The healthcare services market in the United States took its first steps into a new era through the enactment of the Affordable Care Act (ACA), signed into law on March 23, 2010 by President Barack Obama. Upheld by the U.S. Supreme Court in 2012, this single piece of legislation will have the material effect of changing the way a market that represents over 15% of all consumer expenditures in the United States operates now and far into the future. As dramatic an impact as the ACA will have on the market, it’s not acting alone. Converging with the ACA are two other key dynamics: first, U.S. consumers’ rapidly changing expectations about the way they consume services, and second, the technology advancements that support and enable companies to develop flexible, accessible experiences for the customers they serve.

These key changes — regulatory activity, consumers’ service expectations, and companies’ technical capabilities — meet head on in the billing and invoicing back rooms of the healthcare insurance industry. It is the billing and invoicing systems, which impact so much of the information and communications between participants in the healthcare insurance value chain that will feel the impact of these changes most directly. And it is these systems that offer the best near-term opportunity for billers to create differentiated services in the new healthcare market.

In addition, healthcare insurance billers will have to be able to respond to the fact that the ACA will inevitably open or expand services into markets that did not exist previously. This factor alone will drive millions of new individuals into the market, each with their own preferences and needs for services delivery, communication, and information (Figure 1).

Figure 1: Uninsured Population in the United States Is Expected to Decline in Size under the Affordable Care Act

Source: Congressional Budget Office
Based on analysis by the CBO, even with healthcare reform, there will remain a population where health insurance premiums continue to be out of reach. However, as the new market for healthcare insurance stabilizes, some portion of even this remaining population should be brought into the market as new buyers.

New consumer buyers entering the market are not the only channel that is expanding. In addition, according to data recently published by The Henry J. Kaiser Family Foundation, the number of workers covered under the employer self-funded healthcare plans termed Administrative Services Only (ASO) plans increased to 60% in 2012, up from 44% since 1999. This indicates that smaller firms have found the partial or whole funding of healthcare insurance programs to be an efficient means of controlling spiraling costs, particularly with the addition of stop loss coverage. Thus, in a relatively brief time, two new segments are being expanded significantly into a market that has not fundamentally changed in decades. In much the same way as we have seen the retail financial services industry upended by the Durbin Amendment to the Wall Street Reform and Consumer Protection Act (Dodd-Frank Act), which was also signed into law in 2010, the healthcare insurance industry is preparing for a period of equally intense and disruptive activity.

Reframing Efficiencies

These changes come to a focal point at the health plan administrative level. It is here where the often competing forces of mandated changes, increased consumer demand, and new competitive markets meet, necessitate reassessment and recalibration of the business model on a not yet laid road (Figure 2).

Figure 2: Healthcare Plan Administrators Face New Market Complexities

1 Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012
For the first time, healthcare insurers will be measured by their efficiencies. The ACA mandates that large and small group carriers not exceed 15% on administrative costs and 20% on overhead costs. These companies must spend the majority of premiums received on healthcare-related costs, which means that driving efficiency and building scale will be key activities of all insurers in the United States in the coming years. At the same time, delivering products and services under the new law has become more complex. We know from the problems that other segments have faced that introducing new payments-related products to consumers, such as general purpose reloadable cards, can cause confusion among buyers that results in creating barriers that impede market progress. In some cases, regulators have stepped in to require specific communication methods, such as the creation of the Schumer Box for credit card interest, balance, and fees, which was implemented on a national basis for all credit card issuers in 1989. The only national examples of regulated health insurance billing practices in the United States are those required under Medicare rules, which are not preempted by the ACA, but rather, serve as a baseline. Within the new law, there are clear indications that more standards are coming. For example, Sec. 10109 states the following:

Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs.

The Value of Transparency

Clear, accurate, and transparent customer statements and reporting of healthcare services activity will increase in value and become more meaningful as service providers are forced to consider how best to communicate with the large new consumer segments that will buy services directly from them on a largely retail basis. As with all fee-based services, the most persistent, important piece of communication is the periodic billing statement. In the case of healthcare services, this already complicated function is changing as well (Figure 3).

Figure 3: The Nature of Healthcare Billing Is Complex

Source: Mercator Advisory Group

2 www.dpc.senate.gov/healthreformbill/healthbill53.pdf
Healthcare billing will take on new importance in this market as the revenue cycle management value chain includes a larger portion of consumer-initiated payments, first-time insurance buyers, and individuals covered under new employer plans. According to Health and Human Services data, out-of-pocket-spend for physician and clinical services alone was estimated to triple between 2007 and 2017 (Figure 4). As consumers shop for new healthcare insurance policies, many of which will include high-deductible plans, clear and transparent communications, including billing, will become increasingly important as a product differentiator.

Figure 4: Consumer Out-of-Pocket Spend on Healthcare Related Services Is Estimated to Be Rising

![Bar chart showing consumer out-of-pocket spend on healthcare related services from 2007 to 2018.](chart)

Source: U.S. Department of Health and Human Services

We know that with respect to financial services, consumers are indicating their preference for electronic statements (e-statements) and banks welcome the efficiencies offered by online self-service strategies. However, much of what's contained in bank and credit card statements is regulated at the national level. This fact becomes even more apparent as the Consumer Financial Protection Bureau (CFPB) continues to study the market and drive additional changes into the industry.

