

Jay Angoff
Director, Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9989-NC
P.O. Box 8010
Baltimore, MD 21244-8010

October 4, 2010

Dear Mr. Angoff:

The National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue Asian American and Pacific Islander (AAPI) women's organization in the country. Our mission is to build a movement to advance social justice and human rights for API women and girls. The rules that the Department of Health and Human Services (HHS) issues regarding the establishment and operation of the state-based American Health Benefit Exchanges (Exchanges) will have a substantial impact on the access and quality of health care that Asian American and Pacific Islander communities receive. These comments are submitted in cooperation with the National Women's Law Center, National Immigration Law Center and Asian & Pacific Islander American Health Forum

NAPAWF thanks the Office of Consumer Information and Insurance Oversight (OCIIO) for the opportunity to comment on the planning of the state-based American Health Benefit Exchanges. AAPI women stand to benefit significantly from coverage and subsidies offered through the Exchanges. Approximately 24% of AAPI women are uninsured and 16% of AAPI women over the age of 64 live below the poverty level. Compounding these issues, linguistic and cultural barriers prevent many in these populations from attaining quality health care. We urge HHS to promote informational and enrollment features and processes in the Exchanges that optimize accessibility for AAPI women in addition to other low health literacy, immigrant, and limited English proficient populations.

Quality

For AAPI women and other communities that face significant health disparities and inequities, quality health care requires linguistic and cultural competency and an emphasis on coordinated, patient-centered care. In creating the plan rating system, the Secretary should develop distinct rating categories that assess a plan's participating providers for: 1) language capabilities; 2) diversity of their workforce; 3) points of service in medically under-served areas; 4) use of health information technology (HIT); and 5) use of patient-centered medical homes.

Limited English proficient (LEP) populations like AAPI women, where more than one-third struggle with English, encounter significant communication difficulties in health care settings. These difficulties result in patients not being able to fully communicate to providers the extent of their health issues, burdens placed on family members and friends to interpret on behalf of a LEP patient, unnecessary follow up visits due to misunderstanding a health provider's original instructions, and medical errors that sometimes lead to fatalities. LEP consumers will benefit significantly from information on a plan networks' inclusion of providers proficient in their

preferred language. The rating category for language capabilities should assess both the diversity of languages available as well as the number of providers that can offer such services.

Cultural competence is essential to the provision of quality health care to AAPI women and their families. Understanding a patient's daily diet, sensitivities to certain health subjects, and beliefs on disease, transmission, and treatment provides a strong foundation for effective communication with patients and the development of trust between patients and providers. A diverse health care workforce provides one means of developing cultural competence in health care. The plan rating system should assess the racial and ethnic diversity of a health plan's network of providers.

Health Information Technology (HIT) provides a potentially powerful resource for health care providers seeking to provide high-quality and efficient care. Through HIT, providers can collect and analyze health information by ethnic population, generate patient reminders for regularly schedule visits or screenings, view tests and test results ordered by different physicians, and manage a patient's care in conjunction with the patient's other health care providers. HIT can be extremely effective in caring for individuals with chronic conditions that require the coordination of care among various health care staff and repeat visits and screenings. HIT can also be particularly effective in collecting critically needed health information where EHRs disaggregate by AAPI subpopulations. With disparate rates of diabetes, cervical cancer, coronary heart disease, cardiovascular disease, and other serious conditions, AAPI women would benefit considerably from the incorporation of HIT into their health care delivery system. We hope the Secretary will include HIT use within a health plan's provider network in the plan rating system.

As with HIT, patient-centered medical homes (PCMHs) will help to coordinate care for the many AAPI women living with chronic conditions. Within these medical homes, patients will also have the ability to engage significantly in their own care. Participation in the creation of their treatment plan, for example, will draw upon the patient's input and also help ensure that the patient understands the reasons for the course of their treatment. PCMHs have the potential to empower patients from vulnerable communities and provide for more efficient care. The plan rating system should reflect plan networks that support PCMHs.

State Exchange Planning and Establishment Grants

Proper data collection on AAPIs is critically important to advancing health in these populations. Poor data collection methods have perpetuated the dangerous "model minority" myth that the Asian American community face few serious health issues. The fact that studies have found that the cervical cancer rate for Vietnamese American women is five times higher than that of white women, belies this myth.¹ Often data collection methods group all Asian American ethnicities together and Asian Americans as a whole with Native Hawaiians and Pacific Islanders, thereby masking the disparities that persist within subpopulations.

