B2B HEALTHCARE PAYMENTS REPORT

JANUARY 2020

FEATURE STORY – PAGE 08

Oscar Health's Tech-First Focus **For Accelerating B2B Healthcare Payments**

NEWS AND TRENDS – PAGE 12

Healthcare providers' unreimbursed costs climbed from 2015 to 2018

DEEP DIVE – PAGE 18

Unlocking billions in healthcare reimbursements with digital tools

PYMNTS.com

B2B HEALTHCARE PAYMENTS REPORT

04 **What's Inside**

A look at how accounts receivable and claims submission improvements can help ease medical providers' cash flow pains

08 **Feature Story**

An interview with Brett Lotito, Oscar Health's vice president of insurance, on how the insurer streamlines its payments to healthcare provider partners

12 **News & Trends**

Recent headlines from the space, including solutions helping hospitals prepare insurance reimbursement claims and U.S. Bank's partnership with Inworks on virtual B2B healthcare payments

18 **Deep Dive**

An in-depth examination of how digital tools can smooth claims-filing frictions and help healthcare providers get compensation from insurers faster

21 **About**

Information on PYMNTS.com and American Express

Acknowledgment

The B2B Healthcare Payments Report is done in collaboration with American Express, and PYMNTS is grateful for the company's support and insight. PYMNTS.com retains full editorial control over the following findings, methodology and data analysis.

WHAT'S INSIDE

Healthcare providers not only have to offer optimal services to patients, but they must also worry about whether — and when — they will get paid. Slow, sporadic payments can place hospitals in tricky financial binds and providers are responsible for disbursing employees' salaries and replenishing supplies no matter how rocky their cash flows become.

Mitigating such accounts receivable (AR) issues and improving cash flow is possible, however, and healthcare entities can and should take advantage of solutions that reduce business-to-business (B2B) payment frictions. Providers can encourage insurers to stop paying via slow-moving paper checks, for example, or adopt software that can pre-review claims, increasing the chances that insurers will approve claims on the first try and sparing both parties from protracted disputes over insurer payment obligations.

The B2B Healthcare Payments Report examines how healthcare providers are adopting new AR, claims submission and data sharing tools to get paid faster and with less hassle.

AROUND THE B2B HEALTHCARE PAYMENTS SPACE

Many healthcare providers are slow to deploy modern AR solutions because facilities with legacy systems in place are often concerned that modernizing will make it difficult to access and manage existing accounts. Content services and systems integration provider Flatirons Digital Innovations (FDI) recently took aim at this perception by launching a solution intended to pull legacy systems' data into a central, modernized revenue cycle management system.

Hospitals' struggles with legacy AR systems are also drawing attention from B2B financing companies, including Crestmark. The company recently debuted a new division that provides financing to help smooth providers' cash flows when insurers are slow to pay.

Other observers in the space believe that the work of easing cash flows must start with the beginning of the compensation cycle: the claims submission process. Healthcare solutions company Sentry Data Systems recently released an offering to help hospitals review

© 2020 PYMNTS.com All Rights Reserved

claims before sending them to insurers. The tool catches issues that could reduce initial claims' approval likelihood, enabling proactive adjustments that could spare hospitals the pain and time of waiting for insurers' responses, revising rejected claims and refiling them.

OSCAR HEALTH'S TECHNOLOGY-FIRST FOCUS FOR ACCELERATING B2B HEALTHCARE PAYMENTS

Healthcare providers can suffer throughout the insurance claims reimbursement process, meaning insurers that value their clients should work to minimize frictions. The right technology can help, according to Brett Lotito, vice president of insurance operations at health insurance company Oscar Health. In this month's Feature Story (p. 8), Lotito discusses how digital portals and automation systems can improve insurers' and healthcare providers' communications to support quicker claims processing, as well as the ways digital payout methods can offer much-desired visibility and speed.

DEEP DIVE: UNLOCKING BILLIONS IN HEALTHCARE REIMBURSEMENTS WITH DIGITAL TOOLS

Hospitals rely on insurers for reimbursement, but payments that should be quick often get held up if insurers do not approve initial claim submissions. Healthcare providers must then pass medical costs to patients, take revenue hits or fight rejected claims, meaning those concerned about their cash flows must adopt strategies to ensure that insurers pay their full shares on time. This month's Deep Dive (p. 18) explores how digital tools can help providers prevent claims rejections to keep reimbursements coming in.

