



Statement of Consumers Union
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On the Need for More Transparency in Health Insurance Marketplace
December 8, 2009

We urge Congress to give more attention to the need for ‘transparency’ in the reformed insurance marketplace. Only if consumers can see clear, easy-to-understand differences between the various Exchange policies will they be able to make the best economic and quality choices.

While both the Senate and House bills propose various forms of basic, standard, and deluxe policies (e.g., bronze, silver, gold, platinum), those policies only have to be ‘actuarially equivalent.’ The House bill even allows a 10 percent variation around the various co-payment amounts.

The result will be a continuation of the current Tower of Babel—a confusing array of policies with slight differences between plans that are carefully designed to attract healthier patients and avoid sicker patients. The Exchange will look very similar to today’s Medicare Part C, Part D, and Federal Employee Health Plan marketplace—marketplaces where many consumers make poor economic and quality choices and, once having made a choice, drift from year-to-year in the same plan, even though that plan may no longer be best for them.

Attached is an actuarial analysis done for Consumers Union by Watson Wyatt Worldwide that shows a Bronze and a Platinum version of the Senate Finance Committee bill’s insurance policies. One set of policies is very simple and easy to compare; the other set of actuarially equivalent policies is very confusing and impossible for most consumers to compare.

Consumers Union has received an analysis of 92,000 Medicare beneficiaries’ choices of Part D plans. Only about 25 percent of all seniors make the best economic choice. Nearly 20 percent of seniors make choices that are \$500 to \$2000 or more costly per year than the best available economic choice.

We urge that the final legislation make it easier for consumers to shop:

--in each policy category (bronze, etc.) require all participating insurers to offer at least one simple plan package that is totally identical and totally comparable—a policy in which the plans will have to compete only on the basis of their pricing and the record of service quality they have provided. This one comparable policy would resemble the “simple” super-easy-to-compare policy described in the table below;

--every policy offered in the Exchange should use standard insurance and medical terminology (as the Senate bill provides), to encourage competition on the basis of price and quality ratings, not small definitional differences designed to attract healthier enrollees or avoid sicker patients. As the House bill states, to the extent possible, use co-payments rather than co-insurance, which makes dollar comparisons much easier for consumers to calculate.

--through the websites and counseling services, enable consumers to see the estimated total annual cost of a plan, not just the premium costs. When Medicare Part D enrollees shop by their estimated total cost, they save about 14 percent compared to shopping just on the basis of the lowest premium. Estimated total cost can be provided confidentially through the Exchange website (as Part D does now) by matching past medical usage with current insurance open enrollment choices or by permitting enrollees to self-estimate their health status (e.g., my health status is good, fair, poor).

Transparency in the form of standardized benefits and out-of-pocket costs will help consumers make the best economic and quality choices—and that will help hold down total health care costs and taxpayer-assisted healthcare subsidies.

Attachment

Actuarial Value Standards Included In The Senate Finance Committee Proposal

| Designation | Actuarial Value Standard | Sample Plan Design | | | Alternate Plan Design | | |
|---|--------------------------|-----------------------|---------------------|------------------|-----------------------|---------------------|--|
| | | Individual Deductible | Maximum Patient OOP | Other Provisions | Individual Deductible | Maximum Patient OOP | Other Provisions |
| Bronze (minimum creditable coverage) | 65% | \$2,100 | \$5,950 | 20% coinsurance | \$1,900 | \$5,950 | Copays: \$40 PCP \$80 Specialist \$200 ER 3-tier Rx plan:\$20/40/60 20% coinsurance on all other services |
| Platinum | 90% | \$0 | \$1,500 | 20% coinsurance | \$0 | \$1,981 | Copays: \$10 PCP \$20 specialist \$50 ER \$75 OP surgery \$200 per IP stay 3-tier Rx plan:\$10/20/30 |

Note: the sample plan designs comply with the provisions of the Senate Finance Committee proposal (9/22/09), namely:

- Covered benefits: preventive and primary care, physician services, outpatient services, emergency services, hospitalization, day surgery and related anesthesia, diagnostic imaging / screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical / surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that meet minimum standards set by federal and state laws
- No annual or lifetime limits on benefits.
- No cost-sharing for preventive services.
- Maximum Out-of-pocket limits tied to current HSA standards (in 2010: \$5,950 individual; \$11,900 family).

Source: Actuarial calculations by Watson Wyatt Worldwide. Actuarial Value is calculated over a “typical,” pre-65 population.