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Enhancing the Value of Health Insurance by Making it Simpler

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Summary

With the implementation of health insurance exchanges established by the Affordable Care Act (ACA), by early 2015 approximately 11.2 million Americans had enrolled in commercial

health insurance plans, 37 percent for the first time¹. In doing so, the newly insured entered one of the most complex labyrinths of plan choices, exceptions, formulas and jargon-laden systems in the world. Because health insurance (HI) is a fundamental instrument of wellbeing in our society, individuals must be able not only to obtain HI, but also to use it effectively. This policy brief examines health insurance complexity as a structural barrier to plan selection and ease of use.



**“Everything should be made as simple as possible, but not simpler.”
Albert Einstein**

Complexity creates an uneven playing field where some consumers are particularly disadvantaged in spite of system protections. Coupled with known gaps in health insurance literacy (HIL), especially among young adults, racial and ethnic minorities and those with limited English language proficiency, complexity raises social justice concerns; it can widen income

disparities, perpetuate health inequities and ultimately undermine the goals of health reform.

Inherently complex systems can gradually evolve to a point where the system becomes progressively more unwieldy, more costly to manage, inefficient, and less effective in accomplishing its intended purpose. Health insurance may be reaching that tipping point. Current HI products, especially high deductible plans (HDP) with or without health reimbursement accounts (HRA) are excessively complex; they can confuse users, are burdensome to manage, and create countless opportunities for errors. In Connecticut 36 percent of enrollees in QHP have not used their HI at all.

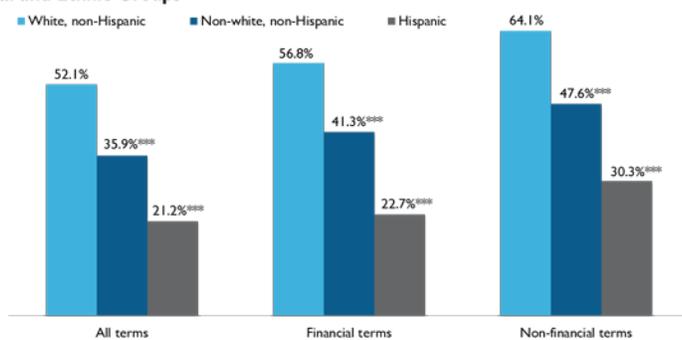
Unreasonably complex systems tend to yield unpredictable outcomes because the cause-effect relationships between their many components are not linear or reproducible with engineering-style reliability². Health insurance complexity should therefore prompt critical examination and, whenever possible, should be simplified.

Connecticut has an unmatched legacy of insurance expertise and is home to Access Health Connecticut, arguably the most successful marketplace in the country. The state is uniquely positioned to explore innovations that can enhance the value of health insurance by making it simpler.

Consumer Health Insurance Literacy Is Necessary but Insufficient to Overcome Complexity

Research predating the ACA showed that consumers had great difficulty understanding even relatively simple forms of health insurance^{3,4}. The 2006 introduction of Medicare Plan D prescription coverage for seniors, featuring the notorious “doughnut hole,” is an example of an unnecessarily complex product design that wreaked havoc among seniors who struggled to understand how it was supposed to work. In the confusion only 12 percent picked the most cost-effective plan^{5,6}. The ACA will eventually close the doughnut hole and, in doing so, will greatly simplify use of the prescription drug benefit. Post-ACA studies continue to show that historical difficulties understanding health insurance have not gone away. But unlike previous generation products, current versions can create significant unforeseen financial liabilities through tortuous mechanisms that are often incomprehensible even to relatively savvy consumers.

Figure 1. Confidence in Understanding Key Health Insurance Terms Among Racial and Ethnic Groups



Source: <http://hrms.urban.org/briefs/literacy-by-race.html>
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Recent surveys have identified widespread low consumer health insurance literacy (HIL) as a key barrier to consumer selection and effective use of benefits^{7,8}. The problem is most prevalent among low income previously uninsured racial/ethnic minorities⁹ (Figure 1).

