



**Testimony of Helen Darling Before the ERISA Advisory Council  
On Behalf of the National Business Group on Health**

**Health Care Literacy  
July 1, 2010**

Good Morning. Thank you for inviting me to speak on the topic of health care literacy and the vital role of employers in fostering this essential element for “bending the cost curve” while improving health care quality for employees, retirees, and their families.

My name is Helen Darling and I am the President of the National Business Group on Health (the Business Group), a member organization of over 292 companies, including many of America’s largest employers (64 of the Fortune 100) who voluntarily provide health benefits and other health services to over 55 million American employees, retirees, and their families.

I am pleased to share the perspective of our nation’s employers on health care literacy with you and to assist the ERISA Advisory Council as you develop recommendations to the Department of Labor (DoL) on:

- (i) Standards for use by group health plans and issuers;
- (ii) Whether the DoL should take proactive steps to assist employers in their innovative efforts to promote health care literacy and employees’ efficient use of available coverage outside of written disclosures or materials; and/or
- (iii) Whether the DoL should provide tools or other resources to employees and retirees that promote health care literacy, and if so, in what form.

Specifically, my testimony today will:

- Provide recommendations for you to consider as you develop your recommendations to the DoL;
- Give an overview of employers’ and federal efforts to improve health care literacy; and
- Respond to the questions the Council submitted to today’s witnesses.

**Recommendations to the ERISA Advisory Council for the Secretary of Labor**

Employers want employees and their families to be well-informed so they can make good choices about their health benefits and health care. Well-informed employees who make good health care decisions will value their benefits more, reducing the costs associated

with administering health benefits and ensuring access to health care services. More importantly, they enjoy better health, a higher quality of life, and are often more satisfied with their jobs.

## Recommendations

The National Business Group on Health recommends that DoL:

- Study ways to increase the user-friendliness of Summary Plan Descriptions (SPDs), and with the input of employers and employees, suggest ways to make SPDs more readable based on the study findings and the recommendations from employers and employees;
- Base summary of benefits and coverage on the standards required by the Patient Protection and Affordable Care Act of 2010 (“The Affordable Care Act”) on already defined for ERISA plans;
- Permit employers’ current SPDs to satisfy the requirements of The Affordable Care Act;
- Reference standard definitions of insurance terms that already exist and provide model language where related to new requirements;
- Reject any change in the federal definition of “welfare benefit plan”, under ERISA, which enables plan sponsors to offer nationally-uniform benefits tailored to the needs of employees and offer more benefits at lower cost;
- Build on the successes of the initiatives made available by employers, health plans, private companies, medical societies, independent non-profits, consumer advocates, state governments and federal agencies, which include report cards, customizable comparisons, checklists, and calculators to assist employees make informed decisions regarding availability of options and the best choices for them and their families;
- Draw upon the best practices for promoting health care literacy currently in use;
- Modify the interim final rules for GINA to allow employers to once again incentivize employees to complete health risk assessments (HRAs) containing questions about family medical history to ensure employees fully benefit from wellness and disease management programs;
- Defer to the HHS to continue to lead the federal government on behavioral economics techniques to foster improved health behaviors and to help bend the cost curve in ways that do not constrain the private sector’s ability, under ERISA, to continue to meet the unique needs of their workforces;
- Undertake a targeted awareness campaign aimed at younger employees leveraging all types of savings vehicles (health accounts, employer-based accounts and individual accounts) at the beginning of employees’ careers with an emphasis on retirement savings to address future health care costs; and
- Work closely with HHS to create communications materials about long-term care products so the agencies do not duplicate efforts and to ensure messaging consistency regarding where people can find available resources of information to improve health care literacy.

## The Connection between Health Literacy and Better Health Care

According to recent statistics from the Agency for Healthcare Research and Quality (AHRQ), only 12% of the 228 million adults in the United States have the skills to manage their own health care proficiently.<sup>1</sup> These “skills” refer to a person’s ability to obtain and use health information to make appropriate health care decisions.<sup>2</sup> According to the American Medical Association, “People from all ages, races, income and education levels are challenged by this problem.” Approximately 45% of high school graduates have limited health care literacy.<sup>3</sup>

Additional research has focused on health care literacy as one of the critical factors affecting health care disparities.<sup>4</sup> Many employers have begun major efforts to address health care disparities and I plan to address this topic further in my forthcoming testimony at the ERISA Advisory Council’s meeting on “Disparities for Women and Minorities in Retirement and Health Care”.

