

Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance

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Executive Summary

Background

The 2010 Affordable Care Act (ACA) calls for a new health insurance disclosure form “so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to that coverage).” The ACA requires all health insurance plans to use this form—group and non-group, grandfathered and non-grandfathered—beginning in 2012. The disclosure will affect over 180 million Americans when it goes into effect.

This disclosure will convey information familiar to health insurance shoppers, such as premiums and patient cost-sharing amounts—deductibles, co-pays and out-of-pocket limits. But it will also include a new component, one which takes those discrete cost-sharing components and calculates the bottom line cost for a consumer for several hypothetical medical scenarios.

This new feature, called the Coverage Facts Label (CFL, also known as Coverage Examples), has not previously been available to consumers when they shop for a health plan. Hence, Consumers Union and the Kleimann Communication Group conducted this consumer testing study to learn more about how this label might help, or possibly confuse, consumers.

Methodology

This study used cognitive interviewing and usability testing to observe consumers’ use and understanding of two prototype versions of the Coverage Facts Label. Cognitive interviewing is a one-on-one technique that uses small numbers of participants to explore how consumers make sense of the information within a document or web site. Despite a small number of participants, this technique yields rich and nuanced data because the consumers’ actions can be precisely observed and their responses explored in great depth. The research literature supports that cognitive interviewing does not require high numbers of participants to get a reliable sense of problems in a document.

The two prototypes were developed by the National Association of Insurance Commissioners (NAIC), charged with recommending the format and content of the overall disclosure form, including the new Coverage Facts Label. Each prototype contained the same three medical scenarios (having a baby, treating breast cancer, treating diabetes) but the layout differed. (See Appendix B.)

For this study, we conducted 16 one-on-one interviews (each lasting 90 minutes) in two sites: St. Louis, MO and Buffalo, NY. Our participants were recruited from two groups—uninsured and self-pay (non-group coverage). We interviewed nine men and seven women, and a range of ages and educational levels. Based on our observations, these consumers had a wide range of familiarity with health insurance concepts, ranging from quite expert to completely unfamiliar with terms like “deductible,” “coinsurance,” and “benefit limits.”

Main Findings

The CFL was well-received by consumers. Compared to the more common discrete listing of plan cost-sharing features (deductibles, copays, etc), consumers found it startling to see the treatment steps, the overall costs for the treatment steps, and the share of those costs paid by the plan. Of the two CFL versions they reviewed, consumers expressed a strong preference for Version #1—which contained more cost detail.

Generally, participants liked the three medical scenarios and felt they made sense. They noted that the examples were “common” events, such as having a baby, and included both a catastrophic illness (breast cancer) and a chronic illness (diabetes). It seemed to them that an appropriate variety had been provided, even though not every scenario was relevant to them.

While participants in this study didn’t describe the CFL as the main feature helping them choose a health plan, the CFL clearly contributed by furthering their understanding of the role of insurance and providing a better sense of the financial protection offered by the plan. Put another way, the CFL helped them understand what they were getting for their monthly premium expenditure.

In fact, consumers often experienced a significant change in their perception of health plan value after reading the CFL. When only the discrete cost-sharing information is reviewed (absent any treatment scenario context), most participants were skeptical about the value of the health plan. They viewed the cost-sharing information as costs they would have to pay, and these costs seemed excessive on top of their monthly premium. However, the same information, viewed in the context of a treatment scenario and paired with the portion being paid by the plan, elicited an entirely different reaction. In this context, the coverage looked valuable and the patient’s portion more reasonable.

The two versions of the prototype CFL included significant “warnings” or disclaimers to ensure that consumers did not assume the examples were “promises” of what would be paid should they need one of the three types of treatment. We found that almost all participants readily understood that the examples did not give a precise estimate of their own costs if they were to need one of these three health services or even a similar health service. Participants arrived at this understanding both from the warning but also based on their previous experience with health insurance. Reflecting the fact that this aspect of the CFL was easily grasped, one of the most

disliked features of the CFL was the repetition of the warnings. Participants felt there was little value in providing more than one disclaimer. On the other hand, while they didn't expect the CFL to be precise, participants wanted the examples to have some basis in reality so the label could be used as intended, namely, be compared across health plans.

One thing that the CFL did *not* do was illuminate the cost-sharing provisions of the health plan in a mathematical way. Few participants tried to relate the cost-sharing components displayed in the CFL (such as deductible or coinsurance) back to the underlying plan provisions on pages 1–4 of the disclosure form. Indeed, such an exercise would have been almost impossible to carry out because many of the relevant cost-sharing rules could not be displayed in the first four pages of the form. To provide one example, in one plan maternity was paid based on a global fee to the provider that includes all prenatal care, delivery and post-natal care. The member only pays for the initial office visit when the pregnancy diagnosis was made despite the fact that treatment includes multiple office visits. This non-standard treatment of office visit copays is detail that would not typically be included in the Summary of Coverage form.

These consumer experiences demonstrate another value of the CFL. The information in the CFL not only complements but *supplements* the information on pages 1–4 of the form. Put another way, the detail on pages 1–4 is insufficient to provide a clear sense of patient costs in some situations. Page 5 provides some information that wouldn't otherwise be on the form.

Finally, this study reinforced the findings of earlier studies showing that consumers have considerable difficulty understanding their out-of-pocket costs using the more traditional plan summaries. In part, this difficulty is because consumers have little idea of the procedures and costs associated with a significant illness or accident. Difficulty also stems from the complex cost-sharing provisions and benefit exclusions included in most health plans today. Indeed, a majority of our participants were unfamiliar with one or more of the key cost-sharing provisions (deductible, coinsurance, annual benefit limit, out-of-pocket maximum, allowed amount). They also struggled with certain medical terms, such as specialty drug. These terms represented a significant barrier for consumers trying to make meaningful comparisons between health plans.

Conclusions and Recommendations

The accessible, readily understood nature of the Coverage Facts Label makes it a true boon to consumers, providing a reliable point of comparison and providing a better understanding of the extent of the coverage they are purchasing for their premium dollars.

Nonetheless, the consumer testing did suggest some modest changes to the prototypes:

- Use Version #1 with the additional cost-detail.
- Use only one warning/disclaimer.
- Develop additional medical scenarios that consumers could view online.

- Consider several formatting and layout suggestions (see pages 23–25).
- Make available short, understandable definitions of key terms commonly misunderstood by consumers.

We also recommend further consumer testing of any revisions to ensure that the changes helped consumers and to yield further insight into how they use the form. In particular, the wording, formatting and placement of definitions should be tested as some of the embedded definitions are currently overlooked by participants.

Broader Policy Implications

Even with the well-received Coverage Facts Label, a majority of consumers still struggle with key health plan cost-sharing concepts. As such, they are essentially shopping “blind” when trying to meaningfully compare health plans. Additional research is needed to understand how to better convey these health plan features to consumers.

Closely related research would guide policymakers on the tradeoffs between reducing plan complexity (by standardizing plan features) and preserving consumer choice. This study—as well as others—suggests there may be a net benefit to consumers by simplifying the underlying choices.

Additionally, while health policymakers, and some sophisticated consumers, readily link the enrollee’s costs to the insurance function of health plans, this linkage is not readily made by many consumers. This limited view has important implications for attracting and retaining consumers into coverage. Providing consumers with a clear indication of what the *plan* pays for in treatment (as opposed to what consumers pay), could help policymakers and exchange designers promote the coverage options available to consumers.

Introduction

The 2010 Affordable Care Act (ACA) calls for a new health insurance disclosure form “so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to that coverage).”¹ The ACA requires all health insurance plans to use this form—group and non-group, grandfathered and non-grandfathered—beginning in 2012. The disclosure will affect over 180 million Americans when it goes into effect.

One required component of this new disclosure form is a new method of comparing health plans called the *Coverage Facts Label*. This label uses common medical scenarios, such as pregnancy, to illustrate the patient’s share of covered services under the terms of the health plan.