Executive INSIGHT

What kinds of AR improvements could help healthcare providers receive compensation from insurance companies faster and more efficiently?

"The healthcare landscape is still very paper-driven. From insurance claims to bills to checks, there is enormous opportunity to digitize the end-to-end process. Payment and collection is a logical area of opportunity [for improving] reconciliation, efficiencies and speed of pay for all the parties in the healthcare supply chain. Card-based payments can help reduce the task of payment [processing], which can save time and money for both the healthcare buyer and supplier. Digitizing this end-to-end process can help … and [give] all parties in the healthcare life cycle a more seamless and secure way to pay. Mobile, portals [and] tokenized emails are all ways to improve the payment process.

At American Express, our teams remain focused on AR automation to [grant] healthcare providers the ability to accelerate the end-to-end invoice-to-cash process for our healthcare suppliers. The benefit [of] our American Express business model is that we manage both the buyer and the supplier relationships, so we are uniquely able to customize solutions to meet healthcare customers' needs on both sides."

DANIELLE K. WALLIS,

vice president and general manager for U.S. merchant services at American Express

 © 2019 PYMNTS.com All Rights Reserved

FIVE FAST FACTS

$12.8M

Value of healthcare providers' 2018 unreimbursed and uncompensated care costs

$6T

Amount the U.S. is projected to spend on healthcare by 2027

$2.3B

Estimated annual savings as a result of digitized claims status inquiries

$250B

Typical cost to process 30 billion healthcare transactions

19.9%

Portion of total 2018 U.S. health spending conducted by private businesses

© 2019 PYMNTS.com All Rights Reserved

FEATURE
STORY

Oscar Health's Tech-First Focus For Accelerating B2B Healthcare Payments

Payments between insurance companies and their healthcare provider partners can cause stress for both parties. Delays always exist between treatments and compensation, and that lag can strain budgets as healthcare providers must continue with their regular purchasing and payroll obligations while waiting.

Physicians who become too frustrated by the administrative headaches of filing claims and fighting rejections may even decide against accepting insurance plans entirely, preferring limiting their customer reach to suffering reimbursement hassles.

Insurance companies must make these processes as swift and convenient as possible to retain and grow their healthcare provider partner bases. PYMNTS recently caught up with Brett Lotito, vice president of insurance operations at health insurance company Oscar Health, for greater insights into the challenges insurers face when providing speedy compensation.

© 2020 PYMNTS.com All Rights Reserved

LETTING DATA — AND MONEY — FLOW

Approximately 375,000 individual members are currently enrolled in Oscar Health's plans, and the company serves an additional 20,000 patients through Medicare Advantage and small-group insurance. Claims disbursements to these patients' providers can hit snags when data is missing or unclear, though.

"When it comes to paying our provider partners, health insurance companies like Oscar face very similar challenges to what members face when going to get care," Lotito explained. "The underlying healthcare system is broken and data systems are a bit disparate."

Insurers assess claims before issuing funds to determine whether treatments were genuine medical necessities covered by their contracts, and they must also ensure they possess all the data they need about providers. Firms must double-check information about providers' systems and ensure that addresses and specialties are all accurate.

Oscar Health takes a technology-based approach to tackling these tasks, creating a digital portal that healthcare providers can use to update details and verify the kinds of submitted evidence they will need to justify different treatments. This ensures that providers include all necessary information in their claims, reducing rejection odds. They can also use the portal to confirm the services covered in different patients' plans, which is helpful in comparing care options.

The company also tries to automate its assessments to be faster than manual review processes. Oscar Health automatically adjudicates approximately 92 percent of submitted claims, compared to only 60 percent three years ago, Lotito said. Technology has enabled the insurer to reduce claims processing windows to a median of five days.

"We try to codify the decisions that [our claims processing teams] need to make based on the data that drives the workflows they have," he explained. "If we can codify appropriately, we can then use our systems and tools to automate those decisions. That's a way we can drive the average [claims processing time] way down."

ISSUING FUNDS

Oscar Health prefers to pay its partners' approved claims digitally through automated clearing house (ACH) transactions or 835, an automated electronic funds transfer system commonly used for healthcare claims payments. Digital transfers are quick, low-cost, easily trackable and can deliver payments with little lag between issuing and receipt. Healthcare provider partners frequently want to know when — or if — they can expect reimbursements, so solutions with only minor latency periods are particularly useful.

