

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:

As organizations that share a strong commitment to children and pregnant women, we appreciate 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 comments that follow, we recommend overarching principles to guide development of the application, as well as more specific suggestions on the proposed data elements of particular importance to children.

Respectfully submitted,

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Children's Defense Fund
Children's Hospital Association
Community Catalyst, New England Alliance for Children's Health
Family Voices
First Focus
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March of Dimes
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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 should be 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 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 authorized to login. 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 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 could be helpful.
- *Allow Applicants to Submit a Partially Completed Application.* Allowing consumers to complete an application to the best of his/her ability and to sign and submit the application with missing information is an important consumer protection. The submission of a partially completed application (regardless of whether all data needed to establish an official application date 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, both 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 applicant 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 states sources of data will allow states 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 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 and that optional data is clearly marked. It could be helpful for HHS to design a shorter application that includes only core elements that could be used

- 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. In telephone applicants should have the ability to stop and return to the process at a later time. It may 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, 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.

KEY DATA ELEMENTS. In the sections below, we offer comments on the data elements outlined by HHS of particular importance in connecting children and pregnant women to coverage.

1. Baseline Applicant Information

- ***Applicant/Non-Applicant information.*** We support the identification of each household member as either an applicant or a non-applicant, so that non-applicants, often parents applying on behalf of children, 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 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 update the application as new categories of immigration status are authorized.

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), 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. Young adults 19 – 26 years of age and connection to the foster care system. 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.

- *Additional information.* Following questions on household income, 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 2 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.
 - *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 sources 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 of 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.

- *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, 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 post-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 thus 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. 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.

- *Plan selection and confirmation.* 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.