Center on Budget and Policy Priorities

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February 28, 2013

Office of Strategic Operations and Regulatory Affairs.
OMB, Office of Information and Regulatory Affairs,
Attention: CMS Desk Officer
Email: *OIRA_submission@omb.eop.gov*.

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the proposed applications that will be used to determine eligibility and to enroll individuals in the new health insurance exchanges, the premium tax credits and cost-sharing reductions for the purchase of coverage offered through such exchanges, and in Medicaid and the Children's Health Insurance Program.

Well-designed applications are vital to the success of the Affordable Care Act. Applications must collect all necessary information to facilitate accurate determinations, avoid creating barriers to eligibility and enrollment and ensure that consumers fully understand their rights and responsibilities when obtaining health coverage. Our comments include general observations on the process and flow of the applications as well as specific comments on sections of the applications.

We appreciate the attention that has already been given to creating applications that will make it as easy as possible for consumers to enroll in the program most appropriate for them. Our comments provide extensive recommendations that we hope are helpful to you as you further refine the data elements and design the model applications. States are eagerly awaiting the finalization of the HHS applications so that they can decide if they will use them, how they will modify them or if they will create their own applications.

Thank you again for the opportunity to comment. If you have questions, please contact Shelby Gonzales (gonzales@cbpp.org) or Judith Solomon (solomon@cbpp.org).

Sincerely,

Shelby Gonzales

Judith Solomon

Appendix A: List of Questions in the Online Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and Medicaid and the Children's Health Insurance Program

General Observations and Recommendations

The application questionnaire screens individuals for eligibility for advanced premium tax credits (APTC) before screening them for eligibility in Medicaid or the Children's Health Insurance Program (CHIP). For example, the first income questions all relate to information from federal income tax returns. Given that the assessment or determination of eligibility for Medicaid and CHIP is made before the determination of eligibility for APTC, the application should first screen for Medicaid and CHIP and then APTC. Income questions should first address current circumstances and then move to projected annual income for individuals that appear financially ineligible for Medicaid or CHIP based on current income.

"Help text" is not included in the draft application. Without this text, it is difficult to assess whether or not applicants will understand the questions. In our comments on the paper application, we provide recommendations for improving the instructions and notices. We ask that you consider those recommendations as you develop "help text" for the online application. We also strongly recommend that "help text" be developed with input from consumer advocacy groups and other stakeholders

The questionnaire should make it clear which questions are optional and which are required. It should also indicate what will happen if the applicant fails to provide information for a required field. The questionnaire identifies some questions such as middle name, suffix, telephone number as optional in the "my account" section and then does not specify that these are optional data elements in the household contact information section. These are questions that should always be optional and need to be marked as such throughout the application. The final application questionnaire should specify what will happen if a consumer does not provide required information. Required fields should be kept to an absolute minimum because applicants may not fully understand the questions or may not have the needed information at the time they are completing the application. The application should encourage consumers to complete the application to the best of their ability, and state Medicaid and CHIP agencies and exchanges should be required to set up processes to follow up with applicants when more information is needed to make the final determination.

It is confusing when key words such as "household and "family" and "exchange" and "marketplace" are used interchangeably throughout the application. We recommend using the same terms throughout and defining what they mean at the beginning of the application.

Throughout the application there is inconsistent use of directions which made it difficult to assess whether or not the application logic supports the accurate implementation of policy. Many questions indicate that specific answers lead an individual to skip to another question. In some cases the question says to continue to the next question, and yet other questions/answers do not have any information about which question the individual should go to next. All questions/answers need to be clear about what happens next for a particular individual. This clarity in directions is vital for state programmers who may use this logic in the development of state applications as well as for the contractors developing the federally facilitated exchange.

We recommend that consumer testing be ongoing throughout the development process. This testing should allow consumers to input their circumstances into a working online application that includes "help text." Consumer testers should include individuals with different incomes, literacy levels, immigration statuses and levels of English proficiency. Once the application is complete, HHS should put processes in place to gather feedback on the application from state workers, consumers, consumer assisters and advocates to ensure the application is meeting the needs of the diverse audience it will serve.

I. My Account

The process to set up an account should only request minimal information from consumers. The Food and Nutrition Services (FNS) has invested considerable effort in evaluating state online application practices and has given states specific guidance on what can and cannot be part of the process of setting up accounts for online applications. SNAP prohibits asking more than name, user name, password, and hint questions. We believe that health program applications should take a similar approach.

The account set up requires that an address be provided. This could be a barrier for consumers who are homeless. The process should be modified to ensure that people who are homeless can still apply for benefits.

