APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

BOARD OF DIRECTORS

2011

Executive Committee

Dexter Louie, MD, JD, MPA
Chairperson

Rea Pañares, MHS
Vice Chairperson

Kathy Lim Ko
President/CEO

Debra Nakatomi
Treasurer

Joyce O'Brien, MPH
Secretary

Bill Imada

Janice Louie, RD, BSPH, MA

Victor Kaiwi Pang

Niyanta Spelman

Gayle Tang, MSN, RN

Wilson Wang, MD, MPA, MPH

Headquarters:
450 Sutter Street
Suite 600
San Francisco CA 94108
Main 415-954-9988
Fax 415-954-9999
www.apiahf.org

Washington D.C. Office:
1828 L Street N.W.
Suite 802
Washington, D.C. 20036
Main 202-466-7772
Fax 202-466-6444

National Advocates for Asian American, Native Hawaiian & Pacific Islander Health

October 18, 2011

Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attn: CMS-9989-P
P.O. Box 8010
Baltimore, MD 21244-8010

File Code: CMS–9989–P (Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans)

Dear Secretary Sebelius and Administrator Berwick:

The Asian & Pacific Islander American Health Forum (APIAHF) and undersigned organizations thank the Center for Consumer Information and Insurance Oversight (CCIIO) for the opportunity to comment on the establishment of the new Affordable Insurance Exchanges (Exchanges) and Qualified Health Plans (QHP) (Proposed Rule). The undersigned national and community based organizations are dedicated to improving the health and well-being of Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions.

The Proposed Rule regarding the establishment and operation of the Exchanges, consumer assistance functions and QHPs 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 14.8% of Asian Americans and 17.3% of Native Hawaiians and Pacific Islanders are uninsured.[1] Compounding these issues, linguistic and cultural barriers prevent many in these populations from attaining quality health care. Thus, we urge CCIIO 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.

General comments

Starting in 2014, millions of individual Americans, families and small businesses will use the Exchange as their primary entry point for obtaining affordable health coverage. As provided in the Proposed Rule, Exchanges will offer these Americans "competition, choice, and clout." While the Exchanges will present a new way for Americans to access high quality, affordable care, their success will depend not only on the raw numbers of Americans enrolling in coverage, but the degree to which each individual is able to enroll in coverage that meets their individual needs. For these reasons, we outline a number of general comments that CCIIO should consider as Exchanges are developed and implemented. These general principles are designed to maximize participation and enrollment in the coverage

[1] 2009 American Community Survey 1-year estimates.

and subsidies offered.

Leverage data collection and reporting standards
Exchanges, QHP issuers and state and federal agencies (e.g. Social Security Administration) should leverage existing data resources to assess the needs of diverse communities, respond to those needs, and ensure quality and accuracy in all processes. As states move toward implementing health information technology and the Exchanges, we urge CCIIO to ensure that demographic data is collected pursuant to the draft standards proposed to implement Section 4302 of the ACA. CMS 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 CHIP. Section 4302 requires all Federally conducted or supported public health and health care programs to collect data on race, ethnicity, sex, primary language and disability status in compliance with OMB standards. This data is essential for program planning, to identify disparities in enrollment and quality of care, and to enforce civil rights laws. Such data collection will provide essential health information on vulnerable and underserved populations, facilitate the development of tailored outreach and aid in the enrollment activities and the development of prevention and health care programing that addresses disparities within these specific communities.

Additionally, we note that we do not interpret Section 1411(g)'s limitations on data collection to restrict the collection of demographic data pursuant to Section 4302. Where such data is not "strictly necessary" to determine eligibility or enrollment, consumers, enrollees or their parents or guardians should be permitted to voluntarily provide this data. In addition, requests for such demographic data should include a notice of privacy and security rights, as well as an explanation for why the information is being collected.

Comply with nondiscrimination laws and guidance
Title VI of the Civil Rights Act of 1964 and Section 1557 of the ACA—which reinforces the prohibition against discrimination by any federally conducted program, or entity that receives funding or assistance on the grounds of race, color, national origin, gender and disability—apply to both the individual Exchanges and the SHOP. At a minimum, federal law requires all limited English proficient (LEP) persons receive oral language assistance if needed. In addition, we recommend CCIIO adopt a single threshold for translation across all aspects of the Exchanges, including application materials and consumer assistance functions. We recommend CCIIO adopt a combined threshold utilizing the existing Department of Labor regulations and the HHS' Office for Civil Rights LEP Guidance, of 500 LEP individuals or 5% in plan's enrollees. The 5% threshold is utilized in both the Department of Justice and HHS LEP Guidance's, CMS Language Access Strategic Plan, as well as recently revised regulations from CMS governing marketing by Medicare Part C & D plans.

Moreover, exchange websites, state Medicaid agencies and consumer assistance providers should provide in-language taglines in at least 15 languages, using

standardized language directing LEP persons to consumer assistance providers. At a minimum, Exchanges must adhere to HHS Title VI Guidance.[2] In addition, Exchanges should make available the same information provided on their websites in written materials available for those without internet access.

Comply with the Tri-Agency Guidance and privacy and security standards
We are pleased that many provisions contained in the three Exchange regulations released on August 17, 2011 apply the principles of the Tri-Agency Guidance. We thank CCIIO for their commitment to ensuring the Exchanges and insurance affordability programs request only the minimum information necessary to determine eligibility and adhere to privacy and security standards, including the application of Fair Information Practice Principles (FIPPs). We encourage CCIIO to require compliance with the Tri-Agency Guidance across all aspects of the Exchanges, including the functions described in the Proposed Rule regarding consumer assistance providers and the single streamlined application.

Ensure ACA-mandated distinctions between the Exchange and SHOP are maintained
Regardless of whether a state merges their individual Exchange and SHOP or maintains separate exchanges, the ACA outlines key differences in both their function and eligibility requirements. Therefore, we urge CCIIO to ensure there is a clear distinction between the SHOP and individual Exchange, particularly in terms of functions in the Proposed Rule.

Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

§155.20 Definitions

Exchange
The final rule should specify that the term "Exchange" encapsulates both the SHOP Exchange and the Individual Market Exchange. Clarification is necessary to ensure that differences in governance and administrative structure between the SHOP Exchange and Individual Market Exchange are clearly implemented. For example, the preamble describes the Exchange as "inclusive of the operation of a SHOP," while the definition provided in this section defines the SHOP as "a Small Business Health Options Program operated by an Exchange."

Lawfully present
The proposed regulations adopt a definition of "lawfully present" used in the Pre-Existing Condition Insurance Plan (PCIP), at 45 CFR §152.2. Although the PCIP definition provides a helpful starting point, we urge CCIIO to use a slightly expanded definition that more accurately encapsulates all lawfully present individuals. First, the definition should include two categories that are currently

[2] Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*.

listed in the definition CMS developed to implement Section 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Specifically, categories eight and nine from the CHIPRA guidance[3] are not included in the PCIP definition: individuals who are lawfully present in the Commonwealth of the Mariana Islanders and American Samoa. These categories were omitted from the PCIP definition because residents of the U.S. territories are not eligible to participate in the PCIP program. By contrast, territorial residents are eligible to participate in the Exchanges, if the territories elect to create one.

Second, we recommend the inclusion of a three additional categories of individuals that should be considered lawfully present:

- Victims of human trafficking who have been granted "continued presence;"
- Individuals whose status makes them eligible to apply for work authorization under 8 CFR §274a.12; and
- Individuals granted a stay of removal/deportation by administrative or court order, statute or regulations.[4]

In addition, we ask CCIIO to revise the current category pertaining to asylum applicants to include pending applicants for asylum under §208(a) of the Immigration and Nationality Act (INA), or for withholding of removal under §241(b)(3) of the INA or Convention Against Torture, whose application has been accepted as complete. These individuals should be considered lawfully present without regard to whether they are eligible for employment authorization, since they have a right to remain in the U.S. pending the adjudication of their asylum application. This process can take years.

