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 Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the streamlining of eligibility proposed by CMS and provide our comments on the draft paper application for financial assistance and the list of questions in the online application. Our comments are divided into sections as follows:

4. COMMENTS ON THE LIST OF QUESTIONS IN THE ONLINE APPLICATION

I	XII	XXIII
II	XIII	XXIV
III	XIV	XXV
IV	XV	XXVI
V	XVI	XXV
VI	XVII	XXVI
VII	XVIII	XXVII
VIII	XIX	XXVIII
IX	XX	XXIX
X	XXI	
XI	XXII	

1. GENERAL COMMENTS ON THE PAPER AND ONLINE APPLICATIONS

Foremost, we appreciate the hard work of HHS staff to develop these draft applications. We also appreciate the opportunity to provide input to help improve these materials, as well as the continued use of consumer testing to make them user friendly and understandable.

While we know HHS has a very short time period to complete the online and paper applications, we look forward to further opportunity for input. In particular, we look forward to the ability to evaluate and provide assistance on the online application "Help Text" as it is being developed, as that is a critical feature to ensure the online application is understandable and consumer friendly. We also look forward to reviewing notices to inform applicants about their eligibility status. Once developed, CMS should further test the online application and notices with consumers, including mixed status families, using real families/scenarios in on-line environment. CMS should also provide a survey, particularly for online application users, to ensure feedback from consumers. We also support and encourage HHS to refine these instruments beyond the October 1, 2013 launch based on data and feedback.

Consumer testing and stakeholder input have resulted in applications are "person-centered." For example, providing separate pages on the paper application for each person in the household make the application easier to navigate. In the on-line environment, the use of dynamic questioning will help people get through the application logically while not requiring that people answer unnecessary questions.

To make the online and paper applications even more consumer friendly for low-income individuals and families, (i.e. those eligible for Medicaid and CHIP), we encourage the application allow those without complex scenarios or tax households to have their Medicaid/CHIP eligibility decided first, so they can get coverage more quickly without having to provide unnecessary information (for example, about Employer Sponsored Insurance). Starting with Medicaid/CHIP eligibility determination also allows them to

avoid some tax filing questions if they do not file or will not need Advance Premium Tax Credits (APTCs).

We also recommend development of an expedited path for both the paper and online versions so those with simple eligibility scenarios, for example, a single person with no income, or a former foster youth with no income requirements, etc. can obtain coverage quickly. This will make the application more usable to those individuals and families. Additional features to make the applications more consumer-friendly would include pop-up worksheets (e.g., UIX2014 or Turbo Tax on income) and ensure that there are auto-fill features in the fields on the online application. This may help with key issues: income fluctuations, pre-tax deductions, option to submit hourly wage information, take into account week-to-week changes and seasonal employment.

For applicants utilizing assisters and navigators, there should be clear directions on who is filling out the form and that person's relationship to applicant. If an applicant has no help, there should be clear and continuous reminders that help is available and how to get it (call, online chat, etc.). Finally, encouraging applicants to fill out as much as they can and to submit the application (even if they don't know how to answer all questions) should be clearly messaged upfront and throughout. This is particularly important for non-dynamic paper applications. Upfront information, such as a video in the online context, should be considered with reassurances and explanation. In paper, an explanation of the value of coverage is a key to encourage submission. Establishing who can use which applications should be clear, and terms should be clearly defined and used consistently.

We recognize that the single streamlined application is not intended to collect all of the information necessary for a full traditional Medicaid *determination*. However, we believe it should collect more information in order to facilitate a complete Medicaid *assessment*.

This is critical for at least three reasons:

- Many traditional Medicaid-eligible individuals who are not identified will be enrolled in the Medicaid Expansion and end up with an ABP benefits package, instead of the traditional Medicaid package that better meets their needs.
- Some traditional Medicaid-eligible individuals who are not identified will be enrolled in the Exchange and end up with a private market benefits package, instead of the traditional Medicaid package that better meets their needs.
- Most alarmingly, in states that do not implement a Medicaid Expansion, many traditional Medicaid-eligible individuals who are not identified will have *no other coverage option*, and remain uninsured. For example, in most states that do not expand Medicaid, non-pregnant women at 75% of FPL will *only* be eligible for a family planning expansion (if one is available).

Therefore, HHS should implement rules to ensure more potential Medicaid eligibility is identified through assessment and solicit enough information on the application to achieve that. HHS should collect information to adequately assess eligibility based on

disability determination, Breast and Cervical Cancer Treatment Program (BCCTP) eligibility, potential to qualify as medically needy, limited-scope family planning, and other traditional Medicaid categories. HHS should also consider collecting this and other information (for example, related to medical frailty) to identify individuals who will be eligible for ABP exemptions.

Finally, HHS should take special care to ensure that the streamlined eligibility process does not fail older adults and persons with disabilities:

- Exchanges may assume individuals age 65 and over are ineligible for assistance since they are not Medicaid Expansion eligible, even though they may be traditional Medicaid eligible.
- Exchanges may assume Medicare-eligible individuals are ineligible for assistance since they are not Medicaid Expansion or APTC eligible, even though they may be traditional Medicaid eligible.
- In particular, Exchanges may miss Medicare Savings Programs (such as QI-1) eligibility, unless they collect the information necessary to make such assessments or determinations.
- Exchanges should also assess (or refer) individuals for potential eligibility for Medicare Part D "Extra Help" (low-income subsidies).

2. GENERAL PRINCIPLES RELEVANT FOR ALL DATA ELEMENTS

To meet the goal of a single, streamlined application, HHS should incorporate a number of general principles as it finalizes the paper and on-line applications.

a. Consumer-centric and Simple

Whether an individual applies online, on paper, or by telephone, the application should be as simple as possible, asking questions that are only relevant to determine eligibility for those applying for coverage or to prevent discrimination (such as demographic data), to minimize the burden on applicants. Any program information, regardless of modality should:

- Be written in plain language at an appropriate reading level to accommodate people with low literacy and avoid the use of contractions;
- Be offered in multiple languages, meeting the meaningful access standards for persons with limited English proficiency;
- Conform to rules ensuring equal access to persons with disabilities; and
- Be focus group tested for readability and comprehension, including testing with low-literacy and limited English proficient populations.

b. Connect Applicants with Available Assistance

As we have previously commented with regard to the Data Standards released in 2012, 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, assisters, certified application counselors, and call centers. Information accompanying the application should let families know how they can get personalized assistance, including the availability of language services and assistance for individuals with disabilities. Additionally, HHS should require states to comply with requirements to provide application assistance in a culturally competent manner that effectively communicates to individuals, including immigrant families, what information is and is not required and ensures a welcoming environment.

HHS should require health insurance affordability programs to collect information from assisters as a condition of their access to the online application when helping individuals through the process. The Exchange website should include a portal for all consumer assistance providers to use that would require them to be authorized to login and to provide specific information to the Exchange and/or state for tracking oversight purposes. Ideally, this portal will provide assisters with additional functionality and tools to ensure that individuals are successfully enrolled, while safeguarding individual data.

c. Consider the Modality in Which People Apply

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 simultaneously addressing the inherent challenges in each. That is, while help text may be easily accessible in the on-line application, relegating all help text for the paper application to a separate instruction booklet will likely cause confusion for many individuals and will be difficult to operate if an individual has to flip back-and-forth multiple times between the application and accompanying materials to ascertain how to answer a question. Instructions should, to the extent possible, be embedded in the application even if more detailed instructions are provided separately.

d. Development of Instructional Materials and Help Text

We are very concerned that CMS did not provide the instructions for the paper application and help text for the online application through the PRA process. It is critical that this information be written in plain language and is understandable to low literacy and underserved populations.

RECOMMENDATION: We strongly urge CMS to obtain input from consumer advocates during the drafting process for instructional materials and help text, as well as prior to finalization of this text.

e. Date of Filing

Allowing individuals to complete an application to the best of their ability and to sign and submit the application with missing information is an important protection needed for both the paper and online applications. This is critical to preserve the effective date of the application, particularly for Medicaid, where eligibility may begin immediately, or even be effective back to the first of the month. It will also likely lead to fewer errors as applicants will not feel they must guess even when the data points are unknown. CMS should establish a minimum set of core data elements that constitute a "valid" application, which could potentially include only minimal information about the applicants, such as name, date of birth, contact information, and signature. Once an applicant completes these elements, an applicant can submit the application to preserve their date of application while they continue to gather additional information.

CMS should also include an "I don't know" option throughout the online application, and should be allowed to skip and return to sections. The goal for both online and paper versions should be the most complete application possible. However, if online applicants were prevented from moving through the questions, the likely result will be abandoned applications with no opportunity for follow up. Applicants should not have to switch from online to paper or telephone applications in order to preserve their application date. The instructions could include language advising applicants that their applications will be processed faster and health insurance can start sooner if their applications are as complete as possible. If applicant utilizes the "I don't know" option repeatedly, the online application should trigger prompts guiding the applicant to assisters.

The submission of a partially completed application (regardless of whether an applicant provides all data needed to establish an official application date) should trigger follow-up procedures whereby the federal data hub and state data sources can be reference. The state agency or Exchange should provide applicants with assistance in gathering missing information, and not simply list what information is missing, and provide a set timeframe for providing such information. Individuals should be informed that delays in completing and submitting the application may have an effect on the start time of their benefits and that they may complete the application to the best of their ability and submit it while gathering additional information or seeking help in understanding questions. If an Exchange can make an eligibility determination 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.

RECOMMENDATION: The "date of application" should refer to the calendar date that an individual submits an application to any of the insurance affordability programs that include the minimally required data elements. We recommend that CMS use the same date of application standard used by the SNAP program, which defines date of application based on the date an individual submits an application including name, signature, and address. See 7 C.F.R. § 273.2(b)(1)(v), (c)(1), and (c)(3). This standard

will maximize enrollment of individuals and create uniformity between state and federal programs. The application should also provide an exception to any address requirement for any individual who lacks an address, allowing merely a way to contact the person by mail, phone, or electronic method (especially if the person self-attests to their residence). If an insurance affordability program requires additional information from the applicant to finalize an eligibility determination, the program may request that information, but this should not be considered a new application and the date of application should not change. Further, as described above, an individual should be allowed to submit an application even if all information is not included and the Exchange should follow-up with the individual to obtain any additional information while the initial submission date remains the same.

RECOMMENDATION: We recommend that the timeliness clock to complete the application begin running on the calendar date an individual submits an application, regardless of whether subsequent steps are necessary to complete the application. This standard is in keeping with customary Medicaid practice and has been reaffirmed in other recent regulations. See e.g., Medicaid Citizenship Documentation regulation discussion at 42 Fed. Reg. 38670.

f. Nondiscrimination and data collection

The nondiscrimination statements at the end of the individual applications should include the full range of protected categories under the federal law governing the activities of the Marketplaces. The full list of categories under 45 CFR 155.120 includes age, sexual orientation, and gender identity in addition to race, color, national origin, sex, and disability.

We support putting mechanisms in place now to collect data on race, ethnicity, and preferred language of all household members, and not just the household contact. Where appropriate, the individual applications should collect a more comprehensive range of demographic information, including sexual orientation and gender identity. This information is an important component of including the lesbian, gay, bisexual, and transgender (LGBT) population in Marketplace functions such as outreach planning, compliance with nondiscrimination requirements, and customer satisfaction evaluations. We endorse the comments submitted by the Center for American Progress which elaborate with respect to these issues.

3. COMMENTS ON THE PAPER APPLICATIONS (FA and non-FA)

The following comments are based on the FA Paper Application. To the extent the same questions are asked on the non-FA Paper Application, the same comments apply.

While a paper application will likely take longer to process than the online application and denies individuals the benefits of real-time eligibility, offering paper applications is an ACA requirement. In fact, individuals will likely continue to widely use paper

applications in Medicaid and CHIP and they will continue to be an important avenue to coverage for many. For example, people have different levels of trust with the security of the Web and may be more willing to apply using a paper application.

While tailoring the application to a particular individual is not possible on a paper application, it is still very important that applicants be aware of what questions are optional and which are required. As such, the paper application in particular needs clearer instructions regarding what items are minimally necessary for submission.

CMS must also ensure the paper application is appropriate for individuals with low literacy levels as well as individuals who are limited English proficient and those with disabilities who may need alternate forms of the application. We strongly encourage greater use of plain language, white space, and clear instructions to improve the paper application. The application should highlight minimal data requirements in a way that individuals are directed to provide the essential data elements needed to constitute a valid application.

Instructions

With regard to the titles of the Financial Assistance (FA) and non-FA applications, we suggest that CMS more clearly delineate the differences on the front page and provide further information to help individuals determine which application they should begin. For example, on the non-FA application, CMS should include a line below “Application for Health Insurance” that says “(if you need help with paying for health insurance, please do not use this application but get a different application by calling 1-800-XXX-XXXX or at www.placeholder.gov).” It should be clear which programs are covered by the application, including Medicaid, CHIP and the APTCs/CSRs. The application should make clear if it does not cover limited-scope Medicaid programs, including family planning programs, and direct applicants to the appropriate applications.

