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Office of Consumer Information and Insurance Oversight (OCIIO)
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: OCIIO-9989-NC
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Re: Comments on Exchange-Related Provisions in Title I of the PPACA
File Code: OCIIO-9989-NC

To Whom It May Concern:

The National Immigration Law Center (NILC) specializes in the intersection of health care and immigration laws and policies, offering technical assistance, training, and publications to government agencies, non-profit organizations and health care providers across the country. For over 30 years, NILC has worked to promote and ensure access to health services for low-income immigrants and their family members.

NILC is submitting the following comments on Proposed Rules for the Planning and Establishment of State-Level Exchanges, published at 75 Fed. Reg. 45584-90 (August 3, 2010).

A. State Exchange Planning and Establishment Grants

Streamlined enrollment for SHOP Exchanges

As many of today's uninsured workers are employed by small businesses, we recommend that the U.S. Department of Health and Human Services (HHS) and the states explore ways to encourage small business employers to participate in the Small Business Health Options Program (SHOP) Exchanges. As part of the planning process, states should ensure that the SHOP Exchanges' enrollment procedures closely resemble those of large employers in today's group insurance market and be even more streamlined where possible. If the SHOP Exchanges increase administrative burdens for enrolling small business employees, there will be less incentive for small business employers to participate discouraging other eligible consumers from participating in the new health insurance marketplace.

In addition, we recommend that HHS require states to study the impact of merging the individual and SHOP markets before doing so. While there may be benefits of merging the two markets, disincentives to small business employers may emerge if, for example, the enrollment processes for its employees are burdensome and less efficient. We recommend that HHS allow states to develop separate enrollment procedures for SHOP participants to help encourage small business employers to participate.

B. Implementation Timeframes and Considerations

In addition to developing new operational regulations for states to create the new exchanges, we recommend HHS exercise its existing authority under the ACA as well as reinforce existing federal guidance that will help states increase the number of consumers participating in the Exchanges.

First, we recommend that HHS develop clear guidance and require states to comply with two specific streamlined enrollment provisions in the ACA: Section 1411(g) of the ACA prohibits unnecessary questions during the application process and limits the use of information provided to the Exchange and Section 1411(e) provides that certain procedures governing verification of eligibility in the Medicaid program, including its due process protections, shall apply to the Exchange. Under these provisions, we recommend HHS develop model enrollment forms and procedures that limit application questions to the most necessary and appropriate information possible from consumers and to find the most efficient means possible for states to standardize and verify eligibility.

Second, we recommend that HHS issue specific guidance implementing the non-discrimination provision of the ACA, Section 1557, which prohibits discrimination based on race, color, national origin, gender and disability for any health care activity or program where any part is receiving federal financial assistance, credits, subsidies or contract of insurance. States must have clear federal guidance on the processes and measures that must be adhered to in implementing the Exchange to ensure equal opportunity to participate.

Third, we recommend that HHS reaffirm and improve the federal guidance issued on September 21, 2000 by the U.S. Department of Agriculture, Administration for Children and Families and Health Care Financing Administration, and the Department of Health and Human Services' Office for Civil Rights ("Tri-Agency Guidance")[1] which provides states guidance on how to ensure that enrollment forms and other eligibility processes do not ask unnecessary questions that have a disparate impact on families of specific national origins seeking to enroll eligible members. HHS should ensure that this guidance applies to on-line enrollment applications for federally funded programs like

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

Medicaid and the Children's Health Insurance Program (CHIP) and to any new enrollment procedures developed by states for the Exchanges.

Finally, as states will be receiving federal funds to implement and finance the Exchange and to establish patient navigator and ombudsman programs, we recommend that HHS ensure that states comply with Title VI of the Civil Rights Act of 1964 to prevent discrimination based on race, color or national origin, including language need in the new Exchanges.

We recommend that states be required to include plans on how their Exchange will specifically comply with Title VI, Sections 1411(e), 1411(g) and 1557 of the ACA, and all relevant federal guidance that addresses non-discrimination requirements in federal programs.

