



# The Affordable Care Act & Racial and Ethnic Health Equity Series

## Report No. 1 Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges

March 2013

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Sponsored by Kaiser Permanente, Community Benefit, National Program Office  
In Collaboration with W.K. Kellogg Foundation and The California Endowment

*Version 2: Minor revisions incorporated September 2013*

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To obtain a copy of the report online, visit:  
<http://www.texashealthinstitute.org/health-care-reform.html>

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# Preface

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Data, research, and experience have demonstrated longstanding and extensive disparities in access to, quality, and outcomes of care for racially, ethnically, and linguistically diverse patients and communities in the U.S. health care system, despite significant efforts to address them. While lack of health insurance is a well established and major contributor to these disparities, children and adults from diverse racial and ethnic heritage often face significantly poorer care and health outcomes than white patients even when insured.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (together the Affordable Care Act or “ACA”) offer an unprecedented opportunity to bridge this divide. While expanding health insurance is a centerpiece in achieving this goal, the ACA includes dozens of provisions intended to close these gaps in quality and outcomes for racially and ethnically diverse and other vulnerable populations. In so doing, the new law provides important incentives and requirements to create a more equitable health care system by expanding the number of health care settings near to where people live and work, increasing diversity among health professionals, and addressing language and culture in delivery of services through innovative, clinical, and community-based approaches. But taking this vision and its well intentioned goals to reality in the short and longer-term will determine ultimate effectiveness and success.

The Texas Health Institute (THI) received support from the W.K. Kellogg Foundation, The California Endowment, and Kaiser Permanente’s Community Benefit National Program Office to monitor and provide a point-in-time portrait of the implementation progress, opportunities, and challenges of the ACA’s provisions specific to or with relevance for advancing racial and ethnic health equity. Given the ACA was intended to be a comprehensive overhaul of the health care system, we established a broad framework for analysis, monitoring, and assessing the law from a racial and ethnic health equity lens across five topic areas:

- Health insurance and the exchanges;
- Health care safety net;
- Workforce support and diversity;
- Data, research, and quality; and
- Public health and prevention.

This report is one of five THI has issued as part of the *Affordable Care Act & Racial and Ethnic Health Equity Series*, and it focuses specifically on the cultural and linguistic requirements in the ACA for health plans and the health insurance exchanges (also referred to as marketplaces). Major funding for this report is provided by Kaiser Permanente’s Community Benefit National Program Office.

# Executive Summary

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One of the centerpieces of health care reform as presented in the Affordable Care Act (ACA) is the creation of health insurance exchanges, also referred to as marketplaces, that will offer access to health insurance for millions of uninsured people in the U.S., especially low and moderate-income racially and ethnically diverse citizens and legal residents. One key to the effectiveness and success of the exchanges will be the ability of consumers to understand and navigate the process of choosing a plan and becoming insured. The ACA acknowledges this and incorporates requirements to ensure that cultural and linguistic competence be part of the exchange process in order to help as many people as possible, including those of limited English proficiency.

Our review has identified eight provisions in the ACA with specific requirements for cultural and linguistic appropriateness as well as non-discrimination and disparities reduction in health insurance exchanges and health plans:

1. Section 1311(b): Establishment of State Exchanges;
2. Section 1311(i): Culturally, Linguistically Appropriate Information in Exchanges;
3. Section 1311(e): Plain Language Requirement for Health Plans;
4. Section 1001: Culturally, Linguistically Appropriate Summary of Benefits and Uniform Glossary;
5. Section 1001: Culturally, Linguistically Appropriate Claims Appeals Process;
6. Section 1311(g): Incentive Payments in Health Plans for Reducing Disparities;
7. Section 2901: Remove Cost Sharing for Indians below 300 Percent of the Federal Poverty Level;
8. Section 1557: Non-Discrimination in Federal Programs and Exchanges.

The objective of this project is to track the progress to date on these provisions, identify and synthesize related resources, highlight model activities, and develop recommendations for states, health plans, federal agencies, and others to ensure effective implementation of cultural and linguistic requirements in health insurance exchanges. Our methods include literature reviews, analysis of the ACA and subsequent regulations and guidance issued by the federal government, and interviews with state exchange officials, health plan officials, advocacy groups, and the federal government. We review the progress of seven leading state-based exchanges in state case studies on California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington. We also give an overview of health plan progress on selected provisions and model cultural and linguistic competency programs in health plans.

Our findings reveal that the states examined are making good progress in establishing exchanges that meet cultural and linguistic competency provisions, and that other states can learn from their experiences and from activities within health plans when designing their exchanges. This report offers five broad recommendations with 12 specific actions for exchanges on ways to incorporate cultural and linguistic competency into their operations in order to meet federal requirements and to extend the opportunity for obtaining health insurance to traditionally underserved populations. The overall recommendations are:

1. Fully integrate diversity and equity objectives in exchange mission, objectives, and planning.
2. Work with trusted advocates and representatives who are reflective of diverse communities and are culturally and linguistically competent to provide appropriate and targeted outreach, education, and enrollment in the exchange.
3. Ensure culturally and linguistically appropriate information, resources, and communication is provided by the exchange.
4. Actively share and disseminate information on experiences, promising practices, and lessons learned in addressing diversity and equity in exchange planning.
5. Use active purchasing to ensure good value and high quality in health plans sold through the exchange and a reasonable number of choices at each benefit level.

Though no program can reach all people and there will still be work to be done, studies show that having health insurance helps in accessing health care, and getting needed health care improves health outcomes, so these activities are promising steps in reducing health and health care disparities in racially and ethnically diverse communities.

# I. Introduction

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One of the centerpieces of health care reform as presented in the Affordable Care Act (ACA) is the creation of Affordable Health Insurance Exchanges—more recently referred to as Health Insurance Marketplaces—which will offer access to health insurance for millions of U.S. residents. These new entities are intended to make available a choice of easily comparable insurance plans to individuals and small businesses and to subsidize insurance premiums for those who qualify. They will also educate consumers, assist them with determining eligibility for the exchange plans and public programs, and provide an electronic system for enrollment.

These insurance exchanges will open doors to many without insurance, especially low and moderate-income racially and ethnically diverse citizens and legal residents who frequently have been denied care due to lack of coverage. One key to the effectiveness and success of the exchanges will be the ability of consumers to understand and navigate the process of choosing a plan and becoming insured. As such, exchanges will need to provide clear information and other resources that aid consumers in understanding insurance options, appeals processes, and other parts of the exchange experience. Exchanges will also need to make a concerted effort to reach consumers who often opt out of coverage for a range of reasons—such as limited English proficiency, lack of understanding of eligibility and enrollment systems, or fear of being identified in the case of undocumented immigrants. The ACA acknowledges these priorities and incorporates requirements to ensure that these needs are taken into account for as many people as possible, in culturally and linguistically appropriate ways.

***“Cultural and linguistic competence***

is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989).”

–Office of Minority Health, U.S  
Department of Health and Human Services

As part of assuring equity in participation, the ACA has included provisions requiring that cultural and linguistic competence be part of the exchange process and experience. Our review has identified eight provisions in the ACA with specific requirements for cultural and linguistic appropriateness as well as non-discrimination and disparities reduction in health insurance exchanges and health plans. These include:

1. Section 1311(b): Establishment of State Exchanges;
2. Section 1311(i): Culturally, Linguistically Appropriate Information in Exchanges;
3. Section 1311(e): Plain Language Requirement for Health Plans;
4. Section 1001: Culturally, Linguistically Appropriate Summary of Benefits and Uniform Glossary;
5. Section 1001: Culturally, Linguistically Appropriate Claims Appeals Process;
6. Section 1311(g): Incentive Payments in Health Plans for Reducing Disparities;
7. Section 2901: Remove Cost Sharing for Indians below 300 Percent of the Federal Poverty Level;
8. Section 1557: Non-Discrimination in Federal Programs and Exchanges.

There are at least three main objectives of this report. First, it intends to provide a point-in-time snapshot of implementation progress of the eight provisions identified above. Second, it offers insight on promising programs and practices that have emerged among seven leading case study states and health plans addressing cultural and linguistic competence in their planning and operations. Finally, this report

provides a set of recommendations for states, health plans, federal agencies, and others initiating or working to implement cultural and linguistic requirements in health insurance and the exchanges.

To date and to our knowledge, there is no existing source which details national and state progress in implementing the ACA's cultural and linguistic requirements in the exchanges, nor a comprehensive resource which offers specific guidance on how to practically and effectively incorporate these provisions in planning and operations. In addition, federal guidance providing more details on many of these provisions is either incomplete or forthcoming. Given the fast-approaching deadline of October 1, 2013, when exchanges must begin enrolling consumers, state agencies and others are in need of more information on how to implement these requirements, to maximize outreach and enrollment among the nation's diverse communities. This report, therefore, is intended to be relevant to and assist exchange personnel, health plans, state and federal officials, organizations representing the vulnerable (especially racially and ethnically diverse patients and their communities), and others involved with health insurance exchange issues and programs to reduce disparities. Following are ways in which this report will be useful to a range of audiences:

- **State exchanges** in initial planning and development stages can look to the seven case study states on promising ways to effectively advance diversity, language access, and cultural competence within their programs. For leading states, this report can help to identify what others are doing, not only to reinforce efforts, but also to address any challenges a state may be facing in a particular area.
- **Health plans**, particularly those that may have limited experience serving a diverse client base, can draw on this report to identify promising actions other plans are taking to meet cultural and linguistic requirements mandated by the ACA, along with other supplemental and voluntary efforts many have in place to address racial and ethnic diversity and equity.
- **Community organizations** may draw on the report's research and sources to help advocate for their populations and to identify opportunities for collaboration with states, particularly to provide input on effective culturally and linguistically tailored programs for outreach and enrollment.
- **National organizations, the federal government, and policymakers** may find helpful information on emerging state and local best practices for addressing cultural and linguistic competence in health insurance that can inform future rules and guidance.

This report is organized into the following sections:

- I. **Introduction:** provides an overview of the goals, objectives, target audience, and value and use of this report. This section also describes the *Affordable Care Act & Racial and Ethnic Health Equity Series*.
- II. **Methodology:** discusses the framework, process, and specific activities that were undertaken in developing this report.
- III. **ACA Provisions, Regulations, and Guidance:** describes the legislative context for the eight provisions, along with federal regulations and guidance published and other implementation guidance from related reports.

- IV. **State Implementation Progress and Case Studies:** describes the status of state exchanges and selected state case studies showing progress and promising practices in implementing the cultural and linguistic provisions.
- V. **Health Plan Implementation Progress and Programs:** highlights progress that health plans have made in implementing ACA's cultural and linguistic requirements;
- VI. **Discussion:** provides a summary of all findings and their implications moving forward in reaching and enrolling diverse communities;
- VII. **Guidance for Integrating Cultural and Linguistic Priorities into Exchange Planning and Operation:** provides a set of five broad recommendations, with specific guidance, practices, and examples, for assuring health insurance and exchange planning and operation appropriately address cultural and linguistic requirements.
- VIII. **Conclusions and Areas for Future Study:** gathers conclusions and discusses topics for future study, due to the fact that many aspects of exchanges such as outreach and marketing to diverse communities and cultural and linguistic competency training for navigators and other assisters are still under development and could reveal useful practices after they are operational.

Given that health care reform is rapidly evolving, with new information and policies emerging almost daily, we emphasize this report offers a point-in-time snapshot of information, perspectives, and resources that were available during the time period this project was undertaken.

## *Affordable Care Act & Racial and Ethnic Health Equity Series*

### **Background and Context**

We have been monitoring and analyzing the evolution of health care reform and its implications for reducing disparities and improving equity since shortly after the inauguration of President Obama in 2009. With support from the Joint Center for Political and Economic Studies in Washington, D.C., the project team tracked major House and Senate health care reform legislation, identifying and reviewing provisions on workforce diversity, language, cultural competence, data collection by race and ethnicity, and other related racial and ethnic-specific initiatives. The team also tracked and compared the implications of broader proposals intended to improve access to insurance and health care, improve quality and contain costs for diverse populations. Nearly half a dozen summary reports and issue briefs were released, providing a resource for community advocates, researchers, and policymakers interested in understanding and comparing the significance and implications of these provisions.<sup>1,2,3</sup>

With the enactment of the Affordable Care Act (ACA), the project team developed a final report that identified and profiled over three dozen provisions specific to race, ethnicity, culture, and language into six major areas of priority: data collection and reporting; workforce diversity; cultural competence education and organizational support; health disparities research; health disparities prevention initiatives; and addressing disparities in insurance coverage. A second set of provisions addressed broader health reform initiatives—such as quality improvement, access, public health and social determinants—with potential relevance and implications for racially and ethnically diverse populations. As part of our analysis we summarized the importance of these provisions and raised issues or questions around implementation, federal agencies responsible for provisions, and appropriations if identified.

The final report, entitled *Patient Protection and Affordable Care Act: Implications for Racially and Ethnically Diverse Populations*<sup>4</sup> was released in July 2010 and was intended to offer a summary of the ACA in a user-friendly format and length as well as easily understandable language on specific priorities as they related to culture, language, and eliminating racial and ethnic disparities in health and health care. In so doing, the report demonstrated the ACA's broadly encompassing vision and opportunities spanning a spectrum of health-related priorities.

### **Purpose and Objectives**

Since the Supreme Court's historic decision to uphold the ACA, and the re-election of President Obama for a second term, the implementation of health care reform has gained momentum, and many provisions face very tight and rigid timelines. While the federal government has issued rules, standards and guidance for many broader provisions in a relatively short period of time, organizations and agencies await specific guidance for others addressing diversity, language access and cultural competence. At the same time, the complexity of the law, new and novel incentives and requirements and fluidity of its execution create significant challenges for states, health care providers, community organizations, advocates, and others in identifying obligations as well as opportunities they can directly tap or leverage to support the diversity and equity objectives of ACA.

The overall goal of the *Affordable Care Act & Racial and Ethnic Health Equity Series* is to provide an informative, timely, user-friendly set of reports as a resource for use by organizations and individuals working to reduce racial and ethnic health disparities, advance equity and promote healthy communities at the national, state and local levels. The *Series* is funded by W. K. Kellogg Foundation and The California Endowment, and additional support was provided by Kaiser Permanente's Community Benefit National Program Office to investigate health insurance exchange progress, with specific focus on seven case study states.

Following are objectives of this *Series*:

- To provide a point-in-time snapshot of implementation progress—or lack thereof—of nearly 60 provisions in ACA with implications for advancing racial and ethnic health equity, detailing their funding status, actions to date and how they are moving forward;
- To showcase concrete opportunities presented by ACA for advancing racial and ethnic health equity, such as funding, collaborative efforts and innovation, that organizations can take advantage of;
- To highlight any threats, challenges or adverse implications of the law for diverse communities to inform related advocacy and policy efforts; and
- To provide practical guidance and recommendations for audiences working to implement these provisions at the federal, state, and local levels, by documenting model programs, best practices, and lessons learned.

### **Design and Methodology**

The project team utilized a multi-pronged, qualitative approach to monitor and assess the implementation progress, opportunities, and challenges of roughly 60 provisions in the ACA across five topic areas:

- Health insurance and the exchanges;
- Health care safety net;
- Workforce support and diversity;
- Data, research and quality; and
- Public health and prevention.

For each topic area, the team conducted a comprehensive review of literature, along with an in-depth assessment of emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. As such, the following information was extracted for each provision within a topic area:

- Legislative language and context of provision, including timeline, funding, and players;
- Research evidence for importance and rationale related to addressing disparities;
- Summary of federal actions, such as issued rules, funding opportunities, and collaboration;
- Related national, state, and local models and programs as well as best practices, either informing implementation or that have emerged as a result of implementing;
- Guidance and recommendations for implementation from the federal government or national think tanks and policy experts, along with challenges and next steps for implementation.

To complement research and evidence gathered through a review of literature, and to fill important gaps in knowledge and experience, the team conducted telephone-based, semi-structured key informant interviews with nearly 70 national experts and advocates, federal and state government representatives, health care providers, health plans, community organizations, and researchers in the field. A full list of participants and contributors can be found in Appendix A.

A review of literature, latest policy updates, and gaps in knowledge guided the development of a series of key informant interview questions. Information gathered from each interview was manually sorted and analyzed to extract overarching common and distinct themes and sub-themes. Findings from the literature review, policy analyses, and interviews were synthesized into five topic-specific, user-friendly reports. Given each report is topic-specific and part of a larger *Series*, every attempt was made to cross-reference subtopics across the *Series*. For example, support for the National Health Services Corps is highlighted under the “Workforce”

topic, although it has direct relevance for and is cross-referenced to the “Safety Net” report. Organizing and cross-referencing the reports in this manner was important to streamlining the large amounts of information and ensuring the reports remained user-friendly.

### **Audience and Use**

With latest policy updates and research, complemented by voices and perspectives from a range of sectors and players in the field, the goal of this *Series* is to offer a distinct resource and reference guide on the implementation status of the ACA’s diversity and equity provisions and emerging opportunities and other actions to reduce disparities. However, given the health care arena is rapidly evolving and expanding, with new guidance, policies, and actions emerging almost daily at all levels, this *Series* offers a point-in-time snapshot of information, perspectives, and resources that were readily available and accessible during the time this project was undertaken. Information and updates as of mid-February 2013 have been incorporated into this brief; however, anything more recent is not captured here. Nonetheless, information, review and findings are intended to be helpful for a broad audience from national, state, and local agencies and organizations.

Following are examples of how a range of sectors may find this *Series* of value and use:

- National organizations or federal government agencies may find information on emerging state and local models and practices for addressing disparities to inform rules and guidance they issue to help others implement specific provisions of the law.
- Nonprofit or community organizations may find the report helpful in laying out specific opportunities for collaboration with federal and state government.
- National and community advocacy organizations may draw on the report’s research and evidence to advocate for appropriations or continued funding for certain diversity and equity objectives.
- Health care providers, state public health agencies and health plans may look to the report for guidance on how to effectively implement reforms related to advancing diversity, language access, and cultural competence within their systems and programs, identifying in particular funding opportunities, guidance, and best practices.
- Policymakers charged with implementing or otherwise taking advantage of related provisions in advancing racial and ethnic health equity nationally, in their states and communities.

## II. Methodology

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We utilized a multi-pronged, qualitative approach to monitor and assess the implementation progress, opportunities, and challenges of the Affordable Care Act's (ACA) cultural and linguistic requirements for health insurance and the exchanges, along with tracking state-level progress, programs and models for seven states. We note that while the federal government is now referring to the exchanges as "health insurance marketplaces," or simply "marketplaces," we refer to them as "exchanges" in the report as this was the terminology included in the original legislation as well as in subsequent rules, regulations, and information that emerged at the time of this writing. In this section, we provide a brief overview of our methodology.

***Literature and Policy Review.*** We conducted a comprehensive review of literature on racial and ethnic disparities in health and health care generally and in context of the Affordable Care Act, complemented by a review of federal regulations, policies, and guidance that have been published to date for implementing each of the eight provisions. Given the constantly evolving nature of the field, information and research included in this report is current as of mid-February 2013. In addition, we conducted an extensive review of research and articles on state activities, particularly related to health-related cultural and linguistic programs that can inform what is required for exchanges, including existing programs in health plans and Medicaid that may help states and others implementing the ACA's provisions. We also reviewed literature on health insurance plans, particularly information on how they are implementing the provisions that apply to health plans, lessons that could help other health plans, and on previous programs that could help inform the new activities.

***State Case Studies.*** We conducted an extensive review of state-level progress and actions around planning and implementation of health insurance exchanges. Our review identified at least seven states—most often cited in reports and articles for their fast-paced progress—both in terms of setting up their exchanges and in addressing diversity, equity, and cultural and linguistic competency prior to enactment of the ACA, as well as after. As such, these seven states were selected for detailed investigations or case studies on their progress, challenges, and emerging programs and practices for reaching and enrolling diverse communities in culturally and linguistically appropriate ways, as required by the ACA. The objective of these cases studies is two-fold: (1) to provide a point-in-time portrait of state progress and actions; and (2) to offer models, experiences, and lessons learned that may inform other states in earlier stages of development effectively address and integrate cultural and linguistic requirements.

While the main criteria for choosing states was progress in implementing their state-based exchanges and in related diversity programs other considerations were to choose states in several different parts of the country and states that have relatively higher percentages of Non-White and limited English proficiency populations. Using these criteria we identified the following states for case studies:

- California;
- Colorado;
- Connecticut;
- Maryland;
- New York;
- Oregon; and
- Washington.

The case studies contain only states that are establishing state-based exchanges, since the states choosing to have partnership exchanges and federally facilitated exchanges, in general, were not as far along in

exchange planning and activities during our research period, especially as the deadlines were extended for states to inform the federal government which type of exchange they will establish.

***Key Informant Interviews.*** To obtain the most recent information and the perspectives from individuals currently working on these issues, we interviewed state exchange officials from all seven case study states, representatives from community and advocacy organizations, and health plans across the country. Appendix A contains a list of individuals interviewed as key informants, and others who contributed information and feedback for our project. Appendix B shows the interview questions for the categories of people we contacted—we modified these when needed and also asked additional situational and follow-up questions in some interviews, and interviewees often provided further information on other related topics as well. We gathered names and contact information for people to interview from various sources including meetings we attended, reports we reviewed, and references from other people we spoke to.

Information from the interviews can be found throughout the sections of the report, and respondents were told that their responses would not be attributed or quoted without their permission. Responses were not statistically analyzed and are not intended to be a representative sample of states or organizations in these categories. Rather, this information is qualitative in nature and serves to further inform the implementation of the specific ACA provisions and provide information on the challenges and successes to date.

