Summary of Consumers Union Testimony
before House Education and Labor Committee
June 23, 2009
on
The Tri-Committee Draft Proposal for Health Care Reform

Consumers Union is the independent, non-profit publisher of *Consumer Reports.*

We strongly endorse the approach taken in the Tri-Committee Draft, assuming that additional cost containment or progressive financing will be added to ensure that it is budget neutral.

We believe the Draft is a plan that would at long last ensure access to affordable, quality, "peace of mind" health insurance for every American.

The Draft has too many major improvements to list separately. A table in the testimony lays out our health reform principles from our August magazine issue, and how the Draft would dramatically advance these key consumer issues.

Of course, in a bill this size, we have a few suggestions for ways to make it even better. (You'd be shocked if we didn't!) But these are minor suggestions compared to the important reforms proposed in the bill:

> --We urge that you more clearly help consumers encourage quality, by increasing the public reporting of infections and other medical errors.
>
> --If Congress wants an efficient marketplace that can help hold down costs, you need to provide more consumer tools in that marketplace. The Health Choices Administration and Insurance Ombudsman are a good start. We hope you can flesh out their powers and duties. We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition
>
> --Consumers are desperately worried about the high cost of health care. We hope you can do more to obtain savings. We will be forwarding a separate set of ideas for major savings, particularly in the pharmaceutical sector, imaging and self-referral abuse, and ensuring the operation of the Medicare Secondary Payer program, etc.

The American health care system must and can be fixed.

The Tri-Committee proposal will bring us to the goal of affordable, quality, dependable health care for all, and we hope you give consumers even more tools to help drive the system toward quality and cost savings.

Testimony of William Vaughan
Senior Health Policy Analyst
Consumers Union
before the
Committee on Education and Labor
U.S. House of Representatives
June 23, 2009

on

The Tri-Committee Draft Proposal for Health Care Reform

Mr. Chairman, Members of the Committee:

Thank you for inviting Consumers Union to testify on the Tri-Committee Draft health care reform proposal.

Consumers Union is the independent, non-profit publisher of *Consumer Reports.*[1] We not only evaluate consumer products like cars and toasters, we evaluate various health products, and we apply comparative effectiveness research that can save consumers hundreds and even thousands of dollars in purchasing the safest, most effective brand and generic drugs.[2]

> --Since 1939 we have been advocating for an affordable, secure, quality health insurance system for everyone.
>
> --Our national polls have frequently shown that the high cost of health care is one of the greatest concerns for consumers, and many fear they would be bankrupted if a major medical problem hit their family.
>
> --Our May 2009 issue features an article on "hazardous health plans," and points out that many policies are "junk insurance" with coverage gaps that leave you with a financial disaster. One of the most prevalent stories we have heard from our readers is that they thought they had good insurance—until they had a major health problem, and then it was too late.

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[1] Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

[2] See www.ConsumerReportsHealth.org/BBD

--Our about-to-be-released August issue includes a 10-page special editorial feature, using examples of families across the country, on why American consumers so desperately need comprehensive reform. We've attached a copy of this special issue.

Tri-Committee Draft

Therefore, we strongly endorse the approach taken in the Tri-Committee draft, assuming that additional cost containment or progressive financing will be added to ensure that it is budget neutral.

We believe the Draft is a plan that would at long last ensure access to affordable, quality, "peace of mind" health insurance for every American.

The Draft has too many major improvements to list separately. The following table lays out our health reform principles from our August magazine issue, and how the Draft would dramatically advance these key consumer issues.

Consumer Union Goals in Health Reform	**Tri-Committee Draft**
Ensure health access to every American: Make insurance simple by creating a national health insurance exchange where one can always go—regardless of one's health or situation in life-- to choose a private or public plan, with sliding scale subsidies based on income to make it affordable.	The Health Insurance Exchange, with reformed private policies (guaranteed issue, no pre-existing conditions) and a public plan option, with premium and cost-sharing subsidies phasing out at 400% of poverty, achieve this goal. Those who have good plans today can keep what they have.
The insurance offered should be comprehensive, bringing financial security and peace of mind.	The minimum standard benefit package (and at least 2 distinct, more valuable options), with no yearly or life-time limits and with out-of-pocket catastrophic protection at $5,000 for an individual and $10,000 for a couple, would achieve this goal. The low-income get even more protection.
Coverage should be especially good for preventive care.	The packages all include comprehensive preventive services; Medicare is improved to make preventive care more affordable; and a new Wellness and Prevention Trust Fund would help spur community wellness.
Eliminating pre-existing conditions and	The individual mandate to have at least the

