

October 4, 2010

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Director, Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
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Dear Mr. Angoff:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Office of Consumer Information and Insurance Oversight (OCIO) for the opportunity to comment on the planning of the state-based American Health Benefit Exchanges. The rules that the Department of Health and Human Services (HHS) issues regarding the establishment and operation of the Exchanges will have a substantial impact on the access and quality of health care that Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities receive.

AAs and NHPIs stand to benefit significantly from coverage and subsidies offered through the Exchanges. Approximately 17% of AAs and 24% of NHPIs are uninsured and over 76% of AAs and 84% of NHPIs live at 400% of the federal poverty level or below. Compounding these issues, linguistic and cultural barriers prevent many in these populations from attaining quality health care. APIAHF's mission is to improve the health and well-being of AA and NHPI communities. Thus, we urge HHS to promote informational and enrollment features and processes in the Exchanges that optimize accessibility for AAs and NHPIs in addition to other low health literacy, immigrant, and limited English proficient populations.

A. State Exchange Planning and Establishment Grants

1. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges? To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g., existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?

Proper data collection on AAs and NHPIs is critically important to advancing health in these populations. Poor data collection methods have perpetuated the dangerous "model minority" myth that Asian Americans face few serious health issues. Often

¹ "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons," available at

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>.

² "Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children's Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits," available at <http://www.fns.usda.gov/snap/rules/Memo/pdfs/triagencyletter.pdf>.

³ Centers for Medicare and Medicaid Services, "Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women," (July 1, 2010) available at <http://www.cms.gov/smdl/downloads/SHO10006.pdf>.

⁴ See Center for Medicare and Medicaid Services, "Re: Citizenship Documentation Requirement," (December 28, 2009) available at <http://www.cms.gov/smdl/downloads/SHO09016.pdf>.

⁵ PPACA Sec. 1411(e)(3) states immigration and citizenship status in the Exchanges should be verified "in the same manner as an individual's eligibility under the Medicaid program is determined under section 1902 (ee) of the Social Security Act."

data collection methods group all Asian American ethnicities together and Asian Americans as a whole with Native Hawaiians and Pacific Islanders, thereby masking the disparities that persist within subpopulations.

In collecting race and ethnicity data, many States do not comply with the Office of Management and Budget (OMB) Revised Standards for the Collection of Data on Race and Ethnicity which mandates that data on Asians be collected separately from “Native Hawaiians or Other Pacific Islanders.” As states move to implement health information technology, we urge HHS to ensure that data on race and ethnicity be collected to minimally comply with the OMB standard. Medicaid managed care regulations already require states to collect data on the race, ethnicity and primary language of enrollees, or their parents or guardians, in Medicaid managed care and for the Children’s Health Insurance program. PPACA Section 4302 requires that within two years, all Federally conducted or supported public health and health care programs collect data on race, ethnicity, sex, primary language and disability status and that data collected on race and ethnicity be collected in compliance with OMB standards. These data are essential for program planning, to identify disparities in enrollment and quality of care, and to enforce civil rights laws. As states move to implement the exchanges States should upgrade data collection systems to comply with OMB, at a minimum, and ideally, collect data disaggregated by ethnicity. HHS should encourage States to use the recommended ethnic and language categories recommended by the Institute of Medicine in its report, “Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement,” released August 31, 2009.

We hope that these data collection standards will be promoted within Exchanges whether they are single or multi-state Exchanges or Exchanges run by the federal government. Such data collection will provide essential health information on our populations that will facilitate the development of prevention and health care programming that address disparities within specific ethnic communities.

