



**Statement of Consumers Union  
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Before the U.S. Department of Labor,  
Advisory Council on Employee Welfare and Pension Benefit Plans  
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**PPACA, Health Care Literacy and Employee Benefit Programs**

Madame Chair, Members of the Council:

Thank you very much for the opportunity to appear before you today.

Consumers Union, the independent, nonprofit publisher of *Consumer Reports*,<sup>1</sup> congratulates the council for taking this in-depth look at insurance disclosures and other communications sent to employees and retirees, with the goal of implementing strong, consumer-friendly standards as required by the Patient Protection and Affordable Care Act (PPACA).

A brief review of HIPAA privacy notices may illustrate the challenge before you. The 2000 HIPAA regulatory guidelines required that the new patient privacy notices be written in "plain language."<sup>2</sup> The regulations specified "[a] covered entity can satisfy the plain language requirement if it makes a reasonable effort to: organize materials to serve the needs of the reader; write short sentences in the active voice, using "you" and other pronouns; use common, everyday words in sentences; and divide materials into short sections."

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<sup>1</sup> Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's income is solely derived from the sale of Consumer Reports and ConsumerReports.org, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports and ConsumerReports.org, with approximately 8.3 million combined paid circulation, regularly carry articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

<sup>2</sup> Final Privacy Rule Preamble. II. Section-By-Section Description of Rule Provisions, <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/privrulet.txt> .

The result: according to many experts, these regulations completely failed to get HIPAA writers to use plain language.<sup>3</sup> The regulations did not include any examples of materials actually written in plain language.<sup>4</sup> According to one analyst, health-care organizations believed that to reduce the likelihood of being non-compliant and getting into trouble with the federal government, the safest thing to do was to use the language of their health-association law firms.<sup>5</sup>

When HIPAA rules were being developed, an early strategy required patients to sign that they understood their HIPAA privacy rights. By the time the final rules came out, that requirement was changed to having patients sign only that they had been given their HIPAA notice-not that they understood it. The distinction may not matter. Patients had to sign; without that signature they could not be medically treated. Compliance *without comprehension* is clearly not the desired outcome from the HIPAA exercise, nor would it be an acceptable outcome for the task before this council.

Returning to the task at hand, the principles for creating effective, appealing and understandable employee communications are fairly well understood, if not always followed. Hence, my statement will focus on five areas, designed to increase the effectiveness of employee communications over and above what we would expect from a well-written and formatted piece. Specifically:

1. The value of consistency between group and non-group insurance related communications
2. Noting disclosures needed over and above those directly listed in PPACA
3. The importance of creating model communications for employers
4. Creating feedback mechanisms to measure value to employees
5. Role for the DOL website

My comments address the roles and obligations that larger employer plans have under PPACA. These plans are more likely to be self-insured, and thus lie outside of state regulation and under the jurisdiction of the Department of Labor (DOL).

The PPACA requires a new standard insurance disclosure form.<sup>6</sup> These disclosures are to be used by all insurance plans, whether group or non-group, grandfathered or non-

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<sup>3</sup> Mark Hochhauser. Compliance vs. Communication: Readability of HIPAA Notices, *Clarity*, No. 50, Nov. 2003, <http://www.privacyrights.org/ar/HIPAA-Reading.htm>

<sup>4</sup> HHS did publish some plain language guidelines: <http://www.hrsa.gov/servicedelivery/language.htm>

<sup>5</sup> Hochhauser, op cit.

<sup>6</sup> Uniform explanation of coverage documents, PPACA, [1001:2715; 10101(b); 10103(d)].

grandfathered. As such, these disclosures will receive substantial scrutiny and will benefit from built-in consistency across various insurance-purchasing venues.

The anticipated consistency across insurance markets will hopefully lead to a leap in consumer understanding of health insurance products, much the way consumers have “learned” to use the nutritional facts labels on food. A recent case study of these nutritional labels found:<sup>7</sup>

Placement of the [Nutritional Facts Panel] on the food labels, so that it is universally available at the time a food purchase is made, is a key to its frequency of use. Consistency of format and content is another key. People can learn to use the tool, either through their own initiative, through the mass media campaigns, through health educators, or other venues. Once they get it, they can count on it not to change drastically.

