Center on Budget and Policy Priorities

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February 1, 2016

CMS, Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development,
Attention: Document Identifier, CMS–10440
Room C4–26– 05,
7500 Security Boulevard
Baltimore, Maryland 21244–1850

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 changes to the online and paper applications used to determine eligibility and enroll individuals in the Marketplace, premium tax credits, Medicaid and the Children's Health Insurance Program.

Well-designed applications are vital to achieving enrollment goals. 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. In key places we have identified concerns that the questions asked and logic in the application may not be correctly implementing policy. We have identified those sections by using bold print.

We appreciate the attention the Centers for Medicare and Medicaid Services has 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 online and paper applications.

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

Sincerely,

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List of Items in the Electronic Application to Support Eligibility Determinations for Enrollment through the Health Insurance Marketplace and for Medicaid and the Children's Health Insurance Program

I. Marketplace account

Individuals can take certain steps online before completing identity authentication and can submit applications over the telephone without completing identity authentication. However, to complete most steps online including submitting applications, selecting plans, renewing coverage, viewing notices, and reporting life changes, consumers must first complete the remote identity proofing (RIDP) process. Certain consumers including young people, people who have been victims of identity theft and families that include immigrants may be delayed or unable to complete this step in the application process. We provide a summary of recommendations below that are taken from our paper on the remote identity proofing process.[1]

- Allow all applicants to submit online applications before completing RIDP. Online applications could be revised to give applicants who cannot complete RIDP the option to submit applications without having information about their identity checked by federal data sources in "real time" (that is, while they complete the online application). The information in the online application would then be checked against trusted data sources after the application is submitted and the results would be delivered by mail, similar to the paper application process.
- Eliminate unnecessary steps in the process. Certain individuals, such as victims of identity theft and people with insufficient credit histories to generate RIDP questions, are required to try to complete RIDP steps online and by phone even when they clearly cannot complete them. Online applications could instead allow these individuals to upload or mail identity documents immediately, without first having to fail the phone step.
- Use documents sent in to verify citizenship or immigration status to clear the identity authentication requirement.
- Expand the list of acceptable identity documents. Applicants whose identity is not confirmed online or by phone must submit specific identity documents to prove identity. Expanding the list of acceptable documents would reduce the barrier that this documentation step can present.
- Prevent the RIDP process from causing applicants to miss enrollment deadlines. Eligible individuals can enroll in Marketplace coverage only during certain open enrollment periods or after a change in their personal circumstances that allows them a special enrollment period. Application processes should be modified to extend the open and special enrollment periods for those who encounter RIDP-related barriers that delay an eligibility determination.

A. Create an account: Since the start of the first open enrollment period, assisters and consumers have raised concerns regarding the requirement to provide an email address in order to create an account. It is our understanding that email addresses are required for

[1] Center on Budget and Policy Priorities and Social Interest Solutions. "Remote Identity Proofing Process: Impacts on Access to Health Insurance." January 7, 2016. Accessed on: http://www.cbpp.org/research/remote-identity-proofing-impacts-on-access-to-health-insurance

healthcare.gov accounts because they are used to re-set passwords that may have been forgotten. Some consumers do not have an email address and some only use email occasionally. Many consumers create email addresses for the sole purpose of completing an online healthcare.gov application. This becomes problematic when the consumer attempts to re-enroll in coverage or otherwise wants to report life changes online. While steps were taken during the third open enrollment season that allowed consumers to change the email used for their online account, this process is time consuming for the Marketplace call center, consumers and assisters. We recommend that consumers be given the option to use mobile telephone numbers in place of email addresses. Many consumers use text messages regularly even if they do not use email. Many companies like credit card companies and banks allow consumers who have forgotten their passwords to use text messages to get links and/or passcodes that allow them to re-set their passwords.

B. Transition to a full account: In addition to our concerns and recommendations about the RIDP process, we think consumers should be provided guidance as to who can complete this section of the application. If it must be an adult in the household of an applicant for health coverage, then that information should be provided. We are also concerned that a social security number is requested at this point in the application without providing sufficient information to the consumer about how it will be used and who must provide one, as required under the Privacy Act. That information should be provided to the consumer when the SSN request is made. Moreover, even when the SSN is provided at this point in the application, the individual providing the SSN may still be asked to provide a SSN at least two other times. Many consumers are hesitant to provide SSNs at all (especially in an electronic environment) and some consumers may think they don't have to provide their SSN later in the application because they already provided it. Once collected, SSNs should be filled in throughout the application rather than requiring consumers to input their SSNs multiple times.

