



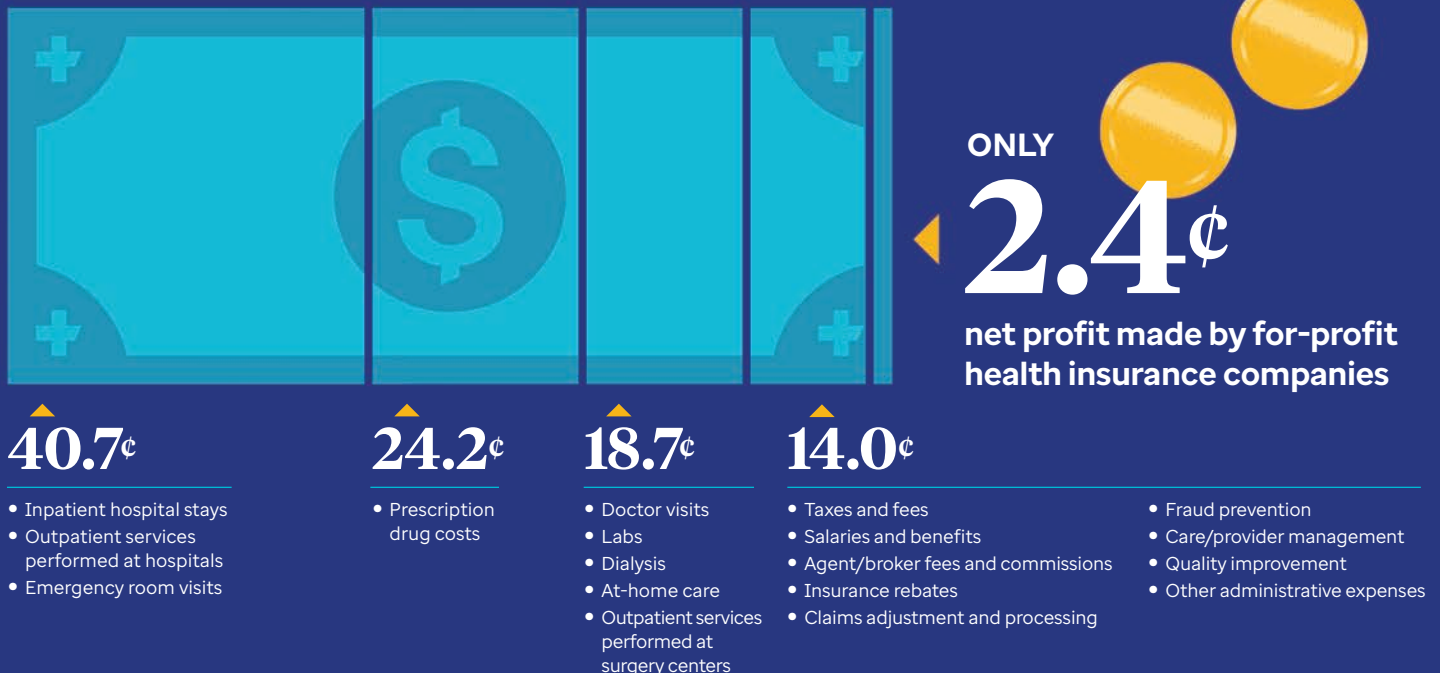
Where do health care dollars go?

Health care costs can be complex. Understanding how costs are determined and paid may help employers and their teams make more informed decisions.

Let's go

The vast majority of health plan spending goes to pay for medical services, including hospital and doctor visits, prescription drugs, lab tests, X-rays and medical supplies.

Health plan dollar cost breakdown¹



Consumer protections

Rates must be...

- ✓ Certified by actuaries
- ✓ Reviewed by regulators
- ✓ Made available for public comment



80¢–85¢

out of every health plan dollar is typically spent on medical care,¹ with that ratio mandated for many plans under the Affordable Care Act²



If insurers don't meet these requirements, they are required to issue rebates to consumers under **state** and **federal law**.

How health insurance companies help make care more accessible and affordable



Spread costs across a large group, so no one pays the full price alone



Negotiate for lower prescription drug and service costs



Help ensure claims are processed and paid accurately



Drive innovation that aims to help make the health system work better for everyone



Support more effective care coordination and management for better health outcomes and lower costs



Understanding the billing process

Before a member receives a health care bill, many steps take place – starting even before they get care. Accuracy early in the process helps ensure smoother billing and fewer issues later.

1

Claim creation

- Register member
- Verify insurance eligibility
- Capture medical codes
- Create medical bill claim



Managed by hospital/provider office

2

Review

- Ensure information is accurate
- Evaluate validity
- Process appropriate payment



Completed by health insurance company

3

Payment

- Send member statement of remaining balance
- Follow up as necessary



Managed by hospital/provider office

For the UnitedHealthcare commercial business...

97.9%
of claims
do not require a
prior authorization review⁵



The remaining
2.1%
of claims
require review³...



Almost
9 in 10
of those were
approved within
24 hours⁴

Common reasons claims are denied or flagged for further review:

- Particular service or procedure was not covered by the member/employee's plan
- Individual receiving care was not enrolled in the insurance plan
- Errors or missing information
- Duplicate claims submitted



"Claim" – A formal request for payment that a hospital or doctor's office sends to a health insurance company after care is provided



Learn how UnitedHealthcare is working for more affordable care —→



¹ Where Does Your Health Care Dollar Go? AHIP. Available: https://ahiporg-production.s3.amazonaws.com/documents/AHIP_HealthCareDollar.pdf. Accessed Sept. 2, 2026.

² Medical Loss Ratio. Centers for Medicare & Medicaid Services. Available: <https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio>. Accessed Sept. 2, 2026.

³ This number was calculated by comparing the number of prior authorization requests to the number of claims submitted for members enrolled in UnitedHealthcare Employer and Individual plans from Jan. 1, 2025 to Dec. 31, 2025. This number does not include all prior authorization requests or claims for: (1) members enrolled in plans issued or administered by non-integrated entities; (2) prescription drugs (not under the medical benefit); (3) transitions to post-acute care; or (4) prior authorization requests submitted to capitated-delegated providers, behavioral health delegates, physical health delegates and dental delegates.

⁴ This number is based on the number of prior authorizations received and approved (including after any appeals) for members enrolled in UnitedHealthcare Employer and Individual plans from Jan. 1, 2025 to Dec. 31, 2025. This number does not include all prior authorization requests for: (1) members enrolled in plans issued or administered by non-integrated entities; (2) prescription drugs (not under the medical benefit); (3) transitions to non-acute care; or (4) members delegated to capitated-delegated providers, behavioral health delegates, physical health delegates and dental delegates.

Employee benefits including group health plan benefits may be taxable benefits unless they fit into specific exception categories. Please consult with your tax specialist to determine taxability of these offerings.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.