We are concerned that States will leverage current data collection systems to conduct health data collection based on race and ethnicity without updating these systems to comply with OMB

¹ National Asian Women's Health Organization (NAWHO), *Learning from Communities: A Guide to Addressing the Reproductive Health Needs of Vietnamese American Women* (1998).

Statistical Directive 15 which mandates the separation of Asians from “Native Hawaiians or Other Pacific Islanders.” Exchanges should urge States to upgrade data collection systems to comply with OMB Statistical Directive 15 at a minimum, and ideally, collect data disaggregated by ethnicity.

We hope that these data collection standards will be promoted within Exchanges whether they are single or multi-state Exchanges or Exchanges run by the federal government. Such data collection will provide essential health information on our populations to completely document and target efforts to eliminate health disparities.

State Exchange Operations

In the coming years, States must establish the infrastructure for consumer outreach and enrollment and ensure substantial health plan participation in the Exchanges. Creating policies and practices to optimize enrollment and the provision of quality health care through the Exchanges will require that States address the needs of the specific populations that will benefit most from the Exchanges.

Access to Abortion Services

The Department has asked, in questions B.2 and B.4, what guidance is needed and what provisions require additional clarification for states, plans, and consumers to begin the process of planning for Exchange implementation and participation. In order to ensure that relevant actors have the information needed to maintain insurance coverage of abortion while still complying with the requirements of the Affordable Care Act, we urge the Department to promulgate Section 1303 implementing regulations, which establishes “special rules” for the coverage of abortion services in qualified health plans, as soon as practicable. We are concerned that any delays in Section 1303 rulemaking will place additional burdens on insurance plans and will decrease the likelihood that plans will provide coverage of abortion care, in violation of Congress’ intent to preserve the coverage individuals currently have.

The Department has requested information to consider as it develops standards for states to create health insurance Exchanges. Because Section 1303 establishes “special rules” for the coverage of abortion services in qualified health plans, the Department must take into account the need to preserve Congressional intent with respect to abortion coverage in the standards and guidance it provides to states governing Exchange operations. To that end, we urge the Department to consider the following:

- Standards for Non-Profit Exchanges - Pursuant to Section 1311(d)(1), a state must decide whether an existing state agency, a new state agency, or a non-profit entity established by the state will operate the Exchange. The Department should make clear that, if a state elects to establish a non-profit entity to operate its Exchange, the non-profit entity must not be permitted to exclude plans on the basis of the coverage the plan provides if it otherwise satisfies the benefit requirements of a qualified health plan as defined under Sections 1302(b) and 1303 and applicable state law. In particular, we urge the Department to ensure that, absent state law as permitted under Section 1303(a), a non-profit Exchange cannot prohibit plans that include coverage of abortion from participation.

- Regional or Interstate Exchanges – Under Section 1311(f)(1)(B), the Secretary is required to approve any regional or interstate Exchange before it can operate in more than one state. We urge the Secretary to establish clear standards for the approval or disapproval of regional or interstate Exchanges. In particular, we urge the Secretary to establish a clear standard that the Department will not approve a regional or interstate Exchange that fails to include at least one plan that provides coverage of non-excepted abortion services unless each of the states participating in the Exchange have enacted laws to prohibit all such coverage under Section 1303(a).
- State Exchange Requirements – We understand that a number of health policy experts and consumer advocates have strongly urged the Department to require insurers to offer the same plans inside and outside the Exchange, as one of many mechanisms that should be put in place to discourage adverse selection and ensure that the Exchanges can provide a vibrant and competitive market for affordable health insurance. However, because the Affordable Care Act created “special rules” for the treatment of abortion coverage, such a rule, if applied without exception, could result in far less abortion coverage than Congress or individual states intend. This is particularly true in states that have chosen to ban abortion coverage in state-run Exchanges but have chosen not to ban abortion coverage outside the Exchange. To account for the special rules that govern abortion, we urge the Department to consider an exception to any rule that requires insurers to offer the same plans inside and outside the Exchange for coverage of abortion. Such an exception would allow the Department to address the serious concerns raised about adverse selection but would do so without running afoul of Congress’ intent of preserving insurance coverage of abortion care.

