



Coverage When It Counts

How much protection does health insurance offer
and how can consumers know?

Karen Pollitz, Eliza Bangit, Jennifer Libster, Stephanie Lewis,
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Introduction

What does it mean to be adequately insured? A growing body of research documents both health-related and financial problems that can arise when health insurance doesn't cover enough. Rates of medical debt are growing, chiefly among the insured.¹ One in five privately insured Americans with chronic conditions live in families with medical bill problems—an increase from 16 percent in 2003.² When out-of-pocket spending for medical care exceeds just 2.5 percent of income—less for low-income persons—financial burdens on families become substantial.³ Studies show that the underinsured and uninsured face similar problems accessing medical care and managing financial burdens.⁴

Knowing whether insurance provides adequate coverage can be a challenge. Health insurance policies are complex products, highly variable in their design, and key information about how coverage works is not always disclosed during marketing. Further, health insurance promises protection against future, unknown events. Consumers who are healthy today can find it difficult to anticipate future medical problems and costs and harder still to evaluate how insurance might cover those needs.

The protection health insurance offers today is highly dependent on the policy purchased. An insured person who becomes seriously ill might have to pay thousands, or tens of thousands, of dollars out-of-pocket for needed care. For many consumers that range represents the difference between health security and financial catastrophe. Consumers compare the prices of health insurance policies, but cannot always reliably tell if they are comparing like products. The affordability of health insurance premiums cannot be considered independently of the adequacy of coverage health insurance provides. At a minimum, the difference in protection health insurance offers should be readily available for all to see.

Health insurance should be transparent, so that consumers know what they are getting in a market filled with options that are not always equal. Many urge that consumers value this plan choice and that choice is vital to efficient competition in health insurance markets. Yet, economists teach that well functioning markets require transparent information so that both buyers and sellers can understand and evaluate options. That's why health insurance transparency and coverage adequacy go hand in hand.

This paper summarizes findings of two reports studying the adequacy and transparency of health insurance in Massachusetts and California.⁵ Those reports suggest a new method

for developing benchmarks to illustrate types and costs of medical care under a variety of scenarios, and for evaluating insurance protection using these benchmarks. Using simulated claims scenarios for different types of patients we analyzed the content of coverage under a variety of health insurance policies sold to individuals and small employers in Massachusetts and California and estimated out-of-pocket costs for care that patients might face. We also reviewed the transparency and accessibility of information that consumers would need to understand how coverage works.

We recommend developing standardized health plan comparison tools—patterned on the U.S. Food and Drug Administration nutrition label, but for health insurance—that could help consumers appreciate the kinds of medical events for which health insurance may be needed and relative levels of protection provided under different policies.

What can it cost to get seriously ill?

In the United States, health care spending per person exceeded \$7,400 in 2007, although few Americans needed an “average” amount of health care. Instead, just 10 percent of the population accounts for two-thirds of all health care spending.⁶ Most people are healthy most of the time, but over the course of a lifetime, most people will also have at least a year or two when medical needs are very high. One out of every three women and one of every two men will be diagnosed with cancer in their lifetimes.⁷ The lifetime risk of cardiovascular disease is 50 percent for men and 40 percent for women.⁸ In addition, chronic conditions account for approximately three-quarters of medical care spending in the United States.⁹ Therefore, medical expenses for a condition may not be confined to one calendar year, even though we buy health insurance coverage in one year increments.

This project estimated cost scenarios for patients with serious medical conditions: breast cancer, heart attack, and diabetes. Under each scenario, care received is based on published treatment guidelines,¹⁰ and no added complications arise.

- The breast cancer patient is diagnosed with an early stage tumor in May, and care continues for 87 weeks. She needs 52 diagnostic tests and imaging procedures; one surgery; 118 visits associated with chemotherapy, Herceptin, and radiation therapy; 36 mental health visits; and 36 prescription drugs and refills. What providers charge and insurers pay for health care varies geographically.¹¹ Total allowed charges for this care are estimated to be \$97,298 in California and \$143,180 in Massachusetts.
- Care for the heart attack patient also begins in May, with treatment extending 56 weeks. He needs one ambulance ride, two hospitalizations for surgery, six cardiology visits, nine diagnostic tests and imaging procedures, 36 cardiac rehab sessions, 50 mental health visits, and 64 prescriptions and refills. Total allowed charges are estimated to be \$81,993 in California and \$89,644 in Massachusetts.
- The third scenario examines the cost of managing well-controlled diabetes. The patient tests her blood sugar at least four times a day and administers insulin, sees her physician quarterly for checkups and lab tests, and has her feet and eyes examined annually. In one year, she would have seven office visits and 10 lab tests. She also would use approximately 1,400 each of test strips, lancets and alcohol swabs, as well as 430 syringes. She would also need to fill or refill 38 prescriptions. Total allowed charges for a year of diabetes management are estimated at \$7,309 in California and \$7,850 in Massachusetts.

