ACAP
Association for Community Affiliated Plans

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February 28, 2013

OMB
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer
RE: CMS Form CMS–10440

Submitted electronically via: OIRA_submission@omb.eop.gov

To Whom it May Concern:

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to comment on draft *Application for Health Insurance* and attendant documents, including the draft application for coverage alone and an application which would allow individuals also to apply for financial assistance, including for premium tax credits and cost-sharing reductions in the Exchange, Medicaid, CHIP and the Basic Health Program. These draft forms were published January 25, 2013 on the CMS.gov website. ACAP strongly supports CMS' efforts to develop a streamlined application for and process that will be clear and easy for applicants to use. Your agency has done tremendous work on the applications to ensure just this.

We appreciate your willingness to consider our comments.

ACAP is an association of 58 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to almost 10 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees. Many Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act. Many of our members intend to build qualified health plans that will participate in the Exchanges operating in their states.

Our comments are summarized below.

1. **Clarify whether the individual referred to in Step 1 in both the coverage-only form and financial assistance (FA) form is applying for coverage with this application.**
2. **Clarify whether an individual will continue to receive information by traditional mail as well if they choose to receive information by email or text. If the applicant will not continue to receive traditional mail, amend the application to provide a clear notification of this fact.**
3. **Ensure that the information requested on both forms is consistent when possible.**
4. **Provide clarification on several aspects of the FA form's request for federal tax return information.**

5. **Ensure the Exchange shares demographic data collected for applicants with qualified health plans, including citizenship, immigration status, ethnicity and race.**
6. **Provide clarity as to the use of certain information collected on the FA form.**
7. **Provide space on both application forms for names and contact information of brokers and agents that have assisted with the application.**
8. **Clarify precisely what is meant by "authorized representative" on both forms.**
9. **Simplify questions about employer-sponsored coverage in Step 3 of the FA form.**
10. **Clarify applicant responsibility regarding Step 3 and the Employer Coverage Form on the FA application.**
11. **Explain how applicants will apply for mid-year redeterminations due to changes in circumstances and new coverage via special enrollment periods.**
12. **Offer both the written and online applications in a sufficient number of languages to be helpful to the population of applicants.**

We explain these positions in greater detail below:

1. **Clarify whether the individual referred to in Step 1 in both the coverage-only and FA forms is applying for coverage with this application.** Step 1 of both the coverage-only and FA forms seeks information about an adult member of the family. Step 2 asks the applicant to provide information on people seeking coverage. ACAP asks CMS to clarify on the forms themselves whether the individual providing name, contact information and other data in Step 1 is applying for coverage by entering this information. On the coverage-only form, fields for detailed information, and the statement "NOW, tell us who else needs insurance" suggest this is the case. It is unclear on the coverage-only form whether the individual named in Step 1 is the same as Person 1 in Step 2, as Person 1 clearly is applying for coverage. If the individual in Step 1 is not automatically included in the application for coverage but desires it, should she repeat her data in the fields for Person 1?

   ACAP respectfully requests substantial clarity regarding Step 1.

2. **Clarify whether an individual will continue to receive information by traditional mail as well if they choose to receive information by email or text. If the applicant will not continue to receive traditional mail, amend the application to provide a clear notification of this fact.** In Step 1, the individual filling out the application is given the option of receiving information related to the application to the Exchange in text or email form. We appreciate the efficacy of these options and anticipate that a large number of applicants will take them up. However, the application text does not clearly indicate that by checking yes on either option whether the applicant will continue to receive information by traditional mail. If checking Yes on either means that the applicant will not receive traditional mail, this should be clearly explained on the application.

   Also, it should be clarified whether it is allowable for applicants to check Yes for both options, and thereby receive information by both email and text.

ACAP suggests CMS clarify the options to receive application information via email, text or traditional mail.

