Developing a Measure of Health Insurance Literacy: Understanding Consumers' Ability to Choose and Use Insurance

Overview

By 2020, the Patient Protection and Affordable Care Act (ACA)[1] has the potential to transform the health care access of more than 34 million previously uninsured Americans. These mostly low- and moderate-income Americans will have the opportunity to purchase insurance from the health insurance exchange (HIX) marketplace or through employers offering insurance benefits for the first time. Fulfilling the potential of this significant legislation hinges upon consumers' understanding of health insurance and their options for coverage. But to get past the industry jargon and understand the intricacies of health insurance is no simple matter. Little empirical information is available about what consumers in the private marketplace actually do understand. Yet such information is critical to communicate insurance concepts and benefit language in a way consumers can apply to their own situations.

To fill this void, the American Institutes for Research (AIR) is developing a measure of health insurance literacy—a means to objectively assess what consumers in the private market do and don't understand as they select health insurance and navigate the benefit structure of their plan. Information generated from the measure could provide direction to those offering health insurance, including state and federal HIXs, employers, and private health plans seeking to better target their outreach efforts and to improve health plan comparison materials. The measure will also help state and federal governments and others interested in effective implementation gauge whether health plan documents are "understandable" as required by ACA legislation.[2] In addition, the measure may help identify benefit rules that are particularly problematic for the majority of consumers to understand and should be adapted or subject to regulatory review.

In this issue brief, we describe the problem and report our findings from interviews with health insurance counselors and other stakeholders about problems consumers face in selecting and using health insurance. Next, we describe our strategy to develop an important new tool: a measure of health insurance literacy.

> *Health insurance literacy is defined as "the capacity to find and evaluate information about health plans, select the best plan given financial and health circumstances, and use the plan once enrolled."*
> Health Insurance Literacy Expert Roundtable, 2011.

Background

New rules under the ACA reduce some of the burden consumers face when shopping for health insurance.[3] Since September 2012, a uniform Summary of Benefits and Coverage (SBC), which some compare to the Nutrition Facts label required for packaged foods,[4] has clarified plan choices and created a consistent format for comparison of key benefit features across plans.[5] A glossary defines 44 important insurance and health services terms, while coverage examples show consumers the value of health insurance in lowering personal financial risk by modeling some typical utilization and cost scenarios.

The new SBC represents a major step forward—yet, for all but the savviest consumers, understanding benefit structures and comparing health insurance plans remain challenging tasks. Even after extensive input from consumer advocacy groups, the SBC is eight dense pages long. The large number of specialized terms, plus coverage rules and exceptions, makes side-by-side comparisons of plans and projections of out-of-pocket costs difficult to understand.

One way state HIXs, the federal government, and other employers are reducing complexity is by using electronic decision support tools, which organize and filter information to guide consumers through the selection process.[6] One advantage of such tools is that, with minimal understanding of health insurance benefit structures, consumers can select a health insurance plan that takes into account their personal circumstances. But there is a disadvantage: A teachable moment to educate consumers about health insurance is lost. Consumers who use decision support tools may not comprehend the cost-sharing structure of the plan they purchased, or what services are and aren't covered. And, consumers will need some knowledge of health insurance terms as they make decisions about health care and communicate with providers and health plan member services representatives about their benefits. In some situations, choice architecture may lead consumers to make the wrong choices.[7] They may never know there were alternatives that could have better met their health insurance needs.

In spite of these issues, the SBC and consumer choice tools are important launching pads for implementing the ACA. Objectively assessing consumers' understanding of private health insurance will inform future improvements to the SBC and the development of other tools to communicate with consumers about health insurance.

Studies of consumer health insurance literacy have concentrated on assessing the literacy of Medicare and Medicaid consumers—not of consumers purchasing insurance in the private marketplace.[8] Consumer data collected by the state HIXs has mostly relied on focus-group research exploring consumer expectations of their state HIX and the health insurance choices offered.[9]

The knowledge gained from a health insurance literacy measure will advance the effectiveness of future modifications to the SBC and to consumer choice technology tools. New strategies to enhance consumer understanding of health insurance will be better informed and more likely to resonate with consumers.

