Development and Testing of Consumer/Purchaser Reports

Creating More Effective Health Plan Quality Reports for Consumers: Lessons from a Synthesis of Qualitative Testing

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Objective. Social marketing techniques such as consumer testing have only recently been applied to develop effective consumer health insurance information. This article discusses lessons learned from consumer testing to create consumer plan choice materials.

Data Sources/Study Setting. Data were collected from 268 publicly and privately insured consumers in three studies between 1994 and 1999.

Study Design. Iterative testing and revisions were conducted to design seven booklets to help Medicaid, Medicare, and employed consumers choose a health plan.

Data Collection Methods. Standardized protocols were used in 11 focus groups and 182 interviews to examine the content, comprehension, navigation, and utility of the booklets.

Principal Findings. A method is suggested to help consumers narrow their plan choices by breaking down the process into smaller decisions using a set of guided worksheets.

Conclusion. Implementing these lessons is challenging and not often done well. This article gives examples of evidence-based approaches to address cognitive barriers that designers of consumer health insurance information can adapt to their needs.

Key Words. Consumer choice, document design, health plan decision making, report cards

BACKGROUND

This article grows out of the challenge presented by a convergence of factors in today's U. S. health care market. These factors include the increasingly

complex health plan choices that consumers face, consumers' understandable unfamiliarity with the implications of different health insurance options, the increasing financial responsibility consumers are facing for their health care choices, the consumer report card movement, and the limits of human information processing. Almost two-thirds of families who have employer-sponsored insurance have a choice of plans (Trude 2000), many Medicare beneficiaries have a multitude of Medicare+Choice options, and Medicaid recipients are increasingly being offered multiple managed care plan alternatives. The growth of managed care and its permutations along with greater cost sharing by consumers for their health care have made for a more dynamic, complicated decision-making environment (Chakraborty, Ettenson, and Gaeth 1994; White 1996). Whether consumers who are faced with a choice among health plans can wade through their options, make sense of the choices, address significant trade-offs, and decide upon a health plan are important questions in today's health care market.

In the absence of some educational background, it is difficult for consumers to make such well-informed choices. Many consumers lack basic understanding of the health care market, the differences between managed care and fee-for-service, and the role that plans play in access to and quality of care (Hibbard, Sofaer, and Jewett 1996; Isaacs 1996; McGee, Sofaer, and Kreling 1996; Hibbard et al. 1998; Friedman 1997; Eppig and Poisal 1996; Jones and Lewin 1996).

In response to the need to help consumers make more informed choices, the movement among some employers and government agencies has arisen to provide comparative plan information to consumers. This movement is fueled by the hope that this information will result in consumers getting higher-quality care (Gibbs, Sangl, and Burrus 1996; Hibbard, Sofaer, and

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Jewett 1996; Hibbard, Slovic, and Jewett 1997; Scanlon, Chernew, and Lave 1997). There are multiple mechanisms by which this intended outcome may occur. Informed consumers or purchasers will choose higher-quality plans or plans will be motivated to improve quality to maintain their market share because they anticipate that consumers or purchasers will pay attention to this information. However, decision theory and empirical research on plan choice suggest that simply giving consumers more information about their choices does not by itself result in more informed consumers or improved decision making (Isaacs 1996; Jewett and Hibbard 1996; Slovic 1982; Minnesota Health Data Institute 1996). Despite consumers' assertions that they are interested in information on quality of care (Robinson and Brodie 1997) this information is new and unfamiliar for most consumers. Many consumers have no underlying framework or understanding of how or why information on quality relates to their plan choice.[1] Instead, to make a plan choice, consumers often rely on traditional plan features such as costs and benefits and sources (Booske, Sainfort, and Hundt 1999) such as personal recommendations.

Although factors such as the method and timing of dissemination can account in part for the attention paid to consumer plan choice materials, the present article focuses on the effect of the materials themselves. If consumers are to be an effective force in improving quality of care, we must develop ways to present comparative plan information to consumers so that they will value, understand, and use it in their plan decision making. An important component of this effort is to develop information for consumers with consumers, not just based on what researchers or other experts think consumers should have or want (Schriver 1997). The work discussed here exemplifies this consumer testing approach. Some government agencies, the National Cancer Institute in particular, have been applying social marketing and consumer testing techniques to the development of their health education consumer materials for years (U. S. DHHS 1994; Weinreich 1999). However, agencies such as the Health Care Financing Administration (HCFA) have only more recently started to apply these approaches (e.g., testing materials with a target audience before implementing more broadly) to health insurance to help their beneficiaries understand the changing health care system and their plan options.

OVERVIEW OF STUDIES

Our findings are based on the qualitative research results of five projects that Research Triangle Institute conducted between 1994 and 1999.

First, in the HCFA-sponsored *Information Needs for Consumer Choice* (referred to hereafter as Consumer Choice) project, we designed three prototype handbooks. The first handbook was designed to help prospective Medicare beneficiaries understand the plan choices they face. The handbook contains one of the few consumer-tested, print-based worksheets for comparing the costs and benefits among Medicare fee-for-service and managed care options. The second and third handbooks are aimed, respectively, at Medicare and Medicaid beneficiaries who want to learn more about HMOs and quality information. We conducted multiple rounds of consumer interviews with alternative versions of the handbooks before developing the final prototypes (Burrus, McCormack, Garfinkel, et al. 1998).[2]

Second, in 1998 we designed and tested a handbook tailored to Baltimore County residents for the American Association for Retired Persons (AARP) that provides basic information about Medicare, an explanation of the trade-offs among available plan options, comparative benefit information, and quality indicators. We developed and revised this handbook using two rounds of consumer interviews.

