Early Consumer Testing of New Health Insurance Disclosure Forms

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Table of Contents

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Staff from the Research Department of Consumers Union (CU) attended all focus group sessions and contributed to the both the findings and recommendations sections of the report. This staff was lead by Ed Farrell, director of Market Research, and included Andrew Vogel, Michelle Leonard and Karen Hoffman. Sambhavi Cheemalapati, research manager from CU's Information Services division, also attended most sessions and provided valuable insights and analysis. Chuck Bell provided early guidance and support.

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Lynn Quincy, CU's senior health policy analyst and research manager, conceived of and directed the project. Ms. Quincy serves as a consumer representative to the NAIC. As such, she tailored the project's schedule and scope to the activities of the NAIC working group developing the prototype *Summary of Coverage* health insurance disclosure forms. She drafted sections of the report, reviewed the report findings and, in concert with the project team, developed the recommendations.

Executive Summary

The Affordable Care Act (ACA) calls for health insurers to begin using a new, standard health insurance disclosure form to convey the benefits and cost-sharing provisions of their health plan offerings. This form must employ standard terms and definitions and is intended to all consumers to "compare health insurance coverage and understand the terms of coverage (or exceptions to that coverage)." The ACA requires all insurance plans to use this form – group and non-group, grandfathered and non-grandfathered – beginning in 2012. As such, these disclosures will affect over 180 million insured Americans when the requirement goes into effect.

This Consumers Union study explores whether early prototypes for this *Summary of Coverage* form meet the needs of consumers. Specifically, do study respondents find the form appealing, does the form provide the information that respondents are looking for and is it a usable document?

The study used focus group discussions and usability exercises to address these questions. These testing sessions included 112 men and women in four small cities around the country. These respondents were evenly divided between those currently uninsured and those enrolled in non-group (individually-insured) coverage. Importantly, the respondents exhibited a wide variety of health insurance literacy levels, enabling us to gauge the effectiveness of the forms with respondents well versed in health insurance terms, as well as those who are unfamiliar with such concepts.

We find that initial responses to the prototype health insurance disclosure forms were positive. The forms were perceived as visually appealing and consumer-friendly. The forms were well suited to comparing health plans due to their grid-style presentation and because they contained most of the information that respondents wanted to see (for example, premiums and whether their doctor was in the plan's network).

The critical and most important exceptions to these favorable reviews were:

- Significant participant difficulty with cost-sharing concepts (allowed amount, coinsurance, benefit limits, deductibles, etc.)
- Significant participant difficulty with covered service definitions (understanding what was included in specific service categories, like preventive care)

These areas of confusion not only frustrated respondents but could lead them to select a plan that was not in their best interest. Significantly, this confusion was almost universal. We observed difficulty with cost-sharing among fairly well-educated folks who had always been insured and among participants who had long periods of being uninsured.

While many policymakers, regulators and researchers may have already have a general understanding of consumer difficulties with cost-sharing concepts, studies such as this one provide the critical, *nuanced* understanding needed to fine-tune disclosure forms. To illustrate, many participants affirmed that they were familiar with the term "coinsurance." Yet, when asked to use the prototype coverage forms to estimate their cost-sharing for a particular service, some were unsure who paid the 20%—the policyholder or the insurer. Other participants understood *who* paid 20%, but didn't understand "allowed amount" – the amount of money the coinsurance rate is

applied to. Consequently, even some of these more savvy participants could not use the information to figure out their costs under a given medical scenario.

In addition to identifying consumer responses to the prototype forms, this report contains valuable information about how consumers approach health insurance purchasing. For example, shopping for health insurance was an aversive task, fraught with anxiety for many respondents. They were afraid of making a costly mistake if they chose the wrong plan. Even respondents with good health insurance literacy skills lacked the *confidence* to choose a plan, reflecting a concern that it would expose them to potential financial liabilities.

We also saw that participants didn't rely exclusively on the *Summary of Coverage* form to assess the plans. They combined information on the form with information from their past or current insurance plan in order to reach conclusions. For example, if their prior insurance plan didn't count copayments towards the deductible, they assumed the plans in front of them operated the same way. This behavior suggests that a need for standardization and consistency of health insurance cost-sharing concepts so that consumers can learn how the various components interact, rather than relying on (possibly false) assumptions.

This deep-seated consumer confusion and lack of confidence with respect to health plan cost-sharing also underscores the challenges facing those tasked with implementing health reform. These findings have significant implications for any venue that provides comparative displays of health insurance information, like the future state exchanges and the HHS web portal. The findings also have implications for policies that rely on the ability of consumers to make informed health insurance purchasing decisions (such as "consumer driven health care" policies). Finally, they have implications for other consumer-facing documents like the "explanation of benefits" statement (EOB) insurers provide when claims are filed.

This Consumers Union study demonstrates how consumer testing can fill evidence gaps and help policy realize its intended goals. As the nation begins to roll out health reform, stakeholders of all types will be very vested in consumer responses to those changes. Policymakers, regulators and others should carefully consider the value of this type of testing and build consumer testing activities into the work of the special commissions and working groups that are tasked with health reform implementation.

Background

The Affordable Care Act (ACA or the Act)[1] calls for a new health insurance *Summary of Coverage* disclosure form which uses standard terms and definitions "so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to that coverage)." The ACA requires all insurance plans to use this form – group and non-group, grandfathered and non-grandfathered – beginning in 2012. As such, these disclosures will affect over 180 million Americans when the requirement goes into effect.[2]

The legislation contains several requirements constraining the form's design.[3] The form cannot be more than 4 pages in length; and must include:

- uniform definitions of standard insurance and medical terms;
- a coverage description, including cost-sharing for major benefits (eg, mental health);
- coverage exceptions, reductions, and limitations; and
- overall cost-sharing provisions (eg deductibles)

The ACA calls for U.S. Department of Health and Human Services (HHS) to draft the regulations governing this form, after consulting with the National Association of Commissioners (NAIC). As directed by the Act, the NAIC formed a Consumer Information subgroup comprised of insurance commissioners, representatives of health insurance-related consumer advocacy organization, health insurance issuers, health care professionals, patient advocates (including those representing individuals with limited English proficiency), and other qualified individuals. The immediate role of the subgroup is to draft the prototype *Summary of Coverage* form and an initial set of medical and insurance terms and definitions.[4]

Ideally, these disclosures will help consumers become informed, activated purchasers of coverage. Improved scrutiny of health plans by consumers can drive market change and help achieve the broader goals of health reform. However, a history of ineffective disclosure statements in other consumer venues suggests that care must be taken to ensure that consumers understand and can act on the information in the new form.[5]

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[1] Through out 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] Estimate of the insured population from December 19, 2009 CBO letter: Douglas W. Elmendorf to Honorable Harry Reid http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf

[3] The complete statutory language can be viewed: http://www.naic.org/documents/committees_b_consumer_information_stat_language.pdf

[4] The working documents for this permanent subgroup are available on: http://www.insurance.naic.org/committees_b_consumer_information.htm

[5] 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.

An essential step in developing an effective form is to have the form tested using real consumers. This report describes an initial round of consumer testing using the earliest version of the prototype forms.

Study Objectives

The core objective of this qualitative research study was to get consumer feedback on two early NAIC prototypes of the health insurance disclosure form, as well as a set of accompanying medical and insurance definitions (the Glossary). Specifically, we sought to understand whether the form(s):

- are useful and appealing, i.e. whether consumers will want to use them
- provide the information that consumers need to make an informed decision in choosing health insurance plans
- can help consumers make decisions, i.e. select a health insurance plan that meets their needs
- are understandable and transparent, i.e. whether consumers can determine what's covered, what's not, and their costs

The specific testing documents consisted of two alternate, prototype *Summary of Coverage* forms, labeled A and B. Both versions of these forms were populated with two non-group (individually purchased) plans, an HMO plan and a PPO, for a total of four *Summary of Coverage* documents. The plan designs were provided by carriers working with the NAIC Consumer Information subgroup and represented real life, non-group policies sold in 2009. Respondents were also given a prototype glossary to be used as a decision aid during the testing sessions. See **Appendix A** for copies of the testing documents.

Methodology

This study used focus group discussions and usability exercises to address our four research questions. These testing sessions included 112 men and women in four small cities around the country. These respondents were evenly divided between those currently uninsured and those enrolled in non-group (individually-insured) coverage. Further, respondents were recruited to achieve an even split among men/women and between two age groups: ages 27-40 and ages 41-60. Individuals associated with the insurance industry were precluded.

The vast majority of individually-insured respondents were either self-employed or the spouse of someone who was self-employed. The others worked for small businesses that either did not offer health insurance, or that offered plans the respondents considered "too expensive" for them.

Complete details of the methodological approach, as well as a demographic profile of participants, is included as Appendix B. Please note that this is a qualitative analysis involving a relatively small, non- projectable sample of men and women (N=112) in 4 cities across of U.S. Thus, the findings should be used in conjunction with other research and judgment to inform and improve form design and policymaking.

Study Findings

This study examined respondents' detailed responses to the testing documents, but also collected detailed information on their insurance background, familiarity and comfort level with insurance

concepts (health insurance literacy), and health insurance shopping preferences. These findings suggest specific changes that should be incorporated into the form itself, but they also provide useful information for other aspects of health reform.[6]

Respondents' Health Insurance Background And Health Insurance Literacy

As discussed further below, our study found that many respondents relied heavily on their prior health insurance experience to interpret and use the *Summary of Coverage* form. Hence, having a variety of health insurance backgrounds is critical to a study of this nature, if the findings are to have broad applicability. We also found that health insurance literacy—that is, familiarity with, understanding of, and confidence using health insurance concepts—greatly influenced their ability to use the health insurance disclosure forms. Participant characteristics with respect to these critical factors are discussed in this section.

Health Insurance Background

Respondents in this study had varied health insurance histories. As noted above, respondents were recruited to be evenly divided between those currently uninsured and those enrolled in non-group (individually-insured) coverage.

Among the uninsured:

- a few respondents never had health insurance during their adulthood
- several had gone for long periods without health insurance, e.g. 10 years+
- the majority had recently lost their health insurance during the recession in response to being laid off, but previously always had health insurance, often times fairly comprehensive coverage.

(Moderator: How long have you been uninsured, Mike?) I can get it through the company, but it's too expensive. I choose not to. It's crazy. I've never had insurance. I pay my bills and suck it up. (uninsured younger men, NH)

Among those individually-insured:

- the majority were self-employed or married to someone who was self-employed; others worked for small businesses that did not provide insurance, a few had been laid-off and were unemployed
- the majority had health insurance all or most of their lives
- others had brief to longer periods with no health insurance, e.g. in-between jobs, or while trying to find private health insurance after going into business for themselves.
- A couple of respondents mentioned negotiated prices directly with their doctor to "supplement" their insurance.

I'm an industrial designer. It's my wife and two boys…My company pays me per project, and they work around it so they don't have to give me medical…so I had to look out for insurance. (Moderator: Has there ever been times when you've been uninsured?) Yes, I want to say about 7 years ago…for a long period of time, I just didn't have insurance. What pretty much brought

[6] Detailed findings with respect to Forms A and B, and specific recommendations for changes, are included as **Appendix D**. Note that the NAIC has since updated the forms reflecting these findings, as well as other input.

me to look for insurance was my first son…Before that, I never had insurance. I would just go out and pay the bill. (individually-insured younger men, CA)

Significantly, many respondents were not sure what type of plan they have or had. Though they had heard of terms like "major medical" and "catastrophic" coverage, they did not know what those descriptors meant. Instead the respondents described their plans as being a "high deductible" (e.g. $5000 deductible or more) plan or a "full coverage" plan (i.e. to some, it meant a plan with a low deductible; to others, it meant a plan that included dental and vision benefits; to others, it had other, more individual meanings). A number of Ohio respondents mentioned that they had Health Savings Accounts.

(Moderator: Do you know what kind of coverage you have?) Not really…but I do know we have a copay, and there's a deductible, I think it's $3,500. (individually-insured younger men, OH)

I've had private insurance for four years, went two years without in between COBRA and looking for it…Mine's mostly catastrophic: a little over 100 bucks a month and a $5,000 deductible on everything. I don't have to go to the doctor that often, but when I do I just pay for it out-of-pocket. The doctor-- I've had probably the same one for about 10 years-- and he's real good about keeping it as low as possible. I always pay cash when I go in. (Moderator: So he kind of works with you?) Yep, exactly…We pretty much make sure everything comes off the generic drug list at Kroger. (individually-insured older men, OH)

Health Insurance Literacy Levels

Participant's familiarity with, understanding of, and confidence using health insurance concepts can be referred to "health insurance literacy." We note that there is no widely accepted definition of health insurance literacy,[7] nor is there a standard tool for measuring health insurance literacy. Nonetheless, health insurance literacy skills are critical to one's ability to use forms such as those being tested in this study.

Health insurance literacy, for the purposes of this study, was assessed qualitatively by the moderator using a combination of factors:

- awareness of and/or an understanding of basic health insurance terminology (e.g. premium, copay, deductible, in vs. out-of-network);
- awareness of and/or an understanding of more advanced health insurance terminology and concepts (e.g. coinsurance, allowed amount, annual limits, out-of-pocket limits);
- ability to use health insurance terms and concepts to determine and weigh potential financial and health outcomes (e.g. which plan would cost less; which plan would be better for me); and
- confidence making health insurance related decisions (e.g. selecting coverage levels or using forms and materials to determine what coverage is being offered).

