Language Access in Washington State

Under the Patient Protection & Affordable Care Act

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Executive Summary

The Patient Protection and Affordable Care Act of 2010 ("ACA") aims to protect health care rights, expand health coverage, and improve health outcomes by giving consumers the information and tools they need to access and understand the health care system.

In keeping with this goal, the law includes a number of provisions aimed at improving access for consumers with Limited English Proficiency ("LEP").[1] These individuals will require language interpretation and translation services to use the new ACA health infrastructure, such as insurance offered in the Health Benefits Exchange ("Exchange").

What is Limited English Proficiency?

Limited English Proficiency is the limited ability to read, speak, write, or understand English by those for whom English is not their primary language.

While the ACA provides a firm foundation for enhanced language access, its provisions have not yet been explained with enough specificity to guarantee meaningful access for all residents with LEP, as this brief will explain. Nevertheless, Washington State must move forward rapidly to build its Exchange and other ACA-related infrastructure to implement the changes required by 2014.

Recognizing this timing tension, it will be crucial for state policymakers to proceed in implementing ACA language access requirements to the greatest extent possible, while at the same time considering state-specific measures to promote health access for populations with LEP.

The three parts to this brief offer tools for Washington State to undertake this work:

- **Part I**: Describes why shifting demographic trends mean that strong language services will be critical to successful ACA implementation in Washington State.
- **Part II**: Outlines the language access standards in the ACA and accompanying regulatory guidance, offering recommendations for how the state could comply with these federal laws.
- **Part III**: Suggests additional steps the state should take to meet and improve these standards to ensure meaningful access for residents with LEP.[2]

This brief is not exhaustive, particularly given rapidly-developing federal guidance. As such, it should be seen as a starting point for further research and dialogue with stakeholders. In addition, efforts to improve Washington State's health care access for residents with LEP need not take place in a vacuum. In shaping its new systems, Washington can build upon decades of experience with language access services for state medical programs and look forward to a healthier future for all its residents.

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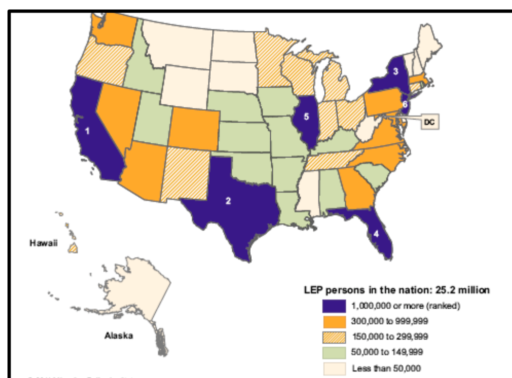
[1] Limited English Proficiency (LEP): A Federal Interagency Website. "Frequently Asked Questions: Who is a Limited English Proficient (LEP) individual?" Available at: http://www.lep.gov/faqs/faqs.html#OneQ1.

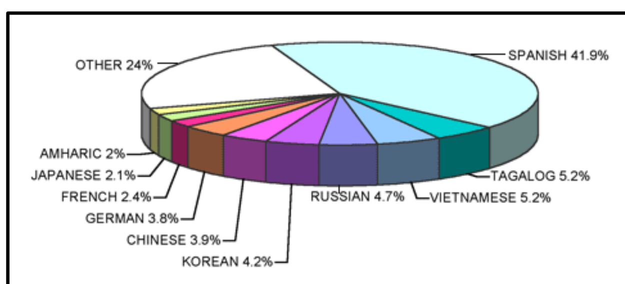
[2] While this brief does not specifically address the needs of other populations with special access needs, such as the 4% of Washington residents who are deaf or hard-of hearing or the 2% with visual impairments or blindness, many of the recommendations apply equally. It should be noted too that state residents with disabilities report an LEP rate of 15%, almost double that of the general population, highlighting that additional specialized language services may be required to guarantee access. *See* Sharkova et. al., "Demographic and socio-economic characteristics of persons with serious hearing loss and other serious health conditions in Washington State" (2011). Available at http://publications.rda.dshs.wa.gov/1430/. We urge further attention to this area, particularly because in 2011, 67% of requests for American Sign Language interpretation for Medicaid enrollees went unfilled, and currently, no ASL interpreters are registered with HCA's Medicaid interpreter Services contractor. *See* http://wsridlegcommittee.wix.com/wsrid-legislative-information/apps/blog/hca-reports-67-of-requests-for-asl; HCA Interpreter Services Stakeholder Meeting Notes, November 5, 2012, available from HCA.

I. Washington State must address language access to achieve the ACA goal of improving health care and coverage for all residents.

