



Issue Brief

Making Health Insurance Cost-Sharing Clear to Consumers: Challenges in Implementing Health Reform's Insurance Disclosure Requirements

LYNN QUINCY, M.A.
CONSUMERS UNION

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For more information about this study, please contact:

Lynn Quincy, M.A.
Consumers Union
LQuincy@consumer.org

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ABSTRACT: The Affordable Care Act calls for a new health insurance disclosure form, called the Summary of Benefits and Coverage, which uses a fixed layout and standard terms and definitions to allow consumers to compare health insurance plans and understand terms of coverage. This brief reports on findings from a Consumers Union study that examined consumers' initial reactions to the form. Testing revealed that consumers were able to use the forms to make hypothetical choices among health plans. However, the study also found deep-seated confusion and lack of confidence with respect to health plan cost-sharing. These findings have significant implications for any venue providing comparative displays of health insurance information, like the future state exchanges, and for policies that rely on the ability of consumers to make informed health insurance purchasing decisions, such as "consumer-driven health care" policies.

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OVERVIEW

The Affordable Care Act calls for a new health insurance disclosure form, called the Summary of Benefits and Coverage (Summary of Coverage), which uses a fixed layout and standard terms and definitions to allow consumers to compare health insurance plans and understand terms of coverage.¹ The law requires all insurance plans—group and nongroup, grandfathered and non-grandfathered—to use this form, beginning in 2012. At that time, more than 180 million Americans will be using these forms and relying on them to understand and select health insurance plans.²

The legislation contains several requirements governing the form's design.³ The form cannot be more than four pages in length. In addition, it must include: uniform definitions of common insurance and medical terms; a coverage description, including cost-sharing for major benefits (e.g., mental health visits);

overall cost-sharing provisions (e.g., deductibles); and coverage exceptions, reductions, and limitations.

The Affordable Care Act calls for the U.S. Department of Health and Human Services (HHS) to draft the regulations governing this form, after consulting with the National Association of Insurance Commissioners (NAIC). In 2010, an NAIC working group drafted a prototype Summary of Coverage form and an initial set of medical and insurance terms and definitions.

Consumers Union, with funding from The Commonwealth Fund and the California HealthCare Foundation, examined an early version of the disclosure form and tested it with consumers.⁴ The study found that many features were well liked by consumers. However, consumer reactions also suggested specific modifications for the form. Significantly, the testing revealed deep-seated consumer confusion about health plan cost-sharing provisions. This finding reinforces the need for many of the reforms in the Affordable Care Act but also suggests significant challenges ahead.

POTENTIAL BENEFITS OF IMPROVED CONSUMER INFORMATION

The intended goal of the Affordable Care Act's insurance disclosure requirement is to help consumers understand their health insurance coverage options and to be able to compare those options. Implicit in this goal is the ability of consumers to *meaningfully* compare coverage options. That is, they must have sufficient understanding to make a plan selection in their best interests and to make informed use of the plans in which they ultimately enroll.

Improved disclosures could be a tremendous boon to consumers, particularly when compared with the difficulty consumers currently experience when shopping for health coverage in the individual insurance market. Most respondents in this study reported that they found the task of comparing health plans exceedingly difficult and described shopping for coverage as a task they “dreaded.”

From a policy perspective, usable insurance disclosures have the potential to not only increase

consumer welfare but also to realize broader policy goals. Improved scrutiny of health plans by consumers, in concert with other provisions of the Affordable Care Act, could drive market change and help achieve the broader goals of lower costs, more activated consumers, and real health plan competition based on price and quality.