We understand that the authentication process needs to occur prior to information being shared between the applicant and the federal data sources. However, the authentication process and the request for social security numbers (SSN) should not occur before applicants receive privacy-related notifications that explain why information is being collected, how it will be used, with whom it will be shared and how it will be protected. Authentication and collection of SSNs for anyone in the household should only occur after the account is complete, the appropriate privacy notices are provided and the consumer hits the "apply now" button. In addition, there will be people who do not have SSNs, home addresses, or other key information that will be used to complete the authentication process. The authentication process needs to allow a pathway for people in this situation to proceed with the application without tapping into the federal data sources in "real time." These consumers should not be forced to complete a paper application if they started their application online. Also, electronic data sources such as the Social Security Administration can be used to verify citizenship after a consumer completes the application.

Instructions for setting up an account should be clear and concise. Password requirements should strike a balance between protecting consumers and limiting burdensome and confusing requirements for passwords. For example, the website should offer tools such as check marks to show consumers whether they have satisfied password requirements. The number of secret questions and answers consumers must select should be minimized, and consumers should be able to select from a diverse list of questions so that they can pick questions that they can easily remember. Consumers should be told about the benefits of setting up an account (such as the ability to start and stop the application and later being able to check benefit status). They should also be given the opportunity to delete their account if they start the application and choose not to apply for benefits.

II. Privacy

The privacy notification in the draft is insufficient. It should be modified to more clearly explain how information will be shared, what entities will have access to the information and the purposes for which the information will be shared. Because families that include immigrants may be particularly concerned about disclosing their private information, this message should include reassuring language that explains that the information collected in the application will be used only to make health insurance coverage determinations.

III. Getting Started

The questionnaire is unclear as to how consumers consent to receive notifications through text messages and email. The current text reads "I can get information about this application by…" This should be re-worded to say "I want to receive information about this application by …" so that consumers understand that they are indicating a preference for receiving notifications, not just stating that they are capable of receiving information through text or email.

Additionally, consumers should be notified that any costs related to receiving text messages will be charged to them in accordance with their phone carrier agreement and that they can opt out of getting these messages at any time by texting stop or end, at which time the preferences will be reset to the default (mail or email if the consumer had also selected email as a way to get information).

Language preferences should be collected for each individual in the household. That way communications sent to adults about the application process, tax credits, renewal or how to access benefits can be made available in all of the languages to meet the needs of each individual in the household. The collection of this data can also help exchanges and state agencies with their outreach, staffing and document translation. Moreover, members of a household may end up in different programs so it will be important for each program to know the language of the household members enrolled in that program.

IV. B. Help Paying for Coverage

We support encouraging consumers who indicate they do not want help paying for insurance to learn more about the possibility that they may be eligible for help. However, because of the complexity of determining households and income, the screener may not effectively screen for potential eligibility for insurance affordability programs. There is not sufficient explanation to the consumer about which members should be counted towards their household size or what their "total income household income" should include. It may be more informative to give a few examples of families. These examples can provide information about these families' household composition, income (including an example that shows how some income such as child support is not counted). Then these examples can show the amount of subsidies the families could get if they applied.

This information should be provided when the consumer first indicates they are not interested in applying for help paying for coverage, but it should also be provided after the consumer begins the plan selection process and sees the price of coverage. At that point it would be good to give the

consumer the ability to seek help paying for coverage with the ability to import all data collected during the QHP eligibility process.

If the screening questions remain as currently drafted, question #2 should clarify what is meant by income.

VI. Family and Household

This section of the questionnaire is the most difficult to follow. We believe that consumers should be provided with instructions at the start of this section about whom to include in the household. Instructions can be adapted from the household instructions on page 2 of the proposed paper application (with modifications we suggest in our comments on the paper application.) We have provided several recommendations below to clarify these questions for consumers and for programmers who need to follow this logic when modifying the application for their states:

- Modify "Does [Household contact] plan to file federal income tax returns for [coverage year]" the first time this is asked of the household contact:
  - Make it clear that there is no requirement to file taxes (Medicaid/CHIP applicants are not required to file taxes, and those receiving APTC are only required to file taxes for a year they receive APTC so no filing requirement would apply in the first open enrollment period.)
  - Make it clear which year the question is asking about: "Does [Household contact] plan to file federal income tax returns for 2014 (the taxes for this year will be filed sometime in 2015)."
- The directions are not consistent in this section. Many questions indicate that specific answers would lead an individual to proceed to the next question or skip to another question, but in some cases there is no information about which question the individual should go to next. Without more clarity, it is difficult to follow and understand if households are being constructed in accordance with policies for APTC, Medicaid and CHIP.
- Q3 should be accompanied by an explanation that married couples are only eligible for APTC if they plan to file a joint return.
- We believe a number of modifications and clarifications to Q8 are necessary to streamline the application and avoid confusion. Specifically:
  - It is unclear why the application makes a distinction between natural, adopted, or step-parents and children. Such distinctions do not play a role in determining Medicaid, CHIP or APTC households. We recommend combining parents and step-parents into one category, and similarly combining son/daughter, stepson/stepdaughter and adopted son/daughter into one category.
  - Guidance is needed on who qualifies as a domestic partner.
  - A husband or wife cannot be the dependent of his or her spouse. Tax rules dictate that they either file jointly, in which case they are each considered taxpayers, or they file separately in which case they cannot claim the other spouse as a dependent. Thus, option A should be deleted.

