

## Executive Summary

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# **Key Conclusions from the Voice of the Customer Executive Roundtables**



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**Following is a summary of key conclusions from the U.S. Bank and Elavon Wholesale Payments Voice of the Customer Executive Roundtables held earlier this year with executives from Healthcare payer and provider organizations.**

## **Payment Practices in the Healthcare Industry Today**

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*Providers and payers have indicated the healthcare payments market is fragmented—some have taken great strides in making the transition to electronic payments, while others clearly have far to go.*

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U.S. Bank and Elavon customers participating in these Roundtables report they are in very different places when it comes to converting to electronic payments. Whether its providers receiving payments from health plans and patients, or payers receiving payments from employers and members, the percentage of electronic payments versus cash or check payments varies greatly by individual organization. Similarly, there's a great disparity in how remittance information and EOBs are sent to providers and members—whether paper or electronic.

For example, a few providers have installed electronic kiosks at point of service (POS) for patients to check-in, as well as review and pay bills and also have online portals to facilitate payments. Others still receive a significant portion of their payments from patients as checks. Payers also are at different points on the continuum of electronic payments, with at least one working on a mobile app for subsidized members to view and pay the amount owed on their premium, while others receive the majority of their payments even from employers by check.

All payers and providers wish for the day when all payments and remittances become electronic—a number of factors are impeding a more rapid adoption in the short term. Yet, some providers believe checks and cash will continue to be a part of the payment mix for another 20 years, both from payers and patients. One Roundtable participant summarizes the goal:

*“Ultimately what we want to do is we want to eliminate all the paper. Literally, I want that online payment...I want that 835 and EFT. I don't want the paper.”*

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*Payers and providers indicate that several factors in the marketplace impact their need to reduce costs and become more efficient in their payment practices. Yet, much uncertainty exists in how the Affordable Care Act (ACA) requirements will play out over time.*

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Payers and providers have clearly identified the need for cost savings and greater efficiency as key priorities for their organizations. Improving payment processes is noted to as an important part of this strategy among payment executives from both the provider and payer side of the healthcare business. Greater automation and efficiency would reduce labor and printing and mailing costs at many organizations. In addition, new consumer payment solutions could help reduce bad debt.

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Providers and payers explain that there are several factors which are influencing these initiatives, including: the adoption of Affordable Care Act (ACA) and with it the focus on Accountable Care Organizations (ACO) in place of a traditional fee for service model. Payers and providers expect reduced reimbursements to their organizations as a result. With these changes comes a great deal of uncertainty about the specific requirements of the ACA and how it will be implemented.

Among the other changes the healthcare industry is seeing today and expects in the future:

- Continued consolidation of clinic and physician offices, as well as hospitals to make more efficient use of resources and reduce administrative costs
- Changes in referral patterns with greater emphasis on primary care doctors as a result of ACOs, and
- A large future influx of individual buyers of health insurance

## Key Business Challenges

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*Providers are most concerned about payments from payers and some suggest the relationships with payers “feel less like a partnership.”*

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Providers (whether clinic or hospital-based) indicate payments from health insurance companies account for the vast majority of their payment revenues coming into their organizations. Consequently, solving issues relative to these payments are their highest priority. Yet, clinic providers suggest the larger payers are requiring more from them in terms of administration. As a result, this is changing the relationship. In contrast, hospital providers report they are working more closely with payers (particularly larger ones) to streamline processes for how payments are received and overall compliance.

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*Payers suggest the change in focus from group business to individual health insurance will be a true “paradigm shift” for their organizations and it will likely present payment challenges.*

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Payers indicate their concerns are on the receivables side of their business, rather than the disbursement side. The majority of payers represented in these Roundtables sell far more group insurance than individual insurance. They indicate that impending changes resulting from the ACA will cause a shift in focus to individual health plans and payments from their traditional group insurance model. This will result in a switch from handling a small number of high dollar payments to a large number of small dollar payments.

Payers are particularly worried about the potential for a significant added financial risk with subsidized consumers from Public Exchanges. These individuals are likely to be less financially savvy and secure, but also less healthy, resulting in more costly claims. While many payers suggest

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they are likely to participate in Public Exchanges, it appears there is some uncertainty about Private Exchanges. With so many changes afoot, payers indicated it was difficult to set priorities in organizations.

