

Statement of

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**House Committee on Energy and Commerce
Health Subcommittee**

**Making Health Care Work For American Families:
Saving Money Saving Lives**

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Mr. Chairman and Members of the Committee,

Thank you for inviting me to testify about transparency in the private health insurance system and how it can help American families. At the Institute for America's Future, we have studied the issue extensively and concluded that the private health care system will never work well for American families without significant changes in the current disclosure practices of the private insurance industry.

Here's why. If you wanted to help out the coming economic recovery by buying a new car, you'd have a vast array of public information about differences, from fuel efficiency, to annual maintenance costs, to crash test performance. But what can you find out about the various makes and models of private health plans? Practically nothing it turns out.

Even the most sophisticated among us have little idea what we are paying for when we buy insurance. Private insurers, in sharp contrast to the public Medicare plan, have been able to keep confidential claims, cost and quality data, on the ground they are business trade secrets. We can't find out what specific services will be covered and when, or average out-of-pocket costs for typical conditions, let alone which insurers deliver the best value for our premium dollars. Informed consumer choice is a myth.

To build an efficient health care system, we need not only doctor and hospital performance information, as AHIP has called for,¹ but insurance company performance information. We need to know how much insurers are spending on health care and on what, in order to be able to assess whether or not the amounts spent are worth it.

I have spent the last 20 years helping people navigate both Medicare and private insurance, for a long time as the founder and president of the Medicare Rights Center. In the next four minutes, I wanted to take you through 1) the structural issues that may preclude needed transparency from the private insurance industry, 2) the data we need from private insurers to drive value and bend the cost curve, and 3) how health care reform can address these issues.

I. The private health insurer business model

In America today, people can't compare health plans based on value—cost and quality, not simply customer service and premiums. Though there is some HEDIS data, it is self-reported and inadequate.

The health insurance market is broken. In a competitive market, insurers would be marketing to health care users, demonstrating why they deliver the best value health care for people with cancer, diabetes and heart disease. Their message would appeal to the 20% of the population who consume 80% of health care dollars. Instead, if they deliver great care to people with costly needs, they don't want people to know. It's like the automobile companies marketing their cars to people who don't drive much.

Twelve years ago, in a New York Times Magazine cover story, Helen Darling, then manager of health care strategy and programs for Xerox and now President of the National Business Coalition on Health made this point very succinctly: “I have been sworn to secrecy by one plan that has the best AIDS program in the world. They don’t want people knowing about it. They couldn’t handle the results. Ideally, if we lived in a wonderful world, we would want a plan to win prizes for their wonderful care. But in reality that would kill them.”²

To maximize their profits, health plans compete for enrollees least likely to use their product. Therefore, health plans do not advertise the specific treatments and tests covered, the conditions under which they are covered or the price of services. This is precisely the information we need to know.

Different private plans offer different value health care. The best of them come between doctors and their patients to ensure good care is received. Yet, their medical necessity and utilization review decisions are largely considered proprietary and unknown. And, we don’t know whether their interventions add value, or simply increase their profits. For one example, a September New York State Medical Society survey revealed that 90% of doctors said they have had to change the way they treat patients based on restrictions from an insurance company; and 92% said insurance company incentives and disincentives regarding treatment protocols “may not be in the best interest of the patients.”³ We need to be able to understand the conditions under which insurers direct the care doctors provide their patients and the extent to which insurer behavior reins in costs and drives value or keeps people from getting needed care.

II. The data we need from insurers

Imagine that you were trying to choose a health plan. To determine whether you were getting value for your money, you’d likely want to know how much of your premium dollar goes to health care costs. If the answer were 51 percent, as the Harris County Medical Society discovered, you might decide it wasn’t good value. And, you might wonder why their Blue Cross policy went up 12.4% that year.⁴ You might also question why, unlike Medicare, private insurers do not have to disclose how their premiums are determined and often have no external constraints on them.⁵

Premium rates aside, are the insurers spending our premium dollars wisely? Are they paying for quality and not quantity? Are they helping to ensure that our doctors provide us reasonable and necessary care? And, are they securing the best provider rates for in-network care?

Finally, unlike Medicare, insurers often won’t disclose the particular services they will pay for, or how much we will owe the doctor and how much they will cover.⁶ Even FEHB plans, it appears, are not required to disclose such information. One new Congressional staffer recently was forced to stay on his family’s COBRA policy rather than take the risk of inadequate coverage from the government because the FEHB plan

would not tell him what services they would cover or how much he would be obligated to pay. It's like not being able to find out how well an automobile's brakes work.

What data do researchers need to help people make informed health care choices?

