InstaMed®

Healthcare Payments Simplified

Healthcare Payments White Paper for Payers March 2018

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InstaMed
1880 JFK Boulevard, 12th Floor
Philadelphia, PA 19103

3300 Irvine Avenue, Suite 305
Newport Beach, CA 92660

(866) INSTAMED
www.instamed.com

EXECUTIVE SUMMARY

The healthcare payments system is reaching a breaking point due to increased payment responsibility for members and the lack of payment assurance for healthcare providers. In recent years, payers and employers have consistently driven benefits towards higher payment responsibility as a way to influence member behavior and to keep medical cost ratios in check. The increased payment responsibility trend is only partially a result of consumer-directed healthcare (CDH) plans, which add alternative payment sources to the mix. Whether or not this trend has the desired effect on member behavior, it has forced providers to absorb additional administrative and financial challenges.

Most providers are dependent on income from their payer relationships, which payers leverage into deep discount arrangements. Providers must work within the administrative rules and transaction requirements of each individual payer in order to receive payment for services. Payers consistently pressure providers with the risk of being removed from the payer's network, which would result in the loss of visits due to re-channeling.

However, the leverage that payers traditionally have had in driving discounts is being eroded by the combination of cost shifting and consumer empowerment. As employers and plans push benefit designs and messages that emphasize member responsibility, members act more like consumers and demand more choices. Likewise, providers are increasing their direct-to-consumer marketing efforts and driving demand through methods generally associated with retail markets. Finally, payers are seeing competition from new market entrants offering non-traditional healthcare payment vehicles as supplements and replacements for traditional plan benefits.

Some payers are reacting with attempts to reduce the pain of providers – creating dedicated service units, offering provider portals, integrating with clearinghouses and proactively educating providers on new health plan products. Nevertheless, these solutions do not sufficiently resolve one of the most important aspects of the payer-provider relationship: Payment Assurance.

The most significant way for payers to maintain and enhance their market and cost positions with providers is to return to what gave them the discounting leverage in the first place – assuring payment to the providers. A true Payment Assurance capability requires that payers engage and facilitate an administrative and payment framework that includes "All Payers, All Banks and All Cards." Single payer Payment Assurance models, no matter how advanced, will not address the issue in most markets and in the long run will have limited success.

The healthcare payments system, led by payers, must learn from the credit card banks of the 1990s. These banks, along with their processors and networks, engaged merchants in an "All Bank, All Card" acceptance model. Those payers that do not engage and choose to ignore the provider's revenue pressures will erode their provider network satisfaction, their discounts and ultimately their competitive advantage in selling health plan benefits to employers and members.

BUSINESS PROBLEMS

PROVIDER REVENUE CYCLE CHALLENGES

The provider healthcare revenue cycle is complex and has many functional components, each of which requires a high degree of competency to manage. Since the typical provider depends on payers (commercial, non-profit or government) for a large portion of their revenue, providers tend to focus on payer payments. This relationship is focused around two types of transactions: administrative and payment. Administrative transactions include eligibility, claims, claim status and remittance – their primary purpose is informational and relative to determining how much will be paid and by whom. Payment transactions include check, ACH, EFT, credit and debit – their primary purpose is to move money, generally from the payer and/or member's bank to the provider's bank.

A healthcare payer's administrative and payment capabilities have a significant impact on two aspects of a provider's revenue cycle: the time it takes to collect revenue for the provider and the administrative costs to the provider of collecting the revenue. Payers with a significant number of members in a geographical region have been able to use revenue control to gain a great deal of influence when negotiating with the provider – which they have leveraged into deep discounts that are passed on to employers and members.

However, providers are seeing a rapid shift in the percentage of their revenue from payers to members. While CDH is a component of this shift, there is a broader trend toward higher levels of payment responsibility in traditional benefit plans. As providers take on this additional burden, the complexity of the payment process increases. As providers become increasingly dependent on cash, check, credit and debit payments from members, they must also concern themselves with the nuances of bankcard associations, interchange rates, bankcard downgrades, PCI, fraud, compliance, NACHA, check processing and many other aspects of the financial networks.