D. Report a life change: We recommend you modify the list of life change examples accordingly:

- You moved to a new location
- You lost your job, got a new job
- Your income changed
- You gained access to health coverage from another source such as Medicaid, Medicare or an employer.
- You or one of your dependents turned 26
- You had family changes, like a new baby or a divorce (Additionally, we think a link or help text should describe additional examples, such as death in the tax family or tax dependent no longer being a tax dependent.)

Under c, we recommend changing the language to:
Report a change in my household's employment, income, size, access to coverage outside of the Marketplace or other information *(If selected, the user is taken back to their application to make changes, starting at section II ["Privacy."])*

III. Get started

A. Contact preferences: The application allows consumers to select email or text messages as ways to receive notices that information is available for them to view in their online accounts. If consumers who have not successfully completed RIDP can't actually view notices in their online accounts, these questions should not appear for them. Also, as noted earlier, some consumers only create email accounts for the purpose of creating a healthcare.gov account and others do not use email regularly. Help text should be included that explains that people who select email as their communication preference will not get important Marketplace documents mailed to them and that they should only select email if they regularly check their email accounts.

The application currently only asks for the preferred written and spoken language of the household contact. We believe this information should be collected for tax filers and any other adults who may need to be contacted. This should continue to be an optional field, but individuals should be encouraged to provide this information to facilitate access to language services. We also think HHS should take steps to better utilize this information. Currently, Marketplace written materials are only provided to consumers in English and Spanish. The Marketplace is falling short in complying with longstanding language access requirements and steps should be immediately taken so that most Marketplace consumers who have limited English proficiency have access to all important documents in the language they select as their preference.

V. Help paying for coverage

C. **Income screener (Get help with costs) optional**

Item 1: The first question asks how many people are on the applicant's federal tax return "this year." It's unclear what is meant by "this year." For an applicant who will apply in December 2016 for 2017 coverage, is it the most recently filed tax return (for 2015), a projection of the tax return that will be filed for 2016, or a projection of the 2017 tax return. While the question is merely for screening and not used to determine eligibility, it should be more specific.

VII. Tell us about each person

B. **Citizenship/immigration status**: Problems with how healthcare.gov determines eligibility based on immigration status have kept substantial numbers of lawfully present poor immigrants from enrolling in Marketplace coverage even though they are eligible for large subsidies. Those affected are lawfully present people in the United States who are not eligible for Medicaid because they don't meet Medicaid eligibility rules related to immigration status. These individuals are eligible for subsidies and coverage through the Marketplace, but many have been shut out or had their coverage delayed due to problems in how their applications are processed.

Healthcare.gov does not collect precise information about applicants' immigration status. Instead, it asks consumers if they have an eligible immigration status and provides them a reference list that includes all statuses considered to be lawfully present for purposes of making an eligibility determination for Marketplace coverage. Then consumers are asked to

provide numbers from their documents that can be used to prove their immigration status by running a data check with information contained in the Department of Homeland Security's files. If this data check can immediately verify a consumer's immigration status, the correct eligibility determination will be made. If not, consumers with income in the applicable Medicaid range will be assessed or determined eligible for Medicaid and the Medicaid agency is responsible for asking the consumer to provide documentation of their immigration status.

Those ultimately determined lawfully present but ineligible for Medicaid based on their status, are sent back to the Marketplace to provide additional information and to get a new eligibility determination. This back and forth between agencies can take a long time and consumers can easily get confused or deterred from completing the process.

To address this problem, we urge you to change the application questions so that those whose immigration status is not verified instantly are asked additional questions so that they can attest to a more specific status. You can do this by including a new optional question that would ask for more specific information about an applicant's immigrant status, such as: "Select [insert applicant's name]'s immigration status from the list below." The drop-down list would include a full list of immigration statuses considered lawfully present under the ACA. The list would not be truncated — for example, it would list all non-immigrant visas. It would also have to include the options: "I don't know" and "other eligible immigration status." Also a new question would need to be added to better rule out that a consumer is not exempt from the five-year bar. Because immigration statuses are complicated and are at times referred to by different labels, we recommend you seek out stakeholder input in creating the list and new five-year bar question and that you complete consumer testing of the list to ensure consumers know how to correctly identify their status.

