

HEALTH POLICY
BRIEF
JANUARY 2012

What's Behind the Door: Consumers' Difficulties Selecting Health Plans

SUMMARY

Consumer testing by Consumers Union confirms the widely held perception that people struggle to understand their health insurance policies. This information gap has grave consequences for consumers and for the success of most health reform approaches. Indeed, improving consumers' ability to shop in the health insurance marketplace is an area of great untapped potential. But realizing this potential will require a multi-layered policy approach. It will require greater standardization of products in the marketplace, along with better tools for communicating health plan features to consumers. Both strategies will require an in-depth understanding of how consumers shop for coverage and the barriers they face. Rigorous consumer testing provides the nuanced information that can lead to measurable improvements in consumer understanding. This brief highlights the findings from three consumer testing studies. These consolidated results provide a strong foundation for regulatory and legislative efforts to enact policies and provide tools that improve consumers' understanding of health insurance, as well as health plans' own efforts to improve customer communications.

Consumer testing by Consumers Union confirms the widely held perception that people struggle to understand their health insurance policies. These difficulties are so profound that the vast majority of consumers are essentially being asked to buy a very expensive product—critical to their health—while blindfolded. As in the game show “Let’s Make a Deal,” they must make a selection without knowing what’s behind the door.¹ This information gap has grave consequences for consumers and for the success of most health reform approaches.

Why Engage In Consumer Testing?

If policymakers or regulators start with an incomplete or erroneous understanding of how consumers shop for health insurance, they will not design appropriate policies or regulations. However, these entities are hampered by a very limited amount of data on how consumers shop and the barriers they face. There is a general perception that shopping for and using health insurance is

difficult, but the detailed empirical evidence needed to improve health plan communications and consumers' health insurance knowledge is virtually absent.²

Consumers Union, the advocacy and policy arm of *Consumer Reports*, conducted three rigorous consumer testing studies that explored consumers' detailed reactions to health plan information (Exhibit 1).³ Using a diverse group of participants, the testing sessions always started with open ended questions about how participants perceive health insurance and how they approach shopping for coverage. The sessions then presented participants with different types of health plan information, noting their reactions and asking them to perform tasks with the information, such as picking the best plan for themselves out of two options. With one exception, the health plan designs were real products offered in the individual or non-group market.⁴

EXHIBIT 1: THREE CONSUMERS UNION STUDIES EXPLORE CONSUMER UNDERSTANDING OF HEALTH INSURANCE

Study Examined:	When:	Locations: Mid-sized cities in...
"Traditional Health Plan Information," as displayed in a new health insurance disclosure	Sept-Oct 2010	IA, NH, CA, OH
A new type of disclosure, called "Coverage Examples"	May 2011	MO, NY
Actuarial Value Concepts	May 2011	CO, MD

Participants were evenly divided between men/women and uninsured/individually-insured (non-group). Participants had a range of education levels, ages (26-64), and racial/ethnic backgrounds. The complete studies are available at www.consumersunion.org.

Key findings from these studies are described on the following pages. These findings provide a critical knowledge foundation for future policy, regulatory and communications development. These findings are relevant not only to the implementation of the Affordable Care Act⁵ but for any policy approach that relies on consumers to play an active and informed role in the marketplace. Specific policy recommendations to strengthen consumers' understanding of their health coverage are included at the end of this brief.

Consumers Dread Shopping for Health Insurance

Study participants report that they dread shopping for health insurance.

While these consumer attitudes may not come as a surprise, the policy implications of this research should be fully considered. Because consumers find shopping for coverage very difficult, they will take short-cuts to "get through"

I think medical insurance is probably one of the hardest things I shop for. And I think one of the hardest things [is] to figure out what's covered.
-Columbus, OH

the task. The use of short-cuts mean that well-intentioned consumer decision aids (like a glossary or improved health plan disclosures) may not be used. Further, policy objectives such as spurring health plan competition may not be realized. As described in more detail below, it is critical that we consider consumers' attitudes towards health insurance when formulating policies and regulations.

Some Consumers Doubt the Value of Health Insurance

A significant number of participants expressed doubt about the value of purchasing coverage.

Many of the study participants approached the purchase of insurance as a budgeting exercise. However, the exercise weighed just their *expected* future medical expenses (paid out of pocket) against the cost of the premium plus remaining costs after insurance. A portion of the participants didn't assign any value to potential *unexpected* medical expenses that insurance could cover. This incomplete understanding of the purpose of insurance—combined with the fact that health insurance is a very expensive product—led some consumers to initially decline all the options provided during testing.

