October 31, 2011

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9998-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: CMS–9989–P
Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans

Dear Sir/Madam:

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.

With the implementation of the Affordable Care Act, it is critical to ensure that the state based Exchanges and the Qualified Health Plans (QHPs) participating in the Exchanges provide the most robust access to affordable, quality health coverage for all eligible residents, especially individuals in vulnerable populations, including low and working immigrant families.

Below are our comments and suggestions per relevant section on the July 15, 2011 Proposed Rule for Establishment of Exchanges and Qualified Health Plans to help HHS and the exchanges ensure the benefits of the ACA reaches as many individuals as was originally intended by the law.

§155.20 Definitions – Definition of "Lawfully Present"

The proposed rule adopts the 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 recommend that the definition be expanded slightly, to incorporate all individuals who are lawfully present in the U.S. First, the definition should include two categories that are currently listed in the CHIPRA definition: individuals who are lawfully present in the Commonwealth of the Mariana Islands and American Samoa, under the law that

applies in those territories.[1] These categories were omitted from the PCIP definition because Congress did not authorize the U.S. territories to operate a PCIP. By contrast, as explained in the preamble to the PCIP regulations, Congress specifically allows the territories to establish an Exchange. 75 Fed Reg. 45017 (July 30, 2010).

Next, the definition should include all individuals whose immigration status makes them eligible to apply for an Employment Authorization Document (EAD or "work permit") regardless of whether they have secured a work permit. An immigrant's lawful status does not depend on whether he or she has an EAD. The EAD requirement, which applies to some of the categories in the PCIP definition, imposes particular burdens on low-income children and persons with disabilities who cannot work. Low-income families and individuals cannot easily afford the fee (currently $380) to apply for and obtain a work permit, particularly if they do not otherwise need it. The final rule should eliminate this requirement.

We recommend that three other lawfully present immigration categories be added to the definition: (a) certain victims of trafficking, (b) asylum applicants, and (c) individuals granted a stay of removal, as described below.

Victims of human trafficking can be granted continued presence in the U.S. by the Department of Homeland Security (DHS) in order to aid in the prosecution of traffickers in persons. This category of non-citizens already was eligible for Medicaid and CHIP under 22 U.S.C. §7105(b), and therefore did not appear in CMS' list of newly covered immigrants for the purpose of implementing CHIPRA § 214.

Asylum applicants 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. throughout the pendency of their asylum adjudication, a process that can take years. Asylum applicants are not eligible for employment authorization until 180 days after the asylum application has been filed, and errors and delays in the administration of this waiting period have made the wait much longer for many applicants, as noted in the USCIS Ombudsman's recent report on this problem.[2]

Stays of removal generally are 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. Grants of prosecutorial discretion under the Obama Administration's recent Department of Homeland Security guidelines will include stays of removal and similar discretionary relief. Individuals granted such relief, including some teenagers and young adults who have grown up in the U.S., should be recognized as lawfully present.

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[1] CMS State Health Officials Letter, "Medicaid and CHIP Coverage of 'Lawfully Residing' Children and Pregnant Women" (July 1, 2010), available at https://www.cms.gov/smdl/downloads/SHO10006.pdf.

[2] USCIS Ombudsman, "Employment Authorization for Asylum Applicants: Recommendations to Improve Coordination and Communication (August 26, 2011) available at http://www.dhs.gov/xlibrary/assets/cisomb-employment-authorization-for-asylum-08262011.pdf

Several states provide health coverage to individuals with these lawful statuses. To promote consistency and to maximize enrollment, it is appropriate to include them among the lawfully present categories for purposes of implementing the Exchange. To aid in these determinations, we have attached a list of “typical” documents that lawfully present individuals may have.

Finally, we recommend that, to avoid unnecessary burdens and increase administrative efficiency, the final rule should provide flexibility to states to include new lawfully present categories as they become available. Immigration law frequently changes, producing new statuses and document requirements. *The regulation should recognize that the list is not exhaustive.*

RECOMMENDATION:
Amend the definition of “lawfully present” by adding the following five categories of individuals:

> (1) who are lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e);
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> (2) who are lawfully present in American Samoa under the immigration laws of American Samoa;
>
> (3) who are victims of human trafficking who have been granted continued presence;
>
> (4) whose status makes them eligible to apply for work authorization under 8 C.F.R. §274a.12;
>
> (5) granted a stay of removal by administrative or court order, statute or regulations.

and by revising the current category pertaining to asylum applicants as follows:

> (6) A pending applicant for asylum under section 208(a) of the Immigration and Nationality Act (INA) or for withholding of removal under section 241(b)(3) of the INA or under the Convention Against Torture, whose application has been accepted as complete.

RECOMMENDATION:
Provide that states may continue using existing administrative mechanisms for determining eligibility, as long as the rules are no more restrictive than federal law.

§ 155.105 Approval of a State Exchange

We applaud the explicit reference to requiring compliance with the IRS' confidentiality policies as a standard for approval of a state exchange. We recommend explicitly requiring the Exchange to also comply with the confidentiality protections set out specifically in the Affordable Care Act under Section 1411(g) and the protections for Social Security Numbers in the Privacy Act (5 U.S.C. § 552a). Compliance of these federal laws is already required by an exchange but should be demonstrated by the Exchange as a standard for obtaining federal approval for operational readiness.

RECOMMENDATION: We recommend amending § 155.105(b)(2) as follows:

> (2) The Exchange is capable of carrying out the information requirements pursuant to ***Section 1411(g) of the Affordable Care Act, the Privacy Act (5 U.S.C. § 552a), and*** section 36B of the Code;

§ 155.110 Entities eligible to carry out Exchange functions

We recommend that states ensure the enrollment process for the SHOP remains distinct from the enrollment process for the Exchange in order to minimize administrative barriers and help ensure small business employers will participate in the SHOP. This remains true whether or not there is separate or a single governance structure. We also recommend ensuring the SHOP complies with confidentiality protections in Section 1411(g) of the ACA, especially if sharing of information with the exchange is contemplated or required.

RECOMMENDATION: We recommend amending §§ 155.110(e)(1) and 155.110(e)(2) as follows:

(e) SHOP independent governance.
(1) A State may elect to create an independent governance and administrative structure for the SHOP, consistent with this section, if the State ensures that the SHOP coordinates and shares ~~relevant~~ information ***that is strictly necessary per Section 1411(g) for the purpose of program administration*** with the Exchange operating in the same service area.
(2) If a State chooses to operate its Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers in the Exchange ***and that eligibility and enrollment process for the SHOP and the Exchange remain separate***.

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

We applaud the requirement that an exchange must not discriminate and comply with existing non-discrimination laws. We also applaud explicitly ensuring a broad range of categories are protected against discrimination in the Exchange which will help reduce historic health inequities in health coverage. We recommend adding explicit reference to the Affordable Care Act's own authority under Section 1557 of the ACA to prevent non-discrimination in furtherance of the

ACA's goals. We also recommend ensuring that this critical non-discrimination requirement applies to all marketing, outreach, and enrollment in the Exchange, which will be the critical access points for consumers.

RECOMMENDATION: We recommend amending 155.120(c) as follows:

(c) Non-discrimination. In carrying out the requirements of this part***, including marketing, outreach and enrollment in the Exchange,*** the State and the Exchange must:
(1) Comply with ***Section 1557 of the Affordable Care Act and*** applicable nondiscrimination statutes; and
(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

§ 155.130 Stakeholder consultation

We strongly support the need for the state to consult with advocates of "hard to reach" populations. We recommend a more inclusive interpretation of "hard to reach" populations per the amended language below.