Studies show that the utilization of health care services is directly associated with the patients’ knowledge of the services.<sup>5</sup> Patients with limited health literacy are more likely to suffer from poor care because of unnecessary doctor visits and possibly incorrect diagnosis and incur up to four times greater medical expenses than patients with adequate literacy skills, costing the health care system billions of dollars every year in unnecessary doctor visits and hospital stays.”<sup>6</sup> Consumers with increased literacy levels increase their knowledge about health care services<sup>7</sup> and receive more appropriate utilization of services.<sup>8</sup>

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<sup>1</sup> U.S. Department of Health and Human Services. National healthcare disparities report. Rockville, MD: Agency for Healthcare Research and Quality; 2007;94. AHRQ Publication No. 08-0041. Available at: <http://www.ahrq.gov/qual/qrd07.htm> Accessed May 27, 2008.

<sup>2</sup> U.S. Department of Health and Human Services. Chapter 11: Health communication. In: Healthy people 2010: understanding and improving health. 2nd ed. vol. 1. Available at: <http://www.healthypeople.gov/document/HTML/Volume1/11HealthCom.htm>. Accessed January 14, 2009.

<sup>3</sup> Kutner, M., Greenberg, E., Jin, Y., & Paulsen, C. The health literacy of America’s adults: Results from the 2003 National Assessment of Adult Literacy (NCES 2006-483). Washington, DC: U.S. Department of Education, National Center for Education Statistics. 2006.

<sup>4</sup> Sentell, T. L., & Halpin, H. A. Importance of adult literacy in understanding health disparities. *Journal of General Internal Medicine*, 21(8), 862–866. 2006.

<sup>5</sup> DaVanzo J, Edwards S, Parente S, Rotwein S. Direct and indirect effects of consumer knowledge on Medicare use. *Assoc Health Serv Res Meet*. 1998;15:158-9. : Toren O, Kerzman H, Baron-Epel O. Patient Knowledge about Medication therapy and Utilization of Health Services. *Academy Health Meeting*. 2004;21: abstract no. 1499.

<sup>6</sup> American Medical Association. Health literacy, 2008. Available at: <http://www.ama-assn.org/ama/pub/category/8115.html>. Accessed January 14, 2009.

<sup>7</sup> Davis TC, Arnold C, Berkel HJ, et al. Knowledge and attitude on screening mammography among low-literate, low-income women. *Cancer*. 1996; 78 (9):1912-20. : Lindau ST, Tomori C, Lyons T, et al. The association of health literacy with cervical cancer prevention knowledge and health behaviors in a multiethnic cohort of women. *Am J Obstet Gynecol*. 2002;186(5):938-43.

<sup>8</sup> Scott TL. Health literacy and preventive health care use among Medicare enrollees in a managed care organization. *Med Car*. 2002;40(5):395-404 : Fortenberry JD, McFarlane MM, Hennessy M, et al. Relation of health literacy to gonorrhoea related care. *Sex Trans Infect*. 2001;77(3):206-11.

## Employers' Initiatives to Improve Health Care Literacy

The U.S. health care system faces between \$50 and \$73 billion per year<sup>9</sup> or more in economic consequences from limited literacy. This makes health care illiteracy a business issue. Employers have long recognized that the quality of health care that their workers receive is important to employees' health, productivity, performance and business outcomes. Improving the health care literacy and health care status of employees is essential to producing high-quality, goods and services, at lower cost, which, in turn, increases shareholder value.

A few examples of employers' initiatives to improve health care literacy include:

- H.E. Butt Grocery Company, which has launched projects in San Antonio and Austin, Texas, aimed at their larger Hispanic markets to educate Hispanic employees about the importance of having a primary care home and “knowing their numbers”<sup>10</sup> in terms of cholesterol, blood pressure and blood-sugar levels. The outreach programs involve developing culturally appropriate bilingual communications and using “promotores,” or Spanish-speaking health workers to provide information about health and the health care system to community members to eliminate many of the barriers to health care services.
- Marriott International Inc. which found, through a segmentation project with Aetna, that, across the board, many of its employees did not receive preventive services or screenings. As a result, Marriott began to cover all preventive services and implemented a “know your numbers” campaign where managers speak to employees in stand-ups (group meetings before every shift) about the importance of preventive care (getting their cancer screenings, etc). As a result, Marriott increased its mammograms and childhood immunizations by more than 20%. Marriott also provided Rosetta Stone language programs to managers to help them better communicate with their employees.<sup>11</sup> Marriott prints almost all of its health care materials in both Spanish and English (many in 8 languages) in order to meet the needs of its 85% hourly workforce, which speaks over 100 languages.
- Viant Corporation, CVS Pharmacy and 8 other employers' “Engaging Consumers@Work” pilot program, which educated employees about workplace

<sup>9</sup> Weis, Berry. M.D. Health Literacy and Patient Safety: Help Patients Understand. Manual for Clinicians. May 2007. American Medical Association. Available at: <http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf>

<sup>10</sup> Wojcik, Joanne. Business Insurance Magazine. Employers target racial, ethnic health disparities. Programs promote disease management and prevention efforts. February 2010.

