

# America's Health Insurance Plans

## Focus Group Summary

### October, 2010

## Background

America's Health Insurance Plans (AHIP) is working with the National Association of Insurance Commissioners (NAIC) to develop an industry template to summarize the basics of a health plan's cost and coverage. In order to ensure that the template is understandable to consumers, focus group research was conducted in two geographies:

- Two groups in Seattle on 9/27/10
- Two groups in St. Louis on 9/29/10

Participants were recruited to be decision-makers in their household's healthcare insurance choices and to be currently insured. Each group was composed of ten participants with the majority (7-8) being "group plan consumers" and the remaining being "individual plan consumers." Group plan consumers were covered by health insurance offered by their employers and were recruited to represent a mix of employer types and company sizes. Individual plan consumers paid for their own individual health insurance plans (being either self-employed, unemployed or working for a company that does not provide healthcare benefits). A mix of insurance providers/plans was represented in each group. An even number of men and women were recruited for each group as well as a mix of ages between 25 and 65. Other demographic variables were not restricted in order to reflect the natural representation of education and income among these segments.

Each discussion group lasted two hours. Upfront discussion covered general questions about health insurance providers and general communication. Each group reviewed two different templates (Forms A and B). The order in which the forms were presented varied. In each city, one group reviewed the HMO version of the templates and one group reviewed the PPO versions. All groups reviewed the same glossary document.

## Findings

### **A template is valued by consumers.**

There was a great deal of variability in how focus group participants accessed information about health plans. Some had a Human Resources representative in their company who would personally explain choices and help compare plans. Some had no choices and simply received a “fat book” with lots of “legalese” leaving them confused about what their plan offered. Some relied on insurance brokers to present alternatives. Some had to actively seek out information online about the different companies and plans that might be available to them. The idea that there might be a standard form or common template that health insurance companies would use to summarize costs and benefits was universally hailed as a great move. All participants felt that they personally would benefit by having a quick read of any given plan and being better able to compare plans. A common template would provide consistency and uniformity. Because plans often change, participants hoped that the template would be used to update them with the new information.

### **The key element of interest in comparing plans is bottom-line cost to the subscriber.**

Overwhelmingly, the large majority of participants were most interested in knowing the cost of any given health plan – what they personally would end up paying. Lowest cost was the primary factor in choosing a policy for these people. To this end, premiums, deductibles, co-pays and annual limits were all critical pieces of information.

After cost, Seattle participants' interest focused on coverage of ancillary health services like acupuncture, chiropractics, massage, physical therapy and mental health. Most every participant in Seattle groups had a personal interest in being able to utilize one or more of these services. They were interested if their service of interest was covered and, if so, how many visits were allowed.

St. Louis participants were more interested in major medical coverage rather than ancillary services. They wanted to check if their doctor(s) would be part of a health plan's network.

## **Both Forms A and B are rated well as templates that summarize important health plan information.**

The forty participants in this research project were asked to review each template individually and then assign a rating before any discussion began. On a scale of 1-10, a 10 would indicate that the template did an excellent job of summarizing important information in an understandable manner; a 1 would indicate the template did a poor job. While these ratings are not statistically significant, they do represent the feelings of the 40 participants in these four focus groups. Seattle and St. Louis participants were similar in their discussion of the templates and the findings represent the feelings common in both areas. Overall, the grid format and use of color were positives for both templates.

### **Average Ratings**

7.8 Form A

7.3 Form B

## **Overall, Form A is preferred over Form B.**

One phenomenon repeated itself. The research process involved one group in each city receiving Form A before B and the other group receiving Form B before Form A. In each of the four groups, participants tended to prefer the second template they were exposed to over the first. It appeared that they became familiar with the information contained in the first template and therefore it was easier to comprehend in a second version.

Over the course of the four groups, a slight majority of participants (22 out of 40) choose Form A as their preferred template. The primary differentiator was the first page. Both Form A's and Form B's first page were felt to contain the critical information one needed to know – most importantly, the cost elements.

