

September 4, 2012

Division of Regulations Development
Office of Strategic Operations and Regulatory Affairs
Centers for Medicare and Medicaid Services
U.S Department of Health and Human Services

RE: Comments on the Single Streamlined Application Data Elements
Document Identifier CMS-10433, CMS-10438, CMS-10439 and CMS-10440

Dear Sir or Madam:

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. Central to our work is providing research and policy assistance to state administrators and state-based organizations on strategies for covering children and their families through public insurance affordability programs, especially Medicaid and CHIP. We conduct research and analysis to inform federal and state policymakers about issues impacting children and families in health care reform and to improve Medicaid and CHIP, particularly around streamlining eligibility, enrollment, and renewal processes.

Thank you for the opportunity to comment on the proposed data elements for the single, streamlined application released on July 6, 2012. In 2014, this application will serve as the pathway to all health insurance affordability programs. It will be vital to ensure the application is designed so that eligible individuals are enrolled in the correct program without the burden and potential confusion of multiple forms and duplicative processes. In the attached comments, we provide some general guiding principles and observations that HHS may find useful as the application is developed, as well as more specific suggestions on the proposed data elements. We also provide additional, more specific comments that focus on issues relating to immigrant families, as they face unique barriers to application and enrollment. While these comments focus on those who are applying for financial assistance paying for health insurance, they are generally relevant for all prospective enrollees, including those seeking to enroll in the exchanges without advance premium tax credits (APTCs) and those eligible for coverage through their employer's participation in the Small Business Health Options Program (SHOP) exchanges.

Respectfully submitted,

Georgetown University Center for Children and Families

Georgetown Center for Children and Families
Comments on the July 6, 2012 Proposed Data Elements for the Single, Streamlined Application
Document Identifier CMS-10433, CMS-10438, CMS-10439, and CMS-10440

GENERAL PRINCIPLES. The design and ease-of-use of applications for coverage will have a significant impact on how easily and quickly consumers are able to enroll in coverage, as well as decrease the administrative burden on states in providing consumer assistance and processing eligibility and enrollment. In order to meet the goal of streamlining the application process, there are a number of general principles that should be incorporated as the single application is developed. It is critical that all program materials and the different modes of application are thoroughly consumer-tested among different populations to ensure ease-of-use and comprehension.

- *Ensure Application is Consumer-Centric and Simple.* The application, whether online, paper, or by telephone, should be as simple as possible, asking questions that are only relevant to determine eligibility for those applying for coverage, to minimize the burden on applicants. Any program information, regardless of modality, should be written in plain language, offered in multiple languages to meet meaningful access standards, and conform to accessibility rules for persons with disabilities.
- *Provide Welcoming and Reassuring Messages.* Information accompanying the application should provide consumers with information about who may qualify for coverage and the value of the coverage. It should use reassuring language to encourage individuals who may have concerns or misperceptions to apply. For example, in order to connect immigrants and their family members to coverage and care, states must overcome immigrants' concerns about the privacy of personal information and the heightened complexity of eligibility rules pertaining to mixed-status families. In particular, it's important to let consumers know they may qualify for coverage now even if they weren't able to get assistance in the past.

There is a great deal of personal information that will be gathered on the application. It will be important that consumers are confident that their personal data is secure and will be kept confidential. It is also important to reassure consumers that all information provided will be used solely for the purpose of determining eligibility for affordable health insurance programs. Such language will be especially critical for those residing in mixed-immigration status families.

While it is important to convey these messages, care should be taken to minimize narrative text that could discourage individuals with low literacy skills from beginning or completing the process.

- *Connect Applicants with Available Assistance.* The new coverage world of the Affordable Care Act (ACA) is complicated and will likely draw many to apply who are unfamiliar with health insurance, both public and private. Assistance for applicants will be available through a number of resources, such as navigators and toll-free hotlines. Information accompanying the application should let families know how they can get personalized assistance, including the availability of language services. Additionally, HHS should require states to comply with requirements to provide application assistance in a culturally competent manner that effectively communicates to immigrant families.

- *Include Specific Web Portal for Navigators and Other Authorized Assisters.* The exchange website should include a portal for navigators and authorized assisters to use that would require them be approved to log in. Ideally, this portal will provide assisters with additional functionality and tools to ensure that consumers are successfully enrolled, while safeguarding individual data. Additionally, the portal can help states track data needed to assure the quality of consumer assistance services.
- *Distinguish Non-Essential Data.* Many questions may be important to ask for program improvement and data collection purposes (e.g., race/ethnicity), but their answers will not impact a determination of eligibility. The application needs to clearly inform consumers when questions are optional, for example by including “optional” or “not required” next to the question, otherwise consumers may believe erroneously that they must provide the information as a condition of eligibility. Applicants should be allowed to proceed and submit an application, electronically or otherwise, without providing answers to questions that will have no bearing on eligibility.
- *Establish a Core Set of Data Elements.* HHS should establish a minimum level of information or core data elements that are required to constitute a “valid” application, which could potentially include only minimal information about the applicants and signature. If these elements are completed, a consumer can sign and submit the application in order to preserve their date of application while they continue to gather additional information. If a limited set of core elements is not established, having a check box for applicants to say, “I don’t know” to questions that are not required should be considered as an alternative.
- *Allow Applicants to Submit a Partially Completed Application.* Allowing consumers to complete an application to the best of their ability and to sign and submit the application with missing information is an important consumer protection. The submission of a partially completed application (one with the core elements supplied, regardless of whether all data needed to establish eligibility is provided) should trigger follow-up procedures to assist the applicant in gathering missing information and provide a set timeframe for providing such information. If an eligibility determination can be made without the missing data, or while verification is pending when allowed by law (e.g., citizenship), it should proceed and coverage should begin during this period.
- *Provide the Ability to Start, Stop and Return to An Application.* Applicants should have the ability to start, stop, and return to an application when applying online, over the telephone, or in person. The amount of information need to complete an application is substantial, complicated, and in some cases will require consumers to track down documents and other information not readily available to them. Ideally, states should be encouraged to include the ability for applicants to establish personal accounts, which will enable consumers to access their electronic application in a format that is readable and accessible. This should allow applicants to complete applications or correct information, as well as receive notices and continue to manage their account after eligibility is determined. Additionally, applicants need to have the ability to skip ahead and submit an application, once a core set of questions are answered.
- *Maximize the Functionality of Each Mode of Application.* While the data elements, and likely many of the questions, will be the same regardless of how a family applies, HHS should keep in mind the various modalities when developing the application to maximize the functionality and ease-of-use, while addressing the inherent challenges in each.

