Consumer Choice of Health Plan
Decision Support Rules for Health Exchanges: Issue Brief #8

Communicating Difficult Concepts

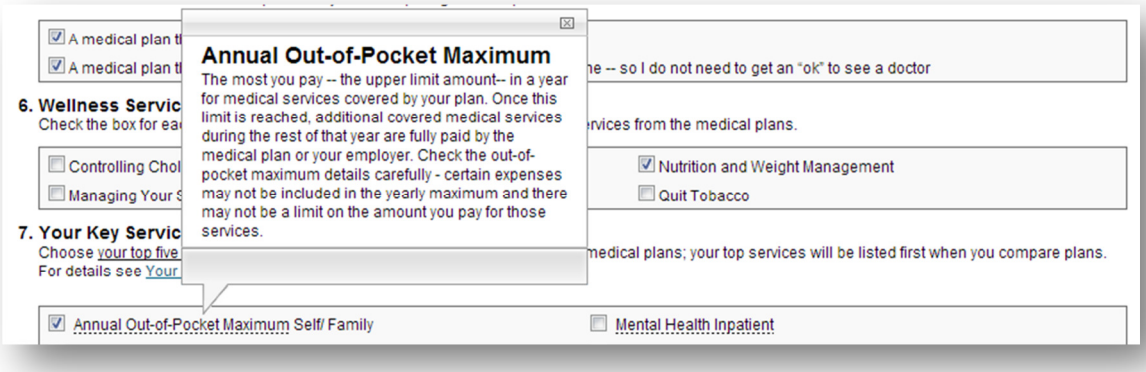
Use multiple approaches to communicate difficult concepts. Choosing a plan is a difficult task in part due to the large number of unfamiliar and/or confusing concepts. To reach the largest number of consumers, communicate key concepts via multiple methods. [1] Appropriate assistance varies by concept, but can include techniques, such as in-line definitions, to explain unfamiliar terms and special approaches, like calculators, to summarize complex information.

IMPLEMENTATION

Explain difficult concepts: Communicate important concepts clearly and via multiple channels. This may include reaching out to consumers to educate them about difficult concepts before they start the process of choosing a plan and continuing this education throughout plan choice. In all communications, text should be written in plain English and targeted toward readers with sixth-grade reading levels.

- **Key terms:** Explain key terms using in-line definitions (Figure 1) and an easy-to-access glossary and/or FAQ section. (For a sample glossary with strawman language, see the Appendix.)

Figure 1. Hovering the cursor over an underlined term produces a pop-up definition.



Simplify complex concepts: Special approaches may be required to simplify and communicate particularly complicated concepts. Our research has identified five such concepts and also suggested approaches to address them.

- **Rules to see a doctor:** Organize rules about choosing and using providers so that consumers can single out a particular rule or consider the full set of related rules. Simplifying rules helps consumers understand how different plans affect their ability to get care. This may be especially important for families whose members span commercial and Medicaid program eligibility and want to have access to the same provider(s) and consumers with fluctuating income who want to ensure continuity of providers across commercial and Medicaid plans.[2]

[1] This brief does not address in-person or phone assistance from assistors, customer service representatives, or other persons.
[2] Among adults whose household incomes are below 200% of the federal poverty level, as many as 50% may experience one or more changes in eligibility between commercial and Medicaid plans in a single year (Sommers & Rosenbaum, 2011).

- Group rules into a topic area that most consumers readily understand – getting care.
- Within this group, parse rules into component requirements:
  - Primary care provider (PCP) election requirements
  - Doctor or service referral/authorization requirements
  - Access to care for specialty networks (e.g., behavioral health)
  - Seeing providers in high-value networks
- Particular attention should be given to high-value networks as many consumers equate narrow networks available at a lower cost share with inferior quality.