THE CONSUMERS UNION STUDY: CONSUMER TESTING THE DISCLOSURE FORM

After querying HHS, the Department of Labor, and the NAIC, the author of this study discovered a gap in the disclosure forms' development process: no funding or plans to conduct consumer testing. In the absence of such testing, it would be difficult to know if the prototype form was usable and providing information that consumers want and need. To fill this gap, Consumers Union partnered with an experienced moderator to test consumer responses to an early prototype of the form. In total, 112 uninsured or individually insured men and women participated in the study. Testing took place in four midsize cities around the country in the fall of 2010. A long version of this study is available from Consumers Union.⁵

The core objective of the study was to get consumer feedback on two early variations of the health insurance disclosure form, as well as a set of accompanying medical and insurance definitions (i.e., the glossary). Two alternate versions of the Summary of Coverage form were populated with two nongroup (i.e., individually purchased) plans—a health maintenance organization (HMO) and a preferred provider organization (PPO) plan. The study used focus group discussions and usability exercises to explore consumers' open-ended responses to the forms. The usability exercises also tested participants' ability to use the forms to understand the terms of coverage, exceptions to coverage, and to compare plans and select a health plan using hypothetical medical scenarios.

Participants' Health Insurance Background

To better interpret consumer reactions, the study collected information on respondents' insurance background, familiarity and comfort level with insurance concepts (i.e., health insurance literacy), and health insurance shopping preferences.

The study found that many respondents relied heavily on their prior health insurance experience to interpret and use the Summary of Coverage form. Their underlying health insurance literacy levels had an even more profound role. Testing consumers with a variety of health insurance backgrounds is critical to a study of this nature, if the findings are to have broad applicability.

Health Insurance Literacy

Health insurance literacy—that is, familiarity with, understanding of, and confidence using health insurance concepts—greatly influenced participants' ability to use the health insurance disclosure forms.

There is no widely accepted definition of health insurance literacy nor is there a standard tool for measuring it.⁶ Health insurance literacy, for the purposes of this study, was assessed qualitatively by the moderator using a combination of the following factors:

- awareness of or an understanding of basic health insurance terminology (e.g., premium, copay, deductible, in-network vs. out-of-network);
- awareness of 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 or 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).

The majority of respondents had between low and midlevel health insurance literacy. There were only a handful of individually insured and one uninsured participant with high insurance literacy. These literacy levels seem to be consistent with the fairly low health insurance literacy levels observed in the general population.⁷ These observed health insurance literacy levels were loosely linked to participants' insurance status but considerable variation remained.

Health Insurance Shopping Preferences

To assess whether the disclosure forms would meet consumers' needs, the researchers examined how participants approached shopping for health insurance prior to showing them the testing documents. All of the respondents, including the vast majority of the uninsured respondents, had a general idea of the basic questions they would ask when evaluating health insurance policies. These included:

- How much does the plan 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? What are out-of-network costs?
- Is it necessary to get a referral to specialists?
- How will preexisting conditions be treated?
- What are the reputation, financial stability, and longevity of the health insurance company?
- What is the most I will have to pay? What is the least I will have to pay?

Depending on their health insurance literacy skills, participants approached the process of choosing a health plan in a variety of ways. Some stated they would chart out their costs using medical scenarios specific to their situation. Others—that is, those

exhibiting lower health insurance literacy levels—felt that such an approach was beyond their abilities and instead focused on a limited number of plan elements, such as premium, deductible, and copay.

Consumers' Attitudes About Shopping for Health Insurance

For many of the respondents, shopping for health insurance was an 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 midlevel to low-level health insurance literacy and occurred in both the uninsured and individually insured groups.

The respondents further reported that they wanted to feel reassured 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.

Factoring into their uncertainty was a lack of trust in health insurance documents. The respondents reported they did not expect clarity in the health insurance materials that they used in the past. They complained that the “big books” (i.e., the policy documents) were deliberately written in “legalese” to protect the company and obscure intended meaning from the consumer.

Confusion About Health Plan Cost-Sharing

Initially, the respondents felt that the new disclosure form was helpful and easy to use. The form demonstrated apparent transparency because it was well laid out and contained long definitions that seemed to communicate key ideas. But when asked to use the form to estimate their out-of-pocket costs for a specific service or common scenario, participants found the forms were much less transparent than they initially thought.

