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

Re: **State Exchange Certification Application (CMS-10416)**

To Whom It May Concern:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Centers for Medicaid and Medicare Services (CMS), and HHS for the opportunity to comment on the information collection practices for the State Exchange Certification Application under the Affordable Care Act (ACA). For 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian and Pacific Islander communities living in the United States and its jurisdictions. The proposed application for information collection for the American health Benefit Exchange has the potential to ensure that quality, affordable health coverage can be obtained for many low and moderate-income Asian Americans, Native Hawaiians, and Pacific Islanders (AA and NHPI).

AAs and NHPIs stand to benefit significantly from the establishment of these State Based American Health Benefit Exchanges. Our analysis of the 2009 American Community Survey reveals that an estimated 11.3 percent of Asian American adults and 12.4 percent of Native Hawaiian and Pacific Islander adults are likely to receive a premium tax credit to purchase plans in the Exchanges.<sup>1</sup> In addition, Asian American and Pacific Islander communities are overwhelmingly immigrant; almost 60 percent of Asian Americans and 14 percent of Pacific Islanders living in the U.S. are foreign-born, representing the full spectrum of immigration status categories.<sup>2</sup> It is essential that CMS work closely with the states to ensure that their applications contain strategies to work with these special populations at the beginning of the process of setting up these health insurance exchanges.

Linguistic and cultural barriers add complexities to the eligibility and enrollment process, preventing many in these populations from attaining quality health care. We urge CMS to include strong language in the certification applications that adequately meet the needs of diverse communities, including those that are immigrant and limited English proficient. It is critical to ensure that newly available health insurance plans purchased through the exchanges are affordable and accessible for eligible individuals, including low-income and working immigrant families.

<sup>1</sup> APIAHF analysis of 2009 ACS Public Use Microdata Sample (PUMS) data.

<sup>2</sup> 2007-2009 American Community Survey 3-year Estimates.

## **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. 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 in an exchange operated by the states. For these reasons, we outline a number of general comments that CMS should consider as this application for approval of American Health Benefit Exchange is developed.

### *Applications should 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 CMS 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.

### *Applications must 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, which should also be evident in the draft application from CMS. At a minimum, federal law requires all limited English proficient persons receive oral language assistance if needed. In addition, we recommend that CMS codify in their application a question requiring states to attest to their work in providing these language services. 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

and can be included as a reference in the application materials.

## **PART 1: Enabling Authority and Governance**

### **II. Governance**

#### **b. Board Membership**

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 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. As such, we recommend the following modifications:

- i. Describe the overall board composition, rationale for this structure, and how members are selected, including a description of the relevant background experiences that were considered.
- ii. Provide a list of all current members and a resume for each member, including a description of each member's experience working with underserved communities such as racial and ethnic minorities, children, and low-income individuals.

### **IV. Non-interference with Federal 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. To ensure the Exchanges comply with these non-discrimination provisions in all aspects of operation, including outreach, education, enrollment and coverage, we recommend the following modifications.

#### **a. Attestation**

- i. Provide an attestation that the Exchange will not establish standards the conflict with those promulgated by the Secretary of Health and Human Services, and will comply with Section 1557 of the Affordable Care Act in all aspects of operation related to the Exchange.

## **PART 2: Exchange Functions**

### **I. Consumer Functions**

#### **a. Outreach and Education:**

We applaud CMS for including text requesting information from states that ensures that outreach efforts include consultation with advocates of hard-to-reach

populations and other relevant stakeholders. We recommend that in order to fully implement these state Exchanges, this section should also include the underlined text:

- iii. Provide a brief summary, evidence of consultation to date, and plans for future engagement with stakeholders (e.g. health care consumers, individuals and entities with experience in facilitating enrollment, state Medicaid offices, representatives from small businesses and self-employed individuals, advocates for 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.

#### **b. Call Center**

Given the requirement under the ACA under Section 1311(d)(4)(B), Call Centers are essential to the functioning of the state Exchanges. It is important that states have the capacity to connect to limited English proficient individuals. We applaud CMS' proposal asking states to "provide a description of the approach to ensure sufficient consumer outreach, interpretation services, and overall consumer experience."