- **Cost at time of care:** Include a calculator that computes estimated cost at time of care given the plan's covered benefits and the consumer's expected medical services use.[3] Combine this cost with the plan's premium net of any tax credit to provide a total cost estimate. By giving consumers a single, easy-to-compare total cost number for each plan, calculators overcome the complexities of numerous covered services categories and their associated cost-sharing amounts.
  - Explain how the calculator works (i.e., how cost at time of care is estimated).
  - Encourage consumers to consider checking "what ifs" (i.e., worst case scenarios) to better understand their potential cost sharing obligation if considerable medical services are needed.
- **Quality ratings:** To communicate quality ratings, use a single, familiar metric, such as stars or "thumbs up" icons. Include a legend that reflects the ratings' nature (e.g., "better" to "worse" for relative ratings and "poor" to "excellent" for absolute ratings), displays the possible range (e.g., 0 to 5 stars), and appears in close proximity to the ratings display. Converting performance scores into quality ratings overcomes consumers' struggle to understand quality information by standardizing scores and avoiding difficult numerical concepts, like percents.
- **Metals tier:** Avoid focusing consumers' attention on metals tiers and instead use cost calculators to emphasize how the available plans compare on estimated yearly total cost.[4] Positioning metals tiers labels as secondary or less prominent information allows metals tiers to be used to further organize and compare health plans without requiring consumers to grapple with yet another health insurance concept.
- **Product type:** Avoid focusing consumers' attention on product type labels, like HMO, PPO, HDHP, etc. Instead highlight how plans compare on dimensions that matter to consumers, such as plan rules to see a doctor, key differences in provider networks, covered benefits, and estimated yearly cost at time of care. Deemphasizing product type labels helps consumers focus on key dimensions.
  - High-deductible health plans (HDHPs) may be particularly difficult to understand. Consumers who select an HDHP could be shown an alert warning them about potentially high costs should they experience unanticipated medical services use (e.g., "In this plan, you are responsible for more of the costs when you use medical services. If you have unexpected health care needs, you may have to pay as much as $<deductible amount> before your insurance coverage starts.").

RATIONALE

Meet user preferences: Our research indicates that consumers struggle with some plan choice concepts more than others. Interventions to explain and/or simplify difficult concepts can improve consumers' understanding of the available plans and their ability to find health plans that fit their needs.

Help vulnerable populations: Our research indicates that health insurance literacy (i.e., comprehension of health insurance terminology) and plan comprehension (i.e., understanding of the selected plan) are lower among consumers who have never been insured and consumers with low numerical ability. Interventions to explain or simplify difficult concepts may be especially helpful for these and other vulnerable populations.

[3] If there is no cost calculator, annual out-of-pocket maximum can serve as a blunt "what if" guide. However, consumers should be alerted to excluded services or costs, such as non-participating provider fees exceeding the plan's allowed amount.
[4] If there is no cost calculator, emphasize metals tiers tradeoffs – higher benefits coverage and higher premiums go hand-in-hand.

RESEARCH EVIDENCE

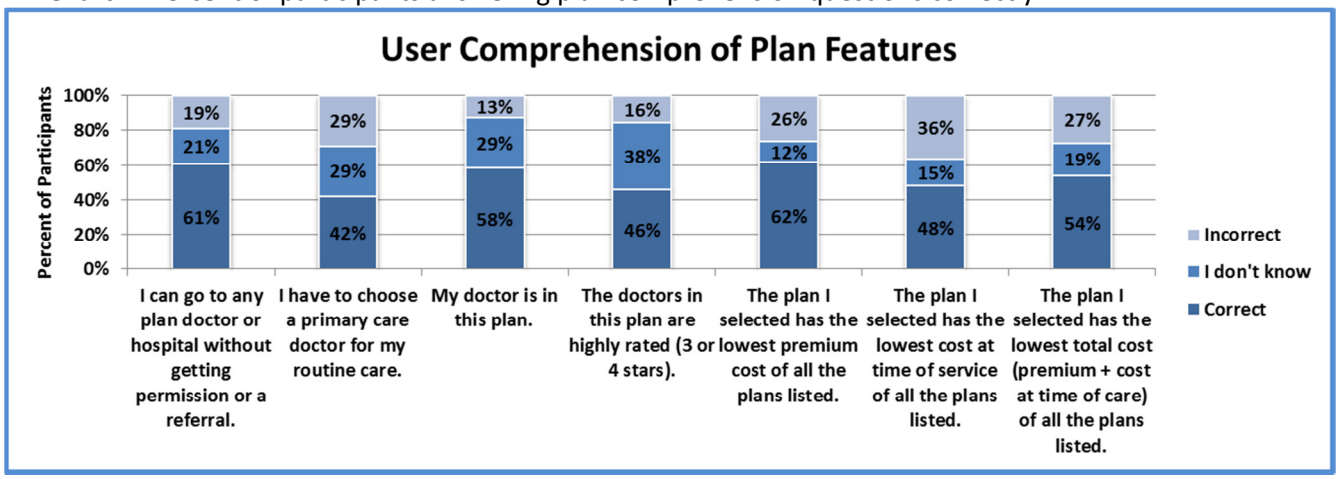
Our research confirms that consumers struggle with certain health insurance concepts.

