



Partnering for Electronic Delivery
of Information in Healthcare

WEDI HSA/HDHP Business Models

Presented by:

Laurie Darst, Mayo Clinic

Pam Stenman, Aetna Inc.

◆ Business Process Workgroup Goal

- identify various business models associated with High Deductible Health Plans (HDHPs) and the associated Health Savings Accounts (HSAs)
- identification of workflows and data flows of the key health care stakeholders
- recommend enhancements to workflows, data flows, transactions, and tools to assist key stakeholders (to be addressed in future work products)

HDHPs, HSAs and Consumer Choice

- ◆ HDHPs with HSAs allow for greater consumer involvement in choosing how to spend their health care dollars
- ◆ Consumers may be presented with new requests to pay for services in advance of or at the time of service rather than after the service
- ◆ Consumers need information prior to seeking services in order to make informed choices on how to spend their healthcare dollars and to be prepared to make payment
- ◆ Health Plans and HSA Administrators are developing more payment options for consumers to assist consumers with paying for their portion of healthcare expenses

Provider Workflows for Collecting Patient Responsibility Amounts

- ◆ Three points where providers may collect personal responsibility amounts:
 - ◆ Pre-service deposit
 - ◆ Point of Service
 - ◆ Collection after insurance has paid

WEDI HSA/HDHP Business Models

◆ Models Developed by Workgroup:

- Model 1-Patient Assigns Health Plan benefits and is responsible for any remainder
- Model 2-Patient Assigns Health Plan benefits and permits payment of HSA funds by Health Plan
- Model 3-Patient Assigns Health Plan benefits and permits payment of HSA funds by Financial Institution
- Model 3a-Patient Assigns Health Plan benefits and permits payment of HSA funds by Financial Institution via hold on card
- Model 4-Patient does not assign Health Plan benefits and is responsible for total payment
- Model 5-Patient assigns Health Plan benefits and arranges for full payment by Health Plan

Model 1 – Patient Assigns Health Plan benefits and is responsible for any remainder

- ◆ Patient does not have any arrangement for a third party to make payments from HSA on their behalf
- ◆ This is the primary way business is conducted today
- ◆ Patient may pay responsibility utilizing cash, check, credit card, debit card, or on-line bill pay

Model 2-Patient Assigns Health Plan benefits and permits payment of HSA funds by Health Plan

- ◆ Patient permits Health Plan to make payments from HSA account
- ◆ Patient responsible to pay any remaining balance

Model 3 - Patient Assigns Health Plan benefits and permits payment of HSA funds by Financial Institution

- ◆ Financial institution provides service to patient where they agree to make payment to the provider on patient's behalf
- ◆ Health Plan forwards patient responsibility to financial institution



Model 3a-Patient Assigns Health Plan benefits and permits payment of HSA funds by Financial Institution via hold on card

- ◆ Financial institution involvement is through presentation of a card at time of service and a **hold** being placed on cardholder's account
- ◆ Health Plan forwards patient responsibility to financial institution
- ◆ Payment is then made to provider through normal arrangement between provider and card association

Model 4 - Patient does not assign Health Plan benefits and is responsible for total payment

- ◆ Patient may no longer have a Health Plan or may have a Health Plan not associated with their HSA account
- ◆ Provider does not accept assignment of benefits
- ◆ Patient is utilizing out of network provider and/or does not assign benefits

Model 5 - Patient assigns Health Plan benefits and arranges for full payment by Health Plan

- ◆ Patient has arrangement with Health Plan to make full payment for health care expenses on their behalf
- ◆ Health Plan may be working with a financial institution partner to support the financial business processes associated with lending and collecting on behalf of the patient

Universal Challenges

- ◆ Patient Education-Patients don't fully understand HDHPs & HSAs and their financial responsibility
- ◆ Providers need more information on types of plans and payment methods offered by specific Health Plans for specific patients
- ◆ Health Plans don't have the tools to fully communicate new types of plans/payment arrangements (e.g., patient payment in ERA)
- ◆ Providers challenged with increasing bad debt-need to explore workflow changes and tools that can help mitigate risk
- ◆ Standard process for handling of payment corrections and transferring dollars (e.g., refunds) in each of the models has not been defined