Many respondents became confused and occasionally frustrated.

Study participants were asked to use the forms to estimate their out-of-pocket costs for a specific service or common scenario. Compared with focus group discussions alone, these usability exercises provide a more rigorous test of whether the forms allowed consumers to understand their coverage and exceptions to coverage.

The vast majority of respondents had difficulty with these exercises. When they began to work with the forms, the concepts they needed to estimate cost-sharing became much more confusing—terms like coinsurance, allowed amount, and annual limits, for example. Difficulty estimating cost-sharing not only frustrated respondents but could lead them to select a plan that was not actually in their best interest.

For example, many participants affirmed they were familiar with the term “coinsurance.” Yet, when asked to use the prototype form to estimate their cost-sharing for a particular service, some were unsure who paid the 20 percent—the policyholder or the insurer.⁸ Other participants understood which party paid the 20 percent, but did not understand “allowed amount”—that is, the amount of money the coinsurance rate is applied to. Consequently, even some of the more savvy participants could not use the information on the form to figure out their costs under a given medical scenario. In fact, a number of respondents stated they would not have been able to understand the information and terminology used in the forms if they had not been in a focus group in which they discussed the meanings.

Similarly, many participants had difficulty with the term “deductible.” In the usability exercises, some participants forgot or did not realize that the deductible had to be met before other cost-sharing provisions went into effect. A more common problem was difficulty understanding how the deductible interacted with other cost-sharing provisions. Did copay amounts apply or not apply to the deductible? Did the deductible count or not count toward the patient’s out-of-pocket maximum? There was also confusion over why some services were subject to the deductible and why some

only required a small copayment. The meaning behind the phrase “subject to the deductible” was not clear to many participants.

This multilayered difficulty was also observed with calculations involving the insurer’s annual limits and the patient’s out-of-pocket maximum. For example, participants often overlooked limits on the number of covered services or struggled to understand their costs once limits were exceeded. Copayment amount was the only cost-sharing concept that consumers perceived as straightforward and easy to use.

The focus group discussions and usability exercises showed that very few consumers could estimate their out-of-pocket costs for a given medical scenario using the plan cost-sharing information provided. Indeed, nearly all the study participants were confused by this exercise. This difficulty with cost-sharing concepts was observed among fairly well-educated participants who had always been insured and among participants with long periods of being uninsured.

While cost-sharing concepts generated the greatest amount of discussion, study participants were also confused by descriptions of covered services. For example, they were not sure how “screenings” differed from the “diagnostic tests” referenced on the table of covered services.

Other factors came into play, as well. Many skilled study participants lacked the confidence to calculate out-of-pocket costs. There was a widespread belief that something in the document’s fine print could render their calculations incorrect.

Available Definitions Were Insufficient

The prototype forms contained embedded explanations of many health insurance terms. In addition, respondents were given a separate glossary containing even more terms. However, these resources were not sufficient to alleviate respondents’ confusion. For example, many did not understand the difference between “out-of-pocket limit” and “annual limit.” It was difficult for consumers to understand whether the limit applied to the insurer or the insured, despite an explanation on the first page of the form.

The definitions may have failed to meet the needs of respondents because they lacked concrete, numeric examples. When focus group participants found terms confusing, others would try to explain the terms, often using concrete examples in their explanations. For example, “if the plan has 20 percent coinsurance and the allowed amount for a procedure is \$1,000, you would pay \$200 after meeting the deductible.” This approach seemed helpful to the participants who were struggling to understand the cost-sharing concepts.

Participants Relied on Past Insurance Experience to Interpret the Materials

The authors also observed that participants did not rely exclusively on the coverage summary in the form to compare plans. They married the information on the form with information from their past or current insurance plan to reach conclusions. For example, if their past insurance plan did not count copayments toward the deductible, they assumed the plans they were currently comparing operated the same way—an assumption that was not always correct.

