

Easing the pain of high-deductible health plans

Sometimes, consumers don't know how much they have to pay before they leave the doctor's office

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BlueCross BlueShield of Tennessee is starting a pilot program to reduce the "hassle factor" for doctors and patients dealing with high-deductible health plans.

The pilot is for a "real-time claims adjudication system," a program that allows health care providers to enter a patient's information into the BlueCross Web site to find out exactly how much they owe for the visit so they can pay the proper amount before leaving the office.

The system is aimed at dealing with BlueCross Tennessee members who have high-deductible (often referred to as consumer-driven) plans that require patients to pay health care costs out of their own pockets up to a certain amount.

"The issue we're running into is a consumer walks into a provider's office and they don't know how much they owe the provider, considering their benefits structure and the provider discount for that

particular plan," says Paul Kulpa, senior product manager for consumer-directed health care at BlueCross Tennessee.

However, BlueCross isn't alone in its effort. Increased interest in consumer-driven plans has many insurers turning to similar systems.

"Consumerism is a challenge for all of us, for all stake holders, because it forces us to do things in a different way. The marketplace is driving toward that," says John Sorrow, president of Cigna Health Care of Tennessee.



Sorrow

Employers are increasingly choosing high-deductible plans because of their lower premium costs. The plans are typically paired with a health savings (HSA) or health reimbursement account (HRA), which help employees cover some out of pocket costs before the employee hits the threshold where the insurer takes over.

In January 2007, an estimated 4.5 million people in the U.S. were enrolled in health savings/high-deductible plans, up from 3.2 million in January 2006, according to a study by America's Health Insurance Plans.

For BlueCross, the state's largest non-profit health plan, consumer plans represent about 10 percent of commercial business,

or about 65,000 Tennesseans.

Without a real-time claims adjudication system, providers could end up in undesirable scenarios: Either they overcharge a patient and then have to reimburse them later - which gets complicated if the patient debited money from an HSA or HRA account — or they opt to bill the patient later, which increases the provider's risk of never receiving payment, which hurts their bottom lines.

"Sometimes a member patient will have \$2,500 to pay out of pocket before the health plan will pay," says Janna Meek, director of integrated provider solutions for national insurer Humana Inc. "That can cause major cash flow issues if that provider does not collect that cash up front."

Kulpa says health plans see real time claims adjudication as the answer to the "hassle factor" associated with consumer-driven plans.

These programs also can save the provider money on billing costs. Meek says Humana's pilot practice in Texas saved \$14,000 a year from billing costs alone.

The Blue Cross pilot, which is already live at several sites in Chattanooga, will roll out to providers statewide by specialty this summer. Kulpa expects primary care physicians will be first to get the pilot.

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