For purposes of the analysis below, study participants were classified as falling into one of three health literacy levels:

[7] 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. See "Health Insurance Literacy of Older Adults." By Lauren McCormack; Carla Bann; Jennifer Uhrig; Nancy Berkman; and Rima Rudd. The Journal of Consumer Affairs. Summer 2009; 43, 2; pg. 223.
for more information on this concept.

- The low literacy respondents were aware of at least some basic health insurance terminology, e.g. premium, copay, deductible, network, but they had limited understanding of how the terms are actually put into practice. Most of the low literacy respondents had never been insured as an adult or never really shopped for health insurance without help from a spouse, parents or an insurance broker.

- The mid-level literacy respondents varied in their knowledge. Although they tended to be aware of some of the more advanced terminology, their facility in working with health insurance terms and concepts varied.

- The few respondents who demonstrated high health insurance literacy showed facility in understanding, working with and explaining health insurance terms and concepts that gave the other respondents trouble. They knew how to estimate the costs of different health insurance plans. They knew how to use potential healthcare scenarios to make decisions about which plan would suit them best.

The majority of respondents seemed to fall somewhere between low and mid-level health insurance literacy. There were only a handful of individually-insured and one currently uninsured participant who appeared to have high insurance literacy. These literacy levels seem to be consistent with the fairly low health insurance literacy levels observed in the general population.[8]

Among our respondents, health insurance literacy appeared to be somewhat related to health insurance coverage history. As a group, the individually-insured appeared to have higher health insurance literacy, e.g. familiarity with terminology and the ability to use at least basic health insurance plan information, than the uninsured respondents. However, there were a few individually-insured respondents who seemed to show low health insurance literacy and there were low insurance literacy respondents among *both* the uninsured and individually-insured respondents.

Among the insured, there did not appear to be a direct linear relationship between amount of time insured and insurance literacy. For instance, among the individually-insured, some people just had a better grasp of health insurance concepts than others, e.g. how to actually utilize the health insurance terms and information to solve problems and make decisions, while others, who may have been insured for just as long, were easily overwhelmed.

> *…I have to pay for my own healthcare because I'm not in a group plan. I've always had a job where I was on group plan insurance, so now I'm on this individual coverage. It's confusing to me because you have to really know the deductibles and the premium and this and that. (individually-insured younger women, OH)*

> *(Moderator: What did you find helpful?) The third page…it breaks down every individual thing, like even the mental and behavior coverage…You pretty much know that if my bill is $1000, I'm paying $200 of that $1000…It's 20% so you have an idea as to what you're going to definitely pay. The third page was just clear-cut. The rehabilitation services and the skilled nursing care flat out (are) not covered. It's clear. (individually-insured younger women, OH)*

[8] There is no widely accepted tool for measuring levels of health insurance literacy but a handful of studies suggest that many Americans struggle with health insurance concepts: e.g. McCormack (Summer 2009) et al. and "Medicaid Consumers and Informed Decisionmaking." By Jessica Greene, PhD and Ellen Peters, PhD. Health Care Financing Review. Spring 2009, Volume 30, Number 3.

Among the uninsured, however, those who had never had health insurance or who had been without health insurance for many years, appeared to consistently have low health insurance literacy. In other words, the never-insured or long-term uninsured were "starting from square one," while those who were recently laid off had at least somewhat higher health insurance literacy due to their experience with health insurance, usually provided by their former employers.

Respondents' Current Insurance Shopping Practices

In order to assess whether or not the forms would meet consumers' needs, it was important to assess how they approached shopping for health insurance prior to showing them the testing documents.

How Consumers Get Started Shopping For Health Insurance

Regardless of their health insurance literacy and their past experience with coverage, all of the respondents – including those who were never insured or long-term uninsured – knew the steps they could take to shop for health insurance. Responding to open ended questions, they indicated they would:

- use the internet to search for:
  - "health insurance"
  - "health insurance in my state"
  - "affordable health insurance"
- talk to friends, family, small business owners or other individually-insured people etc. to find out about their health insurance plans and whether they were satisfied
- call health insurance companies that they are aware of through advertising
- look in the Yellow Pages for listings for health insurance companies
- call an insurance broker, particularly if they have a broker who handles their home/auto /life insurance
- call the state government to find out which health insurance companies offer plans in the state
- check with organizations they belong to, e.g. trade unions, AARP, social organizations like the Elks, etc.
- ask their doctor about the plans he/she participates in

What Consumers What to Know When Evaluating a Health Insurance Plan

Similarly, all of the respondents, including the vast majority of the uninsured respondents, had a general idea of the basic questions to ask when evaluating health insurance policies. Responding to open ended questions, they indicated they'd like to know:

- How much does it the cost, as determined by the premium, deductible and copay?
- What is the cost of the prescription drug coverage?
- Is my doctor in the plan/in the network?
- Is my preferred hospital in the plan/in the network?
- Is there out-of-network coverage, and what are out-of-network costs? This was particularly relevant for those who lived in rural areas, for those who lived near the state border and/or worked out-of-state, and for those who traveled a lot.
- Is it necessary to get a referral to specialists?
- Are there both HMO and PPO plans and what are the differences?

- What about pre-existing conditions: coverage and cost?
- What is the reputation, financial stability, and/or longevity of the health insurance company?
- What is the most I'll have to pay? What is the least I'll have to pay?

How Respondents Compare and Choose Health Plans

The way respondents actually compared and chose health insurance varied widely in terms of how involved they wanted to be in researching plans and their personal preferences.

Some respondents with mid-level to higher literacy reported that they gathered a few plans from a few health insurance companies and reviewed the policies themselves, sometimes making charts to help them gauge the differences among the plans. Conversely, many respondents, representing a range of health insurance literacy levels, reported that they relied on an expert such as a broker or in one case, an attorney, to help them decide on a plan.

Some Made Detailed Cost Estimates

Higher literacy respondents reported that they try to select a plan by trying to determine "the bottom line cost":

- their yearly outlay in premiums: their minimum costs
- total cost of premiums plus the deductible(s), or
- total cost of premiums plus maximum out-of-pocket.

Further, some of the higher literacy respondents try to envision scenarios of how they will use health insurance in the coming year, based on:

- what happened in the past and what's going on now (for example, ongoing prescription usage, estimated number of well visits, estimated number of sick visits to primary care and specialists, any anticipated surgical needs, estimate of emergency room or urgent care visits especially among those with children)

- what could happen in the future for example, trying to anticipate future healthcare events based on
  - age/stage-of-life: e.g. pregnancy, screening for diseases etc.
  - lifestyle: e.g. exercise, smoking, type of work/employment etc.
  - family history – e.g. cancer, diabetes etc.

Some of these respondents reported they tried to calculate costs based on those personal scenarios. Respondents who used a broker let the broker do these analyses for them.

What do I think my health is going to be like? What has it been in the past? What's my money situation going to be? How important is this 3 month waiting period? What kind of medication I might be on?...And I'd probably talk to my friends and say, what health issues have you had because we'll all the same age. (uninsured older women, NH)

I'm considering how much medication I might need, how many times the kids go to the doctor. (individually-insured younger women, NH)

Many respondents took a somewhat different approach. A significant number reported their preferred approach was to compare the premium, deductible and copay across a few plans and

make a more "holistic", i.e. across-the-board, decision on which plan seems best, i.e. the least expensive, for the coverage they need.

The money is really the key. You got to tell them (broker) right off the bat how much you can afford, and they'll go out and look, and they'll call you back quickly. (individually-insured younger men, OH)

I just started calling different companies and see which one gave me better rates. (Moderator: What are the key numbers that you need to know when you're checking rates?) Deductibles and premiums. Those are the main things, and how much for the doctor visit. Yeah, copays. (Moderator: What else do you need to know?) My mistake, I went with a cheaper insurance, and it seemed like I was paying so much in premiums. Then I went to the doctor's office and still forked out $100. What does that pay for? What's covered? (individually-insured younger men, CA)

Many Had Limited Ability to Calculate "Bottom Line Costs"

Even though many respondents wanted an idea of how much they'd have to pay in total, many didn't know how to approach this question. As discussed further below, many of the low literacy, and some of the mid-level literacy respondents as well, had no idea how to go about determining the minimum and maximum out-of-pocket costs in evaluating a health insurance plan.

Some Preferred Plans that Minimized Financial Uncertainty

Some respondents reported that they try to minimize this financial uncertainty when they choose a health insurance plan. In California, a young woman said she chose Kaiser's HMO where "everything is paid for", i.e. she pays only a copay to visit any of the doctors within the network. A number of respondents claimed that they avoided choosing health insurance plans that used coinsurance because it was not possible to figure out what the costs would be. Instead, they chose plans with fixed payment amounts, so they would know what they would be paying.

(Moderator: Did you go for the plan that had coinsurance?) No. (Why not?) You don't know how much if you're in the hospital, how much it's going to be. You could end up owing quite a bit. (individually-insured younger men, OH)

<u>Attitudes and Approach toward Shopping for Health Insurance</u>

For many of the respondents shopping for health insurance, i.e. evaluating different plans and making a decision about which one to buy, was an aversive and anxiety-filled task. Although there were a few respondents who felt capable of choosing a plan, no one enjoyed shopping for health insurance. Anxiety about shopping for health insurance was especially prevalent in those of mid-level to low health insurance literacy and occurred in both the uninsured and individually-insured groups.

I wanted to make sure I understood because I've never been very good at picking out health insurance. I've never understood a lot of it. (uninsured older women, NH)

I think medical insurance is probably one of the hardest things for me that I shop for. And I think it's one of the hardest things to figure out what's covered. (individually-insured older men, OH)

A few respondents, from both the uninsured and the individually-insured groups from low to mid-level literacy, were almost paralyzed when they were asked to make a decision about health

insurance in the focus groups because they were so afraid of making a costly mistake, especially since aspects of health insurance, such as coinsurance, left them with feelings of uncertainty.

> *(Moderator: Was it hard to make a choice between these two plans?) It was for me. It maybe wasn't that hard, but it's just I could have made one (decision), but I'm afraid I'd be making possibly the wrong one…It felt like I'm not real sure whether I'm doing the best thing for me… I was wondering what am I really missing. I almost felt like I'm being pressured to possibly make the wrong decision...I feel confused. (individually-insured older men, OH)*

> *It's that uncertainty. (Moderator: Coinsurance means uncertainty?) Yeah, I'd go along with that. (2nd respondent:) Yeah, it's not comforting to the person that has that insurance. It just doesn't hug you. It's telling you I'm going to stick it to you today, but next week you might make out. There is a lot of uncertainty. People want to know that they're going to be taken care of. (uninsured younger men, NH)*

> *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. (individually-insured older men, OH)*

Very few respondents felt confident in making health insurance decisions, though "confidence" was the feeling they sought. The respondents also reported that they wanted to feel "comfortable" in making decisions or "comforted" they had chosen correctly. Even respondents who were knowledgeable and could apply most health insurance cost-sharing concepts (like deductible and coinsurance) were not always confident. Many found health insurance cost-sharing so challenging and the financial stakes so large, that they preferred if someone else checked their analysis.

Distrust of Traditional Health Insurance Materials

A lack of trust in health insurance documents factored into the uncertainty surrounding health insurance plan selection. The respondents reported that they did not expect clarity in the health insurance materials that they used in the past. They complained that the "big books", i.e. policies, were deliberately written in "legalese" to protect the company and obscure the intended meaning from the consumer. Some respondents felt that health insurance materials were "dishonest", that "they have something to hide".

How Well Did the New Health Insurance Disclosure Forms Meet Consumers' Needs?

Initially, the respondents felt that the new disclosure forms were helpful and easy to use. Both versions of the form demonstrated "apparent transparency" because they were well laid-out, sometimes because they had long definitions that seemed to communicate ideas, and because the forms addressed the basic questions and issues that the respondents cared about, e.g.:

- what is the premium, deductible, copay, e.g. the specific cost?
- is it necessary to get a referral before seeing a specialist?

But when asked to use the forms to estimate their out-of-pocket costs for a specific service or common scenario (see Appendix C for exercises), the forms were, in reality, much less transparent than they initially thought, and many respondents became confused and occasionally frustrated.

> *It made you feel, OK, that's good. But then you get over here, and you don't realize, no that's not so good, because if you read closer…And I don't think I would have picked up on that if I hadn't been in this group conversation. (uninsured older women, NH)*

Visually Appealing and Easy to Read

At first reading, consumers in the focus groups responded favorably to the prototype health insurance disclosure forms. The forms were perceived as visually appealing and easy to read because of:

- the blue and white "blocks" that made it easy to read across, line by line
- the charts that organized the key information.

They kind of separate it with the lines and boxes, and what goes with what in the same box across. (2nd resp:) I do like how one section will be in white and the next one will be in blue, so it's not straining your eyes when you go to look. It's just really easy to look at. (uninsured younger women, CA)

The forms were also perceived as user-friendly because of the language that, at first glance, they thought was "consumer language": e.g. Important Features, Common Medical Events, Services You May Need, Important Questions, Why It Matters etc.

