



**Healthcare Payments White Paper for
Providers**
October 2011

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InstaMed
1880 JFK Boulevard, 12th Floor
Philadelphia, PA 19103
(866) INSTAMED
www.instamed.com

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A DIFFICULT PROBLEM

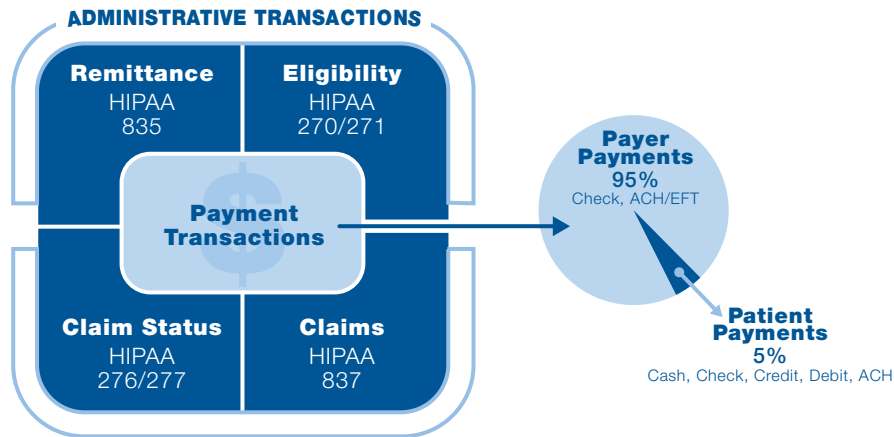
The healthcare revenue cycle is complex and has many functional components, each of which requires a high degree of competency to manage. Among these functional components are two types of transactions: administrative transactions and payment transactions. Administrative Transactions primarily include eligibility, claims, claim status and remittance. Payment transactions include cash, check, credit, debit and ACH (a.k.a. EFT) from both payers and patients. This unique mix of payment sources and their dependence on administrative transactions uniquely earn these payment transactions their own category of competence. That category is "Healthcare Payments."

Until recently, managers of the healthcare revenue cycle have primarily focused on the problem of optimizing payer payments. This practice is logical since over 95% of an average healthcare provider's revenue comes from payers. Accordingly, nobody could have been faulted for ignoring patient payments, which generally make up only 5% of total revenue. Likewise, no revenue cycle consultant or executive could have been criticized for failing to understand the nuances of collecting from patients, which would be a fundamental requirement in a retail business. These complexities include bankcard associations, interchange rates, bankcard downgrades, PCI, security, fraud, compliance, NACHA, check processing and other aspects of the financial networks. For healthcare professionals, there is already enough complexity in understanding claims processing and payer payments.

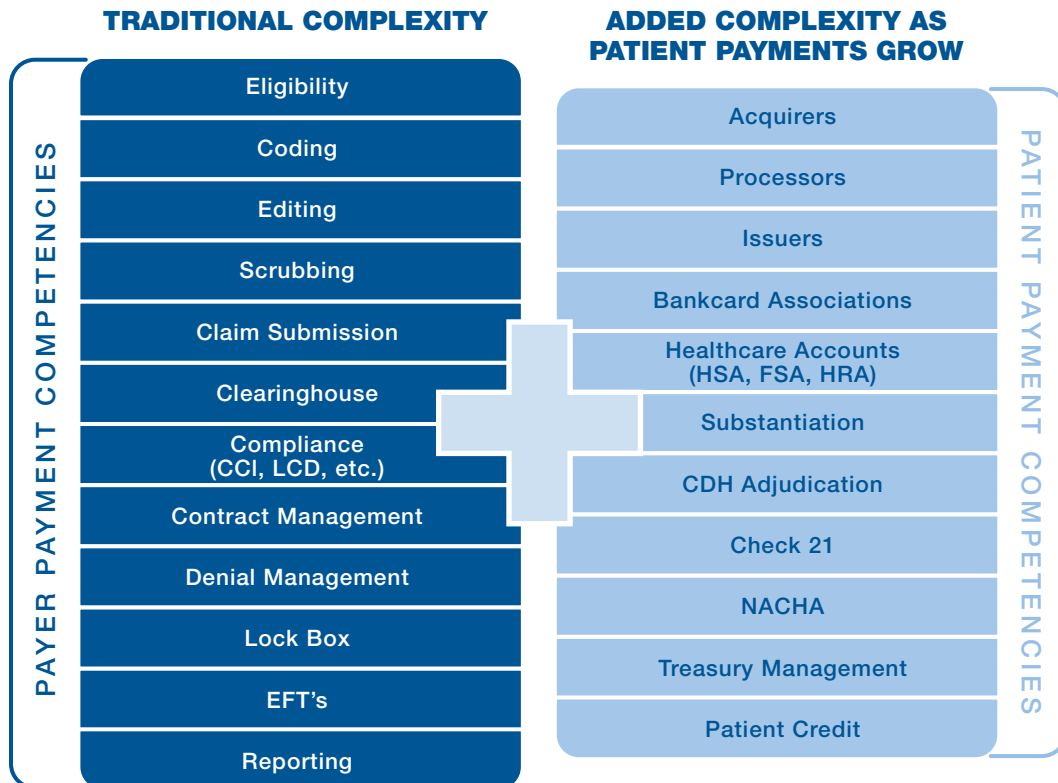
Today, healthcare organizations' system infrastructure and processes have been built around optimizing payer claims and payments, while patient payment systems and processes have evolved into a predominantly back-end