The third, fourth, and fifth projects drawn from for this article were conducted under the Consumer Assessment of Health Plans (CAHPS®) survey sponsored by the Agency for Healthcare Research and Quality. We conducted three CAHPS testing and development initiatives to design research-based comparative plan choice materials for consumers, focusing on quality information. First, as part of our Kansas demonstration we used focus groups to evaluate a Medicare version of the CAHPS 1.0 report created by the CAHPS team for the Kansas City area. Second, also in our Kansas demonstration, we examined reactions to and use of a CAHPS 1.0 report through focus groups with Kansas state employees. The Kansas CAHPS 1.0 reports for both Medicare and private insurance explained and presented the CAHPS comparative plan performance survey data for area managed care plans. The reports also described key differences between plan types and provided assistance to help consumers compare plans.

The third CAHPS-based testing and development initiative was conducted to assist in the development of version 2.0 of the CAHPS report template. The template is the basic framework for content, layout, graphics, and design for the CAHPS 2.0 reports. Sponsors tailor the template to their specific audience needs and enter actual data from their CAHPS 2.0 survey results. We conducted interviews with persons who had employer-sponsored health plan choices to test the penultimate version of the CAHPS 2.0 report template.

METHODS

Across the projects discussed here we conducted 11 focus groups and 182 consumer interviews in six geographic areas with 268 participants who varied by insurance type. The geographic sites varied by prevalence and maturation of managed care markets. Table 1 shows an overview of the participants by insurance type, methods used, and geographic locations. Demographic data were unfortunately not collected for the Medicaid recipients, Medicare beneficiaries, and those approaching Medicare age who participated in the first round of interviews for the Consumer Choice project. Among the 55 percent of the participants for whom we do have demographic data, they were generally better educated (65 percent had at least some college), predominantly female (64 percent), predominantly although not heavily white (54 percent), and older (about 75 percent were at least age 50). The age skewness is the result of the large number of interviews to test Medicare materials.

Focus Groups

We used focus groups in some projects to gain insights into consumers' perceptions and preferences for written materials. The main research questions addressed through the focus groups were as follows. (1) What are consumers' overall impressions of the written materials? (2) Do consumers understand the purpose and intent of the materials? (3) How useful do consumers find the materials and how would they use them? (4) Are there any aspects of the materials that are problematic for consumers?

Table 1: Overview of Participants

	Insurance Type (n = 268)				
Project	*Medicaid*	*Medicare*	*Private Insurance*	*Method*	*Location*
Consumer choice	53	53	51	Cognitive interview	Portland and Washington, DC metro area
AARP	0	16	0	Cognitive interview	Baltimore and Raleigh/Durham
CAHPS	0	0	9	Cognitive interview	Washington, DC metro area
	0	0	29	Focus group	Wichita
	0	56	0	Focus group	Kansas City
	53	125	90		

Participants were sent a copy of the materials prior to the session. Each group lasted about two hours. Immediately following each focus group the moderator and note taker conducted a detailed debriefing on the group and completed a standardized debriefing form to convey main themes and illustrative participant quotes. These debriefing forms were analyzed for key common themes and differences among the groups.

Cognitive Interviews

Our testing used cognitive interviews, which involve testing a set of individual interview methods for investigating the thought processes used by persons as they gather information, explore their options, and make decisions (Lessler and Forsyth 1996; DeMaio and Rothgeb 1996; Forsyth and Lessler 1991; Jobe and Mingay 1991). Over the past two decades cognitive testing has been used as a tool to assist with survey questionnaire development and to examine such issues as item wording, response option wording, and question formatting. These cognitive testing techniques are now being applied to a new domain—the design and testing of consumer plan choice information materials.

In a typical Research Triangle Institute cognitive interview the respondent reads (and works through, if the materials are interactive) the material while the interviewer observes, and the interviewer then asks the respondent questions about the material, either section by section or once the respondent has read the entire document. Cognitive interviews generally employ structured protocols with standardized probes or follow-up questions. The overall purpose of cognitive testing is to pinpoint problems with materials so that researchers can identify ways to make the materials easier to use and more effective. One-on-one cognitive interviews allow for a more in-depth examination of comprehension of materials and how materials work than do focus groups.[3] Cognitive testing issues generally fall into four main areas:

- *Content.* Does the material contain information relevant to the target population of consumers? Is the information complete and sufficient? Is there information that seems unnecessary to consumers?
- *Comprehension.* Do consumers understand the information as intended?
- *Navigation.* How easily do consumers work through the sections of the material? Do the sections help consumers identify and find the information they need? Do the sections help consumers correctly interpret the information they find?
- *Decision processes.* Does the material help consumers understand the health care choice task they face? Do they recognize the trade-offs they

may have to make (e.g., between cost and coverage)? Can consumers use information in the materials to make plan choices?

Each interview we conducted lasted about two hours. After each interview was completed the interviewer rated the participant on their interest in and comprehension of the materials. The interviewer then reviewed the completed protocol to ensure its accuracy and completeness. Each interviewer developed a short list of main findings and edit recommendations based on her or his own set of interviews. Once all interviews were completed for a given round the interviewers met as a group to debrief on main findings. The analysts wrote up the findings and recommendations for each round of interviews based on the completed protocols, interviewer notes, debriefing, and frequencies of responses to the closed-end protocol questions.

Generation of Study Findings

The lessons discussed below are based on our research team's response to the evidence of problems with the materials we collected from the focus groups and interviews. The findings were based on rigorous, replicable focus group and interviewing methods and protocols. (Copies of protocols are available upon request from the primary author.) We identified a problem when at least the majority of participants in a testing round either had negative perceptions about some aspect of the material (i.e., content, navigation, decision making) or did not correctly answer comprehension questions about the material. The ways in which we decided to revise the materials to respond to these problems, however, were more art than science. That is, we used science to examine materials and discern problems while we used experience and art to determine how to address these problems.

