May 6, 2013

SUBMITTED VIA ELECTRONIC TRANSMISSION

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, MD 20144-1850

Attention: **CMS-9955-P**

**Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel**

Dear Sir/Madam:

Thank you for the opportunity to comment on CMS–9955–P, “Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel” (hereinafter referred to as “the proposed rule”). We appreciate the work of HHS in proposing strong standards to protect the integrity of navigator and assister programs and ensure that navigators and assisters are well trained to provide quality, effective assistance in connecting consumers to coverage.

The Center for Children and Families is based at Georgetown University’s Health Policy Institute with the mission of improving access to health care coverage among the nation’s children, particularly those in low-income families. As such, we have a long history of conducting analysis, research and advocacy on issues relating to children’s enrollment in Medicaid, CHIP and other health insurance programs.

We are including detailed comments on the proposed rule below. However, to start, we wanted to address HHS’ request for public comments on the number of navigator grantees or the number of non-Navigator assistance personnel and project leads expected, as well as the number of consumers expected to receive assistance.

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

Information is just beginning to emerge from states with state based (SBE) or consumer partnership (SPE) exchanges relative to their projections for the number of navigators and assisters needed in 2014. California expects to assist 1,090,258 people in accessing coverage in 2014 with an estimated $57.9 million paid to 25,000 navigators and assisters. In New York, 560,000 are expected to enroll in the individual exchange, and the state will spend $27.2 million annually on consumer assistance for the next five years. Contrast that to Texas, the state getting the largest share (15%) of the federal navigator pie ($8.1 million of $54 million), where 7.35 million are uninsured of which the Urban Institute estimates a reduction of 2.5 million if the state does not expand Medicaid and 3.8 million if Medicaid is expanded.

Looking at smaller states, New Hampshire anticipates spending more than $2 million to serve 83,500 and will receive another $600,000 for navigators, while Vermont will spend a total of $2 million on navigators and assisters and expects to enroll 266,500. Contrast that to Kansas, where 336,885 people are uninsured and Urban estimates an 80,000 reduction in the uninsured; the state will receive only $600,000 for federal navigators.

These examples illustrate that the assistance resources in states that are able to tap 1311(a) funds for in-person assistance (SBE and SPE states) is dramatically different than states where only federal navigator grants are available. It is crucial that HHS 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. Given that fact, we would like to highlight in this cover letter several other ways to strengthen the navigator and non-navigator assistance program.

***There are several steps HHS can take to better support and strengthen the availability of assistance:***

1. ***Allow section 1311(a) funds to be used to provide consumer assistance in full FFE states:*** We appreciate the clarification that section 1311(a) exchange establishment grants can be used to support the cost of navigator training, grants management and oversight in SBE and SPE states. As a transition policy, HHS is allowing an SBE to delay the implementation of its state-funded navigator program until it is self-sustaining at the end of its initial year of operation. Section 1311(a) funds can be used in the interim to fill any gaps in its navigator program and ensure that the full range of services the navigator program must provide are available during the initial year of operation. Likewise section 1311(a) funds can be used in consumer assistance partnership exchanges to supplement the limited amount of funding that will support federal navigators in 34 states.

HHS has not indicated that section 1311(a) funds can be tapped by states with an FFE to supplement the navigator funding. Yet, such funds have been made available to several FFE states (OH, NE, KS and MT) to conduct marketplace plan management functions, and recently HHS announced that 1311(a) funds may be used for marketing and outreach with specific conditions. The Secretary’s Q&A on exchanges, market reforms and Medicaid dated December 10, 2012 suggests that it is permissible to more broadly use 1311(a) funds in FFE states. It outlines in the answer to question 9, that states may choose to seek section 1311(a) exchange establishment funding for "activities necessary to support the effective operations of a federally-facilitated exchange." Additionally, the CCIIO Q&A dated February 20, 2012 indicates that states can use 1311(a) funding for evaluation of plan management activities without submitting an exchange blueprint. Extending this funding to consumer assistance activities, including in-person assistance, necessary to support the FFE would increase the capacity of the FFE to assist consumers.

