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HEALTH POLICY BRIEF
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Simplifying Health Insurance Choices

SUMMARY

Today, consumers face a bewildering health insurance marketplace, especially if they buy insurance on their own. Americans find it all but impossible to compare health insurance policies on an "apples-to-apples" basis because the policies are written in legalese and the terms of coverage are so varied. As lawmakers consider comprehensive health care reform, they have an opportunity to fix the way we shop for health insurance. This brief recommends new, consumer-friendly rules for the health insurance marketplace. These rules require clear and consistent definitions of insurance terms, standardized health plan provisions, new health plan disclosure forms, unbiased enrollment assistance and rigorous enforcement at the state and national levels.

Today's Health Insurance Marketplace: Overwhelming Complexity

Health insurance is one of the most important purchases Americans make, yet many consumers feel helpless when it comes to shopping for coverage.

For one thing, unlike most products and services we buy, it's difficult to know the full cost of our health coverage options. While most people understand the varying monthly premiums, it's far harder to calculate and compare potential out-of-pocket costs for medical services or assess possible expenses if you were to get sick and need extensive care.[1]

There are important underlying reasons for this confusion. To start with, policies are written in legalese or impenetrable "health insurance speak." Take, for example, this policy provision from a Rhode Island insurer:[2]

> Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for a Covered Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any

> coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

Very few consumers can make sense of the above paragraph. The average U.S. adult reads comfortably — especially about subjects they do not understand well — at an 8th grade level. Yet the *typical* health plan document is written at a first-year college reading level.[3] As one insurance official stated "it will be difficult for many health system reform ideas to get traction when people literally don't know what we are talking about."[4]

Just 12 percent of adults are fully "proficient" in health literacy.

Navigating the health insurance marketplace takes more than just reading skills. Health literacy is a broader concept that includes the ability to process numbers (numeracy) and at least a basic understanding of how to access care or coverage. Unfortunately, just 12 percent of adults are fully "proficient" in health literacy, according to one analysis.[5]

Lack of standardization adds greatly to the confusion. Terms like "deductible" or "hospitalization" can vary from plan to plan. A recent *Consumer Reports* article, for example, described a health insurance policy in which hospitalization coverage excluded the first day of hospitalization (in the fine print). The problem is that's usually the most expensive hospital day when lab and surgical suite costs are incurred.[6] Similarly, a detailed comparative study of health plans in Massachusetts and California found that plans with seemingly similar provisions would have left policyholders with out-of-pocket obligations that differed by thousands of dollars.[7] For example, a typical course of breast cancer treatment would cost the patient nearly $4,000 in one plan but $38,000 in the other plan — even though the plans contained similar deductibles, co-pays and out-of-pocket limits. In the case of the second plan, the policy's out-of-pocket limit included many "exceptions" that increased costs for the consumer.

Less than a quarter of policyholders understand the terminology used in their health insurance policy.

The bottom line is that consumers end up with coverage they don't understand. One study sponsored by the insurance industry asked adults to define insurance terms and calculate their bill. Most respondents were able to answer the questions correctly just half the time.[8] Another industry-sponsored survey found that less than a quarter of respondents understood the terminology used in their health policy.[9] Unfortunately, when consumers don't understand their coverage they may end up with unexpected costs if they need a lot of medical care.[10]

Surprisingly, consumers have little in the way of national standards that help them buy health insurance.[11] This near absence of consumer protections means that consumers often purchase coverage that doesn't suit their needs, that costs them too much, and ultimately drives up our nation's health care bill.

How Consumers Choose

When choices are overwhelming, consumers take "short-cuts" that may lead to a poor selection or they may decide not to make a purchase at all.

Consumers value "choice" when purchasing almost anything. In health care, the choice they value most is of doctors and places to get care. However, there is emerging evidence that consumers would actually prefer fewer choices of insurance policies in exchange for meaningful distinctions between plans and lower prices.[12]

Indeed, a large body of research concludes that too many choices often paralyze consumer decision-making.[13] When choices are overwhelming, decision-making becomes stressful for consumers. To reduce this stress, people take "cognitive short-cuts." One common short-cut is "sticking with what we know." In the world of health insurance, this often translates to sticking with the plan or policy you have, even if it doesn't cover needed care or better options are available.