RECOMMENDATION: We recommend amending §§ 155.130(a) and (c) to include the following language:

> (a) ~~Educated~~ ***~~h~~Health*** consumers ***experienced with the system*** ~~who are~~***, including both*** enrollees in QHPs ***and those who are uninsured or underinsured***;
> . . .
> (c) Advocates for enrolling hard to reach populations, which include individuals with a mental health or substance abuse ~~disorder~~ ***or other disability, and advocates for individuals who need culturally and linguistically appropriate services***;

§ 155.200 Functions of an Exchange

RECOMMENDATION: We recommend amending § 155.200 per the following language:

- (c) Eligibility determinations. The Exchange must perform eligibility determinations ***consistent with Sections 1311, 1411, 1412, 1413 of the ACA***.

  Although rulemaking on eligibility will be detailed in other regulation, Section 155.200 should make explicit that the exchange must ensure that eligibility determinations done by the exchange should be consistent with Sections 1311, 1411, 1412, 1413 of the ACA.

- (d) Appeals of individual eligibility determinations. The Exchange must establish an appeals process for eligibility determinations ***consistent with Section 1411(f) of the ACA, applicable due process protections, and provides meaningful access to individuals with limited English proficiency.***

Recommend explicit requiring that appeals should be conducted consistent with Section 1411(f) of the ACA, existing due process protections, and be accessible to limited English proficient consumers.

- We recommend that HHS require the exchange to develop mechanisms to refer consumers to health care providers in their area pending start of their coverage or if exempt or excluded from mandate to purchase coverage. This includes referring individuals in mixed status families where some members may not be eligible for affordable coverage.

- We recommend that HHS explicitly add as a required function that the exchanges create an ombudsman office in order to handle complaints and appeals directly associated with the exchange processes and policies.

- We recommend that HHS explicitly add as a required function that the exchange shall have oversight over navigators and must develop mechanisms to monitor navigators for compliance with standards and criteria as specified in 155.210. See comments at 155.210 for recommendations on additional standards and criteria for navigators.

§ 155.205 Required consumer assistance tools and programs of an Exchange

RECOMMENDATION: We recommend amending § 155.205 per the following language:

- We recommend ensuring call centers are also accessible to limited English proficient callers, similar to the access requirements for the web portal. Specifically, amend § 155.205(a) to add at the end before the period: ***including oral language services for limited English proficient callers.***

- § 155.205(b)(2): We support the requirement for the web portal to provide meaningful access for limited English proficient consumers. While the current web portal by HHS is available in Spanish, no other languages are currently served by the web portal, leaving many other LEP individuals out. We recommend the exchange's web portal be translated into all languages in which a significant number of LEP individuals reside in the service area and that links are provided to translated documents.

- We strongly recommend that any requirements either from HHS or from the Exchange to store consumer data on the web portal per the Preamble (pg. 41876) should be allowed only with clear consumer consent and only for the data that is "strictly necessary" for enrollment per Section 1411(g) of the ACA. Any storage of data on the web portal should comply with privacy protections required by the ACA and the exchange. Furthermore, HHS should ensure that the exchanges may only use consumer data for the purpose of administration of the Exchange and other programs and cannot be shared for any other purpose, including marketing and enforcement purposes. This limitation on data sharing on information stored via the web portal should be explicitly included in the regulations.

Add new section (b)(7) at § 155.205(b)(7) to read as follows:
(7) Requests consumer information that is strictly necessary for an eligibility determination, requires explicit consumer consent to retain data, and complies with the applicable privacy protections.

- We recommend that HHS require the exchange to ensure the web portal and call center is able to provide referrals to local health care providers to consumers who are seeking or in need of immediate medical attention. This is for consumers whose application and enrollment are pending as well as for individuals who are exempt or excluded from affordable options and do not submit an application.

- 155.205(c): We recommend that HHS add a requirement that the exchange calculator must be able to correctly calculate eligibility for mixed status families and for lawfully present immigrants with incomes below 133% FPL who are eligible for tax credits instead of Medicaid.

- 155.205(d): We recommend that HHS explicitly require exchanges to ensure consumer assistance functions be provided in a culturally and linguistically appropriate manner. We also support the recommendation in the Preamble (pgs. 41876-77) that discrimination complaints be referred to the HHS Office of Civil Rights. We recommend that HHS explicitly require exchanges to refer complaints of discrimination on the basis of race, color, national origin, disability, age, or sex to the HHS Office of Civil Rights, and that sexual orientation and gender identity be explicitly included in the regulation. Furthermore, we recommend that this requirement to refer complaints of discrimination to the HHS Office of Civil Rights be also required of navigators and included as an explicit duty of a navigator at 155.210(d)(4)). See recommendation for amended language below under comments at Section 155.210.

  Amend § 155.205(d) to read as follows:
  155.205(d) –Consumer assistance. The Exchange must have a consumer assistance function, including the Navigator program described in § 155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate. **All consumer assistance functions must be provided in a culturally and linguistically appropriate manner including the provision of translated materials and oral assistance to limited English proficient consumers.**

  Amend § 155.205(d) to designate current text (as amended above) after "Consumer Assistance" as subparagraph (i) and add new subparagraph (ii):

  (ii) The Exchange must refer all individuals who submit oral or written complaints of discrimination on the basis of race, color, national origin, disability, age, sex, **sexual orientation and gender identity** to the HHS Office for Civil Rights.

- 155.205(e): We support the requirement that outreach and enrollment specifically target "hard to reach populations" and those with low literacy. We recommend that the requirement to target "hard to reach populations" should be explicitly included in 155.205(e) rather than only in the preamble (p. 41877). We also recommend explicitly requiring the

outreach and enrollment strategies developed should be culturally competent and linguistically accessible in order to meet the needs of "hard to reach populations."

<u>RECOMMENDATION:</u> Amend § 155.205(e) to read as follows:

(e) Outreach and Education. The Exchange must conduct outreach and education activities ***in a culturally and linguistically appropriate manner*** to educate consumers**,** ***particularly hard to reach populations***, about the Exchange and to encourage participation.

<u>§ 155.210 Navigator program standards</u>

- We recommend that the exchange require navigators to be operational ***at least one to two months before*** open enrollment period, not by first date of open enrollment as discussed in the preamble on pg. 41878. Consumers will undoubtedly have questions before open enrollment begins and navigators should have sufficient time to assist consumers as well as identify and resolve with the exchange any system problems before the first day of open enrollment so that on the first day, consumers will easily be able to enroll.

- 155.210(b): We support the requirement that at least one of the 2 types of navigators include community and consumer focused non-profits. There is trust and established relationships with many community and non-profit groups which hard to reach populations rely on that the state can leverage by ensuring they are included as navigators rather than just relying on insurance brokers/agents. However, we do not believe that this requirement precludes a requirement that the Exchange ensure navigator grantees reflect a cross section of stakeholders. Instead, we recommend that HHS explicitly include both requirements of navigators discussed in the preamble to the regulations. Specifically, we recommend the following amendments:

  Amend 155.210(b)(1)(ii) as follows:
  ii) Demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, ***with diverse groups of stakeholders, including*** employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

  Amend 155.210(b)(2) as follows:
  (2) The Exchange must include entities that ***in whole reflect a cross section of stakeholder, and include entities*** from at least two of the following categories for receipt of a Navigator grant:

- 155.210(b)(iii): We are concerned that the required licensure of navigators may unnecessarily exclude or delay community organizations or non-profits from becoming navigators due to the administrative costs and barriers entailed in a formal licensure process, not because these organizations cannot meet the standards set. By excluding non-profits from navigators, hard to reach populations will be less likely to enroll in the Exchange due to their lack of trust and understanding of the exchange, eligibility, and knowledge of how to use their coverage to gain access to health care services. Instead, in order to ensure quality, accuracy and consistency of navigators' performance, we recommend that HHS require states

to create certain standards of measurement and training (as discussed in the preamble at pg. 41877), and that the exchange creates mechanisms for initial and on-going evaluation and monitoring of navigators.

