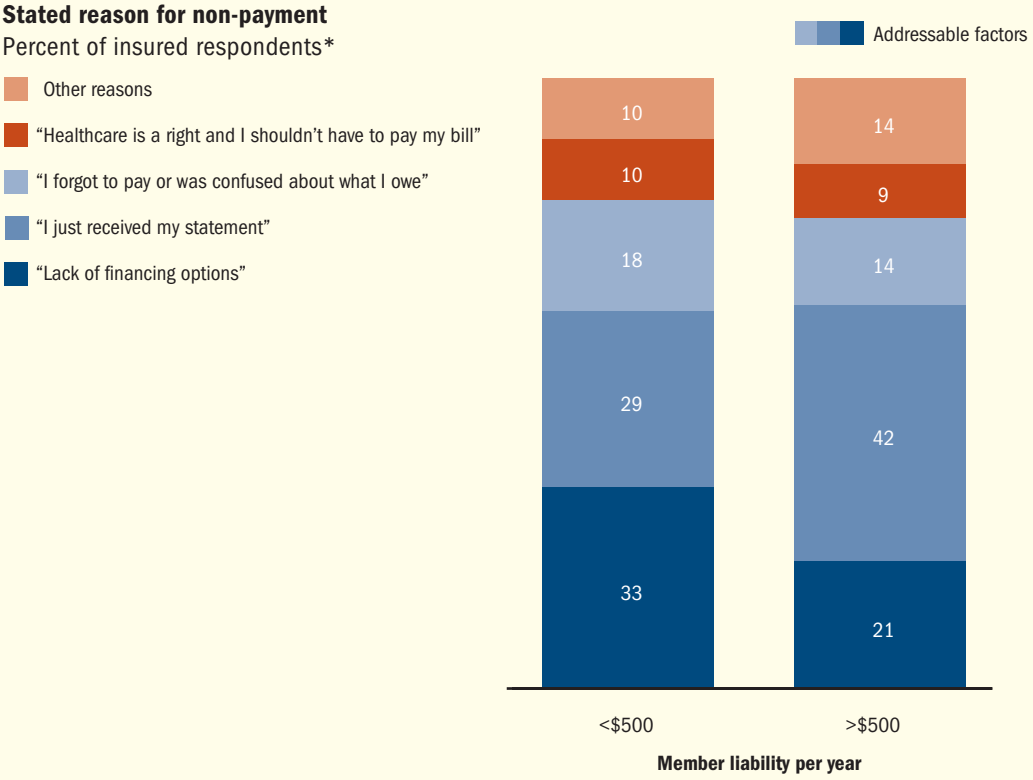
Our view is that most of the bad debt in the system could be addressed if consumers were offered solutions to help them manage their rising healthcare costs. We estimate that if consumers had access to more convenient payment mechanisms and structured payment or financing options to help them smooth spiky medical expenses into tight household budgets, only 10 percent of their bad debt would remain stubbornly uncollectable. In this way, innovative payment solutions could create some $40 billion to $60 billion a year in value as well as achieve substantial savings in the administrative costs associated with inefficient processing and collections.

Implications for providers

As insured consumer liabilities grow, the resulting non-payment puts pressure on already narrow provider margins. At current trends, increased patient liabilities and poor collection rates could reduce the net revenue yield of a hospital by 4 to 5 percent in as little as five years.

Physician practices and specialists will be hardest hit. We estimate that as much as 90 percent of uncollected member liabilities re-

Exhibit 3
Drivers of consumer non-payment



* Does not include responses with less than 10% response rate

Source: 2008 McKinsey consumer healthcare payment survey

sides with physician practices and outpatient care. Where dollar amounts per visit are relatively small, the cost and complexity of consumer billing and collections are particularly onerous. Yet it is exactly these small-dollar amounts that represent a large portion of addressable bad debt.

Implications for payors

Payors – especially those with local market density like local Blue Cross Blue Shield plans – will face challenges as providers attempt to compensate for the incremental costs and bad debt related to retail collections, probably by trying to raise their rates during network-contracting negotiations. In so doing, they will increase costs for payors and, in turn, for employers and individuals.