B. Implementation Timeframes and Considerations

2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

States and health plans will benefit from guidance on the drafting and dissemination of health care information that is clear and concise to a broad range of populations, including limited English proficient (LEP) and multicultural populations. Exchanges, pursuant to PPACA, Section 1303(f), will require that participating health plans provide information on enrollment, policies, practices, and other benefit information in “plain language.” PPACA defines “plain language” as “language that the intended audience, including individuals with limited English proficiency, can readily understand and use.” Exchanges must also establish a Navigator program that will provide patients with health information in a culturally and linguistically appropriate manner. Under PPACA, health plans must provide notice of their appeals and grievance process in a culturally and linguistically appropriate manner

To guide states and health plans in complying with these provisions, HHS should recommend that health information be available at an eighth-grade reading level or

below, the average reading level in America, and in the most prevalent non-English languages spoken by limited English proficient uninsured persons in the state. Additionally, we urge that HHS ensures that its guidance include recommendations that ensures Navigators receive cultural competency trainings and addresses workforce diversity within the Navigator program.

Additionally, States and health plans should receive guidance on the incorporation of health information technology (HIT), especially with respect to its use in collecting race, ethnicity and primary language demographic data. At a minimum, Exchanges and health plans should maintain electronic health records (EHRs) that comply with OMB Statistical Directive 15 when collecting race and ethnicity data. To be truly reflective of the health status of AAs and NHPs, however, APIAHF believes that data collection practices must disaggregate by ethnicity and rely on patient self-identification. The Secretary should provide guidance to States and health plans on data collection through HIT as well as on the Office of the National Coordinator's meaningful use standards and adopt and incorporate the IOM recommendations.

With respect to consumers, APIAHF believes that the same information on the Exchanges HHS currently provides in English should be available in non-English languages to the greatest extent possible. We are strongly encouraged by the launch of CuidadoDeSalud.gov and ask that HHS provide similar resources in Asian and other languages soon. At the state level, outreach efforts should be done in languages that address the demographic needs of various regions.

States will be receiving Federal funds to implement the Exchanges and establish the Navigator programs, and will be receiving federal subsidies from consumers. HHS must ensure that States comply with Title VI of the Civil Rights Act of 1964 and ensure that there is no discrimination based on race, color or national origin, including language need, in the administration of the Exchanges. Additionally, PPACA Section 1557 prohibits discrimination based on race, color, national origin, gender and disability for any health care activity or program where any part is receiving federal financial assistance, credits, subsidies or contract of insurance. HHS and the Office for Civil Rights must issue specific guidance to the States on what measures they need to include to ensure that there is equal opportunity to participate in the Exchanges and that barriers to participation are addressed.

Two specific areas where guidance must be issued are with respect to ensuring meaningful access to the Exchanges for limited English proficient persons, and ensuring that enrollment forms and other processes do not ask unnecessary questions that have a disparate impact on specific national origin families seeking to enroll eligible family members. As such, HHS should adhere to HHS' LEP guidance to ensure compliance with Title VI.¹ HHS and the Office for Civil Rights should also revise the guidance issued on September 21, 2000 by the Department of Agriculture, Department of Health and Human Services, Health Care Financing Administration, and Office of Civil Rights (herein "tri-agency guidance")² to specifically include enrollment applications for the Exchanges.

4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarification would be helpful?

Under PPACA, “lawfully present” immigrants are eligible for coverage in the Exchanges, the Pre-Existing Condition Insurance Program, and the Basic Health Plans, along with premium tax credits and cost-sharing reductions. In defining “lawfully present,” the Secretary should begin with and expand the definition CMS developed in July 2010 to determine Medicaid and CHIP eligibility under CHIPRA of 2009.³

Clarification is also needed to determine state residency rules. These rules apply to citizens and immigrants and are independent of immigration status requirements, however some states have erroneously denied Medicaid to eligible children, mistakenly believing that children cannot establish state residency independent of their parent or guardian. Addressing this issue will be critical to the success of implementing the exchanges.

Lastly, tax credits for purchasing health coverage in the Exchanges will help many low-income individuals receive the coverage they need. However, PPACA’s formula for calculating tax credit amounts only accounts for the population living at 100% FPL or above. In PPACA’s legislative history, a colloquy between Senators Robert Menendez and Max Baucus helps to ensure that tax credits for those living below 100% FPL will be geared towards their true income. We urge HHS to issue additional clarification on the formula that will be used to calculate the tax credits for this population.

