**Health Insurance Literacy:**
*An Exploratory Study of Potential Health Insurance Marketplace Users and Their Need for Assistance*

**West Virginia, 2012**

Richard Crespo, PhD, Catherine Slemp, MD, MPH, and Kim Garrett, MS
Center for Rural Health, Joan C. Edwards School of Medicine, Marshall University

“Our challenge will be to make sure that as many people as possible understand their options and are armed with the information they need to choose what’s best for them.”

*Enroll America: “An Introduction to Health Literacy and Enrollment”*
Maximus Center for Health Literacy, 2011

**Purpose: What Did We Set Out to Do and Why?**

State Health Insurance Marketplaces (the Marketplace) are core to implementation of the Patient Protection and Affordable Care Act’s (PPACA) efforts to expand health insurance coverage for Americans. Effectiveness of these Marketplaces, both as central sites to shop for and select health insurance and as a link for eligible individuals to access subsidies and services, depends on many factors. Beyond moving the Marketplace to a centralized web-based portal, these include efforts to streamline and standardize insurance related terminology, increase plan comparability, and assure defined standards are met for health plans to participate.

User skills and characteristics will also impact the uptake and effectiveness of Marketplaces in increasing insurance coverage and access to care. While literature is limited, it is widely acknowledged that most Americans find comparing and choosing a health insurance plan as well as using its benefits confusing. Required skillsets include navigating unfamiliar and often complicated terminology and systems; evaluating and comparing a wide variety of plan types; applying plan characteristics to one’s own life circumstances (financial, life stage, health needs); prose, document, and numeracy aspects of health literacy; and with web based systems, accessing and navigating web based technologies. Many Marketplace users, especially the currently uninsured and/or never insured, will be facing these complex tasks for the first time. Even with employer-based plans, plan choices have often been limited and negotiated primarily

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by benefit managers. As the Marketplace changes, the availability of accessible, culturally relevant, and effective support systems to assist potential consumers in trusting, accessing and using Health Insurance Marketplaces is critical to reaching the goal of expanded coverage and access to care.

Little systematic research has been done to date to assess health insurance literacy. To some extent, literature and policy makers recognize that much work is needed in this arena.³ Work is now underway to develop the first standardized tool to measure health insurance literacy among Americans.⁴ This tool will support regular assessment and tracking of health insurance literacy skills over time. Hopefully, such will help drive efforts to strengthen system and user capacities that enable effective consumer choice and appropriate health insurance utilization.

The audiences that will use Health Insurance Marketplaces will likely vary widely in insurance related experience and knowledge, education, income levels, and access to as well as comfort with technology. It will be important to assure that tools developed and assessments undertaken shed light on the health insurance literacy levels and needs of all those who may benefit from these systems. Consumers using Marketplaces will likely require various forms of support in using centralized health insurance marketplaces.⁵ There is much yet to learn about the types of support networks and systems that are of greatest interest to potential Marketplace users, especially those who are currently uninsured. In addition, little work specific to health insurance literacy in rural communities has been undertaken.

Through this exploratory study of potential Marketplace users in West Virginia, especially those who are currently uninsured, we set out to gain an understanding of the following:

- Potential Marketplace user confidence in understanding health insurance terminology,
- Demonstrated skill sets and processes applicable to comparing and selecting an insurance plan,
- Preferred sources of information related to health insurance,
- Tasks potential Marketplace users anticipate needing assistance with,
- Preferred methods of assistance,
- From where they would seek such assistance, and
- Their access to and interest in web-based information and Marketplaces.

Methods: How Did We Go About This Study?

Given that health insurance literacy in an era of developing Marketplaces is a relatively new field of inquiry, we used an exploratory methodology. We began with a literature review and by interviewing key informants who could serve as a panel of experts and provide guidance on the issues that might affect consumers’ understanding of and access to health insurance. Key informants were drawn from the field of health literacy, public insurance, private insurance and primary care. The interviews gave us guidance on issues of communication with the uninsured and under-insured, health literacy, barriers to understanding health insurance concepts, barriers to obtaining health insurance, skills sets that people need to make decisions about insurance, and the critical elements about themselves and their families that people need to know in order to appropriately select insurance.

Using a modified Delphi Technique we used the insights and guidance from the key informants to design an interview tool for assessing consumers’ knowledge, experience and perceptions regarding health insurance. The interview tool obtained de-identified demographic data including household income, confidence with health insurance related words, experience with health insurance, barriers to insurance access, anticipated help needed in shopping for and choosing health insurances, interest in centralized web-based systems for choosing health insurance, access to technology, and the ability to complete scenarios utilizing skillsets applicable to health insurance shopping. The interview tool was field tested with patients in a free clinic.

The target population for the research was uninsured, under-insured, and Medicaid beneficiaries. The latter were included because their status often changes due to seasonal and temporary work. The settings chosen for contacting this population were primary care settings and health departments that served people regardless of their ability to pay. These included free clinics, Federally Qualified Health Centers, WIC offices, university based primary care practices, and critical access hospitals. A list of the sites in which interviews were conducted can be found in Appendix 1.

Prior to conducting the interviews we obtained permission from the health care agencies to conduct interviews of their patients. The interviews were conducted in patient waiting rooms, clinic foyers, conference rooms, and clinic pharmacy waiting rooms. Interviewees were selected using convenience sampling. No prior screening was done to ascertain insurance status. Upon entering the waiting room, patients were invited to participate in a 20-25 minute interview about health insurance. If the patient agreed, the interviewer would escort them to a

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side room or a desk in a corner of the room to conduct the interview. Interviewee consents were obtained and interviews conducted. In cases where the interviewee was not able to or chose not to complete the interview, the interviewer stopped and the patient was thanked for participating. The interviewers recruited patients until they interviewed 15-20 people per site or the clinic closed. In three clinics, the numbers were sufficiently low that the interview team returned for another day when typically the patient flow was greater.

Findings: What Did We Learn?

Literature Review and Key Informant Interviews

The Concept of Health Insurance Literacy and its Relation to Health Literacy

- Health Literacy is defined by the National Library of Medicine as “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” This definition is also used in Healthy People 2010.
- By extension, Health Insurance Literacy can be seen either as related to or a subset of health literacy, involving the skills needed to obtain, process, and understand health insurance information in order to access care and “make appropriate health decisions.”
- In addition to the above, Health Insurance Literacy involves other complex constructs including financial and contractual components. The 2003 NCES Health Literacy Survey finds that many of the health literacy skill sets involved in health insurance related tasks (e.g., evaluating information to determine which legal document applies to a specific health care situation, finding the information needed to define a medical term by searching through a complex document, calculating an employee’s share of health insurance costs for a year, etc.) are those falling into the “proficient” skill level (the most complex level defined in this survey).
- Health Literacy is not a single concept or skill. Rather, it requires multiple skills grouped into domains – prose literacy, numeracy, and document literacy, for example. (Other domain groupings for health literacy also exist.)
- Similarly, a variety of domains are also involved in Health Insurance Literacy. Like Health Literacy, it is helpful to think of Health Insurance Literacy in such domains.

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Training for the Health Insurance and Health Care Workforce

- Several tools exist for strengthening health care worker skills in understanding and addressing health literacy issues of their patients. (See Appendix 5 for examples)
- Few Health Insurance Literacy specific trainings or tools for workers developing insurance related materials and systems or for those guiding individuals through shopping for health insurance were identified.
- While not the case with every insurer or provider organization interviewed, very few offered specific training to staff on health literacy concepts. While attuned to the issues and with a variety of material development and testing systems in place, most staff we interviewed were not aware of any specific policies or program standards to address the health literacy needs of those they served.
- In the absence of Health Insurance Literacy specific training, training in Health Literacy concepts is very applicable to those working with or developing materials for persons shopping for or using health insurance. This was articulated by those teaching Health Literacy in West Virginia and by the few West Virginia benefit managers who have taken health literacy related training. Each reported such training to be surprisingly applicable and very beneficial.