Plain Language and LEP Populations

States and health plans will benefit from guidance on the drafting and dissemination of health care information that is clear and concise to a broad range of populations, including LEP and multicultural populations. Exchanges, pursuant to PPACA, Section 1303(f), will require that participating health plans provide information on enrollment, policies, practices, and other benefit information in “plain language.” PPACA defines “plain language” as “language that the intended audience, including individuals with limited English proficiency, can readily understand and use.” Exchanges must also establish a Navigator program that will provide patients with health information in a culturally and linguistically appropriate manner. Under PPACA, health plans must provide notice of their appeals and grievance process in a culturally and linguistically appropriate manner

NAPAWF believes that the development of best practices to serve AAPI and other similarly-situated populations begins with an accurate assessment of need. States should conduct a demographic assessment, especially with respect to race, ethnicity, and primary language, of their residents to determine the linguistic needs of their residents.

To guide states and health plans in complying with “plain language” provisions, HHS should recommend that health information be available at an eighth-grade reading level or below, and in a variety of non-English languages. Additionally, we urge that HHS ensures that its guidance

include recommendations on culturally-appropriate trainings for Navigators and workforce diversity within the Navigator program.

Additionally, States and health plans should receive guidance on the incorporation of health information technology (HIT). At a minimum, Exchanges and health plans should maintain electronic health records (EHRs) that comply with OMB Statistical Directive 15 when collecting race and ethnicity data. To be truly reflective of the health status of AAPI women, however, NAPAWF believes that data collection practices must disaggregate by ethnicity and rely on patient self-identification. The Secretary should provide guidance to States and health plans on data collection through HIT as well as on the Office of the National Coordinator's meaningful use standards.

“Lawfully Present” Immigrants

Under PPACA, “lawfully present” immigrants are eligible for coverage in the Exchanges, the Pre-Existing Condition Insurance Program, and the Basic Health Plans, along with premium tax credits and cost-sharing reductions. In defining “lawfully present,” the Secretary should begin with and expand the definition CMS developed in July 2010 to determine Medicaid and CHIP eligibility under CHIPRA of 2009.² The expanded definition should include the following three categories. (1): Victims of human trafficking who have been granted “continued presence”: individuals whose continued presence in the United States the Secretary of Homeland Security is ensuring in order to effectuate the prosecution of traffickers in persons. (2): Individuals whose status makes them eligible to apply for work authorization under 8 C.F.R. §274a.12. For low-income individuals who have disabilities or are otherwise unable to work, the cost (\$340) and logistics involved in applying for work authorization can be significant. Their lawful status does not depend on whether they obtain a work permit – and neither should this definition. (3): Individuals granted a stay of removal/deportation by administrative or court order, statute, or regulations. This status is generally granted to individuals with cases pending before an immigration judge, the Board of Immigration Appeals, or a court, allowing them to remain in the U.S. lawfully while often lengthy proceedings continue. Several states provide health coverage to individuals with this lawful status, and to promote fairness and efficiency in administering these programs, it is appropriate to include them among the lawfully present categories for purposes of implementing the PCIP program.

Clarification is also needed to determine state residency rules. These rules apply to citizens and immigrants and are independent of immigration status requirements; however, some states have erroneously denied Medicaid to eligible children, mistakenly believing that children cannot establish state residency. Addressing this issue will be critical to the success of implementing the exchanges.

Information and Access Requirements for Web Portals

Limited English Proficient individuals are immigrants, refugees, asylees and naturalized citizens. Language barriers are widely known to reduce enrollment rates and lower the quality and effectiveness of prevention, treatment and patient education programs. LEP populations will

² Centers for Medicare and Medicaid Services, “Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women,” (July 1, 2010) available at <http://www.cms.gov/smdl/downloads/SHO10006.pdf>.

likely comprise a significant percentage of the 24 million individuals expected to participate in the Exchanges. More than 60% of Asian Americans in the US are foreign born, contributing to a significant number who are LEP. Over one in six Asian Americans and one in four Native Hawaiians and Pacific Islanders are uninsured. The Exchanges will serve as a major source of health coverage for significant numbers of AAPI women who work in small businesses and cannot afford to provide health coverage to employees, who are low-income and cannot access Medicaid because they are newly arrived immigrants, and who cannot afford the high premiums and cost sharing in the current individual market. Many of these vulnerable populations, however, will not be able to access the Exchanges and the associated tax credits due to linguistic, literacy, and cultural barriers. To maximize enrollment among these populations, Exchanges must overcome these barriers through the development and implementation of best practices for outreach and enrollment.