C. Family & Household

Item 1: The applicant is asked if he plans to file a federal income tax return for the coverage year and is then told that "you'll need to file next year if you want to get a premium tax credit to help pay for coverage now." We suggest changing "next year" to "for the year you get coverage" or alternatively use the coverage year, i.e. 2017. "Next year" is confusing especially if someone is applying during November or December prior to the coverage year.

Item 2: Applicants are asked if they are married only if no other applicant is listed as a spouse or a domestic partner in a previous section. However, people often misunderstand the term "domestic partner," which is not equivalent to "spouse" for the purpose of filing a tax return. Also a person could have a "domestic partner" but also be married to someone else. A person who lists someone else as a domestic partner should still be asked if they are married.

Item 4: The application continues to rely on workarounds for the exceptions to the joint filing requirement and still fails to disclose these rules to applicants. This can be remedied by adding a question to this section between current items 4 and 5.

4. Does [household contact] live with his/her spouse?

a. Yes
b. No (go to 4.1)

4.1. Do any of the following apply to you?
a. I will live apart from my spouse July 1 to December 31 of [coverage year], will claim a dependent child, and will qualify to file as head of household. (link to Publication 501)
b. I am married but will live and file taxes separately from my spouse for [coverage year] because I am a domestic violence survivor.
c. I am married but will live and file taxes separately from my spouse for [coverage year] because I cannot locate my spouse.
d. None of these apply. I will file taxes separately from my spouse.

Selecting *a-c* would qualify someone for APTC and answering *d* would indicate ineligibility for APTC. While it's not a perfect tool, it is much more transparent to ask the questions outright than to continue to rely on workarounds that require applicants to falsely answer the marriage question.

Item 6: The question asks if a person will be claimed as a dependent, but instead should ask if a person *could* be claimed as a dependent on someone else's tax return. In some cases assisters are reporting that people who can be dependents are applying independently when another taxpayer agrees not to claim them. This is impermissible, from a tax perspective. A person cannot file and claim their own exemption if someone else could claim them, even if that person does not claim them.

Items 7-14: In general, more care should be taken to ensure that dependents are not enrolling in APTC without the taxpayer's involvement or consent. These questions ask for the name and date of birth of the taxpayer, but do not solicit contact information. The taxpayer is presumably not involved in the eligibility and enrollment decision yet will be on the hook for potentially thousands of dollars in APTC. While Medicaid/CHIP enrollment shouldn't require consent of the taxpayer, the taxpayer should be brought into the discussion about receipt of APTC.

Items 15-17: In determining the household for non-filers, MAGI rules apply different rules based on whether the applicant is under 19 years old. The application uses 21 years old, which is incorrect. States do have the option of extending that age limit to 21 years old but the individual must be a full-time student. It seems that the application also fails to collect the information to determine the individual's status as a student.

D. Parent/caretaker relatives

Item 1: We assume that this question is intended to identify whether an applicant is the "caretaker relative" of a child. However, it is our understanding that the question is asked of all adults including parents, and confuses parents who are both in the home, because they don't know who'll be the "main person." We suggest that this question only be asked of non-parent adults in households with children when no parents are present. We also suggest that the question be reworded to ask whether the applicant has "primary responsibility" for taking care of the child, because "main person" is confusing.

E. Other addresses: We support collecting addresses for all applicants and not assuming that they have the same address as the household contact, so that eligibility can be determined for the appropriate state. There are a number of instances where members of the same household do not live together, such as when a student attends college and resides in another state.

F. Race & ethnicity: The collection of accurate information about race/ethnicity is critical to being able to track disparities in health access. In order for this information to be useable it must be collected in a manner that most people will be inclined to answer and will understand how to answer. There also must be consistency in methods used in data collection. The ethnicity-related questions are confusing to many Latinos in the traditional application (which is described in this PRA). The first question 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.

The alternative/simplified application, that is not described in this PRA, does not include any information to encourage consumer to identify their race/ethnicity. This application also provides different choices for how consumers can identify themselves. It's important to have consistency between the applications to be able to use the data collected about consumers.

Section VIII – More about this household

Items 1 and 2: We recommend including text encouraging people to answer these questions if they want the state Medicaid agency to assess them for Medicaid eligibility based on disability, which could entitle them to a benefit package that may better fit their needs. The application needs to convey that applicants have the right to request this determination, and that answering the disability screening question can affect the benefits package they are entitled to receive under Medicaid.