We appreciate the initial instructions and the use of graphics and text boxes to highlight important information. The application gathers a great deal of personal information from applicants about themselves and their household members. It will be important that individuals are confident that their personal data is secure and will be kept confidential. It is also important to reassure individuals 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. Applicants should be reassured that no member of the applicant’s household will be contacted without their consent. For example, an applicant seeking coverage for sensitive services only might not want members of their household to know about the fact of their application.

We support an expanded privacy statement and recommend that it come at the very beginning of the application before the individual begins entering any personal information. Privacy is a distinct issue and applies regardless of whether the applicant is

seeking financial assistance. The privacy statement should make it clear what information the application will collect, how it will be used, who it will be shared with, how it will be stored and for how long. This information should be written in plain English.

For immigrant families, privacy and security of personally-identifiable information (PII), including its collection, use, and disclosure by state agencies and their contractors, is of paramount concern. Exchange rules restrict any use and disclosure of information the state collects to only those purposes necessary to carry out specified Exchange and SHOP functions. 45 CFR §§155.260, 155.705(a), 155.210(c)(1)(v), 155.220(d), 155.730(g). Final Medicaid rules extend confidentiality protections to non-applicant information and to the use of an SSN, applying privacy restrictions broadly to renewal and verification processes. 42 CFR §§431.10, 431.300, 431.305, 435.916, 435.945, 435.907, 435.908. We support the statement that provides an assurance of privacy should inform immigrant families that information will not be used for enforcement purposes.

We are concerned that the literacy level of the application may be too high for many low-literacy individuals to understand and complete. As an example, one study by the AMA Foundation found that among people with low health literacy skills, 86% could not understand the rights and responsibilities section of a Medicaid application.[1] These problems are more common in certain demographic groups such as the elderly, the poor, some minority groups, and recent immigrants. We strongly urge CMS to work with literacy experts and to field test both forms of the application with low literacy populations to ensure the application is understandable. In particular, the use of contractions should generally be avoided.

We greatly appreciate the inclusion of taglines in Spanish informing individuals how to get help and to get an application in Spanish. Yet estimates are that 23% of Exchange applicants speak a language other than English at home, many of whom will not be Spanish-speakers. Thus it is incumbent upon CMS to inform other language speakers how to get assistance with the application. We strongly believe that CMS should include additional taglines, in at least 15 languages, informing other limited English proficient individuals how to access assistance. CMS recently received a letter signed by over 270 organizations requesting translation of the application in multiple languages (available from NHeLP). To comply with the nondiscrimination requirements of Title VI and ACA § 1557, CMS must ensure that all LEP individuals can have meaningful access to the application process and receive needed in-language assistance. Thus CMS must develop a plan for translation but also include language on the English application that informs LEP individuals how to access assistance through the call center and receive

[1] Barry D. Weiss, *et. al., Health Literacy Educational Toolkit, 2nd edition* (AMA Medical Association Foundation and AMA Medical Association), at 12, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf.

translated applications (depending on which languages CMS translates the application). The application should also provide information on access for people with disabilities, including TTY helplines and Braille versions.

RECOMMENDATION: Include the following on the front page (in "THINGS TO KNOW") or prominently and immediately behind the front page, in fifteen languages:

> *If you do not speak English, we will get an interpreter to help you at no cost to you. Please call (XXX) XXX-XXXX.*

The introductory information on the application – both in paper and electronic forms – is critical to ensuring that applicants feel secure in submitting personal and often confidential information to determine their eligibility for a range of programs. This is particularly true for families who may have mixed immigration statuses where some individuals may be eligible for assistance and others may not be but are providing application information. We thus recommend that HHS address certain issues right on the front page of the application or the opening webpage of the electronic application.

In particular, to connect immigrants and their family members to coverage and care, online and paper forms should encourage the applications of eligible family members, even if doing so requires a somewhat longer and more complicated application. The instructions should include a statement about the confidentiality of the information provided, legal protections (including nondiscrimination), availability of free language services, information about the application process, and how to file complaints both generally and regarding discrimination.

HHS must determine the appropriate methods to communicate this information, be it through an attached set of instructions, through introductory information on the front page or homepage of the application, or in attachments (as long as the attachments or instruction booklet is prominent and provided to all applicants).

RECOMMENDATION: Include the following in the "THINGS TO KNOW" section:

> ***Families that include immigrants are welcome to apply for help with health insurance costs.***
>
> ***You may file applications for families that include some members applying for health coverage and others who are not. You do not have to provide a Social Security number (SSN) or citizenship or immigration status for those in your family who are not seeking coverage. We will not delay or deny health coverage because there are family members who are not seeking coverage. For those who do not apply, we can give you information about other ways to get health care.***

We will keep all the information you provide private and secure as required by law. We will use it only to check if you are eligible for health insurance.

Under federal law, discrimination is not permitted on the basis of race, color, national origin (language or limited English proficiency), sex, or disability. To file a complaint of discrimination, go to www.hhs.gov/ocr/office/file.

Finally, we are concerned that some individuals may not understand that applying for insurance will not affect one's immigration status. This is also an area where providing up-front information to applicants and their household members can assist in allaying fears and ensuring all eligible individuals do apply.

RECOMMENDATION: Include the following in the "THINGS TO KNOW" section of the first page or in clearly marked instructions that accompany an application:

Applying for health insurance or getting help with health insurance costs will not make you a "public charge"* and will not affect your immigration status or chances of becoming a lawful permanent resident (getting a "green card") on that basis. Applying for health benefits won't prevent you from becoming a citizen, as long as you tell the truth on the application.

**** People receiving long-term care in an institution may face barriers getting a green card. If you have concerns or questions about this, you should talk to an agency that helps immigrants with legal questions.***

We also recommend that HHS translate the paper application into multiple languages. This will assist applicants, applicant assisters, navigators, and others who will provide application assistance to limited English proficient (LEP) individuals.

STEP 1

The instructions below "Step 1" are too vague to allow an individual to understand the purpose of this step. We suggest CMS add additional language explaining that this information is requested of a household contact who will be contacted about the application. The application appears to contemplate that the applicant's permission is needed before a state can contact members of the applicant's household, including in the case of minor applicants. We urge CMS to add language to clarify this point.

RECOMMENDATION: We suggest the following amended language:

Tell us about yourself..

If you are a minor, can we contact your parent or legal guardian about your application? ☐ Yes ☐ No

For all other applicants, we will need one ~~an~~ ***adult*** ~~member of~~ ***in the family to be the contact person for your application. We will contact this person if we have any questions and to provide information about your eligibility. We will not contact any member of your household unless you give us permission to do so. (If you are not the contact person, please tell us who should be the contact person.***)

We appreciate the collection of language data, both preferred spoken and language read from the household contact. As we have noted in Step 3, however, this data should also be collected for **all** applicants and non-applicants and race/ethnicity should also be collected of the household contact (as well as applicants and non-applicants).

Further, Medicaid and CHIP rules require states to provide assistance with an application and we believe this information should be prominently displayed at the beginning of the application. 42 CFR §§ 435.908 and 457.340(a). These regulations also allow individuals chosen as assisters by individuals to help them navigate application. HHS should require states to provide application assistance in a culturally competent manner that effectively communicates to immigrant families the information they need. Since the application is also an application for Medicaid and CHIP, this same requirement should apply to the Exchanges as well.

RECOMMENDATION: Include text stating that assistance is available in a preferred language, or that the state will accept information from an assister chosen by the application filer.

We also believe that CMS should include information in this Step about the purpose of creating an account, that individuals can save information and come back to the application later, that information will not be reviewed until an individual clicks to submit the application, that an individual can create an account even if that person does not seek health insurance (but is applying on behalf of other individuals), and other messaging to provide individual's with a better understanding of their control of the application process.

STEP 2

Tell us about your family

The application should provide more background and context. Applicants need to understand why they are being asked detailed questions regarding their income, family size, and living arrangements that may seem intrusive and, at times, repetitive. Also, applicants are likely seeking the *best* coverage, not the *most* coverage possible as the text currently includes. The *best* coverage may include considerations related to cost-sharing which *most* coverage may not.

RECOMMENDATION: We suggest changing the language as follows:

> ~~Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible~~. ***You and your family members may qualify for assistance in buying health insurance, or may qualify for low or no cost health insurance programs. The amount of assistance or type of program depends on your family size, income, and who is included in your household. By providing information in this application, we can make sure everyone who wants health insurance coverage gets the best coverage they can.***

Here's who you need to include on this application

This section should begin with "You," because the applicant will need to provide information as a household contact whether not the applicant is also applying for health insurance. Also, the statement "Your partner who lives with you (but only if you have children together who need insurance)" is confusing. It is not clear whether it refers to children conceived together, or that the couple is raising together.

Your information is private

The paper application has a simple privacy statement that promises to protect an applicant's personal information and explains that information provided will only be used for eligibility determinations. We believe, however, that this information should be on p.1 of the application under "THINGS TO KNOW" so that it stands out clearly as some individuals may not want to provide even the limited information requested of a household contact without understanding the context.

Step 2: Person 1

Since the paper application will not prepopulate the Person 1 section, it may be confusing to the person completing Step 1 and who may not see the "Start with yourself" instruction and "Self" under heading "Relationship to you." Therefore, "Person 1" should be changed to "you" or "yourself" throughout this section. We also suggest starting this text with "Start with yourself!" rather than ending with this text.

RECOMMENDATION: Amend "Step 2: PERSON 1" to read "Step 2: YOURSELF" and amend the text below as follows:

> ***Start with yourself!*** Complete Step 2 for ***you,*** your spouse/partner and children who live with you and/or anyone on your same federal income tax return ***(***if you file one***)***. See page 2 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you. ~~Start with yourself!~~

Social Security Numbers

The boxed explanation regarding Social Security Numbers (SSNs) should be moved ***above*** the request for the SSN so that applicants will better understand their rights before coming to the box listing SSNs as "optional." Otherwise, many individuals may not understand the reason for the request and, not wanting to provide sensitive information, stop the application.

RECOMMENDATION: Substitute the following language for the current text regarding Social Security Numbers:

> ***To complete this application you only need to give SSNs of family members who are applying for health insurance and have SSNs. We use SSNs to check the amount of money you make (your income), to see if you and/or your family can get help with health insurance costs. Providing SSNs may speed up your application process. If you don't have an SSN, we can help you apply for one [call (XXX) XXX-XXXX].***
>
> ***You do not have to give an SSN or immigration status for anyone who is applying for Emergency Medicaid or [state funded program].***

We support requesting, but not requiring, SSNs of non-applicants. Under § 1902(a)(7) of the Social Security Act, information concerning applicants, beneficiaries, and non-applicants may be used and disclosed only for purposes directly connected with administering the state plan. The state 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. 42 CFR §§ 431.300(b), 435.907(e), 435.948(c), 457.340(b); 45 CFR §§155.305(f)(6), 155.310(a), 155.315(i).

RECOMMENDATION: In asking for SSNs, clarify that failure to provide an SSN for a non-applicant does not affect the eligibility of applicant family members. We recommend the following language:

> ***You do not have to provide a Social Security number (SSN) for those in your family who are not seeking coverage. We will not delay or deny health coverage because there are family members who are not seeking coverage.***

Spouse/partner

The text at the top of the page and Question 1 both identify a "spouse/partner". This needs clarification because the law in this area is complex and often confusing and the purpose of this request is unclear. Not all spouses are entitled to file joint federal income taxes. Nine states (CT, IA, ME, MD, MA, NH, NY, WA, and VT) and the District of Columbia have legalized same sex marriages. However, these couples are forbidden

from filing joint federal income tax returns under the “Defense of Marriage Act” which defines marriage for federal purposes as a union between only a man and a woman. So someone may have a spouse or partner for whom information should not be provided.

By contrast, 9 states and the District of Columbia recognize common law marriages (AL, CO, DC, IA, KS, MT, OK, RI, SC, and TX). In addition, five states have "grandfathered" common-law marriage (GA, ID, OH, OK, PA). The IRS will accept jointly filed income tax returns from common law married couples if their home states recognize the marriages. Some states allow civil unions or recognize domestic partnerships (DE, HI, IL, NJ, and RI allow civil union, while CA, OR, and NV offer broad domestic partnership. Two other states (CO, WI) have more limited domestic partnership. However, none of these arrangements allow the couples to file joint federal income tax returns. Furthermore, in states that apply community property laws to married couples or registered domestic partners (e.g., California), the IRS requires that such laws apply to the income of gay couples, even though they must file separate federal tax returns. Therefore, the reference to “partner” in this section of the application should be clarified. The application should explain these distinctions either in an information box as attached instructions so that individuals can accurately complete this question.

RECOMMENDATION:

~~*Will PERSON 1 file jointly with a spouse/partner?*~~

1. ***Will you file a joint federal income tax with your spouse in a marriage recognized under federal law?***

   Federal law does not recognize same-sex marriages that are legal under state law. However, some opposite-sex couples may be considered legally married by the federal government, even if they never actually married in their home state. For more information on whether your marriage may be legally recognized under federal law, please visit 1-800-XXX-XXXX or www.placeholder.gov

Applying for health insurance

RECOMMENDATION: Amend the question as follows:

~~Is Person 1~~ ***Are you*** applying for health insurance ***for yourself***?

