



**SUPPLEMENTAL COMMENTS to the Department of Health and Human Services,
Centers for Medicare & Medicaid Services**

**RE: Patient Protection and Affordable Care Act;
Establishment of Exchanges and Qualified Health Plans: Proposed Rule**

CMS-9989-P

October 31, 2011

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) in response to the notice of proposed rule making, CMS-9989-P, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans (QHP).

Community Catalyst is a national advocacy organization that has been giving consumers a voice in health care reform for more than a decade. We provide leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high quality, affordable health care for everyone. We focus our efforts on helping the most vulnerable consumers, including those that have low incomes, come from communities of color, and/or have difficulty speaking or understanding English.

Health insurance Exchanges are one important way the Affordable Care Act (ACA) increases consumers' access to affordable, high-quality health care. Exchanges hold the promise of giving consumers more control, quality choices and better protections when buying insurance. Community Catalyst works closely with advocates on the ground in 40 states to implement the ACA, including working to set-up Exchanges that work well for consumers. We have identified key priorities in Exchanges to ensure that consumers have information about their health plan choices and have the highest quality and value for their health care dollars.

We are focusing our comments on ways the Exchange can help address racial and ethnic health disparities. While these are not exhaustive comments, we wanted to weigh in on these issues that are critical to making Exchanges successful. These comments supplement comments on other issues we submitted previously.

§155.110 Entities eligible to carry out Exchange functions

Racial and Ethnic Diversity in Board Composition

We applaud HHS for explicitly recommending that the majority of voting members on an Exchange board represent consumer interests. To respond to the request for comments on the types of representatives that should be on Exchange governing boards, we recommend that all

Exchange boards be required to have at least one consumer advocate knowledgeable about racial and ethnic health disparities, unless the board is constituted wholly of unconflicted health care experts at least one of whom has knowledge of these disparities. Consumer advocates can include individuals or non-profit organizations with relevant knowledge and expertise. In addition, we recommend that the regulations specify that authorities making appointments to the board take into consideration the racial and ethnic diversity of the state. A recent studyⁱ by the Kaiser Family Foundation found that the population using the Exchange will be more racially diverse than those who currently have private insurance. About 58 percent of purchasers will be white, 11 percent black, and 25 percent Hispanic. To adequately represent the interest of this diverse population, it is critical that people of color from low income and immigrant communities play a meaningful role in the design and governance of the Exchange.

We further recommend that all Exchanges be required to have a formal Consumer Advisory Committee – comprised of consumer advocates and non-profit organizations with relevant expertise and reflective of the racial and ethnic diversity of the population eligible to use the Exchange. This Consumer Advisory Committee would inform board decisions about Exchange operations and implementation. This is especially important for states that establish exchanges inside the executive branch and that do not establish a separate exchange governing board.

§155.200 Functions of an Exchange

We recommend that Exchanges be required – following eligibility determinations – to refer consumers to safety-net facilities such as community health centers, public hospitals, or other health care providers, if those consumers are not eligible for Exchange plans or Medicaid, or are exempt from the mandate to purchase coverage. This is essential to ensure there is really no wrong door to care.

§155.210 Navigator Program Standards

Types of Entities That May Serve as Navigators

HHS has asked for comments on the number and types of entities that may serve as Navigators. We recommend that Exchanges be required to have at least one consumer-oriented non-profit organization as a Navigator and that each state’s pool of navigators demonstrate the ability to serve the diverse racial and ethnic populations of the state.

People of color and immigrants are less likely than whites to have insurance and more likely to have little knowledge of insurance systemsⁱⁱ. Due to distrust of the health care system, language and cultural barriers and misinformation about eligibility rules, people of color in general, and immigrants in particular, are more likely to work with those they trust. To ensure they have full access to Exchanges, they will need tailored information and help from trusted sources. In Massachusetts, community-based organizations from communities of color that fulfilled a role similar to Navigators were a key part of achieving the state’s 97 percent insurance rateⁱⁱⁱ.

Cultural and Linguistic Competency Requirements for Navigators

In response to the request for comments on cultural and linguistic competency requirements for Navigators, we recommend that Exchanges develop Navigator programs that meet the following standards:

- Exchanges should be required to select Navigators with a demonstrated track record of conducting culturally competent outreach to the uninsured, to communities of color, and to populations with language barriers.
- Communications used by Navigators must be available in languages common in the community. Furthermore, Navigators must publicize and post the availability of translated materials and interpretation services.
- The network of Navigators should be able to provide in-person, online, and telephone support to potential enrollees in all languages common in the community. In-person support should be accessible by public transportation and compliant with the Americans with Disability Act.

§155.230 General standards for Exchange notices; §155.205 Required consumer assistance tools and programs of an Exchange; §156.250 Health plan applications and notices

Meaningful access to limited English proficient individuals

The Congressional Budget Office estimates that about 29 million people will have enrolled in a health insurance plan through an Exchange by 2019^{iv}. About seven percent will be immigrants who have lived in the United States for less than five years. One in four enrollees (23 percent) will speak a language other than English at home^v. Language barriers have been found to predict lack of access to health services. Strong requirements on, and enforcement of, language access services in all Exchange operations would help improve access to insurance.