Exchanges will provide a number of informational and enrollment resources to consumers, which must be accessible to the diverse populations that will be eligible for Exchange-based coverage. States should ensure that translated versions of their Exchange web portals, outreach materials, and enrollment forms are available in appropriate languages that reflect the state's demographic needs. At minimum, in choosing the languages for translation, Exchanges should adhere to HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons."

The web portal's presentation of information is equally as important. States must consider best practices in website readability on topics such as font size, color, and layout. NAPAWF also urges States to dedicate portions of the web portals to specific population groups. Some possible sections could include information focused on immigrants, children, women, and low-income individuals.

To provide true access, however, Exchanges should go further than HHS' guidance and also choose for translation the primary languages of smaller populations experiencing significant health disparities in their state. Many of the most vulnerable LEP populations comprise small numbers and states should begin establishing relationships with community-based organizations representing these populations to ensure that these individuals receive the information they need on the Exchanges. In particular, we urge Exchanges to ensure that online enrollment forms and information are available in as many languages as possible. For populations whose primary language is not selected for translation, States should ensure that their web portals contain tags that direct these populations, in language, to language access resources. The Exchange's ombudsman should also assist in directing LEP consumers to language appropriate resources. Exchanges must begin drawing together a database of professional language service organizations or community-based organizations that have the expertise to provide language services on health issues. The combination of low-literacy literature, in-language materials, and established relationships between the Exchanges and language service organizations will help significantly to mitigate the language barriers facing LEP populations in accessing health coverage.

As Exchanges develop policies and practices that address the barriers low-literacy, LEP, and diverse populations face in accessing quality health care, Exchanges should request continual stakeholder input. Such input could be sought through the creation of consumer working groups to advise the Exchanges and the formation of focus groups to assess proposed informational and enrollment materials.

With respect to consumers, NAPAWF believes that the same information on the Exchanges HHS currently provides in English should be available in non-English languages to the greatest extent possible. We are encouraged by the launch of CuidadoDeSalud.gov and ask that HHS provide similar resources in Asian and other languages soon. At the state level, outreach efforts should be done in languages that address the demographic needs of various regions.

Confidentiality

Confidentiality and privacy considerations will be paramount to the Exchanges. Many individuals from diverse backgrounds have strong aversion to revealing personal information to government entities. Many immigrants may be deterred from enrolling in the Exchanges and from seeking tax credits to support coverage without appropriate directions and language on enrollment forms. Specifically, many immigrants fear that enrollment in such programs would adversely affect their immigration status or deem them “public charges.” Many, particularly refugees, asylees and immigrants from high conflict regions, also have strong aversions to sharing private information with government entities.

Equally important is the need for confidentiality for reproductive health services and other sensitive care. Numerous studies have demonstrated the importance of confidentiality to the willingness of many teens and young adults to seek out needed care; AAPI women who are also LEP may seek care that is confidential from a spouse. With the expansion of insurance coverage generally under the Affordable Care Act, and particularly with the new requirements requiring plans to allow for dependent coverage of children to age 26, the need for confidential care is more vital than ever. However, private insurers make use of claims-processing procedures that may inadvertently undermine confidentiality, notably by sending an explanation-of-benefits (EOB) form to the policyholder (who may be a parent or spouse) when a dependent receives services under the policy.

We urge HHS to create a taskforce to work with states to identify best practices in this area and to ensure compliance with the guidance issued jointly on September 21, 2000 by the Department of Agriculture, Department of Health and Human Services, Health Care Financing Administration, and Office of Civil Rights (herein “Tri-Agency Guidance”).³ With respect to enrollment forms, Exchanges should comply with the Tri-Agency Guidance when seeking sensitive information such as social security numbers. Enrollment applications should notify applicants on the use of confidential information at the start of the application process. When such information is necessary, Exchanges should include an explanation of the information’s

³ “Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children’s Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits,” available at <http://www.fns.usda.gov/snap/rules/Memo/pdfs/triagencyletter.pdf>.

intended use and disclose whether an applicant's information will be shared with other agencies for the purpose of eligibility. As many States craft their own enrollment form for the Exchanges and other health benefit programs, States should consider the best practices for enrolling immigrants that have worked in other states. For example, Massachusetts' MassHealth Coverage specifies which programs will require the provision of an applicant's social security number and contains specific instructions for refugees and asylees. Additionally, California's Medi-Cal application states clearly that any sharing of an applicant's information with federal agencies will be for the purpose of detecting fraud alone. Finally, states should highlight the availability of "child-only" applications to the Exchanges and ensure that these applications do not seek sensitive information from non-applicant adults who may be completing the application for an eligible child.

