

## Article

### Don't leave us in the dark

*Health reform is just one worry for brokers - what about the changes Congress won't make?*

BY **SAMUEL FLEET**

Published 3/1/2010 » [More From This Issue](#)

Sure, health care debate and reform provisions have left the broker community worried about their livelihood. But what about the changes Congress won't make? Without a greater emphasis on [transparency](#), brokers will continue to be left in the dark about the best way to help their customers. Yet very little in the various reform packages has targeted areas that should be [immensely important](#), not only to consumers but also to brokers.

#### What's missing?

For the past year, politicians have argued that their efforts are focused on two things: increasing access by providing coverage for the uninsured and improving affordability by lowering the cost of health insurance. However, this "supply side" approach to reform shares the same seeds of failure that eventually turned managed care into a strategy despised by medical providers and consumers alike. What at first promised to be more efficient care at a lower cost too often turned out to be denied care at unsustainable reimbursement rates.

Because the reforms in Congress have centered on the way health insurance is delivered to Americans rather than on how Americans purchase health care, there has been little progress on the kind of market-driven signals that might actually make significant inroads into industry inefficiencies and procedure overuse. Patients who have visibility into their health care options would be able to make better choices. Health care providers would be able to offer services that make medical sense rather than insurance-billing-code sense.

And brokers? They would be able to become valued partners for customers by guiding them to low-cost contracts, high-quality care and clear accountability for outcomes.

#### Price: Out in the Open

A car owner who needs to get his fender repaired after a crash may take his car to several body shops to compare estimates before settling on the place to get the work done. But a person who follows his doctor's recommendation to get a colonoscopy simply makes an appointment with whomever his doctor refers him to. Price rarely enters into the decision.

If the patient did ask for pricing information ahead of time, he is likely to be told it is not obtainable, or even that it is a proprietary matter that is a secret under agreements between insurers and health care providers. The patient may not even know who he should be asking about the cost since there may be separate charges from a surgeon, a hospital or clinic, an anesthesiologist and a lab.

If he could get an answer, he might be surprised to learn how much price varies within the same city. The *Sacramento Bee* reports the California agency that collects hospital pricing data found three hospitals in Sacramento charged \$2,648, \$3,476 and \$4,097 for a diagnostic colonoscopy in 2008. The disparity was even greater for a laparoscopic gallbladder removal: \$25,274, \$46,905 and \$60,979.

If medical providers at all levels were required to give patients estimates of charges just as body shops, general contractors and moving companies do before service is authorized consumers could make informed choices about their care.

In a world with transparent pricing, brokers would be able to assist their customers by designing plans to take advantage of [low-cost](#) providers. Customers would look to them for their expertise in finding the best discounts.

**Quality: Comparing Outcomes**

Almost as difficult to get as pricing information is the data that would allow people to understand the differences in the quality of care provided. While consumers can find ratings in magazines or go online to read reviews about any number of products they plan to purchase, similar data about medical care is very difficult to find. For the most part, the medical community has been resistant to any type of rating system because they believe it is impossible to compare care when patients may have underlying differences that affect outcomes.

The *Wall Street Journal* reports, however, that when medical providers are compelled to participate in rating systems, it not only helps patients make better choices, but it also encourages innovation and changes that improve outcomes. For example, a quality-rating project in Minnesota has demonstrated better care for diabetic patients over the course of a four-year period.

This is another area where brokers would benefit from transparency because they could become the experts who would guide employer customers and employee patients to make the best use of comparative data.

**Disclosure: The Details Behind Decisions**

Even more important to brokers would be a requirement that insurers disclose detailed claims costs at an aggregate level (maintaining privacy by not divulging individual records). This would allow brokers to help their customers track trends, analyze different strategies for effectiveness, and understand the links between claims and rising premiums.

Without data, brokers and their customers are often forced to make decisions blindfolded or worse yet, accept whatever premium increases they are presented without understanding the cost drivers behind them.

Politicians have made it clear that they believe government should have a bigger role in making sure that Americans have better access and more affordability when it comes to health care. Unfortunately, they have shown very little interest in shaping that role around enforcing transparency. If that does not change, consumers will be the losers and so will brokers. Armed with easily accessible pricing, widespread comparative quality ratings, and fully disclosed data about claims, brokers have a shot at becoming consultants with expertise rather than salesmen with off-the-shelf products.

The bottom line? We should all be demanding transparency. Then no one would be left in the dark when it comes to health care choices.

### **While We're on the Subject...**

How to make the benefits industry happy? Congress is getting closer. Organizations, including the American Benefits Council, the American Dental Association and the National Association of Vision Care Plans, called on Congress in January to make a serious adjustment to, if not eliminate, the proposed excise tax on health benefits.

Essentially, organization leaders say, the provision—as it was written before a deal was reached with labor leaders—would compel employers to drop or reduce prevention-oriented benefits (like dental and vision plans) in order to dodge the tax.

“Many employer-sponsored plans exceed or will exceed the [Senate’s] excise tax threshold simply because the plans include many older workers or retirees with higher cost health care needs, or are concentrated in locations with high health costs,” states a letter from the coalition of organizations. “As a result, the excise tax could lead many employers to reduce benefits ([Mercer Survey](#), 12/2/2009) by eliminating limited service supplemental benefits and FSAs that fund much needed and prevention-oriented dental and vision care in order to avoid the tax.”

[American Benefits Council President James A. Klein](#) notes the health care debate has “never focused on dental, vision and other supplemental benefits.”

But Congress and the White House insist an agreement with labor unions has resolved this issue. Starting in 2015, threshold calculations will exclude the cost of dental and vision coverage, under the new agreement.

Thresholds have also been increased to \$8,900 for an individual and \$24,000 for families (\$27,000 for higher-risk jobs). Threshold levels will be adjusted based on age and gender. And the compromise exempts collectively-bargained health plans and government employees from the tax until 2018, which gives unions time to renegotiate agreements with their employers.