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Statement of

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On Transparency in Health Insurance

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Subcommittee on Domestic Policy
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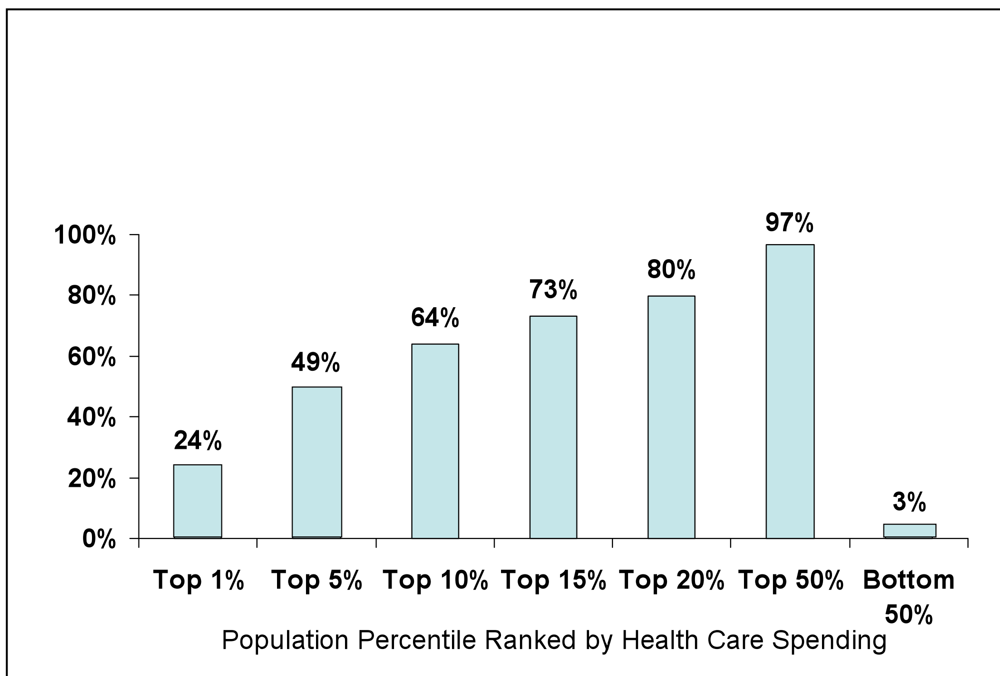
Good morning, Mr. Chairman and Members of the Subcommittee. My name is Karen Pollitz. I am a Research Professor at the Georgetown University Health Policy Institute where I study the regulation of private health insurance.

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 cancelled. At a hearing of the House Energy and Commerce Committee this summer, patients testified about having their health insurance policies rescinded soon after making claims for serious health conditions. One woman who was in treatment for breast cancer testified that her coverage was revoked for failure to disclose a dermatologist visit 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 pre-existing condition exclusions. These rules are important, but alone, will not put an end to health insurance discrimination. 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 achieved.

Transparency in Health Insurance

A health expert from *Consumer Reports* magazine recently testified that health insurance is one of the least transparent consumer products sold today. There is ample evidence that consumers do not understand their coverage and are confounded by complexity.[2] Discriminatory practices by insurers too often go unnoticed and unchallenged.

Transparency in health insurance will make it easier for consumers to understand coverage and for regulators to detect when coverage is not working as it should. Transparency involves three key elements:

- data reporting to regulators on health insurance company products and practices;
- 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 make informed coverage choices.

Data - The primary purpose of health insurance data collected by state regulators today is to monitor solvency. Very little information is collected on an ongoing basis to monitor the accessibility, affordability or security of health insurance for consumers or how accurately, completely or dependably health insurance pays claims when consumers are sick.

There are also sparse data to monitor consumer protections in health insurance. For example, this Committee recently queried all 50 state insurance departments about health insurance rescissions. In response to that query,

- only 4 states could provide data on the number of rescissions that occurred
- only 10 states could provide the number of individual health insurance policies in force, and
- more than one-third of states could not supply a complete list of companies that sell health insurance within their jurisdictions.[3]

Enforcement of consumer protections in health insurance today is largely triggered by complaints. Unfortunately, complaints are not a sufficient basis on which to judge compliance with health insurance consumer protection or the need for stronger oversight and enforcement. Only a fraction of consumer problems with health insurance ever are translated into formal complaints. For example, data provided by the NAIC on behalf of all 50 state insurance departments found that nationwide only 32 complaints about health insurance rescission were filed in 2007, 181 from 2003-2007.[4] In stark contrast, last year this Committee requested data on health insurance rescissions from just three national carriers and learned those companies alone had rescinded nearly 20,000 health insurance policies from 2003-2007.[5]

According to a national survey of health insurance consumers, a majority (51%) of consumers experienced some type of problem with their health insurance in the past year. Yet only 2 percent contacted their state regulator for help. Nearly 90 percent of consumers surveyed could not name the agency that regulates health insurance in their state.[6] Another recent survey found patients rarely register formal complaints about health insurance. Instead, most just "stay quiet and stay put." Even when problems generate costs of more than $1000, or when they delay or deter access to care, rarely (less than 3%) do consumers file complaints with state regulators.[7]