Difficulty Calculating Bottom Line Costs

Even though many respondents wanted an idea of how much they would have to pay in total, many did not know how to approach this question. Many of the lower literacy and some of the midlevel literacy respondents did not know how to determine the minimum and maximum out-of-pocket costs when evaluating a health insurance plan.

Some Chose Plans that Minimized Financial Uncertainty

The inability to calculate bottom-line costs leads to financial uncertainty and anxiety in selecting a health plan. Some respondents tried to minimize this financial uncertainty by choosing plans with the least complicated cost-sharing. For example, one young woman said she chose Kaiser’s HMO under which “everything is paid for.” That is, 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 determine total costs. Instead, they chose plans with fixed payment amounts (i.e., copays) so they would know the amount they would be paying.

Recommendations Made for Improving the Summary of Coverage Form

After completing the testing, recommendations were submitted to the NAIC working group, including:

- Revisit formatting decisions (highlighting and placement) for key definitions in the form, as many consumers failed to notice these decisions aids.
 - Add numeric examples to the cost-sharing definitions in glossary.
 - If applicable, explain that the term “allowed amount” can be determined by contacting the insurer.
 - Add terms to the glossary to clarify covered services. For example, the difference between “screenings” and “diagnostic tests.”
 - Modify explanations in the form so they are specific to the health plan, rather than generic descriptions. For example, in one plan’s form, the explanation of “annual limit” stated that an “allowed amount” means services “may” be limited. However, this generic explanation was paired with a plan that did not limit services. Many respondents were confused by this apparent contradiction.
 - Link to standardized medical scenarios that help consumers compare scenario-specific cost-sharing across policies so they can gauge financial exposure.
- Strengthen instructions for insurers that govern how the forms are populated with plan-specific details. For example, details such as “costs that don’t apply to the deductible” must be consistently located in the forms. Furthermore, cost-sharing provisions must be spelled out unambiguously. In one plan used in testing, the emergency room cost-sharing was listed as “\$100/visit if not admitted; 20 percent coinsurance.” This description did not clearly indicate to respondents how the coinsurance was applied.
 - Explore strategies for providing the policyholder’s minimum and maximum out-of-pocket costs.

After receiving this feedback, NAIC made many changes to the form.⁹ Most of the recommendations in this brief were acted on or included, with the exception of: adding terms to the glossary to further clarify covered service definitions and including strategies for providing the policyholder’s minimum and maximum out-of-pocket costs.¹⁰ The revised form, however, has not yet been consumer tested to determine if it significantly alleviates consumer confusion (See [Appendix](#) for a copy of the most recent form).

Revisions were made carefully in order to preserve the form features that worked well for consumers. For example, the testing showed that providing information about premium costs and deductibles, and whether a doctor or hospital participated as an in-network provider, was highly desired by consumers. Having a standard layout allowed participants to align two plans side-by-side, making it easier to compare health plans—a seemingly simple innovation that was greatly appreciated by respondents.¹¹

IMPLICATIONS FOR HEALTH REFORM IMPLEMENTATION

These findings have important implications not only for the Summary of Coverage form but also for health reform implementation more broadly.

The Affordable Care Act

Increased Benefits Standardization in 2014

In part, the consumer cost-sharing difficulties observed in this study reflect the underlying complexity of health insurance plan design. Reconciling the various cost-sharing provisions—including deductible, coinsurance, copayments, and patient out-of-pocket limits—requires a high level of comfort with and understanding of complicated terms and numeracy skills. In addition, consumers must somehow factor in services that are not covered or for which coverage is limited by an insurer’s annual limit. Beginning in 2014, most plans will conform to an essential benefits standard, reducing (but not eliminating) the variation in covered services. Furthermore, the Affordable Care Act requires that nongroup and small-group health plans feature cost-sharing that falls into one of five tiers based on actuarial value, a measure that indicates the average share of costs paid by an insurer for a standard population.¹² Reducing this variation in benefit design will help consumers more effectively weigh the remaining plan features and will provide an overall measure of plan generosity that is not apparent to consumers today.