The following example of a simple yet actual case we encountered illustrates how we typically moved from testing to revision. In one of the Medicare materials we initially used the term "original Medicare" to refer to the traditional fee-for-service Medicare Part A and Part B options. Looking at interview responses to probes such as, "Based on the page you just read, in your own words, how would you explain what original Medicare is?" we found that many participants did not understand what original Medicare covered and how it paid providers. Specifically, using the term "original" made beneficiaries feel that Medicare as described in the materials was no longer available. Instead of seeing a contrast among currently available options, a disturbingly high proportion of respondents saw a contrast between the past (original Medicare) and the present (other Medicare+Choice options

but not original Medicare). Although this confusion may seem predictable and obvious in hindsight, it would not have been discovered prior to full-scale dissemination without the cognitive interviews.

Based on these interview responses we concluded that we need to better explain what original means in the context of original Medicare. Based on secondary research suggesting that Medicare beneficiaries do not understand well the differences between fee-for-service and managed care options (Hibbard et al. 1998) we decided to explain original Medicare as a contrast to Medicare managed care options. We then tested the revised explanation and found that most participants understood original Medicare as a currently available option that differs from Medicare managed care options. The point here is that the findings suggested a problem but not how to resolve that problem. There are likely numerous ways to respond to each of the problems we identified through testing. The additional testing was the primary means for determining whether the revisions were more effective than the previous versions of materials.

LESSONS LEARNED AND EXAMPLES OF HOW THEY WERE IMPLEMENTED

The developers of consumer information materials face several challenges, including motivating consumers to read and use the materials, addressing diversity among the consumer audience, explaining the fundamentals of the health care market, assisting consumers to determine their preferred dimensions in a plan choice and to prioritize these dimensions, facilitating consumer comparisons among plans, and aiding consumers to narrow their choices down to the plan that best meets their needs and preferences. Below are selected sections from different materials we created to illustrate lessons we learned to address some of these challenges.[4]

Lesson 1: To Capture and Keep Readers' Attention, Strive to Be Short, Clear, and Easy to Use

Consumers are inundated every day with information competing for their attention and have little time to attend to it. Getting and keeping consumers' attention amid this information overload is challenging.[5] Our focus group results suggest that people want to spend little time going through materials. Consumers want materials that are short, simple, and clear from beginning to end. For example, participants in the Kansas City Medicare focus groups

who were sent two types of materials noted that being short and easy to read was an attraction that made them more likely to read the 22-page CAHPS 1.0 report compared to the 50-page *Medicare & You* handbook.

If they cannot discern easily and quickly whether the material will help them, consumers will be less likely to use the materials. Based on responses to interview questions such as, "What do you think this handbook is supposed to help you do?" we found across several projects that although the material developers thought they had clearly presented the goals and objectives of the materials, many participants did not understand the flow of the materials or what they were supposed to do with them.[6] To address this problem we more concisely and clearly state the structure and intent of the materials early in the document (Figure 1). This information allows readers to decide whether the material is relevant to them, if it is worthwhile to continue reading, and what they can expect to accomplish by reading the material.

Another way to capture consumers' attention is to link new, unfamiliar information to more familiar information that consumers already find important. Figure 1 uses this approach by first acknowledging that cost and coverage information are important to readers. Only after making this statement does the text note that, like these factors, quality (the new information) is also important to consider. We added this statement about cost and coverage because focus group participants in the initial testing of the CAHPS booklet noted that the absence of cost and coverage information meant that the sponsors of the booklet did not understand what is important to consumers. After adding this statement we found in focus groups and cognitive interviews that respondents were much less likely to make this criticism.

Figure 2 also shows how to introduce new information by connecting it to information that readers find familiar and salient. Figure 2 explains some key differences between managed care and fee-for-service options (relatively unfamiliar concepts for readers) by focusing the comparison on dimensions, such as doctor choice and costs, that previous research shows are important to consumers (Chakraborty, Ettenson, and Gaeth 1994; Edgman-Levitan and Cleary 1996; Gibbs, Sangl, and Burrus 1996; Isaacs 1996; Jones and Lewin 1996; Robinson and Brodie 1997; Scanlon, Chernew, and Lave 1997; Tumlinson, Bottigheimer, Mahoey, et al. 1997).

Another more subtle way to enhance consumer motivation to use materials is to use navigational aids (e.g., instructions, section overviews, or graphics) that make it easier and less time consuming for consumers to go through the material. Examples of navigational aids include the visual cues at the bottom of Figure 2 linking the current page to the next section of the

Figure 1: Excerpt from *Compare Your Health Plan Choices, Medicare 1998*

How can this booklet help you?

If you are thinking about joining a Medicare HMO or changing to a different Medicare HMO, this booklet can help you. It has information to help you compare the original Medicare plan with Medicare HMOs. It also compares the Medicare HMOs in the Kansas City area.

Whether you are choosing a Medicare health plan for the first time or changing to a different Medicare health plan, you need information that compares your plan choices on topics that are most important to you.

The ***Medicare & You*** handbook sent to you from the Federal Medicare program tells about the health plans for people on Medicare. ***Medicare & You*** tells what services each plan covers and what the costs are for each plan. While costs and coverage are always important, other things are also important to consider—like "health plan quality."

Why health plan quality matters

It used to be that when you picked a health insurance plan, you only needed to think about cost and what services were covered.

Today when you pick a plan, you are also picking the doctors, hospitals, and other health providers that the plan offers. (Page 3 explains more about what this means.) That's where the information in this booklet comes in handy.

This booklet gives you new information that compares Medicare HMOs in the Kansas City area on quality and service. This information tells you about health plan quality from the patient's point of view. Use this information to help you choose a plan.

Before you join a health plan, it's hard to know what the care will be like. It can help to know what other people's experiences have been. People who have used the health plans are the real experts on these topics.