- 155.210(c): We support the requirement that eligible navigators cannot have any conflict of interest with the exchange or be a health insurer.

- 155.201(d): We recommend the following additions to the duties for navigators:

    - 155.210(d)(5): We support the requirement that navigators be culturally competent and linguistically accessible and appropriate and recommend the same standards of cultural and linguistic accessibility required of the Exchange also be required of navigators.
    - We support requirement that navigators must maintain expertise in eligibility/enrollment and other duties. Per our recommendation above regarding the licensure requirement, we recommend that the Exchange periodically requires navigators to demonstrate eligibility/enrollment expertise as part of an ongoing evaluation process.

    - Similar to the requirement on the Exchange at 155.205, we recommend that the requirement to refer complaints of discrimination by individuals to the HHS Office of Civil Rights be also required of navigators and included as an explicit duty of a navigator at 155.210(d)(4)). Specifically, amend § 155.210(d)(4) as follows:

      4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; **Provide referrals to the HHS Office of Civil Rights for any enrollee with complaints of discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation and gender identity;** *and*

    - We support the requirement in the preamble (pg. 41877) that navigators must comply with information sharing, referral strategies, and training requirements in grant award conditions. We recommend explicitly adding this as a minimum duty of navigators at 155.210(d).

      Add Section (6) under 155.210(d):

      (6) Comply with information sharing, referral strategies, and training requirements in grant award conditions.

    - We support the requirement in the preamble (pg. 41877) that navigators must ensure information provided is “fair, accurate, and impartial” and culturally and linguistically appropriate. We recommend explicitly adding this as a minimum duty of navigators at 155.210(d)(5). Specifically, amend § 155.210(d)(5) as follows:

      (5) Provide information ***that is fair, accurate, and impartial and*** in a manner that is culturally and linguistically appropriate to the needs of the population being served by

the Exchange, including individuals with limited English proficiency~~, and~~***;*** ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

§ 155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers or qualified employees enrolling in QHPs.

We recommend that agents/brokers should be required to comply with the same privacy and information sharing requirements under Section 1411(g) that the Exchange must comply with. Specifically, we recommend adding section C to 155.220 as follows:

(c) A State must ensure as a condition of participation that agents and brokers comply with Section 1411(g) and all applicable privacy standards for information solicited and obtained from potential enrollees.

§ 155.230 General standards for Exchange notices.

We strongly support the recognition in the preamble (pg. 41878) that applications, forms, and notices must be provided in plain language and provide meaningful access to LEP individuals. As Section 1001 of the Affordable Care Act directs group health plans and health insurance issuers offering group or individual coverage to provide notices in a culturally and linguistically appropriate manner, HHS should also ensure that all LEP individuals have the ability to communicate effectively with exchanges when legal rights are at issue. Further, Title VI and § 1557 of the ACA provides further support ensuring access to limited English populations. We recommend explicitly adding this requirement to the regulation and that this requirement applies to both on-line and manually generated notices.

RECOMMENDATION: *Amend § 155.230(a) to add "and," at the end of subparagraph (3) and add new subparagraph (d):*

(d) Language Access.

- **Exchanges must translate notices into a non-English language for each eligible LEP language group in an Exchange's service area that constitutes 500 individuals or 5%, whichever is less.**
- **Exchanges must ensure that notices include taglines in at least fifteen languages informing individuals how to obtain assistance in their language.**
- **If an LEP individual makes a request for materials in a non-English language, the Exchange must provide all subsequent notices to the individual in the non-English language.**

We also support the recommendation that the exchange evaluate the notices annually and also recommend that the exchange seek consumer stakeholder input as part of the evaluation process for notices.

<u>RECOMMENDATION:</u> *Amend § 155.230(c) as follows:*

(c) Re-evaluation of appropriateness and usability. The Exchange must reevaluate the appropriateness and usability of applications, forms, and notices on an annual basis ***with consumer stakeholder input*** and in consultation with HHS in instances when changes are made.

<u>§ 155.240 Payment of premiums</u>

- We support the proposed rule in Section 155.240(c) for an employer participating in the SHOP to accept and make payments for premiums in the aggregate in order for administrative simplification.
- We recommend the final rule also clarify that employees will be able to make premium payments for themselves and any covered dependents for coverage in the SHOP through payroll deduction, as in the large group insurance market.

<u>§ 155.260 Privacy and security of information</u>

We recommend that HHS develop a minimum level of standards and protections that exchanges must comply with in terms of information sharing, rather than allowing for complete state flexibility. As recommended in the preamble (pg. 41880), states should be encouraged to provide protections that are stricter than the minimum standards. Yet we strongly recommend that HHS establish a national standard of the minimum protections that consumers can expect when seeking coverage through an exchange, no matter where they reside. We are concerned that without a federal minimum standard, consumers across the nation will have little confidence that they can share personal information with the exchange unless they understand how that information will consistently be used and shared and that there no special loopholes from one area to another. Without minimum, national privacy and security protections for consumers, eligible individuals or families will be prevented or deterred from enrolling in the exchanges.

- § 155.260(b): We strongly support HHS' recommendation in the preamble (pg. 41879) that the exchanges must comply with Section 1411(g) of the ACA with regard to privacy and security of information. We recommend that HHS explicitly add this requirement to comply with Section 1411(g) of the ACA in § 155.260 and revise the phrase "information that is specifically required" to "information that is strictly necessary" consistent with the statutory language in Section 1411(g).

  <u>RECOMMENDATION:</u> ***Amend 155.260(b)(1)(i) as follows:***

  (b) Use and disclosure.
  (1) The Exchange must not collect, use, or disclose personally identifiable information unless:
  (i) The collection, use, or disclosure is ~~specifically required~~ ***strictly necessary*** or permitted by this section, ***Section 1411(g),*** or by other applicable law; or

Amend 155.260(b)(3) as follows:
(3) Exchanges must establish and follow privacy standards consistent with ***Section 1411(g) and other*** applicable law and that establish ~~acceptable~~ ***required*** parameters for proper collection, use, disclosure and disposal of personally identifiable information.

- We recommend that HHS explicitly include immigration and citizenship status and Social Security Numbers in the definition of personally identifiable information for the Exchange at 155.260(a). We also recommend that the definition of personally identifiable information be limited to that of applicants (rather than all members of the tax household) per HHS's existing policies and practices outlined in the HHS's Tri-Agency Guidance.[3]

- We strongly support HHS's recommendation in the preamble (pg. 41880) that the exchange must comply with existing Medicaid/CHIP policies that limit the request for information that is not strictly necessary.

RECOMMENDATION: ***Amend 155.260(b)(4) by adding section (iii) as follows:***

(4) Policies and procedures regarding the use, disclosure and disposal of personally identifiable information must, at minimum:
(i) Be in writing, and available to the Secretary of HHS upon request;
(ii) Identify applicable law governing use, disclosure and disposal of personally identifiable information; ~~and~~
(iii) Require only the personally identifiable information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction per Section 1411(g) of the ACA; and

- We recommend that HHS add a requirement in 155.260 that the exchange may share information only for the purposes of program administration similar to existing Medicaid protections at 42 U.S.C. § 1320b-7(a)(5)(A).