C. State Exchange Operations

Uniformity and Flexibility

As the ACA anticipates much state flexibility, federal rules are required to ensure minimum standards of eligibility, ease and fairness of enrollment, and to promote best practices. Yet flexibility should be encouraged for states that create mechanisms and programs which increase (rather than limit) options for affordable health care to more of its residents, the intent of the ACA.

Uniformity

NILC concurs with the comments of the Leadership Conference on Civil and Human Rights (LCCR) and recommends the following areas in which uniformity and clear federal minimum requirements are essential to ensure nondiscrimination and access:

- developing a standardized culturally and linguistically appropriate format for displaying plan options to consumers;
- determining minimum eligibility requirements through a single portal for exchange participation, individual tax credits, and Medicaid/CHIP;
- determining procedures and due process protections required to verify certain eligibility requirements such as immigration or citizenship status, or income to ensure fairness and consistency.
- developing standardized enrollment forms and notices, including through on-line systems, that reduce administrative burdens on consumers and that comply with HHS's Tri-Agency Guidance and privacy protections.
- determining compliance with the ACA's confidentiality and privacy requirements
- determining compliance with section 1557 of the ACA and other federal laws prohibiting discrimination by federal fund recipients;
- determining exemptions from the individual responsibility requirement; and
- providing information to the federal government on individual exemptions, tax credits, etc.

Federal guidance should also require minimum standards for states to ensure that individuals who remain uninsured under the ACA can continue to seek and obtain affordable emergency and non-emergency services at community clinics and hospitals.

Flexibility

We recommend that HHS provide states the flexibility as well as incentives to provide additional options for quality, affordable health care coverage or services to its residents. Thus, the ACA should be seen as the floor, not the ceiling for states working to provide affordable health care options for their residents.

We recommend that HHS reaffirm for states that nothing in ACA requires them to restrict coverage provided or made available through state or local funds. For example, some states already use state funds to expand Medicaid eligibility or the state's high risk pool to provide affordable coverage to those who are federally ineligible. Federal guidance should clarify that they can continue to do so.

Web portal

States' web portals for the Exchanges will likely serve as the primary source of information and point of application for coverage through the Exchanges. Web portals must be culturally and linguistically accessible and provide information in a "user-friendly" manner.

The manner in which Exchanges present information and provide directions will strongly influence the participation of individuals from diverse cultures in the Exchanges. Thus to ensure the broadest participation of individuals in the Exchange, we recommend that HHS:

- Require states to comply with Section 1411(g) of the ACA and HHS' Tri-Agency guidance in developing their enrollment portals and procedure. Only information strictly necessary for determining eligibility should be requested of consumers and procedures and notice should be created that ensure an applicant's information will be shared with other agencies only for the purpose of eligibility determinations.
- Require states to collect and incorporate existing best practices within and outside the state for enrollment and eligibility determination as a part of its planning process for the Exchange.[2]
- Require all written materials provided to consumers, including information provided on plan benefits, and information placed on websites operated by the Exchange be translated into the top languages established by the HHS LEP Guidance.

[2] Other states' health system enrollment forms can serve as a source of best practices. For example, Massachusetts' MassHealth Coverage specifies which programs will require the provision of an applicant's social security number and contains specific instructions for refugees and asylees. California's Medicaid (Medi-Cal) application states clearly that any sharing of an applicant's information with federal agencies will be used solely for determining eligibility or for detecting fraud. The Tri-agency guidance also provides key examples and principles for the proper collection of personal information based on the Privacy Act of 1974 and Title VI of the Civil Rights Act of 1964.

- Require all grievances processes utilized by the Exchange to operate in a culturally and linguistically appropriate manner.
- Require state exchanges to create mechanisms to not only connect eligible consumers to health insurance but to connect family members who may remain uninsured to patient navigators who can refer them to affordable health care services. This will help encourage more families to enroll in affordable health care.
- Require state or federally run Exchanges to develop mechanisms for ongoing stakeholder input that is representative of its diverse population. Only with ongoing input from actual consumers will the state be able to ensure its enrollment procedures and processes are consumer friendly and encourage individuals to participate in the Exchange.