A 45 year old single man making \$45,000 per year living in New London, CT would face a choice of 38 different plans through Access Health CT. The same

person in Miami, FL would have to sort through 81 plans (at www.healthcare.gov). Benefits would be described using terminology that surveys show an insurance-naïve person usually would not understand¹⁰.

A Kaiser Family Foundation survey contrasted literacy levels between currently insured and currently uninsured subjects (the group the ACA is trying to attract)¹¹. When asked to identify the best definition of the term “annual health insurance deductible,” 77 percent of the insured had the correct answer while only 53 percent of uninsured subjects knew the correct answer; 16 percent of uninsured subjects thought the correct answer was “the amount that is deducted from your paycheck each year to pay for your policy.” Among uninsured respondents, 58 percent did not

know the definition of “health insurance formulary,” and 9 percent thought it was “the form you send to your insurance company when you need to have a medical bill paid.” Even if consumers understood HI terminology, applying the terms to future case scenarios at the time of plan selection would require a level of thought abstraction and integration of personal values, health numeracy, health literacy, probabilistic reasoning, and other skills most consumers do not possess. Given these conditions it is not surprising that consumers only realize what their out-of-pocket (OOP) liabilities are during or after the episode of illness itself.

Interestingly, consumer testing of confidence in understanding health insurance, contrasted with their actual knowledge, shows a marked excess of confidence that can further amplify the perils of navigating the labyrinth of health insurance¹².

Low HIL can certainly detract from the value of health insurance; more aggressive consumer education, use of calculators, “smart defaults” and other decision aids can be helpful¹³. However, focusing on strategies that simplify rather than justify highly complex HI products increases alternatives for enhancing the value of insurance beyond health insurance literacy campaigns and decision aids.

Simplifying Plan Selection

Compared to marketplace enrollees, people with employer-sponsored insurance also face considerable challenges understanding their health insurance; still, they enter the system with several advantages. Employers often engage benefits consulting firms to pre-screen plans for suitability for their employees. Based on the characteristics of the population and exercising leverage on price, employers and employees can see plan choices narrowed to the best two or three options. This strategy harnesses the power of default options popular with 401K plans¹⁴ and many analogous situations^{15 16}. With expert pre-screenings, employees seldom face the possibility of making an obvious bad choice. And while pre-screening does not simplify plan design, it significantly lowers employees’ cognitive burden of choosing. For individual consumers or small businesses that purchase insurance through marketplaces, the equivalent screening process must be self-driven.

Aware of the complexity of plan designs ACA policymakers, philanthropic groups and civic organizations financed and collaborated with marketplaces in an unprecedented outreach campaign to facilitate enrollment. Marketing and enrollment assistance included a plethora of consumer-friendly information through toll-free phone lines, printed materials, web sites and simple language case scenario explanations. In addition, a small army of navigators and in-person assisters (NIPAs) were deployed in the first enrollment cycle. These resources proved valuable in informing individuals about plan options, but they could neither legally recommend a plan that best matched enrollees’ medical and financial circumstances nor inevitably lead them to choose a best plan.

Because access to these resources has dwindled dramatically, alternative solutions are badly needed. Licensed brokers and agents (B&As) working with AHCT are legally permitted to recommend a plan; they must be certified by all Qualified Health Plans (QHPs) and are required to complete a training and certification program. In Connecticut 30 percent of enrollees had

assistance from B & As in the first two open enrollment cycles. A considerably lower percentage enrolled with help from NIPAs. The majority enrolled on their own through a variety of portalsⁱ.

Presently unknown is the precision with which CT consumers matched their plan selection with anticipated health care needs. A recent analysis of 2015 individual enrollees in marketplaces shows that two million people forfeited potential cost sharing reduction by selecting a less than optimal plan¹⁶. Under experimental conditions using six simulation exercises, researchers asked people to choose the most cost-effective plan using a web site modeled after a typical marketplace. Without assistance, subject performance was no better than chance selection, a far cry from rational choices¹⁷. From the system perspective these “errors” illustrate the inefficiency inherent in an excessively complex system that makes communication daunting especially to low education, low income individuals and non-English speakers. While naïve hopes that the invisible hand of the market will, in due time lead to system self-corrections, pervasive system errors transfer wealth from consumers (especially low-income and the sickest) to the delivery system in the form of avoidable OOP expenditures and from taxpayers at large to insurance companies in the form of subsidized premiums for the “wrong plan.” These inefficiencies quietly and systematically widen income disparities and perpetuate health inequities.