Ample evidence suggests that a disclosure of this type is needed. Previous consumer testing of other components of the disclosure form demonstrated that consumers have considerable difficulty understanding their out-of-pocket costs for a given medical scenario, despite having plan provisions such as deductible and coinsurance amounts available to them.² In part, this difficulty is because consumers have little idea of the procedures and costs associated with a significant illness or accident. Difficulty also stems from the complex cost-sharing provisions and benefit exclusions included in most health plans today. The large number of variables affecting consumers’ costs, and the interactions between these variables (“do copays count towards the patient’s out-of-pocket maximum?”), and exceptions make it almost impossible for consumers to calculate their “true” out-of-pocket costs. One detailed study of health plan provisions found that a person undergoing a typical course of breast cancer treatment would end up spending nearly \$4000 in one plan versus \$38,000 in another plan—even though the plans had similar deductibles, copays, and out-of-pocket limits.³

¹ Throughout this report, the term “Affordable Care Act” is used to refer to the collective provisions of the Patient Protection and Affordable Care Act, signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010. More information about this law can be found on: <http://www.healthreform.gov/>

² Consumers Union and People Talk Research, *Early Consumer Testing of New Health Insurance Disclosure Forms*, December 2010.

³ Karen Pollitz et al, “Coverage when it counts: How much protection does health insurance offer and how can consumers know?” Center for American Progress, May 8, 2009.

A history of ineffective disclosure statements in other consumer venues suggests that care must be taken to ensure consumers understand, and can act on, the information in the new form.⁴ A critical step in developing an effective form is to have the form tested using real consumers.⁵

Study Goals

This consumer testing study examined how well the Coverage Facts Label meets the goals of Section 2715 of the ACA and the needs of consumers. Specifically:

- Can consumers read, understand, and use the Label?
- Does the Label provide the information consumers need, both in terms of the medical scenarios available and in terms of the information about each scenario?
- Does the Coverage Facts Label illuminate, or at least not distract from, the usefulness of the information in the other parts of the Summary of Coverage form?
- Is it helpful? Does it make it easier for consumers to compare and select a health plan? If yes, how does the Label support the decision of which plan to select?

A final goal for the project was to identify areas for additional research on this topic.

Terminology Used in This Report

The overall disclosure form, called a summary of benefits and coverage explanation in the Act, is referred to as the “Summary of Coverage” in the prototype documents. The component called the “Coverage Facts Label” in the Act, is called “Coverage Examples” in the most recent prototype document, although the longer term “Examples of Plan Coverage” was used in the test documents. Throughout this report, we use the term **Summary of Coverage** to refer to the six page form and the **Coverage Facts Label** or **Label** or **CFL** to refer to pages 5 and 6. (See Appendix B for an example of the prototype documents.)

⁴ For example, see James M. Lacko and Janis K. Pappalardo, *Improving Consumer Mortgage Disclosures: An Empirical Assessment of Current and Prototype Disclosure Forms*, Federal Trade Commission, Bureau of Economics Reports, June 2007.

⁵ Unfortunately, the Departments charged with implementing these ACA provisions (Department of Labor (DOL), and the Department of Health and Human Services (HHS)) were not provided with funds to do consumer testing of the *Coverage Facts Label*. Similarly, the National Association of Insurance Commissioners (NAIC) charged with recommending the format and content of the label, has no tradition of consumer testing. However, all three of these organizations support current and future consumer testing of the new health insurance disclosures, acknowledging the critical role of the testing in the creation of a successful disclosure.

Study Approach

This study used cognitive interviewing and usability testing to observe consumers' use and understanding of two prototype versions of the Coverage Facts Label.

Cognitive interviewing is a one-on-one technique that uses small numbers of participants to explore how consumers make sense of the information within a document or web site. Despite a small number of participants, this technique yields rich and nuanced data because the consumers' actions can be precisely observed and their responses explored in a consistent manner. At the same time, the one-on-one approach allows the moderator the flexibility to explore individual responses in-depth. Researchers often cannot capture the thinking process of a participant when he or she answers a survey question or participates in a large focus group. Cognitive interviewing allows the researcher to elicit from an individual the thinking behind the answers, providing researchers with a more detailed understanding that is critical to improving consumer documents.

For this study, we conducted 16 one-on-one interviews (each lasting 90 minutes) in two sites: St. Louis, MO and Buffalo, NY. Our participants were recruited from two groups—uninsured and self-pay (non-group coverage). We interviewed nine men and seven women, and a range of ages and educational levels. Based on our observations, these consumers had a wide range of familiarity with health insurance concepts, ranging from quite expert to completely unfamiliar with terms like “deductible,” “coinsurance,” and “benefit limits.” (See Appendix A for demographic summary of participants.)

Cognitive interviewing does not require high numbers of participants to get a reliable sense of problems in a document. According to Virzi, 80% of usability problems are uncovered with five (5) participants and 90% with ten (10) participants.⁶ After ten participants, very few new problems emerge, and the interviews, at that point, tend to provide confirmation of existing findings.

⁶ Indeed, a concurrent CFL testing effort used 4 focus groups of 10 participants each reached similar conclusions. See: http://www.naic.org/documents/committees_b_consumer_information_110603_ahip_bcbsa_consumer_testing.pdf. See also: Virzi, R. (1992). Refining the test phase of usability evaluation: How many subjects is enough? *Human Factors* 34, 457–486.

Structure of Interviews

Each test session was structured to assess how participants interacted with the Consumer Facts Label in the context of choosing a health plan. The testing questions and scenarios were designed to mirror real world shopping for coverage as closely as possible.

Test Documents. We used two different plan designs, each featuring different premiums, cost-sharing, and benefits, displayed in pages 1–4 of the Summary of Coverage form. These pages display standard information, such as plan type, premium, deductible, co-insurance, individual costs to the consumer, such as doctor visit and emergency room visit, and some definitions of terms. The format of pages 1–4 was the same in all test documents.

Pages 5 and 6 of the form, the Coverage Facts Label, had two different designs:

- In Version 1, a table for each example showed costs associated with each healthcare service. Above each table were three figures: (1) the amount owed to providers, (2) what the plan pays, and (3) what the patient pays. We refer to Version 1 as the detailed version.

Exhibit 1. Segment from Version 1 of Coverage Facts Label

Having a baby	
Amount owed to providers: \$10,000	
<ul style="list-style-type: none"> ■ Plan pays \$0 ■ You pay \$10,000 	
Sample care costs*:	
First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200
You might pay:	
Deductibles	\$0
Co-pays	\$0
Co-insurance	\$0
Benefit limits or exclusions *	\$10,000
* Costs are based on in-network rates. Because maternity is not covered under this plan, out-of-network rates may apply, which would be higher than shown here.	

- Version 2 showed a list of healthcare services without showing the cost of each. In the table were two figures: the allowed amount for treating each condition, called “Allowed Amount,” and the amount that the patient pays. We refer to Version 2 as the “rolled-up” version.

