

# CHCS

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## Health Literacy Implications of the Affordable Care Act

*Commissioned by:*  
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# Contents

Acknowledgements.....	3
I. Health Literacy and Health Care Reform.....	4
Health Literacy Until Now.....	5
II. Health Literacy and the Affordable Care Act.....	7
Definition.....	7
Direct Mentions.....	7
Indirect Provisions.....	9
Insurance Reform, Outreach, and Enrollment.....	9
Individual Protections, Equity, and Special Populations.....	11
Workforce Development.....	13
Health Information.....	14
Public Health, Health Promotion, and Prevention & Wellness.....	16
Innovations in Quality and the Delivery and Costs of Care.....	18
Best Practices: “What Are My Medi-Cal Choices?”.....	20
III. Conclusion.....	21
IV. Appendices.....	22
Appendix A: Summary of ACA Provisions with Potential Implications for Health Literacy.....	22
Appendix B: Instances of “Culturally and Linguistically Appropriate” in the ACA.....	31

*The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers and consumer groups to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.*

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## I. Health Literacy and Health Care Reform

Although low health literacy is certainly not a featured concern of the health care reform legislation passed in early 2010, there are those who would argue that the law cannot be successful without a redoubling of national efforts to address the issue. Nearly 36 percent of America's adult population — 87 million adults — is considered functionally illiterate.<sup>1</sup> As the Patient Protection and Affordable Care Act (ACA) extends health insurance coverage to some 32 million lower-income adults and promotes greater attention to the barriers faced by individual patients, those implementing the law should consider how to incorporate health literacy into strategies for enrolling beneficiaries and delivering care.

For the purposes of this paper, health literacy is defined, using the National Library of Medicine's definition, 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.*"<sup>2</sup>

Fortunately, several ACA provisions directly acknowledge the need for greater attention to health literacy, and many others imply it. The law includes provisions to communicate health and health care information clearly; promote prevention; be patient-centered and create medical or health homes; assure equity and cultural competence; and deliver high-quality care. This paper identifies both the direct and indirect links, and provides those concerned about health literacy with provision-specific opportunities to support advancements. These provisions fall into six health and health care domains in the legislation where further action may be called for by concerned stakeholders:

- (1) **Coverage expansion:** enrolling, reaching out to, and delivering care to health insurance coverage expansion populations in 2014 and beyond;
- (2) **Equity:** assuring equity in health and health care for all communities and populations;
- (3) **Workforce:** training providers on cultural competency, language, and literacy issues
- (4) **Patient information** at appropriate reading levels;
- (5) **Public health and wellness;** and
- (6) **Quality improvement:** innovation to create more effective and efficient models of care, particularly for those with chronic illnesses requiring extensive self-management.

Individuals with low levels of health literacy are least equipped to benefit from the ACA, with potentially costly consequences for both those who pay for and deliver their care, as well as for themselves. Rates of low literacy are disproportionately high among lower-income Americans eligible for publicly financed care through Medicare or Medicaid.<sup>3</sup> In 2014, this pattern is likely to extend to individuals newly eligible for Medicaid or for publicly subsidized private insurance through state-based exchanges.

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<sup>1</sup> J. Vernon, A. Trujillo, S. Rosenbaum, and B. DeBuono. *Low Health Literacy: Implications for National Health Policy*. University of Connecticut, 2007.

<sup>2</sup> S.C. Ratzan and R.M. Parker. Introduction. In: *National Library of Medicine Current Bibliographies in Medicine: Health Literacy*. NLM Pub. No. CBM 2000-1 (2000).

<sup>3</sup> M. Kutner et al. *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy*. U.S. Department of Education, National Center for Education. Washington DC, 2006.

## Health Literacy Until Now

In its *Healthy People 2010* aims statement, the Department of Health and Human Services (HHS) adopted the definition from the National Library of Medicine, declaring health literacy to be an important national health priority. *Healthy People 2010* broadened this definition to note that health literacy is not just the problem of the individual, but also a by-product of system-level contributions.<sup>4</sup> Acknowledging the salience of this issue, HHS Secretary Kathleen Sebelius made official a federal commitment to health literacy by releasing in May 2010 the *National Action Plan to Improve Health Literacy*.<sup>5</sup> The plan lays out seven goals that emphasize the importance of creating health and safety information that is accurate, accessible and actionable. It addresses payers, the media, government agencies, health care professionals and others, recognizing the multi-sector effort that will be required to effectively tackle this oft-ignored, national problem.

The U.S. health care system, with its myriad public and private programs, institutions, services, products, and information, poses a significant challenge to those seeking access to affordable, quality health care. Understanding the complexities of insurance eligibility, therapeutic guidance, medical technology, prescription medication, disease management, prevention, and lifestyle modification are difficult for any consumer, let alone one with compromised levels of literacy or numeracy (or quantitative literacy). An individual seeking to participate successfully in the health system requires a constellation of skills — reading, writing, basic mathematical calculations, speaking, listening, networking, and rhetoric — the totality of which defines health literacy.

However, national data suggest that only 12 percent of adults have proficient health literacy.<sup>6</sup> While low health literacy is found across all demographic groups, it disproportionately affects non-white racial and ethnic groups; the elderly; individuals with lower socioeconomic status and education; people with physical and mental disabilities; those with low English proficiency (LEP); and non-native speakers of English.<sup>7</sup> Low health literacy is associated with reduced use of preventive services and management of chronic conditions, and higher mortality.<sup>8</sup> It also leads to medication errors, misdiagnosis due to poor communication between providers and patients, low rates of guidance and treatment compliance, hospital readmissions, unnecessary emergency room visits, longer hospital stays, fragmented access to care, and poor responsiveness to public health emergencies.<sup>9</sup> Accordingly, low health literacy has been estimated to cost the U.S. economy between \$106 billion and \$236 billion annually.<sup>10</sup>

The consequences of low health literacy have been recognized by federal agencies such as the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Office of the Surgeon General, and the National Institutes of Health (NIH), as well as by private organizations such as America's Health Insurance Plans, the American College of Physicians, the American Medical Association, The Joint Commission on Accreditation, Kaiser Permanente, and Pfizer. These entities and many others are promoting awareness, creating program initiatives, funding targeted research, setting readability standards, working with e-health and social media platforms, and providing tools and resources for measurement and quality

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<sup>4</sup> R. Rudd. Objective 11-2. Improvement of Health Literacy. In: *Communicating Health: Priorities and Strategies for Progress*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Washington DC, 2003.

<sup>5</sup> U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *National Action Plan to Improve Health Literacy*. Washington DC, 2010.

<sup>6</sup> National Center for Education Statistics, U.S. Department of Education. "2003 National Assessment of Adult Literacy (NAAL)." Available at <http://nces.ed.gov/naal/>.

<sup>7</sup> L. Neilsen-Bohlman, A.M. Panzer, and D.A. Kindig. *Health Literacy: A Prescription to End Confusion*. National Academies Press. Washington DC, 2004.

<sup>8</sup> N.D. Berkman, et al. *Literacy and Health Outcomes*. Agency for Healthcare Research and Quality (AHRQ). Rockville, MD, 2004.

<sup>9</sup> Neilsen-Bohlman et al, *op cit*; Berkman et al, *op cit.*, Vernon et al, *op cit.*

<sup>10</sup> Vernon, et al., *op cit.*

improvement across providers, health plans, hospitals, and employer organizations. Important policy papers such as the Institute of Medicine's (IOM) 2004 report, *Health Literacy: A Prescription to End Confusion*,<sup>11</sup> and national data such as those produced by the National Adult Literacy Survey<sup>12</sup> have contributed to the knowledge base for this issue.

To date, however, strong legislative language, regulations, and appropriations for concerted efforts to address health literacy have not emerged from the federal government. Congressional bills such as the National Health Literacy Act of 2007<sup>13</sup> and the Plain Language Act of 2009,<sup>14</sup> which mapped out meaningful health literacy strategies, have not yet made it to the President's desk. It remains to be seen whether the ACA can be used to push the national health literacy agenda forward.