The information in this booklet comes from an independent survey of Medicare HMO members in the Kansas City area. The survey results tell about people's experiences with their Medicare HMOs.

If you're thinking about joining a Medicare HMO, the survey results can help you decide whether to join and which one to pick. If you're in a Medicare HMO in the Kansas City area and you plan to stay with it, you can see how it compares to other Medicare HMOs in the area.

This booklet compares Medicare HMOs but it doesn't tell you which plan to choose. You pick a plan based on what's important to you.

booklet; the page references in Figure 3 that tell the reader where to find other information in the materials; the instructions in Figure 4 on how to read the graph, in Figure 5 on how to complete the worksheet, and in Figure 6 on how to read the chart; and the step-by-step overview of the worksheets used to choose a plan in Figure 7. We added several of these navigational cues to the materials based on cognitive interview results that showed that participants did not see the different sections of a handbook as being linked together to guide them through the plan choice task or did not know how to use certain

Figure 2: Excerpt from *Medicare Options*

How Do Medigap Plans and Medicare HMOs Compare?

This chart shows some of the key differences between these options.

	Medigap	*Medicare SELECT**	*Medicare HMO*	*Point-of-Service HMO***
Choice of doctors, hospitals, pharmacies, and other health care providers	Can use any doctor, hospital, etc. Your benefits are not limited by where you get care.	Must use network for full benefits. Can go outside network, but it will cost you more.	Must use network; no benefits outside network—you will pay all costs.	Must use network for full benefits. Can go outside network, but it will cost you more.
Specialty care	Referral not required to get full benefits.	Referral not required to get full benefits.	Referral required from primary care doctor to get any benefits.	Referral required to get full benefits.
Out-of-pocket costs	*[insert range for costs based on user levels]*	*[insert range for costs based on user levels]*	*[insert range for costs based on user levels]*	*[insert range for costs based on user levels]*
Premium cost	*[insert premium range]*	*[insert premium range]*	*[insert premium range]*	*[insert premium range]*

* A Medicare SELECT plan is a special type of Medigap plan (see page 7).

** A Point-of-Service (POS) plan is a special option offered by some HMOs (see page 8).

In the next section, you can use the worksheets to help you decide which plans offer the benefits you need at the cost you can afford. ➤

sections of the handbook. Subsequent testing revealed that these navigational aids facilitated participants' ability to work through the materials.

Lesson 2: Address Diversity Among the Target Audience

Even within a specific targeted population, consumers (e.g., Medicare beneficiaries) can differ by a variety of characteristics (e.g., education, literacy level, interest, particular health needs, available time to read materials) that affect how they respond to the same materials. Layering information (i.e., providing a layer of more general information and a layer of greater detail) is one way

Figure 3: Excerpt from *Choosing Your Medicaid Health Plan*

Things to think about before you pick an HMO

Each of the HMOs you can join must give you the same package of basic health care services. But, there are some differences in how each one works and the extra services they offer.

Here are some questions you can use to look closely at each HMO. To get the answers you need, you have to go to a couple of different sources.

You can call the HMOs for some answers; their phone numbers are in the HMO Comparison Chart on pages 8–9. This chart has other information you may need, such as a list of the extra services each HMO has and the hospitals you can use with each HMO. Other answers can be found in the performance measures that are on pages 11–13.

After you have all your answers, you can begin to compare the HMOs you can join.

Where can you get care?

You want to find a doctor you can get to easily.

- Look at the HMO's list of doctors and pick one with an office near to your home or work.
- If you use public transportation, check with the HMO or the doctor's office to see if the office is on a bus or train line.
- Call your case manager at the Medicaid Office to see if there is any free or low-cost transportation you can use to get to medical appointments.

Who can you see for care?

You want to be sure you can use the doctors, hospitals, and pharmacies you want.

- Talk with your doctors (primary care and specialty) and find out which HMOs they work with. Call their offices to make sure they are seeing new patients from these HMOs.
- If you need to find a primary care doctor for you or your child, get a list of doctors from each HMO you are considering. You and your child do not have to use the same doctor. Your child can see a children's doctor or pediatrician and you can have a family physician or internist for your primary care doctor. Again, call the doctor's office to make sure the doctor is seeing new patients from the HMO.

When can you get care?

You want to know when and where you go to get care . . . in all situations.

- Pick a doctor who has office hours that work with your schedule.
- Find out where you go when you need medical care suddenly or your doctor's office is closed.
- Ask if the HMO has a nurse you can call for medical advice 24 hours a day, seven days a week.

Figure 4: Excerpt from Draft of *Medicare Options in Baltimore City/County*

Using Quality of Care Ratings to Choose a Medicare HMO

The Medicare program has information about the quality of care that HMOs give their members. You can use this information to help choose the HMO that is right for you. The information is collected fairly and carefully by the Medicare program.

The information tells you something about how good a job the HMO is doing at keeping its members healthy or treating them when they are sick. It also tells you how satisfied HMO members are with the care they get.

The bar graphs on the next few pages show quality of care information for Medicare HMOs in your area.

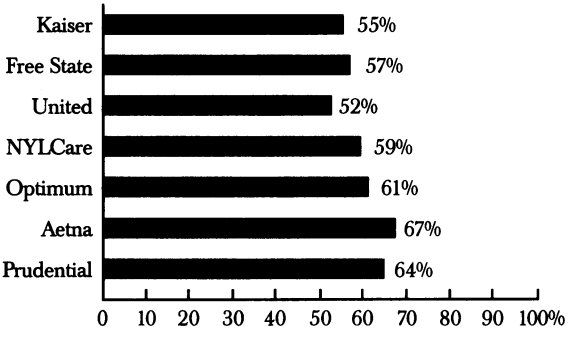
To understand how each plan performs, start by reading the text that explains why the measure is important. Then look at the bar graph to see which Medicare HMO gives the best care.