- a. Online Applications. Of all the application types, online applications have the greatest potential to simplify and speed the eligibility and enrollment process through the use of dynamic questioning and “real-time” verification. The online application should be “smart,” tailoring the questions based on the responses provided. For example, if an individual looks to be eligible for Medicaid and not for advance premium tax credits (APTCs), he should not be asked any questions about access to affordable employer-based coverage, as it is not a condition of eligibility for Medicaid. Customizing the application process to fit the circumstances of individual applicants will ease the burden of completing it by skipping questions that are not required instead of unrealistically expecting consumers to self-identify such questions. However, a pre-screening of eligibility that skips questions should not invalidate the application if it turns out that the consumer is eligible for a different coverage option (i.e., the dynamic process pre-screens the applicant as Medicaid eligible and doesn’t ask about access to affordable employer-based coverage). If additional information is needed, the agency should be required to contact the applicant.

Additionally, in an online environment, technology allows the health insurance affordability programs to “ping” various data sources throughout the process and provide applicants with helpful hints along the way. Alternatively, the system could inform applicants of the information on file by automatically pre-populating parts of the application, asking for verification. Such approaches will likely speed the application process and minimize the amount of follow-up required to resolve any inconsistencies, especially if such verifications are done in real-time. The federal data hub and state sources of data will allow health insurance affordability programs to provide income information, as well as accelerate the pace of other verification requirements, such as citizenship, through the data match with the Social Security Administration. As much as is feasible, verification of available data should be done as the application proceeds, providing the applicant with feedback and pre-populated data when available.

In the online version, alerts could advise applicants how information will be used before the system takes a next step. For example, when entering the Social Security Number (SSN), immigration status, income, and other personal information, the system could prompt the applicant with a message that tells them how the information will be used before they proceed.

- b. Paper Applications. While a paper application will take longer to process than the online application and denies consumers the benefits of real-time eligibility, offering paper applications is an ACA requirement. In fact, paper applications are actively used in Medicaid and CHIP today and will continue to be an important avenue to coverage for people who are not computer proficient or lack confidence in the security of the Web.

Paper applications should be designed for individuals with low literacy levels and those who have difficulty completing forms. Use of plain language, white space, and clear instructions are critical to the success of the paper application. Minimal data requirements should be highlighted in a way that consumers are directed to provide the essential data elements needed to constitute a valid application with optional data clearly marked. It could be helpful for HHS to design a shorter application that includes just the core elements as an alternative means to coverage.

- c. Telephone Applications. HHS and/or the states should develop a script of questions and prompts that is more conversational in nature to facilitate online applications.

Incorporating a “worker view” in the eligibility system will facilitate data entry of telephone applications. Alternatively (and ideally), a worker portal could be developed to provide an interactive tool for conducting telephone applications while completing an electronic application. For limited-English proficient (LEP) consumers, it will be critical to provide quick and easy access to language services in all call centers. Consumers applying over the phone should have the ability to stop and return to the process at a later time. It may also be helpful to incorporate the ability to transfer the saved application to an online account for consumers who wish to complete the process online.

- *Conduct Consumer Testing.* We appreciate that HHS has sought stakeholder input in the development of the application, including through ongoing consumer testing. Such efforts should continue and be structured to include families at all income levels and with language abilities, as well as those living in more complex coverage situations. For example, it will be very important to test the application on families in situations where the parents are covered in the exchange and the children are covered under Medicaid or CHIP, to ensure that families can provide the information needed to enroll in the appropriate source of coverage. Additionally, any language that is developed for the instructions, welcome messages, notices, etc., should be field-tested to be sure that applicants understand what HHS is attempting to convey. Also, HHS should test how consumers react to the use of pre-populated applications or “helpful hints” to determine the best way to present readily available data to applicants.
- *Ensure Alternative Applications Meet the Same Consumer-Friendly Standards.* States are allowed to develop their own applications, with Secretary approval, as long as they are not more cumbersome than the model application. In reviewing these applications, the Secretary should ensure that this standard applies to all features of the application, including the use of plain language and reassuring statements. The standard should also apply to online applications, multi-benefit applications, and eligibility and renewal notices. States should also be required to perform consumer testing and undergo a public process to ensure that the application is an appropriate substitute for the model version. It will also be helpful for HHS to set specific standards for the collection of specific types of information, such as race and ethnicity, in order to protect consumers and promote standardized data collection.

DATA ELEMENTS. In the sections below, we offer comments on the specific data elements outlined by HHS.

1. Baseline Applicant Information

- *Household contact information.*
 - a. Name: When requesting a name in the household contact information section, it should be clear which individuals need to be listed in this section – is the application seeking to identify a person within the household or can it be a person outside of the applicant household who has been designated as an authorized representative? In many circumstances, consumers may have received assistance with applications. It should be clear to the consumer and/or assister who to identify as the household contact name.
 - b. Address: Consumers should have the option to indicate they are homeless or otherwise do not have a stable address so that special considerations can be made in the event that the address provided is not a traditional residential one. Online applications that include real time address checks can be useful in catching data entry errors, but should allow consumers

to proceed without modifying the address in order to accommodate new, rural, and non-traditional addresses that may not be capable of verification through these data checks.