process. In the last several years, the primary tactic that healthcare providers have employed to improve patient payments has been the Healthcare Financial Management Association's (HFMA's) "Patient Friendly Billing® Project" – i.e. the process of improving the patient statement invoice. However, thin operating margins and a rise in bad debt expense for healthcare providers, combined with the growth of consumer-directed healthcare (CDH) and high deductible health plans (HDHPs), mean that this is all about to change. Healthcare providers must now increase their focus on patient payments, and because patient payments are dependent on payer payments and claim adjudication, the revenue cycle is now even more complex.

Transactions in the Revenue Cycle



Added Complexity for the Revenue Cycle

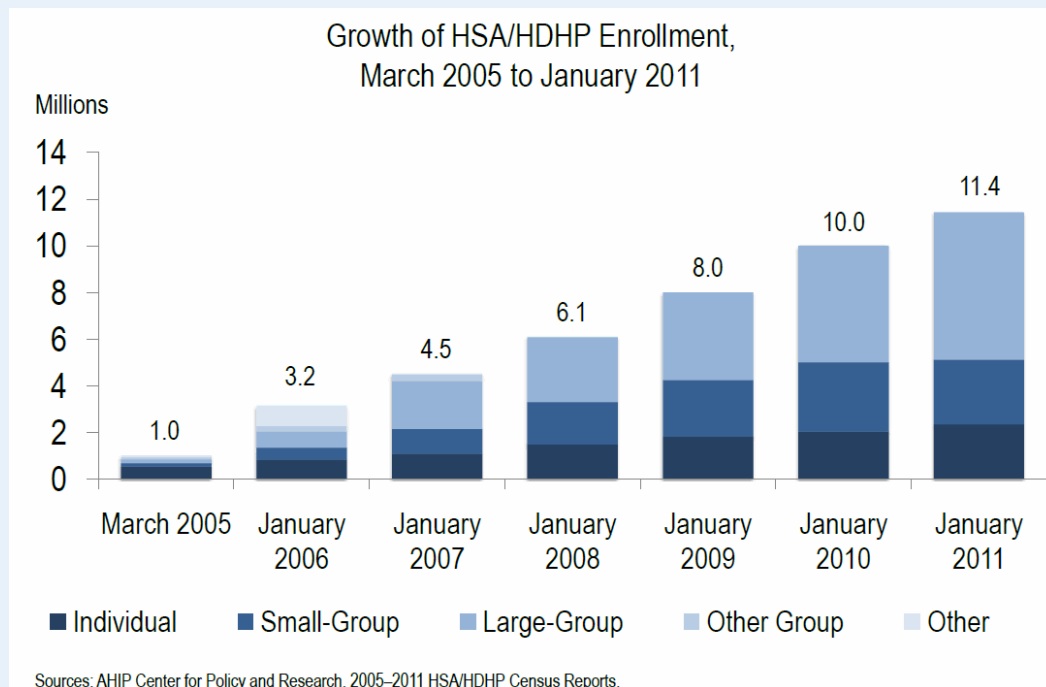


THE PROBLEM IS GETTING WORSE

With bad debt increasing and both employers and payers off-loading more payment responsibility onto their members (i.e. your patients), there is a new requirement in the revenue cycle – collecting dollars from patients – which will increase dramatically with the growth of CDH.

