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VIA ELECTRONIC SUBMISSION

May 6, 2013

Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
P.O. Box 8010  
Baltimore, MD 21244-1850

**Re: CMS-9955-P**  
**Standards for Navigators and Non-Navigator**  
**Assistance Personnel**

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. We are pleased to submit the following comments in response to the proposed rule issued on April 5, 2013 regarding standards for navigators and non-navigator personnel.

As an overarching comment, we recognize that three types of individuals may potentially provide information and enrollment assistance to consumers – navigators, non-navigator assistance personnel, and certified application counselors (CACs). Throughout these comments, we use the general term “assisters” to include all three types. When we wish to address comments to only one or two of the types, we will use the specific terminology.

We commend HHS on reiterating the requirement throughout the preamble that all assisters provide fair, accurate and impartial information. This is a critical protection to ensure consumers can rely on assisters without concern about an assisters’ potential conflict of

interest or values that may conflict with providing comprehensive information.

## **General Comments**

### ***Consumer assistance funding in states accessing only federal navigator grant allocations is strikingly inadequate.***

We support comments submitted by the Georgetown University Health Policy Institute's Center for Children and Families (CCF) about the inadequacy of funding in states that will only access federal navigator grants. The assistance resources in states that are able to tap 1311(a) funds for in-person assistance (state-based and consumer partnership exchange states) are strikingly different than states where only federal navigator grants are available. We ask HHS to identify additional resources to fund navigators in this first critical year of exchange coverage.

As additional states reveal the details of their consumer assistance numbers, HHS should be able to glean a formula for projecting the number of navigators and project leads needed based on 1) the number of uninsured, 2) the percentage expected to enroll in the first year, 3) the average number of individuals on each application, 4) the proportion that will need or want assistance, 5) the period of time for open enrollment, and 6) the average number of applications a navigator might assist given their other duties, including conducting outreach and public education. Such a formula could include a range of projections but would quickly reveal that the level of funding for federal navigator grants is strikingly inadequate to meet the needs of consumers for enrollment assistance.

As CCF outlined in greater detail in their comments, HHS can take several steps to better support and strengthen the availability of assistance:

- allow § 1311(a) funds to be used to provide consumer assistance in full FFE states;
- clarify how private support can leverage federal Medicaid matching funds to provide enrollment assistance;
- establish a dedicated technical assistance unit and helpline in the FFE to support navigators and assisters;
- establish a web-portal with enhanced functionality for navigators and assisters;
- provide key resources needed by navigators through the FFE so that limited navigator grants can be dedicated to direct consumer assistance; and
- release final regulations regarding certified application counselors (CACs) as soon as possible and clarify that states are not prohibited from funding CACs.

## **Comments on Preamble**

### ***Use of § 1311 Funds***

We appreciate that state-based exchanges and state partners in consumer partnership exchanges may use § 1311(a) exchange establishment grants to fund non-navigator assistance programs. As long as § 1311 funds are available to states, a state-based exchange is not required to be self-sustaining in the first year and that as a transitional policy, a state-based exchange may use a non-navigator assistance program in its initial year of operation to fill in any gaps in its navigator program and otherwise ensure that the full range of services that navigators provide are available. It is important these states use the initial year of operation to develop a transition plan to ensure adequate availability of navigators to meet the need for consumer assistance in 2015 and beyond. In doing so, it is desirable to build on the experience of the non-navigator entities and assisters rather than create new programs from scratch.

**Recommendation: Require states using § 1311 funds for non-navigator assisters to develop a plan that transitions their § 1311 funded assistance programs into fully functioning navigator programs.**

### ***Certified Application Counselors (78 Fed. Reg. 20585)***

HHS requested comment as to whether all or some of the conflict-of-interest, training and meaningful access standards should be applicable to certified application counselors. We believe the answer should be yes to all of these standards. Individuals seeking assistance applying for insurance or understanding eligibility requirements may not understand the differences between navigators, non-navigator assistance personnel and certified application counselor. Consumers may select an assister based on geography, language, accessibility or other reasons. Thus the type of assistance and information provided should not depend on a consumer's understanding of the different roles. Rather, a consumer should receive the same assistance regardless of the type of assister providing the information. Otherwise, one consumer may receive less assistance or have to seek assistance from a second assister if the standards and requirements differ. While we recognize that the previous role of certified application counselors (CACs) may have been limited in scope to Medicaid and CHIP enrollment, if HHS' final rule governing CACs allows their use by exchanges or in an assister role, the requirements for training, knowledge, and assistance provided should align with those of navigators and non-navigator assistance personnel as described in this rule.

However, if HHS determines that the full set of standards should not apply, we strongly urge HHS to minimally apply the standards prohibiting receipt of consideration for enrollment (as we propose amending below in § 155.215), requiring assisters to provide information on the full range of QHPs and requiring CACs to make specific disclosures to the exchange and consumers. That said, we also recognize that consumers may not fully understand the implications of disclosed relationships. A study at Georgetown University, "The Burden of Disclosure: Increased Compliance with Distrusted Advice,"

published in the *Journal of Personality and Social Psychology* suggests that consumers may be influenced by disclosures in a negative way. Advisees who received disclosures were aware that the advice may be biased and trusted it less.<sup>1</sup> Yet they also were more likely to comply with their advisor's recommendation and be less satisfied with their choice. Thus, it will be important for HHS to explore this phenomenon in FFE monitoring.

We also suggest that HHS amend § 155.225 to ensure that states do not preclude the ability of certified application counselors to perform the full scope of their duties. We are concerned that states have sought to limit their activities through state legislation. We thus suggest adding the language from § 155.210(c)(1)(iii) into § 155.225.

### **Recommendations:**

- **Apply all navigator/IPA standards to certified application counselors.**
- **Amend § 155.225 to include the text from § 155.210(c)(1)(iii).**

### ***Standards for Non-Navigator Assistance Personnel***

We also suggest that HHS create a new regulatory provision to specify standards for non-navigator assistance personnel. As noted in the preamble at 78 Fed. Reg. 20583, state-based exchanges may delay implementation of a navigator program and instead provide assistance solely through a non-navigator assistance program using exchange establishment funds in the first year of exchange operation. For states that take advantage of this flexibility, the non-navigator program will effectively serve as the navigator program in the first year and it is therefore imperative that it provide the same scope of services and that states do not prevent full functioning of the program. Some states have already sought to limit assisters' activities through state legislation. We thus suggest adding a new regulatory section addressing non-navigator assistance personnel that includes, among other standards, the language from § 155.210(c)(1)(iii).

**Recommendation: Add a new provision defining standards for non-navigator assistance personnel, including the text from § 155.210(c)(1)(iii).**

### ***Conflict of Interest Standards (78 Fed. Reg. 20586-7)***

HHS requested comment on whether conflict-of-interest standards should apply to both navigator and non-navigator assistance personnel. We support the conflict of interest standards and do not see any reason why different assisters should be subject to different conflict-of-interest standards. As stated above, consumers likely will be unaware of the differences between types of assisters and should receive the same unbiased information regardless of the type of assister accessed. If different conflict-of-interest standards exist, one consumer may receive different information than another, solely based on whether the consumer went to a navigator versus non-navigator

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<sup>1</sup> The Burden of Disclosure: Increased Compliance with Distrusted Advice," was published in the [\*Journal of Personality and Social Psychology\*](#).

assistance personnel. The system must operate seamlessly for the consumer so that the consumer selects an assister based on factors the consumer will understand and know (geography or language services provided) rather than unknown.

### ***Written Conflict of Interest Plan (78 Fed. Reg. 20587)***

NHeLP fully supports the proposed requirement that assisters have a written plan to remain free of conflicts of interest. As the preamble recognizes, many entities may have a changing workforce. It is essential that the workforce not have any conflicts of interest, regardless of when someone begins working for an entity. It would be woefully insufficient if an entity could meet conflict of interest requirements upon initiation of an assister contract but not continue throughout. Otherwise, an entity could hire individuals without conflicts to satisfy contract requirements but then hire others during the contract period who have conflicts. HHS must require entities to maintain and document each staff person's ongoing commitment to avoiding conflicts of interest. Thus the entity should have a written plan with policies and procedures to ensure the conflict of interest protections are in place for all employees and contractors, regardless of hire date, and throughout the life of the assister contract.

