

Office of Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Submitted Electronically

Re: Comments on 45 CFR Part 170: State-level health information exchanges;
75 Federal Register 45584 (August 3, 2010)
File Code: OCIIO-9989-NC

On behalf of the Steering Committee of the Coalition to Promote Access and Opportunity, we submit the following response to the request for comments entitled “Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act” (file code OCIIO-9989-0) published August 3, 2010.

The Coalition to Promote Access and Opportunity is dedicated to alleviating poverty for millions of Americans by promoting federal, state and local policy agendas that facilitate comprehensive, coordinated access to underutilized public benefits and related resources. Quality employment should be the first path to financial security and well-being, but when work does not generate enough income, jobs are scarce, or employment is not an option, there should be a coordinated system of supports that is easy to understand and access, free or low-cost, provided without stigma, responsive to economic hardship, and open to all who need it.

The mission of this Coalition is to share and publicize best practices, identify federal opportunities and promote policy reforms that will strengthen the safety net by removing barriers to participation. Our goals are to improve individual and family financial security, to advance health and well-being, to protect against material hardship and to promote opportunity and pathways to the middle class. We support policies that promote access to public benefits and related resources that remain untapped and underutilized for the millions of families and individuals who need them, and improved coordination across public benefit programs to improve outreach, enrollment, retention and verification, and ultimately support families’ efforts to achieve self-sufficiency.

The Steering Committee consists of the Center for Law and Social Policy, the Coalition on Human Needs, First Focus, Seedco and Single Stop USA.

We appreciate the opportunity to comment on the planning and establishment of the health care exchanges to be created under the Affordable Care Act. The implementation of these exchanges

is a critical component of meeting the Affordable Care Act's goals of universal health care coverage and "no wrong door" for access to benefits.

A. State Exchange Planning and Establishment Grants

We believe that the development of health care exchanges offers an opportunity to create, in the words of the Health IT Policy & Standards Committee Enrollment Workgroup "modern electronic systems and processes that allow a consumer to seamlessly obtain and maintain the full range of available health coverage and other human services benefits." We recognize that this may be an evolutionary process, with states focusing on the mandated provisions of the Affordable Care Act before expanding to include other programs. Yet this vision will be much more likely to be achieved if states include the possibilities of such expansions in their current plans. HHS should require states receiving planning grants and establishment grants to describe the integration with their existing human services eligibility and benefits systems and to discuss possibilities for further expansion.

In addition, it is important that the technological choices made keep these expansion possibilities open. As Congress did not specify a formula for these grants, we believe that it is appropriate for HHS to allocate funds in such a way as to encourage cost-effective planning and development processes. When states are locked into proprietary software packages, with only a single vendor able to make modifications, the incremental approach to program improvement can become prohibitively expensive. Specifically, HHS should provide higher funding levels for states or consortia of states that are developing software systems that can be re-used and adapted by other states, especially when they are based on an open-source framework. This will allow improvements developed in one state to be more easily replicated in other states.

One critical aspect of Exchange planning is ensuring that the plans are accessible to individuals with disabilities, those with limited literacy, and those with limited English proficiency. HHS should reserve a portion of the planning funds to support technical assistance to states on accessibility. HHS should also provide states with model policies and procedures, best practices, checklists, and training.

B. Implementation Timeframes and Considerations

Section 1311(d)(6) of the Affordable Care Act requires Exchanges to consult with various stakeholder groups, including advocates for enrolling hard to reach populations. HHS should include such consultations among the milestones that states must meet to show that they are making appropriate progress on implementation. These stakeholder groups should include advocates for low-income populations, for individuals with disabilities, low literacy levels or limited English proficiency, and should not be limited to groups that primarily focus on health care access. Consultation should occur at multiple stages in the process, including initial conceptual discussions, development of the Request for Proposals or other technical specifications, usability testing, implementation and outreach.

C. State Exchange Operations

We strongly support the recommendations of the Enrollment Workgroup aimed at the consistent,

efficient and transparent exchange of data elements between programs and states.

As recommended by the Enrollment Workgroup, HHS should develop a model software package that can be used or modified by the states, implementing standards for obtaining information needed for the verification of initial eligibility, renewal and changes in circumstances from federal agencies and states so that consumers do not need to provide paper verification of information that is already known to other government agencies.

HHS should offer clear guidance to states regarding the use of scanned documents, the ability to store documents for later use (including use by other benefit programs), and the use of electronic signatures. HHS should coordinate with other federal agencies to ensure consistent guidance across federal programs to the maximum extent possible. If inconsistencies are forced by legislative requirements, HHS should clarify the differences in order to reduce confusion.

The Exchanges will be used by consumers with a wide range of income levels, familiarity with technology, understanding of health insurance policies, literacy, English language proficiency, and physical and mental disability. Therefore, it is critical to provide access in a range of formats (e.g. online, by toll-free phone number, in person, and facilitated by family members, community organizations or other intermediaries). Even within the online format, some people will want a simple summary of the options, while others will want to be able to look at all the details.