<sup>11</sup> National Business Group on Health. Addressing Racial and Ethnic Health Disparities: Employer Initiatives. September 2009. Available at: [http://www.businessgrouphealth.org/pdfs/Addressing\\_Racial\\_and\\_Ethnic\\_Health\\_Disparities\\_Employer\\_Initiatives.pdf](http://www.businessgrouphealth.org/pdfs/Addressing_Racial_and_Ethnic_Health_Disparities_Employer_Initiatives.pdf)

walking and wellness programs through customized worksite posters and table tents (with large font and visual graphics) on how daily choices impact health and overall costs, weekly e-mail reminders to promote friendly competition among employees' walking teams and by mailing postcards, nutrition guides and health tracking cards to employees' homes. By combining typically passive education programs with activation components, employees' knowledge and awareness of healthy lifestyles improved and their participation increased in walking programs (from 67% to 76%) and workplace wellness programs (from 68% to 80%).

- Independence BlueCross, which partners with nearly 150 large employers, to provide educational seminars, both onsite and online, including “PREPARED for Health Care,” which is a guide to communicating with your physician and making educated decisions. For example, the PREPARED checklist covers questions for employees to ask their doctors and questions to ask themselves to better understand their own situations. The website also provides an online library of brief videos that teach employees about diabetes awareness and how to prevent diabetes through proper nutrition, weight management and physical activity
- BlueCross and BlueShield of Minnesota, which is working to incorporate health literacy best practices into an employer's existing worksite wellness program with a cross-departmental “health literacy ambassadors” program and an annual educational campaign for “health literacy month” that trains new nurses/case managers on health care literacy.

In addition, employers purchase tools/services that employees can use to improve their health care literacy, to navigate the health care system more efficiently, and to make health care decisions that benefit their families. For example, some companies have taken employees' decision-making to the next level by allowing employees to *design* their own health plans or even entire benefits packages.

- Asparity Decision Solutions helps employees make enrollment decisions by displaying options by “best fit” plans based on personal needs and financial circumstances; comparative views based on selected attributes; the quality of health plans; estimated medical expenses; and tax savings associated with the use of health accounts.
- Extend Health offers a program to both active employees (ExtendChoice) and those transitioning into post-65 retirement (ExtendRetiree). They both provide benefits guidance for defined contribution plans. Employees can choose plans that best fit their needs, based on reimbursable amounts, frequency of visits, deductible levels, co-insurance levels, co-pay levels, and annual benefit amounts.
- Aetna also created an easy-to-read guide that simplifies complicated benefits information, including selecting the right health plans; making decisions that correspond with major life events; taking advantage of all that health plans have

to offer; finding physician/health care professionals; appealing health care decisions; evaluating any future health care needs; and making the connection between health care and financial wellbeing.

Some employers use very creative methods for support in selecting plans in order to catch employees' attention. For example:

- One Business Group member reported printing the health benefit offerings on water bottles to distribute them to employees; and
- Another Business Group member created online modules emulating the feel of *School House Rock* to educate employees about their health care benefits.

### **Current Federal Efforts to Improve Health Care Literacy**

In May, HHS announced plans for a “National Action Plan to Improve Health Literacy,”<sup>12</sup> to communicate health care information clearly to U.S. residents. The plan seeks to address the problem that most U.S. residents have trouble understanding and using normal health information available through the media, websites, medicine labels and health providers. The effort targets seniors, racial and ethnic minorities, recent immigrants and refugees, people with less than a high school degree and those with incomes below the federal poverty level, as these groups tend to lack health care literacy. The plan notes that U.S. residents mostly evaluate health information on their own, such as when they examine labels on an over-the-counter medication, respond to warnings about public health outbreaks or decide which health insurer to select.

The plan seeks to:

- Develop accurate and accessible health and safety information;
- Promote changes in the system that improve health information;
- Integrate accurate health and science information in university education;
- Support and expand efforts to integrate health information in adult education or English classes at the local level; and
- Increase the use of health literacy practices based on evidence.

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<sup>12</sup> U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. National Action Plan to Improve Health Literacy. Available at: [http://www.health.gov/communication/HLActionPlan/pdf/Health\\_Literacy\\_Action\\_Plan.pdf](http://www.health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf)  
Accessed June 16, 2010.

**2010 ERISA Advisory Council Questions for Witnesses**

**1. What should be the standards for use by group health plans and group health issuers in compiling and providing participants a summary of benefits and coverage under the applicable plan or coverage?**

**Recommendation:** The DoL should base any additional summary of benefits and coverage, as required by The Affordable Care Act, on the standards already defined for ERISA plans. The DoL should also recommend that employers' current Summary Plan Descriptions (SPDs) to satisfy the requirements of The Affordable Care Act. The DoL should study ways to increase the readability of SPDs, in light of concerns about literacy, and with the input of employers and employees, suggest ways to make SPDs more readable based on the study findings and the recommendations of employers. Providing model language based on evidence is very helpful.