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*Payers and providers indicate they will be adopting a more “retail-focused” approach to their businesses.*

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As more consumers enter the health insurance market and the use of technology becomes more prevalent in all types of payments, payers and providers indicate they need to meet patients and members “where they are today.” Both segments note they are striving to make the patient billing and payment process as seamless and easy as possible for consumers, as well as for their own organizations.

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*A variety of issues are potential obstacles in the conversion to electronic payments among both payers and providers.*

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Among the factors that U.S. Bank customers cite as inhibiting the conversion of healthcare organizations to accept or receive electronic statements and/or payments:

**Consumer Acceptance**

- Older population is less comfortable with electronic statements and payments
- Subsidized population may be less educated and “new” to health insurance

**Payer and Provider Systems**

- Some payers and providers lack the infrastructure to support electronic payments
- The cost of implementing new systems is also a challenge

**Technology Issues**

- The lack of online portals and other POS (point of service) options for patients/members to easily make electronic payments
- The lack of standardized 835 forms for electronic remittances causes problems

**Cost-driven Issues**

- The cost of merchant fees when using credit card payments
- The cost of handling electronic payments that require manual intervention and special handling

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*Particularly, the lack of integration in payments systems across the board stymies efficiencies today in payments processing.*

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Whether the issues are with providers' practice management software and their own accounts receivable systems, providers indicate the "lack of an integrated payment tool" is a hindrance to greater efficiencies in payments processing. This concern is also noted among payers when discussing the adoption and implementation of their financial partners' payment solutions.

Likewise, the change to ICD-10 for medical coding in October of 2014 brings with it system compatibility concerns among both payers and providers. They also worry about the potential for redundancy with ICD-9 as the transition is made, as well as the additional time and resources required to implement the new coding requirements.

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*Both providers and payers indicate two of their biggest challenges are matching electronic payments with remittance information and dealing with refunds*

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### **Matching Electronic Payment to Remittance**

The lack of a "usable" ERA (electronic remittance advice) with an EFT (electronic funds transfer) is an extremely common complaint from providers when processing payments from payers. This is because 835 ERAs either are not in a standard format or are simply lacking the necessary information for payments to be applied correctly. With multiple providers and facilities often managed by clinics and hospital systems, correctly identifying where the payment should be posted on arrival is extremely challenging.

Similarly, when consumers make payments online to either providers or payers at their own bank website, the electronic payments are sometimes missing critical account information. Significant internal resources are used by both payers and providers to manually sort out and post these payments to the correct accounts/providers.

### **Dealing with Refunds**

Refunds are problematic for both payers and providers. At the core of this problem is the lack of accurate real time adjudication of claims processing and claims payments. As a result, overpayments are made by payers to providers and by consumers to providers. Once again, these payment executives indicate a substantial amount of labor is dedicated to managing the refunds process which includes return mail management and escheatment.

### **Comparing U.S. Bank to the Competition**

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*Many providers and payers see U.S. Bank as a leader in payment solutions for the healthcare industry.*

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U.S. Bank is considered a leading player in the healthcare payments marketplace by many providers and payers. U.S. Bank's focus on the healthcare industry over time and the introduction of payment solutions such as Payment Navigator are cited as key advantages relative to many financial institutions

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Payers and providers indicate that there are more payment solutions, including software and consulting; in the healthcare arena, and that they are inundated with suggested payment and technology solutions from many firms. U.S. Bank has an established reputation and history in the market. This, combined with critical industry expertise, and unique capabilities because of its size all make U.S. Bank a preferred financial partner for many payers and providers.

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*In addition to being an innovator in healthcare payment solutions, payer and provider customers stress the importance of human relationships and communication with a financial partner.*

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Payers and providers stress the importance of human relationships and the role it plays in their selection of preferred financial partners. They explain that even though one company or financial institution may have the most innovative technology-based solution, they must also have the people to present, integrate, and support that product over the long term. Many customers indicate U.S. Bank Relationship Managers excel in this regard.

Providers also indicate they look to U.S. Bank as a financial partner to proactively communicate upcoming changes in financial regulations such as the Dodd-Frank and other consumer protection acts, and the potential impact on their organizations. Both providers and payers indicate they also want U.S. Bank to understand the importance of keeping them informed of interactions with others in their respective payer and provider organizations.

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