Individuals with Low Literacy

HHS regulations should require entities operating Exchanges to ensure that the top level of information on Exchange websites, and material provided by the Exchanges are written, to the greatest extent possible, so they can be read and understood by individuals with limited literacy. Given what we know about the large numbers of consumers with low levels of literacy and the high importance of the information that will be provided by the Exchanges, it is critical that they provide information that is written as simply and clearly as possible, so it can be read and understood by as many people as possible. Individuals who want all the details should be able to drill down to find them, but consumers should be able to submit their applications for Medicaid or tax subsidies, and make a choice between plans, without being overwhelmed by technical language or fine print.

HHS should revise and reissue the materials it issued to states in 1999 about improving readability of Medicaid notices and program materials and make them available to entities operating Exchanges, or provide comparable materials on readability. HHS regulations should require entities operating Exchanges to submit plans to HHS explaining the specific steps they will take to ensure that Exchange websites and material provided by Exchanges are written so they can be read and understood by individuals with limited literacy.

Individuals with Disabilities

HHS regulations should make clear that Exchange websites, and all information and applications provided on Exchange websites, must be accessible to and usable by people with disabilities. This is in accordance with federal law, under the Americans with Disabilities Act and Section

504 of the Rehabilitation Act. Exchange websites must be accessible regardless of who operates them. HHS should require entities operating Exchanges to submit plans explaining the specific steps they will take to ensure that Exchange websites are accessible to and usable by people with disabilities and to ensure that accessibility is maintained over time.

These steps should include incorporation of specific eligibility standards, guidelines or checklists in the RFP or technical specifications for development and maintenance of the website, usability testing, and requirements that insurance companies or other third parties that provide information to the Exchanges do so in accessible formats. In addition, HHS regulations should require entities operating Exchanges to provide materials to individuals with disabilities in alternative formats when necessary to provide meaningful access to the information and effective communication. HHS regulations should require entities operating Exchanges to submit plans specifying how they will ensure that telephone hotlines are accessible to people with disabilities, including how any automated systems for answering and routing calls will be made accessible.

Lawfully Present Immigrants and Individuals in Mixed Status Families

HHS should provide clear guidance to states on how to determine eligibility for lawfully present immigrants and individuals in mixed status families in a streamlined manner. At a minimum, regulations should reinforce existing federal guidance and policies for Medicaid and CHIP that forbid the asking of unnecessary and inappropriate questions about immigration status and social security numbers. Regulations should also ensure that the information collected is used and shared only for the purpose of determining eligibility or administering the program. Written and verbal communications to immigrants should provide accurate notice and instructions that help alleviate privacy concerns that may deter enrollment for eligible individuals. For example, applicants should be told how personal information will be used, whether sensitive information is required or merely requested, and that a health insurance application does not adversely affect adjudication of an immigration application.

The Affordable Care Act provision for child-only medical coverage is a great help to many families, including mixed-status immigrant families. To ensure that immigrant families with ineligible adults are not discouraged or deterred from applying for eligible children, states will need to administer access to child-only coverage in a way that does not inadvertently raise immigration questions or concerns about the lack of participation of ineligible family members. It will also be critical to provide guidance that multiple persons, including parents or other authorized persons may apply on behalf of an eligible child, thus reducing barriers to enrollment for those eligible children.

D. Qualified Health Plans

Low-wage workers rarely receive employer-provided health insurance and often experience periods of unemployment and underemployment in the course of the year. This means that they are likely to move back and forth between exchange-based health insurance (with tax subsidies) and Medicaid plans. Their children may be covered by CHIP as well. In order to ensure continuity of coverage and care, it is important that states provide for as much overlap as possible between the qualified health plans available through the exchange and plans provided

through Medicaid, including with respect to covered providers. When states propose eligibility criteria for qualified health plans, they should be required to analyze the extent to which consumers moving between such plans and Medicaid or CHIP are able to keep their coverage and providers, and include steps for improving continuity if less than a threshold level (e.g. 75%) of consumers are able to do so.

F. An Exchange for Non-Electing States

We recognize that a federal-level Exchange will probably be more difficult to integrate with state eligibility determination systems for other programs than state-level Exchanges. Consumers in states that do not elect to operate exchanges have the same statutory right as those in states that do operate exchanges to learn of their eligibility for Medicaid and CHIP and to be enrolled in these programs. It is critical that systems be in place to support this right. It does not seem cost effective or appropriate for the federal government to duplicate the eligibility systems for each non-enrolling state; therefore, there must be a way for HHS to transmit to non-electing states the information that it collects and for states to return eligibility decisions in a timely fashion. This may require modifications to existing state systems. HHS should therefore specify the format in which it will transmit and receive data, and the standards for timeliness as soon as possible, so that states may make an informed decision regarding whether to create an exchange and may start making any needed systems changes.

The federal Exchange should also serve a model system with respect to the development of the transparent consumer-centric system envisioned by the recommendations of the Enrollment Workgroup. In particular, it should take full advantage of the opportunities for information sharing with other databases, such as those held by the Social Security Administration, and the Internal Revenue Service and National Directory of New Hires to minimize the burden placed on consumers to provide information.