Exhibit 2. Segment from Version 2 of Coverage Facts Label

Maternity (normal delivery)		
	Allowed Amount	Patient Might Pay
Diagnosis, pre-natal care (includes office visits, ultrasounds, and laboratory tests), prescription pre-natal vitamins, normal delivery (hospital stay for 2 days), post-partum care	\$10,000	\$1,000

(See Appendix B for the full versions of the prototype documents used in the testing.) We alternated which health plan design and which CFL version was presented first.⁷

Test Tasks. Participants completed the following tasks:

- **Task 1. Think Aloud Activity.** Participants were asked to “think aloud” as they reacted to the six page Summary of Coverage form. Participants could look at the pages in any order, skipping around if they wished. Without asking them to focus on the CFL, we captured their initial reactions to health plan information: areas they responded well to, areas they did not understand, and areas they questioned. We asked probes as the participants expressed their thoughts about what they were looking at or reading.
- **Task 2. First Comparison.** Participants were given a Summary of Coverage for the second health plan. They were asked to think aloud as they compared the two plans. At the end of this portion, participants were asked which plan they would choose, why they chose that plan, and how the Summary of Coverage affected their decision. We observed the order in which they looked at sections of the documents, which parts weren’t used, and which parts of the documents were difficult for them to understand.
- **Task 3. Comprehension of the CFL.** We asked participants to focus their attention on the CFL. We asked them to find specific information (such as how much the patient would pay for certain treatments) to gauge their comprehension. They were asked why they thought they were given the CFL, and whether the CFL would help them choose a health plan. The moderator noted whether the participants went back to pages 1–4 to see how the examples fit with the health plan information they had previously read over. The moderator also asked for their overall impression of the CFL. Some questions were designed specifically to ascertain whether the participants read and/or understood page 6, the second page of the CFL.
- **Task 4. Comparison of Two Versions of the CFL.** Tasks 1–3 utilized just one of the two versions of the CFL. At this point, participants were asked to react to the second design. We alternated which design the participants saw first. As before, we encouraged the participants to think out loud and took note of their interaction with the new version. We asked targeted questions to determine their understanding of the new CFL. Finally, we asked a direct question about which version they preferred.
- **Task 5. Health care utilization questions.** We asked participants brief questions about their health care utilization, including their history with health insurance, with major

⁷ In St. Louis, some participants were given only pages 1–4 of the Summary of Coverage for one plan, and the full six page form for the other plan, to see if and how the absence of the CFL was commented on. Strong consumer preference for CFL’s inclusion led us to change this approach so that we could use our time to better explore the label by always including it in the materials.

illnesses, and with filing claims. These questions were intended to establish if prior experience with health insurance claims provided a “leg up” in understanding and using the CFL. The questions were optional but all participants agreed to answer them. No participants had significant experience with health insurance claims payments.

Overall Findings for Coverage Facts Label

The CFL filled an important information gap

When consumers shop for health coverage, they overwhelmingly desire a “bottom line” number that tells them how much the plan will pay for health services in exchange for their monthly premium payment. Many refer to this as shopping for the “best value” plan; they want to find the sweet spot between coverage for the health care they need, balanced against the premium they can afford. Participants in this study understood that higher premiums will result in more coverage and lower premiums will result in less coverage but they found it very difficult to get a firm grasp on how much coverage they were actually buying. Multiple information gaps interfere with making this assessment:

- uncertainty about their future health,
- lack of knowledge of treatment steps,
- uncertainty about the cost of treatment steps, and
- uncertainty about their share of the treatment costs under the plan.

Not surprisingly, the CFL cannot help consumers assess their future health care needs. The CFL, however, did help consumers better understand treatment steps, overall costs and their share of those costs. In fact, participants in this study found it eye opening to see this new information.

Armed with this information, the CFL helped consumers formulate a better understanding of the role of insurance in providing financial protection against those costs, and a better sense of what they were getting for their monthly premium expenditure. As one participant put it,

...it's kind of like going into a house when you're buying a house. You want to imagine what is going to be in that house and what kind of furniture you're going to have...this [Version 1] gives you that imagination of what you could be using the plan for, what you could be spending this money for—and on, and how much money you'd be spending.
—St. Louis 3

Participants, in general, could see the tradeoff between costs and benefits, seeing that higher costs result in more benefits.

...price is a big thing for me because it's all coming out of my pocket...[Looking at CFL] I guess this is an average of how much per year, \$7800 and then they would cover the \$6800 a year which would be pretty awesome if you are unfortunate enough to have diabetes. So yeah all those numbers look really impressive. —St. Louis 6

But again, the first thing that sticks out to me is what I pay, and the minute I see what I pay, then I feel like I would be making the right choice on the plan. —Buffalo 3

The CFL provided a concrete anchor for the benefits of the plan

Most of the participants found the discrete cost-sharing information listed on pages 1–3 confusing.⁸ In contrast, the CFL information on page 5 was fairly straightforward and accessible to them. The “bottom line” nature of the information was clearer to participants, whereas the discrete cost-sharing information (pages 1–3) discussed concepts that were unfamiliar to them, as well as required significant calculations on their part in order to be useful.⁹

[In pages 1–4] there is nothing to imagine, there’s nothing to see. There’s nothing to give you an idea of how much you’re going to pay or how much something costs if you have a certain medical condition. Where this, I mean a lot of people...most women can imagine having a baby if they haven’t already, or diabetes or breast cancer—this gives them an idea, a visual of oh my gosh, this really could cost \$64,000 for chemotherapy, and this is what the plan can pay, and this is what I’d have to pay in case of this situation. And this [pages 1–4] gives you nothing. —St. Louis 3

[On the first four pages] there isn’t anything concrete that I can understand exactly what it’s going to be to me, what my fair share is going to be...[on page 5] it doesn’t have to be relevant to you, it gives you a good example.” —Buffalo 6

The CFL reduced participants’ inherent skepticism about health plans

Participants perceived the information on pages 1–4 as costs they have to pay and were sometimes suspicious of the health plan, wondering why there was a premium and then a deductible and then a deductible for pharmacy costs and then copays and then many other things that did not count toward the deductible.

Well, if I was going to get health insurance, I would want a health insurance that’s going to provide health insurance for me [and] that’s also going to pay.... When I go to the doctor, I’m going to pay \$10, \$20 for every time that I go. [It’s] not I get paid my entire doctor bill up until \$5,000, before I’m just paying \$10, \$20 every time I go to the doctor. —Buffalo 6

⁸ Page 4 of the form includes other information (not cost-sharing and not CFL information). The information on this page was fairly well understood by participants. (See Appendix B for an example of the test documents.)

⁹ This cost-sharing confusion is discussed in more detail in Section “Specific Findings, Pages 1–4” below.

Many participants developed a more favorable impression of the coverage after seeing page 5. They felt better about deductibles of \$2,500 and \$5,000 when they saw what they *weren't* paying and also felt better about the premium costs.

I would probably choose the \$481 [monthly payment] because like I said it's easy to pay a smaller amount than "today's Tuesday and now I got to have \$5,000 by Wednesday." So it's a big difference in trying to pay \$2,500 so yeah, I think I would probably rather pay a couple dollars more so when I do get hit, I'll pay less... —Buffalo 4.

[In looking at pages 1–4] \$5,000 deductible. Forget that. ... That's too high. ...there better not be a copay if they want \$5,000 deductible. ... [In looking at page 5] I look at [this deductible] \$5,000, that's ridiculous. But then when you think [breast cancer] may cost you \$98,000... —St. Louis 7

The CFL made it clearer why health coverage is important

After seeing the overall cost of treatment, participants noted that the importance of having coverage was clearer since the cost of a major illness could be financially ruinous.

Wow! Treating breast cancer—\$98,000. That's pretty crazy. I never really thought about that. I have known a couple friends of the family that have had breast cancer and I can't imagine going through that and having to pay \$98,000. That's definitely pretty awesome that they [the health plan] would pay \$94,000 of that. —St. Louis 6

Chemotherapy, \$64,000, wow. Radiation therapy \$13,000. Prosthesis [inaudible], pharmacy \$2,000. Mental health \$200. You might pay deductibles of \$2,500, copay \$200, benefit limit or exclusions up to \$5,000 so maybe \$500. So in total I might pay \$3,200 on a \$94,000 bill. That's not bad at all. —Buffalo 8

Specific Findings, Page 5

Participants looked at tabular information first

Participants, in general, looked at the table presentation on both versions of the CFL before they read the text above and to the left. Their natural inclination was to scan this prose information rather than to read it. Part of this attention to the table occurred because the previous four pages used tables to hold key information and they had “learned” that important information was placed in tables. For example, they skipped the prose “definitions” at the top of page 2. In addition, research shows that participants typically look at graphical presentations of information before even noticing information presented as prose.¹⁰

No, it didn't even cross my mind which now, once I read that it, was like one of those smack yourself in the forehead...the 3 examples they aren't completely relevant; it's just examples. That kind of just summed it up for me, an extra little kick in the butt to realize what I was looking for. —Buffalo 2

I didn't even look at the top [of page 5] because the chart stands out to me more than text. —Buffalo 3

Consumers preferred version 1 due to the detail provided

Most consumers liked having the cost detail in Version 1 because it gave them a sense of what their costs might be. The detail of the individual costs as well as the individual services anchored the consumers to understanding the table. In addition, the three amounts (what was owed, what the plan paid, and what the consumer paid) helped participants to better understand the purpose of the examples. At the same time, the amount of detail was limited (9 items in “sample care costs” and 4 items in “you might pay” and the phrasing was strongly parallel across the three examples, thus allowing participants to process the information without overwhelming them.