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<sup>11</sup> Neilsen-Bohlman, et al., *op cit.*

<sup>12</sup> National Center for Education Statistics, *op cit.*

<sup>13</sup> U.S. Congress. "S. 2424: National Health Literacy Act of 2007." 110<sup>th</sup> Congress. 2007 – 2008. Available at: <http://www.govtrack.us/congress/bill.xpd?bill=s110-2424>.

<sup>14</sup> U.S. Congress. "H.R. 946: Plain Writing Act of 2010." 111<sup>th</sup> Congress 2009 – 2010. Available at: <http://www.govtrack.us/congress/bill.xpd?bill=h111-946>. Note: The Plain Language Act of 2009 was mooted by passage of a related bill, the Plain Writing Act of 2010, which was signed into law by President Obama on October 13, 2010, following completion of this paper.

## II. Health Literacy and the Affordable Care Act

The ACA is, by any measure, a major piece of domestic policy legislation, directly affecting tens of millions of Americans at a cost of nearly one trillion dollars over the next 10 years. The law's primary goals are to increase access to coverage, regulate the private insurance industry to allow more Americans into the system at affordable rates, and begin to control the rate of growth in health care costs. These goals cannot be achieved, however, without efforts to address cultural, linguistic and social barriers to care facing vulnerable populations. Low health literacy is critical among these barriers. The following ACA provisions include direct and indirect language concerning health literacy:

### Definition

Title V, Subtitle A (amending existing laws and creating new law related to the health care workforce) of ACA establishes a statutory definition of "health literacy" consistent with *Healthy People 2010*. The term is defined as "the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions." Other direct mentions of health literacy do not specifically cross-reference the Title V definition (though presumably, HHS will use this terminology when implementing the various titles of the law).

### Direct Mentions

Table 1 contains the law's four other direct mentions of the term health literacy. These provisions touch on issues of research dissemination, shared decision-making, medication labeling, and workforce development. All four suggest the need to communicate effectively with consumers, patients, and communities in order to improve the access to and quality of health care. None of these provisions creates explicit health literacy programs, specifies implementation or regulatory supports, or expounds further on the term "health literacy" beyond its mention. However, they are all consistent with the themes of patient-centeredness and overall quality improvement that are found more broadly throughout the legislation.

**TABLE 1: ACA Provisions with Direct References to “Health Literacy”**

Section Number	Provision Title	Legislative Language
Sec. 3501	Health Care Delivery System Research; Quality Improvement Technical Assistance	Requires that research of the AHRQ’s Center for Quality Improvement and Patient Safety be made “available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of <b>health literacy</b> .”
Sec. 3506	Program to Facilitate Shared Decision-making	<p>Amends the Public Health Service Act to “facilitate collaborative processes between patients, caregivers, authorized representatives and clinicians that enables decision-making, provides information about tradeoffs among treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.”</p> <p>Authorizes a “program to update patient decision aids to assist health care providers and patients.” The program, administered by the CDC and NIH, awards grants and contracts to develop, update, and produce patient decision aids for preference-sensitive care to assist providers in educating patients, caregivers, and authorized representatives concerning the relative safety, effectiveness and cost of treatment, or where appropriate, palliative care. “Decision aids must reflect varying needs of consumers and diverse levels of <b>health literacy</b>.”</p>
Sec. 3507	Presentation of Prescription Drug Benefit and Risk Information	Directs the Secretary to determine whether the addition of certain standardized information to prescription drug labeling and print advertising would improve health care decision-making by clinicians and patients and consumers; to consider scientific evidence on decision-making; and to consult with various stakeholders and “experts in <b>health literacy</b> .”
Sec. 5301	Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship	Amends Title VII of the Public Health Service Act to permit the Secretary to make training grants in the primary care medical specialties. Preference for awards are for qualified applicants that “provide training in enhanced communication with patients. . . and in cultural competence and <b>health literacy</b> .”



## Indirect Provisions

Other instances where the concept of health literacy could come into play include those discussed in the following sections, organized into the six domains introduced at the outset. See the appendices for an extensive list and descriptions of these and other provisions.

### *Insurance Reform, Outreach, and Enrollment*

**TABLE 2: Provisions Related to Insurance Reform, Outreach, and Enrollment**

Section Number	Provision Title
Sec. 1002	Health insurance consumer information
Sec. 1103	Immediate information that allows consumers to identify affordable coverage options
Sec. 1311	Affordable choices of health benefit plans (includes language on “culturally and linguistically appropriate” obligations for plans)
Sec. 1413	Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs
Sec. 2715	Development and utilization of uniform explanation of coverage documents and standardized definitions.
Sec. 3306	Funding outreach and assistance for low-income programs.

Health insurance market reforms have substantial potential for reducing inequities in the health system that are interrelated with insurance status. For example, the National Assessment of Adult Literacy found that adults with no insurance are more likely to have “basic” or “below basic” health literacy than “intermediate” or “proficient” health literacy.<sup>15</sup> A literature review prepared for the Kaiser Family Foundation revealed that health insurance is the single-most significant factor explaining racial disparities in having a usual source of care.<sup>16,17</sup>

Broadly speaking, the ACA intends to improve access to health insurance in four main ways: (1) the individual mandate, which requires all persons to have “qualifying or acceptable coverage”; (2) employer mandates requiring coverage for employees in businesses with more than 50 employees; (3) regional/state exchanges that allow individuals and small businesses to purchase coverage of varying benefit and cost, and choose from subsidized plans (for those up to the 400 percent of the federal poverty level, or FPL); and 4) the expansion of Medicaid eligibility to all individuals up to 133 percent of FPL. Additional provisions seek to broaden the scope and affordability of insurance coverage by, among other things: prohibiting insurance companies from rescinding coverage; extending dependent coverage for young adults until age 26; eliminating lifetime limits on coverage; regulating annual dollar limits on insurance coverage; and prohibiting the denial of coverage to children based on pre-existing conditions.

As many of those charged with implementing the ACA realize, none of these reforms will fully succeed without efforts to make all of these opportunities understandable to the intended beneficiaries. These expansions must be accompanied by targeted efforts to enroll under-resourced populations. Given their

<sup>15</sup> National Center for Education Statistics, *op cit*.

<sup>16</sup> Testimony of M. Lillie-Blanton, Dr.P.H., Senior Advisor on Race, Ethnicity, and Health Care, Henry J. Kaiser Family Foundation, before the House Ways and Means Subcommittee on Health. June 10, 2008.

<sup>17</sup> American College of Physicians. *Racial and Ethnic Disparities in Health Care, Updated 2010*. Philadelphia: American College of Physicians, 2010.

inexperience with health coverage and the delivery system, these individuals will have greater difficulty with a number of its facets: understanding eligibility guidelines for various insurance programs; participating in the buy-in process of the exchange or high-risk pools; providing supplemental identification and citizenship documentation necessary for enrollment; understanding which services are covered; recognizing cost-sharing and premium responsibilities; and choosing a health care provider. All of these tasks require significant consumer education and assistance. Notably, one ACA provision calls for the development and utilization of uniform explanations of coverage documents and standardized definitions. This is an important mandate that could be strengthened with explicit linkages to health literacy.

The ACA also establishes an internet portal to help individuals and businesses interact with the insurance exchange. This tool will have to assist users in understanding eligibility guidelines for Medicaid/CHIP/Medicare/high-risk pools and subsidized private insurance. As such, the portal should contain easy-to-understand explanations in simple English, as well as be available in multiple languages. The ACA also requires that information presented by the national and regional exchanges be culturally and linguistically appropriate.

To be most effective, ACA requirements to make insurance and enrollment information consumer-friendly should extend beyond readable web and print materials to include media such as phone, television, radio, social media, and in-person outreach. Research shows that a higher percentage of adults with low literacy receive their information about health issues from radio and television than through written sources, the internet, or social contacts.<sup>18</sup> Use of community-based organizations, culturally specific media campaigns, *promotores*, and individual insurance brokers (many of whom will be displaced due to the exchanges) will drive effective enrollment of the highly diverse, newly eligible population. The economic recession has shown, for example, that affected families have turned first to community-based organizations for help with linking them to public assistance programs.<sup>19</sup> States can use specially allocated ACA funding for such local outreach and enrollment supports.

