February 28, 2013

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Office of Management and Budget
Office of Information and Regulatory Affairs
Attention: CMS Desk Officer

Re: CMS-10440 – Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies

Dear Sir or Madam:

Enroll America is a nonpartisan, 501(c)(3) organization whose mission is to ensure that all Americans are enrolled in and retain health coverage. We are a collaborative organization, working with partners that span the gamut of health coverage stakeholders—health insurers, hospitals, doctors, pharmaceutical companies, employers, consumer groups, faith-based organizations, civic organizations, and philanthropies—to engage many different voices in support of an easy, accessible, and widely available enrollment process.

We appreciate the opportunity to offer our comments on the model single, streamlined application for health coverage. It is of paramount importance to our organization that the application and enrollment process offers a simple, seamless pathway to coverage that removes confusion and provides consumers with the necessary supports to apply, choose a health coverage option, and complete the enrollment process.

The Affordable Care Act (ACA) requires CMS and states to replace outdated, burdensome application processes with a model single, streamlined application that anyone can use to apply for all types of coverage. Enroll America applauds the efforts of CMS to implement this critical aspect of the ACA by designing a dynamic online application that strives to only ask questions that are necessary and utilizes electronic databases for real-time eligibility determinations and verification. The model applications are significant improvements to the way most Americans enroll in health coverage today and they generally mirror Enroll America's vision for how the single streamlined application for health coverage fits into the Affordable Care Act's (ACA) "no wrong door" approach to enrollment. This vision is outlined in our issue brief *The Ideal Application Process for Health Coverage*.[1]

We divide our comments into four parts: (1) general comments on the proposed model application process, (2) specific recommendations for the model online application, (3) specific recommendations for the model paper application, and (4) recommendations for alternative application approval guidelines.

I. General comments on the proposed model application process

Importance of In-Person Assistance

[1] Enroll America, *The Ideal Application Process for Health Coverage* (Washington, D.C.: February 2012), available online at: http://files.www.enrollamerica.org/best-practices-institute/publications-and-resources/2012/Ideal_Application_Process.pdf

It is important to recognize that no matter how simplified or consumer-friendly the online or paper application is, it will be challenging for many consumers – especially during the initial open enrollment period when millions of uninsured Americans and their families will be applying for a health coverage program for the first time. Enroll America's own research found that people describe feeling "confused," "overwhelmed," "worried," and "helpless" about the process of getting health insurance. Three out of four of those surveyed would like personalized assistance with the application and enrollment process.[2]

Given this need, we believe it is important that **all applicants using the online or paper applications clearly understand that help is available** by phone or in-person and in a language that they understand.

> **Recommendation:** We strongly support CMS's inclusion of text describing the existence of help by phone and in-person on every page of the online and paper application. This text should be prominent and in a consistent place on every page.
>
> **Recommendation:** The existence of help by phone and in-person should be also highlighted at potentially troublesome points of the application process. For example, in the online environment, any help text associated with plan selection or use of advance payments of the tax credits should include information about assistance options.

Need for Continuous Improvement of the Model Applications

Achievement of an ideal application and enrollment process for health coverage should not end with the implementation of the model online and paper applications on October 1, 2013. Despite CMS's best efforts to engage consumers and stakeholders throughout the model application development process, no amount of consumer testing prior to actual implementation will uncover all of the problems with these models.

> **Recommendation:** CMS should **develop feedback mechanisms prior to the start of the initial open enrollment period** so that individuals providing application assistance (such as navigators, assisters, brokers/agents, certified application counselors, etc.), state-based exchanges, state Medicaid/CHIP agencies, and other stakeholders can provide CMS with information about the quality and effectiveness of the model applications. Application assisters will be working with the applications on a regular basis and will be in an ideal position to identify problems with and suggest improvements to the application and/or enrollment process.

Applications should be Accessible to all Applicants

With an estimated 23 percent of health insurance marketplace applicants expected to be limited English proficient (LEP)[3], it will be important to ensure that the online and paper applications are accessible to a diverse population of applicants. LEP individuals may suffer erroneous denials of eligibility and Medicaid/CHIP agencies and marketplaces may incur unnecessary administrative expenses because eligible applicants simply do not understand what information to provide on the applications. We recommend the following to increase access and understanding of the application for LEP consumers.

