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# CONSUMER CHOICES AND TRANSPARENCY IN THE HEALTH INSURANCE INDUSTRY

## HEARING

BEFORE THE

## COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

JUNE 24, 2009

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ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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# CONSUMER CHOICES AND TRANSPARENCY IN THE HEALTH INSURANCE INDUSTRY

**WEDNESDAY, JUNE 24, 2009**

U.S. SENATE,
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION,
*Washington, DC.*

The Committee met, pursuant to notice at 2:31 p.m. in room SR–253, Russell Senate Office Building, Hon. John D. Rockefeller IV, Chairman of the Committee, presiding.

## OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

The CHAIRMAN. This hearing will come to order. Members will soon be joining us. Today's hearing is about protecting consumers.

So I want to start by talking about the consumer. Her name is Jill Faddis. Back in 2001 she had problems with her health insurance company. She and her husband were living in Seattle, Washington at the time.

And the insurance company was the Aetna insurance company. Their Aetna policy covered visits to doctors who were not part of Aetna's network. Now understand when you say not part of her network, you're talking up to about 100 million people in the country. So don't think they're an exclusive little group. It's a huge, huge, group.

The policy promised the Faddis' that if they went to see out-of-network doctors Aetna would reimburse them at the "usual and customary rate" for the Seattle area. So relying on Aetna's promise, Jill Faddis and her husband went to visit a local periodontist. A periodontist is a dentist who specializes in gum work. And it's sort of a hard thing to do.

The periodontist charged Mrs. Faddis $140 for the visit. The charge was sent to Aetna which processed the claim and reimbursed the Faddis' only $65 for the visit for which they had been promised more. Aetna told Mrs. Faddis that the $65 was the usual and customary charge for this service. And that she and her husband would have to pay the $75 balance themselves to make up the difference.

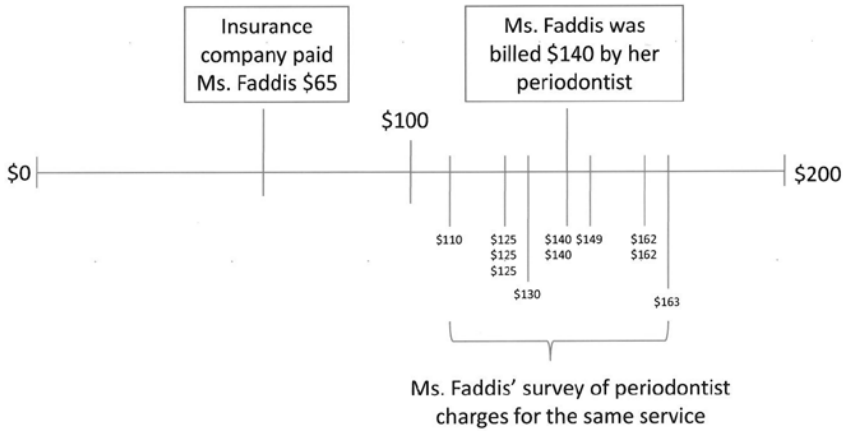
Mrs. Faddis did not take Aetna at their word. She's a classic American. She took out her Yellow Pages and she called every single periodontist in her area, Seattle and beyond.

There were about 11 or 12 folks that she reached. And I'd like to pass out at this point a chart showing what she found. She found that the actual usual and customary fee periodontists in her

area were charging for that service was somewhere between $110 and $163 for that service.

[The information referred to follows:]

Costs of Dental Services as Collected by Jill Faddis in 2001
For a General Office Visit (Code – D0150)




So then she shared her research with Aetna. She told them they had made a mistake. Aetna told her that no, she was wrong. She had made a mistake. Aetna told her that their calculation of the reasonable and customary charge for the service was $65, period.

Now this story does not have a happy ending. Mr. and Mrs. Faddis paid the $75 out of their own pocket, I mean they had to get well. She had to get well. And rather than going on to fight a big insurance company where they would lose and figured it out.

So this to me is a very disheartening story. And the thing that's most disturbing about it is that it gets repeated millions and millions of times a year, over and over again. I repeat there are a hundred million Americans outside of network systems.

Because some must turn to their health care insurance for help and clarity. And they don't get it. They think they pay for protection against the risk of high health care expenses. But the insurance company has figured out a way to wiggle out of providing the protection that they deserve. That's what they are in it for.

So the Faddis' paid the $75 and moved on. But think about the concern over the $100,000 in medical bills for breast cancer treatment protocol or about the heart attack victim whose bills total $80,000 or more, probably much more. When insurance companies fail to meet their obligation to these people and literally therefore, not invectively, but it literally becomes a matter of life and death, financially or otherwise.

Consumers cannot make real choices because the insurance company doesn't use standard language or definitions, I would say, on purpose. That's what the panel knows better than I do, if they agree.

Consumers can't challenge insurance companies' decisions. They just lose. People know that. Because the companies don't explain the terms of coverage in clear language, I would say, deliberately.

To me this is entirely unacceptable. People don't know what they are buying, what they're getting, why they're getting underpaid, while they're being forced to pay more of the difference. So with this said, I'm very happy that we have two health care experts today who can help us understand why consumers get such a raw deal from their insurance companies.

And I'm hoping that they can give us some ideas about how we can level the playing field between what we tend to value in America. And that is a patient who is pain and needs care, and an insurance company which is part of our free market system.

I'm also equally pleased to welcome Mr. Wendell Potter to the Committee today. He's a former insurance executive, who is going to tell us about some of the tactics insurance companies use to keep insurance in the dark. I have a special respect for him simply because he's doing something I think is very courageous and very brave.

I want to really, sincerely thank you, Mr. Potter, for coming forward at this very important juncture, not just in the question of insurance companies. But because of that, the whole question of what's going to happen in the health care debate. And how are we going to divide up the responsibility of what insurance companies do.

Can we depend upon their word? Should we side with consumers? Make sure they get charged only what they should be charged? And you spent most of your career in this. So I just greatly admire you for doing this.

Before I close my remarks, I want to add a very important point. A few months ago this Committee started looking at the many problems consumers have with the health insurance industry. And I think you know that. We've been working at this very, very hard.

In March we had two hearings about the deceptive Ingenix database hearings. That was a—that's a bad product which is now on its way out. Not by their own will, but because they were discovered to be defrauding consumers who were ill in the State of New York, but not beyond that.

The New York Attorney General took action. They paid $350 million. And said well, they were happy to start something, you know, they warmed up nicely. But we had them cold.

So we have pursued this matter. The Committee staff has been continuing to investigate the issue. And recently sent me a written report on what they have found so far.

I circulated this staff report to Members this morning. And I now ask and give unanimous consent to insert this report and its exhibits into the record of this hearing. And I have it in front of me, but I can't throw that all over the room. But please be sure to follow it.

[The information referred to is retained in Committee files.]

The CHAIRMAN. So I look forward to our discussion today. And to what we may learn about the parts of our health care system that are so desperately in need of reform. I mean, we are at the very precipice of doing something or doing nothing or doing some-

thing poor or doing something really good in the national debate on health care reform. We have to do it right.

I happen to be one of those people who favors a public plan. I wish I had more people joining me in that. I think they will join me in that as the debate goes along and as the groups get smaller.

But I just have to tell you that when I hear about these things this morning that I've talked about, this afternoon, about the power of insurance company to withhold information. And I have many more questions about that, to keep the consumer, the patient, uninformed and unpaid. I'm very unhappy about that.

So that concludes my opening remarks. My dear Governor, if you wish to be Ranking Member and say something, I'd welcome your comments.

**STATEMENT OF HON. MIKE JOHANNS, U.S. SENATOR FROM NEBRASKA**

Senator JOHANNS. You know what, Mr. Chairman? It's amazing how quickly you become the Ranking Member here.

[Laughter.]

Senator JOHANNS. I appreciate the Chairman putting this hearing together because it's an enormously important topic. And I'm not going to talk long because for one thing the clock is running. For another thing I'm so anxious to hear from the witnesses.

First thing I would say is that the Chairman's comments are on the mark in so many ways. And the Chairman rightfully points out that there is a national debate going on now about health care reform. And there are so many difficult issues in that and complex policy issues. One of them being the public plan verses private plan and how that might work or not work.

But in order to make sure we don't lose sight of what we're really about here today at the hearing, I do want to indicate that even if there were no debate going on about national health care or public plans, even if there were no debate whatsoever, this would warrant a hearing. This would warrant us looking into this and digging deep to see what's going on.

My sense is that there are a number of very distinct issues at work. And I'm going to ask the witnesses if they would, to try to help educate us on these distinct issues.

First, we do have Ingenix practices. The Chairman has now made the report a part of the record, certainly replete with a lot of errors, if not serious legal problems there. This practice appears to have forced consumers to pay more.

And that's not right. It just simply is not. And the unfortunate thing for consumers is this is such an enormously complicated area for them that unless they're devoting full time to understanding it, they never would have understood it or stumbled onto what was going on here.

And then, if you factor into it some who might be out there who might be doing something that is intentionally deceptive, then the problems even get more acute. They get worse.

Second, we have an issue that I think relates to the whole issue of transparency. Our policyholders, given the opportunity to be aware of the features of the very policy that they think they are buying to protect themselves investing their hard-earned money.

Or are we simply in a situation now where literally this whole arena has become so impossibly complicated, so difficult, that it's going to be nearly impossible.

Again, unless you spend full time to understand your rights under your policy, do these policies get explained to the consumer? What's going on there?

And then we have finally, and most importantly—and that's why I applaud the Chairman for holding this hearing—irrespective of anything going on in the health care industry these days, we have the whole issue of consumer's rights.

Health insurance is an item that we purchase in our lives thinking that by investing our hard-earned money into it. And like I said, it is not inexpensive. And by doing that, we believe that an umbrella of protection now extends around us. And that we can trust and rely upon that umbrella of protection that is there.

And if in fact what we find out in today's hearing is that in some respects that umbrella is not as thorough as we thought it was or as protective as we thought it was, then I think it's the obligation of this Committee to act. And to try to figure out how we can solve that problem and be able at the end of the day to assure our constituents, the consumers of the plan, that in fact, their expectation is being met. That there are laws in place to make sure that they will be protected and their rights will be protected as will the rights of their family.

So, Mr. Chairman, again, thank you. And to the witnesses, I look forward to your testimony. And I look forward to the opportunity for some robust questioning of you. Thank you.

The CHAIRMAN. Thank you very much, Senator Johanns. And his robust questioning will be exactly that. So be prepared.

I'd like to introduce our witnesses now.

And I'd like to start with Wendell Potter. As I mentioned, he spent almost 20 years working in the health care industry. I didn't mention that he was most recently the Vice President for Corporate Communications and Chief Corporate Spokesperson for the CIGNA insurance company. I call upon you, sir.

**STATEMENT OF WENDELL POTTER, FORMER HEALTH INSURANCE EXECUTIVE, PHILADELPHIA, PA**

Mr. POTTER. Mr. Chairman, thank you for the opportunity to be here this afternoon. My name is Wendell Potter and for 20 years I worked as a senior executive at health insurance companies. And I saw how they confused their customers and dumped the sick all so they can satisfy their Wall Street investors.

I know from personal experience that Members of Congress and the public have good reason to question the honesty and trustworthiness of insurance companies. When I left my job as Head of Corporate Communications for one of the country's largest insurers, I did not intend to go public as a former insider. But recently it became abundantly clear to me that the industry's charm offensive which is the most visible part of a duplicitous and well-financed PR and lobbying campaign may well shape reform in a way that benefits Wall Street far more than average Americans.

A few months after I joined CIGNA in 1993 during the last reform debate, the President of CIGNA's health insurance division

came here to assure Members of Congress that he and other industry leaders would help lawmakers pass meaningful reform. They enthusiastically supported covering all Americans, eliminating underwriting practices that excluded pre-existing conditions and that cherry-picked, healthy customers the use of community rating and the creation of the standard benefit plan. Today we are hearing industry executives saying the same things and making the same assurances.

This time though, the industry is bigger, richer and stronger. And it has a much tighter grip on our health care system than ever. Average families don't understand how Wall Street dictates whether they will be offered coverage or that they can keep it and how much they'll be charged for it. But in fact, Wall Street plays a powerful role.

Remember the top priority of for-profit companies is to drive up the value of their stock. To win the favor of influential analysts for-profit insurers must prove that they made more money during the previous quarter than a year earlier. And that a portion of premiums going to medical costs is falling.

Even very profitable companies will see sharp declines in stock prices moments after admitting they failed to trim medical costs. I have seen an insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company's medical loss ratio went up. Insurers routinely dump policyholders who are less profitable or when they get sick.