**Medicaid Expansion.** ACA law mandates that starting in 2014, Medicaid cover everyone under age 65 and 133 percent of FPL (\$14,404 for one person in 2009). Accordingly, Medicaid could be serving upwards of 80 million Americans — or a quarter of the U.S. population — each year after 2014. Recent analyses suggest that this “expansion population” will likely: be racially and ethnically diverse; be predominantly childless adults; have high levels of substance abuse and prior jail involvement; and require integrated care management for complex physical and behavioral health needs.<sup>20</sup> It is fair to assume that health literacy would be a significant issue for this population, as current Medicaid beneficiaries face serious communication barriers related to limited literacy, language, culture, and disability.<sup>21</sup> Most new enrollees are unlikely to have had prior insurance, and thus will have limited knowledge about the Medicaid program, its services, and the complex administrative processes associated with enrollment and participation.

Simplifying Medicaid enrollment for diverse populations is not a new concept: the majority of states have some health literacy standards for their Medicaid programs. About 90 percent of all states have

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<sup>18</sup> M. Kutner, et al. *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy*. Washington, DC: U.S. Department of Education, National Center for Education, 2006.

<sup>19</sup> Kaiser Commission on Medicaid and the Uninsured. *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform*. Kaiser Family Foundation, Publication #8068, April 2010.

<sup>20</sup> S. A. Somers, A. Hamblin, J. Verdier and V. Byrd. *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States*. Center for Health Care Strategies. August 2010.

<sup>21</sup> L. Neuhauser B. Rothschild, C. Graham, S.L. Ivey and S. Konishi. “Participatory Design of Mass Health Communication in Three Languages for Seniors and People with Disabilities on Medicaid.” *American Journal of Public Health* (2009), 99(12): 2188-2195.

specific readability guidelines for Medicaid enrollment materials.<sup>22</sup> Of these, 67 percent call for at least a sixth-grade reading level or a range including, and 22 percent call for the level to be even lower. Ninety-six percent of states have simplified their enrollment forms, using easy-to-read language and repetition of key messages, such as when to use emergency care services. Eighty-two percent of states offer one-on-one enrollment assistance, and 72 percent provide onsite assistance at state agency offices, counseling sessions at local nonprofits and community centers, and/or a toll-free helpline.<sup>23</sup> Despite these efforts, many racial and ethnic minorities eligible for Medicaid or CHIP coverage — more than 80 percent of eligible uninsured African-American children and 70 percent of eligible uninsured Latino children — are still not enrolled.<sup>24</sup>

For current Medicaid beneficiaries who do not speak English or who have LEP, most states provide interpretive and translation services. The Centers for Medicare and Medicaid Services (CMS) has released readability guidelines for Medicaid print materials to states and has mandated certain contract requirements around communication standards for Medicaid managed care plans.<sup>25</sup> However, these guidelines lack strong enforcement or uniform oversight from any particular federal or state agency.

The following three ACA provisions, while not clearly linked to literacy, help further to simplify Medicaid eligibility determinations and streamline enrollment: (1) elimination of the asset test that many states still apply when determining Medicaid eligibility for adults, removing a common administrative burden and impediment to participation; (2) usage of a new, uniform method for determining income eligibility for most individuals (modified adjusted gross income, or MAGI); and (3) the expansion of the state option to presumptive eligibility determinations. The ACA also streamlines citizenship documentation requirements and electronic enrollment processes set forth by the Children’s Health Insurance Program Reauthorization (CHIPRA) legislation in 2009.<sup>26</sup> To the extent that federal entities could provide monetary and technical assistance support for state health literacy efforts, Medicaid programs would be better able to effectively enroll and provide quality care to newly eligible, low-literacy populations in 2014 and beyond.

### Individual Protections, Equity, and Special Populations

**TABLE 3: Provisions Related to Individual Protections, Equity, and Special Populations**

Sample of Indirect Instances where Health Literacy could be addressed	
Section Number	Provision Title
Sec. 1557.	Nondiscrimination
Sec. 4302.	Understanding health disparities; data collection and analysis
Sec. 6301.	Patient-centered outcomes research
Sec. 10334.	Minority health

The Insurance expansions in the ACA constitute significant steps toward universal coverage. All Americans up to a certain level of poverty (133 percent) will for the first time be entitled to health

<sup>22</sup> Health Literacy Innovations, LLC. *National Survey of Medicaid Guidelines for Health Literacy*. 2003.

<sup>23</sup> T. Matthews and J. Sewell. *State Official’s Guide to Health Literacy*. Lexington, KY: Council of State Governments, 2002.

<sup>24</sup> American College of Physicians, *op cit*.

<sup>25</sup> Rosenbaum et al. *The Legality of Collecting and Disclosing Patient Race and Ethnicity Data*. George Washington University Department of Health Policy, 2006.

<sup>26</sup> U.S. Congress. “H.R. 2: Children’s Health Insurance Program Reauthorization Act of 2009.” Available at: <http://www.govtrack.us/congress/bill.xpd?bill=h111-2>.

insurance. Protecting these lower-income individuals' right to health care is important to the successful implementation of the ACA. The law references the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act. Section 1557's Non-Discrimination provision prevents exclusion of an individual from participation in or denial of benefits under any health program or activity.

The ACA also provides consumers with significant new protections, including the ability to choose a health plan that best suits their needs, to appeal a plan's denial of coverage for needed services, and to select an available primary care provider of their choosing. Health plans are now required to communicate these patient protections in media that are "culturally and linguistically appropriate," and by extension, readable for those with low literacy levels. This term is used seven times in the legislation, including in references to: federal oral health and nutrition education programs; clinical depression centers of excellence; workforce training curricula; and the need for patient-centered delivery models to be culturally competent, i.e. sensitive to the beliefs, values, and cultural mores that influence how health care information is shared and received by individuals. Prior efforts of the HHS' Office of Civil Rights to set compliance standards for language aimed to improve access for those who have LEP and are already providing related regulations. But, there is no language in the ACA instructing this body or others to oversee the new "culturally and linguistically appropriate" obligations.

ACA law also requires the collection and reporting of data on race, ethnicity, sex, primary language, and disability status by all federally conducted and supported health care and public health programs (e.g., Medicare, Medicaid), activities, and surveys (including surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census). It also urges the HHS to strengthen existing requirements that state Medicaid agencies collect race, ethnicity, and language data. The law specifies that existing Office of Management and Budget standards must be used, at a minimum, for recording race and ethnicity, and instructs the HHS to issue new standards for measuring sex, primary language, and disability status.

In 2000, the Office of Minority Health (OMH) developed National Standards on Culturally and Linguistically Appropriate Services (CLAS) to provide a common understanding and consistent definitions of culturally and linguistically appropriate services in health care. These standards were intended to be a practical framework for providers, payers, accreditation organizations, policymakers, health administrators, and educators. Post-reform health literacy efforts should make use of this resource, particularly since the OMH is gaining additional recognition in the law. The ACA establishes an OMH in every major agency within the HHS: AHRQ, CDC, CMS, FDA, Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA). These offices will be charged with evaluating the effectiveness of federal programs and targeted research to meet the needs of minority populations. Similarly, a newly created Patient Centered Outcomes Research Institute is tasked with conducting comparative effectiveness research, and ensuring that subpopulations, particularly communities of color, are represented in research designs.

The ACA's disparities agenda includes additional measures to support the rights and unique needs of certain populations. These include standardizing complaint forms for patients in nursing facilities; improving quality of care and protections for those in long-term care institutions; expanding aging and disability resource centers; providing dementia prevention and abuse training for personnel working in geriatric mental health; supporting pregnant and parenting teens and women through health care, social, and educational assistance; and appropriating funds for the Indian Health Care Improvement Act,<sup>27</sup> which supports the growth of the Native American health care force and innovative delivery models for

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<sup>27</sup> U.S. Congress. "S.1790: Indian Health Care Improvement Reauthorization and Extension Act of 2009." Dorgan, B. Available at: <http://www.govtrack.us/congress/bill.xpd?bill=s111-1790>.

rural populations and tribal organizations. Again, however, these provisions make no explicit link to health literacy.