We suggest that each entity have a formal agreement regarding conflict-of-interest that details the specific conflict of interest provisions and the staff person's understanding and agreement. HHS could create a template to assist in this process. Each staff person should sign the document, with the entity also signing it and keeping a copy in the staff person's record. This agreement should be updated and signed each year (or upon contract renewal, if less than one year) to ensure continued lack of conflicts. We also suggest the entity have a written plan on notifying the entity if a new conflict arises and how to resolve potential conflicts, including having an independent review to ascertain if a conflict does actually or potentially exist so that appropriate actions should be taken. Further, prior to hiring assister staff and likely as part of the application process, the entity should conduct a conflicts check to ensure that any individual with a conflict is not hired.

### ***Training Regarding Culturally and Linguistically Appropriate Services and Accessibility for People with Disabilities (78 Fed. Reg. 20589)***

We strongly support the requirements for training regarding culturally and linguistically appropriate services and accessibility for people with disabilities. All assisters are subject to compliance with federal civil rights laws including ACA § 1557, Title VI of the Civil Rights Act of 1964, § 504 of the Rehabilitation Act, and the Americans with Disabilities Act. Further, HHS's final Exchange eligibility and enrollment regulations, at § 155.120, specifically require states and exchanges – and thus the assisters connected with the exchanges – to comply with applicable nondiscrimination statutes and not discriminate based on race, color, national origin, disability, age, sex, gender identity or

sexual orientation.<sup>2</sup> This training is essential to ensure that assisters do not discriminate in the provision of their services.

As HHS recognized with its recent release of the 2013 Enhanced CLAS Standards, numerous ethical and practical reasons exist to provide culturally and linguistically appropriate services in health and health care, including:

- responding to current and projected demographic changes;
- eliminating long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds;
- improving the quality of services and primary care outcomes; and
- meeting legislative and regulatory mandates.<sup>3</sup>

For all these reasons, the training on culturally and linguistically appropriate services and accessibility for people with disabilities is critical to ensure assisters understand how to identify language or accessibility needs, work with these populations (including how to access and use language services, TTD/TTY, and augmentative and alternative communication (AAC) assistance), and ensure nondiscrimination. Unfortunately, despite the longstanding existence of civil rights requirements, significant examples continue to arise of discrimination. Without specific training (and enforcement), this would likely continue since many assisters may not have direct experience or expertise in working with these populations.

We also specifically suggest that HHS include ACA § 1557 in the references to “certain civil rights laws” throughout the document. For example, there is a list under “3. Providing Culturally and Linguistically Appropriate Services” at 78 Fed. Reg. 20590 (middle column). In this list, we suggest adding § 1557 but deleting reference to § 504 since the section is about providing culturally and linguistically appropriate services. In “4. Standards Ensuring Access by Persons with Disabilities” at 78 Fed. Reg. 20591, we also suggest adding in reference to § 1557 and the Americans with Disabilities Act and deleting reference to Title VI.

In addition to these two sections, however, we suggest adding a new section that includes specific reference to nondiscrimination requirements based on race, ethnicity, gender, age, sexual orientation, and gender identity. These are covered by § 1557 and HHS should specify them in addition to culturally and linguistically appropriate services and accessibility for individuals with disabilities.

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<sup>2</sup> 77 Fed. Reg. 18310, 18447 (March 27, 2012) (see 42 C.F.R. § 155.120).

<sup>3</sup> Office of Minority Health, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (April 2013) at 8, available at <https://www.thinkculturalhealth.hhs.gov/>.

## **Referrals**

To comply with the ACA and civil rights requirements, each navigator must provide communication services for limited English proficient (LEP) individuals and individuals with disabilities. Yet the preamble states that an assister may refer an individual to other resources when the assister is unable to provide full enrollment services for a particular person. 78 Fed. Reg. 20589. We ask that HHS clarify that this referral option does **not** negate the requirement of assisters to provide communication assistance. The provision of culturally and linguistically appropriate services is a specific statutory requirement and longstanding civil rights laws prohibit discrimination on the basis of language or disability. If HHS permits an assister to refer LEP consumers or consumers with disabilities because of language or disability needs, it would undermine Congressional intent. It also would likely be discriminatory since only these individuals would have to go to an alternate location to receive assistance whereas other individuals would receive assistance at one location. Providing communication services can be done easily and effectively, as HHS noted in the preamble:

We anticipate that most Navigators and non-Navigator assistance personnel would use readily available telephonic interpretation services and other effective low-cost services in order to meet the requirement to provide language access to the consumers they serve, so that it will not be costly or onerous. 78 Fed. Reg. at 20590.

If HHS permits referral to other assisters, we strongly urge HHS to clarify that referrals may not be done solely due to communication needs. As one solution to help assisters effectively provide communication assistance, an exchange could negotiate a group rate or contract for language services and auxiliary aids and services and provide access to all assisters. As an example, Kansas' Medicaid agency contracted with an over-the-phone interpreting company and then provided the telephone number and an access code to all Kansas primary care case management providers. The providers benefitted by having access to competent interpreters and by not having to research and negotiate independently for language services while the Medicaid agency was able to negotiate lower rates for bulk purchasing, saving the state money.<sup>4</sup>

We also suggest that HHS slightly expand the ability to refer an individual if a navigator does not have "immediate capacity" to also include consumer-specific conflicts of interest. Situations may arise when a navigator has a specific or direct conflict of interest with a particular consumer and should refer that consumer to another navigator entity for assistance. As one example, a legal services organization serving as a navigator will also provide direct legal assistance to consumers. If it provides legal assistance to one spouse for divorce or custody assistance while the other spouse

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<sup>4</sup> National Health Law Program, Medicaid and SCHIP Reimbursement Models for Language Services (2009 update), *available at* [http://www.healthlaw.org/index.php?option=com\\_content&view=article&id=240%3Alanguage-access-publications&catid=45&Itemid=196](http://www.healthlaw.org/index.php?option=com_content&view=article&id=240%3Alanguage-access-publications&catid=45&Itemid=196).

seeks navigator assistance applying for health insurance, the spouse applying for health insurance would have to disclose income to the navigator that could impact the divorce/custody proceedings. Thus, the legal services organization should not have to serve as navigator but refer the spouse seeking health insurance to another entity for assistance to relieve the potential conflict of interest. This could also occur in non-legal navigator entities for a variety of reasons, including conflicts serving certain consumers due to family situations, domestic violence, restraining orders, etc. Thus we recommend that HHS allow referrals both for a lack of immediate capacity (except as noted above) or due to a direct consumer-related conflict of interest.

### ***Availability of Assister Training***

We urge HHS to allow access to the training program for assisters to those trusted resources who may not formally serve as assisters but who will work with consumers by providing education or problem-solving. For example, many legal services organizations and Protection & Advocacy organizations may not undertake formal assister roles but will likely receive referrals from assisters for problem solving. Or legal services organizations may engage in a formal but limited support role with navigators or exchanges, such as current CAP grantees. Thus, they should have access to the training, even if they do not complete the certification examinations. As another example, some community based organizations may not apply to become assisters but still will provide outreach and assistance to consumers they serve and would benefit from access to the training. This particularly includes organizations serving particular segments of the population, such as certain language groups or immigrants. We thus encourage CMS to ensure access to the navigator training programs to all who may be interested while limiting certification only to those who are officially designated as assisters.

While we recognize there may be concerns about providing the training to any interested party, we believe HHS could establish a mechanism for trusted entities/partners to access the training. HHS could limit the access to certain modules that do not address navigator administrative activities. We believe at least three alternatives exist for accomplishing this:

- allow an entity to sign an agreement that its staff will view the trainings but will not seek certification or hold themselves out as certified;
- provide access to training materials and powerpoints but not access to the web-based training itself; or
- authorize a “train-the-trainer” program whereby certified assisters or others can utilize training materials for outreach/education to interested parties.