Finally, we recommend that the definition of lawfully present acknowledge the possibility of new categories of immigrants who may be determined lawfully present in the future.

State

The definition of "State" does not explicitly reflect §1321 of the ACA, which delineates that territories, such as Guam and the Northern Mariana Islands, shall be "treated as a State" for purposes of those provisions that the proposed rule implements, if they elect to establish an Exchange. We recommend CCIIO explicitly track this language in the definition for "State."

Undefined terms

In addition, the Proposed Rule includes some terms that are undefined in the statute or in this section, such as "authorized representative" in §155.405(c)(ii). We urge CCIIO to consider adding a definition to clarify these terms.

---

[3] Centers for Medicare & Medicaid Services, *Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women*

[4] For more information about these categories, see the National Immigration Law Center's comments on the Interim Final Rule for the Pre-Existing Condition Insurance Program – File Code OCIIO-9995-IFC, available at http://www.nilc.org/immspbs/health/Comments-PCIP-regs-2010-09-24.pdf.

§155.105 Approval of a State Exchange

While we understand the specific information required in each State's Exchange Plan will be addressed in future guidance, we recommend CCIIO require, at the onset of Exchange certification, demonstrated compliance with non-discrimination provisions. CCIIO can ensure compliance with non-discrimination laws by requiring States address the following requirements.

Exchange Plans should provide sufficient detail to demonstrate compliance with the Tri-Agency Guidance. Exchange Plans should specifically identify how the Exchange will comply with the Tri-Agency Guidance, including how/when personally identifiable information (e.g. Social Security Numbers) will be collected and how such information will be shared. It is vital that CCIIO require compliance with the Tri-Agency Guidance from the onset of Exchange certification, as research has shown that many state's online public benefits forms are not in compliance. For instance, a review of online SNAP application forms in 26 states by the Food and Nutrition Service (FNS) of the Department of Agriculture revealed that many of the forms inappropriately requested information that was not needed to make eligibility determinations, such as the immigration status of non-applicants. As a result, FNS issued guidance on February 18, 2011 advising states and reaffirming the key policies of the Tri-Agency Guidance.[5] In the event specific materials or plans for Exchange websites and other portals are still in development prior to certification, HHS should require, at a minimum, that Exchanges identify the specific steps they plan to implement to ensure compliance.

In addition, the ACA requires Exchanges consult with various stakeholder groups, including those specified in §155.130. As such, Exchange Plans should specify which stakeholder groups they have consulted in forming the Exchange. As part of the certification process, Exchanges should be required to create consumer working groups to develop policies and practices that address the barriers that low-literacy, LEP and diverse populations face in accessing quality health care. These groups can advise the Exchange during the development and planning process and focus groups can be used to assess proposed informational and enrollment materials.

§155.110 Entities eligible to carry out Exchange functions

§155.110(c)(3) Governing board structure

The establishment of an exchange governing board should take into consideration the needs of racial, ethnic and immigrant communities. The exchange board must be comprised of voting members who have relevant experience in public health and health policy issues affecting these communities. For these reasons, we recommend governing boards be required to include an individual with experience

[5] United States Department of Agriculture, *SNAP- Conforming to the Tri-Agency Guidance Memo through Online Applications*, available at http://www.fns.usda.gov/snap/rules/Memo/pdfs/Tri-Agency_Guidance_Memo-021811.pdf.

in minority health issues, either through policy and advocacy or direct health care service delivery. In the alternative, the governing board should have a representative of a non-profit organization advocating for or serving constituencies served by the Exchange, including but not limited to, organizations representing children, low-income individuals, immigrant families, and communities color.

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

Title VI of the Civil Rights Act of 1964 and Section 1557 of the ACA apply to both the individual Exchanges and the SHOP. The following recommendations are designed to ensure Exchanges comply with these non-discrimination provisions in all aspects of operation, including outreach, education, enrollment and coverage. In addition, the recommendations will help ensure Exchanges comply with Tri-Agency Guidance, as addressed in our recommendations in §155.105.

§155.120(b) Non-discrimination
We support the codification of non-discrimination protections that prohibit states and Exchanges from discriminating based on race, color, national origin, disability, age, sex, gender identity or sexual orientation. In carrying out the requirements of this part, we recommend CCIIO require states and the Exchange comply with applicable non-discrimination statutes by:

- Conducting a demographic assessment, especially with respect to race, ethnicity, and primary language, of the uninsured population in the State;
- Establishing a plan for collecting data consistent with Section 4302 requirements to ensure meaningful access for LEP persons and other vulnerable communities;
- Translating Exchange websites, outreach materials and enrollment forms at the threshold of 5% of the population in a plan service area, or 500 LEP persons, whichever is less. In the event materials are still being developed, HHS should require, at a minimum, that States adhere to HHS' LEP Guidance in selecting which languages to provide, specify these languages, and identify specific steps and/or action plans the Exchange plans to engage in to ensure compliance.

§155.130 Stakeholder consultation

The Exchanges will serve as a major source of health coverage for significant numbers of AAs and NHPIs, particularly those who cannot afford the high premiums and cost sharing in the current individual market and who are low-income and cannot access Medicaid because they are newly arrived immigrants. To maximize enrollment and participation, Exchanges must be developed with stakeholder consultation from diverse groups.

We commend CCIIO for specifically enumerating the stakeholder groups that *must* be consulted, as specified in §1311(d)(6)(A) of the ACA, and as recommended in

comments in the RFC. We acknowledge CCIIO's efforts to additionally encourage Exchanges to include advocates for individuals with disabilities and those who need culturally and linguistically appropriate services. However, we strongly urge CCIIO to *require* consultation with these hard-to-reach populations. Many of the populations participating in the Exchanges will have linguistic, literacy and cultural barriers and stakeholder input from these groups and advocates working on their behalf is central to ensuring Exchanges are developed in an accessible manner to maximize enrollment.

Moreover, given that many of the most vulnerable LEP populations often live in smaller isolated communities, CCIIO should strongly encourage States to begin establishing relationships and partner with community-based organizations representing these populations to ensure these individuals receive the information they need on the Exchanges.

§155.160 Financial support for continued operation

The ACA requires Exchanges be self-sustaining by January 1, 2015 and requires States ensure their Exchanges have sufficient funding to support ongoing operations. Section 155.160 holds states responsible for developing plans to ensure adequate funds are available. We recommend that as part of these plans, states make it a requirement that any savings or cost-shifting that results from budgetary constraints not affect outreach and enrollment programs to low income, immigrant or communities of color.

§155.200 Functions of an Exchange

Section 155.705 of the proposed rule delineates a clear separation of certain functions between the SHOP Exchange and the Individual Market Exchange. These functions reflect the differences in the types of applicants who are eligible for the SHOP and Individual Market Exchanges, as intended under the law. We encourage CCIIO to reinforce this separation by specifying which functions are applicable only to the Individual Market Exchange.

§155.200(b) Certificates of exemption

Section 1411(a)(4)(H) of the ACA requires the Secretary to create a mechanism for granting certificates of exemption to the individual responsibility requirement. While we understand specific standards and eligibility criteria for the certifications will be addressed in future rulemaking, we strongly urge HHS to reconsider proposals that give state-run Exchanges the ability to issue certificates of exemption from the individual mandate. Instead, APIAHF recommends that these exemptions be determined and issued at the federal level. At a minimum, we urge HHS to create a process that aggregates the exemption and exclusion categories under the ACA. Aggregating these categories helps alleviate the privacy concerns of excluded individuals and reduces the possibility of tax con-compliance. We believe it is appropriate for HHS and the Department of Treasury to issue certificates of exemption because the process of making these determinations is linked to the

federal government's responsibility to enforce the individual responsibility requirement.