Insurers have several ways to cull the sick. They look carefully to see if a sick policyholder might not have disclosed a pre-existing condition when applying for coverage. And then they use that as justification to cancel the policy even if the enrollee has always paid his or her premiums.

They also dump small businesses whose employees' medical claims exceed what insurance underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance company to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier or stop offering coverage all together. This practice is known in the industry as "purging."

The purging of less profitable accounts by hiking rates helps explain why the number of small businesses offering coverage to their employees has fallen from 61 percent to 38 percent since 1993. Once an insurer purges a business there are often no other viable choices in the current health insurance market because of rampant industry consolidation. Purging happens all the time.

For instance, between 1996 and 1999, Aetna initiated a series of company acquisitions and became the Nation's largest insurer with 21 million members. Armed with a new computer system, new management and a shift in strategy in 2000 Aetna began sharply raising premiums on less profitable accounts. Because of this and other factors Aetna shed eight million members.

Insurers also protect their profits by being intentionally vague or even purposely misleading them. An estimated 25 million Americans are now underinsured for two main reasons.

First, the high deductible plans many of them have been forced to accept—like the one I was forced to accept at my previous com-

pany—require them to pay more out of their own pockets for medical care whether they can afford it or not.

Second, the number of underinsured people has increased as more have fallen victim to deceptive marketing practices and bought what essentially is fake insurance.

The big insurers have spent millions acquiring companies that specialize in "limited benefit plans." In one policy not only are the benefits minimal, but the underwriting criteria established by the insurer essentially guarantees big profits. Pre-existing conditions are not covered during the first 6 months and an employer must have an annual employee turnover rate of 70 percent or more. So most of the workers don't even stay on the payroll long enough to use their benefits.

Thank you, Mr. Chairman for beginning this conversation on transparency and for making this such a priority. The industry and its backers are using fear tactics as they did in 1994 to tar a transparent and accountable, publicly accountable health care option as "government run health care." But what we have today, Mr. Chairman, is Wall Street-run health care that has proven itself an untrustworthy partner to its customers, to the doctors and hospitals who deliver care and to the state and Federal Governments that attempt to regulate it.

Thank you.

[The prepared statement of Mr. Potter follows:]

PREPARED STATEMENT OF WENDELL POTTER,
FORMER HEALTH INSURANCE EXECUTIVE, PHILADELPHIA, PA

Mr. Chairman, thank you for the opportunity to be here this afternoon.

My name is Wendell Potter and for 20 years, I worked as a senior executive at health insurance companies, and I saw how they confuse their customers and dump the sick—all so they can satisfy their Wall Street investors.

I know from personal experience that Members of Congress and the public have good reason to question the honesty and trustworthiness of the insurance industry. Insurers make promises they have no intention of keeping, they flout regulations designed to protect consumers, and they make it nearly impossible to understand—or even to obtain—information we need. As you hold hearings and discuss legislative proposals over the coming weeks, I encourage you to look very closely at the role for-profit insurance companies play in making our health care system both the most expensive and one of the most dysfunctional in the world. I hope you get a real sense of what life would be like for most of us if the kind of so-called reform the insurers are lobbying for is enacted.

When I left my job as head of corporate communications for one of the country's largest insurers, I did not intend to go public as a former insider. However, it recently became abundantly clear to me that the industry's charm offensive—which is the most visible part of duplicitous and well-financed PR and lobbying campaigns—may well shape reform in a way that benefits Wall Street far more than average Americans.

A few months after I joined the health insurer CIGNA Corp. in 1993, just as the last national health care reform debate was underway, the President of CIGNA's health care division was one of three industry executives who came here to assure Members of Congress that they would help lawmakers pass meaningful reform. While they expressed concerns about some of President Clinton's proposals, they said they enthusiastically supported several specific goals.

Those goals included covering all Americans; eliminating underwriting practices like pre-existing condition exclusions and cherry-picking; the use of community rating; and the creation of a standard benefit plan. Had the industry followed through on its commitment to those goals, I wouldn't be here today.

Today we are hearing industry executives saying the same things and making the same assurances. This time, though, the industry is bigger, richer and stronger, and it has a much tighter grip on our health care system than ever before. In the 15

years since insurance companies killed the Clinton plan, the industry has consolidated to the point that it is now dominated by a cartel of large for-profit insurers.

The average family doesn't understand how Wall Street's dictates determine whether they will be offered coverage, whether they can keep it, and how much they'll be charged for it. But, in fact, Wall Street plays a powerful role. The top priority of for-profit companies is to drive up the value of their stock. Stocks fluctuate based on companies' quarterly reports, which are discussed every 3 months in conference calls with investors and analysts. On these calls, Wall Street looks investors and analysts look for two key figures: earnings per share and the medical-loss ratio, or medical "benefit" ratio, as the industry now terms it. That is the ratio between what the company actually pays out in claims and what it has left over to cover sales, marketing, underwriting and other administrative expenses and, of course, profits.

To win the favor of powerful analysts, for-profit insurers must prove that they made more money during the previous quarter than a year earlier and that the portion of the premium going to medical costs is falling. Even very profitable companies can see sharp declines in stock prices moments after admitting they've failed to trim medical costs. I have seen an insurer's stock price fall 20 percent or more in a single day after executives disclosed that the company had to spend a slightly higher percentage of premiums on medical claims during the quarter than it did during a previous period. The smoking gun was the company's first-quarter medical loss ratio, which had increased from 77.9 percent to 79.4 percent a year later.

To help meet Wall Street's relentless profit expectations, insurers routinely dump policyholders who are less profitable or who get sick. Insurers have several ways to cull the sick from their rolls. One is policy rescission. They look carefully to see if a sick policyholder may have omitted a minor illness, a pre-existing condition, when applying for coverage, and then they use that as justification to cancel the policy, even if the enrollee has never missed a premium payment. Asked directly about this practice just last week in the House Energy and Commerce Committee, executives of three of the Nation's largest health insurers refused to end the practice of canceling policies for sick enrollees. Why? Because dumping a small number of enrollees can have a big effect on the bottom line. Ten percent of the population accounts for two-thirds of all health care spending.[1] The Energy and Commerce Committee's investigation into three insurers found that they canceled the coverage of roughly 20,000 people in a five-year period, allowing the companies to avoid paying $300 million in claims.

They also dump small businesses whose employees' medical claims exceed what insurance underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance company to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier, or stop offering coverage altogether—leaving workers uninsured. The practice is known in the industry as "purging." The purging of less profitable accounts through intentionally unrealistic rate increases helps explain why the number of small businesses offering coverage to their employees has fallen from 61 percent to 38 percent since 1993, according to the National Small Business Association. Once an insurer purges a business, there are often no other viable choices in the health insurance market because of rampant industry consolidation.

An account purge so eye-popping that it caught the attention of reporters occurred in October 2006 when CIGNA notified the Entertainment Industry Group Insurance Trust that many of the Trust's members in California and New Jersey would have to pay more than some of them earned in a year if they wanted to continue their coverage. The rate increase CIGNA planned to implement, according to *USA Today,* would have meant that some family-plan premiums would exceed $44,000 a year. CIGNA gave the enrollees less than 3 months to pay the new premiums or go elsewhere.

Purging through pricing games is not limited to letting go of an isolated number of unprofitable accounts. It is endemic in the industry. For instance, between 1996 and 1999, Aetna initiated a series of company acquisitions and became the Nation's largest health insurer with 21 million members. The company spent more than $20 million that it received in fees and premiums from customers to revamp its computer systems, enabling the company to "identify and dump unprofitable corporate accounts," as the *Wall Street Journal* reported in 2004.[2] Armed with a stockpile of new information on policyholders, new management and a shift in strategy, in 2000,

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[1] Samuel Zuvekas and Joel Cohen, "Prescription Drugs And The Changing Concentration Of Health Care Expenditures," *Health Affairs,* 26 (1) (January/February 2007): 249–257.

[2] "Behind Aetna's Turnaround: Small Steps to Pare Cost of Care," *Wall Street Journal,* August 13, 2004.

Aetna sharply raised premiums on less profitable accounts. Within a few years, Aetna lost 8 million covered lives due to strategic and other factors.

While strategically initiating these cost hikes, insurers have professed to be the victims of rising health costs while taking no responsibility for their share of America's health care affordability crisis. Yet, all the while, health-plan operating margins have increased as sick people are forced to scramble for insurance.

Unless required by state law, insurers often refuse to tell customers how much of their premiums are actually being paid out in claims. A Houston employer could not get that information until the Texas legislature passed a law a few years ago requiring insurers to disclose it. That Houston employer discovered that its insurer was demanding a 22 percent rate increase in 2006 even though it had paid out only 9 percent of the employer's premium dollars for care the year before.

It's little wonder that insurers try to hide information like that from its customers. Many people fall victim to these industry tactics, but the Houston employer might have known better—it was the Harris County Medical Society, the county doctors' association.

A study conducted last year by PricewaterhouseCoopers revealed just how successful the insurers' expense management and purging actions have been over the last decade in meeting Wall Street's expectations. The accounting firm found that the collective medical-loss ratios of the seven largest for-profit insurers fell from an average of 85.3 percent in 1998 to 81.6 percent in 2008. That translates into a difference of several billion dollars in favor of insurance company shareholders and executives and at the expense of health care providers and their patients.

There are many ways insurers keep their customers in the dark and purposely mislead them—especially now that insurers have started to aggressively market health plans that charge relatively low premiums for a new brand of policies that often offer only the illusion of comprehensive coverage.

An estimated 25 million Americans are now underinsured for two principle reasons. First, the high deductible plans many of them have been forced to accept—like I was forced to accept at CIGNA—require them to pay more out of their own pockets for medical care, whether they can afford it or not. The trend toward these high-deductible plans alarms many health care experts and state insurance commissioners. As California Lieutenant Governor John Garamendi told the Associated Press in 2005 when he was serving as the state's insurance commissioner, the movement toward consumer-driven coverage will eventually result in a "death spiral" for managed care plans. This will happen, he said, as consumer-driven plans "cherry-pick" the youngest, healthiest and richest customers while forcing managed care plans to charge more to cover the sickest patients. The result, he predicted, will be more uninsured people.

In selling consumer-driven plans, insurers often try to persuade employers to go "full replacement," which means forcing all of their employees out of their current plans and into a consumer-driven plan. At least two of the biggest insurers have done just that, to the dismay of many employees who would have preferred to stay in their HMOs and PPOs. Those options were abruptly taken away from them.

Second, the number of uninsured people has increased as more have fallen victim to deceptive marketing practices and bought what essentially is fake insurance. The industry is insistent on being able to retain so-called "benefit design flexibility" so they can continue to market these kinds of often worthless policies. The big insurers have spent millions acquiring companies that specialize in what they call "limited-benefit" plans. An example of such a plan is marketed by one of the big insurers under the name of Starbridge Select. Not only are the benefits extremely limited but the underwriting criteria established by the insurer essentially guarantee big profits. Pre-existing conditions are not covered during the first 6 months, and the employer must have an annual employee turnover rate of 70 percent or more, so most of the workers don't even stay on the payroll long enough to use their benefits. The average age of employees must not be higher than 40, and no more than 65 percent of the workforce can be female. Employers don't pay any of the premiums—the employees pay for everything. As *Consumer Reports* noted in May, many people who buy limited-benefit policies, which often provide little or no hospitalization, are misled by marketing materials and think they are buying more comprehensive care. In many cases it is not until they actually try to use the policies that they find out they will get little help from the insurer in paying the bills.

The lack of candor and transparency is not limited to sales and marketing. Notices that insurers are required to send to policyholders—those explanation-of-benefit documents that are supposed to explain how the insurance company calculated its payments to providers and how much is left for the policyholder to pay—are notoriously incomprehensible. Insurers know that policyholders are so baffled by those notices they usually just ignore them or throw them away. And that's exactly the

point. If they were more understandable, more consumers might realize that they are being ripped off.

Thank you, Mr. Chairman, for beginning this conversation on transparency and for making this such a priority. S. 1050, your legislation to require insurance companies to be more honest and transparent in how they communicate with consumers, is essential. So, too, is S. 1278, the Consumers Choice Health Plan, which would create a strong public health insurance option as a benchmark in transparency and quality. Americans need and overwhelmingly support the option of obtaining coverage from a public plan. The industry and its backers are using fear tactics, as they did in 1994, to tar a transparent, publicly-accountable health care option as a "government-run system." But what we have today, Mr. Chairman, is a Wall Street-run system that has proven itself an untrustworthy partner to its customers, to the doctors and hospitals who deliver care, and to the state and Federal Governments that attempt to regulate it.

The CHAIRMAN. Thank you, Mr. Potter, very much. And we will come back to you with questions.

Nancy Metcalf is our next witness, is the Senior Program Editor for *Consumer Reports.* She has written a series of articles on junk insurance for *Consumer Reports.* And we look forward to your comments.