Disability Questions

We believe the purpose of the two disability questions is to identify individuals who may meet disability-based eligibility criteria and be eligible for “traditional” Medicaid rather than expansion-based Medicaid. Yet we also believe collecting this information is important to identify individuals who are medically frail and, if eligible for Medicaid, would be exempt from enrolling in an Alternate Benefit Plan (ABP). Providing the

context for these questions is important so that individuals understand that identifying as having a disability may result in receiving more tailored services at less cost.

We believe 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.

Moreover, some individuals who have chronic or serious medical conditions that would likely qualify them for Supplemental Security Income (SSI) or state disability criteria and thus eligible for Medicaid on the basis of disability may not identify self-identify as "having a disability." Therefore, the questions should be appropriately tailored to identify those individuals.

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 or an exemption from ABPs and should not be called upon to make this determination unaided. Furthermore, research has consistently shown that asking people if they have a disability does not accurately identify people with disabilities. As such, we think it is best to ask a broadly inclusive question first, and allow trained state employees to make a later determination on whether someone does or does not have a disability for the purpose of state benefits. The point in the application is simply to flag those individual or family applicants who may qualify and therefore should be directed toward a state benefit determination first before obtaining private insurance through the Exchange. It should also flag individuals who may be medically frail, even if additional information is later needed to qualify for an exemption to ABP.

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 ACA acknowledges both the prevalence of health disparities among people with disabilities and that health disparities are not the inevitable outcome of disability or disease, but are the result of complex factors including lack of disability awareness on the part of health care providers, and architectural and programmatic barriers to care. Thus, the ACA, in section 4302, calls for identifying disability status through population surveys and among applicants, recipients, or participants in federally conducted or supported health care or public health programs.

The single streamlined application 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.

For many years, the federal health-focused surveys have included questions that allow the identification of disability using a set of questions based either on activity limitation or functional limitation.[2] This provides a basis upon which to identify individuals with disabilities through survey questions, which can be incorporated into the single streamlined application.

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

RECOMMENDATION: Amend the disability-related questions on the application as follows:

~~Needs help with activities of daily living though personal assistance services or a medical facility?~~

> ***You may be eligible for another program that will better meet your needs if you answer yes to any of the questions below.***
>
> ***Do you have a physical, mental, or emotional, health condition that causes limitations in activities? ☐Yes ☐ No (if Yes, please skip the following six questions)***

[2] A number of national population surveys conducted or supported by the federal government collect data on disability status and on health services use and expenditures. The American Community Survey (ACS) and Current Population Survey (CPS) specifically ask questions that identify who have a disability. All the surveys with an explicit health information focus use the patient as the unit of analysis and, with only one exception, ask six or more questions about functional or activity limitation to identify respondents with disabilities.

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?***

CMS should also consider adding at least one question to identify children with special needs. Several states have questions on their Medicaid and CHIP applications tailored to assess children.

RECOMMENDATION: Include the following:

If this person is a child (under age 21), please answer the following:

1) ***Is this person limited or prevented in any way in his or her ability to do the things most children of the same age can do?***
2) ***Does this person need or use more medical care, mental health or education services than is usual for most children of the same age?***

Race/Ethnicity

We appreciate that the application would collect race and ethnicity data from applicants. We urge CMS, however, to expand this data collection to include the household contact (who may be a non-applicant) and non-applicants. Having this data is critical so the Exchange can ensure its compliance with ACA § 1557 and Title VI of the Civil Rights Act of 1964 but also so that it can transmit this information to Qualified Health Plans (QHPs), Medicaid/CHIP agencies, assisters, navigators, and certified application counselors for their compliance. Further, if any state-based Exchange seeks Secretarial approval of an alternate application, HHS should require the Exchange to use the same data fields/standards to collect race and ethnicity to allow comparison among and between Exchanges. Without having the same data fields, comparison is near impossible, as we have seen with HHS' allowance of state Medicaid programs to determine their own fields for collecting race and ethnicity.

In the supporting statement released with the draft paper application and list of questions in the online application, CMS stated that it plans to collect data elements

pursuant to § 4302 of the Affordable Care Act. We greatly appreciate the recognition of the need to collect comprehensive demographic data. As § 4302 states:

> The Secretary ***shall ensure*** that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey. . . collects and reports, to the extent practicable – (A) data on. . .primary language. . .for **applicants, recipients or *participants.*** *(emphasis added)*

The household contact is certainly a participant in the application process and thus, to comply with § 4302, CMS should collect this data from them as well. We believe non-applicants are participants within the meaning of § 4302 since they must provide their income and other information on the application and may also interact with the Exchange post-application and thus HHS should collect their race and ethnicity as well.

Collecting race and ethnicity data is critical for a number of reasons:

- **Complying with ACA § 1557 and Title VI of the Civil Rights Act of 1964** – for the Exchange to ensure it does not discriminate against individuals – applicants as well as household contacts – based on their race or ethnicity, the Exchange needs to have data on all applicants so that it can accurately analyze and stratify its data and, if needed, implement corrective action plans.

- **Assisting insurers** – transferring race and ethnicity data of applicants from Exchanges to insurers can assist insurers to comply with § 1557 and Title VI.

- **Assisting navigators, assisters and certified application counselors** – transferring race and ethnicity data of applicants and household contacts from Exchanges to navigators can assist them to comply with § 1557 and Title VI.

- **Assisting healthcare providers** – if the Exchange collects this data and transfers it to QHPs who transfer it to healthcare providers, it can assist them to comply with § 1557 and Title VI.

While the household contact may assist with an initial application, applicants and non-applicant household members likely will interact with the Exchange on an ongoing basis to get information, submit renewal applications, and file complaints. Thus, the Exchange will benefit from having race and ethnicity data on all applicants and non-applicants to prevent discrimination. For example, once an Exchange determines eligibility, applicants and other non-applicant members of the household – rather than (or in addition to) the household contact – may contact the Exchange with questions about selecting a QHP, accessing services, finding support, or to report changes in status/income. Further, the Exchange is the most centralized source for many newly eligible individuals to obtain insurance and thus its goal of one-stop shopping is equally effective for data collection – if the Exchange collects this data and ensures its

availability to others who need it, it can preclude multiple requests for the same information.

Yet the data elements specify collecting race and ethnicity data only from applicants. We urge CMS to include collection of race and ethnicity data from ***all*** applicants and non-applicants. This is particularly important for applicants who are minors or have legal guardians to have the data of their parent/guardians as well. We believe Exchanges should collect this from all non-applicants because the Exchange will not be able to predict who in the household it will interact with and cannot discriminate against anyone in the household who may seek information or assistance for applicants. For example, a non-applicant may need to assist household members with applications and obtaining information from an Exchange. This could include a non-applicant child seeking coverage for an older parent; an adult child with developmental or other mental disabilities; or other family members who may need assistance. Since we cannot accurately to initially predict how individuals and households will interact with the Exchange, we believe HHS should expand race and ethnicity data collection as widely as possible to ensure effective methods are in place to ensure compliance with § 1557 and Title VI.

For more on the application of Title VI and § 1557 to Exchanges and QHPs, see NHeLP's Short Paper, *The Application of PPACA § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges*, available at http://www.healthlaw.org/index.php?option=com_content&view=article&id=511:health-reform-short-papers&catid=51.

RECOMMENDATION: Move the race and ethnicity questions **above** "Is Person 1 applying for health insurance" so that it is collected from non-applicants as well as applicants.

We also suggest that the request for data include an explanation of the reason. In testing done by the Health Research and Educational Trust, providing a rationale for collecting race, ethnicity and language based on equality provided the greatest response from patients to provide this data. We thus recommend an adapted version of this same language.

RECOMMENDATION: To encourage individuals to provide this data, we believe HHS should include a statement on the application explaining the need for this data (as well as the language data we request below. We suggest the following:

> ***We ask for your race, ethnicity and language so that we can review application information to make sure that everyone gets the same access to health care. This information is confidential and it will not be used to decide what health program you are eligible for. You do not have to provide your race and ethnicity to complete the application.***

Language Access

For the same reasons as it is important to collect race and ethnicity, plus the added necessity of this information for planning language services, we also strongly recommend that CMS collect language data of all applicants and non-applicants, not merely of the household contact.

In the supporting statement released with the draft paper application and list of questions in the online application, CMS stated that it plans to collect data elements ***pursuant to § 4302*** of the Affordable Care Act. We greatly appreciate the recognition of the need to collect comprehensive demographic data. As § 4302 states:

> The Secretary ***shall ensure*** that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey. . . collects and reports, to the extent practicable – (A) data on. . .primary language. . .***for applicants, recipients or participants.*** *(emphasis added)*

We are thus concerned that CMS did not follow the statutory instructions and include language data collection of all applicants on the draft applications. CMS recognizes collecting demographic data is practicable by including race and ethnicity collection from all applicants on the application. There is no basis for excluding primary language data collection of all applicants. Moreover, by only requesting language data information from the household contact, CMS also impedes its compliance with § 4302 since it will not have language data of recipients and participants (unless it implements post-enrollment collection which historically has been very difficult).

Comprehensive language data is essential to ensuring nondiscrimination and compliance with Title VI of the Civil Rights Act and § 1557 of the Affordable Care Act. Having comprehensive language data is also critical to address health disparities and service planning. Exchanges need to know the languages of applicants so they can ensure provision of appropriate language services – both oral and written – in their offices, call centers, and by subcontractors. Collecting this data once on the application will save time and money since the Exchange can share this data with health plans, providers, navigators, assisters, certified application counselors, brokers and others who will be assisting limited English proficient individuals.

Further, only collecting this data from the household contact will likely misrepresent and significantly undercount the needs of LEP individuals. Given the well-documented barriers LEP individuals face in accessing services and healthcare, it is likely that if a household has an English-speaking member, that individual will be the household contact. Yet an estimated 23% of Exchange applicants will speak a language other than English at home, demonstrating the significant need to identify language needs so that appropriate assistance can be provided for all applicants.

The household contact is certainly a participant in the application process and thus, to comply with § 4302, CMS should collect this data from them as well. Non-applicants are also participants within the parameters of § 4302 since they must provide their income and other information and may also interact with the Exchange post-application and thus HHS should collect their language as well.

We have a historic opportunity to comprehensively collect important demographic data collection through the single, streamlined application. We urge CMS to seize this opportunity and ensure comprehensive language data collection for the same reasons we support comprehensive language data collection.

RECOMMENDATION: Add questions to collect "Preferred Language Spoken (if not English)" and "Preferred Language Read (if not English)" for each applicant and non-applicant, and not just the household contact, immediately below the requests for race and ethnicity.

Foster Care

The ACA requires states to extend full Medicaid coverage to individuals who age out of foster care until they reach the age of 26. States also have the option to provide Medicaid to independent foster care adolescents. Those aging out of foster care are exempt from the ABPs/benchmark coverage offered to newly eligible adults, although regulations implementing these provisions have yet to be finalized (see NHeLP's comments on CMS-2334-P *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing*). The paper application should explain why this question is asked since some individuals may be unsure of the reason and not disclose. Yet the fact that these individuals could be eligible for Medicaid needs to be explained to help individuals feel comfortable self-identifying.

RECOMMENDATION: Add the following explanatory language to accompany the question about foster care:

> ***If you or someone else applying for health insurance were once in the foster care system, that person may be eligible for a different health care program or more benefits at lower costs. Help us decide if you are eligible by answering the following question.***

Additional Medicaid-related questions

We appreciate the inclusion of questions with regard to disability status and foster care to help identify individuals who may be eligible for traditional Medicaid so that they can obtain the complete eligibility determination. Yet many other individuals may also be

eligible for traditional Medicaid. We suggest that HHS add additional questions to help identify individuals who may be eligible for "traditional" (as opposed to Expansion) Medicaid. This would include individuals who may be eligible based on a disability determination, through the Breast and Cervical Cancer Treatment Program (BCCTP), as medically needy, or other traditional Medicaid categories. 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.

The Exchanges must ask sufficient questions and be prepared to assess eligibility for Medicare Savings Programs (QI-1, SLMB, QMB). To make such an assessment HHS would need to identify an applicants' Medicare enrollment by Part, income, assets, and current MSP enrollment status. MSP programs are critical programs for older adults and persons with disabilities which are historically under-enrolled, and HHS will need to make an exerted effort to systemically identify and enroll these applicants.

Other Income

This section should better explain how to report additional income sources.

RECOMMENDATION: Add clarification about the intervals for income as follows:

> OTHER INCOME: Check all that apply and give the amount and how often you get it ***(weekly, every 2 weeks, monthly, yearly).***

STEP 3

INSURANCE FROM JOBS:

Is anyone offered health coverage from a job?