1. ***Clarify how private support can leverage federal Medicaid matching funds to provide enrollment assistance.*** HHS has indicated that state navigator funds can be eligible for Medicaid match. Recently, the California Endowment pledged millions of dollars to support Medicaid enrollment and retention that will leverage federal Medicaid match. It would be helpful for HHS to clearly articulate the circumstances and process for private funds to qualify for federal Medicaid match.
2. ***Establish a dedicated technical assistance unit and helpline in the FFE to support navigators and assisters.*** Highly skilled and knowledgeable eligibility, enrollment and system experts are needed to appropriately support the work of navigators and assisters who uncover more complex issues and barriers to coverage, or who are helping a consumer resolve an eligibility problem. Providing an adequate level of easily accessible expert technical assistance is considered a best practice in Medicaid, and Medicare counselors have identified the dedicated counselor line as one of the most important tools they use to assist consumers. Providing access to expert staff who have the ability to resolve eligibility issues has proven to add value by reducing consumer calls to the call center, identifying gaps in training and providing an effective loopback mechanism to pinpoint system issues and other recurring problems.
3. ***Establish a web-portal with enhanced functionality for navigators and assisters as quickly as possible.*** An enhanced portal goes beyond tracking applications by assister. It would allow assisters to check the status of applications and enrollment and provide other functionality such as reporting the birth of a child or other changes in circumstances or checking the status of needed verifications. It could also facilitate reporting of problems directly associated with a specific application or account that would provide a more effective and efficient means of identifying and troubleshooting problems. A dedicated portal for assisters provides a key consumer protection by clearly identifying when data and other changes are submitted by assisters rather than consumers themselves. Establishing a robust assister portal should be a high priority for HHS.
4. ***Provide key support resources through the FFE so that limited navigator grants can be dedicated to direct consumer assistance.*** Specifically, the FFE call center will rely on language translation services to supplement bi- or multi-lingual staff. Such services should be directly available to federal navigators so that their grants can be used to provide a higher level of direct services. Furthermore, access to assistive technologies to help individuals with disabilities, including sensory impairments, should be made available. Pooling the purchasing power of the federal government will make these key services more cost-effective and enable federal navigators to use their limited grant funds for personnel to provide direct assistance.
5. ***Release final regulations regarding certified application counselors (CACs) as soon as possible and clarify that states are not prohibited from funding CACs.*** In states where only an FFE will operate, certified application counselors will be a key resource for consumers needing assistance. The sooner the regulations are finalized, the sooner the certification and training process can begin. We also believe that states should not be barred from providing much needed resources to community-based organizations and safety-net providers that can help fill the assistance gap. Those proposed rules released on January 12, 2013 pointed out that the difference between CACs and navigators and brokers is that CACs are not funded by the exchange, either through grants or directly and could be misinterpreted as prohibiting states from funding CACs. While we understand that HHS is not offering the use of federal funds under section 1311(a) of the ACA or otherwise, we believe clarification will ensure that states are clear that they have the flexibility to do so.

**Detailed comments on requests for information and the proposed regulations:**

***Transition Plans for State Based Exchanges Deferring Implementation of Navigator Programs.***

As noted above, we acknowledge the comments in the NPRM preamble that state-based exchanges and state partners in consumer partnership exchanges may use section 1311(a) exchange establishment grants to fund non-navigator assistance programs. Furthermore, as long as section 1311(a) 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. 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 section 1311(a) funds for non-navigator assisters to develop a plan that transitions their 1311(a) funded assistance programs into fully functioning navigator programs.**

***Referrals.***

The preamble of the regulation indicates that assisters should have the ability to help any individual who presents for assistance. It goes on to recognize that navigators may lack the “immediate capacity” to help someone and may refer consumers to other exchange resources. It would be helpful for HHS to emphasize that the ability to refer is not intended to permit navigators and assisters to generally get around either CLAS (§155.215(c)) or accessibility (§155.215(d)) standards. That said, we know that given the inadequacy of navigator funding in FFE states, it is unequivocally not possible for navigators to help everyone who presents for assistance. It would be helpful for HHS to provide examples of when it is appropriate for navigators and assisters to refer, building on the concept articulated in the preamble that navigators may refer to other resources that have better capacity to serve the individual “more effectively.” It will be very important that navigators become adept at triaging need so that extremely limited in-person assistance resources are available for the most vulnerable consumers. However, navigators should also be mindful of the importance of following up with consumers who were referred to make sure they received the assistance they needed.