Know the terms of health insurance

Health insurance policies vary widely in terms of covered benefits, cost sharing, and other terms—so widely, in fact, it can be hard for consumers to tell how coverage works. Terms and definitions are not generally consistent across policies, even for the most basic and prominent features. This guide defines some of the most important features of insurance plans that consumers might try to compare.

Coinsurance: A percentage of allowed charges for covered care that consumers are required to pay. For example, the health insurance might pay 80 percent of covered charges leaving the patient to pay 20 percent coinsurance.

Co-pay: The co-pay is a flat dollar amount that the patient must pay per covered service. For example, a health plan might require a \$15 co-pay for each generic prescription drug but a \$25 co-pay for brand name prescription drugs.

Deductible: The annual deductible is an amount that patients must pay for covered care before health insurance reimbursement begins. However, insurers structure and apply deductibles differently. Under one policy, all covered care might be subject to a single, comprehensive deductible, whereas separate deductibles might apply for specific ser-

vices such as hospitalization or prescription drugs. Under certain policies, some covered services—such as office visits—might be exempt from the deductible and patients might instead pay a co-pay. Under other policies, office visits might be subject first to the deductible; co-pays would then apply once the deductible is satisfied.

Exclusions: Exclusions refer to specifically listed items or services that a health insurance policy doesn't cover. Covered benefits, exclusions, and limits vary as well. For example, most health insurance covers prescription drugs, but some policies exclude the benefit while others cap it, and cost sharing varies both across plans and by type of drug.

Out-of-pocket limit: The out-of-pocket, or OOP, limit generally signifies the maximum amount of cost-sharing patients will be required to pay for covered services in a year. As such, the OOP provides an overall indication of the financial protection health insurance will provide in a year. Yet, under many policies, the OOP does not limit all cost sharing. The annual deductible(s) might not be included in the OOP. Co-pays for some or all services also might continue even after the OOP has been satisfied for the year. The OOP usually limits coinsurance, although under some plans, even coinsurance for certain services, such as prescription drugs or mental health care, is not constrained by the OOP.

Know the charges

What is the price of any particular item of health care? There can be many. Just a glance at a medical bill or insurance statement reveals that vastly different prices may be charged and paid for the same service. The most commonly encountered types of charges include:

Billed charges: The full, undiscounted price for care billed by the doctor, hospital, lab, or other provider. Providers develop their own billed charge for the services they offer. People who don't have health insurance generally have to pay the billed charge for care they receive.

Allowed charges: The discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with the providers in their health plan network, and network providers agree to accept the allowed charge as payment-in-full. Each insurer has its own schedule of allowed charges; typically these fee schedules are proprietary and not generally available to the public.

Balance billing charges: The difference between the allowed charge and the billed charge. If a patient receives covered care from a provider outside of the health plan's network, the health insurer will pay the allowed charge, but the provider is not obligated to accept it as payment-in-full. Instead, the provider will try to collect the balance between the billed and the allowed charge.

Allowed charges estimated for this report: Because health insurers' fee schedules are unique and proprietary, we did not have access to actual allowed charges for each plan studied. Instead, we relied on an outside database to estimate a single, statewide median allowed charge for each service and assumed this allowed charge would be consistently used by all insurers in a state.¹²

Health insurance in Massachusetts and California

Rules governing what health insurance must cover are mostly state based today. Massachusetts is unique in requiring residents to have health insurance that meets minimum creditable coverage (MCC) standards—a state criteria for ensuring adequate coverage. As a result of this individual mandate and minimum coverage rule, health coverage tends to be much more standardized and comprehensive in Massachusetts compared to most other states. MCC standards for 2009 include inpatient and outpatient hospital and physician care, emergency services, mental health and substance abuse treatment, and prescription drug coverage. In addition, annual deductibles may not exceed \$2,000 and annual maximums on out-of-pocket spending must not exceed \$5,000 for an individual.

Massachusetts residents who work and whose employers offer a health plan that meets MCC standards can enroll in their job based coverage to comply with the state mandate to have health insurance coverage. In addition, small businesses and individuals who need to obtain health insurance on their own can buy insurance through a newly organized market, the Commonwealth Connector. All Connector plans are guaranteed to provide MCC, although variations are allowed.