The organization of the questions could confuse applicants. The section states "**If yes**, answer these questions . . . ," but it includes only one additional question: "Is this a state health benefit plan?" This structure could confuse an applicant regarding whether to proceed to page 16, after answering the additional question, or to continue to the section entitled "**Tell us about the job that offers coverage.**" It is also not clear whether an applicant should answer additional questions on page 15 if they answer no to the state health benefit plan question. CMS should reorganize this section.

Tell us about the job that offers coverage.

The application asks only for "Employee Name" and "Employer Name." CMS should revise the application to clarify that the applicant should include a first and last name. We also believe it is unnecessary to ask for an "Employer Identification Number" here since the employer coverage form will capture this information. Thus, CMS should delete this question. However, if CMS continues to ask this question here, we note that it is difficult to locate the asterisk associated with "Employer Identification Number (EIN)*." CMS should move the associated asterisk from the middle of the page to the bottom of the page, clearly separated from the questions. Further, the application should inform applicants of means, other than asking an employer, of obtaining the EIN (e.g., IRS Form W-2).

Applicants are also unlikely to understand the phrase "lowest cost self-only health plan." CMS should define this term and inform applicant's that they should get this information directly from their employer. We actually are unclear why this is asked of the applicant when the information will be provided by the employer on the Employer Coverage Form. Thus we recommend deleting it from the information provided by applicants. Applicants are similarly unlikely to know whether plans "meet the 'minimum value standard' set by the Affordable Care Act." CMS should explain how the applicant makes this determination.

Just as an applicant may not know the name of the "lowest cost self-only health plan," the applicant may not know how much the employee would have to pay in premiums for that plan. CMS should accordingly add a "Do not know" response option for this question.

The answer to the question, "Do you think the employer's coverage is affordable," is not relevant to a person's eligibility for advanced premium tax credits or health insurance from the Exchange, Medicaid, or CHIP. CMS should delete this question.

RECOMMENDATION:

> **Is anyone offered health coverage from a job?**
> (This includes coverage from someone else's job, such as a parent or spouse, and includes private employer plans as well as TRICARE, federal or state employee plans, and Peace Corps plans.)
> ☐ ~~**YES. If yes,** answer these questions. If there are plans offered by more than one employer and you need more space, attach another sheet of paper.~~
> ~~Is this a state health benefit plan? ☐ Yes ☐ No ☐ Don't know~~
> ☐ ~~**NO. If no,** skip to "Other Health Insurance" on page 16.~~
>
> ☐ **YES. If yes,** answer ~~these~~ questions ***1-2*.** If there are plans offered by more than one employer and you need more space, attach another sheet of paper.
> ☐ **NO. If no,** skip to "Other Health Insurance" on page 16.

1. Is this a state health benefit plan? ☐ Yes ☐ No ☐ ~~Don't~~ Do not know

2. Tell us about the job that offers coverage.

We need to know about any health coverage you could get through a job. You can use the Employer Coverage Form on page 21 to get information from the employer about health coverage this job offers to help you complete this section. If there is more than one job, copy this page.

Employee Name ***(First, Last)***	Employee Social Security Number __ __ __ - __ __ __ - __ __ __	
Employer Name	~~Employer Identification Number (EIN)*~~	
Employer Address	Employer Phone Number ( ) –	
City	State	Zip Code
Who can we contact about employee health coverage at this job?		
Phone Number ( ) –	Email Address	
~~What's~~ ***What is*** the name of the lowest cost ~~self-only~~ health plan ***covering just the employee listed above, but not the employee's family members,*** that 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. ***Your employer can tell you which plans meet this standard.***) Name: _____ ☐ No plans meet the "minimum value standard" ☐ ~~Don't~~ ***Do not*** know		
How much would the employee have to pay in premiums for that plan? $ _____ How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ ~~Don't~~ ***Do not*** know		
~~Do you think the employer's coverage is affordable? ☐ Yes ☐ No~~		
~~*You can ask your employer for this information~~***~~, or obtain it from your IRS Form W-2~~***~~. See page 21.~~		

Who does this job offer coverage to?

Whether a person *thinks* that certain health insurance coverage will be unaffordable next year is not relevant to a person's eligibility for advanced premium tax credits or

health insurance from the Exchange, Medicaid, or CHIP. CMS should delete this question.

RECOMMENDATION: Delete "Check here if you think this health insurance will not be affordable this year."

OTHER HEALTH INSURANCE:

The Veterans Administration health benefits program is not considered a health insurance plan. CMS should revise this question to ask about health ***coverage***, as opposed to ***health insurance***. Veterans eligible for health care services through the Veterans Health Administration system, but not enrolled, are eligible for advance premium tax credits or cost-sharing reductions and health insurance from the Exchange, Medicaid, or CHIP. To avoid any confusion about eligibility, CMS should make clear that it is asking about enrollment in a VA plan, as opposed to merely whether someone is offered coverage.

Similarly, a person offered, but not enrolled in COBRA is potentially eligible for advance premium tax credits and QHP enrollment. Applicants enrolled in COBRA could also be eligible for advance premium tax credits and cost-sharing reductions and loss of minimum essential coverage special enrollment upon termination of coverage. An applicant enrolled in COBRA is also entitled to receive an eligibility determination that the applicant is eligible for payments of the premium tax credits and/or cost-sharing reductions prior to termination of coverage.

We suggest adding an additional question to avoid the Catch-22 that if an individual has COBRA that she is ineligible for an APTC and would not get an eligibility determination for Medicaid, CHIP or APTCs yet could be eligible if she dropped COBRA but would not know her options and cost-savings if she marks that she is enrolled in COBRA. Thus we suggest that that CMS add an additional question asking if the individual would drop COBRA coverage if she was eligible for other assistance. This would allow the individual to receive a determination on eligibility and the eligibility notice could specify that eligibility and enrollment are premised on termination of COBRA.

RECOMMENDATION: CMS should revise this question as follows:

> ~~Does anyone have another~~ ***Is anyone enrolled in another health benefits program*** now, including Veterans, Medicaid or CHIP, Medicare, COBRA, Private/ Other, Retiree Health Plan?
> ☐ Yes ☐ No **If no,** skip to Step 4 on the next page
> ***Would you terminate your COBRA coverage if you were found eligible for another more affordable health program?*** ☐ Yes ☐ No

Further, to ensure that applicants are not deterred from completing the application, CMS should clarify that checking the "Yes" box does not render a person ineligible for

insurance coverage or advanced premium tax credits or cost-sharing reductions. Finally, CMS should also ask applicants when COBRA coverage expires, since this could impact eligibility for advance premium tax credits and/or loss of minimum essential coverage special enrollment.

RECOMMENDATION: To ensure that applicants are not deterred from completing the application, CMS should clarify in the instructions that enrollment in COBRA or a Veteran's health benefit health program does not necessarily render a person ineligible for payments or coverage, particularly if the individual drops COBRA coverage. CMS should also ask applicants when their COBRA coverage expires or if they would drop it if determined eligible for APTCs, since this impact eligibly for subsidies and special enrollment.

RECOMMENDATION: CMS should add "Student Health Insurance" to the list of health coverage in Question 5, which asks about current enrollment in health coverage.

STEP 5

Authorized representatives

This section should include a better explanation of what an authorized representative is, how an authorized representative can be designated, and how it differs from a navigator, assister, or household contact. The scope of the representation should be clarified so the applicant understands that an authorized representative performs that function only for the purposes of the application (and renewal if so authorized). The application should explain that the authorized representative has no role in communicating directly with health care providers, or in making health care decisions on behalf of the applicant unless specifically authorized under state law (e.g., durable power of attorney for health care).

The text specifies that an individual may select "a trusted friend or partner." We also suggest CMS add language noting a relative may also be an authorized representative.

RECOMMENDATION: Amend text regarding authorized representative to state:

> You can give a trusted friend, ***relative,*** or partner. . .

We also suggest that CMS include help text identifying how an individual can rescind the designation of an authorized representative.

Further, the paper application should advise what documents may be needed to establish the representation and how to submit them. We suggest that CMS add in help text or additional information on when documentation is needed, why, and the type of documentation that would be acceptable. We want to ensure that individuals who are incapacitated are able to designate an authorized representative. As recognized in 42

C.F.R. § 435.907, an authorized representative can act on behalf of an applicant who is a minor or incapacitated. This must be an easy process to achieve to ensure compliance with the ADA and § 504 of the Rehabilitation Act.

Renewal of Coverage

We suggest that HHS rework the text under "Renewal of Coverage" because it is confusing.

RECOMMENDATION: Revise text as follows:

> The Marketplace will send me a notice and let me make changes. If I ~~**don't**~~ ***do not*** respond ***to the notice***, the Marketplace. . .

In the designation of an authorized representative, it is unclear whether an individual can designate an authorized representative for ***all*** applicants, even those who are adults. For example, if a mother applies on behalf of herself and her adult child, can the mother designate an authorized representative for the adult child? It seems that adult applicants should have the option to designate their own authorized representative, or no authorized representative, rather than give this authority solely to the individual filling out the application.

We also suggest adding language that asks the applicant if the authorized representative should also be contacted for renewal purposes. If the applicant answers yes, notices about renewal should be sent to ***both*** the applicant and authorized representative (since circumstances may have changed since the initial designation of an authorized representative).

Further, states are prohibited from denying or delaying services to an otherwise eligible individual pending issuance or verification of an SSN by the Social Security Administration which is an important protection for vulnerable families including immigrant and LEP families who often face problems with obtaining Social Security numbers. The Medicaid rules incorporate due process protections to help individuals correct inaccuracies in their records without forfeiting critical coverage. 42 CFR §§435.910(a), 435.952, 435.956, 457.340(b); 457.380(f); 45 CFR §155.315(f)(4).

RECOMMENDATION*:* Provide notice in this section that Exchanges may not deny or delay services pending issuance or verification of an SSN, or on the basis of any information received unless they have sought additional information from the applicant, and have provided the individual with notice and hearing rights.

Allowing individuals to complete an application to the best of their ability and to sign and submit the application with missing information is an important protection. This is critical to preserve the effective date of the application, particularly for Medicaid, where eligibility may begin immediately, or even be effective back to the first of the month. It

will also likely lead to fewer errors as applicants will not feel they must guess even when the data points are unknown. CMS should establish a minimum level of information or core data elements that constitute a “valid” application, which could potentially include only minimal information about the applicants and signature. Once an applicant completes these elements, an applicant can sign and submit the application to preserve their date of application while they continue to gather additional information. If CMS does not establish a limited set of core elements having a check box for applicants to say “I don’t know” to questions that are not required could be helpful.

The submission of a partially completed application (regardless of whether an applicant provides all data needed to establish an official application date) should trigger follow-up procedures to assist the applicant in gathering missing information and provide a set timeframe for providing such information. Individuals should be informed that delays in completing and submitting the application may have an effect on the start time of their benefits and that they may complete the application to the best of their ability and submit it while gathering additional information or seeking help in understanding questions. If an Exchange can make an eligibility determination 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.

We suggest CMS define “date of application” as the calendar date that an individual submits an application to one of the insurance affordability programs including at least the minimally required data elements. The application should provide an exception to any address requirement for any individual who lacks an address. If an insurance affordability program requires additional information from the applicant to finalize an eligibility determination, the program may request that information, but this shall not be considered a new application, the date of application does not change, and the timeliness standards apply based on the date of application. Further, an individual should be allowed to submit an application even if all information is not included and the Exchange should follow-up with the individual to obtain any additional information while the initial submission date remains the same.

We recommend that the timeliness clock begin running on the calendar date an individual submits an application, regardless of whether subsequent steps are necessary to complete the application. This standard is in keeping with customary Medicaid practice and has been reaffirmed in other recent regulations. See e.g., Medicaid Citizenship Documentation regulation discussion at 42 Fed. Reg. 38670. We recommend that CMS use the same date of application standard used by the SNAP program, which defines date of application based on the date an individual submits an application including name, signature, and address. See 7 C.F.R. § 273.2(b)(1)(v), (c)(1), and (c)(3). This standard will maximize enrollment of individuals and create uniformity between state and federal programs.

STEP 6

Many individuals may complete a paper application but still want to personally deliver it rather than mail it. We thus suggest that CMS add language allowing an individual to bring a completed application to an Exchange office (or navigator, assister, certified application counselor) rather than requiring mailing. Further, since individuals must be able to submit Medicaid applications "through other commonly available electronic means",[3] we believe CMS should include information about how to send the application via email.

We also want to provide comment about the eligibility decision sent post-filing. We strongly suggest that states be instructed to provide individuals determined not to be eligible as well as non-applicants with specific information about where they can access care. They may be ineligible for a variety of reasons, including age (Medicare-eligible), immigration status, or receipt of COBRA. In each of these situations, we believe the online system must provide additional information about where to obtain health care . That is, an individual over age 65 should be directed to complete a Medicare application. Ineligible immigrants should be informed of emergency Medicaid, of state- and local-alternative programs, of Medicaid in a state that covers the fetus of a pregnant woman, and free care resources (such as community health centers). Individuals who are ineligible due to COBRA coverage should be informed that they can receive assistance once COBRA terminates or the individual chooses to terminate COBRA.