Lessons Learned from Other Insurance Related Outreach and Marketing Efforts as well as from Efforts to Strengthen Health Literacy of Individuals

- Multi-faceted and sustained partnerships have been key to the success of outreach efforts with some public insurance programs (WVCHIP).
- Linking with individuals where they already are or can be readily accessed is beneficial.
- Integration into existing training programs reaching target audiences or addressing related broader needs has been beneficial and well received in addressing health literacy of individuals.\(^9\)

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Interviews with Potential Marketplace Users

Section I: Demographics of the Study Population

The total number of people interviewed was 193. In data analysis, we excluded 17 interviews of individuals who were ≥65 years of age or were younger than 65 years but covered by Medicare. We also excluded 5 additional cases with incomplete insurance information. Consequently, the number of cases used in the data analysis was 171. Full demographic information for interviewees by Insurance Status is found in Appendix 2. Key observations include:

Insurance Status: Of the 171 persons interviewed, 26.3% (45) were insured, 9.4% (16) were Medicaid recipients, and 64.3% (110) were uninsured. (Figure 1)

Age and Gender: The 171 Interviewees were grouped into 3 age groups for analysis purposes. There were almost twice as many individuals in the middle (30-49 year old) and upper (50-64 year old) age groups than the youngest age group (18-29 year olds). (Table 1). Besides encompassing wider age spans, the predominance of the two older age groups may also reflect those seen in health care settings; younger individuals are often healthier and seek care less, especially if uninsured. By gender, three-fourths of interviewees (75.4%) were female. Medicaid recipients, though few (16), were generally younger and more commonly female than Insured or Uninsured interviewees. (The Medicaid population was comprised of 88% females while Insured and Uninsured were 71% and 76% female respectively.) Insured and Uninsured populations were similar in age and gender distributions. (Table 1). The percent of

![Insurance Status of Interviewees](Figure 1)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total (n=171)</th>
<th>Insured (n=45)</th>
<th>Medicaid (n=16)</th>
<th>Uninsured (n=110)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18-29 years</td>
<td>38</td>
<td>22.2%</td>
<td>20.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>30-49 years</td>
<td>69</td>
<td>40.4%</td>
<td>42.2%</td>
<td>31.3%</td>
</tr>
<tr>
<td>50-64 years</td>
<td>64</td>
<td>37.4%</td>
<td>37.8%</td>
<td>18.8%</td>
</tr>
<tr>
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<td>75.4%</td>
<td>71.1%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Male</td>
<td>42</td>
<td>24.6%</td>
<td>28.9%</td>
<td>12.5%</td>
</tr>
</tbody>
</table>
interviewees that were insured within each of the three age groups was very similar (24% to 28%; not shown in table 1).

**Race and Ethnicity:** The racial distribution of interviewees reflected that of the state population. Although numbers are small, 87.5% of the non-white population (7 of 8 non-white interviewees) were uninsured. Sixty-three percent of white interviewees (63.4% -- 104 of 164) were uninsured. Ethnicity distribution of interviewees was also reflective of broader state population ethnicity. Although numbers are small (6 individuals of Hispanic ethnicity interviewed), 83.3% of Hispanic interviewees (5 of 6) were uninsured.

**Education:** 69% of all interviewees completed high school or less education. (Figure 2). Those with higher education levels were more likely to be insured. By insurance status, 53% of insured persons had completed high school or less; 75% of Medicaid recipients had completed high school or less; and 75% of Uninsured individuals completed high school or less.

**Employment:** Forty-four percent of interviewees (44%) reported some form of employment (full-time, part-time, or self-employed). Forty-two percent (42%) were unemployed, 4% retired, and 10% disabled. Medicaid and Uninsured persons were far more likely to be unemployed than insured individuals (56% and 52% respectively vs 13% of Insured). Of the Uninsured, 35% reported some form of employment.

**Income:** Two thirds of those interviewed (68%) reported being at or below 133% FPL in household income. Very few (7.6%) reported incomes of 400% FPL or greater and all of these were insured. In general, incomes were higher for Insured individuals, however a significant percentage (40%) of insured individuals reported incomes of ≤133% FPL. Of the uninsured, 76%
reported a household income at or below 133% FPL and 24% reported 134-399% FPL. None of the Uninsured in this study reported household incomes >400% FPL. (Table 2).

Interview Settings: Interviews were conducted in 5 setting types chosen to include a variety of insurance statuses with emphasis on a core target audience for the Health Insurance Marketplace -- currently uninsured individuals. The 5 types of interview settings were Free Clinics, Primary Care Centers, Critical Access Hospitals, University Affiliated Practices, and WIC Clinics. Table 3 shows the distribution of facility type within Insurance Status groups and Table 4 the distribution of interviewee insurance status within each facility type. Approximately 44% of interviews took place in Free Clinics (Table 3). The vast majority of individuals in this setting (95%) were uninsured. Primary Care Centers, University-associated Clinics, and WIC Clinics were also sites where uninsured were commonly accessed (all between 47% and 52% of interviewees in these settings). Although found in all facility types except Free Clinics, Medicaid recipients were most commonly identified in Primary Care Centers and Critical Access Hospitals. (Table 4).
West Virginia Region: Interviews were conducted in four regions using the geographic divisions used by the Area Agencies on Aging. (Figure 3). These represent a relatively equitable division of geographic area in the state as well as reflect cultural differences.

The number of individuals interviewed in each region was relatively similar. While interview numbers were fairly well distributed across regions (38-49 persons/region; Table 5), those interviewed in the Southern Region were more likely to be insured than those in other regions (Table 6). This may be due to the fact that a high proportion of interviews in the South were conducted in hospitals and university-affiliated practices – both settings with a relatively high proportion of insured clients (65% and 47% of those interviewed in this setting respectively; See Table 4). Insurance Status distribution within the other three regions was relatively similar. (Table 6).

<table>
<thead>
<tr>
<th>Region</th>
<th>Total (n=171)</th>
<th>Insured (n=45)</th>
<th>Medicaid (n=16)</th>
<th>Uninsured (n=110)</th>
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<tr>
<td>East (III)</td>
<td>37</td>
<td>21.6%</td>
<td>8.9%</td>
<td>37.5%</td>
</tr>
<tr>
<td>North (I)</td>
<td>39</td>
<td>22.8%</td>
<td>13.3%</td>
<td>6.3%</td>
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<tr>
<td>South (IV)</td>
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<td>57.8%</td>
<td>43.8%</td>
</tr>
<tr>
<td>West (II)</td>
<td>46</td>
<td>26.9%</td>
<td>20.0%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Total</td>
<td>171</td>
<td>100.0%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Total (n=171)</th>
<th>Insured %</th>
<th>Medicaid</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>East (III)</td>
<td>37</td>
<td>100%</td>
<td>10.8%</td>
<td>16.2%</td>
</tr>
<tr>
<td>North (I)</td>
<td>39</td>
<td>100%</td>
<td>15.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>South (IV)</td>
<td>49</td>
<td>100%</td>
<td>53.1%</td>
<td>14.3%</td>
</tr>
<tr>
<td>West (II)</td>
<td>46</td>
<td>100%</td>
<td>19.6%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
Key Groupings Used in Data Analysis:

**Insurance Status Grouping:** Individuals were initially grouped into Insured (employer based, private, military, and other insurance), Medicaid, and Uninsured.

**Age Grouping:** Individuals were grouped into three (3) age groups (18-29 years, 30-49 years, and 50-64 years) to evaluate possible age differences among insurance status groupings, as well as age based health literacy screen responses and the modified screening question adapted for health insurance literacy. In addition, these groupings were used to do initial examination of the impact of age on types of assistance needed (further explored through logistic regression and 2x2 analysis).

**Income Groupings:** Interviewees were divided into the following income groupings: <133% FPL, 134-399% FPL, >400% FPL. This grouping is based on the anticipated financial eligibility cut points for Medicaid and for premium/other cost subsidies through the Marketplace.

**Frequency Analysis related to Anticipated Support Needed:** Medicaid and Uninsured were grouped together in frequency analysis related to anticipated support systems needed in enrollment. This grouping was used because those eligible for both Medicaid and premium subsidies will be target audiences to access and engage and both will have original eligibility assessed through a common portal on the Health Insurance Marketplace. In addition, populations may move between Medicaid and being Uninsured fairly commonly. The majority of this combined grouping (87.3%) were currently uninsured individuals. In undertaking this analysis, this grouping was considered more reflective of the target Health Insurance Marketplace audience than use of Income levels, given that several individuals at incomes <133% FPL and 134-399% FPL were currently insured [18 of 116 (15.5%) of interviewees with incomes <133% FPL were insured; 14 of 41 (34.1%) of interviewees with incomes of 134-399% FPL were insured].

**Logistic Regression and 2x2 Table Analysis Examining the Impact of Age on Types of Assistance Needed:** In analyzing the impact of age on the types of help people anticipate needing in shopping for health insurance, we analyzed those age 18-49 compared to those age 50-64. This included all interviewees. Distribution by insurance status among the two groups was fairly similar given that Medicaid makes up a small percentage of both groupings (for the 18-49 year old group: 26% Insured, 12% Medicaid and 62% Uninsured; for 50-64 year old: 27% insured, 5% Medicaid, and 69% Uninsured). Preliminary analysis using all three age groupings (18-29 years, 30-49 years, and 50-64 years) showed that differences were most significant from the mean for the older age group. Thus, the younger two age groups were combined to perform the comparison group for those age 50-64 years.
Section II: Self-Reported Health Status and Use of the Health Care System

Insured individuals described their health status to be Good to Excellent more often (84%) than did Uninsured (48%) and Medicaid individuals (69%). Conversely, the Uninsured were more likely to describe their health status as Fair or Poor (52%) compared to Medicaid (31%) or Insured (16%). (Data not shown)

The Insured in this study had fewer chronic conditions than those in Medicaid and the Uninsured. Only approximately 1/3 of insured respondents (37%) reported having a chronic condition while almost 2/3rds of uninsured (64%) reported having at least one chronic condition. Of the Medicaid respondents, just under half reported having a chronic condition. (Data not shown)

Means revealed that Medicaid patients tended to make more Office, ER, and Hospital visits than either the Insured or Uninsured population (Figure 4).