**STATEMENT OF NANCY METCALF,**
**SENIOR PROGRAM EDITOR, *CONSUMER REPORTS***

Ms. METCALF. Thank you, Mr. Chairman.

The CHAIRMAN. Pull that mic up nice and close.

Ms. METCALF. Thank you for inviting me to testify on this important topic.

As a health writer for *Consumer Reports,* I have talked to a lot of consumers over the years who have bought insurance on their own. And I can tell you they all bought the same, pretty uncomplicated thing, a health plan that they can afford that will not leave them destitute if they get really sick. They do their best to buy this. But way too often what they end up with is something completely inadequate.

Take Susan Kelly, a realtor from Houston. She told me I just wanted something to cover me if something catastrophic happened. Something catastrophic did.

She got breast cancer. And found out that her Mega Life policy didn't cover her outpatient chemotherapy or radiation therapy. She ended up $100,000 in debt.

Another Susan, Susan Braig, from California also wanted catastrophic coverage. And she also got breast cancer. She had a Blue Cross policy that said it covered outpatient treatment. But buried deep in the tiniest print inside a very long policy was an escape clause that they used to get out of paying it. She's $40,000 in debt.

Some of the reform proposals on the table include subsidies that will open the individual market to many millions of new consumers through health insurance exchanges. These must include strong consumer protection and transparency provisions to protect consumers from buying inadequate junk polices like these. Right now it's not a level playing field, not even close.

Consumers have no idea how health insurance works. And insurance companies know this and take advantage of it in how they design and market their plans. Sadly state regulators have not been much help. The only thing they seem to care about is that a plan is actuarially sound.

Every trick and gotcha that I'm going to talk about today is part of a legally approved and marketed plan. Here's how it plays out. Consumers don't understand how health insurance works.

A couple of years ago we ran some focus groups of people who had bought their own insurance. We asked if their policies had an annual out-of-pocket limit. They had absolutely no idea what we were talking about even though buying a policy without one is like buying a car without brakes.

They don't know the difference between co-pays and co-insurance. They don't know that a limited benefit indemnity plan might as well come with a warning label that says this plan will leave you broke if you ever get cancer. They don't understand that premiums are low for a reason.

As consumers we're trained to look for a bargain. People think insurance works the same way. They have no idea that if they're 55-years-old and have diabetes and heart disease, that no insurer could possibly stay in business selling them a policy for $150 a month. And if they do find a plan at that price, it's going to be junk insurance.

They really can't find the booby traps in their policies. I've seen a UnitedHealthcare policy that doesn't cover the first day of hospitalization which is the most expensive day, of course. I see many policies that only cover diagnostic tests if they are done in a hospital.

Aetna's standard individual health plan only covers $5,000 worth of prescription drugs a year. Somebody who needs a $2,000-a-month drug for rheumatoid arthritis would run that benefit out by St. Patrick's Day.

And consumers don't realize how catastrophic a health catastrophe can be. One of the most poignant cases I covered was a middle-aged couple who bought a UnitedHealthcare policy knowing that it had a $50,000-a-year maximum payout. It seemed like a huge sum to them until the husband got colon cancer. And his treatment cost more than $200,000. A lot of people knowingly buy hospitalization-only policies because they don't realize that some of the most expensive treatments are done on an outpatient basis.

Consumers Union believes that policies that exclude or limit major categories of care such as outpatient treatments or prescription drugs should not be sold at all. We think that all health insurance should be comprehensive and come in a few standard flavors. Differentiated mainly by the degree of cost sharing and presented in a format that makes it easy for customers to stop—consumers to shop by price.

This is not rocket science. We already sell Medigap policies this way. And it works just fine.

But absent these reforms at least insurers should be forced to be honest about what they are selling, as you, Mr. Chairman, have recognized by introducing the Informed Consumer Choices in Health Care Act. In clear, standardized, user-tested formats insurers should have to disclose what a policy covers and even more important what it doesn't cover. If a policy excludes or has low dollar limits on hospital or doctor or drug coverage, it should say so.

Consumers need to be told in big letters what their policy's out-of-pocket limit is, including if there are any expenses that don't

count toward that. They need, in other words, a fighting chance not to be ripped off by junk insurance. Thank you.

[The prepared statement of Ms. Metcalf follows:]

PREPARED STATEMENT OF NANCY METCALF,
SENIOR PROGRAM EDITOR, *CONSUMER REPORTS*

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify on this important topic.

As a health writer for *Consumer Reports,*[1] I've talked to many consumers over the years who have bought insurance on their own. And I can tell you they all want the same, uncomplicated thing: a health plan they can afford that won't leave them destitute if they get really sick.

They do their best to buy decent insurance, but way too often, they end up with something completely inadequate.

Take Susan Kelly, a realtor from Houston. She said, "I just wanted something to cover me if something catastrophic happened." It did. She got breast cancer, and found out her Mega Life policy didn't cover outpatient chemo or radiation therapy. She ended up $100,000 in debt.

Another Susan, Susan Braig from Altadena, California, said "I thought, at least I'll be covered if I have, God forbid, a catastrophic illness." The SHE got breast cancer. Her Blue Cross policy *said* it covered outpatient chemo or radiation therapy, but it had a tricky clause in it that enabled the company to deny coverage in her case. She's $40,000 in debt now.

Some of the reform proposals on the table include subsidies that will open the individual market to many millions of new customers through health insurance exchanges. These must include strong consumer protection and transparency provisions to protect consumers from buying inadequate junk policies.

Right now, it's not a level playing field, not even close. Consumers have no idea how health insurance works. Insurance companies know this and take advantage of it in how they design and market their plans. Meanwhile, state regulators have been—with a few exceptions such as New York and Massachusetts—asleep at the switch. The only thing they seem to care about is that the plan is actuarially sound. That's important, but insufficient to protect consumers. Every trick and gotcha that I'm talking about today was part of a legally approved and marketed plan.

Here is how it plays out.

*1. Consumers don't understand the working parts of health insurance.* If people bought cars the way they buy health insurance, they wouldn't be aware that a car has to have a transmission or a battery. 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, even though—if I may stretch the automotive metaphor a bit—buying a policy without one is like buying a car without brakes. They don't know the difference between co-pays and coinsurance. They don't know that a "limited benefit indemnity plan" might as well come with a warning label that says: "this plan will leave you broke if you ever get cancer."

*2. They don't understand that low premiums are low for a reason.* As consumers, we are trained to look for a bargain. People think insurance works the same way. They have no idea that if they are 55 years old, and have diabetes and heart disease, that no insurer could possibly stay in business selling them a policy for $150-a-month—and that if they do find a plan at that price, it's going to be junk insurance.

*3. They can't identify the booby traps.* I've seen a United Healthcare policy that doesn't cover the first day of hospitalization, which is commonly the most expensive day because of ER or surgery bills. I've seen many policies that only cover diagnostic tests in connection with hospitalization. Aetna's standard individual health plan only covers $5,000 of prescription drugs a year. Sounds like plenty,

[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.

but someone who needs a $2,000-a-month drug for rheumatoid arthritis would exhaust that benefit by St. Patrick's Day.

*4. They don't realize how catastrophic a health catastrophe can be.* One of the most poignant cases I ever covered was a middle-aged couple who bought a United Healthcare policy knowing it had a $50,000-a-year maximum payout, which seemed like a huge sum to them. Then the husband got colon cancer, and his treatment cost more than $200,000.[2] A lot of people knowingly buy hospitalization-only policies because they don't realize that some of the most expensive treatments are done on an outpatient basis.

**What Consumers Need**

Consumers Union believes that policies that exclude or limit major categories of care, such as outpatient treatments or prescription drugs, should not be sold at all. We think that all health insurance should be comprehensive and come in a few standard flavors, differentiated mainly by the degree of cost-sharing, and presented in a format that makes it easy for consumers to shop by price. This is not rocket science. We already sell Medigap policies this way.

But absent those reforms, at least insurers should be forced to be honest about what they're selling, as you, Mr. Chairman, have recognized by introducing the Informed Consumer Choices in Health Care Act of 2009. In clear, standardized, user-tested formats, insurers should have to disclose what a policy covers—and even more important, what it doesn't. If the policy excludes or has low dollar limits on hospital or doctor or drug coverage, it needs to say so, clearly and understandably.

Consumers need to be told, in big letters, what their policy's out-of-pocket limit is, including if there are any expenses that don't count toward that. They need to know approximately what their out-of-pocket costs will be for expensive treatments such as cancer chemotherapy or heart surgery.

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.

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ATTACHMENT

*Consumer Reports*—May 2009

**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.

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[2] "Hazardous Health Plans," *Consumer Reports,* May, 2009, pp. 24–29.

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:

- Health 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.

*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 9 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.

## 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.

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 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, 5 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.

## 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

*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.

"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 the company website. 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."

## 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 work-up, 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

| | Massachusetts Plan | California Plan |
|---|---|---|
| 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. | *Monthly premium for any* 55-year-old: $399<br>*Annual deductible:* $2,200<br>*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<br>*Co-insurance:* 20% for some services<br>*Out-of-pocket maximum:* $5,000, includes deductible, co-insurance, and all co-payments<br>*Exclusions and limits:* Cap of 24 mental-health visits, $3,000 cap on equipment<br>*Lifetime benefits:* Unlimited | *Monthly premium for a healthy 55-year-old:* $246<br>*Annual deductible:* $1,000<br>*Co-pays:* $25 preventive care office visits<br>*Co-insurance:* 20% for most covered services<br>*Out-of-pocket maximum:* $2,500, includes hospital and surgical co-insurance only<br>*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<br>*Lifetime benefits:* $5 million |

| Service and Total Cost | 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.

### *How to Protect Yourself*

*Seek out comprehensive coverage.* A good plan will cover your legitimate health care without burdening you with over-sized 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 diag-

nostic and imaging tests. When it comes to life-time 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 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.

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.

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*Consumers Union* Health Policy Brief—June 2009

## SIMPLIFYING HEALTH INSURANCE CHOICES

Written by Lynn Quincy and Steve Findlay

### 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

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[1] Karen Pollitz, Eliza Bangit, Jennifer Libster, Stephanie Lewis, and Nicole Johnston. *Coverage When It Counts. How much protection does health insurance offer and how can consumers know?,* Center for American Progress Action Fund, May 8, 2009.

[2] Rhode Island Office of the Health Insurance Commissioner. *Notice Of Adoption Of Office Of The Health Insurance Commissioner Regulation 5,* "Standards For Readability Of Health Insurance Forms," *http://Www.Ohic.Ri.Gov/Documents/Insurers/Regulations/Regulation%205%20Readability/1_Notice%20of%20proposed%20adoption%20of%20Regulation%205.PDF* (accessed: 5/4/09).

[3] Colleen Medill, Richard Wiener, Brian Bornstein, and E. McGorty, "How Readable Are Summary Plan Descriptions for Health Care Plans," *EBRI Notes,* Vol. 27, No. 10, October 2006.

health system reform ideas to get traction when people literally don't know what we are talking about."[4]

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.

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**

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]

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[4] The Regence Group. "Regence Study Shows Steep Health Plan Learning Curve," *http://www.regence.com/docs/pressReleases/2008/092208-regence-survey-shows-steep-health-plan-learning-curve-press-release.pdf* (accessed: 5/4/09).

[5] Mark Kutner, Elizabeth Greenberg, Ying Jin, and Christine Paulsen. *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy,* U.S. Department of Education, National Center for Education Statistics, September 6, 2006.

[6] "Hazardous Health Plans," *Consumer Reports,* May 2009.

[7] Pollitz *et al., op cit.*

[8] The Regence Group, *op cit.*

[9] 2008 Survey sponsored by eHealth Inc., parent company of ehealthinsurance. *http://phx.corporate-ir.net/phoenix.zhtml?c=201232&p=irol-newsArticle&ID=1090963&highlight*=(accessed: 6/1/09).

[10] "Hazardous Health Plans," *op cit.*

[11] The few standards that do exist are not rigorously enforced. See, for example, Medill *et al., op cit.*

[12] Jonathan Gruber. *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?,* Henry J. Kaiser Foundation, March 2009.

[13] Dale Shaller. *Consumers in Health Care: The Burden of Choice,* California HealthCare Foundation, October 2004.

[14] Personal communication from TNS Media Intelligence, May 20, 2009.

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

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[15] Judith Hibbard and Jacquelyn Jewett. "Will Quality Report Cards Help Consumers?," *Health Affairs,* 1997.

[16] Michael Wroblewski. "Uniform Health Insurance Information Can Help Consumers Make Informed Purchase Decisions," *Journal of Insurance Regulation,* 26(2):21–37, 2007.