The Connector offers plans with high, medium, and low tiers of coverage—characterized as gold, silver, and bronze. Most policies cover the same comprehensive set benefits, but cost sharing can differ. Special policies are offered for young adults only that can cover fewer benefits—for example, no prescription drugs—and cap all coverage at \$50,000 annually. Policies offered by competing insurers within each tier are supposed to be “actuarially equivalent.” Policies are said to be actuarially equivalent if, for the same population covered, they would each pay the same share of the population’s total expected medical bills. However, for any given patient, actuarially equivalent policies might offer different protection.

California is like most other states, in that insurers there have much more flexibility to design covered benefits and cost sharing features. Different rules apply to different types of plans. HMOs and certain other managed care plans are generally subject to stronger regulation and must offer more comprehensive coverage. Other health insurance policies, however, might not cover important benefits such as prescription drugs or mental health care.¹³ Unlike in Massachusetts, California residents are not required to have health insurance, and there are no established tiers for health insurance that shows consumers whether policies provide a high, medium, or low level of coverage.¹⁴ As a result, whether California

residents buy coverage on their own or get coverage from work, there can be wide variation in cost and coverage between plans.

Federal law generally does not address the content of health insurance coverage, with a few exceptions, such as the recently enacted mental health parity requirements. In addition, federal law establishes cost sharing standards for certain high-deductible health insurance policies that can be combined with a tax preferred health savings account. In particular, the OOP limit under such policies cannot exceed a maximum dollar amount (\$5,800 for an individual in 2009) and it must be comprehensive, limiting all in-network cost sharing for covered services.

Variations in coverage

To illustrate how coverage can vary—and how challenging it might be for consumers to appreciate the differences—we mapped the simulated claims scenarios against specific health insurance policies. Ten of these policies are sold to individuals and small employers through the Commonwealth Connector in Massachusetts, and 10 are offered in the individual or small group markets in California.¹⁵ Some of the results were surprising.

Comprehensive vs. non-comprehensive out-of-pocket limits

Key differences among relatively comprehensive and standardized plans in Massachusetts could leave patients at risk for significantly higher expenses than they might otherwise expect or be able to afford. Notably, annual out-of-pocket limits in many policies do not cap all forms of cost sharing. This means even though MCC standards require that the out-of-pocket limit cannot be more than \$5,000 per year for an individual, a patient might pay significantly more than that in cost sharing for covered care in a year.

Among the 10 Massachusetts policies studied—referred to as plans A-J—the breast cancer patient would incur very different cost sharing expenses under two seemingly similar bronze policies. Plan C has a \$2,000 annual deductible with a separate \$100 deductible for prescription drugs, and co-pays do not count toward the annual out-of-pocket limit. Meanwhile Plan D has a \$2,200 annual deductible that applies to all covered care—including drugs—and the out-of-pocket limit is comprehensive, including all co-pays. Both policies have an annual out-of-pocket limit of \$5,000. Yet, the breast cancer patient would pay \$7,641 in cost sharing under Plan D and \$12,907 in cost sharing under Plan C. In fact, under Plan C, the breast cancer patient's cost sharing exceeds the annual out-of-pocket limit by more than \$1,000 in each of the first two years of treatment. Figure 1 further details the differences between these two plans.

Other cost-sharing differences

Cost sharing under Massachusetts policies varies in other ways that affect how much patients may have to pay for care. Under some policies, for example, patients owe only a co-pay for prescription drugs, whereas prescriptions are first subject to the annual deductible and then co-pays—meaning patients might pay the full allowed charge for some prescriptions until the deductible has been met, after which they pay a co-pay.

We observed even more differences in coverage for diabetes care. Under one plan, only the lower prescription drug deductible applied to most diabetes items and supplies, while co-pays for some key supplies—such as test strips—were waived altogether. Tiered cost sharing for the drug benefit also had varied impacts. All policies charge higher co-pays—and some charge coinsurance—for brand name drugs. No generic drug version of insulin is sold in the United States. Consequently, under some plans, the patient with diabetes might pay a \$10 co-pay for generic drugs, but as much as \$100 per insulin refill.

How these differences combine to affect how much a patient ultimately pays depends on the type of care a patient needs. The interactions can be complex and, for healthy consumers who don’t know what future care needs might be, difficult to anticipate.

Take, for example, five plans offered through the Massachusetts Connector (Plans B, C, D, E, and G), each one with a \$5,000 annual out-of-pocket limit and covering essentially the same benefits, albeit subject to different cost-sharing rules. Measured in terms of expenses owed by the patient, the rank of plans from most to least protective for the breast cancer patient would be B, D, G, C, and E. For the heart attack patient, however, the rank would be B, G, D, C, and E. For the diabetes patient, the ranking would be different still: C, B, D, E, and G. Such scenarios are detailed further in Figure 2.