I like it (A1). It's pretty straightforward. I like the simpler, the better. You read straight across. Pretty clear and concise. (2nd respondent:) It let you know from the get go. It was pretty blunt about everything. It didn't seem like a bunch of small lettering. (1st respondent:) Yeah, no legal jargon. (individually-insured younger men, CA)

I would say this is very friendly. (individually-insured older men, OH)

It's not insurance boilerplate. It's more like somebody talking. (uninsured younger men, CA)

Just about all of the respondents thought the forms were very helpful and concise, instead of having to start directly from a big, complex policy.

It's concise, opposed to reading this literature on your own time and having so many questions about what are these terms again when you're home…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. This kind of really makes it simple to pull apart. (uninsured older women, NH)

Forms Could Be Used to Compare and Choose Health Insurance Plans

All but a couple of low literacy respondents were able to use both Forms A and B to compare two health plans and select the one that best met their needs. The vast majority of the respondents chose Plan 2 because it appeared to cost less than Plan 1 when they compared the premium, deductible and out-of-pocket limit on page 1 (the Summary page). In addition, some respondents noted that Plan 2 had no annual limits, did not require a referral to see a specialist, and covered at least some of the costs if out-of-network care was used. The few respondents who chose Plan 1 were interested in the prenatal care benefits.

The majority of respondents believed that the forms made it easier for them to compare and contrast the plans, i.e. to line the plans up side by side, and to choose between them. They felt that the grid-style layout and the somewhat more familiar language made it easier to select a plan, compared to working directly from the policies.

It'll be easier to compare…I can put them side-by-side and see what they each offer. (uninsured younger men, NH)

The more experienced and confident respondents viewed the disclosure forms as a "first step", similar to the charts that some insurance brokers provide, to help them narrow down the options among a variety of plans, and to be used before they review the full policy.

Respondents further described the disclosure forms as:

- a tool
- an overview
- a summary
- an outline.

It's just a tool…to determine what the plan covers…part of the research that we do…to answer some of those questions. (uninsured older women, NH)

Some of the respondents were able to use the forms to make decisions based on their specific healthcare situation and needs. But many made their decision primarily relying on a few high level factors such as the apparent cost as determined by the office visit copay and deductible.

Patient Cost-Sharing Was A Key Area Of Confusion

In addition to investigating their general attitudes toward the prototype forms, study participants were asked to use the forms to estimate their out-of-pocket costs for a specific service or common scenario (see **Appendix C** for exercises). These "usability" exercises provide a more rigorous test of whether or not the forms allowed consumers to understand their coverage and exceptions to that coverage.

The vast majority of respondents had difficulty with these exercises. The difficulty had two apparent sources: ambiguity in the information contained in the forms and general difficulty with cost-sharing concepts among the participants. Significantly, this confusion was almost universal. We observed difficulty with cost-sharing among fairly well-educated folks who had always been insured and among participants who had long periods of being uninsured.

Ambiguous Information On the Forms

The majority of respondents felt that the forms were ambiguous or confusing in communicating some of the key pieces of information that they would need to actually determine accurate patient costs in each plan. For example, the description of emergency room facility costs: "$100/visit if not admitted; 20% coinsurance" was ambiguous. It was not clear how these two cost-sharing amounts interacted with each other.

"Awareness" of Cost-sharing Terms Did Not Equate to An Ability to Use The Conceptss

Furthermore, when they began to work with the forms, the terminology that participants needed to actually use the terms became much more confusing, e.g. terms like coinsurance, allowed amount, annual limits etc. In fact, in a number of the focus groups, the respondents stated that they would not have been able to understand the information in the forms if they had not been in a focus group where they discussed the meaning with others.

Although all of the respondents, including the never insured and the long-term uninsured, were *aware of* the basic health insurance terminology – premium, copay, deductible, network – the lower literacy respondents did not understand how these health insurance concepts worked in practice.

> *I was confused with the out-of-pocket limit and the allowed amount and the deductible. What's the difference between paying your upfront deductible and then the out-of-pocket limit? I looked it up, but I just don't understand…Because (with) the deductible you're paying out-of-pocket also…Are they saying that the deductible does not count towards the out-of-pocket limit? I don't get that part. I don't know…if they're different or similar. (uninsured younger women, CA)*

> *I did think it was totally confusing because I'm still trying to understand the allowed amount. On the first page, it says is there an out-of-pocket limit. The answer is yes, $3000/Individual. So that threw me off. Does that mean like $3000 a year out-of-pocket or do I have to pay $3000 first? I was a little lost there. (individually-insured younger women, OH)*

For some low-to-mid-level literacy respondents – including some who were currently insured – understanding how a deductible functioned gave them significant problems when they tried to solve the situational exercises using the disclosure forms. Many respondents, both uninsured and individually-insured, "forgot" that they had to meet the deductible before other forms of cost-sharing went into effect.

> *I hadn't even thought about the deductible to be honest. It totally slipped my mind because it does oftentimes. I get bills, and I'm like, Oh, that's right! I haven't met that yet, so I have to pay it. I don't think about it until it (the bill) comes. I forget. I'm still in the mindset of I had insurance that covered everything. (individually-insured younger women, NH)*

Similarly, understanding terms like coinsurance and "allowed amount" were very problematic for all but the few respondents. Likewise, prescription drug "tiers" were unfamiliar to all but a few high literacy respondents. Although some respondents figured out that the tiers became more costly as the tiers went from 1 to 4 (the labeling used with Plan 2), the vast majority were unfamiliar with the tier terminology (e.g. they wondered who determined what was a preferred or non-preferred drug?), and they had no idea how to determine which tier their prescription would fall into.

> *I had no idea what a specialty drug is. (individually-insured younger men, CA)*

> *I have never heard of a non-preferred brand drug. (2nd respondent:) Yeah, I was confused on that, too. (1st:) Why mention it (non-preferred) if it's not generic and it's not the real brand? (Moderator: Where would you go to find out what non-preferred brand drugs means?) I thought the Glossary, but it's not there. (individually-insured older men, OH)*

Definitions on Form (and Glossary) Insufficient

The prototype forms contained embedded explanations of many health insurance terms. In addition, respondents were given a separate glossary containing yet more terms. However, these resources were not sufficient to alleviate respondent confusion. For example, many did not understand the difference between "out-of-pocket limit" and "annual limit"; it was difficult for them to figure out or remember whether the limit was for the insurer or the insured, despite the explanation on page 1 of the form.

The respondents who had never had a plan with coinsurance did not know whether the patient or the insurer paid the percentage (20% or 30%) shown on the forms. Other respondents, including

some who had plans with coinsurance, understood *who* paid 20%, but didn't understand "allowed amount" – the amount of money that the coinsurance rate is applied to. Consequently, even some of these more savvy participants could not use the information to figure out their costs under a given medical scenario.

> *I was confused if the 20% coinsurance was what I had to pay or what my insurance covered… (uninsured younger women, CA)*
>
> *It's nice when it says every physician's visit will be $35. Then, I know. Versus 20% coinsurance per visit. That tells me nothing. That's what makes me angry…The coinsurance, I had an issue with that. It's like, 20%, that's what it was, 20% of what? (individually-insured older men, OH)*
>
> *(Moderator: What is coinsurance?) It's like they pay up to a certain amount, and then past that's a percent that you owe, like 30%. (Moderator: Who pays up to a certain amount?) I think the insurance company covers it up to a certain amount, and then you're responsible for a percent of whatever it is over. (individually-insured younger men, OH)*

Both the Forms and The Glossary Lacked Concrete Examples

When respondents discussed the terms they found confusing, others in the group would try to explain the term using concrete examples, e.g. "insurance companies negotiate fixed rates with the doctors and hospitals in their network for procedures that represent the 'allowed amount'. If the plan has 20% coinsurance and the allowed amount for a procedure is $1000, you would pay $200, after you met your deductible. An out-of-network provider could charge more for the same procedure, and you would be responsible for both the 20% coinsurance and for the difference between the out-of-network's procedure cost and the insurance company's allowed amount."

Many Concepts Are Just Exceedingly Difficult

Even when the respondents thought they understood a difficult term like "allowed amount," because a more knowledgeable respondent explained to them, they became frustrated all over again when it was explained that the allowed amount for a particular service isn't "knowable" until the service is incurred.

> *...the insurance company says I'm going to pay this much, and that's all I'm going to pay… They do their surveys and they figure out a cost, and they try to negotiate with the doctors, but the insurance people are only going to pay what they want to pay, and they don't always disclose what they're going to pay for a particular service. (uninsured older women, NH)*

Covered Service Definitions Also Generated Confusion

While cost-sharing concepts generated the greatest amount of discussion, study participants were also confused by descriptions of covered services. To give just one example, they weren't sure how "screenings" differed from the "diagnostic tests" referenced nearby on the coverage table. Other examples are provided in the detailed findings in **Appendix D**.

Prior Experience with Coverage Influenced How They Viewed Testing Materials

The respondents' past experience with health insurance, e.g. health insurance plans that they had or currently have, strongly influenced how they interpreted the prototype health insurance disclosure forms and the sample health insurance plans explored in the focus groups. Thus, for any aspects of

the plans that were confusing or ambiguous instead of direct and clear, they relied upon their experience with their own plans to interpret the ambiguities…sometimes correctly, but more often erroneously.

> *Am I reading it correctly? I don't think I have a deductible…That's what the copay is before you meet your deductible?? (individually-insured younger women, NH)*

Glossary

In addition to the *Summary of Coverage* form, many of the standard terms and definition required by the ACA were included in a separate glossary, also provided to respondents.

Most respondents liked the idea of the Glossary, but not all took the time to use it. Some respondents, especially the younger male respondents, were less likely to use it because it was too much trouble to have to refer to another form; they wanted everything defined on the 4-page disclosure form.

Those who did use it complained that a number of the definitions were unclear, often because the definitions used additional terminology that they did not understand, e.g. the definition of "coinsurance" relied on "allowed amount" that, in turn, referenced "balanced billing", all terms the respondents did not understand.

> *The fact that they used one, two, three different other words that could be used for "allowed amount" could get confusing. (uninsured older women, NH)*

> *We started with 'coinsurance', which then took us to 'allowed amount', which then takes us to 'balanced billing', and then I've got three other glossary terms that I have to look up: 'negotiated rate', 'payment allowance', 'out-of-pocket expense'. So by this time, I'm already angry. It's like I have no idea what that means, and I'm a smart guy. (individually-insured older men, OH)*

In addition, there were terms that they wanted defined or explained that were not included in the Glossary. These included:

- medical underwriting
- an explanation of what a prescription "tier" is
- preferred vs. non-preferred brand drugs
- specialty drugs
- mail order for prescription drugs
- PSA screening test.

As noted above, many of the participants found the concrete examples provided by their fellow participants to be helpful in understanding cost-sharing terms. Adding numeric examples to the glossary are likely to increase its utility.

Conclusions

The study collected responses from a variety of respondents. Their backgrounds ranged from several who were never insured to some who were in and out of coverage and others who had always been insured. Similarly, the respondents in this study appeared to range from low health insurance literacy to high health insurance literacy, with the majority in the low to middle range.

This diversity is important as many respondents' past experience with health insurance strongly influenced how they interpreted the information about the sample health insurance plans provided on the prototype health insurance disclosure forms.

With the caveat that the findings reflect the qualitative design described in **Appendix A** Methodology, the study was able to shed significant insight on our four study questions.

Is the form useful and appealing (will consumers want to use it)?

Most respondents indicated they would use the forms if they were available. Overall, respondents liked the prototype disclosure forms. They found the forms visually appealing. In particular, they liked:

- the grid/chart layout
- the alternating blue and white horizontals that made it easy to read across
- the blue color scheme, perceived as "calming", easy on the eyes and attractive
- the use of bolding or color changes to make key terms/information stand out.
- user-friendly language
- the lengthy definitions of key insurance terms
- that the form seemed to address the respondents' basic questions:
  - what are the costs for the premium, copay and deductible
  - does the plan use a network and is my doctor in the network
  - do I need a referral for a specialist.

With respect to the two alternatives that were tested, there was no clear winner. Respondents were evenly divided on their overall preference for form A vs. form B.[9] However, as described in Appendix D, there were several distinct features from both forms that were strongly preferred by a majority of the respondents.

Importantly, it was clear that for many, shopping for health insurance was an aversive task, fraught with anxiety. They were afraid of making a costly mistake if they chose the wrong plan. They lacked confidence in their ability to read through the policies and choose a plan that would take care of them rather than expose them to potential financial liabilities. Underlying this anxiety is the fact that many respondents had difficulty estimating their cost-sharing (their financial exposure) under the alternate plans.

So, while the prototype forms were perceived as an improvement over insurance documents they'd seen in the past, they did not go so far as to make health insurance shopping anything other than a dreaded chore.

[9] Appendix A contains the testing materials.

Does the form provide the information that consumers need?

Based on consumer preferences for health insurance information expressed at the beginning of each session, the forms did provide the information that consumers were seeking, such as premium cost and deductible information.

Consumers had a strong preference for knowing whether or not their doctor/hospital participated as an in-network provider and Form B provided better information in this instance.

The two pieces of information of great interest to respondents that were missing were the coverage of pre-existing conditions and the final premium after medical underwriting. While it frustrated them, many respondents realized that this information was specific to their personal medical history and couldn't be provided on this summary form. However, many assumed that they could use the website or the toll-free number to get their remaining questions answered.