You'd want to know if I was having such and such done what is going to be covered and what is not going to be covered, It's not exact but it's still going to be close. —Buffalo 6

¹⁰ See Karen Schriver, “How Prose and Graphics Interact, “ (pp. 406–441) in *Dynamics in Document Design*, 1997, Wiley Computer Publishing, New York.

I think this [Version 2] is not as helpful because it's just a lump amount. So even though it tells you what's included it's not breaking down where those expenses are. So this [Version 1] is more helpful than this [Version 2]. —Buffalo 1

I like this [Version 1]. The lump sum one doesn't do you any good. —St. Louis 7

Participants understood that the amounts were estimates

Almost all participants understood that the examples did not give a precise estimate of their own costs if they were to need one of these three health services or if they needed a similar health service. Participants derived this information based on their previous experience with health care/health insurance or their own reasoning skills when they saw the list of “sample care costs” in Version 1 or by noticing one or more of the sentences telling consumers that these were only examples.

They [the plan] don't want to say exactly how much something is because it could be way more or way less. They don't want to pay more than they have to or make someone pay way more than they have to. —St. Louis 2

...you'd want to know if I was having such and such done what is going to be covered and what is not going to be covered. It's not exact but it's still going to be close. —St. Louis 6

...say I have breast cancer I only have to pay \$5700 so I think those are important and again it's nice that they do make it very clear these are just examples. —St. Louis 4

The multiple uses of conditional language undermined the credibility of the CFL

Participants often reacted negatively to the many uses of “might” and other conditional language. More than one participant commented on the ambiguity created by suggesting that coverage exists and then using conditional language to suggest that the information is not quite accurate. For example, the subtitle “How this health plan might cover health care costs;” in Version 1, the first column includes “might cover” and “protection you might get.” Likewise, the information under “Important” tells the reader how not to use the examples.

I think it could ...using the words that give me confidence rather than make me question it more. Like we were talking about “should” and “could” and “would” and “maybe” and “there could be more charges.” There's a lot of things that just makes you worry. —St. Louis 2

The word “might”...patients “might” pay...that is kind of a sketchy word. I’m not comfortable with that word. —Buffalo 2

So I’m going to pay you \$334 a month, I’m going to pay for my family a \$10,000 deductible, and you “might” cover my health care cost? I don’t like the word at all. I don’t even want to read that. —Buffalo 6

The three medical scenarios were viewed as logical and helpful

With a few exceptions, participants liked the medical scenarios and felt they made sense. It seemed to them that an appropriate variety had been provided, even though not all of the examples were relevant to them. They noted that the scenarios were “common” events, such as having a baby, and included both a catastrophic illness and a chronic illness.

It’s a broad spectrum; it’s three completely different things, kind of breaks it down what each one entails as well...I’m going to guess that’s three things that are huge in the nation. I think breast cancer is a big thing. Obviously diabetes is a big thing and maternity may be the biggest thing. To me that’s why they use three examples because it’s three things that are...important things. People are dealing with daily and things of that nature. —Buffalo 4

Maternity is an event, breast cancer is some sort of cancer, so ongoing treatment and [diabetes] is like maintenance of an existing condition, this is like something that someone has to deal with for the rest of their life. —St. Louis 4

Even if participants did not see the examples as relevant to them medically, they could use them to assess the health plan’s level of coverage.

I mean, people with diabetes know it costs them a lot of money to, as it says, have routine maintenance of the condition. So that would be very helpful to them, if they’re in this plan and they’re covered, to know, ballpark, what they might wind up paying. —St. Louis 8

A few participants wanted an example that would be more relevant to them than maternity coverage.

All participants were asked what additional examples (if any) would help them. Participants recommended the following scenarios:

- ER visit for a routine emergency, such as a broken leg, not a catastrophic emergency
- treatment of heart disease/heart attack
- stroke

- cancer instead of breast cancer
- checkup
- colonoscopy

This participant's response was fairly typical:

[In response to a request for an alternative example] Maybe heart surgery. Probably something that you would consider more minor like broken bones or expenses from a car accident or something like that. It might be more common and less expensive but that, hopefully, the insurance would pick up a good deal of money for. —St. Louis 8

The asterisk and associated text did not help participants

For the health plan that didn't cover maternity, both CFL versions included information, referenced by an asterisk, that explained how patient costs should be viewed and reminding them that maternity was not covered. Many participants did not see the asterisk. Once they did, they had difficulty understanding what it was attempting to convey. Few participants understood the text the asterisk linked to, which tried to convey that in-network costs may not be representative of the patient's costs, when maternity is not covered by the plan.

That asterisk ruins everything...The asterisk is confusing without clarification...
—Buffalo 3

...oh, here it's saying that you've got to pay the \$10,000 here because they don't cover maternity, it's an asterisk down at the bottom. I didn't notice the asterisk until now. Because I was looking at the top part, I wasn't looking at the bottom. —Buffalo 6

The CFL helped clarify the coverage of maternity

Some participants understood from pages 1–4 when maternity was *not* covered, but all figured it out by the time they reviewed page 5. On the other hand, most participants had great difficulty assessing when maternity was covered using pages 1–4. In point of fact, participants could only assess this by the absence of an exclusion on a chart on page 3—an incredibly difficult cognitive task. Quite understandably, they were insecure about whether they had figured it out correctly.

Page 5 (the CFL) provided the confirmation that they needed. In addition, it provided an indication of what their share of the cost would be—something impossible to figure out from pages 1–4.¹¹

...and then my plan pays zero so that means if you pay zero to the provider and then I pay \$10,000... So that policy doesn't cover having babies. This one does...they cover this 90%. —Buffalo 8

Few participants reconciled “You Pay” detail with the plan’s cost sharing provisions

Participants rarely tried to reconcile the CFL “you might pay” detail (Version 1) back to the plan’s underlying cost-sharing provisions. Most calculated the rough share paid by the plan, were satisfied with the result, and did no additional calculations. For some, this approach may have reflected the extreme difficulty they had understanding the cost-sharing information on pages 1–3.

A minority of participants did try to reconcile some of the detail in the Version 1 “you might pay” column back to the earlier information. When they could link the information to parts of the Summary of Coverage (such as the deductible amount for breast cancer), they gained confidence in their assessment of the plan. For the remaining provisions, which they couldn’t link back, we observed two responses: most assumed that this was just due to their incomplete understanding of the information on pages 1–4 or they simply assumed it was beyond them. The few participants with an expert understanding of health plan cost-sharing were mildly frustrated that the calculations weren’t more self-evident.

These consumer experiences demonstrate another value of the CFL. The information in page 5 of the CFL not only complements but supplements the information on pages 1–4 of the form. Put another way, the detail on pages 1–4 is insufficient to provide a clear sense of patient costs in many situations. Page 5 provides information that wouldn’t otherwise be on the form.

For example:

- In Plan 1, maternity is paid based on a global fee to the provider that includes all prenatal care, delivery and post-natal care. The member only pays for the initial office visit when the pregnancy diagnosis was made (despite the fact that treatment includes multiple office visits), co-payments for two ultrasounds, and their share of the hospital fee.

¹¹ Patient costs for maternity reflected that fact that the plan pays a global fee to providers, so patients just pay for their initial office visit, co-payments for two ultrasounds, and their share of hospital costs. It isn’t possible to know this based on pages 1–3.