## III. ACA Provisions, Regulations, and Guidance

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This section summarizes the eight provisions in the Affordable Care Act (ACA) examined in this report, including an overview of federal regulations that have emerged with further details following the enactment of the law. It also includes related guidance and information from the federal government and other organizations to assist with implementation. Appendix C includes details on these eight provisions including full text excerpts for context, additional sources, and the dates and development of subsequent regulations.

### 1. Section 1311(b): Establishment of State Exchanges

Section 1311(b) of the ACA broadly outlines the establishment of health insurance exchanges, or marketplaces, that are to operate in each state for individuals and small businesses by January 1, 2014, to facilitate the purchasing of health insurance plans.<sup>5</sup> Exchanges can be operated by the state or by the federal government if a state chooses not to run its own, and an option was added in 2011 for a state and the federal government to partner on an exchange.

Guidance for federally facilitated exchanges and a blueprint for the government to approve state-based and partnership exchanges was released in 2012.<sup>6</sup> States pursuing state-based exchanges had to submit a declaration letter and an exchange application to the Centers for Medicare & Medicaid Services (CMS) by December 14, 2012, and states choosing to have federally facilitated exchanges with their own reinsurance programs also had to send a declaration letter with the required details by this deadline. States not pursuing a state-based exchange had until February 15, 2013, to decide if they wanted to establish a partnership exchange. Additional guidance for partnership exchanges was released in January 2013.<sup>7</sup>

In states not ready to operate a state-based exchange on January 1, 2014, a federally facilitated exchange will begin at that time and the state can switch to a state-based exchange in subsequent years, with 12 months' notice (states can also discontinue their state-based exchange and switch to a federal exchange). States will need to have transition plans to detail how these changes will take effect and not harm consumers or insurance companies.

Enrollment for health insurance through the exchanges in every state begins October 1, 2013, and coverage starts on January 1, 2014.

The state implementation section of this report shows state progress on setting up exchanges and which states will have state-based, partnership, and federally facilitated exchanges in 2014. There have been unforeseen delays in establishing exchanges, and far more states are planning to develop federal exchanges than was originally anticipated by the U.S. Department of Health and Human Services (HHS)—to date 26 states are deferring to federal exchanges. HHS has extended several deadlines and waived a deadline for approval of exchanges that was originally January 1, 2013, in order to encourage states to keep working and to take on at least some functions of their exchanges.

### 2. Section 1311(i): Culturally, Linguistically Appropriate Information in Exchanges

One of the requirements of the exchanges established in the ACA Section 1311 is having a navigator program to assist consumers, and the law provides that information must be “culturally and linguistically appropriate” in the exchanges.<sup>8</sup> Final rules issued in March 2012 state that the exchange must develop training standards for navigators to make sure they are qualified in areas such as meeting the needs of underserved populations, and reinforces that information must be provided “in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including

individuals with limited English proficiency.”<sup>9</sup> HHS stated in the *Federal Register* that it will issue guidance in the future on model standards for cultural and linguistic competency, and also that “(w)e encourage Exchanges to undertake cultural and linguistic analysis of the needs of the populations they intend to serve and to develop training programs that ensure Navigators can meet the needs of such populations. We note that we do not believe that this standard can be met by simply having consumers’ family members or friends serve as interpreters.”<sup>10</sup>

In addition to the requirements for navigators, final exchange rules in 2012 on accessibility specify that all applications, forms, and notices sent by an exchange to applicants, enrollees, and employers, and all outreach and education on the exchange and insurance affordability programs, as well as notices from health plans, must meet standards including being in plain language and having taglines on it in other languages indicating the availability of written and oral language services.

“...we do not believe that this standard [for cultural and linguistic competency] can be met by simply having consumers’ family members or friends serve as interpreters.”

–HHS, March 2012

Between the ACA and subsequent regulations, all aspects and communications of an exchange and of a health plan in an exchange are required to be in plain language and provide language services for individuals with limited English proficiency. The state implementation section discusses what some leading exchanges are planning to do in the area of culturally and linguistically appropriate information in exchanges, and the health plan implementation section shows a number of promising models from health plans’ experiences in this area.

### 3. Section 1311(e): Plain Language Requirement for Health Plans

Another part of Section 1311 on exchanges (which was amended by an addition in Section 10104) lays out the data that health plans wanting to be in an exchange must submit, including financial disclosures and enrollment data, and requires that these items be in “plain language” so that people, including those with limited English proficiency, can easily understand them.<sup>11</sup> The ACA requires that health plans in an exchange submit a variety of health plan data and make them available to the public in plain language, and final rules published in 2012 also require exchanges to provide information to applicants and enrollees in plain language.

“The term ‘plain language’ means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.”

–Affordable Care Act, §1311(e)

Plain language is briefly defined in the ACA and more federal guidance is forthcoming. The future guidance will presumably build on the foundation established by the Plain Writing Act of 2010<sup>12</sup> pertaining to all federal government agencies.<sup>13</sup> HHS as well as other agencies have websites on plain writing that show their progress in this area.<sup>14</sup> As shown in the health plan implementation section, many health plans have experience with modifying their materials to use plain language principles, and there are a number of toolkits and resources

available with instructions on plain language, so this requirement should not be difficult for health plans in an exchange to meet.

#### 4. Section 1001: Culturally, Linguistically Appropriate Summary of Benefits and Uniform Glossary

Section 1001 of the ACA, which amends the Public Health Service Act by adding certain requirements, specifies that all health plans must start using a standard summary of benefits document that is culturally and linguistically appropriate and must provide a standard glossary of insurance terms to their customers and others.<sup>15</sup>

Final rules published in 2012 provide more details and state that group and individual health plans must provide two documents to all beneficiaries, employers, and others who ask—a Summary of Benefits and Coverage (SBC) and a Uniform Glossary. This takes effect for plan years beginning on or after September 23, 2012, and these documents must meet federal standards including language guidelines and must be provided at certain times such as before the first day of coverage and at renewal.

These final rules state that to meet the requirement to provide the SBC in a culturally and linguistically appropriate manner, a health plan must follow the same language rules as required for providing notices on claims appeals processes in different languages (also in the ACA and codified in the Public Health Service Act). HHS released guidance in 2012 providing templates and instructions for compliance with the rules on summaries and glossaries, including more details on the language requirements. Health insurance plans must provide summaries of benefits in other languages when 10 percent or more of the population living in the consumer’s county are literate only in the same non-English language, which will be determined annually based on data from the American Community Survey published by the U.S. Census Bureau. For 2012, 255 U.S. counties (including 78 in Puerto Rico) met this threshold—most of these are for the Spanish language but a few are for Chinese, Tagalog, and Navajo.<sup>16</sup>

Health insurance plans must provide summaries of benefits in other languages when 10 percent or more of the population living in the consumer’s county are literate only in the same non-English language.

Summary of Benefits and Coverage templates and translated documents in English, Spanish, Chinese, Tagalog, and Navajo are available on the HHS website. These will be updated after the first year to incorporate new requirements, and additional languages will be added as needed.

SBC templates and examples of translated documents are available on the HHS website.<sup>17</sup> These will be updated after the first year since once the ACA is in full effect in 2014, new statements will need to be added to the summaries such as information on minimum essential coverage and minimum value. HHS will release guidance in the future on these topics.

Health plans must provide the uniform glossary within seven days of request and must use the standard glossary developed by the federal government (with input from the National Association of Insurance Commissioners and others) “in the appearance specified by the Departments.”<sup>18</sup> Health plans must refer people to an online version of the glossary (linking to the plan’s own website or to a federal website) as well as provide a phone number that people can call to request a paper copy—the glossary is available in five languages and more may come later.<sup>19</sup>

As mentioned in the health plan implementation section, this provision is already in effect and health plans appear to be following it. Some health plans that have enrollees who speak other languages besides the federally designated threshold languages are using their own additional summaries of benefits and coverage and glossaries as well as the federal ones for these populations.

## **5. Section 1001: Culturally, Linguistically Appropriate Claims Appeals Process**

Section 1001 also amends the Public Health Service Act to require that notices to consumers on the processes for appealing claims and coverage determinations must be provided in a “culturally and linguistically appropriate manner.”<sup>20</sup>

Interim final rules and amendments in 2010 and 2011 state that non-grandfathered health plans must provide claims appeals notices upon request in languages other than English if the address to which the notice is sent is located in a county where 10 percent or more of the population is literate only in the same non-English language. The original rules in 2010 had different language thresholds for group and individual plans and sizes of plans, but due to comments received the threshold was changed in the amendments to be the same for all plans.<sup>21</sup> As mentioned above regarding the requirements for the Summaries of Benefits and Coverage, the list of counties reaching this threshold is published online and will be updated annually.<sup>22</sup>

In these counties the health plan must include in the English version of all notices a statement in the non-English language with information on how to access the language services provided by the health plan (the Department of Labor has provided some model language online).<sup>23</sup> The plans may choose to include the statements on all their documents, not just ones in the certain counties, to make administration easier. If plans must send notices to people in counties meeting the non-English language threshold, the plans must provide oral language services (such as a telephone hotline) that include answering questions in the applicable languages and assisting customers with filing claims and appeals, including external review, in the applicable non-English languages.<sup>24</sup> The amendments apply to plan years that start on or after January 1, 2012.

As noted in the health plan implementation section, not all health plans were handling internal and external appeals to the extent required by the ACA, so they have adjusted their processes to meet this requirement. Many advocacy groups take issue with the 10 percent language threshold rule for translation for claims appeals and other services and feel it should be lower in order to accommodate more non-English speaking people.<sup>25</sup>

## **6. Section 1311(g): Incentive Payments in Health Plans for Reducing Disparities**

Section 1311(g) was amended by Section 10104 of the ACA, which added another set of activities that health plans or their providers can do to obtain increased reimbursements or other incentives. These additional activities involve reducing disparities by means such as “language services, community outreach, and cultural competency trainings.”<sup>26</sup>

This section says that the HHS Secretary will consult experts and stakeholders and develop guidelines on implementing market-based incentives in health plans that carry out certain activities aiming to reduce health care disparities. No federal guidelines have been issued on this topic at the time of this writing, so it is not clear what this provision will entail. Most health plans already do at least some of these activities, and some plans have provider incentives as part of other quality programs, so it remains to be seen what the payment structure would be and who would be rewarded. This provision is also discussed in the health plan implementation section.

## 7. Section 2901: Remove Cost Sharing for Indians below 300 Percent of the Federal Poverty Level

Indians (American Indians and Alaska Natives as defined in another law referenced in the ACA) are mentioned in several places throughout the ACA and subsequent regulations, and are provided some special allowances. Section 2901 of the ACA, and Section 1402 that it refers to, specifies that Indians will pay no cost-sharing for health care from a plan in an exchange if they have incomes below 300 percent of the federal poverty level. It also states that Indians enrolled through the exchange will not need to pay any cost-sharing for items and services they receive from the Indian Health Service and tribal organizations.<sup>27</sup>

Besides Indians in the exchanges having no out-of-pocket costs for copays and deductibles in certain situations, the ACA states in Section 1311 that exchanges are required to provide monthly enrollment periods for Indians, not annually as for other consumers, so they will have more chances to choose or change their health plans.<sup>28</sup> HHS stated in March 2012 in comments with the final exchanges rules that future regulations will be issued to clarify the issues related to Indians.

American Indians and Alaska Natives will not have to pay cost-sharing in health plans purchased through an exchange if their incomes are below 300 percent of the poverty level, will not have to pay for health services from the Indian Health Service and tribal organizations, and will not be required to maintain minimum health coverage. Exchanges must formally consult with federally recognized tribes in their service areas.

The ACA requires that exchanges consult with various stakeholders, and the March 2012 final exchange rules add Indians to this list, saying that exchanges must regularly consult with certain stakeholders including “Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994... that are located within such Exchange’s geographic area”<sup>29</sup> The final exchange rules say that Indian tribes, tribal organizations, and urban Indian organizations are included in the groups eligible to be navigators. The associated comments in the *Federal Register* state that, “Development of the Navigator program should be an important element of Exchanges’ consultation with Tribal governments. The Navigator program will help ensure that American Indians and Alaska Natives participate in Exchanges.”<sup>30</sup> It also states that guidance will be provided in the future concerning “key milestones, including tribal consultation, for approval of a State-based Exchange.”<sup>31</sup>

The ACA establishes that members of Indian tribes are exempt from the individual mandate, so they will have no penalties for not having the minimum coverage required of most other people.<sup>32</sup> Relating to health care for Indians, the ACA also revises and permanently authorizes the Indian Health Care Improvement Act (first enacted in 1976), providing for several new programs and financial arrangements.<sup>33</sup>

California has the most American Indians, followed by Oklahoma and Arizona; the national population of American Indians was 5.1 million in 2011.<sup>34</sup> American Indians and Alaska Natives are the only U.S. citizens with a legal right to health care, established through various agreements between tribes and the U.S. government going back to 1787. The Indian population experiences much higher health and health care disparities than the general population, and the ACA aims to reduce these.<sup>35,36</sup>

As detailed in the case studies in the state implementation section, all of the study states with federally recognized Indian tribes are meeting with tribal leaders and developing consultation policies, and some state exchanges such as Oregon and Washington are hiring tribal liaisons. The Centers for Medicaid and Medicare Services (CMS) also consults with tribes on health care reform measures through monthly telephone calls and other means.<sup>37</sup>

## 8. Section 1557: Non-Discrimination in Federal Programs and Exchanges

The ACA contains a section that extends the protections of previous anti-discrimination laws to the additional health programs in the ACA receiving federal funding including the new health insurance exchanges. On the grounds of the Civil Rights Act and other acts individuals “shall not...be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).”<sup>38</sup>

As referenced in the acts cited in Section 1557, several anti-discrimination laws related to race, ethnicity, and other factors are already in place and the ACA applies these protections to new health care programs receiving federal assistance. The March 2012 final rules explicitly add that states and exchanges must comply with federal standards and “not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.”<sup>39</sup>

In comments published in the *Federal Register*, HHS stated that commenters requested clarification on the non-discrimination standards and had recommendations on compliance, and that future federal guidance will be issued on the oversight and enforcement of these standards.<sup>40</sup>

The non-discrimination requirement likely applies also to qualified health plans in an exchange, and to their subcontracted providers, because credits and subsidies going to a health plan could be considered federal financial assistance.<sup>41</sup>

## IV. State Implementation Progress and Case Studies

This section describes how states are progressing in implementing a health benefit exchange or marketplace, including providing culturally and linguistically appropriate information, outreach, and resources. It contains an overview of what type of exchange each state plans to establish, and then looks at progress in meeting the cultural and linguistic requirements and promising practices in seven case study states. For these states we examine the characteristics of the states and their exchanges, the status of their cultural and linguistic competency activities in the exchange, and any disparities or equity-related legislation or other programs that can inform or advance requirements put forth by the Affordable Care Act (ACA).

It is important for exchanges to meet the needs of racially and ethnically diverse populations since the exchanges are predicted to have higher percentages of these groups enrolling as compared to traditional employer-based insurance. An estimated 29 million people will have insurance through the exchanges by 2019, and of the 24 million who will have individual insurance (and not group insurance through small businesses, estimated to be 5 million), 42 percent will be Non-White, compared to 27 percent Non-White in private employer-based insurance.<sup>42</sup> Table 1 shows the percentages of different racial and ethnic groups predicted to enroll in individual insurance through the exchanges as compared to people in private employer-based insurance. Approximately one-fourth of the exchange population will be comprised of Hispanics, and nearly one-fourth will speak a language other than English at home.

**Table 1.**  
**Percent Racial and Ethnic Groups in Exchanges vs. Employer-Sponsored Insurance**

	Individual Insurance in Exchanges (by 2019)	Employer-Sponsored (currently)
<b>White</b>	58%	72%
<b>Black</b>	11%	10%
<b>Hispanic</b>	25%	10%
<b>Other</b>	6%	7%
<b>Language other than English Spoken at Home</b>	23%	7%

*Source:* Kaiser Family Foundation, “A Profile of Health Insurance Exchange Enrollees” (March 2011), online at <http://www.kff.org/healthreform/upload/8147.pdf>, accessed 5 Nov. 2012.

Of the people estimated to obtain insurance through the exchanges, 65 percent will be uninsured, meaning they may need more assistance to understand the different options. Approximately, 82 percent of people in the exchanges will have incomes below 400 percent of the federal poverty level, qualifying them for government subsidies.<sup>43</sup>

### Status of State Exchanges

The new health insurance exchanges will provide a marketplace for individuals and small businesses to compare and buy health insurance plans. States can choose to have a wholly state-based exchange, to partner with the federal government on certain aspects of their exchanges such as eligibility and enrollment, or defer to the federal government to operate their exchanges. States also can choose to have several regional exchanges within the state, or to join with other states in a combined multi-state

exchange, but so far no states have chosen either of these options. Several smaller states discussed joining together but decided it would be too challenging due to differences in state insurance regulations.<sup>44</sup>

Table 2 and Figure 1 show which states, as of February 2013, have elected to have which type of exchange in 2014 (states have the option of changing their types of exchanges in future years with advance notice to the Department of Health and Human Services). As of February 15, 2013, 17 states plus the District of Columbia plan to have state-based exchanges. Seven states plan to partner with the federal government on their exchanges, and 26 states will have the federal government run their exchanges.

**Table 2.**  
**Types of Health Insurance Exchanges for the States**

State-Based Exchanges	Partnership Exchanges	Federally Facilitated Exchanges
California	Arkansas	Alabama
Colorado	Delaware	Alaska
Connecticut	Illinois	Arizona
D.C.	Iowa	Louisiana
Hawaii	Michigan	Florida
Idaho	New Hampshire	Georgia
Kentucky	West Virginia	Indiana
Maryland		Kansas
Massachusetts		Maine
Minnesota		Mississippi
Nevada		Missouri
New Mexico		Montana
New York		Nebraska
Oregon		New Jersey
Rhode Island		North Carolina
Utah		North Dakota
Vermont		Ohio
Washington		Oklahoma
		Pennsylvania
		South Carolina
		South Dakota
		Tennessee
		Texas
		Virginia
		Wisconsin
		Wyoming

*Source:* Kaiser Family Foundation, State Health Facts, “State Action Toward Creating Health Insurance Exchanges” (Feb. 15, 2013), online at <http://statehealthfacts.kff.org/comparemactable.jsp?ind=962&cat=17>, accessed 15 Feb. 2013.

The following map graphically shows the different types of exchanges that the states plan to have for 2014.



## *Massachusetts*

The Massachusetts Health Connector was established as an independent state agency in 2006 to provide coverage for the uninsured in the state, and this and other health care reforms in the state served as models for the ACA. The exchange is an active purchaser of health plans and offers two insurance programs for individuals (subsidized or not, depending on income) and small businesses.<sup>47</sup> With Medicaid expansion, access to employer-sponsored insurance, and an individual mandate encouraging enrollment, the state now has the lowest rate of uninsured in the nation at 4 percent.<sup>48</sup>

After the Chapter 58 health reform legislation passed in 2006, Massachusetts began outreach, education, marketing, and enrollment efforts to reach the uninsured, including dozens of meetings around the state, mass mailings, and advertising to targeted audiences such as on public transportation and in churches.<sup>49</sup> The state exchange and Medicaid agencies along with Blue Cross Blue Shield of Massachusetts Foundation and the Robert Wood Johnson Foundation published five reports in the Health Reform Toolkit Series that cover examples, templates, and lessons from Massachusetts in the areas of outreach, education, health benefit designs, websites, and other aspects of starting an exchange.<sup>50</sup>

The Massachusetts Health Connector served as a model for the state exchanges in the Affordable Care Act. Reducing racial and ethnic health coverage disparities is one of the objectives of Massachusetts' health care reform.

Reducing racial and ethnic health coverage disparities is one of the objectives of Massachusetts' health care reform, with the establishment of the Health Disparities Council; it is also a goal of the Health Care Quality and Cost Council. With these efforts and many other activities targeting racial and ethnic communities, populations with limited English proficiency, and low-income families, studies have found that insurance rates have increased and health care disparities have been reduced, though some often still remain.<sup>51</sup>

Hispanics had gains in coverage more than twice that of Whites in Massachusetts, but they were still more likely to be uninsured. Overall, 96 percent of non-Hispanic Whites had insurance in 2009 compared to 79 percent of Hispanics. But when language was taken into consideration, the difference was greater, with English-speaking Hispanics having coverage rates similar to Whites, but only an estimated 67 percent of limited English proficient Hispanics having insurance. There are also language and financial barriers keeping Hispanics from accessing doctors and using their insurance even when they have it.<sup>52</sup> Another study reported that as Blacks or African Americans gained coverage in Massachusetts, the White population had similar gains, so even though more Black or African Americans were covered after health reform, the gap in coverage remained.<sup>53</sup> These studies show that language and cultural competency are crucial to successful enrollment and uptake of insurance, and in eliminating coverage disparities.

The exchange is making modifications to comply with the ACA and has received a planning grant, two Level I establishment grants, and an early innovator grant as part of the New England consortium.<sup>54</sup> It received conditional approval for a state-based exchange from HHS in December 2012.

## *Utah*

Utah's health insurance exchange, created in 2008 and renamed Avenue H in fall 2012, existed before the ACA and offers insurance to small employers only (defined as 2-50 people).<sup>55</sup> This limitation and some other aspects of the exchange will need to change so it can meet the standards of a state exchange under the ACA.<sup>56</sup> Utah's exchange, administered by the Office of Consumer Health Services within the Governor's Office of Economic Development, is not an active purchaser and does not regulate health plans. The exchange's "hands-off" marketplace approach as compared to the pre-ACA exchange in Massachusetts has some political and other constituents interested in it as a model versus the more

regulated exchanges that aim to transform the healthcare system.<sup>57,58</sup> In November 2012, the exchange covered over 7,500 people (employees and family members) in 318 employer groups.<sup>59</sup>

The exchange is starting activities to help consumers, such as listing insurance companies on its website that offer individual insurance that people can contact directly, improving the website interface, and providing education and decision support to consumers.<sup>60,61</sup> Utah received an exchange planning grant but not subsequent establishment grants. The exchange asked HHS in December 2012 to certify it as a state-based exchange, and it received conditional approval in January 2013, dependent on it establishing an individual market, a navigator program, and other requirements.