Any agreement an entity receiving access to training signs should include enforcement provisions for noncompliance and a requirement that the entity may not charge consumers for providing assistance arising from information provided in the training.



We further urge HHS to establish a public “registry” of certified assisters. Such a registry can help prevent fraud by ensuring public access to a list of those who are appropriately trained and certified as assisters.

## **Comments on the Proposed Rules**

### **§ 155.210**

NHeLP supports the regulation’s pre-emption of any state law that imposes any licensing, certification or training standards upon assisters that *prevents* implementation of the provisions in Title I of the Affordable Care Act. For example, states may not require that assisters be certified brokers, insurance agents, or licensed producers. If assister programs are to be effective in helping to enroll people in coverage, it is very important that states do not implement legislation that has the potential to impede the delivery of the full scope of assister duties.

We suggest HHS clarify, however, in what circumstances a state may require additional training beyond the “up to 30 hours” mentioned in the preamble. In some situations, it may be beneficial for a state to require additional training, such as state-based information or details on eligibility for a state-replacement program available to immigrants. In other situations, however, additional training may serve to thwart the underlying goals of the assister program by adding onerous requirements that are unattainable or would delay operation of assisters beyond the launch of open enrollment. We suggest HHS provide parameters to states that further explain in what situations additional training, licensing or certification is allowable.

We also suggest adding a new subsection that navigator standards include compliance with relevant civil rights laws. To help remedy the persistent problem of insurance discrimination, HHS has issued regulations that prohibit exchanges from discriminating on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity.<sup>5</sup> These regulations also make clear that the nondiscrimination requirements also apply to entities under agreement with exchanges, including navigators.<sup>6</sup> In addition, § 1557 of the Affordable Care Act contains nondiscrimination requirements applicable to all health programs and activities receiving Federal financial assistance.

However, in the proposed rules, HHS does not clearly apply these nondiscrimination requirements to the provision of consumer assistance services. References made in these proposed rules to nondiscrimination obligations are limited to Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, providing an

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<sup>5</sup> 45 C.F.R. § 156.200(c)(2)(2012).

<sup>6</sup> See 45 C.F.R. § 155.110(b) and 77 Fed. Reg. at 18332 (“We clarify that because Navigators are third parties under agreement (that is, the grant agreement) with the Exchange, the nondiscrimination standards that apply to Exchanges in § 155.120(c) will also apply to entities seeking to become Navigators.”)

incomplete description of the antidiscrimination standards applicable to Navigators and other consumer assistance personnel.

To ensure that **all** consumers are protected from discriminatory conduct, we recommend that HHS codify the nondiscrimination requirements of § 1557 and the previously issued exchange regulations for these entities.

**Recommendation: Amend § 155.210(d) to add new subsection (5) as follows:**

***(5) Discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.***

### **§ 155.215(a)**

We strongly support HHS' prohibition on health insurers or subsidiaries serving as assisters, and the prohibition of assisters from lobbying on behalf of the insurance industry. We further support the prohibition on stop loss insurers or those who receive compensation from stop loss insurers from being assisters. We also support the clarification that receiving consideration from a health plan or stop loss insurance issuer includes trailer commissions. The role of assisters is to provide consumer assistance through the entire eligibility and enrollment process, including facilitating plan selection. Thus, HHS should also prohibit receipt of referral fees from insurance brokers and agents.

In subsections (iii) and (iv), we support the clear requirement that these entities provide information to consumers about the "full range" of QHP options and insurance affordability programs for which they are eligible. This standard articulates a fundamental principle applicable to these programs: consumer assistance through the exchanges must be fair and unbiased.

To ensure that consumer assistance activities adhere to this principle, we anticipate that clarification may be needed through training or other means that address what is meant by providing information about the "full range" of options available to consumers. This will have an important impact on women's ability to obtain coverage for comprehensive reproductive health care including abortion services. Because there are likely to be questions and potential confusion over abortion coverage in the exchanges, it is particularly important that assisters be unbiased and share all information impartially and accurately. As another example, equipping consumer assistance entities to provide information about the complete array of coverage options available to LGBT consumers will require both the resources to ensure that assisters are able to provide information that is **relevant** to consumers, and the ability of assisters to convey that information without bias. Since assistance personnel will provide information on insurance affordability programs to a diverse array of families, they must be able to provide accurate and impartial information to families headed by same-sex couples, multi-generational families, mixed status families, and others. Adequate resources to answer inquiries related to affordability programs, which may be complicated by multi-taxpayer-

household status, will be essential in ensuring completeness and accuracy of information provided to consumers. Additionally, consumer assistance entities, including faith-based organizations and other community-based organizations, must be able to provide this information without objection.

We also support the provision requiring assisters to submit written notice attesting to the conflict of interest standards, and promising to remain conflict-free throughout the time they serve as assisters.

While recognize that certain conflicts of interest may not bar assisters from serving, we support the disclosure of these to the exchange. These include selling other types of insurance business (such as life or disability insurance), employment with an insurance company in the last five years, and any anticipated contractual relationship with health insurers. The regulations maintain a balance between ensuring integrity and impartiality of assisters while not imposing regulations so stringent that they become prohibitive. NHeLP thanks HHS for maintaining strong and stringent conflict of interest standards and for demonstrating a commitment to the delivery of unbiased assister services.

### **Recommendations:**

- **Amend §155.215(a)(1)(i)(D) and §155.215(a)(2)(ii)(D) to as follows:**

Will not receive any consideration directly or indirectly from any health insurance issuer, any issuer of stop loss insurance, **or any licensed insurance agent or broker** in connection with enrollment **or referrals for enrollment** of any individuals or employees in a QHP or non-QHP.

- **Amend § 155.215(a)(1)(iii) as follows:**

All Navigator entities, including the Navigator's staff must provide information to consumers about the full range of QHP options, **including the providers and services covered by the full range of QHPs**, and insurance affordability programs for which they are eligible.

- **Amend § 155.215(a)(2)(iv) as follows:**

Provide information to consumers about the full range of QHP options, **including the providers and services covered by the full range of QHPs**, and insurance affordability programs for which they are eligible.

### **§ 155.215(b)**

#### **§ 155.215(b)(1)**

We generally support the certification and annual re-certification standards at

§155.215(b)(1) for navigators and non-navigator assistance personnel. We believe that state-based exchanges (SBE) and state consumer partnership exchanges (SPE) may wish to create and administer their own training programs and therefore support that the proposed regulations allow SBEs and SPEs to do so. We encourage HHS to release further guidance and provide an opportunity for comment on the criteria that will be used to receive HHS approval for state-based training.

In (b)(1), we suggest HHS consider training on issues relevant to particular populations. As one example, while LGBT individuals have many of the same coverage needs as other populations of consumers, coverage for certain services may be of particular importance to LGBT consumers, and assisters must be able to provide adequate information to support an informed choice. For example, the LGBT population has been disproportionately impacted by HIV/AIDS. Individuals who are living with HIV will require specific information regarding prescription formularies and provider networks, to ensure that a plan will meet their basic needs for coverage. Transgender individuals may also have specific questions about coverage. LGBT individuals and people living with HIV, who continue to be disproportionately impacted by unfair discrimination in insurance,<sup>7</sup> may also require information related to appeals and grievance procedures.

Assisters should also receive specific training on eligibility and enrollment rules for immigrants and other populations with special circumstance that impact eligibility, such as DACA-eligible immigrants, COFA migrants, and families with mixed immigration status. Assisters should be trained to understand the rights and needs of mixed status families where one family member may be eligible for a subsidy and another family member is not because of different immigration status. Because some immigrants will not be eligible for either Medicaid or subsidies on the exchange, persons providing consumer assistance should also receive training on where to refer individuals who don't qualify for health insurance coverage through the state Marketplace to other consumer assistance programs.

