Testimony of Nancy Metcalf
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Consumer Reports
before the
Committee on Commerce, Science, and Transportation
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on

Obstacles to obtaining clear, useful consumer information when buying individual health insurance

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify on the obstacles confronting consumers who attempt to buy insurance on the individual market.

I have talked to many such consumers as a health writer for Consumer Reports,[1] and I can tell you that I have yet to encounter to a single one who yearns for a broad choice of "individualized" plans in a highly competitive marketplace. They all want the same, pretty simple thing: a health plan they can afford that won't leave them destitute if they get really sick.

They say things like:

"I knew it was not a great plan but I thought, it's better than nothing."

"I just wanted something to cover me if something catastrophic happened."

"We knew the deductible was going to be high, but I thought that it was a pretty good deal."

"I thought, at least I'll be covered if I have, God forbid, a catastrophic illness."

These are quotes from real people who did their best to buy decent insurance. Then they did get seriously ill and found out their policies did not protect them the way they thought they would…because they were no match for insurance companies who know exactly how to design and market plans whose gaping holes don't become apparent until it's much, much too late.

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[1] *Consumer Reports* is published by Consumers Union, an expert, independent nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

Some of the reform proposals on the table include subsidies that will open this market to many millions of new customers through health insurance exchanges. These must include strong consumer protection and transparency provisions, because consumers really don't understand this market at all. I'll explain why.

1. Consumers don't know the component parts of insurance.
If people bought cars the way they buy health insurance, they wouldn't be aware that a car has to have brakes, or a steering wheel, or an engine. A couple of years ago, we ran some focus groups of people who had bought their own health insurance. We asked if their policies had an annual out of pocket limit, and they had no idea what we were talking about. Though perhaps it wouldn't have mattered, because there's absolutely no standardization about what expenses apply to the out of pocket limit. One of the most common exclusions is prescription drug copays, which can add up to thousands of dollars a year for some people.

2. They don't understand that low premiums are low for a reason.
As consumers, we are trained to look for a bargain. Buying a car or a flat-screen tv, we're proud if we can get it for less than our friend paid. People think insurance works the same way. They never consider that if they are 55 years old, and have diabetes and heart disease, that no insurer could possibly stay in business selling them a comprehensive policy for $150 a month. That's why so many of the junk policies we've looked at are marketed as "affordable."

3. They don't read the small print.
Many of the people stuck with bad health plans blame themselves for not reading the small print. I always tell them it's not their fault, particularly since in most states, you can't even *see* the small print – that is, the real policy -- until you've applied, paid a couple of months premium up front, and been accepted. At that point, you have a brief period to inspect the policy and send it back if you don't like it, but I doubt that many people do. For one thing, they'd be uninsured if they did.

4. Even if they did read the small print, they wouldn't understand it.
It is routine for policies to say they'll cover a certain benefit, such as outpatient doctor visits, up to the policy's limit – but that limit is, of course, on a different page and they don't tell you which one, and it's only four visits a year. Another common dodge: sections on "what is not covered" that leave out vital information, like the United American policy sold in Florida that somehow fails to mention in that section that it only pays for $250 of outpatient doctor bills a year.

5. They have no idea how catastrophic a health catastrophe can be.
Many so-called affordable plans marketed to young adults don't have prescription drug coverage, which seems like no big deal if you're 26 and never need anything except an occasional antibiotic for strep throat. But what happens if, the next year, you're diagnosed with rheumatoid arthritis and suddenly need a bioengineered drug that costs $25,000 a year? One of the most poignant cases I ever covered was a middle-aged couple who bought a United Healthcare policy with a $50,000-a-year maximum payout, which

seemed like plenty to them. Then the husband got colon cancer, and his treatment cost more than $200,000.[2]

WHAT CONSUMERS NEED

Consumers Union believes that what consumers really need is access to affordable insurance that will cover all their medical needs. We don't think policies that exclude or limit major categories of care, such as outpatient treatments or prescription drugs, should be sold at all.

But absent those reforms, at least insurers should be forced to be honest about what they're selling. In clear, user-tested formats, they should disclose what a policy covers -– and more important, what it doesn't. If the policy has low dollar limits on hospital or doctor or drug coverage, it needs to say so, clearly and understandably, and not on a different page, or in a footnote.

Consumers need to be told, in big letters, what their policy's out-of-pocket limit is, and right next to it, in equally big letters, if there are any expenses that don't count towards that.

They need to know approximately what their out-of-pocket costs will be for expensive treatments such as cancer chemotherapy, or heart surgery, or infusions of patented biologic drugs.

They need, in other words, a fighting chance not to be ripped off by junk insurance.

Thank you again for opportunity to testify.

For the record, I am submitting a recent article from Consumer Reports on this subject entitled "Hazardous Health Plans," as well as a Consumers Union Health Policy Brief explaining our recommendations in greater detail.

2 "Hazardous Health Plans," Consumer Reports, May, 2009, pp 24-29.

UNDERINSURED Janice and Gary Clausen thought their insurance coverage was enough. Their six-figure medical debt says otherwise.

Hazardous health plans

Coverage gaps can leave you in big trouble

Many people who believe they have adequate health insurance actually have coverage so riddled with loopholes, limits, exclusions, and gotchas that it won't come close to covering their expenses if they fall seriously ill, a Consumer Reports investigation has found.

At issue are so-called individual plans that consumers get on their own when, say, they've been laid off from a job but are too young for Medicare or too "affluent" for Medicaid. An estimated 14,000 Americans a day lose their job-based coverage, and many might be considering individual insurance for the first time in their lives.

But increasingly, individual insurance is a nightmare for consumers: more costly than the equivalent job-based coverage, and for those in less-than-perfect health, unaffordable at best and unavailable at worst. Moreover, the lack of effective consumer protections in most states allows insurers to sell plans with "affordable" premiums whose skimpy coverage can leave people who get very sick with the added burden of ruinous medical debt.