D. Qualified Health Plans

Although the Exchange may promise consumers access to meaningful and affordable health care, the qualified health plans will be responsible for making that access a reality. As a result, we recommend that HHS and the states require qualified health plans operating within and outside the Exchange to provide access to linguistically and culturally appropriate services and to ensure the plans' outreach and enrollment mechanisms are culturally and linguistically appropriate.

First, we recommend that HHS and the states make enrollment into the various health plans as uniform as possible to allow a family to enroll in different health plans if needed. Also, enrollment into a health plan should be made easy and seamless for mixed status families where only certain members of the family may be eligible to enroll.

Second, to ensure that the services provided by the health plan meet the needs of its members, we recommend that HHS and states ensure that every qualified health plan operating inside and outside the Exchange networks include providers with diverse linguistic abilities and cultural backgrounds where available. NILC supports the existing federal requirement for health plans to include in their network, where available, "essential community providers" that predominately serve medically under-served and low-income populations. These providers have experience with providing linguistic and culturally competent care and have worked to develop trust among the populations they serve. However, we recommend that HHS also require qualified health plans to demonstrate how they will ensure that culturally and linguistically appropriate health care services and access to plan benefits are available for its diverse members. Ensuring that qualified health plans provide culturally and linguistically accessible services for those who are newly eligible for health insurance can also help make outreach and enrollment efforts more effective.

It is important to note that while the federal requirement for qualified health plans to include essential providers in their networks will help expand capacity of primary care for certain populations, the overall capacity and accessibility of providers for medically underserved and low-income populations must be expanded in general if we are to

address health disparities. We strongly recommend that HHS' policies and priorities recognize that many individuals in these medically underserved and low income populations will remain without access to affordable health insurance but will still need access to affordable health care.
We recommend that HHS and the states create additional mechanisms that assess real-time capacity of "essential providers" for those who are newly insured as well as those who remain uninsured. A trusted community clinic for example should remain accessible and affordable not only to newly insured patients in the community, but to those patients in the community who rely on the clinic as their only avenue for affordable health care.

E. Quality

NILC supports the need to develop federal and state guidance on how best to ensure quality of care, especially for low-income, communities of color who have historically faced disparities in treatment and care. We support the following efforts to promote quality:

- Ensuring linguistically and culturally competent care and navigation of the health care system is promoted and available regardless of insurance status.
- Promoting diversity in the health care workforce to facilitate communication and trust between patients and providers.
- Promoting patient-centered medical homes to better coordinate care and encourage regular preventative care.

F. Exchange for Non-Electing States

In order to determine whether a state will have an operational exchange in effect by 2014, specific criteria and benchmarks will have to be met well in advance of that date. We recommend that HHS include as one of its critical benchmarks the adequacy of a state's plan to comply with federal eligibility requirements and non-discrimination in its enrollment procedures. For states that do not comply with minimum federal standards or that operate an Exchange that restricts or limits eligibility in conflict with the ACA, we recommend that HHS make a finding that such an Exchange is non-compliant and require corrective action by the state. If no corrective action is taken, HHS should consider that state a non-electing state and exercise its authority to establish a federally-run Exchange in that state.

Furthermore, if HHS must operate an Exchange in a non-electing state, we recommend that HHS work with the state and local entities to ensure options for affordable care services for the uninsured also remain available and accessible in that state.

G. Enrollment and Eligibility

Strong, uniform federal and state standards are critically needed to advance the vision of the ACA's expanded eligibility and easy enrollment for consumers. As a first step, we recommend that HHS and the states ensure that enrollment in the Exchange is linguistically and culturally appropriate, as discussed above in detail.

Streamlined Enrollment

We recommend that HHS provide clear guidance on what states can do to determine eligibility in a streamlined, non-discriminatory manner.

First, we recommend that HHS require states to comply with two specific enrollment requirements in the ACA: Section 1411(g) of the ACA prohibits unnecessary questions during the application process and limits the use of information provided to the Exchange; and Section 1411(e) provides that certain procedures governing verification of eligibility in the Medicaid program, including its due process protections shall apply to the Exchange. Under these provisions, HHS and the states should develop enrollment forms and procedures that limit application questions to the most necessary and appropriate information possible from consumers and to find the most efficient means possible for states to standardize and verify eligibility.

We also recommend that HHS and state agencies adopt established eligibility and enrollment practices that will minimize the administrative burden of coordinating between Medicaid, CHIP and the Exchanges and streamline access for all eligible persons. Specifically, we recommend that HHS reinforce the Tri-Agency Guidance that forbids the asking of unnecessary and inappropriate questions about immigration status and social security numbers and to require that any information collected is used and shared only for the purpose of determining eligibility or administering the program.

Consistent with federal and state laws, we recommend that HHS and the states create policies and procedures to ensure the privacy and security of consumer data. Written and verbal communications to consumers should provide accurate notice and instructions that help alleviate privacy concerns that may deter enrollment for eligible individuals. Consumers must also be informed of how their information will be used and when and to whom it may be disclosed. Privacy and data security policies that are created should be made available to the consumer before and at the time of enrollment.

We recommend that HHS require application and enrollment forms and procedures created for the Exchange comply with uniform, minimum federal standards. However, to the extent states need flexibility to design effective application and enrollment forms for the exchanges and other health benefit programs, states should be required to adopt best practices for enrolling immigrants that have worked in other states. We recommend HHS create a taskforce to work with states to identify best practices in this area and to ensure compliance with the Tri-Agency Guidance. For example, online enrollment should rely on solutions that are designed to tailor screening questions based on how individuals answer earlier questions. This “hierarchical” approach would simplify the online enrollment process and help to ensure that people are directed to the most appropriate program (i.e. Medicaid or premium tax credits) for which they are most likely eligible, and ask only for information needed for such program (rather than for all the information needed to determine eligibility for all programs).

Family determinations

Based on enrollment procedures that work effectively in the group health insurance market today, states should be encouraged to find the most effective ways for a family to apply and enroll in various options for health insurance through one application or enrollment process. A family will be more reluctant to participate in the Exchange if each family member must complete a separate application when the majority of the information required will remain the same from one member to another. States should also ensure that the application and enrollment process is also easy to complete if only certain members of a family are eligible. Procedures should clearly allow parents, guardians, caretaker relatives to apply on behalf of other individuals in their care without requiring unnecessary information or documentation.

Accessibility of Enrollment

As already discussed, to improve accessibility of enrollment, we recommend that HHS ensure enrollment in the Exchange is culturally and linguistically accessible.

We also recommend that HHS require states to create mechanisms in addition to on-line enrollment for those who need assistance in completing the application process or who may lack web/computer access. States should be required to have strategies and procedures that allow individuals to enroll in the Exchange by mail, over the phone, through existing Medicaid/CHIP enrollment avenues, or in person. Facilitated enrollment through community based organizations, community health providers, or via mobile units in isolated areas should be encouraged by HHS and states. States should also be required to evaluate consumer satisfaction with on-line enrollment processes and the success of such systems in enrolling applicants.

Eligibility based on citizenship/immigration status

We recommend HHS establish uniform and minimum standards for determining eligibility in the Exchange based on citizenship and immigration status. To avoid confusion and exclusion of eligible individuals, states should not be given flexibility to limit or restrict federal eligibility for the Exchange, tax credits, cost-sharing reductions, or federal health programs based on citizenship or immigration status in conflict with the federal minimum standards. We recommend that HHS enforce those minimum standards with states and any entities responsible for enrollment in the Exchange. We also strongly recommend that HHS clarify that states have the flexibility to ***expand*** eligibility beyond the minimum standards using state or local funding.

Any eligibility determination should also comply with the Tri-Agency Guidance that established federal rules regarding inquiries into citizenship, immigration status, and social security numbers (SSN) in state applications for Medicaid and CHIP. Under the guidance, states are required to provide specific notice when requesting an individual's SSN and cannot require SSNs and citizenship-related information from individuals who are not seeking benefits. See also Section 1411(g) of the ACA.

Lawfully present definition

We recommend that HHS work with the U.S. Department of Homeland Security on how to ensure that all lawfully present categories are accepted for enrollment into the Exchange.

Because immigration statuses and documents are constantly evolving – any list of "lawfully present" immigration categories or of documents that may be submitted to prove those statuses should make clear that the list is not exhaustive. To avoid unnecessary burdens, HHS should provide flexibility to states that already provide coverage to a broader group of lawfully present immigrants to continue using existing administrative mechanisms for determining eligibility, provided that the rules are no more restrictive than federal law.