Across four of the studies, participants (N = 1116) used our online plan choice tool to select a health plan. Although this choice was hypothetical, the health plans were based on real-world plan data and participants were asked to "make [their] medical plan choice as if it were [their] actual plan choice". Participants' preferences were queried in the User Preferences section. They then selected a plan in the Plan Comparison section. Finally, they completed a post-choice questionnaire.

We assessed plan comprehension using two metrics. First, we asked participants to rate plan dimensions based on how easy or difficult they were to understand. Second, we asked participants factual questions about their selected plan and scored their answers against the actual features of that plan.

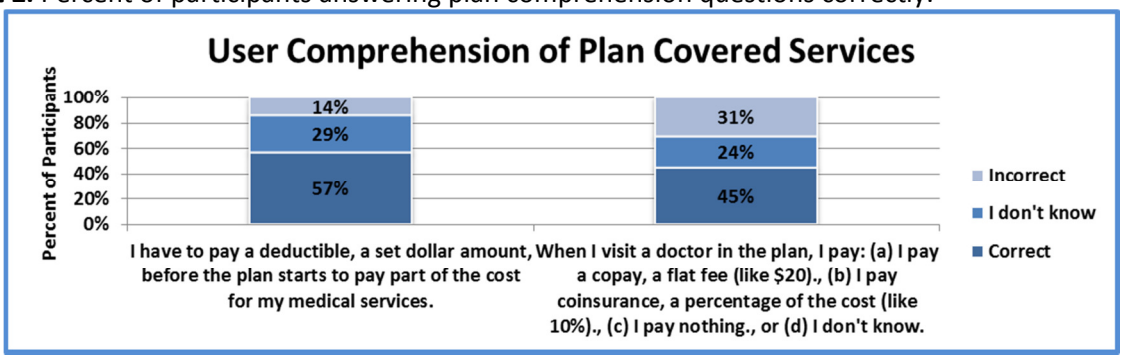
Rules to See a Doctor: Participants reported that rules to see a doctor were the most difficult dimension to understand, followed by cost at time of care and doctor quality ratings. This mirrors other work indicating that consumers have trouble understanding plan rules to see a doctor (PBGH Plan Chooser). Interestingly, participants' tended to understand referral requirements better than PCP selection requirements (Chart 1).

Chart 1. Percent of participants answering plan comprehension questions correctly.



Cost at Time of Care: Cost at time of care is another difficult concept. To manually estimate cost at time of care, consumers must understand many health insurance concepts (such as copay, coinsurance, deductible, and annual out-of-pocket maximum), how these apply to their plan, and how to process the relevant numbers based on their expected health care needs for the following year. Our research indicates that many participants struggle with understanding the necessary cost-sharing concepts (Chart 2).

Chart 2. Percent of participants answering plan comprehension questions correctly.