 © 2020 PYMNTS.com All Rights Reserved

"We'd much rather do electronic payments [so] we can track that payments go out and providers receive them," Lotito explained. "We try to steer as many of our providers as we can to electronic payments because that way we can communicate more information to them about what we paid for, how we paid for it, why we covered it in a certain way or why we didn't cover something. [Digital payment methods help us] make sure we are paying claims accurately and compliantly with all the markets we are operating in — and, clearly, so the players know what decisions we're making and why."

Healthcare providers across all markets and types do not mirror insurers' electronic payments demands, he added. Oscar Health has found that many still have systems geared toward manual payments, so the firm believes its offerings must meet these differing needs.

The B2B healthcare payments market is complex, and many insurance companies and healthcare providers are striving to achieve more streamlined claims processing and easier, swifter reimbursements. Much work remains, but stakeholders are already making strides. A willingness to seek out technological tools to support fast and flexible disbursements may go a long way toward making B2B healthcare payments easier for all involved.

© 2020 PYMNTS.com All Rights Reserved

NEWS & TRENDS

Cards for B2B healthcare spending

U.S. BANK, INWORKS PARTNER ON VIRTUAL B2B HEALTHCARE PAYMENTS

The fifth-largest bank in the U.S. has teamed up with healthcare-focused accounts payable (AP) automation company Inworks to digitize and facilitate the medical sector's B2B payments. U.S. Bank brings virtual payment card capabilities and existing healthcare client relationships to the partnership that began last summer, and the AP automation firm supplies its Intelligent Pay B2B payments platform. The collaborative solution supports digital transactions in various payment types between suppliers and healthcare organizations and will now include U.S. Bank's virtual payment card offering. It also provides transaction tracking and management. U.S. Bank's senior vice president of corporate payment systems, Nicole Tackett, said that healthcare systems will benefit from digital payments' efficiency.

JPMORGAN BUYS DIGITAL HEALTHCARE PAYMENTS PLATFORM

Another major U.S. bank is turning to medical payments, with JPMorgan Chase & Co. spending more than $500 million to acquire medical payments technology company InstaMed, which provides medical billing automation and facilitates healthcare transactions between medical providers, insurance plans, health maintenance organizations (HMOs) and patients. InstaMed processed $94 billion in payments in 2018.

The acquisition is timely as U.S. healthcare spending is slated to hit $6 trillion by 2027. JPMorgan's head of wholesale payments, Takis Georgakopoulos, said that 90 percent of health providers use paper-based billing, but InstaMed's network and digital platform will smooth the flow of funds between providers, payers and consumers. The offering supports a variety of digital transaction methods, including card payments.

© 2020 PYMNTS.com All Rights Reserved

AR data management tools to help with payments

COLLECT RX ANNOUNCES DATA AGGREGATOR FOR REIMBURSEMENTS

Healthcare providers often struggle to receive reimbursements from insurance companies, and partial or slow-to-arrive payments can seriously damage their bottom lines. Out-of-network providers can be especially vulnerable to denied claims or urged to accept low reimbursement rates. Out-of-network healthcare claim reimbursement services and solutions provider Collect Rx is seeking to resolve this problem by launching a new tool that gives medical providers comprehensive aggregated data that can persuade insurance companies to pay.

The CRXISelect solution builds on the company's previously released business intelligence offering and provides details on insurance companies' payment rates for related services in similar locations, enabling providers to fight for those same rates. Collect RX asserts that its tool increases payouts by an average of 59 percent for prenegotiated rates and 87 percent over original payouts for qualified post-payment appeals.

APERVITA RAISES $22M TO DEVELOP DATA SHARING TECHNOLOGY FOR INSURANCE AND HEALTHCARE PROVIDERS

Some companies believe improving insurance and healthcare claims data flows between insurance plans and care providers can make payment management more efficient. Data

 © 2020 PYMNTS.com All Rights Reserved

sharing startup Apervita, which offers a platform to do just that, recently drew $22 million in fresh funding from companies like Baird Capital, Optum Ventures and Pritzker Group Venture Capital, bringing its total fundraising to $43 million.

Apervita merged with Qcentive, a company that provides software to help insurers create contracts with hospitals, earlier this year. The combined entity, which operates under the former's name, asserts it decreases administrative expenses for more than 2,000 hospitals. Apervita plans to focus its new funding on product development, sales and marketing initiatives.

