

Project to Improve the Model Evidence of Coverage (EOC) Document—
Phase 1: Summary Report of Results of Consumer Testing of the
Revised Evidence of Coverage

Purpose: Medicare+Choice (M+C) organizations are required by law to send an Evidence of Coverage (EOC) document to new members upon enrollment and to all members each year. The EOC gives details about benefits and services and how to use the plan. CMS has developed a model EOC template that contains the type of information it expects in an EOC and the manner in which it prefers this information to be presented. Though M+C organizations are not required by law to follow the model, those that do by law receive an expedited 10-day review of their EOC document by CMS. Two phases of consumer testing were done, focusing on revising particular sections of the model EOC. In each phase, multiple rounds of testing were done to test the revised versions and make further improvements.

Results: This report summarizes the results from Phase 1 of the consumer testing of the EOC. Phase 1 consisted of: 1) selecting specific sections of the model EOC for revision; 2) obtaining feedback from stakeholders (i.e., managed care organizations, Medicare beneficiary organizations, and CMS staff) to improve those sections of the model EOC; 3) revising them; 4) consumer-testing the revisions (mockups of revised EOCs) via 37 individual interviews in three cities with current or former M+C plan enrollees and family members who help Medicare beneficiaries with health-related decisions. Key findings from the consumer testing were as follows:

1. General Impressions of the EOC

- With the exception of the most technical and complicated sections (especially the Appeals and Grievances section), most of the people interviewed were able to understand the material reasonably well, despite great variation in the respondents' literacy skills.
- Overall, the respondents differed greatly in their level of interest in the EOC and their attitudes, opinions, and experiences pertaining to managed care.
 - Some respondents made sweeping and/or negative judgments based on their previous experiences, sometimes before they began reading and other times in reaction to specific topics or sentences.
- Respondents differed in their general approach to reading the document.
 - Skimming was the typical reading approach.

- Skimmers often missed important points or misinterpreted what they read.
- The document was rather intimidating to many.
 - Some respondents remarked about the size of the document and its numerous sections.
 - Some were hesitant and seemed intimidated by certain parts of the document, especially the section on Appeals and Grievances.
 - However, others reacted with greater confidence and made favorable comments about content and format, saying that they found the EOC easy to read.
- Doubt and skepticism were common.
 - Interviews revealed the vulnerability of many respondents, and their comments often reflected a good deal of mistrust of the health care system and health plans, especially when appeals and grievances are involved.
 - Others reacted very favorably to learning more about the process of appeals and grievances because it made them feel less vulnerable.
- People lacked knowledge about many topics covered in the EOC.
 - Most of the respondents were unfamiliar with at least some of the information they read about in the EOC mockup, especially in regard to Appeals and Grievances and Involuntary Disenrollment.

2. Purpose of the EOC and How People Would Use It

- Most respondents did not immediately recall having received an EOC from their own health plan.
 - Those who did remember receiving such a document usually did not recall or recognize the term “Evidence of Coverage.”
- Respondents typically viewed the EOC as a reference document, saying they would set it aside, reading it only if the need arose.
- Respondents said they prefer to get information from a real person than to read the EOC.
 - They liked the idea of having the phone numbers of their health

plans prominently displayed on the EOC's cover.

- Some suggested adding bold face to text in various places on the inside that gives contact information.

3. Reactions to the Title and Cover

- The great majority of testing participants favored the longest of the three titles tested, "Your Medicare health benefits and services as a member of Maple Health Plan." (Note: "Maple Health Plan" was the fictional name used for testing the EOC mockup.)
 - Most respondents thought this title explained more, was more specific and more straightforward.
- Overall, respondents reacted very favorably to including the following tag line underneath the title, because it told them the purpose and importance of the document: "This booklet gives the details about your Medicare health insurance and explains how to get the care you need. It's an important legal document, so please keep it in a safe place."
- Respondents liked the convenience of having the health plan's toll-free telephone numbers on the cover, and several commented favorably about the large print and the calling hours (i.e., hours of operation).
 - Several mentioned that they never knew what a TTY-TDD number was until they read the explanation on the cover. (This explanation was included to help deter people from calling the TTY-TDD number when there was a long wait on the regular toll-free number.)

4. Reactions to the Welcome Page

- Overall, respondents thought the content and tone of the Welcome Page were appropriate, and seemed to have few problems understanding it.
- Minor edits were made to the Welcome Page for each new round of testing, based on reactions and suggestions from participants.
 - Ultimately, the Welcome Page was shortened by condensing and cutting some of the information.
 - Some of the bullets were edited and rearranged to emphasize topics of greater interest to respondents.

5. Reactions to the Two Versions of the Table of Contents: Long vs. Short Versions.

- Respondents overwhelmingly preferred the long version of the Table of Contents because it was much easier to locate information of specific interest.
- Respondents also found the long version to be easier to use during consumer testing when they were given navigational tasks to do, such as showing where they would look to find a particular topic.
- The majority of respondents preferred the word “sections” to “chapters” as the label for the main divisions in the document, because calling them “chapters” made it sound like a novel or long book.
- Reactions to the Table of Contents in the mockups that were tested revealed a problem with the sequence of topics.
 - To draw beneficiaries’ attention to the Appeals and Grievances section, this section was moved forward in the mock-up.
 - However, testing showed that this placement didn’t make sense to people: they wanted to read about their coverage before reading about what to do if there’s a problem.
- Respondents’ reactions to the Table of Contents revealed some problems with terminology and a few misunderstandings about content, especially among those with less education and less experience with managed care.
 - Results from testing confirmed the need to provide explanations of terms, such as “formulary”, “SHIPs”, and “PROs.”
 - Several respondents had problems with the Table of Contents entries for emergency care and urgent care because they found it hard to understand the difference between “urgent” and “emergency.”