EMPLOYER COVERAGE FORM

We suggest that CMS allow individuals to attach an employer's documentation of coverage, rather than have to complete this information on the coverage form. Many employers have stated that they will likely place information documenting coverage on the website of the employer or in another location accessible to employees. It seems redundant that an employee would have to transfer that information to the application.

RECOMMENDATION: Add a check box below "EMPLOYER Information" to allow an employee to check if the employer's documentation is attached and then attach it to this form.

4. COMMENTS ON THE ONLINE APPLICATION

General Comments

Overall, we greatly appreciate the work CMS has undertaken to develop the questions in the on-line application. Of all the modalities, online applications have the greatest potential to simplify and speed the eligibility and enrollment process through the use of dynamic questioning, easily accessible help text, and "real-time" verification. Customizing the application process to fit the circumstances of individual applicants will obviously ease the burden of completing it by skipping questions that are not required instead of expecting individuals to self-identify such questions. However, a pre-

[3] *See* 42 C.F.R. § 435.907(a)(1)(5).

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 does not ask about access to affordable employer-based coverage). If additional information is needed, HHS should require the agency to contact the applicant.

As much as is feasible, verification of available data should occur as the application proceeds, providing the applicant with feedback and pre-populated data when available but also the opportunity to correct information or provide supplemental data to clarify.

In the online version, alerts should 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 should prompt the applicant with a message that tells how the information will be used before the applicant proceeds.

We support a strong privacy statement and recommend that it come at the very beginning of the application ***before*** the individual begins entering any personal information or sets up an account. Privacy is a distinct issue and applies regardless of whether the applicant is seeking financial assistance and thus it should be kept separate from this and other questions. The privacy statement should make it clear what information the application will collect, how it will be used, who it will be shared with, how it will be stored and for how long. This information should be written in plain English.

For immigrant families, privacy and security of personally-identifiable information (PII), including its collection, use, and disclosure by state agencies and their contractors, is of paramount concern. Exchange rules restrict any use and disclosure of information the state collects to only those purposes necessary to carry out specified Exchange and SHOP functions. 45 CFR §§155.260, 155.705(a), 155.210(c)(1)(v), 155.220(d), 155.730(g). Final Medicaid rules extend confidentiality protections to non-applicant information and to the use of an SSN, applying privacy restrictions broadly to renewal and verification processes. 42 CFR §§431.10, 431.300, 431.305, 435.916, 435.945, 435.907, 435.908. We support the statement that provides an assurance of privacy should inform immigrant families that information will not be used for enforcement purposes.

We are concerned that the literacy level of the application may be too high for many low-literacy individuals to understand and complete. As an example, one study by the AMA Foundation found that among people with low health literacy skills, 86% could not understand the rights and responsibilities section of a Medicaid application.[4] These

[4] Barry D. Weiss, *et. al., Health Literacy Educational Toolkit, 2nd edition* (AMA Medical Association Foundation and AMA Medical Association), at 12, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf.

problems are more common in certain demographic groups such as the elderly, the poor, some minority groups, and recent immigrants. We strongly urge CMS to work with literacy experts to ensure the application is understandable by low-literacy individuals. In particular, the use of contractions is generally avoided.

We strongly encourage that the homepage for the application include taglines in multiple languages or a language portal that directs limited English proficient individuals to translated versions of the application and how to access assistance completing the application (e.g. call center phone number or local assisters/navigators/certified application counselors who can provide in-language assistance). Estimates are that 23% of Exchange applicants speak a language other than English at home. Thus it is incumbent upon CMS to inform other language speakers how to get assistance with the application. CMS recently received a letter signed by over 270 organizations requesting translation of the application in multiple languages (available from NHeLP). To comply with the nondiscrimination requirements of Title VI and ACA § 1557, CMS must ensure that all LEP individuals can have meaningful access to the application process and receive needed in-language assistance. Thus CMS must develop a plan to ensure the on-line application is available to LEP individuals and informs them how to access assistance through the call center and receive translated applications (depending on which languages CMS translates the application).

In its earlier regulations, HHS requires that Exchange Websites must provide meaningful access to information for LEP individuals and the same should apply to the application itself. This will ensure that Exchanges comply with Title VI and Section 1557. The taglines should explain to LEP individuals how to access information that is not translated and direct individuals to call the Exchange to access oral communication of the application content and assistance with submitting an application.

The development of the tagline is an easy process and should not involve significant cost or time. In fact, HHS could adopt existing taglines from other agencies or organizations for use by the Exchanges. For example, California has a tagline is available in 13 languages. As another example, the Arizona Department of Economic Security has a “Language Notification Flyer” that states – “If you need this notice translated into your language, please call xxx-xxx-xxxx or xxx-xxx-xxxx.” The notice includes 23 languages – 9 of which are included in SSA’s 15.

RECOMMENDATION: Include on the homepage of the application either the following statement in at least 15 languages or a language portal that directs LEP individuals to a webpage for information on how to obtain further assistance.

> *If you do not speak English, we will get an interpreter to help you for no cost to you. Please call (XXX) XXX-XXXX .*

The introductory information on the application is critical to ensuring that applicants feel secure in submitting personal and often confidential information to determine their

eligibility for a range of programs. This is particularly true for families who may have mixed immigration statuses where some individuals may be eligible for assistance and others may provide application information. We thus recommend that CMS address certain issues up front, before the applicant has to provide any information.

In particular, to connect immigrants and their family members to coverage and care, the online application must overcome immigrants' concerns about the privacy of personal information and about the heightened complexity of eligibility rules pertaining to mixed-status families. The online application should encourage the applications of eligible family members, even if doing so requires a somewhat longer and more complicated application. Applications should also help ensure that each low-income family can connect to affordable coverage, even if only through the health care safety net. Effective applications will address and overcome barriers such as limited-English proficiency and distrust of government.

This should include statements about the confidentiality of the information provided, legal protections including nondiscrimination, availability of free language services, information about the application process, and how to file complaints both generally and regarding discrimination.

It is critical that HHS determine the appropriate methods to communicate this information, likely through an attached set of instructions. Some introductory information should be on the front page or homepage of the application while other information can be in attachments as long as the attachments or instruction booklet is prominent and provided to all applicants.

RECOMMENDATION: Include the following on the homepage of the online application:

> ***Families that include immigrants are welcome to apply for help with health insurance costs.***
>
> ***You may file applications for families that include some members applying for health coverage and others who are not. You do not have to provide a Social Security number (SSN) or citizenship or immigration status for those in your family who are not seeking coverage. We will not delay or deny health coverage because there are family members who are not seeking coverage. For those who do not apply, we can give you information about other ways to get health care.***
>
> ***We will keep all the information you provide private and secure as required by law. We will use it only to check if you are eligible for health insurance.***
>
> ***Under federal law, discrimination is not permitted on the basis of race, color, national origin (language or limited English proficiency), sex, or***

disability. To file a complaint of discrimination, go to www.hhs.gov/ocr/office/file.

Finally, we are concerned that some individuals may not understand that applying for insurance will not affect one's immigration status. This is also an area where providing up-front information to applicants and their household members can assist in allaying fears and ensuring all eligible individuals do apply.

RECOMMENDATION: Include the following on the homepage of the application:

> ***Applying for health insurance or getting help with health insurance costs will not make you a "public charge"* and will not affect your immigration status or chances of becoming a lawful permanent resident (getting a "green card") on that basis. Applying for health benefits won't prevent you from becoming a citizen, as long as you tell the truth on the application.***
>
> **** People receiving long-term care in an institution may face barriers getting a green card. If you have concerns or questions about this, you should talk to an agency that helps immigrants with legal questions.***

We also recommend that HHS translate the online application into multiple languages. This will assist applicants as well as applicant assisters, navigators, and others who will provide application assistance to limited English proficient (LEP) individuals.

I. My account

As CMS noted in Section III that some individuals may not have a home address, we believe the same issues may arise in the "My Account" section. Thus we suggest CMS allow an individual to indicate that he/she does not have a home address. And similar to Section III., CMS should include a notation that if individual checks the box to indicate "no home address", the individual will be prompted to enter a mailing address. We believe that help text must accompany the request to provide a mailing address since the mailing address will be likely be used not only to send eligibility information but any ongoing updates and information about redetermination. That is, if a homeless individual designates a homeless shelter as a mailing address, the individual must understand that all communication will go to that address and the individual must be able to retrieve mail from that location on an ongoing basis.

Further, Medicaid and CHIP rules require states to provide assistance with an application. 42 CFR §§435.908 and 457.340(a). These regulations also allow individuals chosen as assisters by individuals to help them navigate application. HHS should require states to provide application assistance in a culturally competent manner that effectively communicates to immigrant families the information they need. Since the application includes applying for Medicaid and CHIP, this regulation applies to the Exchanges as well.

RECOMMENDATION: Inform the household contact, when completing the "My Account" information, that translated applications or other assistance is available, in a preferred language, and that the state will accept information from an assister chosen by the application filer.

II. Privacy

We strongly support having privacy protections stated in a clear and concise manner. We fully support the inclusion of a privacy statement and urge that it come at the very beginning of the application before the individual begins entering any personal information or setting up an account. Privacy is a distinct issue and applies regardless of whether the applicant is seeking financial assistance and thus it should be kept separate from this and other questions.

We suggest that this statement be rewritten from the passive to active voice to assist an applicant with understanding. That is, the applicant should understand who will be retrieving the information but also that the application is confidential and information will not be shared with other agencies, particularly the Department of Homeland Security.

And we suggest that the privacy statement include additional language about how CMS will use any Social Security Number or immigration status provided. That is, it is critical at the earliest point in the application to ensure that individuals understand the limited use of SSNs and immigration status so they feel comfortable providing this sensitive information and do not stop the application process. This is especially important for non-applicants who may have ineligible immigration statuses who are applying on behalf of their eligible children.

The application will gather a great deal of personal information from applicants about themselves and their household members. It will be important that individuals are confident that their personal data is secure and will be kept confidential. It is also important to reassure individuals 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.

For immigrant families, privacy and security of personally-identifiable information (PII), including its collection, use, and disclosure by state agencies and their contractors, is of paramount concern. Exchange rules restrict any use and disclosure of information the state collects to only those purposes necessary to carry out specified Exchange and SHOP functions. 45 CFR §§155.260, 155.705(a), 155.210(c)(1)(v), 155.220(d), 155.730(g). Final Medicaid rules extend confidentiality protections to non-applicant information and to the use of an SSN, applying privacy restrictions broadly to renewal and verification processes. 42 CFR §§431.10, 431.300, 431.305, 435.916, 435.945,

435.907, 435.908. A statement providing an assurance of privacy should inform immigrant families that information will not be used for enforcement purposes.

<u>RECOMMENDATION</u>: Provide reassuring messages about protection of privacy with a privacy statement such as:

> ***We will keep all the information you provide private and secure as required by law. We will use it only to check if you are eligible for health insurance.***

III. Getting started

We appreciate the recognition that an individual can indicate that he/she does not have a home address. The notation says that if this box is selected, the individual will be prompted to enter a mailing address. We believe that help text must accompany the request to provide a mailing address since the mailing address will be likely be used not only to send eligibility information but any ongoing updates and information about redetermination. That is, if a homeless individual designates a homeless shelter as a mailing address, the individual must understand that all communication will go to that address and the individual must be able to retrieve mail from that location on an ongoing basis, possibly for a year or more.

We appreciate the request for preferred spoken and written language from the household contact. We believe help text should accompany this question explaining that the reason for the question.

<u>RECOMMENDATION</u>: Add help text to the language questions as follows:

> ***We ask for your language so that we can help you in your language. We also will review application information to make sure that everyone gets the same access to health care. This information is confidential and it will not be used to decide what health program you are eligible for. You do not have to provide your language to complete the application.***

As we discuss below, however, we strongly urge CMS to request language information from ***<u>all</u>*** applicants and non-applicants and not merely the household contact. If CMS does accept that recommendation, then the information could be deleted from this section or the information provided here could pre-populate the later section on this person's information.

We also urge CMS to include a large variety of languages in the dropdown menu of languages and an "other" option with the opportunity to specify an "other" language. If possible, it would be advisable to tailor the top 20 answers in the dropdown to regional variations – that is, if an individual is completing an application in California, the top languages listed would be different than if in Nebraska. This would make it easier for individuals and assisters to quickly select a language. And if an individual selects a

language in which a translated application is available, the individual should be immediately asked if she wants to switch to that application.

Authorized Representatives

This section should include a better explanation of what an authorized representative is and how an authorized representative can be designated, and how it differs from a navigator, assister. The scope of the representation should be clarified so the applicant understands that an authorized representative performs that function only for the purposes of the application and possibly renewal. The authorized representative has no role in communicating with health care providers and or making health care decisions on behalf of the applicant unless specifically authorized under state law (e.g., durable power of attorney for health care).

The text specifies that an individual may select "a trusted friend or partner." We also suggest CMS add language noting a relative may also be an authorized representative.

RECOMMENDATION: Amend text regarding authorized representative to state:

> You can give a trusted friend***, relative*** or partner. . .