In terms of developing an initial list of immigration categories that are lawfully present, a good starting point, as proposed in HHS regulations for the PCIP program, is the definition of lawfully present that was developed for the purpose of implementing Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), the state option to provide Medicaid and CHIP to lawfully residing children and pregnant women. However, a few additional categories should be included in this context:

- **Victims of human trafficking who have been granted "continued presence":** individuals whose continued presence in the United States the Secretary of Homeland Security is ensuring in order to effectuate the prosecution of traffickers in persons. This category of non-citizens already was eligible for Medicaid and CHIP under 22 USC §7105(b), and therefore did not appear in CMS' list of newly covered immigrants for the purpose of implementing CHIPRA Section 214. This category should be included explicitly in the Exchange eligibility regulations.
- **Individuals whose status makes them eligible to apply for work authorization under 8 C.F.R. §274a.12.** For low-income individuals who have disabilities or are otherwise unable to work, the cost ($340) and logistics involved in applying for work authorization can be significant. Their lawful status does not depend on whether they obtain a work permit – and neither should this definition. Individuals with a status that makes them eligible to obtain a work permit should be considered "lawfully present."
- **Individuals granted a stay of removal/deportation by administrative or court order, statute, or regulations.** This status is generally granted to individuals with cases pending before an immigration judge, the Board of Immigration Appeals, or a court, allowing them to remain in the U.S. lawfully while often lengthy proceedings continue. Several states provide health coverage to individuals with this lawful status, and to promote fairness and efficiency in administering these programs, it is appropriate to include them among the lawfully present categories for purposes of implementing the Exchanges.

State residency

We recommend that HHS establish federal guidance to states on the definition of state residency to be used in the Exchanges so that there is uniformity, especially if there are multi-state exchanges. We recommend that the definition of state residency in the Exchange be consistent with the definition used by states and HHS in the Medicaid program, at 42 C.F.R. § 435.403. Using the Medicaid definition would help facilitate and ease administrative enrollment between public and private health insurance, facilitate screening and referrals to other programs, and would help ensure that eligible individuals are not excluded.

We recommend that HHS and the states develop appropriate eligibility and enrollment procedures that will ensure that individuals who work in seasonal, migrant jobs requiring movement of residence from one state to another within a calendar year are able to enroll in an Exchange and have access to affordable health coverage throughout the calendar year.

Verification

We recommend that HHS and states ensure that the rules and procedures for verifying eligibility are efficient, uniform, and do not add unnecessary administrative burdens or delays to individuals enrolling in the Exchange.

For verification of citizenship or immigration status, income or other eligibility criteria, we recommend that HHS and the states also ensure there are non-electronic alternatives to allow verification for eligibility determinations for individuals whose information may not be easily verified via computer systems if electronic verification is planned.

Verification of income

We recommend that HHS require uniformity in the Exchange regarding which income should be considered in the eligibility determination as well as verification procedures for that income. If income is verified electronically in the Exchange to determine eligibility for Medicaid, premium tax credits and cost-sharing reductions, we recommend that states be required to comply with federal procedures and ensure that individuals are not denied or delayed coverage inadvertently due to inaccuracies or administrative errors in the electronic system. As anticipated in the ACA, we recommend that HHS and the states add due process protections for income verification and allow an opportunity to appeal eligibility determinations based on income or family size.

We recommend that HHS require states to ensure that there are alternative methods and flexibility in the documents individuals can provide to verify their income – such as letters from employers or self-attestation – as part of the initial eligibility determination, not only if there are inconsistencies in the electronic verification. We recommend that states created procedures that easily enable non-traditional workers (e.g., seasonal, contract, part-time workers) to verify their income and to provide them with equal opportunities to comply with the initial eligibility requirements. Without ensuring these alternatives are part of the determination process, many individuals will not be able to enroll in the Exchange from the outset and will remain uninsured.