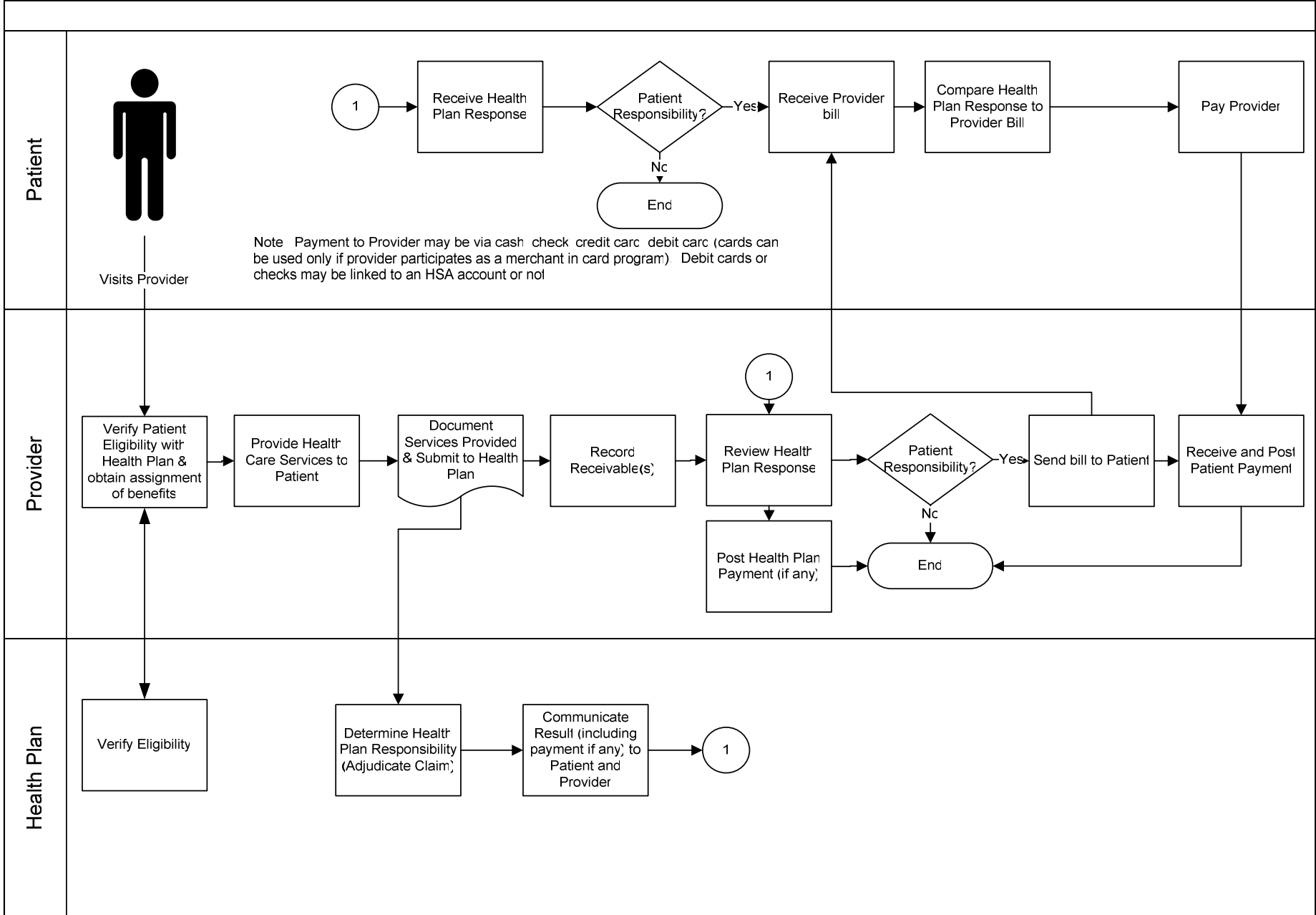
Universal Challenges, continued

- ◆ Health Plan coordination of the deductible for plans with carve-out services (e.g., Rx and mental health)
- ◆ Communication standards between health plans and financial institutions
- ◆ No common definition of preventive services
- ◆ Privacy concerns
- ◆ Authorization management
- ◆ Varying approaches when there are insufficient funds in HSA (partial payment vs. no payment)
- ◆ Financial Institutions don't have the tools to fully communicate health plan data associated with financial transactions

Tools – Initial Thoughts

- ◆ Tools for Patient to estimate the cost of services they are seeking and how much they may need to pay out of pocket based on their current benefit situation including impact of contracted rates between health plan and provider
- ◆ Transparency-Providers should have quality and cost information available to patients
- ◆ Payor specific estimators that can be used while patient is in the office (near term) – used more for pre-service deposit, including impact of contracted rates between health plan and payor.
- ◆ Eligibility information that provides more data (near term), deductible information, current remaining balance of deductible, what preventive services are covered prior to the deductible and at what level, information about patient payment service provided by the health plan or lack thereof
- ◆ Predetermination of benefits
- ◆ Additional information on ID cards
- ◆ Real Time Adjudication to determine patient balance while in the office and explain to the patient how their balance was determined (long term), means it happens after the service is provided - more for post service payment, would need timely response back as well as fast way to submit (timely), accurate, automated interface
- ◆ Develop a standard to identify patient payment in ERA that is being made by health plan.
- ◆ Industry standard list of codes that are agreed to be preventive
- ◆ Model workflows for various scenarios (focus on the patient)

Model 1 – Patient assigns Health Plan benefits and is responsible for any remainder



Model 1-Patient Challenges

PATIENT EDUCATION: (applies to all models):

- ◆ Patient doesn't read through or understand the details communicated in materials provided to them from the health plan or financial institution
- ◆ Patient has deductible based plan and may not be aware of where they are in their deductible.
- ◆ Patient may not understand their full responsibility under their health plan, in addition may not understand their full benefits under the plan, i.e., what is covered at what level, preventative benefits.
- ◆ Patient may not know the balance of their HSA.
- ◆ Confusion on how to access their HSA funds.
- ◆ Patient needs to be aware of daily limits that may be placed on Card activity.

Model 1-Patient Challenges

- ◆ Patient may not expect to have to pay up front when asked by provider
- ◆ Patient may not know how much they should pay up front when asked by provider when the provider has a contractual relationship with health plan
- ◆ Payment corrections may cause confusion/frustration to patients, in some situations, the patient may be required to pay more than they thought
- ◆ Potential increase in patient responsibility due to Preventive Medicine coding issues
- ◆ Multiple providers seen on the same day may cause incorrect payment amounts if pre-service deposit or point of service payment was required
- ◆ Potential access issues to HSA account when patient is family member and not owner of HSA account

Model 1-Provider Challenges

- ◆ As patient responsibility amounts increase with new style health plans, potential for provider bad debt to increase
- ◆ Provider is not aware of the amount of the deductible or where the patient is in their deductible
- ◆ Patient may have been told by health plan not to pay provider until after the claim is adjudicated by Health Plan even when there is no contractual relationship between provider and Health Plan
- ◆ Provider under contract with the Health Plan may be prohibited from billing patient at time of service
- ◆ Provider may not know how much they can charge for the service if they are under contract with the Health Plan until the claim has been adjudicated by the Health Plan
- ◆ Provider may not understand what services are covered as preventative (coding?)
- ◆ Integration issues – Limitations of existing Practice Management Systems - cost and need for upgrades

Model 1-Provider Challenges

- ◆ Provider may not have the ability to collect patient payments via a debit or credit card if they are not a registered merchant under the entity supporting the card (Mastercard or Visa) and may not have the card swipe machine.
- ◆ Multiple providers seen on the same day or other carve out charges may cause incorrect amounts collected if done as pre-service deposit or point of service
- ◆ Managing patient responsibility expectations when services go beyond original estimated amount due to complications, etc.
- ◆ Some providers don't have front office processes to collect patient responsibility dollars
- ◆ Provider front offices need to know Health Plan contractual relationship when discussing with patient
- ◆ Increase in refunds if provider collects too much money based on estimated amount of personal responsibility
- ◆ Provider needs to be aware that daily limits may be placed on Card activity.

