APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

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

File Code: CMS 9974-P (Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers)

Dear Secretary Sebelius and Administrator Berwick:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Department of Health and Human Services (HHS) for the opportunity to comment on Exchange functions and eligibility determinations. For 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian and Pacific Islander communities (AA and NHPI) living in the United States and its jurisdictions. The Proposed Rule addressing eligibility determinations for QHPs and insurance affordability programs 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 the coverage and subsidies offered through the Exchanges. According to one-year estimates of the 2009 American Community Survey, Asian Americans have an overall uninsurance rate of 14.1 percent and Native Hawaiians and Pacific Islanders have an overall uninsurance rate of 13.5 percent. There is wide variation among AA and NHPI ethnic groups, however, with Bangladeshis, Cambodians, Koreans and Pakistanis experiencing uninsured rates of 21-23 percent, compared to 8 percent among Japanese.[1]

Linguistic and cultural barriers add complexities to the eligibility and enrollment process, preventing many in these populations from attaining quality health care. According to an estimate of the projected 2019 Exchange population conducted by the Kaiser Family Foundation, approximately one in four Exchange enrollees will speak a language other than English at home.[i] Thus, we urge CCIIO to ensure the streamlined and coordinated enrollment and eligibility processes used in the Exchanges adequately meet the needs of diverse communities, including those that are immigrant and limited English proficient. In addition, we urge CCIIO to consider the following modifications and additions to the Proposed Rule.

General comments

Starting in 2014, millions of individual Americans and small businesses will use the Exchange as their primary entry point in obtaining affordable health coverage.

[1] U.S. Census Bureau, 2007-2009 American Community Survey, 3 Year estimates

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 best meets their individual needs. For these reasons, we outline a number of general comments that CCIIO should consider as enrollment and eligibility processes are developed and implemented.

Leverage data collection

Exchanges, QHP issuers and state and federal agencies (e.g. Social Security Administration) should leverage 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.

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 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 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.

Codify the Tri-Agency Guidance

We are pleased that the regulations reinforce the civil rights and privacy laws and principles set forth in the Tri-Agency Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applicants for Medicaid, CHIP and other programs. We thank CCIIO for their commitment to ensuring the Exchanges and insurance affordability programs safeguard confidential personal information about applicants and non-applicants, and request only the minimum information needed to make eligibility determinations.

No Wrong Door Approach

We commend CCIIO for proposing processes and rules that are structured to minimize burdens on both the consumer and the Exchanges, and designed to seamlessly direct consumers to coverage that best meets their needs. To that end, we encourage CCIIO to ensure that state agencies are prepared to coordinate and a streamlined, no-wrong-door approach for consumers to enroll in the Exchanges and other insurance affordability programs. All consumers should interact with an accessible interface (online, telephonic, paper or in-person) that seamlessly directs them to all programs, services and benefits to which they are eligible. Accurate eligibility determinations and enrollment in programs and services should occur regardless of whether a consumer goes directly to an agency administering a program (e.g. State Medicaid agency) or to an Exchange. In addition, the principle of no-wrong-door should be extended to individuals who are not eligible for participation in the Exchanges or insurance affordability programs to direct them to appropriate contacts or programs for coverage in the private market.

Issues specific to the U.S. Territories

Under the ACA, the governments of the Pacific territories of Guam, American Samoa and the Commonwealth of the Northern Mariana Islands can elect to establish a Health Insurance Exchange through notice to the Secretary of Health and Human Services by October 1, 2013. We ask that HHS work closely with the territorial governments as they consider establishing these exchanges. The Territories have much to gain from the establishment of a Health Insurance Exchange. Located in the Pacific and about 8,000 miles from the continental United States at its farthest, the over 331,000 residents of these jurisdictions face serious health disparities such as high rates of cervical, lung, and stomach cancer, breast cancer mortality, and suicide[3]. Yet the health insurance infrastructure of the

[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*.

[3] Asian & Pacific Islander American Health Forum. "Opportunities and Challenges: Implementation of the Patient Protection and Affordable Care Act in the U.S. Pacific Territories." April 2011

territories is less developed in comparison to the states, with only small and local insurance companies insuring a large segment of the population.

We also ask that HHS consider the unique challenges that face these jurisdictions related to health information technology infrastructure. As many of the eligibility determinations will be done through state agencies or other entities contracted by the state, it is important that HHS work with territorial governments to find local solutions to these challenges. We ask that HHS ensure that any funds going to private companies tasked with developing systems be locally based or companies that are aware of the territorial health infrastructure environment.