C. State Exchange Operations

1. What are some of the major considerations for States in planning for and establishing Exchanges?

In the coming years, States must establish the infrastructure for consumer outreach and enrollment and ensure substantial health plan participation in the Exchanges. Creating policies and practices to optimize enrollment and the provision of quality health care through the Exchanges will require that States address the needs of the specific populations that will benefit most from the Exchanges.

LEP populations will likely comprise a significant percentage of the 24 million individuals expected to participate in the Exchanges, but states must first consider how to reach and enroll these individuals. Over one-third of Asian Americans are limited English proficient, and language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs. In addressing the needs of LEP populations, States should conduct a demographic assessment, especially with respect to race, ethnicity, and primary language, of the uninsured population. Once States have assessed the linguistic needs of their residents, States should ensure that translated versions of their Exchange web portals, outreach materials, and enrollment forms are available in the most prevalent languages spoken by limited English proficient uninsured populations in the State. We hope that States place special emphasis on translations of all online features, including online enrollment forms, as web-based information will serve as a primary resource for many Exchange consumers. At minimum, States should adhere to HHS’ LEP Guidance in selecting which languages to provide. Many of the most vulnerable LEP populations, however, comprise small numbers and states should begin establishing relationships and partner with community-based

organizations representing these populations to ensure that these individuals receive the information they need on the Exchanges. Under Title VI, States must ensure meaningful access to the Exchange for all persons regardless of the language spoken. States must notify LEP populations of the right to receive language assistance free of charge and must provide language services such as competent bilingual staff and interpreters, including in person or through a language line or video conferencing service.

LEP individuals are immigrants, refugees, asylees and naturalized citizens. Many immigrants, however, may be deterred from enrolling in the Exchanges and from seeking tax credits to support coverage without appropriate directions and language on enrollment forms. Specifically, many immigrants fear that enrollment in such programs would adversely affect their immigration status or deem them “public charges.” Many, particularly refugees, asylees and immigrants from high conflict regions, also have strong aversions to sharing private information with government entities.

As many States craft their own enrollment form for the Exchanges and other health benefit programs, States should consider the best practices for enrolling immigrants that have worked in other states. For example, Massachusetts’ MassHealth Coverage specifies which programs will require the provision of an applicant’s social security number and contains specific instructions for refugees and asylees. Additionally, California’s Medi-Cal application states clearly that any sharing of an applicant’s information with federal agencies will be for the purpose of detecting fraud alone. We urge HHS to create a taskforce to work with states to identify best practices in this area and to ensure compliance with the “tri-agency guidance”. The tri-agency guidance should also be revised to specifically include exchange enrollment forms. Finally, States should highlight the availability of “child-only” applications to the Exchanges and ensure that these applications do not seek sensitive information from non-applicant adults who may be completing the application for an eligible child.

States must also ensure that qualified health plans serving particular populations participate in their Exchanges. Among other PPACA requirements, health plan networks must include “those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” To avoid shortages of physicians serving these populations, States should begin considering incentive programs for physicians to serve their state’s vulnerable populations.

5. What are the considerations for States as they develop web portals for the Exchanges?

States’ web portals for the Exchanges will likely serve as the primary source of information and point of application for coverage through the Exchanges. Web portals must be accessible to LEP and low-health literacy populations and provide information in a “user-friendly” manner.

Web portals must be accessible to limited English language speaker, and reflect the state’s demographic needs. The Social Security Administration has materials on its website available in 15 languages. In particular, we urge Exchanges to ensure that online enrollment forms and information are available in as many languages as

possible. For populations whose primary language is not selected for translation, States should ensure that their web portals contain translated “taglines” that direct these populations to language access resources including state language lines. Additionally, information on web portals must be geared towards an eighth-grade reading level or below to reach the many low-health literacy populations in this country.

The web portal’s presentation of information is equally as important. States must consider best practices in website readability on topics such as font size, color, and layout. APIAHF also urges States to dedicate portions of the web portals to specific population groups. Immigrants, for example, will be subject to additional eligibility requirements when applying for coverage. Web portals should have a section explaining topics such as “lawful presence,” what programs require social security numbers to apply, how personal information will be used, the citizenship and immigration status verification process for the Exchanges, and a number of other immigrant-related issues. Other possible sections include information focused on children, women, and low-income individuals.