Other testing showed that these perceptions can readily be altered. Showing participants how much an unexpected medical event like breast cancer costs, as well as the portion paid by the health plan, had a significant impact on the participants' perception of the value of insurance. Viewing these new materials (called Coverage Examples) made consumers more aware of how expensive medical care can be and provided a more concrete sense of how much the plan would pay in the event of a serious medical event.⁶

Consumers Don't Want The Cheapest Plan

Participants were very clear and consistent about what they looked for when shopping for health insurance. In the introductory discussions, consumers revealed they were very concerned about cost but they didn't want the cheapest plan—they wanted the plan that represented the best *value* they could afford.

Consumers' perceptions of value were fairly sophisticated. For a given premium, they wanted to know how much coverage they would get. They viewed coverage as including both the scope of covered medical services and share of costs paid by the plan. Mentioned somewhat less frequently was whether their doctor was in the plan and/or the quality of providers in the plan.

Consumers Can't Assess The "Value" of Health Plans

Unfortunately, almost all participants were stymied in their desire to identify the best value plan among those offered. While their *concept* of value was sophisticated, participants had little *ability* to assess the overall coverage offered by a plan. Participants' discussions and our observations from the exercises revealed there are myriad reasons why consumers can't calculate value—with profound implications for their role in the health insurance marketplace.

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

—Buffalo, NY

Cost-Sharing Terms Are The Greatest Source Of Confusion

The most critical take away from the testing studies is the fact that consumers can't review "traditional" health plan information like deductibles, co-insurance levels and benefit maximums and figure out what it means for them. In essence, we are asking the vast majority of consumers to buy a very expensive product, yet to do their shopping blindfolded.

Our studies yielded nuanced information about why health plan cost-sharing features are so confusing.

JARGON IS UNFAMILIAR

Many consumers were familiar with the terms premium and co-pay but many of the remaining terms were unfamiliar. In particular, the terms co-insurance, annual benefit limit, allowed amount, out-of-pocket limit and drug tier were often unfamiliar. Yet these terms are used to describe key features present in almost all health plans.

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 cut and dry.

—Buffalo, NY

COST-SHARING CONCEPTS ARE DIFFICULT

Even if consumers were familiar with a cost-sharing term, they often did not have a good understanding of the underlying concept or how to use it to calculate value.

In some cases, participants had a partial understanding of the concept. For example, they realized that co-insurance indicated how costs were shared between the patient and the plan, but they weren't sure *who* paid the indicated 20%—was it the patient or was it the plan? ⁷ In similar fashion, they weren't sure who the out-of-pocket maximum or benefit limits helped – was this good for the patient or good for the plan?

Other concepts, like drug tiers or the terms "preferred drug" and "non-preferred drug," were simply unfamiliar to them.

Significantly for future consumer research, consumers would sometimes self-report that they understood a term like co-insurance, but usability exercises revealed that in fact they couldn't use this concept when trying to calculate their share of costs under a simple, hypothetical medical scenario.

SOME COST-SHARING AMOUNTS ARE UNKNOWABLE

Co-insurance was particularly frustrating for participants, because the implications for the consumer are actually unknowable. Even if they had a good understanding of who paid the indicated co-insurance percentage (the patient), they still didn't know what it really meant for them. This is because co-insurance is applied—not to the actual charge—but to the *allowed amount* for the service. The allowed amount for a service isn't available to consumers when they are purchasing a health plan or even when they are already enrolled and about to use medical services.

The “unknowable” aspect of co-insurance represented a large, undesirable financial risk for consumers. Irrespective of how sophisticated their understanding of co-insurance, consumers simply cannot calculate what this common health plan feature means for them.

CONCEPTS MUST BE COMBINED TO ASSESS OVERALL COVERAGE

As the co-insurance discussion indicated, using health plan cost-sharing concepts in isolation is difficult enough. But if consumers want to understand the overall value of the health plan, they have to be able to combine these concepts to arrive at a bottom line. They must understand the order in which to apply the cost-sharing concepts (*first you pay the deductible...*) and understand the exceptions (*there is a separate drug deductible...*). Then they must take into account rules that vary from plan to plan (*do co-pays count towards the deductible?*).

The bottom line is that grasping all the rules needed to “roll up” the plan's cost-sharing provisions and assess its overall coverage level is an enormously difficult cognitive exercise.

A HIGH LEVEL OF NUMERACY IS REQUIRED

Consumers need two different types of skills to understand and apply health plan cost-sharing provisions. One skill is an understanding of the basic concepts and how they are applied. The other skill is a high level of numeracy. Numeracy is the ability to reason with numbers and other mathematical concepts.

