

# Coverage When It Counts:

What Does Health Insurance In California Cover  
And How Can Consumers Know?

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The background of the page features a large, faint, light green watermark of the Seal of the University of Maryland System. The seal is circular and contains an eagle with wings spread, perched atop a shield with vertical stripes. Above the eagle is a lyre. The entire emblem is surrounded by a laurel wreath. The Latin motto "SIGILLUM UNIVERSITATIS MARYLANDICAE" is inscribed around the perimeter of the seal.

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### What does it mean to be adequately insured?

A growing body of research documents problems that can arise when health insurance doesn't cover enough. Rates of medical debt are growing, chiefly among the insured.<sup>1</sup> One in five (or more than 9 million) privately insured people with chronic conditions live in families with medical bill problems – an increase from 16 percent in 2003.<sup>2</sup> 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.<sup>3</sup> Studies show that the under-insured and uninsured face similar problems accessing medical care and managing financial burdens.<sup>4</sup>

How can people know when health insurance provides adequate coverage? 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. For consumers who are healthy today, it can be difficult to anticipate what kinds of medical problems and costs might arise in the future, and harder still to evaluate how health insurance might cover those needs. Many urge that choice of health insurance is valued by consumers and key 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. Health insurance transparency and coverage adequacy, therefore, go hand in hand.

This report suggests a new method for developing benchmarks to illustrate some types and costs of medical care consumers might need under a variety of scenarios, and for evaluating health insurance protection using these benchmarks. Using simulated claims scenarios for different types of patients – one diagnosed with early stage breast cancer, another who has a heart attack, and a third with diabetes – we analyzed the content of commercial coverage provided by 10 health insurance plans sold in California and estimated out-of-pocket costs for care that patients might face. We also reviewed the transparency and accessibility of information about policies that consumers would need to understand how coverage works.

The report concludes with a recommendation for the development of standardized health plan comparison tools – patterned on the FDA 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?

Per capita health care spending 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.<sup>5</sup> Most people are healthy most of the time, but over the course of a lifetime, most people will have at least a year or two when medical needs are very high. For example, one out of every three women and one of every two men will be diagnosed with cancer in their lifetimes.<sup>6</sup> The lifetime risk of cardiovascular disease is 50 percent for men and 40 percent for women.<sup>7</sup> In addition, chronic conditions account for approximately three-quarters of medical care spending in the U.S.<sup>8</sup> Therefore, for some people who get sick, medical expenses will not be confined to a single, acute event or calendar year, but will persist for a lengthy period of time.

This project estimated cost scenarios for illustrative patients with serious medical conditions: breast cancer, heart attack, and diabetes. (*See Methodology section in appendix.*) These are examples of conditions that occur commonly in the population and that generate the kinds of large medical expenses for which most people would hope to have health insurance protection.

#### Breast cancer

Breast cancer is the most common cancer in women. In 2007, 178,480 new breast cancers were diagnosed; 95 percent of breast cancers occur in women 40 and older, although 59 percent of cases are diagnosed before the age of 65. Thanks to improved early detection technologies, breast cancer is usually detected at early stages when it is most treatable and chances of survival are greatest.<sup>9</sup>

Treatment will vary based on the tumor stage and pathology and other patient characteristics, although widely accepted treatment guidelines are published and regularly updated.<sup>10</sup> The patient described in this scenario was diagnosed in May with a stage II breast cancer following a routine screening mammogram.

Approximately 30 percent of breast cancers are diagnosed as stage II.<sup>11</sup> Her tumor tested positive for estrogen receptors (ER+) and for increased levels of a protein called HER2/neu (HER2+), which makes breast cancer more aggressive. About 25 percent of breast cancers are Her2-positive.<sup>12</sup> Onset of serious illness is also often linked to anxiety and depression. An estimated 15 to 25 percent of cancer patients suffer from depression.<sup>13</sup>

Standard treatment for this patient would include breast conserving surgery (lumpectomy), chemotherapy, Herceptin therapy, radiation therapy, and hormone therapy. In this scenario, surgery takes place about one month after her mammogram. Chemotherapy, with bi-weekly infusions, begins one month following surgery and continues for 16 weeks. About one month following the last chemotherapy infusion, daily radiation therapy begins and continues for seven weeks. Herceptin infusion therapy begins during the second half of chemotherapy

and continues weekly for a year. Diagnostic tests and procedures are also ordered. Various medications and a cranial prosthesis (wig) are prescribed for treatment side effects. The patient also receives short term counseling for depression. From start to finish, these treatments would take place over 87 weeks. Hormone therapy (taken orally) and other follow up care and screening would continue beyond this time frame.

Under this scenario, estimated allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, institutions, and suppliers total approximately \$97,000.

The patient would be billed for 52 diagnostic tests and imaging procedures, one outpatient surgery, 118 visits associated with various cancer treatment therapies and 36 mental health visits. She would also need 36 outpatient prescription drugs and refills with drug prices ranging from \$7 to \$700. (See Figure 1)

**Figure 1.**

**Summary of treatment and allowed charges\* for early stage breast cancer scenario**  
[\$97,298 total treatment costs over 87 weeks, beginning May 1]

Treatment items and services	Number in year 1	Allowed charges in year 1	Number in year 2	Allowed charges in year 2	Number in year 3	Allowed charges in year 3	Total number	Total allowed charges
Office Visit	37	2,317	10	719	1	84	48	3,120
Office Procedure	31	478	16	46	0	0	47	524
Radiology	8	4,200	4	2,156	0	0	12	6,356
Laboratory	24	1,338	16	295	0	0	40	1,632
Surgery	1	2,777	0	0	0	0	1	2,777
Hospital	1	3,205	0	0	0	0	1	3,205
IPMD	1	136	0	0	0	0	1	136
Rx Drugs	16	2,046	19	3,022	1	248	36	5,315
Wig	1	200	0	0	0	0	1	200
Chemotherapy	23	44,569	13	18,750	0	0	36	63,320
Mental Health	15	1,104	21	1,470	0	0	36	2,574
Radiation Therapy	27	6,565	8	1,575	0	0	35	8,140
<b>Total Charges:</b>		<b>\$68,933</b>		<b>\$28,033</b>		<b>\$332</b>		<b>\$97,298</b>

\* Allowed charges are held constant for all California policies studied and are estimated based on data about allowed charges paid by many health plans and insurers in the state. See Appendix 1 for further detail.

### Heart attack

Coronary artery disease is the leading cause of death in the U.S. Over 1.2 million new or recurring heart attacks occur in the U.S. annually. High risk groups include men over the age of 40 and women over the age of 50. Thanks to improved interventions the survival rate for heart attack is increasing.<sup>14</sup>

Myocardial infarction (MI), or heart attack, occurs when a vessel supplying the heart becomes blocked and cuts off the heart's blood supply. This is an acute event that requires immediate medical attention. The American Heart Association and the American College of Cardiology have published well established treatment guidelines for patients that have suffered from MI.<sup>15</sup>

In this scenario, the patient has a heart attack at his home in May and is transported to the hospital by ambulance. There, treatment includes a full cardiac workup and insertion of a stent to reopen the affected coronary artery. He remains in the hospital overnight and then is discharged to recover at home from this procedure.

Several weeks later he is readmitted to the hospital for three days for coronary artery bypass graft surgery. Post surgery follow up care includes 36 cardiac rehabilitation sessions. Thereafter, quarterly visits with his primary care provider are needed to monitor medications, which include drugs to reduce blood pressure, cholesterol, and anti-platelet medication. Major depression occurs in 1 of every 5 patients hospitalized for MI.<sup>16</sup> The patient in this scenario receives short term psychotherapy visits as well as a prescription antidepressant. Active treatment is concluded in 56 weeks following the attack.

Under this scenario, estimated allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, institutions, and suppliers total about \$82,000.

The patient would be billed for one ambulance ride, two hospitalizations for surgery, six cardiology visits, nine diagnostic tests and imaging procedures, 36 cardiac rehab sessions, and 50 mental health visits. He would also need 64 prescriptions and refills with drug prices ranging from \$2 to \$125. (See Figure 2)

**Figure 2.** Summary of treatment and allowed charges for heart attack scenario

Treatment items and services	Number in year 1	Allowed charges in year 1	Number in year 2	Allowed charges in year 2	Total number	Total allowed charges
Ambulance	1	772	0	0	1	772
Hospital	2	58,822	0	0	2	58,822
Inpat Med Care	14	2,550	0	0	14	2,550
Office Visit	4	476	2	238	6	714
Office Procedure	6	266	2	6	8	272
Radiology	2	692	0	0	2	692
Laboratory	5	591	2	72	7	663
Surgery	2	9,423	0	0	2	9,423
Prescription Drugs	44	1,402	20	272	64	1,673
Cardiac Rehab.	36	2,844	0	0	36	2,844
Mental Health	30	2,167	20	1,400	50	3,567
<b>Total allowed charges:</b>	<b>146</b>	<b>\$80,006</b>	<b>46</b>	<b>\$1,987</b>	<b>192</b>	<b>\$81,993</b>

## Diabetes

Diabetes is a metabolic disorder in which the body is either unable to produce or properly use insulin, a hormone needed to convert sugars and other food into energy. It is a lifelong disease that requires constant monitoring and treatment. In 2006 approximately 23.6 million Americans, or 8 percent of the U.S. population had been diagnosed with diabetes, and an additional 1.6 million new cases were diagnosed in 2007. The total economic cost of diabetes in 2007 is estimated at \$174 billion, and one of every 5 healthcare dollars in the U.S. is spent caring for someone diagnosed with diabetes.<sup>17</sup>

The American Diabetes Association has published and regularly updates guidelines for the clinical management of patients with diabetes. Standard treatment for a patient with type I diabetes includes prescription insulin, blood glucose self-monitoring (at least four times per day), quarterly lab tests and visits to a primary care physician or endocrinologist, and annual examinations of the feet and eyes.