Amend 155.260 (c) as follows:
(c) Other applicable law. Data matching and sharing arrangements made between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must be ***made available only to the extent necessary to assist in the valid administrative needs of the program receiving such information and be*** consistent with ***Section 1411(g), section 1942 of the Act, and*** other applicable laws.~~, including section 1942 of the Act~~.

[3] *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* (commonly known as the Tri-Agency Guidance) available at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/tanf/triagencyletter.html

- We recommend that HHS develop explicit standards for the use and disclosure of personally identifiable information.
- We recommend that HHS require the exchanges to comply with HIPPA for protected health information.
- We recommend that HHS explicitly designate in the final rule which federal and state agencies have a right to enforce privacy/security standards and pursue action in the event of violations.
- We strongly recommend that HHS authorize a private right of action for individuals when their personally identifiable information or protected health information is used or disclosed in violation of HIPPA, Section 1411(g), and other privacy protections required by the ACA. The most effective and efficient way to ensure privacy standards are followed is to allow those individuals whose information has been violated to demand compliance with the law. Otherwise, the threat of penalty for violation may be seen as only for egregious violations.
- We recommend that the Exchange require qualified health plans ("QHPs") to comply with same privacy and security requirements that the Exchange must comply with when information is shared between the QHPs and Exchange.
- We support HHS' proposal to require Exchanges to require their contractors to abide by the same or more stringent privacy and security standards than are applicable to the Exchange. It is critical that such standards include the limits set by Congress in Section 1411(g) of the ACA and any of the other express limits urged by these comments and adopted by HHS in the final rule. It is understandable that Exchanges will likely need to use contractors to assist them in performing their functions; but the contract should not be permitted to become a vehicle for unauthorized and unconstrained sharing of the personally identifiable information of insurance applicants. We also recommend that the Exchange require contractors and sub-contractors to comply with the relevant state privacy laws that the Exchange would be subject to.
- We support that Exchanges must be required to adopt privacy policies that conform to the Fair Information Practice Principles (FIPPs). FIPPs provide the roadmap for establishing comprehensive and sound policies to govern the collection, use and disclosure of personal information and typically are the foundation for most privacy legal frameworks. It is equally important that that Exchange privacy policies be developed with public input. We urge HHS in the final rule to include a requirement that Exchanges engage stakeholders, including consumers, in developing its privacy policies and allow for a period of public comment prior to submission to the HHS Secretary.
- We also believe that many potential applicants for insurance through an Exchange will want to explore the Exchange website and investigate the options before formally submitting an application for insurance. We recommend that HHS prohibit Exchanges from collecting any data on an individual exploring the site (including caching on-line activity on the site) until the individual has affirmatively indicated an interest in applying for insurance through an Exchange.
- We recommend that HHS require the exchanges to comply with the "individual rights" provisions of the HIPPA Privacy Rule, which provides individuals with some baseline rights

with respect to personally identifiable information. For example, the HIPAA Privacy Rule gives individuals the right:

- To receive a notice of privacy practices (45 CFR §164.520)
- To request an amendment to personal information (45 CFR § 164.526)
- To access a copy of personal information collected about them (45 CFR § 164.524)
- To receive an accounting of disclosures of their personal information (currently being revised by the HHS Office of Civil Rights to include a right to a report of who has accessed their personal information) (45 CFR § 164.528)

In addition, the Privacy Rule prohibits the use of an individual's personally identifiable information for marketing purposes unless that a particular marketing use has been expressly authorized by the individual. (45 CFR § 164.508((a)(3)). To ensure that individuals across the country can trust their exchange to keep their information confidential, the final rule should require Exchanges to obtain specific, explicit authorization from individuals before they are permitted to use any personally identifiable information (including an IP address) for marketing purposes.

We strongly support the requirement that exchanges must comply with the IRS privacy rules in Section 6103 of the IRS Code. We recommend that HHS ensure that exchanges are able to document policies and procedures that comply with Section 1411(g) of the ACA as well as Section 6103 of the IRS Code as a condition for meeting operational readiness.

- We support the explicit inclusion in the proposed rule of a statutory penalty for knowing and willful uses or disclosures of information in violation of Section 1411(g) of the ACA. Knowing and willful violations of privacy and security regulations can be subject to criminal penalties in HIPPA, with civil penalties reserved for violations that are based on lack of knowledge of the law or mere negligence. We recommend that lesser violations of Section 1411(g) – such as those based on negligence – should be eligible for penalties as well, and that harsher penalties should apply when violations are knowing and willful (and hopefully more rare). We also recommend that HHS explicitly allow exchanges to impose stricter requirements for willful violations of Section 1411(g) if permitted under state law.

  We also recommend that HHS ensure that contractors and sub-contractors who knowingly and willfully use or disclose information in violation of 1411(g) will also be subject to the statutory penalties. We recommend that HHS ensure exchanges demonstrate mechanisms for compliance of 1411(g) and policies that will subject contractors to penalties for violation of Section 1411(g).

§ 155.405 Single streamlined application

§ 155.405(b):

- We support the requirement that HHS must approve alternative application for single streamlined enrollment created by the state exchanges.

- We also recommend adding a requirement that that applications designed must comply with Section 1411(g) and that only information that is "strictly necessary" for enrollment of an applicant be requested on the application.
- We recommend that HHS explicitly include in the final rule that an applicant has permission to refuse to answer irrelevant questions as discussed on page 41881 of the preamble. In addition, we recommend that exchanges be required to develop applications and business rules that clearly identify the mandatory and optional fields that will be required by consumers in order to submit their application (consistent with existing consumer web applications).

§ 155.405(c)(2)(iv):

We support the proposed rule's requirement that exchanges must ensure that individuals are allowed to apply in person for the exchange. The ability to interact with a person is very important to maintain, especially for the elderly and individuals with limited English proficiency.

We support the requirement that "personally identifiable information" must follow FIPP standards.

§ 155.410 Initial and annual open enrollment periods.

- In order to ensure all eligible individuals are aware of and properly enrolled in affordable coverage, we support the proposed rule at Section 155.410(b) that the initial enrollment period be as long as possible, but at a minimum from October 2013 to February 2014.

- Under Section § 155.410(c)(3), we support starting coverage at the 15th or 1st of month for non-tax credit recipients at a minimum. However, we would recommend allowing coverage to start day of enrollment in order to avoid gaps in coverage, especially if these individuals are not eligible for or not seeking tax credits to help offset the costs of the coverage.

- Under Section § 155.410(d), we recommend that HHS

    - Provide exchanges the minimum requirements for materials to be included in enrollment packets. Some suggested essential materials in an enrollment packet include clear and easy to understand information about the benefits, cost-sharing, and a provider directory with explanations on how to select a primary care provider;

    - Require exchanges ensure that enrollment packets must be linguistically accessible to LEP individuals;

RECOMMENDATION: ***Amend § 155.410(d) to add "(1)" at the end of "Notice of annual open enrollment period" and add new subparagraph (2):***

(2) Language Access.