CURRENT DATA ON THE GROWTH OF CDH

As of January 2011, over 11 million people nationwide were enrolled in Health Savings Accounts (HSAs), up from 10 million in January 2010, and 8 million in January 2009, according to America's Health Insurance Plans (AHIP)



HSA/HDHP plans accounted for 10 percent of all new health insurance purchases in January 2011, according to AHIP.

The average employer contribution to an HRA increased to \$1,656, from \$1,481 in 2010, for a single employee, and to \$3,198, from \$2,857, for a family, according to United Benefit Advisors.

In Q1'2010 individual HSA account holders held an average balance of \$714 in their HSAs and family individual HSA account holders held an average balance of \$1,408, according to the Q1'2010 CDHC Market Data Advisory.

In terms of HSA spending, checks are the predominant payments vehicle, according to the Q1'2010 CDHC Market Data Advisory.

In Q1'2010, individual HSA account holders made \$381 in debit card payments for the quarter, and family HSA account holders made \$391 in debit card payments, according to the Q1'2010 CDHC Market Data Advisory.

INDUSTRY APPROACHES TO HEALTHCARE PAYMENTS

PAYERS

Many payers (mostly commercial health plans) are beginning to take action to help healthcare providers cope with their payment problems. There are predominantly four approaches that payers are bringing to market to address concerns of bad debt and the management of payments as CDH continues to emerge. These include: 1) member/patient opt-in; 2) real-time adjudication; 3) device based; and 4) card centric.

MEMBER / PATIENT OPT-IN: means that when a member enrolls with their health plan, they can check a box on their enrollment form that indicates that they will allow for the automatic payment of funds from one or more of their accounts to a healthcare provider upon claim adjudication. This payment may come to a healthcare provider in the form of a check or an electronic funds transfer (EFT). There are several problems with this approach: 1) Members can only opt-in one time per year; 2) Many members do not elect to allow for automatic payment of funds out of their account; 3) The automatic payment of funds occurs without any quality assurance step between the healthcare provider and the member, which opens up the process to disputes; 4) Disputes lead to high fees from banks, increased administrative costs for a healthcare provider and a decrease in patient satisfaction; 5) A healthcare provider has no way of determining if a member/patient has money in their account at the time of service. The net effect is that this approach is unlikely to satisfy even a small percentage of the CDH encounters that will occur between a healthcare provider and a member/patient, and its lack of quality assurance at the point of service will likely make the approach unsustainable.

REAL-TIME ADJUDICATION: means that payers are upgrading their systems to process a claim in real-time so they can determine the total allowed amount and the portions that are the responsibility of the patient and the payer. As a business function, real-time adjudication is certainly a good development for healthcare; however, when it comes to member/patient encounters, it is not necessarily the solution for delivering financial assurance to a healthcare provider. The problems with this approach include: 1) It may take a long time for payers to fully deliver this capability; 2) This is not an all-payer solution, forcing a healthcare provider to change workflow, and potentially systems, for payers that are not able to offer real-time adjudication; 3) Real-time adjudication can only add value towards collecting on deductibles and other self-pay receivables if a healthcare provider submits the claim while the patient is present, which implies real-time coding and billing – an inherent preclusion to the percentage of encounters to which this solution will apply; 4) Forcing real-time billing may lead to coding compliance issues for a healthcare provider.

DEVICE BASED: means that a payer will expect healthcare providers to use a device or terminal to enter and submit claim data. The problems with this approach are similar to those listed for real-time adjudication.