- In Plans 1 and 2, routine eye exams are not covered. Yet these exams were covered for the diabetic scenario because it was a service provided during a normal office visit (Version 2 of the CFL lists eye exams as covered, although that detail wasn't present in Version 1).
- In Plan 2, specialty drugs (including chemotherapy) are subject to 50% coinsurance according to page 3. However, because chemotherapy is not self-administered, these drugs are not subject to the pharmacy deductible but to the medical deductible. (Chemotherapy drugs are administered in the doctor's office.) In the example, the medical deductible was reached once the surgery was complete. The patient's out-of-pocket limit was also reached (being identical to the medical deductible), so the coinsurance on the chemotherapy drugs was effectively zero.

Specific Findings, Page 6

Participants were reluctant to read page 6 in both designs. Both the layout and the content discouraged nearly all participants from even wanting to read the text on this page.

Page 6 used too few graphical elements and was too “wordy”

Participants were put off by the change from the five highly formatted pages that relied on tables rather than prose to convey information.¹² Compared to pages 4 and 5, page 6 had much less white space, so that the contrast with earlier pages was even higher. As a result, many commented that page 6 looked like too much to read and was too dense (“too wordy”). To some extent, they assumed that this information was not important because it had no “special” treatment and so there was little reason to read it.

If something is really important they are not going to put it in a big block of text on the back page [page 6] or at least I hope they would not. —St. Louis 1

[The only graphics are in the Checklist (bullets and checks).] I mean the stuff that is dotted and checked kind of looks like they want to tell you that it's important or more important than other stuff. I would probably read them first. —St. Louis 5

The content of page 6 was repetitive and uninformative

The few participants who read page 6 (either version) on their own thought it added no information or stated the obvious. Even when prompted to look at it, participants did not say that it was useful. One participant said there was no “ah ha” information on the page. For example, after reading “Choosing a Plan” on Version 1, participants felt it had told them what they already knew. However, some liked having their process of choosing a plan reinforced by the bulleted list.

I don't know there is anything that stands out at all [on page 6]...It doesn't seem like it has any facts or any numbers or anything to go by...[It] Looks boring...It doesn't seem like these all would be I guess important things to know...They should make it [pages 5 and 6] all one thing. —St. Louis 2

¹² See Schriver.

It's pretty much saying what I already said through it [that the estimates cannot be exact] and so it's just reiterating it and I'm not seeing that's necessary to drive it home that you're not giving me all the information I need to make a decision [such as when you would pay]. —St. Louis 1

Participants preferred the Q&A format of Version 2 to the prose presentation of Version 1

Participants were able to skim the Q&A format of Version 2 better than that of Version 1. However, their opinion of the layout remained the same. They did not find either format inviting to read and thought the questions, and especially the answers, were repetitive.

[Looking at page 6] I like the fact that there're columns, so it doesn't span across the entire page, each sentence. I like the questions and answers. —St. Louis 3

I like the question and answer format first off because it does—I mean these are questions that you would have. But they are there for you. So it leads you right to what you want to read about. —St. Louis 1

Participants disliked the conditional language

As was true on Page 5, participants disliked the use of the conditional language because it suggested that the health plan was covering itself, rather than helping the participants.

I just don't like any of [the section on Page 6 marked "Using These Examples"]. It's a lot of words. It seems like it could be said a lot simpler...I like clear, concise information and this is just a lot of backpedaling. Could be different based on your doctor's advice, could be different based on your age...tell me something I don't know. —St. Louis 1

Why Version 1 Was Preferred

As noted above, Version 1 was preferred by a clear majority of participants. A few participants preferred Version 2. These participants skimmed the listed services, were interested only in the “Patient Might Pay” information, and found the details of Version 1 confusing and uninteresting.

Most (including those who had a preference for Version 2) struggled with certain elements of Version 2.

In Version 2, the phrase “Allowed Amount” was confusing

In Version 2, participants struggled to understand what “Allowed Amount” meant. To some, it referred to the amount that out-of-network providers would be able to collect or be able to charge. To others, it was the annual benefit limit and many thought it was the amount paid by the plan. Even if they returned to page 2 of the form, they could not find the definition of “allowed amount.”

I’m a little hung up on what “allowed amount” means. I’m not sure what that means.

—Buffalo 8

If I had a better definition here of what allowed amount meant...But here [on page 5], I’d have to go back and say, “Now what did they mean by allowed amount?”—Buffalo 6

Their wording of allowed amount is what is really irritating, without saying what they mean by allowed amount. Is it the maximum?—St. Louis 7

In Version 2, most participants did not calculate what the plan paid

While participants understood the amount of “Allowed Amount” and could see what the “Patient might pay,” they did not comment on the amount that the plan paid. By comparison, with Version 1 participants almost always commented on how much the plan was paying for breast care treatment or for maternity. Making that information explicit as in Version 1 helped participants understand the benefit they received from having health care coverage.

[Looking at Version 2] ...so ultimately the insurance company is not paying this much [allowed amount], this is how much it’s going to cost. You’re paying this much of that and the rest is being covered. So I was completely wrong in saying this is the total.

—Buffalo 4

In Version 2, participants lost the opportunity to see how their personal situation might affect costs.

When participants had the details of Version 1, they were able to determine how costs could change. For example, one participant commented on how she might not need anesthesia for maternity and so her costs could be lower. In addition, without details, participants seemed to question the reliability of the rolled up number of Version 2. They were unsure if they could trust the number because they simply didn't know what the "Allowed Amount" represented and where it was coming from.

[In Version 1] breaking it down as far as what if I didn't want to do the anesthesia for having a baby? It kind of gives you options so you can see how much things cost and see if that would work for you. —St. Louis 3

It is a little bit easier to compare. You can look up how much is chemo by itself and not just having that lumped in with all the other things you'd have to pay for. —St. Louis 6

Specific Findings, Pages 1–4

Although the goal of the project was to test consumer reactions to the Coverage Facts Label, the testing approach allowed us to observe participant reactions to pages 1–4. While an earlier version of these pages was tested, the current version includes untested revisions.¹³

Most participants liked and used pages 1–4

Many participants talked about how the grid-style layout made it easy to find important information, such as premiums and deductibles.

[The summary is] pretty easy to read and appealing, versus just paragraphs and paragraphs of words you don't understand. —St. Louis 1

[The summary is] bullet pointed so they are easy to read, not in big blocks of text. Because people do not have attention spans to go through all that. —St Louis 5

Just basically a break down, a limited break down what exactly to expect from the policy. It's very fair as far as giving you a heads up that there are going to be expenses. It's nice to see nothing can sneak up on you. —Buffalo 8

Most were able to find the key information

Participants could find premium, deductible, and other important plan features. They noticed the column marked “limitations and exclusions.” They also noticed the box listing “services the plan does not cover” and the one listing “other covered services.”

Page 4, services your plan does not cover. Just having that in a box is appealing to me, and just having it bullet pointed. —St. Louis 3

¹³ Consumers Union and People Talk Research, *Early Consumer Testing of New Health Insurance Disclosure Forms*, December 2010.

Almost all were confused by key cost-sharing information

Participants were often confused by terms such as “co-insurance,” “allowed amount,” “annual limit,” and “out-of-pocket limit,” although they understood they were important. To try to understand these terms, some participants read and re-read definitions (if they noticed them, which was also challenging).¹⁴ Many noted that they would get help from a friend or a broker to help them understand the plan’s cost-sharing features.

As a reminder, our participants included a wide-range of individuals – those who’ve had insurance most of their lives as well as some who’ve had long periods of being uninsured. Even those with coverage struggled with the cost-sharing terms on the Summary of Coverage form. In part, this could be attributed to no participants reporting that they used their insurance for a serious illness or accident—an event that sometimes causes them to become more familiar with how their plan features work.