§155.205 Required consumer assistance tools and programs of an Exchange

Exchanges must provide sufficient consumer assistance tools and programs to allow consumers to find and enroll in coverage that meets their needs. The eligible Exchange population will be diverse, including in terms of age, disability status, language spoken, race, ethnicity and geography. Certain groups, such as mixed-immigration status families and those with children, will be navigating multiple enrollment requirements in multiple programs. As such, many of these eligible persons and families will need significant assistance to ensure they are educated about their coverage options. For these reasons, we strongly recommend CCIIO require, as part of the certification process for Exchanges, that each state conduct an assessment of consumer needs and provide a plan detailing which consumer assistance tools and programs will be available. In addition, to assure the highest quality of customer assistance possible, Exchanges should be required to periodically evaluate the effectiveness of their consumer assistance activities.

§155.205(a) Call center

The Exchange call center will serve as an important tool to assist potential enrollees in shopping for and enrolling in coverage. While we understand the need to provide Exchanges with latitude in how to structure their call centers, CCIIO should codify a set of minimum requirements. Specifically, we recommend the Exchange call center:

- Operate outside of normal business hours
- Adjust staffing levels in anticipation of periods of higher call volumes (for example, the weeks leading up to and during open enrollment)
- Ensure meaningful access for limited English proficient persons by complying with the translation and interpretation thresholds proposed in our recommendations to §155.230 and linking to language help lines and translation and interpretation hotlines
- Link to state based 1-800 numbers for persons needing further information on enrolling in public benefits, including Medicaid, Medicare, WIC, SNAP and family planning services
- Have the capacity to provide assistance to consumers and businesses on a broad range of issues, including but not limited to:
    - The types of QHPs offered in the Exchange;
    - The premiums, benefits, cost-sharing, and quality ratings associated with the QHPs offered;
    - Location and availability of linguistically and culturally competent providers;
    - Categories of assistance available, including advance payments of the premium tax credits and cost-sharing reductions as well as assistance available through Medicaid, CHIP and Basic Health Plans (BHP);
    - Eligibility screening and assistance prior to starting an application,

especially in regard to immigrant and mixed-status families;
  - The application process for enrollment in coverage through the Exchange and other programs, including information about the types of information needed;
  - Referrals to Navigators and other consumer assistance programs;
  - Referrals for persons ineligible to participate in the Exchanges, Medicaid, CHIP or BHP to allow for purchasing coverage outside the Exchange
- Allow consumers to apply for coverage over the phone
- As a condition of the Exchange certification process, establish a quality assurance program that evaluates the quality of services provided through the call center and identifies strategies for improvement, consistent with other health insurance issuers.

§155.205(b) Internet website

The manner in which Exchanges present information and provide directions will strongly influence the participation of individuals from diverse cultures in the Exchanges. The Exchange website will likely serve as the first point of contact for millions of potential enrollees and small businesses and should meet the minimum requirements specified in the Proposed Rule. Information contained on the website should be presented in a "user friendly" manner and written between a fourth and sixth-grade reading level or below, as provided in recommendations by the National Institutes of Health (NIH).[6]

In addition, to ensure meaningful access for limited English Proficient (LEP) persons, Exchange websites must be translated into languages other than English, as determined by a demographic needs assessment. We recommend that CCIIO adopt a combined threshold utilizing the existing Department of Labor regulations and the HHS' Office for Civil Rights LEP Guidance, of 500 LEP individuals or 5% in plan's enrollees. The 5% threshold is utilized in both the Department of Justice and HHS LEP Guidance's, CMS Language Access Strategic Plan, as well as recently revised regulations from CMS governing marketing by Medicare Part C & D plans. Moreover, exchange websites should provide in-language taglines in at least 15 languages, using standardized language directing LEP consumers to consumer assistance providers. Notably, the Social Security Administration regularly translates its materials in 15 languages and can serve as a model. At a minimum, Exchanges must adhere to HHS Title VI Guidance.[7] In addition, Exchanges should make available the same information provided on their websites in written materials available for those without internet access. All written materials provided by the Exchanges should be subject to the same translation threshold as the Exchange website and comply with the recommendations in §155.230.

[6] U.S. National Library of Medicine, National Institutes of Health, *How to Write Easy-to-Read Health Materials*. Bethesda, MD, 2011, http://www.nlm.nih.gov/medlineplus/etr.html.

[7] Department of Health and Human Services, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*.

Exchange websites should contain specific sections/pages targeted to specific population groups in the same manner Healthcare.gov has tailored information for different segments of the population. Immigrants, for example, will be subject to additional eligibility requirements when applying for coverage. Exchange websites 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, and a number of other issues relevant to immigrants. Other possible sections could include information for children, women, and low-income individuals.

We also encourage HHS to consider designing Exchange websites to provide functionality for Navigators and other appropriate third party assisters (e.g. Medicaid or CHIP eligibility workers, caseworkers, agents and brokers) to assess real-time information and assist applicants and enrollees in all aspects of the application, enrollment and account management processes. This access should be designed specifically for third parties, with reporting capabilities for Navigators to aggregate their activities and outcomes. In light of the sensitivity of health, income and citizenship/immigration information, it is critical that such functionality be accompanied by appropriate security and audit controls.

Once established, the website should also have a mechanism to solicit feedback from consumers and employers for continued refinement and improvement.

§155.205(d) Consumer assistance
The Proposed Rule requires Exchanges to have a "consumer assistance" function, but does not provide specifics on what constitutes "consumer assistance." Exchanges will receive various types of requests for assistance from consumers, including assistance with eligibility and enrollment, appeals and handling complaints, and must be able to direct consumers accordingly. Given this range, HHS should specifically require Exchanges to ensure that participants are able to secure assistance with:

- Eligibility, enrollment and renewal requirements and processes for Medicaid, CHIP, BHP (if applicable) and both subsidized and unsubsidized coverage in QHPs;
- Premiums and cost-sharing; benefits and coverage limits;
- How to access services;
- QHP quality ratings and transparency of coverage measures;
- How to file a complaint, grievance or appeal; and information and referral for persons ineligible for the Exchange, Medicaid, CHIP or the BHP (if applicable).

To ensure the highest level of consumer access and satisfaction, the Exchange's consumer assistance function should also include the following services in a linguistically and culturally competent manner, as proposed by California's Office of Health Consumer Assistance bill, AB 922:

- Provide outreach and education about health coverage options and how

to navigate the health care arena, e.g. how to choose a plan or doctor;
- Educate health consumers about their rights and responsibilities;
- Advise and assist consumers with health care problems;
- Advise and assist consumers with filing complaints, grievances, and appeals.

§155.205(e) Outreach and education
We urge HHS to codify the requirement that the Exchange conduct outreach and education activities targeted to underserved and hard-to-reach populations, including, but not limited to, children, limited English proficient persons, immigrants and minority owned businesses and those who experience health and health care disparities as a result of factors such as race, ethnicity, language barriers and low health literacy.

Outreach efforts should be conducted in various non-English languages and written between a fourth and sixth-grade reading level or below. Consistent with our recommendations in §155.205(b), we recommend that CCIIO adopt a combined threshold utilizing the existing Department of Labor regulations and the HHS' Office of Civil Rights LEP Guidance of 5% of the population in a plan service area, or 500 LEP persons, whichever is less. Moreover, outreach and education materials should include in-language taglines in at least 15 languages, using standardized language directing LEP consumers to consumer assistance providers. In addition, CCIIO should encourage Exchanges to 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.