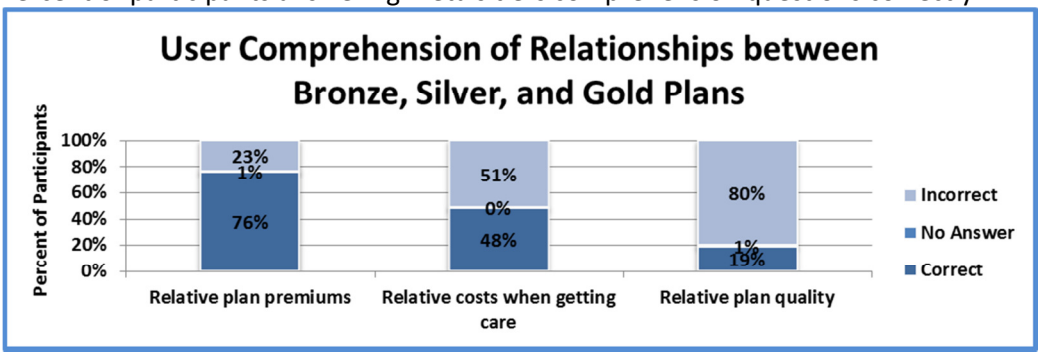
A cost at time of care calculator sidesteps this issue because it automatically processes the relevant numbers, which means that consumers do not need to comprehend the array of insurance terms, nor do they need to perform any math. A total cost calculator that computes an estimate of annual total cost gives consumers a single cost value for each plan that can be straightforwardly compared. Cost calculators may be especially helpful for vulnerable populations, such as those who have never been insured, the less literate, the less health insurance literate, and the less numerate.

Our research indicates that a cost at time of care calculator is helpful, but not sufficient: Even when cost at time of care was estimated by a calculator, many participants' did not understand their plan's relative cost at time of care (Chart 1). Other work has found that explaining how the calculator works (i.e., how cost at time of care is estimated) helps consumers better understand cost at time of care and identify high value health plans (Johnson et al., 2012).

Quality Ratings: Many participants did not understand quality ratings (Chart 1). This is consistent with work indicating that quality ratings are not communicated clearly (Hibbard et al., 2012; Sinaiko et al., 2012), underused by consumers (Quincy, 2012; Kolstad & Chernew, 2008), and particularly difficult for different cultural groups (Derose et al., 2007).

Metals Tier: Many participants did not have a firm understanding of the metals tiers (Chart 3).[5] Roughly three-quarters of participants (74%) correctly understood how premiums change across tiers (i.e., bronze plans have lower premiums and gold plans have higher premiums), but only half of participants (48%) correctly understood how cost at time of care changes across tiers (i.e., bronze plans have higher costs and gold plans have lower costs). Even fewer participants (19%) understood that plan quality ratings are independent of tier. Importantly, half of participants (51%) incorrectly believed that quality increased across tiers such that gold plans are higher quality than bronze plans.

Chart 3. Percent of participants answering metals tiers comprehension questions correctly.



Product Type: PBGH's experience with the Plan Chooser has shown that consumers have a hard time understanding the differences between different benefit structures (e.g., high deductible, fixed copay, personal account plans, etc.).

REFERENCES

For more information or other recommendations for plan choice decision support, including additional issue briefs and an in-depth report, visit http://www.pbgh.org/exchange-plan-choice or contact Ted von Glahn (tglahn@pbgh.org).

Derose, K. P., Kanouse, D. E., Weidmer, B., Weech-Maldonado, R., Garcia, R. E., & Hays, R. D. (2007). Developing a Spanish-language consumer report for CAHPS ® health plan surveys. *The Joint Commission Journal on Quality and Patient Safety, 33*(11), 681-688.

Hibbard, J. H., Greene, J., Sofaer, S., Firminger, K., & Hirsh, J. (2012). An experiment shows that a well-designed report on costs and quality can help consumers choose high-value health care. *Health Affairs, 31*(3), 5605-5668.

[5] We did not include platinum plans in these studies. Participants were asked how gold plans compare to silver and bronze plans, or how bronze plans compare to silver and gold plans.

Johnson, E. J., Hassin, R., Baker, T., Bajger, A., & Treuer, G. (2012). *Can consumers make affordable care affordable? The value of choice architecture.* Manuscript submitted for publication.

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Sommers, B. D., & Rosenbaum, S. (2011). Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Affairs, 30*(2), 228-236. doi: 10.1377/hlthaff.2010.1000

APPENDIX

Table 1. Sample list of important concepts and strawman language to illustrate needed content.

