

## Healthcare Payors and Providers Practice



# Revisiting Healthcare Payments: An Industry Still in Need of Overhaul



# *An Industry Still in Need of Overhaul*

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In an article, “Overhauling the US Health Care Payment System,” published in June 2007, we argued that greater electrification, 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.<sup>1</sup>

But we do see progress. There has been a steady conversion to electronic formats thanks to the adoption of standards across different HIPAA-compliant transaction types (for example, claims submissions, eligibility checks, remittance advice) and the increasing use of transaction-processing clearinghouses for facilitating transfers and electronic formats by physician practices. We estimate that by 2012, about 80 percent of the projected 8 billion in core US health care transactions will be in electronic formats, excluding lab and pharmacy, which are already largely electronic.

Progress has also been made in developing technical solutions to wholesale and retail health care payment problems. There are numerous small-scale experiments under way to improve the transparency and efficiency of payments and innovative companies are offering approaches such as online bill paying solutions, patient liability estimation tools, “hotel model” point-of-sale consumer payment processing, and structured finance solutions. In addition, large health care IT players (for example, McKesson and GE), and a range of financial institutions (JPMorgan Chase, PNC Bank) continue to

make significant investments in health care payment processing while large payors and providers are exploring ways to partner to solve payments issues.

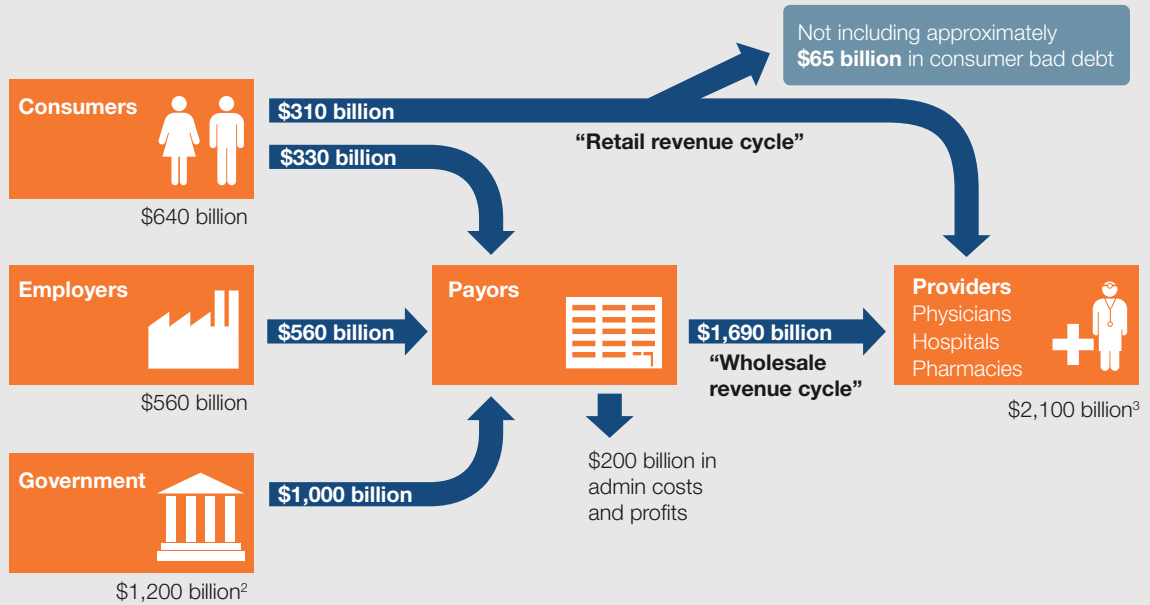
The transition to electronic formats and technological innovation has laid the groundwork for the more fundamental restructuring of health care payments we outlined in our 2007 article. But an overhaul still awaits. The system remains highly fragmented and inefficient, consuming a disproportionate share of health care dollars compared with payment systems in other industries. Unlike scale utility solutions that have emerged in financial services or telecom, innovative solutions 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 estimates (see Exhibit 1).

So what are the prospects for an overhaul of the payments system in the next two to three years? Health care reform could accelerate the pace of change, especially administrative simplification provisions that are likely to be on the table even if a comprehensive package goes nowhere. Yet even without reform of any kind, we foresee big changes in the coming years, with billions of dollar of value remaining at stake.



<sup>1</sup> See “Overhauling the U.S. healthcare payment system,” *The McKinsey Quarterly*, June 2007.