In our experience, the communication between employers and employees concerning health and welfare plans is working, but can always improve. It is very hard to get employees to read what they are given. Employers take their obligations very seriously to be compliant and because, by communicating effectively, they reduce future problems that can absorb staff time, frustrate everybody and decrease the perceived value of the benefits. If employers do not meet the very specific SPD content requirements in ERISA and DoL regulations, they increase their risk of litigation and substantial civil penalties. They also must review the content of any other materials that may be referenced in an SPD and the potential consequences of including provisions in the SPD that are not contained in plan documents. These legal requirements and implications no doubt pose a barrier to simplifying the SPD and a user-friendly summary of benefits and coverage. The DoL's study should explore ways to overcome these legal obstacles that do not expose employers to additional legal risk but also help employees better understand their benefits.

Under the new health care law, The Affordable Care Act, the Secretary of Labor will develop standards for use by group health plans and group health issuers in compiling and providing participants a summary of benefits and coverage under applicable coverage. The new health reform law increases the need for improved understanding of health information, since the law will expand more health services to low-income residents and the uninsured. This summary of benefits and coverage must provide for uniform definitions of standard insurance and medical terms. The summary of benefits cannot exceed four pages in length or include print smaller than 12-point font and must present information in a culturally and linguistically appropriate manner and utilize terminology understandable by average enrollees.

The summary of benefits and coverage must include:

- (A) Uniform definitions of standard insurance terms and medical terms so consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);
- (B) A description of the coverage, including cost sharing for each of the categories of the “essential health benefits” and other benefits, as identified by the Secretary;
- (C) The exceptions, reductions, and limitations on coverage;
- (D) The cost-sharing provisions, including deductibles, coinsurance, and co-payment obligations;
- (E) The renewability and continuation of coverage provisions;
- (F) A coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, such scenarios must be based on recognized clinical practice guidelines;
- (G) A statement of whether the coverage provides minimum essential coverage and ensures that the coverage share of the total allowed costs of benefits provided is not less than 60% of such costs;
- (H) A statement that the outline is a summary of the policy or certificate and that people should consult the coverage document itself to determine the governing contractual provisions; and
- (I) A contact number for the consumer to call with additional questions and an Internet web address where consumers can obtain a copy of the actual individual coverage policies or group certificates of coverage.

If the plans make any material modification in any of the terms of the coverage, not reflected in the most recently provided summary of benefits and coverage, the plans or issuers must provide notice of these modifications to enrollees no later than 60 days before the date when they take effect.

Research, and frankly, personal experiences tells me, that DoL can simplify the requirements for SPDs. One study indicated that the average readability level of 40 different SPDs was equivalent to 9<sup>th</sup> grade to college graduate reading levels.<sup>13</sup> Researchers have not done further study to determine the ability of individuals to comprehend and utilize SPDs for their health care decision-making.

For many years, employers have used the SPD as “the” standard for providing summaries of benefits and coverage to plan participants enrolled in, or considering coverage under, self-insured group health plans.

SPDs tell participants what benefits and coverage plans provide and how employers operate and manage their plans. As you know, ERISA requires group health plans to

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<sup>13</sup> U.S. Department of Labor, Pension and Welfare Benefits Administration. Style and format of summary plan description, Part 2520, Subpart B. Available at: [http://www.dol.gov/dol/allcfr/Title\\_29/Part\\_2520/29CFR2520.102-2.htm](http://www.dol.gov/dol/allcfr/Title_29/Part_2520/29CFR2520.102-2.htm). Accessed May 20, 2009.

give plan participants (and eligible employees and their dependents) specific written information communicating the health plan benefits employers offer them. ERISA specifically requires SPDs to detail the following information for all plan participants and eligible employees (and their dependents):

- Annual or lifetime caps or other limits on covered benefits;
- Cost-sharing requirements including plan participants' premium-equivalent costs for coverage, and their responsibilities for fixed copayment amounts and coinsurance percentages;
- Coverage provided by the plans and the extent of such coverage for:
  - Preventive services;
  - Existing and new prescription medications;
  - Medical tests, devices and procedures;
  - Provisions governing the use of network providers, the composition of provider networks and whether, and under what circumstances, coverage is provided for out-of-network services; and
  - Conditions or limits on the selection of primary care providers or providers of specialty medical care.<sup>14</sup>

The DoL requires that employers sponsoring self-insured plans provide SPDs to plan participants free of charge and on a regular and automatic basis. Employers must provide participants with summaries of material modifications informing participants any time they change plan benefits and coverage. Finally, each year, employers must provide participants with either full annual reports, or summary annual reports, detailing plans' financial results.