FDI DATA TOOL TO SUPPORT LEGACY AR MANAGEMENT, SYSTEM UPGRADES

Healthcare providers may be tempted by technologies and software systems that promise to decrease expenses, yet they remain leery to adopt them. Many are particularly reluctant to upgrade their AR systems, fearing that doing so will complicate accessing information regarding outstanding AR. Healthcare providers that sever their ability to manage outstanding receivables run the risk of nonpayment.

Content services and systems integration provider Flatirons Digital Innovations (FDI) believes the solution lies in data management tools that can pull information from legacy sources into a central system. The company recently announced a new version of its Flatirons Digital Hub for Healthcare revenue cycle management tool that reportedly supports checking AR balances, viewing and searching transaction histories, reviewing information on accounts paid by multiple parties like private insurance or Medicare and exporting AR data. The tool aims to help healthcare entities tied up in mergers and acquisitions blend companies' patient records into single databases while keeping electronic health records (EHR) and payment information easily available for audits, internal reviews and machine learning (ML) analysis.

Cash flow frictions and AR fixes

HEALTHCARE PROVIDERS SEE MORE OF THEIR COSTS GO UNCOMPENSATED

Hospitals are struggling to stay funded because they are receiving fewer reimbursements for the care they provide. Healthcare providers are left shouldering the expenses when programs like the Children's Health Insurance Program (CHIP) or Medicaid do not cover full medical costs, when patients fail to pay their shares of bills or when providers extend free or discounted services to those in need. This problem is worsening as healthcare bills rise: Total uncompensated care costs went up from $11.2 million in 2015 to $12.8 million in 2018.

Industry entities are left shortchanged or must turn to lawsuits when patients cannot pay their shares, a problem unlikely to go away. An increasing number of consumers are being pushed into health insurance plans with high deductibles: The average deductible tripled between 2009 and 2019 to $1,655 for employees with single coverage. Wages for most Americans have largely flattened during

© 2020 PYMNTS.com All Rights Reserved

this time period, too, raising the odds that consumers will be unable to keep up. Healthcare premiums regularly climb, furthering the gap between consumers' funds and their capabilities to pay. This trend explains the expanding gap between what healthcare providers charge for services and the amounts they actually receive: Uncompensated costs at hospitals with more than 250 beds rose 6.2 percent each year between 2015 and 2018, and those at hospitals with fewer than 25 beds rose 8.5 percent annually during that time.

TSI ACQUIRES ALLTRAN BRANCH TO CONNECT WITH MORE FINANCIAL SERVICES, FI CUSTOMERS

Such cash flow obstacles mean hospitals must ensure they collect on claims wherever possible. AR management and healthcare revenue cycle solutions provider Transworld Systems Inc. (TSI) is hoping to assist, boosting its offerings by entering a deal to purchase the financial services branch of revenue cycle management company Alltran. The arm provides AR management for the automotive, debt buyer, financial services and marketplace lending sectors and manages more than 180,000 accounts containing more than $600 million worth of receivables. TSI hopes the move will help it reach more U.S. financial institution (FI) customers.

The purchase combines TSI's 2,400 employees with Alltran Financial Service's 900 workers and is slated for completion in early 2020. It follows two other TSI acquisitions this year: Altisource Portfolio Solutions' financial services business and Credit Bureau of Lancaster County's collection portfolio. The former let TSI expand its presence in India and the Philippines

 © 2020 PYMNTS.com All Rights Reserved

and allowed it to build out its customer relationship management solutions, including AR. TSI made the latter acquisition to grow its healthcare reach in the mid-Atlantic.

CRESTMARK DEBUTS HEALTHCARE AR FINANCING DIVISION

B2B lending and financing-focused savings bank Crestmark is also wading into the healthcare financing space, recently announcing a new division to help healthcare businesses cope with overdue AR. Crestmark president Mick Goik said that these entities need help when insurance companies' slow payments cause cash flow interruptions, but that banks and other credit providers traditionally have not stepped up enough. Crestmark aims to bridge this gap, partnering with consulting firms that can help clients improve their revenue cycles. It already served healthcare sector clients prior to the launch but will now target more of its financing support to the industry.