The issue of language access in health care is pressing for Washington State, which now has over 512,000 residents over the age of five—8% of the state population—who identify as having LEP.[3] In recent years, Washington State's Department of Social and Health Services ("DSHS") reported interpreter requests for medical and social service appointments in over 70 languages, including the 8 "threshold languages" of Spanish, Vietnamese, Russian, Cambodian, Laotian, Mandarin, Cantonese, and Korean.[4] Over the past two decades, Washington's LEP population has experienced one of the fastest growth rates in the country, rising 210% from 165,000 LEP individuals in 1990 to current estimates.[5] By contrast, the average national growth rate in the LEP population over this time period was just 80%.[6]



Washington State Has One of the Highest LEP Populations
Source: Migration Policy Institute, "LEP Data Brief," 2011



Non-English Languages Spoken by WA Residents Over Age 5
Source: American Community Survey, 2005

Given this demographic trajectory, it is more important than ever for Washington State to recognize the well-documented links between LEP status, health literacy, barriers to needed medical care, and ultimately, health outcomes. Individuals who primarily speak a language other than English are less likely to have insurance, see a health provider regularly, or follow instructions for medical care— and more likely to frequent emergency rooms or other safety net options.[7] In Washington State, for example, the federally-qualified community health center network, which served over 750,000 patients in 2010, reported providing language services to LEP patients at 96% of their service delivery sites.[8] In

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[3] US Census Bureau, M1603. "Percent of People 5 Years and Over Who Speak English Less Than 'Very Well', 2005-2009 American Community Survey 5-Year Estimates." Available at: http://tinyurl.com/7xtzqlr.

[4] Washington State Department of Social and Health Services, "Language Testing and Certification Program, Certified Languages." Available at: http://www.dshs.wa.gov/ltc/.

[5] Migration Policy Institute. "Limited English Proficient Individuals in the United States: Number, Share Growth, and Linguistic Diversity." (Dec. 2011). Available at: http://www.migrationinformation.org/integration/LEPdatabrief.pdf.

[6] *Id.*

[7] *See, e.g.,* L. Ku and T. Waidmann, "How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care, and Quality of Care Among the Low-Income Population." Prepared for the Kaiser Commission on Medicaid and the Uninsured (KCMU), (Aug. 2003). Available at: http://www.kff.org/uninsured/upload/How-Race-Ethnicity-Immigration-Status-and-Language-Affect-Health-Insurance-Coverage-Access-to-and-Quality-of-Care-Among-the-Low-Income-Population.pdf; G. Flores, M. Abreu, S.C. Tomany-Korman. "Limited English Proficiency, Primary Language Spoken at Home, and Disparities in Children's Health and Healthcare: How Language Barriers are Measured." *Public Health Reports,* July/Aug. 2005, 120 (4): 418-30. Available at: http://www.commonwealthfund.org/Publications/In-the-Literature/2005/Jul/Limited-English-Proficiency--Primary-Language-at-Home--and-Disparities-in-Childrens-Health-Care--How.aspx; Overview of Health Coverage for Individuals with Limited English Proficiency prepared for the KCMU, Aug. 2012, available at : http://www.kff.org/uninsured/8343.cfm.

[8] National Association of Community Health Centers, "Washington Health Center Fact Sheet." Available at: http://www.nachc.com/state-healthcare-data-list.cfm. This data covers only FQHCs—other types of safety net providers also provide extensive care to LEP populations.

addition, language barriers create a significantly increased risk of serious patient safety problems, resulting in longer hospital stays and more re-admissions.[9,10]

Research demonstrates the most effective way to address these disparities: with qualified language service providers (interpreters or personnel whose skills have been assessed), written translations, multimedia approaches, and other tools such as "taglines" on publications indicating the availability of these services.[11] Yet despite progress toward these goals, Washington State has struggled to address health care access for its residents with LEP, and access is still far from universal across care settings. A 1991 court order[12] found deficiencies in translation and interpretation services for applicants and enrollees in public medical coverage programs, which the state agreed to remedy by taking specific steps toward improving language access.[13] Efforts to comply with this order continue today, but these efforts have frequently fallen short. For example, the Health Care Authority reports widely varying fill rates for requests for in-person interpreters for Medicaid appointments, with 89% of Spanish requests filled but just 28% of Tigrinya requests met.[14] For the uninsured and privately insured, language access resources may be even scarcer.[15]

Put simply, the status quo is inadequate. For Washington to implement health reform in a manner that promotes access for all its residents, it must institute strong language access standards that apply broadly to the pathways to coverage and associated business operations, as well as to health plans and providers. The ACA provides Washington State with the opportunity and mandate to do so.

II. The ACA sets important new standards for language access in the health care system, but the specific parameters of these standards remain unclear.

The ACA provides an opportunity for Washington State to reassess its language access policies in light of new federal standards. The ACA and its accompanying regulations include a number of requirements that call for the provision of services and information in a manner that meets the needs of residents with LEP. These requirements are primarily directed at state Exchanges, but in some cases extend beyond Exchanges to other components of the health care system.

While these new requirements are quite strong, many currently lack the specificity that would be needed to guarantee meaningful health care access for LEP individuals. Additional federal guidance is

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[9] "Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide For Hospitals." Agency for Healthcare Research and Quality, No. 12-0041 (Sept. 2012). Available at: http://www.ahrq.gov/populations/lepguide/.

[10] This is not only a safety and quality-of-care concern, but also presents a risk-management issue under ACA Section 3025, whose Hospital Readmission Reduction Program, already in effect, imposes significant fines on hospitals with excess rates of avoidable re-admissions.

[11] *See, e.g.,* L. Ku, G. Flores. "Pay Now or Pay Later: Providing Interpreter Services in Health Care." *Health Affairs*, Mar. 2005, 24 (2): 435-44. Available at: http://content.healthaffairs.org/content/24/2/435.full.

[12] Stipulation, Agreement of Settlement and Consent Order, *Reyes v. Thompson*, W.D. Wash. March 12, 1991 (No. C91-303).

[13] *See* http://www.dshs.wa.gov/ltc/itsvcs.shtml.

[14] In 2011, the Health Care Authority reported widely varying fill rates for requests for in-person interpreters for Medicaid appointments across languages. While requests for Spanish, Russian, and Cantonese interpreters were filled 89%, 90%, and 85% of the time, respectively, fill rates for other common languages were dismal: interpreters were provided for only 60% of 6,008 requests for Somali; 62% for 3,030 requests for Cambodian; 28% for 1,538 Nepali requests; and 28% for 1,610 Tigrinya requests. *See* Health Care Authority, K559-Interpreter Services RFP. Exhibit I - Information and Data on Languages. Available at: www.hca.wa.gov/documents/rfp/interpreter_services/exhibit_i.pdf .

[15] Puget Sound Health Alliance. "Improving Language Services – Lessons Learned from the Hospital Quality Network" (seminar held Apr. 17 2012) Available at: http://forces4quality.org/collaborative/74/improving-language-services; Washington CAN and Northwest Federation of Community Organizations. "Equal Treatment? Seattle Hospitals Put to the Test" (2009). Available at: http://allianceforajustsociety.org/546/equal-treatment/

likely in the future, but these regulations may not be in place by the 2014 deadline for states to implement many ACA reforms. In the meantime, Washington should view the following ACA language requirements as a clear federal directive for states to dramatically improve language access standards in health care, implementing known minimum federal requirements and imposing clear, enforceable additional state standards to meet the needs of residents with LEP.

a. Section 1557 – Nondiscrimination

ACA Section 1557 extends the application of existing federal civil rights laws to the health care context, prohibiting discrimination by:

- Any health program or activity receiving federal financial assistance (e.g., Exchange tax credits);
- Any program or activity administered by an executive agency (e.g., Medicare) or
- Any entity established under Title 1 of ACA (e.g., state Exchanges and Basic Health Options).

Under this new provision, the above programs, activities, and entities cannot discriminate on the grounds prohibited under Title VI of the Civil Rights Act of 1964,[16] including discrimination on the basis of race, color, or national origin. National origin discrimination has long been interpreted to require entities receiving federal funds (including health providers) to take "reasonable steps to ensure meaningful access to their programs for and activities by LEP individuals" [17] when a balance of factors makes this appropriate. [18]

Section 1557 explicitly extends this and other Title VI civil rights protections to the health care context: individuals with LEP may not be excluded from participating in, denied the benefit of, or subject to discrimination under the health-related programs, activities, and entities listed above.

The plain language of the statute clearly prohibits discrimination against individuals with LEP in the Exchange, but it applies even more broadly because § 1557 *specifically* applies to credits, subsidies, and contracts for insurance. The "credits, subsidies, and contracts for insurance" language expands the scope of § 1557's nondiscrimination requirements beyond the Exchange entity itself to the qualified health plans ("QHPs") contracting to provide coverage through the Exchange, and likely to providers contracting with these plans (to avoid a perverse result where a QHP may be subject to nondiscrimination but avoid its obligations through subcontracts). Though guidance has not yet been issued, there are two primary reasons to support the interpretation that QHPs are obligated to comply with Title VI nondiscrimination provisions:

- Direct - Qualified health plans will directly receive advance premium tax credits and cost-sharing subsidies from the Treasury Department—thereby "receiving federal financial assistance."
- Indirect - Preamble language in Exchange regulations notes that because Navigators are third parties under agreement with the Exchange, the nondiscrimination standards that apply to

[16] 42 U.S.C. § 2000d *et. seq.*

[17] Executive Order 13166, 65 Fed. Reg. 50121 (August 16, 2000); HHS, "Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency," 67 FR 4968 (February 1, 2002). *See also Lau v. Nichols*, 414 U.S. 563, 94 S. Ct. 786 (1974), holding that failure to provide information and services in languages other than English could constitute national origin discrimination where failure to do so resulted in a significant number of LEP beneficiaries from the same language minority being unable to fully realize the intended benefits of a federally-assisted program or activity; *Alexander v. Sandoval*, 532 U.S. 275, 121 S.Ct. 1511 (2001) (driver's license examinations); *Pabon v. Levine*, 70 F.R.D. 674 (S.D.N.Y. 1976) (unemployment insurance information).

[18] *See* Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, 67 FR 4968 (Feb. 1, 2002).

Exchanges under ACA § 155.120(c) will also apply to entities seeking to become Navigators.[19] Given this parallel guidance on a similar issue, there appears to be an affirmative duty for both an Exchange and its third-party QHPs to take reasonable steps toward meaningful access for individuals with LEP.

Recommendation: Washington State should analyze the impact and scope of this new requirement, considering possible methods for enforcement. Under the language § 1557, injured parties may pursue individual legal action in federal court to the extent permitted under other federal civil rights laws or instead rely on federal agencies such as Department of Health and Health and Human Services ("HHS") for enforcement actions. However, these federal remedies are often difficult for individuals with LEP to pursue in practice. As such, Washington should consider state-level remedies, such as cross-referencing §1557 with the Washington Law Against Discrimination (discussed in further detail below) or offering support for injured parties through the state Human Rights Commission. In addition or in the alternative, Washington State could confirm through state law or statute that the Exchange, QHPs, and their subcontractors must comply with Title VI and other applicable civil rights laws.

b. Section 1001 – Notices of Appeals
Section 1001 - Summary of Benefits and Coverage
Section 1331 – Plain Language

In addition to the overarching nondiscrimination provision of Section 1557, the ACA includes three specific language access requirements for QHPs participating in the Exchange:

- Section 1001 requires group health plans and health insurance issuers to provide a notice to enrollees, *in a culturally and linguistically appropriate* manner, of appeals processes and any available Insurance Commissioner or Ombudsperson assistance;
- Section 1001 also requires group health plans and health insurance issuers to provide a summary of benefits and coverage, in *culturally and linguistically appropriate* language that will be understood by the "average plan enrollee" (emphasis added).
- Section 1331 requires qualified health plans to make certain information[20] available in "plain language," defined to mean "language that the intended audience, *including individuals with limited English proficiency*, can readily understand and use…" (emphasis added).

Together, these provisions amount to a requirement that health plans make most communications accessible to LEP individuals. While the ACA does not detail the specific contours of this requirement, HHS provides additional guidance in 45 C.F.R. § 155.205(c) of the final Exchange regulations, requiring the Exchange's "consumer assistance function" to provide: oral interpretation, written translations, and "tag lines" on printed materials indicating the availability of these services for individuals with LEP. Presumably, these requirements will also apply to the Exchange's third-party contractor QHPs, but the interim final regulations do not address this. The regulations indicate there will be future guidance elucidating specific LEP-related definitions and duties, such as a population prevalence standard that would trigger printed taglines in a particular language.

[19] HHS, "Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers,"77 Fed. Reg. 59, 18332 (Mar. 27, 2012) (codified at 45 C.F.R. pts. 155, 156, 157).
[20] This information includes: claims payment policies and practices; periodic financial disclosures; data on enrollment and disenrollment; data on the number of claims that are denied; data on rating practices; information on cost-sharing and payments with respect to any out-of-network coverage; information on enrollee and participant rights; and any information as determined appropriate by the Secretary.

Recommendation: Since Washington State must move forward now to design the consumer assistance function for October 2013 open enrollment, it seems prudent for Washington State to adopt its own provisional standards to ensure consistency across all new ACA-related programs and infrastructure. For example, it will be important for the Exchange, HCA, DSHS and Insurance Commissioner Consumer Protection Division to provide oral interpretation in the same languages and modalities. In adopting these joint standards, the state should look to existing standards for Medicaid as well as nationally-recognized standards, such as the "five percent or 500 person" threshold for language prevalence that some federal agencies use today (discussed further below).[21]

c. Section 1301 – Essential Community Providers
   Section 1311 – Navigators

The ACA and subsequent regulations also include provisions designed to ensure that LEP individuals achieve better access through a linguistically appropriate healthcare workforce.

ACA Section 1311(c)(1)(C) requires QHPs to contract with "essential community providers" ("ECP") that serve predominately low-income, medically-underserved individuals. The final Exchange regulations clarify that the term ECP includes those entities named in Section 340B(a)(4) of the Public Health Service Act[22] and Section 1927(c)(1)(D)(i)(IV) of the Society Security Act[23]—including a number of entities that have historically served individuals with LEP, such as federally-qualified health centers, community health centers, and migrant health centers.

Similarly, the ACA authorizes funding to support patient "Navigator" programs to assist consumers in accessing the Exchange and selecting qualified health plans. In addition to the requirement in guidance that Navigator programs include at least one community-based organization or consumer-focused nonprofit, ACA §1311(i) requires Navigators to provide information that is *culturally and linguistically* appropriate to the needs of the population being served by the Exchange.

Through these requirements, HHS creates an expectation that entities and workers serving Exchange consumers will be embedded in and oriented toward the communities they serve, including LEP communities. However, federal guidance to date lacks the specificity that would be needed to ensure language access in Washington State. The federal standard measuring the adequacy of ECP inclusion in a QHP's network is imprecise: plans must have a "sufficient" number and geographic distribution of ECPs to ensure "broad and timely access" to a broad range of such providers. Likewise, federal Navigator standards offer broad leeway to states in selection and training Navigator entities, creating the risk that Navigators will not be equipped to handle consumers with diverse language needs.

Recommendation: Washington State should act now to build and prepare a qualified linguistically appropriate workforce to serve the growing number of residents with LEP who will enter the insurance market in 2014 and beyond. The state should include a more specific ECP standard in rules regulating

[21] The "five percent or 500" threshold is a combination of HHS and Department of Labor thresholds in use today. *See* National Health Law Program, "Comments in Response to OCIIO's Request for Comment for Planning and Establishment of State-Level Exchanges related to Language Access" (Oct. 4, 2010). Available at: http://www.healthlaw.org/images/stories/NHeLP_comments_OCCIO_language_access_Oct10.pdf; Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affection Limited English Proficient Persons (2004). Available at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/hhslepguidancepdf.pdf.

[22] *See* 42 U.S.C. 256b.

[23] *See* 42 U.S.C. 1396r–8.

Exchange plans and should establish a strong monitoring and enforcement system to assess ECP inclusion in plan networks.

Further, the state should consider the language needs of communities when selecting Navigator entities, giving preference to those entities best-equipped to serve residents with LEP in communities where these services are likely to be needed. For example, the forthcoming Navigator Request for Proposals should specifically require bidders to outline a plan to provide services that meet the cultural and language needs of the relevant communities and target populations.

d. Section 1311 – Quality Improvement Strategies

Beyond the more prescriptive requirements discussed above, the ACA establishes an ongoing obligation to work toward greater language access, with the goal of reducing health disparities. Section 1311(g) requires the Exchange and QHPs to engage in quality improvement activities to reduce health and health care disparities through the "use of language services", among other factors.

Per subsection (c)(1)(E) and subsequent regulations,[24] plans must engage in this kind of quality improvement as a condition of certification as a qualified health plan. To comply, a plan must implement a payment structure that increases reimbursement or offers other market-based incentives for those providers that use language services. The Exchange has a duty to monitor such strategies by requiring plans to regularly report on their activities. While the specific parameters of these duties have not yet been delineated in federal guidance, these provisions indicate a clear intent of the law to afford widespread access to language services through not just the Exchange itself, but also QHPs and providers associated with the Exchange.

Recommendation: The Exchange should partner with the Office of Insurance Commissioner to enforce the ACA's requirement to improve quality through language access. During the initial QHP certification process, the Insurance Commissioner should set high, clear standards for this certification criterion, requiring all plans to specify the market-based strategies they intend to use to reduce health disparities for enrollees with LEP. Once QHPs have been selected, the Exchange or Insurance Commissioner should monitor progress toward QHPs' stated goals, using data reported by plans as well as additional data collected under the authority discussed below. If plans fail to make measurable progress, the Exchange should consider sanctions or decertification.

e. Section 4302 – Data Collection

Given that the ACA's new language access requirements depend in part on the availability of high-quality data depicting which languages are spoken in a given region, Section 4302 requires the HHS Secretary to ensure that to the extent practicable, "any federally conducted or supported health care or public health program, activity, or survey . . . collects and reports data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants," as well as any other demographic data regarding health disparities.

While the statute does not define which federally conducted or supported activities will need to comply with this new data-collection requirement, the plain language of the provision appears broad enough to encompass coverage purchased through the Exchange with the assistance of federal premium tax

[24] 45 C.F.R. §156.200(b)(5).

credits or cost-sharing subsidies. This could require the Exchange and its qualified health plans to collect data to quantify the numbers and types of individuals with LEP who take up coverage through the Exchange in 2014.

Recommendation: While Section 4302 will not officially take effect at a federal level until funding is appropriated, the state should consider how to build data collection capabilities into its ACA-related infrastructure now to minimize the need to modify systems and technology later. For example, in addition to the minimum race, ethnicity, and language data collection on the joint application for insurance affordability programs, the state could also offer open data fields to permit inclusion of groups and sub-groups that do not fit neatly into U.S. Census categories. Other suggestions listed below, such as the development of language access plans, could be helpful in proactively planning for this ACA requirement.

III. Washington State should implement ACA requirements in a manner that promotes language access for residents with LEP, taking additional steps as needed on a state level.

The ACA and its accompanying regulations include a number of new requirements that will significantly improve language access for LEP individuals, but additional specificity is needed to clarify the scope of these benefits and protections. State regulations interpreting these provisions of the ACA are needed to ensure that QHPs will be required to provide and/or reimburse for language services for Washington residents at all points of contact, including interpretation and translated materials in all interactions with medical providers, health plans and the Exchange administration.

The ACA authorizes states to go above and beyond the federal floor, stating in Title I, "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title" (with the exception of a few specific provisions).[25] Under this authority, Washington State regulatory bodies—such as the Human Rights Commission ("HRC"), the Office of Insurance Commissioner ("OIC"), the Health Care Authority ("HCA"), and the Exchange Board—may take additional steps to clarify language access requirements under ACA reforms.

In addition to the recommendations given in Section II of this memorandum, the non-exhaustive list below provides examples of other types of state action that may be needed.

Recommendation:
HRC – Adopt national origin discrimination rules under the WA Law Against Discrimination.

In addition to the federal Title VI protections above, Washington State's Law against Discrimination ("WLAD") creates a civil right to language access services for LEP residents. The statute provides a right to be free from discrimination in a "place of public accommodation,"[26] including national origin discrimination. As an example of a "public accommodation," the statute explicitly lists "where medical service or care is made available."[27] Accordingly, the plain language of the statute appears to require entities providing medical care, such as hospitals or doctor's offices, to ensure that LEP patients have access to needed language services.

[25] ACA §1321(d).
[26] RCW 49.60.030(1)(b).
[27] RCW 49.60.040(2).

Despite this seeming clarity, the exact scope of the WLAD as it applies to language access in health care remains unclear for three reasons:

- First, the state entity charged with regulatory authority over the WLAD, the Human Rights Commission has not yet issued administrative rules on the subject. There are rules describing the parameters of the public accommodation doctrine in the disability access context[28] and rules describing the parameters of language access in the educational context,[29] but no rules describing the parameters of language access in the health care context.
- Second, WLAD does not offer a clear definition of national origin discrimination. Presumably, this term is used in a manner consistent with Title VI case law and guidance to include language access, but additional statutory or regulatory clarification would be helpful.
- Third, case law indicates that WLAD ordinarily applies to physical facilities rather than entities, but it is unclear how this applies in a health care context.[30] The complex world of health coverage and care does not lend itself to a neat division between facilities and entities. For example, is an integrated health care delivery system (such as Group Health) a physical facility or an entity? Similarly, will the new Exchange portal and call center qualify as a physical facility or an entity?

The ACA offers HRC the opportunity to consider these issues as our state health care market undergoes transformation in the years leading up to 2014. The HRC should issue rules interpreting national origin discrimination in our new health care system that are consistent with the ACA. This would prevent the uncertainty that has plagued health providers and plans seeking to comply with WLAD in the past and move toward more uniform enforcement in the future.

Recommendation:
OIC – Incorporate language access into the QHP network adequacy standard.

Washington State law currently requires insurers to meet certain network adequacy standards to ensure that consumers have access to appropriate providers through their insurance plans. The general standard for private insurance plans requires each health carrier to maintain plan networks "sufficient in numbers and types of providers and facilities to ensure that all health plan services to covered persons will be accessible without unreasonable delay."[31] In addition, carriers may not create service areas in a manner "designed to discriminate against persons because of age, sex, family, structure, ethnicity, race, health condition, employment stats, or socioeconomic status."[32]

While these standards are more stringent than those of some states, they lack the precision that would ensure meaningful access to health care for LEP individuals. The general standard makes no mention of providers being equipped to provide language services, and the non-discrimination provision does not specifically include national origin discrimination. By way of comparison, another Washington network adequacy standard used for public medical assistance programs requires managed care plans to consider "the cultural, ethnic, race and *language* needs of the enrollees" in forming provider networks (emphasis added).[33]

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[28] Ch. 162-62 WAC.
[29] WAC 162-28-040.
[30] *Fell v. Spokane Transit Authority*, 128 Wash.2d 618, 911 P.2d 1319 (1996).
[31] WAC 284-43-200(1).
[32] *Id*.
[33] Health Care Authority, "2012-2013 Contract for Healthy Options, Basic Health, and Disability Lifeline." Available at: http://www.hca.wa.gov/documents/joint_procurement_contract.pdf.

The ACA offers the chance to reconsider Washington State's network adequacy standard. The OIC and Exchange Board have indicated that new QHPs in the Exchange will be required to meet the existing private insurance standard described above, on the grounds that this standard meets the minimum network adequacy approach described in the ACA and recommended by the National Association of Insurance Commissioners.[34] This approach will simply maintain the status quo — it will not address QHPs new obligations under the ACA, including § 1557's non-discrimination provision and § 1301's ECP contracting requirement.

Instead, OIC should take a more proactive approach, recognizing that the ACA sections discussed above require a *higher* standard for network adequacy than the standard in use today. OIC should modify the existing network standard through rulemaking to require plans to recognize language needs in network formation and prohibit national origin discrimination. Further, it would be helpful for OIC to clarify the process by which it monitors and enforces network adequacy. For example:

- How is language access considered at the time of initial network adequacy approval?
- How is language access considered in subsequent market conduct exams and recertification?
- How might an individual file a grievance related to language access and network adequacy? Currently, the OIC complaint form is only available in English on its website; OIC should provide translated forms in all relevant languages.

Addressing these and other language access needs will enable OIC to implement the ACA language access provisions on a state level and prepare for a rapidly-changing insurance market in a state with rapidly-changing demographics.

Recommendation:
OIC – Use the Consumer Assistance Ombudsman role to better understand and assist LEP populations.

As Washington State's Consumer Assistance Ombudsman, a new role created by the ACA, OIC will have an ongoing responsibility in the coming years to assist consumers in understanding their health care options and rights. OIC's specific duties will include collecting and monitoring problems consumers face in accessing coverage, as well as assisting with grievances and internal appeals. [35]

OIC should use this new role to better understand the challenges individuals with LEP face in accessing coverage. Given its data collection responsibilities, OIC will be uniquely situated to assess the status quo of language access in health care and any improvements needed moving forward. In order to collect this data, of course, OIC will itself need to ensure that its consumer assistance functions are accessible to individuals with LEP. As such, OIC may also wish to consider whether any of the recommendations to the Exchange Board below may also relate to its consumer assistance functions.

Recommendation:
Exchange Board - Build language access into the Exchange.

As the Exchange Board builds the new Exchange entity from the ground up, there are a number of other opportunities to improve language access. In addition to the recommendations discussed above, the Exchange Board could take the following practical steps during Exchange design and development:

[34] *See* http://www.naic.org/documents/committees_b_exchanges_120627_network_adequacy_white_paper.pdf.
[35] ACA § 2793.