- It is not clear that the household questions capture tax dependents who do not live in the household and are not seeking health care. Such individuals will still be included in the household of the taxpayer seeking APTCs.
- The use of the words "household" and "family" interchangeably is confusing throughout the application including in the title of this section. As noted earlier, we recommend using one word and defining it at the start of the application.
- The use of the term "dependent" is unclear at times as to whether it is referring to a tax dependent or a dependent for the purposes of health plan selection.
- The information provided in this document only outlines the flow of the application. We therefore could only assess whether sufficient information is collected about households to construct APTC and Medicaid households, but we have no way of assessing whether that information will actually construct households according to Medicaid/CHIP and APTC rules. HHS should provide the logic that will be used to construct the households.
- The term "household contact" seems to be misused in some places in the household questions. For example in Q7 it appears that the question is asking if any applicant is claimed as a dependent on someone else's return but instead refers to the "[household contact]."
- There are questions and answers that indicate a household is complete for an applicant when there may still be questions that the applicant needs to complete. For example in Q16 if you select "b. no", then the questionnaire says the household is complete, but there may be times when the individual has not yet been asked if they are married, and in that case they would have to answer Q23 and some people may have to answer Q28 as well.

VII. A. Personal Information

The privacy act notices are incomplete in Q2 when requesting a social security number (SSN). The uses of the SSN should be clarified. The SSN will be used to check income (as indicated) but will also be used to check citizenship status, duplicate program participation and tax filing. It's not sufficient to simply say "other information."

In Q3 it is unclear why the questionnaire asks everyone who provides a SSN if their name matches the name on their social security card. This should be a conditional question and only asked if there is a discrepancy.

VII. B. Citizenship/immigration status

In Q3 naturalized citizens are asked for their naturalization certificate or certificate of citizenship and/or alien number presumably to complete the verification process. Not all naturalized citizens will be able to easily access such numbers. Many adults became naturalized citizens when they were children and once issued passports they use passports as proof of citizenship. These individuals have no need to access their certificate of citizenship or naturalization certificate, and so they may not have them in their possession. Consumers should be given the option to respond: "I do not know" to these questions. Those that do so should be allowed to proceed with the application and be given the option to provide other acceptable evidence of their citizenship in accordance with the regulations at 42 CFR §435.407.

In Q4 the "eligible immigration status" question needs to be clarified. It is difficult to evaluate this question without seeing the detail of the information that will be provided in the link. Very few consumers will know what "eligible immigration status" means. This term does not refer to an immigration status. It refers to standards for eligibility for insurance affordability programs, and therefore most people will not know how to answer without the information that is provided in the link. Furthermore, the "eligible immigration status" term is unclear. If the list of statuses that will be listed in the link is the same as those provided in the proposed paper application, then those statuses are referring to the eligible immigration statuses for enrollment in qualified health plans and should be labeled as such. Medicaid standards differ except in the case where a state has opted to provide Medicaid to children and/or pregnant women without regard to the more restrictive Medicaid standard.

The questionnaire indicates that Q9 is going to be asked of everyone who has indicated they have an "eligible immigration status" and whose date of birth is prior to August 22, 1996. Presumably this is being asked to identify individuals for whom the five-year bar does not apply. The computer logic should skip this question for anyone who can be identified as being in a status that does not require a five-year wait before qualifying for Medicaid. This may be able to be determined for some individuals based on their document type and/or real-time verification with DHS through the federal data services hub.

VII. C. Parent Caretaker Relatives

The note to reviewers indicates that the "age of dependent children may be substituted as 18 instead of 19 in the logic of questions 1-5 for states that take up the option of counting full-time students as age 18." However, states must consider individuals *under* the age of 18 as children and states have the option to consider young people age 18 or older as children if they are fulltime students in secondary school or equivalent training and expected to graduate before age 19. These questions should also be moved so that they are only asked of those who appear to be eligible for Medicaid.