Just ask Janice and Gary Clausen of Audubon, Iowa. They told us they purchased a United Healthcare limited benefit plan sold through AARP that cost about $500 a month after Janice lost her accountant job and her work-based coverage when the auto dealership that employed her closed in 2004.

"I didn't think it sounded bad," Janice said. "I knew it would only cover $50,000 a year, but I didn't realize how much everything would cost." The plan proved hopelessly inadequate after Gary received a diagnosis of colon cancer. His 14-month treatment, including surgery and chemotherapy, cost well over $200,000. Janice, 64, and Gary, 65, expect to be paying off medical debt for the rest of their lives.

For our investigation, we hired a national expert to help us evaluate a range of real policies from many states and interviewed Americans who bought those policies. We talked to insurance experts and regulators to learn more. Here is what we found:

- Heath insurance policies with gaping holes are offered by insurers ranging from small companies to brand-name carriers such as Aetna and United Healthcare. And in most states, regulators are not tasked with evaluating overall coverage.
- Disclosure requirements about coverage gaps are weak or nonexistent. So it's difficult for consumers to figure out in advance what a policy does or doesn't cover, compare plans, or estimate their out-of-pocket liability for a medical catastrophe. It doesn't help that many people who have never been seriously ill might have no idea how expensive medical care can be.
- People of modest means in many states might have no good options for individual coverage. Plans with affordable premiums can leave them with crushing medical debt if they fall seriously ill, and plans with adequate coverage may have huge premiums.
- There are some clues to a bad policy that consumers can spot. We tell you what they are, and how to avoid them if possible.
- Even as policymakers debate a major overhaul of the health-care system, government officials can take steps now to improve the current market.

PHOTOGRAPH BY BRENT ISENBERGER

Good plans vs. bad plans

We think a good health-care plan should pay for necessary care without leaving you with lots of debt or high out-of-pocket costs. That includes hospital, ambulance, emergency-room, and physician fees; prescription drugs; outpatient treatments; diagnostic and imaging tests; chemotherapy, radiation, rehabilitation and physical therapy; mental-health treatment; and durable medical equipment, such as wheelchairs. Remember, health insurance is supposed to protect you in case of a catastrophically expensive illness, not simply cover your routine costs as a generally healthy person. And many individual plans do nowhere near the job.

For decades, individual insurance has been what economists call a "residual" market—something to buy only when you have run out of other options. The problem, according to insurance experts we consulted, is that the high cost of treatment in the U.S., which has the world's most expensive health-care system, puts truly affordable, comprehensive coverage out of the reach of people who don't have either deep pockets or a generous employer. Insurers tend to provide this choice: comprehensive coverage with a high monthly premium or skimpy coverage at a low monthly premium within the reach of middle- and low-income consumers.

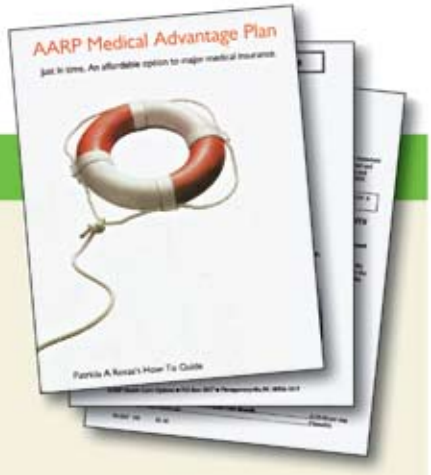
More consumers are having to choose the latter as they become unemployed or their workplace drops coverage. (COBRA, the federal program that allows former employees to continue with the insurance from their old job by paying the full monthly premium, often costs $1,000 or more each month for family coverage. The federal government is temporarily subsidizing 65 percent of those premiums for some, but only for a maximum of nine months.) Consumer Reports and others label as "junk insurance" those so-called affordable individual plans with huge coverage gaps. Many such plans are sold throughout the nation, including policies from well-known companies.

Decent insurance covers more than just routine care.

Aetna's Affordable Health Choices plans, for example, offer limited benefits to part-time and hourly workers. We found one such policy that covered only $1,000 of hospital costs and $2,000 of outpatient expenses annually.

The Clausens' AARP plan, underwritten by insurance giant United Health Group, the parent company of United Healthcare, was advertised as "the essential benefits you deserve. Now in one affordable plan." AARP spokesman Adam Sohn said, "AARP has been fighting for affordable, quality health care for nearly a half-century, and while a fixed-benefit indemnity plan is not perfect, it offers our members an option to help cover some portion of their medical expenses without paying a high premium."

Nevertheless, AARP suspended sales of such policies last year after Sen. Charles Grassley, R-Iowa, questioned the marketing practices. Some 53,400 AARP members still have policies similar to the Clausens' that were sold under the names Medical Advantage Plan, Essential Health Insurance Plan, and Essential Plus Health Insurance Plan. In addition, at least 1 million members are enrolled in the AARP Hospital Indemnity Insurance Plan, Sohn said, an even more bare-bones policy. Members who have questions should first call



WATCH THE WORDING **"Affordable" health plans, like this one purchased from AARP, may end up costing you much more in the long run.**

7 signs a health plan might be junk

Do everything in your power to avoid plans with the following features:

Limited benefits. Never buy a product that is labeled "limited benefit" or "not major medical" insurance. In most states those phrases might be your only clue to an inadequate policy.

Low overall coverage limits. Health care is more costly than you might imagine if you've never experienced a serious illness. The cost of cancer or a heart attack can easily hit six figures. Policies with coverage limits of $25,000 or even $100,000 are not adequate.