These differences also illustrate the limitations of actuarial value as a signal of coverage equivalence for consumers. Actuarial equivalence is a broad measure of the average protection a policy provides for an entire population, but not all people are average. An individual’s care needs may be covered differently by two actuarially equivalent policies.

Figure 1. Estimated patient out-of-pocket costs for breast cancer treatment under two Massachusetts plans

(\$143,180 total treatment costs over 87 weeks, beginning May 1)

Estimated patient expenses (% of total allowed charges)	Plan C (Bronze) \$12,907 (9%)	Plan D (Bronze) \$7,641 (5%)
Patient expenses due to:		
Deductibles	4,300	4,767
Coinsurance	5,447	N/A
Co-pays	3,160	2,869
Non-covered services	0	0
Patient costs meet/exceed amount of annual OOP in		
Year 1	Exceed	Not meet
Year 2	Exceed	Not meet
Year 3	Not meet	Not meet
Key policy features:		
Annual deductible	\$2,000, \$100 for Rx	\$2,200
Coinsurance	20% for most services	n/a
Co-pays (medical)	\$25	\$25
Co-pays (Rx drugs)	\$15 (generic) 50% (brand name)	\$10 (generic) \$25 (preferred brand name) \$45 (non-preferred brand)
Annual OOP max	\$5,000	\$5,000
Includes medical co-pays?	No	Yes
Includes Rx cost sharing?	No	Yes
Includes mh cost sharing?	No	Yes
Special rules: services for which no cost sharing apply after deductible	None	Radiation, chemotherapy, labs/x-rays
Significant exclusions, benefit limits	None	None

Figure 2. Seemingly similar Massachusetts policies work differently

	Plan B - Silver	Plan C - Bronze	Plan D - Bronze	Plan G - Bronze	Plan E - Young Adult
Annual deductible:	\$750	\$2,000 (\$100 for Rx)	\$2,200	\$2,000	\$2,000
Annual OOP Limit	\$5,000	\$5,000	\$5,000	\$4,000	\$5,000
Patient costs [rank]:					
Breast cancer (\$143,180 total)	\$4,039 [1]	\$12,907 [4]	\$7,641 [2]	\$7,983 [3]	\$55,250 [5]
What else causes the relative difference?	<ul style="list-style-type: none"> No cost sharing after deductible for hospital, surgery, chemo, radiation, lab, x-ray 	<ul style="list-style-type: none"> No co-pays count toward OOP 	<ul style="list-style-type: none"> All co-pays count toward OOP No cost sharing after deductible for chemo, radiation 	<ul style="list-style-type: none"> Rx and mental health co-pays don't count toward OOP; however Annual OOP is \$4,000 vs. \$5,000 No cost sharing after deductible for chemo, radiation 	<ul style="list-style-type: none"> Annual cap of \$50,000 on all covered benefits
Heart attack (\$97,298 total)	\$3,251 [1]	\$8,400 [4]	\$7,759 [3]	\$6,237 [2]	\$39,355 [5]
What else causes the relative difference?	<ul style="list-style-type: none"> No cost sharing after deductible for hospital, surgery, cardiac rehab 	<ul style="list-style-type: none"> No co-pays count toward OOP Separate \$100 RX deductible 	<ul style="list-style-type: none"> \$500 /admission hospital co-pay 	<ul style="list-style-type: none"> All OV, cardiac rehab co-pays count towards OOP No mental health visit benefit cap* 	<ul style="list-style-type: none"> Annual cap of \$50,000 on all covered benefits
Diabetes management (\$7,850/year)	\$2,578 [2]	\$960 [1]	\$3,373 [3]	\$4,383 [5]	\$4,126 [4]
What else causes the relative difference?	<ul style="list-style-type: none"> OVs not subject to deductible Labs, office procedures are subject to deductible \$30 and \$45 co-pay for Insulins (brand only) 	<ul style="list-style-type: none"> Most items subject to the \$100 Rx deductible covered under No co-pays after deductible for test strips, lancets, syringes \$15 co-pay (for generics) applied to insulin Labs, office procedures subject to \$25 co-pay, but not deductible 	<ul style="list-style-type: none"> All services and Rx subject to comprehensive deductible, then co-pays apply (\$25 for OV, \$10, \$25, \$45 for Rx) 	<ul style="list-style-type: none"> \$100 co-pay for Insulin (brand only) has \$100 co-pay OV co-pay is \$40 OV co-pay does not include labs and other office procedures 	<ul style="list-style-type: none"> 50% coinsurance for Insulin (brand only) Only three OV before deductible, at \$25 co-pay Labs, office procedures subject to deductible

* In Massachusetts, mental health benefit limits may not be applied to certain serious mental disorders, such as schizophrenia, which are instead subject to mental health parity coverage requirements.