We also suggest that CMS include help text identifying how an individual can rescind the designation of an authorized representative.

Further, under F, Q.5, the option is "submit document for proof" but no information is provided as when that is needed and why, as well as what type of document would be acceptable. We suggest that CMS add in help text or additional information as to when that is needed, why, and the type of documentation that would be acceptable. We do want to ensure that individuals who are incapacitated are able to designate an authorized representative. As recognized in 42 C.F.R. § 435.907, an authorized representative can act on behalf of an applicant who is a minor or incapacitated. This must be an easy process to achieve to ensure compliance with the ADA and § 504 of the Rehabilitation Act.

IV. Help paying for coverage

Under A, Q.1, the text states "Who are you applying for health insurance and health benefits for?" We believe this question is likely to cause confusion since individuals may not understand the differences between "health insurance" and "health benefits."

RECOMMENDATION: We suggest rewording this question, possible to state "***Tell us who wants to get health insurance."***

Under A., Q.2 we understand CMS' inclusion of a question requesting if the applicant is interested in getting help paying for health insurance. However, we strongly urge CMS

to include additional help text that explains what health programs a person may be eligible for (e.g . Medicaid) , in part to ensure more individuals select "Yes" and provide the necessary information to determine eligibility for Medicaid, CHIP, APTCs and CSRs. Otherwise, if an individual answers "no", the applicant will not have a further opportunity during this application process to apply for Medicaid even if they are eligible for the program. For example, if the individual's answer to income questions later on the application indicates potential eligibility for Medicaid, the applicant would not be assessed for eligibility. We thus recommend that if the individual answers "no" but the individual's income level indicates potential eligibility for Medicaid or CHIP, that CMS include an additional question/option at that point to allow the applicant to edit the earlier selection and change from "no" to "yes" to have a Medicaid or CHIP eligibility evaluation.

Under B, Q.1 the text states "How many people are on your federal income tax return *this year?* (emphasis added). This is somewhat unclear. For example, if an individual is applying in October 2013, should the applicant respond with regards to who ***is*** on the individual's 2012 return or who ***will be*** on the 2013 return? The text following the question says "If you didn't file taxes *last year*. . ." So it may be that "this" in the first part of the question should be replaced with "last". We also wonder if an individual enrolls during a special enrollment period, will the relevant tax return change and thus additional clarification would be helpful.

V. Tell us how many people are applying for health insurance

Q.1 states "how many people in *your family and household want. . .".* This is unclear because an applicant may have a different family and household unit. Does CMS want the information regarding the individual's *family* (which may include out-of-state students) or household? The applicant's answer could be over- or under-broad as having reference to both family and household is likely going to cause confusion. We suggest that CMS use only one term and clarify its meaning and what information it needs as an answer to this question.

Q.2 says "Tell us about this person." It is unclear which person this refers to. It would be helpful if the system could start by asking "Tell us about the first person." And then ask the question as many times as necessary based on the applicant's answer to Q.1 (e.g. Tell us about the second person, Tell us about the third person, etc.).

VI. Family & household

VII. Personal information

Social Security Numbers

The online application should provide an explanation regarding Social Security Numbers (SSNs) to help applicants better understand their rights. We support

requesting, but not requiring, SSNs of non-applicants. Under § 1902(a)(7) of the Social Security Act, information concerning applicants, beneficiaries, and non-applicants may be used and disclosed only for purposes directly connected with administering the state plan. The state 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. 42 CFR §§ 431.300(b), 435.907(e), 435.948(c), 457.340(b); 45 CFR §§155.305(f)(6), 155.310(a), 155.315(i).

RECOMMENDATION: Include the following explanation for applicants regarding the requirements and use of their SSNs:

> ***To complete this application you only need to give SSNs of family members who are applying for health insurance and have SSNs. We use SSNs to check the amount of money you make (your income), to see if you and/or your family can get help with health insurance costs. Providing SSNs may speed up your application process. If you don't have an SSN, we can help you apply for one [call (XXX) XXX-XXXX].***
>
> ***You do not have to give an SSN or immigration status for anyone who is applying for Emergency Medicaid or [state funded program].***
>
> ***You do not have to provide a Social Security number (SSN) for those in your family who are not seeking coverage. We will not delay or deny health coverage because there are family members who are not seeking coverage.***

B. Citizenship/immigration status

The online application should include help text to more detailed explanation of US nationals as defined under 8 U.S.C. § 1408.

We support requiring information on immigration status only of applicants. We support asking if the applicant has an "eligible immigration status" and providing a definition of that term, to help applicants and their assisters answer accurately.

RECOMMENDATION: In asking for immigration status, clarify that failure to provide immigration status for a non-applicant does not affect the eligibility of applicant family members. Recommended language is as follows:

> ***You do not have to provide citizenship or immigration status for those in your family who are not seeking coverage. We will not delay or deny health coverage because there are family members who are not seeking coverage.***

D. Ethnicity and race

We strongly support the collection of race and ethnicity information from all applicants. Having this data is critical so the Exchange can ensure its compliance with ACA § 1557 and Title VI of the Civil Rights Act of 1964 but also so that it can transmit this information to Qualified Health Plans (QHPs) for their compliance. We recommend that Exchanges collect race and ethnicity data on all applicants using the standards put forth by the Institute of Medicine in its 2009 report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Exchanges should also provide this data to QHPs which should stratify all of its analyses by race, ethnicity and language data (among other demographic data) to identify any disparities and develop plans to ameliorate them. Further, if a state seeks Secretarial approval of an alternate application, HHS should require the state to use the same data fields/standards to collect race and ethnicity to allow comparison among and between states. Without having the same data fields, comparison is near impossible, as we have seen with HHS' allowance of state Medicaid programs to determine their own fields for collecting race and ethnicity.

The household contact is certainly a participant in the application process (even if not an applicant) and thus, to comply with § 4302, CMS should collect this data from them as well. Non-applicants are also participants since they provide income data on the application and may also interact with the Exchange post-application and thus HHS should collect their race and ethnicity as well.

Collecting this data is critical for a number of reasons:

- Complying with ACA § 1557 and Title VI of the Civil Rights Act of 1964 – for the Exchange to ensure it does not discriminate against individuals based on their race or ethnicity, the Exchange needs to have data on all applicants so that it can accurately analyze and stratify its data and, if needed, implement corrective action plans.

- Assisting insurers – transferring race and ethnicity data from Exchanges to insurers can assist insurers to ensure compliance with § 1557 and Title VI.

- Assisting navigators – transferring race and ethnicity data from Exchanges to navigators can assist them in ensuring compliance with § 1557 and Title VI.

- Assisting healthcare providers – if the Exchange collects this data and transfers it to healthcare providers can assist them in ensuring compliance with § 1557 and Title VI.

The other benefit of collecting race and ethnicity data is the ability to set national standards which can ensure the ability to analyze and compare across Exchanges, Medicaid, CHIP and QHPs. For example, current CMS policy allows state Medicaid

agencies to collect race and ethnicity data of enrollees using state-determined categories. This has created widespread variations and an inability to effectively use this data for cross-state comparison. If HHS sets one standard for collecting race and ethnicity data on the single, streamlined application, we believe this will increase consistency and comparability of this data, a critical element to analyzing and comparing data. We recommend that Exchanges collect race and ethnicity data using the standards put forth by the Institute of Medicine in its 2009 report, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*. Exchanges should use this data to analyze its processes to ensure it does not discriminate against racial and ethnic groups. And Exchanges should share this data with QHPs, assisters, certified application counselors and navigators and encourage them to stratify their data by race and ethnicity to identify any disparities in access or care. Further, if any state seeks Secretary approval of an alternate application, HHS should require the state to use the same data fields/standards to allow comparison among and between states. Without having the same data fields, comparison is near impossible, as we have seen with HHS' allowance of state Medicaid programs to determine their own fields for collecting race and ethnicity.

The benefit of collecting and providing race and ethnicity data to QHPs is in ensuring compliance with ACA § 1557 and Title VI. QHPs should use this data to stratify its own quality and claims data to identify and correct healthcare disparities. QHPs can also use stratified data to indicate on which areas market-based strategies to reduce health and health care disparities should focus.

Healthcare providers, assisters, navigators and certified application counselors also need this data to ensure compliance with ACA § 1557 and Title VI, and identify any potential discrimination or healthcare disparities. If an Exchange collects this data and an insurer makes it readily available to its network providers, a healthcare provider can ensure that it is equitably treating all individuals regardless of race or ethnicity.

Further, collecting this data on all applicants and non-applicants will ensure Exchanges (and QHPs and navigators) will have the information necessary to ensure compliance with Title VI of the Civil Rights Act of 1964 as well as § 1557 of the ACA.

Under Title VI of the Civil Rights Act of 1964,[5] no federal funds can be used in a discriminatory manner, whether intentionally, or, pursuant to federal regulations, through disparate impact. Title VI applies to all programs receiving Federal financial assistance, including private entities. Congress has defined covered programs to include "an entire corporation . . . if assistance is extended to such corporation . . . or which is principally engaged in the business of providing education, health care . . . ."[6] A program also includes "[t]he entire plant or other comparable, geographically separate facility to which Federal financial assistance is extended, in the case of any other corporation,

[5] *See* 42 U.S.C. § 2000d (2006).
[6] 42 U.S.C. § 2000d-4a (2006).

partnership, private organization, or sole proprietorship."[7] Since Exchanges are receiving federal funds to initiate their programs, they are subject to Title VI. QHPs are also subject to Title VI because they will receive federal financial assistance through the payment of premiums for individuals receiving advanced payment tax credits on behalf of eligible individuals and to offset cost-sharing for low-income individuals. HHS' Office for Civil Rights has outlined expectations for compliance with Title VI in its *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (LEP Guidance) available at http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.php. Exchanges and QHPs must ensure that they do not discriminate against anyone served, which likely will include many non-applicants who contact the Exchange or QHPs on behalf of applicants/enrollees.

In addition to Title VI, Exchanges and QHPs must comply with the nondiscrimination provisions of § 1557 of the ACA. Section 1557 expressly extended the protections of Title VI to "any health program or activity, any part of which is receiving *Federal financial assistance, including credits, subsidies, or contracts of insurance*, or under any program or activity that is administered by an Executive Agency or any entity established under this title. "[8] The nondiscrimination protections apply to any financial assistance provided through the ACA, including the tax credits and cost-sharing subsidies in the Exchanges.[9] This provision also applies to all entities created by Title I of the ACA which includes Exchanges and those entities participating in the Exchanges, including QHPs. QHPs have a responsibility to prohibit discrimination and healthcare disparities, in addition to Title VI of the Civil Rights Act of 1964, because of these nondiscrimination requirements.

For more on the application of Title VI and § 1557 to Exchanges and QHPs, see NHeLP's Short Paper, *The Application of PPACA § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges*, available at http://www.healthlaw.org/index.php?option=com_content&view=article&id=511:health-reform-short-papers&catid=51.

We also suggest that the request for data include an explanation of the reason. In testing done by the Health Research and Educational Trust, providing a rationale for collecting race, ethnicity and language based on equality provided the greatest response from patients to provide this data. We thus recommend an adapted version of this same language.

RECOMMENDATION: To encourage individuals to provide this data (and the language data as requested below), we believe HHS should include a statement on the application explaining the need for this data. We suggest the following:

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[7] 45 C.F.R. § 80.13(g) (2010).
[8] *Id*. § 1557(a) (2010) (emphasis added).
[9] *Id*.

> ***We ask for your race, ethnicity and language so that we can review application information to make sure that everyone gets the same access to health care. This information is confidential and it will not be used to decide what health program you are eligible for. You do not have to provide your race and ethnicity to complete the application.***

Language access

We strongly recommend that CMS collect language data of all applicants and non-applicants, not merely of the household contact.

In the supporting statement released with the draft paper application and list of questions in the online application, CMS stated that it plans to collect data elements pursuant to § 4302 of the Affordable Care Act. We greatly appreciate the recognition of the need to collect comprehensive demographic data. As § 4302 states:

> The Secretary ***shall ensure*** that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey. . . collects and reports, to the extent practicable – (A) data on. . .primary language. . .***for applicants, recipients or participants.*** *(emphasis added)*

We are thus concerned that CMS did not follow the statutory instructions and include language data collection of all applicants on the draft applications. CMS recognizes collecting demographic data is practicable by including race and ethnicity collection from all applicants on the application. There is no basis for excluding primary language data collection of all applicants. Moreover, by only requesting language data information from the household contact, CMS also impedes its compliance with § 4302 since it will not have language data of recipients and participants (unless it implements post-enrollment collection which historically has been very difficult).

Comprehensive language data is essential to ensuring nondiscrimination and compliance with Title VI of the Civil Rights Act and § 1557 of the Affordable Care Act. Having comprehensive language data is also critical to address health disparities and service planning. Exchanges need to know the languages of applicants and non-applicants so they can ensure provision of appropriate language services – both oral and written – in their offices, call centers, and by subcontractors. Collecting this data once on the application will save time and money since the Exchange can share this data with health plans, providers, navigators, assisters, certified application counselors, brokers and others who will be assisting limited English proficient individuals.