DoL also requires that employer-sponsors write SPDs "in a manner calculated to be understood by the average plan participants." Furthermore, ERISA, in combination with other firmly established federal laws (such as the Health Insurance Portability and Accountability Act of 1996), already sets the standards for self-insured group health plans to provide participants with clear and understandable communications regarding their benefits and medical coverage.

## **2. What uniform definitions of standard insurance terms and medical terms should be used to best help consumers compare health insurance coverage and understand the terms of, and exception to, coverage?**

**Recommendation:** The DoL can reference a number of standard definitions of insurance terms that already exist. In 2002, the federal government's Interdepartmental Committee on Employment-Based Health Insurance Surveys approved a set of definitions consistent with those used in the private sector for use in federal surveys.

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<sup>14</sup> U.S. Department of Labor, Health and Benefits, Employee Retirement Income Security Act, ERISA. Available from: <http://www.dol.gov/dol/topic/health-plans/planinformation.htm>. Accessed May 12, 2009.

Additional sources include the:

- National employers' health insurance survey definitions;
- Medical Expenditure Panel Survey definitions from AHRQ;
- ERISA-related definitions from the Pension and Welfare Benefits Administration (PWBA);
- Office of Personnel Management's (OPM) Federal Employees Health Benefits Plan (FEHBP) glossary and beneficiary booklets;
- BlueCross and BlueShield Association (BCBSA);
- Health Insurance Association of American (HIAA) glossary of insurance and medical terms; and
- The International Foundation of Employee Benefit Plans' (IFEBP) glossary of terms.

**3. How does the Department's current proposal to change the definition of "welfare benefit plan" impact the discussion regarding the aforementioned standards? What impact could any change in definition have on employers' ability to develop programs, tools and other vehicles that foster the best use of benefits or health care literacy in general?**

**Recommendation:** We believe that any change in the federal definition of "welfare benefit plan" would not be productive. The current definition suffices to describe which health care arrangements constitute welfare benefit plans under ERISA and enables employers to offer more benefits at lower cost. ERISA assures plan participant rights and enables plan sponsors to offer nationally-uniform benefits and innovative health programs tailored to the needs of employees.

**4. Is the current information available to health care consumers adequate to help them?**

**Recommendation:** Consumers have access to a significant amount of customizable information to make health care decisions. Any new efforts from DoL should build on the successes of these initiatives made available by employers, health plans, private companies, medical societies, independent non-profits, consumer advocates, state governments and federal agencies, which include report cards, customizable comparisons, checklists, and calculators.

Consumers make health care decisions at three levels:

- Health plan choice;
- Provider choice; and
- Treatment choice.

Lessons employers, employees, consumers and health plans have learned from these efforts include keeping the information targeted and simple, and using comparison charts, calculators, and examples. For example, a California-based initiative aimed at generating interest in the state hospital comparison tool, [CalHospitalCompare.org](http://CalHospitalCompare.org) among women of childbearing age and pregnant women realized an 11-fold increase in traffic to the website. Based on this program, the California HealthCare Foundation recommends the following:

- Match the medium and message to target your audience;
- Identify the diversity of your target audience;
- Understand where potential users look for information;
- Measure success along the way to allow for campaign adjustments to maximize flexibility and improve outcomes; and
- Carefully consider wording of advertisements. In this case, the provocative message about C-sections rates coupled with a "call-to-action" (find a hospital that's best for you) was most effective.

A meta-analysis of 60 published and unpublished studies on health communications found the following regarding targeted messaging:<sup>15</sup>

- Women are more affected by communications that focus on personal consequences in an emotional manner;
- Men are more affected by unemotional themes;
- Caucasians respond more to health care messages accompanied with a "vivid format" (e.g., pictures) ;
- Messages framed in a positive light (if they do a certain behavior, they will benefit) as opposed to loss-framed messages (if they do not do a behavior, they will lose out) generate higher intentions to act for promotion activities that focus on safety and security; and
- Loss-framed messages motivate audiences affected by accomplishment and growth.

In addition, consumers using clinical decision aids find more comfort with their choices, have better knowledge and become active participants in their own health care.<sup>16</sup> A recently updated Cochrane Review found decision aids improve people's knowledge of their options, create accurate risk perceptions of benefits and harms, reduce difficulty in decision-making, and increase patient participation in the process.<sup>17</sup>

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<sup>15</sup> Keller, P.A. & Lehmann, D.R. Designing effective health communications: A meta-analysis. *Journal of Public Policy & Marketing*, 27(2), 1-26. 2008.

<sup>16</sup> Morgan M et al., Randomized Controlled Trial of an Interactive Decision Aid for Patients with Ischemic heart Disease, *J Gen Intern Med* 200, 15:10, 685-693 and Kennedy ADM et al., Effects of Decision Aids for Menorrhagia on Treatment Choices, health Outcomes and Costs *Journal of the American Medical Assoc* 2002, 288:21.