Interviews with Health Insurance Counselors

To help illuminate the challenges faced by consumers, AIR conducted 20 in-depth interviews with professionals who counsel consumers who purchase private health insurance (Exhibit 1). We focused on three primary questions: (1) What does a consumer need to know, think about, and do to select and use private health insurance? (2) What do consumers tend not to know, think about, or do when selecting and using private health insurance that leads to problems later on? (3) How do private health insurance choices and benefit designs impact the difficulty of selecting and using health insurance?

These interviews illustrate the complexities in transforming consumers into active purchasers and stewards of health insurance. Below are our key findings from these interviews, classified into two categories: consumers *choosing or using* health insurance.

Exhibit 1: Key Informant Interviews

Twenty interviews with consumer assistants working in 18 organizations

- 6 not-for-profit and 1 for-profit consumer assistance agencies
- 4 health systems/providers
- 1 health plan
- 4 state insurance agencies
- 2 insurance agents

Geographic representation: 7 Northeast (6 Massachusetts), 6 South, 3 West, 2 Midwest

Choosing Insurance

CONSUMERS DO NOT UNDERSTAND RISK AND PERSONAL LIABILITY FOR CARE

Many consumers fail to grasp the underlying concept of health insurance and financial liability for cared received. They assess the value of insurance by looking at whether the amount of costs incurred through the year for health services and drugs covered by insurance will match or exceed the monthly premium. Consumers are often unaware of their personal financial liability should they become seriously ill or have an accident. They falsely assume they can receive care in the emergency department without accountability for the cost of treatment.

> *"We've encountered a fair number of people who say, 'I'm not going to pay $300 a month because I'm not going to use $300 a month of anything.' Sometimes, they don't get the concept that if you don't need it now, it's for a potential future health problem and you have to pay in advance. You don't sign up when you get sick."*

> *"I've heard many, many, many times people saying, 'Well, if you really need medical attention, you can go to the emergency room. And I correct them that you may be able to go for life-threatening [situations], and then once you're stabilized you will exit. So, if you went and thought that you could get medical care through the emergency room, say for a cancer diagnosis, they would not treat your cancer. They would stabilize you and you would go out the door."*

CONSUMERS DO NOT FULLY ASSESS THEIR NEEDS OR THE SERVICES THE PLANS COVER

Consumers have difficulty adequately weighing all the factors that are important when selecting an appropriate plan. To begin with, consumers have difficulty in predicting usage, including assessing their overall health status. Not surprisingly, many insurance counselors say that people living with chronic conditions seek care regularly and are among the savvier health insurance consumers. Consumers who obtain care only when acutely ill may not recognize the importance of preventive care or be aware of what preventive services are recommended.

Even when consumers are able to predict their health needs, they purchase insurance without fully understanding what services are covered under the plan. Consumers have a poor understanding of what they purchase because (1) summary documents describing benefits are confusing, (2) benefit structures are increasingly complex, and (3) they lack the knowledge and skills to sort out the implications of selecting one policy over another. The trend toward provider tiers is particularly difficult for consumers to comprehend and navigate. Co-insurance, deductibles applying to some benefits but not others, and allowable amounts are simply not well understood, either.

> *"I just had someone who picked some sort of discount [insurance plan] and thought that that was insurance and it didn't cover… It only covered $3,000 of hospital use which is not enough [for] anything."*

Consumers frequently purchase insurance under the false assumption that they are covered for all the care they need because they pay a monthly premium. Consumers tend to put off reading about their plan benefits because they perceive it requires too much time and is too complicated. Insurance counselors note consumers are at risk for unforeseen costs if they do not understand what providers and services their plan covers, whether the plan limits the amount of care they can receive, or when preapproval or referrals are needed. One counselor tells

of individuals who purchased plans that covered only a small portion of hospital costs; they learned about the inadequacy of their coverage only after a major health event. Another counselor notes how some consumers overlook the importance of coverage for behavioral health services and have difficulty accessing these services when needed.

