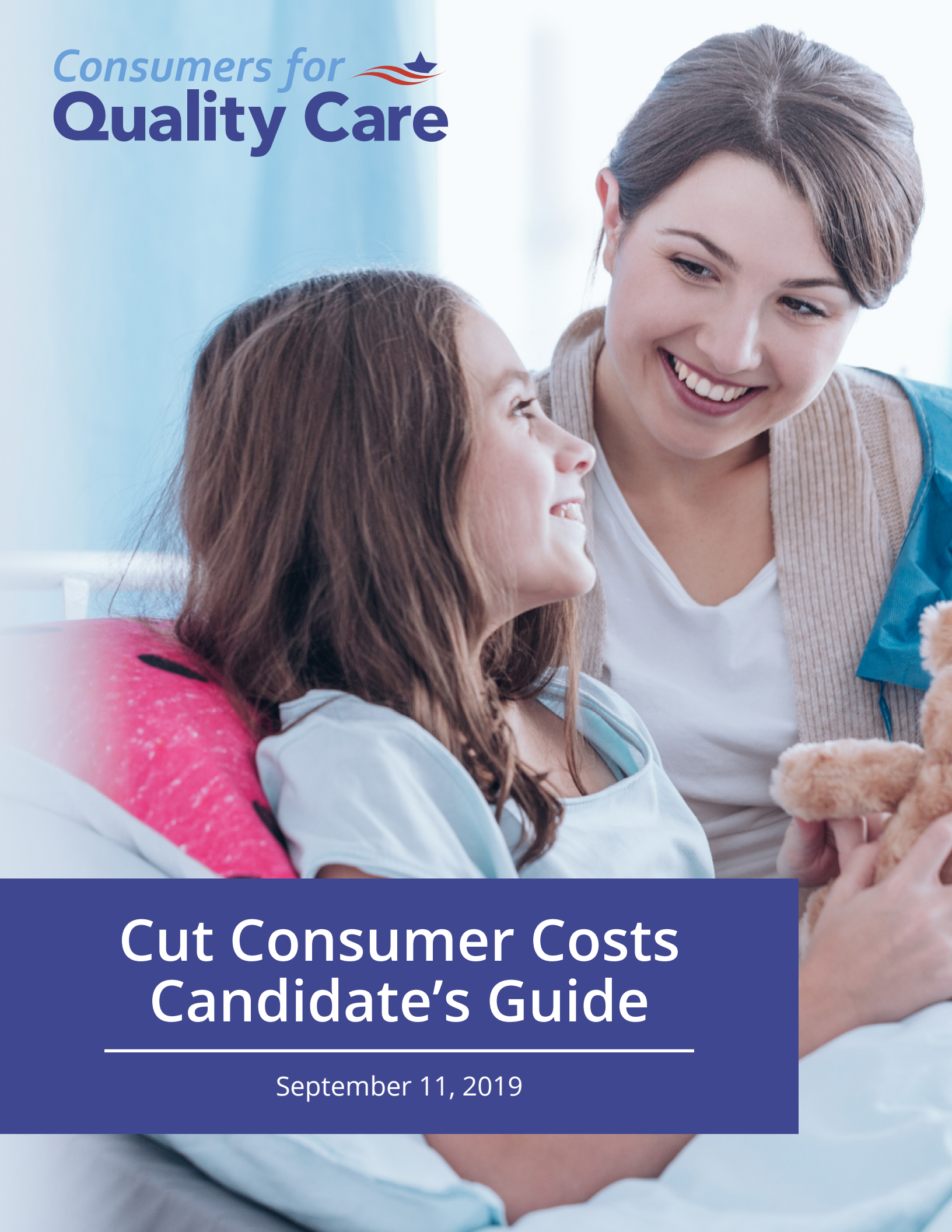
Consumers for Quality Care



Cut Consumer Costs Candidate's Guide

September 11, 2019

INTRODUCTION

Consumers for Quality Care (CQC) developed this Candidate's Guide to give those running for office a clearer understanding of how they can help lower consumer costs in the health care system. It spotlights issues consumers are facing with their insurers, at the hospital and at the pharmacy counter, and outlines how elected officials can tackle those problems head on.

Consumers are deeply frustrated by unpredictable costs and the lack of transparency in health care. There are far too many policies that strain consumers' pocketbooks while padding the bottom lines of health care industry players. This summer, Consumers for Quality Care launched our #HealthCareFail campaign, which highlights the health care experiences of real consumers, as told in their own words.

What we've found is that anti-consumer practices employed by insurers, the lack of transparency in hospital pricing, and increasing out-of-pocket costs for prescription medications are major pain points for consumers across the country, not to mention surprise medical bills, which continue to affect consumers when they least expect it. This guide highlights the impact of these health care failures on consumers and points to solutions elected officials can implement to allow for increased transparency and lower costs.