[17] Gruber, *op. cit.* The author was careful to note that plan selection based on current use of health care services is not necessarily predictive of the protection offered against future health care needs.

[18] U.S. Government Accountability Office. "Medicare Part D: Opportunities Exist for Improving Information Sent to Enrollees and Scheduling the Annual Election Period," GAO–09–4, December 2008.

[19] Gruber, *op cit.*

[20] Washington Consumers' Checkbook. *2009 Guide to Health Plans for Federal Employees,* published 2008.

[21] U.S. Government Accountability Office, *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits, Report to the Subcommittee on International Security, Proliferation, and Federal Services, Committee on Governmental Affairs, U.S. Senate,* GAO–03–236, December 2002.

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.

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[22] Marsha Gold. "Medicare's Private Plans: A Report Card on Medicare Advantage," *Health Affairs* 28, No. 1, w41–w54 (published online November 24, 2008).

[23] CMS Office of Public Affairs, *CMS Issues Guidance For Medicare Advantage And Prescription Drug Plans For 2010* (press release), March 30, 2009.

[24] Requiring that health plans meet a standard of actuarial equivalence—that is pay the same percent of charges on average—but be allowed to vary the benefit design is not a workable substitute. Such a policy would leave consumers unable to meaningfully compare health plans. See Pollitz, *op cit.*

[25] Jim Hahn. *Standardized Choices: Medigap Lessons for Medicare Part D,* CRS Report for Congress, March 8, 2006.

[26] This approach is similar to the one used in Massachusetts for plans offered through the Connector. Connector plans differ from this proposal in that the cost-sharing design must adhere to prescribed levels of "actuarial value" rather than set benefit designs (as is done in Medigap). In addition, these plans must conform to the state's standard for minimum credible coverage.

[27] Pollitz (*op cit.*) describes real health plans whose provisions lead to costs for covered services that vastly exceed the plan's stated out-of-pocket maximum.

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.

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.

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

[28] Alison Rein. *Consumer Choice in the Health Insurance and Provider Markets: A Look at the Evidence Thus Far,* Robert Wood Johnson Foundation, October 25, 2007.

[29] A. Monroe. "Consumer Involvement—A Vital Piece of the Quality Quilt: the California HealthCare Foundation's Strategy for Engaging California Consumers", *Quality and Safety in Health Care,* Vol. 11, No. 2 (2002).

[30] Dale Shaller, Shoshanna Sofaer, Steven D. Findlay, Judith H. Hibbard, David Lansky and Suzanne Delbanco. "Consumers And Quality-Driven Health Care: A Call To Action," *Health Affairs,* 22, No. 2 (2003).

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.

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, D.C.),
- 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).*

[31] Wroblewski, *op cit.*

[32] EHealth Inc. 2008 survey, *op cit.*

[33] For an example, see the "Coverage Facts" prototype included in: Katherine B. Wilson. Check the Label: Helping Consumers Shop for Individual Health Coverage, California Health Care Foundation, June 2008.

[34] Lynn Quincy, Patricia Collins, Kristin Andrews and Christal Stone. *Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the Literature and a Synthesis of Stakeholder Views,* Mathematica Policy Research, December 31, 2008.

| 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.

The CHAIRMAN. Thank you very, very much, Ms. Metcalf. And now we have Ms. Karen Pollitz, who I have had the honor of knowing for a long time. And she's a Research Professor at the Georgetown University Health Policy Institute. I thought you ran the place. You don't.

Ms. POLLITZ. Nobody runs the place.

The CHAIRMAN. I'll wait another year.

[Laughter.]

The CHAIRMAN. She studies regulation of private health insurance in her spare time and her professional time. Karen Pollitz?

## STATEMENT OF KAREN POLLITZ, RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

Ms. POLLITZ. Thank you, Mr. Chairman. It is a honor to be here. I usually—I'm used to sitting at your elbow. So it's very nice to see you face to face at a hearing.

I don't need to tell you, of all people, that health insurance is all about spreading risk. But that's a very difficult thing to do. A small proportion of the population accounts for the vast majority of health care spending, about 1 percent, the sickest 1 percent of us account for a quarter of all medical care spending.

And so there's a powerful, powerful financial incentive, as you've heard from Mr. Potter, for insurers to try to avoid the sickest people or to avoid paying their claims. And that incentive isn't going to go away after health care reform. It will be important certainly to make rules, to say to insurers that they can't turn people down anymore, charge them more, offer poorer benefits. But in order for

[35] New York Office of the Attorney General, "Health Care Report: The Consumer Reimbursement System is Code Blue," January 13, 2009.

[36] M. Marquis, M. Buntin, J. Escarce, K. Kapur, T. Louis, and J. Yegian. "Consumer Decision Making in the Individual Health Insurance Market," *Health Affairs,* May 2006.

coverage to be secure you are going to need greater transparency and accountability in private health insurance than you have today.

Transparency in health insurance is going to involve three key elements.

The first is reporting of data by health insurers to regulators about what they sell, what they—who they enroll, who they dis-enroll. You're going to need to be able to really get into the operations of health insurance companies, make them tell you how they work. And not just in general and not just on average, but in very specific ways so that you can track what's happening to people when they are sick. That small number of people is who you need to be able to keep an eye on throughout the health insurance system. And insurers need to be able to—or need to be required to report that data to regulators on an ongoing basis.

Disclosure to consumers is the second element. As Nancy has said, consumers don't understand their health insurance. Industry studies show that overwhelmingly people don't understand their health insurance.

They find it confusing. They don't know the terms. The majority of people asked said that they would prefer to work on their income taxes than try to read their insurance policy.

It's a very, very complicated document. So disclosure to consumers means telling them in meaningful ways what it is that their coverage does. And how it will work for them and what it will pay and what it won't pay.

We recently completed a study of health insurance policies sold in the State of California looking at the one that Nancy mentioned that covered Ms. Braig. And also even in the State of Massachusetts which is now highly regulated and has a lot of rules. And what we found is that there is still a lot of moving parts in health insurance policies, a lot of different ways in which they can move.

And as Nancy mentioned, the terms of health insurance don't mean the same. So even in Massachusetts policies that had an out-of-pocket limit, mostly didn't cover all of your out-of-pocket costs. They just covered some of your out-of-pocket costs. But other policies did cover all of your out-of-pocket costs, but they used the same term. They all said there's an out-of-pocket limit.

So we found that under one—two bronze policies in Massachusetts. These are supposed to be actuarial equivalent policies. A breast cancer patient might pay about $7,600 of her total treatment costs, out-of-pocket. And under another bronze policy actuarial equivalent, same out-of-pocket limit, she would pay $13,000, out-of-pocket. So we need more standardization in terms of these terms.

And we also need to show people what it is that their coverage would do for them. We have recommended the development of something called Coverage Facts labels modeled on the Nutrition Facts labels that you see on your cereal box that would lay out a set of standardized claim scenarios for some recognizable conditions: breast cancer, pregnancy, heart attack. And then ask insurers to take those standardized claim scenarios and process them under the policies that they sell.

And then show people in a very detailed way, here's what the policy would cover. Here's what the policy wouldn't cover and you would have to pay and give them a bottom line. So that when they are shopping and comparing the price of policies they can actually see what it would cover.

Transparency is going to be important. But accountability is also going to be very, very important because again of the strong financial incentives we just can't run the health insurance system on the honor system. There's going to need to be strong oversight and strong enforcement of the rules that are there to protect consumers.

In particular it's going to be very important for there to be resources to monitor the health insurance industry and to enforce the rules, resources that are sadly lacking today. At a hearing last summer, over on the House side, the Committee on Oversight and Government Reform, a Representative of the Administration testified that at HHS there were four part-time people whose job it was to monitor all of the HIPAA protections for private health insurance in Federal law. Four, part-time people, that's it.

And despite, this was a hearing on rescissions, despite press reports about abusive rescission practices, no one at HHS had looked into it. No one had asked any questions. No one had even checked to see if the state laws were up to speed and were protecting people in these ways.

Over at the Department of Labor which has oversight over employer sponsored health plans, where most of us get our coverage, testimony has been given that there are resources for that department to review each employer sponsored health plan under its jurisdiction once every 300 years.

And at the state level, regulatory resources are also very limited. I think the states are trying very hard. But state insurance departments have to oversee all lines of insurance, not just health insurance. They have seen staffing cuts, significant staffing cuts in recent years.

And most of them also oversee other things, banking, insurance, commerce, real estate. In four states the Insurance Commissioner is also the Fire Marshall. And they do not have the resources to have, in most states, a dedicated team that just keeps an eye on health insurance all the time doing regular monitoring, regular audits, to make sure that consumers are protected. They have to operate in response to complaints.

So in conclusion, Mr. Chairman, I want to congratulate you for introducing the Informed Consumer Choices in Health Care Act. That bill would provide for the transparency and accountability that we need and the resources to make that happen. I hope that will be part of health reform. And I'm very happy to take your questions.

[The prepared statement of Ms. Pollitz follows:]

PREPARED STATEMENT OF KAREN POLLITZ, RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

Good afternoon, Mr. Chairman and Members of the Committee.

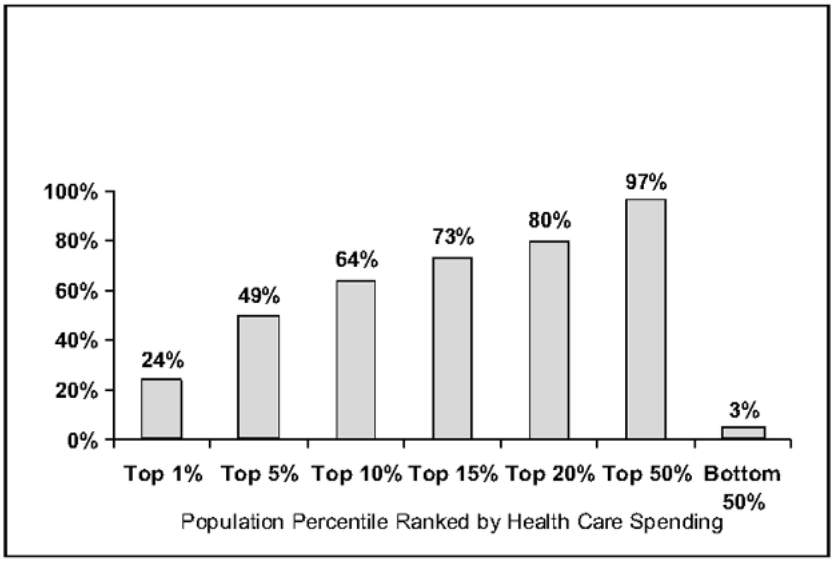
My name is Karen Pollitz. I am a Research Professor at the Georgetown University Health Policy Institute where I study the regulation of private health insurance.

Thank you for holding this hearing today on transparency and accountability in health insurance. These characteristics are lacking in private health insurance today and must be strengthened as part of health care reform.

**The Paradox of Risk Spreading**

It has long been true that a small proportion of the population accounts for the majority of medical care spending. (See Figure 1) Most of us are healthy most of the time, but when serious or chronic illness or injury strikes, our medical care needs quickly become extensive and expensive.

**Figure 1. Concentration of Health Spending in the U.S. Population**




Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003. Population includes those without any health care spending. Health spending defined as total payments, or the sum of spending by all payer sources.

Because of this distribution, we buy health insurance to spread risks and protect our access to health care in case we get sick. However, the same distribution creates a powerful financial incentive for insurers to *avoid* risk. In a competitive market, if an insurer can manage to avoid enrolling or paying claims for even a small share of the sickest patients, it can offer coverage at lower premiums and earn higher profits.

Today, insurance companies employ many methods to discriminate against consumers when they are sick. Medical underwriting may be the best known—a process used to assess the risk of applicants. People who have health problems may be denied health insurance when they apply. Or they may be offered a policy with a surcharged premium and/or limits on covered benefits including pre-existing condition exclusions.

However, underwriting is not confined just to the application process. New policyholders (both individuals and small groups) who make large claims during the first year or two of coverage will likely be subject to post-claims underwriting. During this process insurers will re-investigate the applicant's health status and history prior to the coverage effective date. Any discrepancy or omission, even if unintentional and unrelated to the current claim, can result in coverage being rescinded or canceled. At a hearing of the House Energy and Commerce Committee last week, patients testified about having their health insurance policies rescinded soon after making claims for serious health conditions. One woman who is currently battling breast cancer testified that her coverage was revoked for failure to disclose a visit to a dermatologist for acne. At this hearing, when asked whether they would cease

the practice of rescission except in cases of fraud, executives of leading private health insurance companies testified that they would not.[1]

Health care reform legislation will likely include rules to prohibit these practices—guaranteed issue, modified community rating, and prohibition on rescissions and preexisting condition exclusions. These rules are important, but alone, will not put an end to competition based on risk selection. The incentive to compete based on risk selection will not go away.

