

EXHIBIT 1: Huang Declaration

DECLARATION OF PRISCILLA HUANG

I, Priscilla Huang, make the following declaration based on my personal knowledge and declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I work for the Asian & Pacific Islander American Health Forum (the “Health Forum”) in Washington, D.C. My title is Senior Director of Impact. I am an attorney. I have been working with limited English proficient (“LEP”) and immigrant communities for 10 years.

2. Increasing access to linguistically and culturally appropriate health care is one of the Health Forum’s major priorities. We have been working on language access issues since the 1980’s, and it continues to be one of our enduring policy priorities.

3. The Health Forum is one of four national organizations that created the Action for Health Justice (“AHF”) coalition in July 2013. The coalition is made up of 72 Community Health Centers (“CHCs”) and Community Based Organizations (“CBOs”) in 22 states that focus on outreach, education, and enrollment assistance for Asian Americans, Native Hawaiians, and Pacific Islanders. We know that these communities face challenges enrolling in health care, based upon our experience with Massachusetts health care reform, so we created the coalition to prepare for Affordable Care Act (“ACA”) enrollment.

4. The members of the coalition are closely connected to limited English proficient (“LEP”) Asian and Pacific Islander communities. Most of the CBOs are social

service providers, and many have bilingual staff. Many hired and trained additional staff to be Certified Application Assistants, and trained bilingual volunteers to assist community members with enrollment through the health care marketplaces created by the ACA.

5. There is a widespread need for language assistance in the Asian American and Pacific Islander community. More than half of all Asian Americans and about 14 percent of Pacific Islanders in the United States were born in another country. Many Asian Americans and Pacific Islanders have limited proficiency in English. In some Asian ethnic communities, over 50 percent of community members are LEP.

6. We began engaging with the Centers for Medicare and Medicaid Services (“CMS”) on language access issues under the Affordable Care Act (“ACA”) during the summer of 2013, as part of a group of Washington, D.C., advocates working with the administration on immigrant access issues. We were especially concerned that vital notices were not being translated into languages other than English and Spanish. Vital notices, according to the Department of Health and Human Services’s (“HHS”) own language access guidance, include written documents that could potentially change a person’s coverage or make modifications to their plan, coverage, or eligibility status. We asked CMS whether vital notices would be translated into Asian and Pacific Islander languages but I don’t believe we received a response.

7. The first two inconsistency notices mailed to consumers alerting them to submit additional citizenship or immigration status information were provided only in English and Spanish. I believe that they did not even contain multi-lingual “taglines”

telling consumers about the availability of interpreter services. Taglines are one-sentence additions in multiple languages at the end of a notice.

8. The inconsistency notices sent to consumers in August 2014, which provided the last opportunity for consumers to respond by September 5 before losing their health coverage, were also sent in English and Spanish only. These notices included multi-lingual taglines telling consumers about the availability of interpreter services, but the taglines were inadequate. Taglines should include information about any action a consumer needs to take and the consequences of failing to act. The taglines on the notices did not convey any urgency or even advise consumers that they needed to take action. They were no different than the taglines that might appear on an advertisement. It is a very low burden to provide sufficient taglines—information on what is at stake, including the risk of losing health insurance, can be communicated in one or two sentences.

9. In addition, all of the multi-lingual ‘taglines’ instructed consumers to call the same phone number, which was answered in English and only offered Spanish as an alternative language.

10. According to CMS, inconsistency notices were also emailed and an automated and live call was made to affected consumers. I am not aware of any calls made or emails sent in languages other than English or Spanish. Moreover, our AHJ partners have told me that email is normally not an effective means of communication with our constituents, who are often low-income, limited-English proficient immigrants with low levels of computer literacy. Many set up email accounts for the first time when

they applied for health insurance and have not used their emails since. We have found the more effective channels of communication are through ethnic media.

11. The AHJ partners took it upon themselves to inform Asian and Pacific Islander-language speakers about the need to take action. They created flyers and notices for outreach and mailed information to individual consumers. This effort required a tremendous diversion of organizational resources. Staff worked weekends and around the clock to create translations of documents not provided by the government, to reach out to consumers and ethnic media, and to prepare staff to assist consumers. They also fielded numerous telephone calls and provided assistance to concerned people who were not sure if they had received a notice. In many cases staff had to call the marketplace call center on behalf of a consumer. Yet, in some cases, staff had difficulty connecting with a call center representative who had adequate knowledge about the inconsistency notices. None of the partner organizations received compensation from CMS for these extra efforts, which unquestionably limited their ability to work on programs related to their core mission.

12. I have participated in numerous stakeholder meetings with CMS on language access issues. Since January, 2014, I have participated in regular meetings between CMS and a coalition of advocacy organizations. In addition, I have been in regular contact with different offices within CMS since the ACA was enacted, meeting with them frequently. These offices include the Office of Communications, the Center for Consumer Information and Insurance Oversight (“CCIIO”), the Office of Minority Health (“OMH”) and the Office of Civil Rights (“OCR”).

13. In February 2013, the Health Forum and the National Health Law Program developed and circulated a sign-on letter on language access. A copy of this letter is attached to this declaration as Exhibit 1. The sign-on letter included a number of recommendations related to the www.Healthcare.gov web portal, the use of taglines on notices, and increasing other resources for informing LEP communities about the ACA, in accordance with HHS's language access policy. CMS responded to the letter in April, which led to a series of three meetings conducted by Susie Butler and Ida Kelley at the Office of Communications. These meetings led to the creation of application 'job aids' as a resource for bilingual assisters. CMS translated several of the job aids, then requested that non-profit organizations like the Health Forum to do additional translations without compensation. The job aids are essentially translated application "look alikes" to assist consumers in applying for coverage, but cannot be used for application submission. Assisters working with the job aids must enter consumers' information into the English or Spanish application. The job aids are not available to consumers applying without assistance.

14. In November 2013, the Health Forum co-authored a memorandum to Howard Koh, the Assistant Secretary of HHS, which reviewed all the Asian language outreach materials on www.Healthcare.gov. A copy of this memorandum is attached to this Declaration as Exhibit 2. The memo noted the numerous translation errors and other deficiencies in the materials. We did not receive a response from HHS, but have since used and shared the memo widely in advocacy with other offices of CMS.

15. In July 2014, AHJ produced a policy report focused on three issues in ACA enrollment – language access, immigrant enrollment barriers and health literacy. A copy of this report is attached to this Declaration as Exhibit 3. We conducted a series of briefings after the release of the report, including briefings with congressional members and staff, and informational and strategy sessions with multiple HHS offices, including the Office of the Secretary, OMH, OCR, the Office of Faith-Based Initiatives and the Substance Abuse and Mental Health Services Administration. We also had separate meetings with OCR and its new director, Jocelyn Samuels, and the CCIIO Consumer Support Group, which provides program and policy support for HHS’ consumer assistance programs. In all those meetings, we shared the report and our recommendations and raised the lack of language access on inconsistency notices and inadequate taglines. The Consumer Support Group’s response was to ask if we had raised the issues with the Office of Communications. In fact, we had asked for the Office of Communications to join the CCIIO meeting, but they did not participate.

16. We have raised our concerns about language access in numerous comments to proposed regulations since the ACA was enacted. Our comments refer to the HHS language access plan and data developed by our research team from the American Communities Survey about the prevalence of limited English proficiency in Asian American and Pacific Islander communities. Whenever possible in our comments and meetings we make reference to HHS’s obligations under ACA Section 1557, Title VI, and the HHS language access plan.

17. I believe that if CMS had provided more meaningful access to the ACA marketplaces by translating vital notices into key Asian and Pacific Islander languages and making its taglines more urgent and informative by identifying the risks at stake as in the English notice, more Asian and Pacific Islander individuals and households would have been able to successfully apply for, obtain and maintain ACA health insurance coverage.

Executed this 29th day of September 2014 at Washington, District of Columbia.

A handwritten signature in black ink, appearing to read "Priscilla Huang", is written above a horizontal line.

Priscilla Huang
1629 K Street, NW, #400
Washington, DC 20006
Phone: (202) 466-3550
Email: phuang@apiahf.org

EXHIBIT 1 to Huang Declaration

February 14, 2013

Marilyn Tavenner
Acting Administrator
Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Dear Administrator Tavenner:

The undersigned 270 national, state and local organizations urge the Centers for Medicare & Medicaid Services (CMS) to translate the single, streamlined application for insurance affordability programs into at least fifteen languages. Without translated applications, one out of four expected insurance marketplace applicants who speak a language other than English at home are at high risk of being left behind. The more than 24 million limited English proficient (LEP) individuals across the country deserve equal access to the new coverage options available under the Affordable Care Act (ACA).

The application provides the initial entry point to apply for health insurance and is a vital component of the ACA's "no wrong door" approach to enrollment. Yet LEP individuals may suffer erroneous denials of eligibility because they do not understand what information to provide. Indeed, they may be prevented or dissuaded from accessing the insurance marketplace altogether, undermining the goal of the ACA to expand affordable insurance coverage for all Americans.

The federally facilitated exchange (FFE) must comply with both Title VI of the Civil Rights Act and Section 1557 of the ACA. To prevent discrimination against LEP individuals, the FFE must ensure access and understanding for LEP consumers. In addition to the legal requirements, federal translation of the application would benefit all entities engaged in enrollment, outreach and education. Translated applications will assist in ensuring effective communication by creating a baseline for standardizing ACA-related enrollment terminology and creating translation "glossaries" that can be used by other entities for outreach, education and training, saving costs of re-translating the same terms. Translated applications can also help train bilingual staff and interpreters who will assist LEP individuals to ensure consistency and accuracy, thus aiding effective enrollment and information dissemination.

Translating applications at the federal level is cost-effective for CMS and the states. For example, if the nineteen states operating state-based exchanges use the single, streamlined application but translate it independently, the costs multiply nineteen times. CMS has already recognized the importance of translating its documents into multiple languages with its

commitment to translating beneficiary-related Medicare forms into fifteen languages. The federal investment resulted in significant efficiencies and economies of scale, benefitting virtually all Medicare providers who must comply with Title VI.

We ask that CMS commit to translating the application into at least fifteen languages and creating corresponding translation glossaries of key ACA terms that all enrollment stakeholders can access. Federal translations would save money and resources, improve access for LEP individuals, ensure compliance with federal law, and truly implement the no wrong door philosophy at the heart of creating a single, streamlined application.

For more information, contact Priscilla Huang, Asian & Pacific Islander American Health Forum, (202) 466-7772 or phuang@apiahf.org or Mara Youdelman, National Health Law Program at (202) 289-7661 or youdelman@healthlaw.org.

Sincerely,

National Organizations

AARP

African American Health Alliance

AIDS Community Research Initiative of America

Alliance for a Just Society

American Academy of Pediatrics

American Cancer Society Cancer Action Network

American College of Healthcare Executives

American Diabetes Association

American Federation of State, County and Municipal Employees (AFSCME)

American Heart Association

American Hospital Association

American Lung Association

American Nurses Association

American Translators Association

Asian & Pacific Islander American Health Forum

Asian American Justice Center, Member of Asian American Center for Advancing Justice

Asian Liver Center at Stanford University

Asian Pacific American Labor Alliance, AFL-CIO

Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)

Association for Community Affiliated Plans

Association of Asian Pacific Community Health Organizations

Association of Minority Health Professions Schools

Boat People SOS

CareSource

Caring Ambassadors Program
Catholic Health Association of the United States
Certification Commission for Healthcare Interpreters
Center for Children and Families at Georgetown University
Center for Law and Social Policy
Center for Medicare Advocacy, Inc.
Center for Popular Democracy
Charles R. Drew University of Medicine and Science
Civil Liberties and Public Policy
Community Action Partnership
Community Catalyst
Consumers Union
Cross-Cultural Communications
Disability Rights Education and Defense Fund (DREDF)
DiversityRx - Resources for Cross Cultural Health Care
Doctors for America
Enroll America
Epilepsy Foundation
Families USA
Farmworker Justice
First Focus
GLMA: Health Professionals Advancing LGBT Equality
Guam Communications Network
Healthcare Leadership Council
Hepatitis B Foundation
HIV Prevention Justice Alliance
Hmong National Development, Inc.
Ibis Reproductive Health
International Medical Interpreters Association
InterpretAmerica
Japanese American Citizens League (JACL)
Meharry Medical College
Migrant Legal Action Program
MomsRising
Morehouse School of Medicine
NAACP
National Alliance of State and Territorial AIDS Directors
National Asian Pacific American Families Against Substance Abuse
National Asian Pacific American Women's Forum
National Asian Pacific Center on Aging
National Association of Community Health Centers
National Association of Free and Charitable Clinics
National Association of Health Underwriters

National Association of Public Hospitals and Health Systems
National Association of Social Workers
National Center for Law and Economic Justice
National Center for Transgender Equality
National Council for Behavioral Health
National Council of Asian Pacific Islander Physicians (NCAPIP)
National Council of Jewish Women
National Council of La Raza (NCLR)
National Council on Interpreting in Health Care (NCIHC)
National Health Care for the Homeless Council
National Health Law Program
National Hispanic Medical Association
National Immigration Law Center
National Latina Institute for Reproductive Health
National Minority AIDS Council
National Partnership for Women & Families
National Physicians Alliance
National Queer Asian Pacific Islander Alliance
National Senior Citizens Law Center
National Urban League
National Viral Hepatitis Roundtable
National Women's Law Center
Obesity Action Coalition
OCA
Project Inform
Racial and Ethnic Health Disparities Coalition
Raising Women's Voices for the Health Care We Need
Sargent Shriver National Center on Poverty Law
Single Stop USA
Society for Public Health Education
Southeast Asia Resource Action Center (SEARAC)
Stanford University School of Medicine
The Center for APA Women
The Leadership Conference on Civil and Human Rights
Tuskegee University College of Veterinary Medicine, Nursing & Allied Health
Voices for America's Children
Young Invincibles

State organizations

Arizona

Arizona Alliance for Community Health Centers
Asian Pacific Community in Action
Care 1st Health Plan AZ

Children's Action Alliance

Arkansas

Arkansas Advocates for Children and Families

Legal Aid of Arkansas

California

Alliance for a Better Community

American Cancer Society Cancer Action Network (ACS CAN), California

APAIT Health Center

Asian and Pacific Islanders California Action Network (APIsCAN)

Asian Law Alliance

Asian Pacific American Legal Center

Association for Chinese Families of the Disabled

California Church IMPACT

California Latinas for Reproductive Justice

California Pan-Ethnic Health Network

California Primary Care Association

Cal-Islanders Humanitarian Association

Center on Reproductive Rights and Justice at Berkeley Law

Central Valley Partnership for Citizenship

Children Now

Chinatown Child Development Center

Chinatown Service Center

COFEM

Community Health Councils

Earth Mama Healing, Inc.