VII. D. Race and Ethnicity

Question 1 asks about Hispanic/Latino origin and then requests more detailed information about "ethnicity" listing specific places of origin. The word "ethnicity" before this list of specific places of origin is confusing and should be removed. The specific places of origin does not include Central or South America which are two places of origin for a large number of people who would identify themselves as Hispanic/Latino. The number of people identifying themselves as Hispanic/Latino is growing quickly in the US and large numbers of Hispanics/Latinos are uninsured and will qualify for insurance affordability programs. It is vitally important to improve the data collection for this group to better understand disparities.

VIII. Other Addresses

Question 3 asks if an applicant who lives outside of the home is doing so "temporarily." "Temporarily" should be defined for the consumer.

IX. Special Circumstances

We believe the current questions on disability that focus on 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 may be medically frail. Since the benchmark benefits available to newly eligible adults will likely be less robust than those in traditional Medicaid in most states, it is very important that applicants have a full opportunity to determine eligibility for the health insurance program that best suits their needs. Some individuals with incomes above 138 percent of the poverty line may be eligible for Medicaid, particularly those who may qualify under programs for working people with disabilities.

We support the comments submitted by the Consortium for Citizens with Disabilities in this regard, including their recommendation to use questions that have been tested and found to elicit the required information, and that are now being used in the American Community Survey. The questions should be accompanied by an explanation that applicants 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 were unable to fully assess Q3, Q4 and Q5, because we were unable to follow the logic. It is therefore unclear whether questions are appropriately accounting for state policy options. In one case, the questionnaire appears to ask for the same information from the applicant twice. We recommend reexamining these questions and consulting with state policy experts to ensure they are gathering the information needed to make accurate decisions.

X. Expedited Income

In the note to reviewers, you indicate that additional authentication "challenge" questions may be asked as part of this income section and that those questions will not be shared to protect the integrity of the system. We recommend that careful consideration be given to developing such questions to avoid undue burdens on applicants. As we mentioned earlier in our comments, HHS should clarify what will happen if consumers are unable to complete the authentication process.

As we mentioned earlier in our comments, we strongly recommend that the application first screen for Medicaid and then for premium tax credits. We believe that more individuals will understand how to answer questions about their current monthly income as opposed to projecting their annual income. Also, people who are eligible for Medicaid or CHIP are not eligible for APTC, so a thorough screen should be completed for Medicaid and CHIP prior to APTC. For these reasons we recommend switching the sequencing of these income questions to screen for Medicaid and CHIP before APTC.

To facilitate the collection of income information, we recommend adding a work sheet that will allow consumers to input information such as amount earned hourly and an approximate number of hours worked each week. A worksheet could also collect other key information such as contributions towards employer sponsored pretax benefits. This type of tool would improve the user experience and help insure accuracy of the information that is being collected.

In Q1 the questionnaire needs to clarify what is meant by "income." Because this is tax data, we presume the consumer will be presented with their modified adjusted gross income (MAGI) and

he/she will be asked to indicate what they expect their MAGI will be for the coverage year. We are concerned that consumers will not understand the amount of income that is presented. Most people will be familiar with their gross income for the year or they may be able to find their tax return and identify their adjusted gross income (AGI), but many applicants will not understand what the MAGI figure represents or how to project their MAGI for the coverage year. The help text provided on this screen should be worded carefully to help consumers understand what MAGI represents. Also, the application should ask a few questions to help the consumer estimate their MAGI for the coverage year rather than simply asking them to provide a figure without guidance.

We are concerned that if the applicant's attestation of income is above the applicable Medicaid/CHIP FPL income limit, then the consumer skips to Q2 rather than completing the current monthly income section. Applicants may not have all the information they need to make an accurate attestation. Applicants may not be able to answer Q2 accurately, because they may not understand how to calculate whether their monthly income is above the amount provided. For example, consumers may not know that their income does not include child support, so they may indicate that their income is higher than the Medicaid/CHIP limit. In that case they would be inappropriately moved in the direction of an APTC determination. Moreover, in some cases, an individual's current monthly income may be above Medicaid levels, even though their annual income is below Medicaid levels. This would be the case for people with seasonal employment, and many states take income fluctuations into account in determining Medicaid eligibility. As noted earlier, we recommend that the application be structured to determine eligibility for Medicaid and CHIP before APTC.

XI. Current/Monthly Income

See our comments on the "expedited income section" above regarding the authentication process.