We also believe that referrals should be made when there is a direct consumer-related conflict of interest. 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 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.

**§155.210 Navigator program standards.**

We appreciate that the proposed rule clarifies that state licensing, certification and other standards prescribed by the state or exchange must not prevent the application of the provisions of Title I of the Affordable Care Act, including the navigator program. It will be critical for HHS to monitor state requirements to ensure that they do not impede navigators’ ability to perform all of the functions required of them under the law, including helping people through the entire eligibility process, facilitating the consumer’s selection of an exchange plan and assisting with enrollment. In addition, we agree that any state licensing or certification program for navigators should not prevent at least one community-based consumer or nonprofit organization and at least one other navigator from serving in this capacity. In order to encourage the largest pool of navigator applicants, it is urgent that HHS reassure prospective navigators that the agency will intervene when necessary so navigators and assisters are not caught in the middle of any potential conflict between federal and state standards.

**Recommendation: Assure prospective navigator applicants and actively monitor, and intervene as necessary, when state licensing, certification and other requirements interfere with a navigator’s ability to fulfill all of their legal responsibilities.**

As written, it is not clear that §155.210(c)(1)(iii) extends the same protections to non-navigator assisters or certified application counselors when state licensing, certification and other requirements interfere with their ability to provide the full range of assistance services required of navigators by law. Non-navigator assisters and certified application counselors fulfill the requirement that exchanges provide consumer assistance codified under §155.205(d) and should not be prohibited from doing so by state licensing, certification or other standards.

**Recommendation: We urge HHS to ensure that the final regulations extend the provisions of §155.210(c)(1)(iii) to non-navigator assisters and application counselors certified (§155.225) for the purposes for the purposes of implementing §155.205(d).**

**§155.215(a) Conflict of interest standards.**

We support the conflict of interest standards and specifically the inclusion of stop loss insurance issuers among the types of entities that are prohibited from serving as navigators, as well as prohibiting navigators from receiving consideration directly or indirectly from stop loss insurers for enrollment in a QHP or non-QHP. We also support the clarification that receiving consideration from a health plan or stop loss insurance issuer includes trailer commissions. The role of navigators is to provide consumer assistance through the entire eligibility and enrollment process, including facilitating plan selection. Thus, receiving referral fees from insurance brokers and agents should also be prohibited. While the proposed rule does encompass “indirect” consideration, which could apply to referral fees from insurance brokers and agents, we would like to see this explicitly stated in the rule.

**Recommendation: 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.”**

We appreciate that HHS continues to emphasize the prohibition on receiving consideration is directly linked to “in connection with enrollment.” Many community-based organizations may receive support from health insurers for activities unrelated to enrollment (i.e. event sponsorship or wellness education). Additionally, health care providers receive direct reimbursement from health plans. We believe these examples are exempt from the prohibition on receiving consideration since reimbursement is not “connected to enrollment.” Such activities would be subject to disclosure rules. In this regard, it would be helpful for HHS to be even more specific in providing examples of the types of direct or indirect support from health plans that would not be defined as “direct or indirect consideration in connection with enrollment” in the final regulations or subregulatory guidance.

We also support that navigator and non-navigator entities have a written plan to remain free of conflicts of interest. We note that many navigators may be entities that are required comply with HIPAA and may have procedures in place whereby their employees are educated about HIPAA standards and make attestations. A similar process whereby each employee signs a conflict of interest agreement upon hiring (or initially upon grant commencement for all employees) and updates it annually could help ensure that the entity remains free of conflicts.