The patient in this scenario has well controlled diabetes. She tests her blood sugar four times daily – which requires test strips, a monitoring system, lancets and alcohol swabs. She administers Lantus insulin every morning with a syringe and Humalog insulin from a pre-filled insulin pen three times a day before meals. In addition to her diabetes, the patient also has elevated blood pressure for which she takes a generic prescription drug, Altace, once daily. Finally, once annually she must purchase a glucagon emergency kit to keep on hand in case she becomes unconscious from very low blood sugar, or hypoglycemia. For a patient with this type of diabetes self-management needs, the charge for any single item or service is relatively modest, but ongoing. For example, test strips cost approximately \$1 each, but the patient would use about 1,400 strips per year.

Under this scenario, allowed charges (reflecting insurer negotiated discounts) for treatment billed by providers, labs, and pharmacies total nearly \$7,300 for one year.

The patient would be billed for 10 lab tests, 13 office visits and procedures, and 80 prescriptions and refills (including purchases of diabetes testing supplies and syringes that are typically covered under the outpatient pharmacy benefit), with prices per refill ranging from \$11 to \$153.

(See Figure 3)

**Figure 3.** Summary of treatment and allowed charges for type I diabetes

Treatment items and services	Number per year	Total allowed charges per year
Office Visit	7	591
Office Procedure	6	109
Laboratory	10	183
Glucose Meter	1	0
Glucose Test Strips (box 100)	14	1,680
Lancets (box 100)	14	160
Alcohol Swabs (box 100)	14	42
Syringes (box 30)	14	226
Lantus Insulin	9	1,255
Humalog Insulin	14	2,146
Glucagon Kit	1	104
Other RX	14	814
<b>Total allowed charges:</b>		<b>\$7,309</b>

These common medical conditions were chosen for this analysis because they account for a significant amount of total medical care spending. In addition, together, they permit testing of different aspects of health insurance coverage. Treatment under the breast cancer scenario consists primarily of medical care provided in office-based and outpatient settings. By contrast, treatment under the heart attack scenario is provided largely in the hospital. Treatment for the management of diabetes is heavily dependent on pharmaceutical care. Two of the scenarios (breast cancer and heart attack) also include short term mental health treatment.

## What Does Health Insurance Cover?

In the U.S., health insurance policies vary widely in terms of covered benefits, cost sharing, and other rules.

### Covered benefits and cost sharing

Federal law requires coverage of a select few health benefits under health insurance. In certain health plans and health insurance policies, federal law requires coverage for breast reconstruction, minimum hospital stays for newborns and mothers, and mental health parity. Maternity care is covered by all job-based group health plans sponsored by employers with 15 or more workers,

because of requirements in the Pregnancy Discrimination Act. Federal law also sets minimum standards for certain high-deductible health plans that can be combined with tax preferred health savings accounts (HSAs.) For these plans federal rules limit the maximum cost sharing that can be required for covered benefits but are largely silent on what benefits might be covered or excluded.<sup>18</sup>

State laws generally establish more requirements for health insurance coverage. For example, 50 have enacted mandates to cover mammograms<sup>19</sup> and 47 have enacted diabetes benefit mandates.<sup>20</sup> Even so, coverage for mandated benefits can vary considerably. For example, insurers cover diabetes management medications, equipment and supplies differently. In some policies, all items are covered under the pharmaceutical benefit; in others, items such as glucometers, test strips, and lancets might be covered under the medical equipment benefit.<sup>†</sup> In addition, state mandated benefit laws often are silent on the level of cost sharing that can apply to required benefits, so policies will vary in this respect as well.

Most health insurance requires patients to pay at least some of the cost of covered services. Cost-sharing features include deductibles (an initial level of expense paid entirely by the policyholder, after which insurance reimbursement begins), co-insurance (a percentage of covered costs paid by the policyholder), and co-payments (a flat dollar amount per service paid by the policyholder). Cost sharing rules can differ for different services. For example, office visits may be subject to a \$20 co-pay while co-insurance of 20 percent applies to surgery. Deductibles may be waived for preventive care or certain other services, while separate deductibles may apply to hospitalization and prescription drugs.

Most policies also include an annual out-of-pocket maximum (OOP), a feature to limit patient cost sharing liability in a year. How the OOP operates tends to vary by policy; for example, the annual deductible counts toward the OOP in some policies but not others. Often, the OOP does not limit all cost sharing. Patient costs for prescription drugs and mental health care may not apply to the OOP; sometimes co-pays for other medical care are not limited by the OOP. As a result, patients with ongoing care needs whose health insurance lacks a comprehensive OOP might meet their annual OOP and

still owe hundreds or thousands of dollars in additional cost sharing for covered services.

Importantly, cost sharing rules are applied annually under most policies because the duration of coverage is for one year. Patients whose care spans more than one plan year can expect to pay expenses arising from multiple deductibles and OOP maximums over the entire course of treatment.

### California coverage rules

In a handful of states, rules comprehensively define what health insurance must cover and, as a result, policies are fairly standardized. By contrast, California is typical of most other states where insurers have relatively broad flexibility in the benefit packages they design. However, different rules apply to different types of policies in California. The Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene Act) governs companies which offer products for which the HMO receives a prepaid or periodic charge from the subscriber in order to arrange for the services. The Department of Managed Health Care (DMHC) regulates these companies. Most providers delivering services in an HMO environment are paid capitation by the plan. That is, the medical group and hospital, which contract with the plan, receive a set amount per month for each enrollee (PMPM) for all medically necessary basic health care services to be delivered to the enrollee in the next month. In contrast, the California Department of Insurance (CDI) regulates health care insurance which is of an indemnity/reimbursement category. CDI regulates most of the preferred provider organization (PPO) products in California, point-of-service (POS), and catastrophic coverage. (Certain PPO products were “grandfathered” into the Knox-Keene Act’s regulatory oversight. The DMHC does regulate the HMO portion of a POS product offered by a licensee of the DMHC.)

Plans regulated by DMHC must cover medically necessary basic health care services including physician services, hospital inpatient and ambulatory care, diagnostic lab and imaging, home health care, preventive services, emergency care and hospice care.<sup>21</sup> The Knox-Keene Act does not specify levels of cost sharing that can be applied to most covered services. However, DMHC regulations require that cost sharing cannot “render the benefit illusory,”<sup>22</sup> and this has been interpreted to mean

<sup>†</sup> California mandated benefits laws require all policies to cover diabetes supplies, such as test strips, syringes, and lancets. However, not all policies are required to cover prescription drugs, and only those that do must also cover insulin, glucagon, and other diabetes medications. See Health and Safety Code, Section 136751(a) and (b). See also California Insurance Code, section 10176.61 (a) and (b).

that patient cost sharing for most services cannot exceed 50 percent of the cost to the insurer.<sup>23</sup> By contrast, for CDI-regulated health insurance policies, no minimum or basic set of services are required, although mandated benefits laws do apply. At this writing, legislation was pending in the California state Assembly to require all CDI-regulated health insurance products to cover physician, hospital and preventive services.<sup>24</sup>

Within these state requirements, policies sold in both the individual and small group markets can and do vary significantly. For example, while most individual policies in California provide some prescription drug coverage, an estimated 14 percent of policyholders in CDI-regulated individual policies do not have prescription drug benefits.<sup>25</sup> While most job-based health plans in the state have an annual deductible of less than \$500 per person, 25 percent of covered workers have deductibles of \$1,000 or more.<sup>26</sup> Other policy features also vary significantly, as discussed below.

### Plans studied for this project

This report analyzes coverage under 10 policies sold in the individual and small group market in California in 2008. Plans selected are not intended to be representative of policies sold in the state. In fact, our analysis was limited by the availability of the full health insurance policy, sometimes called the evidence of coverage (EOC). As discussed below, the EOC may not be available until after a policy is applied for or purchased.

We obtained a total of 14 policies from various sources. Six were obtained via the public documents request system on the DMHC web site. Three were obtained from health insurance agents and a fourth from a policyholder. Four others were obtained from insurer or online broker web sites. From this non-random sample of EOCs, we then select for study at least one policy sold by each of the top five insurers in the state.<sup>27</sup> In addition, we used proxy measures of what constitutes a popular plan design. For the individual market, we consulted “ehealthinsurance.com,” a web site where individuals can find and compare health insurance policies, including many, though not all, of those sold in California. The site allows users to sort plans according to those most often sold. Based on the ehealthinsurance ranking, we chose individual market EOCs that matched or were similar to those listed as most popular. This included some policies with high deductibles and some with low or no deductibles. For the small group market, we chose EOCs

that reflected features typically found in job-based health plans as reported by the annual California Employer Health Benefits Survey. This also included some with high deductibles and some with low or no deductibles.

Among plans used for this analysis, annual deductibles per individual ranged from zero to \$3,500. Coinsurance ranged from 20 to 30 percent for most medical services. In two plans, only hospital care is subject to coinsurance, while three other plans relied only on co-pays. Medical care co-pays were in the range of \$25 to \$40 for most services under most plans studied, with higher co-pays (\$100 or more) for emergency care and outpatient surgery.

Annual OOP maximums ranged from \$1,500 to \$7,500. Only two of the plans studied, Plans A and E, provided for a comprehensive OOP that caps all forms of cost sharing for all covered services.

Covered benefits varied somewhat across the plans studied. Two of the policies do not cover mental health care, other than care for specified biologically based conditions mandated by state law. Most other plans limit other outpatient mental health care to 20 visits annually. Two policies limit reimbursement for other outpatient mental health care to a maximum of \$25 per visit. One of the policies does not cover outpatient prescription drugs, other than for drugs to manage diabetes. Diabetes self-management medications and supplies are covered differently by plans. Two cover all items under the pharmacy benefit, subject to co-pays. Two other policies cover test strips and other testing supplies as medical equipment, subject to the medical deductible. One policy covered the emergency glucagon kit as a self-administered injectable, subject to 30 percent coinsurance instead of the usual co-pays applied to other prescription.