Information on maternity coverage – an important coverage for some respondents – was viewed as too difficult to find.

Similarly, the "3 month waiting period" in Plan 2 was considered critical plan information, but many respondents missed it in the "Limitations & Exceptions" column where it was mixed in with other information.

Cost-sharing information was highly desired by the respondents – particularly coinsurance amounts, annual limits and out-of-pocket limits. The forms provided this data but it proved difficult to use. For those that anticipated using specific health services, this created tremendous uncertainty about their potential out-of-pocket costs. [10]

Does the form help consumers make decisions, i.e. select a health insurance plan, in their self-interest?

All but a few low literacy respondents were able to use both Forms A and B to choose between the two sample health insurance plans. The vast majority of respondents first looked at the premiums, copays, deductibles, and out-of-pocket costs listed on the Summary page in order to determine an overall difference in plan costs. Next, the high literacy and some of the mid-level literacy respondents tried to determine which services were covered and which were not. They looked to the charts and the "Limitations & Exceptions" column along with the "Exclusions" to help determine coverage.

By lining up the forms for the two plans side by side, most respondents were able to get a sense of where one plan had an advantage over the other, either in terms of costs or in coverage. They thought the chart format was a big advantage over using the policy itself. The more confident and experienced respondents predicted they would use the health insurance disclosure forms as a first step for them to compare a number of plans, weed out the plans that did not suit them, and then read the policies of the plans that seemed most appropriate for them. Other respondents – those who

[10] One statutorily required feature of the form was not available in time for testing: the *Coverage Facts label* containing examples illustrating common benefit scenarios, such as pregnancy or chronic medical conditions, as well as any related cost-sharing (all based on recognized clinical practice guidelines). The omission of this component is significant. The study findings suggest that a tool or set of tables that allows consumers to understand their full cost-sharing under a range of medical scenarios would quickly and usefully illustrate trade-offs between various plans.

were less motivated or less confident – thought they might make their decision based on the forms alone.

The vast majority of respondents said they evaluated plans using "bottom line costs." In order to estimate the potential cost, the respondents had different approaches based on their general health insurance knowledge and their personal style:

- Mid-level literacy respondents tended to use the holistic approach that is, they looked at the premium, the copay, the deductible, out-of-pocket limit, and prescription drug costs and tried to get a sense of which plan had the lowest costs for the services offered. A few made lists or charts, while others just eyeballed it. Some respondents thought about how they used medical and pharmacy services in the past and tried to get an idea of whether the plan had what they needed and a general sense of what it would cost.

  Respondents who used the holistic approach often claimed to be uncomfortable with plans with coinsurance. Coinsurance created a sense of uncertainty because they had no idea what the actual costs would be. In response, some respondents claimed to try to avoid plans that used coinsurance.

- Low-level literacy used a variation of this approach, typically looking at fewer cost-sharing components and just focusing on premiums and deductibles.

- Some high literacy respondents actually calculated the minimum and maximum costs by multiplying the monthly premiums and adding either the deductibles and/or out-of-pocket limits.

- Some high literacy respondents also generated healthcare scenarios based on past and future medical needs, and they calculated what the plans would cost for those situations.

Is the form are understandable and transparent, i.e. could consumers determine what's covered, what's not, and their costs?

Even though respondents found that the forms appealing and populated with the information that was most important to them, many had difficulty actually using the form to estimate their cost-sharing and some struggled with covered service definitions.

For example, the vast majority of study respondents were familiar with the premium and copay, but, for some, their knowledge stopped there. They didn't really understand how to use the deductible information on the form to figure out their potential out-of-pocket costs. Others understood how a deductible worked, but they often forgot that they had to meet the deductible before the insurance begins to pay a portion of the costs.

Insurance terminology that stumped many respondents included: allowed amount, annual limits, out-of-pocket limit, balanced billing, coinsurance, and prescription drug tiers. The key areas of confusion included:

- how the deductible works: when does the patient pay the full amount, and when does the insurer pay a portion of the claim
- the difference between the deductible and the out-of-pocket limit
- out-of-pocket limit vs. annual limit

- how coinsurance works: which percentage is paid by the insured vs. the insurer, and what is the allowed amount
- how to find out what the actual allowed amount of a particular service is
- the difference between primary care and preventive care
- how prescription drug tiers work and how to find out what tier a particular drug is in.

In contrast to this difficulty with the cost of covered services, most respondents could readily identify what was not covered by the plan from the list of "exclusions."

The Bottom Line

Even though respondents found that the forms appealing and populated with the information that was most important to them, many had difficulty actually using the form to estimate their cost-sharing or struggled with covered service definitions. In future iterations of the *Summary of Coverage* form, as well as other sources of health plan information, it will be critical to improve the clarity of the cost-sharing provisions and covered service definitions. Difficulty estimating cost-sharing and understanding what was included in specific service categories not only frustrated respondents but could lead them to select a plan that was not actually in their best interest.

The consumer confusion detailed in this study reflects, in part, the underlying diversity and complexity of insurance products that exist today. Health plans can vary along many different dimensions (such as network, premium, and service specific cost-sharing, limits and exceptions)—more variation than most consumers can effectively weigh and evaluate.

In 2014, the ACA calls for far greater standardization of health plans and the elimination of pre-existing exclusions. These changes, along with a standard *Summary of Coverage* form, should serve to reduce, but certainly not eliminate, these consumer struggles. Respondents' tendency to view current health plan information through the lens of their prior coverage experience reinforces the need for standardization and consistency of health insurance coverage concepts over time. Such consistency will better allow consumers can learn complex health plan features.

Appendix A – Testing Documents

The testing documents consisted of two prototype *Summary of Coverage* forms, labeled A and B.[11] Both versions of these form were populated with two non-group plans, an HMO plan and a PPO, for a total of four Summary of Coverage documents. The plan designs were provided by carriers working with the NAIC Consumer Information working group and represented real life non-group policies sold in 2009.

To aid in group discussions, the Summary form/plan combinations were labeled as follows:

Summary Form Version	**Plan Design**	**Designation**
A	HMO	"Form A1"
A	PPO	"Form A2"
B	HMO	"Form B1"
B	PPO	"Form B2"

[11] One statutorily required feature of the form was not available in time for testing: the *Coverage Facts label* containing examples illustrating common benefit scenarios, such as pregnancy or chronic medical conditions, as well as any related cost-sharing (all based on recognized clinical practice guidelines). All other required features were included in the tested forms. The omission of this component is significant. The study findings suggest that a tool or set of tables that allows consumers to understand how well they'd be covered under a range of medical scenarios would quickly and usefully illustrate trade-offs between various plans.

What This Plan Covers & What it Costs

FORM A1

Insurance Company 1
Plan Name: HMO 1500
Effective 9/15/2009

- This is a summary of this plan's costs and benefits. You can use it to compare plans.
- This is not a policy. You can get the policy at www.insurancecompany.com/HMO1500 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?	**$280** monthly for Individual	The **premium** is the amount of money that must be paid for health insurance. This is only an estimated premium based on information you've provided. After medical underwriting, your actual premium may be higher.
What is the deductible?	**$1,500** Individual Doesn't apply to office visits, preventive care, and generic drugs.	The plan year **deductible** is the amount you owe for health care covered by your health insurance before it begins to pay. *Typically, only the **allowed amount** for covered services counts toward the deductible.*
Are there any other deductibles?	Yes; **$500** for pharmacy expenses	
Is there an out–of–pocket limit?	Yes **$5,000** Individual	The **out–of–pocket limit** is the most you pay during a policy period (usually a year) before your health insurance begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover.
What is not included in the out–of–pocket limit?	Copayments	
Is there an annual limit on what the insurer pays?	Yes **$2,500** for prescription drugs	Health insurance may limit services you receive on an annual basis, even if your own medical need is greater than this limit.
Does this plan use a network?	Yes, this plan uses a network of participating providers.	If you don't use a participating doctor or other health care provider, your health insurance may not pay at all, or you may pay higher costs for their services.
Do I need a referral to see a specialist?	Yes. You need a referral to see a specialist.	Some plans require you to get permission (a referral) to see a specialist. Some plans may require you to see a specialist who is part of the plan's network. If you don't follow your plan's requirements, it may not pay at all, or you may pay higher costs.

Covered Services, Cost Sharing, Limitations and Exceptions

Some things you need to know to understand this chart:

- **Copayments** are *fixed* dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is the *percentage* you pay (for example, 20%) of the **allowed amount** for covered health care. The **allowed amount** is the maximum amount on which payment will be based for covered services. If your provider charges more than the allowed amount, you may have to pay the difference.
- This plan may encourage you to use **participating providers** by charging you lower copayment and coinsurance 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 physician office visit	$35 copay/visit	Not Covered	
	Specialist office visit	$50 copay/visit	Not Covered	
	Other practitioner office visit (includes chiropractors, acupuncturists and naturopaths)	30% coinsurance	Not Covered	
	Preventive care visit/screening/immunization	$35 copay/visit	Not Covered	No charge for mammograms at a participating provider
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	
If you need drugs to treat your illness or condition	Generic drugs	$15 copay (retail); $30 copay (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-60 day supply (mail order prescription)
	Preferred brand drugs	$40 copay (retail); $80 copay (mail order)	Not Covered	
	Non-preferred brand drugs	$60 copay (retail); $120 copay (mail order)	Not Covered	
	Specialty drugs	Covered	Not Covered	
If you have outpatient surgery	Facility fee	30% coinsurance	Not Covered	
	Physician/surgeon fees	30% coinsurance	Not Covered	
	Other services (e.g. , radiation)	30% coinsurance	Not Covered	

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have a hospital stay	Facility fee	30% coinsurance	Not Covered	
	Physician/surgeon fee	30% coinsurance	Not Covered	
	Other services (e.g., radiation)	30% coinsurance	Not Covered	
If you need emergency care	Emergency room fees	30% coinsurance	30% coinsurance	
	Emergency medical transportation	30% coinsurance	Not Covered	
	Urgent care	$50 copay/visit	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay/visit	Not Covered	
	Mental/Behavioral health inpatient services	30% coinsurance	Not Covered	
	Substance abuse outpatient services	$50 copay/visit	Not Covered	
	Substance abuse inpatient services	30% coinsurance	Not Covered	
If you become pregnant	Prenatal and postnatal care	30% coinsurance	Not Covered	
	Delivery and all inpatient services	30% coinsurance	Not Covered	
If you have a recovery or other special health need	Home health care	30% coinsurance	Not Covered	60 visits per calendar year
	Rehabilitation services	30% coinsurance	Not Covered	60 consecutive day period per instance of illness or injury
	Habilitation services	30% coinsurance	Not Covered	
	Skilled nursing care	30% coinsurance	Not Covered	60 days per calendar year
	Durable medical equipment	30% coinsurance	Not Covered	Covered up to $1,000 per calendar year
	Hospice service	30% coinsurance	Not Covered	
If you or your child need dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Exclusions:

Most policies exclude coverage for some health care services. Services that many people look for, but aren't covered by this plan are listed below. Please check your policy for other exclusions.

- Dental care
- Routine eye care
- Routine hearing tests
- Long-term care
- Cosmetic surgery
- Acupuncture
- Weight loss programs
- Routine foot care
- Infertility treatment
- Private-duty nursing
- Care when traveling outside the U.S.

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:

1. you commit fraud,
2. the insurer stops offering services in the state,
3. you move outside the coverage area.

Your Grievance and Appeals Rights:

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

What This Plan Covers & What it Costs

FORM A2

Insurance Company 2
Plan Name: PPO
Effective 9/15/2009

- This is a summary of this plan's costs and benefits. You can use it to compare plans.
- This is not a policy. You can get the policy at www.insurancecompany.com/PPO 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?	**$270** monthly for Individual	The **premium** is the amount of money that must be paid for health insurance. This is only an estimated premium based on information you've provided. After medical underwriting, your actual premium may be higher.
What is the deductible?	**$1,000** Individual	The plan year **deductible** is the amount you owe for health care covered by your health insurance before it begins to pay. *Typically, only the **allowed amount** for covered services counts toward the deductible.*
Are there any other deductibles?	Yes; there also are deductibles for out-of-network services (**$1,000**) and prescription drugs (**$200** for certain tiers)	
Is there an out–of–pocket limit?	Yes **$3,000** Individual	The **out–of–pocket limit** is the most you pay during a policy period (usually a year) before your health insurance begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover.
What is not included in the out–of–pocket limit?	Out-of-network services, balance billed amounts and premiums don't count toward the out-of-pocket limit	
Is there an annual limit on what the insurer pays?	None	Health insurance may limit services you receive on an annual basis, even if your own medical need is greater than this limit.
Does this plan use a network?	Yes	If you don't use an in-network doctor or other health care provider, your health insurance may not pay at all, or you may pay higher costs for their services.
Do I need a referral to see a specialist?	No. You may call an in-network specialist and ask for an appointment without a referral.	Some plans require you to get permission (a referral) to see a specialist. Some plans may require you to see a specialist who is part of the plan's network. If you don't follow your plan's requirements, it may not pay at all, or you may pay higher costs.