Insurers can use other formal and informal methods to discriminate based on health status. For example, they can make strategic decisions about where and to whom to market coverage, avoiding areas and populations associated with higher costs and risk. So-called "street underwriting" can be used to size up the health status of applicants before deciding whether to continue with the sales pitch. Insurers can also design covered benefits and provider networks to effectively attract healthy consumers and deter sicker patients from enrolling or remaining enrolled. Claims payment practices and care authorization protocols can also create hassles for patients that discourage coverage retention. Fine print in policy contracts may limit coverage or reimbursement for covered services, leaving consumers to pay out-of-pocket for medical bills they thought would be covered.

Therefore, rules will not be enough. To ensure health coverage is meaningful and secure, greater transparency and accountability must also be required of private health insurance.

**Transparency in Health Insurance**

Transparency in health insurance will involve three key elements:

- reporting to regulators of data on health insurance company products and practices;
- greater disclosure to consumers of how their coverage works and what it will pay; and
- standardization of health insurance terms, definitions, and practices so that consumers can have a choice of good coverage options without having to worry about falling into traps.

*Data*—Insurers should report information to health insurance regulators on an ongoing basis about their marketing practices. Data on the number of applications received and new enrollments, as well as data on enrollment retention, renewals, non-renewals, cancellations, and rescissions will be needed. In addition, data must be reported on health insurance rating practices at issue and at renewal. Regulators should know what policies are being sold, what they cover, and who is covered by them. Measures of coverage effectiveness will also be needed to track what medical bills insured consumers are left to pay on their own. Tracking of provider participation, fees, and insurer reimbursement levels is essential. Health insurance policy loss ratios (the share of premium that pays claims, vs. administrative costs) must be monitored. So must be insurer practices regarding claims payment and utilization review. If regulators have access to this kind of information, patterns of problems that affect the sickest consumers won't be easy to hide.

*Disclosure*—Consumers need much more information about their coverage and health plan choices. Adequate disclosure to consumers begins by ensuring that complete information about how coverage works is readily available. Policy contract language should be posted on insurance company websites so that it can always be inspected by consumers and their advocates. Current provider network directories and prescription drug formularies should also be open to public inspection at all times.

In addition, for each policy marketed, insurers should be required to provide "Coverage facts labels that illustrate how the policy will work to cover standard illustrative patient care scenarios. Recently we issued two reports on the adequacy and transparency of coverage sold in Massachusetts and California. Our reports found substantial differences in coverage protection provided by policies that might otherwise appear similar to consumers. Even in Massachusetts, with its extensive health care reforms and market regulation, significant variation in policy features persists and could leave patients to pay medical bills they did not expect and cannot afford. For example, under two so-called "bronze" policies that have the same actuarial value and cover the same benefits, we found a breast cancer patient might pay

[1] Lisa Girion, "Health insurers refuse to limit rescission of coverage," *Los Angeles Times,* June 17, 2009.

$7,600 out-of-pocket for her treatment under one policy, but $13,000 out-of-pocket for the same treatment under the other policy.[2]

To make coverage differences more obvious to consumers, a series of "Coverage Facts" labels could be developed that simulate the medical care claims patients might have under several expensive conditions, such as breast cancer, heart attack, diabetes, or pregnancy. Insurers would be required to take these standardized scenarios, "process" the simulated claims under policies they sell, and then, for each policy, present a detailed summary of what would be covered and would be left for patients to pay. The format for these labels could be patterned after the Nutrition Facts label that help consumers understand the ingredients and nutritional value of packaged foods. See Figure 2.

**Figure 2. Sample "Coverage Facts" Label for Health Insurance**

**Coverage Facts**

**Individually Purchased Health Insurance, 2008**

**Plan C (Bronze)**

| | |
|---|---|
| **Monthly Premium (age 55)** | **$596** |
| **Annual deductible** | **$2,000, $100 for Rx** |
| **Annual OOP limit** | **$5,000** |
| **Cost sharing not subject to annual OOP** | **Medical, prescription, mental health co-pays** |
| **Significant exclusions, benefit limits** | **none** |

**Breast Cancer Scenario** ‡
**(May 1 diagnosis, 87 weeks active treatment)**

| | |
|---|---|
| Estimated allowed charges for all treatment | $143,180 |
| **Estimated paid by patient** | **$12,907 (9%)** |

| Care type | # billed | Total allowed charges ($) | $ paid by patient | % paid by patient |
|---|---|---|---|---|
| Office Visit | 48 | 4,387 | 1,200 | 38% |
| Office Procedure | 47 | 466 | 202 | 43% |
| Radiology | 12 | 5,789 | 898 | 6% |
| Laboratory | 40 | 2,924 | 472 | 10% |
| Surgery | 1 | 3,386 | 1,683 | 34% |
| Hospital | 1 | 3,293 | 659 | 0 |
| Inpat Med Care | 1 | 174 | 35 | 0 |
| Rx Drugs | 36 | 5,473 | 1,185 | 19% |
| Prostheses | 1 | 360 | 72 | 0 |
| Chemotherapy | 36 | 98,124 | 3,967 | * |
| Mental Health | 36 | 2,894 | 900 | 33% |
| Radiation Therapy | 35 | 15,911 | 1,635 | 10% |

* signifies less than 1/2 of 1%

| Source of expense | Number encountered | Amount |
|---|---|---|
| Annual deductibles | 3 | $4,300 |
| Co-pays | 120 | $3,160 |
| Co-insurance | - | $5,447 |
| Non-covered care | n/a | $0 |

‡Breast Cancer Scenario includes outpatient lumpectomy, 4 two-week cycles each of two chemotherapy regimens, 7 weeks of daily radiation therapy, one year of Herceptin therapy, short term mental health counseling, various diagnostic lab and imaging services and prescription drugs. Scenario based on treatment guidelines published by NCCN. ***Individual patient care needs may vary.***

All care assumed to be received from in-network providers following all plan rules for prior authorization. Receipt of care by non-plan providers or without required authorizations can result in substantially higher out-of-pocket costs.

Active treatment over 87 weeks beginning in May assumes patient faces annual deductibles and other cost sharing in three plan years. Diagnosis at different time during calendar year could produce different cost sharing results.

[2] Karen Pollitz, *et. al.*, "Coverage When It Counts: What Does Health Insurance in Massachusetts Cover and How Can Consumers Know?" May 2009. Available at *http://www.rwjf.org/pr/product.jsp?id=42248.*

Consumers will need to know other information about how health insurers operate, including rates of prompt payment of claims and claims denials, loss ratios, and the number and nature of complaints and enforcement actions taken against an insurer. Health plan report cards should be developed to provide this information. As people shop for coverage, they must be able to compare differences in efficiency and the level of customer service that insurers provide.

*Standardization*—People clearly value choice in health coverage, but so many dimensions of coverage vary in so many ways that choices can become overwhelming and even sometimes hide features that will later limit or prevent coverage for needed care. An important goal of health care reform must be to adopt a minimum benefit standard so consumers can be confident that all health plan choices will deliver at least a basic level of protection. Key health insurance terms and definitions must also be standardized. For example, the "out-of-pocket limit" on cost sharing should be defined to limit *all* patient cost sharing, not just some of it. If a plan says it covers hospital care, that should mean the entire hospitalization is covered, not all but the first day.[3] Further, when consumer choice of plans includes low-, medium- and high-option plans, standardized tiers should be developed so people can be confident they are comparing like policies.

**Accountability in Health Insurance**

Finally, Mr. Chairman, accountability in health insurance requires strong rules and the capacity to monitor and enforce compliance.

*Strong rules* must be clear, with few exceptions, so they are harder to evade. Weaker rules and exceptions create opportunities for current problems to persist. For example, health care reform legislation pending in the Senate will prohibit discrimination based on health status in premium rates, covered benefits, and eligibility. At the same time, however, Senate Committees are considering an exception to this rule that would allow premiums to vary based on health status in the context of so-called wellness programs. Some employers today offer wellness programs with pointed financial incentives for employees to not only participate, but actually change their health status. Under one popular program, all employee costs are increased by $2,000 at the outset. Workers then have the opportunity to reduce costs by $2,000, but only if they enroll in the incentive program and pass four health status tests, including normal readings for blood pressure, blood cholesterol, body mass index, and tobacco use. On the website for this wellness program, under "Frequently Asked Questions for Employers" it is acknowledged that employer savings are achieved when some employees "choose other health care options."[4]

Because this program discourages some sicker employees from taking coverage, it operates very similarly to other insurer practices of charging higher premiums to people with high blood pressure or high cholesterol in order to deter their enrollment. If discrimination like this is prohibited in one context but allowed in another, holding private health insurance to a nondiscrimination standard will be a challenge.

*Regulatory resources*—Finally, accountability in health insurance requires resources. Private health insurance regulatory resources at the Federal level are particularly lacking and must be increased. At a hearing last summer of the House Committee on Oversight and Government Reform, a representative of the Bush Administration testified that the Centers for Medicare and Medicaid Services (CMS), which is responsible for oversight of HIPAA private health insurance protections, then dedicated only four part-time staff to HIPAA health insurance issues. Further, despite press reports alleging abusive rescission practices, the agency did not investigate or even make inquiries as to whether Federal law guaranteed renewability protections were being adequately enforced.[5]

Additional resources will also be needed at the U.S. Department of Labor (DOL). After the enactment of HIPAA, a witness for DOL testified the Department had resources to review each employer-sponsored health plan under its jurisdiction once every 300 years.[6]

At the state level, limited regulatory resources are also an issue. In addition to health coverage, state commissioners oversee all other lines of insurance. In several states the Insurance Commissioner also regulates banking, commerce, securities, or

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[3] A discussion of plans that include these kinds of features is available in "Hazardous health plans: Coverage gaps can leave you in big trouble," *Consumer Reports,* May 2009.

[4] See *http://www.benicompadvantage.com/products/faq_employers.htm.*

[5] Testimony of Abby Block, Hearing on Business Practices in the Individual Health Insurance Market: Termination of Coverage, Committee on Oversight and Government Reform, U.S. House of Representatives, July 17, 2008.

[6] Testimony of Olena Berg, Assistant Secretary of Labor, Pension and Welfare Benefits Administration, Senate Labor and Human Resources Committee, October 1, 1997.

real estate. In four states, the Insurance Commissioner is also the fire marshal. State insurance departments collectively experienced an 11 percent staffing reduction in 2007 while the premium volume they oversaw increased 12 percent.[7] State regulators necessarily focus primarily on licensing and solvency. Dedicated staff to oversee health insurance—and in particular, insurer compliance with HIPAA rules—are limited.

**Informed Consumer Choices in Health Care Act of 2009**

Mr. Chairman, I want to congratulate you for introducing S. 1050, The Informed Consumer Choices in Health Care Act of 2009. And I commend Congresswoman Rosa DeLauro for authoring companion legislation in the House of Representatives, H.R. 2427. This bill would create a framework to assure greater transparency and accountability in health insurance. It would establish a new Federal agency within HHS tasked specifically with private health insurance oversight. This agency would develop new consumer information and disclosure tools, including a Coverage Facts label for health insurance. It would require regular reporting by insurers on industry products and practices. The bill provides resources for HHS to hire expert staff to carry out these functions and coordinate with state regulators. And it creates a grant program for state insurance departments so they, too, can have resources to better enforce market rules and protect consumers. This legislation and it deserves to be included in health care reform.

In conclusion, starting with the financial industry bailout this year and continuing with the economic stimulus package, transparency and accountability have become the watchwords of this Congress, as taxpayers demand to know how their money is spent and whether stated goals have been achieved. As Congress prepares to make another significant and critically important investment, this time in our health care system, transparency and accountability must also guide your way.

The CHAIRMAN. Thank you very much, Karen Pollitz. I will lead with the questions, will be followed by Senator Johanns and then Senator Klobuchar.

The focus of today's hearing and there are several focuses. But why is it so hard for consumers to get clear, reliable information? I don't always think so much in terms of insurance policies.

But if I get a prescription for something if I'm not well and then you take that little thing out of the bottom of the bag, and I have to get out magnifying glasses and things that Galileo invented in order to find out, you know, what's actually written there. And there's a reason for that, that I won't read it, which of course, I never do. Therefore whatever they want to have happen, can happen.

I'd like to start this discussion on this document which I'm holding up and which will be to some degree passed out, called Examples of Benefits Documents. And it's not very pretty either in appearance or in substance. It's called an Explanation of Benefits or Explanation of Benefits statement.

Every time a consumer goes to see a doctor or receives medical service he or she receives one of these Explanation of Benefits statements. And the health insurance companies send tens of millions of these statements to their policyholders every year. Now the Explanation of Benefits is supposed to "explain to the consumer how much the doctor charged for the service and how much the insurance company pays as a reimbursement for the service." And it sounds pretty simple, pretty straight forward, I would guess.