Exclusions

Some of the California policies analyzed for this project illustrate the potential effects of benefit exclusions. Among the 10 California policies studied (also labeled Plans A-J), two HMO policies—Plans B and F—appear similar. Neither policy requires an annual deductible; instead most services are subject to co-pays. The two plans vary somewhat in terms of the level of co-pays and how they apply. Both plans have an annual out-of-pocket limit of \$2,500, which doesn’t limit cost sharing for prescription drugs. Despite these similarities, the breast cancer patient would pay \$6,030 in expenses under Plan B and \$3,951 under Plan F. Most of this differential is explained by the fact that Plan B does not cover outpatient mental health care.

Another plan, Plan C, exhibits even more dramatic results due to noncovered services. Plan C also has an annual out-of-pocket limit of \$2,500, and a deductible of \$1,000. It covers both inpatient and outpatient care, and most outpatient care is covered 100 percent once the annual OOP limit is reached. However, outpatient care is not reimbursed at all before the annual OOP limit is satisfied and, with few exceptions, only cost sharing related to care provided in a hospital counts toward this limit. In the breast cancer scenario, treatment takes place over 87 weeks, beginning with lumpectomy surgery performed in a hospital; all remaining treatment is provided in doctors’ offices and other outpatient facilities. As a result, in the first year, the patient satisfies the OOP and Plan C covers most of the rest of her expenses in that year. As care continues into a second calendar year, however, there are no further hospitalizations, and her remaining care, mostly outpatient, is essentially uncovered. The patient’s share of total treatment expenses under Plan C exceeds \$38,000. Plans B, C, and F are detailed further in Figure 3.

Figure 3. Estimated patient out-of-pocket costs for breast cancer treatment under three California plans

(\$97,298 total treatment costs over 87 weeks, beginning May 1)

	Plan F - HMO	Plan B - HMO	Plan C - PPO
Estimated patient expenses	\$3,951 (4%)	\$6,030 (6%)	38,209 (39%)
Annual deductible:	none	none	\$1,000
Annual OOP	\$2,500	\$2,500	\$2,500
Cost sharing not included in OOP	Rx cost sharing, mental health co-pays	Rx cost sharing	Annual deductible
Significant exclusions	Mental health beyond 20 visits/year* wigs	Mental health*	Rx drugs, mental health,* wigs, most outpatient care before OOP is satisfied, primarily with cost sharing for hospital care

* In California, mental health benefit limits and exclusions may not be applied to certain serious mental disorders, such as schizophrenia, which are instead subject to mental health parity coverage requirements.

Challenges to transparency

Consumers should be able to know how much protection a health insurance policy conveys before purchasing a plan. Yet currently it can be difficult to obtain information about coverage ahead of time, and there are numerous challenges to overcome.

Variation in health policies

Possibly the greatest challenge to transparency lies in the sheer number of ways in which health insurance policies can vary. Consumers cannot assume two products called “health insurance” will cover the same benefits, impose the same cost sharing, require the same authorization procedures, use comparable provider networks, or have other similar rules or protections.

Lack of access to full policy language

Some policy differences will be clearly described in plan summaries and marketing materials, but others may not. For example, four of the California policies studied placed the onus on the member to track out-of-pocket payments and inform the insurer when the limit had been reached. Because not all cost sharing applied toward the out-of-pocket limit under these policies, the burden would initially be on the member to try to assess which cost-sharing expenses applied and how. Patients who fail to accurately track cost sharing on their own might pay more than they are liable for under the policy, causing their expenses to be even greater than estimated under this report.

Consumers must consult the evidence of coverage, or EOC—a detailed description of the policy—to learn how coverage works. Yet consumers typically cannot obtain the EOC before a policy is purchased—a challenge to those or their advocates who might want to study coverage details before then.¹⁶

Readability challenges

Once obtained, the EOC remains a complicated legal document that includes technical terms and sometimes vague, confusing, or contradictory language. Reading a health insurance contract requires a sophisticated level of health insurance literacy that most people do not have. According to one insurance industry survey, most people would rather prepare their taxes or go to the gym than read their health insurance policy. The same survey found less than one-quarter were certain they understood the terminology used in their health insurance policy.¹⁷

California has adopted readability standards for health insurance policies. The federal law, ERISA, which governs employer-sponsored health plans, also requires that plan documents be written in a manner that is understandable to the average plan participant. Even so, making complex documents understandable to the layperson is a challenge. One study that applied reading-level analysis to plan documents governed by ERISA concluded a college-level education or higher would be needed to understand terms in the document.¹⁸

Anticipating the unknown

Finally, consumers who have never been very sick may not appreciate the extent and type of medical care that could be required in the event of a serious illness. Nor would they likely anticipate what such care might cost, in terms of either billed provider charges or insurer allowed charges.

