

Informed, engaged consumers are well equipped to judge the value of their health care. And yet, consumers too often are frustrated by hurdles that make it hard to access information about their insurance benefits and out-of-pocket health care costs. By removing some of these hurdles, we can help consumers play a larger role in shaping a sustainable, market-based health care system.

SOLUTION

#1

Improve Access to Important Out-of-Pocket Cost Information

Today's health care consumers are more likely to be insured than ever before, but too many still have difficulty accessing the medicines they need. One of the biggest hurdles is high out-of-pocket costs. In an effort to keep premiums low, insurers are increasingly using higher deductibles and other cost sharing that is passed on to the consumer.

Example: When shopping for an insurance plan in a health insurance exchange, it is virtually impossible for consumers to predict their out-of-pocket costs for specific treatments or services. Because a consumer cannot calculate estimated out-of-pocket costs for the medicines they need before picking a plan, it is especially difficult to figure out which plan meets their needs and fits their budget.

Solution: Consumers should have more information about coverage and total costs, including premiums and potential cost sharing, prior to enrolling in any insurance plan. At a minimum, the federal exchange should improve its out-of-pocket costs calculator to allow more personalized estimates. Better-informed coverage choices may lead to higher satisfaction, better health, slower premium growth and lower out-of-pocket costs.

SOLUTION

#2

Improve Access to Important Quality Information

A range of private entities now evaluate the quality of health insurance plans, yet this information is not relayed in an easily digestible format to consumers.

Example: Health insurance exchange plans do not have easily accessible information on quality available, including how other consumers rate a plan or other forms of evaluation. This information is important to both regulators and consumers to ensure plans meet quality standards.

Solution: Additional disclosure to consumers would raise the bar on health plans and help discourage practices that only benefit insurers. Health insurance exchanges should follow Medicare's lead and make simple, transparent health plan quality ratings available. When insurers are required to disclose key information about their interactions with patients and providers (e.g., consumer and provider complaints; coverage denials and reversals; and clinical bases for utilization management, coverage exclusions and care protocols) consumers can better evaluate their coverage choices – and insurers have an incentive to eliminate practices that leave customers dissatisfied.



SOLUTION
#3

Improve Access to Important Clinical Information

Insurers apply a range of techniques that impact clinical care and patient choices. These practices are directed by insurers and may interfere with a physician's preferred course of treatment for an individual patient.

Example: Health insurance plans use techniques such as prior authorization, utilization management, preferred clinical pathways or protocols and more. These often come with financial incentives for physicians to comply. When different payers use undisclosed and/or variable clinical evidence to support these policies, consumers may be unable to consider their impact when choosing among services, providers or coverage.

Solution: Insurers should be transparent and held accountable for the clinical criteria they use to incentivize or discourage use of specific services and treatments.

SOLUTION
#4

Remove Potential Discrimination in Insurance Benefit Design

Access to prescription medicines is essential to successful treatment of a range of conditions, including cancer, diabetes, HIV/AIDS and mental illness. Yet in some cases, patients with certain conditions have no preferred therapy options available. This can discourage enrollment by individuals with chronic conditions and is in direct conflict with prohibitions against discriminatory benefit design.

Example: In health insurance exchange plans, some insurers are placing all options for medicines to treat a condition on the top cost-sharing tier. In an analysis of 2015 silver exchange plans, five classes of medicines had all drugs placed on the top cost-sharing tier, including generic treatment options.

Solution: State and federal regulators should prohibit plans from structuring formularies in a discriminatory fashion and should carefully scrutinize the use of utilization management tools that might have the same effect.