In sum, the Insured reported better health (84% in Good to Excellent health) and fewer chronic conditions (1/3rd compared to nearly 2/3rd) compared to the Uninsured or the Medicaid population. The Uninsured population had poorer self-rated health status and more chronic conditions. In addition, they reported accessing health care much less than Medicaid recipients and slightly less than the Insured despite a greater number of health problems.
Section III: Insured Respondents on Their Current Benefits and the Value of Health Insurance

Understanding of current health insurance policy: 75% of Insured respondents stated they “understand fairly well,” or “fully understand” their insurance policy.

Importance of Insurance to the Insured: On a scale of 1 (not important) to 10 (very important), 94% of Insured rated the value of their insurance a 9 or 10. Insurance is highly valued by those who have it.

Figure 5 presents the problems that insured respondents reported having with their insurance. Respondents were given a list of potential problems and asked to state “yes” or “no” as to whether or not the issue was a problem for them.

Respondents indicated that the most frequent problems were paying for their insurance, coverage for provider services, policy changes, and issues with medications. The most infrequently identified problem was completing paperwork.
Section IV: Interest of the Uninsured in Health Insurance and Barriers to Getting It

Importance of Health Insurance to the Uninsured: On a scale of 1-10, 93% of uninsured respondents rated the importance of getting health insurance an eight or above. For a rating of 10, 76% did so. Only five respondents rated it a 7 or below in importance. Clearly, uninsured respondents place a high value on obtaining health insurance.

Interest of the Uninsured in Getting Health Insurance: The uninsured were then asked how likely they were to get insurance if it were available to them. A high majority, 87%, said they would get it were it available. (Figure 6). Nine respondents said they would not get insurance or were unlikely to get it. They were asked “If cost were not a factor, how likely would you be to get insurance?”. Six of nine said they would get it. Responses were not available for three. To the extent that the interviewed population is representative of the uninsured at large, uninsured individuals are likely to explore and accept the opportunity to obtain health insurance as long as it is affordable and they are aware it is available.

Barriers in Obtaining Health Insurance for the Currently Uninsured: (Figure 7). Uninsured individuals were asked what problems they have in obtaining health insurance. They rated each item in a list of potential problems using a three-point scale of “1-Little problem”, “2-Medium problem” or “3-Big problem.” The top three problems were:

- “Cost” (Big problem –78%)
- “Knowing Where to Get Information” (Big Problem – 38%)
- “Understanding How Policies Work” (Big Problem – 34%)

![Figure 6](image_url)  
Uninsured: Would You Get Insurance if Available to You? N=105

![Figure 7](image_url)  
Uninsured: Problems in Obtaining Health Insurance (Mean score on 3 pt scale)
“Trusting government programs” followed closely behind these three, with 30% indicating this was a big problem. When considering the problem that was most frequently rated a ‘big problem,’ cost was by far the biggest barrier.

Amount the Uninsured Note They Could Pay for Health Insurance: Uninsured respondents were asked how much they could pay per month for health insurance if it were available to them. A total of 141 interviewees responded to this question. The range was $0 to $1,000 per month, however at the higher end of the range only one person stated $1,000 and another $700. Seventy-one percent (71%) identified an amount of $100 per month or less. The median response was $50 per month. A total of 20% (28 respondents) stated they could pay nothing. The fact that 80% stated they could pay something suggests that the uninsured are sufficiently interested in obtaining health insurance that they are willing to pay something for it.
Section V: Health Literacy and Health Insurance Literacy Related Skill Assessment

A. Need for Help in Understanding Health Information vs. Health Insurance Information:

Health literacy was assessed using the Single Item Literacy Screener\textsuperscript{10} – a tool designed for rapid use in clinical settings to identify those who may have difficulty reading health related material (Sensitivity: 54%; Specificity: 83%). With this screen, patients are asked “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” Response options are a five point scale: 1-Never, 2-Rarely, 3-Sometimes, 4-Often, 5-Always.

The mean score on the Single Item Literacy Screener among interviewees was 2.28. Scores over 2 are considered positive in identifying individuals with limited reading ability who may need help reading health related material. Forty four percent (44%) of the 171 respondents rated themselves as “3-Sometimes,” “4-Often,” or “5-Always” needing help understanding health information from their doctor. This suggests a relatively high rate of limited reading ability, one aspect of health literacy, in this population.

When analyzed by age group, 37% of the 18-29 year old and 36% of the 50-64 year old respondents screened positive for limited reading ability. Over half (55%) of those in the 30-49 year olds were in this range.

The question was modified slightly to address health insurance literacy (“How often do you need to have someone help you when you read instructions, pamphlets, or other written material related to health insurance?” 1-Never, 2-Rarely, 3-Sometimes, 4-Often, 5-Always). Given no standardized method for assessing health insurance literacy at present, this question has not been validated as a general screening tool for health insurance literacy. It was asked simply to compare respondents’ comfort with health insurance information versus general health information. Using the question modified for Health Insurance,

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Health_Literacy_Insurance_Literacy.png}
\caption{Literacy Scale Score (Means), N=171}
\end{figure}

interviewees had a mean need for help rated at 2.63. This indicates that respondents were less confident in understanding insurance concepts and materials than they were general health information. (Figure 8).

By age group, respondents in the 50-64 year old category reported needing less help with health insurance related materials (2.39 – rarely need help) than 30-49 year olds (2.74 – Sometimes need help) and 18-29 year olds (2.86 – sometimes need help). In general, older adults felt more confident in reading health insurance instructions, pamphlets and other written material than younger individuals.

B. Specific Skills Related to Health Insurance Literacy

1. Confidence in Use of Health Insurance Terminology

Respondents were given a list of insurance terms and asked to rate their understanding of the term on a five-point scale, with 1 being “No Idea what the Word Means” to 5 being “Fully Understand; Can Explain it to Others.” While not assessing their actual comprehension of the word or phrase, this question assessed the individual’s comfort with or confidence in their understanding of the term. As presented in Figure 9, the terms respondents were least confident they knew the meaning of (means falling between 2.0 – “ Might be able to guess” and 3.0 – “Think you know, but not sure”) included:

- Drug Formulary
- HMO
- PPO
- In Network Provider
- Out of Network Provider
- Pre-Certification

Terms respondents were most comfortable with (mean confidence level = 4 or above – “Pretty Sure you Know the Meaning” or “Fully Understand; Could Explain to Others”) included:

- Co-pay
- Out of Pocket
- Health Insurance Plan
- Outpatient
- Deductible
- Inpatient

Respondents reported being more confident in their understanding of the term Prior Authorization than Pre-Certification.
Figure 9: Confidence in Use of Health Insurance Terms

Degree to Which Interviewees Feel They Understand Key Insurance Terms
West Virginia, Uninsured, Mean Scores, N=171

Scale
1. No Idea What Word Means
2. Might Be Able to Guess
3. Think You Know; Not Sure
4. Pretty Sure You Know Meaning
5. Fully Understand; Can Explain to Others

Drug Formulary: 2.39
HMO: 2.63
PPO: 2.84
In Network Provider: 2.84
Out of Network Provider: 2.87
Pre-Certification: 2.89
Plan Year: 3.03
Exclusions: 3.07
Behavioral Health Benefits: 3.14
Preventive Benefits: 3.14
Co-Insurance: 3.15
Office Visit Benefits: 3.23
Low Deductible Policy: 3.25
High Deductible Policy: 3.27
Emergency Benefits: 3.45
Prior Authorization: 3.55
Hospitalization Benefits: 3.57
Premium: 3.74
Prescription Benefits: 3.84
Coverage: 3.90
Inpatient: 4.05
Deductible: 4.11
Outpatient: 4.11
Health Insurance Plan: 4.13
Out-of-Pocket: 4.16
Co-Pay: 4.17
2. Numeracy in Relation to Health Insurance:

Respondents were given a scenario describing a patient visiting a specialist and a description of his insurance coverage (co-pay for a primary care doctor office visit=$25, co-pay for a specialist office visit=$50, deductible=$400, co-insurance=20%, and the maximum allowable charge=$150). The scenario included a definition of the terms co-pay, co-insurance, and deductible. The scenario was both shown to and read to the interviewee, unless they requested to read it independently. All necessary information was on a single sheet of paper.

a. Extracting applicable cost information; no calculations required:

The interviewee was first asked to identify the amount of the patient’s co-pay. This involved deciding whether or not the primary care co-pay or the specialist co-pay applied and listing the amount noted on the page. A total of 100 respondents from all the interviewees gave answers to this scenario. Figure 10 presents the percent that correctly identified the co-pay at $50. Approximately two-thirds (65%) of respondents were able to accomplish this task.

b. Calculating co-insurance:

A second question asked how much the patient would have to pay in co-insurance. This involved identifying the amount of the co-insurance listed and calculating 20% of the total allowable charge. Figure 11 presents respondent results. Only 28% correctly identified the applicable information and calculated the amount of co-insurance for which the patient was responsible. Comparing these two charts, far more respondents (almost 3 of every 4) had trouble calculating the co-insurance amount. [Note: Respondents were credited with a correct response if they calculated 20% of the $150 office visit with or without first subtracting the $50 co-pay.]
c. *Extracting information on cost and applying the concept of a deductible.*

A third question asked respondents to determine the effect of a deductible on the patient’s payment responsibility. Specifically, respondents were asked to identify the cost to the patient for the office visit if none of the deductible had been met to date. Beyond determining if the $150 total allowable charge was more or less than the plan deductible ($400), no mathematical calculation was required for this response. A total of 98 respondents answered this question. As presented in Figure 12, less than half of the respondents (41%) were able to reason this out. The incorrect responses ranged from $50 to $745, with no incorrect number predominating. Thus it appears that respondents were either able to identify the information and apply the deductible concept, or did not have any clear idea of what the correct answer should be and guessed the amount.

This was a complex exercise in that respondents had to extract financial information, calculate a co-insurance payment, and apply the concept of a deductible (in individual questions for each). At least one third had difficulty with extracting applicable financial information listed on the same page. Approximately 60-70% struggled with more complex tasks such as calculating a co-insurance or applying the concept of a deductible to calculate charges for which a patient is responsible. It suggests that the system for enrolling patients will have to specifically demonstrate the type of out-of-pocket costs that applicants will incur with different types of plans. It should not be assumed that individuals can extract and independently project the potential financial implications of such factors as co-pay, co-insurance and deductibles.

3. *Applying Life and Health Circumstances to Benefit Selection:*

This scenario described the health and life circumstances of a young couple shopping for health insurance. It then asked respondents to select, from a listing of 13 provided, which benefits or factors were important for the couple to consider in choosing a health insurance plan. While none of the benefits or factors listed were necessarily wrong, the scenario directly implied at least the following set of benefits or factors were appropriate for the couple’s insurance coverage choice: provider network, hospitalization benefits, monthly costs (premiums), other costs (copays, coinsurance, deductibles), what medications the plan...
covers, preventive care benefits, and maternity and newborn benefits. The scenario was verbally presented as well as showing the paper to the respondent so they could read along as desired. If they expressed interest in completing the paper independently, that was allowed. A total of 106 respondents from all the interviewees completed this scenario.

Table 7 presents the percent of respondents who chose each of the core benefits or factors applicable to the situation. Results demonstrate that, for the most part, respondents were able to apply benefit selection to life circumstance. Hospitalization was the item most frequently chosen. Out of 106 respondents, only four did not choose it.

It is interesting to note that 9.4% (10 respondents) did not chose medication coverage and 11.3% (12 respondents) did not chose maternity benefits even though these items were specifically referred to in the scenario. Whether these were missed due to difficulty in extracting applicable information from the story, difficulty in processing a long list of choices, or other factors is unclear.

The percentage of respondents who chose at least all six benefits listed in table 7 was 65% (69 of 106 respondents). This finding indicates that while respondents identified selected benefits (e.g. 96% chose hospitalization) a third of them had difficulty in selecting a whole benefits package that served the range of this family’s health needs. Having to assess the applicability and potential value of a large number of benefits individually likely increases the complexity of the decision making process. While not tested in this study, one way to potentially reduce such complexity is to create packages of benefits applicable to common circumstances. While such an approach somewhat limits flexibility and choice, it requires fewer life circumstance and insurance feature matches to process individually.

<table>
<thead>
<tr>
<th>Health Insurance Benefit or Factor</th>
<th>% Choosing Benefit or Factor as Applicable to Scenario (N=106)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization</td>
<td>96%</td>
</tr>
<tr>
<td>Medications covered by the plan</td>
<td>91%</td>
</tr>
<tr>
<td>Preventive care benefits</td>
<td>90%</td>
</tr>
<tr>
<td>Monthly costs (premiums)</td>
<td>90%</td>
</tr>
<tr>
<td>Maternity and newborn benefits</td>
<td>89%</td>
</tr>
<tr>
<td>Other costs (co-pay, co-insurance, deductibles)</td>
<td>82%</td>
</tr>
</tbody>
</table>
4. Comparing Plan Cost Structures in Relation to Anticipated Healthcare System Use

In this scenario, respondents were shown the basic costs of two plans, one with a high premium and low deductible and the second with a low premium and high deductible. They were then asked which of the two plans they would recommend to a person with a chronic condition requiring one to two visits a month to the doctor’s office and several medications. In the example given, both premiums were relatively low ($70 vs $100/month). Deductible differences were somewhat more ($1000 vs. $300).

A total of 97 respondents answered this question. Table 8 presents the results. Nearly three quarters of the respondents chose the more appropriate plan. When asked why, nearly everyone referred to cost savings. Typical responses were: “It is more cost efficient, lower cost in the long run,” and “the deductible will be met sooner reducing out-of-pocket costs.” This indicates that most respondents had a good understanding of the interplay between deductibles and premium and would be able to make a sound decision.

A follow up question asked respondents to decide which plan they would choose for themselves. 97 respondents completed this task. Responses are in Table 9. Some of the most frequently listed reasons for choosing Plan 1 were:

- It seems more affordable
- I want to pay (out of pocket) as little as possible
- I have three chronic conditions
- I go to the doctor every three months

Of the respondents with a chronic condition, 41 (82%) chose Plan 1 and nine (18%) chose Plan 2. Given that people with a chronic condition are likely to have frequent medical visits, it would make sense that they would chose Plan 1 because they would have less out-of-pocket expenses. This finding also supports the assertion that these respondents understood the interplay in making decisions about premiums and deductibles.
Section VI: Types of Help Potential Marketplace Users Anticipate Needing

Interviewees were asked a series of questions around choosing health insurance and the help they anticipate needing in doing the same. Given the focus of the Health Insurance Marketplace on expanding coverage to those who are currently uninsured through provision of premium and other cost subsidies as well as on reaching newly eligible Medicaid populations (to determine eligibility and link to Medicaid for enrollment), these questions were analyzed for the subgroup of interviewees who were currently uninsured or Medicaid recipients only (unless otherwise noted). This grouping is referred to as the “Expanded Coverage or Subsidy Eligible”. The vast majority in this subgroup were Uninsured (87.3%; 110 interviewees) with current Medicaid recipients comprising the balance (12.7%; 16 interviewees). Looking at income, the majority (78.4%) of “Expanded Coverage or Subsidy Eligible” interviewees reported household incomes of $133% FPL, the category closest to the federal limit for Medicaid Expansion under the Affordable Care Act (138% FPL). The remainder (21.6%) reported incomes of 134 – 399% FPL, the approximate federal range for premium and/or other cost subsidies under the same.

What do “Expanded Coverage or Subsidy Eligible” Interviewees Consider Important in Choosing Health Insurance?

Interviewees were asked “In choosing health insurance, how important is each of the following to you?” They rated 8 common features of insurance plans using a scale with the following options: “Not important at all”, “Not Very Important”, “Important”, “Very Important”.

Importance of Insurance Feature (Means Analysis):
Figure 13 shows the mean and median results for each insurance feature listed in descending order of importance to “Expanded Coverage or Subsidy Eligible” interviewees (Uninsured and Medicaid). In general, respondents rated all 8 of the listed features high in importance. Seven (7) of the eight (8) features had a response mean falling...
between “Important” and “Very Important” with little difference among them. Only “Behavioral Health Coverage” had a mean response falling below the “Important” rating. Fifty (50%) or more of respondents rated this feature at or below the “Important” level. For all other features, at least 50% of interviewees noted the feature to be “Very Important”.

**Impact of age on what’s important in choosing health insurance.** (all interviewees; logistic regression and 2x2 table analysis; Age ≥50 years vs. Age <50 years): The effect of age on the importance of different insurance features was also analyzed (Figure 14). This analysis, for purposes of strengthening statistical significance determination, included all interviewees (Insured, Uninsured, and Medicaid). While both age groups rate Dental Coverage as an important feature (Response mean for those age 18-49 =3.68; Response mean for those age 50-64 = 3.49), interviewees 18-49 years old were approximately twice as likely to rank “Dental Coverage” as “Very Important” in choosing a health insurance plan than those 50-64 years of age. (p<0.05).

The importance of “The amount of the premium or monthly cost”, “cost of copays, coinsurance, or deductibles,” “I get to choose my doctor,” “What medications the insurance will pay for,” “Behavioral Health Coverage,” “Hospital Coverage,” and “Preventive Services Coverage” did not vary significantly by age group in this analysis.