As an example, a portion of our participants struggled with percentages. Some simply couldn't calculate 20% of \$1,000. Hence, even if cost-sharing concepts

Say I get an MRI.
I pay 20% of the
allowed maximum.
I have no idea
what that number
is. I want to know
that.

-Columbus, OH

were simplified, some consumers will still struggle to understand their bottom line if a high level of math skills is required.

PERCEIVING HIGH LEVELS OF FINANCIAL RISK, HMO PLANS ARE PREFERRED BY SOME

The purchase of health insurance carries with it a degree of financial uncertainty for the consumer. Even consumers with a sophisticated understanding of cost-sharing provisions aren't really sure what their future medical expense might look like and how much they'll owe. For some consumers, however, their comfort level is high enough that they accept this uncertainty in exchange for the certainty that they have some degree of coverage in the event of an expensive medical event. They feel comfortable enough to choose among their options.

For some of our participants, however, this comfort level was absent. Lack of certainty about what they would owe represented an enormous risk to them. Many in this group expressed a strong preference for an HMO-style plan with fixed co-pays, because it significantly reduced the risk associated with the "black box" of more confusing cost-sharing provisions. This preference appeared to supersede any assessment of which plan actually provided more coverage.

This perception of risk was compounded by a strong mistrust of health plan materials, as discussed below.

Some Medical Service Descriptions Are Confusing

While not as significant as consumer confusion about cost-sharing terms, consumers did struggle with selected medical service terms. Common examples revealed in testing included:

- What is the difference between primary and preventive care?
- What are specialty drugs?
- How is a diagnostic test different from a screening?

Consumers Need a Manageable Number of Choices

The Consumers Union studies typically asked participants to compare just two health plans at one time. As described above, even this small set of choices was a very difficult exercise for consumers due to the myriad health plan features that varied across plans. This suggests, and consumer behavioral research confirms, that an unlimited number of health plan choices is not helpful to or desired by consumers.⁸ Comparing a large number of options, when a large number of features are all varying at the same time, is simply an impossible cognitive task.

Clarity is Insufficient; Information Must Also Be Trusted

If consumers don't trust the source of the information, they won't use it.

Most consumers in our studies revealed they do not trust health plan documents. A perception that many carried into the testing session was the health insurers are "tricky" and that important information was buried in the "fine print" of the policies.

Unfortunately, that means that even participants with a strong ability to evaluate health plan documents lacked confidence in their own analysis. They wanted someone else to check their assessment because they believed there was something in the proverbial fine print that would represent a critical omission.

This implies that even a well-designed communication may not turn consumers into effective, confident shoppers if it is not trusted. If consumers are to play their role in the health insurance marketplace, health plans, Exchanges and insurance regulators must cultivate and merit a reputation for trusted information.

Implications of Consumer Confusion

The implications of these findings are profound. Health insurance is a product that is necessary for the health and financial well-being of families. It is also very expensive, particularly for consumers without employer coverage who purchase on their own.

This confusion isn't just a hardship for consumers; it has profound implications for the way our health care markets operate. Consumers may end up in plans that leave them underinsured. This isn't just a case of not being able to afford more coverage—it is also the result of not understanding the coverage you bought.⁹ Underinsured consumers delay getting care, with implications for their health and the ultimate treatment costs for their disease.¹⁰ Underinsurance can lead to medical debt and even bankruptcy. If these families can't pay their medical bills—despite having coverage—these costs end up being paid by tax payers and other privately insured consumers.

Consumer confusion also adds costs in the health system, for example, by tying up customer help lines—those operated by health plans and those operated by state regulators and advocacy groups.¹¹

When consumers can't assess their choices, health insurance markets don't operate efficiently. Health plans can exploit this confusion in order to gain market share, rather than compete on the basis of price and value.¹² On both

You know you get handed so much paperwork that you really overlook all this stuff, and you get to the fine print, and you're not really able to read it, or you're tired of reading all this paperwork.

-Manchester, NH

sides of the political aisle, policymakers and experts seek to encourage the “right” type of health plan competition. Many believe efficient health insurance markets are integral to reining in our nation’s rapidly growing health care costs. This proposition cannot be tested until consumers can participate as effective, informed shoppers.

What is the Policy Prescription?

Getting to the point where consumers can function as effective, informed shoppers will require at least four different types of interventions.

INCREASED STANDARDIZATION OF HEALTH PLAN CHOICES

Other interventions will not be effective unless the underlying health insurance product becomes less complex. This isn’t a call for removing all health plan variation, but a call for reducing variation to a point where consumers are faced with a manageable amount of variation.