In addition, we recommend CCIIO issue guidance based on a set of best practices recently used in expanding CHIP enrollment, on how Exchanges can maximize outreach and education efforts to these communities. For example, as a way to conduct outreach and enrollment in immigrant populations, Exchanges can provide information, FAQs and factsheets on important terms for eligibility, such as the definition of "lawfully present." In addition, enrollment materials should specifically address immigrant eligibility for each of the State's health programs and 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.

Similarly, to maximize enrollment in the SHOP, Exchanges can conduct outreach around the small business tax credits using in-language materials and focusing on community-based distribution points. In addition, to maximize efficiency, all Exchange outreach and education efforts should be coordinated with efforts being conducted by Navigators.

To outreach effectively to Asian American, Native Hawaiian and Pacific Islander populations, Exchanges should assess where these communities are located 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.

Exchanges should request continual stakeholder input to inform education and outreach activities. Such input could be sought through the creation of consumer working groups to advise the Exchange 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 population in the state.

Moreover, in any outreach effort, Exchanges should partner with community-based organizations and leaders. These organizations and individuals are knowledgeable about their communities and have already built communication networks within their communities. Moreover, community leaders can draw the attention of community members more effectively than the Exchanges alone.

§155.210 Navigator program standards

Navigators will serve the important function of providing information on the Exchanges and tax credits to a diverse group of individuals. To ensure the Navigator program best serves the intended Exchange population; states should conduct a needs assessment and design their Navigator programs based on this assessment. To ensure Navigators are able to adequately convey information in an accurate, easy to understand manner that is linguistically and culturally appropriate, we recommend CCIIO codify the following general requirements:

§155.210(a) General Requirements
Navigator programs should be funded to provide language access services. States should create a training program for Navigators, with guidance from HHS, that includes best practices for working with low health literacy and limited-English proficient persons, families with mixed-immigration status, and other hard-to-reach populations. Navigators should be trained in eligibility and enrollment procedures through the use of train-the-trainer programs to ensure Navigators are familiar with the intricacies of the Exchanges' enrollment form, web portal, and health plan information resources. In addition, Navigators should understand the types of personal information that will be collected and how such information will be shared (for example, collection of social security numbers).

In addition, Navigator programs must:

- Be geographically accessible;
- Ensure Navigators understand the other federal and state health benefit programs for which consumers may qualify;
- Provide Navigators with an assistance line maintained solely for Navigators to receive advice from staff managing the Exchange;
- Establish quality standards and develop mechanisms to assess Navigator performance and accountability, including ongoing evaluation and

improvement;

- Address workforce diversity within the Navigator program;
- Ensure the program is carried out in a linguistically and culturally accessible manner:
    - Provide or procure oral language assistance to all LEP applicants and enrollees, regardless of whether printed materials are available in-language;
    - Translate Navigator and consumer pamphlets and informational brochures at the threshold of 5% of the population in a plan service area, or 500 LEP persons, whichever is less;
    - Provide in-language taglines in at least 15 languages that inform consumers about the availability of language services

§155.210(b) Entities eligible to be a Navigator

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. Since the role of the Navigator is to assist the consumer impartially, a consumer-focused non-profit organization would seem the most apt to fill this role. These organizations are the least likely to be at risk of posing a conflict of interest and the most attuned to consumer needs.

§155.210(b)(1)(iii) Licensing

Many lay health workers with considerable community knowledge will be eligible to work as Navigators and assist consumers in selecting coverage in the Exchanges. Since Navigators will not be selling insurance, they should not be subject to licensure requirements as brokers or agents. Completion of a required training course should be sufficient to ensure Navigators are capable of fulfilling the duties of the position.

§155.210(d) Duties of a Navigator

In addition to the duties specified in the Proposed Rule, we recommend the addition of the following duties:

> (d) Duties of a Navigator. An entity that serves as a Navigator must carry out at least the following duties:
>
> (6) Assist consumers in applying for coverage in the Exchange, Medicaid, CHIP, BHP and tax credits;
>
> (7) Maintain expertise in how to handle persons who are ineligible to participate in the Exchanges, and how to seamlessly purchase insurance outside the exchange;
>
> (8) Provide information and resources for populations who may not be served by the Exchange in a culturally and linguistically appropriate manner, consistent with the recommendations in §155.210(a), including providing consumers with basic information resources, such as in-language pamphlets.

§155.230 General Standards for Exchange notices

Exchange notices will provide important informational and enrollment resources to consumers and must be accessible to the diverse populations eligible for Exchange-based coverage. According to the 2009 American Community Survey, over 55 million people speak a language other than English at home. Over 25 million of them (9% of the population) speak English less than "very well," and for health care purposes may be considered to be limited English Proficient (LEP). Further, an estimated one out of four Exchange enrollees will speak a language other than English at home in 2019.[8]

Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs. Poor communication between providers and patients can also lead to medical errors that are dangerous to patients and cost the U.S. health care system more than $69 billion every year. It is vital that LEP enrollees have access to all required notices in their language and that Exchanges meet minimum requirements for ensuring meaningful access.

There is significant statutory authority mandating the provision of language services and accessibility. First, § 1557 of the ACA forbids discrimination on the grounds of sex, race, national origin, disability or age in health programs or activities receiving federal financial assistance or by programs administered by an Executive Agency or any entity established under Title I of the ACA. This provision prohibits any individual from being excluded from participation in, denied the benefits of, or subjected to discrimination under "any health program or activity, any party of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." Since QHPs, including those who choose to offer non-excepted abortion services, will receive federal subsidies from individuals purchasing these plans, the anti-discrimination protections in § 1557 apply to their operations.

In addition, because federal financial assistance will be used to administer and operate QHPs, they are additionally subject to Title VI of the Civil Rights Act of 1964.[9] HHS has issued an "LEP Guidance"[10] to ensure that language access is provided by federal fund recipients under Title VI, and requires that language services be provided to LEP individuals in conjunction with all federally funded activities and programs. This would include oral communication for all qualified health plan enrollees and, when certain thresholds are met, written translated materials.

---

[8] Kaiser Family Foundation, *A Profile of Health Insurance Exchange Enrollees*, March 2011, available at http://www.kff.org/healthreform/upload/8147.pdf.

[9] Civil Rights Act of 1964, 42 U.S.C. §2000d et. seq.

[10] *See* Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 153, 47311, 47319-20 (Aug. 8, 2003), *available at* http://www.justice.gov/crt/cor/lep/hhsrevisedlepguidance.pdf.

For these reasons, we support HHS' proposal to codify the requirement that any notice be sent in writing and comply with the general, accessibility and readability requirements specified in the Proposed Rule. In addition, to ensure meaningful access for LEP individuals, we recommend HHS codify the following requirements. Codification will ensure §155.230 is in compliance with Title VI of the Civil Rights Act, Executive Order 13166, §1557 of the ACA, HHS Title VI Guidance, and OCR LEP Guidance.

§155.230(a)(1) General requirements
Expand the written notice requirement to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees to include:

(1) Contact information for available customer service resources, *including but not limited to web-based sources, call centers, Navigators, customer assistance programs and the State Exchange ombudsman (if applicable)*;

§155.230(b) Accessibility and readability requirements
All applications, forms, and notices must be written in plain language, between a fourth and sixth-grade reading level or below, and provided in a manner that provides meaningful access to limited English proficient individuals by:

- Providing notice of a right to an interpreter, available at no cost to the LEP individual, and information on how to obtain such services;
- Translating all required notices in any language spoken by more than 5% of the population in a plan service area, or 500 members in a particular language group, whichever is lesser;
- Incorporating in-language "taglines" in at least 15 languages that direct residents speaking languages not chosen for translation to appropriate language service resources provided by the Exchange, at no charge. Having a standardized tagline in all required Exchange applications, forms, and notices will help LEP individuals begin to recognize the standardized language.