Concept	Explanation
Plan Type[6]	
Metals tier	These plans differ on the monthly insurance premium you pay and on how much you spend when you get medical services.
Bronze	Bronze plans have the lowest monthly premium cost. However, your coverage is lower – you pay more when you get medical services compared to other plans.
Silver	Silver plans are in the middle between Bronze and Gold plans. Your monthly premium cost falls between the Bronze and Gold plans. When you get medical services you pay less compared to Bronze plans but you pay more compared to Gold plans.
Gold	Gold plans are in the middle between Silver and Platinum plans. Your monthly premium cost falls between the Silver and Platinum plans. When you get medical services you pay less compared to Silver plans but you pay more compared to Platinum plans.
Platinum	Platinum plans have the highest monthly premium cost. However, your coverage is higher – you pay less when you get medical services compared to other plans.
Product Type	
Cost sharing reduction plans (CSR)	Medical plans that provide more savings for lower income individuals or families. You pay less when you get care under these plans. Be sure to double check your expected income that you listed – your income must be below <specify $ amount or reference info> to be eligible for these medical plans.
Consumer directed health plan/health reimbursement account	The medical plan includes money that your employer puts in an account, called a health reimbursement account (HRA), that you use to pay for eligible medical expenses. If you spend all of your HRA money, you pay for your share of additional medical expenses like you would in a regular health plan. Any remaining money in the account at year-end is added to your HRA next year if you re-enroll in the plan. You cannot "cash out" HRA money.

[6] Rule contingent on Exchange decision regarding cost at time of care calculator. For concepts such as cost sharing reduction and tax credit, the best approach may be to emphasize how plans compare on cost components.

High deductible health plan/health savings account	In a High Deductible Health Plan you pay a lower monthly premium but it has a higher deductible, which means you pay all medical costs up to the deductible level before the plan begins to pay for any medical services. You can set aside tax-free funds in a Health Savings Account (HSA). You can use this account to pay for qualified medical expenses, including deductibles, coinsurance, and other costs. If you have money in the HSA account at year-end, you keep those dollars and can use them for future health care expenses.
HMO	An HMO (Health Maintenance Organization) is a type of medical plan in which you use a limited set of doctors, hospitals, and other providers. Typically, you choose a primary care physician (PCP) who is your regular doctor and refers you to specialists for any other care. If you get care from a provider who does not belong to the HMO, often you pay the full cost.
PPO	A PPO (Preferred Provider Organization) is a type of medical plan in which you can decide which doctor or other provider you see when you get medical care. You choose providers from the PPO list of 'network' doctors and hospitals. For example, you may choose to see a doctor that belongs to the medical plan (a 'network provider') or see a 'non-network provider'. You pay less when you use network providers, but you pay more when you use non-network providers.
Doctor in Plan	
PCP	Primary Care Physician or Primary Care Provider (PCP) is the regular, personal doctor for many people. Typically, people see this doctor for their check-ups, preventive screenings, and other routine care. People with serious health problems often see a specialist doctor in addition to their PCP. Many HMOs require each member to have a PCP.
Provider directory	A listing of doctors, hospitals, and other health care providers who belong to a medical plan. You pay less for 'in-network providers' compared to those providers who do not belong to the plan.
Rules to See a Doctor	
Preferred provider	Doctors, hospitals, laboratories, and other health care professionals and facilities that belong to a medical plan. Typically, these providers agree to medical service fees and the provider cannot bill the patient for any amount higher than that fee. You pay less when seeing providers that belong to your medical plan. Check if the plan has rules about which in-network providers you can see, or if the plan has a "tiered" network and you pay extra to see some providers.
Non-preferred provider	Doctors, hospitals, laboratories, and other health care professionals and facilities that do not belong to a medical plan. You pay more for non-preferred providers than you pay for preferred providers.
Specialist	A physician specialist treats patients who have certain types of health problems – like a heart condition or a lung disorder. Check the plan's rules to see if you need a referral, an "ok", to see a specialist.
In-network	Doctors, hospitals, laboratories, and other health care providers who belong to a medical plan. You pay less for 'in-network providers' compared to those providers who do not belong to the plan. Check if the plan has rules about which in-network providers you can see, or if the plan has a "tiered" network and you pay extra to see some providers.
Out-of-network	Doctors, hospitals, laboratories, and other health care providers who do not belong to the medical plan. You pay more for 'out-of-network providers' compared to those providers who belong to the plan.
Plan Cost Estimates[7]	These are estimated costs only - your actual costs will be different. Use these cost estimates as a general guide for the differences among plans. These cost estimates come from the information you provided. To see how these estimated costs change if your expected income, use of medical services, or use of prescription drugs is different, change your selections <add language explaining how to change these selections in User Preferences or Plan Comparison>.