Items 3: We support using the question in item 3 as a workaround to get the correct eligibility determination for certain lawfully present immigrants who are ineligible for Medicaid based on their immigration status. However, we think this process is imperfect. We provide recommendations to modify the application in our comments on section VII of this PRA. While these questions remain in use, we think it's important to note that some consumers may not get notices from their state Medicaid or CHIP agencies that clearly specify the reason they are ineligible. Furthermore, in answering the first part of this question that is not specific to immigration status ineligibility, consumers may answer yes to this question if they had been recently denied Medicaid or CHIP eligibility due to a procedural reason such as failing to complete the renewal process. We recommend modifying the language to read:

> "In the last 90 days, were any of these people denied Medicaid or the Children's Health Insurance Program (CHIP) coverage because they did not meet one or more of the program eligibility requirements (don't answer yes if the person was denied eligibility for not completing the eligibility process)?"

Item 6: The instructions should state that the item be displayed if applicant aged 18-22 was selected in *item 5*, not item 4.

Item 7: The instructions need to be modified to also display item if response to item 5 was "b," "c," or "d."

Item 9: The application should also provide more information on what it means to indicate pregnancy, especially for women who are already enrolled in a QHP. Currently, Healthcare.gov is not correctly implementing the policy allowing pregnant QHP enrollees who become eligible for pregnancy-related Medicaid the choice of maintaining their QHP coverage with APTC or enrolling in Medicaid. Once Healthcare.gov has determined that a pregnant woman is within the income eligibility range for Medicaid, it will send the woman's file to Medicaid and terminate her APTC. As a workaround, to continue receiving APTC, the pregnant woman would have to skip the question and not report a change to the Marketplace.

Women who are enrolled in a QHP should be informed that reporting their pregnancy may make them eligible for Medicaid pregnant women coverage. The information should also state that if they are eligible for Medicaid, they have the choice to enroll in Medicaid or keep their current QHP coverage. Women who want to keep their QHP coverage should be instructed to NOT answer the pregnancy questions.

We recommend including the following explanatory text:

> *Answering "yes" to the question "Are any of these people pregnant" means that we will check your eligibility for Medicaid pregnancy coverage.*
>
> ***For new applicants**:*
> *A new applicant who is pregnant should answer "yes." Pregnant applicants are checked for eligibility for Medicaid pregnancy coverage.*
>
> ***For current enrollees:***
> *Women who are currently enrolled in a Marketplace plan do not have to report a pregnancy. If you are enrolled in a Marketplace plan, you should only report a pregnancy if you want to be checked for Medicaid pregnancy coverage. Medicaid coverage for pregnant women has no premiums, copayments or deductibles. You should skip the question if you want to stay in your current plan.*

IX. Income

At the beginning of this section, it would be helpful to orient applicants by reminding them that the application is seeking information about income for two time periods: income for the current month and income for the year 2017.

Item 3: Some of these income items need on-screen explanations to assist people in identifying income that falls into each category. Help text that requires a "hover" is insufficient in some cases, as is relying on additional detail in future questions, since most people will not click on an item unless they can relate the general category to their income. For example, most young people will

ignore the Retirement income option (and any help text associated with it) because they don't understand that "cashing out" an employer-sponsored retirement plan upon leaving a job creates taxable lump sum income. Identifying and predicting lump sum income has been problematic so a special effort should be made to target the sources of lump sum income.

We recommend re-ordering the list to put the most common types of income first. Otherwise, important categories of income can be missed. For instance, unemployment should be moved up and rental and royalty income should move down.

We recommend this revision:

a. Job
b. Unemployment
c. Self-employment, including cash income
d. Retirement, including distributions from 401(k), 403(b), and IRAs. Also include retirement savings that are "cashed out" when leaving a job, even if you are not retired.
e. Pension from an employer
f. Social security benefits
g. Alimony received
h. Capital gains
i. Investment income, including bank interest and dividends
j. Rental or royalty income
k. Farming or fishing income
l. Other income, such as jury duty pay, canceled debts, and gambling winnings.

For each individual income item, consider adding its line number on the 1040. This would help people identify under which general heading their income belongs and would point to the 1040 instructions as a resource.

Item 4: This item may be confusing. It asks for one employer's name, but then asks about "regular pay from all jobs," which implies income from other employers. Also question B asks the applicant to combine regular pay and bonuses, making it difficult to give a clear answer to the next question about frequency. We recommend changing Question B so it only asks for regular pay from one job and its frequency. A subsequent question should ask about bonuses or other one-time amounts or income from other jobs.