For each graph, look for large differences in the size of the bars among the HMOs. Small differences don't mean much.

This information is new and only available for HMOs. This information will be available for other Medicare options in the future.

Treatment of Patients with Heart Attacks

This graph shows the percent of HMO members who had a heart attack and were given ***beta blockers***. Beta blockers help lower blood pressure and reduce the chance of another heart attack. A higher number is better because it means the plan is doing a good job of preventing a second heart attack.



to address this diversity. Layering can be implemented in a variety of ways, for example, to make the same materials useful for persons who want or need detail and those who do not. Figure 1 shows one way to layer, by placing key messages in bold type for readers who want to skim while keeping regular type for readers who want more information. We found in cognitive testing of the CAHPS 1.0 template that several participants missed some of the key messages about the purpose of the booklet. In response we increased the visual focus on these messages. In the focus groups that examined Figure 1 participants paid attention to and absorbed these key messages.

Figure 5: Excerpt from *Medicare Options*

Estimate Your Medigap Costs

Take a look at how much these plans vary in price. There are two costs you will have to pay:

- The Medigap plan's premium. Premiums depend on the Medigap plan you pick, the insurance company, and if the premium increases as you get older.
- Out-of-pocket costs. They include deductibles, coinsurance amounts and costs for non-covered services. These costs depend on how much health care you use. These estimates do not include the Medicare Part B premium.

Follow the directions below to complete the chart. It will help you compare your estimated annual costs for different Medigap plans.

Annual Medigap Premiums & Out-of-Pocket Costs

	Medigap Plan Letter Name									
#1 Circle the letter name of the Medigap plan(s) you picked on page 16. ••••••••➤	Plan Name	A	B	C	D	E	F	G	H	I	J
	Estimated Annual Out-of-Pocket Costs										
#2 For each plan you circled in #1, circle the estimated out-of-pocket costs for the user level you picked on page 12. •••➤	High User	$1,639	$923	$823	$923	$923	$823	$923	$655	$655	$655
	Medium User	$1,543	$827	$727	$827	$827	$727	$827	$605	$605	$504
	Low User	$503	$503	$403	$503	$503	$403	$503	$430	$430	$330
	Medigap Annual Premium										
#3 Use the Medigap premium guide you got from your state to find the premium charged for each plan you circled in #1. Write the premium amount here. ••••••➤	Your Premium										

#4 For each plan you circled in #1, add the out-of-pocket costs you circled in #2 to the premium you wrote down in #3. Write this total here. ➤	Your Total Annual Cost										
	TOTAL COST										

Now . . . write the name of the *one* Medigap plan that offers the benefits you need at a cost you can afford on this line ➤ **Medigap Plan Letter Name** _____

Figure 6: Excerpt from *Choosing Your Medicaid Health Plan*

The chart on these two pages lists some of the benefits and extra services provided by the Medicaid HMOs you can join. The four HMOs are Foundation Health Services, Mercy Medical Group, MedNet, and QualiCare.

Read down the column under each HMO's name to see what it offers

HMO Comparison Chart This column describes the benefits each HMO offers.	**Foundation Health Services** 1-800-XXX-XXXX
How To Get Care	
Extra Services Services the HMO has to make it easier for you to get care when you need it.	■ Nurse always available for medical advice over the phone ■ Member service office in medical center ■ Evening and weekend hours ■ Nurse/midwives for pregnant women
Languages If you do not speak English, the HMO can help. Look in each HMO's column for more information.	Spanish-speaking providers Russian-speaking providers Vietnamese-speaking providers Other languages by telephone translators
Where To Get Care	
Primary Care Doctors You Can Use Call the HMO for a list of primary care doctors you can use. Before you pick a doctor, call the doctor's office to find out if the doctor is seeing new patients from the HMO. To see a specialist, you must have a referral from your primary care doctor.	900 available in network
Hospitals You Can Go To Hospitals that provide services to each HMO's members.	Memorial Hospital Doctor's Hospital Milford Hospital
Pharmacies You Can Use Where you go to get your prescriptions filled for each HMO.	All Costless Pharmacies All Health Wise Pharmacies All King's Drugs Pharmacies

Figure 7: Excerpt from *Medicare Options*

Worksheets to Help You Pick a Health Plan

On the next few pages are worksheets you can use to pick a health plan from the options available to Medicare beneficiaries.

Each option is discussed in a separate section. The final worksheet helps you make a side-by-side comparison of your options. Then you can pick a plan with the benefits you need at a cost you can afford.

To complete these worksheets you will need a copy of your state's Medigap premium guide. To get a free copy call your state's Medicare Information, Counseling, and Assistance (ICA) program, 1-800-XXX-XXXX.

Once you have the premium guide, all you need is a pencil and some free time. You may want to ask a spouse, family member, or a friend to work with you.

These worksheets will help you complete these six steps and pick a plan:

Step 1 **Answer questions to narrow down your options.**
Are you eligible for Medicaid? Will you have employer health coverage?

Step 2 **Identify how much health care you expect to use in a year.**
Do you expect to be a high, medium, or low user of health care services?

Step 3 **Review the benefits and costs of having Medicare Only with no supplemental coverage.**
Do you want coverage to fill in the gaps in Medicare?

Step 4 **Review the benefits and costs of Medigap coverage.**
Which Medigap plan offers the benefits you need at a cost you can afford?

Step 5 **Review the benefits and costs of Medicare HMOs.**
Which Medicare HMO offers the benefits you need at a cost you can afford?

Step 6 **Compare your options and pick a plan.**
Which plan offers the benefits you need at a cost you can afford?