One of the policies studied waives cost sharing for radiation therapy, which would otherwise be subject to a large number and dollar volume of co-pays. This policy also waived cost sharing for cardiac rehabilitation, which also would generate repeated co-pays.

Of note, one of the individual market policies covers both inpatient and outpatient care; however, before most outpatient care is reimbursed, the patient must first meet the annual OOP limit. Cost sharing only for hospital-based care and a select few other services is applied to the OOP. Under this policy, therefore, most treatment for any serious illness that does not begin with a significant hospitalization or hospital outpatient care would, in effect, not be covered. (See Figure 4 and Appendix 2)

**Figure 4.** Key Policy Features for Five Individual and Small Group Market Policies in California  
 [See Appendix 2 for remaining policies]

	Plan A.	Plan B.	Plan C.	Plan D.	Plan E.
Market	Individual	Individual	Individual	Small group	Small group
Regulator	DMHC	DMHC	CDI	DMHC	CDI
<b>Cost Sharing (per individual):</b>					
Annual Deductible	\$1,500	None	\$1,000	None (medical) \$200 (brand Rx)	\$3,500
Annual OOP Max	\$1,500	\$2,500	\$2,500	\$4,000	\$4,000
Includes deductible?	Yes	n/a	No	n/a	Yes
Includes medical coinsurance?	n/a	n/a	Yes (mostly hospital care)	Yes	Yes
Includes medical co-pays?	n/a	Yes	n/a	Yes	Yes
Includes Rx cost sharing?	n/a	No	n/a	No	Yes
Includes mental health cost sharing?	n/a	n/a	n/a	Yes	No
Coinsurance after deductible	n/a	n/a	20% hospital care	30% hospital care	n/a
Co-pays (medical)	n/a	<ul style="list-style-type: none"> <li>• \$10 primary care visit</li> <li>• \$35 specialist visit</li> <li>• \$250 hospital/day up to 4</li> </ul>	n/a	• \$35 office visit	• \$35 office visit
Co-pays (Rx drugs)	n/a	\$10/\$35	n/a	\$15/\$30/\$50	\$10/\$25/50%
Services for which no cost sharing applies after deductible	All	<ul style="list-style-type: none"> <li>• Lab</li> </ul>	<ul style="list-style-type: none"> <li>• Most outpatient care covered 100% after OOP</li> </ul>	<ul style="list-style-type: none"> <li>• Lab</li> <li>• Lancets</li> </ul>	<ul style="list-style-type: none"> <li>• Radiation therapy</li> <li>• Cardiac rehab</li> <li>• Hospital care</li> <li>• DME</li> </ul>
<b>Covered Benefits:</b>					
Diabetes drugs, items covered as:	<ul style="list-style-type: none"> <li>• Med equipment for strips, lancets, meter; Rx other</li> </ul>	<ul style="list-style-type: none"> <li>• Med equipment for meter; Rx other</li> </ul>	<ul style="list-style-type: none"> <li>• Med equipment for strips, meter; Rx other</li> </ul>	<ul style="list-style-type: none"> <li>• Med equipment for meter; Glucagon kit is self-administered injectible with 30% coinsurance; Rx other</li> </ul>	<ul style="list-style-type: none"> <li>• Med equipment for meter; Rx other</li> </ul>
Significant exclusions, benefit limits	<ul style="list-style-type: none"> <li>• Mental health limit of 20 visits*</li> <li>• Wigs</li> <li>• Metoprolol Succinate is not in the formulary</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health*</li> </ul>	<ul style="list-style-type: none"> <li>• Rx drugs (except for diabetes)</li> <li>• Mental health*</li> <li>• Cardiac rehab</li> <li>• Most outpatient care until annual OOP met</li> <li>• Wigs</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health limit of 20 visits*</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health coverage limited to \$25 per visit, and limit of 20 visits*</li> </ul>

\* For non-biologically based mental health conditions, only

## How Are Specific Patient Care Needs Covered?

For this analysis, we compared patient care needs under each scenario to the coverage provisions under each policy studied. We found substantial variation in the level of protection policies provided, even beyond what might otherwise be indicated by key features – the annual deductible and the annual out-of-pocket limit.

### Breast cancer coverage under California plans

Total allowed charges for breast cancer care under this scenario are estimated to be \$97,298. Under the 10 plans studied, the breast cancer patient could expect to pay markedly different shares of the total cost of her treatment, ranging from \$3,602 (or 4 percent of the total) under Plan A to \$38,209 (or 39 percent) under Plan C. (See *Figure 5 and Appendix 2*) The variation in patient costs is attributable to a number of factors.

*Exclusions* – Significant patient costs were incurred under plans that excluded coverage for needed benefits. For example, patient spending for medications alone topped \$5,000 under Plan C that does not cover prescription drugs. Two of the plans studied did not cover mental health care, other than for treatment of select serious mental illnesses. In these plans, outpatient mental health costs of some \$2,600 would also be paid entirely by the patient.<sup>‡</sup> Seven of the 10 plans did not cover wigs for chemotherapy patients.

Plan C generated the highest level of uncovered services because this plan does not reimburse for most outpatient care until the annual OOP maximum has been satisfied using only cost sharing for hospital-based care and limited outpatient care. Under this scenario, the breast cancer patient has surgery in a hospital at the outset of her treatment, satisfying the annual OOP and triggering coverage for outpatient chemotherapy and other services for the remainder of the year. In the second year, however, her outpatient therapies continue with no further need for

hospital care. As a result the insurance does not cover more than \$28,000 in charges for the remainder of her treatment.<sup>§</sup>

*Comprehensiveness of annual OOP* – The annual OOP maximums under the plans studied ranged from a low of \$1,500 to a high of \$7,500. Under all but one plan, however, at least some cost sharing did not count toward the OOP maximum. The OOP maximum was in addition to the annual deductible in two of the plans that had deductibles. In 7 of the 9 plans with a drug benefit, prescription drug cost sharing was not limited by the OOP maximum, while mental health cost sharing was not limited by the OOP maximum in 3 of the 8 plans that covered mental health. Under Plan C, only cost sharing for hospital care counts toward the annual OOP maximum.

As a result, in all but three of the plans studied, the breast cancer patient would incur costs in excess of her OOP maximum in at least one plan year over the course of treatment. In six plans, this is because cost sharing continued even after the non-comprehensive OOP limit was reached. In one plan with a comprehensive OOP, the patient nonetheless had additional costs due to non-covered services.

*Deductible* – Some of the differences in cost sharing were attributable to differences in plan deductible levels. Because treatment in this scenario begins in May and spans 87 weeks, patients could expect to satisfy two annual deductibles and have some expenses apply to a third. However, it was not the case that overall patient expenses increased with the plan deductible. To the contrary, excluded benefits and unlimited cost sharing due to non-comprehensive OOP limits had far greater impact on patient costs. Under the plans studied, the annual deductible would provide a misleading indicator of the overall level of protection a policy provides.

<sup>‡</sup> In fact, patient spending for these services would be even higher than estimated because the patient would not benefit from the insurer's negotiated discounts for these services.

<sup>§</sup> Under a different scenario, the patient might have sought care for radiation therapy in a hospital outpatient department, thereby generating hospital charges to satisfy her OOP limit in year 2, and reducing her total estimated out-of-pocket costs to approximately \$12,000.

**Figure 5.**

**Estimated patient out-of-pocket costs for breast cancer treatment scenario under 5 CA plans**  
 [\$97,298 total treatment costs over 87 weeks, beginning May 1; See Appendix 2 for remaining policies]

Estimated patient expenses (% of total allowed charges)			Plan A.	Plan B.	Plan C.	Plan D.	Plan E.
			<b>\$3,602 (4%)</b>	<b>\$6,030 (6%)</b>	<b>\$38,209 (39%)</b>	<b>\$5,804 (6%)</b>	<b>\$10,161 (10%)</b>
<b>Care type:</b>	<b># billed</b>	<b>Total allowed charges (\$97,298)</b>					
Office Visit	48	3,120	505	1,241	1,422	1,481	1,193
Office Procedure	47	524	248	0	307	0	251
Radiology	12	6,356	195	350	4,206	200	240
Laboratory	40	1,632	149	50	624	0	159
Surgery	1	2,777	487	0	1,319	0	2,525
Hospital	1	3,205	0	250	641	962	0
IPMD	1	136	0	0	27	0	0
Rx Drugs	36	5,315	502	321	5,315	1,246	876
Wig	1	200	200	50	200	200	200
Chemotherapy	36	63,320	0	1,124	19,998	0	1,442
Mental Health	36	2,574	140	2,574	2,574	1,470	1,699
Radiation Therapy	35	8,140	1,175	70	1,575	245	1,575
<b>Expense type:</b>							
Deductible			3,332	0	1,000	600	7,332
Coinsurance			0	0	2,535	962	0
Co-pays			0	3,456	0	3,972	930
Non-covered services			270	2,574	34,674	270	1,899
<b>Policy highlights:</b>							
Annual Deductible			\$1,500	None	\$1,000	None \$200 Rx	\$3,500
Annual OOP Max			\$1,500	\$2,500	\$2,500	\$4,000	\$4,000
Includes deductible?			Yes	n/a	No	n/a	Yes
Includes medical co-pays?			n/a	Yes	n/a	Yes	Yes
Includes Rx cost sharing?			n/a	No	n/a	No	Yes
Includes mh cost sharing?			n/a	n/a	n/a	Yes	No
Patient costs meet/exceed annual OOP in:							
Year 1			Exceed	Exceed	Exceed†	Not meet	Exceed
Year 2			Exceed	Not meet	Exceed†	Not meet	Exceed
Year 3			Not meet	Not meet	Not meet	Not meet	Not meet
Co-pays (medical)			n/a	\$10/\$35/\$250	n/a	\$35	\$35
Co-pays (Rx drugs)			n/a	\$10/\$35	Not covered except for diabetes	\$15/\$30/\$50	\$10/\$25/50%
Services for which no coinsurance or co-pays apply after deductible			All	Lab	Most outpatient care covered 100% after OOP	Lab, Lancets	Hospital care, DME, Radiation therapy
Significant limits and exclusions			<ul style="list-style-type: none"> <li>• Mental health* limit of 20 visits</li> <li>• Wigs</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health*</li> </ul>	<ul style="list-style-type: none"> <li>• Rx drugs, wigs, mental health,* most outpatient care before OOP met</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health* limit of 20 visits</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health capped at \$25/visit and limit of 20 visits*</li> </ul>

\* Non-biologically based mental health conditions only

† Member does not satisfy OOP, but expenses exceed OOP due to cost sharing not limited by OOP.

