America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

February 1, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–10440
7500 Security Boulevard, Room C4–26–05
Baltimore, MD 21244–1850

Submitted electronically via www.regulations.gov

RE: Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid and Children's Health Insurance Program Agencies (CMS–10440) – AHIP Comments

Dear Mr. Slavitt:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Information Request related to the data collection to support eligibility determinations for insurance affordability programs and enrollment through health benefits Exchanges, Medicaid and Children's Health Insurance Program (CHIP) Agencies, published in the *Federal Register* (80 FR 75464) on December 2, 2015 and the subsequent detailed information posted on the CMS Paperwork Reduction Act (PRA) website.

In revising the application, we ask you to consider: 1) proposed new questions and verification processes for special enrollment periods (SEPs) and reporting life changes; 2) recommendations for a more flexible application and sequence for direct enrollment issuers; 3) additional application questions and up front verification of Medicare eligibility so consumers avoid enrolling coverage through a QHP, and potentially receiving advance premium tax credits (APTC) to which they are not entitled, instead of Medicare; and 4) application changes aimed at reducing the number of individuals that are flagged for a data matching inconsistency (DMI).

To date, issuers observed a high volume of SEP enrollments for a wide range of issues. While SEPs are needed in limited scenarios to accommodate consumers who experience major life events, the broad availability of SEPs is increasingly threatening the stability of health insurance exchanges. Issuers have reported significant enrollment volumes outside of the annual open enrollment period, which negatively impacts the risk pool and increases the costs of coverage for all consumers. Now is time to revise the application to encourage enrollment during the annual

open enrollment period, limit SEPs to those who truly qualify and verify eligibility for SEPs. We recommend HHS revise the eligibility application to leverage the experience from the first two years of Exchange enrollment and help stabilize the Exchange risk pool while ensuring consumers are covered for the full benefit year.

Given the proposal in the 2017 Payment Notice that would eliminate the need to redirect to the healthcare.gov website in order for an applicant to obtain an eligibility determination, we recommend HHS use this PRA to streamline and make more user-friendly the application experience for consumers throughout all enrollment channels by providing both issuers using the direct enrollment channel and web-based entities the flexibility to make changes to the application language or sequence to allow them to provide the best enrollment experience to consumers. Allowing changes or additions to the application will encourage development of the most effective ways to communicate with consumers during the application process. This will ensure a straightforward enrollment process for consumers and provide the Exchange with innovative options for future improvements to the Exchange application.

Finally, we recommend that HHS review "optional" application questions and ensure that all information necessary to verify eligibility and support issuer and Marketplace outreach to enrollees be required. The application should clearly state that a consumer's eligibility determination and their experience with their health plan will be negatively impacted if all critical information is not supplied.

Maximize Enrollment during the Annual Open Enrollment Period: Special Enrollment Period Changes

To date a higher volume of SEPs was to be expected because of coverage lapses for transitional policies, some small employers dropping coverage, and transitions between Medicaid and Exchange coverage, each of which trigger the SEP-qualifying event for loss of minimum essential coverage or MEC. While SEPs ensure continuity of coverage during transitions (e.g., job changes, marriage, new dependents, etc.), the current list of SEPs is expansive and negatively impacts the overall risk pool of Exchange enrollees, with SEP enrollees incurring higher costs than the rest of the ACA risk pool. Moreover, late enrollees and their insurers cannot realize the full benefit of care management and consumer-focused value based care programs.

As part of the changes for the fourth open enrollment, collectively we should work to maximize enrollment during the open enrollment period stressing the importance of full year enrollment. We recommend that HHS streamline the existing SEPs to promote enrollment stability and affordability. HHS should reduce the number of SEPs to more closely align with those used in Medicare Advantage, FEHBP and pre-ACA HIPAA criteria. Currently, of the 34 Exchange SEPs, only seven are shared with Medicare and three with pre-ACA HIPAA criteria. HHS should also add new questions and request specific documentation in certain circumstances when

consumers are requesting an SEP outside the annual open enrollment period. In addition to addressing SEPs at the Federal Marketplace, HHS should concurrently work with State-based Marketplaces to encourage them to adopt similar policies and processes regarding SEPs and SEP validation.