8. What specific planning steps should Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

Over one in six Asian Americans and one in four Native Hawaiians and Pacific Islanders are uninsured. The Exchanges will serve as a major source of health coverage for significant numbers of AAs and NHPIs who work in small businesses and cannot afford to provide health coverage to employees, who are low-income and cannot access Medicaid because they are newly arrived immigrants, and who cannot afford the high premiums and cost sharing in the current individual market. Many of these vulnerable populations, however, will not be able to access the Exchanges and the associated tax credits due to linguistic, literacy, and cultural barriers. To maximize enrollment among these populations, Exchanges must overcome these barriers through the development and implementation of best practices for outreach and enrollment.

APIAHF believes that the development of best practices to serve AA, NHPI, and other similarly-situated populations begins with an accurate assessment of need. At a minimum, each state exchange should compare their state residents’ race, ethnicity, primary language, and income levels with enrollment rates in the exchanges, and target those populations that are under-enrolling. With respect to collection of race and ethnicity data, Exchanges should disaggregate the categories to the extent possible. At minimum, Exchanges should follow the categories listed under the OMB Revised Standards and use the IOM categories for ethnicity and language. We urge Exchanges to work with state agencies to collect this information at the local and regional levels.

Exchanges will provide a number of informational and enrollment resources to consumers, which must be accessible to the diverse populations that will be eligible for Exchange-based coverage. Informational and enrollment features in the Exchanges include a website providing comparative information between Exchange-based plans, a standardized format for the presentation of health benefits options, a

tax credit calculator, and an enrollment form. These resources must be accessible for those at an eighth-grade reading level or below and in a number of non-English languages. At minimum, in choosing the languages for translation, Exchanges should adhere to HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons."

To provide true access, however, Exchanges should go further than HHS' guidance and also translate the primary languages of smaller populations experiencing significant health disparities in their state. Translation of simple, relatively short documents are usually less than \$1000 per language and states can translate additional languages every year and make the translations available on the website. Washington State has an office in the Department of Social and Health Services that provides translations of health and social services documents in 89 different languages. Additionally, on any outreach materials, Exchanges should place in-language taglines that direct state residents speaking languages that are not chosen for translation to appropriate language service resources provided by the State at no charge. States must ensure that limited English proficient persons have access to the Exchange's ombudsman regardless of language spoken and need to incorporate language assistance measures such as competent bilingual staff and interpreters and access to language lines. Exchanges must begin drawing together a database of professional language service organizations or community-based organizations that have the expertise to provide language services on health issues and enter into contracts with them to provide the required language assistance. The combination of low-literacy literature, in-language materials, and established relationships between the Exchanges and language service organizations will help significantly to mitigate the language barriers facing LEP populations in accessing health coverage.

The manner in which Exchanges present information and provide directions will also strongly influence the participation of individuals from diverse cultures in the Exchanges. Many individuals from diverse backgrounds have strong aversion to revealing personal information to government entities. With respect to enrollment forms, Exchanges should comply with the tri-agency guidance when seeking sensitive information such as social security numbers. When such information is necessary, Exchanges should include an explanation of the information's intended use and disclose whether an applicant's information will be shared with other agencies for the purpose of eligibility. Other states' health system enrollment forms can serve as a source of best practices. For example, Massachusetts' MassHealth Coverage specifies which programs will require the provision of an applicant's social security number and contains specific instructions for refugees and asylees. California's Medi-Cal application states clearly that any sharing of an applicant's information with federal agencies will be for the purpose of detecting fraud alone. Additionally, the tri-agency guidance provides key examples and principles for the proper collection of personal information based on the Privacy Act of 1974 and Title VI of the Civil Rights Act of 1964. APIAHF urges the Secretary to direct state exchanges to collect and incorporate these best practices as a part of its planning process.

Additionally, immigrants comprise a substantial portion of this nation's diverse populations. The challenges in eligibility they face deserve special attention and

outreach efforts. Many newly arriving, low-income immigrants, for instance, cannot access Medicaid because they have not completed the five-year waiting period required under PRWORA. To streamline enrollment and promote “one-stop shopping,” Exchanges should craft informational materials specifically addressing immigrant eligibility for each of the State’s health programs and create policies for direct referral of patients not meeting any eligibility criteria to patient navigators.

As Exchanges develop policies and practices that address the barriers low-literacy, LEP, and diverse populations face in accessing quality health care, Exchanges should request continual stakeholder input. Such input could be sought through the creation of consumer working groups to advise the Exchanges and the formation of focus groups to assess proposed informational and enrollment materials. These consumer working groups and focus groups should reflect the diversity of the uninsured populations in the State.

D. Qualified Health Plans

2. What factors should be considered in developing the Section 1311 (c) certification criteria?

The Secretary should ensure that qualified health plans (QHPs) can meet the needs of the Exchanges’ target populations, which encompass many low- and moderate-income individuals and individuals from diverse backgrounds. These populations require linguistically and culturally appropriate care and health information that is relevant and understandable.

APIAHF is pleased that PPACA’s minimum requirements will ensure that QHPs maintain health insurance plan networks with “essential community providers where available, that serve predominately low-income, medically-underserved individuals.” Full access to health services, however, must include access to linguistically and culturally appropriate services. We urge the Secretary to bolster this criterion or add additional criteria that would have QHPs maintain health insurance plan networks that include providers with diverse linguistic abilities and cultural backgrounds where available. Providers with these skills and knowledge can most effectively communicate with patients from diverse backgrounds. Additionally, the Secretary should ensure that QHPs denote a provider’s language abilities in its provider directory and maintain a database of community based organizations and language service resources that providers can use to arrange competent language services for LEP patients at no cost to the patients. Consumers in the Exchange should also have access to information about their QHP that is understandable to a general audience. As an additional criterion for participation in the Exchanges, the Secretary should require that QHPs employ best practices for reaching low-literacy audiences when drafting health coverage literature and notices. Among these practices, APIAHF strongly supports literature geared towards an eighth-grade reading level or below.

E. Quality

1. What factors are most important for consideration in establishing standards for a plan rating system? How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

For AA, NHPI, and other communities that face significant health disparities and

inequities, quality in health care must address linguistic and cultural barriers to care and emphasize a coordinated, patient-centered system. In creating the plan rating system, the Secretary should develop distinct rating categories that assess a plan's participating providers for: 1) language capabilities; 2) diversity of their workforce; 3) points of service in medically under-served areas; 4) use of health information technology (HIT); and 5) use of patient-centered medical homes.

High LEP populations like Asian Americans and Pacific Islanders encounter significant communication difficulties in health care settings. These difficulties result in patients not being able to fully communicate to providers the extent of their health issues, burdens placed on family members and friends to interpret on behalf of a LEP patient, unnecessary follow up visits due to misunderstanding a health provider's original instructions, and medical errors that sometimes lead to fatalities. LEP consumers will benefit significantly from information on a plan networks' inclusion of providers proficient in their preferred language. The rating category for language capabilities should assess both the diversity of languages available as well as the number of providers that can offer such services.

Cultural competence is also essential to the provision of quality care to AAs and NHPs. Understanding a patient's daily diet, sensitivities to certain health subjects, and beliefs on disease, transmission, and treatment provides a strong foundation for effective communication with patients and the development of trust between patients and providers. A diverse health care workforce provides one means of developing cultural competence in health care. The plan rating system should assess the racial and ethnic diversity of a health plan's network of providers.

Many AAs and NHPs live in low-income communities that lack adequate numbers of health care providers. Over one in six Asian Americans and one in four Native Hawaiians and Pacific Islanders are uninsured. Health plans that include providers in these medically under-served communities should be highlighted in the plan rating system.