InterpretAmerica

Korean Community Center of the East Bay

Korean Resource Center

Koreatown Youth & Community Center

Latino Coalition for a Healthy California

LIFETIME

LTSC Community Development Corporation

Madera Coalition for Community Justice

Mid-City Community Advocacy Network (Mid-City CAN)

Pacific Islander Cancer Survivors Network

Special Service for Groups

Street Level Health Project

Taulama for Tongans

Thai CDC

Vision y Compromiso

Colorado

Colorado Center on Law and Policy

District of Columbia

CARECEN

Centronia

Housing Works

La Clinica del Pueblo

Many Languages One Voice

Mary's Center

Multicultural Community Service

The Children's Partnership

The Women's Collective

Florida

Florida Legal Services

Georgia

Georgia Legal Services Program

Hawaii

CHOW Project

Hep Free Hawaii

Illinois

AIDS Foundation of Chicago

Campaign for Better Health Care

LAF (Formerly Legal Assistance Foundation of Metropolitan Chicago)

Iowa

Child and Family Policy Center

Mercy Medical Center

Kentucky

Kentucky Equal Justice Center

Kentucky Primary Care Association

Kentucky Youth Advocates

KentuckyOne Health

Louisiana

MQVN Community Development Corporation, Inc. (MQVN CDC)

Vietnamese American Young Leaders Association of New Orleans

Maine

Maine Equal Justice Partners

Maryland

Advocates for Children & Youth

Legal Aid Bureau, Inc.

Maryland Citizens' Health Initiative Education Fund
Maryland Women's Coalition for Health Care Reform
Public Justice Center
Viet Nam Medical Assistance Program

Massachusetts

Action for Boston Community Development
Asian Women for Health
Disability Policy Consortium
Health Care For All (Massachusetts)
Massachusetts Immigrant and Refugee Advocacy Coalition
Massachusetts Law Reform Institute

Michigan

Center for Civil Justice
Michigan Consumers for Healthcare
West Michigan Asian American Association, Inc

Minnesota

Immigrant Law Center of Minnesota
TakeAction Minnesota

New Jersey

Latino Action Network

New Mexico

Disability Rights New Mexico
HELP-New Mexico, INC
New Mexico Center on Law and Poverty
New Mexico Voices for Children
New Mexico Alliance for Retired Americans
NM Asian Family Center
Vision for Dignity, Access, and Accountability in Healthcare (VIDA)

New York

Coalition for Asian American Children & Families
Community Service Society of New York
Empire Justice Center
Health Care For All New York
HIV Law Project
Kalusugan Coalition, Inc.
New York Lawyers for the Public Interest
Project CHARGE

North Carolina

Action for Children NC

Legal Services of Southern Piedmont
MAXIMUS

Ohio

Akron Children's Hospital
Asian American Community Services
Asian Services In Action, Inc. (ASIA)
Contact Center
Easter Seals of Ohio
Legal Aid Society of Cleveland
Mercy Health
National Alliance on Mental Illness of Ohio
Nueva Luz Urban Resource Center
Ohio Job and Family Services Directors' Association
Ohio Poverty Law Center
Ohio Religious Coalition for Reproductive Choice
The Legal Aid Society of Columbus
UHCAN Ohio
Voices for Ohio's Children

Oregon

Asian Pacific American Network of Oregon (APANO)
Mosaic Medical
NCIHC
Oregon State Public Interest Research Group

Pennsylvania

ASIAC (AIDS Services in Asian Communities)
Benefits Data Trust
Centro Hispano Daniel Torres Inc.
Community Action Committee of the Lehigh Valley
Community Legal Services of Philadelphia
Hispanic Center of Reading
Jefferson Hospital
Jefferson School of Population Health
Nationalities Service Center
Pennsylvania Chapter Society for Public Health Education
Pennsylvania Health Law Project (PHLP)
Pennsylvania Immigration and Citizenship Coalition
Public Citizens for Children and Youth
SEAMAAC, Inc.
Thomas Jefferson University

Rhode Island

Rhode Island Free Clinic
The Economic Progress Institute

South Carolina

North Chapter of SOPHE

South Carolina Appleseed Legal Justice Center

Tennessee

Tennessee Justice Center

Texas

Center for Public Policy Priorities

Light and Salt Association

Seton Healthcare Family

South East Center for Agricultural Health & Injury Prevention

Univeristy Health System

Virginia

Virginia Consumer Voices

Washington

Children's Alliance

Doctors for America, Washington State branch

ElderCare Alliance

Health Care for All-Washington

Hopelink

International Community Health Services

Northwest Health Law Advocates

Occupy for Seattle's Healthcare for the 99% + 1%

Puget Sound Advocates for Retirement Action

Samoan National Nurses Association (SNNA)

SEIU Healthcare 1199NW

SEIU Local 925

Statewide Poverty Action Network

Washington CAN!

Washington State Coalition for Language Access

Washington State Hospital Association

Wisconsin

La Causa, Inc.

Wisconsin Alliance for Women's Health

Wisconsin Primary Health Care Association

Cc: Julie Bataille, Office of Communications
Ida Kelley, Office of Public Engagement
Gary Cohen, Center for Consumer Information and Insurance Oversight
Cynthia Mann, Center for Medicaid and CHIP Services

Cara James, CMS Office of Minority Health
Leon Rodriguez, HHS Office of Civil Rights
Nadine Gracia, HHS Office of Minority Health

EXHIBIT 2 to Huang Declaration

November 14, 2013

Dr. Howard K. Koh
Assistant Secretary for Health
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

VIA E-MAIL

Dear Dr. Koh:

On behalf of AIM for Equity, we write to thank you for meeting with us on September 11, and for your ongoing commitment to achieving health equity and improving the health of all communities. We appreciated the opportunity to discuss how our organizations can support your agency's efforts to ensure Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) enrollment in the Affordable Care Act and the critical role document translation plays in these efforts. To this end, this memo offers some concrete examples of where translated Asian language materials produced by the Centers for Medicare & Medicaid Services (CMS) have fallen short and provide recommendations for improving on current translation practices.

AAs and NHPIs are the fastest growing racial group in the United States with dozens of different cultures and languages. Approximately 71% of Asian Americans speak a language other than English at home and nearly 32% of Asian Americans are limited English proficient (LEP) and experience some difficulty communicating in English.¹

Language assistance services, including culturally competent translation, are necessary for individuals who are LEP to access federally funded programs and activities in the health care system. Without language assistance services that ensure meaningful access to the ACA's new insurance programs, discrete communities such as those with large numbers of individuals who are LEP will be systematically excluded from the ACA's opportunities to achieve better health.

Literal Translations

Due to the permanent nature inherent in translated materials, it is crucial that they not merely mirror the source language but rather reflect the core message while also capturing the cultural context, expressions and idioms of the target language. Straight word-to-word translations fail to account for cultural differences in perceptions of health,

¹ Asian Americans Advancing Justice | Los Angeles & Asian Americans Advancing Justice | AAJC (formerly Asian Pacific American Legal Center & Asian American Justice Center, Members of Asian American Center for Advancing Justice), *A Community of Contrasts Asian Americans in the United States: 2011*, at 25 (2011), available at http://www.advancingjustice.org/pdf/Community_of_Contrast.pdf.

wellness, illness, disease, and health care. In its own LEP guidance, HHS acknowledged that “[t]he permanent nature of written translations . . . imposes additional responsibility on the recipient to take reasonable steps to determine that the quality and accuracy of the translations permit meaningful access by LEP persons.”²

Unfortunately, the current version of many ACA-related documents fall far short of this quality standard. For example, the Tagalog version of “The Value of Health Insurance” posted on healthcare.gov uses the word “bawas gastos” for “deductible.” However, “Bawas gastos” actually means “reduction in cost” or “less expense.” This has resulted in a confusing and misleading translation because a “deductible” is the amount you pay – not really a reduction in cost.

Similarly, in the Vietnamese version, the term “Marketplace” is translated into “Thị trường bảo hiểm sức khỏe” which means “stock market for health insurance.” This translation has led some potential consumers to think that purchasing their health insurance from the marketplace is risky, and that there is a chance they may lose their coverage halfway through the year depending upon the economy.

Finally, in the Chinese language brochures, the selection of the term used to translate “Marketplace” leads people to believe that it is a physical supermarket where consumers would have to travel to in order to purchase plans.

We also recommend that HHS support the creation of a glossary of common ACA-related terms. This glossary should be accessible by federal, local and community-based entities to aid them in their translation efforts. Such a glossary will serve as a baseline for standardizing ACA-related enrollment terminology so that the word-to-word pitfalls described above can be avoided in the future.

Phonetic Translations

Word-for-word replacements may fail to capture the right context of the source material and often result in inaccurate and unnatural sounding text. An issue we are seeing with ACA-related materials is the making-up of words in the target language in order to match those used in English. This makes for a confusing and misleading translation that is often unhelpful. For example, in the Tagalog version of “The Value of Health Insurance” from the CMS website, words are made up for “outpatient” and “pharmacy.” The use of made up words such as “Autpeysiyent” and “parmasya”, neither of which is an actual Tagalog word, led one Filipino advocate to claim she was “ashamed” of the document. A translation is more than a word-for-word substitute. Translators must consider the broader cultural and topical context. Instead of making up words that sound like English words, it may be more accurate and helpful to simply leave the word in English.

² Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,317, 47313 (Aug. 8, 2003)

In the Korean version of “About the Health Insurance Marketplace,” the words “deductible,” “out of pocket expense,” “co-payment” and “co-insurance” are phonetically translated to sound like the English words without defining them conceptually. The same phonetic translations are used in the SHOP brochure. In contrast, the Korean brochure titled “Things to Think About When Choosing a Health Plan” explains in a parenthesis what “out of pocket” expense is conceptually translated, not just phonetically.

More Language Support and Uniformity Needed

Outreach, education, and enrollment materials used by the new Health Insurance Marketplace, QHPs, and other participating federally funded entities should be considered “vital documents” falling under the purview of Title VI of the Civil Rights Act and Section 1557 of the ACA. The single streamlined application, which provides the initial entry point to apply for health insurance and is a vital component of the ACA’s “no wrong door” approach to enrollment, certainly does qualify under even the most liberal definition of “vital” and we urge HHS to translate it into at least fifteen languages.³ Without translated applications, one out of four expected insurance marketplace applicants who speak a language other than English at home are at high risk of being left behind.

While we appreciate current efforts to create translated application “job aids” in 34 languages, we believe the single streamlined online and paper application must be operational as a form that can be completed by LEP consumers and processed by the agency. Since it is too late to translate the online applications for this enrollment period, at a minimum, paper applications should be translated with the eventual translation of the web portal into at least the most commonly spoken 15 languages. Where translations are delayed or unavailable, entities subject to the ACA should be required to include in-language “taglines” in at least 15 languages. These taglines should be included at the top of a notice or as a prominent insert in the same mailing, informing recipients that the notice is important and how they can obtain information about the document in their language. Similarly, if the single, streamlined application cannot be translated into all of the 15 languages, taglines should be provided on each page of the application with a number for applicants to call for assistance in completing the form.

If CMS is not able to provide translations in 15 languages, then we recommend CMS consider a regional, community-based approach to language needs taking into account indicators such as high LEP communities and high rates of uninsurance. CMS could work with groups like AIM for Equity or through OMH’s Regional Health Equity Councils to create a community-based approach that would target specific pockets of ethnic communities where high concentrations of LEP individuals are located. This more localized approach can help to fill in the translation gaps left by the top down federal approach, which is governed by thresholds and fails to account for real community need at the local level.

³ AIM for Equity has identified the following as high need languages: Ilocano, Bangla, Hmong, Tibetan, Burmese, Khmer, Nepali, Burmese, Karen, Tongan, Indonesian, Hawaiian and Samoan.

Additionally, we urge CMS to adopt a uniform approach to translating the number and types of documents. On healthcare.gov, some materials are translated into multiple languages, while others are translated in just a few of the listed languages. A uniform approach to translations will help ensure information is being provided in a consistent and reliable manner.

Design and Formatting

In addition to inconsistencies in the content of the translated materials, we noticed inconsistencies in the font and formatting of the publications. For example, the font and formatting looked different from one Korean brochure to another. Design standards are very important and when implemented well, can contribute greatly to the readability of the document and user uptake. These differences in font and formatting do not appear in the English versions of the materials, therefore a design review process should be put in place to ensure that translated publications are also scrutinized for such formatting errors.

Lack of Quality Control

Based on the issues raised and examples given above, there is great need for increased quality control of translated documents. An effective quality control process should involve multiple steps and multiple reviewers. We urge CMS to institute a third party quality review process with specific criteria and benchmarks to ensure high quality translations. This process should include close monitoring of translation contractors and the opportunity for an iterative process where adjustments in materials can be made when needed to ensure comprehensive, culturally competent language is used.

For example, the irregular use phonetic and conceptual translations in the Korean translations made one reviewer think that there were two translators for the Korean materials. In one publication, the concepts of some health insurance terms are explained parenthetically, while another Korean document did not explain the concepts and provided phonetic translations instead. Of course, we have no way of knowing how many Korean translators were used, but it's clear there was either no standard for translated materials or the standards were not uniformly applied.

In the Vietnamese version of “Things to Think About When Choosing a Plan” and “Things to Think About When Choosing a Plan for Your Business,” the first page of the brochures lists the categories of the metal plans in Vietnamese. However, on the second page, the plan names have been changed to their English equivalents. For example, the word “Bronze” is used on the second page, instead of its Vietnamese equivalent, which is “đồng.” This can be very confusing for readers who do not know that Bronze in English means đồng in Vietnamese.

CMS should also “field test” key translated documents to ensure the translations are accurate and culturally appropriate.

Conclusion

Thank you again for meeting with us and for your consideration of our recommendations. We look forward to working with you on this issue. For more information, contact Michael Byun, Asian Services in Action, mbyun@asiaohio.org, Zeenat Hasan, Health Through Action Arizona, Zeenat@apcaaz.org, or Priscilla Huang, Asian & Pacific Islander American Health Forum, phuang@apiahf.org.

