NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

February 28, 2013

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: **CMS-10440**
Appendix A: List of Questions in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program
Appendix C: FA Paper Application
Appendix D: non-FA Paper Application

Dear Sir/Madam:

The National Women's Law Center strongly supports the Department of Health and Human Services' efforts to implement the Patient Protection and Affordable Care Act (ACA) and make quality, affordable health insurance available to millions.

Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. With a staff of over 60, supplemented by legal fellows, interns, and pro bono assistance throughout the year, the Center utilizes a wide range of tools—including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education—to achieve gains for women and their families in education, employment, family economic security, health, and other critical areas. The National Women's Law Center has long advocated for women's health care and reproductive rights. The Center's efforts reflect extensive research regarding women's specific health needs.

We commend CMS for its efforts in implementing the ACA—specifically the ACA's goal to extend comprehensive coverage to millions of Americans through the establishment of exchanges and the expansion of Medicaid eligibility. It is important for all health care consumers that the process of applying for coverage is simple, easy to understand, and ultimately directs the applicant to the coverage option that is right for them. This process is particularly important for women. Women comprise a disproportionate share of health care consumers and, according to the Department of Labor, make 80 percent of health care decisions for their families.[1] Women also have unique health care needs and concerns. Changes in life circumstances like pregnancy, for example, can complicate the process of enrolling in and maintaining comprehensive health coverage. For women to see the full benefits of the Affordable Care Act, it is vital that the process of applying for coverage meets their unique needs and circumstances.

We thank you for the opportunity to comment on both the online and paper draft applications.

General Comments

In this letter we are focusing on a few key issues important to women and relevant to the work of the National Women's Law Center, but there are a number of other issues in the applications that are of great importance to health care consumers. We support the comments submitted by the National Health Law Program (NHeLP) and urge CMS to consider their recommendations for ways in which the applications – both online and paper versions -- could be improved to ensure they are user friendly, understandable, and effective in connecting consumers with the coverage that is right for them.

Non Discrimination

We support the applications' acknowledgement that federal law prohibits discrimination on the basis of race, color, national origin, sex, or disability. CMS, however, must accurately reflect the full range of protections under Section 1557 and other applicable nondiscrimination laws.[2] The Center therefore recommends restating the nondiscrimination standard in the applications as follows: "I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, disability, age, sexual orientation, or gender identity."

Traditional Medicaid Eligibility

We are concerned that the applications do not adequately take into account those applicants who may be eligible for traditional Medicaid. We suggest that HHS add additional questions or information to help identify individuals who may be eligible for "traditional" (as opposed to Expansion) Medicaid. At a minimum, CMS should include information at the end of the application and with any notices sent about eligibility to help individuals identify if they might be eligible for traditional Medicaid and how to request that eligibility determination. This will be critically important in states that do not expand their Medicaid programs because these traditional categories may be the only source of coverage for many low-income individuals. It is also important in those states that have the Medicaid expansion but have different covered benefits for the traditional Medicaid (non-MAGI individuals) than the ABPs/benchmark plan for the newly-eligible.

Disability

We are concerned the current questions on disability and whether the applicant requires assistance with activities of daily living (ADLs) will not identify whether an applicant may be eligible for Medicaid on a basis other than MAGI or medically frail. Since the benchmark benefits available to newly eligible adults will likely be less robust than those in traditional Medicaid, is it important that applicants have a full opportunity to determine eligibility for the health insurance program that best suits their needs.

We do not think that the general population is trained or adept at understanding when someone may have a disability or impairment that may qualify them for Medicaid and should not be called upon to make this determination unaided. Thus we suggest that the application should focus on functional limitations rather than asking an individual to indicate that they have a "disability." People will often resist the label of "disability," but recognize that they have reduced functional capacity. For example, someone who is aging may readily acknowledge that they are having trouble hearing or seeing, but will not check that they "have a disability." People may also be fearful that answering yes to the question will have a negative consequence such as higher prices or being turned down for the insurance.

The applications should incorporate appropriate screening for persons with disabilities consistent with the ACA and advances made in the development of survey questions to identify persons with disabilities. The screening is essential to ensure that individuals have access to the right care for their needs. We recommend that the application include the six questions used by ACS and several other federal surveys asking about functional limitations to help identify persons with disabilities. The questions should be

accompanied by an explanation informing applicants that they may be entitled to a greater array of benefits if found eligible for traditional Medicaid. These additional questions may also help distinguish medically frail individuals who are also exempt from benchmark coverage.

We believe that CMS should include, at a minimum, the six questions on the ACS survey on the streamlined applications.