### Workforce Development

**TABLE 4: Provisions Related to Workforce Development**

Section Number	Provision Title
<b>Direct Mentions of Health Literacy</b>	
Sec. 5301	Training in family medicine, general internal medicine, general pediatrics, and physician assistantship
<b>Sample of Indirect Instances where Health Literacy could be addressed</b>	
Sec. 5205	Allied health workforce recruitment and retention program
Sec. 5307	Cultural competency, prevention, and public health and individuals with disabilities training
Sec. 5313	Grants to promote the community health workforce
Sec. 5402	Health professions training for diversity
Sec. 5403	Interdisciplinary, community-based linkages
Sec. 5507	Demonstration project to address health professions workforce needs; extension of family-to-family health information centers
Sec. 5606	State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations

Within the next 40 years, people of color will make up the majority of the U.S. population.<sup>28</sup> Insurance reforms and expansion of coverage will bring to providers' offices new socially, culturally, and linguistically diverse patient populations, many of which are likely to have limited experience with the health system, difficulty communicating with practitioners, and complex conditions that require effective self-management. There will be increased onus on health care providers and their delivery system partners to be sensitive to the nuanced needs and potential limitations of their patient populations. Not doing so could have major consequences for the patient's health, the physician's performance, and the payer's pocketbook.

Effectively communicating with low-literate patients is not an arcane skill: a survey of Federally Qualified Health Centers, free clinics, and migrant health facilities found that when clinicians use plain language, illustrations, and "talk back" methods, patient understanding, compliance, and trust are greatly improved.<sup>29</sup> As it stands today, however, physicians are given little training in this area during the course of their medical education,<sup>30</sup> and professionals who do receive a modicum of training in this vein — community health workers and nurses, case managers, and public health specialists, for example — lack recognition, funding, and inclusion in most physician-led delivery teams. Other system issues such as pressure on provider time, use of singular modes of communication, and cultural mismatch between provider and patient also contribute to subpar delivery of health care services to low-literate patients.<sup>31</sup>

<sup>28</sup> U.S. Census Bureau. "Projected Population of the United States, by Race and Hispanic Origin: 2000 to 2050." Available at: <http://www.census.gov/ipc/www/usinterimproj/natprojtab01a.pdf>.

<sup>29</sup> Barrett S.E et al. *Health Literacy Practices in Primary Care Settings: Examples from the Field*. The Commonwealth Fund, 2008.

<sup>30</sup> American College of Physicians. *Racial and Ethnic Disparities in Health Care, Updated 2010*. Philadelphia: American College of Physicians, 2010.

<sup>31</sup> M.K. Paasche-Orlow, D. Schillinger, S.M. Green, and E.H. Wagner. "How Healthcare Systems can Begin to Address the challenge of Limited Literacy." *Journal of General Internal Medicine*, 21(8): 884–887 (2006).

Appropriately, the ACA legislation pushes for improvement in the education and communications skills of a wide range of health provider types, positioning workforce development as an important lever for establishing health care equity across diverse patient populations.

The ACA provides scholarships, grants, and loan repayment programs for health care professionals in medical fields such as primary care and mental health; offers continuing education support for those who serve minority, rural, and special populations; and improves medical school and health professions curricula in the areas of cultural competency and disabilities training. The ACA also seeks to increase the racial/ethnic diversity of health practitioners through educational grants and loan programs, and widens the array of professional and para-professionals available to patients through funding for training of community health workers, nurses, geriatric specialists, adolescent mental health providers, home care aides, and others.

Only one of these provisions — the primary care provider workforce training awards — explicitly mentions the term health literacy. But, other language related to cultural and linguistic appropriateness appears frequently, particularly as a condition of eligibility for the workforce grant opportunities.

### Health Information

**TABLE 5: Provisions Related to Health Information**

Section Number	Provision Title
<b>Direct Mentions of Health Literacy</b>	
Sec. 3507	Presentation of prescription drug benefit and risk information
<b>Sample of Indirect Instances where Health Literacy could be addressed</b>	
Sec. 3305	Improved information for subsidy eligible individuals reassigned to prescription drug and MA-PD Plans
Sec. 3503	Grants to implement medication management services in treatment of chronic disease
Sec. 4205	Nutrition labeling of standard menu items at chain restaurants
Sec. 10328	Improvement in Part D medication therapy management (MTM) programs

While the average piece of health care information is written at a 10th-grade reading level, the average American reads at only a fifth-grade level.<sup>32</sup> Numerous studies show that those with limited health literacy skills are at increased risk of misunderstanding medical information on product labels, manuals, package inserts, and nutrition labels.<sup>33,34</sup>

The ACA provisions on nutrition labeling, the presentation of prescription drug information, and medical management assistance are welcome. These provisions do not mandate health system-wide standards but recommend small-scale changes and building an evidence base for future implementation. They constitute an important step in acknowledging that health information, which is often dense, technical, and jargon-filled, must be digestible to the diverse consumers who are trying to use it.

<sup>32</sup> Rosales. "Are Adequate Steps Being Taken to Address Health Literacy in this Country?" *Managed Care Outlook*, 23(11), June 1, 2010.

<sup>33</sup> Institute of Medicine. *Preventing Medication Errors: The Quality Chasm Series*. National Academies Press, 2006.

<sup>34</sup> B.D. Weiss, M.Z. Mays, et al, "Quick Assessment of Literacy in Primary Care: The Newest Vital Sign." *Annals of Family Medicine* (2005), 3:514-522.



For example, due to the high national prevalence of cardio-metabolic conditions, consumers have a greater need to read and interpret labels that provide information on sugar, fat, salt, and cholesterol content. Difficulties in understanding nutrition information are heightened for those with “basic” and “below basic” levels of literacy.<sup>35</sup> These individuals have trouble finding pieces of information or numbers in a lengthy text, integrating multiple pieces of information in a document, or finding two or more numbers in a chart and performing a calculation.<sup>36</sup>

Elders and others with multiple chronic conditions are often given prescriptions for numerous medications by a mix of physical health and mental health providers, who may not communicate with each other about their prescription practices. This places the onus of medication reconciliation on the patient, whose literacy and numeracy skills might be compromised.

Complications around choice of plan eligibility and prescription drug reimbursement add other challenges for Part D Medicare beneficiaries. ACA provisions call for improved information for subsidy-eligible individuals reassigned to prescription drug and MA-PD plans, and put into place medication management programs for Part D seniors and chronic disease patients. These should help vulnerable beneficiaries with their health information demands. To be effective, these efforts should also focus on the verbal communications used by providers, pharmacists, and other dispensers of medication, to ensure that patients understand medication dosage, schedules, side effects and safety precautions.

Given the increasing presence of information technology in health communications, delivery and management, it will be important that this medium be accessible to low-literate, and low computer-literate users in particular. In several instances, the ACA promotes the use of the internet and web-based tools to disseminate health information and to communicate federal activities to a diverse consumer population. Some of these include:

- The “ombudsman” portal to facilitate enrollment into public and publicly subsidized insurance programs and the exchange;
- A website recommending prevention practices for specified chronic diseases and conditions;
- A web-based tool to create personalized prevention plans; and
- An internet portal for consumers to access health risk assessment tools.

Those designing these media should look to resources like the *Health Literacy Online Guide*,<sup>37</sup> a research-based how-to module developed by the HHS’ Office of Disease Prevention and Health Promotion (ODPHP) to guide administrators, providers, and educators seeking to present information to low-literacy Americans using the web.

In terms of promoting the meaningful use of electronic health records (EHRs), there is little in the ACA that speaks to health literacy. However, health literacy advocates might note relevant requirements in the American Recovery and Reinvestment Act (ARRA)<sup>38</sup> legislation: (1) patients must be provided timely access (within 96 hours) to their electronic health information; (2) the EHR should be used to

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<sup>35</sup> The Joint Commission. *What did the Doctor Say?: Improving Health Literacy to Protect Patient Safety*. Joint Commission, 2007

<sup>36</sup> Berkman et al, *op cit*.

<sup>37</sup> U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Health Literacy Online: A Guide to Writing and Designing Easy-to-Use Health Web Sites*. Washington, D.C., 2010. Available at: <http://www.health.gov/healthliteracyonline/>.