"Affordable" premiums. There's no free lunch when it comes to insurance. To lower premiums, insurers trim benefits and do what they can to avoid insuring less healthy people. So if your insurance was a bargain, chances are good it doesn't cover very much. To check how much a comprehensive plan would cost you, go to *ehealthinsurance.com*, enter your location, gender, and age as prompted, and look for the most costly of the plans that pop up. It is probably the most comprehensive.

No coverage for important things. If you don't see a medical service specifically mentioned in the policy, assume it's not covered. We reviewed policies that didn't cover prescription drugs or outpatient chemotherapy but didn't say so anywhere in the policy document—not even in the section labeled "What is not covered."

Ceilings on categories of care. A $900-a-day maximum benefit for hospital expenses will hardly make a dent in a $45,000 bill for heart bypass surgery. If you have to accept limits on some services, be sure your plan covers hospital and outpatient medical treatment, doctor visits, drugs, and diagnostic and imaging tests without a dollar limit. Limits on mental-health costs, rehabilitation, and durable medical equipment should be the most generous you can afford.

Limitless out-of-pocket costs. Avoid policies that fail to specify a maximum amount that you'll have to pay before the insurer will begin covering 100 percent of expenses. And be alert for loopholes. Some policies, for instance, don't count co-payments for doctor visits or prescription drugs toward the maximum. That can be a catastrophe for seriously ill people who rack up dozens of doctor's appointments and prescriptions a year.

Random gotchas. The AARP policy that the Clausens bought began covering hospital care on the second day. That seems benign enough, except that the first day is almost always the most expensive, because it usually includes charges for surgery and emergency-room diagnostic tests and treatments.

800-523-5800; for more help, call 888-687-2277. (Consumers Union, the nonprofit publisher of Consumer Reports, is working with AARP on a variety of health-care reforms.)

United American Insurance Co. promotes its supplemental health insurance as "an affordable solution to America's health-care crisis!" When Jeffrey E. Miller, 56, of Sarasota, Fla., received a diagnosis of prostate cancer a few months after buying one of the company's limited-benefit plans, he learned that it would not cover tens of thousands of dollars' worth of drug and radiation treatments he needed. As this article went to press, five months after his diagnosis, Miller had just begun treatment after qualifying for Florida Medicaid. A representative of United American declined to comment on its products.

Even governments are getting into the act. In 2008, Florida created the Cover Florida Health Care Access Program, which Gov. Charlie Crist said would make "affordable health coverage available to 3.8 million uninsured Floridians." But many of the basic "preventive" policies do not cover inpatient hospital treatments, emergency-room care, or physical therapy, and they severely limit coverage of everything else.

The Wild West of insurance

Compounding the problem of limited policies is the fact that policyholders are often unaware of those limits—until it's too late.

LOST IN THE FINE PRINT Jim Stacey's treatment bills totaled $17,453. His policy, which proclaimed lifetime coverage up to $1 million, paid just $1,480.

"I think people don't understand insurance, period," said Stephen Finan, associate director of policy at the American Cancer Society Cancer Action Network. "They know they need it. They look at the price, and that's it. They don't understand the language, and insurance companies go to great lengths to make it incomprehensible. Even lawyers don't always understand what it means."

Case in point: Jim Stacey of Fayetteville, N.C. In 2000, Stacey and his wife, Imelda, were pleased to buy a plan at what they considered an "incredible" price from the Mid-West National Life Insurance Co. of Tennessee. The policy's list of benefits included a lifetime maximum payout of up to $1 million per person. But after Stacey learned he had prostate cancer in 2005, the policy paid only $1,480 of the $17,453 it cost for the implanted radioactive pellets he chose to treat the disease.

"To this day, I don't know what went wrong," Stacey said about the bill.

We sent the policy, along with the accompanying Explanation of Benefit forms detailing what it did and didn't pay, to Karen Pollitz, research professor at the Georgetown University Health Policy Institute. We asked Pollitz, an expert on individual health insurance, to see whether she could figure out why the policy covered so little.

"The short answer is, 'Beats the heck out of me,' " she e-mailed back to us. The Explanation of Benefit forms were missing information that she would expect to see, such as specific billing codes that explain what treatments were given. And there didn't seem to be any connection between the benefits listed in the policy and the actual amounts paid.

Contacted for comment, a spokeswoman for HealthMarkets, the parent company of Mid-West National, referred us to

Want better coverage? Try running for Congress

President Barack Obama says Americans should have access to the kind of health benefits Congress gets. We detail them below. Members of Congress and other U.S. government employees can receive care through the Federal Employees Health Benefits Program. Employees choose from hundreds of plans, but the most popular is a national Blue Cross and Blue Shield Preferred Provider Organization plan. Employee contributions for that plan are $152 per person, or $357 per family, per month.

Plan features

- No annual or lifetime limits for major services
- Deductible of $300 per person and $600 per family
- Out-of-pocket limit of $5,000 per year with preferred providers, which includes most deductibles, co-insurance, and co-payments

Covered services

- Inpatient and outpatient hospital care
- Inpatient and outpatient doctor visits
- Prescription drugs
- Diagnostic tests
- Preventive care, including routine immunizations
- Chemotherapy and radiation therapy
- Maternity care
- Family planning
- Durable medical equipment, orthopedic devices, and artificial limbs
- Organ and tissue transplants
- Inpatient and outpatient surgery
- Physical, occupational, and speech therapy
- Outpatient and inpatient mental-health care

PHOTOGRAPH BY TONY PEARCE

The real cost of illness can be staggering ...

Few Americans realize how much care costs. Coverage gaps can leave you in debt.