1. The data and formulas used to calculate their premiums.
2. Their claims data (stripped of patient-identifying information) and denial rates
3. Their coverage protocols, including their medical necessity and utilization review edits
4. Their network-negotiated provider rates as well as their rates for out-of-network care
5. Their prescription drug rates
6. Their average cost of covering someone with a particular condition
7. Their members' average out-of-pocket costs for different conditions
8. And, ideally, the demographics of the population they serve

Today, this data would provide invaluable information. I have attached, as Appendix A, a list of basic questions insurers generally won't answer either in advance of our buying a policy or even once we are enrolled in their plans. Over time, this data would help us in efforts to compare health outcomes for people with different conditions in different health plans and how their outcomes correlate with different subpopulations. If we should know how well different cars protect us, shouldn't we know the same about insurers?

As important, disclosure of insurer medical and cost data would drive accountability from the private insurers and promote better behavior. Right now, the countless reports of insurer abuses suggest that the lack of transparency allows insurers to delay and deny care and reimburse inadequately for services rendered, seemingly arbitrarily.

Making this data available should be relatively inexpensive for insurers. As with Medicare, it should all be in their computer systems already. Coverage as well as provider rate information should be available for the general public and claims data should be available to researchers so they can correlate cost data to quality and outcomes data and report their results. Aetna is already posting provider negotiated rate information in 57 markets for its members.⁷

III. How health care reform can address the lack of transparency in the market

Up until now, we have bought into an opaque and inefficient private health insurance model that has undermined our ability to control costs, drive value and meet our health care needs. What we need is insurance that is transparent and accountable, driving delivery and payment system reform that reins in health care costs and improves quality.

Regulations will never address the insurers' obligation to put profits first. But we can drive accountability if we require the insurers to disclose their claims and denial data, their provider rates, their medical necessity and utilization review protocols.

A public health insurance option is also essential. A public health insurance option sets a benchmark for coverage, drives competition among oligopolistic insurers to rein in costs and, through its willingness and ability to be transparent and accountable, can promote

the value and system-wide change that is needed to guarantee everyone in America quality, affordable health care.

End Notes

¹ Stephanie W. Kanwit, "'Transparency' in Principle and in Practice: Health Insurance Plan Perspectives," America's Health Insurance Plans, 2008, <http://www.ftc.gov/bc/healthcare/hcd/docs/Kanwit.pdf>.

² Lisa Belkin, "But What About Quality?" The New York Times, December 8, 1996, <http://www.nytimes.com/1996/12/08/magazine/but-what-about-quality.html>.

³ The Medical Society of the State of New York, "Survey Reveals that Doctors Feel Pressured by Health Insurers to Alter the Way They Treat Patients," September 2, 2008, http://www.mssny.org/mssnyip.cfm?c=i&nm=Insurance_Carrier_Rules.

⁴ Ken Ortolon, "Where's the Money Going? Physicians Want Employers to Ask How Premium Dollars Are Spent," May 2008, <http://www.texmed.org/Template.aspx?id=6699>.

⁵ Centers for Medicare & Medicaid Services, "CMS Announces Medicare Premiums, Deductibles for 2009" September 19, 2008, <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3272>.

⁶ Centers for Medicare & Medicaid Services, "Medicare Overview," 2009, <http://www.cms.hhs.gov/mcd/overview.asp?from2=overview.asp>.

⁷ Emily Berry, "Aetna lets more patients see what doctors are being paid," AMNews, March 16, 2009 <http://www.ama-assn.org/amednews/2009/03/16/bisa0316.htm>.

Appendix A

Basic questions most insurers will not provide answers to in advance of your buying a policy and may not answer even once you have the policy.

1. Do you cover a glucometer if I have diabetes? Do you cover diabetic supplies?
2. Do you cover tamoxifen if I am at risk for breast cancer? How much do I have to pay for it?
3. How much would I have to pay out-of-pocket for an appendectomy in-network? What are fees for surgeon, anesthesiologist and hospital? What do I have to pay for mammogram? colonoscopy?
4. How much is the average out-of-pocket cost for typical pre-natal care and low-risk in hospital birthing?
5. If I am hospitalized in network, can I count on using in-network doctors and using an in-network lab?
6. What is the highest annual/lifetime cap on hospital care available through one of your individual policies?
7. What is the monetary cap on Intensive Care Unit (ICU) coverage through one of your individual policies?
8. What percentage of total claims did you deny in 2007?
9. What is my maximum out-of-pocket costs, including copays, if I am diagnosed with high blood pressure, breast cancer or stroke through your most generous policy?

10. Does the amount you pay for a particular service or test depend on the policy I buy or do you have a standard rate across all your policies?

11. How can I find out how much a service is going to cost me before I receive it?

12. How can I find out how much a drug is going to cost me before I receive it?