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[2] A national survey commissioned by Enroll America and conducted by Lake Research Partners in October 2012 found that 75 percent of those surveyed wanted in-person assistance to help apply for and enroll in health coverage

[3] The Henry J. Kaiser Family Foundation, *A Profile of Health Insurance Exchange Enrollees* (Washington, D.C.: March 2011), available online at http://www.kff.org/healthreform/upload/8147.pdf.

Recommendation: The model application should be translated into at least fifteen languages, and a corresponding translation glossaries of key ACA terms should be created and made publically available. Federal translation of the application would benefit all entities engaged in enrollment, outreach and education. Translated applications will assist in ensuring effective communication by creating a baseline for standardizing ACA-related enrollment terminology and creating translation "glossaries" that can be used by other entities for outreach, education and training, saving costs of re-translating the same terms. Translated applications can also help train bilingual staff and interpreters who will assist LEP individuals to ensure consistency and accuracy, thus aiding effective enrollment and information dissemination.

Recommendation: Applications should collect the language preference of every individual on an application. If an individual notes a language preference on the application, then any information or assistance provided to the applicant should be provided in that preferred language. Since multiple individuals can be included on a single application and may have differing language and/or accessibility needs, information should be provided in multiple languages and/or formats to meet the language and/or accessibility needs of all individuals on a single, streamlined application.

Reduce the Burden on Employees Seeking to Show Lack of Access to Employer Sponsored Coverage

Applicants will have little or no experience answering questions about employer offers of health coverage, so we expect this to be one of the most difficult sections of the application for applicants to complete. Because offers of employer sponsored insurance can prevent consumers from receiving advance payments of the premium tax credits (APTCs) for exchange coverage, this is also one of the most important sections of the application. We strongly support efforts HHS has already made to make this section easier to complete, including asking questions about employer offers of coverage only for those likely to be eligible for APTCs, and providing an employer coverage form. We also believe that more can be done to ensure that providing this information does not become a barrier to completing the application and enrolling in coverage.

Recommendation: All employers should be required to make a completed employer coverage form available to their employees at all times, similar to the requirements for supplying easy-to-understand information about health insurance benefits through the Summary of Benefits and Coverage. This will be more efficient for employers, who would only have to fill out the form once, and would provide privacy protection for employees who may not want their employer(s) to know they are exploring other coverage options.

Key Pieces of the "No Wrong Door" Enrollment Process are Missing from the Model Applications

Enroll America appreciates the opportunity to comment on the list of questions in the online application to support eligibility determinations, the two animated videos depicting the eligibility determination portion of the online application, and the paper application to support eligibility determinations. While these are important parts of the new single, streamlined application process these individual pieces do not reflect the complete enrollment process for consumers either online or using the paper application.

Some key aspects of the "no wrong door" enrollment process that are missing from the model applications addressed in this PRA process and other disclosures by CMS are:

- **The Model Health Plan Selection Tool** – Comparing and understanding health plan options is one of the most difficult aspects of the health coverage enrollment process. CMS should provide future sub-regulatory guidance on how state-based marketplaces should implement this

requirement of the enrollment process and how this tool will appear in a federally-facilitated marketplace (FFM). Consumers Union has done extensive work exploring the best ways to present consumers with meaningful choices with respect to their coverage options, and we recommend HHS take these into account as health plan selection guidelines are developed.[4,5]

- **Understanding the Advanced Payments of the Premium Tax Credit** – The premium tax credit is a centerpiece of the ACA, and the advance payment feature of the tax credit is designed to provide immediate and necessary financial assistance to millions of Americans who cannot afford health coverage today. The decision to receive premium tax credits in advance, however, carries the potential for future tax liability. How to clearly communicate this consequence while promoting broad participation in the program is an important question that marketplaces will need to address as they prepare systems for open enrollment.