Another way consumers may differ is in the desire for technical information. For example, some of our more educated testing participants wanted to see some basic statistical information (e.g., sample size, response rate) in the CAHPS reports. Other, generally less educated participants either did not care about or were confused by this information. As a result, within the CAHPS reports we had to balance the needs of both types of readers by including such technical information so that interested readers could find it while others could easily ignore it. In a revised version of the CAHPS report we accomplished this by moving survey sampling–related information

to the back of the report. We found in subsequent testing that the more detail-oriented, technical readers who wanted such sampling information found and appreciated it while other readers did not pay attention to it.

Lesson 3: Help Consumers Understand the Key Fundamentals of Health Plan Choice

Plan choice materials must include background educational information in a way that is neither overly simplistic nor overwhelming. Beyond the basic managed care versus fee-for-service choice consumers often must decide which type of plan to choose. Many Medicare beneficiaries in particular face a multitude of Medicare+Choice options. Figure 2 shows one way to simplify the choice task, by focusing the comparison on four dimensions that are highly salient to beneficiaries—choice of providers, access to specialty care, out-of-pocket costs, and premiums. This focused approach can help readers compare choices without getting overwhelmed. We developed this chart after we found in cognitive interviews that many participants were unable to narrow down their Medicare plan options to make a final, single plan choice. Based on responses to interview questions about the purpose of text intended to explain the different types of plan options, we learned that participants did not glean key information on plan differences from this text section, which was detailed and relatively dense. In response to this finding we developed Figure 2, which testing participants overwhelmingly said was helpful.

Participants were also asked to describe the most important differences between Medicare HMOs and Medigap plus Medicare based on their review of Figure 2. Every participant noted that the premium costs differ. Many participants acknowledged that with an HMO, doctor choice is restricted to the network. Just over half said that with an HMO, where they can go to get services is limited to the network. We concluded based on this evidence that the simple tabular overview highlighting key differences improved comprehension of differences among plan types.

Lesson 4: Assist Consumers to Determine and Differentiate Among Their Preferences

Previous work (Hubbard and Harris-Kojetin 1997) suggests that consumers find it difficult to determine and differentiate among their preferences. When presented with a list of potential dimensions of plan choice (e.g., costs, benefits, choice, quality, convenience), consumers find all of them very important (as we found when testing Figure 8). Figure 8 is part of a two-page self-test

Figure 8: Excerpt from *Medicaid Managed Care Handbook*

What's Most Important to You When Choosing a Health Plan? Take this test to find out...

Read the next four sections and rate them in order of what's most important to YOU. There is no one "right" answer. Only what's right for you and your family.

> After you've finished reading, rank the four topics in order of what's most important to you.
>
> Place a "1" in the circles by the issues most important to you.
>
> Place a "2" in the circles by the issues that are less important.
>
> Place a "3" in the circles by the issues that are not very important to you.
>
> Then, look at the **comparison chart in the center of this handbook.** (You can pull it out if you like.) As you think about choosing a health plan, look first at the areas which you rated with a "1" as important to you.

Access to Care: Getting Care When You Need It

Imagine that your child is running a fever and is tugging on his ear. You know it's probably another ear infection, so he'll need a new prescription, and you've got to see the doctor. You might have to consider:

- How far away is the health plan hospital or clinic from your home or work?
- What do the health plan's members say about how easy it is to get care?
- Can you get an appointment in the evening? Over the weekend?
- Can you get advice over the phone before you make an appointment?
- Is transportation available?
- If a family member doesn't speak English, will there be staff who can translate?

Provider Choice: Seeing the Doctors You Like

Suppose you've been a patient of Dr. Welby's for many years following your surgery, and now you need to choose a managed care plan. You could be wondering . . .

- Can you continue to see the same doctor if you join the health plan?
- How do other health plan members feel about the number and quality of doctors in the health plan?
- If you need surgery again, which hospital would you use?

exercise intended to help consumers understand the major dimensions of health plan choice, help them think about their own priorities, help them begin to make trade-offs between competing priorities, and help simplify plan comparisons. Cognitive testing participants seemed to understand the goal of the self-test exercise. In response to probe questions a small segment of participants said that they expected the self-test would help them rate the alternative health plans based on their own particular needs. However, most participants had difficulty assigning different weights or different priorities to the self-test dimensions and instead rated almost all of the dimensions as equally important. Because participants did not discriminate among the five dimensions according to importance, they could not use their self-test responses to simplify their comparison task.

In addition consumers will vary in how they make a plan choice such that no one way of structuring the choice task will work for most consumers. With this in mind we replaced the self-test with text that instructs consumers about the kinds of trade-offs they will probably need to make. This is illustrated in Figure 3, which shows a series of issues for consumers to think about before choosing a plan. This approach covers a variety of dimensions that consumers may want to consider (consumers can choose to follow up on all, some, or none of the questions raised). Overall consumers liked this less-structured style because it (1) provided instructions on where to get more information and (2) placed all of the questions in one place. In cognitive interviews most participants said they found this section helpful because it allowed them to decide which topics they would investigate further to compare and choose a plan.

Lesson 5: Help Minimize Cognitive Complexity by Breaking the Plan Choice Task into a Series of Smaller Steps

Decision theory and research suggest that people can only keep about five or six pieces of information in their heads at one time (Slovic 1982). Consumers can be easily overwhelmed rather than empowered by plan information, especially when it is new to them (Hanes and Greenlick 1996; Knutson, Fowles, Finch, et al. 1996; Minnesota Health Data Institute 1996) or their cognitive capacity is limited (U. S. DHHS 1994). The potential for cognitive burden increases significantly as one thinks about all of the factors that should be considered in a plan choice such as cost, benefits, providers, quality, and convenience.