HIT provides a potentially powerful resource for health care providers seeking to provide high-quality and efficient care. Through HIT, providers can collect and analyze health information by ethnic population, generate patient reminders for regularly scheduled visits or screenings, view tests and test results ordered by different physicians, and manage a patient's care in conjunction with the patient's other health care providers. HIT can be extremely effective in caring for individuals with chronic conditions that require the coordination of care among various health care staff and repeat visits and screenings. HIT can also be particularly effective in collecting critically needed health information where EHRs disaggregate by AA and NHP subpopulations. With disparate rates of diabetes, cervical cancer, liver cancer, Hepatitis B, and other serious conditions, AAs and NHPs would benefit considerably from the incorporation of HIT into their health care delivery system. We hope the Secretary will include HIT use within a health plan's provider network in the plan rating system.

As with HIT, patient-centered medical homes (PCMHs) will help to coordinate care for the many AAs and NHPs living with chronic conditions. Within these medical homes, patients will also have the ability to engage significantly in their own care.

Participation in the creation of their treatment plan, for example, will draw upon the patient's input and also help ensure that the patient understands the reasons for the course of their treatment. PCMHs have the potential to empower patients from vulnerable communities and provide for more efficient care. The plan rating system should reflect plan networks that support PCMHs.

G. Enrollment and Eligibility

2. What are some of the key considerations associated with conducting online enrollment?

Online enrollment will likely be the most convenient method of enrollment for many of the Exchanges' new consumers and, thus, should be made accessible to as many populations as possible. To maximize enrollment among LEP individuals, online enrollment sites must be translated into a number of non-English languages. As with other health benefit and enrollment information, enrollment sites should limit the use of jargon and be geared towards an eighth-grade reading level or below. Additionally, confidentiality and privacy will be paramount as enrollment forms will require inputting personal information such as social security numbers. Enrollment applications should explain the use of confidential information at the start of the application process to notify applicants ...

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

HHS and state agencies should adopt proven eligibility and enrollment practices that will minimize the administrative burden of coordinating between Medicaid, CHIP and the Exchanges and streamline access for all eligible persons. For instance, HHS should direct states to adopt the optional state verification process provided under CHIPRA.⁴ Section 211 of CHIPRA amended section 1902(a)(46) of the Deficit Reduction Act to allow verification of Medicaid and CHIP applicants using a data match program with SSA in lieu of burdensome citizenship documentation requirements that require state agencies to inspect and assess identification and proof of citizenship documents. Many states have already adopted the "data match" program which submits an applicant's name, social security number and declaration of citizenship to the Social Security Administration (SSA) for verification through its Numident database. State agencies also commonly use the Systematic Alien Verification for Entitlements (SAVE) system to determine immigrant eligibility for federal benefit programs including Medicaid and CHIP for many years. The SAVE system provides specific program administrators access to data on an applicant's immigration status to ensure that only eligible immigrants are enrolled in the program.

While both databases have been proven to be effective, it is important to note that the SAVE system does not capture all categories of immigrants that are eligible for public programs, such as victims of trafficking and VAWA applicants. The SAVE system may also be unable to verify some individuals with legal status due to

typographical errors or other discrepancies in their record. In addition, both SAVE and the data match program will need to be expanded to facilitate the eligibility determinations of a much larger pool of Exchange applicants who wish to claim an affordability credit or purchase a plan in the Exchange. Thus, safeguards should be incorporated to prevent the immediate denial of coverage to persons who face a discrepancy in their file or need a reasonable opportunity to present the proper documents. Section 1902(ee) of the Social Security Act provides applicants with a 90-day period of benefits coverage during which the state must complete a secondary information request with DHS and the applicant must resolve any inconsistency. HHS should clarify that under the ACA, the 1902(ee) documentation procedures including the reasonable opportunity period apply to the verification of citizenship and immigration status in the Exchanges. This approach is consistent with the Congressional intent of the ACA⁵, and will reduce the burden and delay for eligible individuals and families to access health coverage.

4. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources?