We commend the requirement that all applications, forms and notices be written “in plain language and provided in a manner that provides meaningful access to limited English proficient individuals.” Title VI and Sec. 1557 of the Affordable Care Act both prohibit discrimination on the basis of race, color or national origin in access to health programs supported with federal dollars. In response to your request for comments about setting out more specific requirements, we recommend that Exchanges be required to:

- Translate vital applications, forms and notices into all languages spoken by the lesser of 5 percent or 500 people in an Exchange service area. We draw the 5 percent standard from the Department of Justice (DOJ) and HHS’ Limited English Proficiency Guidance, and the 500 person standard from the interim final rule established by the DOJ, HHS and the Department of Treasury governing appeals documents in non-Medicare health plans.
- Include taglines on non-vital notices indicating the availability of translated material or oral interpretation in the top 15 languages spoken by people in an Exchange service area. This is the current standard used by Medicare and by the Social Security Administration.
- Provide access to oral interpreters or bilingual staff on request, regardless of whether thresholds for written translation are met.

We recommend that this threshold be applied in all Exchange communications, including in appeals of eligibility determinations.

Under **§156.250**, we recommend that you require standards similar to those suggested above for §155.230 for the translation and oral interpretation of materials issued by Qualified Health Plans to enrollees. For the plans, the standard we recommend is 5 percent of *plan enrollees* or 500 people.

Under **§155.205**, we recommend that Exchanges be required to put taglines and notices of the availability of oral interpreters on the Exchange website in the top 15 languages spoken by people in the Exchange service area.

§155.260 Privacy and security of information

We appreciate that the proposed regulations prohibit the Exchange or any Exchange contractor from sharing with other agencies the personal information that is collected to determine consumer eligibility for insurance. However, we urge HHS to detail the specific information to be protected, and to limit collection of information to items “strictly necessary” as specified in Section 1411(g) of the ACA. This will give consumers applying for coverage more confidence that their information will be kept private.

Specifically, we recommend amending the definition of personally identifiable information to include citizenship, immigration status, and Social Security Number.

§156.200 Qualified Health Plan issuer participation standards

Quality improvement strategies and reporting on quality and outcomes

Over the past decade, despite efforts to reduce health disparities, people of color continue to experience poorer health than their white counterparts, including higher infant mortality, shorter life expectancy and increased prevalence of chronic diseases. The Healthy People 2010 Report released this month laid out stark statistics on the persistence of racial and ethnic disparities: while about 15 percent of indicators showed an improvement, 15 percent showed disparities worsening and about 70 percent were unchanged^{vi}. While insurance coverage will help reduce racial and ethnic disparities, research shows that more is needed to tackle this persistent problem. Quality strategies specifically designed to reduce disparities are one avenue. The Exchanges provide an opportunity to extend the reach of these strategies.

We appreciate that you plan to address quality standards for QHPs in future rulemaking, including quality improvement strategies and data reporting. In both that forthcoming rule, and the existing rule, we recommend that you codify the Affordable Care Act requirement that QHPs include activities to reduce disparities within their quality improvement plans. We also recommend that your forthcoming rule include examples of proven strategies that reduce racial and ethnic health disparities. In addition, we recommend that QHPs be required to report their progress in reducing disparities by publishing on their websites health outcomes by race, ethnicity, primary language, gender and disability. The Exchange should also post this information about all plans in the Exchange.

§156.235 Essential community providers

We strongly support the requirement that Qualified Health Plans (QHP) maintain a sufficient number of essential community providers in their care network at all times that serve predominantly low income, medically underserved individuals. We recommend that the regulations include a comprehensive list of essential community providers. We recommend that the list include: federally qualified health centers, family planning projects receiving grant funds under Title X of the Public Health Service Act, Ryan White Care Act providers furnishing HIV/AIDS services, state AIDS drug purchasing assistance programs (ADAP), black lung clinics, hemophilia diagnostic treatment centers, urban Indian health clinics, Indian Health Services, Tribally-operated programs, Native Hawaiian Health Centers, tuberculosis treatment clinics, public hospitals receiving disproportionate share adjustment payments under Medicare, children's hospitals, critical access hospitals, rural referral centers and sole community hospitals meeting disproportionate share adjustment payment thresholds, school-based clinics, community mental health centers, and other mental health and substance use disorder organizations that are licensed or certified by the state as providers.

These institutions have traditionally been the primary source of care for populations with the greatest health needs. They have strong experience providing care for these populations and their special needs, and many have worked to reduce health disparities. They are also on the forefront of providing culturally and linguistically competent services and have worked hard to win the trust of their diverse patient base. We urge HHS to establish broad contracting requirements under which QHPs would have to offer a contract to these types of providers in each QHP's service area. This is an important step to help ensure that the needs of low-income populations are met and QHP's are able to fully comply with national standards for provision of culturally and linguistically appropriate services.

Thank you for the opportunity to comment on these proposed regulations. If you have any questions, please contact Alice Dembner, deputy policy director, at adembner@communitycatalyst.org.

Respectfully submitted,



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Community Catalyst

ⁱ The Henry J. Kaiser Family Foundation (March 2011). A Profile of Health Insurance Exchange Enrollees. <http://www.kff.org/healthreform/upload/8147.pdf>

ⁱⁱ The Henry J. Kaiser Family Foundation (2010). Health Reform and Community of Color: Implications for Racial and Ethnic Health Disparities. <http://www.kff.org/healthreform/upload/8016-02.pdf>

ⁱⁱⁱ Stan Dorn, Ian Hill and Sara Hogan (2009). The Secret of Massachusetts's Success: Why 97 percent of State Residents Have Health Coverage. http://www.urban.org/uploadedpdf/411987_massachusetts_success.pdf

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- ^{iv} Congressional Budget Office (March 2010). <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>
- ^v The Henry J. Kaiser Family Foundation (March 2011). A Profile of Health Insurance Exchange Enrollees. <http://www.kff.org/healthreform/upload/8147.pdf>
- ^{vi} National Center for Statistics, Centers for Disease Control and Prevention (2011). Healthy People 2010: Final Review. http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf