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Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges

Enhanced Executive Summary

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Enhanced Executive Summary[1]

I. Introduction

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. 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 concerns around immigrant status and government reporting for both documented and undocumented residents. The ACA acknowledges these potential barriers 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.

The objective of this report is to track progress to date on the ACA's provisions for advancing equity through the health insurance exchanges, identify and synthesize related resources, highlight model activities, and develop recommendations for states, health plans, federal agencies, and others to ensure effective implementation of related cultural and linguistic requirements. Given the fast-approaching deadline of October 1, 2013, when exchanges must begin enrolling consumers, state agencies, health plans, and others are in need of more information on how to implement these requirements and 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 vulnerable populations (especially racially and ethnically diverse patients and their communities), and others involved with health insurance exchange issues and programs to reduce disparities.

II. Methodology

This study utilized qualitative and analytical methods to monitor and review progress of the ACA's health insurance exchange provisions with major implications for racially and ethnically diverse enrollees. As such, we conducted a systematic review and synthesis of relevant literature; an analysis of the ACA and subsequent regulations and guidance issued by the federal government; and interviews with individuals representing federal and state health agencies, exchanges, health plans, advocacy organizations, and others. In addition, we conducted in-depth case studies of seven leading state-based exchanges—California, Colorado, Connecticut, Maryland, New York, Oregon, and Washington—to identify progress, best practices, challenges, and lessons learned. States were selected based on a set of criteria including progress in establishing a state-based exchange; state efforts to address racial and ethnic diversity and equity; geographic region; and high percentage of racially, ethnically, and linguistically diverse populations. Finally, our review included an overview of health plans status and progress, particularly

[1]Information included in this Enhanced Executive Summary is drawn from the Texas Health Institute's report entitled *Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges,* produced in March 2013. To access the full report, visit: http://www.texashealthinstitute.org/health-care-reform.html.

those leading in equity, diversity, and cultural competency efforts. Model cultural and linguistic competency programs in health plans are highlighted.

III. ACA Provisions, Regulations, and Guidance

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

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

2. ***Section 1311(i): Culturally, Linguistically Appropriate Information in Exchanges*** requires that exchanges establish a navigator program to assist consumers. Final rules issued in March 2012 state that the exchange must develop training standards for navigators to ensure 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."

3. ***Section 1311(e): Plain Language Requirement for Health Plans*** describes the information that health plans offered in an exchange must submit to the exchanges such as financial disclosures and enrollment materials, and requires that these items be in "plain language" so that those with limited English proficiency, low literacy, and others can easily understand them.

4. ***Section 1001: Culturally, Linguistically Appropriate Summary of Benefits and Uniform Glossary*** 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. Final rules published in 2012 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. These requirements take 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.

5. ***Section 1001: Culturally, Linguistically Appropriate Claims Appeals Process*** requires that notices to consumers on the processes for appealing claims and coverage determinations must be provided in a "culturally and linguistically appropriate manner." Interim final rules and amendments in 2010 and 2011 state that all 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. These requirements took effect for plan years beginning on or after January 1, 2012.

6. ***Section 1311(g): Incentive Payments in Health Plans for Reducing Disparities*** added another set of activities that health plans or their providers can undertake 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." 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 at the time of this writing.

7. ***Section 2901: Remove Cost Sharing for Indians*** 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.

8. ***Section 1557: Non-Discrimination in Federal Programs and Exchanges*** extends the protections of previous anti-discrimination laws to additional health programs in the ACA receiving federal funding, including the new health insurance exchanges. As stated in 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)."

IV. State Implementation Progress and Case Studies

Meeting language and cultural needs of diverse enrollees is especially important for exchanges as estimates predict higher proportions will use them compared with traditional employer-based insurance. An estimated 29 million people are expected to 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. ES - Table 1 shows the percentages of projected enrollees in individual insurance by race and ethnicity compared to individuals 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.

ES - Table 1.
Estimated Percent Racial and Ethnic Enrollees in Exchanges vs. Employer-Sponsored Insurance

	Individual Insurance in Exchanges (by 2019)	Employer-Sponsored (currently)
White	58%	72%
Black	11%	10%
Hispanic	25%	10%
Other	6%	7%
Language other than English Spoken at Home	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 those estimated to obtain insurance through the exchanges, 65 percent are currently uninsured, and may therefore need more assistance in understanding the different options. Approximately, 82 percent of enrollees will have incomes below 400 percent of the federal poverty level, qualifying them for government subsidies.

As of February 15, 2013, 17 states and the District of Columbia opted to establish state-based exchanges. Seven states planned to partner with the federal government on their exchanges, and 26 states are expected to have federal government-run exchanges. 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 progress—both in terms of setting up their exchanges and in addressing diversity, equity, and cultural and linguistic competency prior to and following enactment of the ACA. 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. 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. ES-Table 2 summarizes actions related to diversity and cultural competency in the health insurance exchange among the seven states selected.

ES - Table 2. Summary of Exchange Actions in Case Study States Addressing Diversity and Cultural and Linguistic Competency

	CA	CO	CT	MD	NY	OR	WA
State Exchange Development and Planning							
Diversity in board composition	Y	Y	Ni	Y	(1)	Y	Ni
Diversity in vision, mission, or values statements	Y	Ni	Y	Ni	Ni	Y	Y
Diversity specified for stakeholder advisory groups	Y	Ni	Ni	Y	Ni	Y	Ni
Diversity in community meetings or focus groups	Y	Y	Y	Y	Y	Y	Y
*Tribal consultation policy and activity	Y	Y	Y	(2)	Y	Y	Y
Input from diverse community advocates	Y	Y	Y	Y	Y	Y	Y
Outreach, Education, and Enrollment							
*Outreach & education for racial, ethnic, LEP individuals	Y	Y	Y	Y	Y	Y	Y
*Navigators/assisters to assist diverse individuals enroll	Y	Y	Y	Y	Y	Y	Y
*Cultural & linguistic competency training materials to be developed for navigators/assisters	S	S	S	Y	Y	S	S
Website, Qualified Health Plans, and Evaluation							
*Planning for Internet web portal to provide access for LEP individuals	Y	Y	Y	Y	Y	Y	Y
Planning to take cultural & linguistic competency measures into account in selecting qualified health plans	Y	(3)	Ni	(3)	Ni	Ni	(3)
Planning to measure and evaluate success in addressing diversity and disparities in the exchange	Y	S	Ni	S	Ni	Ni	Ni

Notes: "Y" denotes "Yes, the exchange has implemented this action"; "S" denotes "Some progress identified"; and "Ni" denotes "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.
[1] New York's exchange does not have a board and was created by executive order, not legislation.
[2] There are no federally recognized American Indian tribes in Maryland.
[3] 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.

Our findings reveal that these states are making good progress in establishing exchanges that meet cultural and linguistic competency provisions, offering to other states lessons learned from their experiences when designing their exchanges.

- ***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 vision, mission, and values of the exchange specifically cite diversity and reducing disparities, while board members represent the

different ethnicities across the state. In addition, 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 exchange will offer $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.

- ***Colorado*** established a health insurance exchange in June 2011 as a nonprofit unincorporated public entity. The exchange legislation states that the entities appointing the board members "shall consider geographic, economic, ethnic, and other characteristics of the state when making the appointments." 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 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.

- ***Connecticut*** established its exchange in 2011 as a public nonprofit corporation, and hired a chief executive officer in June 2012. 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.

- ***Maryland*** established the exchange in April 2011 with additional legislation in May 2012 as a quasi-governmental organization. The exchange works closely with other state entities to ensure its effective implementation. For example, Governor Martin O'Malley created the Health Care Reform Coordinating Council the day after the ACA was enacted in 2010 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. One of the council's recommendations in 2011 explicitly addressed the priority for eliminating health disparities, which resulted in forming a workgroup on disparities and subsequent health disparities legislation in 2012.

- ***New York*** established its exchange 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. 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. 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.

- ***Oregon*** authorized its exchange in June 2011 and it was finalized in March 2012. The exchange legislation lists the following as one of its central goals: "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." 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." 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. 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 states that it will partner with community-based organizations in order to reach all residents.

- ***Washington*** first established its health insurance exchange in May 2011, with additional legislation passed in March 2012. The exchange's enabling legislation does not explicitly mention diversity, disparities, or equity, but its mission statement mentions equity as one of its values. Marketing and outreach for the exchange will use "considerable resources to reach all communities that are eligible to participate in the exchange." The exchange's customer service program will include remote assistance (through the website and call center) and in-person assistance via navigators and assisters.

V. Health Plan Implementation Progress and Programs

Many health plans were working on health disparities and language priorities for years before the ACA given their rapidly growing diverse customer base and previous laws and regulations requiring language access in programs such as Medicaid and Medicare. Language access and translation services generally gained prominence and support in health care delivery settings and outreach first, and their attention in insurance and policy are more recent. Thus many of the ACA's cultural and linguistic competency requirements are actions that a number of leading health plans have already implemented either fully or in part, in some cases exceeding the ACA requirements.

- ***Culturally and Linguistically Appropriate Summary of Benefits and Uniform Glossaries*** apply to all health plans, both those planning to participate in exchanges and in other insurance programs, and have already taken effect. 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.

- ***Culturally and Linguistically Appropriate Claims Appeals Processes*** were not being used to the extent required by the ACA by all plans for internal and external claims appeals. As a result, before the requirement went into effect, some plans formed internal teams to 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.

- ***Plain Language Requirement for Health Plans in an Exchange*** is a provision for which many of the plans interviewed indicated they are in a good position to comply with since plain language strategies and health literacy have been an area of focus for them, in some cases, well before the enactment of the ACA. Many health plans have hired writers or contractors to develop or refine their outreach documents and are starting to adjust all documentation in accordance with health literacy and simple language principles, such as shorter sentences and simpler wording.

- ***Incentive Payments in Health Plans for Reducing Disparities*** have not seen regulations or guidance 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 conduct such activities internally, so it remains to be seen what the payment structure will be and who will be rewarded.

In general, language access is growing and some health plan websites are offered in multiple languages. 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. One useful development described by several health plans is utilizing "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. 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 their 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. There are many other examples of successful interventions and programs on language access and cultural competency in health plans that can assist other health plans and state exchanges.

VI. Discussion

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

Diversity and Equity in State Exchange Planning and Development is moving forward among the seven states studied as each state has made clear progress in integrating goals around racial and ethnic diversity and equity into current plans and related actions. As of this writing, two states—California and Oregon—are examples of leading states which have addressed diversity and equity broadly 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.

Culturally and Linguistically Appropriate Outreach, Education, and Enrollment will be critical to assure equity in health exchange implementation. 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 navigators, creating culturally sensitive outreach campaigns, and developing training standards and materials on cultural competency for assisters. All of the case study states plan to target outreach and education for specific racial and ethnic populations and those with limited English proficiency. They also plan to operate a navigator or 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 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.

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 to improve the exchange as needed, and two other states have mentioned aspects of assessment and improvement as well.

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 throughout a state and not just in large urban centers.

What Challenges Lie Ahead for States?

Challenges identified by state exchanges during interviews primarily highlighted 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 are unable to read in any language are some of the resource challenges.

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.

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.

What is the Status of Progress for Health Plans?

Health plans we researched and interviewed have taken steps to provide services in a more culturally and linguistically appropriate manner, due to customer necessity as well as regulations, 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, uniform glossaries, and claims appeals processes, are already in effect with health plans modifying their documentation and processes to meet these requirements.

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 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. 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.

Several health plans recommended that organizations and stakeholders work to integrate cultural and linguistic competency as early in the planning process as possible, and to collect data on consumers from the start that will best capture information 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.

What Challenges Lie Ahead for Health Plans?

A prominent 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 challenge that emerged in our review was related to health plans being accustomed 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. As such, 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, and as such 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

This report offers five recommendations 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. ES-Table 3 offers additional tips and advice on advancing and integrating equity.

1. **Fully integrate diversity and equity objectives in exchange mission, objectives, and planning.** Exchanges need to start as early as possible to include racially and ethnically diverse representation and voices in all planning and decisions. They should also seek input from a diverse group of stakeholders through multiple channels. Finally, 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.

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.** 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. Navigators, in-person assisters, call center personnel, and others who work with consumers should receive adequate training in cultural and linguistic competency standards. Translators and interpreters should also be trained and follow professional standards.

3. **Ensure culturally and linguistically appropriate information, resources, and communication is provided by the exchange.** All print 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. Materials should be written in plain language at a low literacy level. In addition, exchanges should ensure that consumers can get help in multiple languages when enrolling, whether in person, online, or by telephone.

4. **Actively share and disseminate information on experiences, promising practices, and lessons learned in addressing diversity and equity in exchange planning.** 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. Resources such as the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS standards), published by the Office of Minority Health, can offer important guidance on effective implementation, especially for racially and ethnically diverse consumers.

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.** 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 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.

ES – Table 3. 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 is 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.

VII. 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. 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.