- **Application Look, Feel, and Function** – Because the online application was not available in an interactive format, it is impossible to gauge whether/how it provides consumers with help language, pop-ups, and links to explanations of terms and concepts. Consumer-tested tools to help guide applicants through the application will be important, and if they are effective, may reduce the volume of applicants that seek more intensive assistance in person or over the phone. Also, consistent with our past comments, we recommend choosing font sizes and color schemes that are easy to read, easy for the applicant to make larger or smaller, and that fit appropriately on electronic devices (e.g. that can be displayed on a computer monitor without left-right scrolling, that can be displayed on mobile devices (especially tablets), etc.).

- **Handoffs to Medicaid/CHIP –** In states where the Medicaid or CHIP agency does not permit the exchange to make a determination of Medicaid or CHIP eligibility, it is not clear how this information will be conveyed to applicants. There is considerable room for confusion if this information is not communicated in a clear way, and we believe CMS can play an important role in providing model language for how such assessments are communicated to applicants. The applicant should have the ability to check on the status of their assessment electronically, should be given contact information at the determining agency in order to follow up on the application's status periodically, and should be given a timeline for when the applicant can expect a decision from the agency. It should also be communicated to the individual that if they are in need of services immediately, they may be able to get temporary coverage (through presumptive eligibility) at the following locations, and a list of health centers, hospitals, and other PE qualified entities should be provided.

- **Anonymous Use of the Application – eligibility calculators and plan browsing –** The model application will only be as useful as the website that hosts it. This PRA process does not provide information about other features of the healthcare.gov website, but it will be important that consumers who visit this site can get the information they need quickly, without unnecessary clicks, and that the site feels secure, credible, and official. Part of building this trust is making tools like an eligibility calculator and plan browsing available to consumers immediately, without requiring creation of an account or provision of other personal information. Once consumers learn that they may qualify for financial help with the cost of coverage, they may be more interested in

[4] Consumers Union, *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making*, November 2012, available online at: http://www.consumersunion.org/pdf/Too_Much_Choice_Nov_2012.pdf

[5]Consumers Union, *Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices*, July 2012, available online at: http://www.consumersunion.org/pdf/Choice_Architecture_Report.pdf

completing the application. We recommend that CMS provide model versions of these tools that all states can use or adapt. Needless to say, we also recommend that the application be readily available and prominently visible on the healthcare.gov homepage at all times.

II. Specific recommendations for the model online application

CMS should consider the following recommendations as it develops the model online application.

A. "My account" Feature

We understand the need to limit some information about the authentication process of establishing the identity of the person filling out the application to protect the security and integrity of the system but were disappointed that both videos depicting the online application process did not disclose any aspect of this feature of the online application. This feature is an important part of the online application process.

Recommendation: CMS should provide stakeholders with detailed visual depictions (screenshots or videos) of the "my account" feature. These depictions should include a description of how this feature can be used to access a saved application and update information after an eligibility determination or successful enrollment.

Recommendation: The authentication process for establishing identity should be carefully designed and consumer-tested to ensure that individuals with basic literacy levels and/or a lack of financial accounts or credit histories can receive authentication in real-time and without unnecessary burden.

While the "my account" feature may enable individuals to easily update personal information, receive notices, and continue to manage their information after eligibility is determined, this feature and its benefits may not be apparent to users as they start the online application. Instead, the "my account" feature may end up serving as a barrier to enrollment for eligible consumers who are concerned about the privacy of their information. According to the note to reviewers on p.4 of Appendix A, consumers who fail to set up an account will not be able to start the online application.

Recommendation: Consumers using the online application should be provided clear language – before setting up an account – explaining that any information stored in the account will be kept private and will only be used for the purpose of enrollment in health coverage. This language should also describe the benefits of the "my account" feature to encourage consumers to set up an account and begin the online application.

We support the "my account" feature not requiring an individual filling out the application to provide an email address or social security number.

B. Privacy Statement

The privacy statement on the videos depicting the online application process states:

> We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health insurance or help paying for health insurance. We'll check your answers using information in our electronic databases and the databases of our partner agencies. If information doesn't match, we may ask you to send us proof.

> This application doesn't ask any questions about your medical history. Household members who don't want insurance won't be asked questions about citizenship or immigration.
>
> **Important:** As part of the application process, we may need to retrieve your information from other government agencies like IRS, Social Security Administration, and the Department of Homeland Security. We need this information to check your eligibility for health insurance or help paying for health insurance if you choose to apply, and give you the best service possible.