Overall

- Establish a language access plan (LAP) for the Exchange, with a scope that includes the current planning and start-up phase as well as ongoing operations of all components. Written LAPs have been recommended in HHS guidance governing recipients of federal funds[36] as a component of, and a method of, documenting compliance with Title VI requirements to ensuring meaningful access to programs and services for LEP individuals.[37] Written implementation plans can also serve as a framework for employees as to how to meet Title VI and other language access obligations.
- Study and adopt an appropriate threshold for language services in Washington State for translation of written materials by the Exchange and QHPs.[38] At minimum, this standard should be consistent with HCA's current practices in Medicaid, since HHS has not yet issued final rules to determine when a particular language is prevalent enough in a region to require written translation. While proposed rules initially considered a "5% or 1,000 persons" threshold for written translation in the Exchange, this threshold would be inadequate in Washington State because it would prevent access in many communities with smaller but significant populations who speak different languages. Perhaps in recognition of this concern, HHS declined to adopt the proposed standard. Instead, we strongly suggest Washington State adopt the "5% or 500 persons" threshold, as discussed above.
- All Exchange consumer assistance service components should follow established industry best practices for securing communication services.[39] Vendor contracts should reflect both the ACA and state laws above, as well as the draft language created by the U.S. Department of Justice for the specific purpose of demonstrating compliance with federal award terms and conditions, which includes Title VI of the 1964 Civil Rights Act and Executive Order 13166.[40]

Web Portal

- Provide full site translations in all languages of significant diffusion (per the threshold standard discussed above). We understand that the Exchange plans to translate the site into Spanish. While this will help a significant portion of Washington's LEP population, the site should also be translated into the most commonly spoken languages in Washington, as identified by the threshold standard. The availability of translated pages should be easily identifiable through taglines on the homepage.
- The home page should also feature taglines in languages of lesser diffusion, indicating the availability of access to the information through telephonic interpreter services.
- Provide clear information on the Web Portal homepage about how to receive information in alternate formats, including large print. Also provide specific information for deaf and hard of hearing callers using relay service providers on how to access the Web Portal or telephonic services.
- Require the plan comparison page to include a graphic indicating when a plan covers language services and in what languages.
- Require the "search by provider" feature to include a search by language spoken and level of competency in that language.
- Consider whether offering a "video chat interpreter" function would promote access, particular among populations who use American Sign Language.

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[36] HHS, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," Fed. Reg. Vol. 61, No. 153, at 47311 (2003).

[37] Elements of a written LAP are: 1) identification of LEP individuals needing language assistance; 2) language assistance measures, including oral interpretation and written translations; 3) training of staff; 4) notification of availability of language assistance measures; and 5) monitoring and updating the written plan. *Id. at* 47320.

[38] This threshold applies only to written translations and does not affect the overall requirement to provide meaningful access to individuals with LEP. There should be no thresholds for oral interpretation, only written translation.

Navigator/In-Person Assister Program

- Require potential vendors to describe language access plans during the bidding and contracting process.
- In accordance with regional needs, preferentially select Navigator entities with certified interpreters on staff/contract and/or consider training certified interpreters to perform Navigator functions.
- Train all Navigators on the following topics: how to recognize the need for an interpreter, how to secure a language interpreter, and how to work effectively with a language interpreter.

Call Center

- Offer callers language interpreter services immediately as the first option. State this message in languages of greatest diffusion in Washington State.
- Consider creating supplemental language-specific phone numbers as entry points for residents speaking particularly prevalent languages. These phone numbers could be advertised in language-specific media and through taglines on written communications.
- (See also vendor selection and training recommendations in above Navigator/Assister section).

By implementing the language access protections described in this memorandum, Washington State will be well on its way to fulfilling the vision of the ACA: access to coverage and care for all residents, including those with limited English proficiency.

APPENDIX A: Washington State Language Profile

The following websites offer information about which world languages are most frequently spoken in Washington State, as an example of the diversity ACA planning must anticipate.

Department of Health and Human Services - Language Testing & Certification Program
http://www.dshs.wa.gov/ltc/
Testing and certification for interpreters and translators in: Spanish, Vietnamese, Russian, Cambodian, Laotian, Mandarin, Cantonese, and Korean. Authorization granted after testing in all other languages.

Health Care Authority - Interpreter Services Program for Medicaid & CHIP
www.hca.wa.gov/documents/rfp/interpreter_services/exhibit_i.pdf
HCA received requests for interpreters in 65 languages for Medicaid patient appointments in 2011. Top 15 languages and number of requests: Spanish (126 194); Russian (46,480); Vietnamese (14,791); Cantonese (6,848); Korean (6,756); Somali (6,008); Arabic (5,492); Cambodian (3,030); Mandarin (2,784); Farsi/Persian (2,671); Tigrinya (1,610); Nepali (1,538); Bosnian (1,129); Ukrainian (1,115); and Amharic (1,013).

Office of Superintendent of Public Instruction - World Languages
http://www.k12.wa.us/WorldLanguages/WLinWashington.aspx
Top 15 languages most frequently spoken by students who qualified for English Language Learner services in 2009-2010 (in order of descending frequency): Spanish; Russian; Vietnamese; Somali; Korean; Tagalog; Punjabi; Cambodian; Cantonese; Arabic; Samoan; Mandarin; Japanese and Amharic.

Refugee Resettlement - Washington Arrivals by Country of Origin, Oct. 2007- April 2009
http://www.seattle.gov/humanservices/lifelines/201007RefugeeResettlementReport.pdf
Top 10 countries of origin: Burma, Ukraine, Bhutan, Iraq, Moldova, Russia, Somalia, Cuba, Burundi, and Iran.

Modern Language Association Language Map - Languages Spoken in Washington
http://arcgis.mla.org/mla/default.aspx
MLA Language Map and MLA Data Center tools can sort languages to county zip code level. They are based on ACS 2005 and 2000, respectively.