#### **c. Insurance Portal**

With the emphasis on Health Information Technology being an important component of the ACA, it is important to ensure broad access to these insurance portals. In order for states to get as many eligible individuals access to the Health Insurance Exchanges, we recommend that CMS include the following addition:

4. How the insurance portal will be accessible to those who do not have computer literacy, access to updated technologies or are limited English proficient.

#### **d. Navigators:**

Navigators will serve the important function of providing information on the Exchanges and tax credits to a diverse group of individuals. We applaud CMS for including this section on the application for states, yet it is important that states certify how they will effectively use a Navigator program. To ensure the Navigator program best serves the intended Exchange population, CMS should ask states to provide a description of their training program and a list of topic areas that Navigators will need to understand. For example, Navigators should be familiar with 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 also understand the intricacies of the Exchanges' enrollment form, web portal, and health plan information resources. As such, we recommend the following modifications:

- i. Provide a description of the Navigator program, including the types of entities serving as Navigators, the types of information Navigators will provide, and avoidance of conflict of interest.
- iv. Provide a training plan that includes information about what types of information and services Navigators will be responsible for providing, and best practices for working with hard-to-reach populations.
- v. Provide an implementation plan that includes how entities serving as Navigators will outreach to 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.

**e. Agents/Brokers:**

We applaud CMS for including a section that allows states to demonstrate how agents/brokers can be utilized for ensuring enrollment in the Exchange. We ask that CMS include the following underlined change:

- i. Provide a brief summary of approach for engagement of agents/brokers, including engagement of agents/brokers working in racial and ethnic minority populations, limited English proficient persons and immigrants.

**II. Eligibility**

**e. Provide a description of relevant 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.<sup>3</sup> We recommend that CMS include the underlined text:

- e. Provide a description of relevant notices and a plan to publish these notices in languages other than English.

**IV. Certification of Qualified Health Plans (QHPs) & Plan Management**

Exchanges, QHP issuers and state and federal agencies 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

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<sup>3</sup> Kaiser Family Foundation, A Profile of Health Insurance Exchange Enrollees, March 2011, available at <http://www.kff.org/healthreform/upload/8147.pdf>.

health information technology and the Exchanges, we urge CMS to ensure that demographic data is collected pursuant to the HHS standards implementing Section 4302 of the ACA.<sup>4</sup> To this end, we propose the following modification:

- iv. Collection and analysis of quality data from issuers consistent with the categories in Section 4302 of the Affordable Care Act.

## **VI. Enrollment**

### **d. Description of relevant notices.**

As we stated above, it is also important to have materials related to have enrollment materials that are in a language other than English. We recommend that CMS include the underlined text in its application:

- d. Description of relevant notices and a plan to publish these notices in languages other than English.

## **VII. Small Business Health Options Program (SHOP)**

With the establishment of the SHOP Exchanges, states have the ability to determine their structure if they are separate from the Health Insurance Exchanges. As of 2007, Asian Americans owned 1.6 million non-farm businesses in the United States<sup>5</sup>. Many of these businesses are small businesses that cannot afford health insurance. It is important that CMS include text in this section of the application that requires states to consider the needs of small minority owned and operated business in all “Consumer Facing Functions.” These include asking states to provide details in the applications in Outreach and Education; Call Center; Insurance Portal; Brokers, Agents, Navigators; and Enrollment.

## **Conclusion**

In summary, we appreciate the opportunity to comment on the Application for Approval of an American Health Benefit Exchange. Please contact Priscilla Huang ([phuang@apiahf.org](mailto:phuang@apiahf.org)), Policy Director, with any questions. We welcome future opportunities to work together on this important aspect of health reform implementation.

Sincerely,



Kathy Lim Ko  
President and Chief Executive Officer

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<sup>4</sup> Office of Minority Health, Reducing Health Disparities with Improved Data Collection: New Refined Data Standards for Race, Ethnicity, Sex, Primary Language and Disability Status, available at <http://minorityhealth.hhs.gov/templates/content.aspx?ID=9232&lvl=2&lvlID=208>.

<sup>5</sup> U.S. Census Bureau. 2007 Survey of Business Owners, available at <http://www.census.gov/econ/sbo/#asian>