Exhibit 1

US healthcare financial flows<sup>1</sup>

1 All figures are estimated for 2010 and are approximate

2 Approximately \$200 billion of this is spent on government public health and research

3 Includes an additional approximately \$100 billion from foundations

Source: National Health Expenditure Data; Centers for Medicare and Medicaid Services; Office of the Actuary; McKinsey analysis

### The case for change

Major change in the payments landscape is inevitable because of fundamental industry dynamics—more health care transactions to deal with, the increasingly prominent role of the consumer in payments, and rising importance of medical and financial risk management.

### Managing the growing volume and complexity of health care transactions

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 compounded annual growth rate of about 8 percent. In addition, new regulations such as 5010 and ICD-10, aimed at creating

more granular and well-defined data standards, are leading to additional complexity and hundreds of millions of dollars in required investment across the industry.

We also foresee an explosion of digitized, stored, and transferred clinical data. Today, less than 20 percent of clinical data are electronic, with little standardization across data fields. In large part spurred by electronic health record requirements within the American Recovery and Reinvestment Act of 2009, we see a rapid shift towards greater use of electronic formats and standardization. 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 effectively leveraged in operational and clinical decision making will require large capital investments and create ongoing management costs. Few health care industry players have the scale or sophistication to manage these issues on their own.

We estimate that industry administrative cost will grow 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. Even if the administrative simplification elements of health care reform become law, the Congressional Budget Office (CBO) has only scored about \$3 billion in administrative cost savings from the Senate and House versions of the health care bill by 2014, a fraction of total industry administrative costs.

The need to manage this cost should increase the willingness of industry participants to collaborate and try new approaches. Such cross-industry collaboration could finally spur the creation of payment utilities such as full-cycle payment automation described in our 2007 article. In fact, the regulatory burden placed on third parties through the HITECH Act within the 2009 stimulus bill may make such payment utilities a necessity to better insulate third parties from liability exposure. We would argue that there is potential for an industry consortium to create a comprehensive, at-scale payment settlement utility that knits health care transaction processing through clearinghouses, the automated clearinghouse payment network, and card network payments for retail payments.

### **Solving the challenge of consumer payments**

Despite the persistence of 46 million uninsured Americans, the rate of cost shifting to insured individuals continues to increase, thus moving the source of bad debt from the uninsured to the insured. This trend will place collections issues regarding balance after insurance front and center in the health care payment landscape. For example, we found balance after insurance from insured patients growing at 30 percent a year at one multi-facility hospital system, compared to 19 percent for patients without insurance paying from their own pockets. Physician practices and hospitals alike must improve collection of balance after insurance through innovative patient financing, better front-end retail revenue cycle solutions, and consumer-friendly collections.

In particular, we believe there will be greater pressure on physicians regarding balance after insurance collections. We see a continuing shift from in-patient to out-patient and physician- or clinic-based setting in the coming years. Physician practices and outpatient clinics must address head on the challenge of consumer collections arising from an increasing number of new patients. Many of these practices are poorly equipped to do so given current mindsets, workflow practices, and capabilities. The need to deal with these issues opens the door for greater penetration of point of service, retail-oriented payment solutions. For the physician segment, how solutions are provided particularly matters—those with bundled financing options or ASP models integrated into the physician workflow and requiring little capital investment will probably see the most uptake.

In addition to transactional efficiency, industry dynamics will likely drive the need for innovative financing solutions 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). Bringing compelling consumer payment solutions will require financial intermediaries to step in and provide financing and structured payment options.

### **Integrating medical and financial risk management**

As the health care industry continues to move towards 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 their economics relating to patient segments, services lines, geographies, and payors. To truly understand profitability at a detailed level in an outcome-focused world, providers must have access to and analyze normalized clinical, claims, and payment data.

To get there, several things must happen. First, electronic health record adoption and data standardization must continue. 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, health information exchange (HIE) infrastructure must be built out to provide connectivity. There are already 150 to 200 HIEs across the country, with a broad ecosystem of technology

players supporting them, ranging from large-scale players like IBM, Cerner, and Misys, to smaller solution providers like Medicity and dbMotion, to publicly backed solutions like the open source software advanced by the National Health Information Network. 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 payors. Finally, relevant clinical data will need to be integrated with claims information, charge data, and remittance information in a way that enables detailed analytics on issues like reimbursement optimization, cost management, service line profitability, and physician management. 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 (payors, IT vendors, and financial institutions) and analytic service providers.

### *Conclusion*

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 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 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 obesity, diabetes, 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. We have seen incremental progress over the past few years, but much greater change is ahead.