Sincerely,

Channavy Chhay, Tana Lepule & Kathy Ko Chin
AIM for Equity Co-Chairs

CC: Dr. Nadine Gracia, Deputy Assistance Secretary for Minority Health and
Director, Office of Minority Health
Mayra Alvarez, Associate Director, Office of Minority Health
Cara James, Director, Office of Minority Health, CMS
Julie Bataille, Director, Office of Communications, CMS/CCIIO
Ida Kelley, Director, Partner Relations Group, Office of Communications,
CMS/CCIIO
Juliet Choi, Chief of Staff, Office of Civil Rights
Kiran Ahuja, Executive Director, White House Initiative on Asian Americans and
Pacific Islanders

EXHIBIT 3 to Huang Declaration



Improving the Road to ACA Coverage: **POLICY RECOMMENDATIONS FOR ENROLLMENT SUCCESS**

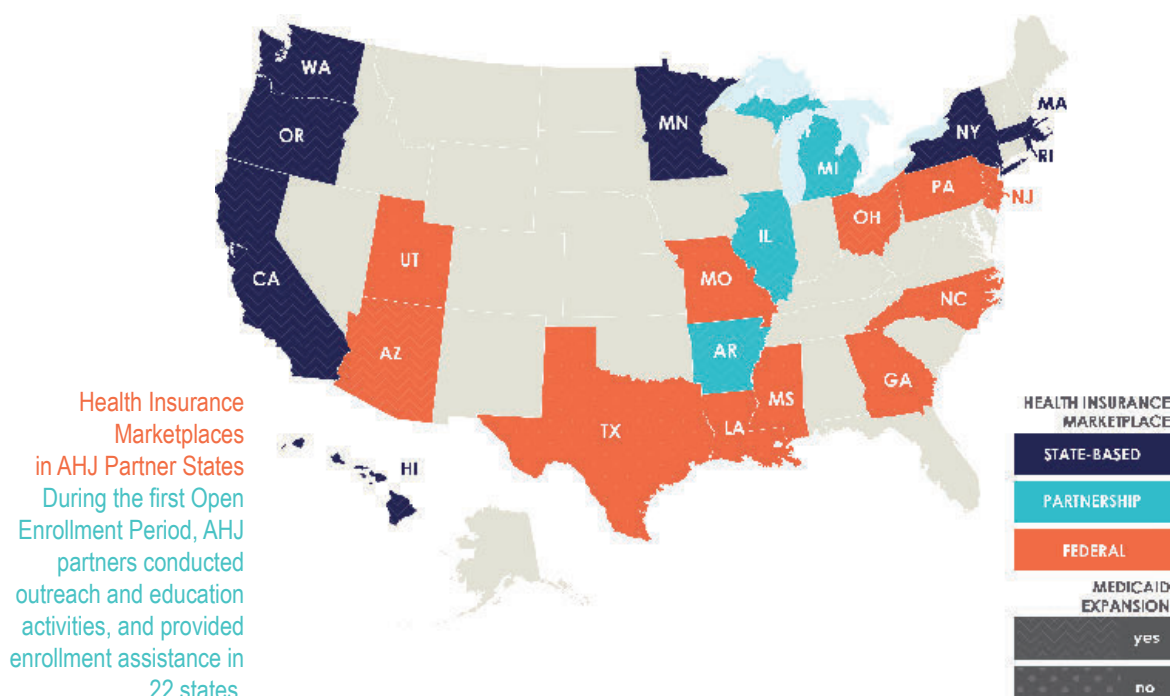
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
Asian Americans Advancing Justice | AAJC
Asian Americans Advancing Justice | Los Angeles

Published: July 2014
Revised: September 2014

INTRODUCTION

2

The Patient Protection and Affordable Care Act (ACA) presents a historic opportunity to provide affordable, quality health insurance and coverage to millions of uninsured and underinsured Americans. Many organizations and collaboratives, including Action for Health Justice, have been actively involved in implementing the ACA across the country. This brief highlights some of the major barriers Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities faced during the first Open Enrollment Period, followed by recommendations to build upon and improve outreach, education, and enrollment efforts in the future.

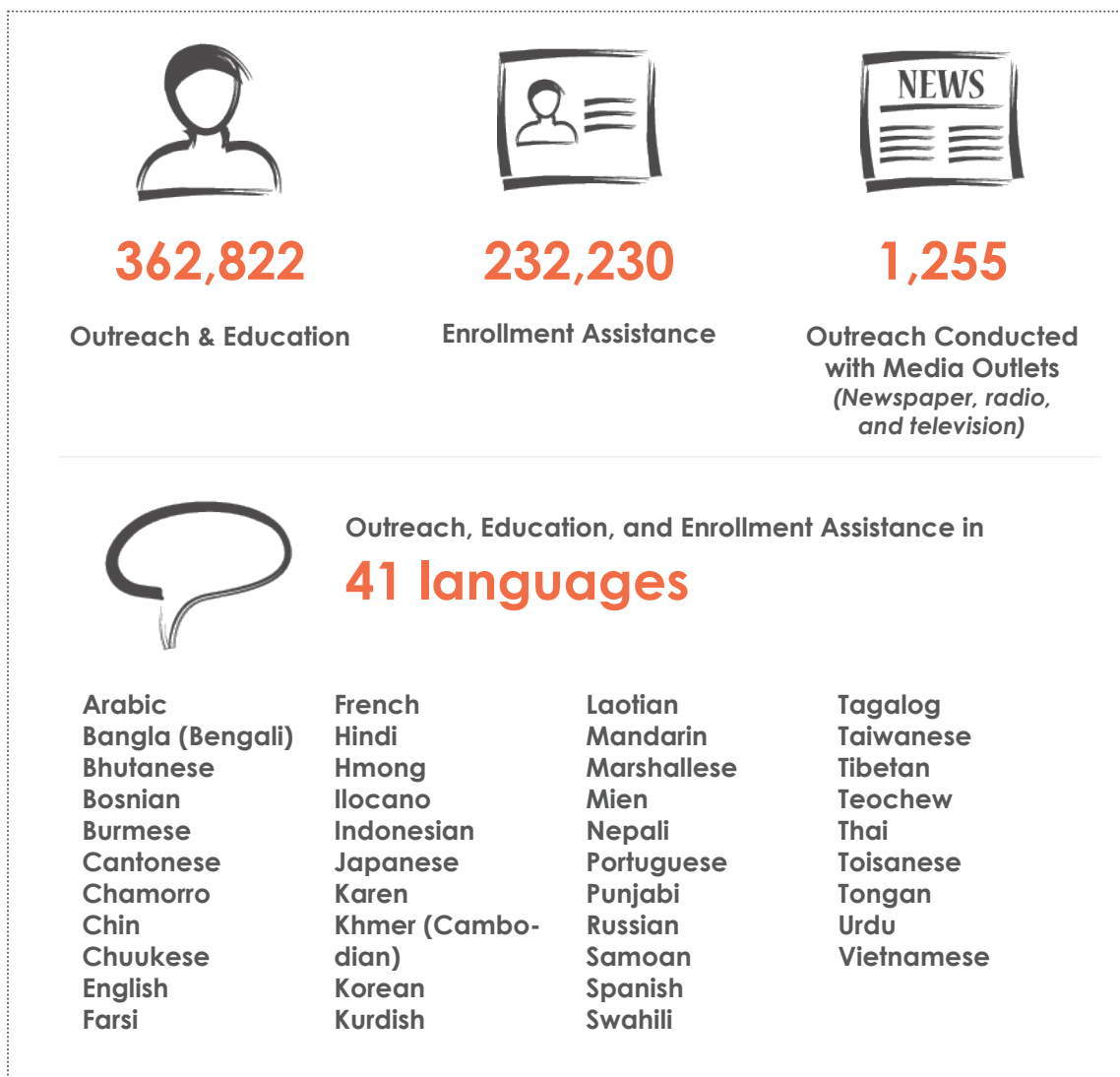


ACTION FOR HEALTH JUSTICE

Action for Health Justice (AHJ) is a network of organizations established in July 2013 to reach and educate Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPIs) about their health insurance coverage options under the ACA, and to maximize enrollment in the Federally-facilitated Marketplace (FFM), state partnership marketplaces, state-based marketplaces, and Medicaid. AHJ focuses on hard-to-reach AA and NHPI communities, particularly individuals who are low-income, limited-English proficient (LEP), or in mixed immigration status families, as well as small business owners and employees and young adults. AHJ builds the capacity of local, state, and national organizations to serve, advocate for, and engage with AA and NHPI communities and improve their health.

AHJ consists of four national organizations (Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice | AAJC, and Asian Americans Advancing Justice | Los Angeles), and more than 70 Asian American, Native Hawaiian and Pacific Islander national and local community-based organizations and Federally Qualified Health Centers dedicated to educating, empowering, and enrolling AAs and NHPIs in health coverage. ZeroDivide serves as the initiative's technology counsel.

Impact of AHJ Partners in the First Open Enrollment Period



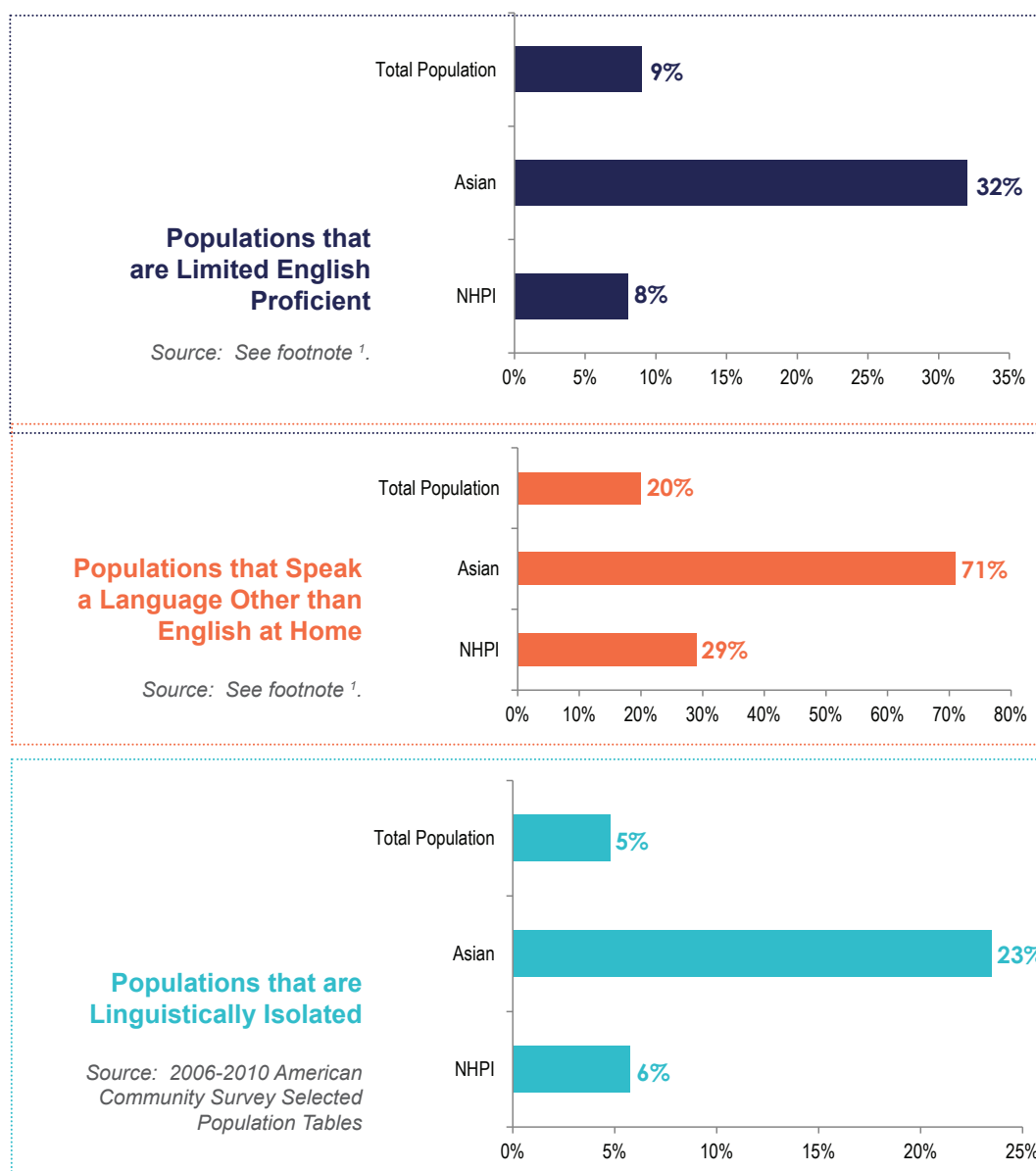
BARRIERS AND CHALLENGES TO ACCESSING AND PROVIDING INFORMATION AND ENROLLMENT SERVICES

During the first Open Enrollment Period, AHJ identified major barriers that significantly hindered the enrollment of AA and NHPI consumers in the marketplaces. Systems put in place to assist and enroll consumers fell short of servicing consumers that had limited English language proficiency, low levels of health literacy, and immigration-related verification challenges. The demographic profile of AAs and NHPIs shows why providing language assistance services and culturally and linguistically appropriate materials should be a top priority for policymakers.

Sixty percent of Asian Americans and fourteen percent of Pacific Islanders are foreign-born, representing a range of immigration statuses.¹ Thirty-two percent of AAs are limited English

¹ Asian Americans Advancing Justice (formerly Asian American Center for Advancing Justice), A Community of Contrasts: Asian Americans in the United States: 2011, at 17, available at <http://www.advancingjustice.org/sites/default/files/CoC%20National%202011.pdf>.

proficient,² meaning they do not speak English as their primary language and have a limited ability to read, write, speak or understand English.³ Twenty-nine percent of NHPIs speak a language other than English at home. Twenty-three percent of Asian American households are linguistically isolated, meaning all household members 14 years old and older speak English less than “very well.”⁴



² Id. at 27. As used here in the context of Census data, “limited English proficient” describes a person who speaks English less than “very well.” See U.S. Census Bureau, About Language Use (2013), <https://www.census.gov/hhes/socdemo/language/about/index.html>.

³ U.S. Dep’t of Health and Human Servs., Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311, at 47,313 (Aug. 8, 2003) [hereinafter HHS LEP Guidance].

⁴ Asian Americans Advancing Justice, *supra* note 1, at 29.