The federal government has worked with state agencies to improve and simplify eligibility and enrollment procedures for public benefit programs including Medicaid and CHIP. The state agencies that administer federal public benefits must verify the eligibility of each applicant. While there is no central registry of information on all U.S. residents, the Systematic Alien Verification for Entitlements (SAVE) system is currently used by state agencies to determine immigrant eligibility for certain federal benefits including Medicaid and CHIP. The SAVE system provides specific program administrators access to data on an applicant's immigration status to ensure that only eligible immigrants are enrolled in the program. SAVE draws on the Verification Information System database operated by the Department of Homeland Security (DHS), and state and local agencies access SAVE through several Web-based Internet technologies or by manual verification.

State agencies are also currently tasked with verifying citizenship eligibility. Some states have a "data match" program where an individual's name, social security number and declaration of citizenship are submitted to the Social Security Administration (SSA) for verification through its Numident database. Other states impose a citizenship documentation requirement that requires physical proof of the applicant's identity and citizenship by submitting certain documents that have been deemed acceptable for manual inspection by the state agency. HHS should ensure that states still using a document-based approach to verifying eligibility accept, at a minimum, all documents recognized by federal agencies to establish citizenship or an eligible immigration status.

5. How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange?

Section 1411 of the ACA mandates that the Secretary develop a program for the determination of eligibility for Exchange participation, subsidies and exemptions. HHS and state agencies should apply the least burdensome verification practices used by state Medicaid and CHIP programs to the state Exchanges to ensure

streamlined enrollment. Many states have adopted a “data match” program where an individual’s name, social security number and declaration of citizenship are submitted to the Social Security Administration (SSA) for verification through its Numident database. State agencies also commonly use the Systematic Alien Verification for Entitlements (SAVE) system to determine immigrant eligibility for federal benefit programs including Medicaid and CHIP for many years.

Any eligibility determination should also comply with federal rules regarding inquiries into citizenship, immigration status, and social security numbers (SSN) in state applications for Medicaid and CHIP. According to the 2000 “tri-agency guidance” issued by the Department of Agriculture, Department of Health and Human Services’ Health Care Financing Administration and Office of Civil Rights, states are required to provide specific notice when requesting an individual’s SSN and cannot require SSNs and citizenship-related information from individuals who are not applying for assistance.

H. Outreach

2. What resources are needed for Navigator programs?

As PPACA tasks Navigator programs with providing information on the Exchanges and tax credits in a culturally and linguistically appropriate manner, we urge Exchanges to prioritize Navigator grants to community-based or consumer-focused organizations as these organizations have strong expertise in providing culturally and linguistically appropriate resources.

To assist Navigators, Exchanges should develop train-the-trainer materials to familiarize Navigators with the intricacies of the Exchanges’ enrollment form, web portal, health plan information resources, and eligibility requirements. Additionally, Exchanges should ensure that the Navigators have access to background material on additional federal and state health benefit programs for which consumers may qualify.

Once Navigators are familiar with the Exchanges and tax credits, Exchanges should ensure that Navigators have basic informational resources at their disposal to disseminate to consumers. These may include a supply of in-language pamphlets with basic information on the Exchanges or an online tutorial that Navigators can watch with consumers to demonstrate how to apply online and how to use features like the tax credit calculator. Where Navigators require additional assistance answering questions or overcoming technical difficulties in relation to the Exchanges, Navigators should have access to an assistance line maintained solely for Navigators to receive advice from staff managing the Exchange.

Navigators will also need sufficient funds to provide additional linguistically and culturally appropriate assistance. Navigators must provide translations of a significant amount of information, develop new resources to gear information towards the communities they serve, and maintain staff for in-person and in-language consultations.

3. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase

coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

With 76% of AAs and over 84% of NHPIs living at 400% FPL or below, many AAs and NHPIs will qualify for tax credits and cost-sharing reductions. Successful outreach efforts to these populations will overcome linguistic and cultural barriers, reach these populations in their local communities, and integrate community based organizations and leaders.