- **Exchanges must translate open enrollment notices into a non-English language for each eligible LEP language group in an Exchange's service area that constitutes 500 individuals or 5%, whichever is less.**

- **Exchanges must ensure that open enrollment notices include taglines in at least fifteen languages informing individuals how to obtain assistance in their language.**
- **If an LEP individual makes a request for materials in a non-English language, the Exchange must provide all subsequent notices to the individual in the non-English language.**

§ 155.420 Special enrollment periods

We support the creation of a Special Enrollment Period (SEP) for individuals who become newly eligible for the individual exchange due to a change in lawfully present status at §155.420(d)(3). As eligibility for the exchange is available only to lawfully present individuals and citizens, individuals should be allowed to enroll in affordable health coverage at the moment they become eligible rather than being forced to wait until the next open enrollment period. The SEP is also necessary because individuals who become newly eligible based on their lawfully present status will also be subject to the requirement to have insurance, and thus should be allowed to enroll in affordable coverage options as soon as possible.

However, with regards to this special enrollment period based on lawful status, we recommend that HHS clarify that:

a) A special enrollment period for **citizenship** is not necessary. An individual, other than by birth, can obtain citizenship only by first obtaining lawful non-citizenship status in the U.S. Thus, any individual who gains citizenship for the first time should already have been considered eligible for the exchange and relevant tax credits as a lawfully present non-citizen. Thus, a change from a lawfully present immigration status to citizenship should not make not make an individual newly eligible for the exchange, and thus no SEP for an individual obtaining citizenship status is necessary. Individuals who become new citizens by birth should be able to enroll at any time through the pregnancy-related SEP.

b) In addition, a special enrollment period is not needed for individuals who experience changes from one lawful immigration category to another. Once an individual has a lawfully present immigration status, he or she should remain eligible for the exchange as long as he or she remains lawfully present, regardless of the specific lawful immigration status he or she currently has. For example, a U visa holder who becomes a lawful permanent resident should have been initially eligible for the exchange as a lawfully present immigrant, and remains eligible for the exchange as a lawfully present immigrant in a different immigration category.

   This clarification of which individuals should be considered newly eligible based on immigration status for the SEP is necessary in order to ensure that eligibility determinations in the exchange are initially made correctly for individuals with lawfully present status. The clarification is also needed to ensure that individuals who are lawfully present, but move from one lawful immigration category to another are not inadvertently expected to enroll as part of a special enrollment period even if eligible during open enrollment. Furthermore, the examples provided in the preamble for special enrollment periods based on immigration or citizenship status changes may lead states to unnecessarily require re-determination and re-enrollment of lawfully present individuals enrolled in the exchange when they experience a

change from one lawful status to another, which is not required by law. Rather, lawfully present individuals are subject to the same change reporting requirements that citizens must comply with, as well as the same renewal or recertification procedures required of all enrollees.

We recommend that HHS indicate that a special enrollment period is required to enroll newly eligible individuals who gain a lawfully present immigration status **for the first time.** Specifically, we recommend §155.420(d)(3) be amended as follows:

> §155.420(d)
> (3) An individual **gains**~~, who was not previously a citizen, national, or~~ lawfully present ~~individual gains such~~ status **after the open enrollment period**;

- We also support a SEP for a change in eligibility for tax credits per §155.420(d)(6). The SEP should apply for a change in eligibility for any eligible individual in the tax household.

- We recommend clarification that the SEP for loss of coverage per §155.420(e) does not include loss of coverage as a result of an intentional failure to pay, but that a loss of coverage due to error would be considered by the exchange for a SEP.

§ 155.430 Termination of coverage

- We recommend that the exchange and QHPs be required to provide termination notices that are linguistically appropriate for LEP individuals at Section 155.430(b)(1).
- We recommend that any tracking of terminations that are conducted by exchanges and shared with HHS under Section 155.430(c)(2) should be publicly reported and available. We also recommend that the number and reasons for disenrollment and terminations be included as part of the public evaluation or report card of QHP's.
- We support the requirement that QHPs be required to establish standards for termination to provide reasonable accommodations to individuals with disabilities per Section 155.430(c)(3). We recommend HHS add a requirement that QHPs also establish standards for termination for enrolled individuals who are limited English proficient.

§ 155.705 Functions of a SHOP

We strongly support the recognition of the need for separate eligibility and enrollment processes for the Small Business Health Options Program (SHOP) and the individual Exchange as discussed in the preamble on pg. 41886 and included in Sections 155.705(a)(1) and 155.705(b)(1).

We agree that there is no need for a special enrollment period in the SHOP based on a change in immigration or citizenship status, but in order to avoid confusion, we recommend that HHS revise its rationale for this policy in the final rule.

Unlike the individual exchange, eligibility for the SHOP is based on whether an individual is a "qualified employee." There is no independent immigration or citizenship eligibility criterion for enrollment in the SHOP. Employers are required to verify immigration and citizenship status

under the existing federal employment rules, and thus individuals have already been subject to this verification. Thus, special enrollment periods in the SHOP should solely be based on whether an individual is newly hired by a "qualified" employer, or becomes a newly eligible "qualified employee," rather than any change in an individual's immigration or citizenship status.

Specifically, we recommend that HHS eliminate the discussion in the preamble regarding the lack of a SEP in the SHOP based on a change in immigration and citizenship status. Since there is no SEP created in the regulation, the discussion is unnecessary and will only create confusion. In the event the final rule retains this discussion, we strongly recommend that HHS clarify that a SEP based on a change in immigration/citizenship status is not needed in the SHOP because eligibility for the SHOP is based only on whether an individual is a "qualified employee." We recommend that HHS clarify when new hires or newly eligible qualified employees may need a special enrollment period or whether they should be allowed to enroll at any time during the plan year by the qualified employer without any special enrollment period.

We support HHS requiring special enrollment periods in the SHOP. However, we recommend that SEPs in the SHOP be aligned with SEPs that already are recognized and used in the large group employer market and/or ERISA. SEPs for SHOP should not be distinguishable from the large group market so that there would be a level playing field between large and small employers and their employees. We oppose efforts to align the SEPs in the SHOP with those in individual market exchanges for two reasons: a) the SHOP will not administer affordability credits for individuals, and b) the enrollment processes for the two markets will be different with potentially different qualifying events that would trigger a SEP. We also recommend that HHS ensure that states that choose to merge their SHOP and individual market exchanges maintain not only different enrollment processes but also different SEPs based on the needs of those individuals in the market.

In addition, we have the following specific comments and recommendations regarding other functions of the SHOP discussed in the proposed rule:

- We recommend the SHOP be required to establish an appeals process in §155.705(a)(1) and that this requirement should not be waived.

- We support the requirement in §155.705(b)(5) that the SHOP must include plans that are qualified health plans.

- We support HHS's goal to ensure that there is less administrative burden and concise and clear information for employers and employees participating in the SHOP as stated on page 41887 of the Preamble. We recommend this be a requirement in order to ensure robust participation of small business employers.

- We support the employer having choice of plans and flexibility of offers to provide its employees in the SHOP per Sections 155.705(b)(2) and 155.705(b)(3).

- We support the requirement in §155.705(b)(5) that QHPs must meet SHOP specific certification requirements.

- We support the requirement in §155.705(b)(6)(i) that QHP issuers can change premium rates in the SHOP at only one interval. We recommend that QHP issuers in the SHOP be allowed to change premiums only annually rather than quarterly or monthly to help ensure stability of the SHOP per page 41887 of the Preamble. This would be consistent with the requirement at § 155.705(b)(6)(ii) that an employer's rate cannot change during the plan year. We support this requirement as it will help encourage participation of both employers and employees and avoids unnecessary administrative hassles. Requiring that the employer's rate in the SHOP remain stable during the plan year aligns with large group employer market practices creating a level playing field between large and small employers.