Comments on Section G: Special Enrollment Periods

- **HHS should validate SEPs by requesting documentation to verify the applicant qualifies.** We have included a proposed list of documentation in the Appendix. For off-Exchange coverage, health insurance issuers require documentation of SEPs before enrollment (e.g., marriage or birth certificates to document loss or addition of dependents or a current utility bill or lease/rental agreement to validate a permanent move). Consumers are used to providing this information when they apply for coverage. Thus, we recommend that HHS establish a similar infrastructure and processes for the Federal Marketplace to verify eligibility. We recommend that HHS conduct additional eligibility checks using existing data prior to granting an SEP and make changes to healthcare.gov to allow consumers to upload documentation as proof of eligibility. In the event that the Exchange cannot obtain proof of a qualifying event from an enrollee or establish the infrastructure in a timely manner we recommend the Exchange make available a process for issuers to request termination if SEP eligibility is not able to be verified.

- **If HHS is unable to implement infrastructure changes this year, issuers should have the option to collect information from the enrollee to validate SEP eligibility.** We recommend that HHS revise the application to indicate that health insurance issuers may request documentation of the requested SEP and allow issuers to terminate an enrollment if SEP eligibility cannot be verified. This will establish the framework for HHS should verify eligibility prior to approving an application for SEP enrollment. In addition, HHS should establish a process for issuers to report to the HHS enforcement unit SEP enrollments that do not appear to adhere to SEP eligibility requirements. For example, if a consumer enrolls in coverage using the MEC SEP but the issuer's records indicate the consumer was recently terminated due to non-payment of premiums, the issuer should be permitted to submit this case for review.

- **Question G-1: As a first step towards SEP validation, HHS should confirm that enrollees who request the "loss of MEC" SEP had prior coverage.** The application should request specific information including the name of the insurer, type of coverage and policy ID numbers.

- **We recommend questions about current health coverage are included, including questions asking if a person is currently covered by Medicare, regardless of whether a**

person is potentially eligible for Medicaid/CHIP or APTC/CSRs. We recommend the following new questions are added:

1. What was the name of your prior insurer?
2. Please indicate the type of coverage (coverage through work, Medicare, Medicaid, CHIP, etc.).
3. What was your policy ID number?

- **We recommend Question G-1 is revised to state this SEP does not apply to enrollees who have recently lost coverage due to non-payment of premium.** HHS should leverage issuer data to validate and enforce this. At the time of application, HHS should check issuer-submitted data on terminations due to non-payment of premium when an applicant selects the "loss of MEC" SEP. If the enrollee was recently terminated due to non-payment, the Marketplace should reject the SEP request. In our comments on the Payment Notice, we recommended HHS permit issuers to reject an enrollment with a "loss of MEC" reason code, when the issuer has their own record of non-payment within the 60 day SEP window.

- **Question G-11. Regarding the permanent move SEP, HHS should validate that the applicant intends to reside at that address by collecting documentation.** We also recommend that the language regarding out-of-state moves ("if an enrolled person is moving out of state, consider applying for coverage …") is broadened to ask about all moves as moves within the same state may have plan eligibility impacts or rating changes, and at minimum would require updates to the person's FFM data. Ideally, HHS should undertake system updates, so that the new address entered by the consumer (including state abbreviation) would trigger a comparison between the current address listed in the account or by using the Plan ID to cascade the next set of questions (in-state versus out-of-state move). Otherwise, a static list of questions would determine whether the move was within the state but in a new zip code/county as the prior address, or to a new state would cascade from the "yes" response and the new address entry.

- **We recommend that the Marketplace share information about prior coverage with the issuer at the time of enrollment.** As the Department matures the Marketplace and develops additional marketing strategies to reach the uninsured population, it is critical that both HHS and health insurance issuers are able to identify at the time of application and enrollment whether the member currently has insurance. This information can also support the verification of SEPs as noted above.