Healthcare providers have been focusing and building competencies around payer payments, but now they must also build competencies around payments from members, much like a retail merchant.

RETAIL HEALTHCARE CHALLENGES

As members increasingly shoulder the costs for healthcare services, providers are forced to take on payment responsibilities that are common in the retail market. Providers are also burdened by complexities that are unique to the healthcare industry, including challenges related to pricing and payment functions, connectivity to sources of payment, and compliance with healthcare and financial regulations.

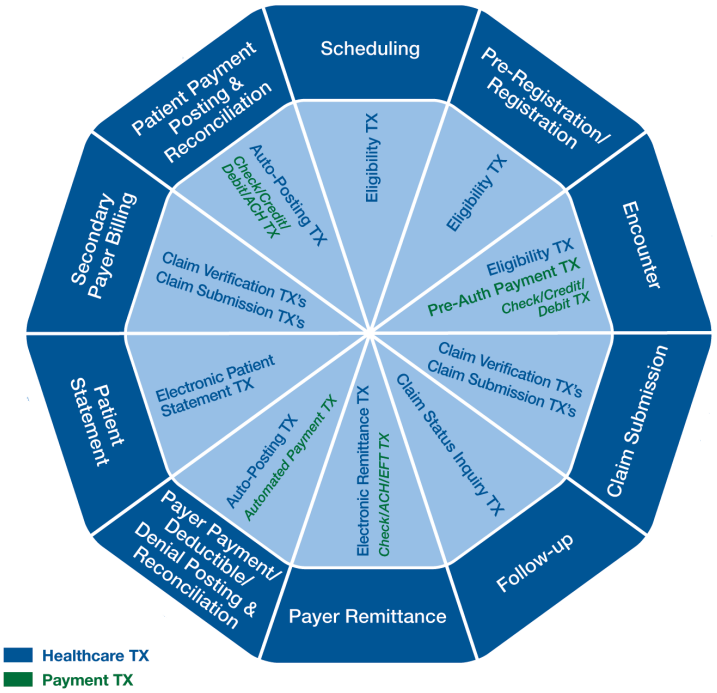
RISING MEMBER RESPONSIBILITY

In 2010, 10 million consumers were enrolled in HDHPs (AHIP), which require consumers to pay a minimum deductible amount before their health plans cover any portion of the cost. Less than a decade later, 75 million consumers are enrolled in HDHPs (CDC's National Center for Health Statistics), a more than seven-fold increase in less than a decade.

Provider Revenue Cycle

HIPAA Transactions
- Eligibility (270/271)
- Claim (837)
- Claim Status (276/277)
- Remittance (835)