The Coverage Facts Label

The Coverage Facts label is a required element of the Summary of Coverage form that was not available in time for testing. The Coverage Facts label will illustrate the plan cost-sharing associated with common medical scenarios, such as pregnancy or chronic medical conditions. The study findings suggest that such a tool would allow consumers to better understand their full cost-sharing under a range of medical scenarios and quickly and usefully illustrate trade-offs among various plans. The study recommendation to include “standardized medical scenarios illustrating

plan cost-sharing” is expected to be addressed by the Coverage Facts label.

Standardization and Consistency of Health Insurance Coverage Terms

The standardization of insurance terms and definitions in the Affordable Care Act is likely to help consumers understand complex plan designs. In this study, consumers relied on past experience with health insurance to “decode” complex cost-sharing provisions. The Affordable Care Act requirement for standardizing health plan terms may help to reduce variation in how these terms are used by insurers, allowing consumers to rely on their past experience with more confidence. As discussed below, these requirements may need to go even further.

Remaining Challenges for Consumers

Deep-seated consumer confusion and lack of confidence with respect to health plan cost-sharing underscore 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 consumers trying to use their health plans, particularly 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 insurers provide when claims are filed.

Recommendations

Additional Consumer Decision Aids: Summary Measures, Benefit Calculators, Greater Standardization

The testing revealed that consumers may benefit from decision aids beyond the information in the four-page Summary of Coverage form to be able to make truly informed health plan selections. Specific recommendations include: new health plan summary measures,

benefit calculators, and possibly greater benefits standardization.

Summary or aggregate measures help consumers weigh the myriad features involved in health plan comparisons, a difficult task for most people. The health care reform law calls for HHS to develop a rating system that would indicate the relative quality and price for qualified health plans and an enrollee satisfaction survey system to evaluate the level of satisfaction with qualified plans. Consumer preferences as revealed by this study suggest that other types of summary measures are also needed.

Many study participants wished for a summary measure that accomplished one of two things: provided a measure of their maximum exposure to out-of-pocket costs or an overall indication of plan generosity. Patient out-of-pocket limit is a measure that, in theory, would meet the first need but many plans have too many exceptions to this limit for it to be useful.¹³ Actuarial value is a summary measure indicating the overall financial protection offered by the health plan. Use of this measure expands under health reform, suggesting that consumer testing of actuarial value measures could help meet the need identified in the study.

Looking ahead, summary measures that indicate network adequacy and provider quality may increase in importance. As the patient cost-sharing “levers” available to insurers become more restricted, insurers may begin to tighten their provider networks.¹⁴ In the focus groups, knowing whether doctors (and in some cases, hospitals) were in-network was very important to participants. Hence, an overall measure of provider access may also be useful to consumers.

Benefit calculators that allow consumers to enter specific medical conditions or care scenarios would also help illustrate and illuminate health insurance cost-sharing concepts. This differs from the Coverage Facts label described earlier because it allows the consumer to select a scenario.

State policymakers may need to consider whether additional benefits standardization—perhaps around the cost-sharing features considered the most confusing—would help consumers meaningfully

compare their health plan choices. At a minimum, careful monitoring is needed to see whether sorting plans into actuarial value tiers is sufficient to allow consumers to confidently and reliably compare health plans.¹⁵

Consistency and Other Measures to Instill Greater Trust in Health Plan Materials

In all proposed tools, standardization and consistent use of terms across insurers and over time will vastly increase utility. Indeed, the Summary of Coverage form should serve as a springboard for other consumer-facing materials and decision aids. All related documents and Web-based information should use consistent terminology and a uniform “look and feel.”

However, consistency alone is insufficient. As the testing indicated, summary measures and other tools will accomplish little unless they are trusted by consumers. Fostering a track record of reliability and consumer trust would remove barriers to consumers’ use of health plan information.