**Recommendation: It would be helpful for HHS to develop a model conflict of interest agreement that could be used by navigator and non-navigator assistance entities to ensure that their employees are and remain free of conflict of interests as required by the proposed regulations.**

The preamble to the NPRM requests comments on whether the conflict of interest (COI) standards should be applied to certified application counselors (CACs). We believe that many, but not necessarily all, should apply to CACs. We encourage HHS minimally to apply these standards to CACs: 1) prohibiting receipt of consideration for enrollment (as amended above), 2) requiring assisters to provide information on the full range of QHPs, and 3) an amended version of the requirement for making specific disclosures to the exchange and consumers.

**Recommendation: The following conflict of interest standards should be minimally applied to certified application counselors:**

1. **§155.215(a)(1)(i)(D) and/or §155.215(a)(2)(ii)(D) (as amended above) prohibiting any certified application entity and their individual counselors may not receive consideration directly or indirectly from an issuer or insurance agent/broker in connection with enrollment.**
2. **§155.215(a)(1)(iii) and/or §155.215(a)(2)(D)(iv) requiring that assisters provide information on the full range of QHPs.**
3. **§155.215(a)(1)(iv) and/or §155.215(a)(2)(v) regarding disclosure to the exchange and consumers should apply with revisions to provision (B) relating to the disclosure of existing or former employment relationships of health or stop loss insurance issuers or subsidiaries.** We recognize the requirement for disclosure for all employees and their spouses/domestic partners within a large organization could be burdensome for large health care systems and suggest that HHS take that into consideration in finalizing conflict of interest standards for COI.

**§155.215(b) Training standards for Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions.**

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 as suggested by the use of the term “HHS approved training.” 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.

We also want to comment on the timing of training and the need for outreach and public education as soon as possible. We encourage HHS to allow navigators to hit the ground running with outreach and public education as soon as the grant awards are finalized or require only that specific aspects of training (i.e. navigator overview and outreach) be completed before starting to get the word out. Requiring assisters to complete the full certification process is not necessary for them to begin to education consumers about the new coverage options that are coming and how to connect to coverage.

§155.215(b)(1)(iv) requires continuing education and recertification, at least on an annual basis. We support these provisions. We also believe that continuing education should include routine opportunities for the exchange of information between the FFE and navigators and assisters, as well as the sharing of best practices among all assister types. Such forums should actively promote two-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 in Medicaid and other public benefit programs.

**Recommendation: Ongoing education should include routine opportunities for exchange of information, sharing of best practices and expertise, and feedback from the field through regular conference calls, webinars and face-to-face meetings.**

§155.215(b)(1)(v) indicates that navigators and non-navigator assistance personnel be prepared to serve both the individual exchange and SHOP. We believe this will limit the pool of applicants for navigator grants and disagree with CCIIO’s interpretation of the law and subsequent regulations. The preamble of the latest proposed rule indicates HHS has “inferred” from ACA section 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 be required to serve both exchanges. Both the ACA and navigator regulations finalized on March 23, 2012 state that to be eligible to receive a grant under paragraph (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 also 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.

**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. Ensure that training includes basic information about the SHOP for all assisters, with more detail training for those that serve the SHOP.**

**§ 155.215(b)(2) Training module content standards.**

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 navigators and other 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 in order 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 in order to ensure that the most comprehensive content and best practices are incorporated.**

We also believe that the training program similar to that offered to navigators and assisters should be made available to trusted entities who may not be navigators or formally recognized assister types (navigators, non-navigator or in-person assisters and certified application counselors) but who will serve consumers and need more in-depth knowledge than outreach partners. For example, there may be community-based organizations funded by other sources such as the Connecting Kids to Coverage grant program that will provide assistance to consumers in accessing insurance affordability programs. Additionally, there may be groups who are not set up to provide assistance with eligibility and enrollment but may work directly with consumers by providing education or helpful problem-solving. For example, many legal services organizations or consumer assistance programs will receive referrals from assisters for problem solving. Clearly this must be done in a way that does not dilute the integrity of the certification process. We believe there are several options for HHS to establish a mechanism for trusted entities/partners to access the training:

* 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.
* Create an amended version of the training that excludes detailed information that should only be available to assisters who are certified.