- c. Phone numbers: Having a phone number is not an eligibility requirement and thus applicants should be made aware that providing one is optional. If one is not provided, processing of the application should proceed.
 - d. Preferred language(s): We support the proposal to ask the household contact, tax filers, and any other adults who may need to be contacted for their preferred language; however, the question should be expanded to differentiate which language(s) is preferred for speaking and in written form. This should be an optional field, but individuals should be encouraged to provide this information to facilitate access to language services.
 - e. Race and ethnicity: Along with preferred language, the form should request race and ethnicity data from the household contact, using the standards put forth by the Institute of Medicine (IOM) in its 2009 report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Having this data is critical so the exchange can ensure its compliance with ACA and the Civil Rights Act of 1964, as well as transmit this information to qualified health plans (QHPs) for their compliance. Comprehensive collection of race and ethnicity data is needed to address health care disparities by improving access and accountability and reducing discrimination across all sectors of the healthcare arena. Applicants should be informed that race and ethnicity information is optional and how such information will be used.
 - f. Paperless notices and other forms of communication: As more people rely on electronic communications for day-to-day activities such as banking, paperless notifications and other forms of electronic communication can be cost-effective and timely. Clearly, such notices must protect the privacy of personal data and be available only in a secure environment. Consumers should be provided information about how their information will be protected when receiving electronic notifications. In order to initiate electronic communications, consumers must affirmatively opt in and choose what kinds of information (e.g., eligibility notices, premium reminders, etc.) they want to receive electronically and how they will be notified (via text message or e-mail). They should be able to easily change their preferences or discontinue electronic delivery of notices and revert to receiving paper notices. Ideally, access to notices would be preserved in the consumer's account for a specific period of time, such as 6-12 months. Consumers should be able to print notices from their online account and should be alerted prior to any notices being purged from the account.
 - g. Applying for coverage for self: We support asking the household contact whether she is applying for coverage for herself. If a household contact is not an applicant, then the application must not ask for information that is not necessary to determine the eligibility of an applicant, such as the household contact's citizenship or immigration status. The application may ask the contact's SSN only as a request/option, but not a requirement if the applicants are not eligible for APTCs.
- *Authorized Representative*. To better differentiate between the household contact (i.e., someone acting responsibly, such as a parent) and the authorized representative (i.e., someone who is not legally responsible, but is providing assistance), this section should be located at the end of the application, similar to how it's currently done on tax forms. It should also be made clear the level of permission the authorized representative has in terms of accessing the applicant's

information and responding to questions and/or requests from the health insurance affordability programs. Authorized representatives should have full capacity to act on behalf of the consumer, if he or she so authorizes them. However, consumers should also be able to revoke the authority of these individuals at any time. It will also be important in this section to highlight the difference between an authorized representative and a navigator or other application assister, who may help the family apply for and renew coverage, but who does not have the authority to act on their behalf. Additionally, it should be made clear that neither the authorized representative nor the assister has any authority to make health care decisions for the applicant unless separately granted.

· *Seeking help paying for health insurance and Privacy Statement.*

- a. Privacy and Civil Rights: We support the inclusion of a privacy statement, however it should come at the very beginning of the application before the consumer begins entering any personal information. Privacy is a distinct issue and applies regardless of whether the applicant is seeking financial assistance, thus it should be kept separate from this question. The privacy statement should make it clear what information will be collected, how it will be used, who it will be shared with, how it will be stored and for how long. This information should be written in plain English.

Applicants should be provided with information on civil rights protections as state agencies and their contractors, including navigators and brokers, are required to comply with non-discrimination laws, including in marketing, outreach, and enrollment activities. Informing consumers at the outset of their civil rights protections may encourage some to apply who would otherwise be reluctant.

For immigrant families, privacy and security of personally-identifiable information (PII), including its collection, use, and disclosure by state agencies and their contractors, is of paramount concern. The final exchange and Medicaid regulations restrict any use and disclosure of information and extend confidentiality protections. A statement providing an assurance of privacy should inform immigrant families that information will not be used for enforcement purposes.

While privacy, civil rights, and third party authorization are important, it should be organized in a fashion that does not discourage an individual from starting and finishing the application process. Having this information in a separate set of instructions, along with rights and responsibilities, may be an effective in achieving this goal, particularly in a written application. Online, a box that is clicked for more information is also another way to provide information but may be easily skipped over by applicants. Consumer testing will be important to determine the best content and format for explanatory text.

- b. Seeking financial assistance paying for health insurance: Asking if someone is seeking financial help in paying for the cost of coverage should be paired with the questions that ask whether an individual is applying for coverage. As someone could apply for coverage in the exchange without applying for an APTC and would still need to provide answers to a number of questions (as laid out in Appendix B), the coupling of these questions would help prevent an applicant who is not seeking assistance from inadvertently skipping important data points. Additionally, grouping together “applying for coverage” and “seeking financial help paying for coverage” by applicant allows families to apply for coverage on one form, even if some may not be seeking financial assistance while others are. It also seems to flow

more logically by having them appear side-by-side. It will be important to define “assistance” so applicants don’t overlook this question when, in fact, they may be eligible for help affording health insurance.

- *Build your household.* This section is likely to be one of most difficult for applicants, as it will require that they provide information on their tax-filing unit, as anticipated for the following year. Who files taxes together is pursuant to IRS rules and can include unrelated people or relatives (such as an aunt who lives with family). These households differ from current Medicaid household and may cause confusion for those who are familiar with the Medicaid rules, but are less knowledgeable about tax-filing units. In addition, there are other features of the new MAGI approach, such as children being considered in the household of whoever claims them, regardless of where they reside, as well as differences between Medicaid and the APTC determinations, particularly for children, which increase the difficulty and the importance of accurately eliciting information from applicants.

Because of these complexities, it will be important to provide clear instructions, definitions, and a easy-to-understand explanation of who should be included and why. For example, definitions of “primary tax payer,” “dependent,” and “household” are a must. It should also be emphasized that people can still apply and may be eligible for coverage even if they did not file taxes last year. For those who did file, it will also be helpful to encourage them to gather last year’s tax return ahead of time, to help guide them through the process. While their family structure may have already changed or be different in the year to come, this will at minimum provide them a starting point. Questions should also be included to determine whether they anticipate any changes (e.g., Did you get married since you filed your taxes or do you plan to do so in the coming year?).