CARD CENTRIC: means that payers and their contracted card processor will integrate their claims and card processing systems in order to perform logic that will match the claims received by the payer with card authorization requests received by the card processor. The problems with this approach include: 1) The member/patient must have their card and can use only that card as their payment method; 2) The solution

will not work for HSA "savers," who prefer not to use their HSA dollars, or for those who want to use a different card such as a rewards card; 3) The solution will not work when a member leaves their existing employer and moves their HSA account from the payer's bank to a different HSA custodian, such as a mutual fund company or another bank of their choice; 4) While this approach can work for simple transactions where the card is present (e.g. pharmacy transactions), it will pose significant challenges in an office or hospital facility, where the price for services may not be known at the point of service.

Unfortunately, these solutions generally require a healthcare provider to do something unique and different for certain member/patients and payers and only solve a small portion of the total problem. The biggest challenge that healthcare providers will face is managing the impact to their workflow, systems and staff... until the industry adopts a standard, uniform front-end process for all payers, all banks and all cards.

“Healthcare providers are beginning to take matters into their own hands.”

HEALTHCARE PROVIDERS

Healthcare providers are beginning to take matters into their own hands. The following approaches are emerging:

COLLECT AND TRUE-UP: Some revenue cycle consultants are urging providers to collect the full rack rate at the point of service from patients with HDHPs. There are challenges with this approach that every healthcare provider should be aware of: 1) A claim must still be submitted; 2) Contracted discounts will not be applied to the transaction, resulting in a need to true up by crediting the patient; 3) If a claim is not submitted, the patient will not get credit towards their deductible. This can result in increased patient abrasion and frustration, and costly processes. Many health plans are instructing their CDH members not to pay at the point of service and to wait for the bill. Additionally, many network contracts with healthcare providers preclude the collection of any payments other than a co-pay at the point of service.

NEGOTIATE A SIDE DISCOUNT: Anecdotally, some providers are negotiating a discount with HDHP patients who pay up-front. The same challenges as above apply to this approach, with the added risk that, for many healthcare providers, this may represent a violation of their network contract.

BUSINESS AS USUAL: For many healthcare providers, the percentage of patients with an HDHP is still tolerable, representing only a minor impact to their business. However, with thin operating margins and a higher cost of collection for patient payments, a shift of a few percentage points in revenue from payer responsibility to patient responsibility can significantly impact a healthcare provider's bottom line.

LEADING PRACTICES FOR PATIENT PAYMENTS

The best practices for healthcare providers to collect patient payments are depicted below:

ELIGIBILITY AND BENEFITS: Verify eligibility and benefits to understand co-pay information and verify coverage. This verification can be performed at more than one instance during the lifecycle of an encounter, which may include the following: scheduling; pre-registration; point of service; and prior to claim submission.

COLLECT PAYMENT AT THE POINT OF SERVICE: To collect co-pay responsibility or an outstanding balance from previous encounters.

PRE-AUTHORIZE PAYMENT: this can be performed at the point of service in order to facilitate future collection of the patient's responsibility.

PAYMENT OPTIONS: Offer the patient every payment option available in order to ensure the highest level of acceptance of a patient's preferred payment method, which may include: bankcards, checks and other payment options.