The first recommendation is: DOL should strive for this consistency of format and content for all *other* closely-associated communications that employees will receive in connection with the new PPACA requirements or normal employer-employee health benefit communications. A partial list might include:

- Insurer Explanation of Benefit (EOB) statements
- Notice of grievance and appeal rights<sup>8</sup>
- Description of new benefit allowing dependents younger than age 26 to stay on their parents’ plan.
- A new disclosure identifying grandfathered plans
- Explanation of an employee’s right to use a voucher to purchase in the exchange (if health insurance costs exceed 9.5% of family income and family income is below 400% of federal poverty guidelines)
- Statement clarifying that the value of an employee’s health insurance coverage, now displayed on the employee’s Form W-2, is not taxable income.

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<sup>7</sup> *Getting Tools Used, Lessons for Health Care from Successful Consumer Decision Aids*, 2009 Center for Advancing Health. See [http://www.cfah.org/activities/Getting\\_Tools\\_Used/homles-rovner.pdf](http://www.cfah.org/activities/Getting_Tools_Used/homles-rovner.pdf)

<sup>8</sup> Historically, employees in self-funded plans have rarely understood their appeal rights or who to turn to for help. Under PPACA, this may become a little simpler. For plan years beginning on or after September 23, 2010, self-funded plans must implement new mandated appeals processes with both internal and external appeal rights, consistent with the processes to be used by fully-funded plans. Grandfathered plans, however, are exempt from this requirement--suggesting that employee confusion regarding appeal rights may continue.

- Explanation of new default enrollment rules. (Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees in coverage. Employees may opt out.)

DOL can achieve the goal of widespread consistency by developing rigorous standards and model documents. These standards, for example, could require that all closely-associated disclosure forms and employee communications use the same standardized insurance and medical terms that will be developed for the uniform disclosure form (referred to above).

These standards should include formatting guidelines. Document design features-such as the amount of white space in margins and between paragraphs, font size, the number of fonts, the use of illustrations, highlighted text or text in boxes, etc.-can make a big difference in a document's appeal to the reader. The HIPAA regulations did not contain any formatting requirements. Without any formatting specifications, most HIPAA privacy notices were simply typed, not designed. It goes without saying that an appealing document is more likely to be used.

Developing a plain language disclosure is a lot of work. Plain language drafting takes training, practice, thought and time. As we saw with HIPAA, ensuring that the disclosure is legally compliant is another step that can unravel a good first draft.

The Department of Labor can jump-start the process of creating employee communications and increase compliance by developing model disclosure statements in each of the needed areas. Even in areas where DOL does not have clear jurisdiction, developing a model statement would give employers and employees a standard to refer to as they interact with their insurer. DOL could also translate these model statements into other languages, a task that many employers are unlikely to do on their own.

Naturally, these model disclosures should follow best practices with respect to appealing formatting and plain language writing. However, they must also be field tested to ensure that they are effective. In other words, do actual employees understand them, use them, and do the forms protect employees from making ill advised choices?

This field testing of model employee communications should be an ongoing process. More broadly, DOL should develop a variety of mechanisms for collecting and incorporating employee and employer feedback on these health insurance communications. While this may seem obvious, it is a part of the process that is too often neglected or abandoned.

A word about insurers' Explanation of Benefit (EOB) statements. The EOB differs from the uniform disclosure statement described above. The EOB tells you what the cost of the procedure was, what the insurance company may (or may not) pay, and what you owe. It is one of the most difficult communications for employees to understand.<sup>9</sup>

It is critical that EOB statements ultimately make use of the same standard definitions for insurance and medical terms, otherwise employees will be thwarted in their ability to learn the new system. DOL must exercise its maximum authority with respect to these the design of these statements, and coordinate closely with state regulators and insurers to ensure consistency across group and non-group products.<sup>10</sup>

A word about grandfathered plans. Grandfathered health plans are health plans that existed on March 23, 2010 and haven't had substantive changes made to them since that time.<sup>11</sup> We anticipate that many employer plans will retain their grandfathered status for years. Many consumer protections in PPACA do not apply to grandfathered health plans, creating the potential for consumer confusion. Individuals in grandfathered plans may incorrectly conclude that some of the key PPACA provisions apply to them (in light of anticipated media exposure). For example:

<b>Selected PPACA Provisions That Do <u>Not</u> Apply to Grandfathered Group Plans</b>
<ul style="list-style-type: none"><li>▪ Essential Benefits Package</li><li>▪ Preventive health benefits with no cost-sharing</li><li>▪ Direct access to OBGYNs</li><li>▪ No prior approval and higher out-of-network cost sharing for emergency services</li></ul>

*See Appendix A for a complete list.*

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<sup>9</sup> In a 2009 online survey, consumers said healthcare EOBs were one of the most difficult documents to understand, second only to mortgage applications (even tax forms fared better). *Siegel+Gale Simplicity Survey: A Clarion Call for Transparency*, January 2009. See also: *2010 Explanation of Benefits Statements (EOBs) Review*, DALBAR, Inc. February 2010.