Covered Services, Cost Sharing, Limitations and Exceptions

- **Copayments** are *fixed* dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is the *percentage* you pay (for example, 20%) of the **allowed amount** for covered health care. The **allowed amount** is the maximum amount on which payment is based for covered services. If your provider charges more than the allowed amount, you may have to pay the difference.
- This plan negotiates rates with health care providers. **In-network providers** have agreed to lower rates than out-of-network providers. Other plans may describe in-network providers as preferred or participating providers.
- This plan encourages you to use **in-network providers** by charging you lower copayment and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care physician office visit	$35/visit	20% coinsurance	In-Network: Coverage applies after 3-month waiting period
	Specialist office visit	$35/visit	20% coinsurance	
	Other practitioner office visit (includes chiropractors, acupuncturists and naturopaths)	Not Covered	Not Covered	
	Preventive care visit/screening/immunization	$35/visit; 20% coinsurance for other services	20% coinsurance	In-Network: coverage applies after 3-month waiting period, not subject to deductible; 3-month waiting period doesn't apply to mammographies, cervical smears and pap smears, PSA screening tests and digital rectal exams
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	In-Network: coverage applies after 3-month waiting period; not subject to deductible if preventive screening
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs (per prescription) (Tier 1)	$15 copay (retail); $37.50 copay (mail order)	$15 copay (retail); $37.50 copay (mail order)	Retail coverage is limited to no more than a 34-day supply for any one order or refill
	Preferred brand drugs (per prescription) (Tier 2)	$35 copay (retail); $87.50 copay (mail order)	$35 copay (retail); $87.50 copay (mail order)	Retail coverage is limited to no more than a 34-day supply for any one order or refill; Tier 2-4 copays are subject to $200 annual deductible
	Non-preferred brand drugs (per prescription) (Tier 3)	$65 copay (retail); $162.50 copay (mail order)	$65 copay (retail); $162.50 copay (mail order)	
	Specialty drugs (Tier 4)	25% coinsurance	25% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee	20% coinsurance	20% coinsurance	
	Physician/surgeon fee	20% coinsurance	20% coinsurance	
	Other services (e.g. , radiation)	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee	20% coinsurance	20% coinsurance	
	Physician/surgeon fee	20% coinsurance	20% coinsurance	
	Other services (e.g., radiation)	20% coinsurance	20% coinsurance	
If you need emergency care	Emergency room fees	$100/visit if not admitted; 20% coinsurance	$100/visit if not admitted; 20% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	Limited to $50/visit, $550 annual max
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	
	Substance abuse outpatient services	20% coinsurance	20% coinsurance	Limited to $50/visit, $550 annual max
	Substance abuse inpatient services	20% coinsurance	20% coinsurance	
If you have a recovery or other special health need	Home health care	20% coinsurance	20% coinsurance	Limited to 7 visits/week and lifetime maximum of 365 visits; RN services limited to lifetime maximum of 1,000 hours
	Rehabilitation services	20% coinsurance	20% coinsurance	Covers rehabilitation or extended care facilities if admitted within 14 days of a hospital stay of 3 days or more, for the same illness or condition; subject to combined 60-day maximum for both rehabilitation and extended care facilities
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	20% coinsurance	20% coinsurance	
	Hospice service	20% coinsurance	20% coinsurance	Limited to 180 days; covered expenses limited to most common room/board rate at hospital affiliated with hospice

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you become pregnant	Prenatal and postnatal care	Not Covered	Not Covered	Complications of pregnancy are covered
	Delivery and all inpatient services	Not Covered	Not Covered	Complications of pregnancy are covered
If you or your child need dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Exclusions:

Most policies exclude coverage for some health care services. Services that many people look for, but aren't covered by this plan are listed below. Please check your policy for other exclusions.

- Dental care
- Routine eye care
- Long-term care
- Cosmetic surgery
- Chiropractic Services
- Acupuncture
- Routine foot care
- Weight loss programs
- Care when traveling outside the U.S.
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

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

1. you commit fraud,
2. the insurer stops offering services in the state,
3. you move outside the coverage area.

Your Grievance and Appeals Rights:

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

Health Plan Name: Insurance Company 1

FORM B1

Summary of Cost and Coverage

This form outlines this plan's cost, coverage and benefits. Please read the complete policy carefully, because it explains the exact scope of this plan's coverage.

Important Features	This Plan's Cost and Coverage
Premium *The amount of money that must be paid for health insurance.*	**$280**/month for one person This is only an estimated premium based on information you've provided. After medical underwriting, your actual premium may be higher.
Deductible *The amount you owe for health care covered by your health insurance before it begins to pay.*	**$1,500**/year This policy has a separate **prescription drug** deductible of $500/year
Out-of-Pocket Limit *The most you pay during a policy period (usually a year) before your health insurance begins to pay 100% of the allowed amount. Some of your costs aren't included in this limit. For example, this limit never includes your premium, balance-billed charges or health care your plan doesn't cover.*	**$5,000**/year This plan does not include copays when calculating this limit.
Coverage Limits *The most this policy will pay for covered services, even if your medical expenses are greater than this limit.*	The most this plan will pay for prescription drug expenses in a calendar year is $2,500.
Excluded Services *Common health care services that this health plan doesn't cover.*	Dental care, routine eye care, routine hearing tests, care when travelling outside the U.S., long-term care, cosmetic surgery, acupuncture, weight loss programs, routine foot care, infertility treatment, private-duty nursing. *Please check the policy for any other exclusions.*
Does this plan use a **network**? *If you don't use a participating doctor or other health care provider, your health insurance may not pay at all, or you may pay higher costs for their services.*	Yes. See www.insurancecompany.com for a list of participating doctors and hospitals.
Do I need a referral to see a **specialist**?	Yes. You need a referral from your primary care doctor to see a specialist.

Questions: Call 1-800-xxx-xxxx or visit us at www.insurancecompany.com.
Standard definitions of the terms used in this form can be found on www.insuranceterms.gov.

Covered Services, Cost Sharing, Limitations and Exceptions

For each covered service, this chart lists the co-payment or co-insurance amounts you must pay. Co-insurance amounts apply after you meet your deductible and before you reach your out-of-pocket limit.

Common Medical Events	Examples of services you may need	Your cost if you use an		Limitations & Exceptions
		Participating Provider *(doctors and hospitals in the plan's network)*	Non-Participating Provider *(you may be responsible for more charges)*	
If you visit a doctor's office or clinic	Primary care physician office visit	$35 copay/visit	*Not Covered*	
	Specialist office visit	$50 copay/visit	*Not Covered*	
	Other practioner office visit	30% coinsurance/visit	*Not Covered*	
	Preventive care visit/immunization	$35 copay/visit	*Not Covered*	No charge for mammograms by participating providers
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	*Not Covered*	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	*Not Covered*	
If you need drugs to treat your illness or condition	Generic drugs (per prescription)	$15 copay (retail); $30 copay (mail order)	*Not Covered*	Covers up to a 30-day supply (retail prescription); 31-60 day supply (mail order prescription)
	Preferred brand drugs (per pre-scription)	$40 copay (retail); $80 copay (mail order)	*Not Covered*	
	Non-preferred brand drugs (per prescription)	$60 copay (retail); $120 copay (mail order)	*Not Covered*	
	Specialty drugs	Covered	*Not Covered*	
If you have outpatient surgery	Facility fee	30% coinsurance	*Not Covered*	
	Physician/surgeon fee	30% coinsurance	*Not Covered*	
	Other services (e.g. , radiation)	30% coinsurance	*Not Covered*	
If you have a hospital stay	Facility fee	30% coinsurance	*Not Covered*	
	Physician/surgeon fee	30% coinsurance	*Not Covered*	
	Other services (e.g. , radiation)	30% coinsurance	*Not Covered*	

Common Medical Events	Examples of services you may need	Your cost if you use an		Limitations & Exceptions
		Participating Provider *(doctors and hospitals in the plan's network)*	Non-Participating Provider *(you may be responsible for more charges)*	
If you become pregnant	Prenatal and postnatal care	30% coinsurance	*Not Covered*	
	Delivery and all inpatient services	30% coinsurance	*Not Covered*	
If you need emergency care	Emergency room fees	30% coinsurance	30% coinsurance	
	Emergency medical transportation	30% coinsurance	*Not Covered*	
	Urgent care	$50 copay/visit	*Not Covered*	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay/visit	*Not Covered*	
	Mental/Behavioral health inpatient services	30% coinsurance	*Not Covered*	
	Substance abuse outpatient services	$50 copay/visit	*Not Covered*	
	Substance abuse inpatient services	30% coinsurance	*Not Covered*	
If you have a recovery or other special health need	Home health care	30% coinsurance	*Not Covered*	60 visits per calendar year
	Rehabilitation services	30% coinsurance	*Not Covered*	60 consecutive day period per instance of illness or injury
	Habilitation services	30% coinsurance	*Not Covered*	
	Skilled nursing care	30% coinsurance	*Not Covered*	60 days per calendar year
	Durable medical equipment	30% coinsurance	*Not Covered*	Covered up to $1,000 per calendar year
	Hospice service	30% coinsurance	*Not Covered*	
If your child needs oral or vision care	Eye exam	*Not Covered*	*Not Covered*	
	Glasses	*Not Covered*	*Not Covered*	
	Dental check-up	*Not Covered*	*Not Covered*	

Terms Used:

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service. The amount varies by the type of health care.
- **Co-insurance** amounts are the percentage you pay (for example, 20%) of the allowed amount for covered health care.

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:

1. you commit fraud,
2. the insurer stops offering services in the state,
3. 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 or plan. Call 1-800-XXX-XXXX or visit www. Xxxxxxxxxxxxx.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. Xxxxxxxxxxxxx.gov.

Health Plan Name: Insurance Company 2

FORM B2

Summary of Cost and Coverage

This form outlines this plan's cost, coverage and benefits. Please read the complete policy carefully, because it explains the exact scope of this plan's coverage.

Important Features	This Plan's Cost and Coverage
Premium *The amount of money that must be paid for health insurance.*	**$270**/month for one person. This is only an estimated premium based on information you've provided. After medical underwriting, your actual premium may be higher.
Deductible *The amount you owe for health care covered by your health insurance before it begins to pay.*	**$1,000**/year This policy has a separate: • **prescription drug** deductible of $200/year • **out-of-network** services deductible of $1,000/year
Out-of-Pocket Limit *The most you pay during a policy period (usually a year) before your health insurance begins to pay 100% of the allowed amount. Some of your costs aren't included in this limit. For example, this limit never includes your premium, balance-billed charges or health care your plan doesn't cover.*	**$3,000**/year
Coverage Limits *The most this policy will pay for covered services, even if your medical expenses are greater than this limit.*	None
Excluded Services *Common health care services this health plan doesn't cover.*	Dental care, routine eye care, care when traveling outside the U.S., long-term care, cosmetic surgery, chiropractic services, acupuncture services, routine foot care, weight loss programs, infertility treatment, and private-duty nursing. *Please check the policy for other exclusions.*
Does this plan use a **network**? *If you don't use a doctor or health care provider in the plan's network, your health insurance may not pay at all, or you may pay higher costs for their services.*	Yes. See www.insurancecompany.com for a list of in-network doctors and hospitals.
Do I need a referral to see a **specialist**?	No. You may contact a network specialist to schedule an appointment.

Covered Services, Cost Sharing, Limitations and Exceptions

For each covered service, this chart lists the co-payment or co-insurance amounts you must pay. Co-insurance amounts apply after you meet your deductible and before you reach your out-of-pocket limit.

Common Medical Events	Examples of services you may need	Your cost if you use an In-Network Provider *(doctors and hospitals in the plan's network)*	Your cost if you use an Out-of-Network Provider *(you may be responsible for more charges)*	Limitations & Exceptions
If you visit a doctor's office or clinic	Primary care physician office visit	$35/visit	20% coinsurance/visit	
	Specialist office visit	$35/visit	20% coinsurance/visit	
	Other practioner office visit	*Not covered*	*Not covered*	
	Preventive care visit/immunization	$35 for office visit; 20% coinsurance for other services	20% coinsurance	In-Network: Coverage applies after 3-month waiting period, not subject to deductible; 3-month waiting period doesn't apply to mammographies, cervical smears and pap smears, PSA screening tests and digital rectal exams
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	In-Network: Coverage applies after 3-month waiting period; not subject to deductible if preventive screening
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	In-Network: Coverage applies after 3-month waiting period
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	$15 copay (retail); $37.50 copay (mail order)	$15 copay (retail); $37.50 copay (mail order)	Retail coverage is limited to no more than a 34-day supply for any one order or refill
	Preferred brand drugs (Tier 2)	$35 copay (retail); $87.50 copay (mail order)	$35 copay (retail); $87.50 copay (mail order)	Retail coverage is limited to no more than a 34-day supply for any one order or refill; Tier 2-4 copays are subject to $200 annual deductible
	Non-preferred brand drugs (Tier 3)	$65 copay (retail); $162.50 copay (mail order)	$65 copay (retail); $162.50 copay (mail order)	
	Specialty drugs (Tier 4)	25% coinsurance	25% coinsurance	