© 2020 PYMNTS.com All Rights Reserved

DEEP DIVE

How Digital Upgrades Help Healthcare Providers' Cash Flows

Healthcare providers must carefully safeguard their cash flows to operate, but many face hurdles to getting fully compensated for provided services. The American Hospital Association (AHA) told PYMNTS via email that hospitals often prefer that insurance companies pay them through the low-cost, digital Healthcare Electronic Funds Transfer standard. Hospitals otherwise may get paid via paper check or virtual cards, but AHA said the high processing charges associated with the latter make it particularly undesirable.

Many steps precede insurers' fund disbursements, however. Reports show that healthcare providers can struggle to earn medical claim approvals. They must then decide whether to handle rejected claims by shifting bill responsibility to patients — a tricky move, given that many are too financially burdened to pay on time — or simply go unpaid for completed work. Those seeking to avoid such budgetary pains must encourage insurers to send electronic fund transfers (EFTs) as soon as possible.

One key intervention focuses on strategically filing claims to maximize approval odds, which can smooth healthcare providers' cash flows. The B2B reimbursement process is complicated and slow, however, and confusing legacy practices only exacerbate its drawbacks. Medical staff first record patients' diagnoses and treatments via descriptions and medical codes in their notes and later send this information to patients' insurance companies by postal mail, electronic submissions or third-party clearing houses. Insurers review these claims and determine the share they will pay based on healthcare provider contracts, plan coverages and internal evaluations of necessity, among other factors, then deliver reimbursements or reject the claims. Denials force healthcare providers to directly bill patients, give up on compensation or adjust their documentation and resubmit, creating other frictions.

Care providers are not helpless, however, and should respond to these growing compensation frictions by modernizing their AR practices and automating and digitizing filing and management systems. The following Deep Dive examines how such upgraded claims processes could give healthcare providers faster reimbursements.

THE HIGH COSTS OF CLAIMS ERRORS

Providers work several compensation models into their health insurance contracts, typically

© 2020 PYMNTS.com All Rights Reserved

submitting claims to firms for full or partial remuneration. Insurers review the claims to determine which prescriptions, procedures and supplies are covered under patients' plans and then reimburse healthcare providers for valid claims.

Alternative B2B payment structures are also being explored. Value-based care models see insurers pay hospitals based on the health of covered patient populations and the quality of services provided, rather than the specific treatments administered. One type of value-based care is bundled payments, which are handled in several ways. Insurers can pay healthcare providers in a lump sum that is then pay for all services administered and physicians. The sum may represent projected costs associated with particular medical conditions, and healthcare providers then pocket the difference if they spend below that amount and eat the costs if they go over.

Reimbursement methods in which providers submit claims for specific treatments and then wait to be compensated for the costs of each remain common, despite some appetite for exploring different models. This standard practice is not without pains, however. Misunderstandings can turn would-be approvals into denials for claims affecting services covered by patients' insurance plans, and procedure explanations or billable item code errors are often at fault. Hospitals faced 270 billion initial denials in 2016, one report noted, and another found $262 billion worth of claims — 9 percent of the $3 trillion submitted — were initially denied that year, though 63 percent of the latter were later successfully appealed.

UPGRADING INSURANCE CLAIMS FOR THE 21ST CENTURY

Healthcare providers may find disputing rejected claims and adjusting them for reappraisal to be overwhelming. Technological updates can help, and switching to electronic filing from paper can improve accuracy and efficiency. The nonprofit Council for Affordable Quality Healthcare reported in 2015 that providers spent $0.35 per electronically submitted claim — a significant savings over the average paper-based claim cost of $1.36.

Automated systems can also be trained to examine billing and coding accuracy, confirm that billed items are covered by plans and even alert remediation specialists to entries unlikely to be approved. This enables personnel to proactively tailor claims and possibly avoid lengthy denial and readjustment processes.

Numerous hurdles block healthcare providers from receiving full, speedy compensation for their work, but newer technologies could improve their chances of reimbursement and relax budgetary constraints. Claim-filing software solutions can play important roles in helping them improve their cash flows by reducing the likelihood that insurers will refuse bills, the first barrier standing in the way of insurers issuing timely digital payments. Such offerings can be powerful additions to healthcare providers' payments technology toolkits and make revenue collection smoother.