CONDITION	TREATMENT	TOTAL COST
Late-stage colon cancer	124 weeks of treatment, including two surgeries, three types of chemotherapy, imaging, prescription drugs, hospice care.	**$285,946**
Heart attack	56 weeks of treatment, including ambulance, ER workup, angioplasty with stent, bypass surgery, cardiac rehabilitation, counseling for depression, prescription drugs.	**$110,405**
Breast cancer	87 weeks of treatment, including lumpectomy, drugs, lab and imaging tests, chemotherapy and radiation therapy, mental-health counseling, and prosthesis.	**$104,535**
Type 2 diabetes	One year of maintenance care, including insulin and other prescription drugs, glucose test strips, syringes and other supplies, quarterly physician visits and lab, annual eye exam.	**$5,949**

... and out-of-pocket expenses can vary widely

With its lower premium and deductible, the California plan at right would seem the better deal. But because California, unlike Massachusetts, allows the sale of plans with large coverage gaps, a patient there will pay far more than a Massachusetts patient for the same breast cancer treatments, as the breakdown below shows.

SERVICE AND TOTAL COST	MASSACHUSETTS PLAN **Monthly premium for any 55-year-old:** $399 **Annual deductible:** $2,200 **Co-pays:** $25 office visit, $250 outpatient surgery after deductible, $10 for generic drugs, $25 for nonpreferred generic and brand name, $45 for nonpreferred brand name **Co-insurance:** 20% for some services **Out-of-pocket maximum:** $5,000, includes deductible, co-insurance, and all co-payments **Exclusions and limits:** Cap of 24 mental-health visits,$3,000 cap on equipment **Lifetime benefits:** Unlimited	CALIFORNIA PLAN **Monthly premium for a healthy 55-year-old:** $246 **Annual deductible:** $1,000 **Co-pays:** $25 preventive care office visits **Co-insurance:** 20% for most covered services **Out-of-pocket maximum:** $2,500, includes hospital and surgical co-insurance only. **Exclusions and limits:** Prescription drugs, most mental-health care, and wigs for chemotherapy patients not covered. Outpatient care not covered until out-of-pocket maximum satisfied from hospital /surgical co-insurance. **Lifetime benefits:** $5 million
	PATIENT PAYS	PATIENT PAYS
Hospital	**$0**	**$705**
Surgery	**$981**	**$1,136**
Office visits and procedures	**$1,833**	**$2,010**
Prescription drugs	**$1,108**	**$5,985**
Laboratory and imaging tests	**$808**	**$3,772**
Chemotherapy and radiation therapy	**$1,987**	**$21,113**
Mental-health care	**$950**	**$2,700**
Prosthesis	**$0**	**$350**
TOTAL $104,535	**$7,668**	**$37,767**

Source: Karen Pollitz, Georgetown University Health Policy Institute, using real claims data and policies. Columns of figures do not add up exactly because all numbers are rounded.

the company Web site. It stated that the company "pays claims according to the insurance contract issued to each customer" and that its policies "satisfy a need in the marketplace for a product that balances the cost with the available benefit options." The spokeswoman declined to answer specific questions about Stacey's case, citing patient privacy laws.

One reason confusion abounds, Pollitz said, is that health insurance is regulated by the states, not by the federal government, and most states (Massachusetts and New York are prominent exceptions) do not have a standard definition of what constitutes health insurance.

"Rice is rice and gasoline is gasoline. When you buy it, you know what it is," Pollitz said. "Health insurance—who knows what it is? It is some product that's sold by an insurance company. It could be a little bit or a lot of protection. You don't know what is and isn't covered. Nothing can be taken for granted."

How to protect yourself

Seek out comprehensive coverage. A good plan will cover your legitimate health care without burdening you with oversized debt.

"The idea of 'Cadillac' coverage vs. basic coverage isn't an appropriate way to think about health insurance," said Mila Kofman, Maine's superintendent of insurance. "It has to give you the care you need, when you need it, and some financial security so you don't end up out on the street."

What you want is a plan that has no caps on specific coverages. But if you have to choose, pick a plan offering unlimited coverage for hospital and outpatient treatment, doctor visits, drugs, and diagnostic and imaging tests. When it comes to lifetime coverage maximums, unlimited is best and $2 million should be the minimum. Ideally, there should be a single deductible for everything or, at most, one deductible for drugs and one for everything else. And the policy should pay for 100 percent of all expenses once your out-of-pocket payments hit a certain amount, such as $5,000 or $10,000.

If you are healthy now, do not buy a plan based on the assumption that you will stay that way. Don't think you can safely go without drug coverage, for example, because you don't take any prescriptions regularly today. "You can't know in advance if you're going to be among the .01 percent of people who needs the $20,000-a-month

TREATMENT DEFERRED Because radiation treatments were unaffordable under Jeffrey E. Miller's "affordable" policy, he postponed care for prostate cancer for five months.

biologic drug," said Gary Claxton, a vice president of the nonprofit Kaiser Family Foundation, a health-policy research organization. "What's important is if you get really sick, are you going to lose everything?"

Consider trade-offs carefully. If you have to make a trade-off to lower your premium, Claxton and Pollitz suggest opting for a higher deductible and a higher out-of-pocket limit rather than fixed dollar limits on services. Better to use up part of your retirement savings paying $10,000 up front than to lose your whole nest egg paying a $90,000 medical bill after your policy's limits are exhausted.

Look for a plan that doesn't cap your coverage.

With such a high deductible, in years when you are relatively healthy you might never collect anything from your health insurance. To economize on routine care, take advantage of free community health screenings, low-cost or free community health clinics, immediate-care clinics offered in some drugstores, and low-priced generic prescriptions sold at Target, Walmart, and elsewhere.

If your financial situation is such that you can afford neither the higher premiums of a more comprehensive policy nor high deductibles, you really have no good choices, Pollitz said, adding, "It's why we need to fix our health-care system."

Check out the policy and company. You can, at least, take some steps to choose the best plan you can afford. First, see "7 Signs a Health Plan Might Be Junk," on page 25, to learn to spot the most dangerous pitfalls and the preferred alternatives.

Use the Web to research insurers you're considering. The National Association of Insurance Commissioners posts complaint information online at *www.naic.org*.