Limited English Proficiency

State and federal agencies provided insufficient language assistance, including inadequate interpreting services by call centers and limited translated resources for LEP consumers. The lack of adequate language assistance led to increased consumer confusion and deterrence from enrolling in the marketplaces and/or Medicaid altogether. Translated materials were not easy to read, required a high level of literacy, and used literal and phonetic translations which made concepts more confusing for consumers. In most states, posters, fact sheets, websites, government presentations, and budgets for media engagement targeting English-speakers were not similarly provided for immigrant and LEP communities. Online application portals were not available in any Asian, Native Hawaiian, or Pacific Islander languages. This required community-based organizations and Federally Qualified Health Centers to fill in the gaps by translating and/or correcting existing marketplace materials and creating their own materials, often without financial support. In-person assisters also spent additional time helping LEP consumers because there were no translated applications, it was difficult to understand English applications, and consumers were discouraged from submitting paper applications (even in the handful of states where translated applications were available).



Low Health Literacy⁵

LEP consumers and immigrants needed tools to understand health insurance terminology. AHJ partners reported that LEP and immigrant consumers knew very little about key insurance concepts such as deductibles, premiums, and co-payments. They often returned to AHJ partners for additional assistance and expressed frustration at being unable to find culturally and linguistically accessible providers and the inability to access out-of-network specialty care services.



Immigration-Related Concerns

Concerns about the potential impact of enrollment on immigration status delayed and deterred enrollment for many immigrants. Lawfully present immigrants mistakenly believed that applying for coverage would have an adverse affect on their ability to adjust their immigration status in the future. This belief is understandable given the rise of the anti-immigration sentiment in some parts of the country and existing policies that make immigrant participation in some government-operated public programs (though not participation in the marketplaces or Medicaid) subject to a “public charge” determination. Mixed immigration status families, where at least one family member has a different immigration status from another family member, were particularly fearful and confused.⁶ As a result,

⁵ The Institute of Medicine (IOM) defines health literacy as “the product of the interaction between individuals’ capacities and the health literacy-related demands and complexities of the health care system. Specifically the ability to understand, evaluate, and use numbers is important to making informed health care choices.” Inst. of Med., *Health Literacy and Numeracy: Workshop Summary*, at 1 (The Nat’l Academies Press 2014), available at http://www.nap.edu/openbook.php?record_id=18660&page=1.

⁶ There are about 1 million undocumented immigrants from Asia residing in the United States. Asian Americans Advancing Justice, *supra* note 1, at 22.

undocumented head-of-households often did not apply for coverage for other eligible immigrant or U.S. citizen family members due to fear of deportation.⁷

When eligible immigrants applied for marketplace coverage, they encountered multiple hurdles throughout the enrollment process including difficulties with identity proofing, verification of immigration and citizenship status, and calculating income and household size. As a result, many immigrant consumers were not able to complete the enrollment process or have been stuck in limbo for months waiting for their cases to be resolved.



Lack of Disaggregated Data

Without adequate collection and reporting of disaggregated race, ethnicity, and primary oral and written language data for the extraordinarily diverse AA and NHPI population, it will be extremely difficult to develop targeted efforts to address gaps in outreach, education, and enrollment efforts. Clear data is needed to track the effectiveness of outreach, education, enrollment, and utilization activities of hard-to-reach groups. For example, preliminary disaggregated data from the Covered California marketplace confirmed that some sub-groups within AA and NHPI communities such as Cambodians, Hmong, and Pacific Islanders are underrepresented within the marketplace's enrollee population.

⁷ A memo was issued by the U.S. Office of Immigration and Customs Enforcement clarifying that the information from the application would not be shared and no immigration proceedings would be triggered when applying for health coverage through the Marketplace. However, the clarification information did not reach many mixed status families due to lack of in-language outreach. Even those who were aware of this memo continued to be fearful of deportation and many chose not to apply for coverage through the marketplaces. U.S. Immigration and Customs Enforcement, Clarification of Existing Practices Related to Certain Health Care Information (Oct. 25, 2013), available at <http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf>.

RECOMMENDATIONS

Based on the experiences of community partners across the country, AHJ proposes several recommendations to address the barriers and challenges that AAs and NHPs faced and improve the enrollment process going forward.

Improve Training for Call Center Operators, Interpreters, Navigators, and Other Enrollment Assistants to Better Serve LEP Consumers and Immigrants

Individuals who provide outreach, education, or enrollment assistance services need additional training to understand the needs of LEP consumers and immigrants.

- Call center operators should undergo cultural and linguistic competency training. This includes training on the following: (1) identifying the language needs of LEP callers; (2) treating LEP callers with dignity and respect; and (3) connecting with and working with third party telephonic interpreters. Many LEP consumers and their assistants experienced problems and delays when trying to access interpreting services through the federal and state call centers.
- Call center operators should be trained to have a thorough understanding of the following topics: (1) immigrant eligibility rules for health plans in the marketplaces and Medicaid; (2) required immigrant documentation for enrollment; and (3) verification processes and workarounds to complete enrollment. Alternatively, call centers should hire technical assistance advisors who can help operators on these matters.
- Third party interpreters who provide their services through the call centers should receive training on basic information about the marketplaces, health insurance terminology, and other commonly encountered topics so they can accurately interpret the context and content of the information to consumers. Consumers often received incorrect interpretations and varying quality of service from interpreters.
- Trainings for Navigators, Certified Application Counselors, and other officially designated marketplace assistants for consumers (collectively, “Assistants”) should include information on cultural and linguistic competency issues, including how to work with LEP consumers.⁸ Assistants should be required to work together within a state or region to connect consumers with in-person assistance in their preferred language. The marketplaces should facilitate these collaborations and information sharing by creating in-language locator tools that list the language capacity of all Assistant entities. Assistants should also receive training to help them understand the intricacies of verifying immigration status, identity, and income for immigrants.

IMPROVE TRAINING

- Train call center operators to better assist LEP consumers and immigrants.
- Train interpreters to better understand marketplace concepts.

⁸ These recommendations supplement existing requirements for Navigators to “[r]eceive ongoing education and training in culturally and linguistically appropriate service delivery.” 45 C.F.R. § 155.215(c)(5).

Create More Useful Translated Resources and In-Language Tools

Assisters working with LEP populations need adequate in-language educational and enrollment materials to help consumers learn about coverage options and enroll. Materials should explain concepts in plain language,⁹ at the appropriate literacy level, be accurately translated, and avoid literal and phonetic translations.

- The Centers for Medicare & Medicaid Services (CMS) and state-based marketplace administrators should create readable and accurate in-language educational and enrollment materials for publication on federal and state marketplace websites, preferably at a fifth grade level of education, using visual aids such as videos and alternatives to written materials. CMS and state administrators should also work with community partners to review materials for accuracy and readability.
- CMS and state administrators should translate marketplace websites, online applications, and paper applications to allow LEP consumers to enroll either online or by mail.
- Consumers should be permitted to upload completed paper applications through the websites for submission instead of requiring applications to be mailed in.

TRANSLATE RESOURCES

- Make in-language materials more accurate and understandable for consumers.
- Translate websites, online applications, and paper applications into multiple languages.

Make Call Centers More Accessible to LEP Consumers and Assisters

Federal and state call center functions and features should be changed to improve effectiveness and efficiency for LEP consumers.

- Call centers should offer prompts in multiple languages and allow for automatic transfer to the appropriate language. For example, when a consumer contacts a call center, there could be in-language messages, such as “For Korean, press 1” which would directly connect callers to a Korean bilingual representative or signal an operator to connect with a Korean interpreter. This will save time and resources both for consumers and the call center. For the Federally-facilitated Marketplace, these prompts could be in the 12 most widely spoken languages of the uninsured across the country. For State-based marketplaces, the prompts can be offered in the Medicaid identified languages or at least the five most widely spoken languages of the uninsured in that state.

⁹ Already, CMS requires the marketplaces to provide information to applicants and enrollees in plain language. 45 C.F.R. § 155.205(c) (2013) (“Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely”); cf. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 1311(e)(3)(B) (2010) (requiring Qualified Health Plans to make information available in plain language to the public and defining plain language as “language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing”).

- Call centers should hire and train more bilingual staff who can speak directly with callers and utilize dedicated language lines. Bilingual language ability should be made a priority for hiring purposes, especially for the most common languages in each marketplace.
- Call centers should implement a “tiered structure” where certain call center representatives receive additional, more complex training on certain issues. If representatives are unable to answer questions from consumers, they can refer them to these issue specialists, who will have more training on complex topics such as immigrant eligibility.
- CMS should also include a dedicated service line for Assisters to answer questions without requiring them to go through the regular federal call center. For example, California and New York created dedicated Assister lines which helped dissipate call center volume and wait times for Assisters and subsequently for consumers as well.

IMPROVE CALL CENTER SERVICES

- Offer prompts in multiple languages.
- Hire bilingual staff and issue specialists.

Create Additional Funding Opportunities to Support In-Person Assistance

Assisters who provide in-person education and enrollment services need adequate funding to account for the additional time needed to help LEP and immigrant consumers. During the first Open Enrollment Period, consumers needed several visits of one to two hours per visit (or sometimes longer) with Assisters to learn about insurance, explain the application process, explain required documentation and personal information requests, guide them through the enrollment process, and select a health plan. Moreover, many Assisters in both federal and state marketplaces (other than Navigators) did not receive any public funding during the first Open Enrollment Period despite conducting vigorous outreach, education, and enrollment services.

- State and federal governments should allocate and increase funding and resources for in-person assistance entities. Many immigrants and LEP consumers preferred using face-to-face services from trusted organizations to learn about their options.

IMPROVE FUNDING OPPORTUNITIES FOR IN-PERSON ASSISTANCE

- Prioritize funding for community organizations that have experience working with LEP, immigrant, and hard-to-reach populations.

- State and federal governments should prioritize funding opportunities for small community-based organizations that have experience working with hard-to-reach and underrepresented populations and can provide culturally and linguistically appropriate services. Assistants must be adequately compensated and need sufficient funding to help them in these efforts.¹⁰

Improve the Enrollment Experience for Immigrants

Many immigrants had difficulties enrolling in marketplace coverage or were unable to enroll because of complicated, inefficient, and unclear policies and procedures that uniquely affected eligible immigrants.

- CMS should continue to work with the U.S. Department of Homeland Security (DHS) to issue clarifying guidance to address enrollment fears and assure eligible immigrants and their families that it is safe to apply for marketplace coverage. U.S. Immigration and Customs Enforcement provided this type of assurance in a memo issued on October 25, 2013, reinforcing existing federal policy regarding the use of personal information.¹¹ DHS should provide similar assurances and public education campaigns to address public charge fears and other information to clarify uncertainties and confusion about the potential immigration consequences of receiving health coverage from the marketplaces or Medicaid.
- CMS and state agencies overseeing state-based marketplaces should engage trusted sources, such as immigrant-serving Assistants and community organizations, to conduct a review of marketplace websites and associated technical issues related to the enrollment process. Website fixes should be in place well before November 15, 2014 to ensure a smooth enrollment process for immigrants.
- CMS should relax the identity proofing requirements to allow persons without established credit histories to proceed with online applications. While we commend CMS for expanding the list of acceptable documents, the process for providing proof of identity is flawed and must be improved for immigrant consumers. If using a credit agency to verify identity, CMS and states should require the credit agency to provide adequate in-language assistance.

¹⁰ At the time of publication, the Office of Minority Health issued a grant opportunity of \$2.7 million for community organizations to “assist and educate minority populations about [Marketplace] and coverage opportunities made possible by the Affordable Care Act.” Office of Minority Health, U.S. Dep’t of Health and Human Servs., 2014 Grants: Partnerships to Increase Coverage in Communities Initiative, <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=1#sthash.4RMBhV6L.dpuf> (last accessed June 17, 2014). Additionally, on June 10, 2014, HHS announced a funding opportunity totaling \$60 million for Navigators in the federally-facilitated and state partnership marketplace with an anticipated award date of September 8, 2014. Press Release, Centers for Medicare & Medicaid Servs., CMS Announces Opportunity to Apply for Navigator Grants in Federally-facilitated and State Partnership Marketplaces, (June 10, 2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-06-10.html>. In comparison to Navigator grants issued for the 2013 to 2014 period, HHS indicated this new grant will place a larger emphasis on community organizations that are connected to targeted populations..

¹¹ U.S. Immigration and Customs Enforcement, Clarification of Existing Practices Related to Certain Health Care Information (Oct. 25, 2013), available at <http://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf>.

- CMS should create a tracking system that allows consumers and Assisters to easily track the status of pending applications and verification checks. This system should also allow consumers and Assisters to submit summaries of applicants' situations to ensure critical information and application histories are accurately conveyed to call center operators and CMS case workers.

IMPROVE THE ENROLLMENT EXPERIENCE FOR IMMIGRANTS

- Ensure identity and immigration status processes on marketplace websites are functional by November 15, 2014.
- Relax identity proofing requirements.
- Create accessible tracking system for pending applications.

Monitor and Enforce Nondiscrimination Laws

The marketplaces must comply with several nondiscrimination laws and standards including Title VI of the Civil Rights Act of 1964, Executive Order 13166, and Section 1557 of the ACA.¹² The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) is charged with monitoring and enforcing these laws to ensure that LEP consumers are not excluded from participation in the benefits of the ACA and have meaningful access to the marketplaces and Medicaid.

- OCR, in conjunction with CMS, should monitor how federal and state marketplaces, Navigators and Assisters are providing public education, outreach activities, and enrollment services that are culturally and linguistically targeted at LEP groups.
- Based on the systemic issues identified in this brief and information HHS has gleaned from meetings with community advocates, OCR should initiate a compliance review of the marketplaces, particularly in states where there are suspected violations. For example, by examining uninsured and enrollment data, precipitous drops in enrollment or sustained uninsured rates of consumers from certain racial, ethnic, or language groups in a service area may indicate that there are barriers to enrollment that OCR should investigate. Where language access plans do not already exist, OCR should work with entities overseeing the marketplaces to develop them. If violations are identified, OCR should provide technical assistance to these entities on developing compliance measures to address cultural and linguistic barriers faced by consumers.¹³

¹² Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin, which includes immigration status and language proficiency. Executive Order 13166 further clarifies that recipients of federal funding, which here includes the marketplaces and their affiliated services, to ensure meaningful access for LEP individuals to federally funded programs and activities. Section 1557 of the ACA applies Title VI and other nondiscrimination laws to the Marketplace and programs established by the ACA.

¹³ See Office for Civil Rights, U.S. Dep't of Health & Human Servs., Case Resolution Manual for Civil Rights Investigations 80 (2009), <http://www.hhs.gov/ocr/civilrights/complaints/crm2009.pdf> (explaining OCR's authority to conduct compliance reviews and their objectives).