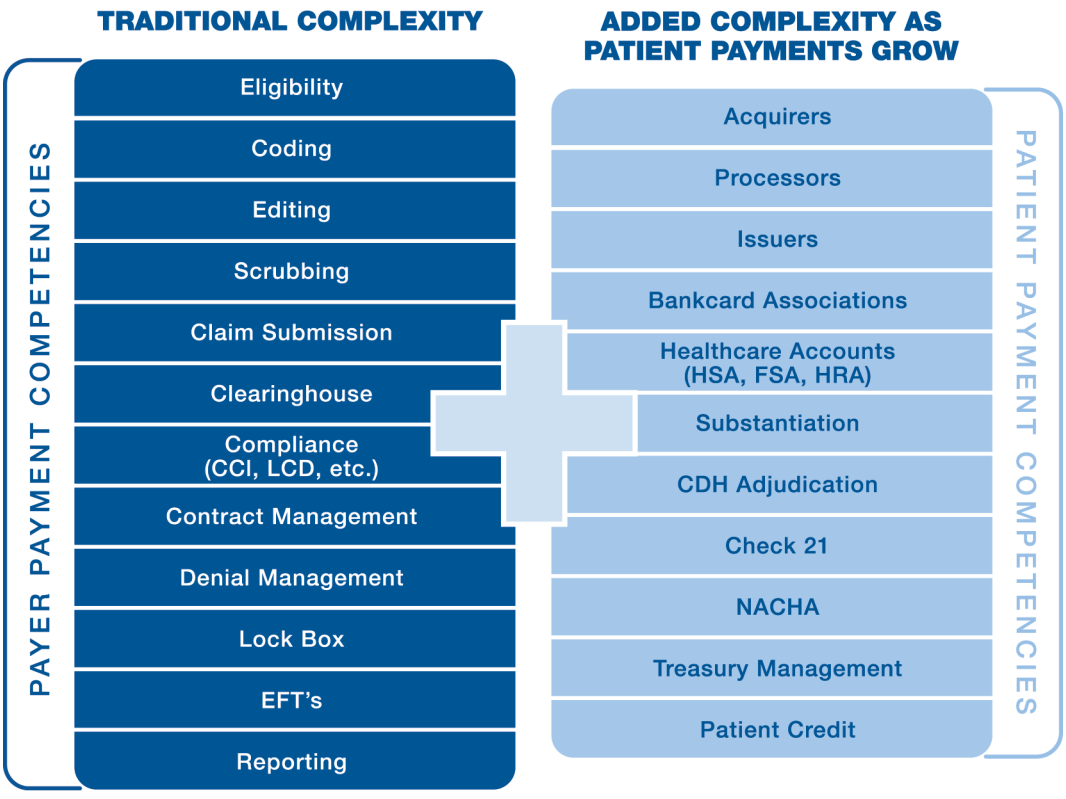
Methods
- Batch
- File Upload
- Real-Time
- Integrated
- Swipe



Payment Transactions
- Credit
- Debit
- Check
- ACH
- EFT

Methods
- Retail
- MOTO
- eCommerce
- ARC
- BOC
- Web/Tel
- Check21

Added Complexity for the Revenue Cycle



- FUNCTIONALITY CHALLENGES: There are significant gaps in the functional processes readily available to providers that would allow them to interact with members as if they were consumers. The most acute gaps are related to the ability for providers to accurately determine the payer and member responsibilities at the point of service. Specifically, there are limited opportunities for providers to receive precise information regarding current year-to-date deductible and coinsurance levels, much less have claims adjudicated in real-time. These gaps prevent providers from knowing the patient's actual liability at the time of service. Essentially, providers must offer services and accept liabilities even though payment is not assured.

- PROCESSING AND CONNECTIVITY CHALLENGES: The EDI infrastructure between payers and providers has traditionally been based on batch processes – often in overnight cycles or in "windows" defined by payers. This cycle does not allow providers to react in real-time as decisions are made at the point of service. Integrating connectivity solutions requires significant investment and cooperation between payers and providers.

- CODING COMPLIANCE AND REGULATORY CHALLENGES: Providers must be able to comply with HIPAA and other regulations, such as: Medicare National Coverage Determinations (NCDs), Correct Coding Initiative (CCI), Medical Necessity, as well as numerous commercial compliance guidelines. As payers and providers interact more frequently with financial networks, they will also be forced to incorporate appropriate security and compliance policies and procedures as required by Visa, Mastercard and other bankcard and financial associations – such as PCI, CISP, KYC and the Patriot Act.

REAL-TIME ADJUDICATION

Real-time adjudication (RTA) of claims has the potential to improve provider payments where it is readily available and usable across multiple payers, but it is not necessarily a silver bullet. In addition to the capability gap for payers to deliver this functionality, provider challenges include:

1. Without real-time coding, RTA is useless at the point of service. Provider specialties that cannot code at the point of service or that face coding compliance risks will not benefit from RTA.
2. Provider system integration with RTA is a challenge.
3. RTA will have many exceptions for: i) member enrollment eligibility grace periods; ii) complex ASO group setups; iii) other payer claim system nuances.
4. Lack of a common process across payers will force providers to have multiple processes.

Based on these factors, a payer cannot expect to deliver Payment Assurance solely by building RTA.

- MULTI-PARTY TRANSACTION CHALLENGES: Transactions have become increasingly complex as payers and employers look for creative means to manage medical costs. This includes engaging re-pricing partners that will apply their own discounts or, in some cases, work directly with a provider to negotiate a deeper discount for faster payment. There is also an increasing focus on proactively catching transactions subject to accident, disability, workers compensation, stop loss and other risk management scenarios (shift from pay-pursue to pursue-pay). Multi-party transactions make it virtually impossible for providers to estimate member and payer responsibilities.

THE FUNDAMENTAL THREAT – LACK OF PAYMENT CERTAINTY

The complexity and challenges in the administrative and payment transaction processes are decreasing the certainty of the providers' revenue cycle. Since the relationship between

payers and providers is based on the promise of payment, the reduction in Payment Assurance is a fundamental threat to the current healthcare system.

- New uncertainty – Providers do not know who is responsible for what at the point of service
- Higher costs – Providers are forced to absorb higher administrative costs to capture the same revenue
- Different process for each payer – Varying access and processes across health plans results in confusion, errors and higher costs
- Variable discounts/payment amounts by payer product – Multiple discount arrangements (even within a payer) increase front/back office costs as providers try to estimate or reconcile payment across payer and member responsibilities
- Provider network contracts preclude collection at point of service – Many payers have forced providers (by contract) to wait for claim adjudication in order to collect deductible and/or coinsurance amounts from members, resulting in increased collection costs and bad debt
- New payment sources – Providers are increasingly required to deal with alternative sources of payment (e.g., CDH accounts) that have their own rules and processes
- Rapidly changing landscape of solutions – The rapid introduction of new solutions by payers and revenue cycle vendors add to provider overhead and confusion

EXAMPLE PROVIDER-PAYER RELATIONSHIP – PART ONE

Current Scenario: Dr. Jones sees an average of 100 members per month from ABC Payer, receiving on average $100 in discounted fees per patient visit (based on the network contract) – resulting in gross revenue of $10,000 per month for ABC Payer's members.

- Dr. Jones currently receives 95% of that revenue from the payer and 5% from members
- Administrative costs to collect from the payer is 8%
- Administrative costs to collect from members is 18% (does not include bad debt)

Current Net Income Calculation:

- Provider Operating Revenue From Payer: ($10,000 x 95%) – (($10,000 x 95%) x 8%) = $8,740
- Provider Operating Revenue From Members: ($10,000 x 5%) – (($10,000 x 5%) x 18%) = $410
- Total Operating Revenue: $9,150 (does not include bad debt)

Future Scenario: Dr. Jones still sees the same number of members from ABC Payer and the discounts remain the same. However, now the benefit plans push member accountability through higher deductibles – meaning Dr. Jones now receives 50% of his revenue directly from members versus 5% as before. Furthermore, this assumes Dr. Jones successfully collects all of the member revenue.

Future Net Income Calculation:

- Provider Operating Revenue From Payer: ($10,000 x 50%) – (($10,000 x 50%) x 8%) = $4,600
- Provider Operating Revenue From Members: ($10,000 x 50%) – (($10,000 x 50%) x 18%) = $4,100
- Total Operating Revenue: $8,700 (does not include bad debt)

Dr. Jones must increase his average revenue per visit by 5% in order to have the same level of operating revenue, even before incorporating the increased write-offs due to bad debt. If Dr. Jones has bad debt of 35%, he must increase his average revenue per visit by 26%. Bad debt is reported by many providers to be as high as 50%.

RISKS TO THE HEALTHCARE MARKETPLACE

The lack of payment certainty presents several risks to healthcare marketplace constituents, including providers, members and payers.

TO PROVIDERS

- HIGHER ADMINISTRATIVE COSTS: Providers are faced with increased administrative costs to maintain the same level of revenue. Provider front offices will need to spend more time with members working through their liability amounts and helping them understand their payment options.
- INCREASE IN A/R: Providers will be forced to deal with varying sources of revenue and increasing challenges to collect payment. This will increase the relative size of the receivables on the books at any given time.
- INCREASE IN BAD DEBT: The increased dependency on payments from members will inevitably increase the level of bad debt that providers are forced to carry.
- DECREASE IN COLLECTIONS: Providers will forego collections for smaller amounts (death by a thousand cuts). In addition, providers may try to negotiate deeper discounts directly with members in return for some level of Payment Assurance.

PROVIDER RESPONSES

In addition to network pressure, providers are taking matters in their own hands by:

- Collecting the full rack rate at the point of service from members with CDH plans and truing up once the payer payment is received
- Negotiating a discount with members who pay upfront
- Calling payers prior to services being rendered to determine member benefits
- Engaging with financial institutions for lockbox solutions

Many providers are hampered by network contracts that preclude collection of anything beyond copays at the point of service. This will be an escalating area of contention during contract negotiations.

TO MEMBERS

- CONFUSION AND UNCERTAINTY: Members will need to be much more aware of their benefit levels and deductible accumulators. There will be uncertainty and surprise at the point of service as to whether or not they will need to pay for part or all of the service. The addition of alternate payment sources (e.g., CDH accounts, incentive accounts) will also add to member confusion.
- DEDUCTIBLE SHOCK: As providers and members engage at the point of service and sometimes negotiate payment, it is possible that claims will not be submitted by the provider for adjudication and accumulation towards the member's year-to-date deductible. This can lead to "deductible shock" later in the year if a member continues to seek services and expects he has met his deductible.

- TIME AND CONVENIENCE: Members will need to spend additional time understanding what they may owe and assessing payment options. Whether at the point of service or in reaction to a provider bill, members will spend even more time paying providers and dealing with refunds and other situations when providers miscalculate member liability.

TO PAYERS

- PROVIDER NETWORK SATISFACTION/ DISCOUNTS: Providers will become increasingly dissatisfied with the arrangements that they have made with payers. Administrative cost pressures will force providers to re-assess their network relationships – which will likely result in lower discounts as the value of network participation is reduced.

- HIGHER ADMINISTRATIVE COSTS: Administrative costs will increase as call volume increases due to the need to assist network providers in estimating member liability amounts in advance of the service as providers attempt to reduce their post-service cost of revenue. Higher member liability amounts will also result in additional calls from members to clarify payment responsibility on claims and provider invoices.

- NEW RISKS ASSOCIATED WITH THE FINANCIAL NETWORKS: Payers will face new challenges dealing with the financial networks as they build new business models, along with the appropriate security and compliance policies and procedures as required by Visa, MasterCard and other bankcard and financial associations—such as PCI, CISP, KYC and the Patriot Act. While most multi-billion dollar banks outsource =payments, many payers have a "build-it" mentality and may find it difficult to yield some control to a partner. Those payers that underestimate the nuances of this new territory or fail to properly execute these projects will face significant risks and costs to their business.