With regard to the requirements in (b)(1)(i), (ii) and (iii), we suggest that HHS evaluate whether assisters may be able to begin assisting consumers prior to obtaining certification. Given that FFE/state partnership assister grants will not be awarded until mid-August, the timeframe for ensuring assisters obtain training and certification is very short. For the initial open enrollment period, we suggest HHS determine whether assisters could begin limited consumer assistance prior to receiving certification, perhaps upon completion of a significant amount of the training. Or HHS could consider, for this initial open enrollment period, that individuals who pass all examinations but

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<sup>7</sup> AIDS.gov. 2012, *The Affordable Care Act Helps People Living with HIV/AIDS*, available from <http://aids.gov/federal-resources/policies/health-care-reform/>. See also Center for American Progress, *Ensuring Benefits Parity and Gender Identity Nondiscrimination in Essential Health Benefits*, available at <http://www.americanprogress.org/issues/lgbt/report/2012/11/15/44948/ensuring-benefits-parity-and-gender-identity-nondiscrimination-in-essential-health-benefits/>.

whose formal certification is not yet approved may be able to begin assisting consumers.

In (b)(1)(iii) and (iv), a particularly important consideration in selecting a plan for some individuals will be whether family coverage offered by QHPs includes same-sex partners and spouses and their children.

Currently, many states, including FFE and Partnership states, extend some form of legal recognition to families headed by same-sex couples. In correlation with legal recognition, many insurance carriers in individual and small group markets across the country extend family coverage to domestic partners and spouses, regardless of whether they are same- or different-sex. Many states with some form of relationship recognition for same-sex couples affirmatively require carriers in the individual and small group markets to extend family coverage to domestic partners.<sup>8</sup> In states where explicit prohibitions on the legal recognition of same-sex relationships exist,<sup>9</sup> insurers still frequently extend coverage to domestic partners,<sup>10</sup> and some states give carriers the explicit authority to offer benefits to these couples.<sup>11</sup> Laws in some states further require that same-sex partners of state employees be offered insurance coverage equivalent to what is offered to opposite-sex spouses.<sup>12</sup> Same-sex partners and their children may thus be eligible to enroll in family coverage, regardless of whether their relationship is recognized by state law.

Recognizing the broad array of family compositions included in family coverage, HHS has made clear that states have the flexibility to include same-sex couples and their children in family coverage sold through the exchanges.<sup>13</sup> Same-sex couples will thus be likely to combine their individually-calculated advance premium tax credits to purchase family coverage through the exchanges.

Given this patchwork of laws, policies, and market practices, selecting insurance coverage may be a daunting prospect for LGBT families. Navigators must be equipped to answer questions regarding calculation of advance premium tax credits and cost-sharing reductions, the ability to combine tax credits to purchase inclusive family coverage through the exchanges, and the tax consequences of these decisions.

In (b)(1)(iv), we believe that continuing education should include routine opportunities for the exchange of information between the FFE and navigators and assisters, as well

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<sup>8</sup> See e.g. Cal Ins. Code § 381.5; Cal Health & Saf. Code § 1374.58; ME ST T. 24-A § 2741-A; CVR 21-020-051.

<sup>9</sup> See e.g. Nebraska State Constitution Article I-29.

<sup>10</sup> For example, a search performed on the [www.healthcare.gov](http://www.healthcare.gov) for individual coverage for two men in zip code 68776 (South Sioux City, Nebraska) resulted in 17 hits for plans offering coverage to same-sex partners.

<sup>11</sup> See e.g. A.C.A. § 9-11-208(a)(3); C.R.S. 10-16-105.

<sup>12</sup> See e.g. 2 AAC 38.010; C.R.S. 24-50-603.

<sup>13</sup> 78 Fed. Reg. 39 (February 27, 2013).

as the sharing of best practices among all assister types. Such forums should actively promote two-way communications and networking among assisters, and serve as a key loopback mechanism that enables HHS to assess how outreach, marketing, communications, systems, eligibility and enrollment procedures and virtually all aspects of FFE operations and access to the coverage continuum is working on the ground level for real people. This type of feedback has proven to play a critical role in pinpointing systemic and recurring problems and identifying opportunities for quality improvement over time.

We also suggest HHS provide more information on the type and length of continuing education and recertification. Assisters must understand how much time may be involved and may need to begin continuing education soon after receiving certification, particularly if certification is valid for only one year. We suggest HHS provide information on the amount of continuing education required, topics that must be covered, what types of training will count (e.g. will only HHS-approved curricula be permitted?), and the costs for ongoing training and recertification. This information will be important for assister entities for planning and budgetary purposes, particularly as they may allow assisters to complete continuing education as part of employment and/or pay for it.

Subsection (b)(1)(v) indicates that navigators and non-navigator assistance personnel should be prepared to serve both the individual exchange and SHOP. We believe this will limit the pool of applicants for navigator grants. The preamble of the latest proposed rule indicates HHS has “inferred” from ACA § 1311(i)(2)(B), which states an entity must demonstrate it has existing relationships, or could readily establish relationships, with employers and employees and the inclusion of Small Business Administration resource partners among entities that are eligible for navigator grants, that navigators must serve both exchanges. We agree that the ACA requires there to be navigators serving the SHOP. We also acknowledge the law requires SHOP navigators and that small employers, particularly those that are minority owned, may be best served by navigators who can provide culturally and linguistically competent services. A particularly large proportion of SHOP participants will be immigrant employers and employees, as many immigrants are small business owners and are employed by small businesses. Many of these individuals are limited-English proficient (LEP), and live in mixed-status families that include eligible and ineligible household members, thus the SHOP presents an opportunity for many immigrant workers and entrepreneurs and their families to obtain affordable coverage.

However, we do not agree that all navigators, as well as all non-navigator assisters (as the training standards also apply to them), should serve both exchanges. Both the ACA and navigator regulations finalized on March 23, 2012 state that to be eligible to receive a grant under subparagraph (1), an entity shall demonstrate to the exchange involved that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan. The use of “or” rather than “and” could be inferred to mean that eligible

navigators must have one or more, but not all, of the relationships noted. Thus, we urge you to reconsider this provision. We believe there is still time to update the federal funding opportunity announcement that parallels this proposed rule to give priority to applicants that indicate they will serve both exchanges but eliminate the requirement that all applicants must serve both exchanges.

If HHS adopts this recommendation, we do recommend that assisters who only serve consumers in the individual exchange should have sufficient information to appropriately refer consumers who need assistance with SHOP exchanges to assisters who can help with those issues.

**Recommendation: Strike the provision at §155.215(b)(1)(v) but ensure that navigator resources are available to assist eligible employers in the SHOP throughout each state.**

### **§ 155.215(b)(2)**

It appears that the range of training topics listed in § 155.215(b)(2)(i) – (xv) largely incorporates the broad content that is needed to ensure that assisters have the training and skills necessary to provide reliable, effective assistance to consumers. We urge HHS to work with knowledgeable stakeholders to review and comment on more detailed training materials to ensure that all the critical content areas and best practices are incorporated.

**Recommendation: Provide an opportunity for stakeholders to review and comment on detailed training materials to ensure that the most comprehensive content and best practices are incorporated.**

We also suggest certain additions and clarifications to these content areas, as follows.

### **§155.215(b)(2)(i)**

Subsection (i) describes the type of QHP information that will be included in the training. The training should emphasize the requirement that assisters provide information on the full range of QHPs and be trained on the importance of providing guidance on factors to consider in choosing a plan without recommending a specific plan. These factors may vary by consumer if, for example, a consumer has a disability or is limited English proficient, is LGBT or transgender, or lives in a rural area. Depending on the consumer's individual circumstances, the consumer may want to evaluate a QHP on specific factors such as any limitations on services covered, cost-sharing, prescription drug coverage, and accessibility or language services provided by a QHP's network providers.

In regard to QHP information, issues regarding pediatric dental benefits, which are essential for children's healthy development, may be especially complex. Having expertise in QHPs must include a clear understanding of the impact of stand-alone

dental plans on accessing pediatric dental benefits, premium tax credits and consumer protections.

Additionally, this section of training should include the process for referring appeals, complaints and grievances to legal services organizations, protection and advocacy (P&A) organizations, state health ombudsman or consumer assistance programs (CAPs), and how to ensure a successful handoff.