- **HHS should review the current questions in Section G to see if they can be combined. For example questions 1-4 include questions that were added to the application at two different times, and could be combined for efficiency with a question re-write.** After

grouping any related questions into groups, they should be priority tiered based on statistics representing which SEPs have been selected most in the prior benefit year.

Comments on Section D: Report a Life Change

Question D-1 asks "Have you had any changes like these?"

- You moved to a different state
- You lost your job, got a new job, or your income changed
- You or one of your dependents turned 26
- You had family changes, like a new baby or a divorce

Important: Check your income information frequently. Your eligibility for help with costs is based on factors including your household income. Accurate information will help you get the right amount of help and avoid differences when you file your federal income tax return.

- **We recommend that instead of a passive statement regarding reporting income changes this should be changed to a Yes/No Question.** The statement is currently a passive entry that is read-only which may be quickly skipped over. We recommend it is changed to direct question asking if they have experienced an income change, with an affirmative Yes or No answer required, before final submission of *any* SEP entry.
    - Many of the common SEPs can result in or include changes to the income reported (marriage, death, divorce, newly eligible due to loss of MEC, and even moving, since that could be job-related).
    - Requiring people to affirmatively confirm whether the SEP they are applying for also could impact their reported income information accounts for the full impacts of a life change, and better engages people about the need to report income changes.
    - This point could even be taken one step further, and the FFM could automatically check the SEP applicant against the Data Hub/other data repositories every time – this base functionality could be of assistance to the FFM as HHS increases its data verification abilities.

- **Regarding the question about dependents turning 26, we recommend the Marketplace capture different state age-off requirements.** For example, if the FFM account has a Florida address the SEP question could ask if the dependent is turning age 31 rather than 26 because state law extends the limiting age past the federal minimum standard. In the interim, we recommend HHS add a parenthetical to note that certain states have different age cut-offs.

Allow Flexibility to Streamline the Application

In the Notice of Benefit and Payment Parameters for 2017 Proposed Rule, HHS proposed changes to direct enrollment functionality to allow issuers and web-based entities (WBEs) that support direct enrollment to host the end-to-end application, plan selection, and enrollment process on their direct enrollment web sites. We support this proposed change, which would allow issuers and WBEs to leverage a web service to host the application and eligibility application on their website without disruptions in the process for consumers. In order to promote an enhanced enrollment experience for consumers, we also support the flexibility for issuers and WBEs to make changes to the wording or order of application questions. This would allow issuers and WBEs to re-order questions, modify wording, and provide additional help text to ensure a streamlined, user-friendly application experience similar to vendors such as TurboTax that provide a simplified online tax filing experience. We recommend the PRA is updated to reflect this flexibility.

In addition, we request that HHS work collaboratively with issuers to re-organize the application flow to more intuitively arrange the questions. For example, within the SEP section, questions about whether a person has moved should be connected to a request for the new address rather than having the move questions and the address questions separate. It would also prioritize the reporting of ANY address change, which is important from a data maintenance perspective to ensure the ability to contact members even if there are no associated plan or rate impacts. During this re-organization and associated re-working of the application, we recommend that beyond conducting consumer testing, the FFM also look to industry innovations and SBEs to leverage positive developments in exchange consumer interfaces. For example, the Colorado Exchange (C4HCO) has an APTC estimator tool that represents a good consumer interface: people-friendly, understandable, and engaging.

Validate Medicare Eligibility to Ensure Consumers Enroll in Appropriate Coverage

In our comment letter responding to the 2017 Payment Notice Proposed Rule, we made several recommendations related to Medicare eligibility status to avoid enrollment of individuals enrolled in or eligible for Medicare in QHP coverage. In those comments, we provide an overview of the disconnect between Medicare anti-duplication laws, guaranteed availability and guaranteed renewability, and lack of Exchange tools to prohibit enrollment of these individuals in subsidized coverage that places issuers at risk of anti-duplication penalties. Thus, we recommend additional front-end measures to identify individuals who are eligible for or enrolled in Medicare, similar to current screening for Medicaid or CHIP eligibility, to avoid enrolling these individuals in QHPs. This would also help avoid payment of APTC or CSR on behalf of Medicare eligible individuals, who are not entitled to subsidies and would subsequently have a tax liability to repay subsidies paid on their behalf.