- *Applicant/Non-Applicant information.* We support the identification of each household member as either an applicant or a non-applicant, so that non-applicants are not asked unnecessary questions. The health insurance affordability program may require an applicant to provide only that information which is necessary to make an eligibility determination (whether for the exchange, Medicaid, or CHIP), or for a purpose directly connected to administration of the program. For example, under this provision, they are prohibited from asking for the SSN or immigration status of a non-applicant if such information is not necessary to the eligibility determination of an applicant. Throughout the application, it should also be made clear which information is required and which is not.
 - a. SSN: Appendix A states that SSNs are optional for non-applicants, implying that they are never optional for applicants. That implication is incorrect, because the SSN may be required of applicants only if they are eligible for an SSN. This exception is important to mixed-status immigrant families, who may have family members who are eligible for benefits, but are not eligible for SSNs or eligible only for non-work SSNs. Additionally, some applicants who are eligible for emergency Medicaid or for prenatal care under CHIP may not be eligible for an SSN and the regulations specify that they may enroll using a unique identifier. As such, it should be clear that SSNs can only be required of applicants who are eligible for SSNs, and explain that other applicants may be assigned a unique identifier, if required by the program, for purposes of enrollment in coverage. It should also be explained that help is available in obtaining an SSN. To further allay applicants’ concerns, it should be made clear that SSNs are used to check the applicant’s income and to verify an attestation of citizenship. While non-applicants’ SSNs are optional in many circumstances, including them on the application could speed up the income verification and eligibility

process. However, the manner in which they are requested could deter families, especially those who have mixed-immigration status, from applying. Requests of non-applicant SSNs should accord with Privacy Act standards, accompanied by notice that the SSN is optional, the authority for the request, and how the SSN will be used.

- b. Eligible immigration status: We support requiring information on immigration status only of applicants in accordance with the regulations. To encourage mixed-status families to apply, when asking for immigration status, the application should clarify that the immigration status of a non-applicant is not needed and does not affect the eligibility of other family members. When asking if the applicant has an “eligible immigration status,” there should be a clear definition of that term based on a broader definition of “lawfully present.” The term should be defined in a list that shows the categories of eligible immigration statuses. This will help applicants and their assisters answer accurately. When issuing the model application, HHS should expand the list of immigration categories encapsulated in the definition of lawful presence to include, at a minimum, children and adults eligible for employment authorizations. HHS should also update the application as new categories of immigration status are authorized. (For the full recommendation, see page 4 of our October 31, 2011 [comments](#) on the proposed definition of “lawfully present” in the NPRM on Health Insurance Premium Tax Credit.)

The lawfully present immigration status of some applicants may not be verifiable by the DHS SAVE program (which will be accessible through the data hub) and only by submission of documentary evidence. The agency must accept any documentation required to establish eligibility, an essential protection for immigrants and others who have evidence of eligibility that is not verifiable electronically. In an online environment, there should be the capability of uploading this document; in a paper or phone application, the filer will need the opportunity to bring or mail in, fax, or e-mail such a document. Whether the opportunity to upload a document occurs at the point where immigration status is requested or at the end of the application will depend on when in the process the electronic verification occurs.

- c. Race/Ethnicity: To aid in protecting civil rights, we support asking for the race and ethnicity of applicants, as well as non-applicants, as long as the answer to the question remains optional. Applicants should be made aware that the data are being collected to ensure that everyone gets the same access to health insurance and that the information is confidential and will not be used to decide which program they are eligible for. Gathering this data will allow HHS to set national standards that allow for analysis and comparison of exchanges and QHPs. Exchanges can use the data to identify racial and ethnic disparities and to analyze their processes to ensure nondiscrimination. They can share this data with QHPs and navigators and encourage them to stratify their own data by race and ethnicity to identify any disparities in access or care.
- d. Preferred language(s): The model application should also request data on the preferred language of applicant and non-applicant household members. While the household contact may assist with an initial application, applicants and non-applicant household members likely will interact with the affordable health insurance program on an ongoing basis to get information, submit renewal applications, and file complaints. Thus, it (as well as any QHP) will benefit from having language data on all applicants and non-applicants to appropriately identify, plan, and provide for needed language services. If the household contact’s language preference differs from that of an applicant, information should be provided in multiple languages to ensure understanding by all parties. For example, if the household contact

prefers Spanish, but the applicant prefers English, all materials should be provided in both Spanish and English. Preferred language questions should be included early in the application and not tied to the optional race/ethnicity questions.

- e. Young adults 19–26 years of age. For young adults between 19 and 26, the application should ask if they are or have been in foster care. Regulations have not been issued on Medicaid for young adults so it is not clear if eligibility for extended Medicaid is available only to those who were in foster care at the age of 18 or some other criteria relating to when they were in foster care. Thus the wording of the question will need to be tailored based on the regulation.

2. Income and Additional Information

Even more so than determining their tax-filing household, reporting income information will be the most difficult section for applicants. As such, the questions should be straightforward and require reporting only what is available to the applicant, for example, by allowing them to report their income as it appears on their paystub, regardless of how frequently they are paid. Additionally, it will be vital to provide clear guidance to applicants regarding what wage information (i.e., pre-tax) is required, perhaps by referencing common terms such as “gross income” or “income before taxes.” Technical terms should be avoided if at all possible and concise, easy-to-understand definitions should accompany any terms that are outside common language.

It is important to consider those who are not paid in the typical fashion – self-employed, those working for multiple employers, those who do seasonal or piece work. These consumers may not have access to a pay stub that allows for easy reference, so accommodations, both during the application and verification processes, must be made so these individuals are able to provide accurate information without undue burden.

Consumers need to understand why accurate income information reporting is important. Information must be provided that clearly indicates that the taxpayer may have to pay back a portion of the premium credit if income ends up being higher than projected. It will be important that this information is conveyed in a reassuring but cautionary manner that does not discourage applicants from seeking financial assistance to pay for health insurance coverage. Conversely, if income is below what was projected, the taxpayer could incur higher premiums which, although will be refunded, could discourage enrollment due to cost. These messages should be repeated during the enrollment process when the applicant decides how much of the premium tax credit to take in advance at the time of enrollment.

- *Current monthly income.* Since applicants are not eligible for APTCs if they are eligible for Medicaid, the gathering and assessing of current monthly income should come before projected income. This will ensure that questions related to APTCs eligibility are not required of those who are clearly Medicaid eligible.

To determine income, for whichever time period is appropriate for the health insurance affordability program, applicants should be asked to provide income as reported on their paystub and the frequency of payment. The receiving agency can then make the appropriate calculation. Under no circumstances should applicants be required to do math in determining an answer to an income question.

In an online environment, a smart tool or worksheet could be provided for the applicant to enter basic wage data that then makes the calculation to determine monthly income. This tool could be devised in a way that also allows seasonal workers or contract workers to provide accurate income information. For example, it could provide a drop down box showing multiple pay frequencies such as weekly, bi-weekly, monthly, quarterly, or allow the individual to insert a specific date range. Such a tool should allow applicants to enter multiple jobs that are accumulated to calculate a monthly income.

In this same section, HHS suggests it will also ask specifically about sources of income other than employment income. Inquiring about these various income sources, such as Social Security benefits and unemployment benefits, in a similar fashion to how we propose asking about earnings would simplify the process for applicants and result in a more accurate overall assessment of an applicant's income. Additionally, in an online application, any more detailed questions (regarding amount and frequency) could be programmed to appear only if the applicant reported a particular source of income.

An online environment, tied to a data hub, provides some additional benefits for collecting income information. As the applicant works through the process, the health insurance affordability program could verify critical information as the application is being completed. If discrepancies are found, the applicant could be alerted and asked to provide clarification or additional information that may resolve the difference. Alternatively, the eligibility system could, to some extent, pre-populate the application form. For example, the system could begin by informing applicants of the income information on file in quarterly wage database and asking if it is accurate. Such approaches will likely speed the application process and minimize the amount of follow-up required to resolve any inconsistencies, especially if such verifications are done in a real-time fashion. Extensive consumer testing will be critical in determining what works best when asking applicants to provide or validate income information.

- *Projected annual income.* We do not recommend asking applicants to “project” forward what they anticipate earning in a given year. Estimating how much your weekly paycheck will total at the end of the year is a complicated task, especially for those with limited math skills. Additionally, trying to account for any changes the family may experience, such as a change in their job or increase in salary, will be an added burden. However, there are other ways to arrive at projected annual income without requesting a top-line figure from applicants. To start, applicants should not be asked to calculate their annual incomes. The process for reporting current income described above should be employed to determine current circumstances, with the health insurance affordability program making the appropriate calculation.

Following these questions, applicants could be asked whether they anticipate any changes in the next year. For applicants who are clearly Medicaid-eligible, it is not necessary to ask follow-up questions regarding future income. While not every applicant will be able to provide these details, those whose pay increases in routine increments or an expected decrease in hours may be able to do so. For others, the answers could be more vague or open ended. Any of these reported or anticipated changes should be factored into income for the applicable time period for the health insurance affordability program (i.e., monthly or annual income), without requiring the applicant to make a projection.

Additionally, the proposed option of responding “I don’t know” should be allowed for applicants who have difficulty calculating their projected annual income, if such a requirement should remain. It will also be important for the application to provide toll-free help lines and encourage

applicants to call as they encounter questions at this and other difficult points in the application.

- *Discrepancies.* We support the idea of gathering information on any discrepancies that may arise when the information provided by the applicant is compared to data in the hub or from other available sources. Inquiring about changes in the last year, as well as any anticipated changes going forward, will help to limit, or at least foresee, discrepancies. Regardless of the type of application (paper, online, telephone, or in-person), applicants should be asked whether they there have been any changes in their family structure (such as a marriage or the birth of a child) or income (such as a change in a job or a decrease or increase in hours). They should also be afforded the opportunity to provide explanations of why a discrepancy exists, with the health insurance affordability program informing the consumer about the data source and the timeframe the data represents. As mentioned above, in an online environment, this could be more of a dynamic process, with the health insurance affordability program providing the applicant data points along the way, asking whether or not the information is correct, and resolving any discrepancies during the application process. At this point, if applicants appear eligible for APTCs, alerts should inform them of the importance of accuracy in providing income information due to the tax implications.
- *Additional information.* HHS has proposed dividing additional questions into questions asked of all household members and questions asked just of those applying for coverage.
 - a. All household members.
 - *Pregnancy.* In Medicaid/CHIP, states must count the pregnant woman as at least two persons in determining her eligibility. For other members of the household, states have the option of counting the pregnant woman as a single person or as more than one person (depending on the number of babies expected). As such, regardless of whether or not she is applying for coverage, the pregnancy status of a family member will be important in determining the size of the household for other applicants. Therefore we support asking all females listed on the application whether or not they are pregnant.
 - *Other addresses, including intended change of residency.* We question the reason for asking residency questions of all household members, both applicants and non-applicants. However, applicants should be asked if they are a resident of the same address as the household contact so that eligibility can be determined for the appropriate location. For example, a student could be a resident of another state, but be part of his parent's household and the eligibility determination would need to take this into account. There is no need to ask applicants or non-applicants whether or not they intend to remain in the state, as recipients are required to report any changes, including moving, to the health insurance affordability program. Applicants should be made aware of this and other requirements in the notice of eligibility determination.
 - b. Applicants only.
 - *Blindness, disability, need for long-term care.* As with many elements of the application, there is a tension between the desire to keep it simple and "real-time" processing with enrolling the applicant in the appropriate coverage source. As eligibility for Medicaid with access to more robust benefits can be based on whether or not an applicant has a disability, the question(s) will need to be worded in such a way to identify those

potentially eligible for other categories of Medicaid without being over burdensome or intrusive. It will be important, therefore, to ask appropriate screening questions that flag the need for additional information. For example, with regards to adults, the question could ask if any applicant has "a medical condition, including a mental or physical illness that makes it hard to work." For children, the question could be phrased similarly, substituting "doing things that other kids do" for "work." By wording the question more generally, additional applicants who may be eligible for a broader array of benefits will be captured. Another way to assess disability is to ask if the applicant receives or has applied for Social Security disability or SSI.

In an online application, if an applicant checks such a box, he or she could be provided with the opportunity to provide additional information related to the nature of the disability, as well as any relevant documentation, at that point. In other modes of application, a preliminary eligibility determination could be made based upon the information provided on the application, and for those who answered "yes" to the screening question(s), follow-up would be needed to determine the nature of the disability and whether or not the individual qualifies for more robust benefits. If applicants are asked to provide more detailed information, it will be important to note how the data will be used. If there are legitimate reasons to share the data beyond the eligibility agency, applicants should be asked for permission for the agency to do so. In either circumstance, it will be important to include additional messages on the benefits available to those with disabilities in the notices that applicants receive. We discuss these in more detail below.

- *Full-time student.* It is a state option as to whether 19- and 20-year-old full-time students who are not claimed as dependents are kept in the household in which they are living or considered a separate household on their own. As such, it will be important to know whether or not the household contains these young adults when determining eligibility. Additionally, Medicaid will have flexibility in determining how students attending school in another state will be treated in terms of eligibility, while the exchange must leave this decision up to the applicants. Providing applicants clear information about this choice will be complicated and should be included in training navigators and application assisters.
- *Enrollment in other health insurance.* Detailed questions regarding other coverage should not be asked in this section, as the information required is program-specific. In Medicaid, the question is irrelevant for eligibility determinations and only needed for third-party liability purposes or enrollment in premium assistance programs. As such, using a simple check box to indicate other insurance should be sufficient to alert the Medicaid agency to follow-up for additional information, which should then be collected post-enrollment. On the other hand, eligibility for CHIP is based on whether the child (and in some cases the pregnant woman) is uninsured. In these cases, eliciting current or recent enrollment in other coverage is required. This will be easier to accomplish in an online environment where questions can be tailored to those who appear to be eligible for certain programs; however, it will also be important to streamline the process for those applying through other modes. We address more specifics in the section below related to program-specific questions.

3. Program-Specific Questions

In an online environment, the following questions can be tailored to those for whom they are

relevant (i.e., those who appear to be eligible for particular health insurance affordability programs). However, in other types of applications, these questions may need to be asked of all applicants, unless the information can be elicited post-eligibility. For questions that are program-specific, HHS should consider which, if any, are among the core elements required for an eligibility determination. In those cases, it will be important to ask them as simply as possible and provide an explanation as to why the information is needed, stressing that it may speed up the application process. However, if applicants do not respond and the information is required, the health insurance affordability program should follow up.

• *Exchange –*

- a. Employer-based coverage. While we recognize the challenges that HHS faces in implementing this provision given the lack of available, reliable data on access to employer-based coverage and the statutory language, we have significant concerns with a requirement to elicit many of the proposed data elements from the applicants themselves (For more details, please see our July 12, 2012 [comments](#) on CCIIO's *Verification of Access to Employer-Sponsored Coverage Bulletin*.)

In particular, the Bulletin and proposed data elements rely heavily on the unrealistic assumption that consumers will be able to gather and provide complex data and information regarding any employer-based coverage available to them. For example, consumers will need to provide information on the lowest-cost plan offered by their employer that meets “minimum value.” Applicants will not know what “minimum value” means and will not be able to determine which of the plans offered meet this standard. Moreover, the lowest cost plan that meets minimum value is not necessarily the same thing as the cheapest plan offered by an employer, adding an additional level of confusion. While the Bulletin indicates that HHS will encourage employers to provide this information on a standardized form, they are not required to do so which may leave many consumers obligated to provide information that is not readily available to them.

We recommend that in an online environment, only certain applicants should be asked to provide these data points, specifically those claiming an exemption because their employer-based coverage is unaffordable and/or does not provide minimum value. For those applying through other modes, they should be asked only the basic questions pertaining to their employer and if they receive any offer of coverage. The more complex questions related to the availability of affordable, minimum value coverage should be asked post-eligibility and only if an individual is determined eligible for APTCs.

Additionally, we support HHS' proposed policy that would facilitate simple and effective pre-enrollment verification by focusing on obtaining information from employers. By developing a standard form or worksheet that employees could use in collecting required information and completing an application, HHS could vastly simplify and streamline the process. The form should be consumer-friendly, and to the greatest extent possible minimize the burden on applicants and employers to provide the information. This form should be shared with all employers accompanied by instructions on how to provide relevant information to employees.

The processing of applications should not be delayed for those unable to provide all the necessary information pertaining to the affordability and value of employer-based coverage. In this situation, we recommend that exchanges follow the guidelines laid out in the final

regulations that describe the approach to resolving inconsistencies. Under this approach, the exchange would proceed with the eligibility determination as data on employer-based coverage are sought through other channels. If such data cannot be obtained, the applicant's eligibility could be determined without it, applying the exception for special circumstances that allows the applicant to attest to information that is not available.

- b. Eligibility for other public coverage. As required by regulation, exchanges must determine or assess eligibility for Medicaid prior to determining eligibility for APTCs. As such, applicants should not be asked to indicate whether or not they are eligible for other public coverage, as this should be determined by the exchange.
- c. SSNs of tax filer(s) if not provided. Regulations require the collection of a non-applicant's SSN only if the non-applicant has an SSN, is a tax filer, and has filed a tax return for the year for which tax data would be used by the exchange in making an eligibility determination. Otherwise, the exchange may not require individuals not seeking coverage for themselves to provide a SSN. It should be made clear that this is required for determining eligibility for APTCs and will be used to verify income through tax data and other available data sources.
- d. Special enrollment period. If an applicant is applying for APTCs during a non-open enrollment period, he/she should be given a list of qualifying events that would trigger eligibility for coverage. Applicants should also have the option of selecting "other" and providing an explanation as to why they are applying for coverage outside the typical enrollment season.

• *Medicaid –*

- a. Past medical expenses. Medicaid will cover medical expenses that occurred in the three months prior to an eligibility determination, if the applicant was eligible for coverage at that point in time. While these data are important to collect in order to assist families in covering costs that may be beyond their means, the exact amounts can be asked post-eligibility, with applicants simply indicating on the application if they have incurred any recent medical expenses through a simple checkbox. If so indicated, the agency can then follow up for the details. It will also be important to convey to families, perhaps in the eligibility notice, that assistance with past bills is available with instructions on how to secure retroactive eligibility.
- b. Pregnancy. Questions related to pregnancy are asked of all household members in the section on "Additional Information." As such, they do not need to be asked again.
- c. Absent parent. For children applying for Medicaid and CHIP, whether they have an absent parent is not relevant to their eligibility. However, cooperation with assigning responsibility for medical support is required, with limited exceptions, from parents applying for Medicaid. These questions can be a barrier to enrollment, thus specific information-gathering regarding medical support should occur after an eligibility determination, with parents simply required to attest on the application that they will cooperate with such procedures as a condition of eligibility. The attestation should be accompanied by language that indicates that accommodations can be made for individuals who believe cooperation will cause harm to themselves or their families. An explanation of why this information is requested should also appear, as well as clarifying language that medical support is not the same as child support.

