What’s Behind the Rise in Health Insurance Premiums?
And What Small Businesses Can Do About It
An attractive health care program is an important part of finding and keeping quality employees. But you need to make sure that your health care plan is not only comprehensive but cost-effective. This combination is no easy feat!

UnitedHealthcare created a series of thought papers to help you meet this challenge. Our goal is to educate small business leaders on the fundamentals of health care and provide insights on the inner workings of an often complex environment – so they can make better, more thoughtful decisions. This can result in delivering quality and efficient health plans for employees and value creation for your business.

### Health Care Cost Trends

The amount spent per person on health care in the U.S. increased 186 percent from 1990 through 2009 and is expected to accelerate at a faster rate through 2019.

Many factors affect how much small businesses pay for health insurance premiums each year. Doing a “deep dive” into this sizeable list would mean an encyclopedic report. Instead, here is a review of the major trends.
Health care cost increases have far outpaced the rate of inflation and workers’ wages over the past dozen years. Small businesses are no different. Health care will continue to take a growing share of your company’s – and your employees’ – annual budget.
What’s Behind the Rise in Health Insurance Premiums?

Trend #1: Increasing Costs of Medical Services

Increases in medical costs charged by many health care providers – such as hospitals, doctors and pharmaceutical companies – may result in higher premiums. Higher unit prices for medical services account for an estimated two-thirds of the year-over-year growth in health care spending. This has more than doubled the health care costs for the average family of four in the last nine years, to $19,393, with an expected increase of 36.3 percent for employers between 2006 and 2011. Here are some of the key reasons behind these trends:

• **Cost shifting** – The Centers for Medicare and Medicaid Services (CMS) pay hospitals less than what it costs them to provide care. The difference is shifted to private health plans. In 2009, Medicare and Medicaid reimbursed hospitals at 90 percent and 89 percent, respectively, of their cost of care. So private payers paid a premium: 134 percent of the cost of care. This allowed hospitals to cover the cost of care of the insured employee, their profit margin, and the shortfall from the Medicare and Medicaid patients.

That trend will likely accelerate. Medicare pays for 42 percent of hospital inpatient days and Medicaid for 11 percent, and both of their shares of inpatient days have been increasing. This pushes more “uncovered costs” onto a shrinking base of private payers. In addition, Medicare and Medicaid rates to hospitals are expected to decline in 2012. For example, the rate increase Medicaid will pay to hospitals this year is expected to be 3.3 percentage points below the actual cost increase hospitals will experience in 2012.

• **Decreased competition among providers** – Hospitals account for about one-third of health care spending. Mergers and acquisitions helped to lower the number of hospitals by 4 percent from 1985 to 2010. Meanwhile, the total U.S. population grew by 29 percent. Because mergers can reduce the number of hospitals in a market, research indicates that they cause price increases of at least 10 percent, and some estimates place this at 40 percent or higher.

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Rising Medicare and Medicaid Spending

As more people draw upon Medicare and Medicaid, the costs these programs do not cover will increasingly shift to private payers.
• **Pharmaceutical costs** – The average cost for patented drugs in the U.S. is 35 percent to 55 percent higher than for other industrialized nations. In 2010, total U.S. prescription sales were $307.4 billion, a 2.3 percent increase from 2009 and up 77 percent from 2001. In 2009, the average retail price for a prescription drug was $76.94, nearly double the $38.93 in 1998. In addition, about one in five Americans was taking three or more prescription drugs in 2006 – nearly double the number in 1994.

These are among the factors that are increasing U.S. real per capita health spending. A study spanning 1996 to 2006 indicated that three-fourths of the money spent during this time came from growth in cost per case (how much it cost to treat each person), versus the one-fourth related to higher rates of disease or treatment (or more people receiving care for a condition).

**Trend #2: Using New Technologies**

Doctors and patients are spurring a trend toward adopting new technologies. While innovative drugs, procedures and devices may improve the quality of or prolong life, they often carry a higher cost. The Congressional Budget Office (CBO) estimates that advances in medical technology account for about half of the growth in health care spending in the past several decades.