The Affordable Care Act (ACA) makes significant strides in this direction. It eliminates lifetime limits, phases out annual dollar limits, and requires full coverage for a standard set of preventive services. In 2014, in the non-group and small group market, the ACA caps the maximum out-of-pocket costs that consumers will have to pay and requires plans be offered at pre-set actuarial value levels. In addition, plans offered in these markets must cover a standard set of medical benefits. Significant cost-sharing and provider network variation will remain, but it is much reduced compared to health plan choices before the reforms.

Consumer testing in Massachusetts suggests that consumers may prefer even less variation. This state enacted reforms that used actuarial value tiers that are similar to those in the ACA. Focus group testing reveals that consumers in that state preferred even greater standardization. This testing found that 6-9 distinct plan designs were the ideal number.¹³

Policymakers and regulators must be cognizant of the trade-off between having many plans that don’t vary too much in their design vs. fewer plans but a greater variety of designs that are offered. Consumer testing in each state should be used to identify the “correct” balance.

BETTER, TRUSTED HEALTH PLAN DISCLOSURES

The format, design, order of presentation and source of health plan information are all features that have a profound impact on how and whether consumers will use the information.

"It's kind of like
...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...[Coverage
Examples] gives
you that image of
what you could be
using the plan for,
what you could be
spending this
money for...and
how much money
you'd be spending."
—St. Louis, MO

A key first step is to identify a trusted source for comparative health plan information. In light of low trust levels for health plans, a third-party may be needed to provide "vetted" information. As brand new entities, the new Health Insurance Exchanges have a unique opportunity to cultivate an image as a trusted source of information. However, this must be a conscious act on the part of Exchange designers. Simply doing nothing may cause consumers to transfer their low level of trust for health plans to the Exchange.

Even more important is that Exchanges or other third-party sources operate so as to *merit* consumer trust. This can be accomplished by using rigorous, data driven methodologies to vet health plans and health plan provided data. Comparative health plan data must be accurate, timely and reflect a keen understanding of consumer preferences. Important coverage exceptions must be easily found, not hidden in fine print. Ideally, this trusted data will be available for all plans in a market, not just those offered through an Exchange.

This trusted data must be presented in a way that is usable for consumers. When consumers are faced with a cognitively difficult task, they look for short-cuts to help them get through the task. An example might be selecting a recognized brand name or asking their neighbor which plan they would choose.

Regulators and consumer educators can anticipate and leverage this tendency by providing consumers with tested, reliable cognitive short-cuts. Examples might include:

- Letter grades indicating health plan quality,
- Out-of-pocket spending estimates that roll up those complex cost-sharing provisions, or
- Having the default sort for plan choices be highest quality first or lowest out-of-pocket costs first.

The Affordable Care Act includes new consumer aids that can also serve this purpose:

- Actuarial Value Tiers – a method of grouping health plans by the average level of coverage provided,
- Coverage Examples – a table that shows the total cost and how the cost would be shared between the plan and the patient for some fixed medical scenarios, to be displayed as part of a new disclosure called the Summary of Benefits and Coverage, and
- Other measures that examine provider network adequacy, claims payment policies and more.

Our consumer testing showed that both the actuarial value tiers¹⁴ and the coverage examples¹⁵ were enormously helpful to consumers. Use of these tools was intuitively apparent to consumers. Further, the tools helped consumers with

the most difficult aspect of plan comparisons for consumers: comparing plans on the basis of how much coverage the plan offers.

More consumer testing work should be done to improve the display of health plan information and to identify the additional decision aids (cognitive shortcuts) that will be reliable and helpful to consumers.

CONSUMER EDUCATION

There is no doubt that timely, well crafted consumer health insurance education will also help. Some of this can be done in academic settings, but there is also a significant need for “just-in-time” information that consumers can use when they are shopping for or using their coverage. By providing a manageable amount of information *at the point when it is needed*, consumers are more likely to pay attention and make use of the information. Again, consumer testing should be used to develop these materials to ensure that they are effective and accommodate a wide variety of languages, cultural backgrounds, and learning styles.

Indeed, the open enrollment period that will precede January 1, 2014 (when leading health reforms take effect) is a unique period in which it will be easier to command consumers’ attention about health insurance issues. The new reforms are a big change and consumers will proactively be seeking information on what the changes mean for them and what they have to do.

IN-PERSON ASSISTANCE

It is not realistic that increased standardization, better disclosures and timely consumer education are sufficient to make a majority of consumers effective shoppers. Health insurance will remain a complex product and a significant portion of consumers will need trained in-person assistance to help them with the task.

In light of the financial and health implications of their choice, it is only right that consumers be provided with understandable choices, and armed with strong disclosures and high quality assistance. Let make consumers make an informed choice – let’s not make them guess what’s behind the door.