<sup>17</sup> O'Connor AM, et al., Decision aids for people who are facing health treatment or screening decisions. *Cochrane Database of Systematic Reviews* 2009, Issue 3, Art. No. CD001431.

## Examples of Resources Available to Consumers to Make Health Care Decisions

- Asparity Decision Solutions, [www.asparity.com](http://www.asparity.com)  
Consumer decision support tools and consumer behavior data provided to employers, government programs, and health plans.
  - Best Buy Drugs, Consumers Union, [www.bestbuydrugs.org](http://www.bestbuydrugs.org)  
Free guidance to consumers on prescription medicines.
  - Cardiosmart, American College of Cardiologists, [www.cardiosmart.com](http://www.cardiosmart.com)  
The American College of Cardiologists' patient education site.
  - Health Dialog, [www.healthdialog.com](http://www.healthdialog.com)  
Exclusive distributor of the Foundation for Informed Medical Decision-Making (Dartmouth Medical School) Shared Decision-Making services.
  - Hospital Compare, Centers for Medicare and Medicaid Services (CMS), [www.cms.gov/HospitalQualityInits/11\\_HospitalCompare.asp](http://www.cms.gov/HospitalQualityInits/11_HospitalCompare.asp)  
Consumer website that provides information on how well hospitals provide recommended care to their patients.
  - Informed Patient Institute, [www.infomedpatientinstitute.org](http://www.infomedpatientinstitute.org)  
Rates usefulness of online health care report cards.
  - National Institutes of Health (NIH), [www.nih.gov/clearcommunication/talktoyourdoctor.htm](http://www.nih.gov/clearcommunication/talktoyourdoctor.htm)  
Resources about talking to your doctor.
  - Questions are the Answer, AHRQ, [www.ahrq.gov/questionsaretheanswer](http://www.ahrq.gov/questionsaretheanswer)  
Questions you can ask to help improve the quality of your care or that of a loved one.
  - WebMD Physician Directory, [www.webmd.com](http://www.webmd.com)  
Find a doctor feature provides background information on most doctors in the country and integrates doctors' hospital and managed care affiliations.
  - The Empowered Patient Coalition, [www.empowerepatientcoalition.org](http://www.empowerepatientcoalition.org)  
Consumer site with a variety of fact sheets, checklists and other resources about patient safety and medical decision-making.
- 5. Aside from written disclosures and materials, what are best practices and effective tools in promoting true health care literacy?**

**Recommendation:** In addition to simplified and understandable written materials, DoL should explore social networks and other internet-based tools, and interactive, multimedia

tools to promote health literacy. DoL can draw upon the best practices for promoting health care literacy for other mediums of communication, including:

- Language appropriate for culture;
- Greater use of pictures and/or videos;
- Improved oral communications between patients and health care professionals (“teach back” and “teach to goal”);
- Training for health care professionals; and
- Patient-centered health care practices with patient safety and understanding as prime components.

The American Medical Association (AMA), American College of Physicians Foundation, and the Joint Commission have recommended a number of health literacy “best practices” to help clinicians better communicate with patients and families.

The AMA provides 6 steps to improving interpersonal communication with patients<sup>18</sup> that translate well to plans on informing people about their health care benefits:

- **Slow down.** Providers improve communication by speaking slowly, and by spending just a small amount of additional time with their patients. This helps foster a patient-centered approach to the clinician-patient interaction.
- **Use plain, nonmedical language.** Providers improve patients’ understanding by explaining things to patients as you would explain them to your grandmother.
- **Show or draw pictures.** Providers’ use of visual images improves patients’ recall of ideas.
- **Limit the amount of information provided—and repeat it.** Patients remember information in small pieces pertinent to the tasks at-hand. Repetition further enhances recall.
- **Use the “teach-back” technique.** Providers confirm that patients understand by asking them to repeat their instructions.
- **Create a shame-free environment: Encourage questions.** Patients need to feel comfortable asking questions. Providers can enlist the aid of others (patients’ families or friends) to promote understanding.

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<sup>18</sup> Weis, Berry. M.D. Health Literacy and Patient Safety: Help Patients Understand. Manuel for Clinicians. May 2007. American Medical Association. Available at: <http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf>

- 6. Are there provisions under applicable regulations and guidance that could impede employers in providing innovative solutions, tools, information, wellness programs, behavioral economic initiatives, onsite clinics, etc.? And if so, what steps could the Department take to remove those impediments?**

**Recommendation:** DoL should modify its interim final rules for GINA to allow employers to once again incentivize employees to complete health risk assessments (HRAs) containing questions about family medical history to ensure employees fully benefit from wellness and disease management programs.