A “Coverage Facts” label for health insurance

To improve transparency and standardize information, we suggest the development of a new information tool for health insurance consumers: a “Coverage Facts” label for health insurance policies, modeled on the Nutrition Facts label required for packaged foods.¹⁹

A Coverage Facts label would summarize key features in a health insurance policy and illustrate how it might cover care for a given treatment scenario. The label would highlight important estimates, such as total treatment costs and the amount the patient might be expected to pay. The label could break down patient cost liability by type of service (highlighting the impact of excluded or limited benefits, for example) and by type of cost sharing (illustrating how co-pays might add up during treatment of a chronic condition). The following page shows a mock-up of such a label for Plan C from California. Additional narrative might accompany each label explaining in more detail how coverage features combined to produce the resulting estimates.

Coverage Facts would need to be conveyed in a series of labels. Because a single policy may cover types of benefits differently, labels would be needed for care scenarios that significantly rely on inpatient care or outpatient therapies, medication therapy, mental health care, and rehabilitation. Labels should also be developed for chronic conditions so that ongoing cost-sharing needs are also highlighted. Scenarios might reflect health conditions that are the most common or costly for the entire population or for different demographic groups.

The Coverage Facts label could be required for all health insurance policies and plans. A regulatory agency or other independent entity would prepare a series of standardized patient scenarios with input from clinical and billing experts. Standardized scenarios could then be distributed to health insurers, who would estimate total care costs for each scenario using their own provider fee schedules. Insurers would “process” claims under each scenario and estimate the share of costs that would be covered. These estimates would be submitted to regulators for review of accuracy and consistency. Finally, a booklet of scenarios and accompanying Coverage Facts labels could be compiled and included with the marketing materials for all health insurance policies. Whenever insurers modify existing policies or introduce new ones, the process would be repeated. Regulatory agencies would likely need additional staff and resources to implement and enforce the Coverage Facts tool, and insurers would probably need to dedicate staff to comply with these requirements.

Coverage Facts

Individually purchased health insurance, 2008

Policy C (California)

Monthly premium (age 55)†	\$113
Annual deductible	\$1,000
Annual OOP limit	\$2,500
Cost sharing not subject to annual OOP	Deductible, cost sharing for outpatient care
Significant exclusions, benefit limits	Rx drugs, mental health (other than specified serious mental conditions), outpatient care not covered until OOP limit is reached using cost sharing for hospital care, wigs

Breast cancer scenario ‡ (May 1 diagnosis, 87 weeks active treatment)

Estimated allowed charges for all treatment	\$97,298
Estimated paid by patient ††	\$38,209

Care type	# billed	Total allowed charges (\$)	\$ paid by patient	% paid by patient
Office visit	48	3,120	1,422	46%
Office procedure	47	524	307	59%
Radiology	12	6,356	4,206	66%
Laboratory	40	1,632	624	38%
Surgery	1	2,777	1,319	47%
Hospital	1	3,205	641	20%
Inpat. Med Care	1	136	27	20%
Rx drugs	36	5,315	5,315	100%
Prostheses (wig)	1	200	200	100%
Chemotherapy	36	63,320	19,998	32%
Mental health	36	2,574	2,574	100%
Radiation therapy	35	8,140	1,575	19%
		\$97,298	\$38,209	39%

Source of patient expense	Number encountered	Amount
Annual medical deductibles	1	\$1,000
Co-pays	0	\$0
Co-insurance	53	\$2,535
Non-covered care	188	\$34,674

† Monthly premium reflects rate quoted on ehealthinsurance.com for applicant in Sacramento in excellent health.

‡ Breast cancer scenario includes outpatient lumpectomy, 4 two-week cycles each of two chemotherapy regimens delivered in physician office, 7 weeks of daily outpatient 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.

†† Treatment scenario could be varied so that patient receives chemotherapy and radiation therapy in hospital. In this case, cost sharing for these services would apply to annual OOP max, increasing coverage under the policy, so that patient cost sharing liability would be reduced to \$19,800.

This information tool has its limits. Most obviously, Coverage Facts labels cannot be developed for every potential scenario. There are too many diseases and conditions, with care needs as varied as the number of patients. It would not be possible to illustrate every one. To address this shortcoming, some scenarios might be developed and used on a rotating basis so that patient care needs for different conditions could be studied. In addition, it might be possible to develop additional interactive web-based tools that would allow consumers to input specific care need information and see how it is covered.