One way to help make this cognitive burden more manageable is to break the complex task of plan comparison and choice into a series of smaller,

connected steps. As shown in Figure 7, the process of choosing a plan is broken down into a series of intermediate steps. These steps include determining which health insurance options are not relevant, estimating future health costs, systematically comparing the costs and benefits of several different options, choosing the preferred plans within those options, and choosing the best plan from among the smaller set of previously narrowed choices. To help consumers compare and narrow down their options based on one factor at a time (like costs or coverage), one or two worksheets are provided for each step. Figure 5 is one among a series of worksheets designed to help prospective Medicare beneficiaries compare the costs of different Medicare options. Each worksheet explains to the reader how the results of that worksheet link to the other worksheets. At the end of the series of intermediate work sheets a final summary worksheet (not shown) helps consumers pull together their key results from each of the previous worksheets to compare and narrow down choices by considering key dimensions (e.g., costs, benefits).

In our last round of testing the worksheets we asked participants to complete a handbook that contained a series of worksheets (like Figure 5). After everyone had completed their own worksheets we conducted a guided discussion about their experiences with the worksheets. A careful review of the worksheets found that every participant completed them and all but one participant was able to identify a preferred plan. Participants unanimously agreed that they would use the handbook if it were sent to their home. We have found that these step-by-step worksheets can help consumers work through cost and benefit comparisons (Gibbs 1995; Gibbs, Sangl, and Burrus 1996).

Lesson 6: Help Consumers Understand How and Why to Use Quality Information

While costs and coverage are topics that are tangible and familiar to most consumers, quality of care is not. To avoid misunderstanding of quality performance indicators and to encourage their use, these indicators need to be explained in terms of how a plan's performance can affect the quality of care consumers get. For example, Figure 4 explains what quality measures can tell consumers about plan quality and how to use the information on specific indicators. Figure 4 also presents a Health Plan Employer Data Information Set measure, appropriate use of beta-blockers, in easily understood language that focuses on how a plan's performance can affect consumers' care. The presentation also explains why a higher number is better and notes that a trusted source, the Medicare program, collected the information. Another

example of how to raise awareness about the importance of using quality information is shown in Figure 1. Here, the introductory page explains that the booklet tells about "health plan quality from the patient's point of view." The link between plan networks and quality is also made by noting that when people pick a plan they are also picking the doctors and other providers that the plan offers.[7]

Lesson 7: More Information Is Not Necessarily Better

Covered benefits are among the most important factors consumers consider when making a plan choice. However, when there are many choices in a market, making comparisons can be overwhelming. To help consumers understand and compare the benefits offered by several plans, we simplified the traditional, potentially cumbersome tabular layout in two ways (not shown). First, where it was important to convey that multiple plans did not offer coverage (vision care) we used an arrow across each cell (or plan) of the row. Second, where plans offered the same coverage for a service, we simply stated "same as [name of first plan]" in a cell rather than repeat the complete text description in each cell. This visually simplified the display so consumers could focus on the differences.

Another example of how we applied the less-is-more lesson can be seen in the difference between Figures 6 and 9. Each shows the left-hand side of a two-page chart intended to compare plans on pertinent dimensions like access and choice. In interviews where we examined Figure 9 (the "before" version of the table) we learned that many participants found it difficult to make comparisons among the plans. Because there was too much text and no instructions on how to use the chart, participants were unsure where to start and how to orient to the chart. Making an informed plan choice involves considering a lot of factors, and in fact consumers say they want more information when considering their choices. However, our testing results showed time and again that consumers can be easily overwhelmed by information and miss important points. As a result we made several deletions to Figure 9 to reduce the cognitive burden of making plan comparisons. We included only key information that previous testing and research suggested most consumers wanted, incorporated more blank space, used larger fonts, and enhanced column and row separations. In interviews with the revised version (Figure 6) many participants found the chart "very easy" to use to compare plans. Participants generally seemed able to pick out particular information included in the chart and to compare plans based on services important to them.

Figure 9: Excerpt from *Medicaid Managed Care Handbook*

Priority Areas (from self-test)		*Person-to-Person Health Services*
	Access to Care	
Special Features	Services offered by the plan to make it easier for you to get health care when you need it, such as transportation or extra hours when the health center is open.	Advice nurse Member service office in medical center Evening and weekend hours Nurse/midwives for maternity care
Languages	Languages spoken by plan staff members. Not all of the plan's offices will have staff members who speak these languages. You may want to ask the plan about languages spoken at the office where you would receive your health care.	Spanish Russian Vietnamese other languages by telephone translator
Member Satisfaction with Waiting Times	What percentage of the plan's members said the plan did a "good", "very good" or "excellent" job in arranging appointments without delay, and in the amount of time they waited to see a doctor once they arrived for an appointment.	84%
Member Satisfaction with Evening and Weekend Access to Care	What percentage of the plan's members said their plan did a "good", "very good" or "excellent" job in providing care during evenings and weekends. Plans do this by extending office hours, offering care at an urgent care center, or providing telephone advice to help you take care of illnesses at home.	78%

Continued

Figure 9: *Continued*

Priority Areas (from self-test)		*Person-to-Person Health Services*
	Provider Choice	
Affiliated Hospitals	Hospitals near you that provide services to the plan's members.	Memorial Hospital, Doctor's Hospital, Milford Hospital
Pharmacy Services	Drug stores where you can get prescriptions filled. If you go to a pharmacy that is not part of the plan, you will probably have to pay more for your prescription.	All Costless pharmacies All Health Wise pharmacies All King's Drugs pharmacies
Member Satisfaction with Choice of Providers	What percentage of the plan's members rated their plan as "good", "very good" or "excellent" in the number and quality of doctors available to them.	82%
Member Satisfaction with Choice of Specialists	What percentage of the plan's members rated their plan as "good", "very good" or "excellent" in the choice of specialists.	75%

CONCLUSIONS

At first glance these seven lessons may seem obvious. No one would intentionally develop and disseminate information materials that were burdensome, unattractive, incomprehensible, or difficult to follow. Nevertheless, materials that fail to address these issues adequately are common in the health insurance industry. Comprehension is a particular challenge in public insurance programs, such as Medicare and Medicaid, because these programs are inherently so complex, far more complex than most private health insurance plans. The problem for the Medicare and Medicaid populations (and possibly the State Children's Health Insurance Program as well) is compounded because the beneficiary audience mainly comprises individuals with diminished cognitive capacity because of aging, disability, or limited education. If public health insurance becomes more oriented toward competitive markets, the complexity of insurance programs will grow and the cognitive burden for beneficiaries may become increasingly intolerable.