Another "short cut" is to enroll in a highly advertised plan or one with a familiar brand name, rather than researching the best and most cost-effective plan. Consumers' distaste for evaluating large amounts of information, or complex information, is one reason companies put so much effort into branding. In 2008 health insurance companies spent over $645 million on advertising.[14]

If consumers don't understand information, they are more likely to dismiss it as unimportant and not use it in selecting their health plan.

Consumers are also prone to dismiss information they don't understand.[15] As a result, people often don't use the information provided by insurance companies. Instead they turn to family, colleagues, and friends for help navigating the health plan selection process.[16]

The experience of seniors purchasing Medicare Part D (prescription drug benefit) plans illustrates the "choice" problem. On average, Medicare beneficiaries have a choice of 48 Part D plans – and some have a choice of *around 70*. One study found that, based on individuals' previous year drug use, only 6 percent of enrollees picked the plan that would save them the most money. Most enrollees were spending $360 to $520 *more* per year than the optimal plan for them.[17] Yet, relatively few enrollees switch into other, more cost-effective plans. Of 17 million Medicare Part D enrollees in 2008, only 1 million switched plans.[18] Surveys show that seniors are aware of the problem. Nearly three-quarters felt that their Part D choices were too complicated. And a majority of seniors agreed with this statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing."[19]

This "paradox of choice" is not restricted to seniors. The "Consumers' Checkbook Guide" to health plans for Federal employees reports that "hundreds of thousands of employees and annuitants are still enrolled in plans that are much more expensive than average, and that give them no needed extra benefits."[20] Federal employees, who face a lot of health plan choices, also like to "stick with what they know." In one recent two-year period, fewer than 5 percent of enrollees switched health plans.[21]

CHECKLIST FOR A BETTER HEALTH INSURANCE MARKETPLACE

- ✓ A manageable number of meaningful health plan choices.
- ✓ Standardized health plan benefits allowing "apples-to-apples" comparisons.
- ✓ Health plan materials written in "plain English," using clear, consistently defined terms, and highlighting the information of most interest to consumers (such as likely out-of-pocket costs and whether their doctor participates in the plan).
- ✓ "Plan chooser" decision aids, including a user-friendly Web-based decision tool, access to local one-on-one counseling services, and a 24-hour toll-free phone number. Proactive outreach to low-income and minority populations should be required.
- ✓ A strong oversight body that conducts consumer education, aggregates and reports on customer complaints, monitors and enforces plan quality reporting, and monitors compliance with new insurance regulations.

A Better Health Insurance Marketplace

There's a better way. We need a health insurance marketplace which has consumer protections commensurate with the importance of the purchase; new rules for insurance plan disclosure that take into account *real* consumer decision-making behavior; and less variation in health plan design so that consumers can *easily* compare benefits and costs.

To create this new marketplace, Consumers Union proposes five specific changes.

1. A MANAGEABLE NUMBER OF PLAN CHOICES

Consumers should have a manageable number of "good" health plan options. Building on current state rules for insurer financial solvency, all health plans should also be required to meet national, minimum standards for coverage, network adequacy, and claims payment and appeal procedures.

If these national standards, in combination with the reforms below, produce an excessive number of coverage plans, then health plans should be required to bid to participate in the market in order to reduce the number of health plan options to a manageable level. This approach would promote competition on price, improved patient satisfaction and quality of care. It would also avoid the problems of an excessive number of confusing, look-alike plans, such as now confronts Medicare beneficiaries in their choice of Part D and managed care (Medicare Advantage) plans. In addition to an excessive number of Part D choices, beneficiaries face 44 Medicare Advantage plans on average and some beneficiaries have 87 choices.[22] Many plans feature only minor differences from each other. Moreover, in 2008 approximately 27 percent of these plans had

fewer than 10 enrollees. [23] Listing such options leads enormously to the "clutter" in the market and provides little benefit to the consumer.

2. STANDARDIZED BENEFIT DESIGNS

What a health plan covers and how cost is shared between the plan and the patient is referred to as the "benefit design." To engage consumers and facilitate informed choice, benefit designs should be standardized and vary around only a few features.[24] In other words, health plan choices should feature clear, meaningful differences.