Verification Procedures

State agencies are currently tasked with verifying citizenship eligibility. HHS and state agencies should adopt proven eligibility and enrollment practices that will minimize the administrative burden of coordinating between Medicaid, CHIP and the Exchanges and streamline access for all eligible persons. For instance, HHS should direct states to adopt the optional state verification process provided under CHIPRA.⁴ Section 211 of CHIPRA amended section 1902(a)(46) of the Deficit Reduction Act to allow verification of Medicaid and CHIP applicants using a "data match" program with SSA in lieu of burdensome citizenship documentation requirements that necessitate state agencies to inspect and assess identification and proof of citizenship documents. Many states have already adopted the "data match" program which submits an applicant's name, social security number and declaration of citizenship to the Social Security Administration (SSA) for verification through its Numident database. Some states impose a citizenship documentation requirement that requires physical proof of the applicant's identity and citizenship by submitting certain documents that have been deemed acceptable for manual inspection by the state agency. State agencies also commonly use the Systematic Alien Verification for Entitlements (SAVE) system to determine immigrant eligibility for federal benefit programs including Medicaid and CHIP for many years. The SAVE system provides specific program administrators access to data on an applicant's immigration status to ensure that only eligible immigrants are enrolled in the program. HHS should ensure that states still using a document-based approach to verifying eligibility accept, at a minimum, all documents recognized by federal agencies to establish citizenship or an eligible immigration status.

While both databases have been proven to be effective, both SAVE and the "data match" program will need to be expanded to facilitate the eligibility determinations of a much larger pool of Exchange applicants who wish to claim an affordability credit or purchase a plan in the Exchange. Safeguards should be incorporated to prevent the immediate denial of coverage to persons who face a discrepancy in their file or need a reasonable opportunity to present the proper documents. Section 1902(ee) of the Social Security Act provides applicants with 90-day coverage of benefits during which any inconsistency must be resolved. HHS should clarify that under the ACA, the 1902(ee) documentation procedures including the reasonable opportunity period apply to the verification of citizenship and immigration status in the Exchanges. This

⁴ See Center for Medicare and Medicaid Services, "Re: Citizenship Documentation Requirement," (December 28, 2009) available at <http://www.cms.gov/smdl/downloads/SHO09016.pdf>.

approach is consistent with the Congressional intent of the ACA⁵, and will reduce the burden and delay for eligible individuals and families to access health coverage.

At minimum, any eligibility determination should comply with federal rules regarding inquiries into citizenship, immigration status, and social security numbers (SSN) in state applications for Medicaid and CHIP. According to the 2000 “Tri-Agency Guidance” issued by the Department of Agriculture, Department of Health and Human Services’ Health Care Financing Administration and Office of Civil Rights, states are required to provide specific notice when requesting an individual’s SSN and cannot require SSNs and citizenship-related information from individuals who are not applying for assistance.

Outreach

With a vast majority of AAPIs living at 400% FPL or below, many will qualify for tax credits and cost-sharing reductions. Successful outreach efforts to these populations will need to overcome linguistic and cultural barriers, reach these populations in their local communities, and integrate community based organizations and leaders. Furthermore, since AAPI women generally act as the gatekeepers to their family’s health and well-being, it is important that outreach is made accessible to AAPI women. In addition, any outreach efforts should be conducted in partnership with community based organizations and leaders. These organizations and individuals have significant knowledge about their populations’ members and have already built communication networks within their communities. Moreover, these leaders can draw their communities’ attention more effectively than the Exchanges alone.

As PPACA tasks Navigator programs with providing information on the Exchanges and tax credits in a culturally and linguistically appropriate manner, Navigators will also need sufficient funds to provide additional linguistically and culturally appropriate assistance. Navigators must provide translations of a significant amount of information, develop new resources to gear information towards the communities they serve, and maintain staff for in-person and in-language consultations. We urge Exchanges to prioritize Navigator grants to community-based or consumer-focused organizations as these organizations have strong expertise in providing culturally and linguistically appropriate resources.

To assist Navigators, Exchanges should develop train-the-trainer materials to familiarize Navigators with the intricacies of the Exchanges’ enrollment form, web portal, health plan information resources, and eligibility requirements. Additionally, Exchanges should ensure that the Navigators have access to background material on additional federal and state health benefit programs for which consumers may qualify.

Once Navigators are familiar with the Exchanges and tax credits, Exchanges should ensure that Navigators have basic informational resources at their disposal to disseminate to consumers. These may include a supply of in-language pamphlets with basic information on the Exchanges or an online tutorial that Navigators can watch with consumers to demonstrate how to apply

⁵ PPACA Sec. 1411(e)(3) states immigration and citizenship status in the Exchanges should be verified “in the same manner as an individual’s eligibility under the Medicaid program is determined under section 1902 (ee) of the Social Security Act.”

online and how to use features like the tax credit calculator. Where Navigators require additional assistance answering questions or overcoming technical difficulties in relation to the Exchanges, Navigators should have access to an assistance line maintained solely for Navigators to receive advice from staff managing the Exchange.

Outreach efforts must be conducted in various non-English languages and be directed towards an eighth-grade reading level or below. In determining which non-English languages to choose, Exchanges should adhere to HHS' LEP Guidance at a minimum. Exchanges should, however, go further and conduct outreach efforts based not only on population size, but also upon which communities demonstrate the most need due to health disparities and social factors such as poverty and uninsured rates. To gear outreach efforts towards immigrant populations, the information provided should emphasize that participation will not impact a participant's immigration or citizenship status and that any personal information solicited will be used for the sole purpose of determining eligibility for participation in the Exchanges.

To outreach effectively to AAPI populations, Exchanges should assess where these communities are and base outreach efforts in locations where women frequent. These efforts may include leaving in-language brochures in grocery stores, local pharmacies and health clinics, conducting in-language health fairs, presentations at local churches, and working with local media.

Consumer Experience

In addition to premium and cost-sharing information, information on the location and availability of linguistically and culturally competent providers will be beneficial to many AAPI women as they make their plan selections. Exchanges should ensure that health plan comparisons and summaries include information on the languages spoken by the plan's network of providers and the number of providers speaking those languages. The proximity of a plan network's providers to beneficiaries will also assist beneficiaries in considering plan options. Ideally, QHPs could provide a mapping tool to display the proximity of a plan network's providers to the beneficiary.

Exchanges should ensure that multiple community-based points of access are available for enrollment. Community health centers, public hospitals, schools, and community-based organizations, at a minimum, should receive training and resources for facilitating enrollment. As with any enrollment venue in which public computers may be used, best practices for providing a secure atmosphere for inputting sensitive data should be implemented.

Section 1002 of PPACA outlines eligibility requirements for states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. To ensure the highest level of consumer access and satisfaction, offices of health insurance consumer assistance or health insurance ombudsman programs should be strengthened to include the following, as proposed by California's Health Ombudsman bill, AB 2787:

- Provide information about consumers' rights and responsibilities with respect to health care coverage in plain language.
- Provide information, referral, and assistance to consumers with limited English language proficiency in their primary language.

- Consult with a network of community-based organizations that have experience with assisting consumers in navigating the local health care system, enrolling consumers in health care coverage, resolving consumer problems associated with health care access, and serving consumers with special needs, including, but not limited to, consumers with limited English language proficiency, low-income consumers, consumers with disabilities, and consumers with multiple health conditions.
- Track, analyze, and publicly report on consumer complaints by health status, age, race, ethnicity, primary language, and gender to determine the most common types of problems and problems faced by particular populations.

Furthermore, partnerships with community-based organizations can help increase the capacity of government agencies to reach individuals who are not served by traditional outreach methods. Community-based organizations can help facilitate enrollment in the Exchange and should be eligible for outreach and enrollment grant funding.

Qualified Health Plans

States must also ensure that qualified health plans serving particular populations participate in their Exchanges. Among other PPACA requirements, health plan networks must include “those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” These populations require linguistically and culturally appropriate care and health information that is relevant and understandable. To avoid shortages of physicians serving these populations, States should be encouraged to consider incentive programs for physicians to serve their state’s vulnerable populations.