Outreach efforts must be conducted in various non-English languages and be directed towards an eighth-grade reading level or below. In determining which non-English languages to choose, Exchanges should adhere to HHS' LEP Guidance at a minimum. Exchanges should, however, go further and conduct outreach efforts based not only on population size, but also upon which communities demonstrate the most need due to health disparities and social factors such as poverty and uninsured rates. To gear outreach efforts towards immigrant populations, the information provided in outreach efforts should emphasize that participation will not impact a participant's immigration or citizenship status and that any personal information solicited will be used for the sole purpose of determining eligibility for participation in the Exchanges.

To outreach effectively to AA and NHPI populations, Exchanges should assess where these communities are and base outreach efforts in those localities. These efforts may include leaving in-language brochures in local pharmacies and health clinics, conducting in-language health fairs, presentations at local churches, and working with local media.

In any outreach effort, Exchanges should partner with community based organizations and leaders. These organizations and individuals have significant knowledge about their populations' members and have already built communication networks within their communities. Moreover, these leaders can draw their communities' attention more effectively than the Exchanges alone.

J. Consumer Experience

1. What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

Consumers need clear, accurate, and easily understood information about their health insurance options. Special care should be given to ensure information is understandable to low-income populations that may have little experience purchasing traditional insurance products and to low literacy populations.

In addition to premium and cost-sharing information, information on the location and availability of linguistically and culturally competent providers will be beneficial to many AA and NHPI consumers as they make their plan selections. Exchanges should ensure that health plan comparisons and summaries include information on the languages spoken by the plan's network of providers and the number of providers speaking those languages. The proximity of a plan network's providers to beneficiaries will also assist beneficiaries in considering plan options.

Ideally, QHPs could provide a mapping tool to display the proximity of a plan network's providers to the beneficiary.

Exchanges should ensure that multiple community-based points of access are available for enrollment. Community health centers, public hospitals, schools, and community-based organizations, at a minimum, should receive training and resources for facilitating enrollment. As with any enrollment venue in which public computers may be used, best practices for providing a secure atmosphere for inputting sensitive data should be implemented.

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

Section 1002 of PPACA outlines eligibility requirements for states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. To ensure the highest level of consumer access and satisfaction, offices of health insurance consumer assistance or health insurance ombudsman programs should be strengthened to include the following, as proposed by California's Health Ombudsman bill, AB 2787:

- Provide information about consumers' rights and responsibilities with respect to health care coverage in plain language.
- Provide information, referral, and assistance to consumers with limited English language proficiency in their primary language.
- Consult with a network of community-based organizations that have experience with assisting consumers in navigating the local health care system, enrolling consumers in health care coverage, resolving consumer problems associated with health care access, and serving consumers with special needs, including, but not limited to, consumers with limited English language proficiency, low-income consumers, consumers with disabilities, and consumers with multiple health conditions.
- Track, analyze, and publicly report on consumer complaints by health status, age, race, ethnicity, primary language, and gender to determine the most common types of problems and problems faced by particular populations.

Furthermore, partnerships with community-based organizations can help increase the capacity of government agencies to reach individuals who are not served by traditional outreach methods. Community-based organizations can help facilitate enrollment in the Exchange and should be eligible for outreach and enrollment grant funding.

K. Employer Participation

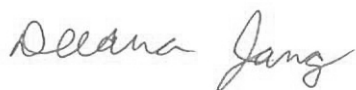
4. What other issues are there of interest to employers with respect to their participation in Exchanges?

As of 2007, Asian Americans owned 1.6 million non-farm businesses in the United States. Many of these businesses are small businesses that cannot afford health insurance. Under PPACA, these businesses can benefit from tax credits if they have 25 or fewer full-time employees and purchase health coverage through the Exchanges for their employees. We urge Exchanges to conduct outreach around these small business credits using in-language materials and focusing on community-based distribution points. Exchanges should assess the ownership demographics of small businesses in their state to determine what languages should be provided.

Conclusion

We appreciate the opportunity to comment on the design and implementation of the health insurance exchanges. The Exchanges have the potential to help reduce health and health care disparities among vulnerable and traditionally under-served communities. We welcome future opportunities to work together on this important aspect of health reform implementation.

Respectfully,

A handwritten signature in cursive script that reads "Deena Jang".

Deena Jang
Policy Director