Further, only collecting this data from the household contact will likely misrepresent and significantly undercount the needs of LEP individuals. Given the well-documented barriers LEP individuals face in accessing services and healthcare, it is likely that if a household has an English-speaking member, that individual will be the household

contact. Yet an estimated 23% of Exchange applicants will speak a language other than English at home, demonstrating the significant need to identify language needs so that appropriate assistance can be provided for all applicants.

The household contact is certainly a participant in the application process and thus, to comply with § 4302, CMS should collect this data from them as well. Non-applicants who have to provide income data and who may also interact with the Exchange post-application are indeed participants and thus HHS should collect their language as well.

We have a historic opportunity to comprehensively collect important demographic data collection through the single, streamlined application. We urge CMS to seize this opportunity and ensure comprehensive language data collection for the same reasons we support comprehensive race and ethnicity data collection.

RECOMMENDATION: Add questions to collect "Preferred Language Spoken (if not English)" and "Preferred Language Read (if not English)" for each applicant, and not just the household contact.

VIII. Other addresses

Household composition can be very fluid, with family and other household members intermittently residing in a particular household. This is particularly true during economic downturn when families double-up and individuals rotate among residences. This gray area of being not quite homeless, but not having a permanent residence, can pose challenges when applying public assistance and insurance affordability programs.

This section should include help text to help applicants and assistors better understand how to address transiency in the often complex and changing living situations for individuals and families, particularly those experiencing economic hardship.

Moreover, under Item 2 which asks where [FNLNS] lives, there should be a section to indicate if that person is in fact homeless or does not have an address other than the mailing address provided earlier.

RECOMMENDATION: Add the following response option to Question 2.

g. No home address

IX. Special circumstances

Disability Questions

We believe the purpose of the two disability questions is to identify individuals who may meet disability-based eligibility criteria and be eligible for "traditional" Medicaid rather than expansion-based Medicaid. Yet we also believe collecting this information is

important to identify individuals who are medically frail and, if eligible for Medicaid, would be exempt from enrolling in an Alternate Benefit Plan (ABP). Providing the context for these questions is important so that individuals understand that identifying as having a disability may result in receiving more tailored services at less cost.

We believe 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.

Moreover, some individuals who have chronic or serious medical conditions that would likely qualify them for Supplemental Security Income (SSI) or state disability criteria and thus eligible for Medicaid on the basis of disability may not identify self-identify as "having a disability." Therefore, the questions should be appropriately tailored to identify those individuals.

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 or an exemption from ABPs and should not be called upon to make this determination unaided. Furthermore, research has consistently shown that asking people if they have a disability does not accurately identify people with disabilities. As such, we think it is best to ask a broadly inclusive question first, and allow trained state employees to make a later determination on whether someone does or does not have a disability for the purpose of state benefits. The point in the application is simply to flag those individual or family applicants who may qualify and therefore should be directed toward a state benefit determination first before obtaining private insurance through the Exchange. It should also flag individuals who may be medically frail, even if additional information is later needed to qualify for an exemption to ABP.

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 ACA acknowledges both the prevalence of health disparities among people with disabilities and that health disparities are not the inevitable outcome of disability or disease, but are the result of complex factors including lack of disability awareness on the part of health care providers, and architectural and programmatic barriers to care. Thus, the ACA, in section 4302, calls for identifying disability status through population

surveys and among applicants, recipients, or participants in federally conducted or supported health care or public health programs.

The single streamlined application 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.

For many years, the federal health-focused surveys have included questions that allow the identification of disability using a set of questions based either on activity limitation or functional limitation.[10] This provides a basis upon which to identify individuals with disabilities through survey questions, which can be incorporated into the single streamlined application.

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

RECOMMENDATION: Amend the disability-related questions on the application as follows:

~~Needs help with activities of daily living though personal assistance services or a medical facility?~~

You may be eligible for another program that will better meet your needs if you answer yes to any of the questions below.

[10] A number of national population surveys conducted or supported by the federal government collect data on disability status and on health services use and expenditures. The American Community Survey (ACS) and Current Population Survey (CPS) specifically ask questions that identify who have a disability. All the surveys with an explicit health information focus use the patient as the unit of analysis and, with only one exception, ask six or more questions about functional or activity limitation to identify respondents with disabilities.

Do you have a physical, mental, or emotional, health condition that causes limitations in activities? ☐Yes ☐ No (if No, display the following six questions)

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?***

CMS should also consider adding at least one question to identify children with special needs. Several states have questions on their Medicaid and CHIP applications tailored to assess children.

RECOMMENDATION: Include the following:

If this person is a child (under age 21), please answer the following:

1) ***Is this person limited or prevented in any way in his or her ability to do the things most children of the same age can do?***
2) ***Does this person need or use more medical care, mental health or education services than is usual for most children of the same age?***

Foster Care

The ACA requires states to extend full Medicaid coverage to individuals who age out of foster care until they reach the age of 26. States also have the option to provide Medicaid to independent foster care adolescents. Those aging out of foster care are exempt from the ABPs/benchmark coverage offered to newly eligible adults, although regulations implementing these provisions have yet to be finalized (see NHeLP's comments on CMS-2334-P *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing*). The online application should explain, via help text, why this question is asked since some individuals may be unsure

of the reason and not disclose. Yet the fact that these individuals could be eligible for Medicaid needs to be explained to help individuals feel comfortable self-identifying.

RECOMMENDATION: Add the following explanatory language to accompany the question about foster care:

> ***If you or someone else applying for health insurance were once in the foster care system, that person may be eligible for a different health care program or more benefits. Help us decide if you are eligible by answering the following questions.***

X. Expedited income

Question 2 asks applicants to estimate their income for this month to determine if it is at or below the monthly FPL threshold amount. However, it does not allow applicants to indicate whether they are seasonal workers or if their monthly income varies. As a result, those who may be eligible for Medicaid or other health insurance affordability programs may be screened out if the month in which they apply happens to be a higher-income month.

Therefore, we recommend adding a question to determine whether the monthly income reported is consistent or varies.

RECOMMENDATION: Renumber the current Question 2 as Question 3, and insert the following:

> ***2. Is [FNLNS]'s [if joint, display names of both filers] income for this month about the same or does it change significantly month to month?***
>
> ***a. About the same/does not change.***
>
> ***b. Is significantly higher or lower than other months (if yes, please estimate your average monthly income for this year).***
>
> ***$***_____
>
> 3. Is [FNLNS]'s [if joint, display names of both filers] income (before taxes) for this month ***or the estimated monthly income*** greater than [monthly FPL threshold amount]?

XI. Current/monthly income

Question 4(b) combines two questions – asking about monthly income and about any one-time payments during the month from a current or former employer. CMS should change this to either two separate questions or provide two response slots. As written, the monthly income amount is combined with the one-time payment amount, which may distort the actual current or monthly income of the applicant. The combined amount does not comport with the next subsection (c) which asks how often [FNLNS] gets paid

this amount. Accordingly, the question should separate any one-time payments from the monthly income calculation in order to arrive at an accurate yearly total.

RECOMMENDATION: On Question 4, renumber the current subsection (b) as new subsection (c), renumber current subsection (c) as subsection (d), and insert the following new subsection (b).

> ***(b) Has [FNLNS] received any one time payments from this employer this month?***
>
> ***i. Amount: $_____***
>
> (~~b~~)***(c) How much does [FNLNS] get paid (before taxes are taken out) by this employer?*** ~~You should also tell us here about a one-time amount you got from a current or former employer this month.~~
>
> (~~c~~) ***(d)*** How often does [FNLNS] get paid ~~this amount~~ ***by this employer excluding any one time payments?***

XII. Discrepancies

Seasonal workers can have higher incomes some months and little or no income other months. They may not be able to accurately estimate or attest to their annual income. Seasonal workers may be eligible for Medicaid, CHIP, but would only be identified if they apply during the low season when they are not earning as much. Question 6, which asks if an applicant is a seasonal worker, only appears if an applicant has attested to an annual income that is in the Medicaid/CHIP range and if the reported monthly income is not in that range.

Given the inherent difficulties in predicting income for seasonal workers, we believe that Question 6 should be asked of all applicants when there are discrepancies in reported income, and not just the scenario described above. This would serve as a useful backup to the question proposed for Section X Expedited Income, Question 2, asking if the applicant [FNLNS] experiences variations in monthly income. By including the question in Section X, and a follow up in the Discrepancies section, the model application could more effectively flag individuals with seasonal income, and help those applicants enroll in the most appropriate insurance affordability program.

XIII. Health coverage (APTC eligible): access

Health coverage information for [FNLNS]

CMS should revise Questions 4-6, which ask about veterans' health benefits and COBRA. The Veterans Administration health benefits program is not considered a health insurance plan. CMS should ask about health ***coverage***, as opposed to ***health insurance***. Veterans eligible for health care services through the Veterans Health

Administration system, but not enrolled, are eligible for advance premium tax credits or cost-sharing reductions and health insurance from the Exchange, Medicaid, or CHIP. To avoid any confusion about eligibility, CMS should make clear that it is asking about enrollment in VA health care coverage, as opposed to merely whether someone is offered coverage.

Similarly, a person offered, but not enrolled in COBRA is potentially eligible for advance premium tax credits and QHP enrollment. Further, applicants enrolled in COBRA could be eligible for advance premium tax credits, loss of minimum essential coverage special enrollment upon termination of coverage, as well as Medicaid. Since someone on COBRA may have lost his job, the affordability of COBRA should be considered and an individual should not have to continue COBRA if income eligibility provides access to less-expensive coverage, APTCs, CSRs, or Medicaid and CHIP eligibility. COBRA enrollees are also entitled to an eligibility determination that they are eligible for payments of the premium tax credits and/or cost-sharing reductions prior to termination of coverage.

Further, the health coverage information section does not expressly seek information about Student Health Insurance coverage, which could impact eligibility for payments and/or health insurance. Indeed, CMS' paper application Step 3 seeks information about all types of health insurance: "Does anyone have another health insurance now ?"

To ensure that applicants are not deterred from completing the application, CMS should clarify that enrollment in COBRA or a Veteran's health benefit health program does not necessarily render a person ineligible for payments or coverage, particularly if the individual drops COBRA coverage. CMS should also ask applicants when their COBRA coverage expires or if they would drop it if determined eligible for an APTC, since this impacts eligibly for payments and special enrollment.

Thus we suggest that that CMS add an additional question asking if the individual would drop COBRA coverage if she was eligible for other assistance. This would allow the individual to receive a determination on eligibility and the eligibility notice could specify that eligibility and enrollment are premised on termination of COBRA.

RECOMMENDATION: CMS should revise this question as follows:

> ***Would you terminate your COBRA coverage if you were found eligible for another health program?*** ☐ Yes ☐ No

RECOMMENDATION: CMS should add "Student Health Insurance" to the list of health coverage in Question 5, which asks about current enrollment in health coverage.

XIV. Employer health coverage information

Question 2, which asks whether the applicant will be enrolled in an employer-offered health plan, could confuse applicants. The question asks about enrollment in a coverage year, but only allows applicants to respond with a specific date as opposed to a date range.

RECOMMENDATION: CMS should revise Question 2 to request a date range, as opposed to a specific date, as follows:

2. Will [FNLNS] be enrolled in a health plan offered by [Employer name] in [coverage year]?
    a. Yes
        i. Date [FNLNS] will be covered by [Employer name]'s plan: ~~MM/DD/YYYY~~ ***to MM/DD/YYYY***
        ii. I ~~don't~~ ***do not*** know
    b. No

Question 3 is confusing because it is not clear to which "changes" CMS is referring. Two types of changes could be relevant to a person's eligibility for advanced premium tax credits, or enrollment in a QHP, Medicaid, or CHIP: changes in the person's eligibility for employer sponsored coverage (e.g., the employer will stop offering coverage) and changes in the health plan itself (e.g., cost). To ensure that a person appropriately answers this question, and is accordingly directed to the correct next question, CMS should revise Question 3 to make clear the types of "changes" about which it is seeking information.

RECOMMENDATION: Revise Question 3 as follows:

3. Does [FNLNS] expect any changes to [***FNLS] eligibility for*** [Employer Name's] health coverage or ***to the health plan*** in [coverage year]?
    a. Yes *(If selected, continue to item 4.)*
    b. No *(If selected and selected "1 b" and "2 b" in section XIII, ["Health coverage (APTC eligible): access"], skip to section XV ["Other insurance"]. All others skip to item 5.)*

Questions 5 and 6 are also confusing, and CMS should revise them. The phrase "offered to" could confuse applicants, especially since it does not indicate who is doing the offering. CMS should rephrase this question to mirror language under Step 3 on the paper application. Specifically, under Step 3 on the paper application, CMS asks about which plan the employee "could enroll in at this job." Applicants also could have difficulty understanding the phrase "lowest cost self-only health plan." CMS should also rephrase this part of the question so that it is easier to understand about which health plan CMS is asking. Applicants are similarly unlikely to know whether plans "meet the 'minimum value standard' set by the Affordable Care Act". HHS should explain how the applicant

makes this determination, rather than simply including a link to the Employer Coverage form.