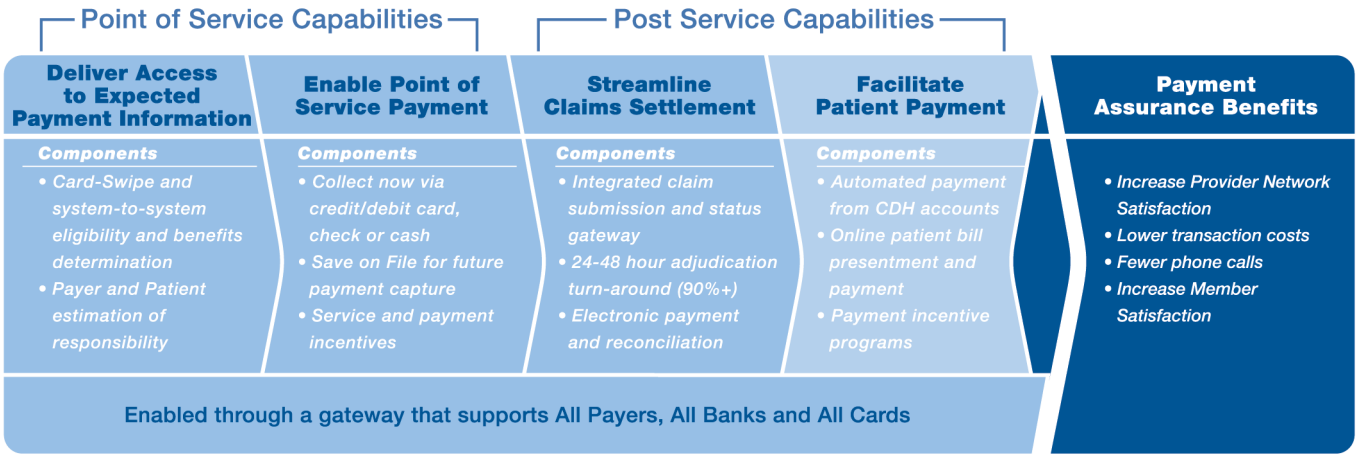
- UNHEALTHY DICHOTOMY: The increased level of member liability means that the value of the discount to the member is rising at the same time that the leverage the payer has to drive the discount is decreasing. This becomes even more striking as more employers move from insured to ASO arrangements, since provider networks and associated discounts are the primary differentiators for payers.

- THE PRIMARY RISK: The lack of Payment Assurance for providers means that provider network discounts available to payers, members and employers are at risk, and since the network discount is the greatest competitive asset that most payers have, the loss of this discount puts their entire business model at risk. Members and employers have become ever more sensitive to healthcare cost increases – creating a vicious cycle of increasing emphasis on stabilizing medical premiums, escalating member/patient responsibility and downward pressure on network discounts.

PAYMENT ASSURANCE FRAMEWORK

When evaluating potential changes in your organization's approach to Payment Assurance, you may find the following framework useful:

Payment Assurance Framework



SAMPLE TRANSACTION SCENARIO

1. Provider front office staff swipes member card at check-in to generate real-time eligibility verification transaction to payer—resulting in pre-authorization of eligibility and payment responsibility for the appropriate handling by the provider.
2. After services are rendered, the provider's back office generates claim transaction to the payer through office management software to gateway which routes to the appropriate payer.
3. The payer processes claim and delivers EOP and payer portion of payment to provider electronically.
4. Remaining member liability amount is either automatically funded to the provider or presented to the member electronically for payment authorization and funding to provider.
5. Provider receives payer and member payments and automatically reconciles EOP to payer and member payments.

KEY ATTRIBUTES OF A SUCCESSFUL PAYMENT ASSURANCE FRAMEWORK

- Deliver expected payment and liability amounts for members and providers prior to claim submission
  - Benefit and eligibility verification through standard transactions triggered from provider front office software and/or member cards
  - Estimation tools for members and providers that can be accessed via portals and standard transactions
- Support member payment for services at the point of service
  - Combined eligibility and payment cards with access to multiple sources of payment when appropriate and loyalty programs to encourage usage
  - Benefit plans and provider contracts that support point of service collection
- Integrate through multi-party gateways for claims, reconciliation and EFT
  - Batch and real-time adjudication of claims (real-time is a bonus, not a requirement)
  - Claim status inquiries via standard transactions
  - Payer payment and reconciliation transactions that can be seamlessly integrated into provider financial management software and billing systems
- Effectively bill and collect member responsibility amounts
  - Streamlined provider payment from multiple sources – payer, secondary payers, CDH accounts, members
  - Member account/financial profile management that incorporates any additional payment vehicles (e.g., other insurance, CDH accounts) and member online bill presentment and payment
- Manage payment through a multi-party transaction architecture
  - Consistent interface points/processes – "All Payer, All Bank, All Card"
  - Use of standard transaction sets for payers, providers, cards and financial institutions
  - Transaction routing, validation and tracking