**Types of Help “Expanded Coverage or Subsidy Eligible” Persons Anticipate Needing in Choosing a Health Insurance Plan**

Interviewees were asked “If you were shopping for health insurance, how much help would you need with the following things?” Each rated the amount of help they felt they would need with 5 specific tasks on a four point scale including the following options: “No Help” “A Little Help” “Some Help”, and “Lots of Help”.

![Figure 14](https://example.com/figure14.png)
Average Help Needed by “Expanded Coverage or Subsidy Eligible” Interviewees (Means analysis): Figure 15 shows tasks listed in order of the average amount of help respondents anticipate needing related to each task. Tasks interviewees felt they would need the most help with were “Comparing Different Plans,” “Calculating Cost,” and “Figuring out if a plan covers my medications”. “Filling out an application” was the task with which they reported needing the least help.

Magnitude of Interviewees Reporting Help Needed (Frequency analysis): A high proportion of “Expanded Coverage or Subsidy Eligible” interviewees anticipate needing a significant amount of help with the core tasks involved in choosing health insurance. Specifically, over 70% anticipated needing “Some Help” or “Lots of Help” with three key tasks – “Comparing Different Plans,” “Calculating the cost per year in premiums and expenses,” and “Figuring out if a plan covers my medications.” “Finding out if my doctors accept that insurance” followed closely behind with over 60% anticipating help needed. Filling out an application ranked at just over 50%. (Figure 16).
Where the “Expanded Coverage or Subsidy Eligible” Would Go for Help in Choosing Health Insurance

Understanding where people would go for help in choosing health insurance is important for designing support programs. Interviewees were asked, “Where would you go to get help in choosing a health insurance plan or to see if you could get a better plan?” Responses were a simple “Yes” or “No”, noting whether or not the interviewee would seek out assistance in that locale.

Where “Expanded Coverage or Subsidy Eligible” Interviewees Say They Would Go for Help (Frequency Analysis):

Uninsured and Medicaid enrollees noted they would go to a wide variety of locales for assistance, were it available there. Figure 17 lists these in descending order of interest. Approximately 60% or above noted they would consider going to the Internet, a Friend or Family Member, the Doctor’s Office, or DHHR for help in choosing a health insurance plan. Site venues clustering around 50% of respondents expressing interest included Insurance Agent, Local Health Department, Employer or Pharmacy. Little interest was expressed in going to Libraries or retail settings such as Big Box Stores or Malls.
Analysis based on age (all interviewees; logistic regression and 2x2 table analysis; Age ≥50 years vs. Age <50 years): The effect of age on interest in using different locales for assistance was also analyzed (Figure 18). For purposes of strengthening statistical significance determination, this analysis included all interviewees (Insured, Uninsured, and Medicaid). Those 50-64 years of age were more likely to seek help from an insurance agent than those age 18-49. No significant differences by age were identified for use of the Library, Internet, Doctor’s Office, Pharmacy, Friend / Family Member, DHHR Office, Employer, LHD, or Mall.

Preferred Information Sources for Learning about Health Insurance Plans

When gathering information, people turn to different types of materials or sources. Understanding what sources “Expanded Coverage or Subsidy Eligible” individuals are most likely to turn to has implications for outreach and support system development. Interviewees were asked “Which of the following sources of information would you likely use to learn about health insurance plans?” Response choices included “Would not use”, “Might Use”, and “Very Likely to Use”.

Type of Information Sources “Expanded Coverage or Subsidy Eligible” Interviewees are Interested in (Frequency Analysis):

Interest in types of information sources varied among participants. Information sources in descending order of how likely participants noted they would be “Very Likely to Use” them are found in Figure 19. Over 70% of interviewees noted they would be very likely to use “Printed Material” (76%) or “In Person One-on-one Assistance” (74%) to learn about health insurance plans. In a second grouping, approximately 60% reported significant interest in “Calling to Speak with a Person” or “Web Based Tools / Internet Sites.” Only about a third of individuals reported being very likely to use “Group Meetings or Presentations”. The use of “Smart Phone applications” as a health insurance information source received little to

![Figure 19](image-url)
no interest fairly universally. Analyzing means for this data showed the same preference order as in Figure 19.

*Analysis based on age* (all interviewees; logistic regression and 2x2 table analysis; Age ≥50 years vs. Age <50 years): The effect of age on interest in using different information source types to learn about health insurance was also analyzed. For purposes of strengthening statistical significance determination, this analysis included all interviewees (Insured, Uninsured, and Medicaid). There were no statistically significant differences between the two age groupings with the one exception that younger age groups were more likely than older age groups to list smart phone apps as an information source they would use. However, since there is little interest in this information source by either those under 50 or those 50 and older, this finding has little practical meaning.
Section VII: Access to Technology

Using an online Health Insurance Marketplace requires access to the necessary technology, an interest in using it, and the skills to do so. Interviewees were asked a series of questions around their access to technology (both computers and smart phones) as well as their interest in use of a common website for shopping for health insurance. Skills in using a website were not assessed in this study.

Access to Technology (Frequency Analysis): Interviewees were asked whether they had a computer at home as well as whether or not they had a smart phone. Having a Computer at home was reported to be far more common (70% of all interviewees) than having a smart phone (32% of all interviewees). (Figure 20).

Home Computer Access by Insurance Status (Frequency Analysis): Insured individuals more commonly reported having a computer at home (79%) compared with those who were Uninsured or Medicaid Eligible. However, home computer access was still fairly common for the “Expanded Coverage or Subsidy Eligible” Group. Two thirds (67%) reported having a computer at home. While noted, these differences by insurance status did not meet statistical significance. (Figure 20).

Internet Access of “Expanded Coverage or Subsidy Eligible” Interviewees (Frequency Analysis):

As noted above, two-thirds (67%) of “Expanded Coverage or Subsidy Eligible” interviewees reported having a computer at home. (Figure 21). The vast majority also report having
internet access (88%). (Figure 22). Almost everyone with internet access reported that their access was high speed (99%).

Computer Access by Age
(Frequency Analysis): There was little difference among age groups in their likelihood of having a computer at home (18-29 years: 66%, 30-49 years: 74%; 50-64 years: 67%). Differences were not statistically significant. (Figure 23).

Computer Access by Region
(Frequency Analysis): Differences across regions of the state were also unremarkable (all between 68% and 72% with home computer access; data not shown).

Smart Phone Access by Insurance Status (Frequency Analysis; Chi-Squared): The insured were significantly more likely to have a smart phone (47%) compared to “Expanded Coverage or Subsidy Eligible” (Uninsured + Medicaid) interviewees (28%). (p=.04) (Figure 20).

Smart Phone Access by Age Group (Frequency Analysis, Chi-Squared): Younger interviewees were far more likely to have a smart phone than older interviewees. In fact, those age 18-29 years old were over 3 times more likely to have a smart phone than those age 50-64 years. (Figure 23). The inverse relationship between smart phone ownership and age was statistically significant (p=.002). The applicability of this data is minimal, however, given that Smart Phone Apps were quite low as a desired information source in learning about health insurance. While younger interviewees have smart phones more commonly, they express little interest in using them for accessing health insurance information.
Section VIII: Interest in a Central Website for Shopping for Health Insurance

All interviewees were asked, “If information about health insurance plans was available on one internet site through a computer, how likely would you be to use it for shopping for health insurance?” Responses included the possibility of doing so with a family member or friend if the individual did not have their own internet access. Interest in such a site was fairly high. Interviewees tended to be either very interested in shopping for health insurance on a common website (Very Likely, 69%) or to be somewhat hesitant to use such a site (Not at all or possibly, 31%). Only 1 of 147 individuals (0.7%) chose "Likely" as a response to this question. (Figure 24).

There was little difference between those in the Insured category and those who would be “Expanded Coverage or Subsidy Eligible” (Uninsured + Medicaid) in their reported likelihood of using a common website (63% vs 70% respectively). (Figure 25).

There was a trend towards decreasing interest in such a site with increasing age; however, the finding did not reach statistical significance. Even with the oldest age group (50-64 years), 64% stated they would be "Very Likely" to use such a site. (Figure 26).
Summary of Key Findings and Observations

A. Both insured and uninsured individuals interviewed place a high value on having health insurance. If the uninsured could afford it, the vast majority state they would enroll in a plan (>90%).

B. Cost is the primary barrier to getting health insurance reported by the uninsured (78% rate this as a “Big Problem”). Lower level barriers reported include “Knowing where to get information” (38%) and “Understanding how policies work” (34%). “Trusting government programs” is a barrier for some, falling slightly behind these three (30%).

C. The Expanded Coverage – Subsidy Eligible population rates several factors as “Very important” in selecting health insurance. These include cost, preventive services benefits, hospital coverage, medication coverage, dental coverage, and the ability to choose their doctor. Only behavioral health coverage drops to the “Important” level.