### Modifying consumer behavior

As consumers take on more of the risk associated with health care, the traditional relationship between consumers, providers, and payors is changing. With persistent medical inflation, employers continue to promote more employee cost sharing to reduce their health care spending. Between direct payments to providers from both the insured and self-pay consumers and their share of insurance premiums, individuals play a major role in the flow of funds within healthcare.

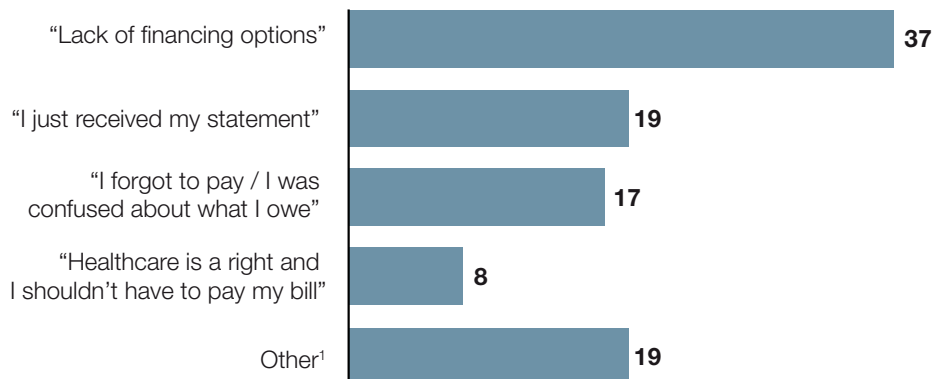
The shift to a more consumer-oriented system poses challenges for providers. Few providers (with notable exceptions such as dental practices) are able to estimate a patient's out-of-pocket expenses, present a bill at point of service, and collect payment there and then. Instead, they send a bill, often weeks after the event, and hope the patient pays. To complicate matters, patients typically receive an "explanation of benefits" 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 about 10 percent for self-pay patients. Uncollected revenues represent between 4 and 6 percent of hospital gross revenues. We estimate that in 2010, bad debt will reach some \$65 billion.

Exhibit 2

#### Stated reasons for non-payment

##### Percent of insured respondents



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

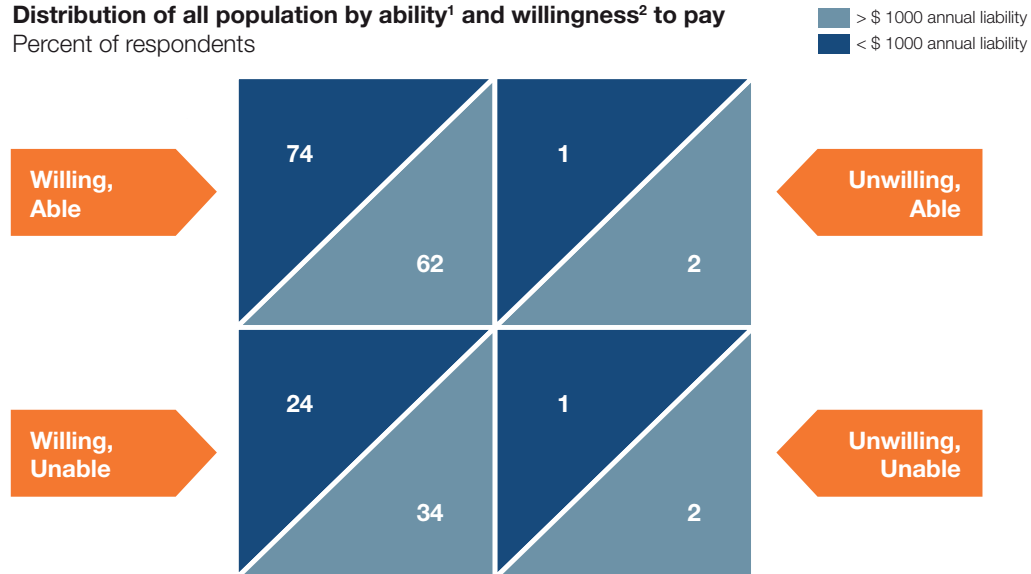
Source: McKinsey Retail Healthcare Consumer Survey, 2009

## Exhibit 3

### Most consumers are willing and able to pay medical expenses

#### Distribution of all population by ability<sup>1</sup> and willingness<sup>2</sup> to pay

Percent of respondents



<sup>1</sup> Ability to pay was determined using consumer's family income and member liability

<sup>2</sup> Willingness to pay determined on the basis of whether consumer's have paid their medical bills, and reasons for non-payment

Source: McKinsey Retail Healthcare Consumer Survey, 2009

The prevailing assumption is that consumers are unable or unwilling to pay their health care 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 2). 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 3). Indeed, over 90 percent are willing and able to pay if these liabilities are less than \$500. Yet collection rates lag well behind, even for these 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. This pressure that consumers face will only worsen as rising deductibles and out-of-pocket expenses and 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 health care costs overwhelm consumers' willingness and ability to pay.