We have a number of specific comments on this section:

- The questionnaire needs to provide clarification on what is meant by "income" throughout this section.
- In several places in this section the questionnaire indicates that there will be help text to explain what should and should not be reported. It is difficult to assess this section without seeing the help text.
- Questions 10, 11, 12, 13 and 15 should allow consumers to indicate that the income is received irregularly.
- Question 12 should also include a way to assess income for seasonal workers.
- Question 15 is strangely worded by starting with what the consumers do not have to list as other income. The question is also difficult to assess without the information in the link.
- Question 15 should clarify what is meant by "veteran's payments," MAGI excludes veteran's disability payments but not normal military retirement. The term "veteran's payments" may be interpreted to mean that all veteran's payments are excluded.
- It appears that the application will not take into account the exclusion of pre-tax deductions from wages from MAGI, which could include employer health insurance premium

contributions, child care, transportation benefit and retirement plan contributions. The application should include a way for consumers to provide this information as it may affect eligibility.

XII. Discrepancies

The purpose of this section is to display information about discrepancies when the household's attestation of their total income puts any applicant in Medicaid or CHIP range but the information available through electronic resources indicates that such an applicant is above the Medicaid/CHIP level. This section should also be completed when the opposite is true: the consumer attestations about income indicate they are in the APTC range and the electronic sources indicate they are income eligible for Medicaid/CHIP.

As mentioned in the other income sections, the application needs to clarify what is meant by income.

XIII. Health Coverage (APTC Eligible)

Consumers should be given information explaining why these questions are being asked and how the information in this section will be used. COBRA needs to be spelled out in Q4 and Q5 and the questionnaire should provide help text to explain what this is. People who have COBRA will probably know what it means but other applicants may not and may need additional information to know it does not apply to them. We are also concerned about the consequences of how individuals' APTC eligibility will be determined based on their answer to this question. Individuals cannot be eligible for APTCs if they are enrolled in COBRA coverage, but they have the option to drop that coverage and qualify for APTCs. Applicants who indicate that they are enrolled in COBRA should not automatically be determined ineligible for APTCs. Rather, applicants should continue to be evaluated based on income and other eligibility factors and if, based on those factors, an applicant is determined eligible for APTCs, the applicant should be informed of his or her choice to continue COBRA coverage and forgo eligibility for APTCs, or drop COBRA coverage to qualify for APTCs.

XIV. Employer Health Insurance Information

This section should be labeled to only apply for those who appear eligible for APTC

While we recognize the challenges that HHS faces in determining whether applicants have access to affordable employer-sponsored coverage, we have significant concerns regarding the approach described in the questionnaire.

As we noted in our comments on the "Verification of Access to Employer-Sponsored Coverage Bulletin" we believe it is unrealistic to assume that consumers will be able to gather and provide complex data and information regarding their employer-based coverage such as information on the lowest-cost plan offered by their employer that meets "minimum value." Applicants are not likely to know what "minimum value" means and will not be able to determine which of the plans offered by their employers meet this standard. Moreover, they are not likely to be able to speculate about whether their employer health coverage will change and will not be able to answer questions about what they expect their employer will do. Even information requests that seem straightforward might

be difficult for people to comprehend and respond to. For example, does "plan name" mean the name of the health insurer providing the plan, the name of the type of plan (HMO, PPO, etc.), or the brand name used in marketing materials? Also, Q7 asks for the person with an offer of employer coverage to say how much it would cost to enroll in the lowest-cost employer plan. But it may not be clear that the person should provide the premium amount for self-only coverage rather than family coverage that may also be available.

We also believe that the alternative approach that requires employees to obtain the information directly from their employer would be burdensome and may unnecessarily delay enrollment. This approach would require a consumer to print up a form (assuming they have printer capability), stop the application, get their employer to fill out the form and then resume the application with the employer information at hand. We believe this approach is not consistent with a streamlined, "real-time" application process. We also believe that stopping the application to gather additional information may result in some consumers never resuming the application. Moreover, some employees may be concerned about their employer's response to this request for information, especially if his/her employer has voiced concern about being negatively affected by the health care law as we have seen when employers earlier this year suggested that they will cut employee hours to avoid penalties for not providing health insurance coverage.

We understand that in 2015, employers will begin providing information to workers about the details of employer offers of coverage. Prior to that time, there will be a much greater burden on workers to ferret out the information they need in order for the exchange to determine whether they are eligible for APTCs. To ease this burden, we urge HHS to issue a template Employer Coverage Form, which is referenced in the draft online application, as soon as possible this year and prior to the exchange open enrollment period that begins October 1, 2013. HHS and the Department of Labor should urge employers to fill out the form as completely as possible and provide it to employees rather than waiting for people to request it. In many cases, employers will already be considering during 2013 what benefit options to offer in light of the ACA and the level of contributions they will make to workers' premiums. To the extent that an employer knows this information within the initial open enrollment period, it should be provided to employees so that they can provide accurate information to the exchange. This approach would be beneficial to many employers, as it would help them to avoid responding piecemeal to a flood of worker requests for this information. Ensuring that employees have the correct information about employer offers would also reduce the cases when employers would have to appeal HHS or IRS determinations should any employees incorrectly receive APTCs.