### Heart attack coverage under California plans

Total allowed charges for the heart attack patient under this scenario are estimated to be nearly \$82,000. Under the 10 plans studied, the share of costs the patient could expect to pay ranged from about \$4,300 (5 percent of total) to \$12,154 (15 percent). (See Figure 6 and Appendix 2) Variation in patient costs is attributable to a number of factors.

*Deductible* – Like the breast cancer patient, the heart attack patient begins treatment in May of one year and care continues into the next calendar year. As a result, the heart attack patient must satisfy two annual deductibles, contributing significantly to overall out-of-pocket spending. Even so, total cost sharing is lower under Plan A, with a \$1,500 deductible, than under Plans B or D, which impose no annual deductible.

*Comprehensiveness of annual OOP* – Also similar to the breast cancer patient, the heart attack patient needed a large number of individual treatments, tests, and medications, but often cost sharing for prescription drugs did not apply to the annual OOP limit. Even though in this scenario he takes relatively inexpensive, generic drugs, the co-pays for medications alone total hundreds of dollars. Under Plan B, the patient's total cost sharing expenses exceed the amount of his annual OOP limit, even though he didn't satisfy the OOP because his drug co-pays don't count against the limit.

Under eight of the plans studied, the heart attack patient incurred cost sharing expenses in excess of the OOP limit during the first year of treatment.

*Exclusions* – Patient expenses were highest under Plan C, which does not cover prescription drugs, cardiac rehabilitation, or outpatient mental health visits for non-biological conditions. Several other plans cap covered mental health visits at 20 annually, leaving the patient substantial costs to pay. Actual patient costs for non-covered mental health visits could be much higher than estimated because the patient would also be subject to balance billing, costs for which are not included in this scenario. Costs for non-covered services, when added to cost sharing expenses, meant the patient would have to spend more for medical year than his OOP limit would otherwise indicate for all of the plans studied.

*Waive cost sharing for therapies requiring repeated visits* – One plan, Plan E, waives cost sharing for the 36 sessions of cardiac rehabilitation.

### Diabetes coverage under California plans

The total allowed charges for treatment and management of diabetes under this scenario were \$7,309 for one year. Under the 10 plans studied, the share of costs the patient could expect to pay ranged from \$1,515 (21 percent of total) to \$7,309 (100 percent). (See Figure 7 and Appendix 2) Variation in patient costs is attributable to a number of factors.

*Co-pays* – Co-pay expenses for the patient with diabetes were substantial under seven of the plans studied, close to \$2,000 per year. Because there is no generic equivalent for insulin in the U.S., patients would be subject to the higher co-pay for brand name drugs. Usually a co-pay would apply to each prescription and each box of test strips, syringes, and lancets purchased, as well as to each office visit and lab test. In this scenario, the diabetes patient could be liable for almost 100 co-pays per year. If the patient were to have other significant medical needs in a year, these co-pay expenses would not be limited by the annual OOP under most of the plans studied.

*Exclusions* – Because diabetes management care is a mandated benefit in California, none of the plans had outright exclusions of coverage for needed care. However, Plan C provides full coverage for outpatient medical care only after the annual OOP limit has been satisfied using primarily hospital cost sharing. As a result, the diabetes patient, who requires no hospital care under this scenario, would pay 100 percent of allowed charges for her care in a year.

*Deductible* – As a lifelong condition, diabetes will generate patient care needs year after year. Therefore a patient with diabetes can generally count on adding the cost of the annual deductible to the overall cost of coverage. Under Plan A, with an annual deductible of \$1,500, and Plan E, with a \$3,500 annual deductible of \$3,500, this would be a considerable expense.

Even so, a policy's annual deductible did not reliably predict out-of-pocket expenses for diabetes. The patient paid more out of pocket under Plans B and D, which had no annual deductible, than under Plan A, which had a \$1,500 deductible. And the patient paid more under Plan C, which had a \$1,000 deductible, compared to Plan E, with a \$3,500 deductible. Instead, the level of co-pays and other coverage terms and exclusions were greater determinants of a patient's out-of-pocket expenses.

**Figure 6.**

**Estimated patient out-of-pocket costs for heart attack treatment scenario under 5 CA plans**  
 [\$81,993 total treatment costs over 56 weeks, beginning May 1; See Appendix 2 for remaining policies]

Estimated patient expenses (% of total allowed charges)			Plan A.	Plan B.	Plan C.	Plan D.	Plan E.
			\$4,298 (5%)	\$6,733 (8%)	\$12,154 (15%)	\$6,276 (8%)	\$7,154 (9%)
Care type:	# billed	Total allowed charges					
Ambulance	1	772	772	50	772	100	772
Hospital	2	58,822	0	1,250	1,034	3,900	0
Inpat Med Care	14	2,550	264	0	637	0	264
Office Visit	6	714	119	175	238	70	224
Office Procedure	8	272	3	35	260	0	3
Radiology	2	692	158	0	93	0	158
Laboratory	7	663	139	0	147	0	139
Surgery	2	9,423	203	0	889	0	2,203
Prescription Drugs	64	1,673	656	596	1,673	806	467
Cardiac Rehab.	36	2,844	0	1,060	2,844	0	0
Mental Health	50	3,567	1,985	3,567	3,567	1,400	2,567
<b>Expense type:</b>							
Deductible			3,000	0	1,000	200	4,087
Coinsurance			0	0	2,500	3,900	0
Co-pays			0	3,139	0	1,476	500
Non-covered services			1,298	3,594	8,654	700	2,567
<b>Policy highlights:</b>							
Annual Deductible			\$1,500	None	\$1,000	None (medical) \$200 (brand name Rx drugs)	\$3,500
Annual OOP Max			\$1,500	\$2,500	\$2,500	\$4,000	\$4,000
Includes deductible?			Yes	n/a	No	n/a	Yes
Includes medical co-pays?			n/a	Yes	n/a	Yes	Yes
Includes Rx cost sharing?			n/a	No	n/a	No	Yes
Includes mental health cost sharing?			n/a	n/a	n/a	Yes	No
Patient costs meet/exceed annual OOP in:							
Year 1			Exceed	Exceed	Exceed	Exceed	Exceed
Year 2			Exceed	Not meet	Not meet	Not meet	Not meet
Co-pays (medical)			n/a	\$10/\$35/\$250 per day; 4-day max.	n/a	\$35	\$35
Co-pays (Rx drugs)			n/a	\$10/\$35	Not covered except for diabetes	\$15/\$30/\$50	\$10/\$25/50%
Services for which no coinsurance or co-pays apply after deductible			All	Lab	Most outpatient care covered 100% after OOP	Lab	Hospital care, cardiac rehab, DME
Significant exclusions			<ul style="list-style-type: none"> <li>Mental health* limit of 20 visits</li> <li>Metoprolol Succinate is not in the formulary</li> </ul>	<ul style="list-style-type: none"> <li>Mental health*</li> </ul>	<ul style="list-style-type: none"> <li>Rx drugs, mental health,* most outpatient care before OOP met</li> </ul>	<ul style="list-style-type: none"> <li>Mental health* limit of 20 visits</li> </ul>	<ul style="list-style-type: none"> <li>Mental health* capped at \$25/visit</li> <li>Mental health limit of 20 visits*</li> </ul>

\* Non-biologically based mental health conditions only

**Figure 7.**

**Estimated patient out-of-pocket costs for diabetes treatment scenario under 5 CA plans**

[\$7,309 total treatment costs over one year; See Appendix 2 for remaining policies]

Estimated patient expenses (% of total allowed charges)			Plan A.	Plan B.	Plan C.	Plan D.	Plan E.
			<b>\$1,542 (21%)</b>	<b>\$2,072 (28%)</b>	<b>\$7,309 (100%)</b>	<b>\$2,128 (29%)</b>	<b>\$4,042 (55%)</b>
<b>Care type:</b>	<b># billed</b>	<b>Total allowed charges (\$7,309)</b>					
Office Visit	7	591	253	245	591	245	457
Office Procedure	6	109	97	35	109	94	103
Laboratory	10	183	53	0	183	0	118
Glucose Meter	1	0	0	0	0	0	0
Glucose Test Strips (box 100)	14	1,680	347	490	1,680	420	784
Lancets (box 100)	14	160	34	140	160	0	130
Alcohol Swabs (box 100)	14	42	42	42	42	420	42
Syringes (box 30)	14	226	48	140	226	226	153
Lantus Insulin	9	1,255	139	315	1,255	379	633
Humalog Insulin	14	2,146	307	490	2,146	481	1,045
Glucagon Kit	1	104	104	35	104	31	104
Other RX	14	814	116	140	814	210	474
<b>Expense type:</b>							
Deductible			1,500	0	0	200	3,500
Coinsurance			0	0	0	31	0
Co-pays			0	2,030	0	1,761	500
Non-covered services			42	42	7,309	136	42
<b>Policy highlights:</b>							
Annual Deductible			\$1,500	None	\$1,000	None \$200 Rx	\$3,500
Annual OOP Max			\$1,500	\$2,500	\$2,500	\$4,000	\$4,000
Includes deductible?			Yes	n/a	No	n/a	Yes
Includes medical co-pays?			n/a	Yes	n/a	Yes	Yes
Includes Rx cost sharing?			n/a	No	n/a	No	Yes
Patient costs meet/exceed annual OOP?			Exceed	Not meet	Exceed	Not meet	Exceed
Co-pays (medical)			n/a	\$10/\$35/\$250	n/a	\$35	\$35
Co-pays (Rx drugs)			n/a	\$10/\$35	Rx not covered except for diabetes	\$15/\$30/\$50	\$10/\$25/50%
Services for which no coinsurance or co-pays apply after deductible			All	Lab	Most outpatient care covered 100% after OOP	Lab, Lancets	DME
Diabetes items covered as:			Med equipment for strips, lancets, meter; Rx other	Med equipment for meter; Rx other	Med equipment for strips, meter, swabs, Rx other	Med equipment for meter; glucagon kit is self-admin. injectible subject to 30% coinsurance; Rx other	Med equipment for meter; Rx other
Significant exclusions			Alcohol swabs	Alcohol swabs	Most outpatient care before OOP met	Eye exam Alcohol swabs	Alcohol swabs