- HHS should clarify its standards for language assistance services related to consumer access to the marketplaces and Medicaid. Clarifying standards are needed to establish detail on literacy levels, thresholds for translation of written information, languages in which “taglines” (informing individuals how to access marketplace-related services) are provided on websites and other materials, and other access issues that have been identified by stakeholders in public comment responses to the agency’s marketplace regulations.
- HHS should finalize the definition of “limited English proficient” used in marketplace guidance.¹⁴ AHJ recommends adopting the definition used by the U.S. Census Bureau and HHS LEP Guidance, which describes “limited English proficient” individuals as those who speak English less than “very well”¹⁵ and “individuals who do not speak or read English very well and who have a limited ability to read, write, speak or understand English.”¹⁶
- HHS should expeditiously promulgate regulations on the interpretation and enforcement mechanisms of Section 1557, the ACA’s nondiscrimination provision which prohibits discrimination on the basis of race, color, national origin, and other protected categories.

MONITOR AND ENFORCE NONDISCRIMINATION LAWS

- Assess the provision of marketplace services for LEP consumers.
- Clarify standards and definitions for language assistance services in the marketplace and Medicaid.
- Promulgate regulations for Section 1557 of the ACA.

Implement Strategies to Address Health Literacy

LEP consumers need appropriate health literacy tools to navigate the complexities of the healthcare system and insurance plans.

- State and federal agencies should work with health plans participating in the marketplace to require that they develop culturally relevant and linguistically appropriate patient and consumer materials, including satisfaction surveys that account for different health literacy levels.
- The marketplace should be required to develop culturally relevant and linguistically appropriate health literacy tools, such as cost-benefit comparison charts of the most common plans.

¹⁴ 77 Fed. Reg. 18,310, at 18,314 (“In the final rule, we do not adopt a definition for the phrase ‘limited English proficient.’ We anticipate issuing future guidance that will interpret this term and will provide best practices and advice related to meaningful access standards for limited English proficient individuals.”).

¹⁵ See U.S. Census Bureau, *supra* note 1.

¹⁶ See HHS LEP Guidance, *supra* note 3.

- CMS should support and promote the development of health risks assessment tools designed to help consumers of varying health literacy levels understand their health risks, needed health services, and recommended health care utilization patterns.
- States should ensure that translated health literacy tools are available to help consumers select appropriate health insurance plans and obtain culturally and linguistically competent health care services.

INCREASE CONSUMER HEALTH LITERACY

- Issue consumer materials and satisfaction surveys at appropriate health literacy levels.
- Develop cost benefit comparison charts of health plans, health risk assessments, and other health literacy tools at appropriate literacy levels and in different languages.

CONCLUSION

Despite the challenges many AA and NHPI consumers faced during the initial Open Enrollment Period, including learning about the health insurance options provided through the ACA and enrolling in coverage, AHJ partners worked together to successfully assist the enrollment of AA and NHPI consumers. Through the creation of culturally and linguistically appropriate materials, direct in-person assistance to consumers, and shared strategies for enrolling AAs and NHPIs, AHJ partners were able to work in local and state-based collaboratives to overcome some language, immigration, and health literacy barriers. Full implementation of AHJ's recommendations will ensure that many more AAs and NHPIs can enroll in coverage to get the care they need, and achieve the true success of health care reform for all communities.

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Educate, Enroll, and Empower Asian Americans, Native Hawaiians, and Pacific Islanders

EXHIBIT 2: Quinones Declaration

DECLARATION OF LUVIA QUIÑONES

I, Luvia Quiñones, make the following declaration based on my personal knowledge and declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I work for the Illinois Coalition for Immigrant and Refugee Rights (“ICIRR”), as a Health Policy Director. In partnership with its coalition members, ICIRR is dedicated to promoting the rights of immigrants and refugees to full and equal participation in the civil, cultural, social, and political life of the United States. Our coalition is composed of other community-based organizations who work with a variety of immigrant communities advancing and protecting their rights, including access to health care. ICIRR started working on health insurance enrollment under the passage of the Affordable Care Act (“ACA”) since the beginning of open enrollment in October 2013.

2. During open enrollment, I provided multiple trainings to ACA enrollment assisters and ACA in-person counselors (“IPCs”), including periodic updates on the health insurance marketplace process. These trainings provided assisters with information related to available resources and upcoming webinars. I also did a lot of work correcting misinformation about ACA policies, which included misinformation about who was eligible for ACA including eligibility based on various immigration statuses as well as who had to pay the penalty based on his/her immigration status.

3. ICIRR conducts trainings for assisters and for some of our member organizations, which began conducting ACA outreach activities to immigrant communities and eventually turned to actual enrollment assistance for these communities. ICIRR members assisted many consumers with their applications online, by paper, and over the phone. Although the specific enrollment funding ICIRR received expired in July 2014, some of ICIRR's members have been able to continue helping consumers with enrollment issues beyond July.

4. Since October 2013 to the present day, I am aware that ICIRR member organizations have assisted approximately 11,500 heads of household with their applications for health care coverage through the federal health care marketplace, www.healthcare.gov, under the ACA. Approximately 7,000 of them were able to enroll successfully. A substantial number of the households ICIRR member organizations assisted had immigrant members, sometimes including naturalized citizens.

5. There were a lot of problems with the healthcare.gov website. From feedback I received from our coalition partners, almost everyone ICIRR member organizations assisted in enrollment had trouble with the online enrollment system. Before April 2014, it is fair to say that the system did not work more often than it worked. Finally, in April, the system worked about half the time, which remained incredibly frustrating for applicants and those attempting to help them. For example, the upload function for clients to submit documentation didn't always work. In addition, the consumer often could not even get to the point where they were asked to submit

documents because they were stopped in the process before then by technical problems, such as with error screens. A lot of our clients had to apply over the phone because the online system just wasn't working, which took more time and distracted from our other work. One client had 8 separate appointments, beginning in October 2013 and that extended over several months, because he encountered every single barrier, including issues with identity verification, getting a "yellow screen" when they uploaded documents, and the upload button not working at all."

6. Most, if not all, of the clients that ICIRR members assisted with ACA enrollment spoke languages other than English. Generally, helping clients in languages other than English was very difficult. The Marketplace didn't let assisters translate for their clients until January 2014. This would cause delays in our ability to help clients because approved interpreters were not always available, especially before January 2014. For example, there was always a problem finding interpreters who could translate in Chinese, as a result of this difficulty there were some Chinese speakers we were unable to serve.

7. Many of the ICIRR clients have received inconsistency notices from the federal government indicating that there is a mismatch in information regarding their immigration or citizenship status information. A majority of these inconsistency notices were in a language the consumer could understand. Even clients who indicated that they preferred Spanish didn't always get a notice in Spanish. When a client received a notice in a language they couldn't understand, the client would make an appointment with a

navigator to understand what it said. I am concerned that some of our clients who received notices in a language they didn't understand may not have known that they needed to take further action in order to keep their health care coverage

8. In most cases where clients received these inconsistency notices, IPCs had worked with clients from the very beginning to try to get them enrolled in coverage through the Marketplace and knew when someone was having trouble with an inconsistency. I was usually contacted only when an IPC had an issue with these inconsistency notices that they couldn't resolve alone. I would try to provide guidance to these IPCs but oftentimes there was just nothing that we could do when a client had one of these technical problems, such as errors with uploading of documents.

9. During the first open enrollment, our 37 community organizations who were IPCs, dealt with a lot of enrollment issues including difficulty in uploading documents. Due to these issues, I can assume that each inconsistency case had different factual details, but one common fact was that each of these consumers had previously tried to submit documents of their immigration and citizenship status since the first time they were notified of a potential inconsistency. Clients tried to submit their documents when they first applied for coverage, but they didn't receive a confirmation that the documents had been received or processed, and most didn't hear back from the Marketplace at all for months until they received an inconsistency notice. Those that were notified of an inconsistency after open enrollment ended tried to re-submit their documents in April 2014. Clients tried to submit documents as many as 3 to 4 times to

resolve these inconsistencies over a period of less than 1 month. Near the end, consumers we spoke to were so incredibly frustrated with the system that they didn't want to keep sending their personal information over and over again if they would simply get another inconsistency notice thereafter. They were worried about where their personal information was going, if not to the Marketplace, since the documents they submitted seemed to have no impact on what the Marketplace was asking them for. Some consumers had previously provided the requested documents 2 to 4 times, by both uploading and mailing them in.

10. The clients we worked with were also confused about whether they were submitting their documents properly. One reason was because there wasn't any guidance on how clients were supposed to submit documents. For example, there was no cover page for submitting copies of documents, and the upload function on the website didn't work. Clients who had already submitted documents multiple times began to worry that they were somehow submitting them incorrectly. In August, we began recommending to assisters that all documents be sent through certified mail so that individuals would have some proof that it was sent.

11. I am aware that some of the assisters would call the call center on behalf of their clients when they received an inconsistency notice and then submitted additional documents, but I don't think it was very helpful because the call center would not provide much information on the current status of the inconsistency or whether the documents had been received. It seemed like the list that the call center had on unresolved

inconsistencies wasn't updated as often as it needed to be and that there was a substantial delay in documents being recorded, since navigators would help clients with submitting documents and wouldn't get confirmation from the call center even days later.

12. I am greatly concerned that many of our clients didn't understand that they may face health care coverage termination if they did not continue to re-submit documents they had previously provided in an effort to resolve their inconsistency. They didn't understand the difference between "you have not submitted documents" and "you may lose your coverage," so they didn't realize that they could lose their coverage by not submitting documents yet again.

13. As someone working on ACA enrollment, I feel that there were also mixed messages coming from the HHS about what would happen to individuals with these inconsistencies. On more than one occasion, in informal conversations, I have heard HHS officials acknowledge that a lot of these individuals with inconsistencies had already sent in documents, indicating that they knew that the system was not processing documents appropriately. However, officially, HHS would say that they hadn't received anything at all from these individuals.

14. Our clients also didn't understand that they might be at risk of having to re-pay the tax subsidies that they received or that they might be eligible for a special enrollment period if they did lose their coverage.

15. The individuals who have continued to come back to ask for help in resolving inconsistencies, even after they've tried to submit documents over and over again to address the issue, are those who are more likely to have medical issues. These are the individuals who have an immediate need for coverage and are incredibly fearful of even a temporary loss in coverage and the impact that might have on their health. A lot of our clients are elderly or disabled, and unlike in Medicaid, there is no fast-track for ACA coverage. If these individuals lose their subsidies, they won't be able to afford the health insurance they need. And, considering the length of time that they had coverage, if they are asked to repay that the tax subsidy it would be a lot to repay.

Executed this 29th day of September 2014 at Chicago, Illinois.

/s/ Luvia Quiñones

Luvia Quiñones

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EXHIBIT 3: Jones Declaration

DECLARATION OF AMY JONES

I, Amy Jones, make the following declaration based on my personal knowledge and declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. I work for the Southeast Asian Mutual Assistance Associations Coalition (“SEAMAAC”) in Philadelphia, Pennsylvania, as the Director of Health and Social Services. SEAMAAC was founded in 1984 by refugees from Southeast Asia to “to support immigrants, refugees, and their families as they seek access to opportunities, which would advance the condition of their lives in the United States.” SEAMAAC has assisted immigrant and refugee families to apply for health insurance and public benefits programs since our founding.

2. SEAMAAC started working on Affordable Care Act (“ACA”) Marketplace health insurance enrollment in 2013, with grant support from the Asian & Pacific Islander American Health Forum (“APIAHF”). SEAMAAC recognized the ACA as a turning point for adults in our Asian & Pacific Islander (“API”) communities who were not previously eligible for affordable health insurance. SEAMAAC also recognized that the Limited English Proficient (“LEP”) communities we serve would face tremendous barriers to understanding the ACA and enrolling in health insurance.

3. For the majority of SEAMAAC’s clients, English is not their primary language, and they need interpreters in order to understand the health care application process. SEAMAAC has staff members who provide in-language outreach, education,

and enrollment assistance in Vietnamese, Mandarin, Nepali, Laotian, Thai, Hmong, Burmese, Chin, and Karen. We rely on telephonic interpretation or trained Certified Application Counselor (“CAC”) volunteers to provide this assistance in Indonesian, Khmer, and other languages that come to our office. We advocate for marketplace insurance providers to hire bilingual staff or to utilize their own telephonic interpretation accounts.

4. SEAMAAC initiated its ACA health care work by conducting a community needs assessment in Philadelphia, Pennsylvania, over the summer of 2013. We conducted five focus groups in seven languages (Vietnamese, Lao, Mandarin, Burmese, Karen, Nepali, and Indonesian) with 75 Asian American community members in Philadelphia. Participants were asked about their knowledge of the ACA and how to best promote knowledge of the ACA within their communities. Participants were also given the opportunity to ask any clarifying questions they might have regarding the ACA. We then began creating outreach and education materials based on these focus group results, and conducting outreach activities to immigrant communities.

5. SEAMAAC became a CAC organization in 2013, which means that SEAMAAC can help to enroll consumers into health care coverage under the ACA health care marketplace. Since then, SEAMAAC has trained staff and bilingual volunteers to be individual CACs. SEAMAAC also allowed “navigators” and other “assisters,” who are available to help consumers understand and enroll in health care coverage through the

health insurance marketplace, to hold office hours at our offices in order to increase the support for LEP Asian Americans to enroll in health care.

6. During the first health care open enrollment period from October 1, 2013, through March 31, 2014, SEAMAAC helped approximately 450 heads of household navigate through the enrollment process. About 150 of them were able to enroll in health care coverage through the federal health care marketplace successfully. We assisted many consumers with their applications online, by paper, and over the phone. Since the end of the first open enrollment period, we have conducted follow-up activities, including helping families with the payment of their health insurance premiums, helping them get connected to a primary care physician, and helping them to understand their insurance.

7. There were a lot of glitches with the ACA online application process. At different points in time over the first open enrollment period, the way you were able to get through the application process changed—sometimes you were able to put in Alien Numbers or “A numbers” (indicating immigration status), other times you could not. The upload feature sometimes worked and sometimes it did not. Different tricks worked at different times. Sometimes you would have to skip parts of the application in order to submit it, because if you tried to fill out certain portions of the application it would not let you proceed any further. Some days the online system was down, so we helped people enroll through the marketplace call center help line and then sent in supporting eligibility documents by mail. On rare occasions during the first few weeks of open enrollment, we helped people submit applications and supporting documents by mail. We later helped

most of these people to apply again by phone or online because they did not hear back about the results of their paper applications in a timely fashion. We waited to hear about these applications for about a month after the documents were submitted before deciding to help clients reapply using the phone or the website.