§155.260 Privacy and security of information

The privacy and security of information collected and reported as part of the operation of the Exchanges is of paramount importance to all consumers. Immigrant communities, including refugees and asylees and those from high conflict zones, may have strong aversions to sharing private information with government entities. The following recommendations help to address these concerns and will ensure consumers understand their privacy rights and the type of information they must disclose.

We support CCIIO's consideration requiring Exchanges to adopt privacy policies that conform to the Fair Information Practice Principles (FIPPs). FIPPs serve as a

good minimum requirement for establishing comprehensive and sound policies to govern the collection, use and disclosure of personal information. However, we believe CCIIO should place stronger limits on the data that can be collected, used and disclosed about a person seeking insurance coverage through an Exchange. For example, Section 1411(g)(1) of the ACA places strong limits on the types of data that can be collected about a person seeking insurance coverage through an Exchange. Specifically, data collection is limited "to the information *strictly necessary* to authenticate identity, determine eligibility, and determine the amount of the credit or reduction." The statute goes on to state in Section 1411(g)(2) that the Exchange can use such information only "for the purpose of, and to the extent necessary in, ensuring the efficient operation of the Exchange." As such, CCIIO should implement these limitations to ensure that data collection, use and disclosure are kept to the minimum necessary.

To further strengthen privacy and security protections, we also recommend codifying and referencing the Tri-Agency Guidance issued in 2000, which clarified that States may not require households to provide information about the citizenship/immigration status or SSN of any non-applicant family member or deny benefits to an eligible applicant for failure to provide this information regarding another family member.

§155.260(b) Use and disclosure
Consistent with Section 1411(g) and the recommendations of the National Association of Insurance Commissioners (NAIC) Consumer Information Subgroup B (Draft Criteria for Uniform Enrollment Form), individuals seeking to enroll in the Exchanges and SHOP should only be required to provide the minimal information necessary to determine eligibility and enrollment. We do not interpret Section 1411(g) to prevent the collection and reporting of demographic data consistent with Section 4302. As recognized by the ACA, consistent, accurate and standardized data collection and reporting is an essential aspect of identifying racial and ethnic health and health care disparities and will be useful for Exchanges and QHPs in assessing whether they are in compliance with nondiscrimination laws. As such, demographic information that is not explicitly required to determine eligibility (e.g. race or ethnicity, language spoken) should be voluntarily requested.

CCIIO should also require that all personally identifiable information be collected consistent with Tri-Agency Guidance, especially in regard to the collection of Social Security Numbers and verification of immigration status and citizenship. For specific recommendations demonstrating compliance with this Guidance, refer to our recommendations in §155.405.

In addition, we support the extension of these requirements to contractors and sub-contractors to ensure compliance with the Exchange's privacy and confidentiality rules.

§155.260(c) Other applicable law
All data matching agreements between Exchanges and state agencies

administering Medicaid and CHIP, for the purpose of determining exchange eligibility, should be subject to existing federal and state law. These agreements should seek to minimize the administrative burden of coordinating between Medicaid, CHIP, and Exchanges and streamline access for all eligible persons, sharing only the minimum amount of information necessary for the sole purpose of determining eligibility.

We also recommend CCIIO ensure that data matching and sharing arrangements be consistent with the protections provided in the Systematic Alien Verification for Entitlements (SAVE) system, commonly used to determine immigrant eligibility for federal benefit programs including Medicaid and CHIP. (See 42 U.S.C. §1320 a-7b.) It is essential that CCIIO emphasize two of its vital protections: (1) that the information provided by and on behalf of the individual be used only for the purpose of verifying eligibility for enrollment, premium tax credits, or cost-sharing reductions under the exchanges or federal health coverage programs and (2) that pending verification, coverage not be delayed, denied, reduced, or terminated.

§155.405 Single streamlined application

The manner in which Exchanges present information and provide directions will strongly influence the participation of individuals from diverse cultures in the Exchanges. As such, the proposed single streamlined application will play a significant role in determining how accessible enrollment in the Exchanges and corresponding QHP, BHPs and public programs including Medicaid and CHIP, will be for many populations.

To ensure meaningful access for limited English proficient persons, the single streamlined application should comply with the accessibility and reasonability requirements in our comments to §155.230.

HHS should codify the requirement that applicants may not be required to answer questions that are not pertinent to the eligibility and enrollment process.
Many individuals from diverse backgrounds have a strong aversion to revealing personal information to government entities. Consistent with Section 1411(g) and the recommendations of the National Association of Insurance Commissioners (NAIC) Consumer Information Subgroup B (Draft Criteria for Uniform Enrollment Form), individuals seeking to enroll in the Exchanges and SHOP should only be required to provide minimal information necessary to determine eligibility and enrollment. We do not interpret Section 1411(g) to prevent the voluntary collection and reporting of demographic data consistent with Section 4302.

§155.405(c)(2)(iv) Filing the single streamlined application in person
We support the requirement that an individual must be able to file an application in person. For many people, enrollment in the Exchanges will be confusing and only complicated by cultural, literacy, language and disability barriers. While we understand the need to minimize paperwork and rely on electronic applications to improve efficiency, paper applications must be available for those that are unable

to complete electronic applications. Providing paper application and in-person assistance recognizes the digital divide as many low-income communities and communities of color lack access to the Internet in their homes, as well as the fact that some populations may not be comfortable with technology. For these reasons, we strongly support the proposal to require Exchanges offer an applicant the ability to file an application through a variety of electronic and non-electronic mechanisms.

Requests for personally identifying information
Similar to our recommendations in §155.260, we strongly recommend HHS require all personally identifiable information be collected consistent with the Tri-Agency Guidance, including the collection of Social Security Numbers and verification of immigration status and citizenship. HHS should issue guidance directed to States and Exchanges on how to comply with Tri-Agency Guidance, as well as best practices from other state's health system enrollment forms. For example, Massachusetts' Mass Health 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.

Consistent with Tri-Agency Guidance, HHS should codify the following requirements in the single streamlined application:

- Notify consumers about their privacy rights before and during enrollment;
- Provide an explicit disclosure explaining the purpose of collecting information, what the intended use is, and whether an applicant's information will be shared with other agencies for purposes of eligibility. The single streamlined application should contain a disclaimer notifying applicants that information is only being collected to determine eligibility and will not affect one's immigration status;
- Any sharing of an applicant's information with federal agencies will be for the purpose of detecting fraud alone;
- The paper application should also align with all appropriate privacy and security measures. The Tri-Agency Guidance provides key examples and principles for the paper collection of personal information based on the Privacy Act of 1974 and Title VI of the Civil Rights Act of 1964.

Moreover, we recommend questions regarding citizenship and eligibility be crafted with immigrant and mixed-status families in mind. Immigrants comprise a substantial portion of this nation's diverse populations and may include refugees, asylees and naturalized citizens. 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. In addition, many immigrants 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 may fear that enrollment in the Exchanges may adversely affect their immigration status or deem them "public charges."

Because different members of families may be eligible for different sources of health care coverage, including Medicaid, CHIP and SHOP participation, the common enrollment form must be structured in such a way to reflect the different eligibility rules, including income and immigration requirements. Exchanges may also consider highlighting the availability of "child-only" applications and ensure that these applications do not seek sensitive information from non-applicant adults who may be completing the application for an eligible child.

§155.410 Initial and annual open enrollment periods

Duration of the initial open enrollment period
The timing of the initial open enrollment period will be essential to ensuring potential Exchange enrollees have sufficient time learn about the existence of the Exchanges and coverage options. In addition to the general challenges facing Exchange enrollees, those with linguistic, cultural and literacy challenges will face additional barriers to enrollment. For these reasons, we support the extended open enrollment period from October 1, 2013 through February 28, 2014, as this will strike a balance between ensuring sufficient time for enrollment and offering time for Exchange testing, certification of QHPs and eligibility determinations. In addition, Navigators and other consumer assistance providers must be in operation prior to, or at the latest, the date the initial enrollment period begins, to ensure consumers are aware of the Exchanges and coverage options.