## Challenges To Transparency

The exercise of estimating patient care costs and coverage under each of these plans and scenarios was complicated and time consuming, likely beyond the abilities of many consumers. A consumer trying to compare levels of coverage under different policies might, instead, be inclined to compare just a few key coverage features, such as the annual deductible, the annual OOP limit, or major benefit exclusions. Doing so could be misleading, however. Other policy features often resulted in significant differences in patient cost liability, and sometimes these were not immediately obvious from plan summaries, or even after close inspection of the full policy.

Further, 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.

How can consumers know ahead of time how much protection a given health insurance policy conveys? The answer is often far from clear, 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.

Policies reviewed for this study were highly variable, even though the list of covered services was generally similar in each. Some offered by the same insurer in the same market nonetheless had significantly different rules, such as the type of expenses that would be counted toward the annual deductible or out-of-pocket maximum. As noted previously, one policy counted only hospital and limited outpatient care cost sharing toward the annual OOP and would not reimburse for any other outpatient

services until the annual OOP had been satisfied. This feature surprised one policyholder we spoke to when she was diagnosed with breast cancer – even though the coverage rule was mentioned in the plan marketing material. She assumed any serious illness would involve substantial hospital care costs, but the costs for her outpatient lumpectomy surgery were not sufficient to satisfy the OOP, leaving her uncovered for the outpatient chemotherapy that followed.

Another variation observed in health insurance OOP limits had to do with the process for tracking out-of-pocket costs. Four of the California policies we reviewed 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 placed 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.

### Example Contract Language on Keeping Track of Cost Sharing Expenses

“Keep a record of your payment for covered medical services and supplies. When the total in a Calendar Year reaches the OOPM [out-of-pocket maximum] amount shown above, contact the Member Services Department at the telephone number shown on your ... ID card for instructions...”

You must notify [Insurer] when the OOPM amount has been reached. Please keep a copy of all receipts and canceled checks for Covered Service as proof of Copayments made.”

### Policy contract not available

Another transparency challenge is that consumers may not receive a copy of the policy contract until coverage is purchased. Until then, information about what a policy covers and how it works is only summarized in marketing materials. These summary brochures describe many key features but, by definition, do not provide comprehensive information.\*\*

In California, the Knox-Keene Act requires insurers to notify applicants that they have the right to review the

\*\* In addition, California insurers are required to develop a summary benefit matrix for every policy sold in the individual and small group market. For certain types of policies – those offered to HIPAA-eligible individuals, conversion policies, and “MRMIP graduate” policies – insurers must follow a standardized benefit matrix so that consumers can more easily compare summary information across plans. Summary benefit matrices for these three types of policies are also available to the general public on the DMHC web site. None of the policies studied for this report were HIPAA, conversion, or MRMIP graduate policies. Summary benefit matrices for other types of policies are not as standardized and are not posted on regulatory agency web pages.

EOC prior to enrollment. No such rule applies to CDI-regulated policies. All policies offered must be filed with the appropriate regulatory agency, but even this source offers limited access for consumers. Policies regulated by the Department of Insurance are not readily available to consumers for review. The EOCs can be obtained from CDI by filing a California Public Records Act request. However, the requesting individual must go to the agency to make copies on site. The Department of Managed Care, by contrast, does make documents available to the public. A catalog of publicly available documents is available on the DMHC web site and copies of documents can be ordered online. Even so, obtaining policies this way can be cumbersome. In particular, some policies are not available in their entirety in a single document. Instead, one must request the policy as initially filed along with all subsequent amendments and then piece components together.

### Challenges to reading and interpreting policy language

Even if health insurance policies were more readily available to consumers and prospective policyholders, the EOC can be a difficult document to read and understand. Reading a health insurance contract requires a sophisticated level of health insurance literacy that most people do not have. According to a survey commissioned by ehealth, Inc., 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 of those asked said they were certain they understood the terminology used in their health insurance policy.<sup>28</sup>

Rules can be adopted to require insurance contracts to be written in a simpler and more straightforward manner, although how successful such requirements are in practice may be in question. A federal law known as ERISA requires that participants in employer-sponsored health plans must receive a summary plan description (SPD) that includes certain information elements and that is written in a manner that is understandable to the average plan participant. Given the complexity of health benefits this is a difficult standard to meet. One study analyzing the readability of SPDs found a college level education or higher would be needed to understand terms in the document.<sup>29</sup> The state of Rhode Island recently proposed

adoption of a standard for all health insurance contracts to be written at an eighth-grade reading level.<sup>30</sup>

California has adopted readability standards for health insurance policies. For example, the Knox-Keene Act requires health insurance materials to provide consumers with “a full and fair disclosure of the provisions of the plan in a readily understood language and in a clearly organized manner.”<sup>31</sup> In addition the law states that an “evidence of coverage shall be deemed to be deceptive if... taken as a whole and with consideration given to typography and format, as well as language, shall... cause a reasonable person, not possessing special knowledge of plans... to expect benefits... that the evidence of coverage does not provide. Even so, all policies reviewed for this study presented barriers to comprehension and transparency of coverage.

*Missing information* – In all cases, the EOCs referenced other rules governing coverage. These include, for example, formularies that specify coverage for prescription drugs. The DMHC requires plans it regulates to make available to the public, upon request, information about whether a specific drug or drugs are on the plan’s formulary. For other policies, in general, it appeared that enrollees would have access to their plan formulary through the insurer’s web site or by calling the customer service department. However, not all insurers whose policies we examined permit nonmembers to access such information. Consequently, a prospective enrollee might not be able to carefully compare how specific prescription drugs would be covered from one policy to the next.

Each of the policies reviewed for the project also stated that the insurer only covered those items and services explicitly stated in the contract. Nevertheless, it was not unusual for us to find that the EOC did not specify all covered items and services. In eight of the California policies we reviewed, the EOC did not mention radiation therapy and/or cardiac rehabilitation as covered benefits. Through telephone calls to the insurer we confirmed these services were covered.

Another policy stated there was a benefit maximum for durable medical equipment which could be found in the summary of benefits; however, the summary did not mention a benefit maximum.

In other instances, the contract clearly stated that benefits were covered but did not say how cost sharing applied. Further research was needed to determine, for example, if a screening colonoscopy was covered as a preventive benefit or as a surgical procedure, for which higher cost sharing tends to apply.

*Confusing, ambiguous, or conflicting language* – Several of the policies reviewed for this report contained confusing, ambiguous or conflicting language that made it difficult to understand how coverage works.

For example, in two policies, offered by the same insurer, it was difficult to determine the scope of coverage for mental health care. The exclusion section of each policy stated that benefits for non-severe mental illness are not covered unless explicitly listed in the coverage section. The coverage section mentioned only severe mental illness. However, the cost sharing section indicated payment terms for non-severe mental illness; specifically, the insurer will pay \$25 per outpatient visit with the patient responsible for all other allowed charges. The policy is silent on whether other cost sharing, such as the annual deductible, also applies before this \$25 payment can be claimed; but the policy does say that cost sharing for outpatient, non-severe mental health care rendered by non-network providers does not count toward the out-of-pocket maximum.

In another policy, chemotherapy was not specifically mentioned in the EOC, though infusion therapy was listed as covered with a co-pay of \$100 per infusion. We called the plan on three occasions to clarify coverage for chemotherapy. On the first call we were advised chemotherapy was subject to the \$100 infusion co-pay, on two subsequent calls we were advised it was not.<sup>††</sup>

In some cases, the policy referred the member to the customer service department to find out if, for example, a piece of durable medical equipment was covered or a service required a prior authorization. In another instance the document did not state what cost sharing would be required for office visits, a very basic benefit. A member might have concluded from a review of the document that there was no co-payment, which we found was not the case during a call to the insurer.

Plan C was particularly challenging to understand. High patient cost sharing under this policy resulted from a feature that restricts coverage for most outpatient care until the annual OOP limit is satisfied with cost sharing for hospital care. However, nowhere in the EOC was this rule simply stated. Instead, a person would need to read through (and know to read through) several distinct and confusing sections of the EOC. These included two cost sharing lists without any guidance on when to use which list or explanation of why one of the lists included cost-sharing responsibility for services that were explicitly excluded from coverage in the section describing covered benefits. It was left to the policyholder to deduce that services specifically excluded from coverage were actually covered once the out-of-pocket maximum was reached.

### A “Coverage Facts” Label For Health Insurance

Understanding what health insurance covers and how it works is a challenge. Policies cover different benefits, and different cost sharing can apply to different kinds of medical care. In addition, most consumers cannot predict what future care needs might entail or cost. As a result, it is difficult to look at a health plan and appreciate how much protection it actually affords. People may tend to rely on certain policy features – such as the annual deductible or OOP limit – as indicators of the comprehensiveness of coverage; but as illustrated in this report, this can be misleading. Health insurance premiums tend to increase as policies cover more; however, when consumers shop for coverage, differences in price are obvious while differences in coverage may be much harder to evaluate.