Entering the name of the company and policy in a search engine can't hurt either. Consumers who did that recently would have discovered that Mid-West National was a subsidiary of HealthMarkets, whose disclosure and claims handling drew many customers' ire. Last year, HealthMarkets was fined $20 million after a multistate investigation of its sales practices and claims handling.

Don't rely on the salesperson's word. Jeffrey E. Miller, the Florida man whose policy failed to cover much of his cancer treatment, recalls being bombarded with e-mail and calls when he began shopping for insurance. "The salesman for the policy I bought told me it was great, and I was going to be covered, and it paid up to $100,000 for a hospital stay," he said. "But the insurance has turned out to pay very little."

Pollitz advises anyone with questions about their policy to ask the agent and get answers in writing. "Then if it turns out not to be true," she said, "you can complain."

What lawmakers need to do next

Consumers Union, the nonprofit publisher of Consumer Reports, has long supported national health-care reform that makes affordable health coverage available to all Americans. The coverage should include a basic set of required, comprehensive health-care benefits, like those in the federal plan that members of Congress enjoy. Insurers should compete for customers based on price and the quality of their services, not by limiting their risk through confusing options, incomplete information, or greatly restricted benefits.

As reform is developed and debated, Consumers Union supports these changes in the way health insurance is presented and sold:

Clear terms. All key terms in policies, such as "out-of-pocket" and "annual deductible," should be defined by law and insurers should be required to use them that way in their policies.

Standard benefits. Ideally, all plans should have a uniform set of benefits covering all medically necessary care, but consumers should be able to opt for varying levels of cost-sharing. Failing that, states should establish a menu of standardized plans, as Medicare does for Medigap plans. Consumers would then have a basis for comparing costs of plans.

Transparency. Policies that insurers currently sell should be posted in full online or available by mail upon request for anyone who wants to examine them. They should be the full, legally binding policy documents, not just a summary or marketing brochure. In many states now, consumers can't see the policy document until after they have joined the plan. At that point, they're legally entitled to a "free look" period in which to examine the policy and ask for a refund if they don't like what they see. But if they turn the policy back in, they face the prospect of being uninsured until they can find another plan.

Disclosure of costs. Every plan must provide a standard "Plan Coverage" summary that clearly displays what is—and more important, is not—covered. The summary should include independently verified estimates of total out-of-pocket costs for a standard range of serious problems, such as breast cancer treatment or heart bypass surgery.

Moreover, reliable information should be available to consumers about the costs in their area of treating various medical conditions, so that they have a better understanding of the bills they could face without adequate health coverage.

PHOTOGRAPH BY BARBARA BANKS

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HEALTH POLICY BRIEF
JUNE 2009

Simplifying Health Insurance Choices

SUMMARY

Today, consumers face a bewildering health insurance marketplace, especially if they buy insurance on their own. Americans find it all but impossible to compare health insurance policies on an "apples-to-apples" basis because the policies are written in legalese and the terms of coverage are so varied. As lawmakers consider comprehensive health care reform, they have an opportunity to fix the way we shop for health insurance. This brief recommends new, consumer-friendly rules for the health insurance marketplace. These rules require clear and consistent definitions of insurance terms, standardized health plan provisions, new health plan disclosure forms, unbiased enrollment assistance and rigorous enforcement at the state and national levels.

Today's Health Insurance Marketplace: Overwhelming Complexity

Health insurance is one of the most important purchases Americans make, yet many consumers feel helpless when it comes to shopping for coverage.

For one thing, unlike most things we buy, it's difficult to know the full cost of our health coverage option. While most people understand the amount of their monthly premium, it's far harder to compare potential out-of-pocket costs for medical services. In fact, it is almost impossible for them to assess the expenses they would face if they get sick and need extensive care.[1]

There are important underlying reasons for this confusion. To start with, policies are written in legalese or impenetrable "health insurance speak." Take, for example, this policy provision from a Rhode Island insurer:[2]

> Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for a Covered Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any

> coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

Very few consumers can make sense of the above paragraph. The average U.S. adult reads comfortably — especially about subjects they do not understand well — at an 8th grade level. Yet the *typical* health plan document is written at a first-year college reading level.[3] As one insurance official stated "it will be difficult for many health system reform ideas to get traction when people literally don't know what we are talking about."[4]

Just 12 percent of adults are fully "proficient" in health literacy.

Navigating the health insurance marketplace takes more than just reading skills. Health literacy is a broader concept that includes the ability to process numbers (numeracy) and at least a basic understanding of how to access care or coverage. Unfortunately, just 12 percent of adults are characterized as fully "proficient" in health literacy, according to one analysis.[5]

Lack of standardization adds greatly to the confusion. Terms like "deductible" or "hospitalization" can vary from plan to plan. A recent *Consumer Reports* article, for example, described a health insurance policy in which hospitalization coverage excluded the first day of hospitalization (in the fine print) — usually the most expensive day when lab and surgical suite costs are incurred.[6] Similarly, a detailed comparative study of health plans in Massachusetts and California found that plans with seemingly similar provisions would have left policyholders with out-of-pocket obligations that differed by thousands of dollars.[7] For example, a typical course of breast cancer treatment would cost the patient nearly $4,000 in one plan but $38,000 in the other plan—despite the fact the plans contained similar deductibles, co-pays and out-of-pocket limits. In the case of the second plan, the policy's out-of-pocket limit included many "exceptions" that increased costs for the consumer.

Less than a quarter of policyholders understand the terminology used in their health insurance policy.

The bottom line is that consumers end up with coverage they don't understand. One study sponsored by the insurance industry asked adults to define insurance terms and calculate their bill. Most respondents were able to answer the questions correctly just half the time.[8] Another industry-sponsored survey found that less than a quarter of respondents understood the terminology used in their health policy.[9] Unfortunately, when consumers don't understand their coverage, they may end up with unexpected costs if they need a lot of medical care.[10]

Surprisingly, consumers have little in the way of national standards that help them buy health insurance.[11] This near absence of consumer protections means that consumers often purchase coverage that doesn't suit their needs, that costs them too much, and ultimately drives up our nation's health care bill.