Model 1-Health Plan Challenges

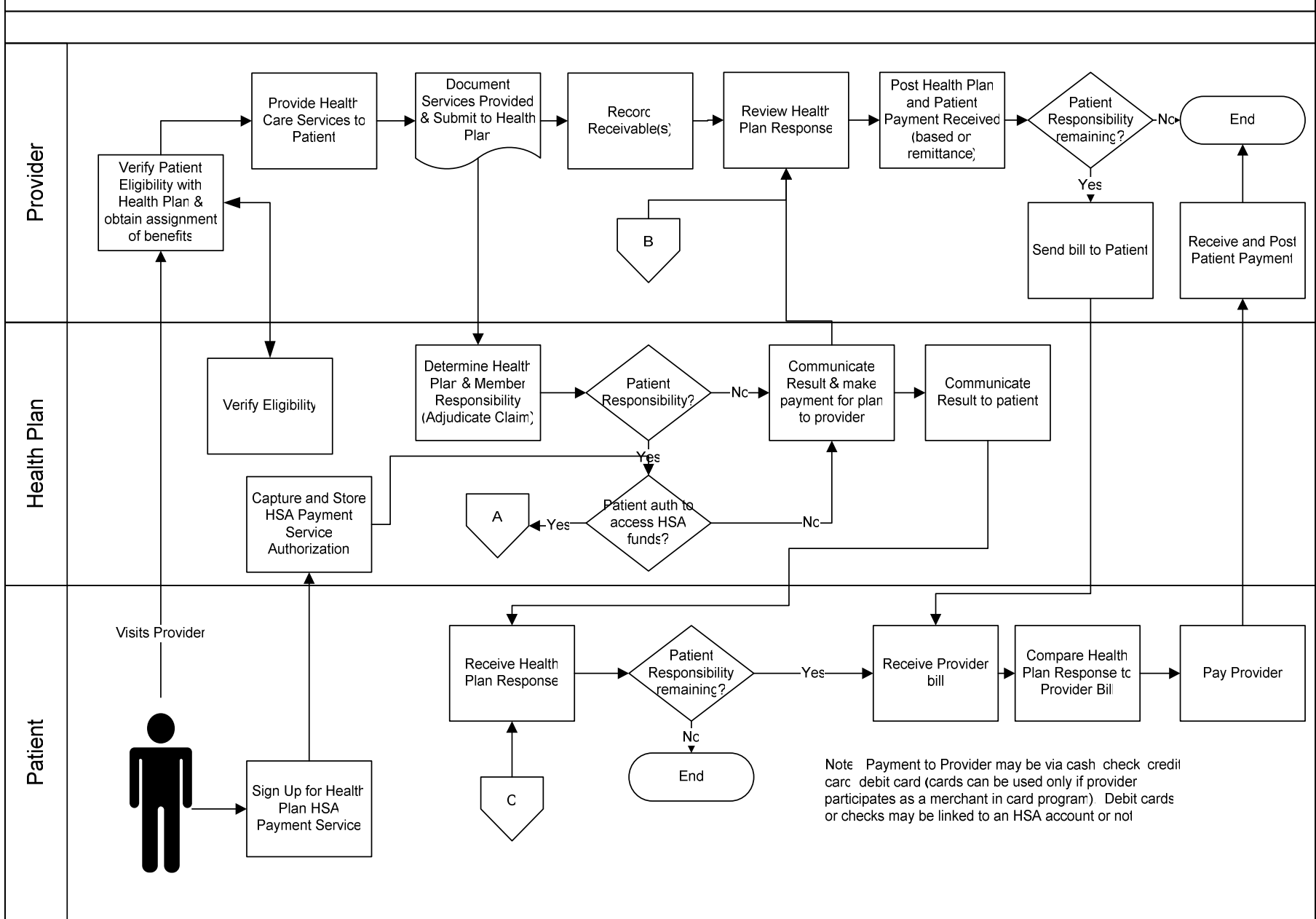
- ◆ May not be able to effectively communicate plan deductible information to providers and members
- ◆ May be challenged as to how to ensure patients and providers understand benefit plans
- ◆ May not be able to effectively coordinate the deductible for carve out benefits such as Rx or Behavioral Health with an external benefit manager



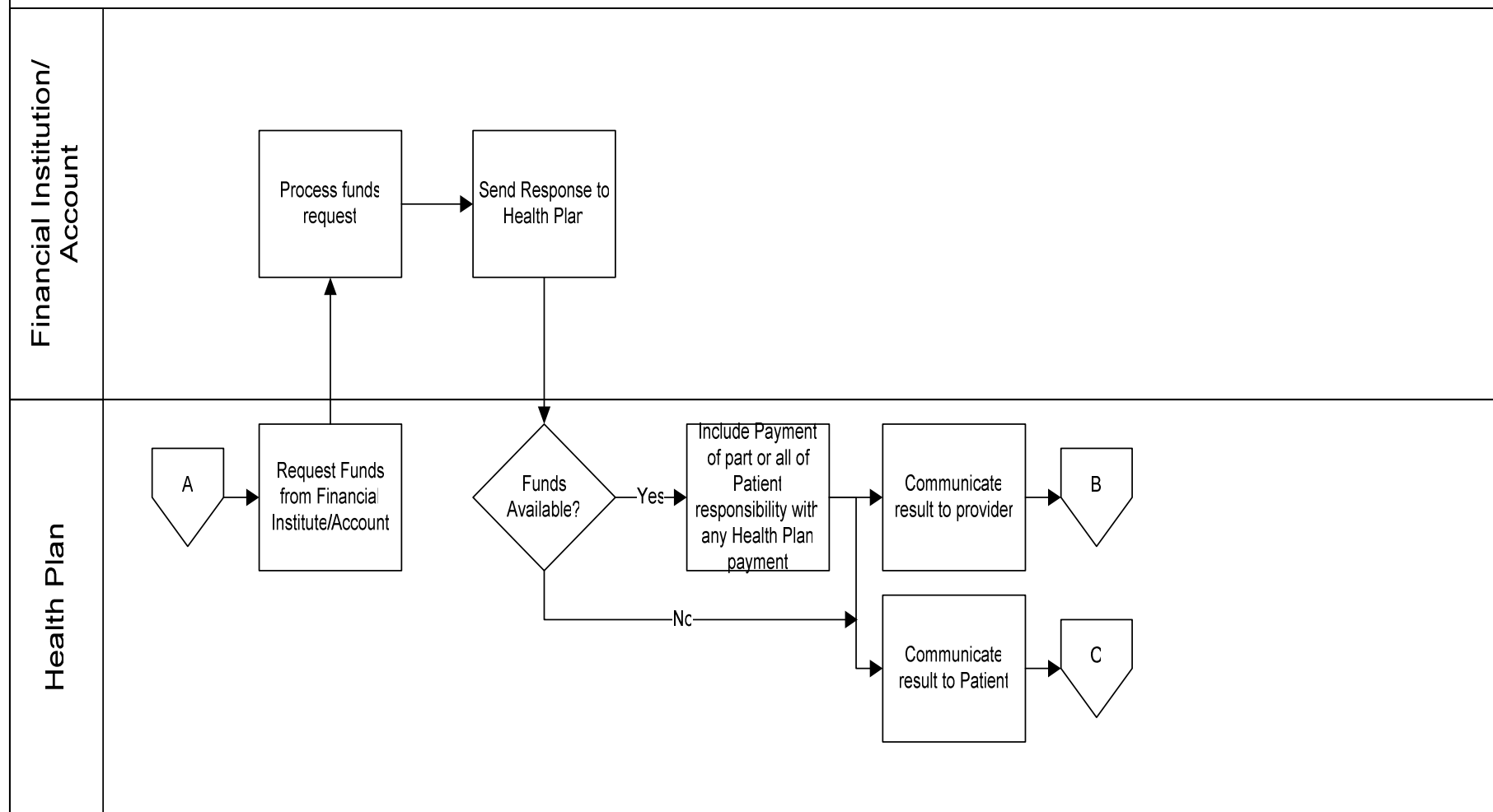
Model 1 Financial Institution Challenges

- ◆ Daily card limits need to be set at a level that is appropriate to balance fraud concerns with the ability for patients to pay medical expenses.
- ◆ Providing HSA Accountholders with a method to return erroneously withdrawn funds to ensure no negative tax implications
- ◆ Financial Institutions need to provide more education

Model 2 – Patient assigns Health Plan benefits and permits payment of HSA funds by Health Plan



Model 2 – Patient assigns Health Plan benefits and permits payment of HSA funds by Health Plan (continued)



Model 2-Patient Challenges

- ◆ See information from Model 1
- ◆ Patient may not understand the payment service they signed up for.
- ◆ Patient needs effective way to manage authorization for payment service.
- ◆ Patient may or not know their HSA balance.
 - Insufficient funds in account to pay personal responsibility in full
- ◆ Patient handling of corrections to payments made on their behalf.
 - Understanding of tax liability if too much money pulled from HSA account
- ◆ Funds deposited in HSA may not yet be available for use.

Model 2-Provider Challenges

- ◆ See information from Model 1
- ◆ Provider needs a way to be aware that the patient has a payment service with the health plan.
- ◆ Provider needs clear communication of payment details that distinguish plan payment from patient payment.
- ◆ Providers need to be able to indicate any personal payment received from the patient on the claim
- ◆ Provider is not guaranteed that there are sufficient funds for health plan to make full patient payment.
- ◆ Provider handling of payment adjustments when corrections are made to prior payments.
 - How to return funds to HSA account sent to provider by Health Plan (need standard)

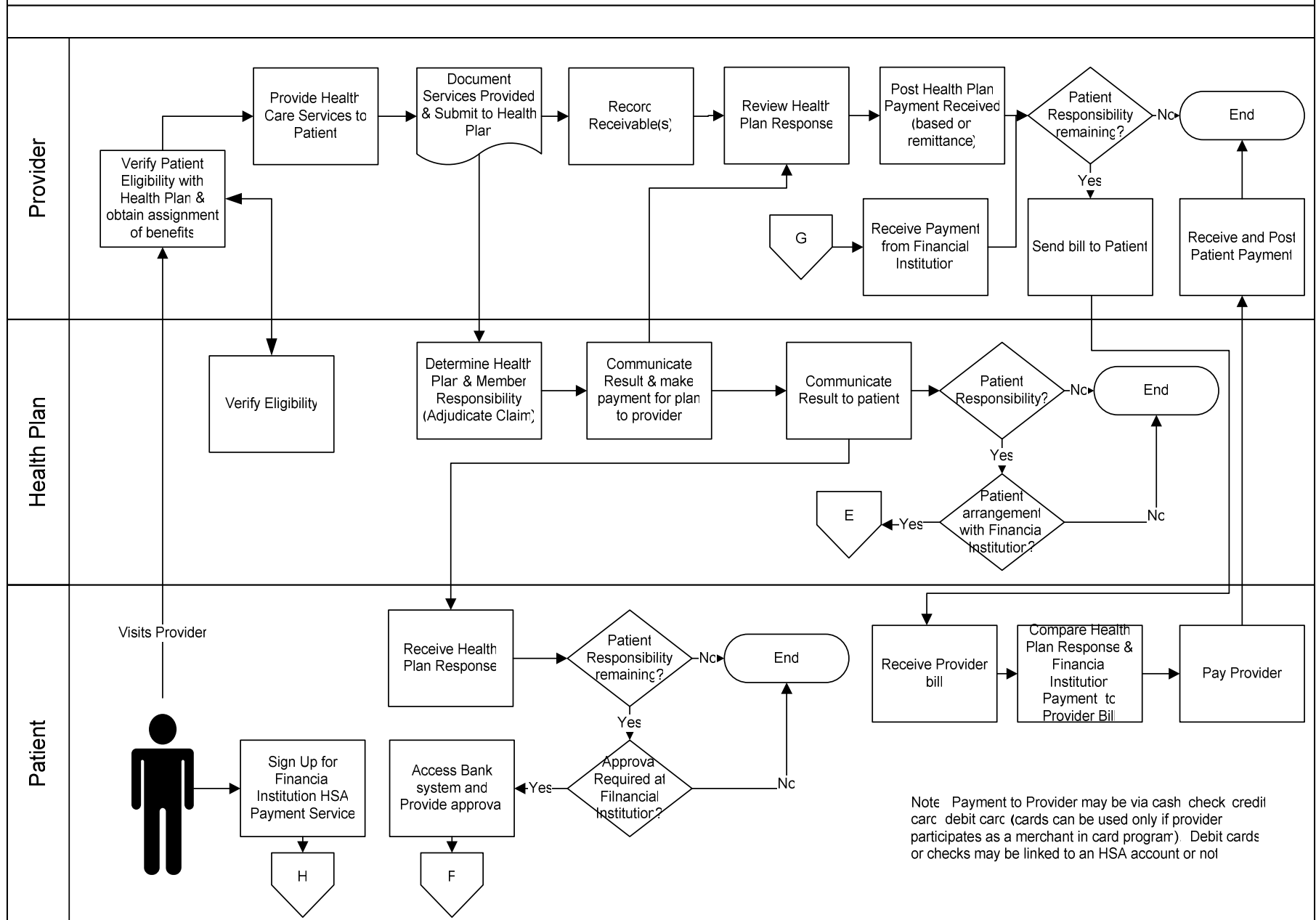
Model 2-Health Plan Challenges

- ◆ See Information from Model 1
- ◆ Health Plan needs clear way to communicate payment details
- ◆ Limit delay between Health Plan adjudication and financial institution responding with HSA payment
- ◆ Health Plans need a way to clearly deal with corrections to payments made (need standard)
- ◆ Health Plan needs effective way to manage patient authorizations for making payments on their behalf
- ◆ Health Plans need to set up infrastructure (e.g. web) to communicate HSA information to patient

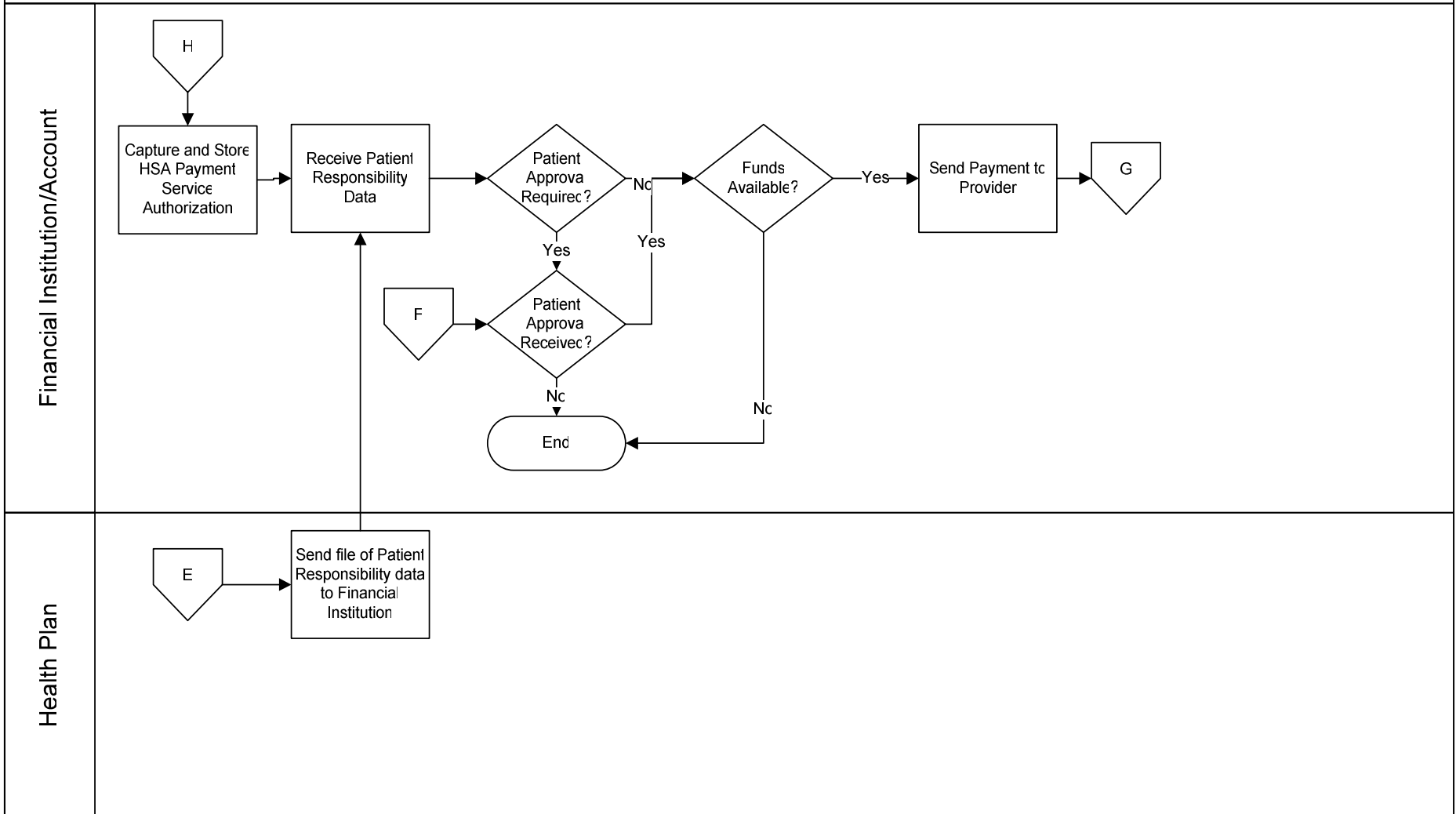
Model 2 Financial Institution Challenges

- ◆ See information from Model 1
- ◆ Communication method between the Health Plan and Financial Institution
- ◆ Standardized approach when there are insufficient funds in HSA
 - Partial payment vs. denial
- ◆ Limit delay between Health Plan adjudication and financial institution responding with HSA payment
- ◆ Financial Institutions need way to clearly deal with corrections to payments made (need standard)

Model 3 – Patient assigns Health Plan benefits and permits payment of HSA funds by Financial Institution



Model 3 – Patient assigns Health Plan benefits and permits payment of HSA funds by Financial Institution (continued)



Model 3-Patient Challenges

- ◆ See information in Model 1
- ◆ Need to understand how information is exchanged between the Health Plan and Financial Institution and the authorization process required
- ◆ Under the “on-line bill pay scenario” the patient needs to be closely involved with potentially authorizing transactions for payment as they come through
- ◆ Under agreement with financial institution, the patient may be giving one time authorizations for funds to be spent as expenses come through and may not be fully aware that they need to monitor availability of remaining funds.
- ◆ Financial institution may not provide enough detail on payment statement to allow matching to specific patient, date of service, and claim event. Information about remaining balance for that claim may not be provided.

Model 3-Provider Challenges

- ◆ See Information in Model 1
- ◆ Provider needs a way to be aware that the patient has a payment service with the financial institution
- ◆ Information from financial institution may not clearly indicate what service and patient the expense is being paid for
- ◆ Providers need to be able to indicate any personal payment received by the patient on the claim
- ◆ Provider is not guaranteed that there are sufficient funds for financial institution to make full patient payment
- ◆ Provider handling of payment adjustments when corrections are made to prior payments
 - How to return funds to HSA account sent to provider by Financial Institution (need standard)

Model 3-Health Plan and Financial Institution Challenges

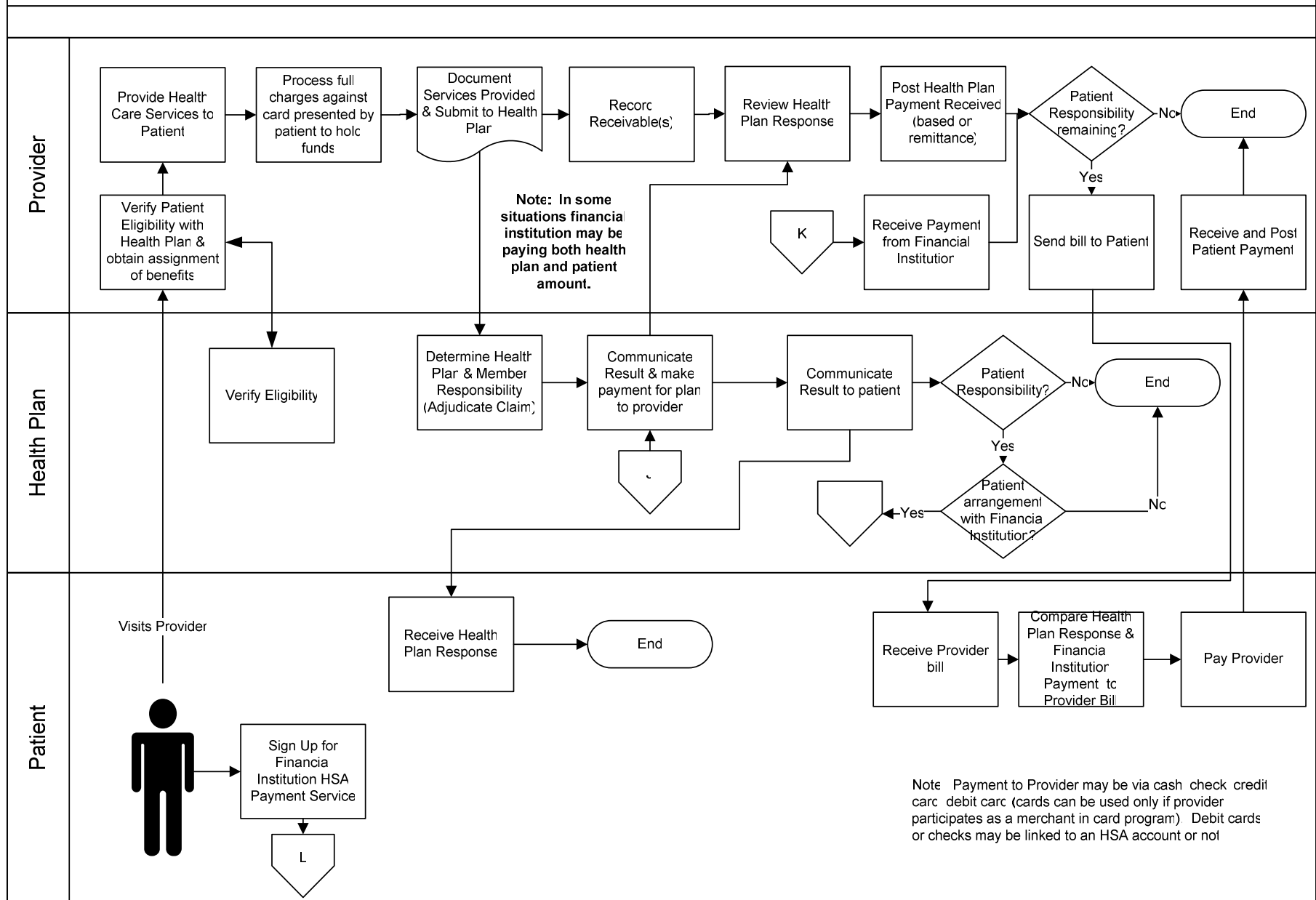
◆ Health Plan Challenges:

- No standard for how to send data to financial institution under these types of arrangements.
- Capturing Health Plan authorization from patient to send information to financial institution.
- Potential HIPAA Issue - Is the Financial Institution a business associate and are they receiving protected health information?
- What is the minimum necessary data needed to send to financial institution for them to make the HSA payment?

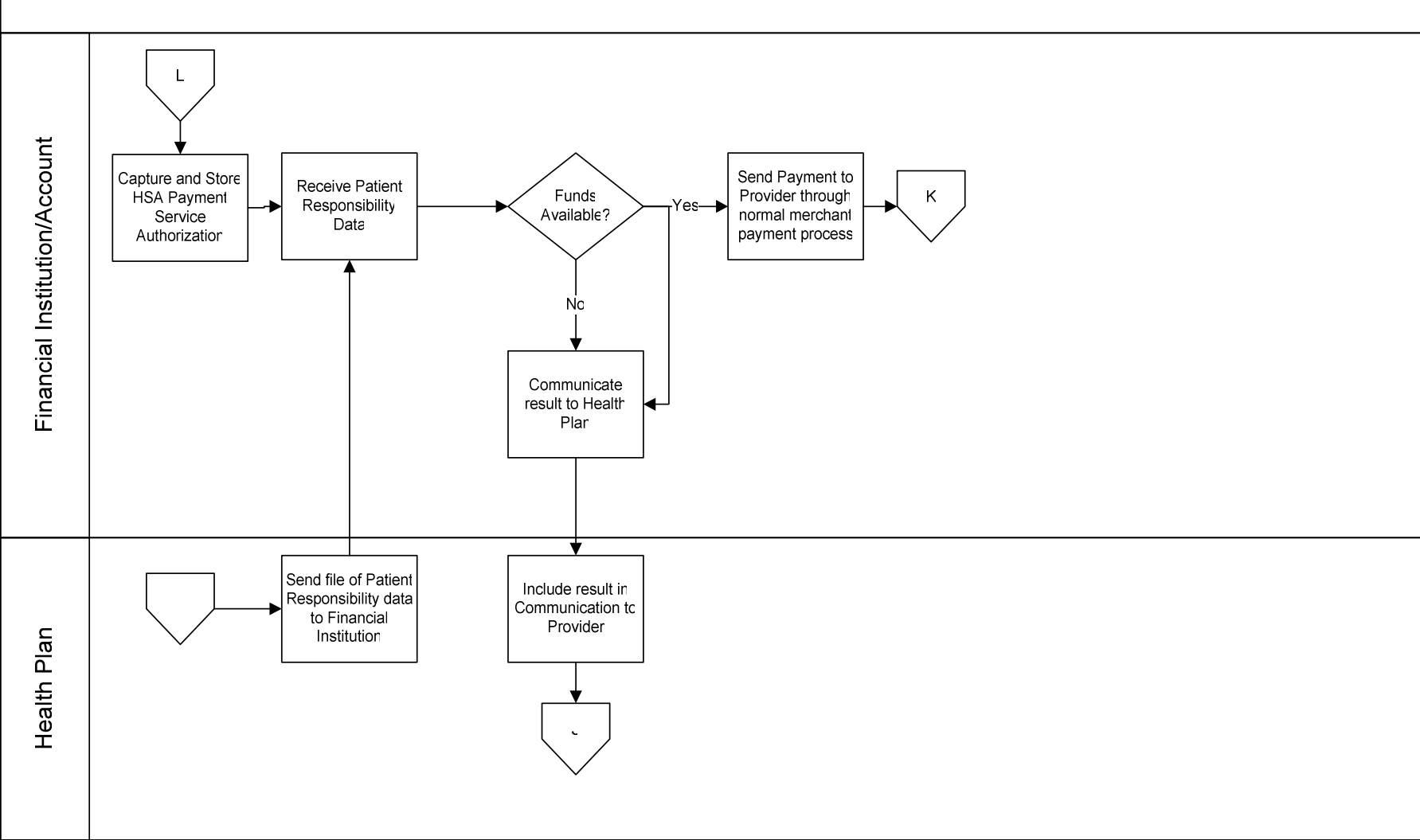
◆ Financial Institution Challenges:

- Communication method between Health Plan and financial institutions.
- Providing clear communication to patients on events that payments relate to.
- What is the minimum necessary data needed to send providers for them to post the HSA payment to the correct service visit?

Model 3a – Patient assigns Health Plan benefits and permits payment of funds by Financial Institution via Hold on Card



Model 3a – Patient assigns Health Plan benefits and permits payment of funds by Financial Institution via Hold on Card



Model 3a-Patient Challenges

- ◆ Under “hold” scenario patient must understand how and when funds are really being withdrawn and paid to provider.
- ◆ Financial institution may not provide enough detail on payment statement to allow matching to specific patient, date of service, and claim event. Information about remaining balance for that claim may not be provided.
- ◆ Hold may be on the card for more than the final charges and patient may need to monitor that the hold is released. Patient also may not be aware of how long hold will be on the funds/card.
- ◆ What communication is sent from Financial institution to patient so that they understand that when transactions are a “hold” versus an actual charge.
- ◆ Error on a charge or “hold” processed immediately but the reversal not processed until up to 5 days later, potential to cause overdrafts and associated charges.
- ◆ If personal responsibility ends up being more than “hold”, patient will need to pay balance. May need to swipe card again.