G. Enrollment and Eligibility

Many of the individuals who are eligible for public benefits or health care subsidies under the Affordable Care Act are already providing information about their income and family composition to the state and federal government through their income tax returns. States (or the federal government, in the case of non-electing states) should add a single question to allow data for uninsured individuals to be shared with the Exchange to conduct a preliminary screening and pre-populate applications.

Studies have found that applications started online are often not completed. Applicants may be interrupted in the process, may be missing needed information, or may be uncertain about how to proceed. Customers who start an application online should be able to save their work and return to it at a later date – either online or in person, by phone, or with the assistance of a third party, such as a family member, community based organization, or Navigator.

The need to provide birth certificates to verify citizenship is often a particularly onerous requirement for applicants. Clients often misplace their birth certificates when moving, and it is time consuming and costly to obtain a new one. Under the Children's Health Insurance Program

Reauthorization Act, states have the option to conduct data matches with the Social Security Administration's (SSA) database to verify applicants' citizenship. This match has already been proven reliable and cost-effective, and the Exchanges should be required to use it.

States have also used other data matches, such as the Income and Eligibility Verification Systems (IEVS) and the Public Assistance Reporting Information System (PARIS) to great effect. These systems can be used for much more than simple identification of income sources. For example, Washington State has used the PARIS system to identify Medicaid recipients who appear to be eligible for health care coverage based on their status as veterans, and even to identify individuals who appear to qualify for higher levels of disability coverage than they are receiving. The state then provides individualized assistance to help clients receive the benefits that they have earned.

H. Outreach

Section 1311(i) provides that Exchanges shall establish grant programs for Navigators to conduct public education activities, distribute enrollment information, facilitate enrollment in qualified health plans and provide referrals for grievances, complaints or questions. Potential Navigators include insurance brokers, trade groups, unions and community-based organizations.

The development of the Exchanges, the expansion of Medicaid eligibility, and the new tax-based subsidies for purchasing individual plans dramatically change the health care options available to many Americans. Therefore, states will have to conduct significant public education activities. However, as we have learned from the CHIP implementation experience, broad-based outreach is not enough to reach all eligible individuals; targeted campaigns will be needed to reach populations who are less informed or are more cautious about government programs.

The statutory language regarding the Navigators states that they shall "facilitate enrollment in qualified health plans." HHS should clarify that Navigators should also help consumers enroll in Medicaid or CHIP when they are eligible for these programs. This is consistent with the overall vision of the Affordable Care Act that there should be "no wrong door" for services. However, because there is no federal financial participation in the ongoing services provided by Navigators, HHS should also clarify that states may claim the costs of Medicaid or CHIP outreach and enrollment assistance activities as administrative costs under the respective program, as is currently permitted.

Given the diversity of consumers who will be served through the Exchanges, it is appropriate that a diverse range of organizations be chosen as Navigators. It is unlikely that a single organization will be equally well-suited to work with and assist an older consumer with a pre-existing condition, a young parent who does not speak English, a small business owner seeking coverage for several employees, and a disabled consumer who believes that she was inappropriately denied coverage. However, given the limited resources that are likely to be allocated to Navigators, it is important that priority be given to Navigators that have the capacity to reach harder-to-serve populations, and to Navigators that use benefits access tools and systems that are proven effective. It does not make sense to pay intermediaries to enroll people who are already aware of the programs and capable of enrolling without assistance.

HHS should encourage states to include among their possible Navigators community-based organizations that have the capacity to conduct outreach and screening for multiple programs. Already, there are a variety of models for such multiple benefit screening. These models have the potential to become even more effective if they are allowed, with clients' permission, to access the data shared with the Exchanges from other programs. Based on the information needed to determine eligibility for Medicaid and health care subsidies, Navigators will be able to help customers access a range of other benefits, such as SNAP (food stamps), the Earned Income Tax Credit, and student financial aid.

Many community- and faith-based organizations that serve low-income populations will see it as congruent with their missions to help their clients access the Exchanges and enroll in health insurance programs. These organizations are often culturally sensitive and trusted resources in their communities and can be valuable in reaching participants. However, without help, many of these organizations will not have the capacity to serve as Navigators. As states develop their outreach and enrollment plans, they should include training and technical assistance for these organizations to ensure that they can provide accurate and complete information to individuals seeking assistance.

J. Consumer Experience

Consumers should have the ability to access the Exchanges by the means of their preference, whether online, by phone, in person at a state agency, or through a school or community-based organization, or through combinations of the above.

One of the lessons of behavioral economics is that no matter how well websites are designed, or how helpful Navigators may be, we know that some customers will become overwhelmed by the options and fail to make a choice. States should be required to establish default choices that have a high probability of resulting in positive outcomes. For example, if someone gets far enough in the process to determine that they are eligible for a subsidy that will allow them to enroll in at least one plan without additional cost, but does not elect a plan, that consumer should be enrolled in a no-cost plan unless he or she opts out, rather than left uninsured. For a consumer transitioning from Medicaid, the default might be a plan from the same insurer.

Thank you for your consideration. If you have any questions about these comments, please contact Elizabeth Lower-Basch of the Center for Law and Social Policy at (202) 906-8013 or at elowerbasch@clasp.org.