Discussions are underway about the direction of health care in the US. We are committed to giving consumers a voice in the ongoing debate. We urge candidates for public office to listen to the problems consumers are facing and enact solutions that provide more certainty for us all through quality coverage and affordable access to care.

Sincerely,

INSURER ANTI-CONSUMER PRACTICES

CQC-Ipsos research shows that two in three Americans struggle with predicting how much they will have to pay for health care when they need it. And with the continuing trend of ever-higher-deductible health plans, the proliferation of short-term, limited-duration insurance, surprise medical bills, after-the-fact emergency department denials and misguided prior authorization protocols, the only thing many consumers can predict about their out-of-pocket health care costs is that they are going up.

THE ISSUE: HIGH DEDUCTIBLES

Nearly one in four covered employees have a single-person deductible of $2,000 or more. While these lower-cost, higher risk plans work for some, consumers who can least afford catastrophic costs associated with accidents or chronic disease are those most likely to be attracted to the lower premiums then get debilitated by the high out-of-pocket costs, or forego needed care.

Real-Life #InsuranceFail: High Deductibles

High-deductible plans are forcing more and more consumers to delay needed care due to cost. One consumer discovered she carries a genetic mutation that increases her risk of breast cancer to 72 percent. Her doctor recommended annual mammograms and MRI breast scans, but her $6,000 deductible put these tests out of her price range. She decided to delay her second-year screenings until she was able to pay off the debt from the first round.

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INSURER ANTI-CONSUMER PRACTICES

THE ISSUE: SHORT-TERM, LIMITED-DURATION HEALTH PLANS

Short-term limited-duration insurance (STLDI) plans are exempt from many Affordable Care Act (ACA) requirements and can exclude coverage for preexisting conditions, have dollar value limits on covered services, are not required to cover preventive services, and have a host of other substantial risks for consumers.

Real-Life #InsuranceFail: STLDIs

Consumers who are seeking lower premiums often don't realize short-term, limited-duration health plans may not protect them when they are sick, leaving them with large surprise bills for uncovered care. That was the case when Charlie Butler was diagnosed with testicular cancer. He believed that his health insurance, an 11-month STLDI plan, would help cover the cost of his care. Instead of paying the tens of thousands in medical bills for Butler's treatment and care, his insurance canceled his plan, citing a preexisting medical condition even though the diagnosis came after he purchased the plan.

THE ISSUE: PRIOR AUTHORIZATION

Prior authorization of medical treatments is a common fixture in modern health insurance plans, intended to control costs to make insurance more affordable. Unfortunately, significant delays and dangerous denials are also all too common. An American Medical Association (AMA) survey of 1,000 physicians found that 9 in 10 reported prior authorizations delayed access to necessary care.

Real-Life #InsuranceFail: Prior Authorization

After her insurer stopped covering her Lupus medication, Amber from Texas saw her symptoms flare up and is still feeling the effects a year later.

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INSURER ANTI-CONSUMER PRACTICES

THE ISSUE: EMERGENCY DEPARTMENT DENIALS

Some insurers are instituting policies that would force policy holders to pay for an emergency room visit if the insurer later deems it a non-emergency. These policies, which essentially require patients to diagnose themselves in order to ensure their condition is serious enough to be deemed an emergency by their health insurer, are harming customers while reducing costs for the insurers implementing them.

Real-Life #InsuranceFail: Emergency Department Denials

In Frankfort, Kentucky, Brittany Cloyd went to the hospital with a fever and strong pain on the right side of her stomach at the advice of her mother, a former nurse, who suggested it might be appendicitis. It turned out Cloyd had ovarian cysts and Anthem denied the $12,596 bill, leaving her to cover the full sum.

