

The Basics

- A consumer-owned, tax advantaged savings account created to pay medical expenses and combined with a high deductible health plan
- Tax free contributions by employer or employee
- Tax free growth of interest or investment earnings
- Tax free disbursement of principal and interest to pay for medical expenses
- Accumulation of unused funds and portability between employers
- Flexible use now or after employment (no use it or lose it)

Why?

- Benefits Employers – costs of providing health care reduced
- Benefits Employees (maybe)
 - Savings plan with tax advantages
 - Increased consumer accountability
 - “Our consumers don’t have to pay retail for health care”
- Benefits carrier

Recent Survey Results

- Only 1% of eligible population are enrolled in CDHPs or HDHPs
- CDHPs are no more likely to have been uninsured prior to enrolling in their plans than more comprehensive plans
- While the law allows people with HDHPs to cover the cost of preventative services, more than half of people in CDHPs have deductibles that apply to all health care services
- People in CDHPs are more likely to miss or delay care
- People enrolled in CDHPs do not report having access to more info re cost and quality of providers
- Only 25% of people with CDHP have more than \$1000 in their account
- People with comprehensive plans report being much more satisfied than those with CDHPs or HDHPs
- There may not be savings for many companies when you add the contribution to the premium

Who does this benefit?

- Highly paid individuals
- Budget constrained
- Planners and savers

The price transparency issue

- At this point, price shopping is nearly impossible
- Will price transparency drive reimbursement up or down?
- Aetna example in PA
- What about quality measures?

What are the concerns for medical practices that need to be addressed?

- Should the contracted rate be extended when timeliness and payment mechanisms are very different than a traditional plan
- AR/collections problems – costs will increase, cash flow will lag, increased bad debt
- Will patient volume increase or decrease?
- This is based on price competition theory, why then stick to contracted rates?
- What about patients that are out of network? How does this affect the deductible?
- Non-covered services – make sure no discount is applied, don't bill
- As quality data is accumulated, what will be measured? Parking, appts, wait-time, e-mail communications, real time test results
- Will clinical efficiency slow down as patients demand more time with providers? Will patients demand convenience? May be good to start patient satisfaction surveys.

What can you do?

- Negotiate “all products” contract language
- What patient fees can be collected at the time of service?
- Know approximately how much will be applied to the patient's deductible
- Get debit card number if permitted (get ability to process)
- Revise your financial policy if necessary
- Assess your collection policies

The future

- Remains to be seen, PPOs took 10-15 years to overtake HMOs
- The AMA supports CDHPs
- Presidential elections

FSA vs HRA vs HSA

UnitedHealthcare®

Feature	“Traditional” Approach	New Approach	Newest Approach
Plan Design	FSA Flexible Spending Account Any type	HRA Health Reimbursement Account Any type	HSA Health Savings Account Qualified HDHP
Employee Contributions	Pre-Tax	N/A	Pre-Tax
Employer Contributions	Yes, but typically employee-funded	Yes	Yes
Funds Available Day One	Yes	Yes	As Deposited
Withdrawal	Tax-free for qualified expenses	Tax-free approved by sponsor	Tax-free for qualified expenses
Qualified Expenses	Section 213d	Section 213d or sponsor specific	Section 213d
Forfeiture	Yes, at end of year	Yes, upon termination	No
Portability	No	No, but some exceptions	Yes
Interest Bearing	No	No	Yes
Balance at Risk from Investment	N/A	N/A	Yes
Expense Substantiation	Yes	Yes	No
Above-the-line Tax Deduction	N/A	N/A	Yes – no itemization required

It just makes sense.

Claim Payment process for a High-Deductible Health Plan paired with a Health Savings Account (HSA)

In-network physician files electronic claim to health plan
For sick office visit, e.g. \$125



Claim adjudicated under patient's medical benefit; Physician's discounted amount of \$ 75 is applied to patient's deductible of \$ 2,000 leaving \$ 1,925 remaining



Patient liability of \$ 75 is determined and applied to the deductible.
Explanation of Benefits (EOB) statement is created and submitted to physician and patient.



Physician receives EOB and bills patient the amount due - \$ 75.

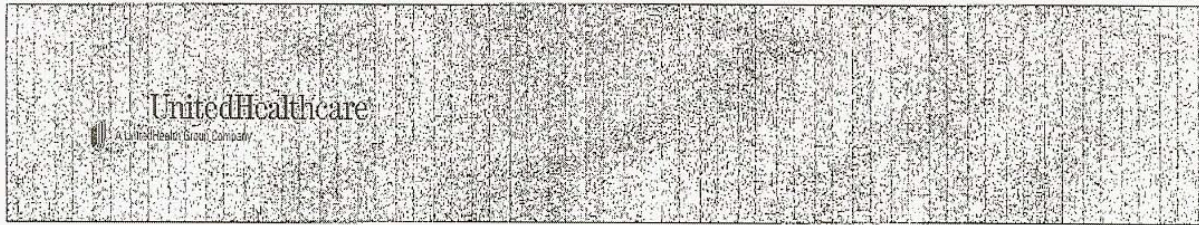


Physician awaits payment.

Some health plan contracts will allow for the collection of patient fees at the time of service while others will prohibit any direct patient payments at the time of service until the claim has been processed resulting in an EOB indicating the patient's financial responsibility. Bottom line is, "Know your contracts".