**Recommendation: Ensure that training includes a thorough understanding of the implications of pediatric dental benefits accessed through stand-alone plans.**

**Recommendation: Ensure that the training incorporates how to make effective referrals to other consumer assistance programs for grievances and complaints.**

§155.215(b)(2)(ii)

Subsection (ii) addresses training on the range of insurance affordability programs. The duties of assisters require that they maintain expertise in eligibility, enrollment and program specifications for all of the insurance affordability programs. Yet, it is not clear to what extent state-specific content, such as Medicaid and CHIP eligibility levels or eligibility and enrollment requirements in states that will not be using the FFE to make Medicaid determinations, will be included in the training. While we appreciate the challenges and time constraints in developing 34 versions of the training for each of the FFE states, it is very important that training include state-specific content so that navigators can fulfill their duty to assist with all coverage options. We note that Medicaid and CHIP eligibility levels and state verification requirements will be available to HHS through the Centers for Medicaid and CHIP Services. These resources should be used to provide state-by-state details on eligibility levels and procedures that should be included in navigator resource materials and linked in the web-based training.

**Recommendation: Compile state-by-state data on final MAGI-equivalence levels for Medicaid and CHIP and use state verification plans to detail enrollment procedures as resources for assisters to ensure they have expertise in Medicaid and CHIP eligibility, enrollment and program specifications.**

Also in (ii), we recommend that the training include information about minimum essential coverage and how that may impact eligibility. For example, a pregnant woman who is receiving pregnancy-related services through Medicaid should not be turned away by a navigator since she may also be eligible to receive services through the exchange and receive a tax credit since pregnancy-related coverage, as proposed in the Department of Treasury regulations, is not minimum essential coverage. Similarly, an individual receiving family planning coverage through Medicaid would also be eligible for an APTC as would some children only receiving limited Medicaid services. Thus assisters must understand the implications of limited coverage categories and inform consumers they can still apply and be eligible for broader coverage through the exchange.



In (ii) and (v), we want to ensure that consumers found ineligible receive information about other programs or providers that may offer coverage. This should include, depending on the individual's situation, information about Medicare, state/local-funded programs, community health centers and free clinics, charity care, and other available assistance. Assistors should receive training on alternate programs and providers, particularly since some families (e.g. mixed status families) may have both eligible and non-eligible family members.

Further, we want to ensure that assistors understand that only certain members of mixed-status families will not be eligible for the Exchange, Medicaid, or CHIP. Research has shown that when some in the family cannot access health care, others in the family are less likely to use medical coverage or services for which they may be eligible. It is vital that navigators be able to connect uninsured family members to coverage and care. If navigators fail to provide effective help to the uninsured, an important opportunity will be lost to improve the health and well-being of vulnerable, hard to reach families. An invaluable resource in this regard would be the development of post-ACA fact sheets or guidance with detailed information about safety net providers and services that are convenient and open to all, regardless of immigration status, including Medicaid emergency services.

**Recommendation: Provide fact sheets or guidance with detailed information about other health insurance programs, safety net providers and services.**

§155.215(b)(2)(iii)

Subsection (iii) requires training on the tax implications of enrollment decisions, which we believe is critical for assistors to understand and be able to clearly articulate to consumers.

**Recommendations: Training on tax implications of enrollment decisions should include**

- **an understanding of the tax reconciliation process so that assistors are able articulate how tax credits are reconciled after the fact through the federal tax filing process for the applicable coverage year.**
- **the availability of tax credits for small business that provide health insurance to their employees.**

§155.215(b)(2)(iv)

Subsection (iv) addresses eligibility requirements for premium tax credits and cost-sharing reductions, and the impacts of premium tax credits on the cost of premiums. As noted in our comments on §155.215(b)(2)(ii), the ACA and regulations finalized on March 23, 2012 require navigators to also have expertise in the eligibility requirements for Medicaid and CHIP. It is therefore critical that training cover eligibility requirements for all the insurance affordability programs.

We also suggest adding training about the relationship between cost-sharing reductions and plan selection. Assistors must understand how cost-sharing assistance may affect the consumer's choice of a plan. Since cost-sharing differs among the tiers of plans, assistors will need to be able to help consumers understand that selecting a plan based solely on premiums may have other financial implications. In particular, individuals eligible for cost-sharing reductions must understand that it only applies if they select a "silver" level plan, and that choosing a bronze plan with cheaper premiums may end up costing them more in cost-sharing later. Currently, the subsection mentions the impact of premium tax credits on the cost of premiums but neglects to emphasize training on the key interaction between premium assistance and cost-sharing assistance.

**Recommendation: Amend § 155.215(b)(iv) to read as follows:**

Eligibility requirements for premium tax credits and cost-sharing reductions, and the impacts of premium tax credits on the cost of premiums ***and plan selection on access to cost-sharing reductions.***

§155.215(b)(2)(v)

We strongly support requiring assistors provide contact information for appropriate public agencies to consumers regarding health care options not offered through the exchange. The health care safety net for uninsured individuals, including immigrants, is comprised of a number of state- and county-funded programs as well as the network of FQHCs, public hospitals, and other essential community providers that can connect family members to health care. These families will heavily rely on the knowledge of navigators and other assistors about additional providers that are available as sources of care, when they are not eligible for the exchange, Medicaid and CHIP. Minimally, the training should provide guidance on how to compile an extensive list of safety net and other available resources for this purpose, as noted in our comment at §155.215(b)(2)(ii).

§155.215(b)(2)(vi)

This subsection addresses the basic concepts of health insurance, the benefits of having it and the individual responsibility to do so. We support the this provision but want to ensure that it incorporates detailed information on who is subject to and exempt from the individual responsibility requirement, and the process for obtaining an exemption. In particular, it is important for navigators to help people not eligible for minimum essential coverage under the ACA understand that although the mandate applies to eligible members of their families, it does not apply to them and they will not incur a tax penalty for failing to have coverage.

**Recommendation: Training should include detailed information on who is subject to the individual responsibility, as well as who may be exempt and the process for securing an exemption.**

We recommend that HHS issue sub-regulatory guidance about, and require navigators to understand, predatory practices in marketing and issuing plans and benefits that are exempt from federal regulations and ACA standards. A recent report by Kaiser Health News explored the growing accounts of scams where vulnerable seniors are offered “fake health coverage, stripped down policies masquerading as real coverage. . . [including] fake Obamacare coverage.”<sup>14</sup> Consumers are likely to be confused by the individual responsibility, and particularly those barred from participation in ACA coverage options but exempt from the mandate, could be targets of such scams. Assisters should clearly educate consumers and caution them about such practices.

#### §155.215(b)(2)(vii)

This subsection references eligibility and enrollment procedures, including how to appeal an eligibility decision. We support this provision and want to reiterate our comments on §155.215(b)(2)(ii) that such training incorporate eligibility and enrollment procedures for the full range of insurance affordability programs, including Medicaid and CHIP. We also suggest that if a consumer asks for information about appeals that the assister refers the individual to legal services organizations or protection and advocacy entities.

#### §155.215(b)(2)(viii)

We strongly support the requirements in (viii) and (ix) regarding providing culturally and linguistically appropriate care and accessibility for individuals with disabilities. The importance of this training cannot be overemphasized for a range of vulnerable and underserved populations. As one example, immigrant communities and mixed-status families need culturally-appropriate services that include specific understanding of the special concerns of these families which have arisen from their experience living in America. Parents in many mixed-status immigrant households are afraid to apply for and enroll their family members in health coverage. In the past, immigrants have experienced hostility, language barriers, harassment and threats when seeking services from federal, state, and local government agencies. At times benefits agencies have reported immigrants to immigration enforcement, resulting in deportation of a family member, separating families.

Mixed-status families face especially complex and confusing eligibility rules, difficulty completing the application process due to language barriers, and concerns about adverse “public charge” determinations, that may impair their application for a green card due to receiving assistance from a government agency. Assisters should be sensitive to these issues and provide reassurances that overcome these barriers for mixed-status families.

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<sup>14</sup> Kaiser Health News, *Seniors Get Hung Up In Health Care Scams* (Apr. 22, 2013), available at <http://www.kaiserhealthnews.org/Stories/2013/April/22/insurance-scams.aspx>.