Administrative Simplification

Occasionally, a legal term does capture the essence of the issue and in this case, contained in the ACA is a section entitled "Administrative Simplification" which most directly addresses billing functions.
Included are such requirements as information standardization, comprehensive billing measures, and determination of co-pays at the point of care. Not exactly a Schumer Box, but reflective of first steps since unlike financial services invoices and statements, healthcare billing remains a largely unregulated function. Yet, as illustrated in the introduction to this paper, the dynamics of the market are not wholly controlled by regulators but also reflect the demands of an increasingly competitive market, which require suppliers to meet the challenge of building billing solutions that are not only cost effective but also relevant to modern consumers.

This leaves health plans with the opportunity to differentiate themselves on consumer education and communication services in addition to plan features, especially since the ACA has acted to standardize insurance product offerings and such standardization often has a commoditizing effect on a market. Consider the example of the debit card industry, where service providers were forced to provide equivalent revenue streams to 80% of the issuing market with the result that value-added services previously used to differentiate programs were dramatically impacted.

Therefore, we view the key issues driving the healthcare insurance and billing market today (Figure 5) converging around three main impacts:

1. A materially larger and more complex market to serve.
2. The service and information expectations of the modern consumer.
3. An imperative to upgrade and modernize existing processing, account management, and billing systems.

The result of these dynamics is a market in motion and at the heart of that motion is a sea change in the technologies and platforms that support administrative systems. Insurance payers require new technologies to be brought on line that are designed to maintain enough flexibility to address the large group market, but also address the standardization needs of the small group/individual market. In addition, these systems have to also support the ancillary products and consumer-friendly capabilities demanded in a new competitive market.

Meeting the Opportunity of Disruption

As we’ve seen with the beginning of implementation of the Affordable Care Act, rolling out new consumer-oriented applications can be fraught with peril. In a complicated services market that is simultaneously introducing new products, how should healthcare payers be designing their next-generation products and services?

Increasingly, consumers pay heed to online references and reputational buzz in making buying decisions. Interestingly, some healthcare exchanges are using pop-up stores to counteract this trend and put themselves on the street where consumers live and shop. These trends illustrate the material impact that the ACA is already having on the delivery of marketing and promotional programs for healthcare insurance services. All the same, the launch problems happening today will fade into the background and the competitive market will take over.
Healthcare Services: Disruption and Opportunity

Figure 5: Key Issues Are Driving Rapid Change into Healthcare Payer Market

<table>
<thead>
<tr>
<th>KEY ISSUES</th>
<th>Regulation</th>
<th>Consumer Needs</th>
<th>Emerging Technologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARKET DYNAMICS</td>
<td>Insurance premiums may only vary by age, tobacco use, family size, and household. Employer sponsored plans must meet the same tiered standard (based on health service costs) as plans sold on the exchange. U.S. citizens and legal residents will be required to have health insurance or pay a fine Employers with more than 50 workers will be penalized if any of their workers buy coverage through an exchange rather than through an employer-sponsored plan.</td>
<td>Information will be accurate and available 24/7. Access to data and services cuts across multiple communication channels. First time insurance buyers will experience a learning curve in understanding new healthcare insurance options and billing. Consumers increasingly turn to social media for references and experiential discussions before making buying decisions.</td>
<td>Revenue cycle management platforms are evolving to support open, flexible product strategies. More retail-oriented infrastructures are incorporating online/mobile technology. Open architecture allows a configuration-driven design approach to revenue management. Systems are consolidating to provide more consistent consumer experience and lowering overhead.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KEY IMPACT</th>
<th>Materially Expanded Market</th>
<th>Consumer - Centric Focus</th>
<th>Platform Upgrades</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARKET RESPONSE</td>
<td>Modifying business models to accommodate less group business and more individual business. Recalibrate administrative workflows for multi-payer scenarios. Create new statement and invoicing process and designs.</td>
<td>Respond to evolving consumer information expectations. Incorporate competitive pressures to deliver consumer-friendly services into statement designs. Be prepared to respond to an untested buyers market.</td>
<td>Control administrative and extract overhead where possible. Streamline customer service capabilities. Create highly flexible and responsive revenue management platforms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KEY ACTIVITIES</th>
<th>Ensure Compliance</th>
<th>Prepare for a New Market</th>
<th>Modernize and Consolidation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source: Mercator Advisory Group</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Healthcare payers then should consider taking the following steps as they recalibrate their systems, products, and business models to meet the new market requirements:

1. Provide clear, accurate, and consistent information and communications to buyers, particularly new small groups and individuals. Statements are a highly sticky aspect of the provider/buyer relationship and can be a significant competitive differentiator.
2. Develop meaningful and accessible reporting that addresses the needs of smaller firms that are entering the self-funded ASO insurance market in whole or in part. Include the ability to respond to variable employee profiles, and manage compliance.
3. Consider the various means consumers and small businesses may wish to pay their insurance premiums and bills and build flexibility into new billing platforms that allow for a wide variety of
payment and collection methods. This also might include implementing payment portals for easier online payments and better self-service options.

4. Review all plan administrative applications looking for redundancy and inefficiencies that extract capital and reduce capabilities. A consumer-focused market demands flexibility and the billing complexities inherent in the new regulations require a modernized infrastructure to ensure compliance and competitiveness.

Plan administrators are at the forefront of ensuring new employer value propositions become a reality as the healthcare services market is shifting from volume to value. The billing experience will become the center of the brand interaction, because once a consumer enrolls or an employer signs up in a healthcare plan, the first real interaction between that plan brand and the new customer is going to be the invoice. The importance of this most persistent communication activity will continue as new standards are developed, the voice of the consumer is heard, and the competitive market exerts its influence on the industry. Preparing for this new reality will require platforms and technologies that have the flexibility and scale to provide a stable base for future growth.