Specifically, we recommend adding questions to the Exchange eligibility application to screen for Medicare eligibility or enrollment. Issuers are prohibited from knowingly enrolling Medicare eligible, entitled, or enrolled individuals in coverage, including through an Exchange. However, Exchange issuers do not conduct an eligibility determination. Eligibility determinations are solely the responsibility of the Exchange and issuers must enroll individuals based on the Exchange's determination of eligibility. Screening questions at the time of initial enrollment or renewal should identify applicants who meet Medicare age (over age 65) and disability (including end-stage renal disease) criteria. If an individual meets those criteria, a pop-up notice should inform the individual of their potential Medicare eligibility, explain that Medicare-eligible individuals are not eligible for Exchange subsidies (and that they may face penalties if they do receive APTC), and redirect those individuals to additional information about Medicare eligibility and enrollment. If an applicant who meets these criteria proceeds to submit an application, the Exchange should verify Medicare enrollment against HHS databases and deny eligibility for individuals enrolled in Medicare.

Require Information Needed to Verify Eligibility and Enroll a Consumer in Coverage

Improvements to the eligibility application should also ensure that all data necessary to verify eligibility is required and ensure critical information is available to issuers to ensure timely effectuation of the enrollment and avoid any disruptions in coverage. Specifically, information needed to verify eligibility should be required, not optional, to reduce the volume of data matching inconsistencies. We recommend that Social Security Number (SSN) be a conditionally required field on the application to ensure any consumer with an SSN submits it. For example, SSN could be a two-pronged question: 1) Do you have an SSN? (required – Y/N); If Yes, then 2) Enter your SSN (required). Additional language may be needed within the application to explain that SSN is needed to verify eligibility and avoid a data matching inconsistency that could result in a gap in coverage and also underscore the security of information submitted on the application.

In addition, some optional information, such as email address, is important for both the Marketplace and issuers to conduct critical enrollee outreach, including new member materials, information about payment deadlines, casework follow-up, data matching inconsistency outreach, etc.. We recommend this data element is required prior to strong language explaining the potential impact of not providing that information.

Thank you for the opportunity to comment on this PRA. Our comments on the eligibility application are intended to offer workable solutions to improve the application for consumers while ensuring a stable risk pool. We would be pleased to discuss these comments with you in detail at your earliest convenience. Please do not hesitate to contact me if you have any questions at 202-861-1491 or jthornton@ahip.org.

Sincerely,
/S/

Jeanette Thornton
Senior Vice President
Health Plan Strategy and Operations

Appendix

Below are examples of the kind of documentation the FFE should be requiring to ensure SEPs are properly verified:

Qualifying Life Event List	Documentation Needed
Adoption or Birth of Child (Foster Child in CO, FL, NC)	If there are **NO** child(ren) listed **OR** child(ren) listed were not born in the past 60 days: Question applicant why no child(ren) are listed and/or why child(ren) listed were not born in the past 60 days. Request Copy of Adoption Papers **OR** Copy of Birth Certificate
Court Order or Guardianship	Request Copy of Court Order
Gain citizenship or legal resident	**Citizenship:** Copy of Naturalization Papers **Legal Resident:** Copy of Green Card, Educational Certificate OR VISA
Marriage (includes Civil Union and/or Domestic Partner)	If couple is not listed, will need the following: Copy of Marriage Certificate, Civil Union Certificate **OR** Domestic Partner Certificate
No Longer Incarcerated	Dates they were incarcerated **AND ONE** of the following: Documentation from Attorney, Correctional Facility **OR** Probation Officer they were convicted of a crime and sentenced/served time in jail or prison AND date they are no longer incarcerated
Permanent move/relocation outside of plan's service and/or to another state	Prior residential address **AND** dated proof of current residential address by providing **ONE** of the following: Mortgage Bill / Renter's Agreement with new residential address and occupancy date **OR** Driver's License with new residential address **OR** Utility Bill with new residential address showing service start up charges **OR** Postal Service change of address receipt (old address/new address/effective date) **OR** Moving company receipt (indicates prior and current addresses)
Permanent move/relocation from another country to US.	Prior residential address **AND** dated proof of moving/returning to US residential address by providing **ONE** of the following: Copy of Naturalization Papers **OR** Copy of Green Card, Educational Certificate OR VISA **OR** Copy of US passport with date stamp of returning to US **NOTE-**Additional proof of establishing residency in US may be