Excess benefit variation was the reason that Congress ordered Medigap policies standardized into 10 designs in 1992. Studies have found these reforms reduced beneficiary confusion, marketing abuses, and consumer complaints, and have improved benefits.[25]

To facilitate consumers' ability to compare health plans, we recommend that all health plans cover exactly the same comprehensive set of medical services, and vary *only* by their cost-sharing features and networks of doctors, hospitals, and other providers.[26]

Cost-sharing variation should be limited. To start, we recommend that annual benefit limits and life-time benefit limits be eliminated. Cost-sharing terms like "deductible" should be defined using standard, industry wide definitions. Furthermore, the plan's out-of-pocket limit should be a "hard" out-of-pocket. In other words, it must not feature exceptions that can drive the policyholder's cost beyond the stated limit.[27] If remaining cost-sharing variation is limited to a small number of designs, consumers can more reliably gauge their out-of-pocket cost exposure and better compare plans.

Exhibit 1 is an illustration of how this might work. In the example, four levels of cost-sharing are permitted (designated as "basic," "bronze," "silver" and "gold"). Within these cost-sharing "tiers," there is additional variation reflecting the comprehensiveness of the plan's provider network — that is, the number of local hospitals and doctors participating as in-network providers. Taking both dimensions into account, a total of 10 variations is permitted.

In the context of a broader health reform effort, the "basic" cost-sharing level might be the minimum (least generous) coverage allowed. On the other hand, the most generous tier might be set at cost-sharing levels that lower-income Americans can afford. Since lower levels of cost-sharing are associated with higher premiums (all other things being equal), premium subsidies would be available to help lower-income families purchase coverage that contains adequate financial protection.

EXHIBIT 1 – ILLUSTRATION OF HEALTH PLAN DESIGNS THAT VARY AROUND FEW FEATURES*						
Plan Tier	**Standard Plans**	**Premium Level**	**Provider Network**	**COST SHARING** (Illustrative only)		
				Deductible (one person)	**Office copay; Coinsurance** (for other services)	**Maximum Out-of-Pocket expense** (one person)
Basic	AA	Lowest	May be limited	$1,150	$35; 20%	$3,500
Bronze	BB	Low	May be limited	$750	$30; 20%	$2,500
	CC	Low	Fairly Comprehensive			
	DD	Low	Comprehensive			
Silver	EE	Medium	May be limited	$300	$25; 10%	$1,500
	FF	Medium	Fairly Comprehensive			
	GG	Medium	Comprehensive			
Gold	HH	High	May be limited	$0	$15; 5%	$500
	II	High	Fairly Comprehensive			
	JJ	High	Comprehensive			

** This table is for illustrative purposes only and does not constitute a recommendation for cost-sharing levels. All plans, AA to JJ, cover the same comprehensive set of services and vary only by their cost-sharing provisions and provider networks. Within a plan "tier" cost-sharing is identical.*

3. STANDARDIZED, CONSUMER-FRIENDLY HEALTH PLAN MATERIALS

Making it easier for consumers to choose a health insurance plan means making the information about those health plans *understandable*, *relevant*, and *"evaluable"* – a fancy word meaning you can readily rank your choices from best to worst.

To ensure that the materials are understandable, insurers should be required to describe their plans in simple, straightforward language, and use consistent, industry-wide definitions for common policy terms like "deductible," "out-of-pocket limit," and "hospitalization."

Health plan materials should also emphasize the information of most interest to consumers, such as out-of-pocket costs and access to doctors and specialists.[28] For example, surveys show that most people's primary interest when switching health plans is whether their current doctor is "in the plan." Further, they like to know if they have the right to see doctors outside the plan's network, and at what cost. While health plans today make this information available, it is often difficult and time consuming for consumers to compare provider networks and access rules for dozens of plans.

"Evaluable" Information

If consumers are to choose from among health plan options, they must be able to rank them. Information that makes this task easier is said to be "evaluable." Evaluable information is presented so that it is easy to find the "best" option(s). Evaluable displays of information anticipate the difficulty of weighing two dissimilar pieces of information (like health plan cost and quality), and provide short-cuts for the consumer – similar to the "Best Buy" designations in *Consumer Reports* ratings of cars or TVs.

Information is more likely to be used if:

✓ better and worse options are more obvious

✓ People don't have to work hard to figure out what the information means.