RECOMMENDATION: Delete all contractions from Q. 6 and amend as follows:

5. ~~What's~~ ***What is*** the name of the lowest cost ~~self-only~~ health plan ~~offered to [FNLNS]~~ ***that covers just [FNLNS], but not other family members, that [FNLS] could enroll in at this job***? (Only include plans that meet the "minimum value standard" set by the Affordable Care Act. ***[FNLNS'] employer can tell you which plans meet the "minimal value standard."***) (Link to Employer Coverage Form.")
   a. _____ (Display free text field.)
   b. I ~~don't~~ ***do not*** know *(Display check box.)*
   c. No plans meet the minimum value standard *(Display check box.)*
   (Skip to item 7.)
6. *(Display if "c," "d," or "e" was selected in item 4.)* ~~What's~~ ***What is*** the name of the lowest cost ~~self-only~~ health plan ~~offered to [FNLNS]~~ ***that covers just [FNLNS], but not other family members, that [FNLS] could enroll in at this job***? (Only include plans that meet the "minimum value standard" set by the Affordable Care Act. ***[FNLNS'] employer can tell you which plans meet the "minimal value standard."***) (Link to Employer Coverage Form.")
   a. _____ *(Display free text field.)*
   b. I ~~don't~~ ***do not*** *(Display check box.)*
   c. No plans meet the minimum value standard *(Display check box.)*
   (Continue to item 7.)

RECOMMENDATION: In Q.8, change "I don't know" in viii to "***I do not know"***

We also suggest that CMS delete Question 9 since the answer is not relevant to an applicant's eligibility for advanced premium tax credits or health insurance from the Exchange, Medicaid, or CHIP.

RECOMMENDATION: Delete Q. 9.

XV. Other insurance (APTC eligible)

CMS should permit applicants to answer "I do not know" to Question 2 since they might know whether individuals are or will be eligible for particular types of health coverage. CMS should also include examples of other types of state or federal health benefit programs, such as Ryan White CARE Act funded services.

RECOMMENDATION: Add new option "f." to Q. 1 & 2 to allow a choice of ***"I do not know."***

XVI. American Indian/Alaska Native (APTC eligible)

XVII. Tax filer & other information

We are very concerned about the language requesting a Social Security Number. For the reasons explained earlier, any request for an SSN must acknowledge that one is not required for non-applicants.

RECOMMENDATION: Amend the text accompanying Q.1 as follows:

> ~~Providing a *SSN*~~***You do not have to provide a SSN, but if you do it*** may help get a better idea of how much help you can get ~~in~~ paying for health insurance. . .

XVIII. Special Enrollment Periods

XIX. Medicaid & CHIP specific questions

We are unclear what happens if the individual checks "no" in answer to Q. 1 in the general section ("Does ___ have health insurance now?"). The application fails to explain what happens next. And if the applicant answers "yes" and goes on to Q. 3 & 4in this same section, why does CMS need the name of the health plan and what will it do with this information? Will it verify enrollment or costs? Why does it need the policy number/member ID? It is unclear why this specific information is needed if the person provides the general type of insurance in answer to Q.2. If CMS needs this information, it should provide an explanation in help text and inform the individual how to obtain this information.

With regard to this section, it is unclear whether coverage under COBRA or Veteran's benefits will enable Medicaid and CHIP eligibility. We believe these two types of coverage should be added to the list of answers in Q.2 and individuals should receive information if they might be eligible if they drop COBRA or have coverage through the Department of Veteran's Affairs. Many individuals with COBRA coverage may indeed be eligible for Medicaid or CHIP since they are likely not currently employed. Thus additional help text should explain to individuals that if they have COBRA coverage, they could drop it and eligibility would be determined based on a lack of insurance (even if the individual wants to continue COBRA coverage until the new insurance's effective date). The same issues apply to A.2.

We suggest adding an additional question to avoid the Catch-22 that if an individual has COBRA that she is ineligible for an APTC yet would not get an eligibility determination for Medicaid, CHIP or APTCs if she marks that she has COBRA. Thus we suggest that that CMS add an additional question asking if the individual would drop COBRA coverage if she was eligible for other assistance. This would allow the individual to receive a determination on eligibility and the eligibility notice could specify that eligibility and enrollment are premised on termination of COBRA.

With regard to the Medicaid specific questions, we suggest that HHS also add additional questions to help identify individuals who may be eligible for "traditional" (as opposed to Expansion) Medicaid. This would include individuals who may be eligible based on a disability determination, through BCCTP, as medically needy, for limited-scope family planning, or other traditional Medicaid categories. At a minimum, CMS should include information at the end of the application 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.

The Exchanges must ask sufficient questions and be prepared to assess eligibility for Medicare Savings Programs (QI-1, SLMB, QMB). To make such an assessment HHS would need to identify an applicants' Medicare enrollment by Part, income, assets, and current MSP enrollment status. MSP programs are critical programs for older adults and persons with disabilities which are historically under-enrolled, and HHS will need to make an exerted effort to systemically identify and enroll these applicants.

Also, we are concerned about A.1. The individual may want assistance paying medical bills from the past three months but at least during the first open enrollment period, when eligibility for the Medicaid expansion group will not be effective until January 1, 2014, these individuals may not be eligible for 3 months of retroactive coverage before January 1 since this is a new eligibility group. And if an individual applies in October or November and is eligible in the expansion category, the retroactivity would not go back to July or August but, if available, would start January 1. So it would be helpful for CMS to explain that the retroactive coverage is only available for certain individuals and the date range, at least initially in 2014 in expansion states.

With regard to B., we have provided comments to CMS' previous proposed regulation opposing waiting periods for children. We thus recommend deleting Q.1 & 2.

XX. Review & sign

This section includes a number of contractions which are generally discouraged when information will be utilized by a low literacy population. We suggest CMS work with literacy experts to determine what language will be understood by individuals at the lowest literacy since any materials developed at low literacy levels will certainly assist individuals with higher literacy levels. Further, developing the information at a low literacy level will assist when information is translated since many LEP individuals may also have low literacy.

We appreciate that the application allows individuals to log in and out of the system and complete the application at a later date. In C, an individual may decide to stop the application to obtain required proof and then log back in to complete an application. We strongly encourage CMS to ensure that reminder messages are built into the system so that if an individual does not complete an application, the individual receives reminders – via email or regular mail – about what is missing and how to complete the process.

In D, we urge CMS to include specific information about traditional Medicaid and CHIP and explain to individuals that although they may be found initially eligible for APTCs or Medicaid expansion that the individual may get more coverage at lower costs if he submits an application for traditional Medicaid or CHIP. That is, the help text or instructions could include examples of individuals who may benefit from completing additional information for a traditional Medicaid eligibility determination. We strongly encourage this as all individuals have the right to the best coverage for their situation since it impacts their health and financial situation, not merely the default coverage which is most easily ascertainable.

We also believe the language regarding reauthorization, B, Q.4, is difficult to understand. Further, it does not explain how an individual can change this selection after the fact. That is, what if an individual selects “4 years” but later decides he want to change it to “1 year” or “Don’t renew”. How would the individual do this? We suggest CMS add additional language to clarify.

Further, in the section related to C, we believe each request for documents should have help text with instructions describing what is needed and where the applicant can obtain the document. With regards to the immigration document, additional help text should guide the application about what documentation is required.

In D, the eligibility results include information about “cost sharing reductions” (CSR) but since this is a new program, CMS should provide additional information about how the applicant can procedurally utilize the CSR and how it operates in practice, such as when the applicant accesses healthcare services. We suggest that CMS include information to help individuals identify if they may be eligible for non-MAGI Medicaid categories and the benefits of submitting additional information to obtain a full Medicaid determination. CMS should do this in a prominent way since it may be confusing for individuals who are eligible for APTCs/CSRs or MAGI-Medicaid to understand why providing additional information may actually benefit them even if they can get immediate coverage.

Further, the answers under D(d) include “Medicaid based on disability or age”. It is unclear that the application collects sufficient information to make this determination so we are unclear if this may be indicated to inform an individual to submit additional information. But in the interim, the individual may be eligible for Medicaid expansion or APTC and thus should also have eligibility indicated for that program.

We also believe this answer should help ineligible individuals obtain information about state- and local-based programs that may provide alternative coverage.

In D, Q.3 we strongly oppose asking the individual if she wants to withdraw the Medicaid application and "just get a tax credit." Many individuals will not understand the significant differences in services covered and cost-sharing required to make an informed choice. If an individual is indeed determined eligible for Medicaid, we believe the individual should receive Medicaid and not be asked to withdraw a Medicaid application. If CMS keeps this question, we believe that a withdrawal should automatically trigger additional written notice to the individual explaining the differences between Medicaid and an APTC, explaining if the individual is eligible for Medicaid, and providing the individual with resources to obtain additional information and an opportunity to reinstate Medicaid eligibility.

XXI. Plan enrollment (for APTC or QHP eligible applicants)

XXII. List applicants

XXIII. Tell us how many people are applying for health insurance

XXIV. Personal information

For the reasons stated above under VII.D, we strongly support collection of race and ethnicity data. We also urge CMS to include collection of language data in this section.

XXV. Other addresses

XXVI. American Indian/Alaska Native

XXVII. Special Enrollment Periods

This section asks if any individual lost health insurance in the past 60 days. Some individuals who have switched from employer-sponsored coverage to COBRA may not think they have "lost" coverage in the traditional sense. Thus, we suggest that either CMS add an additional question specific to COBRA or note in help text that if an individual switched to COBRA coverage, the individual should note "yes" for losing coverage and provide the date in Q.2 that the individual began COBRA coverage. An individual who has COBRA coverage yet is unemployed would likely be eligible for Medicaid, CHIP or APTCs and should receive this information so that he does not believe he is ineligible because technically he has some coverage.

XXVIII. Review & sign

We strongly support providing families with the ability to review and make changes to their applications prior to submission. We appreciate that CMS has built this into the

online application. The design of any of the application modalities should ultimately provide individuals with final control over their application information, allowing them to investigate any other options and potential consequences before formally submitting their application. This control would encourage participation among many applicants, but especially by mixed-status immigrant families who may want to research the potential immigration consequences of applying for health care after they have learned the extent of personal information they must provide.

Applicants should also have the ability to print a copy of their application for reference.

The amount of information needed to complete an application is substantial, complicated, and in some cases will require individuals to track down documents and other information not readily available. Regardless of the manner of application, individuals should be able to submit partially completed applications so that they can get the appropriate level of assistance and gather any relevant information. Individuals, should not, however, be forced to risk their date of eligibility to do so.

The ability to start and stop would also encourage participation by mixed-status immigrant families. These families may want to research immigration consequences of applying for health care after familiarizing themselves with the health care application and benefits, but before actually submitting the application on behalf of their household.

RECOMMENDATION*:* Inform the household contact of options and methods for controlling the information entered on the application, including for deleting, changing, or saving for possible submission in the future.

Further, states are prohibited from denying or delaying services to an otherwise eligible individual pending issuance or verification of an SSN by the Social Security Administration, an important protection for vulnerable families including immigrant and LEP families who often face problems with obtaining Social Security numbers. The Medicaid rules incorporate due process protections to help individuals correct inaccuracies in their records without forfeiting critical coverage. 42 CFR §§435.910(a), 435.952, 435.956, 457.340(b); 457.380(f); 45 CFR §155.315(f)(4).

RECOMMENDATION*:* Provide notice before an individual signs the application that Exchanges may not deny or delay services pending issuance or verification of an SSN, or on the basis of any information received unless they have sought additional information from the applicant, and have provided the individual with notice and hearing rights.

XXIX. Plan enrollment

We appreciate that individuals determined eligible will proceed immediately to plan enrollment. For some individuals, an immediate decision may not be advisable, particularly for individuals who may have chronic conditions or disabilities. These

individuals (as well as others) may want to ascertain whether they are Medicaid eligible under MAGI and obtain coverage quickly. However, if it appears under a MAGI income counting review that they are only eligible for Exchange coverage and APTCs, they may only have immediately available coverage that is not affordable.
We strongly suggest that individuals determined not to be eligible as well as non-applicants receive specific information about where they can access care. They may be ineligible for a variety of reasons including age (Medicare-eligible), immigration status, or receipt of COBRA. In each of these situations, we believe the online system must provide additional information about where care may be available. That is, an individual over age 65 should be directed to complete a Medicare application. Ineligible immigrants should be informed of emergency Medicaid, of Medicaid in a state that covers the fetus of a pregnant woman, and free care resources (such as community health centers). Individuals who are ineligible due to COBRA coverage should be informed that they can receive assistance once COBRA terminates or the individual chooses to terminate COBRA.

Conclusion

In sum, we are certainly encouraged at the progress towards a single, streamlined application. We hope that you will consider the improvements we have suggested. If you have questions about these comments, please contact Mara Youdelman, youdelman@healthlaw.org, (202) 289-7661. Thank you for consideration.

Sincerely,

Emily Spitzer
Executive Director