This privacy statement is not written in plain language that the typical consumer who will use the online application can understand.

> **Recommendation:** The privacy statement should be significantly rewritten to be understandable to the consumers who will likely be reading it. Once the statement is revised it should be thoroughly consumer tested to ensure that a typical consumer can read the privacy statement and make an informed decision when they provide consent to allow their information to be used for the eligibility determination process.

The privacy statement and consent language appears after an individual filling out an application sets up an account.

> **Recommendation:** The privacy statement and consent language should be included either before or as part of the process of setting up an account. As previously stated in our comments to the "my account" feature, consumers will need the reassurance that any information stored in their account will be kept private and only used to determine eligibility for health coverage or insurance affordability programs. Consumers who fail to set up an account will not be able to start the online application

C. "Getting started" Section

We support the collection of information about the preferred written and spoken language of the primary contact on an application. This collection of language preferences should be expanded to include all individuals on an application.

> **Recommendation:** Applications should collect the language preference of every individual on an application. If an individual notes a language preference on the application, then any information or assistance provided to the applicant should be provided in that preferred language. Since multiple individuals can be included on a single application and may have differing language and/or accessibility needs, information should be provided in multiple languages and/or formats to meet the language and/or accessibility needs of all individuals on a single, streamlined application.

The questions in this section about how the consumer consents to receive notifications are written in a potentially confusing way. The current text reads "I can get information about this application by…"

> **Recommendation**: "I can get information about this application by…" should be re-worded to say "I want to receive information about this application by …"so that consumers understand that

they are indicating a preference for receiving notifications, not just stating that they are capable of receiving information through text or email. Additionally, consumers should be notified that any costs related to receiving text messages will be charged to them in accordance with their phone carrier agreement and that they can opt out of getting these messages at any time by texting stop or end, at which time the preferences will be reset to the default (mail or email if the consumer had also selected email as a way to get information).

D. "Help paying for coverage" Section

We strongly support the inclusion of additional questions for applicants that select "No" to the question "Do you want to find out if [you/your family] can get help paying for health insurance?" These additional questions are critical to ensuring that applicants are making a fully informed decision when they opt to forgo financial assistance to help make the cost of health coverage more affordable.

Enroll America partnered with Lake Research Partners and GMMB to conduct a comprehensive national enrollment survey of over 1,800 adults who are likely eligible for free or reduced cost coverage through the new health insurance marketplaces. Our research identified four key facts that consumers should be told to effectively raise their awareness of the new coverage and financial assistance options. These four facts are:

1. There are new, affordable insurance options available for people without insurance.
2. All insurance plans will have to cover doctor visits, hospitalizations, maternity care, emergency room care, and prescriptions.
3. Financial help is available so you can find a plan that fits your budget.
4. All insurance plans have to show the costs and what is covered in simple language with no fine print.

Recommendation: These four facts should be included in these additional questions to ensure that applicants are making a fully informed decision when they opt to forgo financial assistance to help make the cost of health coverage more affordable. Our research has shown a message with all four facts reaches 89 percent of the population and 87 percent of the uninsured population. This means that for 89 percent of the population, the most important fact they need to hear is one of the four facts.

In the video depicting a family of three using the online single streamlined application, this section contained a problematic description of the potential coverage options. Medicaid/CHIP seems to be described as a "$0 premium plan". This way of describing Medicaid is confusing, as many consumers will not understand what a "premium" is, and a "zero premium plan" may actually sound like something with zero *value* rather than zero *cost.* A more effective way to describe the coverage options is used in the list of questions in Appendix A to the PRA on page 8. We support the language stating that a person "may be eligible for a free or low cost plan, or a new kind of tax credit that lowers your monthly premiums right away."

E. "Family & household" Section

This section of the online application is one of the most difficult to follow.

Recommendation: Consumers should be given clear instruction at the start of this section about whom to include in the household. Instructions can be adapted from the household instructions on page 2 of the proposed paper application.