guaranteeing issue can't work for insurers, unless everyone has to have insurance. But we can't force people to buy policies they can't afford or that are inadequate, so subsidies are needed. And a public plan option working on a level playing field can use competition to minimize the need for subsidies by holding costs down and driving quality up.	'Essential' benefit plan, coupled with subsidies, and efforts to control cost, achieve this goal. Cost containment includes the public plan option, medical loss ratio requirements, comparative effectiveness research, form simplification, stepped up anti-fraud, stopping drug and device company 'gifts' to providers, new ways for doctors to deliver quality coordinated care, and implementation of MedPAC recommendations. Consumers Union urges even more be done to control costs.
Increase quality and help consumers choose quality, by making error rates public, particularly infection rates (largely preventable infections kill 100,000 Americans per year). Encourage care based on quality, not just quantity, and help spread the use of electronic medical records. Encourage more primary care doctors.	Division B's Section 1151 reduces payments for hospital readmissions due to poor quality and section 1441 establishes a new center to set priorities for quality improvement. State Medicaid plans are rewarded for not paying for poor care such as infections. We hope it is clearer that infection rates are to be public on a facility specific basis, and that more is done to report 'never events,' and require periodic quality recertification of providers, per the recommendations of the IOM. Efforts to develop accountable care organizations and medical homes will help ensure better care coordination. The Stimulus package HIT monies should help productivity over time and improve quality. The Draft's major sections on the workforce, graduate medical education, and increased payments to primary care doctors should all help.
Help small businessmen get affordable health insurance for themselves and their	The Health Insurance Exchange will make policies more affordable; subsidies to small

employees.	and lower wage firms will make it affordable.

Areas Where We Hope More Refinement Can Occur

Of course, in a bill this size, we have a few suggestions for ways to make it even better. (You'd be shocked if we didn't!) But these are minor suggestions compared to the important reforms proposed in the bill.

On quality

We urge that you more clearly help consumers encourage quality, by increasing the public reporting of infections and other medical errors. Consumer pressure can inspire providers to focus more on preventing infections and other errors—but first, consumers need to be informed.

Ten years ago, the Institute of Medicine issued its report, To Err is Human, noting that medical errors were killing up to 98,000 people a year and costing the health system tens of billions in unnecessary costs. The CDC now says that 100,000 are dying just from largely preventable infections, which add an extra $35.7 to $45 billion per year in treatment costs. No one can say whether anything has really improved over the last decade: the IOM's recommendations have been largely ignored.

We urge you, in addition to the 7 hospital re-admission conditions discussed on page 222 of the Draft, to include public reporting of healthcare-acquired infections such as MRSA and other deadly conditions. We also hope you will take another look at the IOM report, and move to require public reporting of 'never events' (like surgery on the wrong part of the body) the way Minnesota has done. It is way past time to adopt the IOM's proposals for periodic quality re-certification of providers. We retest pilots and others for competency—we should retest providers on a periodic basis. Finally, we urge you to consider some of the excellent language in the Senate HELP bill to improve our nation's failing Emergency Medical Systems.

Do More to Help the Consumer in the Health Insurance Exchange

The honest, sad truth is that most of us consumers are terrible shoppers when it comes to insurance. The proof is all around you.

> --In FEHBP, hundreds of thousands of educated Federal workers spend much more than they should on plans that have no actuarial value over lower-cost plans.[3]
>
> --In the somewhat structured Medigap market where there is a choice of plans A-L, some people spend up to 16 times the cost of an identical policy.[4]

[3] Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.

--In Medicare Part D, only 9 percent of seniors at most are making the best economic choice (based on their past use of drugs being likely to continue into a new plan year), and most are spending $360-$520 or more than the lowest cost plan available covering the same drugs.[5]

--In Part C, Medicare has reported that 27% of plans have less than 10 enrollees, thus providing nothing but clutter and confusion to the shopping place.[6]

The Institute of Medicine reports that 30 percent of us are health illiterate. That is about 90 million people who have a terrible time understanding 6th grade or 8th grade level descriptions of health terms. Only 12 percent of us, using a table, can calculate an employee's share of health insurance costs for a year.[7] Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc.

If Congress wants an efficient marketplace that can help hold down costs, you need to provide more consumer tools in that marketplace. The Health Choices Administration and Insurance Ombudsman are a good start. We hope you can flesh out their powers and duties as follows:

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition. The Draft bill provides 3 broad categories of policies, and we appreciate the fact that these broad groupings will be helpful to consumers. But like Medigap policies A-L, we urge you to make the policies sold in each of these broad categories identical, so that consumers can shop on the basis of price and quality, and not on tiny, confusing differences (10 rehab visits v. a plan with 12, etc.). To only require these broad groupings to be 'actuarially equivalent' is to invite a Tower of Babel of tiny plan differences, designed by the insurers to attract the healthy and avoid the most expensive—and with the end result of confusing the consumer.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.[8] Fewer offerings of meaningful choices would be appreciated. There are empirical studies showing that there is such a thing as too much choice, and dozens and dozens of choices can paralyze decision-making.[9]. The insurance market can be so bewildering and overwhelming that people avoid it. We think

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[4] See also, TheStreet.com Ratings: Medigap Plans Vary in Price, 9/15/06.
[5] Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.
[6] SeniorJournal.com, March 29, 2009.
[7] HHS Office of Disease Prevention and Health Promotion
[8] "Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare Prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors. When asked if they agreed with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative." Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009. Page 2.
[9] Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

that is a major reason so many people having picked a Part D plan, do not review their plan and fail to make rational, advantageous economic changes during the open enrollment period.