Consumers also deserve to know how well a plan serves its enrollees. Currently, formal measures of plan quality are rarely consulted, in part because people distrust information they think comes from the insurers themselves.[29] Consumers have expressed a preference for an independent entity that rates health insurers – similar to the easy-to-use financial ratings that are readily available when purchasing life insurance.[30]

To help consumers choose, government should require insurers to use a standard, consumer-friendly disclosure format to describe their health plan. Standard disclosure forms reduce consumer confusion and increase the likelihood that consumers will choose a plan that meets their needs.[31] While more detailed information should be available, at a minimum this form would 1) identify whether or not a given provider participates in the plan, 2) disclose potential out-of-pocket costs under several common medical scenarios and 3) provide premium cost.

Consumers also need information that compares health plans "side-by-side."[32] Exhibit 2 presents an example of how comparative health plan information could be displayed in ways that help consumers. The example assumes that some basic information about the applicant and their plan preferences has been provided (top of the table).

Consumers Union recommends that actual health insurance disclosure requirements be developed in consultation with consumers, insurers, literacy experts and educators, and tested on representative populations, with special attention to hard-to-reach populations and minorities. [33]

4. "PLAN CHOOSER" DECISION AIDS

Even with the simplification of insurance choices envisioned above, many consumers may still be confused by the choices confronting them. A variety of decision aids should be available to consumers accommodating their language preferences, health literacy levels, internet-access levels and cultural backgrounds.

One-on-one assistance can be critical for getting people enrolled in health plans.

Studies show that one-on-one assistance can be critical for getting people enrolled in health plans.[34] Consumers Union recommends new federal support for a nationwide network of locally-based, non-profit health insurance counseling services, including in-person counseling and phone support. The counselors should be tasked with employing creative, targeted efforts to inform and assist our nation's most vulnerable populations with their health insurance options.

EXHIBIT 2 – ILLUSTRATION OF A STANDARD PLAN COMPARISON FORM

YOU ASKED FOR HEALTH PLANS FOR:

- a healthy, 45 year old woman,
- living in the 20016 ZIP Code (Washington, DC),
- listing Dr. Smith (202-555-1212) as an in-network provider,
- and featuring the least expensive premiums.

HERE ARE YOUR CHOICES FOR THE 2009 PLAN YEAR (JAN 1 – DEC 31):

Plan Tier	Health Plans	Provider Network	Monthly Premium Cost	ANNUAL COSTS			How did last year's enrollees rate this plan?
				Expected costs for medical services for people like you	**Expected Total Cost** (premiums plus expected cost of services)	**The most you will pay** (for covered services using in-network providers plus premiums)	
Bronze	Downtown HMO	Limited	$125	$280	$1,780	$4,000	★★★★
	Uptown HMO	Limited	$200	$280	$2,680	$4,900	★★★
	Premier Insurance	Fairly Comprehensive	$225	$280	$2,980	$5,200	★★★★
	Health Plans R Us	Fairly Comprehensive	$235	$280	$3,100	$5,320	★★
	Humongous Insurance	Comprehensive	$245	$280	$3,220	$5,440	★★★★
	Best Practice IPA	Comprehensive	$275	$280	$3,580	$5,800	★★★

Note: This list excludes plans that a) may be cheaper but don't include your doctor in their network or b) have higher premiums (but may feature less expensive cost-sharing for medical services).

WHAT "BRONZE" PLANS PAY FOR:

The Bronze Plans all feature the same cost-sharing provisions. Subject to these cost-sharing provisions, Bronze plans cover most medical services such as inpatient and outpatient hospitals services, prescription drugs, lab, X-ray, maternity, and physician office visits. These plans do not cover cosmetic surgery, dental or vision care.

EXAMPLE: Based on the experience of prior enrollees, a healthy, 45-year-old woman might use these services during the year and expect to pay:

Service	Cost of Service	Your share	Explanation
Annual Physical, including GYN	$500	$35	Plan copay for an office visit (not subject to deductible)
Mammogram	$200	$200	Subject to the plan's $800 deductible
Doctor visit for Illness	$120	$35	Plan copay for an office visit
Generic Antibiotic	$10	$10	Plan copay for generic drug
TOTAL		**$280**	

Your experience may be different. However, even if you need a lot of medical care, your share of the cost for covered services using in-network providers will not exceed $2,500.