Common Medical Events	Examples of services you may need	Your cost if you use an In-Network Provider *(doctors and hospitals in the plan's network)*	Your cost if you use an Out-of-Network Provider *(you may be responsible for more charges)*	Limitations & Exceptions
If you have outpatient surgery	Facility fee	20% coinsurance	20% coinsurance	
	Physician/surgeon fee	20% coinsurance	20% coinsurance	
	Other services (e.g. , radiation)	20% coinsurance	20% coinsurance	
If you have a hospital stay	Facility fee	20% coinsurance	20% coinsurance	
	Physician/surgeon fee	20% coinsurance	20% coinsurance	
	Other services (e.g. , radiation)	20% coinsurance	20% coinsurance	
If you need emergency care	Emergency room fees	$100/visit if not admitted; 20% coinsurance	$100/visit if not admitted; 20% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	Limited to $50/visit, $550 annual visit maximum
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	
	Substance abuse outpatient services	20% coinsurance	20% coinsurance	Limited to $50/visit, $550 annual visit maximum
	Substance abuse inpatient services	20% coinsurance	20% coinsurance	
If you become pregnant	Prenatal and postnatal care	*Not Covered*	*Not Covered*	Complications of pregnancy are covered
	Delivery and all inpatient services	*Not Covered*	*Not Covered*	Complications of pregnancy are covered
If your child needs oral or vision care	Eye exam	*Not Covered*	*Not Covered*	
	Glasses	*Not Covered*	*Not Covered*	
	Dental check-up	*Not Covered*	*Not Covered*	

Common Medical Events	Examples of services you may need	Your cost if you use an In-Network Provider *(doctors and hospitals in the plan's network)*	Your cost if you use an Out-of-Network Provider *(you may be responsible for more charges)*	Limitations & Exceptions
If you have a recovery or other special health need	Home health care	20% coinsurance	20% coinsurance	Limited to 7 visits per week and lifetime maximum of 365 visits; registered nursing services limited to lifetime maximum of 1,000 hours
	Rehabilitation services	20% coinsurance	20% coinsurance	Covers rehabilitation or extended care facilities if admitted within 14 days of a hospital stay of 3 days or more, for the same illness or condition; subject to combined 60-day maximum for both rehabilitation and extended care facilities
	Habilitation services	*Not Covered*	*Not Covered*	
	Skilled nursing care	*Not Covered*	*Not Covered*	
	Durable medical equipment	20% coinsurance	20% coinsurance	
	Hospice service	20% coinsurance	20% coinsurance	Limited to 180 days; covered expenses limited to most common room/board rate at hospital affiliated with hospice

Terms Used:

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** amounts are the percentage you pay (for example, 20%) of the allowed amount for covered health care.
- **Out-of-network doctors and hospitals** don't have a contract with the insurer. If their charges are greater than the negotiated fee that in-network providers get, you are responsible for paying the difference, in addition to the listed coinsurance or copayment. Other plans may describe in-network providers as preferred or participating providers.

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: (1) you commit fraud, (2) the insurer stops offering services in the state, (3) 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. Xxxxxxxxxxxxx.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. Xxxxxxxxxxxxx.gov.

Questions: Call 1-800-xxx-xxxx or visit us at www.insurancecompany.com.
Standard definitions of the terms used in this form can be found on www.insuranceterms.gov.

Glossary of Health Insurance and Medical Terms

- This glossary has many commonly used terms, but it isn't a full list. Other terms and more information are in your insurance policy or certificate. You can get a copy of the policy at [www.insurancecompany.com] or you may call [1-800-xxx-xxxx.]
- **Bold** text indicates a term defined in this Glossary.

Allowed Amount
Maximum amount on which payment is based for covered services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing
When a **non-preferred provider** bills you for the difference between the provider's charge and the **allowed amount**. A **preferred provider** may ***not*** balance bill you.

Co-insurance
The percentage you pay (for example, 20%) of the **allowed amount** for covered health care.

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus.

Co-payment
A fixed amount (for example, $15) you pay for covered health care, usually when you receive the service. The amount can vary by the type of health care.

Deductible
The amount you owe for health care covered by your **health insurance** or **plan** before your health insurance or plan begins to pay.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury or condition so serious that a reasonable person would seek care right away.

Emergency Medical Transportation
Ambulance services for a medical condition that must be treated right away.

Emergency Room Care
Emergency services received in an emergency room.

Emergency Services
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium.**

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires an overnight stay. An overnight stay for observation may be outpatient care.

Hospital Outpatient Care
Care in a hospital that doesn't require an overnight stay.

In-network Co-insurance
The percentage you pay (for example, 20%) of the **allowed amount** for covered health care to providers who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care to providers who contract with your health insurer. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary
Health care services or supplies needed to diagnose, prevent or treat your condition and that meet accepted standards of medical practice.

Network
The facilities, providers and entities your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percentage you pay (for example, 40%) of the **allowed amount** for covered health care to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, **co-insurance** payments, out-of-network payments or other expenses towards this limit.

Physician Services
Health care services a licensed medical physician (M.D.–Medical Doctor or D.O.–Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drugs** or **durable medical equipment** is **medically necessary**. Sometimes this is called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise that your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can go to all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount of money that must be paid for your **health insurance** or **plan**. It is usually paid monthly, quarterly or yearly by you and/or your employer.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Provider
A physician (M.D.–Medical Doctor or D.O.–Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care are services from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has additional training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for an identical or similar medical service in a geographic area or that providers in your area usually charge for a particular health care service. UCR is sometimes used to determine the **allowed amount**.

Urgent Care
Care for an illness, injury or condition serious enough to require prompt care but not so severe as to require **emergency room care**.

Appendix B – Study Methodology

This study used focus group discussions and usability exercises to address our four research questions. These testing sessions included 112 men and women in four small cities around the country. These respondents were evenly divided between those currently uninsured and those enrolled in non-group (individually-insured) coverage. Individuals associated with the insurance industry were precluded.

Research Design

Phase I: Pre-Test - 17 respondents

Four 2-hour focus groups were conducted among women and men, age 27-60, on September 20, 2010 in Cedar Rapids IA. Six respondents were recruited per group for 4-5 to participate.

The 4 groups were recruited so as to be split by gender and insurance status (uninsured vs. individually-insured).

Phase II: Larger Scale Test- 95 respondents

Twenty-four 2-hour focus groups were conducted among women and men, age 27-60, on September 27-October 6, 2010 in three geographically-dispersed, small cities: Manchester NH (Northeast), Columbus OH (Midwest) and Riverside CA (West). Six respondents were recruited per group for about 4 to participate. A total of 95 respondents participated in the second phase of the study.

Eight groups were conducted in each city over 2 days. Participants were recruited to be evenly split by gender, age (older and younger non-elderly adults) and insurance status (uninsured vs. individually-insured).

Participant Characteristics

As noted, respondents were recruited to achieve an even split among men/women, uninsured/individually-insured and between two age groups: ages 27-40 and ages 41-60. The final distribution was as follows:

Study Phase	**Uninsured Group**					**Individually Insured Group**				
	Women		Men		**Both Sexes**	Women		Men		**Both Sexes**
	Ages 27-40	41-60	27-40	41-60	**All Ages**	Ages 27-40	41-60	27-40	41-60	**All Ages**
Phase 1	1	3	0	4	**8**	1	4	1	3	**9**
Phase 2	14	10	14	10	**48**	16	8	14	9	**47**
Both Phases	15	13	14	14	**56**	17	12	15	12	**56**

Other characteristics recorded from participants:

- household income: fell between <$30K to $100K+ with the majority from the $30-70K range
- education: "as it falls": the majority HS grads or college grads
- employment status:
  - men: the majority worked full-time, and a few were unemployed and looking for work
  - women: mixed employment status, with some full-time employed, part-time employed, full-time homemakers, and a few women who were unemployed and looking for work
- race/ethnicity: the majority were Caucasian, with the remainder African-American and Hispanic.

The vast majority of individually-insured respondents were either self-employed or the spouse of someone who was self-employed. The others worked for small businesses that either did not offer health insurance, or that offered plans the respondents considered "too expensive" for them.

Additional detail on participant health insurance history, employment status and familiarity with health insurance concepts is provided in the "Findings" section of this report.

Research Procedure

Each testing session lasted approximately two hours. The format was as follows.

1. Brief Background

The focus group opened with a brief background discussion of the respondents' experience with health insurance:

- uninsured: were they ever insured; how long ago; barriers to acquiring health insurance
- individually-insured: why are they individually-insured; were they ever uninsured; what type of health insurance coverage did they presently have.

The conversation continued with:

- what process they would go through if they were shopping for health insurance today and
- what questions they would ask if they were shopping for health insurance?

2. Responses to the Disclosure Form and Glossary

   a. Testing Documents

The testing documents consisted of two prototype Summary of Coverage forms, labeled A and B.[12] Both versions of these form were populated with two non-group plans, an HMO plan and a PPO, for a total of four Summary of Coverage documents. The plan designs were provided by carriers working with the NAIC Consumer Information working group and represented real life non-group

[12] One statutorily required feature of the form was not available in time for testing: the coverage facts label containing examples illustrating common benefit scenarios, such as pregnancy or chronic medical conditions, as well as any related cost-sharing (all based on recognized clinical practice guidelines). All other required features were included in the tested forms.

policies sold in 2009. Respondents were also given a prototype glossary to be used as a decision aid during the testing sessions. See **Appendix A** for the testing documents.

To aid in group discussions, the Summary form/plan combinations were labeled as follows:

Summary Form Version	**Plan Design**	**Designation**
A	HMO	"Form A1"
A	PPO	"Form A2"
B	HMO	"Form B1"
B	PPO	"Form B2"

The respondents were given instructions to read the plans as if they were shopping for health insurance for themselves alone, regardless of whether they were single, married or had a family.

b. Top-of-Mind Responses

To start, one set of forms was given to respondents to read: either A1, A2, B1, or B2 in rotated order across the groups. Using two different colors, respondents were asked to highlight on the form itself:

- anything that was helpful to them
- anything that was confusing or hard to understand.

Following the highlighting, a moderated group discussion ensued.

c. Using the Disclosure Forms to Decide between Two Plans

Next, the alternate plan in the same format (i.e. either Plan1/HMO or Plan 2/PPO) was given to the respondents, and they were asked to read through both plans and decide which plan they would choose if they were shopping for a health insurance plan for themselves. They were asked to write down how they made their decision, i.e. what key variables/parts of the plan and its perceived coverage they took into consideration. Afterwards, their decisions and how they made them were discussed aloud.

d. Using the Disclosure Forms to Assess Specific Situations

A number of exercises were developed to assess whether/how the respondents would use the forms to help them choose between the two health insurance plans (Plan 1/HMO vs. 2/PPO) when considering typical healthcare scenarios (see **Appendix C**), e.g. an emergency room visit, chronic back problems, psychotherapy etc. Different exercises also sought to establish whether or not participants could readily identify services that were not covered by the plan. In each group, the participants were given the same "easy" exercise as a "warm-up" (e.g. say you needed new glasses?) followed by an exercise of higher difficulty (rotated across the groups) to complete on their own. Their answers and approach to decision-making using the plans, laid out in either Form A or B (in rotated order across the groups), was then discussed aloud.

e. Responses to the Alternate Format

Next, the respondents were given the alternate format of their preferred plan, e.g. A1, A2, B1, or B2, to evaluate. The respondents were asked for their preference between Form A or Form B and

the specific advantages of their preferred format. A discussion ensued about the advantages/preferred features and disadvantages/non-preferred features of both formats.

Qualitative Nature of Study

This is a qualitative analysis involving a relatively small, non-projectable sample of men and women (N=112) in 4 cities across of U.S. Thus, the findings should be used in conjunction with other research and judgment to inform and improve form design and policymaking.

Appendix C: Usability/Situational Exercises

Exercises were rotated through the groups, with one to two used per session.

I would like you to imagine that you are in the situation described on this sheet of paper.

Warm-up Exercises

You take a medication every month and have the option to buy it as a generic. What would you have to pay for the generic vs. brand name drug under each plan?

You've had trouble reading lately and decide to get an eye exam. What will this cost you under each plan?

Your doctor referred you to a specialist. The insurance company paid for the specialist visit, but has refused to pay for the recommended treatment. What are your options at this point? [PROBE AS NECESSARY] Can you file a complaint and appeal the insurance company's decision?

Comprehensive Exercises

1. You rarely get sick, do not take any medicines and do not have any chronic conditions. Once a year you go to a primary care doctor for a checkup. The doctor charges $200 for that checkup and is in your network.

   Which plan would cost the least for you?
   Which plan would you prefer and why?

2. You do not take any medicines regularly and do not have any chronic conditions. On average, four times a year you see your in-network primary care doctor for a sick visit to be treated for something like a cold or flu, a minor cut or a muscle ache. Your doctor charges $100 for each of those visits. In addition, once a year you go to that same primary care doctor for a checkup. The doctor charges $200 for the checkup.

   Which plan would cost the least for you?
   Which plan would you prefer and why?

3. You have severe allergies. Each year you see an in-network allergy specialist twice for treatment, and the specialist charges $250 per visit. You also take two prescription allergy drugs regularly: A generic medicine ($50/month), and a non-preferred brand-name medicine ($800/month). In addition, once a year you go to your primary care doctor for a checkup. The doctor charges $200 for the checkup and is in your network.

   Which plan would cost the least for you?

Which plan would you prefer and why?

Episodic Exercises

4. Every week you see an in-network psychotherapist, who charges $200 per visit.

Which plan would cost the least for you?
Which plan would you prefer and why?