<sup>10</sup>EOB statements are routinely sent by insurers but DOL has jurisdiction only in certain circumstances. The Employee Retirement Income Security Act of 1974, (ERISA) does not refer to EOBs per se, but requires certain due process protections for employee benefit plan beneficiaries. ERISA mandates notification to a subscriber when there is an adverse benefit determination on a post-service claim, and for any determination on an urgent care claim or a pre-service claim. ERISA requires the plan to provide the claimant with only four pieces of information for an adverse benefit determination, and there are no specific requirements for the information that must be included in a notice of a non-adverse claim determination.

<sup>11</sup> Draft regulations describing what is, and is not, a substantive change were published in the Federal Register/Vol. 75, No. 116/Thursday, June 17, 2010.

To keep employees from making incorrect assumptions about their coverage, Consumers Union strongly recommends that DOL develop a required disclosure statement that clearly indicates whether a health plan is “grandfathered” and explains, in plain language, the implications for policyholders. This disclosure should be crafted in cooperation with state regulators to ensure consistency across group and non-group products, once again allowing employees to “learn” the disclosure form.

Where it has the legal authority to do so, Department of Labor must implement strong enforcement mechanisms for their new standards. As this council found in 2005, publishing a regulation without ensuring compliance yields little benefit to employees.<sup>12</sup> As an example, the federal Employee Retirement Income Security Act of 1974 (ERISA) requires that a key employee communication, the Summary Plan Description (SPD), be written in a manner that is understandable to the *average* plan participant. Yet, a 2006 study found that the Summary Plan Description is written, on average, at a first-year college reading level.<sup>13</sup> Some SPDs use language written at nearly a college graduate (16th grade) level.

One question before this council is the potential role of the DOL website. Most employees would probably prefer to receive the relevant communication in a “just-in-time” fashion from their employer. When it comes to selecting a health plan or appealing a health insurance decision, they are unlikely to think to visit the DOL website for assistance. Nonetheless, a single, easy-to-remember URL, could serve as a central location for the key materials identified by DOL’s focus group testing. These key materials might include employee resources for instance when employee questions are not addressed by the firm’s HR department. DOL should consider whether the new “web portal” (required by PPACA and due to be launched July 1, 2010) could serve as this central location. The usefulness of a second webs “hub” on the DOL website may become clearer once this portal is launched and experience gained with its traffic patterns.

Needless to say, any consumer website (the portal or DOL) should follow the principles of clear, appealing, consumer-friendly design.<sup>14</sup> Tracking traffic patterns on this website could serve as one source of information for the feedback task described above. The site could also be used to collect feedback directly from consumers, if safeguards are in place to ensure the feedback is usable.

As I noted at the beginning, the DOL faces a challenging task but also a critically important one. There is plenty of data which indicates that our nation’s workforce often

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<sup>12</sup> Advisory Council on Employee Welfare and Pension Benefit Plans, *Report Of The Working Group On Health And Welfare Benefit Plans' Communications*, [http://www.dol.gov/ebsa/publications/AC\\_1105c\\_report.html](http://www.dol.gov/ebsa/publications/AC_1105c_report.html)

<sup>13</sup> Colleen Medill, Richard Wiener, Brian Bornstein, and E. McGorty, “How Readable Are Summary Plan Descriptions for Health Care Plans,” *EBRI Notes*, Vol. 27, No. 10, October 2006.

<sup>14</sup> See for example, this guide to Writing and Designing Easy-to-Use Health Web Sites: <http://www.health.gov/healthliteracyonline/>

fails to understand their health coverage.<sup>15</sup> Indeed, this council's 2005 *Working Group on Health and Welfare Benefit Plans' Communications* found that many workers today may not be receiving information about their health care plans that is understandable to them.<sup>16</sup>

Low health literacy has been linked to poorer health outcomes and higher costs.<sup>17</sup> People with low functional literacy have less ability to care for chronic conditions and use more health care services. In addition to the effects of low health literacy on the individual patient, there are economic consequences for employers and society in general. According to the American Medical Association, poor health literacy is "a stronger predictor of a person's health than age, income, employment status, education level, and race."<sup>18</sup> The issue of health care literacy and the information provided to participants about their health care plans becomes even more significant in light of the growing use of consumer-driven health care plans.