But it's not, when you start trying to read these statements. Each insurance company has its own specific terminology. And I want to emphasize that each one has its own specific terminology.

[7] National Association of Insurance Commissioners, *2007 Insurance Department Resources Report,* 2008.

So if you are dealing at various levels or inter family this or cousins or aunts, uncles, mothers, fathers, whatever, who knows what you've got trying to figure out. Each insurance company uses its own coding statement. I'm not, as Chairman of the Committee, quite sure myself of what a coding statement is as I speak.

And I'm embarrassed by that. But that is the fact. And therefore, I think it reflects something, if only about me. And each insurance company has its own set of indecipherable instructions.

Now, Mr. Potter, you worked as an executive for the CIGNA insurance company for many years. Do you think the average CIGNA policyholder could understand the Explanation of Benefits statements that CIGNA sent them?

Mr. POTTER. Mr. Chairman, I couldn't understand them when I got them. And I'd been in the industry for many years, as you noted. Absolutely not.

And it has become more problematic as the insurance industry has begun focusing more on what it refers to as consumer driven care. But these are the high deductible plans that are becoming so prevalent now. The EOB or Explanations of Benefit statements that are sent to people who have enrolled in these plans are far more complex than people used to get when they were in HMOs and PPOs.

The insurers don't have significant incentive to make them clearer or more understandable. I was serving as Co-Chair of the industry's Task Force on Health Literacy when I left. And we had a meeting in Chicago. And I had——

The CHAIRMAN. So you were central to trying to make it work?

Mr. POTTER. That's correct. And we were—I suggested and some of the other members of the Committee agreed that something to tackle, that would be good for the industry to tackle would be the EOBs.

The CHAIRMAN. What happened?

Mr. POTTER. I was told that it wasn't a priority. That they would take the idea to the leadership, but not to expect that this would be something that the industry would want to focus on. And maybe they have.

But there has been no evidence of it because the EOBs I've been getting are no more clear than they ever have been. In fact, they're getting worse.

The CHAIRMAN. Alright. Do you think that CIGNA and other health insurance companies are sending out these benefits because it's in their interest to keep as much information as possible from the policyholders?

Mr. POTTER. I think that's the—I think they know that that's the case. These companies make more than a billion dollars a year. The for-profit companies do.

So they certainly could have the resources to devote something to make them clearer. But it's not a priority. And I think they realize that most people are baffled by these EOBs. And don't know how—what to do with them.

The CHAIRMAN. Explanation of benefits.

Mr. POTTER. Yes, explanation of benefits. And I also think that, you know, they realize that people will just simply give up. And not pursue it.

The CHAIRMAN. And that's the secret, isn't it, knowing that people are going to give up?

Mr. POTTER. I think so, sir.

The CHAIRMAN. You win every time that way.

Mr. POTTER. Senator, I think you're exactly right.

The CHAIRMAN. Now one of the things that Ms. Pollitz and other health care experts have proposed is standardizing all of the language. Now that to me doesn't sound like a very radical idea and in fact like a very sensible idea. And I'd love to see you do that, Karen.

So that all companies use all terms that are equal and mean the same thing to anybody who ever receives them for any reason. And that would be in their written materials and whatever else. That would give consumers at least a fighting chance at understanding what kind of deal they're going to get for their health care dollars.

Mr. Potter, again, during your time and I apologize for extending a little bit here. During your working experience in the insurance industry, did anyone ever discuss standardizing the language of these Explanation of Benefits statements?

Mr. POTTER. Not that I'm aware of, Mr. Chairman. And I think there's also an awareness that most people don't even understand the simple terms that are in there. I read a story recently based on a survey of the American population. More than half of the people in this country don't even understand what the word co-payment is or co-insurance is.

The CHAIRMAN. That's important to say. That's important to say. I thank you, sir, very much.

And I now call upon all of you, but I call upon—when I said earlier, my dear Governor. And now it's Senator Johanns.

Senator JOHANNS. Thank you very much. Just because you're on this side, Mr. Potter, I'll start my questioning with you. And I do want to thank you for being here. I appreciate that immensely.

Mr. Potter, you've had an opportunity in your life, I suspect, to buy a number of pieces of real estate.

Mr. POTTER. I have.

Senator JOHANNS. You sit through the closing and you've got your closing agent there. Sometimes you have your own lawyer there.

It's complicated, isn't it?

Mr. POTTER. Very complicated.

Senator JOHANNS. And you peel document after document. And you're signing document after document. And did you ever stop the closing and say, well, whoa, wait a second. I want to read every one of these documents.

Mr. POTTER. I did once, but not after that. It's overwhelming.

Senator JOHANNS. It is overwhelming. Most of those documents, if you noticed, are required by Federal law.

Mr. POTTER. Yes.

Senator JOHANNS. In our effort to try to simplify this, I think we've made it hopelessly complicated. Have you ever bought an automobile and financed that automobile?

Mr. POTTER. I have, sir, yes.

Senator JOHANNS. Same sort of situation, isn't it?

Mr. POTTER. It is.

Senator JOHANNS. Now when you were sitting there with your real estate transaction and your car transaction and spending very substantial amounts of money—typically the house is the biggest investment most people make in their life—did it occur to you or did you think to yourself, you know, I bet that closing agent is doing something fraudulent to me?

Mr. POTTER. Senator, that really didn't occur to me as much as I have faith that I'm going to be treated fairly.

Senator JOHANNS. Yes.

Mr. POTTER. And that's my experience and how I felt. Maybe, I think the best of people and think that. That that's been what I've hoped for.

Senator JOHANNS. Normally, I have that assumption too. I usually assume people are going to treat me fairly. Now zeroing in on what you've talked about—I've been here long enough to know—that on the spectrum of the downright fraudulent and criminal and people stealing, and that I've seen.

I sat through a hearing involving Bernie Madoff where he made off with $60 billion. Then I've seen the other end of the spectrum where quite honestly we just didn't regulate very well. I sat through a hearing on derivatives recently. Talk about complicated.

Where are we at on the spectrum in terms of your testimony and your claim about the insurance companies? Is it criminal or are we just not regulating very well, or some point in between?

Mr. POTTER. I—it's probably somewhere in between. I think that regulation is not adequate. I think that insurance companies realize, as Ms. Pollitz has mentioned, that regulatory agencies are not adequately resourced and certainly not at the Federal level, but not even at the state level.

Senator JOHANNS. The Chairman knows me well enough to know that I was a Governor once in my life. And Governors have the responsibility of balancing state budgets. In fact, I come from a state where we had a little bit different twist to it.

We not only had to balance it, we also had to make sure we never borrowed any money. The State of Nebraska doesn't owe anybody any money. I think that's kind of unique these days.

But what I'm getting to here is there has been discussion, and there's kind of a raging debate about a government plan or public option or whatever terminology you want to put to it. The label doesn't really matter to me; it's something else.

Let me ask you, you know if you look at Medicare. That's not a balanced budget situation. Every thoughtful analysis of Medicare tells us that pretty quickly here, 7, 8 years out, it's insolvent. If it were a private company, it would be broke. You wouldn't be buying that stock today.

You're familiar with that?

Mr. POTTER. I am.

Senator JOHANNS. Now that's not very good either is it?

Mr. POTTER. In health care reform I think a lot of things need to be addressed. And I think that is one element.

Senator JOHANNS. We should pay for the health care we have already, right?

Mr. POTTER. We should. I think, Senator, as the Members of Congress approach this, we need to look at this certainly as a cost

to taxpayers, but also as an investment in our country and our people. Yes, it will be expensive. There's no doubt.

But what does it say about us when 50 million of us that don't have insurance?

Senator JOHANNS. OK. Let's talk about this 50 million. My understanding is that about 10 million aren't here as American citizens. Is that something we should do in health care reform?

Mr. POTTER. Senator, that's interesting. One of the things I did when I was at CIGNA. I was helping to craft some documents that tried to segment who was uninsured and what, you know, the components of the uninsured.

I think that as lawmakers look at reform that probably and possibly should be crafted so that people who are here illegally should not be covered. If you were to travel to England or Canada, I think possibly if you had an accident or were taken ill, you more than likely would be cared for there and you wouldn't be a legal citizen of those countries.

Senator JOHANNS. Well, the reality here in this country too, as you know, if you end up at an emergency ward, they treat you.

Mr. POTTER. They do. Well, usually they do.

Senator JOHANNS. Yes. They're going to deal with the emergency. We could go all through that number.

But I don't want to get us off track here. Because as you know, there's also about 20 percent of that number that do qualify for a plan, Medicaid or whatever. And they just, for whatever reason, we haven't gotten them signed up.

Mr. POTTER. That's right.

Senator JOHANNS. But anyway, let me get to what we're trying to do here. You've got 50 states that regulate in this area. You've got a Federal Government that regulates in this area. Big debate about what's going on.

In a very succinct answer, if you were to really address the issue of consumers buying the policy and not knowing what they're getting, how best would you address that? So that when that consumer walked out of that agent's office or wherever, policy in hand and you said, Madam Consumer or Mister Consumer, tell me what you have in there? You could assure me as a legislator that they could answer that question thoughtfully and carefully and intelligently.

How do I get there?

Mr. POTTER. I think the work of this Committee is possibly helping the country to get there. I think there should be standardized language. I think that there should be clear and understandable information provided to people about the insurance policies that is available to them so that they understand what the limits are or the limitations are and what's covered and what's not.

I think that more information is vital. And that should be something that's addressed as part of reform.

Senator JOHANNS. Thank you for your answer. Mr. Chairman, you're always patient with me. I'm hoping there will be another round of questions. I don't know if there will, but thank you.

The CHAIRMAN. I will be here as long as the good Senator is here.

[Laughter.]

The CHAIRMAN. Senator Klobuchar?

**STATEMENT OF HON. AMY KLOBUCHAR, U.S. SENATOR FROM MINNESOTA**

Senator KLOBUCHAR. Thank you very much, Mr. Chairman. And thank you for holding this important hearing. Thank you to our distinguished panelists.

You know what's happening with the cost of health care. Families are going under. They can't bear the cost anymore.

My own home State of Minnesota has some of the highest quality, lowest cost care in the country. And part of that, I believe, is because we have been focused for a long time on transparency, and a number of other things, as well as a more organized health care system and a team approach and some of the work that Mayo Clinic is doing.

But in terms of transparency we have been doing a lot. And there's a law in Minnesota that requires health plans and providers to, upon request, to provide consumers with information on the cost of a specific procedure. And to provide information as to what their out-of-pocket cost will be based on their contract.

Would this be a useful model, do you believe, Ms. Pollitz? Maybe you want to go in terms of allowing people to understand or do you think it's still going to be too complicated?

Ms. POLLITZ. No, I think the more information that you can require to be made available to people, the better. It is very helpful to know. It's one thing to be told right before you need to get the procedure if your doctor has already said you need this. At that point the cost is a little bit less important because your doctor has already said you need it.

So—and, but if you step back and try to anticipate what your health care needs might be that's also difficult because we don't really always know what will happen to us tomorrow or next year. So our notion of a coverage facts label was to try to anticipate some common scenarios where people would need health care. And to provide information about all of the care they would need, all of the charges that would be involved.

In part to educate them about how much protection they really are buying or how much they're trying to protect against. But also to let them see in advance, you know, when they are calm and aren't, sort of, in a medical crisis, how well a policy might cover and might pay for the services that they might need down the road.

Senator KLOBUCHAR. *Ucare.com* is a website in Minnesota that allows consumers to compare prices and offerings of health providers in the Twin cities. And it actually allows them to book services kind of like Expedia or *Travelocity.com.* So they can see how much it costs and then book services.

Do you think this is another model that could be helpful as we go forward, as we're trying to figure out how to bring costs down and get that transparency out there?

Ms. POLLITZ. I don't know anything about that. It sounds fascinating. I'm—it's really quite innovative.

Senator KLOBUCHAR. The women are strong and the men are good looking.

Ms. POLLITZ. Good looking. I remember, yes.

[Laughter.]

Senator KLOBUCHAR. And all the recounts are above average.

Ms. POLLITZ. Yes.

[Laughter.]

Senator KLOBUCHAR. OK. So now the—you, I know that Senator Rockefeller has been doing some ground breaking work here with this idea of a coverage facts label. And your research studied conditions like breast cancer or heart attack and this information. Do you think we could do this with other conditions as well to try to show on the label how much this would cost?

Ms. POLLITZ. Oh, you absolutely could. We did a study that preceded this one looking at maternity care. If I can figure it out with my limited medical knowledge, I'm quite sure that other conditions could be developed and spec'ed out that way.