Applicants completing an online, telephone or in-person application should only be asked to provide detailed information on their employer coverage when they need to establish eligibility for APTCs on the basis of having employer-based coverage that is unaffordable and/or does not provide minimum value. All applicants should only be asked basic questions pertaining to their employer and whether they have an offer of coverage. More complex questions related to the availability of affordable, minimum value coverage should be asked only after an applicant who is potentially eligible for APTC based on income and other information indicates that he or she has an offer of employer coverage.

We are concerned about question nine, which asks applicants who have not provided information about the premium cost of an employer offer or who appear to have an offer that is affordable, whether they think the coverage is affordable. We suspect that many people may respond that they

think an employer offer of coverage is unaffordable, even if it does not meet the technical definition of that term contained in the ACA and related regulations. It is unclear from the online application form what the consequences are of answering this question. If a person says that she thinks the coverage is affordable, does this mean she will be found ineligible for an APTC? If the person says that she thinks the coverage offer is unaffordable, does that mean she could be found eligible? If this question is retained in the final application, it should define what is meant by affordable, and should notify the applicant of the consequences of the answer at the point that the question is being asked.

XVII. Tax filer information and Other Information

This section should be labeled to only apply for those who appear eligible for APTC .

XVIII. Special Enrollment Periods

The application should be modified to include all special enrollment periods that have been included in the proposed regulations. We note that there are a few special enrollment periods for which there are no applicable questions in the application. For example, the proposed regulations allow for a special enrollment period in cases when a person is aware that they will soon lose qualifying coverage in an employer-sponsored plan. The application asks about loss of health insurance in the last 60 days, but this does not account for situations where the loss of coverage is anticipated and has not yet occurred. In addition, individuals are entitled to a special enrollment period if HHS, the exchange, or instrumentalities of the exchange have caused an error or delay. We would expect individuals to seek eligibility from the exchange for a special enrollment period (as well as for APTCs), so the application should be modified to ensure that all available special enrollment periods are appropriately reflected.

In our comments on the proposed regulations at §155.420, we recommended a number of changes and clarifications related to special enrollment periods (SEPs) in a qualified health plan. In particular, we believe it is critical to ensure that people found newly eligible for APTCs and CSRs are able to access a special enrollment period, even if they have not already enrolled in a qualified health plan. Should HHS accept our recommendations to the proposed regulations, the online application should be modified to align with the changes and clarifications we have recommended.

XIX. Medicaid and CHIP Specific Questions

We strongly recommend collecting detail about health coverage after enrollment in coverage. While we understand it is easier for states to collect such information at the point of application, this information is not easy for consumers to provide and may deter or delay some consumers from completing the application. Question 3 may be difficult for consumers to answer. As we mentioned in section XIV, while it may seem straightforward to ask about the "health plan name" it may be unclear to a consumer what is meant by this question. Is it soliciting the name of the health insurer providing the plan, the name of the type of plan (HMO, PPO, etc.), or the brand name used in marketing materials?

XIX. A. Medicaid Specific Questions

Question 2 repeats the information collected in Q1 of XIX.

XX. B. Review and Sign

Question 2 should make it clear that a parent can choose to forgo applying if he/she does not want to cooperate and that this will not affect the eligibility determination of the child.

Question 5 is inconsistent with regulations that focus on reporting changes that can affect eligibility. A timeframe should also be added so that consumers know they have a certain number of days to report a change. It also would be helpful to remind those who qualify for APTC that reporting changes could avoid liability to repay excess premium credits at tax time.

XX. C. Review and Sign

Item 6 should let the consumer know to send in required documents along with an identifier [defined by the state and the exchange] that will ensure the state can match up documents with the correct application.

Application for Health Insurance (And to Find Out If You Can Get Help With Costs)

General Observations and Recommendations

We support including placeholder language that directs consumers to a phone number for help. Many applicants will likely need help completing the application and assistance will be available through navigators, toll-free hotlines, and other consumer assistance programs. It will be important for the application to include information about these resources.