Qualifying Life Event List	Documentation Needed
	required
Business Group of One is terminated due to affordability	A letter from employer on Company letterhead and signed/dated by an officer/owner of the Company
Divorce or legal separation results in you and/or your dependents' losing coverage under your spouse's health insurance	Copy of Certificate of Creditable Coverage **OR** Copy of Termination Letter from existing/prior Insurance Company
Employer changes group coverage to another carrier and new premiums are unaffordable	A letter from employer on Company letterhead and signed/dated by an officer/owner of the Company indicating new premiums.
Employer reduces your hours, leaving you without coverage	A letter from employer on Company letterhead and signed by an officer/owner of the Company indicating reduction in hours and loss of coverage
Employer sponsored and/or Group coverage terminates due to non-payment of premium by the Employer – Employees can use this as a QLE	Copy of Certificate of Creditable Coverage **OR** Copy of Termination Letter from existing/prior Insurance Company If these are not available make outbound call to applicant and ask them provide the carrier information, name, and number and member info. Then contact the prior carrier and verify loss of coverage.
Exhaustion of COBRA	Certificate of Creditable Coverage **and/or** COBRA Termination of Coverage Letter from Insurer (proof of prior health care coverage) from existing/prior Insurance Company
Ineligible for Basic/Catastrophic Plan	Copy of Termination Letter from existing/prior Insurance Company If these are not available make outbound call to applicant and ask them provide the carrier information, name, and number and member info. Then contact the prior carrier and verify loss of

Qualifying Life Event List	Documentation Needed
	coverage.
Loss of employer sponsored health insurance as a results of Employer terminating group Coverage- Applicant is one of the owners	Termination of coverage letter on Business Letter head, indicates group plan # , and indicates date of termination
Loss of employer sponsored health insurance, as a result of termination of employment Either voluntary or involuntary (i.e. quit v. fired/lay-off/reduction in-force)	Copy of Certificate of Creditable Coverage **OR** Copy of Termination Letter from existing/prior Insurance Company
No Longer Active Military	Copy of Military Discharge papers
No Longer eligible for CHIP, Medicaid, PCIP (Federal High Risk Pool) and/or State High Risk Pool & Tricare	Certificate of Creditable Coverage (proof of prior health care coverage) **OR** Termination Letter from existing/prior Insurance Company and/or State Agency. If these are not available make outbound call to applicant and ask them provide the carrier information, name, and number and member info. Then contact the prior carrier and verify loss of coverage.
No longer meets definition of dependent due to age	Termination of Coverage Letter from existing/prior Insurance Company indicating dependent is no longer an eligible dependent
Spouse's death leaves applicant without coverage under his/her plan	Copy of Certificate of Creditable Coverage **OR** Copy of Termination Letter from existing/prior Insurance Company. If these are not available make outbound call to applicant and ask them provide the carrier information, name, and number and member info. Then contact the prior carrier and verify loss of coverage.

Qualifying Life Event List	Documentation Needed
Spouse's employment ends as does coverage under his/her employer's plan	Copy of Certificate of Creditable Coverage **OR** Copy of Termination Letter from existing/prior Insurance Company If these are not available make outbound call to applicant and ask them provide the carrier information, name, and number and member info. Then contact the prior carrier and verify loss of coverage.
Employment ends as well as coverage under employer's plan for applicant and/or dependents'	Copy of Certificate of Creditable Coverage **OR** Copy of Termination Letter from existing/prior Insurance Company If these are not available make outbound call to applicant and ask them provide the carrier information, name, and number and member info. Then contact the prior carrier and verify loss of coverage.