§155.410(d) Notice of annual open enrollment period
We support HHS' plan to codify the requirement that notice of the annual open enrollment period be in writing and sent no later than 30 days before the start of the annual enrollment period. Moreover, we support HHS' plan to codify the requirements for what must be included in the annual notice. All notices of annual enrollment periods must comply with §155.230 to ensure meaningful access for LEP enrollees, including translating the annual notice in any language spoken by more than 5% of the population in a plan service area, or 500 members in a particular language group, whichever is less. In addition, we recommend HHS codify the following requirements to be included in the notice:

- Date annual enrollment beings and ends;
- Where individuals may obtain information about available QHPs, including the website, call center, and Navigators;
- Notice of a right to an interpreter, available at no cost to the LEP individual, provided in at least 15 in-language taglines.

§155.700 Standards for the establishment of a SHOP

In designing a SHOP, it is important to balance state flexibility with the principles of

maximizing accessibility, streamlining the enrollment process and minimizing administrative burdens on employers and employees. In order to adhere to these principles, we recommend CCIIO ensure that the distinctions in governance and administrative functions between the SHOP and Individual Market Exchange are clear, as to avoid confusion by states. Clarity of eligibility functions between the two exchanges is particularly important for states seeking to merge their individual and small group markets.

In addition, minimizing the interaction between employees and SHOP exchanges will help streamline the SHOP enrollment process and minimize the administrative burden on employers. The Proposed Rule creates a number of requirements for the SHOP that we feel are unnecessary, such as collecting the social security numbers of employees, collecting employee application forms in addition to employer applications, and creating additional requirements to re-verify employment. Our comments below include suggestions on eliminating some of these requirements.

We commend CCIIO for delineating a clear separation of certain functions between the SHOP Exchange and the Individual Market Exchange. These functions reflect the differences in the types of applicants who are eligible for the SHOP and Individual Market Exchanges, as intended under the law. For example, §1312(f)(1) of the ACA defines a "qualified individual" as "an individual seeking to enroll in a qualified health plan in the individual market offered through the Exchange," while a "qualified employee" is defined in the Proposed Rule as "an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP." The definitions make clear that the term "qualified individual" should only apply to the individual exchange, and the term "qualified employee" should only be used in reference to the SHOP exchange. As such, we urge HHS to continue to ensure consistent application of the term "qualified employee" in Subpart H and refrain from using the term "qualified individual," as that definition is not applicable in the SHOP.

Lastly, we urge CCIIO to require exchanges to conduct outreach about SHOPs and the small business tax credit to minority owned businesses using in-language materials and focusing on community-based distribution points. 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. Exchanges should assess the ownership demographics of small businesses in their state to determine what languages should be provided.

§155.705 Functions of a SHOP

We strongly support the requirement for separate eligibility and enrollment functions of the SHOP, and commend CCIIO for reinforcing these distinctions.

With respect to special enrollment periods in the SHOP, we recommend HHS strike the two exceptions provided in the Proposed Rule. We agree, as the Preamble

notes, that there is no need for a special enrollment period in the SHOP based on a change in immigration or citizenship status. Unlike the individual exchange, eligibility for the SHOP is based on whether an individual is a "qualified employee." Employers are already required to verify immigration and citizenship status under the existing federal employment rules, therefore additional verification of immigration or citizenship status for enrollment in the SHOP is not necessary. Thus, we recommend CCIIO strike the language in the Preamble regarding these exceptions because they have the potential to cause confusion for the SHOP Exchanges and are unnecessary.

Instead, the SHOP's special enrollment period should be aligned with the practices that are currently in effect in the group market, instead of following the rules outlined for special enrollment periods in the individual exchange and its two exceptions. Special enrollment periods for the SHOP should be based solely on whether a new employee becomes a "qualified employee" and therefore eligible for the SHOP.

§155.715 Eligibility determination process for SHOP

§155.715(b) Applications
We do not support the requirement that individual employees submit an application to the SHOP to obtain coverage. The eligibility and enrollment process in the SHOP should mirror the eligibility and enrollment process in the large group employer market. This will lead to consistency for individuals obtaining coverage through their employer, regardless of the size of the employer.

§155.715(c) Verification of application
We do not support the recommendation that eligibility determinations for participation in the SHOP be administered by the SHOP Exchange instead of QHP issuers. We are concerned that the Proposed Rule describes a very involved role for the SHOP in making eligibility determinations regarding qualified employees. In addition, we do not believe that the ACA provides the SHOP with the authority to verify individual employee applications.

As such, we recommend the SHOP align with the current group market practices as much as possible. Specifically, the interaction between employees and the SHOP should be reduced or eliminated. Instead, the SHOP should serve the primary function of determining who is a qualified employer and facilitate communication and collaboration between qualified employers and QHPs.

§155.715(d)(1) Eligibility adjustment period
As stated above, we question whether the SHOP Exchange has the authority to verify individual employee applications. Assuming it does, we urge CCIIO to provide additional specificity as to what could qualify as a triggering event for the SHOP to "doubt the veracity of information" provided by the employee or employer. CCIIO should propose a set of criteria that could lead the SHOP to doubt the information provided by the employer or employee where there are actual inconsistencies, and

not rely on a discretionary standard such as "doubt."

§155.715(g) Notification of employer withdrawal from SHOP
We support HHS' proposal that in the event a qualified employer ceases to purchase coverage through the SHOP, each of the employer's qualified employees enrolled in a QHP through the SHOP be notified of the withdrawal and termination of coverage. In addition, we support HHS' proposal to require that this notice inform the employee of their eligibility for special enrollment periods in the Exchange and the process for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, Medicaid, CHIP and the BHP (if applicable).

Moreover, consistent with the standards applied to all required notices in §155.230, we recommend notices under this section be culturally and linguistically appropriate and contain the contact information for consumer assistance programs, including Navigators.

<u>§155.725 Enrollment periods under SHOP</u>

§155.725(d) Annual employer election period notice
We support HHS' plan to require that participating employers receive 30 days advance notice about their annual election period. As a required notice, the election period notice must comply with §155.230 to ensure meaningful access for LEP employers, including translating the annual notice in any language spoken by more than 5% of the population in a plan service area, or 500 members in a particular language group, whichever is less.

<u>§155.730 Application standards for SHOP</u>

SHOP regulations are designed to maximize accessibility, streamline enrollment, and minimize the burden on employers and employees. In addition, for both employers and employees, the information to be collected is limited to the minimum information needed to determine eligibility to participate in the SHOP. The following recommendations align with these goals.

§155.730(b) Single employer application
We are strongly opposed to the collection of individual Social Security Numbers for each employee, and urges HHS to strike this requirement in the employer application. It is not necessary for an employer to report an employee's SSN because the employer will have to provide a list of qualified employees along with the employer's EIN. This information should be sufficient to complete the employer eligibility process. As such, we recommend 155.730(b) be modified as follows:

> (b) <u>Single employer application</u>. The SHOP must use a single application to determine employer eligibility and to collect information necessary for purchasing coverage. Such application must collect the following –
> (1) Employer name and address of employer's locations;

(2) Number of employees;
(3) Employer Identification Number (EIN); and
(4) A list of qualified employees ~~and their social security numbers~~

§155.730(e) Alternative employer application
Any alternative employer or employee application used by the SHOP should be approved by HHS and conform to the same criteria as the single streamlined employer/employee application (HHS model application). Consistent with the HHS model application, employers and employees should only be required to provide the minimum information necessary that is relevant to the application.