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

§155.300 Definitions and general standards for eligibility determinations

(a) Definitions

Application filer
We support codification of the definition of an "application filer" as an individual who submits an application for health insurance coverage to the Exchange and responds to inquiries about the application. The distinction between an applicant or enrollee and application filer is important for mixed-immigration status families in particular, who may be applying on behalf of a citizen child.

State CHIP Agency
We recommend CMS clarify that "agency" includes state *and* territorial CHIP agencies.

State Medicaid Agency

We recommend CMS clarify that "agency" includes state *and* territorial Medicaid agencies.

§155.305 Eligibility standards

§155.305(1) Citizenship, status as a national, or lawful presence
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 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[4] 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.[5]

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.

The requirement that an individual be "reasonably expected"

Citizenship and immigration status is an important threshold requirement for participation in the Exchanges and insurance affordability programs, and will be confusing for many immigrant individuals and mixed-immigration status families. We strongly encourage CCIIO to craft eligibility standards and functions around these thresholds with the needs of these diverse groups in mind. One way to help ensure immigrant individuals and families understand which programs they are eligible for is to include a link to explanatory information, factsheets or FAQs as part of eligibility screening and enrollment applications. These documents can provide information on important terms, such as the definition of "lawfully present" and what it means to be "reasonably expected" to remain so for the period in which enrollment is sought. Explanatory documents should also contain easy to understand examples illustrating key terms.

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

[5] 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.

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.

Moreover, Exchange websites and the single streamlined application should include an explanation explaining the difference between a benefit year and the "period for which enrollment is sought."

State residency
We support codification of the definition of state residency for persons aged 21 or older as present intent and current residence in the state. In addition, we recommend CCIIO provide clarification that these rules apply to citizens and immigrants and are independent of immigration status requirements. In the past, 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 crucial to the success of implementing the Exchanges.

Special rule for family members living outside the service area of the Exchange of the primary taxpayer
We support the proposal to allow out of state dependents to choose a QHP within the area they reside or intend to reside, or to choose the QHP that services the area of the primary tax filer. This level of flexibility takes into consideration the needs of children and families who move in and out of exchange areas such as the children of migrant or seasonal farmworkers and college students.

§155.305(f)(2) Special rule for non-citizens lawfully present who are ineligible for Medicaid
We support codification of separate provisions related to non-citizens who are lawfully present, but ineligible for Medicaid. In addition, we urge CCIIO to continue to provide clear guidance and instructions where the ACA and existing laws apply a different set of rules for non-citizens. This level of specificity will help ensure robust enrollment of all persons eligible for participation in the Exchanges and insurance affordability programs.

§155.305(f)(6) Collection of Social Security Numbers
Consistent with our comments in §155.405 (Appendix A), 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 the Tri-Agency Guidance, as well as best practices from other state's health system enrollment forms. For specific recommendations and best practices demonstrating compliance with this Guidance, refer to our recommendations in §155.405 (Appendix A).

Reconciliation process
We thank CCIIO for considering the effect the reconciliation process can have on participation in the Exchanges and premium tax credits for persons who experience substantial changes in income during the benefit year. We recommend CCIIO develop a strong initial eligibility process that maximizes accuracy and a strong process by which individuals can report changes that occur during the benefit year. For example, as suggested in the Proposed Rule, we recommend allowing enrollees to report changes in income or status through a variety of electronic and non-electronic formats. In addition, we recommend eligibility and enrollment documents contain links or references to informational materials explaining the statutory reconciliation process and common examples of changes that may occur during a benefit year. This will allow persons who tend to experience fluctuations in income to plan accordingly.

§155.310 Eligibility determination process

§155.310(a)(1) The exchange must accept applications from individuals in the form and manner proposed in 45 CFR 155.405
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 single streamlined application will play a significant role in determining how accessible enrollment in the Exchanges and insurance affordability programs will be for many populations. For these reasons, we support the requirement that the Exchange accept applications in the form and manner proposed in §155.405 and incorporate our comments to §155.405 herein (Appendix A).

§155.310(a)(2) Information collection from non-applicants
We support codification of the requirement that prohibits the Exchanges from requiring non-applicants to provide information regarding his or her citizenship, status as a national, or immigration status on any application or supplemental form. Relatedly, we support the codification of the requirement that an Exchange may not require an individual to provide a SSN, except as described in §155.305(f)(6). The codification of these requirements is consistent with Section 1411(g) and the Tri-Agency Guidance.

In addition, consistent with the Tri-Agency Guidance, we recommend HHS 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;
- Include notice that 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.

§155.310(b) Choice to request determination of eligibility for insurance affordability programs

We support codification of the requirement that the Exchange permit an applicant to decline an eligibility determination for the programs described in paragraphs (c) through (g) of §155.305. To the extent allowed by law, an applicant should always be permitted to opt-out of additional eligibility screening. In addition, to ensure applicants are able to make informed decisions, the Exchange should provide additional information highlighting potential reasons an applicant may wish to decline an eligibility determination.