### ***Other Exchanges***

The concept of a health insurance exchange or a combined risk pool for individuals or small businesses is not new, though the Internet adds a new layer of convenience for consumers and federal requirements in the ACA and subsequent regulations add new complexities and new consumer protections. California, Texas, New York, and Florida are some of the states that have or had specialized exchanges, with varying results.

Possibly the first health insurance exchange was established in California in 1992 to help small businesses join together to negotiate for better health insurance premiums. Called Health Insurance Plan of California, and later PacAdvantage after it was taken over by the Pacific Business Group on Health in 1996, the exchange closed in 2006 as premiums rose due to adverse selection, causing shrinking enrollment after premiums became higher in the exchange than outside of it. At its height the exchange had 150,000 members, which was about 2 percent of the small group market.<sup>62</sup>

The Texas Insurance Purchasing Alliance was created in 1993 by Texas legislation to help small businesses with 50 or fewer employees obtain health insurance for lower and comparable rates charged to larger companies. It was successful at first but closed six years later, partly due to insurers signing up businesses with generally healthier employees outside the exchange and leaving those with more health costs to obtain insurance through the exchange (sometimes known as “cherry-picking”), making costs rise significantly.<sup>63</sup>

#### *Other Past and Present Pre-ACA Health Insurance Exchanges*

- 1992: Health Insurance Plan of California (later PacAdvantage)
- 1993: Texas Insurance Purchasing Alliance
- 1999: HealthPass New York
- 2008: Florida Health Choices

HealthPass New York started in 1999 as a non-profit exchange to help small businesses in the five boroughs of New York City, two counties on Long Island, and seven counties in the Hudson Valley region. It is a defined contribution model, and employees can choose from four types of health plans (in-network only, in- and out-of-network, cost-sharing, and consumer-directed plans with health saving accounts) through four carriers. It uses a common enrollment form for all plans and carriers and its website allows side-by-side comparisons; enrollment can happen through brokers or online. It now has over 30,000 members from 3,500 small businesses.<sup>64,65</sup>

Florida Health Choices was created in 2008 to offer health insurance to small business, small towns, certain counties and school districts, rural hospitals, and some individuals such as state retirees and state employees not eligible for benefits. It has been slow to get off the ground but the web portal is online and it signed up some health insurers in 2012, and plans to start enrolling people in 2013.<sup>66,67</sup>

Being statewide, having a larger market share of the insurance market, requirements for outreach and consumer assistance, offering subsidies to people who qualify, and the mandate for almost all people to have health insurance should help the new state exchanges enroll enough people and be sustainable in

ways that some previous smaller exchanges could not. In addition, the ACA interim final rules published in March 2012 allow public exchanges to contract with “web-based entities” such as agents and private exchanges as an alternative enrollment channel, so there may be a place for some of the current private exchanges in the new state exchanges.<sup>68</sup>

## **State Case Studies: Progress and Promising Practices**

The following case studies examine the health insurance exchanges of seven states: California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington. The case studies include demographic information, features of the exchange, and overviews of their policies and planning activities regarding stakeholders and diversity, including communicating with federally recognized Indian tribes as required in the ACA, and some of the advocacy groups that have had input. The next parts of each case study contain examples of state legislation and programs related to diversity and disparities, some existing state models for exchange activities, and overviews of the exchanges’ planned navigation and outreach programs that include cultural and linguistic competency.

The case studies are not intended to be comprehensive reviews of states’ activities building their exchanges or reducing disparities, but are meant to give an overview of progress to date across leading exchanges and to highlight relevant health equity and cultural and linguistic competency activities that states may find informative and adaptable to their own circumstances and needs. The sources cited were supplemented with interviews with key informants from each state.

## California

### **California at a glance:**

2011 population:<sup>69</sup> **37,691,912**  
Percent of population that is Limited English Proficient:<sup>70</sup> **19.9%**  
Percent of population that is Non-White:<sup>71</sup> **60.4%**  
Percent uninsured:<sup>72</sup> **20%**  
Type of health insurance exchange: **State**  
Exchange grants:<sup>73</sup> **Planning, Level I (2) and Level II Establishment**



### **The Exchange and Stakeholders**

California was the first state in the nation to establish an exchange after the ACA, passing legislation that was signed into law in September 2010. The exchange, named Cover California, is defined as a quasi-governmental organization and is an independent public entity governed by a five-member board. The exchange will be an active purchaser of health plans, and will keep the individual and small business exchanges separate.<sup>74</sup> The exchange received conditional approval from HHS in January 2013.

The vision, mission, and values of the exchange mention diversity and reducing disparities in several places. The mission statement is “to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.” One of the six values is *consumer-focused*, which is defined as: “At the center of the exchange’s efforts are the people it serves, including patients and their families, and small business owners and their employees. The exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.”<sup>75</sup>

According to the exchange legislation, the board must be diverse and represent the different ethnicities in the state. While this is partially reflected in the current board, fully meeting this requirement has been challenging given the board is appointed by three different entities with differing missions and also due to strong conflict of interest rules that prevent insurers, health providers, and some others who may be interested from being appointed.<sup>76</sup> The exchange plans to ensure its staffing also reflects the diversity of the state. Recently, the exchange was considering establishing a specific position for a coordinator of cultural and linguistic access issues. However, given the enormity of the role for one individual, it was later decided that cultural and linguistic access issues be a part of positions across multiple departments.

“The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.”

—California exchange value statements

The exchange established three new stakeholder advisory groups in fall 2012 whose members will represent the cultural, linguistic, and geographic diversity of the state. The advisory groups address the topics of: (1) Plan management and delivery system reform; (2) Marketing outreach and enrollment assistance; and (3) Small employer health options program (SHOP).<sup>77</sup> The exchange also engages stakeholders in other ways, such as: board meetings (which are webcast) and include opportunities for public comments; an e-mail distribution list of exchange updates to over 2,500 people; public meetings around the state; webinars for stakeholders to participate in and give feedback on a variety of topics; and workgroups on individual and small business issues.<sup>78</sup>

In fall 2012, the exchange also established a Tribal Advisory Workgroup following a formal meeting with Native American tribes in the state in July 2012.<sup>79</sup> The board approved a final Tribal Consultation Policy in November 2012 after meeting with tribal leaders and studying the tribal consultation policies of Oregon and other states. This policy provides for ongoing communications and consultation between the exchange and the tribes through a formal annual meeting, other meetings as needed, and the Tribal Advisory Workgroup.<sup>80</sup>

Many community and advocacy groups in California have been active in meeting with exchange officials, giving feedback, and helping to craft exchange policies. These include:

- Health Access;
- California Pan-Ethnic Health Network;
- Latino Coalition for a Healthy California; and
- Greenlining Institute.

### ***Existing Relevant Cultural and Linguistic Competency Legislation and Programs***

California has the highest percentage of population with limited English proficiency in the nation (19 percent), and the third-highest proportion of Non-Whites (60.4 percent), behind Hawaii and Washington, D.C. Given its rich diversity, California has long recognized the need to make public services culturally and linguistically appropriate. In particular, the state has invested in ensuring information on its public programs is available in languages other than English. For example, California's Medicaid program Medi-Cal has 13 threshold languages (including English) that Medi-Cal health plans have to translate their documents into if their enrollees' languages reach certain levels, depending on plan size and other factors. The exchange plans to make all outreach materials and other key materials in the exchange available in those 13 languages, not just the four threshold languages mentioned in the ACA regulations. These languages are Arabic, Armenian, Chinese, English, Farsi, Hmong, Khmer, Korean, Laotian, Russian, Spanish, Tagalog, and Vietnamese. The exchange website itself will be available in English and Spanish, and will have links to telephone, online chat, or Interactive Voice Response (IVR) assistance on the website in the additional threshold languages.<sup>81</sup>

California SB 853, the Health Care Language Assistance Act, was fully implemented in 2009 after phasing in and requires that all commercial health plans and health insurance providers assess the linguistic needs of their enrollees and provide interpretation services at all points of patient contact and translation of vital documents into threshold languages. The threshold for translation is determined by health plan size as well as number of enrollees speaking the non-English language. Following is an overview of these thresholds:

- *Small-sized health plans:* For plans with less than 300,000 enrollees, vital documents must be translated into languages that more than 3,000 enrollees or 5 percent of those enrolled speak.
- *Medium-sized health plans:* For plans of 300,000 to one million, the rule is the top non-English language plus those spoken by 6,000 enrollees or 1 percent, whichever is left.
- *Large-sized health plans:* For plans with a million or more enrollees, translation must be provided in the top two non-English languages plus those spoken by at least 15,000 or 0.75 percent of the enrolled population.

Documents that are not standardized but are customized to individual enrollees do not have to be translated but must include a state-approved statement about the availability of interpretation and translation.<sup>82,83</sup> There are currently 10 languages besides English that health plans may have to translate documents into, depending on their enrolled populations.<sup>84</sup> These are the same as the Medi-Cal threshold languages, minus Farsi and Laotian.

### ***Outreach and Navigator Programs and Other Related Information***

The California exchange is working on an assisters program, which includes the navigator program required by the ACA plus other types of consumer assisters. A report from June 2012 outlines design and compensation options, recommendations, and a work plan for the assisters program. It acknowledges that there are many existing assisters that can be drawn upon for exchange outreach and enrollment. These include, for example, eligibility workers, health insurance agents, and community based organizations, who in many cases are trusted and known assisters in communities, and will be critical in reaching as many consumers as possible, especially in culturally and linguistically diverse markets. The assisters program will include trained Certified Enrollment Assistors that are registered with the exchange and can enroll consumers in exchange products, and only those assisters designated as Navigators will be compensated by the exchange. It recommended that assisters be recruited who speak each of the Medi-Cal threshold languages. One of the guiding principles is “Establish a trusted statewide Assistors Program that reflects the cultural and linguistic diversity of the target audiences and results in successful relationship and partnerships among Assistors serving state affordable health insurance programs.”<sup>85</sup>

A detailed companion report on marketing, outreach, and education plans also released in June 2012 recommends that the state prioritize target audiences and “specifically target multi-cultural audiences, Limited English Proficiency (LEP) and rural Californians.”<sup>86</sup> The report has examples of targeted outreach strategies for Latinos, African Americans, Asian/Pacific Islanders, and Native Americans, and plans are forthcoming for smaller cultural audiences such as Armenians and Russians. The exchange will give \$40 million in grants in 2013 and 2014 for education and outreach to selected partner organizations that will be culturally, linguistically, and geographically diverse. It will also establish measurement and evaluation processes to continually monitor the impact of outreach programs and effects on knowledge, behavior, and enrollment, making changes when needed. The exchange has hired Ogilvy Public Relations as the main contractor for marketing, and Richard Health and Associates is the subcontractor helping to design the navigator and outreach programs.<sup>87</sup>

The exchange board discussed health equity and health disparities at a December 2012 board meeting, and received an issue brief and presentation on these topics. These cover the principles, policies, actions, and plans of the exchange for eliminating disparities. They include multi-cultural outreach and enrollment assistance, engaging diverse stakeholders, and developing health plan and provider contracts to incorporate non-discrimination, culturally and linguistically appropriate communications, availability of interpreters, and use of disparities data.<sup>88,89</sup> In selecting qualified health plans and developing contracts, the issue brief refers to policies adopted by the exchange in August 2012<sup>90</sup> for selecting and overseeing health plans in the exchange, including requiring health plan bidders to provide information on collecting race, ethnicity, and language data, and on addressing health disparities. These measures are part of the eValue8 Health Plan Request for Information,<sup>91</sup> which the exchange will require health plans to complete to aid in oversight and reporting of quality improvement strategies.

***Summary of Progress on Integrating Diversity and Equity  
into Exchange Planning in California***

- ✓ Diversity in board composition mentioned in the exchange legislation
- ✓ Vision, mission, or values statements specifically cite diversity/disparity objectives or needs
- ✓ Diversity specified for stakeholder advisory groups
- ✓ Community meetings or focus groups held that target or consider race, ethnicity, and language needs
- ✓ Tribal consultation policy and consulting with federally recognized tribes
- ✓ Input from advocacy groups representing communities and patients of color
- ✓ Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups
- ✓ Navigator/assisters program will focus on specific race, ethnicity, and language needs in enrollment
- ✓ Planning for Internet web portal to provide access for limited English proficient people (taglines indicating availability of languages services)
- ✓ Planning to take cultural and linguistic competency measures into account in selecting qualified health plans for the exchange
- ✓ Planning to evaluate the success of measures addressing diversity and disparities in the exchange after operational and use the assessment for improvement

## Colorado

### **Colorado at a glance:**

2011 population:<sup>92</sup> **5,116,796**

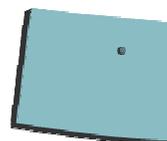
Percent of population that is Limited English Proficient:<sup>93</sup> **7.2%**

Percent of population that is Non-White:<sup>94</sup> **30.4%**

Percent uninsured:<sup>95</sup> **14%**

Type of health insurance exchange: **State**

Exchange grants:<sup>96</sup> **Planning, Level I Establishment**



### **The Exchange and Stakeholders**

Colorado's health insurance exchange, named Connect for Health Colorado in January 2013, was established in June 2011 as a nonprofit unincorporated public entity. It will not be an active purchaser and thus will offer all qualified health plans that meet federal requirements. The individual and small business exchanges will be administered separately by the board, which has 12 members (three non-voting).<sup>97,98</sup> The exchange legislation states that the entities appointing the board members "shall consider the geographic, economic, ethnic, and other characteristics of the state when making the appointments."<sup>99</sup> The executive director of the Colorado Coalition for the Medically Underserved<sup>100</sup> is the chair of the board, which helps bring a disparities perspective to the board. Colorado's exchange received conditional approval from HHS in December 2012.

The mission statement of the Colorado exchange does not mention diversity or ethnicity directly but mentions the unique needs of the state: "The mission of the Colorado Health Benefit Exchange is to increase access, affordability, and choice for individuals and small employers purchasing health insurance in Colorado. The exchange is intended to reflect the unique needs of our state, seek Colorado-specific solutions, and explore the maximum number of options available to the state of Colorado in meeting the goals of access, affordability and choice."<sup>101</sup>

The exchange and other groups have made many efforts to reach out to consumers and have held forums around the state regarding the ACA.<sup>102,103</sup> The exchange website has a link for people to submit questions online and lists board and advisory group information so people can attend meetings. Also, from July to October 2010, before Colorado's exchange legislation was passed, an interagency health reform implementation board created by the governor partnered with two advocacy groups, the Colorado Consumer Health Initiative and the Colorado Coalition for the Medically Underserved, to hold ten forums around the state to get input from stakeholders about creating the exchange. Stakeholders said that the state should establish a quasi-governmental state exchange and that the exchange board should be diverse and representative of the state population, among other recommendations.<sup>104</sup>

The Colorado Center on Law and Policy, the Consumer Health Initiative, and the Colorado Public Interest Research Group contracted with John Snow, Inc., to hold eight focus groups (including one for only Spanish-speakers) around the state in August 2011 to solicit input and gather consumer perceptions and expectations of the exchange. Interest in the exchange was high once consumers learned about it, and feedback included that frequent, varied, and culturally appropriate marketing will be important in making sure people know about and participate in the exchange. Consumers in the Spanish-speaking focus group thought that client testimonies about how to use the exchange or how it helped them would be an especially effective way to reach people, as trust is an issue and they want to hear directly from other consumers.<sup>105</sup>

The initial stakeholder advisory groups for the exchange were the Small Employer Work Group, the Data Advisory Work Group, the Eligibility Verification and Enrollment Work Group, and the Marketing Education and Outreach Work Group. These finished their work in early 2012, and in spring 2012, the latter group changed names to be the Outreach and Communications Advisory Group and three new groups were added on Individual Experience, Health Plans, and SHOP.<sup>106</sup> The Individual Experience Advisory Group is giving input on the navigator program, described below.

The exchange developed a tribal outreach and consulting plan for the two federally recognized Indian tribes in the state, and is working with them to inform them of their options (such as tailoring provider networks to meet their needs) and to get their feedback. The exchange is also working with the Denver Indian Health & Family Services, the Colorado Commission of Indian Affairs, and other stakeholders to ensure the exchange provides a high level of service to Indians.<sup>107</sup> Besides the federally recognized tribes, there are about 50,000 people from many other Native American tribes living in Colorado, and while there is no Indian Health Service (IHS) hospital in Colorado, there are IHS clinics.<sup>108</sup>

Some advocacy groups that have had input in the exchange planning process include:

- Colorado Center on Law and Policy;
- Colorado Coalition for the Medically Underserved;
- Colorado Consumer Health Initiative; and
- Project Health Colorado, which is a large coalition of consumer-oriented organizations.

### ***Existing Relevant Cultural and Linguistic Competency Legislation and Programs***

Legislatively, Colorado developed a number of disparities-focused efforts, such as SB 242 enacted in 2007 that requires the Office of Health Disparities to educate the public, promote diversity in the health care workforce, and reduce language barriers in health care access.<sup>109,110</sup>

The state also has considerable experience with outreach and enrollment in Medicaid and CHIP that can inform the exchange. State and federal grants funded a large statewide outreach effort that used community-based organizations and enrollment assisters to reach people eligible for these programs, resulting in a marked growth (80 percent) in enrollment since 2007. These certified organizations and assisters are culturally representative and are located within the communities they target. They make home visits, taking laptops and tablets to expedite the process by uploading information to the eligibility system immediately. As the infrastructure for this promising community effort is already in place, it can be leveraged for effective outreach, eligibility and enrollment activities for diverse communities through the exchange.

Colorado has experience with outreach and enrollment in Medicaid and CHIP that can be leveraged for the exchange. State and federal grants funded a large statewide outreach effort that used culturally literate community-based organizations and enrollment assisters, and they still work in the communities using laptops and tablets for immediate eligibility and enrollment assistance.

### ***Outreach and Navigator Programs and Other Related Information***

The exchange is currently finalizing an outreach plan, with input from the Outreach and Communications Advisory Group. Exchange staff and board members gave 200 presentations around the state in 2011 and 2012, and have developed partnerships with dozens of organizations that will be used to help reach and educate different targeted groups, such as low-income individuals eligible for subsidies, young uninsured populations, people with individual insurance, and small businesses. The exchange hired an advertising agency that will launch a marketing campaign in spring 2013 to educate people about the value of having

health insurance and to encourage them to go to Connect for Health Colorado in the fall to find a suitable health plan. The outreach and marketing plans will include communications targeted to Spanish-speaking communities and to people with little understanding of health insurance.<sup>111</sup>

The exchange has been developing the navigator program, with input from the Individual Experience Advisory Group and other stakeholders, since November 2012 and issued a Request for Proposals for navigator entities in February 2013. The exchange has proposed navigator selection criteria and conflict of interest rules, and plans to target a range of organizations and governments in the state and to build on the network of entities that already provide related services.<sup>112,113</sup> The program plans to use organizations that currently work with limited English proficient and culturally diverse populations, as well as other vulnerable communities, and they are exploring the use of language telephone services to help supplement access for non-English speakers. The program will have in-person assisters as well as navigators, and there will be no differentiation between the types of assistance to external stakeholders and customers so as not to cause confusion. Both will be trained and certified to the same level of expertise so they can provide the same types of support.

The exchange web portal will have data posted from CAHPS, the Consumer Assessment of Healthcare Providers and Systems,<sup>114</sup> to help consumers decide on health plans, but it is recognized that this alone will not help consumers who are looking for a plan that is appropriate for their cultural and linguistic needs. The exchange board has discussed publishing more detailed data on the website after the first year of operation, such as other scores and measures, and may be able to evaluate, for example, which plans receive higher consumer satisfaction ratings from diverse members and what those action plans have taken that may have contributed to these assessments. At the beginning it will be up to the navigators to help consumers find health plans that may have more providers speaking their language or other preferred coverage criteria. The exchange web portal will be available in English and Spanish, and a call center will be available to provide information and assistance in a variety of other languages.<sup>115</sup>

***Summary of Progress on Integrating Diversity and Equity into Exchange Planning in Colorado***

- ✓ Diversity in board composition mentioned in the exchange legislation
- ✓ Community meetings or focus groups held that target or consider race, ethnicity, and language needs
- ✓ Tribal consultation policy and consulting with federally recognized tribes
- ✓ Input from advocacy groups representing communities/patients of color
- ✓ Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups
- ✓ Navigator/assisters program will focus on specific race, ethnicity, and language needs in enrollment
- ✓ Training materials to be developed for cultural and linguistic competency of navigators/assisters
- ✓ Planning for Internet web portal to provide access for limited English proficient people (taglines indicating availability of languages services)

## Connecticut

### **Connecticut at a glance:**

2011 population:<sup>116</sup> **3,580,709**  
Percent of population that is Limited English Proficient:<sup>117</sup> **8.1%**  
Percent of population that is Non-White:<sup>118</sup> **29.3%**  
Percent uninsured:<sup>119</sup> **10%**  
Type of health insurance exchange: **State**  
Exchange grants:<sup>120</sup> **Planning, Level I and Level II Establishment,  
Early Innovator IT (part of consortium)**



### **The Exchange and Stakeholders**

The exchange in Connecticut was established in 2011 as a public nonprofit corporation, and hired a chief executive officer in June 2012. It has 11 voting members and three nonvoting members on its board. It will be an active purchaser of health plans, and the board will administer the individual and small business risk pools separately.<sup>121</sup> The Health Insurance Exchange Planning Committee within the Connecticut Office of Policy and Management has informed the board's work through several actions including commissioning an extensive review and analysis of insurance markets and related aspects in Connecticut, conducting public forums and meetings, and hiring a vendor to work on market research and outreach strategies.<sup>122,123</sup> The exchange was named Access Health CT and is working on developing a new logo and branding.<sup>124</sup> Connecticut's exchange received conditional approval from HHS in December 2012.