3. **Ensure that the information requested on both forms is consistent when possible.** ACAP recognizes that the FA must collect data in addition to what is collected in the coverage-only form due to their differing purposes. However, both forms must collect information ensuring an applicant is eligible for coverage in the Exchange. The questions asked on both forms for this purpose should be consistent to avoid confusion among applicants and difficulty for qualified health plans. There will be value also in ensuring that data collected on all applicants and enrollees is as standardized as possible. Two examples of inconsistencies follow:
    a. Information provide on the cover sheets, which is very inconsistent between the two forms.
    b. Information collected in Step 1, which on the coverage-only form requests Social Security Numbers and demographic information, but does not on the FA form.
    c. Instructions for Step 2, which do not appear in the coverage-only form.

    ACAP suggests that information requested on both the coverage-only form and the FA form be consistent whenever possible.

4. **Provide clarification on several aspects of the FA form's request for federal tax return information.** The form asks whether each applicant intends "to file a federal income tax return NEXT YEAR" (CMS' emphasis.) ACAP respectfully asks CMS to provide clear justification for the use of the responses. In addition, we ask for clarify about the year to which the application refers. For example, if an individual submits this application in January of 2014 and has not yet filed a tax return for 2013, does this question refer to the 2013 tax return or the 2014 tax return?

    ACAP asks that CMS clarify the purpose for this question and for additional information on the federal tax return year referenced.

5. **Ensure the Exchange shares demographic data collected for applicants with qualified health plans, including citizenship, immigration status, ethnicity and race.** ACAP is aware that CMS has received requests from health plan representatives for all demographic data collected on the Exchange application. We would like to reinforce this request. Qualified health plans in the Exchanges will be required to measure the quality of the coverage they provide, and these quality measures will be, for the first time for many plans, reported publicly. It is important for plans to track their quality efforts by demographics to ensure that improvements to quality are experienced by all covered individuals.

    ACAP respectfully requests that CMS share demographic data from the application with qualified health plans.

6. **Provide clarity as to the use of certain information collected on the FA form in Step 2.** In our question in 3. above, we seek clarity for the application's request for federal tax return information. The FA form asks for additional information for which there does not appear to be adequate narrative justification. Although the purpose for seeking this information may be very important, we suspect that applicants will want to understand the motivation for such questions.

   For example, the application asks whether the applicant has lived in the U.S. since 1996; elsewhere, it asks about applicants' disability status and whether an applicant needs help with medical bills over the last three months. We believe that the Exchange will seek to collect this information so that applicants may, if eligible, receive comprehensive Medicaid coverage. However, these reasons are not likely to be clear to applicants and may have a chilling effect, as applicants may be concerned that answering in a certain way will disqualify them from coverage.

   ACAP suggests that CMS clarify to applicants the purpose for asking for certain information.

7. **Provide space on both application forms for names and contact information of brokers and agents that have assisted with the application.** Some of ACAP's member health plans expect to enroll many individuals who will work closely with brokers and agents to apply for and enroll in coverage in the Exchange. Several plans have questioned how they will know for certain when an enrollee has been assisted by a specific broker or agent. This information is critical for plan payments to brokers and agents.

   Furthermore, while there is space on the applications – page 7 of the coverage-only form and page 19 of the FA form – for authorized representatives and also for certified application counselors and navigators, there is no space for information on brokers and agents. This absence may be confusing to some applicants, who may confuse brokers and agents with these other assisters (see 8. below).

   ACAP requests that CMS include space on both the coverage-only and FA forms for information on brokers and agents that have assisted applicants.

8. **Clarify precisely what is meant by "authorized representative" on both forms.** Page 7 of the coverage-only form and page 19 of the FA form provide space for applicants to select an "authorized representative," defined as a "trusted friend or partner" to whom permission may be given to discuss the application with the Exchange. Although we feel this definition is fairly clear, the absence of space to indicate whether a licensed broker or agent has helped with the application might prompt some applicants to use the authorized representative space for brokers and agents. We suggest that as CMS adds precision to the definition of authorized representatives it also clarifies that agents and brokers are not included in this definition.

ACAP recommends that CMS clarify the definition of "authorized representative."