§155.310(d)(2)(i) Special rules relating to advance payments of the premium tax credit

We support the requirement that the Exchange permit enrollees to accept less than the full amount of advance payments of the premium tax credits to which they are eligible. This proposal will help alleviate some concerns about reconciliation for individuals who anticipate changes in income during a tax year. Individuals should be informed of this option, as well as the potential for reconciliation, and provided contact information for consumer assistance functions if they have further questions. Eligibility screening tools and applications should contain trigger questions to alert persons who may be subject to reconciliation of the process and how to plan accordingly. Using trigger questions will allow electronic applications to tailor later questions to an individual's previous response.

§155.310(f) Notification of eligibility determination

We are pleased CCIIO plans to codify the requirement that the Exchange provide timely notice to an applicant of any eligibility determination made in accordance with this subpart. We support the requirement that the notice be in writing, be provided in addition to any notices that may have been transmitted electronically during the application process, and contain appeal rights. As a required notice, the notification of eligibility determination must comply with the requirements in §155.230. We incorporate our recommendations around the plain language, accessibility and readability requirements from our comments to §155.230 herein (Appendix B).

§155.315 Verification process related to eligibility for enrollment in QHP through Exchange

We strongly support the proposal to allow the Exchanges to accept self-attestation of all eligibility criteria other than citizenship and immigration status, limiting requests for additional information from applicants to cases where information is not available electronically, and formalizing HHS' role as an intermediary between the Exchange and other federal agencies. CMS has a long-standing policy of

accepting attestations of certain eligibility information from the applicant, spouse, parent, caretaker or a representative filing on behalf of an applicant. Self-attestation is particularly helpful for individuals and families whose income, housing situation, or birth date are note recorded in a traditional manner, including homeless families, families fleeing domestic violence or natural disaster situations, and individuals who may face barriers to securing documentation such as seniors and people with disabilities. The degree to which the Exchanges can streamline eligibility and minimize requests for information from an application file will have an impact on the ability of the Exchanges to maximize initial enrollment, promote continuous enrollment and prevent gaps in coverage.

§155.315(b) Verification of Citizenship, Status as a National or Lawful Presence
The proposed rule requires that Exchanges verify citizenship or lawful presence by transmitting information to HHS, which would then transmit the information to the Social Security Administration (SSA) or the Department of Homeland Security (DHS) depending on the individual's attestation of citizenship or lawful presence. The rule does not acknowledge the creation of the electronic service as set forth in the proposed Medicaid rule at §435.949, which will allow states to verify this information through a federal "hub." We recommend that HHS amend the proposed rule to specifically reference the new "hub" as set forth in the Medicaid rule.

§155.315(b)(2) Verification with the records of the Department of Homeland Security
We recommend CCIIO explicitly codify the protections provided in the SAVE system to the verification process described in §155.315. 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. Codifying the protections currently afforded to Medicaid applicants in the SAVE system will help to ensure minimum privacy and security standards, while retaining flexibility.

§155.315(b)(3) Inconsistencies and inability to verify information
We support codification of the requirement that the Exchange follow the procedures outlined in §155.315(e) and in addition, provide the applicant with a 90 day notice period. In cases where the Exchange cannot verify attestation of citizenship, status as a national or lawful presence, the application filer should be permitted to provide satisfactory documentary evidence and the ability to resolve the inconsistency with the Social Security Administration or Department of Homeland Security, as applicable. This approach is consistent with the Section 1902(ee) of the Social Security Act and will reduce burdens and delay for eligible individuals and families trying to access coverage. In attempting to resolve inconsistencies, CCIIO should ensure that Exchanges accept, at a minimum, all documents recognized by federal agencies to establish citizenship or an eligible immigration status.

As a required notice, the notification of inconsistency must comply with the requirements in §155.230. We incorporate our recommendations around the plain language, accessibility and readability requirements from our comments in §155.230 herein (Appendix B).

§155.315(c) Verification of Residency
The proposed rule requires that Exchanges accept self-attestation of residency, except when the state has elected to require verification of residency through electronic data as described in paragraph (2). As stated earlier, CMS has a long-standing policy of accepting attestations of certain eligibility information, therefore we recommend that all states be required to accept self-attestation of residency. Requiring self-attestations will help streamline eligibility determinations and maximize enrollment.

§155.315(e) Inconsistencies
We support codification of a process for addressing cases where the Exchange cannot verify the information required to determine eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. While electronic data matching should be the preferred method of verification, databases used by the Social Security Administration and the Systematic Alien Verification for Entitlements (SAVE) may 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.