- We support requirement in §155.705(b)(7) that once an employer chooses its coverage options in the SHOP, the qualified employee should be allowed to choose which option to enroll. We strongly recommend that if the SHOP is merged with individual market exchange, HHS should require that the eligibility and enrollment mechanisms for each market remain separate to account for the differing needs of each market. We support the proposed requirement on page 41887 of the Preamble that qualified employees should be able to enroll in any QHP in a merged SHOP and individual market that meets SHOP requirements.

§155.715 Eligibility determination process for SHOP

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

  We recommend that HHS require SHOPs to establish a process where the qualified employers submits an aggregate application to the SHOP for the employees on their payroll who are designated as eligible to enroll for SHOP coverage. HHS should require the SHOP to serve only as a facilitator in this process. Because there are no individual tax credits to administer, the SHOP should be responsible only for certifying the employers who are eligible to participate. HHS should streamline the eligibility and enrollment process so that communication and information is shared only between the individual and the employer, the employer and the health plan, and the individual and the health plan. Adding the SHOP as yet another point of required contact for the individual serves only to increase the administrative burdens and costs without any real value.

- 155.715(c)(1): We do not agree that the SHOP has authority to or is required to verify individual employee applications. As discussed above, the points of contact for an individual employee should be limited to the employer and to the qualified health plan enrolling the individual for coverage. The SHOP should be required to play only a facilitator role and not

act as a middleman, which will only add to the administrative burdens and barriers for small business employers and their employees to participate in the SHOP. The employer, not the SHOP, should be responsible for determining the accuracy of the individual employee's information. The SHOP in turn, should be required to accept proof from employer. Moreover, only in the event of an actual inconsistency, not merely "if the SHOP has a reason to ***doubt*** the information's veracity,[4]" the SHOP should be required to notify the employer so the employer can resolve the inconsistency, rather than creating an entirely separate and duplicative verification scheme. We recommend striking §155.715(c)(1) in its entirety.

- 155.715(d)(1): Similar to the concerns raised above, and even assuming that the SHOP has authority to verify individual employee applications, the proposed rule does not specify the criteria or grounds on which the SHOP is permitted to "doubt the veracity of the information" provided by the employee or employer. In addition to establishing these criteria, we strongly support the requirement that the SHOP provide notice to the employer and employee that the information is being verified. We also strongly recommend that the SHOP be allowed to verify information only if there is an actual inconsistency, not merely "if the SHOP has a reason to ***doubt*** the information on the application.[5]"

  The concerns raised above also apply to Section 155.720 of the proposed rule. We do not support the enrollment process as described in Section 155.720, which requires the unnecessary and duplicative step of providing and verifying information that has already been provided by the employee and verified by the employer. Unlike the individual exchange, the SHOP does not administer individual tax credits; thus there is no need for the SHOP to require individual applications. Under the ACA, information should be shared only where strictly necessary to facilitate enrollment under Section 1411(g). Individuals eligible for coverage under the SHOP will be allowed to enroll only if their employer is a qualified employer and designates the individual as eligible for SHOP enrollment. Once determined eligible for enrollment by the employer, individuals should be able to provide their personal information directly to the qualified health plan of their choice. This will streamline the enrollment process, eliminate unnecessary information sharing, and reduce bureaucracy in the SHOP.

§ 155.720 Enrollment of employees into QHPs under SHOP

There is a recognition that small business employers "will only join the SHOP if it convenient to do so.[6]" Thus, the enrollment process between the employer, employees, and the QHP should be as streamlined as possible with requiring the employer and employee to have to go through too many extra doors. If the enrollment process is over complicated and burdensome to its employees, employers will have less incentive to participate in the Exchange.

At a minimum, the enrollment of employees under the SHOP should be aligned with the enrollment of employees in the large group employer market to create a level playing field and in fact should be even more streamlined and simpler to encourage small business employers to

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[4] See Section 155.715(c)(1)(emphasis added).
[5] See Section 155.715(d)(2) (emphasis added).
[6] See Preamble at page 41889.

participate. We are concerned in general that the proposed rule's approach to enrollment in the SHOP is unnecessarily complex with the SHOP exchange potentially becoming an administrative barrier for both employers and employees to overcome to obtain affordable coverage. We recommend that information required to enroll employees in a plan are requested and shared among only those entities that strictly need the information to provide coverage to the employee.

Specifically we recommend that HHS limit the SHOP's role as a middleman between the employer, employee and the QHP and that its primary function is to facilitate communication and collaboration between qualified employers, qualified employees, and the QHP.
Under the ACA, the SHOP's main function appears to be to determine who is a qualified employer based on the requirements of the ACA. As a result, interactions between the qualified employee and the SHOP should be reduced or eliminated as the information needed to enroll employees in a QHP can be more efficiently transferred directly between the employee, the employer, and the QHP. In addition, employees should not be required to interface with the SHOP as they do in the individual market exchange because they are not being determined eligible for individual tax credits as in the individual market exchange. As such, there is no need for an employee to provide personal information to the SHOP when the employee has likely already provided that information to his or her employer and can more efficiently provide that information to the QHP enrolling the employee and their family for coverage. Providing personal employee information to the SHOP only will create administrative barriers and burdens as well duplicate information sharing that must occur between the employee, the employer, and the QHP.

For instance, once an employer is determined to be a "qualified employer" per the SHOP, the employer should be responsible for determining who among their employees should be considered a "qualified employee" since the employer is responsible for paying the premium contribution for their employees. In the large group market, the employer, not the insurance broker, decides which of their employees are eligible or not for group health insurance under the employer's criteria. There is nothing in the ACA that requires the SHOP rather than the employer to determine and verify who is a qualified employee.

We recommend a more simplified enrollment process than the one described in the proposed rule. We recommend that the SHOP's main role should be to help facilitate the pre-enrollment process between the employer and QHP, but not to perform the enrollment functions. In order to align the enrollment process in SHOP with existing group market practices, the SHOP does not take on the responsibility of enrolling individuals but instead works to ensure as many eligible small business employers in the service area are certified as qualified employers and are participating in the SHOP. Once the SHOP certifies an employer to participate in the SHOP and helps the qualified employer choose coverage options for its employees, the enrollment information about the coverage options should be provided directly by the elected QHPs and the qualified employer to the employer's employees. In fact, employees should be able to obtain information from and enroll directly with the selected QHP. The QHP(s) selected by the employer or employees should send all required enrollment forms to the employee which the employee completes and sends directly to the QHP. If there are any inconsistencies or problems with enrollment, the QHP or employer can resolve directly with the employee. In general, we

recommend that the SHOP does not play a role where it is more efficient to have direct communication or interaction between the employee, the QHP, or the employer.

Under the proposed rule, we note that there are too many places where paperwork and verification of employees is required or duplicated increasing the likelihood that information will be lost or that enrollment will be unnecessarily delayed. The end results will be that employees will not be enrolled, will not know which entity has primary responsibility for enrolling them in coverage, and are likely to be frustrated with the unnecessary bureaucracy created in the SHOP.