- *CHIP –*
 - a. Past health coverage end date and reason for termination. Eligibility for CHIP is based on whether the child is uninsured and in most, but not all states, depends upon the length of time the child has been uninsured. The CHIP law requires states to describe the procedures used to ensure that CHIP coverage does not substitute for private coverage. Although encouraged to use other mechanism, states have put waiting periods in place in the name of minimizing this substitution. Many states allow “good cause” exemptions, for example if a child became uninsured after his parent lost a job.

Waiting periods no longer make sense in a post-ACA universe in which everyone is expected to enroll in coverage and, indeed, can face penalties for failing to do so. However, the regulations did not address the issue of waiting periods in CHIP. If the ability of states to impose waiting periods is not prohibited, potentially CHIP-eligible applicants should be asked about current or recent coverage (within the timeframe of the state’s waiting period), as well as the reason for termination. If states are no longer able to impose waiting periods, as is recommended, applicants should be asked only about current coverage.
 - b. Dependent child of public employees. The ACA allows states to cover the dependents of state employees in their separate CHIP programs under specific conditions. At least nine states have been authorized to do so; as such, eligibility for CHIP for public employee dependents will be state-specific. In an online environment, this question should be limited to those applicants who appear income-eligible for CHIP.

4. Confirmation and Eligibility Determination

- *Application summary.* We strongly support providing families with the ability to review and make changes to their applications prior to submission. The design of any of the application modalities should provide consumers with final control over their application information, allowing them to investigate any other options and potential consequences before formally submitting their application. This control would encourage participation among many applicants, but especially by mixed-status immigrant families who may want to research the potential immigration consequences of applying for health care after they have learned the extent of personal information they must provide.

Applicants should also have the ability to print and save a copy of their application for reference. This protection should not be accessible solely online and through the paper application, but copies should be available to those who submit over the phone or through some sort of assistance mechanism. In the online application environment, we reiterate our support for a federal requirement that states establish a personal account to facilitate the review and return to an application at any time throughout the process.

It is critically important to establish a separate web portal for navigators and assisters that not only tracks their activity for audit and evaluation purposes, but also provides them with status and other information needed to assist the individual on an ongoing basis.

- *Rights & Responsibilities and Signatures.* Rights and responsibilities should be communicated in clear and simple language that is non-threatening. On both the application and the notice, families should be given information on how to appeal the agency’s decision as well as file a

complaint if they believe they have been discriminated against. Privacy and civil rights protections should also be included here, in addition to the beginning of the application.

States are prohibited from denying or delaying services to an otherwise eligible individual pending issuance or verification of an SSN by the Social Security Administration, an important protection for vulnerable families including immigrant and LEP families who often face problems with obtaining SSNs. The Medicaid rules incorporate due process protections to help individuals correct inaccuracies in their records without forfeiting critical coverage. Notice of this protection should be included here.

- *Determination and notice(s)*. Families should receive a full and complete eligibility notice, regardless of whether or not the members are all eligible for the same program. The notice should clearly lay out the eligibility (not the **in**eligibility) of each family member. Additionally, if families are split between various programs, an explanation of each should be provided. The notice could begin with a summary page that provides an overview of the coverage determination (e.g., children Mary and Alice are eligible for CHIP; parents Bill and Jan are eligible for APTCs), followed by more detailed information about each applicant on subsequent pages. These appendix-like pages could then explain more specifics about the benefits and cost-sharing requirements of each of the relevant health insurance affordability programs. In situations where eligibility has been determined for some but can not be determined for all family members, the same type of notice could be used, highlighting whose eligibility is pending and why. Any additional verification or documentation requirements could then be listed on the applicant-specific sheet. All notices should include information on the right to appeal an eligibility decision, including the ability to request a full Medicaid determination, which is discussed more below.

Some individuals, including those in immigrant families, will not be eligible for coverage under the exchanges, full-scope Medicaid, or CHIP. However, they should be connected to the limited options that are available to them. For example, some states and counties cover all children regardless of immigration status. The health insurance affordability programs should help ease administrative costs by screening and enrolling for other state and local programs, as required by the ACA.

As HHS is developing the model application, it should also develop model eligibility and renewal notices, or at minimum, language that has been field-tested among potential beneficiaries that states could then use in their own notices. Any alternative notices that are developed by states should be subject to Secretarial approval, similar to the requirement for alternative applications. The same standards that apply to an application, such as the use of plain language and reassuring statements, should be required of notices.

- a. Withdrawal of a Medicaid application. The interim final rule requires states operating a bifurcated eligibility system (i.e., one where the exchange only makes an assessment of Medicaid eligibility) to provide applicants with the opportunity to withdraw their application for Medicaid if they are found to be potentially ineligible for such coverage by the exchange. This type of a request is likely to be highly confusing for families, especially as many will find themselves split between different affordability programs. Additionally, as important protections accompany a Medicaid application that would be given up should an applicant choose to withdraw from the process, it will need to be clearly and carefully explained to applicants what the risks, and possible benefits are, for making such a decision. They should also be provided with contact information to obtain more information. HHS

should provide states with model language they can use in presenting the option to withdraw an application to ensure an informed choice. Furthermore, it should not be suggested that people withdraw their Medicaid or CHIP applications unless their income is above a threshold and they report no medical expenses or potential disability making it highly unlikely that they are eligible for these other programs.

- b. Request for a full Medicaid determination. In some circumstances, applicants who are entitled to broader Medicaid benefits may be determined eligible for Medicaid under a more limited benefit package. In other situations, such an applicant may be determined eligible for APTCs. As described above, it will be important to ask appropriate screening questions for potential disabilities that flag the need for additional information to avoid this outcome for as many applicants as possible. However, as the potential for erroneous eligibility determinations remains, applicants should be given other opportunities to self-identify as having a disability, both with receipt of the eligibility notice and at renewal. The health insurance affordability program should inform applicants of their right to ask for a full-eligibility determination in language that is easily understandable and with information on how to obtain additional information. During this time, they should continue to receive coverage in the insurance affordability programs based on income.

5. Qualified Health Plan Enrollment

Those found eligible for APTCs (or exchange coverage without a subsidy) will need to choose a qualified health plan in which to enroll. While this could be woven into an online or even telephone application process, it will need to be done post-eligibility for those using the paper application. In applying online or via telephone, individuals eligible to enroll in a QHP should be given the option to stop and return to the plan selection and enrollment process at a later date.

Applicants should be made aware of what their premium contribution will be, as well as any cost-sharing requirements. It will also be important to explain which plans are eligible for subsidies and the implications if an applicant chooses another plan (i.e., picking a gold or platinum plan and incurring additional cost-sharing).

- *Plan selection and confirmation.* Applicants should be given enough information to make an informed choice of plans based on the qualifications that are most important to them. For example, if an applicant wants to continue seeing her current physician, she should be able to search plans based on this criteria. In addition, applicants should have the ability to pick multiple plans to secure the most appropriate coverage for their family. This will be especially important for children, who may need to choose a dental-only plan in addition to a medical plan. It will also be helpful at this stage to remind applicants where they can get “authorized and trained” assistance in selecting and enrolling in a plan.
- *Amount of APTC applied toward premiums.* Applicants will be able to determine how much of the APTC they wish to apply towards the premium. At this point, it will be essential to reiterate the implications of this decision should their actual income deviate from that used to determine eligibility. Clear information needs to be provided to the consumer regarding the potential of having to pay back a portion of the premium credit if actual income ends up higher than projected and conversely, the potential for a refund should income end up below what was projected. As mentioned above, it will be important that this information is conveyed clearly, but also in a manner that does not discourage applicants from seeking assistance with paying for health insurance coverage that may otherwise be unaffordable. At this point, applicants should also be able to make their first premium payment if they so choose.

SHOP APPLICATION. We support the proposal that employees and employers will be able to complete and submit SHOP applications over the phone, online, or in person, as it's vital that consumers have an option to select the mode that best meets their needs. As mentioned above, the use of an online application that uses dynamic questioning to reduce the number of questions that consumers will have to answer to complete an application for enrollment will help speed the process. It appears that the in-person option is limited to services provided by an agent, broker, or navigator. We believe that the language should not be restricted to these entities, particularly because HHS has recently highlighted the opportunity and need for other types of "application assisters" to serve individuals and small employers in need of support.

The strong privacy regulations, which apply to both individual market and SHOP exchanges, require a SHOP to restrict any use and disclosure of the personally-identifiable information they collect or create to those purposes necessary to carry out specified functions, and to never use such information to discriminate inappropriately. A privacy statement should appear at the beginning of the application and make it clear what information will be collected, how it will be used, who it will be shared with, how it will be stored and for how long. A strong civil rights statement, as explained above should also be included on the application.

In addition to helping many small businesses provide coverage for their employees, the SHOP exchanges will link many uninsured immigrants and their children to care through family coverage. Small businesses employ a large number of immigrants and many immigrants are also small business owners and entrepreneurs. We appreciate the separate applications for individual market exchange and employee and employer applications for the SHOP exchange. The ACA allows for a merger of the two exchanges, but because the immigrant restrictions are confined to the individual market, there needs to be a clear distinction and separation between the two with regard to verification of eligibility. Additionally, employees eligible for employer coverage through the SHOP do not need to be subjected to the extensive eligibility process required of those applying for financial assistance through the individual market exchange.

1. SHOP Employee Application

- *Options for coverage.* SHOP employee applications should inform consumers that they may qualify for subsidized health coverage through health insurance affordability programs, including Medicaid and CHIP, and link employees to the relevant state resources where they can get additional information and apply for coverage.
- *Race and ethnicity.* To aid in protecting civil rights, we support asking for the race and ethnicity of applicants, as well as their dependents, as long as answering these questions remains optional. Applicants should be made aware that the data are being collected to ensure that everyone gets the same access to health insurance and that the information is confidential and will not be used to decide program eligibility.
- *Language preference.* As with the individual exchange application, the SHOP application should request data on the preferred language of applicants. As employees will need to communicate with the exchange, as well as their chosen QHP, knowing their preferred spoken and written language will help facilitate this interaction.
- *Dependent information.* We appreciate the careful limiting of information gathering on dependents to focus primarily on name, gender, birth date, and relationship to employee.

However, we support voluntary collection of information from all family members on race and ethnicity, and preferred language for adults.

- *Additional information.* Any subsequent information request should only ask applicants to include changes in information or additional information that is specific to their enrollment (for example, regarding their dependents). It should not require submission of any information pertaining to non-applicants or resubmission of any previously provided information.

2. SHOP Employer Application

- *Language preference.* Many small business owners are immigrants and many are limited-English proficient (LEP), as such, it is imperative to collect data on the preferred language of the employer, as is currently proposed. Without knowing which employers have LEP, the SHOP cannot serve those individuals and cannot adequately plan to provide them with meaningful access to services as required by law.
- *Multi-site employer.* The employer application should also include a question allowing applicants to indicate if they have worksites in other states served by a different SHOP(s) and which SHOP shall be serving each worksite. If this is the case, the employee application should also be able to indicate their worksite address so they are seeking coverage under the appropriate location.
- *Employee list.* Employers will also be asked to submit a list of employees who are eligible to purchase coverage through the SHOP exchange, including their tax identification number (TIN). TINs include SSNs as well as Individual Tax Identification Numbers (ITINs), under which people without SSNs file their taxes. It is well documented that the collection of SSNs by benefit programs discourages participation of immigrant families and should be carefully limited to uses that are strictly necessary for program administration and specifically authorized by law. Understanding these serious implications for participation, the ACA requires issuers to report to the IRS the TINs (rather than SSNs) of covered individuals, with the final regulations mirroring the language in the statute. As such, the employer application should ask for a TIN and not a SSN and provide a clear definition of “Taxpayer Identification Number” to ensure that the employer understands that the term includes both a SSN, as well as other TINs.
- *Benchmark reference.* We support the inclusion of a question on the employer’s selection of a benchmark reference plan, as well as the contribution the employer will provide towards coverage for employees and their dependants. Using a benchmark reference plan will allow employers to provide an age-adjusted premium contribution that protects older employees from facing a disproportionately higher employee share for coverage, while still maintaining the option of employees to choose from multiple plans.