These findings—confirming findings of other studies—suggest that consumer difficulties with cost-sharing concepts are a critical barrier to the meaningful comparison of health plans.¹⁵

Participants struggled with the concept of “co-insurance”

I’m confused already, why you have co-insurance if your limits are the same as the deductible. —St. Louis 8

I’m not really understanding this whole coinsurance thing very much. —Buffalo 4

[Reading the coinsurance definition over again out loud] I’m still not totally clear on that. —Buffalo 6

...zero percent coinsurance with 40%... I don’t understand that. —Buffalo 8

Why does this say zero percent? ... I don’t know. They want it to look too good to be true. Somebody is paying something; I just want to know who is paying it. Make it a little more

¹⁴ Another consumer product being developed by the NAIC is a glossary of insurance and medical terms. This document was not provided to participants in light of the significant number of pages we were asking them to review. However, another study included this glossary in the test documents and found that it wasn’t sufficient to overcome participant confusion with these terms. In some cases, the confusing term was missing from the glossary, in other cases the explanation wasn’t robust enough or lacked needed context or numeric examples. Consumers Union and Kleimann Communication Group, *Early Consumer Testing of Actuarial Value Concepts*, July 2011.

¹⁵ Consumers Union and People Talk Research, *Early Consumer Testing of New Health Insurance Disclosure Forms*, December 2010.

cut and dry. The zero percent coinsurance should say...I just want to know what I'm paying. —Buffalo 7

Participants were confused by “allowed amount” and the lack of a definition

And just going down here, the plan's payment for covered services based on the allowed amount, that is unclear about what the allowed amount is because it was just saying basically it is going to pay for everything, you have a deductible and then it will pay for everything after that, so what exactly is the allowed amount if it is paying for everything? —St. Louis 5

Participants were unclear about “annual limit”

So I don't know what they mean by set an overall annual limit? Limit on what? I don't know. —Buffalo 8

Participants were confused by “out-of-pocket limit”

[Out-of-pocket limit] is never going to get hit... Co-payments don't count towards it, premium, billed charges, prescription drugs, health care this plan doesn't cover. That seems to me like everything I would use insurance for... It almost seems as if it's saying once you meet this deductible you're still paying 20% of the hospital bill ... if I'm reading this correctly ..., if I may go back and look again, throws this out-of-pocket limit right out of the window because your deductible matches your out-of-pocket limit. ...it just seems to me as if a lot of this on the front was just hogwash. There is no limit to what you would spend. —Buffalo 4

Why would [the out-of-pocket limit] exceed the limit of \$2,500 if that is the limit? —Buffalo 2

Recommendations

Based on participants' statements and our observation of their reactions, our preliminary recommendations are as follows:

- 1. Select Version 1 and use an information designer to reformat the CFL and the Summary of Coverage (all 6 pages).** Clearly hard work has gone into the development of the Summary of Coverage as well as the CFL, but both need the vision of a professional information designer. An information designer is skilled at keeping design functional and practical. Many of the issues that we have identified could readily be handled with a person who is accustomed to using design to emphasize information and to ensure usability. Here are some of the issues that an information designer would be able to address:
 - **Test a new title for this page and then use consistent language to refer to the [Consumer Facts Label] within the document.** Pages 5 and 6 are labeled “Examples of Plan Coverage” and “Coverage Examples.” It also has a subtitle of “How this Plan Might Cover Health Care Costs” with references to the Plan Summary. All of this variation creates a dissonance for the reader and a lack of clarity. Instead of “Examples of Plan Coverage,” consider testing “Coverage Examples” or “Sample Costs for Three Medical Scenarios” to see if these titles help consumers better understand the purpose of the information.
 - **Put more emphasis on the three key pieces of information in the examples.** In the current design, it is difficult to “quickly” see how the three pieces of information above the “sample care costs” fit together. Putting equal emphasis on the three terms “Amount owed to providers,” “Plan pays” and “You pay” could help. Bullet all or bullet none.
 - **Don't use varied shading in the bullets on plan pay/you pay lines.** Participants tried to link these to the shaded rows down below (i.e., perhaps you just add up all the light blue rows in the table to get to the total). Make these a uniform color that is not the same as the row shading.
 - **Standardize shading for table rows on pages 1–4.** In the forms tested for this study, sometimes every other row was shaded; sometimes, adjacent rows were shaded. Some participants tried to understand the logic behind the shading, but could not. The pattern needs to be intentional. At the same time, the shading needs to avoid the optical illusion of stripes since that can interfere with ease of reading.

2. **Reduce the warnings.** Let the new CFL title carry the bulk of this duty. Remove much of the text from Column 1 and replace it with the assumptions about the examples. Avoid the use of “might” in the section “You might pay.” “Might” was highly distracting for about half of the participants, and seemed to do little to increase understanding of the estimate. To avoid the repetition of “You pay,” consider a phrase like “Your payment comes from.”
3. **Retain one disclaimer about the examples.** This information could be in text in the left column. The warning that runs across the top of the page is too big and will be distracting in Version 1.
4. **Use a different approach than the asterisk approach to convey information on the costs of not-covered-maternity coverage.** The asterisk approach was hard for participants to decipher. Instead, consider adding text like this when the service is not covered:

- **Amount owed to providers: \$10,000**
- **Plan Pays: \$0**
- **You Pay: \$10,000 (because maternity is not covered out-of-network rates apply, which could be higher than shown here)**

5. **Delete the “questions” text in the left column on page 5.** It duplicates the information in the footer and participants easily grasped that they could call the health plan with their questions. In addition, most participants said that they would *google* any term that they did not understand.
6. **Omit most of the current information on page 6.** If consumers don’t read it, then it is real estate that could be put to better use. Including information that consumers consider repetitive or uninformative undercuts the positive attitudes created by the information on page 5.
7. **Retain a less wordy version of “Choosing a health plan.”** While most participants felt the content was self-evident, they also found the information in the checklist to be reassuring.
8. **Use the rest of page 6 for definitions.** Because most participants did not see the definitions on page 2, it seems useful to consider including a short glossary of terms that were most confusing to consumers. The key phrases seem to be:
 - Copay: Show how copay interacts with the deductible, and how copay services are not subject to the deductible.

- Deductible: clarify that some services are not subject to the deductible.
- Coinsurance (move from page 2 where they are overlooking in): Make it completely obvious that 20% is an example. When this was located on page 2, a few participants believed that the plan described in the document had coinsurance of 20% (it did not).
- Allowed amount: See earlier discussion.
- Annual benefit limit: clarify that this limits the patients' coverage and trumps other provisions
- Out-of-pocket limit: Clarify that this benefits the patient

In Appendix C, we've included a sample of what page 6 could be like if recommendations 6, 7, and 8 are used. Compared to the varying approach to definitions on pages 1 and 2, these definitions are grouped together and ordered in a sequence that could be useful to consumers.

- 9. Develop more medical scenarios.** Given the highly accessible nature of the CFL information (compared to consumer struggles with some of the information on pages 1–4), we recommend developing several additional scenarios. The new scenarios should have broad relevance, such as the oft-requested ER example. Other scenarios might be a well child visit, treatment for asthma, or annual treatment for a heart condition. We do not recommend adding more scenarios to the paper version of the Summary of Coverage form but would provide these additional examples online.
- 10. Test any changes.** These recommendations are hypotheses based on consumer feedback and our own observations. Testing future changes will tell us whether the change was useful for consumers and which issues need further refinement.

Remaining Research Gaps

Consumer confusion about cost-sharing concepts remains a critical shortcoming in the ability of consumers to use this form to make an informed choice among health plans. With no clear concept of the financial protection offered by the plan, consumers are effectively shopping “blind.” A key goal of section 2715 of the Affordable Care Act—allowing consumers to “compare health insurance coverage and understand the terms of coverage”—is not yet realized.

The coverage facts label partially addresses this shortcoming. The information was readily understood, and it provided a valuable benchmark as to how well the plan covered three medical scenarios. Despite the fact that consumers appeared willing to use this information to make assumptions about the coverage of closely-related medical scenarios, the coverage facts label doesn’t help consumers understand their costs for other situations. For example, if the patient had been treated for another illness earlier in the plan year, most participants would not have been able to calculate the impact on their costs for diabetes. Most wouldn’t even know how to set up the question.