Therefore, we strongly support codification of the 90 day period to resolve inconsistencies as this approach is consistent with the Section 1902(ee) of the Social Security Act. In addition, we support the proposal to allow the period during which an applicant can resolve an inconsistency to be extended by the Exchange, if the applicant can provide evidence that a good faith effort has been made to obtain documentation. This extension may be necessary for individuals who may not have ready access to necessary documents.

As a required notice, the notification provided in (e)(2)(i) must comply with the requirements in §155.230. We incorporate our recommendations around the plain language, accessibility and readability requirements from our comments in §155.230 herein (Appendix B).

§155.315(f) Flexibility in information collection and verification
We support the requirement for HHS approval of an Exchange Plan that seeks to implement an alternative information collection and verification process. We urge CCIIO to also require compliance with the minimum requirements set forth in our recommendations to §155.315.

§155.315(g) Applicant information
We support codification of the requirement that the Exchanges not require an

applicant to provide information beyond the minimum necessary to support the eligibility and enrollment processes of the Exchange and insurance affordability programs. This requirement aligns with the limitation in Section 1411(g) of the ACA that any data collected be restricted to that which is "strictly necessary" to authenticate identity, determine eligibility and determine the amount of the credit or reduction. As stated in our general comments to this Proposed Rule, we do not interpret Section 1411(g) to limit the voluntary collection and reporting of demographic data pursuant to Section 4302.

§155.320 Verification process related to eligibility for insurance affordability programs

§155.320(a) General requirements
Consistent with the Tri-Agency Guidance, we support codification of the requirement that the Exchange only verify information for an applicant who is requesting an eligibility determination for insurance affordability programs. In addition, we strongly support the requirement that where an Exchange is not able to determine if information is "reasonably compatible" with that provided by an applicant, an applicant who otherwise appears eligible should be permitted to continue the application process and enroll in a qualified health plan pending a final determination.

§155.320(c) Verification of household income/family size
We support the use of self-attestation to verify to family size, and the proposal to give states the flexibility to obtain financial information from alternative federal, state and commercial electronic data sources if an exchange is not able to verify reasonable compatibility with the information provided by an applicant. This flexibility will help ensure that the exchanges capture an accurate picture of an individual's and family's earnings. We also support limited use of paper verification as a last resort.

In addition, APIAHF strongly supports codification of the requirement that the Exchange provide education and assistance to an application filer regarding the income and family size verification process. We recommend providing definitions of common terms, as well as examples of common scenarios and exclusions. Providing assistance on the front-end of the process will maximize enrollment by eligible persons, improve accuracy and limit administrative burdens due to inconsistencies. Education and outreach should occur at various points of contact, including but not limited to Exchange call centers, Exchange websites, Navigators and other consumer assistance functions.

§155.320(d) Verification related to enrollment in an eligible employer-sponsored plan
We support the proposal to allow an Exchange to accept an applicant's attestation of whether they are enrolled in an eligible employer-sponsored plan. As with all terms affecting eligibility, the Exchange should provide a definition and illustrative examples (as applicable).

§155.320(e) Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan

We support the general approach of this provision, which would allow applicants to attest whether they are eligible for employer-sponsored coverage. The preamble suggests that Exchanges would be responsible for determining whether such coverage is affordable and whether it meets minimum value standards based on other information sources. We support standard templates for the information needed to make this determination as suggested in the preamble. Employees should not be expected to provide information regarding minimum value, for example, as this would not be readily accessible.

§155.320(f) Additional verification related to immigration status for Medicaid and CHIP

We urge CCIIO to explicitly codify the protections provided in the SAVE system to the verification process, as we describe in our comments on §155.315. 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. Codifying the protections currently afforded to Medicaid applicants in the SAVE system will help to ensure minimum privacy and security standards, while retaining flexibility.

§155.330 Eligibility redetermination during a benefit year

§155.330(b) Requirement for individuals to report changes

Enrollees must be provided with sufficient information and resources to ensure they understand the need to report changes with respect to the eligibility standards specified in §155.305. In addition, while we understand the need to minimize administrative burdens associated with redeterminations, the Exchange should offer all enrollees periodic reminders to report changes affecting eligibility. Reminders should be written in plain language, between a fourth and sixth-grade reading level or below, as provided in recommendations by the National Institutes of Health (NIH)[6], and contain common examples of changes (e.g. changes in income). In addition, enrollees should receive information and notices regarding possible tax consequences, such as reconciliation, if their eligibility changes.