How Consumers Choose

When choices are overwhelming, consumers take "short-cuts" that may lead to a poor selection or they may decide not to make a purchase at all.

Consumers value "choice" when purchasing almost anything. In health care, the choice they value most is a choice of doctors and places to get care. However, at least one study indicates that consumers would actually prefer fewer choices of insurance policies in exchange for meaningful distinctions between plans and lower prices.[12]

Indeed, a large body of research concludes that too many choices often paralyze consumer decision-making.[13] When choices are overwhelming, decision-making becomes stressful for consumers. To reduce this stress, people take "cognitive short-cuts." One common short-cut is "sticking with what we know." In the world of health insurance, this often translates to sticking with the plan or policy you have, even if doesn't cover needed care or more attractive health plans are available.

Another "short cut" is to enroll in a highly advertised plan or one with a familiar brand name, rather than researching the best and most cost-effective plan. Consumers' distaste for evaluating large amounts of information, or complex information, is one reason companies put so much effort into branding. In 2008 health insurance companies spent over $645 million on advertising.[14]

If consumers don't understand information, they are more likely to dismiss it as unimportant and not use it in selecting their health plan.

Consumers are also prone to dismiss information they don't understand.[15] As a result, people often don't use the information provided by insurance companies, instead turning to family, colleagues and friends for help navigating the health plan selection process.[16]

The experience of seniors purchasing Medicare Part D (prescription drug benefit) plans illustrates the "choice" problem. On average, Medicare beneficiaries have a choice of 48 Part D plans – and some have a choice of *around 70*. One study found that, based on individuals' previous year drug use, only 6 percent of enrollees picked the plan that would save them the most money. Most enrollees were spending $360 to $520 *more* per year than the optimal plan for them.[17] Yet, relatively few enrollees switch into other, more cost-effective plans. Of 17 million Medicare Part D enrollees in 2008, only 1 million switched plans.[18] Surveys show that seniors are aware of the problem. Nearly three-quarters felt that their Part D choices were too complicated. And a majority of seniors agreed with this statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing."[19]

This "paradox of choice" is not restricted to seniors. The "Consumers' Checkbook Guide" to health plans for Federal employees reports that "hundreds of thousands of employees and annuitants are still enrolled in plans that are much more expensive than average, and that give them no needed extra benefits."[20] Federal employees, who face a lot of health plan choices, also like to "stick with what they know." In one recent two-year period, fewer than 5 percent of enrollees switched health plans.[21]

CHECKLIST FOR A BETTER HEALTH INSURANCE MARKETPLACE

- ✓ A manageable number of meaningful health plan choices.
- ✓ Standardized health plan benefits allowing "apples-to-apples" comparisons.
- ✓ Health plan materials written in "plain English," using clear, consistently defined terms, and highlighting the information of most interest to consumers (such as whether their doctor participates in the plan and likely out-of-pocket costs).
- ✓ "Plan chooser" decision aids, including a user-friendly Web-based decision tool, access to local one-on-one counseling services, and a 24-hour toll-free phone number. Proactive outreach to low-income and minority populations should be required.
- ✓ A strong oversight body that conducts consumer education, aggregates and reports on customer complaints, monitors and enforces plan quality reporting, and monitors compliance with new insurer regulations.

A Better Health Insurance Marketplace

There is a better way. We need a health insurance marketplace which has consumer protections commensurate with the importance of the purchase; new rules for insurance plan disclosure that take into account *real* consumer decision-making behavior; and less variation in health plan design so that consumers can *easily* compare benefits and costs.

To create this new marketplace, Consumers Union proposes five specific changes.

1. A MANAGEABLE NUMBER OF PLAN CHOICES

Consumers should have a manageable number of "good" health plan options. Building on current state rules for insurer financial solvency, all health plans should also be required to meet national, minimum standards for coverage, network adequacy, and claims payment and appeal procedures.

If these national standards, in combination with the reforms below, produce an excessive number of coverage plans, then health plans should be required to bid to participate in the market in order to reduce the number of health plan options to a manageable level. This approach would promote competition on price, improved patient satisfaction and quality of care. It would also avoid the problems of an excessive number of confusing, look-alike plans, such as now confronts Medicare beneficiaries in their choice of Part D and managed care (Medicare Advantage) plans. In addition to an excessive number of Part D choices, beneficiaries face 44 Medicare Advantage plans on average and some beneficiaries have 87 choices.[22] Many plans feature only minor differences from each other. Moreover, in 2008 approximately 27 percent of these plans had

fewer than 10 enrollees. [23] Listing such options leads enormously to the "clutter" in the market and provides little benefit to the consumer.

2. STANDARDIZED BENEFIT DESIGNS

What a health plan covers and how cost is shared between the plan and the patient is referred to as the "benefit design." To engage consumers and facilitate informed choice, benefit designs should be standardized and vary around only a few features.[24] In other words, health plan choices should feature clear, meaningful differences.

Excess benefit variation was the reason that Congress ordered Medigap policies standardized into 10 standard designs in 1992. Studies have found these reforms reduced beneficiary confusion, marketing abuses, and consumer complaints, and have improved benefits.[25]

To facilitate consumers' ability to compare health plans, we recommend that all health plans cover exactly the same comprehensive set of medical services, and vary *only* by their cost-sharing features and networks of doctors, hospitals, and other providers.[26]

Cost-sharing variation should be limited. To start, we recommend that annual benefit limits and life-time benefit limits be eliminated. Cost-sharing terms like "deductible" should be defined using standard, industry wide definitions. Furthermore, the plan's out-of-pocket limit should be a "hard" out-of-pocket. In other words, it must not feature exceptions that can drive the policyholder's cost beyond the stated limit.[27] If remaining cost-sharing variation is limited to a small number of designs, consumers can more reliably gauge their out-of-pocket cost exposure and better compare plans.