Verification of immigration status

The ACA requires verification of citizenship and immigration status in the Exchange for lawfully present immigrants, citizens, and nationals. We recommend that HHS develop uniform procedures and standards for states to verify immigration status and to require states to comply with those standards. While states may need flexibility to expand eligibility based on immigration status, verification of immigration status should use standard best practices in order to streamline enrollment, reduce administrative burden or barriers, and to avoid discrimination and confusion. Consistent with the intent of the ACA, we recommend that HHS and the states look to Medicaid's existing procedures and protections to determine citizenship and immigration status as the basis for developing verification procedures in the Exchange.[3]

Specifically, we recommend that HHS and the states ensure that the following verification issues are addressed explicitly in developing procedures for the Exchanges:

Use of SAVE: As there is a wealth of experience at both the federal and state levels with the Systematic Alien Verification for Entitlements (SAVE) Program for enrollment in Medicaid and other HHS benefits, reference to SAVE and existing verification procedures in Medicaid and CHIP are an important ***starting point*** for regulatory guidance on verification of immigration status under the ACA. The use of SAVE, with additional due process protections and recognition of its limits to verify specific immigration categories, will also help streamline eligibility determinations between public health programs like Medicaid and the Exchange.

Due Process: We recommend that HHS and the states ensure that the verification procedures in the Exchange comply with the provisions in section 1137(d) of the Social Security Act. This includes coverage during a "reasonable opportunity period," which allows applicants who have declared an eligible status to secure the appropriate documents, such as a Social Security Number (SSN) or immigration document; [4] and pending the completion of the verification process, which ensures that applicants are not penalized by delays or errors in the verification system. The regulations should incorporate these provisions explicitly.

Acceptable Documents: Federal procedures on acceptable documents should include a broad range of permissible documents and discretion for states to use other, credible sources of evidence as may be necessary to enroll eligible applicants. Per existing federal standards, we recommend HHS require states to accept for eligibility determinations in the Exchange, at a minimum, all documents recognized by federal agencies to establish citizenship or an eligible immigration status for the Exchange. [5]

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

[4] Applicants unable to provide a SSN must also be provided with a reasonable opportunity to gather and present documentation. See 1902(ee)(2)(C) of the Social Security Act.

[5] See, e.g., U.S. Department of Justice, "Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996," 62 FR 61344-613416 (Nov. 17, 1997).

We also recommend that HHS and the states ensure that applicants have an opportunity to appeal any denials based on the document requirement, and where necessary, to provide evidence that they are seeking replacement documents or obtain assistance to do so. This is particularly critical for lawfully present individuals who are in and expected to remain in status but whose documents may appear out of date. Many immigration documents may indicate an expiration date, but the immigrants holding those documents do not lose their lawful status after the expiration date. Rather, the documents may be renewable or one lawful status may change to another lawful status. In addition, some immigrants hold lawful "temporary" statuses that are routinely extended, for example Temporary Protected Status, which has been extended to certain immigrants for over a decade. As a result, we recommend that HHS require states to create enrollment and due process procedures that allow individuals whose documents may be expiring or changing to show that they remain in lawfully present status, either through an extension of that status or adjustment to another lawful status. Given the complexity of immigration law and the number of categories, federal guidance will be critical to ensure lawfully present immigrants are not inadvertently denied or terminated from affordable health coverage in the Exchange.

Confidentiality: We recommend that HHS and the states explicitly incorporate into policies and procedures the provisions in Section 1411 of the ACA that limit the inquiries, use and disclosure of information provided by applicants. Section 1411(g), for example, provides that applicants shall be required to provide only the information strictly necessary to determine eligibility for the program; that information received may be used only for the purposes of and to the extent necessary to verify eligibility or to ensure the efficient operation of the program; and that the information may not be disclosed except as provided in that section.

Affordability for low-income, Medicaid ineligible immigrants

Tax credits for purchasing health coverage in the Exchanges will help many low-income individuals receive the coverage that they need. Many low-income, lawfully present immigrants who would otherwise be eligible for Medicaid but for their immigration status will need to seek affordable health care through the state or federally-run Exchanges. We recommend that HHS and the states develop policies and procedures to ensure that premium tax credits and cost-sharing reductions in the Exchange for this Medicaid "look alike" population are based on their actual income in order to make health care coverage affordable. We recommend states develop enrollment procedures that allow this low-income population to enroll easily and seamlessly for private health insurance in the Exchange.