Understanding and addressing these concerns will help ensure that all eligible persons are enrolled, and that states comply with civil rights and privacy laws, while helping states reduce administrative errors and costs. At a minimum, assisters must be trained to avoid creating barriers to participation. Goals for assister training should include creating a gateway to health care for mixed-status immigrant families that is welcoming, informative, credible, and secure.

**Recommendation: Assisters should be well versed in the common concerns and anxiety faced by mixed immigration families and trained to provide reassurances to help mixed immigration status families overcome barriers to coverage.**

§155.215(b)(2)(x)

We support that assisters should understand the differences among health plans to help consumers fully understand their choices. In doing so, it is critical that provide fair, accurate and impartial information on the full range of QHP options.

§155.215(b)(2)(xi)

This subsection notes that the training will include the section §155.260 privacy and security standards, which is critical to ensuring the safeguard of personally identifiable information for everyone. For certain individuals and families, including immigrant families, privacy and security is even more important. As one example, confidentiality concerns of parents in mixed-status families are paramount and should be addressed directly by assisters. A threshold requirement for assisters is to understand which family members are applicants and which are non-applicants so they only gather needed information without deterring participation.

**Recommendation: Training in privacy standards must include specific applicability to mixed-status households. For example, direct and clear messages for immigrants to help address their confidentiality needs, presented at a timely point in the application process, should clearly communicate information such as the following:**

- Only citizen and lawfully present members of immigrant families are eligible for services, but ineligible adults are encouraged to file applications on behalf of eligible family members.
- Ineligible, non-applicant family members will never be required to provide their citizenship or immigration status to apply for others in their family. There should be no indirect questions asked for use as a proxy for immigration status such as inquiring about a non-applicant's place of birth.
- Requests for Social Security numbers (SSNs) are *always* optional for non-applicants and never required for determining the eligibility of family members who are applying for benefits. The SSN of a non-applicant who chooses to

provide the number, will be used only for the administration of the health care program and not for immigration enforcement purposes.

- Any information regarding immigration status and SSNs that is required of applicants will be used solely for administration of the health care program and not for immigration enforcement purposes.
- Questions about SSNs and demographic data (including race, ethnicity and primary language) are asked to help insure equity and are never used to discriminate; answering these questions is voluntary and declining to answer will not affect the application or an eligibility determination.

#### §155.215(b)(2)(xii)

We support that assisters must be able to work effectively with individuals with limited English proficiency, people with a full range of disabilities, and vulnerable, rural and underserved populations. Such expertise and effectiveness is often gained over time through experience, training and sharing of best practices. While training can describe the issues and barriers to coverage that the people described in this provision face, building skills in working effectively with these consumers is developed through hands-on experience. As a starting point, it is critical that HHS select assisters with proven track records in working effectively with these populations. Equally important is facilitating the sharing of best practices and networking among assisters through regular forums as recommended at §155.215(b)(1)(iv).

We also reiterate our suggestions in § 155.215(b)(2)(xi) to include specific training on working with immigrants and mixed-status families, how to determine eligible immigration status, and what questions can be asked of non-immigrants. This information is relevant both from a privacy and confidentiality lens but also from the lens of working with vulnerable and underserved populations.

#### §155.215(b)(2)(xiii)

We support that the training should include customer service standards and skills. Any sub-regulatory guidance should address the importance of, but not be limited to, 1) active and emphatic listening; 2) using clear, plain language communication; 3) promoting the value of coverage 4) efficiency and follow-up and 5) providing reassurances regarding privacy and confidentiality.

#### §155.215(b)(2)(xiv)

We support that training should cover outreach and education methods and strategies. Much has been learned about effective outreach and public education through Medicaid, CHIP, consumer assistance programs (CAPs) and the Massachusetts health reform experience. It is important for HHS to identify strategies that have worked well in the past, as well as those that have not, to help assisters be optimally effective. Equally important will be assessing the most effective outreach strategies in reaching targeted populations as the ACA is fully implemented and sharing those best practices. As noted

in our comment at §155.215(b)(2)(xii), it is also important that navigators and assisters with a proven track record of effective outreach and public education be selected, as these skills are also developed and enhanced through experience.

#### §155.215(b)(2)(xv)

Clearly assisters will need to understand the administrative procedures and processes, as well as be component in using systems, to executive their duties efficiently and effectively. Ideally, the FFE will build a specific assister portal that includes enhanced functionality for all assisters to be more effective. Such a portal should enable assisters to check the status of applications, submit changes on behalf of the people they serve and other tasks that offload administrative responsibilities from the FFE call center and technical assistance staff. Such a portal should have the ability for assisters to report, and the FFE collect, analyze and act on, system issues and other barriers to coverage.

**Recommendation: Launch an assister portal with enhanced functionality as soon as possible.**

We also suggest including information on applicable administrative rules, processes and systems related to Medicaid and CHIP. This should also include information about redetermination and where to seek assistance during that process.

We also strongly encourage additional training modules content so that assisters fully understand the legal requirements for nondiscrimination and providing culturally and linguistically appropriate care. These modules should include the following information:

- civil rights and nondiscrimination requirements including ACA § 1557, Title VI of the Civil Rights Act, § 504 of the Rehabilitation Act, Americans with Disabilities Act, Age Discrimination Act, and Title XI; and
- where to refer individuals who have issues or problems that navigators cannot address, such as consumers who are denied eligibility and wish to file a complaint.

Finally, we urge HHS to involved consumer advocates in the development and review of the training modules. Many consumer advocates have extensive experience in developing and administering training programs, particularly with regards to working with underserved populations, and can provide needed expertise to ensure the efficacy of the training.

#### **§ 155.215(c)**

We strongly encourage HHS to define what is included in providing culturally and linguistically appropriate services. For many, the common understanding may be limited to race, ethnicity and language. Yet culturally and linguistically appropriate services should have broader reach, including knowledge about additional issues including age, disabilities, sexual orientation and gender identity. All assisters must understand and be

equipped to assist all of the cultural groups in their service area in a nondiscriminatory manner. As recognized by the Enhanced CLAS (Culturally and Linguistically Appropriate Services) Standards recently released by the HHS and its Office of Minority Health, “culture” includes more than race, ethnicity and language but also religious, spiritual, biological, geographical and sociological characteristics. OMH’s “Blueprint” for advancing and sustaining culturally and linguistically appropriate services defines culture to incorporate other factors such as age, gender identity, physical ability or limitations, sex, sexual orientation and socioeconomic status.<sup>15</sup> Thus, the regulatory text should include a broader definition of culture or a direct cross-reference to the new CLAS Standards.

Given the broad implications of culture, we would suggest HHS consider dividing (c) into two subparts – one focusing on cultural issues and one specific to language issues. Subsections (1), (2), (5) and (6) would apply more broadly than language and also include people with disabilities. Subsections (3) & (4) are more tailored to language access. It may also be helpful to include the disability standards as a subpart of this same section to demonstrate that disability is a part of culturally and linguistically appropriate services as well.

We also suggest changing the title of § 155.215(c) so that it does not equate with the Office of Minority Health’s CLAS Standards (and its recently released Enhanced CLAS Standards). To use the same title for this regulatory subsection while not incorporating the same standards may cause confusion about which “CLAS Standards” are applicable and relevant for these regulations. We thus suggest changing the title from “Providing Culturally and Linguistically Appropriate Services (CLAS Standards) to “Standards ensuring culturally and linguistically appropriate services” which is similar to the title for § 155.215(d).

#### **Recommendations:**

- **Include a broad definition of culture to encompass age, disability, sex, sexual orientation, and gender identity.**
- **Split subsection (c) into two parts – one focused on culture and one on language access.**
- **Rename subsection (c) so that it does not mirror the title of OMH’s CLAS Standards.**

#### **§ 155.215(c)(1)**

We suggest that HHS specifically add disability, gender, sexual orientation and gender identity into the list of knowledge required by assisters. As mentioned above, these groups are among the ones recognized by the Office of Minority Health as part of one’s culture and thus it is important that assisters understand their potential impact on eligibility and enrollment decisions.

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<sup>15</sup> OMH, *supra* note 3, at 28-29.