APPENDIX B: SELECTED RESOURCES ON LANGUAGE ACCESS SERVICES

The following websites offer further information about the need for language access services, federal and state laws regarding language access services, and suggested implementation approaches.

Federal Government Resources

- Limited English Proficiency Federal Interagency Website: www.lep.gov
    - Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency": www.lep.gov/13166/eo13166.html
    - Memo to Federal Agencies from AG Holder Reaffirming Mandates of Executive Order 13166: www.lep.gov/13166/AG_021711_EO_13166_Memo_to_Agencies_with_Supplement.pdf
    - Language Access Program Planning Tools: www.lep.gov/resources/resources.html - LAP
- General Services Administration
    - Multilingual Websites: www.howto.gov/web-content/multilingual
- Health and Human Services, Office of Minority Health, Center for Linguistic and Cultural Competence in Health Care
    - Health Care Language Services Implementation Guide: https://hclsig.thinkculturalhealth.hhs.gov/default.asp
    - National Standards on Culturally and Linguistically Appropriate Services (CLAS): http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15
- Department of Justice. "On Choosing a Language Access Provider": www.justice.gov/crt/lep/resources/leptatool.htm

Background, Policy, and Implementation Resources

- Alliance for a Just Society, http://allianceforajustsociety.org/publications/publications-by-subject/health-care-pubs/, particularly:
    - "The State of Health Care Reform"
    - "Opening the Door: the Importance of Language and Literacy Access under Health Reform"
- American Hospital Association
    - Eliminating Disparities in Health Outcomes – Bibliography: http://www.aha.org/content/11/11dispbib-lang.pdf
    - Resources on improving language access to health services: http://www.aha.org/content/11/11dispbib-lang.pdf
- American Translators Association, www.atanet.org, particularly:
    - "Translation: Getting it Right. A Guide to Buying Translations"
    - "Interpreting: Getting it Right. A Guide to Buying Interpreting Services"
- California Endowment Language Access Initiative: www1.calendow.org/Collection_Publications.aspx?coll_id=22&ItemID=312 , particularly:
    - "Health In Brief: Improving Access to Health Care for LEP Health Care Consumers"
    - "Overcoming Language Barriers to Health Care"
    - "How to Choose and Use a Language Agency: A Guide for Health and Social Service Providers Who Wish to Contract With Language Agencies"
- California Pan-Ethnic Health Network
    - "Achieving Equity by Building a Bridge from Eligible to Enrolled": www.cpehn.org/pdfs/EligibletoEnrolledBrief.pdf

- Enroll America:
    - Translations that Hit the Mark http://tinyurl.com/afsbhsw
- Hablamos Juntos/We Speak Together: Language Policy and Practice in Health Care, Robert Wood Johnson Foundation: http://www.hablamosjuntos.org/
- Health Workforce Information Center
    - "Cultural and Linguistic Competency" http://www.hwic.org/topics/introduction.php?id=7
- Language Portal: A Translation and Interpretation Digital Library. www.migrationinformation.org/integration/language_portal/, particularly
    - Sperling, J. "Practitioner's Corner: Drafting Request for Proposals and Contracts for Language Access Services."
    - Palma, K. "Practitioner's Corner: Tips for Ensuring Translation Quality"
- Migration Policy Institute, National Center on Immigrant Integration Policy www.migrationpolicy.org/
- National Center for Cultural Competence, Foundations of Cultural & Linguistic Competence: http://nccc.georgetown.edu/foundations/index.html, particularly:
    - "Conceptual Frameworks/Models; Definitions; Guiding Values and Principles"
    - "The Compelling Need for Cultural and Linguistic Competence"
    - "Policies to Advance and Sustain Cultural and Linguistic Competence"
    - "Tools and Processes for Self-Assessment"
- National Council on Interpreting in Health Care: www.ncihc.org
    - Language Service Resource for Health Care Providers
    - National Standards of Practice and Code of Ethics for Interpreters in Health Care
- National Health Law Program: www.healthlaw.org, particularly
    - The ACA and Language Access, Short Paper #5
    - Podcast: Requirements to Provide Language Assistance Services
- State Health Reform Assistance Network
    - "Call Center Best Practices": http://www.statenetwork.org/
- Teitelbaum, J, Cartwright-Smith L, Rosenbaum S. Translating rights into access: language access and the Affordable Care Act. Am J Law Med. 2012 ;38(2-3):348-73.
- Translation Quality Assessment Tool for Health Education Materials: http://tinyurl.com/a59e3fl
- Washington New Americans Policy Council
    - "A Plan for Today, A Plan for Tomorrow: Building a Stronger Washington through Immigrant Integration: A Year One Report": www.governor.wa.gov/priorities/diversity/report.pdf

Washington State Resources

- Washington State DSHS.
    - "Cultural Competency in Health Services and Care – A Guide for Health Care Providers": http://tinyurl.com/2d58arx
- Puget Sound Health Alliance.
    - "Addressing Health Equity in Race, Ethnicity, and Language in the Puget Sound Region: A Toolkit for Improving the Quality of Care": www.pugetsoundhealthalliance.org/resources/addressinghealthdisparities.html
- Washington State Coalition for Language Access: http://www.wascla.org/