To reduce the likelihood of increased bad debt expenses and maintain positive cash flow, it may be best, if contractually able, to collect the negotiated rates from the patient at the time of service. If collecting too much at the time of service, patient refunds will be necessary.

Under HDHP/HSA plans, most preventive services are covered at 100% with a possible copayment due from the patient.



Important Information for Medical Professionals about UnitedHealthcare's DefinitySM HSA

Attention: Doctors, Hospital Staff and all appropriate billing and administrative personnel
Re: Billing Procedures for Definity HSA members

UnitedHealthcare is committed to improving the health care experience for everyone involved: the employers who purchase it, the doctors who deliver it, and most of all, the people who receive it. For example, our recently introduced consumer-driven health plans, (CDHPs) put more decision-making power in the hands of consumers. UnitedHealthcare's Definity HSA is an example of a CDHP in that it pairs a tax-advantaged account for qualified health expenses with a high-deductible medical plan. Members are responsible for managing how the account is used for payment of services.

Please follow these steps concerning claims processing for Definity HSA members:

1. Ask the member to show his or her UnitedHealthcare Definity HSA medical ID card. Contract numbers appear on the front of the card.
2. Please do not ask members to pay any copayment or deductible at the time of service.
3. Submit all claims to the mailing address on the back of the member ID card. UnitedHealthcare will pay the claim based on the member's medical plan and inform the member of any remaining balance s/he owes to you. The member will then pay any amount due to you directly.

UnitedHealthcare has an established tradition of supporting the doctor-patient relationship by not requiring prior authorization, procertification, or referrals for specialty care. The Definity HSA plan continues this tradition.

Members should notify UnitedHealthcare of any inpatient admissions and certain other procedures as described in their plan documents.

Thank you for your attention to this process.

For questions, eligibility and benefit verification, call your physician service number or Customer Care at the number on the back of the member's ID card.

Reminder about BCBSNC Provider Collections Policy for Blue OptionsSM Deductible and Coinsurance-Only Products



Effective January 1, 2006, we began offering new product choices, Blue Options HSASM and Blue Options HRASM, to our members. These are high-deductible health plans that do not have copayments. They are deductible and coinsurance plans with some preventive care options, and present a different collecting environment for you, the provider.

In the past, BCBSNC's policy for all products was that participating providers should not collect upfront funds from the member (other than copayments) until the Explanation of Payment was received from BCBSNC indicating the correct amount to be collected. This policy is being altered for Blue Options HSA and Blue Options HRA products. And in order to provide you with a consistent collection policy, it will also apply to all Blue Options non-copayment products and plans.

New Collection Policy Statement

For any Blue Options deductible and coinsurance-only product (not copayment products), BCBSNC's in-network providers (including physicians, professional providers, hospitals and ancillary providers) may collect an estimated amount from the member at the time of service for the member's out-of-pocket costs, as described below. To determine whether a product is covered under this policy, check the member ID card to make sure that both of the following criteria are met: 1) The ID card indicates a *coinsurance* amount for physician services. If so, it is a deductible and *coinsurance*-only product; or, 2) The ID card indicates a *copayment* for physician services, which means it is not subject to this policy and no estimated amounts should be collected for any service by any provider.

Make sure that the card indicates that the product is a Blue Options product (including Blue Options HRA and Blue Options HSA). If the card does not indicate Blue Options, it is not subject to this policy and no estimated amounts should be collected. In all cases, in-network hospitals and providers are required to check for a member's remaining deductible or coinsurance amounts using sources such as RealMed, Blue eSM, or BCBSNC Customer Service. Keep in mind that these sources provide the most accurate information available at the time, as the information provided on the Explanation of Payment (EOP) from BCBSNC may differ based on claims that were in transit to BCBSNC or any applicable adjustments.

The limitations on the collection of estimated amounts are as follows:

Physicians or professional providers may collect up to ***the lesser of the member's estimated out-of-pocket costs or \$50*** for services received in the provider's office, including services rendered in a hospital-owned clinic.

Hospitals and ancillary providers may collect up to ***the lesser of the member's estimated out-of-pocket costs or \$500*** for services received in a hospital or outpatient facility such as an emergency room or ambulatory surgery center. ***Providers must inform the member that the amount being collected is an estimate. Providers must also calculate the member's out-of-pocket costs based on the lesser of the allowed (contract) amount or billed charges, taking into account the member's benefit year-to-date deductible or coinsurance benefit status (amount met).***

The final determination of what the member owes will be based on the claim that is submitted to BCBSNC, and will be reflected on the EOP. Any applicable refunds due to the member must be returned within 45 days. If a member is unable to pay at the time of service, the provider should not refuse to provide necessary treatment to the member. If they choose (and if funds are available), the member can use funds from their HSA or HRA to pay for these services.

The provider should be aware of the tax implications if funds are withdrawn for nonqualified medical expenses or for expenses that the member did not incur, without subsequent and timely correction by the member. The member will need to take responsibility for correcting any incorrect withdrawals. Therefore, if your estimated collection was too high, and you are aware that the member used an HRA or HSA fund, you should remind the member to make the appropriate correction.

Again, please note that the current policy for the collection of copayments, deductibles and coinsurance amounts for those members enrolled in copayment products and non-Blue Options products has not changed.