CONSUMERS FALL BACK ON BRAND AND WORD OF MOUTH

Consumers generally want to select the best value plan but are not sure how to assess overall value. Presented with multiple plans and options from different health carriers, consumers experience "decision paralysis" and take cognitive shortcuts. When faced with a difficult comparison, consumers default to picking a plan based on a brand name they know and have had experience with. Insurance counselors frequently report that consumers believe paying more will result in better care. While some gravitate towards more expensive plans, others automatically choose cheaper options without understanding the implications.

> *"A lot of our callers will say 'Okay, well I want to pay the least monthly,' and that's a big obstacle to overcome; that if you're paying the least monthly, that doesn't mean necessarily that you have the coverage that you need."*

> *"People have the tendency to assume that because you have a particular policy from a particular carrier, you have good insurance, which is not true. You can have [name of prominent health plan] but it doesn't mean that it's a good policy."*

Alternatively, consumers may choose plans based on word of mouth, which can lead to erroneous assumptions about coverage. They may face seemingly minor differences in coverage between plans that can have serious implications for how they receive and pay for their care.

Consumers generally do not understand that benefit designs within the same health plan can differ, or that their needs may be very different from those of the person who recommended the plan. Consumers often assume plans are designed to fit the needs of most individuals and fail to comprehend the importance of selecting a plan tailored to their needs.

CONSUMERS DO NOT UNDERSTAND ALL COST-SHARING TERMS

Consumers must be familiar with cost-related terms and how to apply these terms to their personal circumstances in order to accurately assess the trade-offs between a higher premium and reduced cost sharing at the point of service. Most consumers are familiar with the concept of paying a monthly premium, but few recognize that the premiums do not comprise their total cost for seeking care. Consumers who lack an understanding of cost-related terms tend to focus on the monthly premium and are unclear about how co-insurance, copay, and deductible should be considered as part of the overall costs. This misunderstanding can lead consumers to select plans without knowing they might incur additional financial liability when faced with a major health event.

Using Insurance

CONSUMERS DO NOT UNDERSTAND HOW TO OBTAIN CARE

Insurance counselors make it clear that consumers continue to encounter challenges once they attempt to access care. They indicate that many consumers don't know how to use their insurance correctly to navigate the system of care, or where to turn for information or to advocate for themselves. Participants tell how consumers, especially those who were previously uninsured, may be inexperienced in seeking primary care. Some consumers assume they will be assigned to a primary care provider (PCP) upon enrollment, while others don't know how to identify providers who are within network and accepting new patients. Many—especially those without a history of receiving care—don't realize the need to become established with a PCP to avoid problems accessing care and higher out-of-pocket costs for an emergency department visit. According to insurance counselors, difficulty getting a new patient appointment with a PCP leads consumers

to go to the emergency department for routine prescriptions and other nonemergency needs that could have been managed by a PCP.

CONSUMERS DON'T UNDERSTAND PROVIDER NETWORK RESTRICTIONS

In general, insurance counselors describe the risky tendency of consumers to assume coverage for a particular provider, service, or prescription, and attribute the assumption to lack of familiarity with provider networks, drug formularies, and processes for referrals or preauthorization. One insurance counselor notes that consumers should not assume their PCP will always confirm a specialist is in-network. Another points out that consumers can be misled when office staff say they "take an insurance," when in fact the provider may be out of network.

> *"I don't know how many calls [I get] a day where [consumers] decided to go out of network. So they really don't understand it… And I think they're really upset when they get these bills. [They say], 'What do you mean I can't go to see the doctor [I've been to] for 16 years. So that's probably the biggest problem there."*

CONSUMERS DON'T KNOW HOW TO VERIFY OR APPEAL BILLING STATEMENTS

When billing statements are wrong, consumers have difficulty figuring out their share of the costs. Many people do not understand the billing statement or benefit language enough to question invoices. Rather than pursue a questionable noncovered charge by contacting member services or filing an appeal, they pay the bill.