The paper application also contains clear disclaimers that applicants can apply for health coverage even if they do not file taxes. Similar disclosures are missing from the online application.

> **Recommendation:** A disclaimer stating that an applicant can apply for health coverage even if they do not file taxes should be included with the question: "Does [Household contact] plan to file a federal income tax return for [coverage year]?"

F. "Personal Information" Section

The privacy act notices are incomplete in Question 2 of part A of this section when requesting a social security number (SSN).

> **Recommendation:** It should be clear to the applicant how their SSN will be used. The SSN will be used to check income (as indicated) but will also be used to check citizenship status, duplicate program participation and tax filing. It is not sufficient to simply say "other information."

In Question 3 of part B of this section naturalized citizens are asked for their naturalization certificate or certificate of citizenship and/or alien number presumably to complete the verification process. Not all naturalized citizens will be able to easily access such verification information.

In Question 4 of part B of this section the "eligible immigration status" question needs to be clarified. Very few consumers will know what "eligible immigration status" means. This term does not refer to an immigration status. It refers to standards for eligibility for insurance affordability programs, and therefore most people will not know how to answer without the information that is provided in the link.

> **Recommendation:** Consumers should be given the option to respond: "I do not know" to questions in part B of this section with regard to citizenship and immigration status. Those that do so should be allowed to proceed with the application and be given the option to provide other acceptable evidence of their citizenship in accordance with the regulations at 42 CFR §435.407.

Appendix A indicates that Question 9 of part B of this section is going to be asked of everyone who has indicated they have an "eligible immigration status" and whose date of birth is prior to August 22, 1996. Presumably this is being asked to identify individuals for whom the five-year bar for Medicaid eligibility for legally present immigrants does not apply.

> **Recommendation:** The dynamic application system should skip Question 9 of part B of this section for anyone who can be identified as being in a status that does not require a five-year waiting period before qualifying for Medicaid. This may be able to be determined for some individuals based on their document type and/or real-time verification with DHS through the federal data services hub.

G. Expedited Income, Current/Monthly Income and Discrepancies Sections

The process of stating and verifying an applicant's income is one of the most important and potentially most confusing portions of the application. We are pleased that the model application makes immediate use of the federal data services hub to pull an individual's income information (if available), as this will simultaneously simplify and expedite the verification process. However, given that Medicaid eligibility remains based on currently monthly income while eligibility for the APTC is based on projected annual income, we are concerned that some ultimately Medicaid-eligible

applicants will unnecessarily go through the process of verifying a projected annual income. In the spirit of ensuring applicants are only asked to provide the minimum necessary information to complete an application, we recommend that CMS reconfigure this section to better screen for potential Medicaid eligibility first, before introducing the concept of projected annual income. Individuals are more likely to understand how to answer questions about their current monthly income as opposed to projecting their annual income.

Recommendation: The application should pull income information from the federal data services hub, convert the figure to an average monthly figure (by dividing the total by 12), and then present this information to the applicant first and ask whether the applicant's current monthly income is higher or lower than that amount. The Medicaid monthly income screen should proceed from there, until it is established that the individual's currently monthly income is greater than 138 percent of poverty. We recognize that this will be more complicated for individuals with multiple sources of income, but we believe that it is appropriate to screen for Medicaid eligibility first, before moving to an APTC income calculation.

We are concerned that individuals with non-salaried employment, who are likely to be paid on an hourly basis, and whose monthly hours vary considerably from month to month, will find the income verification sections particularly challenging.

Recommendation: To facilitate the collection of income information, we also recommend that CMS create an optional online tool (and parallel paper worksheet) that will allow consumers to enter information such as amount earned hourly and an approximate number of hours worked each week, and other key information such as contributions towards employer sponsored pretax benefits. The tool would help the applicant account for all their sources of income and understand how the ultimate monthly and/or projected annual income figure is calculated. This type of tool would improve the user experience and help insure accuracy of the information that is being collected.

H. Employer Health Insurance Information Section

See our comments on page 3 in the section with recommendations on how to reduce the burden on employees seeking to show a lack of access to employer sponsored coverage.

III. Specific recommendations for the paper application

CMS should consider the following recommendations as it develops the model paper application.