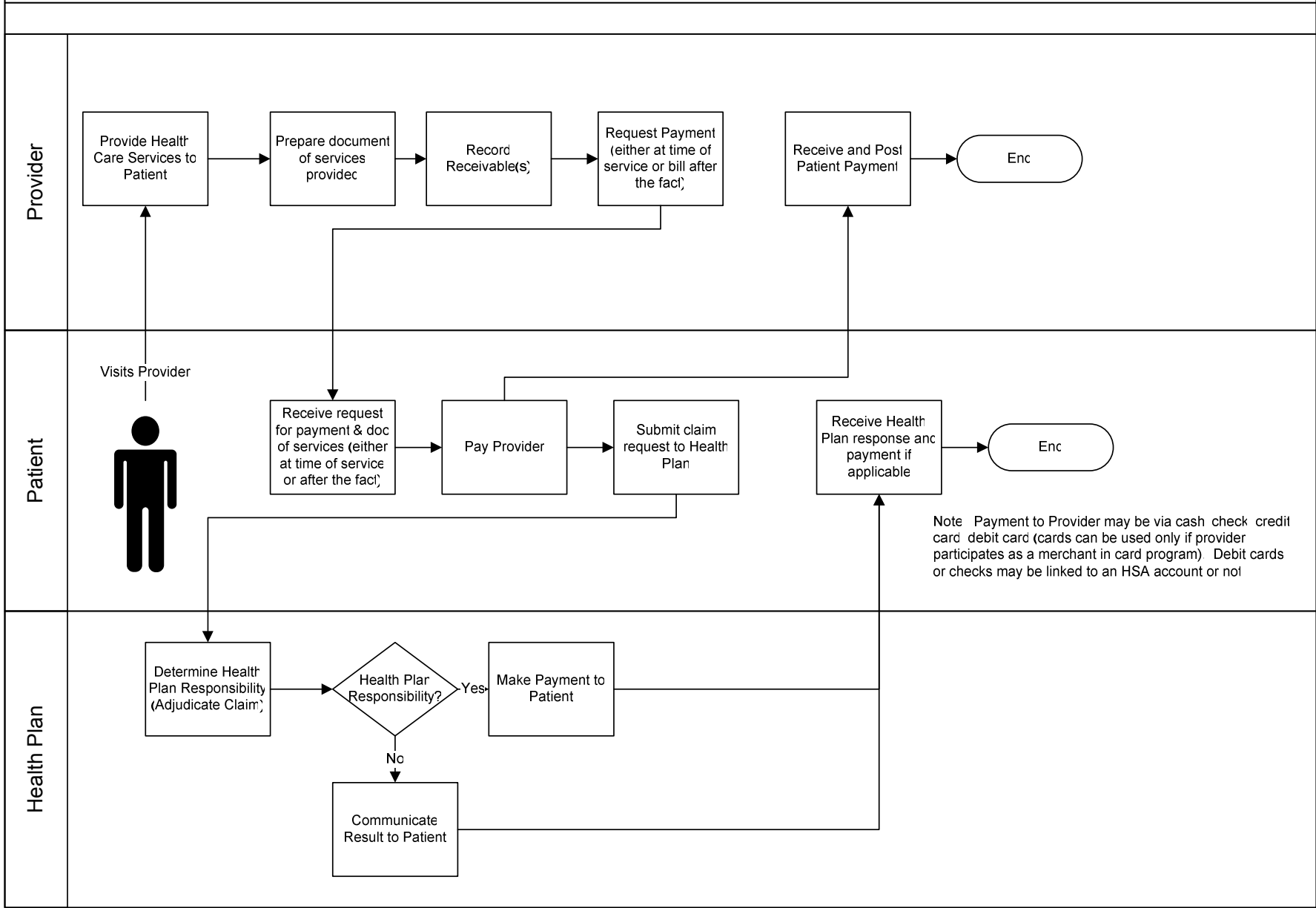
Model 3a-Provider Challenges

- ◆ Provider knowledge of and accounting for credit card “hold” option.
- ◆ Information from financial institution may not clearly indicate what service and patient the expense is being paid for.
- ◆ Provider may be challenged to reconcile the card activity with actual payments under the “hold” scenarios.
- ◆ Bookkeeping processes needed to accommodate credit card hold
- ◆ Contracts may need to be amended to allow providers to collect patient responsibility prior to claim adjudication

Model 3a-Health Plan and Financial Institution Challenges

- ◆ Health Plan Challenges:
 - No standard for how to send data to financial institution under these types of arrangements.
 - Capturing Health Plan authorization from patient to send information to financial institution.
 - Potential HIPAA Issue-is the Financial Institution a business associate and are they receiving protected health information.
 - More information is needed on ID Card
- ◆ Financial Institution Challenges:
 - Communication method between Health Plan and financial institutions.
 - Providing clear communication to patients on events that payments relate to.
 - Timing of processing original transaction versus corrections/reversals of the transaction.
 - Education to Providers on support for Credit Card Hold Feature

Model 4 – Patient does not assign Health Plan benefits and is responsible for total payment



Model 4-Patient Challenges

- ◆ Patient needs to be fully responsible for making payment to the provider and if applicable collecting reimbursements from Health Plan.
- ◆ Patient must be aware of available funds in their HSA account.
- ◆ If HSA funds are used to pay provider full charges and patient then receives payment from health plan, how does patient put funds back into HSA account?

