

# Is There a Doctor in the House?

## *A Payments Prescription for the Health Care Industry*

By Brian Todd

**P**erhaps nothing has caused more headaches than the simple act of paying a medical bill. With patients wondering when and how much to pay, insurance companies needing to verify coverage, and health care providers trying to keep track of it all, everyone is massaging his or her temple, and asking if there is a doctor in the house.

Patients are frustrated by a system that can force them to pay more than once. First, they must pay at the point of service, and again when the insurance company calculates the remaining balance—for the same trip to the doctor. Now, insurance companies must deal with new mandates from the Health Insurance Portability and Accountability Act. And health care providers—large and small—face painfully slow cash flow and patient verification, and an accounting nightmare to reconcile the simplest of bills.

Like a neighborhood kid who incessantly bangs the drums all night, this headache compounds itself, as medical billing, accounting and insurance verification have long been handled via paper and postage. Meanwhile, many providers and insurance companies are still slow to embrace electronic solutions to the old paper models.

### **At the Point of Sale**

The problem begins when the patient visits the doctor's office, says Steven Yecies, vice president and general manager of San Francisco-based Pay By Touch Healthcare.

"Historically, there has not been a checkout lane in the health care field," Yecies says. "But, the consumer portion (of a health care visit) has almost doubled in the past five years." Yecies adds that with more consumers

lining up to pay, a checkout line is needed now more than ever.

Usually, if a patient visits a health care provider, two sets of data must be checked. First, the patient's insurance must be verified not only for a basic office visit, but also for the respective tests or procedures performed. Then, the insurance company must review each line item to determine the

The goal for Pay By Touch is to perform real-time adjudication of the patient's insurance claim, meaning the provider can reconcile the patient's portion of the bill at the time of service. To make this a reality, Pay By Touch takes advantage of its existing connections within the health care field. First, the company confirms coverage and payment



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amount for which the patient and the insurance payer are responsible.

It is this second process that creates problems. With the patient no longer present, the provider reverts to a billing system that harkens back to the pre-electronic transaction era.

Despite the fragmented environment of health care, Yecies says Pay By Touch has moved forward with solutions that speed up providers' cash flow and lower administrative costs—thereby streamlining the process.

For Pay By Touch, the process starts, oddly enough, with a scan of the patient's finger. The finger scan is actually a biometric authentication linking the patient to his or her electronic wallet, from which Pay By Touch can verify insurance coverage. Then, the scan links up to a credit or debit account—perhaps even the patient's health savings or flexible spending account—to make payments as the patient checks in for an appointment.

responsibility through insurance companies' Web sites. Next, it takes care of payment—either through a health spending account or the patient's credit or debit account.

With the payment process resolved up front, the insurance company mails a standard explanation of benefits to the patient, after the payer portion of the bill has been reconciled. Having the patient pay up front is of huge value to providers that often mail multiple bills to confused patients weeks after an office visit.

Aaron Bills, COO and founder of Chantilly, Va.-based 3Delta Systems Inc., says, "We dealt with one vendor who offered a 20 percent discount to those who pay on the first bill."

### **Back of the House**

While Pay By Touch is taking care of the patients, Little Rock, Ark.-based Remettra Inc. offers a dose of aspirin to the billing pains of payers and

providers. Remettra offers both electronic and paper-based billing and tracking services for insurance companies and providers, sending remittance notices in both electronic and paper formats based on the preference of the provider—in accordance with HIPAA.

Remettra's main offering, MedRemit, distributes funds from payers to providers, sending the remittance notice to help providers quickly reconcile their accounts. The company (Remettra) also sends the explanation of benefits (EOB) to patients.

"Unless you coordinate the information and financial portions of each transaction, you don't get the benefits you otherwise would have received," says Rick Morrison, founder and CEO of Remettra.

The problem that payers and providers encounter arises from the current need to operate both paper- and electronic-based accounting and billing systems. All this happens in the HIPAA environment, which mandates the availability of electronic remittance notices, as well as a level of privacy that requires secure communications channels.

Running dual systems costs the health care industry between \$20 billion and \$30 billion a year. "There is such a large potential return on investment that providers and payers realize that ROI immediately," Morrison says.

With market forces driving changes to the health care industry, Morrison, a former president of the Medical Banking Institute, says electronic insurance claims have finally passed the 50 percent level.

Now, the industry focuses on achieving the same for electronic remittances from payers to providers.

As both increase, fewer errors will result from typing and re-typing claim and payment information at various points along the chain. Providers' cash flow will then speed up, and account reconciliation will ease for payers and providers, as files are subsequently downloaded and processed electronically.

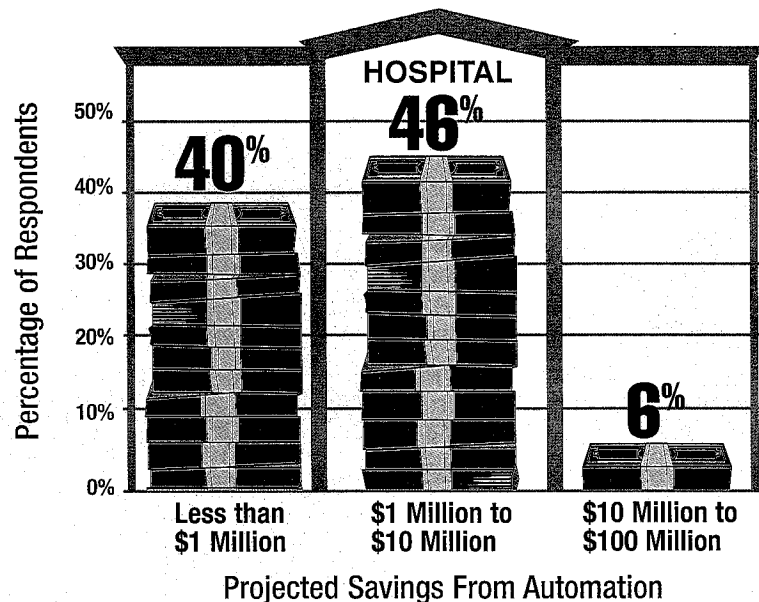
Still, with so many insurance companies using so many different systems, Morrison says the healthy mountain of paperwork currently facing providers has only been reduced to a molehill of red tape. Providers still must reconcile accounts and generate secondary bills or remittances. "Once it hits the provider's office,

network?" And tracking, Bills says, is what 3Delta Systems does best.

Although any company could offer credit and debit processing services to the local clinic or doctor's office, 3DS is building a Level 3 system for the health care industry in which payment reconciliation can be broken down by individual line items.

## PRESCRIPTION FOR SAVINGS

U.S. hospital executives vary on potential savings to be achieved through automated medical claims and payment processing:



Source: PNC Financial Services Group; Survey of 124 hospital executives nationwide; March 2006

there is still a lot of downstream work," Morrison says.

### Devilish Details

As it transitioned into the vertical health care market, Bills says 3Delta Systems has focused on payment and collection processes. Like the industry as a whole, the company is also working toward a more seamless blending of payment and patient data.

"What drew us into the market is its very complexity," Bills says. "This industry is characterized by multiple customer types, channels and tender types. Wouldn't it be nice to get the same tracking flowing through the

That level of detail will help providers organize their data more quickly in this complex field.

While the health care industry is slowly being upgraded into the twenty-first century, Morrison says, most major players understand that to transform the industry to an electronic transaction environment will make a trip to the doctor's office a pain-free experience.

"There is no question and no debate on what the downstream benefits will be," he says. **TT**

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