**Major Advances in Medical Technology**

While innovations in medical technology may increase costs, they can also provide tangible benefits. For example, advances in heart surgery and medicine have decreased cardiovascular-related deaths by 80 percent since 1950.
“One example is the mapping of the human genome,” explains Dr. Lincy Lal, director of health care pipeline and research for UnitedHealthcare. “This is allowing us to uncover the genetic mutations that cause some diseases – and then create specific drugs to address these conditions. Cystic fibrosis (CF), a fatal condition that affects 30,000 people in the U.S., is caused by a myriad of genetic mutations. In early 2012, a new drug, KalydecoTM, was approved that will help correct one of the genetic mutations affecting 4 percent of those with CF. The annual cost for this therapy – which has never before been available – is $294,000.”

New devices also are being invented for conditions people have traditionally chosen to “live with.” The goal, of course, is for these to be used successfully. The repercussion from a health care cost standpoint is that people may live longer and require other types of treatment.

Aortic stenosis, for instance, is a narrowing of the heart valve. This is a normal part of growing older. “In past years, the only treatment available was open heart surgery: a choice made by less than half of people with this condition,” says Dr. Lal. “A new device, called a SAPIENTM transcatheter heart value by Edward Lifesciences, may fix this problem. It can be inserted through a vein, so it doesn’t involve the major trauma or recovery time of open heart surgery – and also has a slightly lower cost due to a less intensive setting for the procedure. We expect to see a number of people who had been putting off surgery choose this approach.”

The Major Factors Affecting Health Insurance Premiums

This graph shows where the estimated $2.7 trillion spent on health care in the U.S. went in 2011. The largest areas were hospitals (31 percent), doctors and clinical work (20 percent), and drugs and other medical products (13 percent). The average annual increases expected in each category over the next 10 years – shown next to each category – indicate these will remain the top health care costs.
Dr. Lal also points to the trend of using a combination of therapies – rather than a single one – to treat the symptoms of conditions that can’t be cured. “A number of drugs are being introduced in the next few years that will be indicated for dyslipidemia – high cholesterol – either by decreasing LDL cholesterol and/or increasing HDL cholesterol,” she says. “This will result in people moving from a single-drug therapy to a dual or triple therapy to better manage their condition. That means the cost of treating their symptoms may double or triple. And the offsetting lower cost – due to decreased cardiovascular events – may not be evident for many years.”

**Trend #3: Increasing Use of Medical Services**

The number of visits to doctors’ offices, hospital ERs and outpatient surgery centers grew by 38.2 percent between 1995 and 2008\(^{15}\) – although the U.S. population expanded only 14.8 percent during that time.

According to a study by the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Health and Human Services,\(^{16}\) a number of factors are causing this: a greater supply of services, new diseases, changes in consumer preferences and demand, and new guidelines that recommend certain tests and treatments. Here are two examples:

- There are more elective surgeries, such as knee replacements (which increased 70 percent from 1996 to 2006).\(^{11}\)
- Advances in treatments for life-threatening diseases helped lead to a 31 percent increase in kidney transplants and a 43 percent rise in liver transplants between 1996 and 2006.\(^{11}\)

“In addition, patients are now more educated – thanks to direct-to-consumer product and drug advertising, and the Internet,” states Dr. Lal. “They often tell their doctors what conditions they have and what treatments they want. And as Baby Boomers age, they will consume more medical services than their parents and grandparents. This will happen not only because they are living longer, but because they wish to remain active despite their advancing years.”

**Aging U.S. Population**

The number of Americans aged 60 and over will more than double between 2000 and 2050, going from 16.3 percent of the population to 25.5 percent. This will have major implications for health care costs – and insurance premiums.
Trend #4: Changing Demographics

Baby Boomers represent the most significant demographic trend. From 2004 through 2019, the number of people over age 65 will grow from 36 million to nearly 52 million, according to CMS. This group will increase from 12.3 percent of the population to 15.5 percent.

“Research by UnitedHealthcare on its book of business indicates that meeting the health needs of a 60-year-old person can cost seven-times more than a 20-year old,” explains Mark Zagorski, director of sales and account management. “This is one reason why the aging population may add about a 1 percent increase to the cost of an insurer’s book of business in a year.”