The main page of the Connecticut exchange website states that the purpose of the exchange is to “increase the number of insured CT residents, improve health care quality, lower costs and reduce health disparities while providing an exceptional consumer experience.”<sup>125</sup> The guiding principles of the board also mention disparities. One of the four principles, Exceptional Consumer Experience, has “a level playing field” as one of its goals, which states that “the Exchange should work to address longstanding, unjust disparities in health access and outcomes in Connecticut.”<sup>126</sup> The board and its advisory committees include members representing both racial and ethnic and geographic diversity, though there is no requirement to make these bodies diverse.

“...the Exchange should work to address longstanding, unjust disparities in health access and outcomes in Connecticut.”  
—Access Health CT Guiding Principles

The exchange established four advisory committees of stakeholders in March 2012 to assist it with establishing policy and other functions:

1. Consumer Experience and Outreach;
2. Health Plan Benefits and Qualifications;
3. Small Business Health Options Program (SHOP); and
4. Brokers, Agents, and Navigators.

The committees meet monthly and are composed of stakeholders representing a variety of interests in the state. The Consumer Experience and Outreach Advisory Committee webpage states that it “is charged with making sure all information regarding the Connecticut Health Insurance Exchange is communicated in ways accessible to all Connecticut residents, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.”<sup>127</sup>

The exchange board approved a tribal consultation policy in December 2012 that calls for the exchange to provide reasonable notice and opportunity for consultation with the two federally recognized Indian tribes in the state on exchange policy development and changes with implications for the tribes. The exchange will assign an employee to act as a tribal liaison as part of his/her job duties. The liaison will regularly contact the tribes to deliver information and receive feedback to make sure the exchange's policies consider the tribes' needs, and the person may also communicate with other state and federal agencies on these matters as needed.<sup>128</sup>

Exchange officials held seven town hall meetings (called "Healthy Chats") in areas around the state with higher uninsurance rates in November and December 2012 to answer questions from consumers, business owners, and advocates about the Connecticut exchange (Spanish interpreters were available at the meetings).<sup>129</sup> These forums were recognized by the Center for Consumer Information and Insurance Oversight as a national best practice.<sup>130</sup> More Healthy Chats were scheduled for spring 2013.<sup>131,132</sup> Public meetings were also held in April through June 2011 in different cities around the state to get input on developing the exchange. Some consumers and advocates have commented that the exchange needs to engage consumers more in policymaking matters that affect them.<sup>133</sup>

The federal Center for Consumer Information & Insurance Oversight has endorsed the Connecticut exchange's Healthy Chats in e-mails to states as a model way to hold public forums.

Some of the agencies and advocates that have had input in the exchange development process include:

- Connecticut Office of the Healthcare Advocate;
- Connecticut Health Policy Project;
- Hispanic Health Council;
- Legal Assistance Resource Center of Connecticut; and
- Universal Health Care Foundation of Connecticut.

### ***Existing Relevant Cultural and Linguistic Competency Legislation and Programs***

The Commission on Health Equity was created by state legislation in 2008 to eliminate disparities, affect legislation, and improve the health of people in Connecticut related to race, ethnicity, gender, and linguistic ability. The legislation notes that "(1) equal enjoyment of the highest attainable standard of health is a human right and a priority of the state, (2) Connecticut residents experience barriers to the equal enjoyment of good health based on race, ethnicity, national origin and linguistic ability, and (3) that addressing such barriers requires data collection and analysis and the development and implementation of policy solutions," and the organization's mission and vision statements reflect these priorities.<sup>134</sup> The Commission has ten strategies including commenting on legislation, proposing regulations, and working as a liaison between groups and state agencies that help it carry out its mission.<sup>135</sup>

### ***Outreach and Navigator Programs and Other Related Information***

The exchange board approved a policy in November 2012 regarding a navigator grant program. It says that the Brokers, Agents, and Navigators Advisory Committee along with exchange staff will evaluate options for a navigator grant program and will make recommendations to the board including performance standards, training requirements, and maximum grant amounts for navigators. The recommendations will take into account the input of the Consumer Experience and Outreach Advisory Committee as well as applicable laws, including the ACA requirement to "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange."<sup>136</sup> The State of Connecticut Office of the Healthcare Advocate is helping with the navigator

program since it has experience assisting consumers with selecting health plans, resolving issues, and conducting outreach.<sup>137</sup>

Updated draft recommendations from the exchange staff to the Brokers, Agents, and Navigators Advisory Committee in October 2012 discuss the roles of navigators and state that one of their responsibilities is cultural diversity, defined as “Providing culturally and linguistically appropriate health insurance education to Hispanics, Asians, Native Americans, those with disabilities and other groups.”<sup>138</sup>

It also lays out proposed plans for a navigator training and certification program, including a four-day training class with a test at the end that must be passed with a grade of at least 80 percent to become certified. It also includes 15 hours of continuing education per year to renew certification, and metrics that will allow the exchange to monitor and evaluate navigator effectiveness. Broker and agents can be navigators but since navigators cannot be compensated by insurance plans for enrolling people, most will choose not to, so the exchange will develop a program that will encourage them to assist people in other ways. It also discusses the in-person assister program that the exchange intends to develop to complement navigator activities; assisters may include people who currently provide enrollment assistance for Medicaid and the Children’s Health Insurance Program (CHIP) and employees of state agencies.<sup>139</sup> According to the September 2012 agenda for this advisory committee, they reviewed navigator program documents from California, Illinois, Maryland, and Washington to help inform Connecticut’s program.

The exchange is planning to partner with community organizations, such as sports teams and diverse neighborhood organizations, to engage harder to reach residents. They acknowledge that grassroots efforts and trusted relationships will be very important in outreach. A consumer communications report released in July 2012 found that most consumers surveyed were unaware of or confused by the ACA, and states that: “Multicultural participants shared many common characteristics with the general market participants, which can serve as a basis for a consistent brand platform. However, there were also distinct cultural differences that will require culturally relevant transcreations and approaches.”<sup>140</sup>

The exchange’s web portal, where consumers can get eligibility determinations for Medicaid and other programs, see if they qualify for tax subsidies, and buy insurance through the exchange, will be offered in Spanish, and may have taglines in other languages to direct consumers to the call center. The call center will offer immediate interpretation in 15 languages, with over 100 other languages available.

Connecticut was one of seven states chosen by the National Academy for State Health Policy (NASHP) to receive technical support and resources as part of the Health Equity Learning Collaborative for an eight-month period in 2011-2012. The three main goals for this effort were:

1. Implementation of the ACA with a conscious consideration of the impact of state policy decisions on diverse populations;
2. Elevation of health equity agendas; and
3. Integration of health equity initiatives across state programs.<sup>141</sup>

This effort includes health disparities training for exchange board members and others that was delayed and is planned to take place in spring or early summer 2013.

***Summary of Progress on Integrating Diversity and Equity  
into Exchange Planning in Connecticut***

- ✓ Vision, mission, or values statements specifically cite diversity/disparity objectives or needs
- ✓ Community meetings or focus groups held that target or consider race, ethnicity, and language needs
- ✓ Tribal consultation policy and consulting with federally recognized tribes
- ✓ Input from advocacy groups representing communities and patients of color
- ✓ Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups
- ✓ Navigator/assisters program will focus on specific race, ethnicity, and language needs in enrollment
- ✓ Planning for Internet web portal to provide access for limited English proficient people (taglines indicating availability of languages services)

## Maryland

### **Maryland at a glance:**

2011 population:<sup>142</sup> **5,828,289**

Percent of population that is Limited English Proficient:<sup>143</sup> **6.3%**

Percent of population that is Non-White:<sup>144</sup> **45.8%**

Percent uninsured:<sup>145</sup> **13%**

Type of health insurance exchange: **State**

Exchange grants:<sup>146</sup> **Planning, Level I and Level II Establishment, Early Innovator IT (part of consortium)**



### **The Exchange and Stakeholders**

The exchange in Maryland was established in April 2011 with additional legislation in May 2012. Named the Maryland Health Connection in August 2012, it is a quasi-governmental organization (defined as a public corporation and independent unit of state government) and has a nine-member board. The individual and small business exchanges will be administered separately. The exchange will allow any qualified health plan to participate for the first two years, and starting in 2016 it will become an active purchaser with the authority to negotiate with insurance carriers.<sup>147,148</sup> Maryland's exchange received conditional approval from HHS in December 2012.

Maryland has planned for implementation of the ACA from the start—Governor Martin O'Malley created the Health Care Reform Coordinating Council the day after the ACA was enacted in 2010 to advise the administration in health reform implementation. The council worked through the rest of that year to engage stakeholders such as consumer advocates, providers, hospitals, health insurers, and business representatives for input and support. The 2011 legislation laid out the governance of the exchange and commissioned six policy studies; six workgroups then produced reports that informed the creation of subsequent exchange legislation in 2012 that provided more design details, thus giving more opportunities for input from stakeholders and consumer advocates.<sup>149</sup> One of the council's recommendations in 2011 was on eliminating health disparities,<sup>150</sup> which resulted in forming a workgroup on disparities and subsequent disparities legislation in 2012 described in the next section.

The 2011 exchange legislation states that the exchange board will reflect the gender, racial, ethnic, and geographic diversity of the state, and has requirements for different board members, including that three members should have expertise in certain areas including as one of the options "Public health and public health research, including knowledge about the health needs and health disparities among the state's diverse communities."<sup>151</sup> One board member who fits this criterion well is an associate professor at the Johns Hopkins Bloomberg School of Public Health and the Deputy Director of the Center for Health Disparities Solutions.

The exchange is required to have at least two standing advisory committees of stakeholders, with the topics changing as needed to support current activities. There were five advisory committees in 2012:

1. Navigator;
2. Continuity of Care;
3. Plan Management;
4. Financing; and
5. Implementation.<sup>152</sup>

Committees have 20 to 25 members, plus consultants to facilitate discussion and prepare recommendations, and members "reflect the gender, racial, ethnic and geographic diversity of the

state.”<sup>153</sup> Public comment is heard at the end of each meeting and comment forms are available for people to leave feedback on policies. Having a transparent and open process in exchange development, considering diversity in all actions, and engaging stakeholders has helped the state in designing the exchange.

Some of the advocacy groups that have worked with the exchange to give input on policies include:

- HealthCare Access Maryland;
- Maryland Women’s Coalition for Health Care Reform;
- Advocates for Children and Youth; and
- Maryland Health Care for All.

### ***Existing Relevant Cultural and Linguistic Competency Legislation and Programs***

The Maryland Health Improvement and Disparities Reductions Act (SB 234) was passed in April 2012 to help reduce health disparities in the state. It establishes Health Enterprise Zones to offer incentives to providers for serving the populations in underserved areas, improves racial and ethnic data tracking, sets standards for provider cultural competency training, and creates the Maryland Health Innovation Prize to encourage innovative ideas and strategies to reduce health disparities.<sup>154</sup> The 2012 legislation was based on the work of the Health Disparities Workgroup of the Maryland Health Quality and Cost Council, which researched disparities in the state and recommended three main strategies for addressing them. The workgroup concluded that these are just first steps in an ongoing effort and that “(t)hrough the use of incentives, education, outreach, technology, and innovation, the work group recommendations seek to empower and engage individuals and communities where the greatest health and health care disparities exist.”<sup>155</sup>

“Health insurance coverage is a necessary but insufficient prerequisite to improving health outcomes. Thus, Maryland must seize the opportunity presented by health care reform to embrace a ‘culture of care’ where individuals have not only health insurance, but also meaningful access to health care services. In its implementation efforts, the state must recognize the many reasons some individuals cannot access health care, which include racial or ethnic disparities, geographic, cultural, or linguistic barriers and provider shortages. Achieving a culture of care will ensure that these barriers are addressed.”

–Maryland Health Care Reform  
Coordinating Council, Final Report Jan. 2011

Other disparities-related legislation was passed in previous years including a law in 2007 allowing health insurers to collect race and ethnicity data for quality and performance measures, and a 2009 law establishing the Cultural and Linguistic Health Care Provider Program to encourage provider education on cultural competency, linguistic competency, and health literacy.<sup>156</sup>

The Maryland Office of Minority Health and Health Disparities, designated in the 2012 disparities reduction law as the focal point for its administration, provides disparities information and supporting data for disparities reduction efforts. This office, part of the Maryland Department of Health and Mental Hygiene, was created in 2004 to provide outreach to diverse communities on tobacco and cancer under the Cigarette Restitution Fund Act and was expanded in 2010 to focus on all causes of racial and ethnic health disparities and how to eliminate them. The office also produces the Maryland Plan to Eliminate Minority Health Disparities, and the current second plan for 2010 to 2014 identifies disparities in the state and presents five main objectives and numerous action steps under each to accomplish them.<sup>157</sup>

### ***Outreach and Navigator Programs and Other Related Information***

The exchange will focus on outreach and training in the first half of 2013, including setting up the Consolidated Service Center, which will be the main starting point for consumers, employers, navigators, and others with questions on the exchange, Medicaid, and other health insurance options. The exchange is currently working with other state agencies and several vendors on how to best implement the service center.<sup>158</sup>

The exchange's communications and outreach plan outlines how it will segment the target audience of uninsured people into groups by factors such as age, ethnicity, income, and media habits and will plan different strategies to reach each group including paid advertisements, sponsorships, faith-based organizations, community organizations, health care providers, and navigator training. The exchange will leverage existing resources and will collaborate with groups sharing a common vision such as advocacy organizations.<sup>159</sup> The exchange plans to hire a plain language writer, which will help in writing and designing consumer materials.

The Navigator Advisory Committee gathered data and stakeholder input in the second half of 2012 and commissioned a final report on options for Maryland's navigator program completed in November 2012. The report prominently mentions diverse populations, stating the following (note that MHBE means Maryland Health Benefit Exchange): "The Committee considered how best to ensure that navigators meet the needs of culturally diverse, disabled and other hard-to-reach populations....The Committee members recognized the importance of cultural competency and accessibility and agreed that standards need to be set for navigator entities. They suggested that MHBE develop standards to address language, culturally-appropriate interpretation/translation and communication, reading level, formats accessible to those with disabilities, physical accessibility and relationships with target communities. The Committee favored setting a minimum floor of standards while giving navigator entities flexibility to determine their own strategies to meet those requirements. MHBE would be responsible for monitoring navigator performance and modifying the standards as needed."<sup>160</sup>

The exchange released a request for proposals (RFP) for the Connector Program, which will include both navigators and other in-person assisters, in January 2013 and proposals were due at the end of February 2013. It has been established that there will be separate navigator programs for the individual and small business markets.<sup>161</sup> The RFP states that initial navigator training is estimated to take three weeks (120 hours) and that "(t)o ensure that the needs of Maryland's uninsured residents are met, the training curriculum will go beyond health insurance and application procedures to include health literacy, cultural competency and other topics that will address the needs of those most vulnerable in the state."<sup>162</sup>

The exchange is working with the Maryland Healthcare Commission to discuss the feasibility of requiring insurers to use the Maryland Race, Ethnicity, Language, Interpreter needs, and Cultural Competence (RELICC) assessment to capture data from health plans in the exchange in order to better measure data on disparities and intervention strategies.<sup>163</sup>

***Summary of Progress on Integrating Diversity and Equity  
into Exchange Planning in Maryland***

- ✓ Diversity in board composition mentioned in the exchange legislation
- ✓ Diversity specified for stakeholder advisory groups
- ✓ Community meetings or focus groups held that target or consider race, ethnicity, and language needs
- ✓ Input from advocacy groups representing communities and patients of color
- ✓ Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups
- ✓ Navigator/assisters program will focus on specific race, ethnicity, and language needs in enrollment
- ✓ Training materials to be developed for cultural and linguistic competency of navigators/assisters
- ✓ Planning for Internet web portal to provide access for limited English proficient people (taglines indicating availability of languages services)

## New York

### ***New York at a glance:***

2011 population:<sup>164</sup> **19,465,197**  
Percent of population that is Limited English Proficient:<sup>165</sup> **13.3%**  
Percent of population that is Non-White:<sup>166</sup> **42.2%**  
Percent uninsured:<sup>167</sup> **14%**  
Type of health insurance exchange: **State**  
Exchange grants:<sup>168</sup> **Planning, Level I (3) and Level II Establishment, Early Innovator IT**



### ***The Exchange and Stakeholders***

The exchange in New York was established in April 2012 by executive order of the governor, after legislation did not pass, and an executive director was hired in July 2012. The exchange is housed within the New York Department of Health, and does not have an independent governing board, though it does have five regional advisory committees established in the executive order. The exchange will be a passive purchaser of health plans, certifying all plans that meet certain qualifications.<sup>169</sup> The exchange is expected to have a new name and branding before summer 2013. HHS gave New York conditional approval for a state-based exchange in December 2012.

The five regional advisory committees have a total of about 175 members representing consumers, small businesses, health care providers, insurance agents, brokers, labor organizations, and other stakeholders.

The five regions are:

1. Western New York;
2. Central New York/Finger Lakes;
3. Capital District/Mid-Hudson/Northern New York;
4. New York City/Metro; and
5. Long Island.

The committees began meeting in September 2012 to provide stakeholder feedback on exchange development.<sup>170</sup>

In 2011 the state held a series of meetings in different areas to get public input on the design of the health insurance exchange, such as if separate exchanges should be offered for different regions of the states and small businesses, and how many health plans should be offered in an exchange. State officials also met with New York Indian tribal representatives in a meeting hosted by CMS and the Indian Health Service in August 2011 to discuss the exchange and provisions related to Native Americans.<sup>171</sup> The exchange has held several subsequent meetings with tribal officials and has included tribal representatives in all five of the regional advisory committees, and a formal tribal consultation policy is under development as of fall 2012.<sup>172</sup>

In September 2012 the exchange hosted a public meeting for discussion on how to reduce health care disparities through the exchange. Panelists presented statistics on health disparities experienced by racial and ethnic communities, the disabled, lesbian and gay individuals, and other groups, and gave general recommendations for addressing these issues as well as taking questions and input from the audience.<sup>173</sup> The exchange plans to put out a report on disparities in early 2013.

Some of the advocacy organizations active in New York health care reform activities include:

- Health Care For All New York;

- Community Service Society of New York (Community Health Advocates);
- New York Immigration Coalition;
- Commission on Public Health System; and
- Medicaid Matters New York.

***Existing Relevant Cultural and Linguistic Competency Legislation and Programs***

In some ways New York has been ahead of the game in implementing the ACA since the state enacted similar health care reform measures in years past including guaranteed issue for individuals and small groups (insurers cannot deny coverage based on pre-existing conditions) and Medicaid for childless adults up to the poverty level.<sup>174</sup>

In October 2012, Executive Order 26 signed by New York Governor Andrew Cuomo in October 2011 went into effect, requiring that all state agencies provide free language interpretation in six languages besides English. These languages—Spanish, Chinese, Russian, Italian, Korean, and Haitian Creole—are the languages spoken by the majority of limited English proficient people in New York, estimated to be 2.5 million people. State agencies have also translated forms, notices of rights, and other essential documents into these six languages. Each agency will conduct a language assessment of the people it serves at least every two years to see if additional languages are needed. Immigrants make up 27 percent of New York’s workforce and 46 percent of the workforce in New York City, and about 22 percent of people in New York were born in other countries.<sup>175</sup> Each of the 41 state agencies has a language access coordinator to implement the language plan, and they are overseen by the Deputy Secretary of Civil Rights in the governor’s office.<sup>176</sup>

***Outreach and Navigator Programs and Other Related Information***

To assist consumers, the exchange will expand on its existing call center, New York Health Options, and the operator contracted to run the call center, Maximus, will help plan the location, staffing, and other details. New York Health Options, consolidated in 2011 from six different toll-free numbers of public health programs, currently provides information and renewals for Medicaid, Family Health Plus, and Child Health Plus.<sup>177,178</sup> The call center averages 90,000 calls per month handled by a live agent, and 17 percent of those calls were in languages other than English.<sup>179</sup>

New York has had a Facilitated Enrollment program since 2000 where 41 community-based organizations and local governments as well as 16 health plans screen people and help with documentation and applications for Medicaid and other programs. Over 1,300 facilitated enrollers within these entities provide services in 60 languages. The enrollers must participate in training programs sponsored by the New York State Department of Health.

Another program in New York that assists consumers with health insurance questions and issues is Community Health Advocates, a program of Community Service Society of New York.<sup>180</sup> It started with 21 community-based organizations and three specialized organizations that provided individual counseling and assistance as well as community-based training and education, and in the first year (ending September 2011) they helped 28,669 people, gave 750 presentations, and provided services in 11 languages besides English. After their Consumer Assistance Program grant ended in 2011 they reorganized under the Level I exchange establishment grant and now have several new organizations and are expanding their capabilities and helping to design and test exchange outreach materials.<sup>181</sup>

New York has also had a Facilitated Enrollment program since 2000 where 41 community-based organizations and local governments (with assistance from a grant) as well as 16 health plans screen people and help with documentation and applications for Medicaid, Family Health Plus, and Child Health Plus. Over 1,300 facilitated enrollers within these entities provide services in 60 languages. The enrollers must participate in training programs sponsored by the New York State Department of Health (current modules include Basic Training, Refresher Training, and Income Calculation for Self-Employed Individuals), and agencies can access the training slides to train their own enrollers when state training sessions are not available.<sup>182</sup>

The New York exchange will operate an in-person assistance program financed with federal funds and a navigator program financed with exchange revenue, both to start in 2013. It will select organizations to participate in these programs through a competitive procurement process that defines minimum standards, and the winning entities will be trained by a subcontractor (Maximus) on education and enrollment assistance for plans to be offered in the exchange as well as public programs. Training will include “the needs of underserved populations” and “cultural and linguistic competency.”<sup>183</sup>

The exchange’s education and outreach plan includes four phases that will segment intended audiences and “reach low-income, diverse and vulnerable populations through targeted outreach.”<sup>184</sup> Phase 3 will include three advertising campaigns starting in summer 2013 to raise awareness of the exchange, and the state will work with an established advertising agency to develop and test materials to make sure the targeted audiences understand the message. The exchange will involve stakeholders and communities in the research and planning stages, and will evaluate the success of the programs in the final phase.