For help with your enrollment decision, call 1-800-PLN-HELP or visit www.planhelp.org

THE PART D DRUG FINDER TOOL — NOT EASY OR EFFICIENT

A recent article in an AARP Bulletin billed itself as the "Quick Route Through the Medicare Drug Plan Finder 2009." These instructions contained 15 steps and 2,500 words. Four instructions were to ignore or overcome a feature of the plan chooser tool in order to complete the process.

These counselors must also provide ongoing feedback to regulators and policymakers with respect to consumers' experiences — providing a key pathway for improved services over time.

Web-based tools can also facilitate health plan comparisons. However, such tools must not introduce their own level of complexity (see side bar on the Medicare Part D tool). Web-based plan chooser tools must have at least one default set of steps that is simple to complete based on the most common consumer preferences. As noted above, consumers have a strong preference for information on which doctors participate in the plan. The web-based tools should allow consumers to enter the name or phone number of their desired doctor(s) and hospital(s) and view only those plans that have the indicated providers in their network.

5. A STRONG FEDERAL OVERSIGHT BODY

Given the complexity of the health insurance marketplace and the fact that state regulatory offices are often understaffed, Consumers Union recommends a new level of federal/state cooperation in the enforcement of insurer regulations and consumer protections. We recommend that a new federal entity, in cooperation with states, perform the following functions:

- **Monitor insurer compliance with new federal standards.** Work with state insurance departments, U.S. Department of Labor (for employer plans), and other entities as needed to ensure that federal health insurance standards are implemented and enforced. The agency should provide for regular collection and analysis of data from insurers to monitor compliance/effectiveness of federal reforms.

- **Monitor state enforcement and provide federal fallback enforcement if needed.** If states fail to enforce federal standards for health insurance consumer protection, federal fallback enforcement is appropriate. The agency should also conduct independent audits and/or "market conduct" exams to verify compliance directly.

- **Collect, audit and publish health plan quality information.** We recommend a federal/state partnership be charged with collecting and verifying quality information and aggregating it into measures that consumers can understand. The underlying detail should also be available to interested consumers, enrollment counselors and outside watchdog groups. The measures should use a five star-type system, graded on a curve to ensure distinctions between plans. An insurance plan that fails to provide the necessary quality data on time would not be included among plan choices. Among other things, these quality measures should include enrollee satisfaction, provider satisfaction, claims resolution records and a history of premium increases.

- **Consumer education.** The new agency should educate consumers on their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems. It should also serve as the first stop (in lieu of courts) for appeals of coverage denials. The grievance and appeals processes should be standardized and simplified so that it is easy for consumers to get what they are paying for.

- **Maintain a complaint hotline,** and compile federal and state data on insurance complaints and report this data publicly.

- **Ensure consumer co-payments for out-of-network care are based on honest, audited data.** Consumers Union supports the recommendation of the New York Attorney General, who has called for an independent, verifiable system of determining usual and customary charges so that consumers and doctors are not cheated out of millions of dollars a year in insurance payments for out-of-network care.[35]

In Conclusion

The impact of a simplified, consumer-friendly, health insurance marketplace should not be underestimated. One study, for example, found that making it easier to get information about insurance products, and simplifying the application process, could increase purchase rates as much as modest premium subsidies would.[36]

The current health reform debate provides policymakers with a unique opportunity to establish new rules that require clear and consistent definitions of insurance terms, standardize health plan provisions, and provide for rigorous enforcement at the state and national levels. We caution, however, that these new consumer protections, *by themselves*, will not accomplish our nation's larger goals of lowering health care cost trends, expanding coverage and removing poor quality care from the system.

This policy brief was written by Lynn Quincy and Steve Findlay.

ENDNOTES

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WWW.CONSUMERSUNION.ORG

HEADQUARTERS
101 Truman Avenue, Yonkers, NY 10703
Phone: (914) 378-2000 Fax: (914) 378-2928

SOUTHWEST OFFICE
506 West 14th St., Suite A, Austin, Texas 78701
Phone: (512) 477-4431 Fax: (512) 477-8934

WASHINGTON DC OFFICE
1101 17th Street NW, Suite 500, Washington, DC 20036
Phone: (202) 462-6262 Fax: (202) 265-9548

WEST COAST OFFICE
1535 Mission Street, San Francisco, CA 94103
Phone: (415) 431-6747 Fax: (415) 431-0906