## § 155.215(c)(2)

We support (c)(2) to ensure that assisters have the information needed to appropriately plan to meet the needs of their clients. While some of this data may be gathered from external sources, we also suggest that CMS require assisters to have some demographic data itself. This could be accomplished by collecting the data itself or having access to data submitted on an application. We also suggest assisters record information about their use of interpreters (both foreign language and sign language), augmentative and assistive communication devices and TTD/TTY. Collecting this data will help the entity monitor needs and ensure that it can meet the ongoing needs of the communities it serves as well as document that it is providing culturally and linguistically appropriate services, a specific requirement not only of federal civil rights laws but also specifically required by the statutory text authorizing navigators. The statutory text states that an entity serving as a navigator must “provide information ***in a manner that is culturally and linguistically appropriate to the needs of the population being served.*** . . .” (emphasis added).<sup>16</sup> Further, we believe part of HHS’ monitoring of assisters must include compliance with these laws so that it will be important for assisters to have this data.

The OMH Blueprint mentioned above also underscores that demographic data are vital to the effective practice of cultural competency. While some of this data will already be collected on the application, assisters should also collect additional data relevant to documenting nondiscrimination and providing culturally and linguistically appropriate services. As the OMH Blueprint notes, although LGBT data collection is not yet as standardized as other demographic data collection, HHS is developing a national data progression plan on sexual orientation and gender identity data and that the CLAS Standards Implementation Blueprint will be updated to reflect advances in this process.<sup>17</sup> The Blueprint is clear that although current data collection tools may not include LGBT demographic data, that “organizations should utilize, and develop if necessary, survey instruments that will encompass the various demographic groups in their community.”<sup>18</sup>

Accordingly, we recommend that CMS require that assisters collect information about their clients that includes sexual orientation and gender identity demographics. This may be done through the use of survey instruments or other means that allow for self-identification, and that ensure that confidentiality and anonymity of information collected for the purposes of understanding the demographic composition of these communities. A question that has been used successfully on state and other surveys is as follows:

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<sup>16</sup> 42 U.S.C. § 18031 (ACA § 1311(i)(3)(E)).

<sup>17</sup> OMH, *Plan for Health Data Collection on Lesbian, Gay, Bisexual and Transgender (LGBT) Populations*, available at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=209>.

<sup>18</sup> OMH, *supra* note 3, at 112.



*Gender identity and sexual orientation single-item protocol:*

Do you think of yourself as (please check all that apply):

- Straight
- Gay or lesbian
- Bisexual
- Transgender, transsexual, or gender-variant

Not listed above (please write in): \_\_\_\_\_

**§ 155.215(c)(3)**

Regarding (c)(3) we have a number of suggestions to ensure that the intent of the provision is clear.

First, we are concerned that the regulation requires provision of oral interpretation and written translation “where necessary for effective communication.” These services should be provided **when requested** by a consumer and the navigator should not have discretion to determine if the services are “necessary.” The current language could leave “when necessary” open to the assister’s determination and thus HHS should clarify it to ensure that limited English proficient (LEP) consumers are not denied services because an assister erroneously believes assistance is not necessary. We recommend changing this language to “when requested by the consumer to ensure meaningful access.”

**Recommendation: Amend §155.215(c)(3) to read as follows:**

Provide consumers with information and assistance in the consumer’s preferred language, at no cost to the consumer, including the provision of oral interpretation of non-English languages and the translation of written documents in non-English languages when ~~necessary~~ **requested by the consumer** to ensure meaningful access.

Second, we have serious concerns about allowing the use of a consumer’s family or friends if requested by the consumer if other interpreter services are offered and declined. The application process is complex and requires accurate information to ensure correct eligibility determinations. For limited English proficient individuals, competent language services must be provided to comply with federal civil rights laws (ACA § 1557 and Title VI of the Civil Rights Act of 1964) as well as the ACA provision authorizing navigators. Interpreting requires specialized skills and abilities that must be learned; being bilingual is insufficient.<sup>19</sup> Guidance from the federal Department of Health and Human Services Office for Civil Rights recognizes the drawbacks of using family members and friends and encourages the use of trained interpreters whenever

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<sup>19</sup> See National Health Law Program, *What’s in a Word: A Guide to Understanding Interpreting and Translation in Health Care*, available at [http://www.healthlaw.org/index.php?option=com\\_content&view=article&id=240%3Alanguage-access-publications&catid=45&Itemid=196](http://www.healthlaw.org/index.php?option=com_content&view=article&id=240%3Alanguage-access-publications&catid=45&Itemid=196).

possible.<sup>20</sup> Further, OMH's Enhanced CLAS Standards also reiterate that "the use of untrained individuals and/or minors as interpreters should be avoided."<sup>21</sup>

Significant problems can arise from the use of family members, friends and particularly children, rather than trained professionals, as interpreters. Adult family members or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything the patient says, and may summarize information instead. They may also inject their own opinions and observations, or impose their own values and judgments as they interpret. Family members and friends who act as interpreters may themselves have limited English language abilities and may be unfamiliar with the complex terminology involved in enrollment and eligibility. All of these factors could directly affect an eligibility determination, rendering an individual ineligible for APTCs or Medicaid.

While many problems can result from using adult family members and friends as interpreters, additional problems arise when the interpreter is a minor. Children who interpret for their LEP parents act as "language brokers" and informally mediate, rather than merely interpret or translate information. Children who act as language brokers often influence the content of the messages they interpret, which in turn affects their parents' decisions. Other concerns with using children as interpreters include:

- requiring children to take on additional burdens, such as decision-making responsibilities;
- creating friction and a role reversal within the family structure, which can even lead to child abuse;
- violating beneficiary confidentiality, which can lead to inadequate services or mistakes in the provision of services; and
- causing children to miss school.

Further exemplifying the problems of using children as interpreters, a study of 150 Vietnamese-American and Mexican-American women who are or had been welfare recipients in California found that more than half (53.3%) used their children to interpret for them.<sup>22</sup> Most used their children for communicating with schools and government agencies and filling out forms. More than half of the women who used their children as interpreters identified problems with this practice. The top four problems were:

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<sup>20</sup> Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. 47311 (August 8, 2003), available at [www.lep.gov](http://www.lep.gov).

<sup>21</sup> OMH, *supra* note 3, Standard 7.

<sup>22</sup> The Access Project, *Language Services Action Kit*, at 45, available at <http://www.accessproject.org/new/pages/pubLanguage.php>, citing Equal Right Advocates, "From War on Poverty to War on Welfare: The Impact of Welfare Reform on the Lives of Immigrant Women" (April 1999).

- the child interpreted incorrectly;
- the child left out information;
- the information was too technical for the child; and
- the child was unable to properly interpret due to limited language skills.

Several of the Mexican-American women reported that their children sometimes answered questions without first checking with them.

Many individuals may choose to have a family member or friend interpret because they do not understand that an interpreter must be provided free-of-charge or think that asking for an interpreter may delay the application process. Thus the offer of interpreting must ensure understanding by the consumer of his rights.

Individuals who choose to have their family members or friends serve as advocates during the eligibility process should be encouraged to do so. But to avoid mistakes and ensure compliance with federal law, assisters should always utilize competent interpreters. If a consumer insists on using a family member or friend, the assister should have a competent interpreter available to monitor the interaction and intervene if a family member or friend initially begins interpreting and makes errors. The regulation should also specifically prohibit the use of children as interpreters.

We would suggest that HHS implement an effective and cost-efficient way to provide access to interpreting services for navigators. Assister grants should include funding specifically for language services. HHS could also enter into contracts with language services providers and allow assisters access. As stated above, Kansas' Medicaid agency contracted with an over-the-phone interpreting company and then provided the telephone number and an access code to all Kansas primary care case management providers.<sup>23</sup>

**Recommendation: In § 155.215(c)(3), strike the following text:**

~~Use of a consumer's family or friends as oral interpreters can satisfy the requirement to provide linguistically appropriate services only when requested by the consumer as the preferred alternative to an offer of other interpretive services.~~

**§ 155.215(c)(4)**

We strongly support the requirement that assisters provide oral and written notice to consumers of their right to receive language assistance services and how to obtain them. We suggest the provision specifically mention that this notice must be provided in the consumer's language as an English notice would be insufficient.