This brief was written by Lynn Quincy, Consumers Union Senior Health Policy Analyst. The consumer testing studies described in this brief were conducted by Consumers Union. Studies one was made possible by the generous support of California HealthCare Foundation and the Commonwealth Fund. Study two was made possible by the Missouri Foundation for Health and the New York State Health Foundation.

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Consumers Union is the policy and advocacy division of *Consumer Reports*. We have a long history of advocating for improvements in the consumer marketplace. Since our creation in 1936, we have worked for safer, more affordable, and better quality products and services at both the state and federal levels. We are a non-profit, non-partisan organization with an overarching mission to test, inform and protect.

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ENDNOTES

- ¹ "Let's Make a Deal" was a popular game show that ran on network television from 1963 until 1977. Contestants had to choose between a known medium value prize and a hidden prize that could be either much more or much less valuable. See: http://en.wikipedia.org/wiki/Let's_Make_a_Deal
- ² See literature review discussion in *Towards a Measure of Consumers' Health Insurance Literacy: An Expert Roundtable Discussion*, Consumers Union, forthcoming, January 2012.
- ³ The complete studies can be found using the links below:

<u>Study Examined:</u>	<u>Date:</u>	<u>URL:</u>
Traditional health plan information, as displayed in a new health insurance disclosure	Sept-Oct 2010	http://www.consumersunion.org/Consumer_Testing_Dec_2010
A new type of disclosure, called "Coverage Examples"	May 2011	http://www.consumersunion.org/Coverage_Examples_Testing_Aug_2011
Actuarial value concepts	May 2011	http://www.consumersunion.org/Actuarial_Value_Testing_Sept_2011

- ⁴ The actuarial value study required using plan designs that fit into specific actuarial value "tiers" so these plan designs were calculated by an actuarial firm. The plan designs are representative of the type of plans that will be available to consumers in 2014, if the current health reform law is not repealed or changed. The plan designs can be viewed in the report *Early Consumer Testing of Actuarial Value Concepts*, Consumers Union, September 2011.
- ⁵ The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act, signed into law March 30, 2010.
- ⁶ *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance*, Consumers Union, August 2011. <http://cu.convio.net/avreport>
- ⁷ The documents used in testing included information on who paid the coinsurance percentage although--as the tests revealed--ineffectively. The complete reports include the testing documents. You can view a representative sample document here:

http://www.naic.org/documents/committees_b_consumer_information_hhs_dol_submission_1107_social_populated.pdf

- ⁶ A large body of consumer behavioral research has demonstrated that there are limits to the number of choices a consumer can effectively evaluate. See, for example, the discussion in Yaniv Hanoch and Thomas Rice, "Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance," *The Milbank Quarterly*, Vol. 84, No. 1, 2006.
- ⁷ For example, see this article about a woman who was surprised to learn her plan didn't cover maternity: <http://www.chicagotribune.com/health/hk-insurance-policies-pregnancy-coverage,0,7041645.story>
- ⁸ Cathy Schoen, Sara R. Collins, Jennifer L. Kriss and Michelle M. Doty. "How Many Are Underinsured? Trends Among U.S. Adults, 2003 And 2007," *Health Affairs*, 2008. <http://content.healthaffairs.org/content/early/2008/06/10/hlthaff.27.4.w298.full.pdf>
- ⁹ For example, research by United HealthGroup found that creating more understandable written communications may help reduce calls to a customer call center. These potential cost savings through call avoidance for this population are estimated at approximately \$4 million dollars per year for Part D and Medicare Advantage products. These findings are not on the web but can be viewed by contacting the author of this brief.
- ¹⁰ Randall D. Cebul, James B. Rebitzer, Lowell J. Taylor, Mark E. Votruba. *Unhealthy Insurance Markets: Search Frictions and the Cost and Quality of Health Insurance*, NBER Working Paper No. 14455, October 2008.
- ¹¹ *Health Reform Toolkit Series: Resources from the Massachusetts Experience, Determining Health Benefits Designs to be offered on a State Health Insurance Exchange*, November 2011. <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/MassachusettsExperienceBenefitDesignsToolkit.pdf>.
- ¹² *Early Consumer Testing of Actuarial Value Concepts*, Consumers Union, September 2011. http://www.consumersunion.org/Actuarial_Value_Testing_Sept_2011
- ¹³ *Early Consumer Testing of the Coverage Facts Label: A New Way of Comparing Health Insurance*, Consumers Union, August 2011. http://www.consumersunion.org/Coverage_Examples_Testing_Aug_2011