Item 5: This must clarify what is meant by "retirement accounts." For the person who isn't retired, they will not understand their cashed-out benefit after leaving a job to be "retirement." List the types of accounts that are considered "retirement."

Item 7: To solicit accurate answers, the item related to self-employment should be broken down into multiple questions. Question 1 should ask for total revenue or earnings, and Question 2 should ask for the allowable expenses, with some examples of allowable expenses provided (e.g., the cost of tools, supplies, licenses, advertising, non-commuting transportation expenses that you will log and report on your taxes). The net amount should be displayed and confirmed by the applicant.

It would also help to give people the opportunity to answer in terms other than monthly income, since many self-employed people have income that varies by season or even by month. As in the question about income from a job, the applicant should have the opportunity to describe the

frequency. Asking about variable income in Items 23 through 25 is insufficient; it's easier and more convenient to get clear self-employment information here.

In addition, help text should contain a link to the IRS Schedule C instructions.

Item 10: Specify that Social Security Disability Insurance benefits should be reported.

Item 16: Question (c) asks if any income reported as "other income" is from a scholarship or grant used to pay educational expenses. The amount is asked presumably to subtract this amount from reported income. However, no question was ever asked about reporting scholarship income and grants are treated differently than scholarships under the Internal Revenue Code. Furthermore, the tax rules regarding scholarship income are complicated and sometimes allow the taxpayer to make choices about its inclusion as taxable income versus excluding it from income entirely. Consider adding a drop-down option on Item 15: "Scholarship income received that is NOT applied to tuition or other allowable education expenses." Or use these questions to solicit only scholarship that will be claimed as taxable income.

Items 17 and 18: The use of the term deduction is unnecessary and potentially confusing. These two items can be combined to make a simpler question asking whether someone pays alimony or student loan interest. Give some indication of what might qualify as "Other" or reference a tax publication.

X. Discrepancies

The instructions for Items 1-6 refer item 10 in this section but no Item 10 is listed.

In general, the questions for this section are reasonable and on-point. However, it's unclear whether the answers will be used to resolve or prevent inconsistencies. Information collected from the applicant at this stage should be used as an alternate form of verification and avoid a data-matching issue. For example, if an applicant answers yes to item 3 confirming that his hours of employment have been reduced, this should be a sufficient explanation as to why his earnings have gone down.

XI. APTC program

A. Tax filer & other information (APTC eligible)

Item 1: The phrasing of this item is awkward. It's not really true that a person can do one of three things related to filing – it implies that a taxpayer could file jointly or not. The last two sentences are also not clear. Rather than redirecting them to another place in the application, repeat here the question about intent to file a tax return.

Sample simplification:

> To get help paying for health coverage, the people listed below must either file a tax return or be listed as a dependent on a tax return for [coverage year]. Will everyone listed here either file a tax return or be claimed as a dependent on a tax return?

Yes, I will file a tax return if I receive help paying for health insurance.

No, I will not file a tax return. This makes me ineligible for help paying for health insurance but does not affect my ability to receive Medicaid, if eligible.

A subsequent question is necessary to determine whether some people in the household, but not others, will file. It would be helpful to have some instruction on how to make someone a non-applicant, if necessary.

Item 2: Rephrasing and/or help text are essential here because there are several exceptions and special rules related to the joint filing requirement that the average applicant has no way of understanding. Keep the first sentence of the Item regarding joint filing then add: "Married taxpayers are not required to file jointly if they qualify as head of household (hyperlink to IRS Publication 501) or if they will file separately from their spouse due to domestic abuse or abandonment (hyperlink to definition)."

Rather than directing a customer to go back, it would again be easier to restate the question here.

Item 3: Several of these relationships need to be defined in Help Text, e.g. guardian/ward, sponsored dependent, collateral dependent and dependent of a minor dependent. The rest of the application uses the tax definitions of terms like "dependent," so the shift to non-tax terms is confusing and there is no guidance to help an applicant understand if any of these terms apply.

B. Health coverage (APTC eligible)

Item 1: For CHIP and Medicare, applicants shouldn't check the box if they are in programs that require the payment of unsubsidized premiums and are still eligible for PTC. If any state using the FFM has such a CHIP buy-in program, help text should appear for that state (only). To minimize confusion, the Medicare full premium option needs explanation to the effect of: "Don't check this box for Medicare if you pay the full, unsubsidized premium for Part A ($407/month). This might be the case if you or your spouse did not pay Medicare taxes for at least 10 years."