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<sup>23</sup> NHeLP, *supra* note 4.

### **§ 155.215(c)(5) & (6)**

We strongly support these provisions. They will ensure compliance with statutory and civil rights requirements. We suggest HHS provide additional specifications or guidance to ensure assisters understanding and compliance. We recommend that HHS provide guidance to organizations on the provision of CLAS-related education and training, including the topics detailed in the CLAS Blueprint that are inclusive of the sexual orientation and gender identity aspects of culture.<sup>24</sup>

As OMH's CLAS Blueprint notes, ongoing education and staff training ensure that individuals within organizations are equipped with the knowledge, tools, and skills to appropriately manage interactions with diverse clients. We recommend that HHS provide guidance to organizations on the provision of CLAS-related education and training, including the topics detailed in the CLAS Blueprint that are inclusive of the sexual orientation and gender identity aspects of culture.<sup>25</sup>

### **§ 155.215(d)**

As we suggested above, HHS should consider reordering § 155.215 to add in a definition of culture and incorporate both (c) and (d) under that subsection. While we recognize that a broad understanding of “culturally and linguistically appropriate services” would include disability issues, it is unfortunate that many entities may understand this term to be more limited in scope to racial, ethnic and language diversity. Thus as we suggested earlier, HHS should adopt and include a broad definition of “culturally and linguistically appropriate services” as defined by the Office of Minority Health in the recently released Enhanced CLAS Standards or specifically include additional provisions clarifying the applicability of (c)(5) & (6) to the subsection on Standards ensuring access by persons with disabilities.

As an alternative, and in addition to our specific comments below, HHS could adapt § 155.215(c)(5) and (6) and add them to (d). Just as it is important that assisters receive ongoing education and training in culturally and linguistically appropriate service delivery and recruiting, supporting and promoting a staff representative of the demographics served, it is also important that assisters receive ongoing training in providing services to people with disabilities and recruit staff that includes people with disabilities.

### **§ 155.215(d)(1)**

We fully support requirements that educational materials, websites and other tools utilized for consumer assistance are accessible to people with disabilities. We suggest including a specific requirement that websites comply with § 508 of the Rehabilitation Act.

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<sup>24</sup> OMH, *supra* note 3, at 67-8.

<sup>25</sup> *Id.*

### § 155.215(d)(2)

We are concerned that the regulation requires provision of auxiliary aids and services “where necessary for effective communication.” These services should be provided when requested by a consumer and the navigator should not have discretion to determine if the services are “necessary.” The current language could leave “when necessary” open to the assister’s determination and thus HHS should clarify it. We recommend changing this language to “when requested by the consumer to ensure effective communication.”

#### **Recommendation: Amend §155.215(d)(2) to read as follows:**

Provide auxiliary aids and services for individuals with disabilities, at no cost, ~~where necessary~~ **when requested by the consumer** for effective communication. . .

We further suggest HHS provide navigators with information about commonly needed auxiliary aids and services, how to access/purchase them, how to use them, and how to identify those who may need them. Many navigators may not have direct experience working with auxiliary aids and services and will need this information and training to effectively assist people with disabilities.

We also suggest that HHS negotiate access to sign language interpreters – in-person or via video-link – to assist navigators since many consumers may not have family members or friends who can assist.

### § 155.215(d)(3)

We recommend including a specific reference to the Americans with Disabilities Act and the Department of Justice’s (DOJ) updated standards to ensure physical accessibility for individuals with disabilities.<sup>26</sup>

### § 155.215(d)(4)

The proposed regulation only permits assistance from a **legally** authorized representative. We urge HHS to delete “legally”. Many individuals with disabilities will have an authorized representative who was not legally determined. Indeed, the draft single streamlined application permits an individual to select an authorized representative to assist with the application. This same individual (or another authorized by the applicant) should be able to assist an individual with a disability in making informed decisions without having to obtain judicial consent. Otherwise, it would render the ability to designate an authorized representative on the application moot since the

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<sup>26</sup> See Department of Justice, *2010 Standards for Accessible Design*, <http://www.ada.gov/regs2010/2010ADASTandards/2010ADASTandards.htm>.

individual with a disability would have to also obtain a legally authorized representative if seeking information from an assister.

Similarly, removal of the term “legally” would make this proposed rule consistent with the way HHS described “authorized representative” in its earlier proposed rule (CMS-2334-P) § 435.923(a) and § 155.227(a) requiring the Medicaid agency and the exchange to permit applicants and beneficiaries to designate an individual or organization to act responsibility on their behalf in assisting with the individual’s application and renewal of eligibility and other ongoing communications with the agency. It is critically important that the individual be able to select a trusted friend, family member or other person they choose rather than having to rely on legal guardians or other legal arrangements.

**Recommendation: Amend § 155.215(d)(4) as follows:**

Ensure that ~~legally~~ authorized representatives are permitted to assist an individual with a disability to make informed decisions;

**§ 155.215(d)(5)**

We appreciate the recognition that assisters must know about long-term services and supports programs. However, we are concerned that the wording of this section may result in an assister “referring” an individual to another entity for assistance, rather than providing the individual with assistance and “informing” the consumer about other potential services/programs. Thus we suggest rewording this section as follows: “Acquire sufficient knowledge to understand the range of supports provided in long term and supports programs that are funded by Medicaid and make appropriate referrals to the Medicaid office and local, state and federal long term services and supports programs.”

***Additional Comments***

We recommend adding a new standard requiring assisters to be knowledgeable about accessibility features of different qualified health plans and how to get more information about plan and provider accessibility depending on the needs of the person with a disability. The exchanges and the plan issuers have responsibilities for ensuring physical and programmatic access and nondiscrimination. It is important that assisters be aware of nondiscrimination protections and accessibility features of plans. Health plans should provide navigator programs with lists of network providers with documented history and experience of serving persons with disabilities.

**Recommendation: Amend § 155.215(d) to add new subsection (7);**

***Acquire sufficient knowledge of the physical and programmatic accessibility of the qualified health plans being sold in the exchanges.***

## § 155.215(e)

We strongly support the monitoring requirement. We suggest that HHS provide details to assisters as to the types of information and data they must provide and include these requirements in grantee contracts. As we have mentioned above, we suggest that assisters collect demographic data from the consumers served for monitoring purposes to document compliance with federal civil rights laws as well as the statutory provision requiring navigators to provide culturally and linguistically appropriate care.

Monitoring of assisters will be key to ensure that the best interests of consumers are well served and that assisters are effective and efficient. It is important that information collected on performance metrics be shared with assisters so they can learn from each other as well as the public. Proposed performance indicators could include:

- number and type of outreach activities and estimated number of consumers reached;
- number and type of public education activities and estimated number of consumers reached;
- analysis of the outreach partnerships that navigators and assisters regularly engage;
- the number of applications facilitated and the number of applicants enrolled in QHPs, Medicaid or CHIP (or referred to Medicaid/CHIP);
- the rate of completed enrollments relative to applicants assisted;
- the demographic breakdown of facilitated applications and enrollments, particularly of the targeted populations;
- the proportion of applications submitted online;
- the number of referrals to social services programs such as the Supplemental Nutrition Assistance Program (SNAP) or the Women, Infants and Children (WIC) program;
- data from customer satisfaction surveys (post-enrollment surveys should be deployed to seek consumer feedback on their enrollment experience); and
- enrollment patterns (to ensure consumers are not being steered to one plan or another).

## **Conclusion**

The Affordable Care Act has already made impressive strides in improving the health of women, low-income individuals, underserved populations and individuals with disabilities. We look forward to continuing to work with the Department to ensure the navigators, non-navigator assistance personnel and certified application counselors work effectively with all individuals and we thank you for this chance to provide input on these important provisions.

Please do not hesitate to contact Mara Youdelman, Managing Attorney at (202) 289-7661 or [Youdelman@healthlaw.org](mailto:Youdelman@healthlaw.org) if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Emily Spitzer". The signature is fluid and cursive, with the first name "Emily" written in a larger, more prominent script than the last name "Spitzer".

Emily Spitzer  
Executive Director