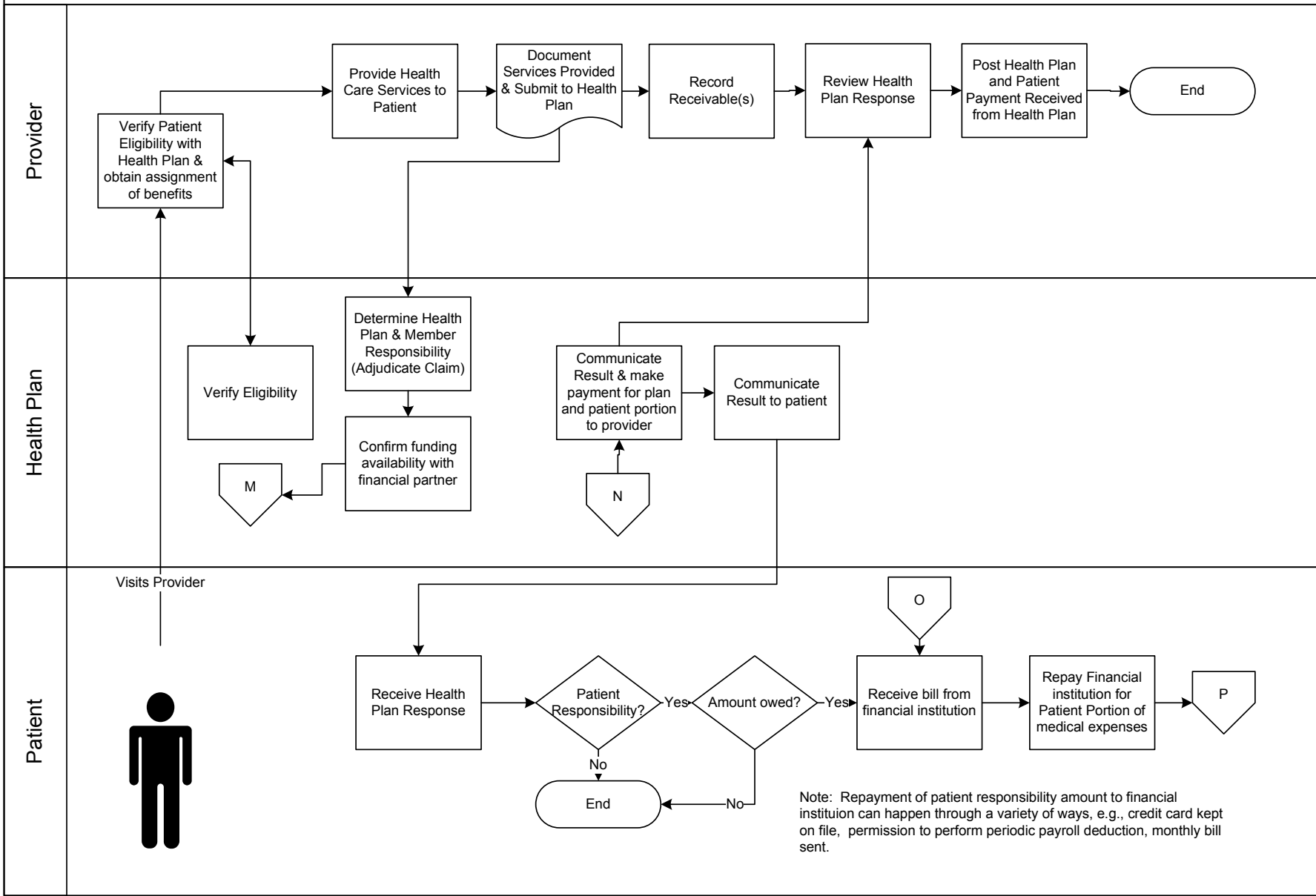
Model 4-Provider Challenges

- ◆ Ability to collect full billed amount from patient without experiencing increase in bad debt.
- ◆ Ability to provide patient with estimated amount of charges prior to service being rendered.
- ◆ Ability to support charging and collecting pre-service deposits.

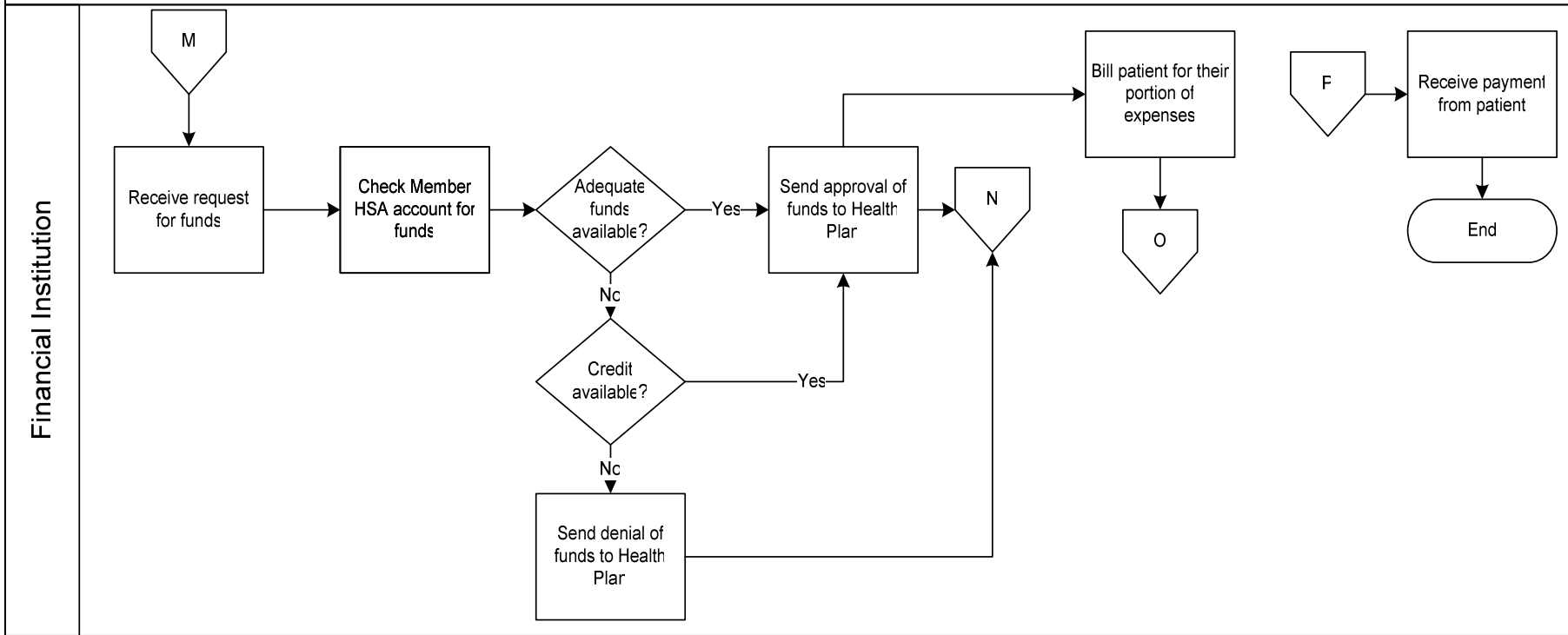
Model 4-Health Plan and Financial Institution Challenges

- ◆ Health Plan Challenges:
 - Ensuring patient is aware of what must be submitted in order to receive reimbursement.
- ◆ Financial Institution Challenges:
 - None identified

Model 5 – Patient assigns Health Plan benefits and arranges for full payment by Health Plan



Model 5 – Patient assigns Health Plan benefits and arranges for full payment by Health Plan, continued



Model 5-Patient Challenges

- ◆ Patient may have more financial responsibility for their health care due to borrowing of funds for health care expenses.
- ◆ Patient needs to track expenses closely and ensure periodic payments are made on schedule to the health plan.
- ◆ Patient needs to know how to explain to provider that they have a full payment service through the health plan.

Model 5-Provider Challenges

- ◆ Provider needs to be aware at time of eligibility check that health plan will make payment for the patient so that they don't collect funds upfront.
- ◆ Provider needs to know if there is a limitation on how much the plan will pay.
- ◆ Provider needs clear communication of payment details that distinguish plan payment from patient payment.

Model 5-Health Plan and Financial Institution Challenges

- ◆ Health Plan Challenges:
 - Health Plan now must support financial business processes such as billing and collection to individuals or they may need to handle financial data interactions with a financial institution.
 - Health Plan needs clear way to communicate payment details.
 - Health Plan needs way to clearly deal with corrections to payments made.
 - Health Plan needs to staff for phone calls on financial transactions.
 - Health Plan may need to deal with patient running out of credit and collection challenge if patient changes employers.
- ◆ Financial Institution Challenges:
 - Communication method between Health Plan and financial institutions.
 - Financial Institution may need to deal with collection challenge if patient changes employers.