For this reason, 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.<sup>‡‡</sup>

A Coverage Facts label would summarize key features under 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 of that the patient might be expected to pay. The label could break down

<sup>††</sup> For purposes of our analysis, we assumed no infusion co-pay for chemotherapy.

<sup>‡‡</sup> The Coverage Facts label has been previously recommended by others. See, for example, Wilson, K., “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](http://www.chron.com/CDA/archives/archive.mpl?id=2009_4705953). Editorial cites legislation sponsored by State Sen. Kirk Watson, D-Austin. See also, “Hazardous Health Plans,” *Consumer Reports*, May 2009

estimated patient cost liability by type of service (for example, highlighting patient cost exposure for non-covered or limited benefits) and by type of cost sharing (for example, illustrating how co-pays might add up during treatment of a chronic condition.) (See Figure 8) 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 rely significantly on inpatient care vs. 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.

Coverage Facts could also help inform policymakers about the content of coverage sold in the market today. In the context of health reform, policymakers could make more informed choices about the tradeoffs between the cost of health insurance and what it covers if they can see illustrations of how patient costs can change under different levels of coverage.

The Coverage Facts label could be required for all health insurance policies and plans. A series of standardized patient scenarios would be prepared by a regulatory agency or other independent entity 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 or introduce new policies, the process would be repeated. Regulators would likely need additional staff and resources to implement and enforce the Coverage Facts information tool, and insurers would likely need to dedicate staff in order to comply.

This information tool has its limits. Most obviously, Coverage Facts labels cannot be developed for every

**Figure 8.** Sample “Coverage Facts” Label for Health Insurance

<b>Coverage Facts</b>				
Individually Purchased Health Insurance, 2008				
<b>Policy A (California)</b>				
Monthly Premium (age 55) <sup>†</sup>				\$211
Annual deductible				\$1,500
Annual OOP limit				\$1,500
Cost sharing not subject to annual OOP				None
Significant exclusions, benefit limits				Mental health limit of 20 visits, Wigs
<b>Breast Cancer Scenario*</b>				
(May 1 diagnosis, 87 weeks active treatment)				
Estimated allowed charges for all treatment				\$97,298
Estimated paid by patient				<b>\$3,602 (4%)</b>
Care type	# billed	Total allowed charges (\$)	\$ paid by patient	% paid by patient
Office Visit	48	3,120	505	16%
Office Procedure	47	524	248	47%
Radiology	12	6,356	195	3%
Laboratory	40	1,632	149	9%
Surgery	1	2,777	487	18%
Hospital	1	3,205	0	0%
Inpat Med Care	1	136	0	0%
Rx Drugs	36	5,315	502	9%
Prostheses	1	200	200	100%
Chemotherapy	36	63,320	0	0%
Mental Health	36	2,574	140	5%
Radiation Therapy	35	8,140	1175	14%
* signifies less than 1/2 of 1%				
Source of patient costs	Number encountered	Amount		
Annual medical deductibles	3	\$3,332		
Co-pays	n/a	\$0		
Co-insurance	n/a	\$0		
Non-covered care	2	\$270		
<sup>†</sup> Monthly premium reflects rate quoted on ehealthinsurance.com for applicant in Sacramento in excellent health. <b>Individual premiums may vary based on health status, age, and other factors.</b>				
<sup>‡</sup> Breast Cancer Scenario includes outpatient lumpectomy, 4 two-week cycles each of two chemotherapy regimens, 7 weeks of daily 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. <b>Individual patient care needs may vary.</b>				
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.				

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. On the other hand, 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-network with no balance billing by providers,<sup>§§</sup> 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 impact 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 patient cost sharing for the ambulance ride would be lower.

Even with these limits, however, 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:

- Standardization of certain policy features could be enhanced. Although choice is generally valued, too much variation can overwhelm and hinder consumers' ability to select a policy that best fits their needs.<sup>32</sup> Approximately 88 different policies are offered in California's individual market alone, and it would be practically impossible for consumers to study all of the variations contained in each. Instead, greater standardization of what health insurance covers would make comparisons more practical and possible. Standard definitions could be developed for key health insurance terms, such as "deductible" or "OOP limit." This 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 continues, 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 ask more sophisticated questions about differences in otherwise similar policies.<sup>33</sup>
- 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 force.

<sup>§§</sup> Balance billing is a practice that can substantially increase costs paid by patients. Typically, the charge billed by a doctor, hospital, or other provider is greater than the charge allowed by an insurer. When care is received in network, contracting providers agree to accept the allowed charge as payment in full. Non-contracting providers, however, can bill the patient for the difference – or balance – between the allowed and billed charge.

- Disclosure of other coverage standards and limitations – such as health plan formularies and participating provider directories – could also be required so this information would be readily available to both policyholders and prospective enrollees.

### Implications For Health Care Reform

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. At a minimum, the difference in protection health insurance offers should be readily obvious for all to see.

As policymakers contemplate national health care reform, a key question will be what 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 only on people when they are sick, and will be ongoing for those with chronic conditions.

These tradeoffs cannot be evaluated entirely in the abstract, nor should they be obscured. More standardization of health insurance policies or coverage features can eliminate much of the guesswork for consumers. For example, if a policy includes an OOP limit of \$4,000, patients should be able to know with certainty that their financial liability for covered services will not exceed that amount in a year. For coverage features that vary, disclosure will help consumers understand the choices they face. However, given the complexity of health insurance and medical care, disclosure must provide detailed information so consumers can synthesize the impact of multiple key policy provisions and consider them in the context of health care situations they can recognize and understand.

# APPENDIX 1

## Methodology

### 1. Determination of Treatment Needs and Costs

To determine treatment needs for each patient profile, we consulted clinical experts, including medical faculty at the Georgetown University Medical Center, as well as clinical experts and staff at the American Cancer Society, the American Heart Association, and the American Diabetes Association. We also consulted published practice guidelines for each of the conditions portrayed. Detailed cancer treatment guidelines are published and regularly updated by the National Comprehensive Cancer Network (NCCN). Treatment guidelines for heart attack are published by the American College of Cardiology and the American Heart Association. Guidelines for the management of diabetes have been developed by the American Diabetes Association. With help of these experts and published protocols, we developed for each condition a comprehensive list of medical services, devices, items, and prescription medications, and a schedule with specific dates for the delivery of care over the treatment period.

Even with the availability of widely used treatment guidelines, patient care needs will vary. In general, the scenarios portray non-complicated patients. No unforeseen infections, drug interactions, or other complications arise that would lead to additional treatment needs. In some cases, though, we designed care scenarios to include treatments that would not be needed by all patients. For example, the breast cancer treatment includes herceptin therapy – an expensive treatment that would normally only be prescribed for those patients with a HER-2 positive tumor. Because health insurance policies vary in the way they cover specific types of care, we decided to include certain care needs when it was possible policies might cover them differently.

In addition, development of treatment scenarios involved assumptions about the date of diagnosis. For diabetes, a lifelong condition, we assumed the patient was already diagnosed with the condition on the start of the health insurance plan year, January 1. For the cancer and heart attack scenarios, we assumed a diagnosis on May 1. This ensured that care would fall across at least two plan years, permitting us to test the impact of reaching annual deductibles, OOP limits, and benefit caps more than once.

Once a comprehensive list of care needs was completed for a scenario, we looked up the billing codes for each item or service on the list. Billing codes for most outpatient care are based on the AMA CPT manual for 2006 and then updated for changes to the CPT manual for 2007 to match the Thomson Reuters data (described below). In several instances, we specified modifier codes identifying whether the physician procedure in our scenario takes place in the physician's office or in a facility or whether the procedure involves a surgical assistant. When a procedure is performed in the physician's office, the physician's charge includes a practice expense charge to cover overhead; when performed in a facility, only the physician's work is included. Hospital billing codes are based on the American Hospital Association National UB-04 billing manual. We also examined samples of actual claims submitted by individuals who had, themselves, been treated for the scenario conditions and who agreed to share copies of their bills and health insurance statements. In addition, we examined a sample of de-identified claims of several hundred patients, provided by the Maryland Health Insurance Plan (MHIP).

This analysis estimates *allowed charges* that might be paid by health insurance companies for covered services. For this exercise, allowed charges are estimated to be the same across all plans studied (including HMOs that might not use allowed charges but pay providers a capitation rate, instead.) Actual allowed charges would vary by insurer and by geographic area. In general, doctors, hospitals, and other providers will submit their own *billed charges* for care provided, but when they participate in an insurer's provider network, will accept as full payment the charge allowed by the insurer – usually a lesser amount. Billed charges are unique to each provider, but they are typically not relevant to what an insured person will pay. Because health insurers' fee schedules are unique and proprietary, we also did not have access to actual allowed charges for each plan studied. Instead, we used a single, state-wide estimate of the allowed charge for each service and item.

To do this, we contracted with Thomson Reuters to provide allowed charge data from the MarketScan® Commercial Claims and Encounters Database\*\*\* for the period of January-December, 2007. These data included individual-level, de-identified health insurance claims

\*\*\* MarketScan® is a registered trademark of Thomson Healthcare Inc

across the continuum of care (e.g. inpatient, outpatient, outpatient pharmacy, carve-out behavioral health care) as well as enrollment data from large employers and private health plans across the United States. Claims data reflect a variety of fee-for-service plans, preferred provider organizations, HMOs, and other capitated health plans. For each billing code, Thomson Reuters provided median allowed charge data for different geographic regions – national, California, and regional (North East, North Central, South, and West – as well as charges at the 25th and 75th percentiles. Because hospital data in the MarketScan® database included a mixture of claims paid according to fee-for-service, per diem, and diagnosis-related group methodologies, Thomson Reuters selected claims with length-of-stay, diagnosis, and procedures reflected in our scenarios and provided allowed charge data for the total hospital stay, using the same data formats.