**Recommendation: Create a version of the training that can be used by certified navigators and assisters in training other helpful partners or otherwise make the navigator training and resource materials available to trusted partners.**

We also think it’s critically important that HHS establish a public “registry” of entities that have been officially certified as navigators, non-navigators or CACs. Such a registry will enable consumers to identify organizations that can provide impartial services and can help prevent fraud. The exchange website should provide a link to the registry so consumers can find help from those who have been trained and certified to do so.

**Recommendation: Establish a public registry of navigators and certified non-navigator assisters and application counselors that is accessible through a link on the FFE website and includes contact information.**

§155.215(b)(2)(i) describes the type of QHP information that will be included in the training. It is important that the training emphasize the requirement that navigators and non-navigator assistance personnel 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.

In regard to QHP information, navigators should be versed in the difference in pediatric benefits and differences in plans and provider networks as they relate to pediatric benefits. In particular, 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.

**Recommendation: Ensure that training includes a thorough understanding of the differences in pediatric benefits and provider networks and specifically address the implications of pediatric dental benefits accessed through stand-alone plans.**

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

**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) addresses training on the range of insurance affordability programs. The duties of navigators 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 navigators and non-navigator assisters to ensure they have expertise in Medicaid and CHIP eligibility, enrollment and program specifications.**

By definition, 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 safety net providers and services.**

§155.215(b)(2)(iii) requires training on the tax implications of enrollment decisions, which we believe is critical for navigators and assisters to understand and be able to clearly articulate to consumers.

**Recommendation: Training on tax implications of enrollment decisions should include an understanding of the tax reconciliation process so that navigators and assisters are able articulate how tax credits are reconciled after the fact through the federal tax filing process for the applicable coverage year.**

**Recommendation: The training should also cover the availability of tax credits for small business that provide health insurance to their employees.**

§155.215(b)(2)(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. Furthermore, it’s important that assisters understand what constitutes minimum essential coverage. For example, the Department of Treasury proposed rules have determined that Medicaid that covers over pregnancy-related services in Medicaid is not minimum essential coverage and thus a pregnant woman would also be eligible for tax credits to purchase a QHP.

**Recommendation: Training on eligibility must include eligibility for Medicaid and CHIP, as well as an understanding of what qualifies as minimum essential coverage.**

It is particularly important that navigators and assisters understand how plan selection impacts cost-sharing and cost-sharing reductions.

**Recommendation: Training should clearly impart that cost-sharing reductions are only available if the consumer chooses to enroll in a “silver” plan and that consumers understand that selecting a plan based only on premiums may have other financial implications.**

§155.215(b)(2)(v). We strongly support requiring that training include contact information for appropriate public agencies in order for navigators and other assisters to provide information 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 assisters about additional providers who are available as sources of care if 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 resources for this purpose, as noted in our comment at §155.215(b)(2)(ii).

**Recommendation: We encourage HHS to work with states to develop a list of safety net resources for navigators and assisters to use in referring people who are not eligible or do not enroll in coverage.**

§155.215(b)(2)(vi) addresses the basic concepts of health insurance, the benefits of having it and the individual responsibility to do so. We support the this provision and not that it should incorporate 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 someone who is exempt and that 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 sub-regulatory guidance also 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](http://www.kaiserhealthnews.org/Stories/2013/April/22/insurance-scams.aspx) 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.” 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. It will be important for navigators to clearly educate consumers and caution them about such practices.

§155.215(b)(2)(vii) 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.

§155.215(b)(2)(viii) requires training on culturally and linguistically appropriate services. The importance of this training cannot be overemphasized. For immigrant communities and mixed-status families especially, culturally-appropriate services include an understanding of the specific 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. Navigators and assisters should be sensitive to these issues and provide reassurances that overcome these barriers for mixed-status families.

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: Navigators and 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)(ix) We support that training should include ensuring physical and other accessibility for people with a full range of disabilities. This aspect of the training highlights why it is important to engage consumer advocates in reviewing and providing feedback on the detail training. Disability advocates have extensive experience in developing and administering training programs and can provide needed expertise to ensure the efficacy of the training.