Below are specific areas of concern regarding the potential barriers to enrollment under the proposed rule:

- Under §155.720(b)(4), we do not the support the requirement that the SHOP must take individual applications for enrollment from individual employees.
- Under §155.720 (b)(5), we do not support the SHOP's jurisdiction or role in verifying individual employee's information. Verification should be done by employer and any inconsistencies should be resolved by the employer directly with the employee. This procedure is more consistent with current group market practices with large employers. It is unclear where in the ACA the law requires the SHOP to verify individual employees' information.
- Under §155.720(c)(1), we do not support role of SHOP being middleman of information. Enrollment information from an individual employee can be sent directly from the employee or employer to the selected QHP.
- Under §155.720(e), we recommend that HHS require that the confirmation of enrollment be sent to the employee and employer directly from QHP rather than the SHOP as proposed.
- Under §155.720(h), we recommend that an individual employee who ends their employment should consult with their employer, not the SHOP, regarding the coverage options available after employment ends. Employers are subject to state labor and COBRA requirements regarding providing coverage options upon terminating employees which they must continue to fulfill when terminating employees even if participating in the SHOP.
- Under §§155.720(f) and 155.720(g), we do not support the requirement in the proposed rule for the SHOP to reconcile information and to keep records. We oppose unnecessarily creating bureaucracy and duplication of records that are already maintained by the employer and employees. Specifically, employers will be required to keep track of who on their payroll is receiving coverage through the SHOP and the QHP must keep record of which employee is enrolled in order to receive payment for coverage. It is unclear under the ACA why the SHOP should maintain records, especially when the SHOP does not administer individual tax credits. If the SHOP needs this information for other purposes, such as certifying exemptions from the individual mandate for the taxpayers for example, those purposes should be clearly specified and the information provided to the SHOP should be strictly limited for administration of that purpose.

§ 155.725 Enrollment periods under SHOP.

Because "small group markets are unique" as recognized on page 41890 of the Preamble, enrollment should be different and unique from the individual market exchange. As discussed above, enrollment procedures in the SHOP should align closely with other group markets rather

than with the individual market exchange because there are no individual no tax credits to administer in the SHOP and individuals enrolling in the SHOP are eligible for coverage on the basis of their employment with a qualified employer. Thus, as outlined below, we recommend the SHOP be limited to playing more of a facilitation role than an enrollment role.

- Under §155.725(a)(2), we recommend that the SHOP facilitate, rather than ensure, enrollment transactions.
- Under §155.725(c)(1), we recommend that only the selected QHP and qualified employer decide how to make the QHP available to the employees. There is no need for the SHOP to have a role in actual plan selection. The SHOP's primary role should be to ensure certification of the QHP and the qualified employer before plan selection occurs.
- Under §155.725(e), we recommend the employer, not the SHOP, decides the open enrollment period for its employees. Many small businesses are cyclical and may hire in different periods of the year; thus the employer not the SHOP is in the best position to determine the appropriate open enrollment period for its business' and employees' needs.
- Under §155.725(f), we recommend the employer, not the SHOP, decides whether and how new hires are able to enroll in the available QHP. This is primarily because the employer must contribute to the coverage of its employees.
- Under §155.725(g), we recommend the employer, not the SHOP, decides the start date of coverage for its employees.
- Under §155.725(h), we recommend the employer, not the SHOP, is responsible for renewing coverage for its employees at the end of the plan year. If an employee is terminated, the employer should be responsible for notifying the employee of their coverage options after employment ends. The employer may be subject to state labor or COBRA protections that require this notification. The employer, not the SHOP, is responsible for deciding who to enroll or disenroll from coverage since coverage through the SHOP is available on the basis of employment by a qualified employer. If the employer is contributing to the employee's premiums in the SHOP, this is another reason the employer should be responsible.

§155.730 Application standards for SHOP

- Under §155.730(b)(4), we do not support the requirement that the employer provide the employees' names and SSN's to the SHOP. That information should be provided by the employer directly to the QHP for enrollment purposes. Since the SHOP is not administering individual affordability credits, it is unclear why the employee's individual information is needed.
- Under §155.730(c), we do not support an application from an employee being sent to SHOP. Instead, we recommend the employer or the employees are able to directly enroll with the QHP once the employer has been certified as a qualified employee and has selected coverage options.
- Under §155.730(d), we do not support the need for a model application to be created by the SHOP.
- Under § 155.730(e), we do not support the need for HHS to approve alternative applications. Because the SHOP does not administer individual affordability credits, it unclear why HHS and the SHOP must obtain an "application" from the individual employee as for what is the employee applying?

- Under §155.730(e)(2), we do not support the requirement for an application for an individual employee for the SHOP. As stated above, we oppose any requirement that an individual employee participating in the SHOP provide his or her detailed information to the SHOP when the employee has already likely provided the necessary information to the employer at time of hiring and for payroll/tax purposes or can provide that information directly to the employer. It seems inefficient and redundant to require an employee to provide personal information she or he has already provided.
- Under §155.730(f), we recommend adding an explicit requirement that the SHOP may solicit, collect, and record information from the employer and individual employees that are only "strictly necessary" to facilitate enrollment per Section 1411(g) of the ACA and only for the purposes of administering SHOP related benefits.

§155.1050 Establishment of Exchange network adequacy standards

We strongly support the proposed requirement in Preamble on page 41894 that QHPs in the individual market exchange must provide access to all enrollees, especially in medically underserved areas. We recommend that the final rule require at a minimum that the definition of medically underserved areas be the definition used by HHS for federally qualified health centers, but that exchanges have the flexibility to add additional criteria based on geographic and local needs. For instance, we recommend allowing the exchange to incorporate information about enrollees who are geographically isolated or populations with higher rates of health disparities (or other at-risk populations) in their definition of medically underserved areas for network adequacy standards. We strongly support the requirement that QHPs in the individual market exchange be required to ensure "reasonable access to all enrollees regardless of the enrollee's medical condition."

In order to ensure coverage equals access for millions of newly eligible individuals in the exchange, we strongly recommend that HHS require exchanges to ensure the QHPs networks adequately can serve limited English proficient populations and demonstrate cultural and linguistic competence. We also support a broad definition of providers who will be considered as those providing primary care (e.g., nurse practioners) within a network per page 41894 of the Preamble. We recognize that access to primary care must be expanded and strengthened and one method of doing so would be to recognize all health professionals that already provide primary care.

§155.1055 Service area of a QHP

We strongly support the requirement in §155.1055(b) that a service area of a QHP operating in the individual market exchange cannot be discriminatory.

§155.1080 Decertification of QHPs

We support the requirement in §155.1080(e)(2) that the exchange ensure that notices of a decertification of a QHP and changes in special enrollment periods are provided to enrolled individuals. We recommend that the exchange be required to translate these notices in the required languages.

§156.200 QHP issuer participation standards

§156.200(c)(2):
We support the requirement that the exchange require child only plans to be provided at all three levels (gold, silver, and bronze). Child only plans will be a critical avenue to affordable coverage for eligible children who are under the care of another family member, who live in mixed status families, and who are otherwise ineligible for employer or public coverage options. Ensuring there is a choice at all benefit levels for child only plans will help these children enroll in the coverage that is appropriate for their health needs. We also recommend that HHS include the definition of a child (and the eligibility age) when promulgating regulations or guidance regarding the child-only plans in the Exchange. We recommend that HHS ensure that child-only plans are available to individuals up to the age of 26, consistent with current rules for dependents under group health insurance.

§156.200(e):
We applaud and strongly support the requirement that the non-discrimination provisions required in the exchange also apply to QHPs participating in the exchange. We strongly support these provisions, based on existing federal civil rights laws as well as Section 1557 of the ACA. We also strongly support the inclusion of nondiscrimination on the basis of gender identity and sexual orientation.

In order to ensure compliance with this requirement, we recommend that exchanges be required to develop a process for consumers to file complaints of non-discrimination by a QHP and that that information becomes part of the public information reported on each plan by the exchange. We recommend that HHS specify that non-discrimination complaints against QHPs will be under the jurisdiction of HHS Office of Civil Rights under the authority of Section 1557 of the ACA.