Increased Emphasis on Consumer Testing

Consumers Union’s testing effort yielded an immediate and direct impact on the prototype health insurance disclosure form being developed. Many changes were made in light of the findings. In the absence of the information provided by the testing effort, it is unlikely the same changes would have been made. Even in areas where consumer difficulties were anticipated, the testing provided a nuanced understanding needed to improve the forms. For example, understanding the multilayered confusion about coinsurance helped the form designers to clarify who paid the indicated percentage and the role of the allowed amount.

While few would dismiss the theoretical value of consumer testing, the fact remains that this critical component of policy development and implementation is often missing in the public sector. There were no provisions to test consumer responses to the Summary of Coverage disclosure form, which will be put in front of 180 million consumers in 2012.

Incorporating testing seems difficult because it takes time, money, and expertise.¹⁶ However, these

costs must be weighed against the value of consumer testing. There is tremendous value to consumers who might be spared a disclosure that is misleading, difficult to comprehend, or unappealing. There is also value for policymakers and regulators. The results from consumer testing can provide clear evidence as to whether or not an associated policy goal has been achieved. Consumer testing also provides data to guide future policy and rule-making.

Finally, consumer testing can also help policymakers, advocates, and other health care experts manage consumer expectations regarding the new reforms. Using nuanced information to fairly and accurately describe consumer benefits and obligations will be critical. Once an inaccurate perception had been developed, it is difficult and costly to reverse that perception.¹⁷

This study demonstrated that some key elements must be present for a rigorous test. For example, testing consumers with a variety of health insurance backgrounds is critical, if the findings are to have broad applicability. In addition, it is important to incorporate usability exercises. These exercises provide a more rigorous test of whether the form allowed consumers to understand their coverage and exceptions to that coverage, compared with focus group discussions alone.

State vs. Federal Roles

In accordance with the provisions of the Affordable Care Act, the federal government will provide minimum standards governing consumers' choice of health plans and how the choices are displayed. This includes the Summary of Coverage form starting in 2012 and the additional benefits standardization that will take place in 2014. As noted previously, HHS must develop a rating system that would indicate the relative quality and price for qualified health plans and a survey

system to assess enrollee satisfaction with qualified plans.

With respect to the recommendations above, HHS would take the lead in developing consumer-tested models for states to use; for example, creating a flexible benefits calculator for consumers. It is likely, however, that states will have to play a large role in testing and fine-tuning health plan information for their residents. States may be particularly well suited to convening with local insurers on establishing consistency and trust in health plan materials.

CONCLUSION

As health reform measures begin to roll out, stakeholders of all types will be invested in consumers' responses and reactions. The choices consumers make will determine, in large part, the success or failure of many health reform initiatives. Will consumers select high-value health plans over low-value plans? Will they respond to incentives to take better care of their own health? Will they report fraud? Will they comply with the mandate?

Many policymakers, advocates, and industry officials understand that consumers struggle with health insurance cost-sharing concepts. However, there is a dearth of detailed information about exactly what confuses consumers and how this confusion might effectively be addressed.

This study of consumer responses to a new prototype health insurance disclosure form demonstrates how consumer testing can fill important evidence gaps and help realize health reforms' intended goals. Significantly, this brief found that confusion about cost-sharing provisions and covered service definitions limited participants' ability to use the new disclosure forms to compare health plans. This confusion led to financial uncertainty and anxiety when asked to calculate out-of-pocket costs. These findings suggest that form revisions and other strategies are needed to mitigate confusion and help consumers become informed, activated purchasers of coverage.