C. Employer health coverage (APTC eligible)

Items 1, 2 and 3: Item 1 has been improved by clarifying that a person should answer Yes if they could have enrolled in employer-sponsored coverage but did not. **Delete the reference to eligibility for insurance through a parent or guardian, since insurance eligibility only bars a person from APTC if they are a tax dependent.** This can be corrected through the system logic so the question about a parent's insurance is asked based on the person's status as a dependent, not based solely on age.

Item 11: If someone confirms they are enrolled in COBRA coverage, the application should ask when the coverage ends, in case it's imminent. While subsequent enrollment may need to be through a special enrollment period at some point in the future, it would be useful to collect this information since so much of the application has been completed by this point.

D. Employer health coverage detail: In general, this section needs clearer instructions to the applicant and an explanation of why this information is important. The instructions indicate that it's necessary to print out the Employer Coverage Tool and have it completed by the employer. It should be made clear that a person who leaves the application can return later to complete it without needing to reenter prior information. Also give an instruction for applicants whose employer will not complete an Employer Coverage Tool. Finally, tell applicants why the information is important, so they are not tempted to guess. Use a message such as: "In general, an offer of coverage from an employer will make you ineligible for help paying for health insurance unless the coverage is determined to be unaffordable or less than minimum value. Information from the Employer Coverage Tool will allow the Marketplace to make a determination about your eligibility. The information you provide may be verified by your employer."

Item 1: Move the caveat in Item 2 to Item 1. ("Most plans offered by employers meet the minimum value standard.")

Item 2: Clarify "self-only" plan and try to break down the requirements. For example: "We need more information about the cost of health plans offered by [employer] to FNLNS. Identify the lowest-cost minimum value plan that [employee] (only) could have enrolled in, just for himself/herself. Do not use the cost of family coverage."

G. Special Enrollment Periods: All of the questions are labeled "optional", but if a person doesn't answer the question, it is assumed that "None of these people" is selected. We suggest that the consequences of not making a selection be made clearer.

Item 1: We recommend that this question include help text so consumers understand the intent. Suggested help text: "This means you lost access to another source of coverage and did not voluntarily drop coverage. For example, this includes quitting or being fired from a job where you had health coverage. It also includes no longer being eligible for other coverage you were enrolled in, such as Medicaid or a student health plan. It does not include cases when you stopped paying premiums for a non-group health plan or qualified health plan or when an insurer terminated your coverage because you failed to make premium payments that you owed. See a full list of examples of what qualifies as a loss of health coverage [link to a list]."
List of loss of MEC examples:

- Loss of eligibility for employer coverage (e.g., loss of a job, voluntarily quitting a job, or a reduction in work hours that causes loss of availability of employer-sponsored plan)
- Loss of Medicaid or CHIP eligibility (including loss of pregnancy-related and medically needy Medicaid)
- Expiration of COBRA
- Cancellation or expiration of non-group plan
- Loss of eligibility for student health plan
- Divorce or legal separation resulting in loss of coverage
- Cessation of dependent status
- Death (i.e., of another person in the family) resulting in loss of coverage
- Decertification of current Marketplace coverage
- No longer living, working, or residing in the area of the plan

- Termination of employer contributions to employee's health coverage
- Newly eligible for the premium tax credit due to discontinuation or change to employer-sponsored plan resulting in plan no longer being considered

Item 11: In the current application there is help text relating to when an enrolled person is moving out of state, and a resource link describing what steps a consumer should take if they are planning to move out of state (link here: https://www.healthcare.gov/help/what-to-do-if-you-move-out-of-state/). We recommend that this link remain in the application because it can help flag the need to sign up in a different state's marketplace. However, we note that, depending on the timing of the application and the future move, it may be that the person should consider signing up for coverage in the current location to avoid coverage gaps.

Also, since this special enrollment period is supposed to be available prospectively beginning in 2017 so that people can set up coverage prior to a move, there should be a question about whether a person is planning to move in the next 60 days, with follow up questions similar to the logic when someone is losing minimum essential coverage at a future date. This would better elicit accurate information about the future move.

Item 12: This question asks for the previous zip code of a consumer, but some people who move within the same zip code may still qualify for new health plans in the new coverage area, making them eligible for the "permanent move" special enrollment period. If a consumer enters the same zip code as his current address, this should not automatically bar the person from receiving an SEP. Also, the updated application should ensure that the applicant can enter a foreign address as the pre-move address and that this situation triggers a "permanent move" SEP.