D. Younger adults highly value dental coverage. They are twice as likely to choose this benefit as “Very Important” compared with older individuals.

E. Forty-four percent (44%) of interviewees rated themselves as “Sometimes”, “Often”, or “Always” needing help understanding printed health information from their doctor. This suggests a relatively high rate of individuals in this population with limited reading ability, a key aspect of health literacy.

F. Interviewees report needing more help with health insurance concepts and materials than with general health information. This is consistent with the common belief that processing and understanding health insurance information involves more complex tasks than processing and understanding general health information.

G. By age group, older adults feel more confident in reading health insurance instructions, pamphlets and other written material than younger individuals (“Rarely” vs “Sometimes needing help” on average).

H. Most interviewees note a low level of confidence in understanding at least some insurance related words. Terms respondents are least confident they know the meaning of include: Drug Formulary, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), In Network Provider, Out of Network Provider, Pre-Certification.

Terms respondents are most comfortable with include: Co-pay, Out of Pocket, Health Insurance Plan, Outpatient, Deductible, Inpatient. Respondents report being more confident in their understanding of the term Prior Authorization than Pre-Certification.
I. Many of those interviewed have difficulty identifying and using relevant cost information to determine a patient’s share of expenses. This may not always be due to insufficient math skills per se, but to the complexity of extracting the right information and then using it to calculate costs due. For example: Two thirds (65%) of respondents are able to extract applicable cost information (a co-pay amount) listed on the same page; one-third (35%) are not. Only 28% demonstrate the ability to correctly calculate the amount of co-insurance due. Less than half of those interviewed (41%) are able to determine the effect of a deductible on the patient’s payment responsibility.

J. For the most part, respondents are able to apply life circumstances to applicable benefit selection. At times, needed benefits were either missed or mistakenly applied when multiple individual life and health circumstances had to be mapped to a list of coverage options.

K. The majority of respondents (73%) have a good understanding of the interplay between deductible and premium. They are able to make an appropriate health plan choice in relation to these two concepts and an individual’s anticipated use of the health care system.

L. Tasks in choosing a health insurance plan that Expanded Coverage – Subsidy Eligible interviewees anticipate needing the most help with are “Comparing Different Plans,” “Calculating Cost,” and “Figuring out if a plan covers my medications”. Over 70% anticipate needing “Some Help” or “Lots of Help” with these three key tasks. “Filling out an application” is the task with which they report needing the least help (51%).

M. The top places Expanded Coverage – Subsidy Eligible individuals report they would go to seek assistance (60% or more) include: the Internet, A Friend or Family Member, the Doctor’s Office, and DHHR. Site venues clustering around 50% of respondents expressing interest include Insurance Agent, Local Health Department, Employer or Pharmacy. Little interest is expressed in going to Libraries or retail settings such as Big Box Stores or Malls.

N. The information sources Expanded Coverage – Subsidy Eligible persons most commonly cite as “Very Likely to Use” are Printed Material and One-on-one Assistance (cited by almost 70% of individuals). This is followed by Calling to Speak with a Person and the Internet (~60%). Only one-third of individuals consider Group presentations a source of interest and very few express interest in Smart Phone Applications.

O. Two-thirds (67%) of Expanded Coverage-Subsidy Eligible individuals report having access to a computer at home. Of these, the vast majority (88%) have Internet Access, almost all of which is reported to be high speed (99%). Smart phone access is far less common (28%).
P. Interest in use of a central website to shop for health insurance is fairly high. Interviewees tend to be either very interested in shopping for health insurance on a common website (Very Likely, 69%) or to be somewhat hesitant to use such a site (Not at all or possibly, 31%). Interest in such did not vary with insurance status.

Conclusions and Recommendations: What Guidance Does This Study Provide in Implementing an Effective Health Insurance Marketplace in West Virginia?

1. **Health Insurance Literacy involves multiple domains and skillsets. Each should be considered in both Health Insurance Marketplace development and in development of user support systems:** In developing the Marketplace, outreach tools and strategies, and associated support systems, it is useful to think about Health Insurance Literacy in terms of domains. While other domain groupings are possible or may evolve through research, the following example provides a start for thinking about this issue.

   - Prose Literacy
   - Document Literacy
   - Numeracy
   - Comparative Analysis / Critical Thinking Skills
   - Technology Access and Skills

   In developing specific tools or systems, it will likely be beneficial to intentionally consider which domains apply to the task at hand and to utilize domain specific health literacy concepts to increase clarity and reduce burden.

2. **Those involved in communicating with or supporting Health Insurance Marketplace users should be trained in health literacy concepts and skills.** These are applicable to helping people learn about, choose, and effectively utilize health insurance.

3. **Individuals seen in healthcare settings for whom coverage will soon be available value obtaining health insurance. Efforts to notify them of emerging coverage options will be important.** The respondents in this study were strongly interested in obtaining health insurance. Although not formally assessed, field experience showed that few of those potentially eligible for expanded coverage or cost subsidies were aware that affordable coverage may soon be available to them. Convincing people to enroll in a Health Insurance Marketplace should not be a difficult task, if ....

   - Health Insurance Marketplace enrollment is made as simple as possible, and
   - Effective Engagement and Support Systems can:
• Raise Awareness of the Health Insurance Marketplace and What It Can Provide,
• Engender Trust in the Marketplace and its Associated Network, and
• Effectively Connect People with Pre and Post Enrollment Support Systems.

4. **Developing and sustaining active partnerships to reach the target audience is likely a key to success.** Integration into existing systems for such will be useful. Free clinics, FQHCs/Primary Care Centers, DHHR, University Clinics, WIC Offices, and others have the potential of being critical partners in reaching out to and/or enrolling those eligible for expanded coverage or subsidies in the Health Insurance Marketplace.

5. **Support Systems will be Important to Success:** Given that over 60% of potential Health Insurance Marketplace users interviewed felt they will need “Some Help” or “Lots of Help” with the tasks below, it is important that support systems be developed to assist enrollees in:
   - Comparing Different Plans
   - Calculating the cost per year in premiums and expenses
   - Figuring out if a plan covers their current medications and their providers

In addition, it will need to provide some with help in completing an application (approximately 50% anticipated need for “Some Help” or “Lots of Help” with this task).

Skill sets evaluated through scenarios, especially those related to numeracy (extracting applicable financial information, calculating co-insurances, determining remaining costs that are the responsibility of the insured, etc.) reinforced the need for assistance in this area.

6. **The Marketplace will need to have not only printed and web-based material, but also a network of advisors to give one-on-one assistance for informing potential enrollees about and enrolling them in the Health Insurance Marketplace.** In addition to web-based information and printed material, highly rated assistance mechanisms include in person one-on-one assistance as well as calling to speak with a person. The complexity of skill sets involved in evaluating and choosing a health insurance plan and the challenges interviewees demonstrated in this study suggest that individual assistance will be needed by a high proportion of enrollees. Free clinics, FQHCs/Primary Care Centers, DHHR offices and other locales have the potential of being well received partners in supporting and enrolling Expanded Coverage or Subsidy-Eligible persons in the Health Insurance Marketplace.

7. **Include explicit examples of how policy terms affect an enrollee’s coverage and costs when providing plan descriptions.** Many insurance related terms were familiar to interviewees in isolation, but in some cases, respondents had difficulty understanding the
interplay between terms, for example, co-pay, co-insurance, deductibles, premiums and how they affected decisions about an insurance plan. For example,

a. The system for enrolling patients will have to concretely define the out-of-pocket costs that applicants will incur with the selections that they make. It cannot be assumed they will be able to calculate the implications of such factors as co-pay, co-insurance and deductibles.
b. Examples of the interplay between premiums, deductibles, and health care system use will be beneficial.
c. Creating packages of benefits applicable to varying life circumstances and/or health statuses may reduce the complexity of the decision making process.

8. Include brief case studies that give enrollees concrete examples of what a plan will do for them. Respondents identified “understanding how policies work” as one of the major problems they have with health insurance. Case studies in which they can see how a plan might affect someone like them will likely be useful in articulating how a plan works.

9. Including dental coverage may increase the attractiveness of an insurance plan to younger adults. This was a highly valued benefit among younger populations interviewed in this study.