Trend #5: Higher Costs from Deductible Leveraging

Health care policy design may also impact costs.

Plans with higher deductibles are designed to (1) increase cost sharing with employees, and (2) keep the cost per person more affordable for employers. However, the deductible must increase every year to keep pace with higher health care costs. If not, the policy will become more expensive to employers because it will not retain its original cost-sharing proportion. This is called deductible leveraging.

For example, a policy offers a $100 deductible over a long period of time. Health care costs will rise every year, while the deductible doesn’t. So if health care expenses increase 10 percent this year, what cost $1,000 last year will cost $1,100 this year. Since the employee is still paying $100, the insurance company’s costs have gone from $900 to $1,000 – which is an 11.1 percent increase. That means employer premiums might increase to cover the added expense.
Trend #6: Higher Costs from Unhealthy Lifestyle Choices

According to the CDC, 50 percent of a person’s health status is a direct result of his or her behavior. Unhealthy activities – such as regularly overeating and avoiding exercise – have a resounding impact on our health, and health care costs.

Research by the International Food Information Council Foundation indicates that 77 percent of Americans don’t meet the U.S. Department of Health and Human Services’ Physical Activity Guidelines. There is very strong evidence linking regular physical activity to improved health and a better quality of life:

- It lowers the chances of dying from coronary heart disease.
- It reduces the risk of developing diabetes, hypertension and colon cancer.
- It helps to control weight.
- It improves mental health by reducing feelings of depression and anxiety.

Making unhealthy choices may not only affect an individual’s health, this can increase health care costs:

- **Adult obesity** has doubled in the last 25 years. The total economic cost of people who are overweight or obese in the U.S. has risen to $270 billion a year, with $127 billion of this related to their increased need for medical care. If current trends continue, $344 billion will be spent on U.S. health care costs related to obesity in 2018 – more than 21 percent of all health care costs that year.

- **Diabetes** affects 25.8 million people in the U.S., and 79 million more are pre-diabetic. The latest available information indicates that the total economic cost of this condition in the U.S. was $174 billion in 2007. The International Diabetes Foundation estimates that in 2011, global health care expenditures on diabetes were $499 billion and will increase 31 percent to $654 billion (in international dollars) by 2030.

- **High blood pressure** affects 31.3 percent of all U.S. adults. Another 22.4 percent have high blood pressure and don’t know it, and 25 percent have hypertension (higher than normal blood pressure). In 2010, the estimated direct and indirect economic cost of this condition was $76.6 billion. Cardiovascular disease (including high blood pressure, hypertension, coronary heart disease, heart failure and stroke) cost the U.S. an estimated $156.1 billion in direct and indirect economic costs in 2010. This is expected to increase 177 percent to $431.8 billion in 2030.

That is why small businesses should consider a wellness component for their health care programs. A 2009 study of 770,000 employees at 106 companies indicated that each person with low health risks cost his or her employers only $1,472 annually in lost productivity, versus employees who had three health risks – who each cost their companies $5,952 in lost productivity per year.

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**Diabetes Prevention and Control AllianceSM Program**

The Diabetes Prevention and Control Alliance is a collaboration among UnitedHealthcare, YMCA of the USA and Walgreens to help prevent and control diabetes, pre-diabetes and obesity. Two programs are offered.

The Diabetes Prevention Program is designed for those at high risk of developing diabetes. A trained YMCA lifestyle coach helps these people to practice good nutrition, increase their physical activity, and change unhealthy behaviors during the 16-session program.

The Diabetes Control Program, for people with the condition, is in partnership with Walgreens and will expand to other retail pharmacies. When participants pick up their prescriptions, trained pharmacists offer them education on healthier behaviors and medication management to help reduce the risk of seeing their diabetes get worse.

Available to key accounts, fully insured and ASO in some states. Contact UnitedHealthcare for your company’s eligibility.
Insurance Company Profits Are Not Driving Up Premiums

There is a misconception that profits at insurance companies are causing the rise in health insurance premiums for small businesses. The average annual profit at insurance companies is 3 percent of every health care dollar spent in the U.S. This is modest compared with the profitability of other health care niches: 15.7 percent for medical technology companies, 25.5 percent for pharmaceutical firms and 26.6 percent for biotechnology companies.