NOTES

- 1 Throughout this report, the term Affordable Care Act is used to refer to the collective provisions of the Patient Protection and Affordable Care Act, signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010. More information about this law can be found on: <http://www.healthcare.gov/>.
- 2 Congressional Budget Office, Letter from Douglas W. Elmendorf to Honorable Harry Reid, Dec. 19, 2009, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf.
- 3 National Association of Insurance Commissioners, Uniform Enrollment/Standard Definitions/Disclosure Subgroup: Relevant and Cross-Referenced Sections of PPACA, http://www.naic.org/documents/committees_b_consumer_information_stat_language.pdf.
- 4 Consumers Union, publisher of *Consumer Reports*, is an expert, independent, nonprofit testing and information organization serving only consumers. Consumers Union provides consumers with information, education, and counsel about goods, services, health, and personal finance. Consumers Union's publications—with approximately 8.3 million combined paid circulation—carry no advertising and receive no commercial support. Consumers Union's income is solely derived from the sale of *Consumer Reports* and ConsumerReports.org, its other publications, and from noncommercial contributions, grants, and fees. For more information: <http://www.consumerreports.org/cro/aboutus/index.htm>.
- 5 The complete methodology, testing documents, and findings are available online. See: Consumers Union and People Talk Research, *Early Consumer Testing of New Health Insurance Disclosure Forms*, Dec. 2010.
- 6 Health insurance literacy differs from health literacy, a broader concept that has been well-defined and has had several measurement tools developed. See L. McCormack, C. Bann, J. Uhrig et al., "Health Insurance Literacy of Older Adults," *Journal of Consumer Affairs*, Summer 2009 43(2):223–48.
- 7 Ibid.
- 8 This occurred despite the fact that the coinsurance amounts appeared in a column labeled "what you pay."
- 9 Feedback was from Consumers Union study and Association of Health Insurance Plans study.
- 10 In its transmittal letter to HHS, the NAIC working-group chairs anticipated that additional improvements would be made in the future. The letter also notes that states are in a position to promulgate additional requirements for health insurance issuers if in the best interests of its residents, if not precluded by federal law.
- 11 Consumers Union and People Talk Research, *Early Consumer Testing*, 2010.
- 12 Except for grandfathered plans, insurers are permitted to offer only plans that fall within one of four tiers of coverage in the individual and small-group markets: bronze, silver, gold, and platinum coverage tiers (the "metal" tiers), plus a catastrophic plan for young adults and others. Among the metal tiers, bronze is the least comprehensive level of benefits and platinum is the most comprehensive. In addition, the metal tiers have limits on patient out-of-pocket cost-sharing, which will serve to further reduce (but not eliminate) the numerous factors involved in comparing plans. See L. Quincy, *What Will an Actuarial Value Standard Mean for Consumers?* (Yonkers, N.Y.: Consumers Union, Jan. 2011).
- 13 Patient out-of-pocket limit is a measure that could potentially meet the maximum exposure need, but many plans have too many exceptions to this limit for it to be useful. One study found a typical course of breast cancer treatment would cost a consumer less than \$4,000 in one plan but \$38,000 in another, despite the fact the two plans contained similar deductibles, copays, and out-of-pocket limits. See K. Pollitz, E. Bangit, J. Libster et al., *Coverage When It Counts, How Much Protection Does Health Insurance Offer and How Can Consumers Know?* (Washington, D.C.: Center for American Progress Action Fund, May 8, 2009).
- 14 As noted, health plans sold in the individual and small-group market must conform to one of five actuarial value tiers beginning in 2014.

- ¹⁵ Massachusetts is moving toward increased benefits standardization after several years of experience with health plan tiers similar to those called for in the Affordable Care Act. P. Precht, *Role Models and Cautionary Tales: Three Health Programs Demonstrate How Standardized Health Benefits Protect Consumer* (Yonkers, N.Y.: Consumers Union, July 2009).
- ¹⁶ However, it does not take that much money. Even after assigning a monetary value to Consumers Union's significant donation of time and expertise, the cost for this study was one tenth of one cent per insured person in 2012.
- ¹⁷ L. Quincy, P. Collins, K. Andrews et al., *Designing Subsidized Health Coverage Programs to Attract Enrollment: A Review of the Literature and a Synthesis of Stakeholder Views* (Princeton, N.J.: Mathematica Policy Research, Dec. 2008).