<sup>38</sup> U.S. Congress. “H.R.1: American Recovery and Reinvestment Act of 2009.” Obey, D. Available at: <http://www.govtrack.us/congress/bill.xpd?bill=h111-1>.

identify and provide patient-specific education resources; and (3) health care providers using an EHR must collect race and ethnicity data on their patients, using the OMB's classification standards.

### *Public Health, Health Promotion, and Prevention & Wellness*

**TABLE 6: Provisions Related to Public Health, Health Promotion, and Prevention & Wellness**

Section Number	Provision Title
Sec. 2951	Maternal, infant, and early childhood home visiting programs
Sec. 2953	Personal responsibility education
Sec. 4001	National Prevention, Health Promotion and Public Health Council
Sec. 4002	Prevention and Public Health Fund
Sec. 4003	Clinical and Community Preventive Services
Sec. 4004	Education and outreach campaign regarding preventive benefits
Sec. 4102	Oral healthcare prevention activities
Sec. 4103	Medicare coverage of annual wellness visit providing a personalized prevention plan
Sec. 4107	Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid
Sec. 4108	Incentives for prevention of chronic diseases in Medicaid
Sec. 4201	Community transformation grants
Sec. 4202	Healthy Aging/Living Well for Medicare
Sec. 4206	Demonstration project concerning individualized wellness plan
Sec. 4303	CDC and employer-based wellness programs
Sec. 4306	Funding for childhood obesity demonstration project
Sec. 10408	Grants for small businesses to provide comprehensive workplace wellness programs
Sec. 10413	Young women's breast health awareness and support of young women diagnosed with breast cancer
Sec. 10501	National diabetes prevention program

ACA establishes a comprehensive framework for federal, community-based public health activities, including a coordinating council, a national strategy, and a national education and outreach campaign. The legislation also addresses prevention and wellness at state, community, clinic, and organizational levels. Specifically, it:

- Expands coverage of clinical preventive services under Medicare, Medicaid, and private health insurance;
- Encourages the development and expansion of personalized wellness programs by employers and insurers;



- Expands federal grantmaking and other public health activities directed at the prevention of disease risk factors such as obesity and tobacco use, with a focus on community transformation; and
- Supports evidence review processes to determine whether specific clinical (e.g. cancer screenings) and community-based prevention interventions (e.g. media campaigns) are effective.

Notably, the large national outreach and education undertaking to be led by the HHS and CDC under Sec. 4004 will include a science-based media campaign; a chronic disease website to educate consumers; a web-based tool for individuals to create personalized prevention plans; and an internet portal with health risk assessment tools developed by academic entities. In addition, each state must design a public awareness campaign to educate Medicaid enrollees about the availability and coverage of preventive services, such as obesity-reduction programs for children and adults. To be successful, these communication efforts should include the use of multiple media streams to reach diverse populations.

ACA also requires Medicaid health plans to cover tobacco cessation counseling and drug therapy for pregnant women. States that include a package of recommended preventive services (as set by the U.S. Preventive Services Task Force) for Medicaid-eligible adults will receive an enhanced federal match. Medicare Part B will be required to cover personalized prevention services for elders, including chronic disease testing and treatment, medication reconciliation, cognitive impairment assessments, and tailored wellness guidance. Other related programs authorized in the ACA that promote prevention and target specific populations or health gap areas include: a national oral health education campaign; early mother-child visiting programs; teenage personal responsibility grants; the pregnancy assistance fund; a national diabetes prevention program; childhood obesity-reduction initiatives; and centers for excellence in depression. These programs will address health literacy to the extent that they are attentive to issues of information usability, consumer engagement and cultural competency.

Although competencies around emergency preparedness and infectious disease are not a notable part of ACA's public health provisions, they should not be ignored during the implementation of national and community-based public health efforts. For example, individuals with compromised health literacy are likely less equipped to receive pertinent information or act expeditiously in the face of environmental disasters and pandemic disease outbreaks.<sup>39,40</sup>

Being healthy or learning how to become and stay healthy requires substantial self-activation, resources, willpower, and lifestyle modification. These are challenging for any patient, let alone one with low health literacy, who may encounter other structural barriers to good health. Such obstacles may include substandard housing; transportation difficulty; low job availability; poor educational opportunities; higher exposure to environmental toxins; involvement with violence and criminal justice; discrimination and socio-cultural marginalization; and limited access to fresh, healthy foods. These social problems and the circumstances of "place" have been shown to have a significant impact on the health of the underserved, many of whom also face low literacy.<sup>41,42</sup>

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<sup>39</sup> C. Zarcadoolas, J. Boyer, A. Krishnaswami, and A. Rothenberg (2007). "How Usable are Current GIS Maps: Communicating Emergency Preparedness to Vulnerable Populations?" *Journal of Homeland Security and Emergency Management*, 2007.

<sup>40</sup> C. Zarcadoolas, A. Pleasant, and D.S.Greer. *Advancing Health Literacy: A Framework for Understanding and Action*. San Francisco: Jossey-Bass, 2006.

<sup>41</sup> B. Smedley. *Building Stronger Communities for Better Health: Moving from Science to Policy to Practice*. Presentation at IOM Workshop, 2010.

<sup>42</sup> Andrulic et al. *Patient Protection and Affordable Care Act: Advancing Health Equity for Racially and Ethnically Diverse Populations*. Joint Center for Political and Economic Studies. Washington DC, July 2010.

*Innovations in Quality and the Delivery and Costs of Care***TABLE 7: Provisions Related to Innovations in Quality and the Delivery and Costs of Care**

Section Number	Provision Title
<b>Direct Mentions of Health Literacy</b>	
Sec. 3501	Health care delivery system research; quality improvement technical assistance
Sec. 3506	Program to facilitate shared decision-making
<b>Sample of Indirect Instances where Health Literacy could be addressed</b>	
Sec. 2703	State option to provide health homes for enrollees with chronic conditions
Sec. 3011	National strategy
Sec. 3012	Interagency Working Group on Health Care Quality
Sec. 3013	Quality measure development
Sec. 3014	Quality measurement
Sec. 3015	Data collection; public reporting
Sec. 3021	Establishment of Center for Medicare and Medicaid Innovation within CMS
Sec. 3502	Grants or contracts to establish community health teams to support the patient-centered medical home
Sec. 3510	Patient navigator program
Sec. 10331	Public reporting of performance information
Sec. 10333	Community-based collaborative care networks

There is no dearth of provisions in the ACA focused on improving health care quality and reducing avoidable costs. The legislation identifies patient-centeredness, safety, efficiency, and equity as both vehicles for and by-products of the quality effort. Except for two mentions of health literacy in provisions regarding shared decision-making programs and dissemination of delivery system research, health literacy is not explicitly featured in the bill's language on quality. However, adults with low health literacy average six percent more hospital visits, remain in the hospital two days longer and have annual health care costs four times higher than those with proficient health literacy skills.<sup>43</sup> As such, literacy should be a core consideration in discussions of quality improvement, health delivery redesign, and cost-reduction.

The legislation uses three broad mechanisms to address quality: (1) a national approach that identifies an umbrella strategy, establishes a federal-level, inter-agency quality workgroup, sets an agenda for measurement, and develops metrics; (2) delivery system redesign through efforts targeting improved care coordination and new patient-centered care models such as the medical home; and (3) the reduction of cost through increased payer and provider accountability across private and public programs (e.g., pay-for-performance incentives and value-based purchasing structures).

<sup>43</sup> Partnership for Clear Health Communication at the National Patient Safety Foundation. *What is Health Literacy? Ask Me 3*. Available at: [http://www.npsf.org/askme3/PCHC/what\\_is\\_health.php](http://www.npsf.org/askme3/PCHC/what_is_health.php).

Health literacy issues should ideally be represented in the ACA-mandated inter-agency quality workgroup to be convened by the President, and in the development of the national quality strategy (i.e., readability standards for all federal health program communications). Quality measure development and endorsement efforts that will be spearheaded by AHRQ and CMS should gauge national health literacy trends and their implications, as well as explore how new measures that identify and stratify low-literacy risk groups can be used to improve care at the community, provider, plan, and hospital levels. The support for public reporting mechanisms in ACA may also provide consumers with better, more readable information about the performance of their health system, enabling more informed health care choices.