From a purely qualitative standpoint, the discussion and reasons for preferring Form A felt more robust, articulated and comprehensive. The visual format of the Form A's first page having three columns – “question,” “answer” and “why this matters” – was a very easy and logical sequence. A couple of participants felt it was “oversimplified” or “talks down to me” but most greatly appreciated the simplification.

Other elements of Form A that were considered positive include:

- Laying out the exclusions in bullet points. Bullet points were preferred for any listings rather than the use of continuous text.
- Defining terms (copayments, coinsurance) on page 2 – the same page they are used.
- The explanations of in-network providers on page 2 were preferred over Form B's use of the explanations in parentheses under the headings of In-Network Provider and Out-of-Network Provider.

### **There are elements of Form B that are appreciated.**

For some, the two-column layout of Form B was felt to be the simpler and easier-to-understand format. In addition, most people agreed that there were some aspects of Form B that stood out as being positive:

- The large-size and bold font for the numbers – drawing one's attention to the elements considered to be most important (cost). Older participants in particular applauded any usage of large type.
- Labeling the name of the health plan and company name prominently in the upper left-hand corner.
- Providing a website for a list of in-network doctors in answer to the question, "Does this plan use a network?"
- The "footnotes" at the bottom of each page informing the reader of where to go for questions and definitions.
- The "Your Grievance and Appeals Rights" section on page 4 was felt to be better organized with distinct sections defining a grievance and an appeal and providing specific numbers and websites for each.

**While people value the simplicity of the templates, health insurance is a difficult subject to summarize and there is some level of confusion with content.**

There were some general suggestions for helping to alleviate confusion:

- Terms should ideally be defined on the pages they are referenced or there should be a link or note as to where to find the definition.
- Real-life examples could be provided (perhaps in an occasional box) using casual language, i.e., “If an out-of-network provider bills \$200 but the plan allows \$150, you pay the difference of \$50. In addition, if your co-insurance is 20%, you will pay 20% of the allowed amount (20% of \$150 = \$30). Your total out-of-pocket cost would be \$80 (\$50 + \$30).”
- Definitions and examples do not necessarily need to be spelled out in the template as long as there is an easy link or note of how to find the definition or example.
- Avoid answering a question with a one-word answer; provide some elaboration.
- Fill in all blanks in columns; don’t leave any empty.
- Provide layers of information – provide links and guidance for how to obtain more detailed explanation.

There were a number of areas of content that confused people in each form. The following provides identification of these areas:

**FORM A – SPECIFIC AREAS OF CONFUSION/SUGGESTIONS FOR IMPROVEMENT**

- People want to know what the cost would be for a spouse or family in addition to an individual.
- “Allowed amount” needs to be defined, either on the page or with a link/direction as to where to find the definition.
- “Balance billed charges” needs to be defined either on the page or with a link/direction as to where to find the definition.
- “Pharmacy expenses” in the HMO version is an unfamiliar term; use “prescription drugs” if that is what it means.
- The “why this matters” explanation of the out-of-pocket limit was confusing. Some recommended that the amount be inserted directly into the explanation, for example, “\$5000 is the most you pay...” It was felt that using a “real life” example might help clarify and differentiate an out-of-pocket limit from a deductible.

- Answer the question, "Is there an annual limit on what the insurer pays?" not with "none" but with something along the lines of, "No. There is no limit on what the insurer will pay in a year."
- Answer the question, "Does this plan use a network?" with, "Yes. This plan uses a network of preferred providers."
- "Specialty drugs" needs a definition or examples provided.
- "Facility fee" needs a definition or examples provided.
- Need more examples of "other services."
- "Urgent care" needs to be defined as distinct from emergency care.
- "Habilitation" needs to be defined.
- "Durable Medical Equipment" needs to be defined.
- Blank columns under the heading, "Limitations and Exceptions" need to be filled in with "No limitations or exceptions."
- Exclusions need to be synched with "not covered" services. For example, it was felt that since the PPO plan stated that prenatal, postnatal and delivery were not covered, then maternity services should be listed as an exclusion; same for vision, habilitation services and skilled nursing care.