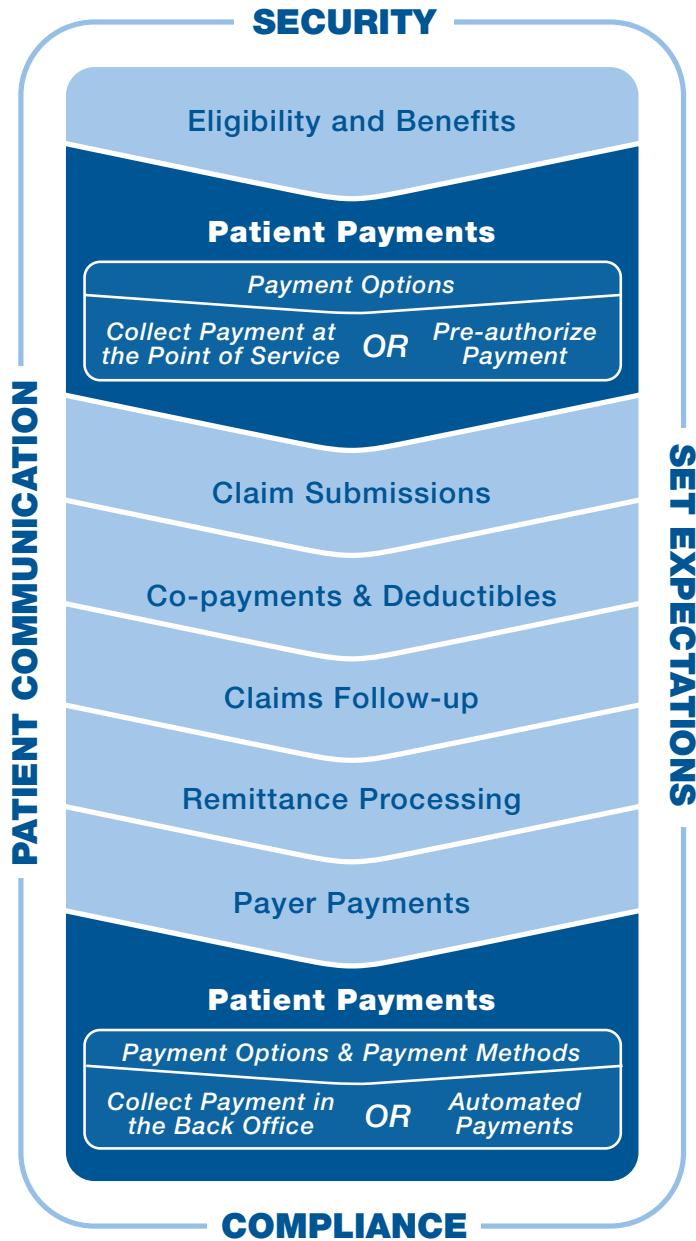
PAYMENT METHODS: Offer the patient the ultimate payment convenience for the method in which they choose to pay, which may include paying at the point of service, online, through the mail, or over the telephone.

PATIENT COMMUNICATION / SET

EXPECTATIONS: Establish proper expectations in all of your payment interactions with the patient. This includes establishing the proper expectations of the patient's responsibility, the terms, the timing and notification, and the next steps that will occur. These may be communicated at the point of service, on statements, verbally from trained personnel, from a service center, etc. This communication should certainly incorporate the leading practices from the HFMA's Patient Friendly Billing® Project.

SECURITY / COMPLIANCE: Your organization must incorporate appropriate policies and procedures for security throughout this entire process. This will apply to all aspects of physical, administrative and technical security and is required by Visa, MasterCard and other bankcard associations, as well as by HIPAA and other internal audits to which your organization may be subject.

Patient Payments Framework



INSTAMED SOLUTIONS FOR PATIENT PAYMENTS

To enable leading practices for healthcare providers to collect patient payments, InstaMed offers the following solutions:

PATIENT PAYMENTS to increase collections and cut costs. This offering enables acceptance of credit, debit and checks. All payments can be made at the point of service, through the mail, or over the telephone. The solution also includes remote deposit of any check to any bank, which can be performed in the front or the back office. Powerful reporting is available along with automated posting of all settled payment transactions into an existing practice management or healthcare information system.

PATIENT PORTAL to increase collections and reduce bad debt. This offering gives your patients a simple, convenient and secure way to pay online with credit, debit or the increasingly common varieties of healthcare accounts.

ELIGIBILITY AND CLAIM STATUS to cut costs, reduce phone calls and claim follow-up by automating eligibility and claim status at various points in an encounter, integrated into your systems and workflow.

CLAIMS provides coding and eligibility edits, comprehensive connectivity to healthcare payers and robust reporting and workflow management tools to accelerate cash flow and reduce administrative costs.

REMITTANCE to automatically post 835 responses in a variety of formats, or use powerful query functionality to access human readable remittance data.