While state-level data are limited, at the federal level we know even less. The Center for Medicare and Medicaid Services (CMS) – the agency responsible for oversight of federal minimum standards for health insurance established under HIPAA – does not collect compliance data or closely monitor the status of state enforcement of federal minimum standards.[8]

A more proactive approach to health insurance oversight is clearly needed. Regulators must be able to monitor patterns of health insurance enrollment and disenrollment in order to know whether insurers are avoiding or shedding. For this to happen, insurers should be required to report regularly on their marketing practices. Data on the number of applications received and new enrollments, as well as 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 also be able to monitor coverage practices in order to evaluate the protection health insurance provides and to detect problems that may discourage patients from remaining enrolled. Regulators must 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.

The Tri-Committee health reform legislation, HR 3200, would give broad authority to federal regulators to collect this kind of data. In addition, HR 3200 would establish a new health insurance ombudsman to provide consumers with information and to help resolve their health insurance problems. The ombudsman would also collect data on consumer experiences in health insurance. Importantly, it would be required to report annually to federal regulators and Congress on its findings regarding consumer experiences and recommendations for strengthening consumer protections.

When health insurance regulators have access to this kind of information, patterns of problems affecting 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.

More detailed, descriptive information about how coverage works will also be important. Earlier this year we issued reports analyzing coverage under seemingly similar health insurance policies and found consumers might owe widely varying amounts for medical bills due to policy differences that may not be so easy to detect. We recommended the

development of standardized labels that illustrate how insurance policies would cover certain common health conditions and estimate the level of remaining medical bills consumers might expect to pay out of pocket.[9]

Consumers will also 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 sometimes even hide features that limit 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, the entire hospitalization should be covered, not all but the first day.[10]

Accountability in health insurance

Insurers must also be held accountable for compliance with market rules and consumer protections. That will require resources for oversight and enforcement. In addition, it is time for the federal government to take a more active role in health insurance regulation.

Regulatory resources –Resources to regulate private health insurance at the federal level are particularly lacking and must be increased. At a hearing of this Committee last year, a representative of the Bush Administration testified that CMS then dedicated only four part-time staff to HIPAA health insurance matters. 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.[11]

Limited regulatory capacity is also a problem at the state level. In addition to health coverage, state insurance departments oversee all other lines of insurance. In several states the insurance commissioner also regulates banking, commerce, securities, or 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.[12] State regulators necessarily focus primarily on licensing and solvency. Dedicated staff to oversee consumer protections in health insurance are limited.

Federal/state enforcement – With the enactment of HIPAA in 1996, Congress created new federal minimum consumer protections in health insurance but limited federal authority to enforce those rules. Instead, Congress opted to rely primarily on state enforcement of federal minimum standards. Federal enforcement is triggered only as a last resort once a finding is made that states have not adopted and substantially enforced federal minimum standards. Further each provision of HIPAA is evaluated separately to determine whether federal fallback enforcement is triggered. This cumbersome process presumes federal action will be rare and, indeed, it has been so. Ironically, the federal fallback structure also provides justification for the lack of federal regulatory resources – it doesn't make sense for the federal government to build and maintain enforcement capacity it does not expect to use. This federal fallback enforcement model is an unfunded mandate on states – the federal government passes laws but expects states to carry them out.

It is time for the federal government to assume an active and effective role in enforcement of federal health insurance standards. Congress should provide adequate resources, including staff in sufficient numbers and with sufficient expertise in private health insurance oversight and enforcement. A federal regulatory presence should not come at the expense of state regulation. Rather, the federal government and states must work in partnership to accomplish effective oversight and enforcement of consumer protections in private health insurance. Congress should also provide resources to strengthen states regulatory capacity, and should take steps to ensure close coordination and cooperation between state and federal regulators.

Notes

[1] Lisa Girion, "Health insurers refuse to limit rescission of coverage," *Los Angeles Times,* June 17, 2009.
[2] Testimony of Nancy Metcalf, Senior Program Editor of *Consumer Reports*, before the Committee on Commerce, Science, and Transportation, U.S. Senate, June 24, 2009. See also ehealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008, available at http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712
[3] Staff memo to Members of the Energy and Commerce Committee Subcommittee on Oversight and Investigations, June 16, 2009.
[4] Roger Sevigny, Therese Vaughan, Sandy Praeger, and Joel Ario, letter on behalf of National Association of Insurance Commissioners to the Honorable Bart Stupak and Greg Walden, July 24, 2009.
[5] Staff memo, *ibid.*
[6] National Survey of Consumer Experiences with Health Plans, Kaiser Family Foundation, June 2000.
[7] Brian Elbel and Mark Schlesinger, "Responsive Consumerism: Empowerment in Markets for Health Plans," *The Millbank Quarterly,* Vol. 87, No. 3, 2009.
[8] 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.
[9] 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
[10] 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.
[11] Testimony of Abby Block, *ibid*.
[12] National Association of Insurance Commissioners, *2007 Insurance Department Resources Report,* 2008.