“The fact is, if you removed the profit from all health insurance companies – so they only broke even – this would hold the health care trend line down for just one year,” says Zagorski. “After that, it would return to its regular pattern of annual increases.”

That said, insurance companies must lead the quest to make health care more affordable. UnitedHealthcare has a wide variety of programs in place designed to help employees get access to high-quality, cost-effective care:

• **UnitedHealth Premium® Designation** program features physicians and facilities that meet national quality of care criteria and local standards for cost efficiency. Employees who choose Premium designated providers not only have access to care that follows evidence-based guidelines, but the employees may also have lower health care costs overall. Premium designation for physicians covers 21 specialties and is available in 148 markets in 41 states. (See page 12 for more.)

• UnitedHealthcare offers several **innovative wellness programs**. The goal of each is to educate employees on their current or potential health issues and help them take action to modify their behavior. The idea is that everyone then can benefit from lower medical costs. (For more, see page 13.)

• Our **eSync Platform** identifies employees at our customers’ companies who will likely face major near-term health challenges. The idea is to contact them before these issues become serious, because successful outreach may improve their health and forestall major health care expenses. (See page 12 for more information.)

• We also strive to **keep our operations efficient**. One main focus is reducing paper. Considering all of the forms involved in health insurance – from proposals to flex reimbursement to claims to changes – the savings for everyone may be significant.

* 2012 addition of three new markets
What's Behind the Rise in Health Insurance Premiums?

What Can Small Businesses Do to Help Lessen the Blow of Premium Hikes?

The trends driving up health care costs – which are totally out of your company’s control – can be daunting. But there are a number of actions savvy small business leaders can take that may help reduce the impact on their operations.

1. Partner with the Right Insurance Broker

According to David Contorno, chief executive officer of Lake Norman Benefits, Inc., decision makers make three common mistakes when selecting brokers. “First, they go to too many. When carriers see more than one or two brokers requesting a quote for the same company, they are less likely to give any of them a good price. Second, leaders think of health insurance as a commodity – and take a transaction approach rather than creating a long-term relationship with a broker. Third, the opposite can be true. Some owners never get a new quote from another broker to vet their current plan.”

When it comes to choosing a broker for your company, consider these criteria:

- Someone who understands the issues faced by small businesses
- An independent broker who can offer you many plan options
- Someone who can translate insurance jargon into plain English
- An experienced professional who has been in the industry for a number of years (who will be there to serve you for a long time)
- Someone who is committed to service, who can help (1) administer your plan (particularly important for any of your operations that don’t have a full-time human resources professional), (2) educate employees on how to use the plan, and (3) with claims when these occur
- A firm with a good relationship with a carrier whose plan you are considering. A broker with a strong, long-term relationship with a carrier may be able to access a larger suite of health care services. (UnitedHealthcare’s United Advantage® program is exclusively designed for the top-performing UnitedHealthcare brokers.)

2. Choose the Right Plan

“This process begins with knowing the goals for your health insurance,” says Fred Garfield, principal and senior vice president of The Horton Group, Inc.

He suggests a number of ideas to consider. Balancing what employees contribute to have a plan, versus what they pay in out-of-pocket expenses. Providing comprehensive care. Offering only catastrophic coverage. Providing additional options, such as vision and

“We use an insurance broker that offers us various alternatives. I would tell other companies they need to look at the entire package with a health insurance company. They need to look at how easy the administration is for their own point of view. But they also need to look at the price, the service, the network that this company offers, and make sure that they’re satisfied with what they’re getting.”

John Groskopf
Controller
Alpine Plywood Corp.
What's Behind the Rise in Health Insurance Premiums?

**eSync℠ Can Predict Potential Health Issues**

UnitedHealthcare’s eSync Platform is a proprietary technology that “synchronizes” different kinds of employee health data: health assessments, health claims, and pharmacy data and lab results. Then it uses hundreds of algorithms to constantly scan this information. eSync “looks” for more than 50 conditions and identifies people who are likely to need intensive health care services in the next 12 to 16 months. This is designed to increase the opportunity to intervene before a major health event occurs.

dental benefits. Offering a plan that is competitive with others in the industry. “Once you make these decisions, it’s easier for your broker to recommend plans in sync with your thinking,” Garfield explains.