1. Are you/is this person deaf or does he/she have serious difficulty hearing?
2. Are you/is this person or does he/she have serious difficulty seeing even when wearing glasses?
3. Because of a physical, mental, or emotional condition, do you/does this person have serious difficulty concentrating, remembering, or making decisions?
4. Do you/does this person have serious difficulty walking or climbing stairs?
5. Do you/does this person have difficulty dressing or bathing?
6. Because of a physical, mental, or emotional condition, do you/does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?

As an alternative, CMS should include explanatory text in the applications and a link to additional information to help individuals ascertain how to answer this question.

Notice of Breast and Cervical Cancer Treatment Program Eligibility
We also want to ensure that women who may be eligible for Medicaid through the Breast and Cervical Cancer Treatment Program are informed of this possibility. Medicaid eligibility for individuals diagnosed with breast and cervical cancer is especially important for low income women. Currently, all states provide coverage for women who meet the breast and cervical cancer screening criteria and whose income is up to 250% of FPL. If caught early enough, both cancers can be successfully treated, but treatment for these cancers is costly and for women without health insurance, accessing lifesaving care can be a huge hurdle. Thankfully for many low income women, Medicaid can provide an important source of coverage. In 2008, nearly 47,000 women with breast and cervical cancer received treatment for their conditions through Medicaid under the Breast and Cervical Cancer Treatment Program (BCCTP).[3] Although the ACA provides new coverage options for low income women, coverage offered through the BCCTP might be a better option for low income women with breast or cervical cancer and this program will certainly be important for low-income women in states that do not expand their Medicaid programs. It is important that women are informed of their potential eligibility.

We recognize that the process for obtaining coverage after screening through the CDC screening program differs from state to state. While this structure makes it difficult to include a single question on the application that would screen for eligibility, we propose that at a minimum, CMS include a brief notice that women may be eligible for the program. For example, "Medicaid covers screening and treatment for breast and cervical cancer. To find out if you are eligible, contact your state Medicaid agency."

Pregnancy
We are also concerned that the application asks applicants if they are pregnant without any context for the question. Applicants might not be aware that being pregnant may make them eligible for traditional Medicaid coverage or might impact their family size when determining eligibility and the question may initially seem invasive and unnecessary. Both the online and paper applications should include notices informing applicants that pregnant women may be eligible for Medicaid coverage and this question will only be used to determine what kind of coverage they are eligible for.

Child Support Enforcement Notice

We are concerned that the applications notify applicants that they may be asked to cooperate with child support enforcement agencies. While we appreciate CMS clarifying that applicants do not have to

cooperate if they believe it will harm them or their children and we understand that eventually applicants may be asked to cooperate, this notice does not need to be part of the initial application.

There is a great deal of evidence suggesting that questions concerning paternity and child support deter individuals from completing applications for coverage. For example, a 2007 Kaiser Family Foundation report found that child support enforcement deterred some women from enrolling their children in Medicaid.[4] Additionally, a December 2000 letter from CMS to state Medicaid directors stated that, "many States and organizations doing outreach and enrollment have identified paternity and medical support questions on Medicaid applications as a barrier to enrollment of eligible children."[5]

While we appreciate CMS's desire to provide applicants with any relevant information they need to complete the process, including this notice on the initial application could potentially deter individuals from applying for coverage for themselves and their children, even in cases where cooperation might not be required. We ask that CMS not include this notice in the applications and instead allow state agencies to follow up as necessary.

Data Collection

We ask that CMS keep track of data regarding online applications that are initiated and completed. In moving forward, it would be extremely helpful to know if there are certain points in the application process where individuals tend to stop the application process. This information could help determine if there are certain questions that are particularly burdensome and these questions could then be altered to ensure that more individuals complete the application process and are connected with affordable coverage.

Thank you for the opportunity to comment.

Sincerely,

Karen Davenport
Director of Health Policy
National Women's Law Center

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[1] US Department of Labor, "General Facts on Women and Job Based Health," http://www.dol.gov/ebsa/newsroom/fshlth5.html.
[2] *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557 (2010), *amended by* Health Care and Education Affordability and Reconciliation Act, Pub. L. No. 111-152 (2010) (to be codified at 42 U.S.C. § 18116); Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13,406, 13,438 (Feb. 27, 2013) (to be codified at 147.104(e)).
[3] National Women's Law Center calculations based on data from The Medicaid Statistical Information System (MSIS) State Summary Datamart (2008), http://msis.cms.hhs.gov (last visited Oct. 26, 2011).
[4] Michael Perry and Julia Paradise, Kaiser Family Foundation, "Enrolling Children in Medicaid and Chip: Insights from Focus Groups with Low-Income Parents," May 2007, available at: http://www.kff.org/medicaid/upload/7640.pdf
[5] Department of Health and Human Services, Center for Medicaid and State Operations, Letter to State Medicaid Directors, December 19, 2000, available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd121900.pdf