Many of the objectives of quality improvement — avoiding waste in the system; reducing the over- and underuse of medications, diagnostic tests, and therapies; and improving patient safety — depend on the patient's ability to be an informed and active player in his or her care. For low-literate populations, interacting with physicians, complying with medical guidance, and managing the disparate demands of multiple providers in fragmented delivery systems is that much more challenging.

Other ACA components that ensure patient-centeredness, such as the shared decision-making program and patient navigator services, should also resonate with health literacy advocates. Regional collaborative networks, primary care extension hubs, health homes in Medicaid, and community health teams to support the medical home would all be strengthened by concerted attention to patients with low literacy, particularly those managing complex, co-morbid physical and mental health conditions. Estimates suggest that 75 percent of those with chronic conditions have low health literacy.<sup>44</sup>

One of the most promising windows of opportunity among the quality-oriented provisions is the newly created Center for Medicare and Medicaid Innovation (CMI) within CMS. CMI will fund demonstration programs that research, test, and expand innovations in payment and delivery system improvement pilots. Given the prevalence of low literacy among individuals in publicly financed care, particularly people with disabilities in Medicaid and those dually eligible for Medicaid and Medicare,<sup>45</sup> this could be a prime opportunity to test health literacy innovations among high-risk populations such as pregnant women or elders with multiple medications. Such demonstrations could convey to federal and state policymakers the mediating power of health literacy to improve quality and reduce costs. This could also help demonstrate the business case for further investments in health literacy by health plans and accountable care organizations serving these populations.

Given the evidence base around populations disproportionately affected by low health literacy, Medicaid, Medicare, and Veterans Administration programs may present the best targets of opportunity for making the case. The Veterans Administration is a closed system with considerable data capacity, but might pose problems for generalizability; while Medicare is still largely a fee-for-service system, which provides few leverage points for concerted action. The 7.5 million individuals dually enrolled in Medicaid and Medicare could benefit from health literacy interventions given their age and complex health needs, but these “duals” are generally not in integrated care management programs that have enormous incentives to prevent the exacerbation of illness and disability associated with low health literacy. However, 71 percent of Medicaid's 60 million beneficiaries are enrolled in managed care;<sup>46</sup> as the nation's largest purchaser of health care, Medicaid could use its leverage to promote innovations in this arena. Medicaid managed care organizations already have the incentives to address health literacy, especially for those with complex conditions. But, to date, none have demonstrated using readily

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<sup>44</sup> Hsu. *The Health Literacy of U.S. Adults Across GED Credential Recipients, High School Graduates, and Non-High School Graduates*. American Council on Education. GED Testing Service, 2008.

<sup>45</sup> Baker et. al. “Health Literacy and Mortality among Elderly Persons.” *Archives of Internal Medicine* (2007), 167(14):1503-1509.

<sup>46</sup> Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. “Medicaid Managed Care Penetration Rates by State as of June 30, 2008.” Special data request, August 2009.

available and easy-to-administer literacy assessment tools (e.g., the short TOHFLA) to: 1) identify and stratify a high-risk population with low literacy skills, and 2) design interventions to support health management and consequently avoid costly exacerbations, hospitalizations and institutionalizations.

### **Best Practices: “What Are My Medi-Cal Choices?”**

Health Research for Action (HRA), a center at UC Berkeley’s School of Public Health, was funded by the California Department of Health Care Services (DHCS) to create easy-to-read and understandable information for seniors and people with disabilities on Medi-Cal, about their Medi-Cal choices. This specific population could choose between Regular Medi-Cal (also known as Fee for Service) and Medi-Cal Managed Care Plans. The goals of this project were to:

1. Use participatory research to develop a guidebook that informed seniors and people with disabilities on Medi-Cal about their unique Medi-Cal choices.
2. Promote informed choice between Medi-Cal fee for service and Medi-Cal Managed Care delivery systems.

HRA conducted extensive formative research to understand how seniors and people with disabilities learn and make decisions about their Medi-Cal delivery options. Findings informed HRA’s development of a draft consumer guidebook called “What Are My Medi-Cal Choices?” in English, Spanish, and Chinese. The formative research used a participatory model where beneficiaries and other stakeholders were consulted in the content and layout of the guidebook. HRA conducted 51 key informant interviews with stakeholders as well as extensive qualitative research with Medi-Cal beneficiaries including 24 one-on-one interviews, 18 focus groups, and 36 one-on-one usability tests. This formative research was conducted in English, Spanish, Mandarin, Cantonese, and American Sign Language. Formative research findings showed that that English-, Spanish- and Chinese-speaking Medi-Cal recipients who are seniors or people with disabilities had very little knowledge about their Medi-Cal choices and negative attitudes about managed care health plans. Several areas of unmet information needs and primary areas of concern for SPD beneficiaries when faced with Medi-Cal choices were also identified. In addition to the above formative research, an advisory group that included disability advocates, managed care plan representatives, health care providers, policymakers, and Medi-Cal beneficiaries provided guidance and feedback on the research, guidebook, the dissemination process, and complementary interventions.

The Department of Health Care Services disseminated the guidebook through a direct mailing to beneficiaries in the target population and via partner organizations. The final guidebook was developed in 12 threshold languages, plus alternative formats including Braille (English and Spanish only) and audio, including MP3, cassette, and CD (all 12 languages).

HRA conducted a multi-lingual, mixed-methods evaluation of the final guidebook including 10 focus groups, 28 stakeholder interviews, and a randomized control trial telephone survey. At six weeks post-dissemination, the intervention group showed significantly higher increases in knowledge, confidence, positive attitudes about, and intentions to consider changing to a Medi-Cal health plan than did the control group. Overall, the findings provided strong evidence that the guidebook was an effective and low-cost way to improve recipients’ abilities to make more informed Medi-Cal choices.

*In 2008, the Institute for Healthcare Advancement jointly awarded HRA and the DHCS the national first place award for Health Literacy for their work on the consumer guidebook.*

### III. Conclusion

The ACA is not a landmark piece of legislation for health literacy, but with its attention to increased coverage, quality improvement and cost reduction, it creates opportunities for bringing cultural competency, disparities, and health literacy to the fore. It establishes momentum for investments in innovation among state agencies, payers, providers, regulators, advocacy groups, and others to improve care in many ways, including patient-centered high quality care. Organizations promoting health literacy will not be armed with forceful legislative or with regulatory mandates or with designated resources, so they will have to continue to find ways to make the case for greater investment and action by both public and private stakeholders in our health care system.

The ACA does create opportunities for driving home the importance of health literacy in all of the key domains of health and health care identified earlier:

1. *The Coverage Expansion*: Establishing what is essentially universal coverage for 16 million Americans up to 133 percent of FPL and subsidized insurance options for another 16 million low income Americans will only be successful if the newly eligible individuals can understand their options and navigate the enrollment process.
2. *Equity*: Moving toward universal coverage and creating the same “floor” for all of our lowest-income populations should help address some of the fundamental disparities in access to care in this country, but as the legislation underscores, that will depend on the attention our health care delivery system pays to cultural differences, language, and by extension, literacy.
3. *Workforce*: The provider training provisions in ACA related to disparities, cultural competency, and patient-centeredness all present opportunities for bringing greater attention to health literacy.
4. *Health care Information*: From medication management to provider performance rating, patient information must be presented at reading and numeracy levels accessible to millions of Americans with low literacy skills.
5. *Public Health and Wellness*: The preparation and presentation (whether in print, electronically, or otherwise) of consumer information on issues ranging from prevention to emergency preparedness must be done with low literacy in mind.
6. *Quality Improvement*: The ACA’s emphasis on developing, testing and spreading best practices for improving quality and reducing costs presents many new opportunities for making the case for investments in health literacy.

## IV. Appendices<sup>\*</sup>

### Appendix A: Summary of ACA Provisions with Potential Implications for Health Literacy

#### *Insurance Reform, Outreach, and Enrollment*

**Sec. 1002. Health insurance consumer information.** The Secretary shall award grants to States to enable them (or the Exchange) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. These independent offices will assist consumers with filing complaints and appeals, educate consumers on their rights and responsibilities, and collect, track, and quantify consumer problems and inquiries.

**Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.** Establishes an Internet portal for beneficiaries to easily access affordable and four comprehensive coverage options. This information will include eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care, rather than administrative expenses, by the issuer. Section 10102 clarifies that the internet portal shall be available to small businesses and shall contain information on coverage options available to small businesses.

**Sec. 1311. Affordable choices of health benefit plans.** Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses.

**Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan.** Amends the Internal Revenue Code to provide tax credits to assist with the cost of health insurance premiums.

**Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs.** Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children's health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.

**Sec. 1513. Shared responsibility for employers.** As amended by the *Reconciliation Act*, requires an employer with at least 50 full-time employees that does not offer coverage and has at least one full-time employee receiving a premium assistance tax credit to make a payment of \$2,000 per full-time employee. Includes the number of full-time equivalent employees for purposes of determining whether an employer has at least 50 employees. Exempts the first 30 full-time employees for the purposes of calculating the amount of the payment. Section 10106 clarifies that the calculation of full-time workers is made on a

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<sup>\*</sup> Adapted from the following:

- Communication with S. Rosenbaum (August – September 2010), Hirsh Professor and Chair of the Health Policy Department, George Washington University.
- Democratic Policy Committee, U.S. Senate. *Affordable Care Act: Section-by-Section Analysis with Changes Made by Title X and Reconciliation*. Updated September 17, 2010. Available at: <http://dpc.senate.gov/dpcissue->
- E. Williams and C. Redhead. *Public Health Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (PPACA)*. Congressional Research Service (CRS) Report for Congress. 7-5700. June 2010. Available at: <http://www.crs.gov>.



monthly basis. The *Reconciliation Act* eliminates the penalty for waiting periods before an employee may enroll in coverage. An employer with at least 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$2,000 for each of their full-time employees total, not including the first 30 workers. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.

**Sec. 2001. Medicaid coverage for the lowest income populations.**

Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on April 1, 2010, as amended by Section 10201. Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare (e.g., childless adults and certain parents). Creates a new mandatory Medicaid eligibility category for all such "newly-eligible" individuals with income at or below 133 percent of the FPL beginning January 1, 2014. As of January 1, 2014, the mandatory Medicaid income eligibility level for children ages 6 to 19 changes from 100 percent to 133 percent FPL. Effective April 1, 2010, states can provide Medicaid coverage to all non-elderly individuals above 133 percent of FPL through a State plan amendment.

**Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.** Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage for applicants, policyholders or certificate holders, and enrollees. Standards must be in a uniform format, using language that is easily understood by the average enrollee, and must include uniform definitions of standard insurance and medical terms. The explanation must also describe any cost-sharing, exceptions, reductions, and limitations on coverage, and examples of common benefits scenarios.

**Sec. 3306. Funding outreach and assistance for low-income programs.** Provides \$45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment.

**Sec. 5000A. Requirement to maintain minimum essential coverage.** Requires individuals to maintain minimum essential coverage beginning in 2014. As amended by Section 1002 of the *Reconciliation Act*, failure to do so will result in a penalties, with exceptions and exemptions.

***Individual Protections, Equity and Special Populations***

**Sec. 1557. Nondiscrimination.** Protects individuals against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program or activity.

**Sec. 2405. Funding to expand State Aging and Disability Resource Centers.** Appropriates, to the Secretary of HHS, \$10 million for each of FY 2010 - 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives.

**Sec. 4302. Understanding health disparities; data collection and analysis.** Ensures that any ongoing or new Federal health program achieve the collection and reporting of data by race, ethnicity, primary language and any other indicator of disparity.

**Sec. 6105. Standardized complaint form.** Requires the Secretary to develop a standardized complaint form for use by nursing home residents (or a person acting on a resident's behalf) in filing complaints with a State survey and certification agency and a State long-term care ombudsman program. States would also be required to establish complaint resolution processes.

**Sec. 6121. Dementia and abuse prevention training.** Requires facilities to include dementia management and abuse prevention training in pre-employment initial training for permanent and contract or agency staff, and if the Secretary determines appropriate, in ongoing in-service training.

**Sec. 6301. Patient-Centered Outcomes Research.** Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board to identify priorities for and provide for the conduct of comparative outcomes research. Requires the Institute to ensure that subpopulations are appropriately accounted for in research designs.

**Sec. 6703. Elder Justice.** Requires the Secretary of HHS, in consultation with the Departments of Justice and Labor, to award grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities.

**Sec. 10212. Pregnancy Assistance Fund.** Establishes a Pregnancy Assistance Fund for the purpose of awarding competitive grants to States to assist pregnant and parenting teens and women. The grants will help fund a seamless network of supportive services to help pregnant and parenting teens and women complete high school or postsecondary degrees, and gain access to health care, child care, family housing, and other critical supports. In addition, funding recipients will be encouraged to address violence against pregnant and parenting women.

**Sec. 10221. Indian health care improvement.** Authorizes appropriations for the Indian Health Care Improvement Act, including programs to increase the Indian health care workforce, new programs for innovative care delivery models, behavioral health care services, new services for health promotion and disease prevention, and efforts to improve access to health care services.

**Sec. 10334. Minority health.** Codifies the Office of Minority Health at HHS and a network of minority health offices located within HHS. Elevates the National Center on Minority Health and Health Disparities at the National Institutes of Health from a Center to an Institute. The Offices of Minority Health will monitor health, health care trends, and quality of care among minority patients and evaluate the success of minority health programs and initiatives.

### ***Workforce Development***

**Sec. 5203. Health care workforce loan repayment programs.** Establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who are or will be working in a Health Professional Shortage Area, Medically Underserved Area, or with a Medically Underserved Population.

**Sec. 5205. Allied health workforce recruitment and retention program.** Offers loan repayment to allied health professionals employed at public health agencies or in settings providing health care to patients in settings located in Health Professional Shortage Areas, Medically Underserved Areas, or serving Medically Underserved Populations.



**Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.** Provides grants to develop and operate training programs, to provide financial assistance to trainees and faculty, to enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

**Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.** Authorizes funding to geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools and family caregivers; develop curricula and best practices in geriatrics; expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing.

**Sec. 5307. Cultural competency, prevention, and public health and individuals with disabilities training.** Reauthorizes and expands programs to support the development, evaluation, and dissemination of model curricula for cultural competency, prevention, and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs.

**Sec. 5309. Nurse education, practice, and retention grants.** Awards grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.

**Sec. 5313. Grants to promote the community health workforce.** Authorizes the Secretary to award grants to States, public health departments, clinics, hospitals, Federally Qualified Health Centers (FQHCs), and other nonprofits to promote positive health behaviors and outcomes in medically underserved areas through the use of community health workers. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, offer informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct primary care services and screenings.

**Sec. 5316. Rural physician training grants.** As added by Section 10501, establishes a grant program for medical schools to recruit and train medical students to practice medicine in underserved rural communities.

**Sec. 5317. Demonstration grants for family nurse practitioner training programs.** As added by Section 10501, establishes a training demonstration program that supports recent Family Nurse Practitioner graduates in primary care for a 12-month period in FQHCs and nurse-managed health clinics. The demonstration is authorized from 2011 through 2014

**Sec. 5401. Centers of excellence.** The Centers of Excellence program, which develops a minority applicant pool to enhance recruitment, training, academic performance and other supports for minorities interested in careers in health, is reauthorized.

**Sec. 5402. Health professions training for diversity.** Provides scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and expands loan repayments for individuals who will serve as faculty in eligible institutions.

**Sec. 5403. Interdisciplinary, community-based linkages.** Authorizes funding to establish community-based training and education grants for Area Health Education Centers and Programs. Supports two programs targeting individuals from urban and rural medically underserved communities, who are seeking careers in the health professions.

**Sec. 5507. Demonstration project to address health professions workforce needs; extension of family-to-family health information centers.** Establishes a demonstration grant program through competitive grants to provide aid and supportive services to low-income individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. The demonstration grant is to serve low-income persons including recipients of assistance under State Temporary Assistance for Needy Families (TANF) programs.

**Sec. 5602. Negotiated rulemaking for development of methodology and criteria for designating medically underserved populations and health professions shortage areas.** Directs the Secretary, in consultation with stakeholders, to establish a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas.