[7] Rule contingent on Exchange decision regarding cost at time of care calculator. For concepts such as cost sharing reduction and tax credit, the best approach may be to emphasize how plans compare on cost components.

Cost at time of care	The estimated cost you pay when you get care -- like when you see a doctor or buy a medication. This is an estimate only -- it is based on the medical service and prescription drug use that you expect in the next year. This estimate assumes that you use network providers *only. If you use providers that do not belong to the plan, your costs are higher.* And, this estimate does not include costs for services that are not covered under the medical plan.
Premium	The cost of the medical plan. Typically, you make monthly payments to cover your share of the premium.
Tax credit	Your premium is reduced by this amount. This tax cut helps middle- and low-income people afford health insurance by paying a tax credit that reduces your cost for the medical plan. This is an estimate only -- it is based on the expected income that you listed for next year.
Total cost	The estimated cost you pay for the medical plan in a year. Your monthly premium cost plus the estimated cost you pay when you get care. This is an estimate only -- it is based on the information you provided. <Add language tailored to information user provides re expected income/tax credit, medical service use etc.>
Covered Services	A service that the medical plan provides to its members and pays a part or all of the cost. Often, you pay a share of the cost for a covered service, too.
Essential health benefits	Covered services that must be included in all of the medical plans offered in the Exchange. Your share of the cost can differ across the medical plans but every plan will include coverage for these services like routine preventive care, hospital stays, emergency services, and medications.
Out-of-pocket maximum	The most you would pay for your share of the costs of covered medical expenses in a year. Once this limit is reached, covered medical services received during the rest of that year are fully paid by the medical plan. Check the plan's yearly maximum carefully -- certain expenses may not be included in the yearly maximum and there may not be a limit on the amount you pay for those services.
Deductible	The amount you pay each year before the plan begins to pay any part of the cost of covered services. For example, if the deductible is $500, you pay all of the costs for your medical services up to $500 before the medical plan coverage starts; then, typically the medical plan pays for services though you pay a share of those costs, too. Check the plan's deductible carefully - certain expenses may not count toward the deductible and there may not be a limit on the amount you pay for those services.
Chiropractic/ acupuncture visit	Chiropractic services are provided by a licensed chiropractor to manage neuromusculoskeletal conditions through manipulation and related physiological treatment of joints to restore motion, reduce pain, and improve function. Acupuncture services are provided by a medical practitioner who specializes in acupuncture, which is part of a centuries-old medical system, Traditional Chinese Medicine (TCM). The practitioner is trained in one or more of the TCM interventions including needles (acupuncture), Qigong, and heat and touch (acupressure). The treatments are based on understanding the flow of energy (Qi) in the body and improving its flow to restore health.
Doctor office visit	A visit to a physician's office on an outpatient basis.
Emergency care	Health care services, delivered in an emergency service setting, that are required to treat a sudden, unexpected injury or serious sickness which could be expected to result in serious complications, permanent impairment, or death unless given immediate medical attention. For example, a heart attack, stroke, severe bleeding, shock, or allergic or sudden reactions to drugs.
Home health visit	Health care services a person receives at home.
Hospice	Services to provide comfort and support for someone who is in the last stages of a terminal illness.
Hospital stay	When a person is admitted to a hospital for care of a medical condition for an overnight stay of one or more days. The hospital is an institution with organized facilities for diagnosing and treating medical conditions and providing 24-hour nursing service and medical supervision.
Lab and radiology	Services include diagnostic lab tests and x-ray procedures including diagnostic imaging.
Maternity office visit	A physician office visit by a woman for care related to pregnancy and the delivery of a newborn child.