PAYER OPPORTUNITIES

Payers are in a unique position to capitalize on the opportunities presented by this marketplace shift. The lack of Payment Assurance in the marketplace is creating additional friction between providers and payers in addition to increasing the complexity for members, both of which are risks to the payer's position. However, those payers that bring Payment Assurance solutions to their members and providers will stand to increase member market share, as well as increase provider network satisfaction and discounts, greatly enhancing their competitive position. These opportunities include:

ENHANCE THE MEMBER EXPERIENCE

- Utilize enhanced member card programs: Supply members with enhanced identification cards that offer a streamlined experience at the point of service and facilitate post service payment on the backend. These solutions can significantly reduce the member hassle that accompanies the higher member liability products. These enhanced cards can also be used as tracking and delivery vehicles for member incentive and loyalty programs.
- Augment member portals with payment features: Give members access to portals that facilitate the determination of their benefits along with an estimation of their liability. Additionally, facilitate and simplify the member's payment to in-network providers. As banks have demonstrated, online bill payment features can drive members to portals, where additional "campaign" messages can be delivered if appropriate.

ENHANCE THE PROVIDER EXPERIENCE

- Engage with swipe card solutions: Make swipe card solutions available to providers to streamline their ability to gather eligibility data and facilitate payment from the member. These solutions need to be available at no cost to the providers and implemented in a manner that improves the workflow for the front and back office staff. These should also leverage emerging healthcare and financial service industry standards, such as those introduced by WEDI.
- Enhance payment estimation tools: Offer providers easy-to-use tools that will enable them to determine benefit and financial eligibility at the point of service. This includes enhanced data on the 271 transaction by including year-to-date accumulators, variable co-pay data and coinsurance information. Integrated gateways should be leveraged to generate standard eligibility transactions that facilitate provider front office activity. Multi-payer solutions will greatly enhance adoption rates.
- Enhance electronic claims connectivity: Give providers access to a gateway that facilitates the entry/upload and processing of claims with multiple payers—including claims status requests. Integrated "All Payer" solutions will reduce the administrative pressure on the providers which will increase adoption of electronic claims processing solutions.

> "Payers are in a unique position to capitalize on the opportunities presented by this marketplace shift."

- Automate settlement for payer and member payments: Give providers reconciled payment transactions in formats that easily integrate into their financial office management software. Solutions must facilitate settlement of payer and member liability amounts – whether through single or multiple payment transactions – and offer easy-to-use reconciliation information.
- Pay providers electronically: Reduce the administrative overhead and cash flow burden of providers by paying them electronically. The added benefit to payers is the reduction in administrative costs associated with printing and mailing checks and remittance advices, along with fewer phone calls. These benefits should more than offset any loss of "float" especially when it comes to a payer's ability to leverage discounts off of increased provider network satisfaction.

Payer action is critical to the evolution of the Payment Assurance relationship with their provider network. Through actions like the ones suggested above, providers will continue to see the value of network participation, and payers will maintain their competitive advantage, even as their role as the primary source of revenue is reduced.

EXAMPLE PROVIDER-PAYER RELATIONSHIP - PART TWO

Alternative Future Scenario: ABC Payer works with Dr. Jones to deploy solutions that enhance the ability of front office staff to estimate and automate the collection of the member liability upon adjudication of a claim. If these solutions reduce the member collection costs from 18% to 11% and the payer collection costs from 8% to 6%, then Dr. Jones can maintain his income with no increase in revenue per visit.

Revised Future Operating Revenue Calculation:

- Provider Operating Revenue From Payer: ($10,000 x 50%) – (($10,000 x 50%) x 6%) = $4,700
- Provider Operating Revenue From Members: ($10,000 x 50%) – (($10,000 x 50%) x 11%) = $4,450
- Total Operating Revenue: $9,150 (does not include bad debt)

The same effect can also be achieved by reducing the cost of members collections to 9% with no change to the cost of payer collections. The bottom line is that the blended cost rate needs to be maintained as the responsibility shifts. In this example, the blended cost rate needs to be 8.5%.