5. You wake up at 2 a.m. feeling very ill. You haven't used your insurance at all this year and don't even have a primary care doctor. You drive yourself to the emergency room, and the charge for the visit is $700. After treatment, the ER sends you home without admitting you to the hospital.

Which plan would cost the least for this visit?
Which plan would cost the least, assuming you had met your deductible for the year?
Which plan would you prefer and why?

6. Six months into the plan year, you injure yourself working around the house and need back surgery. You choose an in-network surgeon who charges $4,000 for same-day back surgery, including fees and related tests. After the surgery you will recover at home and are expected to have minimal other expenses. So far, you've incurred $3,000 in out-of-pocket medical expenses for this plan year.

Which plan would cost the least for this visit?
Which plan would cost the least, assuming you had met your deductible for the year?
Which plan would you prefer and why?

Appendix D: Specific Findings and Recommendations Regarding the Prototype Forms

Recognizing that the specific findings and recommendations with respect to prototype forms A and B will rapidly become dated (as the NAIC and HHS update the forms to reflect these and other studies), we placed these detailed findings in a separate appendix.

Positive Features for Both Formats: A and B

Key features that the respondents perceived as benefits of both formats:

- alternating blue and white blocks of information made it easier to read one section at a time
- important terminology defined on the first page (the Summary Page)
- the Summary page, in general
- listing Excluded Services
- "Terms Used": other important terminology on p. 2 of Format A and the last page of Format B
- "Common Medical Events", a consumer-friendly term, broken down into component parts, e.g. primary care physician office visit, specialist office visit etc.
- In-Network vs. Out-of-Network costs broken out into columns to help them compare benefits within and between plans
- Limitations & Exceptions column
- the 800 number and website on the bottom of each page: where to go to get answers to their questions.

(I like) the way they list their exclusions. If I were shopping and this is something that would affect me, I don't have any dental care with them or routine eye care, so I probably wouldn't choose them. (uninsured younger women, CA)

I thought it was user-friendly because of the colors. Not only was it compartmentalized, but it also gave us a different color for each row, which clearly defined where I'm going across the page. I didn't slip down and look at the wrong thing. (individually-insured older women, OH)

Confusing Features or Disadvantages of Both Formats: A and B

Key features/terms that the respondents perceived as confusing or ambiguous:

- Deductible: Respondents with low to mid-level insurance literacy were often confused by the deductible the copay or coinsurance when trying to figure out their cost for services. They often "forgot" or did not know whether they had to meet the deductible before the copay or coinsurance went into effect. Some relied on current or past experience with their own health insurance plans in which they paid only the copay for an office visit. If the deductible must be met first, it needs to be clearer.

- Coinsurance: a key definition that was unclear to the vast majority of respondents. They were confused by whether the insurer or the insured paid the percent listed on the form. As mentioned previously, most were completely unfamiliar with the term "allowed amount" used in the explanation, and some did not understand the definition in "Terms Used" or in the Glossary.

It's called coin something. (Moderator: How would you explain coinsurance?) I don't think I understand that. (2nd respondent:) It would be the difference between the…It's like they'll pay 80% and you pay 20%. (individually-insured younger men, CA)

I don't know what the allowed amount is. If they told me the surgery's going to be $10,000, but of the allowed amount you pay 20%, I would not know what the allowed amount is. Are they saying that they'd only give you a certain amount that it should cost, and if you go over that, you have to pay the rest? (uninsured younger women, CA)

- Prescription drugs: Several terms related to prescription drugs were confusing.
  - what is tiering? How can one find out what tier a prescription drug is in?
  - what are specialty drugs?
  - what are "preferred brand drugs" vs. "non-preferred brand drugs"?
  - what are generic and brand name drugs? (A minority of respondents were unclear about the distinction between generic and brand name drugs.)

Moderator: For the preferred vs. non-preferred brands, how would you find out the difference between the two?) It remains a mystery. You wait until it gets rejected. And then you find out that you thought you were getting the generic, and it's really not the preferred generic. (individually-insured older women, OH)

- Overall, information that was printed at the top of the page above the chart on page 2 was not seen by the majority of respondents; their eyes went right to the blue chart and then moved down. As a result, they missed important and potentially helpful information.

- It was sometimes difficult for the respondents to compare horizontally from plan to plan (e.g. across a Common Medical Event like "If you have a hospital stay") because the two plans (HMO and PPO) used a slightly different orders for their rows.

- Limits: There was some confusion among the terms Out-of-Pocket Limits, Coverage Limits and Annual Limits, in terms of who has the limit: the insurer or the insured. Respondents suggested using the term "patient" seemed clearer in referring to the insured and made it easier to discriminate from the insurer.

Missing from Forms A and B

As mentioned earlier, some of the high health insurance literacy respondents calculated their overall minimum and maximum costs for plans they were considering (premiums plus maximum patient cost-sharing). The other respondents in the groups seemed quite interested in being able to do that but did not understand how. Some respondents suggested that including the minimum and maximum costs in the Summary would be very helpful to consumers trying to choose among plans.

What's the most I have to pay a year? You don't see that on either one of these. The maximums really aren't listed…It would save a lot of customer service payments for customer service reps if they just listed it on these statements. (individually-insured younger women, NH)

Form A vs. B: No Clear Winner –Take the Best of Both

There was no clear "winner" between Form A and B. Some respondents felt Form A was reassuring, because of the longer definitions, the general wordiness, the "consumer language" of the title, and the "Why This Matters" column. Others were overwhelmed by Form A and preferred the simplicity of Form B with the direction it provided via the bold letters and numbers that led them to the key information that they thought they needed.

In addition to individual stylistic preferences, there seemed to be a backwards order effect, with the respondents sometimes preferring whichever form they saw in the second position.[13] A few respondents suggested that preferring the second format was due to being educated by the first format. In that way, they merely focused on the new features of the second format, rather than starting from scratch in their evaluation.

Regardless, the respondents felt that, rather than having to choose one format over another, they wanted to combine the best aspects of the two forms into a new format. Overall, the respondents wanted the forms to clearly identify on the first (Summary) page as much of the key information that they would need to determine whether the plan would be right for them. In general, they wanted to see on this summary page:

> From Form B: excluded Services and website for the In-Network doctor/hospital list
> From Form A: the clear HMO/PPO designation in the upper right corner of page 1.

In addition, a few respondents wanted a "blank column" to be added to the form (or some type of worksheet) so they can write in figures from another plan.

> *It should leave you space for notes…Let's just say the packet that I now have, on the last page or wherever, leave this blank. Then, I can take it to the other company that I might be thinking about and call them…As I'm on the phone, I can write it down. What's your deductible, as I'm talking to the person. (uninsured older women, OH)*

> *It would be helpful if they could give people blank worksheets to work off of. (individually-insured younger women, NH)*

A Closer Look: Advantages and Disadvantages of Form A

Form A Advantages: Page one (Summary Page)

The favorers of Form A felt that the complete sentences and general wordiness of page 1 gave them **the impression** that Form A provided:

- more complete definitions of the terminology
- more information overall: how to understand and use the terminology
- greater transparency (i.e. "It's more honest").

In the New Hampshire focus groups, some respondents felt that Form A was more "professional-looking", not only because it used more complete sentences, was wordier and thus seemed to provide more information, but also because it did not use contractions or overuse italics and bolding. A few respondents described Form A as "more harmonious", i.e. "calming", because of the words highlighted in blue along with the blue blocks.

Favorers of Form A liked the descriptors on the Summary Page: Important Questions, Answers and Why It Matters. They felt that it was set up the way they think: question, answer, rationale. And some truly connected to the descriptor, Why It Matters, because it seemed to give them the confidence that they lacked in evaluating complex health insurance plans.

[13] Recognizing this tendency from the pre-test, the testing approach rotated (within demographic group) which form and plan the respondents saw first.

It kind of looked like a chart. It organizes everything and asks the questions for you. (uninsured younger women, CA)

I look down at the questions, and it's the things that I'm concerned about. It lays it out in a way that I can really digest it. And the answer is right there. And then it actually explains it. I love this term, "Why This Matters". (individually-insured older men, OH)

In New Hampshire and California, several individually-insured respondents mentioned that they liked that the HMO/PPO designation was clearly identified in a box in the upper right of the first page. Among those with a preference for one type of plan, knowing upfront whether it is an HMO or PPO was a time-saver.

For Form A/HMO plan (A1), respondents found it useful that the following information appeared on the first page: the deductible "does not apply to office visits, preventive care and generic drugs". This information was omitted from the first page on Form B and Form A/PPO.

Advantages: Remainder of Form A

The few respondents who saw the terms and definitions at the top of page 2 liked having them "up front". As noted above, most respondents skipped over this part as their eye went right to the table on page 2.

Both Form A favorers and non-favorers strongly preferred the Exclusions listed using easy-to- read bullet points. Some favorers claimed to like the placement of the Exclusions on the last page. They rationalized that they would first find out what the plan covered, and at the end, they would discover what was excluded.

Disadvantages of Form A

- (compared to Form B) having to look a little harder to find the key figures (e.g. premium, deductibles, out-of-pocket limit) they needed to evaluate and compare plans
- no mention of how/where to find the list of in-network doctors and hospitals
- no mention of where to find standard definitions of terminology (the glossary document)
- confusion for some respondents on the Summary Page when the "Why This Matters" column when it conflicts with the "Answer" column. A number of respondents were especially confused by the information associated with "annual limit". Though the Answer says there is no annual limit, the "Why This Matters" definition made some respondents wonder whether there were indeed annual limits in the plan that they would have to hunt for.

A Closer Look: Advantages and Disadvantages of Form B

Form B Advantages: Page one (Summary Page)

Favorers of Form B strongly preferred the simplicity of the less cluttered Summary Page. The fact that it had more white space made them feel more comfortable and less overwhelmed with information. The respondents in California expressed it as not having to "fish" for the information they need.

I'm completely happy with it the way it is right here…I want to keep the form as compact as possible because I'm confused enough as is. I'm not that smart. I'm not that smart, so I need it simple. (individually-insured older men, OH)

Unlike Form A, the first page of Form B was clearly identified and recognized as a Summary of the key points of the sample health insurance plan. Thus, the respondents were more likely to recognize that the document was a summary of a health insurance plan, rather than the plan or policy itself.

Form B favorers as well as some of the Form A favorers liked the bold numbers – the copay, deductible and out-of-pocket cost, the key pieces of information they thought they needed to determine whether to continue reading the plan or not. The bold numbers directed their eye right to the important information. In addition, Form B favorers preferred the bold letters of the key terms in the Important Features section, with the definitions directly under each term rather than having a third column as in Form A.

I like the bolder numbers, so you're not looking for something if you're sizing up the two (plans)…that's what we're looking for, is what our bottom line number is. (individually-insured older men, OH)

Many respondents, whether they overall preferred Form B or A, liked the fact that a website providing a list of in-network doctors and hospitals was clearly identified on the Summary Page.

Form B favorers preferred having the list of Exclusions on the Summary page rather than the back page as in Form A, although they disliked the format (a run on sentence). The Exclusions were considered key pieces of information that they would need to determine whether to continue reading the plan or not.

Advantages: Remainder of Form B

The listing of the website to find the standard definitions of terms on the bottom of each page was considered helpful.

A few respondents liked the "Terms Used" on the last page of Form B, where they would expect to find an index or glossary in a textbook.

Though seemingly unnecessary for most respondents who understood basically how a network operates, a few respondents mentioned that they liked the explanations under the In-Network/ Participating Provider, e.g. "doctors and hospitals in the plan's network…", and Out-of-Network/ Non-Participating Provider, e.g. "…you may be responsible for more charges".

Disadvantages of Form B

- a couple of respondents in Iowa and Ohio felt that the bold numbers on the Summary Page were either "huckster-ish", reminding them of car dealer advertising with big, bold numbers, or potentially misleading by focusing their attention to certain pieces of information and seemingly hiding other information
- no obvious HMO/PPO designation on the Summary Page
- Terms Used on the last page rather than on page 2
- not giving examples for "Other practitioner office visit" as in Form A: "includes chiropractors, acupuncturists and naturopaths".

I would have liked to have seen the coinsurance definition on this page (p. 2) somewhere…If it had been at the top or at the bottom highlighted, I'm thinking that would help me. (individually-insured older men, OH)

Responses to the Plan Specific Information

As noted above, one of the exercises was to have respondents use the form to choose between Plan 1 (HMO) and Plan 2 (PPO) based on their own personal preferences. Respondents' responses to plan specific information (e.g., the cost-sharing associated with mental health coverage) revealed insights about how the respondents approached "shopping" as well as the clarity of the instructions guiding insurers to complete the form.

Overall Assessment

The vast majority of respondents preferred Plan 2 because of the lower copay, deductible, and out-of-pocket limit and the fact that it provided out-of-network coverage. They felt they could find those key pieces of information in both Forms A and B. The respondents with higher insurance literacy were able to tease out other important differences between the plans:

- routine prenatal care coverage in Plan 1
- better mental health/substance abuse and home healthcare coverage in Plan 1
- better prescription drug coverage in Plan 2
- the 3 month waiting period in Plan 2.

It definitely felt like Plan 1 had more specifics. To me, it looked like there were more home healthcare kind of things…a lot more visits per calendar year. (individually-insured older men, OH)

However, the less literate respondents had to work much harder to find or they never saw those differences between the plans at all. Thus, the respondents felt that critical information that would help identify the key features/differences between the two plans should have been flagged or included on the Summary Page, especially particularly waiting periods, prenatal care benefits, and caps on coverage.