HOSPITAL PRICING

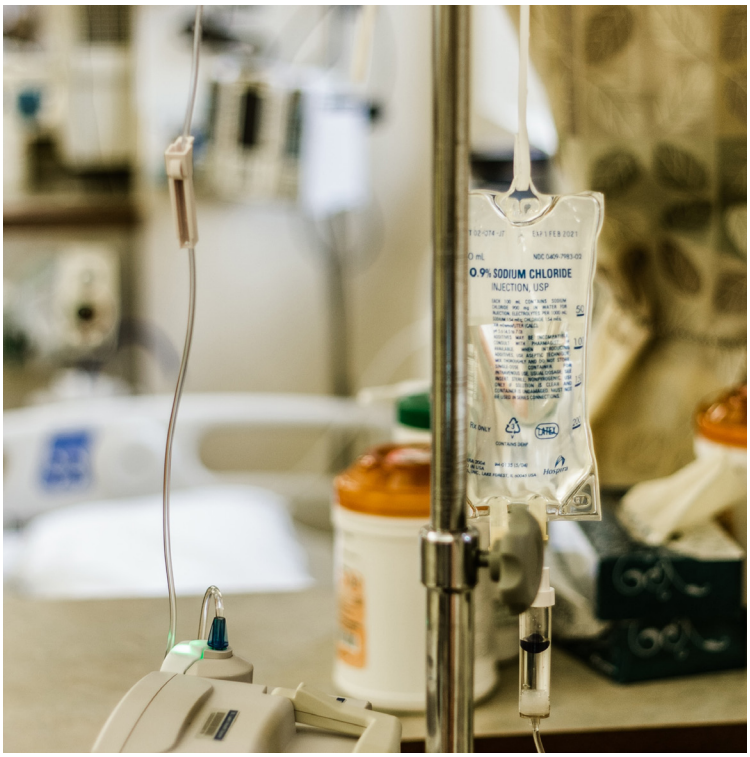
Surprise bills, billing errors and vast swings in average prices for similar tests and procedures underscore the need for transparency and reform in hospital pricing.

THE ISSUE: SURPRISE BILLS

Over 50 percent of Americans have received a surprise medical bill in the past year for a cost we thought was covered by our health insurance. Many surprise hospital bills result from "balance billing" for treatment at in-network facilities by out-of-network providers. Others result from a lack of customer understanding of complex health benefits and opaque pricing and still others are a result of billing errors.

Real-Life #HospitalFail: Surprise Bills

Cristina from Florida shared her #HealthCareFail about the surprise bill that resulted when her son's emergency room visit was improperly coded. What followed was a long-drawn out process of going between the hospital and insurer to get the coding fixed and her son's visit covered.



THE ISSUE: HOSPITAL PRICING VARIATIONS

Prices for hospital services vary widely and hospital pricing in general is opaque, making it more difficult than ever for consumers to determine what they might have to pay. Sixty-five percent of Americans said it is difficult to understand the cost of care received at a hospital, according to Ipsos/CQC research.

Real-Life #HospitalFail: Hospital Pricing Variations

A Florida man received two CT scans ordered by his doctor only a few weeks apart. The first one was performed at a local imaging center for $268, while the second was done at a hospital at a cost of $8,897.

PHARMACY COUNTER

In the ongoing health care industry battle about who is responsible for rising costs, consumers continue to be caught in the middle, facing increasing out-of-pocket costs.

THE ISSUE: ACCUMULATOR ADJUSTMENT PROGRAMS

Many health plans and pharmacy benefit managers (PBMs) are adopting policies that change how they apply the copay coupons many pharmaceutical companies offer to help low- or moderate-income Americans pay for the drugs they need. Copay adjustment – or accumulator adjustment – programs are when insurers no longer allow drug copay coupons to count towards patients' deductibles.

Real-Life #RxFail: Accumulator Adjustment Programs

Last year, Kristin Catton's health insurance plan changed the way it handles the payments that the drugmaker makes to help her with the $3,800 per month copay for a medication to control her multiple sclerosis symptoms and prevent flare-ups. Before, the drugmaker's payments counted toward her family's $8,800 annual pharmacy deductible, meaning her deductible would be met by the time she met the drug company's copay assistance cap for the year, at which point the insurance company will begin to cover the cost of the drug. With her insurer's copay accumulator program, once Kristin meets the copay assistance cap from her drugmaker, she alone is responsible for the per month copay until she reaches her nearly $9,000 deductible, an amount she can't afford to pay.

PHARMACY COUNTER

THE ISSUE: MEDICARE PART D

Rising out-of-pocket medication costs for senior citizens on Medicare are a significant concern. Ipsos/CQC research found that 53 percent of older adults say they are frustrated by out-of-pocket prescription drug costs. Efforts are currently underway in Congress to put an out-of-pocket cap in Medicare Part D. While an out-of-pocket cap will be welcomed, a small percentage of seniors would benefit, and Congress should do more to help by smoothing out their costs over the year and making sure rebates get to patients at the pharmacy counter.

Real-Life #RxFail: Medicare Part D

Tod Gervich has multiple sclerosis and gets regular injections of Copaxone to prevent relapses. He is used to the injections and managing his condition, but the costs continue to pile up. Because there is no out of pocket cap in Part D, Tod is one of the countless older Americans, particularly those with chronic diseases, struggling to afford the thousands of dollars in out-of-pocket drug costs they are faced with every year.

CLOSING

In today's health care environment, too many consumers are unable to afford quality care. Americans need leaders who will take tangible steps and implement real solutions to alleviate the unpredictability of health care costs. We urge you to tackle these important consumer health care issues place the utmost priority on finding solutions that cut health care costs for consumers.

Visit www.cutconsumercosts.org to learn more.

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