The interim final rules for prohibiting discrimination under the Genetic Information Nondiscrimination Act of 2008 (GINA)<sup>19</sup> have had a chilling effect on the use of HRAs as a tool to help identify health promotion and condition management initiatives to help employees and their families prevent illness and maintain health. The rules require group health plans to either include family medical history questions in HRAs *or* offer incentives to complete the HRAs - but not both. As a result, plans sacrifice their ability to effectively use HRAs, administered by third parties in accordance with HIPAA requirements, to create the most effective benefit structures and strategic directions for their group health plans and to help employees who need access to specific care management programs.

DoL should make this change so that employers can once again more easily inform employees of wellness and care and disease management programs that may benefit their health.

- 7. Should the Department provide guidance on best practices for using various behavioral economics techniques to facilitate improved outcomes in terms of choosing coverage and using coverage via deploying choice architecture, loss aversion, overcoming familiarity bias, hyperbolic discounting, etc.?**

**Recommendation:** At the federal level, the Department of Health and Human Services (HHS) has taken the lead in using behavioral economics to advance health literacy. Accordingly, HHS should continue to lead the federal government in these areas. While DoL can support the HHS in these efforts, we recommend that the DoL not invest its time and resources in this area.

Employers have years of experience, under ERISA, using behavioral economics techniques to assist employees to choose the coverage that best meets the needs of their families and to help them make better choices among options based on objective criteria.

Behavioral economic interventions are generally of two basic types: one can restructure the choice environment, or modify consumers' perceived incentives. A few examples of

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<sup>19</sup> U.S. Departments of Labor, Health and Human Services, and Treasury. Interim Final Rules for GINA. October 7, 2009.74 Federal Register page 51664.

behavioral economics from HHS include:

- Stopping payments for “never events,” or preventable hospital errors to improve patients’ safety at hospitals;
- Covering Medicare co-payments for preventive services rated A+B by the U.S. Preventive Services Task Force to encourage more seniors to utilize preventive benefits;
- Requiring everyone to carry health insurance or pay a penalty in 2014; and
- Increasing the percentage discount that employers can offer to employees in the form of HIPAA-allowed incentives/rewards worth up to 30% in 2014 and possibly 50% of their cost of health coverage for participating in wellness programs meeting certain benchmarks.

In addition, The Affordable Care Act’s auto-enrollment of employees into one of employers’ health care plans with the ability for employees’ to opt-out, similar to the enrollment process for 401 (k) plans, is another recent example of behavioral economics.

**8. Should the Department provide tools to employees and retirees on its website that foster improved health behaviors and help bend the cost curve for everyone?**

**Recommendation:** Many departments at HHS already provide a variety of information on health behaviors that can help lower health care costs. While DoL could link to established HHS websites in these areas, these are health issues that lie within the jurisdiction and expertise of HHS and DoL’s efforts would be duplicative.

Employees, health care consumers and patients can already find a plethora of information on staying healthy, choosing quality care and getting safer care at <http://www.ahrq.gov/consumer/> on AHRQ’s website.

In addition, Medicare.gov already has an entire section at <http://www.medicare.gov/navigation/manage-your-health/manage-your-health-overview.aspx> to assist older workers and retirees to manage their health with information on preventive services, the ‘Welcome to Medicare Exam,’ flu shots, a preventive services checklist, personal health records and a drug and pharmacy manager tool. The annual Medicare & You handbook also provides a summary of Medicare benefits, coverage options, rights and protections, and answers to the most frequently asked questions about Medicare.

Employees, health care consumers and patients will also benefit from the comparative effectiveness research findings of the new Patient Centered Outcomes Research Institute.

**9. How can the Department facilitate a better understanding by employees of what they will need with respect to health care in retirement?**

**Recommendation:** The DoL could undertake a targeted awareness campaign aimed at younger employees leveraging all types of savings vehicles (health accounts, employer-based accounts and individual accounts) at the beginning of employees’ careers with an emphasis on retirement savings to address future health care costs.

Employees often underestimate the amount of out-of-pocket costs and the additional premiums for supplemental care during retirement. According to the Employee Benefit Research Institute (EBRI), only 69% of respondents are currently saving for retirement.<sup>20</sup> Furthermore, less than half (46%) of our nation’s employees have attempted to calculate the funding needed for retirement.<sup>21</sup> As a result, employees representing about a third of our nation’s workforce remain unprepared for major health care costs in retirement.<sup>22</sup>

Younger workers are the employees most at-risk. In comparison to older counterparts, employees between the ages of 25 to 34 are least likely to:

- Contribute to employment-based retirement plans;
- Have individual retirement accounts;
- Try to calculate savings needed for retirement;
- Receive workplace-based retirement accounts; and
- Actively save for retirement.<sup>23</sup>

Given that this generation is technology-driven, the DoL has a great opportunity to promote existing retirement saving tools for younger and older employees alike to save for health care in retirement. For example:

- Choose to Save (<http://www.choosetosave.org/ballpark/>), developed by EBRI, offers “The Ballpark E\$estimate” or a basic worksheet that allows users to estimate how much consumers need for a comfortable retirement.
- Fidelity Investments (<https://powertools.fidelity.com/healthcost/personalInfo.do>) offers a free online tool to specifically calculate health care costs in retirement, which takes into account if consumers have employer-sponsored coverage.