MANAGING HEALTHCARE PAYMENT COMPLEXITY AS CDH GROWS

NEW REQUIREMENTS FOR CDH PAYMENTS

As CDH plans grow, even these leading practices will encounter limitations. For example, with HDHPs, two key pieces of data may not be known at the point of service – the patient's year to date spend against his/her deductible and the contracted allowed amount for services to be rendered. In order to provide a high degree of financial and payment assurance, providers need a solution that meets the following requirements:

PAYER AND PAYMENT ACCEPTANCE

- *Payer Flexibility (all payer)*: deliver a solution that works for every patient who walks in the door – irrespective of their payer/health plan
- *Payer Product Flexibility*: deliver a solution that works for both CDH health plans and traditional health plans such as PPOs and HMOs
- *Payer Adjudication Flexibility*: deliver a solution that works for real-time, medium and slow-time adjudication systems
- *Payment Flexibility (all bank and all card)*: deliver a payment solution that works with all new healthcare accounts and all payment cards, whether issued by the payer/health plan or not

WORKFLOW

- *Common Workflow*: provide a common workflow for all patients, not just CDH patients
- *Eligibility / Benefits Verification*: incorporate eligibility, in real-time or prior to the patient visit, wherever possible

“As CDH plans grow, even the leading healthcare payment practices will encounter limitations.”

- *Up-Front Authorization & Payment:* re-engineer the patient payment process from a predominantly back-end process to a front-end process with back-end check-out, similar to that of a hotel. Capture payment authorization at the point of service – don't let the patient leave!

PATIENT COMMUNICATION & EXPECTATION MANAGEMENT

- *Estimated Payment:* establish the expectation for the transaction by estimating the patient's responsibility at the point of service
- *Accuracy:* do not move money until the exact amount of a patient's responsibility has been determined

DESIRED OUTCOMES

- *Payment Assurance:* deliver payment assurance by allowing for the pre-authorization of eligibility and an authorization on a financial account, and when possible, by enabling the healthcare provider to place a hold on funds to the extent that is allowed by the financial networks
- *Security:* set a new standard for security and compliance in dealing with highly sensitive healthcare and financial data
- *Reliability:* provide the same level of service that is expected of credit card and ATM machines
- *Usability and Integration:* where possible, integrate into existing workflow and systems, as opposed to a one-size-fits-all approach

INSTAMED SOLUTIONS FOR CDH PAYMENTS

To meet these new requirements, InstaMed delivers its patent pending, Estimator solution, as described below:

InstaMed's **ESTIMATOR** solution gives healthcare providers a mechanism to receive an estimation of patient payment responsibility at the point of service, save a patient's payment card on file and receive payment upon claim adjudication, or set up a flexible payment plan. The patent pending payment technology works for all payers, all banks and all cards. The solution is built on two new transactions that integrate healthcare and payment exchanges in order to deliver greater payment assurance at the point of service.

InstaAuth®: This transaction automates the process of estimating the patient responsibility and authorizing funds at the point of service.

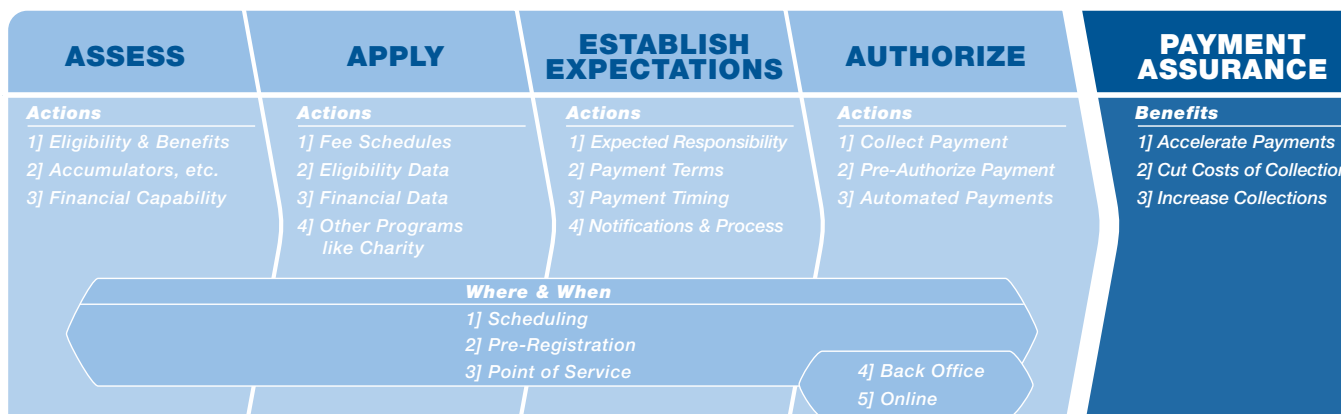
InstaFund®: This transaction automates the process of settling authorized funds from any account based on the exact patient responsibility, triggered by an adjudicated claim.