Appendix. Sample Summary of Coverage Form *After Revision*

Health Plan Name: Insurance Company 1 Policy Period: 9/15/2010 - 9/14/2011
What This Plan Covers & What it Costs Coverage for: Individual | Plan Type: HMO



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	The premium is the amount paid for health insurance. This is only an estimate based on information you've provided. After the insurer reviews your application, your actual premium may be higher or your application may be denied.
What is the overall deductible?	\$1,500 Doesn't apply to office visits, preventive care, and generic drugs.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes; \$500 for pharmacy expenses.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$5,000	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Copayments, premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the insurer pays?	No. There is no <i>overall</i> annual limit, but see page 2 for <i>specific</i> limits on covered services.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See insurancecompany.com for a list of participating doctors and hospitals.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network, preferred, or participating for providers in their network.
Do I need a referral to see a specialist?	Yes. You need a referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 3.

Questions: Call 1-800-XXX-XXXX or visit us at www.insurancecompany.com
 If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

Covered Services, Cost Sharing, Limitations and Exception

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this health insurance plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your coinsurance payment of 20% would be \$200. If you haven't met any of the deductible and it's at least \$1,000, you would pay the full cost of the hospital stay.
- The plan's payment for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower deductibles, copayments 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 visit to treat an injury or illness	\$35 copay/visit	Not Covered	_____ none _____
	Specialist visit	\$50 copay/visit	Not Covered	_____ none _____
	Other practitioner office visit	30% coinsurance for chiropractor and 20% coinsurance for acupuncture	Not Covered	_____ none _____
If you have a test	Preventive care/screening/immunization	\$35 copay/visit	Not Covered	No charge for mammograms at a participating provider
	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	_____ none _____
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	_____ none _____

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about drug coverage is at www.insurancecompany.com/prescriptions	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	
If you have outpatient surgery	Specialty drugs (e.g., chemotherapy)	Covered	Not Covered	
	Facility fee (example, ambulatory surgery center)	30% coinsurance	Not Covered	_____ none _____
If you need immediate medical attention	Physician/surgeon fees	30% coinsurance	Not Covered	_____ none _____
	Emergency room services	30% coinsurance	30% coinsurance	_____ none _____
	Emergency medical transportation	30% coinsurance	Not Covered	_____ none _____
	Urgent care	\$50 copay/visit	Not Covered	_____ none _____
If you have a hospital stay	Facility fee (example: hospital room)	30% coinsurance	Not Covered	_____ none _____
	Physician/surgeon fee	30% coinsurance	Not Covered	_____ none _____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 copay/visit	Not Covered	_____ none _____
	Mental/Behavioral health inpatient services	30% coinsurance	Not Covered	_____ none _____
	Substance use disorder outpatient services	\$50 copay/visit	Not Covered	_____ none _____
If you become pregnant	Substance use disorder inpatient services	30% coinsurance	Not Covered	_____ none _____
	Prenatal and postnatal care	30% coinsurance	Not Covered	_____ none _____
	Delivery and all inpatient services	30% coinsurance	Not Covered	_____ none _____

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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	_____ none _____
	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	_____ none _____
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	_____ none _____
	Glasses	Not Covered	Not Covered	_____ none _____
	Dental check-up	Not Covered	Not Covered	_____ none _____

Excluded Services & Other Covered Services:

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

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

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

- Acupuncture
- Chiropractic care
- Hearing aids

Coverage Facts:

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

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

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ABOUT THE AUTHORS

Lynn Quincy, M.A., is a senior health policy analyst with Consumers Union, the nonprofit publisher of *Consumer Reports*. Ms. Quincy works on a wide variety of health policy issues, focusing primarily on consumer protection and health insurance reform at the federal and state levels. Ms. Quincy also serves as a consumer representative with National Association of Insurance Commissioners. Prior to joining Consumers Union, she was a senior researcher with Mathematica Policy Research, where she performed policy analysis, provided technical assistance, and modeled outcomes in support of state coverage expansion strategies. She has a master's degree in economics from the University of Maryland.

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