NAPAWF is pleased that PPACA’s minimum requirements will ensure that QHPs maintain health insurance plan networks with “essential community providers where available, that serve predominately low-income, medically-underserved individuals.” In order for the provision to have its intended impact, it is imperative that the Department implement the ECP protection in a meaningful and robust way so that patients are guaranteed access to the providers they trust in their communities. Congress identified a number of providers—340B and “340B look-alike” providers—that Exchange-participating health plans must contract with, and the HHS rulemaking should reiterate and emphasize that requirement. This group of providers represents a strong swath of the community-based providers in our country, including public hospitals, community health centers, and family planning clinics.

In fact, implementing regulations should ensure that all the ECPs Congress intended are protected by the provision, including family planning clinics and women’s health centers. Given the unique health care access needs of women, it is especially important that HHS emphasize the importance of requiring Exchange-participating health plans to contract with family planning clinics or women’s health centers.

Selecting and sustaining a sufficient mix of QHPs should—absent a state law prohibiting such coverage—require inclusion of at least one QHP that offers coverage for abortion services described in Section 1303(b)(1)(B)(i). This is necessary to guarantee that women participating in an Exchange are provided with comprehensive coverage options that meet their medical needs, and to ensure that women are able to receive the full benefit of the new law as passed, which

specifically allows for coverage of abortion care in the new health care system (see Section 1303(b), et. seq.).

Full access to health services, however, must include access to linguistically and culturally appropriate services. We urge the Secretary to bolster this criterion or add additional criteria that would have QHPs maintain health insurance plan networks that include providers with diverse linguistic abilities and cultural backgrounds where available. Providers with these skills and knowledge can most effectively communicate with patients from diverse backgrounds. Additionally, the Secretary should ensure that QHPs denote a provider's language abilities in its provider directory and maintain a database of community based organizations and language service resources that providers can refer patients to when language is a barrier.

As an additional criterion for participation in the Exchanges, the Secretary should require that QHPs employ best practices for reaching low-literacy audiences when drafting health coverage literature and notices. Among these practices, NAPAWF strongly supports literature geared towards an eighth-grade reading level or below.

Catastrophic Coverage

The Secretary should ensure that young women who choose catastrophic coverage have access to the full-range of contraceptive options—a key component of preventive care for women—by including it in the list of recommended preventive services that are covered without cost sharing under Section 2713 of the Affordable Care Act. If contraception is not included as part of the Women's Health Amendment under Section 2713, young women who choose catastrophic coverage will be faced with paying for this essential health care entirely out-of-pocket. Given that fifty-two percent of young women ages 20-29 who use contraceptives depend on prescription contraceptive methods⁶, including contraception in the Women's Health Amendment under Section 2713(a)(4) would meet a fundamental health care coverage need for a large segment of Americans, would help to prevent unintended pregnancies, and would improve the health of these young women.

In addition, the Secretary should include all obstetric and gynecological providers in the definition of primary care in the catastrophic coverage provision created by Section 1302. The catastrophic coverage provision of the Affordable Care Act allows enrollees coverage of three primary care visits per year without having to pay towards the deductible. Routine OB/GYN annual exams are primary care visits for women, and are widely recognized as such by states and the federal government. The Affordable Care recognizes that obstetric and gynecological care is primary care by giving women direct access to such care. This is now in line with the twenty-two states and the District of Columbia that require obstetric and gynecological services to be treated as primary care.⁷ By including obstetric and gynecological annual exams in the definition of primary care, HHS will ensure young American women have catastrophic coverage that is on par with their male counterparts.

⁶ Mosher, Jones J. "Use of Contraception in the United States: 1982-2008." *National Center for Health Statistics* 23.29 (2010).

⁷ "State Mandated Benefits: OB/GYNs as Primary Care Providers, 2008." Kaiser Family Foundation statehealthfacts.org, 2008.

Employer Participation

Immigrant AAPI women are more likely to engage in small businesses or low income industries, which may leave them unable to obtain health care. In fact, companies owned by women of color were the fast-growing group among all companies from 2002 to 2008. Many of these businesses are small businesses that cannot afford health insurance. Under PPACA, these businesses can benefit from tax credits if they have 25 or fewer full-time employees and purchase health coverage through the Exchanges for their employees. We urge Exchanges to conduct outreach around these small business credits using in-language materials and focusing on community-based distribution points. Exchanges should assess the ownership demographics of small businesses in their state to determine what languages should be provided.

Thank you for your consideration of these comments.

Respectfully,

Miriam W. Yeung, MPA
Executive Director
National Asian Pacific American Women's Forum (NAPAWF)