New York’s Exchange Blueprint application documents submitted to the federal government show that regarding online applications, the exchange website will guide the user through the selection process using plain language at a fourth-grade reading level, and the applications and content management system are designed to support multiple languages. The initial website in 2013 will be in English and Spanish only, but the website will show instructions to direct consumers who speak other languages to call the call center for help.<sup>185</sup>

***Summary of Progress on Integrating Diversity and Equity into Exchange Planning in New York***

- ✓ Community meetings or focus groups held that target or consider race, ethnicity, and language needs
- ✓ Tribal consultation policy and consulting with federally recognized tribes
- ✓ Input from advocacy groups representing communities and patients of color
- ✓ Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups
- ✓ Navigator/assisters program will focus on specific race, ethnicity, and language needs in enrollment
- ✓ Training materials to be developed for cultural and linguistic competency of navigators/assisters
- ✓ Planning for Internet web portal to provide access for limited English proficient people (taglines indicating availability of languages services)

## Oregon

### **Oregon at a glance:**

2011 population:<sup>186</sup> **3,871,859**  
Percent of population that is Limited English Proficient:<sup>187</sup> **6.3%**  
Percent of population that is Non-White:<sup>188</sup> **22.1%**  
Percent uninsured:<sup>189</sup> **15%**  
Type of health insurance exchange: **State**  
Exchange grants:<sup>190</sup> **Planning, Level I (2) and Level II Establishment, Early Innovator IT**



### **The Exchange and Stakeholders**

Oregon's exchange was authorized in June 2011 and finalized in March 2012. The exchange, named Cover Oregon in October 2012, is a quasi-governmental organization (independent public corporation) that will be an active purchaser of health plans. The exchange board has nine members, including two ex-officio members with voting rights.<sup>191</sup> The exchange hopes to use active purchasing and other strategies to bring accountability and value to the health insurance market in Oregon.<sup>192</sup> Oregon's exchange received conditional approval from HHS in December 2012.

The exchange's mission statement on its website does not explicitly mention diversity or disparities,<sup>193</sup> but the exchange legislation lists this as one of the missions: "Improve health care quality and public health, mitigate health disparities linked to race, ethnicity, primary language and similar factors, control costs and ensure access to affordable, equitable and high-quality health care throughout this state."<sup>194</sup>

Regarding the exchange's board, the 2011 establishment legislation states that the seven members who are appointed by the governor and are not ex-officio members will have certain qualifications including that they will, "to the greatest extent practicable, represent the geographic, ethnic, gender, racial and economic diversity of this state."<sup>195</sup> The legislation also directs the board to establish the Individual and Employer Consumer Advisory Committee to facilitate gathering feedback from stakeholders, and to ensure this committee consists of a variety of people from around the state including "racial and ethnic minorities in this state."<sup>196</sup> This permanent committee currently has 21 members from various backgrounds and organizations and meets monthly.

The exchange board's policy manual states that the exchange will gather input from individuals and small businesses from around the state, will measure user satisfaction, and will "provide materials and website access in languages in addition to English, and access that meets or exceeds ADA requirements for accessibility."<sup>197</sup> While the Consumer Advisory Committee (CAC) is permanent, the exchange has also formed two temporary ad hoc Technical Advisory Groups thus far, on the communications plan and on the request for proposals from health plans. These groups advise the exchange staff, while the CAC makes recommendations to the board.

Oregon was the first state exchange to hire a dedicated tribal community liaison position.

The exchange meets at least monthly with the nine federally recognized Indian tribes and other Indian groups in Oregon to consult on general cultural issues as well as get feedback on details such as proposed webpages. Oregon was the first state exchange to hire a dedicated tribal community liaison position. The exchange is planning on having tribe members lead training sessions for call center staff once they are hired on how to best serve the tribal communities, and to incorporate this information in training manuals for navigators. Oregon's Tribal Consultation Policy, approved in April 2012, has been used as a model by other states.<sup>198</sup>

The exchange has been in contact with many advocacy groups and other organizations who are interested in the exchange, including:

- Hispanic Chamber of Commerce;
- Oregon Latino Health Coalition;
- Oregon Law Center; and
- Other groups such as unions, business groups, and ethnic and immigrant group representatives.

Oregon is different than most states in that 40 percent of the population lives in or around Portland, so the exchange has not had to travel around as much to meet with the public and interest groups as the groups all have headquarters in Portland. The exchange will work to reach the more rural areas, and it plans to reach out to all interest groups to obtain feedback once there is a web portal prototype to demonstrate.

### ***Existing Relevant Cultural and Linguistic Competency Legislation and Programs***

Oregon has been working on health care reform for many years, including in the 1990s when the current governor, John Kitzhaber, a medical doctor, was in office and championed Medicaid reform measures.<sup>199,200</sup> Oregon addresses language access issues in a number of laws including in Medicaid where the family planning program is required to provide all services in the appropriate language, employ bilingual and bicultural staff and volunteers, and make all printed and electronic materials available in the appropriate language and literacy level.<sup>201</sup>

The Oregon Health Policy Board, which oversees the Oregon Health Authority, convened the Health Equities Policy Review Committee in 2010 and 2011 to evaluate recommended policies to make sure that they support the elimination of health disparities and promote health equity.<sup>202</sup> The committee recommended that the exchange create a culturally specific marketing plan, recruit culturally diverse exchange board and committee members, measure providers' cultural competency, and provide information in multiple languages to minority-owned and rural businesses.<sup>203</sup>

The Oregon Office of Equity and Inclusion facilitates several programs including one on migrant health to reduce access barriers<sup>204</sup> and one on health care interpreters. The Oregon Council on Health Care Interpreters has 25 members, which by law must represent the people of Oregon racially, ethnically, culturally, and economically. It assists the state in developing education and establishing standards for health care interpreters for people with limited English proficiency.<sup>205</sup>

### ***Outreach and Navigator Programs and Other Related Information***

The Oregon exchange's business plan states that it will "develop culturally appropriate materials in multiple languages using a variety of mediums, such as brochures, web pages, short informational videos, and social media," and says that it will partner with community-based organizations in order to reach all residents.<sup>206</sup>

The exchange's navigator program, which will be called the Community Partners program and will include other entities, such as application assisters and agents, will use lessons from established state programs such as Healthy Kids (Oregon's CHIP) and will provide grants to community-based organizations. The exchange plans to ensure that the training and certification program for navigators is "rigorous, not overly burdensome for participants, and consistent with existing programs."<sup>207</sup>

Oregon's CHIP outreach efforts over the past few years have been very successful. In 2009 the Oregon legislature expanded health insurance programs for children and set a target of enrolling 80,000 more

kids, which was surpassed. Through August 2012, 114,000 additional children have enrolled for a caseload increase of 42 percent. The Healthy Kids program awarded targeted outreach grants to safety net providers, public health departments, and other organizations around the state, plus recruited volunteer partners to spread the word and started an application assistance program. The targeted outreach campaigns distributed culturally relevant marketing materials, funded bicultural and bilingual outreach staff in communities, and worked through schools to reach teens and work with coaches and sports. They used materials and advertising created for the targeted communities, not just adapted from standard or English versions. They also tested materials with families first to make sure messages and forms were easy to understand and had a good layout (the Center for Health Literacy at Maximus assisted with this).<sup>208</sup>

From July 2009 to August 2012, the enrollment of African-American children in CHIP increased by 18 percent, American Indian/Alaska Native children by 17 percent, Asians/Hawaiian children by 71 percent, and Hispanic/Latino children by 34 percent. Measures from the Healthy Kids program indicate that racial and ethnic disparities have decreased or disappeared after the targeted outreach and increased enrollment. Now about 95 percent of children in Oregon have health insurance, with 40 percent through the Healthy Kids program. Some lessons the state learned during this process are that outreach is harder than initially thought, and requires considerable technical assistance and dedicated staff working with targeted partners. In addition, the state learned the importance of ensuring staff responsible for assisting in eligibility determination and benefits enrollment fully understand the programs and effectively communicate with consumers. Oregon Healthy Kids plans to work with the exchange to have a seamless eligibility system, use existing outreach grantees for education efforts and as navigators, reach out to parents of enrolled children, and have a shared marketing plan to direct consumers to a single website and call center.<sup>209</sup>

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The Marketing and Communications Services Request for Proposal (RFP) released in December 2012 indicates that more research is needed to “explore nuances in values, message, and language within Oregon’s Hispanic and Latino communities” and that to engage Spanish-speakers the exchange will conduct testing in English and Spanish, including focus groups and online surveys. The RFP says that promotional materials will be available in English, Spanish, Russian, Korean, Simple Chinese, Vietnamese, and customized English-language versions for American Indians and Alaska Natives to clearly explain the specific ACA provisions pertaining to them in an easily understood manner. Promotional materials to be shared with community partners and agents to give consumers will also have quick response codes that let people with smart phones link to websites to access additional information including information in other languages.<sup>210</sup>

The RFP acknowledges that the Community Partner program is a key component in that local organizations are “cultural experts” and are influential in reaching members of their communities in a common language. A community partner may have someone trained as a navigator who can help with enrollment, and other partners can provide outreach and education to specific audiences.<sup>211</sup> Community partners, including application assisters helping individuals with limited English proficiency, will be

tested to make sure they are proficient in the target language. In addition, consumers will be able to obtain a list of partners and assisters on the website that can be sorted by language to see where ones are located that can speak the language they need.

The Cover Oregon website has a search function that lists 65 languages besides English, and while picking a non-English language translates most of the links and pages of the website using Google Translate, the documents resulting from a search are in English.<sup>212</sup> Certain limited pages of the Cover Oregon website will be in Spanish, Russian, and Vietnamese, in addition to English. The exchange web portal will initially only be available in English, with Spanish planned for the next version. The exchange plans to offer paper and electronic applications in English, Spanish, Russian, Vietnamese, Large Print English, and Large Print Spanish. It plans to translate notices into 12 languages in addition to these, plus Braille. At least some outreach materials are planned to be in Spanish, Russian, Vietnamese, Korean, Simplified Chinese, and Japanese.<sup>213</sup>

***Summary of Progress on Integrating Diversity and Equity into Exchange Planning in Oregon***

- ✓ Diversity in board composition mentioned in the exchange legislation
- ✓ Vision, mission, or values statements specifically cite diversity or disparity objectives or needs
- ✓ Diversity specified for stakeholder advisory groups
- ✓ Community meetings or focus groups held that target or consider race, ethnicity, and language needs
- ✓ Tribal consultation policy and consulting with federally recognized tribes
- ✓ Input from advocacy groups representing communities and patients of color
- ✓ Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups
- ✓ Navigator/assisters program will focus on specific race, ethnicity, and language needs in enrollment
- ✓ Planning for Internet web portal to provide access for limited English proficient people (taglines indicating availability of languages services)

## Washington

### **Washington at a glance:**

2011 population:<sup>214</sup> **6,830,038**

Percent of population that is Limited English Proficient:<sup>215</sup> **7.9%**

Percent of population that is Non-White:<sup>216</sup> **28.1%**

Percent uninsured:<sup>217</sup> **14%**

Type of health insurance exchange: **State**

Exchange grants:<sup>218</sup> **Planning, Level I and Level II Establishment**



### **The Exchange and Stakeholders**

The exchange in Washington was first established in May 2011, with additional legislation passed in March 2012, and finally named Washington Healthplanfinder in October 2012. The exchange is a quasi-governmental organization defined in the legislation as a “self-sustaining public-private partnership separate and distinct from the state.” It has 11 board members, including two non-voting ex officio members, and it will allow all qualified health plans to sell through the exchange in 2014.<sup>219</sup> Washington’s exchange received conditional approval from HHS in December 2012.

The board has two committees made up of board members, the Operations Committee and the Policy Committee. There are also five committees made up of stakeholders—these are currently the Advisory Committee, Navigator Technical Advisory Committee (TAC), Dental Plan TAC, Role of Agents/Brokers TAC, and the Small Business Health Options Program TAC (TACs are ad hoc and can change to different topics as needed). There are two workgroups that advise the exchange, the Plan Management Workgroup consisting of insurance company representatives, and the Consumer Workgroup consisting of individuals and organizations interested in providing input on the exchange. The committees and workgroups started meeting at different times in 2012, and the public can give feedback or ask questions at all meetings or via e-mail to the exchange.<sup>220</sup> In February 2012, the exchange put out a call for nominations for members of a TAC on Equity who can provide “experience and/or professional perspectives related to health equity with a focus on language access, health literacy, hard-to-reach populations, cultural sensitivity, and other general access to coverage issues.”<sup>221,222</sup>

The exchange’s enabling legislation does not explicitly mention diversity, disparities, or equity, but its mission statement mentions equity as one of its values: “Our mission is to radically improve how Washingtonians secure health insurance through innovative and practical solutions, an easy-to-use customer experience, our values of integrity, respect, equity and transparency, and by providing undeniable value to the healthcare community.”<sup>223</sup>

The enabling legislation mentions Indians, stating “In recognition of the government-to-government relationship between the state of Washington and the federally recognized tribes in the state of Washington, the board shall consult with the American Indian health commission.”<sup>224</sup> While the law does not specifically state that the exchange’s board should be diverse, the board does have several members of different ethnicities. The board’s Advisory Committee also represents a variety of ethnicities, geographic regions, and interests, having members from organizations such as Puget Sound Health Commission, American Indian Health Commission, Whatcome Alliance for Healthcare, Northwest Health Law Advocates, and South Sound Neurosurgery.

The plan for stakeholder engagement in the exchange is “inform, involve, and empower.” The “Inform” goal entails providing accurate information and getting feedback and includes a marketing campaign, the exchange website, surveys, a newsletter, and an exchange speakers bureau. The “Involve” step will ensure

that stakeholders' and the public's concerns are considered and understood and includes board meetings, committees, workgroups, public comment, focus groups, and statewide public meetings. The last goal of "Empower" allows stakeholders to control their engagement and includes the navigators and assisters program, agents, brokers, joint outreach, and partnerships with organizations that can help consumers. The marketing program will use a variety of outreach and education strategies and media including specialized efforts focused on specific audiences that are harder to reach.<sup>225</sup>

The exchange has obtained input from consumers and other stakeholders in various ways, including meetings around the state and commissioning a survey in November 2011 of 570 people in Washington with varying incomes, ages, education levels, and Internet usage habits to ask questions about enrolling in health insurance and get input for the navigator program. A consultant also interviewed 17 stakeholders such as community organizations, insurance brokers, and consumer advocates on the ideal qualities a navigator should have and what organizations should be navigators, which contributed to the development of the navigator program.<sup>226</sup> The general advisory committee, specific technical advisory committees, and the workgroups also bring in a variety of perspectives and feedback from stakeholders with different interests, experiences, and ethnicities from different regions of the state.

Some of the advocacy groups that have participated in the exchange development process include:

- Healthy Washington Coalition;
- Northwest Health Law Advocates;
- Within Reach;
- Consumer Advocates Affinity Coalition;
- Health Coalition for Children and Youth;
- Equal Start Coalition; and
- Washington State Coalition for Language Access.

### ***Existing Relevant Cultural and Linguistic Competency Legislation and Programs***

The Governor's Interagency Council on Health Disparities was established by the Washington Legislature in 2006 to "create an action plan and statewide policy to include health impact reviews that measure and address other social determinants of health that lead to disparities as well as the contributing factors of health that can have broad impacts on improving status, health literacy, physical activity, and nutrition."<sup>227</sup> The legislation also states that the council will conduct studies and public hearings and will facilitate collaboration between state agencies, the private sector, the public sector, and communities of color to address health disparities. The State Policy Action Plan to Eliminate Disparities, published by the council in 2010, looks at the social determinants of health by identifying five priority areas to focus on, 1) education, 2) health insurance coverage, 3) healthcare workforce diversity, 4) obesity, and 5) diabetes. It also makes recommendations on language access in health care and promoting equity in state agencies.<sup>228</sup>

The council also published the Washington Multicultural Health Communications Directory in 2009 to break down available information by every county in the state regarding where multicultural communities reside, what organizations and trusted sources (including media) are in those communities that can help convey information to people with other languages and cultures, and what the needs are of those communities.<sup>229</sup>

## ***Outreach and Navigator Programs and Other Related Information***

Marketing and outreach for the exchange will use “considerable resources to reach all communities that are eligible to participate in the exchange.”<sup>230</sup> The exchange’s customer service program will include remote assistance (through the website and call center) and in-person assistance via navigators and assisters.<sup>231</sup> The guiding principles for navigators state that navigator organizations “must be trusted resources in the communities they serve” and “must demonstrate expertise and cultural competency in assisting those they serve, including communities of color and vulnerable populations, low-income families, individuals who are not functionally literate or have low-English literacy,” among others. It also states that the navigator program is an important part of promoting health equity and helping people access health coverage who have historically had barriers to health care and health insurance, and that navigators should help reduce disparities by means such as targeted outreach and providing services in multiple languages.<sup>232</sup> The navigator program will include a network of several lead agencies for different geographic areas that oversee smaller navigator organizations, plus a separate program to work with Indian tribes.<sup>233</sup> The Navigator TAC started to discuss training requirements in December 2012 for navigators, which may include topics such as “understanding the needs of the underserved and vulnerable populations.”<sup>234</sup>

“The Exchange knows that reaching the full potential of our enrollment will rest in part on the need for culturally and linguistically appropriate outreach and education efforts among all those who are eligible. From the outset, the Exchange has been deeply committed to involving individuals and organizations in our programmatic decision-making process to ensure we may address cultural and linguistic issues and concerns. This includes areas of policy, marketing and outreach, user interface design, and more.”

–“*Meeting the Needs of Washington’s Diverse Populations*,” January 2013

The exchange is looking at several existing programs as models to help develop the navigator program. One is the Statewide Health Insurance Benefits Advisors (SHIBA) program of the Washington State Office of the Insurance Commissioner, where volunteer advisors undergo training in order to be able to offer people unbiased and knowledgeable assistance with finding health insurance coverage (including private, Medicare, and Medicaid), understanding patient rights and appealing health plan decisions, and other healthcare related issues.<sup>235</sup> Another model is Apple Health for Kids, Washington’s CHIP and children’s Medicaid program, which compensates selected community organizations (one per county) for enrollment assistance. Compensation is partially based on the number of children enrolled, and paper and electronic applications have barcodes on them that track where applications originated and let community partners check on the status of particular applications.<sup>236</sup>

Washington’s Department of Social and Health Services has eight threshold languages besides English (Spanish, Vietnamese, Russian, Cambodian, Laotian, Mandarin, Cantonese, and Korean) but has received interpreter requests for appointments for over 70 languages in recent years, not all of which were able to be filled. Northwest Health Law Advocates and the Washington State Coalition for Language Access issued a report in December 2012 identifying language access deficiencies in state programs and calling for the exchange to proactively establish clear and adequate language guidelines in services including the navigator program, in the absence of final federal rules and guidance on language in some areas. The report also recommends that the exchange establish a language access plan and that it offers translation of the exchange website into all the commonly spoken languages in the state according to established thresholds, and not just Spanish.<sup>237</sup>

After discussions on language access, the exchange plans to have the website in English and Spanish as of this writing, as no other state website currently plans to offer more and this will cover more than 95 percent of Washington’s population. The website may have taglines directing people to interpretation in

additional languages. The exchange plans to provide all exchange consumer correspondence in the eight languages that the state's Medicaid program uses, besides English—Cambodian, Chinese (Simplified), Korean, Laotian, Russian, Somali, Spanish and Vietnamese—and the call center will be modeled after Medicaid and have multilingual options as well.<sup>238</sup>

The exchange posted a position in December 2012 for a Translation and Printing Program Specialist, who will plan and implement translation and printing business processes, coordinating with the website and printing vendors.<sup>239</sup> The exchange also posted a position for a Tribal Program Liaison who will plan, manage, and evaluate exchange programs concerning Indian tribes and Indian Health Service programs, and who will coordinate and collaborate with tribal and community organizations, state agencies, and federal programs.<sup>240</sup>

***Summary of Progress on Integrating Diversity and Equity into Exchange Planning in Washington***

- ✓ Vision, mission, or values statements specifically cite diversity and disparity objectives or needs
- ✓ Community meetings or focus groups held that target or consider race, ethnicity, and language needs
- ✓ Tribal consultation policy and consulting with federally recognized tribes
- ✓ Input from advocacy groups representing communities and patients of color
- ✓ Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups
- ✓ Navigator/assisters program will focus on specific race, ethnicity, and language needs in enrollment
- ✓ Planning for Internet web portal to provide access for limited English proficient people (taglines indicating availability of languages services)

## V. Health Plan Implementation Progress and Programs

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This section highlights the progress that health plans have made in implementing selected cultural and linguistic competency provisions in the Affordable Care Act (ACA) required for health plans and exchanges. It also offers examples of relevant programs undertaken by health plans that could help inform the activities of other plans and state exchanges to meet these requirements. This is not a comprehensive or representative list as there are numerous efforts underway to increase language access and reduce health care disparities, and thus results cannot be generalized to all health plans. In addition, many health plans have established medical outreach programs to reduce disparities and have added or increased racial, ethnic, and language data collection efforts. However, clinical interventions and data collection are outside the scope of this report.

Health plans and health insurers have many ACA provisions to comply with. Our review focuses on four major provisions which explicitly address cultural and linguistic competence. These include:

- Providing culturally and linguistically appropriate summary of benefits documents and uniform glossaries;
- Providing culturally and linguistically appropriate claims appeals processes;
- Plain language requirement for health plans in an exchange; and
- Incentive payments in health plans for reducing disparities.

See Appendix C for further details on these provisions.

While these provisions are health plan responsibilities, we recognize they will be of relevance to the exchanges, particularly as health plans begin to participate in these new marketplaces. As such, health plans will need to report various data to the exchange and will need to provide coverage documents and other information to potential enrollees through the exchange once they are operational. Many provisions in the ACA that primarily may be an obligation of another entity overlap with the domain of the exchanges since the exchanges are a significant part of health care reform and have a broad reach that intersects with a range of topics including Medicaid eligibility determination, income tax credits, actuarial levels of benefits, information technology standards, state insurance regulations, and other areas.

The narrative that follows combines findings from our review of the literature, major policy and regulation updates, and information obtained through interviews with health plan representatives.

### **Health Plan Progress on Implementing the Provisions**

#### *Culturally and Linguistically Appropriate Summary of Benefits and Uniform Glossaries*

The provisions on providing culturally and linguistically appropriate summary of benefits documents and uniform glossaries and on culturally and linguistically appropriate claims appeals processes apply to all health plans, both those that will be selling in an exchange and those outside of one, and have already taken effect.

The U.S. Department of Health and Human Services (HHS) provides templates for health plans to use for the summary of benefits and coverage and uniform glossaries, with the intent that all health plans utilize the same format and examples so they are comparable.<sup>241</sup> These templates are simplified and come in the required languages, offering health plans an opportunity to modify them to reflect their specific benefits

and pricing. Some health plans are also choosing to include their original summary of benefits documents for customers when these provide more details. As Highmark Inc.'s informational page states, the standard summary of benefits is "not a substitute for the Summary Plan Description and is not intended to provide a comprehensive description of the plan's terms."<sup>242</sup>

Some health plans are providing documents in more than the required five languages or using lower thresholds than the 10 percent county requirement, especially if they were already using lower thresholds before the ACA, which was the case for many plans either operating in multicultural areas or located in places (such as California) that have more stringent language rules. While the uniform glossaries provided by the federal government are meant to be used as is, some health plans such as Cigna also provide their own glossaries for their customers so they can ensure that they contain the words they need to know for that health plan and are in plain language.<sup>243</sup>

### ***Culturally and Linguistically Appropriate Claims Appeals Processes***

For internal and external claims appeals, some plans were not using these processes to the extent required by the ACA, so before the requirement went into effect they had internal teams examine their processes and identify where they needed to add additional capabilities for language access and cultural competency, hiring outside vendors if needed for translation and interpretation, according to key informants. Plans then reviewed the materials using health literacy guidelines. Only a very small percentage of health plan customers appeal decisions so it may take some time to make sure the processes are working as intended. Cigna summarizes the new requirements and changes for internal and external appeals on its health reform website, including how health plans must meet the requirement to be culturally and linguistically appropriate in their appeals processes.<sup>244,245</sup>

### ***Plain Language Requirement for Health Plans in an Exchange***

The plain language provision applies to insurers selling health plans in an exchange who are required to submit certain plan data to the exchange and make them available to the public in plain language. Regulations also added that health plans in an exchange must provide "all applications and notices to enrollees" in plain language. Since the exchanges are not operational yet, there are no reports to the exchanges or notices to enrollees at this time, but many health plans have been working on health literacy and plain language efforts, and in some cases, well before the enactment of the ACA. Therefore, many of these plans are in a good position to comply with the plain language requirement once exchanges become operational.

Many health plans have hired writers or contractors to work on their outreach documents and are starting to adjust all documentation in accordance with health literacy and simple language principles, such as shorter sentences and different wording. Some have used internal or commercially available computer programs for this that evaluate paragraphs and words and suggest modifications. UnitedHealthcare has internal proprietary software called DocScrub that electronically grades the reading level of documents, and other health plans use different internal or commercially available programs. Harvard Pilgrim Health Care is one of the health plans that has developed a resource guide on plain language and a checklist to check documents for health literacy and cultural appropriateness, including questions on wording, simple sentences, active voice, font size, and respectful tone.<sup>246</sup>

### ***Incentive Payments in Health Plans for Reducing Disparities***

Regarding the provision on market incentives for quality activities such as reducing health and health care disparities, as mentioned in the Provisions section, there are no regulations or guidance on this yet from HHS. It is also not clear, at this time, what this requirement specifically entails besides providers or health

plans being rewarded for implementing activities such as cultural competency training, community outreach, and language access services. Many health plans already do activities such as these internally, so it remains to be seen what the payment structure will be and who will be rewarded. Some health plans do not have a program to reward provider groups for doing these activities, while others, such as Harvard Pilgrim, have projects where they are working with groups to implement patient centered medical homes, and rewarding culturally and linguistically appropriate activities is part of the program. Some health plans have provider incentives built into quality programs, just not with disparities reduction as a measure, but these could be adapted to include cultural competency activities once parameters are known.

## Relevant Activities and Promising Practices in Cultural and Linguistic Competence and Plain Language

Many health plans were working on health disparities and foreign language issues for years before the ACA, due to their diverse customer demographics and to previous laws and regulations requiring language access in programs such as Medicaid and Medicare. Title VI of the Civil Rights Act of 1964 and subsequent regulations require organizations receiving federal funds to provide language services to people with limited English proficiency so they can meaningfully access their programs, but the law was often not enforced in health care settings. More awareness of health care disparities and the need for language services, plus growing numbers of immigrants and changing demographics in some areas, have led to increased interest and activities in language access services in the health care field.<sup>247,248</sup>

Language access and translation services generally gained prominence and support in health care delivery settings and outreach first, and in the insurance and policy areas more recently. Thus many of the ACA's cultural and linguistic competency requirements are actions that health plans have already implemented either fully or in part, in some cases exceeding the ACA requirements. Language access is growing and some health plan websites are offered in multiple languages, such as Highmark Inc.'s website where a box at the top lets consumers switch to Spanish, Italian, Russian, Vietnamese and Chinese.<sup>249</sup> Others such as UnitedHealthcare have different websites targeted to different ethnic groups, such as Asians,<sup>250</sup> Hispanics,<sup>251</sup> and African Americans.<sup>252</sup> Some health plans have a health reform office or department that reviews new laws and ensures the plan is in compliance. Many health plan websites also now have sections on health care reform and some are reaching out to consumers for feedback.<sup>253,254,255</sup>

Furthermore, many health plans have developed departments or programs dedicated to reducing health care disparities, promoting equity, and increasing health literacy. A national survey in 2010 showed that 83 percent of health plans had at least some components of a health literacy program, such as plain writing and low-literacy materials, but there is no consistency on where these programs are housed. Depending on the plan they could be integrated into disparities efforts, quality improvement efforts, cultural and linguistic competency activities, patient satisfaction, or communications and marketing.<sup>256</sup>

Health care disparities and cultural competency issues have become more recognized and more health plans and providers are addressing them, as evidenced by the creation of honors such as the National Quality Forum's Multicultural Award, the National Committee for Quality Assurance's (NCQA) Distinction in Multicultural Health Care, and the NCQA's Recognizing Innovation in Multicultural Health Care Award. Health plans wanting to improve in this area can explore the measures and model programs put forth by these programs.<sup>257,258,259,260</sup>

One useful development is that some health plans (and state agencies and exchanges as well) are using

**Transcreation** means adapting a concept or message from one language or culture to another, while maintaining its intent. Transcreated messages are not literal translations, but rather adaptations that have the same implications in the target language as in the original language while taking into account cultural or local nuances.

“transcreation” to make their materials more culturally and linguistically appropriate. Instead of simply translating existing English documents and materials into other languages, where some words or phrases may not translate properly or may be harder to understand, they are recreating the documents from the original concepts using different cultural contexts instead of a literal translation. This makes documents more culturally appropriate and relatable, and may even include different pictures to include more images of people of the ethnicity to which the materials are targeted. Transcreation, a relatively new term, can also be used for English language documents, in that some people of certain ethnicities such as American Indians may prefer to have their information in English, but it can still be tailored to their cultures so it is more understandable and consumer-friendly.

Many health plans hire outside vendors to translate or transcreate documentation. Some plans test the documents with focus groups or other potential consumers outside of the companies, while others have formed internal committees of their employees from different ethnic backgrounds from all parts of the companies who assist by reviewing documents to make sure they make sense in different languages and are culturally appropriate. Aetna formed an external advisory committee of diverse medical experts to review and evaluate Aetna’s racial and ethnic materials and data and provide insights to assist with initiatives targeting specific populations.<sup>261</sup>

The Center for Health Care Strategies (funded by the Agency for Healthcare Research and Quality and the Robert Wood Johnson Foundation) coordinated the National Health Plan Collaborative (NHPC) from 2004-2008 for several large national and regional health plans to come together to understand, measure, and share strategies to reduce racial and ethnic health care disparities.<sup>262</sup> Since 2008, America’s Health Insurance Plans (AHIP) has led the coordination of the NHPC and there are now 17 member health plans that share resources and meet on monthly phone calls.<sup>263</sup> Main accomplishments have revolved around racial, ethnic, and language (REaL) data collection and standardization; language access services; and the creation of the National Health Plan Collaborative Toolkit to collect and disseminate

The National Health Plan Collaborative and the U.S. Office of Minority Health have both developed detailed guides to help health care organizations implement language access services.

resources on disparities. The toolkit includes information on disparities, racial and ethnic data collection, and language services, and provides helpful examples of models and activities undertaken by health plans in the collaborative.<sup>264</sup>

The National Health Plan Collaborative Toolkit contains steps for developing a coordinated approach for language access services in health plans, which could also be used by exchanges. Following is a summary of these steps and the recommendations for achieving them:

- *Step 1: Assess the plan’s language needs and resources:*
  - Analyze the number of limited English proficient people served and the frequency and type of contact; and
  - Determine the priorities by looking at the types and importance of services members may need at various points of contact.
- *Step 2: Create a written policy with an approach for addressing the language needs of members:*
  - Outline how to identify members needing language services, their points of contact, which types of services are available, and how to notify people of them;
  - Assess how understandable consumer education materials are;
  - Establish a process for maintaining, evaluating, and improving language services.<sup>265</sup>

The Office of Minority Health also has a guide to help health care organizations implement language access services, which besides assessments of member needs and organization capabilities, also includes components on interpretation services, written materials, signage, notices, and community involvement.<sup>266</sup>

Another collaboration involving health plans and other stakeholders is the Health Industry Collaboration Effort (ICE) in California.<sup>267</sup> This nonprofit started in 1998 to educate the public on the Balanced Budget Act of 1997, and has expanded since then to address more issues, including the requirements of California’s language law, SB 853 (described in the California case study). ICE facilitated health plans’ ability to create and share materials and resources for language access services, which helped commercial health plans learn from Medicaid plans that had already been providing language services.<sup>268</sup> The ICE website has a library of documents to help health plans with issues including language translation and services, such as documents with examples of translated taglines.<sup>269,270</sup>

There are many examples of successful interventions and programs on language access and cultural competency in health plans that can assist other health plans and state exchanges. Kaiser Permanente developed the Qualified Bilingual Staff program to educate and qualify employees to be trained interpreters to improve health outcomes for its non-English speaking members. There are three levels of training: 1) bilingual staff—language liaison; 2) bilingual staff—language facilitator; and 3) designated interpreter. Services are offered in at least nine languages, including two dialects of Chinese along with American Sign Language. Kaiser Permanente also created the Health Care Interpreter Certificate Program in partnership with City College of San Francisco to assist in the training of qualified professional health care non-English language interpreters, and assists with teaching, funding, and internship opportunities for students. The partnership has been a success and the model has expanded to other geographic regions.<sup>271</sup>

L.A. Care, the largest public health care plan in the nation (over a million members in Medicaid, CHIP, a Medicare HMO, and other public programs in Los Angeles County) has undertaken a number of language-related activities.<sup>272</sup> It provides a glossary, now in electronic format in a database, of thousands of linguist-approved translated terms for translation and interpretation vendors as well as member services representatives to use for quality and consistency with members. It is in Spanish and Chinese with plans to add seven more languages soon. It also uses culturally appropriate fotonovelas, similar to comic books, in Spanish and English to reach Latino members to inform them about health issues.<sup>273</sup>

Culturally appropriate care requires not just language translation, but awareness of other cultural issues like customs, diets, and even common habits such as how to write dates. Keystone Mercy Health Plan found that providers often wrote appointment dates for enrollees in all numbers, for example 3/6/12, which in the U.S. usually means March 6th, but in many other countries means June 3rd. In order to address the high rate of no-shows for appointments, staff started writing out the name of the month instead of using a number, as well as specifying the day of the week, which helped people keep the appointments.<sup>274</sup> The federal government is also learning about cultural issues. The Medicare Advantage Plan Stars survey had a question asking “Are you feeling blue?” that referred to depression, but the Chinese Community Health Plan in San Francisco found that this idiom did not translate well for its enrollees, and that could be one reason the plan was scoring poorly on Medicare quality measures.<sup>275</sup>

Many Medicaid health plans as well as other organizations, even those who have bilingual employees and interpreters, retain services such as LanguageLine Solutions for instances when customers speak a language not available in the organization. LanguageLine provides telephone access to interpreters speaking over 170 languages, so consumers can quickly be connected to someone who can help. It also provides other services such as document translation and on-site interpreting as needed.<sup>276</sup>

The Center for Plain Language, Enroll America, and America’s Health Insurance Plans are among the organizations with online guides for writing in plain language.

The non-profit Center for Plain Language helps health plans, government agencies, and other organizations use plain language, and has several helpful resources on its website. These include

definitions, checklists, and guidelines for plain language, and a toolkit for starting a plain language program.<sup>277</sup> The federal government also publishes a comprehensive plain language guide.<sup>278</sup> Plain language is part of efforts to improve health literacy, and AHIP has a webpage of tools and models of health literacy activities for health plans.<sup>279</sup> Enroll America's Best Practices Institute has a series of useful briefs on plain language, readability, and translation of health care materials.<sup>280,281,282</sup>

There are also many examples of promising plain language efforts among health plans. UnitedHealth Group publishes a glossary that defines health care terms in plain language in both English and Spanish.<sup>283</sup> Aetna requires every employee to receive plain language and health literacy awareness training. As such, the plan has trained and certified its writers in plain language, allowing them to simplify hundreds of codes and documents. Blue Cross and Blue Shield of Minnesota developed a program called Health Literacy Ambassadors in 2007 that involves employee ambassadors in every division in the company who hold quarterly meetings to share resources, identify places for improvement, and develop tools and training on clear communication for employees, among other activities. WellPoint created the Plain Language Initiative in 2010 to formalize efforts to train all employees on the basics of plain language, with writers receiving more intensive training. The initiative provides employees with software and glossaries of words to use and not use. The initiative has strong executive support, and testing of materials showed that 100 percent of consumers preferred the plain language versions, plus it increased trust in the health plan. Given this success, the program will continue to work on plain language activities.<sup>284</sup>

## VI. Discussion

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### **How are States Progressing in Addressing Diversity and Cultural Competency in Exchanges?**

Though many provisions within the Affordable Care Act (ACA) cite or acknowledge the importance of cultural and linguistic competence, related details in regulations and guidance were not available until 2011 and 2012, and more are still to come. Also, cultural and linguistic competency was not mentioned in the exchange planning grant request for proposals. These delays and omissions as well as events beyond the states' control, such as the Supreme Court-level lawsuits challenging the ACA, have meant delays for many states in establishing their exchanges or marketplaces and in planning for cultural and linguistic competency measures. However, once exchange planning started, many states incorporated diversity in mission statements and stakeholder outreach and are planning to directly address cultural and linguistic priorities, though they cite tight deadlines as a challenge. Although the exchanges are new, examples of similar activities in health plans and existing state programs such as Medicaid and CHIP should help provide models for state exchanges to emulate or adapt as needed.

The narrative that follows highlights common themes, promising actions, and programs that have emerged across states to explicitly address diversity and equity in the exchanges, and discusses their implications, opportunities, and challenges moving forward. This discussion incorporates information and feedback gleaned from interviews with state exchange representatives, along with other research. Table 3 summarizes findings on diversity and equity activity within exchanges across the seven state case studies.

***Diversity and Equity in State Exchange Planning and Development.*** The seven state case studies revealed that each state has made progress in integrating racial and ethnic diversity and equity into their exchange planning and development. As of this writing, two states—California and Oregon—are examples of leading states which have addressed diversity and equity across a range of exchange activities and measures including board composition, vision and mission statements, stakeholder advisory groups, consumer focus groups, tribal consultation policies, and input from advocacy organizations.

At least four states (California, Colorado, Maryland, and Oregon) have legislation that explicitly mentions racial and ethnic diversity as a goal in the composition of their boards of directors, and at least three of these also require diverse racial and ethnic representation among stakeholder advisory groups. States such as California, Connecticut, Oregon, and Washington have integrated specific language into their vision, mission, and/or value statements addressing diversity and equity. All seven states have held meetings in a number of communities to obtain feedback for proposed exchange actions and have sought input from advocacy groups representing stakeholders including diverse populations. All states with federally recognized Indian tribes have met with tribal representatives and have developed tribal consultation policies.

Key informants stated that it is important not only to communicate with stakeholders and advocates early and often, but to build and sustain trust with them, and to seek active engagement and response from these representatives. They emphasized the need for states to “know their communities,” particularly in identifying languages spoken, characteristics of the uninsured, where concentrations of racial and ethnic populations reside, and their language preferences for receiving health information.

**Table 3. Summary of Exchange Actions in Case Study States Regarding Diversity and Cultural and Linguistic Competency**

	California	Colorado	Connecticut	Maryland	New York	Oregon	Washington
<b>State Exchange Development and Planning</b>							
Diversity in board composition mentioned in the exchange legislation	Y	Y	Ni	Y	(1)	Y	Ni
Vision, mission, or values statements specifically cite diversity and disparity objectives or needs	Y	Ni	Y	Ni	Ni	Y	Y
Diversity specified for stakeholder advisory groups	Y	Ni	Ni	Y	Ni	Y	Ni
Community meetings or focus groups held that target or consider racial, ethnic, and language needs	Y	Y	Y	Y	Y	Y	Y
*Tribal consultation policy and consulting with federally recognized tribes	Y	Y	Y	(2)	Y	Y	Y
Input from advocacy groups representing communities and patients of color	Y	Y	Y	Y	Y	Y	Y
<b>Outreach, Education, and Enrollment</b>							
*Targeted outreach and education planned for limited English proficient and specific racial and ethnic groups	Y	Y	Y	Y	Y	Y	Y
*Navigator/assisters program will focus on specific racial, ethnic, and language needs in enrollment	Y	Y	Y	Y	Y	Y	Y
*Training materials to be developed for cultural and linguistic competency of navigators/assisters	S	S	S	Y	Y	S	S
<b>Website, Qualified Health Plans, and Evaluation</b>							
*Planning for Internet web portal to provide access for limited English proficient people (such as taglines indicating availability of languages services)	Y	Y	Y	Y	Y	Y	Y
Planning to take cultural and linguistic competency measures into account in selecting qualified health plans for the exchange	Y	(3)	Ni	(3)	Ni	Ni	(3)
Planning to evaluate the success of measures addressing diversity and disparities in the exchange after operational and use the assessment for improvement	Y	S	Ni	S	Ni	Ni	Ni

Y: Yes, the exchange has implemented this action  
 S: Some progress identified (initial actions or related plans)  
 Ni: No action identified or no information to date

\* These five measures are requirements in the ACA and regulations, while the others not marked are best practices we identified in leading states. Note that these results were identified through research and interviews during the study period ending in mid-February 2013, therefore, it is possible that planning and activities in nascent stages or not in the public domain are not captured here.

<sup>1</sup> New York's exchange does not have a board and was created by executive order, not legislation.

<sup>2</sup> There are no federally recognized American Indian tribes in Maryland.

<sup>3</sup> These three state exchanges will not be active purchasers of health plans (for the first year at least) so will accept all plans that meet the minimum criteria to become qualified.

Equity as a goal and the need to address disparities should be central to planning as early as possible, and related wording should be specified in an exchange’s mission and vision statements and other subsequent documentation. Messages on the importance of cultural and linguistic competency need to come “from the top down as well as the ground up” in an organization; and the active involvement of a senior executive champion to advocate for and shepherd efforts to addressing diversity, equity, and cultural and linguistic competence is likely critical to success.

***Culturally and Linguistically Appropriate Outreach, Education, and Enrollment.*** Addressing cultural and linguistic considerations will be critical to assure effective outreach, education, and enrollment. To meet these enrollee priorities, exchanges will need skilled and trained employees or vendors for translation and interpretation and will need to seek guidance from stakeholders and advocates to assure proper vetting of messages that are culturally acceptable and understandable. Transcreation of materials—or their adaptation from one language or culture to another—instead of word-for-word translation from English, will help in this effort.

All of the case study states plan to target outreach and education for specific racial and ethnic groups and limited English proficient populations, and to operate navigator and other assistance programs that will take into account cultural and linguistic issues and needs. Navigator and assister training programs and guidelines are currently being developed, and the states plan to address cultural and linguistic competency in training and certification. Navigators and other in-person assisters will play an important role in the success of the exchanges and how well they reach culturally and linguistically diverse individuals. The ACA specifies that organizations providing navigator services should have ties to the communities they plan to serve, but they need to have experience with outreach and enrollment as well. In addition, knowing and being able to inform and discuss the insurance options and benefits available to consumers will require navigators and other assisters to receive training in cultural and linguistic competency standards, consumer rights, appeals processes, confidentiality requirements, ethics, and referral protocols.<sup>285</sup> The states examined are planning for language needs in marketing and enrollment and are striving for cultural competence as well in outreach, education, and customer service through activities such as hiring appropriate navigator entities, creating culturally sensitive outreach campaigns, and developing training standards and materials on cultural competency for assisters.

*Promotoras*, who are health care workers based in and frequently living in Hispanic communities, are an example of culturally competent, trusted “messengers” who could be considered potential candidates or models for exchange outreach and enrollment efforts in these communities.<sup>286</sup> Community-based organizations that are not mainly focused on health, such as schools, churches, libraries, tribal organizations, and fire and police departments, have also been successfully used to reach eligible, but not enrolled, families in Medicaid and CHIP—what some call the “trusted hand” model.<sup>287</sup> As part of any direct work with consumers, however, exchanges need to ensure that staff members are trained in the exchanges’ programs and other requirements. At a minimum these organizations can also serve as trusted places for consumers to obtain culturally appropriate brochures and materials on the exchange, with contact information of local navigators and the website address for consumers to seek enrollment assistance.

Receiving information from trusted sources is especially important for reaching eligible immigrants and mixed-citizenship status families (where, for example, the children might be U.S. citizens while the parents are undocumented). These groups often face numerous barriers to enrolling, including some from personal or community experience such as fear of immigration enforcement, limited English proficiency, low literacy, and confusion about the different programs for which different family members may be eligible. Many uninsured who are not citizens have income levels that would qualify them for tax credits in an exchange or for expanded Medicaid. However, undocumented immigrants are prohibited from buying insurance in an exchange (even at full price) and are not eligible for Medicaid. For lawfully

present immigrants and those eligible in mixed-citizenship families, outreach through trusted organizations, language services, and one-on-one application assistance will be critical to enrollment.<sup>288</sup>

All of the state exchanges studied are working on their web portals and know that they are required to make them accessible to individuals with limited English proficiency—most will be in English and Spanish or have taglines in other languages directing consumers to language services.

***Racial and Ethnic Disparities Measures and Evaluation.*** Four of the seven case study states plan to be active purchasers in their first year of operation, choosing the health plans to participate in the exchange, and of these we have identified only California, at this time, as stating that the exchange plans to consider cultural and linguistic competency measures in selecting qualified health plans to sell through the exchange. California’s exchange also mentioned planning to evaluate the success of measures addressing diversity and disparities in the exchange after it is operational and using the results for improving the exchange as needed, and two other states have mentioned aspects of assessment and improvement as well. Others will likely plan similar activities as they progress, after the exchanges are in place and they have time to evaluate their programs and implement improvements.

The state exchanges we studied have initiated and completed many important activities since 2010 and have made notable progress toward integrating cultural and linguistic competency measures into their exchanges. Many have gone above and beyond the requirements by implementing additional related actions such as assuring their exchange governance and stakeholder advisory committees are diverse and by identifying additional dimensions of inclusion, such as geographic diversity, which will help ensure that exchange planning and decision-making reflect the needs of people around the state and not just the large cities. Now that plans are in place they and other states not as far along have the formidable task this year of putting in place mechanisms and a system to ensure that open enrollment begins on time and that consumers, including those with limited English proficiency, can access the assistance they need to understand their options and enroll, so that their coverage can begin in 2014.

## What Challenges Lie Ahead for States?

Challenges identified by state exchanges during interviews mainly revolved around predictable issues such as short deadlines, budget and resources, and how to reach people who may not be familiar with health insurance, such as non-English speakers, different cultural groups, young adults, and people in rural areas. Medicaid and CHIP have successfully reached many low-income families but there are childless adults and others who may not know what types of insurance programs are available and will be available in the exchanges, may not think they need them, or may not know about the mandate for most people to carry insurance. Issues of exchange sustainability, funding navigator programs, and how to reach people who may speak non-threshold languages or not be able to read in any language are some of the resource challenges.

“It is well understood that implementing a state-based exchange does not suffer from lack of challenges and opportunities. Many of the challenges may be summarized in three ways: imperfect information, demanding deadlines, and dependencies beyond state Exchange control.”

—Kevin Counihan, CEO, Connecticut Health Insurance Exchange, in October 2012 exchange newsletter

***Exchange Role and Sustainability.*** There are political differences among those who want state exchanges to be just an insurance marketplace and others who see opportunity to improve, if not transform, the quality and delivery of health care, especially for cultures and communities that have been marginalized in the past. Some states have concerns that information technology is driving the process more than consumer needs. Our review implies that much work remains in both developing technology

infrastructure and in ensuring that important information specific to individuals such as cultural and linguistic preferences and requirements are integrated into these systems. Professional exchange staff members often recognize disparities as a priority and are prepared to assist and take action, although some have encountered some resistance once they try to focus on disparities. Finally, many exchange representatives expressed concern about “just being operational” by the deadline, with plans to add more features and policy considerations to their exchanges in version 2 or year 2 of the program.

**Funding Navigator Programs.** States also have concerns about funding their navigator programs, since using federal funds from the establishment grants for this purpose is prohibited. The August 2012 final blueprint released by HHS for states seeking to establish a state-based exchange created a new category of helper, the in-person assister, for which federal funds can be used. Most states are planning to employ in-person assisters as well as navigators when enrollment begins, using federal funds for the assisters and private grants or state funds (for the states that allow this use) for the navigators. Once the exchanges are operational, most states plan to collect fees from health plans or consumers in the exchange to fund the navigator program. In these circumstances, it may be difficult for any smaller non-profit that works with vulnerable populations and has experience in addressing language and cultural needs to become licensed or post a surety bond.<sup>289</sup> Training and certification of navigators and in-person assisters should alleviate some fears around qualifications, and many states included in our review indicated their intent to assure that insurance agents and brokers have a role in the exchanges along with navigators and other assisters.

## **Tips and Advice on Integrating Diversity, Equity and Cultural Competence into Exchange Planning**

### ***Feedback from Case Study Key Informants***

Interviews with state exchange personnel provided some helpful advice and lessons for other states embarking on exchange planning:

- Communicate with stakeholders and advocates early and often during the planning process, on many different issues, to get input and to form relationships and trust.
- It is important to start with data and see how many languages are spoken in the state, what the most pressing needs are, and where most of the uninsured reside.
- Look to new partnerships and new models for ideas in exchange implementation, not just the usual places and organizations that the state may already use.
- Become familiar with subcultures within a group as much as possible—for example, the term “African Americans” does not represent Haitian or Jamaican residents who may have different health-related language and cultural issues and concerns.
- Consider how it is to be on the receiving end of outreach and messages and think how people would respond—the exchange needs to be empathetic but not patronizing. Consumers need the right education and information to learn how health insurance works, since it is complicated for anyone.
- It helps to define the specific disparities that the exchange wants to address—access to insurance only, or other equity issues.
- Get wording on equity and disparities into an exchange’s mission and vision statements and keep incorporating it into all future documentation as planning develops—it needs to be at the forefront and not an afterthought. It’s important that it continually be present as language drives policy, and it needs to come from the top down as well as the ground up.

## What is the Status of Progress of Health Plans?

Our review found that many health plans, due to customer necessity as well as regulations, seem to have taken steps to provide services in a more culturally and linguistically appropriate manner, and many are undertaking additional actions and implementing more extensive programs on these issues to addressing the needs of diverse members. The ACA provisions on providing culturally and linguistically appropriate summary of benefits documents and uniform glossaries, and providing culturally and linguistically appropriate claims appeals processes, are already in effect with health plans modifying their documentation and processes to meet these requirements. It appears that most health plans are positioning themselves to be in compliance with the plain language requirement for those choosing to be in an exchange, since there are many tools available for writing materials in plain language. Many have already implemented plain language into their materials, and will just need to ensure it is used in the new documentation that will be required within exchanges.

Reports and interviews with health plans and advocacy groups suggest several important points that can apply to health plans and state exchanges as well. As with exchange guidance, health plans recognize the importance of effective and active leadership in promoting cultural and linguistic competence. To that

Organizations need one or more senior executives to champion the cause of reducing disparities and improving language access, so these remain priorities and become embedded in the organization's culture.

end, health plans recommended that organizations should seek out and identify one or more senior executives to champion the cause of reducing disparities and improving language access, so these remain priorities and become embedded in the organization's culture. They also need dedicated staff members so related work and its completion is part of their job requirements, while organizations will benefit from collaborating with others to share best

practices. Medicaid plans can often serve as a model because they have much higher percentages of diverse and low-income enrollees than private plans, and many have been working with related population needs since their contracts have stricter requirements for language access than the ACA. Health plans will also need to assess the competence of their translation vendors and ensure their experience meets health care priorities, including appropriate translation of materials that consider cultural and linguistic contexts.

Several health plans recommended that organizations and stakeholders work to integrate cultural and linguistic competency issues as early in the planning process as possible, and to collect data on consumers from the start that will best capture issues specific to their needs and circumstances. As such, tools and databases may need to increase the number of fields available for specifying race, ethnicity, and language choices, and collect written as well as spoken language preferences, since adding these items to information technology systems later can be more complex and costly. Finally, as health care organizations acknowledge the need for increased attention to health disparities and ways to reduce them, progress will require considerable federal guidance. At the same time progress will also require a critical mass of providers and plans—not just a few settings and systems—to recognize the importance of directly addressing disparities in diverse populations and participating in concerted actions to improve them.

## What Challenges Lie Ahead for Health Plans?

One challenge for health plans, as for states and others affected by the ACA, is that they must start planning for reforms before all the regulations and guidance are published by the federal government. As a result, they are likely to face tight deadlines when details become available. Another issue is that most health plans are used to marketing to employers more than individual consumers, but with the exchanges, it is predicted that many more people will be buying individual non-group insurance, so the plans will need to tailor their marketing strategies and content to individuals and families. In addition, as health

plans seek to advance their client base in new markets, such as Medicaid, they may be less familiar with this population and may perceive a challenge in integrating this group with their more mainstream clientele of privately insured individuals. As diverse individuals are likely to be a significant proportion of new enrollees, adaptation to meet cultural and linguistic needs will need to be integrated into their efforts. Languages, in particular, can be a challenge since some health plans operate in different communities and even different states, so they must decide if they will offer materials in more than the minimum languages required for members who do not reach established language thresholds, and how they will distribute these materials. Individuals who cannot read in the language they speak or use regional dialects of languages pose additional challenges. Finally, many health insurance companies and government agencies will need to undertake more direct actions to build and sustain trust.

## VII. Guidance for Integrating Cultural and Linguistic Priorities into Exchange Planning and Operation

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The following guidance reflects a synthesis of sources of information and expertise focusing on five exchange areas: (1) creating and developing the exchange; (2) reaching and working with priority populations; (3) developing effective communications; (4) dissemination of practice models and lessons learned; and (5) assuming the role of active purchasers. They highlight strategies for effectively integrating cultural and linguistic competency requirements and best practices into state exchange planning and operations, whether state-based, partnership, or federally facilitated exchanges. They also include actions addressing these priorities among health plans.<sup>290,291,292,293,294</sup>

### **1. Fully integrate diversity and equity objectives into the exchange mission, objectives, and planning.**

- A. Exchanges need to start as early as possible to include racially and ethnically diverse representation and voices in all planning and decisions, including board and staff, consumer advisory committees, and input from advocacy groups.
- B. Exchanges should seek out stakeholder and public input and have multiple channels to receive feedback to facilitate and ease the ability of individuals as well as advocacy and business organizations to contribute at each stage of the process. Such actions will help to increase stakeholder participation and reach diverse communities that the exchange and other Affordable Care Act provisions are intended to reach.
- C. Language on the goals of equity, diversity, and cultural and linguistic competency should be fully integrated into the exchange mission and vision statements, committee objectives, planning documents and reports, and other materials so it becomes a core part of the exchange culture. Board and executive staff espousing and actively supporting these priorities will play important roles in assuring inclusion of this content and continuity in exchange actions. Many of the case study states have made good progress in explicitly mentioning equity and diversity in their exchange documents and have champions among their board members, state officials, or others who have kept these goals forefront in exchange activities.

### **2. Work with trusted advocates and representatives who are reflective of diverse communities and are culturally and linguistically competent to provide appropriate and targeted outreach, education, and enrollment in the exchange.**

- A. Early lessons as well as existing state programs suggest that exchanges should leverage trusted organizations within diverse communities to help with outreach, education, and enrollment of individuals from diverse cultures and those who have limited English proficiency. They should also consider providing information at non-traditional settings, often effective in reaching diverse communities, such as social or health events, sporting events, neighborhood retail stores, places of worship, government interactions such as renewing licenses or signing up for school lunch programs, through ethnic media, and through smartphones.
- B. Navigators, in-person assisters, call center personnel, and others who deal with consumers should receive adequate training in cultural and linguistic competency standards, and translators and interpreters should be trained and follow professional standards.<sup>295</sup> All states in our review have

introduced plans for training programs and certification for workers interacting with consumers. As such, their respective exchanges have acknowledged the importance of employing and detailing frontline personnel trained and qualified to carry out the functions to engage and assist racially, ethnically, and linguistically diverse populations who may not be familiar with insurance products and the benefits offered in the exchange.

**3. Ensure culturally and linguistically appropriate information, resources, and communication is provided by the exchange.**

- A. All printed and electronic materials for outreach, education, marketing, health plan benefits, financial details, renewals, appealing eligibility or claims denials, and all other aspects of consumer experiences in an exchange should be available in the four federal threshold languages at a minimum, and as many other languages spoken in the state as feasible. Many advocacy groups recommend a 5 percent threshold or the 15 languages used by Social Security.<sup>296</sup>
- B. Materials should be written in plain language at a low literacy level, whether in English or other languages. Written materials should also contain tag lines in other languages describing the availability of oral interpreters and other translated materials. This will ensure that as many people as possible can access the services and information they need to make informed decisions. (There are several resources for plain language listed in the health plan section, including, for example, Enroll America’s Best Practices Institute which offers a series of useful briefs on plain language, readability, and translation of health care materials.<sup>297</sup>)
- C. Exchanges should ensure that consumers can get help in multiple languages when enrolling, whether in person, online, or by telephone. Besides the previously mentioned strategies, web portals for the exchange should be accessible in all of the common languages in the state, and should contain taglines in as many languages as possible directing consumers to the call center where they can access interpreters for assistance with enrolling. Most of the leading states plan to have their websites in English and Spanish the first year, with taglines in additional languages. While availability in Spanish will help in reaching many non-English speakers in the U.S., some are already exploring the feasibility of offering the website in additional languages in future years.

**4. Actively share and disseminate information on experiences, promising practices, and lessons learned in addressing diversity and equity in exchange planning.**

- A. States and health plans should participate in learning collaboratives to learn from peers, and exchanges should borrow from the experiences and best practices of other states as much as possible, so they are not “reinventing the wheel”—especially given the short timeline for implementation. The National Health Plan Collaborative described in the health plan section is an example of an active collaboration that is addressing health care disparities and health literacy, and the National Academy for State Health Policy’s State Refor(u)m website is one useful place for state exchange personnel and others interested in health care reform to post questions and access resources on implementation actions and best practices.<sup>298</sup>
- B. Exchanges should consider recommending that health plans qualified to be sold in the exchange use resources such as the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) to guide effective implementation, especially for racially and ethnically diverse consumers. The CLAS standards, published by the Office of Minority Health, provide strategies for meeting the needs of diverse communities and serve as useful guidance, with an enhanced and updated version scheduled for release in early 2013.<sup>299</sup>

Four of the 14 standards (numbers 4–7 on language access services including translation and interpretation) are required for all recipients of federal funds. Exchanges and health plans will likely benefit from reviewing, and where applicable, adopting the other 10 standards as well, since they are explicitly intended to assist organizations in addressing the needs of diverse individuals. To date, many of the organizations we interviewed were employing these standards for training staff in cultural competency, incorporating cultural and linguistic competency in performance improvement programs and patient satisfaction, collecting data on written and spoken language preferences, and ensuring culturally and linguistically appropriate grievance processes.

- 5. Use active purchasing to ensure good value and high quality in health plans sold through the exchange and a reasonable number of choices at each benefit level.**
  - A. Exchanges should use active purchasing to set qualification standards beyond minimum financial and regulatory criteria, to selectively choose plans that offer the highest quality for the best value, and to negotiate on price if possible. Active purchasing will allow exchanges to establish criteria for health plans such as employing bilingual physicians and staff in their networks, providing translated materials, and collecting relevant racial, ethnic, and language data. It will also afford exchanges the opportunity to select or recommend plans that meet these criteria. California’s exchange, for example, plans to use active purchasing and selective contracting to choose health plans and gather data that can be used to evaluate progress in reducing health disparities.
  - B. Active purchasing allows exchanges to selectively choose plans and to narrow the number of choices at each plan level and in each geographic region as needed so consumers are not as overwhelmed with information. Studies show that consumers prefer fewer plan choices and simplified coverage options, since most individuals do not have a high level of health care literacy and find health insurance options and terms confusing.<sup>300,301</sup>

## VIII. Conclusions and Areas for Future Study

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The seven case study states are making good progress in implementing the ACA provisions we examined, and reveal lessons and best practices that should prove useful to other states not as far along in exchange planning. Many health plans are also making good progress in implementing the provisions pertaining to them and have experience that will be useful for those who participate in exchanges or marketplaces. There are hundreds of languages and dialects spoken in the United States, and many cannot read in the language(s) they speak, so no health program or legislation can address every single situation. Nonetheless, recent efforts supported by the ACA and elsewhere have great potential to reach larger numbers and improve the quality of the health care system, with integrated care, reduced disparities, and better health outcomes as a result.

There are a number of issues that will be useful to examine in the future as health insurance exchanges continue to unfold, to see how diversity and disparities are addressed, as well as to document, evaluate, and disseminate information about promising programs, best practices, and helpful tools. There are still many questions remaining about the details of how state-federal partnership exchanges and federally facilitated exchanges will be implemented, and how these new entities will compare to state-based exchanges in their navigator programs and other activities. Making a concerted effort to establish metrics, monitor progress, and evaluate actions related to cultural and linguistic competence will be important to help various players—federal, state, and local—ensure diversity and equity are effectively and appropriately integrated into training, education, and outreach. Such monitoring may inform the federal government as it develops details involved with partnering or fully administering exchanges. For example, states' navigator and in-person assister training programs and certification standards are still being developed as of this writing. Monitoring and studying the details of existing and evolving state programs, as well as those in other health care fields, could inform the federal government on best practices and standards for addressing cultural and linguistic competency in outreach and education across the various exchange arrangements. This information would also be of value to states just getting started with planning their outreach, education, and marketing strategies. As the first open enrollment period for all exchanges will be October 2013 through March 2014, many lessons are likely to emerge that states can use to modify and improve their outreach, navigation, and enrollment practices before the next enrollment period.

In conclusion, establishing exchanges is—and will remain—a work in progress generally, and specifically in efforts to ensure effective engagement and enrollment of racially and ethnically diverse individuals. Additional federal guidance is forthcoming on ACA requirements such as navigator training, cultural competency standards, plain writing guidelines, market-based incentives for reducing disparities, and enforcement of non-discrimination, which we will be monitoring and reporting on as they are released. New plans and initiatives are emerging or maturing as the deadline for implementation nears. And much remains unclear about the creation of state-federal partnerships and federally administered exchanges. Longer term, after plans become operational in 2014, the focus will need to expand to include assessing progress in reaching and enrolling diverse and other historically disenfranchised populations, evaluating improvements in access to care and, ultimately, documenting the impact on reducing health disparities. Much is promised in the intent of the exchanges and the vision of the law. Implementation will determine whether that promise is realized.

## Appendix A. Key Informants and Contributors

The Texas Health Institute would like to acknowledge and thank the many individuals who contributed valuable information, feedback, and perspective on various topics covered under the *Affordable Care Act and Racial/Ethnic Health Equity Series*. Nearly 70 individuals were interviewed or consulted. They represented a range of sectors—from federal, state, and local agencies to hospitals, health centers, health plans, professional associations, health policy experts, advocates, and community-based representatives. *Note: Opinions expressed in this report are of the authors only and are not to be attributed to the individuals or organizations listed below unless noted as such in the report.*

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## Appendix B. Semi-Structured Interview Questions

These are the questions we asked when interviewing our key informants from state exchanges, health plans, and community or advocacy organizations. The questions were modified as needed and in some interviews we asked additional follow-up questions as well.

### **State Exchange Progress:**

1. What is the state doing or planning to do to implement the following requirements outlined in the ACA:
  - a. A Navigator program?
  - b. Culturally and linguistically appropriate outreach and marketing?
  - c. Culturally and linguistically appropriate eligibility and enrollment processes?
  - d. Diverse stakeholder representation in planning process?
2. Are there existing state initiatives that can inform the integration of equity/diversity into your exchange planning?
3. What, if any, challenges has the exchange faced in implementing the equity/diversity requirements of exchanges—e.g., state budget, political climate, state readiness to address disparities, etc.?
4. What community organizations and advocates are you are working with to facilitate the implementation of these cultural and linguistic requirements?
5. Based on your state’s experience in exchange planning, what lessons or guidance would you offer on “how to” integrate equity/diversity into the exchange design and execution?
6. Can you provide any helpful reports on the overall progress of the exchange, and particularly the implementation of cultural and linguistic competence requirements? Are there other state or nonprofit officials who you recommend we contact for further information on this topic?