In the past, CMS allowed roughly 1400 Part C plans with less than 10 members to continue to clutter the marketplace. What a waste of time and money for all concerned. Reform legislation should prevent the proliferation of many plans with tiny differences that just serve to confuse a consumer's ability to shop on price and quality.

√ Require standardization of insurance definitions so consumers can easily compare policies on an "apples-to-apples' basis. This is key. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. Attached on the last page of this testimony is an article from our May magazine which demonstrates what radically different coverage two similar sounding policies can provide. It is not clear that the "benefit standards defined" (p. 29, line 11) will guarantee comparability of terms among plans.

√ Require insurers to clearly state (in standardized formats) what's covered and what's not in every plan offering, and to estimate out-of-pocket costs under typical treatment scenarios. The Washington Consumers' Checkbook's "Guide to Health Plans for Federal Employees (FEHBP)" does a nice job showing what consumers can expect, but even in FEHB policies they find it impossible to provide clear data on all plans.[10] HR 2427 by Rep. DeLauro and Rep. Courtney and 23 others is excellent language on how to design such scenarios.

√ Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site. The States would continue to regulate and supervise insurers operating in their state, but with the continual merger and growing concentration of insurers, consumers need a simple place where complaints can be lodged and data collected, analyzed, and reported nationally concerning the quality of service offered by insurers. This type of central complaint office may have allowed quicker detection of the UnitedHealth-Ingenix abuse of underpaying 'out-of-network' claims.

√ Institute and operate quality rating programs of insurance products and services. This would be similar to the Medicare Part D website, with its '5 star' system.

√ Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support (through federal grants) to community-based non-profit organizations providing one-on-one insurance counseling to consumers. These programs need to be greatly expanded if you want the HIE connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public.

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[10]Op. cit., p. 68.

√ Require plans to provide year-long benefit, price, and provider network stability. In Medicare Part D, we saw plans advertise certain drug costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer's effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

√ Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems, and to appeal coverage denials. We appreciate the requirement in Sec. 132 for 'fair grievance and appeals mechanisms,' but urge that the Commissioner, perhaps with the help of the NAIC, develop a **model** system that all participating insurers have to use.

Many are worrying that comparative effectiveness research (CER) may lead to limits of what is covered. We believe CER will help us all get the best and safest care. It makes sense to give preference to those items which objective, hard science says are the best, especially if the research takes into consideration relevant differences such as gender, ethnicity, or age. But if a drug, device, or service does not work for an individual, then that individual must be able to try another drug, device, or service without hassle or delay. The key to this is ensuring that the nation's insurers have honest, usable exceptions processes in place. This legislative effort is where we should be putting our energy to address the otherwise legitimate concern of many people about CER. .

Do More to Obtain Savings. Consumers are desperately worried about the high cost of health care. We hope you can do more to obtain savings. We will be forwarding a separate set of ideas for major savings, particularly in the pharmaceutical sector, imaging and self-referral abuse, and ensuring the operation of the Medicare Secondary Payer program, etc.

Conclusion

We thank you again for this opportunity to testify.

The American health care system must and can be fixed.

The Tri-Committee proposal will bring us to the goal of affordable, quality, dependable health care for all, and we hope you give consumers even more tools to help drive the system toward quality and cost savings.

Appendix II

…and out-of-pocket expenses can vary widely	**Massachusetts plan**	**California plan**
With its lower premium and deductible, the California plan at right would seem the better deal. But because California, unlike Massachusetts, allows the sale of plans with large coverage gaps, a patient there will pay far more than a Massachusetts patient for the same breast cancer treatments, as the breakdown below shows.	**Monthly premium for any 55-year-old:** $399 **Annual deductible:** $2,200 **Co-pays:** $25 office visit, $250 outpatient surgery after deductible, $10 for generic drugs, $25 for nonpreferred generic and brand name, $45 for nonpreferred brand name **Co-insurance:** 20% for some services **Out-of-pocket maximum:** $5,000, includes deductible, co-insurance, and all co-payments **Exclusions and limits:** Cap of 24 mental-health visits,$3,000 cap on equipment **Lifetime benefits:** Unlimited	**Monthly premium for a healthy 55-year-old:** $246 **Annual deductible:** $1,000 **Co-pays:** $25 preventive care office visits **Co-insurance:** 20% for most covered services **Out-of-pocket maximum:** $2,500, includes hospital and surgical co-insurance only **Exclusions and limits:** Prescription drugs, most mental-health care, and wigs for chemotherapy patients not covered. Outpatient care not covered until out-of-pocket maximum satisfied from hospital/surgical co-insurance **Lifetime benefits:** $5 million
Service and total cost	**Patient pays**	**Patient pays**
Hospital	$0	$705
Surgery	981	1,136
Office visits and procedures	1,833	2,010
Prescription drugs	1,108	5,985
Laboratory and imaging tests	808	3,772
Chemotherapy and radiation therapy	1,987	21,113
Mental-health care	950	2,700
Prosthesis	0	350
TOTAL $104,535	**$7,668**	**$37,767**

Source: Karen Pollitz, Georgetown University Health Policy Institute, using real policies and claims data from state high-risk pool. May, 2009 issue