It would be counterintuitive to disparage an abundance of HI choices because, in a free market society, choice is accepted as a desirable system attribute. The strong cultural bias towards greater consumer choice and self-reliance is based on the theory that buyers acting rationally and in their own self-interest will, over time, select the best products (price for value) from many competing offers¹⁸. Since the seminal paper by economist Kenneth Arrow¹⁹ the notion of free choice in health care, unlike the market dynamics of supply and demand at play for items like televisions or clothing, has been repeatedly proven inadequate to explain consumer or provider behavior. In the face of abundant choices and product complexity, the customary response is to offer consumers more information.

Wider choice is desirable if information is accurate and readily comprehended, but when information is imperfect or costly to obtain, a case can probably be made for more limited choiceⁱⁱ. In 2005 the California Healthcare Foundation examined the challenge of consumer choice in health care, particularly HI²⁰. One conclusion of that report was that “*contrary to popular notions that more information is better, decision-making research shows that more information does not always improve decision making, and frequently may actually undermine it.*” The same factors that lead a person unknowingly to choose a lower value health insurance plan and decision inertia drive him/her to repeat the lesser choice when presented with the opportunity to make a new choice.

Access Health CT developed a decision-support calculator that allows consumers to compare, based on the presence of certain medical conditions and anticipated surgeries, their OOP cost over the span of a full yearⁱⁱⁱ. The tool may help computer literate consumers select a lower OOP cost plan but for those living paycheck-to-paycheck, a year long view of OOP cost ignores the financial

ⁱ Personal communication with AHCT

ⁱⁱ Personal communication: Dennis Heffley, PhD. Emeritus Professor University of Connecticut, School of Economics.

ⁱⁱⁱ APCD Advisory Group Meeting, August 13 2015 <http://www.ct.gov/hix/cwp/view.asp?a=4299&q=523252>

exposure on any given month due to a serious illness that may well exceed household cash at hand or credit limits.

From the policy perspective, a preference for low-premium HDPs (with or without HSAs) is the expected consumer behavior. The overarching goal of all consumer-driven health care schemas, including HDP, is to mitigate moral hazard^{iv} 21 22. The Rand Health Insurance Experiment (HIE) demonstrated conclusively that cost sharing proportionally curtails use of discretionary low-cost services²³. However, the HIE also showed that consumers are equally likely to forgo necessary, high-value services. And for low-income individuals, cost sharing can adversely affect health outcomes²⁴. The ACA built some consumer protections against this phenomenon by, for example, eliminating OOP costs for proven preventive services. And in the last two decades, value-based insurance designs tied lower co-pays to high-value services with good results^v. The extent to which QHPs have incorporated value-based benefit designs into their products is not known.

Mechanisms to engage consumers more aggressively in their health care decisions led to the creation of medical savings accounts or MSAs (1997)^{vi}, health reimbursement accounts or HRAs (2002)^{vii} and health savings accounts or HSAs (2003)^{viii}. These policies gave individuals some of the advantages afforded to employers in the form of tax deductions. However, while giving individuals greater discretion in their health care purchases, these options also added complexity to benefit designs. Employees assimilated the added complexity readily because they had previous health insurance experience, and deployment was gradual over the span of many years; employees also had the benefit of employer institutional support. The current situation with the ACA is quite different. With the rapid enrollment of millions of individuals inexperienced with insurance into complex HDPs products, without similar institutional support, it is not surprising that many feel overwhelmed, make less than optimal plan choices, and once insured, are not confident about how to use their benefits.