Because payors are firmly at the center of the payment flow in today's business-to-business healthcare world, they could be well positioned to extend their existing payment infrastructure and relationship with providers to help address eroding revenue yields. However, they lack a consumer-focused payment infrastructure and have generally been slow to innovate. This presents opportunities for attackers – particularly for innovators willing to develop new models to help providers manage their overall revenue yield (for instance, by incorporating payment solutions into product design). Opportunities also exist for more traditional financial institutions and transaction processors that can offer consumer-friendly payment mechanisms.

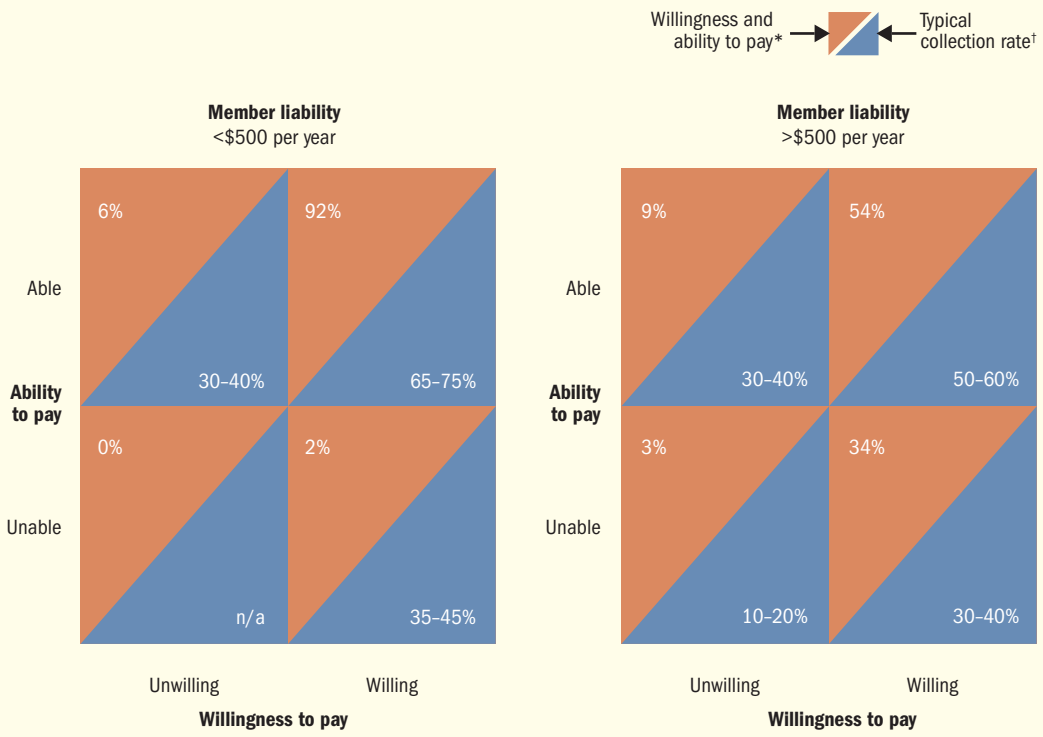
Implications for financial institutions and transaction processors

Because financial institutions have the capabilities in retail payment and electronic processing that the healthcare sector needs, they have a chance to position themselves closer to the center of the payment flow. Although a few early experiments have

Exhibit 4

Collection rates lag consumers' ability and willingness to pay

Distribution of responses by insured respondents



* Ability to pay based on analysis of average annual household spending on out-of-pocket medical expenses and survey respondents' annual accrued member liabilities by income band

† McKinsey estimate

Source: 2008 McKinsey consumer healthcare payment survey; McKinsey analysis

struggled, some players have started to build successful franchises, and many others are considering entering the market. Credit card networks such as MasterCard and Visa and financial institutions such as Bank of America and JPMorgan Chase continue to play an active part in the healthcare arena.

Financial institutions should continue to explore direct retail plays to consumers, partnerships with providers and payors, and other options to help create an infrastructure that would improve the efficiency of consumer-to-provider payments.

In addition, financial institutions should promote more efficient payor-to-provider transactions. Banks with cash-management businesses serving this sector should enhance their ability to handle electronic healthcare transactions by forming partnerships and making acquisitions. Capturing these data flows also opens up opportunities for banks to venture into the factoring of commercial receivables and to offer new consumer credit and financing solutions.

Addressing the challenge

A variety of solutions are being developed and tested to address consumer-to-provider payments. They can be grouped into two broad clusters: the intermediation of consumer-to-provider payments by payors and financial institutions, and the creation of a more retail-oriented revenue cycle through point-of-service payments.