§155.1000 Certification standards for Qualified Health Plans

The Proposed Rule contains definitions for qualified individuals, qualified employers and qualified employees. The provisions in Subpart K apply to both the individual Exchange and the SHOP. To avoid confusion, we recommend the use of the term "qualified applicant" in Subpart K, rather than the term "qualified individual."

§155.1040 Transparency in Coverage

§155.1040(b)Use of plain language
While we understand Section 1311(e)(3)(B) requires the Secretary of HHS and the Secretary of Labor to jointly develop and issue guidance on the best practices of plain language writing, we recommend that at a minimum, all QHP transparency data be provided consistent with the recommendations set forth in these comments under §155.230.

§155.1050 Establishment of Exchange network adequacy standards

QHP issuers must ensure the needs of the Exchanges' target populations, which encompass many low- and moderate-income individuals and individuals from diverse backgrounds are met. These populations require linguistically and culturally appropriate care and health information that is relevant and understandable. In addition, as recognized in the ACA, many potential Exchange enrollees will be from medically underserved and geographically diverse areas.

For these reasons, we are pleased CCIIO plans to codify the ACA's minimum requirements to ensure QHPs maintain health insurance plan networks that are adequate to ensure QHP enrollees can readily obtain health services. In addition to the minimum requirements proposed in the ACA, we urge CCIIO to require the following additional network criteria.

Additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care
We strongly recommend HHS codify the four specific standards provided in the Proposed Rule (Page 108) to create a baseline network adequacy level.

In addition, we recommend QHPs ensure access to linguistically and culturally appropriate services. 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. For these reasons, we urge HHS to require additional criteria to ensure QHPs maintain health insurance plan networks that include providers with diverse linguistic abilities and cultural backgrounds. In addition, QHPs should 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 patient. Information on the location and availability of linguistically and culturally competent providers will be beneficial to many AA and NHPI consumers and communities of color as they make their plan selections.

Many AAs and NHPIs reside in medically underserved areas (MUA) or health professions shortage areas (HPSA), as determined by the Health Resources Services Administration. We recommend QHP issuers take these designations and needs into consideration when establishing QHP networks. In addition, QHP networks should include providers such as primary care physicians, mental health professionals and dentists serving in these areas to ease the transition of people on or off Medicaid and other state health insurance programs.

In addition, we recommend that QHPs have a process to ensure enrollees can access services from an out-of-network provider at no additional cost, if no in-network provider is accessible due to factors such as time constraints and religious or moral objections.

§155.1055 Service area of QHP

We commend HHS for including in §155.1055(b), the requirement that an Exchange ensure QHP service areas are established without regard to racial, ethnic, language and health status factors as outlined in section 2705(a) of the Public Health Service Act. This requirement will help ensure QHP service areas are composed of a population that accurately reflects the demographics at the county level (as recommended), help ensure the unique health challenges these geographic communities face are addressed and help ensure the network provides access to care.

QHP networks must also contain enough providers in the enrollee's geographic area to ensure a choice in provider and must have sufficient providers that are accepting new patients. If a QHP provides coverage for a service or condition, the QHP must have providers in the service area that are able to provide that service. For example, QHPs must have adequate numbers of women's health providers,

including those providing OB/GYN care, that are in-network. In addition, QHPs should ensure adequate numbers of pediatric providers and pediatric specialists as children have distinct and complex needs. Moreover, QHPs should include Medicaid providers to ease the transition of people on or off Medicaid.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

§156.225 Marketing of QHPs

We support the proposal in the Preamble of the Proposed Rule requiring uniform prohibitions against unfair or deceptive marketing practices by all QHPs, but recognizing the "safe harbor" preemption problem that may arise if the federal standard is less protective than existing state law.[11] We recommend that §156.225 require these prohibitions for Exchanges in states which do not already have such consumer protections.

§156.225(a) State law applies
If the QHP issuer operates in a state with more expansive laws than the ACA or federal law provides, QHPs should provide information detailing the differences between state and federal law related to marketing by health insurance issuers. For example, some states may expand coverage under the Essential Benefits Package beyond that which will be required by HHS or may provide coverage for abortion services.

§156.225(b) Non-discrimination
QHPs must market plans to ensure enrollment by eligible persons is maximized. HHS should issue guidance to ensure QHP issuers do not engage in marketing techniques that intend or have the unintended consequence of steering healthier persons into particular plans and steering sicker persons to others.

In addition, we recommend HHS codify the following specific requirements to ensure compliance with non-discrimination laws:

- All information contained in marketing materials must be provided in a culturally and linguistically appropriate manner consistent with our recommendations provided in §155.230;
- QHPs should provide necessary information on plan benefits, limitations, and exclusions using standardized language and written between a fourth and sixth-grade or lower reading level;
- QHPs should have an online directory listing which providers are in-network and out-of-network, what physicians participate in the plans as well as what hospitals and clinics. Information should also be provided as to whether providers are accepting new patients, as well as the language capability of the provider;
- The actuarial value of the plan should be easily accessible for consumers

[11] Establishment of Exchanges and Qualified Health Plans, 41898.

who wish additional information as well as what those values mean;
- QHPs should provide information on what their Medical Loss Ratio is, and what the ratio means;
- QHPs should provide information for consumer assistance if the potential enrollee has additional questions on how the plan operates;
- What types of cost-sharing is required

Exchanges should monitor and regulate the conduct of agents and brokers to protect against predatory marketing processes. QHPs should be prohibited from engaging in predatory marketing practices, including but not limited to in-person door-to-door solicitation, offering financial incentives to enroll in a particular plan, and any practice that seeks to discourage persons with worse health status or the sick or those with disabilities from enrolling in any plan in the Exchanges, or other deceptive marketing practices which misrepresents the benefits, advantages, conditions, exclusions or limitations of a QHP.

§156.235 Essential community providers

Ensuring a sufficient number of essential community providers
We thank CCIIO for proposing to codify the requirement that QHPs maintain networks with "essential community providers where available, that serve predominately low-income, medically-underserved individuals." We are concerned, however, that without strong standards and guidance indicating how or what a sufficient level of essential community provider participation is, networks will be unable to address the needs of their diverse enrollees. For these reasons, we strongly encourage CCIIO to require QHP issuers to offer contracts to all essential community providers in the geographic area served. As stated in the Proposed Rule, this requirement would ensure continuity of coverage in communities where essential providers have been the only reliable source of care. In addition, the requirement would be especially helpful as people transition on and off Medicaid and CHIP and into these private health insurance plans.

Given the unique role health insurance companies play as the payer of services, CCIIO should provide guidance to QHP issuers on how to meet the requirements of this section to ensure timely access for low-income, medically underserved individuals. For example, given the strong focus on patient centered medical homes in the ACA and incentives for creation, CCIIO should provide guidance and standards as this model can be used to address heath disparities in underserved areas.

To ensure access to linguistically and culturally appropriate health services, we recommend CCIIO explicitly add immigrant communities and limited English proficient communities to the definition of communities served by essential community providers. These communities are often not seen as specific populations by QHPs.

In addition, we recommend CCIIO clarify that no QHP offered in the Exchange can

discriminate against any individual health care provider or health care facility because of its willingness to provide, pay for, provide coverage of, or refer for abortions.

Exemption to the essential community provider requirement for integrated delivery plans
The Proposed Rule allows for considerable diversity in integrated network health plans and includes systems where the insurer is also the service provider, such as in the "staff model." We recommend that if CCIIO exempts such organizations or plans from the essential community provider requirement, the exemption be contingent upon demonstrating evidence of compliance with providing services to low-income populations, compliance with national standards for provisions of culturally and linguistically appropriate services (CLAS), and implementation of a plan to address health disparities.