Finally, several respondents across the groups suggested that it would be very helpful if each plan included a quick label as to who it was for either by life-stage or demographics, e.g. families with children, mature men/women, women of childbearing age etc.

First of all, if I get a plan, it should be for males. I shouldn't be looking at anything about pregnancy stuff. (2nd respondent:) I felt the same thing. I agree with that! (individually-insured older men, OH)

Information Specifics: Plan 1

The respondents preferred the familiar designation "In/Out-of-Network" used in Plan 2 rather than "Participating/Non-Participating Providers" in Plan 1.

Information Specifics: Plan 2

There were a number of issues with the way some information was presented in Plan 2.

- Across the board, the cost information for the "doctor's office visit" was confusing: "$35 for office visit; 20% coinsurance for other services". It was unclear what the "other services" are, i.e. are they different from "Diagnostic Tests"?

- The Emergency Room fees needed clarification: "$100/visit if not admitted; 20% coinsurance". As is, this was misinterpreted as: $100 per visit if not admitted; 20% coinsurance if admitted.

I was confused by that emergency room $100 if you're not admitted. What happens if you are admitted?...The 20%, is that if you're admitted? (individually-insured older women, OH)

- Many respondents were confused by the prescription drug "Limitations & Exceptions: "Retail coverage is limited to no more than a 34-day supply for any one order or refill". What does that mean?

I think I know what they mean by "retail coverage is limited to no more than 34 days" but that's not what you know. What you think is that when you go to the retail, you can only get up to 34 days if you go to a regular CVS. But I know that's not what they mean. They mean that you can go one time to a retail to get your prescription, and then you're going to have to do mail order, and if you don't do mail order, it's not going to be covered. (individually-insured older women, OH)

- The "3 month waiting period" under Limitations & Exceptions was problematic:

  - The "3 month waiting period" was considered critical information, but many respondents missed it in the block crowded with other information. Placing the "3 month waiting period" only in the Limitations & Exceptions came across to some respondents as the plan "having something to hide", because it was not highlighted.

  - Many respondents were confused about what was covered and what was not covered during the 3 month waiting period, e.g. were screening tests covered, were sick visits covered, was a check-up covered? In addition, they were confused about whether medical expenses accrued during the 3 month waiting period count toward the deductible, or do expenses start accruing in month 4? Some of the confusion was due to the fact that there was a lot of information in one block under "Limitations & Exceptions", and some confusion was just because it was unclear.

I wouldn't have caught the 3 months. I didn't catch that…and it's a big thing…It's my interpretation that…if you've got coverage, but they don't start paying up until that 3 months, I would think anything you had before that would count towards your deductible, but it's an assumption…"Not subject to deductible". So you're paying for 3 months of coverage and not getting anything. (uninsured older women, NH)

  - "Not subject to deductible" was very confusing. The respondents did not know whether it meant: Preventive Care would always be covered by the copay regardless of whether the deductible has been met, or if it meant that what they spent on Preventive Care would not count toward meeting the deductible.

  - Some respondents felt that the lack of routine prenatal care should be flagged on the Summary Page or as part of the Exclusions because it was such an important piece of information about the plan.

Recommendations

These recommendations are derived from our direct observation of focus group respondents. To make these recommendations as "actionable" as possible, whenever feasible the recommendations are specific to the documents being created by the NAIC subgroup, namely:

- the *Summary of Coverage* form,
- insurer instructions for completing the form (controlling how insurers fill in the plan information), and
- the accompanying glossary.

Global Considerations for Summary of Coverage Form:

- Use prominent bolding for key features and costs.
- Form A, p. 1: Remove horizontal line used to split cells (deductible and OOP box).
- Provide phone #/URL in footer on every page to address questions and include a permanent link to glossary.
- Refer to glossary early in form, such as "If you are unclear about any terms in this form, please see accompanying glossary.
- All words in forms that are included in the glossary should have a designated font/color.
- Page 1: include information on whether this was a PPO or an HMO plan (as was done in upper right box on Form A).
- Page 1: identify the entire time period the policy would be effective: i.e. 1/1/10 – 12/31/10 (Form A only has a start date). Label this as the policy period (or other term) and use that term consistently through out the document.
- Page 2 definitions (form A) – eye skips over these and goes right to the table. Consider: Highlighting with red border and common convention like red triangle enclosing "!". Test an alternate placement at the bottom of page 2.
- Pages 2/3: always use same row order in table so plans can be easily compared.
- If space permits, provide indication of cost of the plan, at the minimum, premium * 12 plus deductible. Consider strategies for indicating the maximum cost.
- Link to standardized scenarios by which consumers can compare across policies so they can gauge the exposure for themselves or family. (Similar to the Coverage Facts label but the availability of additional scenarios isn't currently clear.)

Exclusions:

- Locate exclusions on page 1
- Use a bulleted list to list exclusions
- Insurer Instructions: Require insurers to list all major services not covered. (In the tested forms, exclusions list omits major exclusions found in table on pages 2/3. For example, the PPO plan did not cover maternity, habilitation or skilled nursing but these were not listed in "Exclusions")
- Waiting period information, if applicable, should be included in this table.

Reducing Consumer Cost-sharing Difficulties:

Allowed Amount:

- Proposed definition for page 2 – "Negotiated payment by the insurance company for an in-network or participating doctor for a specific service or procedure. The patient will not be billed more than the allowed amount if using an in–network provider."
- Consider: Provide explanation that addresses the fact that the allowed amount can be ascertained by contacting the insurer.

Coinsurance:

- The coinsurance definition on page 2 should follow the explanation of allowable amount. These two concepts must be linked spatially to be readily understood.
- Proposed Definition for page 2: "This is the percent of the allowable amount that you are responsible for paying for in-network services." If space permits, provide an example, such as: if your coinsurance is 20% and the allowable amount for a specific visit, service, or procedure is $200 the cost to you will be $40 after any applicable deductibles have been met.

Deductibles:

- Insurer Instructions, p. 1: Cost-sharing that doesn't apply to the deductible must be consistently located in the forms. Respondents recommended duplication: providing info on page 1 and in the limitations and exceptions column.
- Insurer Instructions: Separate deductibles should be listed on page 1. The format should follow the example of the HMO plan in form A.
- Glossary: Add the term "separate deductible" and indicate how this interacts with the regular deductible. Distinguish between "doesn't apply" to the deductible and "not subject to" the deductible.

Not subject to deductible:

- Add row in form – explanations: "certain visits or procedures are covered by insurance before the deductible is met, you are only responsible for the co-pay/coinsurance if performed by in-network [participating] physician."
- List of procedures/services not subject to deductible.

Form A "why this matters column":

- Modify the explanations in "why this matters" so they do not introduce ambiguity with respect to the specific coverage being described. Example: Under annual limit (HMO), many respondents were confused by the explanation that said services "may" be limited when the "Answers" column said they were not limited.
- "Medical underwriting": Replace with a more consumer friendly definition. Consider adding some detail about how the consumer would get information about their specific premium.

Limitations and exceptions, Page 2/3:

- Insurer instructions, Page 2/3: In limitations and exceptions column, use template wording to add the underlined words: Coverage is limited to $50/vist and $550 annual max. Respondents didn't always know who was being limited. (example from PPO plan, mental/behavioral/substance abuse outpatient)

Out of pocket limit:

- Proposed Definition, page 1: the most you will have to pay during the policy period
- Add the word "Patient" or "Your" in front of the term
- Insurer Instructions, p. 1: List of cost-sharing that is outside of the out of pocket limit. The format should be: copayments, premiums, balance-bill charges and services your health plan doesn't cover are not included in your out of pocket limit.
- "Why it matters": Move the information on "premiums, balance-bill charges and services your health plan doesn't cover" to "answers" if Form A is used. Add the explanation: Insurance pays 100% of covered charges after you meet this limit (except for listed exceptions)"

Annual limit/Coverage Limit:

- Add to the definition: the maximum the insurer will pay
- Insurer instructions, p. 1: If there are three or fewer $/visit/other limit, list. If more: list any overall limits and then list the services that also have limits such as: This plan $2,500 limit on prescription drugs. There are also limits on home health, skilled nursing and DME (see pages 2/3).
- Consider: replacing "annual limit" or "coverage limit" with "Are there any significant limitations and exceptions to this coverage?"

  Sample answer for the PPO plan:
  Yes, the following commonly used services have limits on coverage:

  - $550 maximum coverage for mental health services
  - 90 day waiting period for preventive services and screenings

  Other limitations and exceptions are noted on the following pages and in the policy.

Pages 2/3 – Services featuring multiple cost-sharing methods:

- Require such provisions to be spelled out unambiguously. In the PPO plan, the ER cost-sharing was "$100/visit if not admitted; 20% coinsurance." This was insufficient for nearly all respondents to understand when and what the coinsurance applied to.
- Avoid the use of Semicolons. Use "and", "or", "plus" to unambiguously reflect the consumer's payment.

Pages 2/3 Out-of-network cost-sharing:

- Require that out-of-network cost-sharing provisions of this type be as close as possible to the service specific out-of-network cost-sharing provisions in the table on pages 2/3.

Example: Inadvertently omitted from the PPO plan was an instruction intended for the top of page 2, form A: "Coverage for services from out-of-network providers will be subject to reasonable and customary charges, reduced by 25%, and subject to a separate annual deductible." This critical piece of cost-sharing information could have easily been overlooked if place above the table. Given its omission, respondents noted and were somewhat befuddled by the fact that the PPO plan apparently had the same cost-sharing in-network as out-of-network.

Reducing Consumer Confusion Over Covered Services:

Primary care physician visit:

- In "Services you may need" column, p. 2: Give examples of what constitutes this visit. Make it clear how this varies from preventive care visits. Example: sick visits for a cold or flu.

Other Practitioner Office Visit:

- Make the list of other practitioners an insurer provided field (eliminating ambiguity when one of the listed providers isn't covered).
- Insurer instructions: list "other" practitioners covered under the plan on page 2.

Preventative care visit/Screening/Immunization:

- In "Services you may need" column, p. 2: Give examples of what constitutes this visit. Make it clear how this varies from primary care visits. Example: regular checkups.
- Page 2 of form: Create separate line on form for screenings – often special payment considerations apply. Provide examples of what is included in screenings and how they differ from diagnostic tests below.

Drug tiers:

- Insurer instructions: Provide link to url or separate document listing drugs in each tier on Page 2 of form so applicants can figure out which tier their drugs are in.
- Insurer instructions: In the Rx rows on page 2, in the limitations and exceptions column, clarify copayment amount for mail order versus retail by providing days supply. Use the format in the HMO plan as a template for this information: Covers up to a 30-day supply (retail prescription); 31-60 day supply (mail order prescription)
- Glossary: include definition for preferred/non-preferred drugs.
- Page 2 of form: Specialty drugs: include an example: chemotherapy drugs (HIV?)

Facility fee (outpatient/inpatient):

- In "Services you may need" column, p. 2: Provide examples of common included charges (hospital room, operating room)

Pregnancy Coverage:

- This was an important coverage and respondents felt they had to hunt for it. Highlight in some way.

Other services:

- Insurer instructions, Page 2: Any time more than one cost-sharing method applies to the services in the row, provide additional definition. Example: The PPO

plan/preventive care had $35 copay/20% coinsurance other services. "Other services" needs to be defined in limitations and exceptions.

Emergency Room Care:

Emergency room fees (page 3): Clarify whether ER fees are facility, physician or both.

Other: Appeals

- Provide more information about how appeals work. In particular it would be helpful to provide some information about how long appeals may take, and what recourse is available for "emergency" situations.

- Consider: start the section with "your rights" instead of definitions. "You have the right to file a grievance with your insurer ..."

Glossary:

Avoid cascading definitions.

Respondents struggled with most cost-sharing terms. They expressed a strong preference for numeric examples to understand the terms and to have confidence that they were using them correctly. **Consider adding numeric examples to the** cost-sharing definitions:

Term	Definition	Example
Coinsurance	The percentage of the allowed amount you must pay for a specific covered service. For in-network providers, your cost-sharing is always based on the allowed amount. For out-of-network providers, you may have to pay amounts in addition to the indicated coinsurance.	*In-network Office visit* *Allowed amount: $100* *Coinsurance for visit: 20%* *You pay: 20%*$100=$20*

Consider developing an online glossary with expanded content, including "real world" examples.

Glossary: Term to be added

Generic Prescription Drug
Brand Name Prescription Drug
Preferred/non-preferred Brand drugs
Drug Tiers
Specialty drugs
Preventive care/services
Screening
Diagnostic
Routine
Other practitioner
Medical underwriting (if used)
Long-term care

Annual limit/ Coverage limit (if used)
Balance billed charges
Separate Deductible

Consider dropping:

in-network coinsurance
in-network copayment
out-of-network coinsurance
out-of-network copayment

With minor tweaks, the regular terms coinsurance and copayment might be sufficient.
NOTE: The term “out-of-network co-payments” is specifically listed in Section 2715 of the ACA but consumer testing showed little utility. Similarly: UCR.

Appendix E: Transcripts

Electronic versions of the transcripts are available (approximately 200 pages) upon request. Please contact Lynn Quincy of Consumers Union for copies.