Mental health: Inpatient	A hospital, residential treatment center, partial hospitalization program, or other mental health care facility that is licensed by the state to provide acute or intensive psychiatric care, detoxification services, or chemical dependency rehabilitation services.
Mental health: Outpatient	A structured outpatient program, day treatment, partial hospitalization program, or other mental health care facility that is licensed by the state to provide acute or intensive psychiatric care, detoxification services, or chemical dependency rehabilitation services.
Outpatient therapy visit	Treatment under the direction of a physician and provided by a licensed or certified therapist such as a physical, speech, or occupational therapist.
Preventive care: Adult	Services include routine physical exams and listed screenings, tests, and immunizations for adults of specified ages.
Substance abuse: Inpatient	A hospital, residential treatment center, partial hospitalization program, or other mental health care facility that is licensed to provide chemical dependency detoxification services or rehabilitation services. These facilities often are known as a Chemical Dependency Treatment Facility.
Substance abuse: Outpatient	A visit on an outpatient basis for the treatment of alcoholism, drug addiction, or other chemical dependency problems.
Surgeon	Surgical services delivered by a licensed surgeon in either an inpatient hospital or outpatient setting.
Well baby visit	Services include routine physical exams and listed screenings, tests, and immunizations for infants and children of specified ages.
Prescription Drugs	
Brand-name drug	A drug that is made by a single company under a patent and costs more than the equivalent generic drug.
Formulary	A list of drugs included in the services paid by the medical plan. If a drug is not on the formulary list, you pay more or even the full cost for the drug.
Generic drug	A prescription drug which is chemically the same as a brand-name drug but costs less. The safety and efficacy are equivalent to the brand-name drug.
Prescription: Mail-order generic/ brand/ non-formulary	Prescriptions - up to a 90-day supply - that are obtained through the mail. Drugs that are approved by the Food and Drug Administration (FDA) and require a prescription either by Federal or State law. See coverage details for other medications and supplies - such as insulin - that may be included in the prescription drug coverage. Generic drugs are sold by their chemical name after the original brand drug patent has expired; their safety and efficacy are equivalent to the brand-name drug and they cost less than the brand-name drug. Brand drugs are made by a single company under a patent and cost more than any equivalent generic drug. Non-formulary drugs are not recommended by the medical plan and typically the member pays more for these medications.
Prescription: Retail generic/ brand/ non-formulary	Prescriptions that are obtained at a retail pharmacy. Drugs that are approved by the Food and Drug Administration (FDA) and require a prescription either by Federal or State law. See coverage details for other medications and supplies - such as insulin - that may be included in the prescription drug coverage. Generic drugs are sold by their chemical name after the original brand drug patent has expired; their safety and efficacy are equivalent to the brand-name drug and they cost less than the brand-name drug. Brand drugs are made by a single company under a patent and cost more than any equivalent generic drug. Non-formulary drugs are not recommended by the medical plan and typically the member pays more for these medications.
Related Covered Services Terms	
Coinsurance	Your share of the costs of certain health care services. For example, if your coinsurance for a service is 20% and the bill is $100 -- you pay $20 and the medical plan pays the remaining $80 of that bill.

Copay	A fixed dollar amount that you pay for certain health care services, usually when you get the service. For example, if your copay for an office visit is $30 – each time you have a doctor visit you pay $30.
Allowed amount	The most a medical plan will pay for a covered service. If the doctor or other provider has not agreed to accept the allowed amount then you may have to pay any costs above that amount. Usually, the doctors and other providers who belong to the plan (in-network providers) agree to accept the allowed amount as full payment and cannot bill you more. This also may be called an “eligible expense,” “payment allowance," or "negotiated rate."
Exclusion	A health condition or service that is not included in the medical plan coverage -- you pay the entire costs for such services.
Medically necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms and that meet accepted standards of medicine.
Preauthorization	A decision by your medical plan that a healthcare service is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Check the plan’s rules -- preauthorization may be required for certain services before getting care.