A. Translation of the Paper Application

We also recommend that CMS translate the application to at least the 15 most prevalent languages. CMS has a significant opportunity to reduce the costs and ensure the quality of the translation. Because states can choose to use the CMS developed application, they would avoid having to pay for the translation individually. This would also ensure that terms are being translated consistently and accurately. Even states that do not opt to use the CMS application can instruct their translators to use the model CMS translations.

Recommendation: The model application should be translated into at least fifteen languages, and a corresponding translation glossaries of key ACA terms should be created and made publically available. Federal translation of the application would benefit all entities engaged in enrollment, outreach and education. Translated applications will assist in ensuring effective communication

by creating a baseline for standardizing ACA-related enrollment terminology and creating translation "glossaries" that can be used by other entities for outreach, education and training, saving costs of re-translating the same terms. Translated applications can also help train bilingual staff and interpreters who will assist LEP individuals to ensure consistency and accuracy, thus aiding effective enrollment and information dissemination.

B. Application Introduction

We strongly support the language in the "What happens next?" section that encourages consumers to sign and send in their application even if they do not have all the information requested in the application. This allows consumers to complete the application to the best of their ability but not delay submitting the application if they encounter questions they do not understand, or need time to gather information. This may have an impact on the dates when benefits begin, which is an important consumer protection.

Recommendation: In the section "Who can use this application?" we recommend adding a bullet to inform families that they can file an application even if their household includes some members applying for health coverage and others who are not. Additionally, it would help reassure families that include immigrants if the application had language that let them know that families that include immigrants can receive help with health insurance costs for family members who meet citizenship or immigration requirements and that applying for health insurance or getting help with health insurance costs will not make them a "public charge."

Recommendation: In the section "What you may need to apply," it should be clarified that SSN and immigrant numbers will only be needed for those applying for health coverage. We understand that the application later suggests that non-applicants can choose to provide an SSN, but it is more important to reassure those at the start of the application who may not have these numbers that they can still apply on behalf of others in their household.

IV. Recommendations for alternative application approval guidelines

States are allowed to develop their own applications with the Secretary's approval. In reviewing these applications, the Secretary should ensure that the standards in the model application developed by CMS apply to the alternative applications being considered, including plain language use and requiring states to collect the same demographic data to ensure consistency. CMS must also ensure that the state consults with consumers and stakeholders in the development and testing of the application.

As CMS prepares this guidance, we offer the following recommendations:

1. Requirements for alternative applications:
    a. Plain language – Alternative applications should be at least as consumer-friendly and easy to understand as the model application. Alternatives should be evaluated by experts in health literacy and plain language writing.
    b. Consumer testing – We recommend that states be required to conduct iterative consumer testing of any proposed alternatives, and share the results of this process when they submit their alternative(s) to HHS for approval.
    c. An alternative application should be available in online, phone, and paper formats, unless there is a specific reason for only making it available in certain formats.

2. Approval process for alternative applications - States should have to provide the following information when submitting an alternative application to HHS for approval:
    a. Reason for alternative application
    b. Proof of consumer testing and revisions made based on testing
    c. Timeline for rolling out (if not as part of the initial open enrollment period) – If an alternative is proposed to begin after the initial open enrollment period, the state should describe the transition process and how it will ensure seamlessness as it moves from one version of the application to another.

3. Additionally, we recommend that the guidance provide clarification on how much a state may deviate from the model application before an alternative application is required. For example, it is our understanding that multi-benefit applications will need to be submitted for approval as alternative applications. As many states have invested in highly integrated multi-benefit eligibility systems in recent years, we recommend that CMS ensure that these states can build upon their progress and are not inhibited from continuing to integrate access to benefits, even as they adopt the new requirements for MAGI-based eligibility and the single, streamlined application.

Thank you for this opportunity to offer our comments on the model application for health coverage, which brings the nation closer to ensuring that the eligibility and enrollment processes for health coverage are as simple and streamlined as possible. We look forward to working with you as the applications are implemented, and we welcome any questions or further consultation you wish to have with us. Please direct any questions to Deepak Madala at deepakm@enrollamerica.org or 202-737-6340.