We support including a tagline in Spanish on every page that directs consumers to a phone number they can call for assistance. However, we believe that the application should be improved by including taglines in multiple languages to meet the needs of people with limited English proficiency (LEP). Title VI of Civil Rights Act of 1964 requires the provision of language services by federal fund recipients and HHS' Office for Civil Rights has longstanding "LEP Guidance" which defines the expectations for language services. Following these guidelines is important to ensure that the approximately 23 percent of exchange applicants expected to speak a language other than English at home have equal access to new coverage opportunities available through health reform. The model HHS application should include taglines in no less than the 15 most prevalent languages instructing consumers on how to access applications and phone assistance in their language. The 15 taglines do not have to appear on every page, but they should at least appear on the first page.

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

Page One: Application Introduction

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

In the section "What you may need to apply," it should be clarified that social security numbers (SSN) and immigrant numbers will only be needed for those applying for health coverage. We understand that the application later suggests that non-applicants can choose to provide an SSN, but it is more important to reassure those who may not have these numbers that they can still apply on

behalf of others in their household at the start of the application. Keeping the language as it stands could deter families with members without SSNs from applying.

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

Step 1: Tell Us About Yourself

- It should be made clear that the person completing this section should be someone in the family who is seeking benefits for at least one person in the family and that the person should be an adult. Otherwise, if someone is helping the family (friend, neighbor, application assister) the person providing assistance may think this section should be completed with his or her information.
- Consumers opting to get information about the application via text should be informed that any costs related to receiving such messages will be charged to them in accordance with their phone carrier agreement and that they can opt out of getting these messages at any time.
- Language preferences should be collected for each individual in the household. That way communications sent to adults about the application process, tax credits, renewal or how to access benefits can be made available in all applicable languages. The collection of this information can also help exchanges and state agencies with their outreach, staffing and document translation planning.

Step 2: Tell us about your family

We support inclusion of the language indicating that information shared on this form will only be used for making health insurance coverage determinations, but we believe the privacy notification is insufficient, and should be modified to more clearly explain to consumers how information will be shared, what entities will have access to the information and for the purposes for which the information will be used. This can help ease concerns for families that include immigrants who may be particularly concerned about disclosing private information.

Step 2: Person (1-6)

- The directions state "Complete Step 2 for 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." This conflicts with the directions on page 2 that indicate that family members who should be included are "your spouse, partner (if you have shared children applying for coverage), children (who live with you) or anyone on your tax return, and then says anyone else needs to file his or her own application. So, for example, if there are two brothers that live together but are not on the same tax return, it is not clear whether they both should be included on the same application. Directions on page 2 suggest they should not, but the

directions for step 2 suggest that they both should be listed in the application. This should be clarified and directions on both pages should be consistent.

- The privacy act notices are incomplete when requesting an SSN. We recommend clarifying the uses of the SSN — to check income (as indicated), check citizenship status, duplicate program participation and tax filing. It's not sufficient to simply say "other information".
- The application needs to be specific about timeframes. When asking if the person plans to file federal tax returns in the next year, the application should indicate the year, since "next year" is vague and confusing. If the consumer is applying in January of the first enrollment period, is the application asking if the person plans to file taxes for year 2015 or 2014?
- We believe it is unnecessary to make a second request for an SSN of applicants. In the first request, the corresponding notice indicates that those applying need to provide their SSN if they have one. This second request is duplicative and should be removed.
- The question "Have a disability" is insufficient. Please see our comments on the online recommendations, which adopt the recommendations of the Consortium for Citizens with Disabilities (CCD) regarding the use of field-tested ACS survey questions.
- The question about "eligible immigration status" needs to be clarified. The list of statuses on page 20 refers to the eligible immigration statuses for enrollment in qualified health plans. Medicaid standards differ except in the case where a state has opted to provide Medicaid to children and/or pregnant women without regard to the more restrictive Medicaid standard. We recommend revising the term "eligible immigration status" to say something like: "eligible immigration status for enrollment in qualified health plans."
- The instructions need to provide additional information about what is meant by "Document Type" and "ID Number" so that consumers know what they need to provide.
- The wording of the question "If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply)" is unclear. We recommend revising this to read: "Check all that apply if person 1 is Hispanic/Latino. (optional)" In addition, we recommend that the check off options provided to those persons indicating they or Hispanic/Latino include Central and South American, which are two places or origin for a large number of people who would identify themselves as Hispanic/Latino. The number of people identifying themselves as Hispanic/Latino is growing quickly in the US and large numbers of Hispanics/Latinos are uninsured and will qualify for insurance affordability programs. It is vitally important to improve the data collection for this group to better understand disparities.
- When requesting ethnicity and race data, consumers should be told that the information is used to ensure that there is equal access to health coverage and not to make the eligibility determination.
- The "current job and income information" section should include a question that allows consumers to indicate that they have seasonal employment, or that their hours and/or pay varies seasonally.
- The question "In the past 6 months, did PERSON 1:" seems to only apply to persons who have a second job. We recommend changing the formatting so that it is clear that this question is being asked of everyone not just those who have a second job. Additionally there should be an added answer that allows consumers to indicate that they have had an increase or decrease in pay.