**Sec. 5606. State grants to health care providers who provide services to a high percentage of medically underserved populations or other special populations.** As added by Section 10501, creates a grant program to support health care providers who treat a high percentage of medically underserved populations.

**Sec 9024. Health professionals State loan repayment tax relief.** As added by Section 10908, excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas.

### ***Health Information***

**Sec. 3305. Improved information for subsidy-eligible individuals reassigned to prescription drug plans and MA–PD plans.** Requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan.

**Sec. 3503. Grants to implement medication management services in treatment of chronic disease.** Creates a program to support medication management services by local health providers.

**Sec. 3507. Presentation of prescription drug benefit and risk information.** Requires the Food and Drug Administration to evaluate and determine if the use of drug fact boxes which would clearly communicate drug risks and benefits and support clinician and patient decision making in advertising and other forms of communication for prescription medications is warranted.

**Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.** Stipulates that a restaurant that is part of a chain with 20 or more locations doing business under the same name are required to disclose calories on the menu board and in a written form, as well as provide customers with additional nutritional information upon request.

**Sec. 10328. Improvement in Part D medication therapy management programs.** Requires Part D prescription drug plans to include a comprehensive review of medications and a written summary of the review as part of their medication therapy management programs.

### ***Public Health, Health Promotion, and Prevention & Wellness***

**Sec. 2951. Maternal, infant, and early childhood home visiting programs.** Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Models aimed at reducing infant and maternal mortality and its related causes.

**Sec. 2953. Personal responsibility education.** Provides \$75 million per year through FY2014 for Personal Responsibility Education grants to States for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Funding is also available for 1) innovative teen pregnancy prevention strategies and services to high-risk, vulnerable, and culturally under-represented populations, 2) allotments to Indian tribes and tribal organizations, and 3) research and evaluation, training, and technical assistance.

**Sec. 4001. National Prevention, Health Promotion and Public Health Council.** Creates an interagency council dedicated to promoting healthy policies at the federal level. The Council will establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy.

**Sec. 4002. Prevention and Public Health Fund.** Establishes a Fund to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

**Sec. 4003. Clinical and community preventive services.** Expands the efforts of, and improves the coordination between the U.S. Preventive Services Task Force and the Community Preventive Services Task Force. The latter uses a public health perspective to review the evidence of effectiveness of population-based preventive services such as tobacco cessation, increasing physical activity and preventing skin cancer, and develops recommendations for their use.

**Sec. 4004. Education and outreach campaign regarding preventive benefits.** Directs the Secretary to convene a national public/private partnership for the purposes of conducting a national prevention and health promotion outreach and education campaign. The goal of the campaign is to raise awareness of activities to promote health and prevent disease across the lifespan. The Secretary will conduct a national media campaign on health promotion and disease prevention focusing on nutrition, physical activity, and smoking cessation using science-based social research. The Secretary shall also maintain a web-based portal that provides informational guidelines on health promotion and disease prevention to health care providers and the public as well as a personalized prevention plan tool for individuals to determine their disease risks and obtain tailored guidance on health promotion and disease prevention. In addition, the Secretary will provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees. Each State will be required to design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services.

**Sec. 4102. Oral healthcare prevention activities.** Establishes an oral healthcare prevention education campaign at the CDC, focusing on prevention and targeting populations including children and

pregnant women. Creates demonstration programs on oral health care delivery and strengthens surveillance capacity.

**Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan.** Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services.

**Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.** States would be required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use

**Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.** The Secretary would award grants to States to provide incentives for Medicaid beneficiaries to participate in programs promoting healthy lifestyles.

**Sec. 4201. Community transformation grants.** Authorizes the Secretary to award competitive grants to eligible entities for programs that promote individual and community health and prevent incidence of chronic disease.

**Sec. 4202. Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries.** The goal of this program is to improve the health status of the pre-Medicare-eligible population to help control chronic disease and reduce Medicare costs. The CDC will provide grants to States or large local health departments to conduct pilot programs in the 55-to-64 year old population. Pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk. Pilot programs will be evaluated for success in controlling Medicare costs in the community. Additionally, the Centers for Medicare & Medicaid Services (CMS) will conduct a comprehensive assessment of community-based disease self-management programs that help control chronic diseases. The Secretary will then develop a plan for improving access to such services for Medicare beneficiaries.

**Sec. 4206. Demonstration project concerning individualized wellness plan.** This pilot program provides at-risk populations who utilize community health centers with a comprehensive risk-factor assessment and individualized wellness plan to reduce risk factors for preventable conditions.

**Sec. 4301. Research on optimizing the delivery of public health services.** The Secretary, through the Director of CDC, shall provide funding for research in the area of public health services and systems. Research shall examine best practices relating to prevention, analyze the translation of interventions from academic institutions to clinics and communities, and identify effective strategies for delivering public health services in real-world settings.

**Sec. 4303. CDC and employer-based wellness programs.** Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers.

**Sec. 4306. Funding for childhood obesity demonstration project.** Appropriates \$25 million for a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity, which the Secretary must initiate under the Children's Health Insurance Program Reauthorization Act of 2009.

**Sec. 10408. Grants for small businesses to provide comprehensive workplace wellness programs.**

Authorizes an appropriation of \$200 million to give employees of small businesses access to comprehensive workplace wellness programs.

**Sec. 10413. Young women's breast health awareness and support of young women diagnosed with breast cancer.** Directs the Secretary of HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer. Supports prevention research activities at the Centers for Disease Control and Prevention (CDC) on breast cancer in younger women.

**Sec. 10501. National diabetes prevention program.** Establishes a national diabetes prevention program at the CDC. State, local, and tribal public health departments and non-profit entities can use funds for community-based prevention activities, training and outreach, and evaluation.

*Innovations in Quality and the Delivery and Costs of Care*

**Sec. 2703. State option to provide health homes for enrollees with chronic conditions.** Provides States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination.

**Sec. 3011. National strategy.** Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a federal health care quality internet website.

**Sec. 3012. Interagency working group on health care quality.** Requires the President to convene a working group comprising federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

**Sec. 3013. Quality measure development.** Authorizes \$75 million over five years for the development of quality measures at Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS). Measures must be consistent with the national strategy. As amended by Section 10303, requires the Secretary to develop and publicly report on patient outcomes measures.

**Sec. 3014. Quality measurement.** Provides \$20 million to support the endorsement and use of endorsed quality and efficiency measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.

**Sec. 3015. Data Collection; Public Reporting.** Requires the Secretary to collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information.

**Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.** The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program.

**Sec. 3501. Health care delivery system research; Quality improvement technical assistance.** Builds on AHRQ's Center for Quality Improvement and Patient Safety to support research, technical assistance

and process implementation grants. Grants funded will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services.

**Sec. 3502. Grants or contracts to establish community health teams to support the patient-centered medical home.** Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.

**Sec. 3506. Program to facilitate shared decision-making.** Establishes a program at HHS for the development, testing, and disseminating of educational tools to help patients, caregivers, and authorized representatives understand their treatment options.

**Sec. 3510. Patient navigator program.** Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients overcome barriers to health services.

**Sec. 10330. Modernizing computer and data systems of CMS to support improvements in care delivery.** Requires the Secretary of HHS to develop a plan to modernize the computer and data systems of CMS to support improvements in care delivery.

**Sec. 10331. Public reporting of performance information.** Requires the Secretary of HHS to develop a “Physician Compare” website where Medicare beneficiaries can compare scientifically sound measures of physician quality and patient experience measures.

**Sec. 10333. Community-based collaborative care networks.** Provides grants to develop networks of providers to deliver coordinated care to low-income populations.

**Appendix B: Instances of “Culturally and Linguistically Appropriate” in the ACA**

<b>Culturally and Linguistically Appropriate</b>	
<b>Section Number</b>	<b>Provision Title</b>
Sec. 1311	Affordable choices of health benefit plans.
Sec. 2715	Development and utilization of uniform explanation of coverage documents and standardized definitions.
Sec. 2719	Appeals process.
Sec. 4102	Oral healthcare prevention activities.
Sec. 5313	Grants to promote the community health workforce.
Sec. 5405	Primary care extension program.
Sec. 10410	Centers of excellence for depression