To arrive at total allowed charges for each scenario, we applied the MarketScan® median allowed charge observed in California for each item listed in the scenario. For a small number of claims for which the MarketScan® data did not provide a state-specific number, usually because of a low number of observations (N<100) in the database, we used other means of obtaining a value.

For most of the physician codes, the sample size was adequate to use the specific medians for California. In most cases where the sample size was low (N<100), we derived an adjuster for California based on a weighted average of the multiples across all services for several different patient scenarios and applied it to the national median. For a few cases where neither the state median nor the national median was suitable, we used either Medicare fee schedule data or data from MHIP. Finally, for a few inexpensive items such as diabetes supplies, values were obtained through drugstore.com. In all cases, we compared values from other available sources to ensure face validity of the values used.

For each hospital stay in the scenarios, we examined charges based on lengths of stay higher and lower than specified in the scenario to ensure that the data used were appropriate. In each case, the median value for the length of stay in the scenario showed a reasonable relationship to the median across different lengths of stay, even where the number of cases with a particular length of stay was small.

Because of the small number of hospital claims for a given scenarios, we used several different hospital scenarios to calculate an overall adjuster for California and applied that adjuster to the national median values for a particular hospital stay to get a value for the state.

When care continued for more than one year, we assumed allowed charges would be held constant over all years in the scenario.

## 2. Determination of What Policies Cover

We obtained the evidence of coverage (EOC) for each policy studied and analyzed the document in its entirety. When language in the EOC was unclear or information was missing, we attempted to contact the insurer directly for clarification. If uncertainty remained, we contacted the insurer again to verify the information provided. In a few instances when we received contradictory advice, we contacted the insurer a third time and relied on the answer provided most often. In general, we did not estimate that a medical care service, drug, or other item would not be covered unless we found explicit language in the EOC or other plan documents or other advice from the insurer so indicating.

In addition, we reviewed information available to the general public regarding the content of health insurer formularies, medical guidelines, and other rules and procedures that might affect coverage. To determine coverage for specific drugs, when we could not access plan formularies, we assumed the drug would be covered under the generic or brand drug tier, as applicable.

## 3. Estimation of Patient Costs

The final step in our analysis was to simulate the processing of claims for the scenarios under each policy. We assumed claims would be received and processed in the order services were provided. We further assumed no claims would be denied (other than when an explicit coverage exclusion applied.) We assumed all care was received from providers in the insurer's network, and all required authorizations and other coverage requirements were met. For each claim processed, we recorded whether the service would be covered and how deductibles, coinsurance, co-pays, benefit limits, and OOP limits would apply. Totals by type of service and patient expense were tallied for each condition under each health plan.

†† MarketScan is a registered trademark of Thomson Healthcare Inc.

# APPENDIX 2

## Descriptive Information and Coverage Results for Five Additional Policies

**Figure 4.** Key Policy Features for Five Individual and Small Group Market Policies in California

	Plan F.	Plan G.	Plan H.	Plan I.	Plan J.
<b>Market</b>	Small Group	Small Group	Individual	Individual	Individual
<b>Regulator</b>	DMHC	DMHC	DMHC	CDI	DMHC
<b>Cost Sharing (per individual):</b>					
<b>Annual Deductible</b>	None	\$1,000	\$1,500 (inpatient hospital only) \$250 (brand name Rx drugs)	\$2,400	\$2,500
<b>Annual OOP Max</b>	\$2,500	\$1,500	\$3,000	\$4,000	\$7,500
<b>Includes deductible?</b>	n/a	Yes	Yes (hospital only)	No	Yes
<b>Includes medical coinsurance?</b>	No (only DME)	Yes	Yes	Yes	Yes
<b>Includes medical copays?</b>	Yes	Yes	Yes	Yes	Yes
<b>Includes Rx cost sharing?</b>	No	No	No	No	No
<b>Includes mental health cost sharing?</b>	No	No	Yes	Yes	No
<b>Coinsurance after deductible</b>	n/a	20% (only DME)	n/a	30%	30%
<b>Co-pays (medical)</b>	<ul style="list-style-type: none"> <li>\$10 lab/\$25 office visits</li> <li>\$100 ambulance/\$200 per day Hospital inpatient care</li> </ul>	<ul style="list-style-type: none"> <li>\$10 labs/\$25 office visits</li> <li>\$150 ambulance/\$250 per day Hospital inpatient care</li> </ul>	<ul style="list-style-type: none"> <li>\$40 office visits/\$80 ambulance</li> </ul>	\$35	\$35
<b>Co-pays (Rx drugs)</b>	\$10/\$25	\$10/\$35	\$15/\$35/50% capped at \$100	\$10/\$35/\$50 or 50%	\$10/\$25/50%
<b>Services for which no cost sharing applies after deductible</b>	n/a	<ul style="list-style-type: none"> <li>Radiation therapy</li> </ul>	<ul style="list-style-type: none"> <li>Labs</li> </ul>	None	<ul style="list-style-type: none"> <li>Hospital care</li> <li>Radiation therapy</li> <li>DME</li> </ul>
<b>Covered Benefits:</b>					
<b>Diabetes drugs, items covered as:</b>	Med equipment for strips, lancets, meter; Rx other	Med equipment for strips, lancets, meter; Rx other	Med equipment for meter; Rx other	Med equipment for meter; Rx other	Med equipment for meter; Rx other
<b>Significant exclusions, benefit limits</b>	<ul style="list-style-type: none"> <li>Mental health limit of 20 visits*</li> <li>Wigs</li> <li>Metoprolol Succinate is not in the formulary</li> </ul>	<ul style="list-style-type: none"> <li>Mental health limit of 20 visits*</li> <li>Wigs</li> <li>Metoprolol Succinate is not in the formulary</li> </ul>	<ul style="list-style-type: none"> <li>Mental health limit of 20 visits*</li> </ul>	<ul style="list-style-type: none"> <li>Mental health limit of 20 visits*</li> <li>Wigs</li> </ul>	<ul style="list-style-type: none"> <li>Mental health coverage limited to \$25 per visit *</li> <li>Mental health limit of 20 visits*</li> </ul>

\* For non-biologically based mental health conditions, only

**Figure 5.**

**Estimated patient out-of-pocket costs for breast cancer treatment scenario under 5 CA plans**

[\$97,298 total treatment costs over 87 weeks, beginning May 1]

Estimated patient expenses (% of total allowed charges)			Plan F.	Plan G.	Plan H.	Plan I.	Plan J.
			<b>\$3,951 (4%)</b>	<b>\$4,801 (5%)</b>	<b>\$5,224 (5%)</b>	<b>\$13,800 (14%)</b>	<b>\$17,055 (18%)</b>
<b>Care type:</b>	<b># billed</b>	<b>Total allowed charges</b>					
Office Visit	48	3,120	1,200	430	1,621	798	745
Office Procedure	47	524	10	248	0	273	284
Radiology	12	6,356	210	355	0	1,097	1,478
Laboratory	40	1,632	415	339	40	467	487
Surgery	1	2,777	100	408	0	1,831	2,073
Hospital	1	3,205	0	150	250	962	962
IPMD	1	136	0	0	0	41	41
Rx Drugs	36	5,315	696	701	1,363	696	321
Wig	1	200	200	200	200	200	0
Chemotherapy	36	63,320	0	160	0	5,747	7,807
Mental Health	36	2,574	945	945	1,470	539	1,699
Radiation Therapy	35	8,140	175	865	280	1,150	1,157
<b>Expense type:</b>							
Deductible			0	2,000	748	4,800	5,035
Coinsurance			0	0	0	7,539	9,220
Co-pays			3,681	2,531	4,406	1,191	1,101
Non-covered services			270	270	70	270	1,699
<b>Policy highlights:</b>							
Annual Deductible			None	\$1,000	\$1,500 (inpatient hospital only) \$250 (brand Rx)	\$2,400	\$2,500
Annual OOP Max			\$2,500	\$1,500	\$3,000	\$4,000	\$7,500
Includes deductible?			n/a	Yes	Yes (hospital only)	No	Yes
Includes medical co-pays?			Yes	Yes	Yes	Yes	Yes
Includes Rx cost sharing?			No	No	No	No	No
Includes mh cost sharing?			No	No	Yes	Yes	No
Patient costs meet/exceed annual OOP in:							
Year 1			Not meet	Exceed	Not meet	Exceed	Exceed
Year 2			Not meet	Exceed†	Not meet	Exceed	Exceed
Year 3			Not meet	Not meet	Not meet	Not meet	Not meet
Co-pays (medical)			\$25	\$25	\$40	\$35	\$35
Co-pays (Rx drugs)			\$10/\$25	\$10/\$35	\$15/\$30/50% capped at \$100	\$10/\$35/\$50 or 50%	\$10/\$25/50%
Services for which no coinsurance or co-pays apply after deductible			n/a	• Radiation therapy	• Labs	None	• Hospital care • DME • Radiation therapy
Significant limits and exclusions			• Mental health* limit of 20 visits • Wigs	• Mental health* limit of 20 visits • Wigs	• Mental health* limit of 20 visits	• Mental health* limit of 20 visits • Wigs	• Mental health* capped at \$25/visit • Mental health limit of 20 visits*

\* Non-biologically based mental health conditions only

† Member does not satisfy OOP, but expenses exceed OOP due to cost sharing not limited by OOP.