- In the "other income" section there is a note indicating that consumers do not have to include information about "veteran's payments." MAGI excludes veteran's disability payments but not normal military retirement. This should be clarified since the term "veteran's payments" may be interpreted to mean that all veteran's payments are excluded.
- The application does not collect information on pre-tax deductions from wages, such as employer health insurance premium contributions, child care, transportation benefit and retirement plan contributions. These pre-tax deductions will affect applicants' MAGI income, and could influence whether applicants are determined eligible for Medicaid/CHIP or APTCs. Given the impact of these deductions on eligibility, the application should include a way for consumers to provide this information.

Step 3: Your Family Health Insurance

It is unclear why this page requests an SSN again. This question should be deleted.

While we recognize the challenges that HHS faces in determining whether applicants have access to affordable employer-sponsored coverage, we have significant concerns regarding the approach used in the application.

As we noted in our comments on the "Verification of Access to Employer-Sponsored Coverage Bulletin" we believe it is unrealistic to assume that consumers will be able to gather and provide complex data and information regarding their employer-based coverage such as information on the lowest-cost plan offered by their employer that meets "minimum value." Applicants are not likely to know what "minimum value" means and will not be able to determine which of the plans offered by their employers meet this standard. Even information requests that seem straightforward might be difficult for people to comprehend and respond to. For example, does "name" of the plan mean the name of the health insurer providing the plan, the name of the type of plan (HMO, PPO, etc.), or the brand name used in marketing materials?

We also believe that the alternative approach that requires employees to obtain the information directly from their employer would be burdensome. Some employees may be concerned about their employer's response to this request for information, especially if his/her employer has voiced concern about being negatively impacted by the health care law as we have seen when employers earlier this year suggested that they would cut employee hours to avoid paying penalties for not providing health insurance coverage.

We understand that employers will need to begin providing information to workers about the details of employer offers of coverage in 2015. Prior to that time, there will be a much greater burden on workers to ferret out the information they need in order for the exchange to determine whether they are eligible for APTCs. To ease this burden, we urge HHS to issue a template Employer Coverage Form, which is referenced in the draft online application, as soon as possible this year and prior to the exchange open enrollment period that begins October 1, 2013. HHS and the Department of Labor should urge employers to fill out the form as completely as possible and provide it to employees rather than waiting for people to request it. In many cases, employers will already be considering during 2013 what benefit options to offer in light of the ACA and the level of contributions they will make to workers' premiums. To the extent that an employer knows this information within the initial open enrollment period, it should be provided to employees so that

they can provide accurate information to the exchange. This approach would be beneficial to many employers, as it would help them to avoid responding piecemeal to a flood of worker requests for this information. Ensuring that employees have the correct information about employer offers would also reduce the cases when employers would have to appeal HHS or IRS determinations should any employees incorrectly receive APTCs.

We are also concerned about the question which asks applicants whether they think the coverage offered to them is affordable. We suspect that many people may respond that they think an employer offer of coverage is unaffordable, even if it does not meet the technical definition of that term contained in the ACA and related regulations. It is unclear what the consequences are of answering this question. If a person says that she thinks the coverage is affordable, does this mean she will be found ineligible for an APTC? If the person says that she thinks the coverage offer is unaffordable, does that mean she could be found eligible? If this question is retained in the final application, it should define what is meant by affordable, and should notify the applicant of the consequences of the answer at the point that the question is being asked.

As noted in our comments on the online application, we are concerned about the consequences of how individuals' APTC eligibility will be determined if they indicate they are enrolled in COBRA. Individuals cannot be eligible for APTCs if they maintain COBRA coverage, but they have the option to drop that coverage and qualify for APTCs. Applicants who indicate that they are enrolled in COBRA should not automatically be determined ineligible for APTCs. Rather, applicants should continue to be evaluated based on income and other eligibility factors and if, based on those factors, an applicant is determined eligible, the applicant should be informed of his or her choice to continue COBRA coverage and forgo eligibility for APTCs, or drop COBRA coverage to qualify for APTCs.

Step 5: Please Read and Sign This Application

It is unclear why there are two places to collect the signature for the application. One place to sign is sufficient and it may be confusing to have two places without any direction about who should sign in the two places.

Step 6: You Can Choose and Authorized Representative

Consumers should be informed that they are able to terminate the authority of their representatives at any time.