The requirement to report changes in income may be confusing for a number of enrollees receiving cost-sharing reductions or premium tax credits. While we appreciate the need to prevent enrollees from being required to report small change in income, we are concerned that requiring minimum thresholds, such as greater than five, ten or 15 percent may be confusing. This requirement would also be burdensome on the Exchanges to administer. Because family circumstances and

[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.

income levels change frequently in lower income brackets, we urge CCIIO to consider the administrative burdens that would be placed on enrollees and Exchanges if a minimum threshold for reporting income and other changes is adopted. Additionally, we appreciate CCIIO's clarification that this provision would have no effect on whether an individual would be liable for repayment of excess advance payments of the premium tax credits.

§155.330(c) Requirement for Exchange to periodically examine certain data sources
The proposed rule requires the Exchanges to periodically examine available data sources to identify changes due to death and eligibility determinations for Medicare, Medicaid, CHIP and the Basic Health Program (BHP). This is important for the Exchanges to ensure seamless transition between QHPs, BHP and Medicaid/CHIP, particularly for lawfully present immigrants who become eligible for Medicaid or CHIP after meeting the five-year waiting period. Because the change in program eligibility due to the fulfillment of the waiting period is not the result of a change in immigration status, immigrants who fall under this category should not be responsible for reporting a change in eligibility. Rather, Exchanges must be able to identify such changes and notify the immigrant of his or her eligibility to enroll in Medicaid and CHIP.

§155.330(d) Redetermination and notification of eligibility
All notices provided pursuant to §155.330(d) must comply with the accessibility and readability provisions in §155.230. We incorporate our recommendations in §155.230 herein (Appendix B). In addition, no enrollee should be removed from coverage until they have been given notice of an eligibility determination and time for appeal. Until the appeals period has been exhausted, enrollees should remain eligible for coverage if the redetermination was based on proactive data examination.

Enrollees should be given the opportunity to review any information being used to determine or redetermine eligibility, and the opportunity to make changes or additions. Any changes to an enrollee's eligibility, based on additional data matching or otherwise, must be affirmed by the enrollee. If an Exchange is not required to seek affirmation from an enrollee prior to using data obtained from electronic sources in an eligibility determination, the Exchange should include a notice to that effect in all application materials and periodic reminders
In addition, any alternative efforts used by the Exchange to verify information should conform to the same minimum requirement provided in the Proposed Rule. All processes must meet minimum standards with respect to accuracy and reliability.

§155.330(e) Effective dates
In paragraph (e)(2), we recommend that CCIIO create a specific timeline to ensure enrollees are given enough time between the notice of a change and the date the change will go into effect. A cut-off date is necessary to ensure enrollees have adequate time to receive notice of redetermination and understand their right to appeal.

In (e)(3), we support the recommendation that in the case of a redetermination that results in an enrollee being ineligible to continue enrollment in a QHP through the Exchange, the Exchange must maintain his or her eligibility for enrollment in a QHP without advance payments of the premium tax credit and cost-sharing reductions for a full month following the date in which notice described in paragraph (d)(3) is sent. In addition, because coverage may become unaffordable without advance payments of the premium tax credit or cost-sharing deductions, we recommend such payments be maintained for a full month following the month in which the notice described in paragraph (d)(3) is sent if the enrollee elects to do so. This will help address concerns of recouping costs during reconciliation in the event the enrollee is no longer eligible for affordability programs, but will allow some enrollees to continue coverage if they feel the redetermination was inaccurate.

§155.335 Annual eligibility redetermination

§155.335(a) General requirement
To ensure consistency to avoid confusion among enrollees, we support the proposal to conduct eligibility redeterminations on an annual basis. An annual eligibility redetermination is consistent with current Medicaid practice, reduces administrative burden and cost, and minimizes the risk of gaps in coverage. Redeterminations should not be required more frequently and should be limited to cases where eligibility for another insurance affordability program is impacted.

Consistent with our comments on §155.330, no enrollee should be removed from coverage until they have been given notice of an eligibility determination and right to appeal. Until the appeals period has been exhausted, enrollees should remain eligible for coverage if the redetermination was based on proactive data examination. To minimize confusion among enrollees, annual redetermination should occur at a consistent point in the year for all individuals when new tax data becomes available, regardless if a redetermination was made at some point during the coverage year.

§155.335(b) Updated income and family size information
Enrollees should never be required to request an eligibility determination. Redeterminations should be automatic during the annual period and the Exchange, and not the enrollee, should initiate electronic data matching to obtain updated tax return information and household income. As with all cases involving electronic data matching, the enrollee should be given the opportunity to review any information being used to determine or redetermine eligibility, and the opportunity to make changes or additions, as provided in §155.335(c).

§155.335(c) Notice to enrollee
We support codification of the requirement that the Exchange provide an enrollee with an annual redetermination notice. As a required notice, the notification of annual eligibility redetermination must comply with the requirements in §155.230

(Appendix B) 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. If an LEP enrollee has previously requested materials translated into their spoken language or requested other language services, the Exchange must provide the notice in that enrollee's language. In addition, we recommend CCIIO codify the following requirements to be included in the notice:

- Date redetermination will become effective;
- Procedures to correct errors in data obtained or used in the enrollee's most recent eligibility determination, including the 30 day requirement to report changes specified in §155.335(d);
- Where individuals may obtain additional information or assistance, including the Exchange website, call center, Navigators and other consumer assistance functions;
- Ability of an enrollee to apply for premium tax credits or cost-sharing reductions in the coming year if they did not request the same in the previous year and how to apply;
- Notice of a right to terminate coverage in an enrollee's current QHP and enroll in a different QHP during the annual open enrollment period;
- Notice of a right to an interpreter, available at no cost to the LEP individual, provided in at least 15 in-language taglines.

§155.335(d) Changes reported by enrollees
This section of the proposed rule should specify that enrollees can report changes using the same modes of communication as those provided during the enrollment period—online, telephone, in person, fax and mail.

§155.335(f) Response to redetermination notice
Requiring enrollees to sign and return the notice described in §155.335(c) is not necessary, and only increases administrative burden and cost on the Exchanges. In fact, this is not a practice currently in use for Medicaid, where annual redeterminations are done without a signature. We recommend that CCIIO strike paragraph (1) of this section.

To streamline the redetermination process, we recommend that CCIIO prepopulate annual redetermination notices with only the information necessary for redetermination (e.g. age, coverage, income, household, etc.) based on the most recent eligibility information available for the enrollee. As with all cases involving electronic data matching, the enrollee should be given the opportunity to review any information being used to redetermine eligibility, and the opportunity to make changes or additions, as provided in §155.335(c).

§155.335(g) Redetermination and notification of eligibility
We support the proposal to allow an enrollee who continues to be eligible for coverage in a QHP to remain in the plan selected from the previous year, unless the enrollee terminates coverage from the plan. This proposal will ensure seamless

coverage and minimize the risk of an enrollee accidentally loosing coverage due to administrative procedures.

§155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions

§155.340 (a) Requirement to provide information to enable advance payments of the premium tax credits and cost sharing reductions

We support the expectation that Exchanges have the capability to transmit data in "real time." To that end, this provision requires Exchanges to instantly transmit information to facilitate the administration of advanced payments of the premium tax credit and cost sharing subsidies to the applicable QHP and HHS. We also suggest that the final rule include a timeliness standard for the transmission of these data to reflect the "real time" expectation, and provide for instances when systems are not functioning properly. We suggest the following language: "the Exchange must transmit data as quickly as possible and under no circumstances take more than one business day."

§155.340(b) Requirement to provide information related to employer responsibility

We are concerned that this provision will be burdensome for the Exchanges, and it raises privacy concerns for employees. We recognize that the transmission of information described in this provision is required by sections 1311(d)(4)(I)-(J) of the Affordable Care Act. However, the final rule should clarify that the Exchange will only transmit a minimum amount of information required by law (employee name and taxpayer identification number). The final rule should also replace all references to "social security number" and replace them with "taxpayer identification number" as specified in the ACA.

§155.340(c) Requirement to provide information related to reconciliation of advance payments of the premium tax credits

We recommend CCIIO provide more detail concerning what information will be provided to consumers about reconciliation or when the information will be provided. We understand that the Secretary of the Treasury will prescribe the content and timing of the notice required under this subsection, but the final rule should clarify that notifications provided by the Exchanges to consumers should be written in plain, easy to understand language that meets meaningful access standards required throughout the eligibility process.

§155.345 Coordination with Medicaid, CHIP, BHP and Pre-Existing Condition Insurance Programs

§155.345(a) Agreements

We support the requirement for Exchanges to enter into agreements with Medicaid and CHIP agencies. Given that Medicaid and CHIP are state-federal partnerships, this requirement will avoid variations in eligibility determinations, facilitate coordination of coverage across programs and ensure Exchange determinations are consistent with a State's approved Medicaid plan and policies. To that end, CCIIO

should specify that the Exchanges determine eligibility for Medicaid and CHIP that are consistent with the methods, standards and procedures set forth in the State's approved plan and procedures of the administering agency.

Further, as not all states will conduct their own Exchange, the federal government will need to work with these states to coordinate a potential federally run exchange. This transfer of information must ensure that privacy and other compliance issues remain in the process.

§155.345(b) Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups
We support the requirement outlined in paragraph (2) that Exchanges offer an applicant who is otherwise eligible for premium tax credits and cost-sharing reductions, access to coverage in the Exchange pending an eligibility determination for another program such as Medicaid. This practice reinforces the principle of seamless eligibility, and affirms the intent of the ACA to ensure that individuals continue to have coverage as they navigate the Exchange for more affordable options.

The "basic screening requirement" described in paragraph (1), however, needs more guidance from CMS. To better facilitate the "screen and refer" process for applicants who may be eligible for a MAGI-exempt category of coverage, we suggest the inclusion of trigger questions in the single streamlined application and any eligibility screening tools used by Exchanges and consumer assistance programs. Trigger questions can prompt applicants to provide the necessary information for determining eligibility for MAGI-exempt categories. These trigger questions should be standardized across state lines and should be part of any process states use to determine eligibility.

§155.345(c) Individuals requesting additional screening
We support codification of the requirement that an applicant be permitted to request a full determination of eligibility for Medicaid based on criteria not described in §155.305. All applicants should be provided notice of their right to make such a request. Applicants should also be provided with additional background information that will assist them in determining if they would benefit from a full eligibility review. For example, Exchanges can work with agencies administering Medicaid to create illustrative examples of common scenarios where a person may be determined ineligible in a screening conducted by the Exchange, but eligible after a full screening. These notices should also be written in plain language at a fourth to sixth-grade reading level. If an individual is limited English proficient, appropriate steps must be taken to provide the screening in a meaningfully accessible way.

We also recommend that CMS provide a specific time period for the Exchange to transmit requests for a full eligibility screening to the State Medicaid agency. The "promptly without undue delay" language used in paragraph (2) is overly vague.

§155.345(d) Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP or the Basic Health Program
We strongly support the requirement that an Exchange work with the state agencies administering Medicaid, CHIP and BHP (if applicable) to ensure that an application sent directly to those agencies automatically triggers a process to determine eligibility for coverage in a QHP or other insurance affordability program without submitting additional information. The processes outlined in this section will help ensure enrollment is seamless and assist potential enrollees determine which eligible programs best meet their needs. Barriers to enrollment should be limited given the challenges that low-income applicants face which include multiple in person visits, access to technology and additional forms for other programs.

§155.345(e) Standards for sharing information between the Exchange and the agencies administering Medicaid, CHIP and the Basic Health Program
All data sharing agreements used under this section must comply with the privacy and security provisions in §155.260. We incorporate our comments to §155.260 herein (Appendix C) with respect to privacy policies, limitations on the types of information that can be collected and compliance with the Tri-Agency Guidance. In addition, we recommend that any data sharing agreement or HHS model agreement explicitly require compliance with 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. Moreover, we support the extension of these requirements to contractors and sub-contractors. In addition, we recommend CCIIO ensure that data matching and sharing arrangements are consistent with the protections provided in the SAVE system, as per our comments to §155.315.

§155.345(f) Transition from the Pre-existing Condition Insurance Program (PCIP)
We thank CCIIO for taking into consideration the unique needs of individuals currently enrolled in the PCIP who may be eligible for coverage in QHPs starting January 2014. We recommend that CCIIO either require Exchanges to have dedicated customer service staff that can accelerate or streamline eligibility determinations or ensure that existing staff and consumer assistance functions are trained on how to transfer PCIP enrollees into a QHP. In addition, Exchange websites should contain a designated section directing persons enrolled in PCIPs to enroll in coverage through the Exchange. Moreover, the Exchange should coordinate with PCIP issuers to ensure information is transferred and shared between these entities and ensure enrollees are not asked for duplicative information.

§155.355 Right to appeal

We are pleased CCIIO plans to codify the requirement that the Exchange include a notice of the right to appeal and instructions on how to file an appeal in any determination notice issued to the applicant pursuant to §155.310(f), §155.330(d),

or §155.335(h).

As a required notice, the notification of eligibility determination must comply with the accessibility and readability requirements in §155.230 (Appendix B) to ensure meaningful access for Limited English proficient persons. In addition, we recommend all appeals notices required under this subpart met the following minimum requirements:

- Describe in sufficient detail the procedure for filing an appeal on any determination referenced in this section;
- Contain referral information for persons ineligible to participate in the Exchange, Medicaid, CHIP and the BHP (if applicable) regarding coverage options outside the Exchange;
- Contain 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);
- Provide notice of a right to an interpreter, available at no cost to the LEP individual, and information on how to obtain such services;
- Translate 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;
- Incorporate 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.

Part 157 – Employer Interactions with Exchanges and SHOP Participation

§157.200 Eligibility of Qualified Employers to Participate in a SHOP

§157.200(b) Continuing Participation for Growing Small Employers
We strongly support the requirement that SHOPs must continue to treat a small employer as qualified, even if it increases the number of employees to exceed the statutory definition of a small employer, until the employer either leaves the SHOP or becomes ineligible for other reasons.

§157.205 Qualified Employer Participation Process in a SHOP

§157.205(c) Information Dissemination to Employees
This section requires qualified employers participating in the SHOP to disseminate enrollment information to their qualified employees. We believe this is a critical role that an employer should play in the enrollment process and, as such, the final rule should create a specific timeline under which employers must provide this information to employees. We recommend that employers be required to provide the information to employees 30 days in advance of the beginning of the standardized employee enrollment period that we recommend in our comments

for §155.725 (Appendix D). In addition, the final rule should specify that this information must be provided to employees before initial and annual open enrollment periods and whenever an employee is newly hired. We also recommend that employees receive notice of any changes to the plan offerings from the previous year in advance of annual open enrollment periods.

The preamble suggests that SHOPs may create a toolkit to help qualified employers explain the key pieces of enrollment information to disseminate to employees. We strongly support this suggestion and recommend that CCIIO create a template for SHOPs to disseminate that includes both information for employers and materials for employers to disseminate to employees. This will make it easier for SHOPs to encourage and ensure employer compliance with this requirement.

§157.205(e) Employees Hired Outside of the Initial or Annual Open Enrollment Period

We support the requirement that qualified employers provide employees hired outside of the initial or annual open enrollment period with enrollment information and with a specified period to seek SHOP coverage. We also support the proposal that this period begin on the first day of employment.

§157.205(f) New Employees and Changes in Employee Eligibility

This section requires qualified employers to provide the SHOP with information about individuals or employees whose SHOP eligibility status has changed. We support this reporting mechanism and encourage CCIIO to codify in the final rule a set amount of time within which employers must provide this notice to the SHOP. The preamble suggests that SHOPs direct employers to provide such information within 30 days of the change in eligibility. We believe that this is too long a timeframe. If an employer did not notify a SHOP that an individual's eligibility had changed until 30 days after the event, individuals could be billed for coverage they no longer have, or they might not receive the coverage they should be enrolled in. Therefore, we recommend that the final rule require employers to notify the SHOP when the eligibility of an individual or employee changes within five business days of the event.

§157.205(g) Annual Employer Election Period

We support the requirement that qualified employers adhere to the annual employer election period described in section 155.725 to change their participation for the next plan year. We also support the requirement that the initial open enrollment period for SHOPs mirror those of the Exchanges, commencing on October 1, 2013. Starting enrollment on this date will be critical for giving both employers and employees ample time to learn about the SHOP and their options or coverage.

In addition, we believe the annual employer election period must be structured in a way that gives the employer ample time to make an informed selection of which QHPs to offer its employees for the coming year, while also leaving the employee sufficient time to make his or her own plan selection. To this end, we support the

requirement that in advance of the end of an employer's plan year, the SHOP provide notice to employers of a pending annual election period, a time period for the employer to select plan offerings and contributions for the subsequent plan year, and a time period for employees to select a QHP.

§157.205(h) Employer participation renewal
We support the automatic maintenance of coverage level and contribution levels if a qualified employer takes no action during the annual employer election period. However, the final rule should require that employers receive notice from the SHOP that if they do not take action, their plan offerings to employees will remain the same. In addition, the final rule should state that employers who do not take action during the annual employer election period must still comply with the requirements to provide information to employees about open enrollment in accordance with §157.205(c).

Conclusion

In summary, we appreciate the opportunity to comment on the Exchange functions in the individual market and eligibility determinations. Please contact Priscilla Huang (phuang@apiahf.org), our 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

Appendix A

Excerpt from APIAHF Comments Regarding File Code CMS–9989–P (Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans)

§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 (Appendix B).

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 (Appendix C), 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.

Appendix B

Excerpt from APIAHF Comments Regarding File Code CMS–9989–P (Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans)

§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.[7]

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.[8] HHS has issued an "LEP Guidance"[9] to ensure that language access is

[7] Kaiser Family Foundation, *A Profile of Health Insurance Exchange Enrollees*, March 2011, available at http://www.kff.org/healthreform/upload/8147.pdf.
[8] Civil Rights Act of 1964, 42 U.S.C. §2000d et. seq.

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.

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.

[9] *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.

Appendix C

Excerpt from APIAHF Comments Regarding File Code CMS–9989–P (Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans)

§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.

[i] Kaiser Family Foundation, "A Profile of Health Insurance Exchange Enrollees" (March 2011). Available at http://www.kff.org/healthreform/upload/8147.pdf.