8. Since August 12, 2014, approximately 25 consumers have contacted us about receiving an inconsistency notice based on inability to verify their immigration or citizenship status. This number is troubling because on August 10, 2014, Pennsylvania had approximately 12,600 applicants who have been identified by the federal government as having an unresolved immigration status or citizenship inconsistency issue. Because these notices are only sent out in English and Spanish, many of those consumers might need the support of our bilingual staff to understand and address the notice because they cannot speak English or Spanish. Based on our experience assisting individuals in enrolling in the ACA, SEAMAAC believes many of those Pennsylvania consumers received an inconsistency notice in a language they could not read.

9. Moreover, the taglines at the end of the English notices that we have seen are insufficient for LEP individuals. These taglines provide a number to call for more information but do not state in any way that the individual is at risk of losing their health insurance coverage if they do not call. The taglines do not even indicate that there is a potential problem with their health insurance eligibility. Additionally, the taglines are not in many of the languages of the clients we serve, including Lao, Burmese, Karen, Nepali, and Indonesian.

10. Most of the consumers who have come in to our offices asking about the inconsistency notice they received have said that they already submitted the documents that are being requested to solve the inconsistency and prove their immigration or citizenship status. We helped them to re-submit these documents in an effort to maintain their health care coverage.

11. For example, one consumer's immigration status changed from refugee to lawful permanent resident ("LPR" or green card holder) recently. He first sent in his I-94 document, which is a federal immigration form showing that he has a refugee admission stamp, during open enrollment and then later submitted his green card when his status changed. He received an inconsistency notice in August 2014 and submitted a copy of his green card by mail, hoping that would solve the problem. As of late September, he has not received confirmation of receipt from the marketplace. He has also not received a cancellation notice. Due to his busy work schedule, he has opted not to take time off to get assistance from SEAMAAC staff to call the marketplace helpline to check on the status of his documents. He is assuming that everything is fine because he still has health insurance.

12. The inconsistency notices sent by the federal government are only being sent out in English and Spanish. This is not helpful for many of the individuals we serve who speak who speak neither English nor Spanish. We are concerned that such individuals have no way to understand that they are at risk of being terminated from health care coverage. We created a letter about these inconsistency notices and translated

it into Chinese, Vietnamese, and Nepali to send to families that we have not been able to reach by telephone. We also created a flyer to get the word out to the general community to understand the urgency of looking in their mail for these notices. This flyer was translated into Chinese, Vietnamese, Nepali, Indonesian, Karen-Burmese and Chin-Burmese. We created general versions of these flyers and letters to share with our local and national partners (see copies attached as Exhibit 1). We hope partners can use these templates to get the word out to the communities they serve and translate them into additional languages.

13. The letter and flyer took about two hours to create with help from Community Legal Services of Philadelphia and APIAHF. It then took five staff three hours each to translate the letter and flyer. It took at least sixteen hours each for seven staff members to conduct community and media outreach about the inconsistency notices, and at least eight hours a week from August through September for three administrative staff to become more educated about the notices, design a response to support our clients with the notices, teach and supervise staff about outreach and individual support on the notices, encourage community leaders and partner organizations to outreach about the issue, and field mainstream and ethnic media and advocacy requests regarding the notices. Staff spent additional time helping clients who came in with notices to understand the notices and address the clients' concerns. Had the U.S. Department of Health and Human Services ("HHS") produced materials in the languages needed by our clients, we would not have had to spend time doing so, and would not have been forced

to take time away from our core program work. That time could have been better spent on planning and implementing leadership development workshops, holding workshops on community domestic violence, conducting civic outreach and engagement, and supporting individual clients with workforce development activities such as enrollment in English as a Second Language (“ESL”) classes and Basic Adult Education, and assisting clients with job search and employment applications..

14. If the client is an existing client for SEAMAAC who we had helped in the past for other programs before the ACA, we are allowed to keep notes in their case record, including their health insurance application and login information. Based on CMS CAC training guidance, however, CACs are not permitted to maintain personally identifiable information (“PII”) of consumers not enrolled in existing programs. It is the policy of SEAMAAC to hold confidential all communications, observations, and information made by and between or about clients (adults and children) and staff, volunteers, and student interns. The names, identifying information, and personal information, of program participants are not to be disclosed except with the explicit written permission of the individual involved. Clients’ phone numbers and addresses frequently change, creating challenges to tracking them down about a potential inconsistency problem.

15. In order to assist a client with an ACA issue like an inconsistency notice, we typically have to start by calling the call center to obtain the client’s account number and log in information. Many clients who come to us don’t know their account number,

and can't log in to their account because of password issues. Passwords were reset for everyone back in April by the health insurance marketplace because of the nation-wide computer bug. Many of our clients are also largely unfamiliar with computer technology and often not very computer literate. Many people struggle to remember their log-in information, as well as the answers to new security questions. If we don't have that information, because of privacy concerns, we must call the call center.

16. The last time we were with a client who called the call center with this problem of not remembering their account number and log-in information, the call center told the client that to get the account number and login, the client would need to go back to whoever assisted him in the first place. The call center staff said it couldn't help without that information. The client tried to explain that that was precisely why he was calling—because the assister could not keep that information on file according to ACA rules. The SEAMAAC assister had to get on the line and explain that SEAMAAC cannot keep that information. In the end, we were finally able to find out the client's account number through the call center. But the call center representative still could not verify that the documents that the client had submitted in an effort to resolve his immigration or citizenship inconsistency had been received.

17. On average our clients have submitted immigration and income information two to three times by mail. Generally, they submit the documents at the same time or shortly after they submit their application. Even after submitting documents verifying

their immigration status or citizenship, some of our clients have still received inconsistency notices, and have had to submit the documents once or twice more.

18. The clients who received immigration or citizenship status inconsistency notices did not understand that they had to take action in order to avoid losing their coverage until they talked to someone who speaks English, understood the ACA, and could explain the inconsistency notice to them. Many of these individuals only came to SEAMAAC's offices for help because they received our flyers in their language.

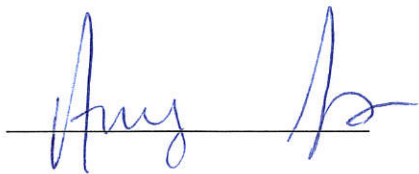
19. The inconsistency notices that I have read do not contain information about the possibility of obtaining a special enrollment period ("SEP") to re-apply for health coverage under the marketplace if your health coverage is terminated due to an immigration or citizenship inconsistency. Many of our clients are confused because the notices say they may lose their health insurance coverage, but the call center staff tells them they don't have to worry about losing coverage.

20. For the majority of SEAMAAC's clients who came in with inconsistency notices, losing their health insurance or having to re-pay the advance premium tax credits would be especially burdensome. The vast majority of our clients are low-income and cannot afford health insurance without the government subsidy.

21. Because we have had to help our clients resolve the inconsistency issues with their health care applications, and because the notices many of our clients received were not in a language they can read, we have been spending many hours helping them to

understand the inconsistencies and to submit or re-submit their documents, and have had less time to focus on our funded program activities such as planning and implementing leadership development workshops, holding community domestic violence workshops, conducting civic engagement outreach, and supporting individual clients with workforce development activities and assistance with job search and employment applications.

Executed this 29th day of September 2014, at Philadelphia, Pennsylvania.



Amy Jones
1711 S Broad St.
Philadelphia, PA 19148
Phone: 215-467-0690
Email: ajones@seamaac.org

EXHIBIT 1 to Jones Declaration


Did you get Obamacare this year?

Did you send your immigration and citizenship documents to the Marketplace?

Some people were enrolled in health insurance, but the Marketplace never got their documents.

These people are receiving a notice in the mail that looks like this:

SSN ROP notice

Health Insurance Marketplace

DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name Suffix (FNLNS) of primary contact]
[Address]

[Notice date]

Application date: []
Application ID: [insert ID number]

Act by September 5, 2014 or Your Marketplace Health Insurance May End

We have contacted you several times about an issue with your Marketplace application, because some data you gave us doesn't match our records. We want to help you resolve these issues so that you can stay covered in the Marketplace. On your application, you told us that a person (or persons) included on the application is a U.S. citizen, U.S. national, or has eligible immigration status. We asked you to send documents to prove that the following individual(s) is a U.S. citizen, U.S. national, or has eligible immigration status:

[FNLNS of each individual who has a Citizenship or Immigration inconsistency]

We know that most people with these data matching issues want to keep their Marketplace health insurance and are working hard to submit their documents. **You are getting this notice because we haven't received any response from you or any copies of the documents we requested.** If you think that is wrong and you've tried to submit documents before, it's still important for you to act immediately so that we can help you stay covered in the Marketplace.

Don't lose your Marketplace health coverage
Because we still don't have the documents we need to verify information on your application, the individual(s) named above is at risk of losing Marketplace health insurance, along with any premium tax credits and help with cost-sharing. Upload the needed document(s) to your account at HealthCare.gov or send it to the Marketplace **no later than September 5, 2014**. Unless you submit the required documents now, you'll get an official notice in September letting you know the date that Marketplace coverage will end for those listed above. After that date, they won't have Marketplace health insurance.

What should I do next?
1. Look at the attached list of documents and make a copy of any you have. It's possible that you need to provide more than one document.

2. There are two ways to send documents to the Marketplace:

Look in your mail to see if you got this notice!

If you get this notice, you must send in your immigration and citizenship documents to the Marketplace by September 5, 2014!

If you get this notice and do not send in your documents, you will lose your health insurance, lose your tax credit, and have to repay the tax credits you already received!

Need help? Call _____ at _____ or come to our office
Monday-Friday 9am-4pm at _____


你今年有奥巴马医保了吗？

你是否已经把你的移民公民 ID 寄给 Marketplace（医保申请部门）了呢？

有一些人已经成功注册获得医保，但是 Marketplace(医保申请部门)从未收到他们的证件。

有一些人收到一封像这样的通知信：

SSN ROP notice

 Health Insurance Marketplace

DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name Suffix (FNLNS) of primary contact]
[Address]

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What should I do next?

1. Look at the attached list of documents and make a copy of any you have. It's possible that you need to provide more than one document.
2. There are two ways to send documents to the Marketplace:

请查看你的信箱里有没有这样的通知信！

如果你拿到这样的通知信，你必须在 2014 年 9 月 5 日之前，把你的有效身份证件 ID 寄回 Marketplace（医保申请部门）！

如果你收到了这封通知信，但是没有寄回你的身份证件，你将会失去医疗保险，政府补助的保险金也会失效，并且您还要把政府已补助的保险金返还。

我需要帮助？请拨打_____，或者在周一至周五 9 点-4 点来到_____获得相关帮助。


Bạn đã có bảo hiểm Obamacare năm nay?

Bạn đã gửi các bằng chứng về quốc tịch và tình trạng di trú của bạn cho Marketplace chưa?

Một số người đã đăng ký bảo hiểm sức khỏe, nhưng Marketplace chưa nhận được giấy tờ chứng minh của họ.

Những người này sẽ nhận được một thông báo qua thư mà trông giống như thế này.

SSN ROP notice



DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name Suffix (FNLNS) of primary contact]
[Address]

[Notice date]

Application date: []
Application ID: [insert ID number]

Act by September 5, 2014 or Your Marketplace Health Insurance May End

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[FNLNS of each individual who has a Citizenship or Immigration inconsistency]

We know that most people with these data matching issues want to keep their Marketplace health insurance and are working hard to submit their documents. **You are getting this notice because we haven't received any response from you or any copies of the documents we requested.** If you think that is wrong and you've tried to submit documents before, it's still important for you to act immediately so that we can help you stay covered in the Marketplace.

Don't lose your Marketplace health coverage

Because we still don't have the documents we need to verify information on your application, the individual(s) named above is at risk of losing Marketplace health insurance, along with any premium tax credits and help with cost-sharing. Upload the needed document(s) to your account at HealthCare.gov or send it to the Marketplace **no later than September 5, 2014**. Unless you submit the required documents now, you'll get an official notice in September letting you know the date that Marketplace coverage will end for those listed above. After that date, they won't have Marketplace health insurance.

What should I do next?

1. Look at the attached list of documents and make a copy of any you have. It's possible that you need to provide more than one document.
2. There are two ways to send documents to the Marketplace:

Kiểm tra thư từ của bạn nếu nhận được một thông báo như thế này!..

Nếu bạn nhận được thông báo này, bạn phải gửi ngay các bằng chứng về quốc tịch và tình trạng di trú của bạn cho Marketplace trước ngày 5 tháng 9, 2014!

Nếu bạn đã nhận thông báo này mà không gửi những giấy tờ chứng minh của bạn, bạn sẽ mất bảo hiểm y tế của bạn, mất khoản khấu trừ thuế của bạn, và phải trả lại khoản khấu trừ thuế mà bạn đã nhận được!

Cần giúp đỡ? Xin gọi _____ tại _____ hoặc đến văn phòng của chúng tôi Thứ hai đến Thứ sáu từ 9:00 sáng đến 4:00 giờ chiều tại _____.

के तपाईंले यो वर्ष ओबामाकेयरको स्वस्थ बिमा लिनु भयो?


तपाईंले आफ्नो ग्रिनकार्ड या नागरिकताको प्रमाणपत्र पठाउनु भयो?

कोही मानिसहरुले ओबामाकेयरको स्वस्थ बिमा किनेका छन् तर उनीहरुको ग्रिन कार्ड या नागरिकताको प्रमाणपत्र

ओबामा केयरमा पुगेको छैन

उनिहरुले तल भएको जस्तो चिठी पाएको हुन सक्छ।

SSN ROP notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name Suffix (FNLNS) of primary contact]
[Address]

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यदि तपाईंले यो चिठी पाउनु भएको छ भने तपाईंको प्रमाणपत्र सेप्टेम्बर 5 तारिक भित्र ओबामा केयरमा पठाउनु पर्छ

यदि तपाईंले यो चिठी पाउनु भएको छ र प्रमाण पत्र पठाउनु भएको छैन भने तपाईंले स्वस्थ बिमा गुमाउनु हुनेछ, Tax credit गुमाउनु हुनेछ र तपाईंको स्वस्थ बिमा तर्फ गएको tax credit फिर्ता गर्नु पर्ने छ

सहयोगका लागि _____ मा _____ मा फोन गर्नुहोस या हाम्रो कार्यालयमा आउनु होस्

सोमबार - सुक्रबार बिहान ९ बजे देखि बेलुका ४ बजे सम्म

Karen


Tu kum chungah Obamacare na tuah maw?

Na catlap a bia mi pawl cu Cozah zungah na kuat dih cang hna maw?

Mi cheukhat cu an min cazin an I khumh hna, na tein a biapi mi an catlap pawl cu an kuat rih hna lo.

Min cazin khumh mi hna nihcun hi bantuak cakuat hi ngah ding a si :

SSN ROP notice

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465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name Suffix (FNLNS) of primary contact]
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What should I do next?
1. Look at the attached list of documents and make a copy of any you have. It's possible that you need to provide more than one document.

2. There are two ways to send documents to the Marketplace:

A cunglei ih ca he a lo mi cakuat na ngah sihcun!

Hi bantuak cakuat na ngah sihcun, September 5, 2014! ni hlah ah phungning tein umnak nawl na ngeinak a biapi mi catlap hna cu cozah zungah kuat dih ding a si.

Hi a cunglei cakuat na ngah ko nan na kuat than lo sihcun, ngandamnakh caih na tuah mi(health insurance) cu na sungh lai, tax credit zong na sungh lai, na ngah cia mi tax credits khan na chamthan a herh te lai!

Bawmh hal khawh? Phone ko ngah- _____at _____ le zung ah ra (Nikhat-Ni nga ni) zinglei 9am- zanlei 4pm ah _____.

EXHIBIT 4: Announcement of Termination Notice

Press release: Federal Health Insurance Marketplace: Send in Requested Documents Now to Keep Marketplace Coverage

Date

2014-08-12

Title

Federal Health Insurance Marketplace: Send in Requested Documents Now to Keep Marketplace Coverage

For Immediate Release

Tuesday, August 12, 2014

Contact

press@cms.hhs.gov

Federal Health Insurance Marketplace: Send in Requested Documents Now to Keep Marketplace Coverage

Administration has closed approximately 450,000 citizenship and immigration status data matching cases and another 210,000 are in progress; warns remaining consumers to respond quickly or their Marketplace coverage could end

The Federal Health Insurance Marketplace began sending notices this week to consumers with a citizenship or immigration data matching issue (also called an inconsistency) who have not responded to previous notices via mail, email, and phone. While the Federal Marketplace has already received documents and cleared a large number of data inconsistencies related to citizenship or immigration status, consumers who have not yet responded must act now and submit supporting documents by September 5 or their Marketplace coverage will end on September 30.

A citizenship or immigration data matching issue can happen when the information reported in a consumer's application, such as a Social Security or Permanent Resident Card number, is incomplete or different than the information the government has on file. A data inconsistency does not necessarily mean there is a problem with an individual's eligibility for enrollment; it means that additional information is needed to verify the information provided in an application. However, if these supporting documents are not received, health insurance plans will be terminated in order to ensure program integrity and protect taxpayer dollars.

"The Affordable Care Act is working to make quality health care more affordable and accessible for families. Over the last several weeks, the Marketplace has reminded affected enrollees in the Federally-facilitated Marketplace via mail, email, and phone to send in their supporting documents so they can keep their Marketplace coverage, and insurance companies have reached

out directly to these customers as well,” said CMS Administrator Marilyn Tavenner. “The good news is that many have responded — we’ve closed about 450,000 of these cases and have an additional 210,000 cases in progress. However, some still have not responded. We want as many consumers as possible to remain enrolled in Marketplace coverage, so we are giving these individuals a last chance to submit their documents before their coverage through the Marketplace will end.”

We have worked hard to reach each consumer with a data matching issue multiple times. Specifically, the Marketplace has asked consumers five to seven times — via mail, phone and email — to submit their information. These Federal Marketplace and issuer outreach efforts have produced results. In May, we had roughly 970,000 people with citizenship or immigration data-matching errors. Since then, we’ve closed about 450,000 of these cases and have an additional 210,000 cases in progress. We continue to receive up to 60,000 documents a day.

Today, we sent out letters to the approximately 310,000 consumers with citizenship or immigration data matching errors who have not responded asking them to submit their documentation. These notices remind them that in order to keep their coverage they have to submit the outstanding documents by September 5th. If they do not, their Marketplace coverage will end by September 30th.

Consumers whose information are currently being processed or have been verified will not receive these notices. Consumers who have outstanding income verification issues will hear from the Marketplace at a later date. In addition, States that are running their own Marketplaces are reconciling any data matching issues separately – as such, only enrollees who have not submitted any necessary citizenship or immigration documents to the Federally-facilitated Marketplace will receive these notices.

Notices are being sent in English and Spanish and provide straightforward instructions on how to submit the necessary information and keep their coverage. Those receiving this letter should log into their [HealthCare.gov](https://www.healthcare.gov) account and select their current application to upload their documents. They can also mail their information to our London, KY address. To ensure timely processing, consumers mailing in a copy of their documents should include the bar code page from our notice with their documents. Consumers may also contact our call center at 1-800-318-2596 to see what documents they need to submit and see whether the Marketplace has received their information.

We will continue our outreach to these individuals with two more calls and one more email ask about citizenship and immigration documents before the September 5 deadline. Those who do not respond will receive a final notice in September informing them that their last day of Marketplace coverage will be September 30. In addition, a network of partners, local assistors and other stakeholders including community health centers have been activated in order to help to get the word out and make sure consumers keep their coverage. Consumers may contact one of our partners in their community to get one-on-one help. To find one of these local partners, visit [Find Local Help](#) on HealthCare.gov.

“Since this is an urgent matter, we are activating our networks on the ground to reach people directly in the communities where they live. Whether it is online, via our call center, or with one of our local partners, consumers will have a number of ways to find the help they need to continue their coverage,” said Tavenner.

For more helpful tips and the steps these consumers need to take, visit
<https://www.healthcare.gov/blog/still-need-to-send-documents/>

For the number of letters going out by state in the federally facilitated Marketplace visit:
<http://www.hhs.gov/healthcare/facts/factsheets/2014/08/data-matching-map.pdf>

###

EXHIBIT 5: Termination Notice



DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

[First name Last name Suffix (FNLNS) of primary contact]

[Address]

[Notice date]

Application date: []

Application ID: [insert ID number]

Act by September 5, 2014 or Your Marketplace Health Insurance May End

We have contacted you several times about an issue with your Marketplace application, because some data you gave us doesn't match our records. We want to help you resolve these issues so that you can stay covered in the Marketplace. On your application, you told us that a person (or persons) included on the application is a U.S. citizen, U.S. national, or has eligible immigration status. We asked you to send documents to prove that the following individual(s) is a U.S. citizen, U.S. national, or has eligible immigration status:

[FNLNS of each individual who has a Citizenship or Immigration inconsistency]

We know that most people with these data matching issues want to keep their Marketplace health insurance and are working hard to submit their documents. **You are getting this notice because we haven't received any response from you or any copies of the documents we requested.** If you think that is wrong and you've tried to submit documents before, it's still important for you to act immediately so that we can help you stay covered in the Marketplace.

Don't lose your Marketplace health coverage

Because we still don't have the documents we need to verify information on your application, the individual(s) named above is at risk of losing Marketplace health insurance, along with any premium tax credits and help with cost-sharing. Upload the needed document(s) to your account at HealthCare.gov or send it to the Marketplace **no later than September 5, 2014**. Unless you submit the required documents now, you'll get an official notice in September letting you know the date that Marketplace coverage will end for those listed above. After that date, they won't have Marketplace health insurance.

What should I do next?

1. Look at the attached list of documents and make a copy of any you have. It's possible that you need to provide more than one document.
2. There are two ways to send documents to the Marketplace:

- a. The fastest option is to **upload documents online**. Log in to your Marketplace account on HealthCare.gov by clicking on “Log in” at the top of the page. Once you’re logged in, select your current application and then use the menu on the left side of your screen to click on Application Details. On the next screen, you’ll see a list of any data matching issues (called “inconsistencies” on the screen) in your application. Follow the steps for each inconsistency (data matching issue) to upload the documents needed to fix the issue. If your application has more than one inconsistency or more than one person has inconsistencies, work through the steps to upload documents for each one. Note: Please don’t use the following characters in the name of the file that you upload: / \ : * ? “ < > | .

OR

- b. **Mail a copy** of the documents to the address below as proof that the individual(s) listed above is either a U.S. citizen, a U.S. national, or has an eligible immigration status. You should keep the original documents.
IMPORTANT: Include the bar code page from the end of this letter together with your documents. This helps the Marketplace match your documents to the correct application.

Where to send your documents

Send a copy of the documents to:

Health Insurance Marketplace
Attn: Supporting Documentation
465 Industrial Blvd.
London, KY 40750

If you have questions or need to find someone who can help you in person, we are here to help. Call the Marketplace Call Center at **1-800-318-2596** and tell them you got a data matching warning notice. TTY users should call 1-855-889-4325. The call is free.

Continuing coverage outside of the Marketplace

If your Marketplace health insurance ends and you still want health coverage, contact your insurance company directly to see what options may be available. Keep in mind that if your Marketplace health insurance ends, you won’t get the benefits you may have been receiving from the Marketplace, such as premium tax credits or help with cost-sharing.

If you receive an official notice ending your coverage, you can ask for an appeal

If you receive another official notice stating the date that your Marketplace coverage will end and you think we made a mistake, you can appeal that decision about your eligibility for health coverage. Information about how to appeal will be included in the official notice of your coverage ending.

Sincerely,

Health Insurance Marketplace
Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

Privacy Disclosure: The Health Insurance Marketplace protects the privacy and security of the personally identifiable information (PII) that you have provided (see <https://www.healthcare.gov/privacy/>). This notice was generated by the Marketplace based on 45 CFR 155.230. The PII used to create this notice was collected on the application you filled out and from other data sources through the electronic eligibility verification process used to get an eligibility determination for enrollment in a qualified health plan through the Marketplace and for insurance affordability programs. For more information about the privacy and security of your PII, visit [HealthCare.gov](https://www.healthcare.gov).

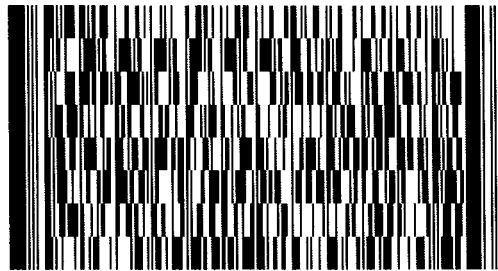
The Marketplace may have used data from a consumer reporting agency to determine eligibility for the individuals on your application. If you have questions about this data, please contact the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1207.

IMPORTANT!

Mail this bar code page
in the same envelope
with your documents.

This page helps the Marketplace match your documents to the correct application.



[State code], Application ID

Send the Marketplace:

1. A copy of the requested documents proving that the following individual(s) is a U.S. citizen, U.S. national, or has eligible immigration status:
[FNLNS of each individual who has a Citizenship/Immigration Status inconsistency)]
2. THIS PAGE.

Getting Help in a Language Other than English

If you, or someone you're helping, has questions about the Health Insurance Marketplace, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-318-2596.

Here's a listing of the available languages and the same message provided above in those languages:

العربية (Arabic)

لك الحق في الحصول على المساعدة والمعلومات في اللغة الخاصة بك مجاناً. وللتحدث مع مترجم في اللغة العربية حول سوق التأمين الصحي، يرجى الاتصال على 1-800-318-2596.

中文 (Chinese)

你有權利免費用您的語言獲得幫助和資訊。要用中文與傳譯員探討健康保險市場，請致電 1-800-318-2596。

Français (French)

Vous avez le droit d'obtenir de l'aide et des renseignements dans votre langue sans aucun coût. Pour consulter un interprète en français quant au Marché d'assurance santé, composez le 1-800-318-2596.

Kreyòl (French Creole)

Ou gen tout dwa pou resevwa èd ak enfòmasyon nan lang ou pou gratis. Pou pale avèk yon entèpretè an Kreyòl konsènan Mache Asirans Medikal (Health Insurance Marketplace), rele 1-800-318-2596.

Deutsch (German)

Sie haben das Recht, Hilfe und Informationen kostenlos in Ihrer eigenen Sprache in Anspruch zu nehmen. Um mit einem Dolmetscher für die deutsche Sprache über den „Health Insurance Marketplace“ zu sprechen, rufen Sie bitte diese Nummer an: 1-800-318-2596.

ગુજરાતી (Gujarati)

તમને વિના મૂલ્યે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. આરોગ્ય વીમા વ્યાપારબજાર વિશે દુભાષિયા સાથે ગુજરાતીમાં વાતચીત કરવા, કૉલ કરો 1-800-318-2596

हिन्दी (Hindi)

आपके पास अपनी भाषा में सहायता व सूचना निःशुल्क प्राप्त करने का अधिकार है। हेल्थ इंश्योरेंस मार्केटप्लेस (स्वास्थ्य बीमा बाजारस्थल) के बारे में हिन्दी में दुभाषिए से बात करने के लिए 1-800-318-2596 पर फ़ोन करें।

한국어 (Korean)

귀하는 귀하의 언어로 도움과 정보를 무료로 받을 수 있는 권리가 있습니다. 한국어로 건강 보험 시장(Health Insurance Marketplace)에 대하여 통역사에게 이야기하려면, 1-800-318-2596 번으로 전화하십시오.

Polski (Polish)

Każdy ma prawo uzyskać bezpłatnie pomoc i informacje we własnym języku. Aby porozmawiać z tłumaczem po polsku na temat Rynku Ubezpieczeń Zdrowotnych (Health, Insurance Marketplace), należy zadzwonić pod numer 1-800-318-2596.

Português (Portuguese)

Você tem o direito de obter ajuda e informação em seu idioma e sem nenhum custo adicional. Para falar com um intérprete de [Português] sobre o Mercado de Seguros de Saúde, ligue para 1-800-318-2596.

Русский (Russian)

Вы имеете право бесплатно получить помощь и информацию на родном языке. Чтобы поговорить с переводчиком на русском о платформе Health Insurance Marketplace (рынок медицинского страхования), позвоните по телефону 1-800-318-2596.

Español (Spanish)

Usted tiene el derecho a recibir ayuda e información en su idioma sin costo alguno. Para comunicarse con un intérprete en español relacionado con el Mercado de seguros médicos, llame al 1-800-318-2596.

Tagalog (Tagalog)

Mayroon kang karapatan makakuha ng tulong at impormasyon sa iyong wika na walang gastos. Upang makipag-usap sa isang tagapagsalin sa Tagalog tungkol sa Health Insurance Marketplace, tumawag sa 1-800-318-2596.

اردو (Urdu)

آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ بیلٹھ انشورنس مارکیٹ پلیس کے بارے میں کسی مترجم سے اردو میں بات کرنے کے لئے 1-800-318-2596 پر رابطہ کریں۔

tiếng Việt (Vietnamese)

Quý vị có quyền nhận sự giúp đỡ và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên bằng tiếng Việt về Thị Trường Bảo Hiểm Sức Khỏe, xin gọi số 1-800-318-2596.



June 2013

EXHIBIT 6: Letter to Burwell

July 31, 2014

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

As organizations that have worked hard to ensure the efforts of the Department of Health and Human Services (HHS) to fully implement the Affordable Care Act are successful, the undersigned organizations look forward to working with you to ensure all eligible immigrant families are able to successfully enroll in affordable health coverage. We commend the Department's efforts to promote enrollment and address the problems encountered by immigrant and mixed-immigration status families, and we are encouraged by your commitment to improving the application process.

However, we would like to bring to your attention serious barriers that continue to keep an untold number of eligible immigrant families from obtaining coverage. There is still time to resolve some serious problems lingering from the Federally-facilitated Marketplace's first open enrollment period, such as individuals stuck in the inconsistency process and incorrect eligibility determinations for immigrants under 100% FPL. We describe these problems and recommended solutions to them below. The remaining problems identified below—identity verification barriers, immigration status verification problems, and language access barriers—are also of great concern as the next open enrollment period is fast approaching. We hope you will act expeditiously to remove these barriers so eligible families may obtain coverage, as is required under the law.

Individuals Stuck in the Inconsistency or Data Matching Process

Currently, there are more than one million applications of immigrant families in the inconsistency process due to problems verifying citizenship or immigration status. HHS has begun sending notices to these individuals, in English only, warning that they have thirty days to submit documentation or they will no longer receive the subsidies that make their insurance affordable. Without these subsidies, it is highly unlikely that these individuals will be able to keep their coverage. Therefore, potentially more than a million eligible individuals in immigrant families may lose their subsidies, and as a result, lose their coverage, because they failed to respond to an additional request.

A significant percentage of families receiving these notices are limited English proficient and read, write and speak a language other than English or Spanish. We fear that these families have not received adequate notice in a language they can understand about the status of their application or the supporting documentation needed to resolve their inconsistency. Also, many of

these individuals have already mailed in or uploaded additional documents and are less likely to resubmit copies of their documents.

HHS should allow these individuals to keep their subsidies and their coverage until HHS has fully fixed the system errors in both the immigration status verification system; the programming of eligibility for subsidies for lawfully present individuals under 100% FPL; and is able to provide adequate, language appropriate notices about the additional information needed to process their application. It is unacceptable for individuals to lose their subsidies, and become unable to afford coverage because of mistakes, technical errors, and language access problems.

Incorrect Eligibility Determinations for Immigrants Under 100% Federal Poverty Level

Many lawfully present immigrants with income under 100 percent of the federal poverty level (FPL), who are ineligible for Medicaid based on their immigration status, have experienced additional barriers to marketplace coverage. These individuals are eligible for premium tax credits even though their income is below the poverty level. However, system errors continue to lead many of these individuals to receive inaccurate eligibility determinations. They are either denied the premium tax credits and cost-sharing reductions that make insurance affordable, or are referred to Medicaid, despite not meeting its immigrant eligibility requirements. This has affected lawful permanent residents subject to Medicaid's five-year bar as well as other lawfully present immigrants who are ineligible for Medicaid, such as applicants for asylum. While workarounds have recently been added to help trigger an accurate eligibility determination, such as adding a question to the application for individuals who received a Medicaid denial to indicate that the denial was due to immigration status, the workaround does not help all individuals in this situation and the fundamental glitch in the system remains. As a result, many eligible lawfully present immigrants with income under 100% FPL have been unable to enroll in health insurance because they cannot afford the cost of full-price coverage.

HHS should continue working to fix all of the system problems so that individuals may receive an accurate eligibility determination without needing to use a workaround. Until these problems are fully fixed, HHS should create another workaround for individuals who do not apply for Medicaid because they know they are ineligible, ensuring they receive an accurate eligibility determination for subsidies while their immigration status is verified. At the very least, HHS should notify individuals who may not have enrolled in a qualified health plan (QHP) because they were impacted by this problem, allow them to resubmit an application or submit additional documentation if necessary, and provide these individuals with a hardship exemption for the months they went without coverage due to this problem.

Identity Verification Barriers

HHS has imposed rigorous identity proofing requirements for persons submitting an application online. These requirements are delaying or deterring many low-income individuals, especially immigrants, from completing an application and enrolling in a QHP. In order to submit an application, the application filer's identity must first be verified using data maintained by the credit reporting company Experian. Many immigrants have limited, and in some cases

nonexistent, credit history, making this electronic verification process impossible. This requirement is particularly problematic for recent immigrants who have not been in the U.S. long enough to establish a credit history. It is also a problem for mixed-status families in which an undocumented parent is attempting to enroll eligible family members, often his or her U.S. citizen children. Making matters worse for many immigrant families, Experian does not provide adequate language access to individuals with limited-English proficiency (LEP) who speak languages other than Spanish; in fact, Experian offers no oral interpretation services in non-Spanish languages.

While we acknowledge that HHS has expanded the types of documents that individuals may use to prove their identity, such as a foreign passport or foreign identity card, HHS could make the identity proofing process more successful by including additional documents that low-income individuals are more likely to have, such as a lease or telephone bill. Moreover, unlike the verification processes for citizenship, immigration status, and income, which include due process protections through an “inconsistency” process that allows individuals to complete their applications while they provide additional proof of eligibility, individuals whose identity cannot be immediately verified are not allowed to proceed with the application process. Individuals whose identity cannot be immediately verified encounter a hard stop in the process and are not permitted to submit an application online and enroll in coverage pending verification of their identity. Countless individuals have experienced unnecessary barriers or have been unable to enroll in coverage for which they are eligible as a result of the identity verification process.

Over the long term, HHS should consult with other federal agencies, and technology experts that have experience serving individuals with low-incomes to identify a strategy to protect consumer privacy but that does not deter or delay eligible people from submitting applications (stakeholders representing consumer interests should also be consulted). This could include investigating other forms of identity proofing, and implementing an alternative application process that is not reliant on dynamic verification of eligibility data, making a rigorous identity verification process unnecessary.

In the short term, HHS could address the identity verification problems by implementing a number of fixes, including: requiring Experian to provide language assistance services in languages other than English and Spanish, tapping into other sources of data than just credit histories; further expanding the list of documents that individuals may use to prove identity; allowing enrollment assisters (including Navigators, In-Person Assisters and Certified Application Counselors) to act as intermediaries between Experian and the consumer and to review identity documents; and improving the paper application process, the alternative for people who have problems verifying their identity, so it allows for functions currently only available online or over the phone such as applying for Special Enrollment Periods and reporting changes.

Immigration Status Verification Problems

The Federally-facilitated Marketplace was designed to communicate in real time with U.S. Citizenship and Immigration Services (USCIS) to verify a lawfully present applicant’s

immigration status, as well as citizenship for individuals whose citizenship cannot be verified by the Social Security Administration (SSA). Unfortunately, the verification system has failed to accurately verify the immigration status of nearly 1.5 million eligible immigrants and naturalized U.S. citizens, in large part because of technological glitches. Although several workarounds were added in the last month of open enrollment, we remain concerned that the fundamental technological problems still are not fully fixed.

Additionally, we are concerned that consumers and assisters have not been adequately informed both of the workarounds that have been added, and the status of applications that have been pending since before the workaround were implemented and for which the consumer uploaded or mailed in additional documents. We are especially concerned about non-Spanish LEP individuals who do not receive any notices in a language they can understand.

Prior to the next open enrollment period, HHS should identify and fully fix the remaining problems with the citizenship and immigration status verification process. Until then, HHS should disseminate information to assisters and consumers regarding temporary workarounds, including instructions for accessing these workarounds, as well as encourage individuals who encountered problems to try submitting their application anew. HHS should also establish methods for individuals to check the status of their document review and provide consumers with notices in their preferred language.

Language Access Barriers

For LEP consumers who speak a language other than Spanish, the options for enrollment are limited. Throughout the open enrollment period, only two out of the four avenues for enrollment—the call center and in-person assistance—were available to these consumers. Reports of poor quality interpreting services through the call center’s language line, weeks-long waiting lists for in-person assistance with bilingual assisters and interpreters, and the complete failure of Experian to provide interpreting services to non-English and non-Spanish speakers indicate a dearth of language assistance services. The Affordable Care Act expands the application of existing civil rights protections to prevent discrimination in health care, and HHS regulations impose affirmative obligations on marketplaces and Qualified Health Plans to provide “meaningful access” for LEP individuals. However, as we witnessed during the first year of enrollment, language access was insufficient, and HHS has yet to promulgate standards for ensuring meaningful access for LEP consumers. Additionally, HHS would be more effective in its outreach to consumers if it collected information on the preferred language of not just the household contact, but of each applicant as well.

Increasing health care coverage for all Americans, including immigrants, is integral to the success of the Affordable Care Act. As such, addressing as many of the barriers described above before the next open enrollment period should be a top priority for your Department. These improvements would also benefit immigrant families nationwide by providing leadership for those state-based marketplaces struggling with similar issues. We urge you to use the resources available to you to eliminate the barriers that immigrant families have faced while trying to access coverage and fully comply with the law.

Thank you for your time and consideration.

Sincerely,

National Organizations

AFL-CIO

Alliance for a Just Society

American Federation of State, County & Municipal Employees (AFSCME)

Asian & Pacific Islander American Health Forum

Asian American Legal Defense and Education Fund

Asian Americans Advancing Justice | AAJC

Association of Asian Pacific Community Health Organizations (AAPCHO)

Children's Defense Fund

Community Catalyst

Dignity Health

Empowering Pacific Islander Communities

Families USA

Farmworker Justice

First Focus

Georgetown University Center for Children and Families

Heartland Alliance for Human Needs & Human Rights

Hmong National Development

Ms. Foundation for Women

National Council of La Raza (NCLR)

National Health Law Program

National Immigration Law Center

The National Korean American Service & Education Consortium (NAKASEC)

National Latina Institute for Reproductive Health

National Tongan American Society

National Women's Law Center

Red Mexicana de Lideres y Organizaciones Migrantes

Samoan National Nurses Association

Sargent Shriver National Center on Poverty Law

Service Employees International Union (SEIU)

Southern Poverty Law Center

UNITED SIKHS

Young Invincibles

Alabama

Alabama Coalition for Immigrant Justice

Arizona

Asian Pacific Community in Action

California

Asian Americans Advancing Justice - Los Angeles
Asian Health Services
California Immigrant Policy Center
California Latinas for Reproductive Justice
California Pan-Ethnic Health Network
Coalition for Humane Immigrant Rights of Los Angeles (CHIRLA)
LIBRE
Operation Samahan, Inc.
The Children's Partnership
The Greenlining Institute

Connecticut

Connecticut Voices for Children

Florida

Farmworker Association of Florida
Florida Immigrant Coalition
Florida Legal Services
Latin American Coalition

Georgia

Center for Pan Asian Community Services
Medlink Georgia

Hawaii

Pacific American Foundation

Illinois

Access Living
AgeOptions
AIDS Foundation of Chicago
Alliance of Filipinos for Immigrant Rights and Empowerment (AFIRE)
Asian Health Coalition
Asian Human Services
Asian Human Services Family Health Center, Inc. (AHSFHC)
Cambodian Association of Illinois
Campaign for Better Health Care
Casa Michoacan Chicago
Centro de Informacion
Centro de Trabajadores Unidos
Chinese American Service League
Community Health Partnership of Illinois
DeKalb County Health Department
ECIRMAC

EverThrive Illinois
EZRA Multi-Service Center
Family Focus
Hanul Family Alliance
HIAS Chicago
Hispanic American Community Education and Services (HACES)
Illinois Coalition for Immigrant and Refugee Rights (ICIRR)
Indo-American Center
Instituto del Progreso Latino
Jewish Child & Family Services
Korean American Community Services
Mano a Mano Family Resource Center
Mujeres Latinas en Accion
Muslim Women Resource Center
Northwest Side Housing Center
P.A.S.O. - West Suburban Action Project
PODER
PrimeCare Community Health, Inc.
SEIU Healthcare Illinois Indiana
South Asian American Policy & Research Institute (SAAPRI)
South-East Asia Center
Uganda Community in Greater Chicago
United African Organization

Indiana

Immigrant Support And Assistance Center (ISAAC)

Kentucky

Covering Kentucky Kids and Families
Family & Children's Place
Family Health Centers, Inc.
Kentucky Equal Justice Center

Massachusetts

Health Care For All (Massachusetts)
Massachusetts Law Reform Institute
South Cove Community Health Center
UU Mass Action

Maryland

CASA de Maryland, CASA de Virginia

Maine

Consumers for Affordable Health Care
Maine Equal Justice Partners

Michigan

Accion Buenos Vecinos
EMU: Healthy Asian Americans Project
Michigan League for Public Policy
Michigan United

Minnesota

Children's Defense Fund - Minnesota
Hmong American Partnership
Immigrant Law Center of Minnesota
TakeAction Minnesota

Mississippi

Children's Defense Fund - Southern Regional Office
Steps Coalition

North Carolina

North Carolina Community Health Center Association
North Carolina Justice Center

New Jersey

Family Voices NJ
New Jersey Citizen Action
New Jersey Policy Perspective
PICO New Jersey
Statewide Parent Advocacy Network

New Mexico

La Clinica De Familia
New Mexico Asian Family Center
New Mexico Center on Law and Poverty

New York

Adhikaar
Coalition for Asian American Children & Families
Korean Community Services of Metropolitan New York, Inc.
New York Lawyers for the Public Interest
SEPA Mujer Inc
The New York Immigration Coalition

Ohio

Asian Services In Action

Oklahoma

Morton Comprehensive Health Services

Oregon

Asian Pacific American Network of Oregon

Pennsylvania

Health Federation of Philadelphia

Seamaac, Inc.

Rhode Island

Center for Southeast Asians

Texas

Children's Defense Fund - Texas

Insure Central Texas, a program of Foundation Communities

Utah

National Tongan American Society

Washington

Family Health Centers

Healthcare Committee, WA State Coalition for Language Access

Northwest Health Law Advocates

OneAmerica

Wisconsin

Wisconsin Council on Children and Families

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