Accessibility of premium tax credits and cost-sharing reductions

In order to ensure that health coverage is truly affordable in the Exchange, we recommend that HHS and the states develop eligibility and enrollment procedures for individuals to apply and receive premium tax credits and cost-sharing reductions that are not administratively burdensome to consumers and that are available immediately when an individual's coverage begins.

Individual Mandate Exemptions

We recommend that HHS provide states uniform procedures and guidance on how individuals should claim an exemption from the individual mandate. Specifically, we recommend that HHS work with the U.S. Department of Treasury to ensure that procedures for claiming and obtaining an exemption are streamlined, do not solicit unnecessary information, protect the confidentiality of the information, limit the sharing of information for purposes of determining eligibility for the exemptions, and include due process protections. Although state Exchanges may need some flexibility to develop procedures to evaluate exemptions based on hardship or affordability, the process and minimum criteria for individuals to be eligible for and claim the various exemptions from the individual mandate should be standardized to avoid confusion and unfairness.

H. Outreach

Outreach to a diverse population of newly insured individuals, many of whom will be new to the health care system, will be critical to ensure that they are not only able to obtain affordable health insurance but can obtain meaningful access to medical care with their insurance.

Any outreach conducted should focus on ease of use by the consumer, the diversity of the population, and enrollment procedures that are not burdensome or discriminatory. First, to address the fact that the majority of immigrant families have members in various citizenship and immigration statuses, outreach to immigrant families should clearly encourage enrollment of eligible family members, address concerns that deter immigrant families, and help find affordable health care options for potentially ineligible family members. In addition, because a family may have individual members who are eligible for private or public health insurance, outreach and enrollment for private and public health insurance should be coordinated in and outside the Exchanges. Consistent messages about the benefits and ways to obtain both types of health insurance should be provided in order to avoid confusion and encourage enrollment.

We recommend that HHS and the states require patient navigators or ombudsmans to clearly demonstrate how they will provide linguistically and culturally competent enrollment, outreach, and advice, as well as how they will appropriately target and respond to specific vulnerable populations. Outreach should be targeted not only based on demographics of the uninsured, but should include criteria that targets communities which demonstrate the most need due to health disparities and social factors such as poverty or social isolation. For example, successful methods used to contact hard-to-reach populations during the 2010 Census should be considered for outreach for the Exchange. In fact, we recommend that HHS encourage states and its grantees to be innovative and share best practices for communicating with hard to reach populations.

In order to ensure that outreach efforts are truly diverse, we recommend that HHS and the states partner with community based organizations and leaders. These organizations and individuals have significant knowledge and experience with their populations' members and have already built trusted and working relationships within their communities that

should be leveraged. We recommend that HHS and the states give priority to grantees who have demonstrated experience or expertise working with vulnerable populations.

In addition, we recommend HHS provide and also require states to provide adequate resources to navigators and other entities responsible for outreach and enrollment. For instance, in order to provide linguistically and culturally appropriate assistance, navigators must provide translations of a significant amount of information in a manner accessible to diverse populations, tailor outreach efforts for the communities they serve, and hire and retain bilingual and culturally competent staff. State agencies as well as patient navigators will also need time and funding to train outreach workers and counselors to serve as resources to consumers in the Exchanges and establish effective outreach to culturally diverse populations.

J. Consumer Experience

We recommend that HHS and the states adopt procedures for the Exchange that will prioritize ease and quick access for the consumer. This will not only encourage participation in the Exchange but will reduce administrative costs and barriers that could arise in creating the Exchange.