The highest priority must be additional research to figure out how to better convey health plan cost-sharing features to consumers, as well as the interactions between those features. This testing must take into account the full range of health insurance literacy that exists in the consumer population.¹⁶ A second, closely related area of research would guide policymakers on the tradeoffs between reducing plan complexity (by standardizing plan features) and preserving consumer choice. This study—as well as others—suggests there may be a net benefit to consumers by simplifying the underlying choices.¹⁷

A third area of research is learning to leverage the finding that displaying information on what the plan pays, instead of what the patient pays, elicits a much more favorable reaction from consumers. As policymakers and exchange designers conduct outreach to increase the take-up of coverage, this finding could be leveraged to reduce consumer aversion to health insurance shopping.

¹⁶ Prior testing found that health insurance literacy—that is, familiarity with, understanding of, and confidence using health insurance concepts—greatly influenced consumers’ ability to use the health insurance materials. Note that health insurance literacy differs from health literacy, a broader concept that has been well defined and has had several measurement tools developed. Health insurance literacy is one component of health literacy. A widely accepted measure of health insurance literacy has not yet been developed, but the concept is nonetheless central to consumer ability to use health insurance materials.

¹⁷ See, for example, Making Health Insurance Choices Understandable for Consumers – Meeting Synopsis (Consumers Union, March 2011) or this summary of consumer focus groups in Massachusetts: https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%20Us/Publications%20and%20Reports/2011/2011-1-13/CommChoice%20July2011%20SOA_Jan13%20Board%20Meeting_v6.pdf

Finally, we highly recommend additional consumer testing of the CFL. Formatting changes, as well as new medical scenarios, should be tested. In addition, it is important to note that this study captures consumers' interactions to the CFL when they are a "blank slate." While many consumers have previously encountered the core elements of pages 1–4, the information on page 5 is new to them. We should anticipate that consumers' response to the CFL (as well as the overall form) will evolve once the form becomes more common. This round of testing (as well as other studies) shows that consumers rely heavily on prior experience with insurance to interpret health plan information. As such, we should reexamine how well the Summary of Coverage form and the Coverage Facts Label are working once they go into widespread use.

Conclusion

The CFL fills a critical need. The CFL information provides a completely different and valuable way for consumers to assess health plan offerings (compared to considering just the enrollee's cost for the premium and the deductible). In addition, the participants in this study readily understood that the CFL was an estimate and not a precise amount that the plan would pay for them. Finally, the CFL provided a concrete anchor for the benefits and cost-sharing described in pages 1–4 of the Summary of Coverage form.

Most important of all, the accessible, readily understood nature of the CFL makes it a true boon to consumers, at least partially revealing the extent of the coverage they are purchasing for their premium dollars. In the absence of the CFL, consumers struggle to extract this information from pages 1–3 of the form.

Introduction of a new process or new information is challenging and risky for both consumers and the health plans. Consumers are at risk of not understanding the information and therefore thinking it irrelevant, not useful, or misleading. Health plans are at risk if consumers misunderstand or misinterpret the materials. Consumer testing, and the resulting refinements to the document, can serve to reduce these risks and help ensure that the document achieves the policy goals associated with the disclosure requirement.

This round of testing identified the relative strengths of two alternative approaches and was able to show based on participants' performance that one design was superior to another. In addition, the changes recommended should further enhance the understanding and usability of the document for consumers. Additional rounds of testing will enable further refinements of language and presentation and further provide insurance that the document will work in positive ways for consumers and for the health plans.

Appendix A. Participant Demographics

For this study, we conducted 16 one-on-one interviews (each lasting 90 minutes) in two sites: St. Louis, MO, and Buffalo, NY. Our participants were recruited from two groups—uninsured and self-pay (non-group coverage). We interviewed men and women, and a range of ages and educational levels. Based on our observations, these consumers had a wide range of familiarity with health insurance concepts, ranging from quite expert to completely unfamiliar with terms like “deductible,” “coinsurance,” and “benefit limits.”

Participant Demographics		Number of Consumers
Total Participants		16
Participants by location	St. Louis, MO	8
	Buffalo, NY	8
Gender	Male	9
	Female	7
Married	Yes	11
	No	5
Race	Black	0
	White	14
	Other (Asian or Pacific Islander)	2
Hispanic/Latino	Yes	1
	No	14
	Other	1
Age	26–30	5
	31–40	5
	41–64	6
Education	Less than high school, high school or GED	3
	Some college or a 2-year college program	3
	College graduate	8
	Post-college education	2
Household Income	Less than \$30k	4
	\$30,000–39,999	2
	\$40,000–59,999	5
	\$60,000–\$79,999	0
	\$80,000–\$99,999	5
Employment Status	Full-time homemaker	2
	Not currently employed but looking for work	2
	Owns own business	1
	Employed part-time outside home	2
	Employed full-time outside home	9
Health insurance status	Currently insured (self-pay)	8
	Not currently insured	8

Appendix B. Materials Used In Testing

The following pages show the six-page form for one plan, using Version 1 of the CFL. The other plan design, and the alternate CFL version, can be viewed on the NAIC website:

- http://www.naic.org/committees_b_consumer_information.htm

PPO Plan 1: Insurance Company 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO



This is not a policy. You can get the policy at www.insurancecompany.com/PLAN1500 or by calling 1-800-XXX-XXXX. A policy has more detail about how to use the plan and what you and your insurer must do. It also has more detail about your coverage and costs.

Important Questions	Answers	Why this Matters:
What is the premium ?	\$481 monthly	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible ?	\$2,500 person / \$7,500 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes; \$300 for pharmacy expenses	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$2,500 person / \$7,500 family	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Co-payments, premium, balance-billed charges, prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.insurancecompany.com for a list of participating doctors and hospitals.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network , preferred , or participating for providers in their network.
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

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PPO Plan 1: Insurance Company 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay/visit	40% co-insurance	—none—
	Specialist visit	\$50 co-pay/visit	40% co-insurance	—none—
	Other practitioner office visit	20% co-insurance for chiropractor acupuncture	40% co-insurance for chiropractor and acupuncture	—none—
	Preventive care/screening/immunization	\$0	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance	40% co-insurance	—none—
	Imaging (CT/PET scans, MRIs)	0% co-insurance	40% co-insurance	—none—
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions .	Generic drugs	\$10 co-pay (retail); \$10 co-pay (mail order)	40% co-insurance	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	20% co-insurance (retail and mail order)	40% co-insurance	—none—
	Non-preferred brand drugs	40% co-insurance (retail and mail order)	60% co-insurance	—none—
	Specialty drugs (e.g., chemotherapy)	0% co-insurance		—none—

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VERSION #1 Page 2 of 6

PPO Plan 1: Insurance Company 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	40% co-insurance	—none—
	Physician/surgeon fees	0% co-insurance	40% co-insurance	—none—
If you need immediate medical attention	Emergency room services	0% co-insurance	40% co-insurance	—none—
	Emergency medical transportation	0% co-insurance	40% co-insurance	—none—
	Urgent care	0% co-insurance	40% co-insurance	—none—
If you have a hospital stay	Facility fee (e.g., hospital room)	0% co-insurance	40% co-insurance	—none—
	Physician/surgeon fee	0% co-insurance	40% co-insurance	—none—
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	0% co-insurance	40% co-insurance	After 8 visits, not covered.
	Mental/behavioral health inpatient services	0% co-insurance	40% co-insurance	—none—
	Substance abuse disorder outpatient services	0% co-insurance	40% co-insurance	—none—
	Substance abuse disorder inpatient services	0% co-insurance	40% co-insurance	—none—
If you have a recovery or other special health need	Home health care	0% co-insurance	40% co-insurance	—none—
	Rehabilitation services	0% co-insurance	40% co-insurance	—none—
	Habilitation services	0% co-insurance	40% co-insurance	—none—
	Skilled nursing care	0% co-insurance	40% co-insurance	—none—
	Durable medical equipment	0% co-insurance	40% co-insurance	—none—
	Hospital service	0% co-insurance	40% co-insurance	—none—
If your child needs dental or eye care	Eye exam	Not covered	Not covered	—none—
	Glasses	Not covered	Not covered	—none—
	Dental check-up	Not covered	Not covered	—none—