Exhibit 1 is an illustration of how this might work. In the example, four levels of cost-sharing are permitted (designated as "basic," "bronze," "silver" and "gold"). Within these cost-sharing "tiers," there is additional variation reflecting the comprehensiveness of the plan's provider network — that is, the number of local hospitals and doctors participating as in-network providers. Taking both dimensions into account, a total of 10 variations is permitted.

In the context of a broader health reform effort, the "basic" cost-sharing level might be the minimum (least generous) coverage allowed. On the other hand, the most generous tier might be set at cost-sharing levels that lower-income Americans can afford. Since lower levels of cost-sharing are associated with higher premiums (all other things being equal), premium subsidies would be available to help lower-income families purchase coverage that contains adequate financial protection.

EXHIBIT 1 – ILLUSTRATION OF HEALTH PLAN DESIGNS THAT VARY AROUND FEW FEATURES*						
Plan Tier	**Standard Plans**	**Premium Level**	**Provider Network**	**COST SHARING** (Illustrative only)		
				Deductible (one person)	**Office copay; Coinsurance** (for other services)	**Maximum Out-of-Pocket expense** (one person)
Basic	AA	Lowest	May be limited	$1,150	$35; 20%	$3,500
Bronze	BB	Low	May be limited	$750	$30; 20%	$2,500
	CC	Low	Fairly Comprehensive			
	DD	Low	Comprehensive			
Silver	EE	Medium	May be limited	$300	$25; 10%	$1,500
	FF	Medium	Fairly Comprehensive			
	GG	Medium	Comprehensive			
Gold	HH	High	May be limited	$0	$15; 5%	$500
	II	High	Fairly Comprehensive			
	JJ	High	Comprehensive			

** This table is for illustrative purposes only and does not constitute a recommendation for cost-sharing levels. All plans, AA to JJ, cover the same comprehensive set of services and vary only by their cost-sharing provisions and provider networks. Within a plan "tier" cost-sharing is identical.*

3. STANDARDIZED, CONSUMER-FRIENDLY HEALTH PLAN MATERIALS

Making it easier for consumers to choose a health insurance plan means making the information about those health plans *understandable*, *relevant*, and *"evaluable"* – a fancy word meaning you can readily rank your choices from best to worst.

To ensure that the materials are understandable, insurers should be required to describe their plans in simple, straightforward language, and use consistent, industry-wide definitions for common policy terms like "deductible," "out-of-pocket limit," and "hospitalization."

Health plan materials should also emphasize the information of most interest to consumers, such as out-of-pocket costs and access to doctors and specialists.[28] For example, surveys show that most people's primary interest when switching health plans is whether their current doctor is "in the plan." Further, they like to know if they have the right to see doctors outside the plan's network, and at what cost. While health plans today make this information available, it is often difficult and time consuming for consumers to compare provider networks and access rules for dozens of plans.

"Evaluable" Information

If consumers are to choose from among health plan options, they must be able to rank them. Information that makes this task easier is said to be "evaluable." Evaluable information is presented so that it is easy to find the "best" option(s). Evaluable displays of information anticipate the difficulty of weighing two dissimilar pieces of information (like health plan cost and quality), and provide short-cuts for the consumer – similar to the "Best Buy" designations in *Consumer Reports* ratings of cars or TVs.

Information is more likely to be used if:

✓ better and worse options are more obvious

✓ People don't have to work hard to figure out what the information means.

Consumers also deserve to know how well a plan serves its enrollees. Currently, formal measures of plan quality are rarely consulted, in part because people distrust information they think comes from the insurers themselves.[29] Consumers have expressed a preference for an independent entity that rates health insurers – similar to the easy-to-use financial ratings that are readily available when purchasing life insurance.[30]

To help consumers choose, government should require insurers to use a standard, consumer-friendly disclosure format to describe their health plan. Standard disclosure forms reduce consumer confusion and increase the likelihood that consumers will choose a plan that meets their needs.[31] While more detailed information should be available, at a minimum this form would 1) identify whether or not a given provider participates in the plan, 2) disclose potential out-of-pocket costs under several common medical scenarios and 3) provide premium cost.

Consumers also need information that compares health plans "side-by-side."[32] Exhibit 2 presents an example of how comparative health plan information could be displayed in ways that help consumers. The example assumes that some basic information about the applicant and their plan preferences has been provided (top of the table).

Consumers Union recommends that actual health insurance disclosure requirements be developed in consultation with consumers, insurers, literacy experts and educators, and tested on representative populations, with special attention to hard-to-reach populations and minorities. [33]

4. "PLAN CHOOSER" DECISION AIDS

Even with the simplification of insurance choices envisioned above, many consumers may still be confused by the choices confronting them. A variety of decision aids should be available to consumers accommodating their language preferences, health literacy levels, internet-access levels and cultural backgrounds.

One-on-one assistance can be critical for getting people enrolled in health plans.

Studies show that one-on-one assistance can be critical for getting people enrolled in health plans.[34] Consumers Union recommends new federal support for a nationwide network of locally-based, non-profit health insurance counseling services, including in-person counseling and phone support. The counselors should be tasked with employing creative, targeted efforts to inform and assist our nation's most vulnerable populations with their health insurance options.

EXHIBIT 2 – ILLUSTRATION OF A STANDARD PLAN COMPARISON FORM

YOU ASKED FOR HEALTH PLANS FOR:

- a healthy, 45 year old woman,
- living in the 20016 ZIP Code (Washington, DC),
- listing Dr. Smith (202-555-1212) as an in-network provider,
- and featuring the least expensive premiums.