10. The internet is a viable tool for communicating about health insurance and for helping many of those eligible for expanded coverage or cost subsidies to enroll. Alternative methods must also be developed if all eligible individuals are to be reached. In this study, two thirds of the uninsured, all of whom were below 400% FPL, had access to a computer and the internet. Approximately two-thirds also expressed interest in using a common website to shop for health insurance. The internet was identified as a highly desirable source of information for learning about health insurance. It should not be assumed, however, that all will either have access to or utilize web-based systems. Alternative methods to reach these individuals will be important.
Works Cited


Appendices

Appendix 1  Listing of Interview Settings
Appendix 2  Interviewee Demographics by Health insurance Status
Appendix 3  Demographics for Combined Medicaid & Uninsured (“Expanded Coverage - Subsidy Eligible” Population)
Appendix 4  WV Counties by Region
Appendix 5  Sample Health Literacy Resources
Appendix 6  Detailed Summary of Findings and Recommendations
Appendix 1

Interview Sites

Ebenezer Free Clinic                               Huntington, WV
Lavalette Family Practice, Marshall Univ School of Medicine  Lavalette, WV
Harrison Access                                      Clarksburg, WV
Wheeling Health Right                                Wheeling, WV
Shenandoah Primary Care Center                       Martinsburg, WV
Eastern Panhandle Free Clinic                        Ranson, WV
Robert C. Byrd Clinic, WV School of Osteopathic Medicine  Lewisburg, WV
Pocahontas Memorial Hospital                        Marlinton, WV
New River Primary Care                               Fayetteville, WV
Mid-Ohio Valley Health Department: WIC Clinic        Parkersburg, WV
Mid-Ohio Valley Health Department: WIC Clinic        Spencer, WV
Mid-Ohio Valley Health Department: WIC Clinic        Point Pleasant, WV
Princeton Community Hospital                         Princeton, WV

Note: Our sincere thanks go to the leadership and staff of the above facilities and to the patients seen within them. Their willingness and enthusiasm to voluntarily take part in this project is what enabled accomplishment of this study and its provision of field-based input into development of West Virginia’s Health Insurance Marketplace and its associated support systems.
## Appendix 2

### Interviewee Demographics by Insurance Status

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<td><strong>Household Income:</strong></td>
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## Interviewee Demographics by Insurance Status, continued

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### Appendix 3

#### Demographics for Combined Medicaid & Uninsured Interviewees (“Expanded Coverage - Subsidy Eligible” Population)

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<tr>
<td>18-29 years</td>
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<tr>
<td>30-49 years</td>
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<tr>
<td><strong>Gender:</strong></td>
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<tr>
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<td><strong>Race:</strong></td>
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<tr>
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</tr>
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</tr>
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<tr>
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<tr>
<td>High School</td>
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<tr>
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<tr>
<td>College</td>
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<tr>
<td>Post Graduate</td>
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<tr>
<td><strong>Household Income (Self Reported)</strong></td>
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<td>≤ 133% FPL</td>
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<tr>
<td>134% - 399% FPL</td>
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Demographics for Combined Medicaid & Uninsured Interviewees ("Expanded Coverage - Subsidy Eligible" Population), Continued

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<td>Employed-- Part Time</td>
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<td>Self Employed</td>
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<td>Retired</td>
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<tr>
<td>Disabled</td>
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<td>Interview Setting</td>
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<td>Free Clinic</td>
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<td>Primary Care Center / FQHC</td>
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</tr>
<tr>
<td>Region</td>
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<tr>
<td>East</td>
<td>33</td>
<td>26.2%</td>
</tr>
<tr>
<td>North</td>
<td>33</td>
<td>26.2%</td>
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<tr>
<td>South</td>
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<tr>
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<td>37</td>
<td>29.4%</td>
</tr>
<tr>
<td>Total</td>
<td>126</td>
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</tr>
</tbody>
</table>
Appendix 4

West Virginia Counties by Region

**Region I (North):** Hancock, Brooke, Ohio, Marshall, Wetzel, Tyler, Pleasants, Wood, Wirt, Ritchie, Calhoun, Gilmer, Doddridge, Harrison, Marion, Monongalia

**Region II (West):** Jackson, Mason, Cabell, Wayne, Mingo, Logan, Boone, Lincoln, Kanawha, Putnam, Roane

**Region III (East):** Jefferson, Berkeley, Morgan, Hampshire, Mineral, Hardy, Grant, Pendleton, Tucker, Preston, Taylor, Barbour, Randolph, Upshur, Lewis

**Region IV (South):** McDowell, Mercer, Wyoming, Raleigh, Summers, Monroe, Greenbrier, Fayette, Nicholas, Clay, Braxton, Webster, Pocahontas
Appendix 5

Sample Health Literacy Resources

   

   


Appendix 6

Health Insurance Literacy:
An Exploratory Study of Potential Health Insurance Marketplace Users and Their Need for Assistance,
Marshall University Center for Rural Health, West Virginia, 2012

Detailed Summary of Key Findings and Recommendations

This exploratory study best reflects individuals with incomes <400% FPL seen within healthcare settings that serve the uninsured (including free clinics, primary care centers, WIC clinics, critical access hospitals, and university based practices) in a primarily rural state.

Study Population Demographics:

Of 171 persons interviewed, key demographics included:

A. Insurance Status: 64.3% were Uninsured, 9.4% Medicaid Recipients, and 26.3% Insured.

B. Age and Gender: 75% of interviewees were female and 78% were between the ages of 30 and 64. Individuals younger than 18 or older than 65 were excluded from analysis. Insured and Uninsured were similar in age and gender distributions.

C. Race and Ethnicity: Race and Ethnicity reflected that of the state population.

D. Income: 92% of all interviewees reported household incomes under 400% FPL. A majority (68%) reported household incomes of <133% FPL with the uninsured more likely to report lower household incomes than the insured (40% of insured, 76% of uninsured <133% FPL). Twenty-four percent (24%) reported incomes of 134-399% FPL (31% of Insured; 24% of uninsured). None of the Uninsured population reported incomes over 400% FPL.

E. Education: 69% of all interviewees completed high school or less education. Those with higher education levels were more likely to be insured. Of the uninsured, 26% reported some form of education beyond high school (vocational training, college, or post graduate).

F. Employment: Medicaid and Uninsured persons were far more likely to be unemployed than insured individuals (56% and 52% respectively vs. 13% of Insured). Of the Uninsured, 35% reported some form of employment.

G. Distribution of Insurance Status within Interview Settings: Free clinics were the setting in which the highest percent of uninsured individuals were accessed (100% of patients). This
is consistent with eligibility for service in these settings. Primary care centers, WIC clinics and university affiliated clinics also provided access to a high proportion of currently uninsured (52%, 48%, and 47% of individuals accessed here respectively). Only 13% of those interviewed in critical access hospitals were uninsured.

**Detailed Summary of Findings and Observations**

**A. Value placed on health insurance;**

1. Insured and uninsured persons interviewed highly value having health insurance. If the uninsured could afford it, the vast majority state they would enroll in a plan (>90%).

**B. Insured: Problems with Current Health Insurance**

1. Among the insured, no more than a third of respondents reported any one specific issue to be a problem with their current health insurance.

2. The insured reported the top three problems they had with their current health insurance as the following: “Hard to pay for”, “Getting coverage for providers or services I need”, and “Knowing how to change my policy if circumstances change”. Completing paperwork was the issue they noted least commonly to be a problem.

**C. Uninsured: Barriers to Getting Health Insurance; Most Important Policy Features in Choosing Health Insurance**

1. **Barriers to getting health insurance**
   a. Cost is the primary barrier to getting health insurance reported by the uninsured (78% rate this as a “Big Problem”).
   
   b. Lower level barriers reported include “Knowing where to get information” (38%) and “Understanding how policies work” (34%). “Trusting government programs” is a barrier for some, falling slightly behind these three (30%).

2. **Most Important Policy Features in Choosing Health Insurance**
   a. The Expanded Coverage – Subsidy Eligible population rated several factors as “Very important” in selecting health insurance. These included cost, preventive services, hospital coverage, medication coverage, dental coverage, and the ability to choose their doctor. Only behavioral health coverage dropped to the “Important” level.

   b. Younger adults highly value dental coverage. They were twice as likely to choose this benefit as “Very Important” compared with older individuals.
D. Health Literacy and Health Insurance Literacy Related Skills

1. Health Literacy vs. Health Insurance Literacy

   a. Forty-four percent (44%) of interviewees rated themselves as “Sometimes”, “Often”, or “Always” needing help understanding printed health information from their doctor. This suggests a relatively high rate of individuals in this population have limited reading ability, a key aspect of health literacy.

   b. Interviewees report needing more help with insurance concepts and materials than with general health information. This is consistent with the common belief that processing and understanding health insurance information involves more complex tasks than processing and understanding general health information.

   c. By age group, older adults felt more confident in reading health insurance instructions, pamphlets and other written material than younger individuals (“Rarely” vs “Sometimes needing help” on average).