Senator KLOBUCHAR. You know, as we look at this issue of transparency and trying to show how much things cost, and maybe this is for you, Ms. Metcalf, Mr. Potter, the issue is also quality.

And one of the things we're trying to do with health care reform based on some of the work done in Minnesota is put a quality index in there. So we're not just measuring costs that we're also looking at quality. And how would that be integrated with this label?

Ms. METCALF. You're talking about quality of care?

Senator KLOBUCHAR. That's right.

Ms. METCALF. By health plans?

Senator KLOBUCHAR. Well, that's right.

Ms. METCALF. There is, of course, some of that today with Hedis measures and the NCQA. There are a number of agencies that already make quality information available to health plans. But to me that's health insurance 300. And we're still on health insurance 100 which is if you can't buy proper health insurance it could be—the health system around you could be the highest possible quality. But you can't access it because you can't afford to pay for it.

But I do think it would be wonderful. And coming from a magazine that is in business to give little blobs, as we call them, to rate things, I think it would be great to be able to rate health insurance plans on all dimensions including quality and service and——

Senator KLOBUCHAR. And one of the things that I was surprised by was, I think in your testimony, where you talked about how sometimes people don't even find out what's excluded. I have here a list of exclusions. They don't even find out what's excluded from their policies, from their insurance policies until they actually buy it. How can that happen?

Ms. METCALF. Because in most states you can't see your insurance policy until you've bought it.

Senator KLOBUCHAR. You mean the states don't even allow you? There's no——

Ms. METCALF. No, what you see before you buy is a promotional material of some kind. And some states are stricter about that than others. But you'll see a list or a description of some kind talking about the health plan that's often extremely unclear.

An example that comes up a lot is you'll see a plan that says, we have a $1,500 deductible. But it won't say what goes into that deductible or not. We have a $5,000 out-of-pocket limit. You can't tell from the promotional material what goes into that out-of-pocket limit or not.

They'll often have a thick line. And then below that they'll have the drug benefit. And they won't explain that the drug benefit is a completely separate thing that has no limit on out-of-pocket payments.

There are all kinds of things that you don't know when you're shopping for a health insurance plan that you only find out after you get a document that's half-an-inch thick and is densely written.

Senator KLOBUCHAR. And also, I think you notice sometimes they have exclusions but they don't include all the exclusions.

Ms. METCALF. They don't include all the exclusions. They'll often not say this policy doesn't cover drugs, even though it doesn't. They'll tell you it doesn't cover a nose job.

But I don't think that most people expect a health insurance policy to cover a nose job. That's not a helpful exclusion to tell people about.

Senator KLOBUCHAR. Very good. On the nose job, I will end.

[Laughter.]

Senator KLOBUCHAR. But thank you very much. This has been incredibly helpful. And I think it shows the reasons to have some kind of a label or some way for people to better understand what these policies are about. Thank you.

The CHAIRMAN. Senator Udall?

**STATEMENT OF HON. TOM UDALL,**
**U.S. SENATOR FROM NEW MEXICO**

Senator UDALL. Thank you very much, Chairman Rockefeller. Good to be here with you. From the just short exchange I heard since I arrived here, it's clear that greater transparency in health insurance policies is needed for consumers to better understand what's available and to compare policies.

And in your report you recommend developing standardized health care comparison tools for health insurance similar to the USDA nutrition labels, Ms. Pollitz. And that could help consumers understand what and how much is covered across different health insurance policies. What would you suggest specifically be included in such a tool or chart?

Ms. POLLITZ. I think actually there should be a series of charts. What we found in studying health insurance policies is that within a single policy there are different levels of coverage. Inpatient care may be covered at one level, outpatient services at another, mental health care at yet another, prescription at yet another, rehab services at yet another.

So I think coverage facts labels should demonstrate the care that people might need under different scenarios that in some cases rely heavily on inpatient care.

The heart attack scenario that we developed, 75 percent of the medical costs incurred there were in the hospital.

But in our breast cancer patient over 90 percent of her costs were incurred outside of the hospital in outpatient settings.

And then we did a third scenario with diabetes where overwhelmingly the costs were spent at CVS on pharmaceutical supplies and insulin and other drugs to manage the diabetes.

So I think you would want a series of labels that would demonstrate for people and test out all of the different types of cov-

erage that they might need from their policy. And then let them see how the policy would work. And if they were standardized scenarios you could then compare two different policies and see them compared on the same situation so that you would get a fairer idea of what the differences might be.

Senator UDALL. But even with that kind of comparison it's still a very difficult choice in many situations, isn't it because you're looking down? If you don't have an immediate situation as you describe, you don't have cancer, breast cancer or diabetes or whatever it is, then you don't know really what to choose to protect yourself in the future?

Ms. POLLITZ. Exactly.

Senator UDALL. And with all these exclusions and the way the policies are put together. They are in many cases trying to make sure that they don't have to get into those situations, is what I assume is happening here.

Ms. POLLITZ. Right. But in the labels that we developed, the exclusions became apparent. Because the scenario was laid out if you had breast cancer you'd need this surgery and these many chemos and these many drugs and a wig.

And then you could look across and see how much would the policy cover of each of those things. And any time there's a zero, chances are that was an exclusion.

Senator UDALL. Do you, Ms. Metcalf or Mr. Potter, have any comment on that?

Ms. METCALF. Well, I was interested in what you said, Senator, about people not knowing—not being able to choose based on their anticipation of a health condition. And it's the reason that we think at Consumer's Union that policies should cover all medical treatment that people need because you can't foresee. It's a mistake that we have found a lot of people make when they buy insurance.

I'll give you a classic example as many companies market special policies to young adults. They are very inexpensive. And one of the reasons—well, they're inexpensive for one thing because young adults are cheap to insure cause they are pretty healthy.

Another one is that they often don't cover prescription drugs. And the young person who doesn't take a prescription drug says, I don't need drug coverage. I don't take any pills.

So they don't have that coverage. They don't realize what can happen. And what can happen is next year they can get multiple sclerosis. And suddenly they need a drug that costs $10,000 a month. And they're shocked when their insurance company won't cover it.

So it's partly a matter, I think, of—I think that one of the good points of one of these coverage facts plan is that it brings home to people the different possibilities of financial disaster if you don't buy a comprehensive plan.

Senator UDALL. And isn't the issue you just brought up of where you have MS for example. And it's diagnosed. And they won't cover it.

Doesn't that also bring up the precondition issue of that? For them, they then have an outstanding condition. And then if they try to go get insurance for it. Many times it's rejected or they just say we're not going to allow you to do that.

Ms. METCALF. Exactly. If they're in the individual market and they develop a condition and discover that their insurance isn't adequate to pay for it, they're really stuck because they can't change to another policy at that point.

Senator UDALL. Yes, yes.

Mr. POTTER. Senator, I agree with Ms. Metcalf. I think it's especially important as insurers start pushing more of these high deductible plans. And there's a term in the industry that executives and financial analysts use. It's called benefit bygones. And we're seeing more and more of that.

And what that means is that increasingly as policies come up for renewal employers will look, well how can I either shift more cost to my employees or what benefits can I cut to be able to continue to offer coverage at all? So you're seeing that all the time. And all the time you hear it, you're on an analyst call. You'll hear about benefit bygones. And as what is happening in the marketplace.

The other point about the pre-existing conditions is let's just step back a minute. Where is the logic and the humanity of having pre-existing conditions not covered in our society? I mean, my children have asthma. They didn't—it wasn't anything that they had any control over.

But their policies won't cover any pulmonary problems they might have had. Where is the logic in that?

Senator UDALL. Yes. I couldn't agree more. Thank you, Chairman Rockefeller, for your courtesies. I went a little over here I think on the time.

The CHAIRMAN. You are welcome to do that because you always have sensible things to say.

You know, I'm still—I want to go back to this business of how confusing all of this is to the consumer. Because I think it's—you know what we're really talking about here is we've got just so many people to—people say we've got 45 uninsured Americans. Well, we have 25 million—45 million uninsured Americans.

We have 25 underinsured Americans. And we have people who have insurance for 6 months and then they lose it so they lose it for much longer. And then you have people who are too rural or too poor in some ways. So that people come and collect them and whisk them off to getting insurance coverage.

But what comes through to me in this whole argument so strongly is that you have so many vulnerable, now here we're talking about out of network. And people say, oh, well that must be a couple thousand people. Yes, it's a hundred million people. It's a hundred million people.

And they're vulnerable. And therefore they deserve to be treated with respect and with care and with a system that works. But what you're looking at is a whole lot of for-profit insurance companies that are not only not giving them coverage through duplicitous methods which have now been, you know, done in in New York State and soon will be.

Ingenix, which I mentioned, is going to cease to exist in about 5 or 6 months. Somebody will take its place, I'm sure. But we'll find them too.

They're making so much money. They're making so much money. But they're spending so much of their time having so much money,

trying to find ways to get rid of people through purging and other things which we can talk about, through getting people who are risks who they think are too poor or not likely to pay them, to get them off their lists all together. So they don't have to fool with them.

I mean, this is not like two equally powerful groups facing each other. This is this mammothly powerful group and this very small, fragile group in need, in pain, sick. And it's an unequal fight.

And the insurance company enjoys that because they know they can take advantage of it. And they know they can win every single time. And that is entirely wrong.

And that's what a lot of this whole health care debate is about which is why I have an argument with some of my friends, who are my dear friends, who say that a public option which would simply put, you know, Medicare dollars in competition with very, very wealthy insurance companies is unfair, somehow. It's un-American. It's against the free enterprise system.

It is the free enterprise system. It is the free enterprise system. It just happens that sometimes you have to trigger the free enterprise system to see how good they really are.

Now I've already used more than half my time. You know, people I've got a little pamphlet here which we'll pass out. I keep saying that. I don't know if we do. Called, "How Aetna pays claims for out-of-network benefits."

[The information referred to follows:]

**How Aetna Pays for Out-of-Network Benefits**

We negotiate rates with doctors, dentists and other health care providers to help you save money. We refer to these providers as being "in our network."

Some of our plans pay for services from providers who are not in our network. Many of those plans pay for out-of-network services based on what is called the "reasonable," "usual and customary" or "prevailing" charge. Here is how we figure out that charge.

**Step 1: We review the data**

We get information from Ingenix, which is owned by United HealthCare. Health plans send Ingenix copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge. Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code.

**Example:** Providers' charges for removing an appendix are grouped into percentiles from low to high. The higher charges are grouped into the higher percentiles. Charges that fall in the middle are grouped in the 50th percentile. Here is a simplified illustration of a percentile chart for an appendectomy for one zip code:

| PERCENTILE | APPENDECTOMY |
|---|---|
| 50th | $1650 |
| 60th | $1650 |
| 70th | $1800 |
| 75th | $2508 |
| 80th | $2625 |
| 85th | $3110 |
| 90th | $3110 |
| 95th | $3400 |

**Step 2: We calculate the portion we pay**

For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services. Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code.

If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use "derived charge data" instead. "Derived charge data" is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed. We also use derived charge data for our student health plans and Aetna Affordable Health Choices® plans.

**Step 3: We refer to your health plan**

We pay our portion of the prevailing charge as listed in your health plan. You pay your portion (called "coinsurance") and any deductible.

Sometimes what we pay is less than what your provider charges. In that case, your provider may require you to pay the difference. This is true even if you have reached your plan's out-of-pocket maximum.

**Example:** You use a doctor who is not in Aetna's network. The doctor charges $120 for a service. The doctor sends the claim to Aetna. Your plan covers 70 percent of the "reasonable," "usual and customary" or "prevailing" charge. Let's say the prevailing charge is $100. And let's say you already met your deductible. Aetna would pay $70. You would pay the other $30. Your doctor may bill you for the $20 difference between the prevailing charge ($100) and the billed charge ($120). In this case, your doctor could bill you for a total of $50.

We may consider other factors to determine what to pay if a service is unusual or not performed often in your area. These factors can include:

- The complexity of the service
- The degree of skill needed
- The provider's specialty
- The prevailing charge in other areas
- Aetna's own data

**Exceptions**

Please note that this general description does not apply to every case. Some plans set the prevailing charge at a different percentile. For some claims (like those from hospitals and outpatient centers) we may use other information and data sources to determine the charge. And not all our plans use Ingenix. (Medicare plans and plans that pay based on fee schedules are examples.)

Our provider claims coding and reimbursement policies may also affect what we pay for a claim. These policies will be shown on your Explanation of Benefits documents.

**Background**

The New York State Attorney General (NYAG) investigated the conflicts of interest related to the ownership and use of Ingenix data. Under an agreement with the NYAG, UnitedHealth Group agreed to stop using the Ingenix databases when an independent database (not owned by a health insurer) is created.