9. **Simplify questions about employer-sponsored coverage in Step 3 of the FA form.** Step 3 of the FA form asks applicants the following question related to employer sponsored coverage:

   "What is the name of the lowest cost self-only health plan the employee listed above could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)"

   ACAP believes that this question and the attendant answer choices ("No plans meet the 'minimum value standard.'") will be burdensome and difficult for applicants to understand.

   Furthermore, it is unclear whether the response "Don't know" is intended to answer both the question about the lowest-cost self-only health plan, the minimum value standard question, or both? It is also unclear whether checking this response will result in an incomplete application and disqualification.

   We suggest that CMS provide clear definitions for "minimum value standard," "lowest cost self-only health plan," and other terms of art, *or* suggest that this question be removed. In addition, ACAP asks CMS to clarify the "Don't know" answer.

10. **Clarify applicant responsibility regarding Step 3 and the Employer Coverage Form on the FA application.** As described in 9. above, the FA form seeks to gather information on available employer-sponsored coverage in Step 3. The application seeks similar information on the Employer Coverage Form on page 21. It is unclear whether applicants are required to complete both sections in order to have submitted a complete application that will be considered by the Exchange, or whether the Employer Coverage Form is simply a vehicle for information collection. It is also unclear whether an individual will be able to enroll if that person has difficulty receiving necessary information from the employer.

    Also, we make the point in 9. that many individuals will not understand what is meant by "minimum value standard." The same may be true of employers, particularly in 2014 and 2015, when Exchanges and the Affordable Care Act are newly implemented. We suggest that CMS provide clear definitions for "minimum value standard," "lowest cost self-only health plan," and other terms of art.

    ACAP requests clarity for applicants related to information requested about employer-sponsored coverage in the application. We also recommend that CMS add a bullet point to the "What you may need to apply" section on the FA form indicating that applicants may need to submit the Employer Coverage Form.

11. **Explain how applicants will apply for mid-year redeterminations due to changes in circumstances and new coverage via special enrollment periods.** The final Exchange Establishment rule published March 27, 2012 includes nine special enrollment periods that allow individuals to newly enroll in a qualified health plan or to change plans during the coverage year. The single, streamlined applications will provide the Exchange with adequate information to enroll people approaching the Exchange for the first time during open enrollment. However, it is not clear whether applicants and current enrollees should also use these forms to inform the Exchange about changes in circumstances that might alter eligibility and trigger a special enrollment period. In addition, it is not clear whether the forms may be used by new applicants who might qualify for coverage and enrollment because of other special enrollment periods. Questions related to gaining or losing a dependent, changing immigration or citizenship status, losing employment, and other triggers for special enrollment periods are not included in either the coverage-only and FA forms.

    ACAP seeks more information related to how enrollees may seek mid-year redeterminations and how applicants may seek enrollment using special enrollment periods.

12. **Offer both the written and online applications in a sufficient number of languages to be helpful to the population of applicants.** Recently, ACAP joined dozens of other organizations in signing a letter to CMS circulated by NHELP, which stated

    "Without translated applications, one out of four expected insurance marketplace applicants who speak a language other than English at home are at high risk of being left behind. The more than 24 million limited English proficient (LEP) individuals across the country deserve equal access to the new coverage options available under the Affordable Care Act (ACA).

    Currently the supporting statement indicates that the application will default to English and display dropdown menu of languages. We recommend that CMS translate the application into at least fifteen languages and create corresponding translation glossaries of key ACA terms that all enrollment stakeholders can access. Federal translations would be efficient, save money and resources, improve access for LEP individuals, ensure compliance with federal law, and truly implement the no wrong door philosophy at the heart of creating a single, streamlined application.

    ACAP urges CMS to publish both the coverage-only and FA forms – in print and online – in no fewer than fifteen languages to ensure access for the broad population of potential Exchange applicants.

Conclusion

Again, ACAP would like to thank you and your colleagues for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact Kathy Kuhmerker regarding Medicaid policy (202-204-7510 or kkuhmerker@communityplans.net) or Jenny Babcock regarding Exchange policy (202-204-7518 or jbabcock@communityplans.net).

Sincerely,

Margaret A. Murray
Chief Executive Officer