“UnitedHealthcare programs really have two goals designed into them: improve employees’ health while addressing cost issues,” Zagorski says.

UnitedHealthcare’s wellness program, standard in all plan designs for customers with 2-99 employees, is one example. The program includes biometric screenings, telephonic wellness coaching, and a fitness reimbursement program.

Many serious health conditions develop over time, but they can be delayed or prevented if employees know their risks and make healthy changes. Biometric health screening allows employees to better understand health risks and learn about the wellness numbers that may help them manage or improve overall health. Once completed, the data is fed into myuhc.com® and populates into an online health assessment and Personal Health Record. It’s an easy, convenient way for employees to store and locate their health information.

Employees can participate in telephonic coaching programs that help them develop a personalized plan to address wellness topics such as weight, stress, nutrition, exercise, diabetes, heart health and tobacco cessation. Available for enrollment at any time, this program allows employees to make changes in their health and lifestyle.

UnitedHealthcare also provides reimbursement for working out at a participating gym in a national network of fitness centers. The fitness reimbursement program allows employees to earn a credit of $20 per month, up to $240 per member per year, by working out at a participating fitness center at least 12 times per month.

The potential result: Employees can take control of their health by being educated and informed about personal health and wellness, being coached on what behavior changes can lead to better health, and developing an action plan that promotes good habits to achieve and maintain good health.

**Personal Health Assessment (PHA) Reveals Ways to Improve Health**

UnitedHealthcare’s PHA takes employees about 15 minutes to complete. Then they receive information to help them assess their overall health, and the top three areas they should focus on to help improve it.

This confidential* information also is automatically imported into (1) their Personal Health Record, which they may show to their doctor and (2) the eSync Platform, so UnitedHealthcare can tailor wellness communications and online information to each member.

* UnitedHealthcare’s online Personal Health Record operates consistent with state and national privacy laws.
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3. Help Employees Understand their Health Issues

Only about 21 percent of people in the U.S. get an annual physical exam from their doctors. Informed employees are often more engaged in protecting or improving their health. And healthier employees may slow the trend line of insurance premium increases your company faces.

Small businesses often don’t have the time – or staff – to make sure employees stay informed about their health. That’s why it’s important for them to select a plan that offers people easy access to their own health information and education on general issues. Consider plans that offer tools to heighten employees’ awareness.

**Employees must have a good picture of their health.** Look for programs that offer an online questionnaire that (1) allows employees to confidentially* share information about their past and current health conditions and family health history, and (2) gives them feedback on what to do to improve their health.

**They should have all of their health care records in one easy-to-use place.** A number of health care plans offer a secure, confidential* online place for employees to compile, store and manage health information for themselves and family members. This includes medical histories, doctor’s visits, lab test results and prescriptions. Another convenience for employees is the ability to print or email this information to share with a doctor, so all health care providers have the same data.

**Employees should have on-demand access to educational information.** The best insurance plans offer a health portal – available in several languages – that includes online articles on different health topics. This allows employees to review information at their convenience. These sites also include online tools (such as a calculator to determine how much a smoker spends on cigarettes every year), and trackers (such as the number of steps walked every day), so employees can be more informed and monitor progress against their health goals.

4. Support Employees in Making Healthier Choices

Once employees are more aware of their current and potential issues, they may choose healthier behaviors.

“One of the best ways I’ve seen to flatten the slope of premium increases and health care costs is an effective wellness program,” says David Streich, owner of Key Financial Group, Inc. “The best ones deliver information and support in a number of ways, so employees can get what they need.”

Most employees need ongoing help to change unhealthy behaviors. While articles can

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* Consistent with state and national privacy laws.