The difference in cost to the consumer when a provider determines a test to be diagnostic instead of screening is an example of the complexity in health care billing. Colonoscopies exemplify the challenge. Insurance counselors find that many consumers don't understand what should be considered preventive and covered and how they should be charged accordingly. With the ACA, consumers incur no out-of-pocket costs for certain preventive tests, but some plans may offer very limited coverage for diagnostic tests. When a physician finds a polyp, the screening colonoscopy then becomes diagnostic, leaving some consumers responsible for a substantial portion of the bill.

> *"Often, for example, it's a colonoscopy, which is technically preventive, but it gets, more often than not, coded as a diagnostic because they find something when they go in and do the colonoscopy."*

CONSUMERS DON'T KNOW HOW TO NAVIGATE DEDUCTIBLES

On a related topic, consumers struggle with understanding what services are and are not applied to the deductible and often don't realize there may be separate deductibles for in-network services, out-of-network services, and drugs. The confusion grows when one part of a visit or service is not part of a deductible but another aspect is under the deductible. Insurance counselors speak of how some consumers do not ask the pharmacy to file a prescription claim because they have not met the pharmaceutical deductible. Consumers don't realize that unless the claim is filed, their out-of-pocket payment will not be counted toward meeting the deductible.

Problems a Measure of Health Insurance Literacy Will Address

Next, we conducted informal interviews with professionals who advise, make, or carry out public policy, to learn about problems related to health insurance access and how health insurance literacy data might benefit their work. We heard the perspectives of 12 individuals representing a wide range of groups: state insurance exchanges, state insurance commissions, federal health policy, government and private personnel management, unions, and consumer advocacy groups. These interviews helped us identify the key themes in Exhibit 2.

The data collected from a health insurance literacy measure could enable the HIXs and health plans to make informed decisions about how to allocate resources for outreach activities. Outreach funding could be better directed, while trend data could be collected to assess the impact of outreach on improving residents' health insurance literacy over time. Outreach funding and the level of effort could then be modified accordingly. Where benefit features are beyond the comprehension of most consumers and create significant barriers to access, state- and federally run HIX decision makers could decide to modify qualified plan certification requirements.

EXHIBIT 2. BENEFITS OF A HEALTH INSURANCE LITERACY (HIL) MEASURE

WHO AFFECTED	PROBLEMS FROM LACK OF HIL DATA	BENEFITS OF INFORMATION GENERATED BY AN HIL MEASURE
Health Insurance Exchanges (HIX) and Health Plans	■ One-size-fits-all approach to developing outreach programs and communicating with consumers about health insurance	***Decision Makers*** ■ Allocate resources to call centers and navigator programs based on HIL of the population served. ■ Assess progress in increasing HIL of target populations. ■ Modify qualified plan certification requirements so plan design features consumers find incomprehensible will be disallowed. ***Outreach Programs*** ■ Provide guidance on content to be included in navigator and in-person assistance training programs. ■ Tailor education and outreach to match complexity and type of information provided to the abilities of specific demographic groups (e.g., age, gender, race/ethnicity, health status). ■ Identify characteristics of the usual insurance decision makers in a family to target outreach to that group.
Policymakers	■ Have no objective HIL data to inform health policy on health insurance access, adequacy of HIX outreach, and adequacy of health insurance options offered by the HIXs	■ Identify characteristics of populations most in need of outreach resources. ■ Assess progress in increasing the HIL of target populations. ■ Identify what facets of benefit design should be addressed through market incentive and regulation.

HIXs and health plans would benefit from a health insurance literacy measure by improving the efficiency and effectiveness of outreach activities. Data on the knowledge and skills gaps that are problematic for consumers by consumer type would guide HIXs' content development for navigator and in-person assistance training programs. Thus, consumer outreach programs could match the complexity and type of information they provide to the health insurance literacy levels of specific demographic groups and match information with the abilities of persons making purchasing decisions for the family.