These transactions can be performed through the InstaMed Platform using InstaMed Connect, an API, or via InstaMed Online, an ASP cloud-based portal. A common workflow performs an optional eligibility inquiry, and determines the appropriate actions for the user – the result of a patient encounter may simply be the receipt of co-payment, or be estimation of patient responsibility combined with an InstaAuth®.

ACHIEVING PAYMENT ASSURANCE

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

Payment Assurance Framework



With an emphasis on payment processing, this new framework integrates the healthcare network of payers (insurance companies, health plans, PPOs, HMOs and TPAs serving employers), healthcare providers (doctors, hospitals, labs, etc.) and patients, with all leading payment networks (Visa, MasterCard, Amex, NACHA/ACH, etc.).

The new framework for Payment Assurance includes the following:

At the point of service, providers must:

- Assess eligibility and benefits, accumulators and financial capability through standard transactions triggered by front office software and/or health plan identification cards.
- Apply fee schedules, eligibility data, financial data and other programs such as charity.
- Establish expectations with patients by estimating the expected patient responsibility and communicating payment terms, timing, notifications and process.

Leveraging this information, providers must support all payers, all banks and all cards, as well as the ability for patients to pay online and make payment arrangements.

Additionally, providers must have access to an integrated electronic claim submission and claim status gateway that features timely adjudication and real-time information, as well as an 835 that is reconciled and linked to an electronic funds transfer for the payer's responsible portion of the claim. This payment must be made to the bank account of the provider's choice, in a timely manner.

Once services are rendered, providers must:

- Collect any known patient responsibility and/or pre-authorize the patient's preferred payment method.
- Submit the claim.
- Upon claim adjudication and receipt of the 835 from the payer, trigger an automated payment to get a direct deposit of the exact patient responsibility from the patient's preferred payment method.

Many companies have already built one or more components of these enabling features of this framework. These features have been shown to dramatically expedite the provider's collection of outstanding receivables, increase patient collections up to 200%, accelerate patient payments up to 50% and reduce operational costs up to 60%. However, the new framework for Payment Assurance is comprehensive, incorporating all features outlined above, rather than offering just one component.

“Leveraging the new framework for Payment Assurance, providers can increase patient collections, accelerate patient payments and reduce operational costs.”

ABOUT INSTAMED

InstaMed is the leading Healthcare Payments Network connecting providers, payers and patients with healthcare clearinghouse, eligibility, estimation, patient payment and patient billing transactions on one integrated platform. InstaMed delivers payment assurance to providers, enables payers to disburse payments at a lower cost with fewer incidents of fraud, and gives patients a simple, convenient and secure way to pay. The InstaMed Network powers healthcare payments for over 200,000 providers nationally with tens of billions of dollars in healthcare payments processed.


Through our channel partner relationships, we currently support the healthcare payment processing needs of all types of providers, from solo practitioners to billion dollar health systems, and hundreds of healthcare payers of all sizes. We are registered with Visa and MasterCard and are certified as a Payment Card Industry Data Security Standards (PCI-DSS) Level One Service Provider. We are also fully accredited by the Electronic Healthcare Network Accreditation Commission (EHNAC) as a healthcare clearinghouse.

InstaMed is a privately held company with a proven management team bringing decades of experience in the healthcare EDI and payment processing industries. Our management team and our investors are firmly committed to InstaMed's mission and success.

For further information, please contact:

Jillian Longpre
InstaMed Public Relations
Tel: (215) 789-3685
pr@instamed.com
www.instamed.com

InstaMed[®]

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