Our research is an attempt to identify ways that the designers of consumer health plan information can minimize the cognitive burden associated with large amounts of complex and perhaps confusing information. The seven lessons described are intended to minimize cognitive burden for consumers. Although the sentiment of these lessons seems obvious, the implementation of the lessons is not. By listing the component parts of each, we in effect create a checklist that will help designers avoid many common pitfalls found in consumer health plan choice materials today. By illustrating different ways that we implemented each lesson, we provide examples of evidence-based approaches to addressing cognitive barriers that designers can adapt to their own situations. Thus, our findings raise awareness of what attractiveness, motivation, ease of use, and usefulness mean for beneficiaries and suggest demonstrated ways to achieve these goals.

Future Research Needs

Consumer plan choice researchers have learned much about what consumers want and need to know to make informed plan choices (Lubalin and Harris-Kojetin 1999) and about how to develop materials that can help consumers make such choices. However, there is still much work to be done. While our testing has shown that some consumers can use the worksheets on their own, many consumers want and need assistance. Thus, the role of different information intermediaries is an increasingly important policy and research area (Sofaer 1999).

How best to integrate the variety of factors that consumers want to consider in making a health plan choice is another area worthy of research. The materials we presented focused on either costs and benefits or on quality; the next step is to bring all of these factors together in a manageable way. Determining optimal decision support strategies (e.g., how much guidance and structure to give to different audiences) and how the support strategies should vary by the stage of one's decision making (e.g., new Medicare beneficiaries versus experienced beneficiaries) are other areas for further investigation.

The materials presented here, and much of the quality-information effort, focus on plan-level comparisons. Future information efforts need to reflect better the reality of overlapping networks by pursuing the challenging measurement, sampling, and reporting issues at the clinic or provider level. Some efforts are currently under way, but more work is needed in this area, including how to report such information to consumers.

Focus groups and cognitive interviews address the efficacy of materials in a more controlled environment than field-based outcome evaluations (Cook and Campbell 1979). Survey-based outcome evaluations address the effectiveness of the materials in the real world. While some outcome evaluations of health plans and providers through the use of report card efforts have been conducted, further evaluations are needed. Topics to be addressed include examining the effects on consumers, purchasers, and plans of repeated consumer exposure over time to comparative health plan and provider information for decision making.

More research and evaluation are needed to strengthen the "informed consumer" movement, which should motivate health plans to compete on cost and quality. However, our research has made a contribution to the movement by demonstrating through cognitive interviews and focus groups how to create materials that get consumers' attention, educate them, and help them make more informed plan choices.

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NOTES

1. The two most prevalent plan-related quality initiatives are CAHPS and the Health Plan Employer Data Information Set (HEDIS). Evaluations of some large state- and employer-based report card efforts that have included CAHPS or HEDIS data suggest that the proportion of consumers paying attention to or using plan comparative information in plan choice is relatively low (Chernew and Scanlon 1998; Knutson et al. 1998; Scanlon, Chernew, and McLaughlin 1999). The percentage of consumers who remember receiving and reading the reports varies by study from 7 percent to 80 percent (Veroff, Gallagher, Wilson, et al. 1998; McCormack 1997; National Committee for Quality Assurance 1998).
2. Before developing the handbook prototypes the study team performed focus groups with Medicaid recipients and with current and prospective Medicare beneficiaries (Gibbs, Sangl, and Burrus 1996). We also conducted case studies of employers and other organizations that were already providing comparative choice information to their members (McCormack, Garfinkel, Schnaier, et al. 1996). Case study and focus group results are reported elsewhere (Burrus, McCormack, Garfinkel, et al. 1998; McCormack, Garfinkel, Schnaier, et al. 1996).
3. We used both "concurrent probing" and "observation-with-debriefing probing" one-on-one cognitive interview protocols. For example, when possible, in a given round of interviews we conducted half of the interviews using the concurrent approach and half using the debriefing approach. The concurrent approach asks the participant to read one section of the handbook at a time; before the participant moves on to the next section the interviewer asks relevant, pre-scripted probing questions about what the participant thinks about what he or she has just read. With the observational-debriefing approach the interviewer waits until the participant has completed the entire booklet before asking the participant a series of pre-scripted probing questions about the booklet. The concurrent approach allows us to focus more on content and comprehension, whereas the debriefing approach better addresses issues of navigation and decision making.
4. Focus group and cognitive interview findings are not generalizable with statistical precision to a larger population. However, focus groups and cognitive interviews provide a rich data source through which we can pursue topics that require further investigation. Confidence in qualitative research findings increases to the extent that patterns emerge among multiple focus groups, cognitive interviews, and studies. We present these patterns in this article.
5. It seems obvious that consumer documents should not contain jargon or be very long. However, there is a continuing challenge in consumer materials development to create documents that are short enough to get consumers to read them yet contain sufficient information to help them make an informed choice.
6. This type of finding, which occurred time and again across our projects, speaks to the value of pretesting materials with the target audience (Schriver 1997).
7. Plan-based quality information can be considered the "first generation" of quality information. The next generation will be physician- and clinic-level information if the technical, logistical, and economic challenges (e.g., adequate sample size to enable reliable estimates) can be addressed.

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