INSTAMED PAYER SOLUTIONS

InstaMed can quickly integrate into existing payer systems to address the challenges and opportunities in the emerging marketplace for Payment Assurance. Healthcare payers of all sizes across the country have already selected InstaMed solutions to address revenue cycle challenges. By leveraging InstaMed solutions in whole or in part, payers can bring increased Payment Assurance to their provider network and to their members, resulting in increased provider network satisfaction, deeper discounts and increased member satisfaction. InstaMed payer solutions include the following:

MEMBER PAYMENTS

The InstaMed Member Payments solution allows payers to embed payment functionality in their member portal to drive member portal utilization, increase consumer payments to their provider network and meet the new demands of employer groups.

PREMIUM PAYMENTS

The InstaMed Premium Payments solution delivers the frictionless, omnichannel payment experience that members and employer groups demand on the most secure and compliant platform in healthcare.

ONE BILL

The InstaMed One Bill solution revolutionizes the premium payment experience for members and employer groups by delivering one consolidated bill across all products and systems to accelerate payment collection and eStatement adoption.

CLAIMS SETTLEMENT

The InstaMed's Claims Settlement guarantees payers 80% ERA/EFT transaction adoption to reduce print and mail costs and meet provider payment preferences.

TRANSACTION GATEWAY

The InstaMed Transaction Gateway solution allows payers to deliver cost-effective clearinghouse solutions, support a wide variety of submission formats and offer a flexible user interface.

ABOUT INSTAMED

InstaMed is healthcare's most trusted payments network, connecting providers, payers and consumers on one platform. Our rapidly growing network connects over two-thirds of the market and processes tens of billions of dollars in healthcare payments annually. InstaMed reduces the risks, costs and complexities of working with multiple payment vendors by delivering one platform for all forms of payment in healthcare, designed and developed on one code base and supported by one onshore team of experts in healthcare payments.

Our full suite of payment and clearinghouse solutions enable providers to collect more money from patients and payers while reducing the cost and time to collect.

InstaMed enables payers to reduce disbursement, settlement and postage costs for claim payments to providers by connecting payers to our network. InstaMed also allows payers to customize every payment option for their members to pay premiums and to make payments to providers from any payment account.

Our forward thinking, innovative technology delivers a simple, seamless and secure healthcare payment experience. We have earned the confidence and trust of healthcare providers and payers large and small, in all fifty states, by delivering real business results and by being the first and only organization that is independently certified at the highest levels for both healthcare and payment transactions.

InstaMed is a privately held company funded by institutional investors. InstaMed's management team brings decades of experience in the healthcare and payment processing industries.

InstaMed owns and operates a 24/7/365 technical and operational infrastructure with over 99.9% uptime. InstaMed is compliant, independently certified and audited at the highest levels for both healthcare and payment processing, including the following certifications and accreditations:

- Registered with Visa and Mastercard and independently certified as a Payment Card Industry Data Security Standard (PCI DSS) Level One v3.2 Service Provider
- The first company to receive financial (FSAP) and healthcare (HNAP) accreditations from the Electronic Healthcare Network Accreditation Commission (EHNAC)
- PCI-Validated P2PE v2.0 Solution Provider
- Certified for Health Information Trust Alliance (HITRUST) Common Security Framework
- EMV certified with Visa, Mastercard, Discover and American Express
- Compliant with the Health Insurance Portability and Accountability Act (HIPAA)
- Certified by the CAQH Committee on Operating Rules for Information Exchange (CORE)
- Compliant with the National Automated Clearinghouse Association (NACHA)
- Completed the Statement on Standards for Attestation Engagements (SSAE) No. 16 SOC 1 and SOC 2 Type II
- Compatible and compliant with the Employee Retirement Income Security Act (ERISA)
- Independently certified to meet web accessibility standards of the Americans with Disabilities Act (ADA), including Section 508 compliance

info@instamed.com
www.instamed.com

InstaMed®

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1880 JFK Boulevard, 12th Floor
Philadelphia, PA 19103

3300 Irvine Avenue, Suite 305
Newport Beach, CA 92660

www.instamed.com

info@instamed.com