The Coverage Facts label also assumes a best-case coverage scenario. All care is received in the network with no balance billing, all required authorizations are approved, and all claims are paid accurately and timely. However, other kinds of health plan report cards could also be developed to make more transparent insurers' claims payment practices, medical necessity determinations, utilization review practices, and other coverage features that affect the protection health insurance provides.

Another limitation of Coverage Facts is that its estimate of patient expenses is sensitive to key assumptions. For example, the 87-week breast cancer treatment scenario assumes diagnosis in May. If the patient were diagnosed in January, patient expenses would be somewhat lower because treatment wouldn't reach a third calendar year and fewer costs would fall in the second year. On the other hand, with a September diagnosis, significant treatment needs and cost sharing would occur in each of three calendar years.

The order in which claims are submitted and paid also affects some of the results reported in Coverage Facts. For example, in the heart attack profile, if the hospital bill reached the insurer first, it would satisfy the annual deductible under many policies and cause patient cost sharing for the ambulance ride to be lower.

Even with these limits, the Coverage Facts label provides an important common standard for comparing coverage under different policies. It illustrates what health care needs might be like under various serious and expensive scenarios. And it helps consumers see the combined effect of different policy features—covered benefits, exclusions, and cost sharing—that might otherwise be challenging to envision. Just as automobile manufacturers crash test cars to evaluate their combined protective features under different circumstances, the Coverage Facts labels would offer consumers a more comprehensive picture of how coverage would work in situations when health insurance protection might be most needed.

In addition to a Coverage Facts information tool, the transparency and understandability of health insurance could be enhanced in other ways. In particular:

- Further standardize certain policy features. Although choice is generally valued, too much variation can overwhelm and hinder consumers' ability to select a policy that best fits their needs.²⁰ Developing standard definitions for key health insurance terms, such as "deductible" or "OOP limit," would help consumers to more reliably compare policies

according to these important features. Standard definitions of covered benefits might also be developed so that, for example, coverage for medical equipment would always mean the same thing. For policy variation that remains, the development of standardized tiers of benefits (as has been adopted in the state of Massachusetts) could signal to consumers whether a policy provides a high, medium, or low level of coverage. Standard tiers could help consumers understand what different levels of coverage mean, and help them ask more sophisticated questions about differences in otherwise similar policies.

- Disclose full policy language. Regulators could require full policy language to be readily available at all times to the public so that consumers, and their agents and advocates, would have an opportunity to thoroughly inspect coverage prior to purchase, as well as once policy is in effect.
- Disclose other coverage rules and limitations. Insurers should also make public their plan formularies of prescription drugs and participating provider directories so this critical coverage information is also readily available to both policyholders and prospective enrollees.

Massachusetts has made great strides toward assuring that all residents will have basic health insurance protection, and the Commonwealth Connector has surpassed other states in the amount and quality of comparative health plan information provided to consumers. Yet even in that state, gaps in coverage persist and consumers may not easily appreciate what those gaps could cost if they get seriously ill. Coverage Facts labeling and additional steps to strengthen and standardize coverage would help all consumers—both in Massachusetts and nationwide—know what health insurance covers and costs.

Implications for health care reform

As policymakers contemplate national health care reform, a key question will be the level of protection health insurance should provide. The answer involves tough tradeoffs. More protection costs more, while less protection leaves patients exposed to higher costs they may not be able to afford. However, premiums are paid by everyone, while the financial burden of high cost sharing and excluded benefits falls on people only when they are sick, and will be ongoing for those with chronic conditions.

The tradeoffs between coverage and affordability cannot be evaluated entirely in the abstract, nor should they be obscured. The development of standardized “tiers” of coverage that designate policies with similar actuarial values, as the Commonwealth Connector has done, gives consumers simple and recognizable, albeit general benchmarks to evaluate coverage differences. Yet, as we have shown, a substantial degree of variation can continue under policies offering actuarially equivalent coverage, and such variation must be made more transparent, too. Consumers must be given tools to synthesize the impact of multiple key policy provisions and consider them in the context of health care situations they can recognize and understand.

Beyond disclosure, greater standardization of benefits and other coverage features in health insurance policies can eliminate much of the guesswork for consumers. At a minimum, if a policy includes an out-of-pocket limit of \$2,000, people should know with certainty that their financial liability for covered services will not exceed that amount in a year.

Finally, as health care reformers consider the issue of subsidies for low-income and working families, care must be taken to ensure that both premiums and out-of-pocket medical care spending are held to affordable levels. Covered benefits and cost-sharing subsidies should be designed so that patient expenses for medical care are affordable, even for the most serious and costly conditions.