Key areas that would help enhance the consumer experience include:

- The burden of eligibility determinations should be shifted as much as possible to the state exchange rather than individuals enrolling in the exchange.
- Individuals should be provided basic information in plain or linguistically appropriate language.
- States should ensure enrollment procedures are easy whether an individual applies only for himself or herself, his or her entire family, or on behalf of another individual.
- Privacy and confidentiality notices should be clear and provided upfront in the outreach and enrollment process to help address concerns and barriers.
- For on-line enrollment, best practices for data security and providing a secure atmosphere to input sensitive data in public settings should be implemented.
- Although “one-stop” enrollment is a helpful goal to streamline enrollment, states must ensure consumers have multiple ways to enroll in the Exchange – beyond on-line enrollment - as one solution may not fit all. Individuals and families without Internet access or proficiency or who prefer not to submit their personal information online due to privacy and security concerns must be provided alternative ways to obtain information regarding the Exchange, to determine their eligibility for affordable care, and to enroll in the appropriate health coverage. Online and telephonic enrollment options are insufficient; in-person enrollment options, including facilitated enrollment, must be available. States should ensure that multiple community-based points of access are available for enrollment; community health centers, public hospitals, schools, and community-based organizations, at a minimum, should receive training and resources for facilitating enrollment.

- States should ensure there are alternatives and/or flexibility for consumers to provide information required for eligibility determinations which will allow consumers to easily comply with enrollment requirements. States should be required to be more flexible at the onset of implementation in order to account for the range of consumers' unique circumstances; however, after some experience, states may be able to standardize procedures that incorporate the most common exceptions.
- Throughout the enrollment process in the Exchange, individuals should be given clear notice of decisions made affecting their application and coverage and an opportunity to appeal those decisions.
- States should be required to establish consumer advisory groups or other evaluation tools that allow consumers to provide real-time feedback and suggestions for improvement. For example, states should consult with community-based organizations that have experience with assisting consumers in navigating the local health care system, enrolling consumers in health care coverage, resolving consumer problems associated with health care access, and serving consumers with special needs, including, but not limited to, consumers with limited English language proficiency, low-income consumers, consumers with disabilities, and consumers with multiple health conditions.

K. Employer Participation

The majority of the uninsured population is in working families. Ensuring that employers – large and small – participate and provide affordable coverage to their employees would help connect more eligible individuals to affordable health coverage.

To enhance employer participation, we recommend that HHS and the states:

- Reduce administrative burdens and requirements as much as possible for employers to enroll their employees in affordable health coverage. One clear way to reduce administrative burdens for employer participation is to ensure information shared between the Exchange and the employer is limited to only the information that is strictly necessary to determine eligibility and protects the confidentiality of both the employer and its employees.
- Allow all small employers (regardless of size) and the self-employed to apply for coverage in the SHOP Exchanges. This will streamline eligibility rules and could help reduce adverse selection in the SHOP Exchanges.
- Align the SHOP Exchanges' enrollment procedures with those used by large employers in today's group insurance market and be even more streamlined where possible. This will allow more consistency and fairness between businesses and not penalize an employer for the size of their workforce. Also, by reducing administrative burdens for enrolling small business employees, there will be more incentive for small business employers who often work with little to no overhead to participate in the SHOP Exchange.

- Require states to study the impact of merging the individual and SHOP markets before doing so. While there may be benefits of merging the two markets, disincentives to employers may emerge if, for example, the enrollment processes for its employees are burdensome and less efficient. HHS should allow states to develop separate enrollment procedures for employers in and outside the Exchange to help encourage employers to participate.

L. Paperwork Reduction

NILC supports HHS and the states in developing enrollment and verification procedures in the Exchange that limit or reduce the need for individuals to provide paperwork (including documents) to establish their eligibility. However, as discussed above, we recommend that HHS and states allow for procedures where facilitated, in-person enrollment is available to those without internet or computer access. In addition, we recommend that HHS and states allow for individuals to provide self-attestation for certain eligibility criteria such as income, if electronic verification or other documentation is not available.

NILC strongly urges HHS to require states to track and evaluate the administrative costs and effectiveness of verifying citizenship and immigration status of those seeking to purchase health insurance through the Exchange and separately for those applying for affordability credits.

M. Exchange Operations

We recommend that HHS ensure that there are clear and strong fiscal as well as legal enforcement mechanisms to address non-compliance or misconduct of Title I by states or other government or private entities involved in the Exchange operations.

Thank you for your consideration of these comments. If you have any questions, please contact Sonal Ambegaokar, NILC Health Policy Attorney at (213) 639-3900 ext. 114 or ambegaokar@nilc.org.

Sincerely,
/s/
Sonal Ambegaokar
National Immigration Law Center