§156.220 Transparency in coverage.

- We support the requirement in §156.220(c) for use of plain language in communications by the QHPs.
- We support the requirement in §156.220(d) that QHPs are required to make cost-sharing information transparent.

§156.225 Marketing of QHPs.

- We support the requirement in §156.225(a) that QHPs comply with any relevant state law regarding marketing by health insurers.
- We support the requirement in 156.225(b) that QHPs do not conduct marketing that discourages individuals with significant health needs from enrolling. We recommend that HHS and the exchanges add an explicit non-discrimination requirement that QHPs do "not employ marketing practices that do not discriminate based on race or ethnicity."

RECOMMENDATION: ***Amend § 156.225(b) as follows:***
(b) Non-discrimination. Not employ marketing practices that discourage enrollment of individuals with significant health needs in QHPs ***or on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.***

§156.230 Network adequacy standards.

- We strongly support requirement in §156.230(a)(1) that QHPs must ensure its networks include essential community providers.
- We support the requirement in §156.230(b) that the provider directory indicates which providers are accepting new patients. We also recommend adding a requirement that the provider directory must indicate the language capacity of each provider.
- We recommend adding a requirement that network adequacy also demonstrates language capacity based on the designated threshold languages in the relevant service area.

§156.235 Essential community providers

- 156.235(a): We strongly support the requirement that QHPs include "a sufficient number of essential community providers" in its network. We also support the requirement that QHPs offer contracts to all essential community providers. Essential community providers have established themselves for many as a trusted and reliable source of care, especially for low-income mixed status families. Ensuring that they are part of the QHP's network will also help ensure continuity of care for many of the newly insured.

- 156.235(b): We support HHS's recommendation on page 41899 of the preamble that there be a broad, inclusive definition of community essential providers, and that the definition not be limited to only those defined in the Public Health Services Act. We recommend that HHS, the exchange, and QHPs develop criteria to be truly inclusive of providers who act as a "community essential provider" in the QHPs network. We also recommend that community essential providers be held to the same quality standards required by other network providers to help to address health inequities common in medically underserved areas.

We recommend that the final rule include specificity and minimum federal requirements rather than providing state flexibility in defining the "sufficient number of essential community providers." At a minimum, for example, each QHP must demonstrate they have contracted with the FQHC in their network area.

We support the requirement that states may enact more stringent participation requirements per page 41899 of the Preamble. However, we recommend that the final rule be as specific as possible regarding the minimum set of federal participation requirements to ensure the most robust access regardless of the differences in the exchange model. We also recommend adding other criteria for "integrated delivery network health plans" to ensure network adequacy for low-income, medically underserved populations if an exemption for community essential providers is created per page 41899 of the Preamble.

§156.250 Health plan applications and notices.

We strongly support the requirement that health plan applications and notices must comply with standards set out in 45 CFR 155.230(b), especially that the notices provide "meaningful access to limited English proficient individuals."

Specifically, we recommend that the final rule include specific requirements for QHPs regarding translation of notices into non-English languages when thresholds are met. We recommend a threshold of 500 LEP individuals or 5% of QHP enrollees, whichever is less. The 5% is utilized in both the DOJ/HHS LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans. The 500 comes from an existing Department of Labor regulation.

RECOMMENDATION: ***Amend § 156.250 to add "(a)" after before the existing text and add new subsection (b):***

- ***(b) Language Access.***
- ***(i) QHPs must translate notices into a non-English language for each eligible LEP language group of QHP enrollees that constitutes 500 individuals or 5%, whichever is less.***
- ***(ii) QHPs must ensure that notices include taglines in at least fifteen languages informing individuals how to obtain assistance in their language.***
- ***(iii) If an LEP individual makes a request for materials in a non-English language, the QHP must provide all subsequent notices to the individual in the non-English language.***

§156.255 Rating variation.

We recommend that HHS ensure that the QHPs be required to include a rating for child-only plans in addition to the other four different types of family composition. We also support creating an alternative to defining family composition to ensure as many of today's diverse families are able to obtain the coverage best suited to their needs.

We strongly support the requirement that QHPs must cover an enrollee's tax household, including for purposes of applying individual and family rates per page 41901 of the Preamble. This will help ensure mixed status families are able to obtain affordable insurance based on actual family size.

§156.265 Enrollment process for qualified individuals.

- We support the requirement in §156.265(b) that the exchange and QHPs use a common set of enrollment information.
- We recommend the final rule add the requirement that the enrollment information must include only what is "strictly necessary" per Section 1411(g) of the ACA. Specifically, we recommend that Section 156.265(b)(1) be amended as follows:

  Collect enrollment information that is ***strictly necessary*** using the application adopted pursuant to § 155.405 of this subtitle.
- We support the requirement in §156.265(e) that QHPs must provide enrollment information packages to new enrollees. We recommend also requiring QHPs to provide enrollment packages in the language indicated on the application as the primary language.
- We support requirement in §155.265(h) that QHPs acknowledge receipt of enrollment information.

§156.270 Termination of coverage for qualified individuals.
We support the requirement in §156.270(d)(1) that QHPs must pay claims during grace period. We also support the requirement in §156.270(e) that QHPs must provide notice for termination. We recommend requiring these notices meet LEP requirements.

We also recommend that HHS require the exchange to ensure enrollees have a right to appeal termination of coverage and that the QHP and the exchanges must create a process for appeal.

§156.280 Segregation of funds for abortion services

- 156.280(i): We strongly support the explicit clarification in the proposed rule that nothing in the ACA changes requirements regarding providing emergency services by state and federal law, including Section 1867 of the Act. We recommend that HHS retain this clarification in the final rule and also consider reiterating this clarification in future regulatory guidance related to essential health benefits .

§ 156.285 Additional standards specific to the SHOP.
- Under §156.285(b)(1) and 156.285(b)(2), we recommend that the employer, not the SHOP, decide the specific requirements and dates for open enrollment and special enrollment periods.
- Under §156.285(c)(3), we recommend adding a requirement that enrollment packets must meet LEP requirements.
- Under §156.285(c), we recommend adding a requirement to the enrollment process for SHOP by QHPs under subpart c that requires QHPs to collect, transmit, and retain only information that is "strictly necessary" for enrollment purposes per Section 1411(g) of the ACA.
- Under §156.285(c)(5), we support the requirement that QHPs must acknowledge receipt of enrollment information in accordance with Exchange standards.
- Under §156.285(d)(1)(i), we do not support requiring QHP issuers in the SHOP to comply with the general requirements for termination of coverage as established in the individual exchange referenced in 156.270(a). The SHOP and Exchange enrollment processes, including termination, should not be the same due to the different populations served in each market. QHP issuers should be required to follow certain procedures at termination, but HHS should not simply apply the same termination procedures for both the SHOP and the individual market exchange due to the additional role of the employer in the SHOP.

  Specifically, we recommend striking the current language in 156.285(d)(1)(i) and replacing it with more specific requirements for SHOP termination.

  ~~General requirements regarding termination of coverage established in §156.270(a).~~

- Under, §156.285(d)(1), we recommend adding a requirement that QHPs must provide notices of termination meet LEP requirements.

Thank you for considering our comments. If you have any questions, please feel free to contact me at (213) 639-3900 ext. 114 or at ambegaokar@nilc.org.

Sincerely,
/s/
Sonal Ambegaokar
Heath Policy Attorney
National Immigration Law Center

Enclosure – List of Typical Documents for Recommended Lawfully Present Definition, National Immigration Law Center, October 2011