HERE ARE THE CHOICES FOR THE 2009 PLAN YEAR (JAN 1 – DEC 31):

Plan Tier	Health Plans	Provider Network	Monthly Premium Cost	ANNUAL COSTS			How did last year's enrollees rate this plan?
				Expected costs for medical services for people like you	**Expected Total Cost** (premiums plus expected cost of services)	**The most you will pay** (for covered services using in-network providers plus premiums)	
Bronze	Downtown HMO	Limited	$125	$280	$1,780	$4,000	★★★★
	Uptown HMO	Limited	$200	$280	$2,680	$4,900	★★★
	Premier Insurance	Fairly Comprehensive	$225	$280	$2,980	$5,200	★★★★
	Health Plans R Us	Fairly Comprehensive	$235	$280	$3,100	$5,320	★★
	Humongous Insurance	Comprehensive	$245	$280	$3,220	$5,440	★★★★
	Best Practice IPA	Comprehensive	$275	$280	$3,580	$5,800	★★★

Note: This list excludes plans that a) may be cheaper but don't include your doctor in their network or b) have higher premiums (but may feature less expensive cost-sharing for medical services).

WHAT "BRONZE" PLANS PAY FOR:

The Bronze Plans all feature the same cost-sharing provisions. Subject to these cost-sharing provisions, Bronze plans cover most medical services such as inpatient and outpatient hospitals services, prescription drugs, lab, X-ray, maternity, and physician office visits. These plans do not cover cosmetic surgery, dental or vision care.

EXAMPLE: Based on the experience of prior enrollees, a healthy, 45-year-old woman might use these services during the year and expect to pay:

Service	Cost of Service	Your share	Explanation
Annual Physical, including GYN	$500	$35	Plan copay for an office visit (not subject to deductible)
Mammogram	$200	$200	Subject to the plan's $800 deductible
Doctor visit for Illness	$120	$35	Plan copay for an office visit
Generic Antibiotic	$10	$10	Plan copay for generic drug
TOTAL		**$280**	

Your experience may be different. However, even if you need a lot of medical care, your share of the cost for covered services using in-network providers will not exceed $2,500.

For help with your enrollment decision, call 1-800-PLN-HELP or visit www.planhelp.org

THE PART D DRUG FINDER TOOL — NOT EASY OR EFFICIENT

A recent article in an AARP Bulletin billed itself as the "Quick Route Through the Medicare Drug Plan Finder 2009." These instructions contained 15 steps and 2,500 words. Four instructions were to ignore or overcome a feature of the plan chooser tool in order to complete the process.

These counselors must also provide ongoing feedback to regulators and policymakers with respect to consumers' experiences — providing a key pathway for improved services over time.

Web-based tools can also facilitate health plan comparisons. However, such tools must not introduce their own level of complexity (see side bar on the Medicare Part D tool). Web-based plan chooser tools must have at least one default set of steps that is simple to complete based on the most common consumer preferences. As noted above, consumers have a strong preference for information on which doctors participate in the plan. The web-based tools should allow consumers to enter the name or phone number of their desired doctor(s) and hospital(s) and view only those plans that have the indicated providers in their network.

5. A STRONG FEDERAL OVERSIGHT BODY

Given the complexity of the health insurance marketplace and the fact that state regulatory offices are often understaffed, Consumers Union recommends a new level of federal/state cooperation in the enforcement of insurer regulations and consumer protections. We recommend that a new federal entity, in cooperation with states, perform the following functions:

- **Monitor insurer compliance with new federal standards.** Work with state insurance departments, U.S. Department of Labor (for employer plans), and other entities as needed to ensure that federal health insurance standards are implemented and enforced. Agency should provide for regular collection and analysis of data from insurers to monitor compliance/effectiveness of federal reforms.

- **Monitor state enforcement and provide federal fallback enforcement if needed.** If states fail to enforce federal standards for health insurance consumer protection, federal fallback enforcement is appropriate. Agency should also conduct some independent audits and/or market conduct exams to verify compliance directly.

- **Collect, audit and publish health plan quality information.** We recommend a federal/state partnership be charged with collecting and verifying quality information and aggregating it into measures that consumers can understand. The underlying detail should also be available to interested consumers, enrollment counselors and outside watchdog groups. The measures should use a five star-type system, graded on a curve to ensure distinctions between plans. An insurance plan that fails to provide the necessary quality data on time would not be included among plan choices. Among other things, these quality measures should include enrollee satisfaction, provider satisfaction, claims resolution records and a history of premium increases.

- **Consumer education.** The new agency should educate consumers on their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems. It should also serve as the first stop (in lieu of courts) for appeals of coverage denials. The grievance and appeals processes should be standardized and simplified so that it is easy for consumers to get what they are paying for.

- **Maintain a complaint hotline,** and compile federal and state data on insurance complaints and report this data publicly.

- **Ensure consumer co-payments for out-of-network care are based on honest, audited data.** Consumers Union supports the recommendation of the New York Attorney General, who has called for an independent, verifiable system of determining usual and customary charges so that consumers and doctors are not cheated out of millions of dollars a year in insurance payments for out-of-network care.[35]

In Conclusion

The impact of a simplified, consumer-friendly, health insurance marketplace should not be underestimated. One study, for example, found that making it easier to get information about insurance products, and simplifying the application process, could increase purchase rates as much as modest premium subsidies would.[36]

The current health reform debate provides policymakers with a unique opportunity to establish new rules that require clear and consistent definitions of insurance terms, standardize health plan provisions, and provide for rigorous enforcement at the state and national levels. We caution, however, that these new consumer protections, *by themselves*, will not accomplish our nation's larger goals of lowering health care cost trends, expanding coverage and removing poor quality care from the system.

This policy brief was written by Lynn Quincy and Steve Findlay.

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