Consumers Union is ready to work with the council so that your efforts emulate the success of nutritional facts labels and not the failure of HIPAA privacy notices.

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**Plain English:** *"The writing and setting out of essential information in a way that gives a co-operative, motivated person a good chance of understanding it at first reading, and in the same sense that the writer meant it to be understood"--Martin Cutts, Oxford Guide to Plain English, second edition, 2004.*

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<sup>15</sup> For example, this 2007 survey found that employers need to focus on improving employees' understanding of basic health plan terms. Just 22% of surveyed employees were comfortable explaining a term like "coinsurance" to a friend or coworker. Watson Wyatt Worldwide, *Employee Perspectives on Health Care: Voice of the Consumer*, 2007.

<sup>16</sup> Advisory Council on Employee Welfare and Pension Benefit Plans, *Report Of The Working Group On Health And Welfare Benefit Plans' Communications*,  
[http://www.dol.gov/ebsa/publications/AC\\_1105c\\_report.html](http://www.dol.gov/ebsa/publications/AC_1105c_report.html)

<sup>17</sup> National Network of Libraries of Medicine, Health Literacy synopsis.  
<http://nmlm.gov/outreach/consumer/hlthlit.html>

<sup>18</sup> Report on the Council of Scientific Affairs, Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association, *JAMA*, Feb 10, 1999

## Appendix A: Application of PPACA to Grandfathered Employer (Group) Health Plans

<b>Apply to Grandfathered Plans</b>	<b>Do NOT Apply to Grandfathered Plans<sup>i</sup></b>
<ul style="list-style-type: none"> <li>• Prohibition on dollar-value lifetime limits [1001: 2711; 10101(a); 2301 of HCERA]</li> <li>• Restriction of annual limits (in group coverage) [1001: 2711; 10101(a); 2301 of HCERA]</li> <li>• Prohibition on rescissions [1001: 2712; 2301 of HCERA]</li> <li>• Dependent coverage for children until age 26 (before 2014, only if child lacks access to employer-sponsored coverage) [1001:2714; 2301 of HCERA]</li> <li>• Uniform explanation of coverage documents [1001:2715; 10101(b); 10103(d)]</li> <li>• Medical loss ratio reporting and rebates [1001: 2718; 10101(f); 10103(d)]</li> <li>• 90-day limit on waiting periods [1201: 2708; 10103(b); 2301 of HCERA]</li> <li>• No denials for pre-existing conditions for children in 2010 (in group coverage) [1201:2704; 10103(e); 2301 of HCERA]</li> <li>• No denials for pre-existing conditions for everyone in 2014 [1201:2704; 10103(e); 2301 of HCERA]</li> </ul>	<ul style="list-style-type: none"> <li>• Preventive health benefits available with no cost sharing [1001: 2713; 1302 (b)]</li> <li>• Plain language disclosure of data on health plans [1001:2715A as added by 10101(c)]</li> <li>• Prohibition on coverage discrimination based on salary [1001:2716; 10101(d)]</li> <li>• Annual reports on health care quality and care coordination [1001:2717; 10101(e)]</li> <li>• Strengthened internal and external appeals processes [1001:2719; 10101(g)]</li> <li>• Choice of participating PCPs including pediatricians; direct access to OBGYNs [1001:2719A as added by 10101(h)]</li> <li>• No prior approval and higher out-of-network cost sharing for emergency services [1001:2719A as added by 10101(h)]</li> <li>• Review of unjustified premium increases [1003:2794; 10101(i)]</li> <li>• Prohibition on health status discrimination [1201:2705]</li> <li>• Prohibition of health plan discrimination of providers, individuals, and employers [1201: 2706]</li> <li>• Essential benefits package [1201:2707; 1301; 1302; 10104(a) and (b)]</li> <li>• Limits on annual cost-sharing exposure [1201:2707(b); 1302(c)]</li> <li>• Coverage for approved clinical trials [10103]</li> <li>• Guaranteed issue and renewability [1201: 2702-3]</li> </ul>

<sup>i</sup> Certain PPACA rules don't apply to grandfathered health plans only when that plan is a non-group plan. These include: Restriction of annual limits [1001: 2711; 10101(a); 2301 of HCERA]; No denials of pre-existing conditions for children [1201:2704; 10103(e); 2301 of HCERA]; Transitional reinsurance, transitional risk corridors, and risk adjustment [1341-3; 10104(r)]; Modified community rating [1201: 2701; 1301; 1312(c); 10103(a); 10104(a)].