Furthermore, individuals reporting a permanent move in advance may not know their future address (within or out of state), but federal regulations permit individuals without a permanent address to enroll in coverage through the marketplace (assuming other eligibility conditions are met). The application should provide guidance for these individuals on what address to use at the beginning of the application (Attachment A, Sections I. B. and I. D and the corresponding sections of the paper applications).

Item 16: This question is labeled "optional." If a person skips this question, but he did receive premium tax credits in the previous year, will the system assume he did not reconcile the premium tax credit in the previous tax year, thereby affecting his eligibility for subsidies in the coming year? The intent of this question, and when a consumer should to answer it, needs to be clearer.

Section XII – Medicaid & CHIP specific questions

Item 2: The reference in the instructions for choice "a" should be to Section XI (not Section XII). In addition, choice "e" on employer coverage is redundant. A person who has employer coverage would have already stated that in Section XI, subsection C, and the response to it would be displayed in "a" of this item. We recommend deleting choice "e" from the list.

XIII. Review & sign

A. Review application: The information consumers review should be made available in a pdf and consumers should be encouraged to download and/or print the information and keep it with their records. This information should also be stored in their healthcare.gov account in a pdf, so they don't have to page through the application to review the information they have presented. The complete application should be paired in the account with the resulting EDN.

B. Sign & submit: We don't have comments on the statements in the PRA. However, it appears at least one additional attestation is required in the current application, to the effect of: "Do you understand that if you were eligible for Medicaid but received APTC/subsidy instead you will be required to pay your entire subsidy back." This is both misleading and untrue. It is misleading because it seems to disclaim any responsibility for the accuracy of the APTC-eligibility determination. Under what circumstances could a person be eligible for Medicaid but enrolled in PTC? Is this attestation intended to address false statements regarding income? (Presumably the income verification process will detect that.) Or is it meant to urge people to report changes when their income changes? That is a separate attestation made elsewhere. It is untrue because a person who received APTC based on the Marketplace determination of eligibility but has year-end income below PTC eligibility levels is <u>not</u> required to repay APTC. Also, repayment caps apply in most cases so it is unlikely someone will need to pay their "entire" subsidy back. This language is intimidating to people who are being thoughtful and serious about their application and does not convey important aspects of the rules. The language that is currently in use should be removed or revised for accuracy.

Appendix A; Attachment 1: Additional electronic application questions

I. Before you get started:

Item 5: The answer options are confusing. They should be ordered Self, My Spouse (displayed only if 3b. is yes), My Dependents – How many? (then the applicant can fill in the blank for the number of dependents?

II. Questions about everyone

Item 2: Add a way to learn about exceptions to the joint filing rule. People who are married but answer No on Item 2 should be asked: "Some exceptions apply. People who qualify to file as head of household (link) or have been abused or abandoned by their spouse (link) are not required to file jointly to receive help paying for coverage. Do any of these exceptions apply?"

Item 4: **What is the significance of ages 18 to 22? A full-time student qualifies as a child for Medicaid up to age 21(at state option) and as a tax dependent up to age 24.**

A. Questions about people applying for coverage

Item 1: There should be a message included to reassure consumers who are not citizens that they may still qualify for Marketplace coverage.

Item 2: There should be a message included to reassure consumers who do not have SSNs that they may still qualify for Marketplace coverage.

Item 3: Many citizens are very confused and at times offended that the application asks here and within the application to identify themselves as naturalized or derived citizens. When these questions are asked, it would be helpful to note that there is no eligibility difference for these groups, it's just potentially a different way to verify their citizenship.

Attachment C Paper Application for Health Coverage & Help Paying Costs (Family Plus)

Page 1:

Use this application to see what coverage you qualify for: It's misleading to say that someone will qualify for a free or low-cost plan at the upper end of the eligibility spectrum. It's more accurate to say that someone may qualify for help paying for coverage.

Who can use this application?: We support that the application includes a welcoming message for families that include, immigrants. However, some consumers may misunderstand the current language: "Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage." The concern is that some consumers may read this to mean, immigrants aren't eligible, but their kids might be so it's okay to apply. We recommend modifying the language to read "Most immigrants qualify to enroll in Marketplace coverage (see appendix X for the full list of Marketplace eligible statuses). People who don't qualify for coverage may still apply on behalf of their children." Note: there is no current appendix that lists this information. Our recommendations strongly urge CMS to include a list in the final application.