In a separate agreement with NYAG in January 2009, Aetna agreed to use this new database when it is ready. We also will work with the new database owner to create online tools to give you better information about the cost of your care when using providers outside our network. Most importantly, you can ask your provider what a service will cost and find the prevailing charge for that service.

**For More Information**

Please see your plan documents to learn more. Or call member services. Their phone number is on the back of your Aetna ID card.

It's not very glossy. I think that's deliberate. It's the kind of thing that you sort of don't want to read because it looks kind of boring.

And so you probably don't read it. And maybe that's the purpose of it. But they don't disclose what they're doing.

They do it in language that consumers cannot possibly understand. And let me give you some of their language because I care about this language. It says in there at one place, "you," that is the consumer. "You pay the co-insurance percentage of the prevailing allowance (usual and customary at the 75th percentile) for covered services. You will be responsible for the difference between the plan payment and the amount billed by the dentist."

Well, how many consumers know what a co-insurance percentage is? How many know what a prevailing allowance is? How many of them, I mean, how many of them know what usual and customary is?

I mean we know that in the health care industry. But they don't. How are they going to look it up? In a dictionary? It's three words.

I mean, they're going to know the word. But everything else is just a fog to them. And that's wrong.

And they've been doing this for years and years and years. And they've been getting away with it. Then they get hit with some lawsuits.

So maybe they're going to back off from it a little bit. Maybe they're not because they're very clever and they've got lots of people, lots of floors, lots of tall buildings to figure out how to get around these things. And big corporations can usually do that.

So anyway, Aetna sent out that little group of words. And Mr. Potter, can you explain please, to me why you have to sue, not you personally, but the American has to sue or has to subpoena or investigate the insurance industry before they'll tell consumers how their policies work in plain, comprehensible English?

We've been talking about this a bit. But I want to drive it home. Why can't we do that? Why aren't we forcing our industries to do that?

Mr. POTTER. I do not know why we're not forcing the industries to do that. We should. Again it's not a priority in the industry to do that.

It's not in their best interest to make it clearer. I was part of the Legal and Public Affairs department at CIGNA. My boss was one of the top lawyers.

I mention that just because these kinds of materials are reviewed. They're a combination of medical, legal, marketing jargon usually. And buzz words and terms that the industry uses that have little meaning to the rest of the American public.

I would have a hard time understanding a lot of what's being written here. Much of it is written to satisfy a lawyer's expectation that it be explicit from the lawyer's point of view, but not from a, you know, regular person's point of view.

The CHAIRMAN. Let me just end this part by saying that it's sad to me because Americans are trusting people. And I'm always very happy about that. That's why I'm glad that I married a young lady from Chicago.

I mean, the Midwest is trusting. The Northeast and the Southwest is a little less trusting. I don't know. But they're good people.

And when you say Aetna or CIGNA or you know, one of these big insurance companies people tend to trust them just because

they're a large institution with large amounts of money with a clearly public interest purpose. That is to pay health insurance for people who are sick. And they have the money to do it and people know that. So people tend to trust them.

And then they turn around and spend their money on figuring out how to get rid of people. So they can make more money. And don't have to—I mean, why would they care so much about that more money?

Why would they be proud about dropping eight million people because they, you know, they were too big a health risk or probably weren't going to be able to pay. What is insurance for? What is public policy for? What is America for? What do we stand for when it comes to the care of our people?

We had a Metro accident obviously and it's tragic in Washington. And the first thing to hit you when you read the news and heard the news was how people were just clawing through hot steel and cutting themselves to try and rescue their neighbors, to get comfort to their neighbors, or give last rites to their neighbors in this wreckage. I mean, we are people that try to protect each other and do the right thing by each other.

And yet here we have insurance companies, as a matter of practice, we don't question them partly because we do trust them. And now we're paying this terrible consequence. A lot of people are just, you know, breast cancer, whatever, just left out in the cold.

And it makes me very, very angry. And I now turn to my more reasonable and sensible Governor, former Governor of the State of Nebraska.

Senator JOHANNS. Well, thank you. I've lived my whole life in the Midwest. I grew up in northern Iowa and spent my adult life in Nebraska.

I would just offer this. We also have, I think, a healthy suspicion about those who claim that government will solve all problems. And I look at the Medicare financial situation and it's easy to reach that conclusion. I, as Governor, dealt with state budgets. And did everything I could to sign up every single child to our Kids Connection program.

I believed in it. I knew my costs were going to go up in the state budget. And I would have to defend that with conservative friends. But I really believed in it.

And you know what? We could only get to 90 percent. You know why? Because there were 10 percent that did not want their kids in the program and that was their right.

When you started your discussion today I got the impression that each witness was——

The CHAIRMAN. Would the Senator yield?

Senator JOHANNS. Yes.

The CHAIRMAN. Then I take this out of my next round.

Senator JOHANNS. I will be happy to yield.

The CHAIRMAN. Well, I'm going to be here as long as you're going to be here.

[Laughter.]

The CHAIRMAN. But West Virginia is in fact more of a Midwestern state than it is an Eastern state or a Northern state or it's more of a Southern state than. But Midwestern basically in its val-

ues and that's what counts. You talked about the 10 percent that don't take advantage of that.

I started out as a VISTA volunteer in West Virginia in a little town with the closest hospital or rural health clinic was so far away that if you had a car and if your car could possibly make it. And if you could afford the gasoline because you didn't have a job, you didn't have an education. You didn't know where the hospital had been.

Some of the people from the community that I worked in for 2 years had never crossed a street with a red light or had been up a building in an elevator. Because that's rural life and you know that from Nebraska. So sometimes, it's like sometimes people would hold their children back from going to school. It was made easier by the fact that the county refused to send us a school bus to pick up our children because they thought we were irrelevant and too far away and not important.

But I mean, sometimes it's not so the government or people being irresponsible. Personal responsibility is a very, very valid concept. I strongly believe in it. But I think that one has to define it fairly.

And I apologize for interrupting you.

Senator JOHANNS. Well, you never have to apologize, Mr. Chairman.

Let me, if I might, focus in. I think we kind of got off to a start here. And Mr. Potter, you were obviously, continuing to be quite critical of your former employer.

But I get the impression what you're really asking me to do, as a member of this Committee and somebody who will try to figure out the legislation, you're really trying to get me to focus in on how can we better explain what people are getting. Right?

Mr. POTTER. Yes, sir.

Senator JOHANNS. OK. And then you mention the pre-existing conditions and I don't disagree with you there. I think you make a compelling point. But I don't hear a lot of disagreement here either as we talk about health care issues.

I'm going to leave you alone now. Thank you for being here.

Ms. Metcalf, if I might ask a question of you. Again, as I hear your testimony and whether you favor a public plan government option, whatever it's called, I think, too, what you're trying to get me to focus on is look, Mike, if you just sat down and read this stuff you won't understand it.

And if you're not understanding it and you're a member of the U.S. Senate, how can you possibly expect a young family to ever figure this stuff out until the insurance company reads it or doesn't read it, sends them a letter, and says, you're not covered. The young family then finally reads it and goes, oh my lord. They've made the point.

What we need, I think, is some really good concrete ideas on how to make that better. Because what it comes down to is this. It's like the questioning with Mr. Potter. You've owned real estate. We've passed tons of laws to make real estate transactions more understandable and it's just page after page of federal-ese.

And it just goes on and on. And if there's one thing we've found about this financial crisis, many people had no idea what they were

signing when they signed their mortgage. Now all of a sudden they've got their letter that their mortgage was going to reset.

And they asked themselves, reset? What does that mean? And they realized they were out of luck. So we need some advice on how best to do that.

Same way with you, Ms. Pollitz, is that how you pronounce it?

Ms. POLLITZ. Pollitz.

Senator JOHANNS. Pollitz. I think you've made some excellent points here. But I would hate to get at the end of this and find out that we've only made it more complicated, not less complicated.

Ms. POLLITZ. Senator, there's no question that health insurance is an inherently complicated thing and medical care is an inherently complicated thing. And I think there have been many efforts to try to, you know, drive all of this down to a fifth grade reading level. And that's just always going to be a very difficult thing to do and a very imperfect outcome.

Having said that, we switched from steadying the policies that were for sale in the private market in other states and for the last few months we've been reading polices that are for sale to you, through the Federal Employees Health Benefits program. And there are requirements. And all of the companies meet them.

And I have to say reading through your health plan is such a relief to me after having read through some of these other ones. So, I mean, there are rules about that things have to be explained. They have to be explained in a way that the average participant could begin to understand.

There have to be examples to illustrate, you know, this is what's covered. This is what's not. This is what we mean by that. Here's an example.

The terms have to be standardized. There's a common order to the brochures. So you always sort of, begin with what's covered and then how it's covered and then in certain orders.

And it does make it easier. It's still hard. But it's a whole lot easier than some of the other policies that I looked at. So I think you can make progress on this without necessarily tackling the whole thing in one try.

Senator JOHANNS. Just off the cuff, not seeing a piece of legislation in front of me, to me, that's a no-brainer. If that's what this is about today that you're saying to us, Mike, if you could just make this as readable as what you got when you signed up for your Blue Cross policy here with the Federal Government, as did every other Federal employee. Man, I'm there.

If that's what we're getting to here today then this hearing has been well worth the effort and well worth your time, I hope, because that makes sense to me. Absolutely. Thank you.

Mr. POLLITZ. Great.

Senator JOHANNS. All of you, I appreciate it.

The CHAIRMAN. Can I just close this hearing unless any of you have statements that you would like to make at the end? By hardly agreeing with what you've said, Senator Johanns. It is, listening to the conversation, you go for this most complicated list of things, but horrifically written and all different. And then we said, we'll just make it right across the board so that everybody understands it.

And all of a sudden you say, now wait a second. That's not going to work. That's not possible.

And the answer is that it probably is possible, but that's it's going to be very hard to do. And that the companies that are involved are going to have to communicate with their people saying they are in the process of doing this.

And they're going to do it. And maybe you can't get it, maybe you can get it done in 2 weeks, maybe in 2 months, maybe in 2 years. I don't know.

But it does have to happen. People have to know what they're buying. And what they're going to get. And what they're not going to get. And that is axiomatic. That is not something that one can argue against.

So I would agree with you, Senator. That's—it's a no-brainer. If this hearing accomplishes nothing else and I hope it did accomplish something else. And we were able to do that.

It is worth it. It is worth it. And I think all of you would be right on the front lines with your number two pencils ready to go.

Do any of you have any closing comments?

Mr. POTTER. Senator, I would just like to make one comment. I—and need to address your point. I hope that I'm not coming across as someone who is just critical of my former employer.

I had a good career at CIGNA and was well compensated. And I was there for 15 years and lasted 15 years. My comments are directed toward an industry that is really going in the wrong direction and taking this country in the wrong direction.

The CHAIRMAN. I don't know why you should be worried about that. I mean, it is nice of you to say. But if we were doing Normandy Beach and we had all of our ships headed away from the beach, I would assume somebody would say this is not good. We ought to change this. And that's really what we've said here.

And I really honor you. I mean, I really respect you.

Mr. POTTER. Thank you, sir.

The CHAIRMAN. I was going to say that you're better than Russell Crowe on The Insider. But actually, I mean, they had to—he really would, you just sort of came out and did it because you cared about the insurance industry because you worked with it for a long time. And you want to see it work.

Mr. POTTER. Yes, sir.

The CHAIRMAN. And I honor you for that. And I thank you all for your presence. And this hearing is adjourned.

[Whereupon, at 3:53 p.m. the hearing was adjourned.]

# A P P E N D I X

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO KAREN POLLITZ

*Question 1.* The minimum creditable coverage standards in Massachusetts for 2009 include inpatient and outpatient hospital and physician care, emergency services, mental health and substance abuse treatment, and prescription drug coverage. In addition, there are maximums for annual deductibles and out-of-pocket spending for an individual. How would you say that this compares with most health insurance policies available for individuals and groups today?

Answer. The policies in Massachusetts are far more comprehensive than coverage offered in the individual market in most other states. All policies in Massachusetts must provide "minimum creditable coverage," which includes key services such as prescription drugs, maternity care, mental health care, and rehab—services often excluded or limited in other state individual health insurance policies.

In Massachusetts, all health insurance is subject to greater consumer protections than apply in most other state individual health insurance markets. No individuals in Massachusetts can be turned down or charged more based on health status. Preexisting conditions are not excluded.

Compared to employer-sponsored group policies—the Silver and Gold level plans offered through the Commonwealth Connector generally provide cost sharing levels that are comparable to typical employer sponsored group plans.

*Question 2.* Do you know what the Massachusetts experience has been in medical bankruptcy compared with other states where health insurance coverage is not as expansive? Is there less?

Answer. I am not aware of any data that would answer this question.