 © 2020 PYMNTS.com All Rights Reserved

ABOUT

PYMNTS.com

PYMNTS.com is where the best minds and the best content meet on the web to learn about "What's Next" in payments and commerce. Our interactive platform is reinventing the way companies in payments share relevant information about the initiatives that make news and shape the future of this dynamic sector. Our data and analytics team includes economists, data scientists and industry analysts who work with companies to measure and quantify the innovations at the cutting edge of this new world.

American Express is a globally integrated payments company, providing customers with access to products, insights and experiences that enrich lives and build business success. Learn more at americanexpress.com, and connect with us on Facebook, Instagram, LinkedIn, Twitter, and YouTube.

Key links to products, services and corporate responsibility information: charge and credit cards, B2B supplier center, business credit cards, travel services, gift cards, prepaid cards, merchant services, Accertify, InAuth, corporate card, business travel and corporate responsibility.

We are interested in your feedback on this report. If you have questions, comments or would like to subscribe to this report, please email us at feedback@pymnts.com.

 © 2019 PYMNTS.com All Rights Reserved

DISCLAIMER

The B2B Healthcare Payments Report may be updated periodically. While reasonable efforts are made to keep the content accurate and up-to-date, PYMNTS.COM: MAKES NO REPRESENTATIONS OR WARRANTIES OF ANY KIND, EXPRESS OR IMPLIED, REGARDING THE CORRECTNESS, ACCURACY, COMPLETENESS, ADEQUACY, OR RELIABILITY OF OR THE USE OF OR RESULTS THAT MAY BE GENERATED FROM THE USE OF THE INFORMATION OR THAT THE CONTENT WILL SATISFY YOUR REQUIREMENTS OR EXPECTATIONS. THE CONTENT IS PROVIDED "AS IS" AND ON AN "AS AVAILABLE" BASIS. YOU EXPRESSLY AGREE THAT YOUR USE OF THE CONTENT IS AT YOUR SOLE RISK. PYMNTS.COM SHALL HAVE NO LIABILITY FOR ANY INTERRUPTIONS IN THE CONTENT THAT IS PROVIDED AND DISCLAIMS ALL WARRANTIES WITH REGARD TO THE CONTENT, INCLUDING THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, AND NON-INFRINGEMENT AND TITLE. SOME JURISDICTIONS DO NOT ALLOW THE EXCLUSION OF CERTAIN WARRANTIES, AND, IN SUCH CASES, THE STATED EXCLUSIONS DO NOT APPLY. PYMNTS.COM RESERVES THE RIGHT AND SHOULD NOT BE LIABLE SHOULD IT EXERCISE ITS RIGHT TO MODIFY, INTERRUPT, OR DISCONTINUE THE AVAILABILITY OF THE CONTENT OR ANY COMPONENT OF IT WITH OR WITHOUT NOTICE.

PYMNTS.COM SHALL NOT BE LIABLE FOR ANY DAMAGES WHATSOEVER, AND, IN PARTICULAR, SHALL NOT BE LIABLE FOR ANY SPECIAL, INDIRECT, CONSEQUENTIAL, OR INCIDENTAL DAMAGES, OR DAMAGES FOR LOST PROFITS, LOSS OF REVENUE, OR LOSS OF USE, ARISING OUT OF OR RELATED TO THE CONTENT, WHETHER SUCH DAMAGES ARISE IN CONTRACT, NEGLIGENCE, TORT, UNDER STATUTE, IN EQUITY, AT LAW, OR OTHERWISE, EVEN IF PYMNTS.COM HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

SOME JURISDICTIONS DO NOT ALLOW FOR THE LIMITATION OR EXCLUSION OF LIABILITY FOR INCIDENTAL OR CONSEQUENTIAL DAMAGES, AND IN SUCH CASES SOME OF THE ABOVE LIMITATIONS DO NOT APPLY. THE ABOVE DISCLAIMERS AND LIMITATION`S ARE PROVIDED BY PYMNTS.COM AND ITS PARENTS, AFFILIATED AND RELATED COMPANIES, CONTRACTORS, AND SPONSORS, AND EACH OF ITS RESPECTIVE DIRECTORS, OFFICERS, MEMBERS, EMPLOYEES, AGENTS, CONTENT COMPONENT PROVIDERS, LICENSORS, AND ADVISERS.

Components of the content original to and the compilation produced by PYMNTS.COM is the property of PYMNTS.COM and cannot be reproduced without its prior written permission.