2. Confidence in Understanding Insurance Terms

   a. Most interviewees noted a low level of confidence in understanding at least some insurance related words.

   b. Terms respondents were least confident they knew the meaning of included:

   - Drug Formulary
   - Health Maintenance Organization (HMO)
   - Preferred Provider Organization (PPO)
   - In Network Provider
   - Out of Network Provider
   - Pre-Certification

   Mean responses falling between: “Might be able to guess” and “Think you know, but not sure”

   c. Terms respondents were most comfortable with included:

   - Co-pay
   - Out of Pocket
   - Health Insurance Plan
   - Outpatient
   - Deductible
   - Inpatient

   Mean responses falling between: “Pretty Sure you Know the Meaning” and “Fully Understand; Could Explain to Others”
3. Numeracy in Relation to Health Insurance

Many of those interviewed had difficulty identifying and using relevant cost information to determine a patient’s share of expenses. It may not always be math skills per se, but the complexity of extracting the right information and then using it to calculate costs.

For example:

a. *Extracting cost information (co-pay):* Two thirds (65%) of respondents were able to extract applicable cost information (co-pay amount) listed on the same page. This task did not require any calculations. One third did not find the applicable information.

b. *Extracting applicable cost information and calculating co-insurance:* Only 28% of those interviewed demonstrated the ability to correctly calculate the amount of co-insurance due. This task involved identifying relevant information on the same page and calculating a percentage.

c. *Extracting relevant information and applying the concept of a deductible:* Less than half of those interviewed (41%) were able to determine the effect of a deductible on the patient’s payment responsibility.

4. Applying Life and Health Circumstances to Benefit Selection:

a. For the most part, respondents were able to apply life circumstances to applicable benefit selection.

b. Data suggested that some applicable benefits were either missed or mistakenly applied when many individual life and health circumstances had to be applied to multiple individual benefits. Grouping of benefits applicable to common life circumstances may be helpful.

5. Comparing Plan Cost Structures in Relation to Anticipated Healthcare System Use

a. The majority of respondents (73%) had a good understanding of the interplay between deductibles and premium. They were able to make an appropriate health plan choice in relation to these two concepts and an individual’s anticipated use of the health care system.
E. **Types of Assistance and Resources Potential Marketplace Users Anticipate Needing**

1. **Types of Assistance Potential Marketplace Users Anticipate Needing**

   a. Tasks interviewees felt they would need the most help with were “Comparing Different Plans,” “Calculating Cost,” and “Figuring out if a plan covers my medications.”

   b. A high proportion of “Expanded Coverage - Subsidy Eligible” interviewees anticipate needing a significant amount of help with the core tasks involved in choosing health insurance. Specifically, over 70% anticipated needing “Some Help” or “Lots of Help” with the three key tasks noted.

   c. “Filling out an application” was the task with which they reported needing the least help.

2. **Locales for Help in Choosing Health Insurance: “Expanded Coverage or Subsidy Eligible”**

   a. The top places from which individuals report they would seek assistance (60% or more) included: the Internet, A Friend or Family Member, the Doctor’s Office, and DHHR.

   b. Site venues clustering around 50% of respondents expressing interest included Insurance Agent, Local Health Department, Employer or Pharmacy.

   c. Little interest was expressed in going to Libraries or retail settings such as Big Box Stores or Malls.

   d. Those 50-64 years of age were more likely to seek help from an insurance agent than those 18-49 years of age.

3. **Preferred Information Sources: Expanded Coverage – Subsidy Eligible Population**

   a. The information sources most commonly cited as “Very Likely to Use” were *Printed Material* and *One-on-one Assistance* (cited by almost 70% of individuals). This was followed by *Calling to Speak with a Person* and the *Internet* (~60%).

   b. Only one-third of individuals considered *Group Presentations* a source of interest and very few expressed interest in *Smart Phone Applications*.

4. **Access to Technology and Interest in Using a Central Website to Shop for Health Insurance**
a. Two-thirds (67%) of Expanded Coverage-Subsidy Eligible individuals report having access to a computer at home. Of these, the vast majority (88%) have Internet Access, almost all of which is high speed (99%). Smart phone access was far less common (28%).

b. Interest in use of a central website to shop for health insurance was fairly high. Interviewees tended to be either very interested in shopping for health insurance on a common website (Very Likely, 69%) or to be somewhat hesitant to use such a site (Not at all or Possibly, 31%). Interest in such did not vary much by insurance status.

**Recommendations**

1. **Health Insurance Literacy involves multiple domains and skillsets. Each should be considered in both Health Insurance Marketplace development and in development of user support systems:** In developing the Marketplace, outreach tools and strategies, and associated support systems, it is useful to think about Health Insurance Literacy in terms of domains. While other domain groupings are possible or may evolve through research, the following example provides a start for thinking about this issue.
   - Prose Literacy
   - Document Literacy
   - Numeracy
   - Comparative Analysis / Critical Thinking Skills
   - Technology Access and Skills

   In developing specific tools or systems, it will likely be beneficial to intentionally consider which domains apply to the task at hand and to utilize domain specific health literacy concepts to increase clarity and reduce burden.

2. **Those involved in communicating with or supporting Health Insurance Marketplace users should be trained in health literacy concepts and skills.** These are applicable to helping people learn about, choose, and effectively utilize health insurance.

3. **Individuals seen in healthcare settings for whom coverage will soon be available value obtaining health insurance. Efforts to notify them of emerging coverage options will be important.** The respondents in this study were strongly interested in obtaining health insurance. Although not formally assessed, field experience showed that few of those potentially eligible for expanded coverage or cost subsidies were aware that affordable coverage may soon be available to them. Convincing people to enroll in a Health Insurance Marketplace should not be a difficult task, if ....
   - Health Insurance Marketplace enrollment is made as simple as possible, and
• Effective Engagement and Support Systems can:
  ▪ Raise Awareness of the Health Insurance Marketplace and What It Can Provide,
  ▪ Engender Trust in the Marketplace and its Associated Network, and
  ▪ Effectively Connect People with Pre and Post Enrollment Support Systems.

4. Developing and sustaining active partnerships to reach the target audience is likely a key to success. Integration into existing systems for such will be useful. Free clinics, FQHCs/Primary Care Centers, DHHR, University Clinics, WIC Offices, and others have the potential of being critical partners in reaching out to and/or enrolling those eligible for expanded coverage or subsidies in the Health Insurance Marketplace.

5. Support Systems are Important to Success: Over 60% of potential Health Insurance Marketplace users interviewed felt they will need “Some Help” or “Lots of Help” with the tasks below. Thus, it is important that support systems be developed to assist enrollees in:
   • Comparing Different Plans
   • Calculating the cost per year in premiums and expenses
   • Figuring out if a plan covers their current medications and their providers

In addition, it will need to provide some with help in completing an application (approximately 50% anticipated need for “Some Help” or “Lots of Help” with this task).

Skill sets evaluated through scenarios, especially those related to numeracy (extracting applicable financial information, calculating co-insurances, determining remaining costs that are the responsibility of the insured, etc.) reinforced the need for assistance in this area.

6. The Marketplace will need to have not only printed and web-based material, but also a network of advisors to give one-on-one assistance for informing potential enrollees about and enrolling them in the Health Insurance Marketplace. In addition to web-based information and printed material, highly rated assistance mechanisms include in person one-on-one assistance as well as calling to speak with a person. The complexity of skill sets involved in evaluating and choosing a health insurance plan and the challenges interviewees demonstrated in this study suggest that individual assistance will be needed by a high proportion of enrollees. Free clinics, FQHCs/Primary Care Centers, DHHR offices and other locales have the potential of being well received partners in supporting and enrolling Expanded Coverage or Subsidy-Eligible persons in the Health Insurance Marketplace.

7. Include explicit examples of how policy terms affect an enrollee’s coverage and costs when providing plan descriptions. Many insurance related terms were familiar to
interviewees in isolation, but in some cases, respondents had difficulty understanding the interplay between terms, for example, co-pay, co-insurance, deductibles, premiums and how they affected decisions about an insurance plan. For example,

a. The system for enrolling patients will have to concretely define the out-of-pocket costs that applicants will incur with the selections that they make. It cannot be assumed they will be able to calculate the implications of such factors as co-pay, co-insurance and deductibles.

b. Examples of the interplay between premiums, deductibles, and health care system use will be beneficial.

c. Creating packages of benefits applicable to varying life circumstances and/or health statuses may reduce the complexity of the decision making process.

8. Include brief case studies that give enrollees concrete examples of what a plan will do for them. Respondents identified “understanding how policies work” as one of the major problems they have with health insurance. Case studies in which they can see how a plan might affect someone like them will likely be useful in articulating how a plan works.

9. Including dental coverage may increase the attractiveness of an insurance plan to younger adults. This was a highly valued benefit among younger populations interviewed.

10. The internet is a viable tool for communicating about health insurance and for helping many of those eligible for expanded coverage or cost subsidies to enroll. Alternative methods must also be developed if all eligible individuals are to be reached. In this study, two thirds of the uninsured, all of whom were below 400% FPL, had access to a computer and the internet. Approximately two-thirds also expressed interest in using a common website to shop for health insurance. The internet was identified as a highly desirable source of information for learning about health insurance. It should not be assumed, however, that all will either have access to or utilize web-based systems. Alternative methods to reach these individuals will be important.