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The authors gratefully acknowledge funding support for this research from the Robert Wood Johnson Foundation and the California HealthCare Foundation.

¹ P. Cunningham, "Tradeoffs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007," Center for Studying Health System Change, Tracking Report No. 21, September 2008, available at <http://www.hschange.org>.

Endnotes

- 2 H. Tu and G. Cohen, "Financial and Health Burdens of Chronic Conditions Grow," Center for Studying Health System Change Tracking Report No. 24, April 2009, available at <http://www.hschange.org>.
- 3 P. Cunningham, "Living on the Edge: Health Care Expenses Strain Family Budgets," Center for Studying Health System Change, Tracking Research Brief No. 10, December 2008, available at <http://www.hschange.org>.
- 4 C. Schoen, et al, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008.
- 5 The study of Massachusetts health insurance policies was funded by a grant from the Robert Wood Johnson Foundation and can be accessed at <http://www.rwjf.org/pr/product.jsp?id=42248>. The study of California policies was funded by a grant from the California HealthCare Foundation and can be accessed at <http://hpi.georgetown.edu/papers.html>
- 6 Samuel Zuvekas and Joel Cohen, "Prescription Drugs And The Changing Concentration Of Health Care Expenditures," *Health Affairs*, 26 (1) (January/February 2007): 249-257.
- 7 American Cancer Society, "Cancer Facts and Figures 2008," available at http://www.cancer.org/docroot/STT/stt_0_2008.asp?sitearea=STT&level=1.
- 8 D.M. Lloyd-Jones, "Prediction of Lifetime Risk for Cardiovascular Disease by Risk Factor Burden at 50 Years of Age," *Circulation* (113) (February 14, 2006)
- 9 S. Dentzer, "Reform Chronic Illness Care? Yes We Can," *Health Affairs*, 28 (1) (January/February 2009).
- 10 For breast cancer treatment guidelines, see the National Comprehensive Cancer Network at <http://www.nccn.org>. For heart attack treatment guidelines, see <http://www.acc.org/qualityandsafety/clinical/topic.cfm>. See also <http://www.americanheart.org/presenter.jhtml?identifier=3004562>. For diabetes management guidelines, see <http://www.diabetes.org/for-health-professionals-and-scientists/cpr.jsp>. In addition to these published clinical guidelines, project staff consulted clinical experts at the Georgetown University Medical Center, the American Cancer Society, and the American Heart Association. Guidance on scenarios for management of diabetes was provided by the American Diabetes Association for a prior study and consulted for this one.
- 11 Allowed charges also vary by insurance company. In these scenarios, however, allowed charges are assumed to be consistent across all insurers within a state. Because insurer fee schedules are proprietary, this project relied on allowed charge data from the MarketScan® Commercial Claims and Encounters Database for the period of January-December 2007. All California insurers studied were assumed to use MarketScan® median-allowed charges for the state of California, while all Massachusetts insurers were assumed to use MarketScan median-allowed charges for the state of Massachusetts. (MarketScan® is a registered trademark of Thomson Healthcare, Inc.)
- 12 For further information on the cost-estimating methodology used for this project, see the full Massachusetts and California reports at <http://www.health-insuranceinfo.net>.
- 13 California requires coverage parity for certain types of severe mental illnesses, such as schizophrenia and anorexia nervosa. All California insurers must cover treatment for these conditions at the same level that other major medical conditions are covered. For treatment of all other mental illnesses, California health insurers have flexibility to limit or exclude coverage or to require higher cost sharing by patients.
- 14 At this writing, however, a bill (A.B. 786) was pending in the California State Assembly to establish such standardized coverage tiers.
- 15 See full reports for results of all 10 policies—labeled A-J in each state.
- 16 In California, managed care plans regulated by the Department of Managed Health Care must make the EOC available to applicants prior to purchase if requested.
- 17 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
- 18 C. Medill et al, "How Readable Are Summary Plan Descriptions for Health Care Plans," *EBRI Notes* 27 (10) (October 2006).
- 19 Others have recommended the Coverage Facts label. See, for example, K. Wilson, "Check the Label: Helping Consumers Shop for Individual Health Coverage" (California Health Care Foundation, June 2008); See also "Truth in Labeling" *Houston Chronicle*, February 26, 2009, available at http://www.chron.com/CDA/archives/archive.mpl?id=2009_4705953. The editorial cites legislation sponsored by State Sen. Kirk Watson (D-Austin); See also, "Hazardous Health Plans," *Consumer Reports*, May 2009.
- 20 See, for example, J. Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (Henry J. Kaiser Family Foundation, March 2009). See also E. O'Brien and J. Hoadley, "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice" (The Commonwealth Fund, April 2008).

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