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<sup>20</sup> [http://www.ebri.org/pdf/surveys/rcs/2010/FS-03\\_RCS-10\\_Prep.pdf](http://www.ebri.org/pdf/surveys/rcs/2010/FS-03_RCS-10_Prep.pdf)

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> [http://www.ebri.org/pdf/surveys/rcs/2010/FS-04\\_RCS-10\\_Age.pdf](http://www.ebri.org/pdf/surveys/rcs/2010/FS-04_RCS-10_Age.pdf)

**10. Should the Department provide information regarding the role of voluntary products, and in particular long-term care insurance? And if yes, what information and in what form?**

**Recommendation:** Voluntary products play an increasing role in employers’ abilities to supplement comprehensive group health plans and better protect their employees and their families. Today, 90% of surveyed public organizations offer or have considered offering voluntary (employee-paid) benefits.<sup>24</sup> The economic downturn has led many smaller and medium-sized employers to add voluntary benefit choices for their employees to compensate for decreases in benefits provided through group health plans. Employers of all sizes also offer voluntary benefits to part-time, temporary, seasonal, and contract employees who do not receive comprehensive group health plans. Accordingly, the DoL should:

- Provide information on the role of voluntary products, and long-term care insurance to add value to the information already provided by human resource departments about the employer-sponsored long-term care programs and other voluntary benefits available;
- Work closely with HHS in creating communications materials about long-term care products so the agencies do not duplicate efforts and to ensure messaging consistency regarding where people can find available information resources; and
- Help employees better understand if, and to what extent, they need other supplemental voluntary benefits.

Employers’ most popular voluntary benefits include life insurance for employees and dependents, and dental, long-term disability, vision, and long-term care coverage. Increases in employees’ responsibilities for health care costs, along with the new emphasis on healthy lifestyles and prevention efforts, has created opportunities for voluntary products to provide valuable protections. Long-term care (LTC) insurance, both individual and group coverage, may also gain in popularity as many more “Baby Boomers” retire, or phase out of full-time employment, and choose to supplement their retiree health plans and benefits under Medicare. Newer LTC products have “shared care” provisions allowing couples to access each other’s policies when either runs out of benefits. LTC products can incorporate annuity options so that participants receive back portions of premiums not used to cover long-term care expenses.

Less popular, supplemental, voluntary benefits such as daily hospital indemnity and specific disease (critical illness) insurance may, in some cases, offer key underlying financial support when employees face severe and often unexpected illnesses. They may

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<sup>24</sup> International Foundation of Employee Benefit Plans and The State and Local Governments Benefits Association (SALGBA), Trends in Public Employee Plans: Survey Results 2010, Benefits & Compensation Digest, June 2010, page 37.

also be more difficult for employees to determine whether, and to what extent, they need this coverage.

### **Increase Coordination with HHS**

HHS already provides a national clearinghouse for long-term care information at [http://www.longtermcare.gov/LTC/Main\\_Site/index.aspx](http://www.longtermcare.gov/LTC/Main_Site/index.aspx) to provide information understanding (definitions and risks, services and providers, costs and paying), planning and paying (cost of care, public programs, public financing, long-term care insurance) for long-term care.

Additionally, HHS will issue regulations for the Community Living Assistance Services and Supports Act (CLASS Act) of The Affordable Care Act that provides daily indemnity benefits similar to the benefits of many voluntary LTC products. While The Affordable Care Act allows LTC products sold through individual state health insurance exchanges to coordinate benefits with any benefits received through the CLASS Act, the law remains silent on whether other insurance products will reduce benefits when covered people receive CLASS Act benefits.

When HHS issues the implementing regulations for the CLASS Act outlining acceptable coordination of benefits practices for long-term care insurance carriers when people receive CLASS Act benefits, the DoL should incorporate the regulatory details into its general communications. This will allow consumers to understand when possibilities exist if their LTC coverage may provide reduced benefits if they receive benefits through the CLASS Act.

Again, the Business Group appreciates the opportunity to submit this testimony before the ERISA Advisory Council on health care literacy. As one of the largest purchasers of health care, under the flexibility of ERISA, large employers are often the driving force to change and improve our nation's health care system and can play a key role in improving health care literacy. The National Business Group on Health looks forward to working with members of the ERISA Advisory Council, the U.S. Department of Labor and Congress to improve health care literacy for the well being of the entire American workforce.