Other similar types of providers that serve predominately low-income, medically-underserved populations
To ensure there is an adequate supply of providers in each geographic area served by the QHP, we strongly recommend CCIIO include other providers that may be considered essential community providers to ensure low-income and hard-to-reach populations have access to care. The addition of the following providers to §156.235(b) is consistent with the ACA as the law does not expressly limit providers to those listed under §340B(a)(4) of the PHS Act and §1927(c)(1)(D)(i)(IV).

The Proposed Rule should reiterate the providers required under the ACA as essential community providers, including community health centers and clinics, HIV/AIDS clinics, and women's health providers, including OB/GYN providers.

QHP networks must also include access to linguistically and culturally appropriate services. We strongly urge CCIIO to include providers with diverse linguistic abilities and cultural backgrounds in the definition of essential community providers. Providers with these skills and knowledge can most effectively communicate with patients from diverse backgrounds. Community clinics and physician groups serving the Asian American, Native Hawaiian and Pacific Islander populations must be codified into the final rule. We also recommend that outreach to these entities be conducted by CCIIO especially given the proposals regarding payment and reimbursement. Given that many of these institutions and practices are minimally staffed, appropriate training, outreach and guidance should be provided to ensure that these entities can meaningfully benefit from the new opportunities afforded under this section.

§156.250 Health plan applications and notices

We commend CCIIO for addressing the need to ensure that all health plan applications and notices be accessible to LEP enrollees and persons with disabilities. We support CCIIO's proposal that QHP issuers must adhere to the standards established for notices in §155.230(b) and incorporate our

recommendations to §155.230 herein. The adoption of these suggestions will ensure health plan applications and notices provided under §156.250 are aligned with the requirements of Title VI of the Civil Rights Act, Executive Order 13166, §1557 of the ACA, HHS Title VI Guidance, and OCR LEP Guidance.

§156.265 Enrollment process for qualified individuals

Information about the QHP's network should be provided in an easy to understand manner, written for the general audience and written between a fourth and sixth-grade or lower reading level. QHPs should be required to employ best practices for reaching low-literacy audiences when drafting health coverage literature and notices.

QHP issuers should make every effort to provide language access services for those who are limited English proficient. QHP issuers should adopt the 5% in a plan's enrollees or 500 LEP individuals, whichever is less threshold, as suggested in our recommendations in §155.230. In addition, QHP issuers should provide in-language taglines in at least 15 languages, using standardized language directing LEP consumers to consumer assistance providers. QHP issuers can use examples such as the following, provided by the National Health Law Program (NHeLP):

> "No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or xxx-xxx-xxxx. For more help, call the XX Department of Insurance at xxx-xxx-xxxx."

Using taglines is a cost-effective method of informing LEP enrollees of the availability of language services. In addition, to further streamline costs, QHP issuers can collaborate with HHS to develop standardized tagline language and translations to be used across marketing and informational materials and in the enrollment process.

QHP issuers should conduct outreach and enrollment initiatives tailored to specific ethnic, cultural and language groups and develop enrollment packets with those populations in mind. In addition, to conduct outreach and enrollment in hard-to-reach populations, QHP issuers should use consumer testing in the form of focus groups or collaboration with advocacy/community organizations to determine the needs/barriers of those populations. Such practices will ensure the pool of Exchange enrollees is as broad as possible and ensure populations such as LEP communities and AAs and NHPIs are able to understand their benefits package before seeing a health care provider.

§156.280 Segregation of funds for abortion services

We are pleased that the Proposed Rules do not exceed the restrictive statutory language of §1303 related to abortion coverage. However, we urge clarifications of several parts of the proposed rule so that abortion coverage may remain in private health insurance and so that consumers will not be deterred from enrolling in the

plan best suited to their needs.

Under the current system of employer sponsored health insurance, many plans offer coverage of abortion services. This benefit is critical to women who cannot afford to pay out of pocket for an abortion procedure on top of the premiums and other cost sharing they may already expend towards their health care needs. Women who require abortion care may be forced to wait until later in their pregnancies for financial reasons if the service is not included in their insurance plan. Many Asian American, Native Hawaiian and Pacific Islander women already face barriers to reproductive health care such as geographic isolation, cultural stigma related to sexual health, domestic violence, and lack of basic health insurance coverage. For these women, maintaining insurance coverage of abortion services is essential. These issues are compounded for persons with limited English proficiency, who may not understand that abortion care can be provided safely and legally in the United States if abortion care is inexplicably segregated from their health care coverage.

§156.280(c) Voluntary choice of coverage of abortion services.
Consistent with §1303 of the ACA, QHPs have the option to include abortion coverage in their plans. For these reasons, we recommend that §156.280 make clear that a QHP is neither required ***nor prohibited*** from including abortion services for which public funding is prohibited, in the absence of a state law barring such inclusion, and so long as the QHP is in compliance with the applicable provisions of the ACA.

§156.280(e) Prohibition on the use of Federal Funds
Only enrollees who receive federal subsidies are subject to the segregation of funding requirement. The regulations should clarify that the requirement to make separate payments only applies to those enrollees who receive federal cost-sharing reductions or credits. By definition, the section entitled "Prohibition in the use of federal funds" §156.280(e) should alert health insurers that the restrictions in the following subpart only apply to federal funds. However, a clarification of this section would help to ensure that insurers would not waste administrative resources applying the restrictions to enrollees who are not paying for their plans with federal dollars, or cease offering the coverage to all enrollees. Ensuring that the additional rules apply only to federal funds will reduce the cost of compliance with the rule and thereby avoid passing on additional administrative costs to consumers.

§156.280(e)(2) Establishment of allocation accounts
The ACA prohibits the use of federal funds to pay for abortions for which public Funding is prohibited, if a QHP opts to include those services in the benefit package. The rules should make clear that the insurance plans, not the enrollees, are responsible for segregating the funds that cover the portion of the premium for abortions for which public funding is prohibited. The term "separate payment" in §156.280(e)(2)(i) should be interpreted as allowing individuals to make their separate payments in one transaction and/or in one instrument. This will ensure

that the funds are maintained separately without placing the burden of producing payment by two transactions or instruments on the enrollee. Requiring two separate transactions or instruments would ultimately compromise the streamlined process with which the ACA endeavors to make coverage accessible and available to consumers. We urge CCIIO to make clear that insurers can meet this requirement by collecting the funds in the same transaction or instrument by submitting an itemized bill to the enrollee. An itemized bill would delineate the portion of the funds to be used for abortion coverage and for other coverage. This practice is standard in the insurance industry, for example, when a consumer purchases auto and homeowners insurance from the same carrier, and can pay the entire insurance bill in one transaction."

§156.280 (f) Rules relating to notice
Notice of coverage, and subsequent changes in coverage, should be made accessible for those who have limited English proficiency (LEP). Language access is one aspect of cultural competence that is essential to quality care. We recommend CCIIO incorporate our suggestions in §155.230 regarding notice requirements. QHPs must ensure that their members understand what services are covered under the plan purchased. If there are changes to the plan, QHPs must be responsible for ensuring that members understand those changes.

Conclusion

In summary, we appreciate the opportunity to comment on the establishment and operation of the Exchanges, consumer assistance functions and QHPs. Please contact Priscilla Huang (phuang@apiahf.org), Policy Director, with any questions. We welcome future opportunities to work together on this important aspect of health reform implementation.

Respectfully,

Kathy Lim Ko
President & CEO, Asian & Pacific Islander American Health Forum (APIAHF)

and the following organizations:

Asian Pacific Community in Action
Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
Asian Services In Action
Association of Asian Pacific Community Health Organizations
Coalition for Asian American Children & Families and Project CHARGE
Japanese American Citizens League (JACL)
National Asian Pacific American Families Against Substance Abuse

National Tongan-American Society
South Asian Americans Leading Together (SAALT)
Southeast Asia Resource Action Center