**Figure 6.**

**Estimated patient out-of-pocket costs for heart attack treatment scenario under 5 CA plans**

[\$81,993 in total treatment costs over 56 weeks, beginning May 1]

Estimated patient expenses (% of total allowed charges)			Plan F.	Plan G.	Plan H.	Plan I.	Plan J.
			<b>\$4,884 (6%)</b>	<b>\$4,371 (5%)</b>	<b>\$5,471 (7%)</b>	<b>\$9,411 (11%)</b>	<b>\$11,213 (14%)</b>
<b>Care type:</b>	<b># billed</b>	<b>Total allowed charges</b>					
Ambulance	1	772	100	772	80	772	772
Hospital	2	58,822	1,000	500	0	2,221	3,251
Inpat Med Care	14	2,550	0	228	264	866	866
Office Visit	6	714	150	50	160	238	238
Office Procedure	8	272	0	6	0	6	6
Radiology	2	692	0	0	158	251	251
Laboratory	7	663	60	72	103	257	257
Surgery	2	9,423	0	0	975	2,105	2,175
Prescription Drugs	64	1,673	974	1,044	851	596	1,230
Cardiac Rehab.	36	2,844	900	0	1,060	0	0
Mental Health	50	3,567	1,700	1,700	1,820	2,100	2,167
<b>Expense type:</b>							
Deductible			0	1,077	1,750	4,115	4,015
Coinsurance			0	0	0	4,000	5,000
Co-pays			3,586	1,996	3,021	596	531
Non-covered services			1,298	1,298	700	700	1,667
<b>Policy highlights:</b>							
Annual Deductible			None	\$1,000	\$1,500 (hospital) \$250 (brand name Rx drugs)	\$2,400	\$2,500
Annual OOP Max			\$2,500	\$1,500	\$3,000	\$4,000	\$7,500
Includes deductible?			n/a	Yes	Yes (hospital only)	No	Yes
Includes medical co-pays?			Yes	Yes	Yes	Yes	Yes
Includes Rx cost sharing?			No	No	No	No	No
Includes mental health cost sharing?			No	No	Yes	Yes	No
Patient costs meet/exceed annual OOP in:							
Year 1			Not meet	Exceed	Exceed*	Exceed	Exceed
Year 2			Not meet	Not meet	Not meet	Not meet	Not meet
Co-pays (medical)			<ul style="list-style-type: none"> <li>\$10 labs/\$25 office visits</li> <li>\$100 ambulance/\$200 per day Hospital</li> </ul>	<ul style="list-style-type: none"> <li>\$10 labs/\$25 office visits</li> <li>\$150 ambulance/\$250 per day Hospital</li> </ul>	<ul style="list-style-type: none"> <li>\$40 office visits/\$80 ambulance</li> </ul>	\$35	\$35
Co-pays (Rx drugs)			\$10/\$25	\$10/\$35	\$15/\$35/50% capped at \$100	\$15/\$35/\$50 or 50%	\$10/\$25/50%
Services for which no coinsurance or co-pays apply after deductible			n/a	n/a	Labs	None	<ul style="list-style-type: none"> <li>Hospital care,</li> <li>DME</li> </ul>
Significant exclusions			<ul style="list-style-type: none"> <li>Mental health* limit of 20 visits</li> <li>Metoprolol Succinate is not in the formulary</li> </ul>	<ul style="list-style-type: none"> <li>Mental health* limit of 20 visits</li> <li>Metoprolol Succinate is not in the formulary</li> </ul>	<ul style="list-style-type: none"> <li>Mental health* limit of 20 visits</li> </ul>	<ul style="list-style-type: none"> <li>Mental health* limit of 20 visits</li> </ul>	<ul style="list-style-type: none"> <li>Mental health* capped at \$25/visit</li> <li>Mental health limit of 20 visits*</li> </ul>

\* Non-biologically based mental health conditions only

† Member does not satisfy OOP, but expenses exceed OOP due to cost sharing not limited by OOP.

**Figure 7.**

**Estimated patient out-of-pocket costs for diabetes treatment scenario under 5 CA plans**

[\$7,309 total treatment costs over one year]

Estimated patient expenses (% of total allowed charges)			Plan F.	Plan G.	Plan H.	Plan I.	Plan J.
			<b>\$1,515 (21%)</b>	<b>\$1,927 (26%)</b>	<b>\$2,308 (32%)</b>	<b>\$2,675 (37%)</b>	<b>\$2,503 (34%)</b>
<b>Care type:</b>	<b># billed</b>	<b>Total allowed charges (\$7,309)</b>					
Office Visit	7	591	175	175	280	591	245
Office Procedure	6	109	0	40	40	109	109
Laboratory	10	183	50	183	0	183	183
Glucose Meter	1	0	0	0	0	0	0
Glucose Test Strips (box 100)	14	1,680	336	336	490	490	140
Lancets (box 100)	14	160	32	32	0	140	140
Alcohol Swabs (box 100)	14	42	42	42	42	42	42
Syringes (box 30)	14	226	140	140	226	140	140
Lantus Insulin	9	1,255	225	315	419	315	379
Humalog Insulin	14	2,146	350	490	601	490	667
Glucagon Kit	1	104	25	35	0	35	10
Other RX	14	814	140	140	210	140	448
<b>Expense type:</b>							
Deductible			0	198	250	789	198
Coinsurance			0	0	0	0	0
Co-pays			1,473	1,688	2,016	1,750	2,169
Non-covered services			42	42	42	136	136
<b>Policy highlights:</b>							
Annual Deductible			None	\$1,000	\$1,500 (hospital) \$250 (brand name Rx drugs)	\$2,400	\$2,500
Annual OOP Max			\$2,500	\$1,500	\$3,000	\$4,000	\$7,500
Includes deductible?			n/a	Yes	Yes (hospital only)	No	Yes
Includes medical co-pays?			Yes	Yes	Yes	Yes	Yes
Includes Rx cost sharing?			n/a	No	No	No	No
Patient costs meet/exceed annual OOP?			Not meet	Exceed	Not meet	Not meet	Not meet
Co-pays (medical)			\$25	\$25	\$40 office visits	\$35	\$35
Co-pays (Rx drugs)			\$10/\$25	\$10/\$35	\$15/\$35/50% capped at \$100	\$15/\$30/\$50 or 50%	\$10/\$25/50%
Services for which no coinsurance or co-pays apply after deductible			n/a	n/a	n/a	None	n/a
Diabetes items covered as:			Med equipment for strips, lancets, meter; Rx other	Med equipment for strips, lancets, meter; Rx other	Med equipment for meter; Rx other	Med equipment for meter; Rx other	Med equipment for meter; Rx other
Significant exclusions			Alcohol swabs	Alcohol swabs	Alcohol swabs	Eye exam Alcohol swabs	Alcohol swabs

# ENDNOTES

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- <sup>10</sup> See National Comprehensive Cancer Network at [www.nccn.org](http://www.nccn.org)
- <sup>11</sup> Ali, Sohrab, "Female Breast Cancer Incidence, Stage at Diagnosis, Treatment, and Mortality in North Carolina, North Carolina Public Health studies, June 2006. <http://www.schs.state.nc.us/SCHS/pdf/SCHS150.pdf>
- <sup>12</sup> Medical News Today, "Herceptin Proven To Benefit Women With HER2 Positive Early Breast Cancer Latest Results From The HERA Study," March 12, 2009, available at <http://www.medicalnewstoday.com/articles/141959.php>
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- <sup>14</sup> American Heart Association, "Heart Disease and Stroke Statistics: 2009 Update At-A-Glance" Available at <http://www.americanheart.org/presenter.jhtml?identifier=3037327>
- <sup>15</sup> See <http://www.acc.org/qualityandscience/clinical/topic.cfm>. See also <http://www.americanheart.org/presenter.jhtml?identifier=3004562>
- <sup>16</sup> National Institute of Mental Health, "Co-occurrence of Depression with Health Disease," Jan. 13, 2009, available at <http://www.healthypace.com/depression/nimh/co-occurrence-of-depression-with-heart-disease/menu-id-1419/>.
- <sup>17</sup> American Diabetes Association, "Diabetes Statistics" available at <http://www.diabetes.org/diabetes-statistics.jsp>
- <sup>18</sup> Federal standards for the annual-out-of-pocket maximum for HSA-eligible policies do not apply to cost sharing (including balance billing) for care received out of network.
- <sup>19</sup> Bunce, V and Wieske, J, "Health Insurance Mandates in the States," Council for Affordable Health Insurance, 2004.
- <sup>20</sup> National Conference of State Legislatures, "Providing Diabetes Health Coverage: State Laws and Programs" March 12, 2009. Available at <http://www.ncsl.org/programs/health/diabetes.htm>
- <sup>21</sup> California Health and Safety Code section 1340 *et seq.*
- <sup>22</sup> California Code of Regulations, Title 28, § 1300.67.4
- <sup>23</sup> California Code of Regulations, Title 28, § 1300.67.24
- <sup>24</sup> California Assembly Bill 786, introduced February 26, 2009.
- <sup>25</sup> California Health Benefits Review Program, 2009 carrier survey, unpublished data, cited in "Policy Considerations Relevant to Assembly Bill 786: Coverage Choice Categories" Issue Brief, April 2009.
- <sup>26</sup> California HealthCare Foundation, "California Employer Health Benefits Survey" December 2008.
- <sup>27</sup> Those are Anthem Blue Cross, California Blue Shield, HealthNet, Kaiser Permanente, and PacifiCare. See Wilson, K., "California Health Plans and Insurers" California HealthCare Foundation, January 2009.
- <sup>28</sup> 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](http://www.insurancenewsnet.com/article.asp?a=top_news&id=89712)
- <sup>29</sup> Medill, C., et al, "How Readable Are Summary Plan Descriptions for Health Care Plans," *EBRI Notes*, Vol. 27, No. 10, October 2006.
- <sup>30</sup> See <http://www.ohic.ri.gov/Regulation%205%20Standards%20for%20Readability.php>
- <sup>31</sup> California Health and Safety Code, section 1363(a).
- <sup>32</sup> See, for example, Gruber, J., "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" Henry J. Kaiser Family Foundation, March 2009. See also O'Brien E., and Hoadley, J., "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice." The Commonwealth Fund, April 2008.
- <sup>33</sup> At this writing, a bill pending in the California state Assembly, AB 786, would also require the development of standardized coverage tiers.