### **Health Plan Progress:**

1. What progress has been made by your health plan (or member plans if an association) to provide culturally and linguistically appropriate information as required by the ACA? Specifically, we are interested in your progress related to the following provisions:
  - a. Culturally and linguistically appropriate Summary of Benefits and Coverage and Uniform Glossaries (when 10% or more of county population has same non-English language; now in effect for new plan years)?
  - b. Culturally and linguistically appropriate claims appeals processes (when 10% or more of county population has same non-English language; now in effect for new plan years)?
  - c. Health plan information and data in “plain language” for plans applying to be in an exchange?
  - d. Outreach and education to racially and ethnically diverse communities?
  - e. Planning for market-based incentives for reducing health care disparities?
2. Are there equity/diversity programs that you or other health plans already have in place that could inform the implementation of the above requirements in the ACA?
3. What challenges are health plans facing to implement diversity/equity requirements in ACA?
4. Are there any early indicators of successes, failures, or lessons learned? Any models or best practices?
5. What guidance would you provide to other health plans tackling these requirements?
6. What related research, reports or initiatives would you recommend we review to further inform this assessment?

**Community Advocates:**

1. What is the primary mission of your organization, and what activities have you been doing to help implement the Affordable Care Act?
2. What kind of progress do you think the state is making in implementing the cultural and linguistic provisions in the ACA that are required for exchanges, including the navigator program and outreach?
3. What do you think are helpful models and examples from other existing programs within the state or from other states?
4. What resources should the state be using to make sure all the functions of the exchange are culturally and linguistically appropriate?
5. What are the main barriers and challenges the state is encountering in implementing these provisions?
6. What other advocates and stakeholders are working on exchange issues in your state, and what still needs to be done?
7. What recommendations related to the cultural and linguistic requirements would you give to other states that are just getting started on their exchanges?

## Appendix C.

# Legislative and Regulatory Details on the ACA Provisions on Cultural and Linguistic Competence in Health Plans and Exchanges

After the Affordable Care Act (ACA) and its amendments were enacted in 2010, the Department of Health and Human Services, the Department of Labor, and other federal agencies involved in the ACA have published and are continuing to publish rules and regulations with more details. This section provides excerpts of the original text from the ACA of the eight provisions examined in this report (highlighted in boxes below), and subsequent regulations and guidance that have been published to date to clarify and assist in the implementation of each provision.

### 1. Section 1311(b): Establishment of State Exchanges

This section of the law broadly outlines the establishment of the health insurance exchanges that are to operate in each state for individuals and small businesses, and subsequent regulations have helped fill in some of the details. Below is the relevant text from the ACA:<sup>302</sup>

1311(b) American Health Benefit Exchanges.--

(1) In general.-- Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an "Exchange") for the State that--

- (A) facilitates the purchase of qualified health plans;
- (B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a "SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and
- (C) meets the requirements of subsection (d).

(2) Merger of individual and shop exchanges.-- A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

The federal government has released requests for comments and additional details and requirements related to the exchanges on a number of occasions including extensive final rules and interim final rules on March 27, 2012, for setting up exchanges, using navigators, and creating systems for eligibility and enrollment.<sup>303</sup> States can establish their own exchanges or have the federal government do it for them, and in July 2011 a third option was added allowing states to partner with the federal government on a state-federal hybrid exchange. Guidance for federally facilitated exchanges was released on May 16, 2012,<sup>304</sup> and a final blueprint for exchange approval was released on August 14, 2012, with the information that states electing to pursue state-based exchanges or state-federal partnership exchanges must provide to the federal government for the exchange application and approval. The final blueprint also established a new category of consumer helper, the "in-person assister," who may have a similar role as a navigator but can be funded from federal establishment grants, unlike the navigator program, which cannot use federal funds.<sup>305</sup>

States pursuing state-based exchanges must submit a declaration letter and an exchange application to the Centers for Medicare & Medicaid Services (CMS) by December 14, 2012 (previously November 16) for the plan year beginning January 1, 2014. States choosing to have federally facilitated exchanges with their own reinsurance programs also must send a declaration letter with the required details by the deadline,

and a letter is optional for states that will have federally facilitated exchanges and use the federal reinsurance program. The Centers for Medicaid and Medicare Services (CMS) originally said it would approve the state-based exchanges by January 1, 2013, or grant conditional approval to those states that have not met all the requirements yet but are making significant progress to being ready for open enrollment starting October 1, 2013.<sup>306</sup> It was announced in January 2013 that there will be no deadline for approval for states willing to work with the federal government to create state-based or partnership exchanges, they just need to meet the operational deadlines.<sup>307</sup> States not pursuing a state-based exchange had an extended deadline of February 15, 2013, to decide if they want to establish a partnership exchange. Additional guidance for partnership exchanges was released in January 2013, with more details for states choosing to run their own in-person consumer assistance programs, states taking on plan management functions, and other responsibilities of state and federal partners.<sup>308</sup>

Since some states were concerned about the timelines, the March 2012 rules establish that if states are not ready to operate a state-based exchange on January 1, 2014, a federally facilitated exchange will begin at that time and they can switch to a state-based exchange in subsequent years, with 12 months' notice to the Department of Health and Human Services (HHS). States can also discontinue their state-based exchange and switch to a federal exchange with 12 months' notice. States will need to have transition plans to detail how these changes will take effect and not harm consumers or insurance companies. The federal government will issue future guidance on transition plans, as well as on other details of the exchanges that are still works in progress.<sup>309</sup>

## 2. Section 1311(i): Culturally, Linguistically Appropriate Information in Exchanges

One of the aspects of the exchanges established in ACA Section 1311 is having a navigator program to assist consumers, and the law provides that this assistance must be “culturally and linguistically appropriate.” Relevant text from the ACA is below (emphasis added).<sup>310</sup>

1311(i) NAVIGATORS.—

- (3) DUTIES.—An entity that serves as a navigator under a grant under this subsection shall—
- (A) conduct public education activities to raise awareness of the availability of qualified health plans;
  - (B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits...;
  - (C) facilitate enrollment in qualified health plans;
  - (D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
  - (E) provide information in a manner that is **culturally and linguistically appropriate** to the needs of the population being served by the Exchange or Exchanges.

Subsequent rules have referenced and clarified the roles of the navigators in the exchanges and their responsibilities relating to cultural and linguistic competency. The final rules published in the *Federal Register* on March 27, 2012 (effective May 29, 2012) and codified in 45 CFR 155.210 on navigator program standards state in (b)(2) that the exchange must develop training standards for navigators to “ensure expertise” in areas including “the needs of underserved and vulnerable populations.”<sup>311</sup> It also states in (e)(5) that one duty of a navigator is to “Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency.”<sup>312</sup>

HHS will issue guidance in the future on model standards for cultural and linguistic competency. HHS also states in the *Federal Register* in the comments about these rules that “[w]e encourage Exchanges to

undertake cultural and linguistic analysis of the needs of the populations they intend to serve and to develop training programs that ensure Navigators can meet the needs of such populations. We note that we do not believe that this standard can be met by simply having consumers' family members or friends serve as interpreters."<sup>313</sup>

In addition to the requirements for navigators, final exchange rules issued March 27, 2012, on accessibility specify that all applications, forms, and notices sent by an exchange to applicants, enrollees, and employers, and all outreach and education on the exchange and insurance affordability programs, as well as notices from health plans, meet standards including being in plain language (as also detailed in the next section) and having taglines on it in other languages indicating the availability of written and oral language services.

Following are these rules as codified in 45 CFR 155.205 on consumer assistance in the exchanges (emphasis added):<sup>314</sup>

155.205(c) Accessibility. Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—

- (1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.
- (2) **Individuals who are limited English proficient through the provision of language services at no cost to the individual, including**
  - (i) **Oral interpretation;**
  - (ii) **Written translations;** and
  - (iii) **Taglines in non-English languages indicating the availability of language services.**
- (3) Inform individuals of the availability of the services described in paragraphs (c)(1) and (2) of this section and how to access such services.
- (d) Consumer assistance. **The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program** described in §155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate.
- (e) Outreach and education. **The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability programs to encourage participation.**

Other parts of the law reference the requirements above from the final rules on language services codified in Part 155.205. The March 2012 rules codified in 45 CFR 155.230 pertain to standards for exchange notices sent to applicants, employees, employers, and enrollees, and state in line (b) that “All applications, forms, and notices, including the single, streamlined application described in §155.405 and notice of annual redetermination described in §155.335(c), must conform to the standards outlined in §155.205(c).”<sup>315</sup> Also, Part 156.250 on qualified health plan (QHP) applications and notices states “QHP issuers must provide all applications and notices to enrollees in accordance with the standards described in §155.230(b) of this subtitle” (which as shown above references §155.205).<sup>316</sup> As shown by the ACA and subsequent regulations, all aspects and communications of an exchange and of a health plan in an exchange must provide language services.

### 3. Section 1311(e): Plain Language Requirement for Health Plans

Another part of Section 1311 on exchanges (which was amended by an addition in section 10104) lays out the data that health plans wanting to be in an exchange must submit, and requires that these items be in “plain language” so that people including those with limited English proficiency can understand them easier. The ACA text on the required information including mentioning plain language is below (emphasis added):<sup>317</sup>

1311(e)(3) TRANSPARENCY IN COVERAGE.— [As added by section 10104(f)(2)]

(A) IN GENERAL.—The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information:

- (i) Claims payment policies and practices.
- (ii) Periodic financial disclosures.
- (iii) Data on enrollment.
- (iv) Data on disenrollment.
- (v) Data on the number of claims that are denied.
- (vi) Data on rating practices.
- (vii) Information on cost-sharing and payments with respect to any out-of-network coverage.
- (viii) Information on enrollee and participant rights under this title.
- (ix) Other information as determined appropriate by the Secretary.

(B) USE OF PLAIN LANGUAGE.—**The information required to be submitted under subparagraph (A) shall be provided in plain language.** The term ‘plain language’ means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

The ACA requires that health plans in an exchange submit a variety of health plan data and make them available to the public in plain language, and the final rules published on March 27, 2012, also mention this in the context of exchanges, stating that “Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely” (codified in 45 CFR 155.205(c) as highlighted in the previous section above)<sup>318</sup> and in the rule codified in Part 156.250 that says that qualified health plans in an exchange “must provide all applications and notices to enrollees in accordance with the standards described” in 155.205, which mentions plain language.<sup>319</sup>

The March 2012 final rules added a definition for plain language codified in 45 CFR 155.20,<sup>320</sup> but it refers back to the definition above in 1311(e)(B) of the ACA.<sup>321</sup> Comments in the *Federal Register* echo the ACA text in stating that future guidance is coming on best practices of plain language writing, but there is no indication of the timeline for this.<sup>322</sup> These efforts will presumably build on the foundation established by the Plain Writing Act of 2010<sup>323</sup> pertaining to all federal government agencies.<sup>324</sup> HHS as well as other agencies have websites on plain writing that show their progress in this area.<sup>325</sup>

#### **4. Section 1001: Culturally, Linguistically Appropriate Summary of Benefits and Uniform Glossary**

Section 1001 of the ACA, which amends the Public Health Service Act, by adding certain requirements, specifies that health plans must start using a standard summary of benefits document that is culturally and linguistically appropriate and must provide a standard glossary of insurance terms to their customers and others. The relevant text from the ACA is below (emphasis added):<sup>326</sup>

SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT. Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended— ...

“SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

(a) IN GENERAL.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the ‘NAIC’), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, health care professionals, **patient advocates including those representing individuals with limited English proficiency**, and other qualified individuals. *[As revised by section 10101(b)]*

(b) REQUIREMENTS.—The standards for the summary of benefits and coverage developed under subsection (a) shall provide for the following:

(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

(2) LANGUAGE.—**The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.**

(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes— ....”

Final rules published on February 14, 2012, and effective April 16, 2012 (amending section 2715 of the Public Health Service Act) state that all group and individual health plans must provide two documents to all beneficiaries, employers, and others who ask—a Summary of Benefits and Coverage (SBC) and a Uniform Glossary. These must meet federal standards and required elements including language guidelines and must be provided at certain times such as before the first day of coverage and upon renewal. This regulation applies to health insurance plan years beginning on or after September 23, 2012.<sup>327</sup>

These final rules state that to meet the requirement to provide the SBC in a culturally and linguistically appropriate manner, a health plan must follow the same language rules as required for providing notices on claims appeals processes in different languages in the Public Health Service Act sec. 2719(e).<sup>328</sup> Guidance released on the same day as these final rules provides templates and instructions for compliance with the rules on summaries and glossaries, including more details on the language requirements.<sup>329</sup> Health insurance plans must provide summaries of benefits in other languages when 10 percent or more of the population living in the consumer’s county are literate only in the same non-English language.<sup>330</sup> This will be determined annually based on data from the American Community Survey published by the U.S. Census Bureau, and in February 2012 when the guidance was published 255 U.S. counties (including 78 in Puerto Rico) met this threshold—most of these are for Spanish but a few are for Chinese, Tagalog, and Navajo.<sup>331</sup>

SBC templates and examples of translated documents are available on the HHS website.<sup>332</sup> These will be updated after the first year since once the ACA is in full effect in 2014, new statements will need to be added to the summaries such as information on minimum essential coverage and minimum value. HHS will release guidance in the future on minimum essential coverage and minimum value statements.<sup>333</sup>

Health plans must provide the uniform glossary within seven days of request and must use the standard glossary developed by the federal government (with input from the National Association of Insurance Commissioners and others) “in the appearance specified by the Departments.”<sup>334</sup> Health plans must refer people to an online version of the glossary (linking to the plan’s own website or to a federal website) as

well as provide a phone number that people can call to request a paper copy—the glossary is available in five languages and more may come later.<sup>335</sup>

## 5. Section 1001: Culturally, Linguistically Appropriate Claims Appeals Process

Section 1001 also amends the Public Health Service Act to require that notices to consumers on the processes for appealing claims and coverage determinations must be provided in a “culturally and linguistically appropriate manner”—relevant text from the ACA and amendments is below (emphasis added).<sup>336</sup>

SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT. Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended— ...

“SEC. 2719. APPEALS PROCESS. *[Replaced by section 10101(g)]*

(a) INTERNAL CLAIMS APPEALS.—

(1) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

(A) have in effect an internal claims appeal process;

(B) provide notice to enrollees, **in a culturally and linguistically appropriate manner**, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 2793 to assist such enrollees with the appeals processes; and

(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

(2) ESTABLISHED PROCESSES.—To comply with paragraph (1)— ...

(b) EXTERNAL REVIEW.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—...

Interim final rules on health plan claims appeals were issued on July 23, 2010, amendments were issued June 24, 2011, and technical corrections were issued August 29, 2011.<sup>337</sup> According to the amendments to the interim rules, non-grandfathered health plans must provide claims appeals notices upon request in languages other than English if the address to which the notice is sent is located in a county where 10 percent or more of the population is literate only in the same language. The original rules in 2010 had different language thresholds for group and individual plans and sizes of plans, but due to comments received the threshold was changed in the amendments to be the same for all plans.<sup>338</sup> As mentioned above regarding the requirements for the Summaries of Benefits and Coverage, the list of counties reaching this threshold is published online and will be updated annually.<sup>339</sup>

In these counties the health plan must include in the English version of all notices a statement in the non-English language with information on how to access the language services provided by the health plan (the Department of Labor has provided some model language online).<sup>340</sup> The plans may choose to include the statements on all their documents, not just ones in the certain counties, to make administration easier. If plans must send notices to people in counties meeting the non-English language threshold, the plans must provide oral language services (such as a telephone hotline) that include answering questions in the applicable languages and assisting customers with filing claims and appeals, including external review, in

the applicable non-English languages.<sup>341</sup> The amendments became effective July 22, 2011, and apply to plan years that start on or after January 1, 2012.

## 6. Section 1311(g): Incentive Payments in Health Plans for Reducing Disparities

Section 1311(g) was amended by Section 10104 of the ACA, which added another set of activities that health plans can do to obtain increased reimbursements or other incentives. These additional activities concern reducing disparities by means such as language services, outreach, and cultural competency training—relevant text from the ACA is below (emphasis added):<sup>342</sup>

1311(g) Rewarding Quality Through Market-Based Incentives-

(1) STRATEGY DESCRIBED- A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for--

- (A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;
- (B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
- (C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;
- (D) the implementation of wellness and health promotion activities; and
- (E) *[As added by section 10104(g)]* **the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.**

(2) GUIDELINES- The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS- The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

As mentioned in paragraph (2) in the excerpt above, the ACA states that the Secretary of the U.S. Department of Health and Human Services will consult experts and stakeholders and develop guidelines on implementing market-based incentives for health plans that carry out certain activities aiming to reduce health care disparities. No guidelines have been issued on this topic at the time of this writing.

## 7. Section 2901: Remove Cost Sharing for Indians below 300 Percent of the Federal Poverty Level

Indians (American Indians and Alaska Natives as defined in another law as referenced below) are mentioned in several places throughout the ACA and subsequent regulations and are provided some special allowances. Section 2901 of the ACA, and section 1402 that it refers to, specifies that Indians will pay no cost-sharing for health care from a plan in an exchange if they have incomes below 300 percent of the federal poverty level, and also that Indians enrolled through the exchange will not need to pay any cost-sharing for items and services they receive from the Indian Health Service and tribal organizations. Relevant text from Sections 2901 and 1402 is below (emphasis added):<sup>343</sup>

SEC. 2901. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.—For provisions prohibiting cost sharing for Indians enrolled in any qualified health plan in the individual market through an Exchange, see section 1402(d) of the Patient Protection and Affordable Care Act.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS. ...

(d) SPECIAL RULES FOR INDIANS.—

(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) **the issuer of the plan shall eliminate any cost sharing under the plan.**

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) **no cost-sharing under the plan shall be imposed under the plan for such item or service;** and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

Besides Indians in the exchanges having no out-of-pocket costs for copays and deductibles in certain situations depending on income and provider, the ACA states in 1311(c)(6)(D) that exchanges are required to provide monthly enrollment periods for Indians, not annually as for other consumers, so they will have more chances to choose or change their health plans.<sup>344</sup> The comments in the *Federal Register* with the March 27, 2012, final rules on health insurance exchanges state, “We are finalizing special Exchange enrollment periods and the reductions in cost sharing for Indians authorized, respectively, by sections 1311(c)(6) and 1402(d) of the Affordable Care Act under this authority in subparts D and E of part 155, and we expect to address others in future rulemaking.”<sup>345</sup> Thus federal rules and regulations will be issued in the future to clarify these areas.

The ACA states in 1311(d)(6) that exchanges must consult with various stakeholders, and the March 2012 final rules add Indians to this list, saying that exchanges must “regularly” consult with certain stakeholders including “Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, that are located within such Exchange’s geographic area” [codified in 45 CFR Part 155.130(f)].<sup>346</sup> The exchange rules from March 27, 2012, codified in 45 CFR Part 155.210(c)(2), say that Indian tribes, tribal organizations, and urban Indian organizations are included in the groups eligible to be navigators.<sup>347</sup> The associated comments in the *Federal Register* state that, “Development of the Navigator program should be an important element of Exchanges’ consultation with Tribal governments. The Navigator program will help ensure that American Indians/Alaska Natives participate in Exchanges.”<sup>348</sup> The *Federal Register* also states that guidance for states will be provided in the future concerning “key milestones, including tribal consultation, for approval of a State-based Exchange.”<sup>349</sup>

The ACA establishes that members of Indian tribes are exempt from the individual mandate, so they will have no penalties for not having the minimum coverage required of most other people.<sup>350</sup> Relating to health care for Indians, the ACA also revises and permanently authorizes the Indian Health Care

Improvement Act (first enacted in 1976), providing for several new programs and financial arrangements.<sup>351</sup>

## 8. Section 1557: Non-Discrimination in Federal Programs and Exchanges

The ACA contains a section that extends the protections of previous anti-discrimination laws to the additional health programs in the ACA receiving federal funding including the new health insurance exchanges. Relevant text from the ACA is below (emphasis added):<sup>352</sup>

**SEC. 1557. NONDISCRIMINATION.**

(a) **IN GENERAL.**—Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), **be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).** The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

As referenced in the acts cited in Section 1557, several anti-discrimination laws related to race, ethnicity, and other factors are already in place and the ACA applies these protections to the new health care programs receiving federal funding. In comments published in the *Federal Register* on March 27, 2012, HHS stated that commenters requested clarification on the non-discrimination standards and had recommendations on compliance, and that future federal guidance will be issued on the oversight and enforcement of these standards.<sup>353</sup> It also provides insight into the application of the standards and the development of the final rules.<sup>354</sup>

The final rules published in March 2012 explicitly add that states and exchanges must comply with federal non-discrimination standards, and are codified in 45 CFR 155.120 as follows (emphasis added):<sup>355</sup>

**155.120 Non-interference with Federal law and non-discrimination standards.**

- (a) Non-interference with Federal law. An Exchange must not establish rules that conflict with or prevent the application of regulations promulgated by HHS under subtitle D of title I of the Affordable Care Act.
- (b) Non-interference with State law. Nothing in parts 155, 156, or 157 of this subchapter shall be construed to preempt any State law that does not prevent the application of the provisions of title I of the Affordable Care Act.
- (c) Non-discrimination. **In carrying out the requirements of this part, the State and the Exchange must:**
- (1) Comply with applicable non-discrimination statutes; and**
  - (2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.**

The non-discrimination requirement likely applies also to qualified health plans in an exchange, and to their subcontracted providers, because credits and subsidies going to a health plan could be considered federal financial assistance.<sup>356</sup>

## Endnotes

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<sup>8</sup> U.S. Congress, 111th Session, “Compilation of the Patient Protection and Affordable Care Act and the Health-Related Portions of the Health Care and Education Reconciliation Act of 2010” (May 2010, §1311(i), p. 89), online at <http://housedocs.house.gov/energycommerce/ppacacon.pdf>, accessed 17 Sept. 2012.

<sup>9</sup> Federal Register, 77 FR 18309 (Mar. 27, 2012), Rules codified in 45 CFR Part 155.210, online at <https://federalregister.gov/a/2012-6125%20/p-2110>, accessed 24 Sept. 2012.

<sup>10</sup> Federal Register, 77 FR 18309 (Mar. 27, 2012, pp. 18309 -18475), online at <https://federalregister.gov/a/2012-6125%20/p-409>, accessed 24 Sept. 2012.

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