#### **FORM B – SPECIFIC AREAS OF CONFUSION/SUGGESTIONS FOR IMPROVEMENT**

- People want to know what the cost would be for a spouse or family in addition to one person.
- Answer the question, "Do I need a referral to see a specialist?" as in Form A with "No. You may call network specialist and schedule an appointment without a referral."
- Coverage limits are only mentioned for prescription drugs; it is assumed there must be other limits as well that are not being addressed.
- It's easier to read the excluded services in bullet points as used in Form A. There was some preference in seeing exclusions listed upfront. At the very least, exclusions need to be prominent somewhere in the document.
- Definitions of copayments and coinsurance are needed where the terms are used.
- "Practioner" is misspelled.
- "Other practioner" needs examples, e.g., is a nurse practitioner included in the exclusion?
- "Specialty drugs" needs a definition or examples provided.
- "Facility fee" needs a definition or examples provided.
- Need more examples of "other services."
- "Urgent care" needs to be defined as distinct from emergency care.

- “Habilitation” needs to be defined.
- “Durable Medical Equipment” needs to be defined.
- Should be “If you or your child needs oral or vision care” not “If your child needs....”

PPO versions provided some additional confusing elements:

- “Tiers” need to be explained.
- The “Limitations and Exceptions” were hard to follow on page 2.
- Mail order coverage is not explained (Does it cover a 30-day supply, 60-day, 90-day?).
- Emergency room fees are stated as “\$100/visit if not admitted.” There were questions as to what constituted admittance – is it an overnight stay?

The HMO versions raised one unique question – it implied that there were non-participating pharmacies (a new concept to most) and thus people wanted to know where they could find a list of participating pharmacies.

### **There is interest in further information about costs.**

While the templates were helpful in laying out the parameters of any given plan and were considered comprehensive in summarizing important information, participants wanted to see how the costs would play out in reality. For instance, it was requested that health plans provide a list of “allowed amounts” for common medical procedures. They were looking for ways to estimate their out-of-pocket costs before going to a doctor’s office or undertaking a medical procedure. One of the greatest frustrations consumers have is getting bills with unanticipated costs.

## **The glossary is useful but there are some concerns about content and design.**

For the most part, the glossary was positively received. Participants were asked to rate the glossary in terms of how well it defined the terms they needed to have defined. On a scale of 1-10 with 10 being excellent and 1 being poor, the glossary was rated an average of 8. The glossary was seen to provide adequate definitions for most of their terms of interest. It was advised to include a direct link to a resource with more information and definitions.

A few definitions raised more questions than they answered.

- Urgent care: "Who decides what is severe enough to require emergency care?"
- Skilled nursing care: "Is there unskilled nursing care?"
- Balance billing: "A preferred provider may not balance bill you – does that mean that they have latitude to balance bill you or are they not allowed to balance bill you?"
- Medically necessary: "Who decides accepted standards?"

"Co-insurance" was a term that was initially unfamiliar to some in the groups who mistook it for a policy that covered two people or for a copayment. It was felt that the definition in the glossary could benefit from clarification by adding something along the lines of, "...your insurance plan pays for the rest of the allowed amount (for example, 80%)."

The definition of a "deductible" as differentiated from an "out-of-pocket limit" would benefit by providing an example, e.g., "If your deductible is \$1500, you are responsible for paying the first \$1500 of your medical care before your co-insurance kicks in. If your co-insurance is 20%, you will pay 20% of medical costs and your health plan will pay 80% after you have paid \$1500 and up to your out-of-pocket limit (for example, \$5000). If your total out-of-pocket costs in a year are over \$5000, you will not pay anything more for the rest of the year." *(Please note that the example is provided only as an illustration; the explanation may be incorrect)*

There were a few terms that were used in the templates and raised questions but were not defined:

- Medical underwriting
- Pharmacy services
- Specialty drugs
- Tier
- Facility fee



From a formatting standpoint, participants generally advised that the definitions be visually more distinct. The use of light shading to differentiate did not do an adequate job. Given that the previous templates used the same shading to highlight rows across columns, it was confusing to have the color not align in the two side-by-side columns in the glossary. A common piece of advice was to use black bold type for the term being defined to make it more prominent and use the blue color to highlight the words within the definition (particularly since blue type is often used as a hyperlink).

Most focus group participants would include the glossary with any distribution of information contained in a template.