What you may need to apply?: We recommend you change the language "Social Security Numbers (or document numbers for any eligible immigrants who need coverage)" to read: "Social Security Numbers for everyone in the household who has one," and you add another bullet that reads "Documents that are used to prove immigration status." Immigrants who are applying for coverage for themselves may also have SSNs and when they do, it's good for them to include those numbers in the application to help electronically verify their income.

Step 1: Tell us about yourself: The application currently only asks for the preferred written and spoken language of the household contact. We believe this information should be collected for tax filers and any other adults who may need to be contacted. This should continue to be an optional field, but individuals should be encouraged to provide this information to facilitate access to language services. We also think HHS should take steps to better utilize this information. Currently, Marketplace written materials are only provided to consumers in English and Spanish. The Marketplace is falling short in complying with longstanding language access requirements and steps should be immediately taken so that most Marketplace consumers who have limited English proficiency have access to all important documents in the language they select as their preference.

Step 2: Person 1

Item 7: Add a sentence indicating that in order to receive some types of help paying for coverage, you must agree to file a tax return.

Item 8: As noted in our comments to the electronic application, we recommend including more explanatory text about the consequences of answering the pregnancy question for women who are already enrolled in a QHP. We suggest including the following explanatory text and instructions:

> Answering "yes" will check your eligibility for Medicaid pregnancy coverage.
>
> Women enrolled in a Marketplace plan do not have to report a pregnancy. If you are enrolled in a Marketplace plan, you should only report a pregnancy if you want to be checked for Medicaid pregnancy coverage.

Item 12: Not all derived or naturalized citizens will have these numbers available to them. A message should be added conveying that they should provide this information if they have it but otherwise they will have the opportunity to submit some other type of proof of their status.

Item 13: Most consumers do not know what an "eligible immigration status" means. The application should include an appendix that can include information to help consumers complete this section of the application. We recommend that you include a comprehensive list of all statuses that are considered lawfully present under Marketplace rules. We recommend that when the consumer is asked to say if he has an eligible immigration status he be directed to look at the list in the appendix.

The 1996 question would be better understood by the consumer if it appeared immediately after he is asked whether or not he has an eligible immigration status. If this change is made, then to be clearer the question can be re-worded to read "If yes, have you lived in the U.S. since 1996?"

The way the document numbers are solicited is very confusing. A consumer may think he needs to provide all of these numbers, even though one consumer is not likely to have all of the numbers. The use of additional titles and explanation is needed to clarify.

We support that the paper application provides consumers the option to input their status type.

Item 19: Consumers should be provided the choices to identify themselves as Central or South American under the Latino/Hispanic ethnicity question.

Item 31: This is limited, according to the heading, to income a person will receive "this month." This discourages the reporting of other income, particularly lump sum income and can cause under-reporting of income. Also, provide a link to some resource to help people figure out what income is classified as "Retirement," etc.

Item 32: Reference a tax resource so people can determine their eligibility for other deductions.

Our comments for Step 2, Person 1 are applicable to what we want to change for Step 2, Person 2.

Step 2, Person 2: The instructions at the top indicate that only Line 1-11 should be completed "on this page." A person could easily misread the heading and fail to continue on to the second page of the application. Tell the applicant to continue to question 23.

Step 4: Your Family's health coverage

Item 1: This question is potentially misleading for new people who are newly claiming PTC. Also, there is no way to distinguish people who have never received PTC from those who received APTC and failed to reconcile.

Item 2: Again, this might be confusing to people who have never applied for Medicaid because the question is being asked in the negative ("found not eligible"). Answering No could either mean that they were found eligible or they didn't apply.

Appendix A
Providing employer contact information is optional in the online application but appears to be required here. The form should instruct the applicant about what to do if the employer is unwilling to complete this information.

Appendix D
As noted in our comments to the electronic application, the permanent move special enrollment period is supposed to be available prospectively beginning in 2017 so that people can set up coverage prior to a move. There should be a question about whether a person is planning to move in the next 60 days, with logical follow ups as to the date of the move and the location. This would also apply to someone with a prospective release from incarceration, so Item 3 should include questions related to a prospective release date.

Also noted in our comments to the electronic application, Item 6 asks for the previous zip code of a consumer, but some people who move within the same zip code may still qualify for new health plans in the new coverage area, making them eligible for the "permanent move" special enrollment period. If a consumer enters the same zip code as he or she's current address, this should not automatically bar the person from receiving an SEP. Also, the updated application should ensure that the applicant can enter a foreign address as the pre-move address and that this triggers a "permanent move" SEP.