Simplifying Health Plan Use

A typical “consumer-friendly” subscriber agreement (SA) is over a hundred pages long. An informal assessment of excerpts from a typical Bronze PPO plan in CT had a Flesch-Kincaid Reading Ease score of 30.7 (scale from 0-100 with higher scores indicating easier readability). That level corresponds on average to a 16.5 grade (10-12 is roughly high school) using five different readability scales^{ix}. The SA is of vital importance because it encodes highly specific instructions for coverage of medical services and products. A generous glossary of terms notwithstanding, the nature of the rules precludes avoidance of jargon and consumer-accessible explanations. And the sheer number of rules, their combinations and permutations precludes just-in-time recall and

^{iv} The tendency to use health services because it is covered by insurance

^v <http://www.nbch.org/Value-Based-Benefit-Design-Introduction>

^{vi} HIPAA, and Balanced Budget Act (for Medicare), 1997

^{vii} Internal Revenue Service

^{viii} Medicare Modernization Act. It also required HSAs to be coupled with a HDP, mandatory deductible levels and maximum OOP expenditures.

^{ix} Text to be read by the general public should aim for a grade level of around 8. <https://readability-score.com/>

application of the rules at the time of the encounter.

How plan complexity has grown over the years is evident: tiered formularies; different network configurations and the myriad conditional coverage provisions (site of care, step care, investigational therapies, post-service denials); unpredictable OOP costs (out-of-network provider using an in-network hospital); service limits (limits on number of visits); exceptions to exclusions (especial cases, overturned denials after appeals); rules within rules (co-insurance with a specific dollar limit for one drug formulary tier but not other tiers); and so on. The fact that deductibles and co-insurance must be calculated and reconciled against unknown “allowed charges” is outside the realm of the “complex” and is overtly unfair to consumers. The cumulative nature of OOP expenses imposes the burden of tracking and complexity to the calculus beyond the ability of even the most organized and sophisticated consumer. Individuals can also be the default risk bearers for the duration of the information blackout period (“service incurred but claims not paid”) due to slow or erroneous claims processing. This period can last months and even straddle enrollment cycles. Consumers who need frequent care cannot know what portion of their deductibles had been satisfied, but until providers and insurers reconcile all previous encounters, each new visit may require an OOP payment. The patient usually has the right to retroactively “claw back” from the provider any overpayments if they can document their case.

It is important to acknowledge here that recent surveys show that most, but not all, consumers are generally satisfied with marketplace plans^x. National and Connecticut-based surveys show a slight year-to-year decline in plan rating satisfaction, predominantly attributable to high costs. However an overarching concern remains that a mismatch between HI complexity and consumer preparedness to use it represents a loss of the full potential value of HI. Aside from OOP cost, the greatest source of consumer dissatisfaction – difficulty understanding and navigating the system – may be contributing to a brewing sense of frustration and dissatisfaction. A recent survey found that 60 percent of those with higher deductible plans rated the value of their plan as “fair” or “poor” compared to only 31 percent purchasing lower deductible plans^{xi}. From a system point of view, these consumer purchases represent wasteful spending that does not or cannot reward competitively superior products. And poorly informed, irrational consumer behavior perpetuates an inefficient, high cost health care system.

Simplification initiatives are periodically necessary when an inherently complex system evolves in ways that makes it progressively more unwieldy and inefficient. Policy solutions aimed at simplification are not uncommon. Tax simplification has been a national aspiration for years. A recent illustration of effective simplification is the case of The Free Application for Federal Student Aid (FAFSA) application form. The form “...has 105 questions and 88 pages of instruction making it as tortuous and perplexing as a federal income tax form”^{xii}. Its length and complexity has deterred a million potentially eligible individuals from low-income families every year from getting financial aid to send their kid to college. A bipartisan bill introduced in January 2015 would reduce the

^x <http://kff.org/health-reform/press-release/most-people-enrolled-in-marketplace-coverage-are-satisfied-with-plans-premiums-cost-sharing-and-provider-networks-new-survey-finds/>

^{xi} HDP defined as \$1,500 or higher for individuals and \$3,000 or higher for families <http://blogs.wsj.com/washwire/2015/05/21/the-value-trade-off-in-high-deductible-health-plans/>

^{xii} http://www.nytimes.com/2015/08/27/opinion/time-to-fix-the-fafsa.html?_r=0

form to two questions. The Obama administration has supported FAFSA simplification measures. It has also introduced technology that would enable the automatic transfer of IRS data into the application form for over 10 million online applicants. Such improvements increased the number of applicants by 30 percent and there are plans underway for additional simplification steps.

