

Statement for the Record
by
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for
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Domestic Policy Subcommittee
Oversight and Government Reform Committee
U.S. House of Representatives

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Legislative Ideas to Reduce Insurance Hassles

Mr. Chairman, Members of the Subcommittee:

The testimony of Mr. Mark Gendernalik is a classic description of everything that is wrong with the operation of health insurance in our nation. It is a litany of abuses that beg for correction, so that others do not have to endure these kinds of life-threatening hassles in the future.

The various health reform bills now being debated (HR 3200, etc.) focus mostly on making sure that every American would have the peace of mind of always having health insurance that is fairly comprehensive and reasonably affordable. A huge task. But we would also like to see more attention given to making sure that existing and new insurance plans will actually work to provide insurance without the hassles we have today.

Of course, if everyone has insurance, if there are no pre-existing conditions, and there is guaranteed issue, insurers will probably spend less time avoiding the sick and trying to get heavy users of health care to drop their policies. But when the healthiest 50 percent of the population uses only 3 percent of the health care dollar, and the sickest 10 percent uses about 65 percent of the health care dollar, there will always be a temptation by for-profit insurers to avoid those 10 percent—they even try to avoid the pre-existing conditions of the 47 percent who use about 32 percent of the health care dollar.

Hassling policyholders and providers and avoiding paying for necessary care can be reduced if there is risk adjustment among plans. The bills should require audited risk adjustment so those plans that enroll sicker people can be paid from those who somehow manage to avoid those enrollees.

The bills should also spell out in detail consumer grievance and appeals procedures. Most of the bills just have boilerplate language that insurers have to have such systems, to be defined by the Secretary of HHS or by the 'Exchange' administrator. On July 31st, the Energy and Commerce Committee accepted by voice vote an amendment by Representatives Burgess and Barrow that spells out in great deal how these systems should work, how there must be an expedited, 72-hour appeal process, etc. While we would like to see even stronger language and truly independent grievance and appeals operations, we support the Energy and Commerce Committee type of detailed language in any final bill.

Also, most of us consumers are not very good insurance shoppers. The terms used are confusing. The fine print is mind-numbing. We pick a plan and we tend to stay with it until something goes very wrong. There is data that shows this is true in the Medicare drug program, in the Federal Health Benefits Plan, and insurance in general, where people do not make the best economic or quality choice and are reluctant to complain or switch. So it is very, very important that people be given the best information up front, at the time of enrollment. We need to know more about the quality history of a company, about other consumers' satisfaction and dis-enrollment rates, and on its total cost of providing care, not just the cost of its premiums. HR 2427 by Rep. DeLauro provides that kind of information, including scenarios on the out-of-pocket cost of treating various illnesses under different policies, and information and protections on your out-of-network co-payment obligations. This kind of detail would be very helpful to consumers.

Most of all, what are the penalties for companies that deny and delay care to their membership? What would really catch their attention? Penalties and fines often just seem to be a cost of doing business (look at the recent repeated penalties on the big drug companies). The money insurers save by denying and delaying and encouraging the dis-enrollment of sick people more than pays for the occasional fine and day of bad press.

Therefore, the House should adopt an idea from the Senate HELP Committee-reported bill that has just been made public. In section 3106, relating to the community health insurance option (public plan option), if a plan has its payment reduced more than once during its 5 to 10 year contract period for poor quality or failure to control cost reasons, then its contract cannot be renewed. Please take that concept and apply it to all plans in the Exchange: if a plan is found to be the worst quality and price stability performer in any 2 out of a 3 year period, prohibit them from participating in the insurance exchange for a period of years. A variation of this idea would be to put some teeth in the medical loss ratio (MLR) provisions. It is good the bills will provide consumers with information on how much of our premium dollar is actually spent on health care, and how much is spent on overhead, ads, profits, etc. But how about terminating an insurer if they are the worst MLR (spend the least on health care, the most on the overhead-type of hassles described by Mark Gendernalik), but have above average levels of complaints for, say, 3 out of 5 years? That would focus companies' attention on doing more for health care and less on wasteful hassling.

Judging from Medicare Advantage and the Medicare drug program and the Federal Employee Health Benefit program, consumers will have lots and lots of choices (one can argue there are too many meaningless, bewildering choices) and getting rid of the worst performer will not interfere with choice. Terminating the worst performer on a periodic basis will weed out the worst profiteers and consumer abusers and inspire all the others to really do their job: help people like the Gendernalik family when they have a desperately ill child.

Thank you for your consideration of these ideas.