The benefits would extend to policymakers: A health insurance literacy measure could direct outreach funding to populations with greater needs and assess the impact of outreach funding on consumers' understanding of health insurance. And, the measure may uncover benefit design rules and features that are incomprehensible to consumers and should be addressed through policy decisions.

Development of a Measure of Health Insurance Literacy

Our interviews with health insurance counselors reveal the complexity of the problems consumers face when selecting health insurance and navigating the health insurance system. Our interviews with professionals who advise, make, or carry out public policy point to the need for data that will enable the HIXs and policymakers to match resources to low, medium, and high literate groups and to assess the impact of outreach efforts on consumers' health insurance literacy.

To meet this need for data on health insurance literacy, AIR is working with a group of more than 80 expert stakeholders from consumer assistance organizations, academia, advocacy groups, health plans, and government to create a validated measure of health insurance literacy that (1) gauges a person's ability to make informed decisions when selecting and using health insurance, (2) is designed for use at the population level, and (3) is a tool with a series of multiple-choice questions easily administered by paper and pencil or over the Internet.

With our stakeholder group, we have designed a conceptual model of health insurance literacy to guide the development of the measure. The model identifies the topic areas where questions are needed (e.g., insurance terms, information seeking, document literacy, and cognitive skills such as numeracy and the ability to assess health insurance value). Questions were drafted by our research team and, when possible, adapted from an extensive range of related measures. Draft questions were reviewed by a technical advisory panel of experts in measurement development and health literacy, and by the project's community of expert stakeholders, and underwent a plain-language review. We completed a draft of the health insurance literacy measure in January 2013. Two rounds of cognitive testing and revisions will occur in early 2013 to ensure items are consistently understood as intended.

After the final revision of the draft measure, we will field test the measure in a Web survey of people with diverse characteristics. Survey data will be tested to establish the validity and reliability of the measure. Once the health insurance literacy measure has been validated, we will survey a representative sample of the U.S. population to generate the information needed to inform states and various groups carrying out the mandates of the ACA and making health policy subsequent to the ACA.

Summary

Health insurance is one of the most complex products consumers will ever purchase. Healthy young adults, people with chronic conditions and disabilities, and singles and families all have different needs, abilities, experiences with health insurance, and opportunities for purchasing insurance. Rather than a one-size-fits-all approach to education and outreach, a systematic tailoring of health insurance information to specific groups is urgently needed. A body of evidence created by a nationally representative survey of health insurance literacy using a validated measure will move the discussion from the nonspecific—"most consumers know little" and "health insurance is just too complicated"—to targeted action where information and outreach can be systematically tailored to the audience. Tailored information will enable consumers to gain sufficient understanding, preparing them to make informed purchasing decisions and to more wisely use health insurance to maximize their health and protect their assets.

End Notes

1 Compilation of Patient Protection and Affordable Care Act (as amended through May 1, 2010). Retrieved from http://housedocs.house.gov/energycommerce/ppacacon.pdf

2 Ibid.

3 "Summary of Benefits and Coverage and Uniform Glossary Final Rule," *Federal Register 77* (February 14, 2012), 866808706. Retrieved from http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf

4 Health Reform to Require Insurers to Use Plain Language in Describing Health Plan Benefits and Coverage, Department of Health and Human Services (February 9, 2012). Retrieved from http://www.hhs.gov/news/press/2011pres/08/20110817a.html

5 "Summary of Benefits and Coverage and Uniform Glossary." The Center for Consumer Information and Insurance Oversight. Retrieved from http://cciio.cms.gov/resources/other/index.html#sbcug

6 *Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices.* Consumers Union, July 9, 2012. Retrieved from http://www.consumersunion.org/pub/core_health_care/018447.html

7 Ibid.

8 Greenwald, L. M., McCormack, L. A., Uhrig, J. D., & West, N. (2006). Measures and predictors of Medicare knowledge: A review of the literature. *Health Care Financing and Review, 27*(4),1–12.

9 Focus group reports can be found on state Web sites for the following: Connecticut, Colorado, California, Delaware, Iowa, Mississippi, New Mexico, South Carolina.

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