HI has reached a level of complexity and inscrutability that creates a deterrent to obtaining care, particularly for previously uninsured individuals. A decisive remedial action plan is necessary.

Conclusions and Recommendations

While millions of Americans now have access to HI for the first time, its full benefits often elude historically vulnerable populations. Key factors contributing to the unequal benefits of HI include low consumer HIL, insufficient real-time support for optimal use of benefits, and the inherent complexity of plan designs. Because HI is a fundamental instrument of wellbeing in our society, individuals must be able not only to obtain HI but also to use it effectively

Some initial measures aimed at helping consumers cope with the complexities of HI could include:

- An assessment of Connecticut consumers' HI and its impact on use of health benefits, particularly in the highest risk populations. This assessment must be followed by a culturally and linguistically appropriate HIL educational program designed to meet consumers' most pressing practical needs.
- Expanded efforts by AHCT to test, validate, and refine user-friendly decision support software to help consumers make more rational plan selections.^{xiii}
- Activation of a cadre of trained community-based workers to function as local "health insurance coaches" who not only educate consumers, but who are also licensed to assist them between open enrollment periods at the point of use. Ideal candidates for fulfilling that role include trained B&As, certified community health workers and clinic or hospital based NIPAs.
- Adoption of health insurance literacy as a topic in the "Choosing Wisely" campaign.
- Based on results of HIL pilot projects, formulate policies similar to the one recently passed by the state legislature to advance financial literacy.^{xiv}
- Expand consumer protection policies in Connecticut's Senate Bill 811 beyond those directed to "the average consumer" or "the average reader".^{xv} Additional protections should be explicit about including the most disadvantaged consumers.

Longer-term measures aimed at HI simplification will require considerable thought, multi-stakeholder dialog, deep consumer engagement, and disciplined testing of alternative designs. Ideas may include:

- Transition current forms of high deductible plans to more aggressive forms of value-based plans that significantly reduce or eliminate low or no-value services.

^{xiii} Provision of Senate Bill No. 811

^{xiv} Public Act No. 15-138 , An Act Concerning Financial Literacy Education, <https://www.cga.ct.gov/2015/ACT/PA/2015PA-00138-R00SB-00319-PA.htm>

^{xv} SB-11 (Sec. 2 (9)(b)(1); Sec. 3(b))

- Reduce the number of plan choices offered through marketplaces. Too many plans confuse consumers and fragment the risk pool into myriad mini-plans, eroding the ability of health insurance to cross-subsidize risk across large population groups.
- Introduce performance based regulation to health insurance similar to that used in public utilities and other industries. Targeted areas for performance or quality-based incentive policies could include: predictability of consumer out-of-pocket costs; readability and comprehension of health insurance service agreements; cost transparency of health services or protections against “surprise medical bills”²⁵. Insurance designs that do not meet targets should be required to improve.

Connecticut, perhaps more than any other state, has the capabilities to develop a comprehensive plan to enhance the value of health insurance and, in doing so, enhance the wellbeing of its citizens, especially its most vulnerable. The state has an unmatched legacy of insurance expertise. Hartford, “the insurance capital of the country,” is home to some of the most respected insurance companies and to Access Health CT, arguably the most successful marketplace in the country. These conditions are ideal to start the dialogue about making HI as simple as possible.

Note

This policy brief was developed by the Health Disparities Institute at UConn Health. The mission of the Institute is to reduce disparities by turning ideas shown to work into policies and actions.

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