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

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PPO Plan 1: Insurance Company 1

Summary of Coverage: What this Plan Covers & What it Costs

Policy Period: 1/1/2011 – 12/31/2011

Coverage for: Individual + Spouse | Plan Type: PPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- | | | |
|---|-----------------------------|----------------------------------|
| • Bariatric surgery | • Dental care (child/adult) | • Routine eye care (child/adult) |
| • Non-emergency care when traveling outside of the U.S. | • Infertility treatment | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Routine hearing tests |
| | • Private-duty nursing | • Weight loss programs |

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- | | | |
|---------------|---------------------|----------------|
| • Acupuncture | • Chiropractic care | • Hearing aids |
|---------------|---------------------|----------------|

Your Rights to Continue Coverage:

You can keep this insurance as long as you pay your premium unless one or more of the following happens:

- you commit fraud
- the insurer stops offering services in the state
- you move outside the coverage area

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Call 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.com.
- An **appeal** is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-XXX-XXXX or visit www.XXXXXXXXXXXXXX.gov.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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PPO Plan 1: Insurance Company 1

Policy Period: 1/1/2011 – 12/31/2011

Examples of Plan Coverage: How this Plan Might Cover Health Care Costs

Coverage for: Individual + Spouse | Plan Type: PPO

About these Examples of Plan Coverage:

These examples show how this plan might cover medical care in three situations.

Use these examples to see, in general, how much insurance protection you might get from different plans.



Important

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

? Questions

Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

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Having a baby

Amount owed to providers:
\$10,000

- Plan pays \$9,000
- You pay \$1,000

Sample care costs:

First office visit	\$100
Radiology	\$300
Laboratory tests	\$200
Routine obstetric care	\$2,000
Hospital charges (mother)	\$4,100
Hospital charges (baby)	\$1,900
Anesthesia	\$1,000
Circumcision	\$200
Vaccines, other preventive	\$200

You might pay:

Deductibles	\$900
Co-pays	\$100
Co-insurance	\$0
Benefit limits or exclusions	\$0

Treating breast cancer

Amount owed to providers:
\$98,000

- Plan pays \$94,800
- You pay \$3,200

Sample care costs:

Office visits & procedures	\$4,000
Radiology	\$4,000
Laboratory tests	\$2,400
Hospital charges	\$3,300
Inpatient medical care	\$200
Outpatient surgery	\$3,400
Chemotherapy	\$64,000
Radiation therapy	\$13,000
Prostheses (wig)	\$500
Pharmacy	\$2,000
Mental health	\$1,200

You might pay:

Deductibles	\$2,500
Co-pays	\$200
Co-insurance	\$0
Benefit limits or exclusions	\$500

Managing diabetes

Amount owed to providers:
\$7,800

- Plan pays \$6,800
- You pay \$1,000

Sample care costs:

Office visits & procedures	\$960
Laboratory tests	\$300
Medical equipment & supplies	\$40
Pharmacy	\$6,500

You might pay:

Deductibles	\$300
Co-pays	\$260
Co-insurance	\$400
Benefit limits or exclusions	\$40

PPO Plan 1: Insurance Company 1

Policy Period: 1/1/2011 – 12/31/2011

Examples of Plan Coverage: How this Plan Might Cover Health Care Costs

Coverage for: Individual + Spouse | Plan Type: PPO

More information about Examples of Plan Coverage:

Using these examples

You should receive a Summary of Coverage for plan(s) you are considering.

Compare the examples in the “Examples of Plan Coverage” section with the examples for other plans. The treatment plan and related costs for each condition are the same for all plans to allow comparison between plans. However, the portion of the costs you pay may differ, depending on the plan’s cost sharing rules and benefit limits.

When you compare the examples from plan(s) you are considering, ask yourself:

Would I be comfortable paying the share of expenses shown in these examples?

Which plan pays a share of costs that I am comfortable with, and charges a premium I can afford?

Important things to know about these examples

These examples are designed to help you compare different plans. They aren’t meant to give complete or specific costs.

While these examples can help you see the different levels of coverage in different plans, you can’t use them to estimate costs for an actual condition. The care you would receive for a condition could be different, based on your doctor’s advice, your age, how serious your condition is, the prices your providers charge, and the charges your plan allows.

These examples are based on the following assumptions:

- The costs don’t include premiums.
- Your condition was not an excluded, pre-existing condition.
- There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.

- You received all care from in-network providers. If you had received care from out-of-network providers, costs would have been higher.
- All services and treatments started and ended in the same policy period.

Why were costs higher the out-of-pocket limit in some examples?

When you receive treatment that a plan doesn’t cover, the amount you pay doesn’t count toward the out-of-pocket limit (OOP). Also, plans may have co-payments, special deductibles, or other costs that don’t count toward the OOP. For example, a plan might limit mental health visits to 8 per year. The breast cancer example is based on more than 8 visits, so the costs of visits after the 8th one wouldn’t count toward OOP.

For more information

If you have other questions about what a plan covers, please call us toll-free at 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

Choosing a plan:

You want a plan that gives you the coverage you need at a cost you can afford. This Summary of Coverage can help you compare plans.

- ✓ Compare the specific coverages and exclusions listed in the chart starting on page 2. See which plan best meets your needs.
- ✓ Compare the “Examples of Plan Coverage” to see which plan pays a share you are most comfortable with.
- ✓ Finally, consider other costs when you compare plans, such as your premium and also take into account contributions to medical accounts such as health reimbursement accounts (HRAs), health savings accounts (HSAs), or flexible spending accounts (FSAs) that help you pay out-of-pocket expenses. Your agent, broker, or employer can help you determine how these impact your overall costs.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com.

If you aren’t clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

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Appendix C. Example of Using Page 6 for Key Definitions

The following, untested, example is included to illustrate recommendation 8.

PPO Plan 2: Insurance Company 2

<p>Choosing a Plan</p> <p>You want a plan that gives you the coverage you need at a cost you can afford. When comparing plans, look at:</p> <ul style="list-style-type: none"> ✓ Which services are covered and which are excluded (pages 2–4) ✓ Your share of the cost for covered services (pages 1–5) ✓ Premium—your [monthly] cost for this coverage. ✓ Other costs, such as contributions you make to Health Savings Accounts or Flexible Spending Accounts. ✓ Other benefits, such as contributions your employer makes to health savings accounts or Health Reimbursement Accounts to help you pay out-of-pocket expenses. <p>Before choosing, consult the definitions or call the plan to be sure you understand the provisions that affect your costs.</p>	<p>Definition of Terms</p> <p>Co-payments or copays are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service. Services paid this way aren't usually subject to the deductible.</p> <p>When a service is subject to a deductible, you must pay all the costs up to the deductible amount before the health insurance plan begins to pay for covered services.</p> <p>Once you met your deductible, co-insurance is <i>your</i> share of the cost of these covered services.</p> <hr/> <p>EXAMPLE: If the allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200.</p> <hr/>	<p>The plan's payment for covered services is based on the allowed amount. This is an amount that the plan and their in-network providers have agreed to limit the charge to.</p> <p>If you use an out-of-network provider, they may charge more than the allowed amount and you may have to pay more as a result.</p> <hr/> <p>EXAMPLE: If an out-of-network hospital charges \$1,500 for an overnight stay but the allowed amount is \$1,000, you may have to pay the \$500 difference, <i>in addition to</i> the normal coinsurance amount. (This is called balance billed charges.)</p> <hr/>	<p>Many of your costs for using in-network providers are capped by the out of pocket limit — the most you pay during a policy period (usually a year). Note: this limit never includes your premium, balance-billed charges or health care your health plan doesn't cover. Some health insurance plans exclude some of your other payments from this limit (see page 1).</p> <p>You may also have to pay the full cost of services that exceed the plan's annual limit.</p> <hr/> <p>EXAMPLE: The plan limits coverage of outpatient mental health to 8 visits. You have to pay the full costs of visits 9 and above.</p> <hr/> <p>You can find more definitions at www.insurance terms.com</p>
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Questions: Call 1-800...