Intermediating consumer-to-provider payments

Several leading insurers and financial institutions, as well as numerous national payors and several Blue plans, are experimenting with intermediating consumer-to-provider payments through payment assurance or improved patient bill-pay solutions that facilitate the payment of consumer liabilities for a

provider. While approaches vary and the market is still developing, the success of this kind of model will depend on:

Most of the bad debt could be addressed if consumers were offered solutions to help them manage rising healthcare costs.

- **Creating a compelling consumer value proposition.** New payment solutions must tackle consumers' confusion and concerns head on. Automated payments, patient statements (instead of bills and explanations of benefits), structured payment plans or lines of credit, and even reward points should all be considered in building a value proposition that consumers will readily adopt. A model will create value only if payors succeed in inducing more consumers to pay more of their medical bills than they currently do, so it must garner adoption beyond those who already pay their bills and who might self-select into a more convenient payment mechanism. It must also reposition healthcare expenses within the household payment hierarchy, since they typically fall at the bottom.
- **Minimizing changes to providers' business processes.** After providing care, hospitals or physicians should be able to submit a claim in the usual way. The solution should settle the transaction for the balance after adjudication, and then remit the patient portion to the provider. Ideally, these remittances would auto-post to the provider's financial management system.
- **Creating sufficient market density.** While a payment assurance or bill-pay solution could boost consumer collection rates, it will be sustainable only if it acquires enough market density to make a substantial impact on a given provider's revenue stream.
- **Linking into broader revenue-cycle management.** A solution that integrates consumer and payor payments and jointly remits the full revenue for a particular claim in a way that ties into providers' practice-management systems can help providers better understand their total revenue yield. Similarly, a solution that enables payments to be timed in a structured way can help providers manage their cash flows (particularly important for small practices).

Creating a retail revenue cycle

Although the payor-centric approach holds promise, it will address bad debt only for those who enroll in a payment solution. It does not give consumers the data they need to make informed choices at the time of treatment, since the financial consequences of their choices are delayed by weeks. For these reasons, an alternative model is emerging. There are two basic flavors to this approach, both of which require changes to providers' workflows:

- **Improving upfront collections.** Providers are becoming increasingly disciplined at managing their revenue cycle and applying lean approaches to billing and collection processes. They are also employing a range of point-of-service (POS) collection techniques to help reduce patient bad debt. These include moving collections of known liabilities to POS or even earlier, and leveraging revenue cycle management tools (such as eligibility for charity care or propensity-to-pay analysis) to help segment patients and channel them into appropriate payment paths.
- **Introducing a "hotel" model for POS collections.** An alternative model emulates the way that hotels settle bills. Hoteliers swipe a credit card, preauthorize the transaction using an estimate of the final bill, and then settle the transaction when the customer checks out. The responsibility for collecting payment lies not with them but with the credit card issuer – a big benefit for hoteliers. For such an ap-

proach to work in healthcare, three things would be necessary.

First, providers must be able to tell patients how much they owe while they are still at the hospital or doctor's office. The real-time adjudication of claims, though technically feasible, will take years to gain acceptance. Meanwhile, providers can give good-faith estimates by using pricing tools from a variety of vendors. Such upfront estimates are essential if credit cards are to be more widely used. At present they account for less than a fifth of consumers' out-of-pocket spending on healthcare. Yet our research suggests that with a good-faith estimate, 57 percent of consumers would be willing to use a card at POS, and at levels that would cover most routine medical expenses.

Innovative payment solutions could create some $40 billion to $60 billion a year in value.

Second, providers must be able to accept credit or debit payments. For hospitals and other providers undertaking larger transactions, sales finance programs are also an option. Real-time submission and adjudication will eventually allow providers to settle credit card transactions while patients are present. Until then, with help from financial institutions, providers can take credit card numbers and process preauthorizations that stay open for 60 to 90 days until claims clear.

Third, providers will need to change the way they interact with patients by collecting payments either at the point of service or before.

* * *

Over time, it should be possible to automate the full cycle of information and payment flows in healthcare, 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 healthcare payments system in a more retail-oriented world.

Beyond the payments 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 innovations 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 obesity, diabetes, and other chronic conditions requiring long-term care changes the underlying nature of healthcare financing risk. The need for a system that helps players to address these issues – and consumers to manage the financial aspects of their healthcare – is becoming ever more pressing.

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