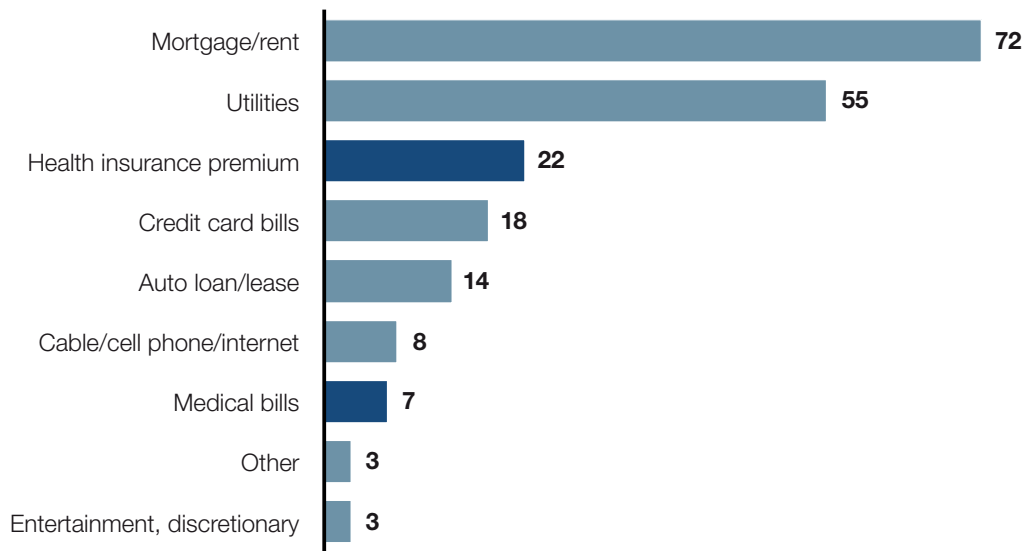
A significant portion of the bad debt in the system could be addressed through solutions that make payments more convenient, less confusing, easier to smooth over time through financing, and that reposition medical bill payments in the household payment hierarchy.



Exhibit 4

**Consumers prioritize paying their health insurance premiums,  
but not their medical bills**

Percent of customers ranking the following expenses in their top two choices



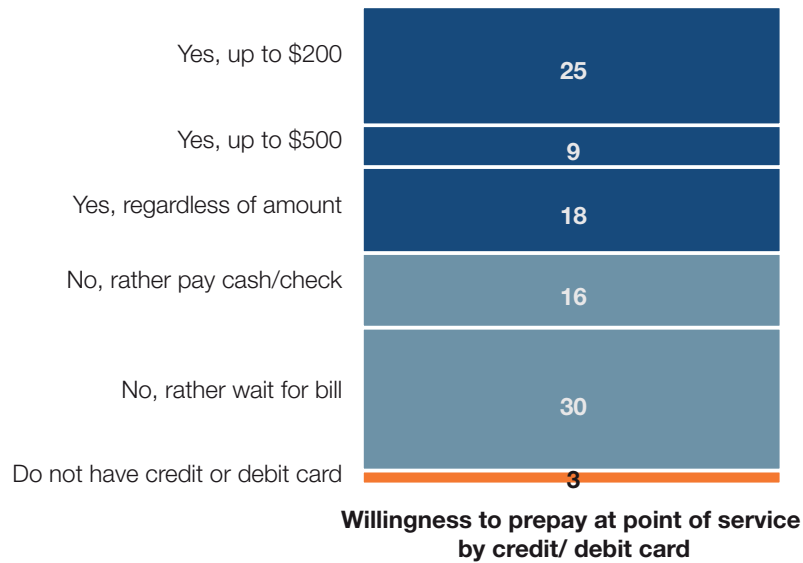
Source: McKinsey Retail Healthcare Consumer Survey, 2009

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 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 payment solutions could create some 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 within the household payment hierarchy, since they typically fall at the bottom (see Exhibit 4).

The payment 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.

## Exhibit 5

**Most consumers would be willing to pre-pay at point of service****Percent of consumers willing to pay their bill by credit card at POS if a good faith estimate is provided**

Source: McKinsey Retail Healthcare Consumer Survey, 2009

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 could include card-based solutions. Our consumer research suggests that 57 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 5).



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North American Healthcare Payors and Providers Practice

March 2010

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