6. Reactions to the Section on Appeals and Grievances

- This long and complex section poses special challenges for readers to understand and use the information in this section, for the following reasons:
 - Many respondents were wary or cynical about the health plan and outside review organizations, lacking confidence that the health plan would really follow through or that the process would work to their advantage. Respondents also showed a general distaste for legal

proceedings.

- Respondents were largely unfamiliar with the information in this section, with only a few having personal experiences to draw on and others having misconceptions.
- The subject matter of appeals and grievances is extremely complex, with three main parts that deal with the rules, processes, and terminologies that apply to different situations (appeals, review of hospital discharge, grievances).
- Although test participants were interested in this section and felt it was important to know about their rights, many found this section to be confusing, frustrating, or problematic in other ways, especially those who had less education and less personal experience related to this topic.
- There is tension between maintaining the integrity of the EOC document in a legal sense and making its language as simple as possible.
 - “Appeal” and “grievance” were difficult vocabulary for most respondents; and it was hard for them to understand the difference between an appeal and a grievance.
 - The concepts of “fast appeal” and “standard appeal” were difficult for many people to understand.
 - The term “Peer Review Organization,” and its acronym “PRO,” were unfamiliar to most respondents.
 - The concept of an “independent outside review organization” also caused problems for a lot of respondents: many failed to grasp the meaning of “independent” in this context and were unable to picture such an organization (e.g., who are involved in this organization, how are they chosen, is it costly).
 - Besides having problems with much of the specialized terminology that appears in this section, testing showed that many respondents reacted negatively to words associated with law and government (e.g., “legal,” “written,” “court,” “judge”), time periods and deadlines (e.g., “calendar days” versus “business days”), and other words that those who work for Medicare and the health care profession take for granted.
- Two tries at revising the Appeal and Grievances section revealed that people had difficulty understanding the six steps of the appeals process.

- Ultimately, the six steps were summarized in the Appeals and Grievances section, and the details of each step were placed in an appendix.

7. Reactions to the Paragraphs about Coordination of Benefits

- Based on the results from testing, the first version of this section was condensed to focus on key points, emphasizing the need for members who have other sources of health coverage to notify their plan.
 - The first version of the Coordination of Benefits paragraphs was significantly longer than the final version because it included a number of examples of other sources of benefits and more details about the process of coordinating benefits.
 - However, testing showed that this extra information served mainly to confuse people rather than to enlighten them.

8. Reactions to the Section on Disenrollment

- The term “disenrollment” is unfamiliar and intimidating to many people.
- To address these concerns, the title of this section was changed from “Disenrollment from *{name of M+C plan}*” to “Disenrollment: Leaving *{name of M+C plan}* and your choices for continuing Medicare after you leave.”
 - The expanded new title incorporates an explanation of the meaning of the word “disenrollment” and indicates what kind of information is in this section.
- The new rules that limit when and how members can disenroll were confusing to some test participants.
 - The phase-in of the new rules, together with a number of exceptions to the rules, made this section harder for people to understand.
 - Some people remarked favorably about the repetition in this section because it helped them understand what the plan and the member can and cannot do during the disenrollment process.
- “Original Medicare” was a confusing term for some respondents, and some thought that it referred to something different than Medicare.
 - Once the term was explained, many respondents thought that using the word “Medicare” by itself would be better than saying “Original

Medicare.”

- The overview of “involuntary disenrollment” that appeared in the first round of testing was revised for the next round of testing to allay worries expressed by respondents that their plan might drop them if they got really sick or made a complaint.
 - The first mockup that was tested included this sentence in the overview: “In addition, as we explain later in this section, Maple Health Plan is allowed to end your membership under certain special conditions.”
 - For the next round of testing, the above sentence was changed to reassure the beneficiary: “In addition, as we explain later in this section, Maple Health Plan is allowed to end your membership under certain special conditions (these conditions do *not* include asking you to leave because of your health).”

9. Reactions to the Appendix on Advance Directives

- Overall, people responded favorably to the topic of advance directives and its inclusion in the EOC.
- People were more familiar with the terms “living will” and “power of attorney” and preferred these to the more generic and less familiar term “advance directives.”
- A few people wanted the EOC to include a sample of a living will.
 - They thought it would be especially helpful to people with lower incomes and less access to an attorney, since they could take the document to their doctors to discuss.

10. Revisions to the EOC in Phase 1 resulting from this study emphasized:

- Making it easier for people to skim and pick up the key points in each section, since the EOC is used as a reference document.
- Addressing people’s concerns directly (for example, emphasizing that they cannot be dropped if they complain or get really sick).
- Using language that is as simple as possible without compromising the EOC’s legal integrity.
- Making the overall tone friendly and helpful.