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A Comprehensive Approach to Wellness

UnitedHealthcare’s suite of wellness programs provides online information with personalized coaching. This approach has given it an enviable record of success:

**QuitPower® Smoking Cessation Coaching Program** – 65 percent of participants are tobacco-free after finishing the program

**Stress Reduction Program** – 100 percent of participants who complete the program successfully use at least three stress reduction techniques

**Heart Health Program** – 25 percent reduce their blood pressure and 13 percent lower their cholesterol by the program’s end

**Diabetes Health Plan** – 34 percent experience a weight loss of 1 percent to 5 percent

**Healthy Pregnancy Program** – This program helps participants avoid becoming one of the 11 percent of women who have premature infants

In addition, the Health Discount Program offers employees discounts of between 5 percent and 50 percent on certain health care-related products and services. These include fitness clubs, weight loss programs (such as Jenny Craig®), vitamins, alternative care (such as chiropractic), vision and dental.
be informative, these alone can’t create a sustainable change. That means your wellness program must provide more than just information. It should include online and telephone coaching with a nurse or medical professional. These people can answer questions, suggest additional resources, offer encouragement and celebrate progress.

5. Help Employees Make More Informed Decisions about Their Health Care

“One of the most difficult questions for employees is how to best use their health care,” Zagorski explains. “How serious is my condition? Do I need to go to a hospital or have surgery? Which doctor should I use?” Making poor choices can affect their health as well as their wallets. Small businesses need to support employees in making good choices.”

UnitedHealthcare has resources that employees can turn to for addressing simple and complex health questions:

• **NurseLine℠** services is a toll-free number that employees may call 24/7/365 to speak with a registered nurse about a wide range of personal and family health issues. These professionals can offer information and support on providers, managing a chronic condition and understanding treatment options.

• **Treatment Decision Support Program** gives employees access to registered nurses who can help with more serious health challenges: back pain, prostate or breast cancer, coronary artery disease and obesity. This includes offering information on their condition or medications, treatment options, discussing the types of questions to ask doctors and sharing the costs of different treatment options.

Employees – and the small businesses where they work – also benefit when they choose with a doctor or facility within their health care coverage network. The insurance carrier has negotiated lower rates with doctors and hospitals in the health plan’s network, so everyone involved usually pays less for the same type of care.

In addition, generic drugs often are a smart choice. Their active ingredients are similar or identical to the brand name product. However, because the company making the generic did not have to pay for developing the product it’s based on (the brand name drug), the price is an average 80 percent cheaper.29 And most insurance companies offer lower coinsurance amounts or copays for generics than brand names, which further reduces an employee’s medical expenses.
6. Claim Your Small Employer Tax Credit

If you have fewer than 25 full-time equivalent employees, and you pay all or part of their health insurance premiums, you may be able to receive the Small Business Health Care Tax Credit. This is designed to help small businesses offer or maintain health insurance coverage for moderate and lower income workers.

The credit is worth up to 35 percent of your premium costs through 2013. On January 1, 2014, the rate increases to 50 percent – but you must purchase your coverage on a benefits exchange starting that year. Talk with your insurance broker to learn if you qualify, and then work with your business accountant to claim the credit on your tax return.

Have a Partner in Value Creation

Even if your employees were healthy and miraculously stayed the same age as last year, your health insurance renewal rate would still increase. This reflects the major expense drivers, including unit cost increases from doctors and hospitals and cost shifting, that are beyond the control of the average small business – or even a large company – as well as insurance carriers.

“A healthy employee is a better employee. That’s why offering wellness and preventive benefit programs, and using doctors with a better history of care and results, are very important to us. And I believe our active approach to health has helped keep our annual rates in check.”

Mark Fletcher
Executive Vice President, General Manager
Mann Travels/American Express

For More Information

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Sources

17. Institute for the Future, Centers for Disease Control and Prevention.

Acknowledgements

UnitedHealthcare thanks the following health insurance professionals for their contributions to this thought paper:

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The health discount program is offered to existing members of certain products underwritten or provided by UnitedHealthcare Insurance Company or its affiliates to provide specific discounts and to encourage participation in wellness programs. Health care professional availability for certain services may be dependent on licensure, scope of practice restrictions or other requirements in the state. UnitedHealthcare does not endorse or guarantee health products/services available through the discount program. This program may not be available in all states or for all groups. Components subject to change.

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