§155.215(b)(2)(x). We support that navigators and assisters should understand the differences among health plans in order 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) 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 immigrant families, privacy and security is even more important. Confidentiality concerns of parents in mixed-status families are paramount and should be addressed directly by navigators and other assisters. A threshold requirement for navigators and assisters is to understand which family members are applicants and which are non-applicants in order to 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 in order 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, race, ethnicity and primary language are asked in order 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 navigators and 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 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 navigators and assisters with proven track records in working effectively with these populations be selected. Equally important is facilitating the sharing of best practices and networking among navigators and assisters through regular forums as recommended at §155.215(b)(1)(iv).

§155.215(b)(2)(xiii). We support that the training will 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 don’t, to help navigators and 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 navigators and assisters will need to understand the administrative procedures and processes, as well as be competent in using systems, in order to executive their duties efficiently and effectively. This training should incorporate both exchange and Medicaid/CHIP procedures and systems.

**§155.215(c) Providing culturally and linguistically appropriate services.**

We support the inclusion of the CLAS Standards in the proposed rule and their regulatory application to navigator and non-navigator training. The CLAS Standards have long been helpful and exemplary guidelines, and this inclusion in federal regulation elevates them by giving them the force and effect of law, making the standards enforceable for the first time. However, for many the common understanding may be limited to race, ethnicity and language. Yet CLAS should have broader reach, including knowledge about additional issues including age, disabilities, sexual orientation and gender identity.

We note that the CLAS Standards are being revised by HHS, and recommend review of revised standards as a possible revision to this rulemaking in the future.

**Recommendation: Include disability, gender, sexual orientation and general identity in list of knowledge required by assisters. Consider separate training modules, or subsections, focusing on the cultural issues and language issues separately.**

We are particularly concerned about using families or friends as oral interpreters as allowed by §155.215(c)(3). Friends or family members, particularly children, as untrained interpreters are prone to omissions, additions, substitutions and voluntary additions, and may inject their own opinions or summarize information. While individuals should be able to choose to have a family member or friend serve as an advocate, to avoid mistakes, assisters should always utilize competent interpreters.

**Recommendation: Assisters should utilize competent, trained interpreters even when individuals insist on using a friend or family member. The trained interpreter would be available to monitor the interaction and intervene if the family member or friend makes an error. Additionally, children should never be used as interpreters.**

**§155.215(d) Standards ensuring access by persons with disabilities.**

We support that educational materials, websites and other tools utilized for consumer assistance are accessible to people with disabilities. We are concerned that this provision gives a navigator or assister discretion to determine if such services are “necessary.”

**Recommendation: Amend the first sentence §155.215(d)(2) to read: “Provide auxiliary aids for individuals with disabilities, at no cast, when requested by the consumer to ensure effective communication.”**

The proposed regulation§ 155.215(d)(4) 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 single streamlined application and the proposed rule at 42 CFR 435.923(a), which defines “authorized representative,” permits 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) to delete “legally” before authorized representative.**

**§ 155.215(e) Monitoring.**

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

* Number and type of outreach activities; estimated number of consumers reached;
* Number and type of public education activities; estimated number of consumers reached;
* Analysis of the outreach partnerships that navigators and assisters regularly engage;
* Number of applications facilitated; 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 the targeted populations;
* The proportion of applications submitted online;
* 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;
* Enrollment patterns (to ensure consumers are not being steered to one plan or another).

That said, we also recognize that consumers may not fully understand the implications of disclosed relationships. [A study at Georgetown University](http://www.georgetown.edu/news/sunita-sah-conflicts-of-interest.html), “The Burden of Disclosure: Increased Compliance with Distrusted Advice,” published in the [*Journal of Personality and Social Psychology*](http://psycnet.apa.org/journals/psp/104/2/289/) suggests that consumers may be influenced by disclosures in a negative way. Advisees who received disclosure were aware that the advice may be biased and trusted it less. 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 this phenomenon to be explored in FFE monitoring.

Thank you for your consideration of these comments. If you have follow-up questions, please contact Tricia Brooks at pab62@georgetown.edu or 202.365.9148.